QIPP Long Term Conditions

Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions

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Supporting the local implementation of the Year of Care Funding Model for people with long-term conditions

Prepared by QIPP LTC Year of Care Funding Model Project Team

Contents

Foreword

This document provides an introduction to the Long Term Conditions (LTC) Year of Care funding model. It is aimed at health and social care commissioners and providers who are implementing integrated LTC care services to improve outcomes and experience for people. We describe a potential new way of funding LTC care.

The funding model has been developed through the QIPP LTC workstream to support health and social care teams in integrating care in a more successful and sustainable way by better aligning the funding flows and incentives with peoples' needs.

This is not a mandated model, it is a concept that has been developed using evidence and best practice and that will be formally tested from 2012 by Early Implementer sites. The model will evolve over time with this testing phase informing future iterations. This document describes the model as it will be tested by the Early Implementer sites and as such prescribes a set approach for the purpose of national evaluation.

Throughout the document the term "Commissioners" refers to both NHS and Local Authority Commissioners. The term "Providers" refers to statutory health and social care organisations, and the third and independent sector organisations providing health and/or social care to people relating to their LTC.

The Case for change

A survey covering 1.75 million people showed the majority of people over 65 have two or more LTC, the majority over 75 have three or more, and more people have two or more conditions than one[1]. There is predicted to be a 252% rise in over 65 year olds by 2050 and a 60% increase in the number of people with multiple LTC by 2016. Around 170,000 people die prematurely in England each year in total, with the main causes being cancers, circulatory diseases and respiratory conditions. We currently spend £19 billion on people with 3+ LTC. This is projected to rise to £26 billion by 2016.

The recent reports on integration from the NHS Future Forum (see annex 1.2 for further information) and the joint response from the Nuffield Trust and Kings Fund are clear on the case for change:

> "One of the key themes people raised with us was that, while many encounters between individual patients and professionals are patient-centred, the system as a whole is not. Too many patients and carers feel that they are required to fit their needs and lives around the services on offer, rather than experiencing flexible and responsive services. Our public services are deeply precious, but no more so than the people we are called to serve. There is a clear commitment from staff working across health and social care to build systems and services which are increasingly designed around people. Commissioners have a central role in ensuring we integrate around the patient, not the system."[2]

[1] The Scottish School of Primary Care's Multimorbidity Research Programme, 2011

> "We have heard [these] challenges (financial and demographic) referred to as the dual "burning platforms". The status quo is not an option. The case for integration is clear."[2]
>
> "Financial incentives are needed to support rather than inhibit organisations to work together around the needs of patients…"[3]
>
> "This [integration] will require significant reform to develop capacity in primary and community care and to prioritise investment in social care to support rehabilitation and reablement. The independent sector and third sector organisations have an important contribution to make in developing new models of care. The result would be to make a reality of care closer to home and to reduce the inappropriate use of acute hospitals"[3].

Patients and service users gave the Future Forum two clear messages about integration[4]

- People want **co-ordination;** not necessarily (organisational) integration.
- People want **care**; where it comes from is secondary.

The NHS Operating Framework for 2012/13 made clear the priority for integrated care:

> "It will be equally important that, as more decision making is taken locally to reflect the needs of patients and the clinicians who support them, the NHS does more to integrate service delivery, not only across primary and secondary care between mental and physical health but also with social care organisations. Each sector needs to look at where it can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions"[5]

The current care and financial system needs to evolve to meet these demands. The QIPP LTC workstream is supporting health and social care teams to improve outcomes for people and use of resources through provision of an evidence based best practice care model.

The care model requires implementation of three key drivers - risk stratification of people with LTC, integrated care teams involving health and social care with one identified lead caring holistically for a given person, and maximising the number of people who can co-manage or self care for their conditions. This model is being spread across the country by a development programme now covering 30 million of the population, and there is a wealth of resources available to support implementation of these three key drivers[6].

The year of care funding model aims to facilitate the commissioning and contracting of this care model and aligns with the key recommendations from the

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[2] Integration A report from the NHS Future Forum, 2011 http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132023.pdf

[3] Integrated care for patients and populations: Improving outcomes by working together http://www.kingsfund.org.uk/publications/future_forum_report.html

[4] Integrated care: what do patients, service users and carers, National Voices, January 2012 want?http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf

[5]The Operating Framework for the NHS in England 2012/13. DH 2011, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

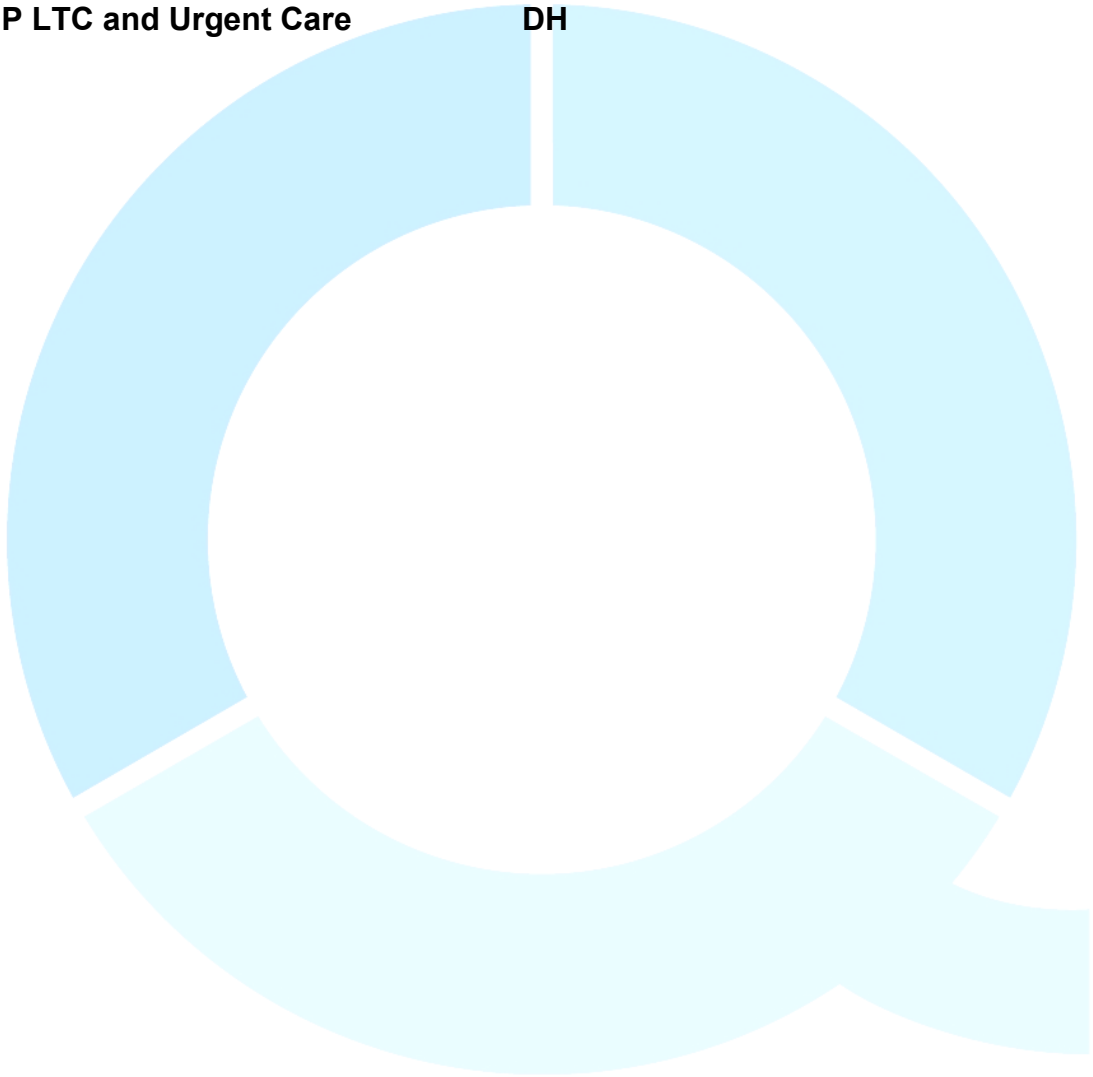
[6] QIPP LTC Workstream http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/about-us

aforementioned reports. The successful development of this model is of crucial importance to the NHS and social care system, providing a route for sustainability. The work of the Early Implementers is, in turn, pivotal to that development and they will place themselves and their citizens in a strong position for the future.

Finally we would like to acknowledge the tremendous work of LTC QIPP national coach and commissioning lead for the team, Jacquie White, and QIPP policy team member, Paul Griffiths in getting us to this point with pace.

Sir John Oldham
National Clinical Lead,
QIPP LTC and Urgent Care
DH

Professor Keith Willett
National Clinical Director – Trauma,
DH



Executive summary

The funding approach

The aim is to have a national LTC "Year of Care Funding Model", which facilitates the delivery of integrated health and social care for people with LTC based on need rather than disease and for those people who need support from more than just their GP practice. These people will be identified through risk profiling GP practice populations and by using a national assessment and classification system to group people according to their needs. Commissioners and GP practices will wish to work together to identify unregistered people with LTC and enable them to register with a GP practice so that they can benefit from this model.

The financial model will be an annual risk adjusted capitation budget which is based on these levels of need. The model aims to improve outcomes and deliver a more effective use of resources by focussing providers on moving away from episodic, activity driven funding flows towards person centred care irrespective of organisational boundaries

Implementation of the funding model will require variation to commissioning, contracts and service delivery to include greater capacity to provide the alternative LTC services closer to home with providers focussing on jointly delivering a year's worth of care. Accountability for the person with LTC, the outcomes and the use of resources across the continuum of that care will lie with all providers. This shift will be supported through strong risk sharing arrangements between commissioners and providers.

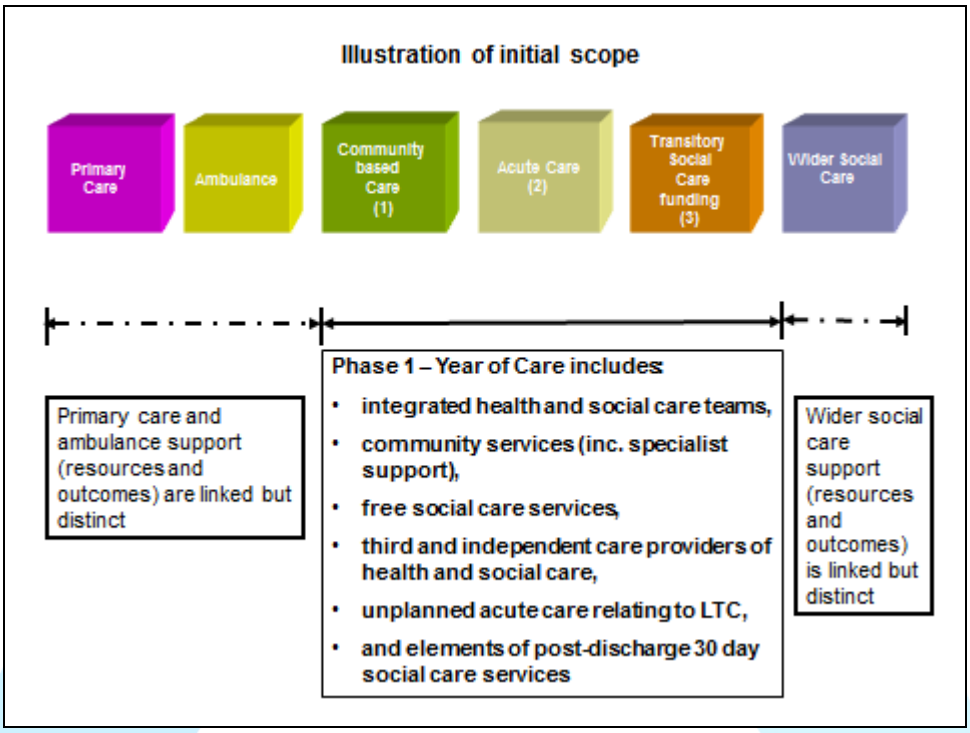
Given the scale of this challenge and the current financial climate in order to develop the model in a manageable phased way there will be two parallel developmental aspects to this work. A set of national LTC year of care currencies based on need rather than primary diagnosis will be developed as a first step towards national prices. Secondly efforts will be made to develop supporting tools and share good practice around business cases, model specifications and risk sharing to facilitate the speedier adoption of such practices locally, building on previous PbR Guidance which suggested local health economies could move to a "year of care".

The Scope

The scope covers health and "free" social care relating to the person's LTC needs in a 12 month period (including integrated health and social care teams). Primary care, ambulance and wider social care funding will be linked but distinct to ensure a total understanding of use of resources and outcomes.

Primary care should be at the core of the integrated care model. Enthoven and Tollen (2004) describe the importance of integration developing "organically", with successful systems growing up and out from primary care[7]. Whilst the resources for this element of care remain outside the scope of this funding model primary care should be an integral part of the discussions, implementation of the model and achievement of outcomes.

[7] The Evidence base for Integration, Department of Health, 2008, http://www.dhcarenetworks.org.uk/_library/Resources/ICN/ICN_advice/The_evidence_base_for_Integrated_care.pdf



Proposed development timeline

The following milestones are proposed, progress will be dependent on the results of an evaluation at each stage.

April 2012 – March 2013:	Test implementation of the model
April 2013 – March 2014:	Shadow LTC year of care currencies (local), and development of national pricing model
April 2014 – March 2015:	National LTC year of care currencies and shadow prices
April 2015 – March 2016:	National LTC year of care prices

Risk Adjusted Capitation Model

The funding model to be developed is a risk adjusted capitation budget, which aims to support improved outcomes through use of a dedicated "budget" based on a person's needs.

Definition[8]:

> "A capitation can be defined as the amount of health service funds to be assigned to a person for the service in question, for the time period in question, subject to any national budget constraints."
>
> "Capitations are usually varied according to an individual's personal and social characteristics, using a process known as risk adjustment. In most nations, the intention is that the risk-adjusted capitation should represent an unbiased estimate of the expected costs of the citizen to the health care plan over the chosen time period (typically one year)."
>
> "Capitation is seen as an important mechanism for securing both equity and efficiency objectives."

Anticipated benefits

The LTC year of care funding model aims to facilitate sustainable implementation of integrated care and help realise the associated benefits (see annex 1 – The Evidence).

The following extract, lifted from "Commissioning Integrated Care in a Liberated NHS" (Nuffield Trust, Sept 2011), best describes the expected benefits of applying this funding approach:

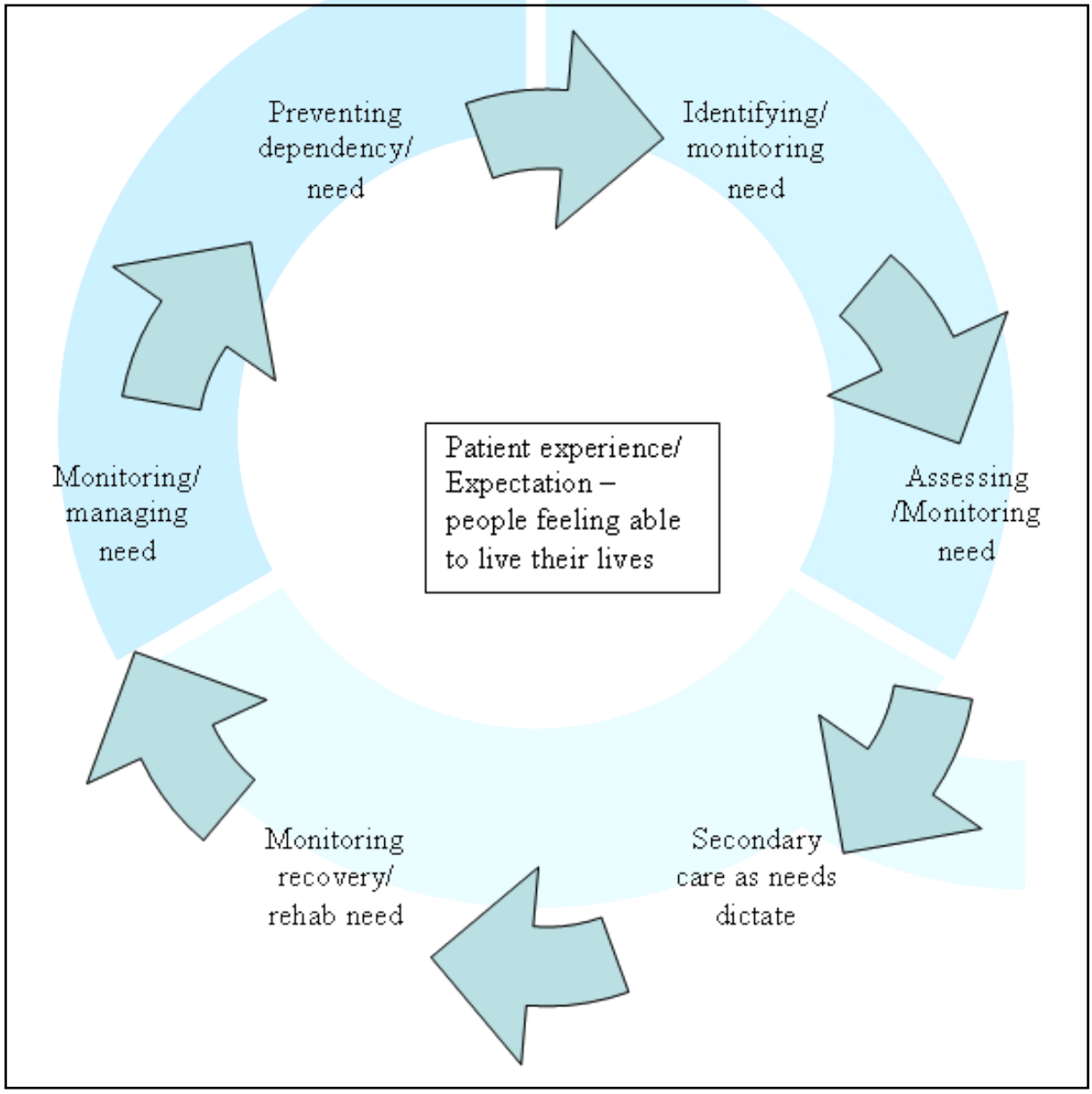
> *"Capitation payments* potentially cover all the costs of care for a defined population over a certain time period (a year, for example). Integrated health care systems such as Kaiser Permanente have pioneered the use of capitation funding (or pre-paid group practice as it was originally known) as a way of creating incentives to support prevention and primary care and avoid the inappropriate use of specialist care. (Fisher and others, 2007).
>
> ***Commissioners need to be able to encourage and incentivise providers to develop better integrative processes, and to work with others to develop more integrated care.*** The research reported here suggests that commissioners do not need to over-focus on specifying details of structures and process within providers – they should instead develop outcome measures with linked incentives that lead providers to work with partners to bring about new forms of more integrated care. Thus, the commissioner becomes not the enforcer of a contract (albeit that they may on occasion have to do this) but the crafter of an environment where providers are both at risk for, and incentivised towards, ensuring that local organisational processes are in place which can deliver high-quality care for a particular population."

[8] Approaches to capitation and risk adjustment in health care: An International Survey, Nigel Rice & Peter Smith, 1999, http://www.york.ac.uk/che/pdf/op38.pdf

Focus and Outcomes

The funding model will look to shift the focus away from managing people and their conditions upon presentation with an exacerbation or acute episode to a more preventative focused model utilising the potential of primary, community and social care and the third and independent sector to manage and support people with LTC in their communities.

