Specialised Services Commissioning Intentions Workshop

8 August 2016
Housekeeping and Overview of the Day

Fraser Woodward
Head of Communications and Engagement, Specialised Commissioning, NHS England
Specialised Services Commissioning Intentions Workshop
8th August 2016

Dr Jonathan Fielden (Director of Specialised Commissioning)
Twitter: @cmoMD
Feedback: Learning from our last event in Nov15

• System change to incentivise greater collaboration: national and local

• Ensure new models can demonstrate financial and quality sustainability

• Capability and capacity of CCGs to commission specialised services

• Clarity of geography when establishing ‘place based’ approaches

• Utilise potential of Provider networks

• Clinical leadership and responsibility

• Importance of system leadership

• Give permission for people to try things

Source: Provider engagement event (The Oval, London) 17th November 2015
Vision: Future specialised services embedded in the delivery of the Five Year Forward View

- The Five Year Forward View set out ambitions for the NHS of a more engaged relationship with patients, carers and citizens to promote wellbeing and prevent ill-health. Our ambitions for specialised services are no different, and fully integrated with the triple aims:

Health and Well Being Gap: To ensure specialised services are continuously improving health for all relevant populations, by focusing on the outcomes that matter most to patients, ensuring a stronger focus on prevention and connecting the commissioning of specialised services more strongly to prevention, precision and personalised medicine.

Care Quality Gap: To integrate specialised services within the pathway, by unlocking new models of provision and enabling more flexibility in how different models can be adapted to local needs, while at the same time addressing unwarranted variation between areas and meeting national outcomes standards.

Finance and Efficiency Gap: To maintain financial sustainability, by in the immediate term maintaining a tight grip on the national spend and maintaining the focus on efficiency programmes, but also by accelerating and supporting transformation to new models of commissioning and provision that can deliver better outcomes for less including stopping treatments and processes no longer of value. Each clinician and patient needs to understand the need to drive value: ensuring we enhance and maintain outcomes and experience whilst mindful of the cost.

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**Strategic Framework:** Place-based care, enabled by national level support and strong financial control

- Achieving the ambitions for specialised services will require collaboration at a local level to agree priorities and deliver service change, but will also need national level support and financial control that enables change. The strategic framework set out **eight priorities as a focus for testing and engagement.**
Implications: What does it look like in 2020?

Improving population health

Clearly differentiated levels of commissioning for Specialised Services, and a much greater role for local health economy leadership in how the ‘Spec Com £’ is spent.

High quality care system

National service standards, but greater flexibility in local delivery to put in place most appropriate service model to meet those standards minimising unwarranted outcome variation.

Maximising Value

New service models (both in the contracting model, and in how providers configure themselves) to ensure value: quality service sustainability within available resources.
Three big opportunities / challenges

• Delivering **place and population based approaches** through the STP process

• **Ensuring best value** (outcomes and experience for cost of delivery) for Specialised £

• Utilising the **research and development opportunities** across specialised services
Integrating specialised service commissioning with wider system planning/STPs

<table>
<thead>
<tr>
<th>Spec Comm planning</th>
<th>Wider system planning</th>
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<tr>
<td>• ~£16bn resource allocation</td>
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<td>• 146 services (highly diverse portfolio)</td>
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<td>• Single commissioner (i.e. NHS England)</td>
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<td>• Four regions contract directly with each provider for specialised activity</td>
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<tr>
<td>• ~£70bn resource allocation</td>
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<tr>
<td>• Primary care services, CCG portfolio, &amp; other direct commission</td>
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<tr>
<td>• 209 CCGs + co-commissioning with NHS England</td>
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<tr>
<td>• Planning done on a population footprint</td>
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**Joined-up planning process**

- **Sep:** Commissioning intentions 17/18 & 2yr planning guidance published at same time
- **Oct:** 44 STPs final plans (links to collaborative commissioning hubs)
- **Oct-Dec:** Single contracting round for whole system

Opportunities to integrate the ‘spec comm £’ with whole care pathway planning & delivery

Opportunities to work with ‘system leaders’ to redesign provider landscape to ensure future sustainability

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Where are we now? Initial plans now submitted by STP footprints

44 STP planning footprints – bringing local health economy leaders together, and their plans should also include the ‘Specialised Service £’

