Focus on the ACO Contract for Fully and Partially Integrated Accountable Care Models

This guidance note provides a high-level overview on the main terms and conditions which apply to the NHS standard contract for Accountable Care Models (the ACOC), alongside the proposed system for suspension and reactivation of a G/PMS contract under the ‘fully-integrated’ version of the contract. This note does not represent an authoritative and complete review of the ACOC, which includes a large degree of local variation, and as such we would strongly recommend that anyone looking to enter into such arrangement seeks appropriate legal and professional advice and discuss with their Local Medical Committee.

This guidance is designed to be read in conjunction with the ACOC, published on the NHS England website.

The BMA retains significant concerns relating to aspects of the ACO proposals and their possible impact for doctors, particularly GP partners. For further information on these concerns and other issues that members should be aware of, there are a number of guidance documents available on the BMA website:

ACO/ACS briefing
Guidance on ACO Contract Framework
Guidance on Virtual ACOs and Alliance Agreements
Guidance for Salaried GPs working in New Models of Care
Overview

What is an ACO?
NHS England’s Five Year Forward View set out several NMCs (New Models of Care) that NHS England believes represent ways to provide integrated care to patients, and which are being trialled in a number of ‘Vanguard’ sites across England.

ACOs are a population based model of care that integrates primary, secondary, community and other healthcare services. To do this, individual providers will need to join to create a combined patient list and bid for a contract from their local commissioner. The contract is aimed at providers who wish to work within this new integrated care model, covering populations of at least 50,000 patients.

The aim of ACOs is 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.’

The Five Year Forward View outlined two types of ACO, MCPs and PACSs which share much in common (for further information on these models please see the BMA briefing on ACOs). Effectively, the main difference between the two is one of scale and scope of services. MCPs could potentially cover all non-hospital services, including general practice, community and mental health services, and NHS England expects them to cover a population of over 100,000, although each will vary in size dependent upon local agreement. MCPs are also likely to heavily led by local GP practices, potentially in partnership with community providers. PACS, however, could provide all the services of an MCP but also include hospital services, and would require the involvement of the local hospital trust in a leading role. As such NHS England would expect a PACS to cover the same population footprint as the trust(s) involved – expected to be at least 250,000.

Why is there a separate ACO contract?
NHS England has stated that much of an accountable care model can be delivered under current contractual frameworks simply through various organisations developing closer working practices. However, the integrated budget, which NHS England views as a key tool for achieving organisational and systemic integration, can only be given to the ACO provider if they hold the contract. NHS England consider that one provider responsible for the entire budget may be more cost effective than each provider/commissioner holding their own budget.

The ACOC is designed so that it can be adapted for use for both the fully and partially integrated care model, as required (the ‘virtual’ ACO model does not use the ACOC, instead utilising a separate ‘alliance agreement’. Guidance on this is available on the BMA website. The difference between these two models will be down to the way in which a GP contractors’ core contract is treated and ultimately where the obligation for providing primary care services will sit.

In its most simplistic terms:
- Under the fully integrated models, the GMS, PMS or APMS contracts (the Core Contracts) held by contractors are suspended.
- Under the partially integrated models, the Core Contracts remain active.

The establishment of these two models recognises the fact that many GP providers (or the networks to which they belong) retain concerns that if they committed to these fledgling arrangements they would be irreversibly relinquishing their autonomy and independent contractor status.
Whilst the concessions made to address these concerns, and encourage GP involvement, are welcome it must be stressed that the interrelation between the ACO and GP providers in a partially integrated model and the practicalities surrounding the suspension, and potential reactivation, of a contractors Core Contract in a fully integrated ACO model remain unclear and could lead to the end of a practice’s previous G/PMS contract should the ability to leave the ACO prove illusory in practice.

Any GP provider should make sure these uncertainties are fully clarified before proceeding to join or work with an ACO. In addition, it is critical that clarity is obtained on the supporting regulations/directions (which we believe will be similar to the PMS Regulations) that will underpin the ACOC. At the date of writing this note, these Directions have yet to be published.

The draft contract is split into three distinct sections:
– The Particulars
– The General Conditions
– The Service Conditions.

The ACOC dictates that if there is any contradiction between any of these three sections then the following order of priority will apply 1. the General Conditions, 2. the Service Conditions, and finally 3. the Particulars.

This guidance will consider some of the pertinent points provided in each of the three sections. However, it should be noted that this only provides an overview of some of the key elements of the contract. Due to the scope and potential for local variation within the ACOC practices should seek a full legal review of any such documentation before signing up to any proposals.
1 Particulars

This section covers both the variable and locally negotiated terms that will apply to the ACO itself and the pre-conditions that the ACO provider must meet, including the services provided and the agreed payment levels.

