NHS Services, Seven Days a Week Forum

Levers and incentives

Gateway reference: 00889

Introduction

The commissioning levers workstream was established to determine the levers and incentives that are available to commissioners and others to encourage the delivery of the clinical standards for seven day services. The workstream was led by Dr Mark Spencer, Medical Director, Quality and Service Design, NHS England (London) and supported by Dr Andrew Stein, Consultant in Acute and Renal Medicine and Clinical Commissioning Director (Secondary Care), Coventry and Rugby CCGs.

This report outlines the approach taken to the workstream and the overall findings and recommendations on both formal and informal levers in the following categories:

- Contractual mechanisms;
- Payment system mechanisms;
- Inspection and assurance;
- Measurement and transparency;
- Education commissioning and revalidation;
- Engagement.

Concurrently, NHS England has undertaken a review of the financial incentives used within the NHS. Steps have been taken to ensure that the recommendations contained in this report are aligned with the wider financial incentives review.

1. Approach

The workstream carried out extensive discussions with key stakeholders to explore incentives and levers that could be used to encourage the delivery of the clinical standards, seven days a week. The views of experienced commissioners, clinicians and other opinion-leaders on the levers and their effectiveness were sought. Depending on their area of expertise, specific commissioning levers or alternative less formal levers that could nonetheless encourage seven day services were discussed with each of the individuals.

Following initial exploration of potential commissioning levers and other incentives and levers, a working group was established to determine their priority and potential effectiveness, and to provide expert input and advice into the final recommendations.

The working group took an iterative approach in the development of the recommendations on levers in relation to the proposed clinical standards and the feasibility of objective measurement of compliance.

The Clinical Reference Group established by the Forum also considered the ongoing measurement and assurance of the clinical standards and their recommendations have fed into this report.

Primary, community and social care were out of scope of the first phase of the seven day services review but are recognised as key to the implementation of consistently high quality urgent and emergency care, seven days a week. The Urgent and Emergency Care Review, which has been undertaken concurrently with this review, will make recommendations in relation to primary and community care including the need for these services to be consistent seven days a week. Levers that may be used to encourage seven day services across the wider healthcare system will be therefore be recommended as part of this review.

2. Findings

Findings from this workstream are that to drive change levers beyond pure commissioning are needed. A mix of formal contractual levers and informal levers are required and there is also a need to work across these levers at different levels – national, local, organisational, team and individual – to bring about the large scale change required.

Moving from a system whereby services are predominantly provided on a five day basis to the delivery of a consistent high quality service for all patients every day of the week requires a significant cultural shift as well as the practical and logistical changes that need to happen. To facilitate this cultural shift, widespread support for the clinical standards and the introduction of seven day services is needed.

As detailed in the evidence base for the development of the clinical standards, patient outcomes and experience are improved when high quality, consistent seven day services are provided. This message needs to be communicated widely to the public, patients and carers. Transparency of the current level of service provision and ongoing achievement of the clinical standards is also required to highlight areas of good practice and expose variation between hospitals and between weekday and weekend service provision. This should support informed choice and also encourage competition between services and providers and drive quality improvements.

Clinical engagement on the evidence base for the clinical standards is also critical to garner support for their implementation from the staff who will be delivering frontline care in line with the standards.

3. Contractual mechanisms

Key recommendations

From 2014/15 local contracts should include an Action Plan to deliver the clinical standards within the Service Development and Improvement Plan section.

A local CQUIN should be considered, based on the standard for time from arrival to initial consultant assessment.

NHS standard contract

The NHS standard contract is the basis on which acute emergency NHS services are commissioned. It comprises service conditions, general conditions and particulars. Service specifications, quality requirements, including Commissioning for Quality and Innovation (CQUIN) schemes, and Service Development and Improvement Plans (SDIPs) appear within the particulars section. The national quality requirements and operational standards cannot be changed by local commissioners. Local quality requirements, CQUINs and SDIPs may be varied by commissioners (NHS England and Clinical Commissioning Groups) in order to address local priorities.

The clinical standards represent a suite of inputs, each of which is vital to the delivery of high quality patient care seven days a week. Clinical opinion is that the interdependency between the standards means that they should be considered together. However, they represent a large-scale change in working practices, and NHS England cannot advocate service changes without fully understanding the financial impact. Inclusion of the clinical standards within the nationally mandated section of the contract may be considered once the full strategic financial analysis of the affordability of delivering the standards is completed.

