The Royal Wolverhampton NHS Trust	

Trust Board Report

Meeting Date:	Monday 28th January 2013
Title:	Contracting and Commissioning 2013/14
Executive Summary:	This update report provides detailed information on the proposed changes to the commissioning arrangements, and the progress with the contracts negotiations for 2013/14.
Action Requested:	Trust Board are asked to note the report
Report of:	Director of Planning and Contracting
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Resource Implications:	LDP and Contract negotiations for 2013/14 are under way and Directors and Senior Management are regularly reviewing the service, contractual and financial implications.
Public or Private: **(with reasons if private)**	Public
References: **(eg from/to other committees)**	
Appendices/ **References/** **Background Reading**	Appendix 1: QIPP Programme Update: Outpatients Project (Newton) Everyone Counts: Planning for Patients 2013/14 Draft Payment by Results Guidance for 2013/14
NHS Constitution: **(How it impacts on any decision-making)**	In determining this matter, the Board should have regard to the Core principles contained in the Constitution of: - Equality of treatment and access to services - High standards of excellence and professionalism - Service user preferences - Cross community working - Best Value - Accountability through local influence and scrutiny

Background Details	
1.	**Introduction** The Trust Board received a report in October 2012 regarding the proposed changes to the Commissioning arrangements. This report provides an update and progress with the current contracting arrangements as part of the LDP Process for 2013/14.
2.	**Background** This report provides an updated position on the progress on the new commissioning arrangements, reflecting the implementation of Everyone Counts: Planning for Patients 2013/14, the DH PbR Tariff for 2013/14 and the current position in respect of LDP / contract negotiations.
3.	**Commissioning Arrangements** The development of the new commissioning arrangements have taken shape throughout 2012/13, and are heading for statutory responsibility from April 2013. Organisations have been operating in shadow form in readiness for the new financial year, and LDP discussions for 2013/14 have been led by the new organisational structures.
3.1	**NHS Commissioning Board (NHSCB)** The NHSCB was formally established on 1st October 2012 as an independent body, at arm's length to the Government. The NHSCB will take direct responsibility for commissioning primary care services, including GPs, dental and pharmacy services, as well as taking over parts of the planning process from the Department of Health.
3.2	**NHSCB Regional Offices** The NHSCB will have four Regional Offices, based on the current SHA cluster groupings. Therefore, the Regional Office covering Wolverhampton will be Midlands and the East. The Regional Office will guide commissioning organisations in contract management and delivery, and in areas relating to quality measurement, including the delivery of CQUIN schemes. Regional Offices are expected to be strong in performance management, both in their direct commissioning responsibilities and in how they steer local commissioners.
3.3	**Local Area Teams (LATs)** There will be 27 LATs in the new structure, which will work on behalf of the Regional Offices. The LAT covering Wolverhampton will be Birmingham and the Black Country. In addition to the commissioning of primary care services, ten selected LATs, including Birmingham and the Black Country, will host the Specialised Commissioning Teams. These teams are expected to see their

	commissioning portfolios increase for 2013/14, and to take on an increased range of specialist high cost / low volume services.
3.4	**Public Health** During the course of 2012/13, the Public Health function moved from PCTs into local authority. This function will take over the commissioning of some services from health, such as healthy lifestyles, sexual health and school nursing.
3.5	**Clinical Commissioning Groups (CCGs)** There are currently 212 CCGs across England who are in the process of undergoing authorisation prior to taking on statutory responsibility for commissioning from April 2013. The commissioning portfolio of CCGs will be those services falling outside of the scope of the organisations covered above. While the first wave of 34 CCGs has now been authorised, Wolverhampton City CCG (WCCCG) is currently awaiting feedback on their responses to their initial review. Management structures are in place, and recruitment to those positions is ongoing. GP involvement is strong, with good clinical representation on groups, and Clinical Quality Review meetings continue to be chaired by a GP. WCCCG have outlined four key commissioning priorities: • Improve outcomes and the cost effectiveness of planned care • Build a sustainable and effective urgent care system • Create a sustainable and effective system for the whole care journey of patients with long term conditions (including mental health) • Reduce the gaps in mortality across Wolverhampton
4.	**Contract Process 2013/14** There is a new standard contract format for 2013/14 with some significant changes to previous versions: • Format and language used have been simplified • The service specification template has been adjusted to move the focus away from processes and towards outcomes • Quality requirements now reflect rights and pledges as outlined in the NHS Constitution and reflect Everyone Counts: Planning for Patients 2013/14. • Stipulation for commissioner or provider to notify the other party should there be changes to activity or referral patterns, leading to Activity Query Notices and joint activity reviews

