## 

## 2019/20 PSS CQUIN Scheme

## Indicator Template

## *[Section B to be completed before insertion in contracts.]*

## PSS13 Rethinking Conversations (v1 published 19 March 2019)

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| Indicator Name | ***Rethinking Conversations towards Open Compassionate Enabling Care of Patients with Long Term Conditions*** | |
| 1. **SUMMARY of Indicator** | | |
| Indicator Sponsor (with email address) | *Alf Collins*  *Jonathan Berry*  [donald.franklin@nhs.net](mailto:donald.franklin@nhs.net) | |
| Improving Value Reference | Enhanced Supportive Care: 1617S23C  **Current national  IV scheme** | |
| Duration | Three years. | |
| CCG Complementarity | *N/A* | |
| **Problem to be addressed (maximum 150 words):**  ***[****Briefly characterise the shortfall in quality or efficiency that the indicator is designed to address; detailed evidence should be placed in section D1****]***  Research, has identified that the timely, honest conversations about their future that patients want are not happening. Many physicians do not feel confident to initiate these conversations, to handle prognostic uncertainty or to discuss decisions about care and treatment that balance duration and quality of life. Yet, these discussions are fundamental to effective clinical management plans, and align with the aspirations of the RCP’s Future Hospital Commission Report and the learning from the NHS England pilot of the Serious Illness Conversations Progamme 2016.  The NHS Long Term Plan 2019 notes the “importance of ‘what matters to someone’ is not just ‘what’s the matter with someone’. Since individuals’ values and preferences differ, ensuring choice and sharing control can meaningfully improve care outcomes. Creating genuine partnerships requires professionalsto work differently, as well as a systematic approach to engaging patients in decisions about their health and wellbeing. We will support and help train staff to have the conversations which help patients make the decisions that are right for them.” | | |
| **Change sought:**  *[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4****.]***  When clinicians have conversations with patients with long-term or terminal conditions, about their prospects and their care, many patients engage more effectively in managing their own health and wellbeing and tend to choose less interventive treatments resulting in improved patient experience. As a result more individuals who are supported to live well with their conditions. Such conversations require providers to ensure   * their clinicians with care-coordination responsibility for people with long term/incurable conditions facing significant care decisions are adequately skilled in skills such as shared decision making, personalised care and support planning and health coaching, * and that they have available an appropriate portfolio of interventions, including interventions that support patient activation, to offer during care planning discussions with patients.   This CQUIN seeks to ensure that people with long term or advanced, progressive or incurable conditions are able to access the most appropriate pathway of support earlier, through an appropriate patient-clinician conversation, and that they are enabled to have the capability, opportunity and motivation proactively to manage their health and wellbeing including making appropriate lifestyle changes.  This will enable more people to be appropriately supported to make choices aligned to their overall needs and values, and clinical ability-to-benefit; and to live as well as possible.  Previous attempts to incentivise these types of conversations have often relied on the production of resources such as Patient Decision Aids to support clinicians and patients in this new dialogue, and questionnaires to elicit patient activation levels. However, evidence from research shows that these work optimally when they are underpinned by a very open and transparent conversation about risks and benefits, and with effort deployed to enhance clinician understanding of patients’ perspective and behavioural change needs. Similarly, evidence from the Enhanced Supportive Care initiative (ESC) shows that it offers Oncology teams and Palliative Care teams an opportunity to understand patients’ perspective through providing a timely supportive care approach.  We know that for many clinicians this will require a different type of conversation with patients to secure these ends, and consequently this indicator will support that change in practice and understand the impact on patients and the system.  Suggested groups include:   * Cancer patients at the point of diagnosis of incurable disease who have been the focus of the 2017/19 CA1 Enhanced Supportive Care (ESC) PSS CQUIN. Other patient groups at a similar point in their care pathway. * Groups that have had been the focus of the 2017/19 GE2 Patient Activation (PAM) PSS CQUIN: particularly HIV and Specialised Respiratory conditions. * Groups that have been the focus of the 2017/19 GE5 Shared Decision Making (SDM) PSS CQUIN.; whether this involves providers wishing further to develop this approach with existing patient cohorts eg cardiac and respiratory diseases, or to extend it new disease groups.   This CQUIN builds on the learning from providers undertaking GE2, GE5 and CA1; it will enable them to progress from work to develop PAM, SDM and ESC services, to focus more specifically on the conversation aspect to understand measure the impact of this using improvement methodology.  