



Improving Value for Patients from Specialised Care

**CQUIN Schemes for
Prescribed Specialised Services
for April 2016 to March 2017**

Volume I - Scheme Guide

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Improving Value for Patients from Specialised Care CQUIN Schemes for Prescribed Specialised Services for April 2016 to March 2017

Volume I - Scheme Guide

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Prescribed Specialised Services CQUIN 2016/17

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Specialised Services CQUIN 2016/17

1 Introduction

This guide is for NHS England's specialised commissioning teams and for healthcare providers who hold NHS contracts to provide Prescribed Specialised Services. It is consistent with, and can be read in conjunction with, NHS England's standard contract and CQUIN guidance for 2016/17, and NHS England's Commissioning Intentions published in October 2015.

As a commissioner, NHS England aims to invest over £250 million each year through CQUINs for specialised care. The approach in this guide reflects our commitment to secure improvements for patients, which are reflective of the scale of this investment, providing targeted resources for clinical teams.

Each commissioning body (such as each CCG) will utilise the NHS England CQUIN guidance to develop schemes meaningful to the particular range of services commissioned and local circumstances. This guide reflects how NHS England is using that guidance and applying it to specialised services. As a single national commissioning organisation we are in a position to design CQUIN measures once, drawing on clinical expertise from providers across the country through Clinical Reference Groups, and implement them consistently.

The guide sets out how the range of CQUIN schemes for these services has been developed and how NHS England local office teams will construct, and engage with provider colleagues to fine-tune, the package of CQUIN proposals offered to each provider for incorporation into 2016/17 contracts. It includes details of each scheme and a new approach to determining ambitious but achievable improvement goals, and to ensuring the incentive payments are commensurate with the effort and resources needed to undertake them, as well as reflecting the value for all patients that those clinical improvements represent.

The approach this year reflects earlier and more extensive engagement with providers in the design of schemes and publication of this guide to allow clinical teams to take them forward locally. It reflects greater links to the published evidence about 'what works' in setting clinical incentives, and a greater role for schemes linked to research, designed for evaluation, and multi-year initiatives; these being success factors in securing genuine and lasting change.

As set out in the NHS England CQUIN guidance, whilst the aggregate CQUIN investment for specialised services remains in line with 2.5% of applicable contract value, a differential approach is being taken:

- The 23 lead providers of Hepatitis C virus (HCV) Operational Delivery Networks will be offered a CQUIN of 2.8% in total of the applicable contract value of their specialised services (this will reflect the significant role that lead providers of HCV ODNs will play in the effective rollout and financial stewardship of the NHS's single largest investment in improving patient care).
- Mental Health providers will be offered CQUIN at 2.5% as the NHS works to take forward the findings of the independent Mental Health Taskforce
- The remaining providers of specialised services will be offered a CQUIN of 2.0% of the applicable contract value of their specialised services.

Section 2 sets the broad parameters of the set of CQUIN schemes including the continued protected funding for operational delivery networks. Section 3 explains how schemes were developed and tested to ensure they are valuable and workable, including incorporating ideas and comments from providers. Section 4 outlines guiding principles and section 5 explains how the scheme specific payments are derived, with the approach taken to partial achievement of goals. Section 6 explains how the individual schemes are selected and aggregated to a provider-specific package, and section 7, the process for dialogue and incorporating the finalised package into contracts.

Some schemes are multi-year in approach, and some are potentially applicable for CCG commissioned services, so may be used within CCG contracts in a complementary way to provide a larger combined incentive and scope to the improvement initiative where there is a good fit with local priorities.

Section 8 provides a summary of the seven schemes for Mental Health services, the four cross cutting and twenty Programme-of-care-specific schemes for acute services. The accompanying document to this guide (Volume II) has the detailed template for each indicator, designed to be largely 'contract ready' to ensure the focus of local discussions can be the leadership and collaboration to achieve improvement rather than the technical details of the financial transaction.