Given their variable nature, it is exceptionally important that anyone considering entering into an ACO reviews this section carefully to ensure that it reflects what they believe they are committing to. Albeit not an exhaustive list, care should be taken to fully understand the following points which are all variables covered by the Particulars:

Services
The services to be provided by the provider. Depending on whether a fully or partially integrated model is being adopted, this may include primary care essential services that would otherwise be provided under core contracts by GP contractors.

Contract Area
The patient catchment area. It is assumed that this will operate in the same way as with the GMS/PMS contracts which use the practice area to establish those residents and temporary residents who can register with the provider.

Term & commencement date
The length (term) of the agreement, the date when the contract is entered into, and (if different) the date upon which the contracted services will commence will all be specifically articulated in the Particulars.

Longstop date
Given that the contract is drafted in such a way that there could be a grace period between the date the agreement is signed off and the date the services will start, the Particulars provide for a long stop date to be inserted stating when the commissioners will expect the services to have commenced. If there is a failure to meet these longstop dates then the commissioner will have the ability to terminate the contract.

Contract Renewal
Subject to the need for the commissioners to have identified the possibility for renewal at the procurement stage, the draft contract allows commissioners to include a right to automatically renew the contract. The Particulars will identify whether this right to renew exists and, in doing so, will articulate:

a. The maximum renewal term they can insist upon.

b. The amount of notice they need to give to instigate a renewal.

c. Whether contractors can refuse such a renewal (note: the draft ACO suggests that this would not be a possibility and that the commissioners would have a unilateral right to extend, although this is not completely clear).

Break Dates
Whether the commissioner and/or provider will have the ability to break the contract early. If such right exists, then the Particulars will go on to identify the notice periods required by the commissioner and/or provider to exercise this right to break.
Pre-Conditions
The conditions that the commissioners will need to exist before the services can commence. These may include, without limitation:

d. Evidence of indemnity arrangements (see the General Conditions section below for further details of the level of cover required).
e. CQC registration (the provider will need to separately register with the CQC as a registered provider); and
f. In situations where the provider is entering into a fully integrated model, notices to suspend any Core Contracts (see section on ‘G/PMS Suspension’).

Integrated Activities
In situations where the ACO is a partially integrated model, meaning that primary care contractors preserve their core contracts, the Particulars will include a potentially far reaching section which will identify what the ACO and the individual GP practices retaining their contractor status (called Associate Practices) must implement to ensure:

‘the Services are fully functionally integrated with the General Practice Service... to the effect that the Services and the General Practice Services... are delivered in a seamless, person-centred fashion.’

This is an exceptionally broad aspiration with little detail as to how this will work on a practical and legal basis and the detail of any such activities will be set out within a separate ‘Integration Agreement’. GP practices should be alive to issues that may be created in seeking to comply with the integration requirements including, without limitation:

g. The additional obligations they will be placed under.
h. The cost of implementing this integration.
i. The potential loss of autonomy.
j. The additional liabilities that may arise on the GP practices in complying with the aims of the commissioner and indeed the ACO’s in these contractual arrangements.
k. The extent to which the proposed integration is capable of separation if GP practices walk away from the ACO.

Minimum net worth
The minimum net worth that the provider must, during the contract term, continue to meet. Care should be taken to ensure that this is set at a level that will not (i) prove prohibitive in terms of those providers capable of satisfying this pre-condition, and (ii) require the injection of excessive capital and/or guarantees from either its individual members, from third party investors or lenders.

Key Documents
The documentation that must be in place to ensure that the provider has the necessary stability to deliver the services under the ACOC. This may include, depending on the legal entity of the party and/or parties entering into the ACOC itself, the providers’ Articles, Shareholders Agreement, Joint Venture Agreement etc.

Whilst the existence of sound governing documents assists in creating stability it should be noted that there is a rather draconian side note to the draft ACOC which indicates that none of these documents are to be varied or terminated without the consent of the commissioner. This means that any ACO provider must be alive to the fact that they may be unable to vary their constitution and/or any private contractual arrangements that may exist between owners of the ACO without the approval of the commissioners.

Payment Schedule
The ACOC establishes two main categories of payment that will be made to an ACO provider and the values attributable to each will be identified in the Particulars.
**Whole Population Annual Payment**
This is a sum set at the outset and reviewed at periodic intervals (as set in the *Particulars*) upwards and/or downwards to take account of such things as variations to the scope or services, variations to the population and/or changes in the demographic. Any such reviews are to be determined in accordance with the rules set in the National Tariff and having regard to the Integrated Budget Handbook (which is basically being a handbook that will be prepared and reviewed by NHSE and NHSE Improvements for use by commissioners when it comes to determined or adjusting whole population payments). If the parties are unable to agree the appropriate variation then the matter goes to non-binding mediation. Ultimately, however, the ACOC is drafted in such a way as to benefit the commissioners in the sense that:

- if the parties are unable to reach agreement on the variation to the whole population annual payment; and
- the commissioner determines that they are unable to make payments at the level they did immediately prior to the review

then either party may terminate the contract.

