HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AGREEMENT OF THE ALIGNED INCENTIVES CONTRACT

Trust Board date	7 March 2017		**Reference Number**			
Director	Lee Bond		**Author**		Lee Bond	
Reason for the report	In recent months the Board have received a number of reports concerning the development of 2017/18 financial plan. This paper focusses specifically on the agreement of a new type of contract for the coming financial year – the Aligned Incentives Contract, with our two largest local commissioners.					
Type of report	Concept paper		Strategic options		Business case	
	Performance		Information	✓	Review	

1	**RECOMMENDATIONS** The Board are asked to note the contents of this paper and support the agreement of the AIC as a landmark step in the development of the Trusts 2017/18 financial plan. In addition the Board are asked to note the significant change in system-wide relationships and working that this contract requires as we move into the delivery phase of the 5 year forward view.					
2	**KEY PURPOSE:**					
	Decision		Approval	✓	Discussion	✓
	Information		Assurance		Delegation	
3	**STRATEGIC GOALS:**					
	Honest, caring and accountable culture					
	Valued, skilled and sufficient staff					
	High quality care					✓
	Great local services					✓
	Great specialist services					
	Partnership and integrated services					✓
	Financial sustainability					✓
4	**LINKED TO:**					
	CQC Regulation(s):					
	Assurance Framework Ref:	**Raises Equalities Issues?** No	**Legal advice taken?** No	**Raises sustainability issues?** No		
5	**BOARD/BOARD COMMITTEE REVIEW**					

HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST

AGREEMENT OF THE ALIGNED INCENTIVES CONTRACT

1. BACKGROUND

In recent months, the Board have received a number of reports concerning the development of 2017/18 financial plan. Within these updates has been a regular commentary concerning the progress made with the agreement of a contract with two of our largest local Commissioners, Hull and East Riding CCGs.

By way of recap, the financial plan update considered most recently shows the Trust planning to deliver a deficit on its revenue plan of £16.8m in 2017/18. This plan is predicated on a contract agreed with the Hull and East Riding CCGs (hereafter known as the Commissioners) totalling £304m and a further, non-contracted, income assumption of an additional £4m based on a belief that, under a cost and volume contract, the Commissioners would not be able to restrict activity to the contracted level of £304m.

Whilst the contracted level had been agreed in principle with the Commissioners, a physical contract had not been signed as a number of residual concerns existed concerning the split of the activity included within the contract, principally these concerns revolved around a difference of opinion on the level of non-elective activity which the Trust would be required to provide in the forthcoming year.

2. PROGRESS: THE ALIGNED INCENTIVES CONTRACT (AIC)

Over the past month the contracting discussions have reverted back to the actual contract value and a recognition that demand for healthcare services at the proposed contract levels (particularly non-elective), would cause all parties significant distress both in terms of operational delivery as well as financial affordability.

To that end, and in-line with emerging experience from another health economy facing similar challenges, a revised approach to the setting of the contract has been explored and ultimately agreed.

The contract has been agreed with an overall fixed value of £312m. This arrangement provides a minimum income guarantee for the Trust which is roughly equivalent to the 2016/17 forecast outturn level with an amount of growth included to enable the Trust to tackle the backlog issues in Ophthalmology (notably Wet AMD and Glaucoma).

Attached at Appendix 1 is an excerpt from the 2017/18 contract which describes the AIC in a little more detail and identifies the 4 prime constituent elements within the contract and the approach to be taken regarding each of those areas and the services therein.

Whilst the Trust has had experience of operating “block” arrangements historically, most recently in 2015/16, this agreement marks a fundamental departure from national prescribed guidance and the PBR supported contract models which have proliferated across the NHS for the past 17 years. It is hoped that the experience and learning from the Bolton health economy, where this arrangement has been in operation for the past 2-3 years can be replicated. In particular, this contract agreement requires a fundamentally different approach to the way in which Commissioners and Providers work together as it provides all parties with a common goal: the effective management of patient pathways irrespective of organisational boundaries.

