Commissioning for Quality and Innovation (CQUIN)

Specialised Scheme Guidance for 2017-2019

November 2016

CQUIN Schemes for Prescribed Specialised Services for April 2017 to March 2019

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1.0 Introduction

This document sets out the CQUIN scheme for Prescribed Specialised Services (PSS) for the two year period from April 2017 to March 2019. It should be read in conjunction with NHS England CQUIN Guidance and Specialised Commissioning Intentions

NHS England will invest almost £600m through the Specialised CQUIN scheme in the next two years. The approach reflects our commitment to secure improvements for patients reflective of the scale of this investment. CQUIN provides dedicated targeted resources for clinical teams to deliver clinical quality improvements and drive transformational change in outcomes, and equity, using resources more effectively.

Some CQUINs apply across acute or mental health services, but many are service specific, by programme of care. Most schemes originate with National Clinical Reference Groups (CRGs), shaped by clinicians with recognised leadership expertise relevant to the services. Providers volunteers have also helped fine tuned most schemes.

To ensure sufficient time to deliver change, PSS CQUIN schemes are again multi-year, with most CQUINs continuing from 2016/17. New schemes are designed for implementation over two years. New schemes have been selected using criteria to ensure that they represent a good use of available funds, are practicable, secure delivery and innovation beyond existing standards, and have due regard for equality and health inequality impacts.

Once standards are reflected in the core contractual requirements set out in the quality schedule, information schedule and/or service specifications, it is not appropriate to incentivise compliance through a CQUIN scheme. For each scheme an exit Plan is in place or in development to address any recurrent costs beyond the end of the scheme that are not offset by recurrent provider savings, to ensure change can be sustained.

The range of schemes reflects ensures that across the diverse providers of specialised care there are relevant opportunities for everyone. The scheme rules inform the number of CQUINS in the package offered to each provider which are proportionate to the overall financial value to be invested to concentrate on a smaller number of well resourced schemes

2.0 Improvement Themes

Specialised CQUINs focus upon the following six themes. This section includes a summary of each CQUIN and web links to each CQUIN contract template

- **Early Expert Involvement**: to ensure the best expert advice is brought at early at each stage of a care pathway:
  - IM3 Auto-immune Management
  - WC3 CAMHS Risk Screening and Referral
  - MH5 CAMHS Inpatient Transition

- **Networked-Care** ensuring consistency of access, good value and quality across the country
  - BI1 Hepatitis C Network Lead Providers
  - BI4 Haemoglobinopathy Networked Care
  - TR3 Spinal Surgery Networks
  - WC4 Paediatric Networked Care

- **Right Care** to support adoption of best intervention when it will be most effective
  - BI3 Automated Exchange
  - IM4 High Cost Cardiac Device Utilisation
  - MH1 High Secure Ward Communities
  - MH2 Recovery Colleges
  - MH3 Reducing Restrictive Practice

- **Patient-empowered, Personalised Care**: empowering individuals to manager their care to suit their needs and preferences:
  - GE2 Patient Activation for Long Term Conditions
  - GE5 Shared Decision-Making
  - BI2 Haemtrack: Haemophilia Home Reporting
  - CA1/IM1 Enhanced Supportive Care
  - CA3 Optimising Palliative Chemotherapy Decisions
  - IM2 Cystic Fibrosis Patient Adherence (Adult)

- **Right Setting** to ensure patients are cared for in the most clinically appropriate setting
  - GE1 Clinical Utilisation Review
  - WC5 Neonatal Community Outreach
  - MH4 Discharge and Resettlement

- **Productive & Efficient Care**: to use resources in the best way to maximise impact for patients
  - GE3 Hospital Medicines Optimisation
  - GE4 Service Redesign and Benchmarking for Locally Priced Services
  - CA2 Chemotherapy Dose Banding

