



**Revised Specialised  
Commissioning CQUINs  
2017-18 / 2018-19**

OFFICIAL

Version number: 1.0

First published: 22 September 2016

Classification: OFFICIAL

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## Specialised Commissioning CQUINs

**NOTES:**

These scheme guides are for use to document locally discussed commitments included in agreed contracts. They are designed for annexation to contract schedules, with sections highlighted in yellow for local adjustment.

Each scheme is also available as a separate document, published alongside this document on the PSS CQUIN web-page at [www.england.nhs.uk](http://www.england.nhs.uk)

## 1 BI1 Improving HCV Treatment Pathways through ODNs

Scheme Name	Hepatitis C Virus (HCV) Improving Treatment Pathways through Operational Delivery Networks (ODNs)
Eligible Providers	<p>Priority CQUIN for all HCV Operational Delivery Network Lead providers as follows:</p> <p>LEAD PROVIDER</p> <ol style="list-style-type: none"> <li>1. The Newcastle Upon Tyne Hospitals NHS Foundation Trust</li> <li>2. Pennine Acute Hospitals NHS Trust &amp; Central Manchester University Hospital Trust</li> <li>3. Royal Liverpool &amp; Broad Green University Hospital NHS Trust</li> <li>4. Sheffield Teaching Hospitals NHS Foundation Trust</li> <li>5. Hull &amp; East Yorkshire NHS Trust</li> <li>6. Leeds Teaching Hospitals</li> <li>7. East Lancashire Hospital NHS Trust</li> <li>8. University Hospitals of Leicester</li> <li>9. University Hospitals Birmingham NHS Foundation</li> <li>10. Nottingham University Hospitals NHS Trust</li> <li>11. Cambridge University Hospitals NHS Foundation Trust</li> <li>12. Imperial College Healthcare Trust</li> <li>13. Royal Free London NHS Foundation Trust</li> <li>14. Barts Health</li> <li>15. Kings College Hospital NHS Foundation Trust &amp; St George's University Hospitals NHS Foundation Trust</li> <li>16. Royal Surrey County Hospital NHS Foundation Trust</li> <li>17. Brighton &amp; Sussex University Hospitals</li> <li>18. Oxford University Hospitals NHS Foundation Trust</li> <li>19. University Hospital Southampton NHS Foundation Trust</li> <li>20. University Hospitals Bristol NHS Foundation Trust</li> <li>21. Plymouth Hospitals NHS Trust</li> <li>22. Kings College Hospital NHS Foundation Trust</li> </ol>
Duration:	April 2016 – March 2019
Scheme Payment	<p>Two elements:</p> <ol style="list-style-type: none"> <li>1. <b>Governance and Partnership Working:</b> £100,000 per network. Where 2 providers share lead status the split of this funding to be agreed with commissioner and the 2 providers.</li> <li>2. <b>Stewardship and NICE compliance</b> 1.6% of provider's overall CQUIN applicable specialised contract value</li> </ol> <p>2017/18 Target Value: <b>Add locally</b></p> <p>2018/19 Target Value: <b>Add locally</b></p>

### Scheme Description

This CQUIN supports the infrastructure, governance and partnership-working across healthcare providers working in HCV networks in their second and third years of operation to achieve the following outcomes:

- Improvements in engagement of patients
- The planned rollout, aligned to NICE guidance, of new clinical and cost effective treatments guidance to improve outcomes through Multi-disciplinary team treatment plans
- Improved participation in clinical trials
- Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments.

Providers across networks are responsible for developing a working group for this CQUIN scheme, mapping patient pathways and producing a plan to improve partnership working. By the end of the CQUIN scheme, ODNs will:

- a. Be part of ongoing HCV clinical care as set out by NICE in published and forthcoming technology appraisal guidance, with all patients receiving Hepatitis C care benefiting from ODN policy-compliant care approved by an MDT
- b. Have clear and fully understood arrangements for partnership working inclusive of local patient groups and providers. There should be a clear written plan for partnership working with clarity of responsibility. There should be agreed communications about the ODN which allow professionals and patients alike to understand how the ODN operates and how to contact it
- c. Have developed partnerships which involve providers, commissioners, voluntary organisations and patients
- d. Provide clear monitoring data on ODN operation and outcomes for patients, including the impact of the ODN model for improving access and real life effectiveness of new treatments. This should contribute to public health, activity, outcomes and experience monitoring needs
- e. Be actively involved in opportunities to share learning and develop solutions within and across ODNs at regional & national level, to build the ODN collaboration model.

### Measures & Payment Triggers – Governance Payment

Where year one triggers were not met in year one they should be included by local amendment for year two.

#### I. Quarter 1 Achievement: (25% of Governance Payment)

- a. **Baseline report** (Year one) including: signed ODN arrangements by all partners; governance arrangements; ODN footprint map including CCG boundaries and provider partners; current baseline of pathways and services; gaps in service provision; populations in line with policy / NICE guidance; evidence of appropriate administrative arrangements to enable MDTs / data reporting
- b. **Engagement plan** (Year one) for regional and national ODN network, and for voluntary sector & patients.
- c. **Pathway Mapping Group** (Year one) established (membership confirmed, schedule of meetings).
- d. **Dataset reporting arrangements\*** (Year one) for all partners clarified and implementation begins.
- e. **Proposals to monitor incidence and re-infection rates** (Year one) in a defined subset of treated patients at risk of re-infection
- f. **Progress Report** (Year two and three)

#### II. Quarter 2 Achievement: (25% of Governance Payment)

- a. **Develop partnership model and plan** (Year one) for implementation and submit to NHS England for comments. This to involve non specialised providers and relevant commissioners.
- b. **Dataset reporting\* fully implemented.** (Year one) **Complete reporting** (Year 2,3)
- c. Evidenced commencement of **5 year ODN plan** development. (Year one)
- d. **Progress report** (Year two and three)

### III. Quarter 3 Achievement: (25% of Governance Payment)

- a. Implementation of the improved **partnership model** and partnership working including systems for data collection, activity and incidence monitoring. (Year One)
- b. Process undertaken to **assess patient experience.**(Year One)
- c. **Communication and engagement plan** agreed (Year one).
- d. **Complete dataset reporting\*** in the quarter.
- e. **Progress Report** (Year two and three)
- f. **ODN Five Year Plan Objectives Refresh** (Year Two and Three)

### IV. Quarter 4 Achievement: (25% of Governance Payment)

- a. **Annual report** of ODN operation submitted including progress on governance, partnership working, activity reporting & patient experience feedback.
- b. **Map of pathways /services** published. (Year one)
- c. **ODN 5 year plan** submitted and includes detailed plans for 17/18 priorities and objectives. To include how services and access to be improved for relevant patient groups. Implementation of communication and engagement plan.
- d. **Complete dataset reporting\*.**
- e. **Progress Report** (Year two and three)

Where necessary to fulfil responsibilities providers may use funding from both the governance and stewardship payment to ensure network operation is adequately resourced to fulfil responsibilities for its own patients as well as its role as undertaking independent expert review for 'prior approval' patients for another assigned ODN.

### **Measures & Payment Triggers – Stewardship Payment**

**A NEW LONGER TERM INDUSTRY AGREEMENT FOR FUNDING DAA TREATMENTS IS EXPECTED TO BE CONCLUDED BY APRIL 2017. STEWARDSHIP PAYMENT TRIGGERS WILL BE REVISED TO ALIGN WITH THIS AGREEMENT, AND TREATED AS A LONGSTOP IN THE NHS STANDARD CONTRACT**

#### **TRIGGER A: Managed resources within indicative financial budget forecast**

- Each ODN will be issued an indicative forecast financial budget on a half yearly basis. Based on the published run rate for each ODN, and the confidential region-specific prices for HCV treatment options clinically appropriate to each genotype and treatment history, inclusive of fees, taxes and charges.
- To avoid localised differences in populations (such as differing genotype profiles by ethnicity) impacting on assessment of this measure, performance against indicative financial forecast of all 22 networks will be reported individually but risk pooled.
- Where the combined committed spend for the half year is less than or equal to the indicative budget, the full 1.6% incentive will be available to every ODN paid on the basis

of the triggers B1 to B4 below

- Where the combined committed spend for the half year exceeds the indicative budget, the incentive available to every ODN and paid on the basis of the triggers B1 to B4 below will be reduced on a £ for £ basis.

**TRIGGER B1: ODN MDT decisions aligned to NHS England published run-rate**

- One fifth of the stewardship incentive available through trigger A is payable provided the ODN delivers MDT treatment initiations in line with the published run rate for the half year. To qualify for payment the ODN treatment rate must be not less than 90% and not more than 100% of the published half year rate. There is no payment for partial achievement of this element.

**TRIGGER B2: ODN Treatment cost per patient relative to lowest acquisition cost**

- One fifth of the stewardship incentive available through trigger A is payable through this trigger. The indicative financial budget incorporates valid clinical exceptions to lowest acquisition cost and will be reviewed twice yearly.
- Each ODNs lowest acquisition cost measure will be adjusted for genotype, cirrhosis status and treatment history of patients initiated.
- Where the ODN average treatment cost per patient is within 10% of lowest acquisition cost for the network this indicator will be paid in full.
- Where average treatment cost per patient is above 10% of lowest acquisition the 6 networks with highest % variance will receive no payment; the remaining networks will receive half payment

**TRIGGER B3: ODN Prioritisation of patients with highest clinical need**

- One fifth of the stewardship incentive available through trigger A is payable through this trigger. Each ODN will set out its local priorities within its baseline report in Quarter one, including the objective criteria by which they will assess achievement of these aims. NHS England regional clinical directors, with advice from public health England and the national clinical ODN lead will assess the network Annual report and the supporting data for evidence that the network has been actively implemented. Data may include the levels of patients initiated with cirrhosis, fibrosis F3 or above, or with relevant comorbidities, and reaching particular patient subgroups relevant to local health needs.
- Where the ODN shows strong evidence of meeting active plans for prioritising highest clinical need it will receive full payment of this element. A partial payment of 75% of this element will be paid where evidence provided gives limited assurance that patients with highest clinical need have been prioritised.

**TRIGGER B4: ODN Effectiveness in sustaining benefits of treatment**

- One fifth of the stewardship incentive available through trigger A is payable through this trigger. Evidence about reinfection rates is not yet sufficiently developed to use as the basis of incentivisation, so this measure incentivises capturing and analysing ODN data about local incidence of reinfection from follow up testing 48 to 60 weeks after treatment completion and using insights to inform clinical practice interventions to promote reduction of patient risk factors.



- Where evidence is gathered for over 85% of patients treated in the preceding 60 weeks and a report identifying trends and applying learning to treatment practices of the ODN is published full payment of this element will be made.
- Where evidence is gathered for less than 50% of patients treated, no payment will be made
- Where the proportion of patients retested for whom data is captured falls between 50 and 85% and a report identifying trends and applying learning to treatment practices of the ODN is published, the payment for this element will be proportional to the % of patients for whom retest data is captured.

**TRIGGER B5: Completeness and Data Quality in the ODN ‘registry’**

- One fifth of the stewardship incentive available through trigger A is payable through this trigger.
- This payment is made where the ODN has a plan for getting all patients known to services (including those yet to be treated) to have an accurate entry in the registry within 4 months of the registry being made available by Public Health England.
- Full payment will be made where data is above 85% complete and warranted as accurate by the clinical lead in each partner organisation within 4 months and maintained each month thereafter.
- No payment will be made where data which is complete and warranted as accurate is below 50%
- Where between 50% and 85% of data is complete and warranted as accurate the payment for this element will be proportional to the % achieved

**Definitions**

**1. MDT Treatment**

- a. Numerator: No of HCV patients whose treatment has been subject to MDT review and accords with ODN guideline.
- b. Denominator: No of HCV patients in catchment population that should be seen in period (set out in MDT plan for network agreed with commissioners)

**2. Supporting Indicators**

- a. Average Drug Treatment Plan Duration (weeks)
- b. % patients completing treatment as planned
- c. Patients drug treatments initiated by genotype and fibrosis/Cirrhosis status

**3. Dataset Reporting** As described and as specified in supporting documentation: BI1 Hepatitis C CQUIN reporting requirements.docx

**4. Registry data completeness**

The denominator for number of patients for this measure is as follows: The number of RNA positive patients who have attended clinic at all providers within the ODN and have not been discharged after treatment, as extracted from provider clinic systems.

The supporting information for measures which relate to confidential prices of treatments are available directly to ODN lead providers on a commercial in confidence basis and should only be shared as needed with ODN partner organisations who are party to a confidentiality agreement. Further information will be provided to ODN lead providers.

<b>Partial achievement rules</b>	
The governance payments are per quarter with no partial payment if not achieved. The stewardship payments partial achievement rules are set out in the measures and payment triggers section	
<b>In Year Payment Phasing &amp; Profiling</b>	
Governance payments are quarterly. Stewardship payments are half yearly for B1 to B3 and full year end for B4 and B5	
<b>Rationale for inclusion</b>	
New HCV Treatments are recognised to be cost effective by NICE, and ODNs are a specified element of NICE technology appraisal guidance. The operation of managed network principles can <ul style="list-style-type: none"> <li>- Ensure clinically appropriate medicine choice and treatment duration is selected in line with latest evidence, and maximise the access to treatment relative to investment, achieving greater health gain.</li> <li>- Ensure patient treatment interventions maximise adherence to treatment regimen and minimise relapse thus minimising the reduction in health outcomes for real world treatment compared to trial conditions</li> <li>- Provide an equitable basis to rollout and prioritise patients with highest clinical need.</li> </ul>	
<b>Data Sources, Frequency and responsibility for collection and reporting</b>	
Two types of data requirement: <ul style="list-style-type: none"> <li>• Narrative reports – produced by ODN Clinical Teams</li> <li>• Dataset: This is demonstrated via 3 sources – Blueteq, drugs MDS and HCV outcomes dataset all of which must be fully completed and complied with</li> </ul> <p>Providers will need to produce evidence of appropriate administrative arrangements in place to enable MDTs / data reporting.</p>	
Baseline period/ date & Value	Not Applicable – performance based on MDT plan not baseline period: MDT Plan Activity for financial year
Final indicator period/date (on which payment is based) & Value	Measures for financial year as at Month 6 and Month 12 except where otherwise stated
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b> <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	The set up costs of HCV ODNs were supported financially in ETO provider CQUIN or central funding allocation in 2015/16. As a year 2 and year 3 CQUIN, the governance costs will be embedded in reference costs from the year after the CQUIN concludes. Governance arrangements will need to reflect funding flows needed from Tariff income in year 4 across partner organisations to fund ongoing network infrastructure. The future of stewardship payments will be reviewed in light of developments during 2017 and 2018.

**Supporting Guidance and References**

NICE has concluded that a number of new oral HCV treatments are cost effective for certain patient groups (see <https://www.nice.org.uk/guidance/conditions-and-diseases/liver-conditions/hepatitis>)

Reducing harm from Hepatitis C is a priority for the NHS. There are estimated to be 160,000 people with chronic Hepatitis C infection in England, of whom 80,000 are diagnosed. In 2012 about 5000 people received drug treatment for HCV in the UK, i.e. about 3% of the prevalent pool of infected patients receives treatment each year. A wide body of literature on generalisability of healthcare research suggests treatment adherence and clinical outcomes achieved in real world settings fall short of clinical trial based outcomes (For example Sculpher et al 2004<sup>1</sup>) Effective clinical networks are one way to minimise this shortfall.

NHS England has implemented the establishment of Hepatitis C networks to ensure clinical and cost effective care is delivered with oversight from Hepatitis C centres and MDTs. Strong partnership working across the complex pathways for patients is essential to ensure patients have access to both clinical expertise and local delivery of care.

There are a large number of commissioners and services involved in the treatment of patients who may have Hepatitis C or are infected and also suffer from other co-morbidities or conditions. Acute services, drug and alcohol services, detained settings, primary and community care providers may be caring for the eligible patient groups. The majority of patients with Hepatitis C are within disadvantaged groups.

The CQUIN scheme is linked to the development of a national group of ODNs which will help support clinicians with identifying the most clinically and cost effective options for patients. It will spread specialist expertise in this rapidly evolving field beyond specialist centres making it more accessible for patients and ensuring all have access to the appropriate therapeutic options and greater integration of care between providers of services whilst preserving local access.

Treatment selection is complex to support adherence, avoid resistance and relapse and to make best use of NHS resources. Hepatitis C ODNs provide a vehicle for ensuring that clinicians are aware of which are the most cost effective, efficacious treatments and to help choose between alternative products and treatment plans  
England has lacked any national data linking across services to improve accuracy of data on patient numbers, treatment, outcomes and access. This CQUIN scheme supports the innovation required by the whole system to work together to manage access to new treatments in a cost effective way. Networks are expected to play an active role in developing and refining the outcome data collected by partner providers over the next 2 years to develop the evidence base of treatment in routine clinical practice

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<sup>1</sup> Sculpher MJ, Pang FS, Manca A et al. Generalisability in economic evaluation studies in healthcare: a review and case studies. Health Technology Assessment 2004; 8:1-206. See also Drummond MF, McGuire A eds. Economic Evaluation in Health Care: Merging Theory with Practice. Oxford University Press

## 2 BI2 Haemtrack™ Severe Haemophilia Home Reporting

Scheme Name	<i>BI2: Increasing patient activation in haemophilia through Haemtrack</i>	
<b>Section A. SUMMARY of SCHEME</b>		
QIPP Reference	<i>[QIPP reference if any: Add Locally]</i>	
Duration	April 2016 to March 2019	
<b><u>Problem to be addressed:</u></b>		
The Haemtrack system, an electronic (or paper) patient-reported record of self-managed bleeding episodes and usage of blood factor products, has been demonstrated to be effective in maintaining treatment compliance, optimising home therapy and home stock control. There is high variation in the adoption of the system, and in the timeliness and accuracy of its use.		
<b><u>Change sought:</u></b>		
Improving adherence, timeliness, and accuracy of patient data submissions to the Haemtrack™ patient reporting system. Primarily to increase the proportion of patients making regular submissions to the Haemtrack™ system, preferably via digital interfaces. In addition, the timeliness of submissions is another desired dimension greatly assisted through use of digital interfaces as opposed to paper. Finally, the data provided must be accurate therefore data accuracy must also be verified and improved where deficient.		
<b>Section B. CONTRACT SPECIFIC INFORMATION</b>		
<b><u>B1.Provider</u></b> (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>	
<b><u>B2.Implementing Timing.</u></b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract?	Year 1 = 2016/17 <sup>2</sup> 2017/18 2018/19 <i>[delete as applicable]</i> One/two years <i>[delete as applicable]</i>	
<b><u>B3.Scheme Target Payment</u></b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>	
<b><u>B4. Payment Triggers.</u></b>		
The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.		
Relevant provider-specific information is set out in this table.		
<b>Provider specific triggers</b>	<b>2017/18</b>	<b>2018/19</b>
<b>Trigger 1:</b>	Proportion of patients providing regular Haemtrack™ data as a	

<sup>2</sup> I.e. scheme was contracted for first implementation in 2016/17, and this template is setting out requirements for 2<sup>nd</sup> (and perhaps 3<sup>rd</sup>) year of scheme.

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<b>Baseline</b>	proportion of all patients registered with the National Haemophilia Database at the centre
<b>Trigger 1: Stretch level</b>	<i>[Add provider specific agreed proportion as per guideline in C4.]</i>
<b>Trigger 2: Baseline</b>	Proportion of all Haemtrack™ users who provide an update once per week in period Q1-Q3 (39 weeks)
<b>Trigger 2 stretch</b>	<i>[Add provider specific agreed proportion as per guideline in C4.]</i>
<b>Trigger 3 Baseline</b>	To assess the accuracy of records made by patients and provide a baseline.
<b>Trigger 3 stretch</b>	<i>[Add provider specific accuracy objectives if appropriate.]</i>

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year. **Month 12 Contract Flex reporting date as per contract. *[Vary if necessary.]***

**B6. In Year Payment Phasing & Profiling**

**Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement. *[Vary if necessary.]***

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

**Eligibility:** Any provider with a regular Haemophilia patient caseload for which it is responsible for regular prophylactic blood factor prescribing.

**Nature of Adoption Ambition:** This scheme is a priority for all providers with baseline Haemtrack™ usage (as per Trigger 1) less than 67%.

Hence, this CQUIN is a priority for the following providers (based upon baseline data is shown in an accompanying workbook – BI2 Haemtrack Baseline Data):

<b>REGI ON</b>	<b>Hub</b>	<b>Provider</b>
L	London	Great Ormond Street
L	London	Lewisham
L	London	St Thomas' and Guy's Hospital (incl Frimley Pk)
M&E	Birmingham & Black Country	Birmingham (Queen Elizabeth)
M&E	Birmingham & Black Country	Shrewsbury
M&E	Birmingham & Black Country	Wolverhampton
N	Cheshire, Warrington & Wirral	Liverpool (R. I. incl Isle of Man)
N	Cheshire, Warrington & Wirral	Liverpool Children's (Alder Hey)
N	Cheshire, Warrington & Wirral	Manchester Children's

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N	South Yorkshire & Bassetlaw	Leeds (St James)
N	South Yorkshire & Bassetlaw	Sheffield (Royal Hallamshire, incl Northern General)
N	South Yorkshire & Bassetlaw	York (incl Harrogate)
S	Bristol, North Somerset & South Gloucestershire	Bristol (Infirmary & Childrens)
S	Bristol, North Somerset & South Gloucestershire	Exeter
S	Bristol, North Somerset & South Gloucestershire	Plymouth
S	Bristol, North Somerset & South Gloucestershire	Salisbury
S	Bristol, North Somerset & South Gloucestershire	Taunton - Yeovil
S	Surrey & Sussex	Bournemouth - Poole
S	Surrey & Sussex	Brighton
S	Surrey & Sussex	Chichester
S	Wessex	North Hampshire (Basingstoke)
S	Wessex	Southampton (incl Guernsey)

## C2. Setting Scheme Duration and Exit Route

NHS England already funds the Haemtrack™ database. Patient education and training will take place within existing consultations and should become routine, with additional costs absorbed into price calculations. This should be achieved by March 2019.

In future a persistent failure to utilise and maintain Haemtrack™ may see services being decommissioned at providers. The CQUIN is effectively an incentive to ensure all providers are up to a high level of attainment from which future service developments can be planned and implemented. The records will also assist providers in delivering more patient-centred consultations and may therefore improve patient experience and efficiency of service provision.

## C3. Calculating the Target Payment for a Provider

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

<£20,000 plus £2,000 per patient to be treated.>

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

## C4. Payment Triggers and Partial Achievement Rules

### Payment Triggers

The interventions or achievements required for payment under this CQUIN scheme are as follows:

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Descriptions	2017/18	2018/19
<b>Trigger 1:</b>	<p>Proportion of patients providing regular Haemtrack™ data as a proportion of all relevant patients (see Definitions) registered with the National Haemophilia Database at the centre.</p> <ul style="list-style-type: none"> <li>➤ If baseline is 66% or less to achieve minimum 80%.</li> <li>➤ If baseline is 67% to 84% to achieve minimum of 90%.</li> <li>➤ If baseline is 85% or more to halve number of non-users</li> </ul>	As 2017/18
<b>Trigger 2</b>	<p>Proportion of all Haemtrack™ users who provide an update once per week in period Q1-Q3 (39 weeks). To exceed 67% in the defined period.</p>	As 2017/18
<b>Trigger 3</b>	<p>To assess the accuracy of records made by patients and provide a baseline. By end Q3 to have assessed accuracy of all patient datasets and report the accuracy to commissioners. To agree a target for accuracy for 2018/19.</p>	Achievement against target agreed in 2017/18.

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	2017/18	2018/19
<b>Trigger 1</b>	50%	33%
<b>Trigger 2</b>	25%	33%
<b>Trigger 3</b>	25%	33%
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

No payments are to be made for partial achievement. Each trigger is either achieved, or not, and payment is similarly binary. When calculating attainment of targets any calculations will be rounded to the nearest whole integer following conventional rules and there will be no deviation from this.

<p><b><u>Definitions</u></b></p> <p><b>Denominator for Trigger 1:</b>  <b>All non-inhibitor patients with moderate and severe haemophilia on prophylaxis.</b></p>
<p><b>C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.</b></p> <p>Number of regular Haemtrack™ submissions where each submission is allocated to a specific provider will be verified against number of registered patients on treatment reported separately as part of UKHCDO registries.</p> <p>Any Haemtrack submissions which have not been allocated to a specific provider will go into a reserve pool from which providers can claim them subject to verification; this will assist providers in increasing the respective numerator and thus target attainment. Verification will be done by a third party as it will likely rely on patient NHS Number. The national haemophilia database team has agreed to perform this task and support this CQUIN.</p> <p>This data will be collated by the Lead Commissioner and reported to each region and hub accordingly. Providers will have the right to challenge the data but the onus will be on them to prove that the data is in some way erroneous. Allowances may be permitted for new patients (i.e. new patients may be excluded from the denominator count) at the discretion of the lead commissioner. No other exclusions will be permitted, especially as the target does not require 100% attainment therefore permitting a small number of exclusions regardless.</p> <p>With respect to timeliness of data submissions; this information will be provided by the NHD team. It will be calculated on an individual patient basis and will be crudely based on observing a minimum of 39 data submissions within the 39 week period. An adjustment will be made for patients who commenced treatment in-year. Each individual patient will either pass or fail the threshold test and the pass rate is that which is counted.</p> <p>With respect to the accuracy of the data: The exact methodology for this has not yet been confirmed. It is likely that the usage recorded by individual patients will need to be verified as being within +/-5% of the prescribed amount. Providers will need to self-verify this parameter however this will in turn be validated by commissioners. A single methodology will be determined which providers can choose to follow.</p>
<p><b><u>Information for Benchmarking:</u></b></p> <p>Baseline data is available in a spreadsheet supporting this CQUIN.</p>
<p><b><u>Information Governance:</u></b> All data will be provided by the National Haemophilia Database, no PID will be provided to commissioners. Where validation or verification is undertaken which requires PID (e.g. NHS Numbers) this will be undertaken by third parties with permission to handle such data.</p>
<p><b><u>Reporting of Achievement against Triggers:</u></b> The NHD will report these for commissioners, except trigger 3 which will be self-reported by providers with commissioner validation (both of</p>



the methodology and reported attainment).
<b>Reporting Template requirement:</b> Not required, however a standard methodology for trigger 3 will be published by the CRG and suitable guidance issued to providers with respect to trigger 3.
<b>C6. Supporting Guidance and References</b>
See UKHCDO website: <a href="http://www.ukhcdo.org">www.ukhcdo.org</a> especially the Annual Report ( <a href="http://www.ukhcdo.org/annual-reports">www.ukhcdo.org/annual-reports</a> ) with various up-to-date statistics, and web pages on the National Haemophilia Database ( <a href="http://www.ukhcdo.org/nhd/">http://www.ukhcdo.org/nhd/</a> ) and Patient Information ( <a href="http://www.ukhcdo.org/patient-information">www.ukhcdo.org/patient-information</a> ).
Haemtrack™ website: <a href="http://haemtrack.mdsas.com">http://haemtrack.mdsas.com</a> Including patient information leaflet:
Evidence for benefit of patient activation: <a href="http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf">www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf</a>
<b>Evidence specific to Haemtrack will be shared as and when it becomes available</b>
<b>Section D. Scheme Justification</b>
<b>D1. Evidence and Rationale for Inclusion</b>
<b><u>Evidence Supporting Intervention Sought</u></b>
Hollingsworth R et al. Haemtrack: UK patient home therapy reporting system. JOURNAL OF THROMBOSIS AND HAEMOSTASIS 2015 Jun 1 (Vol. 13, pp. 583-584).
Osias A et al. Implementation of an online home treatment record-keeping system (Haemtrack) in a large London comprehensive care centre. HAEMOPHILIA 2012 Jul 1 (Vol. 18, p. 59).
<b><u>Rationale of Use of CQUIN incentive</u></b>
Regular use of Haemtrack™ with timely and accurate data is a proxy measure for patient activation and involvement in managing their condition, as well as providing valuable information to clinicians to support clinical care. Despite nationally funding towards the provision of the NHD and Haemtrack™ there is still considerable variation in the use of Haemtrack™ by patients and by individual providers. The laggards must engage with and activate their patients to a higher level to bring them up to the same levels as the innovators, and most providers can do more to increase overall patient participation. A CQUIN is an ideal incentive to drive the desired change as it will focus attention from within and from outside individual departments within providers. The targets mark a significant stretch for some providers although the actual patient numbers involved may be relatively modest.
<b>D3. Justification of Size of Target Payment</b>
The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payments are based on a fixed fee per registered patient (£2,000), with an overhead payment of £20,000 to cover (with mark-up) administrative costs. The per-patient payment covers the per-patient contribution required by Trusts towards the National Haemophilia Database plus an allowance for marginal per-patient costs of additional support for patients.

Overall, the payment is based on an assessment of what incentive payment will adequately support providers to give coaching and other support to patients to use Haemtrack effectively.

#### **D4. Evaluation**

Intermediate outcomes that will be available from the database will include the total number of new Haemtrack™ users, the number of new regular Haemtrack™ users, and the number of providers which have fully delivered the CQUIN.

The system should create the information needed for a full evaluation of patient related outcomes.

### 3 BI3 Automated Exchange Transfusion for Sickle Cell Care

Scheme Name	BI3 Automated Exchange transfusion for Sickle Cell Disease Patients
QIPP reference	QIPP 16-17 S28-B&I '17/18 QIPP reference to be added locally.
Eligible Providers	All providers of exchange transfusion for SCD
The list of providers for whom the CQUIN should be considered is as shown, with providers for whom offering this scheme is a priority asterisked.	<ul style="list-style-type: none"> <li>• University College London</li> <li>• *Bart's Health</li> <li>• Birmingham Children's Hospital</li> <li>• Sandwell and West Birmingham</li> <li>• Central Manchester University Hospitals NHS Foundation Trust</li> <li>• Alder Hey Children's Hospital NHS Foundation Trust</li> <li>• South Tees Hospital NHS Foundation Trust</li> <li>• Newcastle upon Tyne NHS Foundation Trust</li> <li>• Leeds Teaching Hospitals NHS Trust</li> <li>• Sheffield Teaching Hospitals NHS Foundation Trust</li> <li>• Nottingham University Hospitals NHS Trust</li> <li>• University Hospitals of Leicester NHS Trust</li> <li>• University Hospitals Bristol NHS Foundation Trust</li> <li>• Oxford University Hospitals NHS Trust</li> <li>• <i>University Hospital Southampton NHS Foundation Trust (where link to London Trusts agreed)</i></li> <li>• *Barking Havering and Redbridge University Hospitals NHS Trust</li> <li>• *Homerton University Hospital NHS Foundation Trust</li> <li>• Imperial College Healthcare NHS Trust</li> <li>• London North West Hospitals NHS Trust</li> <li>• *North Middlesex University Hospital NHS Trust</li> <li>• King's College Hospital NHS Foundation Trust</li> <li>• Guy's and St Thomas' NHS Foundation Trust</li> <li>• *Croydon Health Services NHS Trust</li> <li>• Lewisham and Greenwich NHS Foundation Trust</li> <li>• St George's University Hospital Trust</li> <li>• Whittington NHS Trust</li> </ul>
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] each year should achieve payment of £420 per automated transfusion for all patients targeted for automated transfusion in a year – both adults and children.</p> <p>2017/18 Target Value:     Add locally 2018/19</p>

Target Value: Add locally
<p><b>Scheme Description</b></p> <p>Patients with sickle cell disease require exchange transfusions to manage their condition. This can be done manually or using automated exchange. This CQUIN scheme aims to incentivise the use of automated exchange by specified specialist centres in order to improve patient experience and use of clinical resources.</p> <p>Implementing this CQUIN scheme may require investment in an apheresis machine if not available. Staff training will be required. Patient information will be required.</p> <p>This CQUIN scheme aims to remove resource barriers to using automated exchange in order to secure best access to care for all patients for whom it is appropriate.</p> <p>The payment amount is determined by the targeted number of patients requiring exchange transfusion each quarter, with a £420 payment per automated transfusion. Target is 95% of all transfusion patients.</p> <p>When calculating the number of transfusions likely in a year, account should be taken of any lead in time if a new machine must be acquired, and a norm of 8 ½ transfusions per year per patient. The £420 payment is appropriate for both adults and children.</p> <p>For example, a provider anticipating 40 patients requiring transfusion, and expecting to give 95% of them automated transfusions the CQUIN target payment would be  38 patients x 8.5 Transfusions x £420 = £135,660</p>
<p><b>Measures &amp; Payment Triggers</b></p> <ol style="list-style-type: none"> <li>1. Numerator. % of Patients with sickle cell disease requiring exchange transfusion (according to the agreed assumptions, noting the 95% target) who receive this via automated exchange</li> <li>2. Improvement. % receiving automated exchange increases in each quarter relative to that achieved on average in 2015/16.</li> </ol>
<p><b>Partial Achievement Rules</b></p> <p>Payment in each quarter is conditional upon Trigger 2 (improvement relative to base year) being achieved.</p> <p>If trigger 2 is achieved, payment is proportional to achievement of Trigger 1, i.e. the number of automated transfusions achieved as a proportion of the total number of transfusions targeted, with a cap of 100%.</p>
<p><b>In Year Payment Phasing &amp; Profiling</b></p> <p>Front-loading of payment could be considered to help defray costs of capital equipment required.</p>
<p><b>Rationale for Inclusion</b></p> <p>Appropriate use of automated exchange for patients with sickle cell disease (SCD) requiring exchange transfusion for the prevention of strokes etc</p> <p>Desired outcome</p> <ul style="list-style-type: none"> <li>- Greater use of automated exchange transfusion</li> <li>- Reduced complications of SCD</li> <li>- Reduced cost of chelation treatment</li> <li>- Improved patient access and experience</li> </ul>

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NICE Guidance shows Automated Exchange to be cost effective in terms of staff resource, bed day usage and chelation therapy	
<b>Data Sources, Frequency and Responsibility for collection and reporting</b>	
With effect from April 1st 2017 OPCS 4.8 will be introduced and will include changes regarding the identification of automated red cell exchange in patients with sickle cell disease. In order to differentiate between manual and automated exchange, from this date the clinical coding standards will state that all exchange transfusions classified at X32 (Exchange blood transfusion) and the extended category X47 (Other exchange blood transfusion), use a subsidiary code for extracorporeal circulation NEC (Y73.2) if the exchange is automated. <b>Providers need to use the mandated coding to evidence achievement of CQUIN</b>	
Baseline period/ date & Value	Baseline data will be available through a national audit and via Peer Review
Final indicator period/date (on which payment is based) & Value	As above
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b> <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	Using the CQUIN to fund automated exchange is a holding solution pending the development of an appropriate payment mechanism, e.g. through the introduction of payments under the new code through tariff.

### Supporting Guidance and References

Sickle cell disease (SCD) is the most common serious genetic disorder in England and affects 1 in 2000 live births, or 350 babies a year (NHS Screening Programmes 2010). Although the disease can vary in severity, all patients experience acute episodes of extreme pain that can have a negative effect on quality of life. For people with more severe forms of SCD, tissue damage can lead to organ failure and stroke. Life expectancy is considerably reduced at 45–55 years.

BSH guidance sets out requirements for exchange transfusion.

