**BI1 Improving HCV Treatment Pathways through ODNs – Revision for Months 1 – 12 2018/19**

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| **Scheme Name** | **Hepatitis C Virus (HCV) Improving Treatment Pathways**  **through Operational Delivery Networks (ODNs)** |
| Eligible Providers | Mandatory for all HCV Operational Delivery Network Lead  providers as follows:  The list of eligible providers (to be confirmed by Regions) is  LEAD PROVIDER  1. The Newcastle Upon Tyne Hospitals NHS Foundation  Trust  2. Pennine Acute Hospitals NHS Trust & Central Manchester  University Hospital Trust  3. Royal Liverpool & Broad Green University Hospital NHS Trust  4. Sheffield Teaching Hospitals NHS Foundation Trust  5. Hull & East Yorkshire NHS Trust  6. Leeds Teaching Hospitals  7. East Lancashire Hospital NHS Trust  8. University Hospitals of Leicester  9. University Hospitals Birmingham NHS Foundation  10. Nottingham University Hospitals NHS Trust  11. Cambridge University Hospitals NHS Foundation Trust  12. Imperial College Healthcare Trust  13. Royal Free London NHS Foundation Trust  14. Barts Health  15. Kings College Hospital NHS Foundation Trust & St  George’s University Hospitals NHS Foundation Trust  16. Royal Surrey County Hospital NHS Foundation Trust  17. Brighton & Sussex University Hospitals  18. Oxford University Hospitals NHS Foundation Trust  19. University Hospital Southampton NHS Foundation Trust  20. University Hospitals Bristol NHS Foundation Trust  21. Plymouth Hospitals NHS Trust  22. Kings College Hospital NHS Foundation Trust |
| Duration: | April 2016 – March 2019  (Metrics updated for April 2018-March 2019) |
| Scheme Payment | Two elements:  1. **Governance and Partnership Working**: £100,000 per network. Where 2 providers share lead status the split of this funding to be agreed with commissioner and the 2 providers.  2. **Stewardship and NICE compliance** 1.6% of provider’s  overall CQUIN applicable specialised contract value |

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|  | 2018/19  Target Value: Add locally |
| **Scheme Description** | |
| This CQUIN supports the infrastructure, governance and partnership-working across health  and care providers working in HCV networks in their second and third years of operation to achieve the following outcomes:   Improvements in engagement of patients   The planned rollout, aligned to NICE guidance, of new clinical and cost effective treatments guidance to improve outcomes through Multi-disciplinary team treatment plans   Improved participation in clinical trials (subject to availability)   Enhanced data collection to demonstrate the effectiveness and equity of this way of working and the availability of new treatments.  This CQUIN aims to support   ODN coordination (By incentivising actions to act as the system leader in coordinating treatment rollout)   ODN case-finding initiatives (By incentivising partnership working on testing and treating in high prevalence or high transmission settings to assist elimination plans)   ODN care cascade improvements (By incentivising actions to link with laboratories to act on new and historic positive tests)  Providers leading networks are responsible for developing a working group for this CQUIN scheme, mapping patient pathways and producing a plan to improve partnership working in collaboration with their ODN treatment partners and whole systems stakeholders. The CQUIN focuses on achievable actions which can be taken by the clinical team and / or Trust. Where resources are made available to all of the involved clinical teams to undertake leadership, coordination, treatment, and data tasks, Trusts will maximise their opportunity for CQUIN achievement.  By the end of the CQUIN scheme, ODNs will:  a. Be part of ongoing HCV clinical care as set out by NICE in published and forthcoming technology appraisal guidance, with all patients receiving Hepatitis C care benefiting from ODN policy-compliant care approved by an MDT  b. Have clear and fully understood arrangements for partnership working inclusive of local patient groups and providers. There should be a clear written plan for partnership working with clarity about the responsibility of each ODN partner in relation to elimination plans, patient treatment run rates, treatment selection, maximising use of first line treatments, blueteq submissions and data registry entry. There should be agreed communications about the ODN which allow professionals and patients alike to understand how the ODN operates and how to contact it  c. Have developed partnerships which involve providers, commissioners, voluntary organisations and patients. Evidence of formal agreements and arrangements to support activity to facilitate the effective operation of the ODN must be available. This must include examples of:   Memorandums of understanding (or equivalent) between the Hubs and spokes within the ODN.   Evidence of how resources have been invested in the work of the entire network | |

wide HCV teams to support the work of all partners in the ODN who have a role in delivery.

