The Strategy Unit.

Outcomes-based commissioning

A framework for local decision-making

NHS
Midlands and Lancashire
Commissioning Support Unit

Context

Context

The NHS Long Term Plan (LTP) calls for a shift to a new service model with patients receiving joined up care, at the right time and in the most optimal care setting. Central to achieving this will be the health and care system working together in alignment and coordinating resources towards these shared goals.

The LTP also sets the NHS's priorities for outcomes and quality improvement for the next 10 years. These relate to:

A strong start in life for children and young people (CYP): Maternity and neonatal services, CYP mental health services, Learning disability and autism, CYP with cancer

Better care for major health conditions: Cancer, Cardiovascular disease, Stroke care, Diabetes, Respiratory disease, Adult mental health services, Short waits for planned care

There is also significant emphasis placed on **prevention** and tackling **health inequalities**.

It is unlikely that any single provider will be able to achieve these outcomes alone. Their attainment will instead be dependent upon the work of a range of providers across health, social care, local government, the third sector and beyond.

Local systems will need to design approaches to contracting and payment that align with their approaches to quality and outcomes improvement, and that reflect the population covered, the scope of services and the associated provider configuration.

An end to PbR?

Productivity improvements have been made by shifting away from block contracts to paying by activity (Marshall et al, 2014). This approach has also had other consequence in that it:

- Encourages providers to increase volumes of activity, which can be at the expense of the wider system and patient outcomes (i.e. providing more care rather than better care);
- Disincentivises delivering services at greater value as this can lead to lower provider reimbursements – eliminating unnecessary procedures, or shifting them to other parts of the system that are more optimal; and
- Puts the emphasis on curative and reactive treatment, rather than preventative and proactive treatment and tackling the wider determinants of health that, in turn, could moderate demand on health and care services.

Shifting the focus away from activity towards outcomes could, it is argued, incentivise systems to make the transformational changes required to meet the triple aim.

A framework for local decision-making

In the absence of a nationally-determined approach, each local system needs to determine how it will proceed.

This resource provides a framework, based on relevant national guidance and the international evidence base, to support local decision-makers embarking on a new approach.

- Confirm **system aims and objectives**;
- Determine the **scope** of populations and services to be included in contracts, and the priority **outcomes**;
- Determine the local **provider configuration** model;
- Assess the appropriateness of the mechanisms available for –
  - **Allocating resource** to providers, and
  - **Generating improvement** in quality and outcomes;
- Understand the drivers of system behaviours likely to operate as a result of, or independent of, those mechanisms.

Aims and objectives

Aims

Each system will have their own bespoke set of aims that they are trying to achieve based upon the local context and priorities. The following offers a generic set as a prompt:

- Collaboration and integration in service provision around shared goals
- Shifting resource upstream from reactive care to proactive intervention and support
- Provision of services closer to home
- Improvement in quality and outcomes
- Compliance with performance standards
- Innovation in service delivery
- Alignment of provision with patient/citizen preferences
- Sharing and management of financial risk across the system
- Transparency, accountability and assurance in the use of public funds
- Release of resource from non-value-adding contract management
- Impacting the behaviours of front-line decision-makers

Scope

Who? - The population

The scope population that is to be covered by the contract needs to be determined early on in the process. This should be assessed locally based on system priorities, needs and objectives.

The contract may cover:

- the whole population

or a segmented approach may be taken. Segmentation may be made by:

- age – E.g. child, adult, elderly
- long term condition
- number of long term conditions
- geography

Mid-Nottinghamshire have initiated a pilot for the MSK pathway, which had been identified as an area of opportunity for considerable improvement. The intention is to then expand scope to other pathways and ultimately to a wider population.

What? – The services

In addition to determining who the contract will cover, what services that a provider(s) will be required to deliver for the population also needs to be established. This will also start to provide an estimate for the financial envelope of the contract.

The contract can be for all services, or some services may be excluded.

Exclusions may be made due to factors such as:

- Risk – some low volume, high cost services may carry higher risk to the contact
- Relevance – some services may be already delivering value / do not need coordination across providers and will therefore not benefit from the new approach
- Ease – current contracting arrangements may not allow inclusion – at least initially

