Back to the Future?

or Brave New World?

Life in the NHS after the Health and Care Bill

November 2021

BAILEY & MOORE

Housekeeping

- The presentation usually lasts 90 minutes, including about 30 minutes of time for questions
- But we are happy to stay online as long as you want us to ☺
- Ask questions as we go, using the chat box or raise your ‘hand’
- All slides will be 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…

- The Health and Care Bill – how did we get here?
- Integrated Care Systems, Boards and Partnerships
- Prime providers, provider alliances & provider collaboratives
- Going back to block contracts and payments – blessing or curse?
- Moving to aligned incentives and contracts – thinking ‘system by default’ and focusing on patient outcomes
- How the money might flow

Firstly, a ‘quick’ jargon buster!

Term	Meaning
Integrated Care System	The collective term for the NHS organisations that cover a specified geographical area, large enough to plan strategically, with input from non-NHS partners
Integrated Care Board	The proposed governing body of an ICS, as set out in the Bill
Integrated Care Partnership	A proposed joint planning committee of NHS, local govt and other interested parties covering an ICS, as set out in the Bill
Place	A ‘natural locality’ within an ICS covering 250-500k people, typically coterminous with a local authority and/or former CCG
Provider Collaborative	A number of providers working jointly across multiple Places to achieve specified objectives, from loose alliance working to a formal contractual joint venture
Place-Based Partnership	Similar to a Provider Collaborative, but where providers work in a single Place
Integrated Care Provider	Previous term used in *The NHS Long-Term Plan* for provider collaborative working, usually specifically referring to integrating primary and secondary care, sometimes also social care

Sorry, more jargon…

Term	Meaning
Alliance Contracting	Where a commissioner holds a contract involving multiple providers
Provider Alliance	The collective term for the providers that are party to an alliance contract
Prime contractor	The lead party within a provider alliance, who holds the head contract with the commissioner. In practice, used interchangeably with prime provider.
Prime provider	A type of prime contractor, where the contractor also provides some of the contracted services. In practice, used interchangeably with prime contractor.
Aligned Incentive Contract (AIC)	General term for a contract where the payment mechanism is based on a fixed block payment, plus a smaller gain/risk share element depending on performance in year
Aligned Payment & Incentive Approach	Specific national rules for implementing AICs, as set out in the 2021/22 National Tariff Payment System guidance (effective from 1/10/21)
Patient Outcomes	A quantifiable measure of the health benefit delivered to patients, e.g. reduction in under-75 mortality rate from cardiovascular disease

Latest guidance can be found here…

Integrated Care Systems

https://www.england.nhs.uk/publication/integrated-care-systems-guidance/

National Tariff/ Payment Reform

https://www.england.nhs.uk/pay-syst/national-tariff/

NHS Standard Contract

https://www.england.nhs.uk/nhs-standard-contract/21-22/

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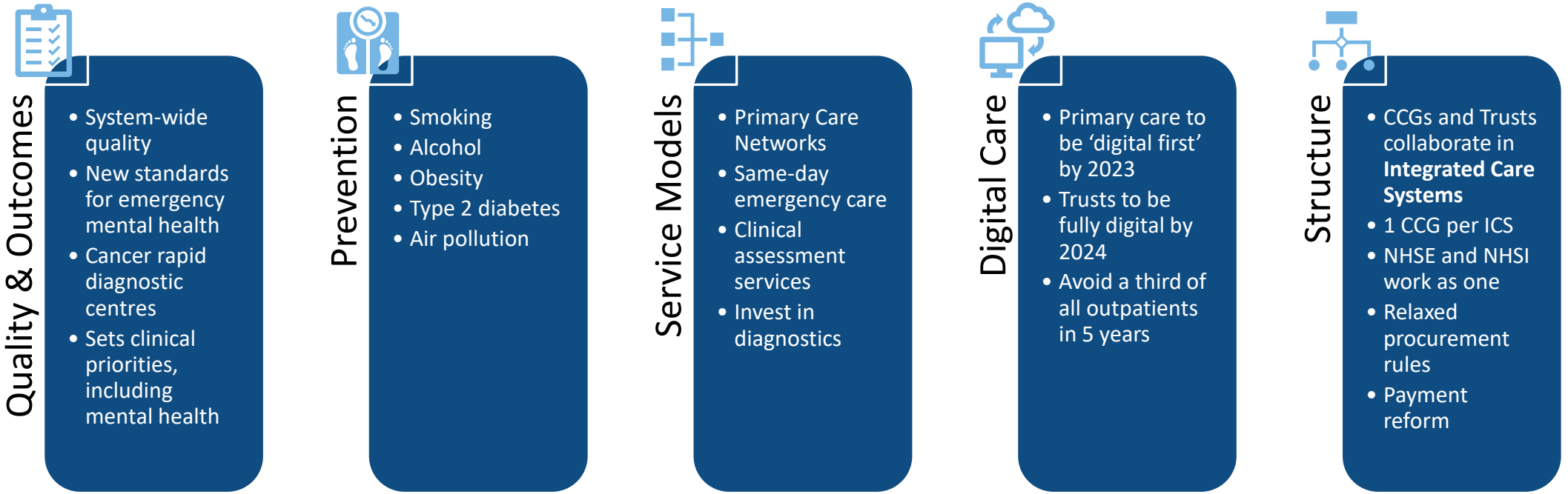
How did we get here?

The NHS Long Term Plan 2019-24: still the overall plan…



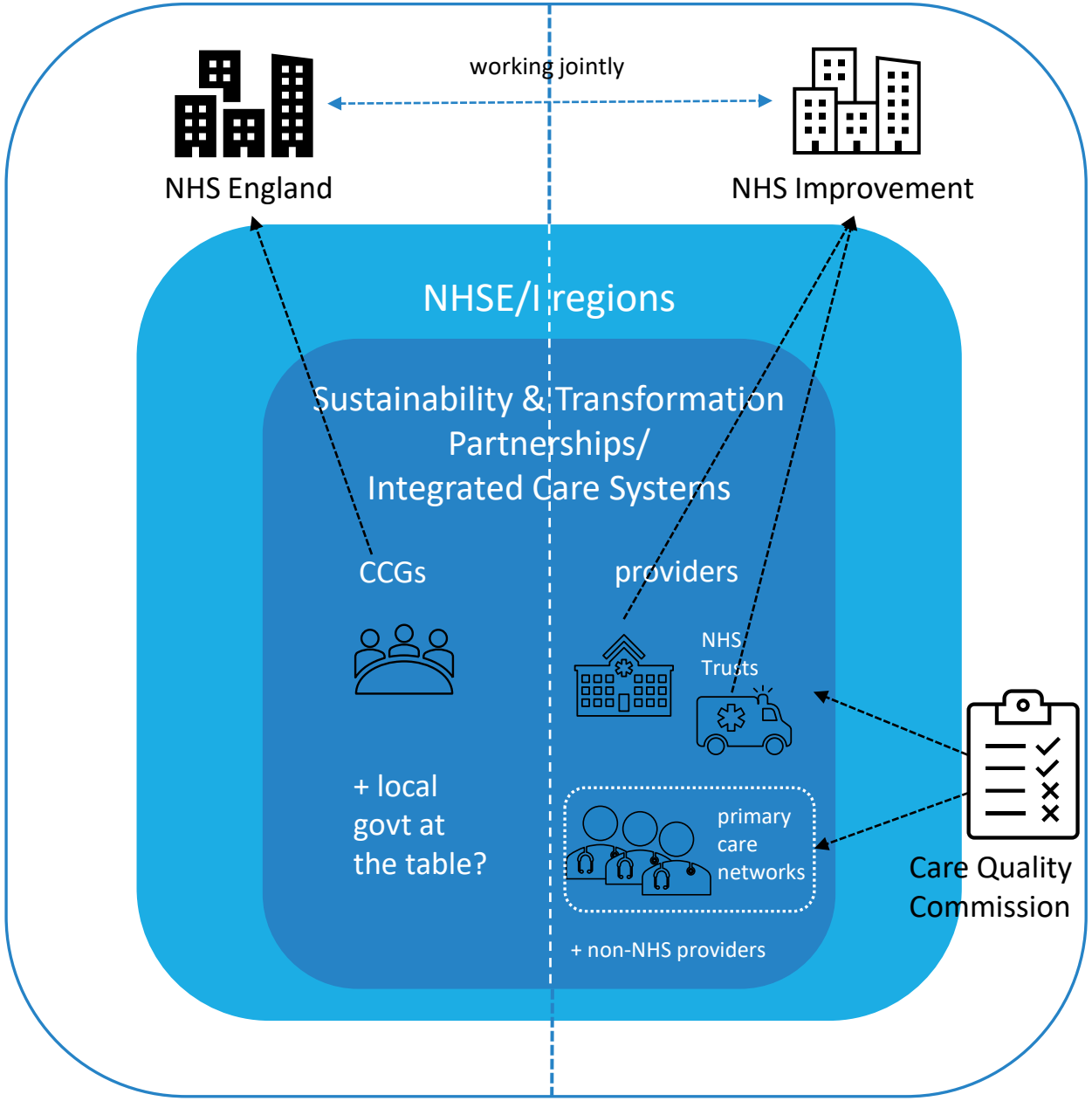
Impact of COVID-19 pandemic

- Signing contract particulars and using National Tariff suspended since April 2020
- Commissioners funded providers by block payment
- Providers and commissioners bid centrally for additional costs, e.g. elective recovery fund, income support for lost non-NHS income
- Non-contract activity funded via host CCG – no separate invoicing
- Arrangements continuing to April 2022

