

How to... bring budgets together and use them to develop coordinated care provision

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The Better Care Fund



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We would like to thank the following organisations for their contribution to this publication.

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Monitor

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The King's Fund

The International Foundation for Integrated Care (IFIC)

The National Institute for Health Research's Health Service and Delivery programme

Outcomes Based Healthcare

COBIC

Wiltshire Council, Help to Live at Home programme

Staffordshire and Stoke on Trent Partnership NHS Trust and Staffordshire County Council

The North West London Whole Systems Integrated Care programme

Nottingham City Council

Sheffield Council and CCG

Oxfordshire CCG

Kent Council and CCG

Pennine MSK Partnership

Salford Royal NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, Salford CCG and Salford City Council

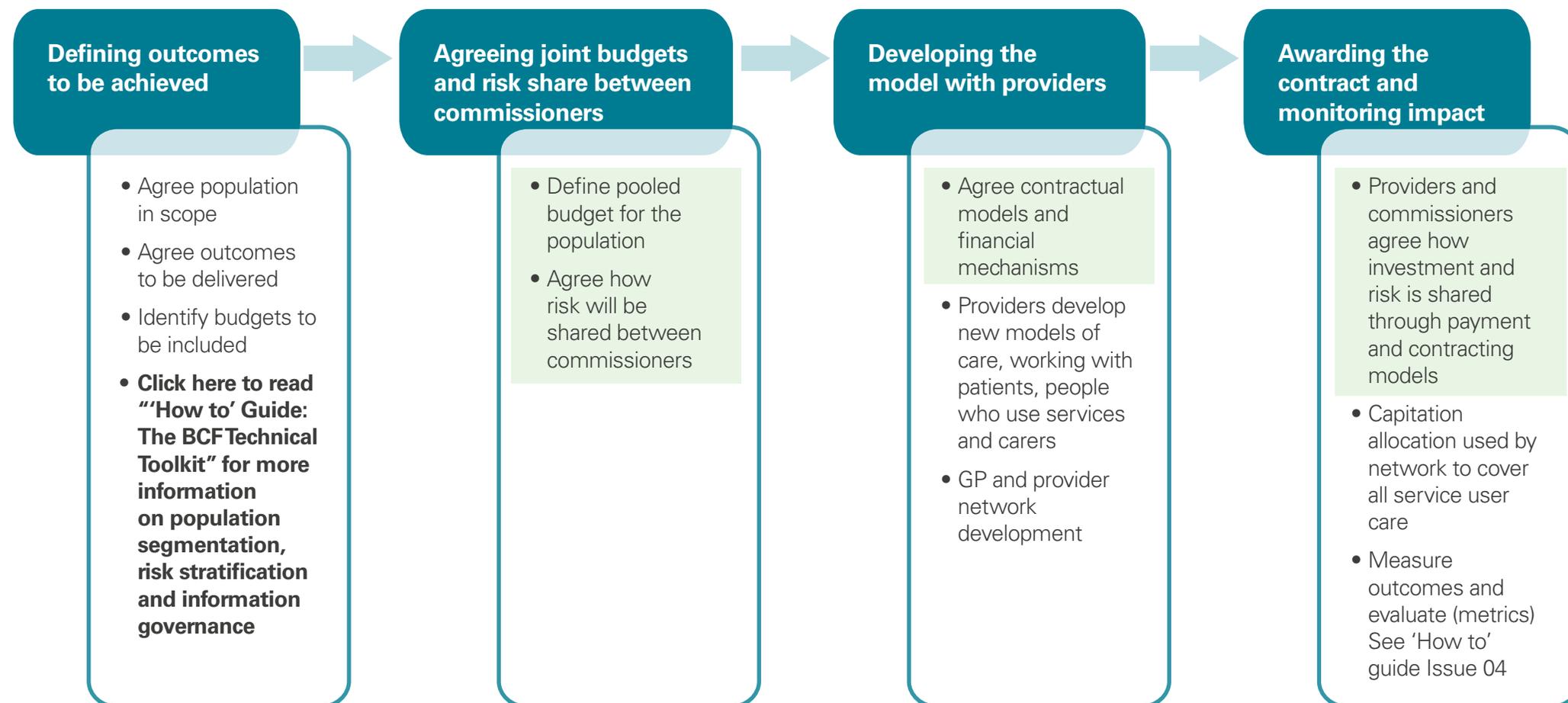
Reading Local Authority, North and West Reading CCG & South Reading CCG

South Worcestershire GP Federation

Aim of this guide

This 'How to' Guide focuses on bringing budgets together and using them to develop coordinated care provision. The scope of this document covers pooling budgets, risk sharing between commissioners, and selecting payment and contracting models, as outlined in the shaded sections of the diagram below. Please note that these are not necessarily discrete phases and some activities will happen concurrently. The guide is aimed at finance leads as well as strategic and operational leads across both health and care organisations and identifies opportunities how resources can be aligned in a more effective way to provide person centred coordinated care.

The process for developing integrated models of care



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The 'how to' guide series is intended to be of practical use to members of Health and Wellbeing Boards (HWBs) of the membership categories: councils, clinical commissioning groups (CCGs), local Healthwatch and voluntary sector members, representatives of NHS England who sit on HWBs, and additional non-statutory members.

Introduction

A shared political agenda in support of pooled budgets

“The important thing is to ensure that when it comes to the services themselves, the connection between health and social care is as seamless as possible. **We want to see more joint commissioning of both health and social care services...** acting together for the benefit of both the cared-for and their carers, rather than in opposition to each other, as they so often do today.”

- David Cameron, Prime Minister, Conservative Party

“I want the approach to evolve rather than having anything imposed. The only imposition is to say that **we have got to get budgets pooled locally completely**, and I've talked to a lot of people about this and I think we've come up with a neat solution to achieve the pooled budget without a national reorganisation, which nobody wants. **The Better Care Fund seems to me to be the sensible way of achieving that objective, to progressively increase the extent of the pooling.**”

- Norman Lamb, Minister for Care and Support, Liberal Democrats

“At the moment the finances are pulling in the opposite direction, pulling people toward the most expensive end of the system, which is the acute hospital. That can't go on.”

