The Better Care Fund

Delivering Integrated Care Masterclass

Sharing Risks and Benefits

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Local Government Association

Department for Communities and Local Government

NHS England

Masterclass organisers

scie social care institute for excellence

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Agenda

Three learning objectives for this session:

1. Risk share can be difficult … but why is it **important**?
2. **Simple 2-part framework** to developing risk and benefit share agreement
3. **5 key ingredients** for successful risk and benefits sharing

Summary

Risk and benefits share can be difficult - but it is essential to making integration work

Financial austerity requires more than ever that financial resources of partners are aligned and reflect the relative risks and rewards of each participating organisation…from CQUIN (performance bonus), commissioner and provider risk-share and reward - to accountable care partnerships. Pooling resources and optimising value is integral to successful health and well-being systems.

Keep it simple. It's about understanding your shared plan and how you can jointly manage it

Do you have a plan for:

- What do you want to achieve?
- Risks to delivery of financial benefits?
- Financial mitigation if that can't be delivered (i.e. worst case scenario)
- 'How' to manage overspends and underspends…
- Withheld from Pooled Fund?
- How/when is it any element paid in?
- Who decides how it is spent?
- If the targets are not met who contributes?
- What happens to overspend?

Summary (cont)

5 key ingredients to successful risk and benefits sharing

1. **Transparency**: Clear baseline and performance measures can be tracked. Needs to be pro-active and regular
2. **Common purpose:** Ensure 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
3. **Build a shared understanding** amongst leaders, staff, partners and people. Understand the extent to which each partner can influence the risks and benefits identified. Work together to drive collaborative working.
4. **Clear and effective governance arrangements** with clarity around decision making and accountability, with shared leadership at political and executive levels.
5. **Trust**: The personal chemistry between local leaders and operational managers is as important as formal plans and strategies.

Examples

- Liverpool & South Sefton CCG and acute risk and benefits share via block contracts
- Oxfordshire Mental Health outcomes-based risk share model
- Torbay ICO risk share agreement

Further information, tools and resources

BCF Risk sharing quick guide (This guide is currently being updated)

Activity 1 (20 mins):

- What is your **definition** of risk & benefit share?
- What would you like **to get out of today**?
- What are the **challenges** to risk share? Examples?

Task:

You have 15 minutes to:

Discuss the following points with colleagues at your table.

Quick plenary group discussion afterwards

Introduction

How can we **incentivise better system outcomes**?

What happens if our **plans don't materialise**?

What is our definition of risk and benefits sharing?

Risk sharing is a management method of sharing risks and rewards between members of a group by distributing gains and losses on a predetermined basis.

Levels of risk consideration:

Service or Project level

- Risks within each service/project are allocated to areas of an organisation (s). This area will bear the risk and benefits on the element of the service/project