Acute CQUIN: New Cross-cutting Schemes

Hospital Medicines Optimisation NEW	**Goal:** Funded pharmacist change programme to optimise use of high cost drugs: adoption of bio-similars and generics; improved drug data quality; utilising most cost-efficient dispensing cost channels; compliance with policies/guidelines, so to tackle variation & waste; **Rationale:**. The Carter Review highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8billion that could be reinvested.
Redesign & Benchmarking Locally Priced Service NEW	**Goal:** A two year programme of redesign to adopt most efficient service models. Payment would be for completing the redesign phase, and reflected in lower local prices. **Rationale:** Resistance to moving locally priced services to a national price often reflects lack of funding to redesign services such that efficient-cost prices would be sustainable. Practice benchmarking is identified in health system performance research as a key intervention to enable efficiency gain.
Shared Decision-making NEW	**Goal:** To ensure ALL relevant treatment options are discussed with patients, to enable choices aligned to patients' overall needs and values and clinical ability to benefit;. **Rationale:** Specialised Commissioning includes many services where patients' pathways become more intensive as their condition progresses. Patients often choose less intensive treatment options when shared care tools are used. Cardiac treatment is one focus area (Medical treatment/PCI/CABG)

Acute CQUIN: Continuing for existing providers

Clinical Utilisation Review	**Goal:** Systematic assessment of the appropriateness of bed utilisation, and of causes of delayed discharge or avoidable admission, and resulting effort to expedite discharge. **Rationale:** There is significant opportunity to use data to right-size alternatives to hospital and for providers to address internal delays to shorten patient-pathways, enhance recovery and free-up beds, improving patient experience. Some savings accrue to commissioners (for beddays beyond trim points).
Self Care: Patient Activation	**Goal:** Systems tailored to patient groups measuring patients' level of activation & tailoring care are implemented, improving adherence to treatment outcomes and experience. **Rationale:** Evidence demonstrates that patients with long term conditions with higher levels of activation (knowledge, skills and capacity to manage their condition) have better outcomes at lower cost. Information about activation levels can be used effectively to focus interventions more effectively.

Acute CQUIN: Trauma

Spinal Networks Data and MDT Oversight	**Goal:** To ensure that the regional spinal surgery network develops, such that patient selection for specialised surgery is carefully discussed and the optimum treatment option is chosen in all cases, **Rationale:** Surgical intervention rates vary markedly, differences in the use of resources and patient outcomes result, and delays in surgery.

Acute CQUIN: Blood and Infection

Hepatitis C Network Lead Providers	**Goal:** Continuation of networks maintaining appropriate roll-out of new HCV treatment, use of the lowest acquisition cost treatment option, addressing reinfection and establishing registry & outcome tracking. **Rationale:** New treatment for HCV promises important improvement in outcomes; to ensure affordability but yet to deliver fair access requires consistent approach across the country, which this scheme funds whilst supporting effective mitigation of major financial risk.
Haemtrack: Severe Haemophilia Home Reporting	**Goal:** To promote the use of Haemtrack, which may be used for patient education and to optimise therapy, so to achieve the most clinically-appropriate approach to Haemophilia treatment whilst maintaining or improving patient outcomes. **Rationale:** The Haemtrack system has been demonstrated to be effective in maintaining treatment compliance, optimising home therapy and home stock control & reducing high cost factor 8 usage.
Automated Exchange for SCD patients	**Goal:** To ensure all Sickle Cell Disease patients for whom it is clinically appropriate have the opportunity to have automated rather than manual exchange of blood. **Rationale:**. NICE has advised that use of automated exchange is in general much better for patients and reduces the build of iron and the need for expensive chelation therapy, yielding significant commissioner savings within two years of implementation.
Haemoglobino-pathy Networked Care	**Goal:** To ensure all providers provide high quality service to all patients, including access to automated exchange transfusion, with greater alignment of local providers to expert centres. **Rationale:**. There is evidence of patchy standard of service provision for a vital service for a condition more common in disadvantaged communities, and the scheme responds to coroners' findings to address this. The two year plan was initiated last year and is linked to a service review in 17/18.

