THINKING IT THROUGH
Accountable care, cancer and the NHS

November 2017
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Foreword

The NHS in England (NHSE) is currently making a transition to ‘Accountable Care Systems’ (ACSs). These systems are considered a means of organising and delivering care for a defined population in line with agreed outcomes. But can the move towards accountable care be an opportunity to do more than just change organisational form? What will it mean for the role of Cancer Alliances? And, most importantly, how will the move affect people living with cancer?

These are some of the questions we explore in this report. It’s worth noting that this report is not about debating the pros and cons of the transition to accountable care systems in the NHS in England – these are being examined in close detail elsewhere. Instead, we want to unpick what the move towards accountable care means and to stress the importance of integrated and personalised care for all patients, including people living with cancer.

At Macmillan, we have been closely monitoring NHSE reforms for some time. We have witnessed the challenges that can come with changes to the commissioning and delivery of cancer care and support. At the time of the Health and Social Care Act 2012, for example, we found that the commissioning of cancer care was leading to disjointed care across the cancer pathway and confusion about commissioning responsibilities. However, we also know from experience that complex system change can be an opportunity to really focus on personalised and integrated care while developing partnerships with patients.

Recently, the Five Year Forward View and the Cancer Strategy for England have led to significant changes in the structures of the NHS in England, and in approaches to commissioning and delivering care and support. Sustainability and transformation partnerships (STPs) and ACSs, focusing on population needs, are being established across England. At the same time, 16 Cancer Alliances and the National Cancer Vanguard have been tasked with delivering improvements across the cancer pathway for their regions.

It is still too early to determine whether these initiatives will address the fragmentation that arose from previous reforms. However, we believe that now is the right time to take a step back from the form that accountable care systems will take. We believe that now is the time to go back to focusing on the principles of personalised and integrated care.

Macmillan knows that significant improvement is possible. Through our own involvement in system redesign partnerships we have learnt that:

• interagency, personalised and integrated care does not always need change in organisational form,
• involving patients, communities...
and health care professionals in system redesign is a key catalyst for change, and
• it is possible to work in partnership with patients and wider stakeholders to define the outcomes that matter to patients.

Our views in this report are shaped by international research on accountable care, by our learning on system redesign partnerships, and by discussions held at a workshop we convened in July 2017. Together, these factors have led us to conclude that the starting point for a move towards accountable care systems should not be organisational form. Achieving integrated and personalised care for all patients is something we view as fundamental and it should be a driving force for change. Therefore, we believe that:
• to achieve integrated and personalised care, the focus must be on more than just contracts and organisational form,
• greater focus needs to be put on developing collaborative mind-sets and behaviours, and
• accountable care systems must work in partnership with communities and healthcare professionals if they are to fundamentally change the way in which care and support is delivered.

We have also considered accountable care from the perspective of cancer and the future role of Cancer Alliances. This has led us to conclude that:

• Cancer Alliances will have an essential role to play in facilitating cross-system working with and across many of these new accountable care systems. This will ensure that the recommendations from the Cancer Strategy for England – and integrated care for people living with cancer – can be delivered, and
• Cancer Alliances should not assume budgetary responsibilities for the cancer pathway at this time.

But most of all through this report, we want to emphasise to local health care systems and national policy makers that system change must and can be compatible with integrated and personalised care for all, designed and delivered in partnership with patients.

John Towers,
System Engagement Specialist Adviser,
Macmillan Cancer Support
What is the problem that needs to be fixed?

Much has been written about the need to better integrate care. This is not a new issue. It is, however, a persistent problem – one which policy makers are constantly trying to solve, and one which continues to have a significant impact on patients and people with cancer.

Research for Macmillan has found that nearly one in five people with cancer (18%) experience poorly coordinated care which, in two-thirds of cases, results in people feeling more stressed and anxious. We also know that integration of care is one of the strongest predictors of overall satisfaction with cancer care in England. As more people survive cancer, and as the complexity of their treatment increases, so too will the need for better coordination. This is exacerbated by the fact that seven out of ten people with cancer (70%) are also affected by one or more other serious long-term conditions.

Increasingly, complex patient needs means the NHS needs to get better at signposting to a range of services, and sharing confidential information securely between those services. Rising multi-morbidities also means the NHS needs to ensure different clinical services take account of one another and work together. For example, patients who are already frail or have a heart condition and subsequently develop cancer may need their clinicians to work together in a multidisciplinary team.