Both the development and the implementation of clinical improvement initiatives that CQUIN facilitate take a great deal of time, effort, leadership and partnership. Thank you for your commitment to making a difference for patients through involvement in delivering the CQUIN programme.

2 CQUIN Purpose and Guiding Principles

The Commissioning for Quality and Innovation (CQUIN) payment framework is a national framework that enables commissioners to reward excellence, by linking a proportion of the providers' income conditional to the achievement of ambitious quality improvement goals and innovations. From April 2009, CQUIN schemes have been developed annually (using non-recurrent funding mechanisms).

The NHS England Business Plan¹ includes 'Ensuring high quality and affordable specialised care' as one of ten business plan priorities for NHS England. An important part of delivering these priorities is the development and implementation of an effective Commissioning for Quality and Innovation (CQUIN) programme across Prescribed Specialised Services (PSS) contracts - as part of a continual cycle of year on year delivery - a programme that delivers improved quality and affordability. This is the focus of this year's CQUIN proposals for Prescribed Specialised Services contracts.

Building on the principles in the CQUIN guidance, the following additional principles have been agreed for specialised care to ensure high quality CQUINs

¹ <https://www.england.nhs.uk/2015/03/27/business-plan-2015-16/>

- The CQUIN programme supports operational improvements in the quality and efficiency of services, by creating new, improved patterns of care.
- These improvements enhance the sustainability of care and support and enable the QIPP programme in every local health system
- CQUIN scheme design recognises that CQUIN monies are non-recurrent.
- All specialised providers should have the opportunity to earn CQUIN payments, regardless of contract size.
- Operational delivery networks (ODNs) facilitate provider collaboration on the quality and sustainability agenda. 0.1% of the CQUIN contract value for Acute Providers should continue, as in previous years, to be deployed directly by NHS England to host providers to support ODNs, supplemented by NHS England commissioner funding to meet approved operating budgets. Provider members of ODNs have discretion to supplement this funding further to expand the scope of the ODN work programme.
- NHS England's CQUIN schemes for specialised care should complement but not duplicate CCG contract CQUIN schemes with the same provider.
- CQUIN schemes are for delivery and innovation above and beyond existing standards. Once standards are reflected in the core contractual requirements set out in the quality schedule, information schedule and/or service specifications, it is not appropriate to incentivise compliance through a CQUIN scheme. (National CQUINs for Sepsis, Acute Kidney Injury and Physical health for those with severe mental illness are covered in these ways by contractual requirements for specialised services.)

3 How schemes have been identified and selected

Proposals for 16/17 were gathered from diverse sources to secure the best overall suite of schemes using a structured template:

- 2015/16 schemes that meet the quality and affordability criteria for '16/17 or could be adapted so to do (for providers who have not previously implemented them to the revised standard)
- CQUIN-suitable Quality Innovation Productivity and Prevention (QIPP) proposals. A specialised services QIPP Steering Group sought proposals for improving value including from Clinical Reference Groups (CRGs) and pharmacy colleagues.
- New CQUIN scheme proposals from Clinical Reference Groups (CRGs). The 6 Programme of Care Boards and Highly Specialised Services team each sought scheme proposals from CRGs and clinical leaders, across Cancer Services, Blood and Infection, Trauma, Internal Medicine, Women and Children and Mental Health programmes of care.

- Proposals from the NHS England national specialised service team in light of international evidence of effectiveness. This included:
 - Review of the working of two existing national schemes (clinical utilisation review and hand hygiene technology) to consider appropriateness for roll-forward
 - A proposal for a CQUIN scheme to support engagement of patients with long term conditions in their care using a patient activation measure, developed jointly with interested providers.

Proposed schemes have been assessed against six criteria:

- Information-feasibility. Ensuring information flows to support goal setting and measurement either exist or can be created. If a scheme requires new flows, collection of new robust data must be costed as part of the CQUIN scheme, and timing must be realistic.

