POLICY RESEARCH UNIT IN COMMISSIONING AND THE HEALTHCARE SYSTEM

STUDY OF THE USE OF CONTRACTUAL MECHANISMS IN COMMISSIONING

FINAL REPORT

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Research team

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Disclaimer:

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*In respect of the first national survey

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Background

Contracts were introduced into the NHS in the early 1990s as part of the internal market reforms. Since 2007 there has been a detailed form of standard national contract made available by the Department of Health (recently NHS England) for use by commissioners, which is evolving over time. Two of the major uses of the contract are to allocate resources to providers through pricing and to act as an instrument to improve services. Although the Payment by Results national tariff cost per case payment system covers much care in acute settings, it should be noted that many procedures are still not covered by the tariff and prices have to be negotiated at local level. There are no national tariffs in operation for mental health and community health services.

A quality framework called 'Commissioning for Quality and Innovation' (CQUIN) was introduced in the 2009/10 contract, which provided financial incentives to achieve specific quality targets. There are also provisions in the standard contract which allow commissioners to impose financial penalties for breaches of nationally specified events and other aspects of poor quality care. Local commissioners can also negotiate additional CQUINs and financial penalties to include in their contracts with local providers.

Despite the clear aims of policies concerning formal contractual mechanisms such as incentives and penalties, difficulties related to contracting for health care services have been highlighted by researchers since the introduction of the quasi-market reforms in the early 1990s. Research has shown that the operation of contracts in the NHS tends to entail flexibility, and there may well be changes in the terms of the contractual relationship which are at odds with the written document signed by the parties. This phenomenon indicated that research is required to investigate how the current policies to use contractual mechanisms including financial levers to encourage quality improvement and financial risk allocation are working in practice.

Aims

This three year project aimed to investigate how commissioners negotiated, specified, monitored and managed contractual mechanisms to improve services and allocate financial risk in their local health economies, looking at both acute services and community health care.

The research questions were:

- What is the range of formal provisions, including positive and negative financial levers in respect of quality of care in contracts across the English NHS? This will entail examining both the locally developed service specifications and the nationally mandated core contractual terms.
- How are contractual financial levers negotiated, specified, monitored and enforced in practice?
- How are prices set? In particular, how are prices for services not included in PbR negotiated?
- What payments are actually made to providers? How do these relate to the prices agreed at the outset?
- What are the effects of the use (or non use) of contractual mechanisms on service improvement and allocation of financial risk?

Design and methods

The project consisted of two aspects:

1. National telephone surveys in 2012 and 2014 to find out what contractual mechanisms, including financial levers were being used in formal written contracts, and how they were implemented or not.

2. A series of three in depth case studies of three local health economies, looking at the contractual relationships between commissioning organisations and their providers of acute, mental health and community healthcare, and how these affected services delivered. A mixture of interviews of contracting parties in commissioners and providers, observation of contracting meetings and analysis of local documents was used.

Results

Overall, the relevant provisions of the national standard contracts remained relatively stable during the four year period. The national tariff was applied to a wide range of acute services implying a cost per case basis for payment, although the parties were able to agree an 'indicative activity plan' and would then be obliged to notify each other if activity exceeded it. And, in line with the National Tariff rules, each year's contract provided that emergency admissions exceeding a local baseline figure from 2009 would only be reimbursed at 30% of tariff. The 2014/5 contract contained provisions specifically designed to allow the parties greater flexibility in pricing. The standard contract did not contain National Tariff pricing rules for mental health and the majority of community services, and in practice these were dealt with locally as block contracts.

The general scheme for incentivising improvements in quality and penalising failures remained the same in the national standard contracts from 2011/2 to 2014/5, although the details of the issues subject to such financial levers changed over time. The percentage of the provider's

turnover which could be paid under the CQUIN scheme increased from 1.5% of the overall contract value in 2011/2 to 2.5% in 2012/3, and subsequently.

The findings of the two national surveys and the three case studies can be considered together, as they reinforced each other. Most of the contractual relationships between NHS owned acute providers and commissioners were characterised by the use of general annual financial settlements outside the terms of the National Tariff rules and the contract. In other words, whatever detailed financial provisions had been agreed in line with the National Tariff, included in the contract and implemented during the course of the year, a final overall agreement was made at year end which did not adhere strictly to the contractual provisions. It was not always possible for commissioners to pay the full contractually designated amount for activity undertaken, as their budgets were not always sufficient. This behaviour appeared to be increasing over time. In 2014/15 a few commissioners reported having used the new pricing flexibilities in the contract at the beginning of the year. In addition, increasing numbers of commissioners and NHS acute providers were agreeing to abandon the national tariff and settle on a block contract (i.e. a fixed budget) in order to limit the financial risk to the commissioners. A range of techniques was used to agree prices for activity not covered by the national tariff. By 2014/5, increasing numbers of local contracts contained block contract provisions for these services, rather than any form of pricing for activity.

Block contracts were used in respect of CHS and MH services, in accordance with national contracting rules.

Financial incentives to improve quality contained in contracts were in widespread use. CQUIN payments were made to providers when earned, and penalties were often imposed. However, CQUINs were seen as time consuming to negotiate and monitor. There was concern that there were too many different CQUINs each year, and some areas had started to reduce the numbers used. The threat of financial penalties was useful. But not all commissioners withheld money from poorly performing providers.

Conclusions

Overall, the findings of the study indicate that retaining a national standard contract is advisable, as it can both ensure a degree of uniformity in respect of nationally important issues across the country, and reduce transactions costs involved in contract negotiation at local level. The provisions of the national contract need to be revised, however, both to take account of the changing situation in respect of the allocation of financial risk in local health economies and to improve the operation of financial incentives for quality.

Our findings indicate that it has not been possible for many local commissioners fully to use the terms of the NHS national standard contract to regulate their relationships with local providers. In particular, the pricing rules set out in the National Tariff and thecontract, do not seem to be appropriate in many circumstances, and are not always applied in practice. This has been recognised in the 2014/15 National Tariff and contract, where greater flexibility has been

permitted. Monitor and NHS England are reviewing pricing in the NHS and this will need to be reflected in more flexible provisions in the contract.

Although financial incentives may encourage quality improvements, the costs associated with implementing the current contractual regime may be too onerous. If payment for quality improvement and penalties for failure to meet targets is to be continued, the national system (and therefore the contract) needs to be stream lined and simplified, so that less effort to negotiate and monitor varying targets is required at local level.

As personal relationships are vital in facilitating local contractual relationships, policy makers should try to reduce the degree of organisational disruption at local level.

Acknowledgements

We would like to thank all the staff in the three case study sites who participated in the study and those who responded to our two national surveys. They generously gave us their time, many on more than one occasion. Without their co-operation, the study would not have been possible.

We are also grateful first, to Richard Dodds, Department of Health national lead on contracting, and later, to Alastair Hill, Senior Lead, NHS Standard Contract, NHS England, for their support at various stages of the research.

Needless to say, the views expressed in this report are ours.

Glossary

A&E	Accident and Emergency
AQN	Activity Query Notice: a notice setting out a query on the part of the Co-ordinating Commissioner or the Provider in relation to levels of Referrals and/or Activity
AQP	Any Qualified Provider. A list of accredited providers that NHS patients can use
Block contract	The NHS payment system used for CHS and MH services under which a healthcare provider receives a lump sum payment to provide a service irrespective of the number of patients treated
DH	Department of Health
CCG	Clinical Commissioning Group
CEDR	Centre for Effective Dispute Resolution: the independent body for setting dispute resolution cases between independent sector providers (including FTs) and commissioners
CHS	Community Health Services
CQC	Care Quality Commission: the regulator for quality of health care services in England
CQN	Contract Query Notice: a notice setting out in detail the nature of a query either by the commissioner or the provider in relation to performance or non-performance of a contractual obligation
CQRG	Clinical Quality Review Group: a regular meeting between commissioner and provider in which performance of quality issues included in the contract are monitored
CQUIN	Commissioning for Quality and Innovation: the performance incentive scheme set out in the contract
CSU	Commissioning Support Unit: NHS or external providers of commissioning support
DQIP	Data Quality Improvement Plan: an agreed plan setting out specific data and information improvements to be achieved by the Provider in accordance with the timescales set out in that plan
First Exception Report	A report issued in accordance with the standard contract General Condition 9.21 (*Contract Management*) notifying the relevant

	Party's Governing Body of that Party's breach of a Remedial Action Plan and failure to remedy that breach
FT	Foundation Trust
HRGs	Healthcare Resource Groups: standard groupings of clinically similar treatments which use common levels of healthcare resource
HSCA 2012	Health and Social Care Act 2012
Local Modification	A modification to a National Price where provision of a service by the provider at the national price would be uneconomic, as approved by Monitor in accordance with the National Tariff
Local Price	The price agreed by the Co-ordinating Commissioner and the Provider for a health care service for which no national price is specified by the National Tariff
Local variation	A variation to a National Price agreed by the Co-ordinating Commissioner and the Provider in accordance with the National Tariff
Monitor	The independent regulator of health care provision in England
MH	Mental Health
MRSA	Meticilin-resistant staphylococcus aureus
National Price	The national price for a health care service specified by the National Tariff
National Tariff	The national tariff in respect of each HRG as published by Monitor for each Contract Year
NHS E	NHS England. An executive non-departmental public body responsible for directly commissioning primary care and specialist services and overseeing the commissioning arrangements created by the HSCA 2012
PbR	Payment by Results: the payment system relying on national tariffs for certain HRGs
PCT	Primary Care Trust: commissioning bodies before the creation of Clinical Commissioning Groups under the HSCA 2012
QIPP	Quality, Innovation, Productivity and Prevention. A national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings.

RAP	Remedial Action Plan: a plan to rectify a performance failure under the Contract, specifying milestones for performance to be rectified and timescales within which those milestones must be achieved
RTT	Referral to Treatment Standards concerning time periods patients may wait from the time they are referred to the start of their treatment for Consultant-led Services,
SDIP	Service Development and Improvement Plan: an agreed plan setting out improvements to be made by the Provider to the Services and/or Services Environment (which may comprise or include any Remedial Action Plan agreed in relation to a Previous Contract)
SHA	Strategic Health Authority: the regional bodies overseeing commissioners and providers (non-FTs) before their abolition in 2013
SUS	Secondary Uses Service: an electronic system via which acute providers submit monthly activity data to commissioners

Introduction

Contracts were introduced into the NHS in the early 1990s as part of the internal market reforms, albeit that they were not legally binding (Allen, 1995). Initially, there was no standard form of contract and the written documents used by commissioners varied considerably (Allen, 2002). There is now a detailed form of standard contract made available by the DH for use by commissioners (DH, 2009). This form of contract was designed for use both with NHS Foundation Trusts and independent providers (in both of which cases it is legally binding), as well as with NHS Trusts (in which case it is not currently legally binding). The standard contract is evolving over time (Dodds, 2011), and a new form of standard contract incorporating core commercial terms and allowing for service specifications to be agreed at local level was introduced for use in April 2013.

The policy aim has been that one of the uses of contracts in the English NHS is not simply to allocate resources to providers, but as an instrument to improve services (DH, 2009). One of the relevant types of contractual mechanisms is a variety of clauses aimed at achieving specified quality standards and improvements. These quality standards are a mixture of national goals, regionally agreed goals (usually facilitated by the Strategic Health Authority (SHA) when SHAs were still in existence), and more localised agreements between commissioners and their providers. The DH introduced in 2009-10 a quality framework called 'Commissioning for Quality and Innovation' (CQUIN), which provided financial incentives to achieve specific quality targets (DH, 2008). DH guidance stated that, in addition to CQUIN, contracting parties can agree to include further financial incentives for quality improvements.

In addition to financial incentives, there are other financial levers (colloquially known as 'penalties') in the standard contract, and since July 2010, commissioners have been able to impose negative financial levers for breaches of nationally specified events (including 'Never Events') and other aspects of poor quality care. Local commissioners themselves can also negotiate additional negative financial levers to include in the contract.

The Health and Social Care Act 2012(HSCA 2012) made it clear that contractual relationships between commissioners (both clinical commissioning groups, CCGs; and the NHS Commissioning Board, now called 'NHS England' in its role as commissioner) and a range of providers (both NHS and independent) would continue to be essential to the structure of health services in England. Quality standards developed by NICE would inform commissioning and payment systems - thus contracts would continue to play a key role in improving quality of care. Moreover, as all NHS trusts were destined to become Foundation Trusts, all contracts in respect of health services would be subject to general contract law (rather than the specific provisions originally introduced with the internal market legislation in the early 1990s).

Although the HSCA 2012 envisaged that the Payment by Results (PbR) tariff would continue to be developed, it should be noted that many procedures were (and are) still not covered by the tariff. Thus, pricing and, through it, allocation of financial risk between purchasers and providers continues to be an important issue, which can influence the capacity of providers to improve the quality of care delivered. Pricing and allocation of financial risk will become

increasingly important as the NHS becomes subject to greater financial constraints in the next few years.

Despite the clear aims of policies concerning formal contractual mechanisms such as incentives, penalties, and pricing, difficulties related to contracting for health care services have been highlighted by researchers on the NHS since the introduction of the quasi-market reforms in the early 1990s (e.g. Petsoulas et al, 2011; Marini & Street, 2007; Allen, 2002, Allen et al, 2002;; McHale, J. et al., 1997; Hughes et al, 1997; Raftery et al., 1996; Flynn et al, 1996; Appleby et al, 1994; Roberts, 1989).

General economic and socio-legal theories of contract indicate that it will be difficult to specify and measure all aspects of care, and, thus the contract cannot be 'complete' (Williamson, 1985) or entirely 'discrete' (Macneil, 1978; Vincent-Jones, 2006). Theory indicates that even where aspects of performance could be measured, the form of contractual relationship which is likely to evolve will include elements of relationality (Williamson, 1985; Macneil, 1978), where the formal aspects of the contract are not always adhered to. Empirical research on contracting in commercial circumstances confirms this view (Macaulay, 1963; Beale and Dugdale, 1975). In particular, financial risk, which is formally allocated through pricing mechanisms, is likely to be dealt with by a range of methods, including *post hoc* adjustments to pricing, which may not be formally recorded as variations to contract. The extensive research on contracting for healthcare mentioned above (and also including research about other countries, such as Ashton, 1998, in respect of New Zealand, and Palmer and Mills, 2005, in respect of South Africa) has shown that indeed, contracts for health care tend to be based on relational norms, as well as varying degrees of 'discreteness'. The former may include trust and flexibility, and may well entail changes in the terms of the contractual relationship which are at odds with the written document signed by the parties. Recent research on NHS contractual governance which investigated the first few years of the standard contract (Petsoulas et al, 2011; Allen et al, 2014) shows that, as yet, in respect of incentives to improve quality of care, commissioners were not attempting to use contractual mechanisms in addition to the nationally mandated ones, and that in the event of a breach, not all of the financial levers available in the contract were being used. It also indicated that actual allocation of financial risk deviated in practice from that set out in the contractual documents, and thus national pricing rules were not always followed.

Previous research has also indicated that the notion of relational contracting is not the only conceptual framework which should be used to understand how contracting operates in the NHS quasi market. As Hughes and Dingwall (1990) and later researchers (e.g. Allen, 2002; and Petsoulas et al, 2011) show, the hierarchical nature of the NHS, in which many detailed policies are made at the centre and all local organisations are required to carry these out, remains a useful way of understanding how local commissioners and providers behave in the NHS. The two key topics of pricing and quality are mainly (although not entirely) stipulated in the terms of the standard contract which is produced at national level and compulsory for use in the NHS (Petsoulas et al, 2011).

These well known problems associated with contracting for healthcare indicate that research is required to investigate how the current policies to use contractual mechanisms including

financial levers to encourage quality improvement and current pricing rules acting to allocate financial risk are working in practice. It is quite possible that formal contractual provisions are not being adhered to. It is necessary to understand the relationships in order to see how effective the use of such formal mechanisms by commissioners can be. Research about contractual relationships as well as formal provisions in documents is particularly important in a time of change – Primary Care Trust (PCT) commissioners have been replaced with clinical commissioning groups (CCGs) and the effect of these changes on the personal relationships which facilitate contractual relationships may be crucial.

The research project

Overall aims

This three year project aimed to investigate how commissioners negotiate, specify, monitor and manage contractual mechanisms to improve services and allocate financial risk in their local health economies, looking at both acute services and community health care.

The research questions are:

- What is the range of formal provisions, including positive and negative financial levers in respect of quality of care in contracts across the English NHS? This will entail examining both the locally developed service specifications and the nationally mandated core contractual terms.
- How are contractual financial levers negotiated, specified, monitored and enforced in practice?
- How are prices set? In particular, how are prices for services not included in PbR negotiated?
- What payments are actually made to providers? How do these relate to the prices agreed at the outset?
- What are the effects of the use (or non use) of contractual mechanisms on service improvement and allocation of financial risk?

Research design and methods

Design

The project consisted of two aspects:

1. National surveys in 2012 and 2014 to find out what contractual mechanisms, including financial levers were being used in formal written contracts, and how they were implemented or not.

2. A series of three in depth case studies of three local health economies, looking at the contractual relationships between commissioning organisations and their providers of acute, mental health and community healthcare, and how these affect services delivered.

Methods

1. *The national surveys*

The first survey in 2012

Considerable effort was required to identify appropriate interviewees. Letters were sent by email to the four newly established SHA clusters in October 2011. Their help was requested in identifying local contracting leads who could be contacted to participate in the first telephone survey. Unfortunately, none of the SHA clusters was able to provide any contact information. Three main strategies were developed and used simultaneously to recruit participants to the survey.

First, the names and contact details of directors of contracting, directors of commissioning and their personal assistants were obtained from PCT websites and by telephoning PCT switchboards. There was a propensity for contact details to be provided for individuals working at a PCT cluster level, and so invitations were targeted at this level. For each PCT cluster, directors of contracting or commissioning were invited to participate in the survey by a telephone call to their personal assistant, followed by provision of information about the study by email. Thirty four PCT clusters were contacted using this method.

Second, after reviewing data from the first five interviews it was felt that interviewing contracting staff working below director level (e.g. senior contract managers), in addition to directors, would provide more detailed information on specific contracts and their application. PCT and PCT cluster websites generally did not contain the names of staff working at this level. However, it was possible to obtain the names of 17 contracting managers, including senior contract managers, from the professional social networking website LinkedIn. PCT clusters were then telephoned to confirm if these individuals were currently in post, and if so, how they might best be approached with an invitation to the study. Following this advice, further telephone calls were made and/or emails were sent to invite people to take part.

Third, participants were asked during telephone interviews if they would be happy to provide the names and contact details of contract leads responsible for managing the other contracts led by their organisation. Invitations were then sent to these nominated colleagues.

These efforts enabled us to interview 23 people (out of approximately 100 who were thought to be undertaking this role at the time) on the telephone between March and August 2012 (two early interviews took place in January-February 2012)*. Some of the interviews included discussion of more than one contract (e.g. the main acute, community health services, mental health and private elective ones locally). The following numbers of contracts were discussed:

Table 1: Numbers of contracts discussed

Type of contract	**Number of contracts discussed**
NHS Acute services	16 plus 2 in writing*
NHS Community health services	5
NHS Mental health services	4
For profit elective services	3
Total number of contracts	*30*

*In addition to the interviews, two PCTs elected to reply to the questionnaire in writing in August 2012.

A copy of the structured interview schedule used is attached at Appendix A.

Three researchers carried out the telephone interviews (CP, BR and PA), each of which lasted approximately one hour.

The second survey in 2014

We were fortunate that, in May 2014, Alastair Hill and his colleagues from NHS England were able to provide a list of potential interviewees in some CCGs and Clinical Support Units (CSUs) across England, indicating which people could be contacted by us. Not all of these people were prepared to be interviewed, so we extended our search for interviewees to other CCGs not included on the list. The latter category were contacted by careful searching of CCG websites and using the information on them to telephone and email the relevant commissioners to request interviews with them.

These efforts enabled us to interview 25 people on the telephone between June and August 2014**.**

Table 2: Number of contracts discussed

Type of contract	**Number of contracts discussed**
NHS Acute Services	23
Integrated Children's Services	1
Small Providers including Any Qualified Providers (AQPs)	1
Mental Health	1
Community services	2
Total number of contracts	*28*

A copy of the structured interview schedule used is attached at Appendix D..

The case studies

The case studies consisted of studying the processes of contracting using the NHS national standard contract, namely the negotiation, monitoring and enforcement of contracts made by commissioners in three local health economies with their local NHS providers of acute, community and mental health services. Selecting three case study health economies to investigate over a period of two years allowed us to understand the context in which the

contracting occurred, to take account of changes in that context over time, and to understand the effect of context on the processes of contracting.

We started contacting potential case study sites in spring 2011 (i.e. before CCGs became statutory bodies). The process of recruiting case study sites took a very long time due to the organisational turmoil that followed the Health and Social Care Bill of 2011 and the subsequent Act of Parliament which finally received Royal Assent in 2012. We initially contacted 14 PCTs and had a mixed response. Six PCTs responded that because of the organisational upheaval they declined to participate in the research. There was a protracted exchange of emails and phone calls during 2012 with the remaining PCTs. Four PCTs had to decline because the GPs, who were taking over as leaders of the new CCGs, did not agree to take part in the research. One PCT accepted but subsequently withdrew because of organisational changes. We lost contact with three CCGs because of changes in personnel. In April 2012, one case study agreed to take part and we started applying for Research Governance (RG) approval. After the approval was granted for both the commissioner and the provider in June 2012, we started observing meetings in September 2012. We observed a Clinical Quality Review meeting and a contracting workshop in September 2012. In November 2012, however, the new Chief Officer of the CCG, decided that the CCG would not be taking part in the research and this site had to be abandoned.

After initial contact in spring 2011, and repeated contacts with different members of staff, case study B responded in July 2012 that they agreed in principle to take part in the research. After obtaining RG approval, we started field work in November 2012. Case study A agreed to take part in summer 2012 and we started field work in November 2012. Case study C agreed to take part in January 2013. We started applying for RG approval which was granted in May 2013 and we started field work in August 2013. In case study A we were also granted access to the combined Community Health Service (CHS) and MH Trust. In case study C the acute trust was also the main provider of CHS. We were not able to gain access to the Mental Health Trust. In case study B, we were not able to gain access to either the CHS or the MH Trusts.

Overall, the case study research was conducted between November 2012 and November 2014.

The methods used in the case studies were analysis of documents, non-participant observation of contracting meetings and semi-structured interviews.

The documents we analysed included local commissioning papers, contracting meeting papers such as agendas and minutes, and documents setting out the locally agreed financial levers, such as CQUINs.

We interviewed personnel in commissioners and providers related to contracting: Contract managers, Directors of Finance, Directors of Performance and Quality Managers. We conducted 27 interviews and observed 21 meetings. (Details are in Appendix F). In case study A and B we were not able to observe any Clinical Quality Review meetings. In case study B we were not able to interview any commissioner clinical quality leads.

The purpose of the interviews was to gather rich data about the application of the contract which would not be possible to obtain by administering survey questionnaires. Although the survey interviews also permitted us to gain interesting data, the absence of contextual information and face-to-face interaction with the participants limited the depth of the findings. Case study interviews, by contrast, were informed by the contextual information gathered during observation of contractual meetings. Specifically, the purpose of observing a variety of contract meetings was mainly to experience contracting interactions in their natural environment to supplement the information we obtained from interviews with the parties, in particular the tenor of the relationships between the parties. In addition, observing meetings was intended to make us familiar with the prominent issues in each case study site so that we could explore these issues in depth during interviews. This triangulated approach enabled us to put together a broader and more reliable picture of our findings: the surveys helped us put the case studies within the overall national context, whereas the case studies enabled us to pursue our research questions in greater depth, informed by in-depth interviews, observation of contract meetings, and examination of local documents (including quality and performance indicators) presented and discussed at such meetings.

Data analysis was conducted with the help of the qualitative research software NVivo. CP and PA agreed the main themes derived from the research questions, the literature on contracting, and additional themes suggested by the data. These themes were subsequently uploaded in NVivo.

Timing and ethical approval

NRES approval for the study was obtained from NRES committee London – Wandsworth in August 2011 under number 11/LO/0685. LSHTM ethical approval was obtained in October 2011 under number 6054.

The actual study began in 2012, rather than 2011 as originally envisaged, due to the policy and research ‘pause’ imposed during some phases of the passage of the Health and Social Care Bill into law.

Relevant provisions in the NHS standard contracts

These provisions will be reported in two blocks, which correspond to the relevant years for the two surveys. The first block is in respect of the contract years 2011/12 and 2012/3. The second block is in respect of the contract years 2013/4 and 2014/5. These contract years are also relevant for the case studies.

The NHS standard contracts for 2011/2 and 2012/3

These contracts contained several provisions which were pertinent to the study.

Pricing and allocation of financial risk

The rules on how the national tariff prices are set for PbR are, of course, not part of the standard contract. Nor does the standard contract set out how any reduced tariff prices and non tariff prices are agreed locally.

a) The 2011/2 acute contract contains several provisions concerning allocation of financial risk

i) It allows the commissioner 'in its reasonable discretion' to refuse to pay the provider for activity which exceeds the amounts forecast. (Schedule 3, part 1, paragraph 6 – Financial adjustments for variations in activity.)

ii) A marginal rate of 30% of tariff is payable for emergency admissions over the agreed thresholds. (Clause 7.2, which refers to the PbR Rules.)

iii) Avoidable emergency readmissions need not be paid for by commissioners (Clause 7.25, which refers to the PbR Rules).

iv) In the event of specified failures to provide information about activity levels commissioners can with hold 1% of the monthly sum due to the provider (clause 29.12), although these must be reinstated once the information has been provided.

b) The 2012/3 standard contract contains similar provisions to those in the 2011/2 contract.

i) A marginal rate of 30% of tariff is payable for emergency admissions over the agreed thresholds. (Part E, Clause 7.2, which refers to the PbR Rules.)

ii) Avoidable emergency readmissions need not be paid for by commissioners (Part E, Clause 7.33, which refers to the PbR Rules).

iii) In the event of specified failures to provide information about activity levels commissioners can with hold 1% of the monthly sum due to the provider (Part E, clause 39.12), although these must be reinstated once the information has been provided.

(There is no provision in the 2012/3 contract to allow the commissioner to refuse to pay for excess activity, as was contained in Schedule 3, part 1, paragraph 6 – Financial adjustments for variations in activity – of the 2011/2 contract. This is due to the fact that the Cooperation and

Competition Panel ruled that commissioners could not place a cap on activity, as it restricted patient choice (CCP, 2011).)

CQUIN

a) In 2011/2 there were separate standard contracts for acute, community and mental health services.

The acute contract specified the CQUIN requirements in Schedule 18, part 2. The financial incentive amounted to 1.5% of Actual Out Turn Value (i.e. including tariff, non-tariff and cost per case income, together with the Market Forces Factor).

Two national goals were included – VTE and patient experience.

The parties were required to include locally agreed goals, and to state the weighting given to each goal in respect of the proportion of the entire CQUIN payment available.

b) In 2012/3 there is a single standard contract for all providers.

Section B part 9.2 contains the CQUIN requirements. This year, the financial incentive has been increased to 2.5% of Actual Out Turn Value.

In addition to the national goals concerning VTE and patient experience, two additional goals in respect of dementia and the use of the NHS Safety Thermometer have been included.

The parties are again required to include locally agreed goals, and to state the weighting given to each goal in respect of the proportion of the entire CQUIN payment available.

Sanctions for low quality

a) The acute contract for 2011/2 set out the quality requirements in Schedule 3, which included the 'financial adjustments' to be made in the event of failure to attain the required standards.

i) In respect of the 18 week pathway from referral to treatment standard, paragraph 8 of schedule 3 set out the 'adjustments', namely the percentage of elective care revenue to be deducted depending on the percentage by which the provider underachieved the standard. This amounted to 0.5% deduction for each 1% not achieved, up to a maximum deduction of 5%.

ii) In respect of the standard in relation to the reduction in the number of cases of Clostridium difficile, paragraph 9 of schedule 3 set out the 'adjustments', namely the percentage of total contract year revenue to be deducted depending on the percentage

by which the provider underachieved the standard. This amounted to 0.2% deduction for each 1% not achieved, up to a maximum deduction of 2%.

iii) In Schedule 3 part 4A, a series of quality requirements are listed for which local agreement must be made in respect of the level of sanctions. These include MRSA infections, E coli in the bloodstream, waiting times from referral to treatment, waiting times in A&E, cancellation of operations, failure to provide sufficient Choose and Book slots, delayed transfers of care and poor data quality.

Parties are invited to add other quality requirements to this list.

iv) In Schedule 3, part 4B, there is a list of nationally specified events breach of which triggers mandated sanctions as percentages of relevant income. These include various time limits for waits in respect of cancer referrals and eliminating mixed sleeping accommodation.

v) Clause 32 states that financial sanctions (2% per month to a maximum of 10%) can be imposed if the provider fails to agree to a Remedial Action Plan in respect of problems raised by commissioners in relation to quality; or if the provider breaches any plan which is agreed.

b) The standard contract for 2012/3 contains similar requirements in respect of low quality to those for 2011/2.

i) Section B part 8.4 contains similar provisions as 2011/2 in respect of the 18 week referral to treatment standard. (Also stated in clause 43 in section E.) In 2012/3 the 18 week standard applies individually to each specialty, and a penalty can be levied for a breach in respect of an individual specialty.

ii) Section B part 8.5 contains similar provisions as 2011/2 in respect of the reduction in cases of Clostridium difficile. (Also stated in clause 44 in section E.) The threshold at which a penalty can be levied has been lowered in 2012/13.

iii) Section B part 8.1 contains the quality requirements for which local agreement must be made in respect of sanctions. These now include some mental health requirements (e.g. number of new cases of psychosis served by early intervention teams, access to psychological therapies), as well as various ambulance response times and numbers of health visitors.

Parties are invited to add other quality requirements to this list.

iv) Section B part 8.2 contains nationally specified events similar to those in the 2011/2 contract.

v) Section E clause 47 contains the same provisions concerning Remedial Action Plans as those in the 2011/2 contract.

vi) Section B part 8.3 lists 25 Never Events. There are no actual sanctions, instead the provider will not be reimbursed for the original procedure nor any corrective care.

Relevant provisions in the NHS standard contracts 2013/4 and 2014/5

The NHS standard contracts for 2013/14 and 2014/15 contained several provisions which were pertinent to the survey. Changes had been made to some of these provisions since the first survey was undertaken in respect of the standard contracts used in 2011/12 and 2012/13.

The 2013/14 standard contract was configured differently from previous years. It consisted of three sections: the Particulars (where customised elements of the contract were recorded), the Service Conditions (containing standard terms about the services themselves, indicating which types of services they applied to) and the General Conditions (containing standard terms for all services). This configuration has been continued in 2014/15.

Pricing and allocation of financial risk

As in the earlier period (2011 to 2013), the rules on how the national tariff prices are set are not part of the standard contract. Nor does the standard contract set out how any reduced tariff prices and non tariff prices are agreed locally.

This continued to be the case in respect of the 2013/4 standard contract, which refers expressly to 'Permitted Variations to Tariff' as being those agreed between the Co-ordinating Commissioner and the Provider in accordance with the PbR Rules, the latter being set by the Department of Health (GC Definitions section).

a) The 2013/4 standard contract contains provisions concerning the allocation of financial risk.

i) The parties may agree an Indicative Activity Plan (SC 29), which sets out the anticipated indicative activity and specifying the threshold for each activity for the contract year. This is neither a guarantee of activity nor a cap on activity. The thresholds are meant to act as a trigger for discussion about changes to activity as set out here. Either party is required to alert the other if there are unusual changes to activity or referrals, and either party can issue an activity query notice. This leads to a joint activity review, activity management plan or utilisation review. An Activity Management Plan can be agreed after these processes, under which methods for reducing activity during the contract year can be set out. (But this plan must not restrict patient choice in any way.)

ii) The parties may also agree a Risk Share Agreement (SC 29.28) (to be set out in Schedule 3, Part C of the SCs) under which the parties have agreed in advance how the costs and consequences of over or under performance will be apportioned, but this must be in accordance with the national PbR code of conduct and guidance. This means it can only be used during a period of significant service design, and not otherwise.

iii) A marginal rate of 30% of tariff is payable for emergency admissions over the agreed thresholds. (Part E, Clause 7.2, which refers to the Payment by Results Rules. These are set out in Monitor's document, '*Payment by Results Guidance for 2013/4'*. The relevant rules are in para, 89-109.

iv) Avoidable emergency readmissions need not be paid for by commissioners (Part E, Clause 7.33, which also refers to the Payment by Results Rules (see above). The relevant rules are in para 137.

In the 2013/4 contract, in the event of specified failures to provide information SC28.12 sets out penalties which can be levied by commissioners, which may amount to a maximum of 1% of contractual sums payable in each month in which the information is not provided.

b) The 2014/5 standard contract continues many of the provisions of the previous year in respect of allocation of financial risk.

i) The Indicative Activity Plan and consequential escalation of the 2013/4 contract remains.

ii) However, the provision for a Risk Share Agreement in the 2013/4 contract has been removed. Instead, any such agreements should be recorded as Local Variations.

iii) In the 2014/5 contract for the first time, it is possible for contracting parties to apply to Monitor in advance to vary national prices. Clause SC36 makes allowance for these pricing flexibilities (Local Modifications and Local Variations) and Schedules 3B and 3C allow parties to record these. (The term 'Payment by Results' has been replaced with the term 'National Tariff'.)

