# new payment model

**A new capitated budget will go live in mid-Nottinghamshire this autumn, underpinning a new musculoskeletal pathway. Steve Brown looks at the new model of care and how the money will flow**

New models of care will need new payment systems, incentivising more integrated and sustainable services. To date, much of the work around these payment approaches – which will often involve capitated budgets – has remained at the theoretical level. But in October, the Mid-Nottinghamshire health economy will go live with one of the first new capitated budgets to underpin its new service approach for musculoskeletal services.

Mid-Nottinghamshire's *Better together* programme started in 2013 – covering the population served by Mansfield and Ashfield and by Newark and Sherwood clinical commissioning groups. Its aim was to join up services, putting more focus on prevention and moving more services into the community, while addressing an estimated £140m funding gap that was expected to open up over the coming 10 years.

At the start of 2015, it was named as one of NHS England's 50 vanguard sites – one of nine health economies exploring the potential to set up primary and acute care systems (PACS).

A PACS is one of a number of different care models being tested as part of the vanguard programme. While both PACS and multi-specialty community providers (MCPs) look to bring together primary, community, mental health and social care services, the PACS model also includes most hospital services, opening up the potential for new accountable care systems to be developed.

A number of accountable care systems have recently been identified for central support to accelerate their development and share learning. Nottinghamshire Sustainability and Transformation Partnership has been selected as one of these systems, although the immediate focus will be on Greater Nottingham, Mid Notts' STP partner.

With all these new models of care, revised pathways have to be put in place first. But, once established, new payment systems will be needed to ensure all providers are properly remunerated to cover appropriate costs and incentivised to work together to deliver sustainable services for patients and reduce system costs.

Having spent a long time thinking about the practicalities of using capitated budgets, Mid Nottinghamshire will be one of the first communities to put the theory into practice when it launches its new payment approach this autumn.

*Better together* has four strands:

- Urgent and proactive care (long-term conditions)
- Planned care
- Women and children's care
- Community and mental health.

A lot of the early work in Mid Nottinghamshire has been around urgent and proactive care (see *Healthcare Finance,* July/August 2016, page 16). As part of this work stream, CCGs commissioned a new service based on integrated community teams.

The service – known as Prism, which stands for 'profiling risk integrated care self management' – uses risk profiling to identify the people in the top 2% of the population most at risk of hospital admission. The new integrated teams proactively support these people, improving their care and reducing unwarranted hospital admissions.

The service has been working well. A new Prism+ integrated home support service also looks to reduce length of stay once patients are admitted to hospital by ensuring the right package of services is put in place to enable discharge.

While initial plans had aimed to launch a capitated budget to support this new model for urgent and proactive care, it was decided that the complexity of the service – with lots of interdependent services – made it a poor choice for the area's first foray into capitated budgets.

## New MSK model

Step forward the musculoskeletal (MSK) service. A new model of care has also been put in place for MSK services – the more self-contained nature of these services made it a more appropriate testing ground for a new payment system.

Redesign of MSK services is part of the programme's elective care work stream. Services in scope included elective orthopaedic, pain management, rheumatology, podiatry and the less complex elements of the spinal service.

'The vast majority of these services were provided in the acute sector and, from a cost point of view, we benchmarked high, with a lot of people attending outpatients and being hospitalised compared to our peers,' says Marcus Pratt, associate chief finance officer for both CCGs. 'We were confident a lot more could be done in the community to the benefit of patients and potentially lowering the overall cost of services.'

This summary is backed by RightCare data that suggests MSK is the single biggest saving opportunity for mid-Notts, amounting to £5.2m if it matches the average performance of the best similar areas.

Analysis of its activity revealed that about 45% of its first outpatient appointments resulted in a patient being further referred to a physiotherapist or discharged with no treatment. They hadn't needed the outpatient appointment in the first place.

So a physiotherapy-led triage service has been introduced for all elective orthopaedic patients. This service is supported by hospital consultants (about two programmed activities per week), but should

free up significant amounts of consultant and other practitioner time previously spent in outpatients.

