



Beginning with the end in mind

How outcomes-based commissioning can help unlock the potential of community services

Who should read this briefing?

- All commissioners and providers considering developing an outcomes-based commissioning approach that includes community health services.
- This briefing is particularly relevant to providers of community services.

What this briefing is for

- This briefing explains outcomes-based commissioning and outlines how it might help enable service transformation.
- It discusses the opportunities that outcomes-based commissioning gives for providers of community services, including the main technical considerations that will need to be addressed.

Key points

- A focus on outcomes is key to personalising care and focusing on people's wellness, reflecting the value delivered by care rather than only the activity undertaken.
- Commissioning based on outcomes has the potential to facilitate the transformation of care and is one way of overcoming the barrier of current payment mechanisms that do not support integrated care.
- Effective engagement of patients is vital.
- Providers of community health services could lead the development of new models that are enabled by outcomes-based commissioning, whether through collaboration with other local providers or by taking on the role of lead provider.
- Careful thought is needed about how outcomes-based commissioning can be developed and applied locally where it can add most value.
- Support to evaluate, share learning and manage risks will be crucial.

Background

Health outcomes have become the standard for measuring successful care. More and more people are living with long-term, and often multiple, conditions. Successful care for this group of people is not about providing a cure or a certain number of procedures, but about enabling and supporting them to live as well as possible with their conditions over the long term. Achieving this will involve transforming the system so that all of its parts work in an integrated way towards the outcomes people want and need most.

Simultaneously, the NHS is facing the biggest financial challenge in its history, requiring it to meet growing demand with, at best, static funding, while social care also faces a challenging financial environment. It is now more important than ever that the system as a whole is as efficient as possible.

Unlocking the unmet potential in community settings is crucial in both transforming care and improving efficiency.¹ Community providers are using innovative ways of supporting and enabling people with high levels of clinical need to be cared for at home or more locally, and are working in partnership with other health and care providers.

The 'rules of the game' need to change to enable this potential to be unlocked. The way funds currently flow around the NHS is a barrier to focusing on outcomes and shifting resources into different models of care.

Innovative approaches to commissioning have a key role to play in shifting the focus from rewarding organisational activity to rewarding outcomes across organisational boundaries. Outcomes-based commissioning seeks to support this shift by aligning incentives across all providers involved in delivering a person's care around a common set of outcomes. This will create an environment where providers are supported to collaborate and innovate to deliver care which achieves the desired outcomes and provides value for money.

Part of the solution will also be to reform NHS payment mechanisms.² This will, however, take time.

With outcomes-based commissioning still at an early stage in England, providers of community services are keen to understand the role it could play. The NHS Confederation's Community Health Services Forum and PwC organised a workshop on this topic for commissioners and providers of community health services in February 2014. This briefing captures the key learning and main discussion points from the workshop.

What is outcomes-based commissioning?

Outcomes-based commissioning is a way of paying for health and care services based on the outcomes that are important to the people using them.

It involves the use of a fixed budget for the care of a population group, with providers working together to deliver services which secure the outcomes required.

“Unlocking the unmet potential in community settings is crucial in both transforming care and improving efficiency.”

What is outcomes-based commissioning?

Traditional commissioning in the NHS has tended to focus on processes (numbers of appointments, attendances, operations and procedures), individual organisations and single inputs of care. This approach has often inadvertently helped sustain a fragmented approach to the way care is delivered, acting as a barrier to the development of more integrated services and models of care. There is a strong case for commissioning differently.

