Whole population models of provision: Establishing integrated budgets

NHS England and NHS Improvement

Whole population models of provision: establishing integrated budgets

Integrated Care Provider (ICP) contract package – supporting document

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Part 1: Introduction and summary

1 Introduction

This overview provides guidance for those looking to develop an integrated budget as part of the Integrated Care Provider (ICP) Contract. It introduces the whole population budget (WPB) approach and summarises the steps involved in designing a pooled budget.

The overview is structured as follows:

- **Part 1** provides an introduction and overview to this guidance.
- **Part 2** contains more detail on WPBs and is aimed at those who wish to gain a general understanding of what they are, their intended purpose and the main steps commissioners will need to take to develop them.

Further technical detail is available to aid planning and WPB implementation. Please contact pricing@improvement.nhs.uk to request this.

Table 1 briefly describes some of the key terms used in this guidance.

Table 1. Summary of key terms

Term	Description
Integrated Care System (ICS)	Advanced local partnerships taking shared responsibility for improving the health and care system for their local population, delivering NHS standards and improving the health of the population they serve.
Integrated Care Provider (ICP)	A provider organisation contractually responsible for providing an integrated set of services to a defined population, under an Integrated Care Provider (ICP) Contract.
Whole Population Budget (WPB)	Represents the total funds available to the ICP for all relevant services in-scope for the whole population. This approach has been developed to encourage the promotion of whole population management, prevention, self-care and a focus on outcomes rather than inputs. The majority of WPB funding is through the WPAP (see below). Other elements of the WPB include payments made on an activity-delivered basis (e.g. for vaccinations and immunisations where these are within the ICP service scope), and payment under applicable local and national incentive schemes (for example Commissioning for Quality and Innovation (CQUIN), and the Quality and Outcomes Framework (QOF)).
Whole Population Annual Payment (WPAP)	Paid in monthly installments, the WPAP represents the majority of the funding available to the ICP under the contract.

2 Summary of whole population budget approach

The NHS Long Term Plan (LTP) outlined ambitions for the NHS in England to provide 'more joined-up and coordinated care'. By reducing existing barriers between health and care, local organisations should be better equipped to redesign care around patient need and improve population health. The LTP also committed to reforms to the payment system, moving funding away from activity-based payments and helping to ensure most funding is population-based. This should make it easier to redesign care across providers, support the move to more preventive and anticipatory care models, and reduce transaction costs.

The LTP also committed to making the ICP Contract available for use in 2019. This is in response to demands from some commissioners and providers for a single contract by which general practice, NHS services and potentially local authority services could be commissioned from a lead provider organisation, responsible for delivering those services in an integrated fashion. Though contracts alone do not deliver integration, commissioners want the opportunity to use a contract of this type to ensure contracting, funding and organisational structures all help, rather than hinder, staff to do the right thing. A contract will also help define more clearly who has overall responsibility for integrating and coordinating care and improving population health.

Successful service transformation requires a new payment approach that will provide financial incentives to facilitate greater coordination of care. An integrated budget will provide increased flexibility for the ICP to effectively manage care for its population across care settings. The ICP Contract enables commissioners to pay for a bundle of in-scope services by means of an integrated budget, as opposed to a service-by-service arrangement. A WPB methodology for developing and implementing an integrated budget supports a more holistic view of population health management, focusing on outcomes, as opposed to inputs and units of activity delivered.

The WPB is the total amount available for payment to the ICP for all relevant services in-scope for the whole population. The bulk of this amount will form the Whole Population Annual Payment (WPAP), which represents the majority of the funding available to the ICP under the contract.

Depending on the nature of services which are in-scope under the relevant ICP Contract, the WPAP may comprise one or both of the following elements. If applicable, each element must be separately identified in Schedule 4A (Whole Population Annual Payment) of the Contract:

- Part A: payment for NHS-funded healthcare services. Payment for these services (both primary medical services and other healthcare services) is governed by the National Tariff Payment System (NTPS) rules, principles and guidance (see sections 3.3.1 and 3.3.2). These may include services with national prices and/or services for which there are no national prices.
- Part B (if applicable): payment for local authority-funded services (see section 3.3.3).

