



Press for change

Providers have complained this year's CQUIN incentive scheme has departed from the original focus on quality, but commissioners say they are merely implementing the NHS forward view. Seamus Ward reports

As reforms of the tariff go, commissioning for quality and innovation (CQUIN) was relatively uncontroversial initially. When it was introduced in 2009/10, there was wide support for paying a percentage of contract value to incentivise providers to improve the quality of care.

But in recent months it has turned sour, with the late publication of some 2016/17 CQUIN guidance, changes to the amounts to be paid for specialist CQUINs and disputes between local commissioners and providers that have reportedly held up the signing of contracts.

With speculation over its future, providers have told *Healthcare Finance* that they believe the initiative has lost its way.

In 2016/17, as in previous years, there are national and local CQUINs as well as CQUINs for specialised services. NHS England says this year's scheme is designed to support the *Five-year forward view* and, when aligned with sustainability and transformation plans, will be a powerful lever to deliver better quality care through clinical and service transformation. There are four national goals: staff health and wellbeing; identification and early treatment of sepsis; improving the physical health of patients with severe mental illness (PSMI); and antimicrobial resistance. Schemes must include goals applicable to the sector.

Payments are made based on the actual annual value (AAV) of the relevant contract. This is the aggregate of all payments made to the provider for services delivered under the specific contract during the year, not including CQUIN and other incentive payments, and after any deductions or withholdings. Payments can be in part or in full based on the achievement of milestones or targets.

The national indicators are worth different amounts and, when added to local CQUIN, total 2.5% of AAV. This year, the staff indicator is worth a minimum of 0.75% of AAV. The others are worth at least 0.25%. Commissioners and providers may agree to increase these amounts and the remainder is available for local CQUINs. For example, if an acute trust agreed CQUINs at the minimum level for sepsis (0.25%), staff wellbeing (0.75%) and antimicrobial resistance (0.25%), 1.25% of AAV would be available for local CQUINs.

CCGs have worked with NHS England to develop a menu of local CQUINs for 2016/17, based on CCG priorities. The menu has seven priority areas and 30 indicators. The priority areas include productivity, integration and urgent and emergency care. The local schemes are flexible, allowing for local targets and payments to be set.

Key concerns

One provider director of contracting has concerns over the direction CQUIN has taken. 'To me CQUIN has lost its way,' he says. 'Our CQUINs are worth £12m, so we cannot afford not to have it, but then again we can't afford to sign up to anything too risky and could lose us money. Because of this we have to restrict what we do to CQUINs that are safe, which means we are not doing what we are supposed to do.'

NHS England says the national CQUINs are aligned to its strategic priorities and support delivery of the government's mandate in areas such as antimicrobial prescribing and resistance rates.

Several providers have told us of their concern that the achievement



of some CQUINs is outside their control – the health and wellbeing CQUIN, for example, a third of which is based on healthier food for patients, staff and visitors (see box overleaf).

A persistent gripe from providers is that changes to CQUINs each year can pull the financial rug from under services they have developed under the initiative.

Central Manchester University Hospitals NHS Foundation Trust director of contracting and income Lee Rowlands says CQUIN can be seen as a pump priming tool, but when funding is taken away to invest in a new and different CQUIN the following year, the providers can still be left with a recurring cost.

‘You can earn CQUIN payments each year, but they’re usually different ones each year. You therefore get a payment that will cover the costs in the first year but the risk is that you are then left with the costs on your books going forward.’

‘There is a danger that commissioners see broadly the same level of CQUIN payments as a “new” resource each financial year, when actually you might only be able to earn the same CQUINs annually (say £10m), but over the course of three to four years the recurrent costs may then exceed this,’ he says.

‘CQUIN has worked best where it incentivised genuine changes or advances in clinical practice (such as VTE monitoring). When this was a multi-year CQUIN, the payments were genuine pump-priming enablers and then, over time, VTE monitoring became part of standard practice and the costs absorbed as part of normal day to day running costs.’

NHS England points out that it does not change all national CQUINs from year to year. This year, for example, is the third year for the mental health CQUIN, while the sepsis CQUIN is in its second year. ‘Specialised commissioners have developed a greater number of multi-year CQUINs, as well as including in scheme design explicit

considerations for how changes will be sustained after the CQUIN is retired,’ it says.

Commissioners should make it possible to achieve local incentive targets over a number of years, it adds, particularly where there is a shift to new models of care or outcome-based payment that will require several years to deliver. ‘However, CQUIN is a dynamic scheme and will change in response to national and local priorities so we suggest that commissioners should avoid agreeing binding CQUIN schemes with the providers that cover the period beyond the duration of the CQUIN scheme – which is currently 31 March 2017,’ a spokesperson adds.

