Monitor
Making the health sector work for patients

NHS England

Local payment examples

Multilateral gain/loss sharing: a financial mechanism to support collaborative service reform

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Contents

1. Purpose of this report

Audience

This document is intended for all organisations involved in commissioning or delivering new care models.

It will be of particular interest to finance, contracting and commissioning staff seeking detailed guidance on developing new financial mechanisms to support service reform.

Separately, we are publishing a brief companion document which provides a short introduction to such mechanisms and their purpose. This may be of interest to chief executives, clinicians and others who do not need detailed guidance.

Across the health and care sector, there is a move towards offering better co-ordinated services through new networked and integrated models of care. The launch of the 'NHS Five Year Forward View' has added impetus to this trend.

The way we pay for healthcare can support or hinder health and social care organisations moving towards these new ways of meeting patients' needs now and in future. Sector feedback indicates that the current forms of payment do not always support, and at worst can discourage, the move towards new models. The varied payment approaches used in different settings and for each element of service tend to reinforce the fragmented nature of care. In particular, current payment approaches may amplify the (perceived or real) creation of winners and losers in local care economies working towards major service reform.

This document is designed to encourage and provide helpful guidance to local care economies that want to design and implement gain/loss sharing arrangements to change care delivery.

It describes:

- why local commissioners and providers might want to introduce gain/loss sharing arrangements into their contracts
- where gain/loss sharing fits in a broader system-change programme
- how multilateral gain/loss sharing can be locally designed by commissioners and providers.

It gives examples of detailed technical designs for a gain/loss sharing arrangement. This is in response to requests from the sector, and to help commissioners and providers in local care economies.

Note on the use of this document

Local providers and commissioners looking to implement the payment approaches set out in this document while they are in their current development stage must follow the rules and principles for locally determined prices set out in Section 7.1 of the National Tariff Payment System. This includes a requirement to send to Monitor and publish any locally agreed payment arrangements that lead to changes to national prices set by Monitor.

Commissioners should also ensure that they follow the framework set out in the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013. Guidance by Monitor on these regulations is available here.

Further background information on this local payment example and how it relates to other areas of Monitor's work can be found here.

2. Why introduce gain/loss sharing?

As new care models emerge, built around patients rather than organisations or services, appropriate payment models need to be in place to support them.

In the NHS, the activity-based payment approach used to reimburse acute providers is often highlighted as deterring reductions in potentially avoidable acute activity. Providing joined-up care in co-operation with other types of provider may reduce acute activity and hospital revenue. Loss of revenue is unlikely to result in a proportionate fall in costs. Similarly block payments, often used for community and mental health services, offer little incentive for providers to expand the volume of care and encourage early discharge from an acute hospital. Therefore providers' financial incentives are not currently aligned with the system-wide changes and outcomes we want to achieve.

Multilateral gain/loss sharing is a potential way to solve these issues.

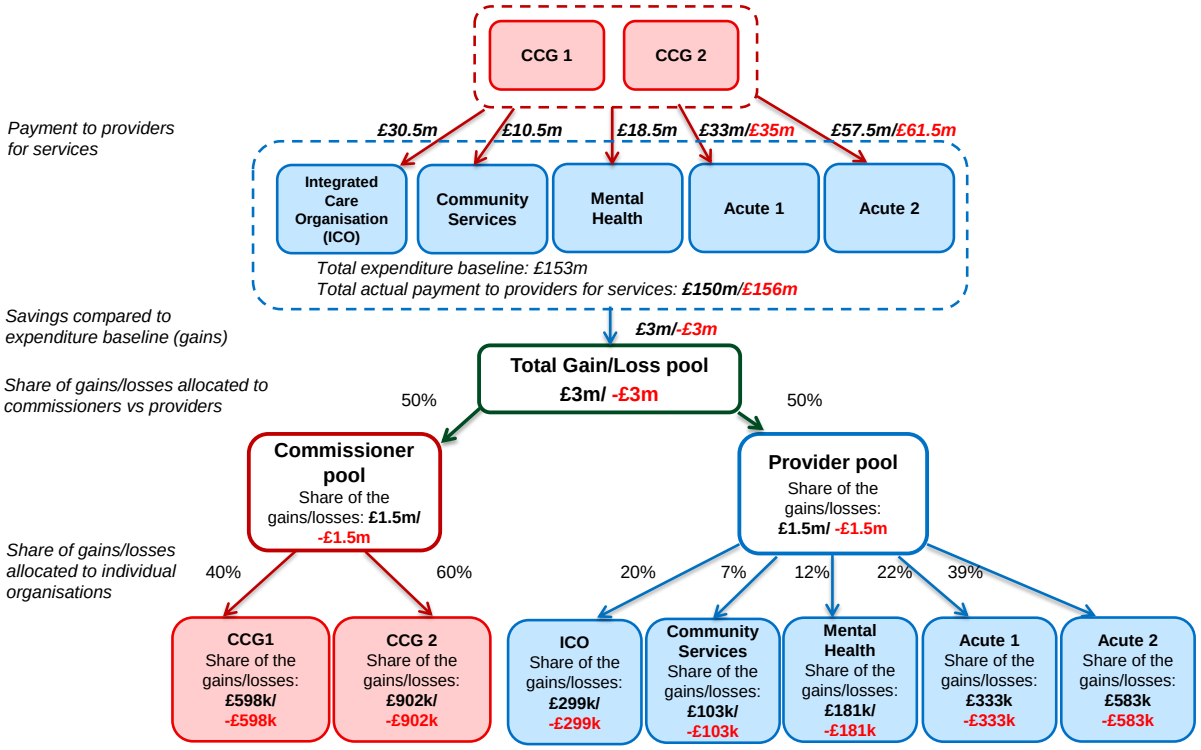
Alongside other levers it can facilitate service changes across local health and social care economies by realigning individual organisations' financial incentives with delivering outcomes for the whole system. It allows commissioners and providers to contribute to system-wide change with some protection from a sudden loss in revenue and from unfunded fixed costs, or from an unpaid increase in activity. It is also a way to manage the uncertainty around the immediate impact of new care models over a number of years.

