Accountable care is the new paradigm of healthcare

John Deffenbaugh

ABSTRACT

This is the first in a series of three articles that explains accountable care and explores its impact on NHS England. This article unearths the rhetoric of accountable care to understand what it is, its impact if it is understood and implemented effectively. This discussion comes at a pivotal time. Previous management structures of the NHS have imposed complexity and transaction costs, but the context now is one of severely limited resources and changing demographics that are stretching these resources to breaking point. Into this mix has been thrust the concept of accountable care, which has been embraced by the NHS without fully acknowledging the implications and impact. The concept of accountable care is introduced and framed by emerging public policy. Discussion is framed by the context surrounding NHS England. Accountable care is explained, and its variants of accountable care system and accountable care organisation are also defined. The challenges faced by leaders as they enter the accountable care environment are explored, leading to the positioning of accountable care as a means to move competition to a new paradigm of public service delivery that is leveraged by accountable care.

Key Words: accountable care ■ organisation ■ system ■ reform

This article is the first in a series that explores accountable care and its impact on the NHS in England, focusing on the concept of accountable care and the emerging public policy that will enable its development.

Accountable care is arguably the new 'wonder drug' of NHS management. However, the NHS has certainly been in this position before: 1974, 1983, 1990, 2004 and 2013. These reforms were, respectively, consensus management, general management, the internal market, the implementation of Trusts and Foundation Trusts, and clinical commissioning. These structural changes had several factors in common, namely their uniformity and focus on structure and process as opposed to behaviour, mindsets and culture. The difference for this latest reform is the piecemeal implementation of structural change against the backdrop of a strong strategic vision, the Five Year Forward View (FYFV) (NHS England, 2014).

The times in which we live

These are interesting times; 2018 will mark the centenary of the end of the Great War as well as the 70th birthday of the NHS. The current generation of leaders is certainly not facing the same level of upheaval as their predecessors, but the present day has its own calamities.

The aging population and the NHS winter crisis is placing pressure on a 70-year old healthcare system that is turning the NHS into the patient. The national budget is stretched to breaking point with the added complication that spending on public healthcare will remain constrained for the foreseeable future.

In this context, the NHS is operating with a structure and modus operandi suited to the times it is leaving. First, the competitive

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framework of the internal market (Department of Health and Soical Care (DHSC), 1989) has imposed constraints and transaction costs that both limit the integration of services for the benefit of patients and divert resources from service delivery to management processes. Interestingly, the word competition does not appear in this white paper, but phrases such as 'earn revenue' and 'get the money' do appear. This competitive nature in healthcare makes it very difficult to ask the question: what is in patients' best interests?

The structure of Foundation Trusts (FTs) (Milburn, 2002) was meant to free up management in order to innovate and operate in a more business-like manner while responding to local community needs. The financial and governance rigour behind authorisation intended to enable privatisation if the political mandate changed. Experience has shown that the FT framework has not been effective in leveraging the change expected by politicians – Mid Staffordshire NHS Foundation Trust (Mid Staffs) is the poster child for this failure. The freedoms offered by FT status did not lead to the anticipated quality improvements, innovative practices or culture change. Management stayed the same, so it was akin to old wine in new bottles. FTs, with their regulatory requirements, are now in danger of blocking system working, though there is now a Single Oversight Framework (NHS Improvement, 2017) for all Trusts. The FT concept is being quietly dropped. However, some positive aspects, such as governor engagement with local communities, will be pivotal to the success of accountable care as providers seek to change behaviour and reduce demand.

The establishment of clinical commissioning groups (CCGs) (DHSC, 2012) led to a void in regional health planning. General Practitioners in this role have matured at a fast pace and are both enthusiastic and driven but, in temperament, many still frame their decision making by individual patient rather than population health, focusing on transactional tasks and operational effectiveness more suited to running small general practices (Deffenbaugh, 2012). Accountable care has significant implications for not only commissioning, but also the role of GPs and others in primary care. In unpicking CCGs, the pivotal role of primary care needs to be strengthened, not diluted.

Each of these structural components offers some benefits that should be retained when exploring accountable care.

Accountable care explored

Accountable care is the accountability for the health and care provided within an agreed allocation of financial resources for a defined population over a period of time. Providers are given a capped budget, and are collectively accountable for achieving agreed outcomes for their patient population. This payment method means that providers have an incentive to work together to change patterns of demand to improve outcomes and reduce costs, both in the short- and long-term.

This accountability can rest with a system or organisation (two different structures):

- An accountable care system (ACS) holds the accountability for care across an identified system. The organisations in that system take a collective role in the provision of healthcare, and possibly social care, in a loose governance arrangement because they are committed to working together, with the lines between commissioners and providers often blurred, though the organisation structure remains
- An accountable care organisation (ACO) is where structured organisations are given accountability for the provision of what could be both health and social care, where leverage of the formal structure of authority enables change in the shape and scope of care to be implemented, and where commissioning holds a valid function.

Some NHS Trusts are exploring the option of turning themselves into an ACO. The FYFV models of multispecialty community providers, primary care at home, and primary and acute care systems are all provider collaboratives that can be called ACOs.