However, the applicability of this CQUIN and the change of approach it seeks to support is not limited to these groups, and commissioners may well encourage providers willing to do so to adopt this CQUIN to the benefit of additional patient cohorts with long term conditions and progressive or incurable conditions. Groups that might particularly benefit from a re-thought conversation and consequential support include:   * patients with two or more physical LTCs coupled with one or more MH condition * young people with LTCs in transition to adult care.   There are 4 stages;   * Training and expertise: ensuring that clinicians have the skills and training to undertake the conversations; * The conversation: enabling and supporting the patient; * Implementation: delivering the agreed plan and support; * Measurement: understanding the impact on patients, services and the system.   Cohort Selection for providers building on PAM, SDM and ESC CQUINs   * Supported Self Management (Patient Activation) `   Providers may wish to conduct a risk stratification, and to concentrate resources on patients within the top 10% risk of admission and or have low activation (Levels 1 or 2) as assessed by the Patient Activation Measure.   * Shared Decision Making   Providers building on existing SDM activity have undertaken work for the SDM CQUIN in specialties such as Cardiology and Respiratory. This might include using any decision support tools created as part of the SDM CQUIN to support the “different conversations.” Providers may wish to concentrate activities on patients whose treatments are high cost and/or high volume and who have a range of different treatment and care options.   * Enhanced Supportive Care Approach  |  | | --- | | The focus should be providers currently providing robust ESC models with demonstrable evidence of improved patient experience, i.e. where existing ESC services are delivering the six key principles of ESC to at least three specific cancer disease group populations enabling all eligible patients to be referred to ESC at the point of diagnosis of incurable disease. This approach is outlined in the NHS England Guideline document <https://www.england.nhs.uk/wp-content/uploads/2016/03/ca1-enhncd-supprtv-care-guid.pdf> |   Stage 1. Trained Staff. See Trigger 1 in section C4.  All relevant staff (identified in Section B) to be adequately trained and experienced in managing difficult conversations. In addition, for providers building on previous CQUIN work in PAM, SDM, ESC:   * Supported Self Management (Patient Activation). Ensure that that the clinician coordinating the care of the patient, perhaps working with a link worker or social prescriber, has adequate training in appropriately-tailored motivational interviewing or Health coaching. * Shared Decision Making. Ensure that all members of the clinical team have adequate training in appropriately-tailored motivational interviewing, risk communication, simplified communication techniques and health coaching in addition to a clear understanding of what SDM is and isn’t. * ESC. Ensure that the clinicians involved in delivering ESC are adequately trained and experienced in advanced communication skills and are used to describing the uncertainties inherent in sensitive converations weighing up the potential benefit and burdens of treatment decisions.   Stage 2. The conversation. See Trigger 2 in section C4.  Depending upon the patient cohort, the conversation may include elements making reference to PAM, SDM or ESC techniques:   * Supported Self Management (Patient Activation). Ensure the administration of the Patient Activation Measure, to assess the extent to which the patient might engage with a “different conversation” and to enable time and resources to be tailored according to level of activation. The conversation needs to be informed by the PAM result, and the PAM itself needs to have been implemented effectively. (For example, over the cohort as a whole there should be less than 15% “outliers” – those who have answered all the PAM questions in the same column.) * Shared Decision Making. To implement a different conversation whereby clinicians take on a facilitative role to support patients fully to understand how they can best manage their own enduring condition based on what matters to them. This should be supported by use of patient experience measures, regular audit of clinical practice, preparing patients for these conversations, use of health literate decision support resources and peer support. * ESC. A clear ESC pathway shoud be in place so that all appropriate patients can access support with these conversations from the ESC clinicians. The model should enable ESC Clinicians to be part of the MDT treatment decision conversations alongside the patient and Oncology team at the point of diagnosis of incurable disease.   Stage 3. The Intervention. See Trigger 3 in section C4.  If the conversation results in a determination for an alternative care pathway, follow on support must be available to deliver the relevant intervention. In some case providers may determine to remedy gaps in their portfolio of patient activation interventions and/or in their portfolio of palliative or other less aggressive treatment options:   * Supported Self-management (Patient Activation). To implement the agreed care and support plan, using resources already in place: to offer activation interventions for patients with low activation levels, and to offer the full range of care options.      * Shared Decision Making. To continue to embed the “different conversation” approach with patients every time a decision needs to be made, following a change in their condition, about all reasonable alternatives and options; and actually to implement options chosen. * ESC. ESC support should be made available to all patients wishing to engage, and include engagement across the system to ensure that the patient preferences are respected, enabled and their goals are achieved. ESC will provide proactive support to the patient to manage their cancer, and the adverse effects of cancer treatment such as chemotherapy side effects, where this is part of their preferred choice of treatment.   Stage 4. Measured Improvement. See Trigger 4 in section C4.  To secure measured positive impact of this approach, using a range of measures including process, outcome and balancing measures, for patients and carers, the provider and specialised commissioning.    ***Resources are available for the implementation of this CQUIN indicator: see section C6.***  This CQUIN is supportive of the implementation of NHS England’s Comprehensive Model for Personalised Care, which has been co-produced with people with lived experience and a wide range of stakeholders and brings together six evidence-based and inter-linked components, each of which is defined by a standard, replicable delivery model. Of the six components, four (emphasised) are supported by this CQUIN:  1. ***Shared decision making***  2. ***Personalised care and support planning***  3. Enabling choice, including legal rights to choice  4. ***Social prescribing and community-based support***  5. ***Supported self-management***  6. Personal health budgets and integrated personal budgets. | | |
| 1. **CONTRACT SPECIFIC INFORMATION** *(for completion locally, using guidance in sections C below)* | | |
| **B1.Provider** (see Section C1 for applicability rules) | *[Insert name of provider ]* | |
| **B2. Provider Specific Duration.**  What will be the first Year of Indicator for this provider, and how many years are covered by this contract? | 2019/20 2020/21 2021/22 *[Adjust locally]*  One/twoyears *[Adjust locally]* | |
| **B3.Indicator Target Payment** (see Section C3 for rules to determine target payment) | Full compliance with this CQUIN indicator should achieve payment of:  Target Value:  *[Add locally ££s]* | |
| **B4. Payment Triggers.**  The triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the indicator, are set out in Section C4.  Relevant provider-specific variation, if any, is set out in this table.  *[Adjust table as required for this indicator – or delete if no provider-specific information is required.]*   |  |  |  |  | | --- | --- | --- | --- | | **Provider specific triggers** | **2019/20** | **2020/21** | **2021/22** | | **Target Cohort of Patients**  ***[Specify Patient cohort/s for application of the CQUIN]*** |  |  |  | | **Size of Cohort** ***[Specify number of patients in that cohort]*** |  | *Number of additional patients per year.* | *Number of additional patients per year.* | | **Trigger 1:**  **Trained Staff**  ***[Identify the staff whose training is to be assured.]*** |  |  |  | | **Trigger 2:**  **The Conversation**  ***[Set targets for proportion of patients within targeted population to have timely supported conversations, and for what decision support tools (PAM, SDM, ESC) to be deployed.]*** |  |  |  | | **Trigger 3:**  **The Intervention**  *Specify what supportive interventions are to be available:*   * *Activation Interventions to available for low activation PAM patients* * *ESC*   ***And set targets for proportion of population to be offered this support.]*** |  |  |  | | **Trigger 4:**  **Measured Improvement**  ***[Select metrics for Trigger 1 baseline and trigger 4 improvement, with specified improvement target.]*** |  |  |  | | | |
| **B5. Information Requirements** | | |
| **Obligations under the indicator to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.** | | |
| Final indicator reporting date for each year. | | Month 12 Contract Flex reporting date as per contract. *[Vary if necessary.]* |
| **B6. In Year Payment Phasing & Profiling** | | |
| Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.  *[Specify variation of this approach if required]* | | |

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| **C. INDICATOR SPECIFICATION GUIDE: STEP CHANGE INDICATORS** |
| **C1. Providers to whom Applicable** |
| **Nature of Adoption Ambition*:*** |
| The CQUIN is applicable to providers with patient cohorts with fluctuating conditions or symptoms, facing alternative care options, including particularly patient groups where poor outcomes may be attributable to low levels of health-activation or on those who are at the point of diagnosis of incurable cancer where ESC services are currently in place.  Providers for whom this is applicable includes providers who currently have one of the following CQUINs for the 2017/19 PSS contracts, and are in a position to build upon progress made: GE2, GE5, CA1/IM1. Providers who have developed services utilising the principles behind these CQUIN, but did not undertake CQUIN previously, may also be considered if they can demonstrate that they have met those requirements sufficiently to enable them to focus on the aspirations of ‘Rethinking Conversations.’ |
