End product

Outcomes-based commissioning could underpin many of the changes in the next few years, but the tricky part is implementing it, reports Seamus Ward

Outcomes-based commissioning (OBC) seems like a logical step for the NHS. If successfully handled, paying for care based on how well the patient is at the end of, or at a natural break in, their treatment could address some burning issues, such as quality and patient experience. Some parts of the service are even developing outcomes-based contracts to underpin their response to other issues, such as service transformation and integration and efficient care.

Oxfordshire Clinical Commissioning Group, for example, is working with the county council and local trusts to implement outcomes-based contracts for older people and mental health services. Although progress was delayed last year, the move towards outcomes-based contracting is driving providers to integrate the services they offer in these clinical areas.

There has been significant progress in Staffordshire, centring on the area's transforming cancer and end-of-life care programme. The programme's outcome-based contracts for these services are currently out for procurement and are expected to be awarded in time for the 2016/17 financial year.

Despite the progress in these areas and a number of others, such as North East London, OBC is not widespread in the NHS.

Rupert Dunbar-Rees is founder and chief executive of Outcomes Based Healthcare, which supports commissioners and providers to adopt outcomes-based contracts. He says there are between 20 and 30 health economies actively working on implementing it – for example, by defining outcomes or letting contracts. However, interest has increased over the past 18 months. This is frequently driven by commissioners, although some providers are beginning to take the lead.

'It's definitely on the horizon for many commissioners. They recognise we can't keep on doing things in the same way as we are going broke as a system. Outcomes-based commissioning offers a sustainable solution, potentially increasing outcomes and ultimately lowering the costs of care, though that is not the prime objective.

'At its most fundamental, outcomes-based commissioning is about reshaping care around the individual who receives care rather than those who provide it. It's also about describing the results of care – not by what's done or not done, but how well someone is.'

Julie Wood, director of NHS Clinical Commissioners, says there is a strong desire among CCGs to increasingly base commissioning on outcomes rather than inputs. 'The issue is that it is not easy to do. Not every form of healthcare is amenable to commissioning for outcomes. CCGs want to use it, but it takes time to work out what the right

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outcomes are, the evidence base to build them into an outcomes-based specification and then to change the contract based on that.

'I don't think we'll ever get to a position where every contract in acute trusts or any other setting can be totally outcomes based, but for some care pathways it is absolutely the right thing to do. For example, long-term conditions will be more amenable to the outcomes based approach than emergency admissions.'

However, OBC is not just about specifying outcomes in the contract. 'Perhaps you have a clear idea of the outcomes you want, but you commission for a series of interventions that evidence strongly suggests leads to improved outcomes,' Ms Wood says.

'For example, in respiratory medicine, a pulmonary rehabilitation service is an intervention, but the evidence suggests that an effective service helps to reduce emergency admissions, which can then reduce the level of mortality in the under-75s.'

The Staffordshire programme director, Justine Palin, says the programme is a partnership that includes four local CCGs, two local authorities, NHS England, Public Health England and Macmillan Cancer Support. Currently, all have a role in commissioning part of the pathways – there are more than 60 contracts for cancer and end-of-life services (for all illnesses) in the county. The programme is a means to integrate services and provide accountability for the delivery of outcomes, she says.

"The clear benefit is that OBC is patient focused, but we are finding that it is not an easy thing to do"
Julie Wood

In addition, survival rates and patient experience have been poor. The programme aims to deliver sustained improvement in cancer survival rates so that the area is in the top three in England by the end of the contract period. The end-of-life objective is to ensure that patients are given seamless care and can choose how they are cared for and where they wish to die. Outcomes-based contracts underpin their strategy to deliver these objectives.

'Providers currently have short-term contracts so they cannot innovate. If they have three-year or annual contracts, they can't do very much to change the system, so we are looking to move to outcomes-based contracts over a longer time,' Ms Palin says.

Contracts will be let for 10 years to allow innovation and, crucially, improvements in outcomes. Each contract will be awarded to a lead provider, known as a service integrator locally to reflect their responsibilities.

Ms Palin says the Staffordshire approach to setting outcomes is very much about co-design. 'Macmillan as a strategic partner provides the patient voice extremely well and helps us look at how we make the system right for patients,' she says. 'We also have a patient champion on the board who helps engage the community and we use that engagement to shape our outcomes.'

The commissioners are also working with providers and clinicians to identify the outcomes they would like to see. They now have a number of high-level outcomes, including the aim to have survival rates in the top three in England, more patient choice and better patient experience (cancer) and better choice in the last year of life (end of life).

Deciding on the outcomes was time-consuming and a compromise between patient, clinician and commissioner requirements, she adds. 'For example, patients might say they want to be closer to home for their treatment, but they might have to travel further to get access to the specialist care needed for the best outcomes.' The procurement process will include competitive dialogue with interested parties to shape the services that will deliver the desired outcomes.