Calibration for achievable stretch. What can be achieved by a proposed intervention must be informed by a provider-specific understanding of the starting point of current attainment, and be realistically within the capability of the provider to achieve. Where this information is lacking, it is collected either in advance of, or as part of, the CQUIN scheme. Where comparative achievement of providers across England is known, or valid international comparisons are available, these support calibration of what is achievable.

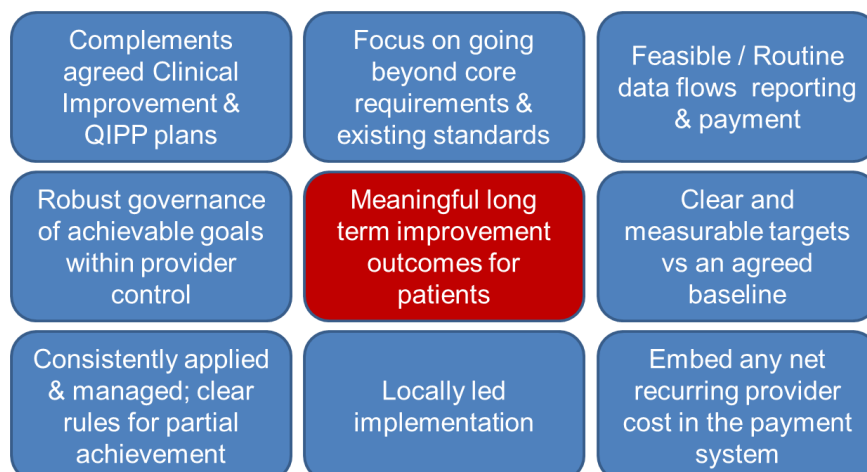
- Appropriate duration. McDonald et al (2013)² noted that one of the aspects of CQUIN inhibiting success was “changing goals and schemes annually” – when change often takes longer to bring about. CQUIN schemes have been tested to reflect the realistic required time for implementation until continued performance improvement has been sustained and ongoing supports to maintain it are in place. For some schemes, providers will realise yearly savings supporting continuation once initial investment has been funded. However, where benefits accrue principally to patients and or commissioners, any net recurrent costs will need in due course to be built into local or national prices, and the scheme needs to reflect this.
- Assessment of Value for Money (VFM). Assessment of value for money of a scheme requires an assessment of both the value of the scheme to all patients if stretch targets are met (including cost savings enabling resources to be redeployed for other patients), and the costs incurred in reaching this target. The potential value in a CQUIN should exceed both its cost to implement and the payment being made compared to alternative uses of that resource. Both the value and the opportunity cost are assessed using the latest Department of Health appraisal guidance. This both avoids poor-value interventions and also sets a limit upon the payment

² A formal evaluation of earlier schemes to date, a DH/NIHR funded study by the Universities of Nottingham and of Manchester, which reported in February 2013: Ruth McDonald, et al (2013), “Evaluation of the Commissioning for Quality and Innovation Framework”, University of Nottingham (Ruth McDonald, Sabeeh Zaidi, Sarah Todd, Frederick Konteh, Kasser Hussein, Sue Brown), University of Manchester (Soren Rud Kristensen, Matthew Sutton)

that could be allocated to a CQUIN incentive. Beyond this, consideration is given as to whether costs of implementation can be reduced further. An overall assessment of plausible VFM is made at scheme level, then later in the process calibrated to particular contracts. (See section 5).

