HENLEY HEALTHCARE
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Housing and Health white paper

Accountable care organisations

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Developing the white paper

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Housing and Health

Housing and Health is a collaboration between HACT and Common Cause Consulting, working to forge links between providers of social housing and health care services.

We believe that an evidence-informed approach can help both sectors to benefit from closer collaboration and understanding. Drawing on our networks of practitioners, policymakers and academics as well as our in-house expertise, we seek to provide innovative solutions to meet the current and future challenges for housing and health in our communities.

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Introduction

There is a lot of discussion at present about devolution in relation to health and social care, but one form of devolution that is less often discussed in this context is that of accountable care. As a way of overcoming fragmented commissioning and service provision arrangements, and bringing them together to meet the needs of a given population, it has the potential to be a real agent for change. It is also one of the most practical expressions of 'place-based' care.

Accountable Care Organisations (ACOs) take responsibility for the needs of the population and encourage providers to come together to innovate and find new solutions to delivering the outcomes commissioners want within an agreed budget. In this model, it is in the interests of the providers to deliver care in a way that is the most efficient and most effective. For many this will mean working 'upstream' to prevent admission, reducing length of stay, ensuring that where there is the need for an admission the patient returns quickly to home - as well as looking for efficiencies in use of estate and developing shared services.

ACO have significance for the future of healthcare services and present major opportunities for housing associations and investors. This is particularly the case for those associations who can bring a range of skills, expertise and resources to the table of local health provider collaborations, as well as health and care systems. There is some evidence that some ACOs are recognising the contribution that voluntary and community sector providers can bring and how housing associations, as mature social enterprises, can bring a range of assets to bear on pathway redesign.

However, the connection between health care providers and housing associations remains relatively underdeveloped. Yet there are many affordable housing providers and developers in the country who, working with their investors, are ideally placed to play a significant role in this emerging agenda. Working together, they can deliver a more creative use of assets to deliver on longer term efficiency targets and transformed pathways of care. In this "white paper" we set out ways in which these collaborations might develop.

Background

Accountable care organisations (ACOs), or accountable care partnerships (ACPs) are a network of organisations involved in care provision brought together to take responsibility for the quality and cost of care of a defined population and a capitated budget. The focus is on clinical, and not organisational, integration[1]. They can vary from more formalised and structured partnerships between organisations to a looser arrangement of competences and responsibilities, usually clinician-led, framed around patient care. The ACO concept rose to prominence in the United States under the auspices of the 2010 Affordable Care Act, premised on the notion that by giving a group of healthcare providers the responsibility of the quality of care and financial efficiency for a defined population area, the financial risk would shift from payers to providers, thereby aligning the motives of commissioners and providers[2].

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[1] Ham, C and Walsh N (2016) "Accountable Care Organisations Can Teach The NHS About Integration". *Health Service Journal*. N.p., 2014. Web. 29 Sept. 2016.

[2] Tu, Tianna et al.(2016) *The Impact Of Accountable Care*. Leavitt Partners, 2015. Web. 29 Sept. 2016.

This forms the impetus for the provider to keep the population healthy and decrease the use of health services, as well as minimizing costly hospital-based care and transitioning to effective forms of community-based care. Partnerships usually consist in the integration of primary, acute, community, and social care, as well as third sector provision, around the care pathway. Currently, there are several models of ACO operating in the United States; they vary from the organisationally formalised Integrated Delivery System, which has a single system and payment mechanism that encompasses all care, to the more loosely arranged independent practice associations, in which a group of physician practices collectively contract with health insurers.

The NHS Context

In the light of the introduction of NHS Sustainable Transformation Plans, the overall tightening of budgets, the spiralling externalities of an aging population, and the increasing importance of place-based systems of care, ACOs are seen as a way to renew the focus of NHS Trusts on population health without risking another systemic restructuring of the NHS[3]. They are a key element of the Five Year Forward View (FYFV) published in 2014 as a way of managing the quality of care and financial sustainability of the NHS as a whole.

The attraction of the ACOs model is the potential to break down organisational barriers without completely restructuring organisations, and thereby cut costs and boost quality of care. However, this has seen mixed results in practice. Of the 32 pioneer ACOs evaluated in the United States, 18 generated savings for Medicare (the commissioner), with 7 generating significant savings, 14 generated losses for Medicare, with 7 increasing costs enough to owe Medicare.

When implemented correctly, it is argued, ACOs provide a model of service integration, a range of professions and services to accommodate the diverse needs of a whole population, a dual emphasis on quality and efficiency, the financial incentive for providers to act collaboratively and holistically, and the flexibility to create different organisational forms depending on the needs and history of the population area[4]. The evidence suggests the limitation of the ACO model is the emphasis on organisational structure and change, which does not guarantee long-term sustainable improvement. Organisational change is attractive to managers and to a certain degree enables smaller-scale positive shifts in services, but these shifts require significant focused effort to be enacted (ibid).

