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EDITORIAL

The Vascular PAD-QIF CQUIN: what is it, why is it important, what does it mean for vascular units?

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The Commissioning for Quality and Innovation (CQUIN) indicators for 2022/23 were recently published by NHS England and for the first time include a vascular indicator, the "Achievement of revascularisation standards for lower limb ischaemia".[1] This is great news and will drive quality improvement for patients with chronic limb-threatening ischaemia (CLTI). In this editorial we describe what this means for English NHS organisations providing vascular services, vascular clinicians and patients.

The Prescribed Specialised Services (PSS) CQUIN framework is a pay-for-performance scheme for English NHS Trusts. It supports improvements in quality of care by linking a proportion of the healthcare providers' income to the achievement of quality improvement goals in clinical priority areas.[2] It was launched in the NHS in England in 2013 but was suspended during the pandemic. This year there are five PSS CQUIN indicators that acute Trusts must adopt. The baseline value for the CQUIN equates to 1.25% of the fixed element of the expected annual contract value, with each of the five indicators worth 0.25%. If the CQUIN target is not met, the CQUIN value will be deducted and reimbursed. For an arterial centre, this penalty is estimated at approximately £500,000 or more depending on Trust size.

The "Achievement of revascularisation standards for lower limb ischaemia" CQUIN indicator is based on the Vascular Society of Great Britain and Ireland Peripheral Arterial Disease Quality Improvement Framework (PAD-QIF) published in March 2019, which recommends a timeframe of 5 days from referral to the vascular team to revascularisation for patients admitted urgently with CLTI.[3] This indicator evaluates quality by measuring the proportion of patients with CLTI that undergo open, endovascular or hybrid revascularisation within 5 days from non-elective admission to vascular provider units.[4] Payment is determined by reference to two thresholds (upper threshold 60%, lower threshold 40%). NHS organisations will receive the full CQUIN value if 60% or more of CLTI patients who are deemed suitable for revascularisation are revascularised within 5 days from admission and no payment will be earned if this proportion is below 40%. Deductions will be graduated if performance falls between the two thresholds. Regional Specialised Commissioning teams will monitor performance of providers using Hospital Episode Statistics (HES) data and data entry to the National Vascular Registry (NVR).

The CQUIN aims to drive improved levels of data entry to NVR, which will be used to quality assure the timeliness of revascularisation and patient outcomes. This supports the Getting It Right First Time (GIRFT) recommendation that case ascertainment rates for lower limb procedures should exceed 85%.[5] Therefore, if comparison between NVR and HES data demonstrates significant under-reporting, there is the potential for commissioners, at their discretion, to withhold or reduce payment. This should ensure providers identify sufficient resources (including administrative support) for vascular services (both surgical and radiological) to meet this target level of case ascertainment to the NVR.

There has been conflicting evidence about the effectiveness of pay-for-performance schemes to improve processes and patient outcomes.[6–8] The CQUIN aims to improve quality of care by measuring clinical processes, and assumes that improvement in these metrics will result in improvement in patient outcomes and a more positive patient experience due to fewer delays. Patients treated within 5 days have been

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demonstrated to have shorter postoperative and overall hospital stays in the recent NVR report,[9] and may experience fewer complications. The positive effect of interventions such as dedicated limb salvage clinics on patient outcomes such as amputation-free survival has also been demonstrated.[10] Additionally, having a vascular CQUIN indicator focuses the attention of NHS providers of vascular services and provides an opportunity for clinicians to seek resources and support from their organisational leadership, by highlighting the potential financial gains thanks to the reduced length of stay and subsequent increased bed capacity, as well as the financial incentive of the CQUIN itself.

Vascular units may need to reconfigure their pathways to prioritise patients with CLTI and expedite patient review, imaging and treatment in order to achieve the target. In this effort, they may benefit from the experience of the early adopters participating in the PAD-QIF, who have introduced a number of innovative solutions that can serve as examples for other units.[11] Vascular units are able to identify their baseline performance, published in the 2021 NVR report.[9]

The PAD-QIF timeframes are challenging and achieving them is likely to require additional resources and a change in the delivery of vascular services. However, we hope that the inclusion of the CLTI indicator in the CQUIN framework will raise the profile of peripheral arterial disease with NHS Executive teams. Furthermore, by highlighting CLTI as a clinical priority, the CQUIN will encourage the adoption of the 5-day target into clinical practice and lead to improved patient outcomes and reduced amputation rates.

Conflict of Interest: PB, KB, ADP, JRB and RDS contributed to the development of the vascular CQUIN application. RDS, JRB and ADP are members of the National Clinical Reference Group for Vascular Services. JRB and ADP are members of the VSGBI Executive Council and RDS is the VSGBI representative at the RCS England Council.

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