- Andy Burnham, Shadow Secretary of State for Health, Labour Party

There is cross-party consensus that health and care should be more integrated: the government has led the formation of a broad-based collaboration to drive local integration and it is likely that any future government will continue to promote this agenda. This 'How to' guide concentrates on how commissioners can come together to drive forward Better Care and explores the mechanisms available to enable them to do so. The way that providers organise themselves to respond to this is paramount, but is not the focus of this guide.

More of us are living longer, with a mixture of physical and mental health care and support needs – so there is an increasing need for person-centred, coordinated care.

This extra demand for better care will only be affordable if we share resources across organisational boundaries. But achieving this in a climate of unprecedented financial austerity is very challenging.

This guide offers some practical pointers to help bring budgets together and use them to develop coordinated care provision. Doing this well is not just a technical matter of policy implementation. It is clear - from our work at the King's Fund on integrated care and from wider evidence both in the UK and abroad - that deeper foundations are needed.

A good starting point is ensuring there is a clear common purpose about the outcomes you are trying to achieve for your local population and how you want to reshape services to meet them. Many places have developed a narrative – Torbay's 'Mrs Smith' is a well-known example – that expresses this in practical terms and helps to build a shared understanding amongst staff, stakeholders and the public. Another essential element is robust governance with clarity around decision making and accountability. This needs to be buttressed by shared leadership at political and executive levels. **Please refer to 'How to' guide Issue 01 "Lead and manage Better Care implementation"**

The personal chemistry between local leaders is as important as formal plans and strategies. The need to invest time in developing trust and a better understanding of partners' pressures and priorities should not be overlooked. The soft stuff is the hard stuff.

The mechanisms identified in this guide – such as pooled budgets, risk sharing agreements and different contracting and payment frameworks – offer a range of opportunities for innovation in better aligning resources with needs. But these are means to an end, not an end in themselves. They will only make a difference, if we keep the goal of better person-centred, coordinated care clearly in mind throughout. Finding the right policy mechanisms to suit local needs will depend on sound foundations of common purpose, strong governance and shared leadership.

**By Richard Humphries, Assistant Director, Policy,
The King's Fund**

In the integrated world, the key is to get the best value for the public pound, and that's a cross-organisational aim. Finance staff should be driven by and support what's good for the whole health and social care system rather than what's good for their organisation alone. They should be enablers, not blockers. They should help empower change through participative budgeting; a focus on outcomes; transparent presentation of the long term effect of decisions; and should encourage, not discourage, the taking of appropriate risks. For example, the right thing may be to invest without strict proof of what will work – because, in the face of current pressures, the risk of doing nothing is greater.

- Rob Whiteman CIPFA, Chief Executive, CIPFA

England's health and social care challenge is significant, and accelerating in complexity and intensity.

The Five Year Forward View has set out the financial challenge facing the NHS, whilst the LGA have identified a £4bn funding gap facing social care by 2019. **Maintaining the status quo is not a realistic option. Implementing co-ordinated better care is a key goal for all health and care organisations in England.**

Unprecedented system change is needed to meet the health challenges of the 21st century. This demands new responses from whole health and social care systems in order to focus on individual patients and service users. This series of 'How to' guides provides practical support for individuals and organisations grappling with these challenges every day.

Andrew Webster, Director of Integrated Care at the Local Government Association **[click here to view publication](#)**, has set out the key challenges of creating a coordinated service response, built around the individual, that maximises effective use of resources to deliver care seven days a week. The key is coordination of service delivery rather than organisational integration.

The King's Fund report from February 2015 has eloquently highlighted the cost and time that organisations and leaders can waste on structural change.

We know that individual and system leadership, the subject of the first 'How to' guide, is crucial to the success of any large scale transformation. Beyond leadership, the building block of resources and their use is a vital part of any Better Care success story. Linking or pooling resources is a great way to overcome many of the inherent fragmentation issues that have bedevilled the NHS in particular, but have also been a block to progress between health and care services. We believe that the pooling of resources as set out in the Better Care Fund initiative is a signal for a new way of working.

There are encouraging pockets of success in which the health and care system have aligned resources to benefit patients, people who use services and carers. This guide provides insight to these areas of good practice and gives tips for successful local implementation.

There are clearly different approaches even within health systems. This guide provides support to help overcome these differences as well as pointing to the benefits of alignment between the broader health and care system. System-wide leadership to deliver this will be required, but we believe a step change transformation is possible, if incentives and goals for providers are aligned.

Building trust as a key foundation

How to transition to a new way of working together

Better Care requires a new way of working across organisations and between system leaders, with leaders, middle managers and clinicians investing time to build a common vision, narrative and set of objectives, and to develop the relationships and understanding that will deliver long term gain for the population. Such an approach:

- ✓ builds trust
- ✓ begins to demonstrate the benefits of working together
- ✓ shows the added value that a joint approach with a focus on the individual brings

Developing strong foundations may seem self-evident, but is often ignored when the focus quickly shifts to immediate delivery.

Creating a shared vision, objectives and language

A fully transparent approach on agreeing goals and resources are key components of gaining trust. The language used by health and care organisations can often have subtle difference in meaning. It is important to develop a common language, backed up by shared underlying data, to help build one *version of the truth across health and care*. Time should be spend setting out clear goals that all organisations understand and sign up to. In our experience time spent up front on soft levers such as this, will pay dividends later but is often overlooked. Documents such as the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy might be helpful. **Please refer to chapter 06 “Engagement and communications” in ‘How to’ guide Issue 01 “Lead and manage Better Care implementation”.**

Overcoming finance departmental barriers

A particular challenge for finance colleagues is to work across health and care organisations.

The current system is not set up to encourage whole system finance approaches and indeed, the statutory responsibilities of the Director of Finance often work against whole system working. CIPFA recognises that “the game is changing” and their recent publication advocates that finance needs to operate in a different

way to benefit local populations. This is explored in more detail in **Chapter 3.**

Building trust with providers

Another soft lever that can benefit the local system is the **connection between health and social care commissioners and local health and social care providers**. Harnessing the expertise of providers can help to transform care outcomes across the local health economy. In our experience, commissioners (be they NHS or Local Authority) gain more when they work in collaboration with providers to improve outcomes for the population. For example, Nottingham City Council worked with Community Catalysts to develop an understanding of the self-directed care micro market and how to support it. It highlighted the benefits of working with stakeholders and partners in a new way to grow a shared vision through innovative policy-making sessions, and to generally use the creative resources of personnel to come up with new solutions to commissioning challenges. **Click here to view publication.**

Building trust as a key foundation

How to transition to a new way of working together (cont.)