Developing work with STPs:
• Service priorities for local population over next 5 years (e.g. Cancer, MH, LD)
• Provider configurations
• New contracting or payment models
• Combined STP footprint arrangements to ensure population coverage
• Governance models to enhance collaboration between partners

BUT …acknowledge that STPs are at different stages of desire, capability and capacity on involvement with specialised services. Differential approaches required and we will support that model through: (i) clarifying service levels, (ii) addressing practical barriers, and (iii) clarifying legal / governance approaches
(i) Clarifying service levels: engage with you to test right level for planning and delivering a service

146 Specialised services portfolio

- **National or Regional?**
  - 10m+ population, ~20 patients/m & planning 1-4 times

- **Collaborative hub (sub-regional)?**
  - 2.5m-10m population, 20-100 patients/m & planning 10 times

- **Health economy/STP footprint?**
  - 1.5m-2.5m population, 100+ patients/m & planning 20-30 times
  - 36 service specifications

- **CCG or groups of CCGs?**
  - Less than 1.5m population & planning 30+ times
  - 7 Service specifications

Indicative services?

- Children’s Epilepsy Surgery Service
- Pancreas Transplant Service (Adult)
- Proton Beam Therapy
- Ear Surgery: Cochlear Implants (All Ages)
- Bone & Joint Infections (All Ages)
- Cystic Fibrosis (Adults)
- Cancer: Chemotherapy (Adult)
- Cardiac Surgery (Adult)
- Renal Dialysis: Home (Adult)
(ii) Identify key barriers: Work with four STP areas to understand the barriers they are facing

### South East London
- Population: ~1.9m
- Total Spend: £3.2bn
- % Specialised: 19.8%

#### Provision
- GSTT, King’s and St George’s account for 72% of total spend
- Vanguards: Foundation Health Care Group (Guy’s and St Thomas) (ACC)

### Greater Manchester
- Population: ~3.0m
- Total Spend: £5.2bn
- % Specialised: 17.5%

#### Provision
- 13 providers
- Vanguards: Stockport Together (MCP) & Salford and Wigan Foundation Chains (ACC)

### Cornwall
- Population: ~0.6m
- Total Spend: £0.9bn
- % Specialised: 14.3%

### Herefordshire & Worcestershire
- Population: ~0.8m
- Total Spend: £1.2bn
- % Specialised: 14.8%

We want to work with these two rural STP examples to understand where and how they can link with neighbouring STPs – need to ensure viable population footprints to plan future services with specialised providers.

www.england.nhs.uk
(iii) **Clarify legal/governance:** develop consistent governance arrangements and the legal framework

<table>
<thead>
<tr>
<th>Seat at the table</th>
<th>Joint commissioning</th>
<th>Delegation</th>
<th>Devolution</th>
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<tbody>
<tr>
<td>• CCG engagement in planning and decision making – potential to devolve AO to NHS England sub-region</td>
<td>• Responsibility delegated to a committee of NHS England including CCGs</td>
<td>• Transfer of functions to CCGs with local authority through section 13Z</td>
<td>• Fully devolved to local authorities through powers in the Devolution Act</td>
</tr>
<tr>
<td>• NHS England retains accountability</td>
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<td>• NHS England retains accountability</td>
<td>• Responsibility transfers to the combined authority</td>
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**Key Issues**

- Supporting pooled budgets and creating shared financial incentives – understanding the implications of legislation including section 75 and section 13V i.e. pooling with local authorities and with CCGs.

- Using the sustainability and transformation plans to identify shared priorities for specialised services – and on-going arrangements for accountability and assurance
Ensuring best value: Clear challenge both this year and following years

**Funding:** Specialised Services allocated £85.96bn for next 5yrs (2016-21):

- 16/17: £15.66bn (+7.0%)
- 17/18: £16.41bn (+4.8%)
- 18/19: £17.15bn (+4.5%)
- 19/20: £17.82bn (+4.5%)
- 20/21: £18.82bn (+5.0%)

Source: NHSE Allocation of resources to NHS England and the commissioning sector for 2016/17 to 2020/21
www.england.nhs.uk
Ensuring best value: Sustainable service provider configurations delivering highest quality outcomes

2014-15 Agreed Provider Spend, £M¹

Cumulative % of total providers spend

Top quartile of providers made up 80% of total NHS specialised services spend

Source: NHSE 2014-15 Provider and Commissioner agree contract values
www.england.nhs.uk
Research, Innovation and Development: in Specialised Services

R&D and innovation should be a systemic part of the specialised services, work with major providers to ‘design in’ R&D to more of our care pathways and open paths for innovation.

