outcomesbasedhealthcare

# outcomes MYTHS?

- "Outcomes are too hard to define..."
- "Outcomes are too hard to measure..."
- "Outcomes are too hard to contract for..."
- "There are too many cultural barriers..."

# Outcomes based approaches to healthcare

## Tackling the myths about outcomes in health

**The idea of focusing on outcomes** is now common currency in healthcare debates. Outcomes-based approaches to planning, organising and measuring the performance of healthcare offer new opportunities to tackle variation, improve cost-effectiveness and, most importantly, put patients first. Most people would agree that outcomes-based healthcare sounds like a good thing.

In reality, implementing outcomes-based healthcare can seem daunting, and some of the challenges almost insurmountable. **At OBH, we work with commissioners, providers, individuals and local communities on a daily basis to help shape healthcare systems that deliver the outcomes that matter most to people.** We are asked lots of questions and we encounter a range of concerns.

We have put together a series of essays to **'bust' some of the common myths about outcomes in health:**

**About us**

At Outcomes Based Healthcare (OBH), we believe that **focusing on outcomes is key to achieving the person-centred system** to which the NHS aspires.

We work with people, local communities and the healthcare system as a whole to define outcomes, whilst providing academic and technical rigour to the process of measuring and contracting for outcomes.

We have a diverse set of backgrounds in medicine, business, economics and technology but what we have in common is that **we care passionately about helping design care that fits around people and their lives.**

**Outcomes are just too difficult to define...**

**Outcomes are just too difficult to measure...**

**Outcomes are just too difficult to contract for...**

**There are just too many cultural barriers to outcomes-based commissioning**

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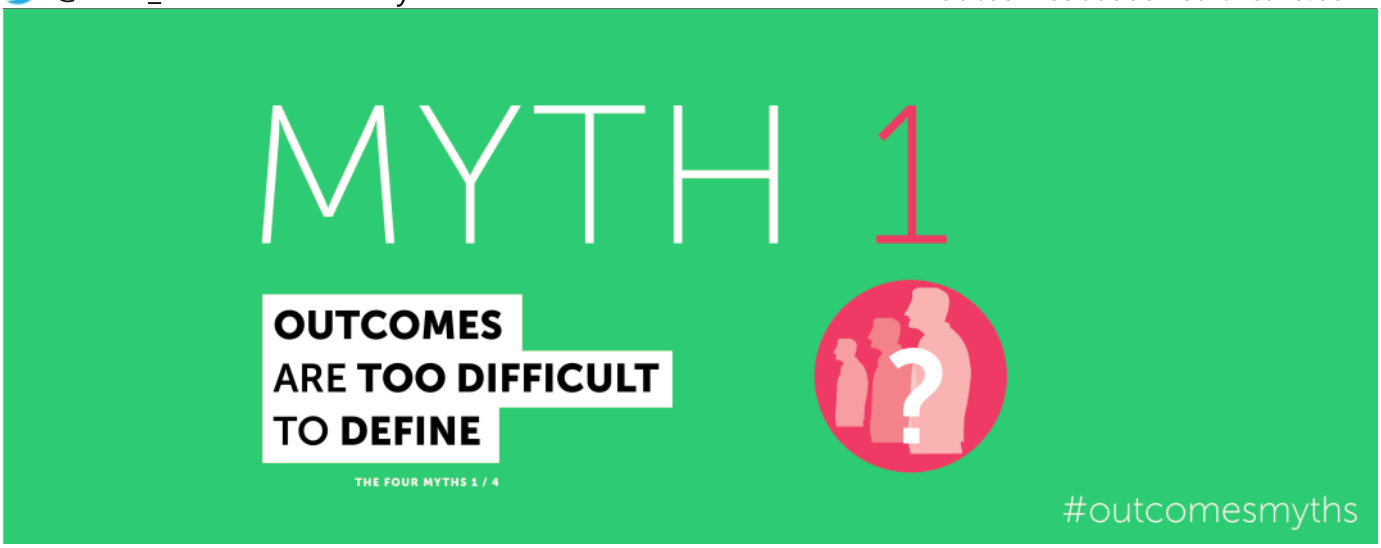
*"My hospital consultant never knew that I suffered mental problems as a result of the pain I experienced after having knee surgery, and neither does he know how my knee is now"*
***Female patient, aged 76, 2014***

*"What are we trying to achieve? A new focus on outcomes for patients and value for taxpayers"*
***Simon Stevens, Chief Executive, NHS England, June 2014***

*"Achieving good patient health outcomes is the fundamental purpose of healthcare"*
***Professor Michael E. Porter, Harvard Business School, 2013***

*"Take risks with processes, but not with clinical outcomes."*
***Professor Sir Bruce Keogh, NHS England Medical Director, March 2014***




**People often think outcomes** are a bit nebulous or abstract, and therefore too difficult to pin down and use as the basis for commissioning a service. After all, designing a service that can deliver 250 hip and knee replacements per annum is a far more concrete task than designing a service that will restore people's mobility, independence and confidence.

The other common concern is that since everyone is different, everyone wants different outcomes, making them too much of a moving target to be useful as a way of managing performance against a contract. With diverse populations and a tradition of commissioning around specialties, services and providers, commissioning for outcomes therefore feels like an onerous task. This isn't helped by the fact that the language of outcomes has become confused and is often confusing.

Our experience proves otherwise. Defining outcomes is much easier when you identify and involve the right group of people and ask them the right questions. We have learnt that:

- There is a **real skill to defining outcomes** – it does not mean taking what people say they want at face value
- Defining useful, meaningful and measurable outcomes is possible once you **identify groups of people with similar needs**, otherwise known as segmenting your population. And those outcomes are remarkably consistent across similar groups of people in different localities
- **Designing services on the basis of outcomes** is trickier than designing services to deliver specified activity or outputs, but it is also more likely to **result in a better and more cost-effective service**

## WHAT IS AN OUTCOME ANYWAY ?

At its simplest, a positive outcome is a change for the better in a person's health. Getting back on their feet after a fall; feeling back in control of their life after an episode of mental health illness; spending less time in hospital despite having COPD and diabetes. The outcomes that matter to people depend on their starting point, like their age and medical condition (or conditions). Their outcomes will be the result of a whole series of health interventions and experiences they have as they travel through the healthcare system.

> *Outcomes are the results people care about most when seeking treatment, including functional improvement and the ability to live normal, productive lives.*
> ***International Consortium for Health Outcomes Measurement (ICHOM)***

Outcomes are distinct from people's experiences of healthcare and whether they feel satisfied with those experiences. They are also distinct from the 'process' of healthcare – an outcome does not tell us whether x or y happened, it simply focuses on the result. Experience, satisfaction and process measures are key to measuring quality, but they are not the same as the results that matter most to an individual.

### Outcomes are about results

If I have diabetes, I may feel positive about the kindness of a nurse or GP and how quickly I can get to see them. I may be getting all the right blood tests e.g. HbA1c, cholesterol and blood pressure checks required by best-practice guidelines, but these are not outcomes. The outcomes that really matter to me might be feeling free from anxiety about how to manage my care or maintaining my eyesight.

*NHS Patient*

> *Reframe the conversation from "What is the matter?" to "What matters to you?"*
> ***Maureen Bisognano, Chief Executive, Institute for Healthcare Improvement, 2013***

# SEGMENTATION MATTERS: '…BUT EVERYONE WANTS A DIFFERENT OUTCOME, DON'T THEY?'

Successful outcomes-based approaches depend on identifying groups of people with similar needs. This approach recognises that such groups share characteristics that influence the way they interact with health care services.

To get the best health outcomes and minimise health care costs, the healthcare system should respond to the needs of different population groups in different ways. Often the best place to start is with conditions and demographics – getting your segmentation right is key.

