IM 3 Auto-immune Management

Scheme Name	IM 3 Multi-system auto-immune rheumatic diseases MDT clinics, data collection and policy compliance
Eligible Providers	All providers of specialised rheumatology services
QIPP	Insert locally
Duration	April 2016 to March 2019
Scheme Payment (% of CQUIN-susceptible contract value available for this scheme)	CQUIN payment proportion [Locally Determined] should achieve payments of £180 per projected number of MDTs (up to one per patient). 2017/18 Target Value: Add locally 2018/19 Target Value: Add locally

Scheme Description

Problem to be addressed

Currently, there is no coordinated process within each Region that ensures comprehensive governance of the management of rare autoimmune rheumatic diseases or supports a cohesive drive to improve outcomes. As a result, there is significant variation in standards of care and outcome depending on where patients are treated, as well as in utilisation of costly therapies, sometimes inappropriately. This tends to be influenced by both the process of care (e.g. within designated specialised as opposed to general clinics) and the degree of availability, support and interaction with specialised centres, where larger volume care, usually combined with research, is delivered.

Systemic auto-immune rheumatic diseases are rare, multisystem, non-genetic conditions that have high morbidity and mortality. They share overlapping clinical and serological features, affect multiple organ systems, and therefore require coordinated multidisciplinary care.

Change Sought

Earlier diagnosis and intervention, enhanced recognition of severe or refractory manifestations requiring specialised centre involvement, and earlier detection/prevention of relapse will reduce avoidable mortality and morbidity, reduce costs, and improve quality of life, aligned with the vision of the NHS Outcomes Framework.

This CQUIN is to support the development of coordinated MDT clinics *and MDT meetings for patients with multisystem auto-immune rheumatic diseases *(see definition of this cohort in definitions section below), and to ensure data collection and compliance with existing NHS England Commissioning Policies. This will be achieved by the development of a coordinated network that involves all rheumatology providers in each senate region, in the context of the establishment of national model Specialised Rheumatology centres.

Target Payment

To set the target CQUIN payment for this scheme at a level commensurate with the cost of implementation, it is necessary to estimate a target number of patients *who met the definition below e.g. whose care will be considered by MDT and data capture as prescribed.

The target payment will be £180 times the number of patients targeted.

To set the value of the scheme, it is therefore necessary to estimate the number of patients that will be seen during 2017/18 and in 2018/19. Where available this should come from electronically flagged attendances at outpatient clinics. Where not available electronically the definitions below should be used to determine likely numbers. Actual payment of triggers 2 and 3 will depend upon the proportion of the caseload (according to the definition adopted) that is compliant – irrespective of whether the outturn caseload differs from that expected.

Enhanced payment is appropriate for providers taking on network responsibilities.

Measures & Payment Triggers

FOR YEAR ONE

Trigger 1. Initiation of hub and spoke arrangements or networks, to review treatment plans of specialised rheumatology patients in line with policies (see Annex). All providers across networks are responsible for developing a working group for this CQUIN and an implementation plan.

Trigger 2. The proportion of patients benefiting from comprehensive governance of the management of rare autoimmune rheumatic diseases though MDTs. Every patient discussed by MDT should have an outcome recorded *which should include a minimum dataset (see data sources section below). If the request for an MDT review is for consideration of high tariff drug the one of 3 potential outcomes should be documented:

a) Diagnosis not confirmed, referred back to clinician
b) Diagnosis confirmed, does not currently meet criteria for policy, e.g. first and second line therapies not exhausted, treatment plan agreed
c) Diagnosis confirmed, meets criteria for policy

Trigger 3. The proportion of patients whose treatment complies with policy and whose *clinical information is collected onto the BILAG BR, DUO and UKIVAS registries in line with the published Specialised Rheumatology commissioning policies. It is therefore necessary to measure:

a) *The number of patients with specific diagnoses who are receiving drugs for which there are commissioning policies
b) The number of patients entered onto the specific register

Triggers 2 & 3 enable respectively (i) Audit of quality of referrals and of initial clinical management i.e. have first and second line therapies been appropriately tried and/or is the initial diagnosis by referring clinician accurate? (ii) Audit of policy compliance and outcomes.

Trigger 4. Achieving local data collection in order to determine the impacts of the network and Commissioning Policies.

FOR YEARS TWO AND THREE

Trigger 1. Further development of network arrangements, to review treatment plans of specialised rheumatology patients in line with policies. All providers across networks are responsible for developing a working group for this CQUIN and an implementation plan. To include use and monitoring of patient outcome/quality of life tools.

Trigger 2. As Year 1

Trigger 3. As Year 1

Trigger 4. Continuing local data collection in order to define the benefits of the network and Commissioning Policies through audit.

