

**Local payment
examples**

**Mental healthcare:
a capitated
approach to
payment with
outcomes and risk
share components**



About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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1. Purpose of this document

Audience

This document is intended for all organisations involved in commissioning or delivering new care models. It will be of particular interest to finance, contracting and commissioning staff seeking detailed guidance on developing new financial mechanisms to support service reform.

This document is aimed at providers and commissioners who are interested in more information on outcomes-based payment models and how they could work in practice. It is intended as a tool to support development of local payment arrangements.

We know many commissioners and providers are looking for ways to promote integrated care for patients who need a range of different services, such as mental healthcare service users. This outcomes-based payment approach can help co-ordinate services, leading to more closely integrated care from the service users' perspective, generate system efficiencies and improve the overall quality of care. It also supports the stated aims of the Five Year Forward View (5YFV).¹

This document focuses on mental healthcare services; however, the outcomes-based payment approach described could have wider application in supporting improved patient outcomes and co-ordination between any health and social care services.

This document describes:

- the need for and benefits of outcomes-based payment in the context of mental healthcare services
- the different kinds of contracting arrangement promoting integrated care in which outcomes-based payment may be used
- the details of one such contracting arrangement, the lead accountable provider model, illustrated by two case studies of its implementation
- the design of a three-component local payment approach that can support the lead accountable provider model:
 - a core component based on capitation, that is a fixed payment per head of the population covered by the contract

¹ www.gov.uk/government/publications/reforming-the-payment-system-for-nhs-services-supporting-the-five-year-forward-view

- a component based on achieving defined outcomes
- a mechanism for sharing the risk of financial gains or losses between commissioners and providers
- the important factors for the implementation of the lead accountable provider model supported by this payment approach
- how to evaluate the model's impact over time.

This document details just one local payment approach that may support a model for care delivery that better meets service user needs. Readers may also find other local payment examples useful when developing local payment arrangements. For example, we have published payment examples for (i) capitation payment and (ii) improving access to psychological therapies (IAPT); the latter also links payment to the achievement of defined outcomes and process measures.²

Note on the use of this document

Local commissioners need to consider case by case how best to secure and pay for services that meet the needs of service users in their local area.

Local providers and commissioners looking to implement the payment approach described in this document while it is in its current development stage must follow the rules and principles for locally determined prices set out in Section 7.1 of the National Tariff Payment System. This includes a requirement to send to Monitor and publish any locally agreed payment arrangements that lead to changes to the national prices set by Monitor.

Commissioners and providers need to consider carefully how a payment approach based on services with local prices (such as mental health) could be used in the context of services with national prices (where a different local payment approach based on variation of national prices would be necessary). Where there is a mix of health and social care the national tariff rules continue to apply to the healthcare services.

Commissioners should also ensure that they follow the framework set out in the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013. Guidance by Monitor on these regulations is available [here](#).

Further background information on this local payment example and how it relates to other areas of Monitor's work can be found [here](#).

² www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models

2. The need to focus on outcomes in mental healthcare

Summary

Commissioners and providers of mental healthcare need to place greater emphasis on achieving the right outcomes for service users. The use of agreed outcome measures in mental healthcare enables clinicians and providers to have a common vision of how to meet service user needs. It allows key units of measurement to move away from an emphasis on inputs, and offers a language to support care that is more patient-centred.

The NHS aims to achieve good healthcare outcomes for patients and ensure value for resources invested in healthcare. Several recent publications have singled out the need for the healthcare sector to focus on quality outcomes rather than processes and on particular care settings, including mental healthcare.^{3, 4, 5, 6} This focus promotes better co-ordination between physical healthcare, mental healthcare and community services, and access to crisis and step-down care at appropriate times. It also allows patients and clinicians to co-develop outcome measures that provide a common vision for care and, critically, reflect patients' health and social care objectives.

Formally measuring and monitoring an agreed set of overarching outcome measures can break down barriers to a patient-centred approach to care. For example, such measures can offer a common set of objectives that clinicians, teams, organisations and local health economies can use to gauge their own performance and develop ways to co-ordinate and deliver care more effectively.

³ Department of Health (2011) *No health without mental health; a cross government outcome strategy for people of all ages*. Available from:

www.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

⁴ Department of Health (2012/13) *The operating framework for the NHS in England*. Available from:

www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13

⁵ Department of Health (2014/15) *NHS Outcomes Framework 2014 to 2015*. Available from:

www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

⁶ Department of Health (2015/16) *Adult social care outcomes framework (ASCOF) 2015 to 2016*.

Available from: www.gov.uk/government/publications/adult-social-care-outcomes-framework-ascof-2015-to-2016

3. Potential benefits of outcomes-based payment for mental healthcare

Summary

The inclusion of an outcomes-based component in payment approaches should incentivise providers and commissioners to provide and pay for services that promote better outcomes for patients, rather than better activities or processes.⁷ There is good evidence from national and international healthcare systems for a range of benefits to be gained from the inclusion of this component in payments.

Moving to an outcomes-based payment approach for mental healthcare services can incentivise providers to collaborate on providing care more flexibly and effectively to achieve the required outcomes at the lowest shared cost, releasing funds for service improvement.

Historically, mental healthcare has been paid for using block contracts and data flows have been centred on activity. This has not encouraged a detailed understanding of where and how service user needs are being met. Many providers and commissioners now use the mental healthcare clusters as the sole basis of payment: these group service users with similar care needs and relate payment to components such as a required number of appointments, attendances and specific treatments completed.

Outcomes-based payment draws the attention of all the players in a healthcare system to achieving the target patient outcomes because it rewards co-ordinated care arrangements that deliver those outcomes more efficiently. The approach is based on the assumption the efficiencies of the current healthcare system can be improved, as suggested by evidence from the United States, Valencia in Spain and many other areas. In these areas, payment arrangements combining a fixed core component based on capitation with an outcomes-based component have improved outcomes for service users and transformed the delivery of care (see Appendices 2 and 3 for examples).

Evidence indicates that such payment arrangements offer benefits for patients, providers and local mental healthcare systems:

- **Benefits to patients:**
 - improved patient experience of care as this care is less fragmented and better co-ordinated

⁷ Joint Commissioning Panel for Mental Health. Outcome specifications. Available from: www.jcpmh.info/commissioning-tools/outcome-specifications/

- improved outcomes, such as more time spent living independently at home, reduced acute readmissions and more timely access to care
- better information for patients about their care
- broader patient choice
- **Benefits to providers:**
 - more stable and predictable income, supporting service delivery
 - better alignment of patient pathways and care processes with outcomes
 - clearer definition from commissioners of what reimbursement will be based on, possibly for a period of several years
 - development of a culture of collaboration and integration between providers across the mental health and social care economic system
- **Benefits to commissioners:**
 - binding contractual agreements with providers, with real rewards and penalties tied to defined outcomes and performance targets
 - improved value for money shown by measurable benefits to patients
 - streamlining of the bureaucracy and administration required to manage multiple providers and contracts
- **System-wide benefits:**
 - reduced duplication and transaction costs across organisations
 - promotion of investment in prevention, quality improvement and working practices that deliver savings and efficiencies over the longer term, where contracts run for a sufficient length of time
 - number of key performance indicators (KPIs) reduced to those central to improving patient outcomes.

4. Forms of contracting that can support co-ordinated approaches to outcomes-based payment

A number of clinical commissioning groups (CCGs) and providers are developing payment approaches with explicit links to outcomes. Examples in this document focus on mental healthcare, but outcome measures are also being developed to support integrated care across other areas of the healthcare sector.

It is possible to link outcomes-based payment to almost any payment arrangement. It is also possible to arrange for service provision with a number of local providers through a range of co-ordinated contractual arrangements. These promote an outcomes-based payment approach that overtly shares common objectives across the system, including outcomes-based payment. Examples of such arrangements in England and elsewhere are:

- **Prime contractor:** a single provider assumes all clinical and financial responsibility for delivering defined patient outcomes. This provider leads the integration of services for patients, sometimes along a whole care pathway, sometimes for a defined patient population, through subcontracts with other providers. Commissioners hold a single contract with the prime contractor. The prime contractor may be an existing provider, a broker or an integrating organisation.
- **Lead accountable provider:** as above, a single provider is accountable for providing a whole care pathway or pathways, or achieving defined outcomes for a defined patient population. Commissioners hold a single contract with this provider, who may subcontract some parts of the pathway or some services. However, in this case, the lead accountable provider retains key accountability for delivery of appropriate, quality care on the pathway (see Section 5 for more details).
- **Alliance:** typically led by commissioners, this contracting mechanism aims to incentivise a number of providers to co-operate to deliver a particular service or an interrelated set of services. Providers enter into linked contracts with commissioners, with the latter evaluating these collectively. Each party maintains its own internal financial controls and shares gain/loss risks with the other commissioners and providers in the alliance.
- **Joint venture:** providers jointly create a new vehicle to facilitate provision of integrated care, but each provider remains independent. The joint venture agreement specifies its nature, responsibilities and governance. Commissioners contract with the joint venture (rather than individual providers) for the delivery of services.
- **Fully integrated care:** as above, commissioners hold a single contract with a single direct or indirect provider of care, but this organisation assumes all

responsibility for providing services for an entire care pathway or patient population.

