Memorandum of understanding for 'shadow' Accountable Care Systems

Dear Tim,

As described in *Next Steps on the NHS Five Year Forward View*, we intend to name a small number of STPs as England's first Accountable Care Systems (ACSs). These will operate in 'shadow' form in 2017/18, becoming 'full' ACSs from 2018/19 if the right progress has been made. We are writing to confirm Dorset as a member of the initial cohort, subject to your agreement (on behalf of all the leaders in your system), and to describe the terms of this new relationship with the national leadership bodies.

The memorandum of understanding (MOU) does not have legal force but it does describe what we need to achieve in 2017/18 and the way we agree to help each other to make the fastest possible progress.

Objectives

As laid out in *Next Steps*, ACSs involve all NHS organisations in a local area working together and in partnership with local authorities to take collective responsibility for resources and population health. They are expected to make faster progress than other STPs in transforming the way care is delivered, to the benefit of the population they serve. The objectives of ACSs are:

1. To make fast and tangible progress in urgent and emergency care reform, strengthening general practice and improving mental health and cancer services.
2. To manage these and other improvements within a shared financial control total and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget.
3. To integrate services and funding, operating as an integrated health system, and progressively to build the capabilities to manage the health of the ACS' defined population, keeping people healthier for longer and reducing avoidable demand for healthcare services.
4. To act as a leadership cohort, demonstrating what can be achieved with strong local leadership and increased freedoms and flexibilities, and to develop learning together with the national bodies that other systems can subsequently follow.

Improving services

Next Steps sets out four priority services in which we expect ACSs to make rapid progress in 2017/18 (as 'shadow' ACSs) and 2018/19 (as 'full' ACSs). ACSs will be judged by the results they achieve, so it is crucial their first priority is to implement changes in the following four areas. Note that this is a summary of the deliverables in the first four sections of *Next Steps* so is not exhaustive – ACSs will also be expected to deliver on other national priorities, including maternity and diabetes.

Urgent and Emergency Care:

- Work with community services and local councils to free up the ACS's share of the 2000-3000 acute hospital beds occupied by patients awaiting social care, and the similar number accounted for by patients awaiting community health services.
- Implement front-door streaming in every hospital by October 2017.
- Provide specialist mental health care in A&Es, ensuring that by 2020/21 all acute hospitals have all-age mental health liaison teams in place.
- Enhance NHS 111 by increasing the proportion of calls receiving clinical assessment to over 30% by March 2018.
- In line with nationally agreed plans, agree sites to be designated as part of a first wave of new 'Urgent Treatment Centres' which will open 12 hours a day, seven days a week, integrated with local urgent care services. A plan for all services currently described as urgent care centres, minor injury unit / services or walk in centres should be developed by March 2018 with implementation complete by December 2019.
- Achieve 90% performance on the 4 hour standard by September 2017, and 95% by March 2018.
- Every hospital within your ACS needs to meet these standards, as well as the wider expectations set out in Chapter 2 of the *Next Steps* document.
- In addition, implement the core components of the Enhanced Health in Care Homes model to improve care for residents and reduce emergency admissions from care homes, as demonstrated by the Enhanced Health in Care Homes vanguards.

Primary Care:

- Deliver extended access to general practice for 100% of the local population by March 2019 for NHS Dorset CCG.
- Support comprehensive local delivery of the General Practice Forward View, including boosting local GP numbers and taking concrete actions to improve retention in 2017/18.
- Catalyse the formation of primary care networks that:
    - Serve registered populations of at least 30-50,000.
    - Are beginning to share workforce, infrastructure and to pool responsibility for urgent care and extended access.
    - Are demonstrably moving towards integrated, multidisciplinary teams together with local community, mental health and social care providers. This should include deploying the ACS's share of clinical pharmacists and mental health therapists, as well as physician associates and more nurses in general practice beginning in 2017/18.
    - Offer an attractive career model and working environment for new GPs as well as incentives for existing GPs to continue practising.
    - Analyse and segment their population to identify people at risk of becoming seriously ill or requiring hospitalisation and take proactive action to prevent this. The most advanced practices may test ways of sharing risk and rewards with hospitals.

        - Deploy capital and premises investments to support team-based and proactive care as well as to invest in additional facilities (e.g. diagnostics) that expand services provided outside of hospital.
    - All CCGs should have delegated commissioning arrangements for primary medical services from 1 April 2018. For those CCGs who haven't already taken on delegated commissioning, we will need to work through the specifics with you.