d. Provide clear monitoring data on ODN operation and outcomes for patients, including the impact of the ODN model for improving access and real life effectiveness of new treatments as evidenced through blueteq and registry data. This should contribute to public health, activity, outcomes and experience monitoring needs

e. Be actively involved in opportunities to share learning and develop solutions within and across ODNs at regional and national level, to build the ODN collaboration model, support sustainable roll-out and goals of elimination.

**Measures & Payment Triggers – Governance Payment**

Metrics are described for 2017/18 (Year1) and 2018/19 (Year 2). Where year one triggers were not met in Year 1, they should be included by local amendment for Year 2.

For 2018/19, payment will be on delivery of progress reporting on the original measures and plans for Year 1.

I. Quarter 1 Achievement: (25% of Governance Payment)

a. **Baseline / Update report** (for Year 2 based on Year 1 progress)including: signed ODN arrangements by all partners; governance arrangements; ODN footprint map including CCG boundaries and provider partners; current baseline of pathways and services; gaps in service provision; populations in line with policy / NICE guidance; evidence of appropriate administrative arrangements to enable MDTs / data reporting

b. **Engagement plan** (for Year 2 based on Year 1 progress) for regional and national

ODN network, and for voluntary sector & patients.

c. **Pathway Mapping Group** (for Year 2 based on Year 1 progress) established

(membership confirmed, schedule of meetings).

d. **Dataset complete reporting** in line with NHS England guidance (for Year 2 based on

Year 1 progress)

e. **Progress Reporting** (all of the above and any other relevant ODN information)

II. Quarter 2 Achievement: (25% of Governance Payment)

a. **Partnership model and plan** (for Year 2 based on Year 1 progress) for implementation and submit to NHS England for comments. This to involve non specialised providers and relevant commissioners.

b. **Dataset complete reporting** in line with NHS England guidance (for Year 2 based on Year 1 progress)Evidenced commencement, review and revision of **5 year ODN plan** development (for Year 2 based on Year 1 progress)

c. **Progress Reporting** (all of the above and any other relevant ODN information)

III. Quarter 3 Achievement: (25% of Governance Payment)

For this quarter a report is required which includes the following

a. A narrative report with appropriate metrics on numbers tested, treated etc. on how implementation of the improved **partnership model** and partnership system is working including the involvement of new partners for increased case finding.

b. A narrative report on the actions undertaken with regard to communication and **patient experience**. This should include how patient representation is included in ODN governance arrangements, what methods has been used to assess patient

experience, the results and the actions taken / planned to address the issues raised. A narrative report on initial actions taken in respect of amended triggers B3 and B4 for Q3.

IV. Quarter 4 Achievement: (25% of Governance Payment)

a. **Annual report** of ODN operation submitted including progress on governance, partnership working, activity reporting & patient experience feedback.

b. **Map of pathways /services** published (for Year 2 based on Year 1 progress)

c. A narrative report setting out the refresh of **ODN 5 year objectives and plan** submitted and includes progress on the original plan, investments made and detailed plans in relation to case-finding to support this. To include how services and access to those services are to be improved for relevant patient groups to achieve equity including implementation of communication and patient engagement plans.

Where necessary to fulfil responsibilities providers may use funding from both the governance and stewardship payment to ensure network operation is adequately resourced to fulfil responsibilities for its own patients as well as its role as undertaking independent expert

review for ‘prior approval’ patients for another assigned ODN.

Assessment of governance and partnership working performance by individual ODNs is locally and / or regionally led as agreed with the regional leads (e.g. regional clinical director, regional HCV lead etc.). Members of the national support team will be available on request to support regional level ODN assessment. This can include availability of clinical review and feedback based on the practice of other ODNs / regions.

In 2018/19, a process of peer review will begin to be implemented which will assist or require amendment to the requirements of these triggers during 2018/19 and potentially beyond. The peer review process is being developed by the Quality Surveillance Team based on the published service specification with ODN clinical lead involvement.

