Population based payment and NHS payment policy

Whole System Payment – deep dive

30 September 2021, 15.00 - 16.00

NHS England and NHS Improvement

About this webinar

- This session follows the September 2021 series of engagement workshops discussing potential finance and payment arrangements for 2022/23.
- In this session, we will discuss in more detail what these arrangements might mean for working at a system level.

- The webinar will be divided into three sections:
    1. Potential ways of approaching (fixed) payment setting for a whole system
    2. Provider collaboration and place-based working
    3. Mechanisms to support sector shift and population health management

- You can ask questions using the chat box and we will address as many of them as we can.
- The session will be recorded and available to view after the event.

Please note: What we are sharing here is work in development. The policies and approaches discussed are not final and will be subject to change as we continue to receive feedback, both internally and externally, and undertake further work.

Fixed payments within a whole system context

Payment approach progression

Current payment approaches

- **Mix of payment approaches**, for example: Payment by Results for acute, blended payment for emergency care, block for community services, some full block contracts – not aligned to care models
- **Limited cost data** means payment unlikely to reflect efficient cost of services
- Some systems moved towards **aligned incentive contracts**, but with limitations
- Variable elements or risk shares are ‘simplistic’
- Generally focused on acute.

Interim payment approaches

- Move towards **aligned payment and incentives across the whole system**
- **Fixed elements** set based on improved cost data and more accurate activity forecasts aligned to ICS plans
- **Variable elements** set based on understanding of costs of activity above/below plan
- Simplification of specific **quality-related payments**
- **Agreed plans** for how resources flow around the system, aligned to care models.

Long-term aspirations for payments

- Based on **patient-level** cost, activity and outcomes data
- Resources are **joined up along the optimal patient journey** and therefore closely align to the model of care
- Funding for all services is reflective of both **local efficient cost and system financial stability**
- Long-term financial planning by system partners enables **proactive investment** in services
- Transparent sharing of activity, costing and finance data supports **efficient allocation** of resources.

How a whole system fixed payment could be agreed

This section puts us in the shoes of a (hypothetical) ICS commissioner with a budget to allocate for a population. It covers:

- Beginning to allocate a budget
- Beginning to maximise value from a budget
- Beginning to address healthcare needs of a whole population

Please note: all content within this section is intended solely to support discussion on whole system payment approaches.

Setting a fixed payment – scope

- Here we are discussing the **setting of fixed payment** only – this section does not cover variable payment, risk/resource sharing or quality incentives
- We would expect guidance on the core scope of fixed payment to be set out. For example:
  - *Fixed payment should be set for at least a one year period, with consideration given to setting for a longer period where there is demonstrable population benefit.*
  - *Agreed fixed payment levels should be informed, set and monitored using the best available national and local data sources.*

Setting a fixed payment – applicability

- There should also be wider guidance on applicability to a given service, such as:
  - *The contractual agreement should be such that payment has not previously been agreed for the 20XX/XX financial period, or is otherwise open to review*
  - *A clear payer/payee relationship must be agreed by the relevant Integrated Care System, or at 'place' level if delegated.*
  - *The provider must be contracted under, and held subject to, the NHS Standard Contract*
  - *Within place-based or provider collaborative arrangements, this would remain applicable in most cases. If the governance and commissioning structure of such arrangements means that aligned payment and incentive rules do not apply to a provider within such an arrangement, we would recommend this approach is still considered, to support consistency and parity.*

Initial elements for a fixed payment - 1

1) Fixed payment default – a starting point

- Systems should be developing trajectories to ensure all fixed payments are population based and informed by the best local and national intelligence. Demonstrable implementation of intelligent population-based payment by all ICSs will be expected within the NHS Long Term Plan period.
- For 2022/23, to support continuity within a challenging context and to act as a starting point from which to apply further adjustments, it may be helpful to begin planning from a more simple default position. This could be similar to that used during 2020/21 and 2021/22.

Example approach

1. *Begin with a simple default starting point*
   - i. *Where available, begin from 2019/20 outturn, and add a net tariff uplift of X%*
   - ii. *Where not available, e.g. due to provider reorganisation, or newly commissioned providers, begin from the simplest available cost profile of the relevant service.*

In future years, national and/or local starting points may be rebased entirely from PLICS, supported by system-wide activity data, or built up from population group analysis

Initial elements for a fixed payment - 2

2) Strategic system expenditure

- In line with strategic plans at national, ICS and place level, **programme budgeting** and other relevant data sources should be used to agree an appropriate trajectory for the proportion of system expenditure within community, mental health, acute and other services, with an adjusted planned breakdown for 2022/23, and indicative trajectory for future years.
- Similarly, strategic trajectories for expenditure within particular service areas may need to be considered.

Example approach

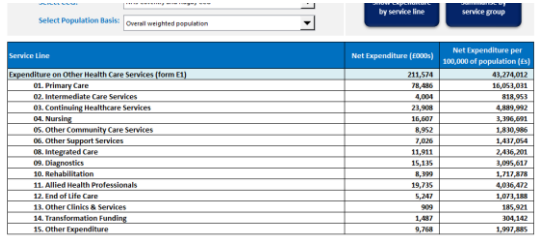
2. Set an expectation as to differential activity from baseline period (e.g. 2019/20)

i. Set an expectation as to what proportion of activity growth can be supported within efficiency and improvement programmes

ii. Agree appropriateness of shifting any proportion of activity to another sector, e.g. from acute to community provision

iii. Using either unit prices, PLICS, or the best available local data, calculate and include an appropriate uplift to fund any remaining net activity growth

We would expect the sophistication of this approach to increase over time as data quality, currencies, and nationally produced supporting tools develop further.



