NHS

# Commissioning for Quality and Innovation (CQUIN)

## Guidance for 2019-2020

Publishing Approval Reference Number **000050**

NHS England and NHS Improvement – Working together for the NHS

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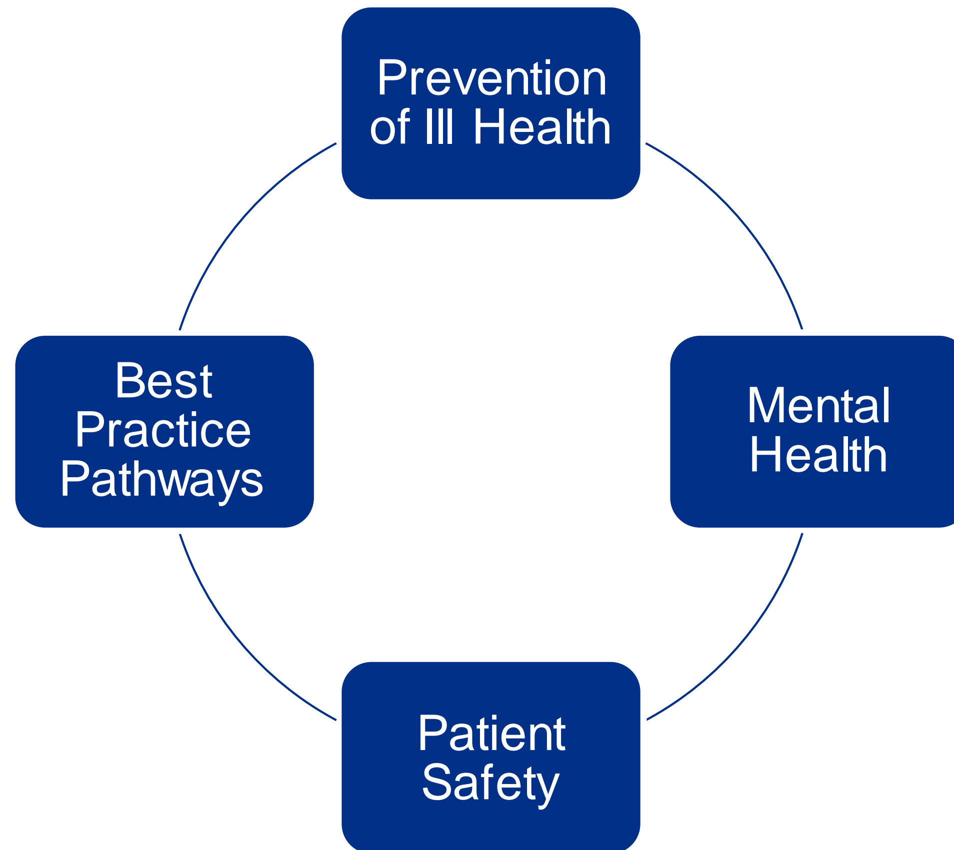
# 1.0 Introduction

- This document provides the guidance for the Commissioning for Quality and Innovation (CQUIN) scheme for 2019/20. It sets out details of both the CCG and Prescribed Specialised Services (PSS) schemes.
- From 1 April 2019, both the CCG and PSS schemes are being reduced in value to 1.25% with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities. A maximum of **5 indicators** will be prescribed nationally for each contract.
- We have recognised that in past schemes CQUIN has attracted criticism for requiring significant cost to implement due to the inclusion of new or complex goals, setting outcome based targets which impose unfairly distributed burden on providers, or require action which is outside the control of a single organisation.
- In response to this, we are taking a radically different approach to CQUIN in 2019/20. Instead of setting new goals CQUIN will simply highlight evidence based good practice that is already being rolled out across the country, drawing attention through the scheme to the benefits for patients and providers, and in doing so allow those benefits to be spread more rapidly. Those measures from the 2018/19 scheme that have been widely recognised as bureaucratic or burdensome have been removed.
- CQUIN is being given fresh clinical momentum, whilst prioritising simplicity and deliverability. Proposals were tested to ensure chosen indicators focus on proven, standard operational delivery methods; support implementation of relatively simple interventions; form part of wider national delivery goals that already exist, thereby not adding new cost pressures; are explicitly supported by wider national implementation programmes; and command stakeholder support. Broad clinical consensus exists over each included method, following wide engagement with national programmes to select from existing interventions in support of the Long Term Plan.
- Alongside this new approach to the selection of areas for CQUIN, the payment rules for indicators within the CCG scheme have been simplified, allowing greater transparency over performance and earnings, based on achievement between lower and upper adoption goals for each supported intervention. The specifications which accompany this main guidance set out the full details.
- 2019/20 is the first year of this new approach, and we intend to refine and improve the process from 2020. To ensure wide engagement, we will establish a national CQUIN Advisory Group to oversee the development of a future pipeline of indicators which will be attractive to providers and deliver clear benefits to patients. This group will bring together clinical leadership alongside commissioner and provider stakeholders.

# 2.0 Overview of quality and safety indicators

# 2.0 Overview of quality and safety indicators

Both the 2019/20 CCG and PSS CQUIN schemes comprise indicators, aligned to 4 key areas, in support of the Long Term Plan. Specific indicator breakdowns are provided in the following slides.



# 2.0 Overview of quality and safety indicators

## 2.1 CCG Scheme

The CCG CQUIN scheme highlights the below repeatable methods and interventions selected from current delivery goals, aligned under four priority areas. All have been reviewed to ensure they are in line with current routine clinical practice, simple and straightforward to implement, with national programme teams providing practical tools, training and support to implement where required.