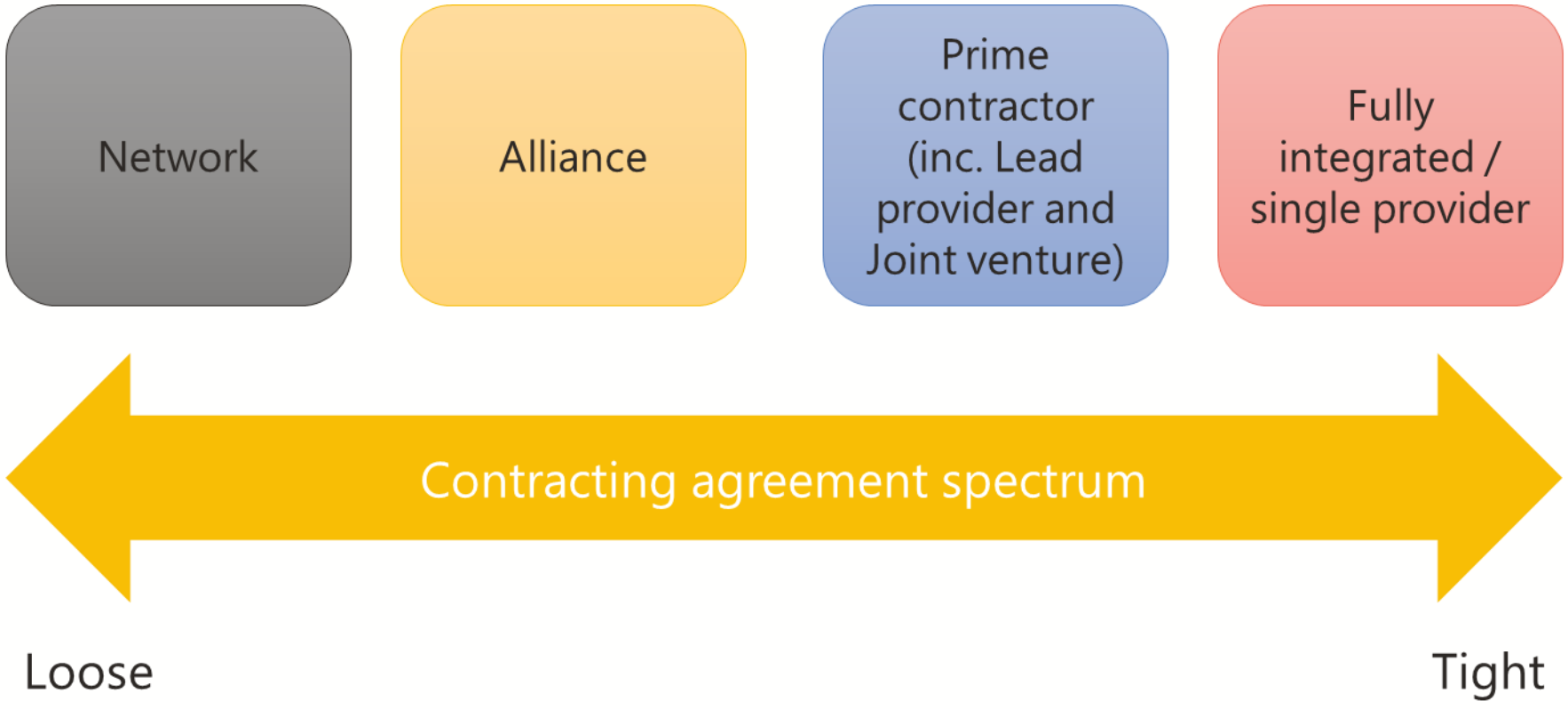
These services may be introduced into the scope over the life of the contract.

Provider configuration model

Configuration and contracting models

There are a number of provider configuration or contracting models available when commissioning across a system, each with strengths and weaknesses.

Decisions about payment and improvement mechanisms need to be made in the light of the expected local model.



Provider configuration

Network: A group of providers working together based on a set of common views / aims / objectives. An MOU may be developed reflecting their understanding of their role, purpose and expectations. Commissioners hold contracts directly with each provider.

Integrated Care Alliance: often led by commissioners, alliances aim to incentivise a number of providers to collaborate to deliver a specific service(s). Commissioners use linked contracts with providers. Each party maintains its own internal financial controls and can share gains or losses the other parties.

Prime contractor: the commissioner holds a contract with a single provider who assumes all clinical and financial responsibility. The provider manages the integration of services for a care pathway or a defined patient population, subcontracting with other providers as required.

Lead accountable provider: the commissioner holds a contract with a single provider who is accountable for providing a care pathway (s), or achieving defined outcomes for a defined patient population. Providers may subcontract some elements / services but the lead accountable provider retains key accountability for delivery of appropriate, quality care on the pathway.

