

Using the Commissioning for Quality and Innovation (CQUIN) payment framework – an addendum to the 2008 policy guidance for 2010/11

This document outlines developments to the CQUIN payment framework for 2010/11. It should be read as an addendum to the guidance published in December 2008 and in the context of the 2010/11 NHS Operating Framework.

Executive Summary

The CQUIN framework continues as a national framework for locally agreed quality improvement schemes.

- Providers of ambulance, community, mental health and learning disability services using national contracts, like providers of acute services, now need a **full CQUIN scheme** to earn CQUIN money.
- Commissioners must make **1.5%** of contract value (or equivalent non-contract activity value) available for each provider's CQUIN scheme.
- There should be a **single CQUIN scheme per provider**, with specified exceptions only.
- CQUIN goals should reflect local priorities and **priority areas** set out in the NHS Operating Framework.
- Goals should be **stretching** and focussed. They must not duplicate specific minimum expectations of providers set out in Existing Commitments, Tiers 1 & 2 Vital Signs or standard contracts.
- Stronger **process** – a standard format will prompt clear definition of goals, measurement and payment.
- For the acute sector, schemes can **no longer reward measurement**.
- Acute schemes must include the **two specified national goals** that the NHS Operations Board has confirmed for 2010/11, on reducing the impact of Venous Thromboembolism (VTE) and improving responsiveness to personal needs of patients.
- SHAs are responsible for **assuring schemes** and ensuring that schemes demonstrate stretch and focus.

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Description	The Commissioning for Quality and Innovation (CQUIN) payment framework allows all local health communities to develop their own schemes to encourage quality improvement and recognise innovation by making a proportion of provider income conditional on locally agreed goals. Two national goals have also been introduced for acute schemes in 2010/11.
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Using the Commissioning for Quality and Innovation (CQUIN) payment framework: An addendum to the 2008 policy guidance for 2010/11

Introduction

1. This document outlines developments to the CQUIN payment framework for 2010/11. It should be read as an addendum to the guidance published in December 2008¹ and in the context of the 2010/11 NHS Operating Framework².
2. The CQUIN payment framework aims to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion everywhere. It was introduced from April 2009, requiring a proportion of provider contract value to be linked to the achievement of locally agreed ambitious quality improvement goals (or, in the first year, a simpler quality improvement plan for non-acute providers). Locally agreed CQUIN schemes are required to include goals in the three domains of quality: safety, effectiveness and patient experience; and to reflect innovation.
3. This addendum sets out changes to the CQUIN framework for 2010/11, clarifying developments that were anticipated and adjustments in response to early learning and feedback from 2009/10. Local organisations will similarly want to reflect on their own and others' experience of using the framework in 2009/10, with the support of their SHA. Many of the 2009/10 CQUIN schemes are published on the NHS Institute website.³

Section 1 - Key policy developments in 2010/11

4. Each provider of acute, ambulance, community, mental health & learning disability services on a national standard contract is entitled to earn 1.5% of contract value subject to agreeing and achieving goals in a CQUIN scheme. Commissioners must collaborate so they can agree a single CQUIN scheme per provider (subject to specified exceptions in Annex 1 eg. for specialised services and providers with sites in more than one SHA region). This is in response to feedback from 2009/10, in order to avoid duplication or conflict between commissioner requirements and to ensure transparency of expectations on providers.
5. The financial value of CQUIN schemes will increase, as expected. In 2010/11, schemes will be worth 1.5% of provider contract value (or equivalent non-contract activity value), up from 0.5% in 2009/10. This reflects the heightened importance of a focus on quality in what will be a challenging financial context
6. The CQUIN framework was intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers. In particular, this means that CQUIN goals must not duplicate specific minimum expectations of providers set out in Existing Commitments, Tiers 1 & 2 Vital

¹

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443

²

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_10107

³ http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin_schemes.html

Signs or in standard contracts. Furthermore, as envisaged in the original guidance, acute schemes will no longer be able to reward measurement, as we are now in the second year of mandatory CQUIN schemes.

7. In the challenging financial context, it is important that CQUIN schemes reflect both local priorities and priority areas set out in the NHS Operating Framework. In addition, CQUIN schemes for acute providers in 2010/11 must include two nationally defined goals, each with a specified indicator, in total linked to around a fifth of the value of schemes (0.3% of provider income).
8. These national CQUIN goals reflect areas where there is widespread need for improvement across the NHS, and are intended to support a consistent approach to delivering improvement. The CQUIN framework remains a national framework for locally agreed schemes, and it is incumbent on commissioners and providers to discuss and agree how to translate these national goals into action at local level. The national goals are set out in Section 2 and more detailed guidance on using them is provided in annexes 3 and 4.
9. It will be particularly important in 2010/11, and beyond, that commissioners carefully consider how to make best use of the CQUIN framework in the context of other commissioning and contracting levers. SHAs can continue with successful regional quality schemes eg. Advancing Quality. CQUIN schemes will be set out entirely within a single schedule of the National Standard Contracts, to provide a clearer distinction between CQUIN goals and other elements of the contract. For example:
 - a) Commissioners may wish to use Schedule 5 of the acute contract to agree data collection to inform baselines on quality indicators which may feed into CQUIN schemes in future years. Similarly, Schedule 3, Part 4 can be used to monitor sustained performance against CQUIN goals achieved in previous years, reserving the CQUIN scheme itself for progressive improvements year on year.
 - b) Commissioners will want to ensure that CQUIN goals do not duplicate financial incentives available through Best Practice Tariffs for stroke, cholecystectomy, cataracts and fractured neck of femur, which are available from April 2010.
10. In order to support transparency and shared learning, commissioners are encouraged to publish their agreed CQUIN schemes on the NHS Institute website: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cqu_in_schemes.html. In addition, it is proposed that providers should make details of their current CQUIN schemes and past achievements available through their Quality Accounts.
11. In 2010/11, the national contracts will include a standard format for CQUIN schemes (see template at Annex 2). The standard format builds on best practice around the process of defining and agreeing schemes in 2009/10 and is intended to facilitate greater clarity on indicators, methods of measurement and payment arrangements.
12. On cash flow, guidance on the national contracts in 2010/11 will recommend as a national default that 50% of the financial value of the CQUIN scheme is paid in advance in monthly instalments, with reconciliation against

