SELF CARE – Commissioning for Quality and Innovation (CQUIN)

Goal number	Goal name	Description of Goal	Goal weighting (% ofCQUIN scheme available)	Expected financial value of Goal(£)	Quality domain (Safety, Effectiveness, Patient Experience or Innovation)
1	Self Management	To adopt patient centred care planning for Long Term conditions as a systematic means of supporting self management..	TBC	TBC	Effectiveness; Patient experience;

Summary of indicators

Goal number	Indicator numbers[1]	Indicator name	Indicator weighting (% ofCQUIN scheme available)	Expected financial value of Indicator (£)
1	1	Patient Centred Care Planning	50%	
1		Training and education of staff in care planning processes	25%	
1		Provision of information to LTC patients to support self management	25%	
4				
		Totals:	100.00%	

Detail of indicator (to be completed for each indicator)

Indicator number	1
Indicator name	Patient Centred Care Planning
Indicator weighting (% of CQUIN scheme available)	TBC- propose 50% of Self Management CQUIN
Description of indicator	To implement systematic care planning for patients with a Long Term Condition. By the end of 2013/2014 to ensure that tbc% of patients with a specified LTC have an agreed Care Plan which meets the minimum standards. The minimum standards for care planning are that: 1. Patient's set their own goals which are agreed in collaboration with their healthcare professional, 2. Have a documented action or care plan which is shared with their own GP and 3. Agree a way to review their goals at subsequent appointments
Numerator	Number of outpatients with specified LTCs

1 There may be several indicators for each goal

	seen for follow up who have a care plan which meets the minimum standards. This will be determined through data reporting and an audit of a sample of care plans to assess quality and compliance with minimum standards
Denominator	Total number of patients being regularly followed up in clinics in the following clinical areas: Diabetes Chronic Kidney Disease Cardiology (incl AF, angina) Hepatitis Respiratory (COPD and Asthma) Arthritis Chronic pain List to be agreed with providers
Rationale for inclusion	There is strong evidence that patients who are more activated in their care are better able to manage their long term condition, leading to improved outcomes and better quality of life. This can be achieved through ensuring that patients are centrally involved in agreeing plans for their care, and in setting their own goals for managing their condition.
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	[Insert Provider name]
Frequency of reporting to commissioner	Provider to submit a quarterly data return
Baseline period/date	Q4 2012/13
Baseline value	TBC
Final indicator period/date (on which payment is based)	Q4 2013/14
Final indicator value (payment threshold)	20%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Percentage of follow up patients with quality care plan- verified by audit of sample (suggest minimum sample of 100 from agreed specialties)
Final indicator reporting date	20 working days after the end of each quarter
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Indicator number	2
Indicator name	Training in Patient Centred Care Planning
Indicator weighting (%of CQUIN scheme available)	TBC- propose 25% of Self Management CQUIN
Description of indicator	Training and education for hospital staff in collaborative care planning and supporting self management, including motivational techniques and supporting behavioural change.
Numerator	Number of clinical staff working within selected specialties who have undertaken training in patient centred care planning and self management of LTCs.
Denominator	Total number of clinical staff, including consultants, doctors, nurses and HCAs working in outpatient clinics in the clinical areas below, who have undertaken agreed training in patient centred care planning. (Note training package to be confirmed. HIEC online module for diabetes is one existing package but generic training resource needs to be confirmed in discussion with providers) Diabetes Chronic Kidney Disease Cardiology (incl AF, angina) Hepatitis Respiratory (COPD and Asthma) Arthritis Chronic pain List to be agreed with providers
Rationale for inclusion	There is strong evidence that patients who are more activated in their care are better able to manage their long term condition, leading to improved outcomes and better quality of life. This can be achieved through ensuring that patients are centrally involved in agreeing plans for their care, and in setting their own goals for managing their condition. This requires a a cultural shift in the way that clinicians approach consultations with patients, and training is required to support staff in understanding co-creating a care plan with patients.
Data source	Provider
Frequency of data collection	Quarterly

Organisation responsible for data collection	[Insert Provider name]
Frequency of reporting to commissioner	Provider to submit a quarterly data return
Baseline period/date	012013/14
Baseline value	TBC
Final indicator period/date (on which payment is based)	Q4 2013/14
Final indicator value (payment threshold)	60% of clinical staff in selected areas trained
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Improvement, as assessment between baseline period and final period
Final indicator reporting date	20 working days after the end of each quarter
Are there rules for any agreed in-year milestones that result in payment?	Yes, agreeing baseline list of staff and agreeing training package in areas outside diabetes
Are there any rules for partial achievement of the indicator at the final indicator period/date?	25% payment for milestone above, 75% payment for achieving target in Q4

Indicator number	3
Indicator name	Provision of Information to LTC patients to support self management
Indicator weighting (%of CQUIN scheme available)	TBC- propose 25% of Self Management CQUIN
Description of indicator	Patients with a diagnosed LTC to be given a range of information on their condition, including information to support self management, and sign posting to community groups, peer support or other resources that promote self management.
Numerator	Number of patients whose care plan or clinic notes clearly describe the provision of information and that this information was discussed
Denominator	Total number of patients being regularly followed up in clinics in the following clinical areas: Diabetes Chronic Kidney Disease Cardiology (incl AF, angina) Hepatitis Respiratory (COPD and Asthma) Arthritis Chronic pain List to be agreed with providers

Rationale for inclusion	There is strong evidence that patients who are more activated in their care are better able to manage their long term condition, leading to improved outcomes and better quality of life. This can be achieved through ensuring that patients are centrally involved in agreeing plans for their care, and in setting their own goals for managing their condition. This requires a a cultural shift in the way that clinicians approach consultations with patients, and training is required to support staff in understanding co-creating a care plan with patients.
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	[Insert Provider name]
Frequency of reporting to commissioner	Provider to submit a quarterly data return
Baseline period/date	012013/14
Baseline value	TBC
Final indicator period/date (on which payment is based)	Q4 2013/14
Final indicator value (payment threshold}	70%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Evidence that 70% of patients with diagnosis of LTC or annual review in the year have been given good quality information to support self management (potential to assess this through patient survey?)
Final indicator reporting date	20 working days after the end of each quarter
Are there rules for any agreed in-year milestones that result in payment?	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No