

Pennine MSK Partnership A case study of an Integrating Pathway Hub (IPH) “Prime Contractor”

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Methodological points about case studies

The NHS knows it needs to learn from best practice.

The NHS knows that across the whole service there are a number of very different good examples of best practice which the rest of the Service should learn from. The writing of case studies is one method of trying to diffuse best practice.

But however good the exemplar case study is, the case study on its own very rarely impacts upon the speedy diffusion of best practice. This lack of speed in diffusion is partly because the drivers for organisations that leave them with no alternative but going through the pain of change are not strong enough. Without very strong drivers for change, even a very good case study becomes just an interesting example of how they do things differently and in a different place from here.

We need to try and rethink how to write case study to make it more likely that the example will be followed by others. In terms of the diffusion of innovation writing a case study is a further attempt to PUSH innovation into other parts of the NHS. To defuse innovation properly there needs to be some more pull drivers.

This case study as with all others will contain a narrative about what changes the main innovator made in order to create the innovation. Its a story of change and how it is led. However as with all successful innovation there are a number of resources that were organic to this particular example of change which proved to be vital to its success. Every case study has these organic resources that are a crucial part of their success. However whilst they are organic to this case study they are rarely organic to the locality that is trying to copy the case study. This means that it is much more difficult for the copier than for the original

Therefore after the narrative about the case study we want to outline what the important organic resources were in the case study and try and explain how these resources might be obtained non organically from those that may want to replicate the case study.

Case studies and integrated care

There is a great deal of discussion about integrated care in the NHS at the moment. This case study is a specific example of how care can be integrated through a main contractor who then has the responsibility for integrating the care for the patients. We are exploring this example because it provides a strong example of how care can be commissioned and then delivered through a single provider where there is a single point of responsibility for the integration of care with that core provider. The Governance arrangements in the Appendix make this organisational structure clear as an Integrated Pathway Hub (IPH)

Narrative

Pennine MSK partnership Ltd is a specialist Personal Medical Services partnership that has been commissioned by NHS Oldham to provide a comprehensive services to the population of Oldham in Rheumatology, Orthopaedics and Chronic Musculoskeletal pain

Pennine MSK Partnership is a single organisation provides an integrated service for all MSK patients in Oldham. It has a single contract with the commissioner and takes responsibility for providing the full range of services from within the same organisation. As specified in its service level agreement, it provides non-admitted care in elective care pathways in orthopaedics, rheumatology and MSK pain. In most places in the country these NHS services have been provided from separate primary, community and secondary care organisations. Across the country there are many attempts to integrate services but it is unusual for those different services to be provided from within the one organisation. The service has three clinical leaders who also own the business, Mrs Anne Browne a nurse consultant in rheumatology and two GPs Dr Hugh Sturgess and Alan Nye, That is what makes the Oldham MSK service different,. It is impossible to see how it could have succeeded without this clinical leadership. .

The provision of an integrated budget for MSK services allows more effective care pathway commissioning and the identification of unwarranted variation that may indicate suboptimal performance. By having a single and clinically led pathway service, with clear accountability and budget for whole pathway quality and productivity, Pennine MSK Partnership is able to use clinical judgment and skills to improve and where necessary redesign services to achieve better value. The integrated programme budget can deliver better clinical outcomes from commissioning spend because providers are incentivised to reduce waste and deliver high quality care. The system also encourages investment in primary care, shared decision making and supports self-care as a means of delivering optimal care for specific patients in the right setting to demonstrate best value for money. This prevents unnecessary referral to secondary care pathways and ensures that patients proceed along the most appropriate pathway. Analysis of outcomes from programme budgeting will facilitate elimination of treatments with low clinical value, ensuring the whole pathway follows best practice. In addition, the aim is to align Oldham PCT with SHA and National benchmarking on MSK spend and therefore generate financial efficiencies. The overarching benefit of the budgeting programme is delivery of better MSK health for the population for the same commissioning spend.

The service is totally funded by Payment by Results. They ensure that value for money for the commissioners is provided by offering a reduction to 90% of the national tariff for some elements of the pathway and a range of local tariffs that improve and reward efficiency. Some pathway elements are charged at full PbR tariff. .

