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Commissioning integrated care in a liberated NHS

Research summary

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The Nuffield Trust report *Commissioning integrated care in a liberated NHS* explores the role of commissioners – the planners and purchasers of NHS care in England – in creating more integrated care services. It finds there are a number of barriers to commissioning more joined-up and efficient services and makes recommendations for how the Coalition Government could address them as part of the next stage of NHS reform. This research summary features analysis and commentary from the Nuffield Trust in light of the research findings detailed in the research report.

Key points

- Efforts to join up – or integrate – services have typically been driven by health and social care providers. This report seeks to shift the analytical focus to the role of commissioners by examining eight areas where organisations have encouraged integration using the policy and management tools at their disposal.
- The policy focus over the last decade on increased competition as a way of improving access to elective care has raised a number of barriers to the commissioning of integrated services for people with complex long-term conditions, leading to variable progress across the eight sites studied in this report.
- Where there were signs of success, determined and committed leadership from senior managers was found to have been critical. Clinical leadership, often expressed through practice-based commissioning, was also evident, with primary care doctors leading the development of integrated services, competing successfully for contracts and being willing to hold new forms of budgets.
- Other factors that appear to support effective integrated care commissioning include robust performance management, sufficient time and resources on the provider (hospital) side to enable participation in planning and development work, and adequate investment in the main stages of the commissioning cycle (needs assessment, service design, contracting and tendering, and outcomes-based evaluations).
- As management and cash resources shrink, there are obvious questions about whether clinical commissioners will have the necessary time and support to plan, contract for and change services in profound ways. The Department of Health can encourage commissioning for integrated care by making sure the NHS Commissioning Board provides appropriate guidance and a menu of options for tendering, paying and contracting for non-elective services.
- Work is needed to ensure that the prices that are paid for NHS services support moves towards integration. It may also be advisable to revisit the split between commissioners and providers, for innovative commissioners would benefit from having the flexibility to 'make' as well as 'buy' services. One option is for GPs and specialists to take on capitated budgets with responsibility for delivering defined outcomes. Eventually, patients might be able to choose between competing clinically integrated networks.

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Introduction

Over the past few years policy-makers, clinicians and managers have shown increasing interest in finding ways of integrating – or joining up – NHS services, to improve care for patients and to reduce some of the fragmentation and inefficiencies that can occur when patients move between services.

The Nuffield Trust has, in a number of publications, described examples of health and social care services, and primary and secondary health services working together, and the lessons to be learned. More recently, the Department of Health (DH) has set up a programme of integrated care organisation pilots, of which an evaluation will be published in late 2011.

This project sought to shift the focus of such analysis to the role of commissioners – the planners and purchasers of NHS services – in promoting integration.

The project began in September 2009. It involved: a national questionnaire survey of primary care trusts (PCTs); an email and telephone survey of strategic health authorities (SHAs); approaches to individuals at the DH, NHS Confederation and NHS Alliance; a literature review of payment systems in the United States; and the establishment of an advisory group of managers and clinicians with an interest in integrated care.

The project hoped to identify examples of commissioners driving integrated care, for example by: commissioning care pathways rather than simply paying for episodes of care under Payment by Results; promoting integration by working with lead providers subcontracting with other appropriate providers; and developing new forms of payment.

However, the PCT survey produced a disappointing response, both in terms of the number of PCTs that responded and the examples they came up with. The SHAs identified more examples, but most were outside the scope of the project, usually because they were instigated by providers rather than commissioners.

The approaches to key individuals and the advisory group proved more fruitful, and the project was eventually able to study eight sites. Visits and interviews with PCT and GP leaders were conducted between November 2009 and August 2010.

Emerging findings and the results of the literature review were discussed at a Nuffield Trust seminar in December 2010, after which issues, themes and policy implications were analysed in the context of the Coalition Government's plans for the NHS in England and, in particular, the shift towards GP-led, clinical commissioning.

The key findings from the case study sites are set out on the following pages.

Case study sites

The following 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 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 integrated care organisation (ICO) pilot programme initiated by the Department of Health.
- *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).

The cycle of commissioning

The commissioning process can be thought of as a cycle, in which needs are assessed, plans are drawn up, contracts are let to deliver the plans, delivery is monitored and ideas are revised (Ovretveit, 1995; DH, 2003).

