Preparing for April 2022

November 2021

BAILEY & MOORE

Housekeeping

- The presentation usually lasts 75 minutes, including about 15 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…

- Recap of what we know about the Brave New World:
  - Health and Care Bill
  - Supporting guidance, policy, etc already published
  - Future of the NHS Standard Contract and National Tariff
- What might be needed for an effective, streamlined contract?
- Some scenarios for discussion

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/

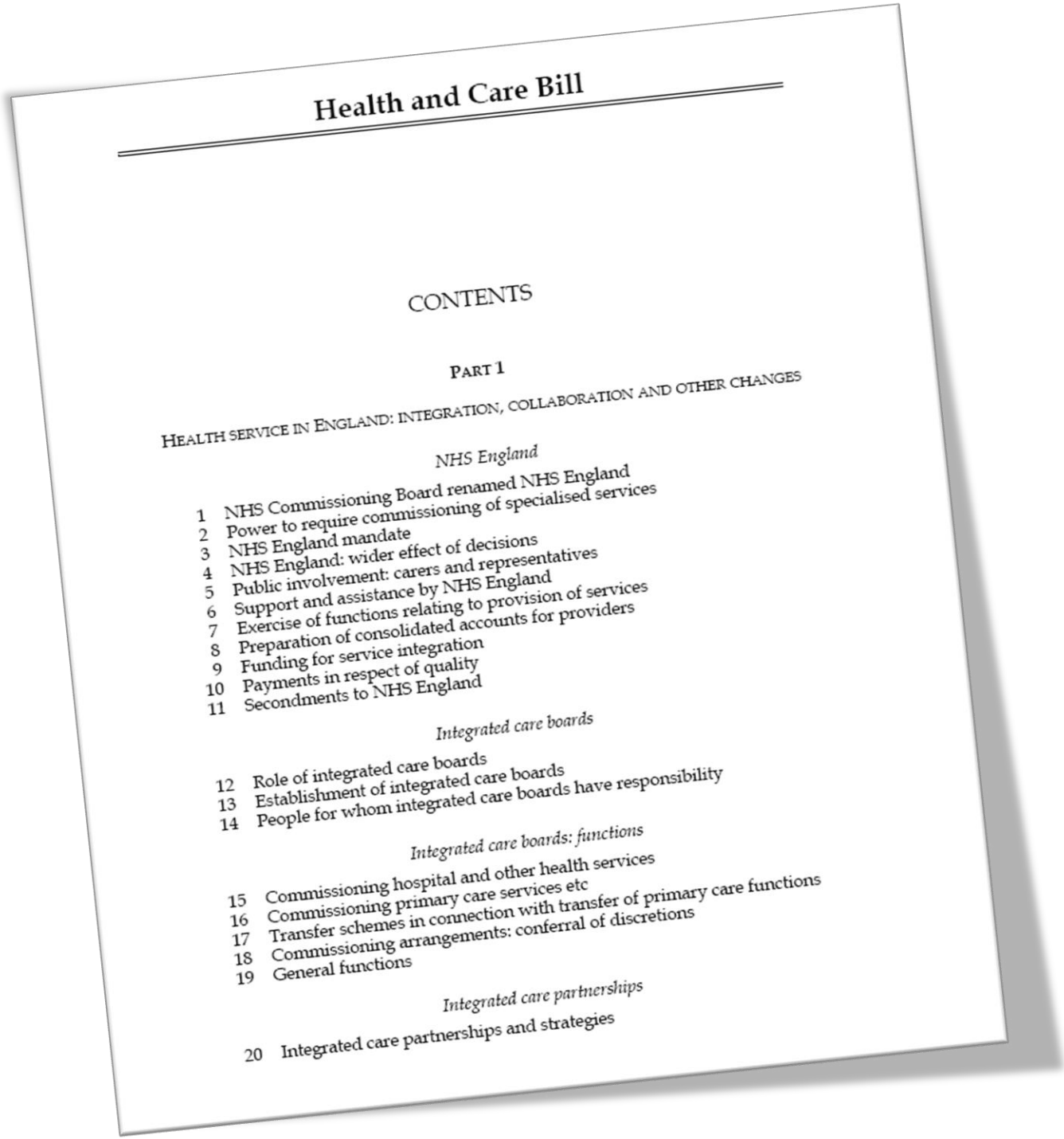
National Tariff/ Payment Reform

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

NHS Standard Contract

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

Health and Care Bill



Health and Care Bill

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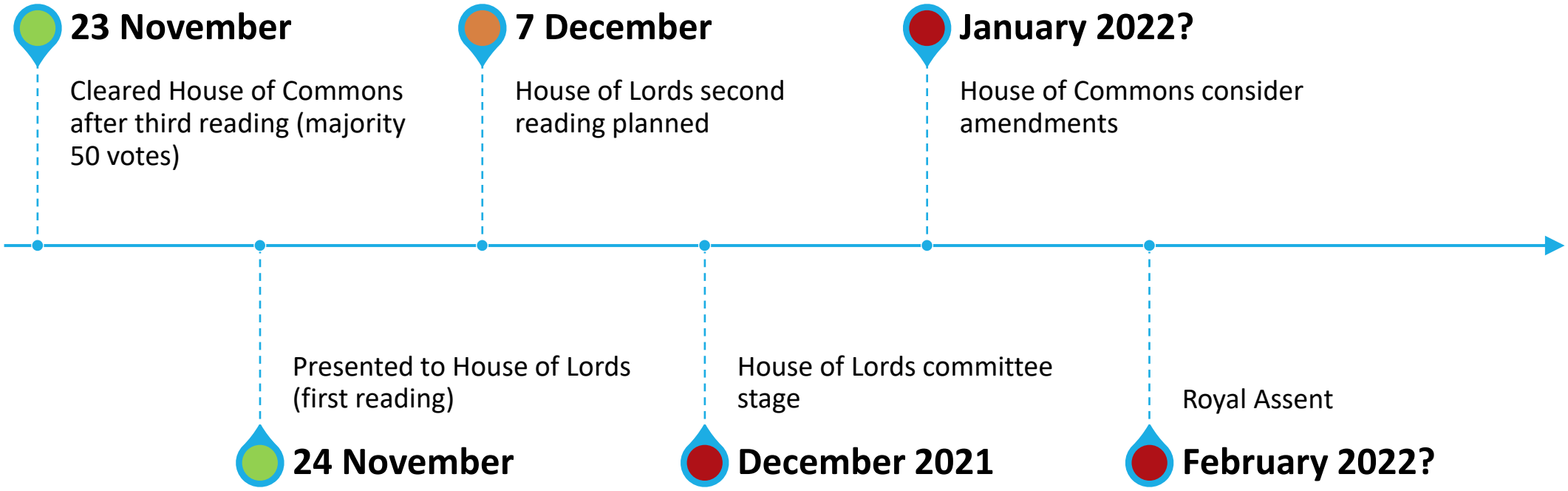
Health and Care Bill: progress to date – already too late for 2022?



