RightCare CASEBOOK

The Accountable Lead Provider

Developing a powerful disruptive innovator to create integrated and accountable programmes of care

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Introduction – The Accountable Lead Provider

There is broad agreement about the need to commission integrated care or as patients and their carers would be more likely to call it "joined up care".

Patient with long term conditions and their carers also want services to be more holistic (biopsychoscoial) and more personalised. They want services to be supportive of them to achieve self-care (self-care support) and to be able to plan their future care (care planning); services which involve them in decisions about their care (shared decision making) and services which support them in their own homes without having to go to hospital if there are alternatives (care closer to home).

This is quite a different type of service than patients with long terms conditions are currently receiving. Our current model of specialist care is predicated upon the hospital based, biomedical and organ–based model.

We are urging commissioners to move away from the traditional 18th century hospital outpatient model and commission a different model of specialist ambulatory care, a personalised and holistic model as described above and one that is community based, multidisciplinary and based around the holistic needs of a group of patients and their carers. However we do not want commissioners to just commission a *service*, we want commissioners to commission an *Integrated and Accountable Programme of Care* for a population of patients with particular needs. Such populations could be "the Frail Elderly" or "Children with Complex Disabilities" or "People with (and at risk of) Respiratory Disease".

We also want commissioners to make their life easier for themselves by *not* commissioning these Programmes of Care via the existing micro-commissioning and micro-contracting methodology. This leaves commissioners trying to micromanage what is probably the most complex supply chain known to man.

We want commissioners to commission these Programmes of Care via an Accountable Lead Provider. By doing so, they give the job of service

transformation and programme integration to a powerful health care provider in the centre of the pathway (between primary care and hospital inpatient care). In order to be able to manage the programme they will need to be able to both provide care and subcontract care to other providers. They will also be able to support primary care in its part of the pathway whilst at the same time managing unwarranted variation in primary care referrals. They will also help manage the gateway into hospital based in patient care.

As the name suggests The Accountable Lead Provider is a provider of care, not just a "navigator" or "integrator". This is because the power needed to provide accountable integrated care can only be delivered from a provider within the pathway of care and ideally in the centre of the pathway. The Accountable Lead Provider is not a commissioner, it is a provider, an integrator and programme manager, a provider that both provides and subcontracts healthcare.

The commissioner would have an outcome based contract with the Accountable Lead Provider and through this contract and the Lead Provider's management of the programme incentives will be aligned – clinical and financial.

Healthcare is too important and complex to commission in any other way.

Dr Steve Laitner
July 2012

1 Executive Summary

Public experience of NHS services is marked by praise for the specific experiences of treatment but problems with the overall experience of service. Whilst most staff and leaders in the NHS recognise the severe problems caused by the organisation of care into episodes of care, there are few models of integrated care that have emerged which have sufficient integrative power to challenge the organisational distinction of episodic care. This is partly because those arguing for integration do so usually within the episodic paradigm but also because they want to develop a new model of integration without disrupting the old model of episodic care.

Here we argue for a strong integrator who is given the power through the contract to both deliver care and also to bring together the previously episodic providers of care into a single pathway. The lead provider in this model is given the responsibility through the contract for subcontracting for the various aspects of care. The contract demands of the lead provider that he carry out that role in such a way as to ensure all of the different aspects of care are fully integrated.

In other industries very complex supply chains come together to provide a simple output for a customer. Walk into a cafe and order a cup of tea and you will not have to go to India to buy a tea plantation this task of logistics or supply chain management has had an important impact upon the way in which better value is produced through various chains of supply.

Many commissioners recognise this issue and are looking to providers to develop properly integrated care, developing different contract mechanisms and preparing to take on programme risk and accountability. This will need different forms of contract pricing and much less pathway micro-management than has been developed in the past. This is a new, sustainable approach to commissioning care and also a mechanism to transform pathways of care in terms of quality and productivity. We outline case studies of these new approaches and conclude by outlining how the NHS Commissioning Board can assist these developments.

2 The case for change - what is the problem

One of the main paradoxes in patients' feedback starts with very many patients saying that each doctor, nurse, pharmacist and ambulance driver was really good. Many patients comment on how each aspect of the care was really well delivered. Then there is a big "..but" about the overall experience.