Started in February this year, Mr Pratt says it had an immediate impact on outpatient activity, with a 25% reduction in February, March and April. This crept back up in May, as physiotherapy referrals outstripped capacity. Additional community-based therapists are now being recruited.

The aim is for all MSK referrals to go through the triage service. Elective orthopaedics is already in place, with back pain and other services to be redirected in the future.

At this point, 13,000 patients would be expected to go through the triage service a year. Mr Pratt says it's about getting the patient seen in the most appropriate setting and involving consultants and surgeons in the cases as appropriate, although there is also an expectation that surgical intervention will reduce.

'At the moment our conversion rate for first outpatient to surgery is below 50%,' he says. 'Our ambition is for this to be 95%, so we broadly filter out everybody who doesn't need surgery before outpatient stage.'

The triage service – known as MSK Together – is being run by Sherwood Forest Hospitals NHS Foundation Trust in collaboration with community service provider Nottinghamshire Healthcare NHS Foundation Trust. There is no formal payment system to underpin this currently, despite the fact that the trust is seeing reduced income from reduced outpatient activity. However, this will change when the new payment system comes in later this year.

**Having spent a long time thinking about the practicalities of using capitated budgets, Mid Nottinghamshire will be one of the first to put the theory into practice this autumn**

There is also some interesting interplay in terms of alliance working. The community physiotherapy service is run by Nottinghamshire Healthcare but some physiotherapy is also provided in the acute sector.

'With fewer inpatients and so less inpatient physio, we are looking to see if we can utilise some of these physiotherapists out in the community or in a different way – without changing the workforce or employee contracts – to support the community activity,' says Mr Pratt.

## Payment system

Now that the revised pathway is effectively in place, attention has turned to getting the right payment system to underpin it. With a plan to use a capitated budget approach, two stages need to be considered – calculating the right overall budget and then setting out how rewards and risk will be shared across the whole alliance.

The capitated budget for each provider, which will operate from

## Capitation budgets: an evolving picture

**There are 50 vanguards in total, including nine primary and acute care systems (PACS sites) and 14 multi-specialty community providers.**

**A PACS framework document, published last year by NHS England, said these two new care models already covered about 8% of England. However, it added that nearly all sustainability and transformation plans involve population-based accountable care models of this kind. National coverage is expected to grow to 25% this year and 50% by 2020.**

**So there is a lot of interest in understanding what works and how to optimise models. And while everyone is clear the new pathway has to be put in place first, the focus is increasingly on how to design a payment system that supports the new models and puts the right incentives in the right places to maximise the quality of patient care.**

**NHS Improvement chief pricing officer Monique Duffy-Brogan (pictured) says NHS Improvement is working with about 10 health economies with new payment systems at different stages of development – Mid-Nottinghamshire is one of the most advanced.**

**She says that getting the payment approach right is complex and requires trust between the various stakeholders and good-quality data – although imperfect data shouldn't be used as an excuse for not starting the process.**

**'We've used some gain/loss sharing simulations with the early implementers to highlight how difficult some of this is,' she says. 'Getting everybody around a table as early as possible to start these discussions is so important.'**

**In terms of setting capitated budgets and devising gain/loss sharing, approaches need to balance technical accuracy, simplicity and achievability, she says. 'We don't have perfect data yet, so let's use historic commissioner spend and supplement this with cost data. Start simple and move on and as the data evolves we can be more sophisticated.'**

**NHS Improvement has been working with NHS England and local health economies to co-develop new payment approaches. This has been used to share learning and develop guidance applicable to the wider health economy.**

**While supporting documentation will continue to evolve, guidance to support systems developing new care models outside the vanguard areas is expected to be published over the summer.**

**The soon-to-be-published handbook will include a step-by-step process that will take providers and commissioners through the stages necessary to develop integrated budgets and gain/loss share arrangements.**

**If the service is moving towards capitation and other new forms of payment, does that mean the demise of nationally determined prices?**

**Ms Duffy-Brogan says she is asked this a lot, but that the tariff is 'not going away anytime soon'. Clearly, NHS Improvement still has a legal obligation to produce a national tariff, which includes nationally determined prices, but even without that obligation, she says, these prices are the starting point for most negotiations around contracts – cross-border activity, contracts with the private sector and block contracts.**

**And it is being used by early implementers to inform capitated baseline budgets to underpin new models of care.**

October this year, started out with the baseline budget for 2015/16 converted to current prices. This is then adjusted for planned activity changes (for example, the expected reduction in acute inpatients) and then the additional costs of the new model have been added in. This might include a new head of MSK, the triage service and the new community physiotherapists.