National Haemoglobinopathy Register includes data on SCD and requirements for exchange transfusion

Cost implications are mainly related to:

- Machine purchase if not available – the depreciation and maintenance costs
- Offset reduction in staff time
- Staff training if not available
- Blood product use

Overtime should be offset against other costs and avoided

Where a new machine is needed it should be confirmed as part of early discussions in the planning round, and in any event before 23<sup>rd</sup> December 2016, to ensure full year achievement of improvement is feasible

## 4 B14 Improving Haemoglobinopathy Pathways through ODN Networks

Scheme Name	B14 Haemoglobinopathy Improving Pathways through Operational Delivery Networks
Eligible Providers	<p>For Providers identified as Lead Specialist or Specialist Haemoglobinopathy Centres. Until the Service Review for haemoglobinopathy is complete, this list is derived from historical agreements. The West Midlands Quality Review Service peer review reports also assess providers (this is external to NHS England processes) <a href="http://www.wmqrs.nhs.uk/review-programmes/view/haemoglobin-disorders-2014-16-reviews-adults-and-children">http://www.wmqrs.nhs.uk/review-programmes/view/haemoglobin-disorders-2014-16-reviews-adults-and-children</a></p> <p>The list of providers for whom the CQUIN should be considered as a priority is</p> <ul style="list-style-type: none"> <li>• University College London</li> <li>• Bart's Health</li> <li>• Birmingham Children's Hospital</li> <li>• Sandwell and West Birmingham</li> <li>• Central Manchester University Hospitals NHS Foundation Trust</li> <li>• Alder Hey Children's Hospital NHS Foundation Trust</li> <li>• South Tees Hospital NHS Foundation Trust</li> <li>• Newcastle upon Tyne NHS Foundation Trust</li> <li>• Leeds Teaching Hospitals NHS Trust</li> <li>• Sheffield Teaching Hospitals NHS Foundation Trust</li> <li>• Nottingham University Hospitals NHS Trust</li> <li>• University Hospitals of Leicester NHS Trust</li> <li>• University Hospitals Bristol NHS Foundation Trust</li> <li>• Oxford University Hospitals NHS Trust</li> <li>• <i>University Hospital Southampton NHS Foundation Trust (where link to London Trusts agreed)</i></li> <li>• Barking Havering and Redbridge University Hospitals NHS Trust</li> <li>• Homerton University Hospital NHS Foundation Trust</li> <li>• Imperial College Healthcare NHS Trust</li> <li>• London North West Hospitals NHS Trust</li> <li>• North Middlesex University Hospital NHS Trust</li> <li>• King's College Hospital NHS Foundation Trust</li> <li>• Guy's and St Thomas' NHS Foundation Trust</li> <li>• Croydon Health Services NHS Trust</li> <li>• Lewisham and Greenwich NHS Foundation Trust</li> <li>• St George's University Hospital Trust</li> </ul>
The eligibility criteria for this scheme are	

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- NHS Trusts who have a contract with NHS England who are funded for activity associated with haemoglobinopathies as evidence by application of the Identification Rules
- Patients with sickle cell disease, thalassaemia or rare anaemias (adults and children) defined as specialised services. Other conditions not defined as specialised are excluded
- Providers must demonstrate they have the staff, skills and infrastructure to fulfil the specification / standards to be a Lead / Specialist Centre
- Providers must demonstrate via written evidence including terms of references and minutes that they have appropriately constituted MDTs making decisions about patient care. Quarters 1-3 update report required and quarter 4 annual report.
- Providers must evidence the governance for the ODN setting out the roles, responsibilities and pathways between the Specialist Centre, all other centres confirmed as caring for haemoglobinopathies in the ODN area, District General Hospitals (for acute / emergency / maternity pathways), primary care, voluntary organisations and links for screening and how these will be monitored, audited and updated. MDT arrangements and membership to be provided, particularly in relation to chelation therapy and complex care. Pathways covering emergency, elective, complex and routine follow up care to be supplied for children and adults. NHS England and local commissioners must be involved in approving ODN governance arrangements.
- Providers must demonstrate that they have sufficient data management capacity to ensure the complete and accurate submission of data to commissioners and to the National Haemoglobinopathy Registry <http://www.nhr.nhs.uk/> for patients within their ODN area
- Providers must demonstrate they have the capacity and ability to offer annual reviews for all patients in their ODN area. The Protocol for the Lead / Specialist Centre annual review must be provided Plan is required demonstrating that by the end of year 3, 85% of all registered patients in the ODN area attend the Lead Specialist / Specialist Centre for annual review in accordance with the protocol.
- Provider must produce a baseline report setting out current arrangements including ODN area, partner organisations, patient numbers in care, % of patients attending for annual review over the last 3 years
- Providers are required to demonstrate improvements in patient experience and satisfaction as a result of implemented network arrangements compared to baseline. A plan to demonstrate this is to be produced and validated by the PPV team.
- Providers are required to demonstrate an improvement in patient outcomes. The definition and baseline for the measure to be proposed by each Lead / Specialist centre. The proposal to be validated with advice from the CRG chair and lead commissioner.

Duration	April 2016 to March 2019.
Scheme Payment	CQUIN payment proportion [Locally Determined] for year two and year three should achieve payment of £75,000 to £150,000 per provider per annum, according to scale of service provision and network responsibility: <500 registered patients evidence through 2016 Peer Review report supplemented by NHR report = £75K 501 – 2000 registered patients evidence through 2016 Peer Review report supplemented by NHR report = £100K 2001 – 5000 registered patients evidence through 2016 Peer Review report supplemented by NHR report = £125K > 5001 - registered patients evidence through 2016 Peer Review

	report supplemented by NHR report = £150K Target Value 2017/18: <b>Add locally</b> Target Value 2018/19: <b>Add locally</b>
<b>Scheme Description</b>	
<p><b><u>Problem to be addressed</u></b>          Clinical consensus recommends haemoglobinopathy care be organised on a clearly defined network basis. This is set out in published standards produced by specialist societies for sickle cell disease and thalassaemia.</p> <p>The prevalence of haemoglobinopathies across England varies widely, with the majority of patients concentrated around urban areas, as does the expertise to manage these conditions. The diseases mainly affect black and minority ethnic populations which often have poorer health outcomes. Despite this, there is not yet a comprehensive, approved network linking lead / specialist haemoglobinopathy centres with non-specialist centres to provide a clear pathway for appropriate referral and care.</p> <p><b><u>Change sought</u></b>          This CQUIN incentivises removal of the remaining barriers to achieving an appropriate network of care by enabling lead / specialist centres to provide MDT led annual review of all patients and the associated communications, clinical support, staff training and data entry to demonstrate the clinical outcome benefits of such a model.</p> <p>By augmenting the work on the Haemoglobinopathy CRG, the CQUIN incentivises approved providers to be responsible for appropriate governance relationships for national networking, ensuring efficient use of scarce specialist expertise / resource. This is especially important in view of a recent staff survey which suggests the availability of consultants will reduce further with many existing clinicians retiring in the next 5 years.</p> <p>Specialist oversight improves appropriate and cost-effective access to appropriate treatment for haemoglobinopathy patients, including chelation therapy prescribing and monitoring, annual review and by developing ODNs and ensuring compliance with ODN guidance through MDT review of individual patients' notes.</p>	
<b>Measures &amp; Payment Triggers</b>	
<p><b><u>Year One</u></b>  <b><u>Q1 Initial Network Meeting (10% Payment)</u></b>          Specialist haemoglobinopathy centre, identified by commissioners as part of contract negotiation, to arrange an initial network meeting with local providers and commissioners to produce a proposal which defines the local area of oversight and that defines the patient group whose treatment is to be compliant with ODN protocols. This meeting must include patient/carer representation and should consider inclusion of local voluntary organisations. Two or more specialist haemoglobinopathy centres may hold this meeting together but achievement of milestone will be judged on individual submissions. The report following the visits to Area Teams (to be published) should provide a framework for local discussions.  <i>Evidence: Meeting agenda and minutes. Proposal for commissioners defining geographical area and local providers, and also the patient group whose treatment is to be compliant with</i></p>	



ODN protocols. Terms of Reference for Network Group.

1. **Q1/2 Agreement of Pathways and Protocols (30% Payment)**

Commissioners to sign-off proposal. Specialist haemoglobinopathy centre to arrange network meeting with local providers and commissioners to describe care pathways and agree areas where protocols will need to be developed. This meeting must include patient/carer representation and should consider inclusion of local voluntary organisations. This meeting may be held at the same time as the meeting described above and again may include two or more specialist haemoglobinopathy centres with the same rules applied regarding achievement.

*Evidence: Meeting agenda and minutes. Including a description of care pathways and protocol areas which will need to be developed, a lead and a timescale for production.*

2. **Q3 Publication of care pathways and protocols & Arrangements for MDTs; Network meetings planned for 2017/18 (10% Payment)**

*Evidence: Copies of all care pathways to be submitted and evidence provided that they are embedded into practice (e.g. screen shot of protocols on trust intranet; evidence of network in use recorded in patient notes; meeting arrangements for MDTs to review patients' notes). Copy of email confirming time of place of 2017/18 meetings.*

3. **Q4. Proportion of haemoglobinopathy patients with care reviewed by MDT to assure it accords to agreed ODN protocols. (50% payment)**

*Evidence: MDTs in place, patients reviewed, number of haemoglobinopathy patients.*

**Year two and three (subject to achievement of previous year triggers – otherwise subject to local adjustment):**

Descriptions	Second Year	Third Year
<b>Trigger 1:</b>	Baseline report (annual, Q1)	Baseline report (annual Q1)
<b>Trigger 2</b>	Evidence of governance arrangements (quarterly reports)	Evidence of governance arrangements (quarterly reports)
<b>Trigger 3</b>	% of total registered patients in ODN attending for annual review at the Lead / Specialist Centre and plan to demonstrate performance to target of 85% by end of Yr 3 (quarterly reports)	% of total registered patients in ODN attending for annual review at the Lead / Specialist Centre and plan to demonstrate performance to target of 85% by end of Yr 3 (quarterly reports)
<b>Trigger 4</b>	Improvement in agreed patient satisfaction and outcome measure(s) (quarterly against baseline)	Improvement in agreed patient satisfaction and outcome measure(s) (quarterly against baseline)

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	Second Year	Third Year
Trigger 1	20%	10%
Trigger 2	30%	10%
Trigger 3	25%	40%
Trigger 4	25%	40%
<b>TOTAL</b>	100%	100%

**Definitions**

Lead and Specialist Centres – as per West Midlands Quality Review Service peer review programme definitions – see reports <http://www.wmqrns.nhs.uk/review-programmes/view/haemoglobin-disorders-2014-16-reviews-adults-and-children>

Annual review – To include Trans-Cranial Doppler screening for all eligible SCD patients and cardiac and liver MRI where indicated for patients with thalassaemia. Centre protocol to be provided

Registered patients – all patients in contact with haemoglobinopathy care services for their SCD or thalassaemia from 1<sup>st</sup> April 2015.

**Partial achievement rules**Year One

Payments in Q1, Q2 and Q3 are paid if achieved on time in full.

Payment of Q4 milestone: under 50% achievement – no payment; above 90% achievement:

Full payment; between 50 and 90% paid according to % achieved

Year Two

Trigger 1: all-or-nothing

Trigger 2: all-or-nothing

Trigger 3: strictly-proportional - under 50% achievement – no payment; above 90% achievement: Full payment; between 50 and 90% paid according to % achieved

Trigger 4: strictly-proportional - under 50% achievement – no payment; above 90% achievement: Full payment; between 50 and 90% paid according to % achieved

Year Three

Trigger 1: all-or-nothing

Trigger 2: all-or-nothing

Trigger 3: strictly-proportional - under 50% achievement – no payment; above 90% achievement: Full payment; between 50 and 90% paid according to % achieved

Trigger 4: strictly-proportional - under 50% achievement – no payment; above 90% achievement: Full payment; between 50 and 90% paid according to % achieved

### **In Year Payment Phasing & Profiling**

In line with milestones

### **Rationale for inclusion**

Clinical consensus states that specialised haemoglobinopathy care should be organised on a clearly defined network basis. This is set out in the following published standards:

<http://sicklecellsociety.org/wp-content/uploads/2016/02/Standards-for-the-Clinical-Care-of-Adults-with-Sickle-Cell-Disease-in-the-UK.pdf>

<http://www.ukts.org/pdfs/awareness/standards2008.pdf>

Providers should be part of an ODN for Haemoglobinopathy. Patients with haemoglobinopathy should have access to appropriate treatments in accord with ODN guidelines. This to be achieved through the development of protocols that will be implemented by MDT review of individual patients' notes.

This CQUIN is to support specialist haemoglobinopathy centres to work with commissioners and the wider haemoglobinopathy community to define and develop networks of care for patients with haemoglobin disorders.

The CQUIN focuses on developing partnership working across services which treat patients with haemoglobinopathies to define pathways and protocols; these may be commissioned through NHS England or through other commissioners

The establishment of these networks and the defining of local protocols for care has been slow across England; this CQUIN aims to prioritise and support the allocation of resource in order that these models of care may be progressed. There have been recent deaths reported which may have been prevented if protocols for access to specialist care had been in place and followed.

### **Data Sources, Frequency and responsibility for collection and reporting**

Each specialist haemoglobinopathy service to submit routine data the National Haemoglobinopathy Registry

*Determination following ODN set up and scope definition: To add measure of patients whose care should be in accordance with policy.*

### **Reporting of Achievement against Triggers**

Evidence of compliance with requirements of this CQUIN to be submitted directly to commissioners by trusts hosting a specialist service

Trigger 1: Baseline report – by Trust to commissioning team (annual, Q1)

Trigger 2: Evidence of governance arrangements – by Trust to commissioning team (quarterly reports)

Trigger 3: % of total registered patients in ODN attending for annual review at the Lead / Specialist Centre and plan to demonstrate performance to target of 85% by end of Yr 3 – by

Trust to commissioning team (quarterly reports) Trigger 4: Improvement in agreed patient satisfaction and outcome measure(s) - by Trust to commissioning team (quarterly against baseline)	
<b><u>Information for Benchmarking and Evaluation</u></b> <ul style="list-style-type: none"> <li>• WMQR peer review report for the centre / ODN providers</li> <li>• National Haemoglobinopathy Registry data</li> <li>• Trust reported data on activity</li> <li>• Trust reported information on governance</li> </ul>	
Baseline period/ date & Value	
Final indicator period/date (on which payment is based) & Value	As above
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b>  <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	Three years will allow new procedures to be embedded and costs to flow into reference costs for inclusion in prices

**Supporting Guidance and References**

None

## 5 CA1/IM1 Enhanced Supportive Care

Scheme Name	<i>IM1: Enhanced Supportive Care – Non Cancer pathways</i> <i>CA1: Enhanced Supportive care – Cancer pathways</i>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any]
Duration	April 2016 to March 2019
<p><b><u>Problem to be addressed</u></b></p> <p>There is growing evidence that good supportive care, provided early to patients with advanced progressing cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatment near the end of life. The same approach is likely to be of benefit in other disease areas.</p> <p>Part A: Cancer Services Approximately 20 Cancer Centres commenced this scheme in 2016-17. For 2017/18 and 2018/19 this scheme is a priority for these existing Cancer Centres to continue with existing patient groups, and for these providers to consider extending the programme to new cancer groups.</p> <p>The scheme will involve implementation of the Enhanced Supportive Care approach originally developed at the Christie NHS Foundation Trust alongside adoption of best practice to optimise treatment in patients with advanced progressing disease (in the disease areas specified above).</p> <p>Part B: Non Cancer services Part B Scheme is also available for introduction of the scheme in centres treating complex hepatopancreatobiliary (HPB) diseases. Existing Cancer centres may also wish to participate in the IM1 scheme for this or other disease areas.</p>	
<p><b><u>Change sought:</u></b></p> <p>The scheme seeks to ensure that patients with advanced cancer and/or advanced Hepatopancreatobiliary (HPB) disease are offered early referral to a Supportive Care Team, to secure improved outcomes and avoidance of inappropriate aggressive treatment.</p> <p>Implementation of the Enhanced Supportive Care approach within specified patient populations. This approach is outlined in the NHS England Guideline document (<a href="https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf">https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf</a> ).</p> <p>This involves a series of recommended service principles: (1) earlier involvement of the supportive care team with the oncology team, (2) supportive care teams that work together, ideally under one umbrella, and have recognition in their centres as a core part of the business (3) a positive approach to supportive care, (4) cutting edge and evidence based practice in supportive and palliative care, (5) technology to improve communication.</p> <p>These improvements in care will require costs to be incurred in raising the standard of care to</p>	

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that of the ESC model and in reaching more patients. The approach will require more intensive MDT input to patient care and may also require system and technology investment.

The use of CQUIN monies will be individual to each provider and available for adoption of Part A and / or Part B of the scheme. Costs may be incurred to increase the capacity of existing palliative / supportive care teams to promote the development of an Enhanced Supportive Care service and in communications systems and technology to allow remote oversight.

**Section B. CONTRACT SPECIFIC INFORMATION** (for guidance on completion, see corresponding boxes in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2016/17 <sup>3</sup> , 2017/18, 2018/19 <i>[Adjust locally]</i> One/two years <i>(Adjust locally)</i>  <i>[Other – as specified in C2: including whether Part A Part B or both parts.]</i>
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>

**B4. Payment Triggers.**

The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

***[Adjust table as required for this scheme – or delete if no provider-specific information is required.]***

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		

<sup>3</sup> I.e. scheme was contracted for first implementation in 2016/17, and this template is setting out requirements for 2<sup>nd</sup> (and perhaps 3<sup>rd</sup>) year of scheme.

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Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month for each part of the scheme adopted , reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

**C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

This scheme is applicable to:

- Providers who are currently working to this CQUIN during 2016-17 should be offered the CA1 scheme as a priority, to: (i) ensure embedding and evaluation; and (ii) expand into additional cancer disease specific populations.
- Providers of Hepato pancreatobiliary (HPB) disease care to patient groups with advanced stages of those conditions should be offered the IM1 scheme.

It should be noted that the CA1 Part A scheme should not be offered to providers that are not currently working on this CQUIN during 2016-17. This is because the scheme requires further evaluation and, given that it places a high burden on palliative care teams, it is considered important to complete evaluation prior to wider rollout.

For HPB, the following is a list of eligible providers, with some marked as priority for the offer of this scheme:

**epatobiliary Providers (\*priority)**

- \*Addenbrooke's Hospital\*
- Bradford Royal Infirmary
- Burnley General Hospital
- Castle Hill Hospital
- Charing Cross Hospital

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- Cheltenham General Hospital
- Churchill Hospital
- City Hospital
- Derriford Hospital
- \*Freeman Hospital\*
- Glenfield Hospital
- Hurstwood Park Centre
- \*King's College Hospital (Denmark Hill)\*
- Leeds General Infirmary
- Manchester Royal Infirmary
- Musgrove Park Hospital
- Nottingham University NHS Trust - Queen's Medical Centre Campus
- Queen Alexandra Hospital
- Queen Elizabeth Hospital
- Royal Bournemouth And Christchurch NHS Trust
- Royal Cornwall Hospital (Treliske)
- Royal Devon & Exeter Hospital (Wonford)
- Royal Free Hospital
- Royal Oldham Hospital
- Royal Surrey County Hospital
- Sheffield Teaching Hospitals
- Southampton General Hospital
- Southmead Hospital
- The Royal Liverpool University Hospital
- \*The Royal London Hospital\*
- The Royal Marsden Hospital (London)
- University College London Hospitals NHS Foundation Trust
- University Hospital (Coventry)
- \*University Hospital Aintree\*
- University Hospital Bristol
- York Hospital

<b>C2. Provider Specific Parameters</b>	
<p><i>The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)</i></p>	<p>Patient Group(s) included, which may include:</p> <ul style="list-style-type: none"> <li>• Cancer groupings</li> <li>• Hepatobiliary end stage disease</li> <li>• Number of additional patients in each year</li> </ul>
<b>C3. Calculating the Target Payment for a Provider</b>	
<p>The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:</p>	



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The CQUIN payment for each part of the scheme adopted is set at (N\*£600) where N is the estimated number of total eligible patients in which it is agreed that the ESC approach should be targeted to (in addition to those who would receive such support under existing arrangements outside of the CQUIN initiative).

A deduction from the £600 per patient payment is made for any activity payment that implementation would attract (e.g. outpatients appointment payments).

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year	Third Year (where applicable)
<b>Trigger 1:</b>	Clinical Lead for Enhanced Supportive Care nominated.	Clinical Lead for Enhanced Supportive Care in place	Clinical Lead for Enhanced Supportive Care in place
<b>Trigger 2</b>	Baseline Audit undertaken and ongoing data collection arrangements in place.	Baseline Audit undertaken and ongoing data collection arrangements in place for new patient populations	Baseline Audit undertaken and ongoing data collection arrangements in place for new patient populations
<b>Trigger 3</b>	Improvement targets established for proportion of patients within targeted population offered referral to ESC	Improvement targets established for proportion of patients within targeted populations offered referral to ESC	Improvement targets established for proportion of patients within targeted population offered referral to ESC
<b>Trigger 4</b>	Delivery against agreed improvement Targets – demonstrated through return of ESC data tool to local commissioner	Delivery against agreed improvement Targets – demonstrated through return of ESC data tool to local commissioner	Delivery against agreed improvement Targets. demonstrated through return of ESC data tool to local commissioner
<b>Trigger 5</b>			

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**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	First Year of scheme	Second Year	Third Year
Trigger 1	10%	10%	10%
Trigger 2	10%	10%	10%
Trigger 3	20%	20%	20%
Trigger 4	60%	60%	60%
Trigger 5	-	-	-
<b>TOTAL</b>	100%	100%	100%

**Partial achievement rules applicable to each part of the scheme**

For Trigger 4 partial achievement

60% is paid on demonstration of the proportion of the target patient population offered access to Enhanced Supportive Care in line with agreed targets for improvement. If 80% of eligible patients, for that period, have been offered referral to the Enhanced supportive Care team then that should be seen as good enough performance to generate the final 60% payment. If performance is below this level then payment is made in line with the performance achieved (e.g. the providers gets 70% of the final payment if they deliver 70% of eligible patients referred to the Enhanced Supportive Care Team.)

**Definitions**

For Trigger 4:

**Numerator:** Number of patients who are offered referral to a Supportive Care Team at the point of diagnosis of incurable disease

**Denominator:** Total number of new diagnosis of incurable disease in those disease group areas where the ESC initiative is being focussed. Where a provider is already receiving funding outside of CQUIN to provide ESC for some patients then the denominator should be set as the additional patients meeting the eligibility criteria to whom the service will be extended.

<b>C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.</b>
<p><i>A reporting tool has been developed to support the reporting of data for this initiative. This includes baseline data on:</i></p> <p><i>Data to support achievement of the CQUIN Triggers</i></p> <p><i>And evaluation data to capture the impact of this initiative on emergency referrals and 30 day mortality and patient QoL.</i></p>
<p><b><u>Information for Evaluation</u></b></p> <p>Audit Data against 5 key standards of Enhanced Supportive Care.</p> <p>Quality of Life impact, Chemo 30 Day Mortality Impact (or equivalent measure for non cancer disease areas), and Emergency Admissions impact.</p>
<p><b><u>Reporting of Achievement against Triggers</u></b></p> <p>Baseline Data on the estimated number of patients in each targeted disease group.</p> <p>Quarterly reporting on numbers of patients offered referral to ESC against total patient population.</p>
<p><b><u>Reporting Template requirement</u></b></p> <p><u>A standard reporting template has been developed for the 16-17 CQUIN</u></p>
<b>C6. Supporting Guidance and References</b>
<p><a href="https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-ehncd-supprtv-care-guid.pdf">https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-ehncd-supprtv-care-guid.pdf</a></p> <p><a href="https://www.england.nhs.uk/2016/03/richard-berman/">https://www.england.nhs.uk/2016/03/richard-berman/</a></p> <p><a href="https://www.england.nhs.uk/2016/07/early-supportive-care/">https://www.england.nhs.uk/2016/07/early-supportive-care/</a></p>
<b>D. Scheme Justification</b>
<b>D1. Evidence and Rationale for Inclusion</b>
<p>Enhanced Supportive Care has developed through recognition of what specialist palliative care can offer. It is a cost-effective and life-extending approach to treatment of patients with incurable cancer or other terminal disorders, but also from recognition of the barriers to achieving earlier involvement of palliative care expertise within the treatment continuum. These barriers may be largely due to the perception of palliative care by the public, patients</p>

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and many health professionals – in particular the association with care at the very end of life. The excellent care that is provided for patients who are nearing the end of life needs to be extended to support them earlier – from the point of diagnosis with incurable disease.

There is growing evidence that good supportive care, provided early to patients with advanced progressing cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatment near the end of life.

- Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer, Temel JS et al, N Engl J Med 2010; 363:733-742 August 19, 2010.

Early palliative care for patients with advanced cancer: a cluster-randomised controlled trial, The Lancet, Dr Camilla Zimmermann.

- Effect of early palliative care on chemotherapy use and end-of-life care in patients with metastatic non-small-cell lung cancer, Greer J A et al, Journal of Clinical Oncology, 2012.

- Nice 2004; Guidance on Cancer Services; Improving Supportive and Palliative Care for Adults with Cancer.

DH 2010; Living with and Beyond Cancer – Taking Action to Improve Outcomes (National Cancer Survivorship Initiative).

- Palliative and Supportive Care: Early Versus Delayed Initiation of Concurrent Palliative Oncology Care: Patient Outcomes in the ENABLE III Randomized Controlled Trial - Marie A. Bakitas, Journal of Clinical Oncology May 1, 2015:1438-1445; published online on March 23, 2015; DOI:10.1200/JCO.2014.58.6362.

- Srivastava P et al. The benefits of early integration of palliative care as a part of standard outpatient oncology care. Journal of Clinical Oncology. 2014;32. [Evidence is required to support:

### **Rationale of Use of CQUIN incentive**

There is growing evidence that good supportive care provided early to patients with advanced progressing cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatment near the end of life. It is suggested that the interface with supportive care services could also benefit other patient groups with life limiting diseases.

Enhanced Supportive Care has developed through recognition of what specialist palliative care can offer – as a cost-effective and life-extending approach to treatment of patients with incurable disease, but also from recognition of the barriers to achieving earlier involvement of palliative care expertise within the specialised treatment continuum. These barriers may be largely due to the perception of palliative care by the public, patients and many health professionals – in particular the association with care at the very end of life. The excellent care that is provided for patients who are nearing the end of life needs to be extended to support them earlier – from the point of diagnosis with incurable disease.

This scheme will expand the implementation of the Enhanced Supportive Care approach which has been piloted at the Christie NHS Foundation Trust, alongside adoption of best practice to optimise treatment (e.g. Chemotherapy) in patients with advanced progressing disease.

The approach is in line with recommendation 49 and section 5.7 of Achieving World-Class Cancer Outcomes - A Strategy for England 2015-2020 which references the Christie pilot.

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The key high-level Impacts are summarised as follows:

- Reduction in the need for aggressive interventions in the last days / weeks of life.  
The project will seek to achieve a 25-50% reduction from baseline in 30 day chemotherapy mortality within those cancer services that adopt the programme.
  
- Improved Patient Quality of Life – Measured through a patient questionnaire  
The project will seek to achieve statistically significant improvement in Quality of Life from baseline.
  
- Reduction in Cost of Treatment  
Reduced hospital admissions  
Reduction in length of stay  
Fewer intensive care hospital days  
Reduced cost of therapy in patients with advanced progressing disease

Intended Benefits of this approach:

For Patients	For Commissioners	For Providers
<ul style="list-style-type: none"> <li>-Coordinated and timely supportive care</li> <li>-Informed choice of treatment from an early stage</li> <li>-Involves patients in decision making about treatment</li> <li>-Improved patient experience and quality of life.</li> <li>-Optimise the use of chemotherapy and reduce the need for aggressive interventions in the last days or weeks of life</li> </ul>	<ul style="list-style-type: none"> <li>-Reduced costs through avoidance of untimely treatments and reduction in inappropriate treatment at end of life.</li> <li>-Delivers the right treatment to the patient at the right time</li> <li>-Optimise the use of therapy in advanced cancer</li> </ul>	<ul style="list-style-type: none"> <li>-Improves patient experience.</li> <li>-Improves communications between specialties and the different elements of supportive care services..</li> <li>-Delivers the right treatment to the patient at the right time.</li> </ul>

**D2. Setting Scheme Duration and Exit Route**

Provided the intended system wide benefits are being realised the approach to mainstreaming Enhanced Supportive Care needs to be developed early in 2017-18 – allowing providers who commenced the CQUIN in 2016-17 to move out of the scheme for 2018-18 with a mainstreamed approach. Mainstreaming will involve agreeing a sustainable funding mechanism and agreeing the responsibilities of non-specialised commissioners in supporting the Enhanced Supportive Care approach (building on the current funding of supportive and specialist palliative care services)

**D3. Justification of Size of Target Payment**

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payment is an estimated payment to adequately cover the costs of additional investment in supportive and palliative care teams in line with experience at The Christie NHS Foundation Trust and the first year of the CQUIN during 2016-17.

**D4. Evaluation**

**Evaluation**

Data collected through the scheme using the data-collection tool will be used to undertake a central evaluation of the scheme at the end of 16-17 and 17-18.

## 6 CA2 Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)

Scheme Name	<b>CA2: Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT)</b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any : Add Locally]
Duration	One or Two Years from April 2016 or from April 2017
<p><b><u>Problem to be addressed</u></b></p> <p>Chemotherapy is the single biggest service area within NHS England’s specialised commissioning spend. It is estimated that NHS England spends approximately £1.5 billion on the routine commissioning of chemotherapy, with drug costs (which are paid by NHS England as pass through payments) being 80% of this. There is a very high rate of annual cost growth of approximately 8%.</p> <p>Standardisation of chemotherapy doses offers one avenue for achieving improved value in this area – with clear system wide benefits.</p> <p>Traditionally, chemotherapy doses have been unique to individual patients based on a per kg calculation. Such specific dosing does not provide additional clinical or patient benefit and significantly increases time and costs of preparation and costs of drug wastage. Additionally, standardised dosing will allow standardisation of the chemotherapy products available by diluent, volume and labelling which will allow access to ready to administer chemotherapy from generic and NHS manufacturers.</p> <p>Dose Standardisation is achieved through a standardised approach to dose banding across England. The approach is in line with the Efficiency and Productivity review undertaken by Lord Carter, which recommends the elimination of waste through a consistent approach to patient care. The HopMOp team have been closely involved with this initiative.</p> <p>Dose banding can be described as a “system whereby doses of intravenous cytotoxic drugs are calculated on an individualised basis that are within defined ranges, or bands, and are rounded up or down to pre-determined standard doses”.</p>	
<p><b><u>Change sought</u></b></p> <p>Implementation of nationally standardised doses of SACT across England using the dose-banding principles and dosage tables published by NHS England (developed through the Medicines Optimisation Clinical Reference Group).</p> <p>It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of SACT drugs in accordance with a nationally approved set of dose tables.</p> <p>Providers will be expected to:</p> <ol style="list-style-type: none"> <li>1. Have the principles of dose banding accepted by their local oncology and haematology teams.</li> <li>2. Have the drugs and doses approved by their local formulary committees.</li> </ol>	

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3. Have SACT prescribed in accordance with the doses of drugs listed in the national dose-banding tables.
4. Agreement and adoption of standardised product definitions

This approach should expand on the 19 SACT agents with standardised dosing tables developed for 2016-17 – implementing standard doses for a new range of SACT agents.

### **Original List of 19 SACT Agents for Dose Standardisation in 2016-17 and onwards**

Bendamustine  
Bortezomib SC  
Carboplatin  
Cisplatin  
Cyclophosphamide (Pick and Mix)  
Docetaxel  
Doxorubicin (Pick and Mix)  
Epirubicin (Pick and Mix)  
Fluorouracil (Pick and Mix)  
Fluorouracil (single unit)  
Gemcitabine (100mg/mL)  
Gemcitabine (38mg/mL)  
Irinotecan  
Oxaliplatin  
Paclitaxel  
Pemetrexed  
Rituximab (Infusion)  
Vinblastine  
Vincristine

### **Additional SACT Agents for Dose Standardisation in 2017-18 and 2018-19 and onwards**

Amsacrine  
Arsenic Trioxide  
Azacitidine  
Bevacizumab  
Cabazitaxel  
Carfilzomib  
Cetuximab  
Cladribine (Leustat)  
Cladribine (LITAK)  
Clofarbine  
Cytarabine  
Dacarbazine  
Daunorubicin  
Doxorubicin Lipsomal (Caelyx)  
Etoposide  
Fludarabine (IV)  
Idarubicin  
Ifosfamide  
Mesna  
Methotrexate  
Mitomycin



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Mitoxantrone  
 Nab-Paclitaxel  
 Nivolumab  
 Pembrolizumab  
 Pentostatin  
 Streptozocin  
 Thiotepa  
 Topotecan (IV)  
 Vinflunne  
 Vinorelbine (IV)

**Additional Drugs will be added as new drugs and dose bandings become available.**

**Section B. CONTRACT SPECIFIC INFORMATION** (for guidance on completion, see corresponding boxes in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2016/17 <sup>4</sup> , 2017/18, 2018/19 <i>[Adjust locally]</i> One/two years <i>(Adjust locally)</i>  <i>[Other – as specified in C2.]</i>
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>

**B4. Payment Triggers.**  
 The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.  
  
 Relevant provider-specific information is set out in this table.  
  
***[Adjust table as required for this scheme – or delete if no provider-specific information is required.]***

Provider specific triggers	2017/18	2018/19
Trigger 1:		

<sup>4</sup> I.e. scheme was contracted for first implementation in 2016/17, and this template is setting out requirements for 2<sup>nd</sup> (and perhaps 3<sup>rd</sup>) year of scheme.

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<b>Baseline</b>		
<b>Trigger 1: Stretch level</b>		
<b>Trigger 2: Baseline</b>		
<b>Trigger 2 stretch</b>		
<b>Trigger 3</b>		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

***Universal Uptake Scheme***

All providers of Chemotherapy services that prescribe any of drugs on the listed drugs above.

**C2. Provider Specific Parameters**

The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	SACT Agents prescribed by provider from the above list Number of Doses administered Number of Doses administered in accordance with national dose banded tables Number of SACT agents to be standardised in year one/year two
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**C3. Calculating the Target Payment for a Provider**

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

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**<1% of the annual value of chemotherapy drug spend that is to be standardised by the end of Q4, for each year>.**

To set the CQUIN payment amount on this basis, as is required, necessitates a judgement in advance of contract signing and thus in advance of formal baseline assessment of the intended scope and approximate value of the intended scope of dose standardisation in the financial year.

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year and Third year (where applicable)
<b>Trigger 1:</b>	Collection of baseline-data for the range of drug doses that are to be standardised as agreed with the commissioner	Collection of baseline-data for the range of drug doses that are to be standardised as agreed with the commissioner
<b>Trigger 2</b>	Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required.	Local Drugs and Therapeutics committee have agreed and approved principles of dose standardisation and dose adjustments required.
<b>Trigger 3</b>	Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug) ; including confirmation of transition from local previously agreed QIPP arrangements (if any) such as legacy gain share.	Targets to be agreed for end of year achievement in relation to the % of doses standardised per drug (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug); including confirmation of transition from local previously agreed QIPP arrangements (if any) such as legacy gain share.
<b>Trigger 4</b>	Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs.	Trust agreement and adoption of standard product descriptions (where these are available) for individual chemotherapy drugs.

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**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>All Years</b>
<b>Trigger 1</b>	10%
<b>Trigger 2</b>	10%
<b>Trigger 3</b>	60%
<b>Trigger 4</b>	20%
<b>TOTAL</b>	100%

**Partial achievement rules**

Triggers 1,2,4: All or Nothing.

For Trigger 3 partial achievement:

The Commissioner will be able to review the data submitted and, where exceptions apply, will be able to agree the full CQUIN payment. In particular where participation in a trial precludes the use of dose-banded SACT.

**Definitions**

For Trigger 3:

**Numerator:** number of SACT doses prescribed of selected drugs that match to the standardised doses

**Denominator:** number of SACT doses prescribed of selected drug

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

**Reporting of Achievement against Triggers**

Baseline Data on drug doses that are to be standardises as agreed with the commissioner

Quarterly reporting on achievement in relation to the % of doses standardised per drug.

**Reporting Template requirement**

A standard reporting template has been developed for the 17-18 CQUIN.

**C6. Supporting Guidance and References**

**The Dose Standardisation Tables and further guidance are published here:**  
<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-b/b02/>

**Section D. SCHEME JUSTIFICATION**

**D1. Evidence and Rationale for Inclusion**

The Efficiency and Productivity review undertaken by Lord Carter recommends elimination of waste through a consistent approach to patient care. The standardisation of chemotherapy dosing is supported by NHS England, through the Medicines Optimisation CRG, having considered the efficiencies to be achieved on a national scale by adopting a single approach.

In Scotland, where dose banding of SACT has been established for a number of years, it has been estimated that 60-70% of all SACT administered is in the form of dose banded preparations. There is still significant potential for the adoption of a single standardised set of doses for a range of SACT drugs across England.

Alongside standardised doses, the next step is also to standardise the chemotherapy products by diluent, volume and labelling. This is the precursor to accessing ready to administer chemotherapy from the generic and NHS manufacturers.

This approach will simplify the process for any Trusts who wish to outsource readymade chemotherapy syringes and bags. Outsourcing has the potential to further reduce costs to the NHS. Having a single set of national dose tables will allow NHS and commercial providers of outsourced chemotherapy to produce the same doses leading to economies of scale and efficiency.

**Intended Benefits:**

For Patient	For Commissioner	For Provider
<p>Fewer dose calculation errors</p> <p>Reduced patient waiting times – chemo is ready to give</p> <p>Facilitation of Administration of chemotherapy on any chosen day</p> <p>Supports treatment of patients closer to home</p>	<p>Same doses used across every provider in England</p> <p>Reduced cost through: Reduced Wastage (by re-use of cancelled doses and avoidance of incomplete vial usage during production)</p> <p>Allows outsourcing of standardised chemotherapy products.</p>	<p>Reduced bespoke pharmacy preparation workload.</p> <p>Maximises opportunities for financial efficiency through outsourcing of standardised chemotherapy product.</p> <p>Fewer dose calculation errors.</p> <p>Reduction in prescription alterations.</p> <p>Quicker dispensing through</p>

		use of pre-prepared doses.
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### **Rationale of Use of CQUIN incentive**

Incentivise the adoption, at pace, of standardised chemotherapy doses and products across England. The incentive payment will support providers with agreements that need to be reached with local oncology and haematology teams, approval of standardised doses at local formulary committees, agreement and implementation of standard product specification and monitoring and reporting of progress in achieving dose standardisation.