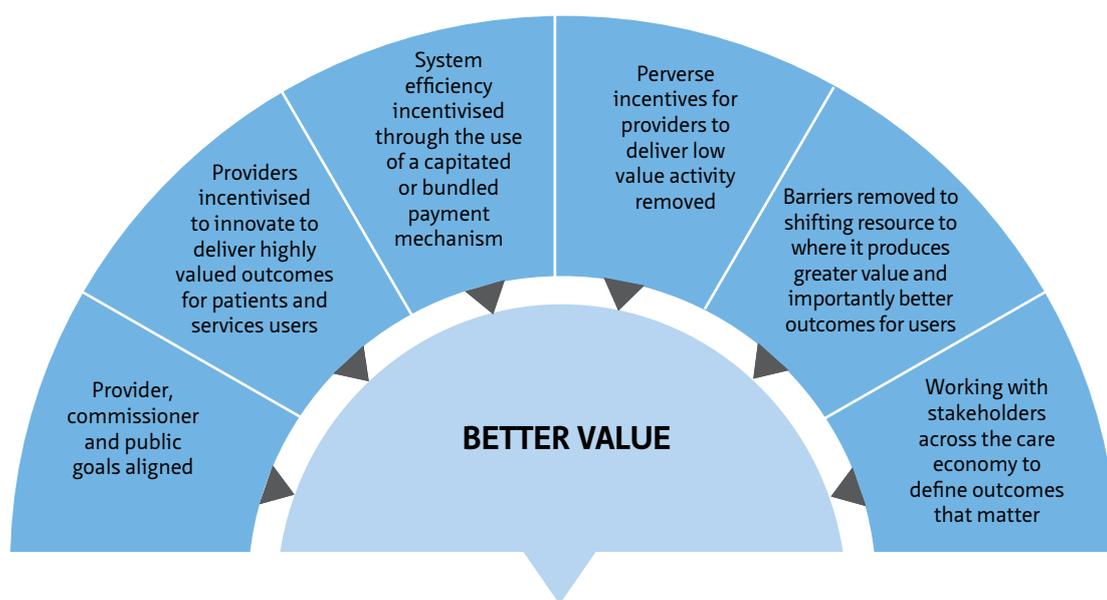
Outcomes-based commissioning is a way of paying for health and care services based on rewarding the outcomes that are important to the people using them – not simply organisational activity or individual organisational performance. Outcomes-based commissioning typically involves the use of a fixed or ‘bundled’ budget for the care of a particular population group, with aligned incentives for care providers to work together to deliver services which meet the outcomes required within the fixed budget.

Outcomes-based commissioning aims to achieve better outcomes through more integrated, person-centred services and ultimately provide better value for every pound spent on health and care.

Outcomes-based commissioning incentivises:

- **high-value interventions** – delivering care in settings where the best outcomes can be delivered at the right cost
- **shifting resources to services in the community** – delivering high-value care will likely mean more services provided in the community and at home, where appropriate, rather than in hospital
- **a focus on keeping people healthy and in their own homes** – investing in services to prevent costly emergency admissions to hospital; support people to return home as soon as possible after a hospital admission; support older people to stay independent and in their own homes
- **delivering outcomes that matter to people using the services** – focusing on the experience of people using the services and achieving the outcomes that matter to them
- **coordinated care** – working in collaboration to provide a coordinated service across organisational boundaries and care settings.

Figure 1. How does an outcomes-based approach provide better value?



Source: Outcome Based Commissioning Alliance (OBC Alliance) formed of PwC, Wragge & Co, Cobis and Beacon

Understanding outcomes

An outcome is defined as a health and/or social gain experienced by a person with an illness, as defined from the person's, rather than the system or clinician's, perspective.

Outcomes can be organised into a hierarchy: health status achieved or retained; process of recovery; and sustainability of health (see Figure 2).

To ensure sustainability of the outcomes-based commissioning approach, it is necessary to develop outcomes relevant to the full cycle of healthcare, from an initial problem through to recovery. However, defining outcomes will also require regular review as circumstances change.

Approaches to outcomes-based commissioning

There are two approaches to outcomes-based commissioning: population based and pathway based, outlined below.

Population-based approach

A provider, or group of providers, is allocated a fixed budget to manage all health and care needs for a defined population group. The contract may apply to the care for a local population within a specific geography, care for a clearly defined segment of this population – for example, older people – or for a group of related conditions. These type of contracts are often referred to as 'capitated outcomes-based incentivised commissioning'.

Pathway-based approach

A single 'pathway' of care is commissioned, making the provider(s) responsible for a person's outcome related to a particular condition (or group of conditions) over a defined period of time.

The best known example is the 'Swedish Hip' model. In this model, once a patient is clinically eligible for a treatment – for example, if they have reached a measureable pain threshold or level of disability – they are referred to a provider, or group of providers, who are then responsible for their care for this condition over a specific time period and are judged by patient outcomes. This means providers are incentivised to choose the right intervention, coordinate care across the pathway, use preventative measures to maintain fitness and take all steps to avoid relapse.

Broadly, a population-based approach is best for complex problems, where co-morbidities are significant factors. A pathway-based approach is best adopted where there can be no confusion about the clinical problem being addressed; however, a single condition is rarely the only condition that an individual suffers from – particularly in relation to older people – so the service area chosen for this type of contract must be considered carefully to minimise ambiguity over causality.

