

# New Models of Care – Services and contract mechanisms

A rapid review of existing evidence

November 2016

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# Overview

This review was requested by the Lewisham CCG Clinical Directors to look at New Models of Care and their services and contract mechanisms across the UK.

Preferences and health needs have changed over recent decades and in order to remain sustainable, the NHS must adapt accordingly. This paper provides a rapid review of current literature and some key examples of initiatives by the Vanguards and other sites across the country.

Desktop research was conducted to identify key publications and literature relevant to the topic which was then summarised to provide context and background. These are followed by five Vanguard examples and four case studies from across the UK. Contact details have been provided for each of the Vanguard examples to allow further contact and research to be conducted by Lewisham CCG if necessary.

The case studies include both successful and unsuccessful schemes to highlight key learnings such as Case Study 1 in Cambridge & Peterborough which failed and cost £1m.

It is important to note that as this is a rapid review, it is not systematic nor does it cover all existing initiatives and data on the subject. Rather it pulls out some key examples to share learning and provide good practice guides.

The following slide lists the studies and provides their key quantified impact, or notes when this was inapplicable or unavailable.

## Methodology

The rapid review used quantitative methods to identify the appropriate literature and capture a range of examples.

The first stage used desktop research via academic resources such as the King's Fund, Nuffield Trust, British Medical Journal and Google Scholar. The research team also examined a range of sources such as project reports, stakeholder websites and press releases and then contacted project leads and practices directly to identify the quantifiable impact of the studies and fill in any missing information.

# Key studies and their impacts

Page	Study	Key Impact
4	Literature Reviews	Does not apply
12	Vanguard 1: Northumberland (PACS)	On-going work
13	Vanguard 2: Erewash (MCP)	No concrete findings
14	Vanguard 3: Modality Partnership (MCP)	Does not apply
15	Vanguard 4: Rushcliffe CCG (MCP)	Does not apply
16	Vanguard 5: Stockport (MCP)	Does not apply
18	Case Study 1: Cambridge & Peterborough	Failed, and process cost £1m
19	Case Study 2: NUKA	Since the 1990s, 36% reduction in hospital days, 42% reduction in urgent and emergency care services, 58% reductions in visits to specialist clinics
20	Case Study 3: MSK services in Bedfordshire	After one year, Circle increased the number of patients it saw from 40% the previous year to 90% that year
21	Case Study 4: Milton Keynes (PCT) – Alliance	Information not available online

# Literature Reviews

# Background

## The King's Fund - Community services - How they can transform care (2014)

- Significant numbers of patients occupying hospital beds could be cared for in other settings if suitable services available, moving care closer to home
- Around 100m community contacts take place each year; the scale of these interventions is poorly understood and not well served by the way the debate on health services often defaults to 'GPs and hospitals' or 'primary and secondary care'
- The King's Fund convened a working group of community providers to explore the steps that are required to change community services in ways that will help create the transformation that was promised in previous policy.
- Despite incomplete evidence, there is an emerging consensus about the impact that community services can have and what is needed to improve their effectiveness. The main steps identified are:
  - reduce complexity of services and wrap services around primary care
  - build multidisciplinary teams for people with complex needs, including social care, mental health and other services and support these teams with specialist medical input and redesigned approaches to consultant services – particularly for older people and those with chronic conditions
  - create services that offer an alternative to hospital stay
  - build an infrastructure to support the model based on these components including much better ways to measure and pay for services
  - develop the capability to harness the power of the wider community.
- This approach requires locality-based teams that are grouped around primary care and natural geographies, offering 24/7 services as standard, and complemented by highly flexible and responsive community and social care services

## The King's Fund - Emerging innovations in governance and organisational form (2016)

- Providers are also using a similar set of approaches to design and deliver more integrated services; many of the vanguards are consolidating primary care in larger groupings, often within neighbourhood clusters, so that they can deliver a broader range of services out of hospital and work more effectively with other parts of the system. They are all building closer partnerships between primary, community, mental health and social care services as a basis for changing how staff and resources are used.
  - In Sandwell and West Birmingham, the Modality Partnership has brought together 15 GP practices within a single super-practice. It has established partnerships with other community services so that GPs can oversee an integrated set of primary and community services based in primary care centres.
  - In Dudley, the clinical commissioning group (CCG) has started the procurement process to select a new single provider to hold a whole population budget and deliver the full range of primary and community services, thereby improving access, continuity of care and co-ordination.
- In its recent publications on the Multispecialty community provider (MCP) and primary and acute care system (PACS) models, NHS England describes three broad contracting approaches: a 'virtual' approach where commissioners do not pool budgets and bring services within a single contract, but where they establish 'alliance arrangements' with providers alongside existing contracts; a 'partially integrated' model where commissioners bring together budgets and re-procure a group of services (excluding core primary care) within a single contract; and a 'fully integrated' model, where commissioners bring together the budgets and re-procure a group of services (including core primary care) within a single contract
- In summary, the King's Fund describe the emerging new care models as a set of changes to payments and contracting and to the organisation of services to allow providers to exploit this new set of improvement opportunities.