Each of these delivery approaches has its own strengths and weaknesses, which are not explored fully in this document. However, when implementing any of them, commissioners and providers should take care to:

- avoid double counting of services, ie ensure that services to be contracted to one or more providers are not contractually covered by another provider
- include sufficient incentives in the contracts to encourage better co-ordination of services between all the providers involved; incentives should promote prevention, early intervention and treatment of service users in the lowest intensity care setting that is appropriate for their needs
- develop service models capable of delivering co-ordinated services on a larger scale, as well as the mechanisms for recording and sharing the data necessary for managing the delivery of larger, longer-term contracts and monitoring progress on outcomes.

The next three sections describe one of these models, the **lead accountable provider model**: how it can be structured (see Section 5), how it is being adopted in two local health economies (see Section 6) and how to design a local payment approach to support it (see Section 7).

5. The lead accountable provider model

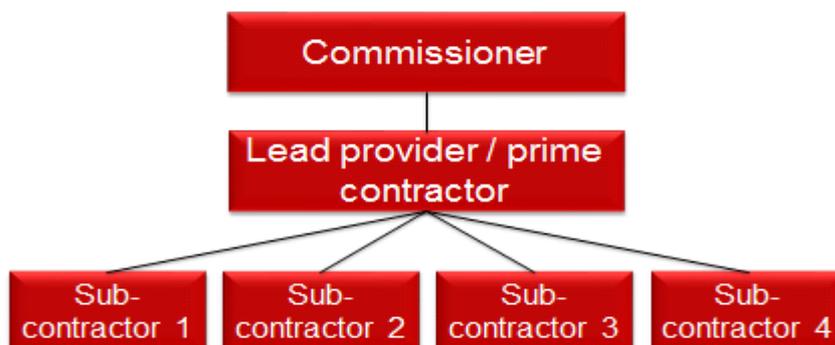
In this model, commissioners have a single contract with one provider organisation – the lead provider – which may have one of two broad types of accountability.

- **For a defined population:** a lead provider or group of providers is accountable for managing an agreed range of health and social care needs and achieving agreed outcomes for a defined population.⁸ The contract may apply to the care for a local population within a specific geography or to the care for a clearly defined segment of this population.
- **For a defined pathway:** the provider(s) is accountable for service user outcomes from the commissioned single 'pathway' of care for a particular condition over a defined period of time.

With either type of accountability, the lead provider organises the other providers of services that are needed by either the population or the care pathway, and is responsible for subcontracting the delivery of their services (see Figure 1). In the existing contractual legal framework, the lead provider cannot decommission subcontracted providers without the approval of the commissioners. Also, an underpinning principle is that service users are closely involved with commissioners and providers in defining the desired outcomes of the services.

The payment arrangement in the contract links a share of the payment made to the lead accountable provider to achievement of defined outcomes. In practice, this arrangement places both accountability for patient outcomes and control over how patient services are organised with the lead accountable provider. It also shifts a degree of financial risk to that provider.

Figure 1: Lead accountable provider model



⁸ Note that the national tariff rules on local pricing apply only to payment for NHS services, not the public health or social care elements of the budget.

It should be noted that in a full lead provider model, the national tariff applies to payments to the lead provider but not to payments made by the lead provider to subcontractors; the lead provider is responsible for determining the appropriate payment arrangements with subcontractors.

The payment has three components (for further details, see Section 7):

- A **fixed core component** paid in regular instalments. This is a proportion of an agreed capitated budget for delivering defined care to defined standards in the contract. It is calculated based on the inputs required to achieve those outcomes and their total efficient costs.
- A **variable component** that is contingent on the defined outcomes being achieved.
- A **mechanism for sharing the gain/loss** associated with risks (eg due to unanticipated savings or demand levels) between commissioners and the lead accountable provider.

The lead provider provides, manages and maintains the patient records system to be used by staff working at all providers serving patients covered by the contract. The lead provider also performance manages all services, monitors patient outcomes in all services and may provide directly a significant proportion of patient care. From a patient's perspective, this means they are likely to experience services as more patient-centred and 'joined up'.

For the lead provider and the providers subcontracted into its network, the model offers the flexibility to design and deliver services that are as efficient and effective as possible. Incentives can be constructed to ensure that all providers benefit from the effective operation of the outcomes scheme and share risks appropriately.

From a commissioning perspective, this model enables commissioners to more directly procure and pay for services that promote better outcomes for patients. Commissioners can hold a single organisation to account for delivering agreed outcomes, costs and performance for care provision across the local health economy. Conferring this management responsibility on the lead provider may also reduce commissioners' need for management resources.

6. English case studies of outcomes-based payment with a lead accountable provider

Some health economies in England have started testing lead provider models; some are progressing to the procurement stage. Bedfordshire CCG has let a £120 million contract for musculoskeletal services. Cambridgeshire and Peterborough CCGs are procuring a lead provider to deliver older people's services and provide integrated acute and community pathways in a five-year contract worth £1 billion. Other CCGs testing this model include Northumberland CCG, Bexley CCG, Croydon CCG, Herefordshire CCG and Sheffield CCG.

The following two case studies and Section 7 describe how the lead accountable provider model with payment based on capitation and outcomes (and including financial gain/loss risk-sharing arrangements) can benefit patients and the local care systems.

Each case study developed a select list of 'outcome' measures that represented a range of patient, clinical and community outcomes as well as some process measures – as such in this document the term 'outcome' measures is used in the broadest sense. Although not pure outcome measures, this mix helps local health economies focus on both desired outcomes and the key process points that enable the desired outcomes. These case studies as well as wider research suggest a mix of outcomes and process measures supports transformation and reduces the risk of unintended consequences⁹ more effectively than patient outcome measures or process measures alone.

6.1. Case study 1: Cheshire and Wirral Partnership NHS Foundation Trust

This trust is working with Western Cheshire Clinical Commissioning Group (WCCCG) to use the lead accountable provider model to pay for the entire mental healthcare pathway for adults. Important implementation features include:

- the lead provider is given the care budget and makes allocation recommendations; these are considered by the Integrated Provider Hub (IPH), a governance group that includes WCCCG
- a two-year pilot to test the care delivery and payment model is led by the nominated lead accountable provider; formal procurement of the mental healthcare pathways from the lead accountable provider depends on the success of this pilot

⁹ Unintended consequences refer to the fact that actions, including changes to policy or payment, can have effects that are unanticipated or unintended and can lead to the change not having the intended impact on service users and the sector.

- focus on four defined outcome domains: clinical outcomes; financial measures; patient and local community outcomes; governance measures
- outcome measures co-developed by the lead provider, other providers, patients, carers, clinicians and WCCCG
- the lead provider is expected to develop and maintain a performance 'dashboard' and share it with the Mental Health Programme Assurance Board, a formal subcommittee of WCCCG, on a monthly basis; all subcontracted providers have also committed to appropriate data reporting and monitoring arrangements
- payment for the first three years (including the pilot) to be a fixed block payment based on historical funding, with the introduction of an outcomes-based element and gain/loss risk sharing in years 4 and 5.

6.2. Case study 2: Oxford Health NHS Foundation Trust

This trust is using the lead accountable provider model to deliver better outcomes for defined segments of a local population. A wide range of adult mental healthcare needs (clusters 4 to 17) is covered. The model specifically includes a range of care for these groups from wellness to integrated community and social care. Children and young people's mental healthcare, forensic services and mental healthcare in acute settings are not covered. Important implementation features include:

- the CCG outlining the desired service specifications and using a formal procurement process to select the lead accountable provider that co-ordinates and administers these arrangements among providers
- commissioning the model in four phases over three years: defining governance and high-level objectives; greater engagement with a wide range of stakeholders to refine outcomes and processes; awarding the contract to deliver services; monitoring, evaluating and ongoing improvement
- having lead responsibility for identifying the population served by the model and the associated defined outcomes
- developing the seven high-level outcomes (see Appendix 1) identified as clinically meaningful and consistent with National Institute for Health and Care Excellence (NICE) and national standards; the trust focused on desirable health and social care outcomes for service users in clusters 4 to 17
- developing outcome measures in a three-stage process: (i) literature review and expert input; (ii) input from clinical leaders and CCG policy objectives; (iii) series of wider engagement events as well as input from a web-based patient survey and assembled expert groups

- phasing the implementation of each new indicator to allow time for the development of relevant datasets for some indicators and to establish a baseline understanding of performance
- distributing 80% of payment among all providers as part of their secure capitated funding; the remaining 20% is contingent on the attainment of defined outcomes
- proposing the use of the NHS standard contract form for five years with a two-year extension – this will give the providers time to implement new care models and for the expected patient benefits to be realised
- fixing the real annual spending on in-scope mental healthcare over the duration of the multi-year contract because a 4% annual efficiency saving is expected from targeting care that delivers the best value to service users and improved use of resources; any savings achieved over this period will be reinvested in mental healthcare.