Commissioning complexity
NHS commissioners will also need to change the way they work. Responsibility for commissioning cancer care in England is fragmented, as Figure 1 shows. This makes it harder to commission joined-up care pathways. While decisions might increasingly be made collectively through new informal structures such as STPs, commissioning responsibility still largely rests with the same organisations.

1 in 5 people with cancer experience poorly coordinated care

2 in 3 people with cancer whose care is poorly coordinated feel increasingly stressed and anxious
In other words, it is difficult to identify which organisation is responsible for the overall outcomes of care. NHSE is making welcome improvements to the way it measures cancer outcomes, for example, by creating a new quality of life metric to be used in addition to its existing survival measures. But who will use that information to improve services in the future?

The integration challenge
Achieving integrated and personalised care has been a stated ambition of NHSE for some time now. In 2013, the Department of Health and 11 arm’s length bodies across health and social care declared a shared commitment to making ‘person-centred coordinated care’ the norm. However, recent reports have found that progress in achieving this integration of health and social care ‘has been slower and less successful than envisaged and has not delivered all of the expected benefits for patients, the NHS or local authorities’.

The case for change is therefore clear. There needs to be a fundamental shift in the way in which care and support is commissioned and delivered to people, including those living with cancer. Crucially, this needs to be done in partnership with patients, communities and healthcare professionals. What is not yet clear is whether accountable care will be the solution.

![Figure 1: Generic cancer pathway - commissioning responsibilities. The diagram is an estimate and is not an exact representation of commissioning responsibilities.](image-url)
What is accountable care in the NHS in England?

This report is not about debating the positives and negatives of a shift towards accountable care. Instead, we want to take the opportunity to ask what these changes mean and if they can be about more than just contracts and organisational form.

‘Accountable care’ can mean different things to different people. This is not helped by the number of different phrases that are used interchangeably with the concept of accountable care. However, for some, it is considered a new way of trying to address the enduring challenge of better integrated care.

When beginning a discussion on accountable care, most commentators look to the United States. There, accountable care organisations (ACOs) have been increasing in number since 2012 under the changes introduced as part of ‘Obamacare’. ACOs in the US are about changing organisational and contractual form, and they were set up with the intention of improving care while reducing growing costs and inefficiencies. However, accountable care in England is starting out from a different place, at least initially, with a focus on systems rather than organisations. This focus on systems inherently recognises that there are currently many legislative and procurement limitations in the extent to which providers can come together in new organisational forms with a single budget. These include the current primary care contractual model, the current purchaser/provider split established under the Health and Social Care Act 2012, and the means through which providers can share risk with each other.

In what has been described as the ‘biggest national move to integrating care of any major western country’, NHS England recently announced the first eight such Accountable Care Systems (ACSs) in England. They defined an ACS as:

‘... an ‘evolved’ version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health. They provide joined up, better coordinated care. In return, they get far more control and freedom over the total operations of the health system in their area; and work closely with local government and other partners to keep people healthier for longer, and out of hospital.’

According to NHS England an accountable care system is an evolved version of an STP that is working as a locally integrated health system.’

NHS England has made it clear that ACSs will be the focus at this time. This is the case because a transition to fully integrated ACOs would be complex and require careful management – including the management of financial risk. However, some parts of the country are expected to begin this journey from systems to organisations soon, working within the realms of what is currently possible.
Accountable care for cancer?

Efforts to improve cancer services through the Cancer Strategy for England have been brought under the umbrella of the implementation of the Five Year Forward View. Cancer was named as a key priority, most recently in the Next Steps on the NHS Five Year Forward View report. Improving cancer care is therefore a task for ACSs and STPs, with the first group of ACSs agreeing with national leaders to deliver fast-track improvements on a number of priorities including improved access to high quality cancer services.

Additionally, the 16 Cancer Alliances and a National Cancer Vanguard across England have been established to facilitate cross-system working and drive transformation and improvement in cancer care and support across their regions. As with elsewhere in the transformation agenda, a shift to accountable care is being considered for cancer. The National Cancer Vanguard is currently trialling an accountable clinical network model and, since April 2017, it has started trialling ‘delegated financial responsibilities’ for the three geographical areas it covers. The aim of the pilot, according to NHS England, is to improve quality and reduce the fragmentation of the cancer pathway. NHS England has also set out the intention that if this model is successful, the 16 Cancer Alliances may follow a similar path. Unlike ACSs, the focus is largely on the needs of a population or place, the focus here is on a specific condition.

