London Health and Care Leaders Forum
11th March 2014

Payment Innovation Break-out

THE NHS CONSTITUTION
the NHS belongs to us all

Speakers

- John Wardell
- Ric Marshall

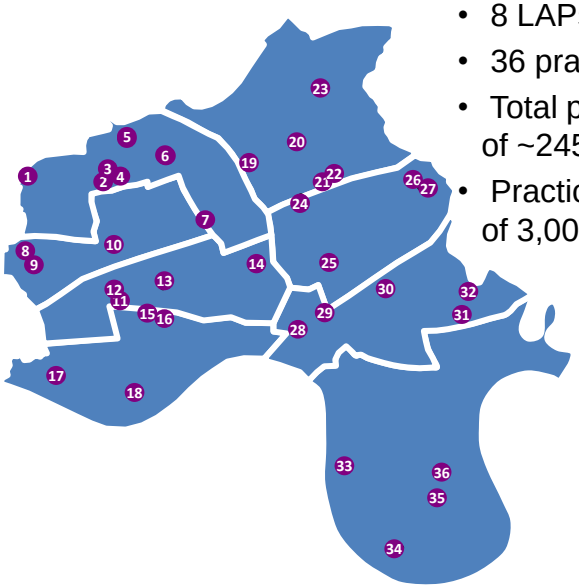
London Health and Care Leaders Forum 14th March 2014

John Wardell
Deputy Chief Officer
Tower Hamlets Clinical Commissioning Group

THE NHS CONSTITUTION
the NHS belongs to us all

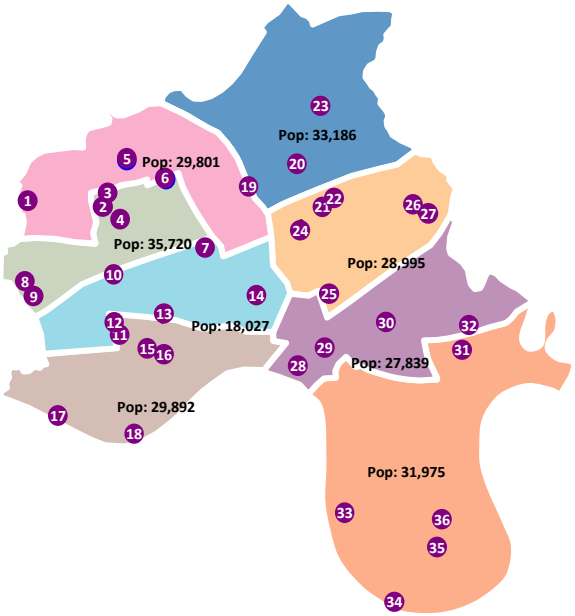
Understanding the development of federated networks

Tower Hamlets before networks



- 8 LAPs
- 36 practices
- Total population of ~245,000
- Practice list sizes of 3,000 to 11,000

8 Networks[1] were formed in the borough during 2009



Why networks?

- Focus on **population health** across a geography
- Collaborative relationships with **wide range of partners** (e.g. Borough, schools, charities)
- Sufficient **scale for** specialisation of staff, ability to access rare skills and ensure access, resources (e.g. equipment)
- Integration with **estates** plan

Case for change…

- Wide variation in clinical practice and outcomes for diabetes patients
- Economies of scale
- Poor uptake of diabetes education and retinal screening
- Need to do things differently
- The right people to do the right tasks at the right time
- Specialist support
- Transparency of data
- Putting the patient at the centre of their care

How did it work…

Care packages are:

- Reducing variability through the use of evidence based pathways
- Ensuring the right people to do the right tasks at the right time
- Enabling transparency of data at individual patient, clinician, practice, and network level
- Facilitating an integrated and coherent approach
- Costing of care packages

Networks:

- Focus on population health across a defined area
- Have collaborative relationships with a wide range of partners (e.g. Borough, Schools, Charities)
- Provide sufficient scale for:
  - Specialisation of staff
  - Ability to access rare skills
  - Resources (e.g. equipment)
  - Ability to ensure access
- Integrate with estates plan

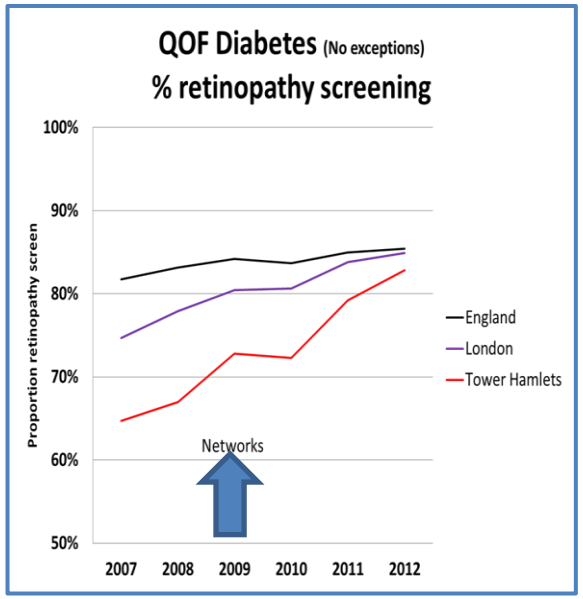
What supports it all?

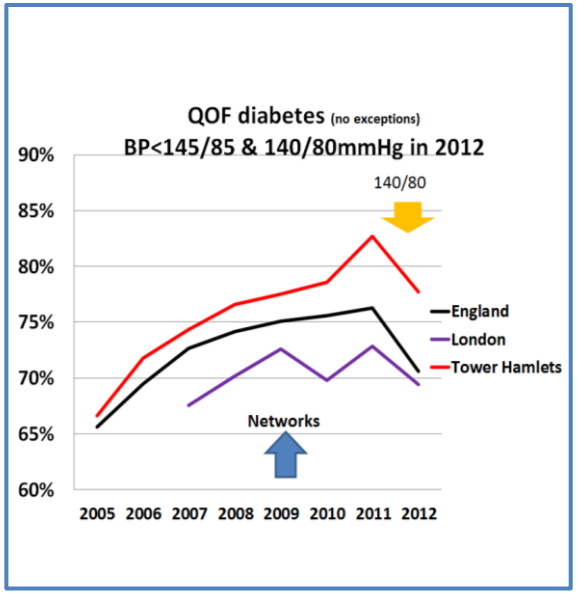
Organisational development **Information and technology**