| **List of Providers for whom Indicator is Applicable. Providers who have made progress with**  2017/19 PSS CQUINs GE2, GE5, CA1/IM1, as follows, but others may be eligible as per previous box. |
| |  |  |  | | --- | --- | --- | | GE 5 | CA1 | GE2 | | Basildon & Thurrock University Hospital FT | Nottingham University Hospitals NHS Trust | Derby Foundation Hospital NHS Trust | | East & North Hertfordshire NHS Trust | Cambridge University Hospital NHS FT | Milton Keynes Hospital NHS Trust | | University Hospital Birmingham NHS FT | Barking, Havering & Redbridge University Hospital NHS FT | Cambridge University Hospital NHS FT | | University Hospital North Midlands NHS Trust | Chelsea & Westminster NHS FT | Luton & Dunstable University Hospital NHS FT | | Royal Brompton & Harefield NHS FT | The Royal Marsden NHS FT | Papworth Hospital NHS FT | | University College London Hospital NHS FT | University College London Hospital NHS FT | Peterborough and Stamford Hospital NHS FT | | City Hospital Sunderland NHS FT | The Newcastle Upon Tyne Hospitals NHS FT | West Hertfordshire Hospitals NHS FT | | Northumbria Healthcare NHS FT | Lancashire Teaching Hospital NHS FT | Great Ormond Street Hospital for Children NHS FT | | The Newcastle Upon Tyne Hospital NHS FT | The Clatterbridge Cancer Centre NHS FT | Homerton University Hospital NHS FT | | South Tees Hospital NHS FT | Royal Devon & Exeter NHS FT | King's College Hospital NHS FT | | University Hospital Southampton NHS FT | University Hospital Southampton NHS FT | Lewisham & Greenwich NHS Trust | |  |  | Royal Free London NHS FT | |  |  | The Whittington Hospital NHS Trust | |  |  | University College London Hospital NHS FT | |  |  | Blackpool Teaching Hospitals NHS FT | |  |  | Lancashire Teaching Hospital NHS FT | |  |  | Liverpool Heart And Chest NHS FT | |  |  | Pennine Acute Hospital NHS Trust | |  |  | Salford Royal NHS FT | |  |  | University Hospital of South Manchester NHS FT | |  |  | Brighton & Sussex University Hospital NHS FT | |  |  | East Sussex Healthcare NHS Trust | |  |  | Maidstone and Tunbridge Wells NHS Trust | |  |  | Solent NHS Trust | |  |  | West Midlands | |  |  | Sandwell & West Birmingham Hospital NHS Trust | |  |  | University Hospitals Birmingham NHS FT | |  |  | Yorkshire & Humber | |  |  | Barnsley Hospital NHS FT | |  |  | Bradford Teaching Hospital NHS FT | |  |  | Calderdale & Huddersfield NHS FT | |  |  | Hull & East Yorkshire Hospital NHS Trust | |  |  | Sheffield Children's NHS FT | |  |  | The Rotherham NHS FT | |  |  | York Teaching Hospital NHS FT | |
| **C2. Provider Specific Parameters** |
| **The indicator requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)** |
| Local agreement is required to determine the optimum setting for application. However where this is building on existing work, it is anticipated that the focus of intervention in that setting should already have been established, around one or more of the following - PAM, SDM or ESC.  This should be further specified (in Section B, above) regarding:   * Staff to receive training (by group and by number) * Patient cohort/s for application of the CQUIN * Number of patients in that cohort * What supportive tools and interventions are to be available:   + Decision Support Tools to be deployed – PAM, SDM, ESC   + Supporting Self-Management (Patient Activation) Interventions to be prescribed * Measurement requirements; selection of metrics for Trigger 1 baseline and trigger 4 measurement. * Number of additional patients per year.     The choices of condition group should be guided by an assessment of ability to benefit: for example, large variation in intervention and outcome rates that is suggestive of poor decision making and/or variability in self-care. |
| **C3. Calculating the Target Payment for a Provider** |
| **The target overall payment for this indicator (the payment if the requirements of the indicator are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:**  Year One:  PAM/SDM. £200,000 or other sum determined locally according to the size of the cohort and any one-off costs that will be incurred in developing effective personalised care for that patient cohort.  ESC. The CQUIN payment for each part of the scheme adopted is set at (N\*£600) where N is the estimated number of total eligible patients in which it is agreed that the ESC approach should be targeted to (in addition to those who would receive such support under existing arrangements outside of the CQUIN initiative).  A deduction from the £600 per patient payment is made for any activity payment that implementation would attract (e.g. outpatients appointment payments).  Year Two: ditto  Year Three: ditto  **See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.** |
| **C4. Payment Triggers and Partial Achievement Rules** |