Multilateral gain/loss sharing arrangements can be combined with an underlying payment approach such as current payment arrangements, a three-part payment approach or a capitation model. They allow (multiple) commissioners and providers to distribute among them any savings or losses resulting from a system change, thus mitigating financial risks. Gains and losses are calculated as the difference between the expected cost (to the commissioners or providers) of delivering care to a defined population and the outturn (ie actual cost incurred). Allowing providers to share in any such gain could give them an added incentive to keep patients in their target population healthy. They would be more likely to identify risks, intervene early, arrange the right treatment at the right time and place, and better manage long-term conditions.

Gain/loss sharing arrangements may embrace a number of parallel commissioning contracts, or a single 'prime' contract and its sub-contracts.

Figure 1 provides an illustration of a gain/loss sharing arrangement.

Figure 1: Example of gain/loss sharing: overview

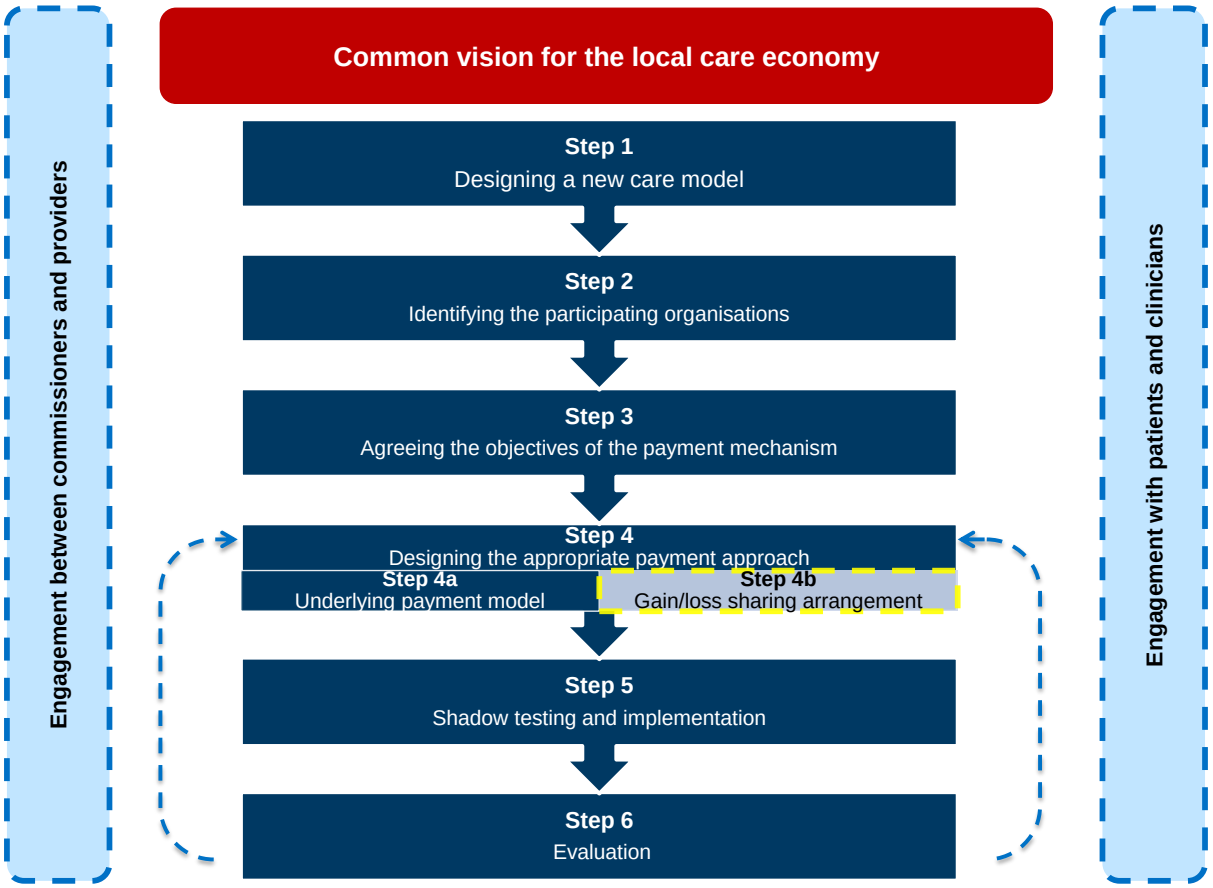


Example of gains: £XX / Example of losses: £XX

3. Where gain/loss sharing fits into broader system change

Designing the right payment mechanism is only one of the steps in devising a new care model, which starts with developing a common vision for the local care economy, as shown in Figure 2. It is an essential step since getting the payment design right is crucial to incentivising the delivery of high quality, good value patient care.

Figure 2: Six-step process to devising a new care model



This process requires strong leadership and governance, good working relationships and trust between the relevant organisations throughout.

While the scope and timing of engagement may depend on local circumstances, considerations may include:

- Whether the arrangement involves a single commissioner or multiple commissioners. Where multiple commissioners are involved, they may decide to align their positions on certain issues (eg vision; general principles for gain/loss sharing) before engaging with providers.
- Whether the arrangement involves a single 'prime' commissioning contract, covering all services to which it relates, or a number of parallel commissioning contracts, which together cover all the services to which it relates. In the first,

the arrangement can be set out in full in the commissioning contract. In the second, all commissioners and providers will probably need to enter into some form of overarching agreement clearly setting out transparent arrangements between them.

- Whether social care forms part of the gain/loss sharing arrangement, and/or at what stage to include it. For instance, the vision and new care model may be agreed between health and social care commissioners but the new payment approach may involve only healthcare organisations for the first year while social care organisations develop the necessary conditions for implementation.

Step 1: Designing the new care model

Any new care model must clearly define the group of patients (which could be the whole population) and set of services it will cover, as well as how these services will be delivered.

Step 2: Identifying the participating organisations

Ideally the arrangement should include all providers involved in the new networked and integrated models of care defined in step 1 and therefore most able to influence whole-system outcomes. As a minimum the arrangement must include those organisations that will most influence the implementation and success of the new care model.