- Complaints about being asked the same questions over and over again
- About hanging about between bits of the service
- About having many people involved in their health care but not really sure who is responsible for what and who is in overall charge of their care
- Of not really knowing what is going on
- Of patients "falling through the gaps"

Whilst the bits of NHS care are reported as being very good, the overall is often poor.

Given the regular nature of this feedback there is strong agreement within the NHS and across external commentators that the NHS fails many of its patients because it fails to provide "joined up" or "integrated" care. This is not simply a failure in the care that most patients experience; it is a very considerable waste of resources. This is one aspect of the waste of resources which brings into question the sustainability of the NHS as a whole.

Seventy percent of NHS and social care funding is spent on caring for people with long term conditions[1], which means that the creation of integrated care is the core business of the future sustainability of the NHS.

The current delivery and payment of episodic care, across multiple, fragmented providers, leaves many patients, especially those with complex needs, with sub-optimal experience and outcomes and an experience of sub optimal care. Most patient groups representing the various diseases and conditions are highly critical of the current system of episodic care (See Richmond group report September 2010.[2]). They themselves argue strongly for the necessity of real integrated care (See same group report April 2012 [3])

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[1] Our NHS care objectives A draft mandate to the NHS Commissioning Board DH July 4 2012 page 7 par 2.9
[2] http://www.richmondgroupofcharities.org.uk/RichmondGroup2010.pdf
[3] http://www.richmondgroupofcharities.org.uk/RichmondGroup2012.pdf

The failure to provide genuine integrated care leaves most patients who suffer from long term conditions with a patient pathway with serious holes in it and again paradoxically with frequent duplication of care. In fact the experience for the patient is in some cases so disjointed that the term pathway cannot be applied in any real sense. It is the gaps in most patient pathways that lead to many of the health exacerbations that in turn lead to the hospital beds that are filled with unnecessary emergencies. Therefore one of the paradoxical outcomes from this episodic approach to the patient experience is many more and longer stays in hospital.

If we are to construct a patient centred future for the NHS, it will have to deliver genuinely integrated care, based around both the needs of patient groups (for example the frail elderly or children with complex disabilities) and also based around the personal needs of individual patients within those groups.

If we are to construct a sustainable future for the NHS it will have to deliver genuinely integrated care, which provides powerful incentives to keep patients at home and out of hospital.

So much is obvious and well known for many years. National policy has been arguing for the necessity of both integrated care and care closer to home for many decades, brought together in the White Paper *Our health, our care, our say: a new direction for community services* in January 2006[4] The policy clamour for integrated care grew until the summer of 2011 when the entire Health and Social Care Bill was amended to lay a duty on all NHS bodies to promote integrated care.

However whilst there may be near unanimity about integrated care as a policy there is a lack of clarity of how integrated care will be delivered and only a few examples of this policy being put into practice. Therefore irrespective of this unanimity about policy if we look at the delivery of most care to most NHS patients, in the summer of 2012, in most parts of the country, for most conditions, it is still essentially traditional episodic fragmented care.

Having a universal agreement of the need for a policy to happen has not meant that it actually takes place in practice.

Why is this? We believe that most attempts to deliver integrated care underestimate two issues.

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http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4127602 - See also Kings Fund 2008 “SEE SAW report” (http://www.kingsfund.org.uk/document.rm?id=7718).

First developing a genuinely coordinated care “supply chain” of health and social care from the complex and varied interactions that are necessary to make that chain work as well is a highly complex task. The very different organisations that provide the very distinct aspects of this care are used to working separately, all having very different perspectives and paradigms of care. Whilst it is easy to create imperfect but much better relationships between these different organisations, creating a complete interlinked and coordinated supply chain of health and social care is a logistical problem with at least the same complexity in creating the supply chain that exists in the retail trade or the automobile industry.

Importantly, those and other industries have had logistical firms working to develop their supply chains across several different industries for decades. They have only succeeded because they recognised the difficulty of getting organisations that had grown up with very different organisational cultures, aims and drivers to work together. These supply chains work because they recognise the absolutely necessary power that the logistics organisation needs to overcome the different cultures and drivers with each separate organisation. Contracts with logistics organisations often lay a duty upon the lead provider to ensure the interoperability of information standards language and terminology. The NHS seems to find it so hard to integrate between the very different systems of different providers.

