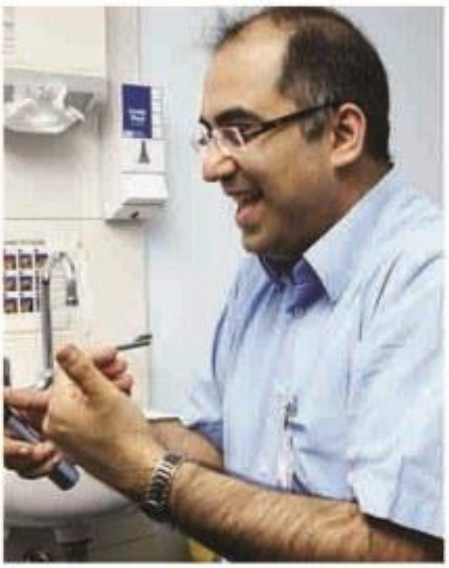
NHS England

Review of incentives, rewards and sanctions

Discussion paper for stakeholders

Summary of Feedback

August 2013



November 2013

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NHS England Review of incentives, rewards and sanctions

NHS England Discussion paper for stakeholders

Summary of Feedback

First published: November 2013

Prepared by: Commissioning Policy and Resources Team, Commissioning Development

Contents

Background

As part of their endeavour to secure better patient outcomes, NHS England are responsible for a range of incentives, rewards and sanctions for providers and commissioners, to encourage improvements in the quality of care commissioned and provided.

In *Everyone Counts: Planning for Patients* NHS England committed to a fundamental review of incentives, rewards and sanctions to inform the 2014/15 planning round. This has involved significant work within NHS England and involving a wide range of internal and external stakeholders.

As part of our engagement with stakeholders, in July 2013 NHS England published a discussion document on the Review of Incentives, Rewards & Sanctions: http://www.england.nhs.uk/wp-content/uploads/2013/07/incent-rew-sanct.pdf

This report is the summary of the feedback to the consultation discussion document, which has been used to inform the recommendations from the review and, ultimately, the package of financial incentives for 2014/2015.

Review of incentives, rewards and sanctions

Feedback from the July discussion document

November 2013

Type of Stakeholders

The Incentives, Rewards & Sanctions discussion document generated 66 responses; the majority being provider organisations, some commissioners and other external stakeholders, demonstrating a fairly broad scope of different Health & Social Care sectors showing an interest in NHS England's Review of Incentives, Rewards & Sanctions.

The majority of NHS providers were Trusts (10) or Foundation Trusts (14), with one Ambulance service Trust, one partly NHS funded Care Home and one General Practice. Private providers included Pharmaceutical manufacturers/suppliers (5), medical (2) and social care (1). The overall coverage of providers amounts to about half (52%) of the overall responses.

Commissioners or commissioning support services yielded relatively lower than expected responses with only 14 CCGs, 1 AT & 3 CSUs, amounting to about a quarter (27%) of the overall responses, although two responses was a collective contribution from a network of CCGs covering a wider area.

In addition to the above, just under a quarter (20%) of the overall responses came from various other Health industry. Finally we received contributions from a Patient based organisation, charities and a Health Communications Consultancy.

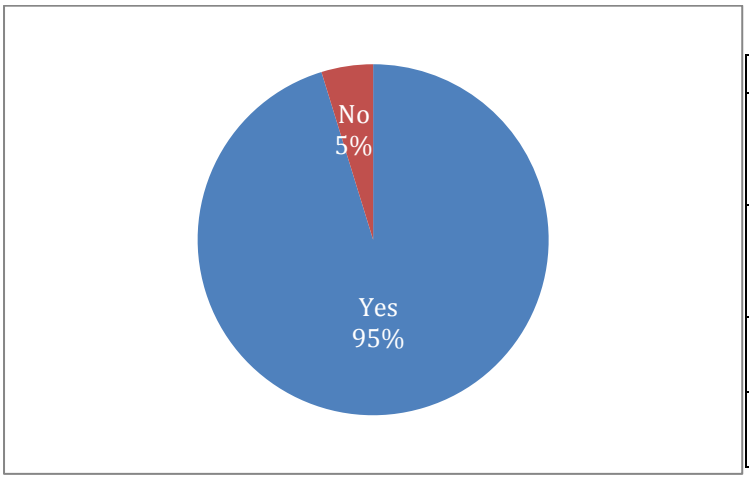
To summarise the style of contributions made from stakeholders, coverage of all questions was relatively low, most opting to concentrate on specific proposals/issues raised by this discussion document which they deemed relevant to them. The responses provided valuable feedback, making suggestions to how we can better align our incentives to achieve improved quality and outcomes. These will inform the recommendations of the Review of Incentives, Rewards and Sanctions for 14/15.

This report will concentrate on baseline statistics achieved from the discussion document to allow us to understand a general trend in how the current system of Incentives, Rewards & Sanctions are viewed and identify key responses to each of the questions.

Which incentives are best used for what

Q1. Do you support these design principles?

Based on only those who responded, 95% welcomed the design principles presented by this paper.



	Yes	No	Abstained
Providers – NHS	16	0	11
Providers – Private	6	0	2
Commissioners	9	1	5
Other	11	1	4

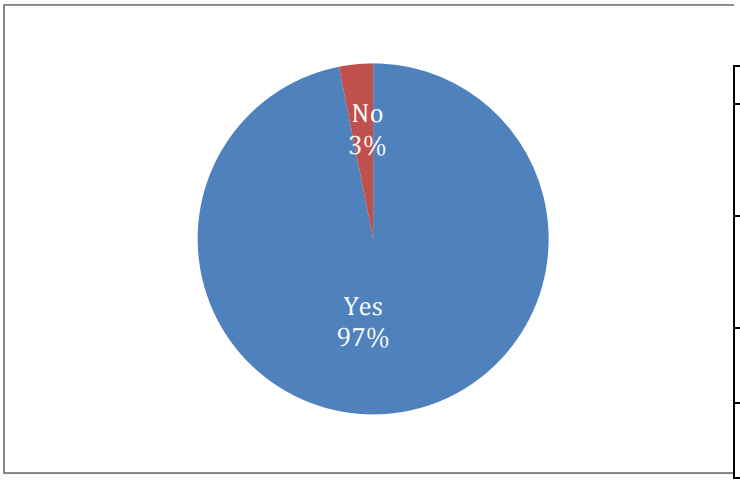
Strong themes expressed by stakeholders included;

- *"clarity is needed about the standards we are seeking to achieve and a robust method of measuring them and any national incentives need to be workable, not unreasonably complex and evidence based,"*
- *"they need to be 'intuitively fair' for providers and [sanctions] proportionate to the health impact of breaches,"*
- *"incentives [should be] linked to improving patient outcomes,"*
- *"should be kept simple, strategically focused and of a magnitude to influence Trust behaviours without distorting clinical (and administrative) practices and priorities."*
- *There was one comment not supporting the principles, who "have concerns that the implementation of well-designed incentives through CQUIN, local incentives, QOF and quality premiums actually work to warrant the investment in these in terms of time and money."*

NHS Standard Contract (General Terms and Conditions)

Q2. Do you support the general proposals set out above?

Based on those who responded, 97% welcomed the design principles presented by this paper.



	Yes	No	Abstained
Providers – NHS	13	0	14
Providers – Private	3	0	5
Commissioners	10	1	9
Other	5	0	7

The general consensus is that stakeholders would welcome the main proposals proposed by this discussion document keeping agreed National Standards consistent across the whole system applied equally for all contracts & providers. Specific arising themes from the stakeholders can be summarised by one particular response which broadly covers a general consensus of stakeholder views expressed;

- *"The NHS Standard Contract should set out agreed national standards to cover all providers. This must contain not only clear statements and standards (such as NICE TA and similar commissioning guidance) but also how these will be measured and publically demonstrated. This could be through publication of national measures or through regular publication of audits against a national framework, perhaps captured through Quality Accounts. The ABPI would also support greater flexibility in contract duration if this enables organisations to focus on medium term service development rather than the annual contract negotiations. However, it is important that within any longer term contractual framework there is still the focus on driving the implementation of change, with regular public feedback and accountability throughout the contractual period."*
- *The other emerging theme is "[we support] The General proposal for a standard set of contract terms combined with the opportunity for local flexibilities that are more service specific."*

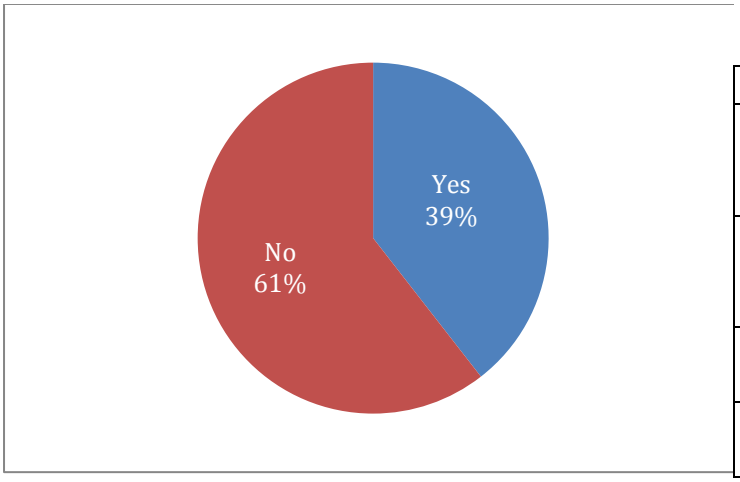
It is worth mentioning that several stakeholders who also responded to the NHS Standard Contract discussion paper abstained from answering the questions of this discussion paper due to duplication.

Q3. Are there specific changes NHS England could make to the NHS Standard Contract general terms and conditions that could improve or safeguard quality?

- Contract flexibilities in duration; See Q5.
- Apply to All services:
  "We would welcome the NHS Standard contract being applied to all services delivering NHS care for example non NHS providers. It can then make explicit the need to provide a quality account and provide robust learning from all incidents and complaints."
- Align specifications with NICE TA, Francis, Keogh reports etc.
  "There may be scope for annual iterations of the contract to add further specific priorities, depending on the availability of relevant NICE quality standards and other evidence, and to remove former priorities on which there has been overall progress. Clarity about when and where NICE guidance and quality standards should be used, beyond the general requirement to meet applicable national standards, may help services improve quality. This could be supported by the use of best practice tariffs."
- Change the sanctions; See Q24 – 34.
- Data collection:
  "In support of the Francis enquiry recommendations there are certain Data information requirements that would assist and support the quality assurance process. The willingness to provide such information varies across Acute providers so mandatory data requirements for Acute and community contracts in particular would provide consistent data nationally and aid local contract monitoring. Data sets to be added should include: Workforce – with a meaningful breakdown to include vacancies, sickness, training %, PDPs etc. Mortality – the reporting mechanism was withdrawn nationally"
- Better definitions
  "The group felt that the application of the 'consequence of breach' to the quality standards needed to be clearer and simplified to enable CCGs to enact with providers. For example, Cancer Operational Standards consequence is 2% of service line, but practically target is across lots of specialities and PODs, so service line is not workable. Similarly with Diagnostic wait target, local trusts don't have a diagnostic service line so practically cannot apply the sanction. The group also felt that the further signposting would be useful in relation to the policies and guidance that is referred to in the general terms and conditions. In particular, links to where the documentation can be obtained from would be beneficial."
- More Clarity on responsibilities
  "There have been areas of the contract that have been very unclear with regard to responsibility for commissioning e.g. military, overseas visitors, dental, screening, and GUM"

Q4. Would mandated specifications, over and above those for prescribed services, be welcomed?

Based on only those who responded, 61% opposed the introduction of further mandated specifications.



	Yes	No	Abstained
Providers – NHS	3	15	9
Providers – Private	3	0	5
Commissioners	5	7	6
Other	4	1	9

Generally stakeholders are opposed to the development of mandated specifications, citing:

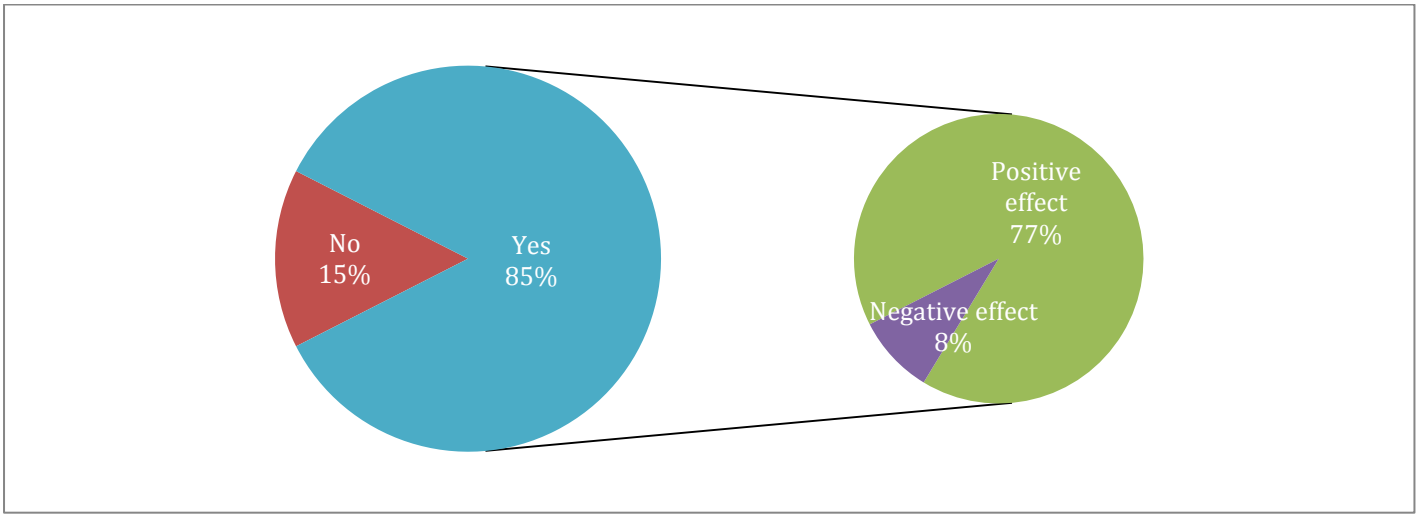
- *"this could be a barrier towards local developments or requirements,"*
- *and "CCG's will want to commission services to meet local need and whilst there will be commonality amongst these there will also be local pathways and referral criteria etc which would not necessarily be captured on national templates. In addition, historically, those service specifications written nationally (ie for AQP and Public Health Services) did not follow the contract technical guidance and included sections that contradicted or replicated the mandated sections of the contract so unless these specifications were approved via the national contracting team experts there is a general nervousness about how helpful they may be. etc."*
- *Furthermore "treatment should be outcome focussed, not specification focussed. Starting with a singularly defined way of working and requiring everyone to work that way will, by definition, stop any innovation as you can't try anything different. A 'justify or comply' focus would be better. For example at Intermountain in Utah, USA (one of the leaders in healthcare improvement and quality), they have a defined way of doing this; people can do differently if they can justify why it is better, otherwise they are required to comply. Where minimum standards are not being achieved, following a thorough understanding of why, if there is no good reason and known best practice is not being followed then organisations should be required to move to known best practice."*
- *"The volume and nature of specifications might become unmanageable. It would be sensible to consolidate and evaluate the specifications of the prescribed services before extending this approach to other services. Within specifications it would be most helpful if it could be made clear which standards are essential and which are desirable,"*
- *and "helpful to have national specifications but recommended as best practice rather than mandated."*

However some stakeholders believed mandated specifications were appropriate citing:

- *they "ensure consistency and standards are maintained and improved uniformly across the country as a minimum,"*
- *but "further work is needed to ensure that specifications are following a prescribed format as there is too much variety amongst nationally commissioned specifications which have been written by Commissioning Reference Groups (CRG's)"*
- *and "there would still require some local flexibility in the way services are provided."*

Q5. Would greater flexibility in contract duration have an impact on quality? If so, how?

Based on only those who responded, 85% of stakeholders believed greater flexibility in contract duration would have an impact on quality, the majority indicating this would improve quality.



	Positive effect	Negative effect	No effect	Abstained
Providers – NHS	15	0	4	8
Providers - Private	3	1	0	4
Commissioners	9	1	2	6
Other	4	1	0	9

The reported potential benefits of greater flexibility in contract duration included:

- Longer for successful outcomes to be achieved as 1 year not enough for changes to materialise.
  "If the duration of contracts was extended to more than 1 year there could be a positive impact on quality since the extended period will allow time for quality improvements to bed in and be properly tested."
- Ensure stability with staffing and commissioner/provider relationship.
  "Flexibility in contract duration would improve quality. There seems to be little evidence that a greater frequency of tendering improves quality and in fact a negative impact on quality may result if staff become unsettled by a service coming towards the end of a contract, even though a TUPE situation is likely to exist. Higher turnover rates and a difficulty recruiting to vacant posts are likely towards the end of the contract period."
- Allow long term planning for improvements.

"Flexibility in contract duration could provide room for more effective partnership working on priorities such as integration between health and social care and other form of service reconfiguration, and so create opportunities to build sustainable services. Criteria for allowing flexibility should include a clear rationale and use of NICE guidance and quality standards and/or other evidence-based guidance to design or re-design service models."
"A greater contract duration would allow providers to develop CQUIN schemes of a much greater length, thus enabling them to plan for large scale changes to improve quality. These larger schemes will need to be more closely monitored as larger amounts of tax payers money are at stake, but it would mean providers could implement schemes that would have a much greater impact on patient quality. There would need to be the opportunity to review relevance on an annual basis."

