Contracting with providers on the basis that they will – collectively - achieve a set of specified outcomes for a given population is a significant challenge. We are often asked:

- How is it possible to hold **several providers jointly accountable**? How does it work if one provider fails to pull their weight?
- How do we **get round a PBR system** that expects us to contract on the basis of activity?
- Outcomes can take years to materialise – how do you **manage provider performance** in the meantime?
- And **isn't it just too hard** to get everyone to agree first on the outcomes and then on how reward/penalties will be applied?

If you want to dive in to the detail of outcomes-based contracting options, download a copy of OBH's paper, developed in association with Capsticks, to assist the outcomes work in North Central London: "Contracting for Outcomes: a value-based approach"[30] (July 2014).

CONTRACTING FOR OUTCOMES IS DIFFERENT

Outcomes-based approaches to healthcare represent a fundamental departure from existing activity and volume-based contracting routes. They demand **innovative contractual solutions** that focus on **incentivising the collective achievement of a set of outcomes**, regardless of the usual boundaries between provider roles.

> *"Outcomes-based contracts for "bundles" of services are still at a relatively early stage of development, but I expect them to become commonplace in the next year or so. It's not terribly complicated in legal terms but does require good advice at an early stage rooted in a real understanding of what you are trying to achieve."*
> ***Rob McGough, Partner, Capsticks***

[30] Contracting for Outcomes: A value-based approach (2014), OBH & Capsticks http://outcomesbasedhealthcare.com/Contracting_for_Outcomes.pdf

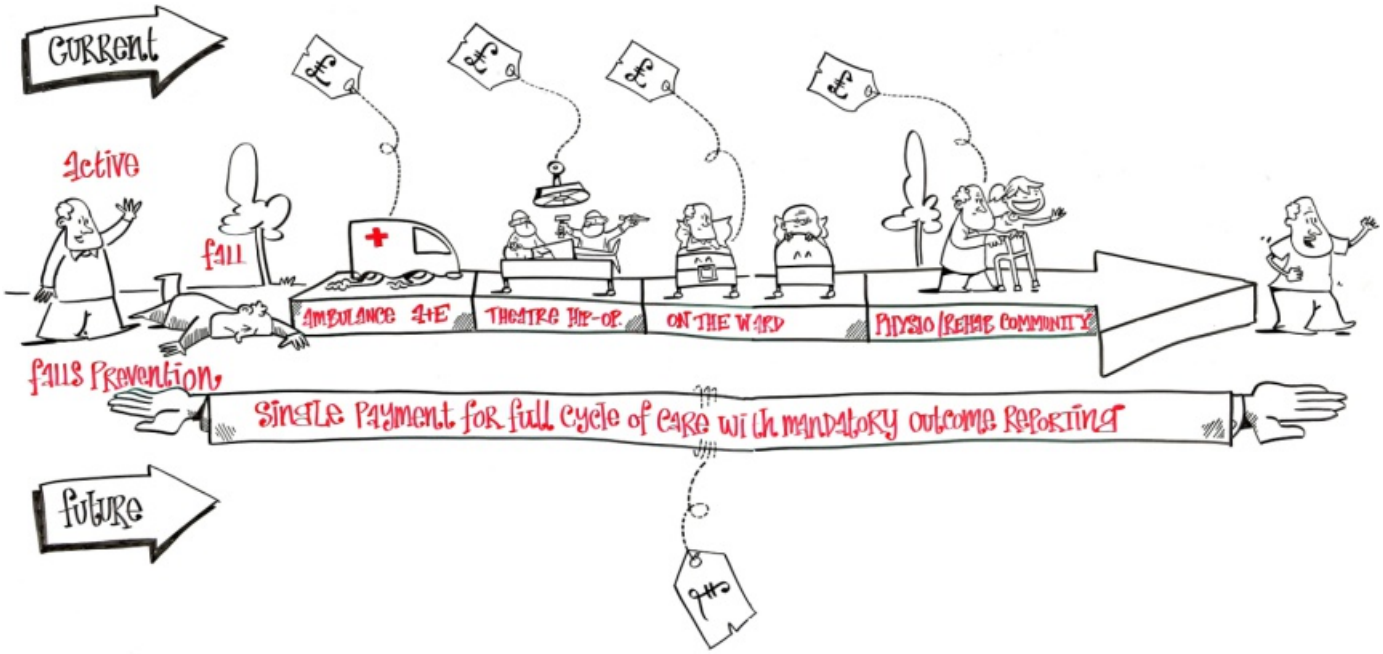
For example, for people with osteoarthritis, contracting for outcomes should result in the coordination of all the services involved in improving their mobility and getting them back to a good level of functioning. This involves **multiple providers working in an integrated way across whole care pathways or 'cycles of care'** – rather than each provider focusing on its own contract for hip replacements or physiotherapy. For the people using healthcare services, this means a much more efficient and straightforward approach to their care: **a system that organises care around them, rather than asking them to organise their lives to suit the system**.