A recent timeline of accountable care in the NHS in England

October 2014
The Five Year Forward View sets out the national vision for the transformation of the NHS, including the concept of ‘new models of care’ (NMOC). As part of this, local areas would be able to develop new ways of delivering integrated care in line with the needs of their local populations or place. It was suggested that some of these new models might take the form of Accountable Care Organisations (ACOs).

January to September 2015
50 Vanguard sites are announced to act as testbeds for NMOC, including the concept of accountable care. One site will act as an Accountable Clinical Network for Cancer, others include MCPs (Multispecialty Community Providers) and PACS (Primary and Acute Care Systems).

July 2015
The Independent Taskforce launches the Cancer Strategy for England. The report recommends the establishment of Cancer Alliances to oversee the entire cancer pathway.

December 2015
The NHS publishes planning guidance for the Five Year Forward View which introduces sustainability and transformation plans (STPs). These require local health and care systems to come together to develop their own plans for the implementation of the Five Year Forward View, building on the learning from the Vanguards.

July 2016
The contract framework for MCPs and PACS are published and feature many similarities to ACOs.

September 2016
NHS England announces the establishment of 16 Cancer Alliances across England that will build on the learning of the National Cancer Vanguard.

October 2016
Final draft STPs are submitted to NHS England, with many detailing plans to transition towards ACOs.

March 2017
NHS England publishes Next Steps on the NHS Five Year Forward View. This report takes stock of progress and affirms NHS England’s commitment to introduce the concept of accountable care with the introduction of Accountable Care Systems (ACSs) instead of ACOs.

June 2017
The first eight ACSs are announced by Simon Stevens as evolved versions of STPs.
Why ‘accountable care’?

Accountable care approaches aim to address the problem of disjointed accountability for patient care.

NHS England say ACSs are a means of enabling local organisations to come together and plan for the needs of their populations, pool their resources and provide better integrated, efficient and quality care.\(^{18}\) This could mean a move away from fragmented accountability, where individual providers are only held accountable for delivering specific parts of the overall care patients receive. The intention being local health and care organisations can be held collectively accountable for improved outcomes for patients and populations. This will inevitably mean changes in the commissioning and provision of care and support in England.

Traditionally, individual providers have received payment based on activity, rather than on improving the health and wellbeing of patients and populations. The commissioning of care and support can also be disjointed with clinical commissioning groups (CCGs), local authorities, and regional and national NHSE teams holding responsibility for commissioning different aspects.

Furthermore, as the performance of organisations is not judged on the basis of overall outcomes, sometimes unintentional but perverse incentives can arise. For example, during times of significant financial constraints in the NHS individual organisations might attempt to move activity and responsibility either ‘upstream’ or ‘downstream’. This essentially means shifting responsibility to organisations handling care earlier or later in the pathway rather than cooperating for the benefit of patients.

Figure 2: A Nuffield Trust diagram demonstrates how the complexities of the current structures in the NHS in England can lead to disjointed commissioning and delivery of care and support.\(^{19}\)
All of this can hamper the efforts of organisations (across primary, secondary and community care) to come together to improve pathways and tackle the underlying and recurring causes of ill health for their populations such as diet, physical activity and smoking.

A move to ACSs could theoretically mean groups of local organisations would instead be held collectively accountable to a lead commissioner or NHS England for achieving improved outcomes for the people in their area. These outcomes could include improvements in patient experience, successful prevention strategies, co-ordinated care and improvements in delayed transfers of care, for example. Local organisations could also be incentivised to achieve these outcomes through sharing financial risk and having access to any savings accrued from successful prevention, protection and promotion strategies.

However, there are also concerns with this model. The Health and Social Care Act 2012 clearly embeds a purchaser/provider split into law. This means that the purchasing of services is separated from their delivery. The reason behind this is a belief that an internal market should achieve greater efficiency, innovation and choice for patients. The move to accountable care could be considered an attempt to circumvent this split. There are also concerns about the high level of risk that these moves may introduce into the market, with some also concerned about the privatisation of the NHS.

NHS England has, however, made clear that the transition to New Models of Care (NMOC), STPs and ACSs is achievable within the current legal context. They have also stated that they will provide assurance and support to areas making such transitions.
What is needed to make change happen?