Figure 2. The hierarchy of outcomes

TIER	LEVEL
Tier 1: Health status achieved or retained	Survival
	Degree of health/recovery
Tier 2: Process of recovery	Time to recovery – maintenance of/ return to normal activities
	Disutility of the care or treatment process – diagnostic errors and ineffective care, treatment-related discomfort, complications, or adverse effects, treatment errors and their consequences in terms of additional treatment
Tier 3: Sustainability of health	Sustainability of health/recovery and nature of recurrences
	Long-term consequences of therapy, for example, care-induced illnesses

Source: Prof Michael Porter, Harvard Business School

Outcomes-based contracting

While commissioning for outcomes is intuitively appealing, in practice it requires contractual innovation to operate. This may be, for example, through the procurement of an accountable lead provider, or integrator, who will be responsible for the services that the commissioners require. The main types of contracts that clinical commissioning groups (CCGs) are likely to consider applying in future include joint ventures, alliance contracting and prime contracting.

Joint venture contracting

A contractual joint venture is a contractual agreement between two or more parties to come together for the delivery of a particular project or service. It can be one, two, or more providers (provider joint venture), or one or more providers plus one or more commissioners (commissioner joint venture).

The joint venture agreement will specify the nature, responsibilities and terms and conditions of the relationship between the parties. While the parties agree under the joint venture agreement to work together on the project, they retain their own separate organisational identity.

A contractual joint venture typically relates to the delivery of a single project.

Alliance contracting

Alliance contracting, a particular form of contractual joint venture, assumes that organisations can achieve better outcomes, particularly in the delivery of complex services, by working collaboratively within a single, overarching contract.

An alliance contract aligns incentives between organisations through a common set of outcomes, encouraging collaboration to enable the delivery

of coordinated services while sharing risk and accountability between alliance partners.

This type of contract enables collaboration between distinct organisational entities; integrated services can be delivered without the need for integrated organisational forms.

Specific pain/gain share mechanisms are pre-agreed by parties within the alliance and defined within the contract, yet are necessarily linked to overall contract outcomes; collective success leads to collective gain, and underperformance affects the whole alliance.

Prime contracting

In this model, a single organisation is accountable for the delivery and coordination of a set of services and related outcomes as defined by the commissioner. The prime provider is typically allocated a capitated budget to manage all care services for a specific population group – for example, the frail elderly. This could even be for the care of a whole population within a defined geography (see, for example, the Alzira model.³)

The prime provider is incentivised to coordinate services around the needs of people using them, invest in high-value interventions and ensure collaboration between providers involved in the delivery of the whole service. It is not expected that the accountable lead provider will provide all of the services.

This contractual form shifts risk from the commissioner to the accountable lead provider, who is responsible for achieving commissioner-defined outcomes for the specified population within the allocated budget.

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Practical examples

Case study: The Integrated Pathway Hub at Pennine MSK Partnership

The Pennine MSK Partnership created a new organisational form – the Integrated Pathway Hub – which works like a lead accountable provider and is responsible for all musculoskeletal services in Oldham. Since 2011, it has held a budget of around £23 million, covering primary, community and acute services.

A key driver for developing the partnership was a desire to focus on improving people's outcomes rather than being micromanaged against detailed, process-driven key performance indicators. There were concerns that care was too fragmented, with no effective performance management of care and outcomes. Payment by results contained perverse incentives to deliver more care in acute settings.

The focus on commissioning this contract is now on health gain, using tools such as patient reported outcomes measures, based on Pennine MSK Partnership's work to develop a framework that combined programme budgeting and marginal analysis as an alternative to payment by results. The partnership is a company which holds a specialist PMS contract with the range of services and terms of operation covered by service level agreement with the commissioner. As lead accountable provider, the Pennine MSK Partnership shares responsibility for care coordination, quality and performance across the entire pathway. This means it is incentivised to performance manage the entire pathway.

For many years, national survey data showed that over 40 per cent of patients wanted more involvement in their care. Given this, and evidence that shared decision making leads to improved outcomes and greater patient satisfaction, shared decision making has been central to the approach, with the AQuA shared decision-making model implemented within the past two years.

The service was developed by two GPs and a nurse consultant in rheumatology. This clinical leadership has been key, particularly in overcoming an initial lack of interest among the wider GP community and helping develop a shared vision among clinicians. The first iteration of the service started, in 2002, as a triage system for rheumatology referrals and was able to divert 70 per cent of GP referrals away from hospital.

In 2006, the service was commissioned as an integrated community musculoskeletal service incorporating rheumatology, elective orthopaedic outpatients and persistent pain services through a specialist PMS contract which then incorporated the lead accountable provider responsibility in 2011.

Most areas considering outcomes-based commissioning will not have ten years to develop the approach and contract, but the developed model has been adopted by other commissioners who have either procured, or are procuring, this approach.