performance at least in months 3, 6 and 9. Commissioners and providers are advised to agree some in-year milestones for payment rather than leaving all balancing payments to year end. This approach has been suggested by NHS colleagues both to avoid CQUIN payments being regarded as automatic rather than earned, but also to avoid cash flow problems for providers. If commissioners wish to adopt alternative arrangements, these will need to be agreed with the provider's host SHA.

13. In view of the larger amounts of money now associated with the CQUIN framework, the SHA assurance role is even more important. As outlined in the original guidance, SHAs are responsible for:
- a. supporting the development of schemes
 - b. ensuring that commissioners are agreeing sufficiently stretching and realistic goals which are aligned with overall commissioning intentions
 - c. ensuring that the CQUIN framework is being used fairly and appropriately, eg. in accordance with the Principles and Rules for Cooperation and Competition (PRCC)
- DH will hold SHAs accountable for these functions.

14. The NHS Institute website PCT portal⁴ gives:
- Illustrated examples of CQUIN goals for different provider types, using the 2010/11 standard format for CQUIN schemes
 - Updated responses to Frequently Asked Questions on the CQUIN framework
 - An email address for enquiries to the Department (cquin.payment.framework@dh.gsi.gov.uk)

Section 2 - Using the national CQUIN goals in acute schemes in 2010/11

15. The CQUIN framework is a national framework for local schemes. In year one, 2009/10, it was important to establish the principles of commissioner-provider dialogue and local clinical engagement to develop and agree CQUIN schemes. These principles remain key to the effective use of the framework.
16. In 2010/11, the NHS Operations Board has decided to support local health economies by providing a consistent national approach to delivering improvement in two priority areas. We want to encourage local engagement and capability building but also to share good practice, encourage benchmarking and avoid duplication of effort across the country.
17. The national goals address topics already identified for inclusion in many CQUIN schemes across the country. They are intended to complement locally agreed improvement goals, which will continue to make up the majority of local CQUIN schemes. They are for 2010/11 only and, just as we expect local schemes to evolve over time, we will review whether to set any national goals in 2011/12 and, if so, what they should be.
18. The two national goals for acute CQUIN schemes in 2010/11 are:
- I. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE) (See Annex 3 - page 11)
 - II. Improve responsiveness to personal needs of patients (See Annex 4 - page 17)

⁴ http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin_schemes.html

The two goals should together account for around a fifth of the value of schemes, 0.3% of provider income. Advice on using each of the national goals is provided in the annexes, including detail of the indicators to be used. Local organisations can consider whether and how they might apply these to other types of providers if they wish.

19. The national goals and indicators should be set out alongside other locally agreed goals within the CQUIN scheme in acute provider contracts. A part-populated version for each of the national goals is provided in the annexes below. It is the responsibility of commissioners and providers locally to determine precisely how much of the overall CQUIN value should be linked to each indicator and, for the national goal on responding to patients, to determine the payment thresholds for rewarding provider achievement.
20. Clearly, the national goals and indicators should only be used where they are relevant to provider services. If commissioners agree that one of the national indicators cannot be applied to a provider, they should replace the national indicator with a locally defined indicator. For example, the National Inpatient Survey is only undertaken amongst adult patients, therefore a specialist children's hospital will not be able to use the data source intended for the national measure. They will need to find a different way of measuring improvements in patient experience.

Conclusion

21. The CQUIN framework remains a framework for local quality improvement and innovation goals, with a small consistent element for acute providers in 2010/11. For subsequent years, we will plan how to engage more widely on potential national goals, with the advice of the National Quality Board (on possible areas such as pressure ulcers or falls).
22. The development of the CQUIN framework in future years will also be informed by the independent evaluation envisaged in the December 2008 guidance. The evaluation is commencing now and will run until March 2012. It will combine in-depth case studies across multiple health economies with a national mapping exercise on the content of CQUIN schemes, to assess the impact of the CQUIN framework and learn how it can best be used to improve quality for patients.

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Annex 1 – One scheme per provider and exceptions

1. As set out in Contract Guidance⁵, it is incumbent on commissioners to make 1.5% of contract value (or equivalent non-contract activity value) available for each provider's CQUIN scheme – and to co-operate to reach agreement on a single CQUIN scheme per provider. Where the provider has multiple NHS commissioners, this single agreed scheme should be set out in all provider contracts. For purposes of clarity and transparency, payment should be made on the basis of achievement against the whole scheme by all commissioners.
2. There are **three exceptions** to the one scheme per provider arrangement, where **more than one scheme will be needed**:

Services commissioned by Specialised Commissioning Groups (SCGs)

Local SCGs are responsible for agreeing a CQUIN scheme with each provider of specialised services in their area, related to the contract value associated with those services. SCGs should work with the main PCT commissioner in order to avoid duplication or conflict between CQUIN schemes. If the SCG is an associate commissioner to a provider contract, the SCG-agreed CQUIN scheme should be set out separately within the contract to support clarity of payment arrangements.