Annexes 1 and 2 contain further details on the two case studies. Readers are strongly encouraged to read this material to understand how each local care system has developed and implemented an outcomes-based approach to payment.

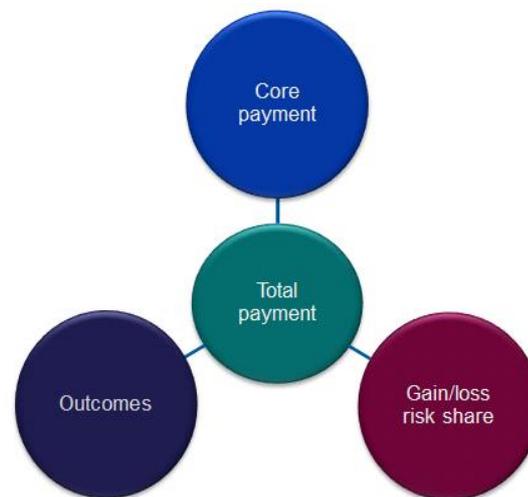
7. The payment design

Summary

This section describes a local payment approach that could be adopted to commission the type of lead accountable provider model for delivering mental healthcare described in the two case studies. The payment approach has three components: a fixed core payment (based on capitation), a proportion of total payment based on outcomes and a mechanism for gain/loss sharing between commissioners and providers.

The local payment approach comprises:

1. a fixed core component
2. an outcomes-based incentive payment
3. a component that shares financial gains or losses between providers and commissioners, relative to the value of the agreed total payment to the provider.



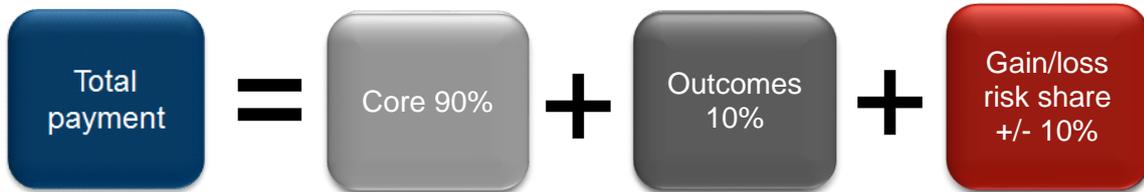
Its aims and nature are consistent with the requirements and guidance for the development of a mental healthcare payment system signalled in the 2015/16 national tariff proposals¹⁰ and described in more detail in the mental health guidance.¹¹

The first and second components are based on capitation: the risk share component may or may not be calculated within the same capitated budget. Depending on local circumstances and the intended care model, local commissioners and providers (including subcontractors) may want to consider:

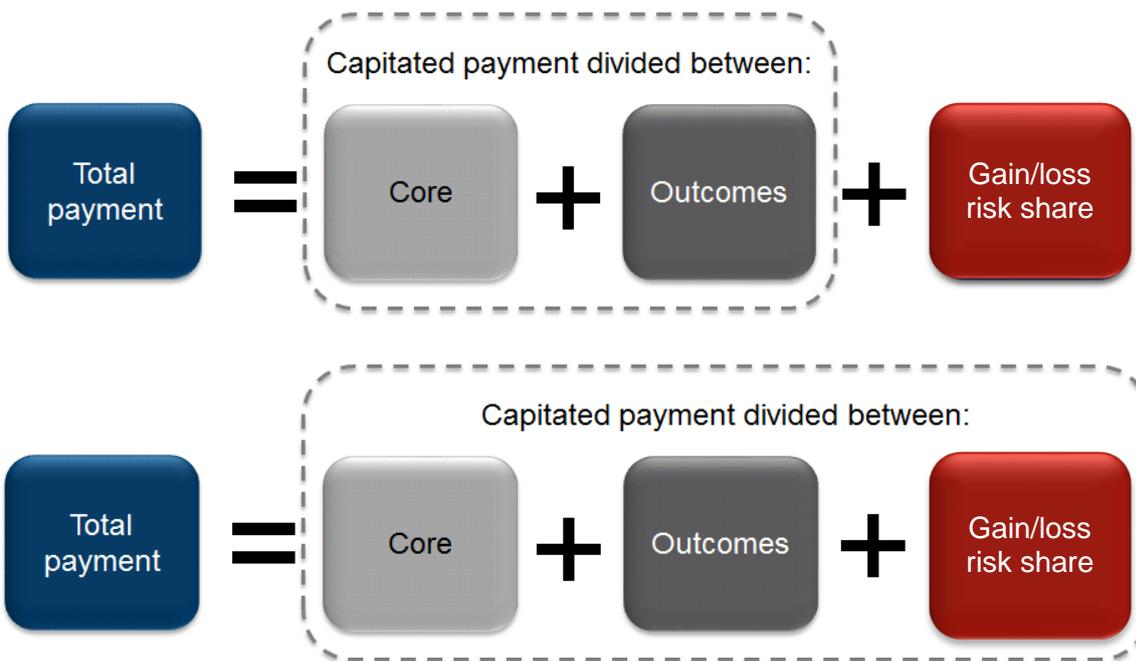
¹⁰ Monitor (2014) *2015/16 National Tariff Payment System: Tariff engagement documents overview*. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/332133/NationalTariff2015-16_EngagementOverview.pdf

¹¹ Monitor (2014) *Guidance on mental health currencies and payment: A supporting document of 2015/16 National Tariff Payment System: A consultation notice*. Available from: www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice

- the appropriate weighting or emphasis to attach to each payment component (note the percentages below have been chosen for illustrative purposes only; in practice the share of payment linked to outcomes may be smaller and the core payment larger)



- whether or not the total capitated budget will be spread across all three components or cover only the core and outcomes components (as in the example above). The option chosen may affect the way parties entering into the payment agreement react to the incentives. For example, if the risk share element is taken from the capitated budget, providers may feel their capitated budget will be reduced if they achieve savings, which could lower staff morale and act as a barrier to innovation and change