11 elements of good practice have been highlighted across all provider types – acute, mental health, community, ambulance etc. - with a maximum of **5 supported methods** applicable to any one provider.

| Prevention of Ill Health | Mental Health | Patient Safety | Best Practice Pathways |
|---|---|---|---|
| • Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery<br>• Staff Flu Vaccinations<br>• Alcohol and Tobacco – Screening & Brief Advice | • Improved Discharge Follow Up<br>• Improved Data Quality and Reporting – Data Quality Maturity Index & Interventions<br>• IAPT – Use of Anxiety Disorder Specific Measures | • Three High Impact Actions to Prevent Hospital Falls<br>• Community Inserted PICC Lines Secured Using a SecurAcath Device | • Stroke 6 Month Reviews<br>• Ambulance Patient Data at Scene – Assurance & Demonstration<br>• Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia |

Detailed specifications can be found here.

# 2.0 There will be a maximum of five CCG indicators for each contract

## 2.1 CCG Scheme

The following table shows how the supported methods and interventions are relevant to different provider types. More information on each is contained in section 3.0.

National indicators must be used where relevant, however where insufficient national indicators are available, CCGs should offer local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract). The total value of indicators should be equal to 1.25%.

| Acute | Community | Mental Health | Ambulance |
|---|---|---|---|
| Staff Flu Vaccinations | Staff Flu Vaccinations | Staff Flu Vaccinations | Staff Flu Vaccinations (0.25%) |
| Alcohol and Tobacco Brief Advice | Alcohol and Tobacco Brief Advice | Alcohol and Tobacco Brief Advice | Access to Patient Information – Assurance Process (0.5%) |
| Three High Impact Actions to Prevent Hospital Falls | Three High Impact Actions to Prevent Hospital Falls | 72hr Follow Up Post Discharge | Access to Patient Information – Demonstration (0.25%) |
| Antimicrobial Resistance – Urinary Tract Infections and Antibiotic Prophylaxis for Elective Colorectal Surgery | PICC Lines Secured Using a SecurAcath Device | Improved Data Quality and Reporting | + Locally Determined Indicator (0.25%) |
| Same Day Emergency Care – Pulmonary Embolus/ Tachycardia with Atrial Fibrillation/ Pneumonia | Stroke 6 Month Reviews | Use of Anxiety Disorder Specific Measures in IAPT | |

# 2.0 Overview of quality and safety indicators

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## 2.2 PSS Scheme

PSS areas included within CQUIN have been simplified in line with the approach taken to the CCG scheme. The design of the scheme has been streamlined since September, with significantly fewer national indicators than currently. The larger indicators (those upon which the bulk of the PSS CQUIN funding will be earned), are extensions of 2017/19 indicators, and seek to build upon success. All indicators support clear well proven steps to ensure benefits are fully realised.

| Prevention of Ill Health | Mental Health | Patient Safety | Best Practice Pathways |
|---|---|---|---|
| • Medicines Optimisation and Stewardship<br>• Towards Hep C Elimination<br>• Cystic Fibrosis Supporting Self Management | • Healthy Weight in Adult Secure MH Services<br>• Addressing CAMHS T4 Staff Training Needs<br>• D/deaf MH Communication Assessment | • Clinical Utilisation Review: Avoiding Inappropriate Hospital Stays<br>• Severe Asthma Specialised Care Review<br>• Immunoglobulin Stewardship<br>• Spinal Surgery | • Promoting Transplantation<br>• Enabling Thrombectomy<br>• Rethinking Conversations: Personalising Care for Long Term Condition Patients<br>• Cirrhosis Care Bundle<br>• Paediatric Movement Therapies |

Detailed specifications can be found here

NHS

# 3.0 CCG Scheme

## Highlighted good practice selected for inclusion

# 3.1 Prevention of Ill Health

| Highlighted action/ method | Benefit delivered | Support and information |
|---|---|---|
| **CCG1: Adherence to national antibiotic guidance in treatment of Lower Urinary Tract Infections in older people and antibiotic prophylaxis in elective colorectal surgery**<br>**Applicability:** to all Acute Hospitals providing UTI treatment and elective colorectal surgery.<br>**CQUIN goal**: 60%-90%<br>**Supporting ref:** NICE guidance NG109 NICE guidance CG74 PHE UTI Guidance | • In support of a major Long Term Plan priority of antimicrobial resistance and stewardship, four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI.<br>• Implementing NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines.<br>• Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay. | • Explicit support provided by NHS I AMR Project Lead via Webinars, regional network support as well as an online support page complete with useful guidance and toolkits.<br>• The NHS I Resources page will be updated with CQUIN specific content from March 2019.<br>• Contact Elizabeth Beech at: Elizabeth.beech@nhs.net |
| **CCG2: Achieving an 80% uptake of flu vaccinations by frontline clinical staff**<br>**Applicability:** to all NHS providers with frontline staff.<br>**CQUIN goal**: 60-80%<br>**Supporting ref:** NICE guidance NG103 | • Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services. | • Delivery supported by NHS I lead, with ImmForm Guidance and a seasonal campaign to drive awareness. Green Book also contains published guidance.<br>• Contact Doug Gilbert at: Douglas.gilbert1@nhs.net |
| **CCG3: Screening and brief advice for tobacco and alcohol use in inpatient settings**<br>**Applicability:** All Acute, Community and MH providers<br>**CQUIN goal:** Screening 40-80% Brief Advice 50-90%<br>**Supporting ref:** NICE guidance PH24, PH45 and PH48 | • Screening and brief advice is expected to result in 170k tobacco users and 60k at risk alcohol users receiving brief advice, a key component of their path to cessation.<br>• A reduced version of 2018/19 CQUIN indicator, this is already being delivered strongly across the country, and is part of an ongoing programme to deliver the Long Term Plan. | • E-Learning programme available for training needs along with additional published Guidance and information.<br>• Contact Don Lavoie at: Don.Lavoie@phe.gov.uk |

