Briefing

OCTOBER 2015

Two for the price of one

BETTER CARE AT LOWER COST

The NHS is facing the biggest change in a generation – it must redesign the way it delivers healthcare while, at the same time, make substantial cost savings. The aim is to establish a better value for money health system. New care models can help achieve this, but they need to be well designed and governed and have the right funding model in place.

It has been a year since NHS England Chief Executive Simon Stevens launched the Five Year Forward View (FYFV) which gave the NHS a dual challenge – to deliver a better system of healthcare at a lower cost. For most involved in healthcare, the challenge is both exciting and daunting.

The FYFV identified a spending gap of £30bn by 2020/21. Only £8bn will be covered by additional funding from Government. The remaining £22bn will need to be found from within the current NHS budget. The FYFV points to how quality of service can be improved for patients by embracing new care models

that, at the same time, rationalise the cost base of healthcare provision and avoid costly care pathways. In short, it assumes that more can be done with less.

There has been a lot of excitement around the new care models that were envisaged in the FYFV, with many seeing the opportunity of a generation to rethink care at the grassroots and develop better, cheaper, more patient-focused healthcare. However, the practicalities of such new models are beginning to become apparent as difficult decisions need to be made: How can we be sure these models of care will deliver benefits and save money? What are the governance requirements for those new models? How will they be funded?

We believe that, as large as these questions loom, there are answers to be found with the help of good quality thinking and solid evidence.

WHAT ARE THE NEW CARE MODELS?

The new care models have started to take shape and find names. Most of these models have been based on collaboration between primary and community care providers (multispecialty community providers or "MCPs") and primary and acute care providers (primary and acute care systems or "PACS").

However, some parts of the country have been experimenting with even more radical changes. Devolution Manchester is leading the way with a single health and social care budget. Further north, Northumberland is attempting to create an even more ambitious degree of collaboration in the form of an Accountable Care Organisation (ACO).

Despite their overarching names, most proposed new models are focusing or likely to focus on subsections of the population, in particular people with long-term conditions who represent only 30% of patients but require 70% of NHS budget.[1] We know that we could reduce these costs substantially with better care in primary and community services and avoid unnecessary hospital admissions[2]. The benefits from reorganising care are therefore large.

Of course, few of the models being developed are entirely new. In the UK, NHS England has been championing local systems since its creation following the 2012 Health and Social Care Act: through the integrated care 'Pioneers', the new care models programme and, more recently, the 'success regime' for challenged local health economies. The Dalton Review has explored a number of models that could bring providers within health economies closer together. These ranged

[1] *"Managing the care of people with long term conditions"*, House of Commons Health Committee , July 2014, http://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/news/long-term-conditions-substantive/

[2] Ian Hunt: *"Focus on preventable admissions"*, Nuffield Trust, October 2013, http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/131010_qualitywatch_focus_preventable_admissions_0.pdf

from collaboration options such as federations to formal consolidation such as a Foundation Group.[3]

In the US, from where many of the current UK new models drew inspiration, the managed care initiatives in the 1980s led to integrated delivery systems or health maintenance organisations such as Kaiser or Group Health, multi-specialty group practices such as Virginia Mason or the Mayo Clinic. They also allowed for a range of looser collaborations such as physician hospital organisations, independent practice associations and virtual physician organisations. The 2010 Affordable Care Act or "Obamacare" provided the impetus for yet further variations on ACOs and 'patient-centred medical homes' which will, no doubt, provide further inspiration to their UK counterparts.

WHAT IS NEEDED FOR THE NEW CARE MODELS TO BE SUCCESSFUL?

Whilst the direction of travel is increasingly clear, the detail still needs to be ironed out. As Simon Stevens admitted, national leaders were "open to ideas" and "still thinking through precisely how we do this".[4] We believe that the NHS needs to focus on the following three areas as a matter of priority:

What are our challenges?	How can we rise to them?
How will we know that we selected the right models?	Develop empirical evidence base to demonstrate patient benefits and value for money.
How will we ensure that the new care models can be implemented?	Devise sound governance framework based on good business practices and regulatory compliance.
How will the new care models be funded?	Develop capitated budgets based on best practice within healthcare and in other regulated industries.

