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**Person-Centred Care**

**Local CQUIN Templates 2016/17**

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**Person-Centred Care: Local CQUIN Templates 2016/17**

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# 19. Motivational Interviewing

|  | |
| --- | --- |
| **Indicator name** | Increased training of staff in core skills of motivational interviewing for improved care planning |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to the indicator:   1. Percentage of identified staff that complete training. 2. Percentage of patients in the agreed cohorts who have had a Care Plan developed utilising Motivational Interviewing techniques.   Percentage improvement in staff reporting confidence in completion of care plans which use motivational interviewing techniques |
| **Numerator** | Part 1 – staff training  Number of identified staff that complete training  Part 2 – Application of training  Number of patients in the agreed cohort who have had a care plan developed utilising motivational interviewing  Part 3 – Staff confidence  To be determined based on how staff confidence is decided to be measured using a self-reported tool. |
| **Denominator** | Part 1 – staff training  Number of identified staff to be trained  Part 2 – Application of training  Number of patients in the agreed cohort  Part 3 – Staff confidence  To be determined based on how staff confidence is measured, using an agreed self-reported tool. |
| **Rationale for inclusion** | The rationale is to develop the skills of appropriate staff in the techniques of motivational interviewing/health coaching, so that effective care plans can be developed which support patients to self-manage their long-term condition and actively participate in the decision-making related to their care.  Motivational interviewing is a tool that care professionals can use to help develop, in partnership with the patient, care plans which encourage self-management and choice; and which empower and support the patient to improve control of their own condition. A key component of this is that health (and other/social) care professionals work with a patient to identify their own care plan, and address potential barriers to behaviour change. |
| **Data source** | Providers |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Providers |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | To be agreed locally |
| **Baseline value** | To be agreed locally |
| **Final indicator period/date (on which payment is based)** | Q4 2016/17 |
| **Final indicator value (payment threshold)** | Payment based on achievement of quarterly milestones |
| **Final indicator reporting date** | To be agreed locally |
| **Are there rules for any agreed in-year milestones that result in payment?** | See section on milestones |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | See section on milestones (note that some elements of the milestones are geared to a multi-year scheme so these will need to be amended as appropriate). |
| **EXIT Route** | To be agreed locally |

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## Milestones

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1** | Providers must identify the relevant staff members required to undergo training, and identify the training provider and course to be undertaken. Providers must also confirm course dates. |  | 5% |
| Providers are to source a self-assessment tool for staff, to establish staff confidence pre training (as a baseline) |  | 10% |
| **Quarter 2** | At least 95% of identified staff must complete the jointly agreed motivational interviewing training, which will be verified by training schedules and attendance records by the end of Quarter 2 2016/17. |  | 25% |
| **Quarter 3** | At least an agreed percentage of the relevant patients have had a motivational interviewing care plan developed. The care plan must be:  Developed with the patient and focus on self-management, with patients setting their own goals in partnership with the healthcare professional.   * Support health and wellbeing by addressing lifestyle improvement. * Integrated across agencies and systems * Shared with the patients’ GP * Monitored for progress against goals at review appointments   Signpost to relevant support agencies, such as the voluntary sector as appropriate |  | 15% |
| Providers to submit a year 2 draft action plan which will have been developed using feedback from staff, and must identify potential patient cohorts for inclusion in year 2, and provide rationale as to their inclusion. |  | 10% |
| **Quarter 4** | At least an agreed percentage of the relevant patients have had a motivational interviewing care plan developed. |  | 15% |
| Audit in Q4 of the care plans of patients discharged from acute care being followed up by the community team in Q3 &4:   * To see if the patients have achieved their goals (Fully, partially or not achieved) * To see whether there has been an increase in staff confidence after training by use of the self-assessment tool developed in Q1.   A report must be submitted to commissioners to include an over-arching milestones plan, and detailed action plan with timelines for implementation in year 2. This must include (but is not limited to) the above audit results, staff feedback and a thorough evaluation of the use of this technique. This will be considered by commissioners and agreement will be reached as to the final implementation plans for year 2 as appropriate. |  | 20% |

**Rules for Partial Achievement at Final Indicator P**e**riod/ Date**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
|  |  |
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## Supporting Guidance and References

Further guidance on the scheme:

1. Training of staff in core skills of motivational interviewing/health coaching

Specialist Nurses working in the Acute or the Community Trust that are involved in direct patient care and contribute to care plan development with patients who have long term conditions e.g. COPD and diabetes.

