

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

**Integration and
Better Care Fund**

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Integration and Better Care Fund series

This series of guides was originally developed to support the mobilisation of Better Care Fund programme plans across the country. These guides continue to be of practical use to everyone involved in planning and delivering joined-up, integrated care for individuals and communities, person-centred care as part of BCF plans as well as other programmes that foster collaborative cross-system working under the new goals and ambitions of the NHS Long Term Plan. This includes frontline professionals and managers, commissioners, as well as councillors and board members in local government and the NHS, community and voluntary groups, independent providers and groups speaking for people who use health and care services.

- [How to... lead and manage better care](#)
- [How to... work together to achieve better joined-up care](#)
- [How to... understand and measure impact](#)
- [Sharing risks and benefits of integrated care: quick guide](#)
- [Transfers of care: signposting resource](#)



1 Introduction

“More of us are living longer with more complex physical and mental health care and support needs, so there is an increasing need for person-centred coordinated care. This extra demand for care will only be affordable if we share resources across organisational boundaries.”

Richard Humphries, Former Assistant Director, Policy, The King’s Fund

England’s health and social care challenge is significant, and accelerating in complexity and intensity. The scale of the financial and delivery challenge is well documented, both within the NHS and local government. To meet the health challenges of the 21st century, health and social care systems will need to do things differently and use funds more effectively to deliver sustainable, person-centred, coordinated care at scale and pace.

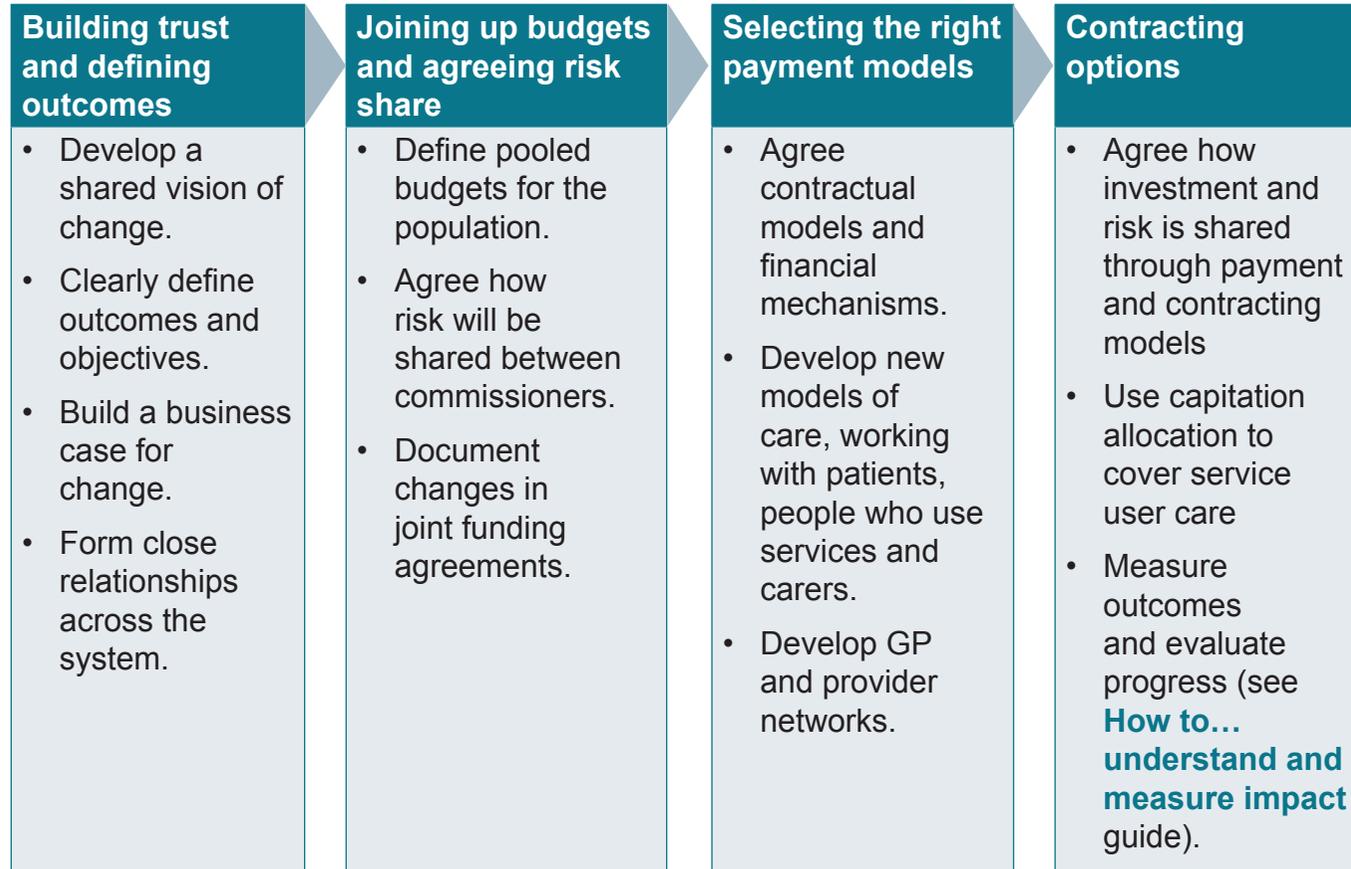
A key element of the Better Care Fund programme has been the pooling of a proportion of budgets between health and social care organisations. The NHS Long Term Plan also provides a **continued commitment** towards supporting local approaches to health and social care budgets where councils and CCGs agree this makes sense.

