APPENDIX 2

Approach to Commissioning and Contracting – Integration Discussion Paper

11/06/2015

Purpose of the paper

Following discussions at the Integration and Neighbourhood Working Programme Board, this paper seeks to identify the next steps in commissioning health and social care services on an outcome basis for the population of Southwark.

Background

Southwark CCG has expressed a clear wish to modify the way the way that it commissions services by moving from an activity based model to an outcome based system. We recognise that activity based contracts can create perverse incentives, and do not always promote joined up care. An unintended consequence of such contracts is that they address only the patient's immediate needs without seeking to prevent ill health or address the underlying health and social issues that may be impacting on their wellbeing.

We are thus seeking to incentivise providers to work collaboratively to integrate care pathways which prioritise clinical and functional outcomes that are meaningful to patients, enhance patients experience of care and promote prevention, wellness and well bring in order to reduce the burden of disease and health inequalities for the whole population. We are currently reviewing a number of whole-pathway contractual options, such as alliance or lead provider contracts, which will best meet these aims by transferring greater accountability to providers and in so doing ensure more joined up care, improve the quality and consistency of local services, encourage innovation and drive better value. We are also progressing plans for joint commissioning between health and social care as a key enabler for more integrated models of health and social care in the future, and we have embarked on a program of provider engagement, development and alignment to ensure that the system locally is able to respond to our ambitions.

Our plans locally will, over the next 5 years, result in a new model of integrated care for the population of Southwark consistent with the Multispecialty Community Provider (MCP) model described in the 5 Year Forward View, and with the shared vision across Lambeth and Southwark co-created by commissioners, providers and citizens in both boroughs that we articulated in our joint Vanguard bid to NHS England for support with system transformation.

Commissioning for a population

In order to commission for outcomes on a population basis, it is necessary to identify segments of the population that have similar characteristics. These would include shared service or treatment needs or support, and could be defined by medical condition or key demographic data such as age. By segmenting the population in this way it is possible to identify common clinical and functional outcomes that are of importance to people within the target group. New contractual arrangements

will mean that providers share responsibility for delivering improvements in these outcomes. The work of identifying cohorts of people within the local population with similar enough characteristics to enable such outcomes based contracts to be developed between providers and commissioners has already begun through the work of the Southwark and Lambeth Integrated Care Programme (SLIC). From a pragmatic perspective it is important that the population segments are homogenous enough to share a set of outcomes that are meaningful to everyone, but not so narrowly defined that that the contract value does not effectively incentivize transformation and innovation within the health and social care system.

The Integration and Neighbourhood Working Programme Board will take a practical, evidence based approach to identifying potential segments of the population for whom we could commission care differently. They will be characterized by a common set of outcomes that are identified as important by the people who constitute these segments.

Over the next two years it is intended that we transform the local model of care delivery in line with the vision of the MCP. This population-based model of care will have at its heart two Local Care Networks (LCNs) – one in the south of the borough and one in the north. These will bring together community health and social care providers from both the statutory and voluntary sector and deliver multidisciplinary care that reflects the needs of individual patients in an empowering, holistic, and personalised way. These LCNs are dependent on primary care being delivered at greater scale and their geographical coherence will support and empower the local population to stay well and make healthier choices - to promote mental and physical wellbeing and reduce health inequalities.

Transformation at this scale cannot be achieved at once. As commissioners we will identify pathways of care and segments of the population to prioritise, and will support the provider and market development necessary to achieve best value for our population. We recognise that this will be a process of discovery and not design and requires us to work collaboratively with providers and share some of the risk associated with this level of transformation in order to stimulate innovation and proceed at the pace necessary to meet the financial challenges we face in the local health and social care economy. In order to prioritise the parts of our population to focus on initially we will take the following approach:

1) Work with Public Health to identify population segments where indicators suggest that outcomes are worse than expected, or where there is potential for significant quality and/or value improvement, for example through a greater emphasis on prevention
2) Ensure that segments are of adequate size and scope so that all relevant providers would have sufficient incentive to dedicate time, resources and energy into redesigning pathways and service offerings to deliver improved outcomes
3) Ensure that segments span multiple provider groups from across health and social care where there is a clear imperative to better integrate services and shift activity from acute settings to community based services

Developing a population based approach

Once a segment has been identified that is suitable for a whole-pathway contracting approach, commissioners will need to develop a tender specification. In order to do this it is recommended that:

1. Commissioners actively engage with service users, patient groups and the public to fully understand their needs, ensure that the contract specifies outcomes that matter to people within the population cohort and that services are co-designed with those who will be using them.
2. Commissioners work with incumbent providers to understand the barriers within the existing model to ensure that any specification acknowledges these challenges and seeks to overcome them.
3. Work with providers to determine the contract cost. This is a complex process based on the current price paid, the true cost of care and the opportunity for increasing value through improved quality, collaboration, innovation and prevention. This process will require a deep understanding of our population and potentially additional actuarial support to forecast and predict clinical and financial risk across the system, including changing population demographics, cost and utilisation. It is recognised that understanding costs and predicting risk in this way across an entire pathway or part of the population will be a challenging process. As such, it may be necessary to engage independent external support to work with providers and commissioners to provide specialist expertise in determining the cost of these contracts.
4. Commissioners, public health and service users would need to agree what outcome metrics, both clinical and functional, they would wish to see from the service. These indicators should cover the entire pathway, but be relatively few in number to ensure clear focus on the areas for improvement.
5. Commissioners will work proactively with providers (both incumbent and potential new entrants) on developing new ways of working and operating models. We recognise that in order for a whole-pathway contract to function effectively, providers must be in a position to engage with each other on an equal footing. The establishment of GP Federations is an example of how this work is being taken forward, but we recognise that these Federations will need continued support as they begin to take on greater responsibilities. A similar approach will also need to be taken with community pharmacies and the voluntary sector to ensure that robust governance arrangements are established, which will enable greater collaboration and integration of services.
6. Consideration will need to be given as to what analytical support is needed to ensure the outcomes in these contracts can be effectively measured and monitored. This is likely to involve significant organisational and workforce development for both providers and commissioners. This will need to be appropriately considered as part of development plans and budgeting arrangements.

Contracting arrangements

There are a number of whole-pathway contractual mechanisms that would support collaborative working between providers and require a shared commitment to improve outcomes for the population. These approaches would help incentivise providers to work together, whilst reducing perverse incentives, which can inadvertently increase activity and costs. In addition, these approaches would encourage greater investment in prevention and in primary and community care – reducing demand on costly secondary and tertiary services. Under a risk/gain share arrangement,

providers would be able to share the rewards accrued by reductions in, for example, hospital and care home admissions.

Whilst we would always wish to work productively and collaboratively with incumbent providers, we also have a responsibility to ensure that we commission services which are innovative and deliver the best value for money against the outcomes that they deliver. We will therefore ensure that we test the market and, as required,, invite interested collaboratives of providers to tender for delivery of services for particular population segments.

We believe that contracting with providers collectively to deliver a shared set of outcomes identified as important by specific segments of the population will be an enabler to achieving more integrated, innovative services. We are aware that whilst whole-pathway contracting potentially has significant benefits, it also carries inherent risks, not least because, for many providers, it would be an entirely new way of working.

Whilst we will ultimately seek to move all commissioned activity to outcome based whole-pathway contracts, we recognise that this will take a number of years. However, to ensure that we are able to maximise impact, the segments that we would choose to prioritise initially would be those that would most benefit from an integrated approach in order to improve quality of outcome and experience. Specific examples currently being considered are:

- People approaching the end of their life
- People with severe mental health problems
- People with diabetes – and possibly other long-term conditions such as COPD or heart failure
- People who are over 75 years old
- People who are experiencing breathlessness as their primary symptom

These are just some initial examples that will enable us to progress our plans and learn experientially as we implement our vision. Whilst developing our understanding of the commissioning mechanisms to catalyse change in the local health and social care system we have also prioritised the need for a parallel process of 'bottom up' organisational and workforce development and alignment to bring about the formation of Local Care Networks.

