

Using the Commissioning for Quality and Innovation (CQUIN) payment framework

For the NHS in England 2009/10

DH INFORMATION READER BOX

Policy HR/Workforce Management Planning Clinical	Estates Commissioning IM & T Finance Social Care Partnership Working
Document purpose	Procedure – new
Gateway reference	10852
Title	Commissioning for Quality and Innovation (CQUIN) Payment Framework
Author	Department of Health
Publication date	08 December 2008
Target audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, Directors of Finance
Circulation list	NHS Trust Board Chairs, Special HA CEs, Directors of Finance, Communications Leads, Emergency Care Leads
Description	The Commissioning for Quality and Innovation (CQUIN) payment framework will allow all local health communities to develop their own scheme to encourage quality improvement and recognise innovation by making a proportion of income conditional on locally agreed goals.
Cross reference	The NHS in England: the Operating Framework for 2009/10 Standard NHS contract for acute services & supporting guidance
Superseded documents	NA
Action required	All PCTs and providers on NHS standard contracts should include in their 2009/10 contract a scheme to link payment to quality
Timing	By 2009/10
Contact details	CQUIN.payment.framework@dh.gsi.gov.uk. Policy & Strategy Directorate Department of Health 79 Whitehall London SW1A 2NS
For recipient use	

Contents

Introduction	4
Context	5
Description of the CQUIN payment framework	8
Approach to implementation	9
Values and Behaviours	10
Scope of the CQUIN framework	11
The content of a local CQUIN scheme	13
Funding the CQUIN framework	14
Timetable	15
Process for developing a CQUIN scheme	17
Support and assurance	26

Introduction

1. *High Quality Care For All* included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.¹ This document introduces the CQUIN payment framework in context, and describes the framework and how it will operate for 2009/10, including the approach to implementation. It then sets out the scope, the content that local schemes should cover, explains how the framework is funded, gives an outline of the timetable and how the process for using the framework might work, and finally describes the support and assurance for local schemes. This guidance will be reviewed for 2010/11 on the basis of local experience.
2. This guidance should be read in the context of the 2009/10 Operating Framework, the revised acute contract and new contracts for community, mental health and ambulance services.² These require commissioners and providers to ensure that all contracts for 2009/10 link payment to quality improvement. For the acute sector, this should be through a CQUIN scheme linking payment to specific locally determined goals. In community, mental health and ambulance services, Primary Care Trusts (PCTs) and providers have the option of developing a CQUIN scheme or linking payment to an agreed quality improvement plan, which could have simple, practical steps to develop their systems for monitoring and improving quality. This option will be available in 2009/10 as an interim stage. From 2010/11, all organisations will need to develop CQUIN schemes, and should be moving towards agreeing goals that reflect measured improvements in performance on quality, building on the progress in developing common indicators to support benchmarking.
3. The key aim of the CQUIN framework is to support a shift towards the vision set out in *High Quality Care For All* of an NHS where quality is the organising principle. The framework has been developed with those working in the NHS, to help produce a system which actively encourages organisations to focus on quality improvement and innovation in commissioning discussions and so to stretch themselves, improve quality for patients and innovate. This will build on, but not replace, existing initiatives such as the separate and different *Advancing Quality* programme in NHS North West.³ Over time, it is expected that the CQUIN framework, and how organisations use it locally, will develop and mature. This will be a collaborative process where Strategic Health Authorities (SHAs), PCTs and providers, supported by the Department where necessary, share information on what works and develop more effective ways of encouraging improvement.

1 *High Quality Care For All: NHS Next Stage Review Final Report* (2008) Dept of Health, para 3.41

2 The Operating Framework for 2009/10 and the standard NHS contracts are available at www.dh.gov.uk

3 The NHS North West *Advancing Quality* scheme is a separate programme that pays additional money to the highest achieving hospitals in the area based on common indicators. The CQUIN framework will operate alongside and complement the *Advancing Quality* in the North West. www.advancingqualitynw.nhs.uk/

Context

4. Ensuring high quality care for everyone will deliver better and fairer outcomes for patients, more satisfying work for staff, and a better value system. The Next Stage Review set out visions for high quality services, both nationally and regionally, and outlined new developments to enable and support the NHS to put quality at the very heart of everything the NHS does. This has to start with local teams and health systems. It will not be achieved through one single initiative, but by enabling NHS staff to better understand the quality of care they provide, discuss how it can be improved and implement practical and innovative plans for improvement.
5. The CQUIN framework forms one part of the overall approach on quality, which includes: defining and measuring quality, publishing information, recognising and rewarding quality, improving quality, safeguarding quality and staying ahead. The CQUIN framework is intended to support and reinforce other elements of the approach on quality and existing work in the NHS by embedding the focus on improved quality of care in commissioning and contract discussions. This will be one element of the ongoing dialogue between commissioners and providers on quality improvement and is not about imposing an economic model of quality improvement on the NHS.
6. The CQUIN framework links closely to the emphasis in the Next Stage Review on needing to measure what we do as a basis for transforming quality. The vision is for an NHS where teams consistently measure what they do, using good and timely information as a basis both to improve the care they provide and to compare themselves with others. Measurement should guide innovation and improvement efforts – it is not an end in itself, only a means to the end of better quality.
7. The engagement process already underway with NHS staff on appropriate quality measures and work on clinical dashboards will be central to ensuring better information on quality is available and accessible to clinical teams.⁴ As part of this process, NHS staff and organisations can consider which of these areas of care requiring improvement could benefit from an additional emphasis at Board level and hence might be most appropriate for inclusion in their local CQUIN scheme.
8. Over time, the CQUIN scheme will also allow commissioners and providers to focus attention on some of the small number of measures, currently being developed with the NHS, which will be common across the system. This will include measures at the level of the team, as well as at the organisational, regional and national level. As more information becomes available on how organisations achieve on these quality measures, commissioners and providers will be able to benchmark their quality against

⁴ The approach to Measuring For Quality Improvement is available at www.ic.nhs.uk/cqi

similar providers. This will inform what level of quality providers should be aiming for, and the sufficiently stretching CQUIN goals they should be setting to achieve this. The development of priorities and indicators for CQUIN schemes will therefore be part of the wider approach on measuring for quality improvement, enabling benchmarking.

