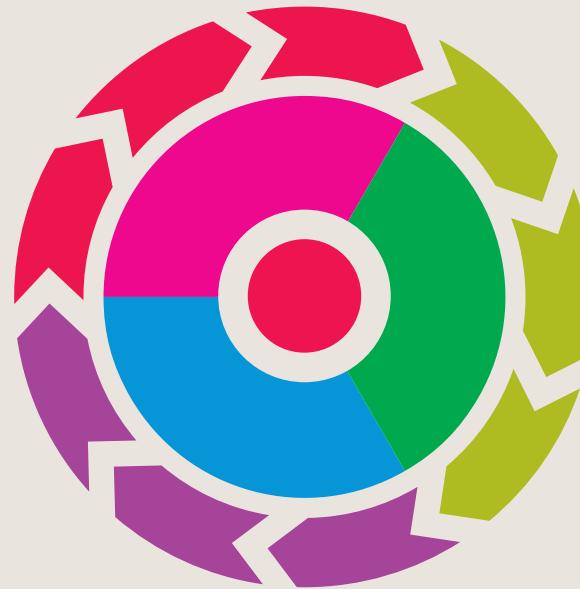


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## NEED TO NURTURE

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Outcomes-based  
commissioning in the NHS



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# Introduction

'Outcomes-based commissioning' is an enigma. Its definition is complex, its evidence base uncertain, and its early adoption in the English NHS has met with a number of issues. Yet it is being lauded as the future of health care by many people, both within the NHS and internationally. This paper examines what outcomes-based commissioning means, the evidence to support it, progress to date on introducing the approach in England, and the optimum role of national policy in response to it. It is aimed at policy makers who are considering how best to support outcomes-based commissioning, and local areas that may be considering adopting the approach. It is based on a rapid literature review and interviews with national policy makers as well as those in the NHS who are leading its development.

## Key points

- Outcomes-based commissioning is an approach to commissioning health care that is based on the combination of five components: (1) use of outcomes; (2) a population approach; (3) use of metrics and learning; (4) payments and incentives; and (5) coordinated delivery. Rather than an individual intervention, it is one part of a broader approach to transforming a whole health care system. It is closely linked to the concept of accountable care organisations (ACOs).
- The problem that outcomes-based commissioning seeks to solve is how financial flows and the commissioning process can best support quality and efficiency improvement across the system. The logic model for it is that providers are incentivised to collaborate to produce integrated services capable of delivering the outcomes that matter to their population, reducing duplication and waste. The current financial pressures facing the NHS mean that commissioners are increasingly attracted to it.

- There is promising evidence from areas that have adopted a form of this approach, including Ribera Salud in Valencia, Spain, the Pioneer ACOs in the United States, and Pennine Partnership in Oldham, UK. However, this is undermined by the lack of independent, robust studies and the perennial problem of untangling the effects of payment mechanisms from other factors.
- The past three years have seen a rapid increase in the use of outcomes-based commissioning in England and this is expected to continue. However, areas adopting the approach are finding that it is significantly harder and taking significantly longer than they expected. Common issues encountered include a lack of capability and skills in areas such as data analytics, measuring outcomes and creating markets.
- The outcomes-based commissioning approach is still in a development phase and will continue to be so for some time. To work well, outcomes-based commissioning needs to be nurtured. It will need careful, long-term support from policy makers, including NHS England, which should develop and support commissioners' capabilities; in addition, NHS Improvement (the combined Monitor/NHS Trust Development Authority) should support providers, particularly in primary care, to respond. There also needs to be far greater peer-to-peer learning between areas experimenting with the approach.

# What is outcomes-based commissioning, and why are people talking about it?

The use of the term ‘outcomes-based commissioning’ is generally misleading. Rather than referring to a commissioning approach that uses outcomes, it typically describes an approach to commissioning that is based on **five** components (including but not limited to outcomes). These are:

- a focus on populations
- the use of outcomes that matter to those populations
- the use of metrics and learning to monitor outcomes
- performance incentives and risk-sharing
- coordination of delivery across providers.

In this sense, ‘outcomes-based commissioning’ is more of a brand name than a description. There are other ways to commission for outcomes that do not use all five components. For example, the New Economics Foundation model of commissioning for outcomes<sup>1</sup> is defined by how commissioners work with service users and providers to define outcomes, rather than the use of performance incentives or coordinated delivery. There is significant crossover with the development of new contractual models such as alliance contracting or the prime provider model.<sup>2</sup> Even when all five components are used, schemes can differ significantly; for example, the amount of payment based on performance in the English NHS is commonly below 5%, compared with 80% in the UK government’s welfare-to-work programme.

Outcomes-based commissioning aims to incentivise providers to collaboratively produce integrated services capable of delivering the outcomes that matter to their population, reducing duplication and waste. The ability to reward higher performance is designed to incentivise providers to continually innovate to find better solutions to meet population needs – for example, through investing in preventing ill-health.

Outcomes-based commissioning requires providers to change their approach as much as commissioners; it is closely linked to the concept of accountable care organisations (ACOs), a term which has been used to define the *provision* of care within a system that uses the same five components. As such, outcomes-based commissioning is best seen as one part of an approach to transforming a whole health care system rather than an individual intervention. There is clear alignment between the principles of accountable care, outcomes-based commissioning, and the new models of delivering health and health care that are widely supported as being the way forward for the NHS.<sup>3</sup> There is a strong theoretical case that outcomes-based commissioning is better able to support the development of these new models than commissioning by activity.