### **D2. Setting Scheme Duration and Exit Route**

It is anticipated that by the end of 2018/19 dose standardisation will be part of mainstream NHS delivery of chemotherapy and further incentivisation will not be required.

### **D3. Justification of Size of Target Payment**

This is an estimated proportional payment to incentivise at pace and at scale adoption of dose standardisation.

### **D4. Evaluation**

Data collected through the scheme using the data-collection tool will be used to undertake a central evaluation of the scheme at the end of each financial year.

## 7 CA3 – Optimising Palliative Chemotherapy Decision Making

<b>Scheme Name</b>	<b>CA3 – Optimising Palliative Chemotherapy Decision Making</b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any]
Duration	April 2017 to March 2019
<p><b><u>Problem to be addressed</u></b></p> <p>Systemic Anti-Cancer Treatment (SACT) can play an important role in extending life in patients with advanced disease, acknowledging also that the beneficial and harmful effects of treatment must be carefully balanced and regularly reviewed.</p> <p>All decisions regarding the starting and continuation of chemotherapy for patients with advanced cancer with/without a poor performance status cannot practically be taken back to the full multi-disciplinary team meeting to discuss, review and endorse. However, such decisions can often be close to the boundary between overall patient benefit and harm.</p> <p>To ensure optimal care it is therefore appropriate that, in specific groups of patients, decisions to start and continue further treatment should be made in direct consultation with peers and then as a shared decision with the patient.</p> <p>This scheme is integral to the overall development of chemotherapy services and, as such, is complementary, but not dependent, to both Dose Banding and Enhanced Supportive Care (ESC) CQUINs.</p>	
<p><b><u>Change sought</u></b></p> <p>That documented peer discussion takes place when making decisions regarding the commencement or continuation of chemotherapy (irrespective of the funding arrangements for the chemotherapy agent, i.e., CDF or routinely commissioned) for patients that fall within the following groups (acknowledging that such decisions cannot practically be taken back to the full multi-disciplinary team meeting to discuss, review and endorse):</p> <ol style="list-style-type: none"> <li>a. Commencement or continuation of chemotherapy in any patients with a performance status (PS) of 2-4 (PS2: up and about &gt;50% of waking hours; PS3: confined to bed or chairs &gt;50% of waking hours; PS4: totally confined to bed or chair)</li> <li>b. Commencement of 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup> line and beyond treatments in patients being treated with non-curative intent who have demonstrated outright disease progression on the previous line of therapy (ie those patients whose only response to that line of therapy has been progression of disease)</li> </ol> <p>Peer discussion does not require a full MDT, but peer opinion needs to be sought and documented from the Team involved with the care of the patient e.g. specialist nurse, palliative care team member, oncology colleague.</p>	

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Chemotherapy providers are asked formally to review existing practice in relation to such decisions and put in place procedures to allow for effective and documented peer discussion where not currently in place.

This scheme will strengthen current shared decision making and informed consent practices. Providers are asked to review local practices in order to incorporate the output of the MDT / peer discussion and improve the information that individual patients receive about the the benefits and disbenefits of treatment options.

Providers are asked to ensure that the requirements relating to the monitoring, review and reporting relating to 30 day mortality following chemotherapy set out within the chemotherapy service specification are adhered to. In addition, providers are asked to ensure that consultant level 30 day mortality data is regularly sent to individual consultants to enable continued professional development.

This scheme will bring about a change in practice within oncology teams and better support clinicians and patients to make treatment decisions. This is different to ESC, which enables early contact with supportive and palliative care teams (at the point of diagnosis of terminal disease); it is considered that where both schemes are in operation there may be synergies as clinicians and patients may feel better able to decline chemotherapy (following MDT / peer discussion) because there are effective ESC arrangements in place. However, this scheme can also be offered where ESC is not in place, as it facilitates change within oncology teams.

### **Section B. CONTRACT SPECIFIC INFORMATION** *(for guidance on completion, see corresponding boxes in sections C below)*

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>Insert name of provider --</i>
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2017/18, 2018/19 [ <i>Adjust locally</i> ] One/two years ( <i>Adjust locally</i> )  <i>[Other – as specified in C2.]</i>
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>
<b>B4. Payment Triggers.</b> The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.	



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Relevant provider-specific information is set out in this table.

***[Adjust table as required for this scheme – or delete if no provider-specific information is required.]***

Provider specific triggers	2017/18	2018/19
Trigger 1:		
Trigger 2:		
Trigger 3		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

***Nature of Adoption Ambition:*** FOR UNIVERSAL UPTAKE

This scheme is appropriate for all providers of chemotherapy services, irrespective of whether ESC is also being delivered.

**C2. Provider Specific Parameters**

The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)

The cohorts of patients, meeting criteria listed in section A, to be included in the scheme.

**C3. Calculating the Target Payment for a Provider**

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The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

**<For each year, target CQUIN payment of <£35,000 plus (£40 times the number of patients commencing treatment meeting the criteria listed in Section A in the last full year available from SACT data).>**

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

<b>Descriptions</b>	<b>First Year of scheme</b>	<b>Second Year</b>
<b>Trigger 1:</b>	Review of current practice in relation to peer decision making and shared decision making in the patient cohorts defined in section A above.	Progress against targets set in year 1 Trigger 3.
<b>Trigger 2</b>	Review of current practice in relation to 30 day mortality reviews ensuring that monthly 30 day mortality review meetings are in place to review all deaths within 30 days of chemotherapy and that consultant specific 30 day mortality data is feedback on a regular basis to individual consultants.	
<b>Trigger 3</b>	Documented improvement plan against all aspects of triggers 1 and 2 agreed and shared. Including % targets set for improvement in relation to number of cases where a documented peer discussion takes place prior to commencement of continuation of treatment within the patient cohorts defined above.	
<b>Trigger 4</b>	Review audit against improvement plans, including review of % of patients within defined cohorts with a recorded peer discussion	

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**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	First Year of scheme	Second Year
Trigger 1	25%	100%
Trigger 2	25%	
Trigger 3	25%	
Trigger 4	25%	
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

% of final payment delivered to be agreed with local commissioner in line with extent of improvement delivered. Full payment should be made where there is demonstrable evidence of implementation of all aspects of the Trusts improvement plan – resulting in quantifiable improvement in the % of patients with documented evidence of peer discussion.

During Year 1, a greater proportion of payment is related to the system development work required to improve outcomes; in Year 2, the payment should relate more to achievement of a substantially higher proportion of patient care decisions appropriately reviewed.

**Definitions**

Not Applicable

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

**Reporting of Achievement against Triggers**

Review of SACT / Trust level data to identify all patients that fall within the 2 defined cohorts:

- i) Patients treated with chemotherapy who have a performance status (PS) of 2-4 (PS2: up and about >50% of waking hours; PS3: confined to bed or chairs >50% of waking hours; PS4: totally confined to bed or chair)
- ii) Patients treated with non-curative chemotherapy at 2nd, 3rd, 4th line and beyond

And review of Notes to baseline and audit improvement in % of cases where a documented peer discussion takes place prior to commencement of continuation of treatment within the patient cohorts defined above.

Review of SACT data to baseline and audit whether all patient deaths within 30 days of

chemotherapy are reviewed.
<b>Reporting Template requirement</b> A reporting template will be developed.
<b>C6. Supporting Guidance and References</b>
N/A
<b>Section D. SCHEME JUSTIFICATION</b>
<b>D1. Evidence and Rationale for Inclusion</b>
<b><u>Evidence Supporting Intervention Sought</u></b>
<p>30 Day Chemotherapy mortality can be a useful indicator of avoidable to harm to patients from SACT. The recent Public Health England published report “Trust-level 30-day mortality after systemic anticancer treatment for breast and lung cancer in England” found that 30 day mortality is:</p> <ul style="list-style-type: none"> <li>• Higher than expected based on findings from previous RCTs in patients receiving curative systemic anticancer therapy for both breast and lung cancer.</li> <li>• Higher for breast and NSCLC patients treated with the intent of relieving symptoms and extending lifespan (‘palliative’) compared with curative intent</li> <li>• Is higher for those that had a worse performance status score of 2-4 (symptomatic patients requiring any amount of bed rest during the day, or who were completely bed bound)</li> <li>• Varies significantly between Hospital Trusts.</li> <li>• The report recommends that Trusts with higher than average 30-day mortality should, as a priority, recheck their own mortality data and encourage treating teams to reflect on practice and service provision in team meetings, audit, mortality and morbidity meetings and through any other established governance processes they have.</li> </ul>
<b><u>Rationale of Use of CQUIN incentive</u></b>
CQUIN is being used to incentivise all providers of chemotherapy to review and audit their approach to decision making for the cohorts of patients described above, agree an improvement plan and deliver this. This will involve additional time and effort for oncology teams and audit departments to review and discuss their practice in this area.
<b>D2. Setting Scheme Duration and Exit Route</b>
This is a two year CQUIN scheme. The implementation costs of the shift in practice required are expected to be of a magnitude as can be absorbed within existing payments, once the new practice has been systematised over the course of the CQUIN.
<b>D3. Justification of Size of Target Payment</b>
<p>The value of the scheme has been based on a cost per patient of £23, which has been set using the cost of a telephone consultation as a benchmark, and noting that this conversation may be somewhat more involved than normal. The normal CQUIN uplift has been applied to yield £40 per patient CQUIN payment.</p> <p>In addition an allowance has been made for overhead costs associated with setting up and implementing the scheme.</p>

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Significant improvements in outcomes for patients, and avoidance of inappropriate chemotherapy drug utilisation, are expected to result, far outweighing the costs incurred.

**D4. Evaluation**

**Evaluation**

Data collection associated with the scheme should allow assessment of outcomes relative to existing practice, using a before and after comparison for the patients recorded on the SACT database as fitting into the categories described above in Section A.

## 8 GE1 Clinical Utilisation Review

Scheme Name	GE1 Clinical Utilisation Review
QIPP Reference	QIPP 16-17 S40-Commercial '17/18 QIPP reference to be added locally.
Eligible Providers	<p>This CQUIN is supported by the national CUR Framework, which has four accredited CUR suppliers. In order to secure the CUR CQUIN, NHS Providers will be required to procure from one of the suppliers identified on the CUR Framework.</p> <p><b><u>For '16/17</u></b> The CUR CQUIN is aimed at large NHS acute providers of specialised services.</p> <p><b><u>For '17/18 and '18/19</u></b> Those providers who have already implemented CUR in 2016/17 as part of a full first year CQUIN should now continue to implement and use the tool as part of the second and third years of this scheme.</p> <p>For providers who have undertaken successful CUR Local Learning Pilots (whether under the national CQUIN scheme or otherwise) in 2016/17, this scheme should be adopted as a full <u>first year</u> CQUIN scheme.</p> <p>[NB: The success of 16/17 CUR Local Learning Pilots will be determined by the Steering Groups set up to oversee their development who must use the national success criteria developed for this purpose. As the pilots will not be completed until March/ April 2017 a provisional CUR CQUIN will need to be agreed and a replacement scheme identified if required.]</p> <p>The total bed-base to be included in the CUR CQUIN is a minimum 400 beds in year 1, increasing to 600 beds in years 2. For those trusts who have less than 400 or 600 as their total bed base, and for year 3, implementation should cover the total applicable bed base.</p> <p>[NB: CUR can also be used in a Mental Health setting and is advocated for use by Providers to support the new MH4 Discharge CQUIN.]</p>
Duration	April 2016 to March 2019
Scheme Payment	<p>CQUIN payment should aim to achieve payment of the sum derived using the excel workbook, 'GE1 CUR CQUIN Calculator', available from the National Team and on the CQUIN website.</p> <p>2017/18 Target Value: <b>Add locally</b></p> <p>2018/19 Target Value: <b>Add locally</b></p>
<b>Scheme Description</b>	

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Clinical Utilisation Review (CUR) - Installation and Implementation; application and use leading to reduction in inappropriate hospital utilisation; reporting of results.

CUR is a proven approach, supported by robust medical intelligence in the form of an internationally developed clinical evidence base built into clinical decision-support software. CUR can help to prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need.

Use of the software as an integral part of Provider transformation/ service improvement programmes has provided information enabling the following benefits to be secured:

- Reduction in Length of Stay,
- Reduction in acute inpatient hospital admissions,
- Reduction in total acute inpatient hospital bed-days,
- Reduction in avoidable discharge delays,
- Reduction in unexplained clinical variation,
- Improved patient experience and satisfaction.

The behaviour sought by implementation of this CQUIN is:

- Establishment of project team and agreed plans for implementation of CUR;
- Implementation;
- Through use of the CUR solution a consequential reduction in bed utilisation at NHS Provider or whole system level;
- CUR Reporting and provision of patient level minimum dataset.

The software and training costs for implementing the CUR tool are estimated between £80,000 and £250,000 over a 3-year period, dependent on the number of beds and the chosen CUR software. Additional indirect costs, including the time required for staff training, IT costs (getting the system running and linked via Trust IT systems), hosting arrangements etc. are also taken account of in scaling the CQUIN payment.

Under the national CUR software Framework contract, licence costs are based on the total bed-base of the provider so a wider rollout in the hospital incurs no additional software cost.

Some of the savings achieved through CUR may be needed to commission gaps or capacity shortfalls in services that improve the flow of patients, once CUR has identified the reasons for patients remaining in inappropriate levels of care. Cash releasing savings will be dependent on local circumstances, and expectations should be explicit at the outset – reductions in length of acute stay may release cash where beds are closed as a consequence; where RTT pressures exist or would emerge in the absence of measures to reduce bed usage, savings are made as a result of cost avoidance – no expensive care outsourcing or additional estate required to meet demand pressures.

The level of ambition will need to be set year by year for each provider (subject to the minimum bed coverage in each year, set above) The aspiration is for year on year improvement through the course of the CQUIN scheme and sustained thereafter; achieving a reduction in bed days and admissions to levels achieved in leading health systems where CUR is embedded.

Improvement goals in each year will depend upon the level of 'criteria-not-met' admissions and bed-days, and the balance of effort on factors wholly within a provider's control, collaboration to improving pathways across the health economy using the capacity insights in the CUR tools

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yield.

Improvements in patient flow can be achieved progressively, with the first 12 months of implementation, following a 3 to 4-month period of data validation. Reductions in length of stay may take over 18 months to implement fully, and will be dependent on both the scale of the initial roll out, and findings from the baseline data. Key to performance improvement will be the requirement for change management to address internal and external obstacles that prevent patients being cared for in more appropriate settings.

Bed and service coverage is a critical factor in the overall scale of improvement possible – a well-constructed roll out that is able to expand quickly into many wards / service areas will achieve greater benefits more quickly. Trusts will need to agree the size and scale of the implementation in order to secure Implementation Payments (Triggers 1-4 below). The baseline position will highlight the source of obstacles and delays, and will indicate areas that can be addressed as a priority (within the first year of implementation) to improve patient flow, as well as those areas requiring multi-agency intervention. These areas will sometimes take longer to implement, the benefits of which should be obtainable within year 2 of the CQUIN.

### **Calculating the target Payment Amount and CQUIN %.**

The Payment Elements are:

Element	Driven By	Previously	2017-19 Payment	Notes
<b>Implementation and Rollout</b>				
Implementation Payment (Triggers 1-4)	Year One Only	£140,000 - £200,000	£170,000-£250,000*	£100,000* Plus number of beds in provider trust x £180* subject to maximum of £250k.
Training & Backfill Payment (Trigger 4)	Additional Wards Implemented in a given year	£300 per person	£360* per person	Number of Staff trained to use the tool on the new wards where CUR is being introduced.
<b>Ongoing Use</b>				
Daily Use of the software on Live Wards (Trigger 5).	Ongoing Steady State use of the Software.	£120 Per Bed Per Full Year Live.	£150* Per Bed Per Full Year Live.	Days for which a completed CUR record is available / Beds in Scope x 365.
Reporting (Trigger 7).	Ongoing Adoption of the new operational processes.	£50,000	£60,000**	£50,000 for Monthly reporting to commissioners and submission of mandated Minimum Data Set to NHSE England. Quarterly reporting to NHS Trust Provider Board also required.  £10,000 for Annual Report to NHS Trust Provider Board.
<b>Benefit Realisation</b>				
Year On Year Percentage Point Reduction in Clinical Criteria Unmet Bed Days (Trigger 6).	Targetting wards with specialised services use.	Unmet Bed Days reduced x £180 x % Specialised beds.	Unmet Bed Days reduced x £210* x % Specialised.	
Year on Year: Percentage Point reduction in Clinical Criteria Unmet Emergency Admissions.	CCG or STP supported use of Tool in ED.	£750 per admission	For Local Discussion ( <u>Not within Specialised CQUIN Scope</u> ).	

\*Increased to cover higher license and implementation costs at larger Provider Trusts.

\*\*Increased to cover the costs of providing an extended Minimum Data Set to NHSE from April 2017.

An excel workbook is available on the NHS England PSS CQUIN site to use to set the initial CQUIN value - the 'GE1 CUR CQUIN Calculator'.

For Year 1, the CQUIN payment is designed to cover the set-up costs (CUR licence) and training (clinical and non-clinical) costs (implementation and 'go-live). Some costs will also be incurred for Reporting.

Beyond this, a payment is made for achievement of reduction in bed days not meeting CUR



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criteria. Achievement of such outcomes may incur costs in reorganising pathways. Where bed days saved are beyond National Tariff Trim Point, they will reduce both provider costs and excess bed day revenue, and where within trim point providers retain full cost savings with no change in revenue. Gains to the whole system extend beyond the CQUIN where improved systems yield enduring improved usage of hospital capital and/or running services less 'hot' reduces the knock on problems this can cause.

The second year CQUIN payment funds a year on year achieved reduction in the proportion of emergency admissions (where used in A&E) and bed-days for patients that do not meet the CUR criteria beyond the baseline reached in year one. The total bed-base to be included in the CUR CQUIN is a minimum 400 beds in year 1, increasing to 600 beds in years 2. For those trusts who have less than 400 or 600 as their total bed base, and for year 3, implementation should cover the total applicable bed base.

The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (*pro rata* – adjustment to be made to results given by the calculator).

This calculation is shown in the benefits realisation section of the excel workbook provided. It involves setting a number of parameters:

- The estimated starting point proportion of criteria not-met bed-days and criteria not met admissions (for CCG / STP supported use in A&E), either from previous year's first three-month average, from Local CUR piloting, or using standard estimates: 42%<sup>5</sup>, 14% respectively
- The targeted percentage point reduction in "criteria not met" by the end of each year
- The numbers of wards and beds in which CUR will be operational in each year
- The targeted percentage point reduction in "criteria not met" by the end of each year
- The proportion of bed days in the targeted wards which are likely to be specialised care.

Bed Days ambition. A reasonable ambition might be a one third reduction in criteria-not-met bed days (e.g. a 14 percentage point reduction in criteria-not-met bed days from 42% to 28%, subject to any necessary adjustments included in the CUR CQUIN baseline calculator), with a minimum acceptable ambition of a six percentage point reduction. Typically, at least a third of the delays are within the hospital's direct control, and the balance can be addressed through collaboration.

Goals will reflect the provider's and commissioner's assessment about what can be achieved, and how large a portion of the CQUIN payment is available for this scheme. Hospitals who commit to more stretching rollout and goals will receive more CUR CQUIN funding accordingly. There is an advantage in being ambitious – setting a cautious improvement target, whether in terms of bed coverage, speed of implementation, or reduction in criteria-not-met utilisation, will reduce the CQUIN payment proportion contracted. In addition, where target improvements are exceeded the CQUIN payment cannot exceed the amount set aside for this CQUIN in the contract agreement (though it will still yield provider operational cost savings and benefits to

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<sup>5</sup> Subject to the Provider Trust specific modifications suggested in the calculator, which may be used to adjust the targets to reflect the proportion of bed days in excess of the lower quartile length of stay by HRG.

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patients).

The result of these calculations is a Standard CQUIN payment value for Benefits Realisation. This is payable in proportion to achievement of the target reduction in criteria-not-met bed-days, and the use of the system.

Worked examples can be found for Year 1 and Year 2 CQUINs in the G.i CUR CQUIN Calculator supporting XL workbook.

The increase in the individual tariffs associated with this CQUIN will uplift payment by c.20% compared to 2016/17 levels in line with the Specialised CQUIN scheme guide.

**Measures & Payment Triggers**

Payment triggers as follows, with payments proportioned as per the following table.

Descriptions	First Year of scheme
<b>Trigger 1:</b>	Provider has established and can evidence a project team with relevant stakeholders to manage CUR installation and implementation.
<b>Trigger 2</b>	Provider and commissioner have an agreed and documented operational/ mobilisation plan with a scope of services which includes: <ul style="list-style-type: none"> <li>1.1. Governance structure;</li> <li>1.2. No of beds on which CUR will be used;</li> <li>1.3. Identified staff roles to undertake the CUR reviews;</li> <li>1.4. No and type of staff who will be trained to use the tool and trained to undertake training of new staff (train-the-trainer);</li> <li>1.5. Established IT software and interface methodology;</li> <li>1.6. Internal and external reporting mechanisms including frequency and type of reporting (note monthly reporting of the CUR Minimum Data Set is mandated)</li> <li>1.7. Timeframe for installation and implementation including a “Go Live” date.</li> </ul>
<b>Trigger 3</b>	Provider can evidence a signed contract of 24 months’ duration or above, with a recognised CUR software provider stating “Go Live” dates in line with agreed implementation plan.
<b>Trigger 4</b>	Software & interfaces are installed and live, and training is completed by the agreed “Go Live” date.
<b>Trigger 5</b>	Daily use in practice of CUR can be evidenced on agreed bed numbers with an achievement of 85-95% compliance rate.
<b>Trigger 6</b>	Delivery against agreed KPIs for the reduction of bed usage throughout the period of CUR operation where patients do not meet clinical criteria for admission or continued stay. The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR

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	<p>assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (at the discretion of local commissioners).</p>
<p><b>Trigger 7</b></p>	<p>Reporting</p> <ol style="list-style-type: none"> <li>1. Production of quarterly CUR CQUIN Reports to commissioners on CUR data showing             <ol style="list-style-type: none"> <li>(i) Numbers of patients with met / not met clinical criteria</li> <li>(ii) Reasons / details for not met criteria</li> <li>(iii) Compliance rate by ward</li> <li>(iv) Evidence of actioned plans to reduce admissions / bed usage where not clinically indicated by CUR criteria.</li> </ol> </li>   <li>2. Production of mandatory monthly CUR CQUIN Minimum Data Set (MDS). The CUR MDS extract has been developed for submission to NHSE commissioners only and will not be shared with CCGs unless agreed with Providers as part of a Joint CQUIN agreement. The extract is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1. From 2017/18 the CUR MDS will be part of the NHS Standard Contract Information Schedule.</li>   <p>The information contained within the database will be used to develop the evidence base for CUR use and to understand the range, scope, size and outcomes of the national CUR programme.</p>   <li>3. Production of quarterly Board report presenting.             <ol style="list-style-type: none"> <li>(i) CUR data showing numbers patients met / not met clinical criteria</li> <li>(ii) Reasons / details for not met criteria</li> <li>(iii) Compliance rate by ward</li> <li>(iv) progress against plans and future plans to reduce admissions / bed usage where not clinically indicated by CUR criteria</li> </ol> </li> </ol> <p>From the above, to provide a quarterly report to commissioners and other local system stakeholders, with specific detail of the</p>

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	externally generated delays, to inform system service planning in 2018/19 and 2019/20. Active participation in any stakeholder meetings arranged to address the external delays to patient flows.
<b>Descriptions</b>	<b>Second and Third Years of scheme</b>
<b>Triggers 1-4</b>	Not applicable.
<b>Trigger 5</b>	Daily use in practice of CUR can be evidenced on agreed bed numbers with an achievement of 85-95%% compliance rate.
<b>Trigger 6</b>	Delivery against agreed KPIs for the reduction of bed usage throughout the period of CUR operation where patients do not meet clinical criteria for admission or continued stay. The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (at the discretion of local commissioners).
<b>Trigger 7</b>	<p>Reporting</p> <ol style="list-style-type: none"> <li>1. Production of quarterly CUR CQUIN Reports to commissioners on CUR data showing <ol style="list-style-type: none"> <li>(i) Numbers of patients with met / not met clinical criteria</li> <li>(ii) Reasons / details for not met criteria</li> <li>(iii) Compliance rate by ward</li> <li>(iv) Evidence of actioned plans to reduce admissions / bed usage where not clinically indicated by CUR criteria.</li> </ol> </li> <li>2. Production of mandatory monthly CUR CQUIN Minimum Data Set (MDS). The CUR MDS extract has been developed for submission to NHSE commissioners only and will not be shared with CCGs unless agreed with Providers as part of a Joint CQUIN agreement. The extract is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1. From 2017/18 the CUR MDS will be part of the NHS Standard Contract Information Schedule.</li> </ol> <p>The information contained within the database will be used to develop the evidence base for CUR use and to understand the range, scope, size and outcomes of the national CUR</p>

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	<p>programme.</p> <p>3. Production of quarterly Board report presenting.</p> <ul style="list-style-type: none"> <li>(i) CUR data showing numbers patients met / not met clinical criteria</li> <li>(ii) Reasons / details for not met criteria</li> <li>(iii) Compliance rate by ward</li> <li>(iv) progress against plans and future plans to reduce admissions / bed usage where not clinically indicated by CUR criteria.</li> </ul> <p>From the above, to provide a quarterly report to commissioners and other local system stakeholders, with specific detail of the externally generated delays, to inform system service planning in 2018/19 and 2019/20. Active participation in any stakeholder meetings arranged to address the external delays to patient flows.</p>	
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**Definitions**

**Minimum patient level dataset is specified with data definitions included, based on the CUR framework supplier software.**

**Partial Achievement Rules**

***Payment types referenced A to I refer to the Calculator spreadsheet, column marked Payment ID.***

Elements **1 to 6** by Month 6 – Payment ID A to D paid in full.

Elements **1 to 6** post Month 6 – 80% of Payment ID A to D made.

Element **7** level of payment proportionate to the percentage application of the CUR Software tool (100% application = 100% payment; 50% application = 50% payment) Payment ID E.

Element **8** level of payment proportionate to the level of delivery against agreed target number of admissions / bed days to avoid. Payment ID F & G.

Elements **9.1 and 9.2** delivery of all reporting required for full payment. Payment ID H

Element **9.3** – delivery of all reporting and active participation in stakeholder consideration and planning required for Payment ID I.

**In Year Payment Phasing & Profiling**

Standard – subject to local variation.

**Rationale for Inclusion**

Used on a daily basis, CUR provides evidence-based decision support for clinicians to ensure that patients receive the ***right level of care, in the right place at the right time*** - according to their clinical needs and best practice, highlighting on a 'live' basis where patients may be better treated in an alternative level of care. The data and reports that it provides allows clinical leads, hospital managers and commissioners to address barriers to optimal patient flow and to re-

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design services to improve efficiency and productivity.

Although in most health systems internationally, and in some UK hospitals, providers already recognise the business case for CUR implementation without commissioner funding, the CQUIN ensures implementation can be undertaken without any risk or cost pressure to core operational trust income. The cost of failing to realise the opportunity of CUR will be considerable – hindering improvements in patient flow that benefit individual organisations, health systems and patients. Furthermore, this will reduce our understanding of patient flows across systems and impede our ability to design service and transformational change that is based on clinical evidence.

### **Data Sources, Frequency and responsibility for collection and reporting's**

Progress towards and delivery of Triggers 1 to 4 will be considered and confirmed at the formal contract meetings (frequency tbc).

Triggers 5 and 6 - CUR CQUIN report

Trigger 7 - reports to be prepared in line with required timescales described, and discussed at either the formal contract meeting or meetings scheduled specifically to discuss the areas highlighted by CUR reporting (commissioner to confirm).

Data extracted from the mandatory CUR CQUIN Report, CUR patient level minimum dataset, standard contract information schedules and from commissioner analysis of SUS data will deliver the source data requirements.

The **CUR Minimum Reporting Data Set** extract has been developed for submission to NHSE only. The report is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1.

Baseline period/date & value	Set annually
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Final Indicator period/date (on which payment is based) & Value	As above
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Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
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#### **CQUIN Exit Route**

*How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?*

CUR data and evidence indicates that savings can be realised from improved patient flows in the mid to longer term, which will more than offset the ongoing costs of the system. We believe therefore that providers and health economies will continue to use the CUR tool once the CQUIN is removed, in order to maintain optimum patient flows and identify blockages on a 'live' basis.

A proportion of savings, particularly reduction of bed-days within Tariff, accrue directly to providers. Once implemented, we would expect it to be within provider's financial interest to continue with the scheme in order to

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secure these savings.

The CUR CQUIN is expected to span two or three years to incentivise providers to continue to use the CUR tool until savings can be realised.

### Supporting Guidance and References

The CUR National Team has produced a “How to” Guide. This guide aims to provide NHS Trusts with high level support on “how to” operationalise CUR and covers 4 key stages including i) implementation and planning; ii) procurement; iii) delivery; and iv) reporting. The guide also signposts to other useful resources and is available on the CUR extranet.

Clinical Utilisation Review is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, in the right place, at the right time and for the right length of time, according to a patient’s individual needs.

CUR guidelines are based on systematic reviews of clinical evidence and are widely used internationally, to provide evidence-based decision support for clinicians. CUR supports clinicians to adhere to clinical best practices. CUR always integrates medical judgment with evidence-based guidelines, including consideration of comorbidities and limitations on community resources and services during the review process.

By adopting the CUR process and utilising the latest technology to provide real time evidence based clinical decision support, healthcare organisations are able to address and quantify key operational issues from daily patient level assessment such as:

- *What levels of clinical care do our patients need?*
- *What are the reasons patients are not in the most appropriate setting for their clinical needs and how can these be resolved?*
- *What is the impact of operational inefficiency on the organisation and when changes are made, does performance improve?*
- *How can we ensure that all our patients receive the right levels of care, in the right settings at the right time?*
- *Where and how do we need to invest in order to reduce hospitalisation and what will be the process and overall reduction in costs?*

The data and reports that it provides allows clinical leads, hospital managers and commissioners to address barriers to optimal patient flow and to re-design services to improve efficiency and productivity. CUR can also help to reduce unwarranted clinical variation and ensure patients are cared for in the optimal setting, and to address barriers to optimal patient flow.

### ***Developing the CUR Evidence Base***

The use of Clinical Utilisation Review tools has increased and developed in the NHS over the past 5 to 10 years. Initially this was through a number of NHS Trusts in England who engaged directly with the supply and implementation of CUR tools as well as commissioners undertaking retrospective audits supported by independent consultants using CUR tools.

The Nuffield Trust report (September 2015, Ruth Lewis & Nigel Edwards, “Improving length of stay - what can hospitals do?”) states that: “There is a significant opportunity to reduce length of hospital stay through improvements in internal processes and the development of alternative services. There are often variations in length of stay, even for patients with similar conditions, and wide variations in the proportion of patients with extended stays”. This report complements further work recently published by Monitor ([www.gov.uk/government/publications/improving-patient-flow-evidence-to-help-local-decision-makers/improving-patient-flow-evidence-to-help-local-decision-makers](http://www.gov.uk/government/publications/improving-patient-flow-evidence-to-help-local-decision-makers/improving-patient-flow-evidence-to-help-local-decision-makers)) and is backed up by evidence from the use of CUR.

The launch of the national CUR CQUIN and national CUR framework in 2015, has seen the uptake of CUR increase with the establishment of 5 national Early Implementer Sites, and latterly the update of CUR CQUINs for 2016/17 across 30 NHS Providers nationally.

One of the early barriers presented by Trusts reluctant to implement CUR has been the lack of available UK data and evidence of the benefits CUR can bring. From the early audit work undertaken, and from the data and case studies provided by the 5 national Early Implementer sites, we now have the evidence to show that many patients are admitted to and/or retained in acute settings that could be managed in an alternative level of care. Acute hospitals typically admit many patients who are not strictly in need of acute care – particularly people in later life.

Data from UK hospitals (concurrent and retrospective CUR audits) over a 3-year period indicated that significant numbers of patients (24% of acute admission, 42% of continued stay) should be managed in alternative levels of care, more appropriate to their clinical needs, or discharged to the home setting (East Midlands CUR programme findings 2008-2011). Similar findings are found elsewhere suggesting substantial scope for improvement.



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**Table 2 – Patients not Qualifying for Acute Hospital Care (international data)**

Country	Patients Not Qualifying for Acute Hospital Level of Care	
	Acute Admissions	Acute Continuing Stay
<b>UK</b>		
Example 1	20 – 25%	20 – 60%
Example 2	45 – 51%	49 -77%
Example 3	5 -10%	30 -40%
Example 4		c.50%
<b>US</b>		
Example 1	4 - 6%	14 – 22%
Example 2	30%+	
<b>Canada</b>	8 – 10%	30 – 40%
<b>Singapore</b>	8%	59%
<b>Australia</b>		30 -40%

Information gathered from the commissioning and implementation of CUR tools, and from the data reported by NHS England’s Early Implementer Sites supports the existing evidence base: -

- During Q1 2016-17 over 112,000 daily reviews (clinical assessments) were undertaken on over 2,600 beds across the 5 Early Implementer Sites (EIS) and three other Trusts providing reports for that quarter.
- Based on the data provided, 45,372 (40%) of those daily reviews (clinical assessments) did not meet the CUR criteria for an appropriate patient stay; with a range of 21% to 66% at the 8 Trusts.
- Across the 8 Trusts, an average of 499 beds, during the quarter, had a patient being cared for that did not meet the CUR Criteria for that level of care.
- Between 10% and 15% of emergency admissions not meeting the CUR Criteria for an acute bed at hospitals with a mixed bed base.

**Costs**

The software and training costs for implementing the CUR tool are estimated between £80k and £250k over a 3-year period, dependent on the number of beds and the chosen CUR supplier. There are additional indirect costs, including the time required for staff training, IT costs (getting the system running and linked via Trust IT systems), hosting arrangements etc.

**NB:** Under the national CUR Framework, the pricing for the licence costs is based on the total bed-base of the provider.

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There may be additional costs associated with the provision of services not currently in place that improve the flow of patients, once CUR has identified the reasons for patients remaining in inappropriate levels of care.

The level of ambition will need to be set individually year by year for each provider. Overall the aspiration is for a ratcheting up of performance through the course of the CQUIN scheme, sustained thereafter; achieving a reduction in bed days and admissions to levels achieved in other health economies where CUR is embedded. What is a plausible level of improvement in each year will depend upon the scale of change to be achieved and the proportion of failing criteria bed days or admissions that are attributable to factors wholly within a provider's control, and the effort that a provider can dedicate to improving pathways across the health economy.

Improvements in patient flow can be achieved within the first 12 months of implementation. Reductions in length of stay may take over 18 months to implement, and will be dependent on both the scale of the initial roll out, and findings from the baseline data. Key to performance improvement will be the requirement for change management to address internal and external delays that prevent patients being cared for in more appropriate settings.

Bed and service coverage is a critical factor in the overall scale of improvement possible – a well-constructed roll out that is able to expand quickly into many wards / service areas will achieve greater benefits more quickly. The baseline position will highlight the source of obstacles and delays, and will indicate areas that can be addressed as a priority (within the first year of implementation) to improve patient flow, as well as those areas requiring multi-agency intervention. These areas are likely to take longer to implement, the benefits of which should be obtainable within Year 2 of the CQUIN.

Many Healthcare providers internationally adopt CUR systems either as a condition of providing services to payors or to capture the substantial provider cost savings. The CQUIN is provided to ensure NHS providers are able to adopt CUR without facing any financial risk or affordability challenges from the one off costs of implementation. Failure to adopt CUR for the NHS would – hindering improvements in patient flow that benefit individual organisations, health systems and patients, reduce our understanding of patient flows across systems, and impede our ability to design service and transformational change that is based on quantified clinical evidence.

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### Annex 1

#### CUR CQUIN Minimum Data Set (MDS)

The production and submission of a monthly CUR CQUIN Minimum Data Set (MDS) is mandated as part of the 2017/18 and 2018/19 CUR CQUIN. From 2017/18 the MDS (see below) will be part of the NHS Standard Contract Information Schedule.

The CUR CQUIN MDS will include the following data fields.

1. Provider Code
2. CUR Vendor ID
3. NHS Number
4. Date of Birth
5. Date of Admission to a Hospital Bed
6. Date & Time Assessment undertaken
7. Time Assessment undertaken
8. Patient Stay Date
9. Level of Care (e.g. Acute Care; Critical Care; HDU; Sub-Acute; Acute Paediatric, Acute Rehabilitation, Community Rehabilitation; Intermediate Care, Other 'Community', etc)
10. Care Setting/ Ward Type
11. Criteria Set Used
12. Met (Qualified) / Unmet (Non-Qualified)
13. Reason Code for Unmet (Non-Qualified)
14. Reason Text for Unmet (Non-Qualified)
15. Reason Category for Unmet (Non-Qualified) e.g. Internal (Operational/Physician) or External.
16. Alternative Level of Care clinically indicated

NB: The mapping of reasons codes needs to be consistent between suppliers. NHSE Guidance on the categorisation of reason codes need to be adopted by Providers and automated by Suppliers.