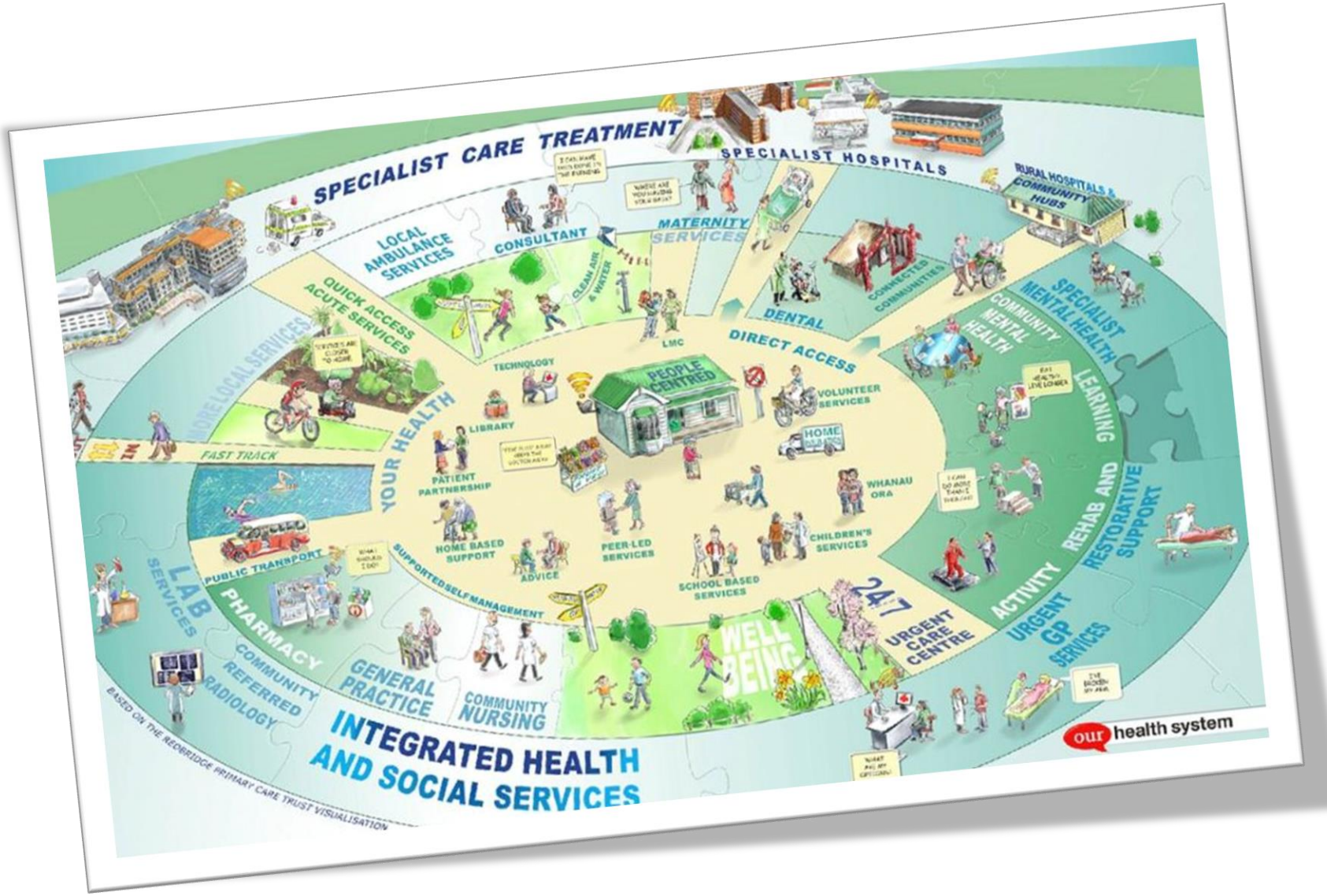
Raises the question: why did we need complicated contracts and national tariff guidance?

Where we are now…

a rather messy compromise between old and new worlds!



Integrated Care Systems, Boards & Partnerships



Health and Care Bill 2021

Broadly welcomed…

- Formalises what's happened anyway… integrated systems, bigger role for local govt, single regulator
- 'Triple aim' of better population health, quality of care and sustainable use of resources
- Removes quasi-market competition and procurement rules
- Local flexibility encouraged… will that last?
- Payment reform… national tariff replaced with NHS Payment Scheme and locally agreed pricing

More controversial?

- New powers for Sec of State to intervene in reconfigurations and to direct NHSE
- Govt proposals on social care reform very limited in scope – just deal with funding mechanism, not investment needed
- Nothing on future role of public health
- No big strategy to address workforce shortages and current staff exhaustion
- Overlapping roles of NHSE v ICB v ICP v Places v Neighbourhoods?

Moving to Integrated Care Systems: why?

- Increasingly complex payment mechanisms and lengthy bilateral contracts between individual commissioners and providers
- Sticks and carrots of an internal market system have outlived their usefulness in the UK health context, e.g. little provider competition, limited private sector interest, no realistic prospect of providers exiting the market?
- Collaboration seen as the way forward – redirect management time to creating 'low bureaucracy, high trust' system that works as a more cohesive unit
- 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: some common themes and values

- Responsible for defined population rather than specific providers or buildings
- Moving to place-based funding and system-wide control totals
- Accountability for patient outcomes, not inputs or outputs
- Information electronic and widely shared
- Prevention – identify and manage patients in need proactively
- Use clinical engagement across organisations, including social care
- Culture change: collaboration & shared accountability replaces internal market

But it’s not all plain sailing…

NEWS

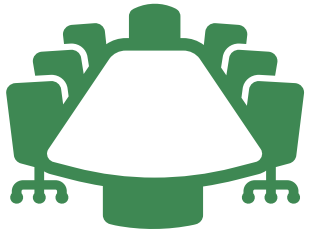
Why we left: Ex-DHB bosses speak out

Cost-cutting demands at the Canterbury DHB are compared to asking Air NZ to maintain its flight schedule while shedding thousands of jobs. David Williams reports

Two former Canterbury health bosses have spoken publicly for the first time since leaving in a rush of recent resignations, blaming hard-headed officials and an unsupportive board for their departure.

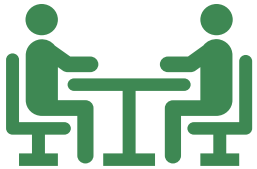
Seven of the Canterbury District Health Board’s (DHB) 11-strong executive team, including chief executive David Meates, have resigned from in an unprecedented blood-letting at the top. They leave amid **relentless pressure** – from the Health Ministry, Crown monitor Lester Levy, and the board, led by former High Court judge Sir John Hansen – to cut costs.

Integrated Care Boards & Partnerships



Integrated Care Board

- **Statutory body** under the Bill
- Must have a Chair and at least 2 non-executive directors
- plus Chief Executive, Chief Finance Officer, Chief Nursing Officer and Chief Medical Officer
- plus at least 1 member nominated by each of providers, primary care & local govt
- Chair and Chief Executive appointed by NHSE

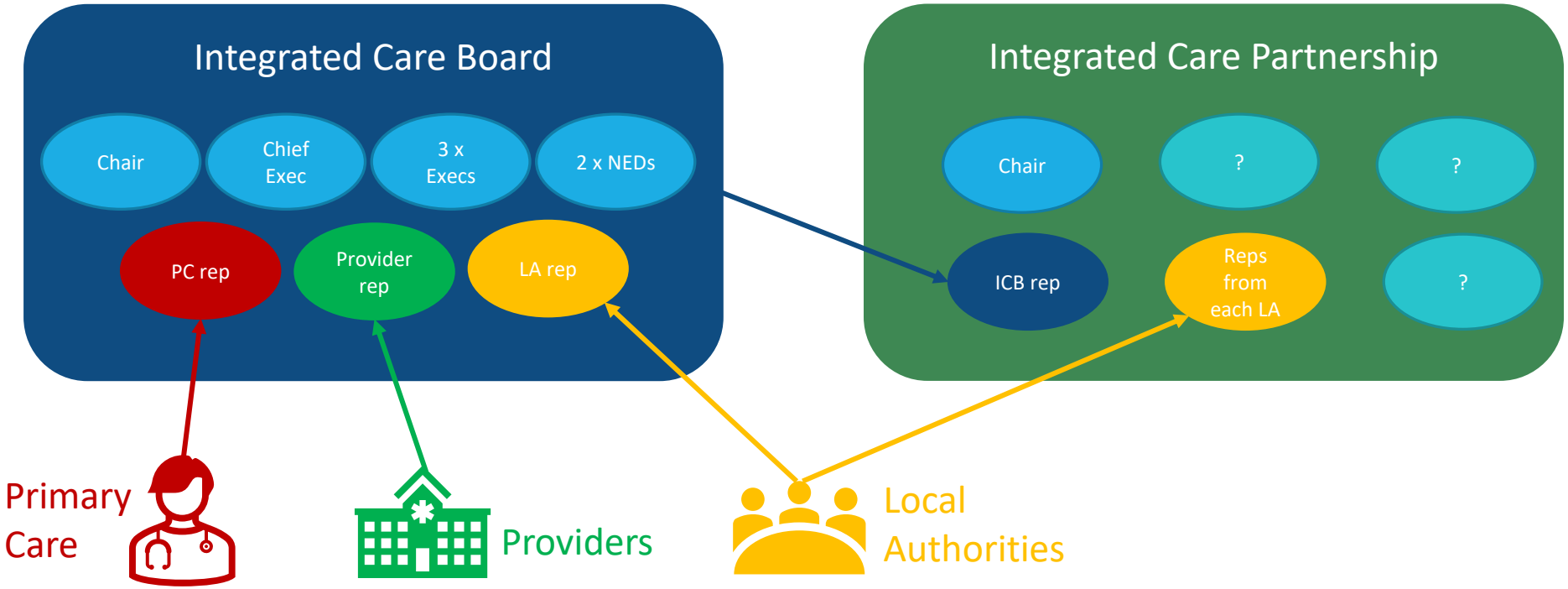


Integrated Care Partnership

- **Statutory joint committee** under the Bill
- One member appointed by ICB and by each local authority
- Other members appointed by ICP locally
- Charged with preparing 'integrated care strategy' for ICS

https://www.england.nhs.uk/wp-content/uploads/2021/06/B0886_Interim-guidance-on-the-functions-and-governance-of-the-integrated-care-board-August-2021.pdf