There are a number of recognised training methods which could be employed and providers have the flexibility of developing their training package, but it must be jointly agreed between providers and:

* Be multidisciplinary
* Be multiagency
* Align with best evidence based practice in behaviour change.

1. Embedding of approach within key staff groups with staff able to demonstrate confident delivery of motivational/coaching interviewing with patients to develop an agreed care plan

Using motivational interviewing/health coaching to develop a patient centred care plan with the patient/client that focuses on behaviour change

The care plan must be:

* Developed with the patient and focus on self-management, with patients setting their own goals in partnership with the healthcare professional.
* Support health and wellbeing by addressing lifestyle improvement.
* Integrated across agencies and systems
* Shared with the patients’ GP
* Monitored for progress against goals at review appointments
* Signpost to relevant support agencies, such as the voluntary sector as appropriate

# 20. Patient Activation Measures

|  | |
| --- | --- |
| **Indicator name** | Introducing an Activation System for patients with long term conditions (LTCs) |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally – indicative costs of implementation provided in the ‘further information’ section of the template. |
| **Description of indicator** | Development of a system to measure skills, knowledge and confidence needed to self-manage long term conditions to support (understanding of how to take medication) adherence to medication and treatment and to improve patient outcomes and experience. |
| **Numerator** | Not applicable as the scheme is based on achievement of milestones |
| **Denominator** | Not applicable as the scheme is based on achievement of milestones |
| **Rationale for inclusion** | The implementation of a system focussed on self-care or support for self-management 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.  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.  The CQUIN aims to encourage use of the "Patient Activation Measure" (PAM) survey instrument, in the first instance to assess levels of patients’ skills, knowledge, confidence and competence to self-manage. Subsequent action will be to support/commission interventions that tailor service provision according to self-management capability and increase people’s activation scores. |
| **Data source** | To be agreed locally.  Reporting of action plans should be sufficiently detailed for stakeholders to be able to identify obstacles to optimum patient flows and the actions that are required to improve flow.  There is a risk of data contamination – completion of the PAM being influenced by expectations of staff administering it. Ultimately, however, the CQUIN will be judged by intermediate and final outcomes, so the incentive to encourage positive self-assessment should be limited.  NOTES:  As part of NHS England’s ‘Patient Activation’ programme, a five-year licence agreement has been agreed with Insignia Health (who hold the commercial rights for PAM) to grant 1.8 million people further access to the PAM tool through key NHSE change programmes..  In the first year of the programme (2016/17), around 40 CGGs and other primary care organisations will be granted access to PAM licences (subject to an application process) to support them to realise the ambition of personalised, person-centred care within the NHS. The application process for licences opens in April 2016. It does not include access to the online Survey and Scoring System developed by Insignia Health.  For further information about the Patient Activation programme, and how to apply for PAM licences, please check NHS England’s [Person-centred Care web pages](https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/). Alternatively, direct queries about the programme can be made to: [ENGLAND.patientactivation@nhs.net](mailto:ENGLAND.patientactivation@nhs.net). |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Not applicable as the scheme is based on achievement of milestones |
| **Baseline value** | Not applicable as the scheme is based on achievement of milestones |
| **Final indicator period/date (on which payment is based)** | See milestones section |
| **Final indicator value (payment threshold)** | See milestones section |
| **Final indicator reporting date** | See milestones section |
| **Are there rules for any agreed in-year milestones that result in payment?** | See milestones section |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | See milestones section |
| **EXIT Route** | To be agreed locally |