In contrast, 8 of the 44 Sustainability and Transformation Partnerships (STPs) have been authorised by NHS England (2017) to become ACSs – two devolution deal areas (Manchester

and Surrey) are also now ACSs. This builds on the work of the 50 vanguards (NHS England, 2016). The guidelines for the implementation of ACSs are very limited. This means that there will be considerable scope for each ACS to evolve in a different way, building on the approaches of vanguards. A variant of the ACS model being explored by some STPs is now what they are calling accountable care partnerships (ACPs).

Accountable care characteristics

The overarching concepts of accountable care are considered to be:

Capitation – Provider(s) will receive a capitated payment to cover the care provided to a specified population across different care settings. This presents risk-share for the provider(s) and has implications for both proactive measures to prevent illness, and rationing if demand exceeds the payment

Outcomes – These are valued by patients. Gawande (2014) observes, 'medical professionals concentrate on repair of health, not sustenance of the soul'. Health outcomes should therefore be determined by patients in partnership with clinicians

Engagement – Providers will have to engage proactively with patients, the public and communities if they are to reshape both patterns of demand and the design of services

Segmentation – The population for accountable care provision must be clearly defined from the outset, and stratified into segments such as disease group, age, socioeconomic profile, etc. Providers will want to know their population, and use this to target high-risk groups

Information – Population health data will therefore need to be gathered and rigorously interrogated to understand overall health needs, diagnose opportunities to reduce the burden of disease, engage clinicians and the public, co-design new care models, tap into technology, and then implement and evaluate for impact

Integration – Accountable care can only be effectively implemented if services are integrated. This means crossing not just NHS boundaries, but also those of social care, third sector services, and into the wider community. Provision needs to move up stream, so that the demand of the aging population does not become overwhelming. This integrated care in an accountable care setting will also be increasingly in the community

Accountability – This is collective and aligned accountability for achieving outcomes within the budget. This accountability also extends to the patient, as they must take greater ownership of their health

Transparency – Performance must be monitored on a transparent basis, using metrics agreed at the outset. This information should be in real-time, readily available, and owned by all the stakeholders, both providers and service users

Technology – Accountable care must be more effective in its use of technology. Healthcare is still designed around bricks and mortar for members of the public who increasingly see technology as a given.

Leadership and strategy

There are several inter-linked challenges for NHS leaders as they move towards accountable care:

Leadership behaviours – The key factor for success in accountable care will be the relationships among its leaders. Structure will be important, but it will be a by-product of effective relationships. Accountable care will require a change in mindset among leaders. They will need to think less of their own organisation and ask of themselves, what can you do for the system? This will not be an easy transition for NHS leaders, many of whom demonstrate pace setting, target-achieving behaviours that can produce negative change climates in their own organisation (Santry, 2012), which then wash over into the wider system.

Public resilience – The NHS was designed to 'secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness' (National Health Service Act, 1946). Along the 70 year journey of the NHS, prevention as a means to improve health lost out to the pressure of demand and the power of hospitals to provide treatment.

> “The behaviours that underpin the new direction of public policy will need to work effectively.”

However, for accountable care to be successful, these priorities will need to be rebalanced

Freedom to act – Leaders of accountable care will want leeway to take risks, to stretch the budget to meet and reshape demands. In order to earn this freedom to act, system leaders will need to work together so that they maximise system resources and give confidence to those holding them to account that this confidence is justified. This freedom will need to be earned

Shaping the future – NHS leaders find that the urgent trumps the important. In an accountable care environment, these leaders will need to shape the future – to have a narrative about long-term change, about public responsibility, about rebalancing the provision of healthcare. Only by taking a long-term view and combining this with the short-term steps will the accountable care model be successful

Clinicians to the fore – For far too long, clinicians have been the silent partners in change. Even by using the word ‘clinician’, the focus on doctors is diluted. Doctors are the principal resource allocators and users yet, when it comes to making the case for change, they are often silent. This applies not only to redesigning pathways of care and making the case in public, but also in tackling variation in care among their colleagues. At the organisational level, guidelines from National Institute for Health and Care Excellence (NICE) and the Royal Colleges steer towards what is best clinical practice. Clinical leaders in accountable care therefore now have a new opportunity to lead the debate that might make some realistic progress

Transparency in decision-making – This is at the heart of accountable care, which needs a framework of open book accounting – absolute transparency among the partners, so that trust can be built. This transparency extends to engaging the public, so that they know the limitations of resources and the trade-offs they must face.

The proverb goes, ‘if you’re going to change the world, first you have to change yourself’. The world will need to change to make a success of accountable care, and leaders will need to lead this change by changing themselves. This is the opportunity presented by the new phase of public policy that, if applied correctly, could enable accountable care to be a real success.