- Reduce administrative processes/costs with renegotiating & implementing each cycle. *"Duration shouldn't be a problem if there is an expectation that there will be an annual review. It could be viewed that the uncertainty of a lengthy contract compromises quality as there may be insufficient funding to invest in 1 year period. We also need to be more practical regarding terms of contracts as the trend towards full blown procurements is resource hungry and expensive – something we do not have as a health service. Staggering the start and end of contracts should be considered – there is a disproportionate workload for contracting teams in the last quarter of the year to deliver new contracts for so many and the availability of the revised national contract does not offer a long lead in time to build preparation into the work schedule."*

However a minority of Stakeholders raised concerns that changing the flexibility of contract duration may have negative changes, citing:

- *"risk of provider complacency if the contract duration is too long, so no more than a 3 year contract,"*
- and *"Longer contracts will only function effectively in periods without significant organisation change."*

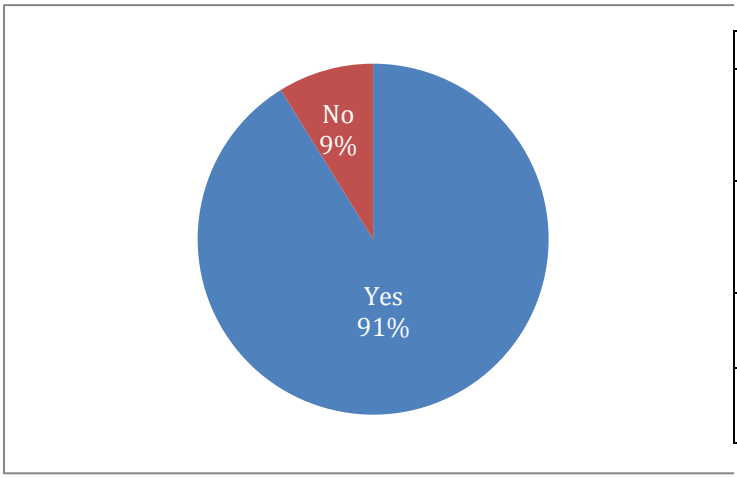
The feedback from stakeholders who did not believe greater flexibility in contract duration would lead to improved quality also cited:

- *"the most important element which will impact quality is the robustness of the underpinning contract monitoring processes put in place to monitor performance and quality and address issues between the provider and commissioner. More important to enact the contractual levers appropriately for contractual quality and performance monitoring processes than duration of the contract term itself."*
- *However one stakeholder outlined "duration of contract is not always an issue for larger NHS Trusts, as the expectation is that we plan to continue to provide the service."*

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

Q6. 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?

Based on only those who responded, 91% of stakeholders welcomed the principles for consistency between local flexibilities within national tariff and national incentives.



	Yes	No	Abstained
Providers – NHS	14	2	11
Providers – Private	1	0	7
Commissioners	11	0	7
Other	5	1	8

The general consensus from stakeholders is that Tariff and incentives should not be treated differently, but specific themes derived from responses includes;

- *"we would support a level of flexibility in the national incentives provided that it is coupled with appropriate governance and a route for approval from a neutral body (such as Monitor). We would advocate a policy of local health economies having to earn the right to autonomy on local variations and flexibilities. Health economies who demonstrate that they are high performing (e.g. have a proven track record of delivering sustainable change that is driven by the patient quality agenda) should be allowed autonomy of the local variation and flexibility agenda. Health economies unable to demonstrate these standards should be subject to a greater level of scrutiny and be required to seek authorisation for local deviation to the rules and also be offered more support."*
- *Also "the overall design principles for incentives and rewards need to be simplified and 'cleaned up'. Specifically they have become confused with basic tariff and by pursuing multiple, cumulative objectives. The basic principle should be; Tariff needs to reflect average cost with a reasonable allowance for margin and objective local/regional economic factors; Incentives need to be over and above tariff, primarily handled through contracts and reflect a mixture of national and local objectives and shorter and longer term objectives; Quality can also be driven by service and geography specific contract elements."*

Comments from stakeholders who did not believe consistency was required were:

- *"the focus should be on quality and outcomes rather than consistency between the two,"*

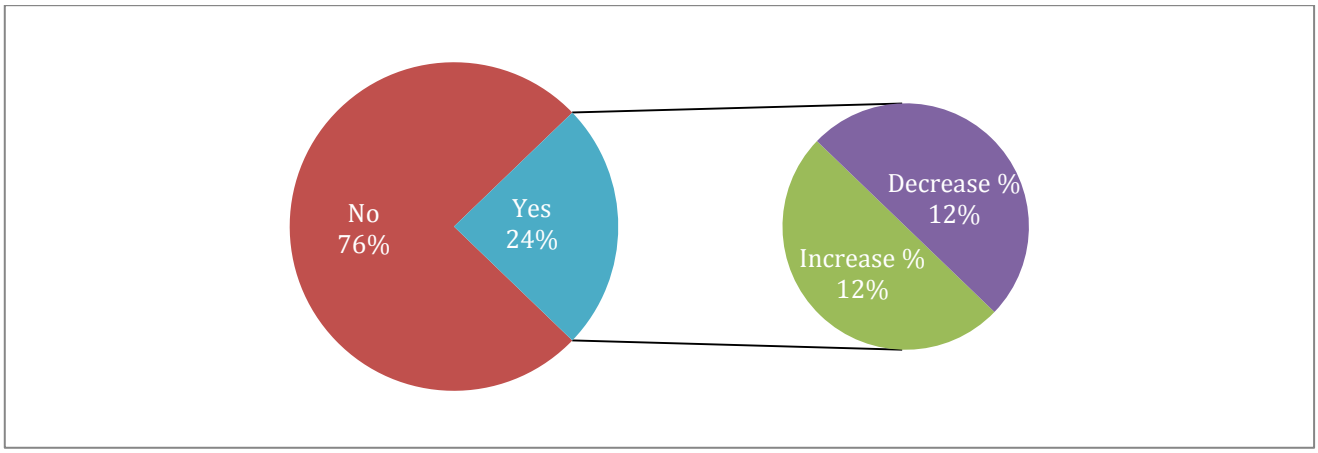
- *and "We do not see the need to ensure the flexibilities in local pricing are aligned to flexibilities with other national incentives. The policy for setting prices does not need to be in line with local flexibility for incentives and penalties."*

Q7. What support could NHS England provide to build capacity and capability?

- Ensure effective data flow exist for real time monitoring or take responsibility for collating & sharing data.
  "NHS England needs to ensure that appropriate data flows are available and can be accessed at CCG level to support any developments for contracting for outcomes. National restrictions on usage of patient identifiable data and subsequent time lags with data mean that real time tracking of patient pathways and outcomes is much more difficult to achieve."
- Use Webinars/workshops to inform of 'best practice' and tried & tested methods of implementing change, variations etc
  "Provide examples of variations, publish good practice, run workshops or webinars, potentially offer consultancy support from within the NHS to assist in development."
  "Clear guidance and training for commissioners, setting out as far as possible what the outcomes and methodologies should be, setting up processes for collecting and monitoring evidence in a standardised way so that there is consistency of approach across all providers/commissioners."
- Support CSUs as not yet self-sufficient.
  "CSU's are at varying stages of 'maturity' and at present evidence would suggest that they require a lot of support to build capability in order to assist CCG's."
- Improve communication
  "NHS England could help most by indicating well in advance what changes are envisaged within contracts and service specifications. The tariff could with advantage be published significantly in advance, and it be made clear what decisions (such as by NICE) have been incorporated into tariff changes."
  "As well as working with CCG's and CSU's, consider involving providers of healthcare as part of those discussions."
  "Looking at contributions to savings that could be made from commissioners for example by reducing duplication, streamlining their processes, and ensuring people with authority to make decisions are in the right meetings. When considering the level of support NHS England should provide to build capacity especially in Commissioning Support Units, we would want them to do this within existing resource or through efficiencies. In 2013/14 there has been evidence that there is lack of communication and an inconsistent approach across the country. Any additional funding supporting the commissioning process, whether this is challenging activity charged under the contract, or imposing fines or challenging CQUIN, reduces funding available for patient care."

CQUIN

Q8. Are there reasons why the current level of funding for CQUIN (2.5%) should change for 14/15?



	Increase %	Decrease %	No change	Abstained
Providers – NHS	3	3	13	8
Providers - Private	0	0	2	6
Commissioners	1	1	13	2
Other	1	1	3	10

The main two comments for maintaining 2.5% is because:

- *"It is large enough to get providers around the table to discuss local quality improvements and small enough not to completely de-stabilise. Providers do have a tendency to think they are entitled to the income. The system also perpetuates this - CCGs are required to agree year end financial positions with providers in advance of determining whether CQUINs have been delivered. This sometimes mean providers are paid CQUINs they may not have achieved,"*
- *and "Increasing the percentage of the contract covered by CQUIN could create some issues with the negotiation of the contract. Our experience has been that we have had more success where we have agreed a small number of CQUINs with higher value, as this has been really helpful in creating focussed improvement. If the value (and hence numbers of work areas) increases there is a danger that effort will be spread too thinly and the drive for improvement becomes diluted for both commissioners and providers."*

Some stakeholders suggested increasing the level of funding for CQUIN:

- *"We would also strongly advocate that there should be a significant increase in the % of recompense that a provider can achieve to reward quality of outcomes rather than their activity inputs. If the NHS is serious about delivering change the funding levels linked with the reward schemes, including CQUIN, should be significantly increased to drive and reward change."*

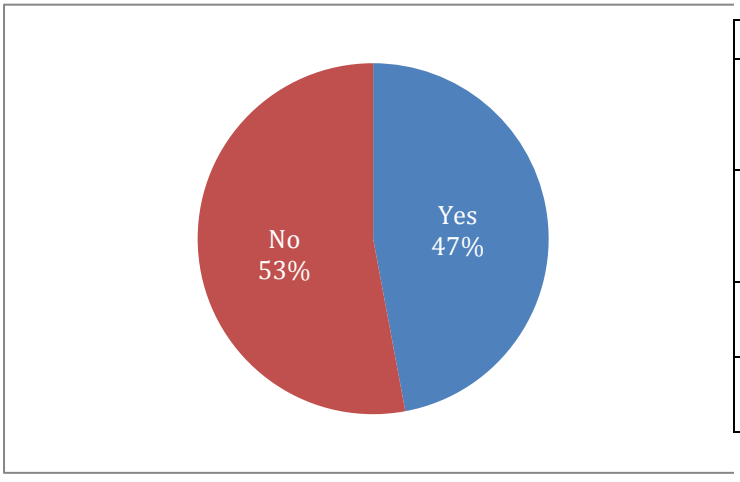
- *"Yes if the aim is that by increasing this it will allow local flexibility on local priorities, but not if the increase is purely linked to national incentives."*

Alternatively an equal number of stakeholders suggested decreasing the level of funding for CQUIN:

- *"At 2.5% CQUIN funding can pose a significant risk for provider organisations, with failure against single indicator potentially having a disproportionate impact on financial stability. The non-recurrent application of CQUIN funding also needs to be reviewed. Having used these funds to achieve a quality improvement in year, providers may then have no recurrent funds provided by commissioners in order to sustain it in subsequent years, and this adds to their cost pressures and may impact adversely on quality."*
- *"There is a case for removing some of the CQUIN % payment and uplifting the tariff by this percentage. Although there is a risk that this is portrayed as a message that quality is not important, the CQUIN regime does not work terribly well as an incentive scheme. The CQUIN quantum – for OUH in excess of £15m – is so great that the regime becomes an exercise in managing financial risk. For example, we cannot afford to agree to a scheme which we are not confident of delivery, or we would fail to meet statutory financial requirements. Similarly, the financial quantum is too large to be able to devolve the incentive scheme to individual services – it has to be part of baseline budget setting. Commissioners understand well that Trusts cannot afford to operate without being paid the majority of CQUIN."*
- *"Percentage could change depending on the size and type of provider contract up to a maximum of 2.5%. If national indicators are not applicable to specific providers then the percentage of CQUIN available to that provider could decrease by the relevant percentage. For some small value contracts it is often difficult to agree full measurable CQUIN schemes with enough stretch to warrant 2.5%. It may be better to scale CQUIN amounts available against a sliding value and complexity of contract matrix?"*

Q9a. Should CQUIN payments apply to i) pass-through payments (for example, for high-cost drugs and devices),

Based on only those who responded, 53% of stakeholders did not believe CQUIN should apply to pass-through payments.



	Yes	No	Abstained
Providers – NHS	13	3	11
Providers – Private	1	1	6
Commissioners	1	12	5
Other	1	2	11

There is a definite general distinction between Providers & Commissioners views on this issue, with commissioners arguing that:

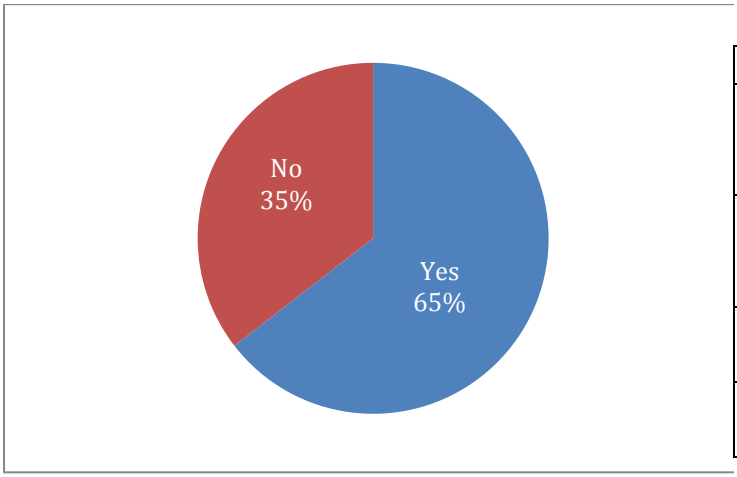
- *"CQUIN should not apply to pass through payments – this would be unaffordable to the NHS and would be disproportionate reward to providers. In the case of some products, treatment of these as pass through costs does not incentivise the provider to negotiate and procure the best value for money; including these in CQUIN will not incentivise the provider to drive down these costs, which are probably the single greatest financial risk."*
- *"No as these are in the main not directly related to quality of services that are being incentivised so should not quality for CQUIN. The risk of applying CQUIN to everything is that it is seen as an automatic right to 2.5% on top of contract value when it should be an optional incentive to earn above baseline and act as a true incentive (rather than being perceived as a penalty when not eared or not paid on pass-through payments)"*
- *Some providers agreed CQUIN should not apply to pass-through payments as "this will add more bureaucracy and the need for resources to manage it."*

In general, providers believed the CQUIN funding should apply to pass-through Payments as:

- *"Pass-through costs should not be treated differently, the reason these items are excluded from tariff, is due to their high value and volatility, which could, if 'averaged through tariff', provide tariff benefits to Trusts that do not usually incur such costs and put those that do, at significant financial risk. I therefore do not understand why NHSE would wish to penalise those Trusts providing such high value/potentially volatile care by not permitting CQUIN on these items as it surely goes against the whole ethos of why NHSE came into existence (to support specialised care). This has been of great concern to the Trust for a number of years, and we have objected to the London SCG's approach on this (London SCG being the only Commissioner previously to take this stance)."*
- *"Pass through payments are actually part of the flexibilities in the PbR guidance – ie they are limited to be something that is an innovation and currently not included in any National Tariff workings (as they have never been in any reference costs) and they are limited to 3 years when National Tariff will have been assumed to have caught up with this innovation. When Commissioners refuse to pay CQUIN on pass through payments, then this can only be for an innovation project not on general High Cost Drugs and Devices that are currently listed as an exclusion to the tariff. In addition to this, CQUIN since its inception has always been a % of the total Cost with no exclusions and as CQUIN is a quality premium for a patients care, any drugs or devices associated with this care should always attract the CQUIN payment. As a result, it is our strong view that CQUIN should always be applied to all elements of a patients care and it is wrong to cherry pick some of the high cost items as being excluded. If there is a true flexibility for an innovation project, then this should be negotiated at the time of agreeing to pay in addition for this innovation."*
- *One commissioner agreed that CQUIN should apply to pass-through payments but offered no explanation to why.*

Q9b. Should CQUIN payments apply to ii) small contracts

Based on only those who responded, 65% of stakeholders believed CQUIN should apply to small contracts.



	Yes	No	Abstained
Providers – NHS	14	2	11
Providers – Private	2	0	6
Commissioners	2	9	7
Other	2	0	12

A similar distinction can be observed between commissioners & providers where the majority of providers believe CQUIN funding should apply to small contracts:

- *"Large Teaching Trusts tend to have a lot of smaller Contracts and would be unfairly penalised, whereas the local DGH who may have only one main commissioner covering 90% of their activity would not lose any funding through this approach. Similarly, these patients would still benefit from CQUIN schemes (as a Trust would not be able to exclude them) and so they should pay a proportionate contribution to the costs."*
- *"As part of overall funding for the contract. There can still be quality improvements on how such items are procured and delivered where the costs of the procurement, delivery and items themselves should be taken as a whole."*
- *Two commissioners agreed CQUIN should apply to small contracts, one citing "quality just as vital here. All contracts including small contracts should be subject to CQUINs. For small contracts that previously haven't had CQUIN then the baseline contract value should be agreed inclusive of CQUIN so there's no pressure on commissioners to increase baselines by 2.5% in Year 1. Set Year 1 as 'introductory' and not too challenging i.e. minimal risk to providers for not achieving. Year 2 and onwards should be more challenging."*

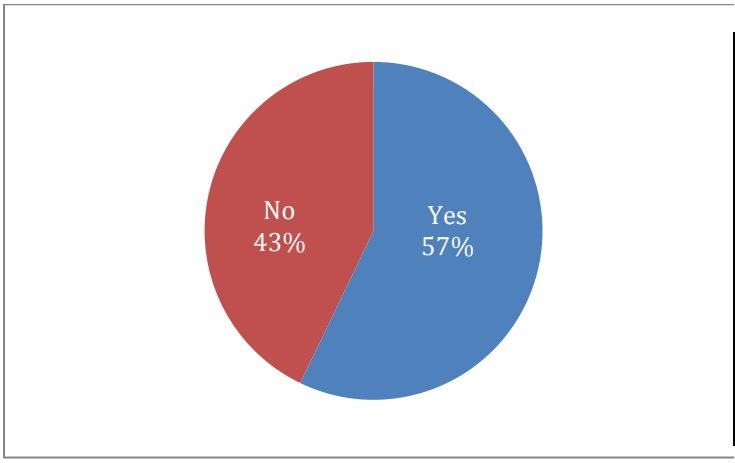
The majority of commissioners however indicated CQUIN funds should not apply to small contracts:

- *"Small contracts of annual value less than £150,000 should not be eligible for CQUIN as the financial value becomes so small as to not be worth the investment from both provider and commissioner in terms of discussing, agreeing, implementing and monitoring a CQUIN scheme."*
- *"The value of CQUINS is usually very small and often the Provider considers them not worth bothering with, i.e. the reward does not cover the cost of doing the additional work to achieve the CQUIN."*
- *Two providers also opposed CQUIN funds for small contracts as "as the costs of managing and monitoring outweigh any financial benefits. However, as commissioners of small contracts will benefit from quality improvements made across the provider organisation, the baseline contract values should be increased by the CQUIN %, if necessary with an*

adjustment at the year end to reflect actual CQUIN achievement under the contracts with the provider's main commissioners."