Key benefits

- Musculoskeletal spend per head decreased by £10 in Oldham compared to an increase of £10 nationally (for the period 2009/10 to 2011/12.)
- Oldham's knee replacement patients received an average health gain of 0.35 in 2011/12, compared to 0.27 in 2009/10, representing a statistically and clinically significant increase in patient health outcomes. (The England average health gain was 0.30 during the period.)
- Involving patients in decisions to treat appears to lead to better outcomes.

For further information, see www.pmskp.org and **Pennine MSK Partnership case study**.

Case study: Capitated outcomes-based contract in Milton Keynes

Milton Keynes was the first area to develop a capitated outcomes- based contract in England, delivered initially for substance misuse services.

Prior to letting the new contract, Milton Keynes substance misuse services were provided by a number of providers across the care economy. As a result, the service was characterised by fragmentation, with users failing to effectively navigate the service and often dropping out of treatment. The large number of contracts, and lack of collaboration between the multiple providers involved in providing services, severely impacted upon the efficiency and effectiveness of the system.

To facilitate and incentivise integration between providers, and deliver value through better clinical and financial outcomes, Milton Keynes PCT and the Milton Keynes local authority worked in partnership to jointly develop an outcomes- based approach to commissioning the substance misuse service.

They initially worked together, and with service users and partner agencies, to understand the outcomes that they wanted to see from the contract. A contract was offered to providers which combined capitation and rewards for improved outcomes; providers were also able to keep money generated from delivering care more efficiently, cutting waste in the system. Both the detail of the contract and the right provider to deliver the service, were selected through a competitive dialogue process.

Key benefits

- The contract was let to a third-sector organisation, acting as prime contractor for the complete substance misuse service.
- The service was transformed quickly, with improved outcomes for service users and financial savings for commissioners.
- Overall spend on the service was reduced by 20 per cent in the first year.

For more information, see www.rightcare.nhs.uk/downloads/RC_Casebook_cobic_final.pdf

“Prior to letting the new contract, the service was characterised by fragmentation, with users failing to effectively navigate the service.”

Case study: Integrating cancer and end-of-life care in Staffordshire

In Staffordshire, four clinical commissioning groups (CCGs), NHS England and Public Health England are working with Macmillan Cancer Support, and with the support of two local authorities, to redesign cancer and end-of-life care services. They are co-designing new care pathways with patients and carers.

Care is to be managed and contracted through a single provider, which will be held accountable for the entire patient experience and clinical outcomes. Providers will need to demonstrate they have achieved a pre-agreed set of quality measures within a given expenditure target. Involvement of service users and carers is central in determining the outcomes for this contract. The prime-provider contracts will replace around 70 separate sub-contracting arrangements.

Contracts will be for ten years. In the first two years, the CCGs and Macmillan will support the selected prime providers to improve the currently available data on activity and costs, which is not yet sufficiently sophisticated to enable a purely outcomes-based approach as it is focused on interventions and individual providers, not on the whole pathway.

Therefore, a key element of the prime provider's work in the first two years will be to improve the data and analytics in order to provide a basis for a truly outcomes-based contract. They will also be expected to demonstrate real improvement in patient and carer experience. During the first two years the contract will be fee based.

Contract responsibility will formally transfer to the prime providers in the third year when the data is robust enough for effective pathway-outcomes performance management. This may then allow for risk and gain share. The prime provider could potentially not be a provider of any of the clinical services involved but rather focus solely on the job of integrator, sub-contracting all service delivery.

For further information, see www.staffordshirecancerandeol.com

“Involvement of service users and carers is central in determining the outcomes for this contract.”

How outcomes-based commissioning can support care transformation

Where might outcomes-based commissioning approaches be helpful?

Outcomes-based commissioning might be helpful for problems where there is enough scope to add value to people's outcomes to justify the investment of time and skill in developing the approach. It will not, however, be suitable for all problems.

The starting point should be an analysis of the nature of the problem. Outcomes-based commissioning could be helpful for:

- groups with poor outcomes, such as children with long-term conditions
- groups on whom a lot of money is spent, such as frail older people
- complex pathways, where making care less transactional would enable better integrated working.

Outcomes-based commissioning is more likely to be effective where:

- there is good data on outcomes and costs, for example, musculoskeletal conditions
- the population or pathway chosen reflects locally-agreed strategic priorities for care transformation.

Outcomes-based commissioning requires considerable capacity and skill to implement, especially on the part of commissioners. This implies extensive prior investment and long lead times. This in turn implies the need to consider whether the expected impact on outcomes justifies this investment. It means commissioners should probably develop only one outcomes-based contract at a time – although some things are more readily transferable than others, for example, elective pathways such as hip surgery.

The outcomes sought are an equally important consideration. To add real value, these must be patient-centred, based on local needs and priorities and address prevention.

