GE1 Clinical Utilisation Review

Scheme Name	GE1 Clinical Utilisation Review
QIPP Reference	QIPP 16-17 S40-Commercial '17/18 QIPP reference to be added locally.
Eligible Providers	This CQUIN 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. **For '16/17** The CUR CQUIN is aimed at large NHS acute providers of specialised services. **For '17/18 and '18/19** Those providers who have already implemented CUR in 2016/17 as part of a full first year CQUIN should now continue to implement and use the tool as part of the second and third years of this scheme. For providers who have undertaken successful CUR Local Learning Pilots (whether under the national CQUIN scheme or otherwise) in 2016/17, this scheme should be adopted as a full first year CQUIN scheme. [NB: The success of 16/17 CUR Local Learning Pilots will be determined by the Steering Groups set up to oversee their development who must use the national success criteria developed for this purpose. As the pilots will not be completed until March/ April 2017 a provisional CUR CQUIN will need to be agreed and a replacement scheme identified if required.] The total bed-base to be included in the CUR CQUIN is a minimum 400 beds in year 1, increasing to 600 beds in years 2. For those trusts who have less than 400 or 600 as their total bed base, and for year 3, implementation should cover the total applicable bed base. [NB: CUR can also be used in a Mental Health setting and is advocated for use by Providers to support the new MH4 Discharge CQUIN.]
Duration	April 2016 to March 2019
Scheme Payment	CQUIN payment should aim to achieve payment of the sum derived using the excel workbook, 'GE1 CUR CQUIN Calculator', available from the National Team and on the CQUIN website. 2017/18 Target Value: Add locally 2018/19 Target Value: Add locally
Scheme Description	

Clinical Utilisation Review (CUR) - Installation and Implementation; application and use leading to 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 help to prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need.

Use of the software as an integral part of Provider transformation/ service improvement programmes has provided information enabling the following benefits to be secured:

- Reduction in 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;
- Through use of the CUR solution a consequential reduction in bed utilisation at NHS Provider or whole system level;
- CUR Reporting and provision of patient level minimum dataset.

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 (subject to the minimum bed coverage in each year, set above) 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 leading health systems where CUR is embedded. 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, with the first 12 months of implementation, following a 3 to 4-month period of data validation. Reductions in length of stay may take over 18 months to implement fully, 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. Trusts will need to agree the size and scale of the implementation in order to secure Implementation Payments (Triggers 1-4 below). 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 Payment Elements are:

Element	Driven By	Previously	2017-19 Payment	Notes
Implementation and Rollout				
Implementation Payment (Triggers 1-4)	Year One Only	£140,000 - £200,000	£170,000-£250,000*	£100,000* Plus number of beds in provider trust x £180* subject to maximum of £250k.
Training & Backfill Payment (Trigger 4)	Additional Wards Implemented in a given year	£300 per person	£360* per person	Number of Staff trained to use the tool on the new wards where CUR is being introduced.
Ongoing Use				
Daily Use of the software on Live Wards (Trigger 5).	Ongoing Steady State use of the Software.	£120 Per Bed Per Full Year Live.	£150* Per Bed Per Full Year Live.	Days for which a completed CUR record is available / Beds in Scope x 365.
Reporting (Trigger 7).	Ongoing Adoption of the new operational processes.	£50,000	£60,000**	£50,000 for Monthly reporting to commissioners and submission of mandated Minimum Data Set to NHSE England. Quarterly reporting to NHS Trust Provider Board also required. £10,000 for Annual Report to NHS Trust Provider Board.
Benefit Realisation				
Year On Year Percentage Point Reduction in Clincal Criteria Unmet Bed Days (Trigger 6).	Targetting wards with specialised services use.	Unmet Bed Days reduced x £180 x % Specialised beds.	Unmet Bed Days reduced x £210* x % Specialised.	
Year on Year: Percentage Point reduction in Clinical Criteria Unmet Emergency Admissions.	CCG or STP supported use of Tool in ED.	£750 per admission	For Local Discussion (Not within Specialised CQUIN Scope).	

*Increased to cover higher license and implementation costs at larger Provider Trusts.
**Increased to cover the costs of providing an extended Minimum Data Set to NHSE from April 2017.

An excel workbook is available on the NHS England PSS CQUIN site to use to set the initial CQUIN value - the 'GE1 CUR CQUIN Calculator'.

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

Beyond this, a payment is made for achievement of reduction in bed days 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. 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 funds a year on year achieved reduction in the proportion of emergency admissions (where used in A&E) and bed-days for patients that do not meet the CUR criteria beyond the baseline reached in year one. The total bed-base to be included in the CUR CQUIN is a minimum 400 beds in year 1, increasing to 600 beds in years 2. For those trusts who have less than 400 or 600 as their total bed base, and for year 3, implementation should cover the total applicable bed base.

