HSJ LOCAL briefing

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OXFORDSHIRE 'OUTCOMES-BASED COMMISSIONING'

HSJ Local Briefing is our new in-depth analysis of the key issues facing the NHS's major health economies

crispin.dowler@emap.com
@crispindowler

In brief

Issue NHS leaders in Oxfordshire are drawing up plans to move maternity, adult mental health and frail elderly services on to a new form of contract, in which providers are commissioned to deliver a set of outcomes for patients. Up to 10 per cent of the contract value could be withheld if performance is not up to scratch. Under some of the contracting models set out, commissioners would bring in a "lead provider", possibly through competition, which would be accountable for outcomes, and would then bring in subcontractors to deliver specialist care.

Context Oxfordshire has a set of performance challenges that will be familiar to many health economies around England. These include demand for acute services exceeding plan and a high rate of delayed transfers of care. However, outcome based commissioning should not be seen as a reaction to any particular current local issue, as it aims to transform services over a longer time frame.

Outcome The first phase of work was completed this spring. A second phase is beginning now, which will draw up a final list of outcomes for each service area, and the performance measures providers will be expected to meet. Maternity and mental health services are expected to move to outcome based contracting by 2014-15. Because the frail elderly services are more complex, those contract changes will not be put in place until 2015-16. As the frail elderly budget accounts for two thirds of the amount to be spent through outcomes based commissioning, a local report explains that cost savings in that area will be "challenging" to achieve before 2017-18.

Local context

Last summer there was agreement that delayed transfers were the single biggest problem in the Oxfordshire health economy.

At the time of the last HSJ Local Briefing on Oxfordshire, the main players in the local health economy were collectively wrestling with the issue.

Nearly a year on, and two years since the county's delayed transfer rate became the worst in England, Oxfordshire's NHS leaders have put in place a set of measures designed to better integrate local services and improve the flow of patients through the system.

Although there were some encouraging improvements during the autumn and early winter, the delayed transfer rate leapt up again during the first three months of 2013 – in line with a national trend. A redesign of the entire local discharge process is now bedding in.

Outcome based commissioning

Even as work to combat the delayed transfers problem continues, the system is turning its attention towards a more ambitious programme to improve health and care services. Leaders believe that the system needs a more transformative change than simply the ability to move people between care settings more smoothly.

To this end, Oxfordshire Clinical Commissioning Group has this spring completed the first phase of its work on "outcomes-based commissioning". If implemented, the approach will result in fundamental changes to the procurement of three key areas of service: maternity; adult mental health; and frail elderly services.

The first two are interesting choices as they have little to do with delayed transfers of care – their inclusion in the project could be taken as evidence that leaders are looking beyond their immediate problems and focusing on more profound long-term challenges for the health system. It is hoped locally that an outcomes based contract system will make it possible to set up more patient-centred care in these areas.

Outcomes-based contracts would hinge on providers and commissioners agreeing to share financial risks and gains. It is hoped this will incentivise efficient working, and will represent a shift away from simply paying providers more if activity levels rise, without a full transfer of financial risk to the provider that a simple block contract approach could bring about.

The model likely to be used is a bit like a beefier version of the commissioning for quality and innovation incentives, which withhold a small amount of contractual payment unless some outcomes are demonstrated.

Under the Oxfordshire outcome based commissioning plans, as much as 10 per cent of the contract value could depend on hitting as-yet-undefined outcome measures. Over time, that proportion could increase even further, or could depend on an ever-rising quality of care.

Phase one of development of the project has resulted in a high-level plan, which is nevertheless detailed enough to give a good idea of how the contracts and the provider mix could change in future years.

Phase two is beginning now, and will involve more detailed planning work. Phase three will include formal procurement process.

Competition, integration and provider mix

The phase one report sets out a range of seven potential contracting models, with short descriptions setting out where each would be most appropriate. The report shows how the CCG will weigh the state of the provider market against the complexity of the services to be tendered, and the degree of integration required.

For instance, "full competition" could be used where there are many potential providers of a service, where service is relatively simple and requires limited amounts of integration. In such a scenario, a range of providers could be competitively procured through an invitation to tender.

However, where there are many potential providers but the services are complex and require fully integrated services, the report says consortia of providers could be competitively procured, through "competitive dialogue".

Other options described include a "single provider" where there is no possibility of competition – to be managed "with strong partnering and incentivisation", a "lead provider with back-to-back subcontract arrangements" and a "specialist integrator with competition for subcontracts".

It is thought likely that through subcontracting, or a consortium model, that outcomes based commissioning will bring about more of a mix of NHS, private and voluntary sector providers. Commissioners believe that lead providers accountable for outcomes will want to bring in other organisations better placed to improve care for patients.

"It will have an effect and it will [challenge] some of the assumptions about who does what," one provider source told HSJ. This could mean NHS trusts no longer directly providing some services, or doing new things for the first time. "That's a good

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thing, and that's part of the point of it. It's certainly stimulating us to think in fresh and different ways about what we're doing."

The source added that this was partly because the focus on outcomes was forcing providers to constantly think about the patient, rather than assume that because they are a certain sort of organisation, that they should therefore be undertaking a certain prescribed set of activities.

Maternity

The outcomes defined for each service area are not yet measureable – precise definitions for how commissioners want to see services improve will be worked up in phase two.