This guide focuses on bringing budgets together and using them to develop coordinated care provision. It sets out tips, tools and practical examples of how resources can be aligned in a more effective way, enabling health and care areas to provide better person-centred and coordinated care. It covers:

- building trust and anchoring pooled budgets in a shared definition of outcomes
- agreeing joint budgets and risk share between commissioners
- payment models: developing the model with providers
- contracting models: awarding the contract and monitoring impact.

The guide is aimed at finance leads and strategic and operational leads across health and care organisations. It identifies opportunities for how resources can be aligned in a more effective way to provide integrated, person-centred care. It focuses on the budget elements outlined in the process for developing integrated models of care (see page 3).

The process for developing integrated models of care



Bringing budgets together is complex and requires strong system leadership and management. A good starting point is to build a clear common purpose about the outcomes providers are trying to achieve for their local population, and how they want to reshape services to meet them. Many areas have developed a narrative about ‘Mrs Smith’, ‘Mary’ or ‘Joe Bloggs’ – narratives that express this in practical terms and help to build a shared understanding among staff, stakeholders and the public. Another essential element is robust governance with clarity around risk and rewards, decision-making and accountability. This needs to be strengthened by shared leadership at political and executive levels, and underpinned by a shared definition of what success looks like and how it should be measured. These themes are covered in more depth in other How to... guides in the series.



Key messages

1. **Work with partners and other stakeholders to build a shared vision**, with a shared narrative for change.
2. **Build a business case** with evidence of the as-is situation and clear articulation of the changes required, with cost and benefit assessment and a realistic plan for benefit realisation.
3. **Clarify accountabilities and agree arrangements for risk–benefit sharing.** The joint funding agreement should have clear documentation of the aims and outcomes, governance arrangements, respective contributions from partners, expected benefits and benefits share, risks to benefit realisation and how they will be managed.
4. **Trial and test a range of payment and contract models**, building on learning and evidence from within the area and elsewhere.
5. **Review performance on a regular basis** and assess progress against the planned changes. Build in review processes to review risks and agree mitigating actions where required.



2 Building trust as a key foundation

Moving forward to a new way of working together

Person-centred, integrated care requires new ways of working across organisations and between system leaders. Over recent years, great progress has been made to jointly fund, co-commission and deliver new models of care. A key lesson has been learned: successful initiatives are anchored in a common vision, narrative and set of objectives, co-created by the whole system – leaders, operational managers, clinical and frontline staff, service users and communities.

The common vision should set out what people want and need. In other words, people's own narratives should be at the centre of defining outcomes. Outcomes should reflect the philosophy, overall aims and mission of that 'narrative'. The **narrative for person-centred coordinated care** and accompanying 'I-statements', developed by National Voices, help to define goals from a user-based perspective. See also **How to... lead and manage better care** and **How to... understand and measure impact**.

Case study: building trust to develop an outcomes-based payment model in Tower Hamlets, London

In Tower Hamlets, outcomes-based commissioning has facilitated stronger joint working across health, social care and community services by identifying and agreeing a single set of outcomes and associated indicators for the system to jointly work towards. The Tower Hamlets Together programme had a key aim to shift the focus from commissioning specific services for primary, secondary and tertiary care, to jointly tackling local risks to mortality across all care settings.

Being a multi-specialty community provider (MCP) vanguard site, Tower Hamlets has been supported by NHS England to develop a new model of care which integrates a range of primary care and community-based services under a single place-based budget. Developing a jointly-designed outcomes framework sets a central tenet for all the services to work towards, shifting the focus to more proactive, preventative and joined-up care around the individual.