Other elements of payment from the WPB include payment on an activity basis (eg vaccinations and immunisations where these are within the ICP service scope), and payment under local and national incentives (CQUIN/QOF/locally-agreed incentive scheme payments) and any personal health budgets administered by the provider.

See section 5.1 for further information regarding incentives.

A payment approach for whole population models of integrated provision should be centred on integrated budgets derived from commissioner expenditure, and ideally drawing on additional information such as costing data, activity trends and benchmarking on spend. Such budgets are commonly described as WPBs and we therefore use this term for consistency. This does not imply that the budget covers all services delivered to an individual, but rather that it is a budget for the whole of the population served by the relevant provider, across the services in-scope of its contract. The WPB approach has been developed to encourage the promotion of whole population management, prevention, self-care and a focus on outcomes rather than inputs.

The WPB approach involves the following features:

- covers the relevant service scope for the ICP's population
- removes the direct relationship between activity and payment where this currently exists
- improves alignment of payment for all service types within the ICP
- incentivises prevention and wellbeing
- focuses on management of outcomes, activity and costs across the system.

This document should be read in conjunction with the wider ICP Contract package and guidance on the Integrated Support and Assurance Process (ISAP).

Part 2: Developing a whole population budget

3 Integrated budgets to support implementation of whole population care

3.1 Need for a supportive payment approach

An appropriate payment approach is needed to support ICPs in delivering whole population integrated care. Sector feedback indicates that the current landscape of 'fragmented' payment approaches across different services does not support delivery of more integrated and better coordinated care centred on the patient.

Activity-based payment models are likely to incentivise the delivery of an increased volume of activity more than prevention or delivery of better outcomes. Traditional block contracts tend to provide a consolidated fixed payment irrespective of activity and outcomes, with little incentive to deliver services or activity beyond those specified in the contract.

3.2 Whole population budgets (WPBs)

A WPB represents the total payment amount available to the ICP for all relevant services in-scope for the whole population.

A WPB can provide increased flexibility for the ICP to effectively manage care for its population across care settings. It encourages a population-wide view of health and care management, focusing on outcomes, as opposed to inputs and units of activity delivered. It is also designed to align financial incentives across the services in-scope of the ICP. We have worked with local sites to help inform how this approach may apply in England, and how it could be combined with risk sharing to align system-wide incentives.

Core characteristics of a WPB include:

Predictability:

- Increases system stability to plan and implement changes. The value of the budget is identified up front and set in the context of a multi-year contract.

Accountability and flexibility:

- Creates clear accountability within a lead provider for the holistic needs of the population (for in-scope services) by providing an incentive to co-ordinate care across settings and providers.
- Encourages and enables providers to make improvements to service delivery across care pathways and settings.
- Reduces the number and complexity of commissioner and provider contractual relationships.

Incentive signals:

- Encourages investment in preventive care and treatment in the most appropriate lowest cost setting.
- Encourages providers to consider a population health approach but without specifying exactly what is done or how care is delivered.

- Reduces incentives to 'cost-shift' (i.e. where providers refer patients elsewhere for treatment which may be less appropriate).

The WPB approach aims to allocate specific types of risk to the party best placed to influence and/or manage and/or bear it. For example:

- Risks borne by CCGs, on the basis that they will be reflected in their allocations and therefore in funding which they can make available to the ICP:
    - Population size: The number of people whose healthcare needs the ICP is responsible for meeting, largely dictated by the registered lists of the ICP and/or its partially-integrated GP practices.
    - Population composition: The age profile and other characteristics of that population, influencing the likely prevalence of long-term conditions and other healthcare needs.
- Risks borne by the ICP:
    - Utilisation: The risk that services are utilised more or less frequently than predicted given the population size and profile.
    - Volatility: The risk that random variation in usage patterns may result in different levels of service use.
    - Technical efficiency: The risk that the intended efficiency gains are not realised, or that the unit cost of services is not as expected.
    - Quality: The risk that a change adversely affects the quality of care provided, and in turn individual health outcomes.

To ensure that there is a balanced approach to risk management, a risk sharing mechanism could be useful to support allocation and management of risk under a WPB (see section 4.2).

NHS England and NHS Improvement have run a series of webinars discussing risk sharing through payments, which consider the above in more detail. These are: An introduction to risk sharing through payments, Activity-based risk sharing and Financial risk sharing.

