NHS Commissioning Assembly

NHS

Commissioning for outcomes:

A narrative from and for clinical commissioners

Gateway reference number: 01801

Foreword

ROS ROUGHTON
National Director, NHS England

*Co-chair of **NHS Commissioning Assembly***

The importance of outcomes in healthcare and the NHS has been widely recognised for many years - from preventing people from dying prematurely to helping people to enhance their quality of life. The pursuit of these outcomes is what has driven and continues to drive people who make up one of the best healthcare organisations in the world today.

As commissioners of healthcare – both at the national and local levels – we want a commissioning architecture that gives people the best possible opportunity to achieve those outcomes, and commissioning models that align incentives for those who provide care with the outcomes that matter most to the populations we serve.

What outcome-based commissioning and contracting models could and should look like is very much a hot topic at the moment, and this is why I welcome this discussion document on 'commissioning for outcomes' produced by the NHS Commissioning Assembly's Quality and Outcomes Working Group.

I believe this paper can be a stimulus to the ongoing conversations, and pioneering work by a number of CCGs on outcomes-based commissioning models, which I hope will encourage all of us – as a community of commissioners – to support and learn from each other on 'what works'. This collaborative, testing, and learning approach is central to the work of the NHS Commissioning Assembly.

The NHS Commissioning Assembly Quality and Outcomes Working Group brings together commissioners to work with each other to find solutions, which is exactly the approach that is needed. This narrative on 'Commissioning for Outcomes' is a really good starting point for us to have those vital discussions to be able to move CCGs from 'where we are now' to 'where do we want to be?'

NHS Clinical Commissioners, the independent membership body for CCGs in England, is pleased to be working with the NHS Commissioning Assembly on this piece of work, and our *Making Change Happen: A CCG manifesto for a high-quality sustainable NHS* document, published on 1st May and welcomed by Simon Stevens at our national members event, provides the groundwork for the discussions. It sets out eight key asks of the system to enable CCGs to fulfil their roles, and looks to change the policy landscape to help turn the 'where do we want to be?' theory into the practicalities of 'how do we get there' in Commissioning for Outcomes discussions.

DR. AMANDA DOYLE
Chief Clinical Officer, NHS Blackpool CCG.
*Co-chair of the Leadership group of **NHS Clinical Commissioners***

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Executive summary

*The purpose of this document from the Quality and Outcomes Working Group (QWG) is to stimulate discussion amongst CCG members on the **practical tools** we now require to be developed for all 211 CCGs, as well **the barriers** that need to be removed, to support our commissioning for outcomes*

QWG developing clinical commissioner narrative on 'Commissioning for Outcomes

1. Why important?

- As clinical commissioners we need to **understand the outcomes that matter most to people in our communities** – these 'citizen outcomes' should guide our decisions and how we work with partners
- Focussing in on health, commissioners are using the outcomes set out in the **NHS Outcomes Framework** – we are all planning in our 5 year strategic plans to improve these 'health outcomes'
- Many clinical commissioners actively want to commission for better outcomes for their local populations, but many of us are **not clear on what the most appropriate approaches are**, and at the same time many of us are also identifying **practical challenges** to commissioning for better outcomes, which we need support to overcome

2. Where are we now?

- We are currently developing our **5-year strategic plans**, and while the pace of the process is challenging, we can use it to enable a system-wide focus on outcomes
- But much of our day-to-day capacity as local commissioners is focused on the immediate challenges we face, creating a risk that we simply **default to 'doing what we already know'**
- There is though, **a wide spectrum of commissioning models and approaches** that we could be considering in commissioning for outcomes
- Effective commissioning for outcomes fundamentally requires **alignment of incentives around those outcomes**, but we require more evidence on 'what works' to best design those incentives

3. Where do we want to be?

- Firstly, we need to have the **capability** to commission for outcomes – we need to share understanding of what approaches may be effective, in what situations and the potential pitfalls
- Secondly, as local commissioners we need to have the **capacity** locally to commission for outcomes – what resources do we need to make sure our commissioning approaches work?
- Thirdly, as local commissioners we need to have **confidence** to be able to transition from existing models of commissioning to new models with the potential to deliver better outcomes

4. How can we get there?

- In the short term, we need to understand **how to work systematically through some of the key questions** we need to answer before we commit our limited resources
- We need to create a **culture of rigorous testing, openness to learning and continuous adaptation –** this means embracing new ideas and getting serious about evaluation
- As local leaders we need to see **positive signals from national leaders** – across the whole health system and political divides – that they will support the testing of new approaches

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Understanding commissioning for outcomes in 10 seconds…

The key principle behind commissioning for outcomes is a clear **focus on the actual results being achieved** for the individual and for populations and putting in place commissioning models and/or pathways of care to achieve those results

Introduction

DR. PAUL HUSSELBEE

Chief Clinical Officer, NHS Southend CCG

Co-Chair, NHS Commissioning Assembly Quality and Outcomes Working Group

The NHS and local commissioners across England face enormous challenges – how to deliver better for less; how to protect the fundamental principle of universal healthcare free at the point of delivery; how to shift the focus towards prevention; how to empower citizens with more control over their own care; and how to create a culture which is open to innovation and new ideas.

So, as clinical leaders we now need to lead our local health economies to use the challenges we face, financial and otherwise, as a platform to drive the systemic and behavioural changes needed to secure continuous improvement in health outcomes for our local populations. To state the obvious; this is challenge for us as clinicians, but it is also a real opportunity for us to make the system work better through our new commissioning partnerships.

I personally have learnt over the last 12-18 months the power of working in partnership with my health and care colleagues locally – providers, other commissioners, local authority colleagues and others – to co-design our vision for the future of our health economy, with an opportunity to truly put citizen outcomes at the heart of everything we do .

Over the past year the NHS Commissioning Assembly – and in particular the work of the Quality & Outcomes Working Group (QWG) made up of local clinical commissioners working hand in hand with area, regional and national directors in NHS England on the quality and outcomes agenda – have been focused on how commissioners can really drive continuous improvements in outcomes across the whole commissioning system.

The first phase of this work involved supporting NHS England in putting in place a mechanism that enables commissioners to articulate what they are trying to achieve for their local populations in terms of the outcomes that really matter to the public over the medium and long term.

Everyone Counts: Planning for Patients 2014/15 to 2018/19, published in December 2013, asked that all CCGs, together with their NHS England Area Teams jointly plan for improvements in seven overarching outcomes, setting quantifiable levels of ambition. For the first time, commissioners have been asked to plan on a five year trajectory. This has given us the chance to compare ourselves against each other in terms of outcomes and to learn from each other.

But to realise this opportunity we all need to understand how we make our ambitions to improve outcomes for everyone in our communities a reality.

We need to understand both how to agree and set outcomes measures around the areas that matter most to our communities, and then how we can contract for these outcomes.

What is apparent is that 'commissioning for outcomes' is a spectrum – from designing services and judging providers in terms of the outcomes they secure, to contracting on a purely outcomes basis. But throughout the spectrum, 'commissioning for outcomes' means focussing less on what is done to people, and more on the results of what is done.