> *"The most valuable lesson health systems can learn from insurance may be to recognize that "one size will never fit all", and a more personalized approach can be successfully achieved by recognizing that groups within the population vary widely and health services need to be structured using a variety of approaches in order to meet the unique needs and values of all segments within a population."*
> ***Snowdon, Schnarr & Alessi, 2014***

The NHS has traditionally categorised populations by the health services they use at a point in time – and providers are reimbursed on the basis of services delivered at specific locations at a specific point in time. People receiving a given service can therefore vary hugely in the nature of their needs or health circumstances: for example, an older man with several co-morbidities having rehab after a fall would fall into the same group as a fit young woman having rehab after a sports injury.

This can mean people having unnecessary appointments, delays and inconvenience because they may be seen:

- by services not tailored to their particular needs
- in settings that do not have appropriate ancillary services
- in acute settings when they could more appropriately be seen in the community.

**Segmentation**, by contrast, aims to categorise the population according to health status, healthcare needs and priorities. This means you can tailor care to that group and provides a stronger foundation for responding to individuals' needs.

The number of segments identified needs to be limited. The criteria for effective population segmentation include[1]:

- **Homogeneity**: each segment shares common health prospects and priorities that can be addressed through careful system planning
- **Distinctiveness**: each segment has unique health and health service delivery needs
- **Completeness**: the set of population segments must include every person, acknowledging that individuals will move between segments as their health needs change

[1] Using Population Segmentation to Provide Better Health Care for All: The "Bridges to Health" Model, Lynn et al (2007), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690331/

# CASE STUDIES AND REFERENCES: SEGMENTATION AND OUTCOMES FRAMEWORKS

**Outcomes hierarchies**[2] are a useful way of thinking about the outcomes that matter to people – this is from Professor Michael E Porter at Harvard Business School, the authority on outcomes and value in healthcare.

The Heart BMJ recently published: From volume to value? Can a value-based approach help deliver the ambitious aims of the NHS cardiovascular disease outcomes strategy[3], which discussed the importance and implications of focusing on people with similar needs.

## North Central London CCGs – defining outcomes for three population groups

A group of five CCGs (Camden, Islington, Barnet, Haringey and Enfield) worked together to design outcomes-based care for three population groups:

- older people living with frailty
- people with diabetes
- people with mental health problems

Expert reference groups worked with OBH on the segmentation, drawing on public health and informatics expertise to identify useful data sources such as existing population data and disease registers. They also advised on 'entry' criteria, such as selecting appropriate frailty scoring systems, and defined common needs or health circumstances that may be shared by people with different diagnoses.

Once those segments were identified, the next step was to involve people with a relevant condition, their advocates and professionals in defining the outcomes they care about. We ran a series of interactive workshops (some people call them 'outcomes parties') led by experienced facilitators and outcomes experts. We also designed and distributed surveys, using a variety of technologies, to collect as broad a range of outcomes ideas as possible. In the first instance, these generated lists of raw outcomes which needed further work to make them meaningful, relevant and measurable.

We worked together on categorising and prioritising the raw outcomes and then refining and agreeing them with local experts. This involved representatives from the commissioner, provider (including consultants, GPs, specialist nurses and social care providers) and patient communities. Their collective knowledge and experience base resulted in robust outcome frameworks that are truly co-produced and 'co-owned' with the local health economy and which can now be used as the basis for designing services.

Dr Caz Sayer, chair of Camden CCG, says two things struck her from this process: "Even vulnerable people were willing and able to participate and to articulate very clearly what was important to them – and this included recovering users and current drinkers. Some of the outcomes that have emerged are diametrically opposed to how some services are being delivered now – especially in mental health, where people told us they found short term, goal-based measures far more important than traditional longer term ones."

[2] What is Value in healthcare? ME Porter (2010) http://www.nejm.org/doi/full/10.1056/NEJMp1011024

[3] From volume to value? Can a value-based approach help deliver the ambitious aims of the NHS cardiovascular disease outcomes strategy, Dunbar-Rees et al (2014) http://heart.bmj.com/content/early/2014/03/11/heartjnl-2013-305269.short?rss=1

## SOUNDS LIKE HARD WORK...

The good news is that work to define outcomes does not have to be repeated from scratch in every locality for every population group. In OBH's experience, something like 80 per cent of the work on outcomes for a specific population segment can be applied to that same segment within a geographically different population.

Moreover, standard outcomes sets for specific conditions and population groups are becoming more widely available, through work done nationally by OBH and internationally by ICHOM[4] . The emphasis will start to shift away from the creation of new outcomes sets, towards reviewing and adapting standard outcomes to fit the specific needs of local people.

> *"Service-driven descriptions of particular communities are just too much of a heterogenous group to have any sensible conversation with about needs or expectations, or any meaningful analysis of outcomes. So outcomes are often dismissed as just too hard- 'everybody just wants a different thing'. When we group people by similar sets of needs, suddenly what matters to different patients starts to make much more sense."*
> ***Dr Rupert Dunbar-Rees, Founder, Outcomes Based Healthcare***

## HOW OBH DOES IT

Once a **segment** has been identified, the next step is to **involve people** with a relevant condition, their advocates and professionals in **defining the outcomes** they care about. At OBH, we do this through interactive workshops (some people call them "outcomes parties") led by experienced facilitators and outcomes experts. We also design and distribute surveys, using a variety of technologies, to collect as broad a range of outcomes ideas as possible. In the first instance, these generate lists of "raw" outcomes which need further work to make them meaningful, relevant and measurable.

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The South Somerset Symphony Project[5] analysed its entire population to identify population segments that could most benefit from more integrated care. This in-depth analysis, conducted with the University of York's Centre for Health Economics, made the important finding that it would be more fruitful to define population segments on the basis of the number of conditions each person has than on the basis of age.

Another good example of working with individuals to define outcomes can be found at Alliance Scotland[6].

[4] ICHOM, www.ichom.org

[5] South Somerset Symphony Project (2014) http://www.rightcare.nhs.uk/index.php/2014/03/research-finds-that-costs-of-health-and-social-care-are-driven-more-by-an-individuals-morbidity-profile-than-by-their-age/

[6] Personal outcomes and quality measures project (2013), http://www.alliance-scotland.org.uk/what-we-do/projects/personal-outcomes-and-quality-measures-project/

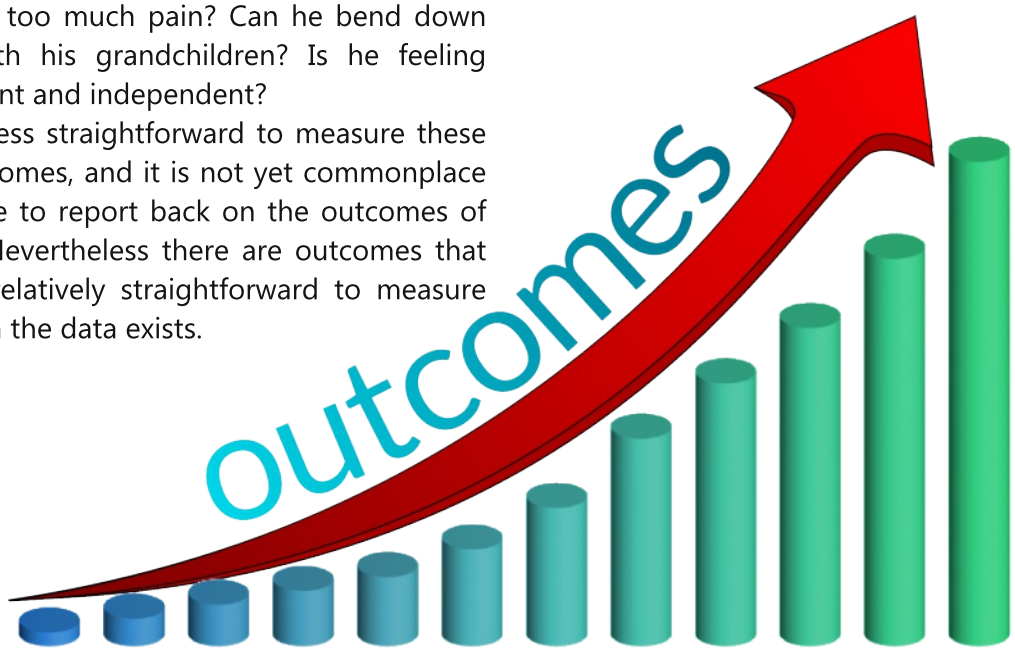

**Defining outcomes is one thing; measuring them is another**. This is often where people tell us they encounter what seem like dead ends. All too often, they are told that the data needed to measure outcomes doesn't exist or that outcomes simply cannot be measured. They are also told that data collection is already too much of a burden in the cash-strapped NHS.