Contracting for patient-centred outcomes will rest on effective user engagement throughout the process of developing the outcomes-based contract, as well as during its delivery. Working in partnership with service users can help secure wider buy-in to the changes to services that may be required. For example, in working with service users and communities to develop proposals for a new approach to end-of-life care in North Staffordshire, Macmillan Cancer Support and local CCGs have developed a shared understanding with local people of the ways in which services are likely to need to be reshaped (see case study on page 8).

In seeking to contract for outcomes which reflect existing local needs and priorities, commissioners are likely to draw on the joint strategic needs assessment and joint health and wellbeing strategy developed by the local health and wellbeing board (HWB). Providers should have been involved by the HWB in developing this strategy. To improve outcomes and efficiency, prevention should be addressed, which means understanding and addressing drivers of existing high levels of patient activity and including, or aligning with, some services funded and commissioned by local government.

Strong working relationships are crucial

Collaboration between large numbers of organisations will be essential to transform care. Providers and commissioners together need to think through the specific problem to which outcomes-based commissioning is to be applied, the improvements to care sought and how financial and quality risks around service change will be managed. This is more likely to work well where relationships are based on a common purpose – of securing the best outcomes for the population from the limited total resource available. This should be seen as an opportunity for a mature and collaborative discussion about transforming care together.

Good relationships between providers and commissioners will be important for commissioners' efforts to develop the market of potential

bidders for outcomes-based commissioning; given that outcomes-based commissioning approaches are in their infancy in England, this is likely to need considerable time and effort.

Collaboration between different commissioners will be vital, particularly where seeking to use outcomes-based commissioning to address complex problems for populations that cross geographical or administrative boundaries. Wider efforts to build collaborative relationships between commissioners, or indeed a pre-existing local culture of joint working, can provide a strong basis. Ideally, multiple commissioners will work together around a common purpose, of securing the best outcomes for the population from the limited total resource available, and aligning contract mechanisms and financial flows to enable this. Given the key role of primary care in integrated, community-based models of care, efforts to join up the commissioning of primary care with that of other types of care will be particularly helpful.

Outcomes-based commissioning approaches can be used for contracts spanning both health and social care. This can enhance the scope and range of services included, and this more comprehensive scope for providers to respond to potentially enables more integrated models of care.

The approach to developing local outcomes-based commissioning should harness and build on good things that have already begun to happen locally.

Involving patients in decisions

Improved patient experience, and achievement of the outcomes that matter to patients, are key to the transformation that is sought and therefore need particular attention throughout.

There are some concerns that outcomes-based commissioning approaches could mean care becomes less personalised and patients less

able to choose between providers or be partners in decisions about their care. Shared decision making supports better outcomes and is key to improved patient experience, and needs to be incorporated (see Pennine MSK Partnership case study on page 6). It is important that outcomes-based commissioning approaches address this by embedding personalisation and choice in the contract itself, with clear expectations around aspects such as shared decision making. This can be supported through outcomes and indicators aligned to this, which have linked incentives for the achievement of improved performance levels.

If service users have been engaged effectively during the development of the outcomes-based contract to agree outcomes, commissioners and providers should already have some understanding of the choices people are likely to make and the services they wish to use.

Barriers to transforming care

The significant barriers to transforming models of care have been highlighted.* Agreeing locally on the need to transform care for a particular group is only the beginning. Barriers include:

- securing investment
- managing risks to individual organisations' sustainability
- working with a payment system that rewards activity in some services rather than outcomes across a whole system
- securing support among patients, the public and staff for any service changes required
- supporting staff to work in different settings and ways.

* See NHS Confederation (2012) *Making integrated out of hospital care a reality*; NHS Confederation and Local Government Association (2014) *All together now. Making integration happen*; ADASS and NHS Confederation (2013) *Snapshot of integrated working: survey of local authority and NHS commissioners*; all available at www.nhsconfed.org/health-topics/integration/social-care

Overcoming barriers to transforming care

Outcomes-based commissioning approaches remove the barrier of a payment system that focuses on and rewards activity levels, replacing this with a focus on collaborating to achieve outcomes.

Through offering longer contracts, this approach may make it less difficult to secure investment in new services and make possible a planned and managed approach to the risks to individual organisations from service change. If it covers a period up to ten years, an outcomes-based commissioning approach would also give time for the financial benefits of care transformation to be realised.