**Measures & Payment Triggers – Stewardship Payment**

**TRIGGER A: Managed resources within indicative financial budget forecast**

 Each ODN will be issued an indicative forecast financial budget on a half yearly basis.

Based on the published run rate for each ODN, and the confidential region-specific prices for HCV treatment options clinically appropriate to each genotype and treatment history, inclusive of fees, taxes and charges at a maximum allowance of £100 per course of treatment.

 All commissioner validated invoiced spend is included with no exclusions.

 To avoid localised differences in populations (such as differing genotype profiles by ethnicity) impacting on assessment of this measure, performance against indicative financial forecast of all 22 networks will be reported individually but risk pooled.

 Where the combined committed spend for the half year is less than or equal to the indicative budget, the full 1.6% incentive will be available to every ODN paid on the basis of the triggers B1 to B4 below

 Where the combined committed spend for the half year exceeds the indicative budget, the incentive available to every ODN and paid on the basis of the triggers B1 to B4 below will be reduced on a £ for £ basis.

 For those ODNs who take up the additional 2400 treatment slots the plan will be compared with the actual or planned patients x planned average costs vs actual patients x actual average costs.

**TRIGGER B1: ODN MDT decisions aligned to NHS England published run-rate**

 One fifth of the stewardship incentive available through trigger A is payable provided the ODN delivers MDT treatment initiations in line with the published run rate for the half year

 Run rates are a per patient not a per treatment count and is attributed at the start of treatment (e.g. even if patient’s treatment spans two CQUIN periods or continues / restarts in another CQUIN period, the count is against the period when treatment first began)

 Patient treatment in trials count against the run rate unless the trial is funded by a drug company when the patient is excluded from this trigger as industry funded research

provides an opportunity to treat above the run rate

 Self- funding patients are not counted as part of the run rate and should be recorded in the Registry

 Extra slots secured via the Bridging Tender (2,400 treatments) are excluded from the run rate calculations

 This metric assumes 90-110% actual patient numbers vs planned patient

numbers. Any additional agreed patients (from the 2,400 treatments) won’t be added to the planned figure and therefore won’t contribute to achievement of this metric. ODN’s will not be penalised for over-performance within a ceiling of 110% plus any extra slots (from the 2,400 treatments)

 Ideally the additional 2,400 treatments should be used by month 6 however can be used up until the end of 2018/2019. If the strategic procurement is successful the rules

regarding the 2,400 treatments will be superseded by the outcome of the strategic procurement

 To qualify for payment above the ODN treatment rate, performance must be not more than 110% of the ODN’s final adjusted treatment run rate (that is the run rate agreed by the end of the period, subject to any revisions during the period)

 To qualify for payment below the ODN treatment rate, performance must be not less than 90% of the ODN’s final adjusted treatment run rate (that is the run rate agreed by the end of the period, subject to any revisions during the period)

 There is no payment for partial achievement of this element.

**TRIGGER B2: ODN Treatment cost per patient relative to first line treatment cost**

**(FLTC)**

 One fifth of the stewardship incentive available through trigger A is payable through

this trigger. The indicative financial budget incorporates valid clinical exceptions to first line treatment cost (FLTC) and will be reviewed twice yearly.

 This measure is based on commissioner validated invoiced treatments. Pricing is based on the rate card price for the CQUIN period and is inclusive of fees, taxes to a maximum allowance of £100 per treatment course (not actuals).

 The cost of all treatments – FLTC and those subject to second sign off – are included in this measure. In accordance with the published retreatment policy [https://www.england.nhs.uk/wp-content/uploads/2017/08/ccp-statement-retreatment- chronic-hepatitis-c-infection.pdf](https://www.england.nhs.uk/wp-content/uploads/2017/08/ccp-statement-retreatment-chronic-hepatitis-c-infection.pdf) there will be a small number of patients who may be eligible to receive retreatment in 2018/19. For the purposes of  **this trigger only** the

initial treatment will be counted (i.e. retreatments and treatments with sof/vel/vox are

excluded)

 Where the necessary information is supplied regarding patient treatment in trials, an adjustment is made to remove the impact of less efficient prescribing arrangements in

order that participation in research is supported.