# Background

## Monitor - Commissioning better community services for NHS patients (2015)

- In 2012/13, the NHS spent about £9.7 billion on community services. By one estimate, patients come into contact with community services about 100 million times per year.
- A questionnaire was sent to all CCGs seeking information about their community services contracts and how they intend to improve services; 147 CCGs responded, covering 70% of the population.
- The responses indicate that most community services are provided under contracts covering a wide range of services with a fixed-sum payment that generally does not vary based on activity or quality of care. The responses also indicate that community services providers are most commonly NHS organisations, with one provider typically providing all or most community services in a geographic area.
- Series of case studies include a look at how commissioners have:
  - used competitive dialogue to commission services that are delivered in a more integrated way for patients
  - developed quality-of-care measures to enable commissioning for patient outcomes
  - empowered patients to take part in the process to select the best provider for community services
  - worked in partnership with local authority / agencies to test a model of integrated support for families with complex health and social care needs.

## NHS Confederation – The Art of the Possible (2015)

- The vision for better and more sustainable care by 2020 rests on community-based models that are coordinated around people's needs.
- Nigel Edwards has suggested that GP federations could cover populations of 50,000–120,000 (30,000+ in rural areas); the population sizes that are covered by new care model vanguard sites vary from 53,000–365,000. This may work best around natural communities rather than being organised rigidly around particular pre-conceived population sizes.
- Care models need to use innovations found across community health services including smaller social enterprise, private and voluntary sector providers.
- Evidence of local population needs, and insights from staff and patients, must drive new care models, instead of starting with organisational structures.
- Community services are well placed to enable better ways for specialists and generalists to work together, support self-management, and develop the community and voluntary sector partnerships crucial for prevention and wellbeing.
- Responsive community services are essential to help avoid **A&E** attendance and admission, and enable prompt discharge of patients from hospital through their 'core' offer of nurse-led, multidisciplinary care in and near people's homes. Same-day home visits from the community nursing service can help manage demand for care. Some providers are already doing this.
- This is crucial for **smaller hospitals** for whom A&E represents a relatively large proportion of their work. Some structurally integrated models use community provision to ensure a sustainable system, including smaller hospitals. Examples include the integrated care organisation in Tameside and the Northumbria primary and acute care model, which will redesign community and acute services to ensure patient care is delivered in the community.
- The ability of community services to work with primary, acute and community care, mental health and palliative services and a wide range of other statutory and non-statutory services simultaneously, and build trusting relationships with patients, means they are well placed to work in partnership with **care homes**. An example includes community nurse practitioners working with care homes in Worcestershire to develop clinical management plans for each resident reduced residents' hospital admissions and A&E attendances by around a quarter in their first year.
- In **Specialised Services**, such as Stroke and neurological services, community services can provide intravenous therapy at home which enables more people to avoid hospital stays.

# Vanguards – New Models of Care

## Background and Case for Change:

- Following publication of the *NHS Five Year Forward View*, commissioners and providers at 23 vanguard sites are developing new, population-based models for local health services.
- Multispecialty community provider (MCP) and primary and acute care system (PACS) vanguards aim to bring together budgets and achieve closer integration of NHS services, in some cases also with social care.
- Commissioners in many of the vanguards are now considering how to contract for the new systems, including which streams of funding to bring together within a whole population budget and which services to commission within a single contract.
- There is considerable interest in bringing together the budgets for core primary care services with other services, but The King's Fund states, based on their findings, it seems unlikely that many GPs will contemplate giving up their core General Medical Services (GMS)/Personal Medical Services (PMS) contracts for new, unproven contractual arrangements in the immediate future.
- While some of the vanguards are still using informal partnerships to take forward their plans, commissioners and providers in many areas are putting in place more formal governance arrangements – in some cases describing the new arrangements as integrated care organisations or accountable care organisations or systems.

## PACS:

- The PACS model describes a vertically integrated system which brings together GP, hospital, community and mental health services for a large population. They could either grow out of acute facilities which would own and run their own GP services or they could grow out of established MCPs which could evolve to take over and run local acute providers. At their most mature, this approach could develop into what is known as an Accountable Care Organisation (ACO) in some other countries and involve the single integrated organisation taking accountability for the entire health needs of a registered patient list under a delegated capitated budget.
- Many commissioners are considering contracting with a local hospital trust, or a partnership between a hospital and other providers, to hold the population budget and manage the system.

