



Guidance on the Standard NHS Contract for Acute Hospital Services for the NHS in England 2009-10 – Part 2

6. Managing activity and referrals

Managing the demand for secondary care services is a shared responsibility between PCTs and providers. It is the responsibility of PCTs to manage the volumes and flows of new referrals made to providers and the case mix of those referrals that is the external demand for the services. This will require cooperation across the system, but commissioners carry the financial risk of failure to get it right.

Providers will be paid under Payment by Results (PbR) rules for any additional activity that results from an increase in the number of referrals or clinically appropriate changes to conversion rates. They will be paid the tariff rate for the actual cases they treat, regardless of the expected case mix.

The Contract includes mechanisms to mitigate the risk of providers conducting activity exceeding that agreed in the Activity Plan. These are described in greater detail in the Practical and Legal Guidance and include mechanisms for applying financial adjustments in relation to excess activity. It is not expected that such financial adjustments will be applied often. There should be no requirement for reviews of clinical decisions to be conducted.

Providers must accept referrals for any patient who chooses that provider and whom it is within their clinical competence to treat. Providers have always had to adjust capacity in response to natural variations in demand, the changing nature of their patient populations or changes in clinical practice. In the past providers have also had to vary their levels of activity – for example, to meet new waiting time targets – without any corresponding variation in their income. Under PbR, and subject to the specific provisions of the Contract, providers will be paid according to PbR rules for additional activity that is conducted as a result of variation in demand.

The coordinating commissioner should monitor levels of consultant-to-consultant referrals, and explore, with the provider, the reasons for any variation in the forecast. When agreeing levels of consultant-to-consultant referrals, the coordinating commissioner and provider should consider setting these out in protocols rather than specifying them for every part of the pathway.

The provider should ensure that consultant-to-consultant referrals for urgent treatment are not referred back to the referring GP. Where a prior approval scheme applies, the relevant commissioner will grant retrospective approval for activity performed on a patient where there is urgent clinical need. However, any care and resource utilisation techniques operated by commissioners should not limit or substitute for proper exercise of clinical judgement, and the interests of individual patients will remain paramount.

There may be instances where there is an insurmountable limit on a provider's capacity to deliver activity. In such circumstances, where certain conditions and criteria are satisfied, the provider may require the coordinating commissioner to participate in a Capacity Review, in order to determine whether the provider should be exempt from any sanction that may otherwise apply for failure to comply with the 18-week Referral-to-Treatment Target.

It is also recognised that there may be exceptional situations where there is a sudden and unpredictable large variation in demand. The Contract confirms how the implications of such variation should be addressed. In these circumstances commissioners should reduce or waive financial adjustments in relation to 18-week performance. Any such exceptions should be agreed with the Strategic Health Authority (SHA). If the commissioner does not reduce or waive financial adjustments, the provider would be expected to accept referrals for any patient who chooses the provider, but could commence dispute resolution procedures.

Prior approval schemes

The coordinating commissioner will agree with the provider the circumstances where the provider will need to seek prior approval (PA) to confirm the appropriateness of a proposed intervention or course of treatment. It is expected that such schemes focus on procedures of limited/low clinical effectiveness, or infrequent high cost and/or complex procedures. In designing and implementing PA schemes, individual patient needs must remain paramount.

Ideally the coordinating commissioner will agree a single set of PA requirements with which the provider is expected to comply. However, there may be exceptional circumstances in which an Associate PCT needs to specify its own PA requirements. These would have to be approved by the SHA.

The Care and Resource Utilisation guidance specifies that the following principles need to be adhered to in conducting PA schemes:

- It is expected that the majority of PA schemes will be at group level, on groups of patients, where commissioners and providers agree in advance how to manage patients or pathways. Under such arrangements, providers do not need to get PA on each individual patient; instead, they agree to treat all patients to the agreed protocol, so in effect patients are automatically approved. Commissioners can retrospectively audit activity to ensure adherence to the agreement.

- For low-volume, high-cost complex pathways, PA at individual level may be appropriate, where providers must get agreement before initiating treatment on a specific patient. Clear agreement over where such PA is required and how clinicians should communicate with patients affected is required.

PCTs will be required to respond to a provider's requests for PA in relation to an individual patient within a timeframe specified in the agreed PA scheme, provided that the provider has complied with the terms of the scheme. A failure by the PCT to respond within this time period will be considered to be an approval for the provider to proceed.

Retrospective approval for individual patients will be given where the provider deems there is urgent clinical need or risk to the patient, subject to ratification by the PCT's medical director.

Utilisation Management schemes

The coordinating commissioner will agree with the provider the terms of a Utilisation Management (UM) scheme, in line with the principles set out in the Care and Resource Utilisation guidance. The Contract does not mandate the contents of any UM scheme and goes no further than to require a UM scheme to be agreed.

