Project Name	**Business Case:** **To support the introduction of Outcomes Based Contracting – MENTAL HEALTH**

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1. Executive Summary


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An outcomes based approach to commissioning mental health services is a key enabler to delivering the "Better Mental Health in Oxfordshire" strategy within an affordable financial envelope. The concept of commissioning for outcomes in mental health is uncontroversial, fits well with concepts of recovery and well-being and promotes a holistic view of the needs of both users and carers. Its development has had significant stakeholder engagement and has been endorsed by the Better Mental Health for Oxfordshire Board and the Mental Health JMG.

Outcomes based commissioning is an innovative approach to commissioning that align incentives to deliver value through improving outcomes for people and their carers, driving transformational efficiencies. This also helps drive the delivery of integrated care across health and care economies. There is a good evidence base of their successful implementation in a number of systems internationally.	**Introduction and approach**
The approach allows focus on relevant population groups, yet retains the link to HONS PBR. This means there will be an improvement of outcomes for people and their carers focusing on their specific problems and issues relating to Anxiety and depression, Alcohol and substance abuse, Psychosis including schizophrenia and Behavioural and developmental disorders.	**The context today**
The financial envelope is £37m. There is potential to fund the investment required in primary care to deliver an enhanced service from efficiencies and so remain within this financial envelope.	**Financial Case for change**
The current system constrains clinicians and professionals to providing care within a setting, resulting in hand offs of the patient. OBC will promote coordination of services around the person with access to different levels and intensity of care and support in a preventative way according the person's need.	**The Vision**
The outcomes have been developed from extensive engagement with experts, clinicians and service users and include: People will live longer, People will improve their level of functioning, People will receive timely access to assessment and support, Carers feel supported in their caring role, People will maintain a role that is meaningful to them, People continue to live in settled accommodation, People will have less physical health problems related to their mental health.	**Segmentation and scope**
Mental Health services should include: Holistic care focused on both mental and physical health, co production between local people and clinicians, collaboration between providers, seamless access to rapid support in a crisis, Health and Social care services working in partnership.	**Segmentation and scope**
A change in contractual arrangements is required. From discussions with Monitor this can be achieved within current guidance.	**Commercial & contractual options**

The process of building the business case in developing the outcomes that matter, engagement with service users and clinicians, has enabled a momentum and dialogue with providers of these services in Oxfordshire that has not been achieved previously.

2. Introduction and Approach


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Support to implement Outcomes Based Contracting

OCCG's specification for this contract for their programme to deliver outcomes based services sought support to develop outcomes based contracts for three service areas maternity, mental health and older people to build on the work undertaken in Phase 1.

The CCG requested that this work was delivered in two further phases (Phase 2 and Phase 3).

This business case represents the activity undertaken in Phase 2 to support this work as required - specifically:

- the clinical vision
- defined outcomes
- financial envelope
- potential for improvement
- recommending contractual options for the service areas

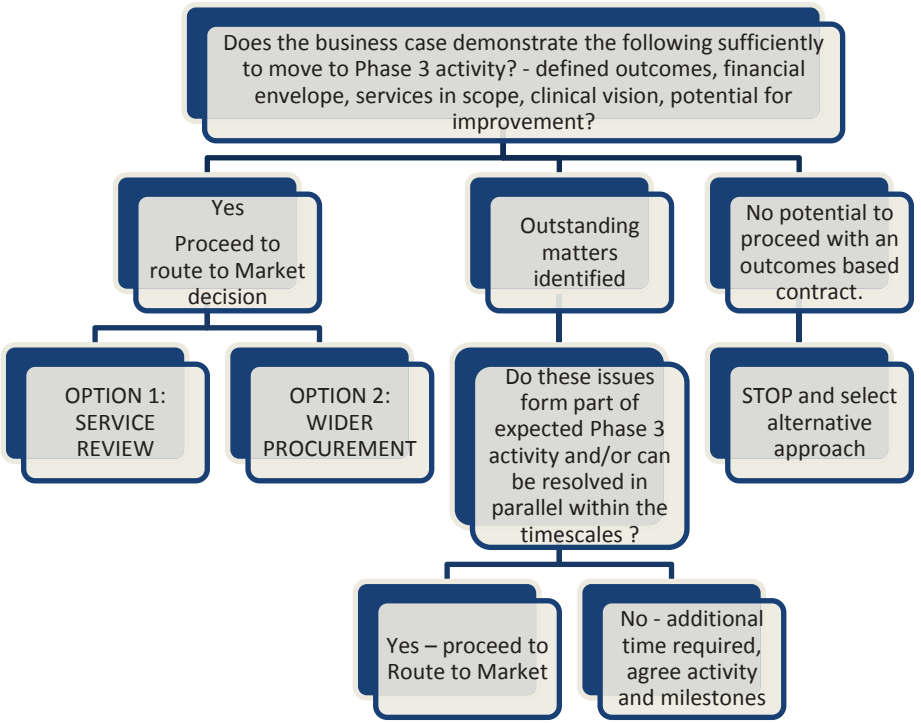
This represents a "stop-go" point in the process for the OCCG to take a decision regarding proceeding to Phase 3.

"The CCG wants the ability to review and monitor this work appropriately; including defined milestones of "stop/go" points, particularly between Stage 2 and Stage 3 and where decision makers can review progress and ensure on-going alignment with CCG strategic objectives."
"Phase 3:- Based of the recommendations agreed from Phase 2 the CCG would require support moving into revised contractual arrangements for 2014-15. (The scope of this will be very dependent on Phase 2)."
(OCCG ITT specification document June 2013)

The process for decision

The final business case will be presented to the OCCG Outcomes Based Commissioning Programme Board on Tuesday 19th November. This group will make recommendations to the OCCG Governing Body on 28th November 2013.

In reaching the decision OCCG is considering the following questions for all service areas.



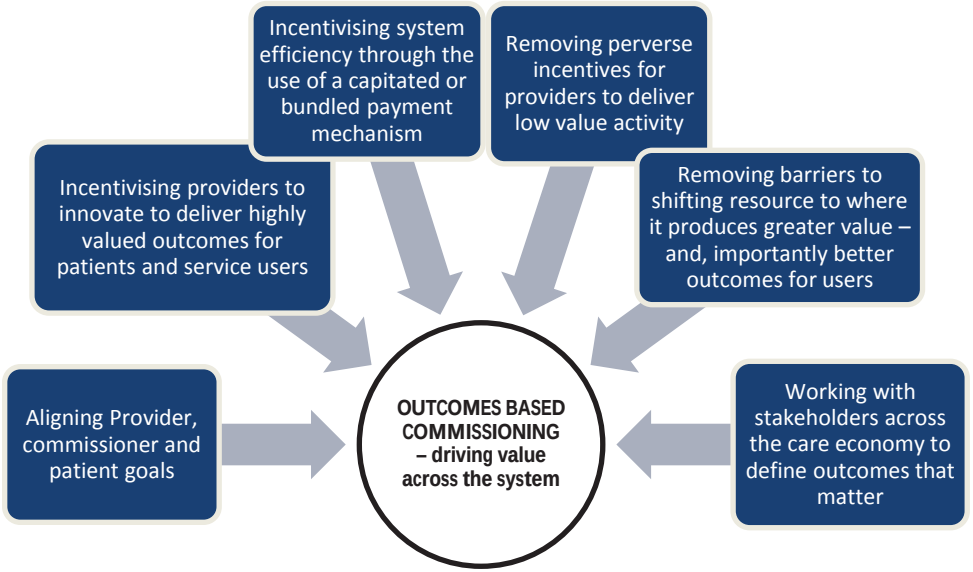
Outcomes Based Commissioning – OBC - is a value-driven approach to commissioning. In simple terms it is a process that links the "Outcomes that matter to patients/carers" to the contractual framework.

The health and care system currently faces an unprecedented set of financial and quality challenges. These are well known, and include a potential funding gap of up to £56 billion for the NHS in England by 2021/22, alongside an existing funding crisis in social care.

Meeting these challenges requires a new approach, a shift from activity to outcomes; from episodic, fragmented care to a co-ordinated whole system approach. OBC seeks to drive this through a new commissioning model; aligning incentives across the care economy to create an environment where providers must collaborate and innovate to deliver outcomes focused care which provides value for money.

Through this approach OBC aims to deliver:

Service innovation	•Through a new clinical model of care designed by both clinicians and key stakeholders across the system that focuses on the outcomes patients want, not on the input activity PbR rewards
Contractual Innovation	•Through the procurement of a Prime Contractor/ Accountable Lead Provider or integrator who will be responsible clinically and financially for the services that the CCG and Local Authority requires
Improved value for money	•With better outcomes and improved quality by incentivising a shift of resources to where they are needed most, and a shift in culture so that providers and commissioners work to a common aim



OBC is a mechanism to drive change, applying a new approach to working with clinicians and stakeholders across the care economy. Central to the approach is engagement with patients and service users to find out what outcomes they want. Outcomes based contracts transfer appropriate risk to providers and create the circumstances and incentives to allow them to innovate and profit from success – provided they manage the costs and deliver the outcomes your population wants. To do so, providers must collaborate, problem solve, and deliver efficient, integrated services.

Each COBIC covers all care for a given group of people – for example, those with or at risk of mental health problems, or children, or those with musculoskeletal disorders.

Oxfordshire Clinical Commissioning Group's (OCCG) aim is to secure improved outcomes and value for money for patients and the public.

In March 2012, OCCG decided to change how it commissions a range of services by introducing an outcomes orientated approach to commissioning and contracting. OCCG decided that Mental Health services would be one of the services that would have this new approach.

The OCCG prospectus states:

'A shift to commissioning for outcomes OCCG recognises there is a need to move away from simply commissioning quantities of activity and instead shift towards measuring outcomes as defined by the patient or service user themselves. We want to radically re-define the basis on which we commission services to put patients experience first. A simple example would be rather than commissioning for a knee operation to take place, we want to commission for an increased level of mobility after a knee operation. Can Mr Jones walk to the shops again?'

Work has been underway since Autumn 2011 when with the formation of OCCG in shadow form it has considered changing the way that services are contracted to achieve better value for money and better value for patients.

The first stage (Phase 1) of this approach – designing an outline programme governance, and developing the case for change / baseline were completed, offering the CCG a 'go/ no go' decision point in January 2013.

This business case represents activity undertaken in Stage 2 of the process. The purpose of this document is to outline the benefits of developing a capitated outcomes based approach to commissioning Mental Health services in Oxfordshire, and the estimated scale of the potential financial opportunity achievable through this approach.

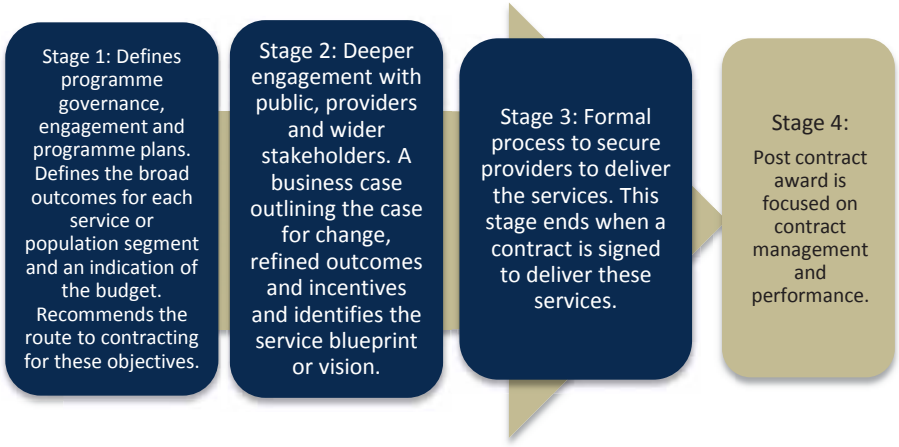
National Support for OBC

This direction of travel - moving away from activity payments to payments for outcomes is supported at a national level. The NHS Outcomes Framework purpose is outlined as *'providing a national level overview of how well the NHS is performing; providing an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board; and acting as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.'*

Importantly from the contractual perspective, the 2014/15 National Tariff Payment System Consultation notice state:

"The clear challenge for the health sector is to improve what matters to patients while keeping within a fixed NHS budget. Our teams at NHS England and Monitor are now working together to define a common direction and put in place a coherent national framework to enable this to happen."

The document then goes onto describe ways in which commissioners can move away from PbR to innovate in the way they contract for services.



What is an outcome?

An outcome is defined as a health and/or social gain experienced by a person with an illness, as defined from the person's, rather than the system's or the clinician's, perspective. Crucially, outcomes are not the same as processes. Outcomes are the things that meaningfully impact a person's life – for example, reducing premature mortality, achieving gainful employment, being able to live in stable housing. Outcomes should not be confused with process measures or outputs such as time taken from GP referral to treatment or the use of a mental health assessment tool.

An evidence-based approach

Our approach for OBC has been to organise outcomes into a hierarchy following that devised by Professor Michael Porter, Harvard Business School. Porter's hierarchy is an evidence-based approach to improve outcomes that has already been successfully applied to international health systems to inform value-based scorecards.

Porter has developed an outcomes hierarchy that has three tiers of outcomes: health status achieved or retained, process of recovery and sustainability of health.

Outcomes for the full cycle of health and care

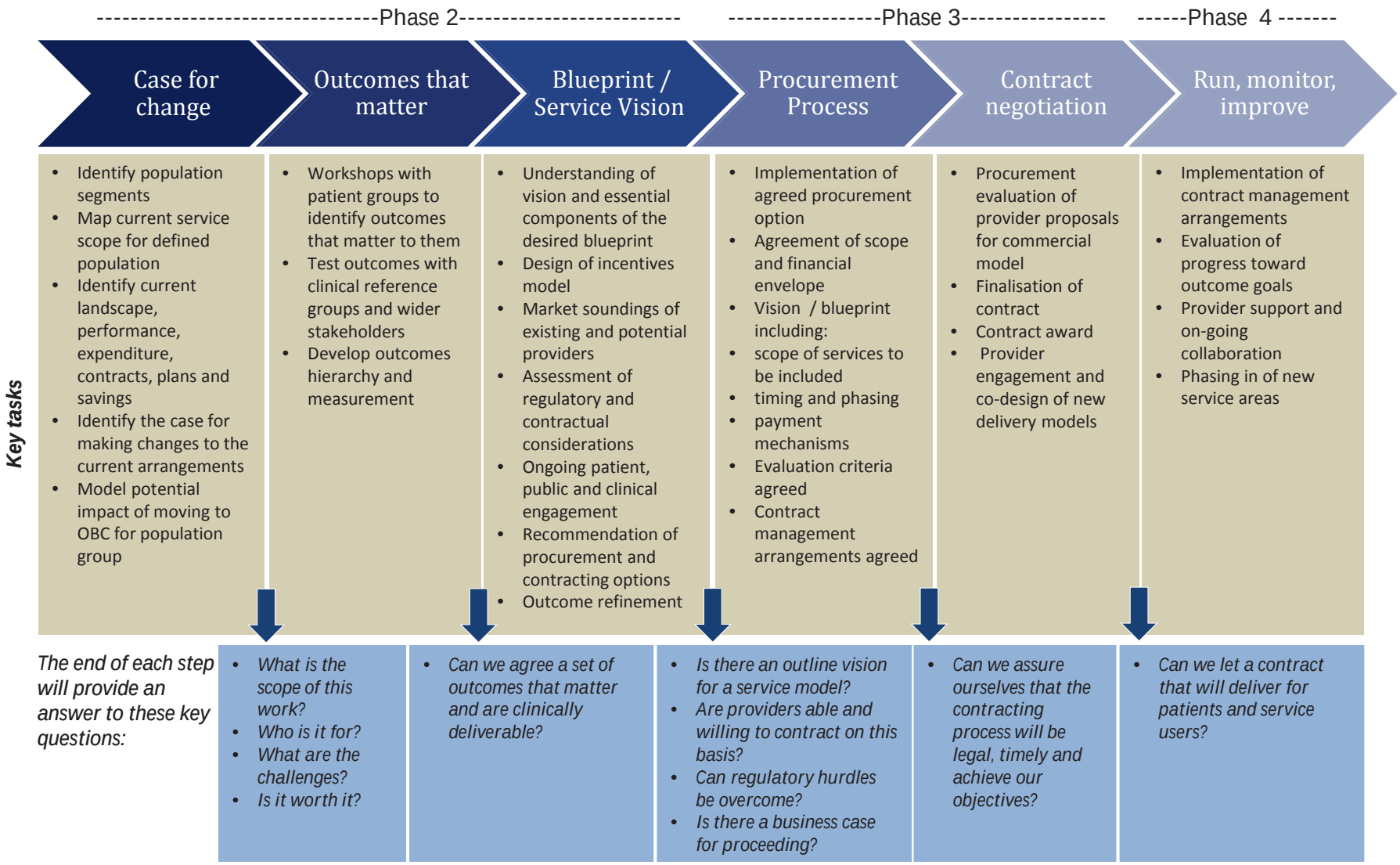
To ensure sustainability of health, it is necessary to develop outcomes relevant to the full cycle of healthcare, from an initial problem through to recovery.

Developing the outcomes and indicators that providers will be contracted to deliver has been a key part of the OBC work, all providers will share responsibility to deliver the outcomes in the contract. The outcomes should be fixed for the duration of the contract (and beyond), but indicators may evolve and change over time. All outcomes should also be consistent with NICE and national standards.

The development of outcomes is discussed in Section 4 (Outcomes that matter)

TIER	LEVEL
Tier 1 Health Status achieved or retained	Survival
	Degree of health/recovery
Tier 2 Process of recovery	Time to recovery, maintenance of/return to normal activities
	Disutility of the care or treatment process – diagnostic errors and ineffective care, treatment related discomfort, complications, or adverse effects, treatment errors and their consequences in terms of additional treatment
Tier 3 Sustainability of health	Sustainability of health/recovery and nature of recurrences
	Long term consequences of therapy e.g. care induced illnesses

The below diagram gives an overview of the key activities undertaken during Stage 2 and how this progresses to develop an OBC contract



3. Mental Health in Oxfordshire - the context today


North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Strategic Context

Better Mental Health in Oxfordshire is the joint commissioning strategy for mental health developed by health and social care commissioners after an extensive stakeholder engagement exercise in 2008-09. The original strategy ran through the period 2009-12 and was then renewed to 2015. The key aims of the strategy are to

- Keep people well
- When they become unwell help people progress with their recovery and get better, quicker
- Ensure that we provide responsive, high quality services

Since the development of the original strategy, there have been 3 major developments to mental health commissioning in Oxfordshire:

- The development of the national strategy, *No Health without Mental Health*
- The quality and financial challenges for both health and social care set out most recently in the Government's *Call to Action*
- The change in health commissioning that led to the creation in April 2013 of the Oxfordshire Clinical Commissioning Group

How are services commissioned?

Currently we contract services from different providers mainly via block contracts. We have developed health and social care pathways to support recovery and well-being for people living with mental health problems. These pathways include preventative public health approaches, a housing and support pathway, employment and recovery services and dedicated support for carers and people with mild to moderate anxiety and depression.

Of its type commissioning for mental health in Oxfordshire has been innovative, patient centred with a focus on quality, personalization and innovation.

However, the measurement of these contracts focuses on processes: access; attendances, types of interventions. We have created several effective pathways but we have not integrated these into one whole. Patients still experience hand-offs , different thresholds for different services and we cannot assess the impact of commissioned services at a patient or system level.

There are currently 18 contracts that would come within the one OBC contract for Mental Health

Outcomes Based Commissioning offers the next step to our strategic approach to mental health commissioning. It would align the outcomes for patients into the contractual payment mechanism, and achieve a level of unity of assessment, planning and care delivery with patients within an integrated approach to clinical governance and quality.

We have engaged extensively with the public and with clinicians and providers: the concept of commissioning for outcomes in mental health is uncontroversial and fits well with concepts of recovery and well-being.

The Better Mental Health in Oxfordshire Programme Board (a user, carer and professionals group) have endorsed the concept of outcomes based commissioning, agreed the outcomes and indicators that have been proposed and advised on how outcomes based commissioning should work in practice.

The Oxfordshire Joint Management Group has approved the approach to developing outcomes based commissioning, the outcomes and indicators, and the scope of patients and services, and the health and social care budgets to be included within the outcomes based contract.

