

Commissioning integrated care in a liberated NHS

Research report

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Foreword

The exacting nature of the financial challenge facing the National Health Service (NHS), combined with increasing demand for NHS services, suggests that new, more integrated forms of care provision may be required in future.

Significant barriers exist to commissioning integrated care within the NHS. Despite managerial and clinical commitment, and evidence of innovation, progress towards more integrated care has tended to be variable, often slow, and with only limited impact. The research results reported here suggest there is an urgent need for the Department of Health, Monitor and the NHS to adapt several longstanding policies and local practice.

This report forms part of the Nuffield Trust's programme of work on health system efficiency. We feel strongly that with the NHS facing the most significant financial challenge in its history, a robust evidence base is needed to help inform the decisions that will need to be made by clinicians, managers and policy-makers. Further reports on other aspects of health system efficiency will be published in the coming months.

This report is accompanied by a research summary that sets out analysis by the Nuffield Trust of the challenges facing a new generation of health commissioners looking towards integrated care as part of improving the quality and cost-effectiveness of care. Both the summary and further copies of this report are available from www.nuffieldtrust.org.uk/publications

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1. Introduction

This report sets out the findings of research that sought to understand how NHS commissioners – those organisations charged with planning, funding and purchasing care – use their leverage to develop services that are better integrated for patients, and hence capable of delivering much-needed efficiencies for the NHS.

The research entailed a national survey of NHS commissioners (primary care trusts (PCTs) in England), a survey of the strategic health authorities who oversee and develop NHS commissioning at a regional level, a review of international research literature on payment approaches in health, and input from several national organisations with expertise in the area of commissioning and integrated care.

A number of case studies of innovative practice in commissioning integrated care were then identified. Eight of these case studies are explored within this report, along with analysis of what their experience reveals in terms of the effectiveness and potential of commissioning for integrated care within an NHS market.

A set of policy implications is identified, with a focus on what the research means for the NHS at a time of major reform within a context of highly constrained resources, and with a renewed focus on the potential of commissioning to bring about major service change.

2. Policy context

There has been increasing interest in finding ways of achieving closer integration of care within the NHS in recent years. Integration has attracted attention because of concern about the fragmentation that may arise when service providers do not work together effectively and also because of the inefficiencies that occur when patients move between settings. NHS chief executive David Nicholson has noted that ‘many of the most significant quality and productivity opportunities lie in the interfaces between organisations’ (Nicholson, 2009: p4) and has encouraged NHS organisations to work together and with other agencies to realise these opportunities.

Many initiatives on integration have arisen primarily from providers of care working together to reduce fragmentation and improve patient experience. Previous work by the Nuffield Trust has described some of these initiatives, including examples of health and social care integration in Torbay, Knowsley and North East Lincolnshire (Ham, 2009), and examples of primary and secondary care integration in Bolton, Surrey, and Birmingham and Solihull (Ham, 2008a). More recent work has reviewed experience in five areas of England in which commissioners and providers have sought to achieve closer integration on a larger scale than many previous initiatives, and has tried to determine the policy barriers to such developments (Ham and Smith, 2010).

Building on local initiatives on integration, the final report of the NHS Next Stage Review included a commitment to:

... empower clinicians further to provide more integrated services for patients by piloting new integrated care organisations (ICOs) bringing together health and social care professionals from a range of organisations – community services, hospitals, local authorities and others, depending on local needs. The aim of these ICOs will be to achieve more personal, responsive care and better health outcomes for a local population (based on the registered patient lists for groups of GP practices).
(Department of Health, 2008: p65)

Subsequently, the Department of Health set up a programme of integrated care organisation (ICO) pilots involving initiatives in 16 areas of England. The pilots are running for two years and are being evaluated to explore how the areas have worked to develop integrated services, which integration approaches have worked well (or not), and the impact on different patient and population groups in terms of utilisation of health and social care services. The results of the evaluation are expected to be available towards the end of 2011.

Evidence from areas where integration of care is well advanced underlines the significant potential to improve performance, for example, by avoiding inappropriate hospital admissions, enhancing patient experience and providing more care closer to home (Ham, 2010b). There are fewer case studies of the extent to which integrated care enables significant efficiencies to be extracted from health service costs and the base could be strengthened by the undertaking of longitudinal studies (Curry and Ham, 2010; Alakeson and Dixon, forthcoming). Such considerations will be critical for the NHS in the next few years, when evidence for service changes and improvements will need to include business cases about improving overall productivity and efficiency.

3. The project

It was against this background and as part of a programme of work focused on NHS efficiency, that the Nuffield Trust initiated a project to explore the role of commissioners in promoting integration. The project focused on the role of commissioners because of the increasing interest within the NHS in using commissioning to bring about improvements in performance. At the outset, this was expressed in the World Class Commissioning programme (Department of Health, 2007) for PCTs and their practice-based commissioning general practitioners (GPs), and is now being taken forward through clinical commissioning groups.

The project started in September 2009 and involved:

- a questionnaire survey of all PCTs in England to request information about innovative examples of commissioners seeking to develop integrated care
- a survey by email and telephone of strategic health authorities (SHAs) as a cross-check on the PCT survey and to gather a further perspective on the role of commissioners in this area of care
- approaches to key individuals in the Department of Health, the NHS Confederation and the NHS Alliance to seek their advice
- a review of literature from the United States on payment approaches within health care
- work with an advisory group of managers and clinicians known to be closely involved in commissioning and with an interest in integrated care.

When the project started, it was envisaged that it might identify examples such as:

- commissioning care pathways rather than simply paying for episodes of care under Payment by Results
- commissioners working with lead providers to promote integration and ensuring that these lead providers subcontracted with other appropriate providers
- the development of new forms of payment to incentivise integration, such as payments for care pathways and other forms of payment bundling.

The questionnaire survey listed these examples in the hope of prompting responses by PCTs that might identify initiatives relevant to the project. In the event, the survey produced a disappointing response both in the number of PCTs that completed the questionnaire and in the examples they provided. The survey of SHAs helped to identify some additional examples, but, as with the PCT survey, most of these were outside the scope of the project. This was usually because they represented examples of integrated care that had arisen from action by providers to work in new and more coordinated ways, and not from innovation or challenge on the part of commissioners.

The approaches made to key individuals at a national level and the ideas supplied by members of the advisory group proved more fruitful. As a consequence, we were able to draw up a long list of potential examples, and further information about these sites was obtained through telephone discussion and documentary review. At this stage, many of the potential examples were excluded because they did not fit the criteria for the study or because ideas were at too early a stage of development to justify their inclusion. Eight case studies were selected for this project and are further described in the next chapter.

Data from these areas were collected through visits and interviews with PCT and GP leaders involved in this work. Fieldwork was undertaken between November 2009 and August 2010 and the following questions were used in the interviews to ensure a degree of consistency in the data gathering:

- What was the reason for selecting this service or area of care to focus on?
- How are the commissioners seeking to commission integrated care?
- What is the nature of the contract or service agreement being used, for example, what does the service specification look like?
- Was this put out to tender?
- If so, what was the response?
- Who was awarded the contract, for example, incumbent or new entrant?
- Is there a lead provider for the service?
- If so, does the commissioner expect the lead provider to subcontract with other providers?
- What is the length of the contract?
- How is the contract funded, for example, through the tariff or some other means?
- If by other means, what was the detail of this? (For example, was it about bundling?)
- What standards/quality criteria have been built into the contract and how were these arrived at?
- What were the main challenges encountered?
- What lessons have been learned?

In parallel, we reviewed work being done in the United States to develop payment systems to promote integrated care; this involved summarising relevant literature and seeking advice from experts there. The rationale behind this was to understand the nature of innovations in payment systems in the United States that might have relevance to the NHS.

The emerging findings from this research were discussed at a seminar held in December

2010 involving participants from some of the areas selected as case studies and a range of invited experts. This report reflects some of the views expressed at the seminar and comments received on earlier drafts by many of those interviewed during the fieldwork.

In the next chapter, we summarise the findings from the case study sites with the aim of providing clear descriptions of the work that is under way to commission integrated care. This is followed by an analysis of the emerging issues and themes across all of the sites and the policy implications. These implications are framed in the context of the Coalition Government's proposals for the NHS in England and particularly the emphasis on GP commissioning.

4. The case study sites

The following examples were chosen as case studies:

- *Milton Keynes PCT*, which has sought to commission integrated care in a number of major blocks and aimed to contract with an ‘accountable care organisation’ in each area. We report on the first block of care they commissioned in this way – urgent care services.
- *Birmingham East and North PCT*, which focused on commissioning integrated care for people at the end of their lives from a single lead provider. The procurement process involved extensive development of the contract and specification, and was ultimately unsuccessful.
- *Cumbria PCT*, which is commissioning integrated diabetes care across the county. A new specialist care organisation was developed to provide the service which is consultant-led with multi-disciplinary teams.
- *West Kent PCT*, which commissioned an integrated out-of-hours primary care and emergency primary care service based in the hospital accident and emergency (A&E) department. The service was managed by a social enterprise and delivered by a team of GPs, nurses, urgent care practitioners and specialists.
- *Knowsley PCT*, which is commissioning a full range of integrated cardiovascular services from a single lead provider with the aim of meeting the needs of a deprived population with major inequalities between socioeconomic groups.
- *Tower Hamlets PCT*, which is commissioning integrated diabetes care as part of a wider programme of work on integration that includes involvement in the national ICO pilot programme initiated by the Department of Health. Networks of GP practices are the basic building blocks for investing in primary care.
- *Smethwick Pathfinder*, which is using a capitated budget to incentivise a local group of innovative general practices to improve care for people with long-term conditions, with the involvement of an independent sector partner.
- *Somerset PCT*, which has commissioned an integrated chronic obstructive pulmonary disease (COPD) service that is provided by a partnership of BUPA Home Healthcare and Avanaula Systems (a company formed by a group of local GPs).

Table 1 outlines details of the services provided in each of these case studies, the arrangement of providers, the procurement process, the incentives used to drive performance and the results of the new integrated services.

Table 1: Comparative dimensions of the case study sites

	Description of the service	Arrangement of providers	Outcomes and incentives
Tower Hamlets	A package of care for diabetes was developed by a GP, consultant diabetologist, community specialists and public health experts. Following roll-out of the diabetes package, the networks of GP practices were encouraged to roll out a second package of care for vaccination and immunisation services.	There are eight networks of GP practices. The networks are the basic building blocks for investing in primary care, strengthening provision of primary care services and improving outcomes. The networks are geographically based.	For diabetes, 70 per cent of the contract is provided upfront and 30 per cent is held back, to be allocated on the basis of achievement of outcomes. Examples of outcomes include patient experience, care planning and the proportion of patients whose diabetes is actively managed and controlled.
Smethwick Pathfinder	The focus of the Smethwick Pathfinder arrangement is on system redesign and reshaping primary care with the intention of providing as many services as possible. Options include designing new services for high-risk patients (for example, children with asthma); and provision of telecare services, home-based intensive nursing support, phone-based care, and group consultations for people with long-term conditions.	Smethwick Pathfinder is a primary care provider organisation – a community interest company that uses practice-based commissioning to provide and commission care for a population. The organisation works closely with Aetna Health Services.	The primary care provider organisation holds a real budget and has taken a loan to develop the population-based programme.
West Kent	NHS West Kent commissioned a new primary care out-of hours and emergency primary care service in A&E. Funding for the emergency primary care service was subsequently withdrawn, in spring 2011. The integrated service ran from hubs in A&E departments in hospitals; with out-of-hours care provided in community hospitals and health clinics.	The service is managed by a single provider (a social enterprise) and delivered by a team of GPs, nurses, urgent care practitioners and specialists.	The specification for the new service included performance indicators (for example, avoiding unnecessary hospital admissions); and requirements for patient services and for integration across A&E and primary care services. For example, there were requirements for opening hours and tailored provision of services for children; and for seamless transition between primary care and A&E services.
Birmingham East and North	Birmingham East and North PCT was interested in commissioning systems and pathways, rather than individual provider activity, and identified eight strategic themes to take forward the new approach (for example, maternity, mental health and dependency, children and young people). The PCT decided to test the new approach to commissioning with services for people nearing the end of life.	The PCT intended to commission a lead provider, instead of contracting with each of the current 16 separate providers. The lead provider would then subcontract with others, using fiscal and organisational levers to create the service. As the PCT was keen to avoid having one provider dominate delivery, the lead provider was limited to delivering up to 40 per cent of the service. Two preferred bidders were identified. One was an alliance between two existing providers and the other was an independent sector organisation new to the market.	The PCT defined the required pathways and outcomes rather than determining the exact nature of the detailed interventions. The PCT chose to design incentives into the contract with the income of the providers related to performance. The cost of the provider was to be met for the first year. Subsequent funding was dependent on the savings the provider delivered.