Crucially, the budget is then also adjusted for stranded costs. This recognises that even if an acute provider reduces inpatient activity, it may take time to eliminate the full costs of delivering that activity – so-called stranded costs, which may, for example, be tied up in overheads. (Sherwood Forest has a big element of fixed estate costs in its private finance initiative unitary charge.) Adjusting the budget by the full tariff rate would create an additional financial pressure for the trust.

'If we are going to see an overall win for the system, we don't want to simply shift cost around,' says Mr Pratt. 'Under the tariff system, you could see cost come out of the CCG budget translating into a loss for the provider. Instead, we need to allow time for providers to manage the costs out. We are all under a lot of financial pressure and the aim has to be to take out as much cost as possible as a system.'

In total, current spend on MSK services is £34m, although just over £6m of this relating to prescribing and high-cost drugs will initially be managed outside of the capitated budget. Just over 62% of this currently goes through Sherwood Forest, while a further 9% is accounted for by the contract with Nottingham University Hospitals NHS Trust. Just 3% starts off with the community provider Nottinghamshire Healthcare.

## Budget reduction

A planned £2m reduced overall budget in 2018/19 – based on a 5% fall in inpatients and 24% fall in outpatients – will see reductions in all components of the contract apart from that provided by Nottinghamshire Healthcare. The community provider will see a more than 40% cash increase – taking its overall share of the budget up to 5%. Under the plan, a slightly smaller proportion of the overall budget would be spent with non-alliance NHS and non-NHS providers. Further reductions in 2019/20 will see an overall cut in total budget of £5.9m.

Additional activity undertaken by acute providers above the levels included in the capitated budget will be viewed as a 'cost to the system'.

## Payment model will come later

**Health and care bodies across Morecambe Bay are working to develop an accountable care system that delivers more integrated care for patients while also providing greater support for the local population to stay healthy and self-manage any conditions. But the focus right now is on getting the pathways right, with a conscious decision to keep contractual issues to one side for the time being.**

**The area first launched its new clinical care strategy, *Better care together,* in 2013. It came on the back of well-publicised problems in maternity, which led to the critical Kirkup report. There had also been wider problems that contributed to the University Hospitals of Morecambe Bay NHS Foundation Trust being put into special measures in the summer of 2014.**

**The new strategy underpins key improvements in recent years. The Care Quality Commission recently included the trust in a set of improvement case studies on the back of a 'good' rating at the beginning of 2017.**

**The strategy proposed an accountable care system-type solution. The Bay Health and Care Partnership – involving 10 local health and care organisations – became a vanguard site in 2015 on the back of targeting a system that was increasingly being seen as a national model for more integrated care.**

***Better care together*'s key focus is the frail elderly community and those with long-term conditions. It aims to more closely match services to local needs, support self-management of conditions where appropriate and improve health and wellbeing more generally.**

**At the heart of the approach are 12 integrated care communities. These have primary care at their core but pull together multi-disciplinary teams from different organisations.**

**While they have different local priorities, their common goal is delivering care as close to home as possible and avoiding the need for hospital admissions wherever possible.**

**There are already early signs of success. The area has seen a 3.1% reduction in emergency admissions and a 1.5% reduction in total bed days compared with 2014/15. Paediatric bed days have also reduced by 10%.**

**There was also a reduction of nearly 4,000 new outpatient attendances last year, compared with 2015/16.**

**Aaron Cummins (pictured), director of finance and deputy chief executive at the foundation trust, says the new service model continues to operate under a mix of tariff payments and block contracts.**