A frail elderly patient with 3 long term conditions and moderate social care needs is likely, over a year, to come into contact with as many as 10 very different organisations. Each of these organisations has a set of incentives and drivers which have helped that particular organisation to survive and thrive. To just take the example of the NHS - The different aspects of current NHS episodic care (primary, community and secondary) have 60 years of very different structures and cultures of provision with totally different financial incentives. These organisations are not used to delivering services to a set of drivers or missions that are outside of their own. When you add the different aspects of social care to this, the cultural push to disintegration of any pathway is significant. Under these circumstances it takes some power to make integration happen.

The second issue of difficulty concerns the very different professions that work within these different organisations. The 10 different organisations are likely to have as many as 20 different work force cultures within them. Most of these will have an approach to their particular episode of practice with the elderly people that have been developed from their own specific professional body with different emphases on different aspects of medical and

other science. The organisations within which they work have very developed and different professional cultures.

Within their own terms each professional is ‘correct’.

Our point is that it takes some considerable strength to overcome these different organisational and professional approaches to care and construct them into a coherent, integrated patient pathway which serves the long term individual need of the patient and their carers.

We would argue that underestimating that necessary strength has been one of the reasons why so little real integrated care is being delivered.

If these very different professionals are in any coherent way going to work together then a new set of incentives are going to have to drive that new way of working. Those incentives will have to be powerful enough to overcome the existing incentives, cultural and organisational barriers that have created the fragmented professional care in the first place. We believe too many attempts at integrated care underestimate the rigour that is needed to achieve this.

As well as a lack of integration, the NHS suffers, institutionally, from a lack of personalised care, disempowered patients, large variations in care, low value interventions and far too often, poor clinical and patient experience and outcomes. These are difficult, engrained problems to fix and as such require, in our view, a powerful “disruptive innovator”, a “Lead Provider” delivering specialist ambulatory care close to home from the pathway centre, whilst managing a transformed programme of care for a defined group of patients.

The problem with achieving this in most current NHS models of integrated care there is no single accountable integrator who can ensure that the various components of the specified programme and pathways really work together for patients. At the moment, in order to ensure some form of integrated outcome, pathways are specified in a very imprecise way. The commissioners specify this way because they empathise with the difficulty that the different providers have to change their existing culture. This empathy for the difficulty of change that providers have to make leaves those commissioners demanding weaker integration than the pathway really needs.

We would argue for a different direction of that commissioner's empathy - to be directed towards the patient who needs to have a strong pathway even if that pathway demands extensive change, and even disruption, from every provider.

The Lead Provider model provides strong power for the integrator, since they have both the clinical and financial accountability (and budget) for the whole programme of care and can create the new integrated incentives that will make integrated care possible.