Integrated Care Boards & Partnerships



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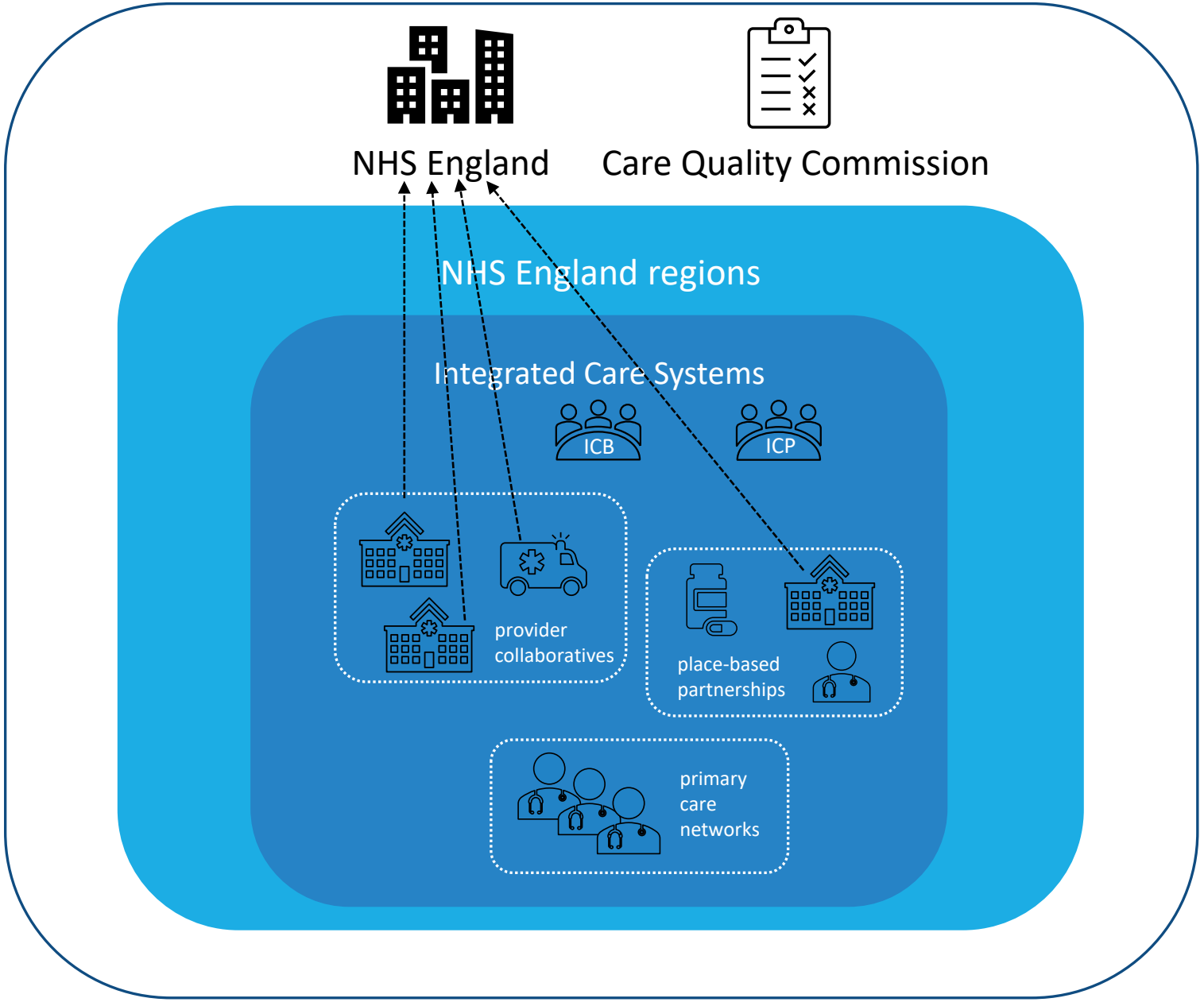
The proposed future…

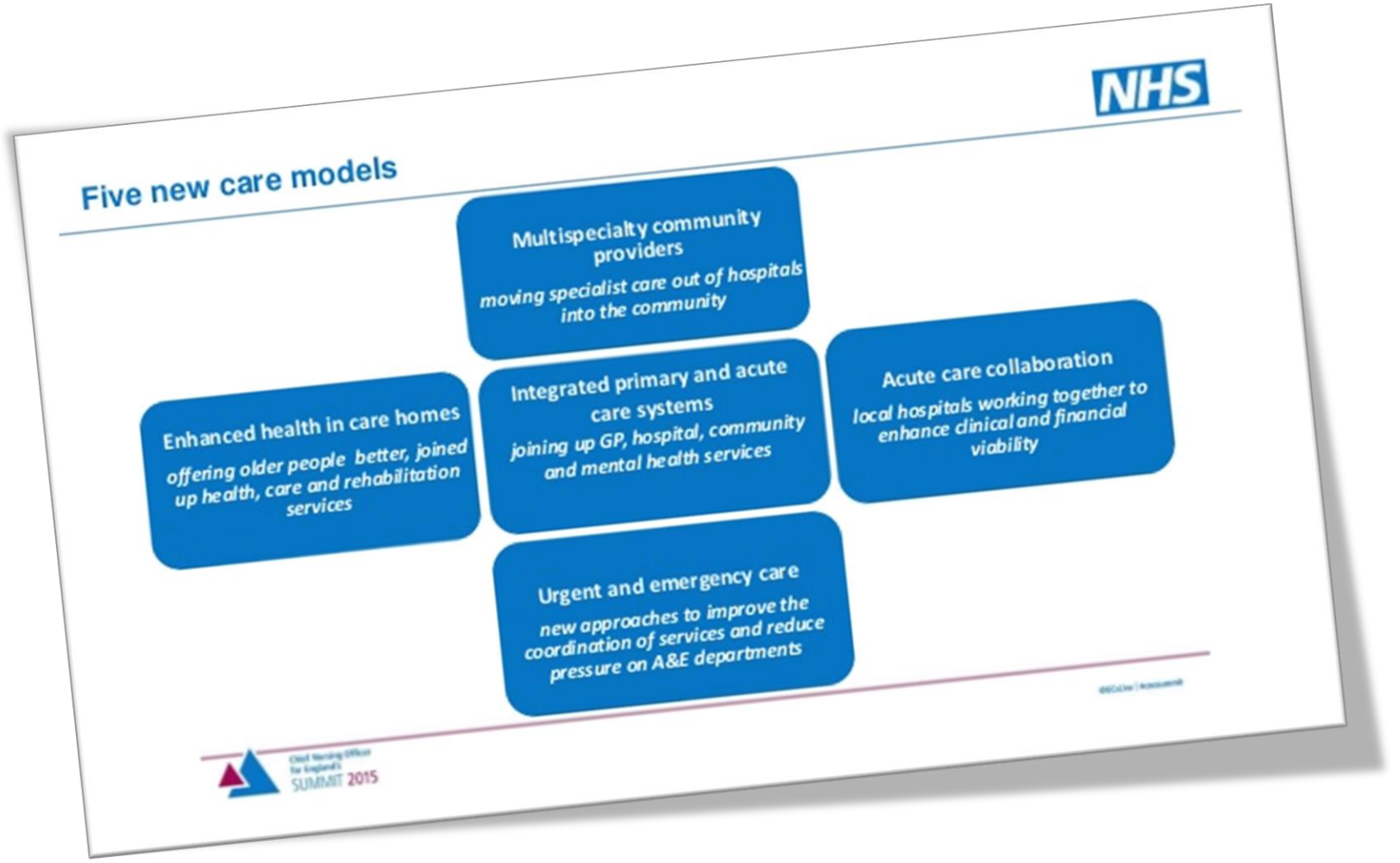
a simpler, if not perfect, structure?



Integrated Care Systems: how to implement in Standard Contract

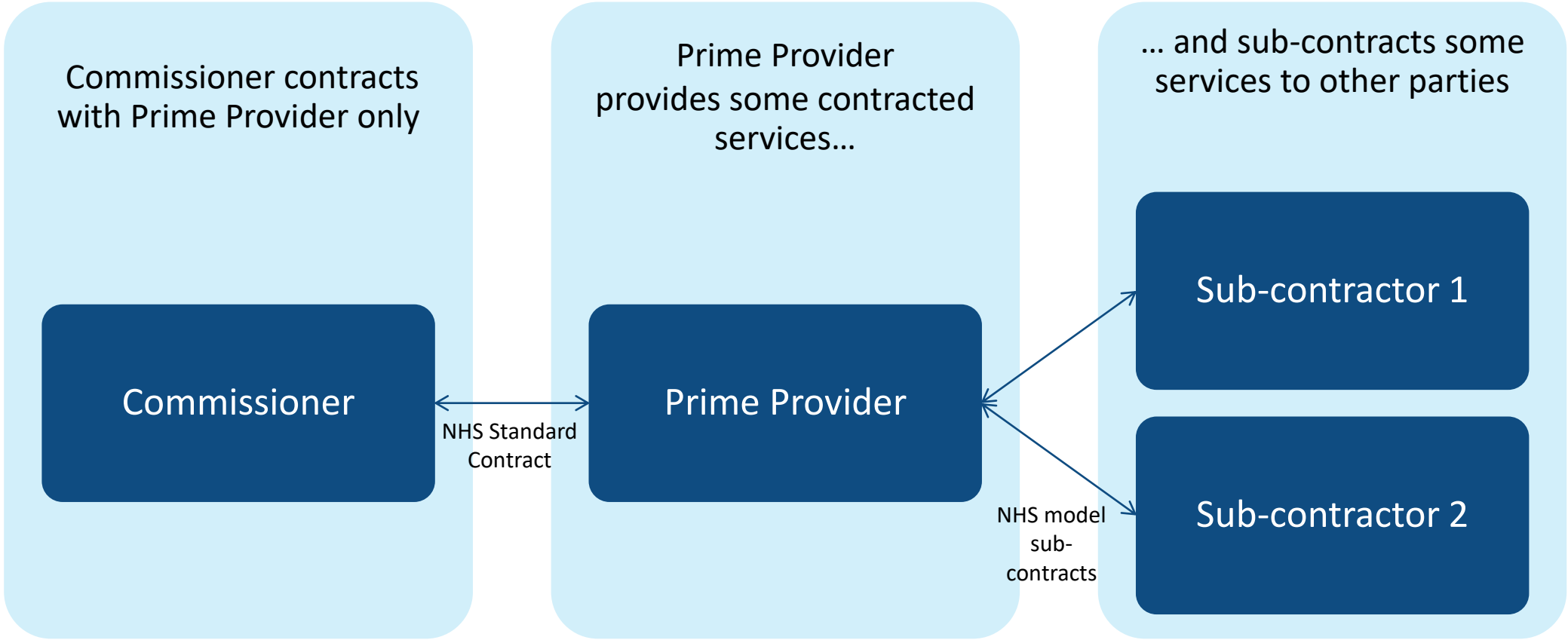
- **Schedule 8 – Local System Operating Plan Obligations (2019/20)**
  - actions which system has agreed to take jointly, to improve service provision and/or to integrate care with other system organisations
- **Schedule 9 – System Collaboration and Financial Management Agreement (2020/21)**
  - describes 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

