Innovative contracting for integrated care: What are the risks and benefits of various contracting methods?

Commissioning & Contracting for integrated care
King’s Fund

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Innovative contracting for integrated care:

1. Why?
2. What’s on offer? ‘OBC’ & ‘VBC’
3. OBC – benefits & risks of:
   - OBC
   - Lead provider
   - Alliance
4. Development agenda – priorities?
1. Why do we need new approaches?

NHS faces unprecedented challenges to sustainability:

- **Demographic pressures** – an ageing population
- **Demand** – incidence of LTCs (diabetes, dementia)
- **Rising expectations** – patients, public, politicians
- **Quality** – failures & gross variation
- **Outcomes** – still often poor comparatively & highly variable
- **Widening gap between demand & resources - £30bn**
- **Outdated & over-stretched delivery systems** (across primary, community & secondary care)

The NHS & its partners need to find bold, transformative solutions that reshape services at pace and at scale.
1. Why do we need new approaches?

“Traditional approaches to commissioning & contracting are unlikely to incentivise or enable “bold, transformative solutions that reshape services at pace and at scale.”

• Hard to challenge existing models of delivery, working & relationships

• Organisational silos impede effective joint commissioning & budget pooling

• Contracts & payments focus on activity, not outcomes, and individual institutions, not the whole delivery system; perverse incentives

• Hard to attribute (& reward) improvements in outcomes to fragmented cohorts of individual providers

• Difficulty of securing ‘cashable savings’ from ‘upstream’ changes & interventions ETC
1. Why do we need new approaches?

“Traditional approaches to commissioning & contracting are unlikely to incentivise & enable “bold, transformative solutions that reshape services at pace and at scale.”

We need approaches which …

• Incentivise high quality integrated pathways which deliver high quality ‘joined-up care’

• Make the best use of resources (NHS-funded, LAs, communities, users)

• Reward delivery of the best outcomes for users, carers & communities (social value)

• Address demand risk explicitly

• Catalyse new configurations/partnership of providers

• Include, not marginalise, non-NHS partners
2. What’s on offer?

- **Outcome-based population commissioning (‘OBC’):** a key *vehicle* to drive transformation & secure better outcomes, service integration and value for specific populations or groups (e.g. frail older people with multiple, complex problems; EoLC), or re-balance incentives by paying for outcomes.

  **NB:** Often conflated with commissioning for outcomes – *OBC is one end of a spectrum of approaches*

- **Value-based commissioning:** emerging approach from U.S. Potentially useful for:
  - assessing priorities
  - comparing disparate service offers
  - re-directing/re-focusing incentives to driving-up value within services commissioned on Tariff
2. What’s on offer? ‘OBC’

What is OBC?

Work in progress:
Draft narrative on OBC
NHS CA Quality
Working Group
(Paul Husselbee)
2. What’s on offer? ‘OBC’

Key components of fully-developed OBC:

- **Population-based** (frail older people, multiple complex problems; EoLC) or **major pathway(s)** (MSK)
- **Outcome-focused capitation payment**
- ‘**Lead provider’ or ‘alliance’**
- **Provider(s) co-ordinates care planning & delivery**
- **Provider(s) takes on much of the demand risk**

Still emerging, but examples: **Bedfordshire** (MSK), **Cambridgeshire** (range of services for older people), **Staffordshire** (cancer & EoLC for 1m+), smaller-scale: **Oxfordshire & Milton Keynes** (sexual health; substance abuse)

**Peterborough Social Impact Bond** (re-offending)
2. What’s on offer? ‘OBC’:

Integral to core OBC model are:

• Identifiable & measurable outcomes

• That those outcomes can be linked to desired behaviours

• That those behaviours can be incentivised through payment systems

• Spans primary, community & secondary care (compatibility with ‘Primary Care Plus’ models?)