The CQUIN scheme agreed by the local SCG should be used for other SCG contracts with the Provider, unless other contracting SCGs prefer to use the provider's main CQUIN scheme. Such SCGs cannot use a separate scheme or a sub-set of an agreed scheme, even if the provider's agreed CQUIN scheme does not cover the specific services which they commission.

Providers with sites in more than one region (eg. national independent or third sector providers)

In order to reflect local quality improvement priorities, one CQUIN scheme should be agreed for each provider site or for each provider contract, with a lead PCT per scheme. Multiple CQUIN schemes for a single provider should give regard to the specific circumstances of the provider and effective use of resources across the national provider's multiple sites or services.

Vertically integrated community services

Where a significant range of community services is commissioned from an acute or mental health provider using a separate contract, a separate CQUIN scheme for community services should be set out within that contract.

3. In addition to the required exceptions outlined above, it may be appropriate in exceptional circumstances for local organisations to choose to agree a CQUIN scheme per contract, rather than per provider; for example where principal commissioners contract with a provider primarily for services delivered by distinct community-based units, serving different populations (most likely to be in community or mental health), with no overlap in quality improvement priorities.
4. In all other circumstances, commissioners should work together in order to agree one CQUIN scheme per provider, even where coordinated or collaborative commissioning is not yet in place. CQUIN schemes are not

⁵ Specific contract guidance published for acute, ambulance, community and mental health/learning disability contracts respectively

intended to be comprehensive of all provider services. Therefore small differences in the range or volume of services contracted by different commissioners cannot be used as an argument for separate CQUIN schemes; and any further local exceptions need to be approved by the provider's host SHA.

Annex 2 - Standard template for CQUIN schemes in national contracts

Coordinating Commissioner	
Associate Commissioners	
Expected financial value of Scheme	£

Goals and Indicators

Goal no.	Description of goal	Quality Domain(s) ⁶	Indicator number ⁷	Indicator name	National or Regional indicator ⁸	Indicator weighting
1			1a			
			1b			
2						
Etc.						

Detail of Indicator (to be completed for each indicator)

Description of indicator	
Numerator	
Denominator	
Rationale for inclusion	
Data source and frequency of collection	
Organisation responsible for data collection	
Frequency of reporting to commissioner	
Baseline period / date	
Baseline value	
Final indicator period / date (on which payment is based)	
Final indicator value (payment threshold)	
Final indicator reporting date	
Rules for partial achievement of indicator at year-end	
Rules for any agreed in-year milestones that result in payment	
Rules for delayed achievement against final indicator period/date and/or in-year milestones	

⁶ Safety / Effectiveness / Experience / Innovation

⁷ May be several for each goal

⁸ Nationally mandated/ Regionally mandated / Regionally suggested/ No

CQUIN Definitions:

“Scheme”

The agreed package of goals and indicators, which in total, if achieved, enables the provider to earn 1.5% of its contract value. Where the provider has multiple contracts, the scheme should be reflected within all contracts, (exceptions specified within guidance).

“Goal”

A description of the intended objective which is being incentivised by the CQUIN scheme eg. “to improve patient satisfaction within maternity clinics”, or “to improve the health of the population by delivering effective stop smoking advice to smokers and ensuring referral pathways to the local NHS Stop Smoking Services” . A goal may be measured using several indicators (see below).

“Indicator”

A measure which determines whether the goal or an element of the goal has been achieved, and on the basis of which payment is made. The achievement of one indicator should not be dependent on the achievement of a separate indicator within the scheme.

“Payment threshold”

The level of performance against the indicator which must be achieved to earn payment. This should be informed by available evidence, (eg. a NICE Quality Standard, a National Service Framework or benchmarking) and by the provider’s own baseline. Where a baseline needs to be set in-year, the payment threshold may also need to be confirmed in-year.

In addition to the final indicator value, it may also be appropriate to agree payment thresholds for a) partial achievement of the indicator and/or b) in-year milestones. However any locally agreed rules should comply with the national policy on rewarding measurement through CQUIN schemes; acute schemes cannot reward measurement in 2010/11, hence any payments for in-year milestones should reward real process or outcome improvements only.

Annex 3 – National goal to reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)

1. Introduction and Background

Venous-Thromboembolism (VTE) is a significant cause of mortality, long-term disability and chronic ill health. The goal of the established National VTE Prevention Programme is to reduce avoidable death and long term disability from VTE. It is thought that there are around 25,000 deaths from VTE each year in hospitals in England⁹. There is strong evidence that many of these deaths are avoidable if a patient is assessed for risk of VTE on admission to hospital, with appropriate prophylaxis then provided based on national guidelines.

In 2004 the cost of treating established VTE in hospitals and the community was estimated at £640m annually by the Health Committee; and the overall burden of management and treatment of established VTE is suggested to consume around 1-2% of Western healthcare budgets¹⁰. In 2008, the financial cost of VTE in Australia was calculated at \$1.72 billion for a population of 21 million (0.15% of GDP)¹¹, which suggests that the £640m estimate by the Health Committee is a significant underestimate of equivalent costs in the UK.