OCCG commission mental health services on behalf of the people of Oxfordshire. There are currently 9 providers who deliver mental health services across the county. The main provider for child and adolescent, adult and older adult mental health care is Oxford Health NHS Foundation Trust (Oxford Health). Oxford Health is currently commissioned on a block contract, with an additional CQUIN programme as an incentivised payment. The remaining providers are in the voluntary and community and independent sectors.

OCCG has been in a challenging financial position for 2013/14. The CCG has been tasked to deliver a QIPP plan of **£13m** to close the financial gap. The CCG is projecting a similar QIPP target for 2014/15. Currently Mental Health does not have any specific savings targets for health, although we are exploring how mental health might support efficiencies against long term conditions giving rise to efficiencies for health and social care.

OCCG currently holds **18** contracts with providers in Oxfordshire to deliver mental health services. Each contract has a different set of performance indicators and criteria for success, and are all positioned to deliver discrete parts of the health delivery system.

In Oxfordshire 11.98% of the population has depression (Public Health Observatories, England, 2013). This is similar to the national average across England of 11.68%. The prevalence of Dementia is 0.47% compared to the national average of 0.53%.

Given the number of providers and contracts, and the payment mechanism for Oxford Health, it is currently difficult to determine the value to patients (both quality and financial) that the CCG receives from the current model of contracting in Oxfordshire.

- Current No. of Providers: 9
- Services included are :
    - Children and young people
    - Community mental health
    - Psychological services
    - Specialist services
    - Forensic
    - Adult and older adult
    - Housing, recovery
    - Employment
    - Advocacy
    - Well-being
    - Carers support
- Current No. of contracts: 18

4. The financial case for change


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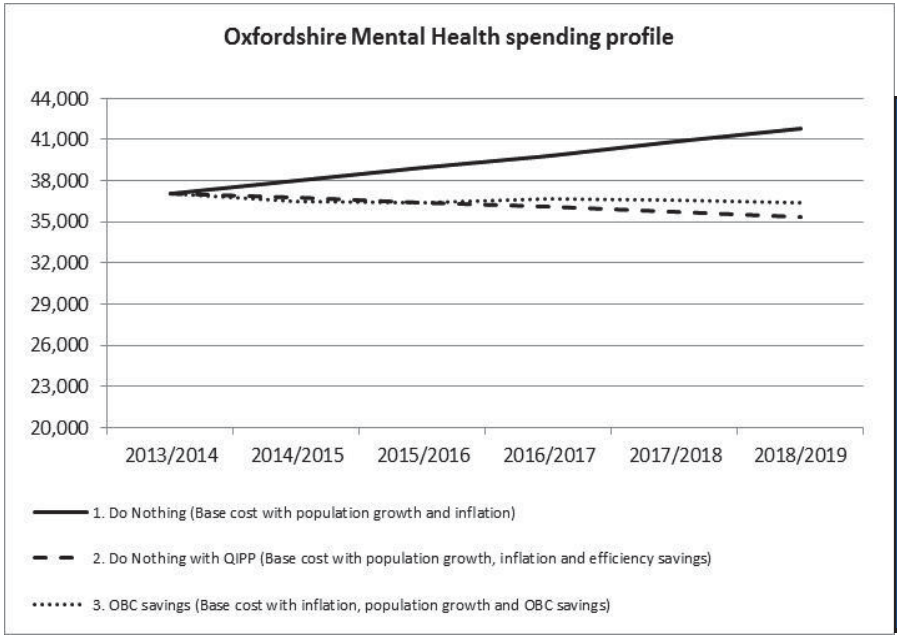
The 13/14 expenditure on the proposed mental health cohort is set out below. The table shows what is proposed to be in scope, out of scope, the services that could be included over the life of the contract as well as those services which are not included but where significant influence should be sought to engender the right behaviours.

Mental Health - Service summary

Service	Estimated MH spend 2013/14 £'000	Initial Scope £'000	Later in £'000	Influence £'000	Out £'000	Comments
Secondary MH-Adults	29,241	29,241	-	-	-	
Supported Independent Living	3,206	2,767	439	-	-	Further work is needed to confirm relationship of Elmore patients to OBC scope
Integrated social care-adult	1,836	1,836	-	-	-	
Supported Housing	1,445	1,445	-	-	-	
Keeping People Well	1,771	871	900	-	-	Further evaluation required to understand what can be brought within scope
Rycote	609	609	-	-	-	Part of OH contract now
Employment support	161	161	-	-	-	
Continuing Health Care	110	110	-	-	-	
Mental Health & Homelessnes	50	50	-	-	-	
Respite care	19	19	-	-	-	
Improving Access to Psychological Therapies (IAPT)	3,424	-	3,424	-	-	Further work required to understand the relationship with secondary MH services
Carers support	319	-	319	-	-	Further evaluation required to understand what can be brought within scope
Aspergers	146	-	146	-	-	New service that will be evaluated and brought in into scope over the life of the contract
Autism Diagnosis Assessments	68	-	68	-	-	New service that will be evaluated and brought in into scope over the life of the contract
Pharma cost	4,148	-	-	4,148	-	Primary care funded, however influence required to promote effective non drug interventions
Secondary MH-Older	9,866	-	-	-	9,866	In scope for 'Older People' OBC
Secondary MH-Children and Young	6,100	-	-	-	6,100	Childern and young adults are not in scope
Complex needs	700	-	-	-	700	Budget is being phased out by DH
IPMS	300	-	-	-	300	This is a primary care service for people with physical needs hence not in scope
Mental Health Act Assessment	241	-	-	-	241	Out of scope as part of the MHA83 package
Advocacy Services	165	-	-	-	165	Out of scope as part of the MHA83 package
Mental Health & Homelessnes	153	-	-	-	153	Out of scope as included in OCC redesign of housing and support services for homeless people
Internal services	150	-	-	-	150	Out of scope as CCG internal cost
Commissioning intentions	84	-	-	-	84	
Forensic services	-	-	-	-	-	Out of scope as not within OCCG commissioning scope
Acute services	-	-	-	-	-	Acute spend for people with MH health is to be brought in later once it can be indentified
Total	**64,315**	**37,110**	**5,297**	**4,148**	**17,760**	



£'000	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
1. Do Nothing (Base cost with population growth and inflation)	37,110	38,003	38,918	39,854	40,813	41,795
Efficiency savings (cluster spend only)		(1,223)	(2,475)	(3,757)	(5,070)	(6,415)
2. Do Nothing with QIPP (Base cost with population growth, inflation and efficiency savings)	37,110	36,780	36,443	36,097	35,743	35,380
1. Do Nothing (Base cost with population growth and inflation)	37,110	38,003	38,918	39,854	40,813	41,795
OBC Savings (cluster spend only)		(1,542)	(2,485)	(3,161)	(4,177)	(5,392)
3. OBC savings (Base cost with inflation, population growth and OBC savings)	37,110	36,461	36,433	36,693	36,636	36,403

- The solid line in the graph above shows the estimated spend for the next 5 years if nothing is changes but population growth and inflation is applied to current spend
- The dashed line show the estimated spend for the next 5 years if a 4% efficiency target is applied to the light blue line above
- The dotted line shows the potential estimated spend if OBC is introduce and savings target estimates are achieved

We would expect the OBC contract to provide a more coordinated approach to service provision and deliver efficiencies that in turn would finance the necessary changes required to address the needs of the future patient cohort. Furthermore we would expect this process of reallocation of resources to support future redesign to be delivered within the existing financial envelope .
We would expect the financial envelope to capped at FY13/14 levels with providers incentivised by the ability to retain and reinvest savings that reduce cost below this level.

	FY 13/14		
In Scope Services	**Plan**	**Forecast (@M7)**	**OBC Financial envelope**
Secondary MH-Adults	29,241	29,241	29,241
Supported Independent Living	2,767	2,767	2,767
Integrated social care-adult	1,836	1,836	1,836
Supported Housing	1,445	1,445	1,445
Keeping People Well	871	871	871
Rycote	609	609	609
Employment support	161	161	161
Continuing Health Care	110	10	110
Mental Health & Homelessnes	50	50	50
Respite care	19	19	19
Total	**37,110**	**37,010**	**37,110**

*The CHC service is currently underspending by c£100k however as this spend is subject to changes in an individual's circumstances; the money has been left in the estimated OBC financial envelope

- An estimate of the OBC financial envelope for MH has been based on the planned expenditure for FY 13/14 .
- Actual expenditure as at month 7 shows a small underspend of c£100k in Continuing Health Care services .
- As this variance is primarily based on the ongoing changing needs of individuals there is a likelihood that it is not recurrent.
- Therefore the full 13/14 plan has been assumed for the OBC financial envelope.

- The FY 13/14 plan includes an overall tariff deflation of 1.9% made up of 2.1% inflation and -4% efficiency savings.
- The forecast graph shown in the next slide is assuming that in the absence of the introduction of OBC this tariff inflation and the efficiency savings target will continue to apply year on year going forward.
- Achievement of the OBC financial envelope will generate the majority of the year on year targeted efficiency savings.

- It is expected that this service will deliver the outcomes to patients and significant benefits to how patients are diagnosed and treated
- In order to ascertain the potential savings, a number of assumptions have been made. This assumptions are an aspirational and subject to further validation with providers. They reflect the areas of improvement that are expected to materialize through a more integrated service delivery and better outcomes for the patients.
- The approach has been to consider a reduction in the current number and associated costs of spells resulting from the implementation of the proposed service vision. The percentages set out in the table below reflect the assumed cumulative reduction in spell activity for secondary mental health care which will then generate the savings outlined further below.

	Cumulative savings assumptions					
	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	
Potential efficiency saving	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Clinical Assumptions**
% Reduction in clusters spells (1-3) due to a move of activity to Primary care	5%	8%	10%	15%	20%	20% cumulative saving by year 5 attainable. We would expect this cohort to be treated in primary care.
% Reduction in cluster clusters spells (11) due to a move of activity to Primary care	5%	8%	10%	15%	20%	Many of these patients are stable and therefore with support, a proportion could be managed in Primary Care
First Intervention effectiveness: % Shift cluster spells from 05-04-03	3%	5%	7%	8%	10%	More rigorous assessment and planning for outcomes will lead to a re-classification of patients into lower clusters
First Intervention effectiveness: % Shift cluster from 14-13-12-11	3%	5%	7%	8%	10%	Earlier detection of first onset psychosis and increased focus on compliance. A higher focus on improving patient functioning and other outcomes. This is expected to lead to a step down in cluster
Comprehensive care coordination -% reduction clusters: 4,5,7,8 and 12-17	5%	8%	10%	12%	15%	Using data and risk assessment approaches with a more co-ordinated and personalised care planning is expected to lead to a more effective use of resources

The table below shows the effect of the above assumptions applied to the current level of activity increased by projected population growth and inflation.

We have applied these savings to the current cost and spell information by cluster in order to quantify them. This remains an estimate and does not take account of the fixed and variable cost structure operated by providers i.e. a reduction in spells may lead to cost savings only where variable and stepped costs are available for reduction. We have also taken into account the investment required to achieve these savings as noted below.

Cluster No	Cluster description	Potential Cumulative Savings 2013/2014	2014/2015	2015/2016	2016/2017	2017/2018	2018/2019
P00	Variance / No cluster	0	0	0	0	0	0
P01	Common Mental Health Problems (Low Severity)	0	(78)	(125)	(158)	(237)	(317)
P02	Common Mental Health Problems (Low Severity with Greater Need)	0	(74)	(119)	(151)	(227)	(302)
P03	Non-Psychotic (Moderate Severity)	0	(245)	(397)	(512)	(737)	(970)
P04	Non-Psychotic (Severe)	0	(255)	(412)	(538)	(641)	(802)
P05	Non-Psychotic Disorders (Very Severe)	0	(74)	(120)	(158)	(187)	(234)
P06	Non-Psychotic Disorder of Over-Valued Ideas	0	(48)	(78)	(98)	(119)	(150)
P07	Enduring Non-Psychotic Disorders (High Disability)	0	(53)	(85)	(107)	(130)	(164)
P08	Disorders	0	(81)	(130)	(164)	(199)	(251)
P10	First Episode Psychosis	0	0	0	0	0	0
P11	Ongoing Recurrent Psychosis (Low Symptoms)	0	(141)	(224)	(265)	(476)	(659)
P12	Ongoing or Recurrent Psychosis (High Disability)	0	(215)	(345)	(441)	(531)	(666)
P13	Ongoing or Recurrent Psychosis (High Symptoms and Disability)	0	(80)	(130)	(161)	(202)	(260)
P14	Psychotic Crisis	0	(68)	(109)	(143)	(170)	(212)
P15	Severe Psychotic Depression	0	(36)	(58)	(73)	(89)	(112)
P16	Dual Diagnosis	0	(47)	(76)	(96)	(116)	(146)
P17	Psychosis and Affective Disorder (Difficult to Engage)	0	(47)	(76)	(96)	(117)	(147)
P18	Cognitive Impairment (Low Need)	0	0	0	0	0	0
P19	Cognitive Impairment or Dementia Complicated (Moderate Need)	0	0	0	0	0	0
P20	Cognitive Impairment or Dementia (High Need)	0	0	0	0	0	0
P21	Cognitive Impairment or Dementia (High Physical or Engagement)	0	0	0	0	0	0
Total cluster savings		**0**	**(1,542)**	**(2,485)**	**(3,161)**	**(4,177)**	**(5,392)**

The assumptions in the previous slide recognise the fact that in order to successfully shift activity to Primary Care, an investment in Primary care resources will also be required.

Areas requiring potential additional investment include:

- Potential Increase in CMHT services available to Primary care
- Primary care to have access to employment and housing support
- Increase availability of psychological therapy services to Primary Care
- Supporting GPs in the identification and on-going management of patients with Mental Health needs

It is envisaged that a proportion of the savings identified above for clusters 1-3 ranging from £0.4m in FY 14/15 to £2.3m in FY 17/18 will be used to fund this additional investment required in Primary Care.

5. Outcomes that matter


North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Development of the outcomes and indicators

Introduction

As discussed in section 2 (Introduction and Approach),developing the outcomes and indicators that providers will be contracted to deliver has been a key part of the outcomes based commissioning work. It is proposed there will be one contract for mental health in Oxfordshire covering the scope of the outcomes based commissioning work and therefore all providers will share responsibility to deliver the outcomes in the contract. The outcomes should be fixed for the duration of the contract (and beyond), but indicators may evolve and change over time. All outcomes should also be consistent with NICE and national standards.

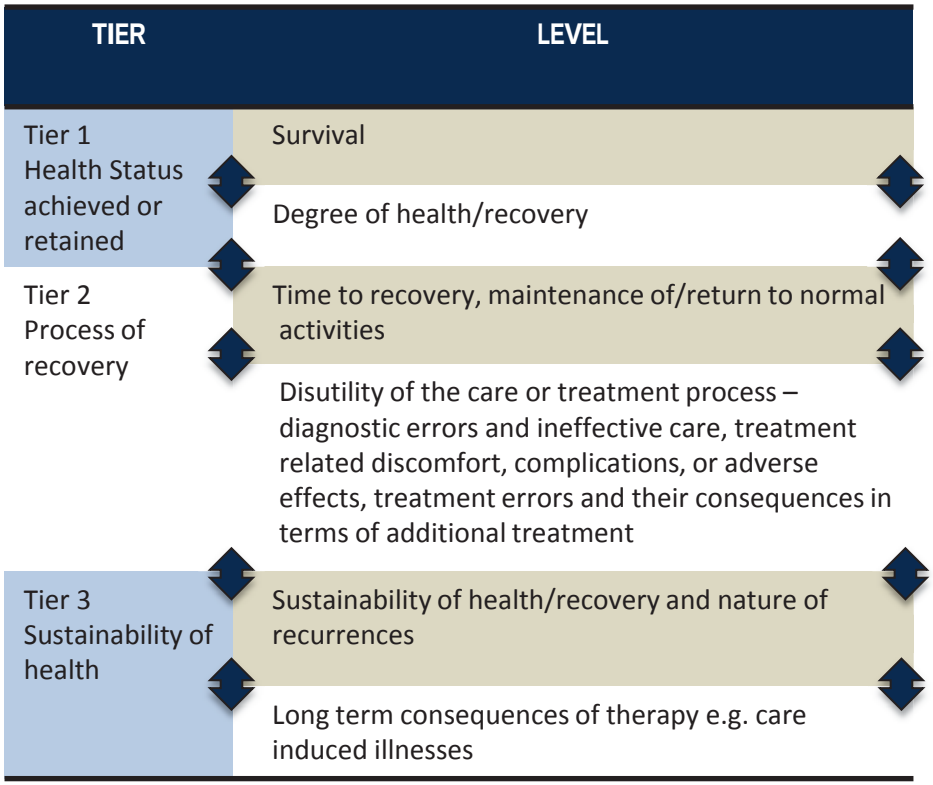
Definition of an outcome

An outcome is defined as a health and/or social gain experienced by a person with an illness, as defined from the person's, rather than the system's or the clinician's, perspective. Crucially, outcomes are not the same as processes. Outcomes are the things that meaningfully impact a person's life – for example, reducing premature mortality, achieving gainful employment, being able to live in stable housing. Outcomes should not be confused with process measures or outputs such as time taken from GP referral to treatment or the use of a mental health assessment tool.

Methodological approach

In developing outcomes it is important to use a recognised methodological approach. This is important so that competing outcomes can be weighed against each other, and also to ensure sustainability of health, it is necessary to develop outcomes relevant to the full cycle of healthcare, from an initial problem through to recovery. Michael E. Porter is a world leading academic on value based healthcare, a key component of which is measuring patient outcomes. Porter has developed an outcomes hierarchy (Porter, 2010) which has three tiers of outcomes: health status achieved or retained, process of recovery and sustainability of health. Each of the outcomes for Oxfordshire falls within one of the three tiers, and there are outcomes across all tiers.

While there are several different ways to think about outcomes, this model is the preferred approach for mental health because it is an evidence based approach to improve outcomes that has already been successfully applied to international health systems to inform value based score cards. The hierarchy is shown opposite:



Porter, M. E. (2010). What is Value in Healthcare? New England Journal of Medicine, 363:2477-2481

The stakeholder engagement that has taken place for mental health has occurred in the context of a long established commitment to using stakeholder engagement as a means of developing and procuring mental health services in Oxfordshire. The tailored and targeted engagement activities described in this section have taken place in the context of programme-wide stakeholder engagement throughout the year. This spans from a high profile exploratory event in January 2013, through ongoing liaison with Localities to the current survey of member practices, and encompasses informal dialogue across the health economy as well as formal provider engagement sessions happening this autumn. All these wider initiatives have influenced a growing awareness of the COBIC approach, and several have also informed the detail of this work on mental health.

A strongly embedded culture of engagement

The production of Better Mental Health in Oxfordshire 2012-15, the joint commissioning strategy between OCCG and Oxfordshire City Council, was characterised by high levels of involvement from service users, their carers, clinicians and other providers in the statutory and voluntary and community sector in the planning, development and implementation of services. Stakeholders were consulted on the draft strategy through an extensive engagement exercise in November 2011 when it was revised in the light of feedback. Mental Health commissioners have engaged with key stakeholders in the community throughout the work, for instance making presentations to the Housing Services Action Group and to the Local Authority Adult Health & Social Care Programme Board.

Alongside this, the Better Mental Health in Oxfordshire Commissioning Programme Board, responsible for providing assurance and making recommendations on the delivery of the Mental Health strategy is a key group bringing key stakeholders together on a regular basis. It is pro-active in engaging internal and external stakeholders to ensure transparent and consistent communication.

Expert Reference Group

An Expert Reference Group (ERG), comprising representation from local GPs, commissioners, voluntary sector organisations and the acute provider trust was formed in October 2012. The ERG remit was to monitor the outcomes based commissioning work and provide expert challenge and input. The ERG discussed issues which included considering and agreeing the scope and segmentation for the mental health and refining the outcomes and indicators. This group has played a key role, reviewing feedback and suggesting revised outcomes to be tested as part of the CCG's engagement. As the main group overseeing the mental health outcomes based commissioning work, it reports to the OBC Programme Board (and through this on to the CCG's Governing Body). A group of local experts in Oxfordshire was also formed to attend a workshop in October 2013 to discuss the blueprint – the future state vision of what mental health care will look like in Oxfordshire in order to deliver the agreed outcomes. The blueprint was shared with the BMHO programme Board at its meeting in November.