Provider alliances & collaboratives

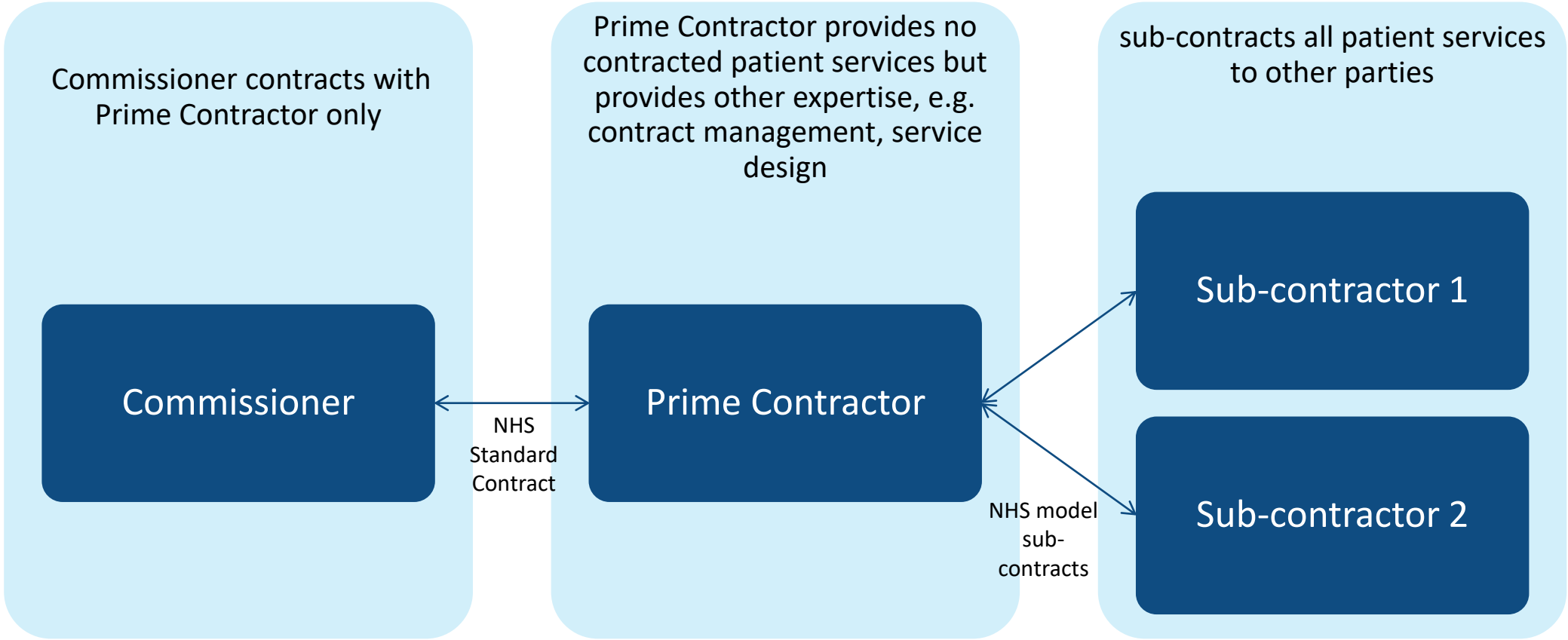


Traditional Bilateral Contract (since 1991)

Prime/Lead Provider Contract



Prime Contractor/Integrator Contract



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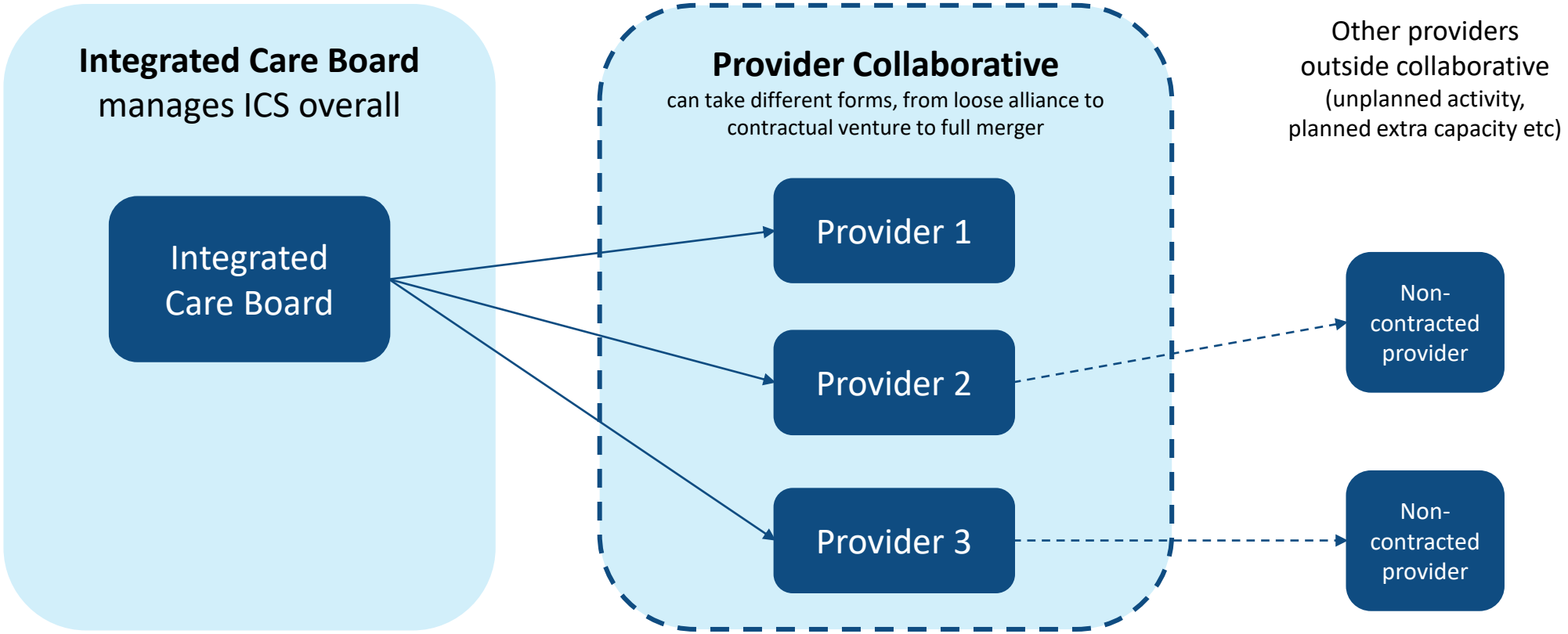
Also known as:
- Alliance contracting
- Integrated care partnerships
- Integrated care providers

Provider collaboratives – loose alliance



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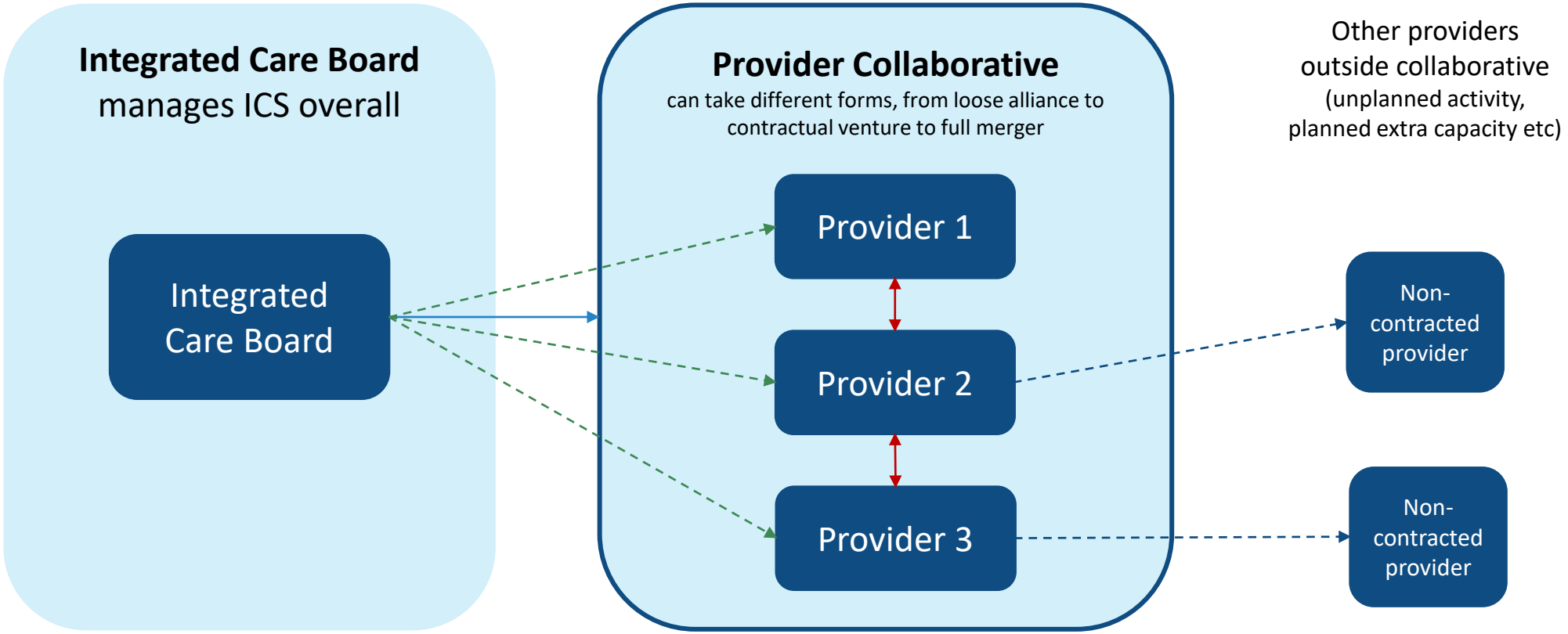
Provider collaboratives – formal JV