Needs assessment and service specification: Most of the eight study sites spent a considerable amount of time, effort and resources on assessing local health needs, reviewing current service provision, and devising new care pathways. The PCTs typically worked with many different professional and user groups in this review and design activity, which was helpful in bringing them together and improving plans, but extremely time-consuming and expensive.

This suggests that commissioners will need to set aside considerable resources for this, and perhaps focus initially on a specific service for which data can be effectively collected, collated and synthesised; detailed costings can be drawn up; and a new care pathway agreed among a relatively small group of professionals, carers and patients. Such work can then be extended across the wider patch to enable integrated care to be developed and tested out 'at scale'. There is also a need for the NHS Commissioning Board (NHSCB) to develop templates and guidance on the commissioning of integrated care so that clinical commissioning groups (CCGs) can avoid reinventing the wheel many times over.

Contracts: A range of mechanisms was used by commissioners to implement new forms of integrated care. For example, in Smethwick the PCT used a primary medical services plus (PMS plus) contract to support the development of a local population health management organisation based around a group of GPs with a longstanding determination to work together.

PMS and other local contract options – such as alternative providers of medical services (APMS) and specialist providers of medical services (SPMS) – already exist, yet few PCTs seem to have used them as an alternative to setting up new, complex organisations to deliver integrated care. There would seem to be potential to use such contract options further in the commissioning of integrated care.

Tendering and procurement: The cost of specifying, tendering and contracting for new forms of integrated care was prohibitively expensive in some of the study sites. For example, Birmingham North and East PCT carried out a considerable amount of work to design a new care pathway for people at the end of their lives, with the aim of tendering for a lead provider to deliver it. But the need to fund the start-up costs of the lead provider meant that the project was not, at that stage, able to proceed as intended.

By contrast, Knowsley PCT managed to award an integrated contract to deliver the full range of cardiovascular care, from prevention through to specialist treatment, to a specialist provider located outside the borough. Early indications are that this has reduced hospital visits and shortened hospital stays, leading to Payment by Results savings in excess of £800,000.

This suggests that the costs of contracting and tendering can be worthwhile, if they are budgeted and justified from the outset. However, it will become increasingly difficult to undertake such radical pathway redesign as NHS management costs are cut by 45 per cent and financial pressure leads to critical scrutiny of spending on anything other than frontline care. Sharing of experience and expertise in contracting for complex and integrated care will be vital.

Outcomes and incentives: The study sites showed it was important to make an explicit link between payments to providers and the achievement of outcomes specified in the contract.

For example, Tower Hamlets contracted for a new, integrated diabetes service with networks of GP practices, and made 30 per cent of the contract value contingent on the practices collecting accurate and timely data, meeting patient satisfaction targets, making sure all patients had individual care plans, and managing their condition effectively.

Contracting for outcomes is very much in tune with the direction of NHS reform, and should in due course be underpinned by a new NHS outcomes framework. The experience set out in this report will be useful to CCGs as they seek to contract for outcomes of care, rather than simply for cost and volume of activity.

Factors that facilitate commissioning integrated care

A number of factors were found to be critical for commissioning new forms of integrated care and getting them to work in practice:

Managerial leadership: Determination and commitment from senior management teams was critical to success at all of the study sites; even when initiatives started within clinically-led, practice-based commissioning (PBC).

For example, Cumbria PCT commissioned an integrated diabetes service through PBC with real budgets; the chief executive was credited with backing the plans of GP commissioners, bringing in national clinical expertise, challenging acute providers who were initially reluctant to move towards a community-based model of care, and funding a community-based diabetologist as a way of getting the new service off the ground.

Clinical leadership: Bold and skilful clinical leadership was also observed at many of the study sites. For example in West Kent, primary care doctors led plans to develop an integrated urgent care and out-of-hours general practice; and a GP-owned social enterprise won the contract to provide it.

Primary care-led commissioning: PBC is often thought of as having been weak and under-developed (Curry and others, 2008; Smith and others, 2010), but at some of the study sites it was a catalyst for service redesign and new forms of budget-holding. This tended to happen when PBC groups worked with their PCT as a single, clinically-focused commissioning entity, as in Cumbria and Tower Hamlets.