While we have considered the ambitions of NHSE in transitioning towards ACSs, what we do not know is how this change will be achieved. What’s more, we do not know how it will feel or look different for patients and communities.

ACSs and, indeed, STPs may lead to changes in organisational form and these justify close examination. However, this should not be the starting point. Particularly if the ambition is having a health system that delivers integrated care focused around the needs of patients and communities, not individual organisations.

It is clear this type of change will not happen overnight and local health systems will need to assess their readiness to transition towards new ACSs.

This is where we feel a maturity progression framework developed by Boston Consulting Group and researchers previously at the Brookings Institution and now at Duke University, in collaboration with the World Innovation Summit for Health (WISH) can help.

The original framework was developed in 2013 through analysis of the characteristics of successful accountable care systems worldwide where a common set of principles were identified:

1. **A specified population**
   Reform needs to be targeted at a defined population, often based on deprivation or health characteristics.

2. **Target outcomes that matter to individuals**
   It is important to develop and deliver performance measures that are related to quality and experience of care.

3. **Metrics and learning**
   It is crucial to monitor performance on outcomes and to learn from variation.

4. **Payments and incentives**
   These should be aligned with the target outcomes so payment mechanisms may need to be redesigned.

5. **Coordinated delivery**
   Collaboration is key when it comes to delivering the care necessary for achieving the desired outcomes.

The framework breaks down accountable care into its constituent parts. As Figure 4 demonstrates, making the transition to an ACS is complex, time consuming and involves a number of different steps and stages along the way before systems mature into their new form and functions. However, more importantly from our point of view, it illustrates that accountable care is about more than just contractual arrangements. It shows that it is also about achieving coordinated care and delivering the outcomes that matter to patients. It is these principles that are the focus for this report.

**Enablers of change**

Since this accountable care framework was developed, further analysis has been undertaken by Duke University, in collaboration with advisory groups coordinated through WISH and the Commonwealth Fund in the United States, on the enablers of change and health policy environment factors. This is in recognition of the fact that there are other factors or capabilities that will impact on the ability of local health and care systems to transition towards accountable care. Figure 5 shows that, as policymakers implement accountable care reforms, healthcare systems will need to possess key capabilities to enable...
them to deliver the innovations in care required. These capabilities include patient engagement, in addition to strong leadership, stratification of patients and data analytics, to name but a few. Therefore we have learned that making a transition to accountable care will be complex and multifaceted, but importantly that it can be about more than organisational form, with the involvement of patients a key capability for achieving meaningful change. At Macmillan we believe our experience of system redesign partnerships supports these principles.

**Internal and external factors for accountable care implementation**

- Population
- Performance measures
- Support for continuous improvement
- Payment and non-financial incentives
- Support for care co-ordination and transformation

- Institutional (agency structure)
- Political (stakeholder interests)
- Regulatory (workforce, payment)

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Figure 4: The accountable care maturity progression framework breaks accountable care down into its component parts. It highlights the many stages involved in making the transition to accountable care.
System redesign: our learning

Since 2012, Macmillan Cancer Support has invested in a number of large-scale programmes in partnership with the NHS, local authorities and other partners. All have aimed to improve and integrate the cancer journey for people affected by cancer.

Each programme is different and specific to the needs of patients living in that area, but all aim to ensure patients have a better experience and improved outcomes. While these programmes were not set up as models of accountable care, we believe that our learning from them can inform areas that are aiming to achieve system change in partnership with patients in a way that delivers better coordinated care.

**Coordinated delivery: Contractual change is not always required**
This is a time of flux and change with some – but not all – parts of England making a transition to ACSs. We at Macmillan are keen to stress that contractual change and payment mechanisms are not the only means of encouraging local organisations to come together to achieve coordinated delivery. This is particularly the case when local organisations are committed to coming together to achieve better outcomes for their populations.

This finding is supported by the research undertaken by the WISH Accountable Care Forum in 2013.

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Figure 6: Since 2012 Macmillan has invested in a number of large-scale system redesign partnerships across the UK. All aim to ensure patients have better experience of care and improved outcomes.
They found that coordinating care across a group of organisations is more complicated in some cases than in others, but that it is not necessary for all members of the group of providers to belong to a single organisation:

‘... independent providers can coordinate very well, particularly if there is willingness and commitment from the organizations’ leadership.’