This will require Clinical Commissioners, and ideally social care, to risk stratify their population to understand the level and with the integrated care team effectively manage the need in that population, including any unmet need (diagram below).



Outcomes for the person and the system
The principle of the model must be that people with LTC should not be admitted to hospital unless the exacerbation exceeds the capacity of what can be provided in the community. The model should support outcomes based improvements in standards of care.

It is anticipated that the new funding model will support the following improvements:

People with LTC:

- Personalisation/Self management/Choice for people and carers;
- Safety and confidence in services;
- Increased independence/well-being and quality of life.

System:

- Assessment of Physical/Mental/Social need and prioritising risk (at the right place and at the right time).
- Improved system enablers (e.g. Data sharing and linked information systems, access to services etc.);
- Prevention of admissions;
- Increased Value for Money;

Outcomes and Measures

Outcome	Measure
1. Person & carer confidence in services/care given & own abilities to self care	• Annual survey of people supported by the integrated care team (from each level of need) using the QIPP LTC 6 questionnaire (annex 2.3), aiming to achieve 75% at level 3 or higher in each question.
2. Person's level of need: Improvement/Maintenance/Reduction of deterioration	• Annual changes in RP score - total number of people whose score has reduced, maintained, or increased (local use of tools such as the EQ5D may provide a more detailed understanding of changes in need)
3. Use of resources: shift in spend across services, reduction in acute admissions and length of stay, reduction in long term care costs	• Total LTC spend, split per sector (community, secondary, social, third and independent sector) and per level of need • Numbers of people and spend in each of the three levels of need (per 1000) and spend per head of population • Number and spend of acute unplanned admissions and bed days relating to LTC for each level of need and the annual % change compared to the previous 12 months (per 1000) and as a subset for the HRGs that are separated through the RRR model (see annex 5) • Total number and cost of bed days in residential and in nursing home beds in each level of need (per 1000) and those that are publically funded • Number of people that were previously living at home transferred from an NHS facility to a nursing or residential home

Use of a balanced score card[9]

The balanced score card was developed to give managers a fast and comprehensive view of performance using a set of key measures. In this model it is used to demonstrate the importance of outcomes for people with LTC as the primary objective.

<table>
<tr><td>Patient/Person:
Outcomes:
Improved confidence in services and ability to self care
Improved experience of services and care delivery
Improved/Maintained/ Reduction in deterioration in level of need</td><td rowspan="3">Integrated YOC LTC Service
Aim: To improve outcomes for people with LTC and use of resources</td><td>Financial:
Outcomes:
Better understanding and use of resources
Shift in spend across sectors to reflect more proactive care delivery
Reduction in acute unplanned admissions and length of stay
Reduction in long term care costs</td></tr>
<tr><td>Process (enablers):
Outcomes:
Assessment of Physical /Mental / Social need and prioritising risk (at the right place and at the right time)
Improved access to care for people with LTC and professionals
Improved communication between services and with individuals
Implementation of new funding flows
Care co-ordination
IT & data sharing across services</td><td>Learning/Growth of organisations:
Outcomes:
Integrated team working
“Boundary-less” care delivery
Improvement in staff experience/satisfaction
Freedom to innovate
Partnership culture/behaviours</td></tr>
</table>

Benefits:

- All partners can sign up to a system wide view of the outcomes supporting early discussions about the model, what needs to be delivered and who could do it
- It is a visual aid/tool to illustrate the system aims rather than the individual organisation’s parts of the model
- It shows the impact of improvement in one area against the other domains and any unforeseen consequences
- It balances financial priorities with quality of care
- In addition to the high level outcomes, organisations can add their own outcomes so staff understand the totality of the approach and the impact of their own role
- Long term outcomes e.g. improved quality of life can sit in the central box allowing a short, medium and long term focus

The tool should be used alongside local LTC data (as per the dataset outlined in the commissioning framework – annex 4.1) to support commissioning discussions and provides the potential to support the development of a cross sector CQUIN[10].

[9] The Balanced Scorecard – Measures that drive performance, Robert S. Kaplan & David P. Norton, 1992 http://www.iluv2teach.com/mgt424/BS1.pdf

[10] Using the Commissioning for Quality and Innovation (CQUIN) payment framework, DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

Assessing and Classifying people with LTC

Assessments of people with LTC (and their carers) are a fundamental part of the LTC care planning process with people supported by a health or social care worker (e.g. case manager or care co-ordinator) to agree goals and interventions to meet their needs.

The Year of Care Programme has demonstrated how to deliver personalised care in routine practice for people with LTC, using diabetes as an exemplar[11]. The RCGP has provided so "patients and clinicians who read it can feel more confident about how to use *Care Planning* in their daily practice to achieve better health outcomes, improve the efficiency of working together and reduce 'strain' on the NHS and social services"[12]

For this funding model it has been assumed that assessment and care planning is an integral part of the local LTC integrated care model. The following supporting process should be used during the assessment to determine a person's level of need.

Population level - Risk Profiling of the LTC cohort

At a population level risk profiling data will be used to identify the numbers of people with LTC in each level of need in order to plan for services and for contract negotiations. Individual assessments of people with LTC will be used to reconcile expected versus actual activity and costs for future planning purposes and contract management.

Whilst no particular risk profiling tool is mandated, the data sources used are. As a minimum this should include primary, secondary and community data and if not immediately feasible should have a plan to include social care data and ambulance activity as soon as possible.

Individual level – Assessment framework and classification system

The NHS Continuing Health Care (NHS CHC) Decision Support Tool[13] will be used to group people according to need using the following classification system (based on what was proposed by the National Funding Review for Palliative Care)[14].

LOW: LTC Stable/low complexity – Symptoms controlled, needs met by current care plan, discrete short-term interventions/support may be needed

[11] The National Year of Care Programme (Diabetes) www.diabetes.nhs.uk/year_of_care
[12] Care Planning – Improving the Lives of People with Long Term Conditions, RCGP, 2011 http://www.rcgp.org.uk/PDF/CIRC_Care_Planning.pdf
[13] The NHS Continuing Health Care Decision support tool, DH http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103329.pdf
[14] National Palliative Care Funding Review, DH, July 2011 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133100

MEDIUM: LTC fluctuating stability/some complexity – Some complexity of symptoms or needs which are mostly met by current care plan at a maintenance level, but occasional exacerbations may require additional management and support

HIGH: LTC unstable/high complexity - symptoms/needs unstable or of high complexity, some expected episodes of deterioration in health with the need to adapt the care plan - regular reviews with worsening family distress and/or social burden - additional management and support needed

Palliative Care/End of Life – it is anticipated that organisations will want to utilise the national palliative care classification and funding system once this is developed to understand and plan for the specific needs of people at this stage of care

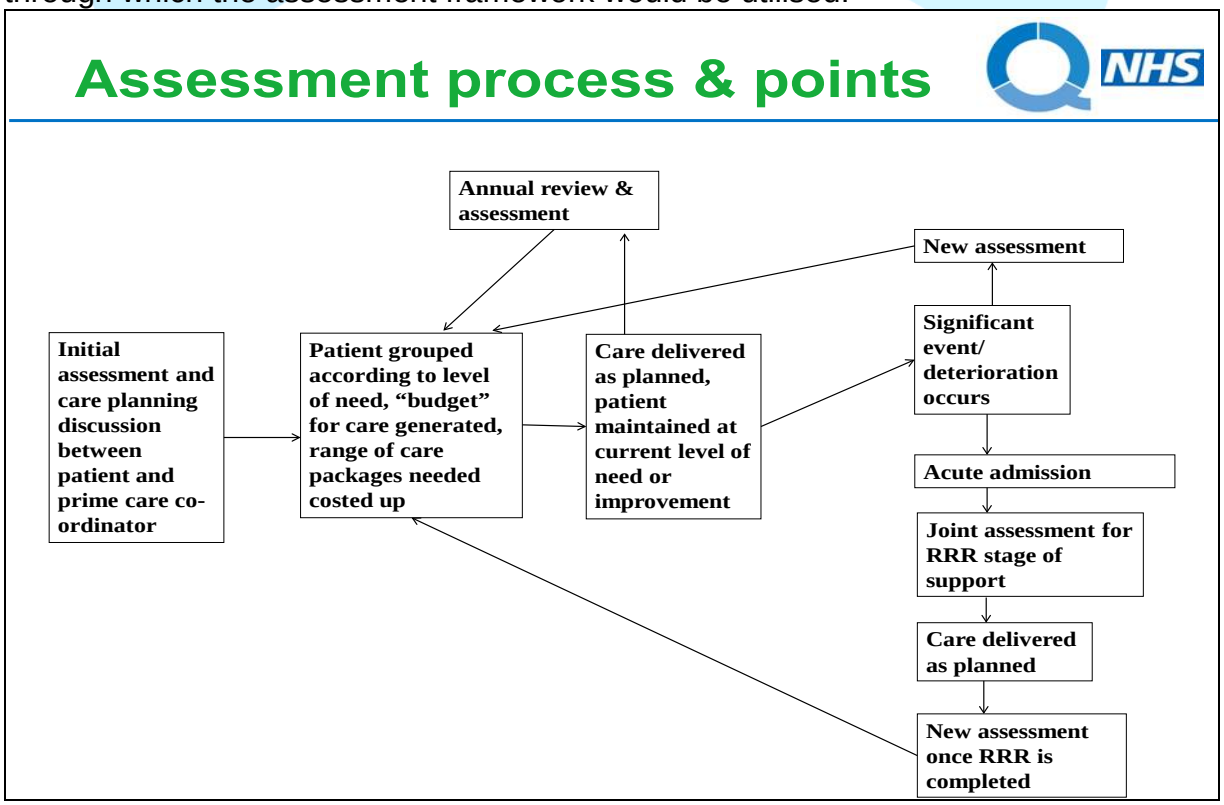
Classification Matrix

It is anticipated that an initial matrix referencing low to high levels of functional need against low to high levels of complexity of health need will support understanding and refinement of the classification system. The matrix allows sub-division of the three main levels of need to provide a more sensitive assessment and classification process.

		Complexity of Health Needs		
		High	Medium	Low
Level of Functional Need	High			
	Medium			
	Low			

Assessment Process & Framework

The following diagram provides a view of the assessment process and points through which the assessment framework would be utilised:



The assessment framework will include the following elements:

- As part of the assessment process, the NHS CHC Decision Support Tool will be used to group people into the low, medium and high categories;
- The prime/main care co-ordinator (i.e. whoever is most suited/able to co-ordinate care with the person with LTC) leads the initial assessment. A carer or advocate could provide valuable support to the person with LTC through the process.
- Use of a validated Single Assessment Process (SAP) tool for Older People is preferable; however, any assessment tool used must have the same information fields as a validated SAP tool to ensure consistency.
- In addition to understanding the biopsychosocial needs of the person the assessment will provide a view of the wider determinants of the person's need e.g. home environment.
- For acute admissions, an early multidisciplinary assessment would occur before the "acute" phase of care ends using the same assessment tool to determine how best to meet the recovery, rehabilitation and reablement needs of the person (see annex 5).

Annex 2.1 provides further details on the classification and assessment process.

In this funding model the NHS CHC Decision Support Tool is used to assess a person's level of need in terms of the LTC year of care classification system. It is not used as part of the assessment process for NHS funded continuing health care.

Funding, costing and pricing methodology

Funding

The total funding available in this model for an integrated LTC year of care service includes all LTC related commissioned care in the following areas: community services (including integrated health and social care teams), secondary care (A&E attendances & acute admissions), "free" social care services, and health and social care provided by third and independent sector services.

Locally, where a lack of data prohibits inclusion of some resources, a phased approach with agreed assumptions, data improvement plan and risk share may be necessary to facilitate progress. Primary care (including prescribing), ambulance and wider social care funding will be linked but distinct to ensure a total understanding of use of resources and outcomes.

The total available resources should be clear including any local constraints and expected efficiencies to be made.

Costs

A review of NHS reimbursement systems by PwC on behalf of Monitor stated that:

> "The reimbursement system should support the overall policy objectives of the NHS. Its success relies on three elements –information, incentives and compliance.
> An effective reimbursement system should incentivise improvements in both the quality of patient care and the efficiency of providers (and therefore the system as a whole).
> This requires a rigorous and comprehensive set of information."[15]

In order to develop national currencies and prices for the LTC year of care funding model, more robust costing information is needed. Currently, considerable activity is undertaken in the community, generally under existing block contract arrangements with a lack of meaningful data. Therefore work is needed to improve the quantity and quality of data in order to understand the totality of cost in supporting people with LTC.

In 2012/13 detailed costing analysis will be undertaken taking into account direct, indirect and corporate costs of providing care for people with LTC. This will be further refined in 2013/14 with the aim of publishing national currencies for 2014/15 and national prices for 2015/16.

The scope of the care to be included in the costing information is all LTC related care commissioned by the NHS or Local Authority (as defined in the above funding section).

The following principles will apply to the costing work:

- The data will not hold up progress and will improve over time;

[15] Evaluation of the reimbursement system for NHS-funded care, Monitor and PwC, 2012 http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/our-publications/browse-category/about-monitor/monitors-proposed-n-0

- The funding model, assumptions and caveats made will be clear with greater emphasis on collaborative risk sharing to support organisations working together;
- Data requirements will be kept simple with audit of the system used for a greater level of granularity and to understand if the required outcomes are being achieved;
- System audit will be built in as part of contracts and would help to manage any potential risk of upcoding of people into higher groupings.
- Benchmarking of costs will help local areas to reduce variation and increase productivity

It is expected that the NHS Manual and costing standards will be used when costing local services (see annex 3.1 & 3.2).

Pricing the year of care capitation fee

The aim is to develop a year of care capitation fee for each level of need using the costing work described above. As the level of need is determined by both a calculated risk score and an individual assessment it is expected that there will be less subjectivity in how people are classified. Small scale testing has shown that the two methods of assessing need map across well.

The capitation fee for each group will be the average expected level of resource needed, and within that therefore there will be some people who need more and some who need less resource. Meeting an individual person's need should not be restricted by this fee and care should be based on outcomes which would include ensuring an effective use of the resource available. As the funding model is based on the LTC population it is anticipated that variance in the cost of delivering care will average out across the LTC population.

Examples will be provided to support local development of prices until the national pricing work is complete (see annex 3.3).

Commissioning the model, contracting options & risk sharing

Supporting documentation and examples of commissioning arrangements will be shared to help local commissioners and providers in developing contracting models that meet their needs and that will support progress towards the year of care funding model being implemented.

There are currently two documents available (see annex 4):

Framework to support commissioning discussions
This document aims to support discussions between commissioners and providers in the development and delivery of an integrated service for people with LTC using the year of care funding model.

The document provides information and advice on the various elements to consider for implementation of the model including the need to comply with the Public Sector Equality Duty in delivering services.

Review of contracting options

There are a variety of ways of contracting for integrated LTC care. As this is a new funding model this document aims to provide some guidance as to the types of contracting models that could support implementation with a review of four key models to support local consideration.

Approaches to risk sharing

> "In a general sense, the concept of risk-sharing may be defined as the process by which two parties or more agree to share the risks associated with achieving a certain outcome. The parties should have a mutual interest in achieving that outcome and should agree on the manner in which they define the risk and deal with it throughout this process. In the commercial and financial worlds, risk-sharing is linked mainly to the issue of financial cost, i.e. the costs that may or may not be incurred by the parties by taking the risk of trying to reach a mutual outcome. In a public setting most importantly, risk-sharing agreements should reflect a true commitment to serve the needs of patients, to allow for greater individual choice, while securing the most effective methods of treatments. This means that the risk may be at the expense of payers, or [providers] or both - but never at the expense of patients.[16]

Risk-sharing arrangements can be defined as "a contract between two parties who agree to engage in a transaction in which there are uncertainties concerning its final value. Nevertheless, one party has sufficient confidence in its claims of either effectiveness or efficiency that it is ready to accept a reward or a penalty depending on the observed performance." De Pouvourville et al (*Eur J Health Econ*, 2006).

There are four key elements to a risk sharing agreement:
- Have a clear goal

[16] Sharing the burden: Could risk-sharing change the way we pay for healthcare, Stockholm Network, 2010, http://www.stockholm-network.org/downloads/publications/Sharing_the_Burden.pdf

- Look for the win-win
- Consider longer-term impact
- Make sure it can be implemented

Principles of risk sharing[17]:

- Simple to understand
- Simple and easy to apply
- Based rely on robust, accredited data
- Recognises the variable use of services over time due to their complex, specialist nature
- Recognises the variable levels of access
- Protect populations from swings in contribution due to minor changes in use of services but which have high costs
- Risk sharing arrangements are documented and agreed

When things go wrong:
The contract should highlight the process of managing the situation, what the definition of non-performance is for each party and the implications of non-delivery of the agreed outcomes.

Examples of risk sharing arrangements are available in annex 4.3

National Commissioning Principles

In commissioning this model it is expected that organisations abide by the following principles:

- National principles and rules for cooperation and competition, and the principles and behaviours defined for commissioners and providers in their contractual relationships (annex 4.4)
- The NHS expected principles and behaviours of commissioners and providers (annex 4.5)
- The procurement process (annex 4.6)

[17] East of England Specialised Commissioning Group, June 2010

The Recovery, Rehabilitation & Reablement (RRR) Model

A key component of the LTC year of care funding model will be to invest in high quality and capable community services to manage people with LTC more effectively including exacerbations thereby avoiding hospital admission, and to provide high quality and safe step down services for people who are hospitalised.

Currently, for those people admitted through urgent and emergency care pathways, the majority of bed days occupied during their admission are not a result of their acute care (the diagnostics, therapeutic interventions or surgery and immediate treatment response) but are for their recovery, rehabilitation and reablement (RRR). Not only is this current service design inefficient for the hospital, but it also frequently delivers an inadequate service for patients by setting limited goals (such as “safe to go home”). There is a very limited or no attempt at reablement (restoration of previous capacity or employment) and there is a poorly managed interface with Social Care characterised by delays, unnecessary assessment criteria failures and avoidable readmissions. For some diagnostic groups Social Care will become responsible for up to 40% of discharges (stroke, multiple co-morbidities etc.). It is illogical that Social Care and primary care are not involved at the earliest opportunity to both minimise and anticipate need. The current model perpetuates and compounds the often large step-down in support from secondary care to community care and accounts for many of the unsustained discharges (readmissions).

For many people their own experiences of coping strategies and their ability to recover independence are based on their physical and social home situation. Independence will be most quickly restored by care and therapies in that environment. This is particularly applicable to the elderly, frail and those with LTC. This approach is already practised in other countries. The CQC (2010) reviewed variance in occupied bed-days for multiple admissions of >75s and concluded that better joining up of Social Care and Health across England would save £2billion.

The health and social care system needs to move to a position where admission to hospital for a LTC is the exception. There must be a greater emphasis on achieving the best recovery and reablement and sustainable community care. Those inheriting the responsibility for post discharge care support must be allowed early input into planning the RRR needs and have the commissioning freedom to innovate and look at alternative options.

The RRR model aims to ***change the responsibility for care, and the tariff, at the point when the patients’ needs change not at the point at which they change institutions.*** Introducing the RRR concept into the year of care funding model will allow the necessary investment to be made in a credible community alternative, including social care and voluntary sector organisations.