This is a radical shift from the fee-for-service, global capitation and block payments models that dominate the healthcare system. When contracting on the basis of outcomes, contracting and payment mechanisms need to:

- Support the integration of services under a **single ('bundled') payment** across full care cycles, with **mandatory outcome reporting**
- Incentivise providers to **improve outcomes across the full care cycle**
- Include **incentives that are shared** between providers on achievement of agreed outcomes

In OBH's experience, there is little point in trying to select a contracting and payment model until there is a clear definition of the population being targeted, the outcomes being sought and how they will be measured. **The outcomes should drive the selection of a contracting route, not the other way round**.

Diagram 6: Bundled Payment vs Existing Payment System



Source: OBH/Capgemini/Beacon North Central London Outcomes Workshops, November 2013

CAN PROVIDERS REALLY SHARE RESPONSIBILITY FOR OUTCOMES...?

Once you have successfully defined a set of outcomes for a given segment of the local population, it soon becomes obvious that **no provider would be able to deliver any given outcome in isolation**. All providers involved in the care cycle need to share responsibility for achieving positive patient outcomes. This undoubtedly presents new complexities in contracting.

Contracting for outcomes means commissioners working with providers – as well as providers working together – in a fundamentally different way. It demands a high degree of consensus-building and collaboration across disciplines and across organisations.

Fortunately there are a **number of proven contract models** in other industries, also used by local government, which are increasingly being successfully adopted by the NHS. These require providers to **work together to deliver outcomes**, and offer **mechanisms for incentivising providers** and **attributing their contribution** so that financial reward can be distributed.

> *It is challenging – particularly for providers who will naturally worry about potential loss of income. The important thing is to build a vision together, allow all parties to be open about their concerns and work towards an approach in which there is opportunity for everyone.*
> ***Sarah Price, Chief Officer, Haringey CCG***

YES THEY CAN! (THOUGH NO-ONE IS SAYING IT'S EASY)

There are **various forms of possible contracting solutions** – from single contracts with prime providers to multi-contract approaches, which use a form of overarching agreement between providers to formal alliance contracts. In selecting a contracting model, there are a number of common considerations:

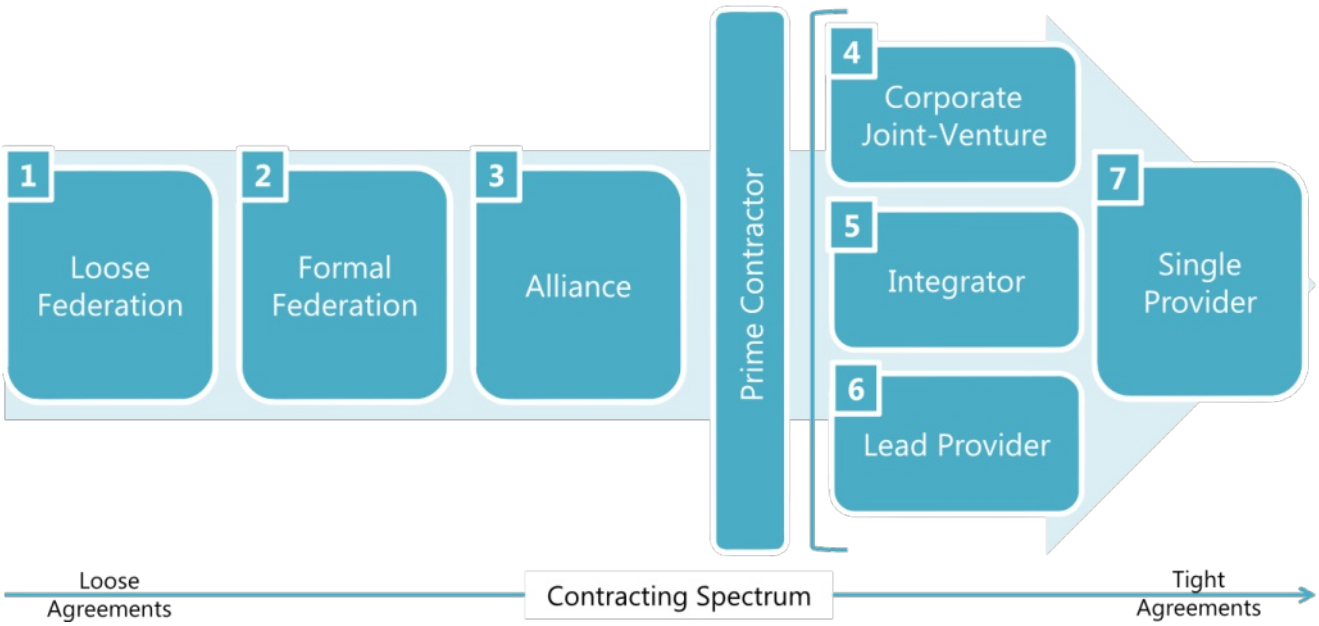
- Establishing a joint management and decision-making structure
- The need for a single patient records system to support outcomes measurement
- Mechanisms for providers to exit or be decommissioned, and new providers to join
- Determining the appropriate balance between trust and capacity to enforce
- Legal considerations such as whether a single contract can legally cover all the services required

