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## 2019/20 PSS CQUIN Scheme

## Indicator Template

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

## PSS8 Severe Asthma (v1 published 20 March 2019)

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| Indicator Name | Severe Asthma Specialised Care Review | |
| 1. **SUMMARY of Indicator** | | |
| Indicator Sponsor (with email address) | Kathy Blacker  [Kathy.blacker@nhs.net](mailto:Kathy.blacker@nhs.net) | |
| Improving Value Reference | A01181913IM  **Current national IV scheme** | |
| Duration | Three years | |
| CCG Complementarity |  | |
| **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****]***  There is currently no assurance process in place to ensure that the right patients are receiving the right high cost biologic medications in severe asthma. Not all patients with severe asthma who are receiving biologics are currently cared for under the auspices of severe asthma networks. Consequently, there is currently significant geographical variation in the prescribing and management of patients with severe asthma  The service specification for severe asthma services promotes a networked model of care as a vehicle for delivering an optimal pathway and maximising patient outcomes and experience. This is not fully implemented. | | |
| **Change sought:**  *[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4****.]***  Through this scheme the geographical variation in the prescribing and management of patients with severe asthma will be lessened; through the development of severe asthma networks all services will rapidly mature to the performance of the best. Patient outcomes will be improved and will be able to be evidenced by the National Asthma Audit and the UK Severe Asthma Registry.  Currently patients in many areas of the country are receiving high cost biologics for severe asthma without the oversight of a specialist severe asthma centre. By developing severe asthma networks, we estimate that approximately one third of current Omalizumab spend could be avoided, as has happened in the areas of the country with the most developed networks. This will result in patients receiving the correct treatment at the correct time with commissioner assurance.  Upskilling of general respiratory clinicians in the linked district general hospitals will also lead to better management of patients with both moderate and severe asthma.  Patient travel can also be minimised by the use of virtual MDTs to discuss case management.  Biologics will be deployed appropriately via refreshed Blueteq prior approval forms aligned with service specification recommendations to support the optimal pathway. The severe asthma specialist MDT will be hosted by a designated severe asthma centre and all specialist centres will adopt the optimal pathway of care. All designated severe asthma centres will collaborate to develop, to agree and to implement an optimal care pathway for severe asthma. There will be a reconfiguration of defined networks for severe asthma in each part of the country.  All patients newly diagnosed with severe asthma   * will receive an MDT review of their care by a specialist asthma MDT hosted by a designated severe asthma centre * requiring acute admission will, wherever clinically appropriate, be cared for within a commissioned severe asthma centre (or be notified to a commissioned severe asthma centre).   All existing patients, not already reviewed by specialist MDT who are currently prescribed omalizumab, mepolizumab or reslizumab will be reviewed to identify patients appropriate for withdrawal from treatment.  All new treatments for omalizumab, mepolizumab and reslizumab (and other similar biologics yet to receive positive NICE Guidance) will be funded only if approved by a specialist MDT hosted by a commissioned severe asthma centre. | | |
| 1. **CONTRACT SPECIFIC INFORMATION** *(for completion locally, using guidance in sections C below)* | | |
| **B1.Provider** (see Section C1 for applicability rules) |  | |
| **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]*  Threeyears *[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** | | **Trigger 1:** |  |  |  | | **Trigger 2:** |  |  |  | | **Trigger 3:** |  |  |  | | **Trigger 4:** |  |  |  | | **Trigger 5:** |  |  |  | | | |
| **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*:*** | 13 severe asthma networks nationally | |
| **List of Providers for whom Indicator is Applicable** | To be chosen by commissioners from following list:  1. Newcastle upon Tyne Hospitals NHS FT  2. Leeds Teaching OR Sheffield Teaching  3. Manchester  4. Birmingham (Heart of England)  5. Cambridge  6. Leicester OR Nottingham  7. Royal Brompton  8. Barts Health  9. Guys and St Thomas’s  10. Oxford  11. Portsmouth and Southampton jointly  12. North Bristol  13. Royal Devon and Exeter | |
| **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.)** | | The provider needs to report:   * numbers of: * Patients referred to a severe asthma centre in the last 2 years * Patients already on a biologic treatment for severe asthma that have been assessed by a severe asthma centre MDT * Patients already on a biologic treatment for severe asthma that have not been assessed by a severe asthma centre MDT. * If they are reporting to the Severe Asthma Registry. * Clear arrangements for member organisations and referring organisations of the Network. |
| **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) are as follows:**  **Year One; £163,000**  **Year Two: £160,000**  **Year Three: £209,000**  **See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.**  These numbers are based upon the costs and indicative patient numbers in section D3; variation in Target Payment in line with the network-specific patient numbers set out in section C2 would be appropriate. | | |
| **C4. Payment Triggers and Partial Achievement Rules** | | |