While few of us would disagree with the principle of commissioning for better outcomes, actually making this a reality is a real challenge – outcomes can be more difficult to measure, improvements take longer to become visible and contracting on an outcomes-basis can be more complex.

This is a journey - some commissioners are already well on their way, either in their thinking or in actually contracting for outcomes on the ground. Yet others are at the start of their journey and are looking for encouragement and confirmation that they are not alone. That is why the NHS Commissioning Assembly are taking a keen interest in supporting commissioners in this area.

To kick off the work, a Task and Finish Group has produced this narrative to stimulate discussion around what the opportunities and challenges are in commissioning for outcomes. This is the first step.

Over the coming year we want to work together to help the pioneers go further, faster and to support those at the beginning of their journey to learn from what has worked. So we will develop practical support and resources, working to overcome some of the more systemic barriers that commissioners are facing.

As clinical commissioners we need to understand the outcomes that matter most to people in our communities – these 'citizen outcomes' should guide our decisions and how we work with partners

Ultimately as clinical leaders we want to enable our local communities to be the healthiest and happiest places for all citizens to live…

I want to live a long and healthy life, and have as much control as possible over my own life and health

I want to enjoy life with those people I care most about – my friends and my family

I need to feel safe and secure where I live

What do we, as citizens, really want?[1]

I want to say I have been able to achieve everything I want to achieve

I want to play an active part in making my community a great place to live

If I do need healthcare, I want to know that I will get the most clinically effective and safe treatment as possible

The NHS Outcomes Framework sets out the health outcomes that the NHS is responsible for securing – see following slide

…but if we stop and think about the real drivers of a healthy and happy life, we see that they reach far beyond the traditional boundaries of a clinician or the NHS

For ideas from the Task and Finish Group on how to think differently about improving some of these 'citizen outcomes' see Annex B

Building blocks of a healthy and happy life[2]

- Income
- Employment
- Education
- Family
- Community
- Environment
- Physical health
- Mental health

Higher **income** is associated with greater **well-being**

Research shows that the happiness of a close contact increases the chance of being happy by 15%. The happiness of a 2nd-degree contact (e.g. friend's spouse) increases it by 10%.

Anxiety, depression, pessimism and a lack of enjoyment of daily activities have all been found to be associated with higher rates of disease and shorter lifespans

1. *Adapted from:* Bowling et al (2003) Let's ask them: a national survey of definitions of quality of life and its enhancement among people aged 65 and over, *International journal on aging and human development, vol. 56(4)*, and Bronnie Ware (2012) The top 5 regrets of the dying
2. Adapted from: Legatum Institute (2014) Wellbeing and Policy

In health, we are all already focussing on the outcomes set out in the NHS Outcomes Framework – we are all planning in our 5 year strategic plans to improve these 'health outcomes'

Everyone Counts: Planning for Patients 2014/15 to 2018/19, published in December 2013, asked that all CCGs, together with their NHS England Area teams jointly plan for improvements in seven overarching outcomes and set quantifiable levels of ambition for improvement over five years.

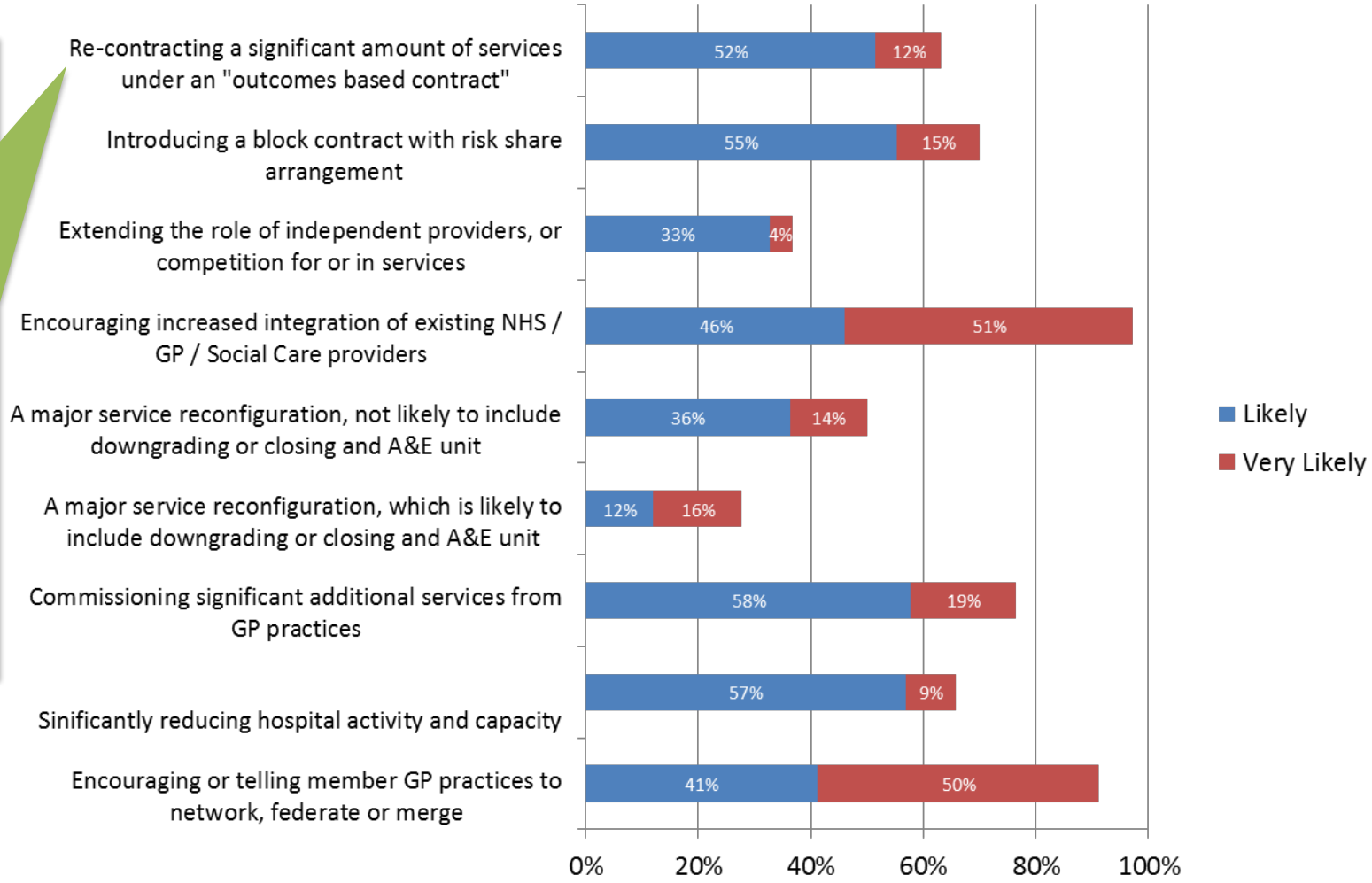
The NHS Outcomes Framework domains…		…articulating our ambition
1	Preventing people from dying prematurely	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
2	Enhancing quality of life for people with Long Term Conditions	2: Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
		3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
3	Helping people to recover from episodes of ill health or following injury	4: Increasing the proportion of older people living independently at home following discharge from hospital
4	Ensuring people have a positive experience of care	5: Increasing the number of people having a positive experience of hospital care
		6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
5	Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

We know that by understanding variation in outcomes within our communities and in comparison to other like-areas, we can maximise our impact on improving outcomes, and in doing so reduce inequalities. However, we need robust and timely data and evidence as to what works.

