Paper NHSE131113

BOARD PAPER – NHS ENGLAND

Title: Outcome of the review of incentives, rewards and sanctions by NHS England.

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Purpose of the paper:

- To inform the Board of the work undertaken to review incentives, rewards and sanctions.
- To seek approval from the Board for the recommendations from that review, including the package of incentives, rewards and sanctions for 2014/2015.

Key issues and recommendations:

NHS England undertook a review of incentives, rewards and sanctions between April and October 2013. The review identified the importance of incentives, rewards and sanctions in enabling the transformation of care, but also highlighted their limitations and wide variation in how existing incentives, rewards and sanctions are applied in practice.

We recommend that changes to national incentives, rewards and sanctions for 2014/2015 are made in tandem with changes to the payment system, and any significant changes are made based on best available evidence. As a consequence, the focus for 2014/2015 should be on allowing maximum local flexibility for genuine transformation of services, whilst otherwise maintaining stability and making incremental improvements to our existing incentives, rewards and sanctions.

We set out key changes to the NHS Standard Contract and recommend a limited number of important changes to the text, concentrating on those which will have the most impact in making the Contract clearer, easier to use and more effective as a tool for commissioning safe and high-quality services with good outcomes.

Action(s) required by Board members:

- To note the work undertaken to review incentives, rewards and sanctions.
- To approve the key messages emerging from the review of incentives, rewards and sanctions.
- To approve our proposed approach to local flexibility.
- To endorse the overall direction for the NHS Standard Contract for 2014/2015 and approve the approach to consultation and finalising the Contract.
- To endorse the recommendations for the CQUIN scheme for 2014/2015 and approve the approach to finalising the scheme and guidance.
- To endorse the recommendations for the Quality Premium scheme for 2014/2015

and approve the approach to finalising the scheme and guidance.

- Approve implementation of and publication of the recommendations of the review of incentives, rewards and sanctions.
- Delegate authority to the NHS England Executive Team to finalise the NHS Standard Contract, CQUIN scheme and Quality Premium scheme.

Recommendations from the review of incentives, rewards and sanctions

Executive Summary

1. The strategic intent of incentives should be to support delivery of NHS England's objectives, but they cannot alone deliver transformation. NHS England undertook in *Everyone Counts: Planning for Patients for 2013/2014*, to review incentives, rewards and sanctions to inform the planning round for 2014/2015. This has involved significant work within NHS England and involving a wide range of internal and external stakeholders.

2. The conclusions of the review can be distilled into 3 key messages, which we ask the Board to support: 1) The payment & incentive scheme is a vehicle to support and enable transformation; 2) Transformation is best initially done, and then evaluated, through local freedom to innovate; 3) Outside of local innovation, we should maintain stability, increase rigour and transparency, and simplify where possible.

3. Where commissioners and providers are seeking to transform services, through radically different contracting and payment models, we ask the Board to allow flexibility in the application of national rules, including CQUIN and contract sanctions. This is consistent with the approach the Board have agreed in respect of payment (National Tariff).

4. We propose to make a limited number of important changes to the text of the NHS Standard Contract and sanctions within it, concentrating on those which will have the most impact in making the Contract clearer, easier to use and more effective as a tool for commissioning safe and high-quality services with good outcomes. We ask the Board to support these changes and our approach to consulting on the draft contract during November.

5. We ask the Board to support maintaining broadly the same structure for the CQUIN scheme in 2014/2015, but remove the pre-qualification gateway for innovation, replacing it with a clear contractual requirement. We recommend four national commissioning for quality and innovation (CQUIN) indicators, in the following areas: Friends and Family Test; Dementia and Delirium (Acute Trusts only); Diagnosis coding and associated quality improvement (Mental Health Trusts only); NHS safety thermometer. Each should be worth a minimum of 0.125% of the total value of the contract (excluding drugs and devices)

6. We ask the Board to support maintaining broadly the same structure for the Quality Premium scheme in 2014/2015, with five goals based on the domains of the outcomes framework and one linked to a local Health and Wellbeing Board priority. The five domain goals would be: Local improvement goal for potential years of life lost; achieving a nationally set level of IAPT access, or delivering improved access where this level is already being met; composite indicator for reducing avoidable emergency admissions; improvement in Friends & Family test scores; and improved reporting of medication error safety incidents.