Table 1 (continued): Comparative dimensions of the case study sites

Contracting process/arrangement	Data and information systems	Results of the new service
<p>The PCT contracts with each of the networks of GP practices to provide additional services and has made a substantial investment in the new diabetes service. This was based on the costing of the additional resources required to deliver the care package. Relatively small sums of money have been required for the vaccination and immunisation services, but this follows a period of increased investment in primary care. Services are funded via a hybrid-enhanced services arrangement.</p>	<p>Information is integral to the system in terms of monitoring the networks and delivering the service. Networks use automated call and recall systems for patients and the PCT draws on real-time performance data for peer review and monitoring. The PCT has found that reporting results motivates the networks, and provides an opportunity for recognition among peers. Networks find the information to be useful because it is timely, the indicators were developed and agreed by clinicians, and data are obtained by an honest broker.</p>	<p>While the impact of the new diabetes service is yet to be determined, the results of the vaccination and immunisation programme are encouraging. For example, the PCT reports an increase in coverage of childhood immunisation (MMR2 at five years) from approximately 55 per cent in 2006/07 to over 80 per cent in 2009/10.</p>
<p>The primary care provider organisation assumes a real budget for their population, through a Personal Medical Services Plus arrangement.</p>	<p>As a result of the population-based approach, Smethwick Pathfinder requires a more sophisticated use of data than in the past, including adopting a risk stratification approach to their population. In the future the organisation hopes patients will see and manage their own records. Smethwick Pathfinder has received considerable support from Aetna Health Services UK with risk stratification.</p>	<p>Smethwick Pathfinder has commissioned a comprehensive evaluation of its approach from the Evidence Centre.</p>
<p>The PCT reviewed performance and value for money of the current services, and service demand. It also assessed a pilot of the new service arrangements. The process of service redesign included comprehensive stakeholder engagement and an assessment of the market to identify potential providers and procurement options.</p>	<p>Through provision of the new integrated service, the provider anticipated improved real-time information sharing with primary in-hours and community care; and improved monitoring information for commissioners on patient activity and experience.</p>	<p>Surveys of the pilot service indicated greater patient satisfaction and a decrease in the amount of time that patients spent in A&E. The commissioner anticipated reduced A&E attendance costs and reduced emergency admissions, with roll-out of the new emergency primary care service. The West Kent Emergency Primary Care Service was withdrawn in spring 2011 when the provider realised they had under-costed their proposal for the service and hence was unable to continue to fund the provision of a GP in A&E departments. This was in the face of evidence that substantial savings were likely in due course, and of high patient satisfaction with the new service.</p>
<p>The procurement process involved extensive development of the contract and specification for the pathway components and the role of the lead provider. The specification was jointly developed by the PCT and the competing providers.</p>	<p>It has been difficult to cost the end-of-life pathway. While the PCT estimates the costs of hospice care and district nurses to be approximately £9 million, the actual cost of the end-of-life pathway could be three times that if acute care and other elements are included. One of the barriers to costing the pathway is defining the currency for end-of-life care.</p>	<p>After going through the service design process and crafting the specification, the PCT decided not to commission the end-of-life care service because initial set-up costs of the lead provider could not be met.</p>

Table 1 (continued): Comparative dimensions of the case study sites

	Description of the service	Arrangement of providers	Outcomes and incentives
Milton Keynes	The original intention of Milton Keynes PCT was to commission defined blocks of care for specific diseases, for example COPD. Subsequently, the PCT chose to be more ambitious and focus on larger blocks of care, for example maternity services and services for people with learning disability. The first block of care to be commissioned is for urgent care services. Map of Medicine was used to define care pathways within blocks of care.	A lead provider will hold the budget and be responsible for delivering care in line with agreed standards. The lead provider is yet to be determined – options include a joint venture between the local acute foundation trust and an out-of-hours organisation run by a group of GPs. The provider will manage the supply chain and work with other providers to achieve a more integrated approach.	The lead provider is expected to deliver the block of care with a budget of approximately 90 per cent of the current expenditure, with an additional 5 per cent based on performance against health, inequality and user experience outcome measures.
Cumbria	Cumbria PCT has commissioned a new integrated service for diabetes, which has moved provision of care away from GP referral to specialists based in hospitals, to specialists working alongside primary care teams in the community.	A virtual integrated diabetes service is delivered in three localities to provide specialist support to primary care; and complex and inpatient care. The service is consultant-led with multi-disciplinary teams of nurses, podiatrists, psychologists etc. The specialist who leads the service is employed by the new specialist care organisation. Around 40 staff work in the service.	A new set of process and outcome metrics has been developed to cover the service, however, the PCT has not yet developed any incentives or penalties.
Knowsley	Knowsley PCT has commissioned an integrated cardiovascular service on behalf of its practice-based commissioners. The service includes consultant clinics within community settings offering diagnostics, treatment and management plans; collocated nurse-led community heart failure clinics; community-based cardiac and stroke rehabilitation; strong links into health and wellbeing services; and a single administrative hub which manages all referrals and enquiries.	The service is led by a specialist provider (Liverpool Heart and Chest Hospital NHS Foundation Trust) which is expected to work collaboratively with other providers to deliver an integrated service.	The service specification details the required outcomes of the service. The contract is part block and part performance-based, with performance payments rising from 20 per cent of the value of the contract in the first year, up to 40 per cent in the third year.
Somerset	Somerset PCT commissioned an integrated COPD service on behalf of its practice-based commissioners (Wyvern Health). The service includes assessment clinics, pulmonary rehabilitation services, a nebuliser service, oxygen assessment services and an urgent response facility.	The service is provided by a partnership of BUPA Home Healthcare and Avanaula Systems (a company formed by a group of local GPs). Specialist nurses deliver the service from 14 community-based clinics.	The service specification was shaped by patients and clinicians. The specification includes outcome measures for reduced emergency admissions, patient experience, equitable access and a formal assessment for all patients using home oxygen. The contract specifies regular performance monitoring and has been let for three years.

Table 1 (continued): Comparative dimensions of the case study sites

Contracting process/arrangement	Data and information systems	Results of the new service
<p>The urgent care service will be contracted through a process of local negotiation rather than an open tender. The PCT is keen to move beyond a Payment by Results arrangement and to create incentives to support integration. The contract will be constructed from a core capitation-based budget plus incentives payments.</p>	<p>A key feature of the new integrated system will be secure arrangements for the sharing of clinical records and information among the professionals involved in a patient's care.</p>	<p>The new service is still in the development phase, with planning taking place during 2010/11 and most of the new contracts expected to be in place from 2011/12.</p>
<p>As diabetes is a complex disorder and often has co-morbidities, the PCT has had difficulty identifying the total income and costs for the service. The PCT sought expressions of interest from qualified specialists and undertook a standard interview-and-assessment process under the preferred provider policies of the time. It proved difficult to arrange for the new service to be hosted by a local acute trust, so a new specialist care organisation was established. The PCT is using a block contract for the new specialist service and a combination of general medical services and locally enhanced services for practices.</p>	<p>Development of the new service has led to a shared IT system that enables easy transfer of data and joint working.</p>	<p>As provision of the new service began in November 2010, the impact of the change is yet to be determined. The PCT is currently focusing on implementation of the monitoring framework.</p>
<p>The PCT assembled a comprehensive dataset to gain a full understanding of the impact of cardiovascular disease on elective and non-elective admissions, and outpatient activity. The PCT was then able to develop projections of provider-level activity, which helped determine the overall investment required to establish the new integrated service. Three organisations responded to the competitive tender and the contract was awarded to a specialist provider located outside the borough.</p>	<p>The community sites have been enabled to support transfer of electronic diagnostic and record data, which enhances the consultant clinic experience for both patient and staff. The service also allows for the use of Wii Fit and telehealth tracking as part of rehabilitation.</p>	<p>The PCT reports excellent patient and GP feedback, with access times currently under two weeks. Early indications are that unplanned A&E attendances have reduced by 10 per cent (a Payment by Results saving of £27,000); approximately 3,880 patients directed away from secondary care in the first eight months of 2010/11 (a Payments by Results saving of approximately £481,000); and shorter stay emergency admissions for cardiology-related events have also seen a decrease of approximately 12 per cent (a saving of approximately £306,000). In addition, the numbers of patients being referred through to cardiac rehabilitation and accepting the offer have increased by 13 per cent; 90 per cent of all early supported discharges had a full health and social care assessment carried out in conjunction with their carer; and 91 per cent of patients have had a reassessment six weeks post-discharge.</p>
<p>Somerset PCT ran a competitive tender process. Two local acute trusts submitted bids for the service, in addition to the successful BUPA/Avanuala partnership.</p>	<p>Baseline and follow-up reports from the Patient Outcomes and Information Service are used to track performance and identify areas for improvement.</p>	<p>Initial results indicate a drop in admissions.</p>

5. Emerging issues and themes

Our analysis of the experience of the eight case studies of innovative commissioning aimed at enabling better integrated care is set out within two main sections. First, we make an examination of how the stages of the ‘cycle of commissioning’ – developed by Ovretveit (1995) and adapted by the NHS to conceptualise its approach to funding, planning and contracting for services (Department of Health, 2003) – operated within the case studies (see Figure 1). Second, we set out an exploration of the factors that appear to facilitate commissioning of integrated care.

Figure 1: Cycle of commissioning (adapted from Department of Health, 2003)



The stages of the cycle of commissioning for integrated care

Needs assessment and service specification

Most of our case studies invested considerable time, effort and resource in the assessment of local health needs and design of new care pathways. The PCT typically worked with many different professional and user groups to review current patterns of service for a particular patient group and develop a new proposed pathway of care. As a result of this extensive engagement, the new patterns of care were considered to be based on sound clinical advice, offer a more integrated experience for users and carers, and (in some instances) to release efficiency savings for investment in other areas.

Striking examples of this approach to care pathway development were: the pathway created by Birmingham East and North PCT for care for people at the end of their lives; the integrated primary care out-of-hours and emergency service in West Kent; the prevention through to specialist care pathway for cardiovascular services in Knowsley; the new specification for services for COPD in Somerset; and the integrated

diabetes service in Cumbria. While this process of engagement was reported as being enormously helpful in bringing groups together to review and improve plans for care, it was extremely time-consuming and costly. Indeed, the process of developing pathways appeared to represent a form of local organisational development, serving to bring different people from across the care spectrum together (for example, hospital specialists, GPs, specialist community nurses, pharmacists, user representatives, social care staff) and offering a rare opportunity to consider how services work (or not) from the patient and carer's perspective. During the process of defining the service to be commissioned, case studies experienced problems in collecting, collating and synthesising the necessary data. This was particularly in relation to the more ambitious proposed integrated care programmes, such as the Birmingham care pathway for people at the end of their lives and the Milton Keynes integrated care systems. This suggests that commissioners will need to identify significant capacity to addressing issues such as:

- data collection and integration
- detailed costing
- collaborative design of a new care pathway with professionals, carers and patients.

Another resounding message from the case studies, however, was how very hard it was to move from pathway development to implementation. Critical to the difficulty of this process was the nature of contracting in the different health economies.

Contracts

We observed a range of mechanisms employed by commissioners when seeking to implement new forms of integrated care, including those designed specifically for the general practice and primary care sector (for example, personal medical services, general medical services) and those focused on secondary care (for example, contracting on the basis of Payment by Results and the NHS tariff).

In Tower Hamlets, for example, the PCT contracted for a new integrated diabetes service with networks of practices, rather than with individual practices, as would usually be the case in the NHS. The PCT was thus acting as the overall integrator of diabetes services, letting parallel contracts with local community health and specialist services run alongside those with general practice networks, and ensuring that the overall mix of contracts added up to the integrated care pathway agreed for people with diabetes in Tower Hamlets. At the time of writing, only the general practice networks have risk-based contracts, which may act as an incentive for practices to exert pressure on community diabetologists, community nursing and allied health professional staff to play their part in enabling overall achievement of population health outcome targets.

In Sandwell, the development of a local population health management organisation (Smethwick Pathfinder) has its roots in the inspiration and dogged determination of a small group of GPs who had worked together in GP fundholding in the 1990s, and then as a Personal Medical Services (PMS) Plus organisation. The PCT used a PMS Plus contract to enable the development of a risk-bearing provider network formed of local general practices, building on the infrastructure and experience that had been developed in primary care, and using this as the basis for delegating a more extensive risk-bearing budget for population health.

PMS and other local contract options (for example, alternative providers of medical services (APMS) and specialist providers of medical services (SPMS)) are readily available vehicles for enacting some of the emerging medical group or ICO approaches being explored in parts of the NHS, and do not require any legislative changes. These could arguably be used more frequently as a ready-made alternative to some of the more complex organisational forms tried for integrated care delivery. It is of note that so few PCTs appear to have used such contractual mechanisms to commission new forms of integrated care and share financial and service risk with local primary care providers.

Tendering and procurement

The process of specifying, tendering and contracting for new forms of integrated care was prohibitively costly in some of the cases examined. These costs fell to both providers and commissioners. For example, as noted above, Birmingham East and North PCT carried out extensive work to design a new care pathway for care for people at the end of their lives, the intention being to tender for a single lead provider who would coordinate and be accountable for the delivery of the overall spectrum of services for people nearing the end of life. It was, however, the need to fund start-up costs for a new lead contractor that finally scuppered the plans to commission this entirely new service; these start-up costs being the straw that broke the camel's back in relation to the overall costs of the process of contracting for a new service.

In contrast, Knowsley succeeded in awarding an integrated contract for the entire spectrum of cardiovascular care (from primary prevention through to specialised acute hospital care) to a specialist acute provider outside the borough. Early reports about the progress of this contract are positive, in terms of both organisational and care arrangements. The PCT reports a 10 per cent reduction in unplanned hospital visits, approximately 3,880 patients directed away from secondary care in the first eight months of 2010/11 and a 12 per cent decrease in shorter stay emergency admissions for cardiology events – a collective Payment by Results saving in excess of £800,000. This suggests that the hard work involved in designing, contracting for and implementing a new integrated care pathway can be worth it, in the end, and if the costs of contracting and tendering are budgeted and justified from the outset.