Many clinical commissioners actively want to commission for better outcomes for their local populations, but many of us are not clear on what the most appropriate approaches are…

How likely do you think it is that your CCG will employ each of these approaches to changing services and staying within its budget, over the next 12 months?[1]

Potentially all of these approaches may be effective in driving improved outcomes and better value for our local populations. As a local clinical commissioner what I really want to know is which approaches would be the most appropriate and effective for the issues we face locally?



1. CCG Barometer, Spring 2014 (HSJ / PWC.) n=101-3

…and at the same time many us are also identifying practical challenges to commissioning for better outcomes, which we need support to mitigate

Over the past year, through the work of the NHS Commissioning Assembly's Quality & Outcomes Working Group, we have heard a number of consistent insights and issues around commissioning for outcomes[1].

We have listed these below, and going forward we will be investigating what support clinical commissioners require to overcome these barriers

Path dependency

- Hard to challenge existing ways of providing care , or break with existing provider relationships
- Traditional organisational silos locally preventing joint commissioning and pooling of budgets.

Incentives & alignment

- Operational contracts and payments continue to focus on activity rather than results and outcomes
- Future (cashable) savings from better early intervention not aligned to where the early interventions need to happen
- Challenges around attribution within shared contractual / delivery / outcome / risk models

Measures

- Commissioners don't have clearly defined and agreed metrics (across providers) to measure success in terms of outcomes
- Issues on both the robustness of the data and timeliness

Complexity

- Hard to attribute role of a single provider vs other factors in improving outcomes. Outcomes can be complex cutting across multiple public services locally
- Getting the risk-reward ratios right, otherwise potential new providers could be deterred
- Challenges of having multiple commissioners across care pathways (e.g. CCG(s), NHS England Area Team(s), local authority – key to overcoming this is working effectively through Health and Wellbeing Boards.

Capacity & Capability

- Transitioning to new contracting models is currently a high-resource and lengthy process
- Commissioners raising concerns with how to de-commission services, and how to manage failure

1. Quality & Outcomes Working Group monthly teleconferences and quarterly workshops with local clinical commissioner leads and NHS England.

We are currently developing our 5-year strategic plans, and while the pace of the process is challenging we can use it to enable a system-wide focus on citizen outcomes

Case study: NHS Southend CCG hosted a workshop in May with stakeholders from all across the local health economy to discuss the development of their '5-year strategic vision'

"We need to move away from a medical view that primarily sees people as patients (passive recipients of care), to one that sees people as citizens (active participants in driving improved outcomes)"

"Let's have one, system wide, collective vision for Southend that citizens understand, rather than 20 different organisational visions"

"Where are the opportunities to pool budgets and co-commission across the whole care pathway, especially for our at-risk populations?"

"How can we all help (social care, primary care, private sector, third sector) to ease the pressure on our A&E services"

(Draft) Southend health system strategic vision 2014-2019 : We aim to ensure that everyone living in Southend on Sea has the best possible opportunity to live long, fulfilling, healthy lives[1]

We want:

- our children to have the best start in life
- to encourage and support local people to make healthier choices
- to endeavour to reduce the health gap between the most and least wealthy
- people to have control over their lives, and to live as independently as possible
- to enable our older population to lead fulfilling lives as citizens

We will deliver this by:

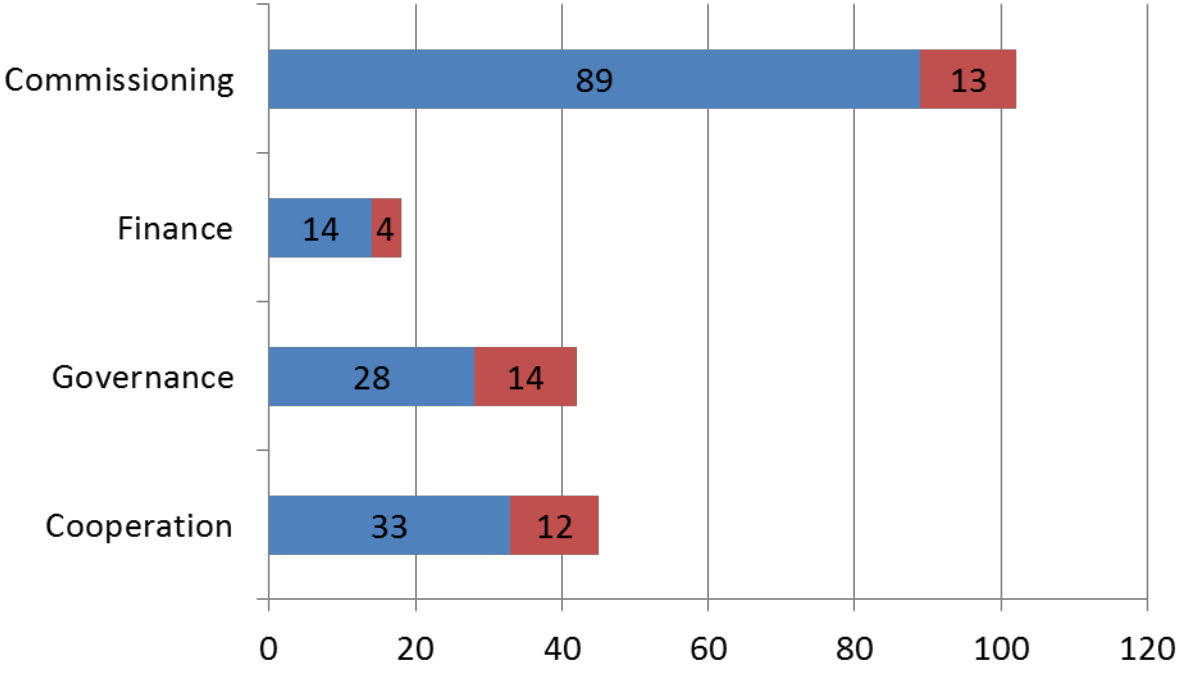
- Planning and operating as a single health system, maximising our offer to the citizens of Southend
- Understanding and proactively improving the health of the people living in Southend-on-Sea
- Providing access to the right care, at the right time, and in the right setting
- Creating an efficient and effective health system that is focussed on quality of care, delivered within our resources

1. NHS Southend CCG 5-year vision workshop (13th May 2014)

But much of our day-to-day capacity as local commissioners is focused on the immediate challenges we face, creating a risk that we simply default to 'doing what we already know'