7. We believe that, taken alongside other initiatives and interdependencies, these recommendations will have a positive impact on patients.

8. We ask the Board to support publication of the outcome of the review of incentives, rewards and sanctions and to approve for our Executive Team to finalise the package of incentives, rewards and sanctions in December 2013, based on these recommendations.

Background

9. The strategic intent of incentives should be to support delivery of NHS England's objectives through both direct and CCG commissioning, 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.

10. We must also recognize that incentives alone cannot deliver the transformation of health and social care. 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.

11. NHS England undertook in *Everyone Counts: Planning for Patients for 2013/14*, to review incentives, rewards and sanctions to inform the planning round for 2014/2015. The scope of this review was agreed in April 2014, to include: the NHS Standard Contract, particularly the financial sanctions on providers; Commissioning for Quality and Innovation (CQUIN) payments – the financial incentive scheme for providers (excluding primary care) to improve quality and innovation, worth up to an additional 2.5% of total provider income; and the Quality Premium financial incentive scheme for CCGs, introduced in April 2013. The review was also to ensure alignment between these incentives and incentives for primary care, and with other levers (e.g. national tariff).

12. Emerging proposals were presented to NHS England's Executive Team on the 27 June 2013 and were broadly supported, subject to wide engagement with internal and external stakeholders. This engagement took place during July, August and September. This paper sets out the main recommendations following that engagement.

13. Significant work has been undertaken to come to these recommendations, the full extent of which cannot be reflected in this paper. This paper may also not fully reflect the detailed work undertaken to align incentives across providers and commissioners, for example, specific projects were successfully undertaken to align incentives in avoiding emergency admissions across primary, secondary and social care and dementia across primary and secondary care.

14. The longer term strategy for incentives, rewards and sanctions (2015/2016 and beyond) is actively being taken forward through the pricing and incentives strategy and builds on the work of this review.

Key Messages

15. The conclusions of the review can be distilled into the following key messages:

- The payment & incentive scheme is a vehicle to support and enable transformation (alongside other regulatory and market shaping tools) but cannot alone drive transformation.
    - Different payment or incentive models are not an end in themselves

- Transformation is best initially done, and then evaluated, through local freedom to innovate
    - We should not pull national levers without a robust evidence base for doing so
    - We cannot radically redesign incentives in isolation from payment and contract redesign
    - There is an urgency to transforming services locally to deliver the QIPP challenge

- Outside of local innovation, we should maintain stability, increase rigour and transparency, and simplify where possible
    - We should improve national incentives & sanctions where there is a clear case for doing so
    - We should use evidence based indicators unless we are seeking to experiment
    - We should publish details of local innovations in our contracts

16. In summary, we propose for 2014/2015, *"A national default position, but with freedom, support and encouragement for genuine innovation"*

The Board is asked to approve these key messages

Key recommendations for the package of incentives, rewards and sanctions for 2014/2015

Local Flexibility

17. Where commissioners and providers are seeking to transform services, through radically different contracting and payment models, we should allow flexibility in the application of national rules, including CQUIN and contract sanctions, where this complies with the following principles.
- It is in patients' best interests.
- It is fair and transparent, published with clear justification.
- Providers and commissioners engage constructively.
- It is within the existing legal framework.

18. The Board have previously supported this approach in respect of national prices (as set out in the National Tariff document).

19. It is not proposed that these flexibilities are applied to the Quality Premium.

20. We will require area teams in their commissioning of specialised services and other directly commissioned services, to be consistent in the application of contract sanctions and use of local flexibilities.

The Board is asked to approve this approach to local flexibility.

NHS Standard Contract

21. The NHS Standard Contract is used by NHS commissioners for all contracts for clinical services other than mainstream primary care.