The PCTs in our case studies appeared to find it difficult to move from pathway development to implementation, a theme common to much of the literature on health service improvement. In addition to costs, the PCTs faced challenges in other aspects of the contracting process, including:

- costing the overall pathway in an accurate and comprehensive manner
- identifying organisations with the capacity and capability to manage such a contract
- handling the process of tendering, assessment and award.

It will become increasingly difficult to fund and undertake such radical pathway redesign and contracting once 45 per cent management costs have been removed from NHS commissioning by 2015, and in a context where resources for anything other than frontline services are subject to major scrutiny as efficiency savings are sought.

Despite the small number of case studies we identified in this research – and the time and cost associated with commissioners developing innovative forms of integrated

care – it is important to note that contracting did prove to be a powerful mechanism through which funders can lever change within providers. The critical question is why the achievement of radical change in service provision via contracting is apparently so rare. Furthermore, in the current highly constrained financial context of the NHS, the costs of service specification, tendering, contracting and review may prove to be simply too high to justify improved services within a constrained timeframe, even if they ultimately deliver the very efficiency gains the NHS seeks.

Outcomes and incentives

Case study sites emphasised the importance of making an explicit link between payments to providers and the achievement of outcomes specified in the contract. This was deemed to be more significant than specifying in too much detail how a service should be delivered. In particular, commissioners were very keen to develop contracts that focused on the achievement of outcomes for patients – service outcomes in the first instance and health outcomes in the longer term.

For the commissioner, a clear vision of outcomes desired of the service and readiness to make this a central lever within the provider contract was what appeared to matter. This is in contrast to usual NHS contracts that are typically concerned with service volumes and rather crude proxy measures of quality (Smith and Woodin, 2011). It is, however, very much in tune with the direction of current NHS reform which is focused on commissioning for outcomes and which will in due course be underpinned by a new NHS Outcomes Framework (Department of Health, 2010a).

In many cases, commissioners designed contracts that linked a significant element of funding to the achievement of measures of performance. For example, in Tower Hamlets, 30 per cent of the contract value was contingent on the network of practices achieving the overall diabetes outcomes indicators, which include patient experience, care planning and delivering stratification data. In this way, outcomes-based contracting is being used both to reinforce a new model of care and to encourage peer review and development of primary care performance. The framework of payments, incentives and performance measures for the Tower Hamlets diabetes contract between the PCT and general practice networks is set out in Box 1.

Box 1: Payment for diabetes care at Tower Hamlets

An innovative contract for commissioning diabetes care from GPs specifies minimum standards of activity and pay for performance to incentivise provider behaviour. The contracts are held and signed by each practice, but monitored and incentivised at network level. Over time the percentage of payment dependent on meeting specified outcomes will increase. The current payment structure is outlined below. The payment for activity ensures adequate care is provided.

% of payment	Definition	Frequency of payment
70%	Undertaking all activity required by the care packages	Quarterly
10%	Accurate and timely data coding	Year end
5%	Patient satisfaction	Year end
5%	Management of HbA1c (a marker of long-term blood glucose control), blood pressure, cholesterol	Year end
5%	All patients have individual care plans	Year end

In Knowsley, the new community-based service for identifying and managing the care of people at risk of, or already experiencing, cardiovascular disease is underpinned by a service specification that describes the outcomes expected by 2012/13. This in turn is supported by a contract that is part block and part performance, with the proportion of contract value linked to performance against outcomes rising from 20 per cent to 40 per cent over three years. See Appendix 2 for examples of the outcome measures used for the cardiovascular contract in Knowsley.

Some of the commissioners in our case studies aspired to use the freedoms presented by PCT and practice-based commissioning, together with a willingness to 'bundle' the Payment by Results tariff and other funding flows into a single overall contract value. However, whereas some commissioners, such as Knowsley, had found ways of matching funding flows to the desired pattern of integrated service provision, and designed a contract that they believed could lever this service pattern into practice, others struggled to get such an approach off the ground, as in Birmingham East and North, and Milton Keynes. In this way, a small number of commissioners appeared to be solving the 'pathway into practice' conundrum that appears to bedevil so much of NHS commissioning.

This raises a question as to why so few PCT and practice-based commissioners have developed and used the apparent freedoms presented by Payment by Results and practice-based commissioning. Previous work by the Nuffield Trust and The King's Fund (Ham and Smith, 2010; Smith and others, 2010) has examined what are assumed to be 'policy barriers' to integrated care; and the practical operation of the Payment by Results system in the NHS, together with the bureaucracy of contracting, have been identified as key inhibitors for commissioners wishing to develop more innovative forms of care. These case studies bear witness to what is in fact possible within the current policy environment.

Having examined the components of effective commissioning of new forms of integrated care, we explore the factors which appear to be critical to putting such elements of commissioning into practice.

Factors that facilitate commissioning of integrated care

Managerial leadership

Effective leadership is frequently identified in the literature as a critical factor for bringing about service change within health care (Baker and others, 2008; Ham and others, 2008; Hartley and Benington, 2010). Within each of the eight case studies, the commitment and determination of senior managers and their team were considered to be crucial to the success of the specific commissioning initiative. Even where the initiative originated within clinically led practice-based commissioning, the sustained and enthusiastic support of senior managers was deemed to have been essential. The nature of this leadership entailed:

- nesting the specific commissioning development within the wider strategy of the PCT
- negotiating permission for those leading the development, in respect of working beyond or around system rules
- providing mentorship and personal support for emerging clinical leaders of commissioning
- acting as champion for the new service development in local, regional and national forums.

The importance of the leadership of the PCT chief executive was evident in a number of examples, particularly where the innovative approach required a degree of risk-taking by commissioners wanting to bend or work around the rules of NHS funding and commissioning. One striking example of this was the Cumbria approach to commissioning integrated diabetes services through practice-based commissioning with real budgets. The PCT chief executive was reported to have striven consistently to develop a more integrated approach to the provision of care for people with long-term conditions, backing the plans of local GP commissioners and funding senior national clinical expertise to support the development. The chief executive also led the process of challenging local acute providers (who were initially reluctant to change to a community-based model of diabetes care) by funding a community-based diabetologist as a way of getting the new service off the ground.

In Milton Keynes, the chief executive of the PCT used his joint role as director of public health to drive through a strategy of commissioning integrated health systems for specific client groups. The approach was based on public health evidence about current and projected health need, and rooted in health economic analysis of funding flows. When the change proved to be more complex and exacting than expected for local PCT commissioners and providers, the chief executive continued to champion the work and renegotiated the overall timeframe. He is currently providing support to emergent local GP commissioners as they look to implement the new integrated approach within the new policy context of clinical commissioning.

Clinical leadership

Alongside effective managerial leadership within commissioning, we also observed bold and skilful leadership by clinicians, where GP commissioners and PCT medical directors were working in close partnership to drive innovations in commissioning. Indeed, in some of the sites, the commissioning of new services was led explicitly by clinicians. For example, in West Kent, primary care doctors led the development of plans for providing a radically different form of integrated urgent care and out-of-hours general practice. While the PCT worked closely with the clinicians and led a process of community and professional engagement and consultation, the overall service change was clinician-led and delivered, with a GP-owned social enterprise winning the contract to provide the new service.

Smethwick Pathfinder is a primary care provider organisation where the practices have taken on a capitated budget for the registered patient population and are managing people's health in a proactive manner. The multi-practice PMS Plus organisation used the delegated budgets available to them through practice-based commissioning to extend their role beyond provision of primary and community health services, into the commissioning of specialist elements of long-term conditions management. Smethwick Pathfinder is now an 'accountable manager' (Fisher and others, 2007) of local people's health, delivering the services they can within practices and commissioning other services from hospital and other providers as necessary. The development of the Smethwick Pathfinder has been led by a small group of committed GPs for some 15 to 20 years and they have benefited from being able to negotiate funding, commissioning and other freedoms from the local PCT.

Clinical leadership within these exemplars of innovative commissioning was not confined to general practice. The more radical initiatives explored new forms of care that transcend primary, community and secondary care services. These required joint clinical leadership across different parts of the local care spectrum. In some cases, as with the Knowsley cardiovascular disease programme, West Kent urgent care, and the Birmingham East and North care service for people at the end of their lives, there was a desire to commission a single lead organisation to coordinate the delivery of care across a number of organisations. Effective commissioning of these services required sophisticated clinical and managerial leadership within and across providers.

Primary care-led commissioning

Practice-based commissioning is often maligned as being weak and under-developed (Curry and others, 2008; Smith and others, 2010) and lacking real commitment from a majority of GPs. It does, however, appear to have been a catalyst for service redesign and new forms of budget-holding within some of the case studies reported here – albeit when practice-based commissioning groups worked hand-in-hand with their PCT as a single clinically focused commissioning entity. For example, the Cumbria diabetes service was implemented via an extension of practice-based commissioning – making the budgets real and allocating them to locality groups of GPs, who in turn take responsibility for the delivery and outcomes of a community-based service for the local population. Likewise, Tower Hamlets developed practice-based commissioning into practice-cluster commissioning, as a means of contracting and paying for some primary care services in a different way.

What is instructive, however, is that these examples appear to represent the minority of commissioners able to innovate apparently irrespective of the prevailing policy context, exploiting emerging policy guidance to enable the delivery of local service priorities. In common with previous work undertaken by one of the authors (Ham and others, 2008b), it seems to be the case that unwavering project and change management enables some commissioners to achieve their service development goals, in other words 'getting the basics right'. In Chapter 6, we examine the potential of clinical commissioning to bring about a more significant degree of innovation in commissioning than appears to have been the case with PCT and practice-based commissioning.

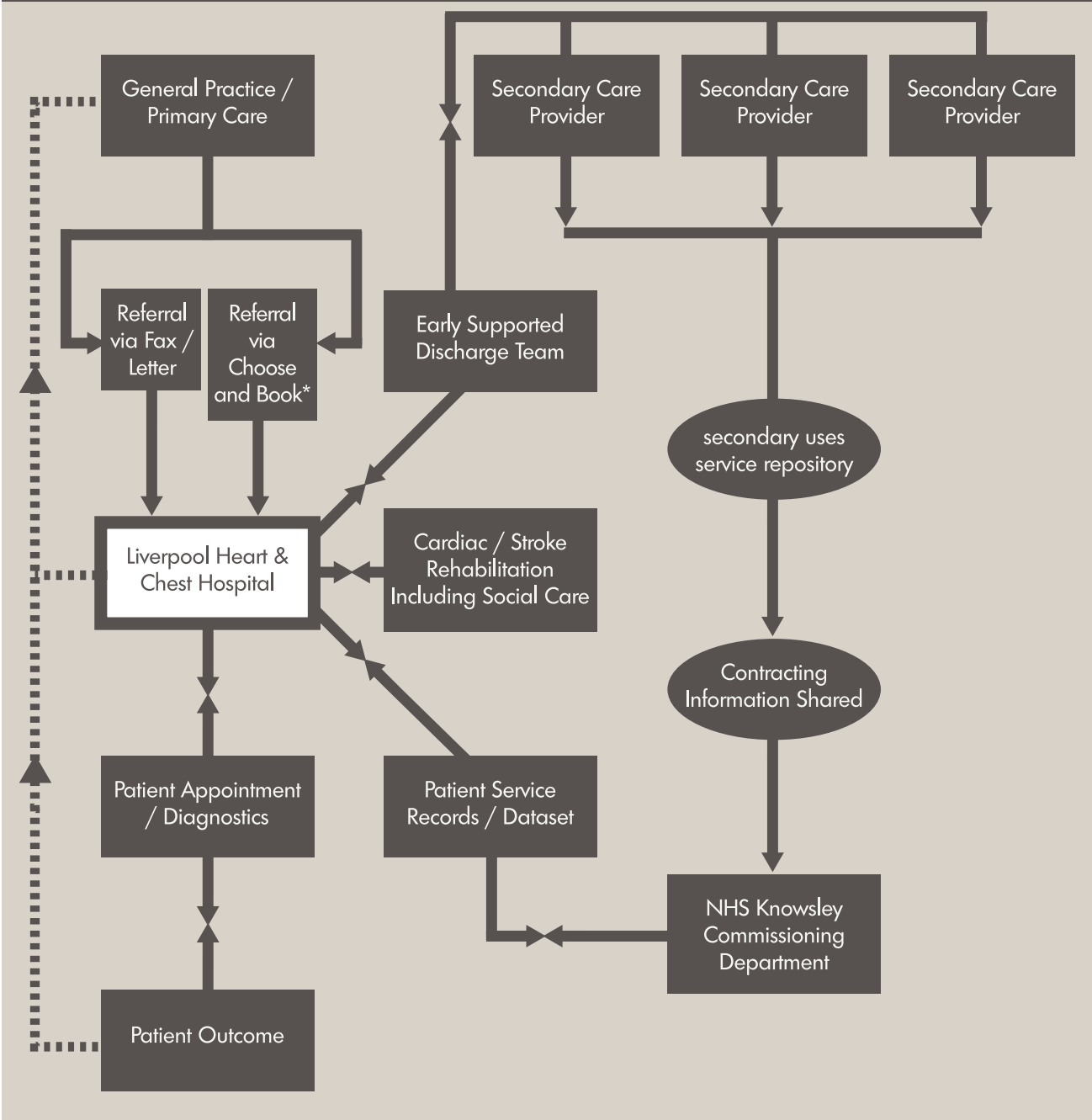
Data and information technology

Case studies emphasised the importance of robust data when measuring performance against outcomes in contracts, especially when outcomes were linked to significant elements of service funding, or practitioner incentive payments. Key requirements for commissioning data included that:

- all parties were using the same data
- the set of precise indicators was agreed across all parties
- the process of data collection and analysis was funded and organised within the overall contract
- data were robust, trusted and timely.