This resonates strongly with our learning from the Improving the Cancer Journey programme in Glasgow ICJ.

Coordinated delivery: components of success

An evaluation of the first year of the ICJ programme found that, ‘Interagency proactive person-centred care has been aspirational policy for decades, yet it rarely materialises to the extent seen in Glasgow’.

The key conclusion from this evaluation is that the components of its success are reasonably straightforward to identify. They are:

• strong leadership,
• strong buy-in from partners,
• a highly-skilled workforce, and
• practising within a clear process.

So, while ICJ has set the bar extremely high, the components are there for others to follow.

Case study: Macmillan Cancer Support’s Improving the Cancer Journey programme in Glasgow

Improving the Cancer Journey (ICJ) is an integrated, multi-agency approach with partners including Macmillan, Glasgow City Council and NHS Greater Glasgow and Clyde. ICJ’s vision is to ‘develop and deliver clear, seamless and accessible care that is accessed timeously and appropriately across organisational and professional boundaries, based upon robust holistic assessment of need.’ ICJ works by contacting every newly diagnosed cancer patient in Glasgow and offering them time with a link worker to discuss their support needs and to co-produce an individual care plan. It aims to create clear pathways designed around the user and make best use of available resources and partnerships.

An evaluation of the first two years of ICJ found that service users reported positive changes in their quality of life and a reduction in their concerns and feelings of isolation. The most up-to-date analysis of routine data also found that:

• 77% of those supported by ICJ came from the two most deprived categories of people living in Glasgow.
• Financial gains of £5,452,076 have been generated for people affected by cancer via ICJ since 2014.
• ICJ has prevented 26 people from becoming homeless since September 2015.

The Scottish government has now pledged support to roll out similar services across the nation.

Key to the success of ICJ has been a joined-up approach between relevant organisations, the offer of support at the earliest opportunity, and the provision of a link worker as a single point of contact. The link workers have helped to address a range of concerns and have made referrals to services such as financial advice, counselling, smoking cessation, re-housing and low-level volunteer support. This level of integration has been achieved without any changes in organisational form. Although the political and policy context is different in Scotland, we believe the principles of this programme can be applied elsewhere. It demonstrates that much progress can be made towards integration that’s focused on the needs of the patient and the community rather than organisational boundaries.
Developing personalised outcomes: Working in partnership with the NHS, local authorities, the third sector, clinicians, patients and communities.

Throughout this report we have emphasised the importance of ACSs delivering personalised outcomes for patients. We have also stressed the importance of involving communities in complex system redesign. From our experience it is possible to achieve both of these things through an outcomes-based commissioning approach involving local patient champions.

Similarities have been identified between the principles of outcomes-based commissioning and accountable care. Through our involvement in the Staffordshire Programme we found that it is possible to work in partnership with patients and stakeholders to not only define the outcomes that matter to patients but to also translate these into an outcomes framework intended for contractual purposes.

Developing the outcomes framework in this programme was a lengthy, complicated but ultimately very rewarding task for the patients and professionals involved. The framework was built around four domains and each domain had a set of outcomes. Each outcome has a set of indicators as well as a data and/or potential measurement that could be used to measure that outcome. There are plans to share the outcomes framework so others can learn from and embed the patient’s voice in their system change.

Our learning and suggestions when developing outcomes frameworks in partnership:

- Address the challenge of making sure that outcomes reflect national requirements as well as the differing priorities of the commissioner, clinicians and patients.
- Create a manageable sized group comprising commissioners, clinicians, a manager and patients with the sole remit of defining programme outcomes.
- Anticipate a divergence between stakeholders on outcomes and targets and plan for a high degree of negotiation and balancing to gain consensus.
- Involving bidders in discussions about programme outcomes. This will help to create a shared understanding of the ambitions and intentions of the programme and allow the programme to benefit from the bidders’ experience and expertise in this area.
Enablers of change: our learning

We have already made reference to the importance of strong leadership as a key component of success in the ICJ programme in Glasgow. However, we have also found that other fundamental factors in achieving real and meaningful change include involving patients and wider stakeholders in system redesign, and recognising the importance of dedicating sufficient time to allow for this.