Cancer:

- Work through the ACS's local Cancer Alliance to deliver the National Cancer Taskforce recommendations, and demonstrate improved cancer outcomes for their populations. This will include:
    - Taking specific action to improve early diagnosis rates. In particular, improvement in the proportion of cancers diagnosed at stage 1 and 2, reduction in the proportion of cancers which present as an emergency, and improved one year survival rates for all cancers.
    - Delivering the 62 day referral to treatment target, including through the introduction of new diagnostic models and pathways, for example rapid diagnostic and assessment centres.
    - Supporting the introduction of new screening programmes and technologies (for example FIT for bowel screening and the and primary HPV testing for cervical screening), and increasing the uptake of existing screening programmes.
    - Improving quality of life and patient experience for their population following cancer diagnosis and treatment, for example by working with their cancer alliance(s) to roll out the recovery package and risk stratified follow up pathways.

Mental Health:

- Produce robust ACS plans in line with STP requirement which align with the Mental Health Delivery Plan 2017/18 and demonstrate how the ACS will meet the targets and deliverables of the FYFV for Mental Health set out in *Implementing the Five Year Forward View for Mental Health* and further set out in *Next Steps*, including:
    - Increasing access to psychological therapies, so that at least 16.8% of people with common mental health conditions access psychological therapies in 2017/18, increasing to 19% in 2018/19.
    - Increasing access to NHS commissioned community mental health services for children and young people, so that 30% of children and young people with a diagnosable mental health condition receive treatment from NHS-funded community mental health services in 2017/18, increasing to 32% in 2018/19, and meeting standards for access to eating disorder services.
    - Implementing physical health checks for people with severe mental illness (SMI): demonstrating delivery against local plans and trajectories, in line with national ambition of 140,000 people with SMI receiving complete list of physical checks in 2017/18 and 280,000 in 2018/19.
    - Meeting standards for access to early intervention in psychosis services.

        - Developing specialist perinatal mental health provision including mother and baby units (where present in the ACS) and community teams.
        - Ensuring ACS wide coverage of 24/7 community crisis response and intensive home treatment teams as a genuine alternative to admission by 2021. From April 2018, delivering a one third reduction year-on-year in adults sent out-of-area for non-specialist acute mental health care, towards eliminating this practice by 2021.
    - In addition, make demonstrable progress on delivering a workforce plan that meets national ambitions for increased mental health staffing, including therapists in primary care and staff to support expanded services, as set out in *Next Steps*.

In addition to the above, ACSs should strive to deliver the 18 week RTT standard, ensuring there is no significant deterioration in waiting list size, across every hospital in the ACS. ACSs should lead the way in demonstrating effective ways of moderating demand for elective care.

Managing collective resources

ACSs are expected to operate within a shared financial control total or system control total. This will be the aggregation of individual CCG and NHS provider control totals as agreed through the 2017-19 planning process. ACSs will have the flexibility to offset under-performance in one organisation with over-performance in another, provided they sign up to individual control totals and there is agreement between all parties within the ACS, NHS England and NHS Improvement.

There is no additional funding available, so the ACS will need to manage within the resources set by existing control totals. During 2017/18, we will support you to manage these resources flexibly so that your ACS as a whole lives within its system control total and delivers its system risk reserve. In the first instance, we will look to the ACS to take responsibility for managing system finances through its own governance arrangements. Where intervention in individual organisations is required we will do this in partnership with the ACS leadership.

The full terms of systems control totals for 'full' ACSs in 2018/19 will be developed and agreed during 2017/18. In general, system control totals are:

- A shared commitment to deliver the overall financial goals and targets of the system alongside the ongoing accountabilities of individual organisations.
- A mechanism to give systems the flexibility to operate effectively together and make local financial trade-offs as they implement transformation which may affect the financial position of individual organisations differently.
- An approach designed to facilitate shared financial risk management across local health economies.
- An enabler of joined up oversight of a system by NHSE and NHSI, with any individual interventions required taking place in partnership with the ACS leadership.

They are not:

- To be applied to non-financial performance targets, at least at this stage.
- A replacement for individual accountability of Boards and Governing Bodies.

- An exemption from the oversight regimes of NHSE and NHSI – or from normal business rules, including system risk reserve requirements.
- Of themselves, extra money – i.e. the system control total is the sum of the allocations and control totals of the constituent organisations not the number the system concerned would ideally like to have.

ACSs should have a clear objective of improving and sustaining the collective financial position for their local health economy, supported by simplified arrangements for collective financial planning and risk management. They will need to have a single system operating plan that aligns the activity and financial plans of CCGs and providers and delivers the efficiencies needed to live within the system control total. ACSs will, where necessary, agree contract variations to ensure that the costs and benefits of actions to manage demand and improve efficiency are shared appropriately between organisations. NHS England and NHS Improvement will work closely with ACSs to develop this approach so that all ACSs start 2018/19 with aligned plans and clear agreements on how costs and savings will be shared between organisations.

