Integrated Care Systems and Aligned Incentives

Everything you always wanted to know... but were afraid to ask

August 2020

BAILEY & MOORE
Housekeeping

- The presentation usually lasts 60 minutes, plus about 15 minutes for questions
- But we are happy to stay online as long as you want us to 😊
- Ask questions as we go, using Chat at the bottom centre of the Zoom screen
- All slides are on our web site – link at the end
- If you’re using someone else's invite, send us your email address if you would like a copy of the slides or to be sent details of further courses
What we will cover...

• Direction of travel before COVID
• The future world: new models of care and Integrated Care Systems
• Should we go back to block contracts?
• What are Blended Payments and how should we use them?
• Moving to commissioning for outcomes
• Working as a system with aligned incentives
Direction of travel pre-COVID
NHS Long Term Plan: main clinical priorities

Quality & Outcomes
- System-wide quality
- New standards for emergency mental health
- Cancer rapid diagnostic centres

Prevention
- Smoking
- Alcohol
- Obesity
- Type 2 diabetes
- Air pollution

Service Models
- Primary Care Networks
- Same-day emergency care
- Clinical assessment services
- Invest in diagnostics

Digital Care
- Primary care to be ‘digital first’ by 2023
- Trusts to be fully digital by 2024
- Avoid a third of all outpatients in 5 years
NHS Long Term Plan: supporting priorities

Structure
- Commissioners and providers collaborate through Integrated Care Systems
- One CCG per ICS
- NHSE and NHSI effectively merge
- Relaxed procurement rules requested

Finance
- 3.4% funding increase
- Payment system reform
- Focus on primary, community & MH
- ‘Financial Reset’
- Finance Recovery Fund
- £700m admin savings

Workforce
- More generalist doctors
- New entry routes, e.g. apprenticeships
- £2.3m investment in volunteers
- Flexible rostering
National Tariff Payment System: consultation for 2020/21

Blended payments
- UEC & adult MH continue from 2019/20
- Outpatients mandated from 2020/21
- Maternity optional from 2020/21
- Adult critical care?
- Ambulance?

Technical adjustments
- Mostly rolled over from 19/20
- Minor changes to best practice tariffs, chemo & excluded drugs
- +2.5% cost inflation
- -1.1% efficiency
- =1.4% net uplift

Other themes
- Blending means most acute activity legally outside national prices
- Emphasis on national approach rather than national price list
- NB 2020/21 NTPS not yet published!
Impact of COVID-19 pandemic

• NHS Standard Contract and National Tariff suspended until at least 30 Sept
• Commissioners fund providers as directed by NHSE, based on 2019/20+
• Providers and commissioners bid centrally for additional COVID-related costs
• No investments approved unless COVID-related
• Not clear what financial arrangements apply for the remainder of 2020/21...
• But 31 July letter from SS & AP confirms that “written contracts with NHS providers for the remainder of 2020/21 will not be required”
New Models of Care (Integrated Care Partnerships)
How did we get here?

1989-97: Working for Patients
purchaser-provider split
simple contracts

2000-05: The NHS Plan
Payment by Results (national tariff)
Foundation Trusts

2010-15: Liberating the NHS
NHS Standard Contract
collaborative contracting

2015-19: 5-year Forward View
new models of care vanguards

2019-24: NHS Long Term Plan
integrated care
blended payments
Traditional Simple Contract (since 1991)
Collaborative Contracting (since 2013)
Prime/Lead Contractor Contract

Commissioner contracts with Prime Contractor only

Prime Contractor provides some contracted services...