NB Levels of Care will be defined with Suppliers and in consultation with National (NHS Trust) CUR Learning Set.

As part of this process a monthly CUR CQUIN MDS extract will need to be submitted, by all NHS Providers in the 2017/18 CQUIN Scheme, to CSUs and then onwards to the national repository. From there it will be matched against patient level national contract monitoring data. Analysis of data will be the responsibility of the *Information and Intelligence, Specialised Services National Support team*.

Whilst CUR suppliers are expected to help automate the production of the MDS it will be the responsibility of NHS Providers.

Due to differences in local implementation of CUR software, local modifications to the software and the differing characteristics of local systems this information will not be used to performance manage individual Trusts. The MDS will not be used for any other contract management purpose outside of the CUR CQUIN. As part of signing up to the CQUIN Providers will be assured that the publication of Trust specific data will only be made available with permission from their Trust Board e.g. to support cases studies or good practice guides. Trusts involved in the National (NHS Trusts) CUR Learning Set will be consulted on the analysis and use of data.

## 9 GE2 Activation System for Patients with Long Term Conditions

Scheme Name:	GE2: Activation System for Patients with Long Term Conditions (LTCs)
Eligible Providers	<p>All providers offering services to patients with conditions meeting the specified criteria.</p> <p><b>For 2017/8 and 2018/19:</b>  <b>The PSS CQUIN scheme is available only to providers who adopted have adopted the PAM system in 2016/17, and are therefore able to embark upon the second year of the scheme.</b></p>
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] should achieve payment of c. £60,000 for each centre for each new patient group targeted for PAM of 500 patients, plus/minus £30 per head for larger/smaller cohorts</p> <p><b>Plus an amount to be agreed with commissioners and the national team, to cover costs of interventions adopted for respectively year two and year three patient groups</b></p> <p>Target Number of Patients, by LTC:  <i>[Add additional groups as required]</i></p> <p>2017/18  Year One Patient Groups  1<sup>st</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  2<sup>nd</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  Year Two Patient Groups  1<sup>st</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  2<sup>nd</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  Target Value: <b>Add locally</b></p> <p>2018/19  Year One Patient Groups  1<sup>st</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  2<sup>nd</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  Year Two Patient Groups  1<sup>st</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  2<sup>nd</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  Year Three Patient Groups  1<sup>st</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  2<sup>nd</sup> LTC [<b>Specify</b>] number of patients: <b>Add locally</b>  Target Value: <b>Add locally</b></p>
Scheme Description	

**Problem to be addressed**

There is a substantial body of evidence demonstrating that patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition) have better outcomes including reduced frequency of exacerbations and associated high cost interventions. There is also evidence that information about activation levels can be used effectively to focus intervention on patients groups more effectively. There is currently no regular and consistent systematic assessment of activation levels for PSS patient groups who are likely to benefit from implementation of an activation system.

**Change sought**

For each patient group with a potential to benefit from it, development of a system to measure patients' level of activation, i.e. the skills, knowledge and confidence needed to self-manage long term conditions, and with that information to support adherence to medication and treatment and to improve patient outcomes and experience.

The CQUIN scheme therefore aims to encourage use of the "patient activation measurement" (PAM) survey instrument, firstly to assess levels of patient skills, knowledge, confidence and competence in self-management for different groups of patients meeting the criteria below. The second stage, for the second and third years of the scheme, seeks to support Activation Interventions to tailor service provision according to self-management capability and/or to raise activation levels.

Only the PAM instrument, licenced from Insignia, is to be used to assess activation rates. The Insignia questionnaire is independently validated as representing the level of patient engagement in such a way as accurately to reflect likelihood of adherence to care plan and likelihood of avoiding exacerbations. Use of a standard instrument across the NHS also will facilitate benchmarking. There are alternative versions for parents, MH patients, carers, and for Clinicians (to test whether they are able to support patients in self-management of their conditions). The survey questions are interpreted via the software that is available with the licence, and allows a patient group to be stratified according to level of self-management of their clinical condition; and also diagnoses the nature of any shortfall - thus helping to determine appropriate remedies – ways in which patient adherence to care plan can be enhanced.

Use of information about activation levels can take two forms:

- a. stratification of the patient groups to help diagnose problems and determine appropriate care plan;
- b. work with patients to raise motivation, skills and self-management, etc). It is recommended that the COM-B model is used as a default understanding of behaviour change: Capability + Opportunity + Motivation=> Behaviour change.

**LTC Groups Who Should Benefit**

Patient groups who stand to benefit include those with persistent conditions for which

- There is a care regime of known effectiveness which is complex
- Symptomatic abreaction to poor adherence is distal (so that patients will realise that poor adherence is responsible for deteriorating health)
- Symptomatic consequences of poor adherence may – if poor adherence is not recognised – lead to misdiagnosis and mistaken prescription

- The severity of the condition does not itself preclude self-care (e.g. through occluding insight (*an understanding of the nature of the condition and the factors that make it better/worse*) or capacity (*in terms of being able to make informed decisions regarding management of the disorder*))

Suggested conditions include: Teenage and Young Adult Cancer, Cystic Fibrosis (which is subject to a separate CQUIN scheme), chronic kidney failure, HIV, haemoglobinopathy, severe difficult to control asthma, ILD, solid organ transplantation patients, severe faecal incontinence, inflammatory bowel disease, schizophrenia, severe depression, COPD, adult congenital heart disease, epilepsy, LSD to support Enzyme Replacement Therapy adherence.

**Year 1 (2016/17) has focused upon Measurement and Team capacity Building. These activities will be required also for Year 2 where the programme is expanding to new patient groups.**

**Specific activities:**

- **Licence.** A licence is needed for setting up a PAM programme for each patient. These would be available under an NHS England contract with Insignia (to be accessed via NHS England<sup>6</sup>) at no additional cost to the provider.
- **Elicitation.** Per patient costs will have to be incurred in eliciting the information using the PAM tool. It is recommended that information is collected in the clinical context – as this has been shown to increase the response rate and to mitigate the risk of non-response bias. There are options regarding administration: paper or (possibly) electronic, to be explored with Insignia, which may affect costs. The administration of the questionnaire may take ten to fifteen minutes including explanation. Costs would depend upon:
  - Mode of measurement
  - Frequency of measurement (per patient)
- **Team Capacity Building.** Staff training in the administration of the instrument element – for example some workshops to develop clinical engagement. The outcome here should be patient activation preparedness of the team: it would be helpful to specify what this will comprise more precisely.
- **Mechanisms for gathering, presenting and analysing Activation information**

Team building costs will be incurred early in the year, elicitation costs as the PAM is administered, in the later quarters of the year.

### **Setting Provider Specific Parameters for 2017/18 and 2018/19**

On agreeing adoption of this scheme for 2017/18 and 2018/19, the following should be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment.

For any new condition-group for whom an Activation System is being developed:

- Agree vision for use of PAM measure with cohorts of patients in context of increasing support for self-care;
- Agree the first year metrics:
  - Patient group(s) –in each year.
  - Number of patients in each condition to be recruited into the programme for

<sup>6</sup> E-mail ENGLAND.commercial@nhs.net

- application of the PAM.
- The number of staff to be trained to administer the PAM.

For existing condition groups, agree the second year Metrics;

- The number of patients to be re-tested with what frequency
- Interventions to be undertaken in support of patient groups according to their level of activation.
- These interventions should in general be drawn from those recognised as effective in the patient activation literature and endorsed by the national team. A taxonomy of patient activation interventions is available here:

: <https://www.ucl.ac.uk/health-psychology/bcttaxonomy>

- . However, innovative alternatives will also be considered subject to expert clinical and behavioural-psychologist input.

### **Calculating the Target Payment for a Provider for each year**

For new patient groups:

£60,000 is an indicative amount for a single group of 500 patients. If the group is larger or smaller, the amount should be adjusted by £30 per head; so

- for a group of 100 patients, £60,000 – (400x£30)=£48,000
- for a group of 1000 patients, £60,000 + (500x£30)=£75,000.

The calculation is done separately for an additional group of patients, as new training would be required for the clinicians etc.

For existing patient groups, for both year two and year three: an amount to be agreed with the commissioner and the national team, determined by:

- the numbers in each patient group at each activation level (from Year 1 outcomes, or by estimation)
- the intervention to be piloted, costed plus 50% CQUIN premium
- the frequency of PAM administration, costed at £30 per application.

## **Measures & Payment Triggers, and proportions of Year Payment**

### **First Year Triggers, for new groups of patients**

#### **ONE: Planning & Set-Up: 20%**

1. A working group has been established; signing of Affiliation Agreement with Insignia – to obtain Licences and PAM Materials (under NHS England contract with Insignia);
2. Implementation plan written and submitted to commissioners including:
  - a. team building and training plan for staff who will administer PAM
  - b. plan for creation of mechanisms for gathering, presenting and/or analysing data, with clarity regarding:
    - i. To whom the data should be fed back (e.g. to the patient; to the team; to the PAM oversight group in the provider; for central evaluation in a standard pseudonymised format);
    - ii. What immediate use is to be made of it
3. Secure licence from Insignia of 2 years duration or more (via NHS England).

#### **TWO: Team Building. 20%**



1. Team building and training plan for staff to administer the PAM has been implemented
2. Readiness Assessment of Patient Activation preparedness of team and any identified shortfalls have been addressed.

**THREE: Elicitation of Activation Information via the PAM. 20%**

1. Pilot testing and evaluation of use of survey instrument completed
2. Baseline measure captured from PAM administered to first cohort of patients
3. Reporting of the proportion of the patient groups targeted in each condition recruited into the programme for application of the PAM, and of any follow up action to raise numbers.

**FOUR: Analysis and Response:20%**

1. Elicited PAM responses gathered and submitted for benchmarking and evaluation.
2. Activation Intervention options developed (to feed into Year 2 planning).
3. Report to commissioners on progress against implementation plan including results from pilot and shared learning.

**FIVE: Planned Intervention and Monitoring. 20%**

1. Activation Intervention options developed and agreed (to feed into Year 2 planning). (A taxonomy of Activation Interventions is available.)
2. Identification of Intermediate Outcome and Final Outcome Measures, where available, to be used alongside the PAM score to monitor progress. Intermediate outcomes might include: adherence indicators, non-elective attendances/admissions. Final outcomes might include: patient reported health outcomes. (For some conditions, maintaining the score might be a good outcome – i.e. preventing deterioration.)
3. Establishment of information system to support monitoring (using patient identifiable information) and benchmarking (using pseudonymised data).

**Second Year Triggers, (2017/18 for Existing Groups of patients)**

**ONE: Intervention. 50%%**

Implementation of actions designed to improve activation or otherwise to respond to information about activation levels.

**TWO: Measurement and Reporting.25%**

Repeat applications of PAM, and of selected intermediate and final outcome measures.

**THREE: Ambition-setting 25%**

1. Agreement of ambition for improvement in PAM score and associated intermediate outcome measures to determine payment in Year Three (2018/19 for patient groups initiated in 2017/18), Covering as appropriate:
  - i. Improvement in PAM Score,
  - ii. Improvement in adherence and a reduction in non-elective attendances/admissions, or other intermediate health outcomes
  - iii. Aggregate improvement of patient reported health outcomes or in clinical health outcomes. (For some conditions, maintaining the score might be a good outcome – i.e. preventing deterioration.)

(These metrics might be developed in the context of the evaluation.)

**Third Year Triggers, (2018/19 for Existing groups of patients):**

**ONE: Measurement and Reporting.25%**

<p>Repeat applications of PAM, and of selected intermediate and final outcome measures.  <b>TWO: Performance 75%</b>                  Patient outcomes measured as per Year two, trigger three.</p>	
<p><b>Definitions</b></p> <p>Denominator for SCALAR (for partial achievement): Number of patients in each of the targeted LTCs whom it is agreed at contract signature should be targeted for completion of the PAM.                  Numerator: Number actually completing the PAM in these groups creating usable data.</p> <p>The targeted number of patients should reflect the number who are expected to be willing to participate, i.e. excluding those who will refuse. Note that it is not recommended to post surveys; they should be administered in a clinical setting, so response rate should be higher.</p>	
<p><b>Partial Achievement Rules</b></p> <p><b>SCALAR:</b> All Year One payments, and all measurement payments for Years Two and Three to be scaled down proportionately if less than 80% of patients targeted to complete the PAM, and to be monitored, do so.</p> <p>For Year Two, trigger one, payment proportional to the number of patients receiving the intervention promised.</p> <p>For Year Three, trigger two, payment proportional to performance against the metrics set.</p>	
<p><b>In year payment phasing and profiling</b></p> <p>Standard/</p>	
<p><b>Rationale for inclusion</b></p> <p>The implementation of a patient activation system is designed to realise significant benefits to the healthcare system from improved patient outcomes and experience of care and from a reduction in the use of non-elective services.</p> <p>Adherence to treatment has been linked to improved health outcomes and has been shown to increase patient satisfaction by supporting independence which can also be linked to higher quality interactions with healthcare professionals.</p>	
<p><b>Data Sources, Frequency and responsibility for collection and reporting</b></p> <p>The NHS England Patient Centred Care team has obtained licences from Insignia. There is no further cost. Insignia will also provide training and support for implementation.</p> <p>The source of data for the Year One payment triggers will be the information available from the application of the PAM for specific patient groups.</p> <p>If a software solution is adopted for administration of the PAM, then extracts from the implemented software will be usable to confirm active users and active records.</p> <p>It is likely that providers will need to identify internal systems to identify the patient cohort and record the data. It is likely that specialist nurses would be used as a resource to identify patients and support data collection; though for inpatients admission under the specialty code may be used as a marker, and to validate of report.</p>	
<p>Baseline period/date &amp; Value</p>	<p>To be reported by the Provider for the selected cohorts of patients with LTC.</p>
<p>Final indicator period/date (on which payment is based) &amp;</p>	<p>The number of patients above baseline proportion completing PAM, to be reported by provider.</p>

Value	
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract.
<b>CQUIN Exit Route</b>  <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	Incorporation of changes in the cost per care episode or year of care into core tariff payments for activation measures and interventions will be developed during the course of the CQUIN scheme's evaluation, based on the balance of expected savings from improved segmentation of care and adherence between providers and commissioners under the relevant payment mechanism for each patient group. Plans will be developed for each patient group to ensure that funding is sustainable.

### Supporting Guidance and References

There has been wide review and implementation of a number of interventions to support the concept of self-care and management of long term conditions. The Kings Fund published an appraisal of the patient activation concept which describes the practical implementation of a behavioural change model and explores some of the potential benefits of implementing a scheme such as this<sup>7</sup>.

The concept of a Patient Activation system, such as this scheme is designed to support, denotes an activation method which can first capture patient's knowledge and skills, and, second, includes population segmentation, interventions to improve engagement, and measuring performance across the healthcare system.

There are two broad categories of Activation interventions:

- a. stratification of the patient groups to help diagnose problems and determine appropriate care plan;
- b. work with patients to raise motivation, skills and self-management, etc)

Regarding activation of patients, there are a large number of behavioural change models available. It is recommended that the COM-B model is used as a default understanding of behaviour change: Capability + Opportunity + Motivation=> Behaviour change.

However, this should not restrict the range of interventions that may be useful in different contexts for different groups, including:

- a. commitment support via:
  1. peer group (as proposed for example for HIV patients)
  2. joint appointments (e.g. as default)
  3. carer involvement, etc.
- b. health coaching with Clinical Nurse Specialist or other professional input.

Support for devising interventions may be drawn the work of the Behavioural Change Centre at UCL. See

<sup>7</sup> <http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health>

<https://www.ucl.ac.uk/behaviour-change-techniques/Resources/BCTTv1Publications>

See also:

<http://www.behaviourchangewheel.com/>

which explains how to develop an intervention systematically, including choosing which behaviour change techniques from the taxonomy to include in an intervention.

### **EVIDENCE BASE:**

The fundamental link between activation and outcomes is well substantiated<sup>8</sup>:

### ABSTRACT

**Objective:** *A systematic review of the published literature on the association between the PAM (Patient Activation Measure) and hospitalization, emergency room use, and medication adherence among chronically ill patient populations.*

**Methods:** *A literature search of several electronic databases was performed. Studies published between January 1, 2004 and June 30, 2014 that used the PAM measure and examined at least one of the outcomes of interest among a chronically ill study population were identified and systematically assessed. Results: Ten studies met the eligibility criteria. Patients who scored in the lower PAM stages (Stages 1 and 2) were more likely to have been hospitalized. Patients who scored in the lowest stage were also more likely to utilize the emergency room. The relationship between PAM stage and medication adherence was inconclusive in this review.*

**Conclusion:** *Chronically ill patients reporting low stages of patient activation are at an increased risk for hospitalization and ER utilization.*

Adherence to medication and treatment is thus linked to health outcomes and patients who are more empowered were able to report greater level of satisfaction and ownership, which is linked to overall improved patient experience.

Health monitoring of biometric indicators can support the review and improve health outcomes for patients with long-term conditions and reduce non-elective attendances. More active patients engage in their own care so to comply with care regimes and to respond to such indicators.

Patient activation models have been shown also to be effective in improving the quality of interactions between patients and healthcare professionals. They involve assessment of activation levels, for example by use of the Patient Activation Measure, the PAM.

Measurement must be complemented by a range of interventions to make effective use of the information to improved patient outcomes. These may well have to be sourced from a separate provider. This might include supportive decision making, motivational interviewing and other interventions as part of a well-evidenced behavioural change model (such as the COM-B model, improving Capability and recognition of Opportunity

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<sup>8</sup> Patient Education and Counselling 98 (2015) 545-552. "The association between patient activation and medication adherence, hospitalization, and emergency room utilization in patients with chronic illnesses: A systematic review" Rebecca L. Kinney et al.

and Motivation to achieve Behavioural change), to improve activation or engagement. Or, more simply, the information can be used better to understand outcomes for patients, to avoid misdiagnosis and mis-prescription. Both have been used dramatically to improve outcomes in the Cystic Fibrosis trailblazer for this programme in Sheffield – that is currently being piloted for a national RCT.

With a behavioural change component, the PAM can then be used at team level to benchmark success of different approaches to bringing about behavioural change.

Ambition must be set separately with respect to different patient groups. For the programme as a whole, the ambition is to reach a range of appropriate patient groups. It is well documented that patients with long term conditions avoidably utilise emergency healthcare services on a regular basis resulting in poor outcomes for patients and decreased efficiency in the healthcare system. This scheme is designed to mitigate this phenomenon.

## 10 GE3: Hospital Medicines Optimisation

<b>Scheme Code and Full Name:</b>	<b>GE3 Hospital Pharmacy Transformation and Medicines Optimisation</b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	<i>[QIPP reference if any: Add Locally]</i>
Duration	April 2017 to March 2019
<p><b><u>Problem to be addressed:</u></b>          Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. The Carter Review has highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8billion per year that could be re-invested to support sustainable service delivery. This CQUIN has been designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. The expectation is that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.</p>	
<p><b><u>Change sought:</u></b>          This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, Trusts, the Carter Review and the National Audit Office, namely:</p> <ul style="list-style-type: none"> <li>• Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU frameworks as they become available</li> <li>• Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT, as well as to meet the requirements of the ePharmacy and Define agendas</li> <li>• The consistent application of lowest cost dispensing channels</li> <li>• Compliance with policy/ consensus guidelines to reduce variation and waste.</li> </ul>	
<b>Section B. CONTRACT SPECIFIC INFORMATION</b> <i>(for guidance on local completion, see corresponding boxes in sections C below)</i>	
<b><u>B1.Provider</u></b> <i>(see Section C1 for applicability rules)</i>	<i>[Insert name of provider]</i>
<b><u>B2.Implementation Timing.</u></b> What was or will be the first Year of Scheme for this provider, & how many years are covered by this contract?	2017/18 Two years
<b><u>B3.Scheme Target Payment</u></b> <i>(see Section C3 for rules to determine target payment)</i>	Full compliance with this CQUIN scheme should achieve payment of: <i>[State Financial value following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>
<b><u>B4. Payment Triggers.</u></b>	

The Triggers and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table. *[For Local Completion, or deletion, as required.]*

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	<i>[Add rows if required.]</i>	

**B5. Information Requirements**

Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

***Nature of Adoption Ambition:*** Providers with significant expenditure on tariff-excluded high cost drugs.

**C2. Setting Scheme Duration and Exit Route**

<p>This is a 2-year scheme. The year 1 payment triggers are focussed on transitioning to new arrangements for the use and management of medicines. The year 2 payment triggers are focussed on further improvement goals.</p> <p>However, the CQUIN for each hospital provider will reflect the development needs of that provider, which will be reflected in the choice of modules and transitional and / or improvement goals.</p>	<p>Most modules are expected to be implemented within 12 months and further improvement goals achieved in the following 12 months.</p> <p>The hospital pharmacy transformation programme will be fully implemented by 2020. This CQUIN and contract covers the first 2 years of the programme and is designed to support hospital providers to carry out the required change management in the first year and embed the changes in second.</p>
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**C3. Calculating the Target Payment for a Provider**

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

**<1% of the Provider’s spending upon high cost drugs>**

If a hospital has anticipated spending on high cost drugs of £25m, this CQUIN scheme would attract a target payment of £250,000.

Year One: 1% of the 2017/18 contract value for tariff-excluded high cost drugs

Year Two: 1% of the 2018/19 contract value for tariff-excluded high cost drugs

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	2017/18	2018/19
<p><b>Trigger 1: Faster adoption of prioritised best value medicines as they become available</b></p>	<p>Adoption of best value generic/ biologic products in 90% of new patients within one quarter of guidance being made available.</p> <p>Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is &lt; 6 months)</p>	<p>Adoption of best value generic/ biologic products in 90% new patients within one quarter of guidance being made available.</p> <p>Adoption of best value generic/ biologic products in 80% of applicable existing patients within one year of being made available (except if standard treatment course is &lt; 6 months)</p>



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<p><b>Trigger 2</b> <b>Improving drugs MDS data quality</b></p>	<p>Improving drugs MDS data quality to include dm+d as drug code in line with ISB 0052 by June 2017 or in line with agreed pharmacy system upgrade as well as all other mandatory fields</p> <p>All hospitals submit HCD data in agreed MDS format fully, accurately populated on a monthly basis and bottom line matches value for drugs on ACM</p>	<p>N/A</p>
<p><b>Trigger 3</b> <b>Cost effective dispensing routes</b></p>	<p>Increase use of cost effective dispensing routes for outpatient medicines:- Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines (plan to be developed by drug category to take into account patient population).</p> <p>Transition to agreed cost per item reimbursement approach as per Appendix A.</p>	<p>Increase use of cost effective dispensing routes for outpatient medicines:- Implementation of agreed transition plan for increasing use of cost effective dispensing routes for outpatient medicines (plan to be developed by drug category to take into account patient population).</p> <p>Transition to agreed cost per item reimbursement approach as per Appendix A.</p>
<p><b>Trigger 4</b></p>	<p>Improving data quality associated with outcome databases (SACT and IVlg) :- All hospitals submit required outcomes data (SACT, Ivlg) in agreed format fully, accurately populated in agreed timescales.</p> <p>Implementation of agreed transition plan for increasing data quality.</p>	<p>N/A</p>
<p><b>Trigger 5</b></p>	<p>N/A</p>	<p>Reviewing and switching existing patients to treatments in line with nationally agreed policy/ consensus guidelines – Existing patients reviewed and</p>

moved to appropriate regimen as per guidelines, e.g. HIV, MS. Further detail will be provided prior to 2018/19.

### **Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>2017/18</b>	<b>2017/18</b>
<b>Trigger 1</b>	33%	33%
<b>Trigger 2</b>	17%%	N/A
<b>Trigger 3</b>	33%	33%
<b>Trigger 4</b>	17%%	N/A
<b>Trigger 5</b>	N/A	34%
<b>TOTAL</b>	100%	100%

### **Partial achievement rules**

#### **Year One**

##### **Trigger 1:**

New patients

Achievement for 90%patients => 100% of target payment

80% patients => 75% of target payment

70% patients => 50% of target payment

Existing patients

Achievement for 80%patients => 100% of target payment

65% patients => 75% of target payment

50% patients => 50% of target payment

*Split of Trigger 1 payment between new and existing patients should be proportional to expected spend, absent the CQUIN, or each group.*

##### **Trigger 2:**

If the target is not fully achieved but 100% of the critical fields in MDS are correctly entered and submitted on time with bottom line value from MDS matching drugs line on Aggregate Contract Monitoring Dataset => 50% of target payment

Trigger 3:

If over 90% of the categories in the transition plan have migrated => 75% of target payment  
 If 75-89% of categories in the transition plan have migrated => 50% of target payment

Trigger 4:

No payment for partial achievement

Trigger 5:

N/A

**Year Two**

Trigger 1:

90% or over of target achievement => 75% of target payment  
 75%-89% of target achievement => 50% of target payment

Trigger 2:

N/A

Trigger 3:

If above 90% of the categories in the transition plan have migrated => 75% of target payment  
 If 75%-89% of categories in the transition plan have migrated = 50% of target payment

Trigger 4:

N/A

Trigger 5:

No payment for partial achievement

**Definitions**

Trigger 1

<b>Numerator</b>	Eligible patients receiving drugs available as best value generic/ biologic (list will be updated quarterly) - new patients and existing patients
<b>Denominator</b>	Patients eligible to receive drugs available as best value generic/ biologic (list will be updated quarterly) - new patients and existing patients

Trigger 2

<b>Numerator</b>	Mandatory fields including dm+d code completed accurately in MDS AND bottom line value from MDS
<b>Denominator</b>	Mandatory fields for completion AND drugs line value from ACM

Trigger 3

<b>Numerator</b>	Number of drug categories transition to new cost effective dispensing routes
<b>Denominator</b>	Total number of categories to be transitioned to new cost effective dispensing routes as set out in the agreed transition plan

Trigger 4	
<b>Numerator</b>	Specified fields completed accurately
<b>Denominator</b>	Specified fields for completion (all mandatory and required fields for SACT; all indicators on Immunoglobulin Quality Dashboard)
Trigger 5	
<b>Numerator</b>	Number of eligible existing patients on approved treatment or have stopped treatment as per policy/ guidelines
<b>Denominator</b>	All eligible existing patients receiving treatment for stated conditions
<b>C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.</b>	
<b>Information for Benchmarking</b> as for evaluation.	
<b>Information for Evaluation</b>	
Trigger 1 - Trust produced report each month	
Trigger 2 – Commissioner produced monthly data quality compliance report	
Trigger 3 – Trust produced report each quarter	
Trigger 4 – Commissioner produced quarterly data quality compliance report	
Trigger 5 – Trust produced report each quarter	
<b>Reporting of Achievement against Triggers</b>	
Trigger 1	
Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q1 17/18	90% of new patients receiving best value generic/ biologic product on Q1 list
Q2 17/18	90% of new patients best value generic/ biologic product on Q1 and Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q1 list
Q3 17/18	90% of new patients receiving best value generic/ biologic product on Q1, Q2 and Q3 list and 40% of existing patients receiving best value generic/ biologic product on Q1 list and 20% of existing patients receiving best value generic/ biologic product on Q2 list
Q4 17/18	90% of new patients receiving best value generic/ biologic product on Q1, Q2 , Q3 and Q4 list and 60% of existing patients receiving best value generic/ biologic product on Q1 list and 40% of existing patients receiving best value generic/ biologic on Q2 list and 20% of existing patients receiving best value generic/ biologic product on Q3 list
Q1 18/19	90% of new patients receiving best value generic/ biologic product on Q1, Q2 , Q3 and Q4 list and 18/19 Q1 list and 80% of existing patients receiving best value generic/ biologic product on 17/18 Q1 list and 60% of existing patients receiving best value generic/ biologic product on Q2 list and 40% of existing patients receiving best value generic/ biosimilar biologic product on Q3 list and 20% of existing patients receiving best value generic/ biologic product on Q3 list

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Trigger 2

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q3 17/18 (Ms 7-9)	Fully and accurately populated MDS submitted on time with bottom line value from MDS matching drugs line on ACM*
Q4 17/18 (Ms 10-12)	Fully and accurately populated MDS submitted on time with bottom line value from MDS matching drugs line on ACM

\* Subject to dm+d implementation timetable as agreed with NHS Digital

Trigger 3

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
End of Q1	Approval of transition plan
End of Q4	Implementation of transition plan and delivery of target dispensing % through designated cost effective dispensing routes at the designated cost per item tariffs

Trigger 4

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q1 17/18	Approval of transition plan
Q2 17/18	Fully and accurately populated submission in line with agreed transition plan
Q3 17/18	Fully and accurately populated submission in line with agreed transition plan
Q4 17/18	Fully and accurately populated submission in line with agreed transition plan

Trigger 5

Milestones	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Q1 17/18	≥ 20% of existing patients reviewed
Q2 17/18	≥ 20% of existing patients moved to approved regimen (or treatment stopped)
Q3 17/18	>40% of existing patients moved to approved regimen (or treatment stopped)
Q4 17/18	>60% of existing patients moved to approved regimen (or treatment stopped)

**Reporting Template requirement:** reporting template will be made available.

**C6. Supporting Guidance and References**

Trigger 1 Supporting information – indicative current example of expected introduction of generics and biosimilars during the CQUIN period which may impact on best value product:

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Drug Name	Anticipated Financial Year and Quarter for Implementation		Priority Level*	Relevant Specialities
Voriconazole	16-17	Q2	2	Chemotherapy, BMT, ITU, CF
Imatinib	16-17	Q4	1	Chemotherapy
Kivexa®	16-17	Q4	1	HIV
Velaglucerase alfa	16-17	Q4	3	Metabolic diseases
Rituximab	17-18	Q1	1	Chemotherapy, rheumatology, dermatology, nephrology
Caspofungin	17-18	Q2	2	Chemotherapy, BMT, ITU, CF
Peginterferon alfa	17-18	Q2	3	Hepatology
Pegfilgrastim	17-18	Q3	3	Chemotherapy
Bosentan	17-18	Q3	1	Pulmonary hypertension, rheumatology
Tenofovir	17-18	Q3	1	HIV, hepatology
Mycophenolate E/C	17-18	Q4	3	Transplant services
Tadalafil	17-18	Q4	2	Pulmonary hypertension
Pegvisomant	17-18	Q4	3	Endocrinology
Trastuzumab	18-19	Q1	1	Chemotherapy
Abiraterone	18-19	Q1	1	Chemotherapy
Anidulafungin	18-19	Q1	2	Chemotherapy, BMT, ITU, CF
Abatacept	18-19	Q2	3	Paediatric rheumatology
Adalimumab	18-19	Q3	2	Dermatology, paediatric rheumatology, Behcets
Everolimus	18-19	Q3	2	Chemotherapy, tubular sclerosis
Darunavir	18-19	Q3	2	HIV
Aprepitant	18-19	Q4	3	Chemotherapy
Thalidomide	18-19	Q4	2	Chemotherapy
Atazanavir	18-19	Q4	2	HIV

\* Priority 1 and 2 drugs should be included in implementation plan for Trusts with relevant specialities. Include priority 3 drugs for Trusts who do not have relevant specialities within priority 1 and/ or 2

## Section D. SCHEME JUSTIFICATION

### D1. Evidence and Rationale for Inclusion

#### Evidence Supporting Intervention Sought

The Carter Review found significant variation in total pharmacy and medicines costs across acute trusts. It states that some of this variation may be explained by the presence of teaching or specialist services, however, at this high level, if all trusts looked at how they might achieve the average cost then the NHS could save at least £800m. Recommendations include:

- Trusts should through a Hospital Pharmacy Transformation Programme (HPTP), develop plans by April 2017 to ensure hospital pharmacies achieve their benchmarks

- Trusts that have not currently outsourced their outpatient dispensing services should ensure their HPTP plans include a review of these services and have a plan in place for improving productivity and efficiency, including consideration of alternative supply routes, such as homecare providers or community pharmacies.
- Trusts should seek to reduce their medicines bill through best choices and from actively monitoring market developments, such as the launch of biosimilar products
- NHS Improvement and NHS England should establish joint clinical governance to set standards of best practice for all specialties, which will analyse and produce assessments of clinical variation, so that unwarranted variation is reduced, quality outcomes improve, the performance of specialist medical teams is assessed according to how well they meet the needs of patients and efficiency and productivity increase along the entire care pathway
- each trust's Finance Director, working with their Chief Pharmacist, ensuring that coding of medicines, particularly high cost drugs, are accurately recorded within NHS Reference Costs
- monitoring clinical outcomes of medicines to meet clinical needs and to support their optimal use
- Trusts identify the true value and scale of the opportunity for rationalisation and integration of hospital pharmacy procurement and production, developing an NHS Manufactured Medicines product catalogue and possibly moving towards a four region model for these services.

The National Audit Office report on the commissioning of specialised services in the NHS has also highlighted issues which need to be addressed to allow NHS England to achieve better control of rising drug costs including:

- By working with providers to guarantee the volumes of drugs to be purchased, the NHS could potentially secure better value;
- Ensuring high cost drug data and patient outcomes is collected consistently is analysed to reduce unwarranted variation
- 

#### **Rationale for Use of CQUIN incentive**

This CQUIN aims to support the procedural and cultural changes required to fully optimise use of medicines commissioned by specialised services, i.e. ensuring that HPTP plans reflect NHS England priorities to improve value from medicines and reduce unwarranted variation. The CQUIN monies will be used to fund additional pharmacy staff to deliver the initiatives and also to ensure that each Trust's HPTP plan is supported at Trust Board level.

Changes required will materially reduce commissioner costs, hence it is appropriate for CQUIN support in its funding.

#### **D3. Justification of Size of Target Payment**

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

The expectation is that a dedicated resource of 1 wte pharmacist time plus admin / analytical support would be required for every £25m of drugs expenditure.

A £25m drugs budget would equate to a payment target of £250,000 (£25m x 1% = £250k)

The full year cost of pharmacist plus admin / analytical support is estimated at £167,000.  
£167,000 x 150% = £250k.

**D4. Evaluation**

Formal evaluation is not sought for this scheme.



## 11 GE4 Service Redesign and Clinical Practice Benchmarking for Locally-Priced Services

Scheme Code and Full Name	<b>GE4. Service Redesign &amp; Clinical Practice Benchmarking for Locally-priced Services</b>
<b>Section A.SUMMARY of SCHEME</b>	
QIPP Reference	<i>[Include QIPP reference if any: : Add Locally]</i>
Duration	April 2017 to March 2019
<p><b><u>Problem to be addressed</u></b> Practice benchmarking is identified in health system performance research as a key intervention to enable efficiency gain. Local price and reference cost benchmarking information suggests at least a £150m saving opportunity to the NHS through a managed provider efficiency programme to drive costs, and therefore prices, down to most efficient provider service models. (Resistance to moving locally priced services to a national price often reflects lack of funding to redesign services such that efficient-cost prices would be sustainable.)</p>	
<p><b><u>Change sought</u></b> A two year programme of redesign to adopt most efficient service models. Payment would be for completing the redesign phase, and reflected cost reductions in lower local prices. A provider-specific agreed plan will be developed for service reform of those services which are above the most efficient levels of cost. Local prices agreed in contract will reflect planned transition to reflect those lower costs over the 2 year period with an agreed programme of service areas and milestones for review embodied in a SDIP. Programme and specialist resources can be employed by trusts using CQUIN funds to enable local clinicians to benchmark practices and implement change.</p>	
<b>Section B. CONTRACT SPECIFIC INFORMATION</b> <i>(for guidance on completion, see corresponding boxes in sections C below)</i>	
<b><u>B1.Provider</u></b> (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>
<b><u>B2. Provider Specific Parameters.</u></b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? <i>(See Section C2 for other provider-specific parameters that need to be set out for this scheme.)</i>	2017/18  2 year programme
<b><u>B3.Scheme Target Payment</u></b> (see Section C3 for rules to determine target payment)	<i>Full compliance with this CQUIN scheme should achieve payment of:</i>  Target Value: <i>[Add locally ££s]</i>
<p><b><u>B4. Payment Triggers.</u></b> The Triggers, and the proportion of the target payment that each trigger determines, and any</p>	

<p>partial payment rules, for each year of the scheme are set out in Section C4.</p>	
<p><b>B5. Information Requirements</b></p>	
<p><b>Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.</b></p>	
<p>Final indicator reporting date for each year.</p>	<p>Local price agreement (as Contract Variation) signed off by provider Chief Executive and Regional Director of Specialised Commissioning for each year savings achieved.</p>
<p><b>B6. In Year Payment Phasing &amp; Profiling</b></p>	
<p>1. Programme costs based on programme spend profile.</p> <p>2. 50% of programme costs payment made on delivery of targeted local price reduction as per Provider/Commissioner signed off local price schedule.</p>	
<p><b>Section C. SCHEME SPECIFICATION GUIDE</b></p>	
<p><b>C1. Applicable Providers</b></p>	
<p><b><i>Nature of Adoption Ambition: Universal Uptake</i></b></p>	
<p>All acute providers with locally priced specialised services identified as having higher than lowest quartile reference costs and local prices</p>	
<p><b>C2. Provider Specific Parameters</b></p>	
<p>The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)</p>	<p>1. Specific locally priced service(s) subject to redesign commencing in Year One.</p> <p>2. Specific locally priced service(s), if any, subject to redesign commencing in Year Two.</p>
<p><b>C3. Calculating the Target Payment for a Provider</b></p>	
<p>The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:</p> <p><b>&lt;Projected programme costs, to be ratified in agreed business plan, plus 50%*&gt;</b></p> <p><u>Year One:</u> Projected programme costs, to be ratified in agreed business plan, plus 50%.</p> <p><u>Year Two:</u> Projected programme costs, to be ratified in agreed business plan, plus 50%.</p> <p><b>Notes:</b></p>	

The scale of the programme must be estimated for inclusion in the CQUIN package in advance of completion of the business plan. If construction of the business plan reveals that a materially larger or smaller programme is required, a Contract Variation may be required.

