

New Care Models Team
Department of Health
Room 229
Richmond House
London
SW1A 2NS

England

3 November 2017

Dear Sir/Madam

Accountable care models contract: proposed changes to regulations

The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

The Association welcomes the opportunity to respond to the consultation on proposed changes in regulations to implement the proposed Accountable Care Organisation (ACO) contract. However, given the potential scale of the changes local health systems will undergo in moving to an ACO model, we feel strongly that there is a need for much greater public consultation and debate beyond the narrow terms of this consultation.

The BMA has been calling for greater integration and collaboration between different parts of the health service, health and social care, as well as more integrated working across the medical profession and other clinicians, for a number of years. We believe that all new models of care should be clinically led, based upon consultation with all necessary stakeholders, and should ensure true collaboration between different sectors, based upon inter-organisational partnerships. We are supportive of NHS England's intentions for improved integration of care across organisations, however we have concerns around the proposals for ACOs (particularly the partially and fully integrated models).

With respect to the ACO contract, we do not believe that new contractual models are required to achieve the stated aim of service integration and that the same outcomes can be achieved using existing frameworks, for example Accountable Care Systems which have the foundations of allowing collaboration/integration with local agreements. We believe there needs to be a system-wide evaluation of the existing Vanguard sites, as well as a comprehensive impact assessment of ACO proposals before any amendments should be made to all for ACOs.

The following are the BMA's main concerns about the development of ACOs which we believe need urgent public debate:

1. Combining multiple services into one contract risks the potential for non-NHS providers taking over the provision of care for entire health economies, as the contract would be subject to open competition rules. Moreover, a single ten-year contract would force re-procurement each time and create significant uncertainty. The BMA strongly supports the ongoing provision of a publicly funded and publicly provided NHS, and calls for the government to clarify what safeguards will be in place to ensure that ACOs do not enable an increase in the role of independent sector providers in the NHS.

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Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.



2. Moving to a fully integrated ACO would also entail radically altering the current model of general practice and would be incompatible with GP independent contractor status. The national GMS contract underpins fair and consistent health service delivery in England, enabling GPs to act as independent advocates for their patients and local communities. The deterioration of the independent contractor status risks losing this, and breaking the personal relationship between local communities and GPs.
3. There is a lack of clarity regarding how implementation of ACOs would affect patient care in border areas with Wales and Scotland (where care might be provided by a GP practice in another country with different arrangements and/or patients are referred across country borders) – this requires significant consideration to ensure patient safety is not compromised.
4. There is a lack of clarity regarding how staff would be employed within an ACO – the BMA asserts that all doctors within ACOs should be employed on national terms and conditions.
5. Moving to any new model of care will require significant time and investment. The success of this process will be severely hampered without such resources, particularly if action is not taken to address the current NHS funding crisis and pressures on services.
6. Genuine engagement with all NHS staff is essential for any service redesign. It is therefore vital that NHS England and the Department of Health fully engages with doctors and patients regarding the formation of new integrated providers. The ACO proposals emerged out of MCP (multi-speciality community provider) contract development, which involved some engagement with primary care. However, it is vital that this engagement is broadened to include all areas of the health system, including secondary care.

NHS England and the Department of Health must invite full and proper scrutiny of the current proposals, with maximum transparency. We do not believe that the current consultation process, based on the narrow technical legal aspects of required regulatory changes, properly allows this. Furthermore, it is important to note that ACOs sit outside of the current legislative framework, so accountability still ultimately rests with CCGs and other statutory bodies. The scale of change that the partially and fully integrated ACOs may entail should require that the proposals undergo proper parliamentary scrutiny.

We have responded to the individual regulatory points in the consultation, but the limited remit does not allow for wider concerns to be expressed. Our response should not necessarily, therefore, be seen as indicative of our wider position on the proposals. We would strongly encourage greater consultation on the wider policy aspects and potential impact of the proposals to allow for the views of patients and doctors to be fully considered.

We hope that our enclosed submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely



Raj Jethwa
Director of Policy

1. National Health Service (General Medical Services Contracts) Regulations

Q1a: Do you agree that the proposed amendments to the National Health Service (General Medical Services Contracts) Regulations deliver the policy objective as set out in the consultation document?

The proposed amendments would make suspension and reactivation of a GMS contract technically possible, however we continue to have concerns regarding some of the policy contained within the proposals.