Action on Hepatitis C

Specialist CQUINs have also come under scrutiny. In March, specialist providers claimed that changes in specialist CQUIN schemes would hamper their attempts to get back into financial balance.

Much of the focus has been on the CQUIN for new hepatitis C treatments. Providers say the goalposts moved as late as mid February, when NHS England published details of the specialist CQUINs. To accommodate the additional cost of new Hep C treatment, it announced that the 23 trusts that are national Hep C providers will be able to receive CQUIN payments of 2.8% of contract value. To accommodate this, the maximum specialist payment for other providers was reduced to 2%. Trusts had assumed specialist CQUINs would be paid at 2.4% and agreed control totals based on this.

Even though the Hep C providers have access to 2.8%, some of the 23 trusts told *Healthcare Finance* they were not happy. One trust said it does not have a ‘clear line of sight to earning 2.8%’. Payment of the full amount relies on all the providers remaining within budget.

‘This is a budget management tool and we will not know our income from this until the end of the year. We could break even on the budget, but if any of the other Hep C providers overspend we will suffer the consequences and vice versa,’ the trust adds.

NHS England states: ‘Since it is only relevant providers themselves who can clinically manage the expansion of patient treatment volumes in line with the legally mandated NICE guidance, we make no apology for providing positive incentives to support them in doing so. The undesirable but unavoidable alternative – given the NICE legal funding mandate – would have been to top slice from available specialised

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Lee Rowlands, Central Manchester NHSFT

Healthy CQUIN

Some tabloids may have dismissed NHS England's focus on staff health and wellbeing as frivolous or screamed with incredulity about Zumba classes for NHS staff, but staff welfare is something to take seriously. As NHS England says, happier staff can reduce costs – whether through higher retention of staff or reduced sickness absence, which is put at £2.4bn a year.

Staff health and wellbeing is encapsulated in a new, three-part national CQUIN. Overall, the CQUIN is worth 0.75% of AAV, with each of the three parts worth 0.25%.

There are two options in the first part, with only one to be selected. Commissioners and providers should choose between achieving a five percentage point improvement in each of the staff survey questions on health and wellbeing or introducing a range of physical activity schemes (such as exercise classes), improving access to physiotherapy services and introducing mental health initiatives.

The second part relates to food sold in hospitals. A range of initiatives are required, including banning price promotions on sugary drinks and ending advertising of sugary drinks and food high in salt, fat and sugar. Healthy options should be available for staff working night shifts. There is also a mandated data collection on existing contracts with food and drink suppliers.

The final part of the CQUIN relates to flu vaccination of frontline clinical staff, with a target of 75%.

Payments are made against achievement

of milestones. For example, in the staff survey option a 2% improvement will lead to payment of a quarter of the weighting associated with this option. Nothing will be paid for improvement of 1% or less. In the flu vaccination element no payment is made for achieving 64% or less; 50% for uptake of 65%-74% and 100% for 75% and above.

NHS England makes no apology for prioritising the staff health and wellbeing indicator by making it worth three times more than the other national indicators.



'Given that its workforce is often put in high-pressure situations, and is responsible for helping to care for the health of England's population, the NHS has a responsibility to take care of its own staff,' a spokesperson told *Healthcare Finance*.

One finance manager closely involved in contracting asked how trusts can achieve the targets on food and drink when they cannot control what's sold in concessions in their buildings. 'Good luck negotiating that with Costa Coffee,' he says.

NHS England says the CQUIN

emphasises the health service role in leading the battle against obesity and lifestyle-related illnesses.

'Provider trusts are significant and influential organisations, and have a major role to play in delivering a changed culture. NHS England will be hosting discussions with the major food suppliers and franchise holders to the NHS to help trusts make progress in the four areas outlined in the CQUIN. Practical steps have already been taken. So, for example, the Royal Voluntary Service has recently sent out a letter to each trust, covering 440 stores, outlining how they will meet the CQUIN measures during 2016/17.'

Liz Preece, workplace health and wellbeing specialist at The Healthy Worker, a company that helps employers develop and deliver staff health and wellbeing strategies, says the CQUIN is a landmark in NHS staff welfare. Two of the staff survey questions on health and wellbeing relate to musculoskeletal problems and stress – two of the primary causes of staff absence, she says. 'If you can improve these, there's an opportunity to make a significant difference,' she adds.

