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**Productivity**

**Local CQUIN Templates 2016/17**

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**Productivity: Local CQUIN Templates 2016/17**

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# 26. Clinical Utilisation Reviews

| **Indicator** | |
| --- | --- |
| **Indicator name** | Installation and implementation of a Clinical Utilisation Review (CUR) system |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | Installation and implementation of a clinical information system and approach over a two to three year period to reduce inappropriate hospital utilisation |
| **Numerator** | Performance is to be measured both qualitatively – achievement of milestones – and quantitatively against several parameters of clinical resource utilisation e.g. Total bed days associated with Active CUR wards at a standard Occupancy level. |
| **Denominator** |
| **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-design services to improve efficiency and productivity.  A Prescribed Specialised Services (PSS) CUR CQUIN is in place for providers of specialised services. A CCG CUR CQUIN presents an opportunity for CUR to be applied across whole health systems. This will provide greater benefits realisation across all healthcare providers including smaller NHS providers, community and mental health providers.  In many providers this will therefore be a joint NHS England and CCG CQUIN, with payment set across the two contracts in rough proportion to Prescribed Specialised Services (PSS), non-PSS bed-days and admissions. The supporting worksheets for this scheme facilitate the creation of a joint scheme. Note however that the national CUR Framework did not include mental health and therefore this would need to be procured locally for Mental Health providers to ensure that the CUR supplier has anglicised mental health criteria sets.  Note that a national CUR framework was launched in July 2015 from which NHS providers should procure their preferred CUR supplier.  NHS Providers can access the Framework by either undertaking a mini-competition between the 4 accredited suppliers or by making a direct award.  To support NHS Providers access the Framework, a CUR Framework User Guide has been developed.  The CUR Framework User Guide and Framework documentation is available on the CUR extranet and can be accessed by emailing [elisa.taylor@nhs.net](mailto:elisa.taylor@nhs.net) |
| **Data source** | CUR system\* and frequent contract meetings between provider and commissioner.  A Minimum Reporting Data Set report has been developed for submission to the National CUR programme Team, NHS England and CCG commissioners.  \*Note that in order to secure the CUR CQUIN, NHS Providers will be required to procure from one of the suppliers identified on the national CUR Framework. |
| **Frequency of data collection** | For further technical guidance on the CQUIN please refer to the PSS CUR CQUIN template (reference G.i) contained within volume II of the PSS CQUIN guidance*: Improving Value for Patients with Specialised Care: CQUIN Schemes for Prescribed Specialised Services for April 2016 to March 2017*” on the NHS England website |
| **Organisation responsible for data collection** |
| **Frequency of reporting to commissioner** |
| **Baseline period/date** |
| **Baseline value** |
| **Final indicator period/date (on which payment is based)** |
| **Final indicator value (payment threshold)** |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** |
| **Final indicator reporting date** |
| **Are there rules for any agreed in-year milestones that result in payment?** |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** |
| **Issues to take into consideration when setting local levels of improvement** |
| **EXIT Route** |

## Supporting Guidance and References

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.

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.

Release of cash 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 outsourcing of care required; no additional estate required to accommodate increasing demand.

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 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. 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.