In England, outcomes-based commissioning represents the latest attempt to see whether commissioning can deliver on the expectations placed on it. Since its introduction in 1991, there has been only limited evidence that the effort put into commissioning has delivered commensurate benefit; a review of commissioning under New Labour concluded that ‘When weighed against the transaction costs of running a commissioning system, the verdict would seem to be weak or at best equivocal’.<sup>4</sup>

Commissioners today are being asked to try and effect change at an ever-greater scale. However, they do not think that the tools they have available enable them to do so; when asked to identify the biggest barrier to addressing financial problems, leaders of clinical commissioning groups (CCGs) commonly

cited the per-treatment tariff system.<sup>5</sup> Many of the commissioners we spoke to saw outcomes-based commissioning as the best or even only way they could meet the financial, quality and transformational challenges they face. For example, comparing an outcomes-based approach to ‘maintaining the current system’, a report by South Nottinghamshire concluded that ‘moving to an outcomes-based commissioning and contracting model is most likely to meet citizen expectations and support the delivery of integrated care and more preventative/proactive care closer to people’s homes, although it will require significant effort and resource from commissioners’.<sup>6</sup>

Or, as one CCG accountable officer put it: ‘What I keep coming back to is, what other choice do we have? If we really want to change the paradigm of delivery, do we have any other options?’<sup>7</sup>

## Promising, but not proven

Are commissioners right to see outcomes-based commissioning as the answer to their woes? Tantalisingly, the evidence says ‘maybe’. The evidence base for using the approach in health care is limited, partly due to its novelty and the complexity of evaluating it. The evidence that is available is mixed, but it does contain promising studies (albeit from atypical contexts).

Evidence from England is particularly limited. In health care, musculoskeletal care in Oldham has been cited as a forerunner of some of the elements of an outcomes-based approach – a single provider acting as prime contractor across a pathway using indicators and incentives since 2006, and with a single budget since 2011. Cost and quality benefits have been reported, but not independently evaluated.<sup>8</sup>

In social care, outcomes-based commissioning has been used in the form of outcome measures and payment incentives (more than coordinated delivery or capitation) – for example, for domiciliary care in Wiltshire since 2012. Wiltshire has seen improvements in the customer experience,<sup>9</sup> but there seem to be few substantial differences from other councils at this stage.

In other public services, welfare-to-work has used an approach (‘The Work Programme’) based on coordinated delivery and payment on outcomes since 2011. Performance and value for money have been found to be similar to previous programmes, although there are some signs that the programme could be an improvement.<sup>10</sup> However, it is unclear whether this approach has discouraged providers from supporting the individuals who are hardest to help and therefore incur the greatest costs. The evidence on this is, as yet, inconclusive; the 2012 official evaluation of the programme observed that it was too early to tell whether the concern was justified.<sup>11</sup> It is reported that subsequent unpublished evaluations<sup>12</sup> have identified that this problem remains.

Internationally, the most commonly cited example of an outcomes-based commissioning approach in health care is the Alzira model in Valencia, Spain. This was developed by the private health care company Ribera Salud in partnership with the regional government. Ribera Salud receives a capitated (per head) payment for its patients (around 75% of the cost per resident elsewhere in Valencia). It seeks to improve patient outcomes through a complex care plan programme that has been running since 2012, and integrates medical and social services for elderly patients with two or more long-term conditions. A key part of its 'triangle for success'<sup>13</sup> lies in how it manages staff, which is seen as just as important as IT capability and clinical/demand management. There is a strong focus on professional development and the use of individual performance incentives.

Ribera Salud has demonstrated improvements, with overall hospital admissions decreasing by 28% and readmissions decreasing by 26% since 2012, although cost-effectiveness evaluations are still underway.<sup>14</sup> It has also seen favourable patient satisfaction scores, and staff absenteeism is well below the national and regional averages.<sup>15</sup> However, there is a lack of independent evaluation of the approach; data on the effectiveness of the model have been provided by Ribera Salud itself. Elsewhere in Spain, the Basque Country has used an outcomes-based commissioning approach as part of its local health service transformation. Reported effects include a 7% reduction in total health care expenditure in 2014 alongside sustained improvements in quality.<sup>16</sup>

In Asia, the Singapore Programme for Integrated Care for the Elderly uses local care centres and home care to enable frail elderly patients to be cared for in the community rather than hospital. It receives a capitated payment for patients, which allows providers to deliver innovative care reforms with defined outcome targets, focusing on wellness and patient preferences. The programme has demonstrated improvements, which include halving the number of emergency admissions and enabling around 70% of those patients who died within a year of its launch to die at home as they had requested.<sup>17</sup>

The Alternative Quality Contract, in Massachusetts, US, has been running since 2009 with a capitated budget and linked quality premium. A *New England Journal of Medicine* study in October 2014 showed that it had improved the quality of patient care and lowered costs in its first four years. Costs in the first two years were 2.8% lower for enrollees whose primary care providers had entered the Alternative Quality Contract. This was due to shifting care to lower-cost providers and, to a lesser extent, reducing utilisation.<sup>18</sup> It appears popular: 75% of eligible providers have adopted the contract.<sup>19</sup>