From this perspective it is essential that the design of the gain/loss sharing arrangement involves all the commissioners and providers whose finances will be affected (positively or negatively) by the new model so they can agree on how to manage its potential financial impact. For example, where success depends on transferring activity from inpatient settings to community-based management of conditions (and consequent loss of hospital income), it is important that relevant acute providers as well as the community providers are involved in designing an approach to manage the transition.

The arrangement does not need to be limited to one provider for each type of service; it could, for example, include multiple community providers and/or acute providers. However, including some but not other providers in the arrangement must not restrict patient choice: a patient must not be denied the choice (where applicable) to be referred to a provider that is not part of the arrangement.[1]

[1] For instance, if a patient chooses another provider (not part of the gain/loss sharing arrangement) for an elective procedure, that provider would be paid for this procedure and this amount would be included in the outturn when calculating gains/losses.

In deciding which providers should be included in the arrangement, commissioners should adopt an approach that is fair, transparent and consistent with the Procurement, Patient Choice and Competition Regulations. Commissioners should always ensure they have selected the providers best placed to meets patients' needs and improve quality and efficiency. Guidance on these regulations is available on Monitor's website.[2]

Step 3: Agreeing the objectives of the payment mechanism

As mentioned above, moving successfully to a new care model would typically require two conditions: aligning commissioners' and providers' financial incentives to whole-system outcomes, and managing the risks and effects (foreseen and unforeseen) from implementing the new model. Gain/loss sharing can be used over a number of years to meet both these objectives and support agreed, planned service transformation.

The local care economy will need to assess the new model's likely financial impact over several years, as the expected savings may not appear for some time. This exercise must cover the full range of possible outcomes, to factor in uncertainty around the size and timing of the expected benefits. Monitor and NHS England will soon make available tools to assist local care economies with this.

This analysis, alongside the vision for the new care model, should inform the detailed objectives of the payment approach. Such objectives might include reimbursing the costs incurred by the community provider(s) due to increased activity and/or helping an acute provider make changes to address reductions in income.

Local care economies may encounter challenging issues that could affect the objectives of the new approach. These may include, for example, providers' pre-existing deficits, or concerns about the impact of gain/loss sharing on historical practices, such as using funds from one service to cross-subsidise another. It is essential that the local governance structure enables open discussions.

In this context a gain/loss sharing arrangement may be used to create alternative incentives or redress undesirable signals from the underlying payment approach. As described in Section 4 below, in agreeing the objectives of the payment mechanism the local care economy needs to ensure consistency with the principles for locally determined prices.

Step 4: Designing the appropriate payment approach

Once the participating organisations have been identified and the specific objectives of the funding mechanism agreed, commissioners and providers can design a

[2] www.gov.uk/government/publications/procurement-patient-choice-and-competition-regulations-guidance

payment approach to deliver these objectives. The design could be divided into two closely connected elements:

- the underlying payment model (step 4a)
- possible gain/loss sharing mechanisms (step 4b).

Section 4 below includes three examples of such payment approaches.

When designing a gain/loss sharing arrangement, local care economies should question whether they avoid potential risks, to mitigate them appropriately. Questions include:

- Is the allocation of financial risk appropriate regarding each organisation's ability to manage risk and cope with potential losses? This could possibly not be the case in a capitation model without any gain/loss sharing.
- Does gain/loss sharing incentivise providers to increase activity and revenue in areas not covered by the arrangement (resulting in an unintended overall increase in commissioner expenditure)?
- Does the gain/loss sharing arrangement incentivise providers to shift care to services it does not cover, putting the commissioner at risk of paying twice for the same care?
- Is the gain/loss share arrangement easily understood? These arrangements range from the simple to highly complex. The right balance must be struck between simplicity and designing incentives that will change organisations' behaviour.

The points highlighted above should be addressed at the design and implementation stages.

Finally, as explained in Section 4 below, local care economies will need to consider whether local variations are required (and similarly what, if any, departures from national currencies for locally priced services are required).

Note that gain/loss sharing operates within the framework of the overall contracting arrangement, which may involve one (where a prime provider model is used) or several commissioning contracts. This overall contracting arrangement (which is not the subject of this document) should provide for adequate monitoring and supervision of the gain/loss sharing mechanism – for example, as part of monthly contract management or technical subgroup meetings between the commissioner(s) and the providers.

Step 5: Shadow testing and local implementation

Finally, once the payment approach has been designed and agreed, commissioners and providers can develop the necessary arrangements for implementation (or finish establishing them) and start implementing it locally.

Step 6: Evaluation

For providers and commissioners wanting to learn from and improve any initiative in their local care economy and find out how successful implementation has been, it helps to track progress and evaluate impact. Further information can be found in the 'Evaluation' section of 'Capitation: a potential new payment model to enable integrated care',[3] in RAND's 'Measuring success in health care value-based purchasing programs'[4] and the Health Foundation's 'Evaluation: what to consider'.[5]

The following sections of this document focus on steps 4 and 5 of the process set out above.

[3] www.gov.uk/government/uploads/system/uploads/attachment_data/file/381940/Local_payment_example_Capitation.pdf
[4] www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR306/RAND_RR306.pdf
[5] www.health.org.uk/publications/evaluation-what-to-consider/

4. How gain/loss sharing can be introduced

This section briefly sets out the rules governing gain/loss sharing arrangements under the National Tariff Payment System, and presents three stylised examples of such arrangements.

Each example assumes a local care economy where commissioners and providers have completed the first three steps described above, and illustrates what the fourth step may look like to support the new care model and agreed objectives.

Pricing rules governing gain/loss sharing arrangements

When designing a gain/loss sharing arrangement, local commissioners and providers must follow the rules on locally determined prices. Following national policy, local payment arrangements can be implemented:

- if at least one of the services to be covered by the gain/loss sharing arrangement has a national price, a local variation will need to be agreed, sent to Monitor and published
- if no service has a national price, a local price can be agreed.[6]

In neither case does Monitor need to approve the local arrangement, but it must be consistent with Monitor's local payment rules and principles.[7] In particular, any local payment approach must be consistent with the three principles for locally determined prices:[8]

- local payment approaches must be in the best interests of patients
- local payment approaches must promote transparency to improve accountability and encourage the sharing of best practice
- providers and commissioners must engage constructively with each other when trying to agree local payment approaches.

