



Department
of Health &
Social Care

Accountable Care Organisations

Government response to consultation on changes to regulations required to facilitate the operation of an *NHS Standard Contract (Accountable Care Models)*

DH ID box
Title: Accountable Care Organisations - Government response to consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)
Author: Commissioning, Integration and Transformation Unit, Care and Transformation Directorate, Community Care Group
Document Purpose: Consultation response
Publication date: March 2018
Target audience: NHSE; NHSI; PHSO; NHS Providers; LGA; ADASS; CQC; Healthwatch; HEE; National Association of Primary Care; NHS Clinical Commissioners; GPC; NHS Alliance; Family Doctors' Association ; RCGP; Practice Managers Network
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Executive summary

Introduction

Caring for the needs of people with long term and complex health needs is now a central task of the NHS, and this requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. The traditional divide between primary care, community services, social care services, public health services, and hospitals is increasingly a barrier to delivering the personalised and coordinated health services patients need. Integrating services benefits both patients and the system.

As NHS England has said, "*There is widespread support for ending the fragmented way that care has been provided to improve services for patients and the NHS has been working towards this in a number of ways. ACOs are just one of these ways and are intended to allow health and care organisations to formally contract to provide services for a local population in a coordinated way.*"¹

Accountable Care Organisations (ACOs) aim to integrate care and bring services together, so people's care is coordinated around them. If introduced, ACOs are designed to help deliver more care in the community and patients' homes, improving access to services and meaning fewer trips to hospital.

An ACO is not a new type of legal entity and would not affect the commissioning structure of the NHS. An ACO would simply be the provider organisation which is awarded a single contract by commissioners for all the services which are within scope for the local accountable care model. The contract holder becomes contractually responsible for improving population health outcomes, rather than simply providing services. The idea behind accountable care is that it brings different organisations from across the health and care system together to work to improve the health of their local population by integrating services and tackling the causes of ill health.

Between 11th September and 3rd November 2017 the Department ran a public consultation on the proposed changes to regulations to support the development of NHS England's model ACO contract. This consultation 'Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)', specifically asked consultees to consider whether the draft regulations delivered the policy objective of the introduction of a model ACO contract.

The development of the ACO contract has been led by NHS England and taken forward with the Department, commissioners and vanguard organisations across the country, informed by wider engagement. Through this process a number of required changes to regulations were identified in order to facilitate any implementation of an ACO contract. In some cases the proposals create additional flexibilities, for example for GPs who wish to enter into ACO arrangements without terminating their existing contracts. However, the vast majority of the changes proposed were technical to ensure that current rules will continue to apply to any new contract, and those organisations operating under it.

¹ [NHS England announces consultation on ACO contracts](#)

Who responded to the consultation?

We received over 45,000 responses to the consultation. We received 9 responses that answered the consultation questions and directly addressed the proposed specific amendments to regulations from the following organisations: British Dental Association (BDA), British Medical Association (BMA), Care Quality Commission (CQC), Healthwatch Committee, Hillingdon Healthwatch, National Community Hearing Association (NCHA), NHS England, Optical Confederation and the Royal College of Anaesthetists (RCOA). The vast majority of the other responses (44,640) were associated with a campaign launched by the online campaign group, 38 Degrees. The campaign highlighted three main concerns: lack of Parliamentary scrutiny; inadequate public consultation; and opposition to perceived privatisation of the NHS. Data science computer technology identified that these responses took the format of one of 23 very similar templates. We received 811 unique responses that did not follow these templates, but also expressed opposition to perceived privatisation, gave examples from their personal experience and voiced general concerns on the future of the NHS.

How have the draft regulations changed following consultation?

Following comments from NHS England, there have been changes to the proposed definitions of ACO for the purpose of clarity. We acknowledge the points made by NHS England (set out in full in chapter 3, pages 11-12 of this document) and wish to ensure that the definition used cannot be misinterpreted as suggested by NHS England. The previous definition of ACO² did not accurately reflect the policy intention and no longer forms part of any of the final amendments to regulations, which will not mandate what form an ACO should take or what an ACO's responsibilities will be. Instead a standard definition of an integrated service provider (ISP) (set out in full on pages 13-15) and an integrated service provider contract (ISPC) is now generally used.

In the consultation document, the definition of "integrated services provider contract" appeared as a separate definition in the relevant interpretation section. This reflected the original intention that an integrated services provider contract was a defined term to be used only in respect of an ACO contract under which primary medical services are provided.

However, following NHS England's comments, we have reconsidered the definitions within each of the proposed draft amendments. Given that the aim of the new ACO contract is to commission integrated health and care services, we have taken the view that transparency and clarity is best served by maintaining a consistent definition that sets out who may be the commissioners of such a contract on the one part, and what services may be provided under or pursuant to that contract. The definition of integrated services provider contract has been refined so that it now applies in all contexts to the contract that will be used by an ACO for the

² "“ACO” means a body known as an accountable care organisation, having been so designated by the National Health Service Commissioning Board because it is providing or arranging the provision of services under the 2006 Act under contractual arrangements which -

(a) have the objective of integrating care and having a single, systematic approach to using the resources for a local population to improve quality and health outcomes; and

(b) allow a single provider organisation to make most decisions about how to allocate resources and design care for its local population;

provision of integrated health and care services regardless of whether primary medical services are included. The revised definitions in the proposed amendments also ensure that there can be no scope for misunderstanding what is meant more generally by the term ACO contract. Various sets of the proposed amending regulations define the term 'integrated services providers' by way of cross-reference to the definition of 'integrated service provider contracts'. The revised definitions clarify that the award of such a contract does not create a new legal entity. Under an integrated services provider contract as defined, the 'ACO' will not commission services. The ACO will be a provider of health care services which enters into an integrated service provider contract with the relevant commissioning bodies.

The standard definition of integrated services provider contract has been adopted in all of the relevant draft amendments to regulations (further details set out on pages 17-20).