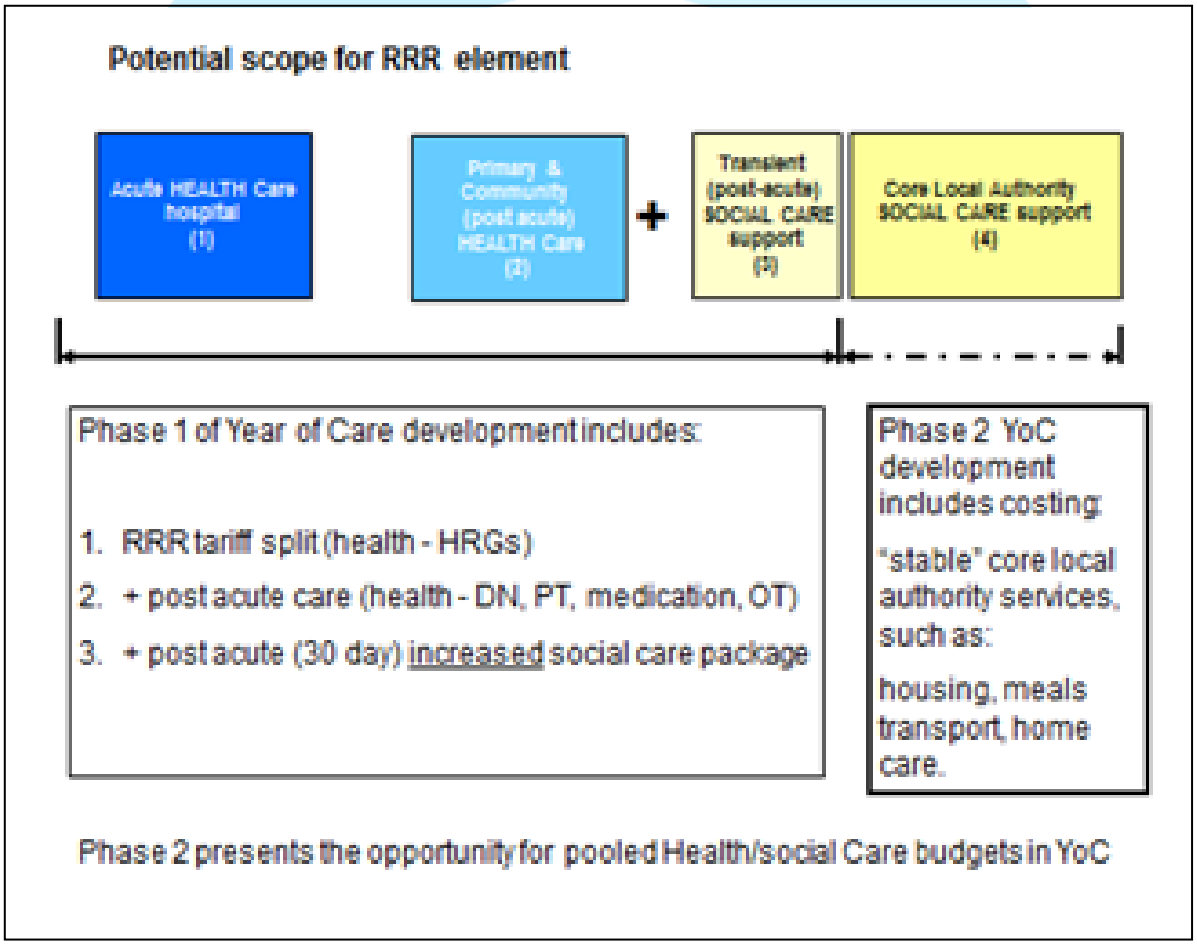
The RRR model looks to move the responsibility for recovery, rehabilitation, reablement and return home much earlier to primary and community care by separating the current acute tariff payment after the acute care phase and starting a new tiered RRR tariff immediately after the acute phase of care (see annex 5 for full details of the RRR model). Clinical oversight of the integrated pathway should be

jointly managed by the acute care team, primary care and the LTC integrated care team(s).

LTC year of care funding model and RRR

For a number of LTC HRGs commissioners and providers will be advised on how the tariff could be separated into the acute phase and the RRR phase of a standard hospital spell. Where possible advice will be provided on how triggers can be used and tariffs restructured so that the RRR element can be jointly commissioned by health and social care. This together with the post discharge care costs can be summated to fund integrated care options and community services to sustain home care. Commissioners will be encouraged to make funding contingent on whether an early assessment of a person's need has occurred.

Costing analysis will be undertaken early in 2012/13 to understand how and when some key LTC tariffs could be separated. Early implementer sites will test the impact of this concept to inform national roll out and implementation processes.



Related national policies

The LTC Year of Care Funding Model does not sit in isolation, there are several related policy developments that can be aligned for local implementation.

LTC Year of Care Funding Model and Personal Health Budgets

Personal health budgets[18] are a key part of the Government's drive to personalise the public services people receive. Like the Year of Care Funding Model, they are essentially an amount of money allocated to meet an individual's healthcare needs. They complement and build on LTC Care Planning[19] and the philosophy of Year of Care[20] and Co-creating Health[21], and focus on patient involvement in decision-making and person centred planning. In addition, as personal health budgets focus on an individual's needs rather than on a diagnosis or particular LTC they could be a key element for commissioners in implementing the year of care funding model.

Personal health budgets are currently being piloted, and there is a clear government commitment to roll out personal health budgets, subject to the evaluation of the pilots. In the longer term, the Government's aim is to introduce a right to a personal health budget for anyone who would benefit from one. Subject to the evaluation, people in receipt of NHS Continuing Healthcare will be the first to have a right to ask for one, by April 2014. Clinical commissioning groups will also be able to offer personal health budgets for other patient groups, on a voluntary basis.

Commissioners will need to consider how personal health budgets fit with their other commissioning tools, including the Year of Care Funding Model. Key considerations include:

- With a personal health budget, individuals know how much money is available to meet the healthcare needs before they start the care planning process.
- With a personal health budget the person (and their family) takes the lead in developing the plan, in partnership with professionals and others who can help them.
- The Year of Care Funding Model includes a much wider range of services than a personal health budget. We do not believe that all of the healthcare needs of an individual will be met through personal health budgets. There will always be medical musts, such as appointments with consultants, diagnostic tests, medication and acute or unplanned admissions that will not be included in a personal health budget but rather traditionally commissioned. We do not believe that personal health budgets will be right for everyone
- With some personal health budgets, NHS commissioners may continue to commission care on behalf of individuals (notional budgets). However, individuals may also be given a cash payment (direct payment) to commission their own care or a third party may do so. This could form part of the overall commissioning of the year of care funding model.

[18] For more information on personal health budgets see http://www.personalhealthbudgets.dh.gov.uk/About/
[19] http://www.dh.gov.uk/en/Healthcare/Longtermconditions/DH_093359
[20] http://www.diabetes.nhs.uk/year_of_care/the_year_of_care_pilot_programme/?#sg_anchor_
[21] http://www.health.org.uk/areas-of-work/programmes/co-creating-health/

LTC Year of Care Funding Model and the Post discharge tariff

The Year of Care funding model will look to incorporate the emerging policy on Post Discharge Tariff as it progresses. This policy looks to support Secretary of State's vision of a shift of responsibility for patient care following discharge from hospital from commissioners to acute providers. As such, with the help of NHS colleagues, post discharge tariffs for four specific rehabilitation pathways have been developed, learning from best practice examples already operating in the NHS and social care.

From 1 April 2012, the acute tariff will be expanded to include new tariffs covering post discharge care in four areas:

- Cardiac rehabilitation
- Pulmonary rehabilitation
- Hip replacement
- Knee replacement.

The tariffs, which are set out in the tariff information spreadsheet[22], are based on clinical advice and, where available, existing DH commissioning packs. They are sufficient to fund an entire pathway and not just the first 30 days after discharge.

LTC Year of Care Funding Model and 3 Million Lives

The LTC year of care funding model will look to support the 3 million lives campaign, through creating a funding system that rewards innovation and greater use of enabling technology.

Telehealth and telecare see the use of electronic equipment to read vital health signs such as pulse, weight, respiration and blood oxygen levels, which can be interpreted remotely by healthcare professionals, without the patient leaving home.

Over the last three years, the Department of Health has been running the world's largest randomised control trial of telehealth and telecare. Involving over 6,000 people across three sites (PCT/LA partnerships in Cornwall/Kent and Newham) and 238 GP practices, the programme will provide a robust evidence base on the benefits for patients and carers, patient outcomes, impact on use of healthcare resources, and the best ways of supporting delivery.

Headline findings from the Whole System Demonstrator programme suggest that telehealth can lead to a:

45% reduction in mortality;
21% reduction in emergency admissions;
24% reduction in elective admissions;
15% reduction in A&E attendances;
14% reduction in bed days; and
8% reduction in tariff costs.

[22] Confirmation of Payment by Results (PbR) arrangements for 2012-13, DH
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654

Now that the Whole System Demonstrator programme has provided evidence of the benefits of telehealth, emphasis is focused on ensuring that these technologies can be adopted by and integrated into the NHS at scale and pace.

To achieve this level of change the Department of Health is working with UK industry, the NHS, social care and professional partners to achieve the "3millionlives" campaign – a campaign to improve the lives of 3 million people with LTC by rolling out telehealth and telecare across the country.

The care of people with LTC accounts for around 70% of the total health and social care budget, which equates to some £70bn. It is therefore hard to suggest that a different way of using that money better should be identified to deliver improved health outcomes. That is why the Department of Health signed a concordat with the leaders of the telehealth and telecare industry agreeing to a unique collaboration to spread the benefits of the technology at scale and pace. Finding new business models that rely on lease or maintenance agreements rather than high cost per unit.

The jointly owned ambition is to see the use of telehealth increase over the next five years to improve three million lives. Three million people benefiting from the kind of changes identified in the Whole System Demonstrator programme and not being reliant on hospital admissions as the only offer. More information on the 3millionlives campaign can be found by accessing the following website: www.3millionlives.co.uk

LTC Year of Care Funding Model and the national Mental Health currencies

The LTC Year of Care Funding Model will complement the national mental health currencies[23]. For those people with predominant mental health needs, the mental health currencies will be the mechanism for reimbursing such care. For those who have low level mental health needs in conjunction with enduring physical health care needs the LTC year of Care funding model will be used to reimburse, given they will predominantly receive health care to reflect the broader needs.

The approach that has been taken for introducing PbR for mental health services from 1st April 2012 has been to develop a set of currencies based on the needs of service users, rather than the use of diagnosis. Clinicians use a tool, known as the mental health clustering tool, to identify how they should allocate service users to a cluster. A range of interventions will be associated with each cluster. Whilst the interventions undertaken for each cluster will depend on the particular needs of each service user, they should cost roughly the same. Every cluster has a set review period associated with it. These range from four weeks for an acute psychotic episode to a year. For those clusters with a longer review, this does not mean that a service user is not expected to make progress within that period. A set of protocols has been developed to guide clinicians on how service users might move between clusters, and move out of them completely. A focus on quality and outcomes has been an integral part of the work to develop PbR for mental health services. A set of indicators is already available for use and further work will be taking place in 2012.

[23] Confirmation of Payment by Results (PbR) arrangements for 2012-13, DH
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132654

LTC Year of Care Funding Model and the Palliative Care Funding Model

The Government recognises that it is important that people approaching the end of life, their families and carers get the right care and support where and when they need it.

In the past, funding for palliative care services has often been poorly distributed and varies greatly across the country. The Government is committed to introducing a per-patient funding system that will ensure all qualified providers of palliative care, whether they be statutory, voluntary or independent, are fairly funded.

Ministers decided to set up Palliative Care Funding pilot sites following a recommendation from the independent Palliative Care Funding Review. The review, chaired by Tom Hughes-Hallett, Chief Executive of Marie Curie Cancer Care, reported in July 2011 and made a number of proposals on how to make sure that the funding of palliative care providers, for both adult and children's services, is fair and transparent. The report recommended that pilots be set up to collect information and refine its proposals due to the lack of good quality data currently available. A copy of the final report can be found at Palliative Care Funding Review

On 20th March 2012, Andrew Lansley, Secretary of State for Health, announced eight pilot sites. The pilot sites, which will receive Government funding support, will collect essential cost and activity data over a two-year period beginning from April 2012. This work will be overseen by the Palliative Care Funding Pilots Working Group.

The learning from the sites testing the LTC year of care funding model and those supporting the development of the Palliative Care funding model will be shared to ensure that the two national funding systems align to support the seamless co-ordination of care for people with LTC once they reach the end of life stage.

Annexes

Annex 1: The Evidence
1.1 Scottish School of Primary care's Multimorbidity Research Programme
1.2 NHS Future Forum report on Integration
1.3 The LTC Commissioning pathway

Annex 2: Classification and assessment
2.1 National classification system and assessment process for LTC YOC Funding Model
2.2 NHS Continuing Health Care
2.3 LTC6 questionnaire

Annex 3: Costing the model
3.1 The NHS Costing manual and costing standards
3.2 Patient-level information and costing systems (PLICS)
3.3 Examples of costing pathways

Annex 4: Commissioning and Contracting support
4.1 Framework for commissioning the model
4.2 Contracting options
4.3 Examples of Risk Sharing arrangements
4.4 National principles and rules for cooperation and competition
4.5 Principles and behaviours for commissioners and providers (NHS contract)
4.6 Procurement Process (Protecting and Promoting Patients' Interests: the role of Sector Regulation)

Annex 5: RRR model

Annex 6: Project Team and Contributors

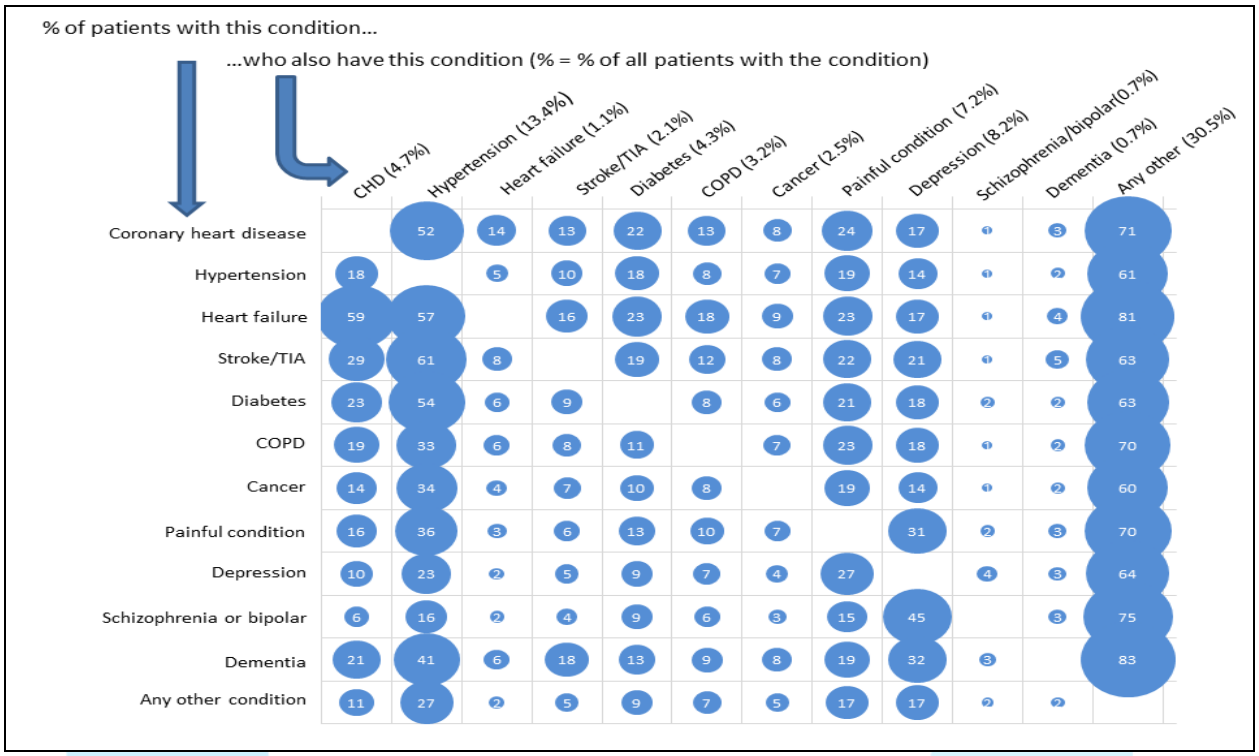
Further supporting resources will be shared throughout the testing phase

Annex 1: The Evidence

1.1 The Scottish School of Primary Care's Multimorbidity Research Programme

The data suggests:

- Only 18% of patients with COPD have just COPD;
- Only 14 % of patients with Diabetes have just Diabetes;
- Only 5% of patients with Dementia have just Dementia etc.



1.2 Future forum report on integration – the case for change

Key recommendations:

- Integrate around the patient not the system
- Make it easier for patients and carers to coordinate and navigate
- Information is a key enabler of integration
- You can only improve what you measure
- Health and Wellbeing boards must become the crucible of health and social care integration
- Providers need to be able to work with each other to improve care
- Clarify the rules on choice, competition and integration
- Freedom and flexibility to "get on and do"
- Allow the funding to follow the patient
- National level support for local leadership is essential
- Sharing best practice and breaking down barriers

Patient expectations

"….people want integrated journeys of care to become the norm for people with complex or long-term health and social care needs. For these patients, poorly integrated care cannot be regarded as good care. We believe that every patient with complex or long-term needs has the right to expect:

- to receive care as close to home as possible;
- to be informed about the options available to them;
- the opportunity to discuss their options with a professional skilled in shared
- decision-making;
- easy access to a named care coordinator who knows them and is able to provide a tailored level of support to navigate their care journey and make choices at appropriate junctures;
- to know what to expect at each step of planned care journeys;
- to have an integrated care plan and where appropriate be offered an integrated budget;

- every provider involved in the individual's care to have access to their care record;
- transitions between professionals, teams and organisations to be safe, smooth and efficient;
- to understand clearly and simply what care and support they are eligible for and how they might pay for it if they are not eligible for state-funding; and,
- to be confident that appropriate information, training and support are available for any carers.

Enablers to integrated care

- A shared vision of the case for change between GPs, local authorities, and other partners
- Strong, courageous and persevering leadership, particularly from local professionals
- Sufficient time spent building relationships, developing a shared culture and governance between organisations
- Involvement of people and communities as key partners in designing services
- Proactive provision of information and support to help people make decisions about their own care
- Sharing information between all providers involved in an integrated journey of care
- Joint commissioning between health and social care based on shared vision and budgets
- Using flexible funding models and innovating around existing incentives
- Alignment of governance procedures, staff management and training
- Leadership investment in supporting behavioural change and shared ambitions within providers
- Responsiveness to feedback of frontline staff
- Strong commissioners prepared to follow through on a vision to integrate around the needs of patients
- Sharing of activity and performance data between commissioners and providers
- Anticipation and mitigation of side effects of service changes, such as initial 'double-running' of services

Barriers to integrated care

- Repeated structural change prescribed centrally
- Lack of clear shared vision among all parties involved
- Lack of strong leadership or organisational alignment
- Lack of attention to issues of culture, staff engagement, behaviour and training to deliver change
- Lack of interest from local GPs, local authorities or other organisations in new ways of working
- Lack of shared culture, language, governance and operating procedures between organisations and sectors
- Insufficient investment in service improvement and project management
- Failure to remove or address conflicting incentives
- Existing payment regimes and information systems
- An expectation that integration of providers will always improve care or reduce costs
- Disparities between commissioners in funding available – particularly between health and local authorities
- Reluctance among providers to share performance data
- Lack of high quality premises in the community for new services
- Provider financial models which disincentivise integration

1.3 The LTC Commissioning Pathway

The pathway has been developed with help from various experts in their field, both from teams on the QIPP LTC workstream and others and has the support of the NAPC, NHS Alliance, and the DH Commissioning Directorate amongst others.

