Briefing
Accountable Care Organisations

Introduction

ACOs (Accountable Care Organisations) and ICSs (Integrated Care Systems – formerly known as ACSs (Accountable Care Systems)) are population-based models of care that integrate primary, secondary, community and other healthcare services. NHS England has described them as aiming to ‘dissolve the divides that exist between services provided by different parts of the health and care system, providing an integrated, holistic and person-centred model of care to a whole population’. Although ACOs and ICSs share similar aims, there are important distinctions between them. ACOs involve effectively merging existing providers of health and social care into one organisation governed by one long-term contract, whilst ICSs focus more on empowering providers to work together more closely within existing structures.

This briefing explains the different models and their development to date in more detail, sets out the BMA’s position and provides advice for members. The BMA is supportive of the principle of integrating health and social care services, and we have called for greater integration and collaboration between different parts of the health service and social care for several years. This includes our longstanding opposition to the internal market within the NHS in England and to the Health and Social Care Act 2012, which limits co-operation between NHS providers and commissioners.

However, we do not believe that NHS England’s current proposals for a new ACO contract are a viable means of delivering integrated care for patients in the context of a procurement framework that requires such contracts to be put out to competitive tender. We have several concerns regarding ACOs, including the lack of clarity and accountability surrounding their development thus far, the risk of privatisation they present, whether the Government will provide the level of NHS funding and investment required for them to work, and how they will ensure services are based on a foundation of strong primary care.
Background

Since the publication of NHS England’s *Five Year Forward View* in 2014, local areas have increasingly been encouraged to develop new approaches to the way they deliver healthcare, to better integrate services around patients and (implicitly) to find ways of providing care in the context of constrained financial resources. NHS England’s intention to develop ACOs and ICSs was set out in March 2017, in its *Next Steps on the Five Year Forward View*, which explained that ICSs and ACOs would build on a number of previous initiatives, most notably the ‘vanguard’ programme and the development of STPs (Sustainability and Transformation Partnerships).

NHS England view ICSs and ACOs as the next logical step for local health economies in England. NHS England has stated that it expects the most advanced STPs to evolve into ICSs and, in time, potentially into ACOs. Eight STPs and two areas with ‘devolution deals’ have been designated as ICSs, with more due to be announced during 2018. No ACOs have been established yet, and it has recently been reported that plans for an ACO in Dudley have been pushed back to 2019; Manchester is still planning to create one in 2018 although no ACO contracts will be awarded until NHS England’s consultation process has been completed.3 In August 2017, NHS England published a draft ACO contract to be used by commissioners when creating ACOs. It is due to be consulted on in 2018.

The term ‘accountable care’ is often associated with the development of insurance-based models of whole-system care in the United States, as well as developments in other systems such as the Canterbury model in New Zealand and the Alzira model in Spain. However, if they do go ahead in England, it is likely that they will have very different characteristics given key differences between the NHS and most other health systems.

ICSs (Integrated Care Systems)

ICSs, formerly known as ACSs,* (also described as ‘virtually integrated’ ACOs) involve local NHS organisations, potentially in partnership with local authorities, working together as an integrated system. The exact scope of services covered is likely to vary between areas, but it will include partnering with local GPs if they choose to do so. The ICS has collective responsibility for resources and population health in its area, with the intention of delivering better and more joined-up care for patients, with improved collaboration between staff in different organisations. ICS leaders will gain greater freedoms to manage the operational and financial performance of services in their area.

Providers would enter into an ‘alliance agreement’ with commissioning bodies, which would overlay (but not replace) regular commissioning processes and contracts. The alliance agreement would set out a shared commitment to achieving greater integration, including how resources will be managed together, how services will be delivered operationally, and what shared governance and risk-sharing arrangements will be put in place. NHS England has produced a template alliance agreement for use by commissioners, but this can be adapted based on individual provider or population needs. The agreement is owned by the providers and commissioners within it.