- Assessment of contribution to promoting Equality and reducing Health Inequalities. Each scheme must be designed in such a way as to be compatible with and where appropriate to contribute to the discharge of NHS England’s separate duties on promoting equality and on tackling health inequalities. With regard to the public sector equality duty (under the Equality Act 2010), schemes are reviewed to ensure that where appropriate they tend to advance equality of opportunity between people who share a protected characteristic and those who do not. In this context, this has been particularly relevant in respect of the following characteristics: age, disability, gender reassignment, pregnancy and maternity, race and sex. The schemes aim to take steps to meet the needs of people from these protected groups insofar as these are different from the needs of other people. Schemes are also promoted (further to the duty established in the Health and Social Care Act 2012) according to their contribution to the reduction in inequalities between patients in access to, and outcomes from, healthcare services.
- CQUIN-appropriateness and plausibility of consolidation plan. Against consideration of the underlying causes of the problem that the intervention is designed to address, this criterion considers whether CQUIN represents the best lever for securing implementation of the intervention, and what the exit strategy is for sustaining improvement when the CQUIN scheme comes to an end. CQUIN is likely to be appropriate where there are upfront costs that are difficult for providers to fund, or where costs fall on the provider but benefits fall elsewhere (quality gains for patients, cost-savings on another provider or on the commissioner). But in the latter case, a mechanism must be found to embed the practice at the end of the CQUIN scheme. The CQUIN proposal template considers this question.

These criteria mix form and content; the following figure summarises the criteria relating to the form of the schemes and their mode of implementation and situates them around the central aim to ensure better health outcomes for patients which is at the core of a good quality CQUIN programme:



The schemes are listed in Section 8. Templates for use in contract documentation for each of the schemes are set out in the accompanying Volume II.

4 Scheme development and governance

CQUIN scheme development has been subject to a structured governance process to oversee design and ensure that insights from engagement with providers and experts from a range of disciplines are incorporated to the final products.

A CQUIN Programme Group with representation from leaders of each clinical programme of care, managers supporting the NHS England QIPP programme, pharmacy leads, supplier managers and business intelligence specialists has overseen the development process. Clinical Reference Groups worked to ensure that CQUINs were produced within agreed principles and guidance, by completing a standard template (a modified version of which is shown in the final scheme collection published with this guide). During the development process, schemes were shared widely with NHS England local office teams. Regular updates were submitted to the Specialised Commissioning Oversight Group (SCOG), ensuring strong governance and scrutiny prior to the final approval and authorisation to proceed.

McDonald et al (2013) identify early engagement with providers as a key success factor for incentives. Proposed CQUIN schemes have therefore been tested by local NHS England supplier managers and business information leads with thirty seven providers across in total, drawn from every region, who expressed interest in contributing to CQUIN scheme development. The CUR scheme has incorporated insights from more intensive involvement through national and regional workshops over the last 2 years. We have also sought a more extensive co-production process facilitated by NHS Providers securing nominations in the promising field of Patient Activation Measures, jointly to shape the form of schemes.

Road testing with contract managers and providers has included a checklist of questions to test scheme appropriateness and contract-readiness. The final version of the suite of schemes, following internal sign off and governance processes, is now being published.

5 Contract-specific payment scaling to ensure value for patients

The published research evaluation of CQUIN found effectiveness to be inhibited by a focus on processes with weak evidence (McDonald et al 2013). Drawing on this lesson, 2016/17 schemes have been subject to a test of the evidence of value for money as mentioned above with respect of the interventions being sought.

This test has also been developed for application at the level of individual contracts, to ensure that costs are justified by benefits expected from implementing a scheme in a particular local context.

Therefore, in contrast with earlier years, there will be no standard payment proportion for individual schemes, given that PSS contracts vary in size, and a standard proportion will inevitably be too small to cover costs for some providers and too generous for others. Rather the CQUIN payment proportion will be calculated using a scheme algorithm that relates the costs and value of a scheme to the scale of operation of the provider and to the PSS contract size.

Determining a CQUIN payment proportion that delivers good value locally involves three steps:

First, for each scheme, a level of aspiration will be set in terms of the intervention sought. There is scope for this to be varied in individual contracts in order to recognise local circumstances, whether this involves a greater or lesser stretch, with payment varying accordingly. To allow for such variation in a consistent way, payment guidance attached to each CQUIN scheme (in the scheme template) sets out how aspiration is to be varied according to baseline and potential for improvement.