The approach to developing outcomes and indicators

The diagram below summarises the approach to defining the outcomes that matter for people with mental health problems in Oxfordshire:

The 3-stage process depicted above has been an on-going dialogue with stakeholders and an iterative process to develop the right outcomes for people with mental health problems in Oxfordshire.

A programme of local engagement

Outcomes that Matter Engagement day, January 2013

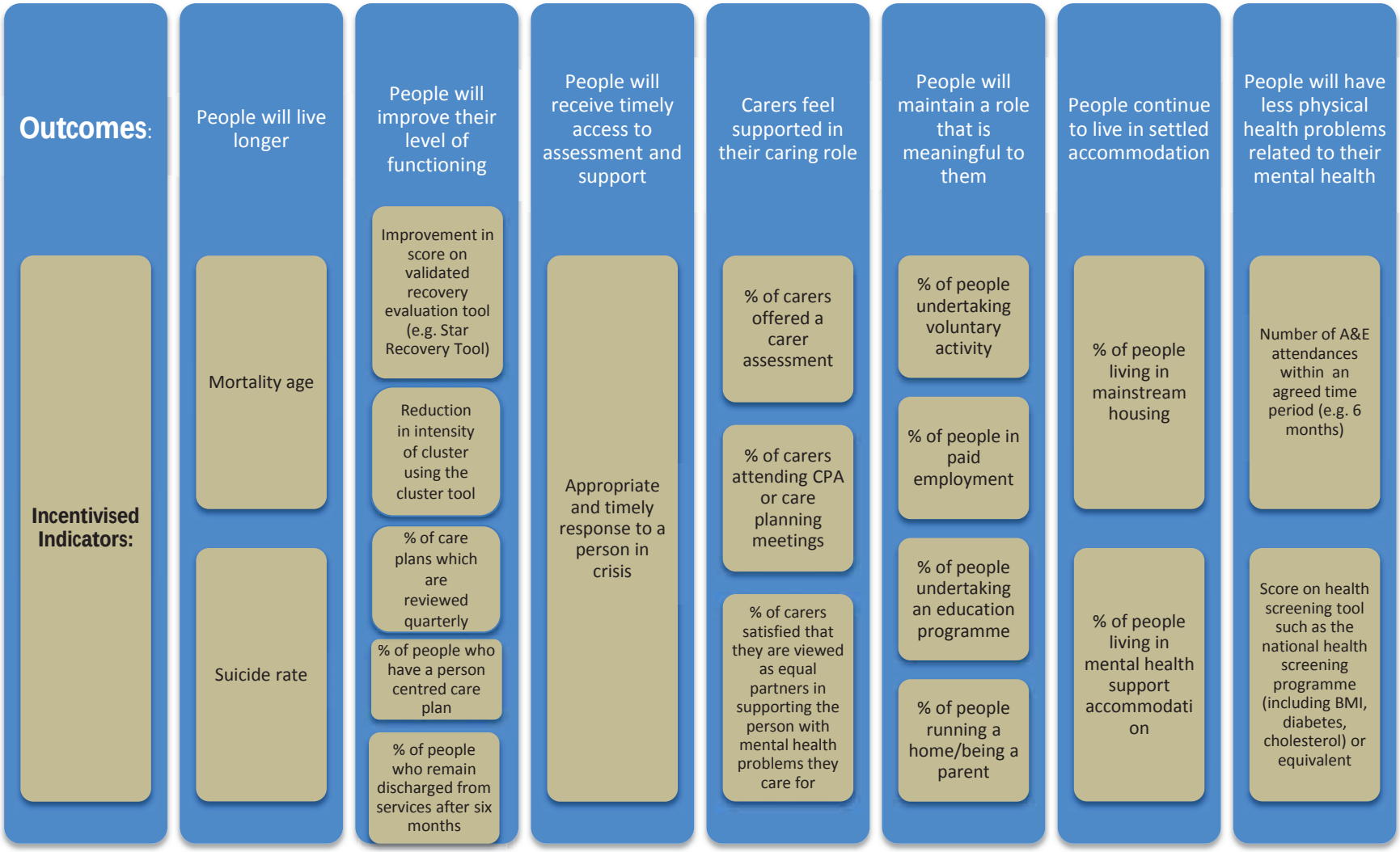
This major event on *Outcomes that Matter*, brought together an invited audience of patients, carers, professional, and provider organisations to share their views on what outcomes mattered most to them.

Talking Health

128 respondents completed an online survey inviting people to express views on the proposed outcomes and measures for mental health and how as commissioners we could measure them. Varied communication and engagement methods are used to promote opportunities for engagement via Talking Health, principally via partner organisations and short, targeted messages to prompt two-way dialogue via social media.

Workshops on Mental Health Services

- Face to face workshops in September, 2013
- Two face to face workshops were held with service users, carers, GPs and other clinicians and the voluntary sector at the beginning of September, one in Banbury and the other in Oxford (the two areas in Oxfordshire with the highest population).
- OCCG held a focus group with Re-energize on 4 September 2013


Outcomes:
Incentivised Indicators:
People will live longer
Mortality age
Suicide rate
People will improve their level of functioning
Improvement in score on validated recovery evaluation tool (e.g. Star Recovery Tool)
Reduction in intensity of cluster using the cluster tool
% of care plans which are reviewed quarterly
% of people who have a person centred care plan
% of people who remain discharged from services after six months
People will receive timely access to assessment and support
Appropriate and timely response to a person in crisis
Carers feel supported in their caring role
% of carers offered a carer assessment
% of carers attending CPA or care planning meetings
% of carers satisfied that they are viewed as equal partners in supporting the person with mental health problems they care for
People will maintain a role that is meaningful to them
% of people undertaking voluntary activity
% of people in paid employment
% of people undertaking an education programme
% of people running a home/being a parent
People continue to live in settled accommodation
% of people living in mainstream housing
% of people living in mental health support accommodation
People will have less physical health problems related to their mental health
Number of A&E attendances within an agreed time period (e.g. 6 months)
Score on health screening tool such as the national health screening programme (including BMI, diabetes, cholesterol) or equivalent

Current contracting arrangements do not promote cross working between settings and providers as in many cases there are strong financial dis-incentives.

Removing financial constraints allows closer cooperation between different providers so they are able to focus on common outcomes. Clinical professionals drive this focus for reasons of patient benefit, but this is reinforced by the commercial arrangements to ensure that managers no longer have a disincentive built into their contracting arrangements. For this reason it is proposed that the outcomes will carry financial rewards in return for enhanced levels of patient care and outcomes through the implementation of an incentivised contract. A number of factors need to be considered when developing an incentivised contract so that:

- it effectively supports and enables good quality outcomes for patients
- it is as simple as possible to manage
- contract management is not disproportionately cumbersome

Pace of Change

The proposed incentivised outcomes framework is developed for a "steady state" position, however it is recognised that information and data for some indicators may not be immediately available.

As a result, a phased approach for implementation of each indicator will be agreed as appropriate. This avoids the need to change indicators over time as data is available and maintains focus on the overall goals for steady state.

For example, year one may be about data collection, year two may have a small performance improvement targeted and the weighting of outcomes changed. The table below illustrates how this may be achieved:

As these contracts are envisaged to be offered for a longer than usual period of time, there will need to be a change mechanism which allows for the improvement of outcomes and indicators as necessary in light of new evidence. Changes will be made by agreement of the parties.

Year	Year 1			Year 2		
Annual 'Incentivisation Pot'	£1m			£3m		
% of 'pot' for each threshold	Good	Improved	Excellent	Good	Improved	Excellent
Outcome 1	9%	18%	40%	18%	25%	50%
Outcome 2	0%	0%	0%	10%	25%	50%
Total	9%	18%	40%	28%	50%	100%

Selecting and incentivising indicators

Indicator Selection - indicators selected clearly demonstrate achievement or otherwise of the desired outcomes and promote joined-up working across providers, without significant perverse incentives. They need to be meaningful for providers and commissioners to monitor and report on. They should aid the provider in managing their operations.

Number of Indicators –limited to ensure focus on monitoring if the desired outcomes are on track. Other measures can still be monitored and reported to aid operational and contract management. Balance required to ensure that monitoring does not utilise a disproportionate resources.

Avoiding portfolio effect - Monitor's work to develop a pricing strategy showed that small incentive amounts across many indicators produce a portfolio effect, where providers effectively choose which indicators to focus on whilst being rewarded year on year with a broadly similar financial value.

Incentive Quantum - The financial value and proportion of the overall contract value that is 'at risk' through Incentivisation needs to be meaningful and material to the provider without destabilising the provider or the wider health economy. Different outcomes and indicators can carry different weightings to allow for flexibility and to recognise complexity of delivery

Indicator Thresholds - a baseline of performance is established ensuring that the performance is an improvement on current provision with an associated threshold reflecting adequate performance. Performance above this attracts the potential financial reward, further split for good, improved and excellent performance. For some indicators a pass/fail approach will be more appropriate.

Incentivisation

In order for incentivisation to work, there needs to be a sharing of any benefits, which can then be reinvested for further development and or delivery of healthcare services. The share will be negotiated in advance between the contracting parties. It is the intention of the CCG to effectively utilise all of the incentivisation budget each year to provide better healthcare for the local population, irrespective of whether or not the providers achieve the performance levels required. To this end, in the event that providers do not receive the full value of the incentivisation 'pot', the CCG will look to direct the unpaid monies into specific healthcare services within Oxfordshire.

Next steps

Subject to this business case being approved, the following decisions will be taken to move towards the delivery and implementation of an incentivised outcome based contract.

Whilst all of elements will be finalised through negotiation with the successful providers, the CCG will need to have a working proposition from which to begin initial provider discussions:

- The overall percentage / value of the total annual contract value that is 'at risk' through the incentivisation
- The weighting between each of the outcomes
- The weightings for each indicator within each outcome
- The weightings between 'good, improved and excellent' where appropriate
- The speed at which each indicator and the incentivisation takes affect

Outcome	Outcome description	Outcome Goal	Outcome points
Outcome 1	People will live longer	Reduce gap in mortality between people who have mental health problems and those who don't	5
Outcome 2	People will improve their level of functioning	As a result of support, people with mental health problems should improve their level of functioning – this should have an impact on where they live and whether they are employed.	20
Outcome 3	People will receive timely access to assessment and support	To ensure that people with mental health problems receive the support they require within an appropriate time period	10
Outcome 4	Carers feel supported in their caring role	Those that care for people with mental health problems are given appropriate support to enable them to perform this role most effectively	15
Outcome 5	People will maintain a role that is meaningful to them	People with mental health problems will be supported to identify and maintain a role that is meaningful to them – be that paid employment, voluntary work, education or something else that matters to them	20
Outcome 6	People continue to live in settled accommodation	People with mental health problems will are able to live settled accommodation, and not regularly move between different living arrangements, including regular lengthy stays on inpatient wards	10
Outcome 7	People will have less physical health problems related to their mental health	People with mental health problems will not have a wide range of physical health problems	10
	Additional incentivisation subject to achievement of all outcome points	Incentivise the achievement of all Outcomes and promotes Engagement	10
		Total	**100**

6. Vision for Mental Health Services in Oxfordshire


North


North East


Oxford City


South East


South West


West

The vision is designed to describe the impact of OBC on the Oxfordshire mental health system. It will

1. Give a whole system view of what mental health provision will look like in Oxfordshire once outcomes based commissioning contracts have been implemented (the 2019/2020 end state").
2. Describe those key changes that we expect OBC to deliver
3. Describe how OBC will need to work in practice to ensure that these changes are delivered

We will develop a blueprint that will set out how OBC will work in practice. The blueprint will not be designed to describe the services needed or contractual relationships between providers but rather to set out the principles and approach that OCCG and OCC expect to govern the delivery of OBC.

The blueprint is still in development, but it will in effect describe the end state of OBC as set out in the diagram on the next page, and describes those approaches to service delivery that may form part of the quality schedule to the contract.

Service users and carers have stressed that outcomes based commissioning must deliver high quality services, and that quality is both inherent in the delivery of effective outcomes and must not be compromised in the effort to deliver effective outcomes.

The blueprint will set out what in effect are our quality expectations for OBC which will form part of the contract.

After consultation with users, carers and the BMHO programme board these quality expectations will cover:

- ✓ The relationship of OBC contract to commissioners and deliverers of non-OBC services, referrers and to the users and carers who may be supported by the contract.
- ✓ Quality standards such as NICE
- ✓ Access
- ✓ Thresholds
- ✓ Assessment
- ✓ Care planning
- ✓ Integration of service provision
- ✓ Recovery
- ✓ Personalization
- ✓ Needs of carers'
- ✓ Co-production
- ✓ Best practice and innovation
- ✓ Change management
- ✓ Workforce and leadership

We have developed key features to support all of these headings. The contract will need to reflect some or all of these as part of our assessment of the quality of services that are delivered within the OBC contract. The key features are summarized in the diagram overleaf

Vision Map

Vision Map

In practice, development and implementation of the service model is flexible, as providers will be encouraged to organise pathways and service delivery in order to best provide the environment for meeting the outcomes that have been co-produced with Oxfordshire's health and social care community as defined in the contract.

Though providers will determine the actual services required, the service model sets out key components of the transformed care system.

One system of care

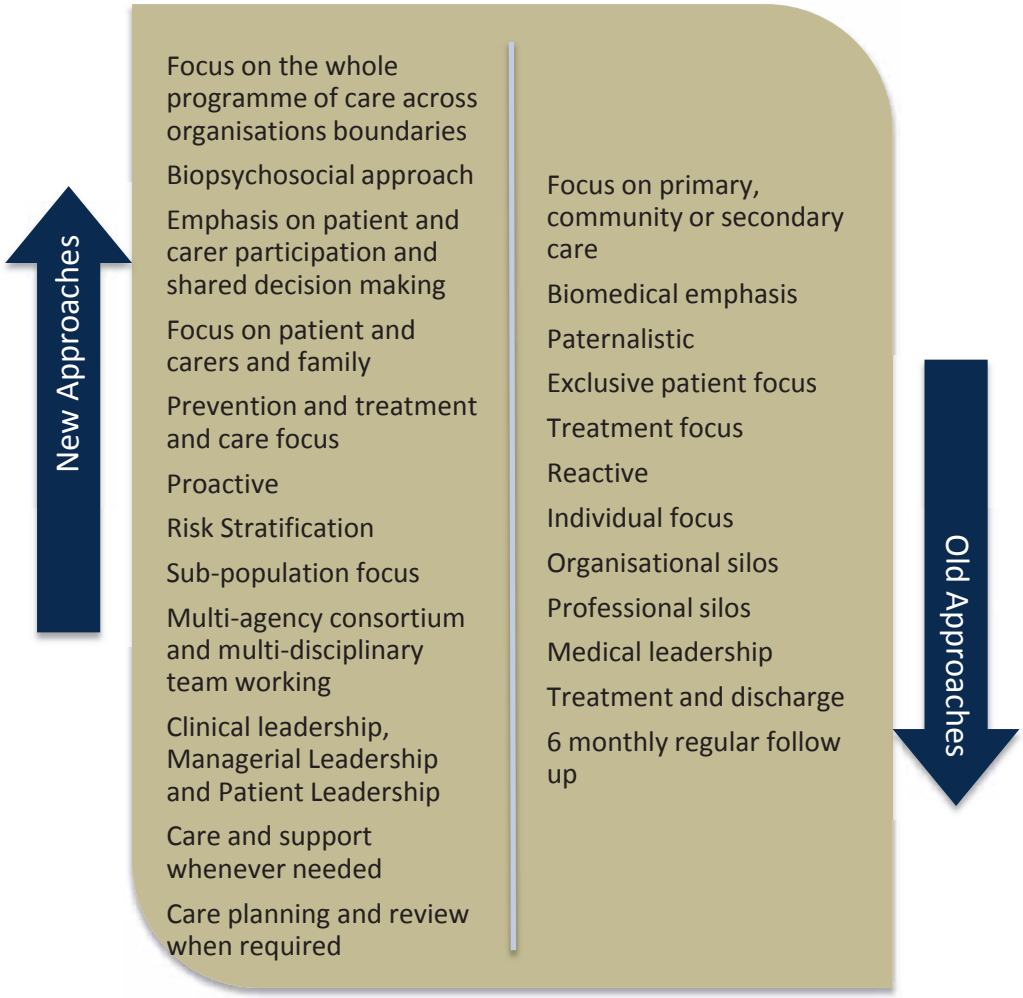
The model proposed in this business case will work as one system of care, organised as a network of integrated services.

A multi-disciplinary team

The network of integrated services will be delivered by a multi-disciplinary team who will work collaboratively to ensure the patient pathway is seamless, reduces duplication of assessment and ensures the correct outcomes are achieved.

No distinction between care settings

For service users and carers, there will be no distinction between care settings: they will experience **one service** throughout their journey along the care pathway.



7. Segmentation and scope options


North


North East


Oxford City


South East


South West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Introduction

This section outlines the potential approaches to and recommended option for segmenting the mental health population in Oxfordshire. This section will also outline the services/areas of mental health which have been determined as in scope and out of scope for outcomes based commissioning.

Why it is important to segment

As mental health is a broad area and conditions vary in nature and severity, it is helpful to segment the population of people with mental health problems into those with similar needs. Specifically, there are three key of reasons why it is important to consider segmenting the mental health population. These are:

1. People with different mental health problems have different needs and outcomes that are relevant to them, so it is important to acknowledge this and contract appropriately.
2. It is less meaningful to measure outcomes at a mental health whole population level, which dilutes the identification of measures relevant to each outcome by mental health segment.
3. Even if different segments share the same outcomes, the measures for these outcomes may be different. It is not enough to say outcomes will be weighted according to different segments – rather, it can be more meaningful to have different measures for each outcome, for each segment. Several mental health segmentation models exist. The following gives a brief overview of these models, the details of which are detailed in the Appendix.

A number of options exist for thinking about segmentation for people with mental health problems:

- HONOS PBR Clusters
- ICD-10 Classification
- Segmentation across the life-cycle
- Example from international best practice – Intermountain Healthcare, Utah, USA
- Blended Segmentation Model

Each of these options present a strong case for segmentation, however each also bring with them their own methodological shortcomings.

HONOS – PbR clusters

HONOS PbR clustering is the proposed method of undertaking a detailed assessment of the needs of each individual person with mental health problems, and then using the outcome of this to allocate them to a needs based cluster. There are 21 clusters, which are divided into four super clusters:

- Non-Psychosis: Clusters 1-8
- Blank: Cluster 9
- Psychosis: Clusters 10-17
- Organic: Clusters 18-21

Individuals can be allocated into HONOS-PbR clusters based on rating scales according to need. While the application of the cluster approach is widespread throughout the NHS, previous analyses have shown significant variation in clinical presentation within each cluster. Although cluster data has been used in the initial Oxfordshire analysis, it may not be the ideal approach for segmentation as it uses a universal rating scale and several diagnoses are excluded – such as eating disorders and child and adolescent mental health problems. In addition, cluster data may be inaccurate as many clinicians do not classify patients according to HONOS PBR clusters regularly.

ICD-10 classification

Chapter V in the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) contains the diagnostic coding for all mental and behavioural disorders as F00 – F99, listed below. ICD-10 coding classifies patients according to their disease diagnosis. This is a medical model of segmentation, which satisfies the clinical establishment in terms of treatment approaches. However, this approach fails to recognise individuals who require primary and preventative care.

F00–F09: Organic, including symptomatic, mental disorders

F10–F19: Mental and behavioural disorders due to psychoactive substance use

F20–F29: Schizophrenia, schizotypal and delusional disorders

F30–F39: Mood (affective) disorders

F40–F48: Neurotic, stress-related and somatoform disorders

F50–F59: Behavioural syndromes associated with physiological disturbances and physical factors

F60–F69: Disorders of adult personality and behaviour

F70–F79: Mental retardation

F80–F89: Disorders of psychological development

F90–F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

F99: Unspecified mental disorder

Segmentation across the life cycle

Developmental psychopathologists suggest that rather than organising segments by underlying pathology, it may be more appropriate to adopt a life course approach. Underpinning this is the hypothesis that individuals have more in common with those at a similar life stage than disease profile. Thus segmentation may occur for: children, adolescents, young adults, working age adults and older adults.