To engage providers and build trust in the new model, Tower Hamlets Clinical Commissioning Group (CCG) and the East London NHS Foundation Trust acted as joint leads on the project. In this way, both commissioners and providers were represented at the most senior level. An outcomes reference group was established – with representation from lay partners – to help develop the framework, and engagement and communication workstreams enabled leaders to reach out to different groups across the locality.

Outcomes-based commissioning in Tower Hamlets has redefined contracts, such as the innovative Community Health Services contract, so that providers are rewarded for improving population outcomes, rather than delivering activities. A certain percentage of each contract will be tied to the achievement of specific outcomes, so that providers will have the incentive to focus on preventative approaches that reduce the need for secondary and tertiary care.



With the programme ending in 2018, Tower Hamlets Together is reporting a number of benefits and positive outcomes for their residents, including an improved system-wide approach to children's and family services, agreed data-sharing practices between health and social care, the development of a population-based payment mechanism and an emerging culture of 'multiple partners, one way of working'.

Our vanguard story: Tower Hamlets together

Developing strong foundations may seem self-evident, but is often ignored when the focus shifts to immediate delivery. Engaging widely to develop, review and refresh outcomes and goals will:

- anchor discussions of funding in a shared vision, with clearly defined objectives and a common language for how to deliver long-term gains for the local population
- build a business case for change, which can be signed up to by commissioners, providers and communities
- establish a shared understanding of how to achieve the intended benefits and investment.

“
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

Creating a shared vision, objectives and language

Time spent on developing a shared vision will pay dividends later on. Providers should remember to do the following:

- **Clearly diagnose the as-is situation and define the need for change.** Consider how the need is likely to develop over time in a 'do nothing' scenario. Use existing evidence, including local data, joint strategic needs assessments, health and wellbeing strategies, sustainability and transformation partnerships (STPs) and national policies and resources.
- **Set out in detail the outcomes that are expected, and what the objectives for the proposed changes are.** What will be different for people and communities? How will that impact the system of funding, commissioning and provision? For the vision to be meaningful, it needs to be shared by stakeholders across the system – from leaders within health and care to operational managers, frontline staff and citizens.



- **Pay attention to language.** Too often, different terms are used by different stakeholders to articulate goals and plans. The language used by health and care organisations often has subtle differences in meaning. Providers should ensure they use similar language to describe the change they want to achieve. For more information, refer to [How to... lead and manage better care](#), particularly the section on ‘engagement and communications’.

Building a strong business case to overcome financial barriers across organisations

Managing finances in health and care is tied to formal lines of accountability and statutory responsibilities. With their different governance systems, we know that joint budgeting and whole-system financial approaches can be complex to develop. However, such approaches are adapting to the need to deliver population health and care in a joined-up way, and local solutions are being developed rapidly. Many CCGs and local authorities have established joint commissioning functions to respond to the pooled funding offered by the Better Care Fund, and the introduction of STPs and ICSs across larger footprints is encouraging such approaches to be scaled up.

Bringing budgets together requires a strong business case, with:

- clearly articulated goals and a robust plan for what, how and when benefits will be realised
- a detailed plan for implementation, with a realistic assessment of the resources required to deliver it
- measures of success with clear links to how and when the investment will generate returns for the stakeholders involved. For more information, refer to [How to... understand and measure impact](#).



Forming strong relationships across organisations and at all organisational levels

Although the technical details of funding arrangements are important, relationships between individuals and teams are key to enabling joint commissioning to function effectively. **The King's Fund report, Options for Integrated Commissioning: Beyond Barker** examines how collaborative partnerships, such as Health and Wellbeing Boards, can facilitate joint commissioning arrangements.

Although local government and NHS staff can share similar values, it is important to recognise that their organisations work in different ways. In addition to cultural differences between the sectors, local government is accountable to locally elected members, whereas the NHS is accountable to national organisations and politicians. This means that the responses of people working in local government can be different to those of people working in an NHS organisation.

Both parties need to be aware of these differences and work together to develop joint commissioning relationships despite the challenges. Further information on how to make joint working a success is included in **How to... work together to achieve better joined-up care**.

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 in new models of care that may not yet have a strong evidence base – because, in the face of current pressures, the risk of doing nothing is greater.

Rob Whiteman CIPFA, Chief Executive, CIPFA

3 Pooling budgets and agreeing risk share

“
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, formerly Director General for Local Government and Public Services, Ministry of Housing, Communities and Local Government

Creating shared public accountability through pooling budgets

Public sector organisations are held to account over their finances, and have robust internal governance systems to oversee the spending of public money. Person-centred, coordinated care is only successful when governance systems can support **similarly strong financial accountability across organisations**.