CCGs have over 200 core functions set out in primary and secondary legislation ranging from a 'duty to commission certain specified health services' through to a 'duty to attend local resilience forum meetings' – we need to ensure as clinical leaders we have the space and strategic capacity to really understand the detail of 'what works' when commissioning so we can use our statutory duties and powers to drive the system, not the other way around

No. of core CCG functions as set out in legislation[1]



the "must dos' that we are legally responsible for delivering

the things we have the freedom to do (if we wish) to help meet these duties

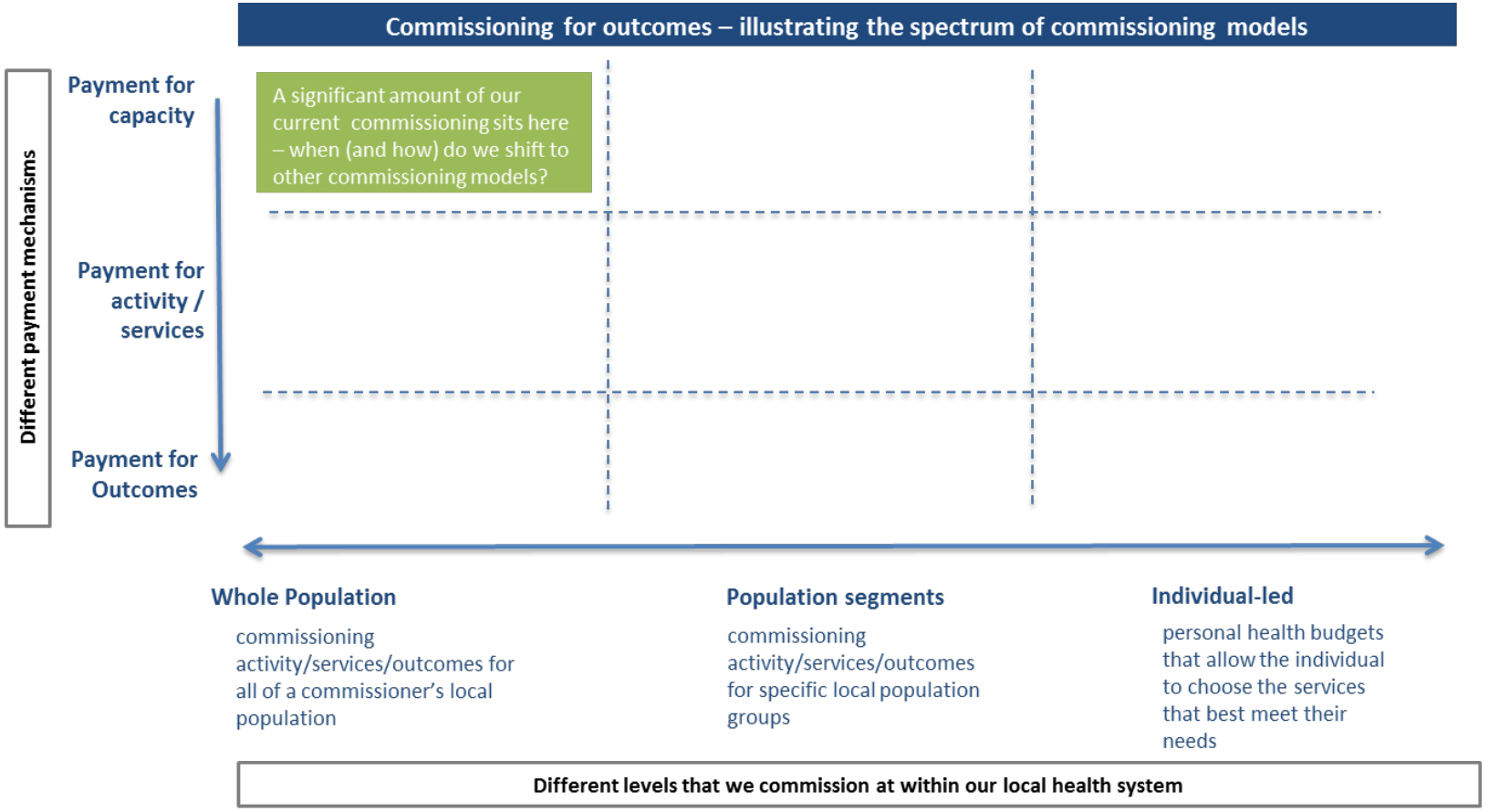
1. NHS England (2013) The functions of clinical commissioning groups

There is though a wide spectrum of commissioning models and approaches that we could and be considering in commissioning for outcomes

While all of us want to commission for the best outcomes possible for our local populations, many of us are currently grappling with which models of commissioning practically help us achieve the best outcomes.

Commissioning for outcomes can take different forms – it does not necessarily mean adopting purely outcomes-based contracting approaches. It could be at a basic level incorporating more outcomes-based success measures into existing contracts.

We know from practical experience that individual direct payments or outcome-based contracts are not always feasible or even appropriate – so we need to be able understand how we determine which commissioning model to adopt. The diagram below illustrates the spectrum of commissioning models. A short description of a number of different types of innovative commissioning models are set out in **Annex C**.



Effective commissioning for outcomes fundamentally requires alignment of incentives around those outcomes, but we require more evidence on 'what works' to best align the incentives

As clinical commissioners we need to understand the whole supply chain – from planning through to implementation, and beyond – and how we can design the system and choice architecture to drive continuous improvement in outcomes

Do we set these for a service or a population? What is feasible in my locality?

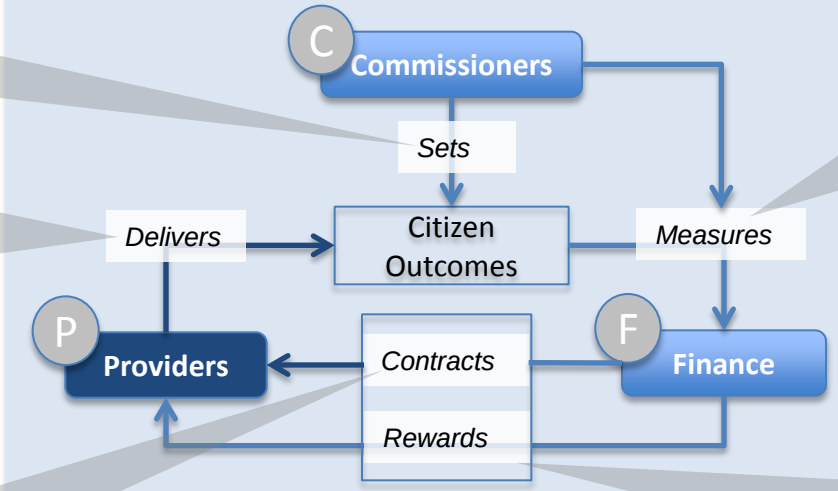
What models work best for integrating all the different assets and provision we have across the local health and care system to improve outcomes across , e.g. primary, community, acute, social care and specialist services

What length of contract is most suitable and feasible to best achieve the outcomes we want – 1 year, 5 year, 20 years?