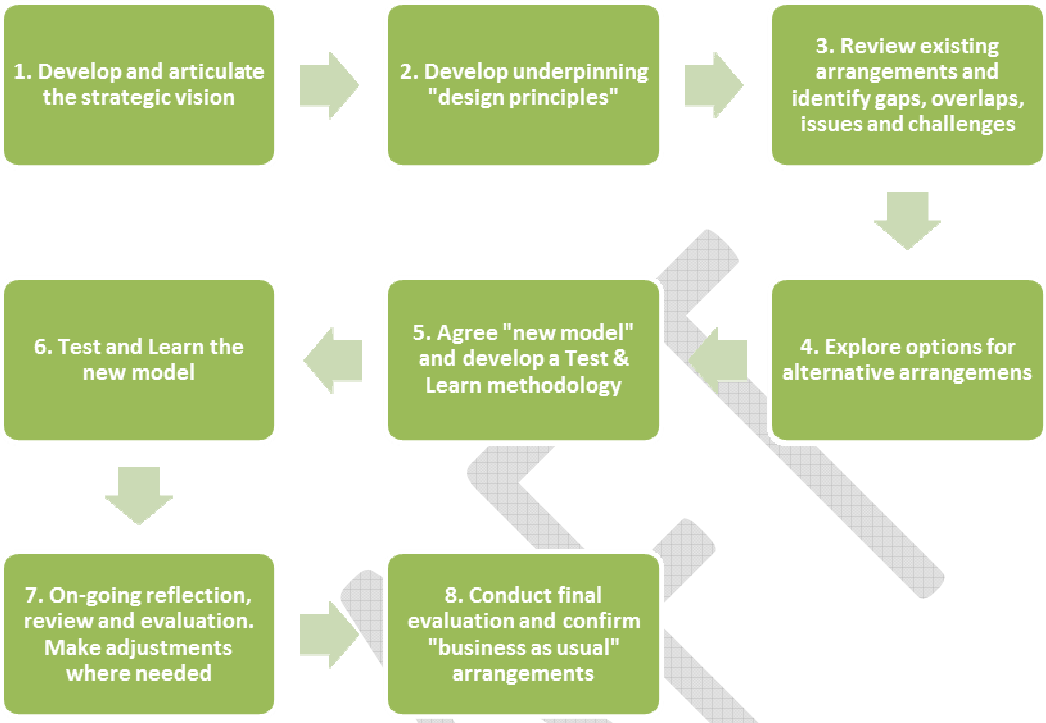
Developing Local Care Networks

As previously described, Local Care Networks will lead in the delivery of care transformation for identified population or patient groups. At any one time they will have a number of different transformative projects that they will participate in. To manage this workload, and to ensure that front-line staff and service users are actively engaged, LCN subgroups will be established to lead on the design and implementation of pathway transformation.

To address the challenge of introducing whole system transformational changes in a considered and focused way it is suggested that a 'Test and Learn' approach could be adopted where appropriate. Blending evidence based methodology and reflective action learning, this approach is focused on introducing transformational change in a stakeholder led, safe and reflective 'test' environment. As opposed to a pilot, the new integrated models of care delivery will need to be implemented at LCN,

borough or bi-borough scale and refined on an on-going basis. The starting point is that system transformation will take place in line with our agreed Vision.

The stages are as follows:



Essential to the design and execution of a 'Test and Learn' approach is the need for demonstrable strong leadership from key stakeholders (sponsors) throughout the process. Experience of using this methodology by the Institute of Public Care (IPC) from Oxford Brookes University has shown that by supporting the approach, leaders are confirming and committing to a vision of transformation where the tangible changes needed (structures, roles, systems, processes etc) will be developed and implemented during the process. This then filters down through organisations, helping empower staff at all levels to challenge existing ways of working, propose new ways of working, and help develop a new cadre of leaders. Commissioners and providers are required to encourage and support innovation and accept that in some instances 'risk and failure' are acceptable and manageable components of the test and learn processes.

This shared approach would support integrated working from the beginning and be a means to implement models of working in practice that can then inform the on-going development of commissioning and contracting approaches. The benefits are that it:

- Provides a practical and structured starting point for operational transformation – tests all aspects of the model - can understand what's happening, why it's happening and through this develop the detail of the operating pathway, systems and processes.
- Front line practice directly informs the model and makes it real for practitioners. Also identifies where there is resistance to change that needs to be addressed.
- Enables understanding and development of the working culture that will need to be embedded and sustained to fully support working across organisational and professional boundaries to deliver an integrated response to people in practice.

- Begins to build and strengthen the inter-professional working relationships as well as develop operational transformational leaders.
- Is a means to quickly and effectively identify and manage the risks as the test develops rather than waiting until the end of a pilot process – enabling the model to be refined and developed from the beginning.
- Creates a safe learning environment – allows for reflective practice through action learning meetings. Gives permission to work across boundaries, to be innovative and creative in trying out different solutions.
- The message to staff and stakeholders is that change will take place – whether the model is the right one or not – there will be learning that can be taken forward and it will inform how commissioners should commit and realign finances to commission integrated and more proactive support.
- Identifies the right information to inform the final service specification(s).

Next Steps

For the year ahead, it is proposed that the following areas are prioritised:

1. Organisational development:
    - Establish joint commissioning arrangements between CCG and Local Authority
    - Commence co-commissioning of primary care and review options regarding full delegation
    - Explore opportunities to increase analytics capability to measure outcomes and activity and forecast and predict clinical and financial risk across the system, including changing population demographics, cost and service utilisation
    - Develop expertise in whole-pathway contracting
2. Provider development:
    - Continue to provide system wide leadership locally by aligning our work with strategic plans at a borough, bi-borough, SE London, London-wide, and national level
    - Participate in a local system wide transformation partnership that acknowledges the necessity for health service transformation at a Lambeth and Southwark scale
    - Continue to work closely with GP Federations on their development
    - Establish Local Care Networks and agree ways of working between providers. Within this, we will encourage and support service developments on preventative services to ensure that new, integrated services that seek to deliver improved outcomes are brought on-stream over the next year.
    - Strengthen collaborative working across pathways
    - Encourage and support federated models for pharmacy and the voluntary sector
    - Use 'Test and Learn' approach within LCN sub-groups
3. Identify 'population segments':

- Identify segments which should prioritised for outcome based whole-pathway contracts
- Establish appropriate outcomes for these segments and evaluate current and future levels of activity and cost for the segments

4. Progress some initial joint working and new contractual arrangements to support commissioner and provider learning and catalyse service transformation

Whilst we would wish all of the identified areas to progress at pace, it is acknowledged that some may take longer than others. As such we would seek to ensure that any slippage on any of these areas should not impede progress on the remaining priorities.