The details concerning these variations are set out in Monitor's document, '*2014/5 National Tariff Payment System'*:

"Local variations
Local variations can be used to agree adjustments to prices or currencies where it is in the interests of patients to support a different service mix or delivery model. This includes cases where services (at least one of which has a national price) are bundled. Local variations must be agreed by both commissioners and providers. They are intended to allow both parties to innovate, redesign services or incentivise a different service mix in a way that delivers better value for patients.

Local modifications
Local modifications are intended to ensure that services are delivered where patients require them, even if the cost is higher than the nationally determined price.
Local modifications can be used by commissioners and providers to agree increases to nationally determined prices (without changing the currencies) in cases where the provider faces unavoidable, structurally higher costs that make the provision of specific

services uneconomic at those prices. If agreement is not possible, in limited circumstances a provider may apply to Monitor for a local modification." (p 14).

"Local modifications are distinct from local variations. Local variations allow providers and commissioners to vary national prices and/or related currencies and this may involve increasing or decreasing national prices or changing a currency with a national price. Local variations must be agreed by commissioners and providers and must be published by commissioners, but do not require approval by Monitor to have effect. By contrast, local modifications can only be used to increase the price for an existing currency or set of currencies, and must be approved or granted by Monitor." (p. 139).

iv) In the 2014/5 contract for acute providers, the Marginal Rate Emergency rule has been amended. SC 36.21 allows the parties to agree a baseline value for emergency admissions, above which the marginal payment rate of 30% applies. The starting point is still the 2008/9 baseline, but the parties can vary this if they can show there is a good reason, such as changes in patient flows. (Guidance on this is set out in the document, '*2014/5 National Tariff Payment System'*, paragraph 2.3.4 on page 38)

v) Moreover, SC 36.22 now allows the parties to agree the threshold above which emergency readmissions will not be reimbursed.

CQUIN and other incentive schemes

a) The 2013/4 contract sets out (Particulars, Schedule 4, Part E) that the total amount of the financial incentive to be promised by commissioners in respect of CQUIN is 2.5% of the annual contract value.

National goals are included – Friends and Family Test, NHS Safety Thermometer, Dementia and VTE.

In the 2013/4 contract (Particulars page 12), the parties are invited to, but not obliged to enter into a local quality incentive scheme.

b) The 2014/5 contract does not set out a total amount of the financial incentive in respect of CQUINs. However, the NHS E *Commissioning for quality and innovation (CQUIN): 2014/15 guidance* makes it clear that the total amount of financial incentive should once again be a maximum of 2.5% of annual contract value.

For the first time, the 2014/5 contract (SC 38.15) allows the parties to vary or disapply any national CQUIN.

Sanctions for low quality

a) *In the 2013/4 contract* there are various sanctions for low quality

i) GC 9.23 provides that financial sanctions (2% per month to a maximum of 10% of the contract value) can be imposed if the provider fails to agree to a Remedial Action Plan in respect of problems raised by commissioners in relation to quality; or if the provider breaches any plan which is agreed.

ii) An extensive list of quality requirements is set out in Schedule 4 to the Particulars, each with different financial sanctions applicable in the case of breach by the provider.

- The first section (A) relates to Operational Standards (which are derived from the NHS Constitution), including the 18 week pathway, A&E waits and cancer waits. Part G contains details of the financial sanctions for breaches of the 18 weeks standard (a maximum of 5% of revenue from the relevant specialty can be deducted).
- Section B relates to National Quality Standards (set through NHS Commissioning Board Planning Guidance), such as C Diff rates, MRSA, ambulance hand over times at A&E, cancelled operations, trolley waits in A&E. Part H provides a formula to calculate the deductions in respect of breaches of the C Diff standards.
- Parties may include local quality requirements in part C of this schedule. Sums calculated in respect of local quality requirements may not exceed 1% of the annual contract value.
- Part D of the schedule contains a list of Never Events, and sets out the penalties for these (which mainly consist of withholding payment for the relevant treatment and no charge being levied for treatment to remedy the mistake).

iii) *In the 2014/5 contract* the Quality Requirements are set out in Schedule 4 to the Particulars and broadly resemble those for 2013/4. They have been updated to include some additional requirements (including completeness of NHS number, completeness of ethnicity data for mental health services and completeness of outcome data for IAPT). Moreover, the financial consequences have been revised in many cases.

It is now made explicit that the sanctions for breach of all Quality Requirements in Schedule 4 are limited to a maximum of 2.5% of actual quarterly value in any quarter.

Moreover, the application of sanctions can now be varied by local agreement (SC 37.6).

Disputes

Changes were made to this aspect of the standard contract since 2012/13.

The 2013/14 contract provides in GC 14 that contractual disputes must be first subject to mediation. The form of mediation varies depending on the parties: where NHS owned providers are concerned, the mediation will be arranged by the NHS Trust Development Authority and the NHS Commissioning Board; whereas mediation in respect of independent

providers will be undertaken by the Centre for Effective Dispute Resolution (CEDR) or other independent mediation body approved mediators.

If the mediation fails, the dispute goes to expert determination (the expert being found by CEDR), and the expert's decision is final.

No rules (e.g. pendulum arbitration) about the way in which the mediator or expert must make their respective determinations are set out in the 2013/14 contract.

These provisions are continued in the 2014/15 contract.

The key provisions of the standard NHS contracts over the period of the research are summarised in table 5 below.

Table 5: **Key changes to NHS contracts 2011-2015**

Themes	**2011-12**	**2012-13**	**2013-14**	**2014-15**
Pricing and allocation of financial risk	• Commissioners can refuse to pay for activity that exceeds the amounts forecast. • A marginal rate of 30% of tariff for emergency admissions over the agreed thresholds • No need to pay for avoidable emergency readmissions • Commissioners can withhold temporarily 1% of the monthly sum due to a provider for failure to provide information about activity levels	• The provision that commissioners can refuse to pay for activity that exceeds the amounts forecast is removed in order to prevent capping activity and restricting patient choice**.** • The parties may agree an Indicative Activity Plan and monitor it throughout the year. • The parties may agree a Risk Share Agreement to be used in periods of major service redesign. • A marginal rate of 30% of tariff for emergency admissions over the agreed thresholds • No need to pay for avoidable	• The parties may agree an Indicative Activity Plan and monitor it throughout the year. • The parties may agree a Risk Share Agreement to be used in periods of major service redesign. • A marginal rate of 30% of tariff for emergency admissions over the agreed thresholds • No need to pay for avoidable emergency readmissions • Commissioners can withhold temporarily 1% of the monthly sum due to a provider for failure to provide information about activity levels	• The provision for agreeing an Indicative Activity Plan remains • The provision for agreeing a Risk Share Agreement is removed. Such agreements to be recorded as Local Variations. • For the first time since the introduction of the contract, the parties can choose to agree to vary national prices after having been granted permission from Monitor. • Parties can agree to vary the baseline value for the 30% marginal

		emergency readmissions • Commissioners can withhold temporarily 1% of the monthly sum due to a provider for failure to provide information about activity levels		rate tariff for emergency admissions, if they can show there is a good reason for this. • The parties are allowed to agree the threshold above which emergency readmissions will not be reimbursed.
CQUIN	• A maximum of 1.5% of the actual outturn value of the contract • Two national targets (VTE and patient experience) • Parties required to agree local targets and stated weighting for each target	• A maximum of 2.5% of the actual outturn value of the contract • Two additional national targets (Dementia and NHS Safety Thermometer) • Parties required to agree local targets and stated weighting for each target	• A maximum of 2.5% of the actual outturn value of the contract • Like in previous years, a number of national quality goals/targets are included. • The parties can also choose to agree a local quality incentive scheme.	• A maximum of 2.5% of the actual outturn value of the contract • Like in previous years, a number of national quality goals/targets are included. • For the first time, the parties are allowed to vary national CQUINs. • The parties can also choose to agree a local quality incentive scheme.

Sanctions for low quality	• 18 week target: 0.5% deduction for each 1% not achieved, up to a maximum deduction of 5%. • CDiff: 0.2% deduction for each 1% not achieved, up to a maximum of 2%. • Targets for which local agreement is needed in respect of level of sanctions: MRSA, E coli, RTT waiting times, A&E waiting times, cancelled operations, Choose and Book, delayed transfer of care, and data quality. • Nationally specified events which trigger sanctions as percentages of income e.g. waits for cancer treatment, mixed sleeping accommodation. • Failure to agree or breach of a RAP: deduction of 2% per month	• The 18 week target applies individually to each specialty and penalty can be levied for a breach in respect of an individual specialty. • CDiff: similar to 11/12 but the threshold at which a penalty can be levied is lowered. • Targets for which local agreement is needed in respect of level of sanctions: similar to 11/12 with added ones for mental health, ambulance response times, and numbers of health visitors. • Nationally specified events: similar to 11/12. • RAP: similar to 11/12. • Never events: similar to 11/12.	• A list of operational standards is provided, which includes the 18 week target: a maximum of 5% of revenue to be deducted for any relevant specialty. • A list of national quality requirements is provided, including a formula to calculate deductions for breaches of the CDiff standards. • Provision for parties to include local quality requirements up to a maximum of 1% of the annual contract value. • A list of never events is included with terms similar to previous years.	• Similar quality requirements to 13/14, but with revised financial consequences in many cases. • It is now made explicit that sanctions for breaches of all quality requirements should not exceed 2.5% of the actual quarterly value in any quarter. • For the first time, the parties are allowed to vary the application of sanctions by local agreement.

	to a maximum of 10%. • Never events: the provider will not be reimbursed for the original or any corrective procedure and care.			
Dispute resolution	• If a dispute is not resolved in the 'negotiation period' (15 operational days after initial submission), the dispute is submitted for mediation. • Mediation: for NHS providers, mediation should be arranged by the relevant Strategic Health Authority. For independent providers, it should be undertaken by the Centre for Effective Dispute Resolution (CEDR). • If the dispute is not settled through mediation it shall be referred to independent binding pendulum	• The provisions are similar to 11/12	• First step should be mediation: for NHS providers, mediation should be performed by the NHS Trust Development Authority and NHS Commissioning Board (renamed NHS England). For independent providers, it should be undertaken by an approved independent body e.g. CEDR. • If mediation fails, the dispute goes to expert determination (the expert to be appointed by CEDR) and the decision is final.	• The provisions are similar to 13/14.

	adjudication undertaken by a panel appointed by CEDR or by another pre-agreed independent body. The decision in independent binding pendulum adjudication has to be wholly in favour of one of the parties in dispute.			

The two national surveys of contracting

As explained in the section concerning the relevant provisions of the standard contract, the nationally mandated documentation evolved during the period of the study, as did other national policies and also the financial context of the NHS. We undertook two surveys in 2012 and 2014 to find out from commissioners how financial risk and financial incentives were handled in practice. The second survey also dealt with a range of other questions specifically requested by NHS England to aid their development of the new model of contract for 2015/6.

The first survey in 2012

Aims

The aim of this survey was to find out from those involved in contracting on the commissioning side:

- how non tariff prices were calculated in 2011/12 and 2012/13;
- how financial risk was allocated in practice in 2011/12
- what financial levers for quality were being inserted into contracts in the two financial years 2011/12 and 2012/13;
- how those financial levers were used in practice in 2011/12;

In view of the changes in commissioning from PCTs to clinical commissioning groups led by GPs, we also asked about the involvement of GPs in the contracting process.

Findings from the first survey

Pricing and allocation of financial risk

Mental health and community health services

During the two contracting years covered by the survey PbR did not apply to mental health or community health services, so other methods had to be found to set prices. All the mental health and community services commissioners told us that they were still using block contracts, mostly with cost and volume elements over certain levels of activity.

In 2012/13, the starting point for negotiations was that value of this block contract had to be reduced by 1.8% in line with the instructions in the Operating Framework (2012). Some commissioners were experimenting with using regional and national reference costs as the basis for negotiations. Others were asking their providers to produce activity schedules, and even attempt estimating local unit costs. In one mental health contract, the parties were using *shadow* PbR prices alongside the actual block contract to see how these would work. In addition, many had agreed productivity improvements which translated into reducing the block

amount payable. Examples of productivity improvements include increasing efficiency in provision of corporate services for community health services which were being merged with an existing FT (saved £1 million); closing whole inpatient mental health wards; more appropriate care for individual patient placements in mental health (risks and savings shared with the provider, which was managing this).

Reporting on the actual allocation of financial risk for the contract year 2011/12, commissioners stated that the amounts in the block contracts were actually those paid to providers. There was one exception where a mental health provider had been given the budget to manage in order to provide more appropriate care for individual patient placements (as referred to above under productivity improvement). In this case, the provider overspent and the commissioners also reimbursed this amount.

Acute services – private providers

The prices for care from private providers of elective care were set almost entirely using the national tariff set out in PbR. In the case of one private hospital, the ultra sound price was an historically agreed local cost per case tariff.

Reporting on the actual allocation of financial risk for the contract year 2011/12, commissioners stated that they had simply paid the PbR tariffs according to the activity reported to have been carried out by the private provider. One commissioner pointed out that there was a problem ensure that the PCT was not paying twice for the same activity. This could occur because some work goes directly to private provider, and some is referred to it via the local NHS Trust. As the PCT already pays for the latter under its contract with them, they monitor carefully to make sure they are not paying the private provider directly for the same patients.

Acute services – NHS hospitals

For the contract year 2012/13, all the commissioners in the survey had agreed local tariff prices for services not included in PbR. These comprise a significant proportion of the total contract amount (30% in one case). The starting point for setting these prices was usually the price from the previous year, reduced in accordance with current national guidance (1.8%). Several commissioners also used national and regional reference costs as a starting point for negotiation. At least three commissioners had agreed block amounts for the non PbR elements of their acute contracts, basing the amount on last year's, reduced by the nationally mandated deflator. One commissioner had agreed to marginal rates for some non tariff activity (e.g. critical care, radiology, direct access pathology), meaning they only pay 30% of the full price for any growth in activity. Similar approaches were reported for the contract year 2011/12.

For the contract year 2012/13, some commissioners reported agreeing to variations to the PbR tariff at the beginning of the year in the sense that in at least two cases a block contract has been agreed instead:

'Although for this year we have a 'fixed financial value' contract, we are still monitoring the contract and going through the processes as if it were a PbR contract. But we really have suspended the method of PbR payment for this year. We cannot afford spending to continue growing year on year.'

No commissioners reported having negotiated different tariffs for specific services.

However, several reported having agreed to apply marginal rates for over performance at the end of the year. Moreover, several commissioners were attempting to encourage providers to reduce their rates of activity. For example, contract contain provisions stipulating reductions in the ratio of new to follow up outpatient visits and/or in the numbers of consultant to consultant referrals.

In respect of the contract year 2011/12, most of the commissioners reported paying the providers the amounts stipulated in the contract in respect of activity (or in accordance with the block contract or activity cap agreed instead). However, three of the commissioners explained that the contractually specified sums had to be re-negotiated in the light of the respective financial positions of the commissioning organisation and the trust at the end of the year. In one case, the PbR based out turn would have come to £120m, but the trust was only paid £116m. In another, although a cap on elective activity had been agreed in advance, the commissioners ended up paying for some of the over performance. In a third case, the negotiation was concluded based on the commissioners' financial position, irrespective of the provisions of the contract:

'It's calculated based on what we can afford and is agreed between the two Directors of Finance in March. And we don't know the difference between that payment and the technical outturn of the contract for another six weeks after the deal is done.'

Summary of findings concerning pricing and allocation of financial risk

Financial risk is still mainly allocated by block contracts for mental health and community health services. PbR works well for elective care delivered by private providers. Significant amounts of acute activity are not covered by PbR, and the remuneration for these tends to be block, with the commissioners trying to use national and regional reference costs to help reach agreement. In some areas, it has become increasingly difficult to use PbR and national tariff prices as these do not seem to be affordable for commissioners, while in others PbR is being used successfully.

Use of financial levers to improve quality

CQUIN incentives

We asked interviewees to send us their CQUIN schedules for 2011/2 and 2012/3, but not all of them were able to do so. The following table gives details. Most of these were in respect of acute care. There was one CQUIN schedule for each provider.

Table 3: Numbers of CQUIN schedules received

Type of contract	**Number of CQUIN schedules 2011/2**	**Number of CQUIN schedules 2012/3**
NHS Acute services	13	19
NHS Community health services	4	4
NHS Mental health services	1	1
For profit elective services	2	2
Total number of CQUIN schedules	*15*	*26*

Appendix B sets out the goals used in the schedules, showing how frequent each topic was in our data set. The two contracting years are shown separately, as are the types of provider. All contracts contained quality measures agreed locally, as well as the national ones. We can see that a very wide range of quality measures were chosen, and many only in one contract.

We asked the commissioners about the operation of the CQUIN requirements in practice. They all confirmed that staged payments were available for appropriate measures, so that providers would be encouraged to achieve at least some proportion of the relevant improvements, even if they were not able to reach the full goal. In respect of the contract for 2011/12, seven of the commissioners reported that one or more of the local quality requirements had not been met, and they withheld a proportion of the money in accordance with the contractual provisions. This ranged from withholding 35% of the possible payment to 10% depending on the level of achievement by the trust.

Moreover, eight commissioners reported that they had withheld part of the payment for failure to achieve all of the national CQUIN requirements. The sums with held were substantial in some cases. In respect of one acute contract totalling approximately £475m, £600,000 was withheld in respect of failures in the area of cancer services performance, and £1.2m in respect of failures in the area of patient experience.

Sanctions for low quality

We also asked interviewees to send us their quality schedules to indicate which additional low quality issues had been agreed at local level would be subject to financial sanctions. Few interviewees were able to do this. The details are set out in the table below:

Table 4: Lists of local penalty schedules provided

Type of contract	Number of penalty schedules 2011/2	Number of penalty schedules 2012/3
NHS Acute services	5	5
NHS Community health services	1	1
NHS Mental health services	1	1
For profit elective services	2	2
Total number of penalty schedules	9	9

Appendix C sets out analyses of the types of locally agreed penalties, including the financial consequences of breach. Along with our findings from the interviews, these indicate that at least two of the commissioners have agreed in advance not to impose penalties in the event of breach of a local quality requirement – they plan to insist on remedial action plans if necessary and to pay the money to the providers in order to carry these out.

We asked the commissioners about the operation of the financial penalties in practice. First we asked whether any remedial action plans had been put in place in 2011/2. There was a widespread use of remedial action plans in at least 10 contracts, mainly acute, but also community and mental health services. These were drawn up in respect of problems including for example, those concerning mixed sex accommodation, cancer service standards, stroke care, several in respect of the four hour wait in A&E, and several in respect of the 18 week wait for elective surgery. In nine cases it had been necessary to impose penalties either for failure to provide one, or, if provided, to carry it out adequately.

But not all commissioners thought that imposing penalties was the best way to achieve improved performance from their providers. Two commissioners thought that the monetary value of some penalties was insignificant to their providers. On the other hand, the accountability process (i.e. getting the provider to acknowledge a breach and work on an action plan) was still considered to have some effectiveness in improving performance. For example:

> *"We prefer to have more constructive relationships with the provider. In terms of some of the amounts involved, it's better to work constructively with them, you see what I'm saying. It's just not worth it if it's £5,000."*
>
> and
>
> *"Two grand, five grand, it's trivial [...] So it's about the process of embarrassing them into having had a performance failure, the money's not a motivator to an FT, certainly at that level."*

One commissioner was aware of the broader nature of his relationship with the providers, as well as the time consuming nature of imposing penalties:

> *'Part of contracting is not just about using the contract itself. It's also about the relationship building with those providers. You need to think about how we actually*

manage the relationship as well. So in some ways, it needs to be tempered. The best way to maybe try and resolve things, depending on how serious the breach is. There may be mitigating reasons, [...] But also, with the staffing that we have now, it's harder to develop those relationships as much as you would like to, because you haven't got the time to do it. If you're doing it for one, you should be doing it for all, and it's a lot of staff time."

And it should be noted (as already mentioned and set out in the relevant appendix) that some of the commissioners had agreed in advance that money would be reinvested in improvement plans.

Some of the commissioners raised an issue about timing of payment and information receipt. Although the final payment in respect of the contractual year was due to be made at the end of the financial year (i.e. in April of the following year), not all of the performance data were available at that point, so the full extent of provider performance was not known. Some data were not available until late May in the following year, in fact.

The answers of the commissioners to questions about the extent to which contractual financial levers in respect of quality were used in practice should be understood in conjunction with their answers to questions about how financial risk was allocated overall, as reported in the previous section of this report. There are several cases where, although the commissioner reported imposing financial penalties or with holding CQUIN payments, the manner in which the total payment to the provider was finally agreed was based on a general negotiation. The best that can be said in those cases is that the quality performance of the provider was one of the factors taken into account in that negotiation.

Contractual disputes

We also asked commissioners a more general question about contractual disputes to find out how any problems in respect of activity and/or quality were dealt with. Two commissioners reported formal disputes, and several commented that they were discouraged from letting disputes get this far. In the case of one formal dispute, the SHA was asked to adjudicate on differences over coding and counting non PbR activity. The SHA made a series of decisions, some of which were in favour of each party, and some 'split the difference'. Another dispute about A& E admission rates went to independent arbitration, and the arbitrator found in favour of the commissioner. This meant that there was a reduction of approximately £2m (on a total contract value of £85m) in costs to be borne by the commissioner.

Summary of findings concerning financial levers

All contracts contained locally agreed financial penalties and incentives. In many cases, there were deficiencies in quality which led to penalties having to be imposed, or to some of the financial incentives being withheld. Not all commissioners used the financial levers available to them, however.

Involvement of GPs in contracting

In view of the ongoing development of CCGs, we took the opportunity to ask commissioners who were not GPs about the current extent of GP involvement in contracting.

All of the commissioners reported that GPs were keen to be involved in contracting. Current involvement varied. Some GPs attend contracting negotiation and monitoring meetings, while some wish to discuss the major issues in contracts separately with the commissioners, rather than attend the actual meetings with the providers.

At one extreme, a commissioner commented:

> *'They have attended meetings but they find them tedious and very little value. But they are still finding their feet. Agreeing the financial value and affordability was led by the Directors of Finance.'*

A more common response is that GPs are particularly interested in quality issues, and some are prepared to look at the monitoring data to check on activity levels as well. GPs are starting to take the lead on general strategy and commissioning intentions. In a small number of contracts, the GPs were taking an active role in finance, but this is expected to increase over time.

> *'We would report to them on the monitoring but they were very involved in the negotiation of the contract. But they were not as involved when it came to the conversations about money. Those two at least now have a very good understanding of the process and the difficulties of it etc. Their clinical input adds a lot of weight at the negotiation process. But at the end of the day the final deal comes down to the directors of finance or the chief executives talking.'*

And some GPs are already picking up the financial aspects of contracting:

> *'CCGs are certainly involved in contract monitoring. They take an active interest in the financial elements of the contract as well as the clinical. For example, they pick up on things such as if the trust is referring patients for diagnostic tests, and they're being billed as outpatients.'*

Conclusions from the first survey

Commissioners are using formal contractual provisions to improve quality and allocate financial risk, where possible.

Our first survey of contracting staff shows that widespread use is being made of contractual provisions in respect of financial incentives to improve quality, and that there are certainly deficiencies in quality which require to be remedied. Many commissioners used performance management processes (i.e. performance notices and remedial action plans). There seems to be

a general enthusiasm among commissioners to use financial penalties, but, in practice, some do not find it possible to withhold money from providers, as this is likely to exacerbate the performance problems. Others did not think it was constructive to impose financial penalties.

On the other hand, some commissioners are experiencing difficulties in using contractual provisions to allocate financial risk overall. This appears to be because some commissioners do not have large enough budgets to pay for the total amount of PbR activity being carried out by providers. The parties are starting to agree ways of dealing with this problem, including using block contracts and limits on activity levels paid at full tariff. As budgets become constrained, it is likely that these practices will increase.

Our later case study field work and second survey in 2014 have enabled us to find out how these issues were dealt with as financial stringency bites across the NHS.

The second survey in 2014

Aims of the second survey

The aim of this second survey of commissioners was to find out from those involved in contracting on the commissioning side:

- how non tariff prices were calculated in 2013/14 and 2014/15;
- how financial risk was allocated in practice in 2013/14
- what financial levers for quality were being inserted into contracts in the two financial years 2013/14 and 2014/15;
- how those financial levers were used in practice in 2013/14;

We were also asked to find out about a range of other specific issues concerning the use of the 2014/15 and 2013/14 standard contracts by Alastair Hill, Senior Lead, NHS Standard Contract, NHS England.

Findings from the second survey

Use of national contract for small providers

In most cases, the standard national contract was now being used, or existing providers were being moved onto it. (Although in two CCGs, the smallest relationships (under £20k) were being kept as grants instead.)

The types of provider with which the standard contract was now being used included for profit cold surgery centres, providers of AQP services (e.g. podiatry), GP practices offering old LES services and third sector providers.

Some commissioners found the format of the contract useful for these smaller providers, and thought that some aspects were particularly useful, such as CQUINs.

But several others took the view that the contract was somewhat over detailed for small providers, and some of the provisions were inappropriate. For example, for a small independent cold surgery provider, the provision about 7 day working was not necessary, and something different had been substituted. Another commissioner noted that they simply left some provisions in the contract blank, if they were not appropriate. Two commissioners noted that the smaller providers were finding the standard contract difficult to deal with, as it was so long and detailed, and they did not have the resources to comply with the reporting requirements. Several commissioners suggested that a shorter standard contract for small providers would be useful.

Another commissioner of mental health services remarked:

> *"The contract does not work well for small providers. There are a lot of quality and operational requirements that do not apply to small providers.[...] We would like to see a*

fit for purpose contract for small providers, retaining sufficient rigour, something between a grant agreement and the standard contract. There should also be a recognition that not all voluntary sector small providers provide a health service which means the quality requirements do not apply. We would like one contract but with the flexibility to leave out things that do not apply."

Several commissioners noted that using the national standard contract at local level for AQP services was too cumbersome and time consuming, as there were many AQP providers in each local health economy. One commissioner suggested having AQP services contracts managed at national level instead.

Contracts for longer than one year

Many commissioners were taking advantage of the possibility of entering into contracts for longer than one year. For example several CCGs had made two year contracts with their main NHS acute and community trusts. The reasons given for doing this were in two main categories: first, this reduced the amount of work needed in respect of contracting on an annual basis (although some provisions will need to be adjusted each year); and secondly, a longer contract increased the certainty about the future financial position for the CCG and the provider. The latter included a range of situations, such as one where a local community trust was going to apply for FT status and needed to be able to demonstrate financial stability to Monitor. On the other hand, in another CCG, the CCG itself was keen to make a longer contract in order to cap its financial liabilities for longer, and thus try to keep the local health economy in balance.

We asked commissioners how they were going to deal with pricing for future years on the contract. In respect of acute care, some stated that this was not a problem, as the national tariffs for PbR activity for the relevant year would apply. However, others stated that they would have to renegotiate activity and prices each year in order to ensure that the overall sum was not too high. (See below for more discussion of allocation of financial risk.)

In one case, the CCG had entered into an alliance contract with a consortium of providers of community services. The head, alliance, contract was for seven years, and was in addition to the standard NHS contracts signed with each provider in the alliance. (See below for a discussion of the financial risk characteristics of the alliance contract.) The reason for entering into a seven year contract was that it gave the providers time to carry out the changes required and for them to absorb the costs required to do so. It should be noted that this contract also included a one year notice period and some aspects of annual renegotiation.

All the respondents were keen to move to longer term contracts, mainly about three years in duration, when appropriate locally.

However, some commissioners had stuck to one year contracts because they were planning large scale change in the local health economy and needed the flexibility in their relationships with their local acute providers.

The e-contract

We asked commissioners how useful and easy to use they found the e-contract for 2014/5. Although they thought it was a good idea in principle, most of them were not happy with how it worked in practice and reported that it was still difficult to use. The help desk was not responsive, it was not certain that amendments would in fact be saved on the system, and it was not always possible to access the system to make amendments in any event. Other problems mentioned were: not enough people in the CCG could have access to the electronic version at once; accessing embedded documents was difficult; uploading documents was difficult; making amendments for small providers was not possible; and it could not be used for a variation to the contract. Most reported having resorted to Word versions of the contract.

For example, one commissioner said

> *It was dreadful. It didn't work to begin with and in general it kept going down. For example just before signing it, the Trust said 'yes, we will sign it if you do this adjustment' and we couldn't get into the adjustment. I'm not a big fan of it. It could be good and it should be but I think it is cumbersome and unreliable. I like having it electronically but as long as it works.*

All commissioners said that the next version needed to be available in September/October 2014 to be useful for contract negotiations for 2015/6. Another suggested that the timetable for training to use the new version should also be brought forward to the autumn of 2014.

New contractual provisions on staffing

We asked commissioners their views on the new provisions in the 2014/5 contract on staffing, being reporting requirements (GC5).

They all said it was too early to say how useful it would be in the medium term, but they welcomed the provision.

One interviewee pointed out that they did not have access to the HSCIC records, which they found frustrating when trying to monitor staffing levels. Another said that the clause was not appropriate for non-acute services, and that they were agreeing a variation to it.

Feedback on the 2014/15 standard contract

We asked interviewees to give us general comments on the 2014/15 standard contract. A very wide range of views was expressed.

Several were happy with it. They noted that it allowed greater flexibility for large providers.

> *I like the contract, I think it is good and I think we should change it to an absolute minimum. Although the changes made this year were absolutely good, they gave us more stuff on*

audit, which we can do at any point, the sanctions are very clear although I don't think they are used very much. I would argue strongly against tinkering very much with it this year. I told Alastair Hill when I saw him that this is now a good piece of work so don't change it for the sake of it. There isn't now anything in it that I could ask for that isn't there.

However, interviewees made a series of detailed suggestions about aspects of the contract which were not working well.

a) CQUINS

Many were dubious that CQUINs were worth the effort required to negotiate and monitor.

The problem with CQUINs is that they are too short term. The schemes may need two or three years to develop. The Trusts don't have money to invest in because they are short term. The national ones change every year. They also take a lot of time to negotiate with the CCG clinicians and the Trust clinicians because they are too busy. We should have just two to three schemes rather than too many. And providers think of CQUIN money as a given and we have very little control over that. And because they are too many and new ones each year you have got as a commissioner more and more to monitor (the old ones become part of the Quality Schedule and you get new ones each year). And we rely on the CSU to monitor all that and I don't always have the assurance that they can do it because of the lack of resource within the CSU. So I think in a way the providers are getting the money because we cannot validate them. Most of the time we just take the providers' word for it rather than the CCG auditing them. It is very resource intensive to manage CQUIN.

Many commissioners would prefer to have local flexibility about how to incentivise improvements in quality, for example, by making a contract for outcomes. One thought that PBR should be entirely replaced with contracts for outcomes.

One commissioner thought the national CQUINs were skewed towards acute trusts, and more effort should be put into national CQUINs for community services.

b) Penalties

Some also commented that penalties were not useful, e.g. for C Diff., where a root cause analysis would be more useful than imposing a financial penalty on the hospital. But others thought the national penalties worked well.

c) Processes to enforce performance

One commissioner commented that the processes to enforce better performance were hard to implement.

The levers are very convoluted. E.g. the timeframes like if you raise a Contract Query Notice (CQN) a meeting has to happen within 10 days and something be agreed within two weeks and often that is not a reasonable timeframe for turning things around. But then the

number of levels you have to go through to get from asking the question to not having had an answer before you hit a level of escalation that is appropriate, can be very time consuming. So the process that holds people to account needs to be harder and clearer. For example, is it a joint investigation or is it a remedial action plan. Providers tend to use the joint investigation to shift responsibility and present it as a joint or system problem even when there is no evidence to support it. And they will use the lack of clarity in the contract to stall it. When it comes to the point of agreeing a remedial action plan (RAP), there is nothing in there that explains how good a RAP has to be. That can be a very lengthy process. So agreeing a good RAP is difficult to achieve and then the provider does not accept any sanctions attached to it for non-delivery. And there is nothing in the contract that says we have to apply sanctions for non-achievement. And if there are no sanctions there is no incentive to deliver. If the provider recognises the problem and is willing to fix it then with joint cooperation it works very well. But if the provider does not recognise the problem and wants to shift responsibility then it is a very time consuming and painful process with no effective levers. We would like to see more teeth in there to make providers do it properly and if they don't perhaps escalate at an earlier stage somewhere higher up e.g. Monitor or another body, so that they take it seriously and are made to do it. Also we need to have clear rules about the Data Quality and Improvement Plans (DQIPs) and things like that. It should not be left down to local negotiation in order to get consistency and uniformity across the country.