Following comments from the BMA and NHS England, changes have been made to the proposed amendments to the National Health Service (General Medical Services Contracts) Regulations 2015, the National Health Service (Personal Medical Services Agreements) Regulations 2015 and the Primary Medical Services (Prohibition on the Sale of Goodwill) Regulations 2018 ('Sale of Goodwill'):

- For both the GMS and PMS Regulations, the period of notice which has to be provided by a contractor in order for a suspended contract or agreement to be reactivated, has been amended to require notice to be given at least six months before the date on which the proposed reactivation of the contract or agreement is to take effect.
- For both the GMS and PMS Regulations the proposed amendments have been revised to allow reactivation of a suspended GMS contract or PMS agreement where the parties to the contract or agreement have agreed, as appropriate, to the reactivation of the contract or agreement.
- For the PMS Regulations, the proposed amendments have been redrafted to allow a suspended PMS agreement to be reactivated as a GMS contract, subject to the parties to the PMS agreement meeting the eligibility criteria for holding such GMS contracts.
- For the proposed Sale of Goodwill Regulations, the draft regulations have been revised to remove the proposed extension of the prohibition on the sale of goodwill in a medical practice from sub-contractors of existing GMS contracts, PMS agreements or APMS contracts, so that they only apply the restrictions on Sale of Goodwill to holders of the proposed new ACO contract and to any sub-contracting arrangements made pursuant to that contract.

Further details of these changes are set out on pages 15-17.

There has also been a change to the proposed amendments to the Medical Professions (Responsible Officers) Regulations 2010 ('Responsible Officers'). The consultation document proposed that NHS England would be able to decide whether a doctor on the performer's list working under ACO arrangements should have a connection to a Responsible Officer (RO) based in the ACO or in NHS England. Following the consultation, we have decided that the connection to a 'designated body'³ should be set out in legislation rather than NHS

³ See section 45A of the Medical Act 1983 and regulation 4 of, and Schedule to the Medical Profession (Responsible Officers) Regulations 2010 (SI 2010/2841)

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England having discretion to determine this. Further detail of this change and the rationale is set out on page 20.

There has been a change to the proposed amendments to the **National Health Service (Performers Lists) (England) Regulations 2013** to omit the amendment to the definition of "scheme" in regulation 3(a)(iv). Further detail is set out on pages 20-21.

There have been changes to the **proposed amendments to the National Health Service (Licence Exemptions, etc) Regulations 2013** to clarify the drafting and policy intention. Further detail of this change is set out on page 21.

The revised draft amendments to regulations and the draft Primary Medical Services (Prohibition on the Sale of Goodwill) Regulations 2018 are published in full alongside this response.

What's next?

The government has noted the public response, particularly around the need for further public and parliamentary consultation. Since this consultation was published, NHS England has [announced a public consultation on contracting arrangements for ACOs](#). Further to this, the Health and Social Care Select Committee (HSC) has added ACOs to the scope of its current inquiry on Sustainability and Transformation Partnerships. The government has therefore taken the decision to delay laying the proposed amendments to regulations until such time as the NHS England consultation is complete. When the amending regulations are laid they will be done so in the form of an omnibus set rather than individual sets of amendments to regulations. However, there will be a separate set of regulations regarding Sale of Goodwill which will revoke and replace the current regulations.

NHS England's consultation will set out how the contract fits within the NHS as a whole, address how the existing statutory duties of NHS commissioners and providers would be performed under it (including how this would work with existing governance arrangements), and set out how public accountability and patient choice would be preserved. NHS England will seek views from stakeholders and the public as well as explaining what the contract is, why it is useful and what it would mean for patients and for the NHS. No ACO contracts will be awarded in the meantime.

1. Introduction

ACOs aim to integrate care and bring services together, so people's care is coordinated around them – not the other way round. If introduced, ACOs are designed to help deliver more care in the community and patients' homes, improving access to services and meaning fewer trips to hospital.

An ACO is not a new type of legal entity and so would not affect the commissioning structure of the NHS. An ACO would simply be the provider organisation which is awarded a single contract by commissioners for all the services which are within scope for the local accountable care model. The contract holder becomes responsible for improving population health outcomes, rather than simply providing services. The idea behind accountable care is that it brings different organisations from across the health and care system together to work to improve the health of their local population by integrating services and tackling the causes of ill health.

Between 11th September and 3rd November 2017 the Department ran a public consultation on the proposed changes to regulations to support the development of NHS England's model ACO contract. This consultation 'Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models)', specifically asked consultees to consider whether the draft regulations delivered the policy objective underpinning the introduction of a model ACO contract.

The development of the ACO contract has been led by NHS England and taken forward with the Department, commissioners and vanguard organisations across the country. Through this process a number of changes to regulations were identified as necessary in order to facilitate any implementation of an ACO contract. In some cases the proposals create additional flexibilities, for example for GPs who wish to enter into ACO arrangements without terminating their existing contracts. However, the vast majority of the changes proposed were technical to ensure that current rules continue to apply to any new contract, and those organisations with the potential to use it.

The Five Year Forward View (published in October 2014) committed to the development of new models of integrated care. These models included the multispeciality community provider (MCP) – a predominantly out of hospital-based care model integrating primary medical services with other community and mental health services – and the integrated primary acute care system (PACS) – a similar model to the MCP, but also incorporating many hospital-based services. NHS England further articulated the development of these new care models in two frameworks published in 2016. [The MCP framework](#), published in June, and [the PACS framework](#), published in October, set out in more detail how these new care models would support the improvement and integration of services. The MCP and PACS models are both population-based care models. Where these models are contracted for by commissioners using the NHS Standard Contract (Accountable Care Models), the organisations delivering either contract are forms of ACO.

In December 2016 NHS England published a draft version of the MCP contract and [a set of supporting documents for engagement](#). This contract was a variant of the generic NHS Standard Contract applicable for integrated service provision. While this package focussed on contracting for the MCP care model, many of the principles are transferable to the PACS care model and ACOs more broadly. On 4 August 2017 NHS England published a further developed draft of the earlier draft MCP Contract known as the NHS Standard Contract – NHS Standard Contract (Accountable Care Models) (ACO Contract) and [support package](#).