3.3 WPB in the context of the National Tariff and GMS/PMS regulations

3.3.1 National Tariff Payment System

The National Tariff Payment System (NTPS) rules, principles and guidance give commissioners and providers broad scope to determine local payment approaches for NHS services that support the development of more integrated ways to deliver care.

In developing an integrated budget payment approach and associated WPAP to support implementation of an ICP, commissioners and providers must be satisfied that their proposed local payment approach complies with the local pricing principles and rules detailed in the NTPS[1] and takes into account relevant guidance. In particular, the commissioner and provider must be satisfied that the proposed payment approach for NHS services within the scope of the ICP Contract is in the best interests of patients. To the extent that these services have national prices under the NTPS, this payment approach may be adopted by the commissioner and

[1] The National Tariff Payment System documents can be found on the NHS Improvement website: https://improvement.nhs.uk/resources/national-tariff/ (Information accessed 3 July 2019)

provider agreeing “local variations” (i.e. by agreeing to vary the prices and/or specifications of the relevant services) in accordance with the NTPS rules (see Section 6.2 of the NTPS). For other healthcare services covered by the NTPS, the payment approach must be agreed in accordance with the rules on local pricing and may involve departing from any national currencies specified for those services by those rules. Where, as will often be the case, the package of services in-scope of the ICP includes both nationally priced and locally priced services, the approach would involve the commissioner and provider agreeing to vary the national currencies for the relevant services and where relevant combining them with other services which do not have national prices or currencies (e.g. community services and primary medical services), to deliver a single package for which a single annual price is paid (WPAP Part A).

The NTPS covers all NHS-funded healthcare services, except those primary care services where the remuneration of providers is determined by or in accordance with regulations, directions or related instruments under the National Health Service Act 2006 (the 2006 Act),[2] and those services which are funded by personal health budget ‘direct payments’. Where payment for primary medical services is not determined by the 2006 Act framework, the NTPS rules on local price setting apply. For example, local price setting rules apply to minor surgical procedures performed by GPs and commissioned by clinical commissioning groups (CCGs). Similarly, NTPS rules will apply to all primary medical services commissioned through an ICP Contract, because the directions on which the ICP Contract relies do not determine what the ICP is to be paid for delivering those services. Community pharmaceutical services, general dental services and community optometry services cannot be commissioned via an ICP Contract.

Local authority funded social care or public health services, including those commissioned under joint commissioning arrangements (a local authority and its NHS partners), are outside the scope of the NTPS.

3.3.2 Inclusion of primary medical services funding in a WPB

Primary medical services are central to the development of an ICP, given the importance of delivering joined-up care and a better experience for patients. An ICP Contract will therefore only be possible where local GPs are supportive, and in areas where commissioners have engaged widely with practices as well as patients, the public and other providers. As outlined in the GP Participation guidance in the ICP Contract Package, where GPs are supportive, different contractual options are available to them to integrate services across primary care and other settings, depending on how far the GPs themselves wish to integrate with the ICP.

The two main approaches to integrated primary medical services are:

- **Partial integration:** this will be the most common option for practices, where primary medical services continue to be commissioned through primary care contracts, (normally GMS/PMS). In this case, practices and the ICP would agree consistent ways of working together across the population to deliver and improve services. Where practices are partially integrated with an ICP, the core GP funding will remain outside of the ICP Contract.
- **Full integration:** this is where GPs wish to work more closely with the ICP, for example as employees or subcontractors. In this case, the GPs would

3 National Health Service Act 2006 (the 2006 Act) https://www.legislation.gov.uk/ukpga/2006/41/contents (information accessed 3 July 2019)

usually suspend their existing GMS/PMS contracts and would deliver those primary medical services directly from within the ICP (or subcontracted to it). In this case, the primary medical services funding for those practices would be included within the WPAP and paid through the ICP Contract

General information regarding GP participation in an ICP can be found in the GP Participation guidance in the ICP Contract Package. These approaches have different implications for calculating the WPAP. In the fully integrated option, funding for primary medical services is included within the ICP Contract for relevant practices. The arrangements will closely mirror those for GMS/PMS contracts, for example:

- Most core funding will be paid via the WPAP: what has previously been paid as global sum payments, GMS/PMS capitation, APMS payments (where core services previously delivered under an APMS contract are in-scope for the ICP), CQC registration fees, Minimum Practice Income Guarantee (MPIG).
- QOF will continue to exist (or a local variation of it, if already agreed locally), and will be earnable by the ICP on the same terms as previously.
- Some further services will continue to be paid on an activity basis, for example vaccines and immunisations.
- Other elements will be paid to the ICP for fully-integrated practices subject to local agreement, such as out-of-area in-hours urgent care.