The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (*pro rata* – adjustment to be made to results given by the calculator).

This calculation is shown in the benefits realisation section of the excel workbook provided. It involves setting a number of parameters:

- The estimated starting point proportion of criteria not-met bed-days and criteria not met admissions (for CCG / STP supported use in A&E), either from previous year's first three-month average, from Local CUR piloting, or using standard estimates: 42%[1], 14% respectively
- The targeted percentage point reduction in "criteria not met" by the end of each year
- The numbers of wards and beds in which CUR will be operational in each year
- The targeted percentage point reduction in "criteria not met" by the end of each year
- The proportion of bed days in the targeted wards which are likely to be specialised care.

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%, subject to any necessary adjustments included in the CUR CQUIN baseline calculator), with a minimum acceptable ambition of a six percentage point reduction. Typically, at least a third of the delays are within the hospital's direct control, and the balance can be addressed through collaboration.

Goals will reflect 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 an advantage in being ambitious – setting a cautious improvement target, whether in terms of bed coverage, speed of implementation, or reduction in criteria-not-met utilisation, will reduce the CQUIN payment proportion contracted. In addition, where target improvements are exceeded the CQUIN payment cannot exceed the amount set aside for this CQUIN in the contract agreement (though it will still yield provider operational cost savings and benefits to

[1] Subject to the Provider Trust specific modifications suggested in the calculator, which may be used to adjust the targets to reflect the proportion of bed days in excess of the lower quartile length of stay by HRG.

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, and the use of the system.

Worked examples can be found for Year 1 and Year 2 CQUINs in the G.i CUR CQUIN Calculator supporting XL workbook.

The increase in the individual tariffs associated with this CQUIN will uplift payment by c.20% compared to 2016/17 levels in line with the Specialised CQUIN scheme guide.

Measures & Payment Triggers

Payment triggers as follows, with payments proportioned as per the following table.

Descriptions	First Year of scheme
Trigger 1:	Provider has established and can evidence a project team with relevant stakeholders to manage CUR installation and implementation.
Trigger 2	Provider and commissioner have an agreed and documented operational/ mobilisation plan with a scope of services which includes: 1.1. Governance structure; 1.2. No of beds on which CUR will be used; 1.3. Identified staff roles to undertake the CUR reviews; 1.4. No and type of staff who will be trained to use the tool and trained to undertake training of new staff (train-the-trainer); 1.5. Established IT software and interface methodology; 1.6. Internal and external reporting mechanisms including frequency and type of reporting (note monthly reporting of the CUR Minimum Data Set is mandated) 1.7. Timeframe for installation and implementation including a "Go Live" date.
Trigger 3	Provider can evidence a signed contract of 24 months' duration or above, with a recognised CUR software provider stating "Go Live" dates in line with agreed implementation plan.
Trigger 4	Software & interfaces are installed and live, and training is completed by the agreed "Go Live" date.
Trigger 5	Daily use in practice of CUR can be evidenced on agreed bed numbers with an achievement of 85-95% compliance rate.
Trigger 6	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. The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR

	assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (at the discretion of local commissioners).	
Trigger 7	Reporting 1. Production of quarterly CUR CQUIN Reports to commissioners on CUR data showing (i) Numbers of patients with met / not met clinical criteria (ii) Reasons / details for not met criteria (iii) Compliance rate by ward (iv) Evidence of actioned plans to reduce admissions / bed usage where not clinically indicated by CUR criteria. 2. Production of mandatory monthly CUR CQUIN Minimum Data Set (MDS). The CUR MDS extract has been developed for submission to NHSE commissioners only and will not be shared with CCGs unless agreed with Providers as part of a Joint CQUIN agreement. The extract is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1. From 2017/18 the CUR MDS will be part of the NHS Standard Contract Information Schedule. The information contained within the database will be used to develop the evidence base for CUR use and to understand the range, scope, size and outcomes of the national CUR programme. 3. Production of quarterly Board report presenting. (i) CUR data showing numbers patients met / not met clinical criteria (ii) Reasons / details for not met criteria (iii) Compliance rate by ward (iv) progress against plans and future plans to reduce admissions / bed usage where not clinically indicated by CUR criteria 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 2018/19 and 2019/20. Active participation in any stakeholder meetings arranged to address the external delays to patient flows.