Other commissioners also noted how long it took to escalate a dispute, and advocated simplifying the processes in the contract.

d) Obtaining agreement from Monitor to certain changes

Similar comments to those about the complexity and time consuming nature of enforcement processes were made about the process of getting variations and modifications agreed with Monitor. Several commissioners thought they should be allowed simply to make these changes by agreement at local level with the relevant provider.

e) Ambulance handover penalties

Several commissioners raised the issue of penalties on acute trusts concerning ambulance hand over times. It was felt that the penalty should not be levied entirely on the hospital, as the ambulance trust also had some responsibility in respect of this.

f) Guidance from ATs

One commissioner noted that they were not getting help they needed in respect of using the standard contract from their local NHS E Area Team. They felt that they were being performance managed, but not given guidance about the application of the contract.

g) *New forms of contract*

Some commissioners pointed out that, as they were starting to experiment with different types of contractual relationships with local providers, such as alliancing and prime providers, they needed new standard forms of contract to deal with these.

Another commissioner felt there were problems with the contract:

Personal opinion is that the contract is not fit for purpose. We tried hard to use it but it does not do what we need it to do. Termination clauses and redundancy costs are not specified in the contract but they are left for negotiation at the local level. Those little things need to be made clear rather than left for local negotiation. In terms of how the contract has been re-structured it is a real positive and it is easier to navigate. Here in [XXX] we don't have many Trusts around but just one big Trust so it is difficult to negotiate because we have no levers with the providers.

<u>Pricing and allocation of financial risk</u>

a) Mental health and community providers

The contracts for community services for 2014/15 were still on a block basis, and so were the mental health ones.

We asked if any of the commissioners had used the new provisions in the 2014/15 contract which allow for flexibility in agreeing national tariff prices. In other words, had they agreed any modified national prices (including risk sharing) as Local Variations (GC36.3.1.2). (Schedule 3 Part B).

One commissioner of mental health services reported having done so, and having sent the paperwork to Monitor. They had varied national currencies (not prices) in respect of MH PbR clusters. At the moment they are still paying their two MH providers on block contracts. But they are planning to move to tariff clusters.

As the contracts were also on a block basis in 2013/4, commissioners paid the agreed amount.

b) Privately owned acute services

These contracts for 2014/15 were on a PBR basis. And most commissioners reported that the contract worked well in respect of this type of provider.

In respect of the year 2013/14, commissioners reported paying the amounts calculated in accordance with the contract, except in respect of a very large for profit provider. The outcome of the dispute with that provider is discussed under the heading of disputes below.

c) NHS owned acute services

Different approaches to setting non tariff prices were being taken for 2014/15

For the contract year 2014/15, many commissioners still had non tariff prices to agree with acute providers. Most of these were based on previous years' prices, which had been arrived at originally by various means, such as bottom up costing, local reference costs and local costing. The national deflator was applied. Some commissioners are using benchmarking information where reference costs did not exist. (One commissioner remarked that reference costs were not reliable.)

But more than one commissioner was planning to renegotiate local prices in order to relate them more closely to actual costs. In one case, it was hoped the renegotiation of all prices would be completed by September 2014 and then be backdated to April 2014.

Several commissioners were not agreeing specific non tariff prices because they were, in effect, using block contracts. In one large urban area, significant service reconfiguration and transformation was being undertaken and block contracts had been agreed with most providers. This meant that they were not applying national tariff strictly either, of course. But these providers had not applied to Monitor for specific tariff variations (see below). One CSU commissioner who had agreed a large number of block contracts across her/his urban area commented that it had been difficult to get agreement to this change from local acute trusts. One factor which had not helped local relationships was the fact that the Trust Development Authority was simultaneously urging providers to renegotiate higher local tariffs in order to protect the financial positions of the provider trusts, thus impeding the work of commissioners to effect service transformation in the local area.

We asked if any of the commissioners had used the new provisions in the 2014/15 contract which allow for flexibility in agreeing national tariff prices. In other words, had they agreed any modified national prices (including risk sharing) as Local Variations (GC36.3.1.2). (Schedule 3 Part B).

Three commissioners reported having submitted variations to Monitor.

One commissioner had submitted variations in relation to six tariff areas to Monitor to approve. The provider is a tertiary hospital and the new approach was needed due to the fact that NHS E now commissions some of the services, as well as the CCG. Variations to national PBR tariffs were needed to keep within the CCG budget while also obtaining an accurate report on levels of activity needed to liaise with the NHS E commissioners.

Another had agreed a lower local tariff with its provider if a patient is admitted for under 2 hours, which was sent to NHSE and Monitor for agreement. They also agreed a local variation on a cardiology package price.

The third was in respect of mental health services, and is reported in that section.

We also asked if any of the commissioners had used the 2014/5 contractual provision to make Local Modifications (Sch 3. Part C), which also need agreement from Monitor.

Some commissioners reported using block contracts with their acute providers as part of their management of the whole local health economy, and having reported this to NHS E.

One commissioner explained that they might be having an integrated care organisation locally, and this, in addition to the financial risks to the acute provider posed by transferring money to the local Better Care Fund (i.e. out of the acute sector), required different payment provisions

> *As a local community with financial pressures that each organisation is under, we agreed that it is financially less risky to have a block contract. We submitted like an 'excusing note' to NHSE explaining why we did that. [....] We [may] have in our area an Integrated Care Organisation . That was part of the reasoning for looking at a different way of contracting this year to assure our providers, particularly given the risks around the Better Care Fund, was to ensure that our acute Trust had that guaranteed income, so we were able to do the long term financial modelling to allow an integrated organisation to proceed. But we will still be monitoring the contract based on the activity that the Trust provides.*

Another commissioner explained that they had made modifications to the contract in order to make it closer to a block contract (which they called 'cap and collar'), which they were sending to Monitor for approval. The contract does contain some financial incentives for the provider related to activity, so it is not entirely a block contract, but national payment for activity rules are not being used.

We also asked about any use of the 2014/15 contract provision which allows for adjusting the baseline referred in cases of increased demand for emergency admissions which is beyond the provider's control (e.g. due to change in demographics). According to national guidelines the 08/09 baseline was to be used for setting the point at which the 30% marginal rate for emergency admissions applies.

Most of the commissioners were still using the 2008/9 baseline, but several have moved to later figures. (Clearly, in the case of contracts which were agreed on a block basis, this provision was not relevant.)

One commissioner had done so because there had been major changes in the configuration of acute services since 2008/9, mainly taking the form of centralisation of services such as trauma and stroke. Figures for 2014/5 were being used instead.

Other commissioners had moved to later base lines, such as 2011/2 in one case after arbitration, and 2009/10 in another. One commissioner had agreed to look at activity in year this year and adjust the figures retrospectively.

We also asked if commissioners included in the contract any specific plans for investing the money retained from the marginal rate payments in order to manage demand for emergency care.

Almost all of the respondents had not. Those who had made plans explained that these involved investing money outside the acute trust in order to reduce demand, rather than giving the money

to the trust under the contract. In one case, the commissioner explained that part of the money would be used by the acute trust as well.

We also asked commissioners about their behaviour concerning the 2013/14 contract.

We asked if commissioners had issued an Activity Query Notice (AQN) in 2013/4 in order to reduce liability in respect of over performance in volumes of care (measured against an agreed activity plan). Most had not, but two had. One of those who had not explained that they were nervous about doing so, because they feared it would provoke the provider to issue one themselves, claiming increased numbers of referrals had caused the increased activity. In one case, this lead to the commissioner issuing an Activity Management Plan, but the provider did not agree it, and this led to a subsequent dispute about how much was owing under the contract.

We asked specifically whether commissioners had paid providers in accordance with the terms of the 2013/14 contract.

There was variation between the commissioners about whether they paid for all the activity under PBR which the providers had carried out. Several of the commissioners confirmed that they simply followed the contract and paid for all activity undertaken, even if it was more than they expected.

However, several commissioners reported that they were not able to pay on a PBR basis, as they did not have sufficient funds to do so. In these cases, most sites came to an agreement about the amount to be paid to the hospital, which amounted to less than it was entitled to under the contract. One respondent reported:

> *It ran into millions. Our Chief Finance Officer sat down with the Trust and agreed an 'end of year settlement' in recognition of the funding we have got available and the pressures on the acute Trust, because ultimately it is about a shared health economy.*

In one case, the resolution of the dispute reported later in this document entailed an enforced compromise in respect of this issue.

Summary concerning allocation of financial risk

Compared to the survey we undertook in 2012, we can see that commissioners were making greater changes to their allocation of financial risk for the year 2014/15 in order to accommodate new forms of contracting (such as alliance contracts, and outcomes based contracts), in addition to increasing financial pressures on local health economies. For the year 2014/5, several agreed block contracts in advance with acute trusts, rather than coming to a post hoc settlement in which the national tariff provisions were not used. And one area was using an innovative alliance contract which stipulated sharing the allocation of financial risk among alliance providers. Nevertheless, there were still instances of post hoc settlements to vary the allocation of financial risk from that in the contract having been made in respect of

the financial year 2013/14. Moreover, due to the difficult financial circumstances for CCGs, not all money retained from providers under sanctions levied in 2013/14 was re-invested in those providers (see below).

Financial incentives to improve quality

CQUIN and other local quality schemes

All the respondents reported that they had agreed local quality requirements.

We asked interviewees to send us copies of the quality schedules to their local contracts, so that we could see what local CQUINs and other quality requirements had been agreed.

We were able to obtain a very small number of quality schedules (five in total) but none of them contained the section on CQUINs. We are therefore unable to provide information about local CQUIN schemes.

Only one commissioner reported having agreed amendments to the national CQUINs under Schedule 4 Part 1 of the 2014/15 contract. This consisted of remitting all of the CQUINs which applied to the local acute and community providers. The reason was related to substantial local reconfiguration of services, aiming at achieving an integrated care organisation.

None of the respondents reported having agreed a local incentive scheme under the provisions of Schedule 4, Part 4 of the 2014/15 contract. But they did have local CQUIN schemes. They reported that it was time consuming to agree local CQUINs, and that they did not have additional time to agree other local incentive schemes as well. (Moreover, it would mean setting aside more money to pay providers.)

We asked if providers had failed to reach national or local CQUIN or other local quality scheme targets in the year 2013/14, and if so, had the commissioners applied the terms of their contracts. In the case of local quality requirements, where there was a breach, all commissioners applied the terms of the contract to retain money.

In the case of failure to reach national CQUIN targets, commissioners also reported abiding by the provisions of the contract.

However, in one case the commissioner noted that the local CQUIN requirement was not clear, and that the provider had disputed whether money should be withheld and arbitration was required to reach a settlement. She remarked that contractual terms concerning CQUINs were not sufficiently clear:

> *People put too much into the contract which complicates things. CQUINs and the consequences were not described appropriately and sometimes local quality requirements were not written in plain English. There ought to be some national development about 'how to write good CQUINs' for example. The national CQUIN team could do with some advice as well, because the national ones are not examples of*

good practice either. I think we have got a lot to learn around writing good CQUINs etc and basic stuff like that ought to be available to commissioners really.

Sanctions for low quality

We asked interviewees to send us their quality schedules to indicate which additional quality issues had been agreed at local level would be subject to financial sanctions. Few interviewees were able to do this. We received in total five quality schedules containing local quality indicators, all relating to acute trusts. Examples of the issues covered are contained in Appendix E.

We asked if commissioners had included financial sanctions for local quality indicators in their contracts. There was an approximately even split between those who had done so, and those who had not. In the former case, one commissioner reported having agreed an overall package of £4m worth of deductions. Another reported having agreed specific sanctions for failing to provide a discharge summary, which amounted to 2% of the price for the episode of care.

Most of those respondents who did not report local sanctions pointed out that they used other mechanisms, many of which were contained in General Condition 9 of the contract, such as CQNs and RAPs. (The use of RAPs is discussed below.)

One commissioner reported that its local provider would not agree to local sanctions, which was one of the reasons why the CCG had decided radically to reshape the local health services using market solutions, instead of relying on contractual sanctions to improve services.

We asked commissioners if, in 2013/14, they had agreed any Remedial Action Plans (RAPs) with their providers following a Contract Query Notice (GC9.13), and if so, what happened subsequently.

Several of the commissioners reported having got as far as agreeing RAPs in respect of issues such as 52 week waiters, mixed sex accommodation; issues in A&E; cancer and stroke performance. One commissioner reported using a RAP as part of the signed contract at the beginning of the year, rather than it being pursuant to a CQN.

Few of the commissioners who had agreed RAPs had got as far as with holding money in relation to non performance of the RAP by the provider. Most of those who did were able to use the contract to work out how much to withhold. But one commissioner which tried to do so had difficulty getting the provider to agree:

Yes, but the provider disputed our right to do that. When we got the letter from the Area Team after the arbitration, it actually said (which is technically incorrect) that there will be no roll-over of previous years' RAPs or penalties. So in effect we were told to start all over again which would mean agreeing again the penalties, which is stupid because the Trust will never accept any penalties. So now we agreed in effect a cap of

total exposure of £10m worth of penalties. If we applied all the rules and penalties it would be £20-30m.

We also asked if commissioners who had RAPs had issued any Exception Reports for breaches by the provider of a Remedial Action Plan (GC9.21), and what happened if they did so.

Several commissioners said they did issue Exception Reports in respect of RAPs. They did then withhold money from the provider, in accordance with the provisions of the contract. In a small number of cases this money was permanently retained by the commissioners. In some cases, the amount was that set out in the contract. However, in one case, the amount the commissioners were able to retain was determined by the mediator who was brought in by the parties to deal with disputed matters, and it did not amount to the whole sum. And in another couple of cases, the commissioners had agreed lesser sums with the providers.

It should be noted that several other commissioners said that they tried to avoid getting as far as CQNs with their providers, and preferred to work through performance issues on an informal basis instead. One reported having agreed with the provider at the beginning of the year that they would not issue any CQNs, but that if there were any performance issues, they would go straight to agreeing a RAP. But some of those commissioners who did not use RAPs stated that they appreciated that they were provided for in the contract, as a back up if needed. One commissioner pointed out:

I believe that if you have to invoke the contract then there is a failure in the relationships. But it is useful to have the levers in the contract if they are used sensibly. For example, if a provider consistently does not achieve something, to be hitting them constantly with penalties does not necessarily help either. More active interventions e.g. removing activity to somewhere else may be more effective.

We asked if any commissioners had *agreed to vary nationally mandated sanctions under the provision of Schedule 4 Part H of the 2014/15 contract.* As mentioned earlier in this section, one commissioner had agreed to a cap of £4million as the total financial sanctions it could impose on one of its local providers. Another had agreed a cap of £10 million. One reported not applying the sanction concerning ambulance handovers because they took the view that this was not entirely in the hospital's control.

Breach of national quality targets in 2013/14

We asked if any providers had breached national quality targets in the contract year 2013/14 (such as A&E, cancer waits, C Diff), and if so, how had the commissioners dealt with these. Had they retained money, and if so, was it the amount specified in the contract. Most commissioners reported breaches had occurred, and that they had retained the sums of money set out in the contract.

On the other hand, two commissioners reported that they had not retained the money, in one case, because they wanted to reinvest the money into the provider. Another stated that they relied on their relationship with the provider, rather than retaining money, pointing out that the breaches were in respect of issues for which they thought it was impossible to plan in advance.

Most commissioners also reported that their local providers had breached the conditions concerning 'never events'. They all reported that they had applied the contractual penalties in these cases, although two remarked that they were more concerned to see it did not happen again than to levy a penalty.

Investment of any retained sums or penalties

Most commissioners confirmed that they re-invested any sums retained or recovered as penalties in their providers, to deal with specific problems which had been identified – sometimes these were the same issues which had led to the breach of contract.

However, several commissioners reported having used these sums to shore up their own financial position.

Interestingly, in the case of the CCG where an alliance contract had been signed, any such money would be put into a shared risk fund and its disposition would be agreed by the Leadership Board of the alliance.

Service Development Improvement Plans (SDIPs)

We asked commissioners if they had agreed a SDIP with their providers. Most said they had done so. Examples of the issues covered, according to the interviewees, were: seven day working, CQUIN innovation; complete review of local prices; district nursing; stroke services.

We asked if any commissioners had levied penalties for failures to achieve SDIPs in 2013/14. Some commissioners explained that there had been no such plan in 2013/14, and most of those who had had one reported it was carried out. In the few instances where it had not been, the commissioners had not levied any financial penalties. They saw the SDIP as a process which would take longer than a year.

Data Quality Improvement Plans

We asked commissioners if they had agreed a DQIP with their providers. They all said they had done so. Examples of the issues covered, according to the interviewees, were: various aspects of MH and community services; reporting MH PBR categories to help the parties move towards a non block MH contract in coming years; improving cardiac rehabilitation data; postcode; GP practice code; recording ambulance CAT number on Trust's system; getting diagnosis codes for A&E.

Some commissioners pointed out that they would levy penalties on their providers if these DQIPs were not adhered to in 2014/15.

We asked if any commissioners had levied penalties for failures to adhere to DQIPs in 2013/4. Several reported not having had such a plan in 2013/14, and one commissioner remarked that, even though they had had a DQIP, it had not been possible to enforce sanctions for any breaches in that year due to the fact that the CCG was in the process of formation and not in a position to carry out adequate data monitoring.

One commissioner reflected that the DQIP for 2013/14 had contained unrealistic targets, and that these had been renegotiated for 2014/15, and this type of view was echoed in another CCG. And another explained that they had not enforced the consequences for breach because the provider had inherited such a poor information system it was not possible for them to comply. But the commissioner intended to apply contractual terms in 2014/15 in the event of any breaches to the DQIP.

Disputes in contract year 2013/14

Very few commissioners reported disputes with their providers, and most that did reported that they were resolved informally at local level. This involved either continuing discussion in contract monitoring meetings or escalation to more senior staff on each side.

Formal disputes included both lack of agreement to contractual provisions in the first place, and lack of agreement about how existing contractual provisions should be interpreted.

One example of the former was a failure by the provider to agree to the commissioners removing activity from the acute trust to the community. This had to be resolved by the NHS E Area Team (the respondent could not remember exactly what procedure was used). Another example of the former concerned agreement of issues, such as the quality premium for maternity services and emergency thresholds. Mediation was used to resolve the dispute, and each party 'won' in respect of different issues under dispute, with the overall effect of the mediation being slightly in the CCG's favour.

One commissioner reported a post contractual dispute of the latter type concerning a range of issues, including CQUIN performance, with its local acute trust which required significant external input to resolve. It went all the way to formal Mediation with the Area Team and Trust Development Authority. The commissioners wanted to go for Expert Determination but they were 'convinced' by the Area Team not to. The outcome was a compromise between the provider and the CCG. The commissioner interviewed felt that the dispute had worsened an already poor relationship with the provider. One of the reasons that the relationship was not good was because there was not enough money in the local health economy to pay the provider the sums it needed to make a surplus, and because it was an independent provider, this was more important to it than if it had been part of the NHS.

In one case, the NHS provider did not want to accept the outcome of the dispute resolution process.

We had a number of issues, and we won some and the Trust won some. After that the Trust did not want to accept the outcome. So we had two more months of arguing. And it got to the point where the TDA and NHSE had to write formally to say we had to accept the outcome.

It should be noted that most respondents did not differentiate between the two different types of contractual dispute outlined here. Nor were they aware of which formal stage they had used in the dispute resolution process.

Early termination or suspension of contracts in 2013/14

None of the commissioners reported terminating a contract early.

One commissioner reported having to suspend a contract with an AQP services provider because it failed to meet the new AQP criteria. The commissioners enabled the provider to bid again, meet the criteria and continue providing services.

Contract review meetings in 2013/14

We asked commissioners about the frequency of their contract review meetings with providers, and whether they signed the contract review record after each meeting (GC 8.2).

All but one of the commissioners confirmed that they had monthly review meetings with their large NHS providers. (One had been running bi-monthly meetings for the past year, and those meetings take a whole day. They find this works better, as they can deal with more detailed issues, if necessary, and they do not have the pressure of meeting every month.) Most had separate finance and quality meetings.

Less frequent meetings were held with smaller providers, although performance information was received monthly from them.

All interviewees confirmed that they took formal minutes, which could be regarded as a contract review record. They all agreed that the meetings were necessary and did not have suggestions for alternative processes (other than the one site where meetings were bi-monthly).

Use of CSUs

There was wide variation in the tasks performed by CSUs at present. Several of the CCGs in the survey did not use them at all, and all contracting functions were undertaken in house. On the other hand, several of the CCGs had contracted out all contracting functions to the CSU and were satisfied with their performance. Another was only using the CSU to provide informatics support.

A large proportion of CCG commissioners interviewed told us that they were dissatisfied with the service provided by their CSU, and that they were either bringing contracting services back in house at the CCG or attempting to renegotiate their contract with the CSU. Some commissioners noted that the CSU did not have sufficient numbers of staff with the necessary skills to monitor contracts well enough, and were not carrying out these tasks well. For example, one CCG was planning to bring quality monitoring back in house, while leaving the CSU to deal with the activity and financial aspects of the contracts.

Involvement of GPs in contracting

GPs were increasingly involved in contracting, mainly in respect of quality issues, such as negotiating local CQUINs and strategic planning of changes to service delivery. They tended not to be interested in the detail of contractual provisions, tendering, monitoring activity or financial issues, which they left to managerial staff to sort out. In some places, problems in respect of these aspects were taken to GPs for decisions.

Conclusions from the second survey

Commissioners continued to use formal contractual provisions to improve quality and allocate financial risk, where possible. However, as we found in the first survey, the contractual provisions in respect of pricing were not adhered to at all times. Commissioners reported that not all local health economies could afford to pay the full amounts which acute providers expected under PbR. Several had applied to Monitor to be allowed to vary the national tariff. Moreover, some commissioners reported using new approaches to setting non tariff prices. In some cases they wished to relate these prices more closely to actual costs; and in others they were reverting to a block contract for this element.

Our second survey of contracting staff found that widespread use was being made of contractual provisions in respect of financial incentives to improve quality, and that CQUIN payments were being made to providers. Many commissioners reported using performance management processes to focus providers' attention on poor quality, and to escalate the severity of these issues. Commissioners reported that the threat of financial penalties could also act as a useful method to focus attention on poor quality, but, in practice, some did not withhold money from providers, as they thought decreasing income was likely to exacerbate the performance problems. Others did not think it was constructive to impose financial penalties.

Summary of survey findings

As is clear from the analysis above, despite the introduction of the HSCA 2012, we found more continuity and similarities rather than substantial variation between the two surveys. In both surveys we found that commissioners tried to apply the contractual levers and provisions in

order to improve quality of care and allocate financial risk. A lot of commissioners reported in both surveys that paying PbR prices was unaffordable in their local health economies and a number of them informed us that they moved away from them where possible e.g. by putting in place block elements in the contract or 'cap and collar' contracts.

Similarly, in both surveys commissioners reported that they tried to apply the contractual levers (sanctions and incentives) as well as performance management processes intended to improve healthcare quality and provider performance. Although most commissioners appeared to be in favour of applying sanctions for breaches in quality targets, in practice many did not in the end permanently withhold money retained from applying sanctions, as this was likely to exacerbate existing financial difficulties faced by providers. Commissioners still believed, however, that the threat of imposing financial sanctions could be an effective tool for improving quality. However, commissioners could not tell with any certainty whether the use of either financial sanctions or incentives resulted in permanent improvements in quality.

Case studies of contracting in three local health economies

Description of the case studies

In this section we present findings from the three case studies. These findings are organised with reference to our research questions and the themes derived from our theoretical framework (i.e., how financial risk was allocated in practice (and how this related to the formal contractual provisions); how the financial levers designed to enhance the quality of care were applied by the parties; how disputes were resolved; and the effect of local relationships on how contracts were used locally.) We have also included some material on the effects at CCG level of some contracting being undertaken by NHS E, as the participants voiced concerns about this issue; and on the changing role of GPs in contracting, as the establishment of CCGs under the HSCA 2012 could be seen as enhancing this role.

Before reporting our findings in each of the case study areas, we present an introduction to each area, in order for the context within which contracting was taking place to be understood. There was some variation in the way in which the processes of contracting were structured in each area.

Case study A

In this case study three neighbouring CCGs worked closely together and shared one commissioning/contracting team and they concluded a single contract with their local acute providers. This was a small team, focusing on service re-design, and overseeing contract negotiation and performance management.

In this case study community and mental health services were commissioned from one single combined NHS trust provider. The community part of the contract was led by the three CCGs but the mental health part was commissioned jointly with the Local Health Authority (LHA) and was led by the LHA. There was one local acute NHS trust which carried out the bulk of work for the CCGs' residents.

The financial position of the three CCGs was healthy. In 13/14 one of them presented a surplus of 2%, one presented a surplus only of 1%, and the third a surplus only of 0.5%. On the other hand, in 2013/14, the local acute trust was financially challenged and presented a substantial deficit (c. £12m). Due to increasing pressures its financial position in 2014/15 continued to be challenged and the trust was again forecasting a further deficit. The combined community and mental health provider was financially healthy, presenting a recurrent surplus.

In terms of competition, in accordance with national policy the commissioners had put in place some Any Qualified Provider (AQP) services such as audiology and podiatry for which the acute trust was accredited.

The commissioners also bought additional secondary care capacity from independent sector providers, but on a relatively small scale. Interestingly, however, when in 2013/14 alternative

private sector providers were offered as a choice to patients in order to clear the backlog for the 18 week pathway, only a fraction of patients took up the option of switching provider, preferring instead to wait longer by staying with the NHS provider.

In 2014/15 the commissioners chose to sign two year contracts with their main NHS and independent sector providers, as permitted by the contract rules. This decision was partly influenced by the intended acute hospital services reconfiguration in the area, and also by the belief that longer term contracts were more appropriate.

Case study B

In case study B three federated CCGs (sharing one executive team) and a fourth CCG (which was a significant associate to the contract) were the main commissioners of the local acute NHS FT. This provider had been in serious financial difficulty for over five years. The commissioners had issued some competitive invitations to tender, including what transpired to be an independent sector Urgent Care Centre, took a substantial amount of activity out of this local acute FT. During the study, the FT is currently in the process of being acquired by a neighbouring acute FT. (This had been concluded by the time of writing – December 2014). The merger impacted on the contracting process in general, as well as on the relationship with the commissioners. By the time fieldwork was completed in late 2014, a formal contract had not yet been signed in this case study due to the changes on the provider side.

The Community and Mental Health providers in this case study site did not wish to participate in our study.

Case study C

In this case study site, there was one CCG commissioning services from a combined acute and community health care NHS trust. The CCG also led on the main mental health trust contract.

The CCG was in a strong financial position, having a strong record from the days of PCTs, always planning a surplus and managing to deliver it. In 13/14 the CCG met its surplus and in 14/15 it reported it was also on target to meet its surplus. The acute provider managed to post a very small surplus in 13/14 but in 14/15 it was planning to post a deficit although the extent of it was not yet clear at the time of the research.

In terms of local provider competition, apart from nationally mandated AQP providers, there was relatively little independent sector involvement. There were new independent providers in respect of end-of-life care and urgent care, but the commissioners did not think this had decreased activity in the main acute NHS provider. (On the other hand, the commissioners reported that, despite the fact that activity had not been moved out of the NHS provider, trying to make the independent and the NHS sectors work together in an integrated way involved a continuous effort.)

Allocation of financial risk

Acute providers

Year-end settlements and demand management schemes

Before reporting on how the contracting parties in our three case study sites dealt with the allocation of financial risk in relation to the contractual provisions, it is necessary to explain the processes by which settlements at the *end* of the financial year are reached in NHS organisations.

Every year, as the financial year end approached, the contracting parties had to reconcile their final financial positions. Due to a delay of about two months in processing the monthly activity data, the parties had to reconcile their respective positions in April *before* having the final data for actual activity. This reconciling exercise was performed between January and March by most contracting parties across the country. In the absence of the final data, differences of opinion between commissioners and providers regarding actual activity result in year-end arrangements, under which estimates are made about the final position and negotiations were undertaken between the parties concerning which organisation should bear the financial burden. One participant explained:

> *In many cases we roll to kind of year end position where we eventually have a big discussion about what year end is, what's the right level of kind of over-performance and then we come to a deal. That's what's happened here in the past.* (CS B, Corporate Income Finance Manager, Acute Trust)

Another participant agreed that year-end deals were pragmatic and inevitable in the context of the NHS.

> *Well, this is, you see, this is where PBR shows its - how can I say? – its limitations. At the end of the day, health economies need to be in balance, it's no one's... it's in nobody's interests to bankrupt any of the parties associated with the relevant health economy, and that's almost a diktat in terms of public policy, okay? So you have situations where during the year there is over- or under-performance, there's usually a dispute around the nature of that or the size of it or some element of it, so it's not a straightforward thing, it never is. And they have to speak, rumble, rumble, rumble, until such time as you've got to close the books and come to a view. And that's when the deal is done. And that's probably no bad thing, and that's, I think, perfectly reasonable.* (CS B, Commissioning Consultant, CSU)

In addition, every year commissioners were required to put in place demand management schemes aiming at reducing activity in secondary care. Since PbR meant that providers should be paid for each item of care they provided, an increase in activity worked to the CCG's financial disadvantage. The problem was that such demand management schemes seemed so far to have had little success. In the two past years, both emergency and elective demand had

been rising in all three case study sites, despite efforts by the commissioners to reduce it (for example by moving activity into the community). Despite attempts to reduce demand using various schemes, demand had risen, and, in all three case study sites, the commissioners had to negotiate a final settlement for the past year with their local acute trust, rather than simply apply the terms of the contract. All three sites made use of 'non-recurring' funds – in other words, the commissioners have paid additional money, over and above the amounts specified in the contract, to their acute providers.

In case study A, in 2013/14, the acute care provider was in danger of sliding into deficit and complained that one of the reasons was that the commissioners were too optimistic about their demand management schemes or Quality Innovation Productivity Prevention (QIPP) programmes, which meant that their estimate of the amount of activity the trust would undertake when the contract was agreed was too low. As the contract provided that activity over the indicated volume would only be remunerated at 30% of the PbR tariff, this would lead to a loss of income for the trust in respect of the activity which exceeded the indicative amount.

> *I think as far as the CCGs' QIPPs are concerned, and the sort of £8 million, £7.8m, whatever it is, I think our sense is always, you know, it's not that we don't think they will ever achieve demand reduction, I think we were just sceptical about whether they would achieve it in one year, because £8 million, I think 5.1 or something of that is purely on emergency admissions, it's a huge amount to achieve in one year, and when we asked them about their phasing of their schemes, actually across the twelve months, it's a really slow start, and then you get to sort of October, when emergency demand normally goes up as well, and they suddenly show a much bigger achievement. So we're just concerned about the risk now, but actually I think over time, yes, we would expect them to have an impact and to start to bring it down.* (CS A, Ass Director of Finance, Acute Trust)

Depending on their size, QIPP schemes could also make capacity planning difficult in relation to elective care (although this was not an issue on this particular occasion).

> *The issue for us and the risk for us with the QIPPs is of course, for these five million of the eight that's on emergencies, if at the end of the year we've done £5 million more worth of emergencies, we don't get £5 million worth more money, because of the impact of the 30% threshold.. on elective or outpatients, in some respects, if they don't deliver it doesn't really matter to us, from a financial sense, but from a capacity sense it would, because if they've said to us, we're planning on taking out 5% of ophthalmology attendances, for the sake of argument, we would have planned our capacity on that basis, and then if they suddenly said 5% more, it would probably cost us more to deliver as well.*(CS A, Ass Director of Finance, Acute Trust)

Although the commissioners thought that their QIPP schemes were realistic, they also confirmed that the trust's challenge of the QIPP schemes resulted in an effective adjustment of the marginal rate for emergency admissions from 30% to 65% after arbitration (see below).

The Trust do challenge commissioners in terms of the QIPP adjustments because, as you know, we've got to make significant savings and their view, and this is to some extent linked to the non-elective issue, is to say you've taken X amount out of the plan for your emergency QIPP, your emergency activity. We don't think you're going to deliver and anything over and above that plan now you'll only pay us at a marginal rate; that doesn't seem fair. (CS A, Head of Commissioning, CCG)

The commissioners claimed that they did not under-commission activity and that their QIPP schemes were robust with a 'clear audit trail' of the financial impact. In the words of one commissioner:

So it's all audited and we feel confident that it's a realistic plan. There is no point in setting an unrealistic plan just to say well I've signed off my budget; it's a nonsense because you just know you'll over-perform. We've been there years ago. (CS A, Head of Commissioning, CCG)

The focus of the CCGs' demand management schemes was in urgent care. They put in place schemes such as: a 'virtual ward'; GPs in ambulances; integrated community teams; and an Urgent Care Centre within A&E. These all aimed either to keep people away from A&E or to prevent unnecessary non-elective admissions in other ways. As one commissioner explained,

In terms of decommissioning services, clearly we are focused, particularly around emergency work is about not commissioning whole scale services but it's about reducing activity that's going into secondary care because we can do it, you know, the view is we can do it cheaper, possibly in a community setting. And the other aspect to all this is about using the procurement process to drive down prices as well in terms of competitive tender. (CS A, Head of Commissioning, CCG)

Most of these schemes were still at pilot stage and for this reason, at the time of the research, it was not clear what their impact had been in reducing demand.