Forming strong relationships across organisations and at all organisational levels

Although funding arrangements are important, there is evidence to show that when undertaking any form of joint commissioning it is **the relationships between individuals and teams** that enables people to work through problems to find solutions. **Click here to view publication** on "Joint commissioning in Health and Social Care: An Exploration of Definitions, Processes, Services and Outcomes".

Staff not only develop loyalty to their organisation but also to their sector. Most people who work in local government or the NHS do so for the majority of their career.

Despite a shared aim of improving outcomes for their respective service users, these organisations work in different ways, as signified by the way in which geography is delineated in their titles (NATIONAL for the health service and LOCAL government). These adjectives describe where the main accountability for resources lies. Local government is accountable to locally elected members whereas the National Health Service is accountable to national organisations and politicians. This means that the first instincts of people who have worked in these organisations, and the governance structures they work to, are very different.

Hence a lot of attention needs to be paid to developing joint relationships. Both parties need to be aware of these differences and work together to overcome them. Further information on how to make joint working a success will be included in the third issue of this 'How to' guide series.



If we are to succeed in integrating health and social care to bring about better experiences and outcomes for people, we need real readiness and commitment to work across organisations, and find better ways to pool our collective resources for better overall value and benefit.

- Dr Jo Farrar, Chief Executive Bath & North East Somerset Council and Spokesperson, SOLACE Community Wellbeing Network Rollin, Strategic Lead for Care and Independence, North East Lincolnshire CCG



Having an integrated commissioning system allows us to begin to shape and mould the whole system around the individual.

- Jake Rollin, Strategic Lead for Care and Independence, North East Lincolnshire CCG

Wiltshire outcomes payment model

Across England, councils provide support to around 500,000 people to live at home with domiciliary support. Wiltshire reshaped its “Help to live at home” service, moving away from the predominant model of commissioning for services on a time and task basis to an approach based on successful delivery of outcomes. The ‘Help to live at home’ service is jointly commissioned with CCG colleagues although there are still separate contracts. Wiltshire built trust with families and carers by engaging with them throughout the development of the new outcomes based payments model and using their ideas to inform the final design.

Wiltshire engaged with people who used services and their families and carers to set out what mattered most to people and what they valued. The process was started by a significant engagement with people who used home care services and their families, as part of a council wide approach to improving outcomes for citizens. There were a number of workshops which identified concerns about quality, consistency and delivery of the current services proceeded by over 90 different agencies. People were involved in setting out what

they wanted from helped to live at home services and these outcomes were agreed as the basis for a new service specification. Workshops were held with health partners, social care staff, social workers and ultimately providers to build relationships, develop trust and jointly design the new service.

These outcomes were worked into a **outcomes based payment model**. The council terminated its existing contracts with over 90 providers and re-procured the service, paying for agreed outcomes defined by the needs of individuals. As a result, the council reduced its number of providers and integrated their own reablement services by transferring their staff to the new providers. Once providers were commissioned, they were heavily involved in developing new ways of working which sees them (rather than the council) undertaking reviews, developing support plans and providing case management support during the first 6 weeks of services that any person who gets referred to ‘Help to live at home’ receives, prior to a longer term assessment which will include a financial assessment.

New providers were involved in defining the way outcomes would be measured and in agreeing how incentives and sanctions would work within the new framework. Staff turnover and continuity was supported by provider contracts covering bigger geographical areas that enabled them to move away from zero hour contracts.

Wiltshire’s defined outcomes, on which payments are based, are about people being able to undertake simple activities of daily life: getting up, bathing, cooking, eating, shopping and maintaining contacts and seeing friends. Outcomes are agreed with the individual and their family or advocates and levels of support are determined by their individual budget allocation. Outcomes are regularly reviewed, and providers are incentivised to deliver those outcomes as efficiently as practicable by being able to retain an element of savings generated. If agreed outcomes are not achieved, the council decides whether the provider was responsible. If this is the case up to 80% of cost is withheld. There is a right of appeal on behalf of the provider when a failure to meet outcomes is determined as their responsibility. Wiltshire Centre for Independent Living and Wiltshire and Swindon

Wiltshire outcomes payment model: cont.

Service User Network are involved in supporting people who use services and in providing feedback on the quality and effectiveness of the service. The service now incorporates all support for people who need intermediate or end of life care.

Contracts are long term 5+2 years and have reduced workforce turnover and improved pay and conditions for home care workers.

Higher satisfaction levels are now being achieved for people who use the service and the council has made significant savings over the cost of its previous commissioning model. Providers are also incentivised to innovate and meet agreed outcomes by thinking about what matters to the individual and their family. This means moving away from a rigid and inflexible approach to costing hours and a task focus, thus improving the practices and performance of home care workers. **Click here to view publication.**

Changing the public accountability for the finance behind person-centred, coordinated care.

Over many years, English public services have been very good at ensuring that there is strong accountability within organisations when they are spending public money. Each different public service organisation is built around its own robust system of governance. Boards, and in particular Directors of Finance, are rightly expected to guard these organisational accountabilities.