| **Payment Triggers**  **The interventions or achievements required for payment under this CQUIN indicator are as follows:**   |  |  | | --- | --- | | **Descriptions** | **Years 1, 2, 3** | | **Trigger 1:**  **Trained Staff** | Relevant staff (identified in Section B) are adequately trained and experienced in managing difficult conversations.  Baseline Audit undertaken and ongoing data collection arrangements in place. | | **Trigger 2:**  **The Conversation** | Evidence of delivery against targets (recorded in Section B) for proportion of patients within targeted population accessing timely supported conversations with Clinicians through PAM/SDM or ESC. Evidence that PAM scores are available and used in MDT discussions. Monitoring of effectiveness of PAM assessment and of the conversations using reporting tools in Section C5. | | **Trigger 3:**  **The Intervention** | Evidence of delivery against targets (recorded in Section B) for proportion of patients within targeted population accessing support with goal achievement through Supported Self Management, and through alternative treatment pathways offered though SDM or ESC. Reporting on interventions adopted as per Section C5. | | **Trigger 4:**  **Measured Improvement** | Delivery against agreed improvement measures demonstrated through return of PAM/SDM/ ESC data tool to local commissioner, as per Section C5. Participation in a learning set if available is required to ensure spread of learning amongst others working with similar cohorts. | |
| **Percentages of Target Payment per Payment Trigger**  **The following table sets out the proportion of the Target payment that is payable on achievement of each of the Payment Triggers.**   |  |  |  |  | | --- | --- | --- | --- | | **Percentages of Target Payment per Trigger** | **First Year of indicator** | **Second Year** | **Third Year** | | **Trigger 1**  **Trained Staff** | 20% | 20% | 20% | | **Trigger 2**  **The Conversation** | 20% | 20% | 20% | | **Trigger 3**  **The Intervention** | 30% | 30% | 30% | | **Trigger 4**  **Measured Improvement** | 30% | 30% | 30% | | **TOTAL** | 100% | 100% | 100% | |
| **Partial achievement rules**  **Trigger 1: all-or-nothing**  **Trigger 2: strictly-proportional**  **Trigger 3: strictly-proportional**  **Trigger 3: strictly-proportional** |
| **Definitions**  *Trigger 1.*  Clinicians who are involved in the care and treatment of the specific cohort of patient that the CQUIN is being used to target.  All providers must undertake an assessment of the skills, knowledge and confidence of those clinicians to undertake a different conversation. They must then meet those needs through access to relevant training/support including peer to peer support and mentoring. A bespoke package is available from the Serious Illness Care Programme. |
| **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.** |
| A reporting tool is being developed to support the reporting of data for this CQUIN. This includes baseline data and data to support achievement of the CQUIN Triggers and to support evaluations through capturing the impact of this initiative on patients and the system/services. |
| **Reporting of Achievement against Triggers:** |
| Baseline data on the estimated number of patients in each targeted cohort.  Trigger One: Trained Staff. List staff whose relevant training is assured.  Trigger Two: The Conversation.  Quarterly reporting on numbers and proportion of targeted cohort of patients who are offered support with difficult conversations through PAM/SDM or ESC.  **The quality of the conversation should be measured by a validated** shared decision making evaluation and monitoring tools, such as   * + CollaboRATE (3 item questionnaire)     - see https://bmjopen.bmj.com/content/7/3/e014681   + CQI-2 (Consultation Quality Index)     - see: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1832233/>   The effective completion of PAM is also an indication of an effective conversation, with the score fed through into EMIS. Maximum of 15% of PAMs should be classified as “outliers” (all responses the same).  **Trigger Three: The Intervention**  Quarterly reporting on numbers and proportion of targeted cohort of patients who are receive named interventions further to their conversations, to implement what was agreed in their conversation: including (for the PAM cohort) interventions to support self-management.  **Trigger Four: Measured Improvement**  **Information flows for measurement of impact cover several elements:**  **Patient experience and outcomes**   * Use of the SDM Q9 patient experience measurement tool with every patient and the results fed back to individual clinicians quarterly * level of application of a health literate decision support resource in partnership with service users * ESC – use of IPOS * Metrics of clinical or self-reported outcome (PROM) pertinent to the patient condition group. * Improvement in PAM score:   + At least 75% of patients in specified cohorts with a Patient Activation Levels 1 or 2 using the PAM, should be complete a further PAM questionnaire with six months (definitely within nine months)   + at least 60% of those patients in specified cohorts with a Patient Activation Levels 1 or 2 using the PAM, should benefit from prescription of an Activation Intervention, with the process logged. A fifteen point increase in PAM score for these cohorts should be expected following these interventions to ensure their effectiveness. An improvement of less than ten points should spark review of the choice of activation intervention and the mode of its delivery.   **Impact on providers**   * SDM Self-assessment checklist * Changes to treatment decisions following a different conversations eg options not previously discussed and percentage of eligible patients who selected each option   **Impact on services**   * Cost of Activity including treatment decisions across the whole service * Percentage of eligible patients who made a different treatment decision following the conversation * Cost of supporting the different treatment decisions following the conversation. E.g.: * Changes in clinic activity; number of clinic appointments avoided/added * Number of onward referrals to other services * Number of procedures/interventions avoided * % change in compliance/adherence with medication * % patients supported to complete course of chemotherapy * % patients supported with decision not to undertake chemotherapy * Number of unplanned admissions avoided * Number of complications eg pain prevented through proactive support |