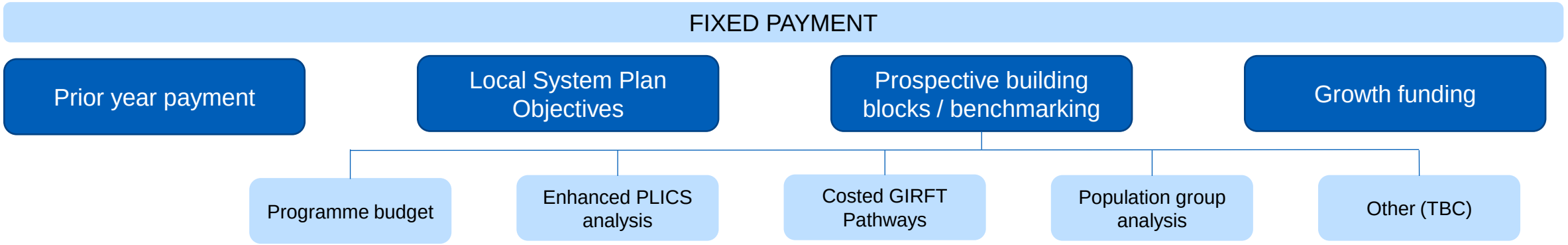
Service Line	Net Expenditure (£000s)	Net Expenditure per 100,000 of population (£s)
Expenditure on Other Health Care Services (form E1)	211,574	43,274,012
01. Primary Care	78,486	16,053,031
02. Intermediate Care Services	4,004	818,953
03. Continuing Healthcare Services	23,908	4,889,992
04. Nursing	16,607	3,396,691
05. Other Community Care Services	8,952	1,830,986
06. Other Support Services	7,026	1,437,054
08. Integrated Care	11,911	2,436,201
09. Diagnostics	15,135	3,095,617
10. Rehabilitation	8,399	1,717,878
11. Allied Health Professionals	19,735	4,036,472
12. End of Life Care	5,247	1,073,188
13. Other Clinics & Services	909	185,921
14. Transformation Funding	1,487	304,142
15. Other Expenditure	9,768	1,997,885

Initial elements for a fixed payment - 3

3) Data infrastructure

- Agreed payment levels should always be informed, set and performance monitored using the best available national and local data sources.
- Where optimal data sources and quality are not available, the agreed payment should include an expectation that data flow and quality will continue to improve, **to provide more robust evidence should the provider intend to seek a fixed payment uplift in future periods.**
- Data sources should be agreed and data quality should be monitored, including via **DQMI**

Possible fixed payment support trajectory



Current	Not published for a number of years. Resource issues in costing for progressing	Dashboard and model system costing focussed on technical organisational efficiency	GIRFT pathways published but no costing analysis	Focus of prices, payment and costing on organisational activity	No other products in pipeline
Year 1 (22/23)	Assessing opportunity to resolve MIS reconciliation issue and publish 2019/20 national information. Start conversation about potential enhancements	Wider access to PLICS dashboard. Publish planned developments with system focus. Engage on other plans and develop enhancement programme.	6-7 published GIRFT pathways with desktop costing analysis. Costing analysis limited but signal whole pathway principle. Presented in the context of changing resources as services transform.	Identify a population group and test collection, sharing and use of population costing and benchmark analysis	Start discussion
Year 2	Implement Phase 1 enhancements.	Implement Phase 1 enhancements	Expand to wider selection of GIRFT pathways including whole pathway costing	Enhance population analysis and expand to wider set of groups	Implement Phase 1 enhancements
Year 3 +	Publish full programme budget analysis in future proof categories, reconciled to PLICS where possible and with provider types analysis	PLICS dashboard that support ICS, place and organisation needs	Analysis from PLICS using GIRFT compliant providers	Population analysis covering whole system and bridge to more detailed local PHM	Range of products and tools valued and well used by sector.

Provider Collaboratives and Place Based Partnerships Payments

Vision for Place based Partnerships and Provider Collaboratives

2022/23

Beginning the process of developing provider collaboratives and place based care as the default way of working across all systems.

Payment flows are to remain between the legally defined entities (commissioner to provider).

The ICB takes on the role of CCGs, leading the commissioning process.

SCFMA and risk sharing agreements to form the basis of the collaborative agreements for provider collaboratives.

Section 75 partnership agreements could be used as governance for Place based partnerships.

Governance arrangements to be flexible including a wide range of options such as consultative forums, ICB committees, shared leadership, and lead provider arrangements.

2023/24 and beyond

Deeper collaboration with more formal arrangements

Place and provider collaboratives take on more responsibility for commissioning functions and managing budgets where appropriate, informed by population needs.

Fixed payments for collaborative/partnership activity informed by PLICS and shared governance arrangements.

Will need to clarify level of expectation and responsibilities for setting and using fixed payment within these arrangements

Network arrangements across ICS boundaries may also need consideration to ensure sufficient flexibility and guidance.