Where the primary medical service funding stream has been incorporated into the WPAP, the primary medical services funding for those practices would be included within the WPAP and paid through the ICP Contract component. Payment should be determined and adjusted in accordance with the rules and principles in relation to locally determined prices set out in the NTPS. In particular, the CCG and provider must have regard to the NTPS efficiency and cost uplift factors when setting the payment. However, as the NTPS guidance makes clear, these are not the only factors to be considered, and in relation to the primary medical services element of the WPAP, regard should also be had to the relevant annual GMS/PMS uplifts. Where a primary medical services payment is earned on a discretionary or activity-delivered basis (e.g. capital costs through Premises Cost Directions (PCD), vaccines and immunisations) no automatic uplift will be applied, but relevant payments will be agreed on a case by case basis, in accordance with the ICP Contract and ongoing GP contract negotiations.

Fully integrated GP practices would have the option to reactivate their suspended GMS and PMS contracts at different points throughout the lifetime of the ICP Contract. This reactivation would otherwise happen by default following the expiry or termination of the ICP Contract.

Where a suspended contract is reactivated during the term of the ICP Contract, the amount by which the ICP's budget is reduced will be for local determination. If a GP practice chooses to reactivate its GMS/PMS contract, and the ICP continues to deliver other (non-primary) medical services to patients registering with the reactivated practice, any WPB adjustment could be determined in order to reflect the weighted funding per patient for those patients choosing to register with that practice.

If, in these circumstances some or all non-primary medical services are to be delivered for those patients outside the ICP Contract, any adjustment to the WPB/WPAP should also reflect the cost to the CCG of purchasing those services from another provider.

The contract terms for the reactivated practice will be those GMS/PMS terms which are effective at the date of the reactivation, subject to any variation of those terms which may be agreed between the provider and the commissioner.

3.3.3 Inclusion of local authority funding in a WPB

A WPB provides a mechanism to consolidate different funding streams from a variety of sources that could include CCGs, local authority adult social care, public health, specialised commissioning and primary care. Identification of adult social care expenditure within a WPAP is required to comply with existing legislation.

A local authority may wish social care and/or public health services to be commissioned (and therefore funding channelled) via an ICP Contract. This will typically be enabled via arrangements between the local authority and NHS commissioners under section 75 of the National Health Service Act 2006 and associated regulations, allowing functions to be exercised jointly, and enabling the pooling of budgets. If agreed, local authority funding may generally be combined with healthcare funding, with any specific requirements for monitoring and reporting spending set out in the ICP Contract. Commissioners must identify the local authority funding element as Part B of the WPAP, as outlined in Section 2.

Local authorities will need to work closely with CCGs and NHS partners to consider how far funding commitments can be made over the lifetime of the ICP Contract and ensure that as far as possible any future changes to the level of available funding are documented in the contract at the outset.

3.4 Essential requirements for developing a WPB approach

It is important to note that payment redesign is only one enabler to service delivery integration and should be considered in this context. Any changes to payment mechanisms should not be expected to exert a significant positive influence unless combined with other enablers and undertaken in the context of a coherent change programme.

In addition to having clearly defined service transformation aims, this overview assumes local areas have addressed, or will address in parallel with WPB development, the following enablers:

Data availability and quality

High quality and up-to-date data on activity, quality and costs is essential for developing, implementing and continually evaluating a WPB, any risk sharing mechanism, and the ICP itself. There is a collective responsibility between those involved in the ICP to ensure that, where appropriate, all parties collect and have access to the information required for such assessments.