Health and Care Bill: key points

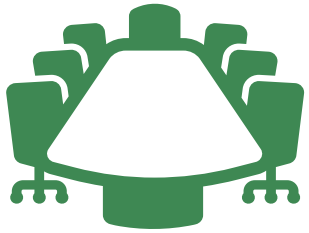
Broadly welcomed…

- 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?

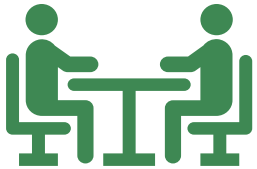
- New powers for Sec of State to intervene in reconfigurations and to direct NHSE
- Govt proposals on social care reform very limited in scope – just deal with funding mechanism, not investment needed
- Nothing on future role of public health
- No big strategy to address workforce shortages and current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

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 NHS England

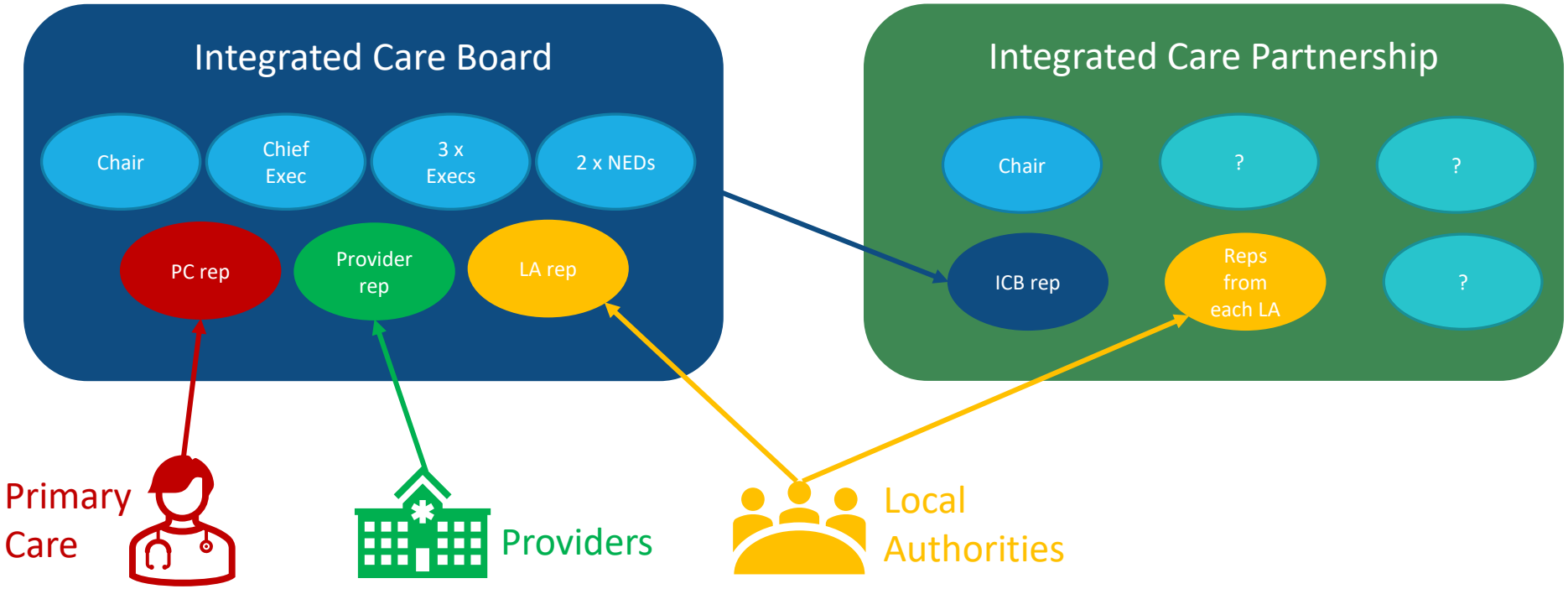


Integrated Care Partnership

- **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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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
- Series of NHSEI engagement workshops during September confirmed direction of travel in 22/23 was to build on 21/22 National Tariff rules