This provides the commissioners with the ability to terminate the contract if they determine that they can no longer afford it (even at a rate which was agreed when the contract was first awarded) whilst a provider can be forced to deliver the contract at sums originally agreed without an equivalent right to terminate on the grounds that the contract has become unviable. GP practices should be extremely wary of the potential financial liabilities of this.

**Activity-Based Payments**
These are variable payments based on the level of activity of a provider in any prescribed area. An example would be payments in delivering vaccination programmes.

In addition to the above, the ACOC may establish an *Improvement Payment Scheme*. The intention is for these payments to be directed in such a way as to realise changing priorities of commissioners. This scheme is intended to replace CQUIN and (in a fully integrated model) QoF.

**Quality Requirements**
The KPIs that the ACO provider must meet. These should be considered with exceptional caution as they not only establish the *quality requirements*, they identify the *means* to which they are to be measured, the *thresholds* that must be met and the *consequences* (which are generally financial penalties and/or the issuing of, what are called, performance notices which start a process of review and remediation) of the thresholds not being met.

**Contract Reporting**
The ‘Reporting Requirements’ that the ACO provider must adhere to. Given their extensive nature all ACO providers should consider their obligations carefully (paying particular attention to the information that needs to be reported on, the frequency of reporting and the method that such reports should take).

In terms of the information that is supplied, and given that the ACO provider may provide services that straddle commissioning areas, the ACOC dictates the fact that the information supplied by the ACO provider must be provided in an aggregate form to the co-ordinating commissioner and in a disaggregated form to each individual commissioner covering the specific individual use of services within their area.

In the event that the required information is not supplied then the commissioner may serve notice of the relevant information breach. If this is not remedied within 5 operational days then the commissioners can deduct a sum from the actual monthly payments of up to 1%.
Transition Arrangements
Given the fact that the ACO aims to bring providers together in an integrated fashion, the *Particulars* will contain a specific schedule which will explain the transitional arrangements that must be implemented. In essence, these arrangements will aim to bring disparate services and their back-office functions together.

Any ACO provider must be careful when it comes to considering these arrangements. Are they legally capable of implementing them (for instance the transferring of staff or the movement away from current operating systems), what are the cost implications for realising these transitional arrangements, and are they capable of being unravelled in the event that the ACOC is terminated or a constituent practice leaves the ACO.

The last point is a critical one for GPs to consider if they are entering into a fully integrated model and suspend their core contract. Whilst they may have the right to reactivate their core contract at a later date if they decide to drop out of the ACO, how practical will that actually prove to be? For example, beyond the initial reactivation point 2 years into the ACOC the patient list will stay with the ACO by default, unless patients actively choose to switch to the newly independent practice. This could have a severe impact upon the practice’s planning and financial viability away from the ACO. This and further potential issues are covered in the BMA ‘Focus on ACO Contract Framework’.

Sub-Contractors
The ACOC requires that most subcontracting arrangements for the provision of services under the ACOC require the prior permission of the commissioner. However, the it also provides for two unique types of sub contract arrangement that attract special treatment in that they do not require prior approval. These are referred to as **mandatory material sub contracts** or **permitted material sub contracts**.

The Particulars will identify (i) the services that, and (ii) the sub-contractors who, fall into each of the two categories. These should be considered carefully as they will either dictate the contractors that a ACO provider must use (in the case of mandatory material sub-contractors) or those they can use without the requirement of seeking prior approval of the commissioners (in the case of permitted material sub-contractors).

Further detail is provided under the section on ‘General Conditions’

Exit Arrangements
Schedule 11 of the *Particulars* will set out the hand-over obligations that will arise on expiry of the contract (however that may occur) and the potential non-reimbursable costs for complying with this. These obligations will be in various areas including staff, premises, IT, patient records and other data, financial matters and equipment and are down to local negotiation and agreement.

It is unclear how these exit arrangements will dove-tail with any rights that GP contractors will have when it comes to either the suspension and/or re-activation of their Core Contracts in a fully integrated model or the separation of primary medical services provided under Core Contracts by GPs in a partially integrated model.

