Outcomes based commissioning

Andrew Smith
11 February 2016
Objectives

- To give a quick snapshot of where we are seeing outcomes being used and what we mean by ‘outcomes’
- To reflect on what NHS England are aiming for regarding outcomes and payments for Mental Health
- To look at some Mental Health Outcomes Frameworks and how incentivisation works
What is an outcome?

“The results people care about most...including functional improvement and the ability to live normal, productive lives”

International Consortium for Health Outcome Measurement, 2013
Output vs Outcome

- Outputs: the stuff we produce
  - The tools that are made
- Outcomes: the difference that stuff makes
  - The benefits to consumers and clients

So outputs should be shaped through understanding the outcomes you aim to achieve

Harvard Business Review blog Nov 2012
Whose outcomes are they?

- **Person: personalised, subjective**
  - I feel that my mental health condition is being controlled enough to let me get on and live the life I want to lead
  - I am treated with dignity and respect and as involved as I want to be in making decisions about my care

- **Professional: appropriateness, objective**
  - CRP levels under 10

- **Provider: technical efficiency, safety**
  - High friends & family test scores
  - Low outpatient DNA rates

- **Population: allocative efficiency, value**
  - High healthy life expectancy and narrow inequalities gap
Outcomes – Direction of travel?

2011-2015

- Disease-specific
- Pathway transformation
- 3-5 year contract length
- Prime provider model
- Based on a referred population
- Market can solve ‘provider problems’

2015-2025?

- Population focused
- System transformation
- 7-10 year contract length
- Collaboration behind the prime
- Based on registered population lists
- Appreciation of incumbent providers, but not just usual NHS ones
### Outcomes-based care across the country

<table>
<thead>
<tr>
<th>Where</th>
<th>What</th>
<th>Where</th>
<th>What</th>
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<tbody>
<tr>
<td>Somerset</td>
<td>Whole population (vanguard)</td>
<td>Herefordshire</td>
<td>Urgent Care</td>
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<td>Oxfordshire</td>
<td>Older People, Mental Health</td>
<td>Cambridgeshire &amp; Peterborough</td>
<td>Older People</td>
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<td>Newcastle Gateshead</td>
<td>Care Homes (vanguard)</td>
<td>Sussex</td>
<td>MSK</td>
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<tr>
<td>NE Hampshire</td>
<td>Whole population (vanguard)</td>
<td>Enfield</td>
<td>MSK</td>
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<tr>
<td>Croydon</td>
<td>Older People</td>
<td>Halton</td>
<td>MSK</td>
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<tr>
<td>Warrington</td>
<td>Intermediate care</td>
<td>Bexley</td>
<td>MSK, Cardiology</td>
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<td>Richmond</td>
<td>Care closer to home Mental Health</td>
<td>Bedfordshire</td>
<td>MSK, Dermatology</td>
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<tr>
<td>Nottinghamshire</td>
<td>Children’s care</td>
<td>Milton Keynes</td>
<td>Substance misuse, Sexual health services</td>
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</table>
National policy

- National outcomes frameworks
  - NHS
  - Adult social care
  - Public health

- Five Year Forward View (October 2014)
  - New models of care

- Monitor / NHS England guidance
  - Payment for outcomes
  - Financial risk/gain sharing
The Five Year Forward View (5YFV) has set out objectives to transform the way healthcare is organised and delivered. Locally developed capitated payment for mental health could support these objectives.
A payment system based purely on episodes of secondary care activity will not drive what we want to achieve in mental healthcare. Our aim should be to develop a payment system based on a ‘tripartite’ understanding of mental healthcare needs and the resources required to meet these needs to deliver the best outcomes.

Our focus must be upon the ‘whole person’ outcomes that most matter to service users. Delivering these will frequently require effective working with partners – for example, good and stable housing was identified as a critical determinant of good mental health.

Our focus must be upon integration wherever this delivers better experience and outcomes – mental health & physical health, secondary care & primary care, health / social care / housing etc.
NHS England – proposals for MH

The need to link the payment system to the achievement of outcomes was one of the strongest themes at the stakeholder event. Routine measurement of outcomes – the ‘outcomes that matter’ – was identified as the area where most work is needed if we are to accelerate progress towards a value-based payment system.