MEASURING THE BENEFITS OF THE NEW CARE MODELS

As a first step, local health economies will need to ensure that the models they are proposing do in fact deliver the intended patient and financial benefits. This

[3] *"Examining new options and opportunities for providers of NHS care"*, The Dalton Review, December 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf

[4] David Williams: *"Stevens: Funding growth may depend on 'transformation' plans"*, Health Service Journal, 13 October 2015, http://www.hsj.co.uk/news/finance/stevens-funding-growth-may-depend-on-transformation-plans/5091115.article#.VjDIsbFFBMs

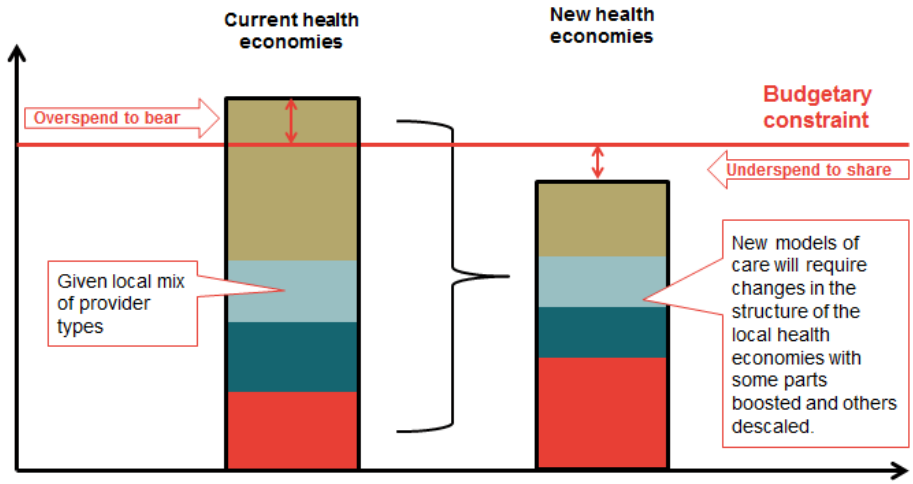
will be important given just how drastic the change is that many of the proposed models are contemplating.

There has been a working assumption that the proposed new care models will automatically lead to savings. Monitor challenged this suggesting that if these models are to generate savings, they will have to lead to decommissioning of existing inefficient capacity, in secondary care in particular.[5]

The current financial crisis has also focused the debate on financial viability assuming that patient benefits would follow from more sustainable financial models. Monitor again challenged this suggesting that the new care models will first need to be shown to work for patients. [6]

There is ample international evidence that integrated models of care work, for instance, the Alaska Southcentral Foundation, the New Zealand Canterbury Health System or the German Gesundes Kinzigtal, to mention but a few. Closer to home, Oxleas, Pennine and Birmingham trusts, as well as many others, have developed programmes that showed great potential for better patient outcomes as well as financial savings. Whilst these examples are helpful, health economies up and down the country will need to develop their own arguments as to why their plans will deliver benefits.

Ambition for the new care models – resize local health economy



Perhaps the most immediate challenge is to identify a simple and manageable group of metrics for measuring improvements across the system, which capture the health economy's success in managing its population's needs rather than individual organisations' efforts.

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5 *"Moving healthcare closer to home: Summary"*, Monitor, 9 September 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/459400/moving_healthcare_closer_to_home_summary.pdf

6 *Ibid.*

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GOVERNANCE AND REGULATORY FRAMEWORK

Once a new care model has been perfected, local health economies will need to decide who has a seat at the table, what the geographic parameters of the new system will be, the group's high-level objectives, and the ground rules for making collective decisions. Almost all of the Vanguard sites in NHS England's new care models are in the process of working through the appropriate governance arrangements for systems that span commissioning and a range of provider organisations. While the Vanguards are at an early stage, work by Elinor Ostrom,[7] and John Kania and Mark Kramer[8] provide some guidance on what arrangements are likely to be effective.

Another immediate priority is to decide which services to focus on and the new care delivery model. At least in the first instance, a useful maxim is that it is possible to integrate all services for some people or some services for all people. Successful systems typically focus on a limited group of services or a particular high-risk population, and then extend success to other areas, rather than trying to do everything at once. For example, ChenMed in the United States, and similar extensive models, aim to deliver holistic primary and community care focusing exclusively on the 2% of the population with greatest need, primarily elderly people with multiple long-term conditions. Southcentral Foundation in Alaska has focused in on integrating physical and mental health for its entire population.

