GE1 Clinical Utilisation Review

Scheme Name	**GE1 Clinical Utilisation Review**
QIPP Reference	QIPP 16-17 S40-Commercial
Eligible Providers	The CUR CQUIN is aimed at large NHS acute providers of specialised services. This 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. CUR can also be applied to Community and Mental Health Providers. However, the 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. Those providers who have already implemented CUR in 2015/16 should now continue to implement the second year (previously CUR CQUIN 2 and 3).
CCG Complementarity	A CCG CUR CQUIN has also been developed to encourage 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 / 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.
Duration	April 2016 to March 2018 (for those now commencing second year) or to March 2019, without-years' performance payments based upon early years' achievement.
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion [Locally Determined] should aim to achieve payment of the sum derived using the excel workbook, 'GE1 CUR CQUIN Baseline Calculator, on the 'Joint Baseline Calculator' tab, on the basis of the agreed scope of the scheme should be used as a guide to the initial CQUIN value. See Annex B, which describes supporting spreadsheets – all available from the CQUIN page on the NHS England website. The calculator allows for a joint scheme with a CCG. Target Value: Add locally CQUIN %: Add locally

Scheme Description
Clinical Utilisation Review (CUR) - Installation and Implementation; 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 prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need. The software has demonstrated the following benefits: • Reduction in unnecessary 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; • Consequential reduction in bed utilisation at NHS Provider or whole system level; • CUR Reporting. 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. Overall 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 other health systems where CUR is embedded. Achievable 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 yield. Improvements in patient flow can be achieved progressively, beginning within a few weeks of implementation. Reductions in length of stay may take over 18 months to fully 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 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 excel workbook, 'GE1 CUR CQUIN Baseline Calculator', on the 'Joint Baseline Calculator' tab, should be used as a guide to the initial CQUIN value.
See Annex B, which describes supporting spreadsheets – all available from the CQUIN page on the NHS England website.

For Year 1, the CQUIN payment is designed to cover the set-up costs (CUR licence) and training (clinical and non-clinical) costs for elements 1-7 above (implementation and 'go-live). Some costs will also be incurred for element 9 - Reporting.

Beyond this, a payment is for achievement of reduction in bed days (and, for schemes joint with CCGs, emergency admissions) not meeting CUR 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. Emergency admissions similarly will save provider costs but also reduce the 70% marginal emergency tariff payments due. 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 needs to fund an achieved reduction in the proportion of emergency admissions and bed-days for patients that do not meet the CUR criteria beyond the baseline reached in year one. The scope of CUR, in terms of the number of beds covered, must be equal or greater than what was implemented in year 1.

The CQUIN proportion for this outcome element of the CQUIN payment should be determined as a percentage point reduction in the proportion of bed-days and emergency admissions for patients not meeting the criteria. This is shown in the benefits realisation section of the calculator.

This involves setting a number of parameters (see separate calculator spreadsheet referenced above):

i. the estimate of the proportion of criteria not-met bed-days (and, for joint schemes, of

criteria not met emergency admissions) that will be identified in the baseline review [standard estimates: 42%[1], 14% respectively],

ii. an appropriate incentive payment per reduction in criteria not met utilisation. The standard estimates depend upon whether this will be a joint scheme with the CCG or just with NHS England:
    - For a joint scheme, incentive payments are £100 per bed day and £750 for emergency admission.
    - For an NHS England only scheme, only reduction in criteria-not-met bed days is incentivised, for each ward at £180 scaled by the average PSS proportion of bed days in that ward.

iii. the number of wards and beds to which CUR will be implemented in the year in question

iv. the period available for action beyond set up, according to the agreed ambition (i.e. circa 9 months in year one – with a minimum 6 months, 12 months in year 2)

v. a reasonable ambition regarding the percentage point reduction in "criteria not met" for both bed-days and emergency admissions, (typically a third or so of the blockages are within the hospital's direct control, and the balance can be addressed through collaboration).
    - 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%), with a minimum acceptable ambition of a six percentage point reduction.
    - Emergency Admissions ambition. A reasonable ambition might be a fifth reduction in criteria-not-met bed days (e.g. a 2.8 percentage point reduction in criteria-not-met bed days from 14% to 11.2%), with a minimum acceptable ambition of a 1½ percentage point reduction.

The last three parameters (the number of beds, the date of implementation, the level of ambition) are determined locally (subject to the minima specified) according to 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 advantage in being ambitious – setting a cautious improvement ambition, whether in terms of bed coverage, speed of implementation, or reduction in criteria-not-met utilisation, will reduce the CQUIN payment proportion contracted. Over performance will not then be rewarded through CQUIN (though it will still yield provider operational cost savings and benefits to 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.