This approach is patient-centred but it does not distinguish between underlying diseases and differing needs that may influence outcomes.

Example from international best practice – Intermountain Healthcare, Utah, USA

At Intermountain healthcare, all individuals are screened in primary care. If a mental health problem is detected, then individuals are allocated into one of three categories: mild, moderate or severe. Resources are then allocated accordingly. For example - irrespective of the diagnosis, individuals will only be seen by a psychiatrist if they are considered “severe”. This approach has been proven to be effective for integrating mental health care into primary care settings but is less applicable to secondary care settings.

Blended segmentation model

The below figure demonstrates a blended model, which provides a possible approach for segmenting people with mental health conditions across Oxfordshire. This approach combines the ICD-10 approach and the life cycle approach to produce a segmentation structure which is centred on the patient, but does not exclude the classification according to disease.

Segment Origin	Segment	ICD-10 Classification	Characteristics
Patient Group	• Healthy People	N/A – Primary Care coding	Healthy with no ongoing mental health needs. At risk – good health but at risk of developing acute or chronic illness so requiring more health care input to prevent escalation
	• Physical health comorbidities	N/A	Mental health problems for people who have primarily physical health problems
	• Children, young people	F90-F98	Mental health problems in child to adolescent age group, including transitions
	• Anxiety and depression	F30-F39 F40-F48	Mood disorders Anxiety disorders
Disorders	• Alcohol & substance misuse	F10-F19	Addiction disorders
HONOS: Psychosis	• Psychosis including schizophrenia	F20-F29	Psychotic conditions that may, at times of crisis, require inpatient admission
HONOS: Organic	• Organic conditions including dementia	F00-F09	Neurodegerative conditions where outcomes will deteriorate over time
Adults: non-HONOS PbR ICD-10 codes	• Behavioural & developmental disorders	F50-F59 F60-F69 F70-F79 F80-F89	Including autism and Asperger's. Eating disorders

Preferred segmentation model for mental health in Oxfordshire

The blended segmentation model is the preferred model. This blended approach combines several different life cycle stages with HONOS PBR and ICD-10 classifications to bring a clear structure to segment the population of people who have a mental health problem. This approach groups people who have similar circumstances together, addresses the severity of illness and the clinical approach required (if required). This combination enables outcomes to be developed which will cover a full pathway of care. There are eight segments in total:

1. Healthy people
2. Physical Health comorbidities
3. Children, young people
4. Anxiety and depression
5. Alcohol and substance misuse
6. Psychosis including schizophrenia
7. Organic conditions including dementia
8. Behavioural and developmental disorders

Bearing in mind the scope of the outcomes-based commissioning contract in Oxfordshire (which is outlined in the following pages), four of these segments are taken forward. These are:

- Anxiety and depression
- Alcohol and substance abuse
- Psychosis including schizophrenia
- Behavioural and developmental disorders

Whilst HONOS-PbR is a good model of segmentation, it does not include all the conditions of mental health that are currently being proposed to include in scope. Importantly two of these four segments from the blended model map onto the HONOS-PbR super clusters (1-9) (10-17). This segmentation approach does not shift away from the current direction of travel of using HONOS-PbR to record activity and use as new mental health tariff.

In using the blended model there would be four mental health segments for the population in Oxfordshire, and meaningful outcomes can be developed for each of the groups of people.

Scope

The following lists show the groups of people in and out of scope for the outcomes-based commissioning contract. The decision regarding what is to be considered in or out of scope was taken by the Expert Reference Group (ERG). The decision of the ERG was endorsed by the BMHO programme board and also sent to the OBC programme board for information.

The following groups of people are *in scope*:

- People with anxiety and depression or psychosis who are assessed as being in HoNOS PbR clusters 4-8 and 10-17. This will include people with co-morbid conditions such as autism, acquired brain injury, and drug and alcohol addiction. This will include carers of people with these conditions
- People who are "pre cluster" who are being assessed by outcomes based commissioned services
- People in mental distress who may or may not be assessed into HoNOS PbR clusters but who experience a significant impairment in their functioning and have similar needs to those in clusters.

The first two of these groups would be core business of services commissioned from the pool budget. The third group represents people who use the services OCCG commissions but who (particularly from the perspective of primary care) do not always do particularly well. They may include people with borderline personality disorders and people who do not necessarily engage very well with conventional services.

The following groups of people may come within scope *later:*

- People with mild to moderate anxiety and depression who may be in HoNOS clusters 1-3 and who use psychological therapy services in primary care
- People with a *primary* diagnosis of conditions with a behavioural impact such as autism, ABIs (acquired brain injury), Huntingdon's, Korsakoff's, drugs & alcohol and eating disorders.

In the development of the business case there has been extensive discussion about both groups:

- It is felt that currently commissioned psychological therapy services in primary care are working with a different population and that more work must be done before bringing this into scope. This will take place during 2014-15
- These behavioural conditions may benefit from an OBC approach, and that this could be achieved by an alignment with mental health services. The challenge for this work is that for the most part budgets that might support these needs sit outside of the mental health pooled budget and so (1) the inclusion of these conditions in scope needs wider clinical and stakeholder engagement and (2) there would need to be a process to bring the relevant budgets into alignment with the MH pool.

A number of groups have been ruled *out of scope:*

- People with organic mental illness (clusters 18-21). The needs of this group will be picked up within OBC for the Older People
- People receiving care for their mental health entirely within primary care. This group will only be considered for scope when it is considered both desirable and is practically possible to align primary care and mental health commissioning
- People seeking general information, advice and support in relation to mental health. At this stage the proposal is to retain a universal information and advice service and to support primary preventative public health approaches (the Oxfordshire Wellbeing Service)
- Children and Young People's mental health services
- People who are homeless and do not have a mental health diagnosis in terms of clusters 4-8 and 11-17
- Forensic services. It is possible that this may be reviewed at a later date should it be possible to align specialist and local commissioning. It is recognised that it would be desirable to have a more effective pathway between forensic and local services to support better outcomes for people who move between these services, and to better manage demand on local services
- Assessment and advocacy in relation to MHA83. It is recommended that the discharge of legal duties around the assessment, detention and advocacy for people under the mental health act is kept separate. Obviously, for some patients the outcome of their assessment will place them in the scope of OBC

It should be noted that there has been considerable discussion especially regarding the potential to include primary care and forensic mental health services in scope. It is proposed that OCCG continues to explore these areas as it proceeds with the development of OBC. The scope carries challenges in terms of money flows for the pool and also contracting challenges where some services may be within an OBC model and others may need to be contracted separately (but currently sit within the main Oxford Health contract, for instance).

8. Commercials and contract options


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North East


Oxford City


South East


South West


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The Mental Health service is facing a number of challenges in terms of how services are commissioned which has hampered the providers' ability to develop services and plan for the future needs. These include:

- Multiple services commissioned separately
- Multiple commissioners
- Limited promotion of common goals and integration
- Lack of certainty year on year for providers in terms of finances, volumes and services
- Lack of coherent commercial strategy

Moving forward, it is desirable for the sector, that commercial arrangements support and are aligned to the outcomes for patients, whilst also ensuring that the optimum value for money is achieved for both patients and taxpayers with an appropriate risk transfer. The following commercial terms have been developed to support this.

An Alternative Payment Mechanism

To enable the providers to have the flexibility to deliver the services in the manner they determine is most appropriate to achieve the desired outcomes, the traditional method of payment (block and or activity based payment) is not appropriate and therefore an alternative approach is required.

Monitor's stated long-term aim is to improve the payment system to support delivery of good quality care for patients in a sustainable way. Their proposals are designed to help commissioners and providers address the strategic challenges facing NHS care in three ways:

- by offering more freedom, to encourage the development of new service models;
- by providing greater financial certainty to underpin effective planning; and
- by maintaining incentives to provide care more efficiently.

Under the Health and Social Care Act 2012 it is possible to make" local variations" to pricing where *"..adjustments to prices, currencies or payment approaches is in the interests of patients to support a different service mix or delivery model. This includes cases where services (with or without national prices) are bundled..".* It also requires that such variations are disclosed to Monitor and published to assist Monitor in facilitating the sharing of experience around new payment approaches. This is expected to help enhance system wide incentives such as prevention, integration, improved outcomes, improved patient experience. Payment approaches might include pathway, capitation or outcomes based payments.

Monitor's consultation document proposes a set of overarching principles to support local price variations. OCCG's approach supports these to date and will need to continue to do so throughout the contracting process. The principles are:

Local agreements must be in the best interests of patients. They must maintain the quality of health care now and in the future, support innovation where appropriate, and make care more cost effective and allocate risk effectively

Local agreements must promote transparency and accountability. They should make commissioners and providers accountable to each other and to patients, and facilitate the sharing of best practice

Providers and commissioners must engage constructively with each other when trying to reach local agreements. This should involve agreeing a framework for negotiations, sharing relevant information, engaging clinicians and other stakeholders where appropriate, and agreeing appropriate objectives.

Monitor have a clear expectation to see more widespread development of new services, particularly services which give better and more sustainable support to growing patient groups with multiple care needs. They are also keen to encourage innovation in service design around integrated care. As a result, they are looking to give commissioners and providers' greater freedom to experiment with new payment approaches to support the new models of care as they develop.

The approach which OCCG is following in determining the financial envelope and the process which will be adopted in negotiating with the provider adhere to the above principles

These principles have been further expanded to provide an indication as to what Monitor will be looking for as evidence to support adherence to them.

Best Interests of Patients		Transparency		Constructive Engagement	
Quality	• Maintain or improve outcomes • Patient Experience • Safety	**Accountability**	• Information should be shared in a way to that allows commissioners and providers to be held to account by one another, patients, the general public and other stakeholders	**Involvement of relevant clinicians and other stakeholders**	• Are relevant clinicians and other stakeholders, such as patients or service users involved, in the decision-making process?
Cost Effectiveness	• More cost effective without reducing quality			**Information Sharing**	• Are there agreed polices for sharing relevant and accurate information in a timely and transparent way to facilitate effective and efficient decision-making?
Innovation	• Support development of new and innovative service delivery models	**Sharing Best Practice**	• Innovations in service delivery or payment approaches should be shared in a way that spreads best practice	**Framework for Negotiations**	• Have the parties agreed a framework for negotiating local prices, variations and modifications that is consistent with the existing guidelines in the NHS Standard Contract
Allocation of Risk	• Allocation should be undertaken in a way that protects the interests of patients			**Short and Long Term Objectives**	• Agree clearly defined short- and long-term strategic objectives for service improvement and delivery before starting price negotiations

In taking the decision to proceed to Phase 3 OCCG are bound by central policy and guidance, their own standing financial instructions and national and EU procurement legislation. OCCG have stated throughout this process that, given the provider geography, it is likely that current incumbents would continue to be involved in the service delivery in some form.

In deciding the appropriate method by which to implement this contract, a number of factors need to be considered.

Current policy and guidance

The awarding of contracts is subject to significant guidance, policies and legislation. Monitor, the healthcare regulator, has recently issued a consultation document regarding their guidance for commissioners in terms of procurement. Whilst this document is currently only at the consultation stage, it provides an indication as to Monitor's approach and interpretation of the Health and Social Care Act 2012.

The guidance makes it clear that commissioners are expected to act in a way that achieves the following whenever they are procuring NHS healthcare service, irrespective of the process by which they identify the most appropriate provider:

- Securing the needs of health care service users
- Improving the quality of services
- Improving the efficiency with which services are provided

Furthermore, commissioners must:

- Act in a transparent, proportionate and non-discriminatory way
- Procure services from providers most capable of achieving the overarching objectives including value for money
- Consider appropriate ways of improving services including services being provided in a more integrated way.

The guidance from Monitor refers to circumstances where 'a commissioner carries out a detailed review of the provision of particular services in its area in order to understand how those services can be improved and, as part of that review, identifies the most capable provider or providers of those services'. In these circumstances it may be appropriate to proceed without running a competitive procurement.

(page 23 of its draft Substantive Guidance on the Procurement, Patient Choice and Competition Regulations 2013).

Monitors website states:

"The guidance makes it clear that the regulations do not force commissioners to go out to tender for every service, but equally commissioners should not simply roll-over existing contracts without first asking how good the service is, and whether it could be improved to give patients a better deal. If so, the next steps might be evaluating alternative providers if there are any and if not negotiating a better arrangement with the existing provider. These are matters for commissioners to consider in exercising their duties……."

Available Market

Given the wide ranging nature of the proposed outcome based incentivised contract, a number of providers will need to participate.

OCCG considers that it is hard to envisage how the service can be provided without at least some of these incumbent providers. That said, their role in the future service delivery model would be need to be determined.

OCCG held a provider event on 5th November 2013 to provide an opportunity for the wider provider market to hear about their plans and to understand the potential interest. The event was attended by 14 NHS organisation representatives, 14 Voluntary Sector representatives and 17 private sector representatives.

Approach

There are two approaches which OCCG could use to identify and appoint providers to deliver the incentivised outcome based contract, taking into account Monitor's guidance and the objectives which they are looking to achieve:

1. **Through existing providers via a service review exercise**
2. **Via a procurement process such as competitive dialogue**

Whilst the competitive dialogue approach is well established and the steps which need to be completed are clearly documented, the service review approach is not.

OCCG, would through this service review approach, be seeking assurance from the providers of their understanding, capability and appetite to work with the CCG in developing and implementing the new commissioning approach within the required timescales. Irrespective of the approach selected, OCCG need to ensure adherence to the Monitor guidelines. Each is not without its risks of challenge and therefore consideration needs to be given to provide clear evidence of how the decisions have been taken and why, and importantly, the impact on patients.

We have also spoken directly with Monitor (Competition Policy Department) who we have updated on progress to date, our approach and our proposed actions following approval of the business case. They have confirmed that OCCG's approach is consistent with the draft consultation which is expected to be finalised in the near future.

It is therefore critical that OCCG can clearly demonstrate and evidence adherence to the above in deciding how to source and identify the most capable provider for the service. This will be achieved irrespective of which route is taken. A thorough evaluation of options, decisions and rationales will be undertaken and documented. The needs of the patient is put at the forefront throughout.

Recommendation

If OCCG were to select Option 1: With existing providers via a service review exercise it is recommended that a staggered twin track approach is taken.

By this process a milestone would be identified at the mid-point of the service review. At this milestone point if, OCCG has concerns as to the successful outcome of the process and or the providers indicate that they are unable or unwilling to continue, initial preparation activity should be undertaken to enable them to go to the wider market subsequently if appropriate. In undertaking this at the midpoint this will also put some competitive tension in the process.

There should not be any activity with the wider market itself, until such time as the service review process has been completed and the OCCG have taken the decision regarding whether or not to competitively tender the contract.

This approach does and should not predetermine the outcome of the provider assessment, but instead looks to limit any delay in implementing the contract should OCCG decide to utilise the competitive procurement route.

This is outlined in the timelines later in this section.

Option	Benefits	Risks
1. *Proceed with existing providers via a service review exercise*	• Less likely to destabilise • Understand the local health economy better • Closer relationships with commissioners • Can be quicker and less bureaucratic • Shows OCCG is collaborative • A smoother and more streamlined process • Flexible approach permitted, unconstrained by formal procurement processes • Reduced risk of destabilising service provision • Reduced risk of issues arising from service transition/mobilisation	• Lack of competitive tension to get providers to go further; faster' • Entrenched views hard to overcome • Current culture not conducive to change • Harder to confirm value for money and that you have indeed got 'the most capable provider' • Risk of challenge from providers not involved in process • Tells wider market that OCCG is not 'open for business', making subsequent procurements slightly harder • Risk of challenge that OCCG should have undertaken competitive procurement in order to comply with the 2013 Regulations • Untested approach in new environment under the 2013 Regulations. Lack of clarity around precisely what evidence is required to identify 'the most capable provider or providers' • Risk of being able to demonstrate best value for money in the absence of competitive tension
2. *Proceed to procurement process such as competitive dialogue*	• Sets clear signal to market that OCCG means business • Get more responsive providers • Better demonstration of value for money • Less risk of challenge • You are assured of getting the best providers (*better due diligence) • Shows OCCG is professional and open to innovation • Provides a safe environment for providers to innovate • Gives third sector and not-for-profit organisations more chance to get involved. • Should ensure full compliance with the procurement regulations • Maintains competitive tension amongst a number of providers until quite late in the process - arguably delivering better value for money • Competitive dialogue may identify solutions not previously considered or identified	• Can take time and is often bureaucratic • Incumbents will feel threatened (but this can be mitigated) • Harder to manage multiple expectations if wider procurement used • More expensive (but better Return on Investment than alternative route above) • Risk of insufficient market interest to generate a genuine competition • Risk that incumbent providers will be able to determine the composition of stronger/successful consortium

The purpose of this service review is for the commissioner to be assured that the providers have the understanding, capability and capacity to deliver their vision for Outcomes Based Commissioning.

Engagement and dialogue throughout the process leading to the contract award is an important lever in OBC which will enable the providers to take greater ownership of the delivery of the service.

The commissioner should to be assured through this approach and in the specification of the contract, evidence and plans that the provider will have that will have in place a successful programme to implement and manage the transition to OBC.

Criteria for assessment evaluation

Critical success factors will be discussed as part of the process. The table provides some potential high level criteria which would be developed further in advance of commencing this exercise.

The critical success factors will be applicable to both option routes in determining the successful providers.

The success factors have taken into account research evidence highlighting a successfully integrated care service

- The desired outcomes must shape the form that enables them to happen
- Making time and effort to understand each other's agendas.
- Have the right people with the right level of decision-making power together
- How to integrate processes as well as services.
- Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes.
- Pay attention to issues in procurement early on, whether they are about how to integrate different legal and planning processes or address issues around building design and IT infrastructure.

Area	Critical Success Factors
Patients/Carers (not providers) are the focus	Will this model result in clear, measurable deliverables to patients? Is there development of a performance and feedback process actively engaging with patients/carers?
Consortium strength	Will the breadth of organisations provide the delivery solution? A clear map of the strategic fit of each of the provider organisations?
New working relationships are accommodated in the arrangements	Does the new structure and governance support the key changes required, e.g. integrated top team, systems, shared identity, What are the contractual relationships with all providers Does the alignment of organisations objectives to meet the desired outcomes
Outcomes v outputs	A delivery mechanism that works toward patient outcomes and not volumes of activity or inputs
Financial Assessment	Demonstration of the investment and savings plan, confidence of achievement. Realistic interaction demonstrated between financial planning and the implementation plan
Prioritisation of objectives and decision-making on workloads and resourcing can take place	Does the structure enable clarity around the strategic objectives to deliver the outcomes? Are their linkages demonstrated across the providers? Is there clarity about who is accountable for what? Are there supporting processes that manage potentially conflicting priorities?
Individuals are clear about their responsibilities and accountabilities and can act in an empowered way.	Does the structure enable application of a performance management system? Can individual and team development needs be identified and resourced to meet desired outcomes?
Timescales/Mobilisation	Proposed route map to achieve outcome based Incentivised contract along with patient outcomes and financial benefits

Contract Form and Content

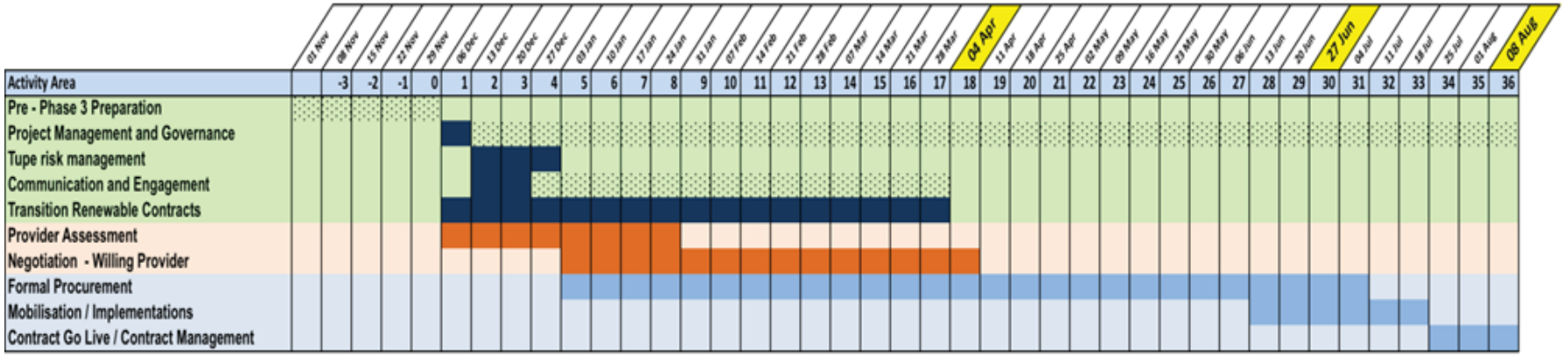
The final contract form will be based on the latest NHS Standard Contract for Clinical Services. Additionally, to reflect the incentivised, outcome based approach, several additional components will be included:

Contract duration	to facilitate effective changes in the service delivery model, a longer term contract is required. This approach supports the providers in developing and implementing their new operational models, and provides an opportunity for the expected benefits to be achieved. A contract length of 5 years with a potential extension of up to 2 years is proposed. There will be appropriate break clauses during the contract period to facilitate a change in provider if required due to unsatisfactory performance.
Change Mechanism	this is required to enable flexibility for both the commissioner and provider so that as the service is developed, the indicators reported and feedback from patients is received, changes can be made as appropriate in a non-cumbersome manner.
Gain share arrangement	to ensure that providers look for efficiencies as well as meeting patient outcomes, a gain share arrangement is required. Whilst the principles of this can be set out upfront, the details will need to be subject to negotiation with the successful provider.
Greater emphasis on patient / carer feedback	direct patient and where appropriate carer feedback on the service being delivered will form part of the incentivised performance framework to ensure satisfaction and provide an on-going opportunity for improvement suggestions.
Incentivised performance framework	this is part of the heart of the contract and will be included as indicated in sections [x] and [y] above.
Back to back arrangements	where there are material subcontractors (in terms of value and or contribution), the contracting provider will be required to have in place back to back legal arrangements to provide OCCG with further assurances that the contract will be delivered as expected. Greater transparency of data and information – this is required to facilitate better partnership working between the contracting parties to deliver changes across the system and better care and outcomes for the patient.
Conditions Precedent	prior to the contract going live and at appropriate stages of the implementation process, there will be check points. For the provider to continue with the implementation of the clinical service, they will have to demonstrate to OCCG that they have satisfied agreed preconditions for service commencement.