While 'pump-priming' funding for service transformation is extremely scarce, for outcomes-based commissioning approaches social impact bonds are one possible way of securing up-front investment prior to the impact on people's outcomes and the financial return. These are, however, still at a very early stage of development and there are associated challenges relating to financial risk and the failure regime. Social impact bonds are a form of financing that aligns returns on up-front investment with 'social outcomes', such as improved health; investors only receive a return if pre-defined, measurable outcomes are achieved.*

The process of developing outcomes-based commissioning is likely to strengthen collaborative working between commissioners, which may help provide a good basis for other efforts at service transformation.

“Outcomes-based commissioning should not suffocate under the weight of unrealistic expectations.”

Outcomes-based commissioning is not a panacea

Outcomes-based commissioning should not suffocate under the weight of unrealistic expectations that it will solve all of the problems around transforming care. These wider issues will require clinical engagement and commitment, courageous leadership and collaborative working at local level, supported by national policies designed to enable change.

Any approach to transforming care that includes community healthcare will need to grapple with the lack of nationally comparable measures for the quality and efficiency of the care delivered by community services. This unavoidably makes it difficult to demonstrate clearly what models of care will deliver best value, and understand the financial savings that different approaches may release. However, work to develop comparable metrics for community services is well underway, instigated and funded by providers themselves, so the picture will improve.⁴ It is notable that some mental health services already have contracts based on complex outcomes, which indicates that this should be possible for community services with a similar degree of complexity.

New models of care will very often need to cross the boundary between health and social care, which brings a number of additional barriers to integration, including:

- different funding streams and planning cycles
- different entitlements for citizens
- different professional cultures
- often incompatible IT systems.

With little or no real-terms growth in NHS spending planned, however funding is shifted it will be crucial to find safe and sustainable ways of taking resources from elsewhere. It is essential to support local leaders to find solutions to this rather than assuming it cannot be done.

*Further information about social impact bonds in public services is available at www.gov.uk/social-impact-bonds

Technical considerations

Alongside contractual innovation and the scope of services for inclusion, consideration needs to be given to a number of commercial matters that providers will contemplate in responding to an outcomes-based commissioning opportunity. The key technical considerations are outlined in Figure 3 and below.

Commercial risk and risk allocation

Understanding the key commercial risks and how they will be apportioned between commissioner and providers is central to the development of any outcomes-based contract. At its core, an outcomes-based contract will look to pass the delivery and activity risk to a provider. However, commissioners are likely to retain population-based risk. Given the uncertainty of, for example, the investment required to drive transformational change, commissioners and providers may wish to consider sharing risk as the new model of care is developed and implemented. As previously unmeasured outcomes are developed, the risk can be transferred to the provider.

Payment mechanism

Payment mechanism is the method by which providers are rewarded for the delivery of services. It could include incentive schemes to

encourage beneficial behaviours and be balanced against the risk the provider takes. Outcomes-based contracts are usually accompanied by a capitated-payment mechanism (see below).

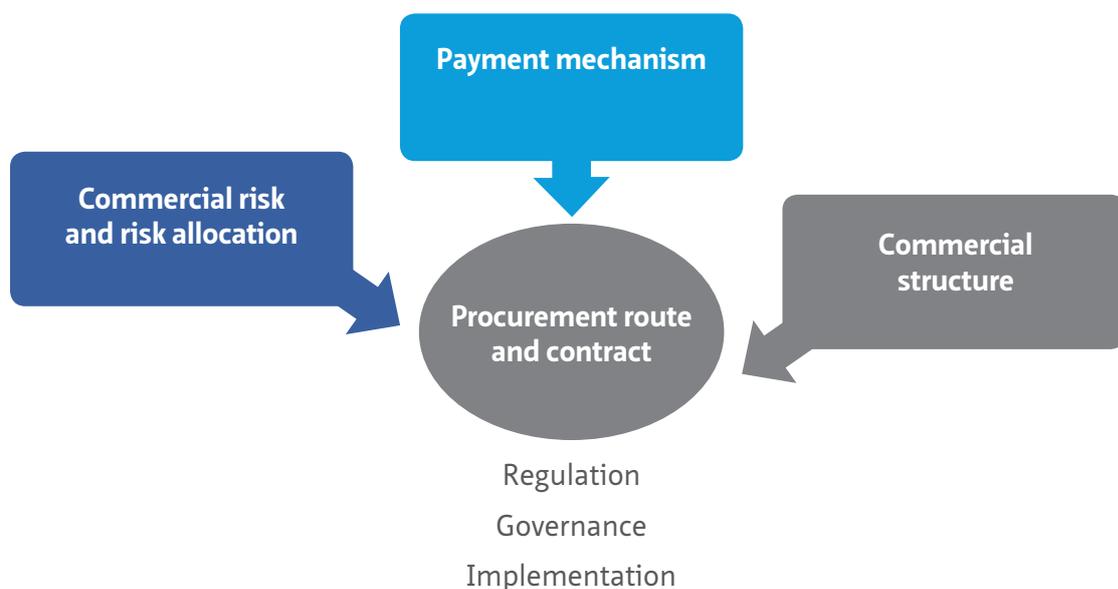
Commercial structure

This is the legal 'wrapper' that binds all the parties together and enables the payment mechanism to incentivise and change behaviours. As mentioned above, it will be driven by the services in scope and market interest. Providers may come together in alliances or joint ventures, or commissioners may prefer to work with a prime provider. Whatever structure emerges, it will need to be tailored to local requirements and in response to commercial and payment considerations.