The pathway aims to support the focus on the patient and population rather than the individual disease treating people in the least intensive, least invasive environment. It encompasses population level support as well individual patient level support using a generic LTC care model that includes care provided by the primary care team, integrated neighbourhood teams (health & social care) and specialist services.

The pathway provides different levels of information to support implementation for all the different stages of the patient's health; Patient pathway, Commissioning, Workforce, Technology, Financial flows and incentives, Data and information.

Annex 2: Classification and assessment

2.1 National classification system and assessment process for the LTC Year Of Care Funding Model

Aim
Implementation of a national classification system for LTC (using the NHS Continuing Health Care (NHS CHC) Decision Support Tool) to support integration of care, outcomes based improvements for people with LTC and better use of resources.

This will enable high quality, personalised, accessible care, supporting people with LTC to develop confidence and competence to participate in managing their circumstances even better.

Objectives
- Improved outcomes and experience for people with LTC as the key drivers
- People will have opportunity to express their needs and preferences and make choices about the support they receive embracing the principle “no decision about me without me”.
- People with LTC will not be admitted to hospital unless the exacerbation exceeds the capacity of what can be provided in the community
- Classification of people with LTC will be undertaken with a balance between the clinical assessment and the information required to support the business, without adding an additional data burden
- The new system will be simple and easy to implement and support all related policies e.g. Post Discharge, personal health budgets, choice, clinical commissioning group authorisation etc.
- Information systems must be interoperable or data sharing arrangements in place to support professionals having access to up to date information to enable them to deliver the right care at the right time in the right place
- Existing assessment processes will be reviewed to ensure individual people with LTC benefit from co-ordinated care and resources are not deployed to repeatedly assess them regardless of where they are currently based.

Benefits of using the NHS CHC Decision Support Tool
- Use of the NHS CHC Decision Support Tool will better embed the principles of this approach and ensure that is aligned for people with LTC who go on to need that next stage of support (see Annex 2.2)
- It will support close working relationships between the LTC integrated care team and the NHS CHC team
- Use of validated Single Assessment Process tools will ensure consistency of approach. Furthermore it would improve the potential for systematic review to be undertaken as “usual business” without creating an additional set of information governance questions
- The framework will be familiar to many practitioners, therefore multi-disciplinary teams will not require much introduction to the approach and logistical deployment can be more easily managed.
- It will support the mainstreaming of a process already in use and which allows for a common language between health and social care The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care are recognised by Social Care agencies and providers.
- It will support the further roll out of Personal Health Budgets already being piloted in NHS CHC services into this funding model for individuals with LTC.
- Applying the principles of this assessment approach throughout the pathway may overcome tensions that exist in local system associated with administrative “boundaries” as the intensity and complexity of need changes.
- The approach would provide front line staff with greater awareness of the level of resource required to maintain individual care packages

Process

The following describes the process for use of the national assessment and classification system at both a population and individual level.

At a Population level:

- Use of system wide validated risk profiling (RP) tools (as a minimum this should include primary, secondary and community data and if not immediately feasible should have a plan to include social care data and ambulance activity as soon as possible) to stratify the population into three levels of need[24]
- RP data will be used to agree contract indicative activity and cost at the start of the year and to plan services needed – risk sharing arrangements should allow risk on the establishment of the baseline to be shared, as opposed to performance KPIs where the organisation underperforming would take the hit.
- Contracts are negotiated based on the LTC year of care commissioning framework (see annex 4.1) which specify the agreed outcome measures for the population
- Risk sharing options are in place to support partnership working & joint accountability of performance and outcomes and reduce the risk of gaming in the system including up coding of a person's needs.
- The actual activity and cost based on individual assessments are monitored throughout the year to understand the how the population level stratification of risk maps with the individual level of needs.
- To reduce complexity a risk sharing agreement as part of the commissioning process will enable the funding level associated with the assessment of need for the overall population group to remain stable in-year, recognising that whilst peoples' needs will move up and down this will generally average out the impact on cost. Margins and thresholds will be negotiated to manage risk.

At an individual level:

- A person with LTC will be referred to the community team/integrated team/or identified in primary care for assessment (through risk profiling data)
- A validated Single Assessment Process tool (or one with the same information fields) will be used to assess an individual's need
- A key worker/Care co-ordinator will be identified to undertake the initial assessment, care planning discussion and commission care packages once the need is agreed with the person (and carer where appropriate)
- The NHS CHC Decision Support tool (see Annex 2.2) will be used to confirm the classification of that person's need into one of the levels (Low, Medium, or High)
- The personalised care plan will be agreed between the individual (and carer) and the key worker based on the individual's goals and objectives and a review date set
- Care packages will be put in place to support the person with their needs
- All acute exacerbations will be flagged to the key worker on admission to hospital to support discharge decisions or via agreed arrangements with the community providers.
- Multi-Disciplinary Team assessment occurs once the person is medically stable prior to discharge from the acute phase of the admission and the person (and carer where appropriate) is supported through their Recovery, Rehabilitation and Reablement phase either by the acute care provider (taking responsibility for the 30 day post discharge period and retaining the whole tariff for the episode of treatment) or through community based services (using the split tariff and taking responsibility for the post 30 day discharge)
- The person with LTC will be reviewed as a minimum annually and at various points as their personalised assessment and care planning process dictates
- The funding banding for the individual will be monitored as part of the overall assessment of need and will be adjusted accordingly to take account of improvement or deterioration in level of need.

Outcomes of the approach

The following outcomes are expected for individuals:

- Enjoy improved quality of life, health and well-being and be more independent
- Be supported and educated to care for themselves (self-care) and take decisions about their support based on their preferences
- Have choice and control and being informed over their care and support, with services built around their needs.

[24] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/choosing_predictive_risk_model_guide_for_commissioners_nov11.pdf

- Design of integrated and flexible health and social care services around their care needs
- Access services that are safe, high quality, efficient and sustainable
- Improved confidence and experience

For the health and social care system:

- Evidence of systematic involvement of local service users and carers in defining their service needs.
- Existence of actively managed and validated patient registers that capture the number of people diagnosed as having LTC using local prevalence and severity data from the Quality and Outcomes Framework (QOF) and Hospital Episode Statistics (HES). Also use of local information such as risk occupations, smoking rates, BMI and age and sex profiles, risk occupations locally; smoking rates; age-sex mix etc. to identify trends in demand and resource utilization
- Use of the NHS number as the unique person identifier
- Risk stratification of the population using validated tools according to a combination of disease severity, the needs of people with LTC, and resource deployment
- Estimated numbers of undiagnosed people using prevalence models such as those developed by Public Health Observatories used for planning purposes.
- Further assessment of those people whose contact with primary care may be insufficient using risk profiling tools available at practice level in the community,
- Reduction in admissions to acute settings and reduction in the time spent in acute settings
- Evidence of a greater number of people receiving support and intervention outside an acute hospital setting
- Assessment of numbers of people suitable for referral to supportive self-management programmes and who accept the referral.
- Improved confidence and experience of people with LTC
- Evidence of people using services more effectively (integrated care teams, Community specialist teams, Rapid response teams, community hospitals, outreach teams and GP practices etc.)

2.2 NHS Continuing Health Care (CHC)

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103161.pdf

In this funding model the NHS CHC Decision Support Tool is used to assess a person's level of need in terms of the LTC year of care classification system. It is not used as part of the assessment process for NHS funded continuing health care.

Core values and principles

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4136389.pdf

The core values and principles that underpin the NHS CHC Decision Support Tool can also be applied to the LTC year of care funding model.

"The assessment for, and delivery of, NHS Continuing Healthcare and NHS-funded Nursing Care should be organised so that individuals and carers understand the process, and receive advice and information to enable them to participate in informed decisions about their future care. …."

"NHS Continuing Healthcare (framework) is based on an individual's assessed health needs and is **not** disease-specific, **nor** determined by either the setting where the care is provided **nor** who delivers the care. Access must be fair and there should be no discrimination based on age, condition or type of health need (e.g. physical, psychological or mental). An individual's preferences and wishes, as to how and where the care will be delivered, should be taken into account, along with the risks of different types of provision and fairness of access to resources, when deciding how their needs will be met. Where a person's express preferences are not met, then clear reasons should be given to them."

The Decision support tool

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_103329.pdf

The tool provides practitioners with needs-led approach by assessing need on the basis of eleven 'care domains'. These domains represent generic areas of need into which the various requirements of an individual can be placed. The domains are sub-divided into levels of need, depending on the domain. The care domains are:

- Behaviour
- Cognitive Impairment
- Communication
- Mobility
- Nutrition – Food & Drink
- Continence
- Skin (including tissue viability)
- Breathing
- Drug Therapies & Medication
- Psychological/Emotional Needs
- Seizures/Altered States of Consciousness

2.3 LTC 6 Questionnaire

The LTC 6 is a 6 item questionnaire. The questions have been drawn from validated questionnaires. These measures indicate changes in knowledge, beliefs and perceptions which are necessary to sustain change over time. Analysis and feedback should be undertaken in a timely manner and communicated widely.

LTC 6 questionnaire for people with LTC (or carers):

What is this survey about? This questionnaire is about your experience and understanding about the care you have received over the last 12 months.

Why should I complete the survey? Understanding your views is vital to help us improve our services for people with long term conditions. It is being sent out to about xxx people in your local area.

Who is carrying out the survey? The survey is being carried out by your local GP practice/primary care trust (*please amend as appropriate*)

Your participation in this survey is voluntary. If you choose not to take part in this survey, it will not affect the care and support you receive in any way. If you do not wish to take part, or do not want to answer a particular question, you do not have to give us a reason.

Your answers will be treated in confidence. Please do not give your name or address anywhere on the questionnaire. No information will be shared in a way that allows you to be identified.

How to complete the survey. There are 6 questions and will take about 5 or 10 minutes to complete. You are asked to circle a number between 0 and 3 with your considered response. There is opportunity to give us more information should you wish in the space provided.

Questions or help? If you need any help in answering the questionnaire, please call xxxxxxxxx and speak with xxxxxxxxx

Thinking about the last 12 months, when you received care and support for your condition(s)…

1. **Did you discuss what was most important for *you* in managing your own health?**

Not at all	
Rarely	
Some of the time	
Almost always	

2. **Were you involved as much as you wanted to be in decisions about your care or treatment?**

Not at all	
To some extent	
More often than not	
Almost always	

3. **How would you describe the amount of information you received to help you to manage your health?**

I didn't receive any information	
I rarely received enough information	
I sometimes received enough information	
I always received enough information	

4. **Have you had enough support from your health and social care team to help you to manage your health?**

I have had no support	
I have not had enough support	
I have sometimes felt supported	
I have always felt supported	

5. **Do you think the support and care you receive is joined up and working for you?**

Never	
Rarely	
Sometimes	
Always	

6. **How confident are you that you can manage your own health?**

Not at all confident	
Not too confident	
Somewhat confident	
Very confident	

How could your care be improved? ……
……
……

What would support you to feel more confident? ……
……
……

Thank you very much for completing this questionnaire.
Please send it to: xxxxxxxxxxxx in the pre- paid envelope provided

Annex 3: Costing the model

3.1 The NHS Costing manual and costing standards

http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/index.htm

This Manual sets out the principles and practice of costing to be applied in the NHS. It is not just designed to support the production of the National Schedule of Reference Costs (NSRC), and through this, the national tariff, but should also be used in developing and monitoring service and financial frameworks, as well as developments in and the monitoring and implementation of National Service Frameworks.

Costing must be undertaken on a full absorption basis. Costs should be matched to the services that generate them and should reflect the full cost of the service delivered. This will be best achieved by maximising the proportion of costs charged directly to services and adopting a standardised approach to the apportionment of overheads and indirect costs

3.2 Patient-level information and costing systems (PLICS)

http://www.dh.gov.uk/en/Managingyourorganisation/NHScostingmanual/index.htm

PLICS represent a change in the costing methodology in the NHS from a predominantly "top down" allocation approach, based on averages and apportionments, to a more direct and sophisticated approach based on the actual interactions and events related to individual patients and the associated costs. Patient-level costs are calculated by tracing resources actually used by a patient and the associated costs by using actual costs incurred by the organisation in providing a service or event. Patient-level costing is defined by the ability to measure the resources consumed by individual patients.

Patient-level costing is the resourcing consequences of clinical activity and is primarily informed by the measurement of that clinical activity. Clinical validity is therefore underpinned by the accuracy and legitimacy of that core activity data. This necessitates the involvement of clinical staff in the definition, documentation and authentication of raw data inputs into a patient level information and patient level costing system.

Benefits of implementing PLICS

- An ability for an organisation to truly understand their economic and financial drivers. PLICS can provide transparency to an organisation of their income and costs at a service and sub service level on a monthly basis. It provides the capability to bench mark, analyse, investigate and evaluate the make up of the organisations service costs. There is a further ability to benchmark individual cost elements (e.g. nursing costs, drugs, theatre cost) and patient cost profiles against other providers.
- Dramatically improved clinical ownership of operating information. Dialogue can be had about resources consumed by individual patients with similar diagnoses and comparisons can be made against peer groups, teams, individuals as well as care pathways.
- Provides crucial information to inform any future change in the grouping and classification of patients. A detailed knowledge of the cost distribution of individual patients rather than the average cost is a necessary precondition for best in class classification.
- Provides necessary and crucial information to inform funding policy for payment of high and low outliers for each HRG. Distribution of patient cost is again a prerequisite to ensure the calculation and payment of a long term sustainable price to an efficient provider – a critical goal of Payment by Results (PbR).
- Provides valuable data in discussions with commissioners.

3.3 Examples of costing pathways

The following are examples of costing services from a commissioning and a provider perspective and aim to stimulate local discussion. They are not suggested as the only approaches to take and other examples will be gathered and shared as the work progresses.

3.3.1 Costing for integrated services in Lewisham

Developing integrated care is likely to be the single biggest contribution to improving quality of care for patients for both their health and social needs as well as having the potential for doing this through affordable pathways. Setting up the right commissioning framework, contracting and payment structures is key to enable clinicians to redesign effectively.

The following approach is being developed to commission and contract for an integrated care process beginning with Diabetes and COPD pathways. This model is being developed by a whole system collaboration run by the Lewisham Health Economies Group. - made up of local providers and clinical commissioners from health and social care.

The approach suspends Payment by Results by developing a budget for LTC and commissioning a pathway-specific Joint Management Board of providers. This will manage the budget and flex resources to deliver the best affordable care and ongoing rewards for the pathway board to support improvements in efficiency over time. In essence, the LTC budget becomes a "joint account" between providers who are all responsible for getting the best out of it – savings are reinvested. This is likely to incentivize upstream and community-based care. It is designed to meet the considerable challenges to deliver high quality affordable care facing the NHS over the coming years.

Who is involved?
The development of an integrated care model represents a commissioning strategy at the highest level in Lewisham. It has received a mandate from chief executives, Business Support Unit Managing Directors, Clinical commissioning Executives, Head of Adult Social services, finance directors, clinical directors, Public Health directors, Joint Commissioners, Health and Well-Being Board, clinical commissioning committee, lay members of the board, patient representative groups (LINK), Lewisham BSU staff, LMC, primary care contracting, acute care contracting team and the South East London Sector as well as project and finance managers. Failure to engage any single one of these groups would lead to significant delay or failing to meet its objectives.

The Costing Model - Define a current budget and budget management systems

- Define a 2-3 yrs health economy financial plan.
- Decide what level of cost reduction needs to apply to integrated pathways as a whole and then to specific pathways.
- Decide what is affordable for a particular pathway within the current financial climate.
- Quantify financial risk to all major parties.
- Maximise positive drivers and address perverse drivers e.g. financial payment mechanisms.
- Formulate financial and governance rules for managing resource spread in pathway and incentives and dispute resolution.
- Ensure that the redesign is clinically better for patients and clinically safe but affordable.

Deciding what is affordable:
To decide what is affordable requires an outline financial plan for the health economy over 2-3yrs agreed between commissioners and providers. The plan defines the health economy's total available spend, identifies the gap from current spend projections, makes a judgment of how much of that gap is amenable to/ needing to be met by integration approaches, identifies how many pathways one needs (and that you have the resources to redesign) to contribute to the gap and makes a call on a notional savings target against each pathway from the perspective of achieving a viable health economy. Its purpose is not to tie people down into financial contract expectations but to ensure that we share an understanding of the scope and scale of what we are trying to do.

Costing the current pathway

2 views can be considered:
- Redesign the pathway and then look at the cost and the resources required with intent to make undefined "efficiency" savings over time.
- Define the budget and then redesign the pathway based on what can be afforded and consider transition funding to cover the time to take out the costs where required e.g. workforce.

If services are costed based on existing pathways and a tariff is then developed on those costs then the tariff will be designed for a pathway that might simply cost too much in the current climate and not one that is radically different from its predecessors in terms of cost/design or outcomes. Instead we need to come to a view on what is affordable but clinically safe – including a more radical approach particularly to workforce and innovative resource use such as Telehealth.

Programme Budgeting Marginal Analysis can be used to cost the elements of a care pathway which can be changed and under the control of a board (as opposed to full programme budgeting methodology which costs a whole pathway in detail but is complex, time consuming and still liable to significant error). The approach looks at the following questions:

- What could be decommissioned? (what could we stop doing because something else would be a better use of resources)
- What resources could actually be released in doing this?
- What could be commissioned differently and at what cost and benefit?
- Can that be done within the budgetary resources freed up?

The currency being discussed is not merely one of income but also the opportunity to take costs out and improve income to cost ratio. (I/C ratio)(profitability in business terms)

For example:
A business has two main market areas – one is profitable, the other is not. The loss making part now exceeds the profit making one. – The business may sell off its loss making one thereby increasing its profitability overall by improving its income to costs ratio (i.e. profit) thus the business remains healthy even though its income overall may have reduced considerably..

This principle is not well acknowledged and should influence what commissioners are willing to pay for a service as it is the basis of potential win-wins in the current climate.

Example: Lewisham Diabetes Pathway
We define the overall budget and then expect pathway partners to improve the pathway together.