By April 2015 all contracts will be underpinned by an understanding of need, evidence-based responses to need and expected outcomes

By April 2016 all contracts will include clear incentives for the delivery of outcomes and outcome-driven payment models will have been introduced in a limited number of areas

By April 2017 there will be a wholesale shift to outcome-focused contracting
SO HOW DO YOU DO IT?
Outcomes based commissioning ...

- Starts from the perspective of the person
  - Move away from “what’s the matter” healthcare to “what matters to you” healthcare

- Changes the culture before changing the structures
  - Collaboration with the patient
  - Collaboration across providers
  - Collaboration with commissioners

- Makes best use of capped resources
  - Could investment deliver better outcomes for more people if used in a different way?

- Makes people think laterally
  - Capture the “if only” and “what if” intelligence
System transformation: the **Cobic** triangle

- **Incentive reform** Led by commissioners
- **Infrastructure reform** Led by providers
- **Service delivery reform** Led by professions

**Driven by patients & carers**

**Individual and population outcomes**
Key elements of an outcome-based approach

1. Define population and scope

2. Describe desired outcomes and associated indicators

3. Set the budget (collaboratively)

4. Decide duration of contract (not over-specific on form)

5. Design commercial structure: incentives, Gain/Pain share

6. Engage with population, professionals and providers always
Local information

International evidence

National evidence

June workshop (n=10)

Outcomes framework iteration 1: high-level generic themes

In depth interviews ICAH (n=5)

Service managers (n=17)

Outcomes framework iteration 3: refined locally-specific themes and goals; proposed indicators

Primary care

Public/patients (n=25)

Clinical teams/therapists

CCG & Council

Public Health

Information/commercial team

Data synthesis

Outcomes framework iteration 2: first cut locally-specific themes and goals

Final public consultation (n=30)

OUT

Outcomes framework iteration 4: prioritised locally specific outcomes themes and goals; with suggested indicators and measures

High-level evidence review
2. Desired MH Outcomes – Patient Experience

<table>
<thead>
<tr>
<th>Outcome domain</th>
<th>Outcome goal</th>
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<tr>
<td>I want to feel I am a full partner in my care</td>
<td>I want the professionals involved in my care to know me and not just my clinical needs.</td>
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<td></td>
<td>I want to have the option of financial control over my care, through, for example, an integrated personal budget, and help to manage it.</td>
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<td>I want to be supported to set and achieve my own goals as part of an agreed care plan.</td>
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<td>I am as involved in discussions about my care and treatment as I want to be.</td>
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<td>I need information, advice and training, provided in a way that is appropriate to my condition and circumstances, for me and my family on my care needs and how best to manage them.</td>
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<td>I want holistic care that considers all my conditions, not just one condition.</td>
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<td>I want to know who to contact when I need advice or help about my health.</td>
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<td>I want regular review of my health, my care and treatment, and my care plan.</td>
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<td>I know where to find people like me where I can share experiences.</td>
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### 2. Desired MH Outcomes – Quality of Life

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<th>Outcome domain</th>
<th>Outcome goal</th>
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<tr>
<td>I want to feel part of a community</td>
<td>I want to participate in activities meaningful to me</td>
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<td>I have the right to choose when and when not to get involved</td>
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<td>I can access the community in a way that suits me, with consideration of options on transport, technology, community support</td>
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<td>I want to live as normal a life as possible</td>
<td>I can live the life I am able to lead</td>
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<td>I want to maintain my independence for as long as it is safe to do so</td>
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<td>I need to have a flexible long term plan, including access to appropriate housing, to keep me as independent and healthy as possible</td>
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<td>I want to have timely emotional and psychological support to keep going</td>
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</table>
3. Set the budget

**Traditional contract:**
- Commissioner paid per capita
- Provider paid PbR /per attendance/admission/bundle
- Commissioner holds significant financial risk with little control

**Outcomes-based contract**
- Commissioner and provider paid per capita
- Much more risk transfer to provider, but also control
- Option for risk and gain share = joint ownership
3. Budgets (Capitation)

- A capitated payment approach is the payment of a provider or group of providers to cover a range of care for a population across a number of different care settings.