Pooled budgets combine funds from different organisations to enable them to fund truly integrated services. Since the introduction of the Better Care Fund in 2015, CCGs and local authorities have been required to operate a pooled budget for the Better Care Fund via a section 75 agreement. This has resulted in a major increase in pooled budgets, starting as part of the BCF but continuing as part of the development of more integrated systems within STP development. An increasing number of areas are transitioning to ICSs with pooled budgets, shared risks and rewards, and shared accountability for outcomes. Integration of care, while complex to deliver, is recognised by leaders across the country as a much needed response to the challenges of rising demand and budgetary constraints.

Section 75 of the NHS Act 2006 allows partners (NHS bodies and councils) to contribute to a common fund which can be used to commission health or social care related services. This power allows a local authority to commission health services and NHS commissioners to commission social care. It enables joint commissioning and commissioning of integrated services. See **Risk sharing/S.75 agreement** for more guidance.

In some cases, such as Section 117 of the Mental Health Act 1983, legislation requires that joint funding be administered by councils and CCGs. Section 117 states that aftercare must be jointly funded for people leaving hospital after being detained for treatment under the Mental Health Act. In other cases, councils and CCGs choose to jointly fund care simply because they believe it is the right thing to do and will help prevent future admissions. The Healthcare Financial Management Association (HFMA) and the Chartered Institute of Public Finance and Accountancy (CIPFA) have produced **Pooled budget guidance and the Better Care Fund Guidance**. See **Sharing risks and benefits of integrated care: quick guide**.



“
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 needs to work with their colleagues to ensure that the accounting and assurance arrangements are as seamless as the frontline 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

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 been implemented and have delivered better outcomes for people who use services.

Greater Manchester

Single budgets underpin a range of health and care devolution initiatives. In Manchester, the most advanced health and care devolution programme in England to date, the Greater Manchester Health and Social Care Partnership now controls £6 billion of health and social care funding made up of a) the commissioning budgets for CCGs; b) the social care budgets of the 10 local authorities in the Greater Manchester area; and c) some of NHS England's budget for specialist commissioning and primary care. The shared vision is to deliver the greatest and fastest improvements to the health and wellbeing of Greater Manchester's 2.8

million population. In terms of governance, the Greater Manchester Health and Social Care Partnership Board includes members of the Greater Manchester Combined Authority (GMCA), 10 local authorities, 12 CCGs, 15 NHS providers, NHS England, representatives from primary care, patients, third sector providers, fire and rescue services and the police and Crime Commissioner. It is underpinned by a joint commissioning board and provider federation.

NHS England awarded Greater Manchester £7.5 million to drive forward **integration of health and care records**.



Southend

Southend was involved in the Integrated Care and Support Pioneers Programme, having been selected in November 2013. As part of their ambition for a truly integrated health and social care system, local organisations in Southend sought to change the way that health and social care was commissioned and undertook work to develop their vision for an integrated commissioning function.

Local organisations in Southend have a strong track record of working together, first through a strategic alliance and then via the joint executive group, made up of the Council, CCG and provider organisations. In 2014, Southend CCG and Southend-on-Sea Borough Council agreed a memorandum of understanding setting out the basis for a longer-term commissioning relationship. In 2015, a

joint commissioning team was formally brought together with the appointment of a joint associate director of integrated care commissioning and a head of integrated care. The services specifically targeted included mental health, learning disabilities, frail older people's care and children's services, with a single point of referral and access service, with a pilot complex care coordination service which went live in 2016.

Since the start of the programme, Southend-on-Sea was assessed regionally and nationally as being a mature health and care system.

See [Options for integrated commissioning: beyond Barker](#).



The Disabled Facilities Grant (DFG) is an integral part of the Better Care Fund, with an allocation of £505 million in 2019/20 to fund housing adaptations for elderly and disabled people. The grant supports areas to think strategically about the use of home adaptations and technologies to support people to live independently at home, and to take an integrated approach to improving outcomes across health, social care and housing. To the right is a short example of how the grant has been used in Croydon.

Croydon

To facilitate the safe discharge of a long-term hospital patient in Croydon, a number of major repairs and adaptations were required to be made to his home to improve accessibility and prevent injury. He was offered an interest-only loan to undertake the repairs and adaptations. As a wheelchair user, he also needed adaptations to the property to enable ground-floor living, and a ramp to provide wheelchair access. The Croydon Staying Put home improvement agency caseworker, in conjunction with the surveyors, arranged a programme of work, including renovation work through the council's interest-only loan, an energy

loan for central heating, major adaptations for a shower and wheelchair accessible kitchenette, and a front access ramp, funded by the Disabled Facilities Grant. The property was badly cluttered with years of hoarding, and was cleared using the reablement funding from the Better Care Fund, as well as fitting clean, safe flooring in the kitchen and bedroom, and a new bed. The success of this case was joint work with the occupational therapist, surveyors and other health care professionals. He is now able to live independently, with a minor care package from social services.