9. Similarly, the CQUIN framework also links to other developments on quality. The agreed CQUIN schemes, and achievement against them, would be a natural part of the Quality Accounts to be published by providers.⁵ The proposed Quality Observatories may be involved in supporting organisations in developing their CQUIN schemes, depending on their agreed role regionally.
10. NHS organisations can also use the CQUIN framework to focus attention on innovation – one of the areas highlighted in the Next Stage Review – by giving greater recognition for innovative work being developed and disseminated by providers. The innovation process is commonly divided into three stages: invention, innovation (or adoption) and diffusion. Invention is the initial conception of an idea; adoption is the first application of the idea to actual practice; and diffusion is the process by which others adopt the innovation. This framework can apply to different types of innovation, for example within pharmaceuticals, medical technologies and service delivery.
11. The CQUIN framework is only one of several drivers for innovation in the NHS, and it is expected that it would be used mainly to promote adoption and diffusion, rather than invention. It is also more likely to be appropriately linked to achieving spread and sustainability of innovative service delivery, either within the organisation or to other providers, rather than for pharmaceutical or medical technology innovation. The CQUIN framework is not expected to provide a mechanism for investment in large-scale change. Rather, it will support a shift towards a culture where innovation is part of what the NHS does and recognises locally. The framework will complement other initiatives such as innovation prizes and the Innovation Fund, the latter being available to support projects requiring extra investment.
12. The CQUIN framework works alongside other financial levers which together reinforce the approach to improving quality and encouraging innovation. It fulfils a different role to the financial penalties linked to failure to achieve fundamental levels of quality and safety. For example, ensuring that these fundamental levels of quality and safety are maintained will remain the role of the regulator and one of their enforcement tools is the ability to impose fines for breaches of registration requirements. In a limited number of key areas, commissioners are able to impose penalties for serious failures in quality, for example a provider not achieving reduced

5 Quality Accounts were announced in *High Quality Care For All: NHS Next Stage Review Final Report*.

levels of healthcare associated infection. In addition, the National Patient Safety Agency is consulting with PCTs on a list of 'Never Events', which will be available in 2009/10 to highlight key failures of patient safety. The future development of this work will include consideration of how this might link to payment systems, but it is not intended that this would be part of the CQUIN framework.

13. The CQUIN framework is intended to encourage stretch and should be about continuous improvement beyond the minimum, helping ensure that improved quality of care, better outcomes and innovation form part of discussions between all commissioners and providers.

Description of the CQUIN payment framework

14. The aim of the new CQUIN payment framework is to support a cultural shift by embedding quality improvement and innovation as part of the commissioner-provider discussion everywhere. The framework is intended to ensure contracts with providers include clear and agreed plans for achieving higher levels of quality by allowing PCTs to link a specific modest proportion of providers' contract income to the achievement of locally agreed goals. All providers should be able to earn this money, but will not have an automatic right to be given it. The locally agreed goals, which should be stretching and realistic, will be discussed between co-ordinating commissioners and providers, with support and oversight from the SHA, and included as part of contracts.
15. This approach makes quality improvement and innovation integral to what commissioners pay for rather than assuming that more money is always needed to drive them. PCTs will continue to be free to invest additional money if they consider it appropriate, but the key principle of the CQUIN framework is that everyone should be aiming for continuous quality improvement resulting in better outcomes.
16. Initially, we expect many organisations will choose to use contracts and the framework to focus on data collection on quality, supporting the wider emphasis on measuring for improvement. This may involve collecting data to establish a baseline of performance in an area of care where the commissioner and provider agree quality improvement is needed. CQUIN schemes could also be used to encourage improvement in the quality of data collected, or help develop metrics for innovation. Where organisations feel they have good quality data they may choose to focus on quality improvement from the start.
17. It is expected that every organisation will move to using the framework to reflect specific quality goals which represent measurable improvements on previous quality performance and innovation aimed at better outcomes. For example, if there are concerns about stroke services, the provider could undertake to increase the percentage of stroke patients who have access to scanning within three hours of admission – a process known to improve outcomes – to an agreed level. There should be a particular focus on outcome measures wherever possible, but proxy measures known to result in improved outcomes can also be used. Outcome measures should not focus only on clinical indicators, but also include patient-reported measures, e.g. Patient Reported Outcome Measures and patient experience indicators.
18. The framework aims to encourage improvement for all providers, whatever their starting point. As more benchmarked information becomes available, it will become easier to identify opportunities for greater improvement, and use this framework to drive up quality and innovation. We would therefore expect that commissioners and providers will change the areas for improvement over time and become more ambitious in their local schemes. The aim is that all commissioners and providers focus on quality improvement – not only in contract discussions, but in year-round quality review conversations – and that this translates into better quality of care for patients.