Regulation

Proposals need to consider regulations faced by providers and commissioners. From a procurement law perspective, it is important to consider both EU procurement law and the NHS (Procurement, Patient Choice and Competition) (No 2) Regulations 2013 (the '2013 Regulations'). Commissioners will also have to consider Monitor's national tariff guidance.

Figure 3. Technical considerations for outcomes-based commissioning



Source: PwC

Governance

Governance and oversight is an integral component of the success of the contract. Appropriate management and monitoring of outcomes and objectives will be vital in order for the agreement to deliver its aims.

Implementation

The practicality and deliverability of the contract needs to be considered.

Additional points for commissioners and providers to consider

Developing the commercial structure will require alignment of service outcomes with the performance and payment mechanism. This is complex and will require an actuarial* approach. In addition to the points outlined above, commissioners and providers will need to consider:

- developing the economic model and assumptions, including demographic growth, deflators for tariff and efficiency
- 'carving out' elements to be excluded, for example, directed enhanced service (DES) / local enhanced service (LES), and age/demography appropriate services as they relate to the scope of services being commissioned
- defining the population and setting the indexed, capitation payment
- defining the performance-related, outcomes-based payment regime
- defining how investment will be made and remunerated – benefits apportioned back to commissioners
- contractual arrangements for primary care/GP networks as providers
- contract term and renewal
- supply chain considerations and constraints/ requirements
- regulatory and other considerations, for example, tax.

Useful resources

Community Health Services Forum, NHS Confederation (2012) *Realising the benefits of community services*.

Community Health Services Forum, NHS Confederation (2013) *Reforming payment mechanisms for community services*.

Presentations from CHSF workshop on developing new approaches to contracting for integrated care.

'Commissioning for outcomes' video.

NHS Commissioning Assembly (2014) *Commissioning for outcomes narrative*.

www.commissioningassembly.nhs.uk

The Grafton Group (2013) *Clinical contracting considerations* **www.pwc.co.uk/government-public-sector/healthcare/clinical-contracting-considerations-a-grafton-report.jhtml**

* Applying mathematical and statistical methods to assess risk

What outcomes-based commissioning means for community health providers

The development of new approaches to commissioning that reinforce the delivery of care in different settings and in more integrated ways – such as outcomes-based commissioning – are key enablers for the development of more community-based, integrated models of care.

However, given the complexity and resource-intensive nature of the process to develop outcomes-based contracts, and the fact there are very few of these models in England (and thus very little learning) it would not be realistic to expect outcomes-based commissioning within the next few years to become widespread, or to rely on it alone to enable the large-scale, whole-system transformation of care that is required.

Community health providers have a significant role to play in providing care for the pathways and populations generally seen as suitable for outcomes-based commissioning approaches. Their role is likely to depend on both their organisational form and size and the type of outcomes-based contract used. It may also depend on how far providers of community services seize the opportunity to drive innovation in models of care. There are examples of primary care providers leading the development of models that include community health elements⁴ but as yet there are few examples of community services themselves building out into primary and secondary care.

Many mental health and acute trusts increased significantly in size when they took on community health services under Transforming Community Services. They are well placed to take on the role of integrator as a lead provider, and there is an opportunity for commissioners to consider this as they develop options for retendering contracts. A standalone community trust could potentially take this role on,⁵ although this has not yet happened.

Smaller providers, including small and medium-sized enterprises and social enterprises, could be involved in a prime-provider arrangement as

sub-contractors, or might be part of an alliance contract between a number of providers and the lead provider. However, there is a concern among these providers that they may be at a disadvantage if outcomes-based commissioning approaches develop in ways which give larger organisations leadership of service transformation.

Whether smaller providers really are disadvantaged will depend on how outcomes-based commissioning is developed, and particularly whether commissioners use it as an opportunity to support collaboration locally, and whether prime providers are expected to (and held to account by commissioners for) put in place governance arrangements that support shared decision making across all providers.