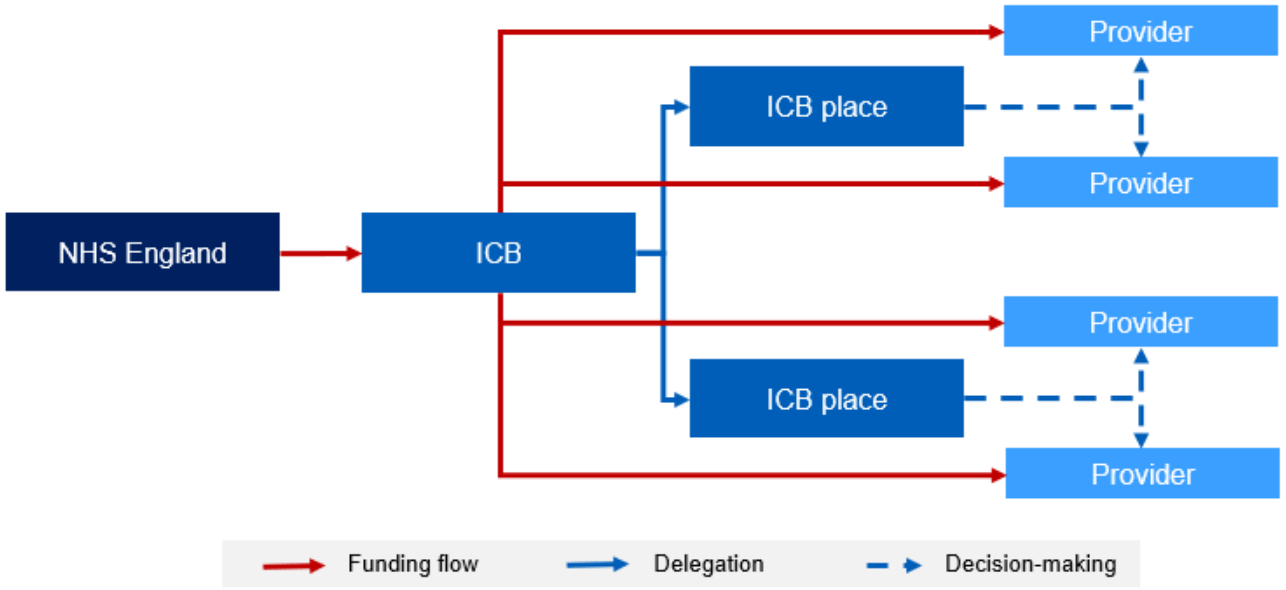
Governance

Governance would be flexible for place based partnerships and provider collaboratives, including a wide range of options such as consultative forums, ICB committees, shared leadership, and lead provider arrangements.	Which of these governance arrangements is in place will have an affect on how payments are made within the collaborative.	Regardless of which form of governance is used, payment should not be a barrier to collaboration.

Payment for Place Based Partnerships

The payments for place based partnerships are made by the commissioner, in this example the ICB, directly to the provider.

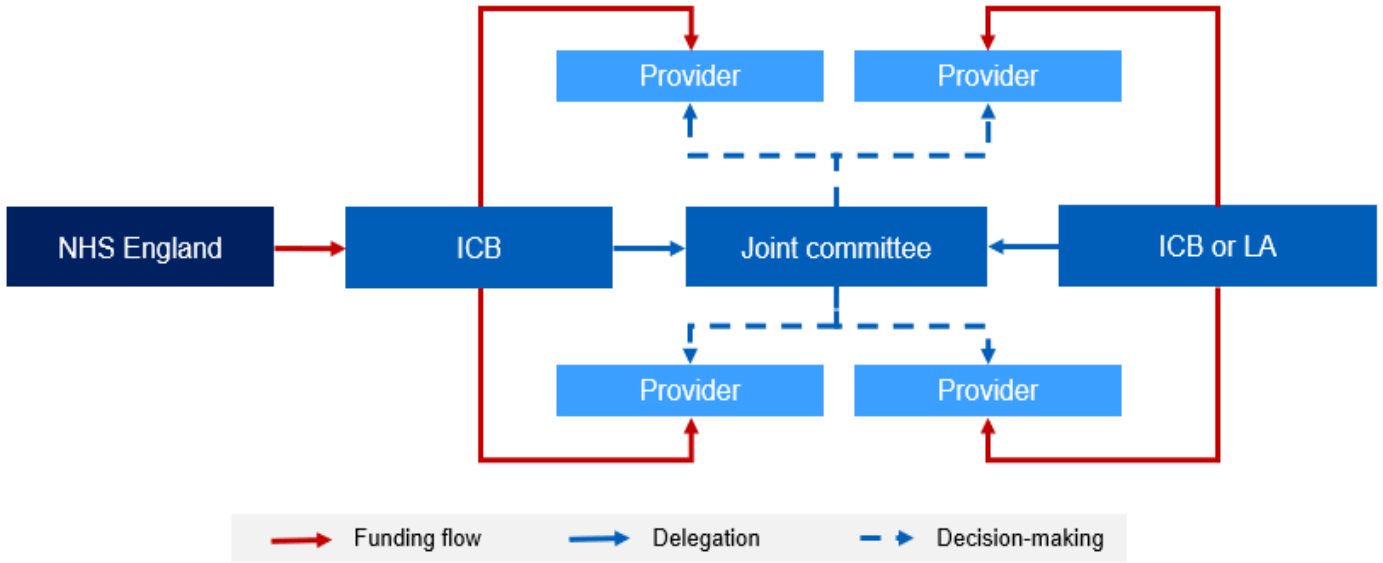
Decisions around payment can be delegated to place but the payment flow remains the same.



Example payment flow, not finalised policy

Payment for Place Based Partnerships

Where a place based partnership involves shared funding streams with a local authority, funding could be agreed through a joint committee or section 75 partnership arrangement.



Example payment flow, not finalised policy

Plymouth's health and wellbeing board has overseen the establishment of **integrated commissioning and provision** across the city. Joint commissioners are co-located and work under a Director of Integrated Commissioning, with an integrated fund, and risk and benefit sharing arrangements. Most adult social care services have been transferred to Livewell South West, an integrated community health and care provider with a single point of access, locality-based services and improved secondary care discharge pathways.

Nottinghamshire uses place-based groups involving county and district councils, the NHS, the voluntary and community sector and local people to support its ambition to achieve '**healthy and sustainable places**' as part of its joint health and wellbeing strategy. The work is coordinated through a Healthy and Sustainable Places Coordination Group which reports to the health and wellbeing board and serves as a conduit between the board and local communities.