What are the best outcome metrics to set contracts with? Do we collect the necessary data? Are we confident in the timeliness and accuracy of that data?

Payment for provision of defined capacity or actual activity, payment conditional on the delivery of specified outcomes or quality standards, or a blend of all of these?

A basic framework to understand Commissioning for outcomes



C — Local commissioners establish (co-designed with their local populations) the outcomes they want providers to deliver for their local populations

F — Commissioners then use these outcomes to establish key measures that they will financially reward a provider or collaboration of providers to deliver over a certain period

P — Providers respond to the financial incentives – aligned to key outcomes - to design and deliver their activity, or even whole care pathways with other providers, to gain that payment

Firstly, we need to have the capability to commission for outcomes – we need to share understanding of what approaches may be effective, in what situations and the potential pitfalls

As we shift to outcomes and population based models of commissioning, we need to learn from what has (and has not) worked. Clinical commissioners are beginning to test new models of outcome based commissioning which should be supported and encouraged. And, as a whole commissioning system, rather than continually reinvent the wheel or innovate in isolation we need to find a mechanism that makes that learning available to all of us in a salient and easy to use format

How can we as clinical commissioners most effectively learn from 'what works' and (equally important) 'what did not work' from new commissioning models being tested around the UK?

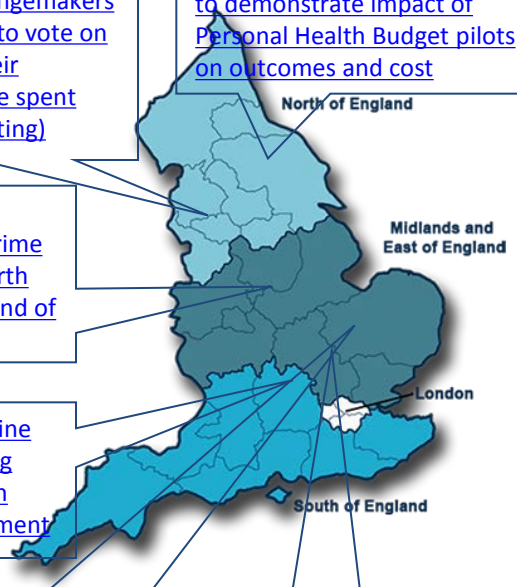
What can we learn from other commissioning models globally, and how do we support a culture for all clinical commissioners to be open to new ideas and continuously innovating to improve our commissioning?

MANCHESTER – Changemakers enabled 550 people to vote on how a budget for their community should be spent (participatory budgeting)

YORK UNIVERSITY – Randomised control trial used to demonstrate impact of Personal Health Budget pilots on outcomes and cost

STAFFORDSHIRE – planning for a 10yr prime provider contract worth £1.2bn on cancer & end of life outcomes

OXFORDSHIRE– Lifeline recovery hub, piloting Payment by results in drug & alcohol treatment



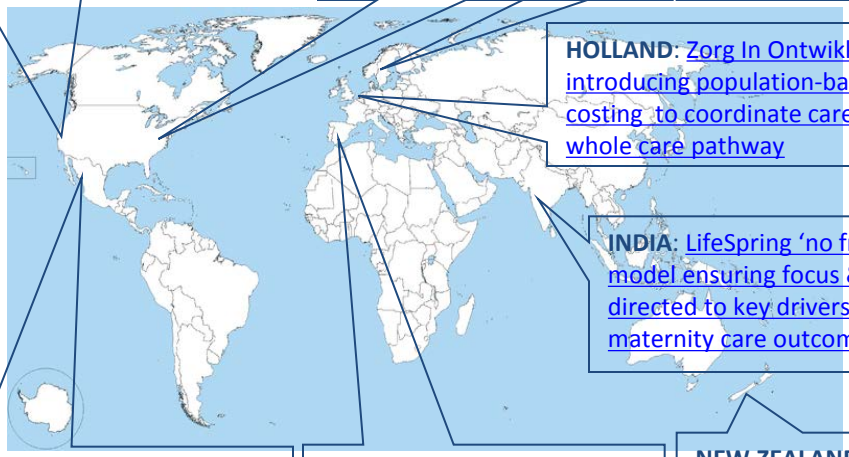
PETERBOROUGH - Social Impact Bond model bringing in private investment and third sector innovation to both improve outcomes (reduce reoffending) and release cashable savings

BEDFORDSHIRE – bundled 20 contracts for musculoskeletal care into one five-year payment-for outcomes contract

USA (CAL): Kaiser Permanente aligning 5-10% provider rewards to patient satisfaction, peer appraisal and Healthcare Effectiveness Data

USA (MASS): Alternative Quality Contract - Links financial incentives to clinical quality, patient outcomes and overall resource use to control provider spending

SWEDEN: Clinicians in Jonkoping county created 'Esther' to map and monitor patient flows and outcomes



HOLLAND: Zorg In Ontwikkeling (ZIO) introducing population-based-costing to coordinate care across whole care pathway

INDIA: LifeSpring 'no frills' model ensuring focus & finance directed to key drivers of good maternity care outcomes

MEXICO: Progresa-Oportunidades social program using direct payment incentives, aligned to improving health, education and general wellbeing outcomes of most vulnerable

SPAIN: Alzira model covering both primary & secondary care. Commissioner confines 15-30 year contract to the specification of outcome measures and only a small number of process measures

NEW ZEALAND: Christchurch District Health Board using Alliance contracting - Providers working collaboratively towards outcomes within a single overarching contract

Secondly, as local commissioners we need to have the capacity locally to commission for outcomes – what resources do we need to make sure our commissioning approach works?

Commissioning for outcomes is resource intensive – it requires time and energy from our teams, whose resources are limited. To give us the best possible chance of succeeding in adopting new models, we need to have the **basics** of commissioning in place throughout the commissioning cycle:

Planning

- Understand the current and future **risk profile** of our local populations
- **Partnerships** with key local partners (i.e. arrangements for joint commissioning / pooled budgets)
- **Benchmarking current performance data** on outcomes against like-areas, best practice and previous trends to identify opportunities to achieve both technical and allocative efficiencies
- Understanding the **current system** and how current **incentives** work
- Effective governance and leadership to lead change

Securing

- Understanding whole **provider landscape**
- Access to **unit prices** and **comparable cost data**
- Ability to negotiate best possible price, and exit clauses if contract failing to deliver desired outcomes / value
- **Contract forms and specifications** – aligning incentives and putting in place effective risk / reward mechanisms
- **Quality Assurance** of contracting – understanding the impact on quality of contracts so that risks can be actively managed