Q9c. Should CQUIN payments apply to iii) non-contracted activity?

Based on only those who responded, 57% of stakeholders believed CQUIN should apply to non-contracted activity.



	Yes	No	Abstained
Providers – NHS	15	2	10
Providers – Private	1	1	6
Commissioners	2	11	5
Other	2	1	11

The debate to whether CQUIN funds should apply to non-contracted activities continues the distinction or views between commissioners and providers, with the general consensus of providers being in support of CQUIN applying to non-contracted activity:

- *"Removing CQUIN from NCA would penalise Specialist Trusts with a wide geographical spread of commissioners and a high level of NCA activity."*
- *"Patients from NCA areas would still benefit from CQUIN schemes (as a Trust would not be able to exclude them) and so they should pay a proportionate contribution to the costs."*
- *"If not there is a perverse incentive for commissioners to withdraw from the contract / consortium. It should also be possible to apply CQUIN to outturn NCA billing values, perhaps with a de minimus level."*
- *Two commissioners who agreed CQUIN funds should apply to NCA cited "We should treat all providers the same" but also indicated this would be difficult to manage.*

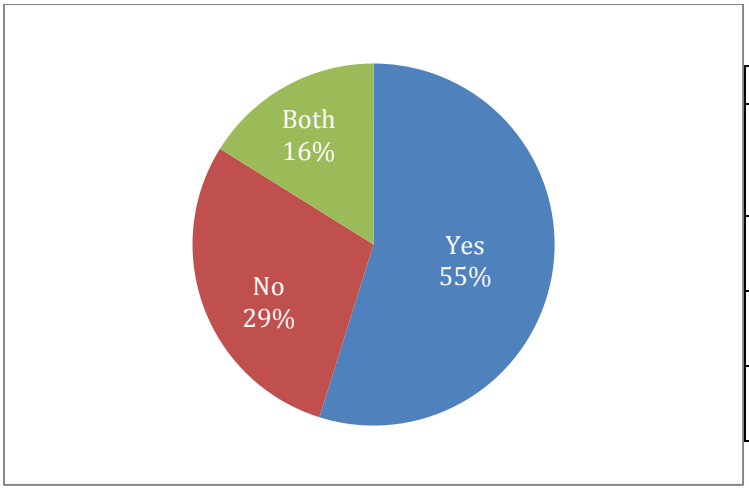
Commissioners generally reported that CQUIN funds should not apply to NCA:

- *"Non contracted activity should also be excluded. There is also the question of CQUIN applying to non recurrent service changes in year – such as pilot schemes of services intended to reduce non elective admissions – which should also be excluded. These should be excluded as they are pilots and not part of delivery of established commissioned services."*
- *"For NCA activity, it is not practical or resourceable to check whether providers of NCA have achieved their local CQUIN. Different approaches are in place across SY commissioners. There is some support for paying CQUIN NCA in the spirit of equity and supporting improvements in quality for patients' choice of services. But in the absence of evidence to demonstrate achievement of quality requirements, there is a reluctance to apply CQUIN to this activity."*

- *The providers response repeated the commissioners view as well as "CQUIN should probably not apply to non-contracted activity as the costs of managing and monitoring outweigh any financial benefits."*

Q10. Would gain share arrangements on pass-through payments be a better incentive than a CQUIN?

Based on only those who responded, 55% welcomed the principle that gain share could be an alternate to CQUIN for pass-through payment arrangements.



	Yes	No	Both	Abstained
Providers – NHS	5	6	5	11
Providers – Private	1	1	0	6
Commissioners	9	0	0	9
Other	2	2	0	10

Stakeholders who were open to gain share arrangements commented:

- *"Gain share would provide an incentive for hospitals to procure items on pass-through payment at the best possible price and so this could be an advantageous arrangement in certain circumstances e.g. service procurements such as homecare. Gain share is dependent on providers and commissioners being able to agree and share relevant data to monitor the agreement and so we would like to stress the linkages here to the NHS Hospital Data and Datasets consultation to support appropriate data flows between providers and commissioners."*
- *"The group felt that gain share arrangements on pass-through payments would be a better incentive than a CQUIN, however the arrangements should be for local determination."*
- *"Yes, if both parties are required to take action and this improves the outcome for the patient."*
- *"Yes, a gain share would be more of an incentive to providers. Locally the Derbyshire CCG's already have a successful arrangement with one large provider."*
- *"We believe that where providers can drive down the cost of pass through payments, through their intervention, then this should also be subject to a gain share. This intervention is for the benefit of the NHS and providers should be incentivised to undertake it."*

Stakeholders who were generally against the use of gain share commented:

- *"There are two issues here. Firstly, that CQUIN applies to overall contract value, Secondly, how provider and commissioner engage and develops system(s) for managing risk/reward and incentives to contain/reduce costs."*
- *"Most providers are already working on efficiency savings and the potential income incentive from this is unlikely to equate to the levels that would be earned through CQUIN.*

Many such arrangements require significant investment from the provider in managing the process of seeking better deals with suppliers or implementing home care schemes. In addition, it is down to providers to cover the administration costs of processing pass-through payments (through validating and processing invoices, developing reporting systems, producing patient level information etc.). This is a further cost that providers must cover and it is often not supported through commissioner investment. Providers who make savings through procurement or process changes should be entitled to reap the rewards, rather than simply passing them on. In order to implement gain sharing we believe that there would need to be a large scale review of the options to ensure that they offer a clear incentive to all parties and any related guidance would need to be explicit in how the arrangements should work."

Stakeholders who would consider both CQUIN & gain share together commented:

- *"The rules should encourage gain share on improved procurement but should not replace CQUIN and its focus on quality."*
- *"Both could be applied – a gain share to incentivise change but CQUIN payments to support the day to day costs of providing the service."*

Q11. What do you understand 'pass-through' payments to mean?

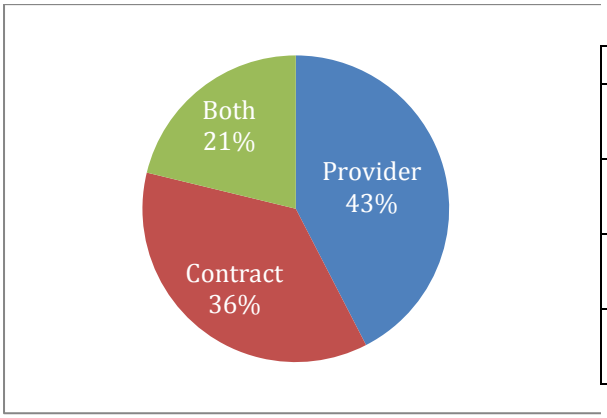
The general theme of responses from stakeholders includes that "Payments made by the commissioner to providers to cover the direct cost to the provider (i.e. with no gain/loss) e.g. for PbR excluded drugs/devices."

Additional comments included:

- *"There needs to be clarity about what is understood as pass through payments. The National Prescribing Centre in 2008 clarified that 'Innovation payments' were formerly known as 'Pass Through Payments'. Innovation payments were developed to allow funding for new devices, medicines, treatments and technologies, including new applications of existing technologies. They were agreed provided specific conditions were fulfilled and were time limited for three years. They are uncommon and should not be confused with the PbR excluded drugs and device."*
- *"Pass-through payments in this context refers to high cost drugs and devices for which there is no tariff incorporating the element of service delivery. The prequalifiers should be removed, and pick-lists are helpful."*
- *"Either a charge to the commissioner that is equal to the cost incurred by the provider (for drugs/devices) or a sum of money paid to the provider as part of a recognised financial recovery plan that is not directly related to service provision."*
- *"Additional funding over and above the tariff in order to cover costs of new treatments which need set up costs."*

Q12. Should CQUIN goals be set at provider or contract level?

Based on only those who responded, 43% believed CQUIN goals should be set at provider level, with 36% at contract & 21% as a combination of both.



	Provider	Contract	Both	Abstained
Providers – NHS	9	3	3	12
Providers – Private	0	1	0	7
Commissioners	4	6	3	5
Other	1	2	1	10

Support for provider level:

- *"Provider level in the main otherwise the potential is that they would be unworkable and unachievable if Providers have to implement a number of competing measures."*
- *"CQUIN goals should always be set at Provider level as it is impossible (especially our Trust who have Contracts with many different Commissioners) to have different CQUIN goals for different parts of the Country. We have always had one set of CQUIN goals that apply to all patients and this needs to continue."*
- *"Provider level – we are still negotiating these with our host CCGs, but there has been a proliferation in CQUIN schemes in this past year, each of which has a cost associated with it, and each of which tends to be based on a local GP's specific interests. NHSE CQUINs have been far easier to negotiate, but I personally feel that it would be sensible to have a national pick-list, so all Trusts are heading in the same direction rather than in a direction selected by one local GP's views."*
- *"CQUIN goals should be about the provider; however this will prove difficult in that there are multiple commissioners and contracts for some larger providers, who will have different priorities."*

Support for contract level:

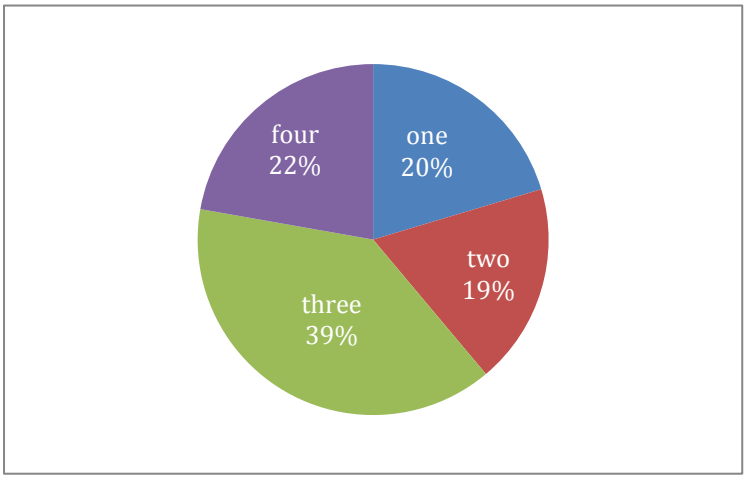
- *"Would be difficult to do at Provider level given the different services commissioned within the spectrum of different services we provide within the different contracts we have, although where commissioners can work together to look at single portfolio of CQUINs where similar services commissioned this is useful. Local quality issues vary and it is useful to link the CQUINs to this agenda to improve performance in the most needed areas."*
- *"CQUIN's should be set at contract level in order to be manageable. This enables Commissioners to develop schemes to improve services in a way that best meets the needs of their local population. However, guidance should require Commissioners to work together to agree common schemes where possible where there is more than one significant contract with a Provider."*
- *"At contract level – we recognise the sense in applying at provider level wherever possible but need the flexibility to address local issues. CCGs have to monitor their own schemes so not likely to overuse this flexibility."*

Support for both to be used in conjunction:

- *"Our view is that fewer nationally mandated CQUIN goals, with greater local autonomy for negotiating local schemes would be most likely to drive up quality. National CQUINS require a high level of investment but attract a smaller proportion of overall funding, which makes them challenging to deliver. Also, national CQUINs have to take in to account all providers performance, which can mean that they are less likely to impact on quality at those providers who are already performing above the national average in these areas. A combination of both National and Locally derived standards should be enabled to take into account different health care delivery systems and population requirements."*
- *"The group felt that, as a broad principle, CQUIN goals should be set at a Provider level where there were a number of contracts that included commissioned services from the same provider. However, CQUIN goals should be set at a Contract level where the types of services differ. This should be for local determination."*

Q13. 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***



	1	2	3	4	Abstained
Providers – NHS	6	4	5	4	11
Providers - Private	2	0	1	0	5
Commissioners	3	6	12	7	2
Other	0	0	3	1	10

Comments for option 1:

- *"would reduce the time spent on negotiations and ensure consistency. However, further discussion needed regarding applicability of national targets. For instance, most do not apply to mental health trusts and it has been difficult to make others (eg. NHS Safety Thermometer) fit."*
- *"If this option were pursued it would be essential for there to be inbuilt flexibility to derogate from mandated areas. However this would not allow for the time required to develop and consult on alternative local CQUINs. It would be far better to start with a known local element that can produce robust clear CQUIN goals and is focussed on local priorities and improvement areas."*

- *"XXX is cautious about signing up to any local CQUIN schemes where we believe that we are not able to deliver as the volume of income at risk is so significant. UHS would suggest that there is a pick list of National CQUINs and locally so many are picked (e.g. 15 national CQUINs are set and locally 5 need to be selected)"*

Comments for option 2:

- *"the balance is currently about right. We do however strongly feel that a concept of regional/Area Team (CSU) level CQUINs should be removed. The processes and robustness of these has been lacking with regard development, agreement and monitoring."*
- *"The current balance is OK. We don't need more national indicators. We need to incentivise local behaviour changes."*

Comments for option 3:

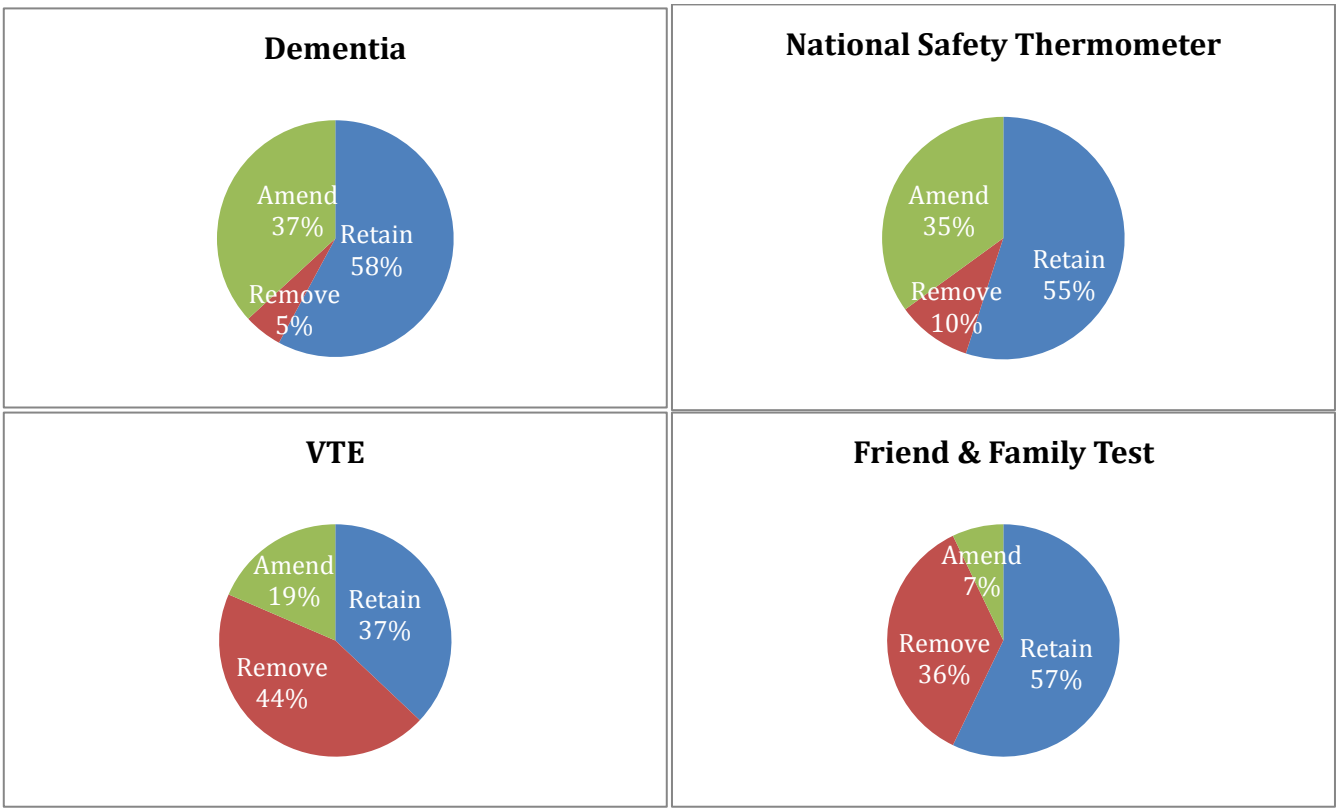
- *"Option 2 or 3 would be the most likely to secure higher quality. It would be helpful to have clear guidance around the development of locally agreed indicators. A pick list could be beneficial, although there would need to be room for locally agreed variations to this as required. The CCG believes option 4 would also not be the best way forward, as there is value to having a proportion of nationally mandated CQUINS. This helps to provide a consistent approach to issues that are a challenge for all areas, and the current balance of 20% seems appropriate."*
- *"The availability of a pick list for local CQUINs has been helpful previously, however we would not want to be limited to areas stated on the list. For a number of Trusts these areas have already been covered in previous schemes and/or they are already performing well in. Pick list or exemplar CQUINs still invariably need to be adjusted to make them appropriate to individual Trusts. | We would need further clarification as to what is meant by "clearer rules around local indicator development". Some clear guidance around CQUIN structures and measuring milestones would probably be welcomed by both commissioners and Trusts. However it is imperative that commissioners retain control over the process and development of local goals whilst also involving our local stakeholders. XXX commissioners are already working collaboratively to develop CQUIN goals as part of more patient centred contracting and are using established service users groups to take this work forward for 2014/15."*

Comments for option 4:

- *"This would improve the control local networks / stakeholders have to determine indicators that support local commissioning intentions."*
- *"This allows providers to work closely with commissioners on both local priorities and specific areas which may arise from local data and information review as areas for improvement throughout the year. It also allows providers to influence a number of schemes which can be clinician driven for both service improvement and improved clinical outcomes for patients that link to local quality priorities (and in which patients should be influencing). However, there needs to be some parity on how local indicator goals are determined and incentivised so that continuous improvement is recognised and rewarded rather than just achievement of an end goal."*
- *"is likely to secure higher quality. The nationally mandated CQUINS restrict the number of local CQUINS that can be developed. There are some national standards where faster progress has been made locally in achieving the quality standards they are not necessarily value for money. Eg Safety thermometer where all staff are publishing data but there is not*

sufficient data this year to set reduction targets. Instead reduction targets have been set for overall reduction in pressure ulcers but the publication of the safety thermometer is still being paid for."

Q14. Are the mandated national CQUINs (dementia, FFT, NHS Safety Thermometer, VTE) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?