Person-centred, coordinated care will only be successful if governance can support **similarly strong financial accountability ACROSS organisations as well as within them.**

Historically, one way of achieving this is pooled budgets which combine funds from different organisations to purchase integrated support and achieve shared outcomes. They enable organisations to build on previous joint working experience in order to fund truly integrated care services. **Clinical Commissioning Groups (CCGs) and Local Authorities will be required to operate a pooled budget from the 1st April 2015.** A defined minimum level of funding must be administered via a pooled budget; funds in excess of that defined minimum level may be administered through a range of options.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to make contributions to a common fund to be spent on pooled functions or agreed NHS or health-related council services. **Click here to view publication.**

The HFMA and CIPFA have produced technical guidance on pooled budgets and the Better Care Fund to assist HWBs. **Click here to view publication.**

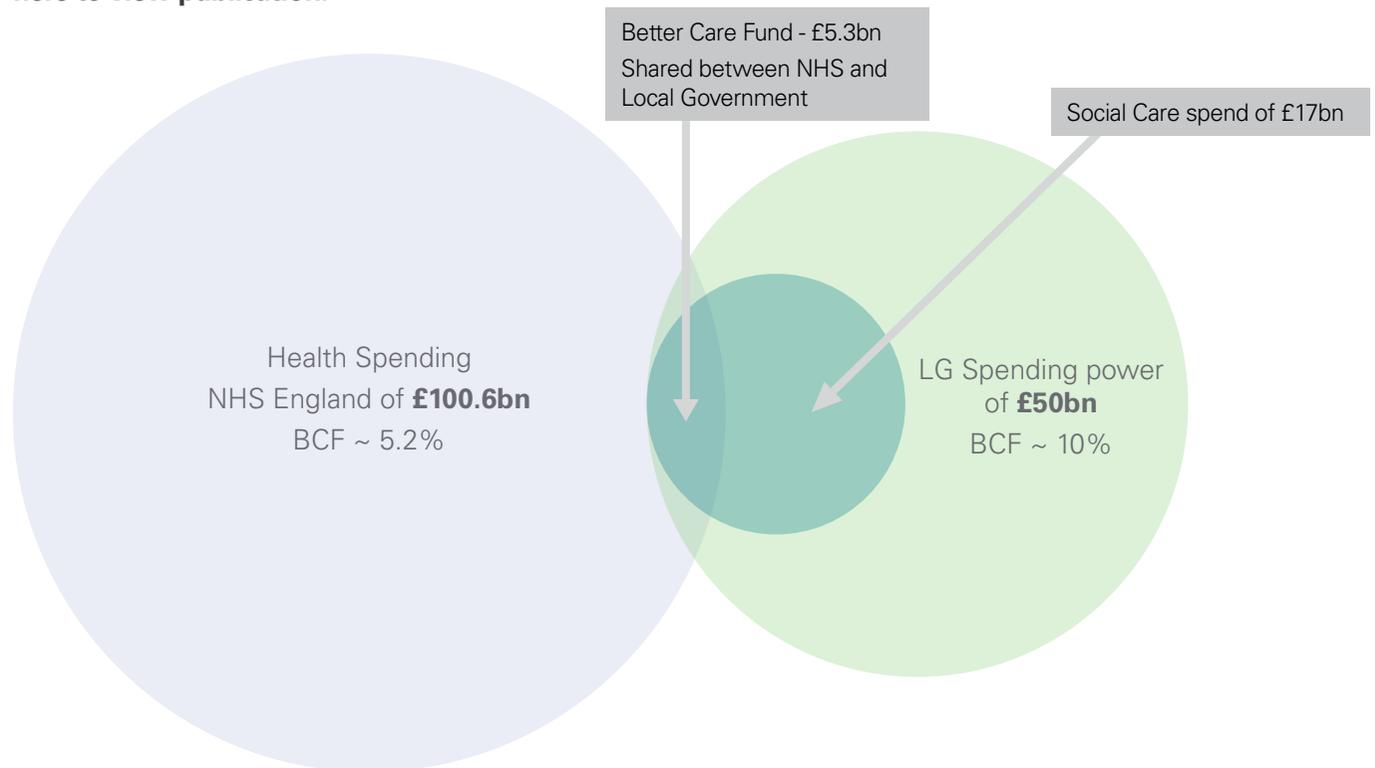


Figure 1: BCF Pooled Funding for 2015/16 as a proportion of total NHS and LG spend

Using joint budgets to develop coordinated care

Pooled budgets provide a solid foundation for integration

Benefits of pooled budgets

- ✓ Pooling budgets between commissioners overcomes the fragmentation of budgets for related services that current health and care systems create – and can be an important step towards integrating services through joint commissioning, joint teams or shared care pathways.
- ✓ Pooling funds can provide the basis for alignment of care providers against the common set of outcomes that coordinated care requires.
- ✓ Pooling budgets can help alignment around the needs of your whole system rather than the needs of individual organisations.
- ✓ Pooled funding (based on section 75 agreements) will potentially get you more ‘bang for your buck’ by reducing duplication and increasing purchasing power.



Our clients and patients do not see our organisational boundaries so we must work together to make sure they don't stand in the way.

The finance team need to work with their colleagues to ensure that the accounting and assurance arrangements are as seamless as the front line services that are provided.

This means getting involved proactively so that all bodies involved in commissioning and providing health and social care services can continue to meet their financial and statutory responsibilities as operational arrangements are put in place.



The Healthcare Financial Management Association (HFMA)

Using joint budgets to develop coordinated care

Case studies: pooled budgets working to deliver improved outcomes

Pooled budgets are not a new concept to health and social care - below are several examples of where **pooled budgets have already been implemented and have delivered better outcomes for patients and people who use services. Some of them go further than the BCF recommendations for localities:**

In **Staffordshire the Council and NHS Trust** have pooled budgets and integrated health and social care services, under a Partnership NHS Trust. Staffordshire and Stoke-on-Trent Partnership NHS Trust has over 6,000 staff, a turnover of almost £400 million and is the biggest integrated health and social care provider in the UK. Underpinning joint arrangements for adult care is a section 75 agreement. The Council and NHS Trust have made a long term commitment to making this new approach work, acknowledging that full integration of services takes time. The agreement began in April 2012 and has a duration of 10 years with a break clause after three years exercisable on to 12 months' notice at the end of year two. **Click here to view publication.**

Torbay Care Trust has pooled budgets for health and social care services ,including a fully integrated model that provides care for the elderly and people with diabetes through a single-point-of-contact co-located MDT system. Care professionals from different organisations sit together in zone teams, and GPs have a single number to call to have all the care coordinated. The case study is used as an example of pooled budgets in the North West London Whole Systems Integrated Care Toolkit. **Click here to view publication.**

Sheffield City Council and NHS commissioners have agreed the biggest pooled fund nationally as part of the Better Care Fund totalling £280m in the first year 15/16, growing to encompass the whole of health and care spend across the city. The shared ambition between the City Council, CCG, the acute trust and other partners has been built on work over several years to get support right first time, and work with children and young people to enable better health outcomes. Their pooled fund is seen as a way of securing best use of the Sheffield budget and of ensuring shared ownership of solutions that break down the organisational priorities which can sometimes prevent the right thing from happening for people and local communities. The governance is worked through under the HWB board and led by a Joint Commissioning Executive co-chaired by the Accountable Officer of the CCG and Richard Mothersole (Chief Executive of the city council). This group guides the work of a number of delivery teams who are responsible for the development of integrated care plans, service specifications and contracting arrangements which are signed off by the Executive in line with the HWB board priorities. The programme has 4 key priorities from joint approaches to prevention and keeping people well, integrated intermediate care, community equipment and support for people with long term high support needs. At present there are not a lot of joint posts but more of a focus on joint working in the delivery teams. **Click here to view publication.**

Using joint budgets to develop coordinated care

Case studies: pooled budgets working to deliver improved outcomes (cont.)