It is relatively easy to count activity and outputs – like the number of knee replacement operations undertaken, the number of post-operative infections or number of physiotherapy sessions delivered – and these data are easily accessible. This is what the NHS does really well. **But as important as these are, they don't really tell us whether these things that have been done to people have done them any good** – is the person who had the knee replacement able to walk without too much pain? Can he bend down and play with his grandchildren? Is he feeling more confident and independent?

True, it is less straightforward to measure these kinds of outcomes, and it is not yet commonplace to ask people to report back on the outcomes of their care. Nevertheless there are outcomes that are already relatively straightforward to measure and for which the data exists.

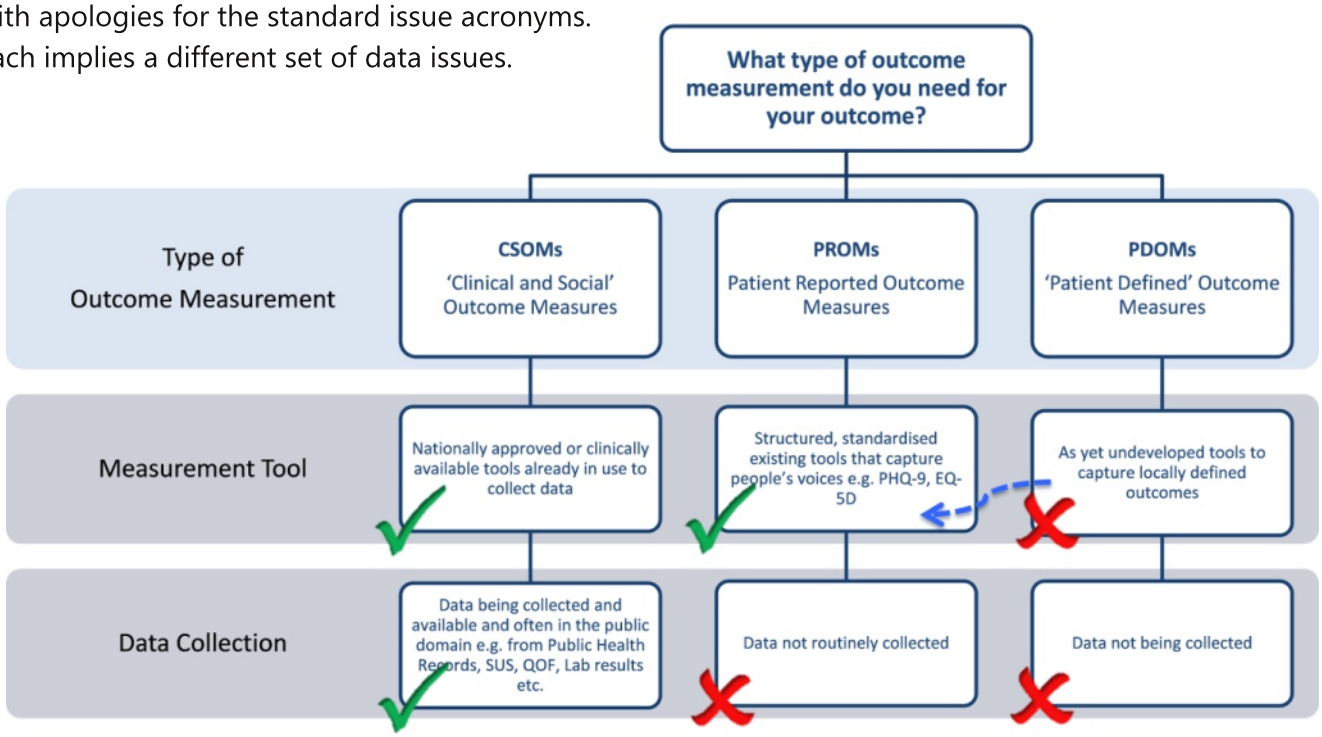
Outcomes measurement is a challenging topic, but at OBH we have learnt that:

- A great deal of the data collected in the NHS is designed to help measure inputs, processes and outputs – but, with care, it can often also be used to measure outcomes
- For a typical patient segment, data exists which allows 50% to 60% of outcomes to be measured – and this may be a good enough start. The rest may require additional data collection, often asking people to report back on their outcomes
- We have yet to come across any satisfactory technical reason why outcomes can't be measured



# DIFFERENT TYPES OF OUTCOMES HAVE DIFFERENT MEASUREMENT CHALLENGES

We work with three types of measures – with apologies for the standard issue acronyms. Each implies a different set of data issues.




## CSOMs - 'Clinical and Social' Outcome Measures

Clinical Outcome Measures are objective measures relating to health and quality of life, such as the physical or psychological aspects of disease, symptom control, complications, the avoidance of adverse effects and the speed of recovery, including the impact on quality of life.

Social Outcome Measures relate more to someone's life situation, such as housing, education and employment, which may be affected by their health condition.

Data useful for measuring clinical and social outcomes is often already collected and available via nationally approved or clinically available tools. Key datasets (all administered by HSCIC[7]) include, Hospital Episode Statistics (HES); a wide range of clinical audits; Quality Outcomes Framework (QOF); Adult Social Care Outcomes Framework (ASCOF); and the NHS Safety Thermometer. Another key source is the Office of National Statistics[8] for public health records.

> *The relevance of social outcomes is clear, when you think about child health. If families and children are having to attend multiple hospital appointments, educational attainment and the impact on employment status of days off work become important outcome measures.*
> ***Nabiha Sachedina – policy expert, NHS paediatrician, MBA and MPP***

[7] HSCIC: www.hscic.gov.uk (HES: www.hscic.gov.uk/hes, Clinical Audits www.hscic.gov.uk/clinicalaudits, QOF: www.hscic.gov.uk/qof, ASCOF: www.hscic.gov.uk/ascof, NHS Safety thermometer: www.hscic.gov.uk/thermometer

[8] ONS http://www.statistics.gov.uk/hub/health-social-care

## PROMs - Patient Reported Outcome Measures

A number of **structured, standardised and validated tools exist** to capture people's own reports on their outcomes – as distinct from their experiences of care or their levels of satisfaction. These have been found to be useful not only for measurement purposes but as an improvement tool in their own right too[9] . The general direction at a policy level is for **routine and systematic collection of PROMs** in the line of care, as outlined in the NHS Mandate 2014/15[10] .

**'Generic' tools** in common use include: EQ-5D[11] , SF-36[12] . These enable valid comparison across large populations of people with different conditions, but they are inevitably less specific, making it difficult to draw firm conclusions for specific groups of people with similar health needs.

**Condition-specific PROMs** are, as the name suggests, more sensitive to the details of that condition. Good examples include:

- The Oxford Hip Score[13]
- Audit of Diabetes Dependent Quality of Life – ADDQoL[14], PHQ9[15]
- Hospital Anxiety and Depression Scale (HADS)[16]

The national PROMs programme[17] measures health gain in patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England, based on responses to questionnaires before and after surgery. However, it is focused on specific procedures rather than conditions or discrete population segments.