New Care Models in the NHS

In conceptualising integrated care for the NHS, there are two different models currently in practice which most closely resemble ACOs: Multispecialty Community Providers (MCPs), and Primary and Acute Care Systems (PACS). These have been developed in response to the strain that general practices have come under, from rising demand and under-resourced primary care services, which NHS England plan to solve through stabilizing core funding for general practices, giving GP-led Clinical

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[3] Shortell, S et al. (2014) *Accountable Care Organisations In The United States And England*. London: King's Fund, 2014. Web. 29 Sept. 2016

[4] Miller, Robin and Judith Smith. "Accountable Care Organisations: The Future Of The NHS?".*Nationalhealthexecutive.com*. N.p., 2016. Web. 29 Sept. 2016.

Commissioning Groups more influence, and providing funding for upgrading primary care infrastructure[5].

Multispecialty Community Providers

MCPs, as defined in the Five Year Forward View, are designed to become 'the focal point for a far wider range of care' than traditional general practices, but incorporate their structure and the strengths of GPs as 'expert generalists' into extended group practices, with the potential to form into networks, federations, or organisations. Larger group practices would employ specialists as consultants and partners, engaging both medical practitioners and experts in social and community care. The aim would be to shift most outpatient consultations and ambulatory care out of hospital settings. Conceptually, as these networks or organisations evolve over time, clinicians would be able to take more direct accountability and decision-making over their registered patients, and manage a combined health and social care budget, and in some cases take over a hospital, which would expand their diagnostic services.

Primary and Acute Care Systems

PACS are defined as a 'vertical' integration of primary and acute care, and most closely resemble Accountable Care Organisations in the U.S. context. The FYFV is permissive as to how the structure of a PACS initially develops, avowing that they are 'complex' and 'take time and technical expertise to implement… [with] unintended side effects that need to be managed'. At their point of greatest maturity, PACS are accountable for the health of a population area, and for taking care of their needs with a capitated budget. It is conceivable that a MCP evolves to the point of becoming a PACS; that is, when it takes over a hospital and begins taking responsibility for a budget and the health of a population area. The converse, with hospitals opening their own GP surgeries, using the investment powers of NHS Foundation Trusts to roll out this new model of care, is an equally viable path; the emphasis here is on the PACS model being flexible enough to respond to local context and need.

As STP footprints are developed there is a move towards a smaller network of CCGs acting as regional or sub-regional funding bodies able to hold contracts with ACOs or other provider networks. The concern here is that that this may see the bigger acute trusts using the ACO model to get 'a bigger slice of the financial pie'[6]. This touches on a larger issue for providers, which is the need to develop the capacity for forming provider networks with the skills and capabilities to deliver a continuum of care.

ACOs could move the debate over integrated care away from organisational structure and arrangement. They stand the greatest chance of success if they focus on a small number of people with complex needs who use the greatest proportion time and resources - using techniques such as risk stratification and predictive modelling. It will also be important that there is greater coordination of support and care across organisational and sectoral boundaries with a shared understanding of risk and risk management, more integrated information-sharing of patient data along the care pathway, and a real focus on what really matters to patients and service users[7]

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[5] NHS England,. *Five Year Forward View*. NHS England, 2014. Web. 29 Sept. 2016.

[6] Bellshaw, Emily. "NHS Integration: Can Accountable Care Organisations Deliver A Truly GP-Led NHS | UCL Improvement Science London". *Blogs.ucl.ac.uk*. N.p., 2016. Web. 29 Sept. 2016.

[7] Ham, C and Walsh N (2016) "Accountable Care Organisations Can Teach The NHS About Integration". *Health Service Journal*. N.p., 2014. Web. 29 Sept. 2016

How housing associations can best contribute to ACOs

Accountable care presents a real opportunity to align objectives so that the two sectors can maximise their combined assets. Given that both types of organisation are often working with the same populations, have complementary skillsets and can bring significant assets to the table it makes sense that both are part of accountable care arrangements. If any group of organisations can make a reality of place-based health care then housing associations can. However, they need to develop a deeper understanding of the challenges facing the local health system and what can best be done to address these both in the short and medium term.

Health care providers in the NHS and housing associations share many characteristics. Both are robust and resilient organisations. Both are well-run not for profit businesses working at significant scale. Both are long-term custodians of public resources and have as their patients / service users / tenants many of the same people who experience the worst health inequalities. They have a tradition of creative problem solving and have a long-term commitment to the communities they serve. Both are going through a period of financial pressure.

Any collaboration within an accountable care setting will need to be to improve both the flow of patients along a particular pathway, improve an individual's resilience by providing the 'social scaffolding' needed to allow for a return / move to greater independence and improve the quality of the outcomes achieved. An ACO gives the opportunity to create an integrated local system (especially outside of mental health) and to look at the whole pathway for the medium to long term. It allows for an unpicking of complex commissioning arrangements, and a perspective from which to make better purchasing decisions.

