NHS England

Review of incentives, rewards and sanctions: Discussion paper for stakeholders

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Document Status

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Review of incentives, rewards and sanctions

Discussion paper for stakeholders

July 2013

Background

Incentives should underpin the delivery of NHS England's strategy, once developed. In the meantime it is necessary to make progress on improving our existing incentives, to support providers and commissioners, within the context of ever tighter financial constraints. They must contribute to improved outcomes through improvement in the quality of health services for patients, their families and carers, and reducing health inequalities, be that through encouraging transformational change or gaining greater value from our existing services. Some incentives (currently defined as contract sanctions) can also ensure basic standards of quality are maintained.

We recognize that incentives alone cannot deliver the transformation of health and social care, as they sit within a wider context of system levers, including leadership (both professional and organisational), training and development of staff, benchmarking/sharing best practice, and other change programmes, as well as statutory and regulatory frameworks. Within this context, and in line with our commitment set out in '*Everyone Counts: Planning for Patients*', NHS England is undertaking a review of incentives, rewards and sanctions, to inform the 2014/15 planning round. The main focus of the review is to have in place a cohesive approach across national tariff (see below), the incentives and sanctions within the NHS Standard Contract (including CQUINs), the Quality Premium, and the Quality and Outcomes Framework, to support our strategic intent.

As part of this work, we will be engaging widely with you to get your views on our proposals for change. This discussion document forms part of that engagement.

For information, the joint NHS England / Monitor discussion document to consider the longer term payment strategy, *How can the NHS payment system do more for patients?,* is available at:

http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-34

Why should I read this document?

This document gives you the opportunity to read about our early thinking on the design of incentives, rewards and sanctions for 2014/15 and enables you to directly influence the direction of the proposed changes.

NHS England is committed to working in partnership to develop workable incentives, rewards and sanctions that help commissioners and providers to deliver efficient, high quality services to patients. We welcome your views on the specific questions in this document. We also hope that you will share your thoughts with us in the forthcoming webinars and regional workshops we are organising to engage interested parties in shaping the national tariff and incentives.

Please send your comments and views on the questions raised in this document to england.incentivesreview@nhs.net by Friday, 2nd August 2013.

The current system

We know that incentives, rewards and sanctions are often not used as intended. Examples of this include: commissioners setting targets that cannot be achieved in order to avoid paying CQUIN monies; individual sanctions not being implemented in the event of performance failures; the impact of all incentives and sanctions being guaranteed through commissioners and providers agreeing block (or cap and collar) arrangements.

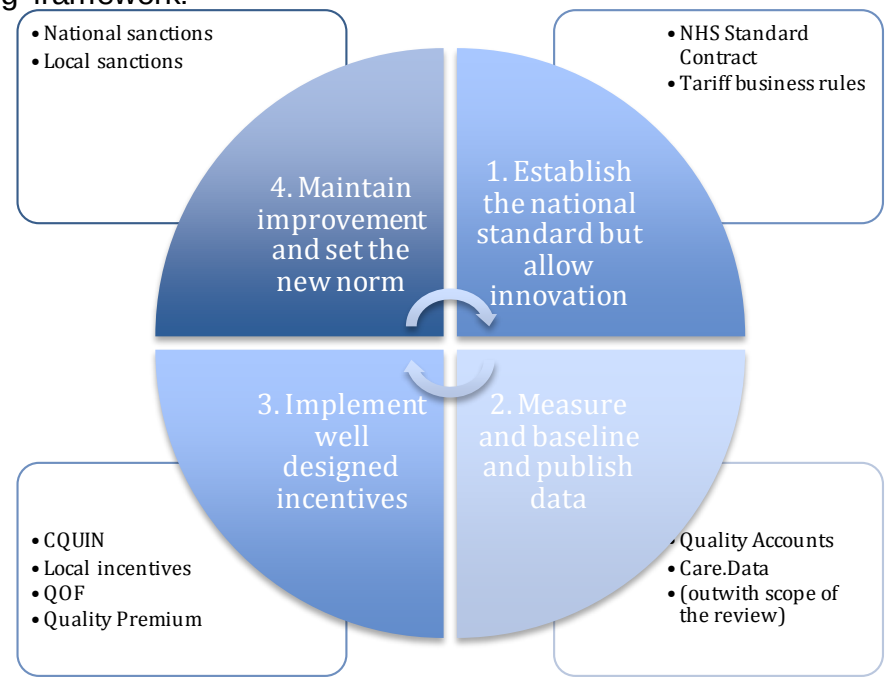
A number of reasons have been cited for this: the level of complexity is too great; there is insufficient contract management capacity and capability; PbR is too volatile; and targets are too difficult or time-consuming to negotiate.
We also know that there is some inconsistency in our national approach to incentive design: some areas are subject to far more national targets, incentives and sanctions than others (particularly noticeable between acute and other contracts); and there is a lack of consistency in the way we design indicators and then reward or penalise against them.