3 How can the lead provider model work for the NHS in 2012

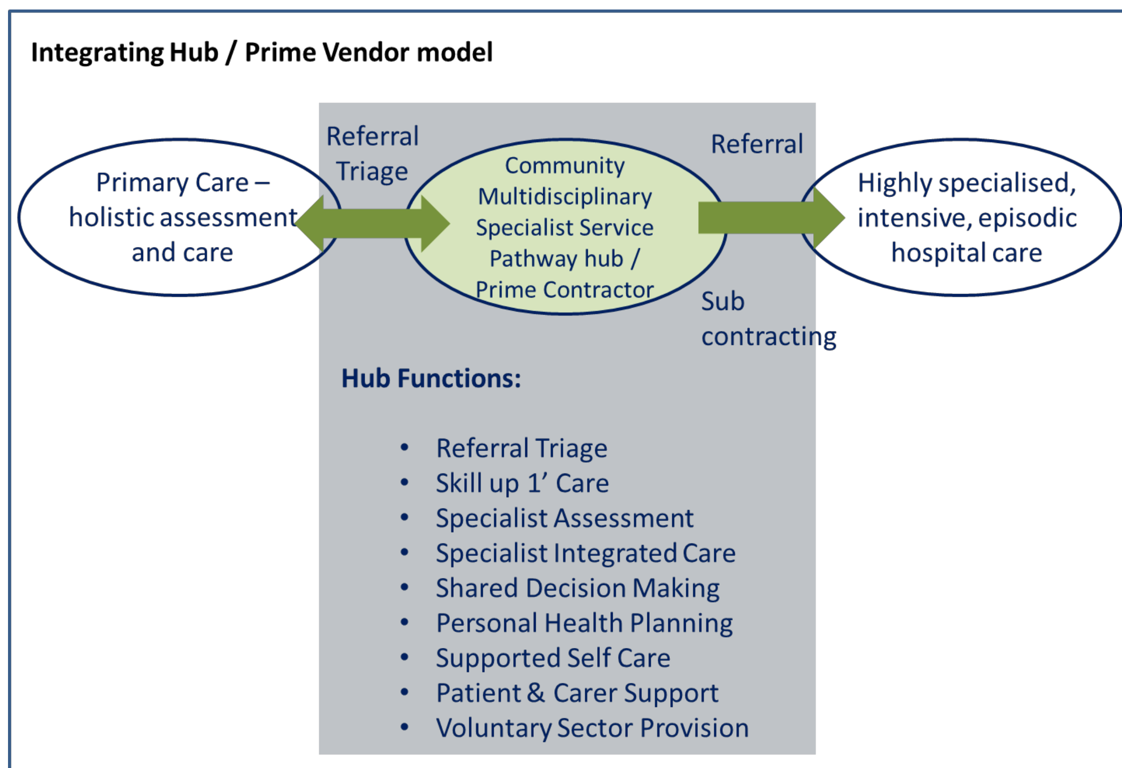
We have said previously that patient feedback on individual aspects of care is often good. The Lead Provider model will almost certainly retain most of the existing providers of the different aspects of health and social care in the new integrated patient pathways. The GP will be the same GP, as will the community nurse, the A&E nurse and doctor, the social care staff – most will still be providing care in the same or similar organisations. However hospital outpatients are likely to move over time to a "community based, ambulatory, specialist, multidisciplinary model". Also the number of hospital inpatients for the programme(s) of care under the lead provider is likely to fall dramatically over time. The main difference in the Lead Provider model compared with other models is that these different aspects of care will be incentivised by the lead provider to work together into a coherent patient pathway .The Lead Provider will be able to make it clear that each aspect of the work will be incomplete unless they meet the necessity of its integration with each other aspect of the work. Further, because the Lead Provider will be providing care from the centre of the pathway they will be able to control the pathway in a way that no commissioner has been able to do, nor will ever be able to do.

This is why we argue for such a strong integrator who would have the responsibility to the commissioners for the outcomes in the commission.

The lead provider model is one model of a strong and accountable integrator.

In this model, commissioners let a contract for an Accountable Integrated Programme of Care (AIPC), each containing a number of related pathways, to a single organisation that will then both provide specialist ambulatory care whilst also integrating existing and other providers into a programme of care for a defined patient group. It is the lead provider's task to ensure that every part of the overall programme (such as "The Respiratory Programme" and each constituent pathway (such as "The COPD Pathway") is delivered in a way that joins up with the other parts of the pathway. This provides the lead provider (with its subcontractors) the ability to construct an overall pathway of care and incentives that provide the commissioner with the outcomes that they want.

For example, the commissioner can let a contract to a Lead Provider which specifically aims as part of its overall commission, for say frail elderly", to diminish the use of emergency beds from this patient group or for this condition by 25%. In addition the commissioner may want a contract that throughout the pathway ensures that information is passed on to the other sub contracted providers in an agreed format and a timely way.



NHS commissioners now need to buy this kind of approach to service because commissioners will no longer be able to afford the high costs of failure that are a normal part of episodic care, nor can they afford the high cost of commissioners attempting to micro-commission, micro-contract and micro-performance manage what many commentators have deemed "the most complex supply chain known to man" - that of health. The Lead Provider will take overall leadership and accountability for the commission, then sub contract the aspects of care to different providers and incentivise those providers to drive towards that desired outcome. The commissioner now has *one* contract for a whole programme of care which contains multiple providers.

However, to be successful integration needs to go beyond the NHS. The need for successful integrated care for the NHS patients will mean that the programme of care will have to integrate care across services which are at the moment being provided by very different industries such as social care and the voluntary sector. Simply placing these existing

services adjacent to each other or even under a new organisational form does not create an integrated care system that adds new value.