# 3.2 Mental Health

NHS

| Highlighted action / method | Benefit delivered | Support and information |
|---|---|---|
| **CCG4: Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge**<br>**Applicability:** All Mental Health trusts<br>**CQUIN goal**: 50 – 80% (Q3-4 only)<br>**Supporting ref:** At present, NICE Guidance NG53 references the national standard of a 7 day follow up, however recent findings from The National Confidential Inquiry into Suicide and Safety in Mental Health evidences the need for a 3 day follow up | • 72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge.<br>• By completing follow up in 3 days providers support the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge.<br>• This activity will increase focus on improving the overall quality of support post discharge. | • Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.<br>• Contact Belinda Yeldon at: England.MHCQUIN@nhs.net. |
| **CCG5: Improving the quality and breadth of data submitted to the Mental Health Services Dataset**<br>**Applicability:** All Mental Health trusts<br>**CQUIN goal:** DQMI 90 – 95% (Q2-4 only) Interventions 15 – 70% (Q3-4 only)<br>**Supporting ref:** Information Standards Notice MHSDS DQMI | • Accurate data is a key enabler for improvement in MH services and is underpinned by the Long Term Plan. Improving mental health data quality and ensuring providers record interventions consistently using SNOMED CT will enable:<br>  • The system to use data in a more efficient and reliable way, ensuring that patients receive appropriate treatment.<br>  • Patients and clinicians to make informed decisions about treatment options.<br>  • The retirement of costly and burdensome duplicate data collections and local flows. | • Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.<br>• DQMI specific information also available along with a document outlining Changes to the DQMI.<br>• Contact Belinda Yeldon at: England.MHCQUIN@nhs.net |
| **CCG6: Achieving 65% of referrals finishing a course of treatment which had paired scores recorded in the specified Anxiety Disorder Specific Measure**<br>**Applicability:** All MH providers with IAPT services<br>**CQUIN goal:** 30 – 65% (Q2-4 only)<br>**Supporting ref:** IAPT manual | • As detailed in the IAPT Manual, the use of specific anxiety disorder measures will:<br>  • Reduce inappropriate early discharge.<br>  • Safeguard patients against serious clinical problems being missed.<br>  • Give clinicians access to critical information to guide the patient's therapy.<br>  • Ensure that patients are benefiting from the most appropriate therapy.<br>  • Allow clinicians to focus on relieving the symptoms that most distress the patient. | • Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.<br>• MH curriculum also already updated.<br>• Contact Belinda Yeldon at: England.MHCQUIN@nhs.net |

# 3.3 Patient Safety

| Highlighted action / method | Benefit delivered | Support and information |
|---|---|---|
| **CCG7: Achieving 80% of older inpatients receiving key falls prevention actions**<br><br>**Applicability:** all Acute Trusts and Community Hospitals<br>**CQUIN goal:** 25 – 80%<br>**Supporting ref:** NICE Clinical Guidance CG161 and NICE Quality Standard QS86 | • Taking these three key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs.<br>1. Lying and standing blood pressure to be recorded<br>2. No hypnotics or anxiolytics to be given during stay OR rationale documented<br>3. Mobility assessment and walking aid to be provided if required.<br>• For a typical medium sized acute provider this would equate to around 250 fewer falls, including four fewer hip fractures and brain injuries. | • Provided by NHS I Patient Safety Team via e-learning and various online quality improvement resources all available via the link below.<br>• NHS Improvement falls prevention resources<br>• Contact Julie Windsor at: patientsafety.enquiries@nhs.net |
| **CCG8: Achieving 85% of peripherally inserted central catheters (PICC) lines secured using a SecurAcath device**<br><br>**Applicability:** all Community providers<br>**CQUIN goal**: 70 – 85%<br>**Supporting ref:** NICE Medtech Guidance MTG34 | • Used as a replacement for adhesive securement devices. Unlike adhesive securement devices, SecurAcath does not need changing and this has significant cost and patient benefits (lowering the chance of complications caused by movement to the catheter when it is unsecured). | • Support will come from the Innovation, Research and Life Sciences Team as well as the AHSNs<br>• NICE guidance on SecurAcath for securing percutaneous catheters<br>• Contact Stephanie Heath at: england.innovation@nhs.net |