Data and IT: Agreeing a set of performance and outcome indicators and then organising and funding the necessary data collection, synthesis and analysis to monitor progress against them was an exacting process. Study sites such as Birmingham North and East, and Milton Keynes, that had ambitious integrated care programmes, had particular problems in this regard. This suggests that careful thought will need to be given to planning, funding and implementing data collection and IT systems for 'at-scale' integrated care initiatives, and commissioners will need to work with providers to develop and resource these.

The registered list of patients: The registered list of patients held by general practices was vital for commissioning new services and allocating budgets to integrated care providers. For example, Smethwick Pathfinder assumed a capitated budget for managing the health of the practice population for a broad range of services and conditions. It went on to build a new, integrated patient record that included information about attendance at NHS services, health status and risk of ill health,

planned screening and observations, and triggers to attend tests and treatment, with *pro bono* (free) support from health insurers Aetna.

GP-led CCGs should be in an unrivalled position to use the registered list as the basis for commissioning for population health management. Their challenge will be to secure sufficient management, analytical and development support to roll out the approach and to convince their peers of the benefits.

Provider engagement: Providers need to find significant amounts of management time and resource to participate in service developments led by commissioners. This can pay off, as in Knowsley, where a specialist acute trust eventually won the contract to provide a new integrated cardiovascular service. But it might not; as in Birmingham North and East, where the PCT was ultimately unable to let a contract for a new care service for people at the end of their lives.

At other study sites, commissioners were trying to 'nudge' providers into assuming accountability for the health outcomes of a given population. This is a major shift for most providers, so it is not surprising that this kind of commissioning has rarely been attempted to date in the NHS and that the commissioners that have tried it have found it difficult to do.

Time and persistence: In many of the case study sites, the process of integrating services had taken place over a number of years – in the most extreme example, the development of the Smethwick Pathfinder had been led by a small and committed group of GPs for some 15 to 20 years.

The NHS has been resource and management rich over the past decade, but it is not any longer. There are questions about whether the new and transitional PCT clusters will have the capacity to help clinical commissioners plan, contract for, and change services in profound and complex ways, as they find their feet and increasingly come under significant financial pressure.

Policy implications

The Nuffield Trust has previously identified a number of policy barriers to integrated care (Ham and Smith, 2010). These include: the emphasis placed on competition rather than collaboration in recent NHS reforms; the focus of acute hospitals on increasing activity, not least because Payment by Results gives them incentives to do so; the weakness of commissioning organisations; the impact of regulation; and the difficulty of reconfiguring – closing or changing – existing services to support integration.

The research in this report can be read as an account of attempts by PCTs and practice-based commissioners to overcome these barriers. Unsurprisingly, it found their progress was variable, protracted and often limited in impact. Their experience also has lessons for the next stage of NHS reform, in which policy-makers are emphasising the role of commissioners in driving up performance and clinicians have indicated that they want a focus on integrated services.

Central support for commissioning: Given the DH's relative lack of focus on commissioning for integrated care to date, commissioners have searched for answers at a local level. As a result, work has been replicated in different parts of the country, which is time-consuming and inefficient in the longer term. The NHSCB needs to

provide guidance on how to commission integrated services in different areas of care and issue advice on contractual and payment options, incentive schemes and outcome indicators.

The role of Monitor and economic regulation: The NHSCB will need to work with Monitor to create a framework for economic regulation that can promote both competition and integration, and reveal where providers and commissioners are failing in one or both areas.

Competition is likely to bring about benefits in planned care, by making sure that patients have rapid access to high-quality diagnostic and elective services. Collaboration and integration are likely to be more appropriate for long-term care and specialist services – such as cancer and cardiac care – in which networks are known to improve outcomes.

In this case, there might be competition 'for' the market, rather than 'in' the market, with commissioners using an open, tendering process to contract a provider to offer packages of integrated care for a given period. The need for such an approach seems to have been recognised by the health secretary and NHS chief executive in recent speeches, and in commitments to work with the Future Forum and others to develop more ambitious integrated care.

The tariff and incentives for integrated care: The Payment by Results tariff was designed primarily to support choice and competition and bring down waiting times for elective treatment. It does not appear, in its current form, to be well suited to supporting integrated care for people with long-term and complex conditions.

