

Commissioning and Health Services for Older People

Arnold Fertig – Retired Cambridge GP and Journeyman Commissioner

Commissioning is the planning and purchasing of NHS services to meet the health needs of a local population

Commissioning

WOULD BE A DODDLE IF

- Limitless money
- Services in line with best evidence & All agreed on that evidence
- All services worked seamlessly together
- Patients always reported an excellent experience

BUT NONE OF THE ABOVE HAVE EVER APPLIED AT SCALE, AT LEAST NEVER TOGETHER

- So this is a story of what has been tried to achieve quality in a cash-strapped universal service

My alternative home for 31 years!

Nuffield Road Medical Centre



- East Chesterton, Cambridge
- 1980 – 4 (male) GPs, 1 nurse, 3 reception. 1 admin, 2 DN, 10,000 pts
 - Employed and attached staff of about 11
- 2011 – 12 GPs, 7 nurses, 7 reception, 5 admin, 7 DNs, 13,000 pts
 - Employed and attached staff of around 50
- Relatively deprived and elderly population
 - E.g., serving around 7 traveller camps and 5 large& medium care homes
- Early adopter, fundholder and teaching practice
- Personal interests - commissioning, LTCs, frailty, practice management, MDT working and communication
- Most recently CCG Clinical Lead for Older people, then Primary Care Advisor to UnitingCare

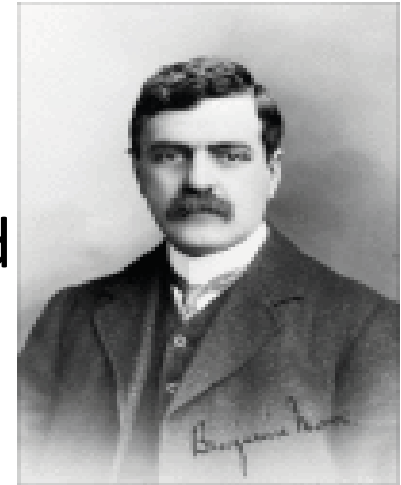
Journey for Today

- The NHS – early thinkers and pioneers
- Crisis, what crisis? Is there a coherent evidenced based strategy from NHS England and others as to how we might dig ourselves out of the current hole
- Why and how did the new C&P CCG begin its thankless journey into the unknown
- Outcomes based commissioning – passing fad or the answer to everything?
- UnitingCare, its winning solution, and the rise and fall of the contract
- Case history video and discussion



Dr Benjamin Moore, FRS (1867-1922)

- First Professor of Biochemistry in these islands
- Affected by poor quality in the Poor Law Hospitals, and the chaotic approach to medicine in the private world
- The Dawn of The Health Age 1910. NHS coined
- 'It is **method** more than money that we want in our battles with disease; we must fight in the future by means of a disciplined army instead of, as at present, with an undisciplined mob, each member doing what is right in his own eyes and working at cross purposes to his neighbour'
- Pioneer in public health areas (affects of crowding on TB), proposed the establishment of an Industrial Health Medical Service, published on chemistry of the spleen, adrenal and salivary glands, TNT poisoning (MRC), and founded the State Medical Association in 1912
- Biography (2011) by his grandson, who was born in Cambridge and studied at Christs



Dr Douglas Gairdner (1910-1995)

- Consultant Paediatrician Addenbrookes (1948-1975)
- Associate Lecturer at the University,
- Editor of Archives of Diseases in Childhood
- In his memoir he comments on his time at GOS 'I recall the sheer enjoyment of working there, but also the periods of overwhelming exhaustion.'
- *The Fate of the Foreskin: A Study of Circumcision*, (BMJ, 1949). **One of the first publications to challenge accepted practice both on therapeutic evidence and cost grounds. Similar publication in 1951 on tonsillectomy**
- Contributions included statistics from SCBU, respiratory disease newborn, nephrotic syndrome



NHS 1948 -1990

- 1948 A medically obstructed birth – we still grapple with the consequences
- 1950 spending already exceeding expectations, huge disaffection by doctors – Royal Commission on pay
- Various things tried e.g. 1962 Hospital plan established the principle of DGHs, 1966 Charter for General Practice, 1974, regional health authorities given responsibility for both hospitals and community
- 1983 Griffiths Report – **modern management processes** to replace consensus management , and advised clinicians to be more involved in management

Professor Alain Enthoven



- American Economist, Stanford, Oxford, MIT and RAND
- In 1985 he introduced the idea of **an internal market** for health. *Reflections on the management of the National Health Service: an American looks at incentives to efficiency in health services management in the UK*
- ‘The NHS is caught in a gridlock of forces that make change exceedingly difficult to bring about. Public policy should seek to create an environment for the NHS that is hospitable to quality-improving and efficiency-improving change.....The NHS runs on the ability and dedication of the many people who work in it. But its structure contains no serious incentives to guide the NHS in the direction of better quality care and service at reduced cost. In fact the structure of the NHS contains perverse incentives.’
- 1988, **Margaret Thatcher** set up a small ministerial team that met weekly
- **1990 NHS and Community Care Act introduced the Internal market**

