Division(s):

CABINET– 16 SEPTEMBER 2014

Outcomes Based Contracting for Mental Health and Older Peoples Services

Report by Director of Adult Social Services

Introduction

1. Outcomes Based Contracting (OBC) is an NHS priority as a way of managing spending and activity by making health care providers responsible for delivering outcomes, rather than paying them for activity. The substantial and ongoing pressures on health and social care services, and large activity pressures with acute (hospital) care mean that there needs to be action to manage costs and activity over the medium term.

2. Outcomes based contracting presents opportunities for Oxfordshire County Council, especially in services for older adults. More joined up services and a greater focus on outcomes has the potential to enable older people to stay independent for longer.

3. The impact of outcomes based contracting in practice on the performance of health and social care is dependent on the ability of providers to change the systems and structures to focus on delivering outcomes that matter to people. In order for us to ensure that the benefits are delivered we will need to manage the performance against the outcomes closely and support NHS commissioners to do likewise.

4. The overall system pressure, combined with the need for Oxfordshire Clinical Commissioning Group and Oxfordshire County Council to manage costs and shift provider behaviour in a fully pooled budget, the relatively low Oxfordshire County Council costs (4% of the pooled budgets), and the overall impact on joint health and social care provision mean that continuing to engage with the outcomes based contracting process for mental health and older adults is prudent.

5. The total budget going in to outcomes based contracting from Oxfordshire County Council is £11.2m. This is 4.1% of the total of the two pooled budgets (£281m). It is 10% of the total outcomes based contracting budget of £111.6m. £62m (55%) from pooled budgets, the remainder from Oxfordshire Clinical Commissioning Group.

Outcomes Based Contracting

6. Outcomes based contracting identifies a group of clients (for example, people with mental illnesses or frail elderly people) and then identifies the outcomes that the commissioners want for those people. It then funds a single provider or a group of providers to deliver these outcomes for people.

7. This is combined with relatively long contracts (5 years) to give providers incentives for preventative and community based work, cost capped contracts to give providers responsibility for activity costs, and payment attached to outcomes to encourage focus on system wide issues.

8. The NHS has historically focused on measuring service 'inputs' (such as attendances and admissions to hospital) and processes (such as waiting times). Alongside this NHS-funded healthcare has become fragmented and inefficient, with siloes of working and evidence of waste across the system. Financial incentives tend to reward acute hospital activity to the detriment of early intervention and prevention. Examples where joined up care has happened are few and difficult to spread quickly into commonplace practice.

9. One of the benefits of outcomes based contracts is that it supports groups of providers to create single clear pathways for patients. This is often accompanied by vertical integration – where services from the community to the hospital and back again become part of one single management structure and accounting framework.

10. The advantages of community and acute health providers working together is that they focus on the final outcome for the patient rather than just what happens whilst they are responsible for their care. The disadvantages are lack of choice for people who need to use the service, lack of market resilience and significant barriers to entry for new innovative providers. Risks for commissioners are that organisation failure (either in performance terms or in financial terms) is more problematic than in fragmented markets where there are more provider options and shifting providers for smaller portions of services is possible.

11. Providers are likely to focus their, necessarily limited, management attention on incentivised outcomes. There is a risk that choosing the wrong set of incentivised outcomes could mean that resource is shifted inappropriately – so, for example, if one of the incentivised outcomes was about reducing delayed transfers of care, but transfer to a care home was just a monitored outcome, this would create a financial incentive for the provider to discharge to a care home. This will require detailed attention to the outcomes, their weighting, and the incentivised outcomes.

12. The overall shift (particularly for the NHS) is away from paying for hospital activity (where providers retain substantial ability to create that activity) towards a system of paying for agreed outcomes.

Background

13. Historically there have been significant pressures on budgets within health in the acute sector (hospitals). This is partly due to payment structures which have encouraged a focus on delivering activity within hospitals, partly on the increasing ability to treat a range of conditions and a subsequent cost increase, and partly due to the balance of power between professional groups involved in the care of people (with hospital based doctors having more influence of resource allocation).

14. This has been compounded by on-going structural weaknesses in health commissioning across the country, as provider trusts are substantially better resourced than commissioners and have significant control over activity datasets, resulting in activity pressures being funded without clear risk sharing agreements.

15. Within Oxfordshire there has been longstanding NHS interest in developing new ways of commissioning based on outcomes. In March 2012, the Clinical Commissioning Group decided to change how it commissioned a range of services by introducing an outcomes orientated approach to commissioning and contracting.

16. In October 2012 Oxfordshire Clinical Commissioning Group retained some external consultancy support, through Solutions for Public Health, to provide additional capacity and skills to work around Outcomes Based Contracting.