# 3.4 Best Practice Pathways

| Highlighted action / method | Benefit delivered | Support and information |
| --- | --- | --- |
| **CCG9: SSNAP six-month review for all discharged stroke patients**<br><br>**Applicability:** to all community service providers of stroke rehabilitation<br>**CQUIN goal:** 35 – 55%<br>**Supporting ref:** NICE Clinical Guidance CG162 | • Improved stroke rehabilitation is a key pillar of the stroke improvement landscape and a commitment in the Long Term Plan. The 6 month assessments have been highlighted as the most fundamental part of that work and the strongest ask from stroke survivors.<br>• The 6 month reviews also provide an opportunity for enhanced personalisation of care through identification of further support needs e.g. through social prescribing. | • The NHSE Stroke team are available for implementation support and online resources and the GIRFT clinical leads will also be prioritising Rehabilitation throughout 2019/20.<br>• SSNAP Guidance<br>• Contact the mailbox at: england.clinicalpolicy@nhs.net |
| **CCG10: Ensure access to patient data at scene, in line with nationally prescribed approaches**<br><br>**Applicability:** to all ambulance providers<br>**CQUIN goal:** 100% passed assurance and 5% records accessed at scene<br>**Supporting ref:** UEC Assurance Statement | • Digital maturity is one of the major short term goals in the Ambulance Digital Strategy and a priority in the Long Term Plan, borne out of the recommendations in the Lord Carter Report. This will support clinical decision making and in turn will lead to improved outcomes for patients and a safe reduction in avoidable ambulance conveyance.<br>• Support from NHS England and NHS Digital already committed to ensuring remaining providers can deliver during 2019/20. | • Guidance available on the Urgent and Emergency care Future NHS Platform with additional support from NHS Digital.<br>• Additional guidance on Ambulance Quality Indicators.<br>• Contact Claire Joss at: england.ambulance@nhs.net |
| **CCG11: Eligible patients to be managed in a same day setting for Pulmonary Embolus / Tachycardia / Community Acquired Pneumonia patients**<br><br>**Applicability:** Acute providers with Type 1 ED<br>**CQUIN goal:** 50 – 75%<br>**Supporting ref:** NICE Guidance CG144, CG191 & CG180 | • These three conditions are all from the top 10 conditions with which patients present in a SDEC setting. Each have been selected due to focus on a limited set of clear actions to be taken by providers. Improved same day treatment will reduce pressure on hospital beds, improving length of stay and patient experience.<br>• The rollout of Same Day Emergency Care is one of the commitments from the Long Term Plan. | • Available via the Ambulatory Emergency Care Network as well as via NHS Improvement.<br>• Ambulatory Emergency Care Directory (6th Edition).<br>• BTS Guidance for the outpatient management of PE.<br>• Contact Rachel Vokes at: nhsi.sdeccquinsupport@nhs.net |

# 4.0 Specialised Services Scheme

## Highlighted good practice selected for inclusion

# 4.1 Prevention of Ill Health

| Highlighted action / method | Benefit delivered | Support and information |
| --- | --- | --- |
| **PSS1: Medicines Optimisation and Stewardship**<br>**Applicability:** to all Acute providers with High Cost Drugs payments > £0.5m, especially those with >£5m.<br>**Principal CQUIN goals**: 75%-95% existing patients on best value medicines; adoption of antifungal audits.<br>**Supporting ref:** Carter Review | • The medicines optimisation programme that this indicator supports is delivering cost savings of hundreds of millions.<br>• Using these techniques also to address over-use of antifungals will enable the NHS to play its part in stemming the worldwide build-up of resistance to antifungals (a WHO priority). This will protect neutropenic patients and others at risk of invasive fungal infections. | • Available from the specialised commissioning national team (with a named lead) together with a network of regional pharmacy leads.<br>• Support Contacts: Suzy.heafield@nhs.net and Malcolm.qualie@nhs.net |
| **PSS2: Towards Hep C Elimination**<br>**Applicability:** to 23 HCV Operational Delivery Network hosts.<br>**CQUIN goal**: 11,200 treated patients nationally.<br>**Supporting ref:** NICE guidance PH43, NICE Guidance re. Direct Acting Antivirals | • Improving treatment of diagnosed patients, and increasing rates of testing and diagnosis, followed by treatment with the new NICE-approved treatments.<br>• Each patient treated reduces others' risk of infection.<br>• This indicator is designed to contribute to the UK target of elimination of HCV by 2025. | • National support available from HCV Programme Manager, HCV National Clinical Lead, Pharmacy, Finance.<br>• Support Contacts: helen.bennett18@nhs.net and g.r.foster@qmul.ac.uk<br>• Contact mailbox at: england.hepc-enquiries@nhs.net |
| **PSS3: Cystic Fibrosis Supporting Self Management**<br>**Applicability:** to all participating Adult Cystic Fibrosis Centres in England.<br>**CQUIN goal**: to recruit 50% to 75% of patients with chronic pseudomonas to the self-management programme.<br>**Supporting ref:** Tappenden et al, PharmacoEconomics 2017; 35:647–659 | • Supports changes in clinician and patient behaviour that will transform Cystic Fibrosis care from a clinician led reactive hospital based rescue service to patient led community based prevention.<br>• Self-management approach, supported as it is by electronic tracking, also minimises waste by enabling just in time drug delivery guided by actual adherence data. | • Implementation team based in Sheffield are available to ensure that providers and commissioners are fully supported with the implementation and benefits realisation.<br>• Support Contact: martin.wildman@sth.nhs.uk |