Dr Ron Zimmern



- Trinity College, Cambridge,
- Director of Public Health for Cambridge and Huntingdon Health Authority from 1991 to 1998
- 1995 Case of Child B in Cambridgeshire – after relapse the cost of a second bone marrow transplant declined by HA on clinical advice
- Health Authority won on appeal – **the right to take into account costs was established** – three law lords in full support

NHS 1990-2016

The Internal Market

- 1991 Hospitals became trusts and **separated from health authorities** which then purchased services from hospitals, & GP Fundholding
- 1997 New Labour elected with a promise to scrap the Internal market
- But NHS staggers under pressures of a winter crisis, Labour responds with an ambitious NHS Plan and massively increases investment. Readopts competition, expands PFI, introduces targets and national guidelines and involves GPs through **practice based commissioning** – locally CATCH
- 1999 PCGs, then from 2000 PCTs – owned community, commissioned GP, hospital services
- **But still costs spiralling – so bring on Payment by Results in 2002!**



Some nuts and bolts of the internal market

- Initial contracts were mainly cost and volume – **so called block**
- In 2002 **Payment by results (PBR)** introduced for hospital care episodes
 - **Facilitates understanding of costs, and increases contestability**, by enabling funds to go to any provider
 - **Enable service innovation and improvements** in quality, by rewarding providers whose services attract patients
 - **Make the system fairer and more transparent**
- **But**
 - Little or no incentive for hospitals to help with controlling demand and system reform
 - community & mental health remain under block contracts – no incentive for them to invest in extra services and help with system reform



Is PBR fit for purpose?

- The current system as applied is not fit for our current and future health and social care (Kings Fund 2012)
- PBR as it stands is not well designed to promote or support larger scale shifts in care from hospital to other
- PBR is not well suited to promoting continuity and co-ordination of care.
- A single hospital episode such as an emergency admission may form just one part of an extended treatment cycle for some patients. **Where the need for the episode is in part determined by the effectiveness of services in primary and community care, hospital treatment may not be required.**
- The emphasis now placed on giving greater priority to the prevention of illness, the treatment of people with long-term conditions, and the development of **INTEGRATED** care requires a radical rethink of the incentives needed. More use could be made of **capitated budgets** to create incentives for providers to focus on prevention and on the provision of care in the most appropriate and cost effective settings.



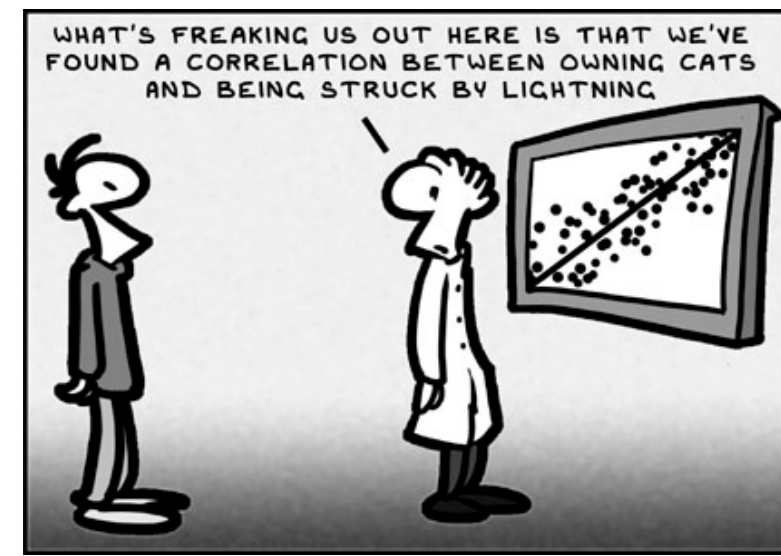
Tensions in the internal market

- For markets to work, successful players nearly always have to **invest** – but there is little or no money for investment
- The NHS Cycle is tied to **annual** contracts – markets can never work over that timespan – for example CCGs have a statutory duty to break even by 31st March each year, no matter what
- **PBR puts all CCG and health system finances at risk** as demand is exploding especially with ageing population and consumerism
- There are **no financial incentives for community services or GPs to maintain patients at home**
- **It works against collaboration**
- **NHS England senior leadership are primarily responsible to ministers for holding CCGs to account financially on an annual basis, Quality comes second. But logical changes to create a more efficient and better quality NHS takes years so experience tells us that latest plans for change may just be a form of ‘the Emperor’s New Clothes’. I hope not**