The general theme which can be derived from the feedback, stakeholders have mixed experiences of whether the nationally mandated CQUINs (Dementia, NHS Safety Thermometer, VTE) are improving quality, largely dependent on personal performance of these particular CQUINs in their organisation:

- *"In some areas the same measures should not be applied across all Trusts for example Friends & Family Test A&E response rates achievement will vary widely between large acute Trusts with large emergency departments and smaller specialist hospitals which see little or no emergencies, however the standard by which they will be assessed is the same. It is also difficult to evaluate the impact that some of the national goals are having on improving quality of care to patients as they are focussed on the completion of data collection in specific areas, with no requirement for achievement to be consistent across all quarters of the year. This can sometimes act as a disincentive for Trusts to continue to concentrate efforts on improving performance steadily through the year which makes the mainstreaming of some of this work less likely. In areas such as VTE risk assessment it is now likely that our local Trusts have reached their optimum in terms of performance and as this scheme has been run for a number of years it may be appropriate at this stage to consider dropping this from the mandated list of goals There are often a considerable number of local priorities which form a long list of potential CQUIN goals in any contract*

year which have to be placed on hold because adopting these would make the overall number of CQUINs unmanageable. We would seek to have a structure that minimises this and gives maximum local flexibility."

The common suggestion is that "National VTE should be removed as it is already measured and monitored through NHS Safety Thermometer," or since it is now more-or-less achieved across the nation, or it could integrated into a national standard where "once achieved should be considered mainstream and replaced with new incentives with continued performance required as a term within the contract"

Other comments included:

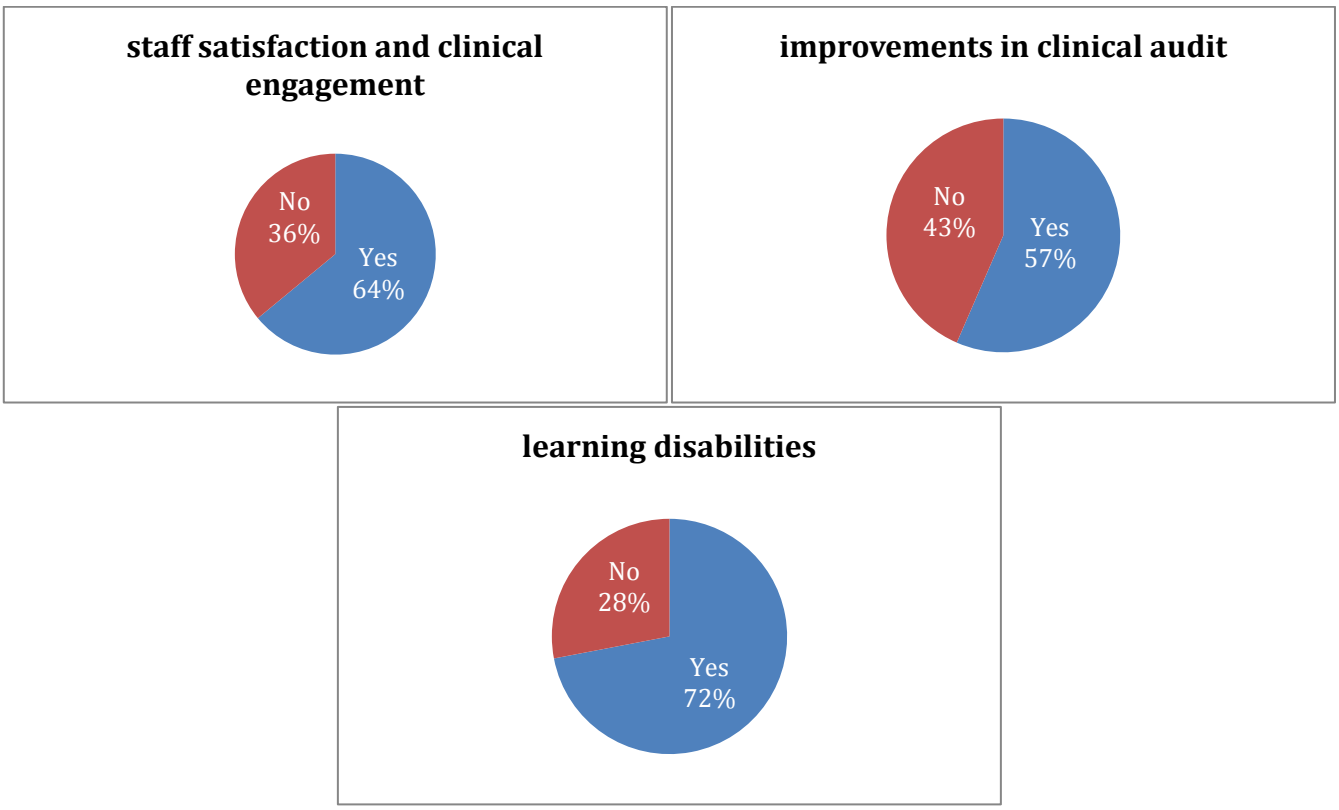
- *"Patient experience CQUIN is difficult to manage as it is based on results which do not appear until the final quarter of the year. The most successful CQUINs have milestones to work to each quarter so there can be real focus on progress during the year."*
- *"We believe the nationally mandated CQUINs listed above have helped to increase provider focus in these areas and improve the quality of services provided. It should, however, be noted that these have all come with additional administrative costs. Data collection requirements to report on these measures could be revisited to help to reduce this burden. Regular audits could be used instead of full data collections. Where CQUINs have been embedded they should be removed, or refined. We have previously fed back issues over the net promoter score and we do not believe that how it is currently constructed adds value, or improves the quality of patient care delivered."*
- *"Think that these would be good to add to a pick list for CCGs."*
- *"We don't think current national indicators around patient experience are effective. They do not reflect what patients are saying locally about services via NHS choices."*
- *"Given that we have multiple commissioners the negotiation of local CQUINs is incredibly problematic and time consuming. The fact that the life of these CQUINs is often just 1 year also makes it very difficult for them to have optimum impact. The most successful CQUIN schemes are the national schemes due to their consistency of message and longevity."*

Q15. Are there other strong candidates for a national CQUIN? How would it be constructed?

- *"Peer conducted observations of care. Effective transition across organisation for non-elective patients; support such areas as discharge arrangements, timely provision of clinically important information, ambulance handovers and transport arrangements. 'Transitions' might also help to identify local requirements for seven day working."*
- *"It would be useful to consider CQUIN's focused in specific healthcare tiers. For instance, Acute, Community, Mental Health."*
- *"We believe that developing a CQUIN which offered financial incentives linked to the number of members of staff who had received appropriate and adequate training in end of life care could help to improve communication skills across the board and drive up standards in relation to the delivery of end of life care."*
- *"There could be value in having a national mortality CQUIN, as there are currently national concerns regarding mortality rates (particularly following Keogh review). However this would need to be constructed carefully so those areas who currently have locally agreed mortality CQUINs are not impacted on negatively."*

- *"The AMBER care bundle (Assessment, Management, Best practice, Engagement, Recovery uncertain). provides a systematic approach to manage the care of patients who are facing an uncertain recovery and who are at risk of dying in the next one or two months. This care bundle helps to initiate conversations with patients and their carers about possible outcomes, including death and dying and advanced care planning."*
- *"The group suggested a specific national CQUIN for Mental Health, in particular an indicator that links physical and mental health."*
- *"No. The Trust would support a focus on priorities, not volume of CQUINs. Fewer CQUIN schemes, which support a longer-term approach to improving quality, would be much more beneficial."*

Q16. Would you support a national CQUIN in any of the following areas: staff satisfaction and clinical engagement; improvements in clinical audit; learning disabilities?



Comments included:

- *"We would support them if an improvement in patient outcomes could be measured as a result of the new CQUIN."*
- *"No. CQUIN should be firmly focussed on outcomes for patients (including patient satisfaction) and the quality of clinical services."*
- *"Would not support any of the above. Any way of measuring them would be either impossibly complicated or onerous, or meaningless. You could extend the FFT to staff."*
- *"We would not support CQUIN for staff satisfaction or clinical engagement or clinical audit and feel these are already part of HR policies and clinical obligations of registered staff and should remain so."*
- *"Learning disabilities could potentially be a good area for a CQUIN next year. We would not necessarily support national innovations in the areas described as data collection would*

not be consistently strong across providers so the CQUIN would probably end up focussing on data collection rather than quality improvement. More scope needs to be given to local innovation CQUINs."

- *"National CQUIN for improvement in clinical audit would be useful, we recommend that there should also be a CQUIN for patient consent."*
- *"Staff satisfaction and clinical engagement are essential requirements for any service Provider. These should be addressed within the contract but not through incentive payments as they are a basic requirement of any service as set out within the recent Francis report. It is important that clinical audit requirements are more clearly linked to the benefits to patient care."*

There was one objection to the removal of CQUIN pre-qualification criteria, citing:

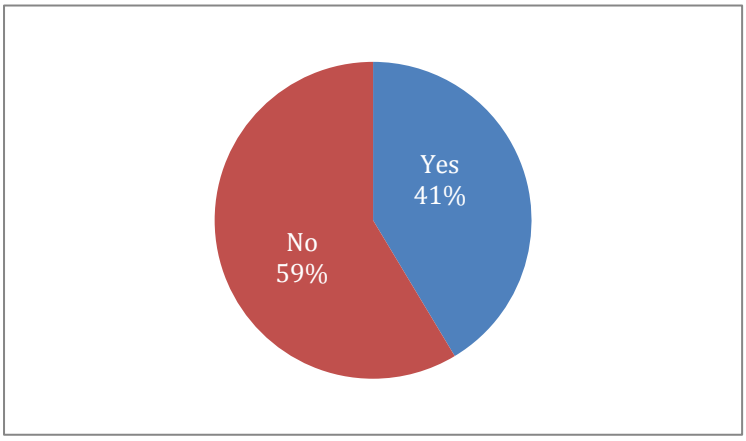
- *"the suggestion in the discussion paper that the pre-qualification gateway should be removed is cause for concern" suggesting this would reduce uptake of particular CQUINs and reduce Innovation.*

Three stakeholders specifically commented supporting the removal of the pre-qualification criteria, one comment being;

- *"The addition of pre-qualification criteria left commissioners and providers with an additional task to agree in short timescales and at a busy time i.e. the contract negotiation quarter. It could be viewed by many that this is a bureaucratic tick box exercise that adds no value."*

Local Incentive Schemes

Q. 17. Have you used or are you intending to use the provisions for local incentive and risk sharing schemes? If so, what for?



	Yes	No	Abstained
Providers – NHS	7	9	11
Providers – Private	0	2	6
Commissioners	4	5	9
Other	1	1	12

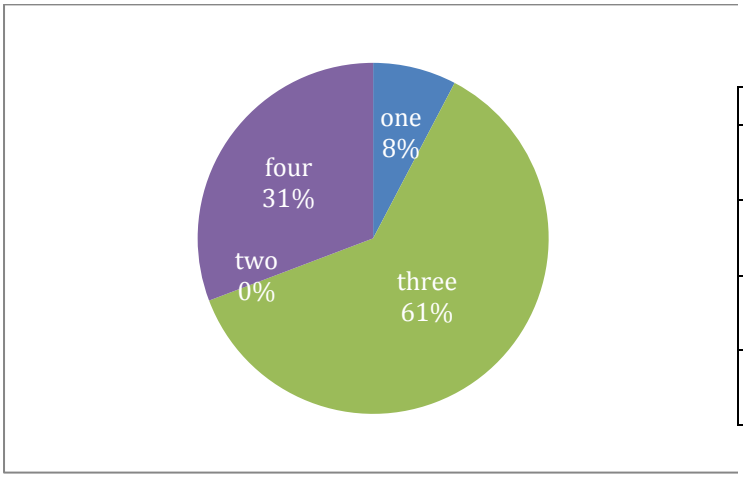
Comments included:

- *"Some CCGs within the group are using the local incentive scheme in their 13/14 acute contracts. The scheme is aligned the CCG quality premium. All CCGs within the group are using the risk sharing arrangements in areas such as: the maternity tariff, unbundled radiology, cost per case, excluded drugs and devices, floor and ceiling on Walk in Centre Activity, pathology, integrated MSK pathway development."*
- *"These have not been used this year although there is discussion about possibly using this next year to support additional investment in the development of community and district nursing teams. Additional funding would be linked to a clear outcomes and payment framework."*
- *"Our commissioners do not seem to be particularly enthusiastic about local incentive schemes and tend to focus on preparing CQUIN schemes and developing KPIs with sanctions. We have had, in the past, a small incentive scheme around incentivising chlamydia screening."*
- *"We have only used the ability to create local risk sharing schemes for a new service to meet the growing demands for mental health input in emergency departments. We can see this provision being used again for similar schemes where it is difficult to project outcomes and costs accurately."*
- *"We have not used any local incentive schemes but we support as much local flexibility as possible."*

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

Q18. 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***



	1	2	3	4	Abstained
Providers – NHS	0	0	1	0	26
Providers - Private	1	0	0	0	7
Commissioners	0	0	6	4	9
Other	0	0	1	0	13

Comments for option 1:

- *"agrees with the principle of refocusing the Quality Premium on areas that commissioners can influence. Patients expect to receive the same comprehensive NHS services with aspirations of the highest standards of excellence and professionalism as set out in the NHS Constitution (2013) irrespective of geography. We therefore recommend that Quality Premium measures should be determined at a national level (option 1), but the local NHS organisations should be given the freedom to decide on how they will deliver their service to meet the needs of their local population. This approach will ensure that patients are not victims of a postcode lottery, but still allow local innovation to flourish."*

Comments for option 3:

- *"The group felt that Option 3 would be most likely to secure higher quality. However, it was suggested that the pick-list is not exhaustive or mandated and should instead include best practice examples that can be utilised. This should not stop local indicators being developed that are not included on the pick list. There is a strong view that some of the national indicators reward improvements outside of the time period to which the quality premium incentive applies eg. potential years of life lost to causes amenable to healthcare. The metrics for 2014/15; need to be decided earlier for 14/15; need to be clearly defined; must be areas the commissioner can influence and reasonably expect to change within the time they expect to achieve payment for."*

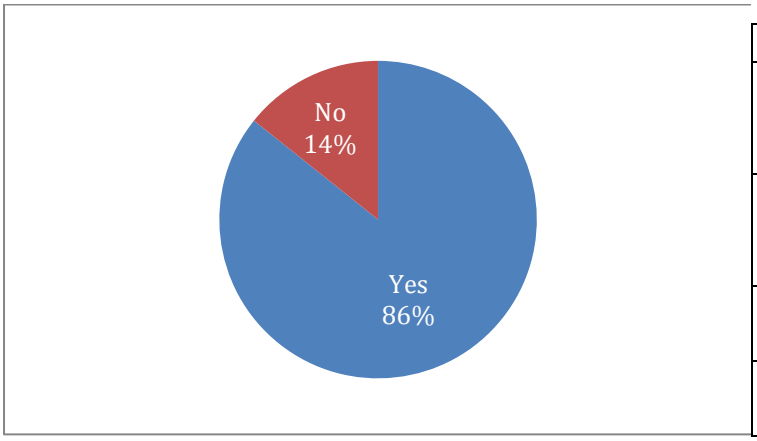
Comments for option 4:

- *"We would support point 4 i.e. fewer national Quality Premium Goals - as we need to ensure the goals are appropriate and relevant, which believe is not the case at present i.e. HCAI for CCGs and Providers should be about those that are avoidable. No trust should be penalised for unavoidable as this can be down to patient choice i.e. if they choose to be non-compliant."*
- *"Option 4 would reflect local autonomy for CCGS so that quality premium based on local need could be set. However these should still be in each of the 5 domains of the outcomes framework Regular reporting and benchmarking will show NHS E the level of ambition across the local schemes and provide an overview of best practice and any shared learning."*

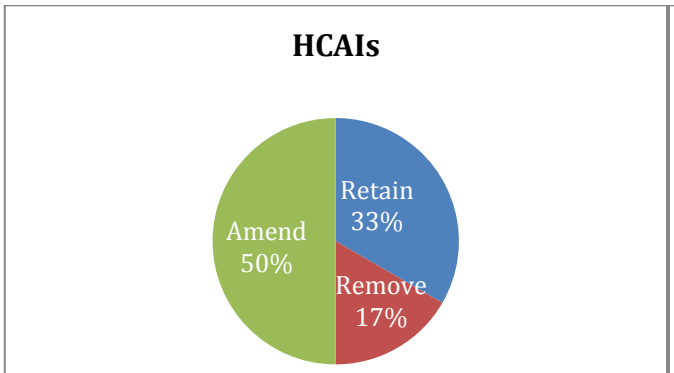
Q19. What level of oversight is required by NHS England to ensure parity in the level of ambition across local schemes?

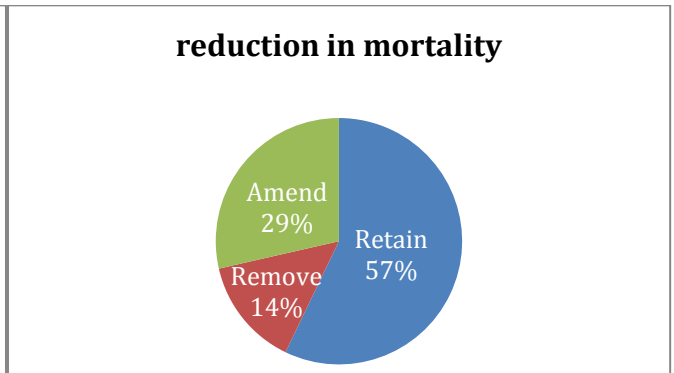
- *"Would suggest attendance to local CCG/Provider Quality forums at which CQUIN and Quality indicators are negotiated and monitored. Examples recently for us around CCG pull and NHS England have been found around Breastfeeding. As a CCG requirement we participate with the Baby Friendly Initiative which is running exceptionally well. The introduction of the Breastfeeding CQUIN has complicated issues to the point where we have a meeting with NHS England and our CCG's next week to come to an agreement. Had NHS England been involved with initial negotiations this could have been ironed out at an early juncture, rather than being half way through the year."*
- *"The group felt that the oversight by NHS England was sufficient in 13/14 and suggested that this remained for 14/15. The group that the level of oversight delivered by NHS England should be in relation to the approval of Commissioning Plans and that no further oversight responsibility was required. The group suggested that it would be good practice for NHS England to formally share all local commissioning plans and incentive schemes across all CCGs. It is recommended that NHS England incentives to areas in its commissioning portfolio are discharged in line with local health requirements and before the start of the contract period."*
- *"Sign off by Area Teams or make part of CCG assurance process"*
- *"Oversight could include monitoring uptake of NICE guidance using performance on the quality measures in NICE quality standards to assess the level of ambition in local schemes."*

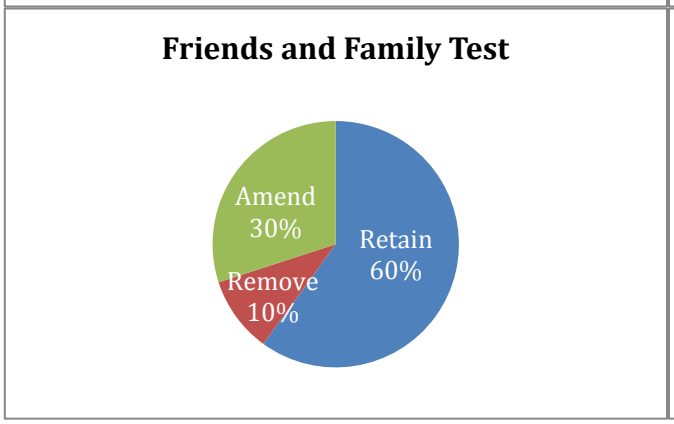
Q20. Are the mandated national Quality Premium Indicators (HCAIs,reduction in mortality, Friends and Family Test, Reducing Avoidable Admissions) delivering improved quality? Which should be retained for 2014/15, which amended and which removed?

