Salford Integrated Care Programme

Proposed implementation of an Alliance Contract
System governance

Shared recognition from the outset that:

• Different arrangements will be required for managing service delivery in the new system
• Contractual arrangements and payment mechanisms are not fit-for-purpose
• Structural solutions may be counter-productive
• Different mechanisms therefore required to ‘bind’ partners and share ‘gain’ and ‘pain’
# 2013/14 expenditure (£m)

<table>
<thead>
<tr>
<th>TOTAL turnover</th>
<th>Relating to Salford</th>
<th>Existing CIPs for 2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALL AGES</td>
<td>H&amp;SC 65+</td>
</tr>
<tr>
<td>Salford Royal</td>
<td>420.0</td>
<td>128.0</td>
</tr>
<tr>
<td></td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Salford City Council</td>
<td>233.7</td>
<td>233.7</td>
</tr>
<tr>
<td>of which H&amp;SC</td>
<td>113.4</td>
<td>113.4</td>
</tr>
<tr>
<td>Greater Manchester West</td>
<td>157.4</td>
<td>28.9</td>
</tr>
<tr>
<td>Other acute</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>General Practice</td>
<td>not yet identified</td>
<td>not yet identified</td>
</tr>
<tr>
<td>TOTAL</td>
<td>811.1</td>
<td>390.6</td>
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<tr>
<td>TOTAL (H&amp;SC only)</td>
<td>690.8</td>
<td>270.3</td>
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Note: Work-in-progress, subject to further review. A number of exclusions have been applied to organisational turnover and forecast expenditure.
Cost reductions (work-in-progress)

Forecast spend ~£100m+ on care for older people
65+ population projected to grow by 24% by 2030
Significant cost reductions already required by each partner

26% reduction in permanent care home admissions
• 84 admissions avoided
• £1.57m value (cashable)

19.7% reduction in emergency hospital admissions
• 2071 admissions avoided
• £8.63m value (part cashable)*

* Only a subset of this will be releasable due to the fixed and semi-fixed costs within the hospital.
Financial context and implications

Current spend: ~£100m on care for older people
65+ population projected to grow by 24% by 2030
Significant cost reductions required by all partners

• Status quo is unaffordable and unsustainable
• Economic risks and benefits not equitably shared by partners

• Integrated care solutions are more cost-effective than the status quo
• Three categories of £ benefit
  – Reduction in admissions (hospital, care homes)
  – Removal of duplication and fragmentation
  – Reducing future demand

• £ benefits need be set against
  – Cost of new delivery models
  – Growth in population and associated demand
  – Existing savings plans

• Integrated care is likely to create costs before it generates savings

• Not a quick fix but the most credible and sustainable solution
• Support and mitigate adverse consequence of cost reductions

• New contractual and financial arrangements will be required
  (section 75 / Alliance contract / JV)
• Modelling assumptions to be refined and tested through pilot work
“Provider income reductions ... should be based on an ability to reduce costs ... the rate and pace of income reduction should ... be equal to the realisable reduction in marginal and fixed costs”

“All parties are required to demonstrate ‘best endeavours’ to deliver the agreed cost reductions ... If resolution cannot be agreed by the Board or the resolution is not actioned ... then standing contractual arrangements ... will apply after 12 months notice of the deadline passing”

“Some parties within the Partnership have separate contractual arrangements with third parties which are governed by separate commercial arrangements.”

“Cost reduction, income loss and any reinvestment will need to be reconciled ... cashable savings will be reinvested in care for this population. If savings exceed the predicted growth in demand, the Integrated Care Board will agree appropriate benefit sharing arrangements.”

Some costs will remain fixed during the duration of the Programme and there is likely to be a time-lag between change and cost reduction.

BUT not an excuse to maintain the status quo

And some costs can be extracted at the same rate that demand is reduced

Benefits and risks need to be shared, recognising that underlying demand may limit cashable savings
As-is (traditional contracting)

DIFFICULTIES FOR INTEGRATED CARE

- Changes difficult to enact; multiple parallel negotiations between commissioners and providers
- Focus on individual institutions rather than the continuum of care
- Payment systems are different in different sectors; no mutual incentives to work together
- Limited mechanisms to move resources between services / providers
- Providers primarily rewarded for treating service users not improving outcomes
- Short term contracts provide limited incentives to invest in longer term outcomes
Commissioner-to-commissioner and/or Provider-to-provider

Depth of relationship

- Formal merger
- Partnership organisation
- Joint Management
- Co-ordinating activities
- Consulting each other
- Sharing information

Breadth of relationship

- Health and social care
- Health and wider LA
- Health, LA and wider community

Increasing complexity
Contracting models

- As-is (do nothing option)
- Informal network—profit/risk sharing
- Accountable Care Organisation
- Integrated Care Hubs
- Prime contactor and subcontracting model
- Single Integrated Care Organisation
- Joint Venture with Joint Management Board of providers
- Alliance contract