Monitoring

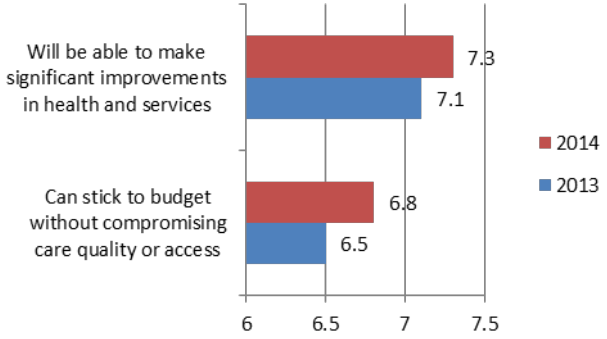
- Clearly defined **outcome (and activity) metrics** to monitor and evaluate impact of contract and hold providers to account
- Regular data reporting in place, at the most granular level possible, on the key outcomes / activity contracted for
- Ability to effectively **renegotiate contract or switch contracts** if failing to deliver and to claw back costs from providers

1. See: NHS Clinical commissioners (2014) *Making change happen: A CCG manifesto for a high-quality sustainable NHS*

Thirdly, as local commissioners we need to have confidence to be able to transition from existing models of commissioning to new models with the potential to deliver better outcomes

One year on, clinical commissioning groups confidence has grown…

On a scale of 1-10, how confident are you that over the next 12 months your CCG…



…and CCGs do have ambitious plans for the next 12 months…

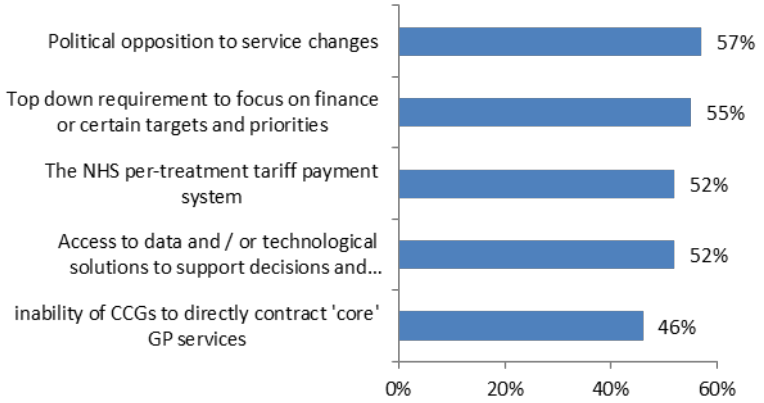
9 out of 10 plan to encourage member GP practices to network, federate or merge

Two thirds of CCG say they're likely to significantly reduce hospital activity

Nearly all (97%) plan to encourage increased integration across the NHS, GPs and social care

…but CCGs will need clear signals and support from national leadership to overcome significant barriers

Top 5 issues identified as significant barriers to delivering service improvements(%)…



This requires strong and collective leadership at the national level, with clear signals that commissioners should be striving and agitating to improve population-based outcomes. This narrative is designed to help start that conversation.

SOURCE: HSJ's CCG Barometer, supported by PwC, was carried out in March 2014. There were 103 respondents, covering 93 of the total of 211 CCGs. 96 respondents were chairs or accountable officers and the remainder were other governing body members. See: PwC (2014) *Clinical Commissioning Groups: one year on*

In the short term, we need to understand how to systematically work through some of the key questions we need to answer before we commit our limited resources

Illustrative decision tree

What do we need to know before embarking on designing and testing new models of commissioning?

Feasibility: have we got the capability and capacity to make it work?

- Have we got the right skill-set / support to do this locally?
- What are our current 'must dos'? What impact will a potentially resource-intensive process on designing new models have on our 'must dos'?
- Do we have the basics in place? (i.e. information on current performance / unit costs of service, or risk stratification of local populations)

Acceptability: do we have good relationships across the local health economy?

- How strong are our partnerships with key local stakeholders?
- Is there a clear clinical case for change, and can we utilise the challenge from NHS England to make our case for co-commissioning?
- Do we really understand how to manage risk (financial, operational AND reputational)

Suitability: Is the resource & costs of shifting to a new model proportionate to the issue we're trying to tackle / gains that are likely?

- How destabilising will this be to our current commissioning and do we know how to mitigate?
- With limited resources, are we focussing on the areas where we really think we can get better value for our resources
- Is the timing right? Does it tie in to current contracting round opportunities?

This is an illustrative decision tree developed by the Task and Finish Group to test whether such a tool would be useful. The aim of such a decision-making tool would NOT be to prescribe any specific contracting model,- rather the aim would be to provide a framework that commissioners can use to identify where it might (or might not) be beneficial to explore more innovative and radical ways of commissioning to improve outcomes

We need to create a culture of rigorous testing, openness to learning, and continuous adaptation – this means embracing new ideas and getting serious about evaluation

We need to be open to new ways to understanding how we can make better choices and decisions as commissioners

For example using tools and insights from behavioural science could help us to understand how to design contracts that take into account the human behaviours better

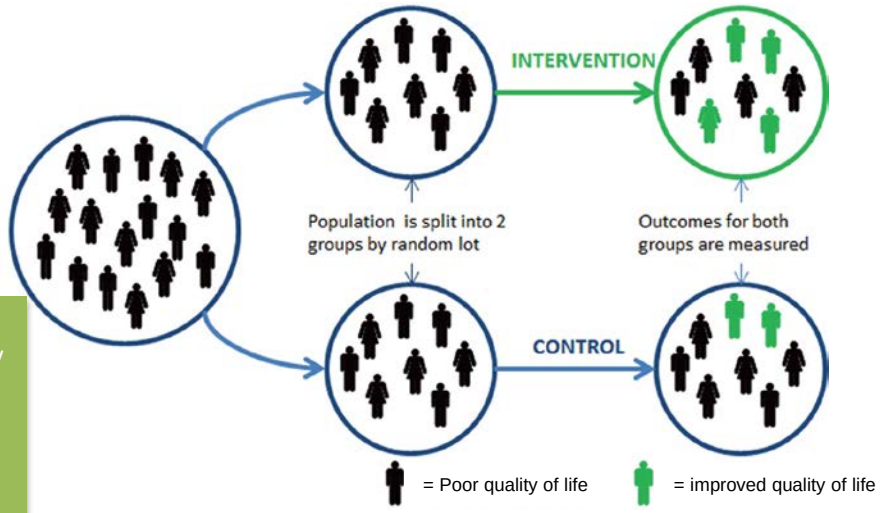
MINDSPACE framework[1]

1. **MESSENGER** (we are heavily influenced by who communicates information)
2. **INCENTIVES** (our responses are shaped by predictable mental shortcuts –i.e. loss aversion)
3. **NORMS** (we are strongly influenced by what others do)
4. **DEFAULTS** (we 'go with the flow' of pre-set options)
5. **SALIENCE** (Our attention is drawn to what is novel and seems relevant to you)
6. **PRIMING** (Our acts are often influenced by sub-conscious cues)
7. **AFFECT** (Emotional associations can powerfully shape our actions)
8. **COMMITMENT** (We seek to be consistent with our public promises, and reciprocate acts)
9. **EGO** (We act in ways that make us feel better about ourselves)

What if we started to apply some of the MINDSPACE framework checks to our contract designs?