22. NHS England is developing a revised version of the Contract for 2014/2015. We propose to make a limited number of important changes to the text, concentrating on those which will have the most impact in making the contract more effective, clearer and easier to use. We recommend that those changes:

- support implementation of recommendations in the Francis report;
- allow greater flexibility of contract duration;
- facilitate more effective use of innovative contracting models ;
- allow the Contract to be more effectively tailored to suit specific service types, through extended use of the electronic Contract system;
- require commissioners and providers to make progress in delivering against high impact innovations and other local innovations, and implementing 7-day services. If a provider failed to do this, then ultimately up to 2% of contract value could be withheld by the commissioner;
- provide a more proportionate package of contract sanctions, with a simpler, more consistent methodology for applying sanctions and new sanctions for data quality failures, with additional focus on mental health providers to support parity of mental health; and
- include the introduction of a sanction for failing to maintain the improvements delivered through the previous VTE CQUIN incentive payment.

23. Standing Rules require NHS England to consult with key stakeholders on material changes proposed to the NHS Standard Contract; we therefore propose to consult on an advanced draft of the Contract during November. It is proposed that the final version of the Contract should be agreed by NHS England's executive team in early December 2013, for publication alongside other guidance later that month.

The Board is asked to endorse the overall direction for the NHS Standard Contract for 2014/2015 and approve the approach to consultation and finalising the Contract.

Commissioning for Quality and Innovation (CQUIN)

24. All providers of clinical services under the NHS Standard Contract are able to earn up to 2.5% on top of their income for clinical services for delivering national and local quality and/or innovation improvements, under the CQUIN scheme, initially introduced in 2009. NHS England is responsible for setting the rules under which the CQUIN scheme should operate and any national improvement goals.

25. NHS England is refreshing the CQUIN scheme and associated guidance for 2014/2015. We recommend a number of key changes, set out below.

26. We recommend removing the current requirement for providers to have met specific milestones with respect of high impact innovations in order to be eligible for any CQUIN payments.

27. We recommend clarifying in the national rules that CQUIN payments do not apply to drugs and devices excluded from tariff.

28. We recommend four national CQUIN indicators, in the following areas: Friends and Family Test; Dementia and Delirium (Acute Trusts only); Diagnosis coding and associated quality improvement (Mental Health Trusts only); NHS Safety Thermometer. Each should be worth a minimum of 0.125% of the total value of the Contract (excluding drugs and devices)

29. We recommend that 2% of the total contract value (excluding drugs and devices) should be used for local CQUIN schemes. We plan to provide a non-mandated list of evidence based indicators for CCGs to use in developing local CQUIN schemes where appropriate, including where possible indicators that support transformation.

30. It is proposed that the final CQUIN scheme should be agreed by NHS England's executive team in December 2013, for publication alongside other guidance later that month.

The Board is asked to endorse the recommendations for the CQUIN scheme for 2014/2015 and approve the approach to finalising the scheme and guidance.

<u>Quality Premium</u>

31. The Quality Premium rewards clinical commissioning groups (CCGs) who demonstrate improvement against a range of national and local goals, alongside good general quality and financial performance. Worth up to £5 per head of population CCGs can use any Quality Premium earned to improve quality of care and/or outcomes for their population.

32. NHS England is refreshing the Quality Premium scheme and associated guidance for 2014/2015. We recommend a number of key changes.

33. We recommend retaining the same basic structure for Quality Premium as in 2013/2014, including carrying forward the rules on reduction or withholding quality premium funding, but providing greater clarity on the requirements.

34. We recommend having six indicators in total, five covering the domains of the outcomes framework and one for a local Health and Wellbeing Board priority.

35. The indicators associated with the five domains are proposed as follows: Local improvement goal for potential years of life lost; achieving a nationally set level of IAPT access, or delivering improved access where this level is already being met; composite indicator for reducing avoidable emergency admissions; improvement in Friends & Family test scores; and improved reporting of medication error safety incidents.

36. It is proposed that the final Quality Premium scheme should be agreed by NHS England's executive team, including the relative weighting of each of the indicators, in December 2013.

The Board is asked to endorse the recommendations for the Quality Premium scheme for 2014/2015 and approve the approach to finalising the scheme and guidance.