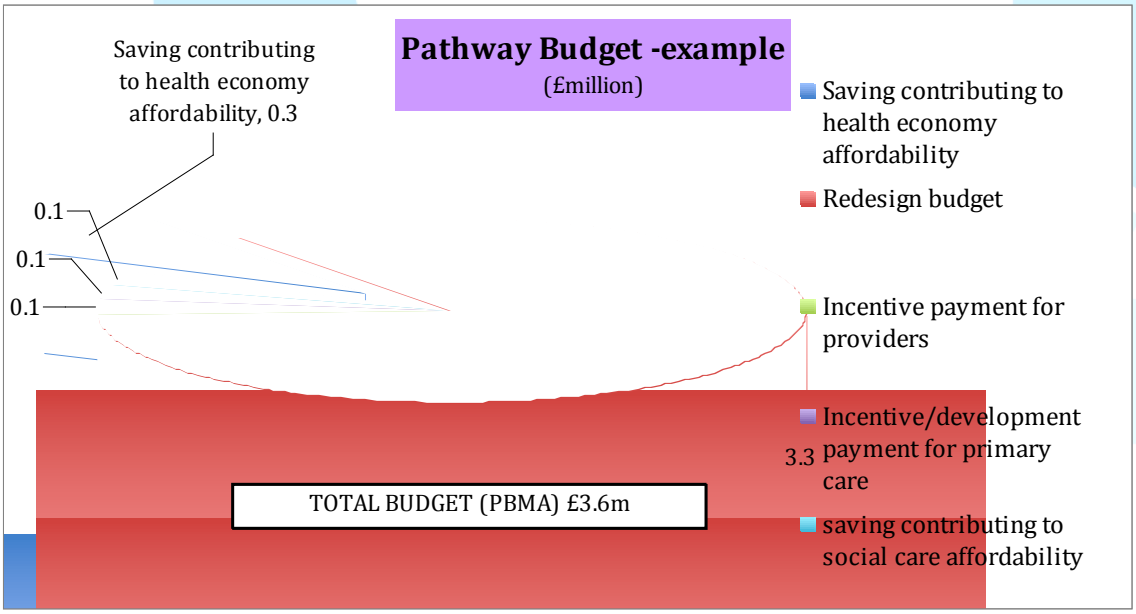
Phase 1: Current pathway budget is calculated using a reproducible method for current and ongoing costs. It includes the community budget for diabetes services, primary care extended provider services, inpatient care (HRGs) and outpatients and social care spend for patients on the population "register" with social care needs.

Phase 2: calculations may include:
- Tertiary spend (as there is limited data currently to understand what this spend is without significantly more modelling.)
- PMS/GMS primary care spend,
- Prescribing
- Dietetics and podiatry services

All these budgets will need to be flexible and under the control of the Joint Management Board and its redesign approaches. (i.e. not fixed immovable costs)

Contracts will be kept flexible to allow inclusion of the phase 2 elements of the budget at a later stage where possible.

Example of a Pathway Budget



TOTAL CURRENT PATHWAY SPEND (PBMA)	3.6m
QIPP saving (i.e. what is needed for affordable health economy from this pathway)	300k
Incentives/savings for providers	300k
Thus - affordable redesign commissioner payment	3m

Internal pathway contingency	**50k**
Provider redesign budget (provider costs)	**2.95m**
I/C ratio	3/2.95= 1.017

Taking a total pathway budget of £3.6m –the health economy outline financial plan suggests that 300k (QIPP saving) needs to be contributed to the health economy on a recurring basis from this particular pathway from 2014-15 onwards.

To achieve this level of health economy contribution an integrated pathway redesign needs to take place between a range of providers including primary care. Incentive payments to support provider development are estimated as £300k meaning that there is £3m available in commissioner payments for the pathway. However the pathway also needs to create a contingency to allow flexibility to respond to its needs and deal with some elements of risk. E.g. £50k. (i.e. a 1.7% contingency) which sits within the JMBs control. Thus the new affordable pathway budget means its provider costs should be £2.95m. This gives an income to cost ratio for providers of 1.017 (£3m /£2.95m)

For 2013-14 the pathway is redesigned to achieve a cost for clinical care of £2.95m however the relevant trusts are unable in that time to reduce their cost base. So the commissioners agree a transition pathway payment of £3.3m (£3m plus £0.3m incentive payments) provided that by 2014-15 costs are taken out and the pathways are able to function at a £3m commissioner cost and still produce the 50k contingency.

Any further savings above and beyond that planned are reinvested in the pathway to deliver improved pathway quality.

3.3.2 The Lincolnshire experience

Clinical teams map the current and desired pathway starting with and following the patient at all times. This includes all the administration and processes such as Multidisciplinary Team Meetings. The level of interaction needed and at what skill level is agreed by the clinical team taking into account the level of support per day a patient can cope with and that will promote recovery and achievement of outcomes. This process challenges teams to improve pathways, reduce any duplication or unnecessary steps and identify any gaps in support. This clinically led process also helps to reduce variation in clinical practice, and all services have to demonstrate that the specification is in line with current evidence.

Once the pathway is agreed it is costed up looking at the following elements:

- Pay
- Non Pay / Recurrent
- Accommodation
- Staff Training
- Patients Equipment
- Patients Travel
- Consumables
- Staff Uniforms/Clothing
- Information Technology
- Clinic Equipment
- Other Costs
- Overhead Costs
- Financial Surplus to Achieve FT Financial Risk Rating
- Cost Summary Sheet

Annex 4: Commissioning and Contracting support

4.1 Framework for Commissioning an Integrated service for People with LTC using the Year of Care funding model

Purpose

The purpose of this document is to support discussions between commissioners (health and social care) and providers (health, social, third and independent sector) in the development and delivery of an integrated service for people with LTC and provide national consistency in the application of a year of care risk adjusted capitation budget. In line with good commissioning practice and national legislation it is expected that people with LTC and the public will be engaged in the development of new services and that due regard has been given to the public sector Equality Duty (this ensures that people are not excluded or discriminated against and that care is delivered in a fair and transparent manner)[25]. The new Equality Duty replaced three sets of equality duty – for race, disability and gender – and covers the following protected characteristics: age; disability; gender reassignment; pregnancy and maternity; race, religion or belief; sex and sexual orientation.

Description of the LTC year of care funding model

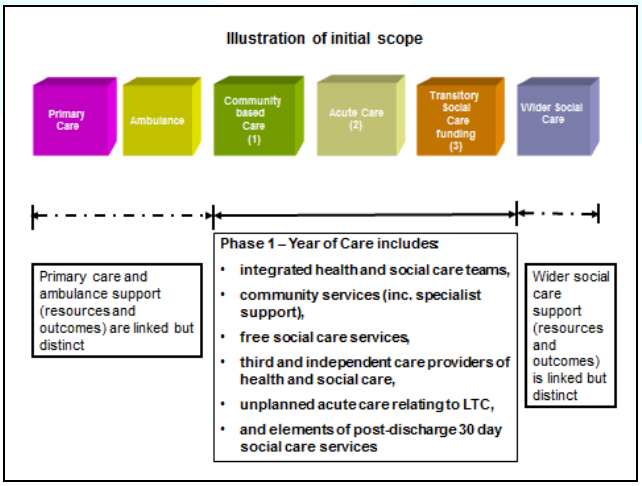
The LTC year of care risk adjusted capitation budget seeks to facilitate the delivery of integrated care for people with LTC based on need rather than disease and for those people that need support from more than just their GP practice. These people will be identified through risk profiling the GP population and, by using a national assessment and classification system, grouped according to their need.

The financial model will be an annual risk adjusted capitation budget which is based on these levels of need. The model aims to improve outcomes and deliver a more effective use of resources by focussing providers on moving away from episodic, activity driven funding flows towards person centred care irrespective of organisational boundaries.

Implementation of the funding model will require variation to commissioning, contracts and service delivery to include greater capacity to provide the alternative LTC services closer to home with providers focussing on jointly delivering a year's worth of care. Accountability for the person with LTC, the outcomes and the use of resources across the continuum of that care lies with all providers. This shift will be supported through strong risk sharing arrangements between commissioners and providers.

Scope of this work

The model relates to provision of LTC related community care, third and independent sector support, acute care, and "free" social care support. Inclusion of ambulance and wider social care support is encouraged through local development. Primary care should be at the core of the integrated model and whilst the resources for this element of care remain outside the scope of this funding model primary care should be an integral part of discussions, implementation of the model and achievement of outcomes.



[25] Equality Act 2010: Public Sector Equality Duty http://www.homeoffice.gov.uk/publications/equalities/equality-act-publications/equality-act-guidance/equality-duty?view=Binary

The funding model covers the care, management and administration of people with LTC as identified with low, medium or high levels of need. These arrangements **do not apply** to any scheduled or unscheduled care including any emergency care unrelated to their LTC.

Evidence

A survey covering 1.75 million patients[26] showed the majority of people over 65 have two or more LTC, the majority over 75 have three or more, and more people have two or more conditions than one. The current care and financial system is unfit for this purpose. The evidence based care model for people with LTC requires risk stratification, integrated care teams involving health and social care with one person caring holistically for a given individual, and maximising people who can co-manage or self care for their conditions.

Local data will be needed to understand the current situation including:

- Risk profiling (RP) data
- LTC registers in primary care
- LTC prevalence and expected prevalence
- QOF scores
- LTC Prescribing
- Acute admissions relating to LTC (and bed days)
- A&E attendances relating to LTC
- Ambulance activity and costs
- Long term care activity and costs (social care)
- People with LTC & carer confidence in the care/services delivered
- Individual's confidence in the ability to self care
- Use of total resources (budget vs. spend on LTC care in primary, community, secondary, and social care, ambulance and third and independent sector)
- Total resources available for an integrated LTC service (all LTC related: community services, secondary care A&E attendances & acute admissions, "free" social care services, third and independent sector services)

Whilst no particular RP tool is mandated the local tool should include as a minimum the following data - primary, secondary and community data and if not immediately feasible should have a plan to include social care data and ambulance activity as soon as possible.

Where data is unavailable (e.g. lack of diagnosis) or of poor quality, organisations should work together to improve this.

Expected outcomes

The following outcomes are expected to be achieved through the effective delivery of an integrated LTC service using the year of care funding model (there will be other benefits demonstrated that could be measured locally)

- **People with LTC & carers experience:**
  - Increased confidence in services/care received
  - Increased confidence in ability to self care
- **Improvement/maintenance of people's needs (and reduction in deterioration)**
- **Use of total resources:**
  - Shift in spend & activity across services (primary, secondary, community, social, third and independent sector)
  - Reduction in acute unplanned admissions and length of stay for cohort (LTC related)
  - Reduction in long term care costs

The principle of the model must be that people with LTC should not be admitted to hospital unless the exacerbation exceeds the capacity of what can be provided in the community.

Use of a balanced score card is recommended to provide a balance between all aspects of the outcomes and avoid an over emphasis on just finances.

[26] The Scottish School of Primary Care's Multimorbidity Research Programme

Benefits

The LTC funding model aims to facilitate sustainable implementation of integrated care and help realise the associated benefits.

The following extract was lifted from Commissioning Integrated Care in a liberated NHS (Nuffield Trust, Sept 2011) best describes the expected benefit of applying this funding approach:

> *"Capitation payments* potentially cover all the costs of care for a defined population over a certain time period (a year, for example). Integrated health care systems such as Kaiser Permanente have pioneered the use of capitation funding (or pre-paid group practice as it was originally known) as a way of creating incentives to support prevention and primary care and avoid the inappropriate use of specialist care. (Fisher and others, 2007).
>
> ***Commissioners need to be able to encourage and incentivise providers to develop better integrative processes, and to work with others to develop more integrated care.*** The research reported here suggests that commissioners do not need to over-focus on specifying details of structures and process within providers – they should instead develop outcome measures with linked incentives that lead providers to work with partners to bring about new forms of more integrated care. Thus, the commissioner becomes not the enforcer of a contract (albeit that they may on occasion have to do this) but the crafter of an environment where providers are both at risk for, and incentivised towards, ensuring that local organisational processes are in place which can deliver high-quality care for a particular population."

The Integrated LTC service

The service to be provided using the year of care funding model is an *integrated service for people with LTC*, which should encompass all the key elements of an effective integrated service (see box below) and including the assessment, pro-active preventative management, acute management, post discharge support and rehabilitation and reablement phases of a person's journey. It is anticipated that a 24 hour service, with a single point of access and rapid response will be required to ensure support can be delivered when it is needed.

Five key elements of an integrated LTC Year of Care service have been defined by the Richmond Group[27]:
- co-ordinated care
- patients engaged in decisions about their care
- supported self-management
- prevention, early diagnosis and intervention
- emotional, psychological and practical support

National Voices have developed, with its members, a set of principles for integrated care[28]. These principles can help commissioners and providers to develop co-ordinated, person-centred care which uses voluntary and community organisations to best effect. These principles state that Integrated care must:

- be organised around the needs of individuals (person-centred)
- focus always on the goal of benefiting service users
- be evaluated by its outcomes, especially those which service users themselves report
- include community and voluntary sector contributions
- be fully inclusive of all communities in the locality
- be designed together with the users of services and their carers
- deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for
- be driven forwards by the commissioners
- be encouraged through incentives
- aim to achieve public and social value, not just to save money
- last over time and be allowed to experiment

The latest evidence, guidance and examples of integrated care are available through the QIPP LTC workstream network site: http://www.networks.nhs.uk/nhs-networks/commissioning-for-long-term-conditions/about-us

Minimum requirements for people with LTC in the three levels of need:

- Identification of key worker/care co-ordinator and support as needed from the integrated care team
- Annual assessment of the person's holistic needs

[27] The "Richmond Group" - How to deliver high quality, patient centred, cost effective care, http://www.macmillan.org.uk/Documents/AboutUs/Commissioners/RichmondGroupPatientCare2010.pdf
[28] Principles of Integrated Care, National Voices, http://www.nationalvoices.org.uk/principles-integrated-care

- Agreement of a care plan and notification to all contracting parties
- Proactive support to enable people, their carers and or their families to self care, and access appropriate care and support as and when appropriate
- Access to specialist care services as and when appropriate and as set out in the care plan
- On-going review
- Recording and reporting the necessary information
- Timely liaison with other services, referrers and agencies

Providers will use the national classification system for LTC and validated assessment tools to allocate people into the following bandings:

- High need (Level 3)
- Medium need (Level 2)
- Low need (Level 1)

People at the end of life stage of need should be supported through the national end of life and palliative care classification system and funding model once developed (http://www.dh.gov.uk/health/2011/11/palliative-care-funding/)

Provider(s) will retain responsibility and accountability for the care of people with LTC throughout the continuum of that care.

The service will be funded through the risk adjusted capitation budget and measured on its ability to maintain and improve people's health and functional needs, and on their outcomes, including they (or their carers) confidence in the care/services provided and in their ability to manage their own care.

Performance Monitoring

The service will be measured on key performance indicators:-

Outcome	Measure
1. Person & carer confidence in services/care given & own abilities to self care	• Annual survey of people supported by the integrated care team (from each level of need) using the QIPP LTC 6 questionnaire (annex 2.3), aiming to achieve 75% at level 3 or higher in each question.
2. Person's level of need: Improvement/Maintenance/Reduction of deterioration	• Annual changes in RP score - total number of people whose score has reduced, maintained, or increased (local use of tools such as the EQ5D may provide a more detailed understanding of changes in need)
3. Use of resources: shift in spend across services, reduction in acute admissions and length of stay, reduction in long term care costs	• Total LTC spend, split per sector (community, secondary, social, third and independent sector) and per level of need • Numbers of people and spend in each of the three levels of need (per 1000) and spend per head of population • Number and spend of acute unplanned admissions and bed days relating to LTC for each level of need and the annual % change compared to the previous 12 months (per 1000) and as a subset for the HRGs that are separated through the RRR model (see annex 5) • Total number and cost of bed days in residential and in nursing home beds in each level of need (per 1000) and those that are publically funded • Number of people that were previously living at home transferred from an NHS facility to a nursing or residential home

The model should support outcomes based improvements in standards of care. Improvements to be made will need to be agreed locally.

Expected individual organisational outputs as part of this model should be agreed (e.g. agreed interventions, roles of different providers etc.)

Good risk sharing arrangements linking achievement of outcomes to financial management should be considered to incentivise providers to continue to drive up quality.

Provider Models
This funding model allows for a mixed economy of service provision to provide flexibility in the local market – It also allows for differing forms of partnership model from a formal integrated model to an informal partnership model. The usual contractual requirements will apply (see the NHS procurement process – annex 4.6).

Examples could include
- An informal partnership;
- Formal legal partnership e.g. integrated care organisation;
- A lead provider with sub-contract arrangement;
- Commercial service providers;
- Independent service providers;
- Social enterprises;
- Any other qualified provider with the necessary skills and qualifications.

Please see the Review of Contracting Options (annex 4.2) for further information on the types of contracts that could be used and comments on the strengths and risks of each (please note this is not an exhaustive list).

Principles of commissioner – provider relations
All parties are expected to work to the national principles and rules for cooperation and competition, and the principles and behaviours defined for commissioners and providers in their contractual relationships.

All providers are expected to work collaboratively to ensure a positive, co-ordinated response to people's needs.

Contracts should be flexible to allow commissioners and providers to plan for and implement agreed changes e.g. in year commissioning intentions for LTC care, delivery of care by providers in more productive manner through use of technology etc.

Risk Sharing
The underlying philosophy in setting up an integrated LTC service is one of working together in partnership for the good of people with LTC with joint responsibility to make it succeed. Risk sharing arrangements provide all the partner organisations with a clear understanding of how risks (and rewards) of working in this way will be shared.

Instead of simply passing costs and responsibility for people with LTC around the health and social care economy the aim is to incentivise organisations to manage people's care jointly – to invest in proactive services that will help keep them in better health and offer timely appropriate support. This will lead to improvements in the quality of care and outcomes for people with LTC.

Jointly agreed risk sharing arrangements that specify accountability for the performance of the service and the achievement of the outcomes should be used. Providers should be supported to plan for and implement the necessary changes in infrastructure in a sustainable and affordable manner. Engaging partners early in the process is important to develop a collective desire and responsibility to manage the local "LTC pound (£)".

The four key factors to risk sharing are:
- Have a clear goal
- Look for the win-win
- Consider longer-term impact
- Make sure it can be implemented

Principles of risk sharing[29]:
- Simple to understand
- Simple and easy to apply
- Based rely on robust, accredited data
- Recognises the variable use of services over time due to their complex, specialist nature
- Recognises the variable levels of access
- Protect populations from swings in contribution due to minor changes in use of services but which have high costs
- Risk sharing arrangements are documented and agreed

[29] East of England Specialised Commissioning Group, June 2010

When things go wrong:
The contract highlights the process of managing the situation, what the definition of non-performance is for each party and the implications of non-delivery of the agreed outcomes.

Governance
Clear governance arrangements should be agreed and cover the clinical governance, information governance and the financial governance of the service.

Information sharing agreements and consents should be put in place with the appropriate Information Governance processes and protocols. This is crucial to ensure organisational data systems are not a barrier to delivering person centred integrated care and need not be onerous or hold up progress (examples are available through the QIPP LTC workstream).

Data and records
The NHS number should be used as the unique person identifier for care services to link data between organisations and to support the use of a single record, which should belong to the person not individual organisations. Data sharing to support true integrated care is a requirement of the approach for all parties.

Considerable activity is undertaken in the community, generally under existing block contract arrangements with a lack of meaningful data. The Community Information Data Set (CIDS), which all providers of Community Services should be using from April 2012 (subject to having suitable systems in place and no later than April 2014), will start to improve the quantity and quality of data available. All providers of community aspects of this service should use the CIDS.

Decommissioning of services
Any potential decommissioning of services as a result of this model should be part of the initial discussions with partners with full impact assessment, clear collaboration from all involved, transparent decisions, and agreed implementation plans to support the process. The capacity and stability of small providers in particular should be considered carefully.

Funding
The total available resources should be understood including any local constraints and the expected efficiencies to be made.