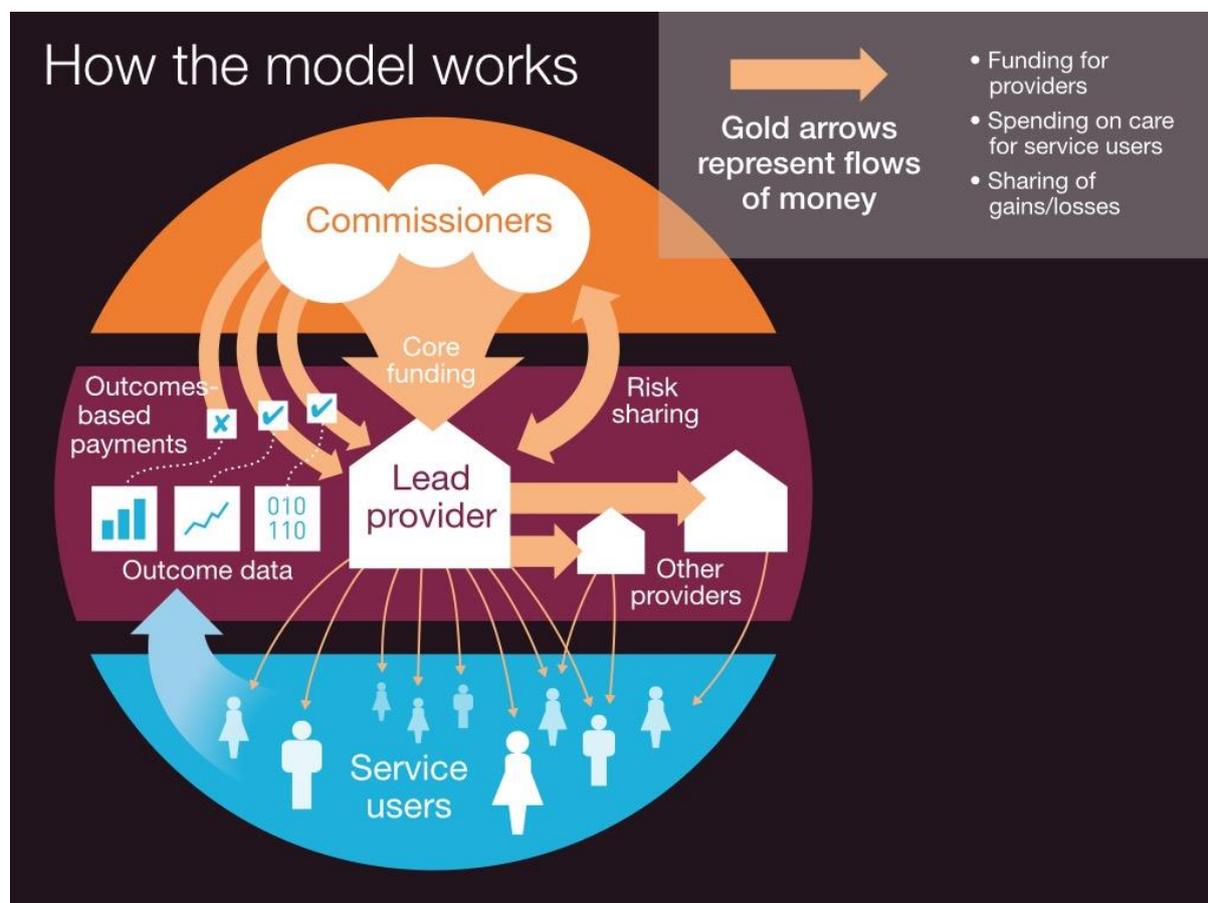


To develop this payment approach, commissioners and providers need to agree a total capitated budget. In principle, payment based on capitation means the provider is paid a lump sum per person for meeting the care needs of a defined target population. The size of that lump sum is (i) determined by calculating the total efficient cost of inputs required to deliver that population's care needs and (ii) dividing this amount by the number of people in the defined population. People in the defined population will have different levels of need, requiring different levels of resources. So, capitated budgets need to be weighted or risk adjusted to take these

differences into account. Detailed information on developing capitated payments can be found in the published capitation payment example.¹²

The model is summarised in Figure 2.

Figure 2: Overview of capitated outcomes-based payment with a gain/loss risk share component



7.1 Core component

The core component is an agreed proportion of the total capitated budget. It is a fixed payment to the lead accountable provider, shared with any subcontracted providers, and is made regardless of the volume of services provided. It guarantees that providers receive a regular, predictable amount to put toward the costs of delivering the defined outcomes with appropriate resources.

The fixed nature of this component means all parties involved bear some volume-based risk. If volumes are lower than expected, commissioners risk overpaying. If volumes are higher than expected, providers (including subcontractors) risk

¹² Monitor and NHS England November 2014 *Capitation: a potential new payment model to enable integrated care*. Available from: www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements

underpayment. However, the gain/loss risk-sharing component (see below) can mitigate the risk for both providers and commissioners.

It may be appropriate over time to adjust the proportion of the total payment assigned to the core component. For example, in the first year a greater share of the total payment may be paid as core funding to give stability while providers move to a new care model. This share can then decrease as the new care model becomes established, with a greater share of the total payment instead linked to the achievement of outcomes.

7.2 Outcomes-based component

A proportion of the total capitated budget is reserved and paid to the lead provider (and then shared with any subcontracted providers) on the achievement of defined outcomes. This proportion is the incentive for providers to deliver the required outcomes for patients within the agreed budget. It is determined in two steps: defining the outcomes and defining the payment based on achieving the outcomes.

Defining and developing the outcome measures

Outcomes should be as specific and as measurable as possible.¹³ The chosen outcomes may affect patients indirectly as well as directly as they outline objectives providers aim to deliver.

Commissioners and providers must be able to capture data that allow them to monitor whether or not the outcomes are being achieved. They must agree upfront the operational definitions of the chosen outcomes, how to measure them and how to link payments to them.

Therefore, providers and commissioners need to carefully consider, and use an inclusive process to define, the outcomes to be achieved. They should reflect the outcomes that patients want and need. Outcome measures should include a mix of clinical outcomes, patient outcomes and key process or governance components that support effective and efficient patient care. The mix of outcome measures should be developed in a way that limits the risk of unintended consequences.⁹ Therefore, it is important to avoid proxy measures where possible as well as overemphasis of any single measure. Proposed outcomes and outcome measures need to be rigorously tested by all important stakeholders, including patients; commissioners; local health and social care providers; clinicians and other frontline staff.

¹³ Research into payment for performance on outcomes rather than processes for mental healthcare services is in its relative infancy. Contracts that incentivise 'true' patient outcomes across complete care cycles and multiple providers are still rare in the NHS. Getting the outcome metrics right in these contracts is essential. Process, structure and outcome indicators need to be aligned and include a range of measures to maximise their impact and reduce the risk of unintended consequences.

Robust datasets to measure agreed outcomes are critical to supporting outcomes-based payment. In some cases, relevant outcomes and key process measures are already collected. In other cases, new measures need to be developed and data reporting mechanisms established. Care should be taken to limit the burden of data collection on staff. It is also vital to ensure staff have access to data outputs. This provides them with information useful in identifying how to improve service user care; it also can improve the data quality as frontline staff see for themselves the value of these data. Once reliable data flows are established it is possible to link payment to them. Where new datasets are needed, it may be advisable to directly incentivise database development and data quality through payment, and then link that payment to the achievement of patient outcomes in subsequent years.

Defining the payment based on achieving outcomes

There is research suggesting that even a small positive financial incentive can have a significant impact on aligning provider goals with system-wide objectives for patients. Ultimately, the proportion of the total payment dependent on the achievement of defined outcomes is at the commissioners' and providers' discretion, taking into account local factors. As noted above, it may be appropriate to change this proportion over time.

When designing the outcomes component of the total payment, providers and commissioners should consider the following:

- **share of total payment to be linked to outcomes:** this will determine the potential value of any payment for achieving defined outcomes in full (or withheld payment for not achieving agreed outcomes)
- **weights to be attached to outcome measures:** some outcomes may be more important or harder to achieve than others, depending on local circumstances; commissioners and providers may agree to assign weights to different outcome measures to reflect their relative importance, or the relative ease with which they can be achieved
- **weights to be attached to the components of outcome measures:** where an outcome measure comprises a number of subcomponents, commissioners and providers may assign individual weights to the subcomponents, as above
- **thresholds that trigger payment (or penalty):** the contracting parties need to:
 - determine the thresholds or values that trigger a payment (or penalty) for each outcome measure
 - consider whether payment is based on:
 - i. achieving a single fixed target

- ii. achieving measures that fall within a given target range or band
 - iii. a sliding scale, or spectrum, based on the measure achieved
- **subcontractor payment to be linked to outcomes:** the objectives of payment incentives for subcontracted providers should be aligned with the defined outcomes agreed by commissioners and the accountable provider; the share of the outcomes-based payment to subcontractors can also reflect the degree to which their performance affects the attainment of defined outcomes, and the impact this may have on total payment to the accountable provider
 - **speed of implementation:** the speed at which each indicator of progress toward a defined outcome will be:
 - measured
 - linked to payment.

7.3 Financial gain/loss risk-sharing agreements

This model for commissioning and paying for mental healthcare changes the balance of risk between commissioners and providers. The third component of the payment approach defines how providers and commissioners should share any over- or under-spend on the anticipated costs of delivering the agreed outcomes.

Commissioner and lead provider negotiate how financial gains or losses are shared before they sign the contract. For example:

- **gain scenario:** provider revenue is more than provider costs; commissioner and provider share the financial surplus
- **loss scenario:** provider loss is more than provider revenue; commissioner and provider share the financial loss.

To limit the potential risk to either providers or commissioners, agreements can define caps on any potential pay-outs of both gains or losses, also known as payment ceilings or floors. This helps the parties share the risk of extreme volatility. Any such payment ceiling or floor can be applied to aggregate payments or on a per-patient level. For example, commissioners might consider insuring providers against costs above a certain level, say £20,000 for each patient. Alternatively, they might insure the providers against costs that are >10% above or below budget. A combination of the two approaches could also be used.

7.4 Phased transition to the new payment approach

A staged implementation may be most effective given it may take time to ensure all data flows and other components are in place to support outcomes-based payment.

For this reason, it might be realistic to fully implement the payment approach described above over three to five years (see Figure 3). Timings will depend on factors such as leadership and technical ability to manage new arrangements as well as the availability of the required infrastructure such as information systems.

The transition can take place in two broad phases:

- **introduction** (eg years 1 to 2): This is the trial period to clarify the relationships between commissioners, lead accountable provider and subcontracted providers, and for the lead accountable provider and subcontractors to embed new service arrangements. Time is required to evaluate outcomes and value for the patient population. During this phase, the whole of the capitated budget for the population may be paid in regular instalments to the lead provider.
- **bedding in** (eg years 2 to 3): Providers and commissioners introduce the other elements of the payment approach. For example, both parties could agree to introduce a financial gain/loss agreement relative to the total capitated budget, based on the evaluation and data collected in the introduction phase, and to introduce outcomes-based payment.