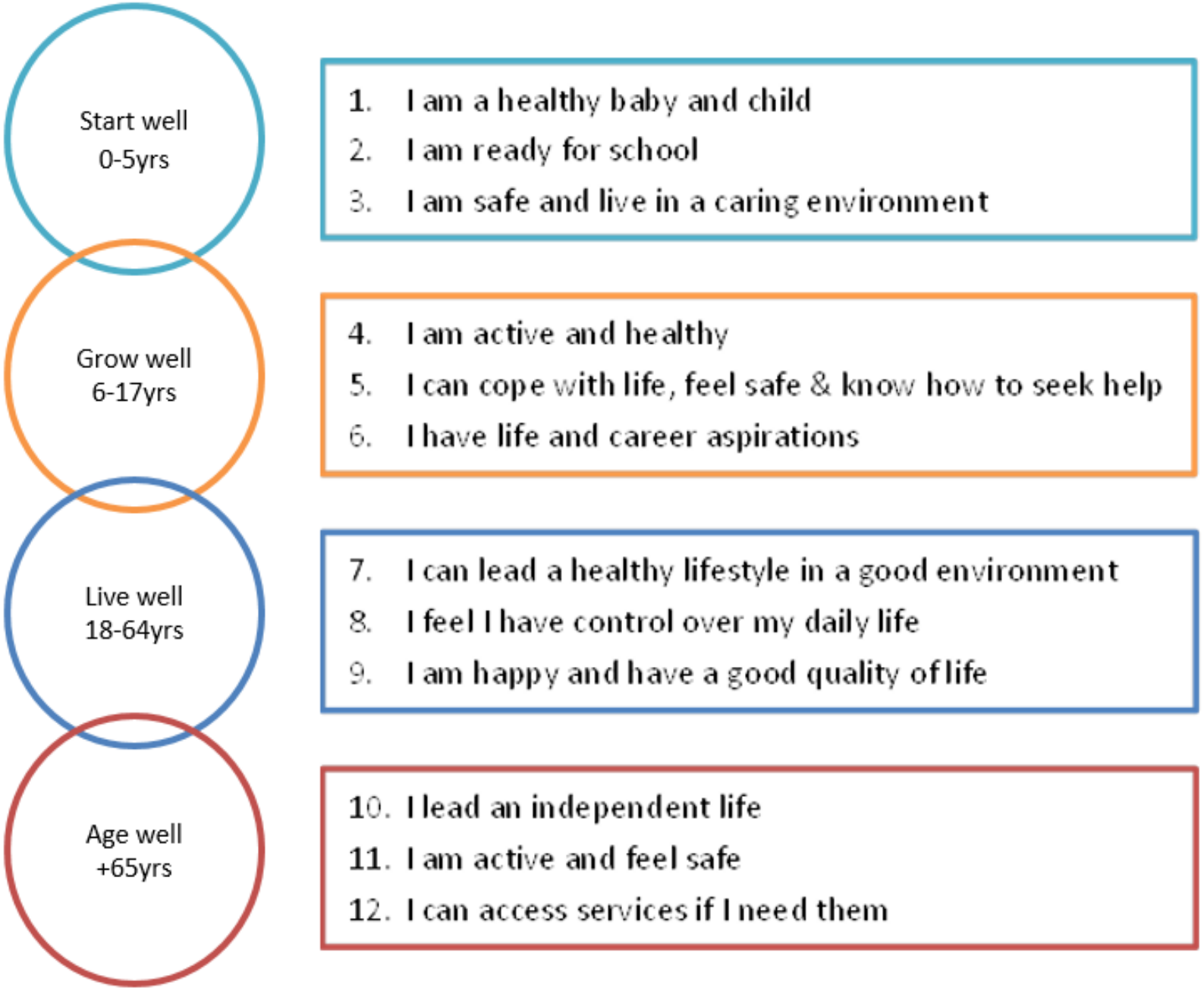
Joint venture: a new vehicle is created to facilitate provision of integrated care, but each provider remains independent. The joint venture agreement specifies its nature, responsibilities and governance. The commissioner contracts with the joint venture, rather than individual providers.

Integrated Care Organisation: commissioners hold a single contract with a single direct or indirect provider of care, but this organisation assumes all responsibility for providing services for an entire care pathway or patient population.

Outcome frameworks

Examples shown are correct as April 19

Tier 1: Top Level Ambitions for the Outcomes Framework



Sandwell Health Outcomes Framework

Best start in life
(Pre-birth—18 years old)

- Healthy Pregnancy
- School Readiness
- Transition into Healthy Adulthood
- Emotional Health and Wellbeing
- Safeguarding & child protection

£££

Living well
(19—64 years old)

- Living healthy and happy lives
- Active and Engage in their communities
- Reduction in substance misuse
- Ability to Self-Care
- Right support for vulnerable people

£

Ageing well
(65+ years old)

- Living Active life and feeling Safe
- Living independently
- Ability manage their long term conditions
- Good experience of care
- Best End of life care

£

Mental Health and Mental Wellbeing

Workforce and System

Access to Integrated Care and Support at the Right Time

Walsall Integrated Care Partnership Outcomes Framework (0.3)

A healthy population

- Living longer lives
- Living healthy, happy, fulfilling lives
- The best possible start in life
- Greater equality in health outcomes across Walsall

Accessible, coordinated and responsive care

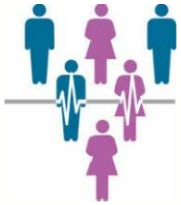
- A good experience of care
- Health and care services which work together
- Access to the right support in the right place at the right time
- The best possible care for people with long-term conditions and the most complex needs
- The best possible end-of-life care

Strong, active communities

- People are supported to feel in control of their health and wellbeing
- People are active and engaged in their communities
- Families and friends who provide informal care are well-supported
- Making a difference to the wider aspects of daily life (such as housing, work, education and social connectedness) which can improve people's health and wellbeing