Value-based commissioning guru Michael Porter has developed tiers of outcomes, including one based on health status achieved or retained and another based on patient experience. Ms Wood says outcomes

should include evidence-based principles and patients' aspirations, which may not have an evidence base. She points to Staffordshire's efforts to have both, working with Macmillan and the population to develop the outcomes wanted by all. In this respect, patient-reported outcome measures (PROMs) can be useful to help define what is important to the patient.

'There will be a trade-off between the two and between outcomes and affordability at some stage. There may be clear evidence of what you can do, but what can you afford? You have to have that conversation with patients and the population to get the right balance,' Ms Wood adds.

While Dr Dunbar-Rees accepts defining outcomes can be tricky, he insists it can be done if the right approach is taken. 'Outcomes are too difficult to define' is one of four myths his organisation believes are held about OBC. The others are that they are too difficult to measure, difficult to contract for and there are cultural barriers to their adoption.

'One of the main push backs we get around outcomes is people saying that if everyone wants a different outcome, they are difficult to define, hard to benchmark and baseline. We agree with that to a degree – if you put 100 people in a room with different life, social and illness circumstances, they all want different things,' he says.

High-level ambitions

In some health economies, this approach has led to high-level statements of the desired outcomes. 'They don't appeal to any particular group, but no one would argue with them. They say things like, "I want to live the best life I possibly can". From that, finding outcome measures for someone with serious mental illness, or someone frail and elderly or with multiple long-term conditions is incredibly difficult.'

He believes the journey to meaningful measures starts with segmenting the population. This could be by disease, demographics or social factors, for example. 'It is easier to get outcomes for specific groups and it's then easier to find appropriate measures.'

Appropriate PROMs include 'I feel I have control over my health or condition' or 'I feel confidence in managing my condition'. But he adds that commissioners and providers should be careful with the PROMs they choose. 'Often people go to the well-known PROMs – such as EQ-5D on quality of life – and use it for every patient. From segmentation, there is evidence it works fairly well for a large amount of people, but less so for specific conditions such as diabetes and mental illness, where more specific measures are needed.'

Setting outcomes is one of the difficulties with OBC. Commissioners and providers also have to agree when to measure the outcome and how this relates to payments, especially since the outcome may be months or years after an intervention. There has been some work on this and the hip and knee best practice tariff, for example, acknowledges there will be a time lag between the culmination of treatment and the return of post-operative PROMs.

'The clear benefit is that it [OBC] is patient focused, but we are finding that it is not an easy thing to do,' Ms Wood says. 'It's difficult to switch it round in terms of the outcomes you want. Then you have to be clear about the money and how the outcomes-based approach does not sit with payment by results.

'You have to somehow put the money together across the pathway and make sure you get the right outcome at each part of the pathway. The contract and payment mechanisms must be set to give you a better chance of delivering every part of the pathway to help deliver the ultimate outcome.'

She adds that each point in the pathway – the completion of a treatment or a handover to another provider, for example – will not always be accompanied by a health outcome. Returning to the example of respiratory medicine, she says that at the appropriate point in the pathway, the best measure may be an intervention, with the right people being chosen for the pulmonary rehabilitation programme.

Dr Dunbar-Rees agrees that current payment mechanisms make it difficult to innovate. He believes capitated payments, based around segments, are best suited to OBC. 'These are what Michael Porter calls bundles of payment around a specific segment,' he says.

'This is different to the global capitation used in primary care. I think we are going to see a segmented approach to capitation, bundling up whole costs of care for specific groups.' As a 'bonus', this should lead to payment mechanisms being 'cleaned up' along pathways, he argues. 'We have analysed pathways and found four or five different currencies in a single pathway. Currently, we have a salad of currencies and it's not in anyone's best interests. We have got to rationalise it.'

Time and investment

Unsurprisingly, implementing OBC can take time. Staffordshire views its 10-year contracts as a two-year scoping and bedding in period, then eight years of implementation and improvement. To reflect this, the service integrators (not necessarily providers) will be paid a fixed fee for the first two years, then a fixed element plus performance-based payment (based on achievement of outcomes) for the other eight.

In the first two years, the service integrators will be responsible for managing existing provider contracts. They will become fully responsible for delivering the services in the second period. Bid documentation says their actions could include decommissioning of services and subcontracting with selected providers.

At the end of year two, when actual pathway costs are known, the integrators will be expected to agree a cost envelope for the services.

Macmillan will contribute to the funding of the programme in the first two years to encourage service redesign and transformation. After this period, it will work with commissioners to monitor performance.

The NHS is still dipping its toes in the water when it comes to OBC, but there appears to be growing interest as a means to deliver quality, efficiency and service transformation and integration. However, it is not straightforward and many local health economies will be looking with interest at the outcomes of the pioneers' work over the next year.