The evidence base on the effectiveness of rewards and sanctions makes it difficult to draw conclusions on the true impact that national incentives, rewards and sanctions have had to date and, going forward, what the level of risk and reward should be, how to determine the correct balance of national and local incentives, rewards and sanctions and what the impact of addition or removal of incentives can be.

We therefore want to hear your views to help us design the right package of incentives for 2014/15 and inform the future strategy. This paper sets out the emerging proposals for 2014/15 on which we would welcome your feedback.

Which incentives are best used for what

We believe the current system of incentives should be be considered within the following framework:



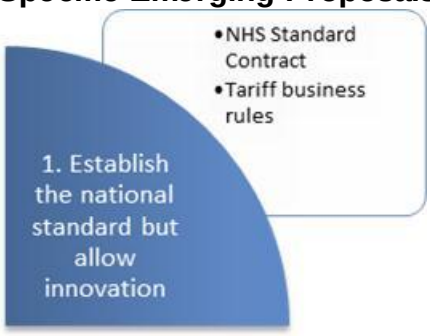
We believe that for incentives and sanctions to work effectively, we need to have a clear understanding of what the standard we are seeking to achieve is, and robust methods for measuring improvement.

We also believe that the overall package of national incentives needs to be at a workable level of complexity, based on evidence wherever possible, and with a balance of risk and reward for providers and commissioners.

Question

Do you support these design principles?

Specific Emerging Proposals for 2014/15



NHS Standard Contract (General Terms and Conditions)

We believe that the NHS Standard Contract should be used to set agreed national standards, where these apply equally to all contracts and all providers, and are not already covered by legislation or statutory guidance. Any new mandated standard should be fully impact assessed to ensure affordability and compliance with our equality statement.

Where standards apply to a specific subset of providers, we propose that national service specifications should be used and either mandated (e.g. prescribed services) or provided as best practice templates (e.g. learning disability)

We propose that greater flexibility in contract duration will be needed from 2014/15 onwards, including flexibility of commencement date.

Questions

Do you support the general proposals set out above?

Are there specific changes NHS England could make to the NHS Standard Contract general terms and conditions that could improve or safeguard quality?

Would mandated specifications, over and above those for prescribed services, be welcomed?

Would greater flexibility in contract duration have an impact on quality? If so, how?

Business rules (rules governing the flexibilities permitted with pricing and contracts)

We believe that the rules on local payment variations, contracting and incentives for 14/15 should focus on ensuring that we have the right level of flexibility to encourage local innovation, coupled with the right level of oversight to build more evidence on what works and doesn't work.

As part of this we should enable and evaluate the use of methodologies for contracting for outcomes for sub-populations/cohorts such as frail older people with multiple complex problems.

We should also consider the level of support NHS England should provide to build capacity and capability, including how we might use CSUs to do this.