Definitions

Patient cohort

Any Multisystem Autoimmune Disease case requiring MDT discussion:

- Patients considered for High-tariff drugs (HTD)
- Patients managed in combined clinics (e.g. Chest/Rheum, Obstetric/Rheum)
- Patients referred to specialised centre MDT from another Rheumatologist for a second opinion
- Patients discussed at face-to-face or Video MDTs for advice regarding diagnosis or management

Trigger 2

- **Numerator** – number of patients discussed or seen by the MDT with a recorded outcome.
- **Denominator** – total number of patients seen or discussed by the MDT.

Trigger 3

Achievement is measured against the following indicator:

- **Numerator** - the number of patients treated within NHS England specialised rheumatology Commissioning Policies during each year whose treatment plans have been considered by a Specialised Centre MDT where required, and whose data collection into the BILAG BR, UKIVAS and DUO registries is compliant with the published policies.
- **Denominator** - the number of patients *who received drug therapies for which there are commissioning policies in specified conditions.

Partial achievement rules

For Triggers 2 and 3, payment proportionate to achievement.
Otherwise: all or nothing.

Payment Weighting

Period	Trigger	Weighting (% of CQUIN scheme available)
Year 1	Triggers 1, 4	25% each

Year 1	Trigger 2	25% Payment should be proportional to the ratio of numerator to denominator as above
Year 1	Trigger 3	25% Payment should be proportional to the ratio of numerator to denominator as above
Years 2 & 3	Triggers 2, 3	40% Payments should be proportional to the ratio of numerator to denominator for the respective indicators as above.
Years 2 & 3	Trigger 1	40%
Years 2 & 3	Trigger 4	20%

Rationale for inclusion

CQUIN support is appropriate given the coordination difficulties of establishing networks. The network will provide essential governance, and also ensure appropriate access to, and compliance with policy pertaining to, the high-cost drugs that are commissioned by NHS England for use in these conditions.

Data Sources, Frequency and responsibility for collection and reporting

Two types of data requirement:
Narrative reports – produced by lead Clinical Teams, quarterly reporting to commissioner
Dataset: Provider submission to commissioner and the BVAS, DUO and BILAG registries in line with the published Specialised Rheumatology policies. *3 monthly reporting of registry data which is in line with the submission of the specialised rheumatology quality dashboard data
Appropriate data collection – to fulfil numerator for CQUIN:

- For non HTD cases:
  - MSAID Diagnosis/Diagnoses
  - Comorbidities
  - Drugs
- For HTD cases:
  - MSAID Diagnosis/Diagnoses
  - Comorbidities
  - Drugs
  - Disease activity scores

Baseline period/date & value	See accompanying Worksheet, “IM.iii Rheumatology Datasheet”, for background data on activity by diagnosis and provider. This should guide the setting of the number of patients to be targeted for MDT consideration and data capture
Final indicator period/date (on which payment is based) & Value	MDT actual activity for financial year as at Month 12

Final indicator reporting date	Last day of the month following end of Q4
CQUIN Exit Route How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?	Ongoing network led audit programme and disease registry data will be available to ensure compliance. Savings arising from the MDTs and data collection would largely accrue to the commissioners. In due course, the cost of the MDTs will feed through into reference costs and should be absorbed in tariff and local prices after the cessation of the CQUIN.

Supporting Guidance and References

Evidence base

The benefits that will be delivered by the coordinated network for multisystem autoimmune rheumatic diseases include:

- Ensuring visibility of outcomes across the region, enable Regional and Sub Regional Teams to identify and ensure uniformity across all services
- Enabling structured assessment of disease activity and damage using validated outcome measures, which will ensure both audit benchmarking of outcomes and that treatment decisions are consistently based on disease status active disease, irreversible damage or relapse
- Embedding formal guidelines and pathways across the whole network, which will enable earlier intervention, structured internal organ screening and reduced risk of progression to organ failure (e.g. renal, lung, vision)
- Enhanced recruitment to research studies in these rare diseases, facilitated directly by the network and also the NHS England Commissioning Policies, which is essential in order to develop future treatment strategies
- Earlier intervention for severe disease with clear pathways of specialised centre involvement, which is likely to improve outcome and reduce costs associated with organ failure
- Patient satisfaction will be improved by reduced attendances enabled by coordinated care, and the reassurance that their care is being provided as part of a specialised network. Improved education, social and psychological support delivered through specialised centres will improve economic activity, and improve adherence and outcomes.