The total funding available for an integrated LTC service should include all LTC related care in the following areas: community services, secondary care A&E attendances & acute unplanned admissions, “free” social care services, third and independent sector support. Locally, where a lack of data prohibits inclusion of some resources a phased approach with agreed assumptions, data improvement plan and risk share may be necessary to allow for progress.

Primary care, ambulance and wider social care funding will be linked but distinct to ensure a total understanding of use of resources and outcomes.

Funding will be provided based on the annual number of people stratified in the three levels of need using risk profiling (RP) data as follows:

- RP data will be used to agree contract indicative activity and cost at the start of the year and to plan services needed – risk sharing arrangements should allow risk on the establishment of the baseline to be shared, as opposed to performance KPIs where the organisation underperforming would take the hit.
- Risk sharing options are in place to support partnership working & joint accountability of performance and outcomes and reduce the risk of gaming in the system including up coding of a person’s needs.
- The actual activity and cost based on individual assessments are monitored throughout the year to understand the how the population level stratification of risk maps with the individual level of needs.
- To reduce complexity a risk sharing agreement as part of the commissioning process will enable the funding level associated with the assessment of need for the overall population group to remain stable in-year, recognising that whilst peoples’ needs will move up and down this will generally average out the impact on cost. Margins and thresholds will be negotiated to manage risk.

The service should be priced on a capitation payment basis for each of the three levels of need (according to the national classification system) and monitored on the basis of the quality of service provided. Any subcontract arrangements below this level should follow the same principles, service model and funding arrangement.

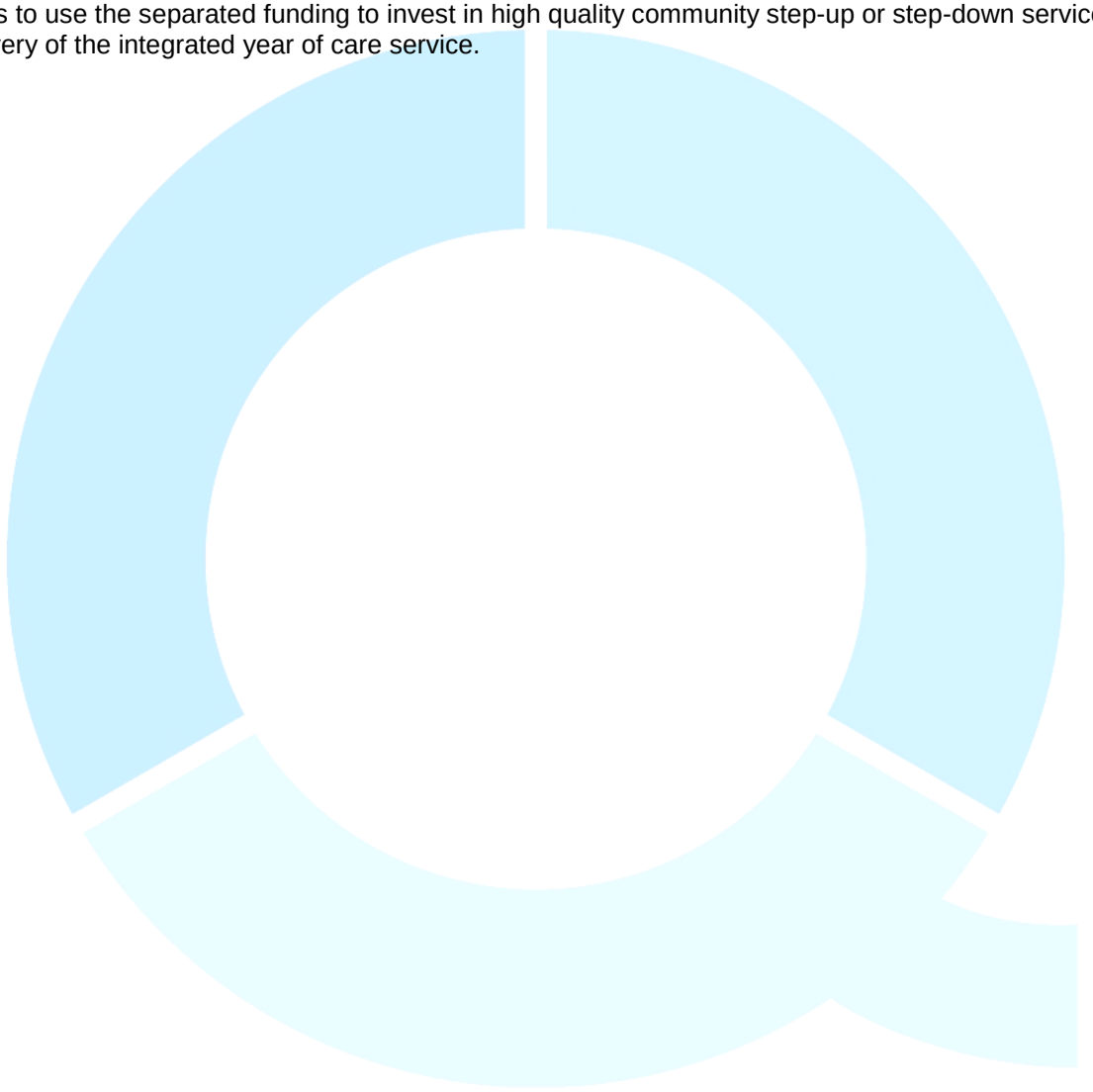
The influencing factors on the cost of the three different levels would be the complexity and cost of the different needs rather than the underlying clinical conditions.

The basis for moving people between the levels of need as their condition / treatment progresses will be the agreed national classification system and assessment process.

The efficiencies made over the lifetime of the contract will be reinvested as agreed by the partners involved in the delivery of the service. It is anticipated that investment will be prioritised in community based care (health, social and third and independent sector providers)

The RRR model

Commissioners and providers should plan for the local implementation of the RRR model to separate the Recovery Rehabilitation and Reablement funds from a few key LTC HRGs (national development work). This will help local organisations to use the separated funding to invest in high quality community step-up or step-down services to support delivery of the integrated year of care service.



4.2 Contracting options

There are a variety of ways of contracting for services depending on the different structures of delivering integrated care locally. The below lists some of the types of contracting models that could support implementation of the LTC year of care funding model. Four key models have been reviewed in detail by commissioners and providers of LTC care to offer comments or questions to consider locally

Contracting models and definitions

Model	Definition	Fits well with…
Informal network approach with profit share	Providers work collaboratively but with no contractual relationship – any cost reductions are used to incentivise participation e.g. general practice.	• Individual pathways or services • High levels of certainty/low levels of risk • Good relationships between providers
Accountable Care Organisation (ACO)	An accountable care organization (ACO) is a type of payment and delivery reform model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population. A group of coordinated health care providers form an ACO, which then provides care to a group of people. The ACO may use a range of different payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, etc.). The ACO is accountable to the people supported through the model and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.	• Bringing organisations together contractually to deliver care • Building relationships between providers • Low levels of certainty/high levels of risk • Need for formal governance arrangements and joint accountability
Integrated care hubs (prime provider model)	A central pathway service, with clear accountability and budget for whole pathway quality and productivity to deliver 1) out of hospital specialist clinical provision 2) performance management of primary care and 3) subcontracting and quality assurance of hospital services	• Individual pathways or services • Commissioners only needing to manage one provider relationship and contract • Containing risk between commissioner and one provider
Alliance	An alliance contract seeks to move away from the traditional “adversarial” approach in which parties are first of all competitors. Alliance contracts involve a collaborative process which aims to promote openness, trust, risk- and responsibility-sharing and the alignment of interests between clients and contractors. The focus is on the best arrangement for project delivery rather than on self-interests, typical of traditional contracts	• Individual pathways or services • Building relationships between providers • Low levels of certainty/high levels of risk • Need for formal governance arrangements and joint accountability
Single Integrated Care Organisation	Formal structural integration of services into one organisation, for example; NHS Trust/FT acute services and community services	• Bringing providers/services/teams together into one organisational structure

	along with a joint management structure with Local authority and pooled budget with social services for intermediate care	• Commissioners only needing to manage one provider relationship and contract • Containing risk between commissioner and one provider
Joint Venture with Joint Management Board of providers	A collaboration of providers run by a Joint Management Board, combining resources and/or expertise with requirement within individual contracts to work together and provide joint governance and accountability arrangements to achieve agreed outcomes and share the risks and rewards	• Individual pathways or services • Building relationships between providers • Low levels of certainty/high levels of risk • Need for formal governance arrangements and joint accountability
Principal provider (contractor) and subcontracting model	A pathway is commissioned from a principal provider who then subcontracts to other providers where necessary within the pathway provision.	• Individual pathways or services • Commissioners only needing to manage one provider relationship and contract • Containing risk between commissioner and one provider (the provider retains the risk relating to poor performance of its sub-contractors)
Capitated outcomes based contracts	A model that uses a budget based methodology, which combines a fixed per-person payment with performance incentive payments based on the achievement of agreed outcomes	• Bringing organisations together contractually to deliver care • Building relationships between providers Low levels of certainty/high levels of risk • Need for formal governance arrangements and joint accountability

Review of 4 key models
Many of the models are variations on others, therefore four models have been reviewed in detail by commissioners and providers of LTC care:

The models have been reviewed against the following domains:
- Delivering financial and service cost and quality improvements (QIPP)
- Potential for delivery in current political climate (political)
- Delivering win- win arrangements for all the main parties (organisational benefits)
- Drivers to change inter and intraorganisational culture (Culture)
- Drivers to change operational/ clinical staff Culture (staff culture)
- Clinical and Financial Governance and accountability (governance)
- Robust contracting arrangements (contracting)
- Ability to control budgets and deal with financial risk (financial risk)
- Ability to repatriate people with LTC to an integrated service (repatriation)

Single Integrated Care Organisation (ICO)
Formal structural integration of services into one organisation, for example; NHS Trust/FT acute services and community services along with a joint management structure with Local authority and pooled budget with social services for intermediate care

Domain:	Strengths /opportunities	Risks
QIPP	The meeting of QIPP rests more clearly with the provider to deliver more effective and efficient integrated pathways	Too much risk may be placed on the provider, posing threat to the sustainability of the local health economy, and ability to make the required savings.
Political		Elections (national and local) dates and campaigns may interfere with local plans Differing views between elected politicians from county, district and parish and governors from health may challenge local implementation Maturity of relationships between commissioners and providers May threaten the spirit of the reforms and delegating such decisions to Clinical Commissioning Groups Such approaches may not be sustainable in major conurbations unless there is a willingness to close services Contentions between the two major players of social and acute health care may be problematic.
Partnerships	Partnerships are formalised in a single "organisation"	Can be perceived as over dominant so needs significant presence of primary care. Potential weaker relationships with and between providers not part of the ICO Such an approach requires mature relationships and discussion and will take time, investment and leadership – could be challenging at a time when local health economies have to realise significant savings

Working with social care	Formalises arrangements to deliver integration with part of social care	May not go far enough to work with other aspects of social care e.g. continuing care
Working with third sector	Working with one ICO rather than individual organisations could make it easier for third sector to contract and provide care based on overall need rather than for different bits of the pathway. Third sector can share a lot of good practice and are good at demonstrating value for money Third sector good at delivering hard and SOFT outcomes – such as combating loneliness / social opportunities Large third sector organisations have regional and national networks and funding streams of their own	Third sector not directly a major player though could be set up to balance this, or subcontracted Smaller third sector groups can struggle to maintain core funding and capacity and stability of organisations needs to be considered. A lot of third sector groups are not prepared for direct payments / PHB's / providing choice
Organisational benefits	Unified structures, decision making, unified financial arrangements Should minimise duplication, provide shared vision and common identity.	Major structural change which requires significant resources and time to implement Perception that some organisations will benefit more than others. May create elements of resistance/reluctance Duplication of effort and activity if staff do not buy into the vision
Culture	Single organisation moving towards single identified shared values	Is there an over- dominant culture? Is it acute/primary care/ community? And does it allow a new balanced integrated culture? Individual personalities may be allowed to shape/define the culture
Staff culture	Single organisation allows for single identified shared values	What is the dominant culture? Does it enable staff to move away from traditional ways of working? Changing structures will change the culture and the way staff behave, staff must be included and involved in the change.

Governance	Single organisation allows strong unified governance structures.	Requires time, investment, including IT and relationships
Contracting	Contracting with single entity more straightforward	Element of "monopoly" issue for commissioners – may make challenging poor performance more difficult. Potentially commissioners less able to define and control future strategy and plans Do alternative settings (i.e. out of hospital) exist? Are they fit for purpose?
Financial risk	Single organisation takes more financial risk.	An unreasonable amount of financial risk may be taken on, without the required activity being closed off elsewhere in the health economy
Doability		Requires the right local regional and national political climate to deliver. Major structural change which takes substantial resources and time to implement
Repatriation	Patient movement back from traditional hospital care into a fully integrated pathway approach can be commissioned	Without the right information flow, there are likely to be delays, duplication and invisible silos created

Joint Venture with Joint Management Board of providers

A collaboration of providers run by a Joint Management Board (JMB), with requirement within individual contracts to work together and provide joint governance and accountability arrangements and with a single pathway budget arrangement funded through capitation approach. No single legal entity exists.

Domain:	Strengths /opportunities	Risks
QIPP	Collaborative approach leads to buy in to quality/productivity by all parties. Shared budget can incentivise all parties to contribute. The meeting of QIPP rests more clearly with the provider to deliver better, more efficient care through integrated pathways	Other partners (not in the JMB) may not be interested / buy into the QIPP agenda QIPP outcomes may not be the same as outcomes for other providers (not in the JMB) May be conflict of interest between providers on the board when bidding for

	QIPP will provide focus to expected outcomes when assigning tasks / projects to various providers	other contracts Potential for thinking in “my organisation” terms
Political	Partnership across pathway allows all to participate equally. Potentially more acceptable to competition panel	Elections (national and local) dates and campaigns may interfere with local plans Differing views between elected politicians from county, district and parish and governors from health may challenge local implementation Maturity of relationships between commissioners and providers Potential for legal challenge in absence of single legal entity
Partnerships	Strengthen partnerships within private / public / voluntary sector Encourages multi agency working at all levels from high strategic to grass roots delivery Provides framework for developing multi agency teams from private / public / voluntary sector Facilitates working with other providers such as Police and Fire Service to address outcomes around vulnerability Cements informal relationships in a shared approach with some joint accountability. Allows for partnerships with patients and patient groups through a Joint Management Board	Joint management Board could have its own internal problems which may need a certain amount of brokerage from commissioners (and management of dispute/arbitration). Potential for competition between providers Outcomes for each provider could be different and lead to conflict May not be able to align different strategic vision of partners
Working with social care	Social care can participate without formal changes Can build on existing good practice for joint working which already exists locally Promotes opportunities for formally integrating care teams / projects	Different working practices Different forms / processes Different culture District / cluster boundaries may not align which can cause difficulties

Working with third sector	Empowering for third sector Third sector can share a lot of good practice and are good at demonstrating value for money Third sector good at delivering hard and SOFT outcomes – such as combating loneliness / social opportunities Large third sector organisations have regional and national networks and funding streams of their own	Smaller third sector groups can struggle to maintain core funding and capacity and stability of organisations needs to be considered. A lot of third sector groups are not prepared for direct payments / PHB's / providing choice
Organisational benefits	Can create win-win for each party. Allows General Practice to develop close partnerships operationally with other providers with clear contractual expectations Supports shared learning Can facilitate joining up of backroom services e.g. HR / ICT etc	Potential for disputes within Joint Venture about "income" Risk management – who is 'liable'? Focus may be on individual organisational benefits rather than building and enhancing relationships
Culture	Potential for unifying integrated culture challenging current "acute/community/primary care/social care/private / third sector" divides. Potential for true partnership working in absence of legal entity	Potential for competition conflict on contracts May be tensions due to Political culture vs. Organisational culture
Staff culture	Buy in and influence of staff – all parts of pathway are everybody's business Supports sharing of best practice between staff Promotes partnership working and enabling professional relationship building	Different cultures can hinder working relationships – such as speed of working / working patterns / understanding jargon / different policies and processes / different views on risk Potential for conflict between individuals Loss of identify may cause resistance Staff may not buy into the concept and therefore won't change behaviours

Governance	Shared governance – pathway everybody's business to deliver Sharing best practice around governance from different organisational perspectives	Potentially weak unless robust contracts exist with each provider requiring collaboration and joint accountability Could lead to conflict / blame culture between organisations
Contracting	Enables financial drivers to be addressed such that pathway board are incentivised to move care out of hospital beds and outpatient settings. Provides drivers to allow movement to more efficient pathways through redesign. Supports development of generic contract specifications identifying shared outcomes	Can be complex and potentially time consuming initially. Commissioners need to effectively empower Joint Management Board by proxy Potential for conflict of interest and accusations of favouritism Do alternative settings (i.e. out of hospital) exist? Are they fit for purpose?
Financial risk	Shared between providers, some providers may be very solvent Partnership working may be looked on favourable in these 'times of austerity'	Can be complex to define financial risks and how they would be apportioned. May be resource intensive setup to ensure JMB works Will it lead to legal disagreements / going to court? Some providers may have more financial backing therefore may think they have more 'power' within the partnership
Doability	In the current climate based on the need to find more cost effective pathways it is very doable.	Potential for internal power struggles – joint working can threaten individual power bases Willingness to work together may not exist Requires the right local regional and national political climate to deliver.
Repatriation	Fully integrated pathway with multiple providers may be more acceptable to competitions panel	

Capitation Outcome based contracts
A model that uses a budget based methodology, which combines a fixed per-person payment with performance incentive payments based on the achievement of agreed outcomes.

Domain:	Strengths /opportunities	Risks
QIPP	Collaborative approach leads to buy in to quality/productivity by all parties. Shared budget can incentive all parties to contribute Savings opportunities across the continuum. Model adaptable to applications for integration.	Potential for missed opportunities to gain efficiencies through close integrated working
Political	Primary care providers can opt in easily. Doesn't require a complete formal single structure	Elections (national and local) dates and campaigns may interfere with local plans Differing views between elected politicians from county, district and parish and governors from health may challenge local implementation Maturity of relationships between commissioners and providers Potential for legal challenge in absence of single legal entity
Partnerships	Incentivises providers to work in partnership to deliver high quality care. Some models set up formal long term partnership (5yr) to support longer term planning and achievement of outcomes	Potential for competition between providers Outcomes for each provider could be different and lead to conflict May be difficult to align different strategic vision of partners
Working with social care	Social care can participate without major formal changes Promotes opportunities for formally integrating care teams / projects	District / cluster boundaries may not align which causes difficulty
Working with third sector	Third sector can share a lot of good best practice and are good at demonstrating value for money Third sector good at delivering hard and SOFT	Smaller third sector groups can struggle to maintain core funding and capacity and stability of organisations needs to be considered. A lot of third sector groups are not prepared for direct payments / PHB's /

	outcomes – such as combating loneliness / social opportunities Large third sector organisations have regional and national networks and funding streams of their own	providing choice
Organisational benefits	More affordable health care rewarding better quality. Commissioners control problems with over performance- providers have financial incentives to deliver high quality care	Potential for disputes about "income" Risk management – who is 'liable'?
Culture	Promotes quality improvement through smarter more affordable working – not just doing more at greater expense. Potential for unifying integrated culture and challenging divides. Potential for true partnership working in absence of legal entity	Potential for competition conflict on contracts May be tensions due to Political culture vs. Organisational culture
Staff culture	A concentration on improved quality based on affordable care	Different cultures can hinder working relationships – such as speed of working / working patterns / understanding jargon / different policies and processes / different views on risk Potential for conflict between individuals Loss of identify may cause resistance Staff may not buy into the concept and therefore won't change behaviours
Governance	Providers remain largely independent so no joint governance issues.	Potentially weak unless robust contracts exist with each provider requiring collaboration and joint accountability Could lead to conflict / blame culture between organisations

Contracting	Formal contract across continuum with individual parties.	Do alternative settings (i.e. out of hospital) exist? Are they fit for purpose?
Financial risk	Capitation based payment so "over performance" presents much less health economy risk. Good approaches to overcoming the risks of purely capitation based system.	
Doability	No major challenges to organisational structures	Needs good local buy in. Requires the right local regional and national political climate to deliver.
Repatriation		May not have the drivers for repatriation per se other than patient choice of improved quality service

Principal provider (contractor) and subcontracting model
A pathway is commissioned from a principal provider who then subcontracts to other providers where necessary within the pathway provision.