 Where drug in a trial is funded by a drug company, the patient is excluded from this trigger as industry funded research provides an opportunity to treat above the run rate,

 Each ODNs first line treatment cost measure will be adjusted for genotype, cirrhosis status and treatment history of patients initiated.

 Where the ODN average treatment cost per patient is within 10% first line treatment cost for the network this indicator will be paid in full.

 Where average treatment cost per patient is above 10% of first line treatment cost, half payment will be made for performance up to 120% of the first line treatment cost for

the network. Above 120%, no payment will be made

 For those ODNs accepting any of the 2,400 additional treatment slots, these patients will be included (to avoid issues with identifying which individual patients make up the excess) however these additional patients should not be adverse for the metric as it calculates an average. If there are a higher proportion of second line treatments, these will be reviewed to ensure they didn’t adversely affect the metric result

 In the event of an ODN breaching this metric due to the additional slots, a case outlining why the additional slots legitimately skewed the performance should be submitted for consideration

**TRIGGER B3: ODN Prioritisation of patients with highest clinical need (including links with laboratories to improve linking to care of diagnosed patients)**

 One fifth of the stewardship incentive available through trigger A is payable through this trigger.

 The original measure of this objective required each ODN to set out its local priorities within its baseline report in Year 1 Quarter one, including the objective criteria by which they will assess achievement of these aims. The ODN should continue to develop and work to its local treatment prioritisation criteria, pertinent to its local patient population.

A report is required setting out the prioritisation criteria and evidence that treatment in the period corresponds to this.

 With the overall approach to patient prioritisation well embedded within ODNs, this Trigger is now being developed to incentivise action on prioritising the linking of diagnosed patients into care and treatment. The focus is on improving the pathway for laboratory reporting direct to ODNs. In order to address this gap in care, ODNs are

required to

a) Identify virology laboratories serving their ODN and this will include information on the mapping of testing in primary care and arrangements for follow up with test requestors where positive RNA results occur.

b) Put in place agreements (e.g. Memorandum of Understanding or Service Level Agreement (MOU / SLA) with the majority of virology testing suppliers i.e. >50% of suppliers, one of which must cover the main laboratory as measured by volume of results as appropriate for the local patch.

c) Work in partnership to set out a plan to describe how to initiate the flow of notifications of all new positive HCV tests from all labs serving the ODN to the ODN by no later than 1st October 2018. The plan should set out the

• Clear timeline with milestones to achieve complete coverage

• Description of how IG issues are being managed

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| • Actions taken so far  • Any risks or issues identified  • Mitigations for the risks  • At least one point of best practice or learning to be shared with other ODNs  d) Produce a report detailing the ODNs pathways and processes to ensure that individuals with a positive diagnosis notified to the ODN are offered and receive an assessment within 3 months of contact by the ODN. This should also include how this will be routinely monitored in order to achieve the access time and contain details of the local system that will capture this.  e) Work in partnership to set out an Information Governance compliant plan and process to describe how to initiate and implement follow up of all previous positive HCV tests by 31st March 2019 for linking to care. The plan should set out the:  • Clear timeline with milestones to achieve complete coverage  • Actions taken so far  • Any risks or barriers identified  • Mitigations for the risks  • Point of best practice to be shared with other ODNs.   To qualify for any payment, every ODN must identify a number of laboratories reflecting the testing arrangements within the ODN and must include at least 50% of  the testing laboratories. If there are an odd number of service providers or laboratories  the number will be rounded up e.g. if there are 5 laboratories or service providers the target is 3 signed agreements. In the event there is not a local lab for the ODN to link with, then alternative arrangements will be required. No payment will be made in the event no lab links exist. The Trust and local commissioner will set out the alternative arrangements and share with the national team for consideration of how the principle of access to and following up diagnosed patients can be demonstrated.   State which labs the ODN already have arrangements for follow up where test requestors receive positive RNA results.   State which ones the ODN does not yet have arrangements in place together with a summary of the action taken, timelines for full coverage of arrangements and any  issues or risks identified   Where the ODN has signed agreements in place with at least 50%, but not necessarily all providers to deliver the requirements above within the agreed timeframe it will receive full payment of this element for full assurance. A partial payment of 75% of  this element will be paid where evidence provided gives partial but not full assurance that an actionable agreement to improve links with laboratories is in place (e.g. evidence of agreement but not signed by all parties by due date OR notifications process agreed but flow not delivered on time OR report on number of tests and % offered assessment is incomplete). Where only limited assurance is provided the payment will be 50%. (E.g. evidence of agreement but not signed by all parties by due date AND notifications process agreed but flow not delivered on time AND report on number of tests and % offered assessment is incomplete). Below this level of assurance (e.g. no signed agreement, and no process for notifications and no report  on number of tests and % offered assessment) no payment will be made. | | | | | |
|  | **Full payment** | **75% payment** | **50% payment** | **No payment** |  |
| Signed agreements  in place with at | Partial but not full  assurance that an | Limited assurance  is provided E.g. | No signed  agreement, and no |