Too often R&D in many services is seen as a ‘bolt on’, but major advances within service provision happen when **testing and continuous learning and improvement is embedded** in both service design and delivery.

Two key areas to now explore with our CRGs and wider provider networks:

1) **Care pathway design, precision and personalised medicine** – how best can we link the research and development eg: on genomics and mainstream it into day-to-day business of service provision

2) **Data** – Systematising data flows, and use of that data, on patient outcomes / value back to providers to inform continuous (and real-time) learning on service design
Questions and Answer Session

Email: Jonathan.Fielden@nhs.net

Twitter: @cmoMD
Opportunities for those who use Clinical Utilisation Review (CUR)
Managing system capacity effectively

Nigel Kee
Chief Operating Officer, BTUH
Kelly French
Head of Operations, BTUH
1. Context
2. What is CUR
3. Baseline
4. How can CUR support System Resilience
5. So what?
6. Next steps
7. Summary
1. Context
2. What is CUR
3. Baseline
4. How can CUR support System Resilience
5. So What?
6. Next steps
7. Summary
Medicine used to be simple, ineffective, and relatively safe. Now it is complex, effective and potentially dangerous.

Sir Cyril Chantler
Delays in discharging older patients from hospital ‘cost NHS £820m a year’

Cut in spending on adult social care mean people wait longer for home care packages or moving to care homes, leading to increase of ‘bed blocking’, says NAO

Operations delayed and targets missed as NHS England has busiest year in its history

More than 500,000 extra people visited A&E between March 2015 and March 2016, making it the busiest year on record

Harriet Storrin | Saturday 14 May 2016

More than 70,000 patients were forced to wait in ambulances outside hospitals for over an HOUR because A&E units are so busy

- Ambulances spent 400,000 hours with patients waiting to be admitted

A&E delays the worst they've ever been, new figures show

The poor figures are likely to cause further concern about the prospect of a total strike by junior doctors

A&E performance in January was ‘worst ever recorded’

Main Entrance

Accident and Emergency
Emergency demand is growing

A&E attendances

2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16 predicted

Emergency demand is growing
Emergency attendances to BTUH have increased 25.6% from the 2011/12 average to the current 2015/16 average. Average attendances are up 2.3% on 2014/15. The largest growth was 10.7% between 2013/14 and 2014/15.

<table>
<thead>
<tr>
<th>Year</th>
<th>Average monthly attendances</th>
<th>Yearly n</th>
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<tbody>
<tr>
<td>2011/12</td>
<td>8,619</td>
<td>103,427</td>
</tr>
<tr>
<td>2012/13</td>
<td>8,998</td>
<td>107,976</td>
</tr>
<tr>
<td>2013/14</td>
<td>9,559</td>
<td>114,706</td>
</tr>
<tr>
<td>2014/15</td>
<td>10,579</td>
<td>126,946</td>
</tr>
<tr>
<td>2015/16</td>
<td>10,824</td>
<td>129,882</td>
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The BTUH Story

Challenging winter periods resulted in 2 reviews

- Review of ‘front door’ processes to identify bottlenecks
- Review of ‘back door’ processes to identify improvement opportunities

- Commissioner (Funder) sponsored review of ambulance conveyancing in the Region
- Joint commitment to review local system working (SRG)
- Successful application to be an early adopter of CUR
Key findings of the Medworxx audit work were

- 199 (¾ med; ¼ surg) unplanned patient pathways were assessed on 11 acute wards.

- 1,738 individual bed days were assessed and 447 potentially avoidable bed days (25.7%) were accumulated by 84 patients needing a less intensive care setting.

- Reasons for potentially avoidable bed days were categorised by Physician and Hospital reasons (internal) and Community based reasons (external).
• Internal reasons accounted for 72%; Physician 160 days (37%) and Hospital 166 days (35%).

  – External community based reasons accounted for 27% of the potentially avoidable delay reasons (121 days).

  – Current patient flow processes were somewhat manual, subjective and in silos.

  – Need for a transparent ‘whole system’ patient flow structure / approach with better local system ‘holding to account’. 
Of the 199 patients assessed 1738 bed days were accumulated and 447 days (26%) were identified as RFD/T days.
Internal reasons accounted for 72% (326) of the potentially avoidable days; Physician 160 days (37%) and Hospital 166 days (35%).