Domain:	Strengths /opportunities	Risks	Ability to mitigate
QIPP	Subcontracting may yield better price. One provider is responsible for overall pathway productivity and quality Can attract new providers who are able to offer cost effective, high quality care	Potential for limited buy into pathway productivity from subcontracted parts. Potential lack of financial incentive for sub-contracting 'prevention' services as impact of this will not be realised within a one year time frame	Each sub-contract would need to have its own productivity, efficiency and performance targets embedded in the agreement which dovetail to the overall main provider agreement
Political	Doesn't require a complete formal single structure	Elections (national and local) dates and campaigns may interfere with local plans Differing views between elected politicians from county, district and parish and governors from health may challenge local implementation Maturity of relationships between	

		commissioners and providers Competition may be an issue	
Partnerships	Can support partnership working with sub-contractors developing new roles, shared care arrangements etc.		
Working with social care	Social care could be the prime contractor or a sub-contractor in this model	May be unwilling to "subordinate" to a principal provider or vice versa Local authority may need to subcontract out again making the contractual relationships increasingly complex	
Working with third sector	Allows for subcontracting with third sector, and could be run with third sector as the prime contractor Third sector can share a lot of good practice and are good at demonstrating value for money Third sector good at delivering hard and SOFT outcomes – such as combating loneliness / social opportunities Large third sector organisations have regional and national networks and funding streams of their own	Third sector may not be brought in as a party in pathway responsibility Smaller third sector groups can struggle to maintain core funding and capacity and stability of organisations needs to be considered. A lot of third sector groups are not prepared for direct payments / PHB's / providing choice	
Organisational benefits	Commissioners have one organisation to contract with Principal provider has greater autonomy	No direct relationship between commissioners and significant parts of the service. Principal provider would need significant infrastructure to 'commission' or subcontract. There would be multiple contracts to manage	Contract review meetings could be multi-agency which each agency identifying its performance against KPIs

Culture	Dominant culture of the principal provider will tend to predominate.	If the principal provider culture doesn't match up with what is required it could cause problems. May be difficult to engage primary care or other major provider groups if it's perceived that the model is dominated by one organisation	
Staff culture	Allows for different cultures in different organisations, may need this flexibility to deliver different parts of the service effectively. Sub-contracted staff can provide clinical leadership for the model	Subcontracted staff may not engage fully in integrated culture. Not a single pathway identity for staff. Subcontracted staff may have limited influence in pathway development What is the dominant culture? Does it enable staff to move away from traditional ways of working?	All subcontractors should be signed up to one vision for care of people with LTC
Governance	The model aligns clinical and financial accountability Clear governance based on contractual relationship provided contracts are rigorous	Lack of shared culture means governance issues may be hidden by subcontractors. Sub-contractors may not have the same systems e.g. to provide assurance regarding safeguarding	Could be an opportunity to support and share systems with third sector providers The provider retains the risk relating to the poor performance of its sub-contractors
Contracting	Clear contractual accountabilities. Low resource requirement to manage contract for commissioners	Larger resource requirement within principal provider to manage subcontracts. Information and costing systems to support the process may not be consistent across the agencies involved Principal provider would need significant infrastructure to 'commission' or subcontract. There would be multiple contracts to manage	Principal provider may expect to be recompensed for managing the contract with the commissioner and the sub-contract arrangements with the other agencies

		Do alternative settings (i.e. out of hospital) exist? Are they fit for purpose?	
Financial risk	Finances clearly defined in contracts.	Principal provider may take most risk Potential for one sub-contractor to "over-deliver" against the service requirements and then charge the costs against the main provider. Costs could escalate or become "unbalanced" across the various agencies	Could agree that each provider has shares in the overall "profit" or "loss" i.e. each provider identifies its costs as a proportion of the overall costs. This will require genuine trust between the agencies so that costs are not exaggerated.
Doability	Very doable provided full political sign up locally	Political sign up may be a problem as potential for it to be perceived as too dependent on one provider Requires the right local regional and national political climate to deliver.	
Repatriation		Potential for competition issue around contracting with single monopoly provider	

Examples of contracting models in use:
The following are examples of contracting models in development or use and are included to help stimulate local discussion. They are not suggested as the only approaches to consider and other examples will be shared as the work progresses. The principles and rules for cooperation and competition (see annex 4.4) must be followed when considering local contracting models.

Single Integrated Care Organisation

Whittington Integrated care organisation with flat funding/cap and collar contract activity
Whittington Health's integrated care strategy adopts a whole system approach to deliver high quality care to whole populations with a focus on older people and people with LTC. The strategy has three objectives: adding value for patients (defined as quality outcome per £ spent); supporting GP practices and clinical commissioners, and improving population health.

This means redefining the provider-commissioner relationship. The trust aims to act as commissioners' agent for hospital and community care, and be rewarded for excellence and innovations that increase value for patients. By providing information and support to patients and GPs, Whittington Health aims to actively support care closer to home and end cost shifting practices that erode trust between clinicians.

QIPP Long Term Conditions

Whittington Health recognises that co-prosperity with our commissioners is vital for organisational survival. We therefore propose a financing model that enables commissioners to transfer risks to the trust by fixing contractual payments at the level of the baseline year (2011/12), in a “cap and collar” contract, for an initial period of two years. During this period, any increase in expenditure from natural activity growth or costs will be absorbed by Whittington Health, as would any savings generated. This arrangement protects commissioners from overspending with Whittington Health whilst giving the trust income certainty and an incentive to innovate and transform services unconstrained by prevailing payment mechanisms.

The contracting framework that is envisaged for 12/13 to 13/14, whilst alternative/additional tariffs are developed to replace/supplement national PbR and local prices, would be based upon an agreed baseline which reflects outturn activity for 11/12 and a cap and collar with changes in acute activity at a marginal rate of 30% around the baseline.

Joint Venture

Lewisham’s Joint Management Board (Lewisham)

Development
Lewisham needed a new integrated culture for staff and organisations moving away from the constraints of current splits across acute/community/primary care/social care and enabling those cultures to be balanced rather than one predominate (usually acute) e.g. principal provider model. This approach was felt to be the most likely option to deliver that. Risks relate to complexity of commissioning and setting up governance arrangements but are not considered major.

Commissioners and all providers developed joint working discussions with an “all in it together” ethos recognising the mutual benefits of taking joint responsibility for our health economy in meeting local health needs based on a shared understanding of affordability. QIPP is every bit a provider responsibility as a commissioning one. Individual drivers and pressures must be identified along with a clear understanding of the different politics, languages, constraints, external issues etc. Success partly depends on all parties having an open mind to the necessary changes and agreeing to an overall vision. However a firm base of developing a win-win approach such that no key party is short changed underpins this approach. This process will no doubt include decommissioning where necessary and jointly delivered outcomes and KPIs within a clear health economy financial framework. We expect that setting a new joint financial responsibility with a shared budget will provide a significant stimulus to collaboration.

The approach encourages providers to look at more radical integrated models of care “outside the box”. It promotes, provides incentives, and contracts for rethinking clinical care based on integrated teams with a new integrated culture, moving away from the divisions of “ acute”, “community”, “primary care”, “social care” cultures which present major barriers to patients. The model aims to create benefits for all including making efficiencies as a whole system rather than just as individual organisations.

Service Redesign
Providers are supported to develop services that will deliver better and more efficient/affordable care. Savings made

- contribute to a healthy local economy
- allow new services to be developed
- are shared as incentive payments

Freedom for the JMB to manage the budget and move resources transcending some of the normal organizational restrictions allows them to implement changes in a collaborative and innovative way.

Joint Management Board Membership
The board is made up of pathway providers and other parties. A wide range of pathway stakeholders will be considered depending on the particular pathway. These will include patients and patient groups, third sector, primary and community care, social care, acute care and social enterprises. In addition the various disciplines of any formal integrated teams need to be represented e.g. nurse specialists, therapists, social workers etc.

An Integrated specification for the whole pathway will be developed in collaboration with providers to define what we agree we wish to achieve. The board is fully responsible against an integrated specification for the whole pathway to the commissioners for the delivery against defined health and quality outcomes. Contracts are made with each individual provider which include commitments to work within the Joint Management Board structure and where appropriate form part of the integrated team. Each provider is responsible both individually for their part as well as for the JMB pathway achievements as a whole.

The Joint Management Board is given delegated responsibilities for clinical governance issues from each provider but is accountable for clinical governance to each of the provider boards. (As no legal single partnership or organization is present). The commissioners do not sit directly on the board but meet regularly with the board (currently first 1/3 of board meetings after which they withdraw) Their role is to hold the board and individual providers to account for delivering the necessary outcomes, and where necessary to provide change agent support and helpful challenge to the redesign needs of the board. They may also act as arbitrators in dispute management between board parties in relation to resource and financial management.

Principal provider

Care groups - Integrated chronic care with bundled payments (Netherlands)
http://www.nejm.org/doi/full/10.1056/NEJMp1011849
Under this system, insurers pay a single fee to a principal contracting entity — the “care group” — to cover a full range of chronic disease (diabetes, COPD, or vascular disease) care services for a fixed period. A care group is a newly created actor in the health care system, consisting of a legal entity formed by multiple health care providers, who are often exclusively general practitioners (GPs). The care group assumes both clinical and financial responsibility for all assigned patients in the diabetes care program. For the various components of diabetes care, the care group either delivers services itself or subcontracts with other care providers. The bundled-payment approach supersedes traditional health care purchasing for the condition and divides the market into two segments — one in which health insurance companies contract care from care groups and one in which care groups contract services from individual providers, be they GPs, specialists, dieticians, or laboratories. The price for the bundle of services is freely negotiated by insurers and care groups, and the fees for the subcontracted care providers are similarly freely negotiated by the care group and providers.

Whilst the concept is still relatively new a number of lessons can be taken from the approach. An evaluation of 10 care groups found that the care delivery process improved thanks to the introduction of bundled payments and care groups — probably because the care groups are fully responsible for the organizational arrangements, which they formalized by clearly defining which activities would be performed by whom and at what price. As a consequence, coordination among care providers improved, as did protocol adherence, attendance at multidisciplinary consultations, and further training of subcontracted providers to facilitate protocol-driven work processes and use of the electronic health records.

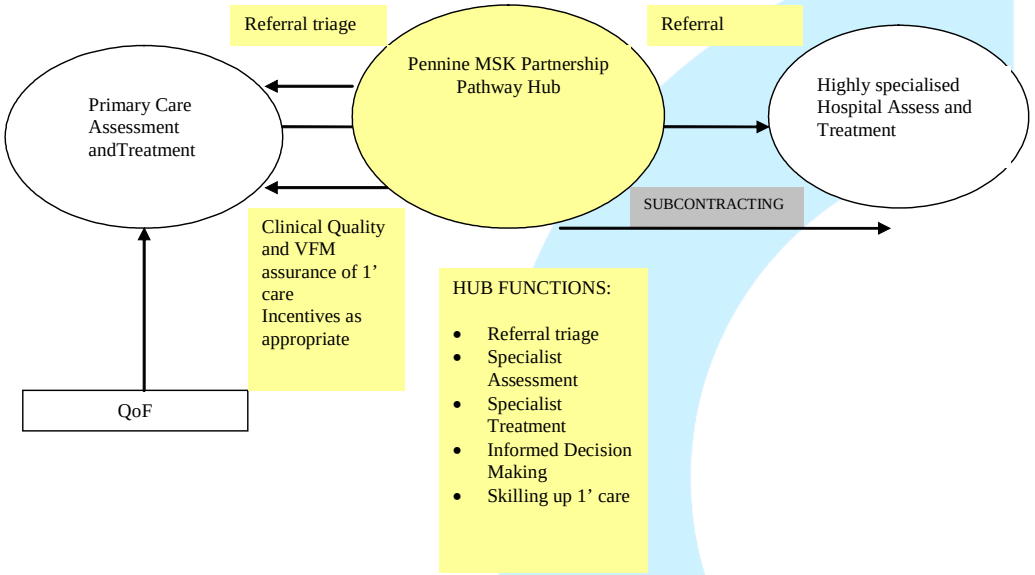
Pennine MSK
This model illustrates a contract between a prime vendor (or lead provider) and the commissioner, with responsibility for delivering a service that relies on sub-contracting with other providers and overall management of the contract.

Extracts from Business Case Proposal:

“A single and clinically led pathway service, with clear accountability and budget for whole pathway quality and productivity will be able to deliver:

QIPP Long Term Conditions

a) Out of hospital specialist clinical provision
b) Performance management of primary care working with Primary Care Oldham LLP
c) Subcontracting and quality assurance of hospital services"



Pathway Hub "Prime Vendor" Model

Oldham have used the programme budget to define the total cost of services in MSK and with the prime vendor identified the efficiencies that need to be achieved.

"Delivering an agreed level of savings on the programme budget, aimed initially at bringing overall spend in line with regional (£2.1m efficiencies), then national benchmarking (3.2m efficiencies) will be the primary aim of this approach. The future intention will be a move towards bringing overall spend in line with the upper quartile (£5m efficiencies)".

The business case identifies KPIs, a list of principles to the programme budget approach and the economic approach that has been agreed to achieve the efficiencies as well understanding the impact and risks to this.

Capitated outcomes based contracts

Alternative Quality Contract (Blue Cross, Blue Shield)
http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf
A global payment model that uses a budget based methodology, which combines a fixed per-patient payment (adjusted annually for health status and inflation) with substantial performance incentive payments (tied to the latest nationally accepted measures of quality, effectiveness, and patient experience).

The goal of this restructured model is to enable the delivery system to give the patient the best result from the most appropriate treatment (e.g. based on the best medical evidence), by the right kind of provider (e.g. specialist, family doctor, nurse), at the right time (when intervention is most appropriate), and in the most appropriate setting (e.g. hospital, physician office, independent laboratory, home).

The Alternative Quality Contract includes several key components that are dependent on each other to create the necessary alignment of incentives:

- Financial structure
- Performance measures
- Sustained partnership (five-year contract)
- Integration across continuum of care
- Savings opportunities.

There are essentially key factors

1. Providers agree accountability for the entire continuum of care for a defined patient population. The organisational structure is unimportant, however, primary care must be at the centre (in Blue Shield half the primary care providers are small or single handed), the key to success is leadership.
2. 5 year contracts are agreed giving sufficient time for organisations to plan for and implement the necessary changes without the pressure of annual contract negotiations
3. Payment model moves from a payment per episode to a global budget based on the population and historical rate of spend. In year 1 providers have the total budget and providers are incentivised to look at how to do things differently or not at all, any savings made are shared
4. Inflation is negotiated up front for the whole 5 year period and is reduced over the 5 years.
5. Robust mechanism to pay for performance with earnings based on achievement of 64 quality measures looking at ambulatory and hospital care. The whole provider network is held accountable for performance on outcomes. Each measure has a range of performance targets based on quality and quality improvement (each increment of improvement is rewarded). Outcomes and the budget (with savings or deficits) are linked. Quality performance drives how much of the budget is shared and how much is owed or kept by providers.

Quality incentives and payment
In addition to the global budget providers are also offered performance incentives with the potential to increase the total payment by up to 10 percent. It is a key feature of the AQC, designed to promote quality, safety, and patient-centred care. These incentives apply to both physician and hospital services, and are intended to support providers in achieving the highest levels of safe, affordable, effective, patient-centred care. The incentives are linked to clinical performance measures related to process, outcomes, and patient care experience, and include inpatient and ambulatory care

In essence a provider can get a 10% quality premium - but there are 5 levels. 1=2% 2=3% 3=5% 4=9% and 5 gets the full 10%. It is skewed to reward early achievement but incentivise best performance.

This is then linked to the overall financial risk management. If a provider is at level 1 they are exposed to 80% of overspend and only 20% of any surplus. However if they are

level 5 then they are exposed to only 20% of overspend but 80% of any surplus.

http://www.kingsfund.org.uk/multimedia/dana_safran_aqc.html

COBICS – Capitated and Outcome-Based Incentivised Contracts (Oxfordshire)
http://www.cobicsolutions.co.uk/what-are-cobics.php
COBICS build on programme budgeting approaches and innovations in ability to define and measure real outcomes. They focus on getting the best outcomes possible within the overall budget available for that clinical condition. They allow Clinical Commissioning Groups to concentrate on outcomes and value in healthcare, rather than the minutiae of individual provider contract management. They allow health and social care providers to collaborate as a system rather than compete.

Each COBIC covers all care for a given group of people and the budget is based on an understanding of the needs of that population and includes significant financial rewards for achieving specified outcome measures. To deliver those outcomes and make the efficiency savings necessary to stay within the allocated budget, providers must collaborate and problem solve. COBICs are not simply contracting with block budgets. A COBIC's finances will be based on a weighted per person cost and, through the outcome-based incentives, will reward groups of providers that together deliver high quality care. COBIC incentives are more than CQUINs: financially, a COBIC outcome measure will be worth a greater percentage of the total contract value than a CQUIN, and its achievement will require providers to work together rather than in isolation. COBICs are a significant shift in commissioning that frees commissioners to concentrate on outcomes that matter to their local population, and frees providers to collaborate and remove the barriers to delivering care integrated around their patients.

4.3 Examples of risk sharing arrangements

The following are examples of risk sharing arrangements in development or use and are included to help stimulate local discussion. They are not suggested as the only approaches to consider and other examples will be shared as the work progresses.

Flat funding / Cap and Collar

This option is where the spend in the previous year is given to providers who bear both the risk and reward and is based on achievement of agreed outcomes for patients. Any growth in activity is borne by the provider and reduction in spend is retained by the provider.

This can support providers to plan for and implement changes over an agreed time period including use of estate etc. to reduce fixed costs.

It can support commissioners to increase capacity and capability to plan for and implement commissioning intentions over an agreed time period

Example: Whittington (see above)

Quality Incentive Payments linked to financial risk management

This option offers providers a payment based on different levels of achievement of quality targets which is also linked to financial management and the amount of risk taken on.

For example:

Blue Cross, Blue Shield providers can get up to a 10% quality premium.

There are 5 levels: 1=2% 2=3% 3=5% 4=9% and 5 gets the full 10%. It is skewed to reward early achievement but incentivise best performance. This is then linked to the overall financial risk management.