17. This resulted in the production of the Phase 1 Outcomes Based Contracting report published in January 2013. A full procurement process was undertaken to secure external support for Phase 2 and Phase 3 work. The Cobic Consortium were the successful bidders.

18. Oxfordshire Clinical Commissioning Group and the Cobic consortium led a number of public engagement events which helped to develop the outcomes being used for the new model. Work continued through 2013 and this culminated in three Outline Business Cases being produced for consideration by the Oxfordshire Clinical Commissioning Group.

19. At the meeting of the Oxfordshire Clinical Commissioning Group Governing Body in November 2013, the three Outline Business Cases were considered, covering maternity, mental health and older peoples services. A number of concerns were raised about the business cases and some further work was requested to enable the Governing Body to make an informed decision at their next meeting, at the end of January 2014.

20. An NHS Gateway review was carried out in January 2014 and reported on 20th January 2014. This found that there was a broad consensus of support for the principles of Outcome Based Contracting and the benefits this could bring to patients but that there was not however a consistent view within the Oxfordshire Clinical Commissioning Group about how Outcomes Based

Contracting should be taken forward and a lack of support for the current approach to implementation from key external stakeholders.

Current Activity

21. Outcomes based contracting is now being considered for two current areas. These are Mental Health and Older People. These are both already commissioned via pooled budgets between Oxfordshire County Council and Oxfordshire Clinical Commissioning Group.

22. These areas are being procured via a most capable provider assessment. This assesses existing providers against set criteria. The contract detail (final budget, amount incentivised, detailed outcomes and activity measures) will be negotiated after award of most capable provider status.

23. About 20% of the budget (approximately £22m across both contracts) will be paid on successful achievement of those outcomes that commissioners have incentivised.

Contracting and Legal Implications

24. There will be two contracts for these services; one for Mental Health and one for Older People. The contract for Mental Health will be between Oxfordshire Clinical Commissioning Group and Oxford Health, while the other will be between Oxfordshire Clinical Commissioning Group and Oxford University Hospital.

25. The contracts will be based on the NHS England Standard Contract. This contract is structured into a number of sections, most of which are standard and cannot be varied. There is, however, a 'Particulars' section at the beginning of the contract that can be varied which will include a description of the services, the outcomes required, the outcomes metrics and any other requirements of the Council.

26. A meeting has been held between the Council's legal services and Oxfordshire Clinical Commissioning Group's lawyers to discuss the contract. A number of issues have been identified that need to be included in the 'Particulars' including TUPE and pensions.

27. As the contracts will be held by the Oxford Clinical Commissioning Group, the Council will need to ensure that all its information requirements are incorporated so that it can make the necessary statutory returns and ensure that information on the outcomes are provided routinely.

28. The contracts will be for five years, with an option to extent for another two years. The term of the contract is much longer than other NHS contracts as the intention is bring about significant change through using incentivised outcomes. The contract can be partly of fully terminated for poor performance and either party can terminate the contract on 12 months' notice. Early

termination, for no reason, may result in the party that issued the notice paying compensation to the other party.

29. Oxfordshire Clinical Commissioning Group has received legal advice that these contracts can be exempted from tendering under the EU Public Procurement Directives as they are health services. The Council's legal team will review the legal advice received by Oxfordshire Clinical Commissioning Group to ensure that the contracting arrangements are legally compliant.

Financial and Staff Implications

30. The total budget proposed from Oxfordshire County Council going in to the outcomes based contracting is £11.2m. This is all from currently pooled budgets and is 10% of the total outcomes based contracting budget.

31. This is for a contract for five years, potentially extendable to seven. This is capped at the current cash value for the life of the contract and there is no commitment to demographic or inflationary increases – which will be managed by providers within the total financial envelope.