As part of your commitment to shared management of resources, your system will need to make rapid progress in achieving system-wide efficiencies, including those described in the '10 point efficiency plan' in *Next Steps*. These include:

- Providers within the ACS to continue to operate within their agency expenditure ceiling for 2017-18 and to collectively explore regional options for reducing agency expenditure.
- Implement the recommendations of Getting It Right First Time (GIRFT) reports, including but not limited to those relating to data provision, service design and workforce deployment. Alongside this, play an active role in engaging with ongoing GIRFT reviews and act on any early quality and efficiency findings without delay.
- Become system leaders in implementing operational productivity improvements and increasing focus on reducing unwarranted provider expenditure, including but not limited to the consolidation of corporate services, the networking of pathology and other clinical support services, and concerted action to drive better value from NHS procurement. This will require you to draw upon the data, analysis and guidance of NHS Improvement's operational productivity workstreams.
- Improve the productivity of trust clinical workforce and estates and facilities by implementing best practice in staff rostering and job planning, as well as making more productive use of NHS land and bearing down on facilities costs. This may require upscaling of IT infrastructure to drive productivity improvement.
- Work with your nominated RightCare delivery partner and team to implement efficiency initiatives through a focus on value and reducing unwarranted variation.
- Be prepared to lead nationally on a specific opportunity for system-wide efficiency – e.g. consolidated backoffice/support function, to be agreed at a later date.

Developing accountable care

Next Steps also set how the national bodies will back areas wanting to go further in integrating services and funding and to develop greater local accountability for population health. There is no complete blueprint for this greater integration. Instead the national bodies want to work alongside leading systems to push existing boundaries, rapidly innovate and evaluate, and develop the 'playbook' for the rest of the NHS, building on the learning from the New Care Models Programme.

The national bodies will work with you over 2017/18 to develop the capabilities required to take on greater accountability for population health, including:

- Creating an effective collective decision making and governance structure, aligning the ongoing and continuing individual statutory accountabilities of constituent bodies, and building sufficient implementation capability to drive both service improvement and development as an ACS.
- Developing as a vertically integrated care system. This will mean local GP practices forming clinical hubs serving populations of 30,000-50,000, and developing new relationships between general practice, community and mental health providers, as well as social services in order to design more proactive care models staffed by integrated, multidisciplinary teams.
- Spreading existing vanguard care models across the whole ACS area and adopting population health care models in areas that have not yet been part of the new care models programme.
- Deploying (or partnering with third party experts to access) rigorous and validated population health management capabilities that improve prevention, enhance patient activation and supported self-management for long term conditions, manage avoidable demand, and reduce unwarranted variation in line with the RightCare programme.
- Realising the benefits of horizontal integration, including clinically networked service delivery, whether through closer cooperation, virtual or actual integration between trusts, learning from the Acute Care Collaboration vanguards.
- Reforming and integrating the payment system to move beyond activity-based reimbursement where appropriate, more assertively moderating demand growth, and effectively abolishing the annual transactional, contractual, purchaser-provider negotiations. This will involve implementing new ways of sharing and managing financial and activity risk across the system.
- Engaging effectively with patients, service users, carers, members of the public and staff.
- Establishing clear mechanisms by which patients will still be able to exercise choice over where they are treated for elective care, and increasingly use their personal health budgets where these are coming into operation.

The national bodies will work alongside you and the wider group of initial ACSs to support the development of these capabilities, providing expertise where we have it and helping to partner with others to provide it where we don't have the right expertise in house. We ask that you

participate in this leadership and development group and assist us in developing learning that can be made available to 'fast followers' and other systems.

Freedoms and flexibilities

The national bodies will grant ACSs the following freedoms and flexibilities, which will only apply fully from 2018/19 onwards, but where possible we will seek to introduce during 2017/18 for shadow ACSs as well:

- Delegated decision rights, where appropriate, on commissioning, or co-commissioning, of primary care and specialised services. We will need to work through the specifics of this with you.
- Streamlined regulation
    - Jennifer Howells will be the lead regional director for your shadow ACS, acting as your main point of contact for the purposes of discussions about system performance and support.
    - The National Director of Operations for NHS England, Executive Director of Strategy for NHS Improvement and the CEOs of both organisations will remain personally involved in sponsoring the ACS group, in coordination with this lead regional director.
    - In 2017/18, together we will identify opportunities to stop or streamline other reporting relationships or processes.
- In the course of 2017/18, the ability to redeploy or embed attributable staff and related funding from NHS England and NHS Improvement to support the work of the ACS, as well as to free up local administrative cost from the contracting mechanism, and its reinvestment in ACS priorities.
- A devolved transformation funding package, as outlined in the table on the next page.