'Finance teams need to be part of the solution, supporting trusts to move forward and not seeing staff health and wellbeing as "a nice to have" any more. Part of the purpose of the CQUIN is to push that thought process – there's a return on investment from it.'

provider income growth a national reserve of up to several hundred million pounds to cover risk of excess provider spending on Hep C.

'Delivering this carefully targeted CQUIN scheme will have negligible, if any, costs to specialised providers themselves, while also giving them extra income and helping protect available funding growth for all providers of specialised care. The vast majority of contracts for Hep C lead providers are agreed.'

NHS England adds that non Hep C providers that were on the default tariff rollover tariff in 2015/16 did not earn any CQUIN last year so are moving from 0% to 2% for specialist CQUINs. 'The change moves around £20m gross income earning potential from over 170 providers – an average income change of a little over £100,000. Given the costs providers need to incur to earn these sums under the CQUIN scheme, which over recovers costs by 25%, the effect on bottom line financial balance is substantially less.'

Trusts say a lot of work – possibly a disproportionate amount – goes into negotiating and verifying CQUINs. 'I think CQUIN has become too important in contracting,' one trust director says. 'When it was first introduced you could see why it was being done – to improve quality and pathways – but it's getting more difficult.'

This year, local disagreement and discussion has contributed to delays in signing some contracts. NHS England acknowledges this. 'We do know that, in some cases, NHS commissioners and providers have struggled to reach timely contract agreements for 2016/17, and in some instances the local element of CQUIN has been one issue on

which they have been unable to agree,' a spokesperson says.

'We recognise that technical discussions on the design of local CQUIN indicators can take time, and we do recommend that commissioners focus on agreeing a manageable number of local indicators relative to the value of the overall contract. This is why this year we have collaborated with CCGs to design a new comprehensive menu of local CQUINs that CCGs can adapt for local use.'

For very small-value contracts, where the effort of designing local CQUIN indicators would be disproportionate to the benefit obtained, national CQUIN guidance allows flexibility, so the commissioner can agree simply to pay the 2.5% in full, the spokesperson adds.

Call for review

Some providers would like the initiative to be reviewed. 'I'd like a stock-take of whether CQUIN should still be considered a fundamental part of the payment system or if the resource should be diverted into other parts of the payment system instead,' Mr Rowlands says. 'It should be a two-part process, in that if it concludes we should stick with CQUIN, we should also go back to the original principles behind it, to incentivise quality improvement – CQUINs should also be properly thought through, consulted upon and published early so we can all plan properly.'

Many providers will sympathise with this view, but commissioners – both national and local – may feel using the initiative to drive forward service transformation while making quality improvements in targeted areas is equally valid. ○

HCL transformation team saves Trust £1.2m

Challenge

Following the successful implementation of a HCL master vendor (MV) solution in 2014, the Mid Yorkshire Hospitals NHS Trust (MYHT) sought to further reduce its dependency on off-framework agency medical locums, increase direct engagement conversions, improve service delivery and realise operational and financial efficiencies.

Solution

In August 2015, HCL's experienced team of advisors conducted a five day on-site diagnostic. Resulting recommendations included:

1. Centralise booking team to manage rotas, bank and agency – An inconsistent approach to rota planning meant locum requests were often given to staffing coordinators last minute and decisions were service driven rather than cost driven.
2. Relaunch Direct Engagement (DE) programme under HCL master vendor solution – The Trust's DE take-up target of 80% would be more easily achieved through HCL as the Clarity technology would give the team the ability to influence and control the supply of locums.
3. Transfer off-framework spend through the MV agreement – HCL Clarity put together a transition plan to completely remove off-framework supply of medical locums at MYHT. All locums supplied off-framework were instructed to register with the MYHT in-house staff bank or with an approved agency if they wished to continue to work at the Trust. No services were disengaged without a viable alternative to ensure safe delivery and continuity of patient care.

Outcome

- New centralised medical staffing structure ensures clarity and visibility on all bookings Trust-wide.
- Access to real-time management information and transparency on workforce data. This enables cost savings through more efficient scheduling and faster identification of skill gaps and high spend areas.
- Off-framework suppliers have been migrated through the MV, ensuring all medical locums are supplied via approved rates and compliance standards.
- The relaunch of DE at the Trust is expected to create savings of £1.2m per annum.

100%
locums supplied
on-framework



"I would highly recommend HCL to any NHS organisation. The team surpassed all expectations and helped the Trust formulate a clear improvement plan that will create circa £1.2 million of annual savings."

Neil Bowman, *Head of Business Delivery*, Mid Yorkshire Hospitals NHS Trust