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*a Accountable Care Systems (ACSs) were formally renamed as Integrated Care Systems (ICSs) in NHS England and NHS Improvement’s new planning guidance *Refreshing NHS Plans for 2018/19* in February 2018. The change in name is cosmetic and no fundamental change in the underlying policy or approach to the model has been announced. The planning guidance also stated that the devolved health and social care systems in Greater Manchester and Surrey Heartlands will also be referred to as ICSs. Read the BMA’s briefing on the planning guidance [here](#).
ACPs (Accountable Care Partnerships)

There is limited information available regarding the role of ACPs within the NHS, but, as defined by The King’s Fund, an ACP is an alliance of NHS providers that agree to collaborate, rather than compete, to deliver care within an area. Providers involved in an ACP typically include hospitals, GPs, and community and mental health services, as well as social care and independent and third sector providers in some cases.

ACPs have been described as a less formal type of ACO in that they bring together organisations to provide services collaboratively, but without the formal contractual or organisational change associated with an ACO. ACPs do not, from the little detail available on their role, have the same degree of strategic or commissioning responsibility as an ICS, and will typically operate on a smaller scale than an ACO. There are several examples of multiple ACPs being formed within an ICS, with the ICS providing overall strategic and commissioning direction and the ACP focusing on frontline delivery. South Yorkshire and Bassetlaw ACS is reportedly developing five ACPs within its footprint and within Greater Manchester 10 LCOs (Local Care Organisations), a model considered to be synonymous with an ACP, are being formed. It should also be noted that collaborative arrangements, such as federations and super-partnerships, already exist across the country in primary care, and all practices are required to be part of a local primary care network by April 2019.

There is a significant lack of clarity regarding the position of ACPs within the wider accountable care structure and more information is needed about what their role is, at both a national and local level.

ACOs (Accountable Care Organisations)

An ACO is similar to an ICS, in that it brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. The key difference is that in an ACO there will be a single contract with a single organisation for the majority of health and care services in the area. The ACO contract holder could be a new organisation, or an existing organisation which would take the lead role within the ACO. It would be responsible for the provision of services but may not necessarily deliver all the services itself; it could instead hold subcontracts with other providers.

NHS England has proposed two paths for ACO development: partially integrated and fully integrated. Both of these options are voluntary, and practices will be able to determine the extent of general practice involvement.
**Partially Integrated ACO**

In a partially integrated ACO, a single contract will cover all in-scope services, apart from core general practice. This could include secondary care, community care, mental health, public health, social care and aspects of local authority care provision.

It may also cover primary care services that fall outside of core general practice, such as QOF (quality outcomes framework), DESs (directed enhanced services) and local provision of primary care. While GP practices would still hold their GMS/PMS/APMS contracts, any primary care services beyond that which fall under the scope of the ACO may either be delivered by the ACO directly, or through a sub-contracting arrangement with practices.

The ACO would be required to directly integrate the services they provide with the core primary medical services in that area and agree with participating GP practices how that would occur using an ‘integration agreement’. Details of the integration agreement would be determined locally, but it would set out how the ACO and practices would work together to increase integration. For example, it may involve sharing data, risk/reward mechanisms, targets or KPIs (key performance indicators). It would also set out terms of reference for a governance system to co-ordinate and oversee implementation of the agreement.

**Fully Integrated ACO**

In a fully integrated ACO, all services will be procured in a single contract between the commissioners and a single legal entity, including core general practice. This organisation would be responsible for the provision and integration of all care services; it could deliver all services directly, or could sub-contract for services to be delivered by other providers. The overall contract would run for a limited period of 10-15 years, and include a break period every two years, to allow for evaluation of the development of the ACO and the services provided under the contract.

Because essential primary care services would be commissioned under the new contract, the fully integrated model requires GPs who choose to participate in the arrangement to be released from their current contractual obligations.

Provision has been made within this model for participating GP practices to suspend their GMS/PMS/APMS contracts (for an agreed amount of time), which may later be reactivated.
However, there are several issues which put into doubt the practicality of doing so. For example, the right of return does not apply to local enhanced services and practice premises may have changed hands.