... and sub-contracts some services to other parties

Sub-contractor 1

Sub-contractor 2

NHS Standard Contract

NHS model sub-contracts
Integrator Contract

Commissioner contracts with Integrator only

Integrator provides no contracted patient services but provides other expertise, e.g. contract management

Sub-contracts all patient services to other parties

Sub-contractor 1

Sub-contractor 2
Integrated Care Provider contracts (aka ‘alliance contracting’)

- Integrated Care System – contracts with ICP (but technically contract must remain with a single provider)
- Commissioner/ICS

- Integrated Care Provider – could be:
  - separate legal entity
  - contractual joint venture
  - looser alliance agreement

- Lead Provider e.g. local FT

- Model sub-contracts
  - Provider 2 e.g. MH Trust
  - Provider 3 e.g. community
  - Provider 4 e.g. GP federation

- Other providers outside ICS
  - Sub-contracted provider 1
  - Sub-contracted provider 2
  - Sub-contracted provider 3
Integrated Care Provider contract forms

• **Option 1:** schedule 2L of the NHS Standard Contract can be used to integrate primary care (APMS) contract into a secondary care contract

• **Option 2:** there is a model ICP contract on the NHSE website that allows secondary and primary care to be jointly commissioned

• Social Care via s75 agreement with commissioner or lead provider

• Prior approval is needed from NHSE Integrated Support and Assurance process
Example ICP vanguards

MDT to manage patients at high risk of hospital admission:
- GPs
- Community pharmacists
- Social workers
- Community nurses
- MH community workers

https://www.canterburycoastalccg.nhs.uk/about-us/encompass/
Integrated Care Systems
Moving to Integrated Care Systems: why?

- Increasingly complex payment mechanisms and ‘arms length’ contracts between commissioners and providers produced limited results since 1991
- Many of the initial attempts at ICP contracts collapsed under their own bureaucracy
- Sticks and carrots of a market system are largely ineffective in the UK health system, e.g. little provider competition, no realistic prospect of providers exiting the market?
- Collaboration is now the way forward – redirect management time to creating ‘low bureaucracy, high trust’ system that collaborates to deliver health gain...
- As NHS organisations, there’s a finite pot of money and we’re all in it together!
The case for Integrated Care Systems

“One of the interesting things about transferring risk in these models is in fact you don’t. Ultimately the risk comes back to the health board. Because if that provider fails, who is going to pick it up? We’re not suddenly going to leave patients without care. So, if you step back and realise that this is about making sure you’ve got care for patients, you move away from these approaches and you move to a collaborative approach.”

Carolyn Gullery, Executive Director for Funding & Planning, Canterbury District Health Board, NZ
Integrated Care Systems:

where are we now?
Developing Integrated Care Systems: some common features

- Responsible for defined population rather than specific providers or buildings
- Moving to population (place) based funding and control totals
- Accountability for outcomes not inputs
- Information electronic and shared
- Prevention – identify and manage patients in need proactively
- Increase clinical engagement across organisations, including social care
- Culture change: collaboration and joint working
Developing Integrated Care Systems: documenting agreements in contracts

• Schedule 8 – Local System Operating Plan Obligations (2019/20)
  - actions which system has agreed to take jointly, to improve service provision and/or to integrate care with other system organisations

• Schedule 9 – System Collaboration and Financial Management Agreement (2020/21)
  - describes collaborative behaviours expected of the parties
  - open book accounting by and financial transparency between the parties
  - processes for reaching consensus and resolving disputes
  - mechanism for management of the aggregate financial position of the parties to achieve and maintain system financial improvement trajectory
Integrated Care Systems: the future?
Exclusive: Ten hospital trusts abandoning PbR for block contracts

By Lawrence Dunhill | 8 June 2017

- One in four acute providers now mostly contracted through some form of block payment or risk share, research suggests
- 28% per cent increase in the cash value of block contracts in 2017-18, compared to 2016-17.
- Analysis was based on freedom of information request responses from 85 trusts, which represents around 60% per cent of the sector.