For individual CQUIN schemes differential payments between providers according to their respective starting points and realistic levels of aspiration are appropriate. Although this may appear to give greater reward to poorer historic performance at an individual scheme level, providers are rarely uniform in their level of performance across services and aspects of outcome, and this approach, together with a consistent overall earnings opportunity in the package as a whole, will mean all clinical teams can be confident in being able to achieve and succeed, with greater resource and support where most needed. The resulting convergence of quality towards best practice improves equity for patients.

The **second** step is to assess the appropriate CQUIN payment proportion for a scheme, by determining an appropriate CQUIN payment for full achievement in money terms, and then taking that as a proportion of the CQUIN-applicable contract value for that provider.

An algorithm for each CQUIN scheme to derive the appropriate CQUIN payment proportion for scheme (the fraction of the total contract value that can be paid in respect to this CQUIN scheme) is included in the payment section at the head of the template. The algorithm is designed such that the CQUIN payment should

- a. **Exceed** the likely provider cost-impact to ensure a positive incentive. The provider cost-impact comprises implementation costs (including start up and per patient), less any provider savings and activity-payment that will accrue from the intervention itself.
- b. **Always fall short** of the net benefit to commissioners and patients. This comprises two elements:
 1. Net cost savings accruing to the commissioner (e.g. lower excess bed day payments, avoided admissions or follow ups, year-of-care case-mix)
 2. Improved Health Outcomes (with health gain in QALYs or equivalent, where possible, valued at NHS Opportunity Cost of £15,000 per QALY).

The horizon for considering benefits and cost-savings in the guideline algorithm is not confined to a single year, for example where a one-off change in practice with non-recurrent costs can have lasting impact on future savings, such as a stream of avoided admissions, or where the CQUIN scheme itself is designed to be multi-year.

These parameters will vary from provider to provider depending upon the scale of the service and other factors and is calculated, using the payment algorithm provided, to determine the provider-specific target payment.

Minor deviations from the algorithm can be justified by local circumstances but should ensure payments do not jeopardise a rate of return - for patients and commissioners - that justifies the investment being made (because if costs exceed benefits the scheme is locally inappropriate).

Where the sum of CQUIN payments for all the schemes under consideration (including ODN) would generate an aggregate CQUIN payment above 2.5% of contract value, the package will be scaled, either through reducing the range of schemes, or aligning the scope and/or stretch to a lower payment level on a particular scheme. (See section 6.)

Third, a proportional payment approach is needed for partial achievement, and a payment schedule. Where not otherwise stated (for example where payment is directly proportional to target achievement) the CQUIN schemes use a standard Red-Amber-Green rating approach:

- Green: Achievement of in excess of 95% of target attracts 100% CQUIN payment
- Amber: 80-94% achievement of target attracts 50% CQUIN payment
- Red: Below 80% achievement attracts no payment.

In general, these details are set out in the template for each scheme, in rubrics tested with supplier managers in discussion with business information experts and providers testing the schemes – with the objective of minimising the need for haggling before contract signature and the scope for misunderstanding during the year. Well justified local variation is possible, but will be exceptional.

6 Contract Specific Scheme Selection

McDonald et al (2013) note that factors that inhibit effectiveness of CQUIN include a lack of benchmarking scope for local schemes. For this reason, the published schemes, developed through a consistent national approach and engagement, will be the range of schemes available for use. And, further, none of the CQUIN schemes will be locally amended in content, except insofar as the CQUIN scheme allows local variation (to vary level of aspiration and payment proportion in tandem, for example). This will ensure those CQUIN schemes that need networking across provider clinical teams are not hindered by inconsistency, and contract development time locally is not diverted onto significant additional work.

NHS England will therefore seek to use each approved scheme with all providers for whom the scheme is applicable (relevant services are provided and there is a significant improvement opportunity) up to the overall CQUIN percentage of contract.