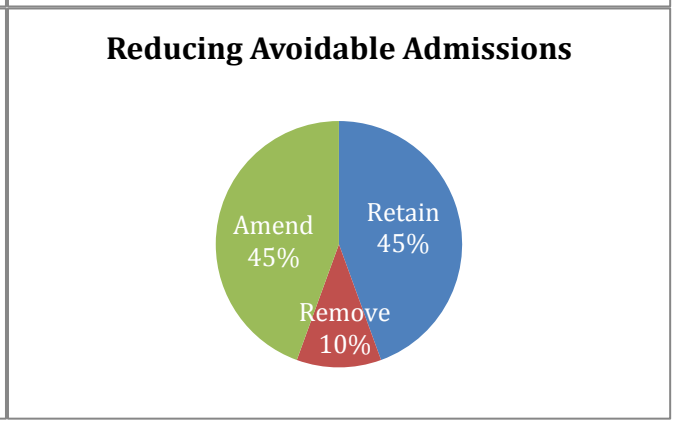


	Yes	No	Abstained
Providers – NHS	4	0	22
Providers – Private	1	0	7
Commissioners	5	2	12
Other	2	0	12









Comments included:

- *"Yes, although the impact depends on the approach being undertaken. Where there has been good collaborative working between commissioners and providers to understand what is going on and try different things out, real improvements have been made in both primary and secondary care. Where there has just been blame/fining for "failure" solely on a number at a point in time without an understanding of what has happened and why, it has entrenched people. Fining trusts via the contract for "avoidable admissions" each year, where causes are shown to be, and remain untackled in, primary care is neither motivating, nor improving patient care. In fact it increases risk since trusts then have to find ways of further efficiency savings without impacting on quality."*

- *"The group felt that the current mandated national Quality Premium Indicators (reduction in mortality, Friends and Family Test, Reducing Avoidable Admissions) were all relevant and meaningful and should remain for 2014/15. However, the group suggest that HCAI is removed/amended to reflect where further improvements on already excellent standards are unrealistic and potentially punitive to CCGs."*
- *"Non avoidable should be rare and there should be robust processes i.e. objective reviews in place for classifying whether an HCAI is avoidable/unavoidable. Trajectories need to be realistic i.e. C-diff – if not there is a risk that Trusts may reduce the amount of screening undertaken. Need to be sure that Trusts are open and honest but there is a risk of penalising them for this as well if trajectories are unrealistic. Most of the National Quality indicators do not apply to the providers we are commissioning eg: Ambulance, Patient transport, home Oxygen. It would benefit to have a generally agreed area and then the CCG apply a local flexibility to it."*
- *"Not uniformly. The Friends & Family Test is not yet fully supported by patients, partly demonstrated by very low return rates, but this might improve in time. HCAI reduction is difficult where good performance, and small numbers, have already been achieved. C Diff. Removed. Cat A Red 1 ambulance calls. Remove. The application of different ambulance triage systems produces a wide variation in the number of calls categorised as 'Red 1'. The issue is a key concern for both ambulance providers and commissioners and therefore should be removed or replaced with another indicator that can be appropriately measured and comparable across all organisations."*
- *"Too early to tell, but incentives for thresholds should be aligned, e.g. maintaining zero MRSA threshold in the QP measurers is not an incentive to delivering reduced HCAI as the threshold is too low and not in line with monitors regulatory framework for acute providers who deliver the target for commissioners. Life years lost measurers are very hard to alter in on year given these plans may take 3-5 years to materialise, suggest removing or extending timescale for delivery"*
- *"For the quality premium to be effective we believe that it should be paid based on achievement of each measure to ensure commissioners do not lose their incentive to push for achievement. We also believe the measures should be nationally mandated to provide a clear steer to commissioners and providers as to which areas are the most important."*
- *"MRSA numbers are now so low that most are now unavoidable. Iif MRSA is to be kept in there should be the ability to demonstrate those that are unavoidable. Indicators where significant improvement has been made should be removed."*

Q21. How could the Quality Premium be used to improve outcomes in mental health?

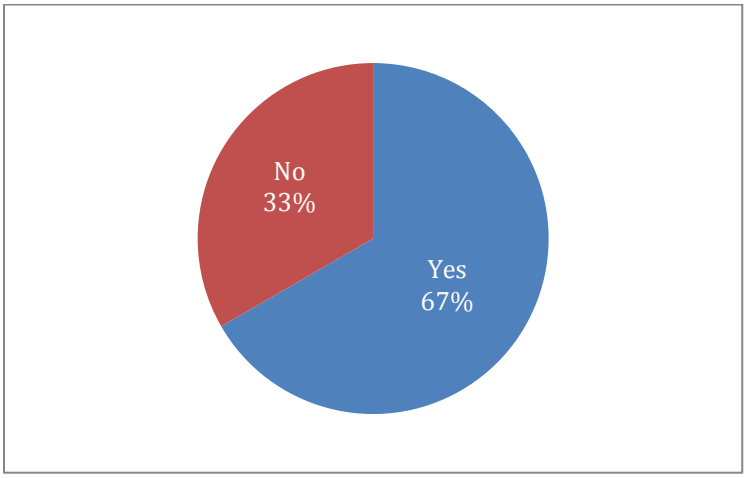
Comments included:

- *"XXX believe the Quality premium could be used to widen the strategic focus beyond dementia and IAPT as these areas are already incentivised and prioritised in the NHS through a range of contract and policy levers. Focus on a general system level issue such as care at the interface between hospital and community care could enhance quality as interfaces and hand-over points are commonly areas of weakness in patient pathways. Effective discharge and hand-over of care is definitely within the gift of local stakeholders so the Quality Premium would seem an appropriate point in the system to create an incentive."*
- *"Link it to Mental Health outcome measurers."*[1]

[1] NHS Dorset Clinical Commissioning Group

- *"Include a measure on evidenced improvement in access and outcomes e.g. using HONOS scores."*
- *"Improve outcomes in mental health by examining the use of service user experience measures by looking to measure feedback on improved outcomes for clients and families, possible around Quality of Life Indicators."*

Q22. Should CCGs be able to set local QP measures that duplicate national QP measures but with a greater 'stretch'?



	Yes	No	Abstained
Providers – NHS	3	2	22
Providers – Private	0	1	7
Commissioners	8	2	8
Other	1	1	12

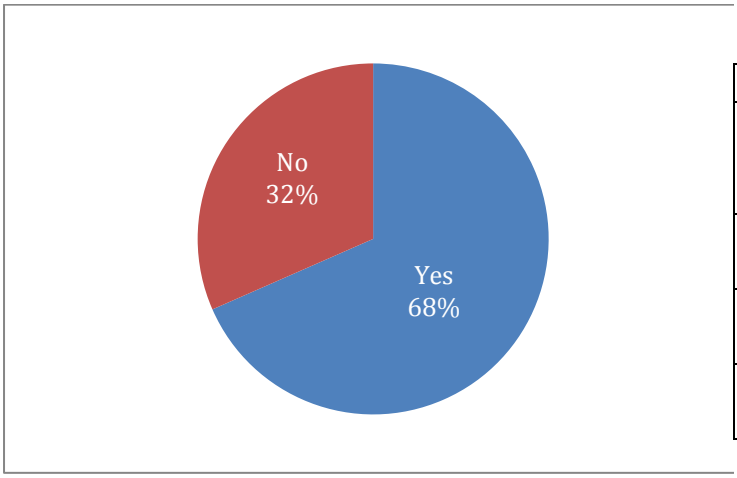
Supporting comments:

- *"Yes. However with 2 conditions. 1) the target should be set based on where the provider is now and ensuring that the proposal target is realistic and practically achievable and within the gift of the recipient of the target to deliver. 2) if it is to be set as an 'improvement stretch' target, this HAS to be set as a reward based target, not a sanction/penalty based target."*
- *"Yes - if a local provider is already meeting national standards, it makes sense to set a stretch target"*

Rejecting comments:

- *"All nationally funded incentive schemes, including Quality Premium measures, should be nationally designed. This will ensure that a minimum quality care standard aligned to the NHS Outcomes Framework is incentivised and delivered for all patients."*
- *"There is a possibility of double payments being made."*

Q23. Should the design of the QP scheme explicitly allow for sharing of the QP earned with partners who contributed to it?



	Yes	No	Abstained
Providers – NHS	5	1	21
Providers – Private	2	0	6
Commissioners	6	3	9
Other	0	2	12

Supporting comments:

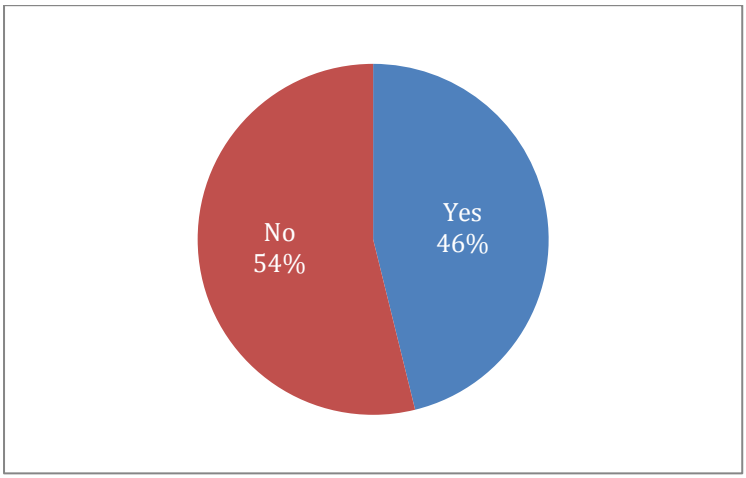
- *"The sharing of earnings, between commissioners and providers, from the quality premium indicators would help commissioners to gain buy in from local providers to meet the measures. This should, therefore, be mandated. As previously mentioned it is imperative to align incentives across the system, to ensure that we are all working to the same aims and aspirations for our patients."*
- *"The Quality Premium should be the source of funding for provider CQUIN schemes and therefore a direct link between the two schemes to ensure economy wide responsibility for achievement."*
- *"Would support designing Quality Premium to allow sharing of the payment with partners (eg GP practices and Trusts) who contributed to it as this would give providers a specific incentive to invest in changes designed to improve patient outcomes."*

Rejecting comments

- *"There is already scope to incentivise providers through local incentive schemes – in XXX, the CCG has included a local outcomes framework incentive which includes the outcomes linked to the CCG's Quality Premium. This approach ensures alignment of the incentives across the CCG and provider. The group did not feel that scheme should set out explicitly that the quality premium should be shared with partners. This should be for local determination."*
- *"There is a commissioner expectation that any additional monies received through the QP award would be considered for investments across a range of service providers. An explicit requirement to share might cause complications when considering smaller providers who do not necessarily have a significant input into achieving QP. The explicit sharing of incentive monies should be considered if all incentive schemes were collectively reviewed."*
- *"we advise against making significant changes on a what would inevitably be an "ad hoc" basis for 2014-15. Looking to a more radical restructuring later, it seems right that partners should be able to share in the QP, but there may be a case for combining this with other schemes and simplifying the whole approach."*

National Sanctions

Q24. Are financial sanctions effective in sustaining quality and performance? Are they particularly effective of or ineffective in some areas over others?



	Yes	No	Abstained
Providers – NHS	7	10	10
Providers – Private	3	0	5
Commissioners	6	7	5
Other	2	4	8

This comment generally summarises the overall theme of responses:

"The Trust does not believe that sanctions are particularly effective in sustaining quality and performance. Providers strive to achieve the quality and operational standards set out in the national contract regardless of the consequences of failure, as we aim to provide the best possible care for our patients. Whilst financial penalties can "focus the mind", the impact of a financial penalty can have a much wider negative impact then positive. Whilst a single performance area may be achieved, this may often be achieved at significant expense in other areas, mainly quality. Financial penalties drive a compliance mentality and a focus on achieving the minimum standard. They do not create commitment, which is what leads to motivation, passion, innovation and exceptional results. A much stronger motivation than financial penalties would be the requirement for trusts to explicitly explain the reason for non-achievement and what is planned to be done. We have found in the past that robust performance management against these standards, along with sensible and proactive discussions about potential improvements with our commissioners, has been beneficial in improving and sustaining quality. Where the discussions have focussed on sanctions, the main topic tends to be the method of calculation for any penalty and the detail of how it should be transacted, rather than how the issues that caused the breach could be overcome and prevented in the future and consequently very little improvement for patients. In the Keogh reports, it identified some trusts who were geographically unable to attract certain staff. Without these staff you won't have capacity to meet demand. Fining someone is not going to positively contribute to a solution. It actually makes the situation worse by destabilising the provider further."

Further comments include:

- *"They are an aid to ensure that Providers make serious moves around the margins to ensure compliance in some instances e.g. mixed sex accommodation and health care acquired infections. However penalising providers who may already be struggling financially*

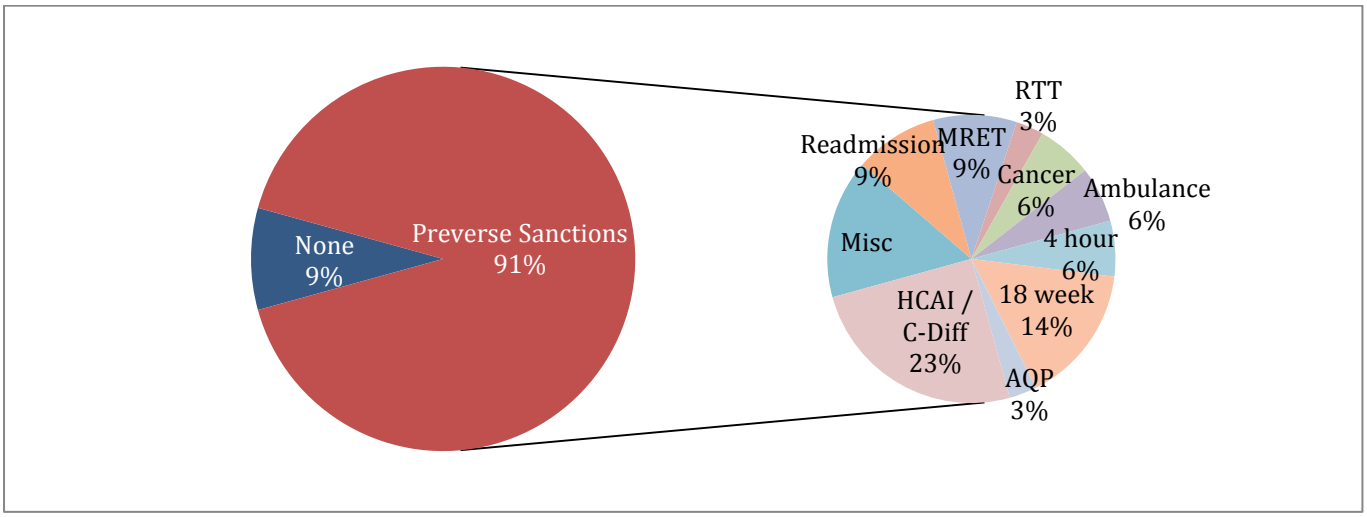
to ensure quality standards are met may not give the best outcome, unless funds can be re-directed specifically to ensure that the quality standards are met."

- *"They are useful levers to have but the application of them can cause perverse incentives."*
- *"Financial sanctions alone do not appear to impact upon Provider ability to meet a quality target or address a quality issue. In some instances these sanctions further exacerbate situations where providers are already struggling to meet financial balance. This seems to be particularly the case when looking at A&E targets where more than one Provider may be responsible for the overall service outcome. Financial consequences that do appear to have an impact are those of withholding funds due to failure to implement an agreed remedial action plan. There are several examples in the local area where the withholding of funds has raised the profile of an issue within the Provider organisation and enabled the departmental managers to gain the resource and support needed from the Organisation to address a performance issue."*

However some stakeholders supported the use of Sanctions:

- *"We believe sanctions can be effective and should be applied in instances where providers demonstrate a continued inability to deliver core components of their contracted obligations. Additionally, sanctions are appropriate if CCGs are not able to deliver on the CCG Outcomes Indicator Set. Sanctions should be applied if no progress is being made in each of the 5 NHS Outcomes Framework Domains. Due to the relationship between CCGs, Health and Wellbeing Boards (HWB) and local Public Health England (PHE) and the joint responsibility for commissioning of high quality care, we believe that if a CCG has a sanction applied that this same sanction should be applied to both HWB and local PHE."*
- *"It is helpful where they back up a must do, such as MRSA and can focus a board on achievement but not helpful where they create a 'commissioners win money back' mentality in the transactions. 18 weeks should go back to aggregate level for fining or create a deminimus for 'by specialty' achievement. The calculation for the fines also mixes actual activity with price, something that means low cost, but high volume activity attracts a much reduced fine than high cost, low volume activity. This appears to be inconsistent with whether the sanction is proportional to the perceived quality reduction."*
- *"The group felt that financial sanctions are effective in sustaining quality and performance as they ensure they are focusing on these as priorities. Indeed they are a key lever for commissioners to drive performance. The group suggested that financial sanctions need to be proportionate for providers, i.e small providers with low financial contracts. The improvements in health care infections targets are punitive for providers with very low infection rates and require review."*

Q25. What, if any, perverse incentives, does the current system of sanctions create? Are there examples where the application of sanctions has damaged service quality?



