

IM3 Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance

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| Scheme Name | IM3 Multi-system Auto-immune Rheumatic Diseases MDT Clinics, Data Collection and Policy Compliance |
| Eligible Providers | All providers of specialised rheumatology services |
| Duration | April 2016 to March 2019 |
| Scheme Payment (% of CQUIN-applicable contract value available for this scheme) | CQUIN payment proportion [Locally Determined] should achieve payment of £150 per projected number of MDTs (up to one per patient in a year). Target Value: Add locally CQUIN %: Add locally |
| Scheme Description | |
| <p>This CQUIN is to support the development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases, 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> <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>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>To set the target CQUIN payment for this scheme at a level commensurate with the cost of implementation, it is necessary to determine a target number of patients whose care will be considered by MDT and data capture as prescribed. The target payment will be £150 times the number of patients targeted. The CQUIN payment proportion is derived by taking the product of this calculation as a fraction of forecast CQUIN-applicable contract value each year.</p> | |
| Measures & Payment Triggers | |
| <ol style="list-style-type: none"> 1. Initiation of regional 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. 2. Ensuring policy compliance and promoting data collection into the BILAG BR, DUO and UKIVAS registries in line with the published Specialised Rheumatology policies. 3. Comprehensive governance of the management of rare autoimmune rheumatic diseases through MDTs. 4. Achieving local data collection in order to define the cash-releasing savings of the network and Commissioning Policies. | |

Definitions

For 2 and 3, achievement is measured against the following indicator:

- Numerator** The number of patients treated within NHS England specialised rheumatology Commissioning Policies during 2016/17 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 treated during 2016/17 targeted for MDT consideration and data capture.

Partial achievement rules

Final payment (50% of total) proportionate to achievement of Q4 target 3 (see profiling): proportion of patients reviewed.

In Year Payment Phasing & Profiling

| Date/period milestone to which relates | Rules for achievement of milestones (including evidence to be supplied to commissioner) | Date milestone to be reported | Milestone weighting (% of CQUIN scheme available) |
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| Quarter 2 | The Provider must submit the following: <ol style="list-style-type: none"> Show that data completeness meets or exceeds 90% for Q1 and Q2. Provide exceptions (e.g. zero relevant admissions) recorded with rationale. Evidence of agreed process for validating and reporting dataset to be established. Evidence that clinical leads are engaged in network discussions to develop patient pathways with an agreed in-year action plan. Baseline assessment of existing policy-related activity to quantify potential cash releasing savings from implementation of published policies within the network. | Where all the Q1&2 requirements are met, 25% of annual CQUIN monies associated with this indicator will be paid. | |
| Quarter 3 | The Provider must submit the following: <ol style="list-style-type: none"> Show that data completeness meets or exceeds 90% for Q3. Provide exceptions (e.g. zero relevant admissions) recorded with rationale. | Where all the Q3 requirements are met, 25% of annual CQUIN monies associated with this indicator will be paid. | |
| Quarter 4 | The Provider must submit the following: <ol style="list-style-type: none"> Show that data completeness meets or exceeds 90% for Q4. Provide exceptions (e.g. zero relevant admissions) recorded with rationale. Demonstrate what proportion of patients have had their care reviewed | Where all the year-end requirements are met, a proportion of the remaining 50% of annual CQUIN monies associated with this indicator will be paid. This proportion should be the | |

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| | according to the agreed policies. | ratio of numerator to denominator as above. |
| Years 2,3 | The Provider must submit the following: <ol style="list-style-type: none"> 1. Show that data completeness meets or exceeds 90% for Q4. 2. Provide exceptions (e.g. zero relevant admissions) recorded with rationale. 3. Demonstrate what proportion of patients have had their care reviewed according to the agreed policies. | 80% payment dependent upon performance, 20% for sustaining system and data flows. |
| Rationale for inclusion | | |
| <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. 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>The Network will provide this 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> | | |
| Data Sources, Frequency and responsibility for collection and reporting | | |
| <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. 6 monthly reporting of registry data.</p> | | |
| Baseline period/date & Value | 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 | |
| Final indicator period/date (on which payment is based) & Value | MDT actual activity for financial year as at Month 12 | |
| Final indicator reporting date | Month 12 Contract Flex reporting date as per contract | |
| CQUIN Exit Route <i>How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?</i> | <p>Ongoing network led audit programme and disease registry data will be available to ensure compliance.</p> <p>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.</p> | |

Supporting Guidance and References

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).
- 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.

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.

| ANNEX | | |
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| Useful documents | | |
| | Document | Location |
| 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 | https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a13-ritux-anca-vascul.pdf |
| 5 | Clinical Commissioning Policy: Sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis | https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/a13pb-sildenafil-bosentan-oct15.pdf |
| 6 | Clinical Commissioning Policy Statement: A13/PS/a Rituximab for the treatment of Systemic Lupus Erythematosus in adults | https://www.england.nhs.uk/wp-content/uploads/2013/10/a13-ps-a.pdf |
| 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 |
| 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 |