Organisational level

- Each organisation takes on the risk and benefits of projects they manage

System level

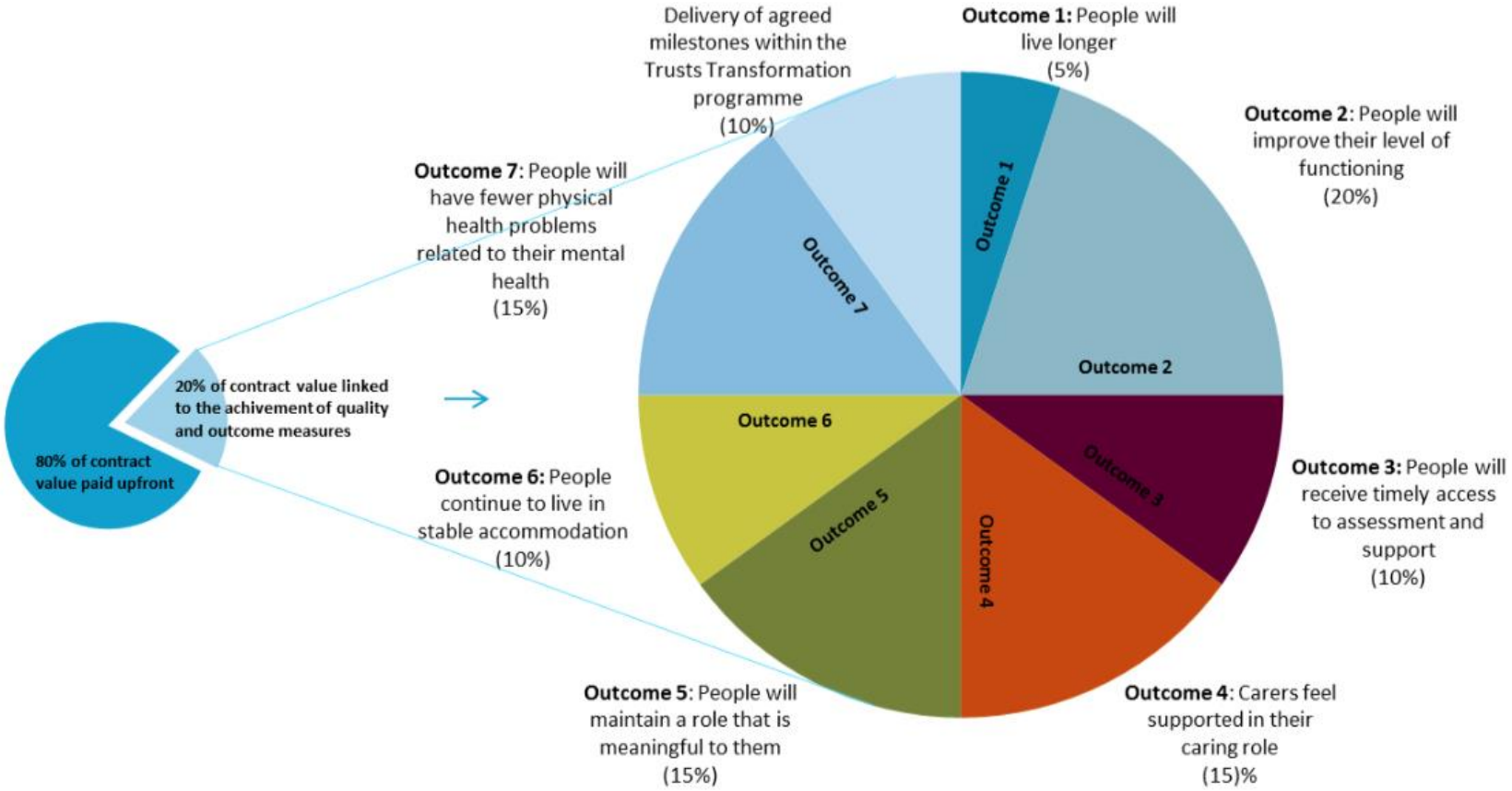
- Sharing risks between all organisations on the a basis of shared understanding of vision and objectives

BCF sharing routes:

Activity commissioned

Pro-rata to contribution

Oxfordshire example…

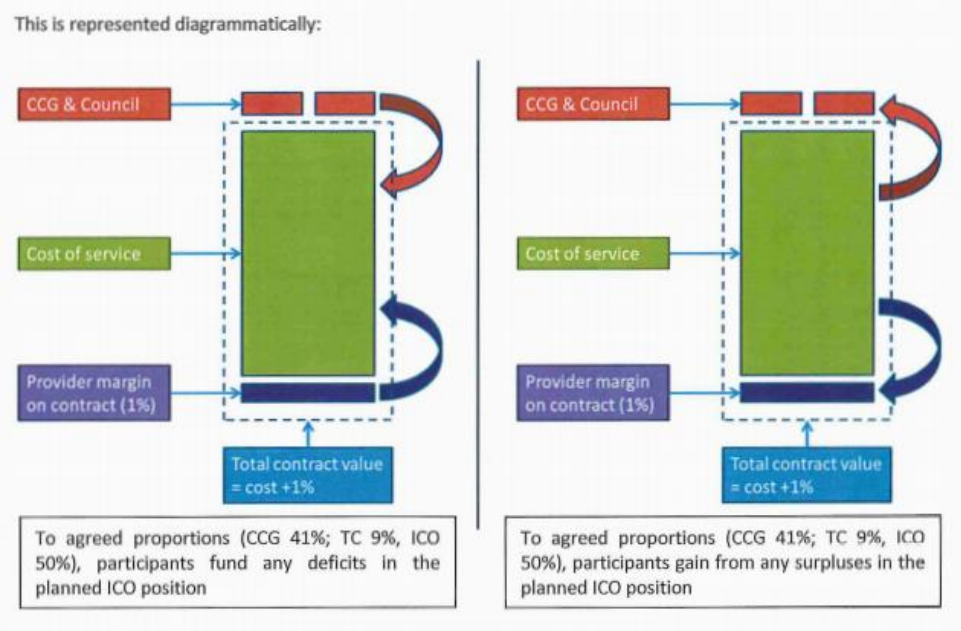


Torbay risk share mechanism example…

1. **Agree baseline:** A planned level of service commitment and ICOs pend on these services will be agreed for an initial five year fixed period. The agreement will move to a rolling three year period beyond this point;
2. **Commit resources:** Commissioners will agree to commit the necessary resources to meet the baseline level of service as described in current plans, allowing for a 1% surplus for the ICO;
3. **Deliver service efficiencies:** The ICO will deliver agreed levels of efficiency improvements throughout the period;
4. **Manage variance:** Any variance in the planned financial performance of the ICO, as initially captured in the LTFM This may be subsequently amended by agreement, and will be shared according to proportions described below;
5. **Changes to risk share contributions:** Changes to risk share contributions will normally only arise where they follow a shift in baseline resource between commissioning organisations not already described in current plans. Changes in baselines already described in current plans will not give rise to alterations in the risk share contributions set out above

Deficit

Surplus



Key learnings from elsewhere?

"Do you have a plan for…"

- What do you want to achieve?
- Who is involved?
- Risks to delivery of financial benefits?
- What are your financial thresholds?
- Financial mitigation in worst–case scenario?

No one size fits all

Be specific & keep it simple

How will you manage both over & underspends?

- Withheld from Pooled Fund?
- How/when is it any element paid in?
- Who decides how it is spent?
- If the targets are not met who contributes?
- What happens to overspend?

Activity 2 (30 mins):

Putting some key concepts into practice

Scenario:
You are using part of your BCF pooled funds to pay for a discharge-to-assess service to ensure people are receiving the right are, at the right place, at the right time!

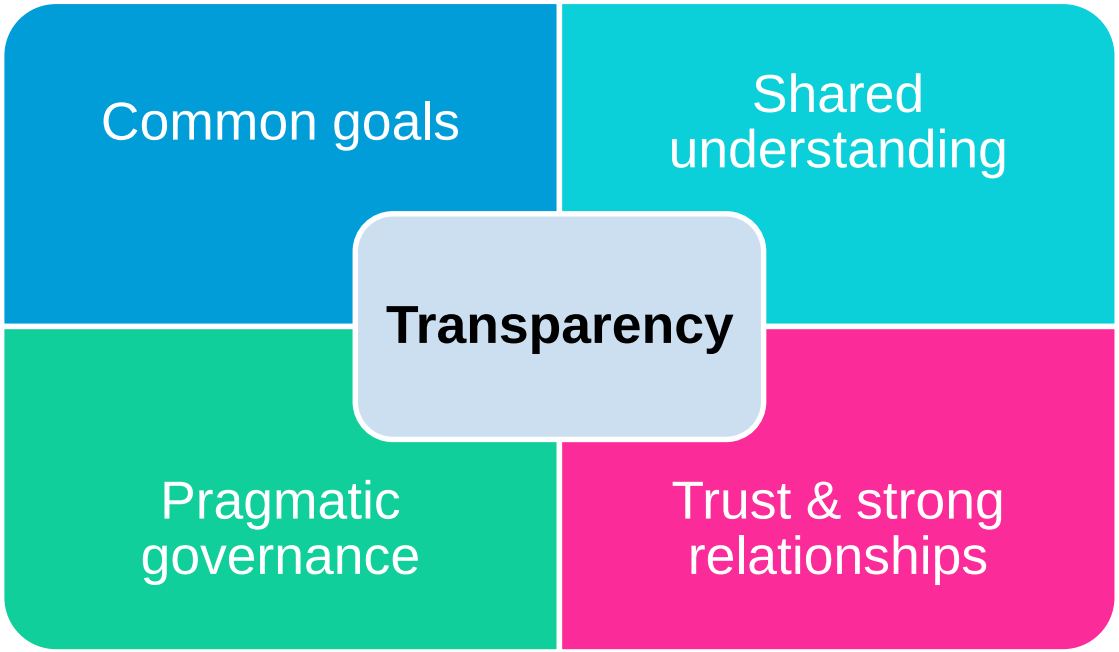
But also to help reduce LOS and DTOCs.