Learning from the sector taken forward

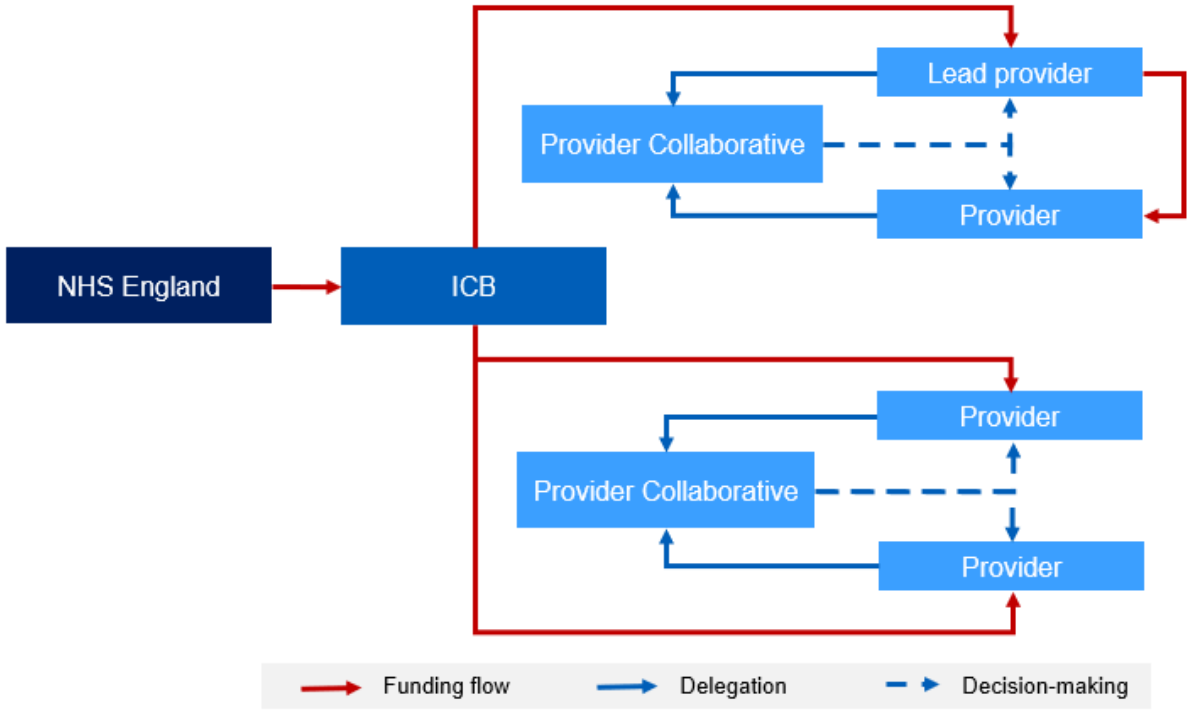
1. **Build** on what you have
2. **Agree** shared purpose before defining structures
3. Develop 'by **doing**'
4. Governance must **iterate over time** to support changing relationships
5. Ethos of **equal partnership**
6. **Define the footprint collaboratively**
7. Develop **culture and behaviours** that reflects shared values

- Membership of the partnership, **for local determination** but we set out a minimum expectation
- Place-based partnerships should systematically involve professionals, people who use services, carers and the public in programmes of work and decision-making processes
- Different governance options to support the different objectives of the partnership, including (**1**) consultative forum, (**2**) joint committee, (**3**) committee of the ICS NHS body, (**4**) individual with delegated responsibility, and (**5**) lead provider arrangement
- Importance of **coherent understanding of accountability arrangements**, engaging NEDs and elected members appropriately, and facilitating **collective accountability** for mutual delivery

Payment for Provider Collaboratives

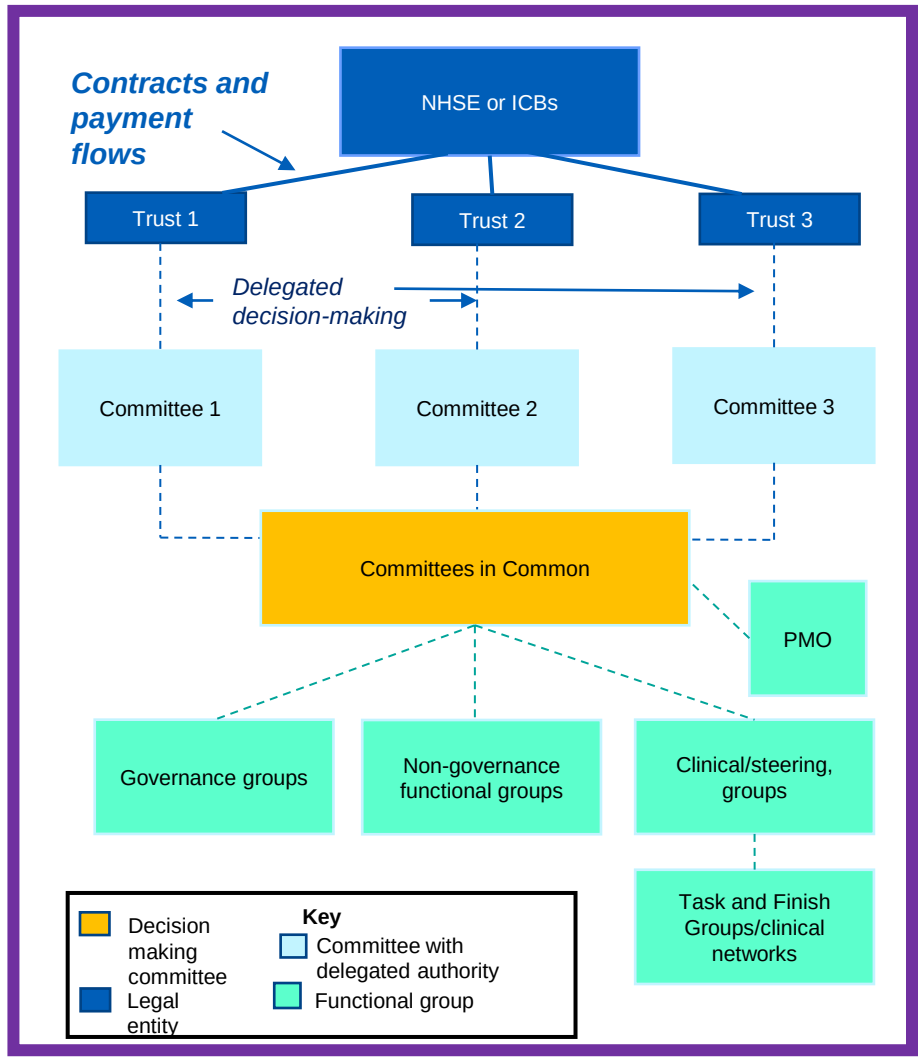
For Provider Collaboratives using a lead provider model, payments would be made to the lead provider which would then pay the other members of the collaborative.