The National VTE Prevention Programme in England (as implemented from the recommendations of Chief Medical Officer's VTE Expert Group¹²) is the most comprehensive of any healthcare system; development of VTE national indicators is therefore at the cutting edge of VTE prevention. Work has already been undertaken across the NHS particularly by the South West, East of England, North Lancashire Primary Care Teaching and Commissioning Trust as well as by Sir Muir Gray's Public Health Commissioning Network. VTE was included in many CQUIN schemes during 2009/10.

In September 2008 the Department published a national risk assessment template¹³ (developed in collaboration by CMO's team and NICE); and Connecting for Health are piloting an electronic version of DH/NICE risk assessment in the NHS.

The National Quality Board has already identified VTE prevention as a key area requiring quality improvement effort by the NHS. Early this year the Board recommended VTE prevention as one of four topics on which NICE should develop a quality standard.

The NICE VTE clinical guideline is due to be published in January 2010 and the quality standard is due to follow in March / April 2010. At this point the NHS in England will be in the unique position internationally of having a national risk assessment tool for preventing VTE in hospitals together with comprehensive national clinical guidance for appropriate thromboprophylaxis. Including a goal on

⁹ *House of Commons Health Committee Report on the Prevention of Venous Thromboembolism in Hospitalised Patients -Second Report of Session 2004-05*

<http://www.publications.parliament.uk/pa/cm200405/cmselect/cmhealth/99/99.pdf>

¹⁰ <http://ang.sagepub.com/cgi/content/abstract/48/1/67>

¹¹ <http://www.accesseconomics.com.au/publicationsreports/getreport.php?report=161&id=209>

¹² *Report of the Independent Expert Working Group on the Prevention of VTE in Hospitalised Patients*

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_073950.pdf

¹³ *National VTE Risk Assessment Template*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

VTE prevention within all acute CQUIN schemes in 2010/11 will help commissioners to ensure that these national best practice resources on VTE are effectively used for the benefit of patients at local level.

2. How will achievement be measured?

Achievement of this goal will be measured using the quality indicator:

% of all adult inpatients who have had a VTE risk assessment on admission to hospital¹⁴, using the national tool¹⁵

And payment will be triggered by achieving 90% or more.

Many hospitals already measure compliance with VTE risk assessment. It is anticipated that compliance with the risk assessment indicator across all trusts will be measured through a monthly Unify data collection, which we are aiming to have in place for 1st April 2010. The Department will pursue approval for this new data collection, with advice from NHS colleagues, through the Review of Central Returns (ROCR). Further guidance will be issued once the method of data collection is confirmed.

In line with good clinical governance, providers are expected to ensure that patients receive appropriate prophylaxis for VTE based on national guidance according to their risk assessment,¹⁶ and also to carry out root cause analysis on all confirmed inpatient cases of pulmonary embolism (PE) or deep vein thrombosis (DVT). Compliance with appropriate prophylaxis will be easier to audit following publication of NICE guidance for all hospitalised patients in January 2010 and RCOG guidance for prevention of VTE in pregnant women (which exists and is being updated). In support of the focus on VTE, commissioners may require providers to report on clinical audit of appropriate prophylaxis and root cause analysis of inpatient PEs and DVTs.

3. What action is required to define and agree this goal in local provider contracts?

The Commissioner and Provider need to complete the template below within the contract, including time periods on which performance is assessed, and ensuring a clear understanding of:

- Numerator and denominator
- Data collection arrangements and timings (pending clarification around proposed national data collection through Unify)
- Payment thresholds

¹⁴ This may include documented risk assessment carried out as part of pre-admission for elective patients. However providers will need to have reassessment protocols in place for such adults admitted to hospital.

¹⁵ The national risk assessment template was published by the Department of Health in September 2008 and developed with NICE for use in hospitals.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215. The tool will be updated when the new NICE guideline is published in January 2010.

¹⁶ A strategy of giving “blanket” thromboprophylaxis to all patients without risk assessment may lead to inappropriate prophylaxis

4. Who do we need to involve in working towards this goal?

Commissioner and provider representatives involved in contract negotiations should consider involving the following key stakeholders to support achievement against it during the year:

- Thrombosis Committees
- Risk and Audit Committees
- Clinical Governance / Patient Safety teams
- Collaboration for Leadership in Applied Health Research and Care (CLAHRC) partnerships
- Academic Health Science Centres (AHSCs)
- Health and Innovation Education Clusters (HIECs)

5. What action is required to support achievement of this goal during the financial year?

Providers will want to:

- ensure clinical staff understand the goal and are able to risk assess patients, record the outcome, prescribe and administer appropriate prophylaxis
- plan and organise data collection on risk assessment of all adult inpatients

A range of resources are available to local health economies in tackling VTE:

NICE guidelines:

- Clinical VTE guideline for all hospitalised patients due at the end of January 2010 (<http://guidance.nice.org.uk>)
- Until the new guideline is produced at the end of January: Clinical VTE Guidelines lines for surgical patients (Venous thromboembolism: reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery) <http://guidance.nice.org.uk/CG46>

National VTE Risk Assessment Template

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

Venous Thromboembolism Prevention: a Patient Safety Priority (June 2009)

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_101398

Published jointly between the All Party Parliamentary Thrombosis Group and the Department in June 2009 following the National Leadership summit for the NHS, this document provides:

- an overview and progress of the National VTE Prevention Programme
- links to VTE Prevention resources for the NHS including Commissioning for VTE.