Reviews of the Clinical Case for Change

- **Safe, compassionate care for frail older people using an integrated care pathway. 2014.** Sets out a vision for better care, and the evidence behind the vision
www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf
- **One Person One System One Team Report from the Independent Commission for Whole Care for the Labour Party 2014**
[http://www.yourbritain.org.uk/uploads/editor/files/One Person One Team One System.pdf](http://www.yourbritain.org.uk/uploads/editor/files/One_Person_One_Team_One_System.pdf)
- **Making our health and care system fit for an ageing population 2014**
http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-health-care-systems-fit-ageing-population-oliver-foot-humphries-mar14.pdf

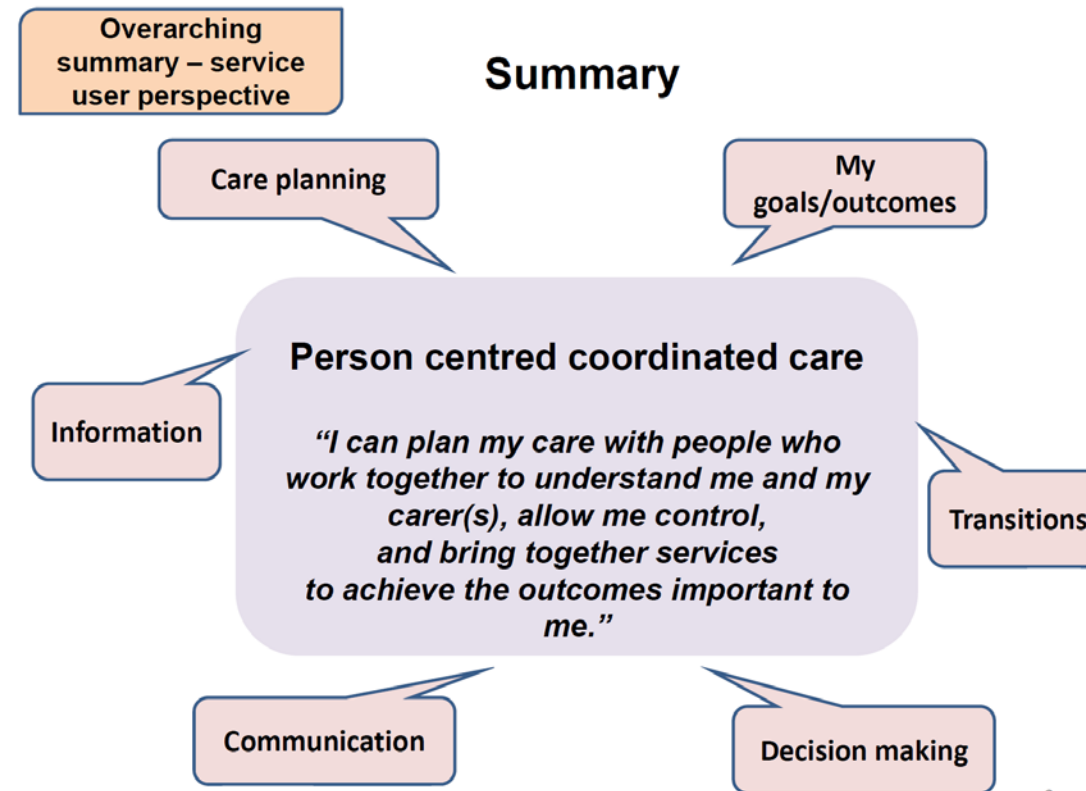


NHS Strategy on Integration

– from their website

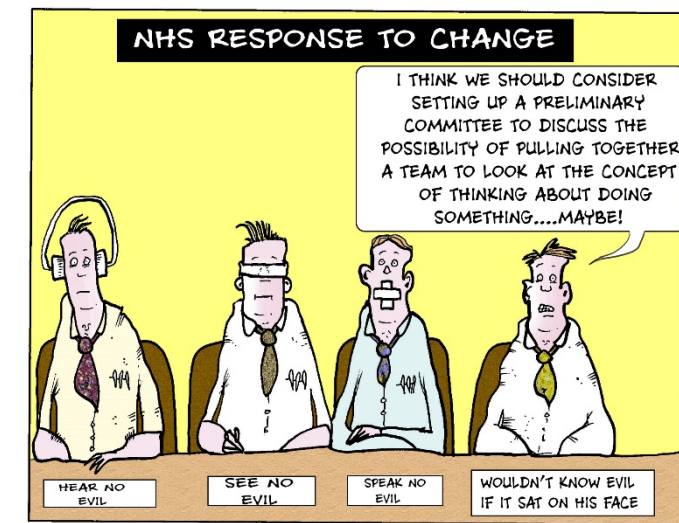
- We will support local areas in delivering integrated care and support in the first ever system-wide ‘shared commitment’, [‘Integrated Care and Support: Our Shared Commitment’](#).
- For health, care and support to be ‘integrated’, it must be person-centred, coordinated,
- Where local areas have succeeded in integrating health, care and support services, too often it has been despite the national system rather than because of it.
- **National Voices**, a national coalition of health and care charities, has developed a [person-centred ‘narrative’ on integration](#). **This is an agreed definition of what we mean by ‘integrated’ care.** It provides a guide to the sort of things that integrated care will achieve, such as better planning, more personal involvement of the person using services, and free access to good information. It also provides some clarity over what local areas should be aiming to achieve practically, in their efforts to integrate services.