In addition to not being paid the full PbR tariff for 'over-performance' in respect of emergency activity, increased demand for emergency services had a negative impact on an acute trust's ability to meet the 18 week referral to treatment (RTT) target for elective work. As this failure to meet the target had financial consequences under the contract, it was also in the providers' interest that demand management schemes succeeded. The provider in case study A was not convinced that these schemes had a good chance of succeeding because of the local ageing population with increasing co-morbidities presenting as emergencies. One participant said:

Certainly, the demographics... I'd say, like, the key ones are demographics... people basically with multiple co-morbidities who've just got... are more likely to get ill,

> *because they're living longer with lots of complex diseases. They've got complex medications, and as soon as they just become a little bit unwell they just tip over, and they just cannot be managed out in the community. They become very acutely unwell. I think that's one.* (CS A, Director of Nursing)

Secondary care interviewees in case study A took the view that the problem with emergency care was not so much an increase in the actual numbers of patients, but an increase in the *complexity* of patients which made discharge more difficult and prolonged.

In case study B, the acute trust had similar difficulties in trying to cope with increasing levels of demand for emergency services. As result of increasing pressures in A&E, the provider missed a number of national targets, such as A&E and 18 weeks RTT (see below). Trust participants attributed the problem to the fact that the CCGs 'under-commissioned' activity and relied on optimistic QIPP programmes:

> *The trust has over-performed but it depends on what measure you consider the over-performance. Say for example if the… if a CCG commissioner buys, you know, can buy outturn for example or buy a sensible view of the flow of activity going forward, well then in theory the level of over-performance will be a lot less than if… than if they have a view on what the activity will be that's shall we say optimistic in my terms and then the level of over-performance could be quite a lot higher if the activity still flows to the hospital*. (CS B, Corporate Income Finance Manager, Acute Trust)

Another provider participant agreed that the commissioners' QIPP schemes were optimistic and cited as proof the fact that at the year-end settlement the commissioners paid for the over-performance out of non-recurrent funds.

> *In our view, however, the vast majority of the activity is still flowing through to the hospital, and to a large extent, the commissioner QIPPs have been aspirational rather than realised...I'll give you an example; we had a year-end settlement, which they paid more than they contracted for, so that in itself is recognition that, actually, their baseline plan in 13/14 wasn't robust enough*. (CS B, Corporate Income Finance Manager, Acute Trust)

When asked whether they were under-commissioning, CCG participants in case study site B denied it saying:

> *I think we proved time and time again, that we have not under commissioned, there's no evidence of under commissioning, and why I say that is because we always buy next year's activity based on what's happened this year. So, if there's over performance in a particular area this year, we'll predict that that over performance will continue, subject to local management, so if the GPs can put in some kind of intervention to pull down the over performance, we'll do that.* (CSB, Senior Management Accountant, CSU)

The same case study B participant argued that if QIPP schemes proved to have been optimistic at the end of the year, the commissioners are paying for 'over-performance', which meant that the financial risk arising from having unrealistic QIPP schemes in place was borne by the commissioners.

> *We'll have a separate plan, called a QIPP plan that will either pull activity out of the system, or redirect it elsewhere, whatever is appropriate for the patient, and we'll model that into the plan. So, the Trust will know what we're meant to be doing, and clearly, the commissioners will know what's meant to be doing, and if the QIPP doesn't happen, we over perform, but we'll also pay for that over performance, because it's normally through PBR, national tariff, so delivering the QIPP is the commissioner's risk. So if there's no... the only financial risk to the Trust is if the QIPP kicks in and delivers, they lose the income, because they lose the activity.* (CSB, Senior Management Accountant, CSU)

It should be noted that, strictly speaking this argument is not correct, since payment for over-performance in emergency activity was paid at 30% of tariff, which means that if QIPP schemes were unrealistic, the provider was at risk of losing substantial income, being the difference between 30% and full PbR tariff.

In case study C, despite various demand management schemes having been put in place, the trust over-performed in respect of emergency activity and the end-of-year settlement also involved the trust receiving a substantial additional sum of non-recurrent money. The understanding was that the trust would spend at least half of this funding on service transformation, especially on expanding community services. The idea was that expanding community services would relieve pressures in the acute side in the long run. As one participant explained, however, given persisting pressures in A&E, it was not easy to achieve hospital transformation.

> *They give us a non-recurring allocation and they have done for a number of years now, which is quite significant, so it's £4 million, and £2 million of that they expect to be spent on the transformation of the hospital, I guess, is the best way of putting it. Now, an element of it is spent on that, but also an element of it, in fairness, is also spent on trying to keep the hospital running, because we have been experiencing unprecedented levels of demand. Therefore, we've been struggling now for 12 months almost to get anywhere near the A&E target, and that's caused huge pressures all over the place because as soon as you start missing your front door, I guess, that then spills out to other areas, whether it be elective work, whether it be treatment, whether it be some of your quality targets because you're spending all your time trying to manage the front door. Therefore, there was, you know, and that has caused friction around the fact that*

> *we have used monies, I guess, to prop up services within the hospital, which we could have been using, I guess, to lever out change, particularly within community services, and that might have helped the situation longer down the line.* (CS C, Director of Finance, Acute and Community Care Trust)

In 2013/14 the trust over-performed in emergency admissions and missed their 18 week RTT target for elective Trauma and Orthopaedics admissions. The commissioners, on the one hand, applied the appropriate contract mechanisms (e.g. contract query notices, remedial action plans, exception reports) and imposed the penalties stated in the contract; but, on the other hand, they also tried to understand the reasons for this over-performance and, where appropriate, help the trust achieve the targets. For example, when asked specifically about how they shared the risk relating to activity over plan in Trauma and Orthopaedics, one CCG participant said,

> *Well, we recognise that they need, in order to meet the performance issue, they need to put in a waiting list initiative, so we're accepting, if we know the reasons for over performance and it's justified, then we accept that*. (CS C, Head of Commissioning and Procurement, CCG)

Asked how they shared the risk when it came to A&E over-performance, one commissioner said,

> *Traditionally, we've over performed. Last year, I think we over performed by something like four or five million, and that's what we paid. But if that was the case, we wouldn't be offering transitional support over and above that, because we couldn't afford to do both. So there is a combination of looking at what non-recurrent resources we've got and how much we're paying in over performance... So that's where we have some of the discussions. And, in a way, that's how we manage some of the risk.* (CS C, Director of Finance, CCG)

The commissioners were using a combination of contractual penalties and demand management techniques which fell outside the terms of the current contract. For example, in A&E, in addition to applying the penalty of 2% per quarter if the provider failed to achieve the target, the commissioners also tried to support the trust by instituting a range of measures designed to reduce demand: putting in place an Urgent Care pathway; commissioning some extra nursing home beds; commissioning some spot-purchase extra beds; co-ordinating a review of capacity in the community; and monitoring whether this capacity is used appropriately.

The commissioners' position was that, on the one hand, they felt they were required to support the local provider, but, on the other hand, they took the view that giving non-recurrent funding to the acute trust had to be followed by specific improvements in services:

> *There's something about pushback, in terms of try and protect your local provider, and that's the TDA response. So at the end of the day, it's a judgement call. So rather like the contract, we don't apply, well, we initially apply every contract measure, but in terms of whether we reinvest it or not, some of the conditions won't be as prescriptive as outlined in the contract. Because up until now, there has been this collective view that we want to support our local provider. But it has to provide the right quality of care, appropriate care, in a timely manner. So it isn't support at all costs and never has been.* (CS C, Director of Finance, CCG)

The year-end settlement (and use of non-recurring payments) depended on the available funds in the local health economy that year. This was not always sufficient to meet expectations of providers, but there was a cooperative approach to agreeing the amount to be paid, as all parties understood the financial limits of the local system:

> *Because what we also try and do is we try and manage the affordability within the health economy. So we kind of usually agree it sort of nine, ten months, that actually, at the outturn, they will pay us X and we will manage that to that level. And he [the CCG Dir of Finance] rang me and said, this was just before Christmas, and said, you know, the £x million, that you're expecting, is not going to come your way... And that was like, oh, God, you know. So that created a bit of tension and friction, as you can imagine...And, in fairness, we got a little bit nearer where we needed to be but it was nowhere near where we wanted that settlement to be. But that was the money that was in the system at that particular point in time, so we had to go with it.* (CS C, Director of Finance, Acute and Community Care Trust)

The national tariff, local prices and risk sharing

The national standard contract and associated guidance provided that types of care (i.e. particular Healthcare Resource Groups, HRGs) which were subject to the national tariff (formerly called Payment by Results, PbR) should be funded on the basis of cost per case, at the set national rate. As noted above, this put the commissioners at financial risk, as they were obliged by the contract to pay for each HRG performed by the provider. (The contract also contained a provision amending this rule in respect of emergency activity over an historic baseline, providing that it should be paid for at 30% of national tariff. The application of this contractual provision is discussed in the next section.) Not all acute activity was subject to the national tariff (as the relevant HRGs had either not been developed, or no national prices had been assigned to them), and parties were permitted to negotiate a local price for these services.

We investigated whether the national tariff/PbR rule was applied in practice in the case study sites and found a mixed picture. Some health economies were able to implement the pricing rules of the national contract more successfully than others.

It should also be borne in mind that each of the three local health economies agreed financial adjustments at the end of the financial year, as discussed in the previous section. Thus, the

effects of following the national pricing rules (to the extent that they were used in each case study) was mitigated by the end of year adjustments.

In case study A, all PbR activity was paid fully at PbR tariff in both years of the research (i.e. 2013/14 and 2014/15. According to participants, no risk sharing arrangements were agreed, other than the contractual provisions in respect of the 30% marginal rate for emergency activity. But, in respect of care which was not subject to the national tariff, different agreements had been made. Referring to 2013/14, one participant said,

> *This year we don't have an overarching risk share, other than the 30%, so we've got the 30% for emergencies, but that's national. On the non-PBR stuff, so like your pathology, radiology, we've got some marginal rates for over performance, so sort of 50% usually, plus or minus, so there's a little bit of a, you know, if they go significantly over then there's a bit of a flexibility* (CS A, Associate Director of Finance, Acute Trust)

The parties had not agreed any major Local Variations or Local Modifications allowed under the 2014/5 national contract, other than a Local Variation for a maxillofacial procedure. Due to the trust's deteriorating financial position, it insisted on PbR payments. Where there had formerly been agreement to vary national prices which were subject to PbR, this had become more difficult in later years. The commissioner explained,

> *Well we did have local prices for certain things but because of the trust's financial position they want to strictly apply the rules of PbR now. For instance, we had a special, we agreed a local tariff for specialist outpatient clinics, specialist nurse outpatient clinics, but the trust said that they want to change the prices.* (CS A, Head of Commissioning)

Thus, the local prices element of the contract was gradually phased out and in 2014/15 it had been more or less eliminated (apart from some local price flexibility that the parties agreed for critical care).

> *I haven't seen the final draft but I think the initial draft said that there wouldn't be any local prices, PbR is PbR. Obviously have a local price if they do something that's not in PbR then that's different. But PbR, some you win some you lose, don't you? I know the Trusts don't like that but that's the reality. Some of the PbR costs they make a bit because they cover more than what it costs them to do it. Some of the other PbR costs it doesn't.* (CS A, Deputy Director of Commissioning)

The commissioners thought that national tariff regime should be more flexible, especially if services were to be moved into the community.

> *Because you could develop a dermatology service in the community but if it's the same service that would have been developed in the acute trust, technically you have to pay tariff, even though you haven't got the overheads of an expensive hospital. If it's a like-for-like service so you've still got a consultant but you haven't got all the overheads of*

a hospital; you still have to pay like-for-like, you still have to pay tariff so where's the incentive to move activity out? (CS A, Head of Commissioning)

One CCG participant reported that for the 2014/15 contractual year, the commissioners had wanted to negotiate a form of contract which did not use the national tariff as the basis for all relevant payments in order to limit their financial risk and reconfigure services, but they were discouraged by the TDA. The trust also preferred to retain the national tariff. The CCG participant pointed out the perverse effects for the local health economy of retaining the national tariff payment system.

We did look, this year, at trying to move the Acute Trust contract away from PbR to more caps and collars contract base, but, again, the Trust Development Agency were not supportive with that approach. Because the Acute Trust are financially challenged, so they didn't want them to do that. But the only way we're going to be able to redesign services and reduce the secondary care footprint is to try and take some of the discussion away from finance and prices to an agreement where we have a set level of income for a set level of activity and we collectively work together to step it down because the PbR system and the contracting is slightly perverse in that why would the Acute Trust want to step down activity when it gets paid for what it delivers? So it's going to crank more work in. So it's kind of, like, perverse in the way the system fights against itself when we all know there's not enough money to carry on doing what we're doing and we've got to do something different. (CS A, Director of Finance, CCG)

In case study A, non-national tariff prices were agreed by negotiation with the acute provider. The commissioners were not prepared simply to agree to changes in prices: they asked the provider to share the reasoning behind their calculations. They were considering if the service could be delivered more cheaply by another provider.

They've informed us already where they want to change the prices. For instance, they want to change the prices now on specialist nurse activity; that could be significant in financial terms. So what we've said to them is, okay share your working papers with us. We also want to understand the nature of those services that are being delivered. What's the new to follow-up ratio? What's the link to consultant? Have a clear understanding before we say yes we're going to commission those, can we commission them somewhere else for a cheaper price; so understanding the very nature of those services before we commission at that new level. (CS A, Head of Commissioning)

In case study B, due, inter alia, to the trust's poor information systems in the past, there had been a contract with a substantial block element (limiting the financial risk to commissioners) and amounting to 20% – 30% of the whole contract, which had been agreed in previous years between the trust and the commissioners (the then Primary Care Trust). In the financial years

2012/13, 2013/14 and 2014/15 the commissioners were trying to move the basis of payment back to cost-per case (i.e. PbR). The two parties worked in close collaboration and put in place a 'price neutrality' agreement (in effect capping the risk to £2m) in order to be able to mitigate the financial risk for either party. This risk sharing agreement was scheduled to apply only for the financial year 2013/14. Although the agreement and the terms of reference of working towards pricing (and thus eliminating) the block element was going on alongside the agreement of the contract, it was envisaged that once the exercise was finished, it would be incorporated into the contract as a contractual variation during the financial year 2014/15.

> *We wouldn't need to vary the contract until the new prices are agreed, then we'd vary the contract to put those prices in, but because of price neutrality the end financial position is unlikely to vary greatly. There are already rules written in the contract to deal with in advance of the project… we effectively dealt with the outcome of it, which would be there could be a financial positive or negative to either party and that's been… as I said, for price it's stuck within certain financial limits.* (CS B, Head of Contracting, Acute Trust)

Apart from greater transparency, paying cost-per-case under PbR would also give the commissioners the flexibility to move activity out of the acute trust and to alternative providers, where appropriate. But there were also financial risks associated with increasing the amount of money paid under PbR. As one commissioner explained in 2013/14,

> *...because they had such poor information systems, what wasn't in PBR was just bundled together into this block, and slowly we've been unpicking little bits of it, but there's still a huge chunk that is all of the local prices. Now, most of that, we could pull out at a cost per case, but by doing that, one, it could destabilize the commissioners, because you pull it out at cost per case, but then it's going to cost the commissioners a lot more. Or, it could go the other way. We start unpicking the block, at cost per case, and it destabilises the Trust... but as things are getting tighter and tighter, and we're deflating year on year, I think it's more in their interest now to work with us and unpick it, and certainly the directors of finance, of which there have been many there, are very keen to move on cost per case basis. If there is a risk, they want to understand the risk and work with the commissioners to manage that risk, but also from a commissioning point of view, by not being able to move activity around the patch, decommission certain services, re-commission them and what have you, it's a block to the longer term strategy, and the appetite from the GPs now is we must do it.* (CS B, Senior Management Accountant, CSU)

As explained above, in 2013/14 the potential financial risk for either party from the exercise to 'unblock' the non-PbR element of the contract was capped. For the 2014/15 contract

negotiations, the exercise appeared to require a re-setting of the baseline, and the CCGs had to decide what steps to take to limit their potential financial exposure. This led to delays in sorting out this element in the contract.

> *The value of the block had shifted between one year and the next, and in understanding that, in reconciling that, it raised issues around the entire contract baseline... it's raised issues of risk, so from a risk management perspective, the CCG needs to have a look at its position to determine whether…. how and how fast it wants to go forward with this exercise in the context of a slightly changed risk landscape, financial risk landscape...*(CS B, Commissioning Consultant, CSU)

For the PbR activity, the mandatory national tariff was applied. The greater flexibility given to contracting parties to vary the national tariff in 2014/15 was welcome by participants who reported that they had started looking at using that flexibility in future contract rounds:

> *In terms of price, the national tariff activity, we have to use that for activity, have to put in the mandatory tariff that is set by the Department of Health. In the past, you couldn't change that very much, but then Monitor introduced rules now where, in theory, you could change that price. So we're just at the beginning of that, sort of, new approach to pricing, which may or may not have a big impact going forward. Currently, in this year, it hasn't had much of an impact, because we've just used the tariff prices.* (CS B, Corporate Income Finance Manager, Acute Trust)

In 2014/15 there were still three main outstanding issues over pricing which needed to be resolved:

1. The historical element contracted under a block arrangement (rather than PbR).
2. Agreeing a price for emergency 'zero length of stay' paediatric admissions
3. Defining clearly and re-pricing 'nurse-led follow-ups'

Although not all issues were resolved, the two parties made good progress towards sorting out a number of their differences. They managed to 'unbundle' most of the local prices element in the block arrangement, but points 2 and 3 were still under discussion.

Local modifications or variations were not applied in this case study but going forward into the next contracting round, the contracting parties were considering implementing a local modification in relation to resolving their disagreement over paediatric zero length of stay, taking into consideration that some flexibility in the tariff was necessary in order to accommodate the short-stay spell for this cohort of patients.

> *What we are trying to do... and this is a broader issue with flaws in the tariff. There's no short-stay adjustment in the tariff for this cohort of patients, so what we're trying to do now is agree on appropriate value for this cohort of patients: an appropriate local price.* (CS B, Corporate Income Finance Manager, Acute Trust)

In case study C, there were no important disagreements over pricing or funding, and the terms of the national standard contract were followed. Asked about whether they had disagreements over financial issues, one participant explained:

> *Obviously we have negotiations but, we haven't got a history in this health economy of having kind of great financial tensions with our providers, and I think that partly comes from how we set ourselves up as a PCT, I think we very much saw our PCT as kind of being the leader of the health economy, we saw ourselves as having responsibility for the financial health of the providers and it wasn't a case of just penalising the providers, so I think we've always taken a kind of very responsible position that it's in our interest that they're financially stable, as much as we're financially stable.* (CS C, Head of Commissioning and Procurement, CCG)

Asked about any risk sharing arrangements for 2014/15, one CCG participant explained:

> *This year, we don't officially have any risk sharing arrangements. In the past, we have had a risk sharing arrangement, whereby the first 1%, for example, we don't pay, or 1% either way. Whereas we haven't a full risk sharing arrangement this financial year...Effectively, we just adhere to the national contract now, which doesn't really have tolerances in there. But up until this financial year, we did have a risk sharing agreement, so we could enact that again and it might be something we need to explore*. (CS C, Director of Finance, CCG)

The participant went on to say, however, that the need for putting in place informal risk sharing arrangements was always present, and that not everything which was going on locally was reflected in the terms of the contract which had been signed.

> *What we do is we have negotiations around what non-recurrent support we offer the Trust in terms of if we want to support them during winter, for example. An example now is not only the systems resilience funding,... but there's a ward, which is, essentially, supported to be a rehabilitation, re-ablement ward, which used to be commissioned by the local authority. And they're moving that from November, i.e. they've got a different model. So we are in discussion with the hospital around ensuring that capacity stays open, and therefore, offering non-recurrent funding for it. So it isn't as simple as, you know, we just adhere to the contract. We recognise that there are elements outside the contract that we need to have discussion on, around.* (CS C, Director of Finance, CCG)

<u>The 30% marginal rate rule for emergency admissions</u>

All three acute trusts in our case studies reported substantial increases in emergency activity. It was agreed in each case that it was necessary to vary the contractual term which used the emergency admission figures from the year 2008/9 as a baseline for the calculation of the 30% of national tariff, marginal rate payment in respect of 'over-performance'.

In case study A, the trust asserted that the 2008/09 baseline was inappropriate due to increased patient flows and tried to convince the commissioners to change it. The commissioners disagreed and this (together with a number of other issues) resulted in the parties escalating their disagreement and seeking formal mediation (see the section on *Disputes* below). In the end, the trust in effect won this point since the commissioners were ordered to pay a marginal rate of 65% of national tariff for emergency admissions instead of 30% as stated in the contract. This fact (together with the funding they lost to specialist commissioning) put an additional strain on the commissioners' finances.

The commissioners accepted that emergency activity had gone up in recent years and that the 2008/9 baseline did not reflect that. They were keen therefore to make sure that their demand management schemes worked. Since that was also in the interests of the acute provider, a joint approach to managing demand was adopted:

> *...what we've seen recently, we've seen a deterioration in 18 weeks because there's been a lot of cancelled elective surgery to accommodate emergency activity. So the Trust don't want to draw in work because they're going to get 65%; they actually want us to manage the activity in primary care. So there is very much a, sort of, a joint approach to making the schemes work and managing activity within the capacity available.* (CS A, Head of Commissioning, CCG)

The trust explained the financial effects on them of receiving less than full national tariff in respect of a significant proportion of their emergency activity:

> *The issues for providers, you know, if you've got a little bit of activity around the edges, and small variation, it may or may not cover your ward costs. But as soon as you put a big change in activity, by using 08/09 as a baseline, of course emergencies have gone up here across the country in that period, there's automatically a huge chunk of activity, that per these rules, is then paid at 30%, when actually you've got the whole infrastructure and your fixed costs and the wards and everything else to, that it just doesn't cover.* (CS A, Ass Director of Finance, Acute Trust)

The trust made a point that going forward into the 14/15 contract negotiations, re-setting the 2008/09 emergency activity baseline would be one of its key priorities. Due to persisting disagreements, this was one of the issues over which the parties sought formal mediation again

just before signing the 2014/15 contract. CCG participants reported that as a result of mediation, the baseline was re-set to the 2012/13 levels of activity.

> *It was reset for this year's contract. It was one of the areas that went to arbitration. We as a commissioner believe that the overall population has only increased in line with the national position. We didn't think it was exceptional. The acute trust believes that the frail elderly was exceptional. Arbitration panel agreed that that was exceptional. Therefore it was… it's been reset to 2012/2013 outturn...I think the reality is, as we move forward, the 30% marginal rate will disappear altogether, is my own view on it. I think it'll just be full cost. In the same way as every other component of it is.* (CS A, Director of Finance, CCG)

In case study B, the issue of agreeing the baseline level of activity for setting the start of the 30% of national tariff for emergency admissions during the 2013/14 contracting round resulted in frequent discussions and disagreements. Participants reported that in 2013/14 they deviated from the rule, using PbR national guidance to allow a change.

> *I mean, the first big hit for the acute providers was the marginal rate on non-elective activity. You can do the work, don't get paid, but I understand the basis of that because effectively if you've funded your A&E department out of your baseline payment the rest should just be a marginal rate. Unfortunately, it doesn't work well for us where our local population is growing rather rapidly or where we've taken over the A&E load of another hospital, so you have to look at it in a local context, the application of these things. The contract wasn't designed to take that into account, but you can always deviate from that contract.* (CS B, Head of Contracting, Acute Trust)

However, despite significant increases in emergency activity later, the parties were not able to agree a different baseline (as the 2014/15 contract allows) but followed the 2008/09 baseline.

> *One of the issues that we had here was trying to agree on what the appropriate threshold was, so we had a long, long discussion over many months and loads of datasets about what is the basis of the threshold, and actually on one hand we were saying, actually thresholds should go up because, you know, we're having more activity, and the CCGs were saying it should go down because the activity shifted to another provider.* (CS B, Corporate Income Finance Manager, Acute Trust)

A relatively high level of emergency re-admissions in case study B was another issue which led to differences of opinion between the provider and the commissioners. Although an audit had been performed two years prior to 2014/15, and despite the involvement of external consultants, the provider questioned the robustness of the audit. This situation led to significant

disagreement between the two parties. The commissioner insisted on the robustness of the audit while the provider did not accept the outcome.

In case study C, there had also been substantial increases in emergency activity over the past few years, and the parties were able negotiate a higher baseline of activity which did not correspond to a specific later year:

> *It wasn't a year, it was a decision whereby we took account of what appeared to be real changes in referral patterns... So we took those into account and arrived at an emergency threshold baseline that was higher than 08/09 levels.* (CS C, Director of Finance, CCG)

Community health services providers

The position concerning the allocation of financial risk in respect of community health services (CHS) was different to that of acute care. As there were no relevant HRGs nor national tariff prices, it was not possible to contract on a cost per case basis. The community contracts were on a block basis (apart from perhaps a small element that is tariff-based for services such as outpatients or minor injuries units, if available). Thus, risk of 'over-performance' was borne by the providers, as the block method of payment amounted to a fixed budget. Of course, the commissioners were at risk that the CHS provider did not carry out enough work, but this was hard to ascertain, due to the poor information systems in respect of CHS.

No issues related to financial risk allocation were reported in either case study A or C. (We were not able to obtain access to the CHS provider in case study B.)

Participants reported that volumes of activity in respect of CHS were monitored throughout the year and any over-performance or under-performance informed the setting of the next year's block amount. Although the block contract provided certainty over finances, it impeded moving the activity from one type of provider (e.g. acute Trust) to another (e.g. community health care setting). In order to make such moves easier, the participants suggested that national tariffs were needed in respect of CHS so that money would follow the patient.

> *There's something about as we move forward, we recognise that we've got to transform services. So essentially, less direct acute provision and more alternative provision, either a primary care, community care or social care setting. Now, in order for that to happen, it's simpler that the money follows the patient. So from that perspective, I think, going forward, a tariff type contract works better, because the money's more easily moved.* (CS C, Director of Finance, CCG)

The commissioners we interviewed said they would have preferred a cost and volume or cost per case contract, but the data to support this was not yet available in the CHS sector.

> *When we've got more confidence about data recording, we would like to move more towards cost and volume contract, but we're not ready yet. So that's the reason why it's stayed as a block.* (CS C, Director of Finance, CCG)

Mental health providers

Similar to the CHS contracts, mental health (MH) contracts also structured payment on the basis of block payments. Both in case study A and case study C, the commissioners were working towards moving to payment for clusters of activity instead of a simple block for all MH work, but neither case study had achieved this yet. As one participant in case study C explained,

> *Similarly, that's block at the moment. We've done quite a lot of work in terms of informing the cluster tariffs. But there seems quite a lot of volatility around their application, so at the moment, we're sticking to a block arrangement.* (CS C, Director of Finance, CCG)

The same view was echoed in case study A. The commissioners were monitoring the MH tariffs in shadow form but they were not yet ready to move into a cost and volume contract because of the financial risks involved. Asked whether they would be ready to move into a cost and volume contract in 2015/16, one participant explained,

> *For this year the contract is all block, but we're doing a lot more work around the implementation of the shadow tariff, so doing more around monitoring and shadow monitoring to see what that looks like because at some point then we will look to implement the tariff and move away from block to a cost and volume. It's just how we do it, as I say, in a way that protects both provider and Commissioner...I think, unless we're told to implement it in 2015/2016, I don't think we probably will. I think we'll want to do some more work in terms of refinement.* (CS A, Director of Finance, CCG)

Summary of findings on financial risk allocation

Our three case studies of local health economies demonstrate that it was difficult to abide by all the rules in respect of the allocation of financial risk set out in the national standard contract each year in respect of acute care. Financial adjustments were made at the end of the financial year, which included substantial elements of additional payments. This appeared to be due to increases in volumes of activity, coupled with increasing financial stringency at local level, and the concomitant desire to reconfigure services to decrease activity in hospitals trusts. Moreover, it was not possible to use the national tariff/ PbR system in year in all places, and one case study site had resorted to block contracting for hospital care.

The allocation of financial risk in respect of CHS and MH was less problematic. However, using block contracts made reconfiguration of services more difficult, as it was not possible easily to identify the costs associated with particular CHS or MH services.

Financial levers to improve quality of care

A range of financial levers, both incentives and penalties were contained in the national standard contract (see the previous part of the report which sets these out in detail). In addition, parties could agree other local targets which attracted financial incentives.

We investigated how the financial levers in the national and locally agreed parts of the contract were used in practice in the three case study sites. In all three sites, the performance of providers regarding the contractual quality targets was monitored by commissioners in separate Clinical Quality Review meetings, rather than at contract monitoring meetings which focussed on activity and finance. (At the time of writing (December 2014) we had not been able to obtain the local quality standards from the case study sites. These might be available in 2015, in which case they will be discussed in the revised version of the report following peer review.)

Penalties

Acute Providers

The national contract set out financial penalties in the case of failure to achieve national targets such as the maximum of eighteen weeks from Referral-to-Treatment (RTT) and the maximum four hour wait in A&E. Achievement of such targets depends on a number of factors, such as a trust's internal organisational processes or external factors such as increases in the number of patients presenting at A&E, increases in patients with complex health problems and co-morbidities, or increasing difficulty in discharging patients into the community. Delayed discharges are a long standing problem in NHS hospitals, which, in turn, can result in failure to achieve the eighteen week RTT target. Due to these factors, many trusts across the country, including those in our case studies, struggled to meet these two targets.

In case study A because of the very good personal relationships between the executive teams in the commissioners and provider, the commissioners had avoided applying the relevant penalties in the past, preferring instead the option of a 'light touch' approach. In 2013/14 and 2014/15, however, the commissioners started gradually to apply the sanctions specified in the contract in a more rigorous way. Asked whether they thought that the penalties had an effect on changing provider behaviour, the commissioners in this case study responded that they found the threat of sanctions to be a powerful lever.

> *It focuses their minds, I think, certainly around the 18 weeks. When I wrote to them and said we'll be imposing this financial sanction, I'll need a trajectory and an action plan to get you back online. We can consider waiving it if you get back on track by,*

and I gave them a deadline, by which to get back and so that was an extra incentive that pushed to say, you know, we can impose this. We will impose it but we'll give you two months to get yourselves back on track. So that was quite useful there. (CS A, Head of Commissioning, CCG)

The ultimate effect of applying contractual sanctions needs to be considered, however. At the year-end financial adjustment the provider effectively received back the money deducted as a penalty for failing to achieve the quality targets. One participant explained:

Last year we fined them, there was a significant fine for C Diff; it run into millions of pounds. On the reconciliation statement we took the money off them and then we reinvested it back in below the line again, so it was a bottom line adjustment. (CS A, Head of Commissioning, CCG)

The commissioners in case study A started taking a different line about contractual penalties in 2014/5:

But what we want to do and we're clear about is that we need to change the culture of the Acute Trust. Whilst last year we went through the fines and we fined them, last year we just handed it back to them on the bottom line and we need to change that culture. They can't expect it's just going to come back; they need to earn it back to raise quality. And that's our approach this year. (CS A, Head of Commissioning, CCG)

Instead of giving the money retained from applying the sanctions back to the Trust, a process was being set up to determine the use of such funds:

Completely different environment now; we take a firm line now in terms of the application of financial sanctions. We've just set up a new process for a decision-making group to decide, okay, we've applied these financial sanctions do we think about a quality initiative to reinvest that money or actually because of our financial position as a CCG we need to retain that money?... last year it was a culture of automatically we reinvest. We're going to put caveats to any reinvestment for this year; we need you to do something for this money and it will be linked to quality. (CS A, Head of Commissioning, CCG)

In case study A in 2013/4, the acute trust was failing to achieve the 18 week RTT target, apparently due to increased activity in A&E. The CCGs applied the relevant penalties stated in the contract, but after discussions with the trust and demands for realistic action plans by the trust, they reinvested the money retained as penalties back into the trust to enable it to meet the targets. Agreement for such re-investments took the form of side letters or oral assurances by the commissioners.

We agreed a side letter to the contract, when we actually signed it, which basically set out a kind of a risk share arrangement, so along the lines of, you know, if the CCGs have access to more funding as the year goes on, then they will direct that to the Trust

> *to resolve some of these issues... If contract penalties are applied, but actually the Trust can prove that, you know, we've acted responsively, there's an action plan and we're trying to address the issue, all that kind of proactive stuff, then they would look to reinvest.* (CS A, Assistant Director of Finance, Acute Trust)

In 2013/14 the commissioners identified the penalties but in the end they did not retain the money. Instead it was in effect given back to the provider as part of the year-end settlement. The commissioners followed a collaborative approach, and seeing that the provider was in danger of presenting a deficit they decided to support the trust in the interest of the broader local health economy.

Asked if they had also signed a side letter to this effect in 2014/15, this participant explained that, while the arrangement relating to re-investing funds from penalties agreed in principle, it had also been made clear that such investment was conditional on the commissioners being satisfied that the provider had made a reasonable effort to resolve the issues.