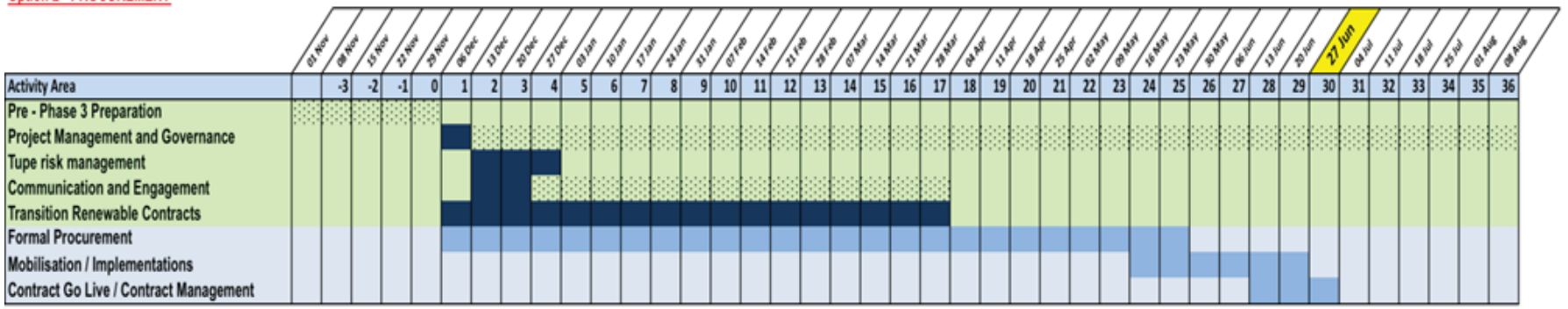
A high level milestone plan for the above recommendation, incorporating both approaches has been developed and is summarised below, along with a brief explanation around the activity required, this is expanded in the Appendix. A full plan would be developed as a first task in Stage 3 depending on the route selected.

PHASE 3 DECISION MAKING PROCESS

Option 1 - SERVICE REVIEW [FOLLOWED BY OPEN PROCESS IF REQUIRED]



Option 2 - PROCUREMENT



Activity Area	Key Activities / Purpose
Pre-Phase 3 Preparation	Activities required to enable OCCG Governing Body to decide whether and how to proceed towards implementing an outcome based incentivised contract
Project Management and Governance	Ensures that appropriate Governance and reporting arrangements are in place to oversee timely delivery of the project and that any issues and risks which arise are identified and managed in an effective manner
TUPE	Clarify TUPE related implications for each option, understanding the activities required to support this and incorporate this into the overall plan
Communication and Engagement	Develop and execute the stakeholder communication and engagement plan, ensuring consultations are undertaken where necessary and that all engagement is held at an appropriate time in the overall process
Transition of Renewable Contracts	As individual service contracts come up for renewal from November 2013 onwards, their new terms will take into account the move to outcome based contracting. Relevant indicators, data collection and outcomes will be included to aid the transition to a common set out of outcomes and a single contract.
Provider Assessment	Process by which OCCG will seek to be assured as to the understanding, capability and appetite of local incumbent providers to participate in the delivery of the incentivised outcome based contract. Providers have the opportunity to share with OCCG their high level service delivery model which they believe would deliver the specified outcomes for the local population
Negotiation – Willing Provider	In the event that the OCCG Governing body are assured that existing providers are able to deliver an effective service delivery model that will achieve the desired outcomes, then a process of negotiation will be undertaken. This will include the finalisation of contractual key commercial terms such as indicator thresholds, risk and gain share, and the financial envelope
Procurement Execution – Competitive Dialogue	Should the OCCG decide to go to the wider market via a procurement exercise, a competitive dialogue approach would be adopted. This enables providers to work with the commissioners to some degree, in developing the final delivery model. There are a number of stages within this and timescales are determined through EU procurement legislation
Mobilisation / Implementation	Following the successful appointment of providers, they will work with OCCG to finalise and agree the mobilisation and implementation plan. Progress against this will be then be monitored
Contract Go Live / Contract Management	The final stage of mobilisation will be to confirm that the provider has put in place those things which were agreed to be critical to the successful delivery of a clinically safe service. At this point, the contract will go live and OCCG, in conjunction with the CSU and the provider, will deliver, monitor and manage the contract

9. Risks and mitigations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For mental health there are a number of risks:

- Resistance from current providers. Whilst there remain significant concerns and uncertainty about OBC in practice (especially amongst providers) broadly stakeholders are supportive of OBC as a concept, and agree with our approach to scope, outcomes and quality. OBC is consistent and a development of both our local and national strategic approaches to mental ill-health and recovery.

- The transition to OBC. There will remain a degree of uncertainty in this until OCCG make their decision re the implementation approach. We continue to engage with our current providers to support the aspect of market development that will be needed to support this process. Note that there are 12 month notice clauses in all of our main contracts, which all run to March 2015.

- OBC in practice. We need to do a lot more modelling to support aspects of the OBC in practice, and there is a considerable risk that the need to deliver efficiency may conflict with the need to test the patient flows within PBR clusters over an extended period. This will need to be considered in the development of the contract and expectations around implementation.

In addition to risks regarding the process we have identified potential unintended consequences of this process. There are risks attached to the development of an outcomes based contract – particularly as Oxfordshire is among the first tier of CCGs nationally to develop this approach. Importantly however, these risks can be mitigated through the delivery of the approach itself. A full risk assessment is included in the appendix.

Risk Description	Severity / Impact (1-5)	Likelihood (1-5)	Risk Rate Score (severity x likelihood)	Controls/Mitigations	Risk Rating after mitigations		
					Impact	Likelihood	Risk Score
Provider Risks							
previously unmet need will be translated into demand if activity risk is no longer held by GPs	2	3	6	a) agree explicit referral criteria with GP s b) include GP s in provider value chain financial incentives c) cap activity risk as part of commercial negotiation between CCG and prime provider	1	2	2
Demand increases during term of contract due to demographic change	3	4	12	a) quantify expected demographic change and reflect in commercial negotiation b) invest in more efficient care systems to reduce duplication, avoidable admission, reduced permanent admission to residential and nursing homes	2	2	4
Lead provider lacks experience of managing value chain	4	3	12	CCG to require reach through rights, to set out its expectations of the relationship between prime and its subcontractors and to seek details of the agreements, including incentive, penalties and performance management arrangements	2	2	4
Incumbent providers do not cooperate with prime , including withholding facilities	5	4	20	CCG to make consequences of not cooperating clear. Inform and Involve Monitor / TDA early in process	3	3	9
Inability to share information required to deliver integrated care	4	4	16	CCG to require evidence from potential providers about how they will share data as part of route to contract.	3	3	9
Increased costs of data collection required by COBIC contract	3	4	12	limit number of incentivised outcomes to approx 20 per contract. Seek to identify indicators that are generated as part of process of delivering care and that also can be used to provide management information for the provider.	2	3	6
Outcomes required are not in the immediate control of the prime provider	2	4	8	Adoption by provider of whole system approach to their work	2	3	6
Investment required in early year of contract . And access to capital may be (perceived as) limited	4	4	16	Adoption of commercial approach to investment with returns over life of contract and beyond. Promote awareness of multiple potential sources of capital (public, private company, social finance etc)	2	3	6
Fear of change	4	5	20	Good leadership and change management required in provider and across value chain. Commissioners may need to make this a criteria in selecting their preferred lead provider.	3	4	12
New contract destabilises incumbent providers and damages their viability and ability to provide (other) service	4	4	16	Impact assessment undertaken depending on route to contract selected. Consider bringing work in scope	4	2	8

Rationale for impact assessment

The proposals for service transformation set out in this business case will, if implemented, have a significant impact on those who provide and use NHS services, and the public. The impact will differ depending on the route to contract selected.

As such, following the Governing Body decision regarding the future direction of travel, the CCG should consider an impact assessment is carried out to ascertain the impact of this decision on providers' sustainability and costs. This assessment will add to the wider analysis of costs and benefits for service users and the public. Undertaking a robust impact assessment of providers will also contribute to the ongoing programme of engagement and will better enable incumbent providers to mitigate risks where necessary.

It is particularly important that this assessment takes place in order to identify any unintended consequences and ensure that services outside of those contracts confirmed to be in scope in the next Phase remain stable. The nature of cost structures and co-dependencies across services mean that changes in contracting patterns could affect the sustainability of local providers.

Scope of impact assessment

The scope and structure of the impact assessment will be informed by national Provider Sustainability Guidance. The key components of the impact assessment could include:

- Defining the objectives of the agreed programme of service transformation
- Assessing impact on incumbent providers: costs and quality
- Assessing impact on incumbent providers: unintended consequences
- Benchmarking
- Broader health objectives

A change management programme

OBC requires organisational development for the CCG and the providers as it represents a shift in the traditional dialogue and relationship between commissioner, provider and the patient/carer. More fundamentally it will require the providers to lead and be accountable for a significant change management programme in order to reconfigure how they deliver services together.

This section focuses on the change management required by providers and how the commissioner can support and influence this change.

OCCG have stated that they wish to minimise destabilising providers and there are a number of steps that could reduce the risks inherent in a change management process.

In our engagement to date patients/carers clinicians and health and social care practitioners have welcomed the opportunity to design how services are provided to deliver OCCG's vision. This shift in practice will however require different working relationships, accountabilities as well as structural and systematic changes.

Effective Communication on change management

- What is the purpose of the restructure?
- How will it operate in practice?
- Who will be affected and how?
- What will it mean for me?
- What are the steps along the way, including milestones and timescales?
- Where do you go to get help and how to be involved?
- What is the new structure and what are the new roles?
- What new behaviours will be required?
- Will training and development be provided?

The commissioner, through the route to contract process (service review or procurement) can support, facilitate and enable change by:

- Support and open communication throughout
- Discussion and agreement with the providers to agree KPIs that recognise the change management required, particularly within the first year of the contract
- Including questions relating to managing change as part of the critical success factors in selection of the provider.

Open communication

Whilst it will be the provider's responsibility for leading the change management process within their organisations, commissioners should provide support for this. This process should be agreed at the beginning of the next stage of OBC development and could include:

- Agree communications with a principle for early, open communication so that providers can manage and control communication through their own channels to their stakeholders and staff
- Regular executive and board level engagement to ensure top-level commitment to the change across the provider organisations
- Joint commissioning/provider workshops to support the process

Impact on Commissioners

This approach similarly needs to be applied to the commissioning team as they move to a new relationship with providers. This will have implications for communications within the CCG but also to identify appropriate learning and development required in moving to:

- Conducting service review/procurement
- Contract performance monitoring and review
- Joint commissioning with OCC in an OBC approach

The dialogue process

Engagement and dialogue throughout the process leading to the contract completion is an important lever in BC which will enable the providers to take greater ownership of the delivery of the service [sync this with the section on this process]

The commissioner should to be assured through the dialogue and in the specification of the contract evidence and plans that the provider will have that will have in place a successful change management programme. In addition through the contract monitoring will agree a process for automatic review of change management programme that is evaluated throughout the lifetime of the contract

Successful change management

- The desired outcomes must shape the form that enables them to happen
- A clear map of the strategic fit of each of the partner organisations
- Continued engagement with patients and carers with within a performance and feedback culture
- Making time and effort to understand each other's agendas.
- Have the right people with the right level of decision-making power together
- How to integrate processes as well as services.
- Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes.
- Pay attention to issues in procurement early on, whether they are about how to integrate different legal and planning processes or address issues around building design and IT infrastructure.

As well as drawing from broader evidence regarding effective change management, providers will be able to access evidence on successful factors that support effective integration specifically in relation to health and social care. A literature review of integrated care commissioned by LGA, Monitor, NHS England and DH from Integrating Care will be made publicly and freely available in December 2013.

10. Options for decision


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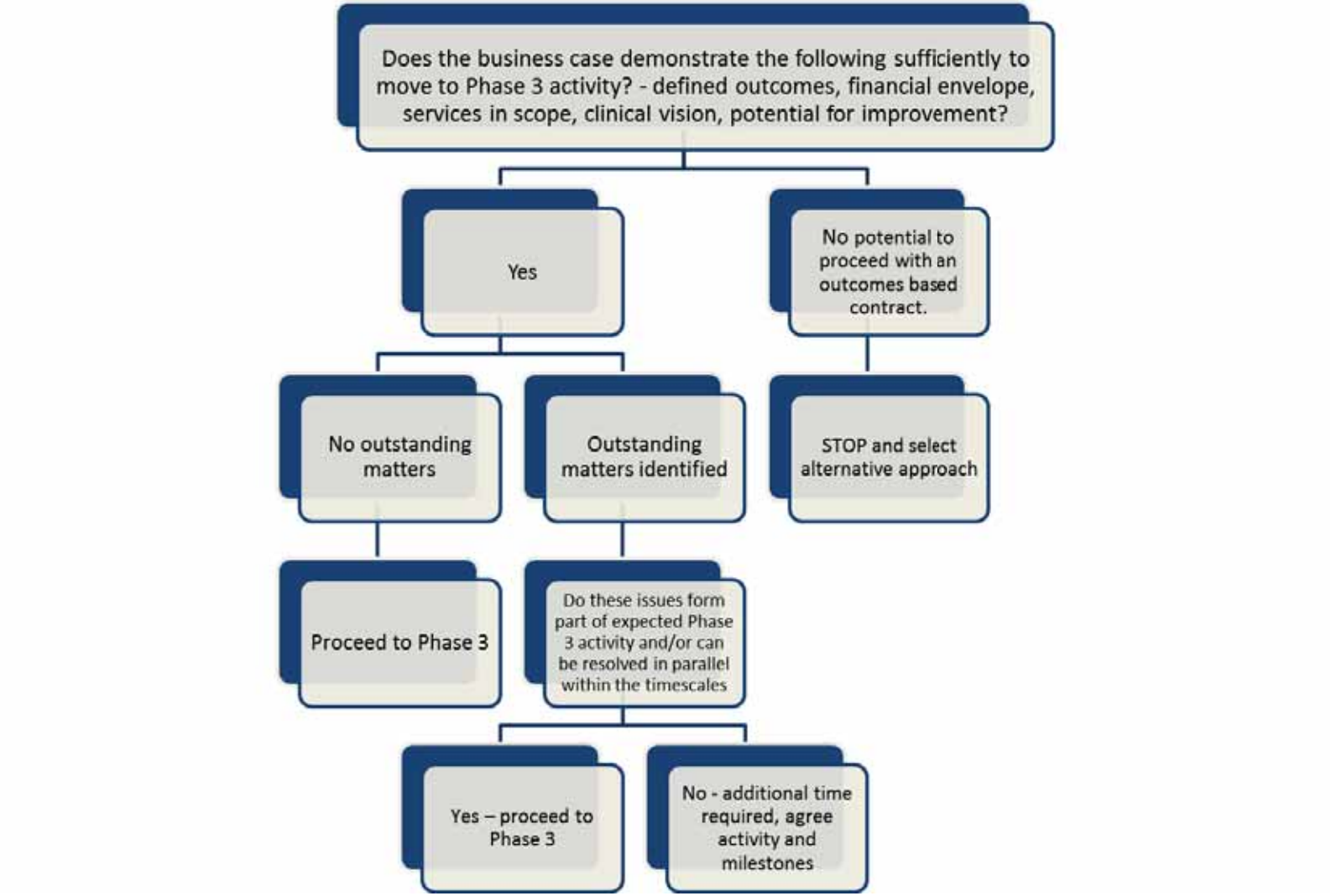
OCCG has requested the following flowchart used to assist the decision to proceed to Phase 3.



Does the business case demonstrate the following sufficiently to move to Phase 3 activity?

- defined outcomes
- financial envelope and Services in scope
- potential for improvement
- clinical vision

Area	Phase 2 activity	Phase 3 activity
Defined outcomes	The outcomes have been developed through a number of stakeholder engagements involving patients/carers, and clinicians. An incentivision model has been applied to all indicators.	Further testing of outcomes and indicators with providers (in both routes to contract). Review of data availability and collection
Financial envelope and services in scope	The financial envelope has been identified with analysis of contracts in scope now and those with potential to be included later.	Further refinement with providers and development of incentivisation and risk transfer model
Potential for improvement	The financial model demonstrates potential impact of OBC compared to PbR/Savings	Providers required to demonstrate how they would work together to deliver efficiencies
Clinical Vision	A clinical vision has been developed outlining the transformation required and what needs to be different with OCCG leads. influenced by the service scope and engagement sessions with the OCCG leads for mental health	Providers required to demonstrate how they can change working practices to achieve vision
Contractual options	Options for route to contract have been outlined with risk assessment, milestones and criteria that could be selected	Negotiation with providers risk transfer, incentivising to develop a contract structure that deliver the requirements.

In light of the above we consider that the business case sufficiently demonstrates that mental health should move to a single outcome based contract in order to improve mental health for people in Oxfordshire and deliver better value for money to commissioners and the wider health economy. The business case outlines the outcomes and indicators to be contracted against, the incentivisation of the indicators, the service vision, the scope of inclusion for a contract and the segmentation model.

ROUTE TO CONTRACT

The Business case has all been developed in collaboration and partnership with stakeholders from across Oxfordshire, service users and clinicians. The mental health expert group has provided ongoing rigor and expert challenge to the development of the business case.

A paper summarizing the business case was taken to the Mental Health Joint Management Group (JMG) on 14th November. At the meeting the Group has approved the approach to developing outcomes based commissioning, the outcomes and indicators, and the scope of patients and services, and the health and social care budgets to be included within the outcomes based contract.

There are two approaches which OCCG could use to identify and appoint providers to deliver the incentivised outcome based contract. These take into account Monitor's guidance and the objectives which they are looking to achieve. The routes are expanded in Section 7: Commercial and Contractual Options, they are :

1. **Through existing providers via a service review exercise**
2. **Via a procurement process such as competitive dialogue**

It is recommended that if OCCG decide to follow route 1 via a service review exercise a staggered twin-track phase is followed. In this method if OCCG has concerns as to the successful outcome of the process and/or the providers indicate they are unable or unwilling to continue, initial preparation activity should be undertaken to enable them to go to the wider market if appropriate without a significant impact on the timeline.