	• An expectation of an increasing use of financial penalties as contractual levers, and greater scope for financial penalties to be applied The mechanism to support financial penalties is to become more straightforward for commissioners to apply. Previously, breaches against quality indicators would generate an agreed Remedial Action Plan (RAP) and failure to deliver against that plan would generate penalties. The new contract document allows penalties to be applied immediately following the breach, and will equate to 2% of the value of the specific service level outturn. Financial penalties are focussed on areas such as waiting times and ambulance handover targets. The contract is also to be made available as an 'e-contract' reducing the need for paper copies and allowing the contract to be reviewed by providers and commissioners as a working document during preparation. The expectation is that financial values will be agreed by the end of February 2013, supported by signed heads of agreement, and that full contracts are signed by all parties by 31st March 2013. Agreement of CQUIN schemes is the only element allowed to slip beyond 31st March, however, RWT have expressed a desire not to allow these to slip and therefore maximise time allowed to achieve the relevant CQUIN milestones. Any new contractual requirements will be considered through the negotiation process, and as changes are recognised these will be cascaded through the organisation as necessary.
5.	**QIPP Update** RWT and WCCCG have been working together to deliver a QIPP review of outpatient follow-ups and activity growth, with the aim of avoiding 8,000 appointments per annum. Achievement of this target will provide annual recurrent cost avoidances of £800k to commissioners and £400k to RWT. A risk sharing agreement is incorporated ensuring that recurrent savings are reinvested. An update to this project, provided by Newton, can be found at Appendix 1.
6.	**Any Qualified Provider (AQP)** AQP services for nail surgery and hearing services both went live under the AQP model from 1st January 2013. Impacts on activity volumes and service delivery will be monitored and reviewed as activity data becomes available.

7.	**CQUINN** There are 11 CQUINs associated with the Acute Contract and 9 CQUINs for the Community Contract and a further 9 CQUINs within the Specialised Services Commissioning (SSC) Contract. Following discussions with the commissioner, a decision was taken in Q2 to withdraw Antimicrobial Stewardship from the Community CQUINs given the low numbers of patients involved. The financial balance for this CQUIN was then apportioned across the remaining CQUINs. Monitoring of all CQUINs is undertaken by the Performance team, a monthly report is presented to the Clinical Quality Review Meeting (CQRM) with a full update provided quarterly. The full Q3 report will be presented at the February CQRM. The meeting is chaired by a Board member of the Wolverhampton City Clinical Commissioning Group and has representation from a t least 1 Executive Director from the Trust. The total value of the CQUIN Contract is as follows: • Acute CQUINs - £5.4m • Community CQUINs - £1.2m • SSC CQUINs - £1.4m **£8.0m** We are currently planning for 2013/14 CQUINs following the release of the national guidance. The CQUIN value for 2013/14 is set at a level of 2.5 per cent value for all healthcare services commissioned through the NHS Standard Contract. One fifth of this value (0.5 per cent of overall contract value) is to be linked to the national CQUIN goals. The national CQUIN Goals are: • *Friends and Family Test* • improvement against the *NHS Safety Thermometer (*excluding VTE), particularly pressure sores; • improving *dementia* care, including sustained improvement in **F**inding people with dementia, **A**ssessing and **I**nvestigating their symptoms and **R**eferring for support (FAIR); • *Venous thromboembolism (VTE)* – 95 per cent of patients being risk assessed and achievement of a locally agreed goal for the number of VTE admissions that are reviewed through root cause analysis. In addition to this, the guidance also states that from April 2013 compliance with high impact innovations (HII) will become a prequalification requirement for CQUIN. By 31 March 2013, providers will need to have put in place measures to satisfy at least 50 per cent of the pre-qualification criteria in order to qualify for the release of any 2013/14 CQUIN funding. The 6 high