The Lead Provider may wish to create some form of Joint Venture between provider partners such as social care, third sector organisations and independent providers, or it may wish to have only lead provider / subcontractor relationship. For certain programme of care such as frail elderly services, it is likely to be appropriate for the lead provider to be dually commissioned by health and social care

The development of Health and Well Being Boards provides the opportunity for a single integrated commissioning organisation that can, from that one body, write a contract that will be able to specify genuinely integrated health and social care. We believe that such an integrated specification will need to be provided from a powerful Lead Provider, pulling together the main paradigms of care required such as bio-medical care, psychological care, social care and patient and carer support services.

4 Examples from other industries?

In other industries very complex supply chains come together to provide a simple output for a customer. Walk into a cafe and order a cup of tea and you will not have to go to India to buy a tea plantation. Others do that for you. This very complex set of interactions is not a problem for the tea drinker. It is a problem for the supply chain organiser who carries out that task in a completely hidden way.

For most simple outputs you need supply chains to work not just within one industry but across very different industries. Filling the shelves of supermarkets is a complex task that involves not just the primary industry of the food production with its own culture and rewards, but also the secondary industry of transport and then the industries of packaging and retail. It may also involve the industry of food processing.

All of these different industries have totally different cultures and reward structures. In the UK we have some of the best logistics companies in the world who have been developing logistical skills on a world market for over 20 years.

Jaguar's Global Aftermarket support a partnership with Unipart Logistics

Maintaining a leading position in demanding global automotive market requires a heavy emphasis on aftermarket and support. Jaguar has worked with Unipart to ensure that the supply chain management for their parts service which ensures that the right part is in the right place in over 60 countries. Unipart logistics applies lean practice across the complex set of services that make up the aftermarket support in these countries. The Unipart way encourages staff to work in teams and to constantly monitor and question the efficiency of the tasks they perform. A series of logistics tools are used to examine processes and drive performance.

Along with the focus on driving out inefficiency Unipart work with the company to support its expansion into new countries such as Russia and China. Unipart has 20 years of implementing lean principles across the whole supply chain.

The lead provider or the integrator in our terms is a normal part of the provision of goods and services. Logistics, the science that constructs these relationships is a major industry in its

own right but in health we believe that logistics should be carried out from within the healthcare delivery system itself.

Providing health care to vulnerable people needs even greater rigour, with explicit checks and balances to mitigate the real risk of patients falling between gaps in care when responsibility transfers between different parts of the pathway or “supply chain”.

5 How ready is the NHS to take up this model

Whilst there is recognition of the importance of developing integrated care within the NHS, there is little evidence of the development of any models which so far have sufficient rigour to enable integrated care to be commissioned and provided at scale. Given the importance of delivering real integrated care we argue the need for a new market place which will develop for new ways of delivering really integrated care We recognise that the accountable lead provider is only one model that provides for a strong integrator. We are not saying this is the only model. Another way of providing strong integration provides a strong power that will unify care by bringing all providers into one organisation. The other major driver towards this form of delivery is the economic imperative to deliver significantly better health care outcomes for the same resource. Existing provision of integrated care is rarely achieving this outcome. As the financial squeeze on the NHS gets tighter, sooner rather than later, real savings are going to have to be found from integrated care provision. We would argue that this will lead to commissioners looking for the providers that can guarantee the level of savings that can only come from systemic saving. This will need contracts across different parts of the system rather than contracts with individual organisations only. The major efficiency improvements will come from better management of the interfaces across the care pathway, for example between self care and primary care, between primary care and specialist "outpatient" or "ambulatory" care and then into inpatient care.

We would argue that, with the right policy signals, a large market can be created from both commissioners and Lead Provider integrators which can provide a model for delivering integrated care at scale. At the moment most of the evidence that the lead provider model will help to provide significantly better outcomes for the same resource comes from other industries.

We do however have three recent examples of how this is working in the NHS (see case studies below). It is also the case that within the last 6 months QIPP Right Care has been developing significant stakeholder interest in the Lead Provider model, including Royal Colleges, National Clinical Directors, Clinical Commissioners and several patient groups. This was initially developed through a set of interviews that have been published as a paper on the Right Care web site. [5]

[5] http://www.rightcare.nhs.uk/index.php/tools-resources/aics/

6 What are the barriers to the lead provider model?

Existing providers

For those existing providers of NHS care who believe that they can provide integrated care without disruption to their existing model of care and business plan, this model will provide a disruption which they will resist.