[6] Please note that in this case, if there is a departure from any applicable national currencies, that departure must be in accordance with Rule 4 of the National Tariff Payment System (section 7.4.2): www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf

[7] www.gov.uk/nhs-providers-and-commissioners-submit-locally-determined-prices-to-monitor

[8] As set out in section 7.1 of the National Tariff Payment System: www.gov.uk/government/uploads/system/uploads/attachment_data/file/300547/2014-15_National_Tariff_Payment_System_-Revised_26_Feb_14.pdf

Design choices for the gain/loss share arrangement

There are a number of design choices required for a gain/loss share arrangement, these include:

a) duration

b) setting the baseline

c) payment model

d) regular reporting and invoicing

e) calculating the gains/losses

f) sharing the gains/losses between providers and commissioners

g) sharing the gains/losses between providers

h) sharing the gains/losses between commissioners.

These design choices are illustrated in Examples 1, 2 and 3 below, which build on the stylised example of an integrated care organisation working with partners (Examples 1 and 2) and an urgent and emergency care network (Example 3).

Example 1: Gain/loss sharing added to the current payment model

Before discussing possible new payment approaches, commissioners and providers have agreed a shared investment and disinvestment plan for the whole local care economy setting out the priority areas for investment to improve care for the local population.

In this example, social care is not part of the gain/loss sharing arrangement in the early years while providers develop the essential tools (eg collection of good quality activity data). It is, however, a key component of the new care model, as mentioned in Box 1 below.

Box 1: Integrated care organisation and partner providers supported by gain/loss sharing – stylised example

Setting the vision for the local care economy

The local care economy, led by the integrated care partnership board, has set a vision to improve health outcomes for people with multiple long-term conditions living in the areas covered by its clinical commissioning groups (CCGs).

Step 1: Designing a new care model

The integrated care partnership board and its participants have agreed to jointly support the formation of an integrated care organisation (ICO), a legal entity formed and led by the local GP federation. The ICO will take responsibility for patients with long-term conditions registered with the practices in the GP federation. The ICO will itself provide enhanced GP services and community health and liaison psychiatry, and will work closely with partner organisations to ensure a seamless well-managed service for patients and users.

The ICO will be evaluated against the following outcomes:

- non-elective admission rates
- non-elective admission bed days
- avoidable non-elective admissions
- non-elective readmissions
- patient satisfaction
- staff satisfaction.

Step 2: Identifying the participating organisations

To deliver the new care model to its full potential, the organisations involved will need to represent the range of patients' needs, including primary, community health, mental health, general and specialist acute care services. As such, the participating organisations will include the two CCGs, the ICO, another community provider, the mental health provider and the two local acute providers.

Step 3: Agreeing the objectives of the payment mechanism

To help implement the new care model and achieve its intended outcomes, it is essential to align providers' incentives. The current payment approach on its own is unlikely to do this, particularly as the ICO will be assessed against a reduction in non-elective admitted activity and thus a reduction in the acute provider's income. Gain/loss sharing has been chosen as a way to align financial incentives and help successfully implement the new care model.

a) Duration

Participants in the local care economy first estimated the care model's impact on provider costs and commissioner expenditure and how long it was likely to take to generate system savings. Because savings are expected to be generated by preventative care in this case, from which any cash-releasing benefits may take time to materialise, it has been necessary to plan for the gain/loss sharing to be in place over a number of years.

Commissioners and providers have agreed to plan over five years, given uncertainty about how long it will take to realise the expected benefits from the new care model and financial arrangement. They calculated and agreed the baseline and shares of any gains/losses (as a percentage of total gains/losses), for each of the five years, before the beginning of the first year. This multi-year planning includes flexibilities to incorporate possible changes in the National Tariff Payment System.

b) Setting the baseline

The baseline is an estimate of the expected commissioner expenditure for the services and patient population covered by the gain/loss sharing arrangement. This estimate is based on historical expenditure and adjusted to reflect expected efficiency gains, trends in patient needs (demographic growth and changes in casemix) and cost uplifts.

As mentioned, the baseline for each of the five years has been calculated and agreed before the beginning of the first year; this is shown in Table 1. Despite this, the contract allows pre-agreed adjustments each year (and the precise methodology to do so) to take into account changes in assumptions (eg regarding casemix).

Table 1: Setting the baseline

(£000)	Year 1	Year 2	Year 3	Year 4	Year 5
Historical expenditure	£150,000				
Cost uplift	£3,000	£3,000	£3,000	£3,000	£3,000
Efficiency gain	-£3,000	-£3,000	-£3,000	-£3,000	-£3,000
Patient population needs	£1,500	£1,500	£1,500	£1,500	£1,500
Expected impact of service reform	£1,500	-	-£750	-£1,500	-£1,500
Baseline	£153,000	£154,500	£155,250	£155,250	£155,250

The baseline has also been estimated for each quarter of the year, to allow reconciliation of performance against baseline (ie gains/losses) on a quarterly basis. To do this, commissioners and providers have apportioned the annual baseline according to historical activity in the four quarters of each year.