	2017/18	2018/19	2019/20	2020/21	Requirements/notes (may be subject to minor amendments)
1. Bidding pots already allocated					
Mental health IAPT and liaison	0.8	-	-	-	Tied to delivery of mental health requirements on IAPT, mental health liaison Where funding flows through lead CCG, ACS share shown based on population share
Diabetes	0.2	-	-	-	Delivery of diabetes requirements as notified 18/19 funding yet to be confirmed
					Other funds may be awarded in addition e.g. TCP, cancer alliances, other MH which do not map consistently to ACS geographies
2. Potential/notified shares of transformation funding items					
Mental health	-	-	0.6	0.6	Mental health strategy
Diabetes	-	-	0.6	0.6	Diabetes FYFV objectives
Cancer	-	-	1.9	2.4	Delivery of Cancer Strategy
Maternity	-	0.4	0.7	1.1	Deliver maternity review recommendations
General Practice Forward View	0.3	3.1	5.1	5.0	Access, training care navigators, online consultations - already notified for 17/18 and 18/19
STP infrastructure	0.2	0.2	-	-	STP Infrastructure support. Not applicable to non STPs
Other	-	0.0	10.6	6.1	Priorities in Next Steps and other national requirements
3. Flexible funding					
	3.8	3.0	-	-	Priorities in Next Steps. Subject to assurance conditions and progress to formal ACS status. £1 per head population notionally allocated to primary care network development
TOTAL	**5.3**	**6.7**	**19.5**	**15.8**	

The specific allocations for mental health, GPFV and diabetes for 2017/18 and in some cases 2018/19 have already been notified to the relevant organisations.

Definitive allocations are subject to formal decisions on ACS accreditation by NHS England. Prior to the release of any of the additional devolved funding included in this package each ACS will need to demonstrate:

- Governance and accountability arrangements so it is clear how decisions are made and who is accountable for delivering value for money from the expenditure.
- A value based allocation process for determining the use of the funding.

- Arrangements for oversight and reporting of expenditure and tracking of benefits realisation.

In keeping with the logic of moving to a delegated transformation fund, for 2019/20 and 2020/21, CCGs and providers in ACS areas will, in general, no longer be eligible to receive funding through national programme allocations or to submit bids to funds which have been included in the devolved funding. This includes mental health, diabetes, cancer, maternity, primary care, UEC, and other transformation objectives such as learning disabilities, care homes, new care models, prevention, obesity, dementia and seven day services. In 2017/18 and 2018/19, where new funds are available for bids/allocation, ACS areas will continue to be able to access these. This does not apply to enhanced health in care homes, which is already included in the devolved funding amounts in 2017/18 and 2018/19, or primary care networks funding which is included in 2017/18, or maternity which is included in 2018/19.

The devolved transformation fund package figures for 2019/20 and 2020/21 are indicative at this stage, and therefore subject to change.

Technology funding through the National Information Board is excluded as a separate allocation and different decision-making arrangements apply to this funding.

Ways of working

To deliver the commitments outlined above, changes in working relationships will be needed at the ACS level and between the ACS and national bodies:

- National bodies and shadow ACSs will work together to achieve the aims set out in this letter and the broader *Next Steps* document, in a spirit of openness and cooperation. We will work together as peers, solving problems on behalf of the populations ACSs. The answers we reach will help us collectively to achieve the objectives set out in this MOU for the initial ACSs and, over time, for the rest of the country.
- To this end national bodies have convened a development group made up of the leaders of the first cohort of shadow ACSs, with the involvement of national directors and regional directors from NHS England and NHS Improvement. The working group will define the issues needing to be resolved to allow you to reach full ACS status (including, but not exclusively, those laid out in this letter), and will be able commission work from national bodies to support resolution of these issues. National bodies will provide expertise and support both to the development group, and to individual shadow ACSs.
- We will appoint a senior sponsor who will be responsible, together with the relevant regional director, for coordinating national support and reviewing progress.
- Through this process, shadow ACSs together with national bodies will develop a pathway to full ACS status and learning for other STPs to follow. National bodies and initial shadow ACSs will work together to spread this learning to other STPs.

Reviews and checkpoints

Over the course of the year, we anticipate a number of checkpoints where we will jointly review progress, culminating in a decision to move from 'shadow' to 'full' ACS status at the end of 2017/18:

- August 2017: agreement of MOU.
- Beginning October: bespoke programme agreed between senior sponsor and ACS lead.
- December: first quarterly review of progress by national and local teams.
- March: decision on whether to move to full ACS.
- April 2018: full ACS status and updating of this MOU.

Signature

Tim Goodson on behalf of Dorset system leaders

Matthew Swindells on behalf of NHS England and Ben Dyson on behalf of NHS Improvement