Descriptions	Second and Third Years of scheme
Triggers 1-4	Not applicable.
Trigger 5	Daily use in practice of CUR can be evidenced on agreed bed numbers with an achievement of 85-95%% compliance rate.
Trigger 6	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. The CQUIN proportion for this outcome element of the CQUIN payment should be determined by measuring the reduction in the % of CUR assessments that do not meet CUR criteria. To ensure the accuracy of this calculation Provider Trusts are required to ensure high compliance in the use of the tool. Compliance rates below 85% will be subject to reduced payments (at the discretion of local commissioners).
Trigger 7	Reporting 1. Production of quarterly CUR CQUIN Reports to commissioners on CUR data showing (i) Numbers of patients with met / not met clinical criteria (ii) Reasons / details for not met criteria (iii) Compliance rate by ward (iv) Evidence of actioned plans to reduce admissions / bed usage where not clinically indicated by CUR criteria. 2. Production of mandatory monthly CUR CQUIN Minimum Data Set (MDS). The CUR MDS extract has been developed for submission to NHSE commissioners only and will not be shared with CCGs unless agreed with Providers as part of a Joint CQUIN agreement. The extract is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1. From 2017/18 the CUR MDS will be part of the NHS Standard Contract Information Schedule. The information contained within the database will be used to develop the evidence base for CUR use and to understand the range, scope, size and outcomes of the national CUR programme.

	3. Production of quarterly Board report presenting. (i) CUR data showing numbers patients met / not met clinical criteria (ii) Reasons / details for not met criteria (iii) Compliance rate by ward (iv) progress against plans and future plans to reduce admissions / bed usage where not clinically indicated by CUR criteria. 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 2018/19 and 2019/20. Active participation in any stakeholder meetings arranged to address the external delays to patient flows.	

Definitions

Minimum patient level dataset is specified with data definitions included, based on the CUR framework supplier software.

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

Standard – subject to local variation.

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

Progress towards and delivery of Triggers 1 to 4 will be considered and confirmed at the formal contract meetings (frequency tbc).

Triggers 5 and 6 - CUR CQUIN report

Trigger 7 - 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, CUR patient level minimum dataset, standard contract information schedules and from commissioner analysis of SUS data will deliver the source data requirements.

The **CUR Minimum Reporting Data Set** extract has been developed for submission to NHSE only. The report is to be submitted on a monthly basis. For 2017 this will be a patient level dataset to be provided through the standard patient identifiable dataset flows via CSU safe haven business intelligence services. Further details are provided at Annex 1.

Baseline period/date & value	Set annually
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 CUR National Team has produced a "How to" Guide. This guide aims to provide NHS Trusts with high level support on "how to" operationalise CUR and covers 4 key stages including i) implementation and planning; ii) procurement; iii) delivery; and iv) reporting. The guide also signposts to other useful resources and is available on the CUR extranet.

Clinical Utilisation Review is a clinical decision support tool that enables clinicians to make impartial and objective, evidence-based assessments of whether patients are receiving the right care, in the right place, at the right time and for the right length of time, according to a patient's individual needs.

CUR guidelines are based on systematic reviews of clinical evidence and are widely used internationally, to provide evidence-based decision support for clinicians. CUR supports clinicians to adhere to clinical best practices. CUR always integrates medical judgment with evidence-based guidelines, including consideration of comorbidities and limitations on community resources and services during the review process.

By adopting the CUR process and utilising the latest technology to provide real time evidence based clinical decision support, healthcare organisations are able to address and quantify key operational issues from daily patient level assessment such as:

- *What levels of clinical care do our patients need?*
- *What are the reasons patients are not in the most appropriate setting for their clinical needs and how can these be resolved?*
- *What is the impact of operational inefficiency on the organisation and when changes are made, does performance improve?*
- *How can we ensure that all our patients receive the right levels of care, in the right settings at the right time?*
- *Where and how do we need to invest in order to reduce hospitalisation and what will be the process and overall reduction in costs?*

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. CUR can also help to reduce unwarranted clinical variation and ensure patients are cared for in the optimal setting, and to address barriers to optimal patient flow.

Developing the CUR Evidence Base

The use of Clinical Utilisation Review tools has increased and developed in the NHS over the past 5 to 10 years. Initially this was through a number of NHS Trusts in England who engaged directly with the supply and implementation of CUR tools as well as commissioners undertaking retrospective audits supported by independent consultants using CUR tools.

The Nuffield Trust report (September 2015, Ruth Lewis & Nigel Edwards, "Improving length of stay - what can hospitals do?") states that: "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 report complements further work recently published by Monitor (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.

The launch of the national CUR CQUIN and national CUR framework in 2015, has seen the uptake of CUR increase with the establishment of 5 national Early Implementer Sites, and latterly the update of CUR CQUINs for 2016/17 across 30 NHS Providers nationally.