The other data challenge encountered by the case studies was developing robust and timely collection of information to inform contracting for outcomes. Agreeing a set of performance and outcome indicators and organising and funding data collection and analysis was an exacting process, especially as this was to underpin significant elements of service funding, or practitioner incentive payments. Trust and accuracy were key principles that had to be observed, and that called for careful and intensive work at PCT, practice and provider levels. An example of how the Knowsley case study approached data and information flows is set out in Figure 2.

Figure 2: Patient information and data flows for the Liverpool Heart and Chest Community Cardiovascular Service



* Choose and Book is a national electronic referral service that gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

The case studies had experienced problems in collecting, collating and synthesising data for commissioning, particularly in relation to the more ambitious proposed integrated care programmes, such as the Birmingham East and North care pathway and the Milton Keynes integrated care systems. This suggests that commissioners may do well to 'start small' when first contracting for innovative forms of integrated care, picking off a specific service that is amenable to data collection and integration, detailed costing and collaborative design of a new care pathway among a relatively small group of professionals, carers and patients. This experience can then be used to develop integrated care 'at scale'.

The registered list of patients

The registered list of patients held by general practices was a vital resource for commissioning new ways of managing people's health in a proactive manner. It was likewise the basis for allocation of capitated budgets to integrated care providers, as evidenced in Smethwick, Cumbria, Knowsley and Tower Hamlets. For example, Smethwick Pathfinder assumed a capitated budget for managing the health of the practice population for a broad range of services and conditions, including management, care and case management of long-term conditions; illness prevention; elderly care; community nursing; anticoagulation; orthopaedics; diabetes pain relief; and a service for asylum seekers. The Pathfinder built a new integrated patient record that included:

- information about attendances at NHS services
- details of health status and risk of ill health
- planned screening and observations
- triggers for the individual to be invited to attend for tests or treatment (for example, triggers can be based on outputs of risk stratification analysis).

The registered list, and the practice that holds and maintains it, is key to any initiative aimed at developing more proactive approaches to managing people's health on an individual and risk-assessed basis. This is in stark contrast to so much of NHS commissioning which is concerned with the provision of services in a largely reactive and episodic manner. Smethwick received considerable *pro bono* (free) support and advice for managing their registered list in a proactive manner through their partnership with the health insurers Aetna. Whether such sophisticated analysis of population health needs and risk could be undertaken at scale in an NHS under financial pressure is a point we return to in Chapter 6 of this report.

Clinical commissioning groups will be in an unrivalled position to use the registered list as the basis for commissioning for population health management. The challenge facing them will be to secure sufficient management, analytical and development support to inculcate such an approach across practices, and in a way that can start to shift the paradigm of how primary care services are delivered. What these new commissioners have to work out is how to move their peers from a largely reactive, short, face-to-face consultation model of primary care, to one that is proactive, based on individual risk assessment and care planning, underpinned by sophisticated data collection and analysis, and able to offer a flexible range of health promotion and care options in a community or home setting.

Provider engagement

Providers featured in a range of different and significant ways within the eight case studies. In Smethwick, West Kent and Cumbria, providers (GPs) had led the process of needs assessment, service redesign and commissioning. In Birmingham East and North and Knowsley, commissioners had worked closely with a range of providers when developing a new care pathway and service specification, seeking to contract with a lead provider who would assume responsibility for delivering the whole pathway of care. In these latter cases, commissioners were seeking to exploit the strength of providers as developers of services, encouraging them to do this in a way that enabled better integrated care.

In Milton Keynes, commissioners were working with providers at a 'whole health economy' level, mapping health needs for the area, linking this to available resources and developing commissioning priorities and plans across a range of services. Providers in this case study were clearly major strategic partners. The need for significant service efficiencies and redesign had led PCT and local authority commissioners to work in close tandem with providers when developing the overall commissioning strategy.

The case studies reveal the extent to which providers need to find significant amounts of management time and resource to participate in innovative service developments that are led by commissioners. This can bear fruit for providers, as in Knowsley where the specialist acute trust eventually won the contract, and in West Kent where a GP-owned social enterprise gained the contract for the new urgent care service (although funding for this service has since been withdrawn). In other cases, the work put in by providers was ultimately less rewarding, as in Birmingham East and North where the PCT was unable to fund the costs accruing to the proposed lead provider of the new total pathway service for care for people at the end of their lives.

In some of our case studies, commissioners were attempting to nudge providers into a population health approach to the organisation of care, whereby providers would take responsibility for a capitated budget for a specific population and some or all of their health needs. Rather than fund a certain volume of health services, commissioners wanted providers to be accountable for a set of health outcomes, such as those for heart disease in Knowsley, and organise preventative and curative services to ensure the achievement of those outcomes. This represents a major shift for most providers – hence it is not surprising that, to date, this form of commissioning is difficult to enact and relatively rare in the NHS.

It is evident from our case studies that innovative forms of integrated care call for significant changes in how primary care and community health services are delivered. This takes us beyond a traditional NHS market view of primary care-led commissioners trying to 'tell' acute providers how to deliver services differently. For example, what we found included:

- primary care leading triage and care in the urgent care service for West Kent
- general practice taking a risk assessment and population health management approach to chronic disease in Smethwick, Cumbria and Tower Hamlets
- primary and community services coordinated and led by an acute provider in Knowsley.

Time and persistence

Evaluating local health needs, taking stock of existing services and undertaking proper service redesign, specification and contracting, calls for sophisticated and long-term work on the part of commissioners and providers. With many of our case studies, the process of integrating services had taken place over a few years and required persistence in the face of challenges and adversity. For example:

- the service review of A&E services in West Kent began in June 2008 and led to the launch of a new integrated service during April 2010
- the GP networks at Tower Hamlets were rolled out in three controlled waves (September 2009, January 2010 and April 2010) after a period of increased investment in primary care and organisational development
- the development of the Smethwick Pathfinder had been led by a small group of committed GPs for 15 to 20 years.

As with previous work on high-performing organisations (Baker and others, 2008), we found the process of integrating services to be resource-intensive and requiring considerable and sustained managerial and clinical time. We identified a small number of examples of innovative commissioning, yet the NHS has been resource- and management-rich over the last decade. This is in sharp contrast with the current situation for the NHS, where management resources are highly constrained. There will be significant pressures on managers and clinicians to just keep services going and avoid deteriorations in quality and performance, let alone change them in profound and complex ways (Smith and Charlesworth, 2011). The imminent sweeping away of PCTs raises questions as to who will undertake innovative service development, and how, beyond 2011, and whether the new and transitional PCT clusters will have the capacity to take on this role while GP commissioners find their feet.

6. Policy implications

The eight case studies bear witness to how hard it is for commissioners within the current NHS policy setting to ‘stretch the boundaries’ and put in place more integrated services that can improve patient experience and secure needed efficiency savings. In a previous report, we identified a number of policy barriers to integrated care (Ham and Smith, 2010). These included:

- the emphasis placed on competition rather than collaboration
- the focus in acute hospitals on expanding hospital activity
- the perverse incentives associated with the way in which Payment by Results has often operated to date
- weaknesses in commissioning
- the impact of regulation
- the challenge of reconfiguring services as a consequence of integration.

The research reported here can be read as an account of attempts by PCTs and their practice-based commissioners to overcome these barriers. In a context in which the NHS reforms of the past decade were not designed first and foremost to support integrated care, it is not surprising that progress in the case study sites was variable, sometimes protracted and often limited in impact.

Despite this, the experience of these sites contains important learning for the next stage of reform as policy-makers continue to emphasise the role of commissioners in driving up performance improvement and efficiency. It also points the way towards the policy mechanisms that are required if the following assertion from the Secretary of State for Health’s statement about NHS reform to the House of Commons on 4 April 2011 is to be enacted:

... doctors and nurses in the service have been clear that they want the changes to support truly integrated services, breaking down the institutional barriers which have held back modernisation in the past. (Secretary of State for Health, 2011)

The implications for policy-makers of this research are set out in the following sections.

Central support for local commissioning

This research underlines the challenges in making a devolved system of commissioning – such as that now proposed by the Coalition Government reforms – work effectively. The question we were investigating – how were commissioners seeking to develop integrated models of care that would in turn enable efficiencies – has not been seen as a high priority in the Department of Health other than through the ICO pilot programme. As a consequence, resources to support PCTs and their partners in addressing this question were lacking. It was left to commissioners at a local level to search for answers, with the result that much of the same work was done in different

areas of the country, usually unbeknown to those undertaking this work. Opportunities for shared learning, or lobbying policy-makers to clear some of the barriers to integrated care, were lacking.

Not only was this inefficient, it also meant that the developmental work involved in commissioning integrated care sometimes extended over a long period of time. The clear implication is that in future, PCT clusters, and subsequently the NHS Commissioning Board, have a major part to play in supporting clinical commissioners in carrying out their core function in respect of developing innovative forms of care that can deliver efficiencies from the NHS. As we discuss below, they also have a role in the transactional aspects of commissioning to enable GPs and other clinicians to concentrate on redesigning care pathways around the needs of patients.

To be more specific, the NHS Commissioning Board has a responsibility to provide resources at a national level to avoid commissioners at a local level reinventing the wheel many times over, especially when this research has shown how costly (in time and money) this more radical commissioning and service development can prove to be. This should include offering guidance on how to commission integrated services in different areas of care, and providing advice and support on contractual routes, currencies and incentive schemes, and outcome indicators for assessment of progress. The NHS Commissioning Board will need to work closely with Monitor as the economic regulator to create a framework to support clinical commissioning groups in facilitating the emergence of integrated care where this will bring benefits, drawing on experience in the United States and other countries where relevant (Hawkins, 2011).

The tariff and incentives for integrated care

Tackling the financial physiology of the NHS is critical to enabling more influential and focused commissioning of integrated care. The Payment by Results tariff was designed by the previous government to support the introduction of choice and competition and specifically to create incentives for providers to increase elective activity to bring down waiting times for treatment and reward them for work undertaken. The tariff has played its part in that process with the consequence that access to planned care has improved significantly. Progress in elective care has enabled attention to now turn to other priorities such as providing high-quality care for people with long-term conditions where continuity and coordination are key objectives alongside access. This includes shifting unplanned care from secondary to primary care settings where this will help to deliver improvements in efficiency (Audit Commission and Healthcare Commission, 2008).

As currently designed and operated, Payment by Results does not appear to be well suited to support the implementation of these priorities and there is a need to develop incentives that will facilitate integrated care for people with long-term conditions and for other services where this approach is likely to bring benefits. Experience in the United States offers valuable learning in this regard, particularly in the development of new forms of payment that go beyond fee-for-service and case-based reimbursement. This experience, which is summarised in Table 2, includes episode-based payments and various forms of capitation funding.

Table 2: Summary of United States experience of different payment strategies in health services

Payment strategy	Description and focus	Strengths	Weaknesses
Fee for service	Payment for an individual medical service, for example, discrete hospital visits or consultant attendances. The focus of this form of payment is on the quantity of services delivered. The risk is fully borne by the payer.	<p>Ease of data collection and payment</p> <p>Favours high-speciality services</p> <p>Supports geographical variation in health care use and spending</p>	<p>No incentive for efficiency – rewards volume of service rather than quality of care</p> <p>Rewards errors with payment for correction of clinical mistakes</p> <p>Encourages the overuse of lucrative services and the underuse of less well reimbursed services</p> <p>May encourage the delivery of unnecessary care</p> <p>Puts little value on the coordination of care, or services which are not explicitly reimbursed</p> <p>Puts little value on preventative care</p>
Pay for performance	A financial incentive based on measures of quality. Providers are rewarded for meeting pre-established targets on quality and efficiency. Providers are at risk as payment is dependent on their achievement against targets. This form of payment can be combined with other payment strategies to enhance quality.	<p>Rewards quality and efficiency</p> <p>Emphasis on adherence to clinical guidance</p> <p>Fosters competition among providers based on performance measures</p> <p>Can incentivise more coordinated care</p> <p>Could improve outcomes for those with long-term conditions</p>	<p>Payment can focus on process rather than outcome</p> <p>Requires adjustment for underlying risk of patients</p> <p>Overuse of some services is not prevented</p> <p>Susceptible to gaming</p>

Table 2 (continued): Summary of United States experience of different payment strategies in health services

Payment strategy	Description and focus	Strengths	Weaknesses
Episode-based payment	A bundled payment for specified services delivered to patients for an episode of care, or for a specific condition over a period of time. A single payment that covers services from multiple providers.	<ul style="list-style-type: none"> Removes incentives based on quantity of services delivered Focus on care coordination and improved outcomes Helps to promote quality and efficiency Incentive for elimination of unnecessary services and cost reduction Incentive for providers to work together 	<ul style="list-style-type: none"> Difficult to define episodes and costs for each component Data intensive Difficult to allocate the payment across providers appropriately May encourage silo working in disease specialties Payment structure may encourage avoidance of high-risk patients
Capitation	A fixed amount per person per month, to cover comprehensive care. Capitation is payment of a prospective single fixed price for all health care needed by the patient over a specified period.	<ul style="list-style-type: none"> Incentive for care coordination to maximise efficiency Allows for flexibility in choice of care provided 	<ul style="list-style-type: none"> Significant financial risk to the provider Providers may withhold or restrict access to expensive care Payment may encourage avoidance of high-risk patients if the capitation payment is too low

The idea behind *episode-based payments* is to remove incentives to deliver increasing volumes of care by bundling together payments for a range of services relating to a particular episode of treatment. One example is the Geisinger Health System ProvenCare programme under which a global fee covers the entire cost of cardiac care from pre-admission through surgery to follow-up for up to 90 days after the operation. Episode-based payments are designed in part to improve the quality of care by placing responsibility on providers for avoiding and correcting errors, thereby encouraging care to be ‘done right the first time’, and hence offer a more coordinated and positive experience for patients.