## MCPs:

- MCPs aim to move specialist care out of hospitals and into the community for a registered population of **30,000 or more patients in close geographic boundaries**. These organisations could provide a majority of outpatient consultations and ambulatory care, and once sufficiently mature, could take over the running of community hospitals thus expanding their diagnostic and other services. At their most developed, they could take on a delegated budget for provision of services for their registered patients.
- Commissioners are considering contracting with a 'super-partnership' or federation of GP practices. There is a trend towards broader partnerships of providers to oversee larger groups of services. There is some concern that super-partnerships and federations may not be ready to take on responsibility for managing budgets covering a range of services going beyond core primary care on their own, leading to other options being considered for the lead provider role.

# Vanguards – New Models of Care - Recommendations

## Key Recommendations:

- Few of the commissioners the King's Fund spoke to were interested in engaging an 'integrator' organisation that would hold the population budget and co-ordinate the contributions of different providers but would not have managerial control of services or established relationships with providers.
- There are similarities as well as differences in the approaches being taken by PACS and MCP vanguards. In most of the vanguards, commissioners are planning to create a single budget to cover the health needs of their local population. New contracting arrangements are being developed to give providers responsibility for managing this budget and overseeing services, along with defined quality and outcome measures to be delivered. The intention is for commissioners to be able to hold providers to account for improving the overall health and wellbeing of their population within available resources. In turn, providers should have greater flexibility to decide how to use funds and reorganise services.
- Some commissioners consider it necessary to pursue a competitive procurement process to minimise the risk of legal challenge. However, few of the commissioners we spoke to saw benefits in using competitive processes for models that are built around established local services.
- A focus on the relational as well as the technical elements of new care models is essential if they are to deliver on their early promise.
- There are particular concerns given the experience of the UnitingCare Partnership in Cambridgeshire and Peterborough, where commissioners went through a competitive tendering process, but where the successful bidder subsequently terminated the contract because of inadequate funding. UnitingCare example illustrates, commissioning and providing new care models involves major risks as well as significant opportunities. This underlines the importance of defining how these models are governed, the organisational form they take, how risks are shared, and how services are commissioned
- Where they are planning to establish a partnership to lead the system, providers are considering what form this should take, including whether to establish a contractual joint venture or a corporate joint venture.

# Nuffield Trust - Evaluating integrated and community-based care

## Background:

- Despite attempts to tackle the challenge of delivering high-quality community-based care for increasing numbers of people with long-term conditions, there is a continuing increase in emergency hospital admissions.
- Over the last five years, the Nuffield Trust has undertaken evaluations of over 30 different community-based interventions.

## Recommendations:

- Planning and implementing large-scale service changes takes time.
- Define the service intervention, clearly including what it is meant to achieve and how, and manage implementation well.
- Be explicit about how the desired outcomes will arise and use interim markers of success.
- Generalisability and context are important.
- To demonstrate statistically significant change, size and time matter.
- Hospital use and costs are not the only impact measures.
- The process of implementation and outcomes are important.
- Consider the best models for evaluation: for example, a light-touch evaluation for an initial phase, then a more comprehensive evaluation if enough progress has been made.
- Organisation and structural change alone may not achieve the desired outcomes.

## Findings:

- **POPPs** – no evidence of a reduction in emergency hospital admissions associated with any of the four POPP interventions studied. The Integrated health and social care team reduced the number of bed days used by patients.
- **Department of Health-funded integrated care pilots** - led to process improvements (increase in the use of care plans, new roles for care staff etc). Surveys of patients indicated they found it more difficult to see the doctor/ nurse of their choice. No evidence of a reduction in emergency admissions. Reduced costs for elective admissions and outpatient attendance exceeded increased costs for emergency admissions.
- **Whole systems demonstrator trial of the use of telehealth and telecare** - In 2006, the Department of Health proposed three large 'whole systems demonstrator' pilots– Newham, Kent and Cornwall. Changes in service use were not significant with respect to costs, while the intervention itself was very expensive and studies of patient wellbeing showed no benefits associated with these technologies (Cartwright and others, 2013). Some emerging evidence that some patients benefit from telehealth but it is still not clear for which patients and under what conditions the technology might be most effective. Analysis of the impact of telecare technologies also yielded negative results, with no reductions detected in the number or length of hospital admissions or in the number of admissions to care homes (Steventon and others, 2013)
- **Virtual wards in three sites** - evaluated three sites in England operating within the periods 2007–11 (Lewis and others, 2011a; 2012) and found no evidence of reduction in emergency hospital use. A reduction was found in outpatient attendances and elective admissions may have been due to several factors including better care coordination, substitution of care, or better informed patient decisions.
- **Other integrated care schemes** – Inner North West London and Trafford – An evaluation of The Inner North West London Integrated Care Pilot revealed that in its first year, substantial progress was made in designing and implementing a complex intervention and in developing governance arrangements and new financial incentives. Staff and professional satisfaction was positive (Curry and others, 2013). However, analysis showed no evidence of a reduction in emergency admissions (Bardsley and others, 2013). With regards to Trafford, one key message was the length of time needed to design and agree change across a range of organisations and the impact that contextual factors (the departure of key personnel and wider NHS structural reform etc) had on implementing the desired changes to (Shaw and Levenson, 2011)
- **Marie Curie nursing service at the end of life** - Marie Curie patients were more likely to die at home and had less emergency hospital use than controls (Chitnis and others, 2012; 2013). The average costs of all hospital services used by those receiving the 'intervention' was lower, particularly so for patients who had been receiving home nursing for longer – though this was in part offset by the cost of the service.
- The service models evaluated to date generally appear not to be associated with reductions in emergency hospital admissions (Purdy, 2010; Purdy and others, 2012). This has also been the conclusion of others with respect to community models of care for frail older people (for example D'Souza and Guptha, 2013).

