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Money Talks

- COSTS, COSTS, COSTS! WHO PAYS IN HEALTHCARE?, *C. MCCAHAN*
- HOSPITAL FINANCE, *M. NOPPEN*
- TRANSFORMING COMMISSIONING TO DO MORE WITH LESS, *C. COTTON*
- MAKING AFFORDABLE HEALTHCARE PROFITABLE, *A. MIR*
- PRESENTING A CASE: FINANCING IT PROJECTS, *M. HASIB ET AL.*
- NATIONAL TELEHEALTH CAN SAVE MONEY AND IMPROVE HEALTH, *H.E. HENRIKSEN*
- FINANCE TECHNOLOGY BLOCKCHAIN IN HEALTHCARE IT SECURITY, *T. LAURENCE*
- FRAUD IN HEALTHCARE, *S. PECK & L. MCKENNA*

Transforming Commissioning to Do More With Less

Making Taxpayers' Money Go Further

How can health and social care commissioners in England reinvent the tools of their trade to make funds go further?

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In England, health and social care commissioners compelled to save money often feel little choice but to reach directly for frontline services. Their various attempts to do so are charted by hostile reports of restrictions on in vitro fertilisation, rationing of hip and knee operations, and shrinking social care packages. On a grander scale, National Health Service (NHS) sustainability and transformation plans (STPs) describe intentions to reduce bed numbers and merge services. Alongside this, however, the most imaginative commissioners are also seeking long-term financial viability closer to home, through a radical transformation of the art of commissioning. Such changes throw into sharp relief how in the future people should receive the maximum amount of relevant high-quality care for each pound available.

A Long Run-Up, With Lift-Off Now Required

The four crucial elements of this story are the fusing of health and social care budgets and commissioning teams, followed by radical new approaches to contracting and market shaping. The first ingredient, which has been around for a long time, gained impetus through the Better Care Fund (BCF), and is now being extended through more ambitious local agreements, such as in Manchester and (most recently) Hackney. At the same time, many well-established joint commissioning teams cover service areas relevant to both Clinical Commissioning Groups (CCGs) and councils. These pooled budgets and integrated teams can help to control costs by making commissioners more conscious of, and able to address, system-wide spending rather than just individual provider funding. By bringing money and commissioners together, they can also combat the shunting of provision and costs between community services and social care that delays or denies the most appropriate support for some people

Yet pooled budgets and joint working, by themselves, often have little impact on the bottom line, especially as demand races ahead. This is shown by the failure of the

national BCF programme to deliver planned savings, as the National Audit Office recently reported (NAO 2017). Rather, their true potential lies as prerequisites to a more complex series of changes. This means overcoming the maze of contracts and fragmented supply chains that drive up costs as commissioners lose control of their markets. It also presents an opportunity to assert the primacy of outcomes over outputs.

From Nought to Lift-Off, in a Single Leap

This can be seen through the story of a health and care system that PA recently supported to design and kick off a major learning disabilities (LD) transformation programme, to supplement the national requirements of the national Transforming Care programme. Combined annual CCG and council costs for LD care had jumped by £11m (15%) in just two years. Without intervention, the commissioners faced adding another £14m to the bill each year by 2020. Strikingly, most of this would come from increasing costs per user rather than more people needing care.

Senior commissioners in the CCGs and council quickly embraced the logic of a pooled budget, as a technical and symbolic means of asserting shared ownership of runaway finances and uncertain value. In this they joined the quarter of areas in England that have taken this approach (Public Accounts Committee 2015). They also set about launching a joint LD commissioning team.

But they understood that these steps alone would not address the fragmented and uncontrolled market that was really driving increases in costs; likewise, they would have no impact on the disjointed supply chain hampering efforts to improve quality.

These commissioners therefore made an additional bold move, informed by the PA team's experience elsewhere and reflecting some of the most forward-looking thinking now circulating amongst their peers: to champion the appointment of a prime provider for all LD services in the county, through a capitation-funded, value-based contract. It is here that the radicalism kicks in, not just in the extreme jointness (a single commissioning voice expressed through a single budget and a single contract) but in its crisp appreciation of what, in future, commissioners should and should not try to do.

Boiled down to its fundamentals, this approach means that a single provider (or group of providers forming a new organisation) will assume financial and clinical responsibility for all LD provision. This provider will, in turn, act as a system integrator, constructing the pathways and incentives required across the rest of the market—its subcontractors—to deliver the user outcomes specified by the commissioners. A growing portion of the prime provider's contract payment will be based on the achievement of these outcomes. The prime provider also bears risk for over-spending and retains part of any savings secured through efficiencies. Over time, some functions destined for the joint commissioning team—such as assessment, review, and brokerage—will logically transfer to the prime provider, as processes more effectively executed within a provider organisation working to a fixed budget and tasked with maximising outcomes.