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|  | least 50%  If there are an odd number of service providers or laboratories the number will be rounded up e.g. if there are 5 laboratories or service providers the target is 3  signed agreements. | actionable agreement to improve links with laboratories is in place (e.g. evidence of agreement but  not signed by all parties by due date OR notifications process agreed but flow not delivered on time OR report on number of tests and % offered assessment is incomplete | evidence of agreement but not signed by all parties by due  date AND notifications process agreed but flow not delivered on time AND report on number of tests and % offered assessment is incomplete | process for notifications and no report on number of tests and % offered assessment |  |
|  This trigger is to be assessed locally and /or regionally led as agreed with the regional leads (e.g. regional clinical director, regional HCV lead etc.). Members of the national support team will be available on request to support regional level ODN assessment.   The prioritisation report accounts for 25% and the laboratory testing pathway improvements account for 75% of the payment based on achievement.   In 2018/19 months 7-12 this measure will be further developed to build on the output of  ODN reporting and the needs of the strategic procurement. This may include measures of performance within the remit of the ODN with a focus on % of new RNA positive patients offered an assessment within 3 months of diagnosis, taking into account the baseline this year and the purpose of CQUIN being about improvement and stretch. The detail will be developed further at a later stage with feedback from providers.   For those ODNs accepting any of the additional 2,400 treatment slots, this metric will apply to those additional patients.  **Summary of B3 outputs required (please read the details above):**  1. A report is required setting out the prioritisation criteria and evidence that treatment in the period corresponds to this  2. List of virology laboratories serving the ODN  3. MOU / SLA with the majority of virology testing suppliers  4. A plan describing how to initiate the flow of notifications of all new positive HCV tests from all labs by 1st October 2018  5. A report on pathways and processes to see referrals within 3 months  6. A plan to follow up all previous positive HCV tests by 31st March 2019  **TRIGGER B4: ODN Effectiveness in sustaining benefits of treatment (including supporting case finding and testing)**   One fifth of the stewardship incentive available through trigger A is payable through | | | | | |

this trigger. Whilst the CQUIN is not going to focus on achievement of re-testing, ODNs are required to populate the information within the Registry.

 The original measure for this objective was retesting a year after cure which aimed to ensure that the care around new direct acting antivirals sustained the benefit, supporting all, but especially vulnerable, patients at risk of reinfection. This remains an important principle but the trigger now moves from a patient level measure to a system level one.

 The measure for this objective now focuses on the contribution ODNs can make to increased case finding and testing initiatives. ODN Lead providers have a key role to play in supporting the whole system to play its part in preparing for improved case finding as set out in the published service specification.

 This includes joint work as required in the service specification and as evidenced by signed agreements with the local prisons, drug and alcohol services, sexual health

clinics and other organisations as appropriate to local population/ disease prevalence need and service provision. Evidence of joint working is focused on how the services and ODN work together to support HCV testing, and it is likely these discussions will be helped by involving the local commissioners of the services involved

 To qualify for full payment, an ODN will have a) identified all relevant services within its boundaries (as evidenced through the governance triggers) and put in place a signed agreement with >50% of all partners to support an agreed opt-out testing pathway and b) produce

 A map / list that identifies all services (specifying number and type) where patients could be tested for HCV in the ODN area (e.g. GP practices, GU services, A&E,

Trusts, drug and alcohol services, other).