| **Payment Triggers**  **The interventions or achievements required for payment under this CQUIN indicator are as follows:**  The change sought is to implement Severe Asthma Networks with a Commissioned Specialised Severe Asthma Centre as the network lead. In addition, all patients with severe asthma receiving biologics will be cared for under the auspices of severe asthma networks.  Change in behaviour sought:   * Appropriate initiation prescribing and annual review of biologics by a severe asthma centre * Virtual network MDTs * Network spokes prescribe repeat medication * Completion of data to the UK Severe Asthma Registry and NHS England Quality Dashboard.  |  |  |  |  | | --- | --- | --- | --- | | **Descriptions** | **First Year of indicator** | **Second Year** | **Third Year** | | **Trigger 1:** | MDT structures formalised including technology infrastructure (informed by work of Improving Value Scheme). | All new patients started on a biologic are discussed by an MDT. | All new patients started on a biologic are discussed by an MDT. | | **Trigger 2** | All new patients started on a biologic are discussed by an MDT | 80% of new patients have their data entered in the severe asthma registry | 95% of new patients have their data entered in the severe asthma registry. | | **Trigger 3** | 50% of new patients have their data entered in the severe asthma registry | 30% of patients currently on a biologic who have not been discussed in an MDT have their Eligibility checked through MDT discussion | 70% of patients currently on a biologic who have not been discussed in an MDT or have had their Eligibility checked through MDT discussion have their eligibility checked. | | **Trigger 4** | MDT attendance is included in job plans for MDT members | 30% of patients commenced on a biologic without discussion at an MDT have their data entered in the Severe Asthma Registry. | 70% of patients commenced on a biologic without discussion at an MDT have their data entered in the Severe Asthma Registry. | | **Trigger 5** | Inclusion of costs of running the network and MDTs into reference costs | Develop a policy for shared decision making including a Shared Decision Making resource that is specific to the particular condition, encompassing the range of options that should be offered, with reference to the local services available | Implement shared decision making. | | | |
| **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** | 25% | 56% | 43% | | **Trigger 2** | 55% | 18% | 16% | | **Trigger 3** | 11% | 12% | 19% | | **Trigger 4** | 3% | 12% | 19% | | **Trigger 5** | 6% | 2% | 3% | | **TOTAL** | 100% | 100% | 100% | | | |
| **Partial achievement rules**  **Year One**  Trigger 2: All new patients started on a biologic are discussed by an MDT   * All: 100% payment * 80% of patients: half payment   Trigger 3: 50% of new patients have their data entered in the severe asthma registry   * 50% new patients registered and data completed: 100% payment * 40% of new patients registered and data completed: half payment   **Year Two**  Trigger 1: All new patients started on a biologic are discussed by an MDT   * All: 100% payment * 80% of patients: half payment   Trigger 2: 80% of new patients have their data entered in the severe asthma registry   * 80% of new patients registered and data completed: 100% payment * 60% of new patients registered and data completed: half payment   Trigger 3: 30% of patients currently on a biologic who have not been discussed in an MDT have their Eligibility checked through MDT discussion   * 30% have their eligibility checked via MDT discussion: 100% payment * 25% have their eligibility checked via MDT discussion: half payment   Trigger 4: 30% of patients commenced on a biologic without discussion at an MDT have their data entered in the Severe Asthma Registry   * 30% are registered and have their data completed: 100% payment * 25% are registered and have their data completed: half payment   **Year Three**  Trigger 1: All new patients started on a biologic are discussed by an MDT   * All: 100% payment * 80% of patients: half payment   Trigger 2: 95% of new patients have their data entered in the severe asthma registry   * 95% of new patients registered and data completed: 100% payment * 80% of new patients registered and data completed: half payment   Trigger 3: 70% of patients currently on a biologic who have not been discussed in an MDT or have had their Eligibility checked through MDT discussion have their eligibility checked   * 70% of new patients registered and data completed: 100% payment * 60% of new patients registered and data completed: half payment   Trigger 4: 70% of patients commenced on a biologic without discussion at an MDT have their data entered in the Severe Asthma Registry   * 70% of the above patients are registered and data completed: 100% payment * 60% of the above patients are registered and data completed: half payment.   **All other Triggers: all-or-nothing.** | | |
| **Definitions**   * A new patient is a patient referred into the Severe Asthma Centre. * Total new patients are the total new patients that have been referred into the Severe Asthma Centre in the financial year. * A patient who is on a biologic who has not been discussed in an MDT is one that has been prescribed the biologic outside of a severe asthma centre or by an MDT that did not include participants from a severe asthma centre. | | |
| **C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.** | | |
| ***NHS England***   * Trigger 2. Bluteq high cost biologic forms quarterly report from Bluteq team * Trigger 3. Dashboard completion quarterly   ***Provider***   * Trigger 1: Submission of report of MDT structure to commissioner * Trigger 4: Submission of job plans for relevant job to commissioner * Trigger 5: Copy of reference cost submission to be sent to commissioner * Aggregate contract monitoring monthly report * Severe Asthma Registry – evidence of entry of patients will need to be provided to DSCRO on a quarterly basis * Information of new referrals received | | |
| **Reporting of Achievement against Triggers:** | | |
| As above | | |
| **Information for Benchmarking:** | | |
| To be obtained from normal monitoring and Severe Asthma Registry reports | | |
| **Information Governance:** | | |
| Covered under existing arrangements | | |
| **Reporting Template requirement:** | | |
| Local | | |
| **C6. Supporting Guidance and References** | | |
| **Further details on implementation, and references to documents that will support implementation:**   * Severe Asthma Commissioning Toolkit * Severe Asthma Service Specification * Severe Asthma Improving Value Scheme 10041713IM | | |