There has been a significant increase in hospital trusts moving away from activity based payment tariffs to block contracts, analysis by HSJ shows.
Back to the future with block contracts

• Many STP/ICS have moved back to block contracts and away from cost & volume contracts and/or national tariff

• Perceived downsides of cost & volume/national tariff contracts include:
  – incentivise growth in activity – volume and/or coding – which may not be agreed as being necessary by other parts of system
  – create commissioner v provider conflict when volumes deviate from plan
  – can lead to toxic behaviours such as ‘patrol the boundaries of my organisation’ and ‘beggar thy neighbour’!
Block contracts – friend or foe?

• Block contracts thought to bring:
  – more financial certainty to ICS
  – reduce scope for conflict within system
  – and focus everyone’s minds on the finite resources available to ICS

• But blocks have significant downsides and unintended consequences...
  – disincentivise accurate recording of activity
  – obscure link between activity and cost
  – can hide financial risk rather than escalating it to resolution
Block contracts – overall pros and cons

Pros
- Financial certainty
- Focus on finite resource available to ICS
- Low transaction costs – avoid monthly bean counting exercise
- Can be useful where simply not feasible to measure activity etc

Cons
- Less incentive to record activity accurately
- Activity still drives cost – so just hiding the problem?
- Cost can become dissociated from the cost drivers
- Lose focus on driving clinical efficiency
What are blended payments and how should we use them?
Blended Payments

- Aim is to combine an agreed block payment with a number of (smaller) variable adjustments:

  - ‘Intelligent Fixed Payment’
  - Variable element for activity
  - Variable element for outcomes
  - Risk/gain share

  \[ \text{£ paid to provider} \]

- Happy medium between unaccountable block and open-ended cost and volume contracts?

- Or just making life too complicated?
Blended Payments: implementation issues

• What is the intended role of the Intelligent Fixed Payment?
  – should it cover current/forecast activity x national prices?
  – should it just cover a provider’s fixed cost base?
  – should it provide a minimum income guarantee?

• When should payments be adjusted up or down?
  – driven by activity volume +/-?
  – or some more appropriate cost driver, e.g. referrals to outpatients?
  – is it possible to begin capturing and incentivising patient outcomes?
Blended Payments: progress to date

- Mandated for **emergency care** and **adult mental health** from April 2019
- Proposed for **outpatients** from April 2020 in 2020/21 consultation doc
- **Maternity** probably follows next – was to be ‘optional’ from April 2020
- Both now more likely to be April 2021?
- After these, who knows? Adult critical care & ambulance services have been mentioned
## Blended Payments: urgent & emergency care services

Mandatory from April 2019:

<table>
<thead>
<tr>
<th>Component</th>
<th>Default position (per NTPS Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent Fixed Payment</td>
<td>Based on agreed forecast outturn activity x national prices and any locally-agreed prices</td>
</tr>
<tr>
<td>Variable element for activity</td>
<td>Activity +/- plan x 20% contract price + any achievement of best practice tariffs +/- plan</td>
</tr>
<tr>
<td>Variable element for outcomes</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Risk/gain share</td>
<td>‘Break glass’ clause – trigger point(s) on activity that invoke binding actions, e.g. review meeting, financial adjustments <strong>Must</strong> be in contract unless both parties agree unnecessary</td>
</tr>
</tbody>
</table>
Blended Payments: working age & elderly MH services

Mandatory from April 2019:

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<thead>
<tr>
<th>Component</th>
<th>Default position (per NTPS Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent Fixed Payment</td>
<td>Based on efficient cost of agreed forecast outturn activity</td>
</tr>
<tr>
<td>Variable element for activity</td>
<td>Yes – based on best estimate of variable costs +/- plan</td>
</tr>
<tr>
<td>Variable element for outcomes</td>
<td>“an element linked to quality and outcome measures and the delivery of access and wait standards” of at least 2% in 2020/21</td>
</tr>
<tr>
<td>Risk/gain share</td>
<td>Yes – “if providers and commissioners consider this appropriate locally”</td>
</tr>
</tbody>
</table>
### Blended Payments: outpatient services

Was to be mandatory from April 2020, now 2021?