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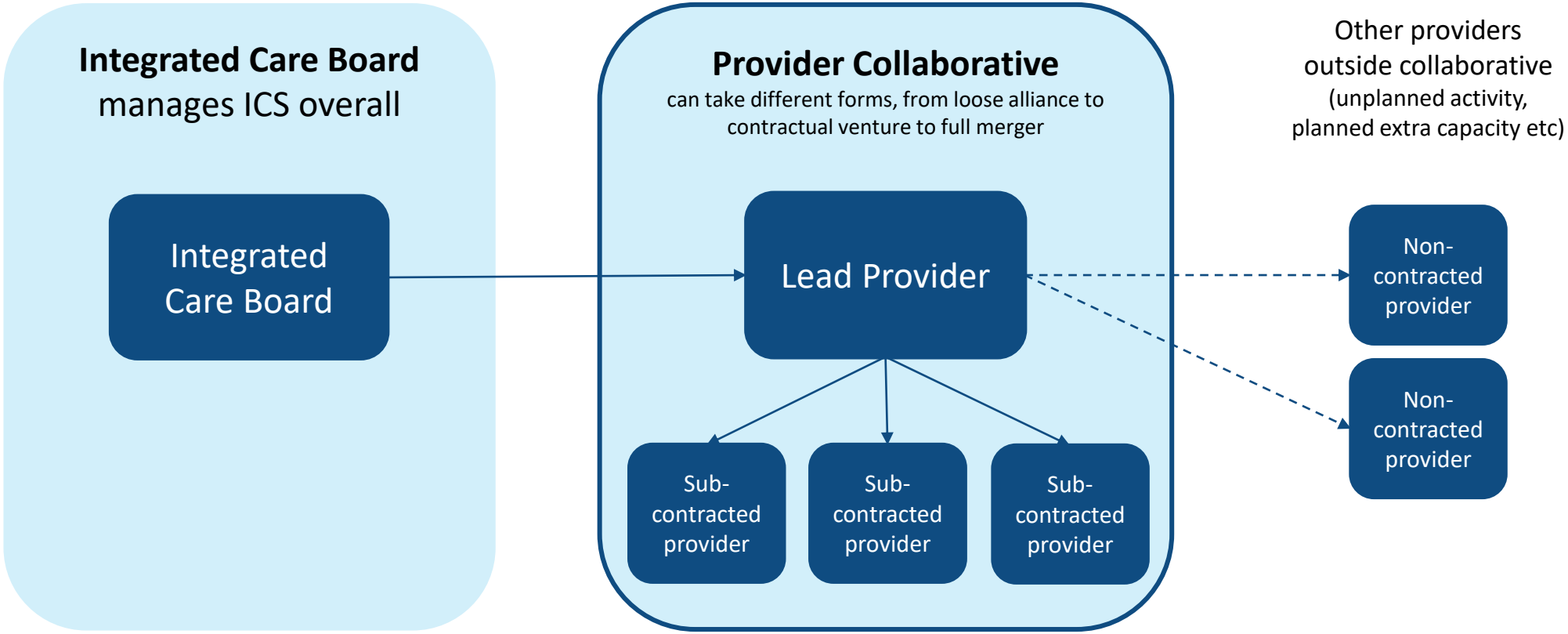
Provider collaboratives – lead provider model



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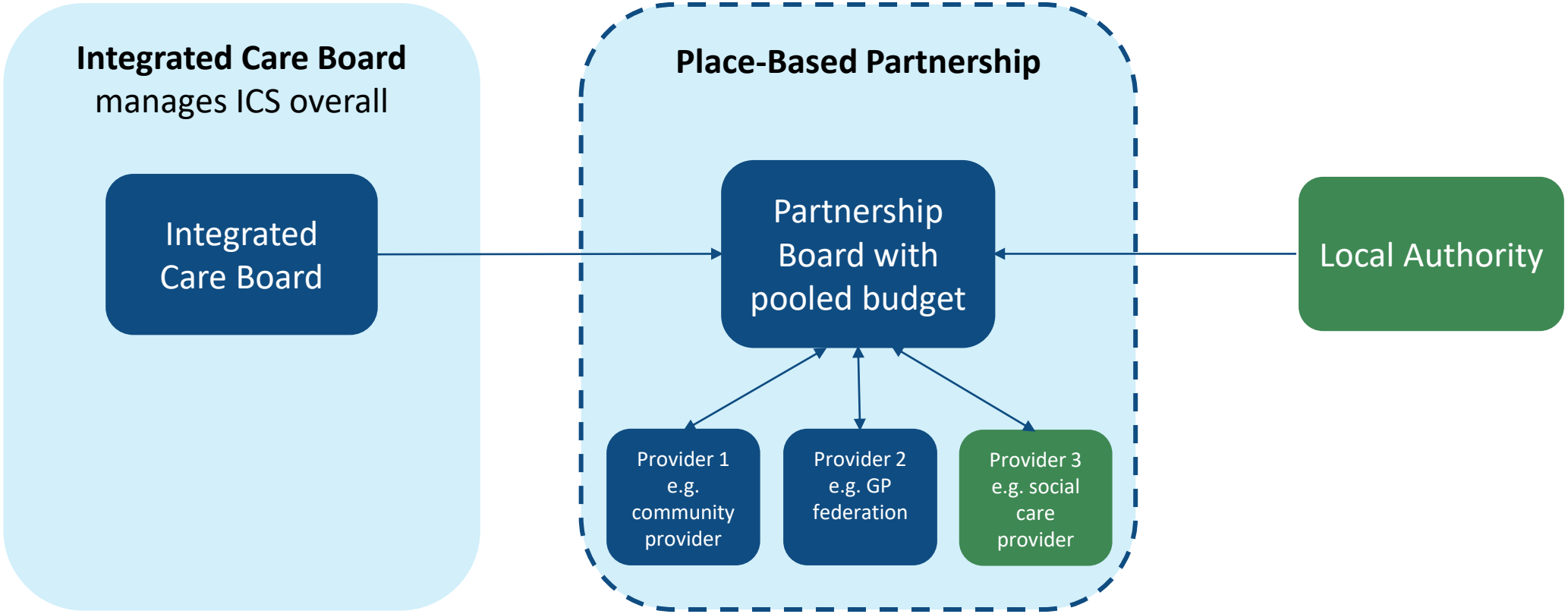
Place-Based Partnerships



https://www.england.nhs.uk/wp-content/uploads/2021/06/B0660-ics-implementation-guidance-on-thriving-places.pdf

Some possible types of collaboration

Footprint	Scope	Focus	Potential Objectives
Cross-system collaborative	All organisations providing NHS and social care	Defined population that crosses ICS boundaries, e.g. adolescent eating disorders	Economies of scale Consistent service offer Integrate health & social care
System-wide 'horizontal' collaborative	All acute NHS providers in our ICS	Best possible service provision within our ICS's limited resources	Rationalise acute services/staff across sites Strategic forward planning
System-wide 'vertical' collaborative	Acute, mental health and social care providers in our ICS	Frail older people in our ICS with >2 LTCs	Integrate hospital & out-of-hospital care Reduce emergency admissions to hospital
Place-based partnership	Community, primary, social and voluntary care services	Defined locality population, e.g. older people registered with this PCN	Integrated health, well-being & prevention service
Neighbourhood partnership	Primary Care Network	Defined neighbourhood with specific health needs	Integrated primary care service (GPs, nurses, dentists, pharmacy, opticians, etc)

Different governance options

Lead provider

- ‘Arms length’ contractual joint venture between providers
- Different members can lead on different issues
- Transfer financial risk from commissioner to lead provider
- Difficult to manage in practice

Partnership Board

- Create an overarching board with reps from all member providers
- Loose alliances can work well if history of good mutual relations
- Or can become another layer of bureaucracy adding little value

Committees in common

- Merge existing Board committees into joint meetings
- Less bureaucratic than having separate Board
- Tends to be a precursor to shared leadership

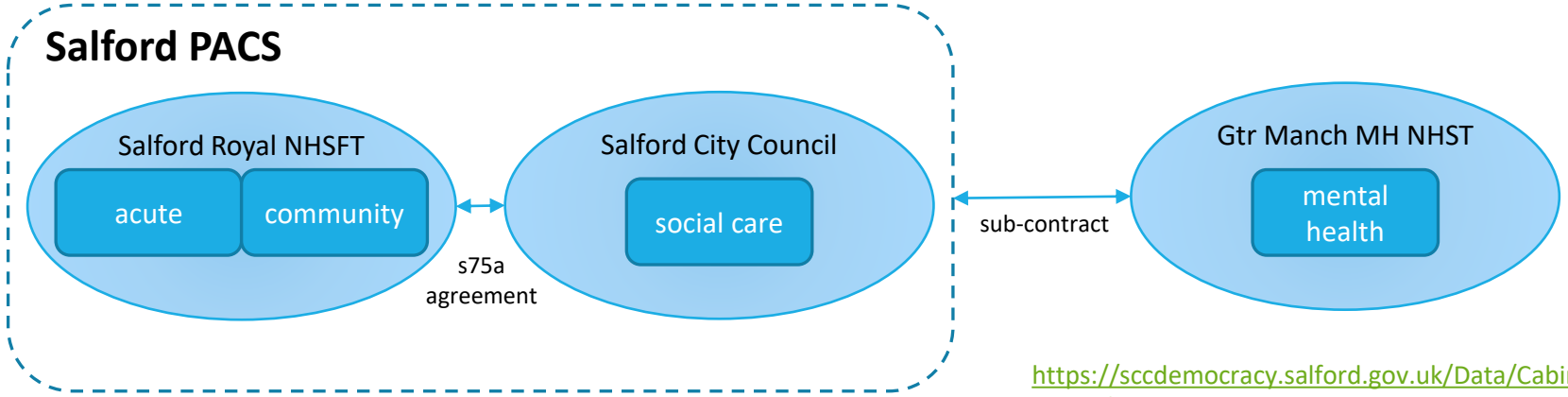
Shared leadership

- Sharing of key Board positions
- Normally combined with a Partnership Board or committees in common
- Tends to be a precursor to full merger!