# Design principles to developing place based systems of care

The Kings fund have developed 10 design principles that should be considered when implementing new systems of care, these can apply to all the different models and are all key to ensuring a system is implemented successfully.

Number	Design Principle
1	Define the population group serve and the boundaries of the system
2	Identify the right partners and services that need to be involved
3	Develop a shared vision and objectives reflecting the local context and the needs and wants of the public
4	Develop an appropriate governance structure for the system of care, which must meaningfully involve patients and the public in decision making
5	Identify the right leaders to be involved in managing the systems and develop a new form of system leadership
6	Agree how the conflicts will be resolved and what will happen when people fail to play by the agreed rules of the system
7	Develop a sustainable financing model for the system across 3 different levels: <ul style="list-style-type: none"> <li>- The combined resources available</li> <li>- The way the resources will flow to providers</li> <li>- How these resources are allocated and how cost, risk and reward is shared</li> </ul>
8	Create a dedicated team to managed the work of the system
9	Develop “systems within systems” to focus on different parts of the group’s objectives
10	Develop a single set of measure to understand progress and use for improvement

Reference: [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/Place-based-systems-of-care-Kings-Fund-Nov-2015\\_0.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Place-based-systems-of-care-Kings-Fund-Nov-2015_0.pdf)

# Vanguards

# Vanguard 1: Northumberland (PACS)

**Purpose: On-going work to establish an Accountable Care Organisation**

## Background and Case for Change:

- This vanguard will help communities to live long and healthy lives at home. This will be supported through the opening of the Northumbria Specialist Emergency Care Hospital, an extension of primary care to create 'hubs' of primary care provision across the county seven days a week.
- Following implementation of the new model, patients will be able to access their GP over the weekend, preventing the need to go to the Emergency Department when symptoms worsen. The model cuts across organisational boundaries and includes enhanced access to community nursing services, fully coordinated discharge and shared IT that will support better care in a number of health settings and in the home

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## Conclusions:

- Northumberland still hasn't implemented their model of contracting and commissioning and so it will be difficult to identify whether it will result in positive outcomes for patients or a reduction in spending.
- However, they will have significant learning in the process of setting up capitated budgets on a population level and should be able to advise on the governance and process associated.

## The Solution:

- Work is now well advanced to develop a single Accountable Care Organisation for Northumberland which will be one of the first of its kind in the NHS and become operational from April 2017, with the strategic commissioning model beginning in shadow form from September 2016.
- With the support of NHS Improvement and NHS England this work is now moving at pace, with a draft memorandum of understanding in place across all partner organisations and a detailed due diligence process underway. A set of population-based health outcomes is being developed in partnership with the King's Fund which will align the work of all providers within the ACO, based on the following:
  - improving outcomes for the people of Northumberland
  - improving the health status of the population
  - contributing to shaping sustainable services for the future
  - moving care outside hospitals where appropriate
  - adopting the philosophy that an unplanned hospital episode is potentially a missed opportunity elsewhere in the system
  - reflecting mutual responsibility for system management and integrating care.
- The ACO will have a capitated budget for the population of Northumberland and work towards shared quality objectives, drawing on services that cross different organisational boundaries to meet individual patient needs.
- This will make it easier for staff to work more effectively together in a joined up way and with the same shared goals for delivering high quality patient care.

# Vanguard 2: Erewash (MCP)

**Purpose: To understand the commissioning intentions of one of the Vanguard sites**

## Background and Case for Change:

- Erewash multispecialty community provider covers a registered GP population of 97,000 and provides 12 GP practices.
- The Vanguard will develop a prevention team made up of health and care professionals including GPs, advanced nurse practitioners, mental health nurses, extended care support and therapy support.
- It will deliver services to people who do not require hospital services and can be treated for their conditions in a community setting. This will include care planning for people with long term conditions including diabetes, chronic vascular disease and chronic lung conditions. There will also be focus on extending access to GP services.

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## Conclusions:

- There are still no concrete findings from Erewash on how they have commissioned and contracted for a population.
- However, they have clearly considered the possible benefits of segmenting populations into disease areas and pathways and may be able to provide advice, guidance and learning on how to do this.