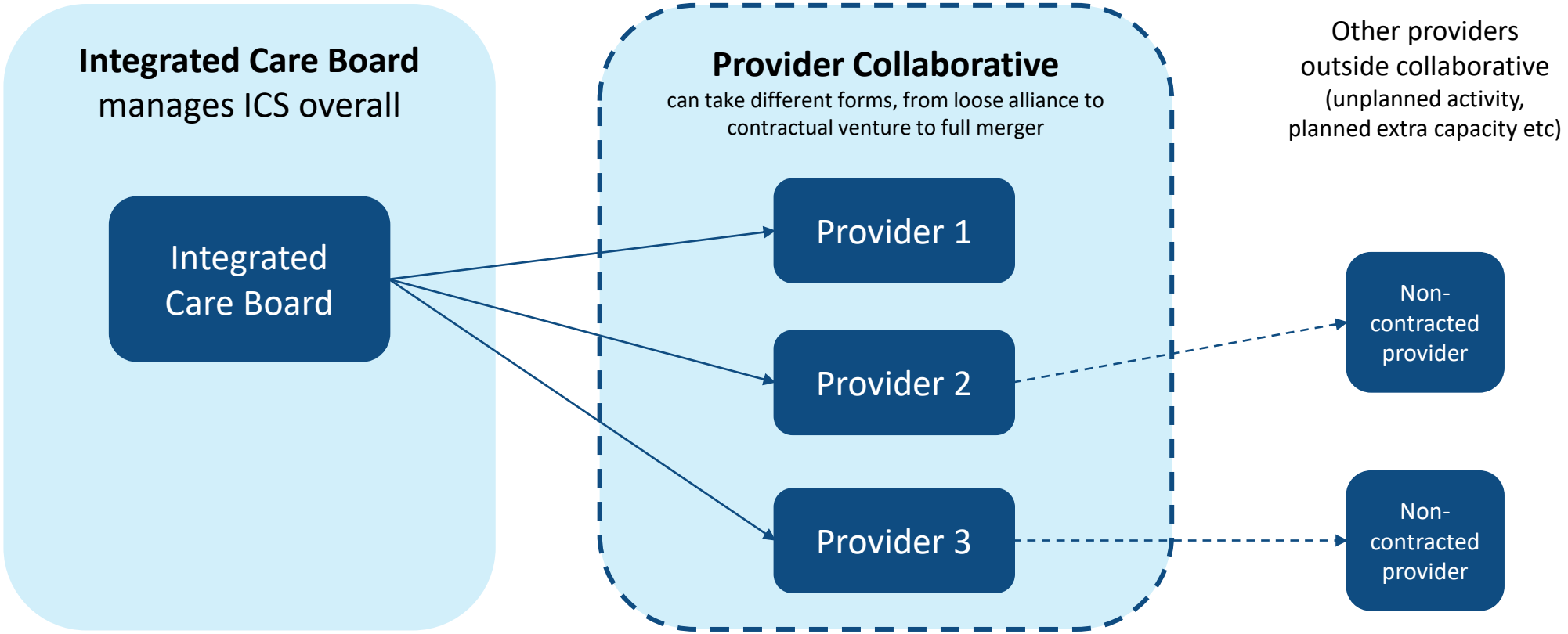
Supporting policy and guidance

Supporting Policy and Guidance

- Unusual to have supporting guidance published in draft before a Bill becomes law, but we already have:
  - Functions and governance of ICBs
  - Provider collaboratives
  - Place-based partnerships
  - NHSEI engagement workshops on 2022/23 payment reform
  - Social Care reform – Health and Social Care Levy Bill 2021
  - Elective recovery (within 2021/22 H2 guidance)

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

Provider collaboratives – loose alliance



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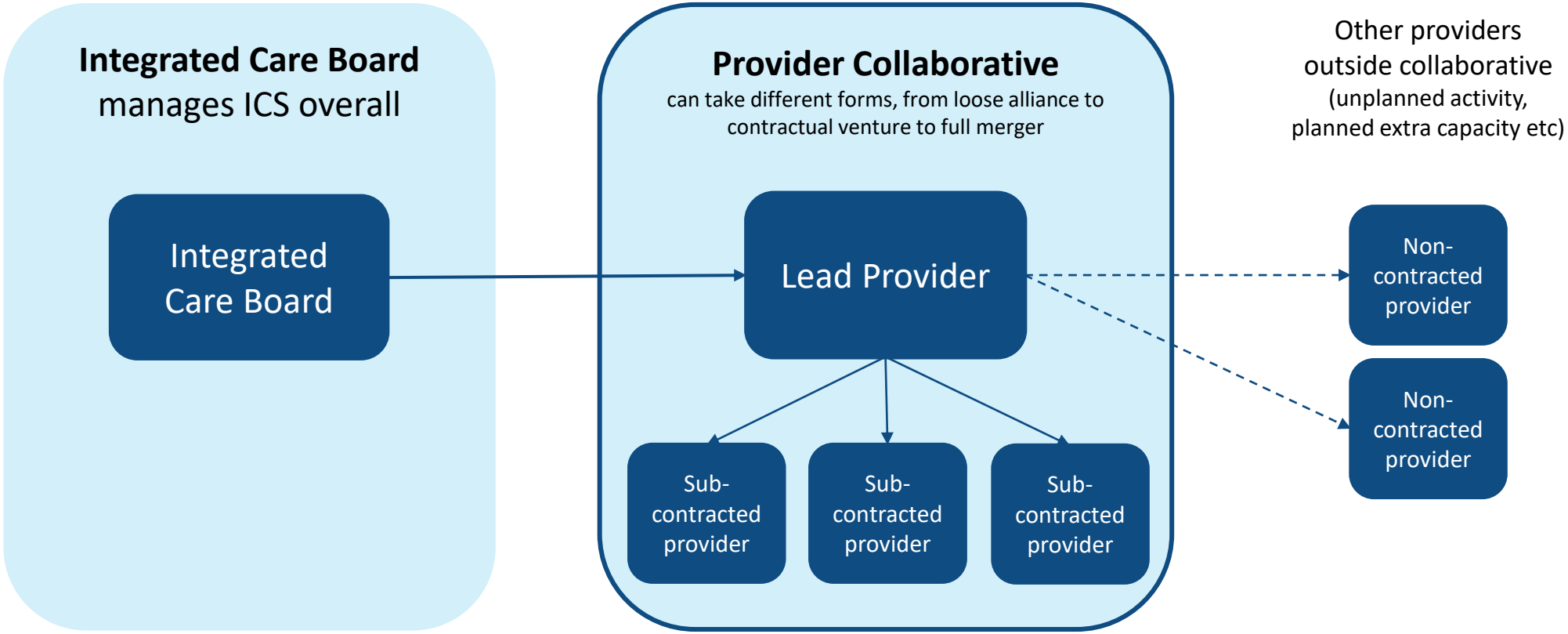
Provider collaboratives – lead provider



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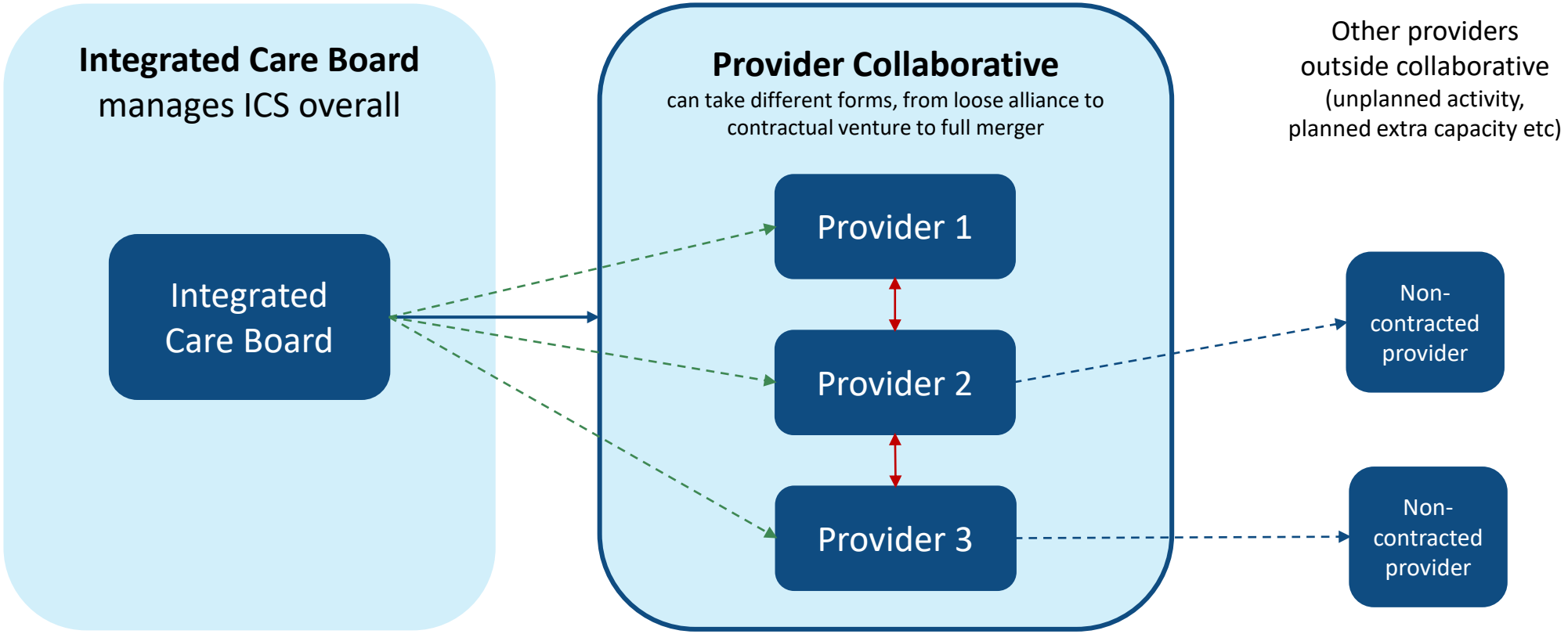
Provider collaboratives – formal JV