Approach to implementation

19. The CQUIN payment framework has been developed – and will need to be used – in ways that reflect the four guiding principles of implementing the Next Stage Review (NSR): co-production, local clinical engagement, subsidiarity and system alignment.⁶
20. **Co-production** has been key to the design of this framework and will be key to its implementation: the design of the CQUIN framework, as described in this document, has been developed through discussions with colleagues in the NHS and independent sector. It builds on their experiences, as there are already many good local and regional quality improvement initiatives in the NHS, some of which use incentives and/or bring quality and innovation into commissioning discussions. Local experiences, and lessons learnt, will inform future steps, nationally and locally so that the framework can continue to be developed in partnership with the NHS.
21. To achieve greatest benefit, **local clinicians**, their teams, support staff and practice based commissioners will need to be involved in the development of CQUIN schemes, which should use clinically meaningful indicators – as demonstrated by similar schemes already running successfully.
22. Consistent with the **subsidiarity principle**, the framework has explicitly been designed to allow commissioners and providers as much flexibility as possible. Organisations can apply it locally in a way which will build on and support the good quality improvement initiatives which already exist. There are a few broad national parameters, where NHS colleagues have advised they are needed, and these are explained in this guidance.
23. Local CQUIN schemes will work best when the **system is aligned**, and the schemes are used in conjunction with wider work on improving quality and increasing innovation as described above. CQUIN schemes will allow PCTs to demonstrate their World Class Commissioning competencies, for example involving primary and secondary care clinicians in agreeing how to improve care for patients will help commissioners demonstrate competency four – clinical engagement. The overall development of their local CQUIN scheme will help demonstrate competency eight – improvement and innovation.⁷ The CQUIN framework should be seen within the wider context of a strengthened focus on quality where providers strive for excellence, supported by better data on quality, PCTs develop into world class commissioners and they work together to improve quality of care for patients.

6 The four guiding principles were set out in the NHS Chief Executive's letter to SHA Chief Executives on 5 August 2008. Letter available at www.dh.gov.uk

7 World Class Commissioning competencies available at www.dh.gov.uk

Values and Behaviours

24. In keeping with the guiding principles of NSR implementation given above, the CQUIN framework allows flexibility for NHS organisations to shape local CQUIN schemes to reflect their own aspirations and visions for better quality care. It can therefore be integrated into their wider work on commissioning for quality and innovation as part of World Class Commissioning or specific programmes such as the Quality Framework for Community Services.
25. The framework provides an opportunity for commissioners and providers to focus on delivering higher levels of quality of care for their populations, rather than responding to centrally directed targets. Organisations will also be able to demonstrate professionalism in measuring, monitoring and improving quality. The expectation is that commissioners will be able to use their scheme to help reduce inequalities and promote equalities, provide more personalised and integrated services, looking across pathways of care, and deliver better outcomes for patients.
26. The development of CQUIN schemes should reflect the duty of partnership and will be most effective where there are strong local relationships, good clinical engagement and a clear direction of travel. Commissioners and providers should work together, supported by the SHA and making use of energy and enthusiasm locally, to identify good opportunities for improvement, not just focusing on the 'easy' options. This will be an ongoing process which will result in changes to the quality goals as priorities change and as better comparable information on quality emerges. Local schemes should not be about 'getting to average', rather about aspiring to excellence and identifying clear goals for improved quality, which progress towards this.
27. Inevitably, this will be a developmental journey, through which organisations, their Boards and partners will need to work together to improve quality and innovate for the benefit of patients. This will require clear leadership, mature dialogue, and involvement of clinical teams, inside and outside the organisation, to develop CQUIN schemes and to monitor progress on quality throughout the year.
28. It will be important to develop practical schemes which work to improve levels of quality, rather than trying to cover all potential areas of quality improvement. Particularly in the initial years, as organisations familiarise themselves with the framework, there is a strong argument for keeping schemes simple. However, there is a clear expectation that commissioners and providers should be looking to link payments to demonstrably higher levels of quality for patients. Where organisations are not initially able to do this, they should be clear about how they will progress towards a CQUIN scheme linked to better quality of care.

Scope of the CQUIN framework

29. Quality and innovation should form part of commissioner discussions with all types of providers. The intention is that the CQUIN payment framework will apply to all services covered by national standard contracts. This means it will cover acute, community, mental health, ambulance and specialised services⁸ as well as independent sector providers and Foundation Trusts on national standard contracts. The revised acute contract and new mental health, ambulance and community services contracts reflect the requirement to link payment to quality.⁹ Where Foundation Trusts are not on standard contracts, they will wish to discuss with their coordinating commissioner how to include a CQUIN scheme in their contract to ensure they have the opportunity to earn the CQUIN money.
30. Where appropriate, and with the agreement of the provider, PCTs could consider applying the CQUIN framework to other areas not covered by national standard contracts. The framework is not intended to replace nationally negotiated primary care incentive schemes, such as the Quality and Outcomes Framework for GP services, but it could be applied to out of hours services or local enhanced services for primary care. In addition, in areas where Integrated Care Organisations are being piloted those involved may wish to discuss how to apply the principles of the CQUIN framework to the care they are providing.
31. In the areas covered by national standard contracts, the CQUIN framework will apply to all patient-related activity. This includes activity reimbursed as part of the Payment by Results system, as well as other activity.
32. The CQUIN framework is not intended to replace existing local quality initiatives. Nor it is expected that it will be the only conversation that commissioners and providers have on quality and innovation. Rather it should be used as a springboard for further development, building on existing work. There are a number of existing quality incentive schemes already being used locally and regionally to encourage greater quality improvement. As they preceded the CQUIN framework, most existing initiatives involve the PCT choosing to invest additional money. As with all other PCTs, they remain free to continue doing this and will want to consider how to link their existing work with their local CQUIN scheme.

8 Specialised in this context, and where the term is used in this document, refers to those services commissioned by Specialised Commissioning Groups and the National Commissioning Group.

9 Guidance on the national contracts more generally is available at www.dh.gov.uk. The elements covering the CQUIN framework are primarily at Schedule 3, Part 4 (CQUIN indicators and quality improvement plan) and Schedule 18 (payment mechanisms for locally agreed scheme).

Building on existing schemes: Ensuring effective clinical engagement

Based on national drivers, local intelligence and data collection, and the patients' perceptions of local health care services, **Doncaster PCT** agreed to support the development of 'aspirational indicators' that would support innovative practice and improve patient experience.