The elephant in the room remains the regulatory framework established by the 2012 Health and Social Care Act, in particular the rules on procurement, patient choice and competition. The former Chief Executive of NHS England, Sir David Nicholson voiced strong concerns that this framework would cause insurmountable difficulties to new care models. His successor has adopted a more sanguine approach accepting that the NHS would need to be pragmatic in how it applied them.[9] From our experience, the solution is often simply for commissioners and providers to clearly articulate the benefits of the changes they are proposing, and to explain why they are preferable to the status quo in a well-evidenced and robust manner.

CAPITATED BUDGETS

NHS England is also likely to demand a coherent approach to pooling individual provider budgets and to sharing risk and reward across providers within the new

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[7] Elinor Ostrom: "*Governing the commons: the evolution of institutions for collective action*", Cambridge: Cambridge University Press, 1991

[8] John Kania, Mark Kramer: "*Collective impact*", Stanford Social Innovation Review, Winter 2011. Available at: http://volunteer.ca/content/ssir-collective-impact, 2011

[9] Sarah Calkin: *"NHS chief will take pragmatic approach to competition"*, Health Service Journal, 29 April 2014, http://www.hsj.co.uk/news/commissioning/nhs-chief-will-take-pragmatic-approach-to-competition/5070412.article#.VjDWQrFFBMv

care models as one of the essential building blocks that hold such system together. One of the key instruments to achieve this will be so called "capitated budgets" which allocate financial resources for a particular patient cohort rather than for each part of the patient pathway.

In the first instance, this will mean developing a robust model which describes with a reasonable degree of accuracy the current population's healthcare needs, healthcare outcomes under the current system, and the current cost of services. This will not be easy. The FYFV assumes that more can be done with less if providers work collectively to adapt the system. In practice, this means that some parts of the system will need do descale and others upscale. Achieving this will require a model of capitation that aligns incentives within the health economy and achieves an outcome that is perceived as fair by all its participants.

This challenge is by no means trivial. In other regulated sectors of the economy, such as gas, electricity or water, providers are incentivised to achieve the most efficient outcome by emulating the efficient providers from *across* their sector. In healthcare, the Lord Carter review proposes to do just that for acute hospitals to unlock additional £5bn savings.[10] New care models present an altogether different challenge – optimisation of resources *within* a local economy with the risk that some parts of the system will be seen as the winners and other as losers.

However, it can be done. For example, in the US, the Blue Cross Blue Shield of Massachusetts' Alternative Quality Contract achieved the sweet spot of improving patient outcomes by 12% and reducing cost by 10% after four years since it has been launched.[11] But local NHS systems will inevitably need to develop capitation arrangements that are tailored to local circumstances.

A NEW IMPETUS

On 13 October 2015, Simon Stevens made a series of policy announcements which created ripples across the NHS. NHS England does not only support new care models, but it will also target the available resources more clearly on these new models. Access to the additional £8bn Government funding by local health economies could depend on their providers, commissioners and wider community developing and agreeing a "shared" five year 'sustainability and transformation' plan.[12] To us, the message to local health economies is clear: "If

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[10] *"Review of Operational Productivity in NHS providers"*, Lord Carter Review, Interim Report, June 2015, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/434202/carter-interim-report.pdf

[11] *"Blue Cross Blue Shield of Massachusetts Alternative Quality Contract"*, US Federal Government Agency for Healthcare Research and Quality http://www.ahrq.gov/workingforquality/pias/bcsbmapia.htm

[12] David Williams: *"Stevens: Funding growth may depend on 'transformation' plans"*, Health Service Journal, 13 October 2015, http://www.hsj.co.uk/news/finance/stevens-funding-growth-may-depend-on-transformation-plans/5091115.article#.VjDIsbFFBMs

you evidence your new care models proposals, you are more likely to obtain a slice of the £8bn funding."

This is significant. So far, new care models, especially early adopters under the Vanguard programme, attracted much praise for good ideas but little funding. This announcement fires the starting gun for local collaborations to develop 'shared sustainability and improvement plans' for 2016 onwards. Those who put forward credible plans will grab a slice of the available funding. Those who fail to think things through in time are liable to miss out.

JOINING THE DOTS

It is clear that the FYFV has set the NHS a considerable challenge. A year on, and the plan appears even more ambitious than originally envisaged. Most providers and commissioners still need to get their heads around what the most appropriate models are in their local areas, how to measure improvement, capitate budgets, ensure patient choice and manage long-term demand. However, these challenges, as complex as they are, can be overcome. The prize is a first class, cost-effective healthcare system.

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