The components that make this work:-

1 A single legal structure to organise delivery

The legal structure is a company limited by share. The company then holds a Specialist PMS contract consistent with that of a GP practice and the range of services and terms of operation are covered by service level agreement with the PCT. Pennine MSK Partnership have developed consultant led pathways in rheumatology and orthopaedics, transferring care out of the hospital and into the community. In addition, a consultant led psychological medicine service for all patients has been developed. Where possible all care is delivered in the community setting, working with a range of acute trust and secondary care organisations to offer choice within the community service to orthopaedics patients. The challenge was to develop a Programme Budget so that commissioning spend could be combined into one single integrated budget for MSK services as a way of maximising the value of commissioning spend

To create real integration of patient pathway it is necessary to confront and change the existing silos that deliver existing care. Pennine MSK Partnership has created a new organisational form that is itself a challenge to the traditional silos of primary secondary and community health care. To ensure that the silos are not reproduced the integrating organisation must have some strength and power over the whole process.

The governance arrangements for this are in the Appendix. The organisation is called an Integrating Pathway Hub (IPH) and works as a Prime Contractor, responsible for the “Musculoskeletal Health” of Oldham

2 Developing a programme budget so that we know what is spent on the condition.

The recent method of funding secondary care through payment for each activity of episodic care has created, across an entire pathway perverse incentive for individual providers of care. The development of the prime contractor model provides the commissioner and the contractor with an opportunity to develop very different financial incentives across the entire patient pathway. Therefore it is vital to ensure that the system of financial rewards within the integrated care pathway is generated in a very different way from those that currently work against integration.

Traditionally service providers are rewarded for activity which could lead to overspend. “A budgeting system that is based on health gain rather than activity and that aims to deliver the best possible care for a population within a determined budget is increasingly important in the current economic climate,” said Dr Alan Nye. In March 2010 Pennine MSK Partnership submitted business case for a Programme Budget Pilot to develop such a system. A range of different data sources were used to plan the programme budget work including: Health Investment Packs; prescribing data; Health Episodes Statistics (HES) data; Health Inequality Data Packs; the Spend and Outcome Tool (SPOT); and the Inpatient Variation Expenditure Tool (IVET). In addition a Programme Budgeting Spreadsheet and Programme Budgeting Atlas were used along with NHS comparators. Analysis of these data sources established that Oldham is typical of PCT populations across the UK facing similar issues in the provision of MSK services as other PCTs.

Programme budgeting outlines how PCTs allocate budget in terms of 23 ICD 10 defined programme budgeting categories and provides a retrospective appraisal of resource

allocation broken down into 'programmes' - with a view to influencing and tracking future expenditure in those programmes. Programme budgeting also allows for cross sectional and time series comparisons, at national, Strategic Health Authority (SHA), PCT and increasingly, practice level. Marginal analysis provides an appraisal of the added costs and added benefits when the resources in programmes are increased, or deployed in new ways.

Using a combination of programme budgeting and marginal analysis Pennine MSK Partnership has developed a framework to help commissioners make, track and evaluate health investment decisions. The focus on commissioning has changed from measuring activity or process (for example the delivery or provision of a certain number of surgical procedures) to measuring health gain. Although more complicated to measure than activity or process, health gain can be measured using various tools such as Patient Reported Outcome Measures (PROMs) and quality of life measures. This change in commissioning focus ensures that service delivery is measured in terms of patient benefit.

The system of financial incentives within the overall programme budget is an essential part of this innovation.

3 A governance structure that works with a clear contract with commissioners

The establishment of a clear and robust governance structure has been a very important part of the development of an integrated budgeting programme. This defines the roles and responsibilities of clinical commissioning groups and providers ensuring that the system of service provision is open and transparent. Pennine MSK Partnership is accountable for

- delivering defined outcomes through monthly reporting
- regular evaluation of quality
- identification of variation across the entire MSK pathway
- ensuring that choice is offered at all appropriate points in the pathway.

It has a clear separation from commissioners and is robustly responsible for the development of an organisation with internal incentives that will meet the needs of commissioners.

The focus on commissioning has changed from measuring activity or process to measuring health gain. They are currently developing a way of displaying performance of the entire programme across the whole pathway using dashboard metrics which, once complete, will give a very valuable overview of how commissioning spend is used linked to health gain outcomes so the effectiveness – and value for money of specific services can be assessed.