| **Information for Benchmarking:** |
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| **Information Governance:** |
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| **Reporting Template requirement:** |
| A Reporting Template will be developed according to the mix of patient cohorts for whom this indicator is applied. (Source: [Donald.franklin@nhs.net](mailto:Donald.franklin@nhs.net)) |
| **C6. Supporting Guidance and References** |
| **Further details on implementation, and references to documents that will support implementation:**  There are a number of resources available to support implementation of this CQUIN:  This CQUIN is supportive of and should be read in the context of the NHS England  Long Term Plan and the associated guidance: “Universal Personalised Care: Implementing the Comprehensive Model”, which is found here:   * [NHS E: Universal Personalised Care](https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/)   Trigger 2, the conversation, builds upon work done in the Serious Illness Programme UK:  Serious Illness Care Programme UK [www.betterconversations.org.uk/](http://www.betterconversations.org.uk/)  Better Conversations Better Care. Serious Illness Care Pogramme UK.Report. Oct 2017.  [betterconversations.org.uk/wp-content/uploads/2017/10/SICP\_Report\_WEB.pdf](http://betterconversations.org.uk/wp-content/uploads/2017/10/SICP_Report_WEB.pdf)  With respect to the intervention options at each stage, guidance is available as follows:  ESC – from the Improving Value team [Jilll.Lockhart1@nhs.net](mailto:Jilll.Lockhart1@nhs.net)  SDM – The SDM Self Assessment Checklist, and various NICE quality standards:  QS15 – Patient Experience in adult NHS services, Quality Statement 6: shared decision making: <https://www.nice.org.uk/guidance/qs15/chapter/Quality-statement-6-Shared-decision-making>  QS14 – Service user experience in adult mental health services, Quality Statement 3: Shared decision making and self-management: <https://www.nice.org.uk/guidance/qs14/chapter/Quality-statement-3-Shared-decision-making-and-self-management>  QS120 – Medicines optimisation, Quality Statement 1: Shared decision making: <https://www.nice.org.uk/guidance/qs120/chapter/Quality-statement-1-Shared-decisionmaking>  In addition, the Multimobidity QS (QS153) doesn’t specifically mention SDM but alludes to it in Quality Statement 2: Assessing values, priorities and goals:  <https://www.nice.org.uk/guidance/qs153/chapter/Quality-statement-2-Assessing-values-priorities-and-goals>  Supported Self Management:  The Patient Activation Measure (PAM) –  Quick guide to implemention of the PAM  Full guide to implementation of the PSM (available to sites with PAM licences via the collaborative platform)  Access to E learning on PAM from Insignia Health on receipt of PAM licences  Online collaborative platform for sites using the PAM licences where the full set of resources are available including case studies, webinar recordings, sharing best practice, peer support forum etc.  “How to Guide”, to be available from [donald.franklin@nhs.net](mailto:donald.franklin@nhs.net).    A number of social networks exist; [healthunlocked.com](https://healthunlocked.com) has been shown to increase activation and is also a national innovation accelerator award winner.    For better conversations and health coaching, see   * + - * <https://www.england.nhs.uk/blog/better-conversations-are-the-key-to-better-health/>       * <http://www.betterconversation.co.uk/health-coaching.html> |

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| **D. Indicator Justification and Evaluation** | |
| **D1. Evidence and Rationale for Inclusion** | |
| **Evidence Supporting Intervention Sought**  Evidence from research, and emerging learning from earlier PSS CQUIN indicators, (for Shared Decision Making, Enhanced Supportive Care and Patient Activation, respectively GE5, CA1 and GE2 in the 2017-19 PSS CQUIN Scheme), show that when clinicians have conversations with patients with long-term or terminal conditions, about their prospects and their care, many patients engage more effectively in managing their own health and wellbeing and tend to choose less interventive treatments resulting in improved patient experience. These conversations result in a different focus and interaction with health care services, and more individuals who are supported to live well with their conditions. Enhanced Supportive Care (ESC) has demonstrated benefits for patients at the point of diagnosis of incurable disease through engagement of an ESC team as part of the treatment decision making process and an enabler for these conversations.  **Opportunity**  NHS England Specialised commissioning, commission a number of high cost services across a range of conditions and complexities, for patients within this cohort - advanced, progressive or incurable illness and long term conditions –therefore incentivising these conversations has wide potential applicability. Together with the knowledge and resources developed from previously mentioned CQUINs, around supporting patients through the appropriate pathway, there is a real opportunity to have a significant positive impact on patients, clinicians, providers and commissioners by incentivising early, transparent conversations.  