Population and service scope

The scope of health and care services to be included in an ICP Contract should be identified as early as possible in the ICP development. In order to mitigate against giving the ICP perverse incentives to inappropriately cost-shift to services and/or care settings outside the scope of the ICP Contract, the scope of services under the ICP Contract should ideally be sufficiently wide, e.g. to include services which may influence and/or are impacted by the ICP. Similarly, the population should be of sufficient size to support integration of care, minimise risks from random cost variation and incentivise prevention.

Shadow test and refine

A key step in the development and local implementation of any new payment approach is the testing phase. Meaningful testing will offer clarity on whether the initial design is performing soundly, as well as providing evidence to support any required amendments prior to implementation. It will supply information and assurance to all parties - particularly governing bodies or boards - that the proposed payment approach can work in practice and as expected.

Provider-to-provider payments

It is unlikely that any single organisation will be able to deliver all of the services that a population requires. Therefore part of the WPB may be used to fund the subcontracting of services to other providers to deliver portions of the service scope. While an ICP might not itself deliver all services which are in-scope of its contract, it will, under that contract, be held to account for their collective delivery. This provides the incentive for the ICP to think carefully about the most efficient way to meet contractual quality and outcome requirements.

3.5 Considerations for commissioners

Commissioners must meet their statutory duties and other obligations, including those under the NHS Act 2006 and the Health and Social Care Act 2012[3,4,5]. As such, they need to assure themselves that the WPB for an ICP is consistent with appropriate distribution of funding between the ICP and all other services they are accountable for commissioning.

The relevant statutory duties include commissioners' duties in respect of pricing.[6] As set out in Section 3.3, implementation of a WPB must comply with NTPS rules, principles and guidance, including that the proposed payment approach is in patients' best interests. Commissioners, in conjunction with key stakeholders, need to consider system sustainability, ensuring that over time the WPAP is both affordable and covers efficient costs. They need to review the planned WPB in the context of pressures across the wider local health and care system, forecasting demand and spend on services within and outside the scope of an ICP in parallel, and ensuring consistency with local sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

This review needs to consider the national model for oversight and regulation of new ICPs and any requirement to mitigate risks, including those set out by the ISAP.

NHS England and NHS Improvement have published the Single Oversight Framework to support NHS providers and commissioners in attaining and maintaining the standards required to meet their regulatory obligations, including during the transition to new care models.

Where the estimated WPB is considered unaffordable or unsustainable for the remaining duration of the ICP Contract, recognising the context of the overall local STP/ICS and commissioning plans, commissioners need to consider what

[3] Guidance for NHS commissioners on Equality and Health Inequalities legal duties can be found on the NHS England website: https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/ (Information accessed 3 July 2019)

[4] The NHS Act 2006 can be found on the Government website: http://www.legislation.gov.uk/ukpga/2006/41/contents (Information accessed 3 July 2019)

[5] The Health and Social Care Act 2012 can be found on the Government website: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted (information accessed 3 July 2019).

[6] See s.115 of the Health and Social Care Act 2012.

adjustments they must make to maintain system sustainability. Any adjustments must be within the scope of potential pre-agreed variations to the contract, recorded in the procurement documentation and the original contract, or otherwise within the scope of flexibilities provided for in regulation 72 of the Public Contracts Regulations 2015. Parties are advised to take legal advice in this regard. Such adjustments may include changes to the ICP care model or its scope and may reflect potential changes to other local commissioning plans. In all cases commissioners will need assurances that delivery of the contract obligations for the population and services in-scope of the (varied) ICP Contract are achievable within the (adjusted) WPB value. As such, local areas need a shared understanding of how any savings will be realised.

Patient choice

Patient choice is a key feature of NHS care, and the ICP Contract requires an ICP to ensure that the rights of choice people have under the NHS Constitution are respected. When people covered by the WPB choose to receive services from providers outside the ICP, these providers will need to be reimbursed from the WPB and appropriate arrangements will need to be set up for this. ICP funding would also need to be adjusted for individuals choosing to register with (or leave) the ICP as their primary care provider during the contract period.

Personalised Care

The ICP Contract, like the NHS Standard Contract, is not prescriptive regarding the use of personal health budgets (PHBs) (or local authority-funded direct payments for social care). The role of the ICP in identifying recipients for PHBs (and/or direct care payments), their administration and provision of services purchased through them, is for local discussion and agreement, and documented locally in Schedule 2D (where additional guidance is provided in the template ICP Contract).