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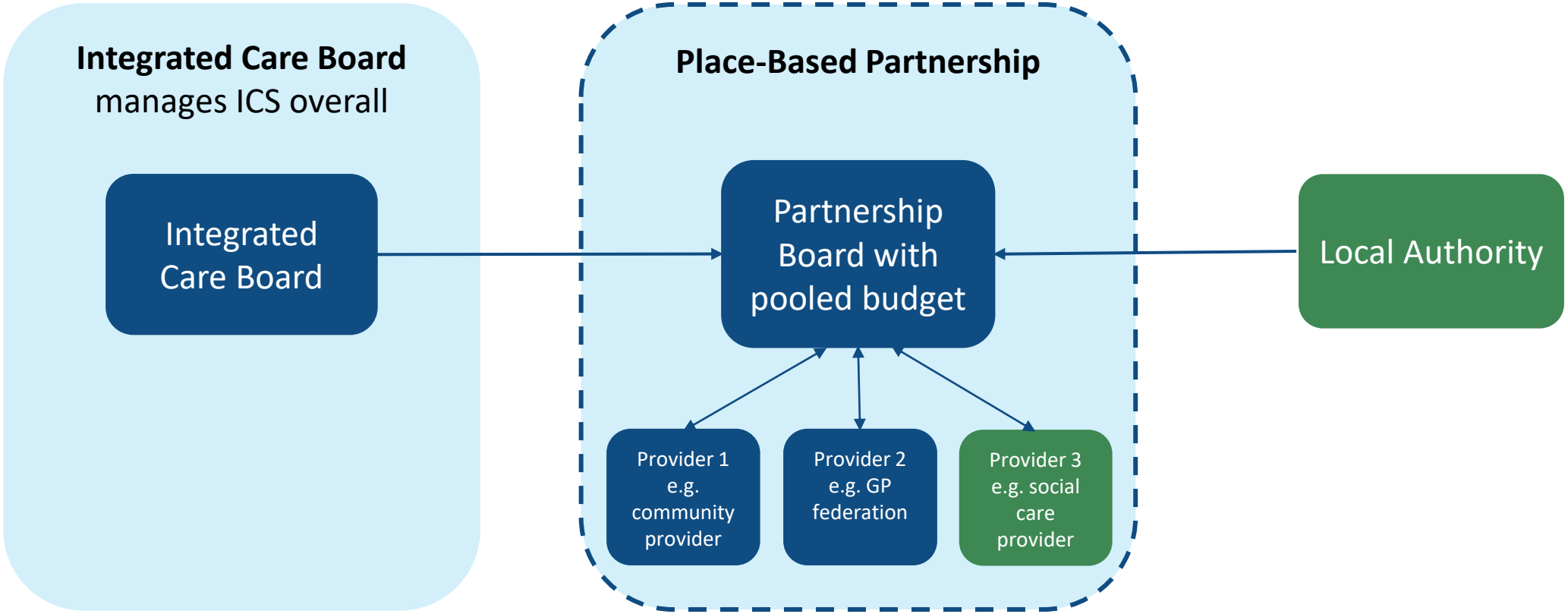
Place-Based Partnerships