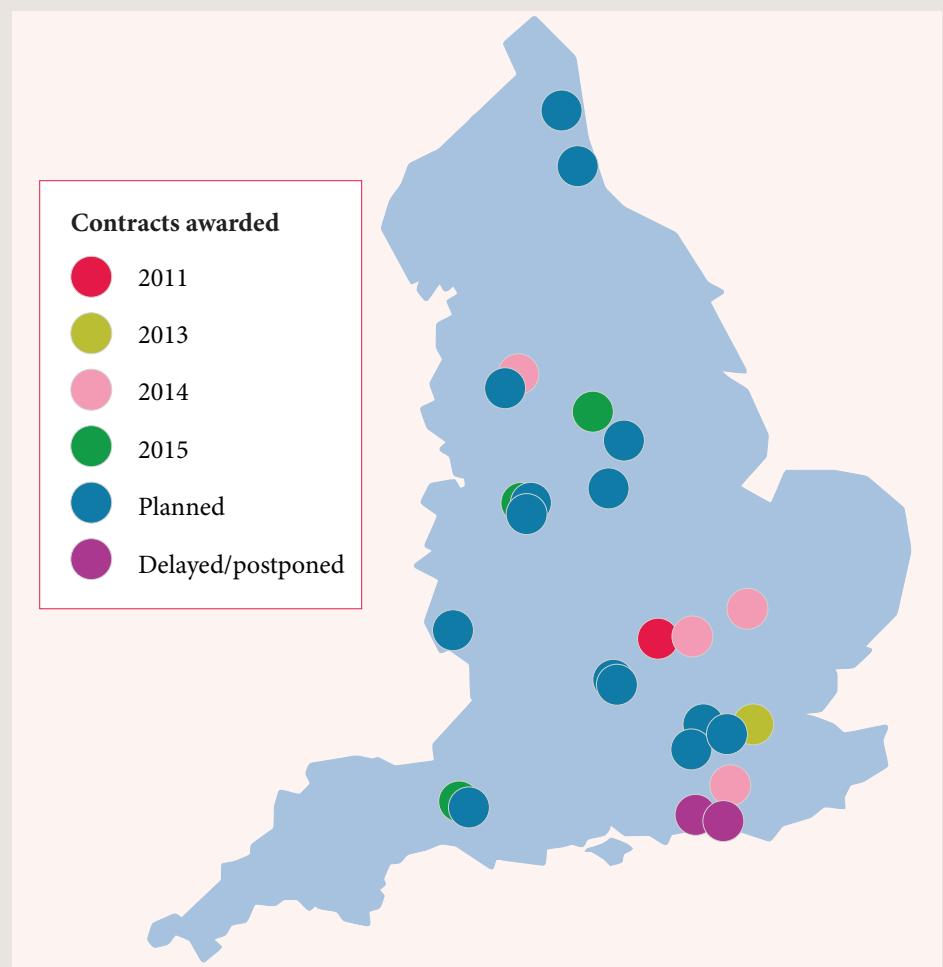
In the United States, 'accountable care organisation' (ACO) refers to a model of payment whereby a group of providers are rewarded if they reduce growth in health spending for a defined population while maintaining or improving quality. A sub-set of these, the Pioneer ACOs, have been running as part of Medicare since 2012. Of the original 32 (selected because they had already demonstrated capacity to manage the care of a patient population), 10 showed statistically significant savings, 10 had significant savings in only one of the two years (with two having significant losses in the other year), and 12 had no significant savings or losses. Savings among the highest performers are likely to be due, in large part, to decreased hospital use; the 10 with savings in both years were more likely to show significant and larger reductions in acute inpatient stays, procedures, imaging and tests than the other 22.<sup>20</sup>

Savings appear to have been achieved without significant impact on quality.<sup>20</sup> In terms of the patient experience, Pioneer ACOs appear to have slightly higher satisfaction scores for timeliness of care and clinician communication.<sup>21</sup> Evaluations of the Pioneer ACO model to date make clear the variability of progress, with the model not guaranteeing success: 'Reducing Medicare spending through the Pioneer ACO model, then, likely depends on an array of market, organizational, programmatic, and physician-related factors that should be better understood in future implementation and research'.<sup>20</sup>

# The English experience

Although the first scheme only started in 2011, there is now rapid expansion of outcomes-based commissioning across England (see Figure 1). For more details about the projects being introduced, see the Appendix to this paper (pages 22-23) and an interactive version of the map, available on [www.health.org.uk/obc](http://www.health.org.uk/obc)

**Figure 1: Award of outcomes-based commissioning contracts in England**



The experience of commissioners to date has highlighted that an outcomes-based approach requires a different skill set to traditional commissioning. This involves a stronger focus on the strategic elements of commissioning, rather than the tactical, as can be seen in how the 'commissioning cycle' changes under outcomes-based commissioning, as shown in Figure 2 overleaf.