TUPE
The *Particulars* place the ACO provider (and any material sub-contractor) under specific obligations when it comes to the handling of staff in a TUPE situation. As part of this the ACO provider (i) is required to provide employee liability information within 20 operational days after it is requested in circumstances where the commissioner intends to tender or retender any services, and (ii) must not terminate the employment of any employee during the 3 months immediately expiry of the ACOC or the date the contract is to come to an end.
Data Processing
A pro forma data processing agreement that will establish the obligations placed on the provider when it comes to the collecting and processing of personal data. The actual obligations are fairly generic but nevertheless any ACO provider should familiarise themselves with the data processing obligations which include, without limitation, the requirement not to transfer data outside the European Economic Area, the requirement to take appropriate technical and organisational measures against any unauthorised or unlawful processing of data and the requirement to train staff. Practices should also be aware of the upcoming introduction of the EU General Data Processing Regulations and the impact that these may have.
2 The General Conditions

This section of the ACOC contains the more legalistic provisions that will govern the working relationship between any ACO provider and commissioner. In this part of the guidance we provide a high-level overview of some of the core terms.

Performance issues (Contract Management)
The ACOC establishes an escalating procedure for handling actual or alleged failures by the ACO provider or the commissioners in complying with their respective contractual obligations. These can be summarised as:

Stage 1: A contract performance notice is issued by the non-defaulting party on the defaulting party.

Stage 2: Within 10 operational days of the contract performance notice being served, a contract management meeting must occur and either (i) a joint investigation must occur to investigate the circumstances given rise to the performance notice, (ii) the performance notice is withdrawn, or (iii) a remedial action plan is agreed to be implemented.

Stage 3: Where a remedial action plan is agreed then its contents must be defined within 5 operational days. This plan must include:
- Actions required to remedy the breach
- The improvement in outcomes/KPIs required
- The officer responsible for ensuring completion of improvement actions
- The financial sanctions or other consequences for failing to complete an agreed action.
  This can be a sanction of up to 10% of the monthly contract sum.

If the remedial action plan isn’t agreed then the commissioner may ultimately withhold payments up 2% of the monthly contract sum.

Stage 4: If a party fails to meet a required action then an exception report may be issued to the defaulting party’s chief executive and/or governing body and withhold payments up to 2% of the monthly contractual sum.

Liability & Indemnity
The ACO provider will face unlimited liability for any loss, damage, cost, expense, liability, claim etc. arising from any negligence or breach of contract. This extends to making the ACO provider liable for any negligence or liability that arises from a breach or negligent act of any sub-contractor that they may use.

Insurance
The ACO Provider will need to put in place and maintain, at its own cost, appropriate indemnity insurance in respect of (i) employers’ liability, (ii) clinical negligence, (iii) public liability and (iv) professional negligence. In addition, and on expiry of the ACOC (however that may occur), the ACO provider must ensure that they maintain sufficient run off cover in respect of any negligence to any service user or commissioner that received services during the term of the ACOC.

In terms of the level of cover required, this is understandably not prescribed but will be subject to the approval of the commissioners at the time the contract is entered into. The requirements in respect of the value of the indemnity arrangements will need to be articulated in the Particulars.

Despite the requirement to maintain indemnity insurance it is critical to appreciate that a provider’s liability is not limited to any level of insurance they may, from time to time, have in place. As such if there is a shortfall between the sums insured against and the liability that arises, the ACO provider will need to meet the difference.
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 the NHS Resolution to provide information to potential ACO providers on their options of securing cover.

**Assignment & sub-contracting**

Any sub-contracting under the ACOC requires the prior written approval of the commissioners. Any ACO provider looking to handle their obligations or rights in such a way must also be cautious of the fact that even if they receive the commissioners consent they are under an express obligation to comply with procurement rules and the governments transparency and procurement guidance.

When it comes to sub-contracting, the standard position is that (i) any sub-contractor must be approved by the commissioner, (ii) the sub contract must follow the NHS standard sub contract, and (iii) that a direct agreement is entered into between the sub-contractor and the commissioners (to allow the commissioner to “step in”).

Despite this standard position, and as mentioned in the Particulars section above, the ACOC provides for two unique types of sub contract arrangement that attract special treatment and do not require the prior approval of the commissioner. These are referred to as mandatory material sub contracts or permitted material sub contracts and the Particulars will identify (i) those services, and (ii) those sub-contractors, who fall into each category. The difference between these two categories of sub contract are:

- any mandatory material sub contract MUST be entered into by the ACO provider. This means that the ACO provider will have no choice but to engage the services of the specified sub-contractor chosen by the commissioner to deliver the specified services that are said to fall within their remit;
- any permitted material sub contract is one that MAY be entered into by the ACO provider. These will likely be providers that the commissioners have pre-approved but are not deemed to be essential to the delivery of the overall service.

In relation to both categories, if a mandatory material or permitted material sub contract is entered into then the ACO provider must not terminate the contract, make any material changes to the contract or replace a mandatory or permitted material sub-contractor without the prior approval of the commissioner.