National VTE Exemplar Centre Network

<http://www.kingsthrombosiscentre.org.uk/cgi-bin/kings/exemplarcentres.pl>

The mission of the National VTE Exemplar Centre Network is to share best practice and improve patient care through more effective prevention and treatment of VTE. This website provides a home for resources of the National VTE Exemplar Centre Network, the National Nursing Network and the National VTE Prevention Programme, and offers a single resource for healthcare professionals involved in thrombosis management.

South West SHA VTE Prevention Initiative

Providing a practical approach to the implementation of national guidance, the initiative is aimed at ensuring that all hospitals providing inpatient care in NHS South West develop a systematic approach to the prevention of venous thromboembolism. The initial focus has been a review of VTE prevention strategies across all acute trusts, independent sector treatment centres and Primary Care Trust provider services (community hospitals). Learning from this regional approach can be found at <http://www.kingsthorbosiscentre.org.uk/cgi-bin/kings/swsha.pl>

Map of Medicine VTE Prevention Pathway

<http://healthguides.mapofmedicine.com/choices/map/index.html>

The Map of Medicine¹⁷ has published a new pathway for the prevention of Venous Thromboembolism VTE in hospital patients in support of the National VTE Prevention Programme. It is now available online to NHS staff in England and Wales and will be made available to patients on Map of Medicine Healthguides, which are accessed via the NHS Choices website.

E-learning on venous thromboembolism: e-VTE

<http://www.e-lfh.org.uk/projects/vte/launch/>

e-learning programme has been developed by the Chief Medical Officer's VTE Implementation Working Group in partnership with e-Learning for Healthcare. Available to all, but of particular interest to health professionals, e-VTE aims to raise awareness of VTE prevention in the hospital setting as well as exploring the challenges in primary care.

e-VTE consists of a pre-learning questionnaire and a post-learning assessment, together with four sessions of e-learning (around 20 mins each) that cover:

- demographics, epidemiology and risk of VTE
- methods of thromboprophylaxis
- implementation of thromboprophylaxis in hospitals
- implementation of thromboprophylaxis in primary care.

¹⁷ a web-based, visual representation of evidence-based patient care journeys covering 28 medical specialties

Standard template for CQUIN scheme (for inclusion in contract)

Goals and Indicators

Goal no.	Description of goal	Quality Domain(s) ¹⁸	Indicator number ¹⁹	Indicator name	National or Regional indicator ²⁰	Indicator weighting
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	1	VTE risk assessment	Nationally mandated	[Insert local weighting]

Indicator 1 – VTE risk assessment

Description of indicator	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the national tool
Numerator	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the national tool
Denominator	Number of adults who were admitted as inpatients (includes daycases, maternity and transfers; both elective and non-elective admissions)
Rationale for inclusion	VTE is a significant patient safety issue, however outcome data on VTE is poor – post mortem studies suggest that only 1-2 in every 10 fatal pulmonary emboli is diagnosed. Whilst work is underway to improve reliability of outcome data, the process measure of VTE risk assessment will set an effective foundation for appropriate prophylaxis. This gives the potential to save thousands of lives each year.
Data source and frequency of collection	Monthly return through Unify [Insert further details to be provided by DH early in 2010]
Organisation responsible for data collection	[Insert Provider name]
Frequency of reporting to Commissioner	Monthly
Baseline period / date	[Insert local baseline period]

¹⁸ Safety / Effectiveness / Experience / Innovation

¹⁹ May be several for each goal

²⁰ Nationally mandated / Regionally mandated / Regionally suggested / No

Baseline value	[Insert local baseline value]
Final indicator period / date (on which payment is based)	[Insert final indicator period, which must be at least a full quarter]
Final indicator value (payment threshold)	90%
Final indicator reporting date	[Insert final indicator reporting date]
Rules for partial achievement of indicator at year-end	N/A
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	[Insert any rules for delayed achievement against final indicator period above]

Annex 4 - National goal to improve responsiveness to the personal needs of patients

1. Introduction and Background

Patients and the public justifiably expect public services which are responsive to their needs and driven by them. It has been estimated that this approach could contribute towards a saving in the NHS of more than £6.9 billion per year²¹.

There is a wealth of evidence which informs our understanding of what is important to patients in delivering personalised care²². A better patient experience and improved patient satisfaction will go hand in hand with service improvements. To provide national focus, and to complement locally defined CQUIN goals and indicators, we have considered what is important to patients alongside evidence which demonstrates room for improvement.

By examining these aspects of experience we have arrived at a new national CQUIN goal and indicator: “*Improving responsiveness to personal needs of patients*”, for inclusion in acute CQUIN schemes in 2010/11.

The nationally defined indicator for this national CQUIN goal uses results from the adult inpatient survey coordinated by the Care Quality Commission (CQC), which is an existing standardised national data source, collected to a common standard and with consistent definitions (see Appendix 1 for further details).

The new composite indicator is based on five survey questions, which collectively describe different elements of this overarching service theme: “*Improving responsiveness to personal needs of patients*”. The chosen questions reflect service issues that are consistent priorities for patients and the public and are applicable to all/most patients (eg rather than focussing on a particular pathway).