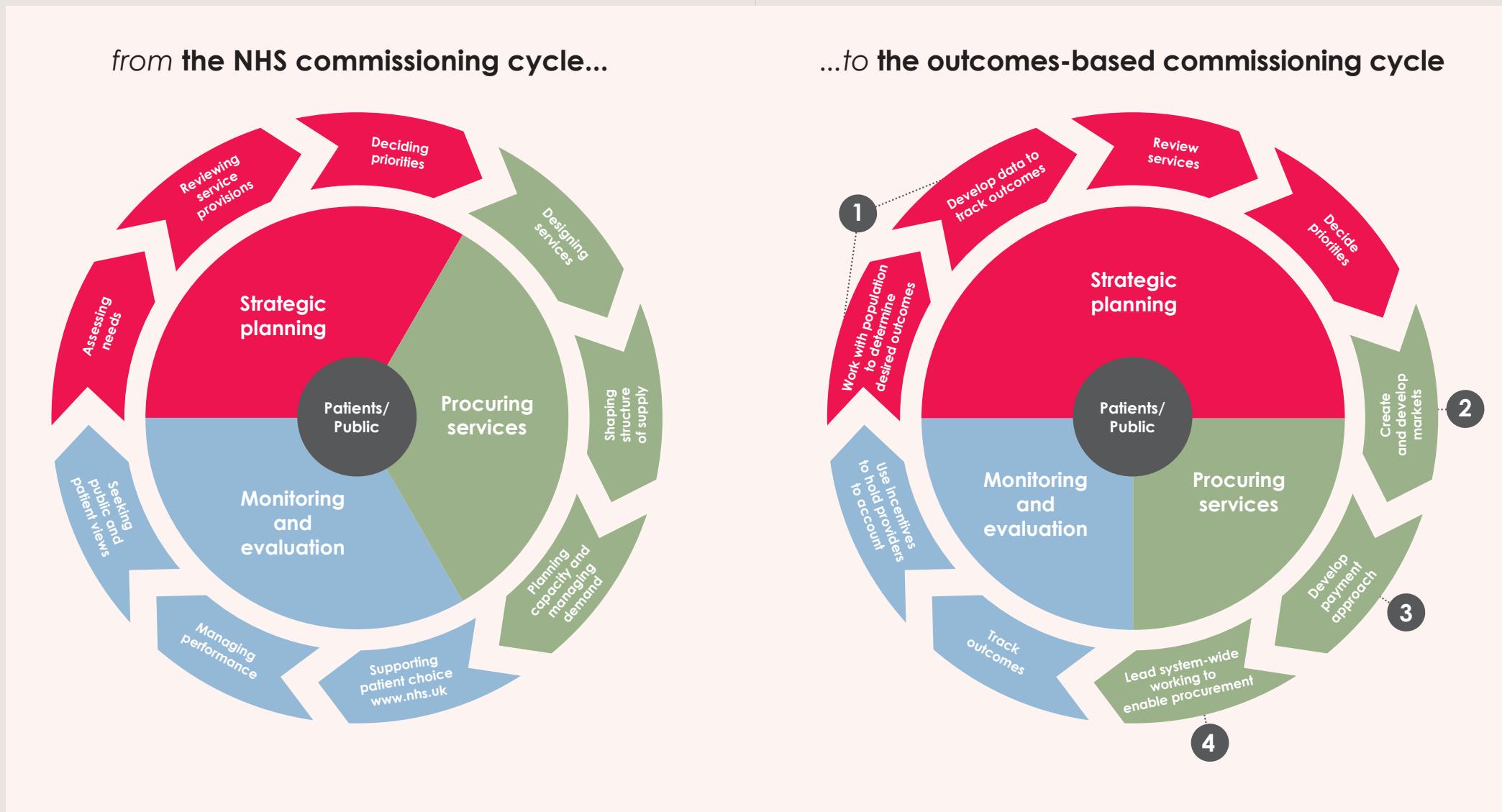
The following pages discuss four areas where different skills and capabilities are needed, drawing on the experience of outcomes-based commissioning in the English NHS to date. While there has been significant attention to the contracting element,<sup>22</sup> the commissioning process is as much a social process (eg working with populations and providers) as a technical one (eg determining payment currencies).

## 1: Work with population to determine outcomes, and develop data to track outcomes

The outcomes-based commissioning process requires commissioners to work constructively with their local populations to determine the health outcomes that matter most to them. This requires capability in patient and public involvement skills, and in developing measures to track outcomes.

A number of areas, such as North Somerset, have used and built on the 'T' statements developed by National Voices.<sup>23</sup> Other areas, such as Milton Keynes, have asked service users and providers to answer some basic questions: 'If this was a good service, what would it achieve? How would we know?' The answers have enabled them to define outcomes around employment, homes, and support required on leaving prison.<sup>24</sup> In Richmond, the process involved working with two other bodies, Commissioning for Outcome-Based Incentivised Care (COBIC) and the Innovation Unit, to undertake ethnographic interviews, and co-design workshops and 'drop-in' sessions in the community.<sup>25</sup>

**Figure 2: From the NHS commissioning cycle to an outcomes-based commissioning cycle**



Given the paucity of outcomes data in the NHS, many outcomes-based commissioning schemes are having to set up new data collection systems in order to track progress. Developing this infrastructure does not necessarily have to run ahead of contracts being awarded; in Staffordshire, the CCGs, Macmillan and the selected prime provider will spend the first two years of a 10-year contract developing the data required to make the outcomes-based contract work. It will not be until the third year that the prime provider is managed and incentivised against outcomes, having been paid a standard fee up until that point.

One other area described its approach as having three parts: data that could be collected and used immediately; data that may be available but requires new analysis or needs a baseline; and indicators that would require new data collection. Its approach to incentives was designed to progress as more data became available.