ACOs present real opportunities to make a long-term commitment to meeting the needs of a population. In these circumstances, it makes sense to brings all the available assets to bear and to create supply chains that can contribute upstream and downstream along a pathway. Along the pathway there are numerous opportunities for housing associations to make a contribution. However, all too often the conversation focuses on land. It is understandable that with the desire to look at land disposal as way of alleviating financial deficits across the system that this might be the case. However, this risks the full potential of the relationship not being realised. It is important that housing organisations bring the whole of themselves to the table and not just their development and asset management skills.

Estate Modernisation

There is considerable opportunity through housing association collaborations with NHS Providers to unlock increased value of the NHS estate: to deliver increased housing, improved healthcare, and deliver an on-going revenue stream to the NHS. With ongoing pressures from the Treasury to bring forward public sector land, and for the NHS to deliver significant efficiencies, if got right, the case for collaboration is compelling. However, asset based partnerships between the NHS and housing associations have, to date, been difficult to achieve, and in some cases, quite negative. With new leadership and commitment from both sectors, this position could be reversed.

The developments around Accountable Care, if they involve housing associations as estate and development partners, could transform the NHS landscape and local healthcare delivery. There are many affordable housing providers and developers in the country who, working with investors, are ideally placed to play a significant role in this emerging agenda. However, viewing the NHS estate only through the lens of development and land disposal, risks creating little value into the longer term. What is needed, is a more creative approach that encourages the exploration of joint ventures and using the estate to deliver on longer term efficiency targets and reformed pathways of care.

Developing associations have access to capital that is not available to the NHS. They have the skills necessary to maximise the value of land. In areas of high land value it would understandable if providers wanted to go for straight land disposal. However, they may also want to look at ways in which land can be used as an enabler of service redesign by providing the accommodation and services necessary to reduce avoidable admission, reduce length of stay or provide for a return to home as an alternative to institutional care. Alternatively, the NHS may want to invest the land in a joint venture to develop the facilities or accommodation required – indeed in areas of low land value this may be the only way of realising any value from the land. They can also help to work with planning authorities and to negotiate S106 agreements.

Housing associations can help to meet the accommodation needs of NHS staff, especially in areas of housing shortage or where affordability is an issue. Housing associations can help to ensure that a range of housing tenures are available – either through equity release or private rented. In equity release, the individual can start to build an equity pot but the property remains available to the NHS when the individual leaves and cashes in. In the private rented model, the property could be offered as an assured shorthold tenancy which could be renewed at the end of two years, provided that the individual(s) concerned were still employed in the NHS.

Service Redesign

Housing associations are skilled at intervening 'upstream' and 'downstream' of pathways – whether they are focussing resources on preventing admission by providing crisis cafes, or services that support people to stay in their own homes, or providing step-down accommodation or rehabilitation prior to a return home. They can provide some of the expertise and accommodation needed to reduce delays in discharge and support the provision of accommodation to meet the needs of people returning from out of area placements.

The clinical and managerial expertise needed to run these collaborations will need to be supported by robust quality governance systems. Structures will not only need to support effective decision-making but also ensure a shared understanding of risk and effective quality systems.

Housing associations, dealing with Supporting People contracts coming to an end, are looking for alternative sources of investment for these services. There are also collaborations emerging between associations in order to look at the assets they can bring collectively to solve a specific issue affecting the NHS. However, it's important that they listen to the needs of local systems and providers and (re)design services to meet these needs. A 'one size fits all' approach will not work.

Above all there need to be ways of ensuring that patients and carers are at the heart of ACOs. There is a danger that benefits realised will tend to be framed in terms of efficiency and that outcomes will not be recognised by patients and carers. Both NHS providers, housing associations and investors are skilled at taking into account the expertise held by patients and service users themselves and can share resources to achieve this.

Workforce

Workforce is needed to deliver community care and to be able to deliver more care in peoples' own homes. Delivering care in this way requires a different combination of technical and relational skills. The recruitment and retention of a suitably skilled and adaptable workforce will be key. Within teams established under different policy frameworks and funding regimes (e.g. floating support, tenancy sustainment, anti-social behaviour) housing associations have many of the skills that will be needed.

Housing associations run employment services that can help to build the workforce of the future and to ensure that the talents of those who have learning disabilities or are seriously affected by mental health problems are helped to attain and retain sustainable employment. Given the issues with recruitment and retention in many areas, thought needs to be given to developing the future workforce and bringing those farthest away from the labour market into the workforce.

Conclusion

The NHS needs to be able to innovate at pace. Accountable care provides a framework for a range of providers need to work together both from within the NHS and other organisations to deliver an agreed set of outcomes to meet the needs of a particular population. If a reality is to be made of "place-based healthcare" then it will be important that all assets – tangible and intangible – are taken into account. The first steps to this are developing a shared understanding of local need, a shared approach to quality and risk, and assembling the skills necessary to improve flow up and down the system, as well as outcomes that are recognised by patients themselves. Accountable care has the potential to be a game changer and part of its success will be dependent on operating at the right scale and then bringing all available assets to the table. Housing associations have considerable assets that they can play into accountable care partnerships that can help to add considerable value in the interests of local people – they need to be at the table.