- Budget is derived based on population size (eg GP reg list AND referral list) & risk adjusted to reflect the different needs of people with mental ill health.

- Capitated payment for mental health will normally include incentive measures linked to achieving agreed quality and outcome measures (see commercial structure).
5. Commercial Structure

Key elements of an outcome-based approach

1. Define population and scope
2. Describe desired outcomes and associated indicators
3. Set the budget (collaboratively)
4. Decide duration of contract (not over-specific on form)
5. Design commercial structure: incentives, Gain/Pain share
6. Engage with population, professionals and providers always

![Diagram showing minimum capitation payment, outcomes incentive payment, and CCG and Council's revenue spends over years 2016/17 to 2022/23]
2&5. MH Outcomes – incentivisation

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- People will live longer
- People will improve their level of functioning
- People will receive timely access to assessment and support
- Carers feel supported in their caring role
- People will maintain a role that is meaningful to them
- People continue to live in settled accommodation
- People will have less physical health problems related to their mental health

- Mortality age
- Suicide rate

- Improvement in score on validated recovery evaluation tool (e.g. Star Recovery Tool)
- Reduction in intensity of cluster using the cluster tool
- % of care plans which are reviewed quarterly
- % of people who have a person centred care plan
- % of people who remain discharged from services after six months
- % of carers offered a carer assessment
- % of carers attending CPA or care planning meetings
- % of carers satisfied that they are viewed as equal partners in supporting the person with mental health problems they care for
- % of people undertaking voluntary activity
- % of people in paid employment
- % of people undertaking an education programme
- % of people running a home/being a parent
- % of people living in mainstream housing
- % of people living in mental health support accommodation
- Number of A&E attendances within an agreed time period (e.g. 6 months)
- Score on health screening tool such as the national health screening programme (including BMI, diabetes, cholesterol) or equivalent
5. Commercial Structure

Incentives change behaviours - Incorporate outcomes and money together in the contract:

1. ‘Game changing’ outcomes attract incentive payments (can be up to 20%) some are measured & rewarded annually, some monthly, some quarterly

2. ‘Core’ outcomes with £ penalties if not delivered

3. Qualitative outcomes collected to demonstrate continual improvement and / or national reporting

4. Need to define sets of indicators that demonstrates whether outcome is being achieved, what is the baseline, what is the target, how collected and how often reported

5. State assumptions and ‘what-ifs’ up front and agree cap/collar on the risk-share.

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Key elements of an outcome-based approach

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Example timeline
Establish needed data flows and a baseline
Partial move to outcomes-based payment in year 2, where data allows
Full move to outcomes-based payment from year 3
Further refinement
## 5. Commercial Structure