## PDOMs - 'Patient Defined' Outcome Measures

In OBH's experience, exploring outcomes that matter with people and clinicians always results in a few outcomes for which neither clinical data nor existing PROMs are available – we call these PDOMs. This is the time to think carefully about whether and how to go about gathering new data.

There are lots of things to consider:

- **how to involve people** with the condition in survey design, as recommended by ICHOM[18]
- whether to aim for a **census-based survey** as recommended by Press Ganey[19], or a **representative sample-based survey**, and if so, how large a sample will be needed
- **when and how often to survey** – at specific interactions with the health service, e.g. post-operative and/or at fixed or rolling monthy/quarterly/annual intervals. There are advantages to making data collection a natural part of the care process, e.g. asking people to complete forms while waiting for an appointment
- **what media to use** – smartphone app, paper survey, online form
- **how to validate data** at each stage of the process
- **the resources required** to distribute the survey, capture data and analyse results

[9] Patient reported outcome measures could help transform healthcare, Black (2013) http://www.bmj.com/content/346/bmj.f167
[10] NHS Mandate 2014/15, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256406/Mandate_14_15.pdf
[11] Using the EQ-5D as a performance measurement tool in the NHS, Devlin et al (2009) http://openaccess.city.ac.uk/1502/
[12] SF-36, 36-Item Short Form Survey from the RAND Medical Outcomes Study, http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html
[13] Oxford Hip Score, Patient Reported Outcomes Measures from the University of Oxford, http://www.isis-innovation.com/outcomes/orthopaedic/ohs.html
[14] Audit of Diabetes Dependent Quality of Life, Patient- Reported Outcome Measurement Group, Oxford A Structured Review Of Patient-Reported Outcome Measures (PROMs) For Diabetes (2009) http://phi.uhce.ox.ac.uk/pdf/Diabetes_2009FINAL.pdf
[15] Patient Health Questionnaire, PHQ9, http://www.patient.co.uk/doctor/patient-health-questionnaire-phq-9
[16] Hospital Anxiety Depression Scale, , Patient- Reported Outcome Measurement Group, Oxford An Overview Of Patient-Reported Outcome Measures For People With Anxiety And Depression 2009, Http://Phi.Uhce.Ox.Ac.Uk/Pdf/Depression%20and%20anxiety%20promgroup%20oxford%20may2010.Pdf
[17] National PROMs Programme, www.hscic.gov.uk/proms
[18] ICHOM, www.ichom.org
[19] Press Ganey, Patient Voice – census-based surveying, http://www.pressganey.com/ourSolutions/patient-voice/census-based-surveying.aspx

## BUT WHAT ABOUT THE DATA COLLECTION BURDEN?

In an ideal world, **data collection would not be a burden**. In an ideal world, the right sort of technology in the right place that links up securely to the right systems would make data collection and outcomes measurement far easier. At the moment, **joining the dots takes time and is a key focus of OBH's work**.

Our experience is that a huge amount of the data that is collected in the NHS tends to be of limited value or is not used in meaningful ways – and that doesn't just apply to data required by national bodies. Often it would be more useful if pockets of data in different parts of the system were linked up, and if information governance practices were better aligned. In other cases, there is a degree of wasted effort going on – resource that could be redirected to collecting the kind of data needed to better measure outcomes.

## PRAGMATISM IS KEY

It is almost never the case that the perfect data is available for measuring any given outcome to begin with. For example:

- **data is not always accessible**: blindness is a potential outcome to avoid for someone with diabetes, but population level data about the prevalence of blindness in diabetes, from the electronic certificate of vision impairment, is not yet accessible. So instead, we have used the NHS Diabetic Eye Screening programme, to find data about the prevalence of severe retinopathy treatment in people with diabetes.
- **data is sometimes fragmented**: taking another example of a possible outcome for diabetes, erectile dysfunction is not recorded well in hospital episode statistics, but may be available in GP data
- **the data that is available may not quite match up to what is needed**: while the 'segment' targeted is perhaps older people living with frailty over the age of 75, available data may relate to older people over the age of 65 and you need to explore whether it is possible to take a 'cut' of the data for the relevant age cohort and the definition of frailty that has been identified
- **data may not be available as frequently** as you would like and often there may be a delay in getting the data, sometimes more than a year

Nevertheless, neither **the NHS nor social care is short on data and plenty of it is useable**. Choices have to be made on whether available data is 'good enough for now', or whether additional data collection is warranted.

> *Measuring outcomes systematically is a journey not a destination. The first step in developing any successful outcomes measurement system is to start somewhere. It means getting all the right people around the table and agreeing to be deeply pragmatic. Is it worth the effort? How else will we know if the care we are providing is doing any good?*
> ***Dr Rupert Dunbar-Rees, Founder, Outcomes Based Healthcare***

**King's Health Partners' Outcomes Books**

King's Health Partners (KHP) is committed to providing **accurate and timely information about patient care**, and believes that **identifying, measuring and publishing healthcare outcomes results in a culture of improvement and increased value**.

Every one of KHP's twenty one Clinical Academic Groups are working towards producing 'outcomes books[20]' for their specialties. These provide contextual narrative and data across a range of outcomes, benchmarked wherever possible. They are aimed at both clinical and public audiences, and will be updated annually. They are underpinned by more detailed data which allow clinicians to discuss and compare performance down to ward level.

**Professor John Moxham, Director of Clinical Strategy at KHP**, is spearheading this initiative:

*"Measuring outcomes is difficult. My advice always is that you have to be pragmatic and start somewhere: use the data that already exists and get people talking. It is those conversations – between clinicians and with patients - that really drive improvements.*

*It is harder in some clinical areas than others, but we regard it as an ongoing process and a permanent change in the way we do things. We may even publish some outcomes books that are incomplete, because we know we will get there over time.*

*Continuing to enrich the data available to measure and compare outcomes is an essential component of our strategy. We are in the process of linking up information systems between our trusts – and beyond them to our local GPs. Working with our partners on the Health and Wellbeing Board, this will enable us to track outcomes for people across full cycles of care not just within the hospitals but out into primary care and beyond."*

## TACKLING THE DATA DETAIL - OBH AND NORTH CENTRAL LONDON CCGS

Having worked on **defining the outcomes that matter to older people** living with frailty, people with diabetes and people with mental health, OBH continues to work with Camden, Islington, Barnet, Haringey and Enfield CCGs.

The next step involves detailed work to **create the right data architecture** for each one – in other words, figuring out what data is needed to measure it, as well as whether it exists and can be accessed.

For each type of outcome (CSOM, PROM and PDOM) and each population segment, we work with **Expert Reference Groups** (ERGs) to seek a range of views and insights on potential measures and to test their practicality.