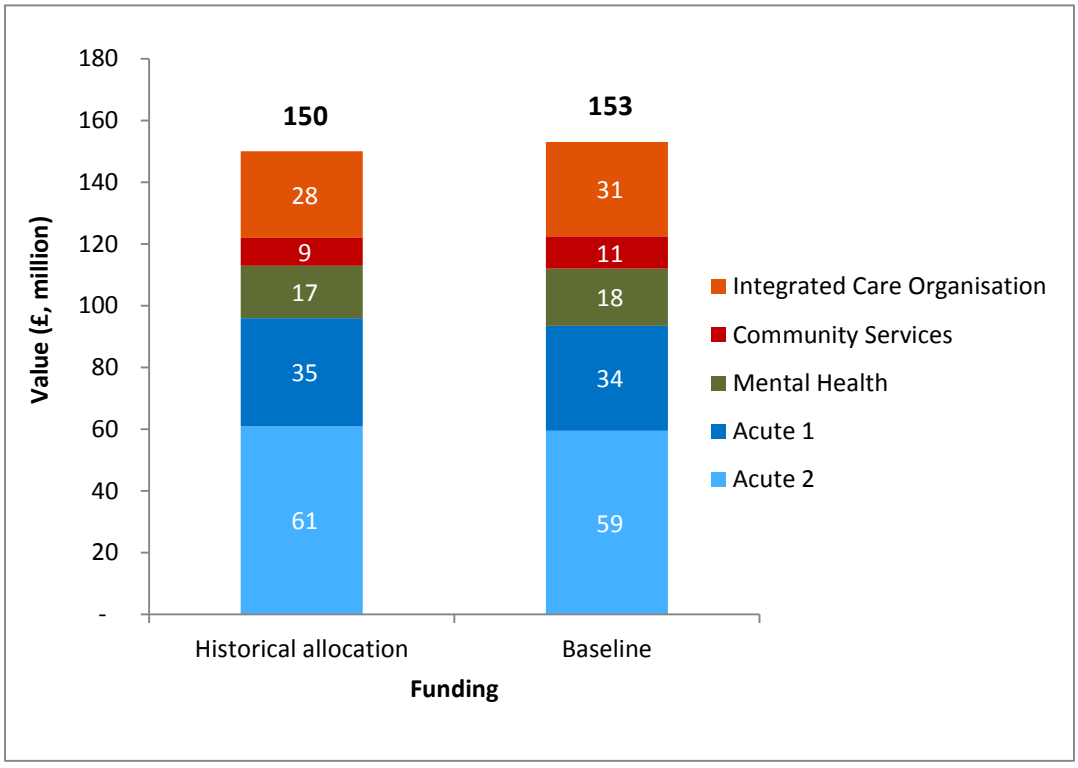
To calculate the baseline, commissioners and providers have used several years' data. This enabled them to check for outliers (ie exceptionally high/low annual expenditure) and relevant trends which they have accounted for in the baseline.

c) Payment model

The main elements of the current payment approaches used in the local care economy remain in place. The acute providers are paid on an activity basis using national prices and relevant national variations. The community and mental health providers receive block payments for the services they provide (although they do report activity counts and agreed shadow prices for some of these services).

The new care model relies on increased prevention and discharge to the community to reduce (more costly) acute activity. To reimburse the expected increase in activity (and therefore in costs) for the community and mental health providers, the commissioners agree an increase in the block payments made to these providers. This is shown in Figure 3.

Figure 3: Historical and expected commissioner expenditure (year 1)



These block payments to non-acute providers are paid in instalments at the beginning of each quarter, which allows them to invest in additional capacity to

implement the new care model. Commissioners plan to fund the investment in community services from the expected reduction in their spending on acute care.

d) Regular reporting and invoicing

The acute providers continue to report activity information and invoice the commissioners in the usual way, receiving regular payments based on healthcare resource groups (HRGs) on that basis. Similarly, the other providers still regularly report activity figures and related (shadow) prices, where available, to the commissioners. Providers flag this activity clearly to show whether it is covered by the gain/loss share arrangement or part of other contract activity.

As well as providing the information from which to calculate gains and losses, regular reporting also enables the commissioner to monitor access to care and to identify any risks to the providers' financial sustainability.

e) Calculating the gains/losses

The gains/losses are calculated as the difference between the commissioner expenditure baseline (as described above under section b) and the outturn (ie actual expenditure incurred to pay for the relevant services). Commissioners monitor both figures (ie baseline and outturn) monthly and reconcile them every quarter, to calculate any gains/losses and share them following the steps described below. The details of the monitoring and supervision processes are included in the contracting arrangement between the relevant organisations.

Where available, the baseline is compared to the reported (monetised) activity. Where there is no activity data available, it is compared to actual costs incurred by the provider, as reported in their accounts. Without activity data, this requires open book accounting and an agreed methodology to allocate cost to the various services. In this example, commissioners and providers have agreed that overhead costs be allocated to services in proportion to direct costs.

f) Sharing the gains/losses between commissioners and providers

As mentioned, commissioners and providers have agreed a shared investment and disinvestment plan for the whole local care economy to support their vision and the new care model. They have decided the purposes for which gains will be used, and have agreed rules to share gains/losses accordingly.

Commissioners and providers have agreed that 50% of the gains will be shared among commissioners, and 50% will be shared among providers. Losses will be shared in the same way.

Box 2: An alternative approach to sharing gains and losses between commissioners and providers

Although in this example losses are shared following the same principles as gains (described above), another option could be to distribute gains differently from losses. Some agreements include only gain sharing in the first year (ie all losses stay with the commissioner), moving to gain and loss sharing from the second year. Such an approach may be used to limit a particular organisation's exposure to losses in the early years – for instance, while it adapts to the new financial arrangement and improves data collection.

The commissioners' share of potential gains is capped at their surplus target for the expenditure covered by the arrangement (1% of total budget for the relevant services, in this example £610,000 for CCG 1 – see Table 2). This is because CCGs cannot carry over a surplus year on year. As most gains are likely to be realised and/or confirmed only at the end of the year, commissioners would not have the opportunity to reinvest any potential surplus above their target.

Therefore, as illustrated below in Table 2, commissioners have calculated their respective surplus target and agreed with providers to cap the commissioners' share of potential gains if/when these targets are reached.

Table 2: Cap applicable to commissioner share of gains

	CCG 1	CCG 2	Total
Baseline (commissioner expenditure) (£000)	£61,000	£92,000	£153,000
Commissioner surplus requirement (1% of total budget) and cap on share of gains (£000)	£610	£920	£1,530
Share of commissioner pool	40%	60%	100%
Share of total pool	20%	30%	50%
Size of total gains pool required to meet cap (£000)	£3,060	£3,060	
as % of the baseline	2%	2%	

g) Sharing the gains/losses between providers

The providers have agreed with the commissioners that the providers' individual shares of the provider pool would be the same as their shares of the commissioner expenditure baseline. Losses are shared according to the same rules as gains. Linking gains and losses to the commissioner expenditure baseline helps ensure gains and losses are proportionate to organisation size and ability to manage risk. Table 3 shows this calculation.