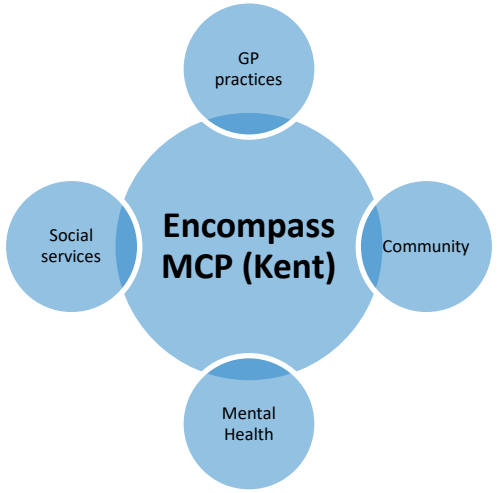
Full merger

- Often the ultimate destination…
- Eliminate organisational barriers
- Perceived as less bureaucratic than Partnership Boards or committees in common
- Economies of scale… or diseconomies?

Existing ICPs/collaboratives as examples…



https://sccdemocracy.salford.gov.uk/Data/Cabinet/201604261000/Agenda/2016%2004%2012%20ICO%20FBC%20PUBLIC%204%202.pdf



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/

See also: https://nhsproviders.org/providers-deliver-collaborating-for-better-care/resources

Provider collaboratives: how to implement in Standard Contract

- NHS Standard Contract not really set up for multiple providers to a contract…
- **Primary/Secondary integration:**
  - **Option 1**: schedule 2L of the NHS Standard Contract can be used to integrate primary care (APMS) contracts into a secondary care contract https://www.england.nhs.uk/publication/schedule-2l/
  - **Option 2**: model ICP contract on NHSE website that allowed secondary and primary care to be jointly commissioned… now killed off https://www.england.nhs.uk/integrated-care-provider-contract/
- **Secondary/secondary integration:**
  - Contract has to be formally with prime provider and they hold sub-contracts with other partners
- **NHS/Social Care integration:**
  - s75 agreement with local authority to pool budgets can be held by NHS commissioner or provider

Going back to block contracts & financial envelopes…

blessing or curse?

Exclusive: Ten hospital trusts abandoning PbR for block contracts

By Lawrence Dunhill | 8 June 2017

12 Comments

- 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.

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Back to the future with block contracts

- Many ICS have been moving 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 – 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

Block contracts – summary

- Great for reducing the monthly bureaucracy
- Great for controlling financial risk, where this stops change
- But let's not throw away all the progress since 2005…
- Need to retain some incentives in the payment mechanism
- Finance should be an enabler for the changes the ICS wants to push
- Let's think about incentives which everyone can align around rather than playing pass the parcel with large financial risks?

Moving to aligned incentives & patient outcomes

What behaviours do we want to incentivise in our ICS?

Focusing on inputs and volumes	→	Focusing on patient outcomes
Monthly debate over national guidance	→	Working as a system with shared goals
Passing deficit around the system	→	Identifying and removing waste
Hitting organisational control totals	→	Hitting our system's finance allocation
Panic cost cutting as year-end looms	→	Investing to save, based on evidence
Risks allocated using contract & tariff guidance	→	Risk sits where it can be best managed
Planning for the contract term	→	Planning for the long term

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Why change current contracts?

- NHS has significant financial challenges going forward
- These have just got much larger post-COVID!
- Why did we spend so much time debating the national tariff & contract technical guidance rather than tackling these issues?
- Why did we often put the contract terms first and common sense second?
- Why did we see relationships between different parts of the local health system deteriorating rather than working together to solve problems?
- If block contracts are not (entirely) the answer, what is?

Aligned incentive contracts

- Aim is to incentivise different parts of local health systems to work together, to deliver patient benefit (using measurable outcomes)
- Unlikely that any single provider of care can deliver patient outcomes in isolation from other providers
- Understand how resources used across the whole patient pathway, rather than individual provider contracts
- So let's design contracts and payment terms that encourage this, rather than each provider trying to maximise its volume of activity under a traditional 'PbR' volume x price contract

Commissioning for outcomes

- If we want the system to work together more effectively, why not start with the patient and the outcomes that the system wants to see?
- Then start to map activity and money based on the system's shared view of what the local population needs to deliver the required health gain
- Inputs and outputs still matter – but we want better patient outcomes…

Much more on this in later sessions, including practical examples of designing outcomes and KPIs!

What might this look like in practice?

- ICB & ICP set system-wide priorities and objectives
- ‘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 changes needed

  e.g. system shared approach to issues such as Low Priority Procedures – let’s agree upfront what activity the NHS cannot/should not provide?

- Overspends and underspends pooled and managed by the system against risk to the system control total

What might this look like in practice?

- Payments based on block element to provide financial stability and cover for fixed costs, so change is not immediately gridlocked
- Plus incentive element for contributing towards patient outcomes and/or risk/gain sharing agreement on volume/cost pressures
- No blame/no fines for ‘failure’ – system uses data to work out how to improve its performance
- Contract levers only used as a backstop – seen as a sign of system failure that needs to be addressed at source

Case Study: Bolton

https://www.kingsfund.org.uk/sites/default/files/2019-03/payments-and-contracting-for-integrated-care.pdf

- CCG & FT were in financial difficulties and exchanged c300 formal letters trying and failing to use the contract to solve their problems
- Agreed instead to work together under 5 guiding principles
- Contract payment moved to agreed block based on cost, not national tariff
- Risk/gain sharing agreement as to how under/overspends are managed

  e.g. if patients diverted from hospital settings to more cost effective pathways, savings are shared across system

- Staff that used to prepare disputes now work in system improvement!

Case Study: Coventry

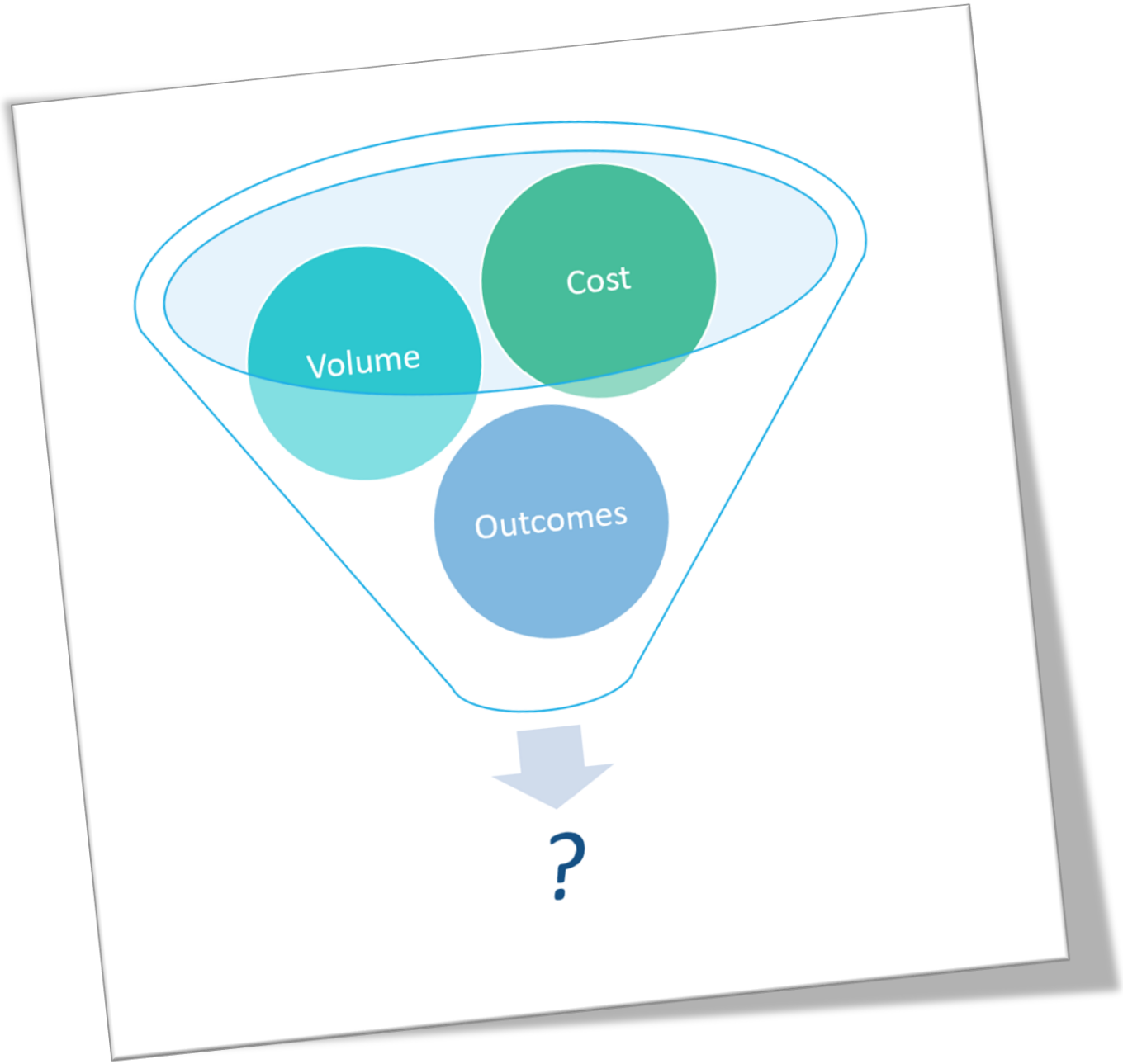
https://www.hfma.org.uk/docs/default-source/publications/Briefings/an-introduction-to-aligned-incentive-contracts.pdf