## The Solution:

- The Vanguard is planning to move towards a capitation funded contract for the MCP.
- The Board has discussed and agreed the development the capitated payment approach.
- The intention is to shadow a place based capitated budget in 2016/17, and move to a real place based capitated budget in 2017/18.
- Our approach is based upon joint guidance from Monitor and NHS England – “Capitation: a potential new payment model to develop integrated care.”
- The providers within Wellbeing Erewash recognise that there are a range of organisational governance options available to them to come together more formally to hold this contract and deliver the outcomes associated with it.
- They are currently commissioning a supplier to work with them to develop and evaluate a comprehensive range of options for delivering integrated care that can form the basis of consideration and consultation with the MCP Board, constituent member’s Boards/ governing bodies and wider stakeholders during 2016/17.
- Erewash CCG recognise that they also have choices open to them regarding future commissioning structures, and are seeking a partner to help produce an outcomes framework that can be used as the basis of creating a future Payor function
- The output will include identifying options as to which current aspects of the CCG function could move into the MCP Provider organisation with clear reasons, population segmentation into disease areas and pathways and other related divisions to support outcomes management, and suggested pace of change from current commissioning, contracts, specifications and evaluations to Payor, outcomes, and a population health improvement focus. The CCG are working with the New Care Models team and NHS England on this development of the commissioning function.

# Vanguard 3: Modality Partnership (MCP)

**Purpose: Understanding the way of organising care to deliver the majority of a pathway in a community**

## Background and Case for Change:

**Patient population:** 70,000

- The vanguard is made up of a single, local GP partnership called Modality Birmingham & Sandwell, which originally operated from 15 practice sites across Birmingham and Sandwell and serves a registered population of 70,000 patients.
- The vision for the vanguard is to develop a health and social care system accessible through GP practices, with a care-coordinator to support patients on their journey. This will be achieved by delivering medical services from a number of primary care centres across Birmingham and Sandwell.
- The larger centres will expand the range of social, mental, community and enhanced secondary care services on offer to patients by delivering community outpatient and diagnostic services. This will mean that, for example, a person who has diabetes and suffers from high blood pressure will benefit from being treated in a familiar environment that is close to home and will be supported by a care co-ordinator to help manage their care plan.

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## The Solution:

- The Modality Partnership services are commissioned by the NHS Sandwell and West Birmingham Clinical Commissioning Group (CCG).
- The Modality Partnership is a single GP organisation that now operates across 17 different locations in Sandwell and Birmingham.
- The Modality Partnership is a super partnership which is created through formal partnership mergers. It delivers a greater degree of scale, offers wider ranges of integrated primary and community health service and offers community based diagnostic services and consultations with specialists. The scale also offers a greater level of career development for primary care practitioners.
- The Modality service offers urology, x-ray, rheumatology and dermatology services in addition to the traditional primary care services. They also offer services such as Skype appointments and phone appointments in order to support their ways of working.
- The super practice is commissioned in the same way as any other provider and bids for contracts and work when the CCG releases them.

## Conclusions:

- There is no information available on how the CCG has commissioned Modality partnership, however, it appears from research that the partnership is commissioned based on usual contracting mechanisms and the partnership bids for contracts in the same way as other providers.

# Vanguard 4: Rushcliffe CCG (MCP)

## Purpose: Commissioning the Principia MCP

### Background and Case for Change:

**Patient population:** 126,000

- Changes in patients' health needs and personal preferences - long-term health conditions now take 70% of the health service budget.
- People want to be more informed and involved with their care, challenging the traditional divide between patients and professionals.
- Changes in treatments, technologies and care delivery – potential to transform our ability to predict, diagnose and treat disease.
- Current and predicted budget pressures across health and social care over the next few years.
- Challenges in finding ways of overcoming the boundaries that exists between hospitals and primary care, between health and social care, between generalists and specialists that get in the way of providing the genuinely co-ordinated care that people need and want.
- The vision is to provide a better quality of care for the people of Rushcliffe through an innovative, patient-centred, coordinated care delivery system, which is designed to improve our communities' health outcomes, increase our clinician and staff satisfaction and at the same time moderate the cost of delivering that care.

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**Website:** [www.rushcliffeccg.nhs.uk/principia-mcp-vanguard/](http://www.rushcliffeccg.nhs.uk/principia-mcp-vanguard/)

### Conclusions:

- Although the MCP in Rushcliffe have not yet implemented anything, their vision for contracting and implementing an MCP for a population has always been very clear; in the last two years they have outlined how they want to contract care and laid out exactly how capitated contracts will work in this area.