Interdependencies

37. There are several interdependencies that affect the impact of the recommendations of the review, which have been taken into consideration. These are set out below.

Setting levels of ambitions

38. NHS England's Executive Team recently supported a proposal for CCGs and Area Teams to set themselves levels of ambition for outcomes in seven areas, in order for us to be able to aggregate these and articulate, in quantifiable terms, what improvement we hope to achieve across the NHS over the next 5-7 years. Our proposals for incentives, rewards and sanctions are consistent with, and complement, the general areas for improvement proposed, but work to a shorter timeframe.

National Tariff Document

39. The National Tariff document was published on 3rd October by NHS England and Monitor, having been approved by the Board. Its key messages are consistent with this review, and the proposed principles for allowing local flexibility are the same.

Primary Care Contract and Incentives

40. There needs to be alignment with the approach to primary care contracts and incentives. This was the major focus of feedback from CCGs on our emerging recommendations. We are working to support more innovative use of local

flexibilities for primary care contracting and incentives including the use of Personal Medical Services contracts.

Incentives across commissioners

41. The review highlighted some of the challenges faced by having multiple commissioners across a pathway, resulting in the potential for perverse incentives for commissioners to cost-shift and the need for commissioners to collaborate when designing incentives locally. The recommendations of the review support increased collaboration in designing incentives

Procurement

42. Commissioners will need to understand the role procurement plays in setting incentives, rewards and sanctions, both when procurement may be used as a tool for implementing commissioner incentive schemes and when procurement (which does not necessarily equal competition) must be used because proposed service models are radically different from currently. NHS England are developing procurement guidance for commissioners, which will set this out.

Integration Transformation Fund

43. The work to design the metrics and rules for the Integration Transformation Fund is outwith the scope of the review, but we are working together to ensure that as far as is possible the Integration Transformation Fund complements the proposed package of incentives.

Collective Impact

44. Taking our recommendations and the interdependencies together, Fig 1. below gives a practical example of how these can collectively support service transformation:

Fig 1. Improving diabetes care

On the basis of their needs assessment, a CCG wishes to develop an integrated diabetes service for their population, which is expected to improve quality of care for patients, improve outcomes and reduce emergency admissions and secondary care resource utilisation.

Providers and commissioners could **contract** for this service for five years using a prime provider model (this is just one of many options), with a single community provider subcontracting elements of care from secondary care physicians.
They could **pay** for this integrated service provision through a local variation to the diabetes tariff, agreeing a core payment, based on cost and assumed cost reductions, with a 20% performance bonus, based on delivering improved outcomes

in patient satisfaction, care planning, blood glucose levels and blood pressure controls. (This would result in a net saving)

Alongside this they could **incentivise GPs** referring into the community service to improve the quality of their referrals and ongoing care (over and above the requirements of the core GMS contract), through use of a local incentive scheme agreed with their Area Team.

Conclusion

45. The recommendations of the incentives review should support and enable commissioners to deliver transformative change in 2014/2015. We propose to implement these recommendations and share them with commissioners and providers, subject to Board approval.

46. Further work is needed to finalise the package ready for publication alongside the planning guidance, including finalising the detailed guidance and metrics. We propose that the final package is approved by our Executive Team.

The Board is asked:

- to note the work undertaken to review incentives, rewards and sanctions;
- to approve the key messages emerging from the review of incentives, rewards and sanctions;
- to approve our proposed approach to local flexibility;
- to endorse the overall direction for the NHS Standard Contract for 2014/2015 and approve the approach to consultation and finalising the Contract*;*
- to endorse the recommendations for the CQUIN scheme for 2014/2015 and approve the approach to finalising the scheme and guidance;
- to endorse the recommendations for the Quality Premium scheme for 2014/2015 and approve the approach to finalising the scheme and guidance;
- approve implementation of and publication of the recommendations of the review of incentives, rewards and sanctions;
- delegate authority to the NHS England Executive Team to finalise the NHS Standard Contract, CQUIN scheme and Quality Premium scheme.

Paul Baumann
Chief Financial Officer
October 2013