The indicator has been tested with SHAs, and the Department will continue to work with key stakeholders as CQUIN schemes are developed and agreed for 2010/11.

Using this indicator provides an opportunity to reward year-on-year improvements and sustained high levels of performance in patient experience. Also, a nationally consistent definition for the indicator allows organisations to benchmark and share good practice across the country. It is important to highlight that commissioners and providers can also continue to use locally defined indicators, in addition to the national indicator described here, to measure improvement across the full range of service and delivery issues that are of importance to local patients and service users. This includes “immediate feedback” initiatives that have been developed during 2009/10 following Alan Johnson’s request in September 2008.

Commissioners and providers may also wish to extend the general approach to identify patient experience indicators for areas not covered by the inpatient survey, but for which good local baseline measures are or could be established eg ambulance, community, mental health & learning disability services and other specialist services in acute settings such as maternity and paediatrics.

²¹ The Human Factor, Harris M and Bunt L, NESTA, 2009

By increasing levels of self-care and patient-focused approaches in health, the NHS could save more than £6.9 billion a year (£20.7 billion by 2014).

²² Survey Coordination Centre, Publications: Development Work
<http://www.nhssurveys.org/publications>

2. How will achievement be measured?

A single composite measure “*Improving responsiveness to personal needs of patients*” for each organisation has been defined for inclusion as a CQUIN indicator. This composite measure is made up of the following five survey questions:

- *Were you involved as much as you wanted to be in decisions about your care and treatment?*
- *Did you find someone on the hospital staff to talk to about your worries and fears?*
- *Were you given enough privacy when discussing your condition or treatment?*
- *Did a member of staff tell you about medication side effects to watch for when you went home?*
- *Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*

In identifying survey questions which explored responsiveness to personal needs, we looked for questions where there was both strong evidence that some Trusts are able to deliver good practice and also evidence of scope for significant improvement across most, if not all acute providers. The data source also needed to have a sufficient number of respondents at each organisation answering each question – so ensuring results give a representative and robust view of performance.

Performance on each of the five survey questions for each organisation will be calculated using the same method as for all previous adult inpatient surveys (i.e. each trust is scored out of 100 and, the higher the score, the more positive the experience). The composite indicator is then defined as the average of these 5 questions. See Appendix 2 for further details.

3. What action is required to define and agree the CQUIN goal in local provider contracts?

The 2009/10 adult inpatient survey is currently ongoing. The survey is coordinated by CQC but is conducted by local trusts themselves using standardised instruments and methodologies - some run the surveys in-house, but most do so via a specialist contractor which they directly procure (using an approved list set-up by CQC).

This delivery architecture has implications for when and how data are available to access and use – locally, regionally and nationally. The timetable and related activity for defining and agreeing this goal in local provider contracts is therefore as follows:

- Mid-January 2010: early data to be made available to trusts by the Department of Health and CQC – based on all data that has been collated nationally. This is an “early” version of the final data that CQC will eventually publish – which means that it is not standardised. The Department analysed early (January) and final/CQC (April-May) data from the 2008 survey, and found a high degree of reliability of early survey results in comparison to the final published data.
- January – March 2010: The Department’s analyses suggest that the early data will provide a sound basis on which to:
 - Initiate contract discussions
 - Identify a baseline position

- Agree arrangements for measuring improvement taking into account when the national survey results are available in 2010/11 (early data in mid-January 2011 with published results in April-May 2011)
- Agree payment thresholds – which may be subject to formal reconciliation using published data (see below). Benchmarked data for similar providers can be used to inform the setting of payment thresholds

The Department will also develop a tool for providers and commissioners enabling them to adjust data for known variations (eg to correct for the profile of survey respondents) for extra local precision.

- April – May 2010: CQC will publish the 2009/10 survey results. If necessary, commissioners and providers can adjust local payment thresholds at this point.

4. Who do we need to involve in agreeing and working towards this goal?

Commissioner and provider representatives involved in contract negotiations will wish to consider who in their respective organisations to involve in setting the achievement levels, as the use of this national indicator needs to be fully aligned with other locally defined indicators and initiatives. You may wish to include:

- Local public and patient engagement & experience (PPEE) leads
- SHA leads on PPEE, who can point to available guidance and tools as well as providing assurance
- CQC and acute patient survey coordination centre (eg. guidance on the survey programme and/or advice on running more frequent local surveys).

5. How should we go about setting payment thresholds locally?

The five survey questions (detailed in section 2) will be used to define a single composite indicator, giving each acute organisation a score out of 100. Commissioners and providers need to agree locally:

- What % of the overall CQUIN value will be linked to the national indicator
- What levels of achievement will be required for payment