**'We are looking to develop a framework for financial flows that enables the system to operate under the principle of "one system, one budget",' he says.**

**Initially the economy has 'steered away from contractual issues' to ensure this 'noise' didn't get in the way of mobilising communities.**

**'We want to make this as light on the bureaucracy and contracting overhead as possible, with our focus being on incentivising the right behaviours to mobilise the clinical model at scale and pace,' says Mr Cummins.**

**'Income reductions on the back of reduced acute admissions or fewer outpatient attendances are fine as long as there is a net financial benefit for the whole system.**

**'That's the dialogue we are having with the regulator to ensure that is how we are performance managed.'**

**With the trust currently struggling to fill all its medical and nursing posts – similar to most providers – it is having to rely on more expensive agency staff to sustain rotas.**

**'The amount of premium cost to service current activity is significant, so if we can reduce demand and activity, any loss we suffer will be mitigated,' adds Mr Cummins.**

Instead of this activity attracting a marginal rate for the specific provider involved, the value of the activity – charged at a marginal rate of 32% in year 1 and 50% in year 2 – will be put into a risk/reward pool. This will then be shared across all alliance providers using predetermined shares.

Each organisation's share of this risk/reward pool has been calculated taking account of how much influence it has over the different elements that drive performance. Sherwood Forest, as lead provider, takes on the biggest amount of risk/reward (51%), with the CCGs taking on a further 24% and the rest spread across the other providers.

Some risks sit with individual providers. For example, the risk of the new community physiotherapy services is viewed as being within the community provider's control. Funding for increased practitioners has been included within the capitated budget.

However, if the provider decided more physiotherapists were needed to meet demand, it would carry the cost – although it may want to discuss the issue as part of a service and financial review of the first six months at the end of 2017/18.

The health economy has modelled two further scenarios. These cover a downside case, where the reduction in inpatient and outpatient activity doesn't reach the levels used in setting the capitated budget, and an upside case where these reductions are exceeded.

Its examples suggest that the sharing mechanism could range from a risk of £1.3m to a shared reward of £1.7m and it has mapped out how this would be shared across the members.

**Hear more about the work in Mid Nottinghamshire and in Morecambe Bay at the HFMA Convergence conference, 5-7 July, www.hfma.org.uk**

There is no separate payment mechanism tying payment to outcomes. According to Mr Pratt, although an outcomes contract had been in place for proactive care last year, this had used the existing CQUIN (commissioning for quality and innovation) mechanism. But the prescriptive nature of this year's CQUIN approach made it inappropriate to have a further element of payment at risk.

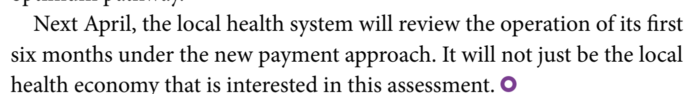
Mr Pratt acknowledges that new pathways are the key focus. But he says that payment systems are also vital to incentivise the revised pathway and that the system can only make the savings it needs to make by working together.

## Looking ahead

At the moment, he recognises that the calculation of the budget (on the acute side) draws heavily on the national tariff in setting the baseline position. But he expects that in future the health system will develop a much more granular understanding of local costs, informed in particular by better patient-level costs.

He believes this will open up the potential for budgets to, at first, be informed by local costs. Then, further down stream, he suggests it could move more towards being based on the efficient local costs of the optimum pathway.

Next April, the local health system will review the operation of its first six months under the new payment approach. It will not just be the local health economy that is interested in this assessment.



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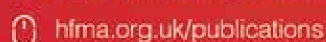

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# outcome and risk

**Stockport is well on the way to establishing a new payment model that links to outcomes and shares risk across the system. Steve Brown reports**

Stockport's health and social care economy has been developing a new system sustainability plan since the start of 2015. Like many areas, it is putting in place new models of care – and has made good progress. But where it is arguably ahead of many other areas is in thinking through the detail of how payment can be linked to real outcomes and how financial risk can be shared across the whole system.

Working together, the five local health and care organisations (CCG, acute and community provider, mental health provider, GP federation and local council) have developed a plan – *Stockport together* – to deliver integrated services that increase independence and reduce the need for hospital services.