> *We have [made an agreement], but the wording of it is such that it's not an automatic, if we fine you we will reinvest it, it's where we fined you and you know, you're actively working on an action plan and you're being responsive and it was outside of your control... so it gives them the ability to reinvest and to not impose the fine, and it gives us the ability to ask them to do that, but it doesn't really hold either party to actually do it.* (CS A, Assistant Director of Finance, Acute Trust)

In this case study, the commissioners thought that the threat of penalties did have the effect of forcing providers to concentrate their efforts on achieving the targets. One participant said,

> *They do have a place because the Trust have to report to their own Board if there's been a financial sanction applied and clearly, you know, it has impact on their reputation if they're not meeting the national standard. So they do definitely have a place.* (CS A, Head of Commissioning)

One trust participant also noted that the threat of penalties focused the attention of providers, However, she argued at the same time that, at least in relation to major national targets such as maximum waiting time of 18 weeks; maximum waiting time of four hours in A&E; numbers of C-Difficile and MRSA infections; and maximum waits of two weeks for cancer referrals, providers were also under intense scrutiny from other agencies (for example, the NHS Trust Development Authority), the contractual penalties were not necessarily the main catalyst for achieving those targets.

> *So for some of them, the penalties become almost a little bit secondary, you're kind of like, well actually yes, we know there's a problem and we know there's an issue and we're having to deal with it anyway, so if you want to slap us further by penalising us, then.* (CS A, Assistant Director of Finance, Acute Trust)

In case study B the acute trust was in deficit and the parties put in place a cap on the penalties which could be levied, both in the 2013/14 and 2014/15 contractual years. The trust failed to reach a number of national quality targets, for example, four hour maximum wait in A&E, and maximum 18 weeks wait in Trauma and Orthopaedics. Asked about whether the commissioners applied penalties in 2013/14, one trust participant explained the interplay with the end of year financial settlement,

> *They come in to play at the year-end settlement, so last year the penalties I think, or threat of penalties, were incorporated into that year-end settlement. This year we have a risk share agreement on penalties, so…Because we are in such significant financial deficit there's no point in fining us because we don't have any money to pay a fine from, whereas some other hospitals will be generating multi-million pound surpluses, we are not, so if you take money out of us it doesn't come out of the surplus, it comes out of the things we're using to deliver services, or that's the argument I explained to the CCGs*. (CS B, Head of Contracting, Acute provider)

The commissioners confirmed they had agreed in 2013/4 both to limit the amount of money deducted from the provider and also to re-invest the money retained as penalties:

> *...whereas the contract has certain limits, so it says for local quality it mustn't be more than 1% of the contract value, and you can't have a withholding notice of more than 2% of the contract value anyway. Those rules have been, let us say, placed to one side and the rules that are working locally is we can't be fined more than £1 million in a year for the local CCGs, and when they do apply a fine 70% of it has to be reinvested in us, and the 30% contributes towards that £1 million. So, if they fine us £1 million for failing 18-weeks £700,000 of that has to go back in to helping us meet 18-weeks.* (CS B, Head of Contracting, Acute provider)

A number of participants in case study site B (mainly from the provider side) believed that the penalties did not achieve anything if the problem was beyond the provider's control. Asked if penalties resulted in quality improvements, one participant said:

> *Well, yes, if you fine us too much we can't deliver any service at all so it can have a very real impact.* (CS B, Head of Contracting, Acute Trust)

Another participant agreed that the penalties were being used to achieve political priorities outside the direct control of providers party to the contract. Penalties, such as that for the failure to reach the maximum waiting time of 18 weeks, depended not only on providers' behaviour but also on a number of different factors, such as ability to discharge patients into the community and the commissioners' ability to manage demand. Penalising the provider in such circumstances would seem to be unfair and also contractually unsound.

> *I mean, penalties… penalties were a good idea badly implemented, is my view. There should be sets of contract penalties, but they should conform to the fundamental principles of contract law, which is that the penalty should be commensurate to the amount of harm or damage caused. At the moment the penalties are all over the place, so the very, very punitive ones are technically unenforceable because they are… they are penalising on the grounds of public policy rather than actual harm. So the contract has been used as a device to penalise trusts and hit them over the head with a big stick for doing things in contravention of public policy - that's not the purpose of the contract.* (CS B, Commissioning Consultant, CSU)

One trust participant in this case study made a more general point about the use of contractual levers:

> *What I'm just saying is that I've got no problem with the contract in principle, I have no problem with the levers in a contract per se, all I'm saying is that a contract can't be the vehicle to address all the ills of the NHS and seek transformational change when all a contract is, is between two partners to deliver A or B. So that's my view. I think the contract is too wide, it's trying to achieve too much and it's become an administrative burden.* (CS B, Corporate Income Finance Manager, Acute trust)

The acute trust staff in case study B also questioned the appropriateness of setting national targets for all acute trusts. This trust (which was also challenged on quality issues) emphasised that certain national targets were not appropriate for a provider of their sort. For example, the national stroke target was not appropriate because the trust was not a hyper-acute stroke unit. Instead, the commissioner and the provider had agreed a remedial action plan (RAP) about an element of stroke care in 2014/15 but, at the time of the research, no money had been withheld because the RAP had just been agreed. One provider participant said that in the past, the commissioners tended to apply financial sanctions for non-achievement of RAPs but, similar to the treatment of penalties, they tended to be paid back when the year-end settlement was agreed.

The provider also expressed dissatisfaction with the large number of local quality metrics and CQUINs which the commissioners had imposed. The trust would have preferred to have fewer, more focused targets. For example, in 2013/14 the number of local quality targets was 120 and in 2014/15 it had risen to 150. In addition to the number of the quality indicators, disagreements resulted from differences between the two parties in interpreting what exactly the agreed quality indicators meant. One participant said:

> *There's always disagreement on how you measure penalties and how you measure CQUIN performance. It would be better if they were agreed in advance but invariably what happens is they're written in such a way that one party or another manages to measure differently to them.* (CS B, Head of Contracting, Acute provider)

Despite our efforts, we were not able to attend clinical quality review meetings, nor were we able to interview a member of staff responsible for quality performance from the commissioner side. One participant commented that the Clinical Quality Review Group (CQRG) did not appear to be well integrated with the rest of the contracting process. Although CQUINs and the Quality Schedule in general were managed through the CQRG meetings, this participant felt that they should be mainstreamed and monitored via the general Contract Performance Management process as well.

> *What we need to do is connect it in more with the sort of KPIs and the contract that the Trust is accountable to us for. Our vision is that the CQRG effectively becomes a subcommittee of the Contract Performance Management Committee, which is your top committee, and that the CQRG also adjusts its agenda to ensure that it covers both issues of patient safety and experience, as well as the accountable elements of the quality schedule in a manner that is much more knitted into contract management.* (CS B, Commissioning Consultant, CSU)

In case study C, the acute trust breached a number of national quality targets, for example, the maximum eighteen week wait from RTT; the maximum four hour wait in A&E and the level of C-Difficile infections. The relevant national penalties set out in the 2013/14 contract were applied by the commissioners. However, as one trust participant explained, the commissioners tended to put the money retained from applying penalties back into the trust to be used for the improvement of services:

> *I mean some things are absolutely, you know, absolutely applied. But I think they're quite good, we get most of the money back actually. So the money that we're fined we get back because we can make bids against quality improvements to the organisation. So we get quite a lot of it back.* (CS C, Director of Nursing, Acute and Community Care provider)

Similarly, a CCG manager confirmed the collaborative approach taken and explained that it would not be in the CCG's interest if the providers within the health economy failed. The CCG therefore re-invested money retained as penalties, when appropriate.

> *'... although we do apply fines and things to contracts, it doesn't stop us, I think, moving more into the performance side, at the moment they're struggling with A&E for our target. And they failed quarter two, but we recognise that as a health economy, we don't want them to fail quarter three, we don't want them to fail that target, we will do whatever we can, if that might include some further investment to try to help them, so it's certainly not a kind of adversarial type of relationship, it's still a...it's a*

collaborative health economy type of relationship'. (CS C, Head of Commissioning and Procurement, CCG)

The participant explained further that most of the funds retained from fines are put into a pot and any provider within the local health economy may bid for it. The money is allocated on the basis of the potential for quality improvements:

'most of the fines, and I think we've categorised certain ones may not be suitable, but generally, we put the fines into a pot, into a quality pot, and the hospital, and any other provider, for that matter can bid for quality improvement. There's got to be a quality improvement scheme, and there's a formal bidding process where the bids are evaluated, is this going to do anything, and they're normally non-recurring schemes, but potentially the hospital can get their money back, for what we fine them, but it has to be demonstrated to be quality improvements'. (CS C, Head of Commissioning and Procurement, CCG)

In areas where performance was weak, for example, in respect of the maximum four hour wait in A&E target in 2013/14, the CCG applied the contract mechanisms according to General Condition (GC) 8 (i.e. Contract Query Notices, Remedial Action Plan). Remedial Action Plans (RAPs) were agreed and monitored. The CCG reported that an exception report was issued to the trust and the CCG intended to withhold money from the trust, according to the contract.

As it is now they've breached a remedial action plan as a result of the contract query notice, and we're on the first exception report which again is another accelerator of the gears of the performance management process that's set in the contract, which is contract query notice, first exception report as a breach of the remedial action plan. And then failure to bring it all back online with the result of a second exception report. (CS C, Contracts Manager, CCG)

The CCG was determined to apply the mechanisms of the contract and, if necessary, permanently to retain a substantial sum of money if the trust failed to comply.

'this is where we're now looking at what are the levers past second exception report? But along with the first exception report there's a withholding of money, so although you don't have that with a contract in the initial stage it does move on to financial penalties later to the tune of... we're holding almost a quarter of a million at the moment, and it's a withhold, it's not a taking off yet. But if a second exception report is issued then it's a take off. So you know we're talking serious money with the contract query notices. (CS C, Contracts manager, CCG)

The same participant explained that Contract Query Notices and Exception Reports were effective because they reached the trust's Board. The trust would then ensure an effort was made towards meeting the target before a penalty was levied.

> *Whereas when it gets to contract query notice and exception it starts getting recognised at the board level, which if, as with any organisation, the minute it starts hitting those kind of senior people within an organisation more things are actioned, a lot more's done a lot quicker, if you like. So I think it's horses for courses with the contract to a certain extent. Penalties are good for some areas, but I think also a contract query notice is another penalty with other levers within the contract are more useful and come with heftier fines in some cases.* (CS C, Contracts Manager CCG)

But, this approach was not always effective, and, in the end, the CCG retained money after issuing a second exception report, only to give it back to the provider in the year end settlement.

> *There were exception reports in relation to A&E. I think there was an exception report for something else as well. And we withdrew the monies. We didn't pay the monies. But we did end up giving it back at the end of the year. But we did exercise the withdrawal option.* (CS C, Head of Commissioning and Procurement, CCG)

Contractual levers (financial or other), however, could not always ensure improvement, especially in the context of rising demand. One participant explained that the trust was making huge efforts to deal with the increasing demand anyway, *irrespective* of the fear of application of penalties.

> *We have, I think, over one thing had a second notice, which I think is the A&E target. And we're trying, you know clearly we're not all sat here thinking oh dear the A&E target's not very good, we are actually doing quite a lot of that. So I think the CCG are recognising that, the TDA are recognising that, but we haven't had any fines as far as I'm aware.* (CS C, Director of Nursing, Acute and Community Trust)

As in case study B, in case study C, the provider complained about the large number of quality metrics in the contract. In this case, CCG participants explained that, following discussions with the trust, the quality metrics became more focused because they would have a better chance of success.

> *'I think when we do local KPIs, we put CQUIN schemes in, we do try to relate those to local priorities, I think we very much relate in the new world, the five domains of the NHS outcomes framework, so I think we try to make sure that they're there for a purpose, yes? I think when we did the last contract round, we took out quite a number of KPIs, and because I thought the feeling was, this is a bit over-bureaucratic, we're trying to do too many, and we tried to prioritise them a lot more. So, again, we're taking notice of the Trust in the sense of trying to get this balance between, you know, being, managing a contract properly but not being over-bureaucratic with it, so I think we're learning to be more focussed, I would say'.* (CS C, Head of Commissioning and Procurement, CCG)

Participants also mentioned that, in the past, penalties for failure to achieve national quality targets were applied at the end of the year, which resulted in uncertainty about the budget closure at the end of the financial year (because the final data from quality performance was received later than the closure of the financial year). In 2013/14 this had already changed, which was welcomed by commissioners, and a number of penalties were applied quarterly.

> *There's been a bit of movement now with contracts because this year for the first time they've actually now started... they've actually changed the penalties around, say, Accident and Emergency, so it's applied on a quarterly basis. They've changed the financial penalty around the cancer targets, so they're also done on a quarterly basis, which is helpful. So, you know, at least there's... there's that earlier intervention possible, right?* (CS C, Head of Performance, CCG)

In case study C, in 2014/15, the situation in respect of the waiting targets for A&E and RTT deteriorated. The trust's performance in respect of waiting times from RTT in particular, dropped substantially and when asked to develop an action plan for clearing the RTT backlog, the trust were not able to produce a viable plan, despite a national incentive being in place in the form of additional funding. The situation was complicated by the introduction of a new IT system which seemed to result in an incorrect validation of data. The CCG staff felt powerless because, on the one hand, they could apply the maximum penalty for failure to achieve the target, but, on the other hand, the trust had not produced a viable Remedial Action Plan (RAP) against which to monitor performance. In addition, the CCG was under pressure from NHS England to sort out the problem, as it was regarded as a systemic failure rather than merely the provider's fault. Applying contractual penalties would make the financial situation for the trust worse.

> *Well, the maximum is 2% of the contract value in any one quarter, so if we were to apply the August figures...that would take us over the 2%. So it gives us an issue. So we're applying the maximum level of fines. The difficulty with that is in… from NHS England perspective, we need to demonstrate that we are being robust in our contract management, but we're also being helpful as well, in terms of helping to try and solve the problems. But, of course, you know, imposing fines on the Trust doesn't help their financial situation, which is also precarious, and, you know, are we doing more damage by imposing these fines? So it's the standard kind of dilemma in the contract, in terms of, you know… that imposing fines sends out a message, but in reality, does it actually deliver any benefits?* (CS C, Head of Commissioning and Procurement, CCG)

The commissioners encouraged the trust to use independent providers in order to reduce the backlog, but, due to administrative staff shortages in the provider trust, the commissioners took on the task of contacting alternative providers themselves. They also encouraged local GPs to offer patients a choice of alternative providers. However, many patients were not willing to use alternative providers, despite the longer waiting times in the local acute trust.

As already mentioned, in addition to failing the RTT target, the provider did not meet the maximum four hour wait in A&E target, despite a number of measures by the CCG to manage demand, and despite the fact that this specialty was not particularly affected by the new IT system. The commissioner used the contractual levers at its disposal, but as one participant mentioned, the use of the contract needs to go hand in hand with wider modelling and control of demand and capacity.

> *So the contract works, in terms of if they're not doing it, we don't pay, and also, if they're not meeting the targets, we apply the fine. But, basically, the lesson that we're learning is the contract should be tied in with a demand and capacity model, and that's where we're moving now, to work collectively with the local trust to actually get a demand and capacity model.* (CS C, Director of Finance, CCG)

In this case study, applying penalties was perceived as being effective:

> *'But I think, yes, there are some examples of areas that we used to fine them a lot, and they're improved, and I think, so we can demonstrate that by having, using the contractual mechanism, we have had some success'.* (CS C, Head of Commissioning and Procurement, CCG)

Participants found the national quality targets useful in changing provider behaviour.

> *I think the national targets that we've had, up until this year, and maybe that's because I'm used to working with those targets, have been really beneficial actually, so things like the 18 week referral to treatment, the four hour A&E, the cancer waits, those sort of things, I think really help to drive change*. (CS C, Lead Nurse, CCG)

Participants felt that an effective balance had to be struck as far as penalties were concerned. If the penalties were too small, they would be ignored by the provider. The penalty had to be of a magnitude which forced the provider to take action.

> *And I think there's a tipping point as well, depending on the value of the penalty. If it's 5k, they'll just take the heat. If it's 50k it makes them, oh, hang on a second. If it's over 100k, they're like, sorry, this is not good. And especially then when it becomes 250k a month, that's when you see real action being taken. So again, it depends on the value of the penalty, and this is what I said to you before about the balance of the penalty needs to be considered more, I think*. (CS C, Contracts Manager, CCG)

Another issue that participants mentioned when asked about the effects of penalties was the fact that penalties on their own were unlikely to achieve behavioural change. One proposal was to co-ordinate the regulatory function of agents such as Monitor, the NHS England Area Team, and the Clinical Quality Commission (CQC), with the application of the contract.

> *'In the grand scheme of things, it's £30,000 out of a £180 million budget. They would spend that on photocopying paper or something. So it's not going to shake things up.*

> *So what I'm saying is that I think what they need to consider is, you know, is actually you've got to think about all the different inspection regimes and processes and actually try and align some of these things up. So if Monitor is saying over here, yes, you fail A & E once or twice or whatever, this is what the implication is, and we're here just applying the fine, bang, bang, bang, what they should be doing is integrating that approach, so it all works together, right?* (CS C, Head of Performance, CCG)

This participant suggested that after the penalty was applied once, the issue should be escalated upwards in the NHS hierarchy if the provider was still failing the target.

Although Trust participants agreed that having penalties and incentives did contribute to improving quality, they also thought that not all penalties are effective.

> *Do penalties make a difference? Probably not - because actually we're working really hard and we get a penalty when we can't do anything about it. So you know we don't deliberately make people wait for ages in A&E and we try very hard to get them through.* ((CS C, Director of Nursing, Acute and Community Care Trust)

Community health services providers

The national contract contains penalties which apply to CHS providers, as well as acute trusts.

In *case study A,* the commissioners chose to adopt a collaborative and supportive approach instead of using penalties in respect of failures related to quality of care. One participant explained,

> *We chose not to go down the fining route for some of it, because we wanted the learning to happen and to get their systems and processes more efficient. So, classical example of that was around serious incident management. Now, serious incidents, their root cause analysis were of poor quality, we were sending them back, they would send them back to us, we were sending them back again, they just didn't give us the assurance that there was the learning taking place and that there was systems and processes in place to prevent them happening again. So, we asked them to focus much more on getting the quality of those better, which is what they've done...But we've done it through my team supporting them and saying, look this is what a good root cause analysis should look like, we're having to share templates with you and since then, we've improved dramatically over the last year. But, I think to have fined them, would have gone down completely the wrong route and we wouldn't have got the results that we've got through the joint working and partnership that we've put in. You can apply sanctions, I believe, but we chose… if you want to, but we chose not to.* (CS A, Clinical Quality Manager, CCG)

The commissioners in this case study reported that they had not had any occasion to apply the penalties in respect of breaches of either national or local quality targets.

In *case study C*, there is one trust encompassing acute services and CHS. They reported that penalties and incentives for CHS were not monitored separately, and they did not tell us of any problems in relation to these standards

Mental health providers

In *case study A*, there is one trust encompassing CHS and MH services. The targets were not monitored separately. Participants did not report the imposition of penalties in respect of MH.

In *case study C*, again commissioners reported they were happy with the trust's achievement of the MH quality targets and they did not impose any penalties.

Incentives – CQUINs

In addition to providing for the levying of penalties for failure to meet certain targets, the national standard contract also provided for the payment of financial incentives on the achievement of certain targets. Parties could also agree additional financial incentives at local level.

Acute providers

In case study A, the provider achieved most of the CQUINS in 2012/13 and 2013/14. The field work for this research project finished before final performance in respect of CQUINs was measured in 2014/15. The provider commented that in recent years the CQUINs they had agreed turned out not to be achievable. In the past two years, however, the trust had learned from this mistake and had made sure they negotiated and agreed achievable CQUIN targets with the commissioners.

> *I think we've had our fingers burnt in the past where we've actually had CQUINs which we've agreed, or perhaps that we've agreed to accept, rather than us being the one that's proposed them, which actually, you know, weren't achievable, and therefore we've almost set... we've almost been set up to fail. But that's a learning, isn't it? So, you know, the learning is, make sure that whatever you're signing up to is achievable.* (CS A, Director of Operations, Acute Trust)

In case study B, despite the financial challenges facing the acute trust, it achieved over 80% of its CQUIN targets. Asked about whether the CQUINs had effected significant changes in the quality of services, one participant explained,

> *They just haven't been used to really drive significant quality forward, although there've been salami slices in so many local bits that they actually lose any resonance at all because there's too many CQUIN schemes chasing a very limited pot of money. So, conceptually a good idea to have, you know, a good chunk – 2.5% of your income – held in reserve against a delivery of certain key things. In practice, not sure that it's worth the way it was envisaged.* (CS B, Commissioning Consultant, CSU)

This participant explained that the commissioners were in the process of undertaking a review of the long-term effectiveness of CQUINs on quality of services, with the intention of making them more narrowly focused in 2014/15.

In case study C, participants reported that the provider consistently met the CQUIN targets (which are combined for CHS and acute services). In setting the targets, the CCG adopted a collaborative approach. The CCG suggested a number of schemes which were CCG priorities which are then discussed with the provider to assess their feasibility.

> *This year the CCG were very keen to have a scheme around alcohol and alcoholic abuse really, but we felt that that was really difficult and we weren't quite sure how we would action that, so it's not in. So we had… they put it forward, I think they had something like 13 or 14 schemes, we've ended up with nine. So we have a negotiation about whether we can do it or, you know, whether it's… because sometimes it sounds like a good idea but actually when you think how am I actually going to provide this information, it's just not a doable thing.* (CS C, Director of Nursing, Acute and Community Care Trust)

A selection of CQUINs for this Trust included: a reduction in the number of falls, a reduction of Grade 2 and Grade 3 avoidable pressure ulcers (but no Grade 4 pressure ulcers), safety thermometer with a particular focus around UTIs and patients with catheters, a national one on dementia screening at 75, and also a local CQUIN on Dementia screening at 65. Trust participants reported that the CQUINs were effective in improving the quality of services. For example, the CQUIN relating to falls resulted in a reduction in the number of falls.

> *So last year's falls CQUIN was we had to reduce the number of falls by 50% and we had to evidence that nobody fell and sustained an injury who was at high risk of falling. So that meant we had to be very clear about the number of people who were at high risk of falling. So what that translated into for me was we had something like...we had about 300 falls the previous year and we had to get them down to 140 which we did.*

And the number of falls that we had, we know that we have about 550 beds, about 250 people will be at high risk of falls at any one time. Before the CQUIN we weren't quite sure about that but now I can be absolutely confident. (CS C, Director of Nursing, Acute and Community Care Trust)

The national CQUIN targets, as well as the local quality targets, were becoming increasingly hard to meet, due to the CCG's more exacting targets. For example, the trust was allowed only one Grade 4 pressure ulcer per quarter and failure to meet that target resulted in the provider losing £40,000.

Nevertheless, trust participants in case study C thought that improvements achieved by local quality targets and CQUINs were maintained because they tended to be incremental and gradually became embedded within the Trust.

Because I think it's been embedded in a year, or most of our schemes are sort of developmental so you start with one and then you sort of…So we started with a 50% in pressure ulcers and then it becomes 50% reduction in Grade 2, 90% reduction in Grade 3, no Grade 4s, so they're sort of iterative really. And I'm sure we will eventually get to a point where actually they say listen we don't need to do this anymore. But I think internally we still continue to monitor that. (CS C, Director of Nursing, Acute and Community Care Trust)

Community providers

In *case study A*, the commissioners tried to reduce the number of CQUINs in 2014/15 compared to previous years.

But we took a view this year that what we really wanted to do was to focus on larger CQUINs but less of them, rather than having multiple local CQUINs we wanted to target our efforts in certain areas... I would say we reduced them by a third, it's probably reduced by a third, but what we have got is… they're more detailed, so there's a lot more to do in them. (CS A, Clinical Quality Manager, CCG)

The payments in respect of the CQUINs were paid monthly but monitored every quarter, so payments where there was in fact a failure to achieve any component were adjusted in arrears. In 2013/14 the provider met all the CQUIN targets.

The commissioners reported that they combined outcomes and processes in setting the CQUINs in this case study.

Asked about whether the CQUINs had permanently improved the quality of services, the commissioner in case study site A explained that, as new CQUINs were introduced each year, it would be impossible to monitor both old and new CQUINs. She speculated that some of the older CQUIN targets might have become embedded in the provider's systems but others might

have been solely the focus for obtaining the funding attached to the particular CQUIN, rather than improving quality in general. But, if the commissioner perceived that an important CQUIN target was no longer being achieved, she would re-introduce it as a target.

> *No, you can't always...I think some organisations had 14 CQUINs last year, and then, this year they'll probably have another ten. You couldn't possibly monitor all the 13 that were last year's and the ten for this year. What you've got to hope is that the changes that were implemented as a result of that CQUIN, the provider takes on board to continue to implement. I know it doesn't always happen and classic was… is the estimated date of discharge. There was a CQUIN around that, I don't know if it was last year or the year before, and they met it for the purpose of the CQUIN, but if you look at their estimated dates for discharge targets now, they're appalling.* (CS A, Clinical Quality Manager, CCG)

Summary of findings on financial levers to improve quality

Commissioners took the view that having the threat of levying penalties in the event of failure to meet quality targets was useful, even if not all of them chose to do so. They noted that escalation procedures contained in the national contract, making sure that the trusts' boards were aware of the problems were also useful in improving performance.

CQUINs were time consuming to negotiate and monitor, although most providers achieved most of the targets which had been incentivised. Interviewees were concerned that there were too many different CQUINs each year, and some had started to reduce their number. There was disquiet expressed by some interviewees about the extent to which it was sought to use the contract to achieve broader aims, related to planning and reconfiguration in the local health economy, rather than issues which could reasonably be agreed between two contracting parties.

Disputes concerning the contract

We investigated how contractual disputes were handled in the case study sites, as one of the main reasons for entering into a formal contract is to regulate the parties' relationship and provide rules for how events which occur during the course of the contract should be dealt with. There were various forms of dispute relating to the contract in the three case study sites during the period of our research. Many of these related to agreeing the terms of the contract in the first place, rather than how to interpret the rules it contained.

In case study A the commissioners and the main acute provider were obliged to request mediation concerning aspects of the contract which could not be agreed in both 2013/14 and 2014/15. As the acute care provider was not a Foundation Trust, the dispute was mediated by the NHS Trust Development Authority (TDA) and NHS England. In 2013/14 the two main issues over which the parties sought mediation were:

- How to deal with the reduction of payment for emergency admissions over the baseline level to 30% of national tariff; and
- Disagreement over the funding of some of the trust's maternity services and some other non-PbR pricing

The situation was aggravated by the CCG's reduced resources available to fund the trust. This was due to adjustments made in order to allocate part of previous years' commissioning resources to NHS England to allow it to undertake specialist commissioning. (See below for further discussion of this issue.)

The main outcome of the mediation was that the marginal rate charged by the trust for emergency admissions over the baseline was adjusted to 65% of national tariff from 30%. On the maternity issue, it was recommended that the CCGs made available to the trust some additional non-recurrent funding that they might receive in year from the Department of Health.

The acute provider was not satisfied with the outcome in respect of the second issue, as they believed that this money (known as a 'quality premium') should be recurrent. One participant explained:

> *They're not happy with that, even though it went to arbitration and they reconsidered the situation and so we've now just had a contract query notice raised to commissioners from the provider to say we need you to quality impact that decision to withdraw the quality premium from maternity services.* (CS A, Head of Commissioning, CCG)

The provider's view was that the mediation favoured the commissioners to a large extent, except on the issue of the 30% marginal rate for emergency activity.

> *They found in favour of the CCGs, so they basically, we went on two principles, one that we didn't think they were setting a baseline appropriately, because they had calculated a baseline, they were saying they couldn't afford to plan for any growth, so they were going to assume that there wouldn't be any demographic growth in year, and they wanted to take £8 million of QIPP out, and we said, we don't think that leaves you with a sensible baseline, because we can see Emergencies going like this, so that was argument number one. We basically said, you can't take out Emergency QIPPs at 100%, and then when it doesn't happen, only pay 30% to buy that activity back, because it's just playing a game. The other cohort we went on was about £8 million worth of what we call non-PBR pricing, things like correcting the pricing on something that should have been sorted a long time ago, or paying for the maternity and paediatrics.* (CS A, Ass Director of Finance, Acute Trust)

In 2014/15 similar issues to those of the 2013/14 contracting round existed in relation to financial risk and the parties went to formal mediation again before the contract could be signed off. In addition to disagreements about the 30% marginal rate baseline, there were also differences about the setting of local prices. One participant explained,

> *Part of how we set the contract with the Acute Trust this year is we've used national average reference costs, so we know locally their prices are a lot higher, so we've gone with the national average. It said, you're too expensive, therefore you need to bring your cost base down....They didn't agree with all of that. That was part of what we went to arbitration, but the arbitration ruling was that we could use national average reference prices because that's what the Tariff Guidance says you can do and seems a fairer way of doing it...So we've got a bit of a mixture, really, but we're doing a lot more work in terms of trying to refresh local prices to get a system that's a bit more scientific than what's probably there at the moment.* (CS A, Director of Finance, CCG)

In case study B because of the issues in the acute trust concerning information coding, data quality, and contract performance there were many disagreements which were discussed in a friendly and professional manner.

In 2014/15 the parties very nearly went to formal dispute resolution concerning the contract for 2014/5 which had not yet been agreed, although in the end they chose not to. The issue was pricing of certain activities which the two parties interpreted differently. Although both sides prepared the necessary paperwork towards it, in the end an agreement was struck at the chief executive level. One participant on the commissioner side explained:

> *It would be really bad for them if we took them to mediation. They've got a poor reputation. They don't need to go to mediation. But it's always there. It's always a possibility. You know? It's not a... You know, in that sense it's not a problem. It's the reputation but it's also do we have the resources to do it and actually if our chief execs can go meet over a cup of coffee, that's the far better relationship answer.* (CS B, Head of Acute Contracts, CSU)

Another participant referred to the general reluctance to seek mediation or arbitration within the NHS because of political pressure.

> *It hasn't happened here, and, you know, it happens, but there is still this perception externally amongst the administration that an arbitration is a sign of failure, which, of course, is wrong because it is a vehicle for sorting out a dispute albeit one that is very inconvenient for everybody concerned. So there is this kind of underlying mantra about keeping the noise in the system down because of the politics associated with this, both local and national... So there is a strong incentive for organisations to come to a view because of all the other extraneous issues that an ongoing disagreement would raise.* (CS B, Commissioning Consultant, CSU)

In case study C the relationship between the commissioners and the local trust was very good and any disagreements were resolved by discussion, sometimes escalated to chief executive level. A good relationship, however, did not mean that disagreements were absent. As one participant recalled,

And if I think about the last commissioning round, there was one particular meeting where, in fairness, they threw us out after 15 or 20 minutes, but that's part of the process in contracting. We'd presented a sort of proposal to them in terms of investment and about what we were trying to spend the money on within the hospital, I guess, and within our community services, and, clearly, we'd missed the point in terms of the previous discussions that we'd had with them. And they were somewhat dissatisfied that we hadn't addressed the points that they thought they'd raised in the previous meeting, I guess, is the best way… So we kind of said, hang on a minute, there's no point in carrying on here. We need to go away and we need to re-think this, and then we'll come back again. So we came back a few days later and started again, basically. So relationships do fluctuate. Director of Finance, Acute and Community Care Trust)

Summary of findings on disputes

We did not find any disputes concerning the interpretation of a signed contract. Instead the disputes in the case study sites were due to difficulties in reaching agreement before the contract was signed. In these cases, most were dealt with by the parties themselves, and it was noted that personal relationships between the managers in the contracting organisations were very important in allowing solutions to be reached at local level. Very few disputes were escalated to higher levels in the NHS.

The effect of NHS England taking over specialist commissioning

From 2013/4 onwards, part of local commissioners' budgets were top sliced in order to allocate funds to NHS England to undertake the commissioning of certain specialist services. Commissioners in two of our three case study sites noted that this had caused difficulties in the first year. We report these findings because they had a direct effect on the allocation of financial risk between the contracting parties.

In case study A during the transfer of specialist commissioning the CCGs suffered a loss of the magnitude of £5m - £7m from their baseline. According to one participant,

We have less money and there's been quite a debacle for the last six months in terms of the specialised services adjustment that was removed from our baseline without any validation from the CCG and we've lost something like, I think it's £7 million. We've lost that money and that's a burden now that we have to pick up as a CCG and it's caused a lot of angst. Specialised services is definitely a concern and about are the algorithms correct in terms of the disaggregation of specialised and CCG responsible activity. (CS A, Head of Commissioning, CCG)

As mentioned above, the former PCT had been supporting the local acute trust via additional non-recurrent funding. Having significantly less money meant that such support had to be withdrawn, which led to disagreements with the trust about levels of funding.

> *We had to have a two per cent non-recurrent risk reserve, and that two per cent non-recurrent risk reserve which last year was £17 million for the PCT, is only £12 million for the CCG so five million has gone off somewhere – goodness knows where – so it's just hugely reduced flexibility for the CCGs really.* (CS A, Director of Finance, CCG)

In case study B in 2013/14 more specialist commissioning funding moved to NHSE than the CCG had expected, which had an effect on its ability to fund services in the local acute trust. One participant said:

> *In theory, the CCGs didn't have the commissioner's activity anymore [for specialist commissioning], therefore they didn't need the funding anymore, so it should have all been cost neutral, but the mechanisms to allow this to happen were very complicated and difficult, so potentially, from what I was told by the CCG, this was one of the potential... one of the pressures on their budget.* (CS B, Corporate Income Finance Manager, Acute trust)

Case study C did not report to have been adversely affected by the transfer of specialist commissioning to NHSE.