Doncaster PCT has agreed a set of quality indicators with its community services provider arm and local Foundation Trust. These indicators were developed in partnership with patients, strategic managers and clinical leads. Hosting a range of interactive workshops a 'sieve and sell' technique facilitated the development of indicators across patient pathways. Individual organisations identified areas of quality which they would like to see improved in four key areas (diabetes; falls; maternity and children's services). Having agreed their organisation's indicators they then met to 'sell' their preferred areas to be incorporated into the other organisations' quality goals.

Examples include:

- Prevention of falls in primary care and improved access to treatment reviews for those patients who have sustained a fracture due to a fall in hospital
- Improved communications and handovers between hospital and community maternity services
- Reducing inappropriate hospital follow-up of diabetic patients and improving information for those diabetic patients cared for in the community.¹⁰

10 Further details are available at www.doncasterpct.nhs.uk or contact Dee.Sissons@doncasterpct.nhs.uk

The content of a local CQUIN scheme

33. To ensure CQUIN schemes cover the three different dimensions of quality identified in *High Quality Care For All* and recognise innovation, commissioners and providers should ensure that local schemes cover:

- Safety
- Effectiveness (including clinical outcomes and patient reported outcomes)
- User experience (including timeliness of provision)
- Innovation

Schemes should include at least one area for improvement in each of these domains.

34. The actual content of the schemes is for local discretion and discussion between the commissioner and provider. Whilst some areas to consider are suggested in this guidance, these are not requirements. In looking across these domains, commissioners and providers may wish to consider how to promote fairness and integrated care. This could be through linking indicators to the underlying care pathway, promoting re-design and integration across pathways, perhaps in areas highlighted through regional NSR visions. There are also likely to be opportunities to reduce health inequalities and promote equality.

35. For the acute sector, commissioners and providers may wish to recognise collection of the four Patient Reported Outcome Measures (PROMs) to reinforce the importance of these measures, now mandated in the acute contract for 2009/10.

36. Some local areas have already been working to develop their CQUIN schemes for 2009/10 and, as schemes are finalised, there will be significant potential for sharing this information across the system, to accelerate learning on what works. The NHS Institute's PCT Portal would provide a useful vehicle for bringing the schemes together in one place. It is therefore suggested that commissioners publish their local CQUIN schemes on the PCT Portal, for the mutual benefit of commissioners and providers.¹¹

11 The NHS Institute for Innovation and Improvement's PCT portal is available at www.institute.nhs.uk/pctportal

Funding the CQUIN framework

37. In line with the principle that payment should reflect quality as well as volume, the 2009/10 financial planning framework defines the financial resources that PCTs will be able to link to locally agreed CQUIN schemes. Last year, in addition to cost pressures, tariff uplift included an explicit element for quality. This year, the planning framework separates this out into a specific amount of money for CQUIN schemes that allows PCTs and providers to agree what quality improvement this money should be linked to.¹² Providers will have a right to have the opportunity to earn this money through a locally agreed scheme, but it will not automatically flow through to providers as it would have in previous years.
38. The CQUIN money will be a modest proportion of a provider's income initially and is likely to increase over time, as use of the framework moves beyond data collection to reflect measured improvements in quality of care and innovation. The proportion is decided nationally to ensure that all providers have a similar opportunity to earn this money, and any future increases will take into consideration the wider financial context. In 2009/10, the CQUIN payment framework will cover 0.5% of a provider's annual contract income.
39. It is expected that each commissioner will need to calculate the expected value of the CQUIN money for the provider, based on their estimated activity levels. This would be 0.5% of the total of provider's anticipated tariff income, including the Market Forces Factor, and their non-tariff income.¹³ The coordinating commissioner would reflect the total expected amount of CQUIN money in the contract. The total amount may need to be adjusted later in the year to reflect any variation in activity levels.
40. Where funding is received from other sources, for example where patients from outside England are receiving treatment in English providers, the CQUIN money may not necessarily be 0.5% of total provider patient related income. Where services are commissioned jointly with other agencies, it is assumed that the CQUIN scheme will apply only to that which is financed by the NHS, unless alternative arrangements are agreed locally.¹⁴ SHAs will have a role in ensuring that the total value of the CQUIN money agreed is fair and appropriate.
41. There will be the flexibility within the CQUIN payment framework for PCTs to offer specific additional investment linked to the achievement of exceptionally stretching quality improvement goals.¹⁵ However this would be for local discussion and there is no expectation that if a provider does exceed their goals that they would receive additional funding. As currently, the use of additional money will be for PCT discretion.

12 Further information on the uplift is contained in the 2009/10 Operating Framework at www.dh.gov.uk

13 It is expected that this would be equivalent to 0.5% of the annual contract value. The final payment will be based on a percentage of the actual outturn value, to reflect any variation in activity.

14 It is recognised that services with pooled budgets will require specific discussions between the relevant commissioners on the value of the CQUIN money.

15 If the commissioner and provider wish to agree a separate incentive scheme, this should be recorded in Schedule 18, Part 3 of the contract.