Introduction

This document sets out who responded to the consultation, the specific points about the draft amendments to regulations that consultees raised and the changes we have made to those draft amendments as a result of the comments received, our analysis of the responses received from members of the public, and our next steps. ACO related changes were also proposed to the NHS Pensions Scheme as part of a separate consultation on wider changes to that pension scheme. A response to [this consultation](#) will be published shortly.

2. Who responded to the consultation?

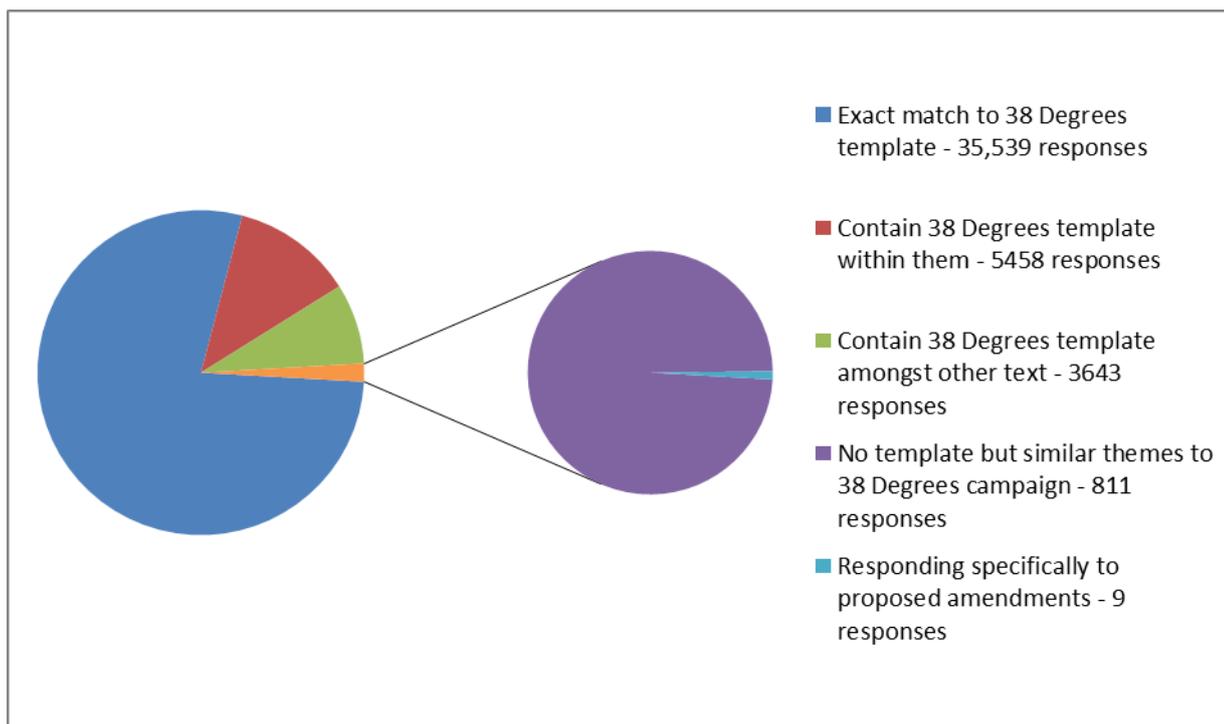
We received **over 45,000 responses** to the consultation.

We received **9** responses that directly addressed the specific amendments to regulations and answered the consultation questions:

- **4** from representative bodies of particular health professionals (British Dental Association, British Medical Association, Optical Confederation, and the Royal College of Anaesthetists);
- **3** from organisations representing particular groups of the public and patients (National Community Hearing Association, Healthwatch Committee, and Hillingdon Healthwatch);
- **2** from executive non-departmental public bodies of the Department, the Care Quality Commission and NHS England.

The overwhelming majority of responses were from the general public. **44,640** of these responses were associated with a campaign launched by 38 Degrees. The campaign expressed three main concerns: lack of Parliamentary scrutiny; inadequate public consultation; and opposition to perceived privatisation of the NHS. The campaign was also used by many respondents to voice their general views regarding the NHS and to give examples from their personal experience with the NHS in general rather than to address the specific issues set out in the consultation questions. The responses took the format of one of **23** very similar templates. Further detail on the range and content of templates and the number of respondents for each is included in the table in chapter 3 of this response.

We received **811** unique responses that did not follow these templates, but also expressed opposition to perceived privatisation, concerns around inadequate public consultation, gave examples from their personal experience and voiced general concerns on the future of the NHS.



3. You said, we did

The consultation proposed making amendments to nine sets of existing regulations and replacing one set of existing regulations (the Sale of Goodwill and Restrictions on Sub-contracting Regulations 2004) with a new set of regulations called The Primary Medical Services (Prohibition on the Sale of Goodwill) Regulations 2018. For each set of amendments we asked the following questions:

- Do you agree that the proposed amendments deliver the policy objective as set out in the consultation document?
- If no, why?
- Are any changes needed to ensure the proposed amendments deliver the policy objective?
- Are there any additional comments you wish to provide with regard to the proposed amendments to the regulations?

Many of the responses commented on broader ACO policy. For example, the following from the BMA, *"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."*

On 25th January 2018, [NHS England announced a consultation on the ACO contract more widely](#). NHS England has said that *"The consultation will set out how the contract fits within the NHS as a whole, address how the existing statutory duties of NHS commissioners and providers would be performed under it (including how this would work with existing governance arrangements), and will set out how public accountability and patient choice would be preserved."* The Department welcomes this consultation and a response received from the Optical Confederation suggests it will also be welcomed by stakeholders: *"NHS England has a golden opportunity to get this right in terms of transparency and accountability to local people from the outset and to open up the system to genuine public scrutiny."*

As set out at the beginning of this chapter, the Department's consultation posed specific questions on the proposed amendments to regulations. This document therefore concentrates on addressing the specifics of the regulations that consultees raised and the changes to the draft amendments we have made as a result of their comments. However, chapter 4 deals with the responses that expressed more general concerns through the 38 Degrees Campaign and associated responses. Where revisions have been made to the versions of the regulations consulted on that do not directly relate to comments received, this chapter also sets out and explains these changes.