Wider stakeholder engagement: involving health and social care professionals in the design and the delivery of system change

One of the fundamental elements of our approach to system change is our commitment to engaging a wide range of stakeholders in our programmes. These include primary and secondary care clinicians as well as other social and community care professionals. In some of our recent evaluation reports there is significant evidence to confirm the value in this way of working, suggesting that effective stakeholder engagement is a key driver of change. While we have found that it can take time to involve a broad range of stakeholders and professionals early on in the process, we have also found that there are many benefits of doing so, including achieving greater sustainability.

Case study: Transforming Cancer and End of Life Care programme in Staffordshire and Stoke-on-Trent

This programme aimed to improve cancer survival rates, patient experience and end of life care in Staffordshire and Stoke-on-Trent. Macmillan worked as a strategic partner and expert adviser on this programme, giving a voice to people affected by cancer. At the beginning of the programme there were over 60 different organisations responsible for delivering cancer and end of life care in Staffordshire and Stoke-on-Trent. None of them were tasked with taking responsibility for making sure they all worked together in the best interest of the patient.

Patients told us they often had to deal with problems such as changed appointments, missing notes, having to repeat their story, not getting the right help or advice, and not always being able to get care at home after being discharged from hospital. The programme aimed to appoint one organisation to take responsibility for coordinating local cancer care services and one organisation to take responsibility for end of life care services. Each appointee would manage multiple service providers over ten years using an outcome-based contract.

Ultimately, the programme did not proceed past the procurement stage for several reasons. One was the concern arising from the failure of other large-scale procurement programmes, and another was the fact the programme predated the Five Year Forward View and the resulting collaborative working though STPs and ACSs. These initiatives will now take forward many of the ambitions of this programme. However, the learning we developed through this process remains largely relevant, particularly as each stage of the procurement process involved patients, clinical and non-clinical commissioning professionals and members of a core programme team.

‘Without patient input we may have ended up limiting the outcomes to things we currently measure. Patient input encouraged us to be innovative.’
CCG representative
Patient involvement: involving communities and patients in complex system redesign

The Next Steps on the NHSE Five Year Forward View stated that addressing the challenges of could not be achieved without the ‘genuine involvement’ of patients and communities. At Macmillan, we have found that patient involvement is key to tailoring services to patients’ needs. We have therefore sought to incorporate patient involvement as a fundamental element of design and delivery of all of our complex system redesign programmes. We have worked with people living with cancer and the wider public, and we know that the public is highly influential in changing the culture of care. We believe that any plans to fundamentally change the way in which care and support is designed and delivered need to ensure that patients are truly at the centre.

System change takes time

It’s important to stress that, in our experience, large-scale transformative programmes may take a long time to deliver outcomes – particularly when faced with ‘on the ground’ realities. Just as it is not possible to ignore the contractual and organisational barriers to change, neither can you bypass change by ignoring the time and effort needed to develop a trusting coalition of support. There is no shortcut. Relationships across the system need to be established and worked on constantly – even more so when change is radical and innovative. Time is not a luxury but an essential requirement. It is more important to get it right than to stick rigidly to timelines.

Patient involvement: our learning

- When cost savings are a driving factor, patients can bring other key elements of the discussion to the fore and balance the priorities of the organisations to reflect the patient experience.
- A patient champion role can be a powerful tool in raising public awareness around survival rates, prevention and self-care.
- True co-production, rather than consultation or engagement, requires substantial investment in planning and co-ordination.
- To be most effective, patients must be given clear roles and a purpose.
So what does accountable care mean for cancer?

So far, we have considered accountable care and system change from the perspective of STPs and emerging ACSs. These areas are defining their populations by geography (the people who live in a given area of the country) rather than by condition (the people with a given disease). This leaves us with questions about what accountable care would mean for a cancer population specifically, and what the role of Cancer Alliances will be in this new way of delivering care and support.

Commissioning cancer care and support
The Cancer Strategy for England recommended that integrated Cancer Alliances should be established at a sub-regional level to address variation and ensure a standardised approach to commissioning. It also recommended that there should be attempts made to pilot the commissioning of the entire cancer pathway in at least one area. What’s more, it suggested that this pilot should test a fully devolved budget for that population, to be delivered over multiple years.

When we considered the role of Cancer Alliances in December 2015, we suggested that a potential role would be as a lead commissioner made accountable for the whole cancer pathway. As such they would align incentives and activity based on population outcomes. However we no longer think this an appropriate model for Cancer Alliances, at this time, particularly given our learning from the Transforming Cancer Care programme in Staffordshire.