## 2: Create and develop markets

Commissioners also need to support the creation and development of markets of providers that can deliver the proposed contracts. As Nick Hicks<sup>\*</sup> said: ‘If the commissioner expects, once they have developed an outcome-based contract, that providers will be able to simply reply to that contract, then they are not recognising the scale of change that will be necessary.’<sup>24</sup>

Commissioners need to work with primary care and voluntary providers in particular so that they are able to develop more services outside of hospital. They need support so they can participate in the procurement process, have the skills and capacity to develop innovative delivery approaches, and are able to manage supply chains where needed. In Staffordshire, for example, a community interest company<sup>26</sup> has been established specifically to help a number of primary care federations, voluntary groups and NHS mental health trusts with the infrastructure they need to be

able to bid for prime provider contracts. In Brighton, procurement has been delayed after the voluntary sector lead provider who won the contract was unable to reach subcontracting agreements with a number of NHS and non-NHS organisations.<sup>27</sup>

## 3: Develop a payment approach

Outcomes-based commissioning enables commissioners to tailor the approach and payment currency used to a specific population and the outcomes that matter most to them. As a consequence, this requires commissioners to have, or acquire, skills to develop their own payment currencies rather than relying on national prices. This requires technical expertise, particularly with regards to the use of capitation and risk-sharing. Monitor has produced a useful guide on this in response to requests from providers and commissioners alike.<sup>28</sup>

Developing payment systems is a significant capability gap for many CCGs; many of those we spoke to had procured consultancy support to enable them to proceed. One commissioner said: ‘The only thing we were clear about was that it was about patients, their carers, and doing the right thing for them. We had no framework for pricing, outcomes, 10-year contracts or service delivery.’

Another commissioner had originally intended to hold back 20% of the contract value to be contingent on achieving certain outcomes. However, after undertaking financial modelling, they realised this would be too risky for prospective providers. Having entered negotiations aiming for 5% based on outcomes, the CCG reached agreement with the provider at 2.5%.

## 4: Lead system-wide working to enable procurement

Outcomes-based commissioning requires commissioners to lead discussions across a health care system about how best to meet the needs of the specified population. This requires a collaborative working relationship with providers, and a particular skill set. Commissioners and providers have both said that the hardest

<sup>\*</sup> Founder of COBIC and Chief Executive of the primary care trust (PCT) that introduced the first outcomes-based commissioning scheme in England.

part of outcomes-based commissioning is building constructive partnerships; putting a contract in place is only the beginning and does not guarantee that providers are going to work together.

There are examples where commissioners and providers have not been able to reach agreement. In Oxfordshire, following objections from two local NHS trusts, the approach was postponed and the CCG accountable officer resigned (although progress has since resumed).<sup>29</sup> In Coastal West Sussex, an independent review found that the removal of MSK services from the local trust would lead to it becoming unsustainable.<sup>30</sup> And in Bedfordshire, the local acute trust refused to become a subcontractor for the winning prime contractor. These cases have contributed to a situation whereby most of the outcomes-based commissioning contracts are now being proposed on a ‘most capable provider’ basis, focusing on local providers rather than competitive procurement.

#### Time and resource

The pioneering commissioners who have already embarked on outcomes-based commissioning also stressed the amount of time and resource it had taken to develop their approach; all of those we spoke to said it had taken significantly longer and been significantly more complex than they expected. Some expressed doubts that they would have started along the outcomes-based commissioning route had they known just what it was going to take. ‘You start off thinking it will be simple, then you quickly learn that it’s not’,<sup>31</sup> was a sentiment echoed in numerous interviews. In Oldham, it took 10 years to develop the Pennine MSK Partnership into its current form. Calculating the overall programme budget for musculoskeletal care proved particularly complex and time-consuming.<sup>32</sup>

In terms of financial resource, the commissioning transformation costs in Staffordshire amounted to £860,000, financed by Macmillan.<sup>22</sup> In Cambridgeshire, the CCG spent £1m a year setting up its transformation programme.<sup>22</sup> Procurement in Coastal West Sussex cost the CCG £348,000 over two years.<sup>33</sup> This is against a backdrop of reduced CCG running cost allowances, set to fall by 20% (real terms, per head) between 2013/14 and 2018/19.<sup>34</sup>

## Need to nurture

The NHS needs to change at pace and scale. Innovative new models of care are being developed (for example in the vanguard sites) that have the potential to improve outcomes and, potentially, efficiency. Policy makers need to consider how the range of NHS policy ‘levers’ can best be used to deliver the change that is needed – or at least not inhibit it.

It is hard to dispute the logic that it is right to focus on the outcomes that matter to a given population, combined with the alignment of incentives and indicators to drive improvement and coordination between providers. Some of the most eloquent advocates of accountable care in the United States, such as Mark McClellan at the Brookings Institution and Tim Ferris at Partners HealthCare, argue that the main strength of the approach is that it enables clinicians to deliver care in a way they always wanted to but were unable to because of payment structures. The evidence to date holds promise in some areas, although is not strong – but then neither is it for concepts such as integration of care. This is not to say it is wrong, only that learning from early experiences should be a priority.

On this basis, outcomes-based commissioning in the NHS is worth further exploration and experimentation. The concept is very much in a development stage, and it may well be five or 10 years before it is possible to proceed with significantly greater confidence than today. The role for policy makers is to have a long-term plan to nurture outcomes-based commissioning through this phase, setting the right pace for its development. Go too slow, and potential benefits will be lost at a time when they are needed most; go too fast, and the whole approach risks being discredited. A limited evidence base, weak capability and mounting financial pressures are all common components of reports by the Public Accounts Committee.

What should a 10-year plan include? The first component is a strategy to develop commissioning capability. When Milton Keynes PCT proposed the first outcomes-based commissioning approach in 2011, its board ‘expressed huge concerns about the capacity and capability of the PCT to deliver the change required.’<sup>35</sup> This concern is now writ large. But how can capability be built, given that recent history is littered with such attempts?