Programme costs (before addition of the 50% CQUIN incentive) should normally be capped at £250k however local flexibility may be applied dependent on size of service redesign programme and level of benefit realisation.

\*Where the scale of convergence to most efficient quartile costs and prices is substantial additional earning potentials for providers from commissioner savings delivered from agreed reduced local price agreements for 2018/19 onwards may be negotiated locally through a one year non-recurrent gain share arrangement on delivery of local price reduction at commissioner discretion.

#### C4. Payment Triggers and Partial Achievement Rules

##### Payment Triggers

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year
<b>Trigger 1:</b>	<p>Provider-specific agreed plan for service reform of those services which are above the most efficient levels of cost - signed off nationally.</p> <p>Specifically, for each service included in this scheme:</p> <ul style="list-style-type: none"> <li>• Production of a Business Case clearly defining service review programme and milestones for KPIs signed off jointly by NHS England and the provider Board, with CQUIN costs of the system-redesign shown to be justified by the projected reduction in service costs and prices.</li> <li>• Agreed reduction in local prices reflecting planned transition to reflect those lower costs over the 2 year period, including gain share arrangements if any.</li> </ul>	Achievement of Year Two milestones set out in the Business Case.
<b>Trigger 2</b>	Where appropriate, creating and participating in network arrangements with peer group providers to enable local clinicians to benchmark practices and implement change.	Agreed signed contract variation for revised Price Schedule reflecting achievement of cost and price reduction as planned.

<b>Trigger 3</b>	Achievement of Year 1 milestones set out in the Business Case	
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### **Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>First Year of scheme</b>	<b>Second Year</b>
<b>Trigger 1</b>	45%	40%
<b>Trigger 2</b>	40%	60%
<b>Trigger 3</b>	15%	
<b>TOTAL</b>	100%	100%

### **Partial achievement rules**

Where more than one service is under review, allocation of CQUIN reward should be proportionate to the anticipated cost reduction in each service.

For each service, reward should be:

- All or nothing for Triggers 1 and 2, year 1.
- For Trigger 4 year 1, and Trigger 1 year 2, payment should be proportional to achievement of milestones against KPIs as agreed in the Business Case agreement for each service.

### **Definitions**

*Not applicable.*

### **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

1. Business Case for service redesign programme
2. Provider specific service redesign plan
3. Agreed signed Price Schedule (for relevant contract year dependent on year 1 or year 2 achievement)
4. Network arrangements Terms of Reference and reporting requirements (where appropriate)

### **Information for Benchmarking**

- National benchmarked local price data
- 2015/16 Reference Costs
- Provider service line costing data

### **Information for Evaluation**

To be agreed locally as per the provider specific service redesign plan.

### **Reporting of Achievement against Triggers**

Milestone reporting of programme as per business case and service redesign plan including any KPI performance reporting.

### **Reporting Template requirement**

To be locally agreed.

## **C6. Supporting Guidance and References**

National Tariff Payment System  
Carter Review  
National Reference Costs

## **Section D. SCHEME JUSTIFICATION**

### **D1. Evidence and Rationale for Inclusion**

#### **Evidence Supporting Intervention Sought**

- Benchmarked data on reference costs and local prices demonstrates material variance in provider costs and local prices respectively.
- Rationale for the specific service re-design will be set out in the business case.

#### **Rationale of Use of CQUIN incentive**

This programme is targeted at delivering efficiencies in commissioner spend, ensuring prices cover provider cost, and deliver the improvements in cost per Weighted Activity Unit set out in the Carter productivity programme reflected in each provider's benefit realisation milestones.

Resistance to moving locally priced services to a national price often reflects lack of funding to redesign services such that efficient-cost prices would be sustainable.

The provider is expected to incur fixed non-recurrent costs from the required service redesign programme to deliver reduction in provider service costs. Therefore NHS England recognises that to fully incentivise the most optimum service design the CQUIN payment is required to ensure that providers are reimbursed appropriately during the redesign phase.

The programme is expected to maintain delivery of quality services whilst reducing commissioner spend and protecting provider financial sustainability.

<b>D2. Setting Scheme Duration and Exit Route</b>
Funding is required to cover one-off fixed costs relating to the service redesign programme. Therefore it is assumed that there will be no recurrent costs incurred by the provider following the end of the scheme.
<b>D3. Justification of Size of Target Payment</b>
The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows: <ul style="list-style-type: none"> <li>• Projected costs will be used to construct payment including a 50% premium as set out in Section C3.</li> <li>• The justification of the costing against projected benefits will be developed in the Business Case to be produced in the implementation of this scheme. If costs cannot be justified, the scheme will be adjusted or aborted via a Contract Variation.</li> </ul>
<b>D4. Evaluation</b>
To be developed locally as per service redesign programme and provider specific agreed plan for service reform of those services which are above the most efficient levels of cost - signed off nationally.

## 12 GE5 Shared Decision-Making

<b>Scheme Name</b>	<b><i>GE5 Shared Decision Making</i></b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	<i>[QIPP reference if any : Add Locally]</i>
Duration	April 2017 to March 2019
<b><u>Problem to be addressed</u></b>	
<p>Specialised Commissioning includes a high number of services where patients will be in a pathway where treatment becomes more intensive as their condition progresses. Patients may only be offered the service normally offered by that practitioner. There is some evidence that patients have an assumption that further new treatment will materially improve their condition. The result may be further treatment that may not result in significant patient benefit. Other treatment options or self-care may better fit with the patients' overall needs and values and clinical ability to benefit. Patients often choose less intensive treatment options when shared care tools are used to create understanding of the alternatives available. Cardiac treatment is one focus area (e.g. choices between medical treatment/PCI/CABG); others are listed below.</p>	
<b><u>Change sought</u></b>	
<p>To ensure ALL relevant treatment options are discussed with patients, to enable choices aligned to a patient's overall needs and values and clinical ability to benefit. To achieve this clinical teams require skills to engage patients in shared decision making and need to be aware of the range of treatment or support options beyond their immediate area of expertise and the associated outcomes. The ultimate aim is to ensure clinical teams understand the full range of treatment options available and emphasise to patients their ability to benefit from all of these options as part of the decision making process. It is anticipated that this should reduce the demand for successive treatments which is particularly relevant to specialised services.</p> <p>Providers will need to develop a Shared Decision Making resource that is specific to the particular condition, encompassing the range of options that should be offered, with reference to the local services available.</p>	
<b>Section B. CONTRACT SPECIFIC INFORMATION</b> <i>(for guidance on completion, see corresponding boxes in sections C below)</i>	
<b><u>B1.Provider</u></b> (see Section C1 for applicability rules)	<i>Insert name of provider --</i>
<b><u>B2. Provider Specific Parameters.</u></b>  <i>What is the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)</i>	<i>2017/18, 2018/19 [Adjust locally]</i>  <i>Two years (Adjust locally)</i>  <i>[Other – as specified in C2.]</i>
<b><u>B3.Scheme Target Payment</u></b> (see Section C3 for rules to determine)	Full compliance with this CQUIN scheme should achieve payment of:

target payment)	<p><i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i></p> <p>Target Value: <i>[Add locally ££s]</i></p>
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**B4. Payment Triggers.**

The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

**Year One payment Triggers**

**Second year Payment Triggers**

*[Adjust table as required for this scheme – or delete if no provider-specific information is required.]*

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*



<b>Section C. SCHEME SPECIFICATION GUIDE</b>	
<b>C1. Applicable Providers</b>	
<b><i>Nature of Adoption Ambition: Early Adopter Scheme</i></b>	
Providers who agree to work on development of SDM.	
Patient cohorts at the following decisions nodes have been identified as likely to benefit from SDM:	
<ul style="list-style-type: none"> <li>• Cardiac patients choosing between Medical treatment, PCI, CABG</li> <li>• pulmonary fibrosis (ILD)</li> <li>• severe asthma</li> <li>• complex surgical oncology</li> <li>• other patient groups proposed by the provider and endorsed by the national team.</li> </ul>	
<b>C2. Provider Specific Parameters</b>	
The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	<ul style="list-style-type: none"> <li>• Named specialties / cohorts of patients for use of SDM measure, identifying the relevant decision node.</li> <li>• Number of patients at each decision node to be recruited into the programme for application of the SDM from 4<sup>th</sup> quarter year 1 through to 4<sup>th</sup> quarter, year 2</li> <li>• Number of staff to be trained to support each decision node.</li> </ul>
<b>C3. Calculating the Target Payment for a Provider</b>	
The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:	
<b>(The Level of financial incentive is set separately for each group of patients pertaining to a specific decision set. The payment for such a group is:</b>	
<ul style="list-style-type: none"> <li>- £60,000 for a cohort of 250 patients,</li> <li>- with variation of £60 per patient for greater or lesser size cohort.)</li> </ul>	
<i>For example:</i>	
<ul style="list-style-type: none"> <li>- A scheme with one patient cohort around a decision node of 100 patients would attract a payment of £60,000 – (150x£60) = £51,000.</li> <li>- A scheme with three patient cohorts of respectively 1000 patients, 500 patients and 100 patients would attract a payment of (3x£60,000) + (750+250-150) x (£60)= £231,000.</li> </ul>	
A separate calculation should be made for each year according to the expected roll out of the scheme to different patient groups.	
<b>See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.</b>	
<b>C4. Payment Triggers and Partial Achievement Rules</b>	

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year: for cohorts carried over from year one. (For any new cohorts, new decision nodes, year one triggers be used)
Trigger 1:	<p><b>ONE: Planning &amp; Set-Up:</b> For each patient cohort,</p> <ol style="list-style-type: none"> <li>1. A working group has been established to agreement on which parts of the pathway (decision nodes) present different treatment options that should be subject to SDM.</li> <li>2. review tools for decision support and other modes of enhancing SDM;</li> <li>3. Implementation plan written and submitted to commissioners including:                             <ol style="list-style-type: none"> <li>a. team building and training plan for staff who will administer SDM</li> <li>b. plan for creation of mechanisms for gathering, and analysing information about decisions made and patient experience of SDM to support formative evaluation, with clarity regarding: What immediate use is to be made of it.</li> </ol> </li> </ol>	<p>The proportion of the patient groups targeted in each condition:</p> <ol style="list-style-type: none"> <li>c. recruited into the programme for application of the SDM in 2018/19 and</li> <li>d. for whom information on decision making in base period and following introduction of SDM, and on patient experience of the use of the SDM tool is gathered.</li> </ol> <p>Standard survey instrument as year one trigger 5 to assess patients' sense of involvement should be used.</p>
Trigger 2	<p><b>TWO: Team Building.</b></p> <ol style="list-style-type: none"> <li>4. Team building and training plan for staff to administer the SDM tool has been implemented – for each patient cohort decision node</li> <li>5. Readiness. Assessment of SDM tool preparedness of team and any identified shortfalls have been addressed.</li> </ol>	
Trigger 3	<p><b>THREE: Pilot Application of SDM Tool.</b></p> <ol style="list-style-type: none"> <li>6. Pilot testing and evaluation of</li> </ol>	

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	<p>use of SDM tool</p> <p>7. Baseline information captured from SDM administered to pilot cohort of patients</p>	
<b>Trigger 4</b>	<p><b>FOUR: Finalisation of SDM tool and supporting information:</b></p> <p>8. To finalise the range of treatment options that can be offered</p> <p>9. To adapt this to local resources and services available</p> <p>10. To develop information to support shared participation</p> <p>11. Report to commissioners on progress against implementation plan including any new patient cohorts selected for year 2</p>	
<b>Trigger 5</b>	<p><b>Five: Implementation:</b></p> <p>12. The proportion of the patient groups targeted in each condition:</p> <p>a. recruited into the programme for application of the SDM in Quarter Four (or earlier) and</p> <p>b. for whom information on decision making in base period and following introduction of SDM, and on patient experience of the use of the SDM tool is gathered.</p> <p>Standard survey instrument “Advancing Quality Alliance Sure Tool or Measuring Patient’s Experience [AQUA] to assess patients’ sense of involvement should be used.]</p>	

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target	First Year of scheme	Second Year: for cohorts carried over from year one.
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Payment per Trigger		[For any new cohorts, new decision nodes, year one proportions be used.]
Trigger 1	15%	100%
Trigger 2	15%	
Trigger 3	15%	
Trigger 4	15%	
Trigger 5	40%	
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

Year One

Trigger 1: all-or-nothing

Trigger 2: all-or-nothing

Trigger 3: all-or-nothing

Trigger 4: all-or-nothing

Trigger 5: Strictly Proportional

Year Two

Trigger 1: Strictly Proportional

**Definitions**

Denominator for trigger 5: Number of patients in each of the targeted LTCs whom it is agreed should be targeted for completion of the SDM.

Numerator: Number actually completing the SDM in these groups creating usable data

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

Information templates to be developed in support of this scheme, and to capture:

- **Information for Benchmarking**
- **Information for Evaluation**

and to address **Information Governance issues.**

**Reporting of Achievement against Triggers**

The source of data for payment trigger 5 (see above), will have to be developed as the SDM CQUIN is adopted at the level of individual providers for specific patient groups.

<p>If a software solution is adopted for administration of the SDM, then extracts from the implemented software will be usable to confirm active users and active records.</p> <p>It is likely that providers will need to identify internal systems to identify the speciality / patient cohort and record the data. It is likely that specialist nurses could be used as a resource to identify patients and support data collection; though for inpatients admission under the specialty code may be used as a marker, and to validate of report.</p>
<p><b><u>Reporting Template requirement</u></b> :A template will be available.</p>
<p><b>C6. Supporting Guidance and References</b></p>
<p>N/A.</p>
<p><b>Section D. SCHEME JUSTIFICATION</b></p>
<p><b>D1. Evidence and Rationale for Inclusion</b></p>
<p><b><u>Evidence Supporting Intervention Sought</u></b></p> <p>See: “PATIENTS’ PREFERENCES MATTER Stop the silent misdiagnosis”; Kings Fund 2012, Al Mulley, Chris Trimble, Glyn Elwyn</p> <p>The implementation of a shared decision making system is designed to realise significant benefits to the healthcare system from improved patient outcomes and experience of care and from a more considered use of higher-cost interventions.</p> <p>Patient engagement with decision making has been linked to improved health outcomes and has been shown to increase patient satisfaction by supporting independence which can also be linked to higher quality interactions with healthcare professionals.</p>
<p><b><u>Rationale of Use of CQUIN incentive</u></b></p> <p>From a provider perspective, under existing payment systems, SDM may well not be self-funding even where it is cost-saving from a system point of view. Hence CQUIN is an appropriate lever.</p> <p>An early adopter approach is appropriate given that the evidence base of cost-consequences of SDM is not well developed.</p>
<p><b>D2. Setting Scheme Duration and Exit Route</b></p>
<p>Incorporation of changes in the cost per care episode or year of care into core tariff payments for SDM interventions will be developed during the course of the CQUIN scheme’s evaluation, based on the balance of expected savings from improved sensitivity of intervention to patients’ needs and wishes. Plans will be developed for each patient group to ensure that funding is sustainable.</p>
<p><b>D3. Justification of Size of Target Payment</b></p>
<p>The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:</p>

Where the scheme requires use of a survey tool in Year 1, the target payments have been modelled on that for the first year of 2016/17 GE2 Activation System for LTC Patients. The Level of financial incentive for that element of the GE2 scheme, including staff training in the administration of the questionnaire, is £60,000 for a cohort of 500 patients, with variation of £30 per patient for greater or lesser size cohort. However, for the SDM scheme, patient numbers are expected to be lower because the survey tool is only really meaningful where the patient pathway offers a range of treatment options. This will require more effort by the Trust to identify suitable pathways and patients than for the main GE2 scheme, and more additional time per patient in consultation. Hence the threshold number of patients is set at 250, and the payment variation per patient is set at £60.

#### **D4. Evaluation**

This scheme requires evaluation, and resources are being sought to support this. Information collection set out above will be designed to support evaluation.

## 13 IM2 Cystic Fibrosis Patient Adherence (Adult)

<b>Scheme Name</b>	<b>IM2 Cystic Fibrosis Patient Adherence (Adult)</b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any : Add Locally]
Duration	April 2016 to March 2019
<p><b><u>Problem to be addressed</u></b></p> <p>Currently, routine clinical management in CF in the UK is carried out without knowledge of adherence. Without objective measures neither patients nor clinicians can reliably estimate adherence. Health economic modelling suggests that, if an adherence intervention of modest effectiveness were to be implemented across the 6000 adults in the UK with CF, savings of more than £100 million might be expected over a 5 year time scale.</p>	
<p><b><u>Change sought</u></b></p> <p>The behaviour change that is sought is:</p> <ol style="list-style-type: none"> <li>1) Improved adherence and self-management by patients, enabling better health outcomes and much less time off work and other life activities.</li> <li>2) Change in clinical teams so that they devote time to delivering structured evidence based interventions to improve and to support patient activation that in turn supports adherence and self-management.</li> <li>3) Change in the attitude of clinicians to the challenges of sustained adherence in clinical care. It is likely that patients will only share personal data with teams that have an appropriate and supportive attitude.</li> </ol> <p>The CFHealthHub software platform supports this intervention by:</p> <ol style="list-style-type: none"> <li>1) Making the capture of adherence data automatic.</li> <li>2) Making adherence data available at all clinical encounters.</li> <li>3) Providing feedback of data to patients which will support behaviour change</li> <li>4) Providing structured interventions to allow clinicians to support behaviour change in patients to increase adherence</li> <li>5) Supporting the fidelity of interventions to increase patient activation through menus available within CFHealthHub</li> <li>6) Providing unit level adherence data to allow units to understand their unit level adherence as a quality indicator</li> </ol>	
<b>Section B. CONTRACT SPECIFIC INFORMATION</b> (for guidance on completion, see corresponding boxes in sections C below)	
<b>B1.Provider</b> (see Section C1 for applicability rules)	[Insert name of provider]
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, & how many years are covered by this contract? (See Section C2 for other provider-	2016/17 <sup>9</sup> , 2017/18, 2018/19 Two years

<sup>9</sup> I.e. scheme was contracted for first implementation in 2016/17 with Southampton, Nottingham and with Sheffield, and this template is setting out requirements for 2<sup>nd</sup> and perhaps 3<sup>rd</sup> year of scheme for those providers; for other providers this contract is for the 1<sup>st</sup> and 2<sup>nd</sup> year of participation in a pilot.

specific parameters that need to be set out for this scheme.)		
<b>B3. Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>	
<b>B4. Payment Triggers.</b> The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4. No local variation is appropriate.		
<b>B5. Information Requirements</b>		
<b>Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.</b>		
Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>	
<b>B6. In Year Payment Phasing &amp; Profiling</b>		
Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.  <i>However, for the '17/18 trial, commissioners should note that</i> <ul style="list-style-type: none"> <li><i>Hospitals will need money to make staff-appointments to support the programme.</i></li> <li><i>Equipment costs for each site per annum will be required in 1 month in advance of patient recruitment commencement within the RCT Sept 2017.</i></li> <li><i>The infrastructure costs of the central team developing and supporting CF Health Hub requires payment at the commencement of the year (April 17) to allow for this support to be redistributed via the sponsor.</i></li> </ul>		
<b>Section C. SCHEME SPECIFICATION GUIDE</b>		
<b>C1. Applicable Providers</b>		
<b>Nature of Adoption Ambition: “Universal Adoption” for designated Trial sites</b>		
<b>C2. Provider Specific Parameters</b>		
The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	<ul style="list-style-type: none"> <li>None</li> </ul>	
<b>C3. Calculating the Target Payment for a Provider</b>		
The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, as follows:		
	<b>2017/18</b>	<b>2018/19</b>
Sheffield (data observatory	£360,000	£300,000



site and RCT co-ordination)		
Nottingham, Southampton (data observatory sites)	£270,000	£195,000
Other Trusts (RCT sites)	£160,000	£220,000

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

#### **C4. Payment Triggers and Partial Achievement Rules**

##### **Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows: (detailed breakdown of the costs are provided in the tables in section D3 below)

##### Payment Triggers:

##### Sheffield data observatory and RCT co-ordination

- 1) Interventionist staff must be funded and in post for 12 months for each CQUIN cycle.
- 2) The trial specified nebulizers, nebuliser handsets, communication hubs and monthly patient data-flow must be funded. This equipment and dataflow will be supported by the Trust under a framework agreement led by the Sponsor with the equipment provider.
- 3) Screening for eligibility for data observatory must be carried out on clinic population and eligible patients approached for recruitment with data presented on reasons for recruitment and non-recruitment to data observatory.
- 4) Staff funded to support data observatory and RCT must follow agreed protocols relating to data observatory and RCT.
- 5) Study specific Infrastructure support not incurred at sites (Treatment costs for CF health hub) will be recovered from sites as per the attached schedule B as a pass through payment at the commencement of the year.

##### Nottingham and Southampton data observatory sites

- 1) Interventionist staff must be funded and in post for 12 months for each CQUIN cycle.
- 2) The trial specified nebulizers, nebuliser handsets, communication hubs and monthly patient data-flow must be funded. This equipment and dataflow will be supported by the Trust under a framework agreement led by the Sponsor with the equipment.
- 3) Screening for eligibility for data observatory must be carried out on clinic population and eligible patients approached for recruitment with data presented on reasons for recruitment and non-recruitment to data observatory.
- 4) Staff funded to support data observatory must follow agreed protocols relating to data observatory.
- 5) Study specific Infrastructure support not incurred at sites (Treatment costs for CF health hub) will be recovered from sites as per the Table C as a pass through payment at the commencement of the year.

##### Other Trusts (RCT sites)

- 1) Interventional staff must be funded and in post for 12 months for each CQUIN cycle.
- 2) The trial specified nebulizers, nebuliser handsets, communication hubs and monthly patient data-flow must be funded. This equipment and dataflow will be supported by the Trust under a framework agreement led by the Sponsor with the equipment.
- 3) Screening for eligibility for randomised controlled trial (RCT) must be carried out on clinic population and eligible patients approached for recruitment with data presented on reasons for recruitment and non-recruitment to RCT. Target recruitment as an average

is 35 per site.

- 4) Staff funded to support RCT must follow agreed protocols relating to delivering RCT.
- 5) Study specific Infrastructure support not incurred at site (Treatment costs for CF health hub) will be recovered from sites as per the Table A as a pass through payment as the commencement of the year.

### **Definitions**

Not applicable

### **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

#### **Information for Benchmarking**

The clinical trials unit at University of Sheffield will support the information flows to support benchmarking. This will include data captured from CFHealthHub which will be provided to participating centres and collects process data documenting engagement with the data observatory and RCT.

In addition structured training will be provided to the staff employed by the CQUIN and this training will involve structured fidelity measures which will assess competency and delivery of the roles that deliver the RCT and data observatory.

For centres within the RCT the clinical trials unit will collect data to ensure that trial procedures are followed and this will include trial monitoring visits that will provide data to allow trusts to satisfy the criteria to trigger CQUIN payments.

#### **Information for Evaluation**

Data for evaluation will come from CFHealthHub that collects data on the use of CFHealthHub to support people with CF and also data on the use of CFHealthHub to support day to day management of PWCF in clinics. These data will be processed by the clinical trials unit and provided back to units to allow evaluation.

#### **Information Governance**

CFHealthHub has been developed to meet all the relevant information governance standards. Formal ethical approvals through the national ethical governance procedures will govern the conduct of both the RCT and data observatory.

People with CF (PWCF) the RCT will receive information allowing them to sign consent forms to ensure that all data use has explicit consent. In addition all PWCF who enter the RCT will retain control of their data and data will only be shared with their permission and within the permitted uses authorised by the ethics approval relating to the RCT.

PWCF entering the data observatory will also be fully informed and sign consent forms to ensure that they agree to any use of their data. Just as in the RCT PWCF will retain control of their data and decide how it is shared.

#### **Reporting of Achievement against Triggers**

##### **2016/17 Pilot**

The Clinical trials unit at Sheffield School of Health and Related Research (SchHARR) will monitor involvement of centres in the trial and will be able to confirm to commissioners that the pilot centres have taken part in all the evaluation activities.

Data sources for RCT (from 2017/18) are discussed in the additional information supporting this CQUIN. The CQUIN will be delivered and evaluated within a structured framework that allows testing of the intervention within an RCT, mixed methods process evaluation of both clinician and patient experience and a formal health economic analysis. Details can be found at <https://www.sheffield.ac.uk/scharr/sections/dts/ctru/actif>

<b>Reporting Template requirement</b>
<b>C6. Supporting Guidance and References</b>
<p><b><u>RCT</u></b>  An intervention and research guide outlines the role of staff employed in each trust. In addition face to face training will be delivered over 2 days at the beginning of the RCT and further telephone support will always be available. Staff will complete competency assessments and there is virtual training available to all staff.</p> <p><b><u>Data observatory</u></b>  Training and support will mirror the training in the RCT.</p>
<b>Section D. SCHEME JUSTIFICATION</b>
<b>D1. Evidence and Rationale for Inclusion</b>
<p><b><u>Evidence Supporting Intervention Sought</u></b></p> <p>This scheme employs an electronic Cystic Fibrosis (CF) adherence indicator captured by an IT platform (CFHealthHub) to deliver a complex behavioural intervention that increases patient activation and adherence, thus delivering better patient outcomes and avoidance of costly escalations. Objective adherence is measured for high cost inhaled therapies collected via chipped nebulisers and displayed in CFHealthHub. CFHealthHub provides feedback to patients and clinicians about the adherence indicator in real time integrated into daily life and routine clinical care. CFHealthHub also provides a co-produced platform delivering a complex intervention designed to increase patient engagement by identifying barriers to patient activation and then using systematic behaviour change strategies to target barriers to patient activation. CFHealthHub also feeds back aggregated CF centre level adherence and engagement data that will support quality improvement at centre and system level.</p> <p>High cost inhaled therapies are prescribed in CF because randomised controlled trials have shown evidence of effectiveness in improving lung function and decreasing exacerbations. Inhaled medications can be considered to be preventative therapy that enables patients to self-manage in the community whilst working and attending school whereas intravenous antibiotics required to treat exacerbation can be considered to be rescue medications that typically require hospitalisation and will typically disrupt daily life. The benefits of inhaled therapies seen in RCTs are typically associated with adherence levels within RCTs of around 80%, whereas the median adherence rates in routine clinical practice are around 36%. Median adherence rates of only 36% for preventative therapy undermines therapy effectiveness and leads to avoidable hospital admissions. Medicine possession ratio data show that patients who collect less than 50% of their preventative therapy cost much more than those that collect 80% and the additional health care costs are related to unscheduled rescue care in hospital.</p> <p>Currently, routine clinical management in CF in the UK is carried out without knowledge of adherence. Without objective measures neither patients nor clinicians can reliably estimate adherence. This makes clinical encounters ineffective and may lead to important waste of resource: for example commissioning criteria allow escalation from bd tobramycin (approx. £7,000 per year) to tds aztreonam (approx. £12,000 per year) if tobramycin is failing. With median adherence of 36% the most likely reason for tobramycin failure is non-adherence and switching to a tds drug will also fail waste money and not allow the clinician to focus on the more important issue of supporting patient engagement and activation. Embedding adherence</p>

data in every consultation has been found to be transformative in trailblazing sites. CFHealthHub is a platform that collects adherence data for high cost inhaled therapies. CFHealthHub, the focus of this scheme, provides a structured intervention to support patient activation by feeding back patient's adherence and linking this to problem solving and motivational interventions.

Health economic modelling suggests that, if an adherence intervention of modest effectiveness were to be implemented across the 6000 adults in the UK with CF, savings of more than £100 million might be expected over a 5 year time scale.

The adherence indicator is generated by CFHealthHub from data from chipped nebulisers, with data displays co-produced with patients and clinicians. Data capture occurs automatically without interrupting the flow of routine care and without adding any burden. The adherence indicator is available in real time for patients and for clinicians to provide feedback, which is a strong driver of behaviour change.

The behaviour change that is sought is:

- 1) Improved adherence and self-management by patients, enabling better health outcomes and a much less time off work and other life activities.
- 2) Change in clinical teams so that they devote time to delivering structured evidence based interventions to improve and to support patient activation that in turn supports adherence and self-management.
- 3) Change in the attitude of clinicians to the challenges of sustained adherence in clinical care. It is likely that patients will only share personal data with teams that have an appropriate and supportive attitude.

CFHealthHub supports this intervention by:

- 7) Making the capture of adherence data automatic.
- 8) Making adherence data available at all clinical encounters.
- 9) Providing feedback of data to patients which will support behaviour change
- 10) Providing structured interventions to allow clinicians to support behaviour change in patients to increase adherence
- 11) Supporting the fidelity of interventions to increase patient activation through menus available within CFHealthHub
- 12) Providing unit level adherence data to allow units to understand their unit level adherence as a quality indicator

### **Link between behaviour change and outcome**

Meta-analysis has demonstrated that feedback of adherence data can increase adherence by around 20% and a further 7% increase in adherence results if relatively simple behaviour change strategies such as problem solving are added. High cost inhaled therapies are effective in reducing exacerbations if they are adhered to. Hence improving adherence will be associated with a reduced need for hospitalisation for intravenous antibiotics. The planned 20 centre RCT evaluation is designed to establish the relationship between the process of adherence and the outcome of reduced exacerbations. Once this relationship is established, adherence can be used as a quality indicator. The NIHR programme team are working with HSCIC to establish adherence as a UK quality indicator.

### **Rationale of Use of CQUIN incentive**

Scheme will generate financial benefits for commissioners as well as providers – on top of

improved patient outcomes. It is therefore appropriate for commissioners to fund it.

## D2. Setting Scheme Duration and Exit Route

The UK CF Registry is currently used to support commissioning in CF. Once the evaluation phase is completed, we will report unit level adherence in the CF registry as an important quality indicator that will be routinely collected by CFHealthHub and regular feedback and benchmarking of unit level adherence in the CF registry reports will drive continued use of CFHealthHub to support adherence in clinical care.

Financial savings from improved adherence, which support the continuation of the programme, are shared between commissioners and providers. Providers continue to benefit from implementing strategies to increase patient activation since patients require less unscheduled rescue care. Costs will in due course feed through into the CF year of care tariff.

## D3. Justification of Size of Target Payment

The target payment is based upon a detailed costing of the requirements falling upon the trial participants, and upon the three centres who have implemented the scheme in 2016/17 and are graduating to become Data Repositories, and upon Sheffield as programme coordinator, so as to ensure payment of at least 150% of average costs incurred. This site costing necessarily includes a site share of the infrastructure support for central teams that are incurred outside of each Trust supporting CF Health hub development. This is shown in the detailed tables A, B and C.

The costing is as follows:

CF HealthHub				
Provisional estimates for Donald Franklin and Ursula Peale - 10th September 2016 v21 ERF				
Required NHS England CQUIN Support April 2017-June 2020				
	12m	12m		39 months
Summary as at 17/008/2016: Provisional figures will be changing as estimates confirmed	2017-18	2018-19		April 2017-Jun 2020 Total
A. Total Sheffield CQUIN for patients as participants within Data Observatory	£ 241,749	£ 196,999		£ 695,848
B. Total CQUIN costs for Nottingham as participants in Data Observatory	£ 179,779	£ 128,953		£ 412,465
C. Total CQUIN costs for Southampton / Poole as participants in Data Observatory	£ 179,779	£ 128,953		£ 412,465
D. Total CQUIN costs for PER SITE in RCT/ Data Observatory unit recruiting 35 patients (for initial 17 centres)	£ 106,923	£ 145,353		£ 497,767
<b>E. Total Costs RCT/ Data observatory 17 centres + Sheffield + Pilot sites -39 months</b>				<b>£ 9,982,808</b>
F. Total CQUIN site cost for additional patients for 35 patients per site > 20 sites	£ 90,873	£ 72,113		£ 299,515

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Table A Details of Costs for RCT sites : Cost per Site (Year 1 and 2)

<b>For 17-18 and 18-19 CQUIN 17 RCT Sites</b>		
<b>NHS Financial Year</b>	<b>2017-18</b>	<b>2017-19</b>
Year ending	<b>31/03/2018</b>	<b>31/03/2019</b>
No completed month costs	<b>12m</b>	<b>12m</b>
Equipment costs	31,366	16,803
eFlow data transfer expenses	940	5,447
Interventionist	27,071	40,606
Interventionist travel to Patient Homes	1,787	1,434
Quality improvement travel for Interventionist	-	1,825
<b>Total Interventionist / Nebuliser Equipment and data flow Trust Incurred Costs</b>	<b>61,163</b>	<b>66,115</b>
Central expenses for Infrastructure not RCT Trust incurred Costs	45,760	79,238
<b>Cost per Site</b>	<b>£ 106,923</b>	<b>£ 145,353</b>

NB : Additional funding from Research Grant to support Interventionist will be part of non-commercial agreement with sites

Table B Details Costs for Sheffield Site Data Observatory and RCT co-ordination (Years 2 and 3)

<b>Sheffield Data Observatory Patients</b>			
<b>NHS Financial Year</b>	<b>2017-18</b>	<b>2018-19</b>	<b>Total</b>
Year ending	<b>31/03/2018</b>	<b>31/03/2019</b>	
No completed month costs	<b>12m</b>	<b>12m</b>	
Equipment costs	112,023	-	112,023
eFlow data transfer expenses	14,454	23,958	38,412
4 x PAs for Senior Investigator	46,260	46,260	92,520
Intrventionist Sheffield	3,408	42,753	46,161
Microsystems Coaching Academy	13,728	14,313	28,041
Central expenses for Infrastructure	51,876	69,715	121,591
<b>B. Total Sheffield CQUIN</b>	<b>£ 241,749</b>	<b>£ 196,999</b>	<b>£ 438,748</b>

NB Additional funding from NIHR Programme Grant to support Interventionist will be part of non-commercial agreement with sites

Table C Details of Cost for Nottingham and Southampton/Poole Sites : Cost per site

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Per Site Costs for Nottingham and Southampton and Poole Data Observatory		
NHS Financial Year	2017-18	2017-19
Year ending	31/03/2018	31/03/2019
No completed month costs	12m	12m
Equipment costs	89,618	-
eFlow data transfer expenses	8,039	17,279
Interventionist	49,332	52,000
Interventionist travel to patient homes	4,175	5,250
Quality improvement travel and accommodation for Interventionist	6,692	7,300
Central expenses for Infrastructure not RCT Trust incurred Costs	21,924	47,124
<b>Total Nottingham and Southampton Site Expenses for CQUIN</b>	<b>£ 179,779</b>	<b>£ 128,953</b>

Additional funding from NIHR Programme Grant and service support costs from local Clinical Research Networks to support 1.0 wte Interventionist will be available in 2017-18 and 2018-19 NHS Financial years.

Allowing the standard 50% CQUIN premium, this would give CQUIN payments as set out in section C3.