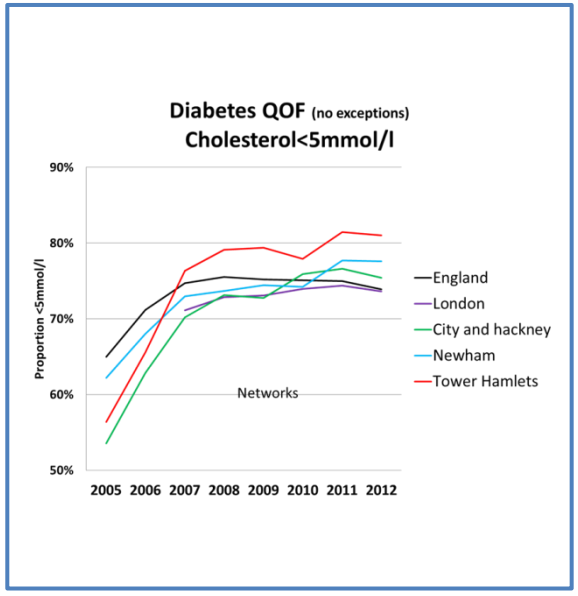
Payment Model

Contracted at network level 70% upfront and 30% on performance

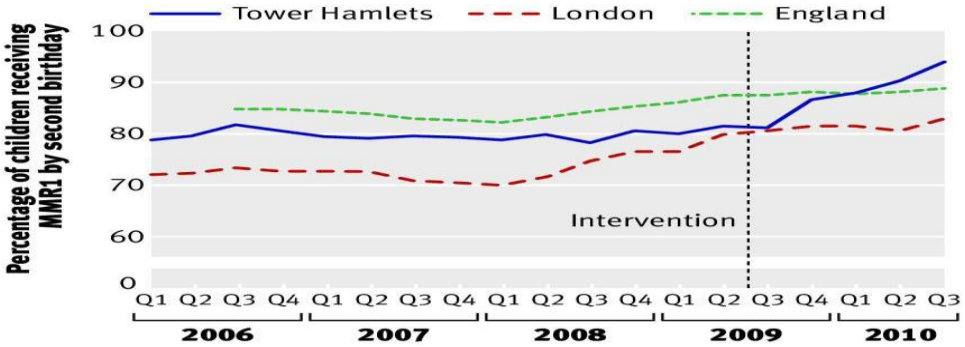
Outcomes


QOF Diabetes (No exceptions)
% retinopathy screening
Proportion retinopathy screen
100%
90%
80%
70%
60%
50%
2007
2008
2009
2010
2011
2012
Networks
England
London
Tower Hamlets


QOF diabetes (no exceptions)
BP<145/85 & 140/80mmHg in 2012
140/80
90%
85%
80%
75%
70%
65%
60%
2005
2006
2007
2008
2009
2010
2011
2012
Networks
England
London
Tower Hamlets

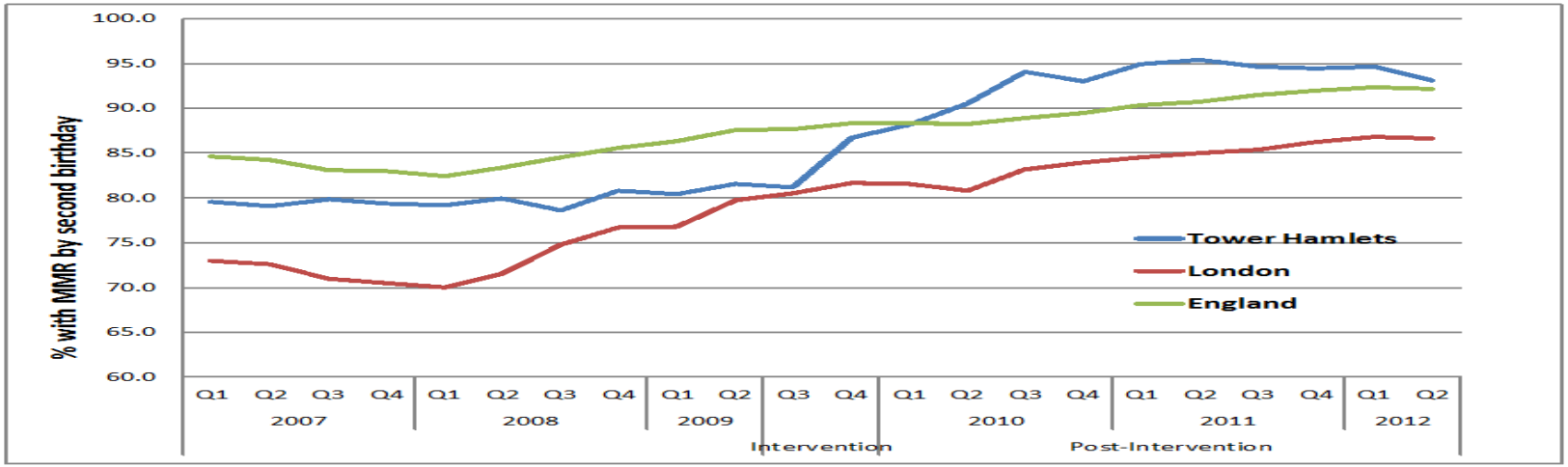

Diabetes QOF (no exceptions)
Cholesterol<5mmol/l
Proportion <5mmol/l
90%
80%
70%
60%
50%
2005
2006
2007
2008
2009
2010
2011
2012
Networks
England
London
City and hackney
Newham
Tower Hamlets