 State which ones the ODN is already working with to promote and support HCV testing

 State which ones the ODN does not yet have arrangements in place

 A summary of the action taken timelines for full coverage of arrangements and any issues or risks identified.

 A report by 1st October 2018 which sets out of all the organisations identified in the map / list of all services where patients could be tested for HCV

 Those with established opt out testing

 The levels of opt out testing being achieved by provider

 The plans to achieve improvement by 31st March 2019 including the action required to achieve improvement, the % improvement sought, any risks, issues or mitigations to

achieve the improvement

 The report should reflect the outcome of active partnership working that involves a range of providers and commissioners. The NHS England regional team should be able to effectively validate the report and its content through the support and encouragement they provide to ODNs who will lead the necessary pathway work described. .

This metric is assessed annually. 50% will be based on baseline reporting and 50% can be earned by reporting on the plans for achieving improved performance. A partial payment of

75% for this metric will be paid where evidence provided gives partial but not full assurance that steps are in place to work in partnership to improve case finding (e.g. one of the following has not been completed - identification of relevant services is complete OR evidence of engagement by all parties is validated by due date OR Report is complete). Where only

limited assurance is provided the payment will be 50%. (E.g. where more than one of the following is not complete - identification of relevant services is complete OR evidence of

engagement by all parties is validated by due date OR Report is complete). Below this level

of assurance (e.g. no service identified, no validated evidence of engagement, and no report)

no payment will be made.

In 2018/19 this measure will be further developed to build on the output of ODN reporting and the needs of the strategic procurement. This may include measures of performance within the ODN area with regard to the performance of other partners on opt out testing coverage and % of opt out testing rate, taking into account the baseline this year and the purpose of CQUIN being about the ODN’s role in advocating for the HCV pathway and acting as a key systems leader promoting the importance of improvement and stretch in HCV testing rates. The detail will be developed further at a later stage with feedback from providers.

For those ODNs accepting any of the additional 2,400 treatment slots, this metric will apply to those additional patients.

**Summary of B4 outputs required (please read the details above):**

1. Signed agreements with the local prisons, drug and alcohol services, sexual health clinics and other organisations

2. List of all relevant services, signed agreements, agreed pathways for opt out testing

3. Map/ list of all services where testing could be offered, and update on whether or not testing is offered

4. Timeline and implementation plan for full coverage including risks and issues

5. A report on the B4 metrics by 1st October 2018 which includes opt out testing rates

**TRIGGER B5: Completeness and Data Quality in the ODN ‘Registry’**

 One fifth of the stewardship incentive available through trigger A is payable through this trigger. The objective of this trigger is to create an active registry of all patients with a confirmed HCV diagnosis and then track the patient through from initial diagnosis to provision of treatment and outcome. This includes all patients including those who are treated in industry funded trials, as well as those patients who self-fund. Neither group (industry funded trials or self- fund patients) are counted in the run rate.

 Payment for this trigger was awarded in 2016 /17 based on the ODN demonstrating a plan for getting all patients known to services (including those yet to be treated) onto the Hep C patient registry within 4 months of the registry being made available by NHS England.

 Payment for 2017/18 was made based on a comparison of expected number of patients to be added to the patient registry (as given in the ODN report described

above) and the physical number of patients recorded on the patient registry 4 months after system go-live.

 Payment for 2018/19 will be made based on data entry timeliness, data completeness and quality. This includes patient demographics; name, NHS number, age and gender must be provided for 90% of patients. For all patients treated 80% of the obligatory

fields must be completed and for all patients completing SVR12 follow up 90% of the

SVR12 data must be completed.

 Trigger B5 CQUIN performance will be assessed by NHS England’s Head of

Information and Intelligence in the Specialised Services National Support Team and

will be based on the content of the Hepatitis C patient registry and treatment outcome system as at 12th April 2019. Full payment will be awarded if the patient registry demonstrates at least 85% completeness in the core data fields. The data selected for measurement will be based on all of the patients who completed or where expected to complete treatment between 1st January 2018 and 31st December 2018.