This resistance to disruption will take many forms but one will be a description of the Lead Provider as dangerous to patient care. Some will claim that the loss of direct relationship between commissioner and provider will destabilise their institution. They will also claim that at the moment the institution bound clinical governance of their work provides safer quality care that would be lost if they were subcontracting to a lead provider. It is in anticipation of these kinds of attacks that we have been developing the model through discussions with the Royal Colleges and patient groups. We believe it is also possible to show that if the lead provider model were to take hold of a number of programmes of care within the NHS, the existing institutions may gain a lot of their business by being subcontractors to different lead providers for different patient pathways. Some existing institutions may say that this explodes the capacity of their organisation to be responsible for a business plan in the same way that they are at the moment. Many providers across the NHS do however like the notion of a Lead Provider but only if *they* themselves are the Lead Provider!

Destabilising local NHS providers

There is anxiety within the NHS that new development in provision will destabilise NHS provision, especially in the acute sector. The problem is that the aim of a wide range of different financial and clinical policies *is* to take care out of the acute sector. This is bound to change the status quo in many acute providers and lead to what is experienced as destabilisation. This is an inevitable part of the search for greater value within the NHS. This model helps because it provides the existing acute provider with an opportunity of being part of a new business model. On their own, many acute providers do not find it easy to move away from their existing bed dependent hospital business. The lead provider model is a challenge because the contract that the Lead provider has is for health care outcomes that are essentially outside the control of the hospital, the acute provider will have the opportunity

to be a part of a very different non-hospital based business model. Over time those acute providers that would start as subcontractors may learn enough about this new business model to become the lead provider themselves. This does not protect the acute sector from the inevitable pressures of change but it does provide an organised way of restabilising the business as it moves away from a bed-based service model. It would also encourage some acute hospitals to rightly focus on their core business of acute, intensive, high specialised episodic care – demonstrating that a new hospital business model could be achieved by both downsizing bed numbers and specialising certain aspects of acute care" whilst allowing other NHS organisations such as mental health and community trusts or new providers to take on both the integrator function and also the specialist ambulatory care function within the community.

Pricing and costing

It is not possible to see how the NHS will thrive in the future under the current pricing model. Nearly all existing pricing relates to episodes of care and under this model standard PbR tariff would exist between the Lead Provider and all its Any Qualified Providers (AQPs). However the policy makers at every level in the NHS recognise that the development of episodic care contains no future for the NHS and many providers realise this too. Therefore it is essential to develop prices that move beyond episodes into pathways. The Lead Provider model will need a budget that is based around the existing budget for a total programme of care and not just the reproduction of episodes. These are nascent in a number of areas - most notably the work of Programme Budgets and The Year of Care within diabetes, but will need to be developed further. Whilst much of the NHS thinks PBR is a sacrosanct instruction from the top, the top of the NHS argues that the localities have the right to set bundled tariffs in the locality. Bundling of tariff along a pathway will provide the basis for many contracts for a Lead Provider model. In April 2012 this was recognised by the DH which is running a competition for health economies to act as demonstrator sites to develop the pricing for a year of care. This is an important development, not only for the content of the issue, that of working out the costs of a year of care for a long term condition patient, but also because of the form through which the DH has decided to carry out that development; asking local economies to do the calculations. [6]

[6] http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133650

Getting the frame right

Existing work that we have carried out shows that it is important to frame the contract at the right level of patient need. This is because integration needs to operate at a horizontal as well as a vertical level. For example, in Oldham is has been important to let the contract for all musculoskeletal services and not just for rheumatology or orthopaedics or carpal tunnel syndrome. There is also a recognised need for a specific focus of the needs of the frail elderly or those people of any age with complex co-morbidities who require a holistic specialist services, working closely with patients, their carers, primary, community, social care and the third sector, rather than a set of parallel highly specialised biomedical pathways. Other care groups such as children with complex disabilities or the homeless may exist outside of traditional medical Programme Budget Categories.