Community Budgets, click here to view publication: This case study provides 'how to' advice as well as examples on whole community budgets e.g. examples of pooled budgets from local government, housing etc. Greater Manchester has developed a set of relationships that are rooted in the economic development of the sub region. The community budgets approach will focus on four areas: early years, transforming justice, troubled families and health and social care. The health and social care budgets for integrated health and social care are pooled around three areas, integrated care, primary care and in-hospital care programmes. The programme is governed by a cross regional Public Services Reform Board with delivery led by a Core Team of co-located staff drawn from health, social care and other public agencies. It shows how health and social care are one part of a much wider set of joint relationships across a sub region. **Click here to view publication. For more information on GMCA and AGMA please click here.**

In developing integrated care in **Scotland**, legislation sets out what has to go into a pooled budget from the Health Board and Local Authority, what is excluded and what may be included. Scottish expenditure on health and social care is £12.3 billion per annum and a minimum of £7.7 billion must be integrated under the new arrangements. In this case study, Alison Taylor - Head of Strategy and Delivery Integration of Health and Social Care for Scotland, discusses the Integration journey so far. **Click here to view publication.**

Click here for more information on integration of health and social care in Scotland.

Click here for a general overview of the aims of integration in Scotland.

Additional information on

- Governance. **Click here to view publication.**
- Functions and budgets that must be integrated. **Click here to view publication.**
- Finance guidance
 - **Click here to view publication 1.**
 - **Click here to view publication 2.**
 - **Click here to view publication 3.**

Using joint budgets to develop coordinated care

How to share risk between commissioners

Risk sharing guidance and examples

By its nature, a successfully pooled budget requires an agreed allocation of risk between the associated parties.

The general principles for risk sharing are:

- The financial impact of unpredictable incidences on system wide deliverables should be shared proportionately, dependent on the scheme and service, amongst the parties to the agreement.
- Where the impact of unpredictable incidents may be so financially significant that individual bodies could be at financial risk, the parties need to work together to mitigate the risk and its impact.

NHS England has written guidance which provides additional support on the risk sharing for the Better Care Fund. **Click here to view publication.** This covers the financial, operational and quality risks and should be read by operational and finance leads.

Monitor have developed guidance on the appropriate allocation and management of risk in its publication Reforming the payment system for NHS services: supporting the Five Year Forward View – pages 6 & 7. **Click here to view publication.**

An example of a risk sharing agreement can be found from Reading Council, North and West Reading CCG & South Reading CCG. **Click here to view publication.**

This key areas covered in the document are:

1. Scope of agreement
2. Risk categories - Financial risk, delivery risk, performance risk and reputational risk
3. Risk management framework & governance arrangements
4. Accounting arrangements (including the pooled budget responsibility)

Using joint budgets to develop coordinated care

Checklist

How do you get the best out of pooling budgets?

- Consider and agree the **aims and objectives** of the pooled budget – including multiple perspectives such as the requirements of the Health and Wellbeing Boards
- Establish the partner organisations that need to be involved
- Clarify the **services in scope** and establish the **required size of the budget**
- Familiarise yourself with the **legislation and funding streams** surrounding the pooled budget
- Develop an **understanding of the risks** attached – both to individual partners and to the pooled budget itself
- Develop a joint funding agreement including:
 - **agreed aims and outcomes**, outlining the relevant functions covered in the arrangement
 - **identification of the host partner**, who will lead on the delivery of the arrangement
 - agreement on how the pooled budget will be **managed**
 - agreed **governance and reporting** arrangements
 - clarity on respective **financial contributions** and other resources provided in support of the partnership (but not necessarily part of the pool)
 - the **duration of the arrangement** including the provision and mechanisms for annual review, renewal or termination of the arrangement
 - technical matters such as treatment of VAT, legal issues, complaints, disputes resolution and risk-sharing

Further reading

Pooled budgets must be soundly based and follow the appropriate accounting arrangements. In the Better Care Fund (BCF) Support and Resources Pack for Integrated Care (NHS England) you can find out more information on what section 75 pooled budgets are, what is required to make them work effectively, other joint financing options, general considerations, what should be included in partnership agreements (which are essential and need to cover e.g. governance arrangements and technical matters), alongside some further references. **Click here to view publication.**

The VAT rules surrounding the Better Care Fund are complex and will depend on the particular arrangement set up in your area. It is anticipated most arrangements will fall under historic guidance issued by HMRC in relation to pooled budgets – **please click here**. While this guidance is fairly old, HMRC have confirmed the basic principles outlined can be applied to the Better Care Fund. If the arrangements in your area don't fall under either Partnership A or Partnership B outlined in the document, advice should be sought from HMRC.

If your NHS entity has a "Customer Relationship Manager" please contact them in the first instance. If not please use one of the following methods of communication -:

- Online – fill out the web query form. **Click here to view form.**
- Telephone – 0300 1231081 (lines available between 9am – 3pm Monday to Friday)
- Post – HMRC Local Compliance, Public Bodies Enquiries S0927, PO Box 3900, Glasgow, G70 6AA

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*Despite being new, Health and Wellbeing Boards are expected to deliver new, person-centred, coordinated models of health and social care to replace the current service fragmentation. Some will feel able to immediately move to capitation funding for a section of their population, others will want to spend the budget they are pooling as a block budget. **It is important to move at the pace that feels right in your locality.**”*

Paul Corrigan

The NHS and local government have been used to paying for specific services rather than the delivery of outcomes. These largely episodic payment systems have played a significant role in underpinning historically fragmented services. **Developing person-centre, coordinated care will require new payment systems.**

Health and Wellbeing Boards (HWBs) are at different stages of on this journey. There is often a desire to move towards **capitation payment models** across health and social care, and there are encouraging signs that some sites are moving towards implementation. Examples include Population Level Commissioning for the Future **Click here to view publication**, which discusses the Long Term Conditions Year of Care Model and the Symphony Project in South Somerset **Click here to view publication**. Both of these examples looked at bringing the finances of different parts of the health and social care system together.