	impact innovations are: 1. 3 million lives - increasing planned use of telehealth/telecare technologies 2. Intra-operative fluid management (IOFM) 3. Child in a chair in a day - provision of wheelchair services to ensure outcomes similar to those achieved by the best-performing providers of mobility services for children 4. International & commercial activity - plans are in place to exploit the value of commercial intellectual property 5. Digital First – strategies to reduce inappropriate face-to-face contact 6. Carers for people with dementia
8.	**Summary** Contractual and commissioning arrangements in the new organisational structure are becoming more complex, and in some areas commissioning arrangements for certain pathways, and associated commissioning budgets, are fragmenting between CCGs, specialised commissioners and Public Health. The contracting function of RWT are using existing strong relationships with all commissioning bodies to manage the transition period, and ensure that the contracting round is delivered as required. Regular monitoring of the environment is continuing, as further development work is still being produced.

Appendix 1: QIPP Programme Update: Outpatients Project

1. Introduction

The Royal Wolverhampton NHS Trust and Wolverhampton City Clinical Commissioning Group worked together in 2012 to set up a project to review and the level of outpatient follow ups and activity growth at RWT in order to support the local QIPP programme and risk sharing agreement. A joint assessment of this area was carried out, which identified opportunities to streamline patient pathways and avoid up to 8,000 appointments per annum, equivalent to an £800k recurrent cost avoidance for RWT's commissioners and a £400k recurrent cost avoidance for the Trust, all to be reinvested under the risk sharing agreement.

A delivery project has since been proposed to deliver these improvements, which is to be led by a joint team of WCCCG and RWT staff. Implementation support is to be provided by Newton Europe, which is being funded by WCCCG and contracted through the existing OJEU framework in place with RWT.

This document describes the joint project plan to deliver these improvements, which was approved by the Modernisation Programme Board and WCCCG Board (as the sponsor) in late 2012.

2. Project Leads

The project lead from RWT is Maxine Espley, Director of Planning and Contracting, and the project lead from WCCCG is Richard Young, Director of Strategy and Solutions.

3. Objectives and Deliverables

The primary objective of this project is to reduce the number of avoidable outpatient appointments at RWT by 8,000 per year. This project will also deliver significant benefits to patients and staff, and support ongoing operational and financial performance improvement.

Detailed pathway improvement plans will be developed and led by individual specialty teams, but the benefits are likely to be delivered through a combination of the following workstreams:

- Pathway redesign and standardisation
    - Run workshops with acute, primary and community clinicians to agree standards for the most common pathways
- Referral information, advice and guidance

    - Implementation of an advice and guidance system between acute and primary clinicians, to avoid referrals and support safe and timely discharge
    - Detailed analysis of inappropriate materials to split solve any areas of the Directory of Service which could be improved to avoid the need for Consultant to Consultant referrals
- Direct access to diagnostic services
    - Implement direct access to diagnostics for specific conditions
- Test results and feedback
    - Implementation of a low cost system to feed back benign test results to patients (e.g. telephone consultations)
- Discharge care plans, feedback to GPs and patients, rapid access back into acute care
    - Standardise and improve care planning information going back to patients and GPs to give acute clinicians confidence in discharge
    - Implementation of “hot” or “SOS” clinics to allow rapid access for patients and GPs back into acute care if required
- Senior – junior reviews
    - Implementation of a process for junior doctors and middle grades to review patient notes with Consultants pre and/or post clinic, to support and challenge decision making in order to ensure quality of care and minimise avoidable appointments
    - Sharing of best practice between clinicians

Delivery of the project will require several supporting workstreams to ensure that the benefits are tracked and realised, likely to include:

- Template balancing
    - The core workstreams will reduce demand, however templates may have to be adjusted to ensure that capacity matches the new demand and activity levels change
- Briefing, education and training
    - All changes made which require behaviour or process changes from primary care clinicians will have to be briefed out and taught to the 50+ GP practices across the city
- Reporting and KPIs
    - It is vital to track several key performance indicators throughout the project, in order to drive improvement and track the benefits against

baseline. Note that follow up to new ratio will be one of the indicators used to understand performance, but it is not the only one to do so. A whole suite of metrics will need to be tracked and understood in combination to define success