Aside from the mandatory material and permitted material sub contracts, the ACOC also contains a provision making it clear that in the fully integrated models, the ACO provider must not sub-contract any of its rights or duties under the ACOC in relation to the provision of primary medical services except in accordance with specified requirements that will be identified in those yet to be published Directions that will support the ACO models. The precise nature of how subcontracting arrangements will work under the ACOC in practice is currently unclear and will largely depend upon local circumstances.
Termination
The ACOC splits termination categories into three categories of events:

No fault termination events
The first category of events that may bring about a termination of the ACOC are referred to as the no fault termination events in that termination may occur even though there has been no breach of contract. The circumstances falling with this category are:

– Termination by mutual agreement.
– Termination on a break date providing the appropriate notice of termination is given.
– Termination on 12 months’ notice where the adjustment to the whole population annual payment is not agreed.
– Termination on no less than three months’ notice where the commissioner believes either (i) there has been a substantial modification to the contract which would have required re-procurement, or (ii) there has been a serious infringement of procurement rules which means that the contract shouldn’t have been awarded.

Commissioner default events
The second category of events that may bring about a termination of the ACOC are referred to as commissioner default events. The circumstances falling within this category, which would enable the provider to serve notice to terminate, include:

– The aggregate undisputed amount due to the ACO provider exceeds 25% of the whole population annual payment
– The commissioner is in persistent breach of any of its obligations so as to have a material adverse impact on the ACO provider and the commissioner fails to remedy the breach within 40 operational days of being notified of the breach.
– The commissioner assigning the contract in breach of assignment provisions within the contract.

Provider default events
The third and final category of events that may bring about the termination of the ACOC are referred to as provider default events. Unsurprisingly, the events falling within this category are extensive and, albeit not an exhaustive list, include:

– The ACO provider facing an insolvency event.
– The ACO provider is in material breach and has not remedied that breach within 40 operational days after being notified of the breach.
– The ACO provider being in persistent or repetitive breach of the quality requirements.
– The ACO provider has breached the financial and asset provisions referred to above.

Consequences of termination
As with any NHS contract, the ACOC contains various provisions dealing with the transfer of the service as and when the contract comes to an end. These provisions include a requirement to co-operate with commissioners to facilitate a smooth transfer of services and to avoid any inconvenience or any risk to the health and safety of service users. As part of this, and at the cost of the commissioner, where requested by the commissioner the ACO provider will need to:

– provide such information and reasonable assistance to effect an orderly assumption of the service by an alternate provider,
– deliver all materials, papers, documents and operating manuals etc. used in connection with the service, and
– use reasonable endeavours to facilitate a transfer of any contract held by the ACO provider in connection with the operation of the services under the ACOC.

Payment terms
The whole population annual payment is paid monthly in advance on the 15th day of each month. The ACO provider must invoice for this payment no later than the 1st of every month. The activity based payments are paid monthly in arrears and are based on the activity undertaken in the previous month. The ACO provider must invoice for this payment no later than 20 operational days after the end of each month.
Any improvement payment scheme payments work on the basis that payments on account of improvements will be made (such payments to be agreed at the outset of each contract year) with a reconciliation occurring at regular intervals after the improvement performance reports which are, from time to time, requested by commissioners are reviewed.

**Charging Patients**
The ACOC replicates provisions within the GMS/PMS Regulations which prohibit the ACO provider from demanding or accepting (whether itself or through any other person or body) a fee for the provision of primary medical services or a prescription or repeatable prescription for any drug or medicine in connection with those primary medical services except as may be set out in the supporting directions that are to apply to the ACOC. In addition to this prohibition the ACOC specifically states that ACO providers must not provide or offer any clinical or medical services to patients for which charges would be payable by the patient except as set out in the ACOC itself or indeed in relevant statute.

**Financial Matters & Assets**
The ACOC contains a whole host of provisions placing exceptionally tight and potentially onerous financial conditions on any ACO provider. These include:

- A requirement to maintain the minimum net worth (as will be set in the *Particulars* section of the ACOC).
- A requirement that at the last day of every quarter the ACO provider satisfies a stress test whereby the ratio between its current liabilities to its current assets does not exceed the ratio that was agreed at the outset of the contract.
- An asset lock requirement preventing the disposal of assets that could be reasonably expected to prejudice the ACO providers’ ability to deliver service under the ACOC (these assets are defined in the ACOC as its “Relevant Assets”).
- A prohibition on creating any mortgage, charge, lien etc. over any Relevant Asset without the commissioners’ consent.
- A prohibition on giving guarantees to third parties.
- A prohibition on carrying out any business other than that contemplated by the ACOC. The ACO provider will, therefore, need to be a single purpose entity.

There is also a specific section within the ACOC which sets a variety of pre-requisites (known as Distribution Conditions) that must be satisfied before a distribution can be made. The definition of “distribution” is exceptionally broadly defined and not only covers dividends but any sort of payment or benefit that may be made by the ACO provider which would see its profits or reserves being distributed.