- Same background as previous slide… long-running disputes meant neither side really knew what their underlying financial position was
- Contract split into 4 blocks: elective, non-elective, OP and high-cost items
- Each block has its own risk share

  e.g. non-elective overperformance at 50% marginal rate up to agreed cap

- Each block has minimum income guarantee to provide financial certainty
- Clinicians encouraged to talk directly to referring GPs to manage demand within elective block

Payment Reform



Payment Reform

- Health and Care Bill replaces national tariff with **NHS Payment Scheme**
- NHSE must consult on and publish pricing rules each year – which may or may not include national prices
- Moving away from published prices towards guidance and tools that facilitate each ICS designing its own payment rules within national policy framework
- National tariff 2021/22 sets out **Aligned Payment & Incentive** (API) rules

  https://www.england.nhs.uk/wp-content/uploads/2020/11/21-22NT_Guidance-on-the-aligned-payment-and-incentive-approach.pdf
- Series of NHSEI engagement workshops for 22/23 payment during September confirmed direction of travel was to build on 21/22 NT

Aligned Payment & Incentive approach (per 2021/22 National Tariff guidance)

- Majority of payment to be fixed block, basis and % to be locally agreed
- Remainder to be variable payment, which must reflect elective volume +/- at 50% price, best practice tariff achievement & CQUIN achievement
- Mandated in theory from 1/10/21, although NHS provider funding still under 'H2' rules
- Mandated for **all** contracts that are **either** members of the same ICS **or** over £10m pa
- Some specific exclusions, e.g. ICF contracts, pass through costs
- Still follow national tariff guidance rules for local pricing
- For contracts < £10m outside ICS there is no mandated approach – both parties can agree payment terms, default is activity x national prices if no agreement (? non-acute)

Proposed national support for locally designed payments

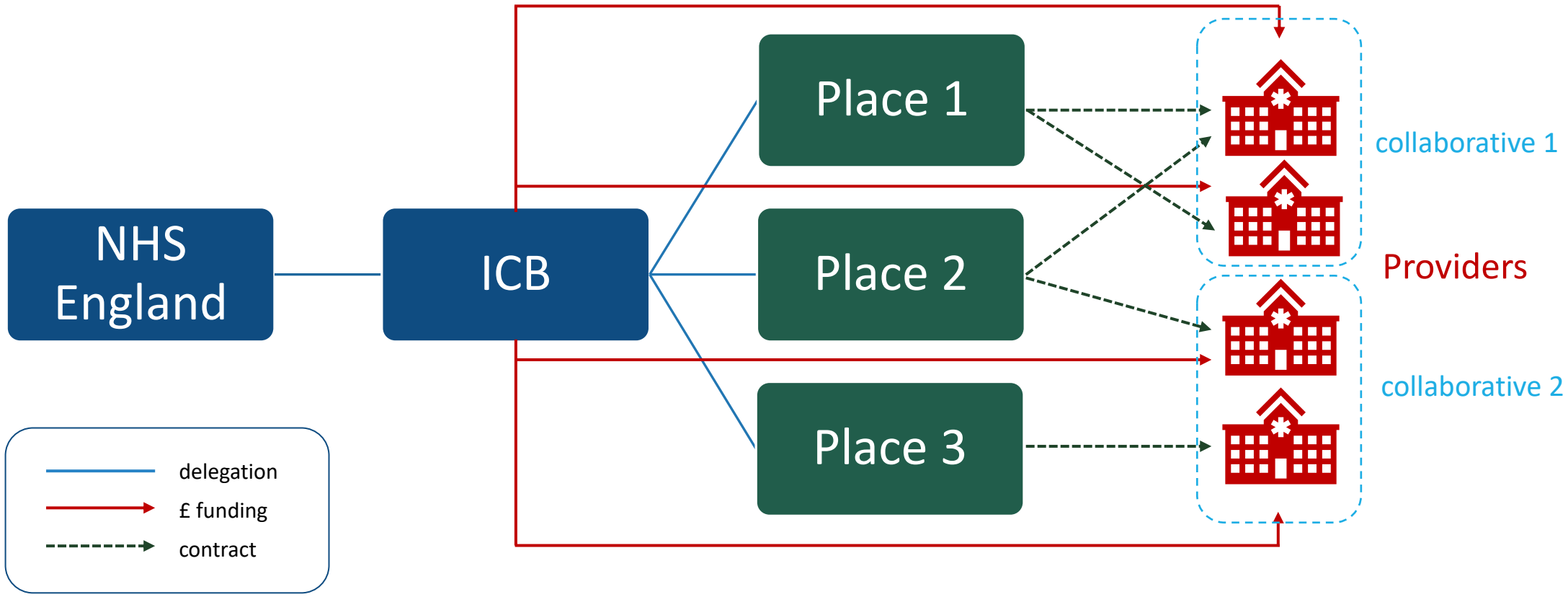
- **Local pricing principles** (currently part of National Tariff guidance) expected to continue to be published
- **PLICS analysis** – analysis of providers' historic costs v peers – to enable benchmarking, planning, intelligent payments, etc
- **Costed GIRFT pathways** – costing of 'exemplar' pathways to enable comparison and discussion, starting with cataracts
- **Population group analysis** – analysing population resource usage by segment
- **Programme budgeting** – whole system costs by healthcare condition

8 principles to consider for your ICS payment system

https://www.health.org.uk/publications/towards-an-effective-nhs-payment-system-eight-principles

1. **Articulate a clear vision**
   what is the proposed approach trying to achieve?
2. **National consistency with local flexibility**
   use national guidance/tools and adapt to your ICS
3. **Realistic expectations**
   financial levers can't solve everything
4. **Aligned incentives**
   finance is an enabler for the changes the ICS wants to deliver
5. **High quality data**
   ensure time and resources invested into understanding system costs
6. **Aim for balance**
   between complexity and ease of use
7. **Independent oversight and support**
   use the experience of third parties to avoid disputes
8. **Embed, review and evaluate**
   before further changes implemented

Possible future payment flows: initial arrangements?



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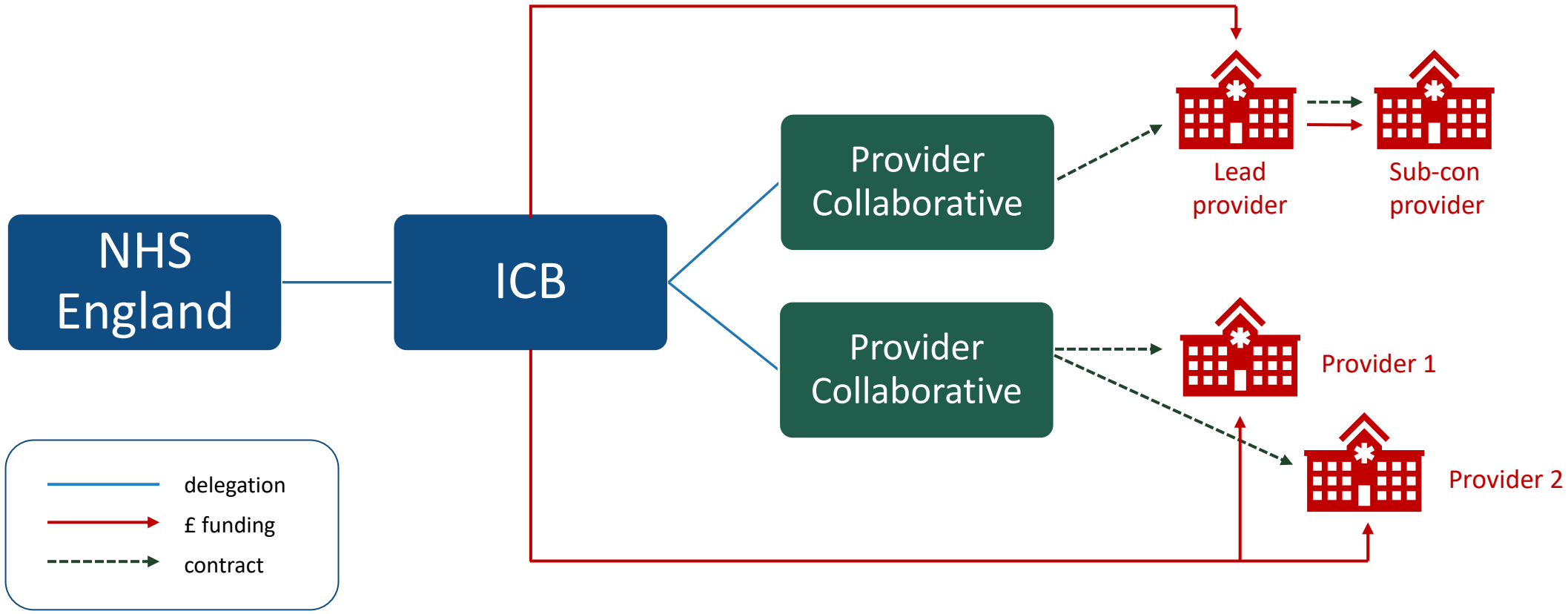
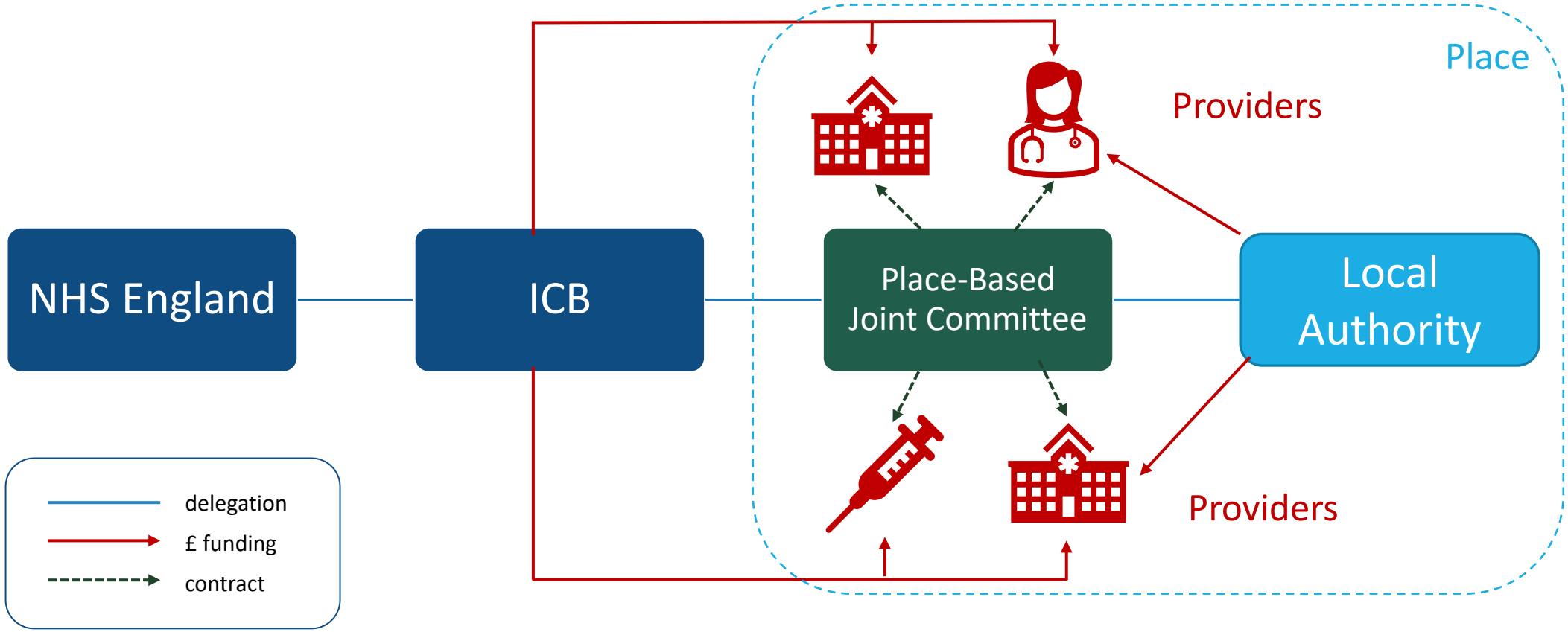
Possible future payment flows: provider collaboratives