4 Clear management of data to deal with unwarranted variation.

Data management systems have also been established in order to identify unwarranted variation in the pathway that indicates suboptimal practice that may not reflect variation in need but rather may suggest inadequate resource use. Collating and reporting on information in timely manner is a key part of monitoring the success of programme budgeting and Pennine MSK Partnership are working in collaboration with a number of organisations to develop a way of displaying performance of the entire programme across the whole pathway using dashboard metrics. "Once complete, this will give a very valuable overview of how

commissioning spend is used, linked to health gain outcomes, so we can assess the effectiveness – and value for money – of specific services,” says Dr Nye.

5 This is the results of 10 years of working together through different iterations

The first iteration of the service started in 2002

Pennine Musculoskeletal (MSK) Partnership was established in 2002 as a triage service for rheumatology referrals which is run by NHS Oldham PCT and managed by Anne , a nurse consultant in rheumatology, and Dr Alan Nye a GP with special interest in rheumatology. Pennine MSK Partnership delivers a very successful service diverting 50% of GP referrals away from hospital.

It was developed as a tier 2 service in Rheumatology run successfully since from March 2002. The Tier 2 service was designed to screen GP referrals into secondary care, managing those patients who do not need to see a consultant rheumatologist and ensuring those patients referred on to secondary care were fully investigated before seeing a consultant. The tier 2 services were highly successful with a 50% diversion of GP referrals away from secondary care.

In 2005, with Dr Hugh Sturgess, they submitted a business case to NHS Oldham PCT to take over the running of the service as a Specialist Personal Medical Services (PMS) practice covering all non-admitted services in rheumatology, orthopaedics and MSK pain.

In March 2006, following a competitive tender, Pennine MSK began a community based services with common referral entry for all MSK problems. The challenge was to develop a Programme Budget so that commissioning spend could be combined into one single integrated budget for MSK services as a way of maximising the value of commissioning spend. Using a combination of programme budgeting and marginal analysis Pennine MSK Partnership has developed a framework to help commissioners make, track and evaluate health investment decisions.

Lessons from the case study for others

1 *Medical leadership*

We often comment on the necessity of medical leadership to ensure innovation and throughout the clinicians that started this programme has been the key to leading its development through all its phases. In the narrative there were several moments when clinical at a primary and secondary level had to change their medical practice and it is likely that having a GP leading this innovation has an important impact on this.

The two other clinical leaders always had key but complementary skills. Anne Browne being an experience nurse consultant with excellent links with the secondary care clinicians and Hugh Sturgess having worked at the Improvement Foundation for many years with skill in large scale change and improvement methodologies

There are a variety of different managerial skills involved here which go beyond the new clinical skills necessary. Whilst it looks inevitable that the leadership needs to maintain clinical practice they also have to learn the separate and distinct skills of leading and improving integration.

It is important to stress that there are occasions when the medical leadership of a significant change such as this will be involved in quite sharp conflict. Bringing about real integration brings the leaders of change into conflict with other clinicians who are working in current organisations. It is important to be prepared for this and take it in your stride in the case for change.

It is important that the prime contractor model of integrated care has clinical leadership that still practices but it is also important they the skills of leading and developing new organisational forms takes place

2 *Experience of the clinicians working across care boundaries*

Setting up and running a clinically led integrated care organisation must mean that the clinicians are going to have to lead secondary care clinicians and other medical staff. Before any of these iterations care models had happened the lead clinical team had been working across traditional care boundaries and had experience of working in integrated teams. The mix of both primary and secondary care clinicians coming together to led a new organisation gives a powerful recipe for success.

Whichever type of clinician leads a core provider for integrated care, that organisation is going to have to either employ or develop close relationships with other forms of clinician. It is important that there is real trust and 'followership' from other clinicians. This cannot be short circuited and if it does not exist organically time and effort needs to be put into it. Clinicians need to have a shared vision of integrated working that spans traditional care organisations and boundaries.