4. Overview of whole population budget development

Our work with local areas undertaking service transformation has provided valuable insight regarding enablers, development and implementation of an integrated budget. From this, we consider the main stages in developing a WPB are:

- calculating the WPB baseline
- estimating WPB values for future years
- converting estimated WPB values to contract values for each year in a contract.

Alongside these, local areas should also consider how the two existing national incentive schemes (CQUIN and QOF) will be reflected in the ICP Contract, depending on the scope of services included. Commissioners may further consider the creation of a risk sharing arrangement to encourage joint working between the ICP and other system providers and/or to help manage the transfer and impact of utilisation risk on the ICP.

A summary of each of these stages is set out below.

4.1. Calculating the whole Population budget baseline

The WPB baseline is the total amount available for payment to the ICP to fund in-scope services for the target population in the first year of the contract. The WPAP

(see Section 2) will cover the bulk of this amount each year. Other elements of the WPB include payment on an activity basis (e.g. vaccinations and immunisations where these are within the ICP service scope) and payment under national incentives (CQUIN and QOF).

Historic commissioner spend may be a pragmatic starting point for determining the WPB baseline, given limitations in the understanding and transparency of provider costs, particularly at patient level and in community settings. However, it should not be considered as an end-point methodology. Basing WPB baseline calculation solely on historic spend risks the assumption that integration in and of itself will drive savings and/or increase quality at a time when new requirements are being placed on the ICP. Predominantly focusing on historic spend may also risk any insufficient historic funding levels being continued in the ICP Contract.

To help improve the accuracy of the baseline calculation, a more wide-reaching approach should be adopted in time. Ideally, baseline calculations would incorporate data beyond historic spend alone and use additional information such as: costing data[7], activity trends, benchmarking on spend, risk stratification and demographic modelling. The baseline should also reflect plans to shift care delivery across settings, any required investment and realistic efficiency aspirations.

As with any other provider, the lead provider in an ICP will need to operate within its allocated budget and understand the delivery costs of the services to be delivered under a proposed ICP model, including considering the long-term sustainability of service provision.

Given the flexibility offered through the WPB approach, it is important all local stakeholders are fully engaged in ICP development discussions as early as possible. This engagement and wider sign-up to the ICP proposals will be examined through ISAP. The ICP Contract also contains a range of safeguards to ensure financial accountability, transparency and service continuity.

4.2. Forecasting whole population budget values for future years

Where commissioners use the ICP Contract, they can determine the duration of the contract, and may agree a contract term of up to ten years. The commissioners will need to forecast the WPB (i.e. total amount available for payment to the ICP) for each year of the contract. They will need to do this using transparent mechanisms and assumptions about future economic factors. These forecasts, to be included in the contract, will facilitate investment by setting provisional indications at the procurement stage of what the WPB might be in each year of the contract.