### The Solution:

- Principia is constituted as a community interest company and has three stakeholder classes: GP practices; community services providers; and the 126,000 registered population of Rushcliffe.
- GP practices have come together and are establishing a new and unique primary care partnership and organisation, which will lead on, and own the transformation of general practice and develop the progressive model which will be the base component and platform of the MCP.
- Principia and Partners Health will also be joined by health and social care partners.
- The proposal is to establish an MCP defined by a culture of mutual accountability, commitment and pride. This will accept contractual responsibility for the health, and the quality and costs of care for the local population within the capitated resource allocated.
- A new model of integrated care will be focussed on early intervention, living well at home and avoiding unnecessary use of the hospital.
- The impact will be a reduction in fragmentation, delays, duplication and inefficiencies experienced by patients and carers. Care will be delivered closer to patients' homes resulting in an enhanced experience and improved clinical outcomes, and better use of available resources. The MCP will move to have a capitated outcomes based contract which will cover health and social care.
- The proposed approach is to move to payment for outcomes that matter to citizens, fixed budgets for a population's care, incentives for preventive, proactive and whole pathways/systems of care together with long-term financial envelopes that enable providers to invest and innovative upfront achieving better value over the longer-term.
- The emerging ambition is to move to a new model of commissioning, at least in shadow form, for the adult population from April 2017.

# Vanguard 5: Stockport (MCP)

**Purpose: On-going work to establish an Accountable Care Organisation**

## Background and Case for Change:

**Patient Population:** 300,000

- The vision builds on the GP registered list and will be integrated around the GP practice at neighbourhood level (20-30,000 population), at locality level (80,000 population) and at borough level (300,000 population).
- Hospital urgent care will be redesigned, with a single point of access that is integrated with community teams.
- People with complex conditions or at the end of life will have an integrated team working with them to support them and help them make the best decisions about their plan of care.

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## Conclusions:

- Alliance commissioning offers benefits including incentivising collaboration and partner engagement and requires investment of time in developing relationships, understanding and buy-in.
- Developing social action and community capacity is a vital part of this approach and enables you to harness emergent and innovative activity by investing strategic support in the communities. It is important to be aware of what motivates resistance
- Support and information must be available to prepare providers when there is a need for decommissioning so that they appreciate and understand the extent of change required and the value of alternative options.
- Consider the way commissioning approaches shape provider behaviour to mitigate negative outcomes which can limit providers' capacity, capability and resilience.
- Decommissioning inevitably involves difficult decisions and will not be easy for those organisations involved. Building new provision using collaboration and working with the community provides many benefits
- The level of engagement with significant change processes will always be varied. It is important to be strategic and reflective in building a network of change agents

## The Solution:

- The vision is one which focuses on prevention, and in order to create a system which focuses on prevention it is necessary to redefine the commissioning and contracting systems in that area.
- In order to commission services differently, they recognised the need for a culture change to help prepare organisations for the shift.
- They selected six areas for delivery:
  1. Advocacy Casework Service: Giving people a voice was regarded as a key foundation for the new services
  2. Wellbeing and Independence at home: Focusing on more practical support in and around the home to enable people to enjoy living independently for longer
  3. Independent Living and Wellbeing in the Community: Supporting people to take part in a wide variety of social, civic, leisure, learning and work or volunteering opportunities
  4. Wellbeing and Independence through Community Transport: A service to enable people unable to use public transport to access the community
  5. Targeted Prevention Alliance: For those who need temporary or longer term support to access universal services or avoid crises
  6. Alliance for Positive Relationships: For those affected by domestic violence and seeking to prevent abuse occurring.
- Stockport ended these contracts and re-commissioned them with alliance contracts to deliver the services in a more innovative and joined up way.
- Alliance contracting has demonstrated its worth in supporting innovation and achievement of shared outcomes, but Stockport is now exploring for example shared Investment Funding across Health, Care and Place to stimulate the community capacity and solutions all parts of the system need.

# Case Studies

# Case Study 1: Cambridge & Peterborough

**Purpose: An example of a prime provider contract for older people's services with lessons learnt**

## Background and Case for Change:

- Cambridgeshire and Peterborough CCG is the second largest CCG in England, with 108 GP practices, more than 800 GPs and a registered population of almost 900,000. It is organised into eight local commissioning groups, which have decision-making authority and manage resources through delegated budgets.
- The CCG felt there was considerable scope for improvement in the delivery of older people's services. The local health economy faced numerous challenges, including an increasing number of older people and significant financial constraints (with minimal or no growth in health and likely reductions in local authority spend).
- Addressing these challenges led the CCG to consider a radical new approach, aiming to develop outcome based commissioning and promote innovation.