External community based reasons accounted for 27% of the potentially avoidable delay reasons (121 days).
160 RFD days were recorded as being physician related. Of these 40 days were attributed to awaiting consultation with the medical team.
Many of the patients on the acute wards were undergoing therapy as their primary reason for the day of stay. This could have been delivered at a lower level of care.
The highest community delay trends were associated with social services.
## External delays: top community details

### Basildon and Thurrock University Hospitals NHS Foundation Trust

**Potentially Avoidable RFD days Community Details**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Days</th>
</tr>
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<tbody>
<tr>
<td>Family delaying transfer</td>
<td>9</td>
</tr>
<tr>
<td>Patient/Family issue</td>
<td>9</td>
</tr>
<tr>
<td>Social issues</td>
<td>11</td>
</tr>
<tr>
<td>Nursing Home Assessment</td>
<td>12</td>
</tr>
<tr>
<td>Other: Identify</td>
<td>23</td>
</tr>
<tr>
<td>Waiting for Rehab Bed</td>
<td>18</td>
</tr>
<tr>
<td>Allocation of Social Worker</td>
<td>6</td>
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</tbody>
</table>

**Total**

<table>
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<tr>
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<th>BTUH</th>
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<tbody>
<tr>
<td>Family</td>
<td>9</td>
</tr>
<tr>
<td>Nursing</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
</tr>
<tr>
<td>Waiting</td>
<td>12</td>
</tr>
<tr>
<td>Social</td>
<td>23</td>
</tr>
<tr>
<td>Allocation of Social Worker</td>
<td>18</td>
</tr>
<tr>
<td>Delay in POC start</td>
<td>6</td>
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[www.england.nhs.uk](http://www.england.nhs.uk)
Service gap analysis; top community delays by patient postcode

Patient Postcode RM1 led to the highest accumulation of potentially avoidable Acute bed days, primarily due to awaiting rehab, palliative care and Social Service delays.
1. Context
2. What is CUR
3. Baseline
4. How can CUR support System Resilience
5. So What?
6. Next steps
7. Summary
✓ Makes data more transparent
✓ Better understanding of the ‘pressure points’ in a system.
✓ Provides momentum to alter the dialogue - acted as a catalyst to review how we operate together as a system.
✓ Differential response from services
✓ Better use of system-wide resources
✓ Useful monitoring tool
✓ Engages clinicians differently
1. Context
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Early Results from CUR Use At Q4 15/16 & Q1 16/17

Reasons for Inappropriate Patient Stay

- Reducing the number of patient stay assessments where the CUR criteria are not met for external based reasons will require action across the ‘whole system’ CUR software supports the production of CQUIN reports that are shared with stakeholders.

- Perception is that majority of the reasons for inappropriate patient stays sit outside of the control of the Trust. CUR changes that perception.

- The top internal based reasons for delay reported by our EIS sites included:
  - Awaiting ‘Physiotherapy’ and ‘Other diagnostics tests/ treatments’
  - ‘MDT intervention’, ‘Awaiting Snr Clinical Decision to Discharge/ At Consultant Request’
  - ‘Medication Related’ and ‘Processing of Transfer/ Discharge by Trust’.

- What are the costs involved? If we assumed that an average sized acute ward (25 beds), cost £1m to provide the inappropriate days caused by internal based reasons would equate to c.£7.1m across our 5 EIS Trusts during Q1 2016/17.
Early Results from CUR Use Q4 15/16 & Q1 16/17

Levels of Inappropriate Patient Stay

**Early Implementer Sites**

% CUR Reviews (Daily Assessments) - Where Criteria Not Met - Inappropriate Patient Stay

- **Q4 15-16**
  - Trust A: 24%
  - Trust B: 35%
  - Trust C: 56%
  - Trust D: 27%
  - Trust E: 36%
  - All Trusts Combined: 32%

- **Q1 16-17**
  - Trust A: 66%
  - Trust B: 47%
  - Trust C: 55%
  - Trust D: 21%
  - Trust E: 31%
  - All Trusts Combined: 38%
CUR CRITERIA NOT MET REASON CODES
EIS SITES COMBINED
Q1 2016-17

- Internal Provider Based Reasons: 63%
- External Based Reasons: 36%
- No Reason Recorded: 1%