Wider provider market.

OCCG held a provider event on 5th November 2013 to provide an opportunity for the wider provider market to hear about their plans and to understand the potential interest. The event was attended by 14 NHS organisation representatives, 14 Voluntary Sector representatives and 17 private sector representatives.

The feedback from the providers was very positive regarding holding an event at this stage and all sectors, particularly third sector providers expressed a keen desire to be involved further.

Over the last year a number of CCGs have started to work in this way and some have already progressed to the procurement stage. Bedfordshire has let a £120m contract for musculoskeletal services and Cambridgeshire and Peterborough CCGs are in the middle of procuring a lead provider to deliver older people services and provide integrated acute and community pathways in a 5 year contract worth £1bn. Other CCGs include Northumberland CCG, Bexley CCG, Croydon CCG, Herefordshire CCG and Sheffield CCG.

National Interest and Support

There is significant interest nationally in the decision OCCG is taking. OCCG have engaged nationally with NHS England and No. 10 in this approach. Monitor are very interested in the outcomes of this. Public Health England are keen to support development of integrated services across health and social care.

11. Appendices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National Strategic Context

One in four people in the UK will suffer a mental health problem in the course of a year (The Mental Health Foundation, 2006). The cost of mental health problems to the economy in England have recently been estimated at £105 billion, and treatment costs are expected to double in the next 20 years (Department of Health, 2011).

National policy advocates commissioning for quality outcomes for people with mental health problems. A number of policies offer different perspectives on the direction of travel toward outcomes-based commissioning, which all align on the benefits of moving to outcomes-based commissioning.

The benefits of moving to outcomes-based commissioning fall into four categories:

1. Personalisation - outcomes-based commissioning incentivises healthcare providers to achieve outcomes that matter most to people with mental health problems rather than those created and negotiated solely by NHS managers
2. Co-production - both patients and clinicians are contributors – they must both be truly engaged in service design
3. Collaboration - multiple providers are encouraged to collaborate and coordinate patient care most effectively
4. Improved value - care is designed around groups of people with similar needs (e.g. problems encountered specifically with psychosis) allowing for more efficient planning and delivery of care.

Many national strategies advocate outcomes-based commissioning for people with mental health problems including:

- The Operating Framework for the NHS in England (Department of Health, 2013-14)
- The No Health Without Mental Health strategy and Implementation Framework (Department of Health, 2011)
- The NHS National Outcomes Framework (NHSOF) published by the Department of Health in 2012/13
- The Adult Social Care Outcomes Framework (ASCOF) published by the Department of Health in 2012/13
- The Public Health Outcomes Framework (PHOF) published by the Department of Health in 2012/13
- The Abandoned Illness (Schizophrenia Commission, 2012)

The Operating Framework for the NHS in England (Department of Health, 2013-14) takes person-centred outcomes as its main theme: 'putting patients at the centre of decision-making in preparing for an outcomes approach to service delivery, whilst improving dignity and service to patients and meeting essential standards of care.' Mental health services features as a core area of priority, particularly in terms of people with SMIs ('increased availability of psychological therapies for people with severe mental illness and long term health problems') and/or people with physical and mental health comorbidities ('the physical healthcare of those with mental illness').

The No Health Without Mental Health strategy and Implementation Framework (Department of Health, 2011) manifests government commitment to improving outcomes for people with mental health problems through high quality services. The statement in No Health Without Mental Health that there should be 'parity of esteem between physical and mental health services' underlines the importance of exploring new ways of commissioning and providing mental health services. It also shows recognition that the achievement of outcomes has to be through integrated and partnership working.

The policy focuses on six outcomes:

1. more people will have good mental health
2. more people with mental health problems will recover
3. more people with mental health problems will have good physical health
4. more people will have a positive experience of care and support
5. fewer people will suffer avoidable harm
6. fewer people will experience stigma and discrimination

The NHS National Outcomes Framework (NHSOF) published by the Department of Health in 2012/13 includes many references to improving outcomes for people with mental health problems. Some of these refer exclusively to NHS responsibilities, for example, 'preventing people from dying prematurely' (Domain 1) and 'improving patient experience of community mental health services' (Domain 4.7).

However, many outcomes are referenced in the Adult Social Care Outcomes Framework (ASCOF) and/or the Public Health Outcomes Framework (PHOF), indicating collaborative working across the sectors. These outcomes include but are not limited to:

- 'Employment of people with mental illness' (NHSOF, 2.5, p. 14; ASCOF, 1E, p. 27; PHOF, 1.8, p.11)
- 'Ensuring people feel supported to manage their conditions' (NHSOF, 2.1, p. 14; ASCOF, 1.B, p. 20, PHOF, 2.3, p. 13)
- 'Enhancing quality of life for carers' (NHSOF, 2.4, p. 14; ASCOF, 3B, p. 27)

Finally, The Abandoned Illness (Schizophrenia Commission, 2012) highlights the need to address outcomes for people with the specific problem of severe and enduring mental illness. There are 42 recommendations within the report that seek to improve integrated working and shared working with people with mental health problems. These include a move towards:

- increased access to psychological therapies
- greater partnership and shared decision-making with service users
- much better prescribing and a right to a second opinion on medication, involving (where appropriate) a specialist pharmacist
- extending GP training in mental illness to improve support for those with psychosis managed by primary care

A capitated outcomes based approach will reinforce and supplement this work, incentivising providers to make its delivery a reality.

CONTRACTUAL transformation

- Working with a lead provider or integrator to lead the provision of mental health services
- Promoting service integration and reducing fragmentation.
- Aligning incentives for organisations with the goals of the system (i.e. better outcomes and better value).
- Using a contract duration that promotes investment up front, to enable shifts in working practices to deliver savings and efficiencies over longer term.
- Reducing the number of KPIs to that necessary – with a focus on outcomes.
- Ensuring that NHS Terms and conditions are maintained, but that the contract reflects the new way of working – if we just continue with block contracts we are not commissioning.

CULTURAL transformation

- Leaving behind the PCT culture of an adversarial relationship between commissioner and provider, and shifting to an approach that is more collaborative, and one of shared problem solving.
- Building a different relationship with the public - patient organisations and representatives involved in maximising value as well as campaigning for more resources.
- Releasing innovative potential in providers, with clinicians taking responsibility for maximising value from the allocated programme budget, and delivering the outcomes the people of Oxfordshire want.
- Facilitating a culture of collaboration and integration between providers across the health and social care economy.
- Doing something different that proves the CCG is different from the PCT, and that encourages providers to "sit up and take notice"

OBC driving change for Mental Health Services

FINANCIAL transformation

- Delivering better value, sustainable services, and removing barriers to a more integrated approach.
- Providing savings to commissioners across both health and social care.
- Incentives aligned with responsibility to deliver the outcomes that are needed.
- Preparing the system for wider transformation - recognising that this contracting model could be applied to all programme budget areas in the future, delivering the same or similar proportions of savings.

OPERATIONAL Transformation

- Working with patients/carers and the public to derive meaningful outcomes.
- Increasing clinical engagement in innovation and service design and improving the use of evidence and information.
- Placing greater emphasis on prevention with incentives to work in partnership.
- Aiding the ability to design population based systems and networks.
- Working closely with partners across the health and care economy to ensure they are able to deliver this model in the future for other services

The following section outlines the key benefits that it is thought can be achieved through the development of a capitated outcomes based approach to commissioning older Mental Health services in Oxfordshire. Case studies are used to highlight the types of benefits that have been achieved through the use of similar approaches elsewhere, and the potential savings estimated to be achievable have been aligned with example savings opportunities in Oxfordshire.

Key points:

Evidence highlights the range of benefits – both financial and non-financial – that have been achieved through the use of similar approaches both nationally and internationally. Typical non-financial benefits include improved health outcomes, significantly reduced acute activity, reduced rates of institutionalisation, and improved user experience.

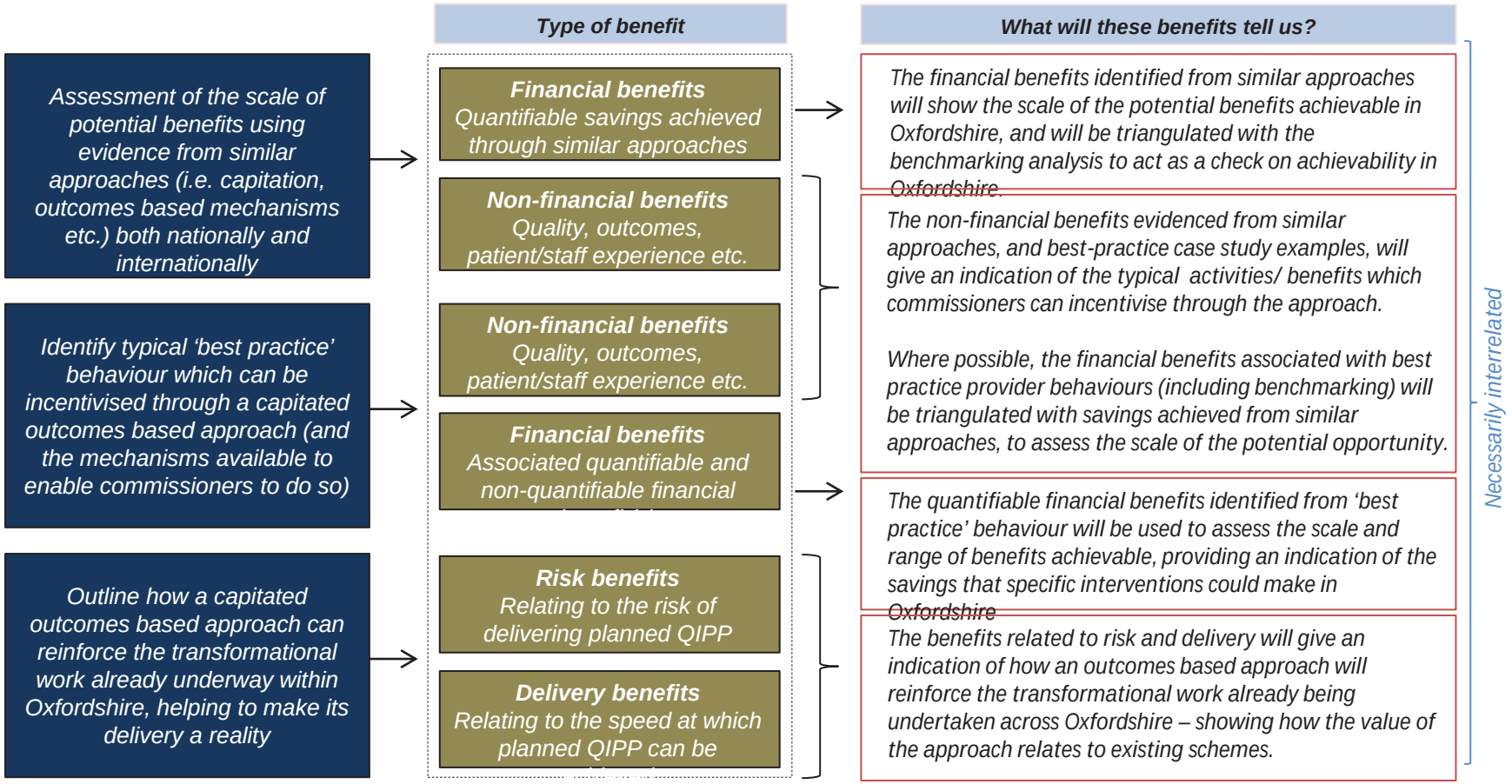
A number of studies evidence cost savings associated with specific elements/interventions relevant to a given approach, and a smaller number quantify the overall cost saving associated with the approach to the commissioner, or per capita. Of those studies which evidenced overall financial impacts, savings were evidenced of between 5-29% of current service expenditure.

Based on this review, a conservative literature benchmark of between 10-15% has been estimated for a capitated outcomes based approach to commissioning Older People's services in Oxfordshire. A number of mechanisms available to commissioners to drive value through this approach have been highlighted.

Analysis
- assessing the benefits

Oxfordshire Clinical Commissioning Group

A capitated outcomes based approach to commissioning Mental Health services will drive value across the system in a number of ways. The following approach has been used to outline this value, indentifying the potential benefits achievable through the approach in Oxfordshire



Evidence from similar approaches both nationally and internationally highlights the potential financial and non-financial benefits achievable through a capitated outcomes based approach.

	*Measured benefits (case study specific)**							
Selected whole system case study	Improved health outcomes	Overall cost savings (where quantified)	Reduced acute activity	Reduced emergency admissions	Reduced bed days and/or LoS	Reduced rate of institutionalisation	Improved patient experience	Key method(s) driving integration
Milton Keynes COBIC, UK	●	15- 20% reduction in spend					●	Capitation + Outcome measures
La Ribera model, Valencia	●	25% reduction in spend	●	●	●	●	●	Capitation + Outcome measures
PACE , US	●	5-15% saving per capita	●	●	●	●	●	Capitation
Vittorio Venito Study, Italy	●	1,125 Lire savings per capita	●		●	●		Integrated provision
Roverto Study, Italy	●	29% saving per capita	●		●			Integrated provision
Geisinger, US	●	Not quantified	●	●	●			Outcome measures
Beacon Health, US	●	Not quantified	●	●	●		●	Capitation
Veterans Health Administration, US	●	Not quantified	●	●	●			Capitation + Outcome measures
Torbay Care Trust, UK		Not quantified	●	●	●	●	●	Integrated provision

* The specific benefits measured between each case study included varies greatly – therefore the above table simply highlights where benefits have been measured in relation to each case study. Gaps in evidence, therefore, do not necessarily indicate the non-existence of various benefits – rather, gaps in evidence more commonly shows that specific benefits have not been measured within particular evidence analysis.

Analysis
Benefits of OBC – potential cost savings

Oxfordshire Clinical Commissioning Group

Of these case studies which measured overall cost savings – in terms of total service expenditure/ savings per capita - savings were evidenced of between 5 - 29% on current service expenditure. Based on these case studies, a conservative benchmark of 10 - 15% savings has been estimated for the approach in Oxfordshire

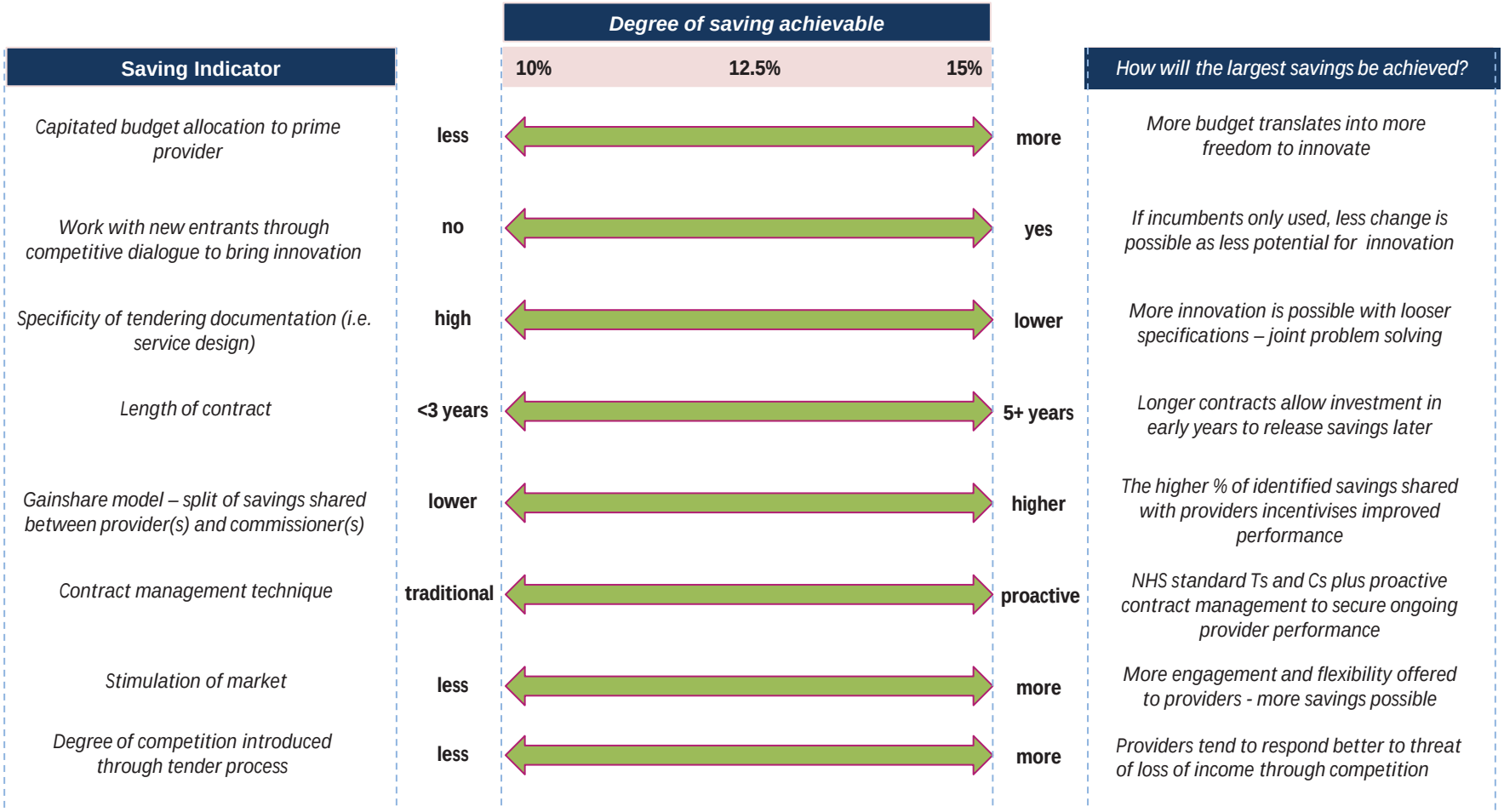
			Calculating savings benchmark for Oxfordshire		
Case study	Brief summary	Quantified financial benefit	% saving adjustment	Adjustment rational	Adjusted saving
Milton Keynes COBIC	Capitated outcomes based approach to commissioning substance misuse service - Jointly delivered by PCT and Local Authority.	15-20% overall saving to commissioner(s) in y1	60%	Different service	N/A
La Ribera model	Model using both capitation and outcomes-based contracting mechanisms to deliver integrated services for all patients registered within the region.	25% reduction in overall service expenditure	80%	Basic risk-adjustment applied	20%
PACE model	Integrated provider model using capitation payments, aimed at maintaining frail older people living in the community for as long as possible.	5-15% saving per capita over stand fee-for-service care	80%	Basic risk-adjustment applied	4-12%
Roverto and Vittorio Venito Studies	Studies aimed at integrated care for elderly patients, focussing specifically on integrated delivery across Health and Social care functions.	Up to 29% saving per capita	40%	Small scale study – no capitation mechanism used	12%

- These case studies give an indication of the scale of financial benefits which might be expected through the use of a capitated outcomes based approach in Oxfordshire if the change in the Oxfordshire system approximated the change seen elsewhere
- The speed at which this saving will be able to be achieved in Oxfordshire & its precise magnitude will depend on the responsiveness of providers to the outcomes based approach.

Using these case studies to form a conservative literature benchmark, it is been estimated that approximately 10-15% of service expenditure could be saved through the use of a COBIC approach in Oxfordshire.

The following slide explores mechanisms of the approach which can drive this savings value.

The level of savings achievable in Oxford can be driven by Oxfordshire CCG itself, with a number of mechanisms to drive provider value enabled through an outcomes based approach.



Analysis – Best practice provider behaviours

These mechanisms can be used to incentivise providers to deliver 'best practice' services through an outcomes based approach. Examples of best practice behaviours that could be incentivised through this approach – and their financial and non-financial benefits - are outlined below. The benefit of adopting these practices Oxfordshire will depend on the extent to which they are already in place (at scale) across Oxfordshire.