Changes to definitions used across the amendments to regulations

Before proceeding with an explanation of the post-consultation revisions for each of the proposed sets of amendments to regulations, it is important to address comments received by

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NHS England that applied to all the draft amendments to regulations and have resulted in changes.

The draft amendments to regulations included a number of different definitions of ACOs and related terms:

- Definitions of Integrated Services Provider Contract and Integrated Services Provider are provided in the proposed amendments to the National Health Service (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015. The proposed amendments to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 cross-referred to that definition,
 - 'accountable care organisation' or ACO was defined in the proposed amendments to the National Health Service (Travel Expenses and Remission of Charges) Regulations 2003, the National Health Service (Charges for Drugs and Appliances) Regulations 2015 and the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and
 - a different definition of 'accountable care organisation' as given in the proposed amendments to the Medical Profession (Responsible Officers) Regulations 2010.
- NHS England's response commented on the definitions used in the draft amendments to regulations, "*(We) would suggest that some amendments are made to the drafting to ensure that the policy aims are achieved. Amongst these... we note that multiple different definitions of accountable care organisation, integrated services provider and related terms are currently used in the draft regulations... These different terms and definitions may cause some confusion and we would query whether it is necessary to distinguish in legislation between accountable care organisations and integrated services providers.*" NHSE also said of one specific definition which referred to NHS England 'designating' an organisation as an ACO and to an ACO being an organisation that makes "*most decisions about how to allocate resources and design care for its local population*" that it was "*not clear*" what designating was intended to mean and that the definition was "*problematic as it may suggest that an ACO can usurp or exercise the statutory duties of a clinical commissioning group. This is not the case. An ACO will not commission services.*"

Government response

- We acknowledge the points made by NHS England and wish to ensure that any definition used in the draft amendments to regulations cannot be misinterpreted as suggested by NHS England. This particular definition of ACO used in the consultation version of the proposed amendments has been changed, and is no longer contained in any of the final proposed amendments to regulations. These definitions will not mandate what form an ACO should take or what an ACO's responsibilities will be. Instead the definitions of an integrated services provider (ISP) and an integrated services provider contract (ISPC) are now used (revised draft set out in italics below). In the consultation document, the definition of "integrated services provider contract" appeared as a separate definition in the relevant definition section. The original intention was that an integrated services provider contract was a defined term to be used only in respect of an ACO contract under which primary

medical services were being provided. However, following NHS England's comments, we have reconsidered the relevant definitions within the proposed set of amendments. Given the aim of the new ACO contract is to commission integrated health and care services, we have taken the view that transparency and clarity is best served by maintaining a consistent definition that sets out who may be the commissioners of such a contract on the one part, and what services may be provided under or pursuant to that contract. The definition of integrated services provider contract has now been refined so that it now applies in all contexts to the contract which will be used by an ACO for the provision of integrated health and care services regardless of whether primary medical services are included in those services. The revised definitions also ensure that there can be no scope for misunderstanding about what is entailed by the ACO contract. By cross-referencing 'integrated services providers' to 'integrated services provider contracts', the new definitions make clear that the ACO contract does not create a new legal entity. Under an ACO contract, the 'ACO' will not commission services. An 'ACO' is simply a provider of health care services which enters into an integrated service provider contract. The definition that is to be inserted into Schedule 3A to the National Health Service (General Medical Services Contracts) Regulations 2015 is set out below.

Integrated services provider contracts

3.—(1) *For the purposes of this Schedule, an “integrated services provider contract” is a contract entered into [on or after coming into force⁴] which satisfies the following sub-paragraphs.*

(2) *An integrated services provider contract must be between—*

- (a) *one or more of the persons specified in sub-paragraph (3) on the one part; and*
- (b) *a person who is a provider of services specified in sub-paragraph (5) on the other part.*

(3) *The persons specified in this sub-paragraph are—*

- (a) *the Board;*
- (b) *one or more CCGs; or*
- (c) *one or more local authorities in England.*

(4) *An integrated services provider contract—*

- (a) *must relate to the provision of two or more of the services specified in sub-paragraph (5); and*
- (b) *must not be a contract to which sub-paragraph (6) applies.*

(5) *The services specified in this sub-paragraph are—*

- (a) *primary medical services;*
- (b) *secondary care services;*
- (c) *public health services; and*

⁴ A specific date will be inserted before the amendments to regulations are laid in Parliament.

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(d) *adult social care services,*

and include such services where they are provided under arrangements entered into by an NHS body or a local authority in England by virtue of section 75 of the Act.

(6) This sub-paragraph applies to a contract for the provision of primary medical services to which directions given by the Secretary of State under section 98A of the Act (exercise of functions) relating to the provision of alternative provider medical services under section 83(2) of the Act apply.

(7) In this paragraph—

“adult social care services” means services provided pursuant to the exercise of the adult social services functions of a local authority in England;

“adult social services functions” means social services functions within the meaning of the Local Authority and Social Services Act 1970 so far as relating to persons aged 18 or over, excluding any function to which Chapter 4 of Part 8 of the Education and Inspections Act 2006 applies;

“primary medical services” means services which the Board considers it appropriate to secure the provision of under section 83(2) of the 2006 Act (primary medical services);

“public health functions” means—

(a) the public health functions of the Secretary of State under the following provisions of the Act—

(i) section 2A (Secretary of State’s duty as to protection of public health);

(ii) section 2B (functions of local authorities and Secretary of State as to improvement of public health); or

(iii) paragraphs 8 or 12 of Schedule 1 (further provision about the Secretary of State and services under the Act);

(b) the public health functions of a local authority in England under the following provisions of the Act—

(i) section 2B (functions of local authorities and Secretary of State as to improvement of public health);

(ii) section 111 (dental public health); or

(iii) paragraphs 1 to 7B or 13 of Schedule 1 (further provision about the Secretary of State and services under this Act);

(c) the public health functions of the Secretary of State that a local authority in England is required to exercise by virtue of regulations made under section 6C(1) of the Act (regulations as to the exercise by local authorities of certain public health functions); or

(d) the public health functions of the Secretary of State where they are exercised by the Board, a CCG or a local authority in England where those bodies are acting pursuant to arrangements made under section 7A of the Act (exercise of the Secretary of State’s public health functions);

“public health services” are services which are provided pursuant to the exercise of public health functions;

“secondary care services” means—

(a) such services, accommodation or facilities as a CCG considers it appropriate to make arrangements for the provision of under or by virtue of section 3 (duties of clinical

You said, we did

commissioning groups as to commissioning of health services) or 3A (power of clinical commissioning groups to commission certain health services) of the Act; or

(b) such services or facilities as the Board is required by the Secretary of State to arrange by virtue of regulations made under section 3B (power to require Board to commission certain health services) of the Act.