## 

## Milestones

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1** | Provider to:   * submit an application to NHS England’s Patient Activation programme to bid access to PAM licences * agree vision for use of PAM measure with cohorts of patients in context of increasing support for self-care, refer to the [Patient Activation programme narrative.](https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/) * agree the baseline metrics e.g. proportion of patients in each condition recruited into the programme for application of the PAM; * establish a working group; * submit an implementation plan to the commissioner; * agree training plan, including engagement activities to help the workforce understand the importance of patient activation; |  | 30% |
| **Quarter 2** | Demonstrate local engagement, regular working party outputs, performance against implementation plan |  | 10% |
| **Quarter 3** | Implementation of the programme locally with pilot testing and evaluation |  | 10% |
| **Quarter 4** | Implementation of the programme: baseline measure of PAM administered to first cohort of patients.  Report to commissioners on progress against implementation plan including results from pilot and shared learning.  Development of plan to roll this programme into next year and expand patient cohort or develop additional parameters for inclusion. Suggested steps for subsequent years outlined in the ‘further information’ section. |  | 50% |

## Supporting Guidance and References

**What is Patient Activation?**

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and offers care that is suitably personalised and supports people to recognise and develop their own strengths and abilities. It is an asset-based approach that puts individuals in the driving seat by increasing their capability. It supports people by giving them information they can understand and act on, and provides them with support that is tailored to their needs.

It is closely linked to other concepts such as ‘self-efficacy’ and ‘readiness to change’, and is a broader and more general concept, reflecting attitudes and approaches to self-management and engagement with health and healthcare, rather than being tied to specific behaviours1

1 The King’s Fund (2014) ‘Supporting People to Manage Their Own Health’

**Identifying appropriate patient groups**

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

* + There is a Care regime of known effectiveness;
  + Adherence to care regime is complex;
  + Symptomatic abreaction to poor adherence is distal;
  + 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: Chronic kidney disease; maternity; Chronic Heart Failure, COPD, Coronary Artery Disease, Diabetes, Asthma, severe depression, that have a high rate of unwarranted/preventable A&E visits and hospital admissions.  A growing body of evidence underscores the importance of self-management of these long-term conditions: people who recognise that they have a key role in self-managing their condition (and have the skills and confidence to do so) experience better health outcomes, have fewer unplanned admissions to hospital and report an improved experience of care. Effective self-management requires patient involvement in many areas — self-monitoring, medications, nutrition, physical activity and managing stress.

**Steps for extension of the programme into subsequent years**

The aim of the CQUIN scheme described above is to implement a system for the measurement of patient activation. Measuring individuals’ levels of knowledge, skills and confidence, and then tailoring support through interventions that improve their activation, helps to empower patients and enables them to be in control of their own health and care. This should be the focus of subsequent efforts that will help to enable a wider system shift towards self-care and person-centred care, particularly for patients with long term conditions.

Locally, this may lead to the following outcomes and benefits:

* Changes in patient behaviour, with patients managing and making informed decisions about their own health and care, that is, engaging in healthier behaviours such as those correlated to smoking, obesity and adherence to medication;
* Improved health and wellbeing, with better health outcomes and increased patient safety;
* Improved patient and clinician experience;
* Reduced demand on services including unplanned care admissions and A&E visits.

There are two broad categories of Activation interventions:

* + stratification of the patient groups to help diagnose problems and determine appropriate care and support plan;
  + work with patients to raise motivation, knowledge, skills and confidence to self manage, 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:

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

**Indicative costs of implementation**

The main cost drivers and their indicative values are as follows:

* number of patients in each condition recruited into the programme for application of the PAM (subject to appropriate exclusions). £45 per patient
* team building and training of staff to administer the PAM. £50,000 per team

Total payment is scaled by the proportion of patients within the designated patient group(s) receiving a PAM score.