The pre-requisites that apply are similarly broad in their scope. Albeit not an exhaustive list, no ACO provider may make a distribution unless:

- The ACO provider has provided the commissioner with details of the proposed distribution and evidence that the distribution conditions are satisfied.
- The audited financial statements for the relevant year show a distributable profit.
- There is cash available to make the distribution.
- The minimum net worth and stress test requirements mentioned above are satisfied.
- There is no remedial action plan in place.
- All operational standards and national quality requirements have been met in the relevant year.
- All local quality and outcome requirements have been met for the relevant year.
Financial transparency
The ACOC contains detailed provisions requiring the ACO provider to be transparent when it comes to their business plans, accounts and earnings. This covers a requirement to:

– act in an open and transparent manner in relation to its revenues, costs and expenses (and to this regard the ACO provider must maintain and make available to the commissioner full records of their revenues, costs and expenses),
– to provide annual audited financial statements for itself and any material sub-contractor,
– to provide quarterly financial statements for itself and any material sub-contractor, and
– to publish
  – the GP mean net earnings information,
  – the amount of any distribution made by themselves or a material sub-contractor,
  – the gross remuneration of any staff member of the ACO provider or any member/owner of the ACO provider that earns in excess of £142,500, and
  – information as required under paragraphs 2.30 – 2.54 of the Department of Health's Group Accounting Manual (which deals with the disclosure of remuneration and pay).

There is also a requirement for all ACO providers to supply an independently audited financial business plan to the commissioner. This will cover the anticipated revenues and expenditure (whether recurrent, capital or otherwise) of the ACO provider and will be used (i) to demonstrate the financial robustness of the ACO provider, and (ii) to assess any variation to the ACOC or indeed the whole population annual payment.

The relevant financial business plan must be updated, independently audited and supplied annually to the commissioner. This is a crucial point. Any variation to a financial business plan will need to be independently verified by accountants before it will be accepted by the commissioner.

Dispute
Disputes are handled in a three stage. As an initial step, the parties will negotiate in order to reach a compromise. These negotiations are to initially occur between senior persons but then escalated to chief executive and/or director level. If a negotiated compromise cannot be reached then the matter is referred to mediation and if that proves unsuccessful then it will be referred for expert determination whose decision shall be final and binding save in the case of fraud or collusion, bias, manifest error or material breach of their instructions.

Information (Confidential, FOI etc.)
In relation to confidential information, all information disclosed between the ACO provider and commissioner in connection with the ACOC is to be classed as confidential and shall not be disclosed. This is subject to the usual exceptions (including where a party has consented to its disclosure, it is in the public domain already, it must be disclosed under law, it is to staff members who are under obligations of confidentiality etc.)

In relation to freedom of information, the ACOC reiterates the fact that the commissioners will be subject to the FOI Act and that the ACO provider must therefore provide such assistance and co-operation that the commissioner may require in order to help it fulfil its duties and obligations when it comes to disclosure.

Change of control
Any change of control or ownership of the ACO provider or any material sub-contractor requires the prior approval of the commissioner.
Warranties
In entering into the ACOC, an ACO provider is automatically deemed to give certain warranties. Warranties are contractual promises that if found to be false will entitle the other party, in this case the commissioner, to bring a claim. ACO providers should, therefore, take care to understand the warranties they are being asked to provide. Under the ACOC they include a warranty that they (the ACO provider) have full power and authority to enter the ACOC, that the documents and information supplied by the ACO provider are complete and their contents are true, and that the ACO provider is unaware of any fact or circumstance which would have impacted on the decision to award them the ACOC.

Entire Agreement
There is an express provision making it clear that the three parts the ACOC, being the Particulars, the General Conditions and the Services Conditions, constitute the entire agreement between the ACO provider and the commissioner. It is therefore essential that the three sections accurately reflect what it is that the ACO provider has agreed to provide and what the commissioners have agreed to commit to.
3 **The Service Conditions**

This part of the ACOC contains the more practical provisions concerning the specific standards and obligations that are required of and/or fall on the ACO provider when it comes to the delivery of services.

Given their specific nature it would be impractical to provide an exhaustive commentary on these standards and obligations within this guidance note. As a consequence, it provides details of a limited number of the core overarching standard and/or obligations. Any ACO provider entering into an ACOC should, therefore, consider the full-service conditions carefully order to ensure that they are capable of complying with same.

Looking at some of the key standards/obligations the ACO provider is required to:

- Provide the services to the population (being the population within its contract area) in accordance with the terms of the ACOC, all laws and regulations, good practice, the fundamental standards of care as set out in regulations 9 to 19 of the Care Act 2014 and the service specifications (being the commissioners specifications as set out in the Particulars).
- Have regard to the need to reduce inequalities between members of the public when it comes to their ability to access health services.
- (In connection with fully integrated models only) accept for inclusion on their patient list any individual permanently or temporarily in their contract area.
- (In connection with fully integrated models only) must ensure that their list is and remains open.