The United States provides some ideas for developing new forms of payment. These include episode-based payments, such as those developed by the Geisinger Health System ProvenCare programme, which pays a global fee for cardiac care from pre-admission to surgery and follow-up after 90 days. They also include capitation-based payments, such as those developed by Kaiser Permanente to support prevention and primary care, and avoid inappropriate use of secondary care for members.

In the NHS, various options might be pursued, such as combining payments to cover an episode of care or a care pathway, or taking forward the 'year of care' that has been piloted for diabetes. Commissioners might choose to contract foundation trusts to deliver integrated care for a specific population, and accelerate (with the NHSCB) work on personal health budgets so individuals can commission their own care packages where appropriate.

A period of active experimentation is needed to find out what works and to work through the consequences. This will enable potential problems to be overcome, such as providers trying to avoid high-cost patients or 'cost-shunt' those with multiple conditions into other services, providing inefficient or unnecessary care, or limiting access to high-cost treatments. Experimentation would also be useful for determining the data and monitoring requirements, and wider impacts, of any new arrangements.

Contracting and procurement: Commissioning integrated care is likely to mean a substantial change in service specification or the setting in which care is delivered that will require an open tender. One approach open to commissioners is to place a contract with a lead or prime contractor – either one provider or a partnership/joint venture

– that can then subcontract with other providers to deliver services in line with the commissioner's specification.

The role of GP commissioners as makers and buyers of services: Commissioners can 'make' as well as 'buy' innovative services. In Smethwick, for example, a group of GP practices took on such a contract to improve care for people with long-term conditions.

Policy-makers will need to make sure that GPs are not prohibited from taking on similar, innovative roles because of concerns about the conflicts of interest that might arise when clinical commissioners use their budgets to place contracts with organisations in which they have a financial interest as providers. One approach might be to show that potential conflicts of interest are being effectively managed, for instance by developing robust governance arrangements that involve the public and patients, requiring all decisions above a certain value to be published, and making sure that aggrieved parties can get decisions reviewed.

The future of commissioning: This raises the wider issue of whether it is desirable for there to continue to be a strict separation between commissioning and provision. International evidence shows that all commissioners face challenges in understanding health care, obtaining information from providers and finding the skills to commission effectively.

There is a need for realism about what commissioners can achieve, and to consider alternatives. One alternative might be to learn from integrated medical groups in the United States, in which hospital-based specialists take on risk-bearing capitated budgets and account to commissioners for outcomes.

In England, GPs and specialists could create and take on capitated budgets, and account to NHSCB outposts, PCT clusters or clinical commissioning groups for financial, service and health outcomes. One option would then be to migrate towards a system in which patients chose between competing but clinically-integrated services holding the budget for defined populations.

This would be more likely to deliver the efficiency that the NHS needs to achieve, and better integrated services for patients, rather than promoting choice between a fragmented array of providers. It would also provide a practical example of how choice and integration can work together in the next phase of NHS reform.

Conclusion

For the past two decades, the focus of NHS reform has been on increasing competition to improve access to elective services. This put barriers in the way of commissioning integrated services to improve services for people living with long-term conditions and those needing care at the end of their lives.

Providers still have more incentives to increase activity than to prevent inappropriate admissions to hospital or take a more population-focused approach to care, and one of the strongest messages from this research is that PCT commissioners have struggled to overcome these barriers.

However, the examples of Somerset and Knowsley show that it is possible to tender for a new pathway of care from a lead provider or partnership of providers, and to put them at risk for service quality, health outcomes and financial performance.

This suggests that other commissioners who want to incentivise providers to develop better integrated services should focus on developing outcome measures and incentives that encourage them to bring about these new forms of care. This is much more likely to be successful than trying to over-specify the details of the structures the commissioners feel the providers should put in place.

In other words, a new generation of commissioners should seek to craft an environment in which providers are both encouraged to put new processes in place to deliver high-quality care for a particular population and are put at risk for failing to do so. There is also a need for more robust and sustained studies of integrated care initiatives, to develop measures of success that can be used in tendering, contracting and monitoring new services in the future.

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This research summary is based on *Commissioning Integrated Care in a Liberated NHS* by Chris Ham, Judith Smith and Elizabeth Eastmure; the summary contains additional commentary by the Nuffield Trust. To download the full report and further copies of this summary visit **www.nuffieldtrust.org.uk/publications**

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