3 *The development of integrated care models over time*

The prime provider model that has developed in Oldham where a single contractor takes responsibility for all the services being provided in a patient pathway, has developed over time from a range of different aspects of integrated care. The iteration of different models that have provided ever more integrated care may have been important in allowing the development of a strong prime provider model. These 10 years have allowed the strong model to develop organically

The NHS cannot 'afford' for every locality to spend 10 years working through different models to get to the full integrated care model, so it may not be possible to organically wait for this decade of development. However if that time cannot be spent learning to work together there needs to be time and effort put into the relationship building that would exist over a 10 year period

4 *The medical leadership of the prime contractor had experience of commissioning*

One of the medical leaders of all of the iterations of these integrative organisations had early prior experience of commissioning- though not of rheumatology but of addiction services. This meant that throughout the last decade PCT commissioners recognised that the medical leader of the provision understood what commission was and how it needed to work. This was a real skill which meant that a provider could speak the language of the commissioner and knew their needs.

The commissioner in NHS Oldham was key for the service to develop. It required a degree of trust in the new service provider to allow the new service to develop, both initially in 2006 with the launch of the integrated service and again with the devolving of programme budget in 2011.

GP led commissioning should increase the number of GPs who have an understanding of what commissioning means and what a commissioner needs to know about provision in order to commission it. This will increase the number of clinicians with a clear understanding of commissioning.

5 *Programme budgeting is essential*

It is really essential for the core provider and the commissioner to develop a better and better understanding of what the existing cost base is for the whole pathway. This is not a straightforward process and may take several iterations to get it right. But it is vital to be able to know how much is actually being spent in order to reshape the service within the existing cost envelope

Pennine MSK is hoping to complete that process this year.

Across the NHS there are better and better costings of each part of the service, but there are few examples of where this has been fully worked out. The year of care project has some real experiences of it. The needs to be a real move away from the perverse incentives of payment by results which reward discrete multiple episodes of care towards a system that rewards better value across a programme of care for a defined population

6 The Limited Company form provides an organisational base for the prime contractor model

Pennine MSK Partnership as a Specialist PMS also employs a range of different clinicians and medical staff. This is the strongest form of integrated care organisation where the incentives and the management are all internal and there is one relationship with the commissioner.

There are wide range of integrated care models that do not provide sufficient strength to the prime contractor to be able to develop internal incentives to make sure the pathway works. It is important that the integrative model has sufficient strength to make real integration happen.

7 Open procurement as a means of shortcutting 10 years of difficult challenging "collaboration"

Most services will not have the luxury of 10 years to develop the service like Pennine MSK. Even though the service was commissioned using a competitive tender in 2005, the resulting service was an additional provider and it was not till 2010/11 that the PCT began decommissioning the hospital based rheumatology service. If other health communities were to replicate this model the procurement of the new service who need to be mirrored with decommissioning the existing provider model.

Appendix 1 Governance framework for the Integrated Pathway Hub

1.0 Context

The current definition of an Integrated Pathway Hub (IPH), is a health care organisation that is accountable for the quality and cost of the entire patient pathway, whilst providing care in the centre of the pathway itself. The theory of this approach is that enhanced quality, outcomes and cost control could be delivered by the delegation of a programme budget to a clinical organisation who has expertise of understanding the total integrated pathways and understand how suppliers should work together to deliver enhanced outcomes.

The IPH will carry out this role by supporting the delivery of quality primary and community care, providing multidisciplinary specialist health services itself, and referring the patient on to more specialist care, including acute trusts, voluntary and independent sector providers, as required. This would include better clinically led referral and demand management than the present contractual approach.

This governance framework outlines the principles by which the IPH will operate within Oldham, accountable to the Oldham NHS Clinical Commissioning Group.