The national incentives review aims to limit the number and value of the sanctions imposed through the NHS standard contract. Given this, and the large scale change likely to be required, at this stage there is no recommended financial sanction relating to the delivery of the clinical standards, seven days a week.

➢ Local contract variation

Whilst the clinical standards cannot yet be mandated within the NHS standard contract, commissioners and providers should be encouraged – through effective engagement – to

implement the clinical standards including, where appropriate, local quality requirements, in line with the ambition of the Seven Day Services Forum.

The clinical standards should be made available by NHS England as a service specification for inclusion within the NHS standard contract, to encourage commissioners and providers to consider where they are now against those standards. In addition, CCGs commissioning urgent and emergency care services should develop action plans with providers on the delivery of the clinical standards, seven days a week, as part of the SDIP, to be included in contracts with providers of these services. These plans should include a commitment to undertaking a baseline self-assessment of existing services against the standards and planning for achievement of the standards over a specified timeframe. Commissioners and providers should use the action plan to ensure that progress is made towards delivery of the clinical standards.

The development of an action plan will facilitate staged implementation, and should address the particular implementation difficulties that providers may have, for example in rural areas, due to limited workforce. Alternative solutions such as networked arrangements, in line with the forthcoming recommendations of the urgent and emergency care review, may be considered to ensure quality and adequate access are maintained.

The development of an action plan should also facilitate discussions with local stakeholders, such as Health and Wellbeing Boards, on what standard of care will be available to the population and progress towards the delivery of the clinical standards, seven days a week.

The case for 7-day services, with links to the clinical standards and their evidence base, should appear in the NHS Planning Guidance for 2014/15 to signal forthcoming expectations and to stimulate the required engagement. The Forum will work with the Planning and Assurance team at NHS England to ensure the necessary focus is given to seven day services in the next iteration of the planning guidance.

- **Specialised commissioning**

NHS England is the direct commissioner of specialised services. Clinical Reference Groups (CRGs) covering all the different specialised services are responsible for preparing national specialised service strategy and developing service specifications to guide the commissioning of these services. It is recommended that the CRGs responsible for areas relating to urgent and emergency care consider the clinical standards in the development of related service specifications. The service specifications should reflect the clinical standards, where appropriate, to encourage their delivery, seven days a week.

- **Commissioning for Quality and Innovation**

The Commissioning for Quality and Innovation (CQUIN) payment framework enables commissioners to reward providers for delivering specific quality and innovation improvement goals, above the baseline requirements set out in the NHS standard contract, by linking a proportion of providers' income to their achievement. National and local CQUINs appear in the particulars section of the contract under the national and local quality requirements.

CQUIN funding is currently earned by providers within a financial year and the monies remain non-recurrent. The national element - 0.5% of contract value - includes the Friends and Family Test, safety (which focuses on pressure sores, healthcare-associated infections, medication errors, and maternity safety), dementia and venous thromboembolism (VTE). The remainder - 2% of contract value - is linked to local commissioning priorities and strategies.

As part of the national incentives review the evidence of the impact of CQUINs on outcomes has been reviewed. Findings have shown that the evidence of the effectiveness of local CQUINs is limited in terms of impact, and the non-recurrent funding to enable investment in the change process does not allow recurrent investment in the service. However, careful construction of a CQUIN alongside regular assessment of progress may increase the potential impact and the output of the national incentives review is expected to address the short term nature of CQUINs. Allowing the incentive to remain in place over a longer period of time to encourage greater planning, alongside simplification (or abolition) of some of the requirements, are under consideration.

In the short-term, CQUIN does provide an opportunity to encourage the delivery of the clinical standards, seven days a week. While seven day services as a whole are too extensive to be covered by a single national or local CQUIN, individual standards (or elements of the standards) relating to seven-day services could be addressed through local CQUIN schemes.

Any new CQUIN requires, as a minimum:

- A clear standard to reach, or improve upon;
- A means of measuring progress from the current position, to the ideal future position;
- An exit strategy (to normalise the improvement once reached, so that CQUIN payment can cease).

To incentivise progress in meeting the clinical standards in 2014/15, a CQUIN based on the standard for an initial consultant assessment within 14 hours of arrival for all patients, seven days a week, should be developed. If accepted, this should form part of the list of CQUIN indicators being developed by NHS England for commissioners to choose according to local circumstances and priorities.

Further to this, it is recommended that consideration be given to including day of admission as part of ongoing Friends and Family Test development work, to allow comparison of the quality of care experienced by patients between weekdays and weekends, where possible and appropriate, and to encourage parity.