There needs to be an understanding that payment systems are only one of many levers that can be used to achieve change. Creating strong foundations, based around strong relationships and pooling of budgets, will be the first steps to enable the development of more sophisticated payment methods in the future.

“

We think person-centred, coordinated care is essential when thinking about the redesign of health and social care services locally. This requires coordination across multiple stakeholders at strategic and operational levels, supported by national partners, with a view to fairly sharing the benefits and risks. At Monitor we're keen to allow flexibility for new care models to emerge and this includes developing a more flexible and adaptable payment system that encourages shifts to more integrated service delivery, and helps to ensure the sustainability of services for the benefits of patients.”

Catherine Pollard, Pricing Development & Integrated Care Director, Monitor

Once the budgets have been pooled, the following different payment models can be applied within the context of integrated care.

Using the North West London toolkit [Click here to view publication](#) and payment system guidance by the World Bank [Click here to view publication](#) as a guide, we appraise the three most applicable payment models that HWBs should consider when incentivising integrated working across health and social care systems: block contracts; bundled payments and stratified population capitation.

1. Block contract model

As a starting point, commissioners could use a block contract(s) to cover multiple providers. This funding arrangement could put in place block contracts with one or more providers to provide a service (or set of services) for a set period of time. This encourages provider productivity in meeting service outcomes for the lowest cost. In this system, commissioners transfer the risk to providers if more people require services than planned. Block contracts can be viewed as a crude payment mechanism, but can be an appropriate starting point to enable honest conversations around the scope of the joint health and social care activity covered by BCF agreements.

- ✓ Pro: If managed correctly, providers have an incentive to manage demand for their services and improve productivity.
- ✓ Pro: The contract is buying joint provision.
- ✓ Pro: Providers can be innovative in designing and delivering services to meet required outcomes.
- ✗ Con: Providers may respond to the incentive by reducing the availability of the service or by attempting to shift demand to providers of other services. Careful management of outcomes is required to ensure the incentives work appropriately.

✗ Con: Historically, establishing block contracts has not created or encouraged increased transparency over costs and activities.

✗ Con: A concern with block contracts is that the value of the contract may get out of sync with the costs of care – either due to changes in volumes, or casemix, or in treatment protocols – which means that they need to be managed correctly.

2. Bundled payment model

A bundled payment (or pathway payment) is a single payment for a group of services relating to a treatment or condition. This can involve multiple providers in multiple settings. A provider, generally operating under a 'prime provider' or 'accountable provider' model, is paid a fixed fee for a defined bundle of services surrounding an episode of care. An episode of care is a complete pathway for a particular condition, usually including all pre- and post-care as well as a provision for complications. An example for a bundled payment for a hip or knee replacement would include any consultations preceding the operation, the procedure itself, rehabilitation as well as any required readmission.

- ✓ Pro: Bundled payment is usually based around a condition or treatment, which discourages unnecessary care, encourages coordination across a particular pathway by the accountable provider, and potentially improves quality.
- ✓ Pro: It can be combined with other payment models like capitation. For bundled payments to make sense from the patient's perspective you generally need to be sure that either their pathway based care needs are self-contained (e.g. maternity, certain life-long conditions) or where the costs of managing the condition obscure everything else (e.g. active cancer treatment). This is because you need to be able to cover the maximum feasible scope of care in order to make significant dynamic and allocative efficiencies, and to account for the make the set up / transaction costs.

Selecting the right payment models

Evaluating the options against different payment models (cont.)

- ✗ Con: While it can help to control costs, it does not incentivise prevention to reduce overall volume, if payment is on a pure activity delivered basis. Many models that have been implemented in the past have seen providers trying to extend hospital care.
- ✗ Con: To work effectively, a bundled payment model requires an extended data system and is often problematic trying to link records across providers.

As bundled payments can be linked to the capitation model, this may be an evolutionary step when moving in that direction. Issues around data linkage, joint governance arrangements, sharing benefits / risks and contracting arrangements may be identified at this stage. However, studies have shown that this payment to model is of limited effectiveness for elderly patients with multiple conditions (a key targeted population group for most BCF plans).

For bundled payments to make sense from the patient perspective you generally need to be sure that either their pathway based care needs are self-contained that they can be easily carved out of the rest of their care needs (e.g. maternity, certain life-long conditions) or where the costs of managing the condition obscure everything else (e.g. active cancer treatment). This is because you need to be able to cover the maximum feasible scope of care for significant dynamic and allocative efficiencies to be made, and to make the set up / transaction costs worthwhile.

3. Stratified population capitation model

A capitation payment model includes a fixed price paid per individual over a defined period of time for a range of services. This encourages providers to meet care needs in the most efficient cost settings and coordinate to minimise unnecessary duplication.

- ✓ Pro: Encourages coordinated, preventative care that keeps people well at home and avoids unnecessary high cost care.
- ✓ Pro: Encourages HWBs to segment their populations and risk stratify them, developing a better understanding of need in the area which can in turn help to ensure that services are better planned and delivered. Link to How to Guide on Population Segmentation, Risk Stratification and Information Governance **Click here to view publication.**
- ✓ Pro: Providers have the incentive and flexibility to innovate and allocate their resources to achieve the greatest efficiencies so that they can share in savings realised.
- ✗ Con: Requires significant capabilities, in particular the ability to coordinate between professions and information systems that can track an individual's activity and costs across many organisations. Many areas are in the process of developing the infrastructure to support this model of payment.

- ✗ Con: There is a large incentive to restrict access to care or "cherry pick" patient cohorts, which commissioners must seek to prevent through appropriate contractual requirements and compliance processes which they must carefully monitor.