Place-based budgets: Overview of models and options for placed-based budgets

Whilst s75 agreements are a requirement of the 2019–2020 Better Care Fund Policy Framework, there are other models and options available for place-based budgets that can be considered for local systems moving towards integrated care. These are listed below:

Seat at the table	<p>Under this model:</p> <ul style="list-style-type: none"> it is possible to align budgets it is possible to create bespoke risk/gain share arrangements locally between NHS England and CCGS e.g. through joint contracts.
Joint arrangements	<p>Under this model:</p> <ul style="list-style-type: none"> it is possible to pool budgets using s13V (between NHS England and CCGs), or pool budgets using s75 (between health bodies and local government) it is possible to create bespoke risk/gain share arrangements locally between partners to the s13V or s75.
Delegation	<p>Under this model:</p> <ul style="list-style-type: none"> budgets would be delegated to a group of bodies under a 13ZB arrangement (must include local government partners) it is possible to create bespoke risk/gain share arrangements locally between the partners to the delegation agreement.
Devolution*	<p>Under this model:</p> <ul style="list-style-type: none"> the budget would be transferred to local government under a s105A transfer order as the function (including responsibility for overspends or underspends) would be fully transferred to local government, risk/gain share arrangements with NHS England would not be applicable).

*NB: There are three options for devolution under the Cities and Local Government Devolution Act. We have only included the option of a full transfer of functions in this pack.



Sharing risks and rewards

Pooling resources requires investment decisions from a range of different stakeholders. In the context of financial pressures, each participating organisation will need to consider costs and benefits, as well as risks and rewards. Across the system, it is critical to establish how risks and benefits will be shared and develop a plan for how gains and potential losses will be distributed. Gains and losses are calculated as the difference between the baseline (expected cost) of delivering care to a defined population and the 'out-turn' (actual cost).

Developing a robust plan for risk and reward sharing requires answers to two key questions: **How can we incentivise better system outcomes and what will happen if plans don't materialise?** [Sharing risks and benefits of integrated care: quick guide](#) sets out the building blocks.

- 1 **Transparency** – baseline and performance measures can be tracked. This needs to be proactive and regular, so that issues can be dealt with 'in-flight'. There should, at minimum, be a review every quarter.
- 2 **Common purpose** about the desired outcomes for the local population and how services will be reshaped to meet those outcomes. There should be a focus on system and individual outcomes – the rest will come through efficiencies.
3. Build a **shared understanding** among leaders, staff, partners and people – how can each partner influence the risks and benefits and work together to drive collaborative working? This also involves considering what 'levers' to use, such as, for example, the Commissioning for Quality and Innovation payments framework (CQUINS), incentive payments and delayed transfer of care reimbursements.
4. Clear and **pragmatic governance arrangements** setting out decision-making and accountability structures, with shared leadership at political and executive levels.
5. **Trust and strong working relationships** – the personal chemistry between local leaders is as important as formal plans and strategies.

Five steps to agree risks and benefits: establish risks and benefit share agreements



Topic areas

Governance

System context



Checklist for pooling budgets

- Consider and agree the aims and objectives of the pooled budget, using documents such as the local joint strategic needs assessment.
- Establish which partner organisations should be involved, and clarify the role of each one.
- Clarify the services in scope, and develop business cases with clear outlines of cost and benefit realisation over time.
- Based on the business cases, identify how the initiatives are to be funded and how the pooled budget will be managed.
- Develop a detailed and shared understanding of the associated risks, both for individual partners and the programme as a whole.
- Develop a joint funding agreement with documentation that outlines:
 - aims and outcomes, and the relevant functions covered
 - expected benefits and how they will be measured, realised and shared
 - key risks, and how they will be managed, shared and – where possible – mitigated on an ongoing basis
 - respective financial contributions and other non-financial resources provided in support of the joint initiative
 - how the pooled budget will be managed, with associated governance and reporting arrangements
 - the duration of the arrangement, including the provision and mechanisms for annual review, renewal or termination
 - technical matters, such as treatment of VAT, legal issues, complaints, dispute resolution and risk-sharing.

Further reading

Pooled budgets must be soundly based and follow the appropriate accounting arrangements. In the Better Care Fund ‘Support and resources pack for integrated care’ (NHS England) there is information about **section 75** pooled budgets, including what is required to make them work effectively, other joint financing options, general considerations and what should be included in partnership agreements.

