NHS
Islington
Clinical Commissioning Group

MEETING:	Islington Health and Care Scrutiny Committee
DATE:	23rd November 2015
TITLE:	Value Based Commissioning
AUTHOR:	Becky Kingsnorth, Head of Service Transformation
CONTACT DETAILS:	rebeccakingsnorth@nhs.net

1 Purpose of the report

Islington CCG is working with partner CCGs in North Central London to test a new approach to commissioning health services, which creates an increased focus on the outcomes achieved for people in Islington. The approach is called 'value based commissioning'. This short paper introduces Islington Health and Care Scrutiny Committee to this new approach, and provides details of work currently underway.

2 Recommendations to the scrutiny committee

The Scrutiny Committee is asked to NOTE this introductory paper and is invited to comment on this new approach to commissioning.

3 Intended impact of the report

The intention of the report is to keep one of the CCG's key stakeholders informed and engaged, to invite comment on the wider implications of developing this new approach to commissioning, and to continue to maintain transparency on the work of the CCG.

4 Contribution by community and professional partners to the report

There has been a high level of engagement over the past two years with patients, carers, clinicians, local providers, GPs and other stakeholders to discuss this

approach, define outcomes and agree how it could be introduced. This started with large workshops with this range of stakeholders in Autumn 2013, to identify what is important to people with diabetes, older people with frailty, and people living with psychosis. The projects have been led by the outputs from these workshops, which were used to define the outcomes we would focus on. The CCGs then carried out further work with specific local patient groups or networks to review and prioritise the outcomes. Each project continued with a series of design workshops, including service providers, patient and voluntary sector representatives to look at how services would need to be provided differently in order to achieve the selected outcomes.

While the CCG does not directly commission core primary care services, or social care services, there is the potential for these services to be involved in the changes. Local GP leaders have been at the forefront of our planning on value based commissioning. Where it is possible, we will use any additional services we commission from GPs, over and above core primary care, to ensure that they too are involved in delivering improved outcomes. Social care, for some groups in particular, has a very important impact on outcomes. Health and social care organisations will increasingly be asked to work together on achieving outcomes. Wherever possible, with agreement from our local authority partners, the same principle of linking payment to outcomes can be applied to social care services, but this may happen over a longer period of time.

5 Key issues, challenges and risks and their management - focusing on prevention, partnership working and reducing inequalities

CCGs currently commission most health services under a model known as ‘payment by results’. This means that we pay providers for each unit of activity they provide to a patient, such as an attendance at an outpatient clinic, an attendance at an Emergency Department, or provision of a diagnostic test. We commission slightly differently for the care that is provided outside of hospital (e.g. district nursing and other community nursing or therapy services). We have a single ‘block’ contract with community providers, which provides an overall amount of funding based on the amount of activity we expect to be provided, rather than paying for each unit of activity separately.

This current way of commissioning and reimbursing health services can make it difficult to encourage a shared focus across the health and care system on maintaining health and independence. Providers and the staff who work in different organisations often only see their part of the picture and it is left to the patient and family to link care together. We want to promote a system where different organisations are more aware of each other and their overall impact on outcomes.

5.1 About value based commissioning

Value based commissioning means changing how healthcare is organised, measured and reimbursed in order to improve the value of services. In a value based commissioning system, services delivered by a number of providers are organised around patients with similar sets of needs, to ensure that these needs are met in the most effective way.

We would like to bring about a significant shift in the extent to which organisations providing health and social care work together to focus on improving clinical outcomes for patients and supporting their independence. We are asking health and care organisations to work together, across boundaries, for patients with similar needs. As commissioners, we will support this approach by having a contract which describes the outcomes that we expect to be achieved. A proportion of payment for services will be linked to the outcomes that are achieved collectively by the range of providers involved in providing care for that group of patients.

We no longer want to pay providers just on the basis of the number of people who receive treatment, but for how well they manage to achieve the outcomes that have been defined by patients. Providers will still be paid for the patients that they treat, but commissioners will base a proportion of funding on the outcomes that are achieved.