For other forms of Provider Collaborative such as shared leadership or provider leadership board, each provider is paid by the ICB commissioner. Decisions around these payments could be made at the collaborative board in tandem with the ICB.

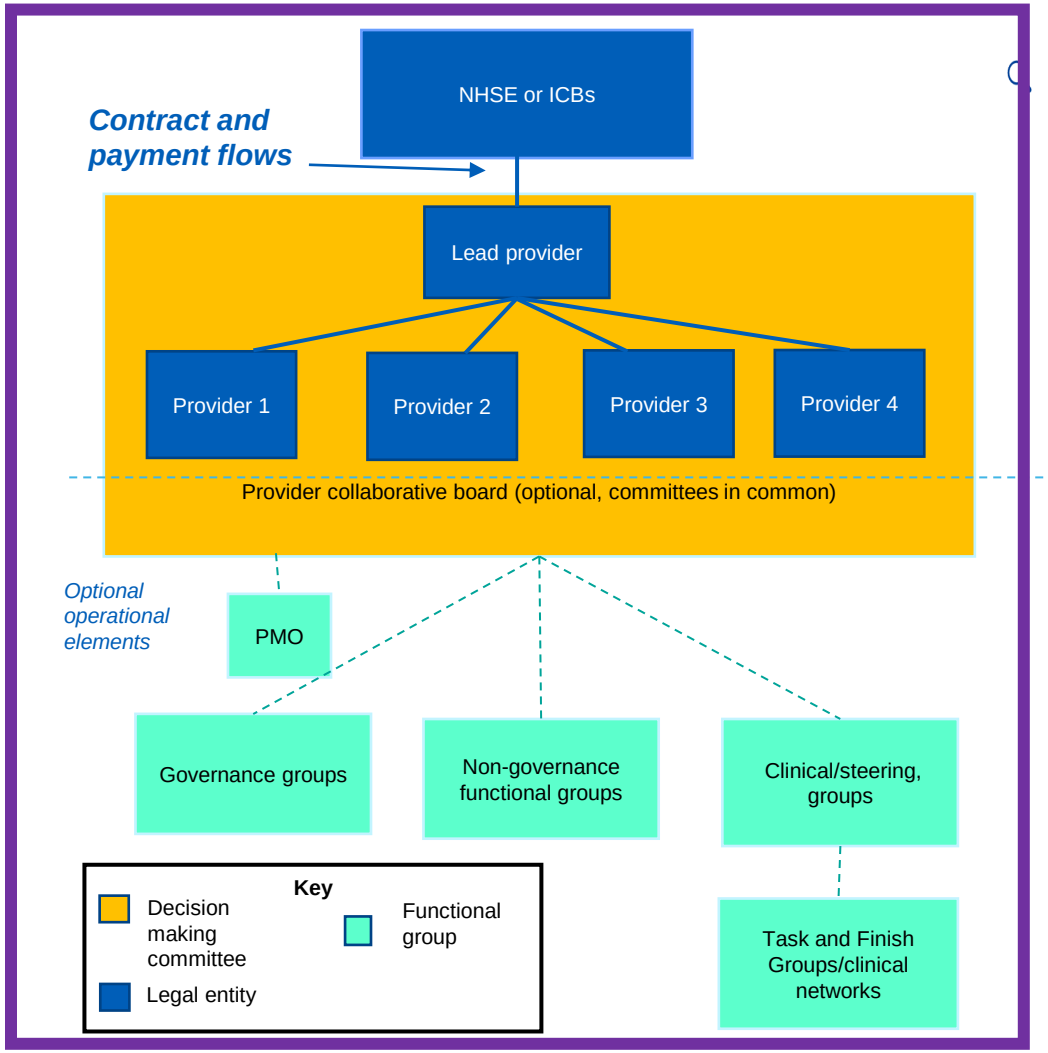