Proposed amendments to the National Health Service (General Medical Services Contracts) Regulations 2015 and the National Health Service (Personal Medical Services Agreements) Regulations 2015

The British Medical Association (BMA) commented in detail on the sets of amendments and six of their suggestions have subsequently resulted in revisions to those amendments. On the amendments to the GMS and PMS regulations, the BMA commented that the length of notice period which a general medical services (GMS) or a personal medical services (PMS) contractor is required to give for reactivation of a suspended 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*”.

Government response

- The proposed 12 month notice period for reactivation of a suspended contract was intended to allow sufficient time for the contractor to make alternative arrangements for the provision of GP services to its patients, following the receipt of the notice to reactivate a GMS contract or PMS agreement. The BMA, in their comments, were looking for parity with the notice period for suspension of a contract/agreement. As many of the discussions concerning the suspension of a contract/agreement would have taken place prior to the issuing of the formal notice, the view was taken that the two situations were not comparable.
- Following the consultation, NHS England discussed policy with the General Practitioners' Committee (GPC) of the BMA. As a result of these discussions, the period of notice for the reactivation of a suspended GMS contract or PMS agreement has been amended to require notice to be given by the contractor at least six months before the date on which the proposed reactivation of the GMS contract or PMS agreement is to take effect.

In relation to holders of GMS contracts and PMS agreements, the BMA commented that “*additional burdens on practices are not appropriate (eg the requirement for the GMS practice to write to all patients in addition to the Commissioner)*”.

Government response

- The proposed policy aim was to ensure that patients were aware of the change in the arrangements under which GP services were being commissioned, and to allow them the choice of transferring to the list of service users of the ACO, or registering with another GP practice. We have reconsidered the burden on GP practices of writing to all patients to notify them of the changes as a result of the comments received in response to the consultation. While NHS England has overall responsibility for maintaining lists of patients registered with each provider of GP services, under current arrangements they are able to delegate this

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function to a CCG. In relation to future ACOs, we have amended the regulations to place the requirement to write to patients notifying them of proposed suspension/reactivation of a GMS contract or PMS agreement on NHS England. While the regulations place responsibility on NHS England, they are able to delegate this function to a CCG.

For both GMS contracts and PMS agreements, the BMA commented that *“the decision-making processes relating to reactivating... 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”*.

Government response

- Where a GMS contract, or PMS Agreement is to be suspended or reactivated, the draft amendments aim to ensure that all parties to the contract or agreement have agreed to such action. The GPC advised that it is customary for most GP practices to have a partnership agreement which sets out the agreed decision making process. In order to allow such agreed procedures to apply to the decision to suspend/reactivate a contract or agreement, the proposed amendments have been revised to allow reactivation of a suspended GMS contract or PMS agreement where the parties to the contract or agreement have agreed, as appropriate, to the reactivation of the contract.

Additionally, the BMA commented 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.”*

Government response

- The National Health Service (Personal Medical Services Agreements) Regulations 2015 provide for PMS contractors, who hold a list of registered patients, to transfer to providing services under a GMS contract – with the agreement of the commissioner and where the contractors meet the eligibility criteria for holding such a contract. In response to the comments received, the proposed amendments have been revised to make clear that this entitlement will apply on reactivation of a suspended PMS agreement.

Draft Primary Medical Services (Prohibition on the Sale of Goodwill) Regulations 2018

The BMA responded to the consultation saying they agree that the proposed new regulations deliver the policy objective, *“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.”*

Additionally, the BMA commented on the breadth of the provisions: *“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,*

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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."

Government response

- The Primary Medical Services (Sale of Goodwill and Restriction on Sub-contracting) Regulations 2004 prevent GMS, PMS and APMS contractors from including an element of goodwill in the sale of a medical practice which provides NHS GP services. In order to achieve a level of parity with other providers of GP services, the new draft Sale of Goodwill Regulations proposed to impose similar restrictions on ACO contractors. In addition, as ACOs are likely to sub-contract some of their responsibilities, the policy was extended to impose the restrictions on sale of goodwill to sub-contractors of ACOs.
- For consistency, the draft regulations proposed extending the existing restrictions to apply to sub-contractors of GMS, PMS and APMS contractors also. We accept that, as GMS, PMS and APMS contractors are less likely to sub-contract the provision of services, the application of the restrictions to sub-contractors of GMS, PMS and APMS contractors has therefore been removed.

The BMA also highlighted that *"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"*.

Government response

- The words 'that has a registered patient list' were removed in error. The wording has now been reinstated.

Proposed amendments to the Local Authority Social Services and National Health Service (Complaints) Regulations 2009

NHS England commented specifically on one of the definitions of "ACO" used in the proposed amendments to the regulations *"We have noted our wider concern relating to the existence of multiple definitions... within this context, the definition proposed for the purposes of the complaints regulations also raises specific concerns. We note that the proposed definition is very broad. While this may be intended to accommodate a range of different types of ACO, subsection (b) in particular is problematic as it may suggest that an ACO can usurp or exercise the statutory duties of a clinical commissioning group. This is not the case. An ACO will not commission services. The draft definition refers to NHS England 'designating' an ACO. However, it is not clear what this is intended to mean and NHS England has not suggested such a process. A body would become an ACO if it is awarded an ACO contract, rather than by being 'designated' as such."*

Government response

Accountable Care Organisations

- We acknowledge the points made by NHS England and wish to ensure that the definition used in the regulations is clear and cannot be misinterpreted as suggested by NHS England. This particular definition of ACO is no longer contained in the final draft regulations. Instead there is a cross-reference made in these regulations to the definition of an integrated services provider contract (ISPC) which will be inserted into the National Health Service (General Medical Services Contracts) Regulations 2015, which is set out in italics on pages 13-15. We have also referred to an integrated services provider and an integrated services sub-contractor.