3. FINANCIAL RISK

The AIC provides the Trust with an income guarantee which is set at a reasonable level. It does not allow for significant growth over and above 2016/17 outturn levels and as such, there is a requirement for the Trust and Commissioners, working together as a system, to manage demand in a more effective manner in order to prevent significant growth and to enable the overall health system to live within this financial envelope.

The AIC does recognise the risk of excessive demand for service going forward. In such an event, and in the absence of effective mitigations, the Trust may have to incur costs in excess of plan in order to deliver services. In such an event, the AIC provides for the reimbursement of actual costs incurred thus mitigating, in part, the exposure of the Trust.

Financial risk under the AIC is not confined to the Trust alone. In agreeing the AIC at this level, the Commissioners have had to include a £5m savings assumption into their financial plans. The Trust, as part of the contract agreement, is committed to working with system partners to identify and deliver savings which will deliver this value as a minimum. Failure to achieve this will be seen as a system wide failure and will be borne by all parties under the contract.

In a similar manner, the financial risks posed by the Trust CIP programme are recognised by the AIC. Here again, the system is committed to working together to support re-design and transformation such that this risk can be managed effectively. Once again, failure to achieve would be seen as a system failure and would be borne by all parties.

As part of the AIC, it has been agreed that the Commissioners will look to dismantle much of the existing machinery which exists to support the now redundant contracting process. Resources released through this process will be redirected to work on the joint delivery of the Provider CIP and Commissioner QIPP programmes.