Monitor has published guidance to support HWBs in implementing a capitation model. **Click here to view publication on "Capitation: a potential new payment model to enable integrated care".**

Monitor has signalled capitation as the direction of travel for integrated care. This is highlighted in their long-run payment system strategy, *Reforming the payment system for NHS services: supporting the Five Year Forward View*. **Click her to view publication.**

Suggested Further Reading

Cobic is an innovative organisation that provides strategic, commercial and clinical consultancy to the health and social care sector. They have pioneered the development of capitated outcomes-based incentivised commissioning (COBIC). **Click here to view publication.**

The development of person-centred, coordinated health and social care services **radically shifts the focus for commissioners from the traditional approach of contracting separate providers for episodic activity, towards achieving a pathway which leads to outcomes for the individual.** In the traditional contracting model, each provider is accountable for the episodic care that they provide. No one has accountability for or visibility of the whole cycle of care. However, to successfully provide a coordinated pathway of person-centred health and social care, the accountability for delivering outcomes and the drive to reduce costs needs to be joined up, which in turn will require existing contracting models to change. Commissioners must, however, be aware that they must operate within existing regulatory requirements governing commissioning responsibilities and powers, forms of commissioning contracts, delegation and pooling of budgets, and within procurement rules. They should take expert legal and procurement advice where necessary.

This section explores the development of different coordinated models of care through a range of case studies. In not every case has it been considered necessary or appropriate to run a competitive procurement exercise in order to put into place a new model of care.

“
As commissioners of health care at both a national and local level, we want a commissioning architecture that gives people the best possible opportunity to achieve the outcomes and commissioning models that align incentives for those people that provide care with the outcomes that matter most to the population we serve.”
- Ros Roughton, National Director, NHS England
[Click here to view publication.](#)

“
We must ensure that people who use services, patients and citizens are in receipt of person-centred, coordinated care. Commissioning must focus on making available a range of services to help achieve people's best outcomes. These will promote prevention and wellbeing, improve quality of life and reduce the need for crisis treatment, care or support away from home. However we decide locally to join up our budgets and commission services together, our aim is to make ensure that our money stretches as far as it can in helping people to live well.”
- David Pearson, NH Corporate Director, Nottinghamshire County Council and President of the Association of Directors of Adult Social Services

Some areas have developed a model of joint commissioning for health and social care provision, but others have developed a joint accountability between existing providers and commissioners that supports new coordinated provision. Refer to the following presentation on the decision not to procure in South Kent. **Click here to view publication.**

Some commissioners create change through novel contracting models and commissioning tools, which are used by local authority and NHS commissioners to drive transformational and sustainable service integration. Others bring all the main players across the systems together (commissioners and providers) to share experiences, learn, jointly develop and implement better care for individuals.

Depending on where you are on the journey to integrated commissioning, you may need to take different steps. Example case studies show that it takes a number of years for programmes deliver the intended transformation. Contractual vehicles do not replace the need for continuing to work at cementing local relationships to ensure that there are strong foundations. **See Section 2.**

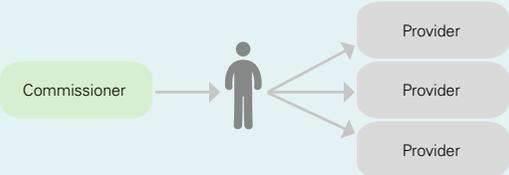
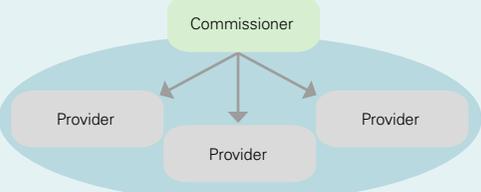
For more information please refer to:

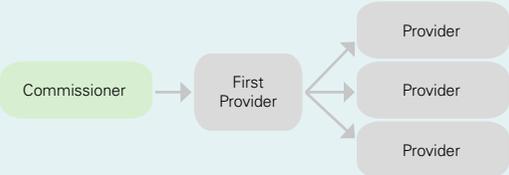
- Commissioning and contracting for integrated care. **Click here to view information.**
- Contracting for outcomes. **Click here to view information.**

Contracting options to enable integration

Evaluating different contracting options

The approach and contract model will ultimately depend upon the local partnerships, provider landscape, existing partnerships and required outcomes. How radical the joint commissioners need to be should be clearly established at the outset, as well as an understanding of the complexity of the service(s) involved. The more challenging the services, the more complex commissioning a single pathway model becomes. There are several procurement and contract type approaches for commissioning for outcomes. The main ones are listed below:

Contracting option	Characteristics	Criteria for use	Case Study
<p>Personal budgets</p> 	<p>A personal budget can be allocated to an individual to purchase the services that are believed to be best suited to achieve the desired outcomes.</p> <p>Local government has created over 400,000 individual social care budgets through which individuals and their carers have been able to choose and - in many cases - employ the care that they know is required. This puts the individual in complete of commissioning of their own care around their own pathways of need. In February 2015, NHS England have also promoted this contracting model through personal health budgets.</p> <p>Click here to view publication 1. Click here to view publication 2.</p>	<p>Individuals' needs are amenable to a range of provision and there is extensive choice in the market. Care needs are not complex and can be understood by people who use services.</p>	<p>Kent Council and CCG</p>
<p>Federation</p> 	<p>Individual commissioners hold contracts with a range of providers. Providers work together (either formally or informally) and have joint responsibility for the delivery of outcomes.</p> <p>Whilst most health and social care providers are used to providing services separately, they recognise that different organisations pick up the subsequent aspects of care when their intervention ends. For example, a hospital whose patient has their discharge delayed, will recognise that there is a need for care at home to enable the discharge to take place. A federation develops, when these providers recognise that they have to work together, despite the fact that different contracts for episodic services are held by the commissioner.</p> <p>Click here to view publication.</p>	<p>Suited to complex care across a number of settings but predominantly used to deliver within one sector such as health or social care.</p>	<p>South Worcestershire</p>
<p>Alliance</p> 	<p>A number of commissioners (can be from different sectors) are jointly commissioning services either from a single provider, a federation of providers, or a prime contractor.</p> <p>An alliance contract places such a federation on a collective contractual basis where joint commissioners hold a single contract for all providers. Providers agree to share the risk for joint activity and collectively hold a single contract for a coordinated pathway of activity. This contract places a premium on the capacity of the organisations to work together. If they are able to share their collective and individual contractual risk, they should be able to create coordinated care for their different episodic interventions. Click here to view publication.</p>	<p>Best used when a range of services from different sectors are required to deliver specified outcomes for a defined patient group or range of conditions</p>	<p>Salford</p>