 The clinical lead of each ODN is required to confirm that data entry is an accurate reflection of service delivery.

 This will allow a 12 week period between the end of treatment and capture of the SVR12 test result and a 2 week period at the end of the financial year for organisations to submit any outstanding data entry. Outcomes for patients who commence

treatment then cease ahead of the expected duration should also be captured

 No payment will be made where data completeness and accuracy in the core data fields is below 50%

 Where between 50% and 85% of data is complete and warranted as accurate the payment for this element will be proportional to the % achieved

 Subject to the outcome of the strategic procurement it may prove necessary to make further changes to the Hep C Registry, this will be done in collaboration with the ODN Clinical Leads For those ODNs accepting any of the additional 2,400 treatment slots, this metric will apply to those additional patients.

**Definitions**

**1. MDT Treatment**

a. Numerator: No of HCV patients whose treatment has been subject to MDT review and accords with ODN guideline.

b. Denominator: No of HCV patients in catchment population that should be seen in period (set out in MDT plan for network agreed with commissioners)

**2. Supporting Indicators**

a. Average Drug Treatment Plan Duration (weeks)

b. % patients completing treatment as planned

c. Patients drug treatments initiated by genotype and fibrosis/Cirrhosis status

**3. Dataset Reporting** As described and as specified in supporting documentation: BI1 Hepatitis C CQUIN reporting requirements.docx (revised)

**4. Registry data completeness**

The denominator for this measure is as follows: the number of patients completing or expecting to complete their treatment between 1st January 2018 and 31st December

2018 multiplied by the number of core data fields within the registry.

The supporting information for measures which relate to confidential prices of treatments are available directly to ODN lead providers on a commercial in confidence basis and should only be shared as needed with ODN partner organisations who are party to a confidentiality agreement. Further information will be provided to ODN lead providers.

**Partial achievement rules**

The governance payments are per quarter with no partial payment if not achieved. The stewardship payments partial achievement rules are set out in the measures and

payment triggers section

The aim of the 2018/19 amendments is to align to the goals of the ODN service specification, to increase attention on case finding and to enable capacity to achieve rates in excess of the treatment run rate. This will be demonstrated by increases in patients added to the registry. Where providers do not achieve the metric for full payment on the revised B3 (ODN Prioritisation of patients with highest clinical need) and B4 (ODN Effectiveness in sustaining benefits of treatment) measures, the rate with which new patients have been added to the registry will be taken into account as a mitigating factor in the assessment .of performance.

**In Year Payment Phasing & Profiling**

Governance payments are quarterly.

Stewardship payments are half yearly for B1 to B3 and full year end for B4 and B5

**Rationale for inclusion**

New HCV Treatments are recognised to be cost effective by NICE, and ODNs are a specified element of NICE technology appraisal guidance. The operation of managed network principles can

- Ensure clinically appropriate medicine choice and treatment duration is selected in line with latest evidence, and maximise the access to treatment relative to investment, achieving greater health gain.

- Ensure patient treatment interventions maximise adherence to treatment regimen and minimise relapse thus minimising the reduction in health outcomes for real world treatment compared to trial conditions

- Provide an equitable basis to rollout and prioritise patients with highest clinical need.

The rationale for revisions in 2017/18 and 2018/19 is as follows:

- Clinical advice has highlighted that the clinical challenges of treating HCV in the context of the WHO strategy for elimination by 2030 requires a focus on improving case finding of diagnosed patients and increasing testing and diagnosis. Whilst the wider health and social care system has a role to play, ODNs as expressed in the service specification has a key leadership role to play in supporting these actions.

- We received requests for clarification of definition and evidence requirements which are now provided

- We have increased the upper limit of performance of B1(ODN MDT decisions aligned to NHS England published run-rate) metric in response to requests for a tolerance

- We have proposed a new rule for partial payment for performance on B2 (ODN Treatment cost per patient relative to the first line of treatment as per the rate card) in response to feedback

- We have focused B3 (ODN Prioritisation of patients with highest clinical need)

measurement for prioritisation action to link diagnosed individuals to care

- We have revised the B4 (ODN Effectiveness in sustaining benefits of treatment) measure of sustained benefit (retesting) to a clinically advised measure regarding partnerships supporting opt-out testing of high risk populations.