Possible future payment flows: place-based partnerships



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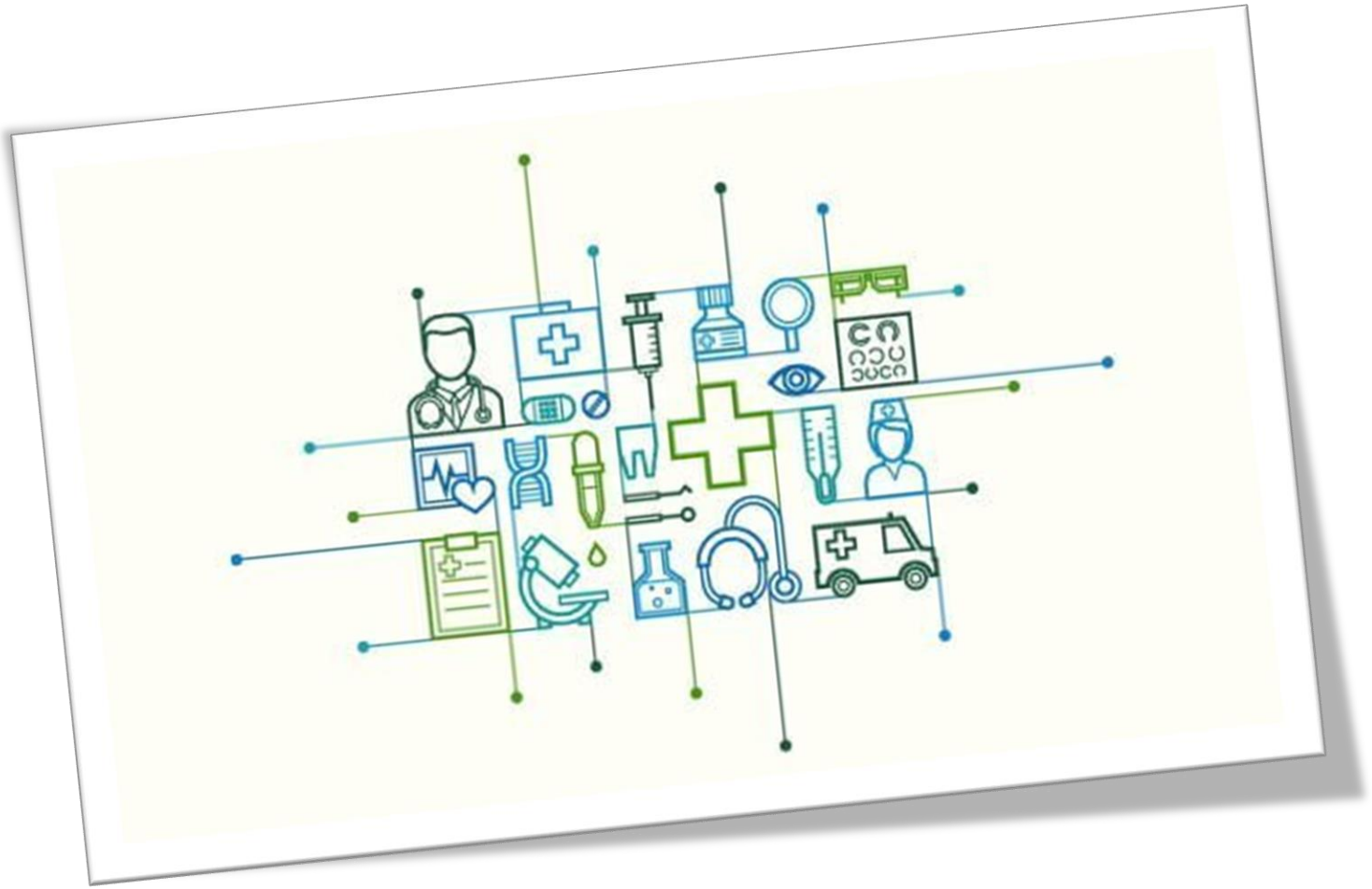
Evolution or revolution?

- Policy moving away from a published national tariff towards a ‘national rules 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 & CQUIN excepted)…
- And actively disincentivised acute providers to shift care out of hospital
- Use a more stable fixed payment to cover agreed costs and give headroom
- Plus additional sum to incentivise national and/or local system priorities
- With activity volume being reconciled and costed maybe once a year?

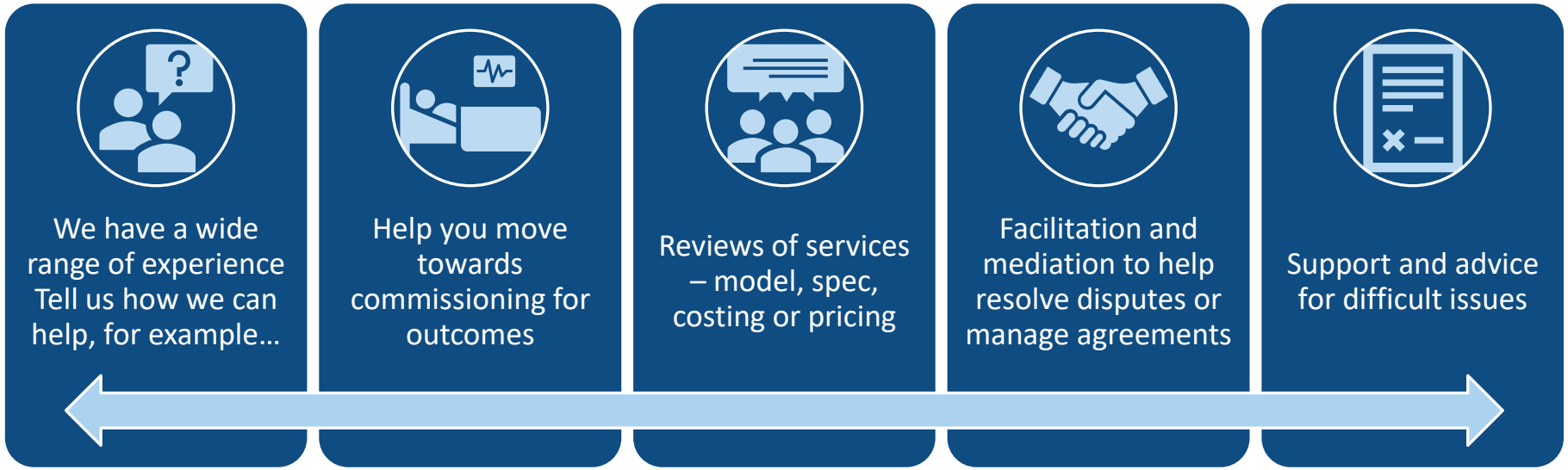
Integrated Care Systems: in summary



Integrated Care Systems: our thoughts in a nutshell

- Opportunity to work differently and get different parts of the system aligned around common objectives
- Put the horse before the cart… start with the patient and the desired outcomes
- Redirect management time spent on contract/tariff disputes towards improving patient care services
- Money will be the biggest constraint… but you know it always is!
- Challenge is to make ICS a new model of networked leadership rather than just reinventing another layer of desktop management oversight

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

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Other courses we offer include

- *Understanding and documenting service pathways*
- *Commissioning for outcomes – adding value not volume*
- *Why costing matters more than ever*
- *Preparing for April 2022 – a practical guide*
- *Tips for managing and avoiding disputes*

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

Thanks for listening!

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training@baileyandmoore.com

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