New approaches need to be robustly tested, using control groups – in exactly the same way we test out new medicines

Basic design of a randomised control trial



Randomised controlled trials (RCTs) are an effective way of determining whether a new model is working. They are now used extensively in international development, medicine, and business to identify which policy, drug or sales method is most effective. Where they differ from other types of evaluation is in the introduction of a randomly assigned control group, which enables comparison between the effectiveness of a new intervention against what would have happened if you had changed nothing.

RCTs are just one approach to testing – they may not always be appropriate or possible, and re are others methods. For example, peer review.

1. Cabinet Office and Institute for Govt (2010) Mindspace, 2. Behavioural Insights Team (2012) Test, Learn, Adapt

As local leaders we need to see positive signals from national leaders – across the whole health system and political divides – that they will support the testing of new approaches

Department of Health – Secretary of State

"I want to challenge you to be the guiding lights in your areas …You are the people who know what to do with your area, and you are the people as doctors who can also persuade other doctors of the care pathways that need to happen, and I think this will be a real moment when we can do something incredibly exciting."

(Jeremy Hunt, NHS Clinical Commissioners conference 01/05/2014)

NHS England - CEO

"…as NHS managers we're not just in the business of performance; as NHS leaders we're in the business of change. As the legendary Peter Drucker put it: 'There is nothing so useless as doing efficiently that which should not be done at all.' That means constantly asking: why are we doing it like this? Is there a better way?"

(Simon Stevens, Kings Fund speech 21/05/2014)

NEXT STEPS: Where do we need to go next?

The purpose of this document is to frame some of the high level opportunities and challenges around commissioning for outcomes, where we are in June 2014 in the development of the commissioning system.
In developing this narrative, and engaging with other commissioners , we have identified a number of areas where we believe further work is needed, either to develop practical support, resources and learning for commissioners to draw on, or to overcome some of the more systemic barriers commissioners are facing.

Key issues for further consideration and support development:

How to define the priority areas and the target populations for outcomes-based commissioning	Evidence of cost / benefit from adopting different models for different groups	Models of care and Innovative contracting models	Practical steps to developing and implementing an outcomes based approach, including competency framework	Pricing & incentives (including learning from aligned initiatives e.g. Year of Care & Personal Health Budgets)
Overcoming systemic challenges – competition rules, multiple commissioner arrangements, provider willingness to collaborate	Defining outcomes and metrics	Understanding risks and approaches to risk-sharing arrangements	Collaboration - across whole communities and care pathways and also between specific groups	Data and information sharing

This is a diverse and complex topic list. Our work so far tells us that commissioners would welcome a library of 'how-to' guides perhaps as part of a web-based interactive tool, to guide them going forward. This should facilitate continuous improvement, acknowledging all that those accessing may be at different starting points.

The Quality & Outcomes Working Group and Commissioning for Outcomes Task & Finish Group of the NHS Commissioning Assembly will be working to take this forward. More details on both are in the following slide.

NEXT STEPS: How to get involved

Commissioning for outcomes is an agenda which commissioners (both CCG and NHS England) across the country are thinking about. The NHS Commissioning Assembly has identified this area as a priority for its work programme in 2014/15. This will be taken forward both through the national network and through focussed working groups.

Quality & Outcomes Working Group

The Quality & Outcomes Working Group (QWG) was established by the NHS Commissioning Assembly in 2013 to enable local commissioners and national directors to work together on the Quality agenda and to drive implementation of the NHS Outcomes Framework.

It is chaired by Dr Paul Husselbee, Chief Clinical Officer at Southend CCG. Currently there are over 45 members (including the five national clinical domain directors, the national director for the NHS Quality Framework, over 30 directors of local CCGs and a number of NHS England area and regional team directors).

The role of QWG members, and the products being developed, focus on two key aspects:

- Supporting commissioners in fulfilling their role in assuring the quality of care being provided to their communities, by identifying what more could be done to clarify and support them in this role
- Connecting the local priorities and activities of CCGs with the national action of NHS England, under a common vision for driving improvement in quality and outcomes, with associated resources and materials to support commissioners

While the group was only formed last year and is very new, it meets regularly and is now highly active and influential in driving the quality agenda across the whole NHS commissioning system. If you would like to be involved please contact Karen Kennedy (Karen.kennedy7@nhs.net)

Commissioning for Outcomes Task and Finish Group

The Commissioning for Outcomes Task and Finish Group was established at the beginning of 2014 to look at the best ways of offering practical help to commissioners who want to explore innovative ways of contracting and commissioning. The group is chaired by Dr Sunil Gupta, Clinical Accountable Officer for Castlepoint and Rochford CCG and led by Sarah Pudney, Commissioning Skills Lead at NHS England. Seven other are CCGs represented on the group.

To date the group has identified and is working towards a number of support offers. These are:

- A roundtable event focussing on enablers and practical actions to help commissioners with outcome based commissioning. This took place on 17 June and a summary report, videos and a full report will follow.
- A scoping exercise to identify current CCG activity around outcome-based commissioning and innovative contracting. The first phase will be a searchable database on the NHS England Learning Environment.
- A decision-making tool for commissioners to help identify possible commissioning models.

If you would like to get involved in any way please contact sarah.pudney@nhs.net.

ANNEXES:

Annex A: **Further Reading**

Annex B: **Possible opportunities for commissioners collaborate with others operating in local communities**