• At-scale for populations (but can be done on a smaller scale, introducing a % payment for specific outcomes)

• More mature & long-term relationship with providers (7+ year contracts)

• ‘Lead provider’ or ‘Alliance’ contracting
2. What’s on offer? ‘OBC’ - Staffordshire:

Leading-edge exemplar …

• **Collaborative**: 5 CCGs + Macmillan Cancer Support (strategic partner) + NHS England + CSU

• **Outcome-focused & integrated services**:

• **At scale**: key services for 1m people across the footprints of people 3 acute provider trusts. The biggest contracts yet tendered for integrated NHS care

• **Transformational** : patient-centred re-design; joined-up care

• **Innovative contracting**: *lead provider*; 10 year duration
3. OBC – benefits & risks of:

Upside:

• Potential to deliver sustainable whole-system service transformation

• Better care co-ordination & planning> more ‘joined-up’ care, better outcomes & value

• Strong synergy with integration

• Can catalyse & incentivise providers to work differently

‘Urban myths’:

• Doesn’t preclude personalisation or choice – embed in requirement for ‘lead provider’

• Shouldn’t freeze-out SME & SE participation - enable through sub-contracting
3. OBC – benefits & risks of:

**Downside:**

- Resource-intensive
- Long lead times
- Clarity re desired outcomes & behaviours crucial
- Requires commissioner collaboration at-scale
- Effective user engagement from the outset crucial
- May require substantial (and challenging) market development – will be difficult if existing relationships are immature/tense
- For most commissioners, probably one OBC project at a time
- Funding double-running costs & deferred payment (SIBs?)

**Is it the right approach for the problem? “Sledge-hammers & nuts”**
3. OBC – benefits & risks of:

**Lead Provider/Prime Contractor:**

An arrangement where the commissioners issues a contract for a care pathway to a **single lead provider**, and the lead provider is then responsible for either providing, or subcontracting, the care specified. It is suggested that this approach to contracting is best suited to the complexity required to integrate care and enables commissioners to bring together multiple providers of care into a single pathway.
**3. OBC – benefits & risks of:**

**Alliance contracting:**

An approach used in healthcare in New Zealand, which involves commissioners issuing a single contract with a number of providers, who share a common performance framework with collective measures. This approach cannot be taken easily within the current contract rules, but some areas are also starting to exploring it. In this approach there is collective accountability for services delivered, with providers judged on performance as a whole rather than as individual components, thereby incentivising cooperation to drive successful delivery of services. This approach was used in the Year of Care capitation tariff pilots.

- PWC, *NHS@75: Towards a Healthy State*, 2013
### 3. OBC – benefits & risks of:

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<thead>
<tr>
<th>Attribute</th>
<th>Lead Provider</th>
<th>Alliance</th>
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</thead>
<tbody>
<tr>
<td>Fit local culture</td>
<td>Requires significant trust &amp; effective partnering</td>
<td>Probably easier to implement where relationships less mature/damaged</td>
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<td>Shift in risk from commissioner</td>
<td>Substantial post-mobilisation</td>
<td>Significant post-mobilisation</td>
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<td>Requirement for commissioners to coordinate care &amp; providers</td>
<td>Low</td>
<td>Low for care Low-Medium for providers – accountability &amp; procurement processes</td>
</tr>
<tr>
<td>Resource intensity &amp; lead times</td>
<td>High</td>
<td>High</td>
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<tr>
<td>Proof of concept in NHS</td>
<td>Limited</td>
<td>Very limited</td>
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<tr>
<td>Evidence base in NHS Evaluation?</td>
<td>Minimal</td>
<td>Nil?</td>
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<tr>
<td>Fit NHS Standard Contract</td>
<td>Can be accommodated</td>
<td>Not currently</td>
</tr>
<tr>
<td>Deferred funding/pump</td>
<td>Major problem</td>
<td>Major problem</td>
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4. Development agenda – priorities?

- Accessible information on who’s doing what?
- Dissemination of early learning on best practice
- ‘Bulldozing’ the perceived & real blocks
- Optimising the opportunities (*Better Care Fund; Innovation Pioneers*) for spearheading innovative approaches & forms
- EVALUATION!!!