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**Capitation-based budgets are seen as the best way to drive integrated services and underpin new models of care being developed in vanguard sites. Steve Brown reports**

Work in Mid-Nottinghamshire to transform its model of care got underway long before the area was awarded vanguard status by NHS England. However, the central support and profile has helped to accelerate development and put in place key strands of its new integrated care system. It is also one of the areas to have made most progress with a new capitation payment system to underpin the new way of working. In fact, it is just one of a number of sites that will run capitation systems in shadow form this year.

Mid-Nottinghamshire (or, to be precise, the population covered by Mansfield and Ashfield and Newark and Sherwood clinical commissioning groups) started developing its new model approach as part of its 'Better together' programme three years ago. Patients, the public and clinicians had identified a reactive system that operated in silos, was difficult to navigate and where referral times and waits could be lengthy. It was also recognised that the system was simply not sustainable – heading towards a funding gap of £140m (estimated at the time) within 10 years as a result of a rising and ageing population.

The collaborative approach, including an alliance of local providers, the two CCGs and the county council, is now an NHS England integrated primary and acute care system, one of nine so-called PACS sites among the 50 vanguards.

New models of care are being implemented across all of the programme's focus areas – proactive (long-term conditions) and urgent care; planned care and women's and children's care – although the most eye-catching changes so far have been for proactive and urgent care.

## Integrated community network

At the heart of the new model is an expansion of integrated community services across Mid-Nottinghamshire. Using risk profiling, the top 2% of the population at most risk of hospital admission are identified and supported by multi-disciplinary integrated teams (and crisis support). The aim is to avoid admissions and improve levels of self-management.

In urgent care, GP and accident and emergency services have been integrated so that there is now a single front door to both primary care and emergency care services at local accident and emergency and minor injuries units. Combined with changes to processes at Sherwood Forest NHS Foundation Trust and changes in how patients are discharged, this has been a huge success. The trust moved from the bottom five in terms of the A&E four-hour wait to top quartile in about nine months.

Marcus Pratt, associate chief finance officer for both CCGs involved, says you need the care model in place before you can turn attention to payment. 'Otherwise you are just shifting financial risk around the system,' he says. But payment is an important component to making the system work and the vanguard is one of six sites leading the way in developing new payment systems. These sites (see box) will shadow-run their funding mechanisms during this year, with some potentially starting 2017/18 with the new payment systems in place.

Current incentives do not support the changes the health economy has made or wants to make to care delivery. If the new model works, there should be a shift of care out of hospital and into the community. Yet in some instances, tariff continues to incentivise increased acute activity. 'And in the community sector under a pure block contract, the incentive can be to look solely at internal organisational efficiencies as much as possible and not necessarily focus on what the best outcomes are for the system,' says Mr Pratt. 'So, as a system, we want to create a payment mechanism that gets everyone working together for the same goal and takes away those potential perverse incentives.'

The alliance, involving the commissioners and their seven provider organisations, is crucial. Commissioners continue to have contracts with individual organisations for the delivery of services, but a new alliance contract (based on the NHS England standard alliance contract) brings everyone together around common goals and sets out the payment approach. With one element of the new payment approach live in 2016/17 (an outcome-based payment), individual organisation contracts effectively point to the alliance contract for this payment.

Mr Pratt says having a forum for senior finance leaders to come together through the alliance has been key to driving the programme forward. 'The alliance members have been keen to ensure the payment mechanism is co-designed by all parties to ensure full sign-up and to keep a focus on what's best for the system,' he says.

However, the full capitated payment approach will have three elements. The first is a fixed element for each provider based on planned activity and commissioner spend. This is adjusted for inflation, population changes, efficiency and the impact of shifts in resource usage from, say, acute to community as a result of the new delivery model.

The second – unique to Mid-Nottinghamshire and not reflected in

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national models – is a variable element the vanguard believes will support patient choice. 'In our alliance, we have multiple acute providers and we need to acknowledge some money should follow patients if they choose treatment by one provider rather than another, because of preference or the perceived quality of services at those providers,' says Mr Pratt.

So this is not just a marginal element for any additional activity above the activity assumptions in the fixed payment, but something to fund changing patient flows – for example, due to patient choice. The actual mechanism had not been finalised as *Healthcare Finance* went to press, but it could involve payments linked to changes in the percentage share of activity of the acute providers, perhaps operating with a cap and collar mechanism.

A third element will link payment to outcomes and is already live in 2016. The stand-out feature of this payment is that it is an all-or-nothing mechanism. Either all of the partners receive it, if the outcomes are achieved, or no-one receives it. This provides a financial incentive for all partners to work together to plan and implement initiatives and meet the system outcomes.

The scheme was co-designed by all alliance members and is set at 1.8% of contract value for each alliance provider. It is paid on the achievement of a set of outcomes and in this year is a variation to the CQUIN incentive scheme. This gives all alliance members a direct interest in the achievement of the overarching system goals and activity targets – reducing the potential for parochial financial self-interest.