Before starting in earnest with outcomes-based commissioning, some areas can be planned and prepared for, such as:

- commissioners engaging with providers to build relationships and ensure a common purpose around population health objectives and priority areas for service transformation
- commissioners and providers building a clear understanding of what they are trying to achieve through outcomes-based commissioning, and agreeing some clear metrics for success
- working with patients and the public to discuss the outcomes that matter to them
- commissioners and providers considering the risk-sharing arrangements they could apply
- providers reviewing the breadth of their skills, especially commercial, and the collaborative/partnering arrangements they have in place with other providers.

⁴For example, the Penning MSK Partnership (see page xx), and Canterbury, New Zealand, where general practice has taken on many activities that used to take place in acute settings (see The King's Fund (2013) *The quest for integrated health and social care*).

Confederation viewpoint

There is an established consensus that new models of care are needed to adapt to the very different needs of people in the 21st century, and that the current health and care system too often fails to align incentives to the outcomes that people want. Commissioning is a key element in transforming care, and innovative approaches to finding ways to align providers' incentives to outcomes will be crucially important.

In pursuit of greater value from NHS resources, there is a growing focus on people's health and wellbeing, which requires concentration on population health outcomes; the increased emphasis on personalisation and partnership with patients also requires that individuals have an influential voice in setting the outcomes from their own care. In pursuit of service transformation which meets these aims, there is an inexorable move towards commissioning more on the basis of outcomes, including through outcomes-based contracts.

Outcomes-based commissioning approaches have already been successful in helping transform the delivery of care internationally – where evidence is emerging of improved outcomes, often at reduced cost – but are in their infancy in England. Inevitably, the early stage of development of outcomes-based commissioning means the evidence base is still emerging for where, and why, it can succeed in delivering better outcomes for patients and better value for taxpayers.

The development of these approaches, and work to draw out learning and evidence from them, needs to continue at pace. Careful thought is needed to understand how outcomes-based commissioning can be developed locally to enable changes in the way services are delivered. The rewards for patients, and the system, are potentially great if outcomes-based commissioning can be used to enable a greater focus on and accountability for patients' holistic needs and better support integrated care.

In the meantime, this early stage of development poses some challenges for commissioners and providers seeking now to apply outcomes-based commissioning. It is important to support those

areas considering outcomes-based commissioning to maximise their chances of success in improving outcomes and delivering value.

National bodies, particularly NHS England, have a key role to play. Academic health science networks could support innovation in commissioning, through building and sharing an evidence base, supporting the creation of new ideas and their evaluation, and helping rapidly spread learning and implement concepts that have been shown to work.

Individual organisations will of course need to consider risk. For community services with comparable metrics still in development, there are risks in working with 'unknowns'. Care should be taken to contract on a basis that does not assume metrics will definitely work well as soon as they are chosen. Rather, metrics may need to be developed further for two to three years during the contract itself. Attribution of a specific provider's role in securing a person's or population's outcomes continues to be challenging – especially where outcomes are complex and cut across multiple services – and this risk, too, needs to be managed. Smaller providers will also be conscious that they have less scope to mitigate financial risks if the contract leads to them running services at a loss.

However, there are also risks for providers in not exploring outcomes-based commissioning. These providers could find they are behind the curve in using a powerful tool to align incentives and transform care. The current way we do things too often obstructs the shift to more community-based, personalised, integrated models of care that providers of community services want to see.

Providers of community services will no doubt be paying close attention to how outcomes-based commissioning develops, as evidence emerges of results and the best implementation approaches, markets and shaped, and the potential risks and utility become clearer.

For more information on the issues covered in this briefing, contact kate.ravenscroft@nhsconfed.org

References

1. See King's Fund (2014) *Community services. How they can transform care.*
2. See **CHSF submission to Monitor November 2013.**
3. See NHS European Office (2011) *The search for low-cost integrated healthcare: the Alzira model.*
4. *Demonstrating the Value of Community Services* is a sector-led programme which is developing comparable metrics for community services. For further information, see www.bridgewater.nhs.uk/demonstratingthevalueofcommunityservices or contact the Programme Director, Dr Christina Walters: christina@hhconsulting.co.uk
5. See Right Care (2012) *The accountable lead provider. Developing a powerful disruptive innovator to create integrated and accountable programmes of care*

The Community Health Services Forum

The NHS Confederation's Community Health Services Forum (CHSF) is the only forum that brings together and represents organisations from across the community health sector. Our membership includes community NHS trusts and foundation trusts, social enterprises, independent sector providers of community health, and integrated mental health/community and acute/community trusts. The CHSF is part of the NHS Confederation.

For more information about our work, please visit www.nhsconfed.org/communityhealth

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