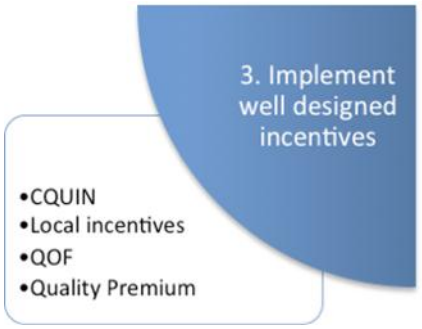
We are currently engaging on the appropriate level of flexibility within the national tariff jointly with Monitor (see the link below) and intend to use the findings from this work to design the right level of flexibility and oversight across all incentives. The consultation on this document closes on 9th July.

http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishLocalPaymentVariationsDoc13June13.pdf

Questions

Do you agree that there should be consistency between the rules on the level of local flexibility within the national tariff (Local Payment Variations) and the rules on local flexibility with other national incentives?

What support could NHS England provide to build capacity and capability?



CQUIN

We believe that there isn't a strong case at present to increase the value of the CQUIN scheme beyond 2.5% for 2014/15 so we should consider maintaining the current 2.5% level.

We propose that there is a need to agree a national policy position for 14/15 on the applicability of CQUIN to pass through payments; small contracts; and non-contracted activity.

We believe we should ensure a more rigorous approach to the indicators that are used for CQUIN schemes. There are a number of options for achieving this: fewer or no local indicators; clearer rules around indicator development; or a pick-list for local indicators. Recognizing the importance of local autonomy, any increase in the mandating of indicators should be seen alongside our proposals on business rules, above.

We believe we should consider removing the current pre-qualification gateway for CQUINs on the basis that where this prohibits entry into CQUIN schemes, providers may lose motivation to improve quality.

Questions

Are there reasons why the current level of funding for CQUIN (2.5%) should change for 14/15?

Should CQUIN payments apply to i) pass-through payments (for example, for high-cost drugs and devices), ii) small contracts or iii) non-contracted activity? (Please give a reason for your answer)

Would gain share arrangements on pass-through payments be a better incentive than a CQUIN?

What do you understand 'pass-through' payments to mean?

Should CQUIN goals be set at provider or contract level?

Which of the following options is most likely to secure higher quality and why:

1. *Nationally mandated CQUIN goals for the full 2.5% (with flexibility for commissioners and providers to derogate from this where it is in the interests of patients to do so)*
2. *No change to the current balance of national and local indicators*
3. *No change to the current balance of national and local indicators, but with clearer rules around local indicator development, including a pick-list of potential indicators to be used.*
4. *Fewer nationally mandated CQUIN goals, with greater local autonomy for negotiating local schemes*

Are the mandated national CQUINs (dementia, CQUIN, NHS Safety Thermometer, VTE) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?

Are there other strong candidates for a national CQUIN? How would it be constructed?

Would you support a national CQUIN in any of the following areas: staff satisfaction and clinical engagement; improvements in clinical audit; learning disabilities?

Local Incentive Schemes

We believe we should provide clearer guidance on the use of local incentive schemes within contracts, with particular regard to alignment with the variation rules to be set out within the National Tariff Document.

Question

Have you used or are you intending to use the provisions for local incentive and risk sharing schemes? If so, what for?

Quality Premium (to be paid in 15/16 based on 14/15 performance)

We believe we should consider refocusing the Quality Premium to focus on those areas commissioners can influence, and specific goals of NHS England.

We believe we should ensure a more rigorous approach to the indicators that are used for Quality Premium schemes. There are a number of options for achieving

this: fewer or no local indicators; clearer rules around indicator development; a pick-list for local indicators. Recognizing the importance of local autonomy, any increase in the mandating of indicators should be seen alongside our proposals on business rules, above.

We must include a mandated indicator on mental health (pre-commitment).

Questions

Which of the following options is most likely to secure higher quality and why:

1. *Nationally mandated Quality Premium goals for the full £5*
2. *No change to the current balance of national and local indicators*
3. *No change to the current balance of national and local indicators, but with clearer rules around local indicator development, including a pick-list of potential indicators to be used.*
4. *Fewer nationally mandated Quality Premium goals, with greater local autonomy for negotiating local schemes*

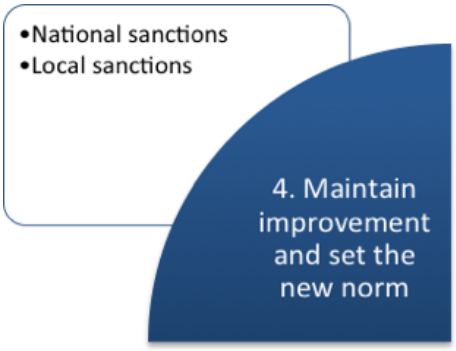
What level of oversight is required by NHS England to ensure parity in the level of ambition across local schemes?