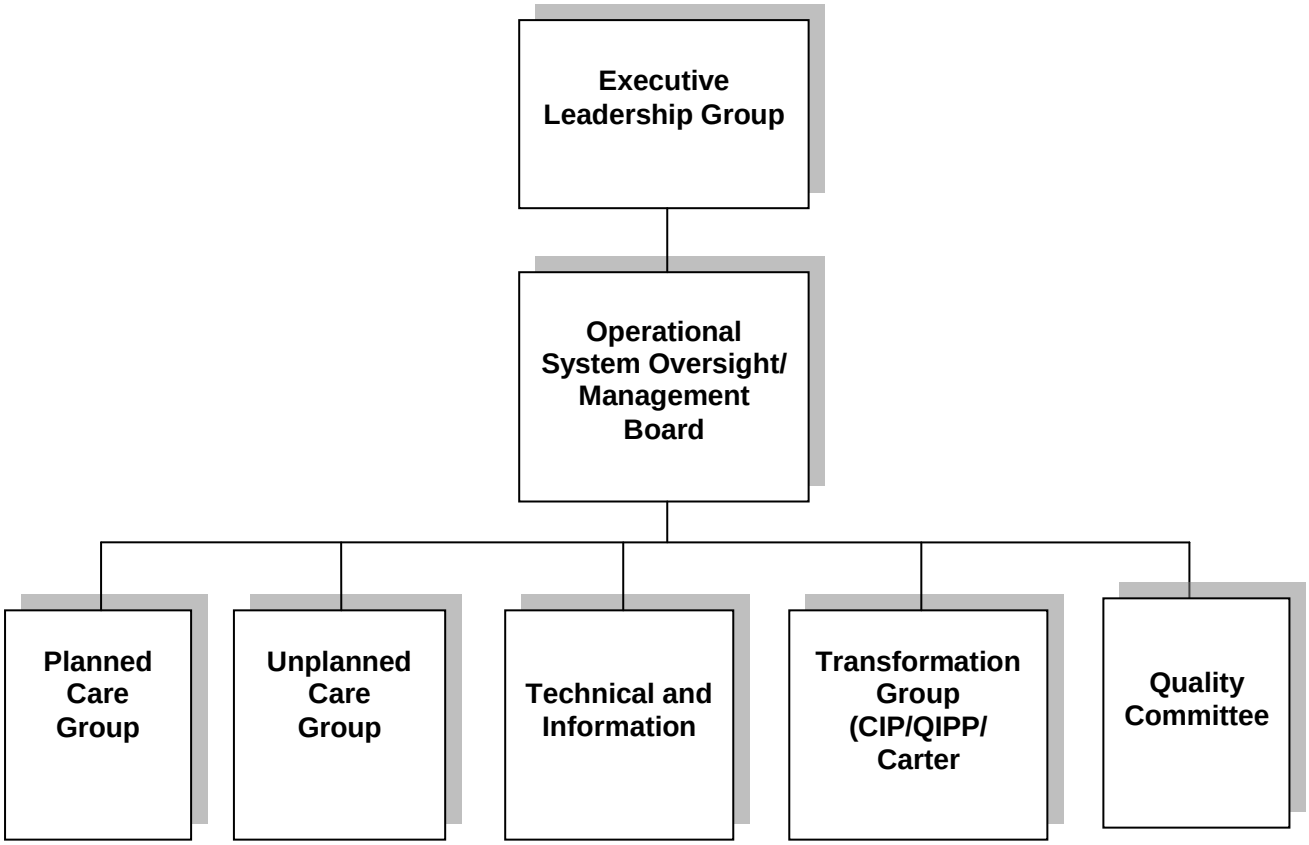
4. CONSTITUTIONAL STANDARDS

Work is underway to understand what impact the AIC will have in terms of its impact on the delivery of the constitutional access standards. The biggest concern is the impact on RTT if demand isn't managed effectively and there is no additional money, besides that set aside for Ophthalmology, to undertake additional activity as a means of improving RTT performance. This remains a significant unknown at the present time. As a system we are required to agree revised trajectories for each of the constitutional standards, this work is currently underway.

5. SYSTEM GOVERNANCE

The focus of contract management going forward is simplicity and a commitment to system-wide service improvement. Fundamental to this approach is a review of the governance framework that surrounds the many varied interactions that currently exist between Provider and Commissioner with a view to creating a revised structure which centres around this principle of simplicity and a belief that we should seek to rationalise and streamline assurance processes wherever possible.

The diagram below describes a simplified model which is currently under development:



The two largest component parts of the AIC, the planned and unplanned care elements, would each be managed through their own Group or Board. A key challenge in the short term will be the agreement of appropriate, cross sector membership, such that cross fertilisation of ideas and clinical practices between primary, secondary and community care can take place. This is absolutely essential if this new approach to working is to be successful.

Further groups would be added as necessary, but as a minimum it is likely that some sort of technical/information group would need to be constituted to deal with the many varied technical challenges facing our services. A further group to review and support the multi-faceted transformation agenda is also likely to be required.

From a quality assurance perspective, the existing Quality Committee is likely to remain in the short term. Over time it may be possible to incorporate or amalgamate the Trusts internal quality assurance processes with that of the Commissioners however that will require some time as systems and relationships mature and become embedded.

In the very short-term, a process will be instigated which looks to quickly identify all of the existing groups and forums in operation in order to evaluate their effectiveness and to streamline the process as far as possible. Where possible existing groups or networks will be co-opted to fulfil the functions required of the Planned and Unplanned Care Groups. For example, the existing ED Delivery Board could become the vehicle for all of the discussions regarding unplanned care?

Overall system leadership will be provided under this model by a small group compromising the three Chief Executive Officers and Executive Officer support.

6. CULTURAL CHANGE: COMMUNICATION AND ENGAGEMENT

The agreement of the AIC and the successful implementation of the changes to the way in which the system partners will be required to interact going forward represents a major cultural change. The abandonment of the cost and volume, tariff based contract system is a major change and is one which will require significant re-education of our clinical teams. The behaviours which the PBR based system fostered need to be left behind with a new outlook focussed on system integration and partnership working taking its place. To that end, a significant programme of communications and engagement is required across the entire health system. Clinicians in all settings will need to recalibrate their thinking about how we deliver health care across the whole system and not just within the confines of their won individual fiefdoms. A series of stakeholder events and workshops will need to be delivered in the coming weeks if we are to successfully generate the impetus and momentum required to generate the change required to make the AIC a success.

7. IMPACT ON THE FINANCIAL PLAN

The agreement of the AIC at £312m is a positive step for the Trust. The agreement of a minimum income position at this level gives the Trust greater freedom to plan changes to service. From a financial planning perspective, work is now underway to agree activity baselines with the clinical health groups and to then agree the expenditure envelopes required to deliver that service. It is expected that this will also lead to a nett benefit in terms of the Trust overall deficit position planned for 2017/18. This process is to be completed in the next couple of weeks as a revised financial planning submission is required by NHSI sometime in March. Discussions around control totals and the availability of STF funding will also then be able to take place.