Case study (micro-level)	*Brief summary of specific intervention*	*Measured benefits (case study specific)*
Brent Integrated Care Coordination Service	Jointly delivered Health and Social Care service provided to people aged 65+ at risk of possible avoidable hospital admissions or premature admission to residential care. Patient needs assessed by care-coordinator, who then refers patients to most appropriate setting – including voluntary sector providers.	Cost effective in reducing hospital A&E attendances and hospital bed days – after a two year period, the net savings associated with the scheme were estimated to be between, 3 and 7 times the service cost per capita.
Bradford Intensive Community Support team	Provision of specialist support to older people with mental health problems at risk of admission to hospital or institutional care.	26% reduction in care home hours; 13% of patients seen had hospital admission prevented or delayed; £0.5m savings on service expenditure.
Fife intermediate care demonstrator project	Creation of team able to carry out home assessments during evenings and weekends	Improved discharge from hospital shortening length of stay.
EPIC (Elderly Care Project in Cornwall) - Cornwall PCT	Community matrons working alongside GPs in practices to improve primary care access to community services.	47% (457) reduction in emergency admissions of the elderly, and 84 facilitated early discharges, reducing LoS in one year of the service; reduced GP visits and increased patient satisfaction.
Northumberland District Nursing Service	Matching staff capacity to demand; introducing care pathways for home care; and setting targets for avoided admissions.	17% reduction in non-elective admissions; £668,000 saved in 5 months.
Buurtzog Community Nurses, Holland	Self-organising teams of community nurses able to undertake multiple care tasks.	Increased user and staff satisfaction; Dutch employer of the year x2; large reduction in non-clinical management; 50% reduction in community care costs.
Comprehensive Geriatric Assessment (multiple)	A review of evidence/ case studies measuring the effectiveness of specialist multidisciplinary assessment, usually from a specialist geriatric unit, and usually linked to care planning.	22% reduction of institutionalisation; 15% increase in chances of being alive and living in own home at end of period of follow up (typically one year); significant benefits on cognition. Most individual studies report cost savings of 5-15% - usually direct hospital costs - with other savings – e.g. due to reduced institutionalisation – un-quantified.

Evidence Base	Large Scale Change	Outcomes for patients
Evaluating integrated and community-based care: how do we know what works? Bardsley, M et al Nuffield Trust. (2013)	• That planning and implementing large- scale service changes takes time.	• Pay attention to the process of implementation as well as outcome. • There is a need to be explicit about how desired outcomes will arise and to use interim markers of success.
From the Ground Up: A report on integrated care, design and delivery. Institute of Public Care, Oxford Brookes University (2010)	• Clearly map the strategic fit of each of the partner organisations to identify opportunities as they arise. • Have the right people with the right level of decision making power together around the table.	• Have trust and confidence in each of the partners and recognise that all are working to the same outcomes. • Keep the service user at the heart of the process of change with a strong focus on achieving better outcomes. • For a successfully integrated care service, the outcomes must shape the form that enables them to happen.
Making integrated care happen at scale and pace. Ham, C, Walsh, N. The Kings Fund (2013)	• Find common cause with partners and be prepared to share sovereignty and develop a shared narrative. • Develop a persuasive vision to describe what integrated care will achieve • Establish shared leadership • Build integrated care from the bottom up as well as the top down • Pool resources to enable commissioners and integrated teams to use resources flexibly. • Recognise that there is no 'best way' of integrating care • Set specific objectives and measure and evaluate progress towards these objectives • Innovate in the use of commissioning, contracting and payment mechanisms and use of the independent sector	• Identify services and user groups where the potential benefits from integrated care are greatest. • Support and empower users to take more control over their health and wellbeing •
Joint Commissioning in Health and Social Care: An exploration of definitions, processes, services and outcomes.Dickinson, H et al **National Institute for Health Research, Service Delivery and Organisation Programme (2013)**	• The study confirms the findings of numerous previous studies of patient and public involvement; that it is difficult, time consuming and fragile in the face of radical organisational or policy change.	• The value of joint commissioning as a concept is seen as inherently good and able to deliver against a range of issues that health and social care organisations struggle with e.g. involving the public and service users in the design and delivery of care services.
Commissioning in health, education and social care: models, research bibliography and in- depth review of joint commissioning between health and social care agencies. Newman et al	• Trusting relationships between commissioners, and how these are built up over time by continuity of staff. • Clarity over responsibilities and legal frameworks, particularly in the context of any shared or pooled financial arrangements. • The importance of coterminosity between organisational geographical boundaries; the development of clear structures, information systems and communications between stakeholders.	

Case study reference list (1)

Cawston T et al, 2012, 'Healthy Competition', *Reform*, available at: http://www.reform.co.uk/resources/0000/0364/Healthy_competition.pdf

Cochrane et al, 1998, 'Senior surgeons and radiologists should assess emergency patients on presentation: a prospective randomised controlled trial', *J Roy Coll Edin*: 43:324-7.

Curry N and C Ham, 2010, 'Clinical and service Integration: The route to improved outcomes', *The King's Fund*, available at: https://www.kingsfund.org.uk/sites/files/kf/Clinical-and-service-integration-Natasha-Curry-Chris-Ham-22-November-2010.pdf

European Observatory on Health Systems and Policies, 2009, 'Capital Investment for Health: Case Studies from Europe', available at: http://www.sfes.info/IMG/pdf/capital-investment-for-health.pdf#page=27

Corrigan P, Hicks N, 2012, 'What organisation is necessary for commissioners to develop outcomes based contracts? The COBIC Case Study' Available at: http://www.rightcare.nhs.uk/downloads/RC_Casebook_cobic_final.pdf

Imison C et al, 2012, 'Older people and emergency bed use: exploring variation', *King's Fund*.

Johri M et al, 2003, 'International experiments in integrated care for the elderly: a synthesis of the evidence'. *International Journal of Geriatric Psychiatry*, 18(222–35).

Klein S, 2011, The Veterans Health Administration: Implementing Patient-Centered Medical Homes in the Nation's Largest Integrated Delivery System', *The Commonwealth Fund.*

Case study reference list (2)

KPMG, 2013, 'Buurtzog Community Nurses, Holland', available at: http://www.kpmg.com/global/en/issuesandinsights/articlespublications/value-walks/pages/netherlands.aspx

Mitchell F et al, 1996, 'Intermediate care: lessons from a demonstrator project in Fife: J Integrated Care 2011:19 (1)

McCarthy D et al, 2009, 'Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives', *The Commonwealth Fund.*

NHS Confederation, 2011, 'The search for low-cost integrated healthcare: The Alzira model – from the region of Valencia', available at: http://www.nhsconfed.org/Publications/Documents/Integrated_healthcare_141211.pdf

Torbay Care Trust, 2009, 'Integrating health and social care in England: Lessons from early adopters and implications for policy'. *Journal of Integrated Care*: 17 (6).

Turning Point, 2010, *Benefits Realisation: Assessing the evidence for the cost benefit and cost effectiveness of integrated health and social care*, available at: http://www.turning-point.co.uk/media/23642/benefitsrealisation2010.pdf

Weatherly H et al, 'Financial integration across Health and Social Care: Evidence review', *The Scottish Government Social Research*, available at: http://www.scotland.gov.uk/Resource/Doc/303234/0095107.pdf

White et al, 2010, 'Impact of senior clinical review on patient disposition from emergency department', *Emergency Medicine Journal:* 27:262-5

Young et al, 2007, 'Post-acute care for older people in community hospitals: a multicenter randomized controlled trial'. *J Am Ger Soc*: 55: 1995-2002.

Overall engagement approach for outcomes based commissioning

Building on firm foundations

The approach taken within the COBIC work-streams this past year builds on the firm foundation of existing practice within the CCG as reflected in the Communications and Engagement Strategy (May 2013). It set three overarching objectives, to:

- continue to build meaningful engagement with the public, patients and carers to influence the shaping of health services and improve the health of people in Oxfordshire
- increase confidence in OCCG as a responsive commissioning organisation
- further develop a culture within OCCG that promotes open communication and engagement within and outside the clinical commissioning group

This means that community, clinical and public engagement has been an integral aspect of prior work in developing the priorities, strategies and plans for each service area for which it is proposed that outcomes contracts are awarded.

Guiding principles of engagement

Amongst the principles identified within the CCG's Communications strategy is the need to use a range of engagement approaches to ensure that the work to develop commissioning based on patient-centred outcomes is underpinned by the views of patients, service users and carers. In taking forward the work, the COBIC team has also adopted the following additional principles that outcomes and indicators must be:

- evidence based – informed by both quantitative and qualitative research
- developed iteratively, supported by robust local engagement processes involving patients, carers and clinicians

Engaging with key stakeholders

The OCCG Outcomes Based Commissioning Programme Engagement Strategy (January 2013) recognised the need for effective management of the complex and multiple relationships that form as part of successfully delivering an outcomes based commissioning programme to the benefits of patients. To be effective such engagement needs to be contextualised by an understanding of local health needs and aspirations, and provide opportunities for key stakeholders to shape decisions.

Key to the approach adopted has been the decision to optimise existing structures and processes for engagement, rather than overlay temporary mechanisms to support outcome based commissioning. Hence, the CCG and COBIC team leads for each work-stream have been fortunate to be able to engage with the key stakeholder groups identified below using tried and trusted local routes, tools and techniques:

- Clinical engagement: Outcomes workshops involving GPs and clinicians from provider organisations, local services; updates and briefings to the six Locality meetings with member practices, understanding different perspectives. A
- Clinical Reference Group of subject matters experts for each service area provides clinical assurance
- NHS England Area team and Strategic Clinical Networks for Maternity and Mental Health (Can we confirm this has taken place for MH?)
- Patients and public: via local condition specific support groups/charities; face-to-face public events and outcomes workshops, CCG communication channels – including the website, Talking Health at https://consult.oxfordshireccg.nhs.uk/consult.ti, newsletters; media links
- Politicians: briefings; written correspondence with Members of Parliament
- OCCG Staff: including regular staff briefings
- Providers: via commercial senior management level meetings and more broadly through wider provider events
- Third sector: via Oxfordshire Community and Voluntary Action; condition specific support groups/charities; Healthwatch

The CCG has recognised the need for internal engagement. So, throughout the past year engagement on the three work-streams has been underpinned by initiatives to build greater understanding of the aims of the work, and of the COBIC concept and process. Building on from Board to Board meetings between the CCG's governing body and the COBIC Board, a series of presentations has been made to decision-makers, including via the Finance and Investment and Quality and Performance Committees. The COBIC team has engaged with the Executive, managers and wider staff of the CCG as well as of the Commissioning Support Unit.

At a national level the COBIC team has forged links with charities such as Age Concern to gain commitment to engage in work on outcomes definition and has kept HealthWatch informed (Jennifer – has this happened with Age Concern and HealthWatch?). It remains in close touch with NHS England. In line with the commitment in the NHS Mandate to "spreading better commissioning practice, including redesigning services, open procurement and contracting for outcomes, to ensure consistently high standards across all areas of commissioning" there is complementary work taking place externally to build greater understanding of COBIC amongst other commissioners and providers, for example via the forthcoming PCC workshop in Leeds in December.

A year of engagement: a phased approach to developing the outcomes and indicators

A programme of engagement to understand the outcomes that matter most to OCCG stakeholders has been progressed through the year, using a phased approach as described in the next slide below. OCCG values all the contributions that people have made to this process.

The intensity and nature of communications with stakeholders has changed during the life of the programme. For example, as part of phase 2, wider engagement with public and patient groups was key to further develop, test, and achieve buy-in to the outcome measures being developed. With each service area progressing at different paces, there have been varying levels of engagement required at different times.

The process of constructing outcomes, associated indicators and sharpening the vision for the future has been iterative. After each event and engagement activity the feedback has been considered and the outcomes refined to ensure the best fit with those matter to the service users. In each phase, the learning from generic engagement, about the programme as a whole, has been blended with greater understanding and insights gleaned from more specialised engagement with relevant subject matter experts and service users within specific work-streams.

Opportunities to ask questions of the CCG leadership about outcomes based commissioning have been built into the fabric of the programme - as part of informal dialogue as well as explicit within formal events. Those 'Q&As' shared as a routine part of reportage from engagement events and circulated to attendees have now been collated into generic Q&As published on the website.

Phase 1: Define criteria for outcomes for contracts

Initial work concentrated on answering the question "What makes an outcome appropriate for a contract?" For instance, for this outcome an indicator/s can be defined and measured at contract outset - or measurement can be developed over life of contract - and there is evidence that changes in the delivery of health and social care can make an impact on the outcome.

- The exploration of 'Outcomes that Matter' was launched at a major event for an invited audience of 118 patients, carers, professional, and provider organisations on January 8th 2013. Participants joined in themed workshop cafés to discuss outcomes for their respective care areas – mental health, maternity, and older people. Overall, the event set out to listen to what matters most to those involved in providing and receiving care; seeking the views of patients and public to incorporate into the outcome measures and explore and agree high-level outcomes for each service area. 84% of participants scored the engagement day as excellent/good

Phase 2: Define specific outcomes and indicators

During this phase the team refined the outputs of phase 1 and developed these further using both quantitative and qualitative data:

- defined a long list of high-level outcomes and indicators by means of a literature review and engagement with subject matter experts
- a review of the interviews in relevant modulesonhttp://healthtalkonline.org has been carried out to support and identify any gaps in the outcomes defined through research and engagement processes, thus widening the base of engagement
- prepared a cut-down list based on whether the outcomes proposed fit the 'outcomes for contracts' criteria
- tested the shortened list with CCG colleagues, and refined them where necessary

Phase 3 Further develop and test high-level outcomes and indicators (in progress)

A busy period of engagement is underway this autumn, using a range of engagement processes to test the list of outcomes with a broad range of clinicians, providers plus public, patients and carers, at both local and national level, as illustrated below:

- Briefings to member practices via CCG Locality meetings. These spanned the full process - the development of outcomes and indicators, scope and cohort definitions, the financial envelope, the blueprint and procurement options. Participants reviewed and challenged the draft outcomes in small group discussion. The CCG leadership has swiftly addressed feedback from Localities calling for more engagement by writing to all Oxfordshire GPs to outline the rationale and invite views via an online survey
- The team presented to the Oxfordshire County Council Social & Community Services Annual Provider Commissioning Conference in October. Also a Provider Information Event was held for incumbent providers (NHS and voluntary sector) to report on progress to develop Outcomes Based Contracts for maternity, mental health and older people and explain the commercial model
- An Outcomes Based Contracting (OBC) Information Event to inform and stimulate interest from the market was delivered on 5th November. Publicised via Supply2Health, this session provided an opportunity to understand the programme of work, the potential contractual vehicles, and address key commercial questions that have been asked so far.
- Final engagement workshops are envisaged to validate and prioritise outcomes and indicators with local stakeholders (November/December)

Going forward the outputs of Phase 3 will be a fully tested package that can be taken into a formal contractual process. OCCG has begun to consider, in conversation with the main providers, engagement principles to be applied in this next stage. These are to include: design principles for the service vision/blue print; key evaluation criteria; contractual principles; transition period arrangements.

Impact

It is noteworthy that the long list of high level outcomes originally shared with stakeholders in January 2013 has altered little throughout the process. Rather, the impact and benefits of engagement have been brought to bear in the subtlety and depth of understanding gained, and the way in which individual indicators have been refined as a result. The mental health workstream offers a good example of the importance of stakeholder engagement. Here an outcome of gaining (or regaining) 'paid employment' has been changed in response to service users and carers who have expressed a wish that maintaing a role that is 'meaningful' to them is a far more important outcome.

In summary, extensive stakeholder engagement has been undertaken over this past year. In part this has been directed at raising awareness of the work underway to introduce a more outcomes orientated approach to commissioning that will deliver better patient pathways and better value. Crucially, however, the main thrust of engagement activity has been on actively engaging groups of stakeholders in the detail of defining outcomes that matter and in agreeing associated indicators as a robust platform for moving on towards a formal contractual process.

Stakeholder engagement activity summary

At a large event on Outcomes that Matter held in January 2013, an invited audience of patients, carers, professional, and provider organisations came together with commissioners to share their views on what outcomes mattered most to them. Three separate 60-minute themed café workshops were held in relation to anxiety and depression, psychosis, and dementia, each focussed on exploring and co-producing high level outcomes.

The exploratory event was followed up in March with a focused workshop at which those same service users and carers who participated in January looked in detail at mental health outcomes and considered further priorities. In the light of their input, initial outcomes were developed for two segments of the mental health population – people with anxiety and depression and people with psychosis. These were further refined into a group of six outcomes and associated measures and presented to the Better Mental Health in Oxfordshire (BMHO) Board in August. As outlined in section 3.7 of this business case, the number of segments in the mental health population has subsequently expanded to four.

Since the summer there has been significant engagement to fully test and revise the outcomes, running concurrently with the work the ERG has done to define the scope of OBC for mental health and segment the local population. This engagement has included:

- Face to face workshops
- Two workshops were held with service users, carers, GPs and other clinicians and the voluntary sector at the beginning of September, one in Banbury and the other in Oxford (the two areas in Oxfordshire with the highest population).
- OCCG held a focus group with Re-energize on 4 September 2013
- Talking Health: 128 respondents completed an online survey inviting people to express views on the proposed outcomes and measures

Varied communication and engagement methods were used to promote these opportunities for engagement:

- Other websites: Key stakeholder organisations were encouraged to share information about Outcomes Based Commissioning for Mental Health and engagement opportunities and to link to OCCG's website so that the information could reach a wider audience
- Newsletters: The consultation was promoted in OCCG's Talking Health online newsletter and Oxfordshire Mind newsletter
- Local Media: via the Oxford Mail; Jack FM
- Partner organisations: including Oxfordshire County Council, Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Foundation Trust were asked to cascade to as many stakeholders and staff as possible that might be interested in sharing their views
- Social Media: short, targeted messages to prompt two-way dialogue via Twitter and Facebook, reaching over 4,500 followers

Stakeholder engagement activity summary

Reviewing and refining outcomes and measures in the light of engagement

All but one of the six outcomes initially proposed have been adapted in the light of stakeholder engagement. Additionally, one has been removed and two new ones proposed. Changes are being made to ensure that the final outcomes are robust, and reflect the following:

Robust methodology: additional outcomes have been articulated:

- to ensure that all aspects of a patient life cycle are supported, including survival, recovery and sustainability of health
- and that are informed by Professor M. E. Porter's 'Outcomes Hierarchy' which includes different tiers, relevant to a patient's life cycle and has been successfully applied to international health systems

Local engagement: to reflect the views of local people with mental health problems, and their carers, as expressed at engagement events held in Oxford and Banbury in September, and via an online engagement exercise. Key messages from the events are:

- Physical health – the importance of this concept was strongly endorsed
- Paid employment: people were concerned that the value of other forms of activity was not being recognized. They worried that a presumption about paid employment might have a negative impact
- Housing: people supported the importance of housing; definitions of "successful outcomes" were problematic
- People like the idea of a clinical assessment of recovery that felt as if it did not involve the patient and carer
- Participants felt that the outcomes and measures should be set up to ensure that financial reward for the provider is not at the detriment of the patient, so that sufficient quality controls are put in place

Expertise: to incorporate the guidance of external experts in outcomes based commissioning so that outcomes:

- are considered at a 'population' level
- include an outcome relevant to health improvement
- turn attention to the poor mortality outcomes for people with mental health problems rather than focusing on good physical health alone. This latter resonates with feedback from local engagement events

Further stakeholder engagement

Once the proposed measures were endorsed by the ERG in September, they were presented in draft form to the Mental Health Joint Management Group Meeting in September and then on to the Outcomes Based Commissioning Programme Board at the beginning of October. Minor refinement of the outcomes and measures has continued in October.

In summary, focused engagement has been undertaken throughout the year to enable the development of meaningulf outcomes for the mental health population of Oxfordshire. Supported by colleagues, including those within the Commissioning Support Unit, the OCCG leads have successfully adopted an incremental approach, permitting the considered development of outcomes and measures, and ensuring they have been genuinely co-produced with people with mental health problems and their carers.

Outcomes evidence

The outcomes are supported by national and international evidence. National and international policy indicate the universal importance of the outcomes, whilst national and international best practice demonstrate the impact of such outcomes on improved wellbeing and reduced cost.

The table on the following pages map these outcomes to examples of international and national policy and best practice. A legend is below.