Task:

You have 20 minutes to discuss:

- Who has the most **influence? The least influence to** make success of it?
- Who will **benefit** from…
  - improved independence?
  - reduce acute bed days?
  - reduce long-term social care package?
- Who should **pay** for the service?
- What if you only achieve your **½ the intended benefits**?
- Who will **pay** for both the D2A and increase in service provision elsewhere?

The building blocks of successful risk and benefit sharing:



Do you already have a risk share in place for your BCF?

Ambitions to…

- Enable person-centred care and independence
- Improve system working (e.g. DTOC)
- Reduce Non-elective admissions

Some areas may consider risk & benefit share as part of their schemes including CCG, LAs and health and care providers

- **DTOCs** – joint partnership arrangements between acute and LA providers – to incentivise and stimulate increase provision in community and services by voluntary sector
- **NEL** – lead provider arrangements with acute, CCG and primary care providers
- **Out of Hospital -** looking at joint commissioning arrangements between CCGs and LA,
- Other - NHS, LA and voluntary sector partnerships

Where HWBs plan to reduce NEL above the CCG operating plans (optional):

BCF plans are asked to **consider** putting the equivalent NHS OOH ring-fenced funding in a contingency reserve *(mitigation)*

Useful links and resources

1. Better Care Guides – Risk Sharing Quick Guide (Being updated)
2. NHS England – BCF Risk Sharing & S75 Guidance
3. Torbay ICO – Risk-Share Agreement Example
4. Monitor – “Multilateral gain/loss sharing: an introduction”
5. Health Foundation, Need to Nurture, Outcomes Based Commissioning
6. McClellan M et al (2014) Accountable care around the world: a framework to guide reform strategies, in Health Affairs, 33 (9) 1507
7. NHS England Quick Guide – Discharge to Assess

The Better Care Fund

Sharing risks and benefits

Collated notes from all workshops

Local initiatives to consider

Oxford Mental Health: In Oxford they pooled resources together and scrutinised spending patterns. This helped to reveal that they were not achieving the outcomes that they want. Through stakeholder, partner and clinician engagement, they developed eight outcomes that 'really mattered' – with identifiable and measurable markers to monitor productivity. 80% of funding is now given up front in block contract, 20% retained and related to outcomes (closer to PBR). The lead provider is a large voluntary sector organisation

Liverpool and Merseyside, "*Block contracts and growth":* £750 million was set aside for six months which was placed in to a block contract and agreed on a block growth. The results were positive and allowed for stability in the shared risk and a focus on delivery rather than ongoing discussions about funding. For example they are now discussing how to use the workforce more effectively across the whole system (eg medical staff in community). System does not currently include a community provider, or adult social care – focus on acute and primary health. The 'acting as one' model has two years to prove itself.

Calderdale Hospital, 'step down service': This 12 bed service is supported with input from the council, CCG and Trust, and managed by social care. People are admitted to this unit directly from hospital ward when they are medically fit, but not ready for home. Within seven days they are given a core MDT assessment. The scheme has enabled the reduction of packages of care from every 4 patients to 2.

"GP's cannot believe the difference from what they are like in hospital to what they become in to the community".

Wigan ICO: At early stages, but agreed to share risks and benefits. They are considering how to weight the gains/losses. Block contract over two years (+1% uplift) includes risk and benefits sharing agreement.

Nottingham City Council has an alliance agreement and is moving towards contractual goodwill. **Nottinghamshire Alliance** PACS vanguard focused on seven priority outcomes which were reliant on a CCG CQUIN funding pot. Previously, a lot of providers were reliant on this pot, now being aligned to different services. Funding delivered from the CQUIN pot

has strict adherence guidelines. Main challenges are faced in: sexual health contracting; accountable care approach and reducing the envelope from the previous contracts.

North West London: One of NWLs mental health providers, has a placement efficiency programme. Two of the CCGs, along with mental health provider, agreed they would do a continuous review of placements. Once the £250K threshold was reached for each, there was a 50/50 split of savings on top of that. In first 2 years they over performed. They believe that the learning from this scheme could be applied to other areas. They reinvested savings by cushioning overspending on further events and increased activities.