Annex C: **Different types of innovative contracting models**

Annex A: **Further Reading**

- UK Cabinet Office Centre for Social Impact Bonds (2013) *Knowledge Box.* www.data.gov.uk/sib_knowledge_box/printpdf/book/export/html/13
- Institute for Government (2012) *Commissioning for success.* *http://www.instituteforgovernment.org.uk/publications/commissioning-success*
- Institute for Government (2014) *Beyond Big Contracts: Commissioning public services for better outcomes.* *http://www.instituteforgovernment.org.uk/sites/default/files/publications/Readiness%20for%20Complex%20Contracting_final_word_version_feb_2014.pdf*
- 2020 Public Services Trust at the RSA (2010) *Payment by outcome: a commissioner's toolkit.* *http://clients.squareeye.net/uploads/2020/documents/payment_outcome.pdf*
- 2020 Public Services Trust at the RSA (2011) *Payment by outcome in long-term condition management.* http://clients.squareeye.net/uploads/2020/documents/LTCM%20case%20study.pdf
- The Kings Fund (2004) *Managing chronic disease: what can we learn from the US experience?* *http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/managing-chronic-disease-what-can-we-learn-from-US-experience-publication-dixon-lewis-rosen-finlayson-gray-1-january-2004.pdf*
- HM Government (2011) *Open Public Services White Paper.* https://www.gov.uk/government/publications/open-public-services-white-paper
- KPMG (2011) *Payment for success – how to shift power from Whitehall to public service customers.* *http://www.kpmg.com/ca/en/issuesandinsights/articlespublications/pages/payment-for-success%E2%80%93how-to-shift-power-from-white-hall-to-public-service-customers.aspx*
- Sir John Oldham and the independent commission on whole person care (2014) *One person, one team, one system.* *http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf*
- The Health Foundation (2014) *What can the UK learn from Healthcare innovation in India?* *http://www.health.org.uk/publications/what-can-the-uk-learn-from-healthcare-innovation-in-india/*
- UK Behavioural Insights Team (2012) *Test, Learn, Adapt: developing public policy with randomised control trials.* *https://www.gov.uk/government/publications/test-learn-adapt-developing-public-policy-with-randomised-controlled-trials*
- Paul Corrigan and Nick Hicks (2013) *What organisation is necessary for commissioners to develop outcomes based contracts?* *http://www.rightcare.nhs.uk/downloads/RC_Casebook_cobic_final.pdf*
- NESTA (2014) *Which doctors take up promising ideas?* *http://www.nesta.org.uk/publications/which-doctors-take-promising-ideas-new-insights-open-data*
- Halima Khan (2013) *Five hours a day: systemic innovation for an ageing population.* *http://www.nesta.org.uk/publications/five-hours-day*
- NHS England (2013) *The NHS belongs to the people – a call to action.* *http://www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf*
- NHS England, TDA, Monitor (2014) *A report of the NHS Futures summit February 2014.* *http://www.hsj.co.uk/Journals/2014/03/13/x/j/z/Final-Futures-Summit-Report-Feb-2014.pdf*
- David Bennett (2014) *'Adapt or face the consequences'.* http://www.hsj.co.uk/comment/david-bennett-adapt-or-face-the-consequences/5068791.article
- NESTA (2012) *Neighbourhood Challenge Learning paper.* *http://www.nesta.org.uk/publications/neighbourhood-challenge-learning-paper*
- NHS Clinical Commissioners (2014) Making change happen: *A CCG manifesto for a high-quality sustainable NHS.* *http://www.nhscc.org/latest-news/making-change-happen/*

Annex B: **Possible opportunities for commissioners collaborate with others operating in local communities**

As clinical leaders, we need to think more creatively about how we can use our commissioning powers to 'crowd-in' all the stakeholders across the local that impact on the outcomes that really matter to our local populations

Outcome: Helping people to live longer

*We know that positive behavioural change can reduce premature mortality for people with diabetes. And we know the choice architecture of peoples lives is becoming more complex – the number of items in a typical grocery store has grown from 3,700 to 45,000 over past 20 years. 100 breakfast cereals are now launched in the UK each year. What if we partnered and co-commissioned with our **local supermarkets** the testing of new ways to provide personalised shopping advice using information gathered at the check out for those on our GP lists at higher risk of diabetes (i.e. additional receipt stating number of grams of sugar in your shopping basket)*

Outcome: Helping people to live happier lives

*We know loneliness is a major cause of unhappiness within our communities – especially for the frail elderly living alone. What if we started to see our GP list as a community asset, and catalysed **local voluntary groups** to explore new ways to offer easy-to-access opportunities for citizens to get more actively involved in making their communities healthier and happy places to live (i.e. community challenges, timebanks, befriending schemes)*

Putting citizen outcomes at the heart of everything we do can open up new, challenging, but exciting opportunities for us to explore as commissioners

A selection of ideas from the Task and Finish Group

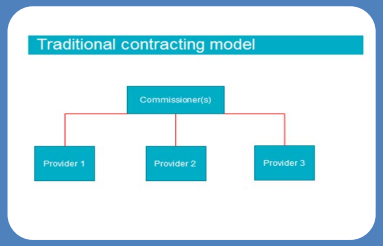
Outcome: Helping people to experience the best healthcare possible, as near to home as possible

*We know public expectations of their NHS have – rightly – kept on rising over the past 65 years. But we also know that it is the quality of care citizens receive rather than the 'bricks & mortar' of where that care is delivered that is crucial to meeting those rising expectations. What if we were to collaborate with **local providers and citizens** to explore new ways of unlocking all that expertise and skills sitting in our **acute sector** to enhance our offer in the community (i.e. **specialists** working with **primary care services** on early diagnosis, **consultants** assigned to **local care homes**)*

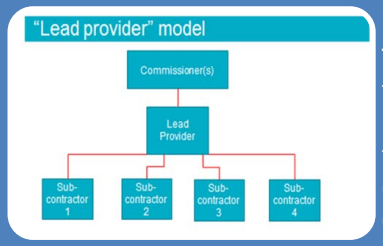
Outcome: Helping people to experience the best healthcare possible

*We all know patients who have had difficulty in navigating their care pathway and moving from one service to another. What if we were to design **single long-term contracts for specific populations** in our local communities (i.e. adults with mental health support needs) to cover the whole pathway of services needed? What if we really did pool budgets and commissioning of different organisations within our local area and aligned the financial rewards to achieving better outcomes for our local populations over the long term?*

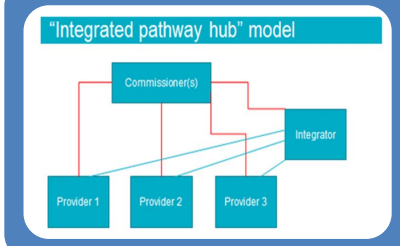
Annex C: **Different types of innovative contracting models**



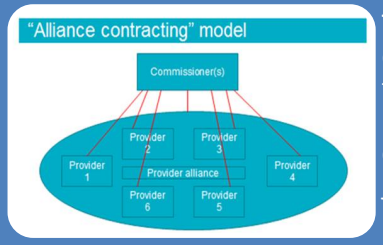
Under this approach, a commissioner may commission different elements of a care pathway, or of the care for a particular population, through a series of separate contracts with separate providers.



Under this model, the commissioners enter into a contract with a provider (the prime contractor or lead provider). That contract allocates risk and reward as between the commissioner and the prime contractor. The prime contractor then sub-contracts specific roles and responsibilities (and allocates risk associated with their performance) to other providers. The prime contractor remains responsible to the commissioners for the delivery of the entire service, and for the co-ordination of its 'supply chain' (ie its sub-contractor providers) in order to ensure that it can and does deliver that entire service. The prime contractor is likely to be a provider of clinical services itself, but it could sub-contract all but the co-ordination role.



In this case, the commissioners enter into separate contracts with a number of providers, all of whom contribute towards the delivery of an integrated service. Risks and rewards are allocated as between the commissioner and the provider under each contract. One of the providers (the IPH provider) assumes responsibility for the co-ordination and management of the integrated service and risks and rewards are allocated as between the commissioner and the IPH provider in relation to that integration and management function. The IPH provider may be a provider of clinical services itself, but may just take on the non-clinical co-ordination and management role. No one provider is responsible for the delivery of the entire integrated pathway.



The concept of alliance contracting derives from the construction and engineering sectors and can cover a number of different contracting models (including prime contractor and IPH structures). In other sectors, an alliance contract will typically bring together a number of separate providers under a single contract, but the term is often used in a broader sense, where multiple parallel contracts are put in place. In either case, key characteristics of alliance contracting are said to be alignment of objectives and incentives amongst providers; sharing of risks; success being judged on the performance of all, with collective accountability; contracting for outcomes; and an expectation of innovation.