SOMERSET LMC

Newsletter Special Edition

JULY 2015 **Issue 198**

OUTCOME BASED COMMISSIONING

In the words of Heraclitus "The only constant is change". With the problems that beset public services - and the NHS in particular - we might assume that a period of stability would be a good thing just now, but there is a strong argument that the whole system is now so unstable that we cannot make it work for much longer without substantial redesign. If that is the case we might as well do the job properly – there is no point in re-plastering the walls today if the foundations need to be dug up next week. So, if what we have is falling over, what are we trying to build in its place? Do we have a new design plan? Well, possibly we do. Read on…

Summary

- In line with an accelerating trend across the whole NHS, Somerset CCG is preparing a business case with other local health and social care commissioners for a radical change from process to outcome based commissioning (OBC) of health and social care services.
- The current proposal includes the whole population of the county, tentatively divided into East and West areas, and ultimately it could take in about 65% of the current health and social care spend in Somerset. Initially children's social care will be excluded.
- Health and Social Care will be expected to work collaboratively to achieve the OBC targets. The CCG is keen to involve general practice as well as the acute trusts and Somerset Partnership, possibly using an "alliance" contracting model.
- The first of these new contracts will not be introduced before April 2017 and so far the CCG Governing Body and the Cabinet of the County Council have only agreed the principles that the full business case will be based upon. Contract changes will be incremental, initially involving only a small proportion of any provider's income.
- How providers work together to meet the new contracts will be up to them, but if we are to be involved, general practice will need to have some sort of collective voice in these conversations.
- Core GMS/PMS contracts are not included in the current proposal, but in the longer term these may have to be embedded in a new contracting structure if practices wish to join the new scheme.
- This development will trigger a cascade of changes that have the potential to contribute to solutions to some of the pressing problems of primary care, but the transition will be complex and difficult, and it needs to be managed with great care.
- OBC is not the solution to the problems of the NHS, nor is it the only way of tackling the problems of general practice, but it could potentially provide a better structure for organising patient care.
- The LMC strongly believes that if general practices choose to take part, an exit strategy must be agreed at each stage that allows for a reversal or change of direction if any new arrangement does not work.

Introduction

The NHS is failing. Not only is the black hole in the middle of its finances growing spectacularly but we are spending our money on the wrong things. Too many interventions too late in the disease process take up too much of the money, so preventative care is largely side-lined, and standard treatments are simply delivered to individuals who have often have little responsibility for their own care. Some patients are thus disenfranchised, and health inequalities are growing. Generally, the Health value of successive technical interventions progressively diminishes, whilst with each investment in prevention, the greater the cumulative health benefits.

Viewed objectively, it clearly makes sense for health services to be commissioned according to outcomes and not process measurements. Paying providers to ensure that a given percentage of eighty-five year olds are

independently mobile is better than paying them for the number of hip operations they do, as this will focus attention on preventative health and simple interventions, reserving expensive surgery for those who really need it. There will be no perverse incentives to operate in marginal cases, and healthcare harm will be reduced. Indeed, OBC should be a significant step towards creating a service genuinely based on health rather than illness.

The implications of this change are enormous, and adopting OBC will lead to far reaching changes in both the form and the function of NHS providers. Decisions about it need to be taken carefully, as the more generic an outcome is, the more it will be seen as the default responsibility of general practice.

Which Patients to Include?

Experiments with OBC in the UK have, so far, been fairly tentative and piecemeal, and until now no health community has included general practice in the initial contracts. Much experience comes from the USA, which has a very different healthcare system, but in principle OBC should be relatively easier to apply in the UK where ultimately the government directly commissions over 80% of all health expenditure. Generally some degree of "segmentation" is adopted when a new OBC contract is agreed, with particular patient groups for inclusion chosen by age, morbidity or some other combination of factors. But that does not really make long term sense. If the objectives are to shift to preventative strategies and re-design the system to offer early intervention, that really requires a whole population approach. This is what is proposed in Somerset.

