Commissioning for Quality and Innovation (CQUIN)

Guidance for 2016/17

March 2016

Contents

National CQUIN Guidance 2016/17

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1.0 Introduction

This document sets out the Commissioning for Quality and innovation (CQUIN) scheme for 2016/17.

The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. These will impact on reducing inequalities in access to services, the experiences of using them and the outcomes achieved.

The design of the 16/17 scheme has been influenced by the ambitions of the Five Year Forward View (FYFV). CQUIN in isolation will not address these issues, but if aligned with the Sustainability and Transformation Plans (STPs) covering the whole health and social care systems, it can be a strong lever to help bring about changes: to deliver improved quality of care to patients through clinical and service transformation.

To deliver the FYFV, organisations will move to more place based commissioning, geared towards transforming services to deliver better quality standards for patients, improving the working environment for staff, and delivering financial balance. The national indicators reflect these priorities. There is a focus on clinical quality improvements which that will help achieve better outcomes for patients. There is a new standard focussed on the health and well being of staff, directing collective action to develop a sustainable workforce – we know our greatest strength is having a healthy workforce. And, commissioners will be able to use the local CQUIN quantum to finance transformation priorities linked to delivery of their operational one year plans and the five year STPs.

2.0 National CQUIN Goals

The national indicators are:

1. **NHS staff health and wellbeing;**
2. **Identification and early treatment of Sepsis;**
3. **Improving the physical health for patients with severe mental illness (PSMI);**
4. **Antimicrobial resistance.**

More detail on these indicators is available in section 2.1.

The 2016/17 national goals on Sepsis and PSMI continue the focus on priorities from 2015/16 and build in a higher level of ambition. We have also introduced two new indicators:

- **Improving the health and well being of our NHS staff is a priority for us all. This brand new three part indicator will focus on getting our staff better access to health and wellbeing initiatives, supporting them to make healthy choices and lead healthy lives. The collective effort we make will support good outcomes for patients, through delivering continuity of care, and will help contribute to the financial position of providers through reduced sick days and potentially through reduced agency spend.**
- **Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The CQUIN aims to reduce antibiotic consumption and encourage a prescribing review within 72 hours of commencing an antibiotic.**

2.1 National CQUIN Goals

NHS England

[National templates can be found here]

Improving the health and wellbeing of NHS Staff	**Goal:** Improve the support available to NHS Staff to help promote their health and wellbeing in order for them to remain healthy and well. **Rationale:** Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. Evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients**.**
Identification and Early Treatment of Sepsis	**Goal:** Systematic screening for Sepsis of appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. **Rationale:** Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented.
Physical Health of People with Serious Mental illness (PSMI)	**Goal:** Service users with SMI have comprehensive cardio metabolic risk assessments, the necessary treatments and the results are recorded and shared with the patient and treating clinical teams. **Rationale:** There is an excess of over 40,000 deaths, which could be reduced if SMI patients received the same healthcare interventions as the general population. NHS England has committed to reduce the 15 to 20 year premature mortality in people with psychosis through improved assessment, treatment and communication between clinicians.
Antimicrobial resistance	**Goal:** Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours **Rationale:** Reducing consumption of antibiotics and optimising prescribing practice by reducing the indiscriminate or inappropriate use of antibiotics which is a key driver in the spread of antibiotic resistance.

3.0 Local CQUIN Menu

In collaboration with NHS Clinical Commissioners and CCGs, we have designed a new, shorter menu of local CQUINs. This replaces the much longer picklist previously published with the scheme. The new menu of indicators is based on the priorities identified by CCGs. The menu contains 7 priority areas and 30 indicators. Some of the examples used in the menu are of indicators which CCGs have already tried and tested and others are brand new indicators. Section 3.1 gives a high level overview of the priorities and some of the indicators that are included in the menu. CCGs are advised to review the full list of goals and indicator definitions to help them decide which might be appropriate for local inclusion. A template is provided for each goal for commissioners to include in their local schemes if they wish or they can be adapted to reflect the particular ambitions of the local area.

By creating the menu, we have designed indicators that can be adapted to local circumstance, for example setting local levels of improvement and payment. The intention behind this menu is that CCGs and providers are generally working to deliver similar clinical and service improvements. Therefore by having access to a common set of indicators local systems can get on with delivering the relevant clinical and service changes rather than focus time and effort on the construction of indicators. We anticipate that areas testing new models of care will wish to use the local portion of CQUIN to develop local incentives for 16/17. Therefore CCGs are not limited to choosing from the local CQUIN menu and have the flexibility to develop their own local indicators.

The percentage available for local CQUINs will be dependent on the values applied to the national indicators and the type of provider (see figure 1, page 7). The percentage is to be agreed between commissioner and provider in line with section 5.0 Rules and Guidance (or, in the context of a competitive procurement, as determined by the commissioner).