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

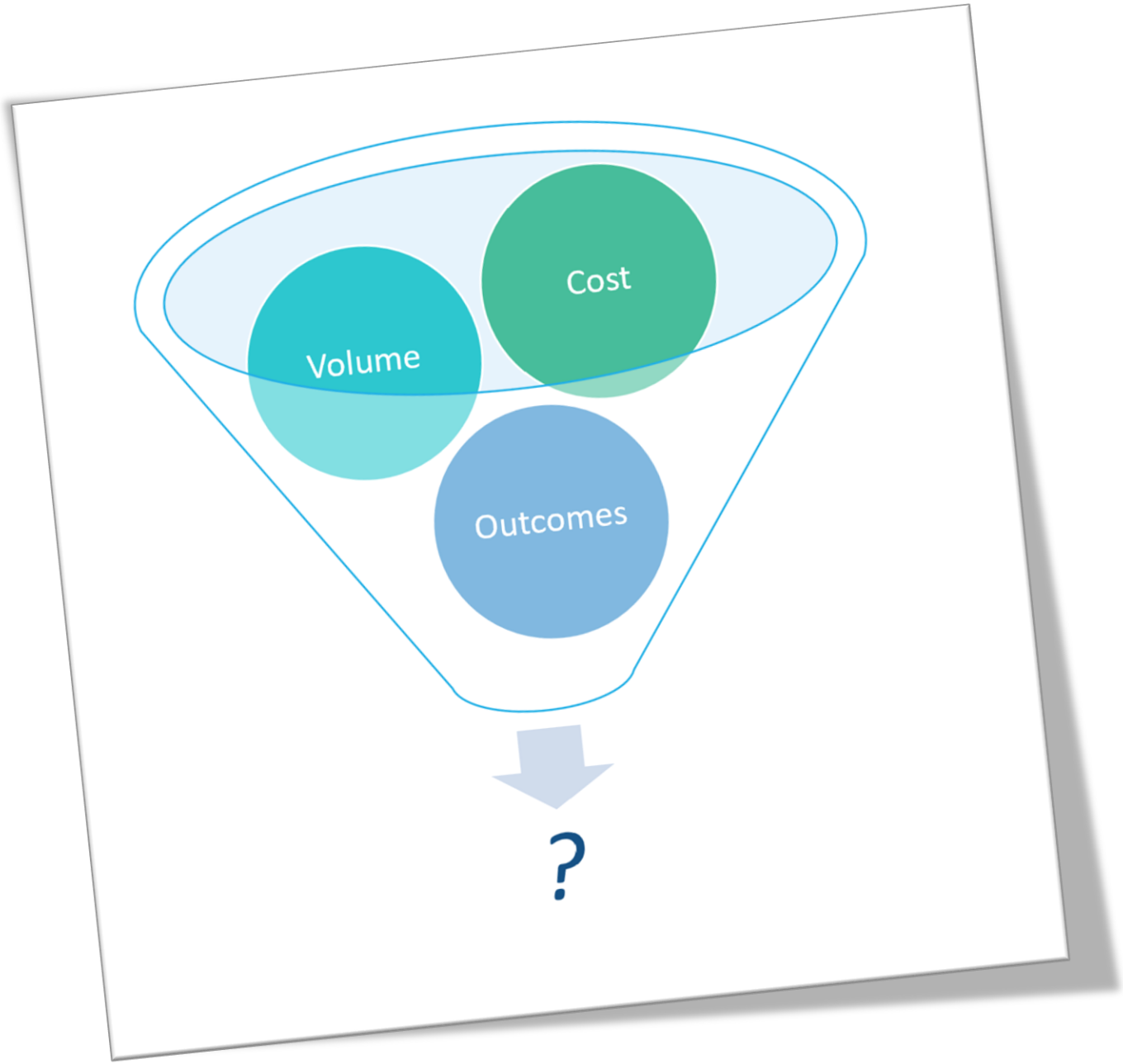
Social Care reform: Health and Social Care Levy Bill

- Bill to introduce 1.25% new tax passed by Parliament in September 2021
- Expected to raise **£12bn pa** for health and social care…
- Currently only **£5.4bn** earmarked for social care over next 3 years
- Changes to social care system:
  - Means test for local authority assistance raised from £23,250 to £100k
  - Individual's liability for personal care costs capped at £86k
  - Concerns raised that there is no plan to tackle c100,000 workforce vacancies
  - Opportunity missed for more radical reform (compared to Wales & Scotland)?

Elective Recovery

- 2021/22 H2 guidance confirmed political focus remains on waiting lists/times
- Providers must clear 2-year waiters by March 2022
- Systems asked to stabilise other waiting list at Sept 2021 levels
- Additional issue of drop in referrals during pandemic – estimated 7m referrals have gone ‘missing’, disproportionately from disadvantaged areas
- Targeted Investment Fund (£700m) & Elective Recovery Fund (£1bn) to provide additional £ for RTT performance >89% of 2019/20 levels
- But NHS constrained by capacity – what other solutions are out there?

NHS Standard Contract & National Tariff



NHS Standard Contract 2021/22

- Future of the Standard Contract unclear – designed for a different world
- But will probably still be used in the short term to document agreements between ICBs and providers/collaboratives
- Longer term developments might be:
  - Rebranded to something less commercial sounding (like ‘SLA’ in 1997)?
  - Form that accommodates multiple providers acting collaboratively
  - Less focused on commissioning by micro-management
  - More x-refs to national policy/law rather then repeating them in GC/SC
  - More suited to longer term contracts (5-10 years?)

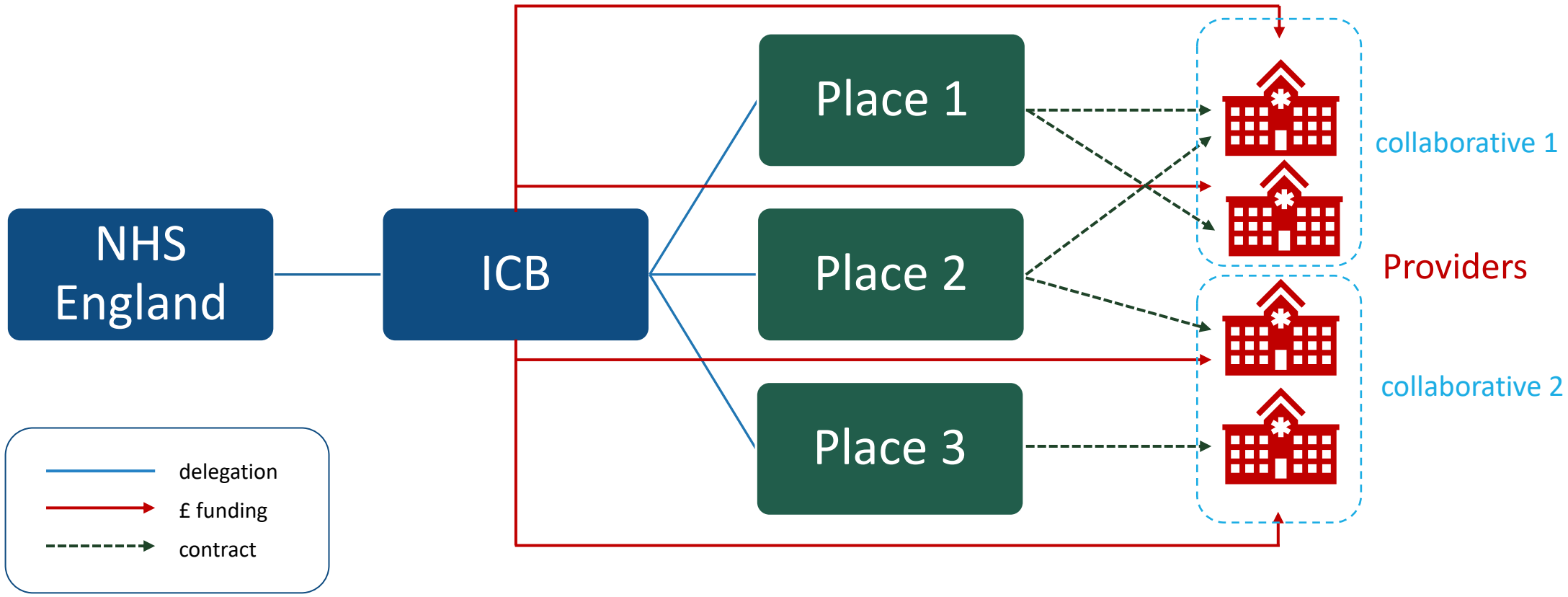
National Tariff guidance 2021/22: Aligned Payment & Incentive approach