Commissioners and providers have told us it is beneficial to be able to focus some incentives on local priorities such as outcome payments for local QIPP plan delivery or transition towards new care models so an allowance for this is built into this year's arrangements. NHS England commissioners working with their providers will therefore offer schemes that secure good value from their CQUIN payments, adopting the following approach:

Provider	Overall CQUIN	Make Up
Mental Health Providers	2.5%	<ul style="list-style-type: none"> At least 1.2% from the 7 mental health schemes and applicable cross cutting schemes in the national PSS list Up to 1.3% for local QIPP outcome / NMOC transformation priorities.
Lead HCV ODN providers	2.8%	<ul style="list-style-type: none"> 1.6%³ for the HCV CQUIN (BI1) A further 0.8% for acute and cross cutting schemes in the national PSS list Up to 0.4% for local QIPP outcome / NMOC transformation priorities
Other Providers	2.0%	<ul style="list-style-type: none"> At least 1.0% from the Acute and Cross cutting schemes in the national PSS list Up to 1.0% for local QIPP outcome/ NMOC transformation

CQUIN funding for ODNs previously paid via a 0.1% top slice of the 2.5% acute payment will continue to be made in addition to the payments above.

The approach will also reflect:

- In line with PSS Commissioning Intentions, CUR is to be adopted in all NHS England acute contracts above £50m in value as a priority, but is open to all acute providers; the level of ambition within the CUR scheme can be scaled up by specifying a larger number of beds to which the CUR technology will be applied and/or a larger reduction in bed days not meeting CUR criteria, or where Trusts assess that there is scope for making headway more quickly
- All PSS CQUIN schemes relevant to each provider will form part of the offered package except where
 - CQUIN funds are exhausted on other schemes delivering better value from this provider.
 - The behaviour sought is already business-as-usual in the provider, so no stretch would be involved.
 - There is a consensus between commissioner and provider that the cost of attainment of the performance required would demonstrably exceed the value to commissioners and patients.

³ As set out in the BI1 scheme, the ODN governance payment of £100,000 per network is in addition to the 1.6% and adds to the overall 2.8% CQUIN payment

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- 3. Local QIPP outcome or New Model of care transformation payments will be designed locally subject to regional assurance processes

In relation to individual schemes:

- Patient Activation Measure CQUIN is a priority for those providers willing to participate in the evaluated roll-out of this innovative scheme.
- All Trusts providing services with excluded Devices using the new centralised purchasing and supply chain arrangements will have opportunity to earn the 'Optimal Device' CQUIN payment.
- The Hand Hygiene technology CQUIN is appropriate for any providers who wish to enhance wider strategies to address HCAI reduction.
- No providers will be offered to repeat CQUIN schemes from previous years without resetting baseline and enhancing the level of aspiration.

Commissioners will finalise the provider-specific CQUIN package to be offered in the 2016/17 contract taking into account the above factors following dialogue with each provider.

7 Incorporating the CQUIN package into provider contracts

The following principles will govern the approach that NHS England (through its regional hubs) takes to proposing a package of CQUIN schemes with its providers:

- A suite of schemes will be offered to each provider which provides healthcare services under the NHS Standard Contract
- The commissioner may offer a combined scheme to a number of related providers or may seek to align the content of separate schemes across different providers.
- The maximum value of the scheme – that is, the maximum amount which a provider can earn under it – will be set at 2.0%/2.5%/2.8% of the actual annual value of the contract (that is, after any contractual deductions or withholdings, and prior to CQUIN or other incentive payments), subject to certain exclusions in line with NHS England CQUIN guidance, such as:
 - high-cost drugs, devices and listed procedures identified in the National Tariff Payment System for 2016/17 and all other items for which the commissioner make payment on a “pass-through” basis to the provider (that is, where the commissioner simply meets the actual cost to the provider of a specific drug or product, for example); and
 - The value of all services delivered by the provider to Chargeable Overseas Visitors (as defined in the NHS Standard Contract), regardless of any contribution on account paid by any commissioner in respect of those services. (CQUIN quality indicators may still utilise the outcome data for this activity.)