Inclusion of General Practice

Since more than 80% of NHS encounters take place in general practice it is clearly nonsensical not to include it in a whole system contracting model. There are considerable problems with including GPs, largely because the funding of general practice is so different, with GP partner incomes depending directly on the efficiency with which they manage their contracts. Furthermore, GMS and PMS contracts are valuable assets that it would be very unwise for any practice to consider surrendering without good reason, especially during these difficult times. And general practice is in a fragile state – too much system change risks increasing the exodus of experienced doctors from front line practice. But equally we know that many new GP training completers see that finding a work/life balance that will be sustainable for over 40 years is going to be more important than preserving an independent contractor model of service that is beginning to fail under the relentless tide of demand, regulation, and technical advance. OBC will certainly lead to an acceleration of the existing trend for practices to work in larger functional organisations, and closer integration with large NHS providers offers an opportunity to use their considerable management, capital and human resources to provide better support for general practice.

Most important of all, once long-term patient care becomes a shared responsibility, the current deluge of work being transferred to practices by NHS trusts and others can be properly considered and addressed.

The CCG Business Plan allows general practice to join the project at various different points, or not at all. It is not clear whether there will be a critical mass of practices needed to make this viable. There is a nice balance here between jumping in before the implications for day to day work have been thought through, and being left behind by an evolving NHS community that is starting to do things very differently. For the near to medium term future, OBC will directly affect a relatively small proportion of day to day work in primary care. In the longer term it should mean a seismic change in working practices.

Provider Inter-Dependency

Process measurements are easy to use, and they can readily be attributed to a particular provider. The proportion of diabetic patients with a cholesterol measurement in the last year records a mainly primary care activity, and the proportion of patients assessed and discharged on the day of admission is essentially a secondary care measure. But outcomes such as patient activation or health status for those with a particular long term condition are determined by the social demography of the patients concerned, interactions throughout the health and social care system, and, ultimately by all sorts of other parties such as housing services, education, community groups and third sector organisations. Providers therefore become closely dependent upon one another to achieve the required outcomes. This is a powerful way of driving change across the system, but it also means that an obstructive or failing provider could cause serious problems for other

participants. The CCG is currently suggesting that only 2.5% of the shared budget may be at risk, although this will rise over time, so practices should feel reasonably comfortable that core income will remain stable during the early stages.

Alliance Contracting

In the current health economy in which multiple separate providers contribute to health care, the most elegant answer to the difficulties of joint working is alliance contracting. The parties jointly agree with their commissioners a particular set of outcomes. Initially there will only be a few of these, but the number and therefore the proportion of funding represented will grow over time. Each provider in the alliance then works out its basic costs to deliver the services required to achieve those outcomes, and that sum is guaranteed in the contract. The actual contract price also includes a further incentive element on top of the cost price. If the targets are achieved, the providers share this income ("profit") but if they do not they will have to meet the overhead costs of the contract themselves. We know from experiences like the introduction of QOF that GP practices can adapt very quickly to changes contract requirements. The question for GP collaboratives/localities considering participating in OBC is whether they feel all the other potential participants can do likewise, and whether they will be able to put aside historical arguments and difference of culture to do so.

OBC Will Not Be Cost Saving

OBC is not the answer to the financial problems of the NHS, and we must not let anyone assume or suggest that it is. Only the Government can decide on the balance it wishes to strike between cost and services, and that needs to be emphasised at every opportunity. OBC has the potential to lower some costs by reducing duplication and promoting self care and early intervention, but these are long term benefits. In the short term the need for "double running" as well as the expense associated with change on this scale, means that costs will rise, and the transition, management and opportunity costs will be considerable. The LMC often uses the analogy that making major changes to very busy front line NHS services is like trying to change the wheel of a racing care without coming in to the pits. Introducing OBC will be akin to changing all four wheels simultaneously. There is some international evidence to support the change, and there are certainly efficiency savings that we know can be made by better system integration and organisation. What we do not know is whether the paper savings projected by management consultants will actually translate into real cash savings for providers, or whether integration and personalisation will produce better care, but at the same or greater cost, by recognising unmet need. There is precious little evidence that demand for NHS services can be moderated by provider intervention.

OBC and General Practice Contracts

NHS provider trusts are paid through conventional contracts that cover the costs of the services provided and the overheads, including management costs, of the provider. Apart from some APMS providers, GP practices are still largely run by partner principals whose income is directly dependent on the efficiency with which they can maximise income from contracts and services and contain the costs associated with providing them. If a conventional shared contract fails, GP participants would be risking their personal income, whilst individual trust managers would definitely not.