Example payment flow, not finalised policy

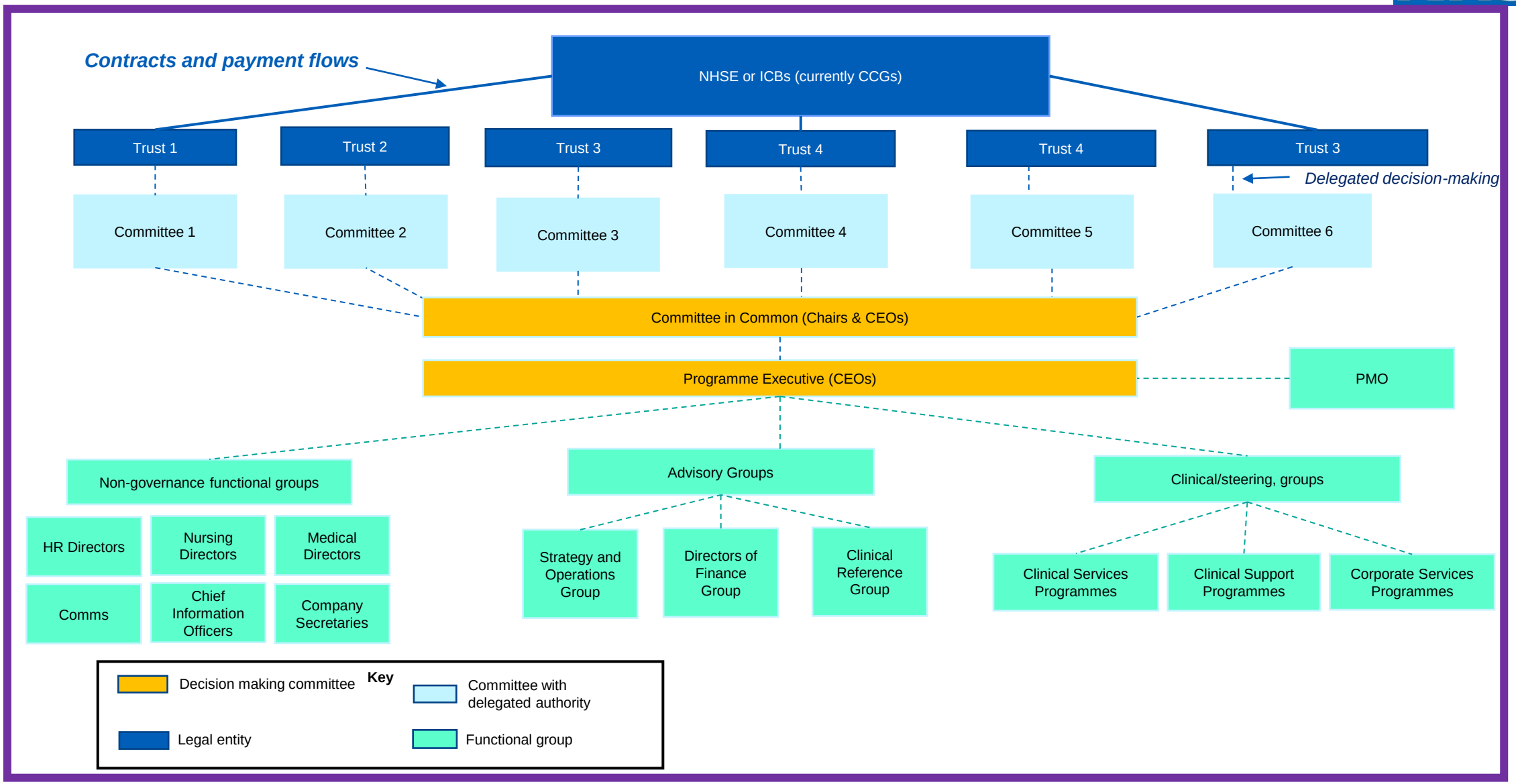
Provider Leadership Board



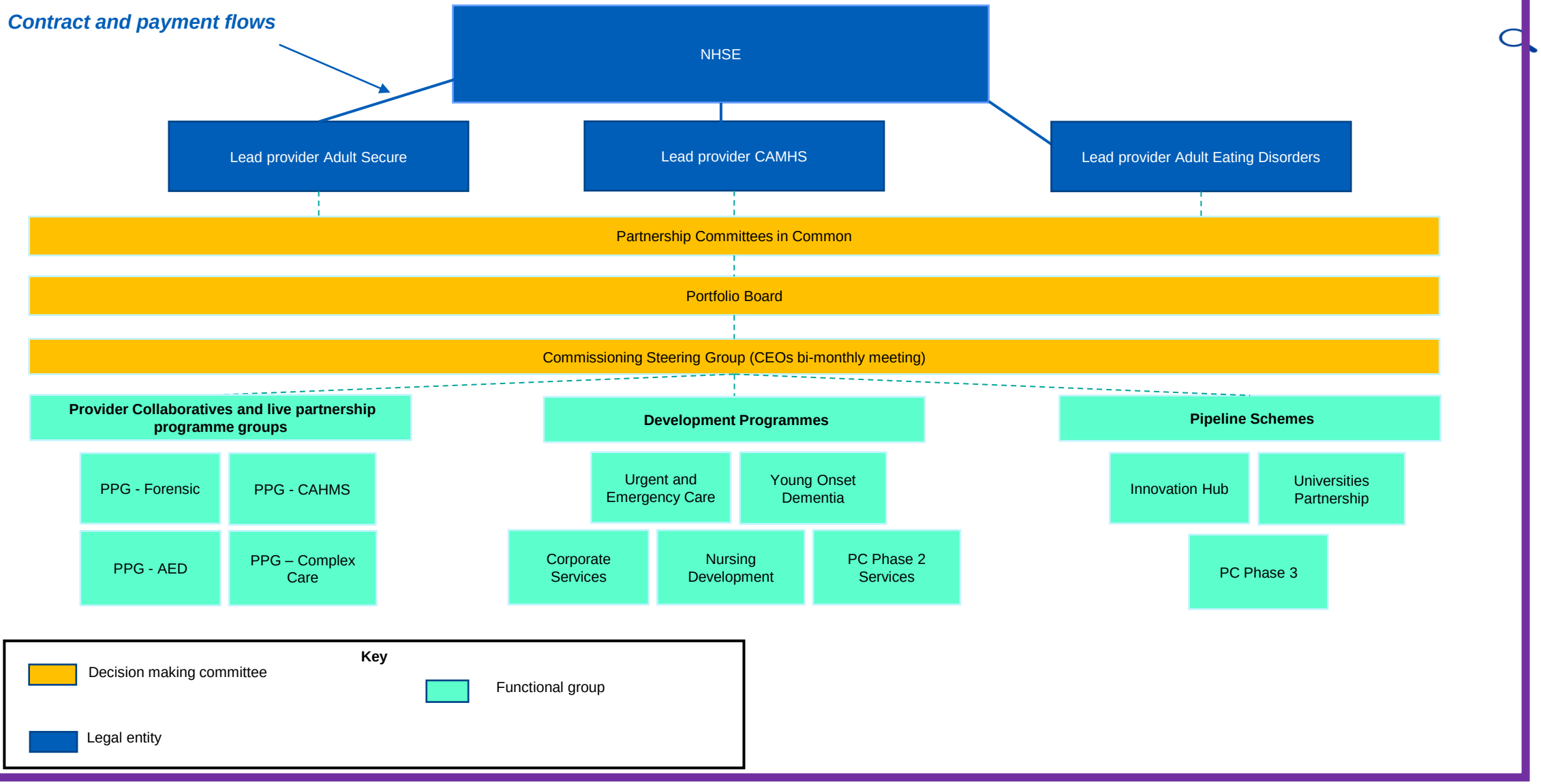
Lead Provider



Provider Leadership Board: The West Yorkshire Association of Acute Trusts (WYAAT) is a partnership of six acute trusts in West Yorkshire and Harrogate ICS.