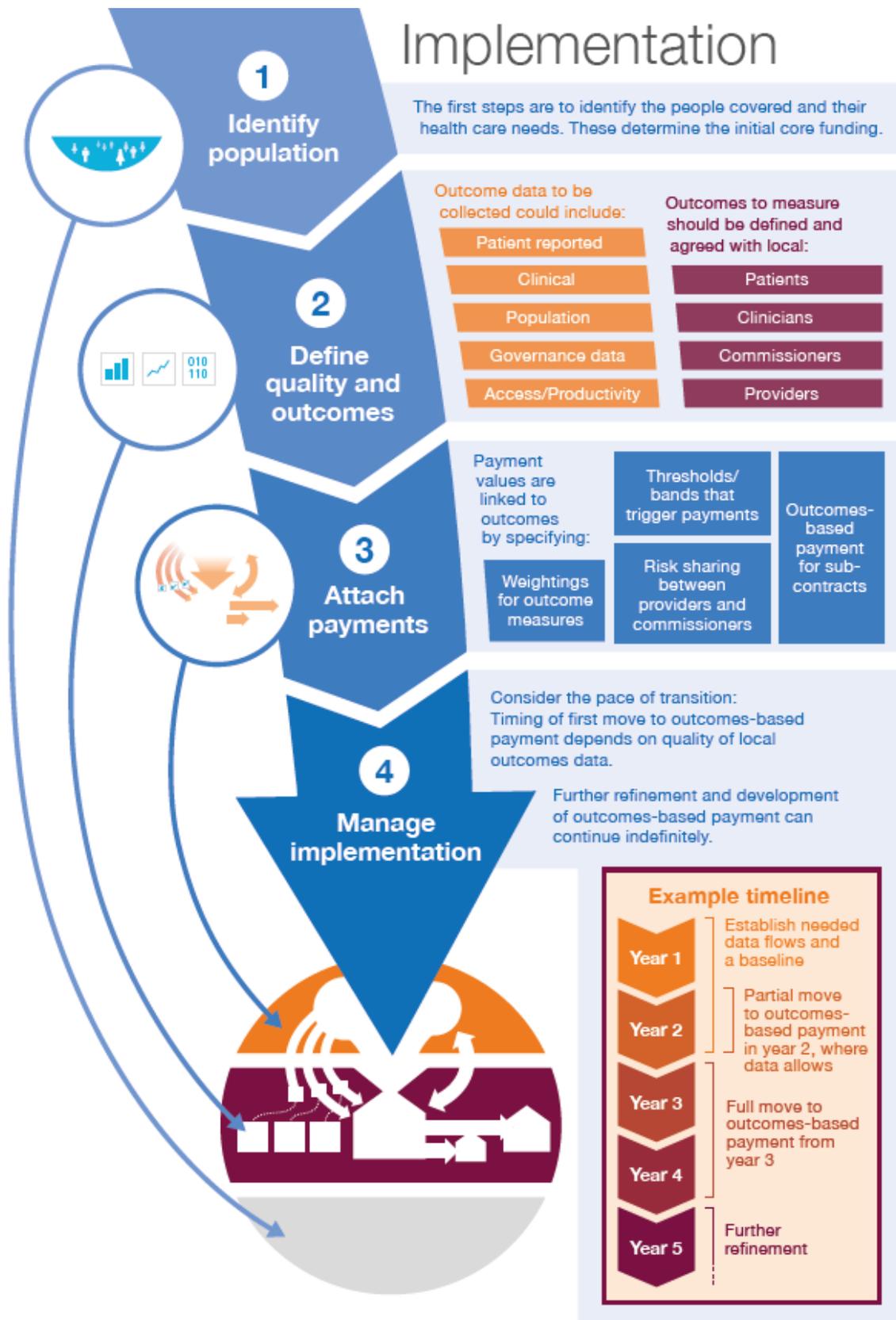
There follows a phase of **continual improvement** (eg years 4 to 5 onwards). After implementing the payment approach, providers and commissioners should continue to determine local needs and evaluate care options. It may be appropriate to revise or improve some outcome measures over time or tweak aspects of the payment calculation to ensure they continue to incentivise delivery of efficient and effective patient care.

7.5 Budget adjustments over time

When setting an overall capitated budget, commissioners may deem it appropriate to adjust the proposed budget year on year to reflect local factors and expected changes in need, service design or underlying costs. These include:

- **efficiency expectations:** these should be based on local judgement and may change with local circumstances; for example, in relation to healthcare services, commissioners could initially be guided by Monitor's planning assumptions or historical cost improvement plans (CIPs)

Figure 3: Overview of the transition process



- **cost uplift factors:** eg expected increases in pay, drug costs, changes to the costs of the Clinical Negligence Scheme for Trusts (CNST), costs associated with increasing NICE concordance, costs associated with training or changes in care models to meet outcomes targets and other operating costs
- **changes to the local population:** from year 2 onwards the capitated budget baseline may need to be adjusted to reflect growth in the local population, and by implication growth in the defined target population. If actual annual population growth varies from the agreed local projections by more than a defined tolerance, the budget should be adjusted.

8. Key enablers for implementing the outcomes-based payment approach

Experience from the sector has shown that a number of factors are needed to support the delivery and implementation of an outcomes-based payment.

8.1 Governance and clinical leadership

An established governance structure with the appropriate leadership and reporting mechanisms is needed to support service delivery and ensure accountability for the operation and impact of the payment model.

There should be an integrated approach to governance and risk management across all the relevant stakeholders that embraces financial, organisational, clinical and non-clinical risks.

Good governance is about establishing the right policies and procedures to ensure that things are done in a systematic and proper way. All structures and operations, not just those for governance, need to be designed and implemented to ensure the payment model is built for sustainability and with the capabilities to foster continual improvement, best possible outcomes and clinical effectiveness.

8.2 Better communication and engagement

Research has demonstrated the need for a well-established and trusting relationship between commissioners and providers for outcomes-based commissioning and payment to work effectively. This is vital given the required shift of direct control over the co-ordination and commissioning of specific care and contract management from commissioners to the accountable providers: the providers rather than the commissioners have more direct responsibility for ensuring the range of services are delivered effectively and meet patient needs. Good communication and mechanisms such as open-book accounting may strengthen the trust between commissioners and providers. Commissioners are more likely to gain the trust of providers if they:

- consult them at an early stage in the commissioning process and actively seek to develop good working relationships with them
- use data and information to work with them in a transparent way to share and develop an understanding of patient needs and what care may provide best value
- provide adequate training and support to provider managers and clinicians on the lead accountable provider model and associated payment approach and their implementation.

8.3 Data and information management requirements

Good patient-level cost, activity, process and quality data are essential to an accountable lead provider model with outcomes-based payment. High quality data support effective clinical outcomes and economic, efficient and effective operations.

Providers and commissioners need to consider the methods of documenting and sharing relevant data and information.

Baseline data on costs, inputs and current outcomes are needed to provide a benchmark for monitoring and measuring improvement in achieving outcomes. This will enable more accurate measures of trends and progress over time.

It may therefore be necessary for both the commissioners and providers to consolidate and standardise the data they collect to assess current levels of patient wellbeing, recovery or sense of security. Performance indicators need to be measurable, clinically valid, reliable, feasible and amenable to audit. They must also accurately reflect progress towards the desired outcomes.

9. Evaluation

Evaluation is the systematic assessment of the implementation or impact of a service, project, programme or initiative. It helps providers and commissioners improve the implementation of any service in their local health economy and identify how successful this has been and where further improvement is possible. Evaluation can enable commissioners and providers to:

- refine existing service implementation to deliver optimal results: to ensure implementation is flexible and responsive to 'on the ground realities', eg changing environment, meeting unmet needs
- identify best practice implementation approaches: to catalyse innovation and support the roll-out and scale-up of successful approaches
- generate evidence: data and information allow robust decisions to be made on service implementation, eg the benefits being realised are worth the cost of/investment in a particular service.

Providers and commissioners can use many forms of evaluation. The optimal methods depend on the purpose of the evaluation, the priorities of the local health economy, the available resources and the available timeframe. Evaluations should balance theoretical robustness with 'real world rigour'. The investment in evaluation (eg time, resource, money) needs to be proportionate to the potential benefits.

Evaluations fall into two broad categories, formative and summative. These serve different purposes and take place in sequence, with any summative evaluation building on and drawing from the findings of the formative evaluation.

9.1 Formative evaluation

Formative evaluation is conducted while the service is still in development. It aims quickly to give an understanding of how and why things work well, to improve implementation. Ideally, formative evaluations are designed alongside the service being designed and implemented alongside service implementation. Formative evaluations usually focus on assessing processes qualitatively and include feedback loops so that those implementing the service can 'learn as they go'. Formative evaluations can use the monitoring mechanisms that are in place to oversee implementation (eg existing contract or financial monitoring systems). This type of evaluation enables decision-makers to:

- identify the key enablers that facilitate and barriers that hinder implementation
- respond to interim findings and adjust and refine implementation accordingly on an ongoing or 'real-time' basis.