# 4.2 Mental Health

| Highlighted action / method | Benefit delivered | Support and information |
|---|---|---|
| **PSS4: Healthy Weight in Adult Secure MH Services**<br>**Applicability:** to all providers of Adult Secure Mental Health Services<br>**CQUIN goals**: healthy service environment, healthy lifestyle choices for their patients, assessed through monitoring of activity, obesity and wellbeing.<br>**Supporting ref:** NICE Guidance CG189, NICE Guidance PH53, NICE Quality Standard QS111 | • Substantial consequential cost savings for the health and social care system by tackling obesity rates among service users.<br>• Contributing to earlier recovery. | • A national task and finish group has been established. Reference material and guidance is provided.<br>• Support Contact: Louise.Davies10@nhs.net<br>• rajesh.moholkar@nhs.net<br>• Mehdi.Veisi@beh-mht.nhs.uk<br>• joanna.brook-tanker@dhuft.nhs.uk |
| **PSS5: Addressing CAMHS T4 Staff Trainings Needs**<br>**Applicability:** to all provides of CAMHS inpatient services<br>**CQUIN goal**: all care staff to have capability to deliver psychologically informed care.<br>**Supporting ref:** embedded in indicator specification. | • Reduction in unwarranted variation in access, delivery of effective treatment modalities, and patient outcomes in Tier 4 service settings (inpatient and community).<br>• Ensuring clinically appropriate lengths of stay. | • Support to be available via the HEE local provider collaboratives, which are already established nationally.<br>• Support Contact: LouiseDoughty@nhs.net<br>• Tim.Atkin@lancashirecare.nhs.uk |
| **PSS6: D/deaf MH Communication Assessment**<br>**Applicability:** to providers of specialised MH services for the D/deaf<br>**CQUIN goal**: Communication Profiles completed for >25% of existing patients by end of Q4, and for all new admissions in previous quarter.<br>**Supporting ref:** embedded in indicator specification. | • Enabling better assessment of communication needs of D/deaf people, expediting access to effective treatment. | • Reference material and guidance is provided.<br>• Providers will be supported by the Deaf Advisory Group, a subgroup of the Specialised MH CRG.<br>• Support Contact: Victoria.Man@nhs.net<br>• alexanderhamilton@nhs.net |

# 4.3 Patient Safety

| Highlighted action / method | Benefit delivered | Support and information |
|---|---|---|
| **PSS7: Clinical Utilisation Review: Avoiding Inappropriate Hospital Stays**<br>**Applicability:** to all Acute providers currently implementing the CUR project, and any (including MH providers) wishing now to join the project.<br>**CQUIN goal**: reduction of 250k inappropriate bed-days nationally.<br>**Supporting ref:** from CUR programme support. | • CUR provides information to providers enabling them to identify reasons for inappropriate bed use, and to take action.<br>• This activity is in direct support of the Long Term Plan goals to “improve performance at getting people home without unnecessary delay..,reducing risk of harm to patients from physical and cognitive deconditioning complications” | • National CUR Programme Team which supports Quarterly CUR Learning Networks<br>• Commissioning CUR Learning Networks, a CUR extranet<br>• Support Contact: h.heywood@nhs.net |
| **PSS8: Severe Asthma – Specialised Care Review**<br>**Applicability:** to severe asthma specialist centres.<br>**CQUIN goal**: 80% - 100% new patients started on a biologic are discussed by an MDT<br>**Supporting ref:** NICE Guidance TA278 | • Patient outcomes will be improved as significant variation in prescribing and management of severe asthma is addressed, in line with Long Term Plan 1.34.<br>• Through Multi-Disciplinary Team (MDT) oversight of high cost biologics use, one third of current spend could be avoided. | • Project Manager for the related Improving Value scheme<br>• National Respiratory Clinical Reference Group<br>• Support Contacts: alannah.thornton1@nhs.net and Kathy.blacker@nhs.net |
| **PSS9: Immunoglobulin Stewardship**<br>**Applicability:** to all selected Immunoglobulin Assessment Panel hosts.<br>**CQUIN goal**: 80%-100% of new patients, 65% existing patients reviewed by Panel<br>**Supporting ref:** Immunoglobulin Use Clinical Guidelines | • Manage immunoglobulin use, ensuring appropriateness of use, dose, frequency and outcome monitoring.<br>• Protect supply issues with immunoglobulin. | • Immunoglobulin Project group and regional implementation and pharmacy leads.<br>• Support Contact: Robcoster@nhs.net and england.immunoglobulin@nhs.net |
| **PSS10: Spinal Surgery**<br>**Applicability:** to all specialist spinal centres.<br>**CQUIN goal**: MDT oversight of all specialised surgery.<br>**Supporting ref:** NICE Guidance: spinal & back conditions | • Reduce inappropriate surgery.<br>• Reduce substantial variation in practice across England.<br>• Cut waiting lists and save litigation costs. | • Available from the CRG Chair and Lead Commissioner<br>• Support Contacts: jacquiekemp@nhs.net and David.Stockdale1@nhs.net |