Table 3: Sharing the gains/losses between providers

	ICO	Community services	Mental health	Acute 1	Acute 2	Total
Baseline (£000)	£30,500	£10,500	£18,500	£34,000	£59,500	£153,000
% of total baseline *(equals % share of gains and losses)*	20%	7%	12%	22%	39%	100%

Following this method, acute providers would get a greater share of potential gains, aimed at compensating some of their residual costs arising from the loss of activity (and related revenue).

h) Sharing the gains/losses between commissioners

Each commissioner's share of the commissioner pool would equal its relative contribution to the baseline, as shown in Table 4 below.

Table 4: Distribution of gains and losses between commissioners

	CCG 1	CCG 2	Total
Baseline contribution (£000)	£61,000	£92,000	£153,000
% of total baseline (equals % share of gains and losses)	40%	60%	100%

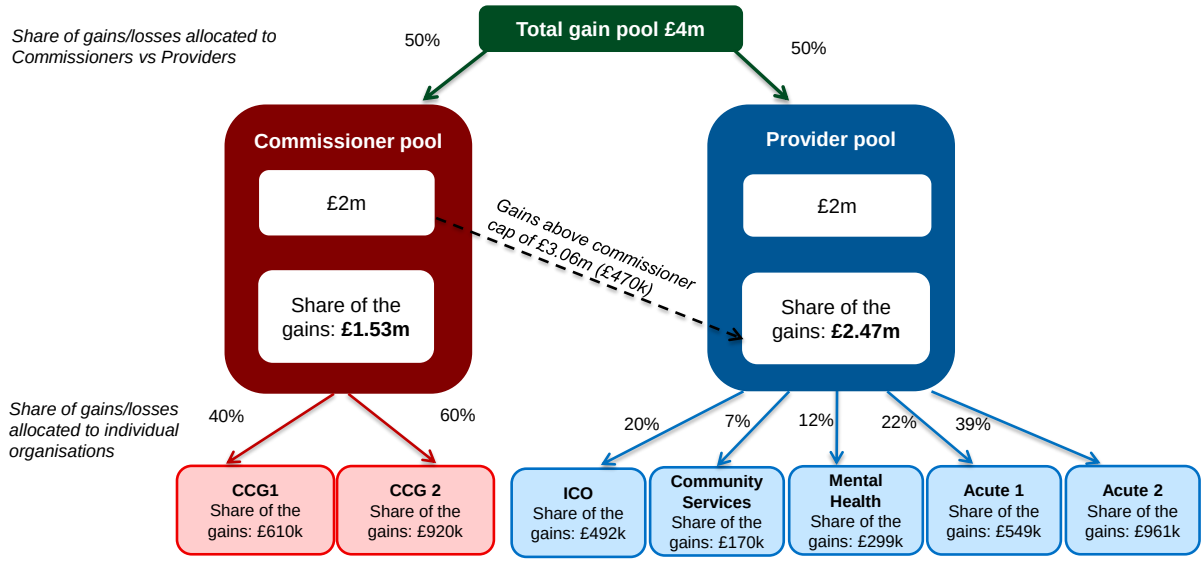
Table 5 below shows how potential gains and losses would be shared between providers and commissioners, taking into account the cap on commissioner gains.

Table 5: Distribution of gains and losses between providers and commissioners (example: gains of £4 million)

Gains and losses	Providers	CCG 1	CCG 2
Below £0 (losses)	50% (N/A)	20% (N/A)	30% (N/A)
Up to £204,000 (CCG cap) (£000)	50% £1,530	20% £610	30% £920
Up to £3,060,000 (CCG cap) (£000)	100% £940	0% -	0% -
Total (£000)	£2,470	£610	£920

Figure 4 below provides an illustration of the distribution of gains and losses between commissioners and providers.

Figure 4: Distribution of gains pool between commissioners and providers



Example 2: Gain/loss sharing incorporated in a capitation model

Commissioners purchase services for the target population (as described in Example 1) from a lead provider who is paid for these services through a capitated budget. The lead provider (ie the ICO) holds a contract with the relevant commissioners and directly provides some services to the population, subcontracting the remainder from other providers. The local care economy recognises the risk a capitated budget places on providers and has agreed to put in place a gain/loss sharing arrangement to mitigate some of this risk.

In this example, the gain/loss sharing arrangement covers primary care (provided by the ICO), community health services (provided by the integrated care organisation and another provider), acute care (two providers), mental health (one provider) and social care (one provider).

a) Duration

As in Example 1, the duration of the payment approach is set as five years.

b) Setting the baseline

As in Example 1 this is calculated on historical expenditure, with relevant adjustments.

Box 3: Alternative approach to calculating the baseline

In Examples 1 and 2 the starting point for the baseline is historical commissioner expenditure. An alternative could be to calculate a baseline from estimated provider cost of delivery of the services. This method would, however, require robust costing data (which would need to be at a patient level if the gain/loss share arrangement only covers a specific group of patients).

c) Payment model

Capitation means paying a provider or group of providers a lump sum per head of the relevant patient population to cover most (or all) care provided. This lump sum is based on historical commissioner expenditure using the same approach as the gain/loss share baseline (described in Example 1). The capitated budget and the gain/loss share baseline are set at the same value. More information on capitation can be found in Monitor and NHS England's 'Capitation: a potential new payment model to enable integrated care'.[9]

The capitated budget is paid to the lead provider as a lump sum for all the care needed by the patient population covered by the agreement, whether provided by that provider itself or by its subcontractors.

This involves a variation of both currency and price for all the healthcare services covered by the arrangement (the social care elements are not subject to any local variation or local price-setting rules). However, the national tariff rules (including those on locally determined prices) do not apply to the payments made by the lead provider to the subcontractors.

Similar to Example 1, the block payments made by the lead provider to the other non-acute providers are more than they received in the past, to reimburse their expected increase in activity. The total amounts the acute providers receive are smaller to reflect their expected decrease in activity.