The current proposal is to limit the risk to practices by only including particular elements of the contract, such as part of QoF/SPQS, or the Avoiding Unscheduled Admissions enhanced service. This is a starting point, but although practice funding is derived from several strands, in reality there is a total amount which is amalgamated to fund the services provided. OBC will have little effect on the number of patients wanting to see the doctor on Monday morning, and the core GP function of being available to see patients who, in the words of the GMS contract, "are, or believe themselves to be, ill" will continue. Premises still have to be maintained and staff paid, so the essential requirement for practices is that their work/income balance is not adversely affected. As small or medium sized enterprises, practices do not have the reserve capacity to cope with any significant intermediate or long term funding or demand fluctuations, and this must be a central principle of discussions with both commissioners and other providers.

What About The Politics?

OBC has some very interesting organisational and political consequences. A progressively more integrated service will make the artificial "market" in health care increasingly irrelevant, and it is notable that the "choice" mantra of the last decade appears to be chanted I more quietly in NHS circles: it is difficult to see how patients would be able to select different bits of an integrated service, even if they really wanted to. Procurement of an integrated service can either be by open completion or by the "most capable provider" route, which allows commissioners to select a lead provider, joint venture or collaborative that is self-evidently the right one. This is a rigorous process, and at various stages it may fail, with the commissioners reverting to an open procurement. The financial, management and opportunity costs of taking part in this are going to be considerable so GP localities will wish to be assured that the potential benefits are worthwhile. This will be another key point for discussion with the CCG. But perhaps the most significant change is that OBC in effect transfers much responsibility for how services are provided from commissioners to providers, which will change the role of the commissioners in the future. It also means that providers in the integrated service will have considerable influence over who can participate in health care.

What is the End Game?

The logical consequence of OBC is the formation of an accountable care organisation (ACO) serving a defined population, which could perhaps be defined by provider catchment areas, local authority boundaries, or natural geography and communications. Distinctions between "primary" "community" and "secondary" care are likely to gradually be replaced by functional streams – such as "prevention", "long term conditions" and "unscheduled" and "elective" care – supported by clear patient pathways. The benefits of this are self evident, though the disadvantage are less so, but the role of general practice is going to change rapidly whatever happens, and we would be wise to position ourselves for the realities of the new world.

Can We Make it Work?

Yes. Paradoxically, the 70+ GP practices in the county are likely to find it easier to adjust their way of working than some of the other potential participants. Small, flat, flexible and reactive organisations can change much more readily than large, complex and highly segmented ones. Somerset has many advantages when it comes to joint working – notably in that the CCG, County Council and the LMC all have the same borders. Nearly 90% of current health activity in Somerset is internal, with the three Foundation Trusts based in the county providing the majority of community and secondary care, and if the proposed operational merger of Taunton & Somerset and Weston General Hospital goes ahead, only the Royal United in Bath from outside the county will be providing hospital services for a significant proportion of Somerset residents.

There are, however, some problems. Culture and philosophy differs between local trusts, perhaps more so between trusts and general practice, and certainly yet more between health and social care. To make changes at this scale requires a great deal of mutual confidence, and profitable NHS providers (most practices) will be wary of sharing contracts with acute hospitals who are already in the red and a social care sector whose funding is evaporating. All these things can be resolved, but not quickly.

Conclusion

The LMC recognises that fundamental change is required in almost every part of the NHS. There is an urgent need to squeeze political demands out of healthcare, and for health and social care providers to work together to give patients the best affordable outcomes, whilst always emphasising that it is the responsibility of government to decide how much care it is prepared to pay for. Outcome based commissioning looks set to proceed with or without general practice involvement. It is likely that whether we choose to break the mould and take part, or not, will depend on detail that is yet unknown, but we encourage all practices to take part in the forthcoming CCG Consultation process.

Somerset Local Medical Committee, Crown Medical Centre, Venture Way, Taunton TA2 8QY

Tel No: 01823 331428 Fax No: 01823 338561 E-mail: lmcoffice@somersetlmc.nhs.uk

LMC Website: http://www.somersetlmc.co.uk