West Cheshire CCG Integrated Provider Hub employed formative evaluation to understand the impact of the new payment model on patient care. It used largely qualitative analysis with a strong emphasis on ongoing patient engagement. It used the information and analysis both to improve service delivery and consider if improvements to payment design may support this. Annex 1B gives further details of its process and findings.

9.2 Summative evaluation

Summative evaluation is conducted once service implementation is complete or well established, and shows the extent to which stated objectives have been achieved. This type of evaluation tries to elicit information on effectiveness – that is, the cost and sustainability of services – as well as patient outcomes.

Summative evaluation helps decision-makers understand the:

- impact on the service of the implementation of outcomes-based payment for the service
- difference the approach has made, eg improvement in patient care and cost savings to the local health economy
- outcome for the service in meeting its goals and objectives.

Both evaluation methods are recommended to give decision-makers (providers and commissioners) a better understanding of and meaningful information about the value of the services being paid for. Good evaluation design depends on an appropriate fit between the purpose of the evaluation, the stakeholders' requirements and the available resources.

The type of evaluation that is most appropriate to each local health economy depends on local circumstances and should be agreed by decision-makers and users of the services (eg managers, clinicians, service users, commissioners, regulators, etc). Mechanisms that allow parties to understand service user experiences should be included in the evaluation process – both quantitative and qualitative input can aid this understanding.

10. Wider considerations

10.1 Personal health budget

Local CCGs and providers developing outcomes-based payment to meet the needs of the mental health population need to ensure that the delivered mental healthcare outcomes do not compromise the principles of personal healthcare budgets. Personal healthcare budgets offer individuals greater choice and control over their care package, including mental healthcare, than traditional services. This gives some patients the ability to tailor care in a way that better suits their needs and can lead to a marked improvement in wellness and quality of life. In collaboration with their clinical team, individuals can plan how best to meet their personal needs within an indicative budget that is not greater than that for traditional services.¹⁴

Personal healthcare budgets are compatible with outcomes-based capitated budgets. Providers and commissioners can consider the option of personal healthcare budgets within a lead provider model that gives choice to the population defined by the contract. A proportion of the capitated payment can be used for indicative personal health budgets, and also to release money from existing contracts so that it can be offered as a direct (or indirect) payment for an individual's care.

10.2 Choice and competition

In developing the outcomes-based payment approach, local CCGs and providers need to work together to meet the needs of the community and ensure that the delivered mental healthcare outcomes are consistent with the rights that individuals with mental health illnesses have to choose a provider¹⁵ and guidance from Monitor (see Notes on the use of this document, page 5). For example, when choosing an accountable or lead provider to deliver the outcomes-based payment contract, they should consider Monitor's guidance.

This guidance considers circumstances where 'a commissioner carries out a detailed review of the provision of particular services in its area in order to understand how those services can be improved and, as part of that review, identifies the most capable provider or providers of those services'. The guidance makes it clear that the regulations do not force commissioners to tender for every service, but equally commissioners should not simply roll over existing contracts without first asking how good the service is, and whether it could be improved to give service users a better deal.

¹⁴ www.personalhealthbudgets.england.nhs.uk/Topics/latest/Resource/?cid=8603

¹⁵ www.england.nhs.uk/ourwork/qual-clin-lead/pe/bp/guidance/

11. Further resources

The following documents and contacts can provide further information.

- Other published payment examples:
www.gov.uk/government/collections/different-payment-approaches-to-support-new-care-models
- West Cheshire Clinical Commissioning Group (May 2013) *Governing body report, mental health integrated provider hub*:
www.westcheshireccg.nhs.uk/document_uploads/Papers-may2013/WCCCGGB130507-MHIntegratedProviderHub.pdf
- Oxford Clinical Commissioning Group business case: To support the introduction of outcome based contracting – mental health:
www.lgcplus.com/Journals/2013/12/04/y/x/x/13.59-Part-2a-Mental-Health-Report.pdf
- For more details on the Integrated Provider Hub: Tim Welch, Deputy Chief Executive and Finance Director at the Cheshire and Wirral Partnership NHS Foundation Trust
- For more details on the Oxford Health NHS Foundation Trust outcomes-based model: Stuart Bell, Chief Executive Officer and Mike McEnaney, Finance Director at Oxford Health NHS Foundation Trust.

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Appendix 1: Oxfordshire Mental Health Partnership: The outcomes that matter and illustrative incentivised indicators

Outcomes	Incentivised indicators
People live longer	Mortality age Suicide rate
People improve their level of functioning	Improvement in score on validated recovery evaluation tool, eg Star Recovery Tool Reduction in intensity of cluster using the cluster tool % of care plans that are reviewed quarterly % of people who have a person-centred care plan % of people who remain discharged from services after 6 months
People receive timely access to assessment and support	Appropriate and timely response to a person in crisis
Carers feel supported in their caring role	% of carers offered a carer assessment % of carers attending Care Programme Approach (CPA)* or care planning meetings % of carers satisfied that they are viewed as equal partners in supporting the person with mental health problems they care for
People maintain a role that is meaningful to them	% of people undertaking voluntary activity % of people in paid employment % of people undertaking an education programme % of people running a home/being a parent
People continue to live in settled accommodation	% of people living in mainstream housing % of people living in mental health support accommodation
People have fewer physical health problems related to their mental health	Number of A&E attendances within an agreed time period, eg 6 months Score on health screening tool such as the national health screening programme, which includes body mass index (BMI), diabetes and cholesterol, or equivalent

* www.nhs.uk/conditions/social-care-and-support-guide/pages/care-programme-approach.aspx

Source: Oxford Clinical Commissioning Group business case, To support the introduction of Outcomes Based Contracting – mental health – Slide 27. Available from: <http://www.lgcplus.com/Journals/2013/12/04/y/x/x/13.59-Part-2a-Mental-Health-Report.pdf>

Appendix 2: Evidence for financial and non-financial benefits from case studies

			Measured benefits (case study specific)*					
Selected whole system case study	Improved health outcomes	Overall cost savings (where quantified)	↓ acute activity	↓ emergency admissions	↓ bed days and/or LoS**	↓ rate of institution-alisation	Improved patient experience	Method(s) driving integration
Milton Keynes COBIC, UK	•	15-20% ↓ in spend					•	Capitation + outcome measures
La Ribera Model, Valencia	•	25% ↓ in spend	•	•	•	•	•	Capitation + outcome measures
PACE Model, USA	•	5-15% saving per capita	•	•	•	•	•	Capitation
Vittorio Veneto Study, Italy	•	1,125 lire saving per capita	•		•	•		Integrated provision
Roverto Study, Italy		20% saving per capita	•		•			Integrated provision
Geisinger, USA	•	Not quantified	•	•	•			Outcome measures
Beacon Health, USA	•	Not quantified	•	•	•		•	Capitation
Veterans Health Administration, USA	•	Not quantified	•	•	•			Capitation + outcome measures
Torbay Care Trust, UK		Not quantified	•	•	•	•	•	Integrated provision

* The specific benefits measured in each case study varied greatly. Therefore this table just highlights which benefits each case study has measured. Gaps do not necessarily indicate benefits do not exist, rather they more commonly indicate that specific benefits were not measured in a particular analysis of the evidence.

**LoS: length of stay.

Source: Oxford Clinical Commissioning Group business case, To support the introduction of Outcomes Based Contracting – mental health – Slide 68. Available from: www.lgcplus.com/Journals/2013/12/04/y/x/x/13.59-Part-2a-Mental-Health-Report.pdf

Appendix 3: Case studies on financial benefits of outcomes-based contracting and payment – estimating potential cost savings

Case study	Brief summary	Quantified financial benefit
Milton Keynes, UK	Capitated outcomes-based approach to commissioning substance misuse service – jointly delivered by primary care trust and local authority	15-20% overall saving to commissioner(s) in year 1
La Ribera model, Valencia	Model using both capitation and outcomes-based contracting mechanisms to deliver integrated services for all patients registered in the region	25% ↓ in overall service expenditure
PACE Model, USA	Integrated provider model using capitation payments aimed at maintaining frail older people living in the community for as long as possible	5-15% saving per capita over stand fee-for-service care
Rovertio and Vittorio Veneto Studies, Italy	Studies aimed at integrated care for elderly patients focusing specifically on integrated delivery across health and social care functions	Up to 29% saving per capita

Source: Oxford Clinical Commissioning Group business case, To support the introduction of Outcomes Based Contracting – mental health – slide 69. Available from: www.lgcplus.com/Journals/2013/12/04/y/x/x/13.59-Part-2a-Mental-Health-Report.pdf

These case studies give an indication of the scale of financial benefits that could be possible when local health economies use a capitated outcomes-based approach.