Capitation payments go much further than episode-based payments in potentially covering all the costs of care for a defined population over a certain time period (a year, for example). Integrated health care systems such as Kaiser Permanente have pioneered the use of capitation funding (or pre-paid group practice as it was originally known) as a way of creating incentives to support prevention and primary care and avoid the inappropriate use of specialist care. Although capitation funding has a long history, there has been renewed interest in this approach in the United States in discussions of the role that ‘accountable care organisations’ might play in health care reform (Fisher and others, 2007).

An example of a promising recent initiative is the Alternative Quality Contract put in place by Blue Cross Blue Shield of Massachusetts which rewards medical groups that volunteer to take on capitated contracts for the achievement of quality standards included in the contract (Chernew and others, 2011). One of the features of this contract is the use of measures of quality of care that cover primary care and secondary care. Medical groups that work in collaboration with hospitals are able to maximise the rewards they are able to earn under the contract and agree on how these rewards are shared (Ham and Zollinger-Read, 2011). The proposed commissioning outcomes framework for the NHS and the associated quality premium could adopt a similar approach as a way of incentivising clinical commissioning groups to work closely with hospitals and other providers to improve quality of care.

In the NHS, there are various options that could now be pursued. These include:

- combining payments to cover an episode of care, or care pathway
- taking forward the idea of the ‘year of care’ that has been tested in three national pilots for diabetes and exploring how it might support integrated care
- contracting with local clinical networks (of primary, secondary, or primary and secondary care clinicians) or foundation trusts to deliver integrated care for a specific population
- accelerating work on personal health budgets to enable patients to commission care packages for themselves, with support from carers and families.

In practice, it is likely that all of these options, and others, will have a part to play and a period of active experimentation and evaluation is now needed to work through the consequences. All health care systems use a mix of payment systems related to the service that is provided (for example, episodic or long term) and where care is provided (for example, primary or secondary care). The NHS is no exception and attention is needed to the way in which financial incentives can be developed to support integrated care where it will bring benefits to patients. The prospect of four years in which the NHS budget will only increase in line with inflation underlines the urgency associated with this work and the need to focus on improving the quality of care and not simply incentivising extra activity at a time when resources are not available to do this.

An indication of the shape of things to come in relation to financial incentives that place more risk with providers is the decision to make NHS trusts responsible for emergency readmissions that occur within 28 days of discharge after planned hospital care (Secretary of State for Health, 2010). In part this is designed to counteract the perverse incentive within Payment by Results to increase activity as a way of increasing income, and in part it is intended to encourage hospitals to provide high-quality care that avoids the need for readmission. The importance of such measures is evidenced by the 11.8 per cent increase in emergency admissions that took place in the NHS in England over the five years ending 2008/09 (Blunt and others, 2010).

Any approach that focuses on funding for specific diseases or conditions will face the challenge of ensuring that the scope of services is well defined at the outset. This must avoid the dangers of cost shifting, especially for people with more than one medical condition. A more promising development than disease-based funding is to build on the example of the Smethwick Pathfinder approach described in this report and allocate a capitated budget covering all or almost all the needs of a defined population.

This could include going further than was attempted in Smethwick by encouraging GPs to work with specialists to take responsibility for budgets in what we have termed local clinical partnerships and clinically integrated groups (Smith and others, 2009; Curry and Ham, 2010).

Policy on clinical commissioning is particularly relevant to the tariff and incentives for integrated care in so far as commissioning groups will be allocated capitated budgets that are similar in some respects to arrangements in the United States for funding integrated medical groups (Ham, 2010a; Thorlby and others, 2011). Clinical commissioning groups and their constituent practices will therefore be in the position of taking 'make or buy' decisions, and having incentives to provide more services directly where this is both clinically appropriate and offers the prospect of savings. We now go on to discuss policy implications of our research in relation to rules on contracting and procurement.

Contracting and procurement

Where clinical commissioners wish to commission integrated care, they will need to do so in a way that is consistent with rules on procurement as set out in the *Procurement Guide for Commissioners of NHS-funded Services* (Department of Health, 2010b). This guidance distinguishes between:

- new services which should be tendered openly
- services where the commissioner is seeking substantial change in specification or setting which should also usually go through open tendering
- services where there is only one capable provider and which are therefore suitable for single tender action
- services where there are incremental improvements which can be handled through contract variation
- those encompassed by any qualified provider which do not have to be tendered as they are covered by the accreditation of any willing providers.

In many cases, commissioning integrated care will fall into the category of a substantial change in specification or setting that should go through open tendering. One approach would be to do so by placing a contract with a lead or prime contractor (either a single provider or a partnership/joint venture between providers as in the Knowsley, Somerset and West Kent examples in our case studies) who might in turn work or subcontract with other providers to deliver services in line with the commissioners' specification. This could be funded through a fixed budget that would transfer risk to the lead contractor and might include incentives linked to performance against agreed outcomes. An initiative along these lines is already under way in the East of England through work on commissioning integrated pathway hubs.¹

1. www.eoe.nhs.uk/page.php?page_id=2045

Recent advice from the Department of Health (DH 2011: pp14–15) has endorsed this approach, arguing that:

Where service integration and continuity of care is important to secure the best clinical outcomes, patient experience and value for money (for example, in end of life care), the intention is that commissioners will be able to go to competitive tender and offer the service to one provider or 'prime contractor'. In this model, patients would still have choice of treatment, setting or lead clinician, and potentially of provider for certain services within the pathway.

The Procurement Guide (Department of Health, 2010b: p6) states that partnerships and joint ventures are:

... likely to be particularly important where new service models are required, for example, in the development of home-based end of life care, or the community management of long-term conditions such as COPD or diabetes.

It goes on to note that voluntary and independent sector providers can often bring particular expertise to partnerships. Commissioners are encouraged in the guide to use procurement to facilitate and encourage partnership working, making use of 'long-term contracts and innovative funding and risk-sharing mechanisms which may help to support sustainable strategic partnerships' (p6).

An example of how contracting partnerships currently work is Guy's and St Thomas' Serco (GSTS), a joint venture between Serco and Guy's and St Thomas' NHS Foundation Trust focused on pathology services. GSTS is based on the principle that the contract should focus on the desired outcomes of the service. Within the contract there are clear incentives related to the delivery of these outcomes and also the use of gain-sharing arrangements to motivate providers to meet or exceed the requirements of commissioners. Serco's work in health care draws on experience in other areas including Welfare to Work where it is the prime contractor and manages the supply chain through a network of high-performing subcontractors.

The role of Monitor and economic regulation

The provisions of the Health and Social Care Bill build on previous policies to promote competition both through the role of Monitor and also through the involvement of the Office of Fair Trading and the Competition Commission in ensuring a level playing field between providers. As a result of the work of the NHS Future Forum (2011), the government has decided to amend the Bill to place Monitor under a core duty to protect and promote the interests of patients and not to promote competition as an end in itself. One of the main recommendations of the Future Forum was that the emphasis on competition in the government's plans should not create barriers to the development of integrated care, and this was accepted in the government's response.

Going forward, the main priority is to ensure that Monitor adopts a nuanced and proportionate approach that promotes both competition and integration, and keeps in mind the overall need to improve health outcomes and increase service efficiency. Competition is likely to bring benefits in areas such as planned care by ensuring that patients have rapid access to high-quality elective and diagnostic services. Collaboration is more appropriate in the case of unplanned care and in specialist services such as cancer and cardiac care where networks are needed to coordinate services and improve outcomes.

This highlights the need to determine the most appropriate method of competition for unplanned and long-term care. Unlike in elective care, where choice of provider in relation to episodes of care is often appropriate, competition might operate at a network level, with patients and their clinicians able to select a provider capable of delivering high-quality packages of care over time, if necessary in collaboration with other providers. This would be an example of competition for the market, as distinct from competition in the market, and it could be facilitated by commissioners using an open tendering process as described above to select a provider able to offer these packages of care for a defined contractual period.

The implication is that Monitor and the NHS Commissioning Board need to support clinical commissioners in using both competition and integration to realise the benefits of the reforms for patients. This includes working with commissioners as to when the use of tendering – something seen to be costly and time-consuming in our research – is required as a means of bringing about necessary changes to local services. This appears to have been recognised by the Secretary of State for Health and by the NHS chief executive in recent speeches and guidance. For example, David Nicholson's letter to NHS chief executives on managing the transition stated that:

In future, commissioners will have greater scope to develop integrated care pathways where this makes sense, working with a range of local clinicians, and new health and wellbeing boards will promote integration across the NHS, social care and public health. We are encouraging GPs to work with local hospitals to improve care pathways. Clinician-led commissioning will support integrated care and commissioners will have the flexibility they need to be able to bundle services together across a pathway where this makes sense. (DH 2011: p14)

As these comments indicate, clinical commissioners will in future have a major role in respect of using their control of budgets to support integrated care, within the framework set by the Health and Social Care Bill and the role within this of Monitor. In a recent speech, the chairman of Monitor argued that:

... it would be Monitor's job to seek to achieve a healthy combination of competition and collaboration through the approach we take. Allowing patients with long-term conditions to choose the best care packages for themselves, in consultation with their doctor, would also no doubt drive some further integration. GPs should be able to work with clinicians from hospitals, and hospitals should be able to work with other hospitals, to plan ways in which patient care can be improved, provided that this does not exclude other qualified providers from participating in the provision of care as well. (Bennett, 2011: pp15–16)

The role of GP commissioners in 'making' as well as 'buying' services

Under the government's plans, GPs are well placed to take the 'make or buy' decisions that offer the potential to improve patient care by delivering integrated care closer to home through closer collaboration between practices, community health service providers and other partners, including specialists. For example, Smethwick Pathfinder reports a reduction in hospital admissions due to innovative practices under a PMS Plus contract. The policy challenge is to ensure that Smethwick Pathfinder, and others like it, are not in future prohibited from adopting this approach by legitimate concerns about conflicts of interest surrounding GP commissioners who may use their control over budgets to place contracts with organisations in which they have financial interests as providers.

One way of squaring the circle would be to develop a proportionate approach that does not deter innovative GPs from playing a full part in commissioning, while giving assurance that conflicts of interest are being managed effectively (Ham and others, 2011). Such an approach would include robust governance arrangements in commissioning groups, for example, having patients and the public on commissioning group boards and requiring all decisions above a certain value to be published. As well, commissioning groups should be required to adopt open-book accounting with an opportunity for aggrieved parties to ask for commissioning decisions to be reviewed. GPs with a financial interest in providers who might benefit from commissioning decisions should not take part in making these decisions.

In this context, it is relevant to note Porter and Teisberg's (2006) argument in the context of the United States that 'Government policies creating artificial obstacles to integrated multi-disciplinary care (for example, the Stark laws) should be modified or eliminated' (p357). The laws that Porter and Teisberg are referring to are those that prohibit doctors from referring patients to services in which they have a financial interest. These laws have the effect of 'fracturing the care cycle' (p357) as well as making it 'more difficult for physicians to organise integrated practice units addressing the care cycle' (p358). The challenge in England is to avoid creating similar barriers to the delivery of high-quality integrated care (Ham and Smith, 2010; Lewis and others, 2010).

This challenge is particularly important when many GPs who are in the vanguard of commissioning are motivated by the prospect of providing more services directly in collaboration with other practices and the providers of community services. This interest by primary care-led commissioners in developing new and extended provision of primary and intermediate care services has been identified as a consistent feature of different primary care organisations over the past 20 years (Smith and others, 2004; Smith and others, 2010). New provider organisations have been set up by GPs to support these developments and doctors often have a financial interest in these organisations. Clinical commissioning offers an opportunity to build on these developments and strengthen and reshape the community-based health care infrastructure in the NHS in ways that have for so long eluded the NHS, provided that concerns about conflicts of interest can be handled appropriately.

The future of commissioning

In emphasising the opportunities available to GPs as providers as well as commissioners to drive improvements in performance, we are led to reflect on the implications of our research for the future of commissioning. In previous work, one of the authors has drawn on international evidence to raise major questions about the desirability of there being a clear separation of commissioning and provision. These questions derive from the universal challenges facing commissioners because of the complexity of health care provision, information asymmetry between providers and commissioners, and shortages of people and skills to undertake health care commissioning (Ham, 2008b).

The work reported here lends support to this argument in illustrating the inherent difficulties faced by primary care trusts in commissioning integrated care. In view of these difficulties, there is a need for realism in relation to what clinical commissioners are likely to achieve, at least in the short term, alongside active consideration of the alternatives. In our view, one of the most promising alternatives is to explore how clinical commissioners can learn from the experience of integrated medical groups in the United States. As discussed above, this includes encouraging hospital-based

specialists to work alongside GPs in commissioning and enabling consortia to facilitate the development of multi-specialty clinical partnerships to provide services (Ham, 2008a; Smith and others, 2010; Ham and others, 2011). GPs and specialists would in this way take on risk-bearing capitated budgets, accounting to commissioners (PCT clusters, NHS Commissioning Board outposts or commissioning consortia) for financial, service and health outcomes.