- **Additional financial support**

Additional resources to support and enable the delivery of seven day services will also be available to commissioners working across health and social care through the Integration Transformation Fund (ITF). The ITF aims to encourage innovative and collaborative ways of working between the NHS and social care to ensure seamless care for patients requiring both NHS and local authority commissioned services, and is likely to include a precondition for working towards seven day services. One area where the availability of social care and its integration with NHS services, seven days a week would impact upon delivery of the clinical standards would be the timely discharge of patients from hospital to the community and the avoidance of readmission. The ITF is open to joint applications from all CCGs and their local authorities.

As the delivery of seven day services moves beyond the initial scope of the Forum there will be increasing opportunities for joint strategic ownership and progress towards the provision of high quality services seven days a week, supported by the ITF.

4. Payment system mechanisms

Key recommendation
NHS England and Monitor should ensure that the new payment system reflects the extent to which clinical standards are being delivered on every day of the week.

The current payment system consists of a fixed standard price list for hospital provided NHS treatments, interventions and operations. It forms part of the payment system known as payment by results (PbR). In the main, PbR pays for patient activities, not patient outcomes.

From 2014/15 NHS England and Monitor will have joint responsibility for the payment system. They will publish the National Tariff, which will set out a new set of rules for governing the payment system. The National Tariff will include national prices, the methodology for national price-setting, rules for varying national prices and rules for local price-setting. These two bodies published a discussion paper on a proposed new basis for the national tariff and, as part of this process, they aim to develop a more transparent and sustainable structure of payment based more on outcomes than activities.

In 2014/15, there will be minimal change to national prices in order to provide continuity and help providers with their planning. There will also be new encouragement for local innovation in system redesign, supported by greater flexibility to vary national prices. Any variations that promote the interests of patients, that are conducted transparently and with constructive engagement between providers and commissioners will be enabled. More widespread changes are planned from 2015/16 onwards.

One of the proposed objectives of the new payment system as set out in the discussion document is to reimburse outcomes for patients rather than treatments or inputs. The Forum fed back during the engagement period that, in some cases, outcomes such as morbidity and mortality may be difficult to measure effectively or in a timely way. It would therefore be appropriate in these cases for reimbursement to be based on treatments and inputs where these are evidence-based to improve outcomes. It is therefore recommended that emergency care is reimbursed based on the evidence-based clinical standards.

It is further recommended that the assessment of service delivery models that represent value for money and the design of payments and contracts should also be founded on the evidence-based clinical standards. Where there is a variation in payment in relation to quality, only providers meeting the required clinical standards for emergency care, seven days a week, should be reimbursed at the maximum rate.

There may be several trusts that have already moved towards the introduction of seven day services through the adoption of evidence-based clinical standards. The Forum supports changes to the payment system that allow local experimentation in payment approaches to encourage early adopters of the clinical standards.

The design of payments should consider the whole emergency and urgent care system. Interdependencies exist that mean that costs incurred by one provider may be influenced by other providers' provision of seven day services. These costs should be shared appropriately to encourage the provision of seven day services throughout the NHS.

The Forum's response to the discussion paper reflects the recommendations made above.

5. Inspection and assurance

Key recommendation
No hospital rating equivalent to “outstanding” should be awarded by the CQC and Chief Inspector of Hospitals, unless emergency services in line with the clinical standards are provided on every day of the week.

The Care Quality Commission (CQC) regularly assesses hospitals, GP surgeries, care homes and other sites delivering NHS services to ensure they provide high quality, safe and effective services to patients. Services are measured against a set of national standards and results are published. Most hospitals, care homes and domiciliary care services are inspected at least once a year.

The CQC has recently appointed a Chief Inspector of Trusts, Professor Sir Mike Richards, to oversee a national team of inspectors that will carry out targeted inspections in response to quality concerns. Regional teams of inspectors will also undertake routine inspections of all hospitals. Professor Richards will further lead the development of a ratings system for NHS and Foundation acute and mental health trusts allowing clear comparisons between the services provided by different organisations.

Inspection is critical to ensuring the delivery of the clinical standards, seven days a week, ensuring emergency services are responsive to patients’ needs regardless of the day or time they are admitted. It is recommended that the achievement of the clinical standards, or progress towards them, is therefore assessed through the inspections described above. The clinical standards should form part of the standards under consideration by the CQC in the three categories: fundamentals of care; expected standards; and high quality care. The clinical standards developed by the Seven Day Services Forum are likely to fall into the latter two categories.