Timetable

42. Developing and introducing local CQUIN schemes will be challenging and different sectors are at different starting points: use of the framework will develop over time. There may be particular capacity issues where a particular PCT is coordinating commissioner for many different providers.
43. In the acute sector, the development of the schemes can build on the fact that contracts and data systems tend to be more mature, but introducing schemes may be more challenging for providers in non-acute sectors. Given the variation in current practice and availability of data, it is recognised that in many areas it may be difficult for some sectors to produce effective CQUIN schemes for 2009/10. However, there is an expectation that if providers wish to gain the CQUIN money for 2009/10, they will need to agree some form of action aimed at improving quality. The type of actions agreed will vary depending on the sector. This will be a short term position, before they are expected to move towards developing full CQUIN schemes and linking the money to defined improvements in levels of quality.
44. In the acute setting, the amendments to the national contract for 2009/10 specified in the Operating Framework include the requirement to agree a CQUIN scheme as part of the contract, which links 0.5% of contract value to specific quality and innovation goals. The scheme will need to be outlined in Schedule 18, Part 2 of the acute contract, with the indicators listed alongside other quality indicators at Schedule 3, Part 4C.¹⁶
45. In community, mental health and ambulance services, where national standard contracts are entirely new for 2009/10, and for those on specialised service contracts, commissioners and providers may initially wish to focus on developing an agreed quality improvement plan.¹⁷ This plan could focus on simple, practical steps to develop systems for monitoring and improving quality and could help commissioners and providers prepare to introduce CQUIN schemes in the following year. For example, mental health providers and commissioners may choose to link the CQUIN money to the Services Quality and Safety Improvement Plan agreed as part of their contracts. For community services, the money could be linked to the plans for continual service improvement agreed as part of service specifications. Commissioners and providers will wish to bear in mind links to other planned improvement work, for example the Quality Framework for Community Services.
46. Where commissioners and providers on mental health, ambulance and community contracts agree that they have sufficient capacity and availability of data, they will have the option in 2009/10 of going further than a quality improvement plan and developing a full

¹⁶ The revised acute contract and new mental health, ambulance and community service contracts are available at www.dh.gov.uk.

¹⁷ The exact position of the relevant text in non-acute contracts varies depending on the contract, however the relevant schedules will be Schedule 18 and Schedule 3, Part 4. The Quality Improvement Plan will need to be reflected in Schedule 3, Part 4 of the contract.

CQUIN scheme with specific quality goals linked to a proportion of contract value. This will be a requirement for 2010/11.

47. In 2009/10, SHAs will have a key role in supporting and encouraging the development of local CQUIN schemes, providing a formal assurance function, and ensuring that any agreement linking money to quality improvement plans is realistic and fair. SHAs will also have a key role in helping commissioners and providers on non-acute contracts prepare for 2010/11, when they will need to move from quality improvement plans to developing a CQUIN scheme with specific indicators to be included in contracts. If commissioners and non-acute providers choose to focus on developing a quality improvement plan in 2009/10, it is expected that their first year of using the CQUIN framework i.e. 2010/11 may focus on data collection.

Process for developing a CQUIN scheme

48. To develop a local CQUIN scheme, organisations will want to select priorities for improvement, identify agreed evidence based, relevant and robust indicators and agree improvement goals. The final schemes, and achievement against previous years (when available), should then be published, for example in Quality Accounts. Commissioners and providers should be aiming for a high quality, auditable process with clear definitions of indicators and goals, and criteria for payment. In the first year, organisations may wish to focus on just a few areas to ensure the scheme is workable. At each stage, commissioners and providers will wish to seek input from appropriate sources, for example practice-based commissioners, provider clinicians, public health experts, patients and the public.
49. As this is part of the contract process, the coordinating commissioner should lead discussions on the provider's CQUIN scheme. This is intended to ensure that, as far as possible, each provider has only one CQUIN scheme. If, in specific circumstances, there is no coordinating commissioner, PCTs,

Working to develop a CQUIN scheme

Westminster PCT and **Imperial College Healthcare** have collaborated to implement an ambitious programme of change that puts measuring quality at the heart of the joint working between the PCT and Trust. The two organisations have initiated a joint Trust/PCT clinical group to steer quality improvement. The PCT and Trust will build on and accelerate existing work by applying the CQUIN framework to its existing quality improvement approach.

The measures focus on key areas for change across the health economy and link to the areas of concern prioritised by patients in the borough as well as national and local clinical priorities. Westminster and Imperial will apply the CQUIN framework methodology to develop their local scheme as follows:

- ensure a rigorous process of prioritisation to the measures, including reviewing feedback from the local population and benchmarking of national priorities
- review routes of information collection and new ways of measuring outcomes in a timely manner
- map incentives and penalties and their impact on leveraging improvements in quality
- ensure that clinicians are placed at the heart of quality and leading change through a health economy wide clinical group.

The pilot includes measures of safety, effectiveness and a particularly innovative patient experience scheme where real time experience information will be collected starting early 2009.

NHS London has asked Westminster PCT and Imperial College Healthcare to present their results back to PCTs and Trusts across London early next year and produce recommendations on the best ways to use the CQUIN framework to drive improvements in quality across organisations.

specialised commissioners and the provider may wish to discuss with their SHA a mechanism for developing a scheme which minimises duplication and burden on organisations. Any disputes regarding local CQUIN schemes should be managed through the dispute resolution procedures in place for contract negotiation.¹⁸ It is expected that CQUIN schemes would be agreed before the new financial year starts, so by 31 March 2009 for 2009/10.

50. In future years, discussions on changes to goals in the CQUIN scheme should be part of the annual review of the contract schedules by the coordinating commissioner and provider. It is not expected that money would be carried over financial years and a CQUIN scheme would be agreed for each financial year.
51. The payment framework is based on the principle of local flexibility in identifying priorities, agreeing appropriate indicators and goals, finalising payment mechanisms and the overall scheme, and ensuring the infrastructure is in place to monitor and review the scheme. This section offers some practical advice on these steps in turn which providers and commissioners may find helpful.

Identifying priorities for the local CQUIN scheme

52. In selecting the areas for quality improvement for the local CQUIN scheme, commissioners and providers may want to take into account:
 - their Next Stage Review regional vision
 - PCT strategic plans, the priorities and improvement goals within them – including the 10 outcomes identified through World Class Commissioning – and the areas of need identified through Joint Strategic Needs Assessments
 - existing local quality improvement initiatives that would benefit from an additional emphasis
 - areas of performance where there is potential for significant improvement, perhaps areas identified by clinical teams, patients and the public, through data or from recent reports by the Healthcare Commission/other visiting teams

Focus on pathways

Bradford & Airedale PCT and its local acute provider have identified several areas for local quality improvement arising from their regional Next Stage Review (NSR) work. One goal is to increase compliance with the best practice pathway for palliative care patients, the Liverpool Care Pathway. They felt that this was also a good candidate for financial incentives as it was identified as a key priority in both their regional NSR vision and the End of Life Strategy. The goal currently stretches over a two-year period and is aimed at achieving compliance in 100% of all ward environments.