If a provider is at level 1 they are exposed to 80% of overspend and only 20% of any surplus. However if they are level 5 then they are exposed to only 20% of overspend but 80% of any surplus.

4.4 Principles and rules for cooperation and competition (PRCC), Department of Health, 30 July 2010

The PRCC set out the principles and rules that the Department of Health expects commissioners and providers of NHS services to follow to ensure co-operation and competition.

Principle 1: Commissioners must commission services from the providers who are best placed to deliver the needs of their patients and populations.

Principle 2: Commissioning and procurement must be transparent and non-discriminatory and follow the Procurement Guide issued in July 2010.

Principle 3: Payment regimes and financial intervention in the system must be transparent and fair.

Principle 4: Providers and commissioners must cooperate to improve services and deliver seamless and sustainable care to patients.

Principle 5: Commissioners and providers should promote patient choice, including - where appropriate - choice of Any Willing Provider and ensure that patients have accurate, reliable and accessible information to exercise more choice and control over their healthcare.

Principle 6: Commissioners and providers should not reach agreements which restrict commissioner or patient choice against patients' and taxpayers' interests.

Principle 7: Providers must not refuse to accept services or to supply essential services to commissioners where this restricts commissioner or patient choice against patients' and taxpayers' interests.

Principle 8: Commissioners and providers must not discriminate unduly between patients and must promote equality.

Principle 9: Appropriate promotional activity is encouraged as long as it remains consistent with patients' best interests and the brand and reputation of the NHS.

Principle 10: Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.

For each of the principles the following is provided:

- the rationale for each one providing some context and setting out the underlying reason for each principle
- the rules which are requirements for commissioners and providers of NHS-funded services
- recommendations on the appropriate actions or behaviours
- guidance on how the appropriate regulator is likely to apply the principle and rules. application of the principles

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_118220.pdf

4.5 Principles and behaviours for commissioners and providers

The Guidance to the 2012/13 NHS Standard Contract identifies the following aims principles and principles to the contracting process

- The standard contract provides a framework to hold providers to account for the delivery of high quality NHS funded services.

- In using the contract, commissioners are expected to maintain a mature and regular dialogue with providers and act in an open and transparent manner. At all times the contract requires that commissioners and providers act reasonably.

- Where the national Payment by Results (PbR) tariff does not apply, commissioners and providers will agree non-tariff prices, and where applicable, will be required to comply with the Code of Conduct for Payment by Results and with applicable Department of Health PbR Guidance.

- Commissioners will be expected to behave in accordance with the Principles and Rules for Cooperation and Competition (PRCC). Any SHA-led commissioning 'rules' or requirements must also be consistent with these principles and rules.

- The members of the Contract Stakeholder Reference Group agreed a set of guiding principles put forward by the Foundation Trust Network, the PCT Network and the Mental Health Network for the development of the Contract, namely that it should:

    - Reflect vision, long term planning and change
    - Recognise the community interest
    - Provide clarity on commitments that need to be made to stakeholders
    - Clarify and define respective roles and responsibilities
    - Recognise that open information is required to manage the contract
    - Underpin a relationship between equals
    - Understand mutual dependency and benefit of the parties in aiming for a partnership approach
    - Support co-operation and collaborative behaviours that benefit all parties and cement the positive relationship between them
    - Be based on terms that are deliverable in practice.

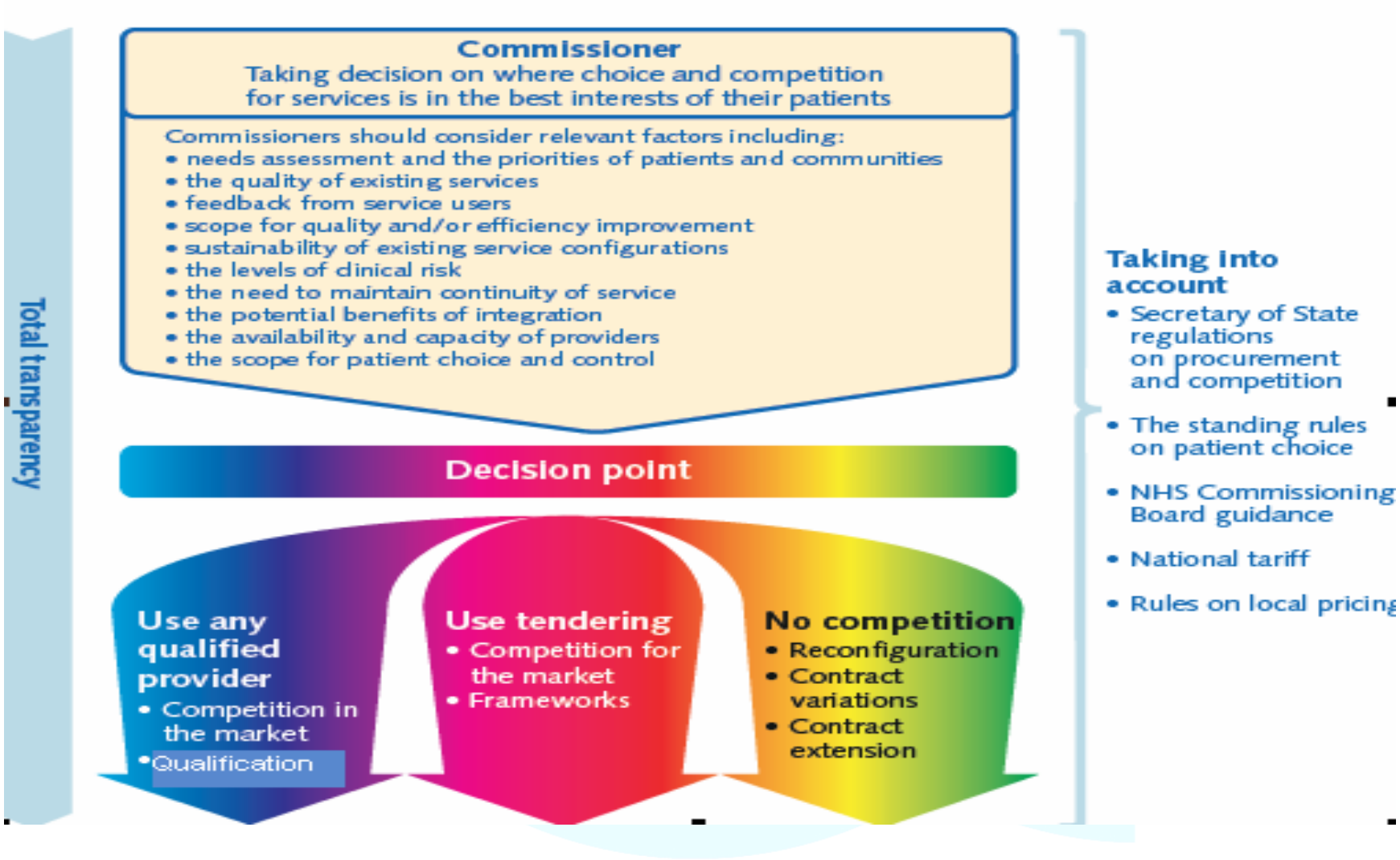
- Stakeholders also agreed that the following behaviours are expected of Providers and Commissioners in their contractual relationship. They should:

    - Find and support win-win solutions
    - Achieve appropriate risk sharing, and sharing of any benefits that are realised by mutual effort
    - Maintain mature, regular dialogue within a professional code of conduct
    - Ensure flexibility where there are genuine problems in delivery
    - Provide incentives as well as sanctions
    - Recognise investment required to achieve requirements over a reasonable time period
    - Support providers to change their service offer over time in relation to changes brought about through patient choices
    - Maintain honesty and transparency – across both parties and with patients and the public

- Emerging Clinical Commissioning Groups (CCGs) working with FT providers have identified a number of principles which it is felt should underpin successful service design and delivery in future. These are based on the over-arching principle that the purpose of the commissioning/ provider relationship is to improve the health of the population and that the patient voice must always be considered in dialogue and decision-making. These principles are:

    - Services should be strategically designed to add value to patients and service users
    - Discussions need to be clinically driven and informed by outcomes
    - Innovations pursued should be from agreed information and data, supported by a clinical evidence base where available
    - Different cultures should be understood and respected
    - Problems and issues should be proactively defined, surfaced and managed early in dialogue
    - Mutual dependency needs to be understood and stressed
    - Local flexibility is needed around including national contract levers

4.6 Procurement Process (Protecting and Promoting Patients' Interests: the role of Sector Regulation Department of Health, December 2011)
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131610.pdf



Annex 5: The RRR model

Liberating and personalising post acute hospital care: the "RRR redesign" (Recovery, Rehabilitation and Reablement)

1. Currently, for those people admitted through the urgent and emergency care pathways, the majority of beddays occupied during their admission are not a result of their acute care (the diagnostics, therapeutic interventions or surgery and immediate treatment response) but are for their **recovery, rehabilitation and reablement (RRR)**. This is applicable to both surgical and medical patients and for those with an acute exacerbation of a LTC. For the future we need to move to a position where admission to hospital for a LTC is the exception. There must be a greater emphasis on achieving the best recovery and reablement and sustainable community care. Those inheriting the responsibility for post discharge care support must be allowed early input into planning the RRR and have the commissioning freedom to innovate and look at alternative options.

2. The acute admission and immediate care phase may be reasonably defined by the admission disease diagnosis (ICD10 code + OPCS) and is it appropriate to adopt this reductionist biomedical approach to define the funding allocation (DRG). The RRR phase however is more complex with multiple interplaying personal, social, family and co-morbidity factors defining the appropriate interventions, the length of care and support needed and the outcome. For this more bio-psychosocial RRR phase a more complex multi-component hierarchy pricing structure is required.

3. The RRR component of the care pathway is predominantly delivered and "managed" by allied health professionals, (physiotherapy, occupational therapy, medical social worker) and nurses. The medical/surgical staff input rapidly diminishes after the correct diagnosis, effective intervention and treatment response have been witnessed in the acute phase; their focus moves to the next acute patient. Yet the current funding structure, tariff allocation and hospital organisation structure remain directed at the short acute element of the care that usually lasts just a few (1-5) days. This is frequently a small proportion of the average total NHS superspell for that diagnosis (e.g. hip fracture median 23 days). See Figure 1.

4. In addition, the AHP staff in most hospital Trusts responsible for delivering the recovery and rehabilitation phase are not part of or managed by, the clinical service receiving the tariff income nor are they accountable to community services. AHPs are usually managed as a Trust support service attempting to function across the breadth of clinical services; as such historically, they have been seen as not "front-line" and are an early target in cost-reduction initiatives. Such cuts have in the past often proven counter-productive by increasing the length of stay, yet we are already seeing them occurring in 2011/12.

5. Not only is this current service design inefficient for the hospital, but it also frequently delivers an inadequate service for patients by setting limited goals (such as "safe to go home"). There is a very limited or no attempt at **reablement** (restoration of previous capacity or employment) and there is a poorly managed interface with Social Care characterised by delays, unnecessary assessment criteria failures and avoidable readmissions. For some diagnostic group Social Care will become responsible for up to 40% of discharges (stroke, hip fractures, multiple co-morbidities etc). It is illogical that Social Care and primary care are not involved at the earliest opportunity to both minimise and anticipate need. The current model perpetuates and compounds the often large step-down in support from secondary care to community care and accounts for many of the unsustained discharges (avoidable readmissions).

6. For many people their own experiences of coping strategies and their ability to recover independence are based on their physical and social home situation. Independence will be most quickly restored by care and therapies in that environment. This is particularly applicable to the elderly, frail and those with LTC. This approach is already practiced in other countries. The CQC (2010) reviewed variance in occupied bed-days for multiple admissions of >75s and concluded that better joining up of Social Care and Health across England would save £2billion.

7. The opportunities for significant quality and cost advantage are found across a wide range of unplanned admission patient groups especially in the older people with medical and surgical complaints and younger people with injuries, respiratory disease, gastrointestinal disorders, fallers, major fractures etc.

The Principles of the Recovery, Rehabilitation and Reablement "RRR" redesign:

8. ***Change the responsibility for care, and the tariff, at the point when the patients' needs change not at the point when they change institutions.***

9. Move the selecting of the options for achieving recovery, rehabilitation, reablement and return home to those who have on-going responsibility to much earlier in the hospital admission – directly after the acute phase. Separate the current acute tariff payment after that acute care phase and start a new tiered RRR tariff (see Figure 2 below).

10. Restructure tariffs so that the RRR element is jointly commissioned by the NHS and Local Authorities bringing financial responsibility right up to the immediate post acute care phase and **is based on the patient's needs and not the institution.**

11. That RRR tariff will be stratified or tiered appropriate to the single assessment of needs undertaken during the acute phase of care. The needs assessment will be multi-faceted reflecting the individual bio--psychological and social aspects to be addressed. It will be initially applicable for a clinically appropriate period and after a reassessment it will be reset to reflect progress in recovery and reablement.

12. This tariff separation will liberate all the RRR costs embedded in secondary care when the patient is frequently held in a high nursing cost environment with low rehab input when they require the reverse. The NHS Institute estimated 25% of patients are in this position.

13. Those unlocked funds could be redirected to commission and incentivise new models of cost-efficient RRR with earlier discharge from expensive secondary care into enhanced recovery programmes, early supported discharge, specialist rehabilitation and integrate with step-up response services. Commissioners working with other qualified providers, the third sector or the secondary care provider would be free to draw on the innovative models across the UK and on the best elements of international experience (Canada, USA, Scandinavia).

14. There is also the opportunity for pooled budget options with Social Care. This is immediately available with reablement monies for which all patients are eligible.

15. Such a cross pathway commissioning and service delivery would:

    15.1. place the receiving services and patients (primary care and social care) much earlier in the decision making process to optimise the recovery and independence.
    15.2. significantly reduce the step-down in support between secondary and community care
    15.3. be compatible with and facilitates tariff adjustments to address 30 day discharge responsibility.
    15.4. liberate funding to more cost-effective community recovery and reablement models so facilitating cash release within hospitals without the risks of premature discharge
    15.5. promote sustainable discharges and the development of reactive community services to avoid hospital admission
    15.6. address the weaknesses of the reduction categorisation of patients complex rehabilitation needs to their admitting diagnosis
    15.7. by linking data by NHS number across Social Care, NHS (and potentially DWP and Education), patient-important outcomes would be available for all diagnoses

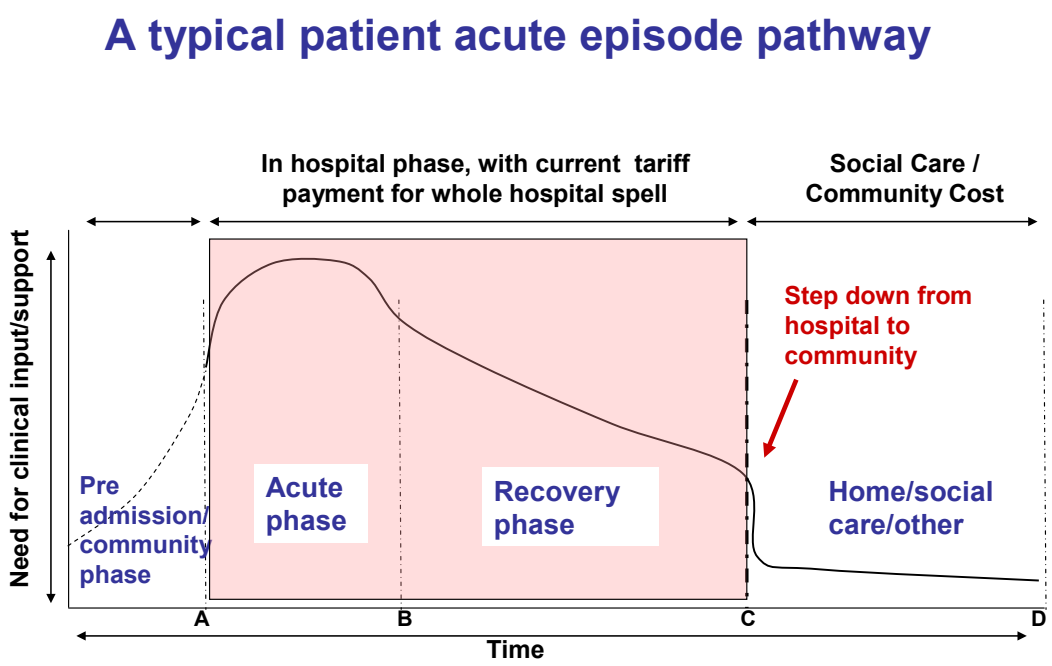
16. This RRR concept model has been developed over the last 2 years. It is now proposed to be a major component of the QIPP LTC workstream and has been recently successfully debated at a large national workshop with ADASS and NHS Confederation and is supported by the NCDs.

17. Tariff restrictions are perceived as one of the greatest difficulties in making the new NHS Clinical Commissioning arrangements successful.

18. In the wider agenda to move services from hospital to community settings, the RRR redesign would be a flexible, readily applicable, liberating tool.

    Professor Keith Willett, National Clinical Director for Trauma Care

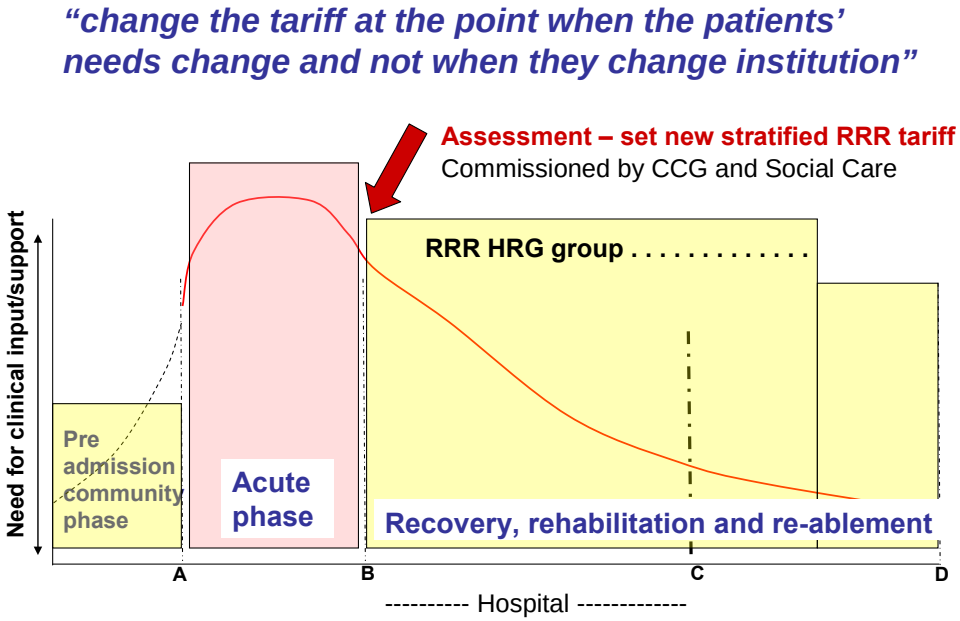
FIGURE 1.



1. Rehab resources locked-in acute unit, 2. Wrong match nursing : rehab intensity

3. Step down to community, 4. primary care and social care recipients but no influence

FIGURE 2.



1 crosses secondary – community, 2. unlocks rehab resource for different models

3. Puts primary care and social care at earliest point in rehab, 4. an option to fit LTC?

Annex 6: Project Team and Contributors

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