# 4.4 Best Practice Pathways

| Highlighted action / method | Benefit delivered | Support and information |
|---|---|---|
| **PSS11: Promoting Transplantation**<br>**Applicability:** to all transplantation centres.<br>**CQUIN goal**: significantly reduced live donor work-up times and organ decline rates<br>**Supporting ref:** https://www.nhsbt.nhs.uk/tot2020/ | • Improving donation and utilisation rates results and increased survival rates for recipients. Should also reduce demand for renal dialysis and for high cost interim devices.<br>• Meeting National targets for Kidney, Liver, Heart and Lung transplantation (Taking Organ Donation to 2020). | • The NHS BT Clinical Leads and Living Kidney Donor Strategy Implementation Group (SIG).<br>• Support Contacts: sarah.watson23@nhs.net and jon.gulliver@nhs.net |
| **PSS12: Enabling Thrombectomy**<br>**Applicability:** to up to ten thrombectomy providers with capacity to provide training.<br>**CQUIN goal**: nationally, 20 additional interventionists<br>**Supporting ref:** NHS E Mech. Thrombectomy policy. | • "Expanding mechanical thrombectomy – from 1% to 10% of stroke patients – will allow 1,600 more people to be independent after their stroke each year." Long Term Plan 3.75 | • The NHS E thrombectomy programme team.<br>• Support Contacts: freddie.drew@nhs.net and jacquiekemp@nhs.net |
| **PSS13: Rethinking Conversations: Personalising Care for Long Term Condition Patients**<br>**Applicability:** to (1) providers making progress with '17/19 CQUINs GE2 PAM, GE5 SDM, CA1 ESC; (2) others with patient groups likely to benefit.<br>**CQUIN goal**: increased % of patients receiving timely supported conversations and support for goal achievement<br>**Supporting ref:** NHS E: Universal Personalised Care | • "We will support and help train staff to have the conversations which help patients make the decisions that are right for them." Long Term Plan 1.37.<br>• Supports consideration and access to alternative treatment options, including patient-activation and enhanced supportive care options. | • Available from NHSE Personalised Care Team<br>• Support Contacts: donald.franklin@nhs.net alf.collins@nhs.net jonathan.berry2@nhs.net, |
| **PSS14: Cirrhosis Care Bundle**<br>**Applicability:** to HPB specialist providers in a position to network non-specialist partners.<br>**CQUIN goal**: completion of cirrhosis bundle in >50% of patients with decompensated cirrhosis<br>**Supporting ref:** Cirrhosis Care Bundle | • This bundle should reduce mortality (given a 25% higher rate of in-hospital deaths for similar cohort of patients who are treated in non-specialised centres). Also will reduce variation in care and treatment in non-specialised hospitals.<br>• The care bundle has been shown to reduce length of stay by 3-5 days. | • Available from the CRG, with National mailbox<br>• Support Contact: g.r.foster@qmul.ac.uk |
| **PSS15: Paediatric Movement Therapies**<br>**Applicability:** to all 17 named centres, who are coordinating care across regions.<br>**CQUIN goal**: MDT assessment for 80% new patients within 18 weeks of referral, with CPIP assessment; regular assessments with follow up interventions<br>**Supporting ref:** NICE Guidance CG145 & NG 62 | • To replace ineffective traditional forms of practice; to match efforts to improve interventions in Scotland and in Sweden that have seen significant falls in hip displacement requiring costly surgery.<br>• Anticipated cost saving from reduced surgery of £6 million pa across England.<br>• Patient benefit (and system cost-savings) from prevented deformity and pain. | • Paediatric Neurosciences CRG chair, and from Lead Commissioner<br>• Support Contact: charlie.fairhurst@gstt.nhs.uk |

# 5.0 Scheme eligibility and value

# 5.0 Scheme Eligibility and Value

## 5.1 Eligibility

Any provider of healthcare services commissioned under an NHS Standard Contract (full-length or shorter-form version) is eligible for CQUIN. This is inclusive of the independent sector e.g. care homes and the third sector.

## 5.2 CCG CQUIN scheme values

Depending on provider performance, for CCG contracts, the CQUIN scheme is worth a maximum of 1.25%, payable in addition to the Actual Annual Value (AAV). There continues to be a differential approach to the percentage allocated to CQUIN for specialised services; see section 5.3, pg. 21. The AAV (for both CCG and PSS schemes) is the aggregate of all payments made to the provider for services delivered under the specific contract during the contract year, not including CQUIN and other incentive payments, and after any deductions or withholdings), subject to certain exclusions (see section 6.1 Rules).

The 1.25% payable for the CCG CQUIN scheme, depending on performance is to be split as follows:

- Each national indicator has a minimum weighting of 0.25%, with the exception of providers (typically smaller, non-NHS) to whom some of the national indicators don't readily apply. In those cases, CCGs should offer additional local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract). There should be **no more than five indicators** in total for each contract.

- For providers whose range of services would make them eligible for more than five indicators e.g. those who carry out both acute and community services, the five acute specific indicators should be prioritised, each attracting 0.25%.

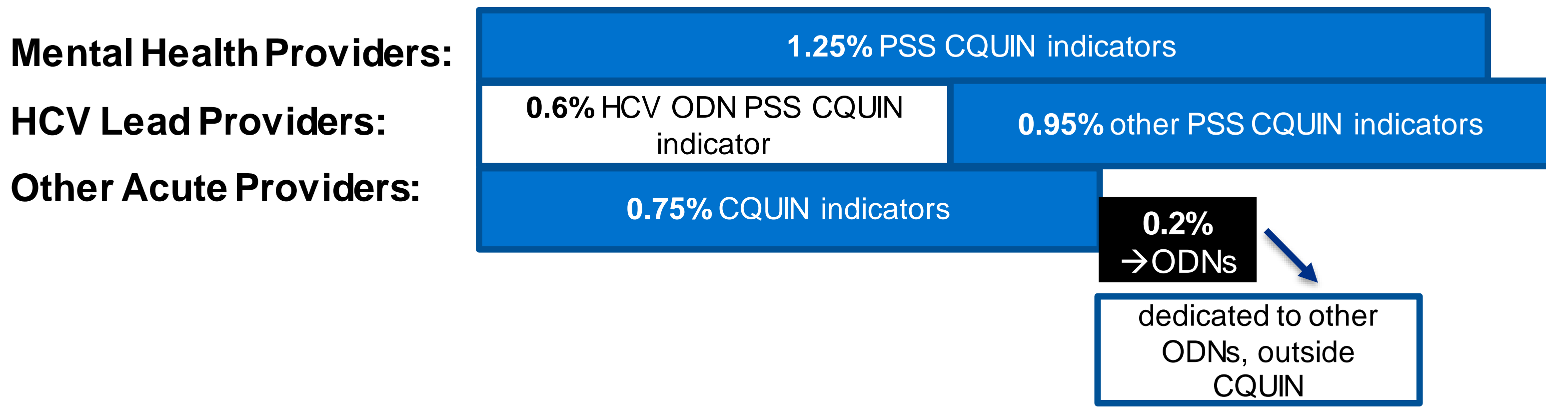
- For providers whose range of services would make them eligible for more than five indicators but the acute indicators do not apply e.g. community and mental health services, by mutual agreement the commissioner and provider will be expected to agree the five national indicators most relevant to their service. These should be equally weighted at 0.25%.