The number and content of local CQUIN schemes is entirely for local agreement, however we recommend designing a scheme with a small number of indicators, focussed on key priorities. This is particularly important for low-value CQUIN schemes with smaller provider organisations.

3.1 Local CQUIN Menu

NHS England

Complete local CQUIN menu can be found here

Priority Area	Indicator Examples, not exhaustive list
Integration	•Integration of providers across pathways including acute, community and social •Integration of workforce
Learning Disabilities	•Improved physical health outcomes for people with learning disabilities •Identification and care planning
Mental Health	•Depression in older people and those with long term conditions •In-hospital care for patients with dementia •Improving access to psychological therapies
Person Centred Care	•Holistic care planning involving patients •Patient Activation Measures
Physical Health	•Identification and care planning for those living with frailty •Acute Kidney Injury diagnosis and treatment in hospital and care planning •Cancer 62 day waits
Productivity	•Reducing inappropriate hospital utilisation - Clinical Utilisation Reviews (CUR) •Delayed transfers of care - enabling better discharges
Urgent and Emergency Care on Centred Care	•Reduction in inappropriate NHS 111 referrals to 999 or A&E •Improving mental health diagnosis and A&E re-attendance •Reducing the rate of ambulance 999 calls that result in transportation to A&E

4.0 Scheme Eligibility and Value

4.1 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.

4.2 National and Local Indicator Values

Depending on provider performance, the CQUIN scheme is worth a maximum of 2.5%, payable in addition to the Actual Annual Value (AAV). The AAV 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 5.1 Rules).

Fig 1: The national indicators

National Indicator	% of CQUIN quantum
1. NHS staff health and wellbeing	0.75
2. Identification and early treatment of Sepsis	0.25
3. Improving the physical health for patients with severe mental illness (PSMI)	0.25
4. Antimicrobial resistance	0.25

4.0 Scheme Eligibility and Value

4.3 National and local indicators application

Minimum weightings have been established for each of the indicators. Commissioners and providers in agreement may increase the proportion of CQUIN funds for the national indicators if they choose. The remainder of the 2.5% is then available for local indicators. Figure 2 demonstrates an example of the split by provider type between national and local indicators (if the minimum levels are retained).

Figure 2: Illustration of national and local indicators split by provider

Type of Provider	Applicable National indicators	National CQUIN %	Local CQUIN %
Acute	Sepsis, NHS Staff health and wellbeing, Antimicrobial resistance	1.25	1.25
Community	PSMI, NHS Staff health and wellbeing	1	1.5
Ambulance	NHS Staff health and wellbeing	0.75	1.75
Mental Health	PSMI, NHS Staff health and wellbeing	1	1.5
Independent Sector	NA	0	2.5
Care Homes	NA	0	2.5

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

This national CQUIN guidance applies to commissioners and providers using the NHS Standard Contract in 2016/17.

The national indicators are not mandatory for inclusion in CQUIN schemes in contracts where NHS England is the sole commissioner. NHS England will separately publish specific indicators for use in its contracts for directly-commissioned services.

Commissioners should plan to make challenging but realistic CQUIN schemes available for providers; we expect that a high proportion of commissioner CQUIN funding will be earned. Within local CQUIN schemes, it is important to state clearly that it is reasonable and legitimate for commissioners to prioritise indicators that focus on quality improvements and also deliver efficiency savings. But CQUIN schemes must not be used to incentivise actions by providers which will in any way damage patient care.

5.1 Rules

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 5.7, pg. 14) and low-value contracts (section 5.6, pg. 13)).
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 5.2, pg. 11))
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 – that is, the maximum amount which a provider can earn under it – will be 2.5% of the Actual Annual Value of the contract as defined in the NHS Standard Contract 2016/17, subject to certain exclusions, see rule 5.

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.1 Rules Continued…

Rule	Detail
5	The exclusions, on the value of which CQUIN is not payable, are: a) (For the avoidance of doubt) any payments made to providers from the Sustainability and Transformation fund; b) High cost drugs, devices and listed procedures (available at: https://www.gov.uk/government/consultations/nhs-national-tariff-payment-system-201617-a-consultation) and all other items for which the commissioner make 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 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	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 up to the 2.5% available – but must also support achievement of the commissioner's plans to commission high-quality services. Further detail on the process for proposal and agreement of schemes is set out in section 5.3
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. A spreadsheet to capture the agreed indicator set is available here.
10	Actual in-year 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.

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.2 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.