Through our involvement in this programme we have witnessed some of the challenges and risks that can exist, especially when seeking to appoint a service integrator to manage the full cancer pathway. In this programme the role of the service integrator was to manage a number of provider contracts and to refocus the clinical pathways to early intervention and detection.

Procuring service integrators for the cancer pathway: our experience
- Healthcare data may not be collated or coded in a way that is supportive of costing patient pathways.
- Identifying the budget and contract value for the cancer pathway is challenging and it is difficult to unbundle the costs for cancer and other conditions included in block contracts. This can be particularly difficult given the complexity and number of the organisations involved.
- A high level of expertise and negotiation skills are required to gather the evidence needed for the model, and commissioning external expertise may be needed.
- The timeframe required for this level of change is significant. The complexity of the task, the changes in governance and approval processes, and the volume of stakeholder engagement means timescales may often need to be revised and extended.
The role of Cancer Alliances

We believe that the leadership of Cancer Alliances is essential in ensuring that there is not a recurrence of the confusion that led to fragmented cancer care under previous reforms. Cancer Alliances will have a key role to play in facilitating cross-system working and championing the principles of coordinated delivery and outcomes that matter for people living with cancer. But will assuming commissioning responsibilities enable them to better fulfil this role?

Here are some points to consider:

- In the autumn of 2016, NHS cancer leaders told us that Cancer Alliances should have an essential role in facilitating cross-system working, but they had much less of an appetite for them managing the budget for cancer services.

- NMOC, STPs and ACSs are already focusing on integrating care and support for populations, of which cancer patients will be a part. This should mean better co-ordinated care for people living with cancer.

- 70% of people living with cancer have at least one other long-term condition. To achieve truly personalised care, there must be a recognition that a person is more than just their cancer diagnosis.

- The cancer pathway will now sit across a number of ACSs and STPs. Some needs of cancer patients will be met at an ACS level and others, including services covered by specialised commissioning, at a larger footprint.

- The National Cancer Vanguard is currently trialling the creation of cancer population budgets to integrate commissioning of cancer surgery, radiotherapy and cancer drugs. It is vital we learn from this pilot and that we pay attention to how they engaged with the ACSs and STPs in their areas.

The reforms under the Five Year Forward View mean that Cancer Alliances will now need to work across and with a complex matrix system of care. By doing this they will ensure that the needs of the cancer population are being met and that the transformation envisaged within the Cancer Strategy for England is being realised. It is Macmillan’s view that developing an accountable care model for a cancer population alone is not something Cancer Alliances should be focusing on at the moment given the time and complexity involved. They have an essential role in driving forward improvements and integration in cancer care and support, and nothing should detract them from this vital task.
Conclusion

Establishing an ACS is complex and challenging, and it involves consideration of procurement, payments and contracts. However, Macmillan believes that this should not be the starting point.

We believe more needs to be considered if we are to have a health service that focuses on the needs of people rather than individual organisations. To begin with four key questions should be considered by any area considering the transition to an ACS or similar model. They are:

• **What is the problem that needs to be fixed?**
• **What is needed to make change happen?**
• **How will you deliver integrated and personalised care?**

• **How can patients and healthcare professionals be involved in the design and delivery?**

From a cancer perspective, Cancer Alliances will have a crucial role to play in supporting and working collaboratively with the new emerging structures to consider these questions from the point of view of people living with cancer. Assuming budgetary responsibility should not be the starting point if Alliances are to achieve this.
Glossary

**Accountable Care Organisation (ACO)** can be defined as, ‘a group of providers who are held jointly accountable for achieving a set of outcomes for a defined population over a period of time and for an agreed cost.’ WISH Accountable Care Forum 2013

**Accountable care system (ACS)** defined by NHS England as ‘an “evolved” version of an STP that is working as a locally integrated health system. They are systems in which NHS organisations (both commissioners and providers), often in partnership with local authorities, choose to take on clear collective responsibility for resources and population health.’ (March 2017)

**Cancer Alliances:** Are non-statutory entities that NHS England define as bringing “together local senior clinical and managerial leaders representing the whole cancer patient pathway across a specific geography.” (https://www.england.nhs.uk/cancer/strategy/alliance-guidance/) There are 16 Cancer Alliances in England and they were established by NHS England in October 2016. They are tasked with driving improvements in cancer care and ensuring the implementation of the Cancer Strategy for England for their local areas. There are no Cancer Alliances in those areas that the National Cancer Vanguard covers.