Dudley Multi-Specialty Community Provider Outcomes Framework

Population Health



- Increase Healthy Life Expectancy
- Reduce Inequality in Healthy Life Expectancy
- Improve Health Related Behaviours
- Improve Prevention and Risk Reduction

Access, Continuity and Coordination

- Improve Access to Services
- Improvement in Patient Reported Outcomes
- Improvement in Patient Reported Experience
- Improve Screening, Case Finding, Monitoring and Management

Empowering People and Communities

- Improve Levels of Health Literacy
- Reduce Social Isolation
- Increase Employment for those with a Mental Health or Learning Disability
- Improve Housing and Independence for those with a Mental Health or Learning Disability

System and Staff

- Staff Recruitment, Retention and Motivation
- Safety and Quality Improvement

All Together Better

Payment mechanisms

Payment mechanisms

The payment mechanisms used in the NHS are shown below.

Mechanism	
Payment by Results (PbR) / Case based	Used in the acute sector. This has been combined with Pay for Performance (P4P) mechanisms – CQUIN, BPT
Block	Used commonly in contracting Mental Health and also Community services. Supplemented with P4P - CQUINs.
Capitated	Used for calculating CCG allocations and some GP payments. GP contracts are supplemented by P4P mechanisms - QOF.
Bundle	Examples of use for the MSK and Maternity pathways
Cost pass through	Used when paying for high cost devices and drugs, estates
Sub mechanism	
Pay for Performance (P4P)	Commissioning for Quality and Innovation (CQUIN), Best Practice Tariff and Quality and Outcomes Framework (QOF).
Gain & loss share	Included in the guidance for Integrated Care Provider contracts

The following slides examine the potential benefits and drawbacks of each mechanism.

Payment by Results

Description

Payment is made to providers for a defined episode of care retrospectively. Prices are based on classifications of patients and the type of care they require. It is known as Payment by Results in the NHS but is measured by activity rather than results. It is also known as a 'case-based' contract outside of the NHS.

Overview

+ Providers are incentivised to reduce costs, where prices are fixed
+ Greater transparency around cost allocation
+ May incentivise improvements in quality to attract more patients and therefore revenue (where there is patient choice)

- Incentivises providers to increase activity, not necessarily in the right place for the patient
- Push for cost reduction may be at the expense of quality
- Innovation is discouraged as providers are not reimbursed for this
- Higher transaction costs
- Accurate payments are reliant on correct coding of activity
- Leads to contract dispute/data definition arguments between commissioners and providers

Activity Risk is borne by the commissioners although Cost Risk remains with providers

Block

Description

Payments made to a provider for a specific, often broadly defined, service(s). Contract value is irrespective of the number of patients treated or activity undertaken. Payment is prospective and often based on historical prices.

Overview

+ Predictable in value
+ Flexibility – value not restricted by activity levels
+ Low transaction costs
+ Encourages innovation, where cost-neutral / reduction

- Lack of transparency and accountability
- Does not incentivise performance – greater performing providers attract more patients, increasing financial pressures
- Can lead to rationing services / quality reductions where demand / cost increases
- Providers may avoid higher cost / complex patients
- Can limit innovation, where investment is required

Capitated / Whole Population Budget

Description

Prospective lump sum payments made to a provider, or group of providers, to provide some or all services for a specified population. Payments are based on population demographics and are ideally risk adjusted to take into account more costly patient groups. Payment is not linked to how much care is provided.

Overview

+ One budget for all of a patient's healthcare needs – facilitating coordinated, integrated care
+ Flexibility – value not restricted by activity levels.
+ Incentivises innovation through spending on services for the best outcome of the patient
+ Drives efficiency – minimising duplication and waste
+ Predictable and stable provider incomes makes it more feasible for them to plan and implement service changes.

- May incentivise reduced access (minimum delivery standards can be set)
- Requires skills / systems for coordination and tracking costs and activity across system
- Risk adjustment may increase transaction cost
- Can cause 'cherry picking' of least complex patients

Impact is influenced by contract length and the elements of care covered.
Risk is transferred to the provider.

Bundle

Description

A fixed fee is paid to a provider, or group of providers, retrospectively for an entire cycle of care for a patients medical condition, not just a single intervention. Payment is most effective based on the true cost of care but historical prices can also be used.

Overview

+ Providers are incentivised to maximise value across a pathway
+ Encourages collaboration and coordination of resources across the system
+ Easy for clinicians to target as it is at the pathway level (can be combined with other mechanisms)

- Does not incentivise reduction in volume
- Requires information and data system that extends beyond individual providers
- Difficult to calculate

Cost-based contracts

Description

This system involves paying **costs** providers incur for services, rather than a set price. This could include reimbursing providers' costs for high-cost devices or drugs, or reimbursing providers' estates costs, for example.