The paper on Contracting for Outcomes: a value-based approach[31], contains detailed descriptions of the range of contracting models listed in the diagram below, together with an analysis of their strengths, weaknesses, risks and legal implications.

> *"The NHS Standard Contract presents no technical barriers to commissioning for outcomes. There are freedoms built in now, for example allowing contracting parties to depart from the national tariff. What is true is that no single commissioning or contracting model is uniquely placed to deliver better outcomes."*
> ***David Savage, Head of Legal Support - NHS Standard Contract, NHS England***

[31] Contracting for Outcomes: A value-based approach (2014), OBH & Capsticks http://outcomesbasedhealthcare.com/Contracting_for_Outcomes.pdf

Main Outcomes Based Contracting Routes



Alliance contracts are a particularly hot topic, so it is worth highlighting one FAQ that comes up a lot. The **NHS Standard Contract does not currently permit a true alliance contract** where one contract is entered into by multiple providers. However, there is **scope to introduce alliance principles** within other types of model, or through an overarching agreement between providers in addition to their core contracts (each of which would typically use the NHS Standard Contract).

> *"The power of alliance contracts lies in the fact that they require and enable a collective focus on the whole system. If you are to exploit this power to achieve real change, the aim should be to include as much as possible in the overarching alliance agreement (and correspondingly less in the individual NHS Standard Contracts with providers) even if this has to be phased over time."*
> ***Linda Hutchinson, Director, LH Alliances***

There is **no single 'magic bullet' solution** – in practice, people are exploring ways of introducing contract models that will foster joint accountability, whilst dealing with the existing regulatory framework. **Ultimately, the decision should always be made in light of the outcomes being sought**.

In our experience, the **technical challenges take second place to the challenge of building the kind of trust, transparency and collaboration** between commissioners and providers that is essential to make a success of any outcomes-based contract.

> *Contracting for outcomes should be recognised as a very different process to the historical annual contracting cycle – from at times adversarial to collaborative in the best interests of patients. A longer contract duration creates the space to achieve real changes to clinical pathways and build the workforce to deliver improved service. It can no longer be claimed that 'the system' presents barriers to outcomes-based healthcare: NHS England has been clear in its support for this new direction of travel."*
> ***Dr Stephen Richards***

BUT WE'VE TRIED 'PAY FOR PERFORMANCE' SCHEMES...

Outcomes-based contracts are a form of 'pay for performance', but they entail payment for the achievement of **outcomes that matter to people** rather than targets relating to activity or process. Most existing schemes, like QOF and CQUIN:

- Reward compliance with structural/training requirements and specified processes - not outcomes for specific population groups with similar health needs
- Are designed to incentivise individual providers at specific points in the pathway – not shared accountability across a whole pathway