**Key contractual, financial and regulatory issues**

**Service Specification**

The individual contract will define the exact range of services to be covered in the ACO (within the boundaries of nationally set minimum and maximum parameters) with a process to allow this to be varied over time. The specification will consist of national requirements, core elements of the ACO care model, and local service requirements and standards. To maintain some degree of consistency nationally, any local variation will need to follow a set of standard terms, effectively providing the commissioners with a menu from which they can tailor their individual service specification.

**Payment models**

Payment models under ACSs would remain unchanged. The partially integrated model would provide a pooled budget for those services that are delivered through the whole population provider, while GP practices would maintain the funding provided under their contract (note that funding for optional or non-contractual services may not be available for practices if those elements are delivered by the ACO).

It is proposed that payment models under a fully integrated ACO will comprise of three main components that combine to create an ‘ACO contract sum’:

1. A capitated budget based upon the ACO’s registered list (ie the combined lists of all constituent GP practices) to create a single whole population budget (WPB). The intention is for WPBs to be multi-year and to be adjusted in line with changes in CCG allocations.

2. An Improvement Payment Scheme (a performance related pay system), which could constitute up to 10% of the contract value and would be top-sliced from the WPB. It would include a mix of national and local elements and would recycle monies from the existing CQUIN and QOF schemes. Targets would be subject to change, to align with national and local priorities.

3. ‘Gain/loss share agreement’ (where the organisations involved agree to a set of common incentives relating to the overall performance of the system, rather than the individual bodies) to align financial incentives across services provided for the population.
Procurement
Under EU law, and enshrined in UK law, public procurments over €750,000 must be advertised and will likely go to open tender. To counter this, NHS England proposes that the initial PIN (Prior Information Notice) put out to advertise the contract would, amongst other things, require prospective bidders to demonstrate that they had the support of local GPs (GPs could support more than one bid if they so wished), as the population based ACO models are built upon the foundation of the registered lists of constituent GP practices. However, it is not yet clear exactly how GP support will be judged.

As ACOs are a developing area, the precise procurement process is still somewhat uncertain. However, NHS England advises that commissioners should begin by engaging with providers and other stakeholders to assess the appetite for engaging in an ACO model, and the type and scope of model they might wish to adopt. If only one provider expresses an interest in response to an advert for the contract, the commissioner can assess whether the provider is suitable and negotiate the contract. If more than one provider expresses an interest, the commissioner must run a competitive process to award the contract.

Governance and organisational structure
It has been reported that NHS England and NHS Improvement could use existing organisational forms – particularly NHS trusts and FTs (foundation trusts) – to house ACOs as a means of ensuring they are grounded in statutory bodies. This could take the form of newly created NHS trusts, or could be established through “repurposing” shells of trusts that are no longer needed or “spinning out” new FTs from existing ones in a “demerger”. The governance of these bodies would, it is claimed, be designed to ensure a balance of representation between secondary and primary care. In theory, the use of a statutory body could help ensure that ACOs are accountable to parliament in the same way as most other NHS providers; however, the intention to use these organisational forms has not yet been publicly announced.

The role of CCGs
Under the Health and Social Care Act 2012, CCGs have statutory duties around the commissioning of healthcare services for their local areas, and will be responsible for determining whether or not to commission an ACO, based on its appropriateness for their area. Once established, an ACO will be accountable for the cost and quality of care for its defined population and budget. However, if ACOs are not housed in existing organisational forms (as above) they will have no legislative basis. Regardless of the organisational form, we expect statutory accountability for commissioning care to remain with CCGs and other NHS bodies. CCGs cannot delegate responsibility for their statutory roles, and while there may be minor changes to their governance, major statutory changes are not expected. CCGs will therefore be required to work closely with providers in establishing an ACO, and the ACO itself once delivery of services is underway. ACOs will also be able to subcontract any of the services that they are contracted to provide. While this will remain subject to approval by commissioners, it does increasingly blur the divide between providers and commissioners and raises broader questions regarding the future of CCGs.
**Employment models & conditions**

There is no explicit mention of what employment models should be used within ACOs. Within the latest draft of the contract, NHS England has stated that the contract 'Directions' will include a requirement that the contracts of any GPs employed within an ACO must meet the minimum terms and considerations set out by the BMA model contract for salaried GPs (an existing requirement for GMS practices). Similarly, it is expected that terms for consultant, SAS doctors, junior doctors, and other employed medical staff working within an ACO will also follow existing employment contracts.