National Voices



The 2015 - 5 Year Forward View – Simon Stephens

- The NHS will take decisive steps to **break down the barriers**.
 - **The future will see far more care delivered locally**
 - Local health communities will be supported by the NHS' national leadership
- and **then given the resources and support to implement them where that makes sense.**
- **Several structural options are proposed which essentially brings hospital, primary, community and emergency care together in different ways**
 - **The national leadership of the NHS will need to act coherently together**, and provide meaningful local flexibility in the way payment rules, regulatory requirements and other mechanisms are applied. We will back diverse solutions and local leadership, in place of the distraction of further national structural reorganisation. We will invest in new options for our workforce, and raise our game on health technology - radically improving patients' experience of interacting with the NHS.
 - **Improve the NHS' ability to undertake research and apply innovation – including by developing new 'test bed' sites for worldwide innovators, and new 'green field' sites where completely new NHS services will be designed from scratch**
 - **£30 billion a year gap by 2020/21**. So for survival we will need action on three fronts – demand, efficiency and funding.
 - **Efficiency needed – perhaps rising to as high as 3% by the end of the period**
 - **Decisions on these options will be for the next Parliament and government,**
 - **Meanwhile every health and care system needs to produce a top down Sustainability & Transformation Plan - but the legislative & structural environment environment that encourages competition and fragmentation remains in place**



Meanwhile back in 2011, our new CCG (Andrew Lansley 'reforms') choose care of the elderly as a priority and realised it needed to do something very different – why?

- Second largest CCG, 107 practices, 900,000 people, nearly a billion pound budget, six local trusts under great duress
- Unsustainable Local Health economy
- Mounting demographic pressure – annual increase in over 85s is 5%
- Fractured health services special problem for people with long term conditions and frailty with poor quality of services
- Patient Voice – better integrated care closer to home please
- Around 20% acute admissions and 20% hospital days preventable
- Do nothing – older people admissions will grow by 31% by 2020
- Need to realign financial incentives and longer contracts
- Need to develop an Outcomes based approach to commissioning whole pathways of care that go across organisational boundaries

Why procurement?

- Sum of money involved
- Five-year contract - enables investment early on
- Drive for innovation and new approaches through competitive dialogue
- Could the services be provided by more than one provider?
- Legal advice on the CCG proposals was to use an open procurement process
- The formal procurement process provides pace, focus and discipline to deliver improvement with set time-scales and processes.
- Outcomes Based contract and a capitated budget for whole pathway of care is new approach to reverse the shrinking of community services

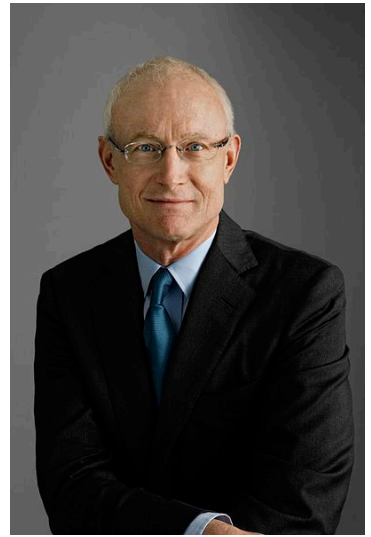
Procurement Process – 15 months

- **Invitation to Bid described the Outcomes Framework, and gave 9 clinical scenarios to which the bidders had to respond**
- 60 expressions of interest initially
- 11 organisations completed Pre-Qualification Questionnaires (July 2013)
- Competitive dialogue at each stage
- 10 Outline Solutions submitted (January 2014) and evaluated
- 4 organisations shortlisted (March 2014) and their proposals included in the public consultation
- 3 Full Solutions submitted (July 2014) and evaluated
- **Evaluation very extensive** around 30 GPs plus other clinicians, patient/lay reps , subject experts and managers - quality, patient engagement, clinical scenarios, mental health, corporate governance, workforce, estates and facilities, IM&T, legal, transition and integration and finance, Local Authority reps including housing and social care plus **External advisors for finance, legal, property and IM&T.**
- Preferred Bidder announced (October 2014)

The Contract – Older People (65 and over) & Adult Community Care from age 18 (OPACS)

- Five years (£725 Million) , plus two years
- Capitated Budget covering for older people all acute admissions, all community and mental health care, voluntary sector, palliative care, and GP care home service
- In this way, financial incentives realigned to encourage healthcare delivered outside of hospital where it is safe to do so
- achievement of better clinical outcomes and patient experience linked to payment through the contract. 10% by year 2 and 15% by year 4
- achievement measured through the 'Outcomes Framework' which was at the heart of the invitation to bid and the contract itself

Dr Michael E Porter



- **Porters Hierarchy of Outcomes**

"A Strategy for Health Care Reform—Toward a Value-Based System" (NEJM, July 2009), lays out a health reform strategy for the U.S.