One of the early barriers presented by Trusts reluctant to implement CUR has been the lack of available UK data and evidence of the benefits CUR can bring. From the early audit work undertaken, and from the data and case studies provided by the 5 national Early Implementer sites, we now have the evidence to show that many patients are admitted to and/or retained in acute settings that could be managed in an alternative level of care. Acute hospitals typically admit many patients who are not strictly in need of acute care – particularly people in later life.

Data from UK hospitals (concurrent and retrospective CUR audits) over a 3-year period indicated that significant numbers of patients (24% of acute admission, 42% 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 programme findings 2008-2011). Similar findings are found elsewhere suggesting substantial scope for improvement.

Table 2 – Patients not Qualifying for Acute Hospital Care (international data)

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%

Information gathered from the commissioning and implementation of CUR tools, and from the data reported by NHS England's Early Implementer Sites supports the existing evidence base: -

- During Q1 2016-17 over 112,000 daily reviews (clinical assessments) were undertaken on over 2,600 beds across the 5 Early Implementer Sites (EIS) and three other Trusts providing reports for that quarter.
- Based on the data provided, 45,372 (40%) of those daily reviews (clinical assessments) did not meet the CUR criteria for an appropriate patient stay; with a range of 21% to 66% at the 8 Trusts.
- Across the 8 Trusts, an average of 499 beds, during the quarter, had a patient being cared for that did not meet the CUR Criteria for that level of care.
- Between 10% and 15% of emergency admissions not meeting the CUR Criteria for an acute bed at hospitals with a mixed bed base.

Costs

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.

NB: Under the national CUR Framework, the pricing for the licence costs is based on the total bed-base of the provider.

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.

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 delays 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.

Many Healthcare providers internationally adopt CUR systems either as a condition of providing services to payors or to capture the substantial provider cost savings. The CQUIN is provided to ensure NHS providers are able to adopt CUR without facing any financial risk or affordability challenges from the one off costs of implementation. Failure to adopt CUR for the NHS would – hindering improvements in patient flow that benefit individual organisations, health systems and patients, reduce our understanding of patient flows across systems, and impede our ability to design service and transformational change that is based on quantified clinical evidence.

Annex 1

CUR CQUIN Minimum Data Set (MDS)

The production and submission of a monthly CUR CQUIN Minimum Data Set (MDS) is mandated as part of the 2017/18 and 2018/19 CUR CQUIN. From 2017/18 the MDS (see below) will be part of the NHS Standard Contract Information Schedule.

The CUR CQUIN MDS will include the following data fields.

1. Provider Code
2. CUR Vendor ID
3. NHS Number
4. Date of Birth
5. Date of Admission to a Hospital Bed
6. Date & Time Assessment undertaken
7. Time Assessment undertaken
8. Patient Stay Date
9. Level of Care (e.g. Acute Care; Critical Care; HDU; Sub-Acute; Acute Paediatric, Acute Rehabilitation, Community Rehabilitation; Intermediate Care, Other 'Community', etc)
10. Care Setting/ Ward Type
11. Criteria Set Used
12. Met (Qualified) / Unmet (Non-Qualified)
13. Reason Code for Unmet (Non-Qualified)
14. Reason Text for Unmet (Non-Qualified)
15. Reason Category for Unmet (Non-Qualified) e.g. Internal (Operational/ Physician) or External.
16. Alternative Level of Care clinically indicated

NB: The mapping of reasons codes needs to be consistent between suppliers. NHSE Guidance on the categorisation of reason codes need to be adopted by Providers and automated by Suppliers.

NB Levels of Care will be defined with Suppliers and in consultation with National (NHS Trust) CUR Learning Set.

As part of this process a monthly CUR CQUIN MDS extract will need to be submitted, by all NHS Providers in the 2017/18 CQUIN Scheme, to CSUs and then onwards to the national repository. From there it will be matched against patient level national contract monitoring data. Analysis of data will be the responsibility of the *Information and Intelligence, Specialised Services National Support team*.

Whilst CUR suppliers are expected to help automate the production of the MDS it will be the responsibility of NHS Providers.

Due to differences in local implementation of CUR software, local modifications to the software and the differing characteristics of local systems this information will not be used to performance manage individual Trusts. The MDS will not be used for any other contract management purpose outside of the CUR CQUIN. As part of signing up to the CQUIN Providers will be assured that the publication of Trust specific data will only be made available with permission from their Trust Board e.g. to support cases studies or good practice guides. Trusts involved in the National (NHS Trusts) CUR Learning Set will be consulted on the analysis and use of data.