Introducing value based commissioning: Questions and answers

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How do CCGs currently commission services?
CCGs currently commission services under a model known as ‘payment by results’. This means that we pay providers for each unit of activity such as attending an outpatient clinic, A&E or having a diagnostic test. We commission slightly differently for the care that is provided outside hospital (e.g. District Nursing and other community nursing or therapy services). We have a single 'block' contract with community providers, rather than paying for each unit of activity separately.

What is value based commissioning?
Value based commissioning means changing how healthcare is organised, measured and reimbursed in order to improve the value of services. In a value based commissioning system, services delivered by a number of providers are organised around patients with similar sets of needs, to ensure that these needs are met in the most effective way.

We are asking health and care organisations to work together, across boundaries, for patients with similar needs. We would like to bring about a significant shift in the extent to which organisations providing health and social care work together to focus on improving clinical outcomes for patients and supporting their independence. As commissioners, we will support this approach by having a contract which embeds delivery of outcomes and that links a proportion of payment for services to the outcomes that are achieved.

So how is it different?
The current way of commissioning and reimbursing health services does not encourage a shared focus across the health and care system on maintaining health and independence. Providers and the staff who work in different organisations often only see their part of the picture and it is left to the patient and family to link care together. We want to promote a system where different organisations are more aware of each other and are more aware of their overall impact on outcomes. That is why we are going to put more emphasis on measuring outcomes, basing payment on outcomes and asking health and social care providers to work together in new and more formal ways.

Why are we changing the way we commission?
We no longer want to pay providers just on the basis of the number of people who receive treatment, but for how well they manage to achieve the outcomes that have been defined by patients. Providers will still be paid for the patients that they treat, but commissioners will base a proportion of funding on the outcomes that are achieved.

What is the key aim of value based commissioning?
The key objective is to improve patient outcomes and experience by integrating care around the patient. In practice this means planning and organising care for conditions on a population basis. An understanding of the different needs of the population must be considered with a focus on what patients need, rather than what organisations can provide. The model aims to enable people to be as independent as possible though care and support provided by the most appropriate person and in the most appropriate setting.

Who is going to be commissioning in this way?
A number of CCGs are starting to develop value based contracts, but it is still a new approach. In north central London:

- Haringey CCG and Islington CCG are developing value based commissioning contracts for people with diabetes.
- Haringey CCG is developing value based commissioning contracts for older people with frailty.

How do we define value and outcomes?

- Patients, carers, clinicians and commissioners work together to define outcomes for a specific population group.
- These outcomes are then prioritised and measurement of these outcomes is determined.
- Providers work together to deliver these outcomes.
- Commissioners focus on monitoring and measuring outcomes.

The outcomes that have been defined for people with diabetes and older people with frailty are outlined in appendix A of the Memorandum of Information (MOI). The MOI is available on Islington and Haringey CCG websites (www.islingtonccg.nhs.uk and www.haringeyccg.nhs.uk) and on www.supplying2nhs.com

What are the benefits of value based commissioning?
There are many benefits for patients and population groups of commissioning in this way, including enabling people to remain independent, faster recovery and maintaining physical and mental health and wellbeing. There are also financial benefits for providers involved if outcome targets for population groups are achieved, as well as savings through efficiencies.

How will patients notice a difference?
Over the next year we would expect more people aged 75 and over to be contacted by health and social care workers who will help to coordinate their care; to identify signs of frailty and to help provide early support. For people with diabetes we would expect a gradual move towards more health and social care services being brought together under one roof. We would expect that information will flow more quickly and efficiently between, for example, hospitals and general practice. We will see more patients having a plan for care that they have been involved in and opportunities for patients to be supported by professionals to manage their condition.

What engagement has taken place on value based commissioning within Haringey and Islington?
Both CCGs have involved patients and front-line staff in formulating the outcomes that we are going to be commissioning. The CCGs then carried out further work with specific local patient groups or networks to review and prioritise the outcomes. We also involved patient and voluntary sector representatives in the work that we have done on thinking about the services that we think would best deliver the outcomes.

What's the timeline?
We are asking providers now to really start focusing on how they think they might work together differently to deliver the outcomes of care that matter to our populations. On the 20th March we will be holding a briefing event for providers who think that they would like to be

involved and who work with people who have diabetes or older people with frailty. We will then ask providers who think that they could have a leadership role to come forward and we will ask some questions to establish their suitability to act as leaders in the process.

How will you ensure local providers aren't disadvantaged?
We are looking for leadership from providers who:

- have experience of providing services for people with diabetes or older people with frailty within our boroughs
- have good links and relationships with other local providers and partners and experience of partnership working
- provide high quality care

If providers do not meet these criteria they won't be able to progress to the next stage of the procurement process. Please refer to the Memorandum of Information for more information about the process.

What's a Memorandum of Information (MOI)?
The purpose of a Memorandum of Information is to provide interested parties with a transparent overview of the programme and the open process of identifying providers who may be able to take a leadership role. Further information about the process is available on www.supplying2nhs.com

Are you looking to use this approach in other areas?
We are trying to build an outcome focus into how we commission a wide range of services. Through the projects for diabetes and older people with frailty we will see if a new type of contracting approach supports this focus on outcomes. We will evaluate as the work progresses and may look to roll it out more widely at a later stage.

What about GPs?
GPs are not primarily paid by CCGs but CCGs can pay for some additional services from GPs. We are very keen that GPs are closely involved in how integrated services are developed and local GP leaders have been at the forefront of our planning on value based commissioning. Where it is possible, we will use any additional payments we make to GPs to ensure that they too are involved in delivering improved outcomes.

What about social care?
Social care, particularly for older people, has a very important impact on outcomes. Health and social care organisations will increasingly be asked to work together on achieving outcomes. Wherever possible, with agreement from our local authority partners, the same principle of linking payment to outcomes will be applied to social care services.

Will there be new money?
Our plans do not involve changing how much is being spent on health and care services. We are trying to link part of our payment to achieving outcomes rather than spending any more or less money overall. In the long term we hope that a more integrated approach to care provision will be more efficient and will allow us to meet increased demand for services.

How much money will be linked to achieving outcomes?
This is going to be developed in negotiation with providers. It needs to be enough to make a difference without causing financial instability. The aim of the programme is to encourage a focus on outcomes; it is not to destabilise or financially penalise providers.

Are you looking for a lead provider? Hasn't this model failed in other areas?
We are looking for clear leadership and we know that this will be necessary to drive a real focus on outcomes. We are willing to have an open dialogue with providers about how this will work in practice. There is also a very robust provider assurance process which will be used – this is outlined in the Memorandum of Information.