5.3 Offer and agreement between commissioners and providers

In line with rule 7, it is important to be clear about how commissioners and providers should engage on the content of the CQUIN scheme – 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.**
- **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 and provider should make every effort to agree the CQUIN scheme as part of the overall contract, as per the national deadline for agreement.**
- **Ultimately, where the commissioner has made a reasonable offer of a CQUIN scheme to the provider, in line with the requirements of this guidance and the provider has not accepted it as part of a signed contract (or contract variation) by 31 March 2016:**
    - **the provider will be entitled to earn CQUIN only in respect of the national indicators applicable to its services and with each at the % value set in fig 2 (section 4.0, pg. 8) - subject to provider performance, of contract value; and**
    - **the commissioner will be entitled to withdraw the offer of local CQUIN indicators and need not make available local CQUIN indicators to that provider for the remainder of that contract year, even if a contract (or contract variation) is subsequently signed.**
    - **In this scenario, the commissioner should ensure that it reduces accordingly any CQUIN payments it makes on account to the provider**

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.4 CQUIN Variations

There maybe exceptional circumstances where local areas need to vary national indicators and instead use funds to incentivise radical service transformation initiatives. The NHS Standard Contract will permit such variations, provided commissioners and providers apply the following three rules:

1. **The variation is in the best interests of patients. It will support the development of new and innovative service delivery models which are in the best interests of patients today and in the future. It will create a more effective incentive for the provider(s) to achieve the desired outcomes for patients.**
2. **The variation promotes transparency to improve accountability and encourage sharing of best practice. It must be documented in the NHS Standard Contract using the CQUIN Variation template and submitted to: e.CQUIN@nhs.net. Submissions will be published. Providers must still use all reasonable endeavours to improve services in line with national CQUIN goals and must continue to collect and submit any mandated data returns.**
3. **The variation should be developed through consultation. Commissioners and providers must engage constructively with each other when seeking to agree variations. This process should involve clinicians, patient groups and other relevant stakeholders where possible. Providers and commissioners should agree short and long-term objectives for service improvement and a framework for agreeing variations, including the sharing of information and whether other stakeholders will be involved in making decisions on the variation.**

CQUIN variations can be agreed between one or more commissioners and one or more providers. CQUIN variations only have effect for the services specified in the agreement and for the parties to that agreement. Any CQUIN variation should apply at the whole contract level, rather than to individual commissioners only.

The CQUIN Variation template is available here

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.5 Multiple-Year CQUIN Schemes

We recognise that commissioners may wish to incentivise providers to achieve priorities on a multi-year basis particularly where there is a shift to new models of care and or outcomes-based payment that will require several years to deliver – and this should be possible through the agreement of local incentive schemes. However, commissioners should avoid agreeing binding CQUIN schemes with the providers which cover the period beyond 31 March 2017.

5.6 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 up to 2.5% value to providers where this value would be non-material, rather than develop a specific scheme.

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.7 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.

It is important, though, that we do not put in place a perverse incentive for a provider to avoid agreeing contracts with commissioners, on the basis that it will then be easier to earn CQUIN payments. Therefore:

- **If a commissioner has made clear to a provider that it wishes to put in place a contract for a flow of activity that could otherwise be handled as NCA and has proposed a CQUIN scheme in line with this guidance; and**
- **If the provider has refused to agree a contract, relying instead on the NCA approach; then**
- **The provider will not be entitled to claim any CQUIN payment from the NCA commissioner for that year, other than in respect of national goals and their respective indicators.**

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.8 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. CCGs may wish, for instance, to use funding they expect to earn through the Quality Premium scheme to offer additional incentives to providers – and this approach is encouraged.

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 2016/17.

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 2.5% envisaged) 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 2.5% 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.

5.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

5.9 Differential CQUIN for Specialised Service providers

The value of the national CQUIN scheme is set at 2.5% for all commissioned services, other than for prescribed specialised services commissioned by NHS England.

Historically, CQUIN for specialised services acute providers has been set at 2.4% of the applicable contract value of specialised services, with the remaining 0.1% used to provide separate funding for certain Operational Delivery Networks (such as burns, critical care and neonatal care).

For 2016/17, there will be a differential approach for specialised services.

- **The 23 lead providers of Hepatitis C virus (HCV) Operational Delivery Networks will be offered a CQUIN of 2.8% in total of the applicable contract value of their specialised services (this will reflect the significant role that lead providers of HCV ODNs will play in the effective rollout and financial stewardship of the NHS's single largest investment in improving patient care).**
- **The remaining providers of specialised services will be offered a CQUIN of 2.0% of the applicable contract value of their specialised services.**
- **Mental Health providers will be offered CQUIN at 2.5% as the NHS works to take forward the findings of the independent Mental Health Taskforce.**

In addition, NHS England will continue to provide separate funding in 2016/17 for those other Operational Delivery Networks at specific providers.

For further details please refer to the prescribed services specialised CQUIN scheme available here