#### D4. Evaluation

The scheme is being evaluated as part of an NIHR Research Grant

#### Appendix: Providers

	From	Confirmed Y/N
Sheffield	current	
Nottingham	current	Y
Southampton	current	Y
Birmingham Heartlands	17/18	Y
Bristol	17/18	tbc
Cambridge Papworth	17/18	tbc
Royal Devon & Exeter	17/18	tbc
Frimley Park	17/18	tbc
Hull/York (service merging)	17/18	tbc
Leeds		tbc
Leicester	17/18	tbc
Liverpool	17/18	tbc
Barts	17/18	tbc
Kings College London	17/18	Y
Royal Brompton	17/18	tbc
UHSM	17/18	tbc (were going to be in pilot)
Newcastle	17/18	Y
UHNM (Stoke)	17/18	tbc
Norfolk & Norwich	17/18	tbc
Oxford	17/18	Y in principle
Plymouth	17/18	tbc

## 14 IM 3 Auto-immune Management

<b>Scheme Name</b>	<b>IM 3 Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance</b>
Eligible Providers	All providers of specialised rheumatology services
QIPP	Insert locally
Duration	April 2016 to March 2019
Scheme Payment (% of CQUIN-susceptible contract value available for this scheme)	<p>CQUIN payment proportion [Locally Determined] should achieve payments of £180 per projected number of MDTs (up to one per patient).</p> <p>2017/18 Target Value: Add locally</p> <p>2018/19 Target Value: Add locally</p>
<b>Scheme Description</b>	
<p><b><u>Problem to be addressed</u></b></p> <p>Currently, there is no coordinated process within each Region that ensures comprehensive governance of the management of rare autoimmune rheumatic diseases or supports a cohesive drive to improve outcomes. As a result, there is significant variation in standards of care and outcome depending on where patients are treated, as well as in utilisation of costly therapies, sometimes inappropriately. This tends to be influenced by both the process of care (e.g. within designated specialised as opposed to general clinics) and the degree of availability, support and interaction with specialised centres, where larger volume care, usually combined with research, is delivered.</p> <p>Systemic auto-immune rheumatic diseases are rare, multisystem, non-genetic conditions that have high morbidity and mortality. They share overlapping clinical and serological features, affect multiple organ systems, and therefore require coordinated multidisciplinary care.</p> <p><b><u>Change Sought</u></b></p> <p>Earlier diagnosis and intervention, enhanced recognition of severe or refractory manifestations requiring specialised centre involvement, and earlier detection/prevention of relapse will reduce avoidable mortality and morbidity, reduce costs, and improve quality of life, aligned with the vision of the NHS Outcomes Framework.</p> <p>This CQUIN is to support the development of coordinated MDT clinics *and MDT meetings for patients with multisystem auto-immune rheumatic diseases *(see definition of this cohort in definitions section below), and to ensure data collection and compliance with existing NHS England Commissioning Policies. This will be achieved by the development of a coordinated network that involves all rheumatology providers in each senate region, in the context of the establishment of national model Specialised Rheumatology centres.</p>	



**Target Payment**

To set the target CQUIN payment for this scheme at a level commensurate with the cost of implementation, it is necessary to estimate a target number of patients \*who met the definition below e.g. whose care will be considered by MDT and data capture as prescribed.

The target payment will be £180 times the number of patients targeted.

To set the value of the scheme, it is therefore necessary to estimate the number of patients that will be seen during 2017/18 and in 2018/19. Where available this should come from electronically flagged attendances at outpatient clinics. Where not available electronically the definitions below should be used to determine likely numbers. Actual payment of triggers 2 and 3 will depend upon the proportion of the caseload (according to the definition adopted) that is compliant – irrespective of whether the outturn caseload differs from that expected.

Enhanced payment is appropriate for providers taking on network responsibilities.

**Measures & Payment Triggers****FOR YEAR ONE**

**Trigger 1.** Initiation of hub and spoke arrangements or networks, to review treatment plans of specialised rheumatology patients in line with policies (see Annex). All providers across networks are responsible for developing a working group for this CQUIN and an implementation plan.

**Trigger 2.** The proportion of patients benefiting from comprehensive governance of the management of rare autoimmune rheumatic diseases through MDTs. Every patient discussed by MDT should have an outcome recorded \*which should include a minimum dataset (see data sources section below). If the request for an MDT review is for consideration of high tariff drug the one of 3 potential outcomes should be documented:

- a) Diagnosis not confirmed, referred back to clinician
- b) Diagnosis confirmed, does not currently meet criteria for policy, e.g. first and second line therapies not exhausted, treatment plan agreed
- c) Diagnosis confirmed, meets criteria for policy

**Trigger 3.** The proportion of patients whose treatment complies with policy and whose \*clinical information is collected onto the BILAG BR, DUO and UKIVAS registries in line with the published Specialised Rheumatology commissioning policies. It is therefore necessary to measure:

- a) \*The number of patients with specific diagnoses who are receiving drugs for which there are commissioning policies
- b) The number of patients entered onto the specific register

**Triggers 2 & 3** enable respectively (i) Audit of quality of referrals and of initial clinical management i.e. have first and second line therapies been appropriately tried and/or is the initial diagnosis by referring clinician accurate? (ii) Audit of policy compliance and outcomes.

**Trigger 4.** Achieving local data collection in order to determine the impacts of the network and Commissioning Policies.

FOR YEARS TWO AND THREE

**Trigger 1.** Further development of network arrangements, to review treatment plans of specialised rheumatology patients in line with policies. All providers across networks are responsible for developing a working group for this CQUIN and an implementation plan. To include use and monitoring of patient outcome/quality of life tools.

**Trigger 2.** As Year 1

**Trigger 3.** As Year 1

**Trigger 4.** Continuing local data collection in order to define the benefits of the network and Commissioning Policies through audit.

**Definitions**

**Patient cohort**

Any Multisystem Autoimmune Disease case requiring MDT discussion:

- Patients considered for High-tariff drugs (HTD)
- Patients managed in combined clinics (e.g. Chest/Rheum, Obstetric/Rheum)
- Patients referred to specialised centre MDT from another Rheumatologist for a second opinion
- Patients discussed at face-to-face or Video MDTs for advice regarding diagnosis or management

**Trigger 2**

- **Numerator** – number of patients discussed or seen by the MDT with a recorded outcome.
- **Denominator** – total number of patients seen or discussed by the MDT.

**Trigger 3**

Achievement is measured against the following indicator:

- **Numerator** - the number of patients treated within NHS England specialised rheumatology Commissioning Policies during each year whose treatment plans have been considered by a Specialised Centre MDT where required, and whose data collection into the BILAG BR, UKIVAS and DUO registries is compliant with the published policies.
- **Denominator** - the number of patients \*who received drug therapies for which there are commissioning policies in specified conditions.

**Partial achievement rules**

For Triggers 2 and 3, payment proportionate to achievement.  
Otherwise: all or nothing.

**Payment Weighting**

Period	Trigger	Weighting (% of CQUIN scheme available)
Year 1	Triggers 1, 4	25% each
Year 1	Trigger 2	25% Payment should be

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		proportional to the ratio of numerator to denominator as above
Year 1	Trigger 3	25% Payment should be proportional to the ratio of numerator to denominator as above
Years 2 & 3	Triggers 2, 3	40% Payments should be proportional to the ratio of numerator to denominator for the respective indicators as above.
Years 2 & 3	Trigger 1	40%
Years 2 & 3	Trigger 4	20%
<b>Rationale for inclusion</b>		
<p>CQUIN support is appropriate given the coordination difficulties of establishing networks. The network will provide essential governance, and also ensure appropriate access to, and compliance with policy pertaining to, the high-cost drugs that are commissioned by NHS England for use in these conditions.</p>		
<b>Data Sources, Frequency and responsibility for collection and reporting</b>		
<p>Two types of data requirement:            Narrative reports – produced by lead Clinical Teams, quarterly reporting to commissioner            Dataset: Provider submission to commissioner and the BVAS, DUO and BILAG registries in line with the published Specialised Rheumatology policies. *3 monthly reporting of registry data which is in line with the submission of the specialised rheumatology quality dashboard data            Appropriate data collection – to fulfil numerator for CQUIN:</p> <ul style="list-style-type: none"> <li>• For non HTD cases:               <ul style="list-style-type: none"> <li>○ MSAID Diagnosis/Diagnoses</li> <li>○ Comorbidities</li> <li>○ Drugs</li> </ul> </li> <li>• For HTD cases:               <ul style="list-style-type: none"> <li>○ MSAID Diagnosis/Diagnoses</li> <li>○ Comorbidities</li> <li>○ Drugs</li> <li>○ Disease activity scores</li> </ul> </li> </ul>		
Baseline period/date & value	<p>See accompanying Worksheet, “IM.iii Rheumatology Datasheet”, for background data on activity by diagnosis and provider.            This should guide the setting of the number of patients to be targeted for MDT consideration and data capture</p>	
Final indicator period/date (on which payment is based) & Value	MDT actual activity for financial year as at Month 12	
Final indicator reporting date	Last day of the month following end of Q4	
CQUIN Exit Route How will the change including any performance	Ongoing network led audit programme and disease registry data will be available to ensure compliance.	

requirements be sustained once the CQUIN indicator has been retired?	Savings arising from the MDTs and data collection would largely accrue to the commissioners. In due course, the cost of the MDTs will feed through into reference costs and should be absorbed in tariff and local prices after the cessation of the CQUIN.
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## **Supporting Guidance and References**

### Evidence base

The benefits that will be delivered by the coordinated network for multisystem autoimmune rheumatic diseases include:

- Ensuring visibility of outcomes across the region, enable Regional and Sub Regional Teams to identify and ensure uniformity across all services
- Enabling structured assessment of disease activity and damage using validated outcome measures, which will ensure both audit benchmarking of outcomes and that treatment decisions are consistently based on disease status active disease, irreversible damage or relapse
- Embedding formal guidelines and pathways across the whole network, which will enable earlier intervention, structured internal organ screening and reduced risk of progression to organ failure (e.g. renal, lung, vision)
- Enhanced recruitment to research studies in these rare diseases, facilitated directly by the network and also the NHS England Commissioning Policies, which is essential in order to develop future treatment strategies
- Earlier intervention for severe disease with clear pathways of specialised centre involvement, which is likely to improve outcome and reduce costs associated with organ failure
- Patient satisfaction will be improved by reduced attendances enabled by coordinated care, and the reassurance that their care is being provided as part of a specialised network. Improved education, social and psychological support delivered through specialised centres will improve economic activity, and improve adherence and outcomes.

Costs associated with this CQUIN are estimated (by one provider feeding back on the draft scheme) as follows:

- establishing regional network
- Working group meeting followed by teleconference meeting x 1/ month for 12 months involving consultant, nursing and manager representative at each site - establish patient pathways and NHSE categories for referrals, guidelines / governance for biologics and cyclo prescribing
- establishing mechanisms for recording NHSE patients and auditable MDT discussions in electronic records / specialist databases
- establish mechanism for coding and reimbursement of this activity

Maintenance costs:

- Clinical time for discussion patients in MDTs, and recording discussions - estimate 4 hours per week for consultant, nurse and trainee for 20 patients ( average 12 mins per patient )
- Clinical time for capture of clinical outcome measures - 2 hours per week currently partially funded by CLRN research- no sustainable funding currently
- Network review meetings quarterly to review data and audit of outcomes, discuss governance issues
- Coding of MDT discussions

Key outcomes to be the following:

- Savings related to implementation of the Rituximab in ANCA Vasculitis Policy £3.6 million
- Savings related to implementation of the Bosentan and Sildenafil in Digital Ulceration Policy £6.5 million

The improved clinical care arising directly from the Network is likely to lead to direct savings via a **15-20% reduction** in each of the following:

- Number of patients with Lupus and Vasculitis who progress to end-stage renal replacement therapy (each single avoided case saves £30,000 per year, estimated minimum 12 cases avoided = £360,000).
- Number of patients with Scleroderma-related Interstitial Lung disease or Pulmonary Hypertension who progress to end stage disease/high cost drugs/respiratory failure. There will also be reduced activity costs of screening (Echo and Lung Function) of 25% by implementing the DETECT screening protocol. This is estimated to reduce the number of echocardiograms by 500-1000 and of CT scans by 500, with a (reference) cost saving of £93,000-£136,000.
- Costs associated with managing suspected Giant Cell Arteritis via the institution of networked GCA Fast Track Pathways. An economic evaluation of a Fast Track pilot in Southend indicates an average saving of £400 per case of suspected GCA, and significant reduction in the risk of permanent visual loss. The Incremental Cost-Effectiveness Ratio (ICER) of implementing the fast-track pathway is -£840 per QALY. There are 12,000 new cases of GCA each year; assuming that only 50% of the savings in the pilot are realisable, equates to a saving of £2.4 million.
- Number of hospital admissions by rapid identification of disease progression and early institution of ambulatory therapy.
- Number of hospital admissions related to complications of non-cancer Chemotherapy.
- Costs associated with accelerated cardiovascular disease (related to both vascular inflammation and chronic corticosteroid toxicity) via regular assessment of risk factors.
- Costs associated in osteoporosis and fracture morbidity by early identification, treatments and reduction in chronic corticosteroid use (a major risk factor).

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- Some of these savings will continue to occur each year in addition to recurrent savings (hence savings escalate each year).
- It is expected that with the implementation of the networks it will on average take 3 years for the maximum (apart from escalated cost savings) value of the QIPP to be released.

See accompanying Worksheet, “IM.iii Rheumatology Datasheet”, for background data on activity by diagnosis and provider.

It is anticipated that change will be made over a 12 month period. The worksheet mentioned above details activity and cost by diagnosis and provider. Potential for, and phasing, of savings will depend on local circumstances and baseline position.

<b>ANNEX</b>			
<b>Useful documents</b>			
	<b>document</b>	<b>location</b>	
1	ANCA Associated Vasculitis (AAV) baseline audit proforma	Data collection	
2	Iloprost baseline audit proforma	Data collection	
3	Lupus audit form	Data collection	
4	Clinical Commissioning Policy: Rituximab for the treatment of ANCA-associated vasculitis in adults	<a href="https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a13-ritux-anca-vascul.pdf">https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a13-ritux-anca-vascul.pdf</a>	
5	Clinical Commissioning Policy: Sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis	<a href="https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/a13pb-sildenafil-bosentan-oct15.pdf">https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/a13pb-sildenafil-bosentan-oct15.pdf</a>	
6	Clinical Commissioning Policy Statement: A13/PS/a Rituximab for the treatment of Systemic Lupus Erythematosus in adults	<a href="https://www.england.nhs.uk/wp-content/uploads/2013/10/a13-ps-a.pdf">https://www.england.nhs.uk/wp-content/uploads/2013/10/a13-ps-a.pdf</a>	
7	Patient eligibility checklist for Sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis	Specifications	
8	Patient eligibility check list for ANCA Vasculitis - remission induction	Specifications	
9	Patient eligibility check list for ANCA Vasculitis - maintenance therapy	Specifications	
10	Rituximab-funding in SLE: Patient eligibility checklist	Specifications	
11	NS20 Specialised Rheumatology Coordinated Networks PID	Specifications	

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12	CQUIN Coordinated network for Specialised Rheumatology	Useful information CQUIN		
13	Terms of Reference for Coordinate Network for Specialised Rheumatology	Useful information TOR		
14	NS20 Data Pack	Data		

## 15 IM4 Complex Device Optimisation

Scheme Name	<i>IM4 Complex Cardiac Implantable Electronic Devices (CIED) Optimisation</i>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	<i>[Add locally]</i>
Duration	April 2017 to March 2019
<b><u>Problem to be addressed</u></b>	
<p>Complex implantable cardiac devices comprise of Implantable Cardioverter Defibrillators (ICD) and Cardiac Resynchronisation Therapy (CRT) devices. The latter are further subdivided into devices incorporating a defibrillator (CRT-D) and those incorporating a pacemaker (CRT-P)</p> <p>Given appropriate patient selection, complex devices can reduced risk of sudden death, improve quality of life and improve the prognosis in patients with heart disease. Clinical decision making around device selection varies between implanting units and may impact on clinical outcomes as well as inflating the overall cost of the complex devices.</p> <p>The staffing establishment of cardiology departments involved in implanting complex cardiac devices varies across NHS England which impacts on the effectiveness of MDT decision making, results in variation of device programming and outpatient follow-up arrangements as well as on-call cover for related emergencies.</p>	
<b><u>Change sought</u></b>	
<p>This scheme seeks to promote:</p> <ul style="list-style-type: none"> <li>• Enhancement and maintenance of local governance systems to ensure compliance with national policies and specifications;</li> <li>• Development of sub-regional network policies to encourage best practice when determining device choice including minimum standards for patient consent to ensure optimal device selection.</li> <li>• To improve timely access to all patients who need referral for consideration of complex device implantation.</li> <li>• To ensure that referral pathways and robust MDT decision making processes are developed for complex and clinically unusual cases, revisions and lead extractions.</li> </ul> <p>This scheme seeks to ensure that device selection for patients remains consistent with the commissioning policy, service specification, and relevant NICE guidance and that contractual requirement are in place for providers while new national procurement and supply chain arrangements are embedded.</p> <p>Considerable improvements in the NHS's purchasing efficiency for high cost tariff excluded devices have been forecast from the centralisation of procurement and supply chain arrangements.</p>	



Additional stretch to this scheme (Part B) will be offered to providers who wish to participate in the national devices work programme to optimise the clinical care and value by transforming service provision and improving clinical effectiveness cost effectiveness and clinical safety across a geographical area. This CQUIN scheme supports creation of the infrastructure, governance and partnership-working across a number of healthcare providers working in heart rhythm and heart failure networks to achieve the following outcomes:

- Improvements in engagement of patients in decision making for device selection and also enhanced supportive care.
- That the service is consistent with NICE guidance TA 314 and that the introductions of any new clinical treatments have been shown to be congruous with the NICE TA.
- Those clinical and cost effective treatments to improve outcomes are planned through multi-disciplinary team treatment plans, delivered throughout a clinical network of care.
- Enhanced data collection to ensure individual patient data capture and demonstrate the effectiveness and equity of this way of working and access to new commissioned treatments to patients in the future
- Service oversight and consolidation where this is appropriate
- The consistent adoption and spread of effective technologies (and decommissioning of out-moded technologies)
- Clinical streamlining to ensure a consistent approach to complex heart rhythm management
- Inform the device category range to be covered by the centralised supply chain

The part B section (stretch-variant) of this scheme seeks to describe a system leadership approach to the management of complex device implantation across a clinical network and will be available for selected providers.

**Section B. CONTRACT SPECIFIC INFORMATION** (for guidance on completion, see corresponding boxes in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>Insert name of provider --</i>
<b>B2. Provider Specific Parameters.</b> <i>What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract?</i> <i>(See Section C2 for other provider-specific parameters that need to be set out for this scheme.)</i>	2016/17 <sup>10</sup> , 2017/18, 2018/19 <i>[Adjust locally]</i> One/two years <i>[Adjust locally]</i>  <i>[Other – as specified in C2: whether Part B is included.]</i>
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> <b>Part A</b> <b>Compliance and supporting clinical effectiveness.</b>

<sup>10</sup> I.e. scheme was contracted for first implementation in 2016/17 (as GE4 Optimal Device scheme), and this template is setting out requirements for 2<sup>nd</sup> (and perhaps 3<sup>rd</sup>) year of scheme.

	<p>Full compliance with this CQUIN scheme should achieve payment of: [Add locally, following C3 guide]</p> <p><b>Part B</b> <b>Governance and partnership working:</b> Target Value: <b>£100k</b> <i>[Delete if not applicable]</i></p>
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**B4. Payment Triggers.**

The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

*[Adjust table as required for this scheme – or delete if no provider-specific Trigger information is required.]*

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
Trigger 3 stretch		
Trigger 4		
Trigger 4 stretch	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

For Part B, suggested:

For each year:

- Q1 50% of proposed part B payment for upfront funding
- Q4 50% of proposed part B payment on satisfactory provision of required evidence.

## Section C. SCHEME SPECIFICATION GUIDE

### C1. Applicable Providers

#### ***Nature of Adoption Ambition:***

FOR UNIVERSAL UPTAKE SCHEME- Part A

FOR Selective UPTAKE SCHEME: Part B

#### **FOR UNIVERSAL UPTAKE SCHEME:**

Acute providers that implant High Cost Tariff Excluded cardiac devices with aggregate cost of at least £500,000 per annum.

#### **For part B, (Stretch) of the scheme:**

Selected providers who mutually agree with NHS England to undertake the required role. *Centres bidding for the additional stretch element of the scheme should be based in a geographical network, cover a wide range of referral pathways for complex and non-complex specialised heart failure/ specialised heart rhythm services. The centre should be able to demonstrate that they are able to provide specialist advice on complex device decision making either through current MDT processes or via an agreed access/referral route. Centres should provide a sufficient implant volume to demonstrate centre and clinician expertise which avoids occasional practice and provides expertise and support to the Complex Cardiac Devices MDT. Centres should also be commissioned to deliver a complex electrophysiology and ablation service and should be able to provide 24/7 on-call for heart rhythm management issues, including device therapy. Many of these centres will be participating in post graduate training for cardiology SpRs, Specialist Nurses and Cardiac Physiologists and also providing dedicated cardiac rehabilitation and psychological support.*

Appendix A : sets this out in more detail

### C2. Provider Specific Parameters

<i>For Part A this is applicable to all commissioned providers of complex device Therapy.</i>	Whether Part B is included as well as Part A.
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### C3. Calculating the Target Payment for a Provider

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

**Part A: 2% of high-cost cardiac device expenditure subject to a minimum of £40,000.**

**Part B: £100,000**

2017/18:

Before contract, providers must select with the agreement of commissioners whether they are committing to Part A only or Part A and Part B.

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

### C4. Payment Triggers and Partial Achievement Rules

#### Payment Triggers

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Part A

Descriptions	2017/18	2018/19
<b>Trigger 1:</b>	Q1 Presentation of network policies and process for implementation and audit which should include: Demonstration of compliance against the quality matrix developed from the national service specification (A05) and the BHRS standards to support and allow the commissioners to audit and monitor clinical quality and support clinical assurance.	Q1 Implementation of locally agreed MDT framework (for selected cases) and standards of access and the use of a decision making process.
<b>Trigger 2</b>	Q2 Baseline for implementation audit and agreed trajectories for delivery against the standards. Measure device selection against patient indication for optimal patient specific	Q2 Audit of device usage against the decision making framework and MDT standards.

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	outcomes. (NICOR/CCAD) audit data submitted on ¼ly basis and Blue-teq form.	
<b>Trigger 3</b>	Q3 Commence regular audit and review of device complications. Shadow implementation of Blue-teq form for all complex cardiac devices.	Q3 Audit of device usage against the decision making framework and MDT standards.
<b>Trigger 4</b>	Q4. Confirm evidence submitted during Q1 of compliance against the specification standards and where necessary reasoning for variance and action plan for improvement. Agree the timelines and implementation plan for year 2 with commissioners to include specific improving value schemes which can be either local or national.	Q4 Audit of device usage against the decision making framework and MDT standards.

Part B (Selected providers only)

Descriptions	2017/18	2018/19
<b>Trigger 1:</b>	Q1 a) Development of a working group for this CQUIN scheme including providers across the clinical network led by the Part B provider, mapping patient pathways and producing a plan to improve partnership working, clinical governance, operational protocols, education and the improvement of pathways. Referral arrangements. Arrangements for revisions and extractions b) Establishment of partnerships which involve providers, commissioners, public health colleagues and patients.	Q1 Review implant rates and performance against previous commissioned activity and performance and support the planning process to inform the planning round in line with any QIPP priorities. Review pathways for revisions and extractions.
<b>Trigger 2</b>	Q2 c) Baseline report including: agreed arrangements by all partners; governance arrangements; network footprint map including CCG	Support as necessary: <ul style="list-style-type: none"> <li>• Service consolidation – where this is appropriate.</li> <li>• The consistent adoption and</li> </ul>

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	<p>boundaries and provider partners; current baseline of pathways and services; gaps in service provision; populations in line with policy / NICE guidance; evidence of appropriate administrative arrangements to enable data reporting.</p> <p>d) Engagement plan for regional/sector network, patients and CCG stakeholders.</p> <p>e) Pathway Mapping Group established (membership confirmed, schedule of meetings).</p>	<p>spread of effective technologies.</p> <ul style="list-style-type: none"> <li>Clinical streamlining to ensure a consistent approach for straight forward/complex/revision/extraction cases.</li> </ul>
<b>Trigger 3</b>	<p>Q4 f) Dataset reporting arrangements for all partners clarified and implementation begins.</p> <p>g) Proposals to monitor device implant rates and selected complications against quality standards.</p>	<p>Measure device selection against patient indication for optimal patient specific outcomes. (NICOR/CCAD) audit data submitted on ¼ly basis and Blue-teq form. Report submitted to commissioners.</p>

**Percentages of Target Payment per Payment Trigger**

The following tables sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers, respectively for Part A and Part B payments.

**Part A**

<b>Percentages of Target Payment per Trigger</b>	<b>2017/18</b>	<b>2018/19</b>
<b>Trigger 1</b>	20%	25%
<b>Trigger 2</b>	15%	25%
<b>Trigger 3</b>	15%	25%
<b>Trigger 4</b>	50%	25%
<b>TOTAL</b>	100%	100%

**Part B**

Percentages of Target Payment per Trigger	2017/18	2018/19
Trigger 1	30%	30%
Trigger 2	40%	40%
Trigger 3	30%	30%
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

All are in All-or-nothing.

**Definitions**

*Not applicable*

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

Required information flows to be developed by the *Part B* providers, covering the following issues as required:

Information for Benchmarking

Information for Evaluation

Information Governance

Reporting of Achievement against Triggers

Reporting Template requirement

**C6. Supporting Guidance and References**

**NHS England Service Specification** Implantable cardiac defibrillators and CRT therapy  
<https://www.england.nhs.uk/wp-content/uploads/2013/06/a09-cardi-implant-cardi-defib.pdf>  
 NICE TA 314 Implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure - <https://www.nice.org.uk/guidance/ta314>

**Section D. SCHEME JUSTIFICATION****D1. Evidence and Rationale for Inclusion**

Evidence Supporting Intervention Sought

This CQUIN seeks to provide a level of clinical input to drive clinical improvements in the

<p>patient pathway, support clinical decision making by agreeing network, clinical arrangements for referral and transfer of all categories of cases. This will promote improved access to specialised assessment, patient selection, review and long term surveillance in a timely, cost-effective way and reduce variation. Improvements will be expected for elective and non – elective pathways.</p> <p>Part B which will be agreed through a bidding process requires specialised centres to provide a network clinical leadership and Lead Provider/s role within a geographical location (expected across usual referral pathways).</p>
<p><b><u>Rationale of Use of CQUIN incentive</u></b></p> <p>The improvement in practice yields savings to commissioners that justify funding providers' costs.</p>
<p><b>D2. Setting Scheme Duration and Exit Route</b></p>
<p>Two years support should be sufficient to embed better practice as routine.</p>
<p><b>D3. Justification of Size of Target Payment</b></p>
<p>The scheme is a development of the GE4 Optimal Device CQUIN scheme. In negotiation of implementation of that scheme, it was apparent that the costs required to improve practice had been underestimated. A higher guide reimbursement has been adopted. The evidence of variation is such that the higher cost is justified.</p>
<p><b>D4. Evaluation</b></p>
<p><b><u>Evaluation</u></b></p> <p>Not proposed for this scheme.</p>

## Appendix A

### **Centre requirements for the part B of the complex device CQUIN this is provided over and above the minimum standards set out for all device implant centres**

- Centres should be able to demonstrate the appropriate training and expertise in complex device therapy. Each centre should implant a minimum of 60 complex devices (80 preferable), Two implanting clinicians who undertake at least 30 new complex device implants per year.
- Centres should be able to show evidence that they are able to provide 24hour/7 day per week follow up and support post implantation.
- Access to specialised Echocardiography for optimisation of complex device therapy for heart failure patients.
- Be part of a specialised electrophysiology service for the management of atrial and ventricular arrhythmias.



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- Be able to demonstrate regular MDT working and decision making in particular in regard to assessment for suitability of device therapy for rare conditions e.g. Brugada syndrome, congenital long QT syndrome and specialised heart failure services for the assessment for suitability of CRT therapy.
- Be compliant with the co-location and interdependency standards for this service including being interdependent with cardiac MRI, cardiac surgery and interventional cardiology services for the consideration of complex device therapy as adjunct to revascularisation.

### Appendix A

#### **Centre requirements for the part B of the complex device CQUIN this is provided over and above the minimum standards set out for all device implant centres**

- Centres should be able to demonstrate the appropriate training and expertise in complex device therapy. Each centre should implant a minimum of 60 complex devices (80 preferable), Two implanting clinicians who undertake at least 30 new complex device implants per year.
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- Access to specialised Echocardiography for optimisation of complex device therapy for heart failure patients.
- Be part of a specialised electrophysiology service for the management of atrial and ventricular arrhythmias.
- Be able to demonstrate regular MDT working and decision making in particular in regard to assessment for suitability of device therapy for rare conditions e.g. Brugada syndrome, congenital long QT syndrome and specialised heart failure services for the assessment for suitability of CRT therapy.

Be compliant with the co-location and interdependency standards for this service including being interdependent with cardiac MRI, cardiac surgery and interventional cardiology services for the consideration of complex device therapy as adjunct to revascularisation.

## 16 MH1 Patient Ward Communities, Implementing “Sense of Community” in High Secure Wards

Scheme Name	MH1 Patient Ward Communities, Implementing “Sense of Community” in High Secure Wards
Eligible Providers	The Three Providers of High secure MH services
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] should achieve payment of £300,000 + B*£3,000 + C*£9,000, (B, C are patients respectively in partial and in full intervention arms, as in Payment Trigger section, below):</p> <p>2017/18 Target Value:     Add locally</p> <p>2018/19 Target Value:     Add locally</p>
Scheme Description	
<p>The aim is to implement an intervention across selected wards focused on developing a psychological <i>Sense of Community</i> (SoC). SoC is described as a sense of belonging, that individual members matter to a community and to each other, and that individual needs can be met through a shared community commitment (McMillan &amp; Chavis, 1986).</p> <p>The aim is to implement the SoC in full on three wards, partially on three wards and not at all on three wards (i.e. community as usual group). This will allow for comparison across the wards to determine the impact of the intervention.</p> <p>The actual intervention will be recorded according to a taxonomy devised within the evaluation protocol. Interventions in the full and partial intervention arms of the trial should be costed respectively at £2,000 and £6,000 per patient (assuming a minimum of six months). This would be justified by staff assignment to roles supportive of the SoC intervention.</p> <p>The intervention would be assessed using a standard pre, during and post follow-up design where records of incidents, Security Information Reports, Suspected Bullying reports and ward atmosphere ratings are collected, with clinical records reviewed. It would also include use of the Psychological Sense of Community Index (SCI). The intervention will then be implemented and review of progress determined at eight weeks (during), and at two further time points of eight weeks (post 1 and post 2).</p> <p>The 50% premium for CQUIN incentives established for 2017/18 and 2018/19 translates this scheme into a CQUIN payment of £300,000 + B*£3,000 + C*£9,000, (B, C as in Payment Trigger).</p> <p>Hence for a 180 patient provider, with 60 patients in partial and 60 in full intervention arms (for a minimum of six months), the CQUIN Payment would be £k(300+180+540)=£1,020,000.</p>	

<p>The same payment mechanism is appropriate for each year of the CQUIN scheme, but the payment for the evaluation should be adjusted downwards if the cost of the evaluation has proved less than anticipated.</p>	
<p><b>Measures &amp; Payment Triggers</b></p>	
<p>A. Commissioning by the three providers of an academically sound research trial to explore the effectiveness and cost-effectiveness of different interventions in creating ward communities and achieving better outcomes for patients.</p> <p>B. The number of patients in wards included in the in the partial intervention arms of the trial</p> <p>C. The number of patients in wards included in the in the full intervention arm of the trial</p>	
<p><b>Partial achievement rules</b></p>	
<p>Payment is contingent upon setting up a research trial as indicated.                  Payment is proportional to the number of patients receiving the interventions and the months during which they receive them, weighted by 3:1 for intervention vs partial intervention arm, as a proportion of planned numbers (similarly weighted) – capped at 100%.</p>	
<p><b>In Year Payment Phasing &amp; Profiling</b></p>	
<p>Local determination. However, the costs of intervention should include some upfront set up costs, followed by more intensive involvement with the intervention wards to implement the scheme. Hence, costs will be incurred fairly evenly across the intervention period.</p>	
<p><b>Rationale for inclusion</b></p>	
<p>The change expected is an improvement in patient well-being through the development of being part of a positive community. It would do this by decreasing the risk for intra-group aggression. Any intervention that can develop a positive sense of community and enhance belonging and well-being would be expected similarly to improvement ward running, atmosphere and patient perceptions of safety.</p>	
<p><b>Data Sources, Frequency and responsibility for collection and reporting</b></p>	
<p>Reports to commissioners will be required detailing:</p> <ul style="list-style-type: none"> <li>- the commissioning of the research oversight of the trial</li> <li>- the staff assigned to support the full and partial intervention ars of the trial</li> <li>- the interventions undertaken in the course of the Trial, specifying the numbers of patients and duration of their involvement in each arm of the trial</li> <li>- the Trial evaluation</li> </ul>	
Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<p><b>CQUIN Exit Route</b>  <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i></p>	<p>For review following conclusion of evaluation – regarding whether the intervention is cost-increasing or otherwise</p>

**Supporting Guidance and References**

SoC is described as a sense of belonging, that individual members matter to a community and to each other, and that individual needs can be met through a shared community commitment (McMillan & Chavis, 1986). It comprises four key elements, all of which will be addressed by the intervention:

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- Membership: This includes creating emotional safety [security], a sense of belonging and identification [community acceptance], personal investment in the ward community, a common symbol [e.g. logo development] and boundaries.
- Influence: Increasing a sense of empowerment among the patient community which involves raising shared decision-making [e.g. teaching patients how to express views at community meetings, the importance of acknowledging the needs and values of others].
- Integration and fulfilment of needs: Building in rewards for participation in group aims; Identifying group similarities and building on these as shared group values.
- Shared emotional connection: Developing a shared history/community story through art; increasing opportunities for personal positive interaction; Ensuring no negative events are left without closure; increasing individual investment in a community; raising the potential for public community rewards and removing the risk of public humiliation.

The aim of such an intervention is focused on the development of a positive community as a means of enhancing feelings of safety and reducing incidents of aggression. It is becoming increasingly applied in non-secure settings, being utilised for example with gang related work.

Research suggests, for example, that intra-group aggression (e.g. patient bullying) is driven substantially by the environment and the community that is developed from this. Managing the community more effectively and developing a 'Healthy Community Approach' in the form of intervention and strategy is thought a primary means of enhancing safe living spaces. The more a community invests in each another, the less likely they are to display uncontrolled and manipulative aggression.

Each element of the SoC will be designed to capture what is possible and appropriate at ward level. For example, the element of membership could comprise a ward activity focusing on developing a logo for their community [common symbol] and shared group activities [sense of belonging through group activities such as games]. Boundaries would focus on input with patients on their expectations of behaviours towards one another and what as a shared community they consider acceptable.

Any intervention that can develop a positive sense of community and enhance belonging and well-being would be expected to similarly improve ward running, atmosphere and patient perceptions of safety.

## 17 MH2 Recovery Colleges for Medium and Low Secure Patients

Scheme Name	MH2 Recovery Colleges for Medium and Low Secure Patients
Eligible Providers	All providers of medium and low secure mental health services
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] for first year should achieve payment of £12,000 per provider plus £2,400 per eligible patient (as per snapshot end December 2016, or latest available date):</p> <p>2017/18 Target Value:     Add locally</p> <p>2018/19 Target Value:     Add locally</p>
Scheme Description	
<p>The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services. This approach supports transformation and is central to driving recovery focused change across these services.</p> <p>Recovery Colleges deliver peer-led education &amp; training programmes within mental health services. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals, and are based on recovery principles.</p> <p>In mental health the term recovery is used to describe the personal lived experiences and journeys of people as they work towards living a meaningful and satisfying life. Recovery does not only equate to cure or to <i>clinical</i> recovery, which is defined by the absence of symptoms. Recovery principles focus on the whole person in the context of their life, considering what makes that person thrive. Positive relationships, a sense of achievement and control over one's life, feeling valued, and having hope for the future are some of the factors we know contribute to personal wellbeing.</p> <p>Most secure services will have access to an appropriate base from which the college will run. Staffing costs are incurred as re-profiling roles and job plans of individuals displaces other activity. Service user involvement is crucial but voluntary. There are some costs associated with printing and publicity.</p> <p>It is expected that after one year of this CQUIN, a needs analysis and patient engagement programme would have produced a prospectus, and the means to deliver the programme identified, and by quarter four course will have commenced. In year two, the college will have begun to establish itself and begin delivering courses and the expected outcomes in terms of patient engagement and satisfaction.</p> <p>The CQUIN payment is scaled to cover the greater costs incurred by larger providers, though</p>	

recognising an overhead element. Target payment is £2,400 per eligible patient. (defined below), plus £12,000 per provider for administration overhead. A provider with 100 eligible patients as at 31<sup>st</sup> December 2015 attracts a target CQUIN payment of £12,000 overhead plus £2,400\*100 = £252,000.

### Measures & Payment Triggers

Year 1

Trigger 1:

- Evidence of engagement of staff and patients in developing the Recovery College.
- Minutes of planning groups
- Course Prospectus
- Outcome Measures
- Agree standardise measures of intervention to allow evaluation of impact.
- Agree groups of patients to be targeted for courses by Q4, with exclusions justified.
- Q1: agree plan of milestones for process measures for rest of year.

Trigger 2:

- Proportion of target patient group enrolled and participating in courses in Q4.

*Note that the purpose of linking payment to enrolment and participation is to ensure courses are designed in such a way that patients find them valuable; that aim would of course be subverted were engagement with patients to encourage participation coercive.*

Year Two scheme requires:

Trigger 1,

Evidence of implementation of Recovery College strategy and description of evaluation and assessment tools:

- Quarterly Report
- Course Prospectus

Trigger 2:

Take up

- % of patients participating in courses

Trigger 3

Outcomes report

% of patients reporting positive outcome measures (using Patient Reported Outcome Measures)

### Definitions

“Participation” is to be defined locally and reasonably – the intention is to count those patients who are likely to be deriving benefit from the College.

