HFMA briefing
June 2020

An introduction to aligned incentive contracts

Introduction

The aligned incentive contract is increasing in popularity within the NHS and, for many, it is seen as the way in which effective system working can be achieved. However, there is no model aligned incentive contract and definitions do vary. This introductory briefing looks at the key parts of the contract and considers the advantages and disadvantages of the approach. A case study example is included to demonstrate how aligned incentive contracts work in one organisation.

What is an aligned incentive contract?

An aligned incentive contract in the NHS is an agreement between a commissioner and a provider to work towards the achievement of agreed population health aims across a system or a place. These aims can cover the whole range of population health needs and may include access targets for individual services as well as broader aims to support an increased focus on prevention, for example.

Aligned incentive contracts remove the payment by results approach which traditionally pays based upon the activity carried out. The contract structure instead builds upon the basic block contract by including a gain and risk share element which recognises the achievement, or not, of the agreed objectives. Some risk sharing arrangements are tightly defined, others less so, perhaps reflecting the level of mutual trust between parties.

The CPD Standards Office
CPD PROVIDER: 50137
2018-2020
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The contract should be underpinned by good costing information to not only set the financial envelope correctly but also to fully understand the incurred costs and support the decision making necessary to enable the value-based service transformation that the contract encourages.

Using aligned incentive contracts across a system can support effective system working by encouraging all partners to work towards the same aims and, to some extent, creates population health budgets. Blended payments may also be compatible with an aligned incentive approach, where they support the agreed objectives.

Some aligned incentive contracts include an expected, or minimum, income guarantee. This is the minimum sum that the provider can expect to receive against an agreed activity plan, with associated performance and quality requirements. The guarantee delivers some certainty of cost and income for both parties.

Benefits of an aligned incentive contract

Aligned incentive contracts can promote innovation in service delivery as providers are operating within a known financial envelope. Any gain and risk share parts of the agreement mean that financial savings can be reinvested in the system, while giving a safety net for areas where activity significantly increases beyond that expected.

System working can also benefit from an aligned incentive approach, where all contracts within a system include some of the same, or similar, objectives in order to promote a culture of collaboration that enables all organisations to meet their targets.

For both provider and commissioner, the transactional cost of administering the contract is much reduced, freeing up time and resource to invest in areas such as service transformation and cost improvement programmes. For the commissioner, the aligned incentive contract can reduce the risk of uncontrolled cost increases due to activity changes although some flexibility is needed.

Disadvantages of an aligned incentive contract

An aligned incentive contract works best where the achievement of the objective is within the provider's control or includes all stakeholders that can contribute to the achievement of the agreed objective. Failure to include all stakeholders can leave the participating organisations risk sharing around an objective that they do not have full control over. However, the inclusion of some system working objectives could support the development of joint working relationships, similar to the ambitions of the national financial recovery fund which links 50% of the payment to system performance.

The aligned incentive contract has to be nuanced to reflect the different elements of service. For example, with ever increasing emergency attendances, a 'block' payment based upon previous year's activity may not be suitable. However, to ignore this area from the approach would be to negate the full benefit of an aligned incentive contract if costs were allowed to increase exponentially. Instead, this area may need a different activity envelope to work within, while still offering incentives to both sides to work to reduce demand.

An aligned incentive contract can require significant culture change, moving away from the cost and volume approach of tariff and looking more widely at outcomes and population health. The contract model can see risk transfer between organisations, and this has to be well understood to effectively implement the model without damaging the financial sustainability of either organisation. Relationships between organisations need to be more collaborative and supportive, removing the contracting disputes common in the past.

Part of the benefit of an aligned incentive contract is its ability to effect behaviour change within an organisation. However, this can only be realised if departmental and service budgets are also set on

an aligned incentive basis. As a provider, the model enables service transformation to be undertaken within the safety net of a known financial envelope. In order to encourage specialties to find new and innovative ways to deliver services, or even to just make the changes that they know will benefit patients, a similar freedom must be granted to them.

Case study

University Hospitals of Coventry and Warwickshire NHS Trust

The aligned incentive, or intelligent risk share, contract was established between Coventry and Rugby CCG and University Hospitals of Coventry and Warwickshire NHS Trust in 2019/20.

Background

A contract dispute in 2018/19 highlighted the fact that there was a finite amount of money in the system and, despite costly mediation processes and the development of cases for spend, or not, there was no more money available. Both parties ended the process where they expected to, with effectively a 50/50 split.

The traditional contract structure meant that most of the risk sat in the latter part of the year. The risk of contract disputes meant a lack of certainty over the financial position and made it difficult to set budgets for specialties which were looking to increase their income under the payment by results (PbR) system. In addition, the transactional cost of managing a PbR contract was huge, adding extra costs into the local healthcare system. In contrast, the aligned incentive contract meant that both income and expenditure were set, and it was necessary to manage within it. This benefited both parties.