It is possible that existing job plans or work schedules could be amended to reflect a different way of working. For example, a doctor may agree to work one PA (programmed activity) a week for another employer at a different site run by their NHS employer. This type of change to working patterns could be agreed through the job planning process without the need for any substantial contractual change.

External organisations, or new organisations formed by mergers, may take on the provision of a service previously provided by a doctor’s employer, which the doctor was employed to undertake. In these circumstances TUPE (Transfer of Undertakings (Protection of Employment) Regulations) may apply, in which case their contract of employment would be transferred to the new organisation.

Arrangements for GPs will vary depending on the model of care adopted. In the fully integrated model, where practices give up their individual core contracts, the ACO may subcontract provision to local practices or run them directly; alternatively, GP partners may become sessional GPs employed by the ACO. Current sessional GPs who are permanently employed by a practice that gives up its core contract, could be transferred to a new organisation; in this case TUPE may apply.

**Regulation**

It is proposed that the CQC could inspect the ACO as a whole as it currently does for hospital trusts, rather than the constituent parts, and include governance structures and accountabilities within its assessment criteria, however, CQC would still be able to inspect any constituent part of the ACO if it wished.

**Indemnity**

In October 2017, the Secretary of State for Health and Social Care announced plans to develop a [state-backed indemnity scheme](#) for general practice in England. The scheme, due to commence in April 2019, would provide clinical negligence cover to providers of GP services through which the activities of individual GPs and practice staff would be covered. It would be available to all contractors who provide primary medical services: GMS, PMS and APMS plus any other integrated urgent care delivered through NHS Standard Contracts. While the scheme is being developed and its scope finalised, NHS England and the Department of Health and Social Care will work with NHS Resolution to provide information to potential ACO providers on their options for securing cover. This would mirror the situation for hospital doctors, removing clinical negligence indemnity costs from individual GPs and transferring them to the ACO’s corporate body. All doctors within the ACO will continue to need, and pay for, personal indemnity arrangements to cover them for any activity that takes place outside the ACO, and for GMC investigations, criminal proceedings, and good Samaritan acts, as well as run-off cover for historic, pre-ACO activity. In an ACS or virtual or partial ACO, GPs would not generally make any changes to the way in which their clinical indemnity is purchased.
**Pensions**
Under current regulations, income derived under arrangements where the ACO is lead provider and GPs and others are engaged under sub-contracting arrangements would not be pensionable for the purposes of the NHS Pension Scheme. NHS England states that there is an in-principle agreement to allow access to the NHS Pension Scheme as a sub-contractor when an NHS Standard Sub-contract is used. These changes, however, are not yet in place and are subject to public consultation.

**ACO Contract**
The general contract conditions released by NHS England in August 2017 relate specifically to services within an MCP (multi-specialty community provider), rather than ACOs more widely. They therefore do not relate to acute services, social services or public health. However, NHS England has been explicit in stating that this contract will develop to accommodate these other care settings. One standard contract has been prepared for both partially and fully integrated models, but with specific clauses highlighted for use in one or other model. The contract is modelled on the NHS Standard Contract (between CCGs and hospitals) with some additions.

This contract sets out the nationally mandated processes for managing the relationship between the commissioners and the ACO provider. Throughout the contract, reference is made to the ‘Directions’, but these are still in development and have not been released. It is difficult, therefore, to provide an accurate analysis of this contractual document. Further guidance will be provided once the ‘Directions’ are released.

You can read the BMA’s guidance on the ACO contract [here](#).

**BMA View**
The BMA supports the principle of integration and we have called for greater collaboration and integration across and within health and social care services for several years. However, we do not believe that ACOs and the significant contractual changes they would require, are a necessary or appropriate way of achieving this. Moreover, ACOs and ICSs fall outside of existing legislation, have not been subject to full public or parliamentary scrutiny, and, in the case of ACOs, present a serious risk of handing area-wide NHS budgets to private providers in the future.

