

New CQUIN guidance and implications for clinical audit

January 2010

The Department of Health has recently issued new guidance around using the Commissioning for Quality and Innovation (CQUIN) payment framework for 2010/11¹. It outlines developments to the CQUIN payment framework and should be read as an addendum to the guidance published in December 2008 and in the context of the 2010/11 NHS Operating Framework².

The executive summary from this document is shown below with implications for those whose work involves clinical audit shown in bold italics.

Executive summary with implications for clinical audit

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.

All providers will have to have a CQUIN scheme - clinical audit is one of the key ways of gathering evidence of performance against existing quality standards which will be required as part of the monitoring process.

- Commissioners must make 1.5% of contract value (or equivalent non-contract activity value) available for each provider's CQUIN scheme.

The stakes have increased considerably from 0.5% to 1.5% so both commissioners and providers will want accurate, reliable information against the indicators in the CQUIN scheme some of which will be provided by clinical audit.

- 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.

There may be overlap with existing clinical audits so double check to ensure that work is not being duplicated.

- 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.

¹ http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_110431.pdf

² http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_110159.pdf

See Annex B for existing commitments and Annex C for Vital Signs in the Operating Framework 2010/11.

- Stronger process – a standard format will prompt clear definition of goals, measurement and payment.

A standard template is included in the guidance document which outlines what information is required for each indicator in the CQUIN scheme. Clinical audit staff who are involved in data collection should use the template to ensure that they are collecting exactly what is required.

- For the acute sector, schemes can no longer reward measurement.

Evidence that performance is being measured is not sufficient – there has to be real evidence of quality improvement and innovation so it is important that there are actions and implementation plans linked to any relevant clinical audits.

- Acute schemes must include the two specified national goals that the NHS Operations Board has confirmed for 2010/11,
 1. On reducing the impact of Venous Thromboembolism (VTE) and
 2. Improving responsiveness to personal needs of patients.

1. Reducing the impact of VTE – this has quite specific implications for clinical audit so the following section has been lifted from the original document.

Achievement of this goal will be measured using the quality indicator: % of all adult in-patients who have had a VTE risk assessment on admission to hospital, using the national tool
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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 1 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, 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.*

So although the data for the indicator may be gathered via monthly Unify data collection, the evidence around appropriate prophylaxis and root cause analysis of PEs and DVTs will be from clinical audit.

The draft NICE Quality Standard for VTE is now out for consultation until 9 February 2010.³

2. Improving responsiveness to personal needs of patients – this indicator is based on 5 questions currently contained within the adult in patient survey coordinated by CQC.

- *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?*

A composite score out of 100 will be derived using responses to these 5 questions. There may be no direct involvement with clinical audit teams but an awareness of this indicator is advisable.

Please note that these indicators apply to Acute schemes only.

- SHAs are responsible for assuring schemes and ensuring that schemes demonstrate stretch and focus.

It is important for clinical audit staff to be aware of the CQUIN schemes in their organisations and, where possible, to play an active role in their development. They are well placed to provide advice and guidance around the practical role of clinical audit in supporting quality improvement.

Eleanor Thomas
Healthcare Quality Improvement Partnership
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³ <http://www.nice.org.uk/aboutnice/qualitystandards/VTEPreventionQualityStandard.jsp>