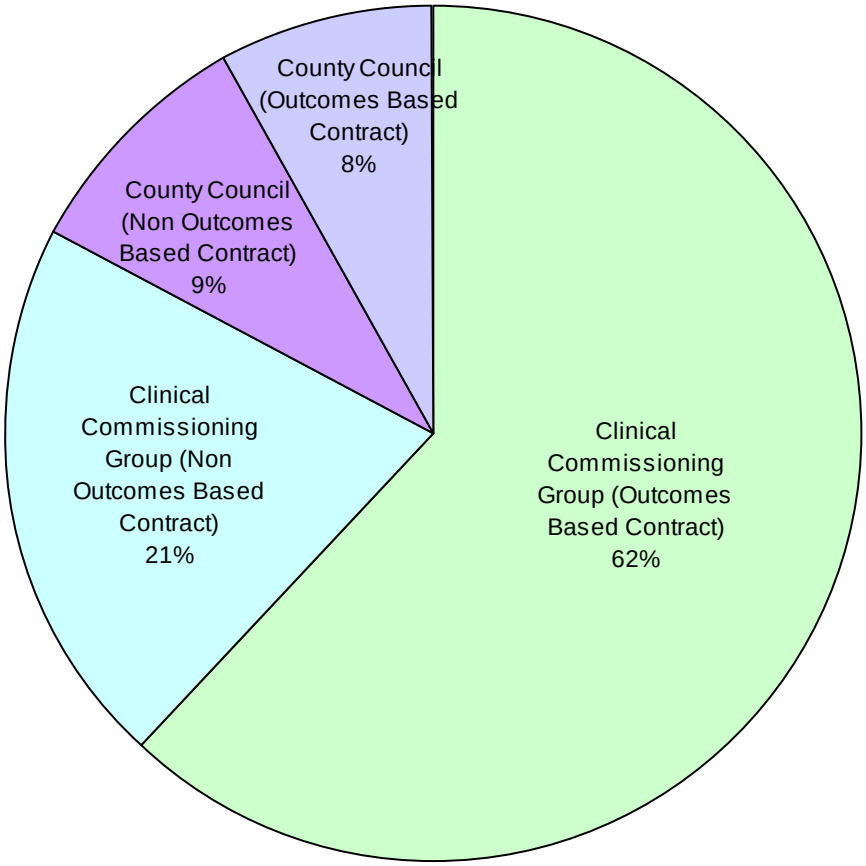
32. The length of the contract would prevent corporate savings being sought from these budgets. However achieving outcomes specified in the contracts will drive better value for money across all services and should reduce demand in other parts of the system. The commitment from providers to managing inflationary increases and demographic pressures whilst still achieving outcomes also mitigates this risk.

33. The total budget being proposed for outcomes based contracting is £111.6m. Being part of outcomes based contracting offers the County Council the opportunity to influence £100m of NHS spend and ensure that the focus of providers' (particularly in relationship to older adults) moves from hospital based activities to outcomes for people.

34. £62m (55%) of the total being proposed for outcomes based contracts comes from budgets that are pooled between Oxfordshire Clinical Commissioning Group and Oxfordshire County Council.

Mental Health Finances

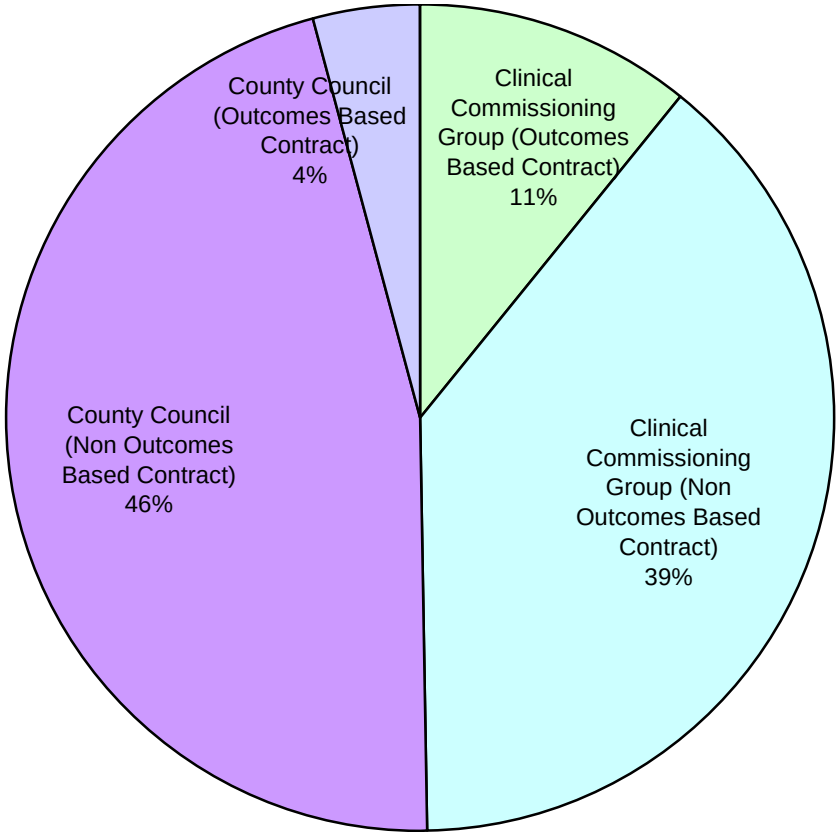
35. The overall budget being considered for mental health is £35m (£4m from Oxfordshire County Council and £31m from Oxfordshire Clinical Commissioning Group). This would mean that about 70% of the pooled budget would be in an outcomes based contracting arrangement.



