Commissioning for outcomes: Musculoskeletal care
NHS Bedfordshire CCG

Planning an innovative new service

Through their planning processes, Bedfordshire CCG (BCCG) recognised the need to both change the services they commission and the way they commission services. They decided to take a whole systems approach to redesigning their Musculoskeletal care (MSK) service, which at the time represented the fourth highest area of spend but delivered a fragmented, variable and inequitable service for patients.

BCCG wanted to provide an innovative MSK service that would deliver demonstrably high value care, use hospital facilities only when necessary, empower more care within primary care, and improve patient experience and outcomes. This would be commissioned via a lead provider (prime contractor) model.

The new MSK service aims to provide integrated care, linking care through from prevention and early intervention, to complex, hospital based care.

The key parts of the MSK system are:

Part 1
Prevention, support for self-care and advice to patients, carers and professionals

Part 2
Primary Care assessment, investigation, management, and onward referral

Part 3
Community-based specialist MSK triage, assessment, investigation & management

Part 3a
‘Discharge’ (i.e. transfer) back to support by primary care or supported self-care

Part 3b
Shared decision making, patient choice, surgical listing and fitness for surgery assessment

Part 4
Hospital-based specialist MSK intervention and immediate rehabilitation

Part 4a
‘Discharge’ (i.e. transfer) back to support by community-based specialist MSK team, primary care or supported self-care

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Bold, clinical leadership

BCCG aims to put improving patient outcomes at the centre of its strategic commissioning plan, but appreciates that no single organisation can improve the health of their local population on their own.

Instead, all stakeholders within a health economy need to collaborate to improve the patient’s experience of care and to ensure that, collectively, the patient’s needs are met through integrated care. For this reason a whole system approach to delivering care has been pursued.

In the early stages of the MSK project, BCCG brought together a local network of MSK-related professionals, including physios, podiatrists, rheumatologists, orthopaedic surgeons and nurse specialists, as well as patients and local GPs. This network endorsed the case for change, the proposed approach of integration of care and the move towards a more community-based focus.

Alongside patients, a team of GPs representing all of the CCG’s localities developed a detailed specification for the integrated MSK system. Each of these GPs, supported by the MSK project lead and lead MSK GP, was also responsible for informing all local practices about the MSK project and gathering their feedback on proposals and ideas for new approaches to MSK care.

The draft system specification was reviewed by national professional bodies and patient groups, and their feedback incorporated into the final version issued as part of the procurement process.

The GP team also evaluated all submitted bids and provided feedback to unsuccessful bidders. The MSK project was discussed in detail at key points in the process, at CCG governing body meetings and executive meetings.

Public engagement

As part of developing the case for change, current users of existing MSK services were asked to give feedback on their care and how it might be improved. Comments such as feeling “ping-ponged” around the system were not uncommon.

The two LiNks groups active within the BCCG boundaries sourced volunteer patients to participate in the specification development working groups and be part of the evaluation team for submitted bids.

Securing the service

Taking an innovative approach to commissioning the service

BCCG recognised that maintaining a fragmented service was not sustainable and managing over 20 separate contracts was unlikely to create an improvement in patient outcomes. Improving patient outcomes requires ‘joined up’ or integrated care, and to do this BCCG decided to take a whole system approach.

To achieve better local value in healthcare, and focus on outcomes from both the patient and clinical perspective, the CCG decided to pursue an innovative commissioning technique – the lead provider approach – to plan and deliver their service.

BCCG has approached this by reinforcing the lead provider arrangement with a capitation-based funding formula, incorporating risk/gain-share and adding financial incentives for delivering improved patient and clinical outcomes.

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To ensure that the local economy is not destabilised in the process of moving to a new system of care delivery, the process aims to share financial risk between commissioners and providers. This means that not only can commissioners accurately predict annual spend on MSK, but the lead provider is incentivised to improve quality of clinical care, identify and eliminate waste from within the MSK ‘supply chain’ and deliver joined-up experience of care to the patient. The contract will last for 5 years.

Collaboration to identify patient outcomes

Introducing a whole system approach to care delivery is dependent on having clearly defined outcomes.

To design their new system specification, BCCG ran working groups with clinicians and patients. By so doing, consensus could be reached on how it would feel to refer to, and receive care from, an integrated MSK system.

As well as describing how the system should feel to use, the specification describes the basic outcomes expected within the capitation funding (such as meeting NHS Constitution rights on waiting times). It also includes more ambitious outcome metrics, which, if achieved, attract an additional financial bonus for the prime contractor, and in particular pioneer the incorporation of a standard set of health outcome measures for low back pain (as defined by the International Consortium for Health Outcome Measurement).

As a result of this engagement, the contract has a set of health outcomes and improvements built in as core deliverables.

Working with stakeholders to minimise risk in developing an innovative approach to service delivery

Pursuing a lead provider approach for the MSK service represents a new approach to commissioning, so BCCG incorporated a number of activities to ensure a successful transition to the new model of service delivery.

Due to the innovative nature of the requirement, and complexity within the model, during the project lifecycle the project team engaged with the Co-operation and Competition Panel and with its successor competition directorate of Monitor, which have provided further assurance to the procurement process and the clinical model.

In preparation for the new lead provider approach, BCCG held four MSK provider & engagement events during 2012. Provider engagement was also supported in the development and publishing of the MSK system redesign within BCCG commissioning intentions during 2012. This approach was adopted to ensure a transparent and open process to the system redesign for all providers and the patients of Bedfordshire.
Outcomes based focus

Macmillan Cancer Support is providing funding for the project management and infrastructure costs that are necessary to radically transform the way that cancer and end of life care services are commissioned.

The core aim of the programme is to transform the commissioning process, from the current system of commissioning intervention or services, to commissioning the entire patient journey. This will ultimately lead to one sole provider being responsible for the whole cancer and end of life pathway from beginning to end. The programme is defining the outcomes for cancer and end of life services with the public and community; and will continue to do this throughout the process, and once the prime provider is in place.

By the end of the programme, the aim is to have appointed two prime providers, one each for cancer and end of life care, who will hold the contracts for a term of 7-10 years. These prime providers will then organise the best model of outcome-based care across a network of providers, who would be subcontracted to deliver specific services.

Innovative Programme

Working with patients and carers, health and social care professionals, the outcome of the programme will make the experience as seamless and integrated as possible. At the moment, cancer and end of life care is organised around the needs of care providers such as doctors, nurses and hospitals. This will change so that it is organised around the needs of patients, becoming truly person-centred care.

In this way, all patients and carers receive the best possible support wherever and whenever it is needed and no-one feels as though they have been lost in the system. The care and support services that patients and carers receive should be personal to them, regardless of where they live.

This new and innovative project will pioneer a different way of working and will benefit everyone involved in cancer or end of life care. This is a major transformation that is going to mean big changes to the way that providers of health and social care work together. There is a real willingness to change and excitement now that the programme has been identified as one of 14 pioneers of integrated care in England.