The need for integrators

It has proved difficult within the NHS to understand who will be actually carrying out the integrator role. Often the answer within the NHS is that it is "*everyone's role"* with every organisation having the duty to integrate. Of course such an answer will mean that it becomes "*nobody's role"* to do the hard work of integrating. This is why the NHS looks to organisational integration which we know is not the answer. The NHS looks at its existing institutional framework and sees very large institutions that provide secondary and tertiary care and mainly very small institutions that provide primary care. The former may well organise any integration around its own needs and not act as an honest broker and in most parts of the country the latter lacks the size to take this difficult task on. Since April 2011 some mental health trusts have increased substantially in size by taking on community health services and these, although they are new organisations, could act as Lead Providers. The few stand-alone community trusts could carry out this role in the future but for the moment they are currently organising themselves in their original role. It will be important for this model to be developed to scale to demonstrate how the skill of integrator will develop both within and outside the NHS. In our case study of Diabetes at Bexley the role of integrator has been carried out by a skilled individual who, whilst they are not medically qualified, has Type 1 diabetes and extensive knowledge and experience of the whole range of different services.

Contractual form

Most people within the NHS are used to operating within a very specific contractual form. GPs have a variety of contracts but most GP services result from individually based

providers. Secondary care consists of very large institutions that gain their revenues from payment by results contracts. These contracts are nearly all based upon payment for inputs rather than outputs or outcomes. Commissioners are used to using these contracts to micromanage providers around inputs and processes. The contractual form for a lead provider model would be very different since the commissioner will have no management function with any of the subcontractors but will need to have a clear relationship with the lead provider around delivery of high level patient centred outcomes with related milestones. The good news is that across the country there are GP commissioners that are working with new models of contracts to commission new models of care and a number of new contractual organisational forms have been developed that will meet these requirements.

Information & Intelligence

In healthcare as in any industry, knowledge transfer is critical when a process involves the collaboration of different parties or organisations. All effective supply chains (especially those dependent on a discrete logistics function) are characterised by explicit standards for terminology, coding and language which are written into contracts. These can then be supported by simple technologies for monitoring and assuring the efficient transfer of intelligence between the commissioner, the lead provider, and subsidiary providers.

The NHS has recently focused on new technology solutions (which is not in itself a bad thing), but has not addressed the disparity of terminologies or information standards used by different commissioners and providers. For example, very rarely do NHS commissioners robustly define what they mean by “Outpatient”, “Day Case” and “Inpatient”, or the critical information needed when care transfers between providers. If these are unequivocally defined, how these are achieved can be left to the various parties using whatever new or existing technology meets their wider business needs. A commissioner of an integrated care pathway that might be provided through a range of providers could lay a responsibility of the lead provider to ensure that there is a commonality of language and meaning from each of the contractors in the pathway. Most existing IT systems could support this but they are not used at the moment because there is insufficient power to drive the use of similar language and coding from very different partners. The Lead Provider model could make that happen.

7 How to make this happen

In the recent past many policy initiatives have not flourished because the capacity and the skills to carry them out have not been there when required. For example, with the current policy and practice of pricing. At the level of SHAs and the DH there is a policy that PCTs can, with agreement in their localities, unbundle the tariff and price their contracts in a way that make sense locally. But at PCT level and below they believe that the national policy does not allow them to develop unbundled prices. This is because the capacity and confidence to set prices are not there at these levels.

The same may be true for setting outcome based contracts for integrated care with an Accountable Lead Provider. This is a different process from the traditional input contract that has been at the core of NHS commissioning. It is also the case that the provider side of the market is not *there* at the moment; in the history of NHS commissioning there have been many occasions when it has been believed that the commissioner’s job is to *manage* the market when in fact first the market needs to be *made*. That is the case with the Lead Provider model. Whilst this is perfectly normal in a range of industries it is very unusual in health services and the market of potential integrative providers will have to be developed.

