WC1 Difficult to Control Asthma Assessment in Twelve Weeks

Scheme Name	WC1 Difficult to Control Asthma Assessment within Twelve Weeks
Eligible Providers	22 specialised paediatric respiratory centres
Duration	April 2016 to March 2017, with possible extension with higher performance threshold..
Scheme Payment (% of CQUIN-applicable contract value available for this scheme)	CQUIN payment proportion [Locally Determined] should achieve payment of c. £31,250 per unit. Target Value: £31,250 CQUIN %: Add locally

Scheme Description

The CQUIN scheme aims to ensure assessment and investigation of children with difficult to control asthma within twelve weeks of referral, so to ensure that all eligible children have appropriate and timely assessment and investigation in order to improve asthma control, reduce hospital admissions and avoid inappropriate escalation of therapy including the initiation of expensive monoclonal antibodies.

In order to achieve this, specialist respiratory services need a dedicated difficult asthma team which requires an appropriate standardised skill set and strong leadership.
Providers need to establish systems and processes within their MDTs to ensure that patients are seen in a timely way and that a comprehensive management plan is initiated.

Currently, where units do not have an MDT approach, there may be different OPD attendances for the physio, psychology etc. An MDT approach would amalgamate these separate reviews but the exact length of appointments would need to be quantified depending on the approach and individual patient.

Problematic Severe Asthma (PSA) services will need to have in place the appropriate members of the team to carry out this assessment. Most services will have a medical lead and children's asthma nurse. Access to specialist physiotherapy and psychology may take longer to establish and providers would need to ensure sufficient personnel with the appropriate expertise are employed to enable the timely assessment of patients.

Estimated additional cost per centre:

- 0.2 WTE (1day) of Band 7 Physiotherapist
- 0.2 WTE (1day) of Band 7/8 Clinical Psychologist
- 0.25 WTE (1day) of Band 4/5 Difficult Asthma Database coordinator.

It is thought that some 50% of patients already receive this level of service however these is some variability. Whilst a baseline assessment of current performance will be discussed with each provider, a minimum target of 70% of children seen within 12

weeks is being applied to all centres.

This scheme could be considered for extension to a second year with a higher threshold for Year 2.

High performing units may be given a stretch target above 70%, or may be asked to act as champions mentoring and supporting improvement in other centres.

Measures & Payment Triggers

1. At least 70%[1] of (newly referred) difficult to control asthma patients (the denominator) to achieve all three numerator conditions – i.e.

Numerator: Number of patients who

a. undergo a systematic MDT assessment within 12 weeks of referral carried out by a Respiratory Paediatrician, Children's Respiratory Nurse Specialist, physiotherapist and psychologist ideally (but not exclusively) in a one stop clinic. are issued a detailed management plan
b. have assessments entered onto the Difficult Asthma Database.

Denominator:
Number of children referred to the service with a suspected diagnosis of difficult to control asthma.

2. Providers are required to produce an end of year CQUIN report which will be standardised across all centres and will include information to support improved outcomes such as reduced DNAs, reduced hospital admissions etc. This data will be taken from the database and a template for submission of the report by providers will be issued prior to Q1.

Definitions

As above.

Partial achievement rules

80% is payable on achievement of Trigger 1, as above.
Payment for partial achievement follows a RAG principle:

- achieving GREEN, >100% of the threshold, merits 100% of payment;
- achieving AMBER, > 90% of threshold (i.e. 63% compliance with trigger 1, against a 70% threshold), merits 50% of payment.
- No payment for RED.

20% is payable for achievement of Trigger 2; no partial payment is envisaged.

In Year Payment Phasing & Profiling

For local agreement.

Rationale for inclusion

It has been demonstrated that a thorough multi-disciplinary assessment of children with problematic severe asthma (PSA) (poor asthma control despite high intensity treatment) can successfully distinguish children with difficult asthma from those with severe therapy resistant asthma. The former group account for approximately 75% of

[1] *A higher target may be agreed locally as a stretch target.

children with PSA. Attention to the basics of asthma management leads to a reduction in exacerbations and reduced treatment burden. Using the CQUIN tool will accelerate achievement of improved outcomes for patients, not only medical but also socioeconomic in terms of improved school attendance and reduced time off work for parents.	
It has been demonstrated that a thorough multi-disciplinary assessment of children with problematic severe asthma (PSA) (poor asthma control despite high intensity treatment) can successfully distinguish children with difficult asthma from those with severe therapy resistant asthma. The former group account for approximately 75% of children with PSA. Attention to the basics of asthma management leads to a reduction in exacerbations and reduced treatment burden. Using the CQUIN tool will accelerate achievement of improved outcomes for patients, not only medical but also socioeconomic in terms of improved school attendance and reduced time off work for parents.	
Data Sources, Frequency and responsibility for collection and reporting	
Clinical audit would need to be undertaken to determine number and timing of referrals. The National Registry can then be used to determine the date by which the assessment has taken place. The database is up and running – paediatric teams are not inputting yet into the DB and the CQUIN will be used to incentivise data entry and reporting. DB is hosted by E-Dendrite - units will have access to their own data. HSCIC are sighted on this database and are involved in the outputs.	
Baseline period/ date & Value	N/A
Final indicator period/date (on which payment is based) & Value	Whole year performance.
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?*	It is intended that the standard required in this CQUIN scheme will be mandated in the service specification in which case providers will need to derogate with a plan to achieve in 12 months. Regional commissioners will need to consider their commissioning position and ensure that risk mitigation is in place with an achievable action plan for delivery/achievement. Achieving waiting time may require additional initial investment via this scheme, but beyond that time should be self-funding. Providers may receive reduced remuneration but also

	incur less cost per patient if they are having one MDT instead of a number of OP attendances. During the period of this CQUIN scheme, double running costs should be funded by the CQUIN scheme. Thereafter, providers would have to make savings corresponding to reduced non-MDT OP appointments.

Supporting Guidance and References

There are 22 specialised paediatric respiratory centres in England who see the cohort of “difficult asthma patients”. A specialised centre would expect to see approximately 30 new patients per year who would undergo this assessment.

A number of units do not see sufficient patients, and are staffed / resourced to an inadequate standard. The collection of data may facilitate the coalescence of units to maintain adequate resources in line with activity, if appropriate. We expect the numerator to be 30 patients per year for a centre. However, it is likely there are many more children who fit the criteria for PSA but are not referred to the appropriate centre. A more systematic assessment and better organisation of services should lead to a greater number of referrals leading to greater benefit for more patients. Throughput should appropriately rise with support from CCG commissioned services, perhaps to around 1000 patients per annum across England.

At present there are a small number of outstanding centres that have pioneered this approach. This standard should be achievable by all difficult asthma teams.

Evidence of effectiveness:
Chung, K., 2014; International ERS/ATS guidelines on the definition, evaluation and treatment of severe asthma. *ERJ -43;343 – 373*
Bracken, M., et al. 2009. The importance of nurse-led home visits in the assessment of children with problematic asthma. *Arch.Dis.Child* 94:780-784

There is retrospective data from published studies i.e. the study referenced:
Sharples, J., et al. 2012. Long-term effectiveness of a staged assessment for paediatric problematic severe asthma. *Eur.Respir J* 40:264-267.