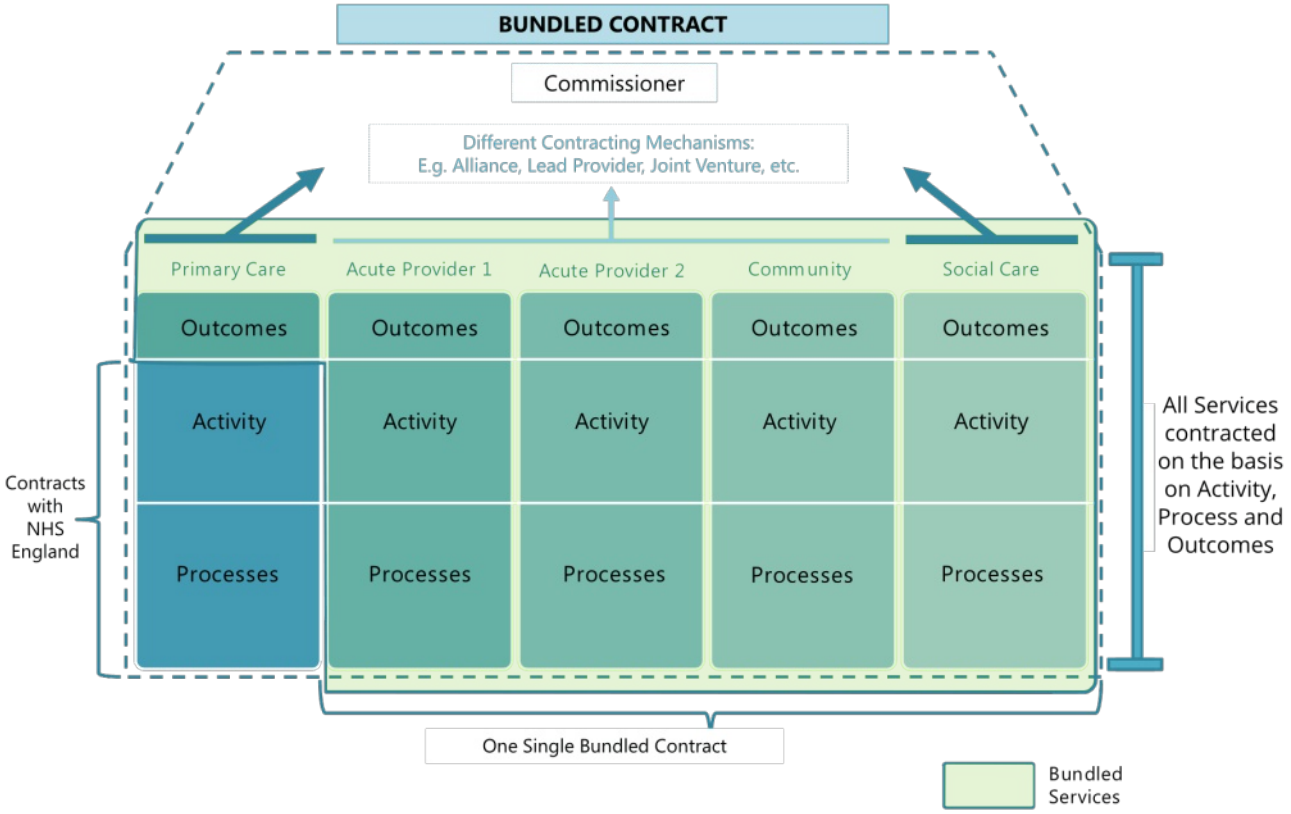
We would argue that these are the reasons why a number of studies (from the Kings Fund[32], Eurohealth[33], HBR[34] and Health Policy[35]) evaluating the effectiveness of 'pay for performance' have shown limited evidence of success.

OK, BUT WHAT CAN OR SHOULD BE INCLUDED IN AN OUTCOMES-BASED CONTRACT?