Costs associated with this CQUIN are estimated (by one provider feeding back on the draft scheme) as follows

- establishing regional network
- Working group meeting followed by teleconference meeting x 1/ month for 12 months involving consultant, nursing and manager representative at each site - establish patient pathways and NHSE categories for referrals, guidelines / governance for biologics and cyclo prescribing
- establishing mechanisms for recording NHSE patients and auditable MDT discussions in electronic records / specialist databases
- establish mechanism for coding and reimbursement of this activity

Maintenance costs:

- Clinical time for discussion patients in MDTs, and recording discussions - estimate 4 hours per week for consultant, nurse and trainee for 20 patients (average 12 mins per patient)
- Clinical time for capture of clinical outcome measures - 2 hours per week currently partially funded by CLRN research- no sustainable funding currently
- Network review meetings quarterly to review data and audit of outcomes, discuss governance issues
- Coding of MDT discussions

Key outcomes to be the following:

- Savings related to implementation of the Rituximab in ANCA Vasculitis Policy £3.6 million
- Savings related to implementation of the Bosentan and Sildenafil in Digital Ulceration Policy £6.5 million

The improved clinical care arising directly from the Network is likely to lead to direct savings via a ***15-20% reduction*** in each of the following:

- Number of patients with Lupus and Vasculitis who progress to end-stage renal replacement therapy (each single avoided case saves £30,000 per year, estimated minimum 12 cases avoided = £360,000).
- Number of patients with Scleroderma-related Interstitial Lung disease or Pulmonary Hypertension who progress to end stage disease/high cost drugs/respiratory failure. There will also be reduced activity costs of screening (Echo and Lung Function) of 25% by implementing the DETECT screening protocol. This is estimated to reduce the number of echocardiograms by 500-1000 and of CT scans by 500, with a (reference) cost saving of £93,000-£136,000.
- Costs associated with managing suspected Giant Cell Arteritis via the institution of networked GCA Fast Track Pathways. An economic evaluation of a Fast Track pilot in Southend indicates an average saving of £400 per case of suspected GCA, and significant reduction in the risk of permanent visual loss. The Incremental Cost-Effectiveness Ratio (ICER) of implementing the fast-track pathway is -£840 per QALY. There are 12,000 new cases of GCA each year; assuming that only 50% of the savings in the pilot are realisable, equates to a saving of £2.4 million.
- Number of hospital admissions by rapid identification of disease progression and early institution of ambulatory therapy.
- Number of hospital admissions related to complications of non-cancer Chemotherapy.
- Costs associated with accelerated cardiovascular disease (related to both vascular inflammation and chronic corticosteroid toxicity) via regular assessment of risk factors.

- Costs associated in osteoporosis and fracture morbidity by early identification, treatments and reduction in chronic corticosteroid use (a major risk factor).
- Some of these savings will continue to occur each year in addition to recurrent savings (hence savings escalate each year).
- It is expected that with the implementation of the networks it will on average take 3 years for the maximum (apart from escalated cost savings) value of the QIPP to be released.

See accompanying Worksheet, "IM.iii Rheumatology Datasheet", for background data on activity by diagnosis and provider.
It is anticipated that change will be made over a 12 month period. The worksheet mentioned above details activity and cost by diagnosis and provider. Potential for, and phasing, of savings will depend on local circumstances and baseline position.

ANNEX **Useful documents**				
	document	**location**		
1	ANCA Associated Vasculitis (AAV) baseline audit proforma	Data collection		
2	Iloprost baseline audit proforma	Data collection		
3	Lupus audit form	Data collection		
4	Clinical Commissioning Policy: Rituximab for the treatment of ANCA-associated vasculitis in adults	https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/a13-ritux-anca-vascul.pdf		
5	Clinical Commissioning Policy: Sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis	https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/10/a13pb-sildenafil-bosentan-oct15.pdf		
6	Clinical Commissioning Policy Statement: A13/PS/a Rituximab for the treatment of Systemic Lupus Erythematosus in adults	https://www.england.nhs.uk/wp-content/uploads/2013/10/a13-ps-a.pdf		
7	Patient eligibility checklist for Sildenafil and bosentan for the treatment of digital ulceration in systemic sclerosis	Specifications		
8	Patient eligibility check list for ANCA Vasculitis - remission induction	Specifications		
9	Patient eligibility check list for ANCA Vasculitis - maintenance therapy	Specifications		
10	Rituximab-funding in SLE: Patient eligibility checklist	Specifications		

11	NS20 Specialised Rheumatology Coordinated Networks PID	Specifications		
12	CQUIN Coordinated network for Specialised Rheumatology	Useful information CQUIN		
13	Terms of Reference for Coordinate Network for Specialised Rheumatology	Useful information TOR		
14	NS20 Data Pack	Data		