## Key Learning:

- The National Audit Office investigated and found the following:
  1. Neither the organisation nor the CCG made proper arrangements to fund the VAT liability –often not considered and adds substantial costs
  2. The CCG expected the organisation to invest its own funds in transformation - although the CCG included £10m for transformation, it was not explicit that it expected the successful bidder to take risk and invest its own funds into the mobilisation of the service. As this was not explicit in the contract it was not considered in the tendering process.
  3. The basis for the contractual value included a 10% reduction in costs
  4. The procurement advisors did not provide thorough advice to the CCG when reviewing the bids.
  5. Additional clauses were added during the negotiation process which exposed the CCG to considerable financial risk – the idea of a prime provider contract is that the risk is shifted to an organisation which is legally permitted to take on this risk.

## The Solution:

- Care for older people across Cambridgeshire and Peterborough has been fragmented and reactive, and focused on measurement of specific processes rather than outcomes. These problems have manifested in failure to achieve accident and emergency (A&E) targets, delayed transfers, high rates of hospital occupancy, challenges in sharing information, and pressure on limited resources in community and primary care services.
- Traditional payment systems reinforce fragmentation, and the CCG wanted to use its commissioning levers to stimulate more transformational change.
- The CCG wanted to extract money from different contracts into a single pool, and establish a five-year arrangement with a single prime provider to control the budget for the whole patient pathway and relevant services. The CCG also wanted the provider to directly deliver community services and take responsibility for integrating care, in order to avoid any further fragmentation
- This was an £800 million contract over five years, worth approximately £160 million in the first year. The payment model was essentially a 'year of care' capitated approach for the population aged 65 and over, combined with a new 'payment by outcomes' system worth up to 15 per cent of the total contract value in the latter years of the contract.
- The contract was awarded to Uniting Care after a 15 month procurement process. 8 months into the contract, the prime provider pulled out on the basis it was financially unsustainable. Previous bidders had pulled out of the process during procurement because they felt it to be financially unviable.
- The CCG set the maximum bid at £752million, most bidders set their bids at that point, Uniting Care set their bid at £726 million. This low bid led them to win the contract, however, as there was limited data neither the CCG or Uniting Care could determine whether this was actually viable. When the contract was signed there were considerable cost implications which hadn't been agreed, despite this the organisation agreed to start the mobilisation of the service. The organisation requested an additional £34million to deliver the contract, however, after some negotiations Uniting Care decided to pull out.

# Case Study 2: NUKA

**Purpose: Understanding an internationally renowned model of care and its delivery of outcomes**

## Background:

- Southcentral Foundation is a not-for-profit health system, owned and run by and for Alaska Native people
- It delivers a broad spectrum of services including primary care, dentistry, behavioural health (including residential and day treatment programmes), paediatrics, obstetrics, complementary medicine, traditional healing, domiciliary services and education.
- It also co-owns and co-manages a 150-bed hospital, the Alaska Native Medical Centre, providing inpatient, specialist and tertiary services. It delivers services to a population of 65,000 Alaska Native people in Anchorage, Alaska and across the Southcentral region

## Conclusions:

- When Southcentral Foundation in Anchorage, Alaska, assumed responsibility for primary, community and mental health services for Alaska Native people in the mid-1990s, the quality of care and outcomes for the population were among the worst in the United States.
- Seventeen years later, Southcentral is widely regarded as one of the most successful examples of health system redesign in the United States and internationally. Costs are down and quality is up, with health outcomes among the best in the United States based on a wide range of measures.
- Like the NHS, Southcentral is a state-funded health system, with a large proportion of its resources coming from taxation. In the mid-1990s, it faced many of the challenges that NHS organisations are currently seeking to address. It therefore seems to be a relevant case study for local NHS organisations embarking on system-wide redesign.
- Southcentral's transformation began when it was given control of a single budget and responsibility for a broad range of services for its population. It delivered transformation entirely 'from within' rather than as a response to top-down performance.

## The Solution:

The South Central Foundation has identified a series of steps which led them to successfully deliver the outcomes which they have seen over the last 20 years:

1. **Defining a clear vision with engagement from the community it serves:** understanding its role as more than a health care provider but also the social impact it had. The goals are very deeply connected to the culture of the local people. The vision and principles are embedded into all aspects of the organisations' activity.
2. **Putting customer owners at the heart of the system:** empowering them to take control of their care, gaining feedback and measuring satisfaction, engaging them with the running of the system, communicating with the community and creating governance with community ownership
3. **Developing an easy- to-use strategic planning and decision making system**
4. **Redefining primary and community services:** defining the core product, choosing the right model for the population and developing multi-disciplinary primary care teams
5. **Integrating this system with the hospital system**
6. **Embracing the use of data and analytics**
7. **Investing in people:** improving the recruitment processes, creating career ladders, providing training and development opportunities and growing leaders within the system.
8. **Creating a culture of improvement.**
  - Over three decades, Southcentral has transformed health care for Alaska Native people from among the worst in the United States to among the best in the world.
  - It is in the 90th or the 95th percentile for many measures such as diabetes testing, asthma-appropriate medications, tobacco screening and quit rates.
  - Southcentral's redesign of primary care has allowed it to move from four week waits to same-day appointments while reducing the proportion of doctors and nurses per head of population. It succeeded in eliminating a backlog of more than 1,000 patients for behavioural health programme.