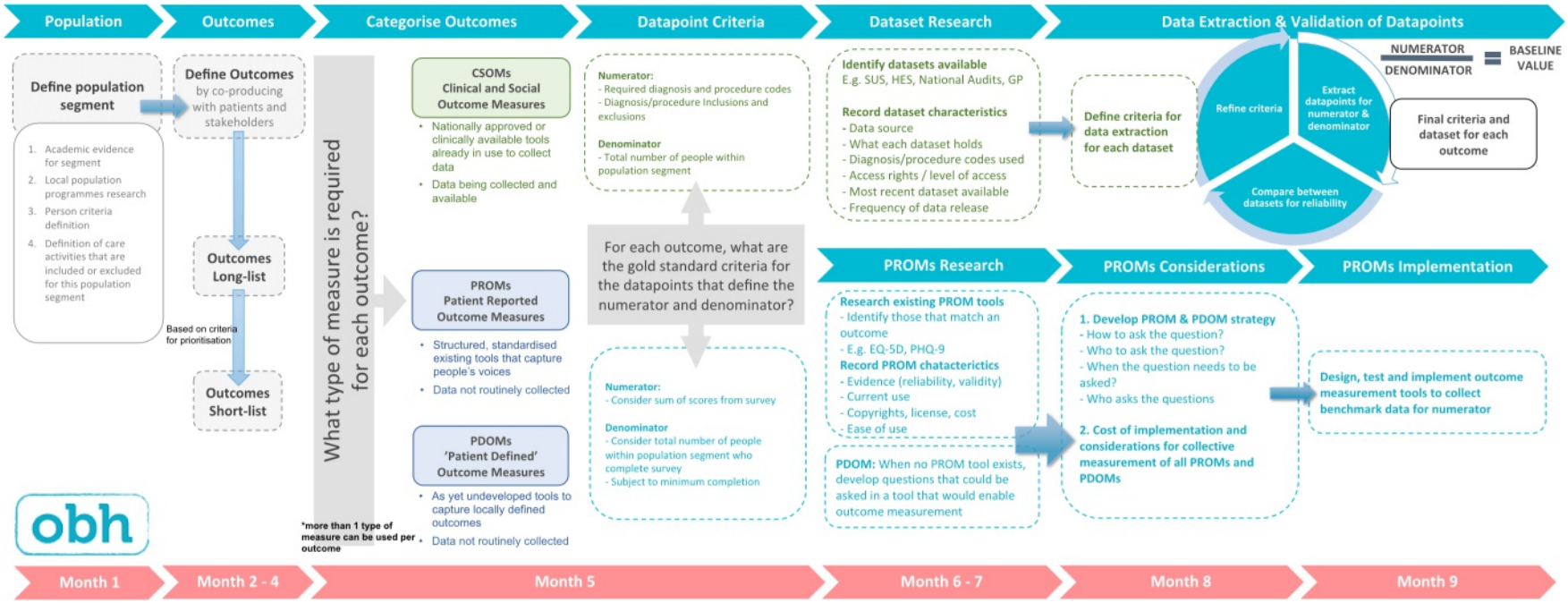
OBH has put together a process map to summarise the process for creating the data architecture

Creating a data architecture means addressing a series of questions:

- What data would be needed to measure this outcome?
- Is that data available – or is there a good enough proxy? If so, which dataset and who holds it?
- What exactly does that dataset cover? Who and what is included and excluded?
- How often is the data collected and what is the delay before it becomes available?
- What permissions are required to access the dataset?
- Are there any other constraints or issues with the dataset?
- What is the detailed technical measure we need? What numerator and denominator is appropriate?
- What is the most appropriate baseline position to use so that progress over time can be measured?

[20] King's Health Partners, http://www.kingshealthpartners.org/flipbooks/medicine/

# Outcomes Measurement Process Map



This can be painstaking work – but it is **essential upfront activity** when the aim is to measure whether the care being provided is making a positive difference to people's lives. The work in North Central London is ongoing – the key has been to get the right knowledge and expertise in the room, particularly public health and informatics experts, and to be open to adopting the solutions others have found. To pick out just a few examples:

- **The National Diabetes Audit**[21] will be invaluable in measuring some of the clinical diabetes outcomes. There is some timelag to deal with, but it is possible to take bespoke cuts of the data to match specific outcomes requirements
- **The NHS Safety Thermometer**[22] contains a useful indicator on falls within 72 hours of leaving a care setting, which matches a key outcome for older people living with frailty
- **The Adult Social Care Survey**[23] contains a good outcome indicator for the same group: older people still at home 91 days post-discharge. While that indicator relates to the over-65 age group, it should be possible to extract data relating to the over-75 age group
- **In some cases, choices need to be made**: whether to use a clinical measure for symptom control albeit with shortcomings on its completeness (e.g. A&E admission for Diabetic Ketoacidosis (DKA)) or whether to use a PROM which asks patients to report on how well they feel they are able to control their symptoms

The result of this work will be a **clearly articulated description of the outcomes required**, and how they can be **measured, which can be incorporated into a contract** in which all parties have confidence.

> *"It's a process of exploring the best fit between available data and the outcome you want to measure, until you get something that both commissioners and providers are comfortable with."*
> ***Alisha Davies, Acting Consultant in Public Health at Haringey Council***

## "IF WE DEFINE AND MEASURE OUR OWN OUTCOMES, WE CAN'T BENCHMARK AGAINST OTHERS"

This is true – to some extent – but it's a poor reason not to begin measuring outcomes. **Outcomes-based commissioning is in its infancy**. The more localities develop outcomes frameworks and the more standard frameworks are developed at national and international level, the more **benchmarking will become possible**. You could also argue that:

- Useful local, national and international benchmarks do exist for a number of outcomes – from mortality rates to complications of diabetes to a number of generic PROMs
- Benchmarking your own performance over time is really valuable and a good place to start regardless
- There is value in locally defined outcomes that have limited applicability elsewhere – that is where PDOMs come in. For example, in one area it might be very significant that people are able to bend down to pray post-knee surgery but for another the most important outcome is the ability to drive as they live in a remote area with few transport links
- Collaborating with local CCGs or others with similar populations is worth exploring for benchmarking purposes – OBH is working with five CCGs in London to do exactly this.

[21] National Diabetes Audit UK, www.hscic.gov.uk/nda
[22] NHS Safety Thermometer, www.hscic.gov.uk/thermometer
[23] Adult Social Care Survey, http://www.hscic.gov.uk/catalogue/PUB10284/meas-adul-soci-care-fwrk-fin-eng-11-12-rep.pdf

> *"Measuring outcomes is not that hard: the important thing is to make sure you have intelligent conversations about what the data does and doesn't show."*
> ***Dr Tim Williams, Co-founder, myClinicalOutcomes***

## READING LIST

- Every one of King's Health Partners' twenty-one Clinical Academic Groups are working towards producing 'outcomes books[24]' for their specialties. King's Health Partners is the Academic Health Science Centre that brings together King's College and three NHS Foundation Trusts: King's College Hospital, Guys and St Thomas' and South London and Maudsley.

- Professor Michael E. Porter: a supplement on measuring outcomes[25], to his seminal paper What is Value in Healthcare?[26]

- Getting the most out of PROMs[27], a 2010 report from The King's Fund provides a great overview of PROMs. Nick Black also looks at the potential of PROMs to transform healthcare in his 2013 BMJ article[28].

- The PROM group in the Nuffield Department of Population Health at the University of Oxford[29] provides a near comprehensive resource, including work on patient reported measures relating to integrated care.

[24] King's Health Partners, Outcomes books, http://www.kingshealthpartners.org/info/outcomes-books
[25] Supplementary Appendix 2 to: Porter ME. What is value in health care? N Engl J Med 2010;363:2477-81. DOI: 10.1056/NEJMp1011024
[26] What is Value in Healthcare? Porter (2010) http://www.nejm.org/doi/full/10.1056/NEJMp1011024
[27] Getting the most out of PROMS, Putting health outcomes at the heart of NHS decision-making, Devlin & Appleby (2010), http://www.kingsfund.org.uk/sites/files/kf/Getting-the-most-out-of-PROMs-Nancy-Devlin-John-Appleby-Kings-Fund-March-2010.pdf
[28] Patient reported outcome measures could help transform healthcare, Black (2013), http://www.bmj.com/content/346/bmj.f167
[29] PROM Group, University of Oxford, http://phi.uhce.ox.ac.uk/home.php