Primary care commissioners can use a variety of techniques to ensure correct utilisation of services – the key aim being to make best use of clinical time. UM schemes enable PCTs and providers to look at the reasons for inappropriate 'over-utilisation' of healthcare resources and can be used as a service development tool to:

- redesign services – eg where the patient care package received could have been effectively provided within a less acute setting
- highlight gaps in primary care resource
- target and reduce delays that add no value to the patient
- release beds

7. Activity plans and monitoring

Before the start of each contract year PCTs will agree an Activity Plan with providers.

The Activity Plan will set out the monthly levels of activity necessary for the provider to meet the forecast levels of demand, including levels of activity required for the provider to meet the 18-week performance targets.

Further detail on the contents of the Activity Plan is set out in Annex 3 to this guidance and in the Contract itself, at Schedule 3 Part 1.

The Activity Plan for each PCT will have to reconcile with the 18-week local delivery plans (LDPs) for that PCT. The PCT 18-week LDPs will be robustly assessed by SHAs in terms of whether the activity levels will be sufficient to deliver the 18-week target.

Coordinating commissioners and providers will meet each month to review performance under the Contract, including the Activity Plan. The format of the monitoring reports for the monthly review meetings needs to be agreed locally and specified in the Contract. Performance problems should be identified in these meetings and agreed actions should be recorded to maintain an audit trail to inform the annual reconciliation process.

The provider will produce the monitoring report for the review meeting in the agreed format every month. The reports require to compare actual performance against the forecasts set out in the Activity Plan.

The NHS Operating Framework confirms that providers should focus on improving the quality of their data submission through the Secondary Users Service (SUS) so that it becomes the standard repository for activity and performance monitoring, reconciliation and payments. Providers should deliver initially coded datasets on a weekly basis from April 2009.

8. Maintaining the delivery of the 18-week Referral-to-Treatment Target

Providers and PCTs should agree specified symptom-based patient pathways. For multi-provider care pathways, the specified pathway will

split accountability across providers for different stages of the pathway. For pathways that include an interface service in primary care – such as a Clinical Assessment Service – PCTs and providers need to agree the maximum timescales allowed for the remainder of the pathway beyond the primary care stage.

The actual patient pathways that relate to the contract and their level of detail should be determined locally, based on the level of risk to the delivery of the 18-week Referral-to-Treatment milestones and target.

Providers are expected to follow recognised waiting list management practice such as taking patients of equal clinical urgency in turn.

The coordinating commissioner may make financial adjustments to payments due to the provider based on performance against the 18-week Referral-to-Treatment Target. For the avoidance of doubt, the intention of financial adjustments is to provide an incentive to follow best practice in waiting list and capacity management and to deter any manipulation of activity.

The principle is that activity levels required to achieve the 18-week target should be reflected in the agreed Activity Plan and paid for under PbR. During the course of the year, through regular review, the Activity Plan must be amended as necessary to take into account any additional activity which may be required to deliver the target.

A financial adjustment of a 0.5 per cent deduction in total elective income will be applied for each one per cent by which the provider underachieves the 18-week milestone or target. The adjustment will be capped at a maximum of five per cent of total elective income applied if the provider underachieves the 18-week target by ten per cent or more. The overall adjustment will be capped at two per cent of total contract income if this is less than five per cent of total elective income.

Financial adjustments will be weighted based on performance against the separate 18-week targets for admitted and non-admitted patients. Adjustments relating to performance for admitted care will apply to 75 per cent of total elective income. Adjustments relating to performance for non-admitted care will apply to 25 per cent of total elective income.

18-week performance will be measured and financial adjustments applied in relation to the overall contract. For a provider which holds more than one contract, it would be possible for an adjustment to be made on one of these – on the basis that the targets were not achieved on the activity within that contract – and not on another where it performs in line with plan.

The 18-week performance in relation to pathways that include referrals to the provider's tertiary care clinical team from a different provider's secondary care clinical team will not be subject to financial adjustments, provided that the provider's tertiary care clinical team has at all times acted reasonably and in accordance with the 18-week targets and guidance.

The measurement of 18-week performance and the performance targets appropriate for individual providers in relation to the 18-week Referral-to-Treatment Targets will follow Department of Health guidance.

Commissioners will be able to reduce or waive financial adjustments in relation to 18-week performance where the commissioner does not consider the financial adjustments appropriate in the context of the overall performance of their local health community.

9. Quality and outcomes

Providers will be expected to comply fully with the national standards including implementing technology appraisal guidance from the National Institute for Health and Clinical Excellence (NICE).

Commissioners and providers should agree additional quality requirements, including clinical quality performance indicators with clear methods of measurement and defined consequences for failure to remedy performance problems.

Clinical quality reviews

Clause 33 of the Contract continues to have a requirement for clinical quality reviews. The Coordinating PCT will chair a monthly meeting with the

provider to review clinical performance and identify any performance problems. A joint clinical investigation will be conducted into any clinical performance problem which has not been resolved, leading to the agreement and implementation of a remedial clinical action plan. Any consequences for failure to achieve the required improvement will be related to the implementation of this plan.