<table>
<thead>
<tr>
<th>Ref</th>
<th>Name</th>
<th>Outcome Domain</th>
<th>Goal No</th>
<th>Outcome Goal</th>
<th>Indicator</th>
<th>Indicator priority (H/M/L)</th>
<th>Priority Score</th>
<th>Incentivise/ Monitor?</th>
<th>Bundle?</th>
<th>Baseline</th>
<th>Improve 1</th>
<th>Improve 2</th>
<th>Improve 3</th>
<th>Improve 4</th>
<th>Improve 5</th>
<th>Threshold Expected and % of outcome pool available</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Independence</td>
<td>I want to be as independent as possible, and achieve the things that are important to me</td>
<td>1.1</td>
<td>I want support to go home or remain at home, so long as it’s appropriate for me to do so</td>
<td>Permanent admissions of older people (&gt;65) to residential and nursing care homes, per 100,000 population</td>
<td>H</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>50%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
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<td>Proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into re-ablement/rehabilitation services</td>
<td>M</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
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<td>Returning to usual place of residence following hospital treatment: fractured proximal femur</td>
<td>M</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>70%</td>
<td>90%</td>
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<td></td>
<td>Returning to usual place of residence following hospital treatment: stroke</td>
<td>M</td>
<td>2</td>
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<td>1</td>
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<td>55%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
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<td>1.2</td>
<td>I want to be supported to set and achieve my own, realistic goals</td>
<td>Years 1-2 Proportion of clinicians/healthcare professionals who have achieved the appropriate training for administration of PAM tool</td>
<td>L</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>50%</td>
<td>60%</td>
<td>75%</td>
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<td>1.3</td>
<td>I want to be supported to set and achieve my own, realistic goals</td>
<td>Social care-related quality of life in people in the target population</td>
<td>L</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
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<td>2</td>
<td>Confidence/self-management</td>
<td>I want to feel reassured and confident that I can manage my care</td>
<td>2.1</td>
<td>I want to feel safe and reassured</td>
<td>Proportion of people who use services who say that these services have made them feel safe and secure</td>
<td>L</td>
<td>1</td>
<td>0</td>
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<td>50%</td>
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<td>I want to feel confident that I can manage my care, including my medication, with support where I need it</td>
<td>Years 1-2 Proportion of clinicians/healthcare professionals who have achieved the appropriate training for administration of PAM tool</td>
<td>L</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>50%</td>
<td>60%</td>
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<td>80%</td>
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<td>I want to manage my care</td>
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<td>3</td>
<td>Positive experience</td>
<td>I want to have a positive experience of care</td>
<td>3.1</td>
<td>I am treated as a person, with kindness, dignity and respect</td>
<td>Proportion of outpatients/inpatients that felt they were treated with dignity and respect</td>
<td>TBC</td>
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<td>I want to feel that the people who care for me have the time to do so</td>
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<td>I want to build a rapport with the people who care for me</td>
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<td>I want to be treated by people who are competent, friendly and caring - I want to have confidence in them</td>
<td>Proportion of people who feel that the person acting as their first point of contact understands them and their condition, and they can approach their point of contact with questions at any time</td>
<td>TBC</td>
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<td>I want all aspects of needs and care considered together, including my emotional needs</td>
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<td>3.6</td>
<td>I want to have a positive experience of care</td>
<td>I want the people who care for me to speak to one another</td>
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<td>4</td>
<td>In control and informed</td>
<td>I am involved in decisions about me/my care, and I can access information and advice easily</td>
<td>4.1</td>
<td>I want to be treated by people who listen, know me and understand my needs</td>
<td>Proportion of people who feel that the person acting as their first point of contact understands them and their condition, and they can approach their point of contact with questions at any time</td>
<td>TBC</td>
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<td>I am involved in decisions about my care, I want to be asked, rather than have assumptions made about me/my care</td>
<td>Proportion of people who feel that the person acting as their first point of contact understands them and their condition, and they can approach their point of contact with questions at any time</td>
<td>TBC</td>
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<td>I can access information and advice easily, in a way</td>
<td>Proportion of people who use services who have control over their daily life</td>
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<td>I have a named person to contact if I need support, information or advice, especially in a crisis</td>
<td>Proportion of people who use services who have control over their daily life</td>
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<td>5</td>
<td>Effective</td>
<td>I want to receive care that is well-planned, personalised and meets my needs</td>
<td>5.1</td>
<td>I have a care plan, that I have been involved in creating</td>
<td>Total non- elective admissions into hospital (general and acute) all ages</td>
<td>TBC</td>
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<td>I want to get better</td>
<td>Proportion of people who reported that they have regular reviews of their care and treatment, and of their care and support plan.</td>
<td>TBC</td>
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<td>My care is delivered in an appropriate place and at an appropriate time</td>
<td>Proportion of patients and carers who report that they have a named health or social care professional who co-ordinates their care and support.</td>
<td>TBC</td>
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Accountable lead provider / Prime contractor

Alliance contracting
Provider responses - 2

‘Most Capable Provider’
response

Could be JV, SPV, contractual agreement
Thank you!

Andrew Smith
Director of Finance

Andrew.smith@cobic.co.uk