TRUST A
- 12%
- 88%

TRUST B
- 52%
- 40%

TRUST C
- 29%
- 71%

TRUST D
- 38%
- 62%

TRUST E
- 62%
- 22%
- 16%
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Embedding and systematising.
Culture change
Implement across our STP footprint (3 acute Trusts) and community?
Refinement in the reports function to include:

- Search by Delay Reason
- Search by Consultant/Speciality
- PDD
- Definite Discharge

Critical Care Module

- ICU Enhancement (allows you to differentiate between various levels of CC acuity)
- Determine the CC level requirement of the patient.
- Identify the CC level of service associated with specific beds.
- Compare and flag CC level of patient and bed mismatches.
- Capture and display information about specialist supervision required for a patient.
- Capture and display information about concurrent issues of patients
- Outreach
1. Context
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Its a journey!
Questions and discussion
Two sides of the same coin?
Overview

• Set out emerging thinking about key themes of our commissioning intentions

• Appreciate the stage in the process

• Early input followed by moving at pace to hit contract signature by 31st December
Draft CI Themes

UNFINISHED BUSINESS
Completing changes

Carter Transformation (GIRFT, RIGHT CARE)

Optimal Medicines Commissioning (High-Cost Drugs Review)

World Class CANCER Outcomes & Personalised Medicine

Strategic Framework PLACE BASED CARE & STP, NEW MODELS

MENTAL HEALTH TASKFORCE

CLINICAL SERVICE REVIEW “Year 2 & 3”
Payment Reform & Delivering World Class Cancer Outcomes

- Direction for Molecular Genetic Testing – from single markers to panel diagnostics

- Radiotherapy – how to support the transition to and replacement programme for linear accelerators
  - should replacement cost of capital be separated from activity based payment?
Delivering new ways of funding secure mental health services

- 6 secondary commissioning pilots
- Wider programme via service review

<table>
<thead>
<tr>
<th>Facility Payment</th>
<th>• Fixed costs of ‘always on’ staffed bed capacity</th>
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| 3 part Spell based Payment | • Assessment & Admission  
| | • Treatment & recovery phase  
| | Discharge and resettlement |
| User designed PROMS | • Real time recording by user friendly tool / app |

Case-mix classification: Cluster AND Pathway
Life-cycle optimisation, with an agile response to changing conditions

The objective for commissioners is twofold. Firstly to proactively realise the benefits associated with the normal cycle, and secondly to look for opportunities to re-shape cost reduction profile to delivery greater cost effectiveness.
Carter approach can play a role for both providers and commissioners

| COST IMPROVEMENT PLANS | Reduced unit-cost per care-episode delivered (technical efficiency) | Affect Provider costs
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<td></td>
<td>Reduced unit-cost per care-episode delivered (technical efficiency)</td>
<td>May not affect commissioner expenditure</td>
</tr>
<tr>
<td>CANNOT DELIVER SERVICE WITHIN AVAILABLE INCOME WITHOUT IT</td>
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| QIPP / Improving Value Programme | Fewer episodes per patient treated (productive efficiency) Fewer people needing to be treated/ lower acuity (allocative efficiency) | Affects Commissioner expenditure & usually also provider costs Bottom line effect can be -ve, +ve, or neutral |

CANNOT PURCHASE SERVICES PATIENTS NEED WITHOUT IT

Neither COST SHIFTING nor INCOME GENERATION is efficiency

Many Initiatives will be a mix of QIPP and CIP
Primary focus 6 Areas to address variation in hospital ‘inputs’ : £5bn (9%) p.a. by 2020

- Optimised use of clinical workforce: £2bn
- Hospital pharmacy and medicines optimisation: £0.8bn
- Diagnostics – pathology and radiology: £0.2bn
- Procurement: £0.7bn
- Estates and facilities management: £1.0bn
- Corporate and administration (back office) costs: £0.3bn

Minimum estimated savings opportunity by area £bn: £5.0bn
Carter Key Recommendations

- New Metric "Weighted activity unit" for comparative cost per spell (clinical, non pay)
- Major emphasis on **NHS improvement** to support and drive Trust progress
- Hospital Pharmacy Transformation Programme per Trust and Nationally
- Pathology & Diagnostics consolidation
- Reforming **procurement** & Purchasing price index, including drugs & devices
- **Outcome variation** / Getting it Right First Time
- Earlier discharge & step down
- Digital hospital: Eprescribing, RFID, ecatalogue
- **Model hospital** metrics & Benefits Realisation over 4 years

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Delivering the whole coin….