Acute CQUIN: Cancer

Chemotherapy Dose Banding EXPANDED	**Goal:**. Nationally standardised dose banding for adult chemotherapy. Rolled out so far for 19 drugs; further rounds of drugs now to be included in succeeding years. **Rationale:** Standardised banding generates efficiency within hospital and avoids waste, but also, when implemented systematically across the NHS, jointly creates opportunity for commissioning solutions with significant savings.
Enhanced Supportive Care EXPANDED	**Goal:**. To ensure patients with advanced cancer (and late stage patients with other conditions) are, where appropriate, referred to and treated by a Supportive Care Team **Rationale:** There is evidence that good supportive care provided early can improve quality of life, lengthen survival and reduce the need for aggressive treatment near the end of life. 16/17 scheme, expanding to other clinical areas, in Internal Medicine including to cover Respiratory and HPB.
Optimising Palliative SACT Decision Making NEW	**Goal: T**o ensure systematic review of further-chemotherapy decisions for patients with poor clinical response. **Rationale:**. Where patients are failing to respond to chemotherapy, continuation of aggressive and costly treatment may not be in patients' best interests, and duration and quality of life may be improved by changes in approach.

Acute CQUIN: Internal Medicine

Cystic Fibrosis Patient Adherence (Adult)	**Goal:** To roll out of CFHealthHub to monitor through chipped nebulisers patients' adherence to their medical plan & drive patient activation. Pilot expanding to full trial (over 20 centres) supported by NIHR. **Rationale:** Poor adherence generates costly rescue therapy and poor outcomes. Recurrent saving of £45m pa within 3 years modelled, with the NIHR research underpinning the rollout.
Auto-immune rheumatic disease management	**Goal:**. Development of coordinated MDT clinics for patients with multisystem auto-immune rheumatic diseases and data collection and compliance with existing NHS England commissioning policies. **Rationale:** Evidence of variation in practice, and significant inappropriate prescription of high costs interventions – substantial potential savings (£13m pa) from gaining control.
High-cost Device Utilisation – ICDs NEW	**Goal:** Enhancement of local compliance systems and development of local policies to ensure best practice is used when determining device implant and usage. **Rationale:**. Cardiac resynchronisation therapy device selection can vary between units and can have an impact on clinical outcomes as well as having wasting resources.

Acute CQUIN: Women and Children

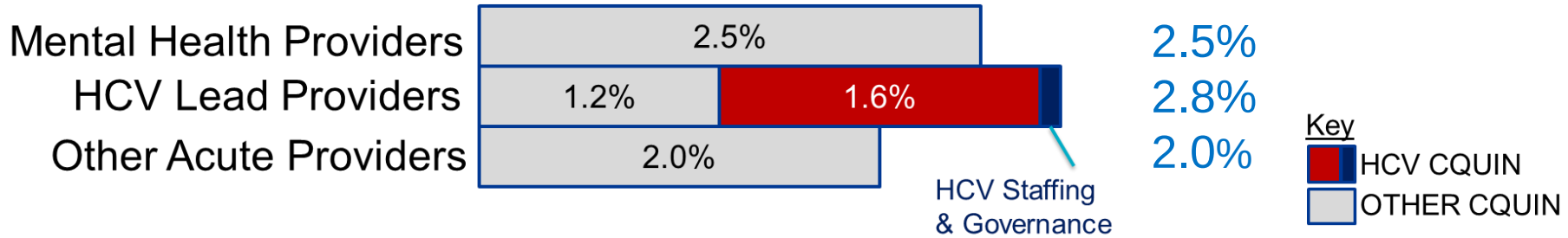
CAMHS Risk Screening & Referral EXPANDED	**Goal:** Early diagnosis and treatment of patients with mental health issues. Funding of CAMHS liaison service to meet revealed need. **Rationale:** There is evidence that a very simple questionnaire, administered by parent or nurse, can give early indication of issues, and also substantial evidence that early diagnosis and treatment can pre-empt exacerbation and costs.
Paediatric Networked Care NEW	**Goal:** To reduce variation in invasive ventilation rates, inappropriate use of paediatric critical care beds by avoiding inappropriate admission, and developing alternative models for the small numbers of children requiring tracheostomy care and long term ventilation. **Rationale:** Evidence of highly variable levels of utilisation of paediatric intensive care beds and expert advice suggests scope for many more children to be treated closer to home.
Neonatal Community Outreach NEW	**Goal:** To improve community support and to take other steps to expedite discharge, pre-empt admission, and otherwise to improve care so to reduce avoidable use of critical care beds. **Rationale:** Over one third of units were running at above the recommended safe level with on average over 80 per cent of their funded cots occupied throughout 2014/15. At the same time there is evidence that perhaps half of babies in special care units could better be cared for closer to home.