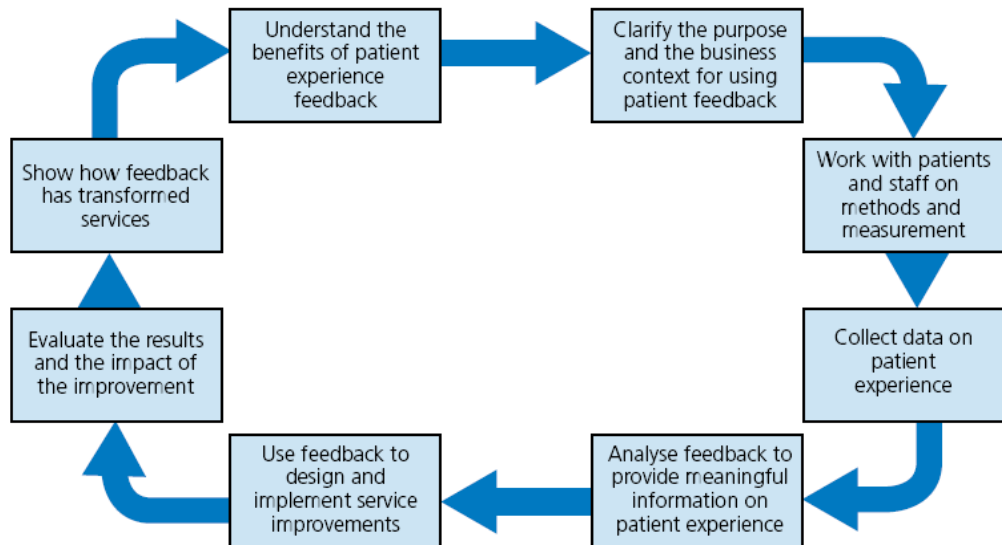
One option might include splitting payment between a reward for improvement against baseline (measured in points out of 100) and a separate reward for exceeding an absolute value (which could be the national average score for this indicator in 2009/10). However, commissioners will wish to take local provider baselines into account when setting a payment threshold to encourage ambition.

The Department will prepare detailed guidance to assist organisations in understanding and benchmarking their own performance. The guidance will be complemented by benchmarking support tools, developed rapidly with input and comment from SHA colleagues. It will address how to use survey based data to set appropriate thresholds, taking account of margins of error in the data.

6. What action is required to support achievement of this goal during the financial year?

Organisations will wish to consider how the scheme fits with their own locally agreed processes for capturing and using patient/user feedback to monitor service quality and inform local improvement activities. This might include the use of other locally

defined indicators within CQUIN schemes. The patient experience feedback cycle may be of help at this point²³:



Patient experience feedback cycle diagram

A range of support tools and packages are available to help local organisations monitor and improve the experience of their patients' and service users in-year. This includes:

- A support service for trusts that provides advice and guidance on how to capture patient feedback, conduct surveys, and use the results to inform local improvement activities. This can support more frequent, comparable monitoring if required. This is run by the NHS acute patient survey coordination centre, and they can be contacted by telephone (01865 208127) or by e-mail (advice@pickereurope.ac.uk). Further information is available from the coordination centre website at <http://www.nhssurveys.org/localsurveys>
- A series of patient experience data toolkits, aimed at assisting organisations to identify areas where nationally available data suggests they could focus on in their local improvement activities. These are available on the Department of Health website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091660
- In the past, case studies of best practice have typically been collected and used locally and regionally. To build on this local work, the Department has recently commissioned the NHS Institute (NHSI) to collate a range of examples/case studies, along with evidence of what works and why. This work will form part of an on-line support network for the sharing of best and effective practice across the NHS. This is due for launch early in 2010, and will be available from the NHSI website: http://www.institute.nhs.uk/nhs_alert/patient_experience/patient_experience.html

²³ The patient experience feedback cycle is taken from “*Understanding what matters: A guide to using patient feedback to transform patient*”, which is available from the Department of Health website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099780

- The NHSI have also recently developed a pilot Patient Experience Action Learning Set: this new course focuses on how to better use patient feedback and self-defined outcomes to develop and meet local patient experience and service improvement goals. The course is fully subscribed for this year, but the Institute are taking requests for future roll-out; please contact them direct for further details (patientexperience@institute.nhs.uk).

Standard template for CQUIN scheme (for inclusion in contract)

Goals and Indicators

Goal no.	Description of goal	Quality Domain(s) ²⁴	Indicator number ²⁵	Indicator name	National / Regional indicator ²⁶	Indicator weighting
2	<i>Improve responsiveness to personal needs of patients</i>	Patient experience	2	Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey	Nationally mandated	[Insert local weighting]

Indicator 2 - Composite indicator on responsiveness to personal needs

Description of indicator	<p>The indicator will be a composite, calculated from 5 survey questions.</p> <p>Each describes a different element of the overarching theme: “<i>responsiveness to personal needs</i>”:</p> <ul style="list-style-type: none"> Involved in decisions about treatment/care Hospital staff available to talk about worries/concerns Privacy when discussing condition/treatment Informed about medication side effects Informed who to contact if worried about condition after leaving hospital
Numerator	Index-based score reflecting positive responses to the 5 questions within the composite indicator
Denominator	N/A
Rationale for inclusion	The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England.
Data source and frequency of collection	Adult inpatient survey, from the CQC nationally coordinated patient survey programme. The survey is conducted annually between October and January for patients who had an inpatient episode between July and August.
Organisation responsible for data collection	[Insert name of responsible organisation: either provider or their appointed contractor]
Frequency of reporting to Commissioner	Annually:

²⁴ Safety / Effectiveness / Experience / Innovation

²⁵ May be several for each goal

²⁶ Nationally mandated / Regionally mandated / Regionally suggested/ No

	<p>1) Early local data (mid-January 2011)</p> <p>2) Published data. (April-May 2011)</p>
Baseline period / date	Adult inpatient survey 2009/10 (based on inpatient episodes between July and August 2009)
Baseline value	[Insert local baseline value based on local data available in mid-January 2010]
Final indicator period / date (on which payment is based)	Adult inpatient survey 2010/11 (based on inpatient episodes between July and August 2010)
Final indicator value (payment threshold)	[Insert final indicator value]
Final indicator reporting date	[Insert final indicator reporting date, including any local arrangements for final payment adjustments arising from official data before 2010/11 accounts are closed.]
Rules for partial achievement of indicator at year-end	[If agreed locally, insert rules for partial achievement]
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	N/A

Annex 4, Appendix 1 – Background on the national patient survey programme

The survey programme is designed to provide robust organisational measures on service quality from the *patients' point of view*, and each questionnaire contains a wide range of questions asking patients detailed questions about different aspects of their treatment/care.