<table>
<thead>
<tr>
<th>Component</th>
<th>Default position (per NTPS Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent Fixed Payment</td>
<td>Based on agreed forecast outturn activity x national prices and any locally-agreed prices + cost of delivering advice &amp; guidance services</td>
</tr>
<tr>
<td>Variable element for activity</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Variable element for outcomes</td>
<td><strong>Must</strong> agree “a locally determined measure to support the successful delivery of the advice and guidance services” + further outcome or quality measures can be agreed as required</td>
</tr>
<tr>
<td>Risk/gain share</td>
<td>Optional – for local agreement (This is where cost implications of activity +/- would be picked up?)</td>
</tr>
</tbody>
</table>
# Blended Payments: maternity services

Was to be *optional* from April 2020, mandatory from April 2021:

<table>
<thead>
<tr>
<th>Component</th>
<th>Default position (per NTPS Guidance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent Fixed Payment</td>
<td>Based on agreed forecast outturn activity x national prices and any locally-agreed prices for activity within the Local Maternity System</td>
</tr>
<tr>
<td>Variable element for activity</td>
<td>Not mentioned</td>
</tr>
<tr>
<td>Variable element for outcomes</td>
<td>For local agreement “to bind all system partners to the delivery of LMS priorities and population outcomes”</td>
</tr>
<tr>
<td>Risk/gain share</td>
<td>Optional – for local agreement to manage financial risks, e.g. casemix variation</td>
</tr>
</tbody>
</table>
Blended Payments: simplifying maternity financial flows

Current pathway system:
- Payments based on monthly activity x price
- CCG pays lead provider for whole pathway
- If other providers provide part of pathway, they bill lead provider

New blended payment system:
- Intelligent Fixed Payment for year
- CCG pays each provider directly for their annual costs in delivering LMS services
- No provider-provider billing
Blended Payments: evolution or revolution?

- Tempting to see blended payments as yet another complex technical tariff issue
- But... changes fundamental purpose of national tariff – away from a published price list towards a ‘national approach’ that supports local payment mechanisms
- Weakness of national tariff was always that it was ‘payment by volume’ rather than ‘payment by results’ (best practice tariffs excepted)
- Opportunity now to move away from paying on volume towards a more stable fixed sum to cover agreed costs + additional sum to incentivise outcomes
- With activity volume being reconciled and costed maybe once a year?
Commissioning for outcomes

Understanding commissioning for outcomes in 10 seconds...

Do outcomes matter?

Brilliant surgery! Well done! Shame the patient died.

The key principle behind commissioning for outcomes is a clear focus on the actual results being achieved for the individual and for populations and putting in place commissioning models and/or pathways of care to achieve those results.
NHS Outcomes Framework

These are the high-level national outcomes for the NHS everyone should be working towards securing:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1</td>
<td>Preventing people from dying prematurely</td>
</tr>
<tr>
<td>Domain 2</td>
<td>Enhancing quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>Domain 3</td>
<td>Helping people to recover from episodes of ill-health or following injury</td>
</tr>
<tr>
<td>Domain 4</td>
<td>Ensuring people have a positive experience of care</td>
</tr>
<tr>
<td>Domain 5</td>
<td>Treating and caring for people in safe environment and protecting them from avoidable harm</td>
</tr>
</tbody>
</table>

Why commission for outcomes?

- Huge opportunity to get different parts of local health systems working together, to deliver patient benefit
- Understand how resources are used, what health gain outcomes are delivered and how these can be measured
- Redesign the application of resources to maximise health gains delivered
- To expand the skills capabilities and expertise across the system so this approach becomes “business as usual”
- Inputs and outputs still matter – but we want better patient outcomes…

AND btw… Commissioning for Outcomes is NOT a savings programme…
Commissioning for outcomes

• Unlikely that any single provider of care can deliver any given outcome in isolation from other providers

• Only possible if appropriate contracting mechanisms are in place

• Existing contracting models require modification to encourage/reinforce shared accountability - strengthening existing arrangements won’t work

• Need to agree outcomes across provider organisations and the full pathway

• Rather than working against each other through ‘arm’s length’ contractual negotiations
Working as a system with aligned incentives
Why change the current system?