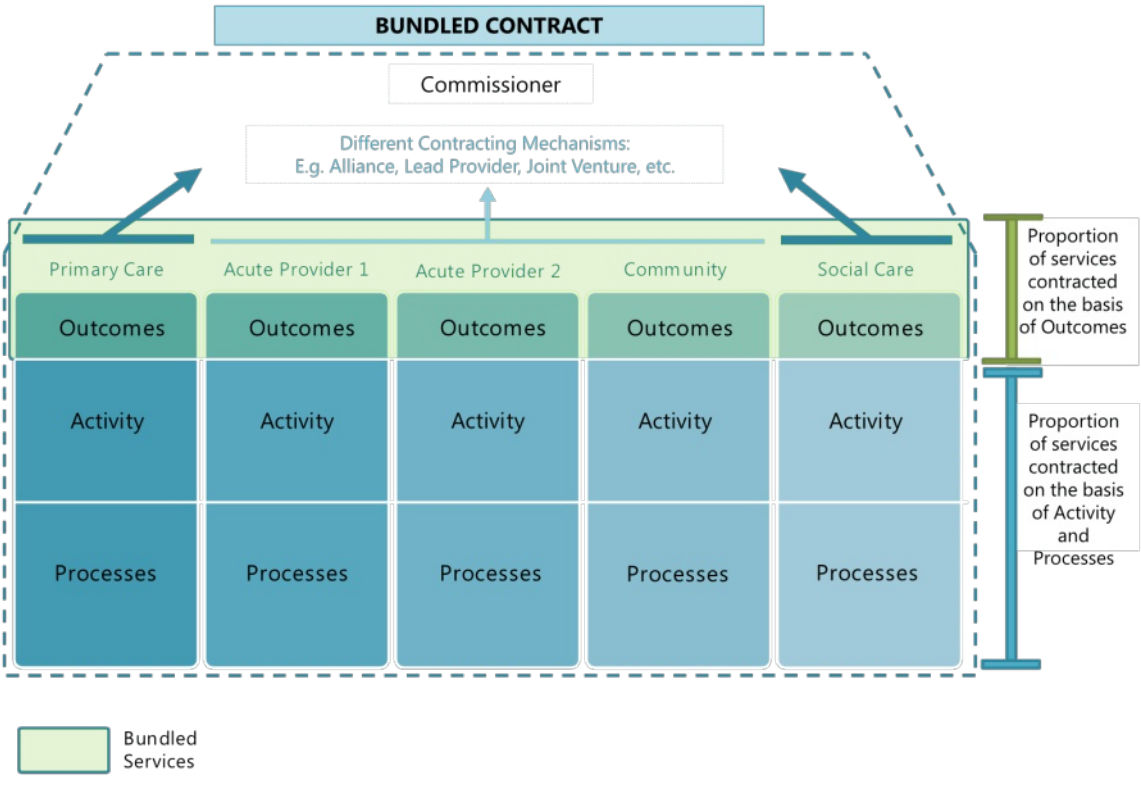
'Bundles' is a term that comes up a lot in discussions about outcomes-based contracting. This refers to the **bundle of services that are involved in providing a full cycle of care** and which may therefore be included in a contract (i.e. one or more acute services, community services, primary care etc). It also refers to the degree to which one bundled contract covers payment for all activity, processes and outcomes relating to those services – or whether only a portion of total contract value is attributed to the achievement of outcomes, leaving existing (activity and process) contracts largely intact. This latter option is usually known as a **partial bundle**. A partial bundle option is considered less risky in a scenario where the costs of providing full cycles of care may be underestimated, as the financial impact of not achieving the desired outcomes will be less destabilising. It is also somewhat simpler to implement.

[32] Impact of Quality and Outcomes Framework on health inequalities, Dixon et al (2011), http://www.kingsfund.org.uk/publications/impact-quality-and-outcomes-framework-health-inequalities
[33] Pay-for-Performance in the US: What lessons for Europe? (2007) http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/eurohealth/VOL13No4/Gemmill.pdf
[34] Doubts About Pay-for-Performance in Health Care, Andrew M. Ryan and Rachel M. Werner (2013), http://blogs.hbr.org/2013/10/doubts-about-pay-for-performance-in-health-care/
[35] Effects of pay for performance in health care: A systematic review of systematic reviews Frank Eijkenaar (2013), http://www.healthpolicyjrnl.com/article/S0168-8510%2813%2900018-3/abstract

Full Bundle Excluding core General Practice Contracts



Partial Bundle



These diagrams illustrate this question of bundles but they also highlight another common issue. **Primary care can only be commissioned under certain specific contracting regimes** (and at present is commissioned by NHS England). Excluding primary care from the bundle altogether would make it less likely that the outcomes being sought would be achieved. However, it is **possible to include primary care only in the outcomes component of the bundle, using the NHS Standard Contract**.

AND HOW DO YOU CALCULATE BUNDLED PAYMENTS ANYWAY?

Designing a **bundled payment in an NHS context is possible**. The key factors involved in the successful implementation are:

- Being guided by the nature of the outcomes being sought (again!)
- Engaging providers closely in discussion of options and the potential changes that lie ahead
- Being creative around the contracting and payments options that are available, while conforming to legal requirements.