Useful tools or resources

Key learning: Focus on the worst case scenario, plan a process for managing risk and benefits share in that instance, and build the agreement on that.

Warwickshire's three CCG's work together in a **joint pathway** with risks.

Stockport is **pooling small amounts** which is helping to manage risk better. The first year has seen some limited benefits and the system is being refined.

Stockport is also relocating hospital staff in to the community to make assessments leaner. By having the hospital **assessment done in the community** this is helping to avoid and reduce the instances of duplication, increase education and patient satisfaction. There is an additional bonus as managers are located in the community, therefore this functions through the same provider

Using shared outcomes: for example Sheffield and Warwickshire Discharge to Assess (D2A) schemes initially used c£200K from the BCF fund. Currently in Phase II of the scheme as they are now in the proof of concept. They now have pooled budget from the social care domiciliary care homecare spend to create the functioning business of the D2A.

Challenges

Incentivising both risk and benefit sharing

- There is risk sharing, but not benefits sharing.
- How to incentivise people to risk and benefit share, and how to encourage them to understand other partners' challenges and shared interests.
- How to take an asset based management approach.

"You cannot work in partnership unless there is a mutual benefit".

Silo working

- How to share the benefits of the changes and to encourage positive behaviour from providers.
- Ensuring that change in one part of the system does not have a negative impact on another part. For providers it is a challenge as they have fixed as well as variable costs. Need to show added value of sharing risks and benefits – for example small voluntary organisations could have a lot to lose.

Governance and accountability

- When systems are being monitored, people do not want to expose themselves.
- Each individual organisation has its own individual statutory duties and KPIs to meet. In many cases, when pressure hits, each organisation believes they have enough risks without taking on a share of partners' risks.
- When working across multiple CCGs it is hard to align different governance.

Finance and commissioning

- As finances get tighter people withdraw from risk share – financial mitigation is needed
- Several different mechanisms in the system.
- How would you stop payment to services?
- There is an over-focus on financial aspects of risk and benefit sharing – and BCF pushes it in that direction.
- Should whoever is hosting pooled funds, manage spending?
- A lot of the time the savings are not actually savings, they are just reducing deficit.
- For commissioners it is mainly risk and not benefit share. Risk always sits with CCG. Solution would be contract amendment.
- How to develop a multi-speciality community provider (MCP) or alliance agreement to risk share (i.e. here is a whole system cost, how do we shift this cost in to the community organisations).

Over-focus on financial risks and benefits

- Integrated care risk sharing is really about workforce, estates, the wider care market etc – not just about finance. Need to "lift our heads above risk sharing of finance"
- Ensure there is a focus on people's experiences.

Alignment of BCF and STPs

- Local authorities have not bought in or are not sufficiently engagement with Sustainability and Transformation Plans (STPs).

- Duplication of effort across multiple plans and reporting processes (eg BCF, STP, CCG). Could merging all into the BCF be a solution?

Relationships and trust

- Continuity of staffing is a challenge across all partners. Relationships are critical to good joint working but if individual staff members leave, you need to rebuild those relationships.
- BCF is useful for services where good relationships have already been established.
- Trust is key and this needs to come at a senior level – what is needed is a courageous leader.

"Unless you have a great relationship, risk sharing becomes hard"

Data sharing

- We will never be fully integrated until data is available to all - LA, CCG, Health and Social Care. This is a big issue that needs to be addressed although there are major privacy issues at stake if done incorrectly.

Areas or types of further support needed

- Better Care Fund and STPs should all align and should be owned by their local areas. STP footprints go across boundaries, which can be complicated.
- Sharing data, risks and benefits
- CCGs know very little about the BCF generally – including issues
- Encouraging local authorities to become more engaged with STPs
- Support to enable chief finance officer to understand when there are risks and how to engage with this.
- Need clearer and more integrated national policies and initiatives across all departments.
- NHS needs to recognise that social care is not just there to help the NHS – it has a wider remit.
- How to tell the story of integration to partners and public in a consistent way: where we are now, where we want to get to, and how we plan to get there.
- Support for council members to enable them to connect range of initiatives (BCF, STPs etc).

Further information

All presentation materials and notes for Delivering Integrated Care Masterclasses March 2017 are available on the **SCIE website**