The experience of the United States serves as a cautionary tale in illustrating the potential of multi-specialty clinical partnerships to deliver high-quality integrated care while also highlighting the obstacles that have to be overcome along the way (Ham, 2010a; Casalino, 2011; Thorlby and others, 2011). Having experienced rapid growth in the early 1990s, many integrated medical groups working with capitated budgets went into retreat and only those that were well led and managed and with the necessary experience and infrastructure (such as information technology (IT)) to manage risk have continued to operate in this way. These are often large groups that have had time (typically 15 to 20 years) to evolve and realise the benefits of being able to make as well as buy services.

Recent research has drawn on the experience of medical groups in the United States to highlight some critical factors for successful primary care-led commissioning and service development (Thorlby and others, 2011). These factors include a strong sense of ownership by doctors of the group; being multi-specialty in nature; continuity of medical and managerial leadership; a clear and negotiated approach to financial risk, including flexibility to adapt this over time; having clear and meaningful financial incentives for clinicians that are linked to quality, and not cost of care; and investing heavily in management and IT support. Also important is being able to access commissioning support to enable clinicians to focus on service redesign rather than the transactional aspects of commissioning (Ham and Zollinger-Read, 2011).

The point to emphasise is that integrated medical groups deliberately blur the boundary between commissioning and provision rather than insisting on a clear separation of these functions. Not only this, but also commissioning of care by medical groups working with capitated budgets is complemented by strategic commissioning undertaken by health insurers. The latter often support medical groups by taking the lead in negotiating contracts with hospitals and other providers (for example, in relation to prices and quality standards) as well as themselves commissioning medical groups through the use of capitated budgets linked to the achievement of improvements in quality (as in the Alternative Quality Contract in Massachusetts described above). Health insurers have access to a wide range of medical and other expertise to enable them to work in this way.

It follows that clinical commissioners are likely to benefit from the support of PCT clusters, the NHS Commissioning Board and other sources of expertise as they take on their responsibilities. Equally important is recognition that harnessing the provider expertise of GPs and specialists in commissioning could be a real strength if the concerns about conflicts of interest discussed above can be addressed through the mechanisms outlined. Put more positively, the weaknesses in commissioning that have been evident in the NHS since the introduction of the internal market in 1991 are more likely to be tackled by making use of the expertise of doctors and other clinicians in decisions on resource allocation rather than by insisting on a rigid separation between commissioners and providers.

To make this point is to underscore the importance of integrated care in relation to both how services are provided and how they are commissioned. Evidence from high-performing health care systems like Kaiser Permanente in the United States illustrates the benefits that derive from bringing together responsibility for commissioning and provision into the same organisation and policy-makers need to act on this evidence in taking forward plans for the reform of the NHS in England. Kaiser Permanente and other established integrated systems lever the benefits of collaboration between clinicians and they are stimulated to deliver high levels of performance because they operate within a market environment in which members can choose to have their care provided elsewhere if they are dissatisfied with the service they receive.

Learning from this experience, one option would be to migrate towards a system in which NHS patients can choose between competing clinically integrated systems that hold the budget for defined populations and are responsible for the full continuum of care (Ham and others, 2011). By focusing choice and competition primarily at the level of integrated systems, there is much greater potential to deliver the improvements in efficiency that the NHS is required to achieve than promoting choice between a diverse and fragmented array of providers. This would also be a practical example of how to make use of both competition and integration in the next stage of NHS reform.

Conclusion

The balance of risks and incentives placed on commissioners and providers in the NHS appears at present to be wrong. Commissioners seek to develop more population-focused and preventative approaches to care, and avoid inappropriate admissions to hospital, yet providers remain incentivised to increase activity and expand services within their organisation. Perhaps the strongest message from this research is that **PCT commissioners have struggled to put providers sufficiently at risk in relation to developing better integrated and more efficient care.** The examples of Somerset and Knowsley are partial exceptions to this rule, showing how this can be done through tendering for a new pathway of care from a lead provider or partnership of providers, putting the providers at risk for service quality, health outcomes and financial performance.

The power of an outcomes-based approach to commissioning is evident from the eight case studies explored in this report. This focus on having processes in place that enable providers to deliver more integrated care, while being held to account for health, service and financial outcomes, accords with evidence on the use of outcome measures to incentivise and monitor sustained innovation in health care, and research into the key ingredients for integrated care that points to the importance of ‘integrative processes’ rather than heading straight for an integrated provider organisation (Rosen and others, 2011). Such processes include: IT and data; governance; leadership; clinical service protocols; and incentives.

As for commissioners, as well as needing the correct financial physiology of incentives to apply across primary and secondary (and arguably also social) care, and a clear set of measurable outcomes, **they need to determine the appropriate scope and scale when seeking to integrate services.** This means focusing on areas known to be susceptible to a more integrated approach (such as chronic disease and care for people at the end of their lives), where it is felt that patients are being most poorly served, and experimenting with new forms of payment and contracting in a way that promises significant service changes, reductions in inappropriate hospitalisations and hence much-needed efficiencies.

Commissioners need to **be able to encourage and incentivise providers to develop better integrative processes,** and to work with others to develop more integrated care. The research reported here suggests that commissioners do not need to over-focus on specifying details of structures and process within providers – they should instead develop outcome measures with linked incentives that lead providers to work with partners to bring about new forms of more integrated care. Thus, the commissioner becomes not the enforcer of a contract (albeit that they may on occasion have to do this) but the crafter of an environment where providers are both at risk for, and incentivised towards, ensuring that local organisational processes are in place which can deliver high-quality care for a particular population.

Finally, the international evidence on integrated care supports its significant potential to improve service quality and patient experience, even though there are as yet fewer

studies that have examined its capacity to yield efficiencies for funders (Ramsay and Fulop, 2008; Curry and Ham, 2010; Alakeson and Dixon, forthcoming). The mixed nature of the evidence appears to be a result of the lack of longitudinal studies, the fact that evidence is scattered across services and disciplines, and that those seeking to develop integrated care in the NHS have not always had the necessary wider policy and organisational support when embarking on what can be profound changes to how, where and when services are delivered. This highlights **the need for more robust and sustained research of integrated care initiatives**, and for such studies to be used as a means for developing measures of success for integrated care – measures that can be used in tendering, contracting and monitoring of new services. Only if this is done will we get a true sense of the quality and efficiency benefits of integrated care for commissioners and patients.

Key points

- Previous integration initiatives have tended to come from the providers of health and social care. This report looked at the role of commissioners because policy-makers are increasingly interested in how commissioning can be used to improve services and make them more efficient.
- Eight areas in which PCTs and their GP commissioning partners had tried to commission more integrated services were studied in detail. In all cases, the process of assessing needs, drawing up contracts and tendering for services was time-consuming and expensive, suggesting that commissioners need to identify significant resource for this purpose, and wherever possible learn from the experience of other commissioners.
- Determined and committed leadership from senior managers and clinicians was needed for success, as were access to the registered list of patients held by GPs and other sources of data, the provision of good IT systems and effective provider engagement.
- The last decade of NHS reform has focused on increasing competition to improve access to elective services. This has raised a number of barriers to commissioning integrated care to meet the complex needs of people with long-term conditions, so it is not surprising that the eight study sites had made variable progress over a protracted period.
- The Coalition Government can encourage commissioning for integrated care by: making sure that the NHS Commissioning Board provides appropriate guidance and support and helps clinical commissioning groups reinvent the wheel when specifying services and developing contracts or payment approaches; aligning the regulatory framework and the tariff – or price paid for NHS services – with that of guidance that encourages more integrated care; and exploring new tendering and contracting options for non-elective services.
- There may be a need to revisit the split between commissioners and providers, so that innovative commissioners can ‘make’ as well as ‘buy’ services. One option would be to encourage GPs and specialists to take on capitated budgets and organise services to deliver defined outcomes. Eventually, patients might choose between the competing but clinically integrated networks.

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Appendix 1: Details of the case studies

1. Tower Hamlets – commissioning with networks of GP practices

Background

Approximately three years ago a benchmarking study was undertaken that indicated the PCT had been consistently underinvesting in primary care in Tower Hamlets. The PCT responded to the findings of the study with increased recurrent investment of approximately £6 million in primary care, moving the PCT from the bottom quartile to the top quartile against the benchmarked spend. At this time the PCT also felt they could do more in the way primary care services were commissioned to improve performance.

The strategic direction was to create networks of GP practices. The networks are the basic building blocks for investing in primary care, strengthening provision and improving outcomes.

Approach

The overall purpose of the networks is to enable integrated clinical provision of care packages. The scaling up from practices to networks was important, as networks of practices could share resources and specialist staff. They provide a basis for looking at the use of the estate and provide scale to develop extra services. Importantly, they are also a basis for peer review and peer comparison among practices.

The networks are geographically based, and are coterminous with the local authority boundaries of Local Area Partnerships.

There is one commissioning consortium in Tower Hamlets. As part of the implementation of a network approach, the membership of the consortium changed to ensure each network was represented (a mix of clinical leads and GPs) at the consortium meetings.

The operational arrangements (for example, management and governance) of each network were assessed by a panel, comprising the PCT chief executive, medical director, local medical committee (LMC) representatives and others, prior to approval of the network.

The networks were rolled out in three controlled waves (September 2009, January 2010 and April 2010) which enabled lessons to be learned and applied. As part of network development, the PCT provided approximately £149,000 to each network to assist with administration, invest in the management structure (for example, setting up a board) and back-fill GP and nursing time. The organisational development needs of the networks were met through a combination of pan-network development, and each of the networks was also able to commission support to assist with its specific needs.

Diabetes

The first care package to be rolled out was for diabetes. Diabetes was chosen because of prevalence and need in Tower Hamlets. In addition there is a strong base of clinical evidence for diabetes management.² The PCT had specific objectives around diabetes management that could be met through the networks, for example:

- decreasing the geographic variation in delivery of care
- getting the right person, in the right place, doing the right things, at the right time (i.e. appropriate use of workforce)
- using secondary care more appropriately (for example, through multi-disciplinary meetings).

The PCT is commissioning on outcomes rather than activity for diabetes, through a hybrid-enhanced service arrangement. Seventy per cent of the funding is provided upfront and 30 per cent is held back, to be allocated based on achievement of outcomes, for example, patient experience and the proportion of patients for which their diabetes was actively managed and controlled.

The network holds the contract with the PCT. The contract is signed by each practice, thus allowing for the practices to be managed as a group. The outcomes and remuneration are measured at the network level. The care packages now form part of a broader alternative provider of medical services contract which allows a number of services to be managed and monitored at network level.

The PCT has separate contracts with the community diabetologist and the PCT provider arm for the community nurse input. Only the networks have risk-based contracts. The PCT did consider contracting through a lead provider arrangement, but felt it was too much too soon, preferring instead to integrate provision first.

Immunisation and vaccination

Following the roll-out of the diabetes programme, networks were encouraged to roll-out a package of care for immunisations and vaccinations. The focus of the programme has been to implement a call/recall system across the network. As there are issues with literacy levels in Tower Hamlets, people are also contacted by telephone or in person.

An IT system was developed to support roll-out of the programme. The system was developed with clinical assessment groups (who are responsible for data entry). The PCT has found that the reporting of results motivates the networks and provides an opportunity for recognition among peers. The information is trusted and considered to be useful because it is:

- frequently updated – not live, but everyone can see the impact of activity on the indicators within a week
- clinically led (the indicators were developed and agreed by clinicians)
- obtained by an honest broker.

2. The package of care was developed by a GP, community specialists and public health experts.

The PCT has invested £14–15,000 into each network to enhance the immunisation and vaccination services. The impact has been transformational, due to:

- the move to clinical (as opposed to managerial) leadership
- everyone using the same data
- the recognition of the increased investment in primary care
- transferable benefits from organisational development of the networks
- the PCT managing itself differently (with discussions focusing on outcomes rather than management of activity)
- improved relationships and camaraderie across GPs, particularly those who were isolated previously.

Outcomes

While the impact of the new diabetes service is yet to be determined, the results of the vaccination and immunisation service are encouraging. For example, the PCT reports an increase in coverage of childhood immunisation (MMR2 at five years old) from approximately 55 per cent in 2006/07 to over 80 per cent in 2009/10.

Challenges

The PCT has encountered a number of difficulties with developing the network system:

- It was initially difficult to align the community health services with the networks.
- Some partners were less willing to engage.
- One practice was reluctant to share its data, even though it is a high-performer.
- There were problems with bringing together practices that did not know each other.
- Currently there are no levers or incentives for secondary care to support the network approach.

In the future, the PCT will continue to strengthen the networks, improving their links with community health services and social care. Levers and incentives for secondary care to support the networks will be built into the secondary services contracts. The networks are currently exploring options for their legal status and are keen to clarify arrangements for employing staff, liability and insurance.

Lessons

The networks have been very positive for PCT/GP relationships. The managers have been at the PCT for a long time, and the continuity of support for the development of networks and investment in primary care has been crucial to their success. The PCT is very conscious that good relationships between the PCT and GPs will be essential in the future.

2. Smethwick Pathfinder – primary care-led commissioning of population health

Background

Smethwick Pathfinder is a Personal Medical Services (PMS) Plus primary care provider organisation that uses practice-based commissioning as the vehicle for assuming a population-based and risk-adjusted budget to provide and commission care for its registered population.

Pathfinder has worked closely with Aetna Health Services UK in developing the care management programme that focuses on self-care and independence, and reducing reliance on secondary care services and health professionals.