The most drastic ‘pre-1991 option’ is to seek to abolish commissioning, and focus all capability-building efforts on the provider side. It is clear that some areas are actively seeing this as their preferred option; Northumberland, Somerset and South Nottinghamshire CCGs have all published proposals for whole population contracts (potentially with values of between £700m and £900m per year), which leave a very small role for the commissioner. One CCG accountable officer interviewed had banned the word ‘commissioning’ from the organisation due to it being an ‘outdated concept’. They had invested the majority of their running cost allowance into the development of new provider models.

Even if issues with procurement and competition law (which are actively being explored) are resolved, the question of who holds providers to account for their outcomes would remain. This is an expert function, and one which requires capability to deliver it. It would also represent seeking to implement outcomes-based commissioning in the largest possible way immediately. This is in contrast to the experience of accountable care organisations in the United States which indicates that taking an incremental approach is likely to be more beneficial.

The similarly structural ‘2005’ option is to look to radically rationalise the number of CCGs in order to concentrate the available talent; this was the rationale used a decade ago when the number of PCTs shrank from 303 to 152. However, there is limited evidence that such a move would work: increasing the size of any organisation also increases complexity, which means a shortage of talent is likely to remain.<sup>36</sup> Any such benefits

would have to be balanced against the inevitable disruption that organisational change incurs; those PCTs that were reorganised in 2005 performed significantly less well in the Healthcare Commission 2006/07 Annual Health Check than those that were left unchanged.<sup>36</sup> Studies of reorganised Whitehall departments typically show a dip in effectiveness and a two-year delay before any benefits are realised.<sup>36</sup>

In contrast, the ‘2008 option’ was to invest in the capability of commissioning staff through the World Class Commissioning programme. While it was never evaluated, there is evidence<sup>37</sup> of improvements prior to the programme’s abolition; in their final assurance test in 2010, PCTs improved by an average of 42% in scores across tests of their individual competency.

The ‘2015 option’ needs to learn from all of these attempts to develop commissioning capability, placing support for CCGs at the centre. There is room for a stronger role for national bodies – in particular NHS England in supporting CCG development and Health Education England in supporting the long-term capability of commissioning staff. NHS England’s current role in supporting CCGs is unclear: in 2013, its ‘Commissioning development’ directorate published a development framework committing that ‘every CCG will be supported to access development support that recognises its local circumstances and differing stages of maturity’.<sup>38</sup> This framework has not reappeared, and the directorate no longer exists.

Instead, current policy puts the onus on individual CCGs to procure their own support. This needs to be complemented by using the scale of the NHS to deliver far greater support across England. This could include the right system leadership skills for large-scale change, or ensuring that CCGs have access to analytical and actuarial expertise so that they can accurately assess risk or deployment of resources. An emphasis on national bodies supporting local organisations is already being seen with the rise of NHS Improvement, which aims to help make the NHS ‘the world’s largest learning organisation’.<sup>39</sup> NHS England

should follow suit with a more proactive role in supporting commissioners, particularly given that CCGs are starting to take on the co-commissioning of primary care and specialised services. Commissioning needs to be recognised as an expert skill; Health Education England's mandate should be expanded to include commissioners in order to develop long-term capability.

Learning needs to be fostered between the areas that are already experimenting. The primary implication of the limited evidence base so far is that successes and failures, across providers as well as commissioners, must be shared more readily. Such an approach is seen in the United States, in the 'accountable care organisation learning network' facilitated by the Brookings Institution. An equivalent body is needed in England, and could potentially grow out of the vanguards programme. It should look to connect and glean knowledge not only from health, but from all areas of the public sector (such as social care, welfare to work, and justice) that are experimenting with similar approaches, as well as from international organisations.

Given the acute short-term pressures on the NHS, mandated top-down reorganisation is likely to hinder rather than help capability at this critical time. CCG functions are increasing at the same time as their resources are reducing. Greater joint working and shared services across organisations are likely to be essential; the implication of outcomes-based commissioning is for commissioning to focus on being strategic, not tactical, and shared across the health and care systems. As such, there will be areas where structural change (even of the radical variety proposed in Somerset and elsewhere) best fits the local context and should be supported. The test – for commissioners and for NHS England – must be whether such changes help in the short term and deliver potential benefits in the medium or long term.

Capability building for commissioners needs to be matched by capability building for providers. Delivering outcomes-based care requires providers to understand their own costs in delivering that care and take responsibility for population health

management; a prime provider will need to commission other providers to deliver different elements of a pathway of care and then coordinate patient care along those pathways.<sup>40</sup> The question for NHS Improvement is how such capability building can be accelerated over the next five years, and which areas should receive priority.

Strengthening capability in primary care is key: CCG reform plans are focused on services outside hospital, and many prefer primary or community providers to be in charge of new arrangements.<sup>41</sup> For the most part, they do not have the capacity or capability to take responsibility for population health management, risk stratification and care coordination at scale.<sup>42</sup> Increased working with providers of community services may be one way for emerging GP provider organisations to operate at scale more quickly, particularly providing practical support in areas such as data analysis or communications.<sup>43</sup> The formation of GP federations also starts to provide a base for this, and over time, federations may move to a position where they can start to do this. Fundamentally, if effective, outcome-based commissioning will result in new models of care displacing existing models, most likely to be hospital services. Disruption is part of the proof that it is having an effect. If policymakers and politicians are to support outcomes-based commissioning it will entail facilitating change to happen, then backing it even in the face of controversy.

To want outcomes-based commissioning to succeed requires an acknowledgement that it is fragile, risky, and has the potential to fail. This is an experiment the Health Foundation supports; but it has to be treated as just that – an experiment that requires close observation and keen learning to build understanding and capability over time.