Are the mandated national Quality Premium Indicators (HCAIs,reduction in mortality, Friends and Family Test, Reducing Avoidable Admissions) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?

How could the Quality Premium be used to improve outcomes in mental health?

Should CCGs be able to set local QP measures that duplicate national QP measures but with a greater 'stretch'?

Should the design of the QP scheme explicitly allow for sharing of the QP earned with partners who contributed to it?



National Sanctions

We propose continuing to have national sanctions for failure to maintain agreed national standards within the NHS Standard Contract for 14/15.

We believe we should consider limiting the total proportion of contract value that can be imposed through sanctions and/or whether to set rules around reinvestment of funds retained through implementing sanctions.

We believe we should consider whether there are any perverse incentives within current sanctions that negatively impact on quality, including the rules around retention of payment.

We believe we should consider looking to rationalise the range, proportionality and timing of national sanctions and propose a more consistent approach to calculating the fine associated with any given sanction. We should distinguish between the requirements of the NHS Constitution and other sanctions.

We believe should seek to ensure greater parity of approach across mental health, ambulance and community services

Questions

Are financial sanctions effective in sustaining quality and performance? Are they particularly effective of or ineffective in some areas over others?

What, if any, perverse incentives, does the current system of sanctions create? Are there examples where the application of sanctions has damaged service quality?

Should there be national rules on how funds withheld through sanctions imposed are used by the commissioner? If so, what should these be?

Does the timing of sanctions impact on their effectiveness? Is there a case for a range of timings for sanctions or should all be considered to the same timescale (Annual? Quarterly? Monthly? Sanctions to take effect the following contract year?)

Are sanctions broadly proportionate as currently devised? Where might adjustment be required?

Is the range of existing sanctions manageable for commissioners and providers?

Are there any national sanctions that are no longer necessary?

Would assessment of composite performance on specific areas (e.g. waiting times) be more helpful?

Could a balanced scorecard approach work?

Should there be more national sanctions for non-acute contracts? If so, in which areas?

Is there a case for financial compensation to be offered by providers direct to affected service users, rather than (or as well as) to commissioners?

Locally Agreed Sanctions

We should provide clearer guidance on the use of locally agreed sanctions within contracts, with particular regard to alignment with the variation rules to be set out within the National Tariff Document.

Questions

Are the current arrangements effective in enabling local sanctions to be applied?

Does the 1% ceiling on local sanctions provide any benefits or disadvantages? Is there a case for a combined cap across nationally-mandated and locally-agreed sanctions?

Which of the following options is most likely to secure higher quality and why:

1. *No locally agreed sanctions*
2. *Requirement for locally agreed sanctions to a specific % of contract value, with clear supporting guidance.*
3. *No change to the current rules.*

Long-term direction of travel on incentives, rewards and sanctions

We believe we should consider whether it would be desirable and feasible to switch, from 2015/16 onwards, from the current contract regime of sanctions and CQUIN incentives, to a new consistent pay-for-performance regime. Providers would receive a core payment for a given quantum of service provision, with this potentially flexing up and down in line with activity levels – but providers would then have the opportunity to earn a significant further percentage payment for meeting the NHS constitution, operational standards and agreed improvement goals, some nationally driven, others locally specified.

Questions

Is this a direction of travel you would support?

In designing the package of incentives, rewards and sanctions for the future, what balance should we strike between national mandation and oversight on the one hand and flexibility, local autonomy and freedom to innovate on the other?

Conclusion

Your views and experiences will help us to design the right package of incentives for 2014/15 and inform the future strategy, and we welcome your feedback.

Please send your comments and views on the questions raised in this document to england.incentivesreview@nhs.net by Friday, 2nd August 2013.