¹⁸ Outlined in the contract guidance available at www.dh.gov.uk

- areas where there is a good evidence base on what improved quality would look like, and how to achieve it, for example through NHS Evidence (when available in 2009)
 - any national priorities identified in the Operating Framework or, in future years, by the National Quality Board (when established).
53. In seeking to identify the most appropriate areas to be included within the local CQUIN scheme, commissioners and providers may find it helpful to refer to *Prioritise Commissioning Opportunities* in assessing opportunities for improvement.¹⁹ If there is significant variation in the local priorities of commissioners for the same provider, the coordinating commissioner may wish to seek views from their SHA on the most appropriate areas for improvement.
- ## Agreeing the indicators and goals
54. The number of indicators used for the CQUIN scheme should be determined locally to ensure that improvement is focused appropriately. To avoid schemes becoming over-complex and bureaucratic, it is not expected that they would try to cover all service areas in a provider or all planned areas of quality improvement.
55. In identifying indicators, commissioners and providers will want to align this with the work to engage staff in development of quality metrics currently underway and decide how to involve clinical teams in developing indicators for CQUIN schemes.²⁰ Over time, organisations should particularly consider including some of the small number of common measures, currently being developed with the NHS. Some of these will be common across the country, others will be identified at regional, local and team level. Using these indicators, particularly those common at regional and national level, will allow commissioners and providers to better benchmark performance on quality and is likely to mean that indicators and goals will be more evidence based and clinically relevant.
56. There will be different approaches to using indicators for CQUIN schemes. For example, indicators could be used to judge whether required levels of quality are being delivered, or to highlight areas where changes in clinical practice will lead to improved quality. This is likely to require a focus on service lines, rather than just relying on organisation-wide measures. Similarly, indicators could be process or outcome measures, but where process indicators are used there should be a clear link to quality. This could be through using a group of indicators associated with best practice clinical care, for example clinical focus areas such as those being used in Doncaster or by NHS North West.²¹ Where

19 *Prioritise Commissioning Opportunities*, NHS Institute for Innovation and Improvement (2008) available at www.institute.nhs.uk/commissioning

20 Measuring for Quality Improvement document and survey on measures available at www.ic.nhs.uk/cqi

21 The clinical indicators used by NHS North West are in five clinical focus areas. These had an international consensus around the evidence base which was supported by the National Institute for Health and Clinical Excellence.

commissioners wish to encourage integration of services, they could consider developing shared sets of goals across providers.

57. In addition to the common measures mentioned above, using established indicators, which have a good evidence base, for CQUIN schemes will help in benchmarking and thereby further encourage improved quality of care. Established indicators could also include those developed by a professional or specialist body, or using existing data, for example the information on maternity available in the recent Healthcare Commission report *Towards Better Births*.²² Information may also be available from existing patient surveys or those in

development.²³ Work to develop more real-time data on patient experience may be used for CQUIN schemes in future years. Some examples of indicators are available on the Healthcare Commission's website²⁴ or through the survey currently hosted by the NHS Information Centre.²⁵ Others will be developed through the regional and local process on metrics. Where an established indicator is not available, the coordinating commissioner and provider may decide to use (or develop with the appropriate clinical teams) an indicator based on local data sets.

Using existing data to drive improvement

King's College Hospital and **Guys & St Thomas' NHS Foundation Trusts** have been working with **Lambeth** and **Southwark PCTs** to get a better understanding of the quality of maternity services, in particular looking at how women access services. They have undertaken a baseline audit of the maternity services to find the percentage of women for whom a needs, risk and choice assessment has been completed by the end of the twelfth week of pregnancy. This is the Maternity Indicator defined in the 2008/09 Operating Framework and was chosen to address the particular issue around equity of access to services for specific groups. The PCTs are aiming to develop a more effective practical model of commissioning where service user representation, maternity service providers and commissioners work together, to inform better quality commissioning based on both the needs of local populations and their current access to services.

22 *Towards Better Births: a review of maternity services in England* (2008) Healthcare Commission, available at www.healthcarecommission.org.uk

23 The National Patient Survey Programme run by the Healthcare Commission collects data on patient experience. <http://www.healthcarecommission.org.uk/yourviews/patientsurveys.cfm>. Other options could include local tailored surveys, feedback from the Patient Opinion website www.patientopinion.org.uk, or some of the existing local work.

24 www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/improvingclinicalquality/developingbettermetrics.cfm

25 A list of existing indicators used by various parts of the NHS to measure performance is available at NHS Information Centre website inviting feedback from NHS staff about the usefulness of each indicator and suggestions for other measures they may already use but which are not on the list – www.ic.nhs.uk/cqi.

58. Once the coordinating commissioner and provider have agreed the priority areas for improvement and relevant indicators, they should discuss appropriate and specific goals for improved levels of quality, which are stretching and realistic. There should be transparent mechanisms for setting and agreeing these goals. It is not expected that commissioners will try to identify the monetary value of the quality improvement being sought.
59. In some cases, the indicators or goals may apply over more than one contract year, signalling a general direction of travel for the providers' quality improvement. This could also allow commissioners and providers to include some areas of quality improvement where change may be less easy to observe within the financial year.
60. Even in clinical areas where indicators are used for more than one year, the goals may be different in the first year if organisations choose to focus on data collection, examples might be using the CQUIN money to encourage increased participation in national clinical audits, or to improve collection of equality information e.g. on disabled or minority ethnic groups.
61. Initially, recognising that there are limited metrics on innovation, these goals could be linked to specific milestones or achievements relating to innovations in service delivery or management. This could be based on putting on new inventions into practice, adopting changes already proven elsewhere or spreading proven changes within an organisation or to other providers. This could be linked to an initiative providers are already planning. One specific example might be, if a provider is involved in one of the Pacesetter initiatives, developing new methods of service delivery to achieve better outcomes for minority groups, this could be recognised as part of the CQUIN scheme.
62. Over time, there will be more innovation metrics available. The aim is to ensure that there are simple and consistent metrics, which will allow commissioners and providers to measure progress in a range of areas and, in time, to benchmark themselves against others. These metrics may look at patient experience, cultural aspects such as staff views, and value for money of innovation. Where there is interest in developing metrics for innovation, SHAs could work with the Department to explore what national support could be provided for this.