- The length of notice period for suspending a GMS contract is not appropriate and should be for a three-month period.
- The length of notice period for reactivation of a GMS contract is not appropriate and should be much shorter than the 12-month period proposed; we would suggest a three-month period would be sufficient and would be consistent with the notice period for suspending such a contract.
- The decision-making processes relating to reactivating a GMS contract are not appropriate. The practice should go through their standard decision-making processes (prescribed within the individual partnership agreement) rather than a requirement for unanimous agreement of all partners to the GMS contract;
- The treatment of patient lists when reactivating a GMS contract is not appropriate. Whenever a GMS contract is reactivated, the default should always be for patients to return to the GMS practice, unless a direct request is made to remain with the ACO;
- Additional burdens on practices are not appropriate (eg the requirement for the GMS practice to write to all patients in addition to the Commissioner).

While we have raised these concerns as part of this consultation, they should also be taken up by the Department of Health and NHS England in detail via the additional formal consultation processes for amendment of the GMS Regulations. Additionally, we believe that these amendments should be subject to negotiation through the annual GMS contract negotiations.

Q1b: If 'No', why?

N/A

Q1c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q1d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

2. National Health Service (Personal Medical Services Agreements) Regulations

Q2a: Do you agree that the proposed amendments to the National Health Service (Personal Medical Services Contracts) Regulations deliver the policy objective as set out in the consultation document?

The proposed amendments would make suspension and reactivation of a PMS contract technically possible, however we continue to have concerns regarding some of the policy contained within the proposals.

- The length of notice period for suspending a PMS contract is not appropriate and should be for a three-month period.
- The length of notice period for reactivation of a PMS contract is not appropriate and should be much shorter than the 12-month period; we would suggest a three-month period would be sufficient and would be consistent with the notice period for suspending such a contract.
- The decision-making processes relating to reactivating a PMS contract are not appropriate. The practice should go through their standard decision-making processes (prescribed within the individual partnership agreement) rather than a requirement for unanimous agreement of all partners to the PMS contract;
- The treatment of patient lists when reactivating a PMS contract is not appropriate. Whenever a PMS contract is reactivated, the default should always be for patients to return to the PMS practice, unless a direct request is made to remain with the ACO;
- Additional burdens on practices are not appropriate (eg the requirement for the PMS practice to write to all patients in addition to the Commissioner);
- The amendments do not permit the reactivation of a PMS contract where that contract would cease on a date before the second anniversary or each subsequent two years. This is not appropriate and suggests the suspension is valid for all elements of the contract apart from the validity date. For example, if a PMS contract is suspended with 18 months left, it should be permitted to be reactivated under the same terms as it was previously operating for that 18-month period.

Additionally, we believe that there should be an ability for a suspended PMS contract to be reactivated as a GMS contract, with the agreement of the practice and the commissioner.

While we have raised these concerns as part of this consultation, they should also be taken up by the Department of Health and NHS England in detail via the additional formal consultation processes for amendment of the PMS Regulations. Additionally, we believe that these amendments should be subject to negotiation through the annual GMS contract negotiations.

Q2b: If 'No', why?

N/A

Q2c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q2d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

3. Sale of Goodwill and Restrictions on Subcontracting Regulations 2004

Q3a: Do you agree that the proposed amendments to the Sale of Goodwill and Restrictions on Sub-contracting Regulations 2004 deliver the policy objective as set out in the consultation document?

Yes, the categories of performers and providers to whom the prohibition applies has been broadened to include a contractor who is an ISP provider, as intended in the consultation. However, we have two additional points which we believe need to be taken into consideration (See Q3d).

Q3b: If 'No', why?

N/A

Q3c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q3d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

The previous prohibition (at Regulation 3(1)(d) of the 2004 Regulations) was limited to medical practitioner with a registered patient list performing essential services during core hours, other than under arrangements to provide enhanced services, solely as a locum or both.

The amended regulations represent a significant broadening of these provisions, with the prohibition applying to subcontractors of any of the prohibited categories (GMS, PMS, APMS or ISP) who provide primary medical services, not just subcontractors of ISP providers. The intention should be for the provisions to apply to GMS, PMS or APMS contractors who are subcontracted by the ISP, and should not apply to subcontractors of GMS, PMS or APMS contracts.

Additionally, in relation to PMS contractors, the words "that has a registered patient list" have been removed, broadening the prohibition to all PMS contractors. Consideration should be given as to whether this will have any practical effect;

4. Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

Q4a: Do you agree that the proposed amendments to the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 deliver the policy objective as set out in the consultation document?