- Contracting mechanisms
    - Support the implementation of the risk sharing agreement, to share the risks and benefits of this project and to incentivise the right behaviours for all organisations
- Realising the benefits
    - Practically reducing the number of paid Consultant PAs required to support the increasing demand in one area, and therefore avoiding cost which can be re-invested in other areas

Following initial reviews of this proposal, WCCCG have made the following additions to the project:

- An external review of best pathway practice will be carried out, with the target of being able to increase savings targets to £2m by year 2014/15. Note that at this stage, the detail of the specific actions required to deliver these additional savings is not clear. The external review will aim to assess the feasibility of this increase and, if appropriate, enable specific actions and plans to be put in place to deliver the savings

4. Project Benefits

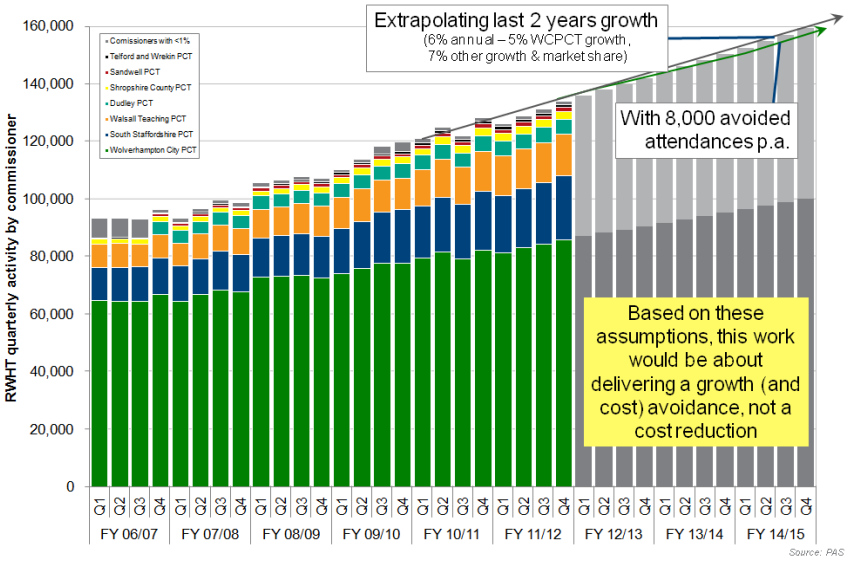
This project will deliver significant benefits to patients and staff, and support ongoing operational and financial performance improvement, including:

- To patients:
    - Improved access to care
    - Capacity freed up for unmet healthcare demand
    - Direct access leads to shorter pathways
    - Reduction in variation in practice gives patients certainty of outcome
    - Improved information flow between primary and acute leads to improved outcomes
    - More care provided closer to home
    - Greater choice
- To staff:
    - Greater confidence and responsibility for junior doctors

    - Improved feedback to GPs as a learning aid, virtuous circle
    - More time with patients who really need access to care
- Operational:
    - Shorter pathways with less variation leads to improved 18 week performance
    - Reduced demand frees up capacity
- Financial:
    - £800k p.a. cost avoidance for RHWT's commissioners and £400k p.a. cost avoidance for RWT, supporting QIPP and CIP programmes in the local health economy to enable reinvestment into unmet demand over coming years
    - Note that following an initial review of this proposal, WCCCG have requested that an external review of best pathway practice be added to the project, with the intention of being able to increase savings targets to £2m by year 2014/15. Note that at this stage, the detail of the specific actions required to deliver these additional savings is not clear. However the external review will aim to assess the feasibility of this increase, and will enable specific actions and plans to be put in place to deliver the savings.

The focus of this project will be on reducing the number of avoidable review appointments. However, it is highly likely that the workstreams described will also result in a reduction in the number of avoidable new appointments. Hence the overall deliverable of this project is a reduction in the total number of avoidable appointments, not just reviews.