Mental Health CQUIN

High Secure Ward Communities	**Goal:** To implement and to evaluate an intervention across selected wards focused on developing a psychological Sense of Community (SoC). **Rationale:** SoC is described as a sense of belonging, that individual members matter to a community and to each other, and that individual needs can be met through a shared community commitment (McMillan & Chavis, 1986). It is expected to deliver improved wellbeing and enhanced recovery.
Recovery Colleges (Secure)	**Goal:** The establishment of co-developed and co-delivered programmes of education and training to complement other treatment approaches in adult secure services. **Rationale:** Embedding a recovery-based approach will play a central role in achieving positive patient reported outcomes and improving patient experience. This in turn leads to improved clinical outcomes, reduced lengths of stay and fewer readmissions.
Reducing Restrictive Practice (secure)	**Goal:** The development, implementation and evaluation of a framework for the reduction of restrictive practices within adult secure services, to improve patient experience whilst maintaining safe services. **Rationale:**. Adult secure services are committed to ensuring that least restrictive practice is observed at all times, in line with Department of Health policy.
Discharge & Resettlement NEW	**Goal:** To fund initiatives to remove hold-ups in discharge when patients are clinically ready to be resettled into the community. To include implementation of CUR for MH at pilot sites. **Rationale:** Discharge is often held up, partly through failure adequately to plan. This scheme will smooth introduction of improvements to the payment system to give providers resources and accountability for discharge planning.
CAMHS Transition Pathway NEW	**Goal:**. To improve transition or discharge for young people reaching adulthood to achieve continuity of care through systematic client-centred robust and timely multi-agency planning and co-ordination. **Rationale**: There is widespread poor experience of safe transition and wide variation in access and effectiveness of services with co-ordination problems leading to repeated assessments and fragmented care.

3.0 Scheme Eligibility and Value

The next two years continue the current approach to Total CQUIN payment value for different service providers:



NHS England will, as last year, provide additional funding for other established Operational Delivery Networks resourced from the total national CQUIN investment deployed directly by NHS England hubs to host providers to meet approved operating budgets.

Commissioners will offer a provider-specific CQUIN package at a sum equivalent to the above percentage of planned CQUIN-applicable contract value, as set out in National CQUIN Guidance

The CQUIN payment offered for each scheme will be based on the payment mechanism in the CQUIN contract template and is not for local negotiation, although where provider and commissioner agree that a greater scope or scale of improvement is appropriate the individual scheme value increases

In 2016/17 CQUIN payments were developed to cover typical provider costs with an additional 25% incentive income. For 2017-19 payments have been increased to 50% above typical provider costs. Whilst changes that matter for patients often require significant effort and resource one third of the scheme value is a genuine incentive for successful delivery. Provider financial plans should reflect this effect of specialised CQUIN income.

4.0 CQUINs per provider

The number of PSS national CQUINs within each provider CQUIN package offer will be based on the guidelines below, in general ensuring the average investment per scheme does not fall below £200,000 and ensuring total number of schemes is manageable even at the largest trusts, whilst offering value relative to the investment.