We believe that integration can be achieved within existing contractual and organisational frameworks, but existing barriers must be addressed. We have consistently raised concerns about the fragmentation of NHS services and have opposed the current purchaser provider split and competition framework, which undermine collaboration. If these issues were remedied, it is possible that a less formal system of collaboration, without widespread contractual change, could be developed to enable meaningful change.

The ICS model could potentially achieve this, but given the association with ACOs and its evolution from STPs, the BMA’s existing concerns around the development and implementation of STPs extend equally to ICSs, namely: plans need to be developed in an open and transparent way; all proposals need to be realistic, evidence-based and funded properly; there needs to be full and early consultation with patients and healthcare professionals across all care settings; existing nationally negotiated employment terms and conditions of service should also be used for employed medical staff working for such organisations; and any changes should be clinically-led and prioritise patient care, not savings.
Our specific concerns regarding the development of ACOs, and to a lesser extent, ICSs, include:

**Transparency and accountability**

There has been insufficient transparency and public scrutiny of the ACO proposals. So far, the Department of Health and Social Care has carried out a single, technical consultation relating to changes to regulations needed to facilitate ACOs, which focused only on the narrow legal aspects of required regulatory changes and did not allow for full and proper scrutiny of the wider proposals. A further consultation is expected to be launched by NHS England in March 2018; NHS England and the Department of Health and Social Care must ensure that this and future consultations allow full and proper scrutiny of the proposals, with maximum transparency and opportunity for patients, doctors, and other health and care professionals to raise concerns.

ICSs and ACOs, like STPs, also have no legislative basis, raising significant governance issues. It is currently unclear where accountability within each ICS or ACO will rest, as individual CCGs and NHS Trusts remain the principle statutory bodies within each model. This is especially important in the context of the scale of change that the partially and fully integrated ACOs may entail, and, therefore, these proposals require proper parliamentary scrutiny. It has been suggested that ACOs, being a formal, contractual model of integration, could be centred on individual NHS Trusts in order to provide them with a statutory basis. If pursued, this will require significant scrutiny to ensure that the whole structure is properly accountable. However, the contract does clarify that ACOs will, for example, be open to Freedom of Information requests.

Genuine engagement with all NHS staff is also essential for any service redesign. It is vital that NHS England and the Department of Health and Social Care fully engages with doctors, from all branches of practice, other health and care professionals, and patients regarding the formation of ACOs, ICSs, and any other form of integrated model.

**Terminology and transparency**

The introduction and development of new models of integrated care has brought with it a raft of new acronyms and terminology, much of which is used interchangeably. As a result, it is increasingly difficult for NHS staff, patients and the public to follow the changes that are happening to their local healthcare system. For example, NHS England has now confirmed that ACSs have been renamed as ICSs, and it has been reported that ACOs, may also be rebranded. It is vital, therefore, that the Department of Health and Social Care and NHS England provide comprehensive information to the public on what reorganisation is taking place and what each new model involves, and that local health systems engage with clinicians and the public about the changes they are making.

**Competition and privatisation**

There is a significant risk that under existing competition rules, combining multiple services into one contract, as would be the case in an ACO, could allow non-NHS providers to take over the provision of care for entire health economies. Moreover, a 10-year contract could require re-procurement every decade, potentially creating significant uncertainty. Equally, however, it is also possible for a commissioner to activate a contract extension clause for ACOs, extending their contract for a further 10 years. 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.
**The future of general practice**

Many practices are already part of local collaborative, at-scale arrangements, and all practices are required to be part of a local primary care network by April 2019. However, 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 and any deterioration of the independent contractor status risks losing this. While provision has been made for participating practices to have a ‘right to return’ to their previous contract, as highlighted above there are several issues which put into doubt the practicality of doing so. There are also risks for practices within the partially integrated model, as any primary care services which fall outside of core general practice may fall under the scope of the ACO, and therefore significantly limit the services that practices can be paid to provide. Greater clarity is also needed regarding the terms under which staff would be employed within an ACO. The BMA is calling for assurances from the Department of Health and Social Care and NHS England that all doctors working within ACOs will be employed on national terms and conditions.