Contracting option	Characteristics	Criteria for use	Case Study
<p>Prime Contractor</p>  <pre> graph LR C[Commissioner] --> FP[First Provider] FP --> P1[Provider] FP --> P2[Provider] FP --> P3[Provider] </pre>	<p>The commissioner has one contract with one provider who then sub-contracts services to other organisations to deliver specified outcomes.</p> <p>Joint commissioners hold a single contract with one provider who has the accountability to provide outcome based pathway of care through a range of other providers with whom it subcontracts. The accountable provider will then have complete responsibility to ensure that all individual providers provide care that joins into a complete pathway. In other industries this is called a supply chain manager. Click here to view publication.</p> <p>The difficulties of developing this approach are outlined in the case study.</p>	<p>Can be used for commissioning care for cohorts of patients with comorbidities such as older people</p>	<p>Oxfordshire CCG</p>
<p>Single Contractor</p>  <pre> graph LR C[Commissioner] --> P[Provider] </pre>	<p>A single contract is held with one provider who delivers services that, on their own, achieve a specified outcome.</p>	<p>Suited for very specialised highly complex services</p>	<p>Isle of Wight CCG</p>

Personal Budget case study

Kent Council and CCG

For personal health budgets as well as for social care budgets, evidence suggests that **people get better outcomes when they have input into how their budget will be spent**. In Kent this meant developing a joint approach across health and social care and creating single point of contact for advice so that individuals could access holistic support. The Council and CCG have also adopted the same payment processing systems and aligned monitoring timescales to ensure a consistent approach.

[Click here to view the whole case study.](#)

[Click here to view main reference for personal budgets in social care.](#)

[Click here to view main reference for personal health budgets: Personal Budgets Toolkit.](#)

Federation case study

South Worcestershire GP Federation

South Worcestershire GP Federation was set up to strengthen primary care in the area and help practices to generate new income streams and reduce costs. All 32 practices within the CCG are now signed up to the Federation, which works closely with the CCG to ensure the delivery of the CCG's vision for primary and community services. Successes to date include working with drug companies to more effectively source and utilise the support on offer, such as a diabetes nurse, and securing income to fund the overheads of the company through the provision of dermatology and ENT services across the CCG.

[Click here to view publication.](#)

Alliance case study

Salford

Salford Royal NHS Foundation Trust, Greater Manchester West Mental Health NHS Foundation Trust, Salford CCG and Salford City Council formed an alliance, bringing together commissioners and providers to enable the provision of more integrated care and services and to share risk. These four statutory organisations, who have a strong history of partnership working, embarked on a programme to integrate support for older people, developing a new model of care which focuses on the transformation of services for people aged 65 years and older. The agreement began in October 2014 and initial insights are that:

- **Existing contractual and payment mechanisms are acting as a potential barrier to integrated care**
- Designing new models of integrated care will mean looking at **suitable contracting vehicles and payment arrangements** to support these

[Click here for more information on Salford Integrated Care Programme – Memorandum of Understanding in relation to the development of an Alliance Agreement.](#)

Prime Contractor case study

Oxfordshire outcomes-based commissioning programme

In response to a challenging financial position, fragmentation of provision and the commissioning budget following the Health and Social Care Act 2012, Oxfordshire CCG's approach was to opt for a single provider or consortium (prime contractor) to deliver care for specific patient populations. **Outcomes-based commissioning** relies upon **alignment between clinical outcomes and commercial aspects of the contract**.

Following discussions and feedback from patients, the public and partners in health and social care, Oxfordshire CCG has been progressing a new form of contract **to deliver improved outcomes for patients and greater financial stability for the health economy** called outcomes-based contracting.

The aim is to drive change by focusing on outcomes that matter most to patients rather than on activity, and in doing so improve integration and reduce costs. It was agreed that the top priority was 'older people' as it was identified that care of people greater than 65 accounted for greater than 50% of spend and it was agreed that there was 20% wastage in the system from delivering poor value care. Phase 3 of the work will see outcomes based commissioning being developed and enacted for Older People's and Mental Health Services.

For more information click here.

Single Contractor case study

Isle of Wight CCG, Isle of Wight NHS Trust and Isle of Wight Council

The Isle of Wight has the only combined hospital, ambulance, community and mental health services in the country. It is the largest off shore island in England with a population of 140,000, 24% of whom are over 65 years old. The Isle of Wight's population is older than the English average and the number of people in the island aged over 65 with a long term condition is expected to increase by 64% by 2033. The single contractor option was chosen to help deliver integrated care due to the small population size and geographical area.

Currently, the IWCCG has joint commissioning arrangements in areas including domiciliary care for learning disability clients, community equipment and a joint commissioner for carers in place. It follows an **Any Qualified Provider (AQP) procurement process** which enables providers to qualify to deliver a specified service for a given price. Any provider who meets the qualification criteria can provide the service. This process is used to enable patients to have a choice of community services provider, where quality has been assured and the provider has a contract which is awarded with the NHS.

Click here to view publication.

Contracting options to enable integration

Checklist

Developing contract mechanisms

- Develop, identify and agree a **range of integrated models for contracting** that capture the **local commissioning intentions**
- Identify **appropriate** incentives
- Review terms and conditions to **ensure contracts will drive the right behaviours**
- Identify and agree **risk sharing** arrangements
- Develop an **implementation plan** for contracting
- Ensure **appropriate compliance** processes are in place
- Develop and implement a **contracting monitoring framework**
- Review performance** on a regular basis and take correcting actions if required
- Develop a **procurement strategy** to help establish the approach to delivering procurement activities, including objectives and key initiatives. The strategy should provide information on expenditure, procurement structures and regulatory considerations as well as a statement of commitment about how the organisation will deal with all potential suppliers. **Click here for more information on public sector procurement**

Introduction

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Contracting options to enable integration

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The Better Care Fund