Local relationships and the use of formal contractual provisions

As discussed in the introduction to this report, research on contracting makes it clear that the quality of personal relationships between contracting parties is very important in ensuring the contract is used effectively, to the mutual advantage of both parties. Research also indicates that one way in which good contractual relationships are maintained is by both parties being flexible in their use of contractual terms.

The foregoing report of findings on specific issues of allocation of financial risk and use of financial levers in the contract indicates that relationships varied in the three case studies, and the tenor of the relationships had an effect on the use of contractual provisions. This section will address the issue of relationships directly.

In case study A, relationships were generally good despite the fact that the parties went to mediation in respect of both the 2013/14 and 2014/15 contracts. The key participants had been working in the area for a long time and relationships remained friendly on a personal level. One participant said:

> *'...we can come round the table and we can negotiate and both take a very firm line because, as you know, the CCG and the Acute Trust went to arbitration. And whilst each organisation is going to take a firm line, it's always done in a professional way.*

> *And after that meeting, we come out of that meeting and we say, well, how was your holiday then? And it's really interesting, so I think there's an acceptance and a recognition that we're all officers of our own organisations, we're trying to do the best for our organisation* (CS A, Head of Commissioning, CCG)

Before the health care reforms instituted by the HSCA 2012, the chief executives of the PCT and the acute trust knew each other well and problems tended to be solved in an informal way. This also meant that the commissioners were reluctant to apply the contractual levers, such as financial sanctions.

Having a friendly relationship was thought to be useful, but participants also reported certain drawbacks. One of the issues was that instead of stipulating adequate funding in the contract at the outset, the providers relied on non-recurrent funding which was orally agreed by the commissioners. When finances became tight, this informal arrangement broke down, resulting in the need to seek arbitration before the contract could be signed.

> *So this year has significantly worsened compared to where we had been. Part of the reason for that is around a change in funding. So over the years in our area, although we've had this nice, you know, contractual relationship and we've worked jointly and it's worked out in the wash, most of that has been through extra funding coming to us through transitional support, rather than properly funding the baseline. So we would argue, for example, there are things within our baseline that aren't currently properly funded that they should pay for properly.* (CS A, Ass Director of Finance, Acute Trust)

In case study A, the relationship between the commissioners and the community and mental health care provider was also described as good. There were no formal disputes and any informal disagreements were resolved by being escalated to Chief Executive level.

> *I guess there have been some informal issues, but they've always been resolved informally, but, no, to my knowledge there's never been any major areas of concern. I mean, yes, there was some issues to do with the Care Quality Commission and their inspection of some of the prison health services, and obviously that was quite difficult to work through all that, but we did in the end. You know, we worked through it and… together, but, no, overall I would say the relationships are fairly good with that provider, yes.* (CS A, Clinical Quality Manager, CCG)

Another participant confirmed the importance of personal relationships:

> *I think it's fundamental to any working relationship, even though there's a big contract framework and we don't always agree on everything, but relationships are the key because if you haven't got the right relationships, you'll never get anywhere forward with those issues and take things forward. So we spent a lot of time in this area working on the relationships through lots of different one-to-ones, local meetings, as well as the*

> *formal contract meetings, so a lot of what comes up at the Contract Management Boards and through the contract has been discussed elsewhere, people are aware of it, so…both in other forums with the Trust through different working groups or through informal, regular one-to-one conversations.* (CS A, Director of Finance, CCG)

In case study B, relationships between the commissioners and the provider were also reported as being good despite their differences. This had not always been the case. One example of the quality of the relationship was the frequency with which the contract performance mechanisms (e.g. contract query notices, activity management reviews, utilisation improvement plans) had been used in the past. One participant explained:

> *But I think we had a situation a few years ago where the person on the CCG side was very keen on using every lever in the contract whether it was appropriate or not really, or whether it was proportionate or not. So we were getting inundated with loads of these contract query notices type of things. Then there was a change and the person on the other side was more selective in the use of these things. I mean it depends on the relationship; it depends on how it works*. (CS B, Corporate Income Finance Manager, Acute Trust)

The commissioning team thought that having a clinical chair in the contract performance meetings contributed to maintaining a good relationship:

> *That's very much a change in focus now, so having a clinician there is really good. It just gives a real different flavour to the meetings, but it's the same arguments, so we're still arguing about money, or activity, or counting and coding, and various adjustments, but I think it's fair to say that we've got a lot more transparency and openness now, between ourselves as commissioners and the providers.* (CS B, Senior Management Accountant, CSU)

Commissioners were concerned that personal relationships would be disrupted when the local acute trust was taken over by another FT in the near future.

> *We work very closely with the Trust over the years, and we've now got a very open and transparent relationship with them, and I think it's a fairly healthy relationship. It's one we've worked hard on, and we're maintaining that dialogue. With [the other Trust], they're an aggressive foundation trust... And, if they adopt the practices that they operate on this site, it could quite easily bankrupt the local health economy.* (CS B, Senior Management Accountant, CSU)

This participant thought that, in the short term, the relationship with the new provider might be difficult and that it would probably take a few years before the commissioners could establish the same transparent and understanding relationship which they had built over the past years with their local trust.

*In case study C, r*elationships were very collaborative with an attitude adopted by the CCG from its inception that commissioning was a process that should happen in partnership with the providers. One commissioner explained that this collaborative approach was not new, but had been in place since the PCT days.

> *Obviously we have negotiations but we haven't got a history in this health economy of having kind of great financial tensions with our providers, and I think that partly comes from how we set ourselves up as a PCT, I think we very much saw our PCT as kind of being the leader of the health economy, we saw ourselves as having responsibility for the financial health of the providers and it wasn't a case of just penalising the providers, so I think we've always taken a kind of very responsible position that it's in our interest that they're financially stable, as much as we're financially stable.* (CS C, Head of Commissioning and Procurement, CCG)

One Trust participant confirmed the CCG's collaborative approach:

> *I think generally, relationships are good between the CCG and the Trust, and in my previous role as well because the CCG was also the biggest commissioner that I had in the Mental Health Trust, and they've always adopted an attitude of that their success is linked to the hospital's success in some shape or form, and there always has been an element of partnership working around commissioning. I mean, don't get me wrong, at times it's fractious and it gets strained, you know, which is right. But generally, I think, we do try and come at it from a joint point of view.* (CS C, Director of Finance, Acute and Community Care Trust,)

Two years prior to the research, the trust was failing to achieve a number of national quality targets (e.g. patient experience outcomes, C-Diff, MRSA, pressure ulcers, mortality rates). The commissioners adopted an approach of using the contract not in a heavy handed way, but as a support to developing a collaborative relationship.

> *So, we started from that starting point, and I think it's worth saying that our approach wasn't, which I know in some areas it has been, let's get the contract and hit them as hard as we can with the contract, our approach was actually right, let's work with them to try and understand what the issues are here.* (CS C, Lead Nurse, CCG)

The participant explained that, in the past, the commissioners were reluctant to apply the penalties, trying instead to work with the trust towards achieving quality improvements. In the past two contracting years, however, the CCG would first apply the penalty and then work with

the providers to try to find out the reasons for the failure and ways of supporting them to improve. The fact that NHS organisations had less money to spare was given as a contributing reason for this change. Becoming better at administering the contract was another reason.

> *I would say we were more… relaxed to a certain extent but there was more time to work with them. More time to do a lot more work around the edges before the penalty was applied. Now it's more apply the penalty and then work around the edges, if that makes sense. And it has a different effect. It focuses them more to work with us*. (CS, C, Contracts manager, CCG).

The commissioner was also keen on making sure that the contract was applied as a means of achieving more permanent change.

> *Because when they have a failure they produce an exception report for us which does try and set out the reasons why that issue occurred and how they're trying to fix it. And hopefully that fix, you know, is a sort of solution, long term sort of cure for that particular thing* (CS C, Head of Performance, CCG)

Participants in this case study reported that most of the contractual measures did help achieve the desired behavioural change. The providers themselves welcomed a degree of external pressure, such as that applied by the CCG using the contract, to bring about internal changes.

> *And, you know, some of these things have worked. I mean, I'm not saying that everything works always, but by and large we have got some improvements in the system and the... you know, if you talk to the performance team in the hospital, I mean, even what they say sometimes is that, look, you know, when we get pressure from outside, say, from the CCG, it's actually helpful to us because it's a real lever then for us to put pressure on people in the divisions.* (CS C, Head of Performance, CCG)

Summary of findings on relationships

It was clear that personal relationships were important in all three case study sites, and that the formal provisions of the contract could be used effectively to achieve mutually desired results at times, as well as there being many times when the parties judged it better to be more flexible, and to use more collaborative approaches. Some interviewees noted that recent financial stringency in the NHS had tended to encourage the parties to rely more heavily on formal contractual provisions in respect of quality (if not pricing).

GP involvement in contracting

The HSCA 2012 created opportunities for clinical involvement in contracting. Our three case studies approached GP involvement in contracting discussions in different ways:

In *case study A*, the acute provider reported that despite their expectations, the contracting process had not changed in any significant way. Provider participants felt that the same people were involved in negotiating and monitoring the contract as before the introduction of CCGs. Although they knew that their contracting colleagues on the commissioner side did consult the GPs, they thought that this process was happening indirectly. One participant commented:

> *I know they [the commissioners] have various committees and forums and their head of contracting has to take the papers through all these different forums so I'm sure they do. I think it's just from where we're sat, when we hear about engagement from the GPs, it's the same limited subset of people and I don't get a sense of…and I think that's the one thing we really hoped would happen, that it would almost engender this real buzz about driving things clinically and then making the contractual stuff fit. In some other areas of course, the CCGs have got some very different people, they've not moved the old people into the new roles, so they've almost had to start afresh, and they've been starting afresh, they've had more success at engaging the GPs, where in this area it kind of still feels a bit like the old school, and we haven't really moved on.*(CS A, Assistant Director of Finance, Acute Trust)

Our observation of meetings confirmed that view. The presence of GPs, at least in the Contract Performance Review Meetings, was not prominent. The commissioners agreed that the involvement of GPs in formal contracting discussions was indirect. GPs were involved mainly where clinical input was required, for example the change of clinical pathways and the Clinical Quality Review meetings. One commissioner explained:

> *We took a decision very early on that because their time is precious and they don't need to be involved in contracting. We produce an integrated report for our CCG which involves contracting, finance and quality and so we discuss, every month, with our clinicians performance, where we are with those things and that's all we need to do. Where we focus their precious time is we involve them in particular groups looking at clinical pathways In terms of contract management, the clinical quality review group have a clinical representative from each of the three CCGs.* (CS A, Head of Commissioning, CCG)

Another participant on the commissioner side confirmed that GPs were very involved in setting the strategic goals of the CCG, for example reducing secondary care activity, investing in community primary care services and in general shifting the balance of power by planning service re-design.

In *case study B*, clinical involvement in the contracting process was visible, as the both the Contract Performance Review and the Clinical Quality Review meetings were chaired by GPs. Provider participants were happy with this presence and thought that clinical presence and

involvement clearly added value in the contracting discussions. One commissioner explained that relationships with the acute trust had also improved as a result of clinical engagement:

> *Yes, so that's very much a change in focus now, so having a clinician there is really good. It just gives a real different flavour to the meetings, but it's the same arguments, so we're still arguing about money, or activity, or counting and coding, and various adjustments, but I think it's fair to say that we've got a lot more transparency and openness now, between ourselves as commissioners and the providers.* (CS B, Senior Management Accountant, CSU)

The provider also reported that relationships had improved and welcomed the clinical presence in the contracting meetings.

In *case study C*, the commissioners thought that one area that still required development within their model of commissioning was to seek greater clinical involvement.

> *I think we probably need to work hard at getting more clinical engagement in the contract… I think the issue is making sure that the noises that are out there, with GPs, about providers...they, somehow, get represented in those contract discussions. So, we… for example, in mental health contract,...you look at the contract performance, it's very good, they're meeting all of the targets, you know,… we would appear to have very little performance issues, with that trust, whereas if you go and talk to some of the GPs, they may be quite unhappy about the service. Now, clearly, the things they're unhappy about aren't manifesting themselves in our contract monitoring, and therefore it's important that when we're doing the contract preparations and negotiations, we need to tap into that intelligence...* (CS C, Head of Commissioning and Procurement, CCG)

Summary of findings from the case study sites

In relation to the allocation of financial risk, we found that in all three case studies, the acute trusts received a non-recurring allocation at the end of the financial year. This meant that, even if the commissioners stated that they paid their acute providers according to the provisions of the contract, in fact additional funding was being provided. We also found that in one of the sites, it had been necessary in the past to abandon PbR and revert to a block contract. The parties were attempting to return to national tariff based payments.

In relation to the use of financial levers to improve quality, all three case studies reported that penalties are applied more rigorously in the past two years, compared with earlier years. The acute trusts in each case study site were struggling to meet the targets in respect of a maximum

four hour wait in A&E and the various maximum waiting times for RTT and, although the commissioners applied the penalties, removing money from the providers was not an effective way to improve performance. The commissioners used other mechanisms to re-invest money in the trusts to help them meet the targets.

Participants thought that, although the threat of penalties was useful in encouraging providers to focus their attention on improving the relevant aspects of quality, their repeated application for serious failures or their application in the case of financially challenged providers was not helpful. There were often underlying problems affecting the entire local health economy which required broader approaches than punishing a particular provider, such as service reconfiguration.

In all three case studies, relationships were good and differences were resolved in a professional manner. Both commissioners and providers understood that, being part of the same health economy and dependent on each other meant they had to work collaboratively. The impact of this on contracting was that commissioners did not always enforce contractual clauses, such as penalties.

Discussion and conclusions

Summary of our findings

In this study, we aimed to identify the financial levers in respect of pricing and quality in the NHS national standard contract and to understand how they were negotiated, monitored and used in practice by local commissioners over a period of three years. We collected data about this by analysing four years of the national standard contract (2011/2 to 2014/15), undertaking two national telephone surveys in 2012 and 2014 and carrying out a series of three in depth case studies which ran from 2012 to 2014.

Provisions of the national standard contracts

Overall, the relevant provisions of the national standard contracts remained relatively stable during the four year period. Nevertheless, it should be noted that greater local financial flexibility was permitted in the 2014/5 contract.

Allocation of financial risk

Starting with pricing of acute services (including independent providers), in each year the contract provided for the use of both national tariff (formerly PbR) prices and the negotiation of local prices in respect of care which was not covered by the national tariff. (Details concerning the national tariff rates were not set out in the standard contract, but in a series of other national guidance documents.) Although the principle behind the use of PbR was that providers should be paid for every episode of care delivered (i.e. cost per case), the 2011/2 national contract included limits on activity which would be reimbursed. The 2011/2 contract allowed commissioners to refuse to pay for 'excess activity' (i.e. more activity than had been forecasted). Thereafter, there have been no such provisions in subsequent contracts because the CCP ruled in 2011 that commissioners could not place a cap on activity, as it restricted patient choice. (Instead, the parties were able to agree an 'indicative activity plan' and would then be obliged to notify each other if activity exceeded it.) Nevertheless, each year's contract did provide that emergency admissions exceeding a local baseline figure from 2009 would only be reimbursed at 30% of tariff.

The 2014/5 contract contained provisions specifically designed to allow the parties greater flexibility in pricing, which extended flexibilities in the 2013/14 contract. The detailed rules concerning the operation of these 'local variations' or 'local modifications' were set out in guidance on the national tariff (Monitor: '*2014/5 National Tariff Payment System'*) and incorporated into the contract by reference. The former were designed to allow adjustments to prices or currencies in order to allow for significant service redesign or reconfiguration. The latter were made available in the case of unavoidable higher local costs. Moreover, the 2014/5 contract also allowed the parties to vary the base line figure over which emergency activity would be reimbursed at 30%.

The standard contract did not contain pricing rules for mental health and community services, and in practice these were dealt with locally as block contracts.

Financial incentives to improve quality

The general scheme for incentivising improvements in quality and penalising failures remained the same in the contracts, although the details of the issues subject to such financial levers changed over time. The percentage of the provider's turnover which could be paid under the CQUIN scheme increased from 1.5% in 2011/2 to 2.5% in 2012/3, and subsequently. Each year, the contract set out particular failures in quality for which specified penalties could be levied by the commissioner.

In the 2014/5 contract however, more flexibility was allowed. The local parties were allowed to vary or disapply any national CQUIN and also the application of sanctions. And that year's contract made it explicit that the overall maximum level of sanctions was set at a maximum of 2.5% of actual quarterly value.

A wide range of different CQUINs were agreed at local level, both for acute and CHS providers. Similarly, there was a range of different issues which attracted local penalties.

Negotiation, monitoring and enforcement of contracts

The types of information collected in the surveys and the case studies were similar, although of course the case studies allowed us to explore the issues in much greater detail, and over a period of several years, as opposed to the two 'snap shots' we obtained from the surveys. It is striking the extent to which the different sources of data produced similar findings, which allows us to write a cohesive summary, and to draw conclusions which we can be confident are likely to apply across the English NHS.

Allocation of financial risk

We will first discuss the allocation of financial risk through the various pricing mechanisms being used in the NHS. This is an overarching issue which affects the interpretation of our findings in respect of the financial levers used to improve quality of care in NHS acute services. The reason for this is that most of the contractual relationships between NHS owned acute providers and commissioners were characterised by the use of general annual financial settlements outside the terms of the contract. In other words, whatever detailed financial provisions are set out in the National Tariff, agreed in local contracts and implemented during the course of the year, a final overall agreement was made at year end which did not adhere strictly to the National Tariff and contractual provisions. The financial year end settlement took account of other factors. The most important factor was the overall respective financial positions of the organisations in the local health economy. It was not always possible for commissioners to pay the full contractually designated amount for activity undertaken, as their budgets were not always sufficient. This behaviour appeared to be increasing over time. On the other hand, we also found that in some places, commissioners felt obliged to pay so called 'non-recurring' additional amounts to their acute providers in order to help the hospitals balance their books at the end of the year. Another reason given for not adhering to the financial rules at year end was the need to facilitate the reconfiguration of local services, which might require transitional payments to support changes in service delivery in the short term. In 204/5

a few commissioners reported having used the new provisions in the National Tariff and the contract to make local variations or modifications in respect of pricing.

Moreover, over time, more commissioners and NHS acute providers were agreeing to abandon PbR and settle on a block contract (i.e. a fixed budget) in order to limit the financial risk to the commissioners. It should also be noted that a range of techniques was used to agree prices for activity for which a national tariff was not available. These included simply reducing the prices paid the previous year by the current NHS wide efficiency target; attempting to bench mark local prices with those in other areas; and attempting to undertake more accurate costing exercises in respect of some of these services. In addition, by 2014/5, increasing numbers of commissioners were insisting on agreeing a fixed sum in respect of these non PbR services – effectively another block contract.

All commissioners reported being able to pay independent providers of acute services in accordance with the PbR rules. This was mainly due to the fact that there were insignificant volumes of such activity.

Block contracts were used in respect of CHS and MH services.

Financial incentives to improve quality

Financial incentives to improve quality contained in contracts were in widespread use. CQUIN payments were made to providers when earned, and penalties were often imposed. However, CQUINs were seen as time consuming to negotiate and monitor. There was concern that there were too many different CQUINs each year, and some areas had started to reduce the numbers used. Many commissioners used performance management processes to focus providers' attention on poor quality. The threat of financial penalties was useful. But not all commissioners withheld money from poorly performing providers. The argument made was that reducing their income could exacerbate providers' difficulties in achieving performance targets. It should be noted, however, that the financial effects of these provisions on providers should not be considered in isolation, but should be understood in the context of the overall financial settlements made between the parties, as discussed above.

Context for contracting

The context in which the contractual relationships we studied took place was very important. *First*, the personal relationships between the staff in the respective contracting parties (including CSUs, where relevant) were a vital element in facilitating effective contractual relationships. The degree of flexibility required could only be achieved where these personal relationships worked well. *Secondly*, the increasing financial stringency affecting the NHS during the course of the study had an effect on the way in which the contracts could be used at local level. As less money was available, it become increasingly difficult for commissioners to adhere to the national tariff rules. *Thirdly*, (and partly due to the financial situation) in the later years of the study national and local policies were moving towards major service reconfigurations at local level. These included the nationally mandated BCF, which entailed shifting of resources from acute care to social care and CHS. These changes sometimes had the

effect that the contractual pricing rules were difficult to apply. *Fourthly*, some contracting was being undertaken by NHS England, rather than local commissioners. This was causing difficulty to local commissioners in terms of uncertainty about the allocation of responsibility for contracting in respect of some services.

Limitations of the study

The limitations of the study should be noted. The response rates for the two national telephone surveys were not very high, mainly due to the national organisational changes in respect of commissioning being carried out. It was particularly difficult to obtain copies of local financial incentive schemes. However, we collected sufficient data to gain a good insight into how contracts were being used between 2011/2 and 2014/5. Secondly, it was not possible to gain access to all the CHS and MH providers in the case study sites. We were able to make up for this lack of data to some extent by interviewing the commissioners of these services, so we did obtain information about how these contracts were being operated.

Implications of the study

The findings of this study can be compared to the earlier research on contracting in the NHS quasi market which was discussed in the introduction to this report. The extent to which the evidence about contracting for healthcare has been constant over the past two and a half decades is striking. It remains the case (as found earlier by e.g. Flynn et al, 1996; McHale et al, 1997;Allen, 2002; Petsoulas et al, 2011) that formal contracts are not able to deal with all eventualities, and that, in particular, allocation of financial risk is often dealt with outside the formal structures of the written document. Interestingly, in the case of the current research, informal flexibilities used by front line staff have actually been incorporated into the formal system by the introduction of new flexibilities into the 2014/15 standard contract. This is a new development for NHS contracting, and appears to be due to the new dual role of Monitor and NHS England in setting pricing rules which are transparent. (This can be seen as a consequence of the new structures in the HSCA 2012 designed to ensure that a fair playing field is created for all providers of care, including independent, non NHS entities.) Furthermore, as discussed in the introduction, previous research on NHS contracting (e.g. Petsoulas et al, 2011; Allen, 2002; Hughes and Dingwall, 1990) indicated that the hierarchical nature of the NHS remains salient, if not dominant, despite the aim of creating decentralised structures through contracting in quasi markets.

Our findings indicate that, as time goes on, it has not been possible for many local commissioners fully to use the terms of the NHS national standard contract to regulate their relationships with local providers. In particular, the pricing element of the acute contract does not seem to be appropriate. Although this has been recognised in the 2014/15 contract, where greater flexibility has been permitted, it appears that it will be necessary for Monitor and NHS England to reconsider pricing in the NHS. This is particularly important in the light of the NHS

England policy document of November 2014 (NHS E, 2014), *The Five Year Forward View*, which indicates that different configurations of providers should be explored. The current pricing rules set out in the National Tariff and associated documents are insufficiently flexible to facilitate these changes. Indeed, Monitor has indicated that they are undertaking such a review. Monitor's document of December 2014 (Monitor, 2014), *'Reforming the Payment System for NHS services: supporting the Five Year Forward View'* states that the NHS should be moving towards a blended payment system including 'activity-based, outcomes-based and capitated payment approaches' (p. 7). It is not clear how easy it will be to reconcile this wider range of pricing mechanisms with *both* the current system of contracting *and* the organisational changes which the *Five Year Forward View* envisages. The latter appear to be more aligned with notions of hierarchy and planning than with market structures using contracts.

The second implication of the study is that, although financial incentives may encourage quality improvements, the costs associated with implementing the current contractual regime may be too onerous. The costs of running the complex system of contractual financial incentives does not seem to have been taken into account. If payment for quality improvement and penalties for failure to meet targets is to be continued, the national system (and therefore the contract) needs to be stream lined and simplified, so that less effort to negotiate and monitor varying targets is required at local level. As more issues are stipulated at national level, the understanding of the NHS contract as part of a market orientated, as opposed to hierarchical system, becomes weaker.

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Appendix A – First survey in 2012: Structured interview schedule

Contract year 2012/13

1. Which PCTs are in the Cluster?
2. Who is doing the contracting (i.e. do you have separate contract managers for each provider)?
3. Which are your main providers?
4. Do you have any private providers?
5. Which ones? (i.e. name of private provider and what type of care?)
6. Who does the contracting for the private provider? Is it you? (if yes, repeat questions separately)
7. How many CCGs relate to your Cluster?
8. Are they involved in contracting (e.g. do GPs attend negotiation and monitoring meetings)?
9. Are they involved in all aspects of contracting or mainly in clinical and quality issues?
10. What is the value of the 2012/13 contract (For the NHS and private sector trusts)?
11. How did you calculate non-tariff prices?
12. Did you agree any 'reduced tariff prices' in relation to PbR?
13. If yes, how did you calculate them?
14. Did you include any productivity improvements in the contract i.e. have you changed prices for services?
15. If yes, what exactly?
16. Did you agree any **local** quality requirements (i.e. in addition to the national ones)?
17. If yes, do you remember one or two examples?
18. Are specified penalties attached for possible breaches of such local requirements?
19. If yes, can you give me an idea what they are?
20. Can you give me one or two examples of local CQUINS if you agreed any?
21. What happens if the providers achieve the CQUINS partly rather than completely? (i.e. do they get paid in full or partly?)
22. Could we have a copy of your quality schedule including the CQUIN document? If possible can we have a copy of Section B ('The Services') of the contract?

Contract year 2011/12

The contract

1. What was the value of your 2011/12 contract?
2. How did you calculate non-tariff prices?
3. Did you include any productivity improvements in the contract i.e. have you changed prices for services?
4. If yes, what exactly?
5. What was the financial position of your organisation in 2011/12?
6. What was the financial position of your providers?
7. Did you agree any local quality requirements beyond the national ones?
8. If yes could you give me one or two examples?
9. Did you agree any local quality incentives beyond CQUIN with your main provider?
10. If yes, could you give me any examples?
11. Could we have a copy of your quality schedule including CQUINS?

Behavioural

Now I am going to ask you some questions about actual application of the contract in 11-12, focusing on your main acute care provider (and the private provider if any):

12. Did you agree any remedial action plans with your provider following a performance notice?
13. Did you withhold any money for failure by the provider to achieve the remedial action plan?
14. If yes, was it the amount specified in the contract?
15. Have you had any disputes with your provider?
16. If yes, over what?
17. If yes, how formal did they get? (E.g. were they resolved through mediation, arbitration, or adjudication)?

Various clauses in the contract lead to penalties for breaches or incentive payments for achieving specified indicators. I am going to ask you questions relating to that now:

18. Did your provider breach any national quality targets? (e.g. 18 weeks, C Difficile)?
19. If yes, did you withhold any money for non-achievement by the provider of any of the national (e.g. 18 weeks, CDiff) quality targets?
20. If yes, was it what was specified in the contract?
21. Did the provider breach any of the nationally specified events thresholds?
22. If yes, could you give me any examples?
23. If yes, did you withhold any money for it?
24. If yes, was it the amount specified in the contract?
25. Did the provider breach any 'never events'?
26. If yes, could you give me any examples?
27. If yes, what were the consequences?
28. Did the provider breach any local quality requirements?
29. If yes, could you give me any examples?
30. If yes, did you withhold any money for breaches?
31. If yes, was it the amount specified in the contract?
32. Did your provider fail to achieve any of the national CQUIN indicators?
33. If yes, examples?
34. If yes, did you withhold any money for it?
35. If yes, was it the amount specified in the contract?
36. Did your provider fail to achieve any local CQUIN indicators?
37. If yes, examples?
38. If yes, did you withhold any money?
39. If yes, was it what was specified in the contract?
40. Did you make payments for activity in accordance with the contract you agreed at the beginning of the year? (i.e. did you pay the agreed rate – PbR or otherwise- for each episode of care the provider delivered?)
41. If not, how did the payments you made differ from what the contract stipulated? How did this change come about?

Appendix B – First survey in 2012: Analyses of CQUIN schedules in contracts

Acute providers (incl. private providers) - 2011-12 CQUINs

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
VTE prevention (national CQUIN)	15	VTE prevention	VTE prevention	Venous Thromboembolism (VTE) - Appropriate prophylaxis	VTE prevention	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	VTE	VTE	VTE Prevention	VTE Risk Assessment	VTE prevention	VTE Assessment	VTE prevention	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	VTE Prevention
Patient experience (national CQUIN)	15	Patient experience - personal needs	Patient experience - personal needs	Patient experience - personal needs	Patient experience - personal needs	Patient experience	Patient experience	Patient experience - personal needs	Patient experience - personal needs	Composite Indicator on responsiveness to personal needs	Patient experience - personal needs	Patient Experience	Patient experience - personal needs	Improve responsiveness to personal needs of patients	Improve patient experience	Patient experience
Discharge communication	3	Quality of clinical correspondance: Assessment of the quality of clinical correspondance relating to discharges of non-elective patients					Discharge Planning: Communications				Discharge Communication					
Responsiveness of GP Direct	1	Responsiveness of GP Direct														
Neonatal readmissions	1	Neonatal readmissions														
End of life	6	End of Life care				End of Life care			End of Life	End of Life Care	End of Life		End of Life			
Enhanced recovery	3	Enhanced recovery										Enhanced Recovery	Enhanced Recovery			
Pressure ulcers	7	Pressure ulcers	Pressure Ulcers			Pressure sores	High Impact Actions: Pressure Ulcers		Pressure ulcers	Reduction in hospital acquired pressure ulcers		Safe care – Hospital Acquired Pressure ulcers				

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
Acute myocardial infarction	4	Advancing Quality: AQ AMI							Acute Myocardial Infarction best practice bundle		Advancing Quality: AMI			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): Acute Myocardial Infarction		
Heart Failure	4	Advancing Quality: AQ Heart Failure	Heart Failure								Advancing Quality: Heart Failure			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): Heart Failure		
Advancing Quality: Hip & Knee	3	Advancing Quality: AQ Hip & Knee									Advancing Quality: Hip & Knee			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): Hip & Knee Replacement		
Advancing Quality: Pneumonia	3	Advancing Quality: AQ Pneumonia									Advancing Quality: Pneumonia			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): Pneumonia		
Stroke care	6	Advancing Quality: AQ Stroke				Stroke	Stroke			Stroke Care	Advancing Quality: Stroke			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): Stroke		

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
Stroke discharge	2			Early supported discharge (stroke)									Stroke Discharge			
Advancing Quality: Patient experience	3	Advancing Quality: AQ Patient Experience Measure									Advancing Quality: Patient Experience			To promote Clinical Effectiveness, Safety & Patient Experience through Advancing Quality (AQ): PEMS		
Trauma Audit and Research Network (TARN)	3	TARN									TARN			Improved trauma care for patients with better outcomes: TARN		
Increasing normal births	2		Maternity - increasing normal births: Caesarean section rate						Caesarean Section: To increase the normal birth rate and eliminate unnecessary caesarean sections							
Enhanced VTE	1		Enhanced VTE													
Reduction in Non Elective Excess Bed Days (NELXBDs)	1		Reduction in Non Elective Excess Bed Days (NELXBDs)													
Reduction in A&E attendances	1		Reduction in A&E attendances													
Reducing non elective admissions	2		Reduction in Non Elective (NEL & NELST) admissions		Reducing unnecessary non elective hospital admissions											
Discharge audit	1			Discharge: Discharge audit												
Discharge complaints review	1			Discharge: Discharge complaints review												

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
Reducing outpatient cancellations	1				Out-patient Cancellations											
GP Diagnostic turnaround	1				GP Diagnostic Turnaround											
Discharge planning	4				Improving Discharge: Discharge Planning		Discharge Planning				Discharge Planning	Discharge planning				
Discharge patient checklist	1									Improvement in Patient Discharge: Proportion of discharged patients from medical and elderly wards (defined cohort) who have a discharge checklist completed						
Dementia	2			Dementia					Dementia Care							
Admission avoidance	1			Admission avoidance												
Smoking	3			Smoking Cessation		Smoking prevention							Smoking Cessation			
Achievement of national indicators (gateway)	1			Achievement of national indicators (gateway)												
Improving Cancer Care	1				Improving Cancer Care											
Identifying LD and ensuring adherence to care pathway	1					Identifying LD and ensuring adherence to care pathway										
Alcohol	2					Alcohol							Alcohol Screening			
Nutrition	4					Nutrition screening			Nutrition	Improving nutritional Assessment			Nutrition			

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
Self-harm – Improve services for individuals who self harm by ensuring effective recognition, assessment and onward referral	1					Self-harm – Improve services for individuals who self harm by ensuring effective recognition, assessment and onward referral										
Reducing DNA rates in Outpatient Clinics	1					Reducing DNA rates in Outpatient Clinics										
Length of Stay (LOS)	1					Length of Stay (LOS)										
New Outpatient Models of Delivery	1					New Outpatient Models of Delivery										
Falls	6						High Impact Actions: Falls Risk Assessment	Reduction of Harm from Falls	Falls	Falls		Safe care – Falls				Fall prevention
Catheter care	2						High Impact Actions: Catheter Care		Urinary Cathether Care Bundle							
Development of pathway for frail elderly patients	2						Frail Elderly Pathway: Development and implementation				Unscheduled care: Develop pathway for frail elderly patients					
Urgent care	1						Urgent care									
Planned Care: Follow Ups reduction	1						Planned Care: Follow Ups reduction									
Improving Inpatient Diabetic Care	1							Improving Inpatient Diabetic Care								
Safeguarding	2								Common Assessment Framework: To improve the safeguarding of vulnerable children		Safeguarding: Children and adults					