# Delayed Transfers of Care

| **Indicator** | |
| --- | --- |
| **Indicator name** | Increasing the proportion of patients discharged to their usual place of residence within 7 days of admission. |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | A [x] percentage point improvement in the proportion of patients discharged to their usual place of residence within 7 days of admission (based on a baseline position taken from the end of Q1 / beginning of Q2 2016/17).  The indicator is primarily aimed at supporting improvements in patient flow within the acute sector during 16/17. However, the indicator could be expanded to include other local providers, including community providers and care homes, to support overarching system improvements in patient flow and discharge. |
| **Numerator** | The number of patients discharged to their usual place of residence within seven days from the date of admission.  Patients with a length of stay of 0 days should be excluded from the numerator. |
| **Denominator** | The total number of patients discharged.  Patients with a length of stay of 0 days should be excluded from the denominator. |
| **Rationale for inclusion** | There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures.  Shorter lengths of stay can act as a powerful proxy indicator of good patient flow. During the course of winter 2015/16, patient flow indicators have been trialled with systems taking part in the Emergency Care Improvement Programme (ECIP), and have supported reductions in length of stay and improvements in patient flow. This CQUIN indicator is designed to improve patient outcomes and ensure that ongoing care is delivered in the most appropriate setting.  The focus of the current monthly Delayed Transfer of Care (DToC) collection is to identify patients who are in the wrong care setting for their current level of need. However, there are a number of acknowledged limitations to the DToC measure, one of which is that it only captures a sub-set of delays along the patient pathway.  The CQUIN indicator reflects a medium-term intention to move beyond the DToC measure and to improve the way systems gather intelligence on patient flow and transfers of care. Adopting this indicator in 16/17 should allow systems to become familiar with this type of indicator ahead of any wider roll-out in future. The indicator and underlying data should also act as a helpful tool to support systems in working collaboratively to address the underlying drivers of delays.  There is a wide experience base for ‘what works well’ to improve patient flow in urgent and emergency care systems; some key sources are referenced in the guidance below. |
| **Data source** | Hospital Episode Statistics / SUS  The following data fields should be used:  (i) Length of stay, based on the Date of admission (ADMIDATE) and Date of discharge (DISDATE) fields;  (ii) Destination on discharge (DISDEST).  Providers are reminded that DISDEST should be recorded as 19 (The usual place of residence, including no fixed abode) if a nursing / residential home, or other place of care is the patient’s ‘usual place of residence’. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | June – July or August 2016 (if using SUS)  June 2016 (if using HES, due to longer time lag before data is available)  Commissioners should note the potential for seasonal variation and consider whether the baseline should also take account of performance in 2015/16. |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | October 2016 – March 2017 (Q3-4 2016/17) |
| **Final indicator value (payment threshold)** | To be agreed locally |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | N/A |
| **Final indicator reporting date** | As soon as possible after the end of Q4 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | To be agreed locally |
| **Issues to take into consideration when setting local levels of improvement** | Local systems are encouraged to consider graded improvement levels (e.g. 5/10/15%) in order to incentivise continuous improvement.  If this approach is followed, the allocation of payment between the different improvement levels should balance the incentive for continuous improvement against the incentive for initial improvement from baseline performance.  Providers and commissioners should carefully monitor readmission rate as a ‘balancing metric’ during implementation. |
| **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 | Establish current data quality as a priority (early Q1), focusing on discharge destination (**DISDEST**) field.  80% or more of discharge destination field to be collected and captured correctly by end of Q1. |  | To be agreed locally |
| Quarter 2 | Agree baseline based on performance at end Q1 / early Q2 (depending on data source). |  | To be agreed locally |
| Quarter 3 | Measure performance against baseline throughout Q3 and Q4. |  | To be agreed locally |
| Quarter 4 |  |  |  |

## 

## Supporting Guidance and References

SAFER bundle and best practice

Local systems are encouraged to refer to the **SAFER Patient Flow Bundle**, which can be found [here](https://www.england.nhs.uk/wp-content/uploads/2015/03/breaking-the-cycle-safer-flow.pdf).

It is a combined set of simple rules for adult inpatient wards to improve patient flow and prevent unnecessary waiting for patients. Trusts that routinely undertake all the elements of the SAFER patient flow bundle should improve the journey that patients experience when they are admitted to hospital. The bundle centres on the following key elements:

**S** – Senior Review. All patients will have a Consultant Review before midday.

**A** – All patients will have an Expected Discharge Date (that patients are made aware of) based on the medically suitable for discharge status agreed by clinical teams.

**F** – Flow of patients will commence at the earlier opportunity (by 10am) from assessment units to inpatient wards. Wards that routinely have patients transferred from assessment units are expected to ‘pull’ the first (and correct) patient to their ward before 10am.

**E** – Early discharge, 33% of patients will be discharged from base inpatient wards before midday. TTOs (medication to take home) for planned discharges should be prescribed and with pharmacy by 3pm on the day prior to discharge wherever possible.

**R** – Review, a weekly systematic review of patients with extended lengths of stay (> 7 days) to identify the issues and actions required to facilitate discharge. This will be led by clinical leaders and supported by operational managers who will help remove constraints that lead to unnecessary patient delays.

A collection of related best practice examples can be found in the NHS England guidance document ‘*Safer, faster, better: good practice in delivering urgent and emergency care*’, which can be found [here](https://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf).

Evaluation

Local systems should consider involving local government and social care partners in evaluation of the CQUIN indicator.