Perverse Sanctions as per chart: 3o day emergency Readmissions, MRET (Marginal Rate Emergency Threshold), RTT (Referral to Treatment), Cancer, Ambulance, 4 hour A&E, 18 week referral wait, AQP (any qualified provider), HCAI (Health Care Associated Infections) & c.diff (Clostridium Difficile),

Misc perverse sanctions includes: Underperformance, Culture of 'threat', effect on cash flow, A&E 95% standard.

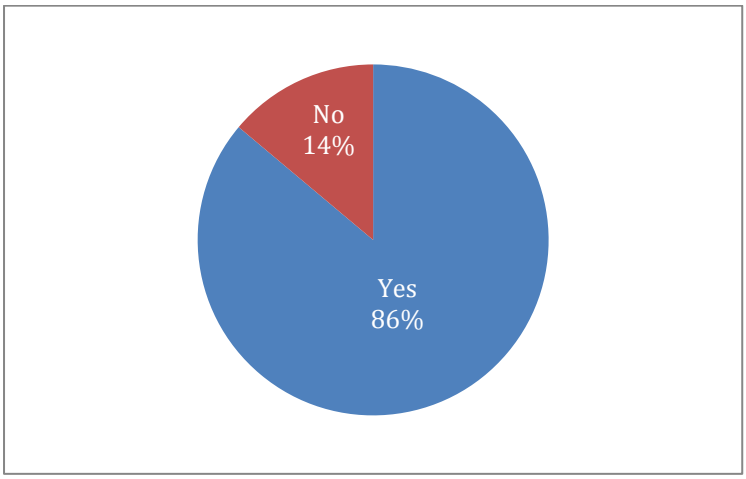
Comments included:

- *"There can certainly be perverse incentives in national and local incentive schemes and sanctions. Examples include the incentive not to test for infection because finding infections results in fines. And we have recently launched a new initiative to improve reporting, prevention and treatment of pressure sores – this drive for improvement has resulted in us losing CQUIN funding for a national CQUIN. A further example relates to ambulance handover penalties – when the Trust is at full stretch to the effect that this begins to impact on the ambulance service, the Trust is penalised for ambulance staff delays. This makes little more sense that fining the ambulance service for the Trust being busy."*
- *"The application of sanctions that have penalised the Trust financially has delayed some areas of investment to further drive up the quality of care given. MRET and 30 day emergency readmissions have perverse incentives on commissioners and non-acute providers to send patients to providers that have a level of activity that triggers a reduction in payment or non-payment."*
- *"Quality premium, CQUINs and other local incentives should be more joined up. At present there seems to be a jumble of incentive schemes across providers and commissioners. It seems particularly perverse to have quality premium which awards CCGs for provider performance in certain areas, where there is a corresponding sanction to providers for not achieving a standard. E.g. readmissions, where providers are deducted the value of avoidable readmissions, and CCGs are rewarded when readmissions are reduced. It is particularly frustrating as providers are penalised for readmissions regardless of whether they were within their control to prevent."*
- *"In A&E, the national average reference cost (using the national average case-mix) in 2011/12 was approximately £122 per patient (combining both leading to admission and not*

leading to admission). Applying the 2013/14 tariffs to this average case-mix shows average income of £95 per patient. This would suggest that every A&E attendance is treated at a net cost to the provider, even before sanctions are applied. If you were to add a 2% fine for a 4hr wait breach and a handful of £200/£1,000 fines for ambulance turnaround times over 30/60 minutes the department becomes a significant loss making service. It is difficult to see how providers can be expected to deliver a high quality service when faced with such a stark financial situation. Specific examples of where the threat of sanctions have inappropriately affected patients are: In the last year we have seen some patient referrals refused by the independent sector on the basis that they were referred too late and may therefore breach. This is not patient-focussed. So the options are for the NHS Trust to accept them (whose performance then deteriorates and they get fined) or for the patient to have nowhere to go. Spinal surgery: several providers all shut their doors since they couldn't meet the target and were being fined. Where do the patients go? They all went to one trust, who then got vilified and fined for "breaching standards". What response do you want to achieve here? There has to be an intelligent understanding of the reasons for any breaches prior to application of blame/sanctions. This will become even more important now the CQC are looking at comparative performance in terms of standard deviation from the norm to assess areas of "high risk". Cancer: Automatic fine for not achieving a standard, where every referral is due to patient choice (there was capacity available). The current national rules do not allow clocks to be stopped. So there are 3 choices - (1) support the patient choice, breach, be fined and nationally be perceived to be a worse performer than other trusts. (2) don't adhere to the national rules. (3) refer the patient back to the GP and tell them to re-refer the patient again (not in patient interest). Which behaviour do we want to drive? HCAI: Evidence around Clostridium Difficile rates suggest that reported rates are likely to increase if you have a more robust and timely testing regime, rather than batching tests and running them less often. Yet the hospitals who test more (and thereby potentially have a high rate) will get fined, whilst the ones who test less (and potentially are not identifying all patients who could be receiving better care) are not. Is this the result we want? What is this likely response of fining the more robustly testing trust? They could choose to move to a less rigorous testing regime comparable to other trusts. The numbers will improve. The patient care will reduce."

- *"There is also currently disparity around what is nationally mandated versus Monitor's requirements for trusts; these need to be aligned moving forward."*
- *"The penalties can be so severe that it can compromise the strategy of short term underperformance to achieve long term and widespread benefit – for example the RTT penalties maintain the status quo. It is difficult to address long waits if this increases breach numbers and penalties are applied as a result."*
- *"If not set at the right level some sanctions can lead providers to decide that it is better to miss the goal/target and accept a level of financial penalty than to try to achieve the goal/target. E.g. small penalties for 18 weeks at speciality level have allowed some providers to choose to miss these as the cost of delivering is greater than the fine for missing the standard."*
- *"The group felt that the current system of sanctions does not create any perverse incentives."*

Q26. Should there be national rules on how funds withheld through sanctions imposed are used by the commissioner? If so, what should these be?



	Yes	No	Abstained
Providers – NHS	15	0	12
Providers – Private	3	0	5
Commissioners	8	5	5
Other	5	0	9

Supporting comments

- *"Firstly, funds should only be withheld in clear, fair and appropriate circumstances. Not solely on the basis of a target being failed. It should be proportional to the patient impact of the target being failed and be levied against the part (or parts) of the health and social care system which have not performed as required. Where funds are withheld, it is absolutely essential that it is clear how they should be re-used and they should be reinvested in a way that mitigates again future risks to patients from failure of the standard. However this can still cause difficulties for providers, as the tight financial margins often mean that the original income will have been earmarked against routine expenditure, therefore the loss of income will require a corresponding reduction in the routine expenditure over and above existing cost improvement initiatives."*
- *"Yes, so as to ensure that they are not used to prop up sub-optimal services which should rightly be put out to tender."*
- *"Yes. For example with regards to Ambulance Turnaround sanctions, these could be pooled (Acute and Ambulance Service sanctions) with all types of providers allowed to bid for access to these funds to implement initiatives that would directly or indirectly improve ambulance turnaround times, CCGs could then decide which schemes to reinvest the funding in. This would promote and reward innovative providers."*
- *"Financial consequences that do appear to have an impact are those of withholding funds due to failure to implement an agreed remedial action plan. There are several examples in the local area where the withholding of funds has raised the profile of an issue within the Provider organisation and enabled the departmental managers to gain the resource and support needed from the Organisation to address a performance issue. National Rules should support Commissioners to directly invest funds permanently withheld through contract sanctions to address the issue that caused the funds to be withheld in the first instance."*

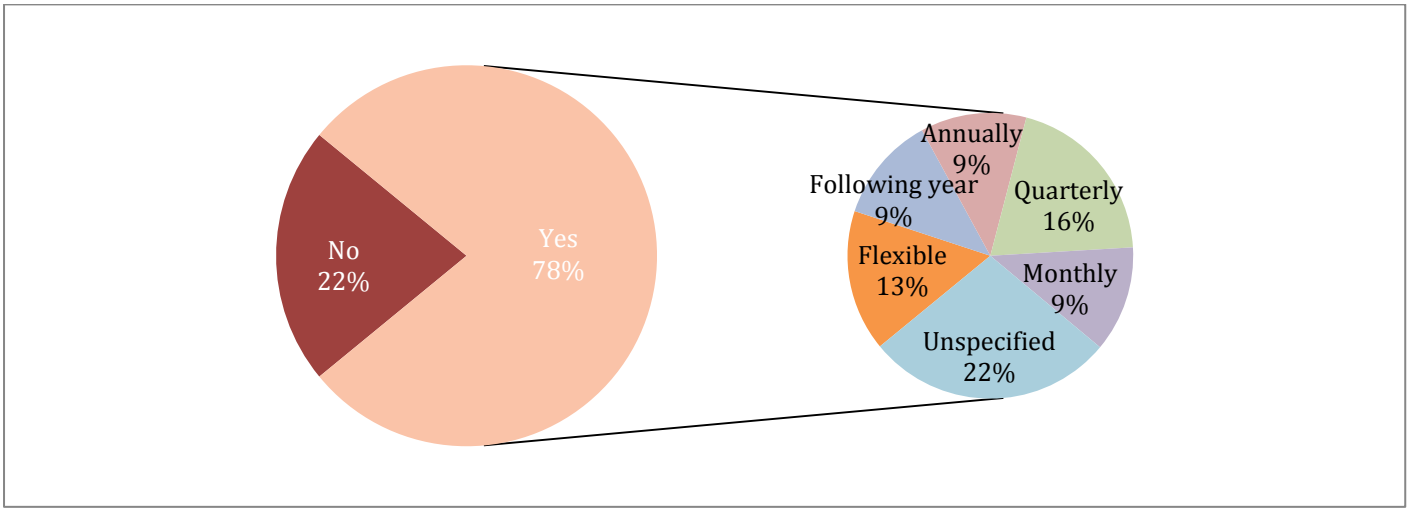
Rejecting comments:

- *"The group felt that this should be for local determination and therefore there should not be any national rules set. Local CCGs should be able to choose whether to reinvest any sanctions imposed and the national documentation should support this by including some*

broad principles of reinvestment. If sanctions have to be reinvested, one of the key lever to drive performance is removed."

- *"No – this should be a commissioner decision with the only rule being that funds must be used to improve quality or outcomes and not for financial balance reasons."*

Q27. 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?)



	Following Contract year	Annually	Quarterly	Monthly	Flexible	Unspecified	No	Abstained
Providers – NHS	2	1	2	1	2	3	4	12
Providers – Private	0	0	0	1	0	0	1	6
Commissioners	1	1	3	1	2	2	2	6
Other	0	1	0	0	0	2	0	11

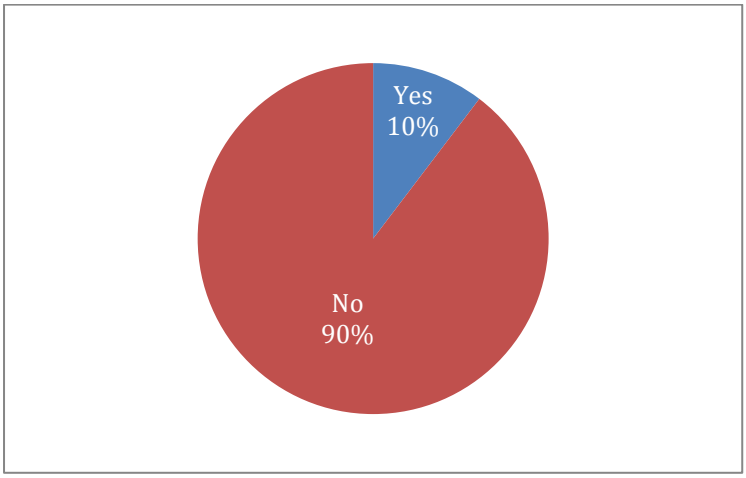
Stakeholder comments:

- *"We believe that sanctions would be better applied for the following year as this would reduce the risk of financial risk if deviations occur late in the year. It would also reduce the risk of perverse incentives.. The CDIFF sanction is not proportionate to the breech threshold currently and requires review."*
- *"we do have a range of timings, which are complex to manage. The idea of sanctions taking effect the following year appeals, but what happens when services are decommissioned in the following year? There would be no incentive at all for a provider to deliver."*
- *"In some circumstances yes, for example restricting cash flow when it is most needed does not aid improvement in quality and may actually result in year-end failure. In the case of annual targets with monthly withholding, a better solution might be to note the failure and*

apply at year-end should failure achieve i.e. the provider is sanctioned for the months below threshold towards year end."

- *"Best to have monthly or quarterly sanctions or at least the withholding of funds for these periods, otherwise planning for financial impact at year end can be difficult. To incentivise the incentive has to remain in the system each month or quarter, if a target is achieved early on in the year the incentive may decrease if the payment is guaranteed by being annual. Monthly may be small a unit of measurement with variable low number targets and quarterly would be better.all sanctions should occur in the year of the breach."*
- *"The timing of sanctions can impact on their effectiveness. For example, a target that is monitored and assessed monthly ensures that it regularly reviewed and addressed by providers. However, it is recognised that some national sanctions cannot be monitored monthly (e.g. RTT waits). XXX recommends that when possible, sanctions should be assessed on a monthly basis."*
- *"It depends on the sanction and the state of the local health economy and the need for finances to stay in balance within the economy. Better option may be to flex timing of implementation of financial sanctions to ensure that individual circumstances are accounted for. E.g. cashflow requirements in current year may not allow for sanction implementation in that year but forward planning would allow for the sanction to be applied in the following year or on an agred timeline over a number of years."*
- *"The timing of sanctions do not impact on their effectiveness in general terms. Sanctions the following year might dilute the impact."*
- *"We do not believe financial sanctions change behaviour. Monitoring and constructive feedback are valuable and important to moving towards targets."*

Q28. Are sanctions broadly proportionate as currently devised? Where might adjustment be required?



	Yes	No	Abstained
Providers – NHS	0	12	15
Providers – Private	0	2	6
Commissioners	3	8	7
Other	0	4	10

Of the above 90% who believe sanctions are not proportionate, half of them specifically outlined that the HCAI & c.diff indicators are not proportionate and require review/adjustment. The general consensus among stakeholders is that:

- *"the sanctions are disproportionate in many areas. They should be proportionate to the impact on patients. The consequences of breaching the Clostridium Difficile threshold is still a significant financial pressure to most providers. For example, the threshold the Trust has been set for 2013/14 is a 48% reduction in cases compared to the prior year. Unless there is a significant increase in occupied bed days, any breaches will exceed the 13 per*

100,000 ratio and would therefore be valued above the suggested £50,000 per breach. This has created a risk of up to £5.5m for breaches that can often be unavoidable and indeed patients may get C-Diff from receiving care and antibiotics entirely consistent with best practice guidance. As described in a previous response, the A&E sanctions are also disproportionate. For example, a £1,000 fine for a single patient with an ambulance turnaround time of over 60 minutes is effectively the same as a provider treating 10 patients for free."

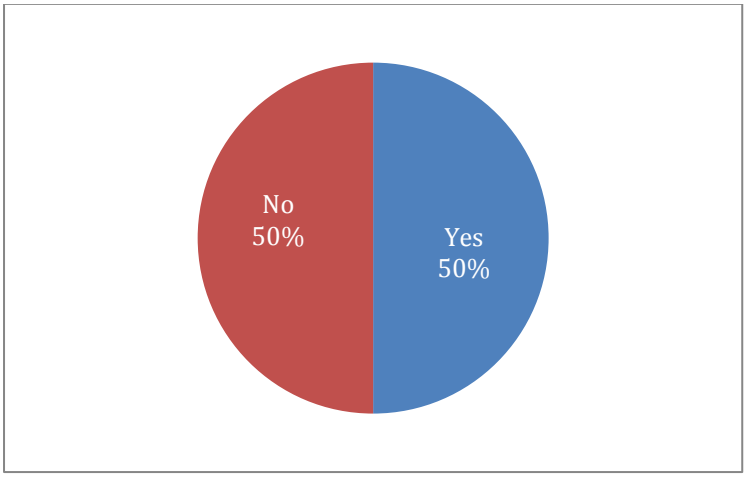
Further comments included:

- *"Where sanctions are applied based on income levels, it can lead to significant penalties – breaches should be consistent (and proportionate to the indicator involved) regardless of organisation."*
- *"The publicity and performance management implications of failing to hit a national target are often more significant than the financial impact of any sanctions. Nevertheless, where the financial impact of a sanction is significant in terms of the overall income for an organisation, this is unlikely to enable the organisation to make the necessary improvements to deliver the targets. There should be local flexibility in the level, application, and reinvestment of any national financial sanctions as well as locally agreed sanctions."*
- *"Pressure Ulcers and Never Events are too small. C Diff is too great. Ambulance handover - discrepancy in the values of financial penalties between ambulance and acute trusts makes it harder to encourage collaborative approach to improvement."*
- *"The Trust feels the fines against the A&E 95% standard is unfair as the whole fine is directed at the acute sector whereas it is a whole system's target. Likewise, the non-payment against 30 day readmissions (avoidable) places the entire non-payment against the acute sector however other providers contribute towards avoidable admissions (i.e. inappropriate community and mental health services). Acute providers should not be fined where poor performance is due to a lack of primary care / community provision. Fines should be set at a level that does not further increase the likelihood of failure and perhaps returned to the provider as ring-fenced funding to resolve the issues causing the failure thus improving performance going forward. Fines should be not be levied where the Provider is over-performing for reasons outside of their control (i.e. if there is unexpected demand in a specialty and this has a detrimental impact on the delivery of RTT, is it then fair to fine the Provider?)"*

Stakeholders who believed sanctions were proportionate commented:

- *"Broadly OK. One example that has come to light in the North West is applying the withholding sanction 2% of service line revenue for cancer targets at a specialist cancer trust such as XXX. As their business is almost entirely cancer services, this is not a proportionate sanction."*
- *"Yes, except HCAIs (the group suggest that HCAI is removed/amended to reflect where further improvements on already excellent standards are unrealistic and potentially punitive to CCGs). The group requested clarity around sanction stating '2% of revenue derived from the provision of the locally defined service line in the quarter of underachievement' and how this should be applied. It was felt that this was not being interpreted consistently by all CCGs."*

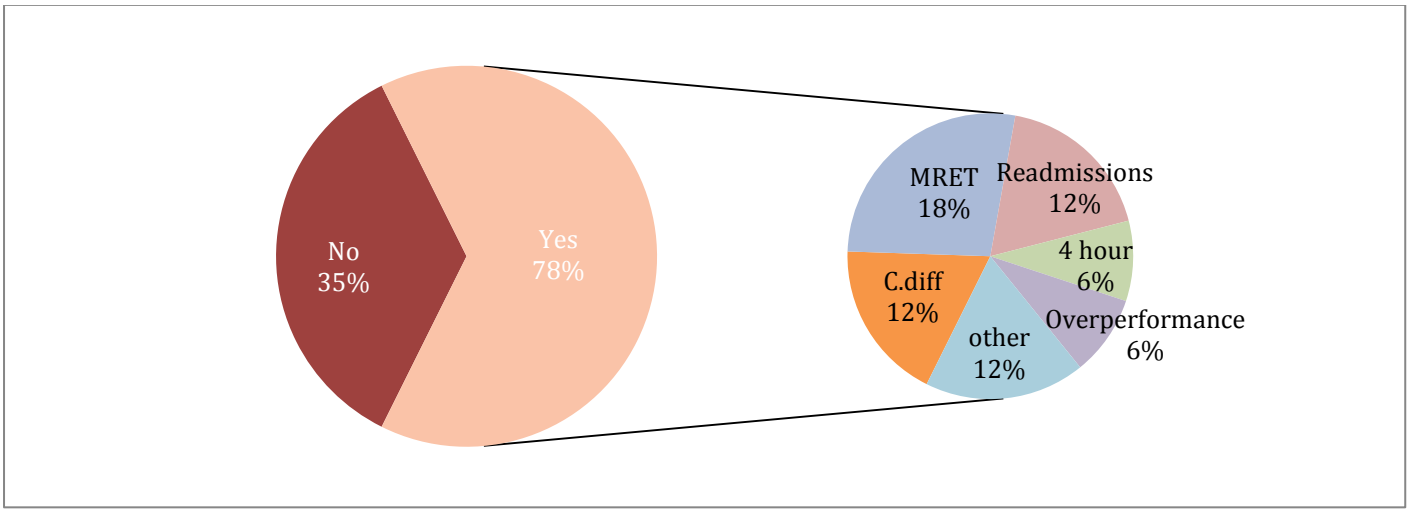
Q29. Is the range of existing sanctions manageable for commissioners and providers?