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| **D. Indicator Justification and Evaluation** | |
| **D1. Evidence and Rationale for Inclusion** | |
| **Evidence Supporting Intervention Sought**  There is currently significant geographical variation in the prescribing and management of patients with severe asthma. Through this scheme the variation will be lessened as the development of severe asthma networks means that all services will rapidly mature to the performance of the best. Patient outcomes will be improved and will be able to be evidenced by the National Asthma Audit and the UK Severe Asthma Registry.  Currently patients in many areas of the country are receiving high cost biologics for severe asthma without the oversight of a specialist severe asthma centre. By developing severe asthma networks we estimate that approximately one third of current Omalizumab spend could be avoided, as has happened in the areas of the country with the most developed networks. There is published evidence from centres in Manchester and Southampton to support this saving. This will result in patients receiving the correct treatment at the correct time with commissioner assurance.  Upskilling of general respiratory clinicians in the linked district general hospitals will also lead to better management of patients with both moderate and severe asthma.  Patient travel can also be minimised by the use of virtual MDTs to discuss case management. | |
| **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.**  There is currently no assurance process in place to ensure that the right patients are receiving the right high cost biologic medications in severe asthma. Not all patients with severe asthma who are receiving biologics are currently cared for under the auspices of severe asthma networks. | |
| **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.**  Three years will allow the embedding of a network approach to delivering severe asthma care across the country. This will enable costs to be incorporated into reference costs and thus feed through into tariff by the end of the CQIN. | |
| **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:**  **Cost estimates**   |  |  |  |  | | --- | --- | --- | --- | |  | Number | £ per head | Totals | | MDT for all patients | 120 | £286 | £34,320 | | New patients onto registry | 60 | £113 | £6,780 | | Severe Asthma registry fee |  |  | £5,000 | |  |  |  |  |   Plus Infrastructure costs:   * Network Co-ordinator band 7 (0.75 x WTE) * Videoconferencing licences e.g. WebEx, image exchange portal * Data entry - Network Co-ordinator band 7 (0.25 x WTE) | |
| **D4. Evaluation: Approach, data and resources** | |
| **Evaluation Approach:** | |
| **Information for Evaluation** | *As above in C.5* |
| **Resources for Evaluation** | *Routine local monitoring of CQIN performance* |