With regard to the rating system to be developed by the Chief Inspector of Trusts, it is recommended that no hospital achieve a rating equivalent to ‘outstanding’ unless it delivers emergency care that consistently meets the clinical standards, seven days a week. Any guidance for providers produced by the CQC should refer explicitly to the clinical standards.

6. Measurement and transparency

Key recommendations

Future revisions of the CCG outcomes indicator set by NHS England, supported by NICE, should include indicators relating to delivery of the clinical standards.

NICE should consider accrediting the clinical standards as an evidence-based resource. If accredited, the standards should then be used to inform any future quality standard produced by NICE on seven day services.

Data and information on the extent to which the standards are being achieved, and the provision of seven day services, should be published in an accessible format that lends itself to comparisons.

Measurement

Demonstrating achievement of the clinical standards requires effective data gathering mechanisms and there is currently no established data flow in place. In addition, the national incentives review undertaken by NHS England is aiming to reduce the burden of information collection. In the short term, the action plan on the delivery of the clinical standards, within the Service Development and Improvement Plan of the NHS standard contract would be monitored for improvement in delivery, locally.

For the longer term, further work is underway to establish ongoing measures for the delivery of the standards and associated patient outcomes.

Further to this, a national indicator on avoidable deaths in hospital is to be developed by Lord Ara Darzi and Professor Nick Black. This will be an additional means of benchmarking providers on the quality of their services. This measure should record the differences in mortality rates between weekday and weekend admissions to enable effective comparisons between providers and further support the drive for delivery of the clinical standards, seven days a week.

The CCG outcomes indicator set (CCG OIS) is revised and owned by NHS England, supported by the National Institute of Health and Care Excellence (NICE), which develops, tests and makes recommendations on proposed indicators. The OIS provides information to CCGs to allow benchmarking and quality assessment of the services they commission. It also allows comparative information for patients and the public about the quality and health outcomes associated with services commissioned. It is recommended that, once data flows

are in place, that consideration is given to the inclusion of indicators related to the delivery of the clinical standards.

NICE's accreditation programme assesses the processes used to produce guidance and advice. The clinical standards are robust and evidence-based. In addition to possible inclusion of indicators relating to the standards in the CCG OIS, NICE should consider accrediting the clinical standards as an evidence-based resource. Once accredited, the standards may then be used by NICE to develop its own quality standard on seven day services.

Transparency

There is evidence that publishing audit data, and ensuring it is accessible to peers and the public, improves the achievement of standards or guidelines. A system that allows providers to benchmark their achievement of the clinical standards against others would engender healthy competition in relation to the quality of services across the seven days of the week. Such reputational levers would also be an effective tool for driving competition between Clinical Commissioning Groups (CCGs) and their commissioning of high quality seven day services.

Effective comparison between providers or commissioners requires a culture of transparency alongside robust and easily accessible information. Appropriate reporting mechanisms and the timely publication of results are needed to allow providers and commissioners to benchmark one another easily. This information, and how it is reported, also needs to be transparent and accessible to the public.

In the immediate term, the Forum will publish the full results of the survey of current arrangements undertaken in August 2013 as part of the review. This survey highlights current variation in service provision across acute medicine, emergency general surgery and diagnostics between weekdays and weekends.

In the longer term, inclusion of the clinical standards for seven day services in the measures recorded by both the new Chief Inspector of Trusts and the CQC, as described above, will represent a means of benchmarking trusts and encouraging competition between providers and commissioners.

Reports by the Inspector of Trusts and CQC and the CCG outcomes indicator sets will be routinely published. Comparisons of providers' achievement of the clinical standards, seven days a week should also be published elsewhere to ensure accessibility of information, particularly to the public. Platforms for reporting this type of data already exist or are in development by NHS England's Patient and Information directorate. An integrated customer

service platform, designed to take over from NHS Choices, is under development and would be an appropriate repository for data on achievement of the clinical standards.

To ensure the transparency of information is effective as a reputational lever, and to garner support for the standards and their implementation, significant engagement with all stakeholders on the evidence base for the clinical standards is required. The clinical standards must be perceived as credible and founded on clinical evidence, or any reputational levers will have little impact.

7. Education commissioning and revalidation

Key recommendations

Education contracts with Health Education England and the developing "failure regime" should include consultant availability to provide adequate supervision of doctors in training seven days a week, in line with the clinical standards.