Improving equality information

Bristol PCT has developed a number of financial incentives with both their local acute District General Hospital and Foundation Trust. As well as identifying areas relating to quality of care, they have also highlighted areas where the quality of data needs to be improved. For example, one of their priorities is improving the quality of data surrounding physical, sensory and cognitive disabilities. There are specific goals for the next three years over the proportion of records that will contain this information, with goals increasing each year.

63. When discussing potential innovative ideas with providers, commissioners may wish to use *Commissioning to Make a Bigger Difference* which sets out practical tools and a framework to evaluate proposed innovations.²⁶ In future years, PCTs will also be able to refer to resources for commissioners which will be provided through NHS Evidence when it is launched in 2009.
64. When commissioners and providers develop quality goals they may choose to base these on improvement over time, in particular where there is little benchmarking of standardised data. Given current variation in quality levels, and the need for local schemes genuinely to reflect discussion with individual providers, it is expected that goals will be based on relative improvement and there will be variation in goals between providers. As more benchmarked data becomes available, commissioners and providers may decide to use CQUIN schemes differently, perhaps using absolute performance or more challenging improvement goals. However, there may be some areas where measuring relative improvement continues to be more appropriate, for example when monitoring changes in patient experience through survey data.

Payment of CQUIN money

65. As part of agreeing contracts, the coordinating commissioner will agree with the provider how the CQUIN money will be paid, taking into account the need to maintain cash flow, allow investment and ensure payments are kept as straightforward as possible. To reduce the potential for conflicting payment schedules for associate commissioners, NHS colleagues have suggested there should be a national default. It is therefore suggested that 90% of the CQUIN money is paid in monthly intervals alongside payment of regular income, on the assumption that the provider will achieve the majority of its goals. If PCTs and providers wish to establish alternative arrangements, these should be agreed with all associate commissioners and the SHA.²⁷
66. There would then need to be reconciliation points at year-end and at regular intervals during the year, it is suggested at six and nine months, to adjust payments as needed. Adjustments may be required to reflect variation in activity levels and/or progress towards achieving agreed goals, depending on the availability of data. In line with current practice in managing contracts, the coordinating commissioner may need to communicate information on any adjustment to income to associate PCTs.

26 *Commissioning to make a bigger difference*, NHS Institute for Innovation and Improvement (2008) available at www.institute.nhs.uk

27 The agreed mechanism for payment and reconciliation for CQUIN schemes should be set out in Schedule 18 of the contract. Suggested text is included in the contract for commissioners and providers to use. This is optional for non-acute contracts.

67. Where significant delays in data availability are anticipated, the coordinating commissioner and provider may choose to specify the period on which the payment is based to facilitate recording of CQUIN payments in financial accounts. The period agreed could potentially include some part of the previous year's performance, where the provider had agreed this goal in advance. For example, it could be based on performance from January to January, or the goal could apply for more than one year.

Finalising local CQUIN scheme

68. As part of working through how the CQUIN goals and payment mechanisms translate into the final agreed scheme in contracts, commissioners and providers will want to look at the overall consistency and fairness of the scheme.

69. For example, in agreeing the list of indicators for the CQUIN scheme, the commissioner and provider will need to agree appropriate relative weighting of indicators in the scheme and include this in the contract schedules.²⁸ Commissioners and providers may wish to agree in advance any arrangements for recognising intermediate achievement of goals to prevent an 'all or nothing' approach

to payment. They will also want to consider possibility of any perverse incentives, for example whether goals might inadvertently discourage reporting or detract attention from clinical areas not covered in the scheme. Similarly, commissioners will want to ensure that goals do not unintentionally encourage providers to only focus on 'easy to reach' groups, whilst reducing access for those who might be excluded, for example people who have problems communicating for language, cultural, cognitive or other difficulties.

70. Commissioners will also need to give regard to the *Principles and rules for Cooperation and Competition*,²⁹ ensuring they are transparent and fair in the treatment of different providers, both in terms of the goals for improved levels of quality, and the payment mechanisms agreed. It may be beneficial to both providers and the commissioner to have different schemes for different providers, enabling each provider to focus on areas where they need to and wish to improve.

71. It is not intended that the goals for local schemes be based on the 'lowest common denominator', rather they provide the opportunity for providers to be aspirational and strive for excellence. If schemes for different providers do reflect different priorities, indicators or goals, commissioners will want to seek roughly equivalent levels of challenge from different providers. Over time, a greater degree of standardisation may arise

²⁸ These details would need to be recorded in Schedule 3, Part 4 of the contract.

²⁹ *Principles and rules for Cooperation and Competition* (2007) Dept of Health www.dh.gov.uk

as more information emerges on what organisations should be aiming for, and as commissioners and providers strive to achieve recognised best practice.