There is a substantial body of evidence demonstrating that patients with long term conditions with higher levels of activation (the knowledge, skills and capacity to manage their own condition) have better outcomes including reduced frequency of exacerbations and associated high cost interventions. There is also evidence that information about activation levels can be used effectively to focus intervention on patients groups more effectively.  **Legal context for Shared Decision Making**  Following the UK Supreme Court ruling in 2015 (Montgomery v Lanarkshire Health Board) it is now a legal requirement that health professionals must take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments. The approach outlined above will enable clinicians to discharge that duty and to help their patients to achieve the best outcomes.  **Decision confidence**  This approach will improve patient experience, both in decision making and in managing their conditions. Clinicians often worry about the risks of being criticised if they do not offer every possible treatment. This new approach will enable decisions to be made in partnership with people, helping them to make the choices about their treatment and care (including self-care) that are best for them as individuals. In addition to reducing the likelihood of decision-regret, this approach is also effective in reducing the likelihood of complaints as when the patient has been fully engaged there is much less of a possibility that the outcome will come as a nasty surprise.  **Reducing inequalities and inappropriate variation**  This approach can also assist in tackling what is often referred to as the “silent misdiagnosis”. This is when clinicians are unaware of patients’ circumstances, capabilities and preferences, and patients are unaware of all reasonable options and outcomes, including the extent to which their condition can be improved by behavioural change. Changing the conversation to one where understanding is shared can support the reduction of inappropriate variation in care (currently a significant issue) and can also help address health inequalities by ensuring those people with the lowest levels of health literacy are involved in a discussion that makes sense to them and which they can apply to their everyday circumstances. This in turn will increase true patient choice, through better informed decision making, which in turn means that the likelihood of allocative efficiency is also enhanced.  **Evidence and strategic alignment**  This CQUIN also aligns into the discussions that have commenced among clinicians about how to change the conversations they are having with patients. There is a growing awareness that clinicians and patients tend to overestimate the benefits of treatment, and understate the potential benefits of behavioural change. NHS England, in partnership with NHS Improvement and some Royal Colleges is currently developing a new publication aimed at the medical profession as part of its work to highlight the importance of clinicians having these changed conversations. The document (working title: Rethinking Medicine) has a likely publication date of late 2018/early 2019. This means that launching this new CQUIN on 1/4/19 would represent a concrete way for some clinicians to start acting on the recommendations which are likely to be contained in “Rethinking Medicine”.  In addition, the Patient Activation CQUIN has delivered lessons about how best to implement assessment of patient activation and consequential behavioural change interventions. A guidance booklet is being produced alongside this CQUIN (see C6, above). | |
| **Rationale of Use of CQUIN incentive**  **CQUIN as an instrument is justified if net costs beyond normal service requirements are incurred by providers whilst benefits and cost savings accrue to patients and commissioners.**  **COST SAVINGS AND BENEFITS ARISING**   1. Improved patient outcomes and experience of care;  * enhanced patient engagement with decision making has been linked to improved health outcomes because patients are equal partners in the decision making process, and ‘own’ the outcomes. This in turn, means it will match their circumstances and ability to implement e.g. undertake a more physical activity, which in turn optimises outcomes * patients experiencing these type of conversations are better equipped to undertake prehab activities which in turn optimises surgical outcomes * a more equal partnership based relationship with healthcare professionals which takes account of their circumstances, such as their health literacy level or their responsibilities as a carer * Increased patient satisfaction by supporting discussion which leads to patients making informed decisions – national surveys tell us that, at present, around 30% of patients do not feel involved in decisions about their health and care. * Improved patient safety around optimising access to the right care at the right time e.g. ESC enabling appropriate alternatives to unplanned acute hospital admission, and trips to A and E, side effects and potential complications of chemotherapy/ renal dialysis.  