From a Commissioner perspective their overall affordability problem in 2017/18, as assessed by NHSE, lies somewhere around the £1m mark. At this point, the Commissioners are being asked to revisit their financial plans in order to remove this risk.

8. CONCLUSION

Whilst not being a perfect solution to all of the local health systems finance and performance challenges, it is hoped that the agreement of the AIC and the changes that are implicit within that agreement relating to system wide ownership and accountability marks a a significant step forward.

Agreement of the contract itself represents just the first small step on this journey together. The development of the revised governance framework in which we are to operate, together with a programme of re-education for our clinical teams are sizeable challenges which require urgent attention. Clearly, the AIC doesn't eliminate financial risk for any party, however, it does endeavour to categorise where that financial risk lies and what our respective roles are in regard to that risk in a simple, and transparent manner.

It is hoped, that learning from the experiences of others we are able to make the changes necessary to deliver the required health outcomes demanded of our local population.

9. RECOMMENDATION

The Board are asked to note the contents of this paper and support the agreement of the AIC as a landmark step in the development of the Trusts 2017/18 financial plan. In In addition the Board are asked to note the significant change in system-wide relationships and working that this contract requires as we move into the delivery phase of the 5 year forward view.

Lee Bond
Chief Financial Officer

28 February 2017

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APPENDIX 1

Hull and East Yorkshire Hospitals, Hull CCG and East Riding CCG

Aligned Incentives Contract- shared risk, shared opportunity, shared vision

The contract has been agreed with an overall fixed value of £312m for 2017-18. This arrangement provides a minimum income guarantee for managing activity in line with forecast 16/17 levels, with growth for Wet AMD and backlog follow-ups for Glaucoma.

This is no longer an organisational based contract, but a system contract which is divided into the following quadrants, each with a work programme to deliver the "local vision" for the Hull and East Riding System (the system) – ultimately ensuring patients receive the right care, in the right setting, as efficiently as possible.

The focus of contract management is simplicity. There is a commitment to system wide service improvement, with the following values and behaviours to support this approach:-

- Fairness,
- Transparency
- Honesty.
- Trust
- Integrity
- Objectivity
- Doing the "right thing" – for the System.

Unplanned Care £131.9m (Cost reduction incentive)	**Scheduled Care £145.3m (Lower Activity incentive)**
Principle- Level of payment guaranteed. In the event of activity above plan the System will take joint responsibility and develop action plans.	**Principle-** Level of payment guaranteed. Opportunities exist for demand management, to streamline & modernise pathways and to introduce health optimisation programmes, including education and prevention packages.
PODs & Services • A&E • ACU/PASSU • Critical Care • Non-Elective	**PODs & Services** • Elective IP/Daycase • All O/P PODs • Diagnostic Imaging

There will be a jointly agreed clinically – led programme to transform pathways of care. Risk will be shared and where appropriate transitional funding will be agreed to support pathway changes, based on transparent **costs** which are shared and mutually agreed. ED trajectory to be agreed between parties, delivering improvement in line with constitutional standard.	• Direct Access • Wet AMD (growth included) Where clinically appropriate and economically beneficial, services could transfer or reduce in a planned way, with transitional arrangements to support any stranded fixed costs. In the event of activity and/or demand above plan the System will take joint responsibility and develop action plans within agreed cost envelopes. RTT trajectory to be agreed between parties, delivering improvement in line with constitutional standards.
Pass-Through £12.7m **Principle-** Opportunities for cost reduction and innovative procurement. **PODs & Services** • PBR excluded Drugs & Devices • CPAP If costs reduce then the Trust will retain any benefit for an agreed period. In the event of cost / demand above plan the System will take joint responsibility and develop action plans within agreed cost envelopes. This is intended to put rewards into the system for reducing costs in this area.	**Fixed Income £22.1m** **Principle**– Services where activity and costs are relatively controllable or non-volatile and can be prioritised within available resources. **PODs & Services** • Historical “Block” services • Readmissions/MRET • Best Practice Tariffs • Audiology • Maternity Pathway • CQUIN The payment level is fixed for the year. A programme to undertake a review of services in –year to assess effectiveness and whether contract type is appropriate in the longer term.