To what end? The purpose is to assert the power of commissioning to work most effectively at the level of the whole population group, setting outcomes and the total budget through which they must be achieved, and managing both against a single point of responsibility. At the same time, commissioners are freed from micro-management of the local market to concentrate on dealing with strategic risks and opportunities, such as the growing complexity of need, demographic and social change, and regulatory uncertainty. This work is frequently squeezed out by urgency of the operational level at which so much commissioning effort is now expended. The point is to enable the commissioners to become the masters of their market—and the outcomes it delivers—rather than, as is sometimes the case, subservient processors of its invoices.

It is also an acknowledgment of what commissioning, particularly of out-of-hospital services, is largely failing to achieve in its current form: the management of a complex and fragmented supply chain in a way that imposes cost discipline and cultivates consistent quality improvement. This work doesn't go away, which is why staff flow to a prime provider, but this model enables it to be done from within the market—driven by all the right incentives—rather than at one step removed.

It also creates the potential to drive efficiency by constructing a market with the incentives to apply its own cost restraint: up to £40m in this system over a five-year contract, against the current spend trajectory, even after sensible allowances for natural growth in costs. This is a big attraction for cash-strapped commissioners, especially in the care sector that the Local Government Association (LGA) has shown is the hardest from which to extract savings (LGA 2016).

The Even Bigger Picture

This is just one example of a gathering, but not yet general, trend for commissioners to redefine their role. It is also a partial example, focused on a single pathway, as with similar programmes for musculoskeletal services (Bedfordshire), mental health (Lambeth), and older people's services (Salford). In each of these cases, commissioners have sought to impose financial rigour and improve outcomes through a single contract with a prime provider, a prime contractor, or an alliance.

The new care models described in the *Five Year Forward View* (NHS 2014) take this much further, collecting wider service portfolios within unified contractual arrangements.

Dudley CCG, for instance, has now issued its proposed 15-year outcomes-based contract for a single entity (rather than the current 177 local providers) to be responsible for health, social care, and public health services for more than 30,000 people, valued at over £200m each year. The entity might also assume various CCG functions, including financial management, service redesign, and medicines management. In this way, the CCG will retain accountability for strategic commissioning—deciding the outcomes that providers need to focus on and the budget available—whilst the single provider entity will be responsible for operational commissioning, which means deciding, within the overall budget, who can best deliver the processes that maximise the specified outcomes.

Meanwhile, some STP footprints, such as Frimley Health, Lancashire and South Yorkshire, are moving even further to whole-population accountable care systems. These, declared Simon Stevens, CEO of NHS England, could effectively dissolve the historic purchaser/provider split by bringing together strategic and operational commissioning. Of course, providers have been key to driving these most ambitious new models; in this respect, the reinvention of commissioning they represent is as much of a provider achievement.

As ever with innovation, not all has gone smoothly. The failure of the Cambridgeshire and Peterborough older people's contract provided a salutary lesson about misunderstanding risk and excessive optimism about overnight efficiency savings. Staffordshire's ten-year, £690m cancer contract also had a difficult gestation, before being cancelled over doubts about its financial viability. However, success tends to start with failure, and the regulators' new assurance process for complex contracts (NHS England and NHS Improvement 2016) is a recognition both of the fiendish complexity of executing a relatively simple concept and the many more opportunities to work it out that are on the way.

Conclusion

The transformation of commissioning covers a continuum from half-hearted BCF implementation to well-executed pathway programmes, and now to the brave but unproven (in an NHS context) world of the new care models. As this brings a consolidation and shrinking of commissioning organisations, it is tempting to conclude that commissioning is now in retreat. But really this should be seen as an assertion of commissioners' core purpose: to commission once across whole populations or population groups, to construct markets incentivised to minimise costs and drive value, to devise contracts that promote system responsibility, and—most important—to marshal markets behind the achievement of outcomes rather than delivery of activity. When commissioners next feel the squeeze of tightened treasury purse strings, the front line is unlikely to escape unscathed. However, this will at least be after the mechanisms by which money reaches the front line have been transformed to enable and incentivise markets to deliver the maximum amount of relevant high quality care for each pound still available. ■

KEY POINTS

- ✓ All commissioners of health and social care are faced with the requirement to simultaneously deliver financial savings and improve frontline service delivery
- ✓ However, only the most innovative are transforming the art of commissioning to make sure that each pound delivers the maximum amount of relevant high-quality care
- ✓ This includes new and radical approaches to contracting and market shaping, on top of further cross-system fusing of budgets and teams
- ✓ It also involves a crisper appreciation of both the power and limitations of commissioning, as well as a creative redefinition of the purchaser/provider split
- ✓ By tackling the mechanisms by which money reaches and influences front-line care delivery, these new approaches represent an alternative—or at least a supplement—to securing financial efficiencies directly from service provision

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