**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

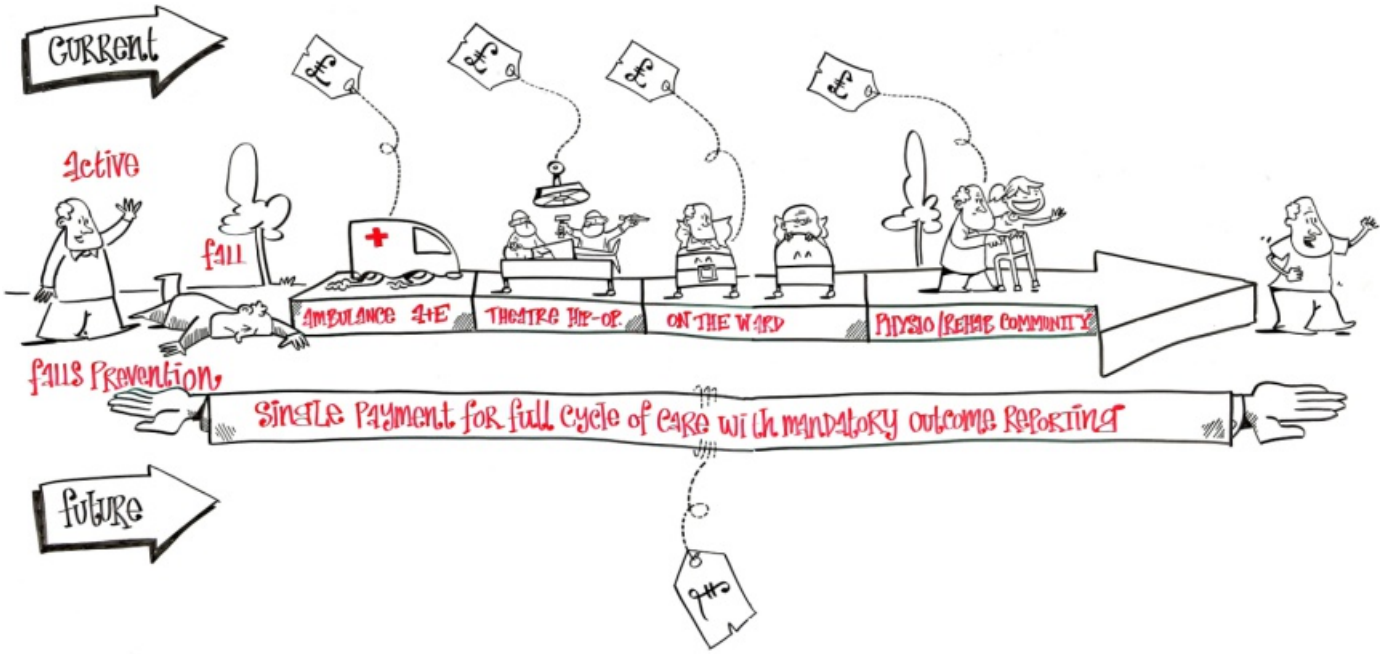
For example, for people with osteoarthritis, contracting for outcomes should result in the coordination of all the services involved in improving their mobility and getting them back to a good level of functioning. This involves **multiple providers working in an integrated way across whole care pathways 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:

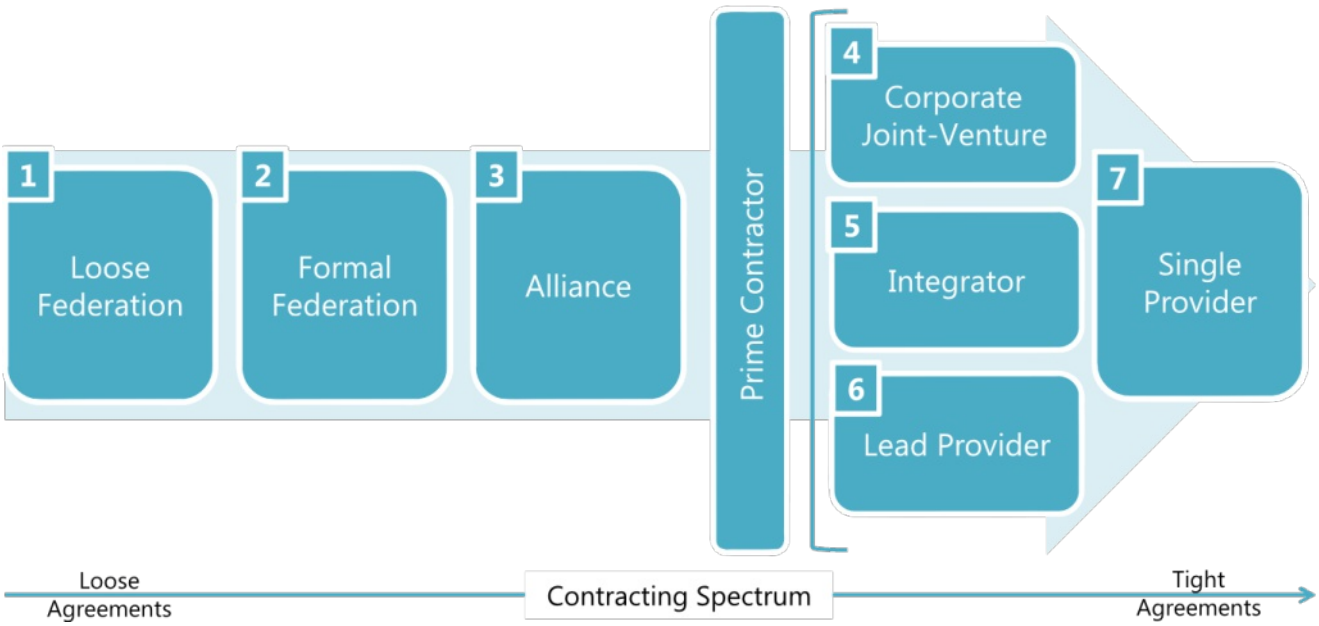
- Establishing a joint management and decision-making structure
- The need for a single patient records system to support outcomes measurement
- Mechanisms for providers to exit or be decommissioned, and new providers to join
- Determining the appropriate balance between trust and capacity to enforce
- 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

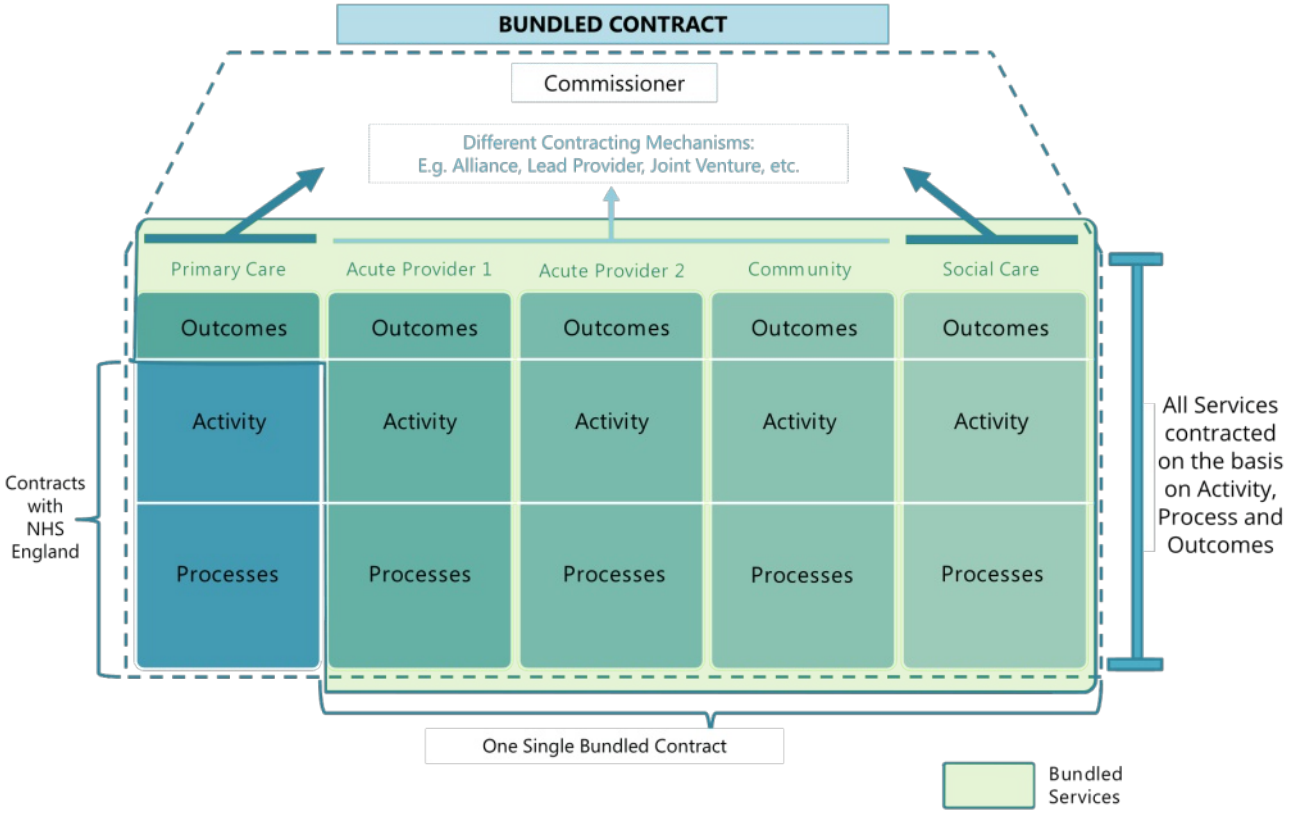
We would argue that these are the reasons why a number of studies (from the Kings Fund[32], Eurohealth[33], HBR[34] and Health Policy[35]) evaluating the effectiveness of 'pay for performance' have shown limited evidence of success.