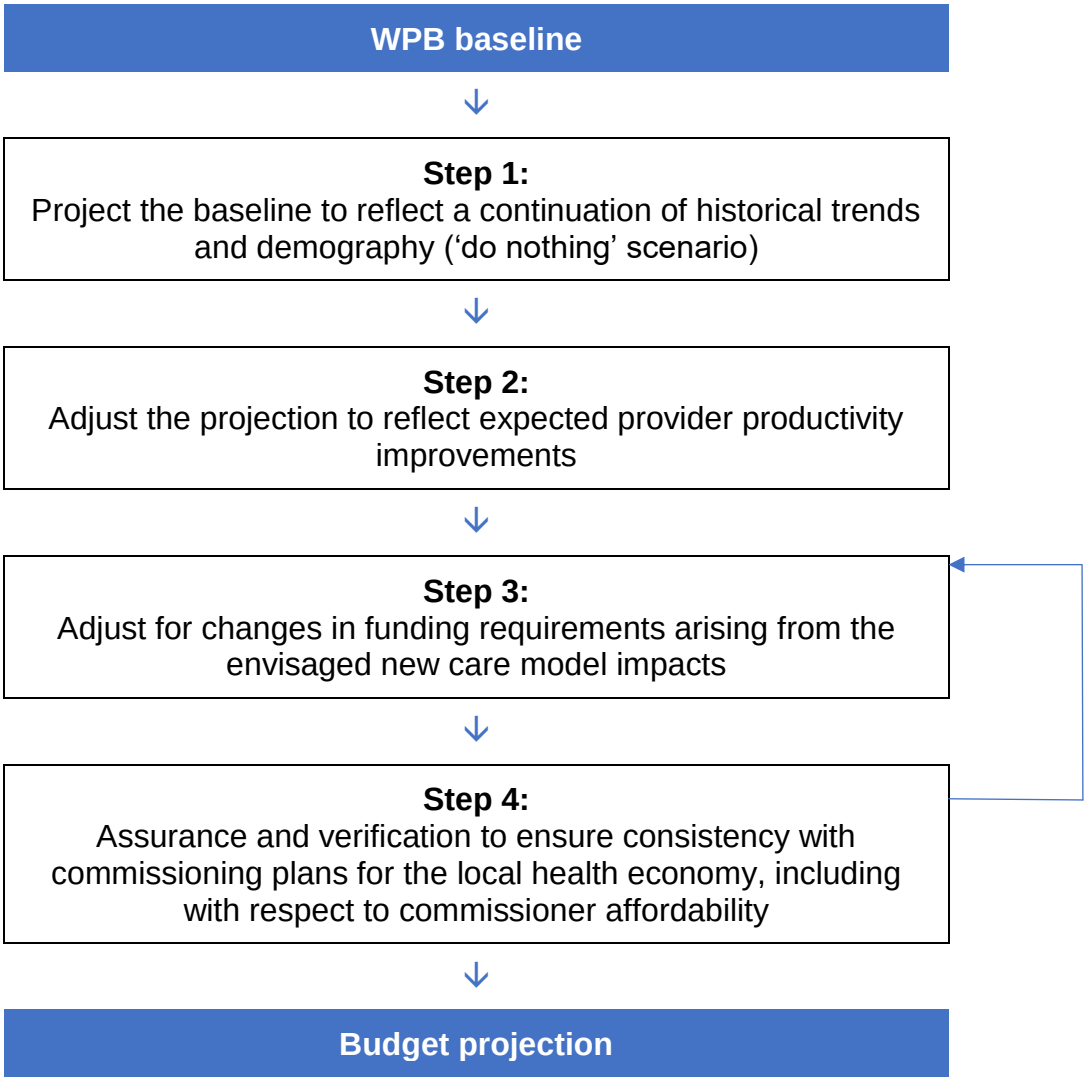
The forecast WPB values should take account of expected:

- future cost and activity pressures, for example anticipated changes in population size and demographics, as well as inflation in health and care provision costs (as reflected in national planning assumptions)
- provider efficiencies, for example annual efficiency targets
- funding requirements associated with implementing the ICP care model plus any efficiencies over and above those expected of the NHS more broadly as the care model scales up
- shifts in care delivery settings

[7] NHS Improvement and NHS England have undertaken extensive work to support providers to better understand their costing data. Further detail on the development of Patient-Level Costing (PLICS) across care settings can be found here: https://improvement.nhs.uk/resources/transforming-patient-level-costing/ (information accessed 3 July 2019)

- future primary care and community funding streams, including the minimum cash spending requirements at the level of every region (from 2020/21) and ICS (from 2023/24) to implement the additional funding for primary medical services and community services committed in the NHS Long Term Plan.

Figure 1: Summary of steps in forecasting a WPB



4.3. Converting whole population budget values into contract values

The baseline and forecast WPB values are central to agreeing the ICP Contract values. However, it may not be possible to fully forecast population movements, treatment developments and the impact of service transformation for the full contract period. Commissioners and providers should therefore agree a mechanism to assess and adjust the integrated budget value so they continue to reflect the needs of the population in-scope of the ICP, as well as accommodating the use of up-to-date or improved data. In doing so, commissioners must take into account current procurement rules and regulations.

Commissioners should refer to the procurement and assurance approach guidance in the ICP Contract Package to identify where changes to service or population

scope would trigger a renegotiation of the ICP Contract itself, not just an adjustment to the WPAP value in the contract.