NHS England also commented on the extent to which the draft amendments to regulations applied in circumstances where a non-NHS body subcontracts to a non-NHS body subcontractor and noted that "*a similar gap applies in all circumstances in which a non-NHS body lead provider sub-contracts to a non-NHS body sub-contractor, DH may wish to consider this, and amend the Amendment regulations to cover all such circumstances, not just those arising in an ACO context.*"

Government response

- In response, we have included a duty on sub-contractors outside the ACO context to handle complaints. We have also included amendments to ensure that duties on commissioners in relation to complaints about service provision apply to complaints about services provided by sub-contractors.

Proposed amendments to the National Health Service (Charges for Drugs and Appliances) Regulations 2015

NHS England's comments in relation to the definitions of ACO used in the draft amendments to regulations (see pages 11-12) and the complaints regulations (pages 17-18) applies to these regulations.

NHS England also noted that an amendment was needed to the Explanatory Note to these draft amendments to regulations as it referred to services 'being commissioned by ACOs, but as noted above, ACOs will not commission services.

Government response

- As set out above, we acknowledge the points made by NHS England and wish to ensure that the definition used cannot be misinterpreted as suggested by NHS England. This particular definition of ACO is no longer contained in any of the draft amendments to regulations. The regulations will not mandate what form an ACO should take or what an ACO's responsibilities will be. Instead there is a cross-reference made in these regulations to the definition of an integrated services provider contract (ISPC) which will be inserted into the National Health Service (General Medical Services Contracts) Regulations 2015, which is set out in italics on pages 13-15.

You said, we did

- We have also amended the text of the Explanatory Note to refer instead to services being commissioned and provided under new contracts known as integrated services provider contracts.

Proposed amendments to the National Health Service (Travel Expenses and Remission of Charges) Regulations 2003

NHS England made comments in relation to the proposed definition of 'ACO' in these draft amendments to regulations which were similar to those made in relation to the other amending regulations consulted on. They also commented that as currently drafted, the proposed amendments to these regulations might only result in the lead ACO being responsible to meet the costs of NHS travel expenses, as it was not clear to what extent the draft amendments addressed the policy intention that sub-contractors to an ACO would be captured by these regulations.

They also suggested that the Department should give some consideration to ensuring that other elements of the proposed changes to these particular regulations do not risk conflating the functions of a commissioner with the activities of an ACO. NHS England commented on a reference in the Explanatory Note, similarly to their comment on the Explanatory Note to the proposed amendments to the National Health Services (Charges for Drugs and Appliances) Regulations 2015. The Explanatory Note to both sets of draft amending regulations referred to services 'being commissioned by ACOs, which they considered should be deleted as ACOs would not be commissioning services.

Government response

- Changes have been made to the definition of ACO which are similar to those made to the proposed amendments to the Local Authority Social Services and National Health Service (Complaints) Regulations 2009, please see pages 17-18, which set out those changes. In relation to the comments about who will be responsible for paying NHS travel expenses where services are provided by integrated services sub-contractors, we have made the following changes. Where integrated services providers are NHS trusts or NHS foundation trusts, they will be responsible for making NHS travel expenses payments to patients in respect of services they themselves provide and services provided on their behalf by integrated services sub-contractors. In circumstances where services are provided, or commissioned, by local authorities, NHS travel expenses payments will be made by the relevant CCG. In all other circumstances, the commissioners of the integrated services will be responsible for making these payments, including where services are provided by integrated services sub-contractors.
- The changes have been made in this way as some potential integrated services providers or sub-contractors may not have powers to themselves make NHS travel expenses payments. This is to ensure that eligible patients will not lose their entitlements to NHS travel expenses payments under the new arrangements. We have clarified the regulations to ensure that the functions of commissioners are clearly distinguished from the activities of integrated services providers and sub-contractors. We have also amended the Explanatory Note in these amending regulations to refer to services being commissioned and provided under new contracts known as integrated services provider contracts, in line with the similar

amendment made to the Explanatory Note in the draft amendments to the National Health Service (Charges for Drugs and Appliances) Regulations 2015.

Proposed amendments to the Medical Profession (Responsible Officers) Regulations 2010

The consultation document proposed that NHS England would be able to decide whether a doctor on the performer's list working under ACO arrangements should have a connection to a responsible officer based in the ACO or in NHS England. Following the consultation, we have decided that the connection to a designated body should be set out in legislation rather than NHS England having discretion to determine this.

We have amended the draft amendments to regulations to set out that, where a medical practitioner is directly employed by an ACO, the responsible officer will be provided by the ACO as the designated body. Where a medical practitioner is engaged to provide primary medical services for an ACO on a contractual basis (for example under a sub-contract with the ACO), the responsible officer will be provided by NHS England, as the designated body. Where a medical practitioner is engaged to provide non-primary medical services health services (secondary care) on a contractual basis, the ACO will be the designated body responsible for appointing a responsible officer for that medical practitioner. As in all cases, where a medical practitioner has a prescribed connection with more than one designated body, the prescribed connection is with the designated body for which the medical practitioner carries out the majority of their practice; if there is no significant difference in the amount of clinical practice, the designated body will be an NHS body, otherwise the prescribed connection will be with the designated body in closest proximity to the medical practitioner's address registered with the General Medical Council.