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
Patient Experience: Using Real Time Patient Monitoring	1								Patient Experience: Using Real Time Patient Monitoring							
COPD	1								COPD							
Implementation of Modified Early Warning Score (MEWS)	1									Implementation of Modified Early Warning Score (MEWS)						
Improvement in Fractured Neck of Femur Operating Times	1									Improvement in Fractured Neck of Femur Operating Times						
Advancing Quality: CABG	1										Advancing Quality: CABG					
Long term conditions	1											Long term conditions				
Care closer to home	1											Care closer to home				
Medicines Management	2												Medicines Management	Improved Prescribing both as inpatients and post-discharge: Medicines Management		
Mortality Review	1												Mortality Review			
To promote clinical patient experience through improved monitoring and performance improvement: Patient Experience Strategy	1													To promote clinical patient experience through improved monitoring and performance improvement: Patient Experience Strategy		

CQUIN topics	Total	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS FT	Private provider	Private provider
To promote clinical effectiveness, safety and patient experience through improved health economy management of patients with 'senility and organic disorder'	1													To promote clinical effectiveness, safety and patient experience through improved health economy management of patients with 'senility and organic disorder'		
Implementation of WHO safer surgery checklist	1														Implementation of WHO safer surgery checklist	
Pain management	1															Pain management

Acute providers (incl. private providers) - 2012-13 CQUINs

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
VTE prevention (national CQUIN)	21	VTE prevention	VTE prevention	VTE prevention	VTE prevention	VTE prevention	VTE prevention	VTE prevention	VTE prevention	Venous Thromboembolism (VTE) - Appropriate prophylaxis	VTE	VTE Risk Assessment	Reduce avoidable death, disability and chronic ill health from VTE	VTE	VTE	VTE prevention	VTE Risk Assessment	VTE Prevention	VTE prevention	VTE	Reduce avoidable death, disability and chronic ill health from VTE	National - VTE Prevention
Patient experience (national CQUIN)	21	Patient experience	Patient experience	Patient experience	Patient experience	Patient experience	Patient experience	Patient experience	Patient experience - personal needs	Patient experience	Patient experience – personal needs	Patient Experience	Patient experience - Improving responsiveness to personal needs	Patient experience	Patient Experience	Patient experience - personal needs	Composite Indicator on Responsiveness to Personal Needs	Patient experience - personal needs	Patient experience	Patient Experience	Patient experience - Improving responsiveness to personal needs	National - Patient Experience
Diagnosis of dementia (national CQUIN)	19	Diagnosis of dementia	Diagnosis of dementia	Diagnosis of dementia	Diagnosis of dementia	Diagnosis of dementia	Diagnosis of dementia	Diagnosis of dementia	Dementia	Dementia	Dementia	Assessment for Dementia	Improving awareness and diagnosis of Dementia	Dementia	Improving Dementia Diagnosis	Dementia	Dementia	Dementia	Diagnosis of dementia	Dementia		
NHS Safety Thermometer (national CQUIN)	21	Safety thermometer	Safety thermometer	Safety thermometer	Safety thermometer	Safety thermometer	Safety thermometer	Safety thermometer	NHS Safety Thermometer	Patient Safety - NHS Safety Thermometer	NHS Safety Thermometer	Patient Safety Thermometer	Incentivise the use of the NHS Safety Thermometer	NHS Safety Thermometer	NHS Safety Thermometer	NHS Safety Thermometer	Safety Thermometer	Safety Thermometer	Safety thermometer	NHS Safety Thermometer	Incentivise the use of the NHS Safety Thermometer	National - NHS Safety Thermometer
Improving communication with GPs	10	GP real-time information	GP real-time information	GP real-time information	GP real-time information	GP real-time information	GP real-time information	GP real-time information						Clinical Information - Improving patient level clinical information	GP Communications						Improved discharge information	
Compliance with integrated formulary	7	Compliance with integrated formulary	Compliance with integrated formulary	Compliance with integrated formulary	Compliance with integrated formulary	Compliance with integrated formulary	Compliance with integrated formulary	Compliance with integrated formulary														
COPD discharge bundle	4	COPD discharge bundle		COPD discharge bundle									COPD (incl. Joint discharge planning)					Transfer of care (incl. COPD)				
Enhanced recovery	1	Enhanced recovery																				
Anti-coagulation	1	Anti-coagulation																				
12 hours consultant assessment	4		12 hours consultant assessment		12 hours consultant assessment	12 hours consultant assessment	12 hours consultant assessment															
End of life / palliative care	9		End of life care	End of life care	End of life care			End of life care	Development and rollout of palliative care support tool				To improve End of Life care		End of Life Care	End of Life	EOL care					
Neonates/BCG	1		Neonates/BCG																			
Integrated care	1				Integrated care																	

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
Nutrition	3					Nutrition							Nutrition screening				Nutrition and weight management					
Case management	1					Case management																
Patient discharge / Delayed Transfers of Care	4					Discharge planning			Delayed Transfers of Care			Patient Discharge				Transfer of Care						
Diabetes care standards	1						Diabetes care standards															
Reducing duplication of tests etc.	1						Reducing duplication of tests etc.															
Reducing outpatient cancellations by hospital	1						Reducing outpatient cancellations by hospital															
Dementia training	1							Dementia training														
GP access to consultant advice	1							GP access to consultant advice														
Local goal regarding patient experience	6								Patient experience - local enhancement		Patient Experience Escalator			Patient Revolution - maintain and build on improvements from National Patient Survey	Net Promoter Score/Patient Experience/Patient Revolution		Net Promotor - Patient experience	Real Time Patient Monitoring				
Assistive technologies	2								Assistive technologies					High Impact Innovations - Use of assistive technologies								
Oesophogeal Doppler Monitoring	4								Oesophogeal Doppler Monitoring	Trajectory for six high impact innovations - Oesophageal Doppler monitoring	Oesophageal Doppler/Cardiac Flow Monitoring			High Impact Innovations - Oesophageal Doppler Monitoring								
Child in a Chair in a Day	3								Child in a Chair in a Day	Trajectory for six high impact innovations - Child in a chair in a day				High Impact Innovations - Child in a Chair in a Day								

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
Digital by Default	3								Digital by Default (incl. digital support in dermatological diagnoses)	Trajectory for six high impact innovations - Telederm				High Impact Innovations - Digital by Default								
Improved medical support for surgical patients with long term conditions	1								Improved medical support for surgical patients with long term conditions													
Introduction of care bundles for high volume medical conditions (incl. COPD)	3								Introduction of care bundles for high volume medical conditions (incl. COPD)			Respiratory Care Bundles (incl. COPD)						COPD Care Bundle				
Liaison psychiatry for the elderly	1								Liaison psychiatry for the elderly													
Compassionate excellence in nursing care	1								Compassionate excellence in nursing care													
Standardisation of pathway for spinal surgery	1								Standardisation of pathway for spinal surgery													
Medicines reconciliation for inpatients - 7 days/week	1								Medicines reconciliation for inpatients - 7 days/week													
Capacity	1									Capacity												
Sepsis	2									Infection control (Sepsis)	Sepsis 6 implementation											
Community Services (incl. productivity)	2									Community Services (incl. productivity)								Productive Community Programme				
Trajectory for six high impact innovations - Increase digital outpatient appointments	1									Trajectory for six high impact innovations - Increase digital outpatient appointments												

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
Acute Kidney Injury	2										Acute Kidney Injury				Acute Kidney Injury							
Supporting Clinical Change programmes	1										Supporting Clinical Change programmes											
Pressure Ulcers	6											Pressure Ulcers	Pressure sores	Safe Care (incl. pressure ulcers)			Reducing avoidable pressure ulcers		Harm free care: Pressure ulcers			Harm free care: Pressure ulcers
Falls	4											Falls		Safe Care (incl. falls)					Harm free care: Falls			Harm free care: Falls
Learning Disabilities	2											Learning Disabilities	Identifying LD and ensuring adherence to care pathway									
Fractured Neck of Femur	2											Fractured Neck of Femur				#NOF Management						
Clinical pathways	1											Clinical pathways										
Alcohol	4												To improve the health of the population by reducing alcohol-related harm.				Every contact counts - Alcohol		Public health: Alcohol abuse identification and advice			Public health: Alcohol abuse identification and advice
Smoking	4												Smoking prevention				Every contact counts - smoking in pregnancy		Public health: Smoking status and smoking cessation support			Public health: Smoking status and smoking cessation support
Self-harm – Ensuring effective recognition, assessment and onward referral	1												Self-harm – Ensuring effective recognition, assessment and onward referral									
Stroke	4												Stroke			Stroke	Stroke			AQ: Stroke		
Performance on Trauma Audit and Research Network	1												Performance on Trauma Audit and Research Network									
Local Productivity	1												Local Productivity									
High Impact Innovations - National and International Health Care activity	1													High Impact Innovations - National and International Health Care activity								

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
High Impact Innovations - Carers for People with Dementia	1													High Impact Innovations - Carers for People with Dementia								
Follow ups	1													Follow ups								
Non-Elective Activity	1													Non-Elective Activity								
Outpatient	1													Outpatient								
Making Every Contact Count - Maternity	1														Making Every Contact Count - Maternity							
Older & Vulnerable People	2														Older & Vulnerable People	Elderly Care						
Advancing Quality: AMI	2															Advancing Quality: AMI				AQ: AMI		
Advancing Quality: CABG	1															Advancing Quality: CABG						
Advancing Quality: Heart failure	2															Advancing Quality: Heart failure				AQ: Heart Failure		
Advancing Quality: Hip & Knee	2															Advancing Quality: Hip & Knee				AQ: Hip & Knee		
Advancing Quality: Pneumonia	2															Advancing Quality: Pneumonia				AQ: Pneumonia		
Advancing Quality: Patient Experience	2															Advancing Quality: Patient Experience				AQ: PEMS		
Dementia - To improve inpatient care	3															Dementia - To improve inpatient care		Dementia - Local indicator	Dementia - Improve care for patients with dementia			
Safeguarding	1															Safeguarding						
Appropriate use of warfarin	1																Appropriate use of warfarin					
Use of antibiotics - Antimicrobial Stewardship	1																Use of antibiotics - Antimicrobial Stewardship					
Mortality review	1																Mortality review					
Safe surgery	1																Safe surgery					
Harm free care: Tissue viability	2																		Harm free care: Tissue viability			Harm free care: Tissue viability risk assessment

CQUIN topics	Total	NHS Trust	NHS FT	NHS FT	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS Trust	NHS Trust	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	NHS FT	NHS Trust	NHS FT	NHS FT	NHS FT	Private provider	Private provider
Harm free care: Catheter care	2																		Harm free care: Catheter care			Harm free care: Catheter care
Harm free care: Leadership for harm free care	2																		Harm free care: Leadership for harm free care			Harm free care: Leadership for harm free care
Harm free care: Patient stories	2																		Harm free care: Patient stories			Harm free care: Patient stories
Public health: Health inequalities training	2																		Public health: Health inequalities training			Public health: Health inequalities training
Public health: Breastfeeding initiation and maintenance	1																		Public health: Breastfeeding initiation and maintenance			
Public health: Fuel poverty	2																		Public health: Fuel poverty			Public health: Fuel poverty
Making Every Contact Count: Establish Baseline	1																			Making Every Contact Count: Establish Baseline		
Making Every Contact Count: Train the Trainer	1																			Making Every Contact Count: Train the Trainer		
Making Every Contact Count: Cascade Training	1																			Making Every Contact Count: Cascade Training		
Making Every Contact Count: Year 1 Training	1																			Making Every Contact Count: Year 1 Training		

Community providers - 2011-12 CQUINs

CQUIN topics	Total	NHS FT	NHS FT	NHS Trust	Social enterprise
Patient experience (national CQUIN)	4	Improving Patient Experience	Patient experience	Patient experience - personal needs	Service User experience
VTE prevention (national CQUIN)	2			VTE prevention	VTE
Patient Safety: Safe and effective medicines management	1	Patient Safety: Safe and effective medicines management			
Rehabilitation service analysis	1	Rehabilitation service analysis			
Advanced care plans - To ensure that an advanced care plan is offered to all palliative care patients in the community and is in place for all of those who wish to have one	1		Advanced care plans - To ensure that an advanced care plan is offered to all palliative care patients in the community and is in place for all of those who wish to have one		
To improve End of Life care	3		To improve End of Life care	End of Life Care	Demonstrate Community Nurse effectiveness in supporting people to die in their place of choice
Emergency admission rates for community service caseloads	1		Emergency admission rates for community service caseloads		
Nutrition screening	1		Nutrition screening		
Self-harm	1		Self-harm		
Dementia	1		Dementia		
Pressure sores	1		Pressure sores		
Reduce incidence of falls	1		Reduce incidence of falls		
Reduce DNA rates for Therapy Services	1		Reduce DNA rates for Therapy Services		
Urinary catheter care	1			Urinary catheter care	
Unscheduled care services	1			Unscheduled care services	
Support for carers	1			Support for carers	

CQUIN topics	Total	NHS FT	NHS FT	NHS Trust	Social enterprise
Reduce emergency admissions for very high intensive users	1				Reduce emergency admissions for very high intensive users
Reduce acute hospital bed days	1				Reduce acute hospital bed days
Increase community productivity to reduce urgent care activity in line with QIPP plans	1				Increase community productivity to reduce urgent care activity in line with QIPP plans

Community providers - 2012-13 CQUINs

CQUIN topics	Total	NHS FT	NHS FT	NHS Trust	Social enterprise
Patient experience (national CQUIN)	4	Patient Experience	Service User experience	Service User experience	Improve responsiveness to personal needs of patients (Adult Inpatient Survey)
NHS Safety Thermometer (national CQUIN)	4	NHS Safety Thermometer	NHS Safety Thermometer	NHS Safety Thermometer	NHS Safety Thermometer
VTE prevention (national CQUIN)	3		VTE	VTE	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)
Diagnosis of dementia (national CQUIN)	3		Dementia: Improve awareness and diagnosis	Dementia: Improve awareness and diagnosis	Improve awareness and diagnosis of dementia
Assistive technologies	2	Assistive technologies		Innovations: Assistive Technologies	
Digital by default	2	Digital by default		Innovations: Digital by Default	
End of life / palliative care	3	Palliative care	End of Life care		End of life: Supporting patient choice regarding their desired place of death
Introduction of care bundles for high volume medical conditions: Cellulitis care bundle	1	Introduction of care bundles for high volume medical conditions: Cellulitis care bundle			
2 - 2.5 year health checks	1	2 - 2.5 year health checks			
Breastfeeding	1	Breastfeeding			
Delayed Transfers of Care	1	Delayed Transfers of Care			
Patient safety: Pressure sores	1		Patient safety: Pressure sores		
Patient safety: Falls	1		Patient safety: Falls		
Reducing A&E attendances	3		Reducing emergency admission rates	Frequent Attenders	Appropriate use of urgent care services
Nutrition screening	1		Nutrition screening		
Self-harm	1		Self-harm		
Stroke: Improving post discharge interventions	1		Stroke: Improving post discharge interventions		
Adult Learning Disabilities: Identification	1		Adult Learning Disabilities: Identification		
Long Term Conditions	1		Long Term Conditions		

CQUIN topics	Total	NHS FT	NHS FT	NHS Trust	Social enterprise
Community IV therapies	1		Community IV therapies		
Watch & Wait: Admission avoidance – paediatrics in urgent care	1		Watch & Wait: Admission avoidance – paediatrics in urgent care		
New to review ratios	1		New to review ratios		
Innovations: Child in a Chair in a Day	1			Innovations: Child in a Chair in a Day	
Innovations: Carers for People with Dementia	1			Innovations: Carers for People with Dementia	
Non elective admissions (NEL) Scheme	1			Non elective admissions (NEL) Scheme	
Health Promotion: Smoking	1			Health Promotion: Smoking	
Health Promotion: Healthy weight	1			Health Promotion: Healthy weight	
Health Promotion: Alcohol consumption	1			Health Promotion: Alcohol consumption	
Introduction of live PANDA data flows: GP communication	1				Introduction of live PANDA data flows: GP communication
Improved Discharges 7 days per week	1				Improved Discharges 7 days per week
Promotion of collaboration to support and manage impact associated with delivery of healthcare to Very High Intensity Users	1				Promotion of collaboration to support and manage impact associated with delivery of healthcare to Very High Intensity Users

Mental health provider - 2011-12 CQUINs

NHS FT
Achievement of national targets
Dementia Awareness
Outcomes/recovery

Mental health provider - 2012-13 CQUINs

NHS FT
Achievement of national targets
NHS Safety Thermometer
Patient Experience Survey
Psychiatric Liaison
Mental Health PbR Development
Dementia Diagnosis
Placements Review
Health Improvement

Appendix C – First survey in 2013: Analyses of penalty schedules in contracts

Local quality requirements have been summarised in the tables below according to their consequences. The tables have been compiled with the aim of showing the different types of financial and non-financial penalties for breaches of local quality requirements, rather than the range of local quality requirements specified in contracts. Therefore, a large number of diverse local quality requirements may be compressed into one row in a table if the consequences seemed to be identical for all of them.

Acute providers (incl. private providers) – 2011-12 examples of local penalties

NHS FT

Local clinical quality performance indicators	Consequence of breach
3 indicators related to timeliness of discharge summaries or clinic letters sent to GPs	Financial penalty maximum £500k to be applied across the 3 indicators. For 2 of these indicators, there are no financial penalties during Q1 and Q2 because they are set aside for producing and rolling out an action plan. Instead, the consequence of a breach is in line with clause 32/33 of the contract.
Readmission rates-Elective	Funding already withdrawn as part of £2m savings
Readmission rates-Non-Elective	No reimbursement for breaches but value of financial penalties will be returned for reinvestment in improvements in urgent care
34 indicators covering a wide range of issues including HSMRs, reporting of PROMs, maternity care, screening, health promotion, health of staff and staff training	In line with clause 32/33 of the contract

NHS FT

Local quality requirement	Consequence of breach
4 hour maximum wait at A&E from arrival to transfer, discharge or admission	Weekly assessment of performance at site level: <95% but >93% = £500; <93% but >90% = £1k; <90% = £1500
Avoidable MRSA bacteraemia	Recovery of cost of patient spell for any avoidable infections per month. However, if action plan is not delivered against or there is a further case for the same reason penalty of £20k will be applied and not reinvested.

Breastfeeding initiation within 48 hours (as per VSMr guidance)	Failure to achieve target for Q4 (Jan-Mar 2011) at a host PCT (Trust) level will result in penalty of: (1) Until maternity service specification agreed: <60% but >58% = £4k; <58% = £7k Or (2) When maternity service specification is agreed, a more challenging target will be required with sliding scale for penalty to be agreed.
Maternity 12 week bookings	Failure to achieve target at a host PCT (Trust) level will result in penalty of £5k
Chlamydia screening	Penalty of £10k applied if target not achieved for 2011/12, applied at PCT level
No patients waiting over 6 weeks for the 15 key diagnostic tests	Penalty of £2k applied per test line on a monthly basis.
Quality Stroke Care: People with stroke spending at least 90% of their time on a stroke unit Higher risk TIA cases are treated within 24 hours	Penalty of £10k applied per target not achieved for 2011/12, applied at PCT level
Discharge summaries arriving within 24 hours	Penalty of £50k for each quarter where performance is not met
Submission of Trajectories to support Operating Framework and DH returns	£2,000 per return which misses a deadline set by / agreed with DH
Falls: patients assessed within six hours of admission to identify those that are at high risk of falling	Penalty applied on quarterly basis at trust level: <98% but >95% = £2k; <95% but >90% = £4k; <90% = £6k
Falls: for patients that are identified as being at high risk of falling, a falls protocol (action plan) to be instigated within 12 hours of admission.	Penalty applied on quarterly basis at trust level: <100% but >95% = £2k; <95% but >90% = £4k; <90% = £6k
Choose and Book – Consultant led teams	Penalty of £5k for any month where 95% not achieved Action plan to be agreed

N.B. The commissioner in this case applied a reinvestment policy to all of its providers, including private providers. Here is an excerpt from the policy:

"The coordinating commissioner will follow clause 32 of the contract (Performance Management) in the management of performance against the agreed penalty scheme. In the event that it is necessary to penalise the provider due to poor performance, the coordinating commissioner will reinvest the financial sum attached to the penalty back into the provider's services with the re-investment linked to a clear action plan for improvement that will be monitored via the monthly clinical quality review group. This approach is consistent with the

spirit of partnership working between the commissioner and provider and demonstrates the commissioner's commitment to improving performance and quality of services.

The exception to this approach will be where there is gross and/or continued poor performance on the part of the provider. To provide additional clarity to the LSA, the likely scenario for an exception to this rule is where an action plan is not implemented successfully and poor performance continues into the following months. In such circumstances the PCT may choose to instigate the penalty and not reinvest the associated funding."

NHS FT

Locally defined indicators	Consequence of breach
Commissioner policies on medicines management and low clinical priorities	Non-payment for activity where there is non-compliance; recovery of cost of any proven shortfall in discharged or outpatients medication
Procedures not carried out as defined by Health Resource Group ("HRG") WA14Z. The commissioner will not accept charges for any WA14Z HRGs unless a case for exceptionality is presented within the agreed ' non- mandatory' reconciliation process and timescales.	Approved exception cases only to be paid by commissioner
New to follow up ratios, and conversion rates from A&E attendances	Non-payment by Commissioner for activity over threshold
36 indicators covering a wide range of issues including infection prevention and control, WHO surgical safety checklist, HSMRs, Choose and Book, screening, timeliness of diagnostic results, reporting of PROMs, maternity, cancer, stroke, management of discharges, excess bed days, consultant to consultant referrals	Exception report under clauses 32 and 33

NHS FT

Local performance and activity KPIs, local quality KPIs and service specification KPIs	Consequence of breach
Several activity KPIs such as A&E / Emergency admission conversion ratios and spells with complications	Activity management plan

Pre-procedure Bed Days (Elective & NEL)	No payment for pre-procedure bed days where excess bed days have been incurred - above the agreed threshold
Timeliness of discharge letters to GPs	Letter received within 2 days – £0 Letter received after 2 days £50. A cap of £100k per quarter.
Emergency readmissions of post elective and post non-elective cases	There appears to be a reinvestment policy: "The amounts accruing under readmissions penalties will be recycled within the Trust in the expectation that sustainable improvements will be made in the Trust's readmission rates"
A few other local performance and activity KPIs	No financial consequences of breach. One of them will be used to inform activity planning and commissioning intentions for 2012-13 and one is a KPI under development.
2 indicators related to serious untoward incidents policy	Failure to provide reports within agreed timeframe will result in withholding of 1% of the monthly contract value until a remedial plan to ensure future timely reporting is agreed and actioned.
Timeliness in resolution of complaints	Reasons reported by Trust, Remedial action plan to ensure prompt resolution of patient complaints where necessary
CQUIN indicators from the previous year (2010-11)	The Trust's performance will be monitored over the course of 2011/12 to ensure that the quality improvements attained and remunerated via CQUIN in 2010/11 are sustained. If Commissioners determine that there is insufficient evidence in this respect, the Trust will repay up to the 2010/11 investment to Commissioners, in line with the relevant weightings and financial values assigned to each CQUIN target for that year.
4 service specification KPIs related to maternity services	Cluster tariff top up of £110 per birth withheld

NHS FT

Local quality requirements	Consequence of breach
Risk Assessment of the compliance with NICE quality standards, NICE guidance & technology appraisals within 3 months of publication	Effective from end of quarter 1. £2,000 for each month that breached
% of SUIs reported on STEIS within 72 hours of being agreed as a SUI.	£5,000 for each month the threshold is breached

% of SUIs where full reports were completed within 45 working days of date agreed as a SUI	£10,250 for each month the threshold is breached
3 quality requirements covering occurrence of serious incidents, severe falls and grade 3 & 4 pressure ulcers	Breach of annual target £12500 per case over the annual threshold
% of patients with a discharge summary within 24 hours (including TTO)	If summary is not received within 24 hours a £50 charge is levied and if no summary received within 7 days then the treatment pertaining to the missing summary is not paid for
2 quality requirements covering the number of cardiac arrests and end of life care	Quality aspiration for high impact change Action plan to be provided if threshold is breached
10 indicators covering urinary tract infections, unplanned hospital admissions, length of stay, waiting times, readmissions for patients over 65 years of age and implementation of the Maternity Dashboard	No penalty
Planned Procedures not carried out (HRG WA14Z)	Recovery of the cost of the number of procedures above threshold limit at year end
Percentage of COPD; Asthma & Diabetes patients with care plan (by service)	The Trust will explore the feasibility of providing care plan information to the GP's
Percentage of COPD; Asthma & Diabetes patients feeling supported whilst in hospital to manage their condition (as part of patient satisfaction reporting)	The Trust will explore the feasibility of collating this information with other data collections.
Percentage of patients seen within 48 hours of contacting the genito-urinary medicine service.	Action Plan to review if below the threshold
Consultant to Consultant Referrals – Catchment (All PCTs)	No payment for referrals that do not meet agreed criteria within C2C Policy Quarter 2 onwards
Consultant First to Follow-up attendance ratio for Gynaecology, General Surgery (including sub-specialties), Ophthalmology	If rates do not reduce to the threshold levels by the quarter 3 and 4 position
2 indicators covering emergency readmissions	Total block adjustment for readmissions agreed as part of contract settlement. Annual sum by main PCT commissioner: - PCT 1 £305,743 - PCT 2 £183,916 - Other £16,481
7 indicators covering maternal health and breastfeeding	Action Plan
Reduction of Caesarean Section Rates	Trust to repay the difference between a Normal Delivery tariff (HRG NZ01B) and a Caesarean Section tariff (HRG NZ03A) for the number of spells breaching the threshold

Declaration of Compliance with Care Quality Commission Standards. To maintain registration with the Care Quality Commission and to respond to and report any in year alerts or concerns.	If threshold is breached £100,000 for each month until corrected
Hospital Mortality Rates	If threshold breach - Action plan/ /audit required plus assurance via Trust Board
4 quality requirements on medicines management	Any cost implications for primary care of Trust not complying to be recharged by commissioner to acute Trust

Private provider

Local clinical quality performance indicators	Consequence of breach
1 indicator related to timeliness of discharge summaries sent to GPs and 1 indicator related to timeliness of clinic letters sent to GPs	For every 5% below quarterly threshold, 0.1% of quarterly value of the elective elements of the contract to be withdrawn, up to a maximum of 0.5%
Readmission rates-Elective	No reimbursement for breaches
16 indicators covering a wide range of issues including reporting of PROMs, nutritional assessment of patients, MRSA screening, reduction in DNA rates and health of staff	In line with clause 32/33 of the contract

Private provider

Local quality requirement	Consequence of breach
Avoidable MRSA bacteraemia	Recovery of cost of patient spell for any avoidable infections per month. However, if action plan is not delivered against or there is a further case for the same reason penalty of £20k will be applied and not reinvested.
No patients waiting over 6 weeks for the 15 key diagnostic tests	Penalty of £2k applied per test line on a monthly basis.
Discharge summaries arriving within 24 hours	Penalty of £10k for each quarter where performance is not met
Choose and Book – Consultant led teams	Penalty of £2k for any month where 95% not achieved Action plan to be agreed

N.B. The commissioner in this case applied a reinvestment policy to all of its providers, including private providers. Here is an excerpt from the policy:

"The coordinating commissioner will follow clause 32 of the contract (Performance Management) in the management of performance against the agreed penalty scheme. In the event that it is necessary to penalise the provider due to poor performance, the coordinating commissioner will reinvest the financial sum attached to the penalty back into the provider's services with the re-investment linked to a clear action plan for improvement that will be monitored via the monthly clinical quality review group. This approach is consistent with the spirit of partnership working between the commissioner and provider and demonstrates the commissioner's commitment to improving performance and quality of services.

The exception to this approach will be where there is gross and/or continued poor performance on the part of the provider. To provide additional clarity to the LSA, the likely scenario for an exception to this rule is where an action plan is not implemented successfully and poor performance continues into the following months. In such circumstances the PCT may choose to instigate the penalty and not reinvest the associated funding."

Acute providers (incl. private providers) – 2012-13 examples of local penalties

NHS FT

Local clinical quality performance indicators	Consequence of breach
2 indicators on the quality of stroke care (patients spending at least 90% of stay on stroke unit, and patients arriving in designated stroke bed within 4 hours of arrival)	£100 financial penalty per breach below threshold. Applied quarterly
1 indicator on the quality of stroke care (proportion of high risk TIA cases investigated and treated within 24 hours)	£50 financial penalty per breach below threshold. Applied quarterly
Emergency Readmissions	As per PBR rules for 2012/13. Non-reimbursement for emergency readmissions within 30 days of discharge
25 indicators covering a wide range of issues including VTE, discharge summaries, maternity, Equality Delivery System, choice of consultant led team, serious incidents, nutrition and staff training	Clause 47 Remedial Action Plan or Immediate Action Plan as appropriate
Provider cancellation of new and follow up outpatient appointments	Clause 47 Remedial Action Plan or Immediate Action Plan as appropriate- no payment for first or follow up appointments cancelled at tariff
Pre-op days deducted from excess bed days for Electives. Ensure commissioners do not pay for excess bed days equivalent to number of pre procedure bed days.	Financial Adjustment

Issue Discharge Summary (as defined in section E of the national contract) to service users GP within 24 hours of all patients discharge from Provider premises. As per section C part 6A paragraph 4. Suggested delivery methods include electronic discharge direct to GP clinical systems where compatible; via PDF file to an NHS.net email address, or secure fax	Financial consequence

NHS FT

Local quality requirement	Consequence of breach
Avoidable MRSA bacteraemia	Recovery of cost of patient spell for any initial avoidable infections per month. However, if action plan is not delivered against or there is a further case for the same reason penalty of £20k will be applied and not reinvested.
Breastfeeding within 48 hours (as per IPMr guidance)	Failure to achieve target for Q4 (Jan-Mar 2013) at a host PCT (Trust) level will result in penalty of: <60% but >58% = £4k; <58% = £7k
Maternity 12 week bookings	Failure to achieve target at a host PCT (Trust) level will result in penalty of £5k
Chlamydia screening	Threshold TBA by end Apr-12; implemented from May-12
Stroke: People with stroke spending at least 90% of their time on a stroke unit	Penalty of £10k applied per target not achieved for 2012/13, applied at PCT level
Stroke: Higher risk TIA cases are treated within 24 hours	Penalty of £10k applied per target not achieved for 2012/13, applied at PCT level
Discharge summaries arriving within 24hrs	Penalty of £100k for each quarter where performance is not met at trust level
Discharge summaries: medication errors	£50k penalty if reduction of at least 20% not achieved
Failure to notify GP of death within 24hrs	From Q2, penalty of £20k for each quarter where performance is not met
Falls: patients assessed within six hours of admission to identify those that are at high risk of falling	Penalty applied on quarterly basis at trust level: <98% but >95% = £2k; <95% but >90% = £4k; <90% = £6k
Falls: for patients that are identified as being at high risk of falling, a falls protocol (action plan) to be instigated within 12 hours of admission	Penalty applied on quarterly basis at trust level: <100% but >95% = £2k; <95% but >90% = £4k; <90% = £6k

Choose and Book – Consultant led teams	Penalty of £5k for any month where 95% not achieved Action plan to be agreed
18 weeks RTT - incomplete pathways	Monitored on quarterly basis at PCT level, by specialty £500 per specialty breach; cap of £1500 per PCT, per quarter
Percentage of patients seen within 18 weeks in respect of Consultant-led Services to which the 18 Weeks Referral-To-Treatment Standard applies	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT and specialty level
Percentage of A & E attendances where the patient spent four hours or less in A & E from arrival to transfer, admission or discharge	Weekly assessment of performance at site level: <95% but >93% = £500; <93% but >90% = £1k; <90% = £1500
Proportion of patients receiving first definitive treatment for cancer within 62 days of - an urgent GP referral for suspected cancer - referral from an NHS Cancer Screening Service - following a consultant's decision to upgrade the Patient priority	Penalty of £10k where combined performance target of 85% is not met, applied on a quarterly basis at PCT level
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT level
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment - surgery	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT level
Proportion of patients waiting no more than 31 days for second or subsequent cancer treatment - drug treatments	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT level
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT level
Percentage of patients with breast symptoms where cancer not initially suspected referred to a specialist who are seen within two weeks of referral	Penalty of £10k where performance is not met, applied on a quarterly basis at PCT level

N.B. The commissioner in this case applies a reinvestment policy to all of its providers, including private providers. In the event of a breach, the provider incurs a penalty, and then the provider draws up a corrective action plan, and after agreement of this plan with the PCT, the penalty money is 'reinvested' back into the provider to improve performance with regard to the quality requirement that was breached.