	Yes	No	Abstained
Providers – NHS	5	7	15
Providers – Private	2	0	6
Commissioners	5	3	10
Other	1	3	10

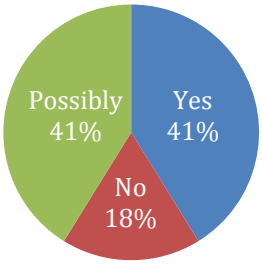
- *"It is manageable but there is a significant resource gathering data on all KPIs and CQUINs. XXX has 81 KPIs, 40 CQUINs, and 10 Monitor indicators in addition to all the local "internal" indicators. In some cases indicators have been developed at Greater Manchester level which are not relevant locally but there is pressure from the CSU to include these KPIs (as "mandated" KPIs) even though the rationale for inclusion is sometimes not entirely clear."*
- *"Yes but smaller numbers of more high profile sanctions would be beneficial."*
- *"The range of sanctions is difficult to manage, especially considering the interdependencies between many of them. For large providers it can be particularly difficult to allocate and apportion any financial penalties to the appropriate services. The volatile nature and large value of some fines also makes it very difficult to forecast financial performance accurately. Often the margin between the actual performance and the target is very small, meaning a couple of cases can swing it either way. In many cases, these couple of cases can be the difference between a significant penalty or not. The range of cancer targets is particularly difficult to manage; for example in distinguishing whether there should be a separate service-line revenue linked to each individual target or set of targets (2ww, 31 days and 62 days) and defining whether the breaches were avoidable or down to patient choice or late tertiary referrals."*
- *"No. We feel that financial penalties that can result in 20% loss in contract income are unmanageable for providers in AQP contracts where there is no guaranteed activity."*
- *"Thorough and robust management of all sanctions would probably require excessive staff time and is unlikely to be efficient. The range of sanctions should be reduced."*

Q30. Are there any national sanctions that are no longer necessary?



- *"Yes, those where the consequence is to withhold / remove a percentage of outturn value. Possibly, replace with the principle of non-payment for failure to care, where 'failure to care' may be applied to patients who have to wait too long (RTT, cancer, discharge, follow ups, GP letters) or who are not safely managed."*
- *"Acute providers should not be fined where poor performance is due to a lack of primary care / community provision; Fines should be not be levied where the Provider is over-performing for reasons outside of their control (i.e. if there is unexpected demand in a specialty and this has a detrimental impact on the delivery of RTT, is it then fair to fine the Provider?); No local fine can be imposed in the same year that particular area is part of a CQUIN scheme; MRET needs to be revisited especially with regard to increases in population since the 2008/09 baseline was set (particularly in areas of high migrant populations)."*
- *"Financial penalties for MRSA and C.difficile should be retired with a refocus on other significant infections. The Chief Medical Officer's Annual Report 2011 Volume 2 notes that gram-negative bacteraemias have increased year on year. The Health Protection Agency suggests that up to 5000 people die of Gram-negative sepsis each year which greatly exceeds current mortality due to MRSA and C.difficile. XXX strongly recommends a review of the proportionality of existing national sanctions so that they drive better outcomes for patients, reflect the current needs and priorities of the NHS and are not perverse incentives."*

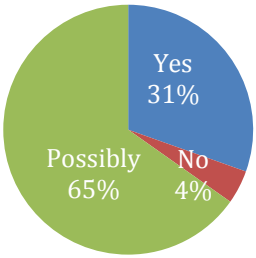
Q31. Would assessment of composite performance on specific areas (e.g. waiting times) be more helpful?



	Yes	No	Possibly	Abstained
Providers – NHS	3	1	2	21
Providers - Private	1	0	0	7
Commissioners	2	2	2	12
Other	1	0	3	10

- *"Yes. This would also ensure that any deviation due to the impact of a single patient choice in a small specialty, or natural variation which occurs in practice, do not massively distort organisations performance and the associated fines. Assessment of composite performance could be more helpful for waiting times, rather than having individual sanctions for the three sub-requirements as in the current contract. This would potentially make the process more manageable, however the impact would need to be fully explored and understood before implementation."*
- *"It would depend on timeliness and availability of data. Composite scores provided nationally for example on AQUA schemes take a long period of time to be calculated and disseminated. Data often arrives after deadlines for agreeing year end outcomes with providers."*
- *"All of these areas merit exploration as part of a longer term review (not for 2014-15), taking into account our comments in response to earlier questions. We see dangers in a composite approach to areas such as waiting times as that could obscure breaches of individual patients' rights under the NHS Constitution and undermine pressure for "choice" to be made available."*
- *"Composite performance targets are generally more complex to manage as would be a balanced scorecard approach. The current system is simple and effective. There is, however, a need for more nationally mandated quality requirements and financial sanctions to promote consistent minimum standards of practice for providers of community healthcare services."*
- *"We report at a Trust level and take a Trust view and discuss areas of concern with our host commissioners."*

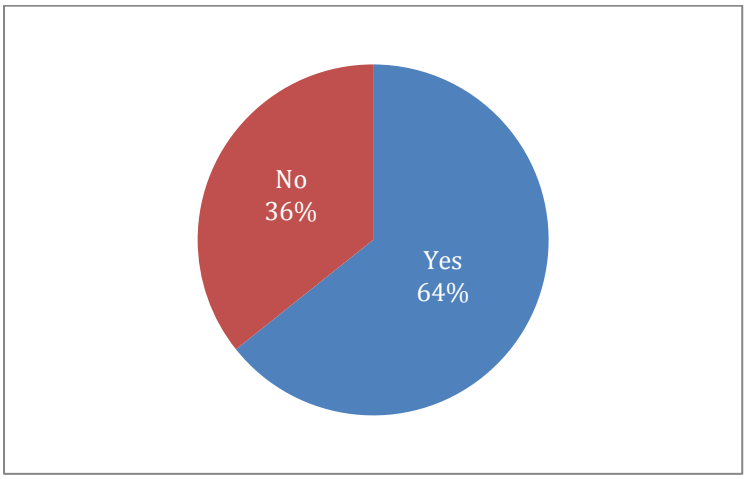
Q32. Could a balanced scorecard approach work?



	Yes	No	Possibly	Abstained
Providers – NHS	3	0	7	17
Providers - Private	1	0	0	7
Commissioners	2	1	6	9
Other	1	0	2	11

- *"A balance scorecard approach could work well in rewarding and penalising Trusts, since Trusts which perform well will do generally well across the board. It would remove the impact of variability of service demand from the overall performance assessment."*
- *"Yes – and would resonate with Monitor framework – the key will be the escalation rules"*
- *"Would be more helpful in terms of sanctions, but we would still want to know if providers weren't achieving in specific areas."*
- *"This is an approach that is well worth considering. For example, a balanced scorecard for HCAI would allow broader system measures to be considered as well as performance for different types of HCAI (healthcare acquired infection)"*
- *"Yes it would ensure greater proportionality. However, NHS England must be aware of any burden on either Commissioners or Providers in the level of data that might be required. Any measures should be easily collectable and systems already in place. They should not create yet another 'cottage industry'."*
- *"A balanced scorecard would seem to be a sensible approach, however options for this would need to be fully reviewed, understood and impact assessed by commissioners and providers before implementation. It would be helpful to invite some providers to take part in this approach as a trial."*
- *"No - Composite performance targets are generally more complex to manage as would be a balanced scorecard approach. The current system is simple and effective. There is, however, a need for more nationally mandated quality requirements and financial sanctions to promote consistent minimum standards of practice for providers of community healthcare services."*

Q33. Should there be more national sanctions for non-acute contracts? If so, in which areas?

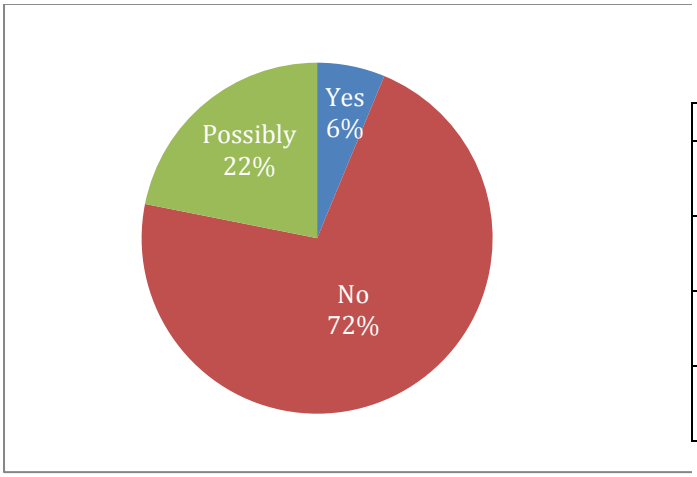


	Yes	No	Abstained
Providers – NHS	5	0	22
Providers – Private	0	1	7
Commissioners	4	1	13
Other	0	3	11

- *"Wherever sanctions are applied, they should be applied to all contributors to the performance aspect, e.g. A&E is across the whole of health and social care and the ambulance sector, HCAI are both community acquired and hospital acquired, and readmissions are a whole health and social care sector issue. Currently only acute trusts seem to face the consequences of sanctions relating to these performance targets."*
- *"We would welcome a review of sanctions and targets used in non acute contracts such as community based services and also for primary care services, such as GMS reviewed by NHSE. We believe there is currently a widening gap between the focus on the performance of acute contracts and non acute contracts. This can lead to serious problems in local systems and needs to be addressed, as we are not all joined up to effectively deliver care for our patients."*
- *"The group felt that in principle, there should be more national sanctions for non-acute contracts as the current system is not proportionate. However, an issue was raised around whether the information flows are advanced enough to allow for the data to be produced. If national sanctions were applied to non-acute contracts, this would drive and focus non-acute providers to the same levels as acute providers. In addition, most of the Never Events are not applicable to community outpatient settings. It would be helpful to have some that did and/or amend some of the administration of drug error ones to include prescribing errors too."*
- *"Yes e.g. patient transport services which have a high impact on patient satisfaction and care but are often on non-NHS standard contracts."*
- *"Yes clear guidance on levels of financial penalty to be applied on block contract arrangements. E.g. guidance is clear for never events and is easy to calculate for Acute Providers based on tariff costs however much harder to implement on non- acute Providers. Range of 'fine' rates may be more suitable for proportionate application."*
- *"Yes – mental health services provided to Acute A&E"*
- *"No. We do not believe this is necessary for community eye/hearing care. An effective sanctions system should be tailored to the service being delivered and requires a detailed understanding of how it should work, coupled with robust data. This is resource intensive, complex and costly, and therefore as stated above we believe that the overarching principles and guidance should be co-produced nationally, recognising that community eye/hearing care providers operate in an open market with minimum standards of service provision."*

- *"A 'good practice' approach rather than 'sanctions' would be more effective as the range of providers and services maybe too large to cover."*

Q34. 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?

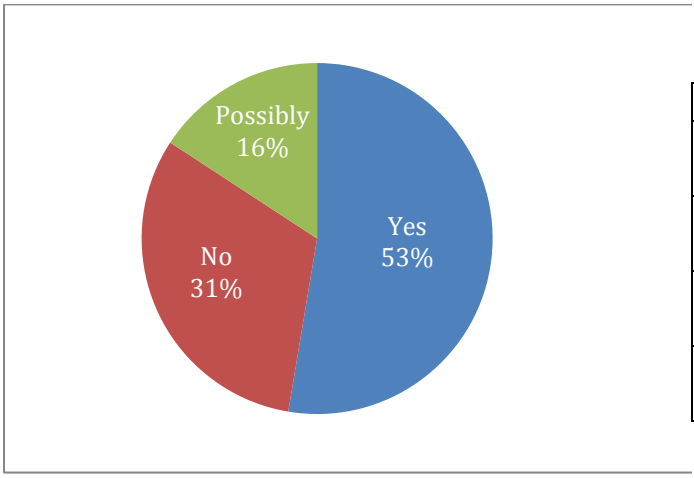


	Yes	No	Possibly	Abstained
Providers – NHS	0	11	1	15
Providers - Private	0	2	0	6
Commissioners	1	6	3	8
Other	1	4	0	9

- *"While we recognise the significant personal impact substandard care can have on patients, we do not believe there is a case for financial compensation to be routinely offered directly to affected service users. Notwithstanding a patient's legal right to redress, XXX believes that financial penalties should be redirected back into the local health economy. As Commissioners are charged with understanding the needs of their patient population, they are best suited to determine how these funds can be appropriately reinvested."*
- *"No this could create a perverse incentive to falsely claim compensation and generate a new claims management industry, taking valuable resources away from improving quality."*
- *"Financial compensation should not be offered to affected service users - this is likely to prove costly and unwieldy to administer and may result in speculative claims which take resource to investigate and refute."*
- *"The patient could be recompensed through litigation so this may not be appropriate. A failure in respect of waiting time targets could be as a result of patient choice and the possibility of financial compensation could incentivise the patient not to co-operate with the offer of earlier treatment."*
- *"This would be an interesting development which could sensibly be applied where rights in the NHS constitution are breached, thus giving real "teeth" to such rights. It would still need to be clearly the commissioner's responsibility to decide that sanctions should be applied."*
- *"Compensation for service users could be provided in some instances rather than to the Commissioner eg when mixed sex accommodation has been breached or 18 weeks. However, to do so suggests there is a financial value to these situations and would need to be balanced with the likely outcomes of any formal complaint or legal action against a Trust which may be more pertinent in scenario such as Never Events. If this were to be implemented it should sit outside of the contract, within a national framework for Providers."*

Locally Agreed Sanctions

Q35. Are the current arrangements effective in enabling local sanctions to be applied?



	Yes	No	Possibly	Abstained
Providers – NHS	5	4	1	17
Providers - Private	1	0	0	7
Commissioners	3	2	2	11
Other	1	0	0	13

Supporting comments included:

- *"We have always worked on the principle that any sanction should be proportionate to the service total value and the seriousness of the breach. There should be no minimum or maximum to this, but commissioners should always be aware of the impact of any sanction made to both the provider and the health community. Any sanction must be large enough for the provider to take notice and commit to the remedial action plan to rectify performance."*
- *"We believe having the ability to set local sanctions alongside national sanctions helps local systems address specific concerns that relate to them. The ability to set these should, therefore, be maintained. This does, however, need to be a collaborative process between providers and commissioners to ensure that the targets set are achievable in any one contracting period."*
- *"The ceiling is useful, as we have had locally agreed sanctions whose impact was not assessed by some Trusts and again it was not in the name of quality that the values were added."*

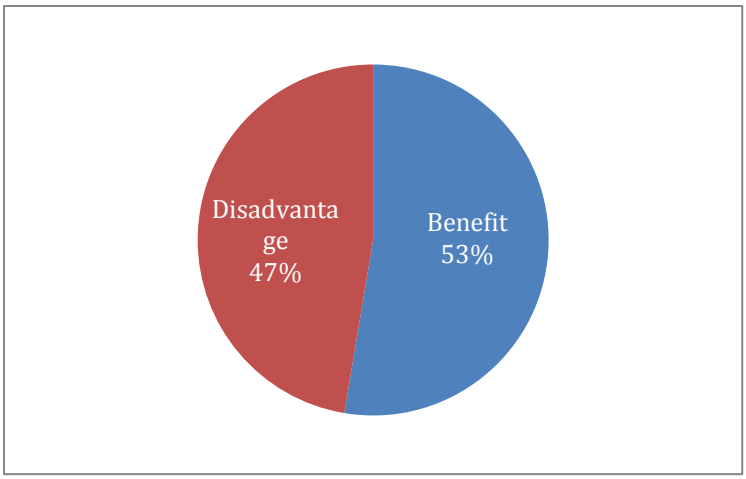
Comments which suggested was a possibility:

- *"It would be helpful if there was more clarity of what should and should not be included in local sanction schemes. Given the scope and potential consequences relating to national schemes, it would be better if local schemes were kept to a minimum wherever possible. Moreover, this will depend on the maturity of the local health and social care system. If it is mature, parties will agree appropriate sanctions for their own expected contributions. If it is not mature everyone will just look to blame and fine each other. In every occasion the question which must be asked is whether applying the sanction is truly going to benefit patient care. If not, it shouldn't be done."*

Rejection comments included:

- *"No locally agreed sanctions would be our preferred approach. Local approach should be about cooperation and joint working. Sanctions are incredibly negative. Also, even the national measures and sanctions have design flaws, so local ones would likely be even more susceptible to process issues that would make them unworkable."*
- *"There are now so many nationally required sanctions that we have no local sanctions agreed. We do, however, monitor a range of locally agreed measures and targets."*
- *"No as they require mutual agreement and most providers do not agree any locally."*

Q36a. Does the 1% ceiling on local sanctions provide any benefits or disadvantages?