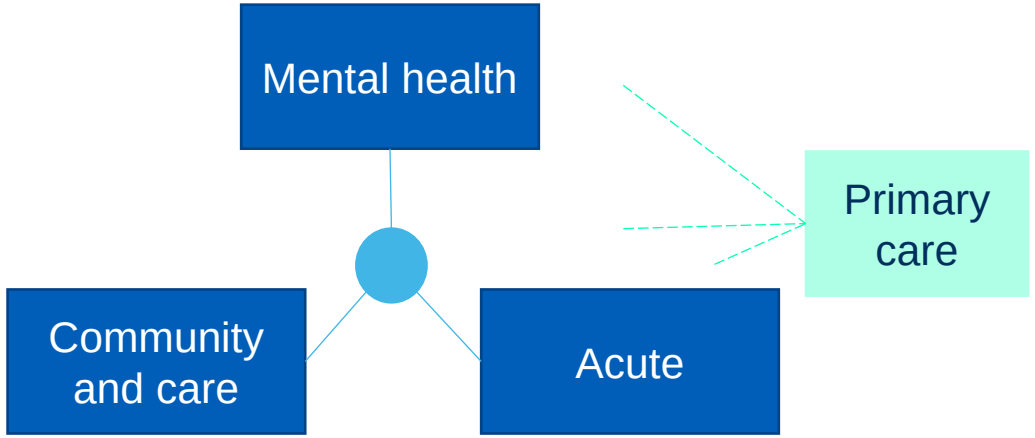


Lead provider structure: South London Mental Health and Community Partnership (SLP) is an NHS-led mental health provider collaborative with a lead provider.



Two case studies – Humber Coast & Vale, and Cheshire and Merseyside

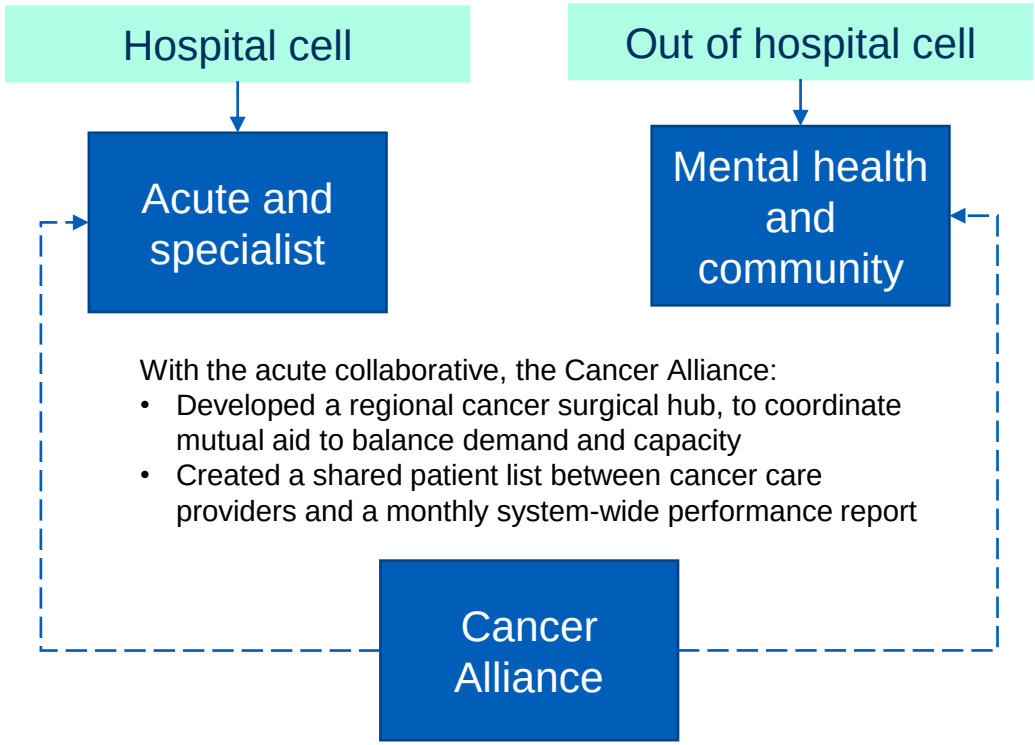
Humber Coast & Vale – three provider collaboratives



- Leads the implementation of the Ageing Well programme, including the two-hour urgent crisis response
- Leads programmes related to hospital discharges and end-of-life care

- Elective recovery plan based on joint capacity
- Leads community diagnostic hub programme
- Delivered significant investment into clinical support networks
- Oversees range of networks and alliances and other programmes

Cheshire and Merseyside – two provider collaboratives



The collaboratives and Cancer Alliance have agreed areas of mutual benefit that benefit both parties (e.g. Cancer Alliance can tap into collaborative discussions on surgery, and the collaborative benefits from expertise and learning from the Alliance to share and apply to other priorities)

Budgets/PLICS

- Currently, ledgers are held at ICS and Provider level.
- In the future, budgets could be held at place level.
- PLICS, and other costing data could be used as a basis for payment.
- Costing analysis at place allows for money to get to where it needs to be. It brings into focus allocations and cost.
- A PHM approach together with PLICS could reduce deprivation and inequity.