- Funding paid to providers under the scheme is non-recurrent.
- Discussion between the commissioner and provider (or groups of providers) on the content of each scheme is encouraged, but in the end it is for the commissioner to determine, within the framework of this guidance, the priorities and focus for each scheme.
- NHS England teams commit to working through any practical issues or concerns with providers in relation to the CQUIN package offered. In line with NHS England CQUIN guidance, if a provider is not willing to accept the CQUIN package offered, they are not compelled to do so, but they do not have a right to substitute schemes within the package or to require changes in the CQUIN payment for a given scheme. The provider would forfeit the earnings opportunity from the CQUIN package if it is not incorporated into contract, and/or forfeit scheme specific earnings within the package for any scheme in which the provider does not participate.
- Each scheme must be recorded in the Schedule 4E of the local contract (which will be in the form of the NHS Standard Contract). Contracts must set out clearly the proportion of payment associated with each CQUIN scheme and the basis upon which payment will be made.
- Actual in-year payment to the provider must be based on the provider's achievement of the agreed objectives within the scheme, in line with the detailed arrangements set out in this guidance and in the NHS Standard Contract.
- Any in-year disputes about schemes which have been agreed and recorded within contracts should be resolved in accordance with the dispute resolution mechanism set out in the NHS Standard Contract.

7.1 CCG scheme alignment

Where possible NHS England and CCG sets of CQUIN schemes with a single provider should be discussed in tandem, and local commissioners coordinate final decisions regarding both which CQUIN schemes to include in a contract with a particular provider, to ensure complementarity and to avoid double payment by appropriate calibration of reward.

The payment algorithms for the CUR scheme are designed to allow a joint Scheme to be agreed by CCG and NHS England with a provider to secure benefits for all three parties.

7.2 Multiple-year CQUIN schemes

A number of the CQUIN schemes are envisaged to run over multiple years, with ambitions and payments calibrated each year, as indicated in the templates. Such agreements are subject to annual confirmation as set out in the main CQUIN guidance.

8 List of 2016/7 PSS National CQUIN Schemes

Each Programme of Care has a number of CQUIN schemes designed to deliver enhanced value for service users from the NHS budget. In addition, there are four general CQUIN schemes with broad applicability across a range of programmes of care. All are listed below. The completed templates for each scheme are reproduced in Volume II. These templates include algorithms that are designed to yield a payment value appropriate for a provider adopting this CQUIN scheme within their contract

PSS NATIONAL CQUIN SCHEMES 2016/17			
16/17 number	Provenance/ 15/16 Number	Scheme Name	Intervention Sought
GENERAL SCHEMES			
GE1	QIPP CUR1-3	Clinical Utilisation Review	Installation and implementation of Utilisation Review from recognised UR provider; together with efforts to reduce numbers of bed days (and emergency admissions) that do not meet criteria of clinical appropriateness
GE2	New	Activation System for patients with Long Term Conditions	Systematic measurement of self-management of patients by use of a recognised Patient Activation Measure (PAM); to use this information to improve outcomes by raising self-management and by stratification of support
GE3	HH1	Hand Hygiene Technology	Introduction of routine use of monitoring technology so as to achieve consistently high levels of hand hygiene and lower levels of healthcare acquired infections. For use where locally appropriate
GE4	New	Optimal Device	Use of the right specification of device appropriate to patients clinical needs
BLOOD AND INFECTION			
BI1		Hepatitis C Virus Improving Treatment Pathways through Operational Delivery Networks	Providers need to participate in ODN; and HCV patients' access to treatment should accords with ODN guideline
BI2	New	Severe haemophilia Haemtrack patient home reporting system	Increased proportion of severe haemophilia patients on the Haemtrack patient reporting system, an electronic (or paper) patient-reported record of self-managed bleeding and blood product home-therapy usage
BI3	QIPP New	Automated Exchange for Sickle Cell Disease patients	Automated exchange transfusion for those Sickle Cell patients for whom it is appropriate
BI4	CB5	Haemoglobinopathy Improving Pathways through Operational Delivery Networks	To improve access to appropriate treatment for haemoglobinopathy patients by developing ODNs and ensuring compliance with ODN guidance