Overview

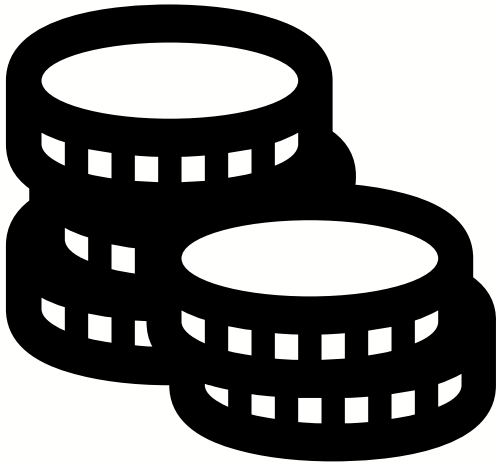
+ Incentivises an "open book approach" to the costs of service provision
+ Minimises some of the "cost shifting" behaviour associated with PbR

- May reduce the incentivisation for cost reduction and efficiency
- May lead to stasis in current service provision if new investments harder to fund

Pay for Performance (P4P)

Description

Where an organisation or individual receives payment conditional on functioning in a certain way, in this case in an attempt to increase the quality of care



Overview

- Can lead to improvements in service delivery, e.g. the use of tests or treatments, and the quality and productivity of processes of care.
- May lead to little or no improvement in health outcomes.
- **CQUIN**: did not lead to statistically significant improvements in outcome indicators. Many goals concern processes as opposed to outcomes.
- **BPT**: Mixed but positive picture, suggesting that BPTs improve outcomes in some conditions (Hips) more than others.
- **QOF**: Initial improvements for some conditions and intermediate outcomes but were not sustained. Limited impact on outcomes because of focus on process based indicators.

Sources

- Flodgren et al (2011)
- Scott et al (2011)
- Yuan et al (2017)
- Marshall et al (2014) – Nuffield
- Mcdonald et al (2012), (2013)
- Langdown and Peckham (2013)

Assigning value to outcomes

When assigning value to outcomes under pay for performance arrangements, there are a number of elements that need to be determined:

- The outcomes and measures that are to be linked to payment – based on what matters to patients, local and national priorities
- The structure of the payment – bonus / withheld element
- The financial envelope assigned to outcomes – large enough to incentivise, without risking financial destabilisation
- The weighting of different outcomes within the envelope – equally, or differently based on priority areas

Methods associated with allocating values to outcomes range from a scientific approach (e.g. using methods such as QALYs or DFLYs) to a deliberative process involving some combination of stakeholders – citizens, LA and NHS commissioners, providers, clinicians.

Gain and loss share

Description

An agreement that allows savings or losses to be distributed across providers and commissioners. Payment is made on a standard basis but is then retrospectively adjusted to reward / penalise parties depending upon whether conditions have been achieved. It can be used as a supporting mechanism designed to mitigate some of weaknesses in the underlying mechanism.

Overview

Can realign an organisations financial incentives with delivering outcomes for the whole system

+ Method for managing uncertainty when new care models are introduced
+ Provides a mechanism to distribute financial benefits of new care models around the system
+ Can incentivise providers to keep their populations healthy – prevention, early intervention, treatment in the right place at the right time

- Significant detail required to design in every eventuality - results in considerable complexity
- May risk substantial losses to providers – political implications (maximum loss caps can be used)
- May require significant sums to be held to mitigate losses – cannot be spent on delivery
- Incentives may not function if savings cannot be carried forward
- Increases transaction costs

Further SU research: https://www.strategyunitwm.nhs.uk/index.php/publications/risk-and-reward-sharing-nhs-integrated-care-systems

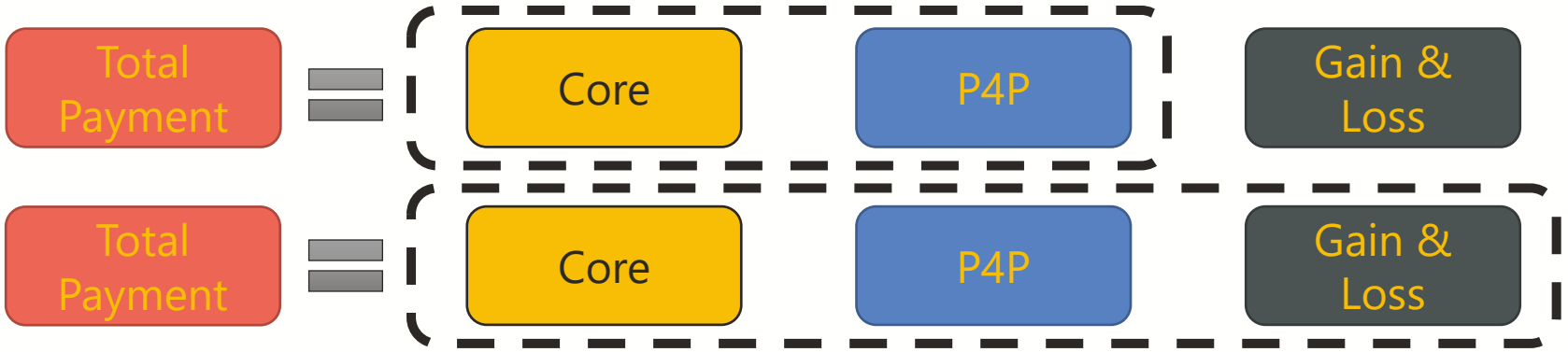
Payment mechanism components

Policy has moved towards the use of payment mechanisms made up of three components:

- A **core component** paid in regular instalments
- A variable component that is contingent on the defined **outcomes being achieved.**
- A mechanism for sharing the **gain/loss** associated with risks (e.g. due to unanticipated savings or demand levels) between commissioners and the provider(s)

This is often the model used for capitated payments.

There is a question as to whether the gain & loss share component should be part of the main payment, or separated.



Payment mechanism examples

Service(s)	Payment Mechanism	Contract value	Examples of other mechanisms	Provider configuration
Oxfordshire Adult Mental Health	Capitated P4P 19.5% - local outcomes 0.5% national CQUIN	£37m	Efficiency savings reinvested in MH services	Lead provider
Bolton A&E, UC, maternity, elective, OP, community	Block Gain share – savings from reducing cost / activity CQUINs monitored to target improvement	c.£186m	Collaboration, System sustainability, Transparency, Risk share not transfer CMT to QI	Single provider
Dudley - MCP	Capitated 7.5% - Local outcomes 2.5% - national Opportunity to bid for monies where withheld. Potential risk/gain share	£270m		Lead provider
Mid Notts (initially MSK pilot, moving to wider population)	Capitated Risk and gain share	£34m		Lead provider for pilot. Overarching Alliance agreement across system

Payment mechanism examples

Service(s)	Payment Mechanism	Examples of other mechanisms	Provider configuration
Canterbury (New Zealand) – full range of health services	Block - Cost based Where efficiencies are made, the alliance decides how best to deploy these resources across the system.	Vision, collaboration, training in improvement, leadership development, public reporting	No purchaser / provider split. Health board owns hospital. Close strategic alliances with independent providers.
Alzira (Spain) - hospital, community and primary care services	Capitated Risk and gain share – dependant performance against quality measures Performance linked staff salaries	Competition between hospitals within network, Audit and peer review, Culture	Lead provider
US ACOs	Capitated Risk and gain share – dependant performance against quality measures	Public reporting of quality measure and savings achieved	Lead provider

Other considerations

- The approach will need to comply with National Payment Tariff System local pricing rules
- The requirement for the selected approach to take into account the rights that individuals have in choosing a provider and their treatment.
- Commissioners will need to consider procurement law and regulations
- Commissioners should assess the role of personal health budgets and how they can be incorporated
- The difficulty of the long-term nature in measuring improvement in outcomes compared to the short term need to pay for the costs of service provision
- There is a fundamental question about whether payment systems are attempting to “cover” the costs of service provision, or are just incentivisation processes. Old “market based” approaches replicated a cost plus approach on behalf of providers – is this still appropriate in more “collaborative” systems

Approaches to improvement

Overview

Mechanisms

- Audit and peer review
- Public reporting of performance / league tables
- External accreditation / regulation
- Quality improvement methodologies

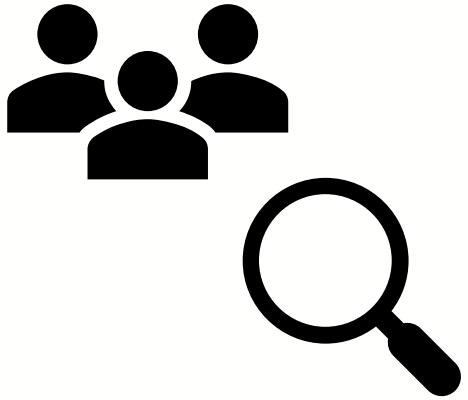
Enablers

- Vision
- Culture and organisational development
- Leadership
- Clinical Engagement
- Patient Engagement
- Rapid-cycle learning and evaluation

Audit and peer review

Description

An individual's professional performance is measured and then compared to professional standards or targets, with advice of where improvement can be made and decimating best clinical practice.



Overview

- Can be effective in improving compliance with desired professional practice and process of care measures e.g. prescribing / use of lab tests.
- Effect is greater where baseline adherence to recommended practice is low
- Impact upon patient outcomes has a limited evidence base, though some small improvements were found.
- Efforts to change provider practice should be targeted at behaviours for which there is evidence between processes and patient outcomes.

Sources

- Ivers et al (2012)
- Roberts et al (2012)

Public reporting of performance / league tables

Description
The public release of performance data in relation to quality improvement and clinical outcomes

Overview

- Evidence suggests potential for modest stimulation of quality improvement activity at a hospital level.
- There has been found to be no evidence of direct effects on clinician performance or outcomes.
- The 2001 hospital star rating system introduced ranking with apportioned blame. Studies show significant reductions in elective care waiting times (noting unprecedented increase of NHS expenditures during this period)
- Authors note the potential perverse and unintended consequences that can occur from 'blame'.