**Cross-border care**

There is also a lack of clarity regarding how implementation of ICSs and 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 or where patients are referred across borders. This requires significant consideration to ensure patient safety is not compromised.

**Funding and investment**

Moving to any new model of care will require significant time and investment. The success of this process will be severely hampered without adequate resources, particularly if action is not taken to address the current funding crises facing both the NHS and social care and the growing pressures on services.

The Autumn 2017 budget saw an additional £2.6 billion set aside to support STPs, including an initial £260 million allocated to those STPs considered to be performing best, some of which are advancing towards ICS and ACO models. However, this was significantly less than the £9.5 billion in capital funding that STPs have indicated they need to implement their programmes. If the Government continues with its accountable care agenda, it will need to review its funding of the NHS, otherwise it risks further destabilisation at a time of unprecedented pressure.

**Advice for BMA members and what you can do**

As we have highlighted above, it is vital that any service change or development is clinically led. It is therefore important for members to be aware of the proposals and get involved in discussions locally. Different areas will be at different stages of development; members should try to engage as early as possible, but even if plans are further advanced, doctors are still in a powerful position to influence changes for the benefit of patients and the NHS more widely.

It is particularly important for GPs to be engaged in this issue, because of the link between ACOs/ICSs, and the registered patient list: GP practices will be able to choose whether or not their practice and patient list becomes part of any new arrangement. The different contractual and alliance options described above are voluntary; practices should ensure they are fully informed before making any decisions, and should not feel pressurised into doing so. Equally, ACOs will not be able to move forward without the initial support of GPs, as CCGs must demonstrate that this support exists locally, before commissioning an ACO.
BMA members across all branches of practices have a vital role to play in deciding the future direction of services in their areas. We therefore encourage you to engage with local decision-making structures in your area:

- CCGs remain accountable to parliament for the commissioning of care; engaging with your local CCG is, therefore, an important means of influencing reform of the healthcare system in your area.
- Similarly, Trusts are likely to play a key role in the development and running of any ACO, and it is important that you continue to engage through existing structures and influence your Trust’s leadership.
- We also encourage members to get involved in local bodies such as LMCs, LNCs, and BMA regional councils, so that the BMA’s collective voice is as strong as possible at a local level.
- Information on your local BMA contacts, facilities and support is available here.

There are also a number of key questions you can ask decision makers in your local area:

- What consultation will there be on any proposed changes?
- How will commissioners decide if proposed changes have the support of NHS staff and the public?
- What organisational form will the proposed new structures take?
- How will governance structures work, and how can BMA members, others in the NHS and the public have a say in how any new structures are run?
- Who will any new bodies be directly accountable to?

Further Guidance and Support

- ACO legal guidance
- BMA contract checking service
- BMA employment advice
- BMA Law
- Collaborative working in general practice
- Latest ACO information of the BMA’s website
- Local BMA contacts, facilities and support
- NHS England ACO documentation
- Salaried GPs working under new models of care
Glossary

**Integrated care systems (ICSs)**
ICSs (formerly known as ACSs (Accountable Care Systems) will be an ‘evolved’ version of an STP, working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They are intended to provide joined up, better coordinated care, and operate on a horizontally and vertically integrated basis, either virtually or through actual mergers. They are expected to partner with local GP networks. The scope of services covered is likely to vary between different areas.

**Accountable care organisations (ACOs)**
An ACO is very similar to an ICS, in that an ACO brings together a number of providers to take responsibility for the cost and quality of care for a defined population within an agreed budget. Similar to an ACS, their structure can also vary, from fully integrated systems to looser alliances or partnerships between different providers. The key difference is that in an ACO there will be a single contract with a single organisation for the majority of health and care services and for population health in the area. There is a risk that, under existing competition rules, that contract may be won by a private provider, placing a significant range of NHS and social care services, staff and resources under the control of a for-profit enterprise.