[9] www.gov.uk/government/uploads/system/uploads/attachment_data/file/381940/Local_payment_example_Capitation.pdf

d) Regular reporting and invoicing

This follows the pattern in Example 1, except that any subcontractors report activity first to the capitated budget holder before the budget holder reports to the commissioner.

e) Calculating the gains/losses

This too follows Example 1, except gains/losses are calculated as the difference between the baseline (or capitated budget) and the costs to the capitated budget holder (including payments to subcontractors) for delivering the care. If the capitated budget holder and its subcontractors are able to provide the care for less than the baseline/capitated budget, gains may be generated and form a ‘gains’ pool. If the cost of providing care exceeds the baseline/capitated budget this will generate a ‘loss’ and form a ‘loss’ pool.

f) Sharing the gains/losses between commissioners and providers

As in Example 1, gains/losses are purely financial. If the system generates savings, commissioners and providers agree that 50% of the gains go to the provider pool, 30% to the commissioner pool and the remaining 20% would be set aside for a possible payment to providers based on clinical quality and patient outcomes performance. If the system makes a loss, 50% of these losses would go to the commissioner pool and 50% would be allocated to the provider pool.

The local care economy has agreed a list of metrics which all relate to the services to which the payment method (capitation and gain/loss sharing) applies.

Linking gains to quality enables the commissioner(s) to withhold some gains if a minimum level of quality is not met, and therefore discourages the provider from generating savings by reducing access or quality. For the quality performance component, commissioners and providers have co-designed and agreed 10 metrics and related targets. A share of the 20% of potential gains set aside is allocated to each of these metrics (see Table 6). The amount attached to the targets reached by the providers would go to the provider pool (and be split between providers following the same rules as the other gains – see below). The amount attached to the missed targets would go to the commissioner pool.

Table 6: Applying a quality adjustment – hypothetical example

	Target met?	Additional contribution to provider pool (% of total gains)	Additional contribution to commissioner pool (% of total gains)
Metric 1	✓	2%	
Metric 2	×		2%
Metric 3	✓	2%	
Metric 4	✓	2%	
Metric 5	✓	2%	
Metric 6	×		2%
Metric 7	×		2%
Metric 8	✓	2%	
Metric 9	✓	2%	
Metric 10	✓	2%	
Total		**14%**	**6%**

Commissioners and providers have agreed that the target for each metric would change over the years. The first year focuses on collecting and reporting good quality data for each metric to set a reliable baseline. The second year sets targets at the baseline levels to ensure consistency. These targets are regularly raised from the third year onwards, to incentivise quality improvements. Each year, if (some of) the quality targets are not met, the related amount would go to the commissioners.

g) Sharing the gains/losses between providers

This is the same as in Example 1, except the proportion of gains/losses each provider receives is the same as their share of the capitated budget. This figure is then adjusted to reflect the greater influence that some providers may have on the system-wide outcomes, and to encourage their active participation accordingly.

Table 7 provides a worked example of how gains and losses may be distributed between providers in Example 2 where gains total £4 million.

Table 7: Distribution of gains and losses between providers

Example: Gains of £4,000,000 (£2,470,000 provider share)	**ICO**	**Community**	**Mental health**	**Acute 1**	**Acute 2**	**Social care**	**Total**
Baseline (£000)	£30,500	£10,500	£18,500	£34,000	£59,500	£32,000	£185,000
Baseline (% total)	16%	6%	10%	18%	32%	17%	100%
Adjustment to baseline split (percentage point)	+3ppt	+2ppt	+2ppt	-5ppt	-5ppt	+3ppt	-
Final share of provider pool	19% *£481,316*	8% *£189,589*	12% *£296,400*	13% *£330,446*	27% *£670,905*	20% *£501,343*	100% *£2,470,000*

Box 4: Alternative approaches to sharing gains/losses between providers

Other bases for determining the split of gains/losses between providers include:

- patient flows and patterns of demand – based on referral, conversion or conveyance rates; this relies on the assumption that in some cases, certain providers' increased activity could reduce referrals to acute services
- impact of change on the provider (reduction in activity and revenue) – the lower a provider's volume of activity, the greater its share of the gains (and the smaller its share of the losses) while the provider reduces its fixed cost base
- individual provider performance on specific targets – for example, their individual scores against performance and quality metrics.

These options are not mutually exclusive and a combination could be used.

h) Sharing the gains/losses between commissioners

As in Example 1, each commissioner's share of the commissioner pool of gains/losses would equal its relative contribution to the baseline.

Example 3: Gain/loss sharing incorporated into a three-part payment approach for urgent and emergency care

This example shows a gain/loss sharing arrangement added to a three-part payment for urgent and emergency care (UEC).

The reason for moving to a three-part payment to help transform services will be set out in a forthcoming publication on local payment examples for UEC. This will provide an example of a three-part payment approach, where explicit financial incentives for co-ordinated service provision operate predominantly through payment linked to outcome and performance. In that example, providers can earn a predetermined proportion of their estimated revenue requirement based on the network's performance against agreed metrics.

Here we take that same example and add a one-sided gain-sharing arrangement, where providers share in commissioner savings against the whole network's estimated revenue requirement. The use of gain-sharing could strengthen financial incentives for the network to collaborate without relying on additional metrics. If providers and commissioners across the UEC network co-ordinate to generate savings against the estimated baseline, they share in the savings made.

a) Duration

The timeframe envisaged for implementing the service reforms is three to five years. Therefore, providers and commissioners have agreed a five-year timeframe for the three-part payment and gain-sharing arrangement. This multi-year planning includes flexibilities to incorporate possible changes in the National Tariff Payment System.

For simplicity, this example provides figures for the last year of the multi-year timeframe, when service reforms have had an impact on patient flows.

b) Setting the baseline

The baseline is an estimate of the expected commissioner expenditure for the services in the UEC network. Table 8 shows the services covered by the three-part payment and the gain-sharing arrangement.

The baseline commissioner expenditure is, in this example, estimated by forecasting activity levels for each service[10] and applying prices based on average cost[11] to the forecast activity. Table 8 shows the resulting estimated baseline expenditure for the relevant services.

[10] This takes into account assumed demographic growth, changes in casemix and the envisaged impact of service reforms.

[11] These prices may be national, local or estimated. They are adjusted to reflect health cost uplifts and expected efficiency gains.