# Appendix: Outcomes-based commissioning in England

This table gives details of outcomes-based commissioning contracts awarded in England. This list is not exhaustive and there are many other areas that are planning to introduce an outcomes-based commissioning approach.

| Area   | Services covered                              | Contract length (years) | Contract value (per year) | Contract awarded |
|--|---|-------------------------|---------------------------|------------------|
| Bedfordshire                                       | Musculoskeletal                               | 5                       | £24m                      | 2014             |
| Bexley   | Musculoskeletal                               | 5                       | £3.3m                     | 2013             |
| Brighton   | Dermatology                                   | 3                       | £2m                       | Delayed          |
| Brighton and Hove, Crawley and Horsham, Mid Sussex | Musculoskeletal                               | 5                       | £42m                      | 2014             |
| Cambridgeshire                                     | Older people's services                       | 5                       | £160m                     | 2014             |
| Coastal West Sussex                                | Musculoskeletal                               | 5                       | £47m                      | Postponed        |
| Croydon  | Older People                                  | 10                      | £178m                     | Planned          |
| Herefordshire                                      | Urgent care services                          | N/A                     | N/A                       | Planned          |
| Mid Nottinghamshire                                | Older people, mental health, adults with LTCs | N/A                     | N/A                       | Planned          |
| Milton Keynes                                      | Substance misuse                              | N/A                     | N/A                       | 2011             |
| Northumberland                                     | Whole population                              | N/A                     | N/A                       | Planned          |
| Oldham   | Musculoskeletal                               | 3                       | £22.5m                    | 2014             |
| Oxfordshire  | Adult mental health                           | 5                       | £35m                      | Planned          |
| Oxfordshire  | Older people                                  | 5                       | £80m                      | Planned          |

| Area                  | Services covered  | Contract length (years) | Contract value (per year) | Contract awarded |
|-----------------------|---|-------------------------|---------------------------|------------------|
| Richmond              | Adult community services  | N/A                     | N/A                       | Planned          |
| Salford               | Older people  | 3.5                     | £200m                     | Planned          |
| Sheffield             | Musculoskeletal   | 5                       | £40m current spend        | 2015             |
| North Somerset        | Community services  | 5                       | £26m                      | 2015             |
| Somerset              | Whole population health and care (with exceptions)  | N/A                     | £793m current spend       | Planned          |
| South Nottinghamshire | Whole adult population  | N/A                     | £930m current spend       | Planned          |
| Staffordshire         | Cancer  | 10                      | £68.7m                    | Planned          |
| Staffordshire         | End of life   | 10                      | £53.5m                    | Planned          |
| Staffordshire         | Coordinate services for frail elderly patients, those with long term conditions and intermediate care | 7                       | £40m                      | 2015             |
| North West Surrey     | Musculoskeletal   | 5                       | N/A                       | Planned          |
| Newcastle Gateshead   | Care homes, extending to home care and community services   | N/A                     | N/A                       | Planned          |

For more information, and details of the information sources about these contracts, see the interactive map at [www.health.org.uk/obc](http://www.health.org.uk/obc)