Patient eligibility:

- Excluded, patients expected to stay less than three months
- Other restrictions of scope (if any) as agreed at contract between provider

In both cases, groups of patients who are excluded from the scope of the CQUIN scheme are not being judged ineligible for the Recovery College *per se*, or unable to benefit. Eligibility for the scheme is rather determined on the basis of prioritisation:

- nationally priority is given to patients with expected length of stay > 3 months;

<ul style="list-style-type: none"> <li>locally priority may be given to particular groups of patients according to the commissioner's and provider's judgment of the best value roll-out of the Recovery College service.</li> </ul>	
<b>Partial achievement rules</b>	
<p><u>Year 1</u> payment: 80% process (Trigger 1) and 20% outcome (Trigger 2)</p> <p>Payment trigger 2: % targeted population enrolled and participating in courses in Q4 determines payment: Enrolment percentage plus one ninth i.e. 100% payment at 90%+ enrolment and participation, 50% payment at 45% enrolment and participation. Proportionately lower payment for lower achievement.</p> <p><u>Years 2 and 3:</u>            Trigger 1, 20%            Trigger 2, 40%            Trigger 3, 40%</p> <p>Payment triggers 2,3: % targeted population enrolled and participating in courses in Q4 determines payment: Enrolment percentage plus one ninth i.e. 100% payment at 90%+ enrolment and participation, 50% payment at 45% enrolment and participation. Proportionately lower payment for lower achievement.</p>	
<b>In Year Payment Phasing &amp; Profiling</b>	
<p>Local determination. However, the costs of intervention should include some upfront set up costs, followed by more intensive involvement to implement the scheme. Hence, costs will be incurred fairly evenly across the intervention period.</p>	
<b>Rationale for inclusion</b>	
<p>The Government's Mental Health Strategy 'No Health without Mental Health' sets an objective for more people with mental health problems to achieve recovery. This builds upon the objectives in the Health and Social Care Act to allow service users to be partners in their care, to have clear involvement in planning at both individual and service level and have genuine treatment choices made available to them. Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience. This in turn leads to improved clinical outcomes, reduced lengths of stay and fewer readmissions.</p>	
<b>Data Sources, Frequency and responsibility for collection and reporting</b>	
<p>Reports of achievement of payment triggers should be made available to commissioners on a standard report form.</p>	
Baseline period/date & Value	N/A
Final indicator period/date (on which payment is based)	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b>	<p>The start-up costs of a Recovery College relate to the initial scoping, identification of need, developing courses and securing an appropriate base to operate from. A temporary financial incentive will allow providers to prioritise the development of a recovery college which will yield longer term benefits. Once established, it is expected that the running of Recovery College should be met within the general operating costs of a service.</p>
<p><i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i></p>	

## Supporting Guidance and References

“Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services, NICE clinical guideline 136” National Institute for Health and Clinical Excellence (2011)

[www.nice.org.uk/cg136](http://www.nice.org.uk/cg136)

‘No Health Without Mental Health’ DH (2011)

‘Recovery Colleges briefing’, Centre for Mental Health (2012)

This scheme is relevant to all adult medium and low secure providers nationally. Benefits from this CQUIN scheme are service-user focused and include:

- Improved Patient Experience
- Improvement in recovery related outcomes
- Improvement in self-awareness and self-management
- Reduced length of stay
- Fewer readmissions

Secure services represent high cost low volume services, with lengths of stay running into many years and an annual bed price of between £150,000 and £200,000. Costs of establishing and running a Recovery College centre are estimated to be modest in relation to the outcome gains expected.



## 18 MH3 Reducing Restrictive Practices within Adult Low & Medium Secure Services

Scheme Name	MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services
Eligible Providers	All providers of medium and low secure mental health services
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] for first year should achieve payment of £24,000 per provider (in the first year of implementation only) plus £1,440 per patient:</p> <p>2017/18 Target Value:     Add locally</p> <p>2018/19 Target Value:     Add locally</p>
Scheme Description	
<p>The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, in order to improve service user experience whilst maintaining safe services.</p> <p>For providers that have already implemented an effective Restrictive Practice Framework, this CQUIN scheme should be adapted to fund their partnership with other providers who have not yet done so. In what follows these providers are referred to as <b><u>Framework Champions</u></b>.</p> <p>Adult secure services are committed to ensuring that least restrictive practice is observed at all times. A number of important national documents have recommendations associated with this issue: e.g. the MIND Report 'Restraint in Crisis' (2013); Department of Health guidance: <i>Positive and Proactive Care: reducing the need for physical interventions (2014)</i>, the revised Mental Health Act Code of Practice (2015) and recent NICE guidance (NG10) Violence and Aggression: Short Term Management in mental health, health and community settings (2015) have highlighted the need for services to review and reduce restrictive practices in services.</p> <p>The overall aim is to develop an ethos in which people with mental health problems are able fully to participate in formulating plans for their well-being, risk management and care in a collaborative manner. As a consequence more positive and collaborative service cultures develop reducing the need for restrictive interventions.</p> <p>This CQUIN scheme proposes to support secure services in meeting this national guidance in an innovative and systematic way by producing and implementing a framework to reduce restrictive interventions, restrictive practices and blanket restrictions in a number of domains (as set out in item 2 of the Payment Triggers section).</p> <p>The impact of these changes would be to improve service user and staff experience and safety indicators on the wards. It is expected that the use of restrictive practices would reduce in the</p>	

domains identified.

Findings indicate that where this is achieved, there are often financial benefits in terms of reduced cost pressures such as staff sickness and mitigation claims. Furthermore, there are organisational benefits in terms of improved service ethos and environment by the development of a positive and compassionate culture.

Year 1 – Costs will be incurred in Identification of current restrictive practices, and in developing and implementing the framework with service user engagement.

Years 2,3 – Costs incurred in implementation and evaluation, through reporting and dissemination, and in realising the potential to share across geographical footprints through network sharing

The CQUIN payment for this scheme, based upon a realistic covering of costs in the first year, should be approximately £1440 per patient (i.e. per occupied bed), including the CQUIN premium. This needs to be complemented by an administration cost for setting up the programme. £24,000 per provider is allowed in year one only.

For simplicity, it is suggested that the number of patients in beds as of 31<sup>st</sup> December 2015 be used as the scaling factor to determine the CQUIN target payment and hence the CQUIN payment proportion.

Commissioners should identify which providers they wish to identify as Framework Champions. Payment amount would be calculated on the same basis, but payment triggers differ (as set out below).

**For Framework Champions, a partner organisation of similar scale should be identified in advance of contract signature who will benefit from the support of the Champion in implementing this CQUIN scheme.**

### Measures & Payment Triggers

YEAR 1

Quarter 1

- Develop a working group which includes service user representation which will be responsible for developing the framework. The Framework should be designed to allow future consideration of additional restrictive practice issues as they arise. It should identify how service users and staff will identify new areas/issues that need to be considered and reviewed and the process by which this may take place.
- Identify restrictive interventions, practices and blanket restrictions in service and gather baseline policy information including with respect of to the following eight areas, in the expectation that introduction of the framework will:
  - 1) Reduce episodes of physical restraint by the employment of a restraint reduction strategy e.g No Force First, safe words, restrain yourself.
  - 2) Reduce episodes of supportive observations by developing an appropriate framework e.g. care zoning.
  - 3) Reduce seclusion and Long term segregation by utilizing best practice guidance in this area.
  - 4) Reduce episodes of medication-led restraint.

5) Increase positive ward culture by developing conflict reduction practice based initiatives e.g. positive handovers, 'saying No Audits' (safewards); developing a psychologically-informed Sense of Community.

6) Increase the involvement of service users, carers and their advocates in these initiatives and including them in the development of training for staff to deliver these objectives.

7) Ensure robust evaluation of outcomes and governance is in place to monitor the progress of the improvement strategies.

8) Ensure the application of blanket restrictions which are no more than proportionate, measured and justified responses to individuals' identified risks, and which restrict patients' liberty and other rights as little as possible. These will include reference to:

- Courtyard/grounds access
- Kitchen/Laundry facilities access
- Access to telephones including mobile phones
- Supervised visits/visiting hours
- Access to money
- Access to the internet
- Incoming or outgoing mail
- Access to certificate 18 media
- Bedroom/personal searches

- Produce an action plan outlining the development of the framework which will outline: a process for staff/patient engagement; staff/patient training; piloting of new policies; implementation and evaluation process.
- Monitoring Information: collecting monitoring data flows covering the eight areas identified in Trigger 1.
- Monitoring outcomes: Design and implementation plan for collecting the following monitoring data flows, with input from CRG to ensure a standard approach taken across the service:
  - % of service users that show positive outcomes in outcome-focussed CPA plans, in particular focused on improved mental health, reducing problem behaviour and developing insight.
  - % service users involved in discussions around individualised least restrictive practice and managing individual risk
  - % of service users in particular focused on improved mental health, reducing problem behaviour and developing insight.
  - Service user feedback in respect of positive outcome of in-patient experience - % of service users who believe they have been listened too in respect of their needs being met where restrictions are necessary.

#### Quarter 2

- Implementation of action plan, including: engagement, training of staff, adoption of policies, evaluation plan.
- Provision of training in accordance with Positive and Proactive Workforce (2015) to ensure staff are committed to and have the necessary skills and competencies to deliver change.
- Progress report on action plan.
- Evaluation report of staff/patient engagement process

Quarter 3

- Implementation (as Q2)
- Develop a draft framework including an implementation plan to address issues arising across service providers.
- Pilot framework within the service
- Monitoring data (as per items 4 and 5 in Q1) arising from the pilot.

Quarter 4

- Implementation continued (as Q2)
- Provide detailed report to evaluate pilot and showing what changes in practices have occurred. This should include a description of any good practice initiatives that have occurred from the introduction of the framework, and monitoring data (as per items 4 and 5 in Q1)

YEARS 2,3

Quarter 1

- Develop robust governance and evaluation to ensure long term sustainability.
- Roll out training across whole service
- Review monitoring information data collection and insights gained; modify collection as appropriate in coordination with CRG.

Quarter 2

- Progress report on implementation plan.
- Evaluate framework implementation and consider further improvements

Quarter 3

- Progress report on implementation plan.
- Evaluate framework implementation and consider further improvements, taking account of monitoring information.

Quarter 4

Write up and disseminate the success as a joint report with service users, through national forum/s. Provide evidence of the report and success of the scheme including initiatives that have changed the way the service has been delivered.

**For Framework Champions, payment is dependent upon supporting providers of similar aggregate scale in each of these Trigger activities, as well as sustaining their own good practice, and collecting and providing monitoring information on their own performance (as per items 4 and 5 in Q1).**

**Partial achievement rules**

A judgment is reached each quarter by the commissioner regarding whether progress should be rated Good (Green), Partial (Amber), or Unacceptable (Red), with payments as follow:

- GREEN merits 100% of payment;
- AMBER merits 50% of payment.
- No payment for RED.

Establishment of a monitoring system (items 4 and 5 in payment triggers) is a requirement for

any payment.	
Each quarter, progress is assessed relative to what has actually been achieved by start of that quarter. (Hence if nothing is achieved by end Q2, for example, Q3 is judged as if it were Q1.)	
<b>In Year Payment Phasing &amp; Profiling</b>	
25% each quarter for meeting process targets as set out above	
<b>Rationale for inclusion</b>	
Evidence indicates restraint reduction approaches can have a beneficial financial effect by reducing cost pressures on services e.g. reducing levels of sickness, bank staff usage and improving staff morale.	
The development and evaluation of a framework that adult secure services can implement to reduce restrictive practice that is consistent with the security requirements at each service level will improve service user experience and safety outcomes for service users and staff, leading to beneficial mental health recovery outcomes and increased opportunities for progression through the secure pathway.	
The absence of a framework creates a risk of overuse of restrictive practice without adequate risk assessment, affecting the rights and recovery of individuals. Services may be unable to meet guidance requirements in a comprehensive manner and fail to meet the appropriate criteria for regulated activity e.g. CQC.	
<b>Data Sources, Frequency and responsibility for collection and reporting</b>	
Reports to commissioners will need to provide evidence as set out in the patient triggers. Further context information is required as follows: Evidence of staff and service user engagement in developing a restrictive practice framework and the piloting of this. Monitoring information as per payment trigger 4 (in year 1, Q1). Reports of achievement of payment triggers should be made available to commissioners on a standard report form.	
Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b> <i>How will the change be sustained once the CQUIN indicator has been retired</i>	Service changes will be integrated within service structures, governance and practice and will be monitored via quality schedule in contract from the conclusion of the CQUIN.

### Supporting Guidance and References

Positive & Proactive Care: reducing the need for physical interventions (2014) – DH.  
The Mental Health Act Code of Practice revised (2015) NICE guidance (NG10) Violence and Aggression: Short Term Management in mental health, health and community settings (2015).  
This guidance applies to all adult secure providers nationally and is consistent with current DH strategy.

## 19 MH4 Discharge and Resettlement (subject to revision)

Scheme Name	MH4 Discharge and Resettlement - Reduction of Length of Stay in Specialised MH In-Patient Services
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	<i>[QIPP reference if any]</i>
Duration	April 2017 to March 2019
<p><b><u>Problem to be addressed</u></b>  Blockages and protracted delays in discharge impacts significantly and adversely on patient quality of life and speed of recovery, and upon availability of specialised inpatient beds for others. Specialised mental health services are experiencing ongoing capacity and demand pressures for inpatient beds.</p>	
<p><b><u>Change sought</u></b>  This scheme is designed to achieve at least a 10% reduction in the current average LOS (more in some service lines). Discharge planning should commence sufficiently early in the patients pathway to enable patients to move on when active treatment has finished and patients are ready for discharge. Providers will be expected to develop a strategy for how they will implement plans for optimising the care pathway from admission to discharge and work with stakeholders as appropriate to deliver the target set for their service and speciality. For adult secure services, providers are required to utilise outcomes from PROM indicated in Local Quality Requirement to inform the strategy. Additionally the scheme seeks to fund those Trusts who are willing to pilot the use of Clinical Utilisation Review systems approved by the commissioner in a Mental Health context.</p>	
<p>A. <b>CONTRACT SPECIFIC INFORMATION</b> (for guidance on completion, see corresponding boxes in section C below)</p>	
<b><u>B1.Provider</u></b> (see Section C1 for applicability rules)	<i>[Insert name of provider ]</i>
<b><u>B2. Provider Specific Parameters.</u></b> <i>What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract?</i> <i>(See Section C2 for other provider-specific parameters that need to be set out for this scheme.)</i>	2017/18, 2018/19 Two years <i>[Other – as specified in C2.]</i>
<b><u>B3.Scheme Target Payment</u></b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i>  Target Value: <i>[Add locally ££s]</i>

**B4. Payment Triggers.**

The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

*[Adjust table as required for this scheme – or delete if no provider-specific information is required.]*

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

***Nature of Adoption Ambition: Universal Adoption***

All providers of PSS MH Inpatient Services.

**C2. Provider Specific Parameters**

<p>The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)</p>	<ol style="list-style-type: none"> <li>1. Specific type of specialist MH service to which this applies.</li> <li>2. For each service, 2015/16 number of admissions and number of discharges. Any expected change from this number for 2017/18 and 2018/19 and reason why to be specified</li> <li>3. Whether CUR is being piloted.</li> </ol>
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**C3. Calculating the Target Payment for a Provider**

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

**<Expected number of discharges [clearly based upon recent trend]> times <expected number of weeks' reduction in average length of stay> times £3000.  
PLUS <cost of CUR implementation for CUR Pilot sites agreed with commissioner>times 1½.>**

*Example:*

- 20 bed service provider is:
  - expected (on basis of 2015/16 data) to have 15 discharges in 2017/18;
  - is reckoned to be able to reduce length of stay by on average three weeks
  - CQUIN payment for 2017/18 would be
    - $15 \times 3 \times \text{£}3000 = \text{£}135,000$ .
- If expansion/ contraction of this provider is planned for 2018/19, a proportionately higher/lower figure would be appropriate.
- If CUR is being piloted, the cost plus 50% of that implementation would be added to the scheme value.

Similar calculations would apply to setting the 2018/19 target payment.

The expected reduction in average length of stay and appropriate payment target should be negotiated with the provider, and specified in section B3.

As a default, 2015/16 discharge and admission numbers can be used for both years.

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	First Year of scheme	Second Year
<b>Trigger 1:</b>	Establish a system for specifying and recording estimated discharge dates (EDD) for all patients in service at 1 April 2017 and for all future	Reduction in bed days in excess of expected date of discharge, relative to agreed ambition, as per Year 1 trigger



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	<p>admissions (if not already in place), with commissioner and independent expert involvement, within <i>[max 12 weeks – to be varied according to patient group]</i> weeks of admission. And for ongoing monitoring of all cases as they move through pathway phases.</p> <p>This baseline report will be shared with commissioners and will be updated for each service in line with the following timescales</p> <ul style="list-style-type: none"> <li>- Adult Secure - quarterly</li> <li>- CAMHS T4 - weekly</li> <li>- Adult ED – monthly</li> <li>- Deaf MH - monthly</li> </ul> <p>Note: Providers design reporting template to include Initial EDD (fixed), change to EDD and comments/reason for change in EDD.</p>	<p>5.</p> <p>For this purpose, “discharge” relates to discharge to home or from secure into non-secure (or to prison).</p> <p>Further, a discharge to another hospital that results in delay beyond EDD is attributed back to all the hospitals upstream. (E.g. Hospital A determines EDD of a patient of 1st Jan '18; patient is transferred to hospital B on 1st Oct '17, receiving a revised EDD of 1st Feb '18. Patient discharged home 28th Feb '18. Then Hospital A has exceeded EDD by 31+28 days. Hospital B by 28 days.)</p>
<p><b>Trigger 2</b></p>	<p>Creation of a system, with funded provider resource, to plan discharge in advance of expected discharge date, building upon existing – Care Programme Approach (CPA) and Care and Treatment Reviews (CTR).</p>	<p>Maintenance of fund as in year 1 trigger 4</p>
<p><b>Trigger 3</b></p>	<p>Create system to review each delay if not resolved within the timeframes set out below. The review will include all stakeholders. Timings of these are service specific and will take place at these points beyond the expected discharge date, unless this is adjusted for clinical reasons:</p> <ul style="list-style-type: none"> <li>• Adult Secure: 4 weeks</li> <li>• CAMHS: 7 days from date identified as delayed week</li> <li>• Adult ED: 1 week</li> <li>• Deaf MH: 1 week</li> </ul> <p>The format of the stakeholder review will be in the form of a teleconference in the first instance with face to face meetings held if this does not resolve issues.</p>	

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	<p>All delayed discharges from adult secure to report monthly, CAMHS T4 weekly to relevant MH Case Managers, with reasons for delay and actions taken or proposed to facilitate discharge. Adult Eating Disorder service to report MH case Mangers where applicable or alternatively to MH Supplier Managers weekly. Deaf MH services to report to MH Case manager or MH Supplier Manager as applicable monthly.</p>	
<p><b>Trigger 4</b></p>	<p>Creation of a fund to be used to reduce delays caused by issues of minimal expenditure which create further delay e.g. payment of rental deposit, essential items not in place (washing machine, furniture)</p>	
<p><b>Trigger 5</b></p>	<p>Agreement of ambition for year two for reduction in bed days in excess of expected date of discharge. This to be based upon a strategy and implementation plan as follows:            Services to submit a strategy and timetabled implementation plan that sets out how the service plan to achieve the target reduction in excess days beyond EDD. This plan will need to describe the key areas the service will focus on over Year 1 and Year 2 to improve throughput and free up capacity for new admissions and decrease the average LOS across the service.            In developing the strategy commissioners will expect services to address the following aspects and identify areas for change to be addressed in the implementation plan:</p> <ul style="list-style-type: none"> <li>a) Management of pathway phases, with timeline, to include referral, decision to admit and intended outcome for admission, through assessment phase, active treatment and discharge planning.</li> </ul>	

	<ul style="list-style-type: none"> <li>b) Bed management processes and ways to improve the discharge planning phase</li> <li>c) How providers will demonstrate a proactive, MDT/multi-agency approach to the whole of pathway planning</li> <li>d) How they propose to ensure plans for discharge commence early enough to identify potential barriers to discharge and or anticipated blockages are known (as Trigger 2)</li> <li>e) Consider how providers will manage lack of engagement of local care co-ordinators and develop internal provider strategy to resolve this critical issue.</li> <li>f) For CAMHS and adult ED, service practice in respect of management of patient leave (trial and home leave) and (if appropriate) actions to be taken to reduce.</li> <li>g) Strategy for readmission avoidance - CQUIN achievement payments will be moderated where readmission rises offset reductions in length of stay.</li> <li>h) Include any other aspect that provider plans to address e.g. skills, staffing to deliver therapeutic programmes etc.</li> </ul> <p>It is expected that the services will develop this strategy and implementation plan in consultation with staff, service users, CCGs, LAs and NHS England. The services will brief and engage with all stakeholders including staff/SUs /carers to explain the CQUIN requirements and the benefits of optimising the care</p>	
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	<p>pathway. Ideas from the stakeholders, including service users, must be used be to inform the strategy.</p> <p>The strategy should also address the following issues to ensure that the discharge strategy is consistent with wider community goals:</p> <ul style="list-style-type: none"> <li>a) Management of referrals and reasons for refusals when units have spare capacity and to develop a strategy for reducing these occurrences</li> <li>b) Current waiting list management</li> <li>c) Repatriations in conjunction with MH Case Managers (CMs) (Secure and CAMHS Tier4 specifically but also where teams have Adult ED CMs) and as part of network discussion.</li> <li>d) How services ensure effective usage of in region spare capacity (where applicable) working as a network of provision.</li> </ul>	
<b>CUR TRIGGERS</b>	Additional triggers should be added for CUR pilot sites.	

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>First Year of scheme</b>	<b>Second Year</b>
<b>Trigger 1</b>	20%	80%
<b>Trigger 2</b>	20%	20%
<b>Trigger 3</b>	20%	

<b>Trigger 4</b>	20%	
<b>Trigger 5</b>	20%	
<b>CUR Triggers</b>	%age representing CUR payment [other %ages to be adjusted if applicable]	%age representing CUR payment [other %ages to be adjusted if applicable]
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

Year One

Trigger 1: **all-or-nothing**

Trigger 2: **strictly-proportional (that is payment should not exceed size of fund created)**

Trigger 3: **all-or-nothing**

Trigger 4: **all-or-nothing**

Trigger 5: **all-or-nothing**

Year Two

Trigger 1: **strictly-proportional**

Trigger 2: **strictly-proportional**

**Definitions**

Delayed discharge: ‘Patient will be a delayed discharge once it is agreed at CPA (and CTR where applicable) that the patient is clinically and legally ready for discharge and patient remains in the service.’

EDD: Expected Date of Discharge, is the expected date at which a patient is expected to be clinically and legally ready for discharge.

For further definitions, see accompanying document: MH4 Disc&Reset Definitions

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

All services will be expected to establish from the start reporting mechanisms to inform MH case managers and MH supplier managers in respect of delays and use of leave. Wherever possible existing reporting mechanisms/ templates and processes will be used or strengthened.

**Reporting Template requirement** A template will be available.

**C6. Supporting Guidance and References**

**Section D. SCHEME JUSTIFICATION**

**D1. Evidence and Rationale for Inclusion**

**Evidence Supporting Intervention Sought**

- ***The characterisation of the problem.***

The rationale of this scheme is given by its expected outcomes, namely:

- to improve capacity and access for individuals who need a specialised inpatient mental health bed through the reduction of average LOS specifically targeting cases with significantly longer LOS and/or blockages to discharge.
- to reduce out of area placements due to improved throughput of patients within inpatient specialised mental health services
- to improve access to beds geographically closer to home
- to improve service users experience and expectation in regards to length of stay
- to deliver changes to practice across the management of the whole pathway based on care pathway review of each of the phases of the care pathway; assessment/active treatment and discharge planning including management of leave
- increased productivity and reduction in cost of individual patient care episodes by reduced length of stay of completed episodes of care
- The choice of behavioural change to remedy the problem - in terms of its cost-effectiveness.

Providers are encouraged to work together and with commissioners both from NHS England, CCGs and LAs where possible to develop innovative system solutions. Services should be working to the same service specification. Where there are significant variations in throughput and/or LOS, they will be expected to consider what is being done differently. This should include an examination of the differences in practice and/or how they deliver operationally. If appropriate they should then develop strategies to bring about change. It is recognised that there will be factors outside of providers' control that impact on LOS, but there will be areas of clinical and operational delivery that are under their control and it is these areas that providers will be expected to change.

Each service will be given a % of expected achievement target, based on a review of activity data for their service (and will take into account national averages for service type). This will be agreed in discussion with commissioners.

The recent publication of the Mental Health Task Force Five Year Forward View (Feb 2016) and Implementation Plan (July 2016) lists several recommendations that support the consideration of optimising throughput and care pathways. Building the Right Support (October 2015) encouraged Transforming Care Partnerships to plan for their local populations in this way with emphasis being on community provision wherever possible.

Providers will need to review and refresh their plans to reflect the impact of the recommendations as they are introduced including factoring as applicable the impact of transformational plans to be implemented within community settings (specifically CAMHS T4 / ED/ LD and ASD populations) which may impact on capacity requirements within the specialised end of the pathway.

The overall aim of this CQUIN is the development of strategies for optimising the care pathway. This will be done by decreasing the length of time service users within specialised services spend through the pathway to achieve the outcomes expected, as agreed and described in the initial care plan prior to and at admission. There will be an expectation on admission that an 'expected discharge date' will be set and all plans and pathway progression should be aligned to achieving this outcome in line with an x% target reduction to the average LOS set for the service.

Services will be set a target average reduction in LOS which will need to be considered by the service when designing their strategy and taking forward the CQUIN work streams to ensure they are working from the outset toward achievement.

Reference to CUR evidence from UK and overseas justifying CUR piloting in MH context is available on request.

### **Rationale of Use of CQUIN incentive**

Payment system currently militates against investment to reduce Length of Stay. Reform is under development.

### **D2. Setting Scheme Duration and Exit Route**

One off costs will be incurred in adopting processes to facilitate early discharge. Processes that require recurring investment that are of proven benefit can be built into prices with agreement of the commissioner from year three.

### **D3. Justification of Size of Target Payment**

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payment is proposed at C3 is "<Expected number of discharges [clearly based upon recent trend]> times <expected number of weeks' reduction in average length of stay> times £3000.

The effort and costs that are appropriate to incur are proportionate to the reduction in excess bed days, beyond readiness for discharge that is achieved. This in turn will be proportionate to the number of expected discharges per annum. Effort is also needed at admission, to agree expected length of stay and put in place plans for discharge.

The sum that is appropriate per discharge depends upon the expected drop in length of stay consequent upon the intervention. If this is set as a fortnight, then target CQUIN payment should be scaled by around £6,000 times expected no of discharges. This assumes that costs are around £3,000 per week. However, for some services much larger reductions in LOS might be targeted, in which case a higher CQUIN value should be set.

### **D4. Evaluation**

Evaluation is desirable for this scheme; information flows will be designed to support it.

## 20 MH5 CAMHS Inpatient Transitions

Scheme Name	<i>MH5 CAMHS Inpatient Transitions to Adult Care</i>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any : Add Locally]
Duration	April 2017 to March 2019.
<p><b><u>Problem to be addressed</u></b></p> <p>The main concerns for discharge / transition are:-</p> <ul style="list-style-type: none"> <li>• Delayed discharge due to lack of social care provision is a significant problem.</li> <li>• Difficulties around availability of community support from CAMHS</li> <li>• The transition issues becomes a greater problem when the child / young person re-present in crisis (i.e. after discharge from CAMHS Tier 4) post 18 and then receive a different type of response. All young people transitioning to AMH should have a crisis/care plan that has been developed jointly with the young person, their family, CAMHS and AMH.</li> </ul> <p>In addition the following factors should also be highlighted:-</p> <ul style="list-style-type: none"> <li>• <b>Different thresholds:</b> The Adult Mental Health Service (AMHS) threshold in terms of severity of illness is typically higher than Child and Adolescent Mental Health Services (CAMHS), so for many young people their illness has to reach crisis point before service is renewed with the effect that their entry to services is more traumatic and more costly to the young person, family and to services than it would have been had their needs been met earlier.</li> <li>• <b>Postcode lottery:</b> The transition from CAMHS to AMHS is subject to extreme local variation, with regard to age, and effectiveness. A recent study of transitions in London found only 4% of young people reported a good transition, with many disappearing from services.</li> <li>• <b>Communication:</b> Poor communication between CAMHS and AMHS often leads to repeated assessments, and lack of continuity of care.</li> <li>• <b>Negative perceptions:</b> Differences between the service location and style of the two services alienates many young people who end up slipping off the radar of services.</li> </ul>	
<p><b><u>Change sought</u></b></p> <p>To improve:-</p> <ul style="list-style-type: none"> <li>• children and young people's experience of transition from children's to adult's mental health services</li> <li>• children and young people's outcomes following transition</li> <li>• children, young people, parent and carer involvement.</li> </ul> <p>To ensure the safe transfer of care for children and young people. To reduce the number of delayed transfers of care from inpatient services and impact on length of stay. To maximise the effective utilisation of inpatient capacity.</p> <p>This CQUIN will improve transition planning, improve patient and carer involvement, and improve experience and outcomes with regard to transition between services. It will incentivise</p>	



the safe transfer of care of young people who are moving to either AMHS or to other services, or being discharged from CAMHS.

**Section B. CONTRACT SPECIFIC INFORMATION** (for guidance on completion, see corresponding boxes in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>Insert name of provider --</i>
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	2017/18, 2018/19 Two years  <i>[Other – as specified in C2.]</i>
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of: <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>

**B4. Payment Triggers.**  
The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.

Relevant provider-specific information is set out in this table.

***[Adjust table as required for this scheme – or delete if no provider-specific information is required.]***

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		

	[Add rows to match C4 requirements.]	
<b>B5. Information Requirements</b>		
<b>Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.</b>		
Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. [Vary if necessary.]	
<b>B6. In Year Payment Phasing &amp; Profiling</b>		
Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.  [Specify variation of this approach if required]		
<b>C. SCHEME SPECIFICATION GUIDE</b>		
<b>C1. Applicable Providers</b>		
<b>Nature of Adoption Ambition:</b> Universal Adoption		
All providers of NHS-funded CAMHS Inpatient Services		
<b>C2. Provider Specific Parameters</b>		
The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	The patient population to be covered by the scheme.  The process to determine appropriate scale of scheme.	
<b>C3. Calculating the Target Payment for a Provider</b>		
The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:  Local agreement of appropriate investment, for each year, to achieve change, with a 50% uplift to provide Provider incentive, moderated by the National Team.  Guideline: < ½ % of expenditure on CAMHS>  <b>See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.</b>		
<b>C4. Payment Triggers and Partial Achievement Rules</b>		
<b>Payment Triggers</b>		
The interventions or achievements required for payment under this CQUIN scheme are as follows:		

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Descriptions	First Year of scheme	Second Year
<p><b>Trigger 1:</b></p>	<p><b>Plan for discharge/transition at the point of admission:</b>  Evidence:  1. goals for admission and discharge planning <b>PRIOR</b> to admission  2. admission documentation (referral forms 1 &amp; 2)  3. weekly/fortnightly MDT reviews  4. CPA meetings  5. identification of NHS England case manager at the point of admission and included in all transition / discharge planning  6. providers to audit themselves at the start and finish of CQUIN period</p>	<p>Achievement against criteria agreed in Year 1, Trigger 6</p>
<p><b>Trigger 2</b></p>	<p><b>Involve the young person in all discussions and decisions</b> (as much as possible/appropriate):  Evidence:  7. survey of patient satisfaction with involvement in CQUIN at beginning and end of CQUIN period.  8. Q1: Services to survey all patients discharged in that quarter  9. Q4: Survey all patients discharged in Q2, 3 and 4. (survey/feedback template to be provided)  10. Signed care plans, or documentation that care plans have been given to the child / young person.</p>	
<p><b>Trigger 3</b></p>	<p><b>Involve the family/carers in all discussions and decisions</b> (as much as possible/appropriate)  11. evidence using surveys as Trigger 2</p>	
<p><b>Trigger 4</b></p>	<p><b>Liase early with other agencies – children’s/adult social care, CAMHS/AMH, Education:</b>  Evidence:  12. services to audit themselves at the start and finish of the CQUIN  13. Other agencies on the invite list at CPAs.</p>	

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<p><b>Trigger 5</b></p>	<p><b>Numbers of delayed discharges: –</b> (refer national definition) Evidence: 14. Q1 - number of delayed discharges at baseline 15. clear actions plans in place to address and evidence of progress documented 16. services to submit minutes from quarterly CQUIN delivery group or similar 17. numbers at end of Q4 18. reasons for delayed discharges identified</p>	
<p><b>Trigger 6</b></p>	<p>Agreement, signed off by CRG, of levels of ambition for year 2 for 19. Survey results (as Triggers 2, 3) 20. Delayed discharge results (Trigger 5) 21. Weightings across indicators</p>	

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

Percentages of Target Payment per Trigger	First Year of scheme	Second Year
Trigger 1	10%	100%
Trigger 2	10%	
Trigger 3	10%	
Trigger 4	10%	
Trigger 5	10%	
Trigger 6	50%	
<b>TOTAL</b>	100%	100%

<p><b><u>Partial achievement rules</u></b></p> <p><u>Year One</u> All Triggers <b>all-or-nothing</b></p> <p><u>Year Two</u> Trigger 1: <b>strictly-proportional</b></p>
<p><b><u>Definitions</u></b> N/A</p>
<p><b>C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.</b></p>
<p>Local agreement required to cover the following issues:</p>
<p><b><u>Information for Benchmarking</u></b> National Specialised Mental Health Database</p>
<p><b><u>Information for Evaluation</u></b></p>
<p><b><u>Information Governance</u></b></p>
<p><b><u>Reporting of Achievement against Triggers</u></b></p>
<p><b><u>Reporting Template requirement</u></b></p>
<p><b>C6. Supporting Guidance and References</b></p>
<p><b>None</b></p>
<p><b>Section D. SCHEME JUSTIFICATION</b></p>
<p><b>D1. Evidence and Rationale for Inclusion</b></p>
<p><b><u>Evidence Supporting Intervention Sought</u></b></p> <p>Transitions, particularly those from CAMHS to Adult Mental Health Services (AMHS), are recognised as a point of potential upheaval for children and young people who may find it difficult to navigate new service settings. This is compounded when the availability and offer of support can change dramatically from CAMHS to AMHS.</p> <p>The transition from CAMHS to AMHS and other services, or discharge from CAMHS, must be supported by robust and timely planning. A coordinated multi-agency approach to transition planning is widely recognised as the key to a successful transition. This process is further strengthened by early and effective planning, which may start as young as 14, and putting the young person at the centre of the process to help them prepare for transfer to adult services, which may have profoundly different delivery models to CAMHS. The process, in many ways a preparation for adulthood, will need to support young people to be as independent as possible. In spite of this, services are often poorly coordinated, and it is vulnerable services users who are left to suffer. <i>Future in Mind</i> recommended that vulnerable young people, such as care leavers and children in contact with the youth justice system, should be taken into account in local strategic planning on transition.</p> <p>By assessing the level of compliance with the robust planning of transition of care , this CQUIN</p>

will incentivise providers to collaborate and integrate across service boundaries and is supported by the following key Policy and Reports:-

- Mental Health Task Force Report (February 2015)
- Building The Right Support (October 2015)
- Five Year Forward View For Mental Health – Implementation Plan (July 2016)
- CAMHS Local Transformation Plans
- New Care Models for Tertiary Services

This CQUIN follows from published [NICE guidelines on CYPMH transition](#), which recommend:

- Ensuring transition support;
- Ensuring health and social care service managers in children's and adults' services should work together in an integrated way to ensure a smooth and gradual transition for young people
- Involving young people and their carers in service design;

Ensuring service managers in both adults' and children's services, across health, social care and education, should proactively identify and plan for young people in their locality with transition support needs.

**Rationale of Use of CQUIN incentive**

It is anticipated that this indicator would be incentivised initially for a two year period in order to enable changes that are required to systems and processes in Mental Health Trusts to become business as usual.

This CQUIN will promote cross-agency collaboration and a change to standard practice that, once achieved, will not necessitate future funding.

**D2. Setting Scheme Duration and Exit Route**

Exit arrangements will be developed as the implementation strategy is developed.

**D3. Justification of Size of Target Payment**

Target payment is designed to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms).

**D5. Evaluation**

Evaluation plans will be built into the programme as it develops, where appropriate.