4 Selecting the right payment models

New payment models to support integrated care

Traditionally, the NHS and local government have paid for delivery of services rather than outcomes. Commissioning care in this way has contributed to a health and care system in which services are fragmented and service users experience gaps or delays in care.

Developing person-centred, coordinated care, in which services are designed to meet the holistic needs of people, requires new models of care and new ways of financing, commissioning and paying for services.

Innovative finance, commissioning and payment systems are some of many levers that can be employed to integrate health and care. Creating solid foundations, based around strong relationships and the pooling of budgets, is the first step in enabling the development of more sophisticated payment methods in the future.

“For a decade now, there have been a variety of different policy drivers trying to provide the framework for integrated care. The fact these have differed tactically over the decade does not signify the fact that governments cannot ‘make up their mind’— rather it designates the strategic importance of the agenda. Every major health care system in the world is struggling to better integrate health and social care. None are finding it simple and all will be working on it as an issue for many years to come.”

Paul Corrigan CBE National Care Integration Adviser and Non-executive Director of the Care Quality Commission



Designing contracts to support coordinated models of care

True integrated care 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 they provide. No one has accountability for, or visibility of, the whole cycle of care. To successfully provide a coordinated pathway of person-centred health and social care, the accountability for delivering outcomes and the drive to reduce costs need to be joined up, which will, in turn, require existing contracting models to change. This section explores the development of different coordinated models of care.

Some areas of the UK have developed a model of joint commissioning for health and social care provision, while others have developed a joint accountability agreement between existing providers and commissioners to support coordinated provision.

“
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, Director of Transformation, Department of Health and Social Care, former National Director, NHS England

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 together all the main providers and commissioning organisations in the system to share experiences, learn, and jointly develop and implement better care for individuals.

Depending on where an organisation currently stands on the journey to integrated commissioning, it may need to take different steps. Example case studies show that

it takes several years for programmes to deliver the intended transformation. Contractual vehicles do not replace the need for continuing to work at cementing local relationships and ensuring there are strong foundations on which to develop integrated commissioning (see Section 2).

For more information please refer to:

- [Integrated care: what does it mean for commissioning?](#)
- [Integrated commissioning for better outcomes.](#)

Evaluating the options against different payment models

There are three main types of payment model that can help incentivise integrated working across health and social care systems:

- block contracts
- bundled payments
- stratified population capitation.

The potential benefits and disadvantages of using each model are discussed below, drawing on insights from the [North West London toolkit](#), and payment system guidance from the [World Bank](#).



Model	Description	Pros	Cons
<p>Block contract model</p>	<p>This funding arrangement enables commissioners to put in place block contracts with one or more providers to provide a service (or group of services) for a set period of time. The payment model encourages provider productivity in meeting service outcomes for the lowest cost. In this model, commissioners transfer the risk to providers if more people require services than planned. Block contracts are sometimes viewed as a crude payment mechanism, but can be an appropriate starting point to enable honest conversations about the scope of the joint health and social care activity covered by Better Care Fund and sustainability and transformation partnerships agreements.</p>	<ul style="list-style-type: none"> • If managed correctly, providers have an incentive to manage demand for their services and improve productivity. • The contract enables commissioners to purchase joint health and care provision. • Providers can be innovative in designing and delivering services to meet required outcomes. 	<ul style="list-style-type: none"> • 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 function appropriately. • Historically, establishing block contracts has not created or encouraged increased transparency around costs and activities. • The value of the contract may not cover the costs of care, due to changes in numbers of users over time, or changes in recommended treatments.



Model	Description	Pros	Cons
<p>Bundled payment model</p>	<p>A bundled payment (or pathway payment) is a single payment for a group of services relating to a specific 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 of a bundled payment for a hip or knee replacement would include any consultations preceding the operation, the procedure itself, rehabilitation, and any required readmissions.</p>	<ul style="list-style-type: none"> • Bundled payments are usually based around one condition or treatment, which discourages unnecessary care, encourages coordination across a particular pathway by the accountable provider, and can improve quality of provision. 	<ul style="list-style-type: none"> • While the model can help to control costs, it does not incentivise prevention to reduce overall volume if payment is for activity rather than outcomes. There have been instances in which providers have been thought to deliberately extend hospital care within this model. • To work effectively, a bundled payment model requires an extended data system; it can often be difficult to link records across providers.