The programme²⁷ is run on a devolved basis: CQC have responsibility for developing and coordinating the surveys, while acute trusts are responsible for conducting (and paying for) their own local survey using a standardised instrument and methodology and in line with an agreed timetable. While some trusts conduct their survey in-house, most contract out this work to one of 12 contractors that are approved by CQC.

The annual survey follows a specific timetable, which is in place for the survey that is currently underway. This involves the following:

- Autumn 2009: trusts select their sample based on patient records identifying patients who had an inpatient episode between July-August
- October 2010 - January 2010: survey fieldwork
- Mid-January 2010: trusts submit their local results and a raw national data-set is collated (containing results from all participating trusts) – although trusts, or their approved contractor, will have the early/local data in advance of this date (December 2009 - January 2010)
- February 2010: centrally collated data is cleaned/quality assured by CQC
- March 2010: local benchmark reports for each organisation produced by CQC. (This data is standardised by sex-age and pathway, to ensure that stable comparisons can be made across organisations)
- April-May 2010: CQC provide trusts with final survey results. (The date on which CQC will formally publish the results is yet to be decided.)

²⁷ Further information on the national patient survey programme is available on the CQC website, as well as the acute patient survey coordination centre:

<http://www.cqc.org.uk/usingcareservices/healthcare/patientsurveys.cfm>
<http://www.nhssurveys.org/>

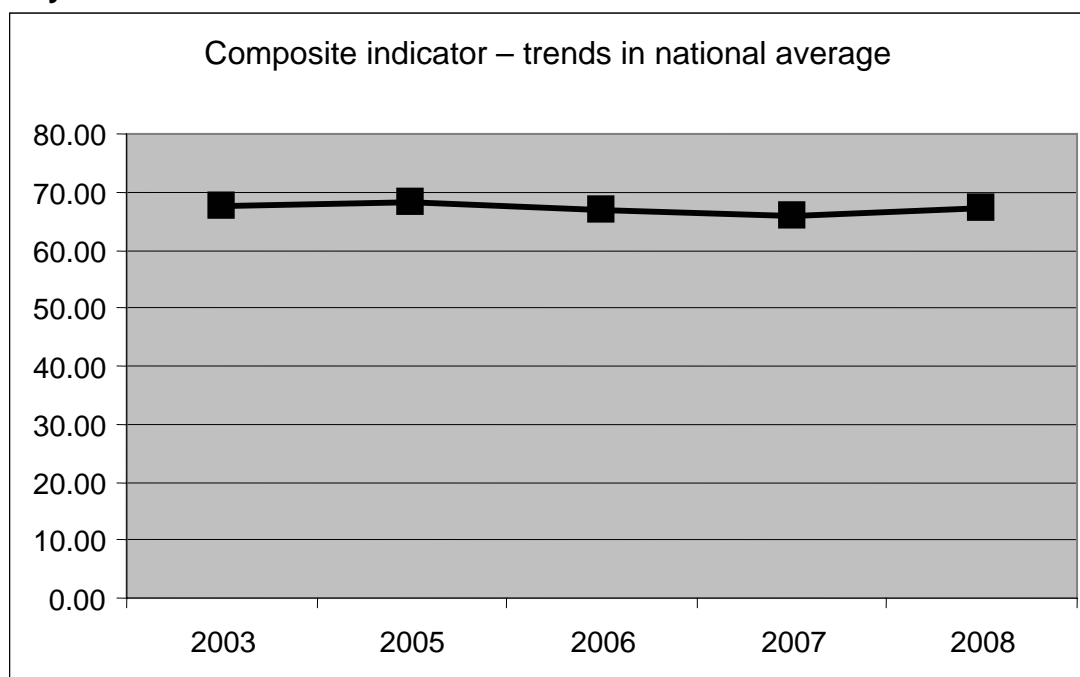
Annex 4, Appendix 2 – An illustration of a composite measures approach

The use of composite indicators is consistent with use of survey data by DH and CQC in the past, and it provides an additional degree of robustness/stability in the data as a performance and improvement measure.

The composite indicator is calculated by taking an average across the five questions that make up the indicator. This approach is in line with the methods used by both DH (eg for PSA 19.1 – “improving patient experience”) and CQC (in the Annual Health Check). We have produced an illustration of NHS performance on this goal using data from previous surveys

Using data for the five indicator questions from the adult inpatient survey, composite scores can be calculated from recent surveys.

- **At national level, performance has been fairly static over a number of years²⁸**



- **But trust-level performance differentials are wide²⁹.**

²⁸ The national average in the most recent data from the 2008 survey is 67.07. This compares to 66.02 in 2007; 67.03 in 2006; 68.23 in 2004; and 67.40 in 2003.

²⁹ In 2008, trust-level performance ranges from 56.94 through to 83.40.

Baseline performance: Scores against the indicator in 2008