5.2 Defining outcomes

Focusing on outcomes means focusing on the results of care for the individual, for example, whether a person with frailty has been enabled to live independently, or whether a person with diabetes feels able to manage their condition. For the projects that are underway (see below), we have worked with patients, carers, and clinicians to identify what it is important for each group of patients to achieve, and we have used this to define outcomes for a specific population group. These outcomes are

then prioritised and the way of measuring these outcomes is determined. It may be possible to measure the outcomes clinically, or by observing the results of care, but in many cases we need to ask patients themselves how they feel about the outcomes that have been achieved. This means a much greater focus on 'Patient Reported Outcomes'.

5.3 Current projects

A number of CCGs across the country are starting to develop value based contracts, but it is still a new approach. In Islington, we are working with Haringey CCG to develop a value based commissioning contract for care for people with diabetes, and we are working with Camden CCG to develop a value based commissioning contract for people living with psychosis. Haringey CCG is also developing a value based commissioning contract for older people with frailty, and Camden CCG already has a similar approach in place for people with diabetes.

6 Intended impact on reducing inequalities and improving health, wellbeing and value for money

The key aim of value based commissioning is to improve patient outcomes and experience by integrating care around the patient. In practice this means planning and organising care for particular groups within the population, for example people with frailty, people with diabetes or people with psychosis. An understanding of the different needs of the population must be considered with a focus on what patients need, rather than what organisations can provide. The model aims to enable people to be as independent as possible though care and support provided by the most appropriate person and in the most appropriate setting.

There are many benefits for patients and population groups of commissioning in this way, including enabling people to remain independent, faster recovery and maintaining physical and mental health and wellbeing. There are also financial benefits for providers and commissioners involved if outcome targets for population groups are achieved, as well as savings through efficiencies. The 'value' provided by healthcare is increased by increasing the outcomes achieved per pound spent. This is particularly important where we expect to see a growth in certain population groups.

7 What success looks like, measuring success and targets

Over the next year we would expect that for people with diabetes there will be a gradual move towards more health and social care services being brought together to be provided as an integrated model. We would expect that information will flow, with patient permission, more quickly and efficiently between, for example, hospitals and general practice. We will see more patients having a plan for care that they have been involved in and opportunities for patients to be supported by professionals to manage their condition. For people living with psychosis we will see an increasingly proactive focus on their physical health needs as well as their mental health needs, again with services brought together to be provided when the patient is already in contact with care, rather than offering multiple appointments in multiple settings, which can be difficult for a patient to navigate.

We will expect to see improvements in the outcomes that have been prioritised, over a period of five years. Where this will be measured through patient reported outcomes, we are developing new surveys to gather this information each year.

8 Legal implications

Implementing this approach to commissioning has required consideration to be given to a new form of contract, which describes how organisations will work together to achieve outcomes. This will operate in addition to the NHS Standard contract, and has been developed by lawyers.

9 Resource implications

Our plans do not involve changing how much is being spent on health and care services. We are trying to link part of our payment to achieving outcomes rather than spending any more or less money overall. In the long term we hope that a more integrated approach to care provision will be more efficient and will allow us to meet increased demand for services.

10 Next steps

For the project relating to people with diabetes, we have undertaken a process to establish which organisation providing health and social care to our population would

be best placed to lead implementation of the new service model. Information about this process was provided on our website. We were looking for leadership from a provider with: experience of providing services for people with diabetes within Islington and Haringey; good links and relationships with other local providers and partners; experience of partnership working; and evidence that they already provide high quality care. For this project, Whittington Health has been identified as the preferred provider to lead the next stage of the project, and we are currently discussing the new contract with them.

For the project relating to people living with psychosis, we are currently undertaking the above process, to find an organisation to lead the next stage. Given the need, in this case, for specialist mental health expertise in addition to the range of experience described above, we have initially invited Camden and Islington NHS Foundation Trust, the current mental health care provider for both Camden and Islington CCGs, to participate in this process. We will be presenting the outcomes of this process to the Governing Bodies of each CCG in January 2016.

We are trying to build an outcome focus into how we commission a wide range of services. Through the projects for diabetes and older people with frailty we will see if the new type of contracting approach supports this focus on outcomes. We will evaluate as the work progresses and may look to roll it out more widely at a later stage.