Building on existing quality elements in the Contract, such as the review, there are new requirements aimed at implementing the vision set out in High Quality Care for All: the Commissioning for Quality and Innovation (CQUIN) payment framework and patient-reported outcomes measures.

Commissioning for Quality and Innovation (CQUIN) payment framework

The Commissioning for Quality and Innovation (CQUIN) payment framework is one of a suite of enablers supporting the vision set out in High Quality Care for All of an NHS where quality is an organising principle of commissioner-provider discussions. The Contract includes, in Schedule 18, a CQUIN payment framework which requires a proportion of providers' income to be made conditional on quality and innovation.

The framework enables providers and commissioners to develop local schemes – or complement existing schemes – linking payment to specific locally determined goals (to be set out in Schedule 3, Part 4C). Commissioners and providers will wish to align schemes with the development of metrics currently underway through the Measuring for Quality Improvement framework.

Patient-reported outcome measures

The Contract supports an increasing emphasis on commissioning for outcomes by introducing a new requirement, in Schedule 5, to report from April 2009 on patient-reported outcome measures (PROMs). These will cover NHS patients undergoing hip and knee replacements, groin hernia repair and varicose vein ligation.

The requirements for the administration of the PROMs instruments is set out in separate guidance, but, in summary, the following key requirements for acute services providers are:

- to nominate a member of staff to act as a contact point between the provider and the PROMs contractor(s)
- to administer pre-operative PROMs questionnaires to patients, ensuring that the collected data are as representative of their patient populations as possible
- to detach and retain patient consent forms
- to work with the PROMs contractor(s) to ensure that patients who require translations are signposted to local translation services offered by providers or commissioners

Commissioners and providers are encouraged to agree further outcomes measures and indicators to be included in the Contract.

10. Dispute resolution

A dispute resolution procedure may be invoked by either party to the Contract if there is a failure to agree. This may occur either before or after the Contract is agreed. The dispute procedure has three stages: negotiation and mediation, followed by adjudication if the dispute remains unsettled. The process will work differently for NHS Trusts and NHS

Foundation Trusts (FTs). Disputes between commissioners and NHS Trusts will be resolved locally by SHAs.

The negotiation period must be formally invoked and represents the formalisation of a difference of opinion as a dispute. Either party may trigger the 15 operational day negotiation period by making a written negotiation offer to the other.

The initial mediation approach will be common. The SHA and Monitor, in conjunction, will mediate disputes involving FTs. The option exists to invite the Centre for Effective Dispute Resolution (CEDR) to mediate in place of the SHA and Monitor, though the costs will be borne by the parties to the dispute.

At the mediation stage the decision about the solution to the dispute remains with the parties in dispute. The two parties are assisted in coming to a resolution through the good offices of the relevant SHA, in conjunction with Monitor where an FT is involved.

In order to invoke the mediation, the two parties concerned must submit to the mediators a position statement that describes the precise points over which they disagree. If the mediators are satisfied that the nature of the dispute has been adequately documented, they will invite the parties to describe their own solution to the dispute. The parties will have five working days to comment on the other party's position. The mediator(s) will challenge and test, and at the end of this time will invite the parties to agree.

If a dispute involving NHS Trusts cannot be resolved at the mediation stage, the SHA will adjudicate.

If a dispute involving an NHS FT cannot be resolved at the mediation stage, a process of independent binding pendulum adjudication is invoked. The proposals submitted by the parties at the mediation stage will be provided in evidence. The process will be undertaken by an independent panel appointed for the purpose. Panel members will be drawn from a group of appropriately experienced and independent members identified by the ten SHAs and Monitor collectively, and then called on as necessary on an 'in-turn' basis. The panel itself will then be appointed by CEDR and will be made up of three members – a senior and experienced individual from each list and a wholly independent chair. The costs of the adjudication will be borne by the unsuccessful party to the dispute.

Disputes arising prior to contract signature will be handled in precisely the same way as disputes on existing contracts. More detailed guidance on the principles and mechanisms involved in mediation and adjudication are published by each SHA.

11. Impact assessment

Commissioners are expected to undertake their own local impact assessment of the agreement reached with providers, focusing particularly on the service specifications, care pathways and protocols and any local requirements included.

Schedule 5 of the Contract introduces the requirement for a monthly equality monitoring report to be completed, to comply with statutory obligations and to support equality impact assessments.

Further information

To view the annexes mentioned in the Guidance, please visit:

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081100



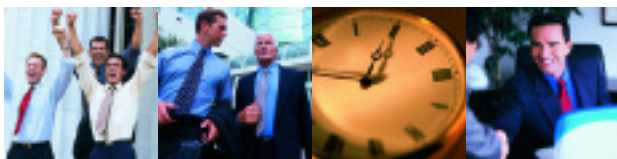
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