**Note:** as the regulations/directions that will ultimately underpin the ACOC remain outstanding it is unclear whether there will be any right for a ACO provider to suspend their list and/or refuse patients in circumstances akin to those provided for in the GMS and PMS Regulations.

- Perform its obligations in such a way as to secure continuous improvement in the quality of services provided to the population.
- Develop and implement strategies to, amongst other things, work collaboratively with commissioners and (in partially integrated ACO models) GP providers.
- Implement information systems and analytical capacities to understand the health and care needs of the population, identify unwarranted variations to care, identify opportunities to improve the quality equity and efficiency of care etc.
- Use reasonable endeavours, when it comes to the delivery of primary medical services, to
  - offer each member of the population a choice of a range of premises at which they can receive services during core hours (being 8am – 6.30pm Monday to Friday except Good Friday, Christmas Day and bank holidays),
  - offer sufficient pre-bookable and same day appointments to meet the needs of the population (including during evenings and at weekends)
  - offer a choice of evening and weekend appointments as a realistic alternative to appointments during core hours.
- Carry out such pre-employment checks against individuals engaged to help deliver the services under the ACOC as required under NHS Employment Check Standards and the DBS.
- (In connection with partially integrated ACO models) use reasonable endeavours to ensure that all referrals made by GPs are made through the NHS e-Referral service.
- Provide members of the public, their own population (i.e. the population within their contract area), staff members, GPs etc. the ability to provide feedback.
- Comply with strict provisions concerning the transfer of and discharging from care. This includes, in partially integrated ACO models, a requirement
  - to provide GPs with a discharge summary within 24 hours of the transfer or discharge occurring,
  - to issue clinical letters to GPs where, in the course of an outpatient service, they become aware of any matter or requirement pertinent to their ongoing care and treatment.
– Maintain health records for each patient electronically.
– Maintain IT systems that comply with IS80160 (the safety standards to manage clinical risk in respect of health software in the NHS)
– Act in an open and transparent way and notify notifiable safety incidents to the CQC, apologies to the service user for the incident and publish details on its website.
– Establish, publish, maintain and operate a procedure for dealing with complaints.
– Maintain appropriate arrangements for infection control and decontamination.
Suspension of G/PMS Contracts

In order to enter into an ACO, operating fully under the ACOC, GP practices will have to agree to suspend their G/PMS contracts. In order to facilitate this NHS England has introduced changed to the GMS and PMS Regulations which set out the processes for suspension, and potential reactivation, of these contracts, when a practice is entering into an ACO.

The below summarises the key aspects that practices should be aware of. Previous BMA guidance has outlined general concerns with the suspension/reactivation proposals and can be found on the BMA website.

Suspension
Notice Period
Practices will be required to provide at least one month notice to the commissioner of their intention to suspend their G/PMS contract, the date of which should immediately precede the start of the ACO contract.

Timeframes
The first breakpoint in the ACOC is at the 2-year mark (and then every two years thereafter) so practices should be aware that there will be no-opportunity to reactivate their G/PMS contract for a minimum 2 year period.

Outstanding Payments
Under the Regulations, commissioners must pay any outstanding payments that are owed to practices that are suspending their contract within 3 months, unless otherwise agreed with the respective practice.

Reactivation
Notice Period
If a practice wishes to leave an ACO it will need to provide 6 months notice to allow the reactivation of it’s G/PMS contract. This is to allow the practice and commissioners adequate time to disentangle the practice form the ACO and ensure that everything is in place (finances, staff, premises etc.) before reactivation.

Timeframes
As the break clauses within the ACOC can only be activated every 2 years, the practice will need to submit notice of reactivation at least 6 months before the break points within their ACOC. For example, if a practice wishes to leave at the first break point, notice will need to be submitted no later than 18 months into the ACOC.

Patient List
The patient list of the practice is handled one of two ways, depending upon how long the practice has been operating under the ACOC. At the first 2-year breakpoint, the patients on the original practice list before it joined the ACO will remain with the practice as it leaves, unless they opt to move to the ACO. At subsequent breakpoints this is reversed – the patients will move to the ACO unless they opt to stay with the practice. This means that beyond the initial 2-year break point, practise will need to provide notice to leave the ACO without knowing the size of their practice list when they leave, causing significant uncertainty over their financial viability once separate from the ACO. Potentially, the practice could exit the ACO without a patient list large enough to operate and could run the risk of going out of business. The Commissioner will write to all affected patients once a notice for reactivation of a G/PMS contract has been given by a practice.