- Mandated in theory from 1/10/21, although NHS provider funding still under 'H2' rules
- 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 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)

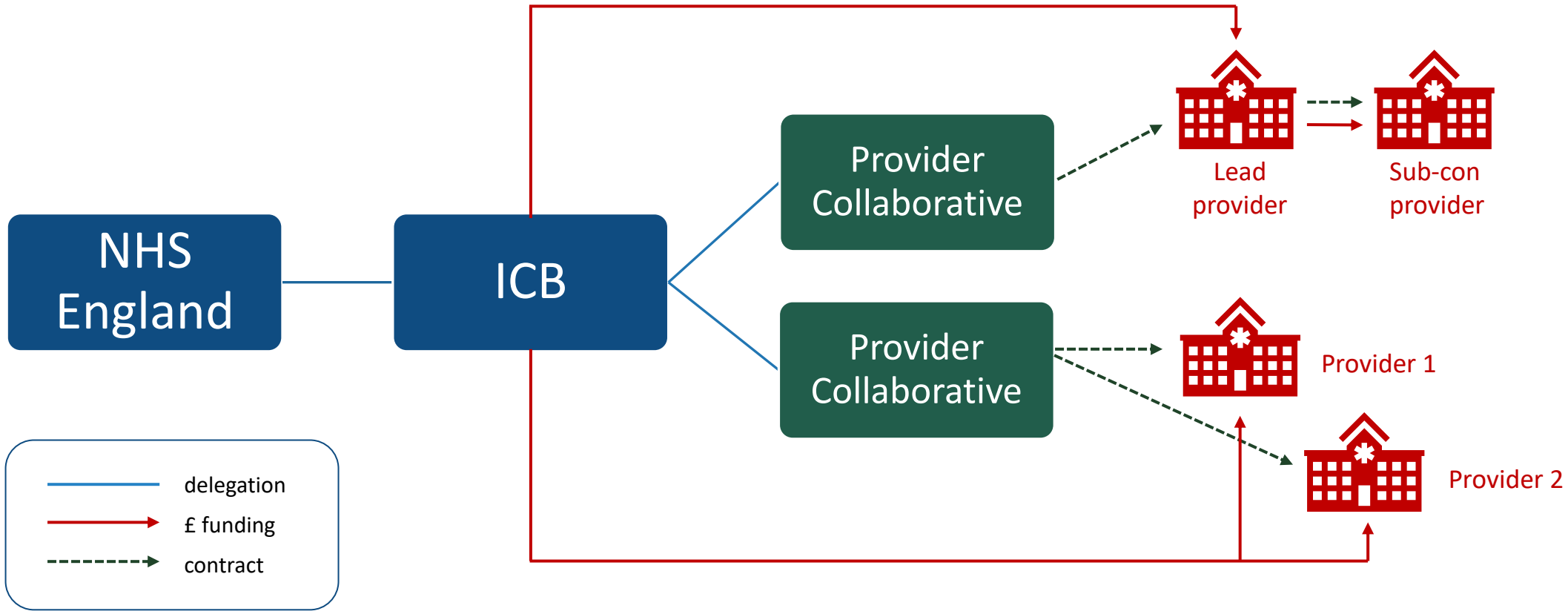
Proposed national support for locally designed payments from 2022/23

- **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

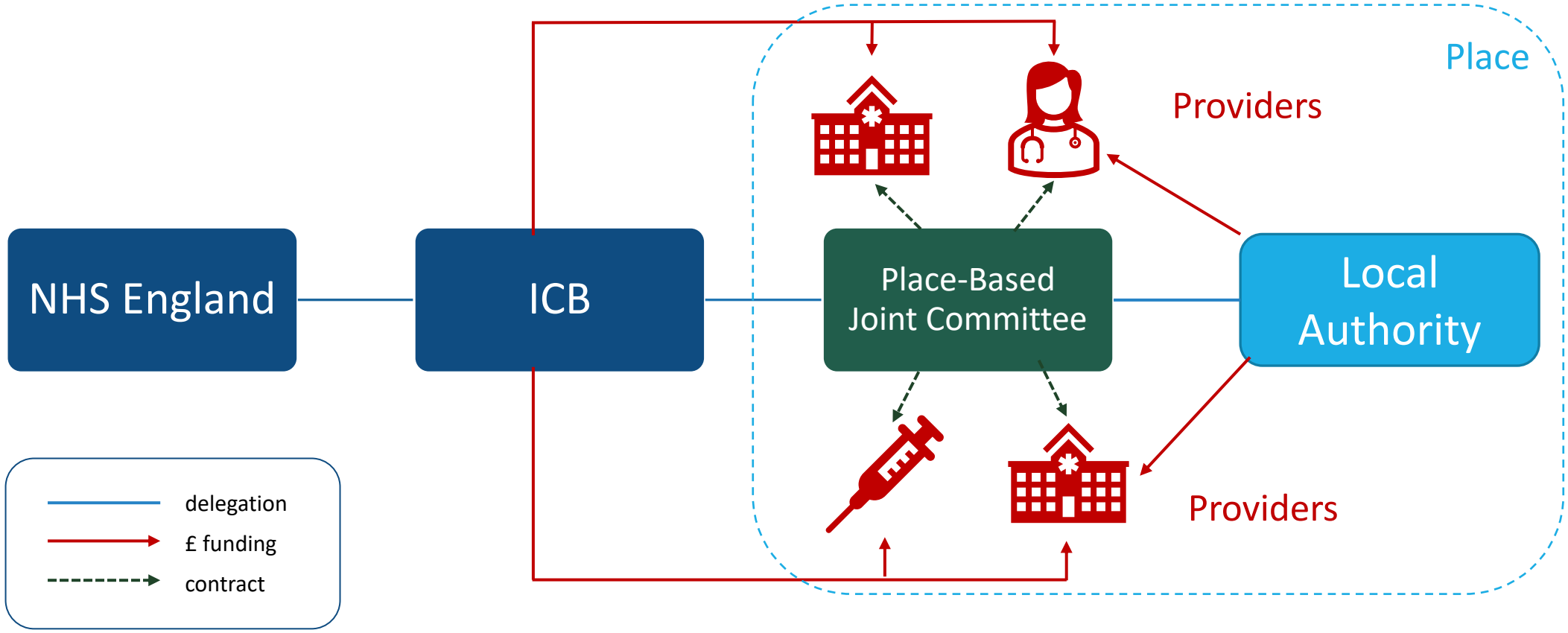
Possible future contract/payment flows: initial arrangements?