Clinical **Service Redesign** Programme using operational practice & cost **benchmarking**

Rollout & realise benefits from **CUR** to **BAU** including right-sizing community services

Conclude **High Cost Device** Centralisation, Clinically led range review, & **GRFT**

Best value dispensing channels, High cost medicines optimisation work programme

Aligning ‘Right care’ intervention rate variation, with GRFT programme, & service review

ePharmacy agenda, addressing data flows, opportunities of RFID for productivity & HCAI

**Targeted Resources needed per WAU**

**LOS, Discharge & Step Down Measures**

**Procurement PTP & Purchase Price Index**

**Hospital Pharmacy PTP**

**Tackles outlying outcome variation**

**Digital Hospital by October 2018**
Concluding thoughts

• Many of the existing & new ‘asks’ may be combined if we can agree a structured change programme with milestones that deliver commissioning objectives as well as carter commitments
  – Bring together HPhTP, PTP, SDIP

• Multi year contract & carter benefit realisation framework give us an opportunity to address things often crowded out by lack of in-year payback

• The health & wellbeing gap, care & quality gap, funding and efficiency gap are the agenda for specialised services too.
Marketplace Sessions
North Region – Development of Accountable Lead Provider Model
Principles

- Framework should be built on clinical drivers
- Incorporate networks, both strategic and operational
- Aim is to ensure service sustainability, quality and patient safety
- Structure of framework based on specialised commissioning bundles of care

- Aim to deliver one bundle via Accountable Lead Provider model by April 2018.
Issues to consider

• Commissioner driven service configuration, networks as *advisors*
• Delivery of streamlined pathways of care
• Care as close to home as possible
• Commissioner clarity on payment mechanisms – *not* a purist lead contractor/sub contractor arrangement
• Performance metrics – responsibility shared across providers
• Clarity on information flows
Options

• Formal lead provider and sub contracting arrangement, but with more formal use of networks as commissioner tool, option of setting clearer requirements of lead providers in procurement

• Alliance model, with all providers contracting separately with NHS England, shared CQUIN schemes
CQUIN Principles & Future Plans

8th August 2016
Incorporating learning & feedback

“Changing things every year is problematic”

“We may be left with ‘stranded’ costs when it finishes”

“Please involve us more and earlier”

A proper up front dialogue about the principles

Two thirds of Specialised CQUIN schemes multi-year

Every Scheme has an ‘exit plan’ considered up front

CRG clinicians +37 providers tested, & co-produced PAM

Reflections from this event will inform national discussions
Similar Annual Investment

60,000 ED
36,000 NEL
30,000 Electives
3,000 Births
760k Community

£230m

£280m+
Thinking for 2017-19

• Payment Approach builds on last year:
  Invest proportionate to patient benefit

  Value of change for Patients should exceed CQUIN paid
  CQUIN payment should be greater than Provider costs

  > Last year CQUIN payment norm 125% of typical costs
  > Intention to move to norm of 150% of typical costs
    – greater bottom line return than 2016/17

  > Clear assumption to support financial planning
  > Number and scale of schemes lower for the same £
Thinking for 2017-19

• Maintaining the quantum of investment rather than a uniform CQUIN % per provider

  Already differences from HCV ODN
  Some Trusts seeking fewer areas of focus
  Others willing to go further and faster

• Potential approach:
  Schemes seeking universal uptake (all patients benefit)
  vs.
  Fixed total investment and number of providers to award, but scale & improvement stretch can secure greater funding.
  Award CQUIN to strongest proposals / early adopters willing to support later entrants
CQUIN Themes

- Networked-Care
- Productive & Efficient Care
- Earlier Expert Involvement
- Secondary & Tertiary PREVENTION
- Incentivising RIGHT Intervention
- RIGHT Setting (incl. Timely discharge)
- Patient-empowered, Personalised Care
Concluding Questions and Thoughts

- Degree of continuity with 2016/17 (inevitable given compressed development timescales)
- Expect to see greater links to the national strategies in cancer and Mental Health
- Some CQUIN have included wider support structures (e.g. CUR learning network, weekly HCV data sharing)- is this an area we should expand?
- Opportunity to discuss shared principles for the kind of initiatives CQUIN provides protected resources for
Workshops
Feedback from Workshops and Closing Remarks
Thank you