NHS FT

Regionally and locally defined quality requirements	Consequence of breach
Availability of Services on Choose & Book All 2 Week Wait services delivered by the Provider shall be available via Choose & Book as a Directly Bookable Service	a) For any breach as at 1 June 2012, contract management actions in accordance with Clause 47, where the period for any remedial actions shall not exceed 28 days from the commencement date of the plan. b) For any subsequent breach (after the expiry of the period for any remedial action agreed in (a) above), the Provider must pay the Co-ordinating Commissioner £5,000 per service not available.
Directories of Service Provider shall minimise the number of 'Do Not Use' or 'Test' services on their Directory of Services	Provider shall pay the Co-ordinating Commissioner £500 for each 'Do Not Use' or 'Test' service (or any equivalent wording) in excess of 5.
Availability of Appointment Slots Provider failure to ensure that "sufficient appointment slots" are made available on the Choose & Book system.	a) The Co-ordinating Commissioner shall ascertain on a monthly basis a. the ASI rate; b. the number of actual slot issues (as per Department of Health/Connecting for Health published figures) b) The Co-ordinating Commissioner shall ascertain the number of actual slot issues which exceeded the ASI rate of 0.03 in the relevant month. e.g. ASI rate = 0.12 and number of actual slot issues 120. ASI rate of 0.03 = 30 actual slot issues. Number of actual slot issues exceeding ASI rate of 0.03 = 90. c) The following consequences shall apply: ASI Rate: Provider shall pay the Co-ordinating Commissioner per actual slot issue exceeding the rate of 0.03: 0.04-0.05 £75 0.06 – 0.09 £150 0.10 and above £250
Provision of Advice and Guidance Provider shall provide an Advice & Guidance service for all specialities	a) For any breach as at 1 June 2012, contract management actions in accordance with Clause 47, where the period for any

(excluding those services appearing in the "Excluded Services" list approved by SHA) published within its Directory of Service, in accordance with the provisions of Clause 10 "Service User Booking Choice and Referrals"	remedial actions shall not exceed 60 days from the commencement date of the plan, and shall not extend past 1 October 2012. b) For any subsequent breach (after the expiry of the period for any remedial action agreed in (a) above), the following consequences apply: Services providing Advice & Guidance: Provider shall pay the Co-ordinating Commissioner: 90-95% £1,000 80-89% £5,000 70-79% £7,500 <70% £10,000 c) For each request not responded to within 3 working days (urgent) or 5 working days (routine) of the request being made via Choose & Book, the Provider shall pay the Co-ordinating Commissioner £50.
Satisfaction of the Provider's obligations under each Ambulance Services Handover Plan	As per Clause 47 of the Core Legal Clauses Where the Provider fails to achieve the threshold in any month the Commissioner shall: (i). Subtract from the total time ambulances were waiting beyond 30 minutes of arrival a proportion that is equal to the percentage of delayed handovers which were not completed within 15 minutes of recorded time of arrival at A&E where it was agreed that any delay was not the fault of the Provider; (ii). Using the figure obtained in (i) calculate the cost of waiting time by multiplying the time (rounded down to the nearest 15 minutes) by £70.00 (the average hourly cost of an A&E ambulance). (iii)The Provider shall pay 100% of the sum calculated in (ii) above.
Ambition One a) Eliminating avoidable Grade Three and Four pressure ulcers: Reduce category 3 and 4 'avoidable' pressure ulcers. 100% reduction from agreed baseline in incidence in acute care by March 2012	(a) £500 reduction per case over threshold at quarter end; (b) monthly monitoring of the agreed action plan and achievement of agreed milestones within that action plan; (c) Quality Improvement Visits (QIV) by the Co-ordinating Commissioner. The Co-ordinating Commissioner may request a revision of the action plan following the outcome of any QIV.
Ambition One b) Eliminating avoidable Grade Two pressure ulcers:	(a) £250 reduction per case over threshold at quarter end;

Reduce category 2 'avoidable' pressure ulcers. 100% reduction from agreed baseline in incidence in acute care by March 2013	(b) monthly monitoring of the agreed action plan and achievement of agreed milestones within that action plan; (c) Quality Improvement Visits (QIV) by the Co-ordinating Commissioner. The Co-ordinating Commissioner may request a revision of the action plan following the outcome of any QIV.
12 indicators covering a range of issues including availability of services on Choose & Book, Directories of Service, pressure ulcers, infection control and prevention, breastfeeding, medicines management, trolley waits, summary hospital-level mortality rates and clinical audit plans	As per Clause 47 of the Core Legal Clauses

NHS FT

Local quality KPIs	Consequence of breach
% of patients with a data of discharge on or before Estimated Date of Discharge	Action Plan
Percentage of adults receiving a senior doctor review within 24 hours of admission	Action Plan
Discharge Letters are to be received by the patients GP within 24 hours of discharge for patients with an episode of care in A&E, Inpatient or Daycase.	Letter received within 2 days – £0 Letter received after 2 days £50. A cap of £100k per quarter.
2 indicators on discharge summaries	Clause 32 action plan/ or Financial consequence (to be determined locally)
2 indicators on Choose & Book bookings	£20,000 per quarter should the performance be below target in any one quarter. This will be split equally across these indicators
Sleeping Accommodation Breach	Retention of £250 per day affected as may be pursuant to guidance
Emergency re-admission following elective	As per PBR rules for 2012/13. Non reimbursement for emergency readmissions within 30 days of discharge following an elective admission.
Emergency re-admission following non elective	Needs further PBR guidance
2 indicators on the quality of stroke care (patients spending at least 90% of stay on stroke unit, and patients arriving in designated stroke bed within 4 hours of arrival)	£100 financial penalty per breach below threshold. Applied quarterly. Can only financially penalise for 1 KPI at a time if failing either of these KPIs at any one time.
1 indicator on the quality of stroke care (proportion of high risk TIA cases investigated and treated within 24 hours)	£50 financial penalty per breach below threshold. Applied quarterly

% of complaints responded to within timescale agreed at the outset upon receipt of the complaint with the complainant	Action Plan to include how identified issues will be resolved. To be submitted within the quarter where breach occurs. Failure to provide resolution within quarter will invoke financial penalty equivalent to the cost of the relevant case
Patients discharged on sip feeds should have been assessed by a Dietician in secondary care and their continued requirement for sip feeds on discharge approved by the Dietician	PCT recharge of patient sip feed cost where found that dietician not approved in writing and plan set out
Pre-procedure Bed Days (Elective & NEL) The commissioner will not fund excess bed-days above the agreed threshold. The adjustment calculated at Trust level and the co-ordinating Commissioner will determine how this will be applied across themselves and the Associate PCT.	No payment for pre-procedure bed days where excess bed days have been incurred - above the agreed threshold
15 indicators covering a wide range of issues including staff training, dementia, stroke, serious incidents, maternity, nutrition, and Equality Delivery System	Clause 32 Remedial Action Plan
2 indicators on medicines management	Clause 47 / 32 Remedial Action Plan or Immediate Action Plan as appropriate

NHS FT

Local quality requirements	Consequence of breach
Risk Assessment of the compliance with NICE quality standards, NICE guidance & technology appraisals within 3 months of publication	£2,000 for each month that breached
8 quality requirements covering E. coli infections, complaints, reporting of incidents, waiting times and implementation of the Maternity Dashboard	No penalty
% of SUIs reported on STEIS within 72 hours of being agreed as a SUI.	£5,000 for each month the threshold is breached
% of SUIs where full reports were completed within 45 working days of date agreed as a SUI	£10,250 for each month the threshold is breached
Reduction in occurrence of (SUI's) similar-severe harm and death incidents	Breach of annual target £12,500 per case over the annual threshold
% of patients with a fully contractual compliant Discharge Summary within 24 hours	No penalty when discharge summary receipt is between 90% and 95%. Penalty applies when 90% is not achieved. If summary is not received within 24 hours a £50 charge to be levied for all discharges that breach the threshold in month. In

	addition if no summary received within 7 days then the treatment pertaining to the missing Discharge Summary/Summaries will not be paid for.
2 quality requirements covering severe falls and grade 3 & 4 pressure ulcers	Breach of annual target £12500 per case over the annual threshold
Reduction in the number of cardiac arrests in hospital wards, outside A&E, Theatres, CCU and ICU'	Quality aspiration for high impact change Action plan to be provided if threshold is breached.
Consultant to Consultant Referrals – Catchment (All PCTs)	No payment for referrals that do not meet agreed criteria within C2C Policy
3 indicators covering readmissions	Work together with Partners to address health economy performance
7 indicators covering maternal health and breastfeeding	Action Plan
Reduction of Caesarean Section Rates	Trust to repay the difference between a Normal Delivery tariff (HRG NZ01B) and a Caesarean Section tariff (HRG NZ03A) for the number of spells breaching the threshold
Declaration of Compliance with Care Quality Commission Standards. To maintain registration with the Care Quality Commission for all sites where services are provided and to respond to and report any in year alerts or concerns.	If threshold is breached £100,000 for each month until corrected
Hospital Mortality Rates	If threshold breach - Action plan/ /audit required plus assurance via Trust Board
4 quality requirements on medicines management	Any cost implications for primary care of Trust not complying to be recharged by commissioner to acute Trust

Private provider

Local clinical quality performance indicators	Consequence of breach
Emergency Readmission Following Elective	As per PBR rules for 2012/13. Non-reimbursement for emergency readmissions within 30 days of discharge following an elective admission.
23 indicators covering a wide range of issues including VTE, discharge summaries, choice of consultant led team, serious incidents and staff training	Clause 47 Remedial Action Plan or Immediate Action Plan as appropriate
Provider cancellation of new and follow up outpatient appointments	Clause 47 Remedial Action Plan or Immediate Action Plan as appropriate- no payment for first or follow up appointments cancelled at tariff

Follow up Ratios Maintain rates at 11/12 outturn level (11/12 defined as the period November 2010-October 2011)	Clause 47 Remedial Action Plan or Immediate Action Plan as appropriate or non payment once thresholds breached
Pre-op days deducted from excess bed days for Electives. Ensure commissioners do not pay for excess bed days equivalent to number of pre procedure bed days.	Financial Adjustment
Discharge summary to include all of the relevant clinical communication required as per agreed local spec from 1/4/2012 to 30/9/2012	Clause 47 action plan/ or Financial consequence (to be determined locally)

Private provider

Local quality requirement	Consequence of breach
Avoidable MRSA bacteraemia	Recovery of cost of patient spell for any avoidable infections per month. However, if action plan is not delivered against or there is a further case for the same reason penalty of £10k will be applied and not reinvested.
18 weeks RTT - incomplete pathways	Monitored on quarterly basis at PCT level, by specialty £500 per specialty breach; cap of £1500 per PCT per quarter
Percentage of patients seen within 18 weeks in respect of Consultant-led Services to which the 18 Weeks Referral-To-Treatment Standard applies	Penalty of £3k where performance is not met, applied on a quarterly basis at PCT and specialty level
Discharge summaries arriving within 24hrs	Penalty of £10k for each quarter where performance is not met
Choose and Book – Consultant led teams	Penalty of £2k for any month where 95% not achieved Action plan to be agreed

N.B. The commissioner in this case applies a reinvestment policy to all of its providers, including private providers. In the event of a breach, the provider incurs a penalty, and then the provider draws up a corrective action plan, and after agreement of this plan with the PCT, the

penalty money is 'reinvested' back into the provider to improve performance with regard to the quality requirement that was breached.

Community provider – 2011-12 examples of local penalties

NHS Trust

Local performance indicator	Consequence of breach
16 indicators covering a wide range of issues including MRSA screening, PEAT inspections, wound care, falls, insulin prescribing, lithium prescribing, end of life, staff survey, patient experience, VTE and discharge	Clause 32
Pressure ulcers: Continued reduction of hospital acquired pressure ulcers	Subject to Clause 32 (Performance Management) 0% retention/ withholding clause pursuant to Clause 32.12 PCT Cluster to decide penalty

Community provider – 2012-13 examples of local penalties

NHS Trust

Locally agreed quality requirement	Consequence of breach
15 quality requirements covering a wide range of issues including reducing fractures, care for vulnerable patients, patient reported experience outcomes, complaints, experience of carers, end of life, safeguarding, patient incidents, harm free care, dementia, HCAIs and health promotion	Clause 32
Discharge summaries: Improve timeliness, content and legibility of Discharge Summaries for In Patients	Q2 will hold a Fixed Penalty of £15,000 if not compliant Q4 will hold a Fixed Penalty of £15,000 if not compliant Clause 32

N.B. 6 other quality requirements were also tabulated in the locally agreed quality requirements section of the contract, but the 'Consequence of Breach' column was left blank for them. These

concerned depression/dementia, leg ulcers, warfarin, medicine reconciliations, NSAIDs and insulin.

Mental health provider – 2011-12 examples of local penalties

NHS FT

Local quality requirements	Consequence of breach
PRESSURE ULCERS: Pressure Ulcers acquired within a provider care setting. The provider will implement best practice to continue to work to reduce the number and severity of hospital acquired pressure ulcers.	Subject to Clause 32 (Performance Management) 0% retention/ withholding clause pursuant to Clause 32.12 PCT Cluster to decide penalty
2 quality requirements covering falls and medication errors	Subject to Clause 32 Subject to Clause 33 (Joint Clinical Investigation followed by Remedial Clinical Action Plan and Exception Report – escalated as appropriate)
3 quality requirements covering clinical audit for mental health and learning disability services, end of life care, and preventing suicide	Clause 32
2 quality requirements regarding safeguarding children and vulnerable adults	Remedial action plan within 5 working days of being requested by commissioner (Clause 32)
DISCHARGE SUMMARIES: The Provider will complete audits of Discharge Summaries against the standards set out in Clause 18 (in main body of contract) and Schedule 7 Part 3 as per Commissioners Audit Tool.	Penalty against core discharge area: £50 penalty per discharge summary incomplete discharge summary. This is to be calculated across all discharges for that audit period. (e.g. if 10% of the core areas are not at 100% there would be a £50 fine for 10% of all discharges for that time period e.g. 6 months). The value of the penalty shall be periodically identified and reinvested into the areas that resulted in the penalty, as agreed at the CQRM meeting. Other areas of audit: Clause 32 (Performance Management).

Mental health provider – 2012-13 examples of local penalties

NHS FT

Local quality requirements	Consequence of breach
25 quality requirements covering a wide range of issues including mortality, depression/dementia, promoting recovery, essential standards of care, long term conditions, re-admissions, substance misuse, complaints, end of life care, safeguarding, harm free care, suicide, lithium prescribing and smoking	Clause 47
DISCHARGE SUMMARIES: Improve timeliness, content and legibility of Discharge Summaries for inpatient services.	Q2 will hold a Fixed Penalty of £15,000 if not compliant Q4 will hold a Fixed Penalty of £15,000 if not compliant Clause 47

N.B. 3 other quality requirements were also tabulated in the locally agreed quality requirements section of the contract, but the 'Consequence of Breach' column was left blank for them. These concerned warfarin, medicine reconciliations and insulin.

Appendix D - Second survey in 2014: Structured interview schedule

Contract year 14/15

23. Are you using the NHS standard contract for small providers?
24. If yes, who is responsible for these contracts? (Could we have name and contact details).
25. Are you collaborating with other CCGs in your main contracts (i.e. acute, community and mental health)?
26. If yes, which ones and how?
27. If you are involving a CSU which contracting functions exactly are you buying from them?
28. Which are your main providers (acute, community, mental health)?
29. Do you have separate contract managers for each provider?
30. If yes, are they at the CCG or the CSU?
31. Could we have their names and contact details?
32. Do you use any private providers?
33. Which ones? (i.e. name of private provider and what type of care?)
34. Who does the contracting for the private provider? Is it you? (if yes, repeat questions separately)
35. Are GPs involved in contracting (e.g. do GPs attend contract negotiation and monitoring meetings)?
36. Are they involved in all aspects of contracting or mainly in clinical and quality issues?
37. What is the approximate value of the 2014/15 contract (For the NHS and private sector trusts)?
38. Under the new rules, you can sign contracts for longer than one year. Have you signed any contract to last more than one year?
39. If yes, for how long?
40. With which provider and what are the reasons that led you to choose a longer contract?
41. Have you agreed the basis on which you calculate the prices for the following years?
42. How did you calculate non-tariff/local prices?
43. The 2014/15 contract allows for flexibility in agreeing national prices. Have you agreed any modified national prices (including risk sharing) as Local Variations? (GC36.3.1.2). (Schedule 3 Part B).

44. If yes, what are they?
45. How did you calculate them?
46. Have you agreed any Local Modifications (Sch 3. Part C)? (This needs to be approved by Monitor).
47. If yes, what are they?
48. According to national guidelines the 08/09 baseline is to be used for setting the point at which the 30% marginal rate for emergency admissions applies. The 2014/15 contract allows for adjusting the baseline in cases of increased demand for emergency admissions which is beyond the provider's control (e.g. due to change in demographics). Have you made any such baseline adjustment for 14/15 with your provider?
49. If yes, how did you calculate it?
50. Have you included in the contract any specific plans on investing the money retained from the marginal rate payments in order to manage demand for emergency care?
51. If yes, could you give me one or two examples?
52. Did you agree any Data Quality Improvement Plan with your providers?
53. If yes, what does it include (could we have a copy of it)?
54. Have you agreed any **local** quality requirements (Sch 4. Part C)?
55. If yes, do you remember one or two examples?
56. If yes, are specified sanctions attached for possible breaches of such local requirements?
57. If yes, can you give me an idea what they are?
58. Have you agreed a local incentive scheme with your provider (Sch 4. Part F)?
59. If yes, what exactly?
60. The 14/15 contract allows for contracting parties to vary nationally mandated sanctions if they consider it necessary. Have you agreed with your provider to vary the application of any nationally mandated sanctions (Sch 4. Part H)?
61. If yes, which ones?
62. Have you agreed any local variations to nationally mandated CQUINs (Sch. 4. Part I)?
63. Have you agreed any other formal variations (Sch 6. Part A) to the contract generally (i.e. other than any variations to tariff?
64. If yes, could you give me one or two examples?

65. When you decided the local CQUINs or the local quality indicators did you take your local levels of ambition into consideration? (Did the levels of ambition translate into your local quality requirements?)
66. Could we have a copy of your Quality Schedule (Sch. 4)?
67. Could you tell me how you find the new provisions on staffing, especially reporting requirements introduced in the 2014/15 contract (GC5)?
68. How did you find the e-contract? Easy to use? Anything to be changed?

Contract year 2013/14

The contract

42. What was the approximate value of your 2013/14contract?
43. Did you buy any functions relating to contracting from a CSU?
44. If yes, which CSU and which functions did you buy?
45. How did you calculate non-tariff prices?
46. What was the financial position of your organisation in 2013/14 (surplus or deficit)?
47. What was the financial position of your providers (surplus or deficit)?
48. Did you agree any local quality requirements?
49. Did you agree any local quality incentives beyond CQUIN?
50. Could we have a copy of your Quality Schedule?

Behavioural

Now I am going to ask you some questions about actual application of the 13/14 contract:

51. How frequently did you have contract Review meetings with your provider?
52. Did you sign a Review Record after each Review meeting (according to GC 8.2)
53. Did you find the process of review meetings effective in monitoring the contract or do you think it should be changed?
54. If so, do you have any suggestions about how it should be changed?
55. Did you agree any remedial action plans with your provider following a Contract Query Notice (GC9.13)?
56. Did you withhold any money for failure by the provider to agree a Remedial Action Plan (GC9.19)?
57. If yes, how did you determine the amount of funding to withhold and was this done in accordance with the provisions in the contract?
58. Did you have to issue any Exception Reports for breaches by the provider of a Remedial Action Plan (GC9.21)
59. If yes, did you withhold any money following issue of a First Exception Report (GC9.23)?
60. If yes, how did you determine the amount of funding to withhold and was this done in accordance with the provisions in the contract?
61. Did you permanently retain any money following issue of a Second Exception Report (GC.24)?

62. If yes, how did you determine the amount of funding to withhold and was this done in accordance with the provisions in the contract?
63. Did you terminate any of your contracts or provider services in the last 12 months?
64. If so could you tell me which ones and why?
65. Did you suspend any provider services in the last 12 months?
66. If so, which ones and why?
67. Did you agree any Permitted Variations to Tariff?
68. If yes, why and how did you calculate them?
69. Did you have any disputes with your providers (formal or informal)?
70. If yes, over what?
71. If informal, how were they resolved?
72. Did you use any of the stages in the process of Dispute Resolution (i.e. Escalated Negotiation, Mediation or Expert Determination)?
73. If yes, which one?
74. If yes, over what and what was the outcome?

Various clauses in the contract lead to penalties for breaches or incentive payments for achieving specified indicators. I am going to ask you questions relating to that now:

75. Did your provider breach any national quality targets? (e.g. RTT, A&E, Cancer waits, C Difficile etc)?
76. If yes, did you retain any money for non-achievement by the provider of any of the national quality targets?
77. If yes, was it what was specified in the contract?
78. Did the provider report any 'never events'?
79. If yes, could you give me any examples?
80. If yes, what were the consequences?
81. Did the provider breach any local quality requirements?
82. If yes, could you give me any examples?
83. If yes, did you retain any money for breaches?
84. If yes, how did you determine the amount to withhold and was this done in accordance with the provisions in the contract?
85. Did your provider fail to achieve any of the CQUIN indicators?
86. If yes, examples?

87. If yes, did you retain any money for it?
88. If yes, how did you determine the amount to withhold and was this done in accordance with the provisions in the contract?
89. Did your provider fail to achieve any local quality incentives?
90. If yes, examples?
91. If yes, did you retain any money?
92. If yes, how did you determine the amount to withhold and was this done in accordance with the provisions in the contract?
93. Did you issue any Activity Query Notice to the provider this year?
94. If yes, in which specialty?
95. If yes, was that followed by a Utilization Improvement Plan?
96. If yes, what were its main elements?
97. Did you have to agree an Activity Management Plan in relation to any specialty?
98. If yes, which one?
99. If yes, what were its main elements?
100. Was that Activity Management Plan breached by either the Provider or the Commissioner(s)?
101. If yes, what were the consequences?
102. Were they specified in the contract?
103. Did your provider breach any Data Quality Improvement Plan?
104. If yes, what were the consequences?
105. Were they specified in the contract?
106. Did your provider deliver against any Service Development Improvement Plan?
107. If not, what were the consequences?
108. Did you make payments for activity in accordance with the contract you agreed at the beginning of the year? (i.e. did you pay the agreed rate – PbR or otherwise- for each episode of care the provider delivered or did you vary it at the end of year settlement?)
109. If not, how did the payments you made differ from what the contract stipulated? How did this change come about?
110. Did you have any formal variations in the course of this contract?
111. If yes, could you give me any example?

112. Finally, could you tell me briefly how you invest any funds retained from the application of sanctions or non-achievement of incentives?

113. Are any plans for investment of such funds specified in the contract?

Appendix E – Second survey in 2014: Analyses of penalty schedules in contracts

In most of the contracts we received for both the years 2013/14 and 2014/15, local quality requirements were grouped into five domains:

1. Preventing people dying prematurely
2. Enhancing the quality of life of people with long-term conditions
3. Helping people to recover from episodes of ill-health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

The majority of the consequences of breach for any of the quality requirements in each domain were not financial penalties but either application of GC9 i.e. asking the provider to produce a Remedial Action Plan (RAP), or Joint Investigation between the commissioners and the providers. Some examples are provided in the first table below.

Some contracts did contain financial sanctions, and example of these are listed in the second table below.

Examples of local quality requirements which do not attract financial penalties:

Local quality requirements	**Threshold**	**Consequence of breach**
Domain 1: Preventing people dying prematurely		
Maternity • Women to be seen by a midwife or an obstetrician for health and social care assessment of needs and risk in less than 13 weeks of their pregnancy	90%	Remedial action plan.
• Smoking Cessation % of women referred to stop smoking service	<90% aggregate achievement	Remedial action plan.
• Smoking Cessation % of women smoking at delivery	< annual 20% reduction in smoking at delivery from 2012-13 baseline.	Remedial action plan.
• Midwifes trained in appropriate smoking cessation intervention training	<100% trained by the end of quarter 4 2013-14	Remedial action plan.
• Breastfeeding initiation rates Stroke	<80% <65%	Remedial action plan Remedial action plan

• Quality Stroke Care Patients with low risk TIA have access to MRI or carotid scan within 7 days	No improvement in % from 2012-13 baseline	Remedial action plan
• Quality Stroke Care People with stroke who are discharged from hospital with a joint health and social care plan.	No reduction in rates	Joint investigation
• Mortality within 30 days of hospital admission for stroke.	>90%	A remedial action plan to be developed if targets are not met
• Proportion of patients admitted directly to stroke unit within 4 hours of hospital arrival	>90%	Remedial action plan
	>60%	Remedial action plan
• Proportion of time patients spend on stroke unit	>12%	Remedial action plan
• Management of high risk TIA treated within 24 hours		
• Stroke patients thrombolysed within 3 hours		
Domain 2: Enhancing the quality of life of people with long-term conditions		
<u>Reducing avoidable admissions</u>	<u>No reduction on 2011/12 or 2012-13 outturn</u>	
• Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	System wide responsibility for delivering reductions	Joint investigation
• Emergency admissions for acute conditions that should not usually require hospital admission	System wide responsibility for delivering reductions	Joint investigation
• Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	System wide responsibility for delivering reductions	Joint investigation
• Emergency admissions for children with lower respiratory tract infections	System wide responsibility for delivering reductions	Joint investigation
		The penalty which will be calculated at total Trust level

• Emergency Admissions for alcohol related liver disease • 1st Outpatient Attendance to Follow-up Outpatient Attendance ratio	System wide responsibility for delivering reductions Higher ratio than that contained in Capacity Assumptions Annex 1 for each specialty.	for each specialty will be apportioned across Commissioners by the method detailed in Capacity Assumptions.
Domain 3: Helping people to recover from episodes of ill-health or following injury		
▪ Clinical pathway review	No less than four joint clinical pathway audits or reviews to be carried out per quarter. The pathways will be identified through variances in clinical thresholds or identified by joint agreement between local clinicians	Joint investigation
▪ Emergency readmissions	A clinical audit will determine the 15% of all readmissions which should be credited to Commissioners	The financial value to be credited will be the % of readmissions found on audit, in line with PbR baseline guidance, to be avoidable as a % of the financial value of readmissions in month excluding national exemptions
▪ Increase appropriateness of emergency admissions	No reduction in of patients admitted from A&E with 0 or 1 day length of stay and no primary diagnosis on discharge from 2012-13 baseline.	In quarter 1 the Trust will undertake an analysis of these patients to identify the reasons for admissions and whether and how they can be avoided. Commissioners will ensure there will be no double charging with QIPP
▪ Increase treatment of patients in ambulatory care settings	Increase in patients in defined conditions who are seen in an ambulatory care setting rather than in A&E or as an emergency admission	Joint investigation

▪ Delayed transfers of care to be maintained at a minimal level	Operating Standard of <5%	Remedial Action Plan
Domain 4: Ensuring that people have a positive experience of care		
▪ Admissions from A&E	>5% above 2011-12 levels	Remedial Action Plan
▪ Complaints Management - compliance with Sections 17 & 18 of the Local Authority Social Services & National health Services Complaints (England) Regulations 2009	100% Compliance with National Standards	GC9
▪ Adherence to Operating Principle for 6Cs - Care & Compassion	Internally or externally identified risks against National Standards and Operating Principles for 6cs - Care and Compassion	Remedial Action Plan
▪ Adherence to Operating Principle for Equality and Diversity	Internally or externally identified risks against National Standards and Operating Principles for Equality and Diversity or failure to publish EDS within deadline	Remedial Action Plan
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm		
▪ % of staff who have undertaken level 1 safeguarding adults training at induction	85%	Remedial Action Plan
▪ % of staff who have undertaken level 1 safeguarding adults training every 3 years	95%	Remedial Action Plan
▪ Compliance with all national standards including CQC and the	100%	Remedial Action Plan

Safeguarding Adult Assurance Framework	1:29	Remedial Action Plan
▪ Ratio of midwives to births	No greater than 1% above national average	Remedial Action Plan
▪ Caesarean section rate planned and emergency	25%	Remedial Action Plan
▪ MRSA screening	100% of relevant elective patients, 95% of relevant emergency patients	Remedial Action Plan
▪ Urinary Catheter Care: The provider will conduct point prevalence audit of compliance with EPIC 3 guidance on the insertion and care of urinary catheters	Submission of report	Remedial Action Plan
▪ Medication Errors. Incidence of errors reported that involve medications	95%	Remedial Action Plan
▪ Care Planning Summaries. Provider will ensure timeliness of CPS (paper copy taken with service users on discharge and receipt by GPs within 24 hours) on discharge from in-service users stay		

Examples of local quality indicators where a financial penalty was attached

Local quality requirement	**Consequence of breach**
Insulin use in T2 diabetes: Human insulin (as opposed to analogue insulin) to be used as insulin of first choice for all new T2 diabetics needing insulin, unless patient meets the locally agreed criteria for long-acting insulin.	Single penalty of £30,000 at year end if target not achieved in monthly rolling average.

Provision of discharge summaries within 24 hours as set out in section SC11 of the contract to referring or named GP	Inpatient: 2% of episode fee per week summary is outstanding Outpatient: £5 of episode fee per week summary is outstanding A&E: £5 of episode fee per week summary is outstanding (Agreed episode fees are: Outpatient £137 A&E £111 Inpatient £1764)
All admissions to critical care beds to be within 4 hours	Patient review to be completed within 1 month of each 4 hour breach. If breach could have been avoided through Trust action, £2,000 penalty is applicable. If demonstrated that breach was unavoidable and all actions were taken by trust no penalty is applicable.
Emergency readmissions	The financial value to be credited will be the % of readmissions found on audit, in line with PbR baseline guidance, to be avoidable as a % of the financial value of readmissions in month excluding national exemptions
Stroke Quality Standards	Non-payment of the additional tariff
<u>Quality of discharge letters</u>: • Reason for admission • Diagnosis • Complications (if applicable) • Relevant investigations carried out to enable ongoing care and any resulting actions taken by the treating clinician • Copy of care plan • Note as to who is responsible for organising any follow-up (if applicable)	50%-79%: £5,000 per percentage point below 80% <50%: £15,000 per percentage point below 50% 50%-79%: £5,000 per percentage point below 80% <50%: £15,000 per percentage point below 50% <50%: £10,000 per percentage point below 50%

• Exception report if the patient is going to be discharged to a place other than the place from which they were admitted (if applicable)	50%-79%: £5,000 per percentage point below 80%

Appendix F- Case studies: Details of interviews and meeting observations

List of interviews			
Code	**Title**	**Organisation**	**Date of interview**
B1	Head of Acute Contracts	CSU	15/5/13
B2	Head of Commercial & Business Development and Head of Contracting	Acute Trust	12/8/13 **and** 16/06/14
B3	Senior Management Accountant	CSU	10/10/13
B4	Commissioning/Contracting consultant (interim)	CSU	15/11/13 **and** 27/05/14 (not recorded)
B5	Corporate Income Finance Manager	Acute Trust	16/06/14
B6	Quality Manager	Acute Trust	16/06/14
A1	Assist Finance Director	Acute Trust	10/9/13
A2	Director of Operations	Acute Trust	10/9/13
A3	Head of Commissioning	CCG	3/10/13 & 23/08/14
A4	Deputy Director of Commissioning	CCG	3/10/13
A5	Chief Finance Officer	CCG	28/10/13
A6	Contracts Manager	CCG	6/11/13
A7	Clinical Quality Manager	CCG	2/5/14
A8	Director of Finance	CCG	2/5/14
A9	Clinical Quality Manager	CCG	23/08/14
C1	Head of Commissioning and Procurement	CCG	22/10/13 & 5/11/14
C2	Lead Nurse	CCG	22/10/13 & 21/08/14
C3	Contracts Manager	CCG	30/10/13
C4	Head of Performance	CCG	30/10/13
C5	Director of Finance	Acute and Community Care Trust	30/05/14
C6	Director of Nursing	Acute and Community Care Trust	30/05/14
C7	Director of Finance	CCG	5/11/14

List of contracting meetings attended		
Case Study	**Type of meeting**	**Date**
A	Contract Performance meeting (Acute)	16/11/2012
A	Contract Performance meeting (Community and Mental Health)	20/11/2012
B	Contract Performance meeting (Acute)	29/11/2012
B	PCT internal contract strategy meeting	04/12/2012
B	Contract negotiation meeting (Acute)	08/01/2013
A	Contract Performance meeting (Community and Mental Health)	04/02/2013
A	Contract Performance meeting (Acute)	15/02/2013
A	Contract negotiation meeting (Acute)	15/02/2013
B	Contract negotiation meeting (Acute)	12/03/2013
B	Contract Performance meeting (Acute)	21/05/2013
C	Contract Performance meeting (Acute and Community Trust)	07/08/2013
A	Contract Performance meeting (Acute)	15/08/2013
A	Contract Working Group (Acute)	05/09/2013
A	Contract Performance meeting (Acute)	12/09/2013
C	Clinical Quality Review Group meeting (Acute and Community Trust)	23/09/2013
A	Contract Performance meeting (Community and Mental Health Trust)	15/10/2013
B	Contract negotiation meeting (Acute)	19/11/2013
A	Clinical Quality Review Group meeting (Community and Mental Health Trust)	28/11/2013
C	Contract Performance meeting (Acute and Community Trust)	09/04/2014
A	Contract Performance meeting (Acute)	10/04/2014
B	Contract Performance meeting (Acute)	29/04/2014