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

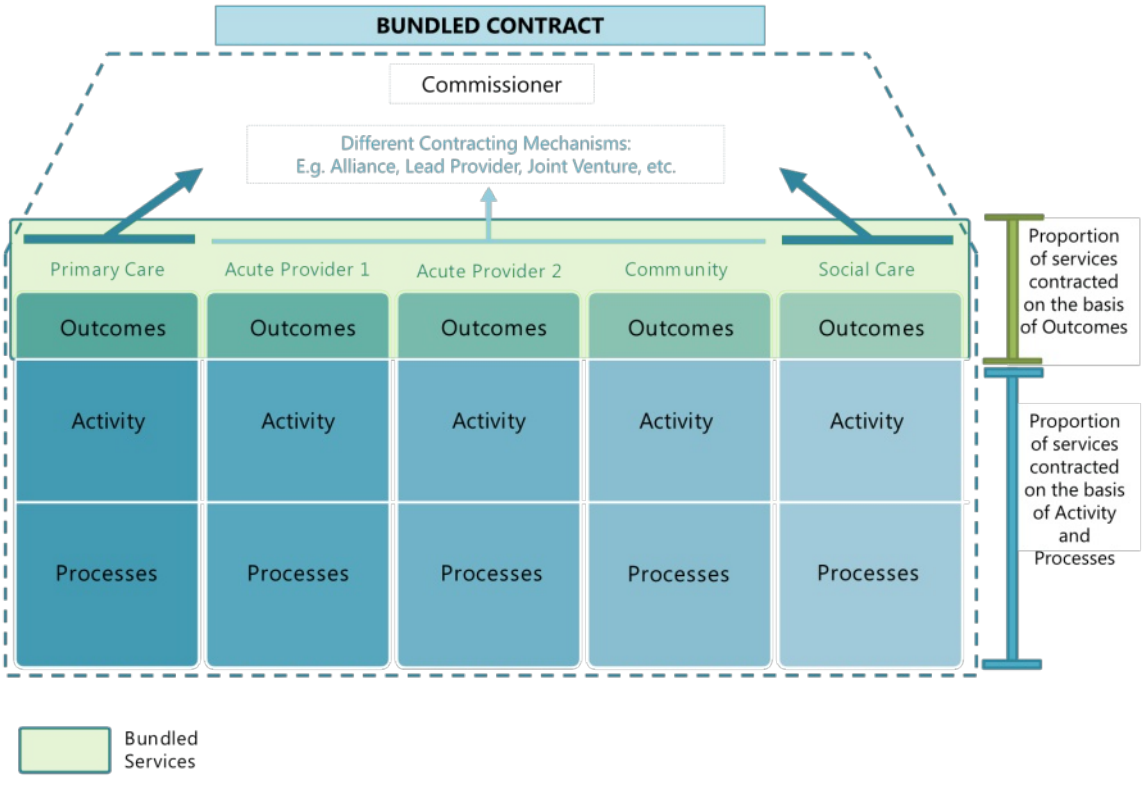
**'Bundles'** is a term that comes up a lot in discussions about outcomes-based contracting. This refers to the **bundle of services that are involved in providing a full cycle of care** and which may therefore be included in a contract (i.e. one or more acute services, community services, primary care 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


**Shifting to an outcomes-based approach**, whether as a commissioner or provider, is a significant departure from the norm (for now). As with any change, success will be determined not only by getting the right infrastructure and technical detail in place but by people's attitudes and behaviours. As with any change, there will often be people and organisations who are resistant or reluctant to take the plunge.

Our experience is that:

- The **arguments for outcomes-based approaches are powerful** in themselves – it is hard to disagree with the principle of focusing on outcomes and results of care
- **Resistance is rarely irrational** – there is no alternative to investing time in understanding and directly addressing people's concerns
- **Leadership** –at all levels, and a firm focus on the prize – **is key**

## BURNING AMBITION – AND A BURNING PLATFORM

There is a groundswell of recognition that we need to **do things differently if the NHS is to maintain its proud heritage**. Delivering better outcomes for patients more cost-effectively for taxpayers is now the NHS mantra. Continuing to commission on the basis of activity, while tolerating variation in quality and outcomes and the waste inherent in poorly joined-up services, is not a rational response to the challenge.

> *"We need to move away from diseases to whole people, not retain an obsession with individual medical targets, and ensure that CCGs are focused on the needs of their populations and not on the attainment of medical targets. A direction needs to be signalled and a pace of change determined. We do not have the luxury of waiting until the financial situation is more favourable."*
> ***Dr Charles Alessi, Chairman,***
> ***National Association of Primary Care***

While the financial constraints facing the NHS present obstacles to change, they also present an unassailable argument for change. No part of the healthcare system is immune from the financial pressures or less than passionate about better outcomes and better health.

> *"You never let a serious crisis go to waste. And what I mean is that it's an opportunity to do things you thought you could not do before."*
> ***Rahm Emmanuel, former White House Chief of Staff***

## NO-ONE COULD OBJECT TO FOCUSING ON OUTCOMES, COULD THEY?

We have yet to come across anyone that objects to the concept of focusing effort on achieving the outcomes that matter to people. But we are not blinkered in our ambition.

No-one is under any illusion that the system is facing huge financial constraints and much of the day job is taken up with managing these. Moreover, the nature and scale of the pressures vary from locality to locality, giving some greater headaches - or headspace - than others.

No-one has the luxury of starting with a blank sheet of paper. Contracts for services are already in place with one or more incumbent providers, who will naturally see financial risk in any contractual changes even as they welcome a focus on outcomes.

No-one is free from doubt. They worry about data quality and timeliness and the technical complexities of contracting, as well as the prospect of adverse media attention if it doesn't work out.

All of these are entirely good reasons to tread carefully.