2.0 Core principles

- Improving quality and reducing variation is the primary aim of this approach. However delivering the agreed level of savings on the programme budget, aimed initially at bringing overall spend in line with national and regional benchmarking, will remain a core principle.
- Any additional savings made over and above the agreed targets, will be reinvested in patient care, with investment suggestions, being led by the community provider.
- In the initial phase, the cash budget will not be transferred to the programme hub provider, and will be retained within the PCT
- Spend relating to clinical activity included within the programme budget, will be clearly defined from go live.
- To act as an IPH, it is an essential requirement that the provider is responsible for undertaking the assessment function across clinical pathways, to undertake effectively the coordination of care.
- The IPH will be held to account by the Clinical Director and CCG for a range of specific indicators relevant to the clinical programme. Monthly performance indicators will be agreed and reported so that any clinical quality issues and overspend can be quickly identified, and discussed openly with CCG, and plans put in place to manage the variance agreed at the earliest opportunity.
- The IPH will be able to access the enabling infrastructure of CCG to access information and support to deliver clinical service transformation. This will be estimated based on the programme budget value.
- For legal purposes, contractual relationships with providers in the initial phase, will remain between the PCT and the provider, with contractual reviews being driven by the IPH.
- Implementation of the IPH model will be funded through the CQUIN monies available through the provider contract, for the prime vendor. If the IPH are successful in delivering all of the programme outcomes, in line with other provider CQUIN payments, 1.5% of the provider contract would be awarded. The proportion of the payment made, will be based upon the outcomes delivered.
- No partner should incur costs as a result of implementing this programme.

3.0 Defining the responsibilities and parameters

3.1 CCG

- CCG will retain budget responsibility for all programme budgets and will reimburse the IPH via a CQUIN payment. CCG will not transfer its commissioning budget to a single provider organisation and arrange for that organisation to take the consortium's commissioning decisions, or to 'make or buy' all the services that the consortium is required to commission. It would be unlawful for consortia to sub-delegate their functions in this way.
- CCG will monitor outcomes delivered by the IPH via the programme budget balanced scorecard, on a regular basis to ensure the approach delivers enhanced clinical outcomes, improved patient experience and improves cost control.
- CCG will effectively manage potential conflicts of interest. This will include decisions in relation to service prioritisation and specification, not just decisions in relation to procurement. Where an

individual member of a consortium has a financial stake in an organisation that is a prospective provider of services to be commissioned by the consortium, there are well-established arrangements that enable that individual to declare their interest and to stand aside from relevant decisions. Where all (or most of) the GP practices that are members of a consortium are also part of a provider organisation, or have a financial interest in that organisation, this will require a different approach to commissioning and procurement decisions. CCG will need to make provision in its constitution for dealing with conflicts of interests of members or employees.

- CCG will support quick execution of market tactics in line with CCP regulations, to deliver identified efficiencies. CCG must make commissioning decisions that take account of the requirements in relation to procurement, patient choice and competition. For more complex, integrated services, this is likely to mean commissioning services through competitive tender and, where possible, requiring that the service provider (i.e. the prime contractor) offer patients choice of any willing provider for some individual services within the pathway.
- CCG will be responsible for managing unforeseen risks in year, in conjunction with the IPH.
- CCG will tackle jointly with the IPH, variation in primary care.

3.2 IPH

- The IPH will be accountable for managing the defined outcomes for the clinical programme area. The IPH will be required to attend the CCG Board on a quarterly basis. The scorecard will be provided on a monthly basis.
- The IPH will define and manage clinical pathways in line with localised Map of Medicine pathways (including EUR criteria).
- The IPH will regulate quality and outcomes across all providers delivering care across the supply chain.
- The IPH will ensure choice of provider is offered at the appropriate points, and patients' constitutional rights can be met.
- The IPH will spot, isolate and reengineer unwarranted variation and overuse of the specialty based services, and inform commissioning decisions to be enacted through CCG contractual processes.
- The IPH will have access to a schedule of information in a timely manner to manage effectively the clinical programme area.
- The IPH will tackle jointly with the CCG, variation in primary care.
- The IPH will not automatically reprovide services where efficiency opportunities exist. The appropriate market management approach will be defined by CCG and executed quickly.
- The IPH will not be solely responsible for managing unforeseen risks in year a joint risk management approach will be agreed in conjunction with CCG.
- The IPH will not extend the scope of their service outwith the specification as a result of this pilot.

4.0 The accountability framework

The IPH will be monitored by CCG based on an accountability framework. The accountability framework will be based on 4 schedules including:

- Clinical outcomes
- Financial outcomes
- Patient and local community accountability
- Governance

The IPH will via the CQUIN contract, with the Director of Finance and Chair of the CCG, agree to the above terms and conditions of operating the IPH.