Contract structure

The aligned incentive contract is split into four areas: elective, non-elective, outpatients, and high cost items (such as drugs and those that are directly linked to services, for example CQUIN). Each area has its own quality and performance objectives linked to the contract and includes some QIPP elements. This means that each area has its own level of risk, recognising the level of control possible over each part. For example, high cost drugs are still primarily agreed on a cost and volume basis, with the trust receiving payment at full cost above an agreed threshold but only losing 50% of the contract below the corresponding level. This incentivises the trust to push activity down but removes any associated risk of activity increasing due to factors beyond their control. However, for elective care, an upper performance objective is set and, if activity is above that, the trust does not receive any more income, meaning that the trust holds the whole risk for over activity. If activity falls below the lower limit, an agreed minimum level of income is payable. Between the two bounds, activity is reimbursed at normal tariff rate. Outpatients are transacted within the minimum income guarantee. This allows the Trust to undertake service transformation required in the *NHS long term plan* within an agreed level of income without concerns about the impact on tariff payment.

Emergency care is treated in a similar way, based upon a risk share. It is based on a 50% marginal rate for activity over the agreed threshold up to a certain point and is then capped. Setting this threshold requires a full understanding of baseline activity and expected growth, coupled with discussions around the impact of transformation programmes. Value becomes central to the discussion, rather than that of margin on growth.

The aligned incentive contract highlights the importance of trust and transparency in effectively implementing this model. The commissioner and provider jointly agreed the objectives that would be achieved under it, using a full activity model (bed capacity, theatre capacity and so on) to determine what was affordable and realistic. It was key to develop collective aims that all parties supported and recognised.

Involving clinicians

It is essential to involve clinicians in the development of the aligned incentive contract, enabling them to take ownership of their own activity. For example, at University Hospitals of Coventry and Warwickshire NHS Trust, an elective care streamlining workgroup was set up under the leadership of the head of surgery. This group looked at every service, procedure, and intervention to determine what should and should not be done in hospital, considering the benefits and evidence for undertaking them. Under PbR, the incentive was to do everything that had income attached but, with an aligned incentive contract, there is an incentive to really think hard about what is undertaken in hospital and whether pathways are correct. The trust is encouraged to think about ways to reduce activity and redesign services to better support patients. One of the outcomes from the elective care streamlining group was guidance for GPs about managing some elements outside of hospital and not referring in.

Setting the financial envelope

Tariff still has a place as a starting point to set the contract value, in the absence of other financial data. However, understanding the true cost of services enables better information to be used when setting the contract value, so that it more accurately reflects the expected activity. The benefit of a block amount rather than linking individual activity to a price is that it removes conversations about money that might be lost by doing something differently. Instead doing something differently can create a saving for the trust where it allows quality objectives to still be met.

Minimum income guarantee

University Hospitals of Coventry and Warwickshire NHS Trust also has a minimum income guarantee against each area of activity, although this is primarily linked to elective and non-elective activity. This means that even if the contract as a whole is operating above the agreed level, if elective care is below that expected then the minimum income for that area will be received.

The trust is incentivised to reduce activity below the level set for the minimum income guarantee to create capacity to undertake additional activity that would otherwise be undertaken in the private sector. Under a scheme agreed with Coventry and Rugby CCG, any reduction in private activity as a result of increased elective activity in the NHS trust leads to a corresponding increase in trust income. The aligned incentive contract provides the motivation to ‘do the right thing’, through encouraging the trust to create extra capacity within the safety net of a minimum income guarantee.

Contract monitoring

The need for contract monitoring has reduced, as a number of areas have been included within the block amount such as penalties and best practice payments. However, the trust and CCG have chosen to keep the monitoring process at a similar level as before to ensure that both parties fully understand activity levels and quality indicators.

Lessons learnt so far

Aligned incentive contracts require a level of openness between parties that was not there under a PbR regime. A level of trust is needed to fully share information about financial positions; CCG plans for investment elsewhere in the system; and the impact on activity levels in order to effectively work in an aligned manner. Relationships take time to establish and continuity is important.

The cultural change must not be underestimated. For the board at University Hospitals of Coventry and Warwickshire NHS Trust, the aligned incentive contract represented a significant transfer of risk to the trust. This was mitigated through the inclusion of demand management schemes and realistic growth estimates, but still required a leap of faith to change the basis of the majority of CCG income.

However, the positive cultural change is that it has given everyone in the organisation a real incentive to transform and innovate, with the financial headroom to do it. It has increased productivity and it has contributed to the Trust’s first breakeven position in five years with Coventry and Rugby CCG also achieving a breakeven position.

Acknowledgements

The HFMA is grateful to Su Rollason, chief finance officer, University Hospitals of Coventry and Warwickshire NHS Trust for sharing the trust's experience of aligned incentive contracts.

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About the HFMA

The Healthcare Financial Management Association (HFMA) is the professional body for finance staff in healthcare. For 70 years, it has provided independent and objective advice to its members and the wider healthcare community. It is a charitable organisation that promotes best practice and innovation in financial management and governance across the UK health economy through its local and national networks.

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