Approach

Pathfinder Healthcare Developments is a community interest company (it reinvests any surpluses for the good of the community) and is owned by Smethwick Medical Centre in the West Midlands. It regards itself as a social health maintenance organisation, assuming a population-based budget that enables it to stratify its population according to health and social care risk, and develop a range of screening, self-care, patient education and chronic disease management services for its patients.

Smethwick Pathfinder raised capital to develop the population health programme via a loan from Big Issue Invest which was underwritten by an additional mortgage on the Smethwick Medical Centre building. In this way, the GPs were making a very real and personal investment in (and taking a risk for) the proposed new approach to care management. The PCT has also provided financial backing, as has Aetna.

The principle of practice-based commissioning was part of the background to the approach, with the GPs and their team wanting to do more than have an indicative budget for health services planning. They preferred instead to use their significant provider base (developed through PMS Plus) to negotiate a real and population-based capitated budget for their population, and to put in place a much more proactive approach to the management of people's health and the avoidance of illness.

Aetna has been the main strategic partner of Pathfinder, providing significant support in relation to risk stratification, population health management and chronic disease care. Pathfinder sees itself as a managed care organisation that is both commissioner and provider, using its registered list and population health approach as the basis for providing as many services as possible in primary care, and commissioning a different spectrum of services to support patients and avoid unnecessary admissions to hospital.

Through the new population health management approach being adopted by Pathfinder and Aetna, the following areas of work and services are being developed:

- telecare, telephone-based care-management support for people with long-term conditions and home-based intensive nursing support
- targeted work for children with asthma, this being a cohort that has emerged from the stratification work as being high-risk
- services for the group of people who attend hospital even when general practice is open, that is patients who regard A&E as their primary care centre

- appointment of a doctor who provides telephone-based advice to patients who cannot get an appointment. The doctor rings the patient back and assesses if they need to go to hospital, or if they need some other form of urgent care
- development of group consultations for patients with long-term conditions such as back pain, hypertension, and families of children who have had multiple admissions to hospital.

Outcomes

Smethwick Pathfinder has commissioned a comprehensive evaluation of its approach from the Evidence Centre.

Challenges

The organisation has become much more proactive and strategic in its approach to managing patients' care, and in identifying those individuals and families most at risk of hospital admission or other care complications. As population health management often focuses on the frail elderly and other adults with long-term conditions, Pathfinder has had some surprises, such as the need to focus on children with asthma and those having multiple hospital admissions.

The new approach is concerned with upstream health and care, and in identifying and managing risk. It is leading to the development of new forms of primary care service, such as a different urgent care offer, telephone management of care, internet and telephone consultations, and a more sophisticated approach to the collection, analysis and use of patient data.

Lessons

Specific lessons learned include:

- the need for high-quality and sustained project management, including support from Aetna
- the importance of moving the work forward by having a total population budget (Pathfinder is seeking this from the PCT) in order that acute care could be managed by Pathfinder, selecting providers who will deliver care in ways that are agreed with Pathfinder GPs and nurses
- the value of having Aetna nurses as part of the clinical team, along with practice and district nurses, and all based in the same building
- the importance of being able to commission community services to the population health model via use of PMS Plus freedoms
- the way in which a population health management approach leads to changes to general practice, including changes to the role of the GP towards being a supervisor and mentor within the wider team
- the value of training and using lay health workers to assist with risk identification and self-care training
- the need for extensive patient and public involvement to explain the new approach and to monitor its roll-out.

3. West Kent – commissioning a new integrated primary care out-of-hours and emergency service

Background

In April 2010, NHS West Kent launched a new integrated primary care out-of-hours and emergency primary care service in A&E. Funding for the emergency primary care service has subsequently been withdrawn. The integrated service ran from hubs in Maidstone Hospital and Darent Valley Hospital. Emergency primary care clinicians were based in A&E 24 hours a day, 7 days a week, providing emergency primary care as a means of reducing avoidable hospital admissions. In addition, primary care out-of-hours services are provided from six locations across West Kent, in community hospitals and a health clinic.

The service is managed by South East Health and is delivered by a team of local GPs, nurses, urgent care practitioners and specialists (for example, community psychiatric nurses). South East Health is a social enterprise and not-for-profit organisation owned by local GPs, and grew out of the local out-of-hours cooperatives in Kent, Sussex and Surrey.

The previous configuration resulted in a number of unsatisfactory outcomes. For example, patients felt confused about where to go with their urgent care needs, and clinicians felt frustrated by the fragmented deployment of resource. Often patients would default to an acute A&E department, perceiving this to be their only option for rapid assessment and treatment.

Approach

A service review was carried out by the PCT from June 2008–March 2009, including a review of the performance and value for money of current services, an assessment of the pilot emergency primary care service in Maidstone Hospital, a review of service demand (based on activity data and needs assessment) and benchmarking against national best practice.

Alongside the service review, the PCT undertook comprehensive stakeholder engagement with the public, patients and health professionals, and developed a vision for primary care out-of-hours. Clinical and public stakeholders were also involved in service specification and the process of procuring the new service.

A market assessment helped the PCT to identify potential providers and to consider its procurement options. This provided the project team with a clear picture of the number of market players, the innovative service models within the market place and a view on the competitive climate.

Using stakeholder feedback and analysis of provider options, the project team developed potential models of out-of-hours and emergency primary care services. This led to a decision to commission an integrated primary care out-of-hours and emergency primary care service in A&E.

The PCT developed an outcomes-based service specification which included: a set of key performance indicators; service requirements (for example, opening hours, tailored provision for children); and ways in which integration was to be enacted, for example:

- links between specific services
- close working between senior managers for the development of pathways, performance monitoring and training
- links and signposting to all interfacing services (for example, ambulance, social care, palliative care, substance misuse)
- seamless transition between services
- incentives for the provider to avoid unnecessary hospital admissions.

Outcomes

A pilot of the integrated service indicated there would be benefits for patients, financial savings and strategic benefits across the health community. Surveys indicated greater patient satisfaction, a significant decrease in average time from arrival in A&E to assessment and a decrease in the average total time patients spend in A&E.

The pilot emergency primary care service in Maidstone resulted in reduced A&E attendance costs and emergency admissions. Gross savings over the life of a three-year contract were expected to be £3–4 million when compared to previous out-of-hours and A&E attendance costs. In particular, approximately £600,000 of activity was decommissioned from the acute hospitals for 2010/11.

Challenges

The PCT recognised the value of proactive engagement with the public, clinicians and community stakeholders in reviewing current services and in developing new service models, especially in relation to the quality of the service specification. Nevertheless, the process of engagement took far longer than was anticipated.

Lessons

NHS West Kent reports lessons learned from the experience of commissioning the new integrated service include:

- there was a need for strong project governance – NHS West Kent had effective project leadership and a dedicated multi-agency/professional steering group which kept the PCT board up-to-date with regular reports on progress
- engagement with acute trusts needed to take place right from the outset, to build relationships, undertake joint working in the pilot stage and be part of the decision-making process
- the decommissioning of acute activity takes strong leadership and acute trust buy-in to make this happen
- arrangements regarding estates, information management and technology, and human resources issues need to be agreed early in the procurement process
- developing the contract at the same time as developing the invitation to tender documentation would have saved time in the later stages of the process.

4. Birmingham East and North – commissioning for care for people at the end of their lives

Background

Birmingham East and North (BEN) PCT set out to develop an approach to commissioning that was based on capitation funding and resulted in managed care. Elements of the approach include:

- managed care systems – the organisational framework
- integrated care pathways – the quality assurance tool for individual patient care
- clinical protocols – for example, in Map of Medicine.

Approach

In BEN, the new approach to commissioning has been taken forward through the following eight themes:

- maternity
- children and young people
- trauma
- infectious diseases
- mental health and dependency
- long-term disease
- frail older people and dementia
- end of life

By commissioning managed care systems, the PCT is able to let a single contract and commission a pathway, rather than individual provider activity. The PCT chose to test the new approach through care for people at the end of their lives.

This area of care was selected because of the diversity of need and current provision which, with the lack of joined-up care, results in poor choice and outcomes. The thinking at the outset was that the PCT would commission a lead provider instead of having separate contracts with many different providers (16 in the current system). The aim was to use the learning from this area of care and to apply this in other areas, such as a managed care pathway for stroke care.

In the approach taken by BEN, the role of commissioners is to define the pathways and quality outcomes required and not to determine the detailed interventions. The role of the lead provider is one of organisational coordinator, managing subcontracted providers, using fiscal and organisational levers, to make the service delivery to the patient and family the central focus of the work. The PCT wanted to avoid any one provider dominating delivery, so if the lead provider actually provided services to the patient, then this provider was able to deliver a maximum of 40 per cent of the total service.

The PCT went about commissioning a new model of care for people at the end of their lives through a competitive dialogue procurement process. This has taken a year, with extensive developmental work on an appropriate contract and specification for both the pathway components and the role of the lead provider. The importance of this process is that the specification is jointly developed and improved by the PCT and the competing providers.

The aim is to use incentives to share gains with providers. Under the proposed contract, the income of providers is related to performance. The cost of the lead provider will be met for the first year and subsequently will depend on the savings that are delivered.

The initial advertisement was published in the summer of 2009. The PCT had 29 expressions of interest and nine applications (50 per cent of these from consortia organisations). The market is made up of multinationals, national commercial providers, charities and local NHS providers. The procurement process proved to be a powerful learning experience for all concerned.

Outcome

At the end of the competitive dialogue, the PCT identified two preferred bidders. One was an alliance between two existing providers and the other was an independent sector provider new to the market. In the event, the financial pressures facing the PCT during 2010/11 led to the procurement process being withdrawn as the initial cost of the lead provider could not be met.

Challenges

A number of challenges were identified in this work. Most importantly, the PCT does not know the cost of the care pathway. As an estimate, about £9 million of work is currently delivered through hospice care and by district nurses but there is a lot of uncertainty and costing for pathways is difficult. The true cost may be three times this amount if acute care and other elements are included. Defining the currency for the pathway for people at the end of their lives is a further challenge, particularly a currency able to differentiate between different levels of need and risk associated with delivery.

Lessons

The PCT found that there are few organisations with the capacity to manage such large contracts, and even fewer who have a developed vision to support the patient and family-led service design that is required. Also, the appropriate organisational model to deliver the contracts is not clear. The most obvious may be an existing organisation but it is more likely that some form of hybrid organisation may be more effective, where a number of organisations come together to form a special purpose vehicle to deliver the contract. Such a vehicle may be a limited company, a GP consortia or social enterprise.

5. Milton Keynes – commissioning urgent care services

Background

Milton Keynes PCT set out to develop new forms of commissioning to manage care. The PCT's chief executive was influenced by experience in the United States and especially the role of payers in facilitating the emergence of integrated care. Milton Keynes was faced with the need to make substantial savings, reduce waste and inefficiency, and address misaligned incentives. Specifically, Payment by Results created incentives to increase hospital activity when the aim was to give more emphasis to prevention and care closer to home.

Approach

The PCT's Strategic Plan Refresh for 2009–14 summarised the proposed approach in the following way:

NHS Milton Keynes proposes to improve outcomes and reduce waste by catalysing the formation of 'Integrated Care Systems' using new payment methods that incorporate significant outcome-orientated financial incentives. Integrated care systems will provide care for categories such as children's care, mental health, older people's care, and be defined by this rather than the providers' location or service type. Each system will be made up of groups of general practices working together and in partnership with integrated multi-disciplinary teams of generalist and specialist community and hospital-based care.

The key features of integrated systems are:

- *involvement of the patient in the management of their own care*
- *clear leadership for professionals within each integrated system*
- *(secure) sharing of clinical records and information between professionals involved in a patient's care*
- *shared pathways of care with clear responsibility at each step*
- *strong management and administration of integrated services, with clear accountabilities and governance arrangements*
- *funding shared between providers such that prevention and early management are incentivised.*

Each integrated care system will be led by an accountable provider (or consortium of providers) with which Milton Keynes will contract. The contract will be constructed from a core (capitation-based) budget plus significant incentive payments based on performance against health, inequality and user experience outcome measures.

The PCT explored a new approach to commissioning focused on commissioning defined blocks or categories of care. Originally, the thinking had been to do this for specific diseases such as COPD. It was quickly realised that a more ambitious approach was needed, focusing on larger blocks of care such as maternity services and services for people with learning disabilities. The PCT sought to identify a lead provider to take responsibility for delivering the care within each block in association with other providers who would work as subcontractors.

The lead provider was considered to be an 'accountable care organisation' that would take on a budget and would be responsible for delivering care in line with agreed standards. The accountable care organisation would manage the supply chain and work with other providers to achieve a more integrated approach. In order to achieve savings and improve performance, the lead provider would be expected to deliver care with a budget comprising approximately 90 per cent of existing expenditure with the prospect of receiving an additional 5 per cent based on performance.

In the early stages, the PCT and partner organisations spent considerable effort defining blocks or categories of care. The PCT also recognised the need to define care pathways for specific conditions and diseases, within the blocks of care. Map of Medicine was seen as the best way of doing this as it provided 400 to 500 evidence-based care pathways that could be taken off the shelf and used in the commissioning process.

Outcomes

A four-year programme has been put in place with 2010/11 as the planning year, and most new contracts are expected to be put in place from 2011/12. Urgent care has been selected as the first block to be addressed and this will be done through local negotiation rather than an open tendering process. There are a number of options for lead provider of urgent care, including a joint venture between the acute foundation trust and the out-of-hours organisation run by local GPs.