Annex 1

Case study 1A: Cheshire and Wirral Partnership NHS Foundation Trust: Outcomes-based payment approach for mental healthcare services

Overview and case for change

Western Cheshire Clinical Commissioning Group (WCCCG) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) developed a lead provider model for delivering mental healthcare locally. They felt it would incentivise integration between providers as they all have an interest in ensuring the services they provide collectively deliver the defined outcomes. Further, it was felt this model leverages the experience and expertise of clinical organisations that understand and can deliver fully integrated pathways that enhance quality, improve outcomes and ensure value for money.

They have been piloting a lead accountable provider model since June 2013. The purpose of the pilot is to allow both the CCG and the provider to test the lead accountable provider model with outcomes-based payment and to fully understand the associated potential risks and costs. Realised benefits were analysed after 18 months, a period that is long enough for meaningful analysis.

The two organisations have created a joint governance arrangement, known as the Integrated Provider Hub (IPH), through a memorandum of understanding. The memorandum establishes the principles by which each party will work with the other during the pilot to deliver the mental healthcare programme for the available budget. During the pilot period, contractual relationships with subcontracted providers remain with WCCCG. The IPH is also the forum for making decisions on funding non-contracted activity from the mental healthcare budget during the pilot.

CWP has been designated the lead provider and is responsible for designing and overseeing the adult mental healthcare service and managing the mental healthcare pathway across the entire local health economy for this service user group. To fulfil this responsibility, the lead provider:

- organises the delivery of quality primary, community and acute inpatient care from different providers
- manages the agreed budget
- itself provides multidisciplinary specialist healthcare services
- refers service users to more specialist care, including acute trusts, mental health trusts, and voluntary and independent sector providers, as required.

Commissioning aims

In setting up the pilot, the CCG aimed to:

- create a gateway process to determine which activities are within and which are outside the scope of the contract. As the lead provider, CWP provides a gateway system to examine the costly current practice of out-of-area placement of service users with complex needs. It also manages this non-contract activity and spend. By working closely with the local commissioning support unit (CSU), the lead provider aims to ensure, where possible, that service users are cared for closer to home; service users needing complex care are placed in appropriate care environments and their needs are reviewed regularly
- manage outcomes (clinical, financial, service user and local community): the lead provider supports the CCG by monitoring and managing other providers' contracts that are defined in the budget
- ensure care pathways are reviewed and continuously improved: the lead provider reviews the current pathways from clinical and process perspectives across the entire local health economy
- get better value for money for service users; the lead provider conducts analysis involving a range of stakeholders to highlight where money can be redirected and where resources can be redeployed for the better care of service users, and analyses the benefits and costs of potential service investments.

Approach to identifying the population

- The lead provider is given responsibility for identifying and segmenting the various mental health population groupings into care pathways during the pilot phase.

Approach to defining quality and outcome

- High-level outcomes were defined and developed by the lead provider in conjunction with WCCCG, service users, carers, clinicians and other providers of healthcare services.
- The pilot is developing and testing potential outcomes that can be grouped under a range of headings (listed below). In all cases a proportion of payment may be based on achieving agreed thresholds for each of the outcome measures.

- **Clinical outcomes:**
 - increased percentage of individuals with mental health illnesses who are in control of their mental health
 - increased number of service users receiving care according to NICE guidance
 - all service users having timely access to the appropriately identified services
 - improvement in service user reported outcomes and experiences
 - improvement over time in Health of the Nation Outcome Scores (HONOS)
 - reduction in readmission rates
 - reduction in length of stay and delayed discharges
 - improvement in national programme budget performance benchmarking
 - reduction in the number of service users in independent and non-contracted NHS placements both in and out of the area
 - improvement in reporting outcomes for non-contracted activities
 - increased opportunities for service users to develop/maintain independent living skills and local networks.
- **Financial outcomes:**
 - maintenance of spending within the designated amount of the mental healthcare programme budget
 - reduction in out-of-scope contracted activity spend.
- **Service user and local community outcomes:**
 - demonstration of public involvement
 - demonstration of service user experience feedback
 - demonstration of consultation
 - demonstration of engagement with partner organisation.
- **Governance outcomes:**
 - risk register in place, risks escalated and managed
 - governance arrangements in place

- agreed memorandum of understanding
- terms of reference for the Programme Assurance Board agreed between the CCG and the lead provider
- agreed IPH operational policy concerning the delivery of the mental health service for the local health economy.

Attaching financial values to outcomes

The CCG and the lead provider agreed to link mental healthcare outcomes to payment in phases:

- payment for the first three years (including the pilot) is a fixed capitated core payment based on historical funding
- in years 4/5 and onward, payment will be linked to agreed quality outcomes with a gain/loss risk share arrangement.

The value of the capitated core payment will be subject to change during the course of the pilot as more up-to-date spending data become available. All changes will be approved and logged in the minutes of the Mental Health Programme Assurance Board (see below) and a full reconciliation maintained.

Accountability and financial responsibilities

During the pilot phase, the mental healthcare budget will not be delegated to the lead provider. Financial risk will be managed jointly by the lead provider and WCCCG but WCCCG will remain financially responsible for any overspend against the programme budget.

WCCCG manages and holds the lead provider to account via a Mental Health Programme Assurance Board (a formal subcommittee of the WCCCG governing body). This board oversees performance management. It agrees KPIs, agrees proposals for service redesign, identifies emerging risks and oversees delivery of efficiencies and outcomes.

CWP is expected to develop and maintain a performance 'dashboard' and make this available monthly to the Mental Health Programme Assurance Board. This will include monitoring of the financial position against the agreed budget.

Stepped approach to sharing risk

The lead provider has agreed a gain/loss risk-sharing arrangement with commissioners and subcontractors based on an understanding of the mental healthcare services and prevalence of mental health problems in the local population.

The lead provider will ensure that the data and information needed to measure outcomes and assess care are collected and used appropriately to ensure best value and care provision.

All parties (CWP, WCCCG and subcontracted providers) are committed to enabling the more effective and efficient management of mental healthcare resources and to reinvesting any identified savings in improving services to achieve best service user outcomes.

Case study 1B: Formative evaluation: West Cheshire Clinical Commissioning Group Integrated Provider Hub

The formative evaluation at WCCCG used qualitative methods to assess the impact of the IPH. The evaluation was undertaken several months after the start of the pilot phase of the new care model and focused on the impact of this on service user care, and on collaboration and co-operation among providers. The main aim of this interim evaluation was to identify the mental healthcare pathway services that deliver the best service user outcomes (that is, the most absolute service user benefits) irrespective of who the lead provider is.

The evaluation team gathered information and experiences from service users on the new care model. This methodology was chosen because it has a strong focus on continual service user engagement, which was identified as important to the development and delivery of the service.

Full service evaluation is to be undertaken once the project moves out of the pilot phase.

Lessons learned

WCCCG and CWP have identified the following important lessons:

- The clinical recording system must be right and one clinical system must collect all the service user data. Not having such a system in place has been a hindrance to getting all the subcontracted providers and the local authority to formally agree the new model.
- Workshops with commissioners and clinicians encourage quicker buy-in and acceptance of the lead provider model. The evaluation uncovered concern about how smaller providers were interpreting the model.
- Emphasis on informatics and data analysis is instrumental in implementing outcomes-based payment contracts, together with constant attention to data quality and developing KPIs for reporting and monitoring.

- The evaluative process helps demonstrate the value of this payment approach and the potential benefits to service users. It can also be an effective administration tool.
- Both evidence and personal relationships developed between providers and commissioners may enable wider application of the model across other mental healthcare services.
- The availability of local authority funds and payment for social care-related outcomes is a concern.
- Understanding and observance of information governance requirements and an information-sharing protocol are essential for all parties involved in care co-ordination and integration.
- Building trust across organisations and between teams is a challenge. Other providers were doubtful that the lead mental healthcare provider would be willing to allow other organisations to provide care. This challenge was overcome by timely, transparent and constructive engagement with all organisations from the development stage of the project.

Annex 2

Case study 2: Oxford Health NHS Foundation Trust: Outcomes-based commissioning model for mental health

Oxfordshire Clinical Commissioning Group (OCCG) commissions mental healthcare services on behalf of the people of Oxfordshire. It has been working with providers, service users and the public to develop a lead accountable provider contract with a capitated payment linked to outcomes. The aim is to deliver better outcomes for service users while maintaining financial stability for the local health economy. In its model, the success of healthcare provision is measured by the outcomes that are most meaningful to service users, rather than by activity.

Overview and case for change

Before this change the main provider for child and adolescent, adult and older adult mental healthcare was Oxford Health NHS Foundation Trust (OHFT), and OCCG appointed Oxfordshire Mental Health Partnership as 'most capable provider'. OHFT acts as the lead accountable provider, and its partners are Mind, Response, Restore, Elmore and Connections. OHFT acts as the lead contractor for other partners. OHFT is paid through a block payment, with an additional Commissioning for Quality and Innovation (CQUIN) programme as a quality incentive.