4.3.1. Potential variations to value and scope during the contract term

It is important that any procurement documents for the relevant contract set out the indicative annual contract values and the way in which payment may be made (including any possible extensions/variations).

Commissioners may, for example, wish to have dialogue with potential providers in relation to payment mechanisms as part of the commissioning process. Commissioners must do so taking account of their obligations to be transparent and to treat bidders equally and in a non-discriminatory manner.

Commissioners should take steps to ensure, so far as possible, that potential changes to contract value or payment during the term of the contract are anticipated in any procurement documents, to limit the risk of a subsequent change triggering a need to run a fresh procurement process. Commissioners will take their own professional advice but, for example, it may be beneficial to provide a list of non-exhaustive options as to the types of changes that may occur during the term of the contract.

All payment proposals, insofar as they relate to NHS-funded services, must comply with NTPS rules and principles, including that they are in the best interests of patients, as explained in Section 3.3. Changes to the value or scope of the WPAP during the contract may require the commissioner to update its published local variation template (if it includes NHS-funded services subject to national prices). A WPAP, or any adjustment to it, will constitute a local variation if it covers any nationally priced services. Commissioners have a statutory duty to provide a statement of each local variation, in accordance with NTPS rules and guidance (see Section 3.3).

5. Incentives and risk share in an ICP

5.1. Incentives

Incentive payments are an important component of the ICP Contract, particularly to encourage improvements in care quality, outcomes and transformation. The ICP Contract, like all other NHS contracts, contains a range of controls and reporting requirements. In addition, it may help to mitigate any potential risk that introduction of a WPB may result in rationing of access to and/or reduced quality of care. However, all aspects of the contract, including the service specification and any additional reporting requirements, are needed to ensure that a commissioner can hold the ICP to account for delivering high-quality care.

There are two existing national incentives which will be reflected in the ICP Contract, depending on the scope of services included. These are CQUIN and QOF. The ICP would also be eligible for any additional payments under national Directed Enhanced Services (DES) specifications, for example the Network DES introduced in 2019/20.

These national schemes help to ensure similar standards and requirements are in place across the ICP in accordance with all other NHS providers.

Commissioners may wish to use local flexibilities to attach additional payment from the ICP's available budget to locally-developed indicators. This flexibility recognises

that different approaches may be appropriate for different areas and allows local priorities and ambitions to be reflected in developing and implementing any outcomes-based payments as an integral part of the ICP Contract.

5.2. Risk sharing

The introduction of a risk sharing mechanism to support a WPB can be a useful way to help deliver local aims. A well-designed risk sharing mechanism could deliver benefits including:

- supporting service transformation by better aligning payment and any incentive mechanisms with future health and social care models
- managing risk more effectively across the ICP and other parts of the system
- encouraging funding to follow the patient, rather than the organisation, contributing to a payment system which effectively allocates suitable funding to the services which provide the best outcomes for patients and the healthcare system
- strengthening incentives for providers and commissioners to work together, reducing organisational 'barriers' through the collective management of risk, demand and cost
- building trust and supporting collaborative working between system partners.

NHS England and NHS Improvement are developing frameworks to support the local design and implementation of risk sharing mechanisms. We will share these once completed. The frameworks will describe how risk sharing can support a WPB – or other payment approaches – to share specific risks more appropriately between commissioners and providers.

The work to date on risk sharing mechanisms has been primarily focused on 'Activity-Based Risk Sharing'. This aims to complement a WPB by allowing activity risk to be more appropriately shared by commissioners and providers. We will also work on developing 'Risk Sharing through Payments' and assessing possible mechanisms for sharing other types of risk.

NHS England and NHS Improvement have run a series of webinars discussing risk sharing through payments, which considers the above in more detail. Recordings are available to view:

- An introduction to risk sharing through payments
- Activity-based risk sharing
- Financial risk sharing.

6. Further information

Additional technical detail is available on:

- calculating the WPB baseline
- estimating the WPB values for the duration of the multi-year contract
- converting estimated WPB values into contract values
- financial incentive payments and risk share.

To request this please contact pricing@improvement.nhs.uk.

For any non-payment information regarding ICPs, please refer to the ICP Contract.