# Case Study 3: MSK services in Bedfordshire

**Purpose: To understand how services were commissioned for a specific pathway**

## Background and Case for Change:

- Bedfordshire CCG is under some financial pressure. Musculoskeletal care is its fourth biggest area of spend (consuming 7 per cent of the budget), largely driven by a reliance on hospital-based services in some locations.
- There has not been a formal network of musculoskeletal providers across Bedfordshire, but there are some informal relationships that have successfully emerged because of the relatively small geographical area.
- The CCG felt that it had already addressed the 'low-hanging fruit' and needed to make a more substantial impact on reducing spend. It made the initial decision to focus on musculoskeletal services because it was a high-cost and high-volume area.

## Conclusions:

- The process of setting up this contract was long and protracted, the NHS system is not quite set up to deal with prime contractors as they sit somewhere between a commissioner and provider. The legal process and the setting up of sub contracts can take a long time.
- MSK is also an area which is often an area where AQP is in place and establishing a process whereby the pathway is integrated and yet patient choice is upheld can be tricky for the commissioner and the prime contractor to navigate.
- However after one year Circle increased the number of patients it saw from 40% the previous year to 90% that year.

## The Solution:

- Given the high spend, problems with access and an over-reliance on hospital-based services, the CCG determined that more attention needed to be given to managing the musculoskeletal referral pathway and providing more care in the community through a prime contract.
- The CCG decided to commission and incentivise an organisation to manage the pathway – the ambition was that a single prime contractor would have greater ability to align incentives across the pathway through a programme budget and overarching outcomes.
- Needed to develop a market and go out to procurement, as it was not confident that a prime contractor could be appointed from existing local organisations. The CCG originally built the specification through talking to GPs, other clinicians and patient representatives. It also sought input from external and national experts, mindful of potential conflicts of interest arising from involving local experts who might be attached to any bid for the contract.
- In April 2014, the CCG appointed a consortium led by Circle Clinical Services Ltd as the prime contractor. The CCG now has a direct contractual relationship with Circle, which manages the contracts within the supply chain.
- In practice, the CCG has continued to play a brokering role with local providers as Circle establishes their sub-contracts. The CCG holds a standard NHS contract with Circle; however, Circle cannot issue NHS standard contracts because it is not a statutory NHS body. Instead, it is starting with a contract that resembles the terms and conditions of a standard NHS contract.
- The prime contract arrangement is underpinned by a capitation-based funding formula, incorporating risk/gain-share and additional financial incentives for delivering improved patient and clinical outcomes. The annual budget started at £26.5 million in the first year, increasing approximately 1.3 per cent each year over the course of the five years.
- Circle receives 95% of contract value up front, for which it takes full financial risk. An additional 2.5 per cent is paid to Circle to cover management costs. For this sum, the Circle consortium must deliver the basic service specification. Circle can retain the first 5 per cent of any surplus from this 95 per cent at the end of the year. Anything over 5 per cent is split 50/50 with the CCG. This serves as a further financial incentive to the CCG and GPs (who are outside of the Circle contracting pathway) to improve the quality and efficiency of care.

# Case Study 4: Milton Keynes PCT – Alliance

**Purpose: How does a third sector as a prime provider work?**

## Background:

- Milton Keynes was the first area to develop a COBIC in England, delivered initially for substance misuse services.
- Milton Keynes PCT and Milton Keynes Local Authority worked in partnership to jointly develop an outcomes based approach to commissioning the substance misuse service.

## Conclusions:

- The contract was let to a third-sector organisation, acting as prime contractor for the complete substance misuse service.
- The service was transformed quickly, with improved outcomes for service users and financial savings for commissioners.
- Overall spend on the service was reduced by 20 per cent in the first year.

## The Solution:

- Prior to letting the new contract, Milton Keynes substance misuse services were provided by a number of providers across the care economy. As a result, the service was characterised by fragmentation, with users failing to effectively navigate the service and often dropping out of treatment.
- The large number of contracts, and lack of collaboration between the multiple providers involved in providing services, severely impacted upon the efficiency and effectiveness of the system.
- The PCT and LA worked together to understand the outcomes that they wanted to see from the contract, working with both service users and partner agencies to do so. A contract was offered to providers which combined capitation and rewards for improved outcomes.
- The contract was let to a third sector organisation, acting as prime contractor for the complete substance misuse service. The service itself was transformed extremely quickly, with improved outcomes for service users and financial savings for the commissioners.
- This contractual form shifted the risk from the commissioner to accountable lead provider, who is responsible for achieving commissioner defined outcomes for the specified population within the allocated budget.
- The overall spend on the service was reduced by 20% in the first year as a result of the outcome based approach.