1. Allocative Efficiency   By countering the “silent misdiagnosis” referred to above we will move from a position of uninformed demand to informed demand on services because both parties will have shared, among other things, outcome probabilities and attitude to risk. There is evidence that when patients are fully informed that they choose more conservative options. A shared decision making example from the field of MSK (in Bedfordshire) shows that 35% of patients having the type of discussion referred to above choose alternative options to surgery resulting in a 24% reduction in Secondary Care referrals.  This offers the scope for commissioners to be able to invest in services that are not only more cost effective and reflective of people’s informed preferences but also to use this as an opportunity to redesign pathways and thus reinvest in a manner that reflects allocative efficiency.  Cost savings through optimising decisions around use of higher-cost interventions and intensive treatments   * More appropriate use of chemotherapy * More appropriate use of high cost drugs e.g. biologics * More appropriate use of cardiac devices * More appropriate use of neurological interventions   **Chemotherapy**.  NHS England spend £1 billion on IV chemotherapy. Learning from CA1, and CA3 CQUINs indicators in the PSS 2017/19 CQUIN scheme, is that there is potential to reduce waste in chemotherapy through supporting patients not to undertake chemotherapy where this is their preference, and by better support for those at risk of not completing a course of chemotherapy, to do so.  **LTCs**  There are opportunities through patient activation to reduce potential unplanned admissions and A&E attendances for people with chronic illness. Health economic modelling work around an RCT in cystic fibrosis (the subject of a separate CQUIN) and behaviour change in relation to activation, suggest opportunities for whole system savings of between £4 to 11.8 million per annum (approx. £1,300 to £3,900 per patient per annum) 25,000 bed days per annum for this patient group alone. The GE2 CQUIN indicator has shown improvement in activation rates. The cohorts selected have included HIV, respiratory and renal patients. | |
| **D2. Indicator Duration and Exit Route** | |
| **The appropriate duration of an indicator depends upon how long CQUIN support is required before the change in behaviour sought can be embedded in services specification or otherwise.**  Many providers undertaking this CQUIN will already have been part of an existing CQUIN for up to three years. A further 1 – 3 years may be necessary to fully embed the services within which the difficult conversations will be taking place, and to measure the breadth of impact reqired. The latter, may necessitate additional data collection or setting up processes to access data that is not currently captured. Consequential shifts in casemix and costs associated with different groups of patients will over this time feed through into cost collection and tariff determination. | |
| **D3. Justification of Size of Target Payment** | |
| **The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:**  [  **Evidence regarding costs**  **Trigger 1.**   * + PAM/SDM training is likely to require a day and half of the clinician’s time. (The training might cost £600-£800 per day.) Face to face training may be supplemented with on line support)   ESC – Funding may be required to assist clinicans with training to manage the benefit burden conversation eg. The connected Advanced Communication Skills Course or the Serious Illness Programme training.  **Trigger 2**  This would depend on what is already in place within the organisation to support the approach. Some additional investment in staff may be required to embed the approach e.g. Band 7 Nurse, AHP with a background/training in Quality improvement. This individual will need to engage   * at strategic level within the Trust to ensure senior level commitment and support * with patients and patient services to ensure engagement and preparedness for the process * with senior clinical staff, to ensure workforce engagement, skill development and clinical champions * with QIPP and IT/ business intelligence teams to measure financial impact.   PAM - New providers would need to apply to NHS England for licences but we would ensure that this is a simple process. There would be some governance around this, signing and MoU and an agreement to use the licences are required. There is no cost to sites for licences - NHS England paid Insignia upfront for licences in 2016 for a five year contract.  However, there will be a need for employment of a PAM administrator to liaise with Insignia and to oversee the administration of the PAM. Such an administrator could be shared across local providers.  Participation in a PAM learning set will require some clinician time. | |
| **D4. Evaluation: Approach, data and resources** | |
| **Evaluation Approach:**  One of the challenges to measurement of impact of CA1, GE2 and GE5 was the absence of robust quantitative data demonstrating ROI.Therefore this CQUIN has been specifically designed to focus on measuring the impact of quality changes associated with changes in behaviour and culture - for patients, clinicians and the system – through incentivising further, those services that have established ESC, PAM, SDM successfully in order to progress understanding and move the emphasis away from creating the processes to measuring the benefits through ROI. | |
| **Information for Evaluation** | *[Information flows required for evaluation should be referenced here, building on those set out at C5]*  As set out above. |
| **Resources for Evaluation** |  |