It is important that the medical practitioner has the most appropriate connection to a designated body and responsible officer in order to ensure best oversight and governance. We have amended the regulations to ensure where a medical practitioner is not directly employed to provide primary medical care by an ACO, the connection is to NHS England, as it currently provides this role for contracted primary care practitioners, and has strong governance systems already in place. There are no equivalent oversight arrangements for contracted secondary care providers, so the ACO is the most appropriate connection to ensure governance arrangements are in place, and we have amended the regulations to ensure this.

Proposed amendments to the National Health Service (Performers Lists) (England) Regulations 2013

The consultation document proposed that amendment is needed to the regulations to ensure that all types of primary medical services contracts that practitioners work under when providing primary medical services are considered, when a practitioner is applying to be included on the performers list.

We received no comments that disagreed with that proposal, and the BMA responded that "*The proposed NHS (Performers List) (England) (Amendment) Regulations 2018 provide clear amendments which appear to meet the aims of the policy.*"

As part of the post consultation revisions, we have made changes to the draft amendments to omit the definition of "scheme" which appeared in regulation 3(a)(iv) of the consultation version of the amending regulations because this provision is no longer relevant to the operation of the medical performers list.

Proposed amendments to the National Health Service (Licence Exemptions, etc) Regulations 2013

The BMA agreed that the amendments deliver the policy objective. However they flagged that the current amendments suggest a wider scope than just to allow for ACOs, *“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.”*

Government response

- Although the inception of ACOs has provided much of the impetus for developing policy in this area and bringing forward the proposed changes to the regulations, the overall purpose is to rectify an anomaly in the licensing regime that applies to any and all current and/or potential providers who otherwise fulfil the criteria for needing to be licensed and are able to benefit from licensing exemptions. We acknowledge that the activities of some private sector providers will come within the scope of this change, but consider that the additional effort required will be minimal. This is because the need to be aware of the amount, source and likely longevity of an income stream is a normal business practice for such providers anyway. The cost/benefit of licensing has already been accepted. This is for the benefit of patients' safety and the public purse.
- We recognise that this change may require providers who may be able to benefit from this exemption to assess their turnover indefinitely; we will ensure that the guidance accompanying the revised regulations includes wording to the effect that i) the requirement applies only to providers of NHS healthcare services, ii) that it ceases when they cease to provide such services, and iii) that it should fit with their current business planning obligations and will be proportionate to their turnover. The amendments to those regulations have also been redrafted to make this clearer.
- In reviewing this proposed exemption post consultation, as a result of the need to ensure a level playing field, as well as to protect the public, we have decided that providers will not be able to rely on this licence exemption simply due to short term changes in their turnover. We have therefore introduced a new requirement that providers that estimate their applicable turnover will be less than the £10 million threshold must remain licensed for a further year where they continue to hold a contract which was taken into account for the purposes of assessing their applicable turnover and which resulted in the provider being required to hold a licence.

Proposed amendments to the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

No consultation responses were received in relation to this set of regulations other than those from NHS England that applied to the definition used in this proposed amendment and others. Therefore no changes have been made, other than to update the cross-reference to the definition of 'integrated services provider contract' in the proposed amendments to the National Health Service (General Medical Services Contracts) Regulations 2015.

4. 38 Degrees campaign

Using data science computer technology, analysts identified that 23 templates had been used. Many of the templates are largely identical to each other, but with a variation in the first sentence. For example, “It is my opinion that” rather than “My view is that”. The following table details the content of each template and the number of responses received for each.

		No. of matches		
		Exact	Partial	Within
2	i am contributing to this consultation because i believe the voice of the public should be heard on new plans for our nhs called accountable care organisations please will you ensure that no fundamental changes to our nhs happen without parliament having a vote new plans for the nhs put patients first so as many members of the public are consulted as possible all details of the new plans are published so that the consultation is fair	3201	600	1407
2	i am contributing to this consultation because i believe the voice of the public should be heard on new plans for our nhs called accountable care organisations please will you ensure that any changes to the nhs are voted on in parliament new plans for the nhs put patients first so as many members of the public are consulted as possible all details of the new plans are published so that the consultation is fair	3162	590	
2,6	i am contributing to this consultation because i believe the voice of the public should be heard on new plans for our nhs called accountable care organisations please will you ensure that nhs plans face full parliamentary scrutiny new plans for the nhs put patients first so as many members of the public are consulted as possible all details of the new plans are published so that the consultation is fair	3082	558	30
5,7	it is my opinion that the consultation on accountable care organisations doesn't go far enough please will you announce full details of the plans and make sure they face a parliamentary vote i also believe that the public should be consulted properly to ensure patients are at the heart of decisions about the nhs	2891	384	84
5,7	my view is that the consultation on accountable care organisations doesn't go far enough please will you announce full details of the plans and make sure they face a parliamentary vote i also believe that the public should be consulted properly to ensure patients are at the heart of decisions about the nhs	2792	379	
5,7	i think that the consultation on accountable care organisations doesn't go far enough please will you announce full details of the plans and make sure they face a parliamentary vote i also believe that the public should be consulted properly to ensure patients are at the heart of decisions about the nhs	2788	353	

Accountable Care Organisations

1,4,9	i am writing to you today because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure no changes to the nhs happen without parliament having a vote the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1114	136	1323
1,4,9	i wanted to write to you because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure no changes to the nhs happen without parliament having a vote the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1079	134	
1,4,9	i'm writing because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure no changes to the nhs happen without parliament having a vote the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1079	133	
1,4,9	i am writing to you today because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure any changes to the nhs are voted on in parliament the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1068	130	
1,4,9	i am writing to you today because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure nhs plans face full parliamentary scrutiny the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1033	127	
1,4,9	i wanted to write to you because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure any changes to the nhs are voted on in parliament the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1031	125	
1,4,9	i'm writing because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure nhs plans face full parliamentary scrutiny the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1023	122	
1,4,9	i'm writing because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure any changes to the nhs are voted on in parliament the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1008	117	