Consultant revalidation and appraisals should reflect delivery of the clinical standards, seven days a week, as appropriate to the specialty and setting.

Education commissioning

Responsibility for the commissioning of medical education and training falls within the remit of Health Education England (HEE). HEE's budget for training future doctors is approximately £5 billion. As such, the income of individual provider organisations' training programmes is significant, and potentially a powerful financial lever.

Junior doctors are integral to the functioning of most hospital departments. However, historical patterns of Monday to Friday working for consultants mean relatively few doctors in training are covering high numbers of patients in hospitals, with limited senior supervision at weekends. This, among other factors, impacts on patient outcomes and experience. The presence of consultants and the supervision they provide to doctors in training is integral to the delivery of the clinical standards, seven days a week.

Linking the allocation of medical training posts to assurance of appropriate seven day consultant clinical supervision is therefore a powerful lever to drive implementation of the clinical standards. The loss of training recognition and the associated doctors in training posts would risk the viability of many services and is therefore a strong incentive for delivery.

It is therefore recommended that Health Education England (HEE) ensure that the education contract includes a requirement for the availability of consultants to provide adequate supervision of doctors in training seven days a week, in line with the clinical standards.

HEE is currently developing a formal failure regime to be followed in the event that providers do not ensure the necessary training and education of doctors in training, including appropriate supervision seven days a week. As a final stage in this regime, training places would no longer be allocated to the provider. The Forum supports the development and implementation

of this regime to ensure doctors in training are supported and supervised appropriately to deliver high quality and safe patient care, seven days a week.

Critical to the implementation and sustainability of seven day services is a cultural shift. HEE are asked to support this cultural shift by ensuring the expectation amongst medical students is that careers will involve working within seven day services.

Revalidation

A clinician's revalidation, including continuing professional development (CPD) and regular appraisal, represents a further lever to encourage the delivery of the clinical standards, seven days a week. It is recommended that individual clinicians' CPD and the requirement to demonstrate quality improvement activity in appraisals reflect the urgent and emergency work they undertake, and includes reference to the delivery of the clinical standards, seven days a week.

Benchmarking of individual performance against the clinical standards also represents an additional lever, linked to the reputational levers discussed in this report.

8. Engagement

Key recommendation
The evidence base for the clinical standards, quality and outcome benefits, and the working life implications of the delivery of the clinical standards should be widely shared through comprehensive engagement with a wide range of stakeholders - patients and carers, clinicians, commissioners and providers.

Previous large-scale change programmes in the NHS have shown the value of significant and ongoing engagement. Effective engagement with all stakeholders – patients and carers, clinicians, commissioners and providers – will be key to gain buy-in to the clinical standards. This should help drive implementation of the standards across the seven days of the week.

To achieve the cultural shift required the standards must be viewed as evidence based and associated with delivering real differences in outcomes for patients. The evidence base for the clinical standards and the detrimental impact on patient outcomes, including mortality, of not having consistent high quality services seven days a week, should therefore form the basis of extensive engagement with all stakeholders.

Professional engagement

The size of the culture change required is significant and support from clinicians, commissioners and other professionals on the need for change will be vital in order to achieve it.

Earlier experience has shown the value of engagement across all professional groups to encourage delivery of a specific set of clinical standards. The London Quality Standards represent a set of credible evidence-based standards that garnered significant support from both clinicians and commissioners. Clinicians in both provider and commissioning organisations understood the evidence base for and the quality benefits of the clinical standards, which led to the standards being endorsed by the local Clinical Senate and CCGs then collectively agreeing to commission them.

Professional engagement on the benefits of seven day services is needed both in terms of patient outcome and experience, but also in terms of how seven day services can improve working lives. For example, most health professionals will benefit from the avoidance of the ‘typical Monday morning chaos’ experienced in many hospital departments. Positive stories following the introduction of seven day services need to be communicated widely.

Patient and public engagement

Similarly, patients and the public need to understand the level of current service provision and the need to ensure that urgent and emergency care services are delivered consistently on a seven day basis and the potential implications of this issue. The message that hospitals do not provide the same service seven days a week, and the impact of this on outcomes including mortality, needs to be communicated effectively to the public.

A full engagement plan is under development by the Forum to ensure effective engagement with all stakeholders. A Call to Action will also be an effective means of engagement and ensuring ideas and solutions are framed in the context of the need to ensure urgent and emergency care services are delivered consistently, seven days a week.