New models of care will be developed to serve the whole community, although the initial focus has been on older people with complex needs. The approach is being developed as a multi-specialty community services provider and Stockport was named as one of the key test sites in NHS England's vanguard programme.

## Structural benefit

The focus is prevention at scale underpinned by transformed out-of-hospital care based on integrated neighbourhood teams. While all systems are looking to work in a more integrated way, Stockport's relatively simple and well-defined structure gives it an advantage. There is one commissioner, which is coterminous with one local authority; one GP federation (Viaduct Care); one acute and community foundation trust (Stockport); and one mental health FT (Pennine Care).

This helps, but Mark Chidgey, chief finance officer at Stockport Clinical Commissioning Group, says what they are trying to do is still massively challenging. The starting point was leaders coming together to look at future needs and challenges as a system rather than single organisations. 'We'd always set separate strategies, or been led by our regulators to set strategies that didn't align,' he says.

The new system-wide approach has prompted some refreshing statements – the acute trust chief executive acknowledged the hospital needs to be smaller in the future, while the commissioner recognised the importance of a strong acute provider.

Four business cases have been published alongside a summary economic case, setting out key pathway changes.

For example, an ambulatory care business case sets out to address the fact that Stockport currently admits around 30% more patients to hospital than similar systems, many of which have ambulatory care sensitive (ACS) conditions. New model plans will establish collaborative triage in primary and secondary care, as well as co-locating a primary care ambulatory illness team in the emergency department and extending the hours of the ambulatory care unit.

**"We've not agreed the contract value split yet – it could be anything from 60:40 to 90:10 – but it has to be the right level to support change"**
Mark Chidgey

As well as setting out the planned service changes, Stockport has done a lot of work on enablers such as a single patient record system accessible by all care providers.

Mr Chidgey says there are already signs of a positive impact, with the system being one of the few to see a reduction in non-elective admissions in 2016/17.

Getting the money right to support the new system is vital, as all parts of it currently face financial challenges. The pressures on local authorities are well known. The CCG delivered a 0.7% planned surplus in 2016/17, short of the national 1% requirement. And Stockport NHS FT ended the year in deficit, albeit improving on its control total. 'The challenge in 2017/18 – most immediately at Stockport FT – is really significant,' says Mr Chidgey. However, he says the difference to previous years is that this is now seen as a system problem to be tackled collectively across health and social care.

The system has made a lot of progress on a future payment system based on a capitated budget and linked to outcomes.

'Without the outcome part, it is just a block contract, and that won't drive improvement,' says Mr Chidgey. 'The risk is that it would just mean things will stagnate.'

With support from consultants BDO and Outcomes Based Healthcare, the area has developed 38 outcome measures (25 clinical and 13 personal) to supplement existing NHS Constitution targets. These will form the basis for how a more strategic commissioner will describe requirements in future contracts.

The approach could involve a far greater proportion of contract value than existing CQUIN incentives. 'We've not agreed the split yet – it could be anything from 60:40 to 90:10 – but it has to be the right level to support change,' says Mr Chidgey.

Should the outcome target improvement be moderate and linked to a large proportion of overall spend, for example, or much more aspirational and linked to a smaller amount of spend?

The capitation budget baseline will be set using historic spend levels adjusted for the impact of the business cases.

After looking at more complex ways to share risk of over-performance, the agreed proposal to the health and social care economy from its finance leaders is a simple three-way split – with any overspends or gains within the scope of the business cases shared equally by the CCG, the local authority and the provider alliance.

Resource distribution between the providers and between, say, acute and community services would be 'primarily for the providers to determine,' says Mr Chidgey. However, some of the outcome measures would have a clear influence on this – personal outcome measures around keeping people in their own homes, for example, or enabling people with mental health problems to return to work.

The payment model is not there yet. There are key decisions to be made around how much should be linked to outcomes, what happens to funds that are not paid out if outcomes aren't achieved, and how different providers should share in any unpaid elements. But the system is well on the way to a payment model that actively supports its more integrated service delivery.