MMR Immunisation 2006-10



Improving MMR vaccination rates: herd immunity is a realistic goal. Cockman P, Dawson L, Mathur R, Hull S, *BMJ2011;343doi: 10.1136/bmj.d5703*

Maintaining MMR improvement



Critical success factors

- Good clinical leadership and engagement of specialists
- Emphasis on quality of care and outcomes for patients
- Contracting and paying for outcomes
- Organisational development
- IT and information sharing
- Presentation of the right data regularly
- Geographical network boundaries (not based on historical practice relationships with one another)

Behaviour change

Guideline

Education

Comparative Feedback

Incentives

Belief

Act

Motivate

Organisation change

Practice networks

IT Dash-board

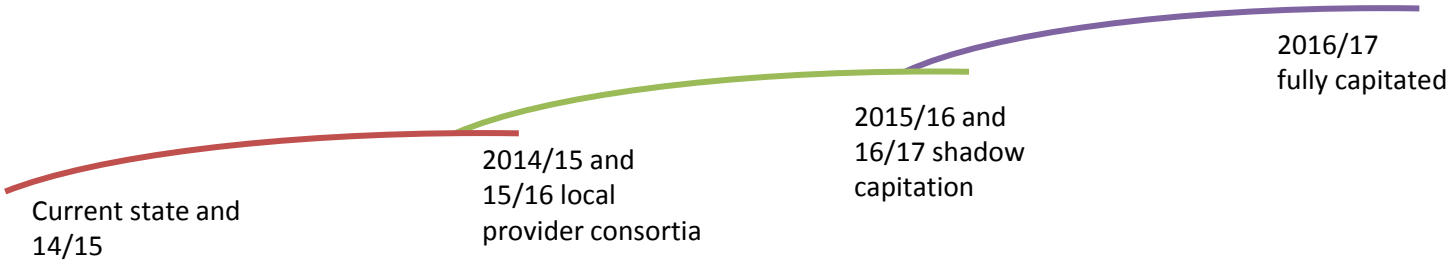
IT Prompts & Decision support

IT Review & recall

IT Equity audit

Integration Going Forward

Forward Plan



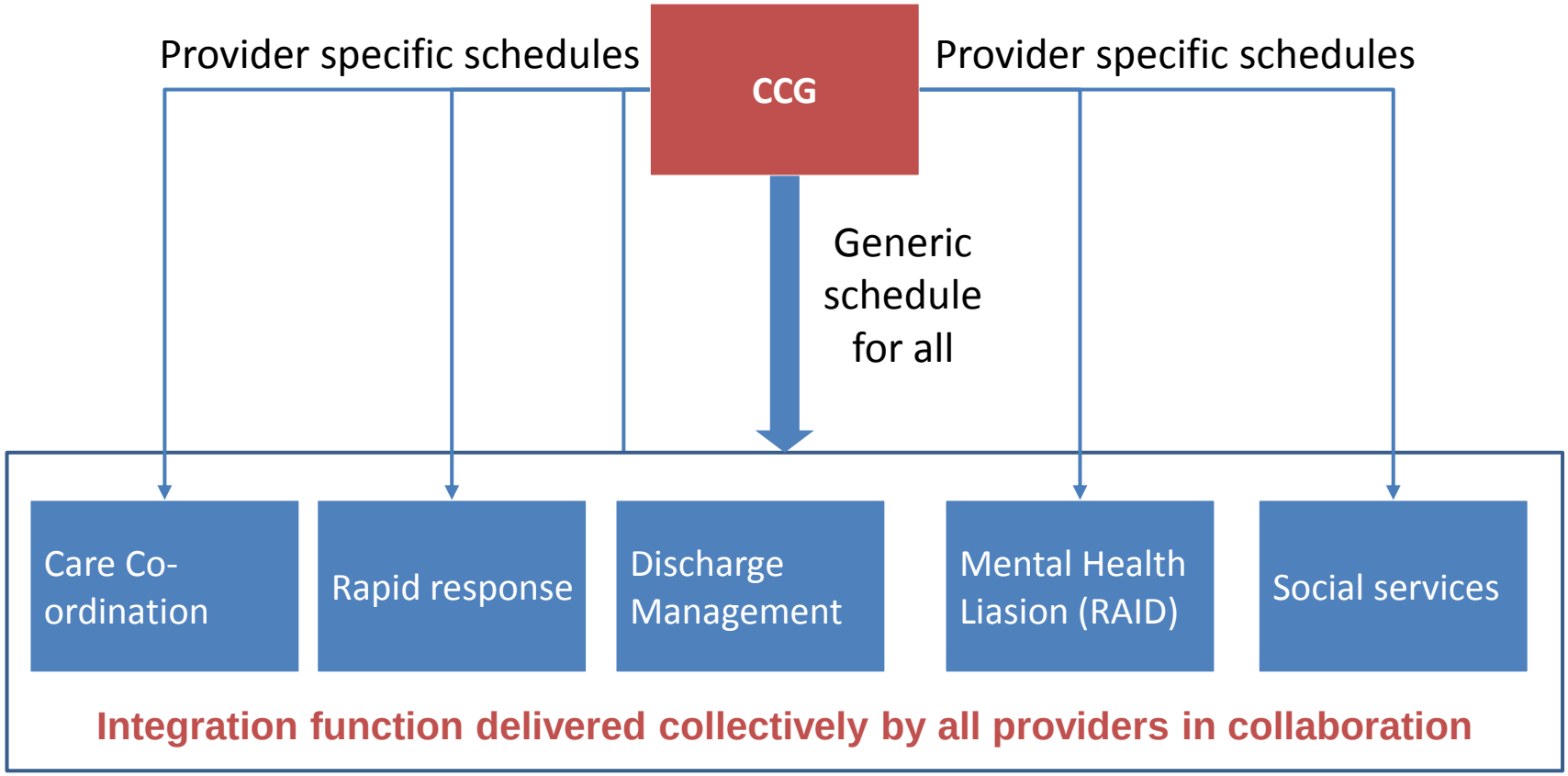
	Current state and 14/15	2014/15 and 15/16 local provider consortia	2015/16 and 16/17 shadow capitation	2016/17 fully capitated
Payor/provider configuration	Local CCGs provider consortia for all IC services	Local CCGs provider consortia for all IC services	Local CCGs provider consortia for all IC services	Local CCGs provider consortia for all IC services
Reimbursement model	Pay for performance model	Pay for performance model	Pay for performance model	Capitated model
Service configuration	Services contracted individually	Services contracted through consortia	Services contracted through consortia	Services contracted through consortia
Health and social care	Separate social and health funding	Joint working agreed	Joint working agreed	Pooled social and health funding
Outcome linked reward/risk	Commissioners bear risk for activity and outcomes	Providers share more risk for activity and outcomes	Providers share more risk for activity and outcomes	Provides control/share full risk for activity and outcomes
Enablers for end state	Agreement on reimbursement models to be implemented	Indicative individual budgets	Indicative individual budgets with shadow capitation model	Might need to break PbR for target population

What are we commissioning for integrated care

WELC will provide nine key interventions for its population underpinned by five components and enablers