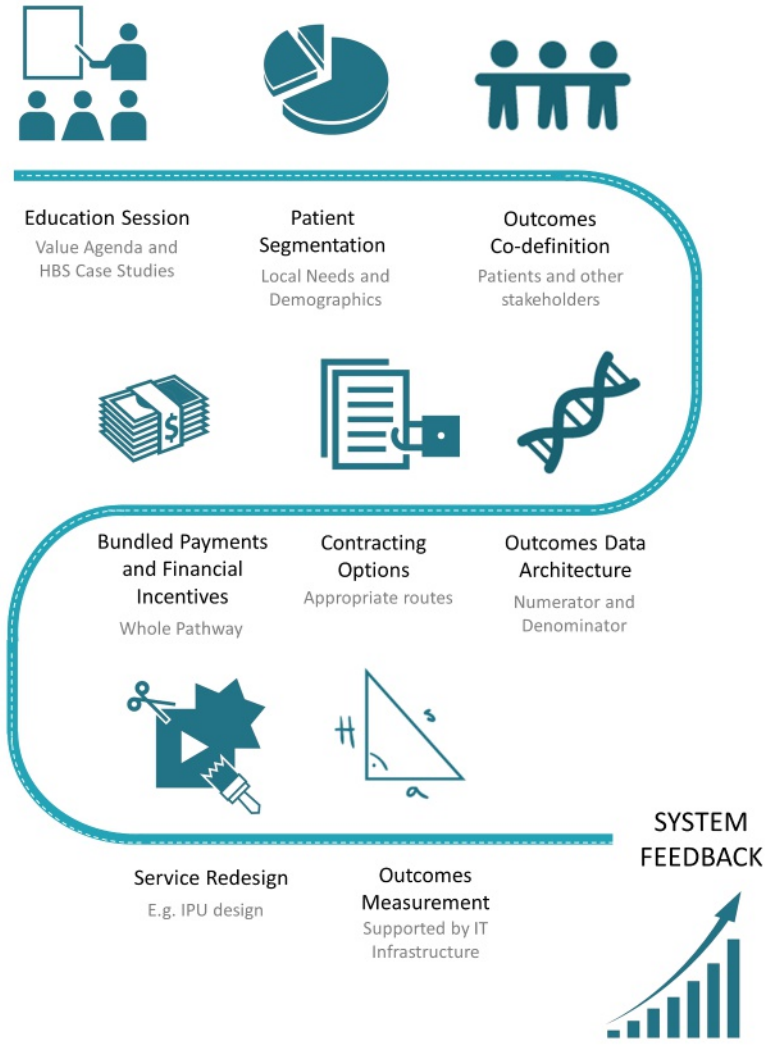
> *"Commissioning for outcomes takes both commissioners and providers out of their historic comfort zones with multiple meaningless performance indicators being replaced by a much smaller number of clinical and patient-centred outcome measures. My advice is that this has to be seen as a long-term project, with early engagement of everyone concerned and a practical focus on agreeing how best to phase the process. Bite sized pieces that all parties can swallow are critical."*
> ***Dr Stephen Richards***

## THERE ARE NO SHORT CUTS – THE OBH APPROACH

People have legitimate and often very practical concerns about outcomes-based approaches to healthcare. This 'myth-busting' series is all about tackling those kinds of concerns.

The way forward is through a **systematic, inclusive and evidence-rich process** – along with a healthy dose of bold ambition and a willingness to take risks. This process needs to **combine clinical expertise, the voices of patients, carers and service users as well as commercial nous**.

OBH's eight step process is outlined below. Wrapped around this kind of process, there is an **unavoidable need for conversations and engagement** – from the outset and throughout.




> *"To sustain a culture focused on outcomes and quality, the emphasis needs to be on releasing front line staff to innovate and improve, supporting effective teams and enabling cross-boundary working. Aligning objectives is key so that people don't feel distracted or overwhelmed by conflicting priorities."*
>
> ***Professor Michael West,***
> ***Professor of Organizational Psychology, Lancaster University Management School and Senior Fellow, The King's Fund***

## LEADERSHIP AND ENGAGEMENT IN NORTH CENTRAL LONDON

The five clinical commissioning groups in North Central London, representing 1.4 million people in Barnet, Camden, Enfield, Haringey and Islington, are working towards outcomes-based commissioning for key population groups, starting with people who have diabetes, older people living with frailty, and those with mental health problems. They are **collaborating not only with each other but with clinicians, providers, local authority partners and patient groups**. This is no small task.

### David Cryer

**David Cryer, Chief Officer at Camden CCG** told us:

We recognise that this approach is a radical departure for everyone: the prize may be great but the practical and financial concerns are real. That is why we are putting a lot of time and effort into engaging with each other as CCGs, with clinicians and with our providers from across the area.

You can't underestimate the work involved. You have to work with the willing and seek out the early adopters. Starting from a focus on the outcomes that patients say are important to them is essential. You then need to focus on building a collaborative partnership with clinicians to make the clinical model work before you move on to the money. You have to develop strategic relationships with providers, built on mutual respect and trust.

One of my key messages to providers is that **this is an opportunity not a threat**. We are matching the responsibility they feel for delivering the best possible care for people with the authority to do just that.

## TOP TIPS

> *"Focusing on outcomes means redefining what we mean by success for clinicians – innovating to deliver results for patients rather than complying with a pre-determined process. This is challenging – but liberating and motivating too."*
> ***Caleb Stowell, MD, VP of Research and Development, ICHOM***

## LEADERSHIP AND ENGAGEMENT IN NORTH CENTRAL LONDON

Based on our own experience and observations, and the many conversations we have had in putting this myth-busting series together, a number of practical tips have emerged:

- **Set out a vision** and keep bringing people back to the big picture
- **Be pragmatic**, start small and phase the approach
- **Seek out the willing and enthusiastic** - you need a broad coalition of support when things go wrong (which they may well do)
- **Use what already exists** – from outcomes frameworks to data to contracting models in use elsewhere
- **Identify and prioritise the segments** of your population on which to focus
- **Involve people with similar health needs in defining the outcomes** that matter – along with outcomes, data and clinical expertise to figure out how to measure those outcomes
- **Get clinicians on board** and focused on designing the pathways and clinical models
- **Engage providers** in figuring out what is possible and be open to hearing and addressing their concerns – trust and collaboration is all
- **Make sure you have access to expert financial analysis** when it comes to designing contracts and payment bundles

> *"Innovation comes from people talking to each other. When you bring people together who don't usually spend much time together and give them common purpose, behaviours change and attitudes follow."*
> ***Professor Susan Llewellyn, Professor of Clinical Psychology, University of Oxford***

## READING LIST

> *"Despite the technical challenges to overcome with outcomes based approaches, it is actually the change in mindset required which is the most significant challenge, and our greatest opportunity."*
> ***Dr. Rupert Dunbar-Rees, Founder, Outcomes Based Healthcare***

- HSJ article discussing the need for the NHS to focus on outcomes Only the brave succeed[44].
- While not about outcomes-based healthcare as such, this is a fascinating discussion of culture and behavior in the NHS[45] and the importance of a patient-centred approach
- Talking Points Personal Outcomes Approach: Practical Guide[46], recently published by The Joint Improvement Team (JIT), is a good source of information on outcomes-based approaches.

[44] Only the brave succeed when focusing on outcomes, Dawson & Burke (2014), http://www.hsj.co.uk/comment/only-the-brave-succeed-when-focusing-on-outcomes/5072559.article#.U-C6XajmVab

[45] Culture and behaviour in the English National Health Service: overview of lessons from a large multimethod study, Woods et al (2013), BMJ Qual Saf doi:10.1136/bmjqs-2013-001947, http://qualitysafety.bmj.com/content/early/2013/08/28/bmjqs-2013-001947.full

[46] Talking Points Personal Outcomes Approach: Practical Guide (2012), http://www.jitscotland.org.uk/wp-content/uploads/2014/01/Talking-Points-Practical-Guide-21-June-2012.pdf

> *"all about taking outcomes OUT of the 'too difficult' box."*

We can offer **masterclasses** to help your organisation **move beyond ideas** about using outcomes and start building a road-map towards **value and outcomes in health** for your local population.

This usually involves a face-to-face group discussion, with some case-based teaching, to help bring the ideas to life. If you are interested to know more, do get in touch via:

**info@outcomesbasedhealthcare.com**

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