<table>
<thead>
<tr>
<th>Contracting Model</th>
<th>Description</th>
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</table>
| **Prime Contractor** | - The commissioner(s) hold one contract with one provider which has full accountability for the care model  
- The prime contractor subcontracts some provision to other provider organisations  
- The Prime Contractor determines any risk and benefit sharing arrangements with subcontractors |
| **Joint Venture** | - Collaborative approach between providers, promoting joint ownership of outcomes and accountability, and shared risk |
| **Alliance Contract** | - Variant to the traditional Joint Venture  
- Collaborative approach with all organisations (commissioners and providers) sharing contractual responsibility and risk  
- The emphasis and focus is on the joint ownership and responsibility for agreed outcomes |
Currency options

- Tariff / PbR
- Block / rolling contracts
- Bundled payments
- Capitation
- Cap and collar
- Pooled budgets
- Aligned budgets
- Spot contracting

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<tr>
<th>Bundled Payments</th>
<th>A single payment covering multiple elements of care (across sectors) for an individual over a fixed period of time</th>
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<tr>
<td>Capitation</td>
<td>Fixed annual risk-adjusted fee paid per registered older person for the entire continuum of care / services provided. Might exclude specified services for which separate payment arrangements could apply.</td>
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<tr>
<td>Activity based payment</td>
<td>If either elective surgical services or specialist hospital or mental health services are included, it may be appropriate to include some form of activity based payment for high cost interventions.</td>
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**Lead Commissioner**

- **CCG, City Council, SRFT, GMW**
- **Health, social care & wellbeing for 65+** (may excl. specialist & elective surgical services)
- **Some services subcontracted or directly contracted by commissioners**
- **General Practice or other parties could be incorporated**
- **Phased introduction from 2014/15**

**BENEFITS**

- Full range of services within a single management arrangement – more effective, efficient and coordinated care
- Collaborative environment without the need for new organisational forms
- Aligns interests of commissioners and providers, removing organisational and professional ‘silos’ that contribute to fragmented and sub-optimal care
- Collective ownership of opportunities and responsibilities; any ‘gain’ or ‘pain’ is linked to performance overall
- Supports a focus on outcomes and incentivises better management of population demand
Alliance contract

Partners have been asked to
1. Support the proposed implementation of an Alliance Contract in 2014/15, encompassing health and social care services for older people in Salford
2. Comment on the proposed scope of the Alliance Contract

SCOPE OF THE CONTRACT
- Population / client focus
- Proposed strategic partners
- Service content
- Aims and improvement measures
- Decision-making principles
- Management arrangements
- Payment options
- Commercial terms
- Pace of change
### Competition, choice and procurement

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<thead>
<tr>
<th>Potential Adverse Impact</th>
<th>Options for Resolutions</th>
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<tr>
<td><strong>Competition between providers</strong></td>
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<tr>
<td>▪ Inbuilt incentives of capitation could keep older people within services provided by partners to maximise care outcomes and avoid revenue ‘leakage’</td>
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<td>▪ This form of collaboration could be considered ‘anti-competitive’ in that parts of the upstream care pathway are captured by an Alliance, to the exclusion of other potential suppliers</td>
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<td>▪ Anti-competitive behaviour is permitted if in the interests of service users. In assessing this, Monitor will carry out a cost/benefit analysis</td>
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<tr>
<td>▪ Monitor will consider whether the changes remove or materially reduces the incentives on providers to provide high quality services, value for money and/or improve services – and whether the changes give rise to any material benefits to users of NHS health care services</td>
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<td>▪ It will need to be demonstrated that integrated care improves (not diminishes) quality and VFM and that service users benefit from more integrated care – and that the combined benefits outweigh any costs</td>
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<td><strong>Patient choice</strong></td>
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<td>▪ Incorporating GPs, community services, hospital services and social care within an Alliance could reduce the choice available to service users at the point when they would have normally been referred to a community or hospital service for further care</td>
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<td>▪ Commissioners are not required to extend patient choice or promote competition where it does not already exist</td>
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<td>▪ For older people, it could be argued that patient choice is less prevalent and that continuity / care coordination is more important than choice</td>
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<td>▪ Patients could be offered the choice to access care outside the integrated care system for specialist services and AQP services</td>
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<td><strong>Procurement</strong></td>
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<td>▪ Restricting the Alliance to the existing statutory partners could be seen to restrict ‘competition for the market’, as potential new entrants would not be allowed to tender for services</td>
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<td>▪ Procurement of services without a tender process is permitted where only one provider is capable of providing the services or a detailed review is carried out to identify the most capable provider(s)</td>
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<td>▪ The issue also relates to the extent to which new services are required or the focus is on redesigning and integrating existing services</td>
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<td>▪ Specific services could be subcontracted from third parties, selected through a competitive procurement process</td>
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Proposed next steps

• Formal feedback to be provided from each partner organisation ~ end of July
• Steering Group to consider feedback and identify areas of consensus and options for securing compromise
• Integrated Care Board to consider feedback, options and next steps at its meeting on 20 August

Recommendations

• Note the process underway to seek formal feedback from each partner organisation for review at the August ICB meeting
• Seek and consider any interim feedback from the four partner organisations