Possible future contract/payment flows: provider collaboratives



Possible future contract/payment flows: place-based partnerships



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What might be needed for contracts in the new world?

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

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

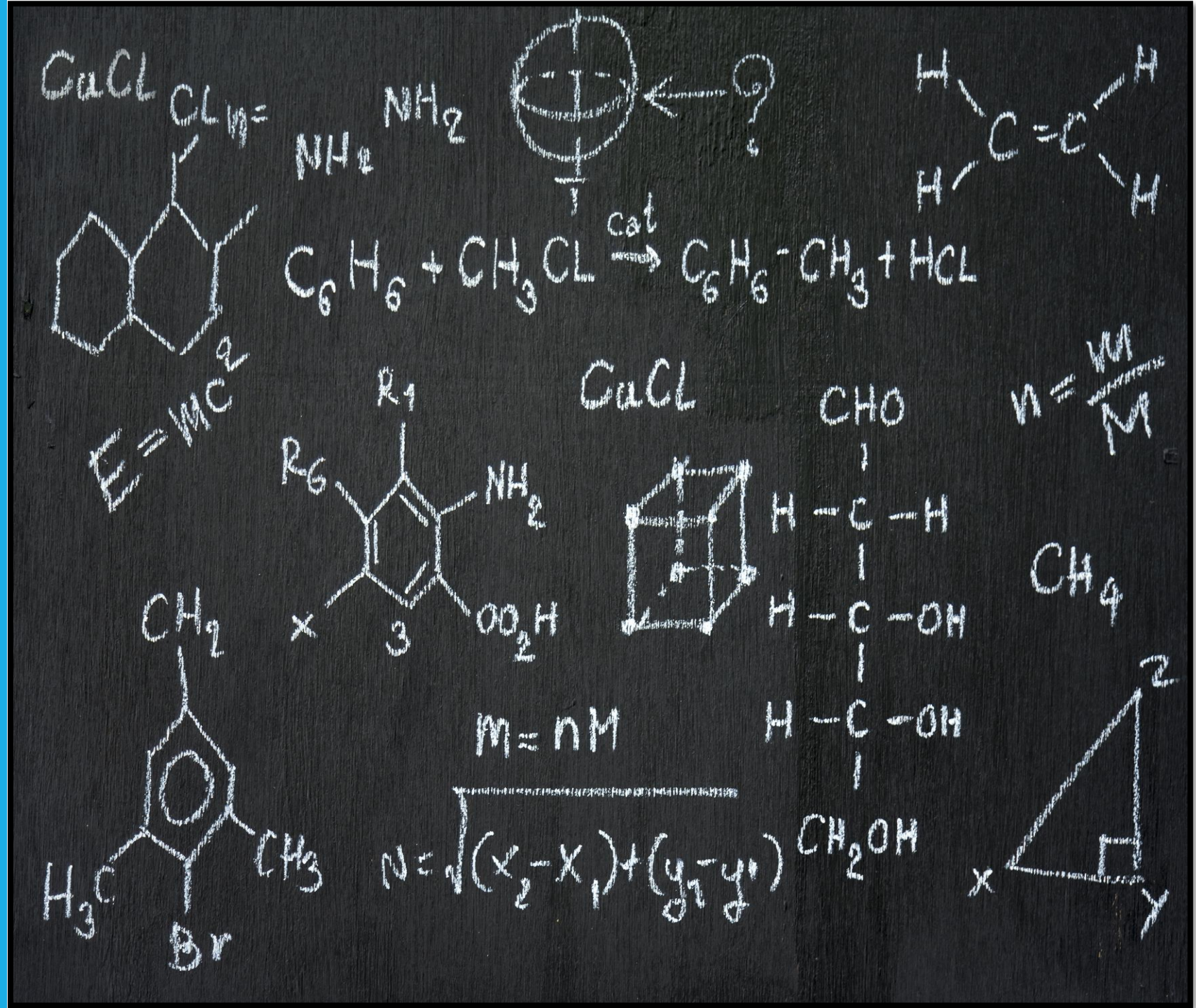
What might this look like in practice?

- 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

Which parts of the Standard Contract might be most useful next year?

Theme	Service Condition	Contract Schedule	Reason
Thinking "System First"	SC4 – Co-operation	Schedule 8 (LSOP), 9 (SCFMA)	All providers work to one agreed ICS plan, facilitated by ICB
Service specifications	SC3 – Service Standards	Schedule 2A (service specs)	ICS needs to jointly agree and document how services provided
Patient outcomes	SC37 – Local Quality Requirements	Schedule 4C (local quality reqs), 4D (local incentive scheme)	Focus on patient outcomes, not volume of activity
Payment arrangements	SC36 – Payment Terms	Schedule 3A (prices), 3D (API), 3F (contract value)	Funding = block based on benchmarked cost ± variable adjs for volume/outcomes
Indicative activity plan	SC29 – Activity Management	Schedule 2B (IAP)	Still need to monitor volume/ outputs as these drive costs
Reporting requirements	SC28 – Information Requirements	Schedule 6A (reporting reqs)	Can't do any of the above without good data!

Scenarios


CuCL
NH2
Cat
C6H6 + CH3CL → C6H6-CH3 + HCL
E=MC2
R1
R6
NH2
CH2
X
3
CO2H
CuCL
CHO
CH4
M=nM
CH2OH
Br
CH3
H3C
X
Y
Z

Setting the contract ‘baseline fixed element’ (aka block) under API rules

- First time that acute, community, mental health and ambulance all covered by the same nationally mandated approach?
- 3 main options to setting baseline (per 21/22 guidance and 22/23 workshops):
  - Agree activity baseline and use national prices + MFF (acute)/previously negotiated prices (non-acute) just like the old days
  - Use historic actual costs e.g. NCC for 2019/20 + inflation + CQUIN ± benchmarking intelligence
  - Agree prospective costs based on ICS plans – possibly the most difficult option until plans and relationships develop more fully

Setting the fixed baseline element: one possible basic approach

1. Decide on best activity baseline to use – 2019/20 (i.e. mostly pre-COVID) outturn or more recent period?
2. Decide on pricing up methodology, e.g.:
   - National prices, if published for 22/23, for services included + MFF and other top ups
   - Provider's own costs (national cost collection 2019/20 or just submitted for 2020/21)
   - Peer group or national average costs (national cost collection 2019/20)
3. Increase for inflation/efficiency (2.5% + 2.3% + tba%), CQUIN (1.25%) and demographic growth (per ICB allocation % uplift)