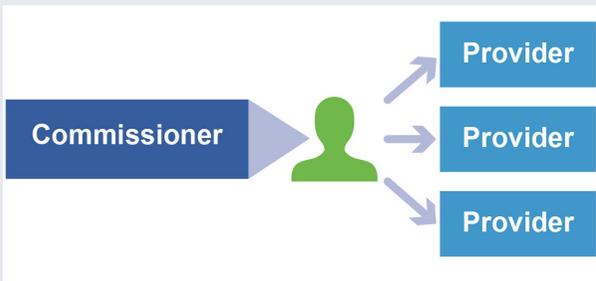
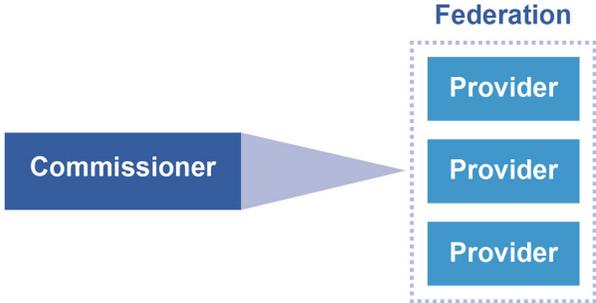


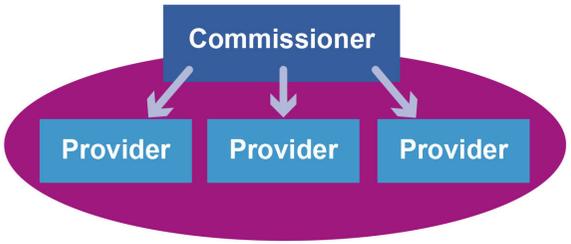
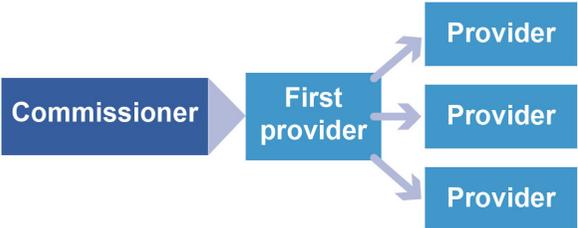
Model	Description	Pros	Cons
<p>Stratified population capitation model</p>	<p>Different areas of the UK are at different stages of this journey. More areas use capitation payment models across health and social care. For example, Population Level Commissioning for the Future in Kent, and the Symphony Project in South Somerset. A capitation payment model offers providers 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 to coordinate services in order to minimise unnecessary duplication.</p>	<ul style="list-style-type: none"> • The model encourages coordinated, preventative care that keeps people well at home and avoids unnecessary high-cost care. • The model encourages commissioners to segment their populations and ‘risk stratify’ them, developing a better understanding of need in the area. This can, in turn, help to ensure that services are better planned and delivered. Further information about this can be found in Sharing risks and benefits of integrated care: quick guide. • Providers have the incentive and flexibility to take innovative approaches and allocate their resources; they are incentivised to achieve the greatest efficiencies so they can share in the savings realised. 	<ul style="list-style-type: none"> • The model 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. Numerous sites in the UK are in the process of developing the infrastructure to support this model of payment. • There is a large incentive to restrict access to care, or ‘cherry pick’ patient cohorts. Commissioners should seek to prevent this by establishing appropriate contractual requirements and compliance processes which are then carefully monitored.

5 Contracting options to enable integration

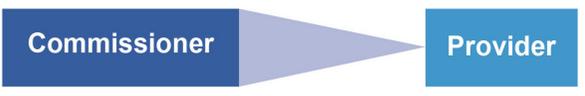
The approach and contracting model implemented in local areas will ultimately depend on the local partnerships, provider landscape and required outcomes. The more complex the services, the more complex

commissioning a single pathway model becomes. There are several procurement and contract model approaches for commissioning for outcomes. The main ones are shown in the table 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 control of purchasing their own care around their own pathways of need. In February 2015, NHS England also promoted this contracting model through personal health budgets.</p>	<p>Individuals' needs are amenable to a range of provision and there is extensive choice in the markets. Care needs are not complex and can be understood by people who use services.</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. While 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>Primary care federation toolkit (The King's Fund)</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 (which could be both NHS and local authority commissioners) commission jointly and/or independently a range of services from various providers under a discrete commissioning contract.</p> <p>An alliance agreement (which supplements the individual commissioning contracts) documents how all parties are to work together to achieve agreed overall outcomes in respect of a defined patient group or set of conditions. Providers agree to share responsibility for delivery of those outcomes, and are jointly incentivised to work together to do so in a coordinated fashion. Commissioners and providers considering adopting an alliance approach are advised to contact the NHS Standard Contract team and NHS England, who are developing a template alliance agreement. Email: nhscontractshelp@nhs.net</p>	<p>Best used when a range of services from different sectors are required to deliver specific outcomes for a defined patient group or range of conditions.</p>	
<p>Prime contractor</p> 	<p>The commissioner has one contract with one provider who then subcontracts 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 pathways 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 deliver care that forms a complete pathway. In other industries, this accountable provider would be known as a supply chain manager. NHS RightCare.</p>	<p>Can be used for commissioning care for cohorts of patients with co-morbidities, such as older people.</p>	