Whilst the Regulations will set out various requirements relating to suspension and reactivation of a G/PMS contract there is still a great deal of uncertainty over the practicalities involved, especially when a practice is looking to reanimate its G/PMS contract after a number of years operating within an ACO.
FAQs

What is the contractual basis of ACOs?
An ACO will use the ACO Contract, as detailed above. This has been developed from a mixture of the NHS Standard Contract and the APMS contract by NHS England, with input from the vanguard and pilot sites, and will be a service contract between the relevant commissioning bodies. This may include one or more CCGs, other local health bodies such as Foundation Trusts, Local Authorities etc. depending on the scope of the ACOC and services being procured. The ACOC will then be overlaid with a set of ACO Directions, in a similar way to how the GMS contract interacts with the GMS Regulations. To date these Directions have not been published.

Will the ACO contract be consulted on?
NHS England will run a full public consultation on the ACO Contract in 2018. Further to this, due to the scope of the service change individual CCGs should also run local consultations in their respective geographic area when making the decision as to whether to procure such a contract, in line with legal requirements.

Will ACO contracts require procurement?
Due to EU and UK procurement law provision of an ACO contract will be required to go through a full procurement process. This means that hypothetically such a contract could be won by a third-party provider. However, the for an ACO provider to have the active cooperation of local GP practices in order to be able to function (either via signing an Integration Agreement in a partially integrated form, or as part of the ACO itself in a fully integrated one) means that GP practices have a key role to play in the process. A partially integrated provider will need local practices to agree to sign an Integration Agreement, whilst a fully integrated provider will need the full involvement of practices.

What influence can doctors have on the contract?
GP practices are core to the ACO process. The ACO can only operate with a registered patient list, created by combining the list of participant practices. Therefore, any successful tender will need to be able to demonstrate the support and cooperation of practices within the area proposed to be covered by the ACO.

Additionally, before deciding on any move towards developing an ACO, we would expect CCGs to undergo a full and transparent process of discussion with all local healthcare actors, including GP practices and doctors in local community and hospital services who may be impacted by the policy.

As membership organisations GP practices have the power to hold their local CCG to account and should not let them engage on a course of action if that is contrary to the wishes of their members.

What services will ACOs provide?
The services provided by the ACO will be set out within the Contract, the scope of which will be set out by the commissioning body at the time of the procurement, and the ACO must agree with the commissioner as to how it will meet these requirements. Deviation away from these parameters without a formal variation of the contract agreed with the commissioner, would represent a contractual breach. This means that an ACO cannot unilaterally cease to provide service for which it has been contracted.

Will ACOs be able to charge patients for services?
ACOs will be bound by the same legal and contractual requirements to offer NHS services free at the point of use for UK residents as current NHS Organisations, including the same exceptions that currently exists, for example as provided by the Overseas Visitors Charging Regulations. Furthermore, the ACO Contract replicates the requirement of the GMS contract that providers may not demand any fee for the provision of Primary Medical Services, except in those instances set out within the Directions.
Will ACOs be able to sub-contract services?
As set out in more detail above, ACOs will be able to sub-contract services, but only with prior permission of the commissioner and the ACO will remain responsible for the provision of such services. As detailed in the main body of this note the commissioners also has the power to issue mandatory subcontracting instructions to the ACO provider.

What are the employment contract arrangements under ACOs?
When TUPE applies, the existing contracts of employment would be transferred to the new organisation. This usually covers commercial organisations, such as social enterprises and limited companies. The main purpose of TUPE is to protect the terms and conditions of employees who are employed in a business that is being transferred, so that their contracts of employment are not terminated or changed. Therefore, staff employed under nationally agreed terms and conditions would be able to retain these terms under their new employer.

It remains unclear what are the obligations of new organisations in situations in which TUPE does not apply. However, the BMA expects that all doctors will be employed under the terms and conditions that have been agreed at a national level.

There seems to be more clarity regarding the contractual arrangements for GPs. Under the 'virtual' and the 'partially integrated' models, practices retain their G/PMS contracts and are therefore required to offer terms no less favourable than the nationally agreed model contract for salaried GPs. Under the fully integrated ACO, it is anticipated that all GPs (whether previously contractors or salaried) would be employed by the ACO. The latest draft of the contract states that the contract Directions will include a requirement that the contracts of all GPs employed within an ACO must meet the minimum terms and conditions set out by model contract.

As an employee of an ACO you must ensure you receive at least the terms and conditions that have been nationally agreed, that you are not contractually disadvantaged, and that the employment and pay offer is equal.

Where can I find out further information?

BMA
ACO policy briefing
ACO contractual frameworks
Virtual ACOs and Alliance Agreements
Salaried GPs working under new models of care

Kings Fund
Making sense of accountable care
Accountable care explained

NHS England
NHS England New Business Models – contracts and supporting documentation