Overarching this whole three-part payment is a risk and reward mechanism that attempts to align financial incentives across the whole health economy to ensure alliance members are acting in the best interests of the patient and the system as a whole. (National models for

## Linked data benefits

Tower Hamlets Clinical Commissioning Group has been working towards more integrated services for several years. In September 2013, it set up local integrated community health teams to support high-risk patients – those with the most complex needs were a key focus for attention, often older adults with long-term and multiple conditions.

Its planning document for 2013-2016 said these patients accounted for about 80% of the CCG's spend on hospital care, often the result of avoidable emergency admissions. These patients were also frequent users of GP, community and social care services.

More integrated care was identified as a way of improving the response for this group. The CCG's involvement in the multispecialty community provider vanguard to create an integrated provider partnership is a way of accelerating these developments. The vanguard – 'Tower Hamlets Together' – also includes Tower Hamlets GP Care Group Community Interest Company, Barts Health NHS Trust (acute and community services), East London NHS Foundation Trust (mental health and community) and London Borough of Tower Hamlets (social care), although the aim is to broaden this to include local voluntary and community sector organisations.

The integrated model includes initiatives to improve continuity and patient-centredness, such as the use of care navigators (embedded in multi-disciplinary community teams), rapid response and discharge support to support the area's high-risk patients. CCG strategic development manager for payments and incentives Mary Mulvey-Oates says the model works well, but adds: 'We have got to a certain point, but one barrier to progress is how the payment system works.'

The vanguard is helping NHS England and NHS Improvement think through how payment


arrangements can be put in place to support new care models. While the centre has been thinking through creating capitation budgets based on whole populations, Tower Hamlets has begun shadow testing a baseline budget for a specific cohort of patients.

This creates extra challenges. While it is fairly straightforward to identify acute spend at patient level, this can be harder for community, mental health, social care and primary care spend.

It is early days, but the vanguard has the advantage of a well-developed patient-level linked data set, which includes detailed primary care data such as appointment types.

This opens up the possibility of breaking down overall commissioner spend into spend on different patient cohorts, which might provide a way forward for setting a budget for the integrated partnership. Key decisions have yet to be taken and the CCG is keen to engage further with its clinical community to develop its approach.

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capitation include risk and reward as one of the three elements alongside fixed and outcome-based payments.)

The CCG has invested in the integrated community teams in its contract with its community and mental health service provider, Nottinghamshire Healthcare NHS Foundation Trust. Under old rules (and during the transition this year), the CCG is taking the risk of the upfront investment (supported by vanguard funding). If the investment does not lead to the expected reduction in acute emergency admissions written into acute contracts, it will continue to pay for the 'extra' acute activity undertaken by its acute providers (under existing marginal rate rules). But there is also risk in the acute sector where marginal tariff income may not cover the increase in planned costs.

## Shared risk

In future, the costs of exceeding the planned levels will be shared. 'If the model fails, we will share the risk across all the alliance partners that can influence the planned target – in this case, the acute providers, the community provider and the CCG,' says Mr Pratt. This will be done in a planned way rather than using an arbitrary marginal tariff percentage.

Another good example is with high-cost drugs. With current pass-through payment arrangements, there are no financial incentives for acute providers to minimise the use of high-cost drugs where there are more cost-effective generic drugs available. The hit is taken by the commissioner, but all the influence lies with the acute provider. But new risk and reward plans could see savings made from increased use of appropriate generics shared between the provider and commissioner.

With the planned payment mechanism nearly finalised, a big task has been calculating the right capitated budget to start with. This is a whole population budget – preferred by NHS England and NHS Improvement over budgets targeted at specific sub-segments of population as they are seen as offering 'greater opportunities to integrate care and incentivise prevention' and because they 'mitigate the impact of random cost variations, which cannot be controlled by the budget holder'.

For Mid Nottinghamshire, population – the combined registered populations for the two CCGs – is relatively straightforward. There have had to be adjustments with social care (who have services in scope of the payment mechanism) as the boundaries are not quite co-terminus with the local authority.

In terms of delivery of health and social care in Mid-Nottinghamshire, all services are in-scope and there is a desire to bring as much as possible into scope of the payment mechanism over time. In the short-term the local priority has been identifying a subset of services based on urgent and proactive care that will form a shadow capitation budget from July.

**"Even those without linked data can come to a view on their WPB and then increase their understanding of population and activity"**
**Alex Guite, NHS Improvement**

For acute services, Mr Pratt says identifying current payments on the population was straightforward, thanks to the tariff system. The spend on new integrated teams to deliver community services was also easy to identify and adult social care has been included with the exception of personal budgets. Continuing healthcare is currently not in scope due to commissioning and risk-sharing arrangements across the whole county, which is a wider population than the vanguard.