36. Currently the mental health pooled budget is not completely risk shared. Oxfordshire County Council carries the risk of any overspend in social care costs. In practice this related to the costs of housing (the Support into Independent Living pathway). A move towards outcomes based commissioning in mental health will need to be combined with a fully pooled and risk shared budget as one of the main ways costs are likely to move across the budget is a shift from hospital based care to supported housing. This shift would be in the interests of patients, and would reduce the overall costs against the pool. It would, however, increase social care costs. A fully risk shared budget is therefore essential.

Older People Finances

37. The overall budget being considered for older people is £76.6m (£7.2m from Oxfordshire County Council and £69.4m from Oxfordshire Clinical Commissioning Group)..



38. £47m in the older peoples outcomes based contract comes from Clinical Commissioning Group budgets (primarily for A&E and emergency care for people over 65) rather than the Pooled Budget. The balance of £22.4m comes from the Clinical Commissioning Group Pooled Budget Contribution.

Risks

	Risk	Mitigation
39.	**Outcomes based commissioning on this scale is untried**	This can only be managed through careful specification by commissioners on how it will work and careful monitoring. The results will be reported to the Joint Management Groups and through them should be reported to the Health and Wellbeing Board. We will also need to work closely with other areas who are exploring this. A meeting is being arranged with Croydon
40.	**National policy developments are uncertain**	All three major political parties appear to be supporting this approach. We should manage it through the same way that we manage the fact that it is untried.
41.	**Longer contracts**	The total exposure of the County Council to this risk

	may restrict the ability of Oxfordshire County Council and Oxfordshire Clinical Commissioning Group to make savings against and to move resources to as policy and population need shifts.	is small and it is within a known context of expanding need and demographic pressure. The benefit of cost capped longer term contracts is that providers are incentivised to manage activity and focus on outcomes for people. We should be cautious about significantly expanding this approach to other areas of procurement or increasing the proportion of our spending committed to longer term contracts.
42.	**Providers are likely to focus their, necessarily limited, management attention on incentivised outcomes**	This will require detailed attention to the outcomes, their weighting, and the incentivised outcomes. We have an internal task and finish group collectively reviewing proposals and ensuring they align with our operational and strategic needs. The results will be reported to the Joint Management Groups and through them should be reported to the Health and Wellbeing Board.
43.	**Measuring short term targets**	This is a key part of the specification. We have to know if this is working. However, it is likely that there will be national requirements such as reducing admissions to hospital which will help (see recent developments concerning the Better Care Fund)
44.	**Ensuring that socal care services like reablement work well**	We have already made clear that there must be specific measures for this service. We need to consider whether there are specific measures that we will require for mental health services and intermediate care. The internal task and finish group is reviewing these.
45.	**Outcomes based contracts may not appropriate for the vast bulk of adult social care services which are purchased by the service user**	We will make clear to the NHS that these cannot be included and will not be in the future.
46.	**These proposals are unlikely to develop the adult social market**	This is a possible loss. We should monitor this carefully and review at the end of the five year period.
47.	**Loss of flexibility and the ability to respond quickly**	We are constrained currently by the time it takes to change services and go through a procurement process. This can take up to a year for adult social care.
48.	**NHS will be the senior partner**	They already are when it comes to mental health. However, in the case of frail older people, the County Council will still be the accountable body for the Older People Joint Management Group.

Recommendations

Cabinet is recommended to:

(a) Support the transition of the NHS to focus on outcomes rather than activities as the right direction for the benefit of the health of people in Oxfordshire; to recognise that the change is essential if the NHS in Oxfordshire is to be able to manage with the resources available and that the NHS managing within the resources is crucial to securing the resources of £8m from the Better Care Fund to protect Adult Social Care services and to secure resources to pay for the costs of the new Care Act.

(b) delegate authority to negotiate Oxfordshire County Council's engagement with these two OBC contracts to the Director of Adult Social Services w**ith certain conditions namely:**

(a) that this is limited to adult social care services for people with mental health problems and reablement and intermediate care services for older people;
(b) that there are specific outcome measures for both reablement and intermediate care that relate to our strategy of limiting demand for health and social care;
(c) that there is a genuine pooling of resources for mental health; and
(d) that the final negotiated position is subject to the prior agreement of the County Solicitor as to compliance with proper procurement requirements.

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September 2014