38 Degrees campaign

1,4,9	i wanted to write to you because it is my view that the public's voice should be heard on new plans for how the nhs is structured called accountable care organisations please will you commit to making sure nhs plans face full parliamentary scrutiny the new plans rule out further privatisation of the nhs further details of the plans are published in full and consulted on	1003	116	
3,8	i am worried because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure more details of the plans are released and consulted on by the public	1436	274	151
3,8	i am concerned because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure more details of the plans are released and consulted on by the public	1390	266	
3	i am worried because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure mps are able to scrutinize the plans in parliament	1375	239	648
3	i am concerned because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure the new plans are debated and voted on in parliament	1335	229	
3	i am concerned because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure mps are able to scrutinize the plans in parliament	1326	226	
3	i am worried because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure the new plans are debated and voted on in parliament	1289	220	
3	i am worried because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure the new plans are debated and voted on in parliament imps [sic] are able to scrutinize the plans in parliament	21		
3	i am concerned because new plans for our nhs called accountable care organisations could mean further privatisation of our nhs please will you make sure the new plans are debated and voted on in parliament imps [sic] are able to scrutinize the plans in parliament	13		
		35,539	5,458	3,643

Across the board, the campaign responses raised the following three concerns:

- Lack of parliamentary scrutiny;
- inadequate consultation;
- and opposition to perceived privatisation of the NHS

Accountable Care Organisations

This chapter sets out the Government response to these concerns and provides further information about what an ACO is and is not. Chapter 5 details what the next steps will be.

All the responses from members of the public demonstrated the high value the public place on the NHS. Many of the responses highlighted the lifeline that the NHS has been to them and the reality that many people rely on the NHS day to day. The Government remains committed to the founding principles of the NHS and the Secretary of State retains a duty to promote a comprehensive health service free at the point of use.

Caring for the needs of people with long term and complex health needs is now a central task of the NHS, and this requires a partnership with patients over the long term rather than providing single, unconnected 'episodes' of care. The traditional divide between primary care, community services, social care services, public health services, and hospitals is increasingly a barrier to delivering the personalised and coordinated health services patients need. Integrating services benefits both patients and the system.

As NHS England has said, "*There is widespread support for ending the fragmented way that care has been provided to improve services for patients and the NHS has been working towards this in a number of ways. ACOs are just one of these ways and are intended to allow health and care organisations to formally contract to provide services for a local population in a coordinated way.*"⁵

ACOs aim to integrate care and bring services together, to ensure that people's care is coordinated around them. If introduced, ACOs are designed to help deliver more care in the community and patients' homes, improving access to services and meaning fewer trips to hospital.

An ACO is not a new type of legal entity and would not affect the commissioning structure of the NHS. An ACO would simply be the provider organisation which is awarded a single contract by commissioners for all the services which are within scope for the local accountable care model. The contract holder becomes contractually responsible for improving population health outcomes, rather than simply for providing services. The idea behind accountable care is that it brings different organisations from across the health and care system together to work to improve the health of their local population by integrating services and tackling the causes of ill health.

Perceived Privatisation

It is misleading to suggest that ACOs are a step towards privatising the health system. The objective of the new care models programme is to deliver joined up, patient-centred care. ACOs will always offer free healthcare at the point of use.

International examples of organisations calling themselves 'ACOs' look very different in the context of different health economies and different legislative frameworks. Comparisons to other countries' health economies are misleading and NHS England has published several documents describing what an ACO might look like in the context of the NHS.⁶

⁵ [NHS England announces consultation on ACO contracts](#)

⁶ [MCP framework](#), [PACS framework](#)

38 Degrees campaign

The two areas at the forefront and that may choose to use an ACO contract are Dudley, and Manchester's proposed local care organisation. Currently, emerging bidders for both proposals are NHS body led, have the support of local GPs and are not private sector organisations.

More generally, we currently believe it is unlikely that an Independent Sector provider could satisfy the conditions of an ACO contract. Therefore while the procurement of these contracts is always a matter for local commissioning bodies, we cannot currently envisage a situation, where ACO contracts could be held by non-NHS bodies.

Certain groups of campaigners have made claims about so-called privatisation over many years and these have proved unfounded time and again. The current debate could be seen as comparable to that which took place at the outset of Foundation Trusts, which were accused of being a tool for privatisation, and yet few people today would suggest our Foundation Trusts are in any way examples of privatisation

Parliamentary process and scrutiny

The government has noted the public response, particularly around the need for public and parliamentary consultation. Since this consultation was published, NHS England has [announced a public consultation on contracting arrangements for ACOs](#). Further to this, the Health and Social Care Select Committee (HSC) has added ACOs to the scope of its current inquiry on Sustainability and Transformation Partnerships. The government has therefore taken the decision to delay laying the amendments to regulations until such time as the NHS England consultation has been completed.

5. What's next?

In this consultation we have responded to comments specifically on the proposed amendments to regulations. As mentioned above, NHS England has committed to consulting on the ACO contract more widely. The consultation will set out how the contract fits within the NHS as a whole, address how the existing statutory duties of NHS commissioners and providers would be performed under it (including how this would work with existing governance arrangements), and will set out how public accountability and patient choice would be preserved.

Following the outcome of NHS England's consultation, the government intends to consult on new draft Directions to ensure that the criteria for an ACO delivering primary medical services (GP services) are consistent with the criteria for existing providers of primary medical services. If NHS England introduces the ACO contract for use following this consultation, the directions will initially be limited to Dudley and Manchester. Directions would be made available for other local areas wishing to use the ACO contract as long as they are signed off through ISAP, satisfying Government scrutiny requirements.”

The government has noted the public response, particularly around the need for further public and parliamentary consultation. As well as NHS England's consultation, the Health and Social Care Select Committee (HSC) has added ACOs to the scope of its current inquiry on Sustainability and Transformation partnerships. The government has therefore taken the decision to delay laying the amendments to regulations until such time as the NHS England consultation is complete.

Nothing in the proposed legislative changes mandates what NHS England may subsequently decide to do. Even if the legislative changes are made, NHS England may decide not to introduce a standard model contract for ACOs at all. The proposed legislative changes do not ‘enshrine’ or ‘assume’ any particular form or terms of ACO contract.