- NHSOF: NHS Outcomes Framework (Department of Health, 2012/13)
- ASCOF: Adult Social Care Outcomes Framework (Department of Health, 2012/13)
- PHOF: Public Health Outcomes Framework (Department of Health, 2012/13)
- NHWMH: No Health Without Mental Health Implementation Framework ('IF') and Strategy ('S') (Department of Health, 2012/13)
- ICHOM: ICHOM holds outcomes metrics that are related to specific medical conditions rather than all of mental health. These metrics are provided by specific medical registries as opposed to one singular provider of metrics. Two of these registries have been used to compare OCCG's outcomes with international guidelines. These are:
  - SPR: the Swedish Psychiatry Registry
  - DPCTR: the Danish Psychiatric Central Treatment Register

Outcomes evidence

Outcome	National and International policy/guidelines	Best practice
People will live longer	• **NHSOF: "**Reducing premature death in people with severe mental illness." **(1.5);** "Improving people's experience of integrated care." **(4.9)** • **PHOF:** "Excess under 75 mortality rate in adults with severe mental illness." **(4.9)** • **ICHOM:** "Mortality, measured by survivor status/time of death.**" (DPCTR)**	**Schön Klinik Hospital Group's outcomes measurement at the Roseneck Specialist Eating Disorder Unit, Germany.** • In 2011, the Schön Klinik routinely measured over 3, 300 indicators across 130 physical and mental health conditions using a structured process called 'Quality Empowered Documentation' (scorecarding). ✓ This led to patients with anorexia nervosa experiencing an average 2.54 increase in their Body Mass Index & improvement on every outcome measure, including mortality.
People will improve their level of functioning	• **NHSOF:** "Ensuring people feel supported to manage their conditions." **(2.1)** • **PHOF:** "Self-reported wellbeing." **(2.23)** • **NHWMH:** "Public services work around people's needs and aspirations." **(IF, 7)**	**Schön Klinik Hospital Group outcomes measurement at the Roseneck Specialist Eating Disorder Unit, Germany.** • Outcomes were measured in a way that allowed patients to indicate their personal recovery rate within the parameters set by clinicians. Patients were asked to choose their desired weight from within a 'weight corridor' of 700 to 1000 grams rather than a single weight threshold. ✓ Weight outcomes surpassed the Klinik's sister eating disorder unit at the Bad Staffelstein Hospital.
People will receive timely access to assessment and support	• **NHSOF:** "Improving hospitals' responsiveness to personal needs." **(4)**; "Reducing time spent in hospital by people with long-term conditions." **(2)** • **ICHOM:** "Reintervention/readmission – measured by readmission timeframe and date."	**Family Support Team (FST)/ Child and Adolescent Mental Health Service (CAMHS) in Norfolk, UK.** • Norfolk's FST aimed to abolish the waiting list for CAMHS and enhance the outcomes achieved for children and young people. To do this, the FST applied some of the thinking of lean operations and 'six sigma' to provide a waiting list free process. FST set this within a model of leadership with a value base that was dependent on user views and the strengths of the incumbent workforce. ✓ The FST abolished waiting lists in a pilot programme of 2005. In addition, a range of changed ways of working across the service nearly halved the total number of families waiting for a service. It also reduced the number of families who had been waiting over eight weeks from thirty three in January to four at the end of May 2006.

Outcomes evidence

Outcome	National and International policy/guidelines	Best practice
Carers feel supported in their caring role	• **NHSOF:** "Enhancing quality of life for carers." **(2.4)** • **ASCOF:** "Carers can balance their caring roles and maintain their desired quality of life." **(1D)**; "People who use social care and their carers are satisfied with their experience of care and support services." **(3B)**; "Carers feel they are respected as equal partners throughout the care process." **(3C)** • **NHWMH:** "People with mental health problems, their families and carers, are involved in all aspects of service design and delivery." **(IF, 2)**	**Ipswich and East Suffolk CCG's Integrated Wellbeing Approach, UK.** • Ipswich's Wellbeing Service specification was developed through consultation with service users and carers, aiming to empower users to live as independently as possible (particularly younger users, aged thirteen and above). ✓ One of the outcomes monitored by the contract is the support given to users and specifically their families. The CCG is awaiting report metrics at the time of writing (01/11/2013).
People will maintain or achieve a role that is meaningful to them	• **NHSOF:** "Employment of people with a mental illness." **(2.5)** • **ASCOF:** "Proportion of adults with a learning disability in paid employment." **(1E)**; "Proportion of adults in contact with secondary mental health services in paid employment." **(1F)** • **PHOF:** "Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services." **(1.8)** • **NHWMH**: "People with mental health problems have a better experience of employment." **(IF, 9)** • **ICHOM**: "Achieved functional status -measured by elements of social/civic life." **(SPR)**	**Beacon Health Strategies's New York Care Coordination Program, USA.** • Beacon's person-centred care planning intervention, part of a care management programme based in New York, involves the following: a comprehensive bio-psycho-social assessment, a personalised care plan held by an entire inter-disciplinary team, and a single point of accountability from the consumer perspective, led by a mental health care manager. ✓ The programme resulted in, amongst other outcome improvements, a 44% increase in gainful employment.

Outcomes evidence

Outcome	National and International policy/guidelines	Best practice
People continue to live in settled accommodation	• **ASCOF:** "Proportion of adults with a learning disability who live in their own home or with their own home or with their family." **(1G)**; "Proportion of adults in contact with secondary mental health services living independently, with or without support." **(1H)** • **PHOF:** "Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation." **(1.6)** • **NHWMH:** "More people who develop mental health problems will have a good quality of life… a suitable and stable place to live." **(S, 2)**	**Milton Keynes PCT's Capitated Outcomes Based Commissioning Contract for substance misuse services, UK.** • Milton Keynes PCT tendered its substance misuse services (using an NHS contract) in order to include the following user-defined outcomes: drug users being in employment; drug users staying in their own homes; reduced offending, and courts access to clinical services instead of prison. ✓ The results, one year later, were positive. There was an increase in activity and improvement in outcomes. A single provider ('Crime Reduction Initiatives') took responsibility for services, generating reports of improved accountability and accessibility of services. In addition, CRI's annual spend was reduced by 20% in week 1.
People will have less physical health problems related to their mental health	• **NHWMH:** "More people with mental health problems will have good physical health." (S, **3**)	**Sandwell PCT's (now Sandwell and West Birmingham CCG) Collaborative Primary Care Model for mental health and wellbeing, UK.** • Sandwell PCT commissioned a new £1.2 million three-year contract for a 'Confidence and wellbeing service' targeted for those people at Step 0-1. Through early intervention, prevention and a stepped approach to provision, the Sandwell primary care change in mental health and wellbeing wrought promising early outcomes in the following areas: improved physical health for people with mental health problems, improved access to community mental health services, reduced heavy use of secondary mental health services & improved mental health of people from low socio-economic backgrounds. ✓ Over 4000 people completed the preventing, wellbeing and health improvement programme, saving around £800, 000 in prevention costs. In addition, over 3, 000 people accessed talking therapies, saving around £600, 000.

The following section outlines the outcome development process from January to November and describes how and why they changed.

In light of user engagement events in January and March 2013, some initial outcomes were developed for two segments of the mental health population – people with anxiety and depression and people with psychosis. The groups identified a number of outcomes and ranked the top five outcomes as:

Outcomes for people with anxiety and depression	Outcomes for people with psychosis	Outcomes for people with dementia
1. Appropriate and timely diagnosis 2. Service users reengage and are active in the community 3. Service users build and maintain quality relationships 4. Service users understand their condition 5. Individual treatments developed by user involvement	1. Service users attain employment 2. Service users attain stable housing 3. Service users have improved financial management 4. Service users have improved physical health 5. Service users avoid inpatient admission	1. Service users remain living at home for as long as possible 2. Service users are treated with dignity and respect 3. Carers feel supported to act in the best interests of the service user 4. Treatment preserves independence and self-care 5. Dementia is diagnosed early and by the appropriate professional

The outcomes were further refined into the group of six outcomes outlined below and their associated indicators, which were presented to the Better Mental Health in Oxfordshire (BMHO) Board in August.

Outcome	Potential Indicators
People with severe mental illness will have good physical health	• Reviews of physical state, mapped into care plans • Health checks in primary care • Increase in physical exercise • Harm minimisation: reduction in risky behaviours • Local mortality rate
People with severe mental illness (in clusters 4-17) will be in paid employment	1 % of people in clusters in paid employment The measure/expectation will be tailored to the cluster
People with severe mental illness will be in settled, independent accommodation that supports their recovery and well-being	2 % of people moving to less intensive accommodation within the supported to independent living (SIL) pathway 3 % of people successfully managing independent accommodation
People with severe mental illness will move towards recovery and wellbeing as assessed by clinicians using the Cluster tool	➢ Reduction in amber/red ratings in cluster score ➢ % of people with their care needs reviewed ➢ Number of people moving down and up the cluster levels ➢ Numbers of people stepped down to "no significant MH problems" and discharged to primary care
People with severe mental illness will achieve their personal goals in relation to recovery and well-being	3. Service users have self-defined & self-reported social inclusion measures 4. Service user report level of inclusion meets their expectations 5. % of service users satisfied with support to achieve their goals 6. % people with a personal recovery plan 7. Measures in relation to community engagement; reducing reliance on services; controlling own support; sustaining personal relationships; self-esteem 8. % of people achieving their goals as set out in their plan
Carers of people with severe mental illness (in clusters 4-17) will be supported in their caring role	• % of carers feeling involved in care planning • %of carers able to find information and support • % of carers satisfied with support from providers • % of carers satisfied with the support the person they care for has received

Over time, a significant amount of work was undertaken to revise the outcomes presented to the BMHO Board. The table below outlines revised outcomes and indicators to measure them. It also describes which tier they are within Porter outcomes hierarchy. The reference to different 'segments' should be noted in the indicator column below – the reason for and explanation of different segments of the mental population is described in section 3.7.

Porter Outcomes Hierarchy Tier	Outcome	Indicator
1 – Health Status Achieved or Retained Survival	1. People will live longer	• Mortality per segment • Suicide per segment
1 – Health Status Achieved or Retained Degree of recovery / health	2. People will improve their level of functioning	• Improvement in score on Star Recovery Tool (or similar) related to employment/accommodation and living independently by segment • Improvement in cluster tool measures related to employment/accommodation and living independently by segment • Percentage of adults on CPA that have had at least one formal review in the last 18 months by segment • Patient Feedback – do patients feel involved as much as they want to be in decisions about care and treatment? • Percentage of people in each segment will have a defined plan to either maintain or increase their level of meaningful employment below the statutory retirement age • Percentage baseline of the number of service users stepping down to "No significant mental health problems" and thus being discharged by segment • Percentage of people within each segment will have self-defined & self-reported social inclusion measures within their CPA/Care plan
2 – Process of Recovery Time to recovery	3. People will receive timely access to assessment and support	• Time from GP referral to confirmed diagnosis by segment (percentage of patients with a confirmed care plan within 4 weeks of assessment) • Time from GP referral to the start of support by segment • Responsiveness to people in crisis (number of people in crisis admitted to an inpatient bed by segment) • Percentage of inpatient admissions by segment that have been gatekept by crisis resolution/ home treatment team or other appropriate measures • Percentage of people by segment referred to crisis with a face to face assessment within 4 hours
2 – Process of Recovery Disutility of care or treatment process	4. Carers feel supported in their caring role	• Carer stress – using carer strain index • Percentage of carers offered a carer assessment • Percentage of carers attending CPA or care planning meetings • Percentage of carers satisfied with their involvement in supporting the person with mental health problems they care for
Tier 3 – Sustainability of Health Sustainability over time	5. People will maintain a role that is meaningful to them	• Percentage of people in each segment undertaking voluntary activity one year after diagnosis • Percentage of people in each segment in paid employment one year after diagnosis • Percentage of people in each segment undertaking an education programme one year after diagnosis • Percentage of people in each segment running a home/being a parent one year after diagnosis

Tier 3 – Sustainability of Health Sustainability over time	6. People continue to live in stable accommodation	• Percentage of people in each segment continuing to live in settled accommodation one year after diagnosis
Tier 3 – Sustainability of Health Long term consequences of therapy	7. People will have less physical health problems related to their mental health	1 Number of A&E attendances per segment within an agreed time period (e.g 6 months) 2 Score, by segment, on national health screening programme (including BMI, diabetes, cholesterol)

The revised outcomes changed from the original proposed outcomes as follows. As the table shows, five of the original six outcomes were adapted. One outcome was removed and two new outcomes put forward:

Original Proposed Outcomes	Current Proposed Outcomes
People with severe mental illness will have good physical health	**People will have less physical health problems related to their mental health**
People with severe mental illness (in clusters 4-17) will be in paid employment	**People will maintain a role that is meaningful to them**
People with severe mental illness will be in settled, independent accommodation that supports their recovery and well-being	**People continue to live in settled accommodation**
People with severe mental illness will move towards recovery and wellbeing as assessed by clinicians using the Cluster tool	**People will improve their level of functioning**
People with severe mental illness will achieve their personal goals in relation to recovery and well-being	
Carers of people with severe mental illness (in clusters 4-17) will be supported in their caring role	**Carers feel supported in their caring role**
	People will receive timely access to treatment and support

There are a number of reasons why the outcomes developed and changed as outlined above. Namely:

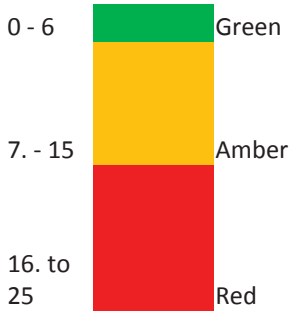
It is important to use a methodological approach to creating outcomes, to ensure that all aspects of a patient life cycle are supported, including survival, recovery and sustainability of health.

There were two engagement events held in Oxford and Banbury in early September, after the initial outcomes were proposed, which were attended by local people with mental health problems and carers. The views of local people are crucial to the development of the outcomes. The exercise has informed the outcomes and measures in table 2. OCCG also conducted an online engagement exercise via 'Talking Health' which enabled local people and their carers to input further on the refinement of the final outcomes.

The views of external experts in the field of outcomes based commissioning was sought out to provide rigor to the process and their feedback was included in the revised outcomes. They were clear that outcomes need to be considered at a 'population' level and that it is important to include an outcome relevant to people's mental health improving.

Risk management is an important part of the programme management. Anticipation and mitigation ensuring the programme delivers the transformation required.
The risks have been categorised as using the methodology shown below with risk assessments undertaken before and after the recommended mitigations.

Risk Score



Risk Rate Score – Automatic calculation [Severity/Impact] multiplied by [Likelihood]. Will show green for scores between 0 and 6, amber between 7 and 15, red between 16 and 25.

Severity / Impact	Severity Impact Descr
1	Insignificant
2	Minor
3	Moderate
4	Major
5	Catastrophic

Likelihood	Likelihood Descr	Likelihood Detail
1	Rare	Condition currently welll managed or no evidence to support effectiveness of treatment, or the event is not expected to occur apart from in exceptional circumstances.
2	Unlikely	Satisfactory (average when compared to other comparators), or the event could occur some time.
3	Moderate	Some management of condition, or the event should occur at some time.
4	Likely	Poor management of condition (higher than other comparators), or the event will occur in most circumstances.
5	Certain	No or innefective management of condition, or the event is expected to occur in most circumstances.

There are risks attached to the development of an outcomes based contract – particularly as Oxfordshire is among the first CCGs nationally to develop this approach. Importantly however, these risks can be mitigated through the delivery of the approach itself.

Topic	Risk Nor	Risk Description	Severity / Impact (1-5)	Likelihood (1-5)	Risk Rate Score (severity x likelihood)	Controls/Mitigations	Risk Rating after mitigations			Date Closed
							Impact	Likelihood	Risk Score	
General	1	Failure of OCCG Governing Body to agree to proceed to OBC for MH	4	3	12	OCCG Governing Body members and key stakeholders engaged throughout the development of the business case, to understand the benefits of a move to an innovative contracting model, including future system efficiency and improved outcomes for local people with mental health problems.	2	2	4	
General	2	Political/external interest and pressure due to innovative and 'radical' nature of OBC	3	3	9	Cobic have identified key external/political stakeholders who will be interested in the programme (e.g. NHS England, LAT, CCP) and could exert external influence. Cobic are already working with NHSE (e.g. Bob Ricketts) and others (e.g. CCP) to ensure that the OBC work underway at OCCG is seen as an innovative programme that receives encouragement. In partnership with OCCG; keep these stakeholders informed and engaged throughout process. As a member of the COBIC club, OCCG will be able to draw upon resources and experiences from other club members to tackle problems together and present a coherent and practical approach to senior stakeholders	3	1	3	
General	3	Failure to reach decision about Oxfordshire County Council and Area Team Involvement - this limits the impact and scope of OBC	3	3	9	Regular engagment and involvement of OCC in future discussions about OBC and its benefits to the people of Oxfordshire. Exploration of greater involvement of OCC in developing outcomes based contracting and multi-agency working to achieve outcomes that matter for the people of Oxfordshire. We will undertake early dialogue with potential partner commissioners against clear project plan that indicates when decision is required from partners as to whether they are 'in' or 'out'. We will develop a bespoke communications plan to keep Oxfordshire County Council fully informed of our progress and will continue to advocate staff from the County Council being members of meetings and board.	2	2	4	

General	4	Failure to adequately develop the prime provider market resulting in domination of CCG by existing providers	4	4	16	Work with providers (both incumbent and external) identifying their capacity, capability and willingness to undertake significant change. This will give us the understanding of whether we need to look only to the current provider market, seek new entrants, or develop a mixed market approach. Our team has a vast degree of expertise in building and managing markets and has mapped out a clear approach	4	2	8
General	5	Letting a contract that destabilises existing providers risking security of provision of other services to the population of Oxfordshire	4	2	8	Following testing with OCCG board about preferred procurement approach, we will develop a clear communications plan for the approach to be taken, to ensure all providers are aware and can prepare. We will also ensure we negotiate a win-win transition process with preferred providers that properly considers the position of existing providers. We do not expect a potential new contract across any of the three work streams to start at full change from day one. Instead, we have planned a ramp up period to ensure that providers are stretched to work differently, focusing on delivering the outcomes that matter to people, but have a protected period of the time to make sufficient changes.	3	2	6
General	6	Ability of CSU to support OCCG and project with sufficient pace, drive and commitment.	5	4	20	tThe CSU will be required to help deliver some of the process and local engagement, in their supporting role to OCCG. We understand that it will be necessary to demonstrate a partnership approach with the CSU in some areas. We therefore aim to help the CSU 'learn as they do' regarding any areas they assist the programme with. The CSU will play a key role in phase 3 of the project moving to OBC.	3	3	9
General	7	Mis-pricing the capitation and incentive elements of the proposed OBC contracts	5	2	10	We propose a period of open book accounting to understand true costs and revenue of patients from the main provider organisations. Within the different commercial options we model, we will also look at different financial risk outcomes for providers. Our approach to allocative budget setting is predicated on input from providers on what level of incentive is needed to deliver a set of outcomes, so before any pricing is agreed, a lot of engagement has already taken place	3	2	6

General	8	Resources required to move from phase 2 to phase 3 of developing OBC. This is an intensive programme and will pull heavily on OCCG and CSU resource	4	4	16	A clear timeline and plan to move beyond phase 2 to actually developing OBC has been prepared, and Cobic will be in situ to support OCCG as it progresses	3	3	9	
General	9	Timeframe to move from phase 2 to phase 3 by 2014 is challenging, particularly with additional pressures associated with the winter period and likely annual leave during the Christmas period	4	4	16	A clear timeline and plan has been developed. This must be rigidly managed to ensure all key milestone are achieved, with the OCCG Governing Body communicating the importance of OBC to all staff involved in progressing from phase 2 to phase 3	3	3	9	
General	10	Challenging OCCG financial position driving an expectation of immediate savings associated with OBC. This has a potential impact on initial provider behaviour and associated commissioning negotiations, meaning providers may not be able to invest as heavily in innovative delivery to achieve savings and improve outcomes further into a contract	4	4	16	Mature conversation between commissioners and providers to establish what is feasible within intial phases of an outcomes based contract. This should be viewed as a long term aspiration and short term ambitions must be considered in this context	3	2	6	
General	11	Provider ability to deliver OBC	4	4	16	This is a new form of contracting so providers must be engaged and supported to outline their concerns about certain aspects of a developed outcomes based contract. If either an incumbent or new provider is selected to deliver OBC, there must be sufficient time given to exploring the challenges it presents	3	3	9	