In an ideal scenario, 'bundled' payment mechanisms mean changing the way costs are recorded and measured. **Outcomes and their associated costs should be measured around the patient not the organisations**, which means:

- Costs should be **aggregated over the full cycle of care**, spanning all settings and providers involved, and not for departments, services, or line items
- Where the care cycle is not defined by discrete episodes, a **set period of care** is usually chosen for measurement of costs, typically a year of care
- Cost is the **actual expense** of patient care (personnel, facilities, supplies), not the charges billed or collected, i.e.:

  - The time devoted to each patient by these resources
  - The capacity cost of each resource
  - The support costs required for each patient-facing resource

This is not currently straightforward. However, as a starting point, it is reasonable to work from a whole pathway 'price' calculation i.e. on the basis of historical prices paid for care.

A difficult issue to resolve is the appropriate "size" of the incentive for achieving outcomes. If the outcomes part of the bundle is not sufficiently material, it will not offer an effective incentive. If it is too large, it can cause too much disruption to the system. There is no 'right' answer – yet.

> *"It is important to invest in skilled financial analysis when you are exploring contracting options in order to disentangle existing costs and budgets and look at what and how much to include in bundled payments. More than that, you need to engage, engage again and then do some more engagement."*
> ***Dr Diane Bell, Director, COBIC***

AREN'T OUTCOMES TOO LONG-TERM TO BE USEFUL IN CONTRACT MANAGEMENT?

Plenty of outcomes can be tracked both in-year and year-to-year.

For example, it is possible to measure clinical outcomes such as the number of people with diabetes who have to have an amputation in any given year as a result of diabetes. For an individual, amputation is likely to be a long-term complication of diabetes. However, at population level, even very long term complications vary markedly year-to-year in response to changes in care processes. These can be tracked and reimbursed for within existing contracting cycles. Additional clinical outcomes relating to nerve damage or blood circulation which are possible precursors to amputation – such numbness, foot infections or foot ulcers – can also be measured in the short term.

PROMs, such as whether a person with diabetes feels anxious or confident about managing their condition, can be tracked and measured on the basis of any given time interval using robust and internationally benchmarked PROM tools.

READING LIST

- Contracting for Outcomes: a value-based approach (2014)[36], by OBH and Capsticks, commissioned by the north central London CCGs. This paper provides a comprehensive overview of the contracting options and issues around value (or outcome) based commissioning.
- The pioneering work on commissioning for outcomes in musculoskeletal services in Bedfordshire[37]. And NHS England's interactive guide to commissioning for effective service transformation[38].
- Alliance contracting: LH Alliances[39] offers useful blogs and resources. You may also be interested in this HSJ article[40], and this piece from Pulse[41] referencing an NHS alliance contract recently signed by three CCGs in Leicestershire and Rutland.
- Updated technical guidance on the NHS Standard Contract 2014/15[42]
- The Accountable Lead Provider[43], a paper by Professor Paul Corrigan and Dr Steve Laitner published as a Right Care casebook.

[36] Contracting for Outcomes: a value-based approach (2014), OBH & Capsticks, http://outcomesbasedhealthcare.com/Contracting_for_Outcomes.pdf
[37] Commissioning for outcomes: Musculoskeletal care NHS Bedfordshire CCG (2014) http://www.england.nhs.uk/wp-content/uploads/2014/02/est-cs-comm-musculoskeletal.pdf
[38] Commissioning for Effective Service Transformation: What we have learnt (2014) http://www.england.nhs.uk/wp-content/uploads/2014/03/serv-trans-guide.pdf
[39] What is an alliance contract? http://lhalliances.org.uk/what-is-an-alliance-contract/
[40] Team effort: Commissioning through alliance contracts, Mc Gough &Dunbar-Rees (2013), http://www.hsj.co.uk/home/commissioning/team-effort-commissioning-through-alliance-contracts/5065272.article?blocktitle=Resource-Centre&contentID=8630#.U-CuCKjmVaZ
[41] GPs sign groundbreaking 'alliance' contract to help slash hospital activity by up to 40% (2012), http://www.pulsetoday.co.uk/news/commissioning-news/gps-sign-groundbreaking-alliance-contract-to-help-slash-hospital-activity-by-up-to-40/20006644.article#.U-CuVajmVaY
[42] Updated technical guidance on the NHS Standard Contract 2014/15, http://www.england.nhs.uk/wp-content/uploads/2014/02/tech-guide-240214.pdf
[43] The Accountable Lead Provider, developing a powerful disruptive innovator to create integrated and accountable programmes of care, Corrigan & Laitner (2012), http://www.rightcare.nhs.uk/downloads/Rightcare_Casebook_accountable_lead_provider_Aug2012.pdf