**Integrated care:** The National Collaboration for Integrated Care and Support has indicated that “for health, care and support to be ‘integrated’, it must be person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family. It means moving away from episodic care to a more holistic approach to health, care and support needs, that puts the needs and experience of people at the centre of how services are organised and delivered.” In England there are examples of integrated health and social care as well as horizontal (eg. GPs coming together) and vertical (e.g. a full range of hospital and general practices coming together) integration of health care.

**National Cancer Vanguard** The National Cancer Vanguard is one of the 50 Vanguards established by NHS England in 2015 as part of the new models of care programme. It is one of 13 acute care collaborations – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency. The National Cancer Vanguard is jointly led by three provider organisations: The Christie NHS Foundation Trust in Manchester, The Royal Marsden NHS Foundation Trust in London, and University College London Hospitals NHS Foundation Trust which is also in London. Together they cover a population of approximately 10 million and has the overarching aim to introduce accountability for the whole patient pathway and population service planning and provision. As this project progresses, the intention is to share learning with the Cancer Alliances across the country.

**The National Health Service (NHS)** is the public health services of England, Scotland and Wales.

**NHS England (NHSE)** leads the National Health Service (NHS) in England.

**New Models of Care (NMOC)** The Five Year Forward View (published October 2014) established a number of new models of care that would aim to support improvement and integration of services locally. These included:

- integrated primary and acute care systems – joining up GP, hospital, community and mental health services
- multispecialty community providers – moving specialist care out of hospitals into the community
- enhanced health in care homes – offering older people better, joined up health, care and rehabilitation services
- urgent and emergency care – new approaches to improve the coordination of services and reduce pressure on A&E departments
- acute care collaborations – linking local hospitals together to improve their clinical and financial viability, reducing variation in care and efficiency.

**Sustainability and Transformation Partnerships (STP)** These are non-statutory entities. There are 44 STP “footprints” covering all of England, where local NHSE organisations and councils have drawn up proposals to improve health and care in the areas they serve.

STP can also stand for ‘sustainability and transformation plan’, plans drawn up in each of these areas “setting out practical ways to improve NHS services and population health in every part of England.” (NHS England)

**Vanguards** Between January and September 2015, 50 vanguards were selected to take a lead on the development of the new models of care. https://www.england.nhs.uk/ourwork/new-care-models/vanguards/about-vanguards/

**Voluntary Community and social enterprise sector (VCSE)** is often used as a catch all to describe third sector organisations or civil society organisations. The (VCSE) sector is diverse in size, scope, staffing and funding of organisations. It provides a broad range of services to many different client groups.
References

1. Health Service Journal New care systems must be truly accountable; Commentary 18 September 2017 https://www.hsj.co.uk/comment/new-care-systems-must-be-truly-accountable/7020576.article (This is referenced for illustrative purposes)


6. This workshop brought together local cancer leaders, national policymakers, the think tanks to collectively explore the question, “What does accountable care in the NHS mean for cancer?” The workshop was held under the Chatham House rule.


13. ACOs can be defined as, ‘a group of providers who are held jointly accountable for achieving a set of outcomes for a defined population over a period of time and for an agreed cost.’ Cohen http://www.wish-qatar.org/research/reports/accountable-care


16. The National Cancer Vanguard is jointly led by three provider organisations: The Christie NHS Foundation Trust in Manchester, The Royal Marsden NHS Foundation Trust in London, and University College London Hospitals NHS Foundation Trust which is also in London.


30. Guy’s and St Thomas’ Charity. 5 Key ingredients to sustain impact in health and care https://www.gsttcharity.org.uk/sites/default/files/GStt_sustaining%20impact%20paper_digital_FINAL.pdf

31. Based on unpublished data/findings as of November 1 2017. Two evaluations of the Staffordshire Transforming Cancer Care and Support Programme undertaken by The Wendy Effect (June 2017) and OPM (May 2016) established best practice on patient involvement

32. Ibid


38. Based on unpublished data/findings as of November 1 2017 from an evaluation of the Staffordshire Transforming Cancer Care and Support Programme undertaken by OPM (May 2016)

39. Ibid
At Macmillan, we know how cancer can affect everything. But you are still you.

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