# References

1. Slay J, Penny J. *Commissioning for outcomes and co-production: a practical guide for local authorities*. London: New Economics Foundation, 2014.
2. Billings J, de Weger E. Contracting for integrated health and social care: a critical review of four models. *Journal of Integrated Care*. 2015;23(3):153–75
3. See, for example, Taunt R, Lockwood A, Berry N. *More than money: closing the NHS quality gap*. The Health Foundation, 2014. pp 24–25
4. Smith J, Curry N, ‘Commissioning’. in Mays N, Dixon A, Jones L (eds). *Understanding New Labour’s market reforms of the English NHS*. London: The King’s Fund, 2011.
5. Thomas R. CCG barometer: ‘worrying’ lack of confidence in dealing with deficits. *Health Service Journal*. 11 August 2015. [www.hsj.co.uk/5089528.article#.VdcP5vVhBc](http://www.hsj.co.uk/5089528.article#.VdcP5vVhBc) (accessed 16 Sept 2015).
6. South Nottinghamshire Case for Change for outcomes-based commissioning and contracting. [www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2015/02/OBCCaseforChange-Exec-Summary.pdf](http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2015/02/OBCCaseforChange-Exec-Summary.pdf) (accessed 16 Sept 2015).
7. Roundtable discussion, CCG Accountable Officer
8. NHS Confederation. *Beginning with the end in mind: how outcomes-based commissioning can help unlock the potential of community services*. London: NHS Federation Community Health Services Forum, 2014.
9. Bolton J. *Emerging practice in outcomes-based commissioning for social care: discussion paper*. Institute of Public Care, 2015.
10. National Audit Office. *The Work Programme*. HC 266 Session 2014–15 2 July. London: Department for Work and Pensions. 2014.
11. Newton B, Meager N, Bertram C, Corden A, George A, Lalani M, Metcalf H, Rolfe H, Sainsbury R, Weston K. *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery*. DWP Research Report 821, November 2012, p 124
12. Gibbon G. Work programme needs more work. *Channel 4 News blog*, 12 March 2014. <http://blogs.channel4.com/gary-gibbon-on-politics/work-programme-work/27769> (accessed 16 Sept 2015).
13. de Rosa A. *New Management Models: The Experience of Ribera Salud*. NHS England, 2014.
14. Brookings Institute. *Spain: Global accountable care in action*. Brookings Institute, 2015.
15. NHS Confederation. *The search for low-cost integrated healthcare: The Alzira model – from the region of Valencia*. NHS Confederation, 2011.
16. Kent Surrey Sussex Academic Health Science Network. *Delivering more sustainable services: Basque country shows it can be done*. Crawley, 2014.
17. McClellan M, Kent J, Beales S, Cohen S, Macdonnell M, Thoumi A, Abdulmalik M, Darzi A. Accountable care around the world: a framework to guide reform strategies. *Health Affairs* 2014; 33(9):1507–15.
18. McClellan M, Rivlin A. Improving health while reducing cost growth: what is possible? In: *The future of US healthcare spending conference, 11 April 2014*. The Brookings Institution.
19. Rosen R. Learning from the Alternative Quality Contract. *Nuffield Trust blog*. January 2012. [www.nuffieldtrust.org.uk/blog/learning-alternative-quality-contract](http://www.nuffieldtrust.org.uk/blog/learning-alternative-quality-contract)
20. Pioneer ACO Evaluation Findings from Performance Years One and Two. Evaluation of CMMI Accountable Care Organization Initiatives Contract HHS-500-2011-00019i / HHS-500-T0002. Washington DC: L&M Research, March 2015.
21. Nyweide DJ, Lee W, Cuerdon TT, Pham HH, Cox M, Rajkumar R, Conway PH. Association of Pioneer Accountable Care Organizations vs traditional Medicare fee for service with spending, utilization, and patient experience. *JAMA*. 2015;313(21):2152–2161. doi:10.1001/jama.2015.4930
22. Addicott R. *Commissioning and Contracting for Integrated Care*. London: The King’s Fund, 2014.
23. National Voices, Think Local Act Personal. *A Narrative for Person-Centred Coordinated Care*. London: NHS England, 2013.
24. Corrigan P, Hicks N. *What organisation is necessary for commissioners to develop outcomes based contracts? The COBIC case study*. Right Care, 2012.
25. COBIC. *Transforming community services for 187,000 people in Richmond*. [www.cobic.co.uk/community-services-in-richmond](http://www.cobic.co.uk/community-services-in-richmond) (accessed 17 Sept 2015).
26. CareMesh. [www.caremash.org](http://www.caremash.org) (accessed 17 Sept 2015).
27. Barnes S. Dermatology procurement delayed after preferred bidder pulls out. *Health Service Journal*, 2015.
28. Monitor and NHS England. Local payment examples. *Capitation: a potential new payment model to enable integrated care*. London: Monitor and NHS England, 2014.
29. Williams D. Trusts force delay in outcomes based commissioning plan. *Health Service Journal*, 2013.
30. Barnes S. Bupa and CSH Surrey pull out of £235m MSK contract. *Health Service Journal*, 2015.
31. Roundtable discussion, CCG Accountable Officer

32. Corrigan P, Nye A. Pennine MSK Partnership: A case study of an Integrating Pathway Hub (IPH) 'Prime Contractor', 2012. [www.rightcare.nhs.uk/downloads/Right\\_Care\\_Casebook\\_oldham\\_IPH\\_april2012.pdf](http://www.rightcare.nhs.uk/downloads/Right_Care_Casebook_oldham_IPH_april2012.pdf) (accessed 17 Sept 2015).
33. Ryan S. Aborted Bupa contract costs NHS £348,000. *The Argus*, 7 February 2015.
34. NHS England. *Calculation of CCG Running Costs Allowances 2014-15 to 2018-19*. Gateway Reference 01135. [www.england.nhs.uk/wp-content/uploads/2014/02/calc-run-costs-allow.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/02/calc-run-costs-allow.pdf) (accessed 17 Sept 2015).
35. Minutes of the Trust Board Meeting held on Thursday 27th May 2010, Milton Keynes Primary Care Trust Board.
36. Edwards N. *The triumph of hope over experience: lessons from the history of reorganisation*. London: The NHS Confederation, 2010.
37. Gainsbury S, Taylor A, Lewis S. World class commissioning: PCTs raise the bar in final assurance test. *Health Service Journal*, 2010.
38. NHS England. CCG development framework. NHS England, 2013, p5.
39. Hunt J. Making healthcare more human-centred and not system-centred. Speech delivered at The King's Fund, July 2015. [www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred](http://www.gov.uk/government/speeches/making-healthcare-more-human-centred-and-not-system-centred) (accessed 17 Sept 2015).
40. Bell D, Kelley T, Hicks N. How true outcomes-based commissioning can really 'liberate' healthcare services. *Future Hospital Journal* June 2015.
41. Welikala J, West D Exclusive CCG survey: Deficits threaten hopes for radical reform *Health Service Journal* 3 September 2014. [www.hsj.co.uk/news/commissioning/exclusive-ccg-survey-deficits-threaten-hopes-for-radical-reform/5074409.article?blocktitle=CCG-barometers&contentID=15612#VfvUat9VhBc](http://www.hsj.co.uk/news/commissioning/exclusive-ccg-survey-deficits-threaten-hopes-for-radical-reform/5074409.article?blocktitle=CCG-barometers&contentID=15612#VfvUat9VhBc) (accessed 17 Sept 2015).
42. For example, see: Smith J, Holder H, Edwards N, Maybin J, Parker H, Rosen R, Walsh N. *Securing the future of general practice: new models of primary care*. London: Nuffield Trust, 2013.
43. NHS Confederation discussion paper. *The art of the possible: what role for community health services in reshaping care?* NHS Confederation, 2015.

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