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CANCER			
CA1	QIPP New	Enhanced Supportive Care access for Advanced Cancer Patients	To improve access to Enhanced Supportive Care for patients with a diagnosis of incurable cancer
CA2	QIPP New	Nationally Standardised Dose Banding Adult Intravenous Systemic Anticancer Therapy (SACT)	Standardisation of chemotherapy doses through nationally consistent dose banding
INTERNAL MEDICINE			
IM1	New	Reducing Cardiac Surgery non-elective Inpatient Waiting	CABG within ten days of angiogram based referral, from within a provider or from any other hospital
IM2	New	Cystic Fibrosis, Patient Activation	Proposed for '16/17: participation in a pilot of CFHealthHub in two centres; '17/18 extended to national trial across all centres. CFHealthHub gives patients and clinicians direct feedback on compliance with treatment regime, promising to yield improved outcomes and cost reduction
IM3	IM7	Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance	Review of cases by MDTs to ensure policy compliance, with data flowing to registries
TRAUMA			
TR1	QIPP TH4	Adult Critical Care Timely Discharge	Discharge from Adult Critical Care within 4h/24h of clinical decision to discharge
TR2	TH5	Acute Spinal cord Injury Centre (SCIC) Outreach Visits to Newly Injured Patients	Outreach visits to improve timely access to specialist expertise and to pre-empt costly complications
TR3	QIPP TH7	Spinal Surgery Networks, data, MDT Oversight	Setting up regional networks to establish MDTs to sanction all referrals for surgery, entering surgery into British Spinal Registry or Spine Tango
WOMEN AND CHILDREN			
WC1	WC2	Difficult to control asthma assessment within twelve weeks	MDT (Respiratory paediatrician, children's respiratory nurse, physiotherapist, psychologist) assessment for problematic severe asthma for patients who could benefit within twelve weeks
WC2	new	Univentricular Infants - Home Monitoring	Home monitoring using specified inputs (machinery and nurse time) to pre-empt costly problems for infants with univentricular hearts
WC3	new	CAMHS Screening for Paediatric Patients with Long Term Conditions	SDQ screening for paediatric inpatients with relevant (listed) LTCs

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MENTAL HEALTH			
MH1	new	Patient Ward Communities, Implementing "Sense of Community" in High Secure Wards	Structured implementation and evaluation of 'sense of community' interventions in high secure wards
MH2	New	Recovery Colleges for Medium and Low Secure Patients	Establishment of Recovery Colleges to deliver peer-led education and training programmes within low and medium secure mental health services
MH3	New	Reducing Restrictive Practices within Adult Low and Medium Secure Services	Development, implementation and evaluation of a framework on the reduction of restrictive practices within adult low and medium secure services
MH4	MH8	Improving CAMHS Care Pathway Journeys by Enhancing the Experience of Family/Carer	Taking specified steps to involve the family / carer and to enhance their experience of the CAMH service
MH5	New	Benchmarking Deaf Child & Adolescent and Adult MH Services and Developing Outcome Performance Plans and Standards	Developing outcome benchmarking process followed by performance planning and standard setting
MH6	New	Adherence to Standards for Gender Identity Clinics	Adherence by Gender Identity Clinics to standards developed through the Gender Identity Task and Finish Group
MH7	MH06	Perinatal Involvement and Support for Partners/Significant Others	Offer of appropriate emotional, informational and practical support to partners and significant others

Questions in relation to the Specialised Services CQUIN schemes should be addressed through your NHS England supplier manager.