Prescribing is seen as critical as different levels of prescribing could affect acute activity – optimum prescribing could avoid admissions or reduce length of stay. While the vanguard remains keen to bring it in scope in future, it remains out for purposes of shadow running. This is because although primary care has a seat at the alliance table, it is not a formal part of it. Also, there is a lack of detailed data at patient level.

In general, primary care is seen as central to multispecialty community

## Capitation explained

'There's lots of international evidence that outcome-linked capitation budgets are a reliable form of payment to align incentives for integrated care,' says Alex Guite, pricing development lead at NHS Improvement (right). 'That makes them particularly relevant to multispecialty community providers (MCPs) and primary care acute care systems (PACS).'

It comes in two flavours – with budgets covering a whole population or targeted at a specific sub-segment – and it is a whole population approach that NHS Improvement and NHS England are focusing support efforts on. A draft payment systems handbook says whole population budgets (WPBs) offer 'greater opportunities to integrate care and incentivise prevention and mitigate the impact of random cost variations that cannot be controlled by the budget holder'.

WPBs are the preferred approach for anyone making new moves towards capitation budgets, but the two bodies are happy for local areas already pursuing the more targeted budgets to continue.

A whole population budget covers the population of an area – rather than a particular age group or pathway. This leaves the task as identifying the services that are in scope and their related funding, rather than trying to carve funding up between different parts of a population.

Most people's contact with capitated budgets would be with commissioner allocations, where budgets (or at least target allocations) are created using a weighted capitation approach – each area's population is weighted to reflect its make-up in terms of age and relative need, then each 'weighted' head attracts the same proportion of the total national allocation to CCGs.

But whole population budgets come at capitation from a different starting point. You still get a budget to provide the agreed services – though they may be defined in broad terms – for a specified population, with the baseline budget initially created on the basis of existing spend on the services deemed as 'in scope'. What differentiates this from a block contract are elements of payment linked to outcomes (typically for the whole health economy) and a mechanism to share financial risk across all the commissioners and providers involved.

In contractual terms, this may involve a contract between a commissioner and a lead provider and sub-contracts between the lead provider and other providers. Or, as in Mid-Nottinghamshire (see main feature), it could involve a contract with a provider alliance, underpinned by commissioner-provider contracts.

Identifying spend for a WPB is relatively straightforward for in-scope acute services as spend on the secondary uses service database can show relevant activity and this can be calculated at current prices. Block contracts for community, mental health and social care services – and identifying the spend on in-scope primary care services – can be more challenging. It may involve estimates, weightings or the use of provider costs. NHS Improvement and NHS England's WPB handbook will contain guidance on identifying in-scope spend when it is published in the autumn.

So there is no per capita amount as such – and 'the policy direction beyond WPBs is not set yet', says Mr Guite. But he expects commissioners and providers to challenge the appropriateness of historical spend levels and make adjustments for efficiency and inflation.

Patient-level data sets – linked across different providers – will play an important role, but the lack of them shouldn't be seen as a barrier to progress. 'Sites with better data can make faster progress and make more nuanced, granular and robust approximations and forecasts for their budgets,' says Mr Guite.

'But even those without that linked data can make progress and come to a view on their WPB and then increase their understanding of population and activity over time. In fact this better understanding of population and services is a good initiative in itself.'

providers and integrated primary and acute systems. However, at the moment in Mid-Nottinghamshire, core primary care services are outside the scope of the budget, but enhanced services are in. The vanguard is also keen to include mental health services.

However, it is not straightforward to deconstruct the existing block contract to identify those services that directly align with urgent and proactive care. The work done around clusters has provided a way in and so certain clusters have been included, even though there is recognition that this doesn't fully align with the intended scope. For example, all dementia services have been included.

In total, around £100m of services are expected to be in the shadow budget – nearly 20% of the combined CCG (£450m) and social care (£100m) budget. Mr Pratt says the shadow running will provide insight into how the system can work together to deliver shared goals. He admits that the current finances in the NHS add to the challenge.

The capitated budget is set on the basis of commissioner spend not provider costs – as this represents the money available to the health economy. But he says the reality locally and across the country is that there are widespread deficits, particularly in the acute sector. So there may need to be some form of transition to a truly capitated budget to ensure financial sustainability in the short and long-term – and everything has to align to the overarching sustainability and transformation plan.

Mr Pratt says the financial position also provides extra incentive. 'It is a burning platform,' he says. 'We clearly need to do something differently to cope with pressures now and those that will arise from demographic change in the future. By working across organisations and aligning the system and incentives around the same goal, we have the best shot at delivering the right services and reducing cost.'

## Intensive payment sites

**Multispecialty community providers**

- Tower Hamlets Integrated Provider Partnership
- Dudley Multispecialty Community Provider
- Encompass (Whitstable, Faversham and Canterbury)

**Integrated primary and acute systems**

- Mid-Nottinghamshire Better Together
- Northumberland Accountable Care Organisation
- My life a full life (Isle of Wight)