## 21 TR3 Spinal Surgery: Networks, Data, MDT Oversight

<b>Scheme Name</b>	<b>TR3 Spinal surgery: networks, data, Multi-Disciplinary Team (MDT) Oversight</b>
QIPP Reference	16-17 S5-Trauma [Add 17/18 local QIPP reference]
Eligible Providers	All c.35-40 spinal centres, providers of specialised spinal surgery and neuro-surgery
Duration	April 2016 to March 2019.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion should achieve payment of c. £60,000 for each MDT network, plus £180 times the expected number of patients scheduled for PSS IR defined spinal surgery or neuro-surgery expected to receive an MDT for that network (capped in agreement with the commissioner), to be distributed across host and contributing centres.  2017/18 Target Value:     Add locally  2018/19 Target Value:     Add locally
<b>Scheme Description</b>	
<p>Establishment and operation of regional spinal surgery networks, data flows and MDT for surgery patients. The scheme aims to promote the better management of spinal surgery by creating and supporting a regional network of a hub centre and partner providers that will ensure data is collected to enable evaluation of practice effectiveness and that elective surgery only takes place following MDT review.</p> <p>All spinal surgery hubs have several hospitals in their vicinity that tertiary-refer patients for possible treatment. Additionally, some partner hospitals provide a spinal surgical service. (There are currently no formal arrangements to provide a regional spinal MDT.) One of the principal benefits of a network is that a single or double handed service in a DGH has opportunity to discuss elective cases prior to treatment, determine if their practice mirrors those in other providers and the ability to compare outcomes.</p> <p>Closer collaboration also helps with the management of emergency patients. Cases of late diagnosed cauda equina and spinal cord compression can lead to permanent damage (with a typical litigation claim costing many hundreds of thousands of pounds). Many such cases could be avoided by closer working between hospitals, and a network helps produce the closer ties necessary to ensure patient safety is maximised.</p> <p>The target payment per network should be derived as indicated, £60,000 plus the expected flow of MDT cases, i.e. the number of patients scheduled for PSS IR defined spinal surgery expected to receive an MDT. (This averaged 117 patients per centre in the year to September 2015) A ceiling beneath this number may be agreed with the commissioner, or a higher number may be agreed for example to clear a backlog: for providers with a significant backlog, it may be appropriate to schedule MDTs sufficient to clear the backlog over an agreed period – with</p>	

the expectation that surgery rates will decline through this process, but without removing the scope for affordability gains.

Division of the targeted sum across the members of each of the 35 networks is for local determination by the commissioner in consultation with the providers. The payment will go to where the contract is held (usually the hub); it is the responsibility of the hub to ensure that the scheme is delivered, and this may involve defraying costs of partners.

### Measures & Payment Triggers

Trigger 1. Regional Spinal Network: (a) Agree Terms of Reference for and establish a Regional Network Board, Regional Meeting and Sub-Network Clinical Governance Bodies. Appoint a Regional Network Administrator. (b) Commence 4-6 monthly Regional Network Board Meetings and appoint a Clinical Lead. Minutes to be available and must follow the National template. (c) Establish a Sub-Network Clinical Governance Group with meetings every 2-4 months. Minutes to be available and must follow the National Template (d) Regional Policy to manage spinal emergencies including transfer; (e) Regional Policy for emergency imaging.

Trigger 2. Data. All specialised and non-specialised spinal surgery will be entered on the British Spine Registry or Spine Tango. Administrative support for clinicians must be available.

Trigger 3. MDT Governance. All elective specialised spinal surgery taking place within the network should have the agreement of the Local MDT (if more than 2 Spinal Surgeons) or Sub-Regional Clinical Governance Group MDT either by individual case or mandatory audit (including meeting inclusion/exclusion criteria and complications) at the agreement of the MDT and Commissioners.

The payment triggers are therefore, for each year:

- (1) Achieve 1(a) to 1(e) above. Minutes to be available and reviewed by Spinal Services CRG.
- (2) Entry of specialised and non-specialised spinal surgery activity in the spinal network on to the British Spine Registry or Spine Tango.
- (3) Discussion of elective specialised surgery in the spinal network at the regional MDT. Audit of specialised surgery every 2 quarters to be completed and presented at the Sub-Network Clinical Governance Body.

### Definitions

1. Spinal Surgery. Spinal surgery is undertaken by neurosurgeons and orthopaedic surgeons. Of the 35 providers, 24 are neurosurgical centres. Some of the neurosurgery providers also have orthopaedic spinal surgeons. Very often they are performing the same procedures and the only point of difference is that the neurosurgery activity is coded to specialty code 150 and the orthopaedic activity to 110. Some Trusts use the bespoke spinal surgery code. Both neurosurgeons and orthopaedic surgeons can be and are spinal surgeons.
2. Spinal Hub(s): The Spinal Hub is where the 24/7 emergency spinal service is located but not necessarily where all the emergency work is done. A region may have more than one Spinal Hub. A minimum of 6 Consultants are required for a 24/7 emergency spinal service. The Spinal Hub(s) will often but not always be the Major Trauma Centre(s)
3. Spinal Partner Hospitals: Spinal Hubs will have relationships with a number of partner hospitals which will in general be Trauma Units and District General Hospitals. Spinal Partner Hospitals will have Spinal Consultants offering 'non-specialised' +/- 'specialised' spinal surgery and may offer an emergency service without a 24/7 emergency on-call.
4. Non-Spinal Partner Hospital: Hospitals with an emergency department but without any



- surgeons undertaking spinal surgery on site.
5. Regional Spinal Network (RSN): An Operational Delivery Network (ODN) with geographical boundaries decided by local and national consultation to be consistent with Trust/CCG and Commissioning boundaries.
  6. Sub-Regional Network: One Spinal Hub and affiliated partner hospitals and AQPs.
  7. Regional Network Board: Board responsible for Monitoring the delivery and strategy of the Regional Spinal Service. Template for Terms of Reference available from Spinal Service CRG Chair.
  8. Sub-Network Clinical Governance Body: A meeting of the Spinal Hub, Spinal Partner and Spinal AQP providers for a given Spinal Hub. They will decide pathways, policies and guidelines for the Sub-Regional Network and monitor clinical governance issues. They will report to the Regional Network Board. There will usually be 2-3 Sub-Regional Networks within one Regional Network. Template for Terms of Reference available from Spinal Services CRG Chair.

#### **Partial Achievement Rules**

Payment is proportional to the proportion of patients receiving MDT assessment for whom triggers 1-3 are achieved relative to that upon which the payment amount was agreed, capped at 100%.

#### **In Year Payment Phasing & Profiling**

Quarterly payment with end year reconciliation.

#### **Rationale for Inclusion**

The aim is to ensure that the regional spinal surgery network operates efficiently, ensuring that patient selection for specialised surgery is carefully discussed and the optimum treatment option is chosen in all cases.

As well as benefiting patients clinically the challenges of meeting 18 week RTT targets are best served by a network approach.

Better patient selection will minimise surgical intervention where not clinically warranted, accumulating considerable savings.

#### **Data Sources, Frequency and responsibility for collection and reporting**

Each provider must provide evidence quarterly of achievement of the three measures for its patients.

Information should be submitted to the commissioner drawn from submission to British Spine Registry/Spine Tango.

The Regional Network Board and Sub-Regional Clinical Governance Bodies should submit minutes of their meetings which will include information on pathways, policies, guidelines, clinical governance issues, service evaluations, audits, education, research, risk register, workforce planning, objectives and work plan.

All providers should supply the list of spinal consultants. Providers should immediately notify the Regional Network Board if a consultant leaves or joins their spinal surgery service and if a consultant is on a period of extended leave.

Relevant data should be entered onto BSR/Spine Tango daily.

BSR/Spine Tango. This data is not yet available for contract monitoring. In the absence of flow from the registries, providers will need to provide a report regarding the flow of data.

## OFFICIAL

Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	As above.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract
<b>CQUIN Exit Route</b>  <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i>	A three year CQUIN is proposed to allow the costs of MDTs to feed through into reference costs and to Tariffs and local prices as a routine element in the cost of providing this service.

### Supporting Guidance and References

Administrative overhead of organising MDTs, and clinical expert time in participating: for the latter the cancer MDT reference cost collection gives an indicative cost – of some £110 per patient reviewed. For a spinal MDT it would be important to have input from consultant in Pain management and physiotherapist to consider alternatives to surgery. (Note: these MDTs do not require patient attendance)

One of the spinal network pilot sites reviewed 92 long waiting patients and concluded that only 30 required surgery. This ensured that patients received appropriate care and saved about £70,000 of surgery. (The cost of the avoided surgery varies greatly: many cases will be of fairly low value e.g. £700 to £1,500, with average of £1,100.) The most expensive surgery may cost more than £40,000. Some cases will have less than an hour of surgical time, others a full day. If this example was a proxy for England, the surgical savings would be £140m.

## 22 WC3 CAMHS Screening for Paediatric Patients with Long Term Conditions

Scheme Name	WC3 CAMHS Screening for Paediatric Patients with Long Term Conditions
Eligible Providers	35 specialised children's providers (those receiving specialised children's top up).
Duration	April 2016 to March 2019.
Scheme Payment	<p>CQUIN payment proportion [Locally Determined] should achieve payment of c. £30 for each additional patient targeted to receive SDQ mental health screening, An additional locally negotiated fixed sum CQUIN payment to cover the expected expansion of CAMHS liaison service to cover revealed need should be included.</p> <p>2017/18 Target Value:     Add locally</p> <p>2018/19 Target Value:     Add locally</p>
Scheme Description	
<p>Increase in the number of paediatric patients on whom a mental health screen (using the SDQ Tool<sup>11</sup>) has been completed to a minimum of 30% for <b>4 long term condition areas chosen with commissioners.</b></p> <p>The aim is establish screening and provision of mental health services for specialised paediatric <b>inpatients</b> who have a chronic severely disabling medical condition e.g muscular dystrophy, renal failure. Long term Conditions which could be considered include:</p> <ul style="list-style-type: none"> <li>• Renal</li> <li>• Congenital heart</li> <li>• Rheumatology</li> <li>• Asthma (complex difficult to manage)</li> <li>• Metabolic disorders</li> <li>• Neurology/neurodisability (e.g. Epilepsy)</li> <li>• Gynaecology</li> <li>• Gastroenterology (IBS)</li> </ul> <p>This is not an exhaustive list however services where a best practice tariff applies (eg: diabetes / cystic fibrosis) will not be permissible.</p> <p>The SDQ is used as a Mental Health screening tool, see (from PHE): <a href="http://www.chimat.org.uk/resource/item.aspx?RID=114105">http://www.chimat.org.uk/resource/item.aspx?RID=114105</a></p>	

<sup>11</sup> [www.sdqinfo.com/](http://www.sdqinfo.com/)

The target payment is £30 for each additional patient to receive SDQ mental health screening:

The payment is set as £30 x the number of additional patients targeted to receive screening each year.

Actual payment is then determined by the proportion of the targeted number who actually receives screening (capped at 100%).

There is a minimum number of patients to be targeted: 30% of the patients in the selected conditions. For which the denominator: Number of admissions in the LTCs identified.

The scheme is designed to incentivise an increase in the screening practice. Therefore, it is necessary to calculate the proportion of patients in any LTC who were being screened in the baseline period (probably 2015/16 – depending upon data availability). The targeted number of patients for incentivisation is:

- In 2016/17, the number of patients ***in addition*** to those who would have been screened were baseline period percentage screening sustained into 2016/17;
- In 2017/18, it is number of patients ***in addition*** to those who would have been screened were the projected 2016/17 percentage screening sustained into 2017/18.
- In 2018/19, it is number of patients ***in addition*** to those who would have been screened were the projected 2017/18 percentage screening sustained into 2018/19.

**EXAMPLE:**

- A provider expects the following admissions per year for paediatric patients:
  - Renal 1000
  - Congenital heart 1250
  - Asthma 800
  - Neurology 600
- In the baseline year, 10% of renal patients had been screened, none of the others.
- The minimum target is 30%, but the commissioner proposes a target of 40%. Thus 1460 patients (40% of 3,650) are to be screened, but this is an increase of only 1360 as 100 of the renal patients would have been screened on existing practice. This gives a target payment of £40,800.

If in the outturn 1360 patients or more are screened, then the full payment is made. If less than 1360, then the payment is reduced pro rata.

Additional payment to address CAMHS need

A possible requirement in addressing the psychiatric conditions revealed by the SDQ is the creation or expansion of a CAMHS liaison service within the hospital to address inpatient needs, particularly for out of area patients.

Liaison services are one of the main focuses in the recent MH taskforce report and areas should be increasing capacity and providing a 24/7 response, however their focus is on adults and older people so would not readily provide a solution to increasing CAMHS capacity. (HRGs do allow for a higher payment where a patient has additional complexities and hospitals may code accordingly in these cases, but this will not work for all cases.) It is important to encourage acute providers to support MH issues just as we want MH providers to support physical health care needs.

Hence – an appropriate stretch element for this CQUIN may be to kick-start funding of a CAMHS liaison service – with the expectation that the costs would in future be included in

overheads for relevant services (akin to anaesthetics), with costs recouped through reduced length of stay etc.

The provider and commissioner should agree what expansion might be required, and funding can be agreed under the CQUIN scheme to cover costs plus 50%. Local triggers should be constructed to ensure that the service is successfully set up and is addressing need.

**Measures & Payment Triggers**

Increased number of paediatric patients on whom a mental health screen (e.g. SDQ Tool) has been completed to a minimum of 30% for the **4 long term condition areas chosen with commissioners for focus.**

On this basis, provider and commissioner should agree a target number of patients with the selected conditions to be screened, focused upon those thought at highest risk, with an agreed cap in overall numbers. The payment trigger is then the proportion of that number for whom screening takes place through the year.

The SDQ tool needs to be applied with sufficient expertise and followed through with referral and intervention.

However, SDQ can be scored online with little or no training.

See <http://www.sdqinfo.com/>

SDQ should be completed by parent or child (aged 11+, using self-rating sdq). The mostly likely approach is for the parent to complete the form and the paediatrician to assess it – using the web resource that is freely available. This will not be too onerous for paediatricians, anyone can put answers for questionnaire onto computer which will give results as the analysing software is freely available and minimal training is needed: it is self-explanatory.

**Partial achievement rules**

As per trigger

**In Year Payment Phasing & Profiling**

Payment will be made quarterly – according to achievement each quarter.

**Rationale for inclusion**

There is a growing evidence base that those with co-morbid mental health and physical health problems present more frequently to hospital, recover more slowly and have shortened life expectancy.

A survey completed in 2015 for NHS England by Lee et al demonstrated very patchy provision for CAMHS/psychiatry in paediatric hospitals nationally. The implication is that this high-cost vulnerable group of paediatric patients are not receiving an appropriate assessment or subsequent intervention and support and a target of 30% is therefore being applied.

This CQUIN will aim to incentivise paediatric hospitals to identify mental health problems and provide input for this group. The aim is to improve the quality of care and reducing health costs by shortening length of stay and reduce co-morbidity.

Cost of patients to acute services would ultimately go down if they addressed their emotional needs, with reduced recurring admission etc, for those with somatisation, asthma, better

diabetic control, concordance with treatment, reduction in stress etc.	
<b>Data Sources, Frequency and responsibility for collection and reporting</b>	
It is likely that providers will need to identify internal systems to identify the patient cohort and record the data. It is likely that specialist nurses would be used as a resource to identify patients and support data collection. Exploration nationally of a new code in HES would be advantageous. These patients are in-patients and will be admitted to the specialty code. For those patients in the LTC, the provider would need to utilise specialist nurse input to identify the patients.	
Baseline period/ date & Value	To be reported by the Provider for the selected cohorts of patients with LTC. Baseline is the proportion of such patients screened for using the SDQ tool in the most recent year for which data is available.
Final indicator period/date (on which payment is based) & Value	The number of patients above baseline proportion receiving screening to be reported by provider.
Final indicator reporting date	Month 12 Contract Flex reporting date as per contract.
<b>CQUIN Exit Route</b> <i>How will the change be sustained once the CQUIN indicator has been retired?</i>	As the savings will be long term and recurring (and the cost savings will be primarily with the acute provider) the scheme should be self-sustaining.

### Supporting Guidance and References

The 2015 NHS England survey demonstrated variable provision of CAMHS/ Psychiatry to paediatric departments across England. All paediatric inpatients are suitable, with particular benefit for those with chronic/severely disabling health conditions.

The following is an extract from *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing (DH 2015)*:

- 12% of young people live with a long-term condition (LTC) (Sawyer et al 2007)
- The presence of a chronic condition increases the risk of mental health problems from two-six times (Central Nervous System disorders such as epilepsy increase risk up to six- fold) (Parry-Langdon, 2008; Taylor, Heyman & Goodman 2003).
- 12.5% of children and young people have medically unexplained symptoms, one third of whom have anxiety or depression (Campo 2012). There is a significant overlap between children with LTC and medically unexplained symptoms, many children with long term conditions have symptoms that cannot be fully explained by physical disease.
- Having a mental health problem increases the risk of physical ill health. Depression increases the risk of mortality by 50% and doubles the risk of coronary heart disease in adults.
- People with mental health problems such as schizophrenia or bipolar disorder die on average 16–25 years sooner than the general population.
- The Birmingham RAID study demonstrated a 4:1 cost benefit for investing in Adult Psychiatric Liaison services (in this study an investment of £1.5m resulted in a savings of £6m)

**Evidence of efficiency as a screening tool:** (from the sdqinfo website:)

'Screening. In community samples, multi-informant SDQs can predict the presence of a psychiatric disorder with good specificity and moderate sensitivity ([abstract1](#)) ([abstract2](#)).'

The abstracts suggest that multi-source completion should be preferred if possible, but that 'A "probable" SDQ prediction for any given disorder correctly identified 81-91% of the children who definitely had that clinical diagnosis. There were more false positives than false negatives, i.e. the SDQ categories were over-inclusive. The algorithm appears to be sufficiently accurate and robust to be of practical value in planning the assessment of new referrals to a child mental health service.'

See also: <http://www.scie-socialcareonline.org.uk/screening-efficacy-of-the-child-behavior-checklist-and-strengths-and-difficulties-questionnaire-a-systematic-review/r/a1CG000000GexPMAS>

## 23 WC4 Paediatric Networked Care

Scheme Name	<i>WC4 Paediatric Networked Care</i>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any: add locally]
Duration	April 2017 to March 2019
<p><b><u>Problem to be addressed:</u></b></p> <p>At present Paediatric Intensive Care (PIC) capacity is being utilised ineffectively.</p> <p>In some cases children could be better managed by providing high dependency care closer to home but more needs to be done to understand demand particularly in relation to care delivered in acute hospitals.</p> <p>For those children requiring tracheostomy and long term ventilation more appropriate models of care which encompass the social and secondary / primary care needs of these children could be developed.</p>	
<p><b><u>Change sought:</u></b></p> <p>This scheme aims aligns to the national PIC service review. It aims to gather information which allows the demand across the whole paediatric critical care pathway to be considered.</p> <p>Paediatric Intensive Care Units will need to undertake a leadership role among their referring units and through this scheme will be asked to:</p> <p><b>Part 1:</b> Review the delivery of activity undertaken by the acute hospitals in their usual catchment that trigger the Paediatric Critical Care Minimum Data Set (PCCMDS).</p> <p>Units will be expected to work with their local acute hospitals to collate data in line with <u>Appendix 1</u> over a six month period August to December 2017 and to provide a summary report in line with <u>Appendix 2</u> by February 2018.</p> <p>The intention is to put together information on known variation in ventilation rates with a more comprehensive view of demand for high dependency; this will be used to inform future discussions about better utilisation of beds which more appropriately the care needs of children and young people.</p> <p><b>Part 2:</b> Oversee the review of each of their referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards at <u>Appendix 3</u> and provide a report as per <u>Appendix 4</u>.</p> <p>It is envisaged that this will be achieved by PCC Teams working with acute hospitals and NHS England &amp; CCG commissioners to consider the configuration of beds within their regions and to consider alternative models of care. This will be supported by the CRG and through the national service review processes.</p>	



Regional implementation plans would need to take into account local geography and identify the existing resource, skills and service capability and any development required to enable change.	
<b>Section B. CONTRACT SPECIFIC INFORMATION</b> (for guidance on completion, see corresponding boxes in sections C below)	
<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>[Insert name of provider ]</i>
<b>B2. Provider Specific Parameters.</b> <i>What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract?</i> <i>(See Section C2 for other provider-specific parameters that need to be set out for this scheme.)</i>	2017/18, Two years
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of:  <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i> Target Value: <i>[Add locally ££s]</i>
<b>B4. Payment Triggers.</b>  There are no provider specific triggers.	
<b>B5. Information Requirements</b>	
<b>Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.</b>	
Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
<b>B6. In Year Payment Phasing &amp; Profiling</b>	
Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.  <i>[Specify variation of this approach if required]</i>	
<b>C. SCHEME SPECIFICATION GUIDE</b>	
<b>C1. Applicable Providers</b>	
<b>Nature of Adoption Ambition: [</b>	
FOR UNIVERSAL UPTAKE SCHEME:	

All Paediatric Intensive Care Units.

<b>LONDON</b>	
	<b>Barts Health (Royal London)</b>
	<b>Evelina Children's Hospital</b>
	<b>Great Ormond Street Hospital</b>
	<b>Imperial (St Marys Hospital )</b>
	<b>King's College NHS Foundation Trust</b>
	<b>Royal Brompton Hospital</b>
	<b>St Georges Hospital</b>

<b>MIDLAND AND EAST</b>	
	<b>Addenbrookes (Cambridge)</b>
	<b>Birmingham Children's Hospital</b>
	<b>Glenfield Hospital (Leicester)</b>
	<b>Leicester Royal Infirmary</b>
	<b>University Hospital of North Staffordshire PICU</b>
	<b>Nottingham Children's Hospital</b>

<b>NORTH</b>	
	<b>Alder Hey Children's Hospital (Liverpool)</b>
	<b>James Cook University Hospital</b>
	<b>Leeds Teaching Hospitals</b>
	<b>Sheffield Children's Hospital</b>
	<b>The Freeman Hospital (Newcastle)</b>
	<b>The Royal Victoria Infirmary PICU (Newcastle)</b>
	<b>Royal Manchester Children's Hospital</b>

<b>SOUTH</b>	
	<b>Bristol Children's Hospital</b>
	<b>Frenchay Hospital (Bristol)</b>
	<b>John Radcliffe Hospital (Oxford)</b>
	<b>Southampton University Hospitals NHS Trust</b>

**C2. Setting Scheme Duration and Exit Route**

The CQUIN is designed to achieve a step change in the network support for paediatric patients who might otherwise have required intensive care. The change should be sustainable with existing funding flows.

**C3. Calculating the Target Payment for a Provider**

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

Year One and Year two

**<An average payment of £210,000 per PICU per year is the guideline.>**

It may be appropriate to vary this locally in line with the number of referring units aligned to each PICU.

**C4. Payment Triggers and Partial Achievement Rules****Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

*[Set out the behavioural changes and outcomes against which some portion of the payment should be made, in terms of inputs or processes, information flows, and/or patient outcomes.]*

Descriptions	2017/18	2018/19
<b>Trigger 1:</b>	<p><b>Part 1:</b> Review the delivery of activity undertaken by the acute hospitals in their usual catchment that trigger the Paediatric Critical Care Minimum Data Set (PCCMDS).</p> <p>Units will be expected to work with their local acute hospitals to collate data in line with <u>Appendix 1</u> over a six month period August to December 2017 and to provide a summary report in line with <u>Appendix 2</u> by February 2018.</p>	Delivery of care in an appropriate clinical setting and as close to home wherever possible, as measured by the plan agreed in 2017/18 Trigger 2.
<b>Trigger 2</b>	<p><b>Part 2:</b> Oversee the review of each of their referring acute hospitals in their usual catchment against the Paediatric Intensive Care (PICS) standards at <u>Appendix 3</u> and provide a report as per <u>Appendix 4</u>.</p> <p><b>Part 2</b> Assessment and reports to be completed by July 2017.</p>	
<b>Trigger 3</b>	Agreement of milestones for change in 2018/19, with Regions and by the Paediatric Critical Care CRG in order to establish milestones, based upon Trigger 1 and 2 data.	

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>2017/18</b>	<b>2018/19</b>
<b>Trigger 1</b>	30%	100%
<b>Trigger 2</b>	30%	
<b>Trigger 3</b>	40%	
<b>Trigger 4</b>		
<b>Trigger 5</b>		
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

There are no partial achievement rules for year one.

Partial achievement rules for year two may be agreed under year one trigger 3.

**Definitions**

See appendices – on CQUIN website: WC4 Paediatric Networked Care appendices.

**C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.**

*As indicated above.*

**Information for Benchmarking**

**Information for Evaluation**

**Information Governance**

**Reporting of Achievement against Triggers**

**Reporting Template requirement**

**C6. Supporting Guidance and References**

N.a.

<b>D. Scheme Justification</b>
<b>D1. Evidence and Rationale for Inclusion</b>
<p><b><u>Evidence Supporting Intervention Sought</u></b></p> <p>Please refer to the two attached documents;</p> <p><a href="#"><u><i>Paediatric Intensive Care Audit Network (PICANet)</i></u></a></p> <p><a href="http://www.rcpch.ac.uk/sites/default/files/page/HDC%20for%20web.pdf"><u>http://www.rcpch.ac.uk/sites/default/files/page/HDC%20for%20web.pdf</u></a></p>
<p><b><u>Rationale of Use of CQUIN incentive</u></b></p> <p>Will provide the data required to support the national service review process and will support the delivery of a more cohesive pathway of care.</p>
<b>D3. Justification of Size of Target Payment</b>
<p>The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:</p> <p>It is likely that implementation will require Senior Clinical Leadership and data management expertise and analysis.</p> <p>Payment is therefore set at 3 Clinical PAs per week at £30k per annum. The audit work will be supported by one full time equivalent Band 8a Data Manager at an approximate cost of £50k per annum.</p> <p>Costs are therefore estimated at around £140,000 per provider based on 3 Clinical PA per week for senior clinical leadership, with data management expertise, analysis with audit work supported by 1 x 8a.</p> <p>With CQUIN uplift, this translates to a target CQUIN payment of £210,000 per centre.</p>
<b>D5. Evaluation</b>
<p><b><u>Evaluation</u></b></p> <p><i>The evaluation of this scheme will be supported by information collated as part of Appendices 1 to 4.</i></p>

## 24 WC5 Neonatal Community Outreach

<b>Scheme Name</b>	<b>WC5 Neonatal Critical Care Community Outreach</b>
<b>Section A. SUMMARY of SCHEME</b>	
QIPP Reference	[QIPP reference if any]
Duration	April 2017 to March 2019
<b><u>Problem to be addressed</u></b>	
<p>Over one third (32 out of 90) of neonatal care units were running at above the recommended safe level with over 80 per cent of their funded cots occupied throughout 2014/15 on average. Nine per cent (8 out of 90) had over 100 per cent occupancy during the year. This problem was significantly worse in neonatal intensive care units, 70 per cent (21 out of 30) of which were running above recommended occupancy levels.</p> <p>However, there is also strong evidence that babies are being kept in neonatal units for longer than necessary, or are admitted unnecessarily, when less intensive community support would be as safe and keep babies near their parents.</p> <p>Early discharge would optimise the use of special care cots with better consequential utilisation of intensive care and high dependency capacity (as cots at the high levels of care are not occupied with special care babies) having an impact on patient flows and improving the service provision</p>	
<b><u>Change sought</u></b>	
<p>To improve community support and to take other steps to expedite discharge, pre-empt re-admissions, and otherwise improve care such as to reduce demand for critical care beds and to enable reduction in occupancy levels.</p> <p>Supported early discharge has the potential to reduce GP and A&amp;E attendances and re-admissions in the early stages of post discharge.</p> <p>Early discharge will lead to a positive reduction in stress arising from time consuming travel to hospital for parents with other young children.</p> <p>Early discharge supports the family centred approach to care as families take their babies home at the earliest possible opportunity changes.</p> <p>Babies receiving specialist neonatal care would have their health and social care plans coordinated to help ensure a safe and effective transition from hospital to community care.</p> <p>To discharge babies earlier from inpatient neonatal special care / transitional care by providing:</p> <ul style="list-style-type: none"> <li>• Support for tube feeding babies and their families</li> <li>• Monitoring of Nutrition and Growth</li> <li>• Support for oxygen dependent babies and their families</li> <li>• Support for Neonatal Abstinence Syndrome (NAS) babies on reducing doses</li> </ul>	

Care Delivery:

- Repassing Nasogastric (NG) tubes
- Support the transition from tube feeding to full enteral feeding
- Growth and weight monitoring
- Nutritional Advice / assessing nutritional needs
- Liaison with other health care professionals / referral on
- Weaning off oxygen therapy / oximetry studies
- Spot monitoring of saturations
- Liaison with respiratory lead on NICU
- Review of Neonatal Abstinence Syndrome (NAS) greater than 5 days

NICU to work with LNU and SCU in the same patch to scope differing approaches across a range of settings: a much more modern approach is needed than 7 day home visiting particularly when journey times are long as they might be in busy cities, but particularly in rural areas. Options might include:

- Issuing all parents with accurate scales / feeding charts for “hospital at home” accuracy in assessing progress
- Daily Skype / face time support
- Lots of online educational and other materials to support
- Weekly drop in clinics for parents
- The option to develop wider packages of support e.g. psychology, dietetics etc. to be bolted on to the drop in sessions.

**Section B. CONTRACT SPECIFIC INFORMATION** (for guidance on completion, see corresponding boxes in sections C below)

<b>B1.Provider</b> (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>
<b>B2. Provider Specific Parameters.</b> What was or will be the first Year of Scheme for this provider, and how many years are covered by this contract? (See Section C2 for other provider-specific parameters that need to be set out for this scheme.)	This scheme will cover two years: 2017/18, 2018/19
<b>B3.Scheme Target Payment</b> (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN scheme should achieve payment of <i>[set sum £s following the Setting Target Payment guide in section C3 for setting target payment according to the scale of service and the stretch set for the specific provider.]</i>

**B4. Payment Triggers.**  
The Triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the scheme are set out in Section C4.  
Relevant provider-specific information is set out in this table.

***[Adjust table as required for this scheme – or delete if no provider-specific information is required]***

Provider specific triggers	2017/18	2018/19
Trigger 1: Baseline		
Trigger 1: Stretch level		
Trigger 2: Baseline		
Trigger 2 stretch		
Trigger 3		
	<i>[Add rows to match C4 requirements.]</i>	

**B5. Information Requirements**

**Obligations under the scheme to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.**

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
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**B6. In Year Payment Phasing & Profiling**

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

*[Specify variation of this approach if required]*

**Section C. SCHEME SPECIFICATION GUIDE**

**C1. Applicable Providers**

***Nature of Adoption Ambition: Universal Adoption***

Uptake will be through the 41 Neonatal Intensive care providers. These providers will work with their local ODNs, and with LNU and SCU in the same patch to scope differing approaches across a range of settings, to create and deploy appropriate outreach teams. These centres are best able to achieve outcomes that ensure equity of care, consistency in terms of discharge criteria and improved patient flows.

**C2. Provider Specific Parameters**



<p><i>The scheme requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)</i></p>	<p>This is a 2 year scheme. The patient group to be covered are neonatal babies cared for in neonatal units.</p> <p>Each provider adopting the scheme will need to identify:</p> <ul style="list-style-type: none"> <li>• The catchment population of neonatal babies who would benefit from community support</li> <li>• The baseline level of performance will be linked to the 2015/16 data (current unit average occupancy levels, patient flows and appropriate use of cots in the networks).</li> <li>• Projected impact that the outreach teams will have on occupancy rates and improve patient flows and also keeping babies within the network.</li> </ul>
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**C3. Calculating the Target Payment for a Provider**

The target overall payment for this scheme (the payment if the requirements of the scheme are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

**< <£200,000 pa> times < number of Community Outreach Teams required\* of the provider > for each year.**

\*The requirement for Community Outreach Teams is subject to advice from the ODNs.

**See Section D3 for the justification of the targeted payment, including justification of the costing of the scheme, which will underpin the payment.**

**C4. Payment Triggers and Partial Achievement Rules**

**Payment Triggers**

The interventions or achievements required for payment under this CQUIN scheme are as follows:

Descriptions	2017/18	2018/19
<p><b>Trigger 1:</b></p>	<p>All units to present their 2016/17 average occupancy rates for their funded cots and patient flow data.</p> <p>National Definitions on discharge criteria for outreach care, to be developed by neonatal intensive care CRG</p> <p>All Units to present to their ODNs their current discharge definitions and criteria for outreach support.</p> <p>(ODNs will assess and analyse the difference between their current state definitions and criteria and the National Definitions for babies that fall into the</p>	<p>Outreach teams to be fully functional at full capacity by September 2018</p>

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	criteria for outreach support.)	
<b>Trigger 2</b>	<p>Providers that have presented information to their ODNs outlining the number of babies that would have been discharged (linked to the new criteria) and the impact that this would have had on occupancy rates.</p> <p>ODNs to work with NICU to scope the additional support required to provide an outreach service in line with the National Definitions and discharge criteria.</p> <p>Plan adopted to create outreach units and target reduction in occupancy levels agreed.</p>	Fall in occupancy rates by Q4 relative to projection (as per Trigger 2, year one)
<b>Trigger 3</b>	Providers (with support from ODNs) to recruit outreach teams to support all parts of the network to comply with national occupancy rate standards	

**Percentages of Target Payment per Payment Trigger**

The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.

<b>Percentages of Target Payment per Trigger</b>	<b>First Year of scheme</b>	<b>Second Year</b>
<b>Trigger 1</b>	25%	40%
<b>Trigger 2</b>	50%	60%
<b>Trigger 3</b>	25%	
<b>TOTAL</b>	100%	100%

**Partial achievement rules**

Year One

Trigger 1: all-or-nothing

Trigger 2: all-or-nothing

Trigger 3: all-or-nothing

<p>Year Two</p> <p><u>Trigger 1: all-or-nothing</u></p> <p><u>Trigger 2: strictly-proportional</u></p>
<p><b><u>Definitions</u></b></p> <p>To be specified by ODNs and CRG.</p>
<p><b>C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.</b></p>
<p><b><u>Information for Benchmarking</u></b> - The number of babies receiving outreach service follow-up</p>
<p><b><u>Information for Evaluation</u></b> - Neonatal Networks through Badger discharge information</p>
<p><b><u>Information Governance</u></b> – Covered by existing protocols.</p>
<p><b><u>Reporting of Achievement against Triggers</u></b> - Local and network data collection- Reporting Template requirement to be agreed by CRG and ODNs.</p>
<p><b>C6. Supporting Guidance and References</b></p>
<p><b>NICE 2010 Quality Standard 7 “Coordinated transition to community care” nice.org.uk</b></p> <p><b>The British Association of Perinatal Medicine (BAPM)</b></p> <p><b>P.C 104 “A Review of the Neonatal Outreach Community Team Service for Babies going home on oxygen” A.Singh et al., Arch Dis Child,2014</b></p>
<p><b>Section D. SCHEME JUSTIFICATION</b></p>
<p><b>D1. Evidence and Rationale for Inclusion</b></p>
<p><b><u>Evidence Supporting Intervention Sought</u></b></p> <ul style="list-style-type: none"> <li>• <b><i>The choice of behavioural change to remedy the problem -- in terms of its cost-effectiveness.</i></b></li> </ul> <p>Discharge pathway for babies with a gestational age under 36 weeks has been developed suitable for short term-nasogastric tube feeding at home: Units that have adopted this approach have reported reduced length of stay on average by one week. They have also reported enhanced parental/family experience and improved continuing breastfeeding rates.</p> <p>To improve community nursing support to enable timely discharge for babies less than 36 weeks gestation. Early discharge will optimise the use of special care cots with better consequential use of intensive care and high dependency capacity.</p> <p>A study from Leeds (2009) showed that: from April 2007 to March 2008, 12 babies were discharged home for short-term tube feeding. There was a reduction of 162 NNU days in hospital. Between April 2008 and March 2009, 28 babies were discharged home for short-term tube feeding. There has been a reduction of 313 NNU days in hospital.</p> <p>Ref: Nursing Practice (2015) Leeds Neonatal Outreach service named Team of the Year 1 December, 2009</p> <p>Community care would provide unique support for families who have not had the normal</p>

experience of having a new-born baby and bonding. By developing a service that provides on-going care, advice and support.

Units in the UK which have adopted this approach have reduced the length of stay on average by one week with reported enhanced parental/family experience and improved continuing breastfeeding rates.

**Rationale of Use of CQUIN incentive**

Provider investment is required to shorten length of stay, whilst this will yield cost-savings to commissioners.

**D2. Setting Scheme Duration and Exit Route**

Two years should be sufficient period to establish the Outreach Teams. A mechanism for funding the Outreach Teams beyond the period of the CQUIN will be established if the scheme is successful, recognising the offsetting savings from reduced occupancy

**D3. Justification of Size of Target Payment**

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Costs of a community outreach team are estimated to come to around £130,000.

**D4. Evaluation**

Data flows on BadgerNet and through the ODN will create the information needed to evaluate the effectiveness and cost-effectiveness of the scheme.