- We have amended the requirements for B5 now the deadline for data upload has passed.

**Data Sources, Frequency and responsibility for collection and reporting**

Two types of data requirement:

 Narrative reports – produced by ODN Clinical Teams

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|  Dataset: This is demonstrated via 3 sources – Blueteq, drugs MDS and HCV patient registry and treatment outcomes system data input all of which must be fully completed and complied with  Providers will need to produce evidence of appropriate administrative arrangements in place to enable MDTs / data reporting. | |
| Baseline period/ date &  Value | Not Applicable – performance based on MDT plan not baseline  period: MDT Plan Activity for financial year |
| Final indicator period/date (on which  payment is based) & Value | Measures for financial year as at Month 6 and Month 12 except where otherwise stated |
| Final indicator reporting  date | Month 12 Contract Flex reporting date as per contract |
| **CQUIN Exit Route**  *How will the change including any performance requirements be sustained once the CQUIN indicator has been retired?* | The set up costs of HCV ODNs were supported financially in ETO  provider CQUIN or central funding allocation in 2015/16.  As a year 2 and year 3 CQUIN, the governance costs will be embedded in reference costs from the year after the CQUIN concludes. Governance arrangements will need to reflect funding flows needed from Tariff income in year 4 across partner organisations to fund ongoing network infrastructure.  Stewardship payments will be reviewed in light of future year requirements to inform CQUIN incentives for 2017/18 |

**Supporting Guidance and References**

NICE has concluded that a number of new oral HCV treatments are cost effective for certain patient groups (see [https://www.nice.org.uk/guidance/conditions-and- diseases/liver-conditions/hepatitis](https://www.nice.org.uk/guidance/conditions-and-diseases/liver-conditions/hepatitis))

Reducing harm from Hepatitis C is a priority for the NHS. There are estimated to be

160,000 people with chronic Hepatitis C infection in England, of whom 80,000 are diagnosed. In 2012 about 5000 people received drug treatment for HCV in the UK, i.e. about 3% of the prevalent pool of infected patients receives treatment each year.

A wide body of literature on generalisability of healthcare research suggests treatment adherence and clinical outcomes achieved in real world settings fall short of clinical trial based outcomes (For example Sculpher et al 20041) Effective clinical networks are one way to minimise this shortfall.

NHS England has implemented the establishment of Hepatitis C networks to ensure clinical and cost effective care is delivered with oversight from Hepatitis C centres and MDTs. Strong partnership working across the complex pathways for patients is essential to ensure patients have access to both clinical expertise and local delivery of care.

1 Sculpher MJ, Pang FS, Manca A et al. Generalisability in economic evaluation studies in healthcare: a review and case studies. Health Technology Assessment 2004; 8:1-206. See also Drummond MF, McGuire A eds. Economic Evaluation in Health Care: Merging Theory with Practice. Oxford University Press

There are a large number of commissioners and services involved in the treatment of patients who may have Hepatitis C or are infected and also suffer from other co- morbidities or conditions. Acute services, drug and alcohol services, detained settings, primary and community care providers may be caring for the eligible patient groups. The majority of patients with Hepatitis C are within disadvantaged groups.

The CQUIN scheme is linked to the development of a national group of ODNs which will help support clinicians with identifying the most clinically and cost effective options for patients. It will spread specialist expertise in this rapidly evolving field beyond specialist centres making it more accessible for patients and ensuring all have access to the appropriate therapeutic options and greater integration of care between providers of services whilst preserving local access.

Treatment selection is complex to support adherence, avoid resistance and relapse and to make best use of NHS resources. Hepatitis C ODNs provide a vehicle for ensuring that clinicians are aware of which are the most cost effective, efficacious treatments and to help choose between alternative products and treatment plans.

England has lacked any national data linking across services to improve accuracy of data on patient numbers, treatment, outcomes and access. This CQUIN scheme supports the innovation required by the whole system to work together to manage access to new treatments in a cost effective way. Networks are expected to play an active role in developing and refining the outcome data collected by partner providers over the next 2 years to develop the evidence base of treatment in routine clinical practice.