The Standard CQUIN Value assumptions detailed above and in the Calculator will not automatically be adjusted once the actual baseline is determined during initial implementation of the tool. The percentage point reduction is fixed, and maintains the same overall CQUIN payment value irrespective of the actual starting proportion of criteria not met days. If the starting point turns out to be much lower than anticipated,

[1] subject to modification as suggested in the calculator according to the proportion of bed days in excess of the lower quartile length of stay by HRG

commissioners will consider reasonable proposals to achieve the same reduction in criteria-not-met bed days by implementing the scheme across more wards and/or more rapidly.
Commissioners will work with Trusts on the implementation plans to ensure hospitals do not end up with reduced CQUIN earnings potential.

This Benefits Realisation CQUIN sum is added to the Installation and Set Up and Reporting elements of the CQUIN payment (which cover the costs of steps 1-7 and 9), and taken as a proportion of total contract value to determine the appropriate CQUIN proportion – again, as set out in the Calculator.

Measures & Payment Triggers

The Elements 1-9 described within this section match those detailed in the 'GE1 CUR CQUIN Baseline Calculator workbook, on the 'Joint Baseline Calculator' tab, in the column marked 'Payment trigger "Element"'. See Annex B, which describes supporting spreadsheets – all available from the CQUIN page on the NHS England website.

Elements:

1. Provider has established and can evidence a project team with relevant stakeholders to manage CUR installation and implementation. (Year one only.)

2. Provider and commissioner have an agreed and documented plan with a scope of services which includes
   i. beds on which CUR will be used,
   ii. staff roles which will undertake the review function
   iii. numbers of staff to use tool & receive training
   iv. Timeframe for installation and implementation including a "Go Live" date.

3. Provider & commissioner have an agreed and documented operational /mobilisation plan including
   i. governance structure
   ii. reporting mechanisms
   iii. Established IT software & interface methodology.

4. Appropriate information flows established, datasets and a schedule of regular reports are agreed with commissioners.

5. Provider can evidence a signed contract of 24 months payment rules duration or above, with a recognised UR software provider stating "Go Live" dates in line with full/partial

6. Software & interfaces installed & live; training completed by the agreed "Go Live" date.

7. Daily use in practice of CUR can be evidenced in agreed bed numbers - payment is based on % of days used.

8. 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. For this element, the indicator is the %age point reduction in number of bed days (or admissions) subject to CUR and failing to meet criteria, whilst the Denominator is

the number of bed days (or admissions) that would be subject to CUR implemented across the whole year. (The KPI is set with sensitivity to the period of implementation.)

9. Reporting
   9.1. Quarterly reports (from month 7 in year one) to commissioners showing:
      i. numbers of patients with met / not met clinical criteria
      ii. reasons / details for not met criteria
      iii. evidence of actioned plans to reduce admissions / bed usage where not clinically indicated by CUR criteria
   9.2. Production of quarterly Board report (from Q3 in year one) presenting:
      i. CUR data showing numbers patients met / not met clinical criteria
      ii. reasons / details for not met criteria
      iii. progress against plans and future plans to reduce admissions / bed usage where not clinically indicated by CUR criteria
   9.3. 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 2017/18. Active participation in any stakeholder meetings arranged to address the external delays to patient flows.

Definitions

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

The “Elements” are detailed above within the Payment triggers section and match those detailed in the ‘GE1 CUR CQUIN Baseline Calculator workbook, on the ‘Joint Baseline Calculator’ tab, in the column marked ‘Payment trigger "Element"’.
Payment types are referenced A to I in the Calculator spreadsheet, column marked Payment ID.
Payment Trigger Elements 1 to 6 to be completed by month 6
Payment Trigger Elements 7 to 9 based on month 12 evaluation

	Rules for in year payment and partial payment
Q1	
Q2	Payment Trigger Elements 1 to 6 complete – Payment ID A to D can be made
Q3	
Q4	Payment Trigger Elements 7, 8 & 9 subject to M12 review Payment ID E to I to be made

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. 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

Elements referred to in this section are detailed within the Payment triggers section below.
The source of data for Elements 1 to 6 of this CQUIN is delivery of the agreed plans and documents that form the basis of the CQUIN requirements. This includes the % of staff who have completed CUR training during the year (including refresher training) vs the planned number of staff to be trained.
For Elements 7, 8 & 9 CUR standard contract data requirements may be sourced from the CUR software tool:

- Extracts from the CUR software tool to confirm active users and active records, transferred monthly, as part of information schedule following implementation.
- Information derived from the CUR standard contract data requirements. Calculated by either commissioner or provider (for local agreement), to include:
    - Total occupied bed days for the wards and services agreed as within scope; % of bed days with a clinical utilisation review record for those wards & services
    - Proportion and numbers of bed days / admissions where 'clinical criteria not met', and a breakdown by the agreed categories (tbc)
- Detailed monthly reporting of actions taken to reduce levels of 'criteria not met' activity to be completed by Provider
- Quarterly CUR activity reports to be prepared for the Provider Board to confirm levels of 'criteria not met' and progress against action plans. Evidence of inclusion in Trust Board Agenda.
- Quarterly CUR reports to be prepared and shared with stakeholders to highlight the number and reasons for external delays to patient flows.