As confirmed in the NHS Operational and Contracting guidance 2019/20, where the total value of CQUIN has not been earned, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

# 5.0 Scheme Eligibility and Value

## 5.3 PSS CQUIN Scheme Values

For the PSS scheme, as in previous years, a portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of Hepatitis C, ODN leads for Hepatitis C will, alongside mental health providers, continue to be eligible for a higher PSS CQUIN allocation when compared to other acute providers of specialised services. Consequently, for HEP C ODN leads, the PSS CQUIN scheme is worth a maximum of 1.55% payable in addition to the Actual Annual Value (AAV). For MH providers the PSS CQUIN scheme is worth a maximum of 1.25%, and for other Acute providers it will be worth a maximum of 0.75%.




Commissioners will offer a provider-specific PSS CQUIN package at a sum equivalent to the above percentage of planned CQUIN-applicable contract value. 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 or lesser scope or scale of improvement is appropriate, the individual scheme value adjusts.

Commissioners will include **up to five national indicators** within PSS CQUIN packages where applicable, and where CQUIN funding within the PSS contract for that provider allows. Where there is a shortfall of applicable national PSS CQUIN indicators, NHS England commissioners may construct local CQUIN indicators as part of the package of five. Additional indicators may be included only by mutual agreement.

NHS

# 6.0 Rules and guidance

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.1 Rules

This guidance applies to commissioners and providers using the NHS Standard Contract in 2019-2020. The CCG indicators are not mandatory for inclusion in CQUIN schemes in contracts where NHS England is the sole commissioner. Our intention is to make challenging but realistic CQUIN schemes available for providers; we expect that a high proportion of commissioner CQUIN funding will be earned. The following established rules (1-11) should govern the approach to establishing the CQUIN scheme locally:

| Rule | Detail |
|---|---|
| 1 | A scheme must be offered to each provider which provides healthcare services under the NHS Standard Contract (but see notes on non-contract activity (section 6.8, pg. 27) and low-value contracts (section 6.6, pg. 27). |
| 2 | There should be one scheme per contract, offered by the co-ordinating commissioner to the provider. (See note on arrangements for agreeing schemes among the commissioners who are party to a contract (section 6.2, pg. 25). |
| 3 | The commissioner may offer a combined scheme to a number of related providers or may seek to align the content of separate schemes across different providers. |
| 4 | The maximum value of the scheme – the maximum amount which a provider can earn under it – will be the percentage specified in sections 5.2, pg. 20 and 5.3, pg. 21 of the Actual Annual Value of the contract as defined in the NHS Standard Contract 2019/20, subject to certain exclusions, see rule 5. |
| 5 | The exclusions, on the value of which CQUIN is not payable, are:<br>a) (For the avoidance of doubt) any payments made to providers from the 2019/20 Provider and Sustainability Fund;<br>b) High cost drugs, devices and listed procedures (available at: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/) and all other items for which the commissioner makes payment on a "pass-through" basis to the provider (that is, where the commissioner simply meets the actual cost to the provider of a specific drug or product, for example); and<br>c) The value of all services delivered by the provider under the relevant contract to Chargeable Overseas Visitors (as defined in the NHS Standard Contract), regardless of any contribution on account paid by any commissioner in respect of those services. However, services delivered to any Chargeable Overseas Visitor is still contract activity under that contract, and so must be included in calculations in relation to national or local CQUIN indicators. |

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.1 Rules continued…

| Rule | Detail |
|---|---|
| 6 | Funding paid to providers under the scheme is non-recurrent. |
| 7 | Discussion between the commissioner and provider (or groups of providers) on the content of each scheme is encouraged, but in the end it is for the commissioner to determine, within the framework of this guidance, the priorities and focus for each scheme. |
| 8 | The scheme offered to each provider must be in accordance with this guidance and must give the provider a realistic expectation of earning a high proportion of the percentage available. Further detail on the process for proposal and agreement of schemes is set out in section 6.2, pg.25 – 6.10, pg.28. |
| 9 | Each scheme must be recorded in the Schedule 4D of the local contract (which will be in the form of the NHS Standard Contract). Contracts must set out clearly the proportion of payment associated with each scheme indicator and the basis upon which payment will be made. |
| 10 | Payment to the provider must be based on the provider's achievement of the agreed objectives within the scheme, in line with the detailed arrangements set out in this guidance and in the NHS Standard Contract. |
| 11 | Any disputes about schemes which have been agreed and recorded within contracts should be resolved in accordance with the dispute resolution mechanism set out in the NHS Standard Contract. |

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.2 Agreement between commissioners

Where multiple commissioners are proposing to be party to the same contract with a provider, they must identify one of them to act as co-ordinating commissioner and put in place a Collaborative Commissioning Agreement (http://www.england.nhs.uk/nhs-standard-contract/). This Agreement can be used to describe the governance arrangements; how the co-ordinating commissioner will consult and engage with other commissioners to determine the proposed content of the CQUIN scheme to be offered to the provider.

## 6.3 Updating CQUIN schemes in multi-year contracts

There will be situations where existing contracts remain in place for 2019/20. The terms of the NHS Standard Contract are clear that any CQUIN scheme must be in accordance with national CQUIN guidance and we therefore expect that commissioners and providers will agree appropriate changes to the CQUIN schedules in their local contracts to reflect this updated National CQUIN guidance and will implement those changes, by 31 March 2019, as part of a wider Variation to their contracts. This Variation will need to enact the reduction in the value of CQUIN from 2.5% to 1.25%, with the necessary offsetting increase in any Local Prices and in the (pre-CQUIN) Expected Annual Contract Value. Updating of CQUIN schemes to reflect this national guidance should be straightforward and should not lead to disputes.