Challenges

A number of challenges have been identified in Milton Keynes:

- the complexity of commissioning in this way which is quite different to the traditional NHS approach
- the capability of the PCT's staff to commission blocks of care in relation to both the technical issues and the relationships involved
- the capability of providers to work in this way with the PCT and with other providers in a supply chain
- the difficulties in developing new payment systems that go beyond Payment by Results and create incentives to support integration
- the time taken to migrate from the traditional approach to the new one and to release savings in the process.

In the medium term, there is a question about the fit between this approach and the rules on cooperation and competition developed by the Department of Health.

Lessons

The PCT has found it is necessary to develop clinical leaders in both primary and secondary care to support this way of working. There is also a risk of creating new silos by defining blocks of care.

6. Cumbria – commissioning integrated diabetes care

Background

Cumbria PCT has focused on commissioning integrated diabetes care as part of a more broadly based programme to devolve budgets and responsibility to GP-led localities. The PCT's chief executive has had a long-standing commitment to integrated care based on a visit to Kaiser Permanente a decade ago and in Cumbria has worked with GP leaders to take this forward at a locality level. Practices in localities are aligned with community health services and GPs are involved in the provision of care in community hospitals. Commissioning is increasingly undertaken in localities, with the PCT retaining a role as system manager.

Approach

Work on diabetes builds on the development of integrated service models in Northumbria and Bolton and has been taken forward with advice and support from Sue Roberts, formerly national clinical director for diabetes in the Department of Health, who has acted as clinical adviser to the Professional Executive Committee (PEC). The Cumbria diabetes model of care has the following four components:

- core primary care services that deliver all routine care for patients with Type 2 diabetes
- enhanced primary care services that provide core services and routine continuing care (including care planning) for patients with Type 1 diabetes and insulin initiation for Type 2 diabetes
- specialist support for primary care, entailing assessment of patients with newly diagnosed Type 1 diabetes before referring to enhanced primary care services for routine care; regular visits to primary care teams; and coordination of all the support services for primary care traditionally provided from multiple providers (including patient education, staff training, nutrition, podiatry and psychology)
- complex care services for individual patients with complex needs, including inpatients.

Within the model, pathways of care have been defined for both Type 1 and Type 2 diabetes.

Central to Cumbria's approach is a shift away from GP referral to specialists based in hospitals, to specialists working alongside primary care teams in the community. The specialist provides one-to-one care and works with primary care teams to improve the quality of diabetes care for the whole population. This has been achieved by arranging for the specialist to move from the hospital to the community.

Following discussion with GPs, it was agreed to establish a virtual integrated diabetes service delivered in three localities, to provide two components: the specialist support to primary care; and complex and inpatient care. The service would be consultant-led with multi-disciplinary teams of nurses, podiatrists, psychologists etc. Around forty staff work in the service and the contract is worth around £2.3 million. The PCT decided to establish the service by seeking expressions of interest from qualified specialists and a standard interview and assessment process under the then government's preferred provider policy.

Outcome

As provision of the service began in November 2010, the impact of the change is yet to be determined. The PCT is currently focusing on implementation of the monitoring framework.

Challenges

A key challenge has been finding a way of making this happen. One of the two local acute trusts was approached to host the service but this proved impossible to arrange. The trust was seeking to become a Foundation Trust at the time the service was being developed and also it wanted to go through a lengthy due diligence process which would have delayed implementation. A further complication was that this acute trust was seeking a management fee to cover the cost of its involvement.

As a consequence, the PCT appointed a specialist (formerly working at the acute trust that was invited to host the service) to lead the service and she became employed by the integrated care organisation set up in the south of the county and led by GPs. Both acute trusts had difficulty identifying income and costs for a complex disorder (often a co-morbidity) such as diabetes and broader financial discussions stalled the transfer of staff to a single provider organisation. Resources were made available by the PCT for additional sessions for the clinical director, a lead GP, a service coordinator and an additional specialist nurse to complete three locality-focused multi-disciplinary specialist teams. The service became operational in November 2010 (28 months after the work started and the model had been agreed). Further changes mandated under *Transforming Community Services* (Department of Health, 2009) mean the new specialist organisation will have a further transfer to the local mental health foundation trust in April 2011.

Other challenges in Cumbria include:

- Securing support from both GPs and specialists to the new way of working. In the case of GPs this was facilitated by extra payments to fund enhanced primary care services.
- Securing user involvement. This was initiated too late to influence the strategic direction and service specification but is beginning to provide valuable input on user experience of the service.
- Estimating the cost of the new service and the form of contract and incentives required to make it work effectively.

Having put the Cumbria diabetes model in place, the PCT is now intending to develop other integrated services such as children's services.

Lessons

A number of factors contributed to the successful implementation of the model. These included the vision and leadership of the chief executive, the professional expertise and credibility of the clinical adviser to the PEC, the active support and enthusiasm of GP leaders and the ability to recruit a specialist willing to work in the new model. Also important was the persistence of those most closely involved in the work in the face of obstacles that occurred along the way.

7. Knowsley – commissioning an integrated cardiovascular service

Background

Knowsley PCT serves a deprived population with a high level of health-need residing between Liverpool and Manchester. The borough has poorer health than the national average with wide inequalities that are closely linked to deprivation. The prevalence of cardiovascular disease (CVD) is 1.2 per cent higher than the national average and around 30 per cent of premature deaths are due to CVD. The borough does not have a main acute provider and residents access services for CVD at four local acute trusts each providing care in different ways.

Approach

To address these challenges, practice-based commissioners reviewed and redesigned existing service provision to develop a new service model. The model removes the fragmentation which came from multiple providers and provides a basis for reducing variations in how care is delivered. It builds upon previous work undertaken by the Knowsley at Heart programme which focused on prevention by reaching out to groups in the population.

The redesigned care model has the following features:

- improved access – ten working days from referral
- consultant clinics within community settings offering diagnostics, treatment and management plans in a single visit wherever clinically possible
- co-located nurse-led community heart failure clinics
- community-based integrated cardiac and stroke rehabilitation including social care and third sector
- rehabilitation delivered in leisure venues where clinically possible
- strong links into existing health and wellbeing services, for example Activity for Life, Fag Ends and community cooks
- a single administrative hub through which all referrals and enquiries from patients and/or clinicians are handled. This was important to the residents as they found navigating complex health systems off-putting.

The service model was approved in early 2009 and the decision was taken to procure the new service via competitive tender. The PCT, on behalf of practice-based commissioners, tendered for the delivery of an integrated cardiovascular service during 2009.

The service specification produced by the PCT set out the outcomes expected by 2012/13. It included the service pathway that the PCT wished to be commissioned and emphasised that the successful provider would be expected to work collaboratively with other providers in delivering an integrated service.

The contract offered was described as ‘part block and part performance’ and was designed to incentivise the successful bidder to achieve the outcome and quality measures included in the specification. The proportion of the contract that was performance-based increased from 20 per cent in the first year to 40 per cent in the third year. Following a competitive tendering process in which three organisations submitted bids, the contract was awarded to the Liverpool Heart and Chest Hospital NHS Foundation Trust, a specialist provider located outside the borough.

Outcome

The PCT’s experience in the time the contract has been in place is very positive, with the provider actively engaging with all stakeholders to deliver the specification and achieve the quality outcomes. The roll-out of community clinics has been faster than expected due to the popularity of the service with both patients and GPs. The new provider has been particularly active in exploring innovative delivery methods for the rehabilitation programmes with the aim of increasing uptake and completion rates.

Early indications are that:

- unplanned A&E attendances have reduced by ten per cent (a Payment by Results saving of £27,000)
- approximately 3,880 patients have been directed away from secondary care in the first eight months of 2010/11 (a Payment by Results saving of approximately £481,000)
- shorter stay admissions for cardiology-related events have decreased by about 12 per cent (a saving of approximately £306,000).

In addition:

- the numbers of patients being referred through to cardiac rehabilitation and accepting the offer have increased by 13 per cent
- ninety per cent of all early supported discharges had a full health and social care assessment carried out in conjunction with their carer
- ninety-one per cent of patients have had a reassessment six weeks post-discharge.

Feedback from patients accessing the service is excellent and the GPs are particularly pleased with the improved access times and the quality of communication from the service.

Lessons

The most important factor in the successful development of the model was the involvement and engagement of the public, clinicians from all providers, social care, leisure and culture and third sector partners, as well as GPs, to produce an integrated solution.

8. Somerset – commissioning an integrated COPD service

Background

Somerset PCT has focused on commissioning an integrated community-wide COPD service. This has developed in response to concerns about the fragmented nature of previous arrangements. Particular concerns included lack of support in the community for people with COPD, resulting in inappropriate hospital admissions and weaknesses in discharge from hospital. This led to patients being in hospital longer than necessary.

Approach

The new service was procured through a competitive tendering process. The tender was won by a partnership between BUPA Home Healthcare and Avanaula Systems (a company established by local GPs), in competition with the two local acute trusts. The aim is not only to provide an integrated service but also to reduce inappropriate use of hospital and emergency services. The service specification was shaped by patients and clinicians, and was initiated by the practice-based commissioning consortium in association with the PCT. A three-year contract has been put in place.

Agreed outcome measures for the service are:

- year-on-year reductions in emergency admissions for patients with primary diagnosis COPD
- improvement in wellbeing and service satisfaction
- equitable access to pulmonary rehabilitation, evidence of improvement to health and support for optimal self-care
- that all patients using home oxygen, or who may benefit from doing so, receive a formal assessment and prescriptions appropriate to their needs.

In developing these outcomes the aim was to reduce variations in how COPD services were delivered and to ensure greater consistency with relevant guidelines, for example, from the National Institute for Health and Clinical Excellence. The contract contains incentives to support delivery of these outcomes with the provider being at risk in the event of failure to deliver. The early results have been positive with the service provider reporting a drop in admissions.

Challenges

One of the challenges in making the new service work has been to establish effective relationships with the two acute trusts that bid unsuccessfully to run the service. The service provides integrated care in the community and has been successful in linking the work of general practices with that of nurses and other staff in the community, but relationships with hospital-based specialists have not always been easy.³

3. J. Hincks, 17 December 2008. *Pulse*. Using the private sector to provide a new COPD service.

Appendix 2: Quality outcome measures for cardiovascular disease service at Knowsley

Outcome indicator	Target yr 1	Target yr 2	Target yr 3
A. Diagnostic/treatment/management service			
1. 95% of all referrals will be seen within ten working days.	75%	85%	95%
2. 90% of all referrals receive a one-stop service to include diagnostics, diagnosis and treatment/management plan in a single appointment.	60%	75%	90%
3. 100% of all patients diagnosed/managed by the service will be treated and managed in line with the most up-to-date evidence-based clinical guidance.	85%	95%	98%
4. 100% of all patients seen will have an electronic summary sent to their GP within two working days of their appointment.	70%	85%	100%
5. 100% of patients requiring onward referral to secondary care will be offered choice of provider and be booked via Choose and Book.	100%	100%	100%
6. 95% of patients known to the service who enter the terminal phase of their life are identified formally and referred to palliative care services.	50%	75%	95%
7. 100% of patients identified as palliative have a specialist symptom control and management plan within their palliative care plan.	70%	85%	100%

Outcome indicator	Target yr 1	Target yr 2	Target yr 3
B. Community cardiac rehabilitation service			
1. In line with British Association for Cardiac Rehabilitation (BACR) standards all eligible patients will receive an invitation to attend a cardiac rehabilitation programme. BACR target is at least 85%.	85%	90%	98%
2. Patients who receive an invitation and wish to participate are able to access an individualised programme within three weeks of discharge unless formally stated to be clinically inappropriate.	85%	90%	95%
3. The percentage of eligible patients who take up the invitation to attend cardiac rehabilitation should increase year on year (current = 45%).	60%	75%	90%
4. The number of patients completing an individualised cardiac rehabilitation programme will increase year on year (current = 36%).	45%	65%	85%
5. The number of patients upon completion of cardiac rehabilitation able to return to work or take up voluntary activity should increase year on year.	Baseline data to be collected		

Outcome indicator	Target yr 1	Target yr 2	Target yr 3
C. Community stroke rehabilitation service Note: current performance not measured unless stated			
1. 100% of patients who are admitted with a confirmed diagnosis of stroke are known to the service and recorded on the stroke register.	75%	90%	100%
2. 100% of all stroke patients at the three main acute trusts who may be eligible for early supported discharge referred to the Early Supported Discharge (ESD) Team will be assessed within 48 hours of the referral being received.	75%	85%	100%
3. Patients who survive a stroke and are discharged from hospital will have a multi-disciplinary assessment and agreed care plan/ package for onward community care prior to discharge to include carer assessment. This will include social care, housing and benefits etc. The community stroke rehabilitation service will be proactively involved in discharge planning.	50%	75%	100%
4. In line with the National Stroke Strategy (QM 14) patients will have a health and social care assessment (including carers) performed and documented at the following times: six weeks post-discharge, again at six months post-discharge and one year post-discharge; continually annually thereafter.	50%	75%	98%
5. Patients who survive a stroke, do not meet the threshold for ESD and who are discharged from hospital should have access to community-based stroke rehabilitation within two weeks of discharge.	50%	75%	100%
6. The number of patients able to return to work or take up voluntary activity should increase year on year.	Baseline data to be collected		

Outcome indicator	Target yr 1	Target yr 2	Target yr 3
D. Across the whole community CVD service			
1. Patients and their families/carers have a positive experience of the service, and perceive they have been treated courteously and with respect.	70%	80%	90%
2. There will be a reduction in the number of outpatient attendances at acute trusts in line with the supplied trajectory	30%	60%	70%

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