For maternity, there are three "tiers" of outcomes defined. The first gathers outcomes around general health such as cutting smoking rates among expectant mothers, reducing the caesarean section rate and keeping mortality rates in line with national standards.

The second tier is around the "process of recovery", and includes support for breastfeeding, rates of post natal infections and improved post natal mental health.

The final group of outcomes includes a range of patient experience measures, with providers also to be assessed on whether they provide a "single point of access" and "seamless care" for new mothers.

Commissioners intend to extend the scope of maternity services, to provide care for eight weeks after birth, rather than the normal two weeks.

The report also reveals that in phase two commissioners will "determine whether a local tariff can be adopted".

The CCG will also test the possibility of bringing in a "lead provider" of maternity services from outside Oxfordshire, although with the caveat that this "may not be an effective option". Currently Oxford University Hospitals Trust carries out more than 95 per cent of local maternity services by value, and patterns of use suggest that mothers in the county choose OUH despite there being other alternatives.

Phase one places great emphasis on the need for integration between the future main provider and other organisations such as NHS England and Oxfordshire County Council.

On maternity, the report concludes that the likely commissioning model is for a "lead provider" or "specialist integrator", in which a dominant organisation co-ordinates other agencies. It is therefore possible to imagine a scenario in which OUH is effectively sub-commissioning screening services from NHS England's local area team, or breastfeeding support and other public health programmes from the county council.

Frail elderly

Outcomes for frail elderly services follow a similar pattern to those for maternity. There is a set of outcomes around staying healthy, a second around improving the recovery process and a third emphasising the patient's experience of care and their ability to live independently after treatment.

The point, HSJ was told, is to focus the resources of the health system on keeping people with long-term conditions stable, and when an incident such as a fall occurs, to work to return the patient back to a normal, stable condition as quickly as possible. The effect of this would hopefully be to prevent "a full drastic acute response every time something goes wrong", one senior provider source told HSJ. In turn, this would relieve pressure on the system and take out unnecessary costs.

The existing provider landscape for the frail elderly is mixed: currently 25 per cent of health and care spending goes to OUH, while 24 per cent goes to Oxford Health Trust – the local community and mental health services provider. Meanwhile 32 per cent is spent with Oxfordshire County Council.

Like for maternity services, a lead provider from outside the county might not be effective, but the option will still be tested in phase two.

"Lead provider" or "specialist integrator" models are thought to be the most appropriate, possibly procured through "competitive dialogue" rather than a full tendering process. A well placed figure said it is fair to assume, as both of Oxfordshire's local NHS trusts are major providers of elderly care, that this could lead to Oxford Health and OUH competing for the lead provider contract. Under such a scenario the main provider could then end up bringing in the other trust as a subcontractor.

Initial options for contracting frail elderly services set out in the phase one report go beyond the over-65 age group, in addition seeking to include vulnerable younger people with multiple conditions.

As the services are more complex and there is more money involved, it is now understood locally that outcomes based commissioning for frail elderly services will take longer to implement than for maternity and mental health.

For the other two areas, the first year of outcomes based commissioning is currently expected to be 2013-14. Radical changes to contracting for frail elderly services will have to wait until 2015-16.

Mental health

While the lists of outcomes have been drawn up collaboratively between providers and commissioners, on the provider side there is a feeling they require significant development, and the addition some objectively measurable metrics before the new model can be implemented. For instance, it has been noted that there are no outcomes set out for assessing hospital-based mental health care.

Instead, there are five outcomes each for three groups of adult mental health service users: people with anxiety and depression; people with psychosis; and people with dementia. These include people with depression being about to re-engage and become active in the community, people with psychosis being able to find jobs and stable housing, and people with dementia being able to stay at home for as long as possible.

Different commissioning models are being considered for each service area. For anxiety and depression the CCG is exploring developing the market and setting up a consortium of providers. For psychosis the CCG's analysis indicates that a lead provider could be brought in, with competition for specialist services. Meanwhile for dementia there could be competition for both lead provider contract and specialist services.

As with maternity services, local sources suggest it is likely that the existing main provider would end up being the lead provider under an outcomes-based system.

Financial outcomes

The phase one report also concludes that outcome based commissioning will drive better integration and efficiencies. Frail elderly, maternity and adult mental health services in the county account for £300m of health and social care spend, three quarters of which comes from NHS budgets. It is notable that the exercise assumes that health and social care budgets should be treated

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as one. The CCG believes it should be targeting efficiencies worth 2-3 per cent, which could lead to savings of £6m to £9m, year on year, based on current activity levels.

However, over the longer term, commissioners hope that the changes are going to be so radical that by the third year they could yield potential savings worth even more, although no figure beyond the basic 2-3 per cent has yet been suggested.

It is worth bearing in mind that more than two thirds of the £300m total in play is for frail elderly services, for which the adoption of outcomes based commissioning will not happen before 2015-16. The phase one report says that for the frail elderly "cost savings will be more challenging to achieve in the short term", meaning the first two years after implementation.

That means that the work is not thought likely to start contributing substantial savings until 2017-18. There is considerable optimism locally that focusing NHS contracting on outcomes could lead to the transformation of services and a much better experience for patients. However, it is also the case that outcome based commissioning is not an answer to more immediate issues such as the financial squeeze and pressures on the acute sector.