Conclusion

Tangible evidence is emerging of how the new public policy of ACS/ACO will shape service delivery. The FYFV and the New Models of Care programme are now being mirrored in other public sector areas. The new strategic vision for rail (Department for Transport, 2017) proposes a ‘new generation’ of regional rail operations built around public-private partnerships. In announcing this development, Chris Grayling, then Secretary of State for Transport (BBC Radio 4, 2017) stated that these partnerships will be ‘one team working together using money they have side by side’. This places great emphasis on teamwork between partners, both in the public and private sectors. This approach will not be easy; as evidence shows, the NHS continues to suffer the pains of contracting (Matthews-King, 2017).

The FYFV provides a powerful platform for accountable care. Accountable care offers the opportunity to develop collective responsibility for addressing social determinants (Hunter et al, 2009). This represents a win-win for everyone: for citizens to lead healthier, more productive lives; for communities to become more vibrant and self-sustaining; for providers to stretch the public sector pound and use resources to build health instead of repairing illness.

The behaviours that underpin the new direction of public policy will need to work effectively so that the existing legislative, regulatory and structural constraints do not hinder progress. With government focus on Brexit, it is very unlikely that new laws or regulations will be passed. While the NHS Act 2006 and the Health and Social Care Act 2012 can put roadblocks in the way of accountable care, these can be overcome as providers build trusting relationships and allocate resources

KEY POINTS

- Accountable care is being introduced at a time of significant upheaval, where a focus on public good is helping to re-shape policy and underpin implementation of this new approach
- There is a significant difference between accountable care for a system and an organisation
- To understand accountable care and what it will take to make it successful, we have to focus on leadership and strategy rather than structure
- Leadership of accountable care will need to re-balance their attention away from the organisation towards population health so that the long-term benefits of this approach can be realised, and the risks managed

collectively in a risk-share manner. Stakeholders in accountable care will face a tension between legal duties and partnership working, so they will need to give up sovereignty to take these collective risks. The NHS Constitution can be the backdrop for this new way of working and decision making, enabling leaders to take a strategic perspective that their role is to make a success of the organisation for the benefit of the public, not for the organisation itself.

Finally, a new generation of leaders is emerging. The Baby Boomers who established the internal market are retiring. Generation X, who used pacesetting leadership to achieve results, are being challenged to put compassion into their leadership. Generation Y, the digital natives and ones who bring a sense of purpose and meaning to work, along with an approach to social networks that embraces open/honest communication (Redmond, 2016), are the ones to make accountable care work. The challenge of their leaders is to develop Generation Y so that they move into positions of power and influence so they can shape the new environment.

The new paradigm of accountable care , or 'integrated care' as some leaders prefer to call it, is there to be seized. In the second article, I will explore how an ACS can be implemented as an alternative to the internal market. BJHCM

References

BBC Radio 4. BBC Radio Four Today Programme. [Internet]. 2017. [cited 2017 Dec 3]. Available from: http://www.bbc.co.uk/programmes/b09gbn8j

Deffenbaugh J. On the right person for the job. Health Service Journal. 2012;122(6297):14

Department for Transport. Connecting people: a strategic vision for rail. [Internet]. 2017. [cited 2017 Dec 3]. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/663124/rail-vision-web.pdf

Department of Health and Social Care. Working for Patients. London:HMSO;1989:4

Gawande A. Being Mortal: Medicine and What Matters in the End. Metropolitan Books, New York, NY; 2014:128

Hunter DJ, Popay J, Tannahill C, Whitehead M, Elson T. Learning lessons from the past: shaping a different future. Marmot Review Working Committee 3 Report. [Internet]. 2009. [cited 2017 Dec 4]. Available from: http://www.instituteofhealthequity.org/resources-reports/the-marmot-review-working-committee-3-report

Matthews-King A. NHS pays undisclosed amount to Virgin Care in legal dispute over contracts. Independent [Internet]. 2017. [cited 2017 Jan 18]. Available from: http://www.independent.co.uk/news/health/nhs-richard-branson-virgin-care-legal-settlement-tendering-contract-a8080961.html

Milburn A. Milburn unveils hospital franchise plan, The Guardian. [Internet]. 2002. [cited 2017 Dec 3]. Available from: https://www.theguardian.com/politics/2002/jan/15/publicservices.uk2

NHS England. Five Year Forward View. [Internet]. 2014. [cited 2017 Dec 3]. Available from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England. New Care Models: Vanguards - developing a blueprint for the future of NHS and care services. [Internet]. 2016. [cited 2017 Dec 3]. Available at: https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf

NHS England. NHS moves to end 'fractured' care system. [Internet]. 2017. [cited 2017 Dec 3]. Available from: https://www.england.nhs.uk/2017/06/nhs-moves-to-end-fractured-care-system/

NHS Improvement. Single Oversight Framework. [Internet]. 2017. [cited 2017 Dec 3]. Available from: https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework___update_Nov_2017_v2.pdf

Redmond P. Generational Investing: the world according to Generation Selfie. [Internet]. 2016. [cited 2017 Dec 3]. Available from: http://www.paul-redmond.co.uk/articles/2016/11/13/generational-investing-the-world-according-to-generation-selfie

Santry C. 'Most senior leaders failing to create 'strong work climates'. Health Service Journal. 2012;12(1):122