- **Harvard economist, most cited economist in the world**

- **In his paper 'What is value in Health care(NEJM, Dec, 2010), he wrote**

- In any field, improving performance and accountability depends on having a shared goal that unites the interests and activities of all stakeholders. In health care, however, stakeholders have myriad, often conflicting goals, including access to services, profitability, high quality, cost containment, safety, convenience, patient-centeredness, and satisfaction. Lack of clarity about goals has led to divergent approaches, gaming of the system, and slow progress in performance improvement.

Outcomes based Commissioning – what is it?

- Outcomes based Commissioning is a commissioning **approach that uses Outcomes**. It involves:
 - a focus on populations
 - the use of outcomes that matter to those populations
 - the use of metrics and learning to monitor outcomes
 - performance incentives and risk-sharing
 - coordination of delivery across providers.
- In England, **there are about 25 sites** using or planning to use such an approach. Not yet proven and still in development
- It Seeks to solve how financial flows and the commissioning process can best support quality and efficiency improvement across the system.
- **The logic model for it is that providers are incentivised to collaborate to produce integrated services** capable of delivering the outcomes that matter to their population, reducing duplication and waste. The current financial pressures facing the NHS mean that commissioners are increasingly attracted to it
- There is promising early evidence from areas that have adopted a form of this approach e.g. Ribera Salud in Valencia, Spain, the Pioneer ACOs in the United States, and Pennine Partnership in Oldham, UK.

In 2012/13 we decided to develop an Outcomes Framework for Older People

- Extensive Public Health literature search (Dr Kirsteen Watson)
- **Modified the Porters Hierarchy of Outcomes**
- Input from the public and a range of experts
- Programme of work to develop the metrics underlying each outcome
- 28 Outcomes spread across Seven Domains