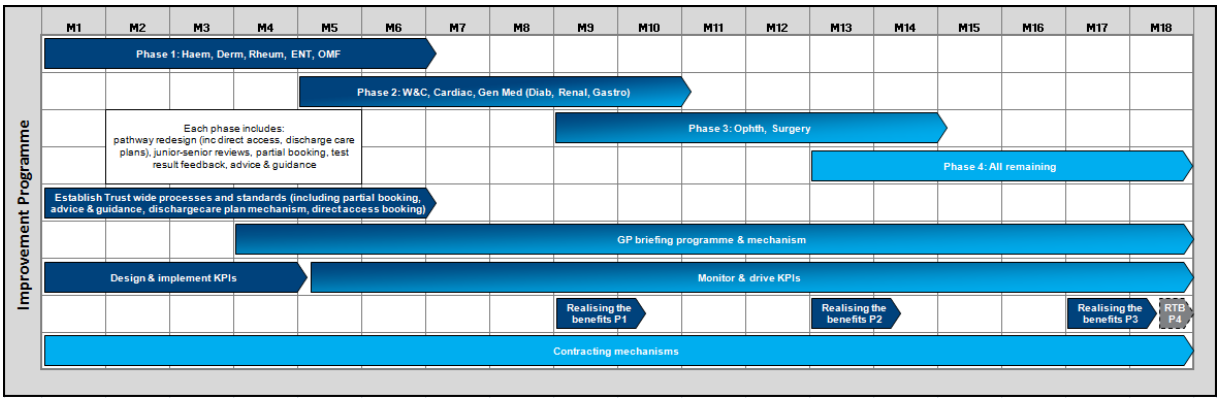
Note that RWT outpatient activity has been growing at a rate of approximately 6% per annum for the last 3+ years (5% WCCCG growth, 7% other growth and market share) which equates to more than 30,000 annual attendances added every year. Hence the 8,000 appointments to be avoided every year through delivery of this project will slow (but not negate) the growth and deliver a cost avoidance, as opposed to a cost reduction. This is illustrated in the figure below.



5. Project Resource and Timetable

The delivery project is to be led by a joint team of WCCCG and RWT staff. Implementation support is to be provided by Newton Europe, which is being funded by WCCCG and contracted through the existing OJEU framework in place with RWT.

The specialties to be included in each of the phases will be reviewed and agreed with the project clients as part of the project initiation phase, but a suggested phasing which would deliver value as rapidly as possible is shown below.

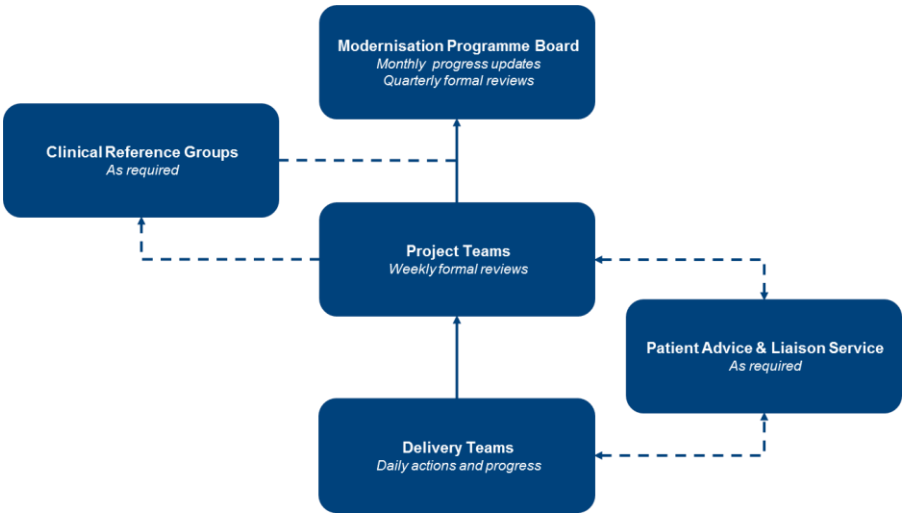


Note that some specialties (such as T&O) have already completed a considerable amount of work in this area. The joint project team should work with these teams in order to avoid duplication of work.

6. Project Governance Structure

The project's main reporting line will be to the Modernisation Programme Board, with monthly progress updates and quarterly detailed reviews. Project teams will be established for workstreams and specialties as required, and meet on a weekly basis feeding into the monthly Modernisation Programme Board. Delivery teams will meet

daily to review progress and drive actions. Input and feedback will be sought from patient groups for significant pathway changes as required.



7. Next Steps

The project will formally commence on 14 January 2012, and over the course of the following two weeks the joint delivery will be established before implementation of phase 1 begins.