• NHS has significant financial challenges going forward
• These have just got much larger post-COVID... e.g. need to retain surge capacity, post-COVID rehab, untreated non-COVID conditions, etc
• Why do we spend so much time debating the national tariff & contract technical guidance rather than tackling these issues?
• Why do we put the contract first and common sense second?
• Why do we see relationships between different parts of the local health system deteriorating rather than working together to solve problems?
What might be the values of a high-performing ICS?

- We use the resources of the ICS collectively and transparently, to invest in improving patient outcomes and a sustainable health system
- We take important decisions jointly and accept shared accountability for the outcomes of our decisions
- We regard financial deficits as a system issue, not an organisation’s issue
- We pool and share scarce human resources to support delivery of our priorities
- We say what we mean and do what we say
- We accept fair criticism and defend unfair criticism
What might this look like in practice?

• ICS Partnership Board of NHS and local govt leaders sets system priorities

• ‘Commissioner QIPP’ and ‘provider CIP’ merged into single programme for clinical efficiency – identify and eliminate waste (inefficient cost)

• Develop a single clinical community to drive the change

• System-wide approach to issues such as Low Priority Procedures – activity that the NHS cannot and should not provide

• Overspends and underspends pooled and managed by the system

• No fines for ‘failure’ – system uses data to work out how to improve
What is happening now?

• Per the 31 July letter from SS & AP, health system development plans are required to demonstrate by 1 Sept:

  “Collaborative leadership arrangements, agreed by all partners, that support joint working and quick, effective decision-making. This should include a single STP/ICS leader and a non-executive chair, appointed in line with NHSE/I guidance, and clearly defined arrangements for provider collaboration, place leadership and integrated care partnerships.”

  “Organisations within the system coming together to serve communities through a Partnership Board, underpinned by agreed governance and decision-making arrangements including high standards of transparency – in which providers and commissioners can agree actions in the best interests of their populations, based on co-production, engagement and evidence.”
What behaviours do we want to incentivise in an ICS?

Disincentivise

• Focusing on inputs and volumes
• Monthly debate over who is following national guidance
• Passing deficit around the system
• Hitting organisational control totals
• Panic cost cutting as year-end looms
• Risk allocated by using national contract & tariff system
• Planning only for the contract term

Incentivise

• Focusing on patient outcomes
• Working as a system with shared goals
• Taking inefficient costs out
• Hitting system control total
• Investing to save, based on evidence
• Risk sits where it can be best managed
• Planning for the long term
Working as a system with aligned incentives – summary

• Start with the patient journey rather than the activity and money – put the horse back before the cart again

• Put time into designing aligned outcomes – difficult to define and measure

• Find the happy medium between unaccountable block contracts and open-ended cost & volume – blended approaches and risk/gain sharing

• Share scarce resources – clinical, finance, IT etc

• Shared objectives and accountability requires honest communication and joint decision-making – are we ready for the cultural change?
Can we help? We offer retainer services...

We have almost 30 years’ experience at senior level within the NHS and can provide practical support across a wide range of issues.

Email us at info@baileyandmoore.com to discuss how we could help.
Other courses we offer include

• **Step by step guide to writing a service specification**
• **Commissioning for outcomes – developing KPIs and metrics**
• **A ‘how to’ guide – local pricing and costing reviews**

If you are interested in these or other topics, email us at training@baileyandmoore.com and we can discuss your requirements
Thanks for listening!

Email us with any comments or requests for training courses at:

training@baileyandmoore.com

Slides available at:

http://baileyandmoore.com/resources/training-slides/