## 6.4 Offer and agreement between commissioners and providers (new contracts)

For 2019/20, commissioners and providers will in most cases be seeking to agree a new contract to take effect on 1 April 2019. Where this is the case, then – in line with rule 7 – it is important to be clear about how they should engage on any content of the 2019/20 CQUIN scheme which is to be locally agreed – and what happens if they are unable to reach agreement:

- Commissioners will wish to engage with providers, or groups of similar providers, at the earliest opportunity, in order to discuss proposals for CQUIN schemes.

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.4 Offer and agreement between commissioners and providers (new contracts) cont…

- Where multiple commissioners are party to the same contract with a provider, it is for the co-ordinating commissioner to lead the discussions with the provider on CQUIN.
- The commissioner must make a reasonable offer of a CQUIN scheme to the provider.
- Ultimately, where the commissioner has made such an offer and the provider has not accepted it as part of a signed contract by 21 March 2019, the commissioner will be entitled to withdraw the offer of local CQUIN indicators from the percentage specified in sections 5.2, pg.20 and 5.3, pg.21 and need not make available local CQUIN indicators to that provider for the remainder of that contract year, even if a contract is subsequently signed. In this scenario, the commissioner should ensure that it reduces accordingly any CQUIN payments it makes on account to the provider.
- For the avoidance of doubt, the agreed scheme should be recorded in section 4D of the NHS Standard Contract.

## 6.5 Independent and third sector providers

The CQUIN scheme has been designed to be offered to the full range of providers that deliver services under the NHS Standard Contract. Where national indicators apply, commissioners should aim to ensure scheme compliance by locally contracting for these. Commissioners must explicitly offer the CQUIN to all independent and third sector providers unless they have decided to apply the small value contracts exemption (6.6, pg. 24). The explicit offer of CQUIN also applies to providers commissioned under the NHS Standard Contract on the Any Qualified Provider framework.

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.6 Small-Value Contracts

Providers should have the opportunity to earn CQUIN payments, regardless of how small the value of their contract is. We recognise, however, that it may not always be a good use of time for commissioners and providers to develop and agree detailed schemes for very low-value contracts. At their sole discretion, therefore, commissioners may choose simply to pay the percentage specified in sections 5.2, pg.20 and 5.3, pg. 21 to providers where this value would be non-material, rather than develop a specific scheme. Where they intend to do this, they must make it clear at the outset of their procurement or contract negotiation process, so that providers understand that a separate CQUIN scheme is not to be offered. Within their contracts, they should then:

- Select the appropriate option within the CQUIN Schedule (4D), so that it is clear that the small-value contract exception is being applied; and
- ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed at full value (that is, including any value which would otherwise have been paid as CQUIN), as now required under Service Condition 38.15 of the 2019/20 NHS Standard Contract.

## 6.7 Joint Commissioning

Where NHS and Local Authority commissioners are jointly commissioning services under the NHS Contract for example care homes but not pooling funds, CQUIN only applies to that healthcare funding part. Local Authority commissioners could choose to match funding to the CQUIN equivalent but this is for local determination.

## 6.8 CQUIN and Non-Contract Activity

Non-Contract Activity (NCA) billing arrangements are not intended as a routine alternative to formal contracting, but for use where there are small, unpredictable flows of patient activity delivered by a provider which is geographically distant from the commissioner.

As a general principle, CQUIN payments may be earned by a provider on NCA. Subject to the restrictions below, the terms of a provider's CQUIN scheme with its main commissioner for the relevant service will be deemed to apply to any NCA activity it carries out in that service. Providers will need to supply reasonable evidence to NCA commissioners of that scheme and of achievement of incentive goals.

# 6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

## 6.9 Local Incentive Schemes and Services Covered by Local Prices

It is of course possible for commissioners, at their discretion, to offer additional incentives to providers, on top of the main national scheme.

Such schemes should be recorded as Local Incentive Schemes in the relevant schedule of the NHS Standard Contract. If local incentives affect services covered by National Prices, commissioners may need to submit a Local Variation to Monitor, as outlined in the National Tariff Payment System 2019 - 20.

We recognise that, particularly where a competitive procurement approach is being used, commissioners may choose, as an explicit part of setting a local price for a contract, to create a broader local incentive scheme, incorporating the national CQUIN scheme but linking a higher proportion of contract value (above the percentage specified in sections 5.2, pg. 20 and 5.3, pg. 21) to agreed quality and outcome measures, rather than activity levels. This is a legitimate approach, and there is no requirement in this situation for the commissioner to offer a further CQUIN scheme to the provider, on top of the agreed local price. Commissioners should ensure that they make their intended approach clear from the outset of the procurement process.

## 6.10 CQUIN Earn-ability

Following on from the successfully trialled CQUIN Finance Return in 2018/19, NHS England and NHS Improvement will be seeking to collect in-year information in order to confirm whether CQUIN awards are expected to be earned during 2019/20. Providers and Commissioners will be expected to comply with the requirements of that return. More information will be shared on this in due course.

As confirmed in the NHS Operational and Contracting guidance 2019/20, where the total value of CQUIN has not been earned, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

# Version Control

| Date | Update |
| --- | --- |
| 7th March 2019 | Initial Publication |
| 8th March 2019 | Section 6.4 (p26) amended |