System Based Working
From an affordability perspective it is acknowledged that funding the contract at this value requires the release of savings from other CCG expenditure lines totalling a minimum of £5m. The System will jointly develop and agree a programme to deliver these savings. Any shortfall will be split equally between parties.

There will a single monitoring system, provided by HEY, with jointly agreed key performance indicators linked to service improvement, and improved patient outcomes. In the spirit of the AIC, the Trust will review all transactional KPIs and update where agreed with all Commissioners.

Information leads will agree schedules and flows to enable system wide understanding of patient activity, cost drivers and other health system dynamics. The focus will be on working together to understand the health system and data quality in relation to counting and coding.

Single source monitoring will release transactional costs which will be redirected to support the transformational efforts in the system.

New ways of working across the System will be explored with CCG and Trust Staff, with a view to reconfiguring informatics, finance, commissioning and contracting.

Jointly owned QIPP & CIP governance programmes will be introduced to drive through savings and to deliver the £5m minimum affordability gap which exist on the contract. Any shortfall on the CIP programme will be split equally between parties

Jointly agreed constitutional standard trajectories will be developed before the end of March.

Scheduled Care
There are two specific areas of focus for scheduled care:

1. An agreed action plan will be developed on referral management which will look to keep referrals and waiting times/numbers at 2016/17 levels as a maximum. This work will be clinically led and data targeted. In the event that activity/demand is not reducing in line with expectations, the system will work to understand the cause. If this growth is due to GP referrals or other factors not relating to activity shift, this will be discussed at the Planned care group to discuss options available. This may include the introduction of referral support schemes, pathway changes, or the funding of additional activity based on actual costs incurred. Joint governance will be developed to ensure the capacity and capability to remove activity where it is clinically & economically appropriate to do so.

2. Working together the System needs to develop a plan to reduce the flow of planned care into the private sector within the patch. The System will need to be able quantify the shift and its impact on the RTT position in particular. Actions would then need to be discussed and agreed to ensure that the system manages this patient cohort economically, and in line with constitutional expectations.

Unplanned Care
An agreed transformation plan relating to the totality of the non-elective pathway will be developed through the Unplanned Care Board, with oversight from the ED Delivery Board. This is expected to cover pre-hospital, in hospital, and the post hospital elements of the pathway. The ultimate aim of this plan will be to reduce, as far as possible, the volume of non-elective admissions to the Hospital. Activity rising above expected levels and resulting in

additional cost over 16/17 forecast outturn levels will be managed by the System working jointly on operational solutions to control the risk. Joint governance will be developed to ensure capacity and capability to remove activity where clinically & economically appropriate.

Activity Shifts
The System will monitor shifts in activity flows into the Trust and other providers. Where these have changed due to Commissioning decisions, patient choice, or other material factors, the Chief Finance Officers will agree a financial adjustment to be made to reflect the change in cost. Plans to shift activity out of the Trust will be discussed in advance, with implementation and risks considered. An appropriate adjustment will be made to reflect any changes in cost.

Penalties
Penalties triggered due to performance issues will be quantified and agreed and system level actions agreed. The minimum income guarantee will not be affected.

CQUIN
Approved CQUIN schemes will operate during the year. Where schemes are not succeeding, the underlying reasons will be ascertained and reported to the Quality Board. The minimum income guarantee will not be affected by any CQUIN under-performance.

Governance
Governance of the System will be undertaken by revisiting existing structures, such as the Planned and Unplanned Care groups, and by maintaining the work currently being done by the existing Quality Board. The current Contract Management Board will be reconfigured to provide a technical forum where all monitoring can be shared and where system wide issues such as the role out of Electronic Referral System (ERS) or Directory of Service (DOS) issues can be coordinated. A Chief Executive sponsored Executive Group will maintain monthly oversight of the AIC. This revised Governance structure will be in place by the end of March 2017

Signed on behalf of Hull and East Yorkshire Hospitals NHS Trust

Signed on behalf of Hull CCG

Signed on behalf of East Riding CCG