Contracting

- Whichever governance arrangement the collaborative/partnership forms, it is necessary that the administrative burden of contracting and sub-contracting is reduced.
- A feedback mechanism could be implemented withing a place-wide contractual framework, the aim of which would be to reduce the numbers of small transactions between providers
- Whichever organisation carried out the work would receive the funding from the commissioner directly, rather than from other providers in the Place.

Payment approaches supporting: sector shift and population health management

Key Question

<u>This sections addresses this key question:</u>

How do we support systems to **shift investment and activity** away from acute settings, **towards primary prevention, mental health and community** provision?

The section covers:
- A possible overall approach to funding transformation
- Possible use of blended payment elements
- Possible roles for system partners
- Possible areas to start

Recognising the scale of this challenge, and the variable starting points between systems, we might each have different perspectives as to the best next steps within our systems.

Possible overarching approach to transformation

Traditional patient pathway cost profile

Traditional approach to service transformation

Action	Impact
MH/Community based services deliver transformation from block	New care model delivery not optimised
Acute contract value reduced by anticipated activity reduction	To protect fixed cost acute resists change or backfills income in another way

Population Health Management approach to service transformation

Action	Impact
Use of growth monies to invest in new model of care	All parties buy in to new model and investment allows optimisation. Quality and outcomes improve.
System agree profile of actual cost saving and re-purpose	All parties buy in to new model & collaboratively agree how to re-invest actual savings

Possible use of blended payment elements

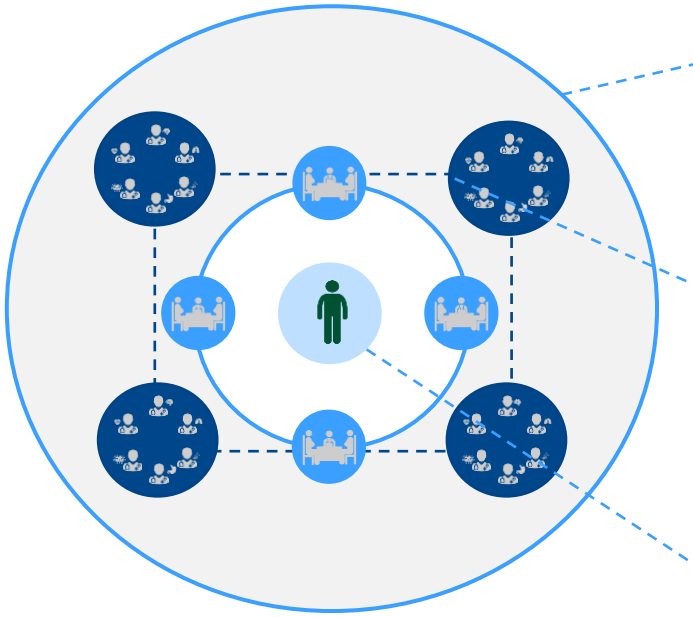
Aligned payment and incentives element	Potential objectives
Fixed payment	• Provide certainty for organisations regarding income and expenditure. • Focus on managing demand and costs across an ICS within a defined financial envelope, • Reflect and reimburse efficient costs, maximising allocative and technical efficiencies. • Develop a shared understanding of value based on high quality data and information.

Variable payment	• Provide a mechanism for funding to follow the patient (passive) or address unmet need (active)
	  ○ Recognise activity above or below agreed levels and mitigate financial risk (passive)
	  ○ Provide incentives to collectively manage demand and address backlogs (active)

Supporting element	Potential objectives
Quality-based payment	• Signal that patient outcomes are a priority for all system partners. • Mitigate any risk that fixed payments may encourage rationing or reduce quality of care.

Risk share	• System-wide risk management between all parties
	• Manage the impact on individual organisations during the transition phase to new models of care, such as:
	  ○ Where changes to activity flows impact on an organisation's income.
	  ○ Stranded costs

Possible roles within a system



System:

- Drive consistency in payment reform across the ICS
- Ensure system level plans based on a shared understanding of the future needs of the population
- Agree an approach to sharing system-wide financial pressures between ICS partners.

Place:

- Share activity, costs and finance data to support the efficient allocation of resources
- Use population health techniques such as costed segmentation and actuarial modelling
- Secure agreement from individual boards to embed reforms that align with the system plan
- Regularly monitor risks and collectively agree suitable mitigating actions

Neighbourhood:

- Drawing on localised expertise to inform current and future planning and to help direct funding through appropriate mechanisms
- Wider contracts and incentive mechanisms may be included as part of an expanded aligned payment and incentive approach for services or pathways

Possible early opportunities

Providing a sample of areas for consideration to support long-term financial management via prevention, reduction, supported self-management and the redistribution of demand and activity ‘upstream’ or in more appropriate settings.

Area	Opportunity Type	Further information
CVD management	Preventing acute event	(audits, programme page)
Mental Health	Reducing A&E attendance	FutureNHS site
Frailty	Community stabilisation	Published guidance
Supported Self Management	Reducing disease progression	NHSE Personalised Care guidance
Addressing wider determinants of health	Mutual benefit to Health and Social Care outcomes	PHE guidance, reports with case studies

Discussion

Discussion

- **What incentives might be created by ‘fixing’ payment for UEC?**
    - What incentives might this create for an acute provider?
    - What impact might this have on non-acute providers?
    - How might this play out within a 'place' or 'collaborative'?

- **How does the move to blended payment alter opportunities for redesigning pathways? e.g.**
    - Investing in additional therapy services to reduce need for repeat operations
    - Pooling clinical HR – working more flexibly across a 'place' or 'collaborative'

- **What challenges need more focus in shifting value to the community & mental health sectors?**
    - Embedding new currency models?
    - Ensuring PLICS analysis is drawn out effectively?
    - Maintaining a consistent payment approach for these sectors at within 'places' or 'collaboratives'?