	+/ve	-/ve	Abstained
Providers – NHS	8	2	16
Providers – Private	0	1	7
Commissioners	2	5	11
Other	0	1	13

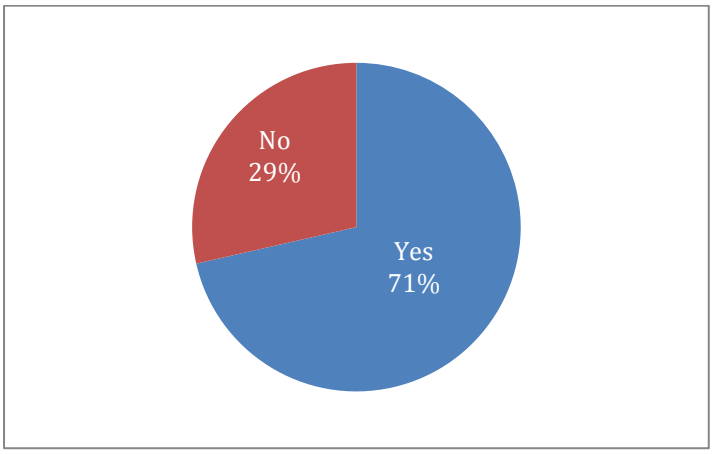
Benefit comments included:

- *"it provides a Provider with some certainty over its income."*
- *"The cap of 1% should be applied across all sanctions as this still represents a significant portion of trust's income as most trusts will only achieve a surplus under 2%."*
- *"The 1% ceiling is beneficial and probably should cover nationally mandated and locally agreed KPIs. The locally agreed sanctions should only be transacted if the target is reasonable and the provider has been given ample opportunity to undertake remedial action"*

Disadvantage comments included:

- *"One disadvantage is this limits the ability for performance related pay or risk sharing. However this also limits financial risk and instability for the Provider."*
- *"We have always worked on the principle that any sanction should be proportionate to the service total value and the seriousness of the breach. There should be no minimum or maximum to this, but commissioners should always be aware of the impact of any sanction made to both the provider and the health community. Any sanction must be large enough for the provider to take notice and commit to the remedial action plan to rectify performance."*

Q36b. Is there a case for a combined cap across nationally-mandated and locally-agreed sanctions?



	Yes	No	Abstained
Providers – NHS	8	0	18
Providers – Private	0	0	8
Commissioners	1	3	14
Other	1	1	12

Agreement Comments included:

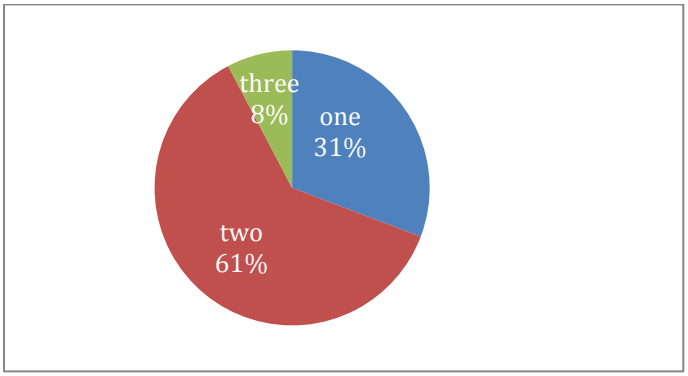
- *"Yes, as some local commissioners seem obsessed with having fines for absolutely everything, with some totally disproportionate to the 'infringement' eg: £100,000 for the lack of an NHS Number (we are still discussing this one!)"*
- *"Yes there is a case for a combined cap across nationally mandated and locally agreed sanctions. The current cap of 1% on local sanctions ensures that commissioners do not look to include unrealistic local targets in their contracts in order to recover money from providers. If a "cap" is being exceeded then it is saying one of two things. Either the arrangements for sanctions in place are totally inappropriate, or there is a significant problem with the provider/healthcare system which needs rapidly investigating. Applying a major financial fine without looking into the reasons why is of no use and will more likely harm patients than benefit them."*

Disagreement comments included:

- *"There should not be a cap on nationally-mandated sanctions."*
- *"A cap limits a providers exposure and this might not be in the best interests of delivering quality"*
- *"we would have reservations about an ad hoc change for 2014-15 ahead of a wider re-shaping of arrangements and schemes. Specifically on the issue of a combined cap, it seems to us that an aggregate cap is irrational if the basic requirements are in themselves proportional and reasonable."*

Q37. 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.***



	1	2	3	Abstained
Providers – NHS	6	11	0	12
Providers – Private	0	1	0	7
Commissioners	0	3	1	14
Other	2	1	1	10

Comments for option 1:

- *"if a sanction is good, then it should apply to all 'alike' services so NHs England could be the over-seer of any locally agreed?? Otherwise commissioners may see it as 'mandated' to have additional sanctions worth up to 1%."*

Comments for option 2:

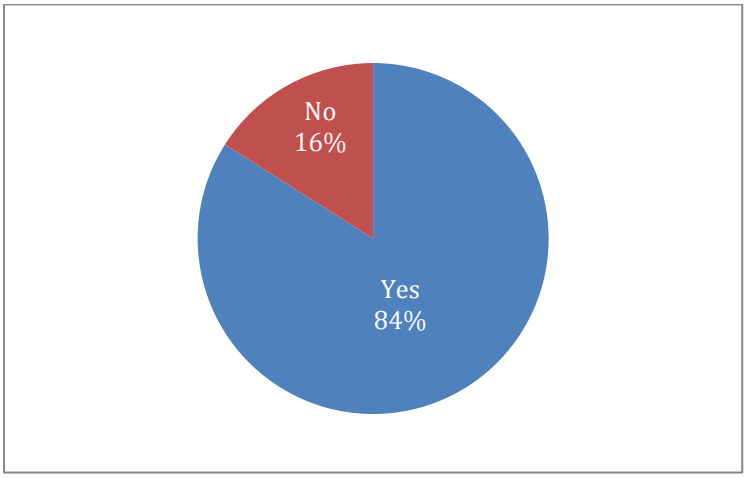
- *"One disadvantage is this limits the ability for performance related pay or risk sharing. However this also limits financial risk and instability for the Provider. The preferred option would be for a combined cap across nationally and locally agreed sanctions"*
- *"The Trust is supportive of the 2013/14 cap on locally set fines but believes the current threshold is excessive and counter-productive (i.e. if you fine a service failing RTT, it has no contingency to buy in additional staffing support and thus amplifying the problem);"*
- "*The cap of 1% should be applied across all sanctions as this still represents a significant portion of trust's income as most trusts will only achieve a surplus under 2%. The current rules on sanctions should continue as this ensures national areas of focus are maintained, as well as providing for the introduction of local focus areas when they are required."*

Comments for option 3:

- *"useful as eases negotiations."*

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

Q38. Is this a direction of travel you would support?



	Yes	No	Abstained
Providers – NHS	8	2	17
Providers – Private	1	1	6
Commissioners	9	1	8
Other	3	0	11

Supporting Comments:

- *"Although XXX supports the intent behind pay for performance, we do not believe a change should be implemented from 2015/16 because given the recent complex changes to the NHS and the current design of incentives, it is too early to assess whether pay for performance will be appropriate at that date. However, we believe that it is important for the NHS to improve quality of care in part through adoption of innovation at pace. As a direction of travel, we would welcome such an approach of pay-for-performance that includes adoption of innovation over the long-term."*
- *"It is important the NHS system is significantly incentivised to make a step change in the quality of its service provision. Embracing proven technology rapidly and consistently must be a key part of this. As a direction of travel therefore we would welcome an approach that mandates the clinically appropriate use of national frameworks, service specifications, priorities, guidelines and TAs to provide patients with a consistent level of high quality care, but enables local providers to innovate and deliver improvements in care that exceed national expectations."*
- *"Yes the switch to additional percentage payments for meeting key standards would be supported by the Trust. This approach should help to shift the culture away from sanctions and penalties and focus manager's minds on how they can improve performance to earn additional income. The core payment would absolutely need to be flexed based on actual activity levels. However, it is very important that the core payments are sufficient to ensure the day-to-day running of providers, to ensure that cash flow issues do not prevent them from meeting the required standards of care. A large scale review of the options and potential impacts will need to be carried out to ensure that this approach would work for all parties."*
- *"It is an interesting proposal. It might balance out the balance between sanctions and incentives. As a general comment penalties can be set too high and incentives too low. As part of the proposal perhaps consideration could be given to performance improvement trajectories / directions of travel having both an incentive AND a penalty element, perhaps set around the mid-point (rather than a straight penalty for trajectory / stretch target). An*

example would be C-Difficile where considerable stretch targets are set, with a penalty mechanism for not delivering the full stretch despite some improvement being made. In this scenario it would be fairer for there to be a penalty for minimal improvement/reduction in performance with an incentive for delivery of some stretch."

- *"I would support a switch from sanctions and CQUIN, with pay for performance. I think this will focus providers more effectively, reduce workload around small CQUIN schemes which offer little in the way of quality improvements. They are a distraction to both provider and commissioner."*
- *"Broadly, yes. PbR has too many opportunities for gaming and has not had the desired effect in giving appropriate funding to Trusts. Having, in effect, a core block with flex options to reflect actual activity sounds like an appropriate way forward."*
- *"The group agree with the principle of this long-term direction; however this would need to be nationally mandated. It was felt that implementing this in 2015/16 would be quite ambitious given the recent structural changes in the NHS during 12/13. The consensus was that there was a need for a period of stability before introducing this. The group felt they would need to understand what the benefits of this would be in terms of what additional outcomes would be met if this was to be introduced. There would also be a need to ensure baselines are accurate before introducing a system of pay-for-performance. The group suggested inviting some pilot sites to test the pay-for-performance out before rolling this out nationally."*

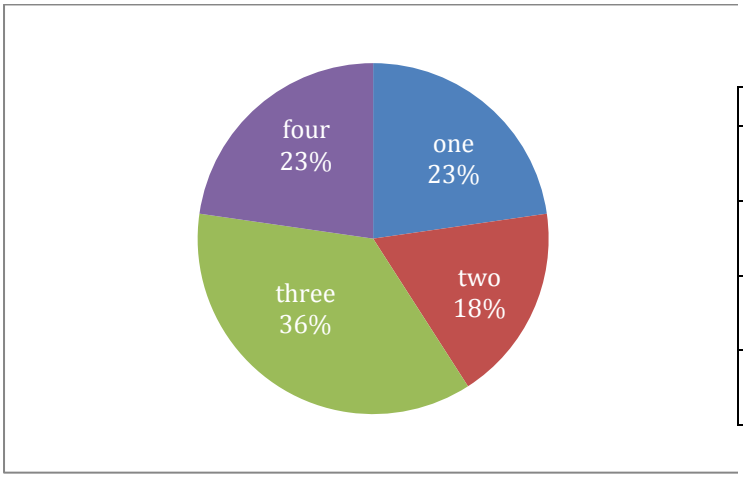
Rejecting comments:

- *"We believe there is scope to increase the value of CQUIN payments to ensure a greater focus is given to specific areas of quality improvement. The current system allows for this tool to be used to drive national, as well as local standards. PbR should continue to be used to ensure that providers are remunerated for the activity they undertake as fluctuations in demand for services should result in movements in funding. We would support the introduction of standards that relate specifically to meeting the constitution but believe this can be undertaken in the current framework. We do not believe there is a need to move away from the current PbR, CQUIN and sanction system to achieve the aims of the wider NHS and the local systems."*
- *"The proposition about a new package of incentives will probably lead to the same outcome as present. Where mature relationships exist between commissioners and provider's pragmatic solutions are found to enable both organisations to deliver their objectives in a mutually agreeable way. Problems arise where these relationships do not exist. This will apply to whatever system is in place. At least the current system is understood and there is so much change an uncertainty at the money, further complexity is probably not a good thing. Finally, whatever systems are in place there needs to a level playing field between commissioner and provider that places the interests of the patient at the centre. If this is not the case problems will occur."*

Q39. 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?

Broadly four options have been identified for stakeholder preference to where the focus of how the package of incentives should be designed:

1. *National Mandation & oversight*
2. *Flexibility, local autonomy & freedom to innovate*
3. *Balanced approach with set nationally mandated specifications and local flexibilities (50/50)*
4. *Focus on sector specific specifications; (eg specialised trusts, smaller providers)*



	1	2	3	4	Abstained
Providers – NHS	2	1	4	2	18
Providers - Private	1	0	0	1	6
Commissioners	1	0	4	0	13
Other	1	3	0	2	9

Comments in support of more empathise on national mandation and oversight (option 1):

- *"We would see a greater benefit in greater mandation and oversight as a means of preventing market fragmentation. Conclusion: There is little wrong with the present establishment of incentives, rewards and sanctions however the application of these by commissioners is in our view the underlying issue. As a national provider we face off with over 30 commissioners and the level of capability and capacity to work with contracts and manage providers is massively variable. The best are exceptional and use their available levers in the best interests of patients and with understanding to drive provider performance, however we would say that the "average commissioner" is not good at contract management and provider partnership which is where the main issues lie. This whole interface is far too adversarial and not one of cooperation and mutual benefit. We do believe there is scope for developing a balanced score care approach to elements of the drivers flowing through NHS contracts."*
- *"It is important the NHS system is significantly incentivised to make a step change in the quality of its service provision. Embracing proven technology rapidly and consistently must be a key part of this. As a direction of travel therefore we would welcome an approach that mandates the clinically appropriate use of national frameworks, service specifications, priorities, guidelines and TAs to provide patients with a consistent level of high quality care, but enables local providers to innovate and deliver improvements in care that exceed national expectations."*

Comments in support of more flexibility, local autonomy and freedom to innovate (option 2):

- *"It would be very helpful if the national incentives encourage longer-term improvements such as reducing health risk factors in patients and improving rehabilitation of patients so that they are better able to continue with activities of daily life. Incentives with regards to health outcomes would be very welcome. Local incentives in addition to this would be helpful to allow fine tuning of the system."*
- *"High performing local health economies will utilise flexibilities to continue to improve patient care. Less successful ones may utilise flexibilities to avoid having to deal with the issues. Health economies should be required to demonstrate that they have a mature relationship with each other and have a track record of compliance and achieving a set standard of quality to earn autonomy in local flexibilities."*
- *"Keeping it on the balance of CQUIN where national measurers are approximately 20% of the total seems sensible."*

Comments in support of a balanced approach with set nationally mandated specifications and local flexibilities (50/50) (option 3):

- *"Local flexibility is important to retain the engagement and enthusiasm of local clinicians in particular. There does however need to be some consistency and prioritisation nationally. There does need to be limits to how many "layers" can be added. Multi-year approach to incentives in particular would also be beneficial (not revisiting and replacing annually). Concluding remarks: We have welcomed the opportunity to participate in this consultation, as well as the parallel one on contract documentation. We would like to offer ourselves for further dialogue and testing of examples, scenarios and documentation. We can also offer a lead into wider stakeholders (e.g. the Shelford Group, Contract group of GM providers and a joint GM Contract group of GM providers and commissioners)."*
- *"There is a need for a mix of local and national incentive payments schemes, however, these need to be clear and concise and simpler to manage and administrate than the current CQUIN schemes and may include more service development proposals or profit share arrangements. Sanctions are (because of their nature) very difficult to agree at a local level and these should be nationally mandated. However, there seems little real benefit in applying these except where Providers have failed to make agreed service improvements."*
- *"There are benefits to both national mandation and local flexibility. The best approach would be a small number of key nationally mandated standards (aligned with the key goals of the NHS), supplemented by local goals collaboratively set, with provider and commissioner input and based around local health needs. Any nationally mandated goals need to be relevant to the various organisations affected."*
- *"In designing the package of incentives, rewards and sanctions for the future, it is important to maintain a balance between national direction and oversight and local autonomy and flexibility. However, there needs to be clearer guidance to facilitate this, as there is often uncertainty. Local autonomy shouldn't mean that ten different organisations are allowed to interpret the same measures differently, it should mean genuine innovation."*

Comments in support of changing the focus on sector specific specifications; (eg specialised trusts, smaller providers) rather than balance between national & local focus (option 4)

- *"We feel duplication should be avoided as it creates added layers of complexity and as a result increases risks. More importantly duplication diverts resources away from patients without any benefit (in particular for low risk services). Any final package should be proportionate to the service involved and co-produced with the relevant stakeholders. NHS England should avoid a "one size fits" all system for all services as this cannot deliver the quality and efficiency gains required to meet the anticipated growth in demand for health care services. The correct balance is not necessarily that between national and local, but more specific to the nature of the service and to the profession providing it."*
- *"Suggest it be described as per for outcomes not performance. Agree that paying for outcomes is a good idea as long as all providers can be measured equitably. We would need to see more details about how this would be measured."*

Other Comments included:

- *"If the 2.5% CQUIN was split 1.5% CQUIN but 1% for delivery of all the KPIs then commissioners would be able to penalise providers through the CQUIN rather than the sanction route. It is much better to penalise the provider by not giving them something that is effectively an "addition", than to sanction them with taking part of the core contract off them. As an illustration – this "KPI Premium" would be applied to delivery of KPIs. For example a premium of 1% of contract value is set aside and is only paid when the KPI is delivered. As a simple illustration a Contract of £100m and 20 KPIs would have £50k per KPI. A simple scoring for completion would be 0% (not done at all), 25%, 50%, 75% and 100% (completely satisfactory). Provider and commissioner would score, so if it was 50% the provider would lose £25k. This might be difficult to implement as provider opposition is likely."*
- *"What is important is that local sanctions are properly thought through and relevant and not just included because one commissioner believes that it is important for their health economy."*
- *"Further clarity on the proposals and how these would be aligned with current payment for performance systems, including for example best practice tariffs, would be helpful."*