1. Better experience of care

2. Safe care

3. Well organised care – cultural change

4. Keeping healthy - prevention

5. Treatment in acute illness or injury – admission avoidance/less days in hospital

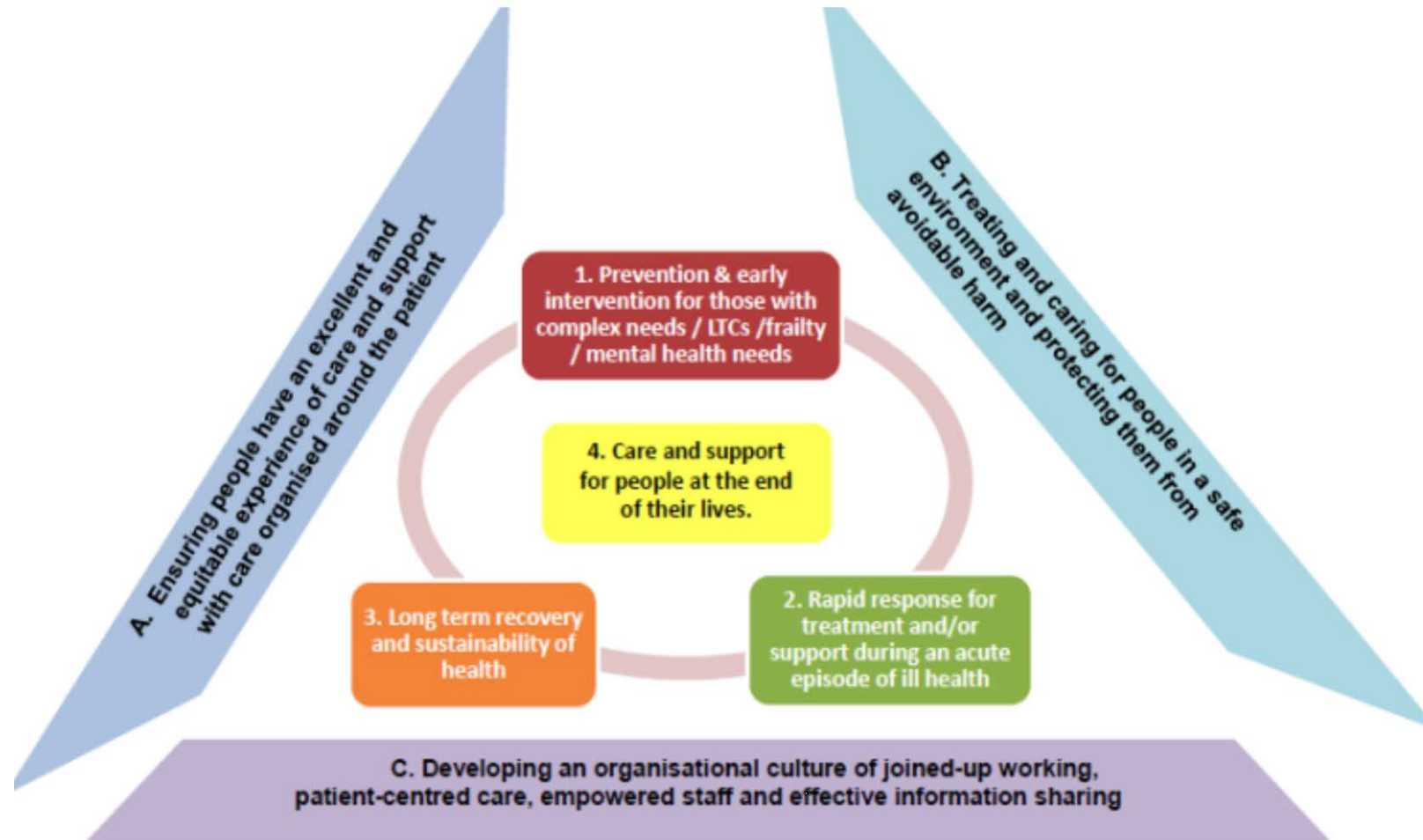
6. Recovering from illness or injury

7. End of life care

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/older-peoples-programme.htm>

<http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/Have%20your%20say/Outcomes%20Framework%20Mark%203.pdf>

Measurement by 'outcomes'



Examples of indicators as markers of positive outcomes 1

- Proportion of patients with diabetes (referred to community services) who demonstrate improvement in **HbA1c** and proportion of people with diabetes under the care of community services who experience a complication of diabetes
- Proportion of patients and carers who report that those involved with their care worked as a **team (communicating well together)**, sharing information & co-ordinating care)
- Proportion of patients and carers who report that **their history and care plan was known and used by all involved in their care.**
- Patients and carers report that: they were not in hospital or a care setting for longer than medical necessary and their care was arranged and coordinated **without unnecessary delays**
- Assessment of whether patients in hospital are receiving the right level of care (eg **clinical appropriateness protocol**)
- **Local partner organisations and their staff report effective joined-up working including GPs, social care, voluntary organisations, housing.**

Examples of indicators as markers of positive outcomes 2

- Proportion of patients urgently referred to the community team who received an assessment (and home visit where required) **within two hours** of referral and received a care package to enable them to cope at home if medically appropriate, within two hours of assessment.
- Proportion of those assessed as frail who receive a **comprehensive geriatric assessment by the frailty team within two hours of arrival** and if admitted, are admitted under the care of a Care of the Elderly Consultant.
- Proportion of patients and carers who are assessed as having **achieved the long-term health outcome or functional goals they desired/planned** for jointly with staff (e.g. activities of daily living).
- Percentage of those with a **stated preferred place of death who died in that setting**
- Proportion of carers who state that overall the level of support given in the following areas was excellent or good for **relief of pain and other symptoms, spiritual & emotional support, support to state what they wanted.**