**Accountable care partnerships (ACPs)**
ACPs are defined by The King’s Fund as alliances of NHS providers that agree to collaborate, rather than compete, to deliver care within an area – bringing together hospitals, GPs, and community and mental health providers, as well as social care and independent and third sector providers in certain cases. ACPs appear to be primarily focused on the delivery of services and can be distinguished from ACSs and ACOs in that they do not play as significant a role in commissioning or strategy. Multiple ACPs can exist within an ACS. However, there has been a distinct lack of clarity as to where ACPs formally sit within the accountable care structure, which needs to be rectified to ensure that NHS workers, patients and the public can understand how the structure of their local healthcare system is changing.

**Local Care Organisations (LCOs)**
Used primarily within the Greater Manchester devolution area, an LCO, like an ACP, is a grouping of providers focused on the delivery of services within a specific area. Ten LCOs are being established within Greater Manchester, with the intention of NHS and social care providers within each LCO collaborating to improve population health and to integrate care.

While the terms LCO and ACP are currently used interchangeably, it is vital that their role is set out clearly to the public and health and care staff, and that proper accountability structures are in place.

**Sustainability and transformation partnerships (STPs)**
In March 2016, England was divided into 44 STP geographic ‘footprints’ made up of NHS providers, CCGs, local authorities and other health and care services. These organisations were asked to work together in partnership to create a sustainability and transformation plan based on local health needs, detailing how local areas will work together to modernise health and care and achieve financial balance by 2020. Plans were submitted to NHS England and NHS Improvement in October 2016 and are now being taken forward by these local partnerships, or STPs. Amid concerns expressed by the BMA and others that insufficient consultation had taken place and that STPs were focusing too narrowly on cost savings, these plans were eventually published in late 2016.
TUPE (transfer of undertakings (protection of employment))
The purpose of TUPE is to protect the terms and conditions of employees whose contract of employment is transferred from one organisation to another, so that their contract of employment is not terminated or changed. This should ensure continuity in the terms and conditions of the employee, and that the new employer takes on the same responsibility as the previous employer. In the event of the formation of an ACO or ACS, external organisations, or new organisations formed by mergers, may take on the provision of a service previously provided by your employer, and which you have been employed to undertake. In these circumstances TUPE (Transfer of Undertakings (Protection of Employment) Regulations) may apply, in which case your contract of employment would be transferred to the new organisation.

Vanguards
Launched in 2014, the vanguard programme saw the creation (and funding) of 50 pilot sites across England tasked with exploring new models of care. Two of the models explored were MCPs (Multispecialty Community Providers) and PACS (Primary and Acute Care systems). These are population based models of care, built upon the GP registered lists of the practices involved, and are a forerunner of ACOs.

MCP (multi-specialty community provider)
MCPs are a type of integrated provider that could potentially combine the planning, budgets and delivery of primary and community care services. MCPs could potentially cover all non-hospital services, and seek to offer a wide range of community-based care, including shifting some services out of hospital settings. They will use integrated, multi-disciplinary teams, working with GPs, and employ a range of health and social care professionals, including specialists from secondary care. MCPs are expected to cover a population of over 100,000 people.

PACS (primary and acute care systems)
The PACS model is similar in approach to an MCP, but also includes secondary care. PACS therefore have the potential to provide list-based primary care services, most secondary care services, along with community care, mental health and some social care services. As with MCPs, the intention is for PACS to bring a greater focus on prevention and integrated community-based care. But, they will have even greater scope to reshape services and use their workforce more flexibly. Given the inclusion of secondary care, PACS are likely to operate on a larger scale and NHS England would expect a PACS to cover the same population footprint as the trust(s) involved – at least 250,000.
References


3 NHS England announces consultation on ACO contracts: www.england.nhs.uk/2018/01/consultation-aco-contracts


5 Health Service Journal. New form of NHS organisation planned for first ACOs. December 2017. Available at: www.hsj.co.uk


8 The King’s Fund. Bottom up, top down, middle out: transforming health and care in Greater Manchester. November 2017. Available at: www.kingsfund.org.uk