		Areas of interventions	Essential components	Enablers
Joint health, social care and mental health approach	Self-care	Self-care, behaviour, and expectation management	Information sharing platform	Patient engagement
	Care coordination	Care planning	Evidence-based pathways & care packages (e.g. last years of life, diabetes, COPD, CHD. falls,alcohol and substance misuse)	Joint decision making and accountability
		Health and social care navigation		
		Case management		
		Specialist input In the community	Joint health & social care assessment	Clinical leadership and culture development
	Ensuring people are in the most appropriate setting of care	Discharge support for mental health patients from secondary to primary care	Creation of new roles within the workforce: • Case manager • Hybrid health & social worker • Health & social care coordinator • Discharge coordinator based in acute wards	Information sharing and decision support
		Rapid response with short team reablement		
		Mental health liaison (RAID)		Aligned incentives and reimbursement models
		Discharge support from acute to community	Organisation of practices into networks	

Contracting approach – Standard NHS Contracts



Provider assurance process

Indicative summary provider development approach to commissioning integrated care services

SEP

Provider letter
- Lists for each provider the services we anticipate they will provide in 14/15
- Signals 70/30 split for 14/15
- Outlines next steps (below comes from CCG)

⊕ Prospectus
- Brings key documents together
- Adds detail to provider letter
- Signals what might be in future phases

⊕ Payment mechanism
- Sets out approach to payment on outcomes
- Outlines incentives for providers to work together to provide integration of services

⊕ KPIs
- Sets out individual services and system side performance measures

OCT

Stage 1 assessment
- Individual providers outline how they will provide services against the borough integrated care services specifications
- Also asked about how they will integrate with others

NOV-JAN

Stage 2 assessment
- Providers given feedback to Stage 1
- Providers asked jointly to outline how they will ensure services are integrated
- Asked if they are revising responses to Stage 1 in the light of and feedback or work done with other providers to date

JAN

Provider collaborative interview
- Providers given feedback to Stage 2 and questions to answer at interview
- Presentation and interview on collaboration governance arrangements and plans to deliver jointly on KPIs

FEB

Evaluation
- Further dialogue with providers about plans and clarification of details

MAR

Not approved

Formal tender process
- Likely to be competitive dialogue
- Likely to be 6-9 months

6-9 month procurement process

Approved

Contracting process
- Service specification and integration written into existing contracts with providers
- Payment on outcomes 14/15

Monitoring
- Development of 15/16 contract begins for similar process to start in Sept 2014

Dashboard

Questions?

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14th March 2014

Ric Marshall
Director of Pricing
Monitor

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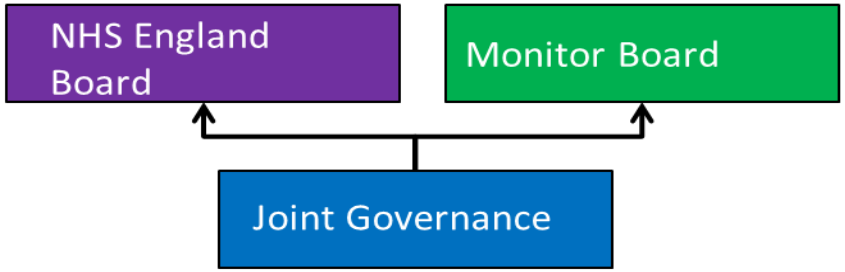
Contents

- The Health & Social Care Act 2012
- What next for 2014?

The Health & Social Care Act 2012 sets out the approach for pricing and the roles for NHS England and Monitor



NHS England leads on:

- Scope and design currencies
- Variation rules to National Tariff

Close working and agreement

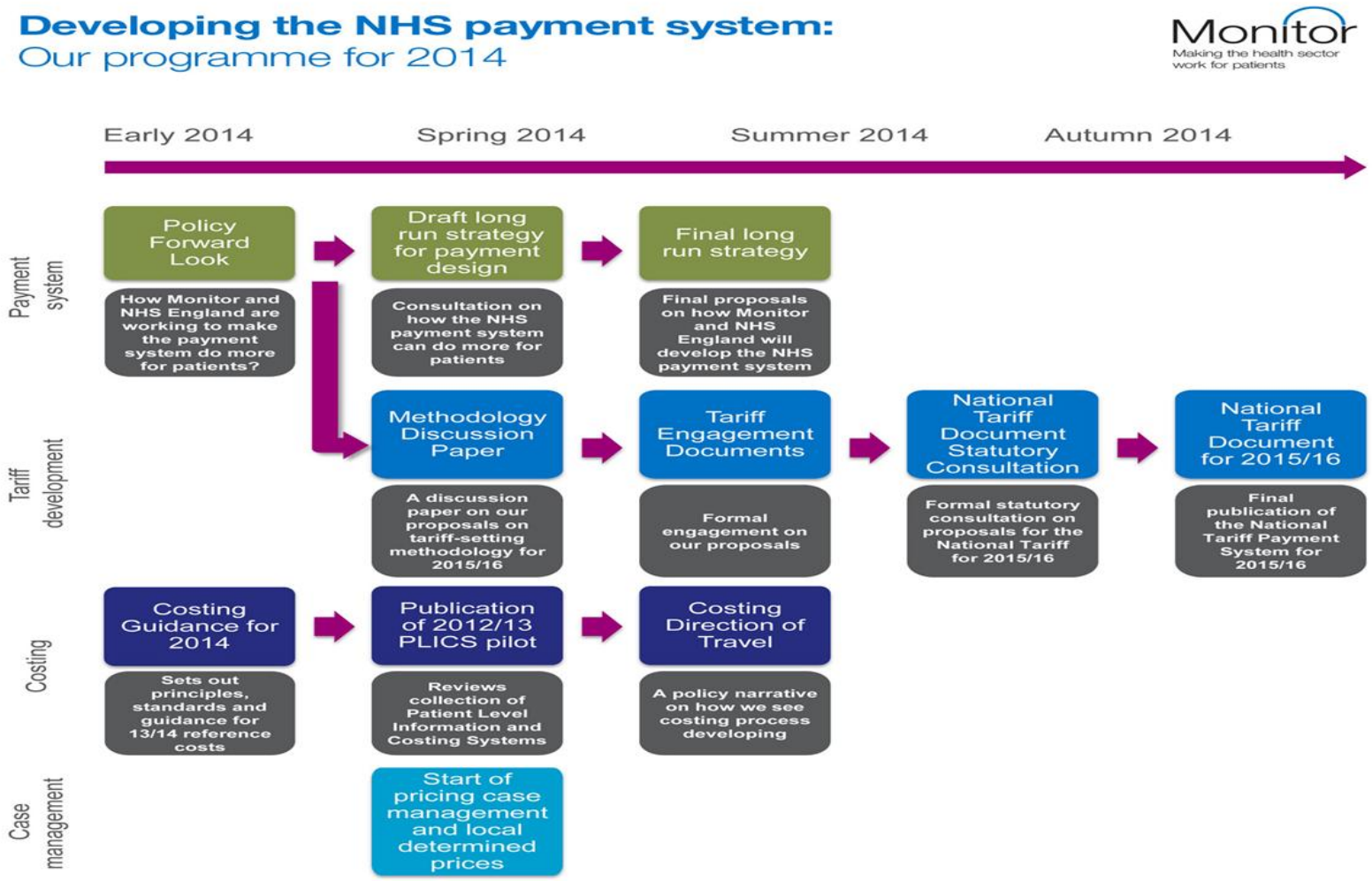
Monitor leads on:

- Methodology for national prices and calculation in the national tariff
- Setting rules for local price setting and variations to national prices
- Local modifications
- Enforcement

The first year for which Monitor is responsible for pricing is 2014/15

Monitor
Making the health sector work for patients

What next for 2014?



Thank you…..

- Any questions please?

- Further information:
  - http://www.monitor-nhsft.gov.uk/sites/default/files/publications/MakingThePaymentSystemDoMore%20-%2028Feb.pdf