Setting the fixed baseline element: one possible basic approach

4. Discuss and agree other cost/activity base changes from period used to 22/23 levels, e.g. recurrent impact of COVID, additional elective recovery volume
5. Compare funding available to provider's costed baseline
6. Discuss as a system how to prioritise competing demands, handle differences and share risks
7. Plan how to analyse services that look 'cost inefficient' using national tools provided

"Providers and commissioners should continue to collaborate closely together to make the most effective and efficient use of resources to improve quality of care and health outcomes for the entire health care system"

Mental Health & Community contracts using API

- Under 2021/22 API rules, this would be block ± 1.25% variable element for CQUIN achievement (as few elective inpatients or best practice tariffs apply)
- MH fixed baseline needs to demonstrate Mental Health Investment Standard has been met, but this will not show £ has been spent well
- Consider adding suitable outcomes with some variable payment or shadow monitoring initially? National priorities for MH are in the MHIP, for Community e.g. performance against 2-hour emergency response?
- NB new currencies planned for MH & community for 2023/24!

Incentivising elective recovery

- Under 2021/22 API rules, default would be agreed block payment ± under/ overperformance at 50% of agreed contract prices
- Additional £ also available centrally via ERF, where providers RTT performance >89%, providers can earn up to 120% price
- Approach likely to continue in 2022/23 and beyond?
- But given capacity constraints, what other options are there to reduce waits? Independent sector, invest in technology (TIF £ available), new elective/ diagnostic centres, shift to outpatients/community/primary care?

Contracting with independent sector

- Under 2021/22 rules, these contracts generally fall outside API (although NHSE may change rules in 2022/23)
- So ICBs have discretion as to payment rules used with IS provider contracts
- Most will opt for ‘traditional’ activity x price cost and volume contracts to secure additional elective capacity as needed, but could go to a longer term API approach if offers better VFM overall
- Under 2021/22 rules, prices default to national tariff if no agreement can be reached… Presumably same if national prices published next year?

Emergency/urgent care contracts using API

- Under 2021/22 API rules, this would be block ± 1.25% CQUIN + any additional payments for best practice tariff performance (stroke, hip fracture, etc)
- So no automatic payment adjustments if activity increases/decreases
- 4-hour ED target likely to be abolished
- Could be an area where cross-system working gets an early acid test?
- Priorities for investing in outcomes likely to be: 111 First, 2-hour community response, red/green hot/cold separation, ambulance liaison

Local Maternity Systems

- Under current national tariff rules, there has been an industry of provider-provider invoicing when patients are seen at ‘non-lead’ providers
- Hot potato likely to be passed back to ICBs to handle… so check if you need to get close to the data on this?
- Providers will recover their income from ICBs or could agree their own collaborative, but on the basis of block payment for historic activity levels
- Could be tricky in practice if activity is volatile and/or crosses ICS boundaries!
- Overlaps with broader **Low Value Activity** reforms planned (next slide)…

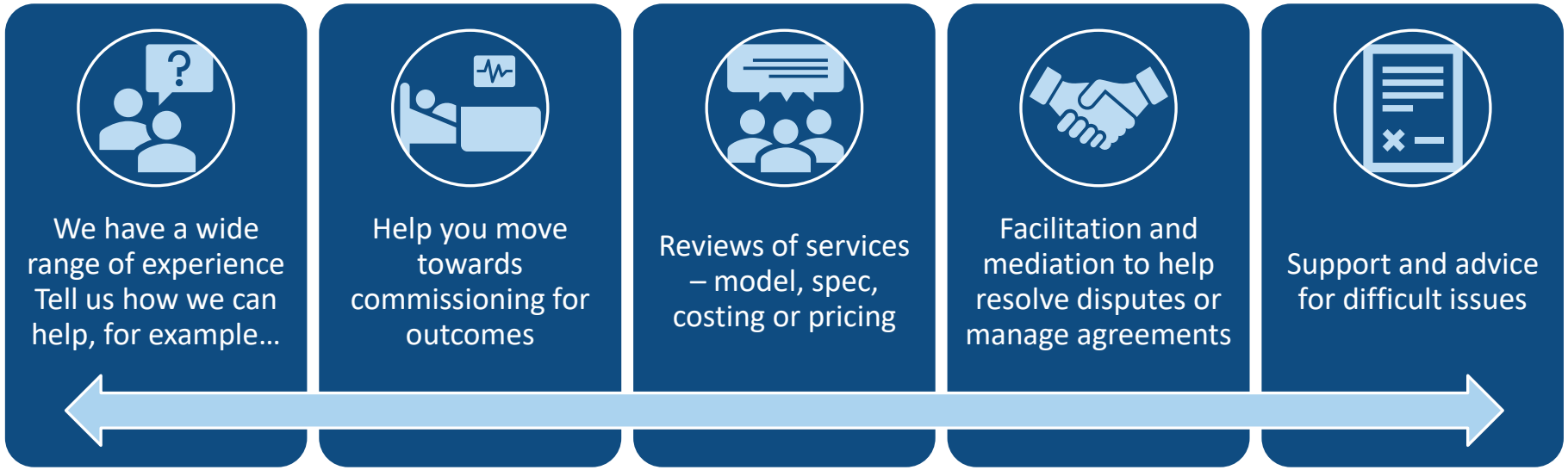
Low Value Activity – reforms (?)

- Current NCA system in place since 2006, where providers invoice commissioners individually for any activity outside contracts
- But suspended since 2020 and £ incorporated in host commissioner blocks
- Policy debate for some time about not going back to NCA rules – too much time and cost spent on low-value transaction processing
- Will probably be some form of providers being funded in block based on historic activity, rather than low-value invoicing when activity occurs in year
- Emphasis will be on simplicity over accuracy of income recovery

In summary…

- 2022/23 likely to be a year of relatively minimal change, with contracts being agreed between ICBs and providers, using something like the 2021/22 contract and national tariff API rules
- Opportunity to get used to working together as a system – Bill confers quite significant powers on ICBs and requires Trusts to co-operate with ‘system’
- Priorities likely to be around keeping your urgent/emergency services running by investing in non-acute and stabilising elective waiting lists
- Nature of contracts will be to set block funding at start of year, resist the temptation to micromanage and focus efforts on delivering system priorities

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

- *Brave New World? Life in the NHS after the Health & Care Bill*
- *Understanding and documenting service pathways*
- *Commissioning for outcomes – adding value not volume*
- *Why costing matters more than ever*
- *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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