Table 8: Setting the baseline – example

Providers	NHS 111	GP OOH	Ambulance	A&E	Emergency admissions
Forecast activity	189,520	27,810	42,436	92,700	30,900
Baseline commissioner expenditure (£000)	£2,870	£1,965	£7,282	£11,696	£35,869

c) Payment model

The three-part payment for each UEC service, as illustrated in Table 9, incorporates:

- a fixed core payment (ranging from 60% to 80% of the estimated baseline expenditure in this example)
- a predetermined amount of funding (equal to a 5% top-slice from each provider's estimated baseline in this example) linked to outcomes and performance
- volume-based funding (in the form of a marginal price paid on all units of activity delivered).

Table 9: Three-part payment example

Providers	NHS 111	GP OOH	Ambulance	A&E	Emergency admissions
Baseline (£000)	£2,870	£1,965	£7,282	£11,696	£35,869
Core payment (% total)	80%	60%	80%	70%	60%
Core payment amount (£000)	£2,296	£1,179	£5,826	£8,187	£21,521
Maximum funding linked to outcomes and performance (£000)	£143	£98	£364	£585	£1,793
Marginal price (£)	£2	£25	£26	£31	£403
Outturn activity level	197,760	27,810	42,848	87,550	30,282
Volume-based payment on outturn activity (£000)*	£449	£688	£1,103	£2,762	£12,303
Outturn commissioner expenditure (£000)*	£2,888	£1,965	£7,293	£11,534	£35,618

*Numbers may not sum due to rounding of the marginal prices shown, which are adjusted to reflect health cost uplifts and expected efficiency gains (not shown here).

The core payment and payment linked to outcomes and performance are calculated on the basis of the forecast activity and associated baseline commissioner expenditure. The volume-based payment is paid on outturn activity. Table 9 shows the volume-based payment for a scenario where outturn activity differs from forecast activity. For simplicity, the example assumes that there is one commissioner in the network. The example amounts for each payment part will be explained further in the publication on the UEC local payment example.

d) Regular reporting and invoicing

The acute provider will report activity information, invoice the commissioner in the usual way and receive regular (HRG-based) payments using the marginal prices, on this basis. Similarly, the other providers will regularly report activity figures and related (shadow) prices, where available, to the commissioner. The commissioner will need to agree reporting arrangements with the providers for performance against the system-level outcome and performance metrics.

e) Calculating the gains/losses

The gains/losses are calculated as the difference between the baseline commissioner expenditure and the outturn actual commissioner expenditure incurred to pay for UEC services across the network.

Under a three-part payment in this example, the amounts of core payment and payment linked to outcomes and performance are predetermined. Therefore the financial value of any gains generated by the UEC network is determined by monetising the outturn activity levels for each provider across the network (using marginal prices) and comparing this to the expected expenditure through the volume-based element.

f) Sharing the gains/losses between commissioners and providers

As set out in Table 9, and explained in detail in the forthcoming UEC local payment example, the volume-based payment is paid on activity delivered using *marginal prices*. This means that provider income varies from the expected level at a lower rate than it would do under average unit cost pricing. If volume is higher than expected, the provider income is lower than it would be under average cost prices; if volume is lower than expected, the provider income is higher than it would be under average cost prices. As such, compared to average cost prices, the marginal prices in this example give an incentive to providers to keep their own activity within expected levels and to reduce it if possible.[12]

Sharing commissioner gains for the network as a whole reinforces these signals. This example operates as a one-sided arrangement where *only network gains* are shared between commissioners and providers. The example assumes that the marginal prices provide a strong enough signal to deter activity increases above the expected level and, as such, any network losses (ie commissioner expenditure overruns using the marginal prices) are not additionally shared with the providers.

Table 9 illustrates a scenario where NHS 111 and ambulance activity is higher than expected and A&E attendances and hospital admissions are lower than expected. This generates network gains against the baseline as summarised in Table 10.

[12] The strength of this incentive depends on how flexible costs are (ie the marginal cost) when activity is higher or lower than expected.

Table 10: Example of network gains/losses

	NHS 111	GP OOH	Ambulance	A&E	Emergency admissions
Baseline commissioner expenditure (£000)	£2,870	£1,965	£7,282	£11,696	£35,869
Outturn commissioner expenditure (£000)	£2,888	£1,965	£7,293	£11,534	£35,618
Gains/losses (£000)*	- £19	-	- £11	£162	£251
Network gains/losses (£000)*	£384				

*Gains/losses may not sum to network gains/losses due to rounding.

In our example, we assume that network gains are shared 50/50 between the commissioner and the UEC providers. Therefore, the commissioner retains £192,000 of the network gains and £192,000 goes to the provider pool.

Without any gain-sharing arrangement in place, the commissioner would benefit fully from the £384,000 network saving. With the gain-sharing arrangement in place, providers across the network are able to share the gains that individual actions generate for the network as a whole – providing a financial incentive to collaborate to generate these gains.

Individual providers generating gains for the network – eg an ambulance trust treating patients at the scene of an incident rather than taking them to hospital where clinically appropriate – can share the gains generated by a reduction in A&E attendances and emergency admissions. Providers losing activity as a result are also able to share the gains, reducing the impact of losing revenue – especially where they face sticky costs.

The strength of the additional financial incentive for network collaboration provided by the gain-sharing arrangement depends on the marginal prices used to monetise outturn activity levels. The use of a marginal price means the gains shared will be lower than if activity was monetised at average cost prices. The closer the marginal prices are to the average cost prices (ie prices in the absence of a fixed core payment), the higher the gains generated from a given change in activity.

g) Sharing the gains/losses between providers

In this example, providers agree with the commissioner that their individual shares of the provider pool will be the same as their shares of the commissioner expenditure baseline.

Table 11 illustrates the resulting distribution of gains to individual providers. This could be made periodically (eg quarterly) depending on the detail of the gain/loss sharing arrangement.

Table 11: Example distribution of providers' share of gains

Providers	111	GP OOH	Ambulance	A&E	Emergency admissions	Total
Baseline commissioner expenditure (£000)	£2,870	£1,965	£7,282	£11,696	£35,869	£59,682
Provider's % share of baseline *(equals % share of gains)*	5%	3%	12%	20%	60%	100%
Distribution of provider pool of gains (£000)*	£9	£6	£23	£38	£115	£192

* Individual provider gains may not sum to provider pool due to rounding.

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