8 Case studies

Right Care is developing a series of case studies of different approaches to the Accountable Lead Provider model that are being developed in the NHS, covering both provider and commissioner perspectives. As of early July 2012 the first completed case study is of the Pennine Musculoskeletal (MSK) Partnership which can be found on the Right Care website http://bit.ly/rc_oldham_casebook

Over the summer of 2012 we will be developing further case studies including:

Bexley PCT – Diabetes care

Somerset – Pain services

Milton Keynes – COBIC (Capitated Outcomes Based Incentivised Contracts)

These will be published on the Casebook section of our website at:

http://www.rightcare.nhs.uk/index.php/tools-resources/casebooks/

9 How can the NHS Commissioning Board (NHS CB) support the development or more lead providers?

New outcome-based contracts around programmes of care

The Coalition Government have made it clear that they intend to measure the NHS against its new Outcomes Framework. This will mean that the NHS Commissioning Board, through the mandate that it will be given by the Secretary of State will be committed to driving Clinical Commissioning Groups to a set of national and local outcomes. The overall outcomes from which the specific will be drawn have been published in the outcomes based framework outcomes based model of commissioning health care. If the NHS Commissioning Board is going to transparently achieve that national mandate it will need to deliver for local and national commissioners a set of contracts that are outcome based. At the moment nearly all contracts used by NHS commissioners and providers are based upon activity - inputs and outputs. It is therefore unsurprising that most of the day to day experience of working with contracts in the NHS at the moment is based upon inputs and not outcomes. Unless the NHS Commissioning Board provides strong signals that it wants to develop relationships between commissioners and providers that drive for outcomes then it is unlikely that new behaviours that achieve outcomes will be delivered. We would argue that the lead provider model, because it has clear transparency and accountability from the commissioners to the lead provider is one of the models that is best suited to an outcome based model.

The NHS Commissioning Board will have a duty to help develop integrated services.

The draft mandate between the Secretary of State for Health and the National Commissioning Board makes it clear that the NHS Commissioning Board is expected to play a significant role in integrating care. "*Whilst shared local leadership will be essential, the Board will also have an important role to play in encouraging and facilitating integrated working, both as a national and local commissioner of services and through the way it supports CCGs. The Health and Social Care Act 2012 places a duty on the Board*

concerning promoting integration in the way in which services are provided" [7] There will be a range of different models of integrated care that the NHS Commissioning Board will want to signal to commissioners and providers. The one theme that will unite these models is that they will all have to operate within the existing model of providers, but can achieve integration in a variety of different ways. In encouraging new local commissioners to carry out their own duty to integrate care the NHS Commissioning Board will need to develop guidance around a number of different and alternative models of integrated care. One of those signals should be for the lead provider model. The NHS Commissioning Board could also assist the development of this model by requiring all providers of NHS services to use specified standardised information requirements. If they were to say that all providers had to have the same meaning and coding for sets of activities, it would make the lead providers task of bringing all of this information together a lot easier.

New forms of pricing for outcomes

Both monitor and the NHS Commissioning Board will have a duty to develop pricing systems .At the moment prices within the NHS have been developed for inputs and some outputs. If the NHS Commissioning Board wants to move NHS health care towards an outcome based framework, it will have to develop prices for outcomes. As these are developed we would argue that a lead provider model will be well placed to succeed in using such a form of pricing. The year of care model is developing its own pricing that has moved beyond the traditional episodic care. The work on the year of care project has been carried out within a number of localities. But from April 2012 the DH has started to run a competition where local health economies are being asked to demonstrate how, over this coming year, they will succeed in developing the detailed pricing model of a year of care

[7] Our NHS care objectives A draft mandate to the NHS Commissioning Board DH July 4 2012 page 20-21 par 3.16

Appendix 1

There are a number of localities in the NHS that are already working on this model but are at different stages of development. We hope to publish further Case Studies on these as they develop.

1. Have been commissioned but services not yet up and running

- Oldham - sexual health
- Oldham - mental Health (£35M)

2. Currently being commissioned

- Oldham - Visual Health
- North and Mid Essex PCT – Diabetes – in this case the CCG/PCT is running a competitive dialogue to develop a specification for a lead provider of integrated services for diabetes. This will be issued in the autumn after the dialogue
- Sussex PCT – Musculoskeletal disease
- Bedford PCT – Here, the CCG is developing a Capitated Outcome Based Incentivised Contract (COBIC) for all of its musculoskeletal services (over £30 million) which it aims to let to a single accountable Lead Provider

3. Currently at advanced planning stage

- Peterborough PCT - Respiratory and MSK
- Gloucestershire PCT - MSK
- Oxfordshire -Frail Elderly - In response to a failure by providers to deal with delayed discharge the CCG is developing a Capitated Outcome Based Incentivised Contract (COBIC) for all of its frail elderly services which it aims to let for a single contractor