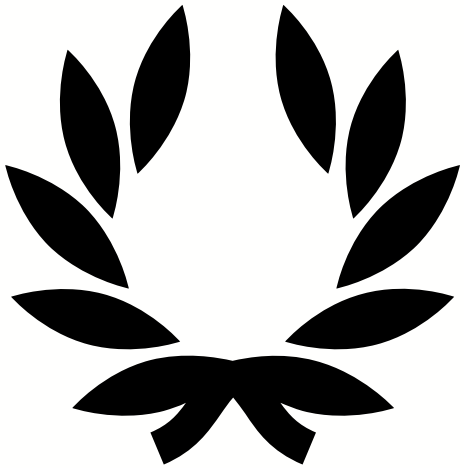
Sources

- Scott (2009)
- Oliver (2014)

External accreditation / regulation

Description

Formal reviews of institutional performance by external agencies granting recognition of high standards of performance to incentivise improvement.



Overview

- Studies found no impact upon quality / quality outcomes in the US or Australia
- Difficulties in establishing direct evidence between accreditation and outcomes
- The financial and opportunity cost of pursuing accreditation should be weighed up against other improvement initiatives.
- Qualitative elements of a KF study on the CQC highlight some positive impact on quality but also negative consequences of regulation. No quantitative impact has been found.

Sources

- Scott (2009)
- Greenfield and Braithwaite (2008)
- Smithson et al (2018)

Quality improvement methodologies

Description

A systematic framework that can be utilised to understand, analyse, communicate, implement and establish quality improvement in an area. This looks specifically at the application of Lean.

Overview

- A number of positive results in productivity, eliminating waste and improving patient safety – increased throughput, reduced waiting times, reduced errors.
- Evidence focus upon quality and outcomes is limited
- Limited number of examples of a system wide approach
- Emphasis on Lean quality improvement tools in isolation, with inconsistent results.
- Lean tools must be part of a comprehensive management system, within a supportive institutional culture, and with committed leadership – Virginia Mason Health System

Sources

- D'Andreamatteo et al (2015)
- Kaplan et al (2014)

QI Packages

Advancing quality

Mechanisms:

1. Tournament style scheme, publicly reporting results
2. Hospitals in the top two quartiles of league table received bonus payments

Supported by:

- feedback on performance,
- support to standardise data
- shared learning events across hospitals – despite competitive dimension

Clinically significant reduction in mortality during the first 18 months of the programme.
Statistically significant for one of the three conditions studied (pneumonia)

(Source: McDonald et al (2015))

US Veterans Health Association

Mechanisms:

1. Performance related bonuses are to network senior managers
2. Performance league tables are used to encourage healthy competition

Supported by:

- effective leadership with a clear vision
- transformation to a broader health care system
- the development of integrated health care networks
- the development of a EHR

Significant improvements in process quality by 2005.

Note – recent issues. Some argue caused by poorly conceived performance measures and perverse incentives.

(Source: Oliver (2007))

Enablers

- **Vision:** Positioning quality improvement strategies at the heart of how the system / organisation operates, rather than as individual / standalone projects
- **Culture and organisational development:** developing a culture of reflection and adaptive learning, providing the conditions for innovation and improvement. Developing organisational cultures in which staff focus on better value as a primary goal, embedding a quality focused approach in everyday work
- **Leadership:** working across the system with partners to improve the wider health and well being of populations served developing a collaborative / system leadership approach. Leaders understanding, valuing and showing a real commitment to quality improvement
- **Clinical Engagement:** makes a critical contribution to achieving innovation and improvement for patients
- **Patient Engagement:** helps to define 'shared accountability' on clear measures of value. A commitment to listening to and learning from the experiences of patients and carers and assuring their full participation in design, redesign, assessment and governance
- **Rapid-cycle learning and evaluation:** using information for rapid cycle evaluation and feedback loops to achieve and sustain transformational change. Investment in robust high-quality information on cost and quality encourages trust and collaboration. The sharing of information and intelligence can facilitate joint accountability for informed and consistent decisions