<p>Single contractor</p>  <p>Commissioner</p> <p>Provider</p>	<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>
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Case studies: contract models that facilitate coordinated care

Personal budgets

Evidence suggests that people **get better outcomes when they have input into how their budget will be spent**. The Kent **Money Management programme** sets out a joint approach across health and social care. It includes a single point of contact for advice that individuals access to support their decisions about how personal budgets could be spent well. The council and CCG have also adopted the same payment processing systems and aligned monitoring timescales to ensure a consistent approach.

For more information about how to optimise personal budgets across health and care, please see the **Personal Budgets Minimum Process Framework**.

SW Healthcare

SW Healthcare is a GP Federation set up to strengthen primary care in South Worcestershire, deliver better services for the 303,000 patients in the region 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 delivery of the group'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 ear nose and throat (ENT) services across the group.



Bedfordshire CCG

Bedfordshire CCG faced problems with its musculoskeletal services, including fragmentation, quality variations, uncoordinated care and long waiting times, leading to an inefficient service which did not support patients as well as it should. To better integrate services, the group decided to adopt a prime contractor model for its musculoskeletal provision, and chose **Circle Integrated Care** (formerly Circle Health) to act as the prime contractor.

As part of the arrangement, Circle has been in charge of organising the system and integrating all the providers around a central service. Circle takes accountability for both financial control and the delivery of high-quality systems of care by managing the supply chain. Any patient requiring

treatment for a musculoskeletal condition is referred to a hub for specialist triage by their GP – ensuring that all are referred on to the right care. Patients are offered a choice over who provides the service, being able, for example, to choose which hospital they attend.

Although not without challenges, the scheme as a whole has seen significant improvements in terms of reductions in secondary care referrals and unnecessary diagnostics and interventions, as well as improved patient experience and outcomes. Circle is now also the prime contractor for musculoskeletal services in Greenwich, showing the replicability of the model and the opportunity for new areas to adopt a similar approach.



The Isle of Wight single contractor model

Isle of Wight CCG, Isle of Wight NHS Trust and Isle of Wight Council, Contracting for Services.

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

Currently, the Isle of Wight CCG has joint commissioning arrangements in areas such as domiciliary care for learning disability clients, and the group has put in place a joint commissioner for carers. The CCG follows an 'any qualified provider' (AQP) procurement process which enables providers to qualify to deliver a specified service for a given price. Any provider that 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.



Checklist for effective contracting

- 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.
- Appraise and agree contract mechanisms.
- 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**, such as through the **Introduction to Public Procurement** to help establish the approach for 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.



6 Contributors

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

Edition 2 (August 2019)

Dr Steve Boxford	Director	Cordis Bright
Dr Sam Benghiat	Associate Director	PPL
Nick Hicks	Chief Executive	Cobic
Lisa Larsen	Associate Director	PPL
Carmen Colomina	Practice Development Manager	SCIE
Shirish Gandhi	Publishing Manager	SCIE
Iris Steen	Head of Communications	SCIE

Edition 1 (May 2015)

Paul Carey-Kent	Policy Manager (Health, Social Care & Welfare Reform)	CIPFA
Paul Corrigan CBE	Former Director of Strategy and Commissioning	NHS London Strategic Health Authority
Dr Jo Farrar	Former Director General, Local Government and Public Services	Ministry of Housing, Communities and Local Government
Warren Heppolette	Executive Lead	Greater Manchester Health and Social Care Partnership
Richard Humphries	Assistant Director, Policy	The King's Fund
Richard Jones CBE	Trustee	Shared Lives Plus and Action on Hearing Loss
	Former Director	NHS England
Damon Palmer	Director of Health & Care Transformation Lead for Health & Social Care Integration	Oxford CCG Department of Health



David Pearson	Corporate Director Former President	Nottinghamshire County Council Association of Directors of Adult Social Services
Catherine Pollard	Director of Pricing Development & Integrated Care, and Provider Sustainability Solutions	Monitor
Jake Rollin	Assistant Director	North East Lincolnshire CCG
Ros Roughton	Former National Director	NHS National Director of NHS Commissioning & National Primary Care Leader
Lily Tang	Pricing Strategy Lead	NHS Improvement
Andrew Webster	Director of Public Services and Health Former Director of Integrated Care	KPMG UK Local Government Association
Rob Whiteman	Chief Executive	CIPFA