Acute Provider's CQUIN Contract Size*	Schemes in package	Average £ per Scheme	Acute Trusts
Over £2.5m	**10**	£370k	18
£2.0 - 2.5m	**8-9**	£260k	10
£1.5 - 2.0m	**6-7**	£270k	7
£1.0 - 1.5m	**4-5**	£270k	13
£0.6 - 1.0m	**3-4**	£240k	23
£0.2 - 0.6m	**1-2**	£225k	46
Under £0.2m	**1**	<£200k	82
			199

MH Provider's CQUIN Contract Size	Schemes in package	Average £ per Scheme	MH Trusts
Over £1.0m	**4-5**	£380k	11
£0.6 - 1.0m	**3-4**	£230k	8
£0.2 - 0.6m	**1-2**	£270k	22
Under £0.2m	**1**	<£200k	33
			79

* CQUIN relating to Hep C and ODN top slice is excluded from the above to avoid distorting average investment figures. The HCV CQUIN is offered in addition to the number of schemes in the guideline above

5.0 PSS CQUIN Package Composition

None of the National PSS CQUIN schemes will be locally amended in content, except insofar as the CQUIN scheme allows local variation (such as to vary level of aspiration and payment in tandem). In any case, the focus of local discussions will be on improvement goals rather than locally negotiation of payment levels.

Selection of schemes from amongst the national PSS schemes will reflect the following principles.

- Multi-year schemes will be offered for all of the applicable years.
- Schemes will be selected by supplier managers to follow through on previous multi-year commitments such as for patient activation and clinical utilisation review at providers who have already begun to pilot or implement in 2016/17.
- A starting point for schemes identified as ‘universal adoption’ schemes should be selection by those providers needed to achieve national coverage, and to scale the CQUIN to achieve the intervention as a standard intervention for all eligible patients.
- Early Adopter schemes are those appropriate for innovations that may need adaptation for use in different contexts, and are aimed at providers willing and able to participate. Such schemes can be flexibly scaled up for greater local ambition beyond a minimum level. Clearly, the scale of proposed adoption must be explicit in the CQUIN package offered and in the contract agreement to ensure there is up front clarity about payment.
- Flexing these particular schemes will allow packages to be designed that scale up to the CQUIN value. Commissioners will look to maximise schemes that give the strongest returns.

For providers with substantial CQUIN values over £1m, where CQUIN funds remain uncommitted **after** scaling up **all** relevant schemes, NHSE England commissioners have local discretion to make available funding for locally developed and reported outcome based schemes that deliver commissioner efficiencies for specialised care, support STP plans, complement CCG CQUIN schemes, or otherwise yield returns equal to or greater than the value of the funds invested.

6.0 Finalising the contracted CQUIN package

In line with the CQUIN rules and guidance, the steps to finalise CQUIN packages in contracts are:

- NHS England commissioners will develop and offer a CQUIN package proposal selecting relevant schemes, and reflecting the number of CQUINs appropriate to the contract value
- Local discussion between provider and commissioner will consider the relative improvement ambition in each scheme which may lead to some changes in the value of individual schemes. The goals set will be added into the parts of the CQUIN template that are for local completion which are shaded yellow in the templates.
- Commissioners and providers will take a constructive approach to working through any practical issues to ensure CQUIN goals set are stretching but achievable. The resulting CQUIN package will be a key element of the overall contract offer to the provider.
- If a provider is not willing to accept the CQUIN package offered, they are not compelled to do so, but they do not have a right to substitute schemes within the package or to require changes in the CQUIN payment or start date for a given scheme. The provider would forfeit the earnings opportunity from the CQUIN package if it is not incorporated into contract, and/or forfeit scheme specific earnings within the package for any scheme in which the provider does not participate.
- Commissioners will value feedback from providers on the composition of the CQUIN package, including on the level and scope of ambition in individual schemes. This recognises that in the end in line with guidance it is for the commissioner to determine, within the framework of this guide and the National CQUIN guidance, the priorities and focus for each scheme. A fully invested CQUIN scheme successfully delivering improvements is the best outcome for patients.