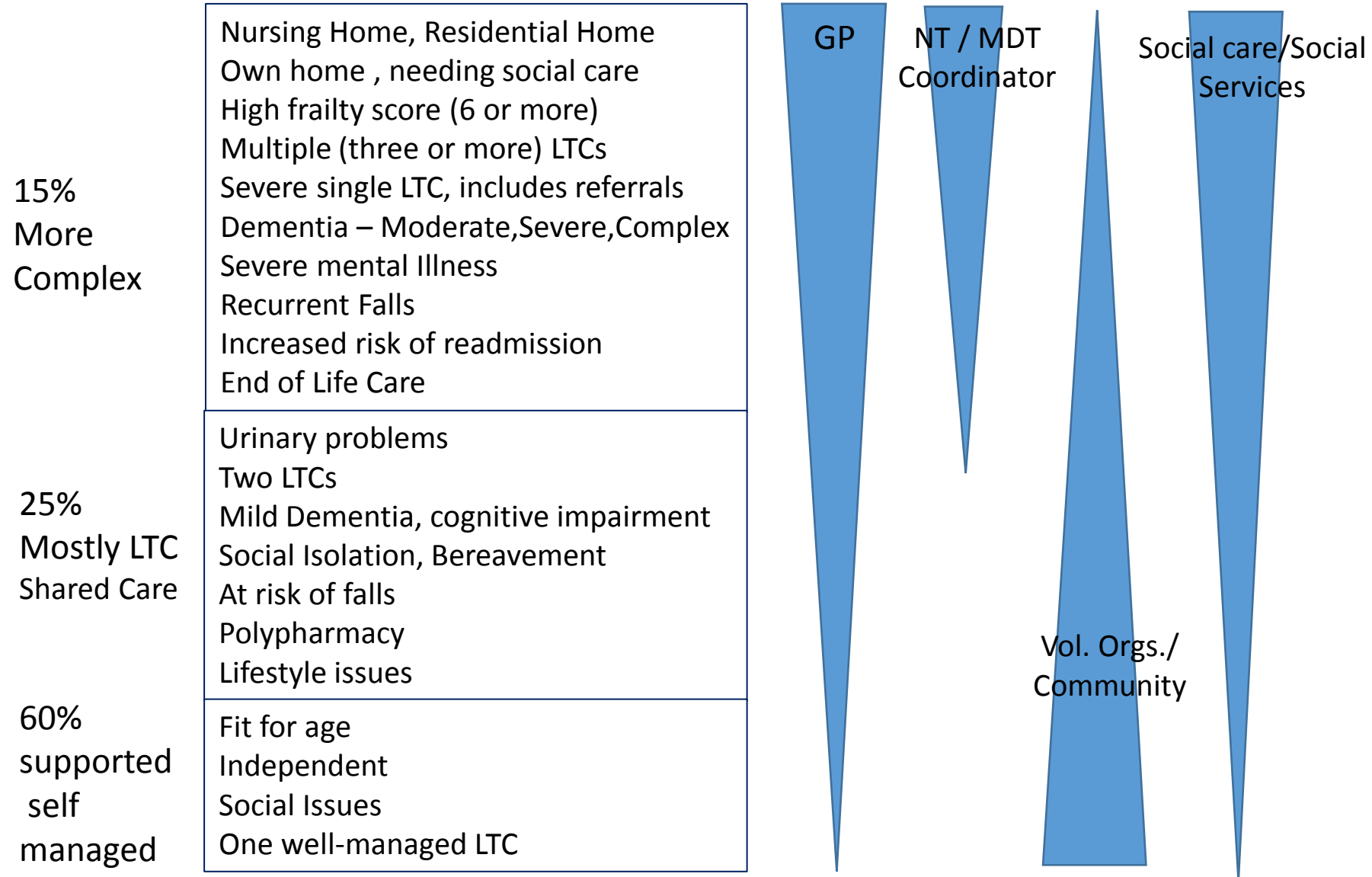
The Winning Integrated Care Model of UC -1

- **A multidimensional approach**
 - Whole population – aimed to identify and engage the 15% most frail of the 65 and over. A well being service for all
 - Patient Centred
 - Joined up across organisational boundaries – policies, in reach, out reach, information
 - Prevention, effective crisis intervention and earlier discharges through active case management
- **16 Neighbourhood Teams each** around groups of 3-7 practices and a population of around 50,000 people
 - District nurses, community matrons, CPNs, therapists plus aligned social worker, GPs, vol orgs, care homes, pharmacists plus coordinators. **Target to reduce avoidable admissions by 18 per day, A&E by 28 per day, hospital days by 20%**
- **4 Joint Emergency teams(JET)** with 2 hour response
- **OneCall, OneView**

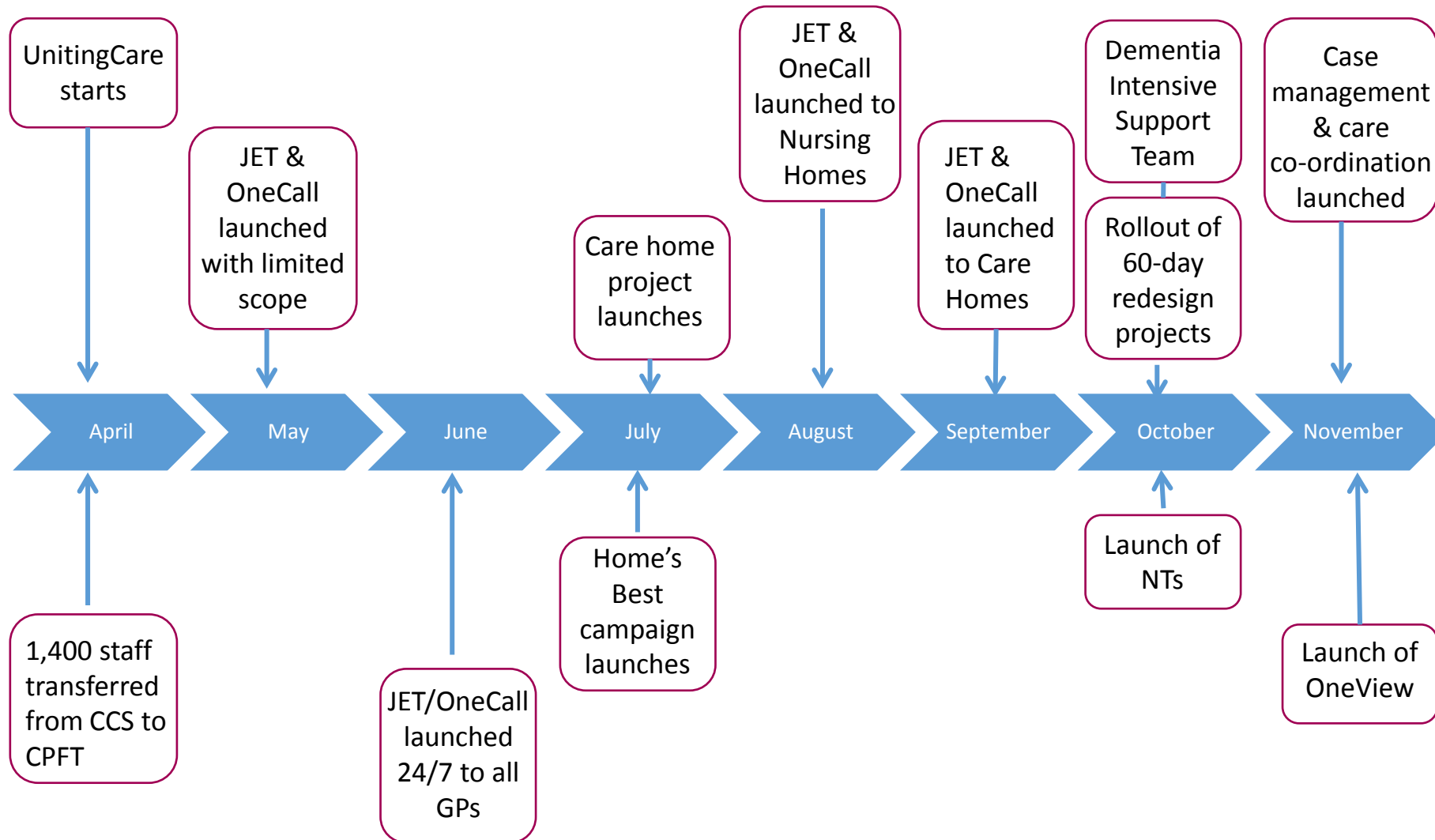
The Winning Integrated Care Model of UC -2