72. In finalising the scheme, the coordinating commissioner and provider, in consultation with the SHA, may wish to take an overview of the measures agreed, for example looking at the coherence with local strategic plan priorities and Local Area Agreements. One particular issue they should consider is whether schemes are consistent with the need to reduce health inequalities and promote equality, taking into account the information in the CQUIN framework Impact Assessment.³⁰

Monitoring and reviewing schemes

73. Agreeing the CQUIN scheme is only the first part of the process. Commissioners and providers will want to discuss how to ensure that professional processes are in place to collect and assure data, communicate it to clinical teams and the commissioner, and discuss progress towards the agreed levels of improved quality. Ensuring there is a clear, easy to use and well understood process to achieve this will be a key step in allowing the

measurement of CQUIN goals to inform improvement in the quality of care. This should build on the infrastructure developed for collection and assurance of quality metrics more generally, and existing work on quality. The process of using these data will help the quality of data improve over time. Organisations may also wish to build on the experience of NHS North West in developing their *Advancing Quality* programme. For example, they have identified some key factors in driving quality improvement in the NHS (see example box).³¹

74. Commissioners and providers will need to agree how the CQUIN scheme will be monitored. As specified in the national standard contracts, monthly Clinical Quality Performance Reports should be produced, and monitored through the clinical quality review meetings. This should include progress against local CQUIN schemes unless an alternative approach is agreed locally. Where specialised services are included in a CQUIN scheme, it may be appropriate to monitor progress through existing forums with specialised commissioners. Within these meetings, the commissioner and provider should be discussing the progress against agreed goals, and future plans for maintaining or improving their achievement, to inform reconciliation of payments. This should be based on appropriate assessment of the data.³²

30 Impact Assessment for Commissioning for Quality and Innovation (CQUIN) payment framework available at www.dh.gov.uk

31 More information about the North West *Advancing Quality* scheme is available at www.advancingqualitynw.nhs.uk

32 This could include techniques which allow more developed assessment of data, for example statistical process control.

75. At the end of the year, commissioners and providers will want to review the scheme to consider which areas worked well, identify any lessons learnt and share this information with other commissioners, providers and their SHA. Similar reviews should be held at the

regional level, looking at the support they offered and any common themes, and will be held at the national level. This will help inform the development of future local schemes and the national framework.

How to drive continuous quality improvement

In developing the **NHS North West Advancing Quality** scheme, they identified that continuous improvement revolves around the four R's of *Rigour, Reputation, Recognition, and Relevance*. They can be described as follows:

- **Rigour** – Clear unambiguous data definition (including exclusion and inclusion criteria), simple processes for collection & analysis of data which compares service processes on a 'like for like' basis, regular comparable performance data & information at local level, outcome focused measurement and a small number of evidence based measures for each pathway of care.
- **Reputation** – Public reporting of information is a key driver to levelling up performance and provides sufficient incentive to improve. Peer pressure is also a strong lever in the process with changes in clinical practice taking place quickly once the clinical indicators start to be collected. There is a certain organisational pride in encouraging patients to choose them as their preferred hospital for care. The commitment to the sharing of best practice and process, coupled with a willingness to learn from others has demonstrated a healthy appetite for learning and continuous improvement.
- **Recognition** – Each clinical lead has been keen to know their levels of performance against the clinical indicators and compare these with members of their own team. Clinicians and managers alike have been keen to see performance data at hospital and Trust level in order to identify areas of weakness and highlight areas of strength. This enables appropriate prioritisation and target improvement efforts.
- **Relevance** – the information can be returned quickly to clinical teams, allowing for more real time performance improvement. The triangulation of clinical outcome, Quality of Life (PROMs) and patient experience makes the output relevant to all stakeholders.

Support and assurance

76. The SHA will have three main roles in relation to the CQUIN payment framework. Firstly, they will have a role in supporting and encouraging the development of schemes in their area and facilitating sharing of information and learning. In some areas, local health economies may choose to coordinate work and follow a regional approach to developing CQUIN schemes, which will help benchmarking across organisations. As part of this role, SHAs should ensure that all CQUIN schemes are published in a way that helps other commissioners and providers understand and learn from other schemes: the NHS Institute's PCT portal will be available to facilitate this.
77. Secondly, SHAs will have a formal oversight role for local CQUIN schemes as part of their commissioning assurance role, and should ensure that commissioners are setting sufficiently stretching and realistic quality goals. Thirdly, as part of their market management role, SHAs should also ensure that coordinating commissioners are setting fair goals for providers, agreeing appropriate amounts of money for schemes, and not creating barriers to entry for new providers.
78. As commissioners and providers seek to develop CQUIN schemes as part of contracts, they can direct specific queries through the contact point for contract queries.³³ SHAs and the Department, and other organisations as appropriate, will also seek to raise awareness of the CQUIN payment framework and what it means for providers on acute contracts in particular.
79. As well as the key role of SHAs, other organisations may look to provide support for those developing CQUIN schemes. For example, the NHS Institute for Innovation and Improvement will be consulting those involved in its High Volume Care Rapid Improvement Programme to see how their CQUIN schemes might be used to support their improvement work and deliver improved outcomes from 2009/10. The development of CQUIN schemes will also be discussed as part of the NHS Institute's *Turning Data into Information for Improvement* development programme in which almost 600 staff from some 100 PCTs are currently participating.
80. In developing local schemes in future years, commissioners and providers will be able to refer to the schemes developed by others. It is for this reason that organisations are asked to make their schemes available in a way which allows for comparison between schemes, for example through the NHS Institute's PCT Portal. In future, it is expected that providers' CQUIN schemes, and their achievement against them, would be included in their Quality Accounts.
81. To inform future development of the national framework and local schemes, interested NHS colleagues will be encouraged to develop one or more exemplar schemes in cooperation with the Department, which would consolidate learning from the reviews undertaken by commissioners, providers and SHAs. Such schemes would not be intended as mandatory schemes, nor would they try to set a common level of quality across all areas.

33 For queries, contact contractshelp@dh.gsi.gov.uk

They would aim to develop a more evidence based approach in identifying areas for improvement and common indicators that would be available for commissioners and providers to use.

82. To look at the longer term impact of the CQUIN payment framework, the Department will also be looking to commission a formal evaluation looking at the implementation and outcomes of the payment framework.