Yes, the proposed changes extend the application of current complaints requirements to ACO contractors. However, it should be noted that the requirement in Regulation 18 for responsible bodies to prepare an annual report is broadened from primary care or independent providers providing or agreeing to provide services under arrangements with a CCG or the NHS Commissioning Board to add primary care providers or independent providers under or pursuant to arrangements with an ACO or an NHS body. This broad reference to an NHS body does not appear to be necessary for the policy aim set out in the consultation and so should be removed.

Q4b: If 'No', why?

N/A

Q4c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q4d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

5. National Health Service (Charges for Drugs and Appliances) Regulations 2015

Q5a: Do you agree that the proposed amendments to the NHS (Charges for Drugs and Appliances) Regulations deliver the policy objective as set out in the consultation document?

Yes. The proposed amendments will broaden the application of the existing Regulations to cover all persons or partnerships providing primary medical services under section 83(2), including ACOs.

Q5b: If 'No', why?

N/A

Q5c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q5d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

6. NHS (Performers Lists) (England) Regulations 2013

Q6a: Do you agree that the proposed amendments to the NHS (Performers Lists) (England) Regulations deliver the policy objective as set out in the consultation document?

Yes. The proposed NHS (Performers List) (England) (Amendment) Regulations 2018 provide clear amendments which appear to meet the aims of the policy.

Q6b: If 'No', why?

N/A

Q6c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q6d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

7. Medical Profession (Responsible Officers) Regulations 2010

Q7a: Do you agree that the proposed amendments to the Medical Profession (Responsible Officers) Regulations deliver the policy objective as set out in the consultation document?

Draft amendments to these Regulations do not appear to be available on the consultation's website save for a Keeling Schedule which states that it only includes amendments to existing provisions in Regulations 1(2), 10(1) and Part 1 of the Schedule. It is therefore not possible to provide a fully considered view on the efficacy of the proposed amendments.

Q7b: If 'No', why?

N/A

Q7c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q7d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

The proposed insertion in Regulation 10(1)(aa) appears to be incomplete. The new paragraph refers to medical practitioners employed or engaged by or providing medical services for an ACO under or pursuant to an ISP contract held by the ACO or is engaged by or provides other specified health services under the ISP Contract Directions for or on behalf of an ACO, but does not specify who the designated body is in this situation. It is presumed that the designated body ought to be specified to be the ACO, given the insertion of an ACO into the designated bodies list in Part 1 of the Schedule.

8. National Health Service (Licence Exemptions, etc) Regulations 2013

Q8a: Do you agree that the proposed amendments to the National Health Service (Licence Exemptions, etc) Regulations 2013 deliver the policy objective as set out in the consultation document?

Yes, although the current amendments suggest a wider scope than just to allow for ACOs (see below).

Q8b: If 'No', why?

N/A

Q8c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q8d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

As worded these amendments will not just affect new ACOs but would appear to affect all new providers of NHS health care services and established providers who have a turnover of less than £10m and are currently exempt. Rather than simply considering whether turnover for a business year is less than £10m, the new provisions would require proactive consideration of likely turnover before the provider commences provision of services, and every month thereafter, indefinitely, rather than reactive assessment from accounts completed at the end of a business year. This would appear to impose a significant additional accounting burden (even if that provider does not intend to bid for an ACO contract), particularly within the first year of the establishment of a new provider until accounts are produced from which likely turnover can be assessed.

We are also uncertain how these amendments would work in practice since Monitor became subsumed within NHS Improvement. We would welcome clarification on the body holding regulatory responsibility for ACOs (Monitor or NHS Improvement).

We would also welcome additional information on the regulatory model for ACOs, as there is a lack of clarity on this matter.

9. The National Health Service (Travel Expenses and Remission of Charges) Regulations 2003

Q9a: Do you agree that the proposed amendments to The National Health Service (Travel Expenses and Remission of Charges) Regulations 2003 deliver the policy objective as set out in the consultation document?

Yes, these appear to represent straight forward extensions of the current regime to ACOs.

Q9b: If 'No', why?

N/A

Q9c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q9d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A

10. The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

Q10a: Do you agree that the proposed amendments to the The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 deliver the policy objective as set out in the consultation document?

Yes

Q10b: If 'No', why?

N/A

Q10c: Are any changes needed to ensure the proposed amendments deliver the policy objective?

N/A

Q10d: Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

N/A