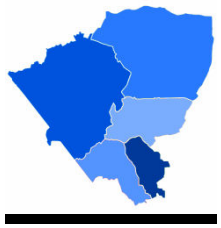
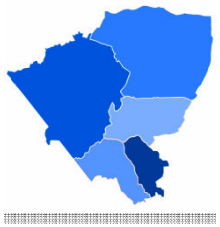


NHS
North Central London

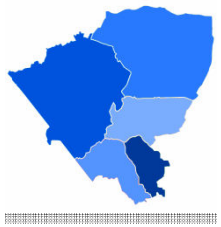
Financial Management of Acute Contracts (demand/ contract management)

Simon Currie
Interim Director of Contracts



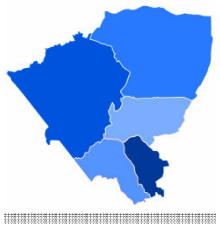
General introduction

- Acute contracts are largely ‘cost and volume contracts’, that is the commissioner takes the volume risk
- Volume drivers can be split into demand led (eg the number of A&E attendances) and supply led (eg the ratio of consultant to consultant referrals).
- The approach to managing the risk is different for the two types



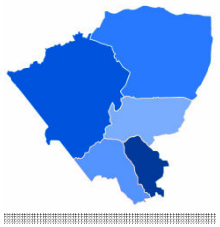
Open Access System

- The health system is largely an open access system – for example anyone can walk straight into A&E
- Demand for the system is difficult to predict, in part because demand is influenced significantly by supply
- Access is protected through eg NHS Constitution right to treatment within 18 weeks, and A&E 4 hour maximum wait



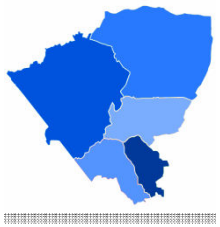
NCL Contract Position

- NCL currently commissions around £1.2bn of acute contract activity per annum
- Around £580m of this relates to ‘block’ or ‘cap and collar’ contracts which give a high degree of finance risk protection
- The remaining contracts have no such restrictions so represent a greater risk to commissioners



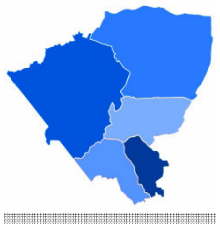
Payment by Results

- Acute expenditure calculated according to PbR framework - units of activity x price
- Rules-based system covered by national guidance, although some room for interpretation, and some flexibility
- National tariff set for around 70% of expenditure
- Local prices agreed for the remainder



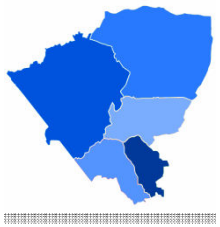
Annual Contract Cycle

- Contracts set annually with each provider
- Include an estimate of the likely volume of patients to be seen by each trust and how much will be paid based on treatment provided
- Also includes impact of contract levers to control spend, and impact of ‘demand management’ to control volumes



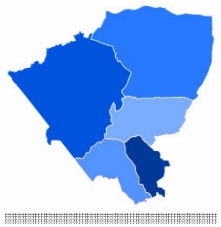
Monthly Contract Cycle

- Each month trusts submit a ‘bill’ to the commissioners
- Commissioners analyse and scrutinise the submission
- Routine rules based challenges are raised on common issues each month
- Additional contract queries are raised on other areas where charges appear incorrect



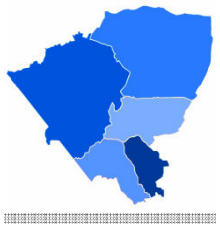
Supply driven volume

- Volume created by direct actions of trusts, such as high patient follow up rates, consultant to consultant referrals and ‘unnecessary’ admissions
- Volume created by indirect actions, such as opening a new clinic, reducing waiting times for surgery and keeping escalation beds open when not required



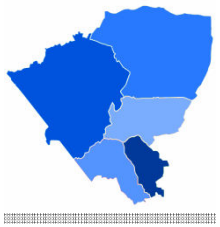
Contract levers

- KPI targets for ratios including first to follow up outpatients, daycase to outpatient procedures, and consultant to consultant referral ratios
- Price levers such as urgent care centres offering minor A&E type activity at reduced prices
- Controls over areas such cosmetic procedures and weight loss surgery



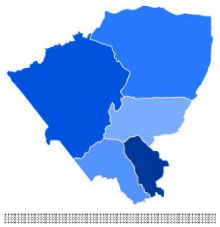
Demand driven volume

- Volumes driven by health factors such as poor care of the elderly, or acute episodes in people with long term chronic conditions
- Volumes driven by service provision such as ability to access a GP
- Volumes driven by behavioural factors such as a preference to choose A&E rather than visit a GP



Managing activity levels

- Tightly managing GP referrals for outpatient appointments
- Proactively supporting care homes to reduce emergency admissions
- Providing greater support to COPD patients to prevent admissions
- Falls management schemes to reduce the number of falls related admissions
- Patient education programmes



Future arrangements

- Acute commissioning largely falls to CCGs from 1st April 2013
- Contract management will be provided by the N&EL Commissioning Support Unit
- Expect that current levels of performance will be the baseline for the CSU
- Stephen Rubery – NCL Contracts Director
- Will Huxter – Director of Contracts & Quality