In past years there were nine providers delivering mental healthcare services across the county, with which OCCG held 18 separate delivery contracts. Each contract had a different set of performance indicators and criteria for success, and each delivered discrete parts of the total mental healthcare service. The number of providers and contracts, and the payment mechanism for OHFT made it difficult for OCCG to determine the value to service users (in terms of both quality and financial cost) from that form of contract.

Provision of effective and efficient mental healthcare is urgent as local demand for mental healthcare is increasing much faster than expected from the population growth. This new model should ensure that mental healthcare offers value and is service user centred with a focus on quality, personalisation and innovation. Service users should no longer have to navigate an unco-ordinated, fragmented system; better planned care packages should reduce the number of visits to and time spent in hospital. In addition, OCCG is operating in an increasingly challenging financial environment, so ensuring value for money is vital.

Shaping this new model of service and payment has involved engaging widely with providers, including OHFT, Oxford University, clinicians, service users and members of the public. Some elements are already up and running and the system is due to go live within the 2015/16 financial year.

Steps being taken

OCCG plans to implement outcomes-based commissioning in four phases.

- **Phase 1:**
 - define programme governance, plan stakeholder engagement and identify expert resources
 - use the services' financial baseline to map current service scope for a defined population or a segment of the population with mental health problems
 - define the outcomes for each service or segment of service and the population to be served, and give an indication of the budget required
 - recommend the route to contracting for achieving these outcomes
- **Phase 2:**
 - deeper engagement with the public, service users, providers and wider stakeholders
 - test and refine outputs of phase 1 via engagement
 - fully test the care packages to be included in the formal contractual process
- **Phase 3:**
 - formal process to secure providers to deliver the services (procurement)
 - consider different options for running the process of commissioning and contracting for outcomes
 - award contract to deliver these services
- **Phase 4:**
 - after the contract has been awarded, focus on monitoring the mental healthcare services to manage the contract and improve performance
 - evaluate progress toward outcome goals
 - support ongoing collaboration between the lead provider and subcontractors

The pilot is currently in phase 3. OHFT is working with OCCG on the formal procurement of the lead contractor.

Approach to identifying the population

Mental health illnesses vary in nature and severity and people with these illnesses have different needs and outcomes that are relevant to them. Measuring mental healthcare outcomes for segments of similar service users is therefore more meaningful than measuring outcomes at a whole population level. Even if different service user segments care about the same outcomes, how these outcomes are measured may differ between them.

For these reasons, OCCG began phase 1 of the project by segmenting the mental health population using the mandated mental health currencies – care clusters. It initially used the Mental Health Clustering Tool (ie HONOS) as providers were already submitting cluster-based data. However, while HONOS provides a useful segmentation, OCCG found that it does not include all the mental health illnesses it proposes to cover in any outcomes-based contract with a lead provider.

It therefore adopted the segmentation shown in Table 1. This combines life-cycle stages with HONOS and International Classification of Diseases (ICD-10) codes. This approach groups people with similar circumstances, including severity of illness (if any) and the clinical approach required (if any). This combination enables outcomes to be developed for each segment and will cover a full pathway of care.

Two of the four segments in the OCCG segmentation map directly onto the HONOS super clusters (1 to 9 and 10 to 17). So, this segmentation is consistent with the current requirement to use care clusters as the currencies for recording the data required for the Mental Health Learning Disabilities Data Set.

Table 1: Segmentation combining HONOS and ICD-10

Segment origin	Segment	ICD-10	Characterisations
Service user group	Healthy people	N/A (primary care coding)	Healthy with no ongoing mental health needs. At risk – good health but at risk of developing acute or chronic illness so requiring more healthcare input to prevent escalation
	Physical health co-morbidities	N/A	Mental health problems affecting people who have primarily physical health problems
	Children, young people	F90-F98	Mental health problems in child to adolescent age

			group, including transitions
	Anxiety and depression	F30-F39 F40-F48	Mood disorders Anxiety disorders
Disorders	Alcohol and substance misuse	F10-F19	Addiction disorders
HONOS: Psychosis	Psychosis including schizophrenia	F20-F29	Psychotic illnesses that may at times of crisis require inpatient admission
	Behavioural and development disorders	F50-F59 F60-F69 F70-F79 F80-F89	Including autism and Asperger Eating disorders

Approach to defining quality and outcome

The approach is critical to the success of the lead provider model and outcomes-based payment. The outcomes that matter to people with mental health problems in Oxfordshire have been developed from extensive engagement with experts, clinicians and service users through an iterative process. The three-stage development process is outlined in Figure 4.

Figure 4: Three-stage approach to defining the outcomes that matter to people with mental health problems in Oxfordshire



As part of this process five key objectives were agreed:

- people with severe mental illness will be in good physical health

- people with severe mental illness (clusters 4 to 17) will be in a role meaningful to them (eg employment, education, volunteering)
- people with severe mental illness will be in settled independent accommodation that supports their recovery and wellbeing
- people with severe mental illness will achieve their personal goals in relation to recovery and wellbeing
- carers of people with severe mental illness (clusters 4 to 17) will be supported in their caring role.

Then seven high-level outcomes were developed, underpinned by a number of supporting indicators (see Appendix 1).

OCCG proposes the single contract for mental health in Oxfordshire defines the required outcomes for each segment. All providers involved will share responsibility for delivering the outcomes in the contract. The outcomes should be fixed for the duration of the contract, but indicators may evolve and change over the long term. All outcomes should also be clinically meaningful and consistent with NICE and national standards.

Attaching financial values to outcomes

- **Payment approach** The lead provider payment arrangement is underpinned by a capitated funding formula for the mental health population, but also includes a financial incentive for delivering improved clinical and patient outcomes. The CCG proposed that expenditure in 2013/14 on the mental health cohort should be the baseline budget for the first year of the contract for the lead provider (£35 million).

It is anticipated that cost pressures will rise over the next five years. However, the expected real annual spending on in-scope mental healthcare will remain fixed over the duration of the multi-year contract (see Contract duration below). This is possible because a 4% annual efficiency is expected from targeting care that delivers the best value to patients and improved use of resources. Any savings achieved over that period will be reinvested in mental healthcare.

- **Incentivisation** The lead provider receives 80% of the total capitated contract value upfront. This part of the capitated budget is distributed among all providers (including subcontractors) for service provision. The final 20% of the payment (excluding the value for national commissioning for quality and innovation) is contingent on attainment of defined outcomes. The lead provider is ultimately accountable for providing the defined population with services that meet given standards of quality and safety. However, subcontracted providers also have terms in their contracts that link part of

their payment to achieving agreed outcomes. This approach helps ensure that all providers are working toward a common set of objectives.

The CCG will pay the lead provider the remaining 20% of the mental healthcare budget, or a share of it, depending on the degree to which the defined outcome targets are met or exceeded (see Annex 1A for a list of indicators). A proportion of the 20% budget is allocated to each outcome indicator and that proportion remains fixed throughout the contract term.

Contract duration

The final contract agreed between the CCG and lead provider will be consistent with the latest NHS Standard Contract for Clinical Services, and includes the service specifications, payment approach and accountability measures outlined above.

This standard contract typically lasts three to five years with the possibility to extend it by a further two years. In this case, the CCG proposes a contract with the accountable lead provider of five years with a potential extension of up to two years. This should be long enough for the providers to develop and implement their new operational models, and for the expected benefits for patients and the local health economy to be achieved.

There will be appropriate break clauses during the contract period to allow a change of provider if performance is unsatisfactory. The contract will also include clauses to allow both outcomes and outcome measures to be improved, and adjustments made, in line with developing trends or issues, if agreed by the relevant parties (ie between commissioner and lead provider or between a lead provider and a subcontracted provider).

Pace of change

The list of important outcomes to be measured and linked to outcomes-based payment is consistent over time. However, data for some outcome indicators may not be immediately available. As a result, a phased approach to the implementation of each indicator will be agreed, as appropriate. Outcomes will be linked to payment once data are available and deemed to be robust. For example, as illustrated in Table 2, outcome data are available in year 1 for outcome 1, so achievement of that outcome can be linked to payment in the first year. However, data will not be available for outcome measure 2 until year 2, so payment is not linked to achievement of outcome 2 in the first year. The necessary data collection for outcome 2 will be set up in year 1. Weighted outcomes-based payments can then be linked to data in subsequent years.

Table 2: Example for linking payment to outcome in stages

	Year 1			Year 2		
Annual 'incentivisation pot'	£1 million			£3 million		
% of 'pot' for each threshold	Good	Improved	Excellent	Good	Improved	Excellent
Outcome 1	9%	18%	40%	18%	25%	50%
Outcome 2	0%	0%	0%	10%	25%	50%
Total	9%	18%	40%	28%	50%	100%



Making the health sector
work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000

Email: enquiries@monitor.gov.uk

Website: www.gov.uk/monitor

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