Supporting your decision

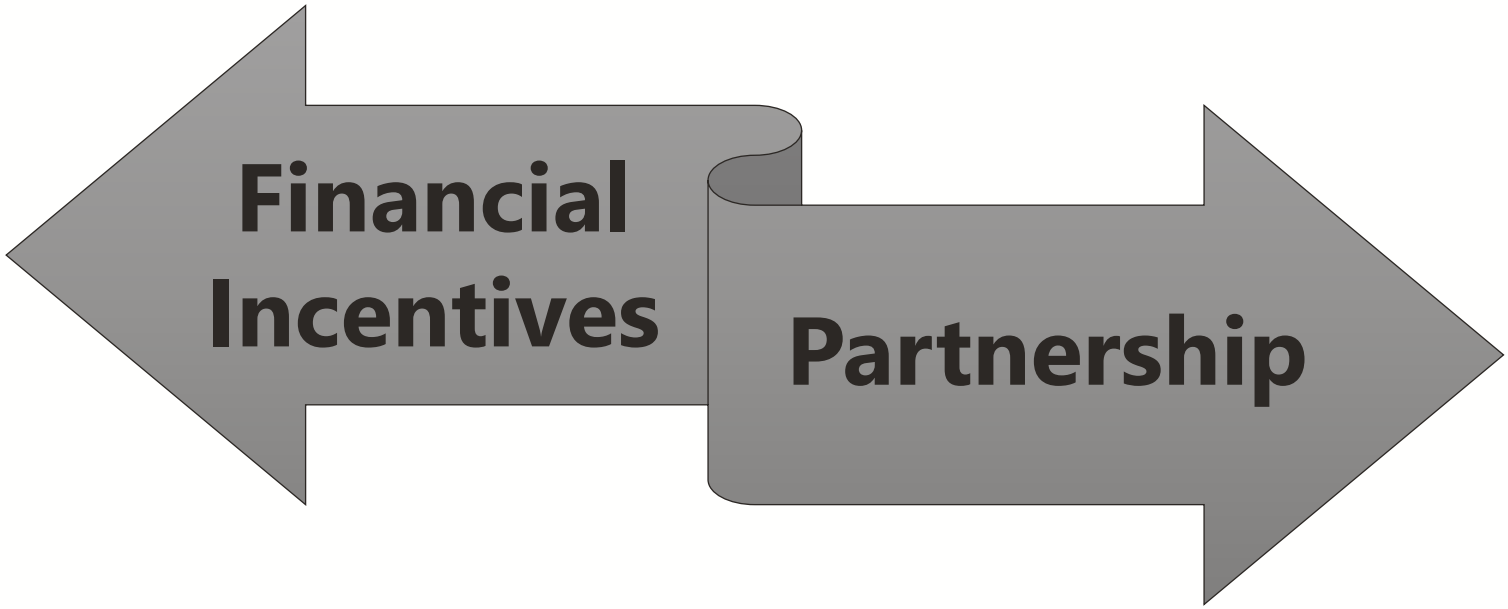
This final section looks to use the set of aims previously introduced as a framework for the assessment against each of the mechanisms.

The intention is for this to be utilised as a tool to support decision making when users are looking to introduce a new contracting and payment mechanism package.

The matrix can be used to build an approach from scratch or to validate and enhance existing proposals.

There is also the option to start with one two emerging approaches (introduced in the subsequent slides) and then adapt the local approach from the matrix as required to suit the local environment and system dynamics.

Two emerging and contrasting approaches (Kings Fund)



Capitated contracts / whole population budgets with the use of financial incentive(s) – P4P / Risk & gain share.

Assigning financial value to outcomes and rewarding providers for performance and transferring risk to them.

E.g. US ACOs, Oxfordshire adult mental health services

Minimum payments based on past revenues / expected costs. Sharing the risk of higher demand but allowing providers to retain improvement savings.

Focusing on enablers - system collaboration and partnership
Shifting CMT resources towards exploiting opportunities for system wide quality and outcomes improvement.

E.g. Canterbury (NZ), Bolton CCG & FT

Improvement & Payment Mechanisms	PbR	Block	Capitation	Bundle	Cost-based	P4P	Gain/Loss share	Audit/peer review	League tables	External regulation	QI method-olgogies	Shared vision	Culture and OD	Leadership	Clinical engagement	Citizen engagement	Rapid-cycle evaluation
Collaboration & integration	-	0	+	+	+	+ -	+	0	-	0	0	+	+	+	+	+	+
Proactive intervention	-	-	+	+	+	+ -	+	0	0	0	+	+	+	+	+	+	+
Closer to home	-	-	-	0	0	+	+	0	0	0	+	+	+	+	+	+	+
Quality/outcome Improvement	-	-	-	-	0	+	+	+	-	?	?	+	+	+	+	+	+
Performance standards	+	-	-	+	+	+	+	+	?	?	+	+	+	+	+	0	+
Innovation	-	+ -	+	+	+-	+	+	0	0	0	+	+	+	+	+	+	+
Citizen preferences	+	-	+	+	0	+ -	0	0	0	0	+	+	+	+	+	+	0
Managing financial risk	-	0	+	+	+	+	+	0	0	0	0	+	+	+	+	0	+
Transparency	+	-	-	+	+	+	+	0	+	+	0	0	0	0	0	0	+
Reduced contract management cost	-	+	+	-	+	-	-	0	0	0	0	0	0	0	0	0	0
Impact on front-line behaviours	+	0	0	+	0	+ 0	0	+	-	?	+	+	+	+	+	+	+

Summary template

Element	Selection
Scope	
Provider configuration	
Priority outcomes	
Payment mechanism(s)	
Improvement mechanism(s)	

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