- **Care Home Support Programme – GPs, educators, pharmacist**
- **A Cultural Programme of Staff Training – moving from main loyalty from their service/employer to the patient**
- **4 Integrated Care Teams – specialist nurses, dietician, podiatrist, continence, Geriatrician**
- **4 Integrated Care Boards – one for each system**
- **Unique role as an Integrator bringing hospitals, community, mental health, palliative care and vol orgs together by contracting with them all in a unified way, and GP, care homes, social services, community pharmacists and ambulance by aligning themselves with these organisations – plus a new deal for patients**
- **Investment in the community by reducing hospital costs**

POPULATION STRATIFICATION 65 AND OVER



UnitingCare – How far did they get?



Who is in a Neighbourhood Team?



THE RISE AND FALL OF UNITINGCARE

- UnitingCare was a consortium of Addenbrookes and CPFT (mental health). They formed an LLP with its own Board - the contract was between the CCG and the LLP. UC was not an employer - it was an Integrator
- The contract was signed end of March 2015 subject to further baseline negotiations. This enabled 1400 staff to transition in April to CPFT and the integrated solution mobilised
- The baseline negotiations failed despite good clinical progress and a relatively small gap of £14 million leading to contract end in December 2015. It was more costly to stop the contract, and the programme was in line with NHS strategy, the 5 year forward view and evidence.
- Internal Independent Audit (March 16) found procurement process and financial evaluation of the CCG was robust. BUT, there was a clear mismatch in the expectations of CCG and UC over the cost/value of the contract – and factors leading to this were highlighted
- External Review (Apr 16) concluded that start date should have been delayed, and recommends a review of all major NHS contracts, and specialist advisors to CCGs
- It seems to me that these reports take a purely technical approach and do not analyse what happened at the most senior levels of the NHS. It could have been very different if a strategic view had been taken, and not an inflexible accountability view

Perhaps this can be summarised in a Proverb

*For want of a nail the shoe was lost,
for want of a shoe the horse was lost,
for want of a horse the knight was lost,
for want of a knight the battle was lost,
for want of a battle the kingdom was lost.
So a kingdom was lost—all for want of a nail.*

- *Benjamin Franklin used a variation of this in 1758 in his essay 'The Way to Wealth', a collection of adages about work and ethics. Other examples are "There are no gains, without pains", "One today is worth two tomorrows"*

In Summary

- Pride in the NHS, but in crisis and cannot cope with people with frailty, for example
- Artificial organisational boundaries mitigates against quality
- The quasi internal market and contracts produce many perverse incentives
- The local CCG programme for change was a grass routes attempt to break the mould - but NHS England was not ready for it, despite their rhetoric.
- System wide Health and Care Outcome measures are needed so all can share the same values, wherever we work
- The latest 'alphabet soup' – STP (sustainability & transformation plans) – signals a nod towards collaboration – yet legislation forces trusts to think otherwise and will continue with a siege mentality (BMJ Editorial Feb 16) unless we have much better leadership, structural and cultural change
- What would Dr Benjamin Moore say – are we still behaving like a mob?