Progress towards and delivery of Elements 1 to 6 will be considered and confirmed at the formal contract meetings (frequency tbc)
Element 7 – monitoring to be submitted on a quarterly basis, in line with the specific CUR CQUIN Report contract data requirements stated within the Information Schedule.
Elements 8 & 9 – 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, standard contract information schedules and from commissioner analysis of SUS data will deliver the source data requirements.

The **GE1 CUR Minimum Reporting Data Set** report has been developed for submission to the National CUR programme Team, NHSE and CCG commissioners. The report is to be submitted on a quarterly basis (from month 7 in year one).	
See Annex B, which describes supporting spreadsheets – all available from the CQUIN page on the NHS England website. Advice on the categorisation of reason codes is also attached at Annex A. Reporting of action plans should be sufficiently detailed for stakeholders to be able to identify obstacles to optimum patient flows and the actions required to improve flow. There are a number of smaller risks round data integrity which will be managed locally.	
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
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 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 Nuffield Trust[2] recently reported: "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 is endorsed in a recent NHS Improvement publication (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.

Data from UK hospitals (concurrent and retrospective CUR audits) over a 3 year period indicated that significant numbers of patients (14[3]% of acute admission, 42[4]% 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

[2] September 2015, Ruth Lewis & Nigel Edwards, "Improving length of stay - what can hospitals do?")
[3] Median 42% bed days (Range 35%-69%) needed less intensive setting
[4] Median 14% admissions (Range 7%-23%) did not meet acute criteria

programme findings 2008-2011). Similar findings are found elsewhere suggesting substantial scope for improvement:

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

Additional UK and international benchmarks are available from the CUR suppliers on the national framework.

Examples of improvements achieved by UK Hospitals using the software of CUR suppliers on the national framework are highlighted below. Note: In line with the procurement process suppliers should be approached directly for their case studies, including a substantial international evidence base.

Setting	Findings
Commissioner working with local hospital Trusts.	Used CUR over 2 years to manage admissions resulting in: • Improved Hospital at Home service by 30% saving >1000 emergency admissions or 700 bed days per month by avoiding admission and facilitating early discharge, almost an entire ward. Estimated saving £1.2m • Avoided over 1500 short stay emergency admissions per year where no significant clinical intervention occurred. Estimated saving £1.3m (1st year saving reinvested in alternative care).
Tertiary Hospital	Use of CUR allowed the closure of 20 cancer beds as a result of more outpatient work and shorter length of stay.
University Hospital	Over two years achieved: 300 bed reduction (11 wards), a +5% patient throughput increase and a '4 week LOS' reduced by 35%.
Large tertiary level hospital.	A large tertiary level hospital reduced average LOS from 5.6 to 4.5 days. The likely length of stay was posted in the patients' rooms and patient satisfaction scores increased.
Medium Sized	25% reduction in length of stay for unplanned medical admissions.

Setting	Findings
Acute Trust	
UK DGH	Using CUR with its GI surgery beds the hospital achieved faster recovery times, - 50% avoidable hospital days and a decrease in GI surgery-related readmissions. Post-op complications fell almost 60% and resulted in cost savings of £4.72m over 18 months.

The cost of the accredited software has encouraged some Providers to consider developing in-house systems in order to secure the CUR CQUIN.

Where there is an exceptional prima facie case that an **existing in-house system** is able to demonstrate that it is delivering all the outputs of clinical utilisation review, and is able to report on a live basis against the CUR CQUIN Minimum data-set, a provider may propose that it be subjected to the rigorous central assessment that has been established to ensure that only those systems that meet the national CUR framework criteria are used.

Providers are asked to note however that all CUR software tools are differentiated from other operational systems (bed management, EPR, acuity management systems etc.) by an extensive international clinical evidence base, developed over 20 plus years by CUR suppliers. This evidence base underpins the CUR software and this is further supported by teams of clinicians who continually review international clinical evidence and best practice to ensure that the software reflects the most up-to-date clinical evidence and best practice guidelines.

For this reason In House solutions will not be approved as eligible for the CUR CQUIN in 2016/17 without this rigorous quality assurance process, which will include demonstrating the breadth and depth of the clinical criteria underpinning the CUR solution.
Providers wishing to develop an in-house CUR solution during 2016/17, or providers whose systems only comply with part of the specification will **not be** approved for the 2016/17 CUR CQUIN.

A number of NHS Providers completed the quality assurance process for in-house systems during 2015/16 but all failed the assessment process. For this reason whilst NHS England are open to providers exploring this option in exceptional cases, it needs to be undertaken quickly so as not to delay the implementation and benefits realization for the local health system.

Providers should request a copy of the CUR In-House Assessment Framework from their commissioner to help to determine the likelihood of being successful in this assessment process.

Providers will need to notify their commissioner of their intention to pursue the in-house assessment process by Friday 29th April 2016 at the latest.