**CQUIN Indicator Specification Information on CQUIN 2017/18 - 2018/19**

Publications Gateway Reference 06023

**Contents**

[1. The CQUIN scheme 2017/18 – 2018/19 2](#_Toc466290249)

[1. Improving staff health and wellbeing 3](#_Toc466290250)

[2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) 14](#_Toc466290251)

[3. Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) 27](#_Toc466290252)

[4. Improving services for people with mental health needs who present to A&E 44](#_Toc466290253)

[5. Offering advice and guidance 61](#_Toc466290254)

[6. NHS e-Referrals 67](#_Toc466290255)

[**7.** **Supporting proactive and safe discharge** 75](#_Toc466290256)

[**8.** **Preventing ill health by risky behaviours – alcohol and tobacco** 93](#_Toc466290257)

[**9.** **Improving the assessment of wounds** 114](#_Toc466290258)

[**10.** **Personalised care and support planning** 118](#_Toc466290259)

# The CQUIN scheme 2017/18 – 2018/19

This Annex sets out the technical specification for each of the indicators in the scheme.

This document should be read in conjunction with the 2017-2019 CQUIN guidance found at <https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/>

# Improving staff health and wellbeing

There are three parts to this CQUIN indicator.

|  |  |  |
| --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** |
| CQUIN 1a | Improvement of health and wellbeing of NHS staff | 33.3% of 0.25% (0.0834%) |
| CQUIN 1b | Healthy food for NHS staff, visitors and patients | 33.3% of 0.25% (0.0833%) |
| CQUIN 1c | Improving the uptake of flu vaccinations for front line staff within Providers | 33.3% of 0.25% (0.0833%) |

#### Indicator 1a Improvement of health and wellbeing of NHS staff

| **Indicator 1a** | |
| --- | --- |
| **Indicator name** | Indicator 1a: Improvement of staff health and wellbeing |
| **Indicator weighting  (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0834%) |
| **Description of indicator** | Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question.  Year 1 (17/18)  The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey.  Year 2 (18/19)  The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey.   1. **Question 9a**: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer “yes, definitely” compared to baseline staff survey results or achieve 45% of staff surveyed answering “yes, definitely”. 2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the answer “no” compared to baseline staff survey results or achieve 85% of staff surveyed answering “no”. 3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? Providers will be expected to achieve an improvement of 5% points in the answer “no” compared to baseline staff survey results or achieve 75% of staff surveyed answering “no”. |
| **Numerator** | NHS staff survey results for the Provider  Year 1  **Question 9a:** 2017 number of responses of “yes, definitely”  **Question 9b:** 2017 number of responses of “no”  **Question 9c:** 2017 number of responses of “no”  Year 2  **Question 9a:** 2018 number of responses of “yes, definitely”  **Question 9b:** 2018 number of responses of “no”  **Question 9c:** 2018 number of responses of “no” |
| **Denominator** | NHS staff survey results for the Provider  Year 1  **Question 9a**: 2017 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*)  **Question 9b:** 2017 Total number of responses (*Yes/No*)  **Question 9c:** 2017 Total number of responses (*Yes/No*)  Year 2  **Question 9a**: 2018 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*)  **Question 9b:** 2018 Total number of responses (*Yes/No*)**Question 9c:** 2018 Total number of responses (*Yes/No*) |
| **Rationale for inclusion** | The Health & Wellbeing CQUIN introduced in 2016 encourages providers to improve their role as an employer in looking after employees health and wellbeing. Part of this scheme provided the option to introduce schemes focussing on mental health, physical activity and MSK –many of which are being introduced during the second half of 2016-17. The focus of this element of the CQUIN will shift from the introduction of schemes to measuring the impact that staff perceive from the changes – via improvements to the health and wellbeing questions within the NHS staff survey.  Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.  The Five Year Forward View made a commitment ‘to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy’. A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged. |
| **Data source** | The NHS Annual Staff survey  **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response.  **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response.  **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response. |
| **Frequency of data collection** | Annual release of staff survey results |
| **Organisation responsible for data collection** | National NHS staff survey co-ordination centre |
| **Frequency of reporting to commissioner** | On the publication of 2017 (year 1) & 2018 (year 2) staff survey – expected to be released in February 2018 & 2019 respectively |
| **Baseline period/date** | Year 1 - 2015 staff survey – released in 2016  Year 2 – 2016 staff survey- released in 2017 |
| **Baseline value** | Individual trust performance against each staff survey question |
| **Final indicator period/date (on which payment is based)** | Year 1 - Quarter 4, 2017/18  Year 2 – Quarter 4 2018/19 |
| **Final indicator value (payment threshold)** | Achievement of the 5% point improvement in 2 of the 3 questions in the staff survey results |
| **Final indicator reporting date** | Year 1 – Publication of 2017 staff survey – expected in February 2018  Year 2 – Publication of 2018 staff survey – expected in February 2019 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes |

#### Rules for partial achievement of indicator 1a

The partial payment structure below will be applied to each question individually. For instance, a 5% point improvement in question 9a and a 3% improvement in 9b would result in 75% payment of this indicator calculated by:

1. Question 9a – 50% indicator weighting x 100% payment for achieving 5% improvement = 50%
2. Question 9b – 50% indicator weighting x 50% payment for achieving 3% improvement = 25%

**Total = 50%+25% = 75%**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 3% point improvement | 0% payment of weighting associated to staff survey results |
| 3% point (or above) and less than 4% improvement | 50% payment of weighting associated to staff survey results |
| 4% point (or above) and less than 5% improvement | 75% payment of weighting associated to staff survey results |
| 5% point or greater improvement or achievement of uptake target | 100% payment of weighting associated to staff survey results |

**Indicator 1b Healthy food for NHS staff, visitors and patients**

| **Indicator 1b** | |
| --- | --- |
| **Indicator name** | Indicator 1b: Healthy food for NHS staff, visitors and patients |
| **Indicator weighting  (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0833%) |
| **Description of indicator** | Providers will be expected to build on the 2016/17 CQUIN by:  Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19   1. The banning of price promotionson sugary drinks and foods high in fat, sugar or salt (HFSS)[[1]](#footnote-1).   The following are common definitions and examples of price promotions:   * + 1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal);     2. Multi-buy discounting: for example buy **one** get **one** free;     3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);     4. Price pack or bonus pack deal (for example 50% for free); and     5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals).  1. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS);   The following are common definitions and examples of advertisements:   * 1. Checkout counter dividers   2. Floor graphics   3. End of aisle signage   4. Posters and banners  1. The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;   The following are common definitions and examples of checkouts;   1. Points of purchase including checkouts and self-checkouts 2. Areas immediately behind the checkout   and;   1. Ensuring that healthy options are available at any point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue.   Secondly, introducing three new changes to food and drink provision:  In Year One (2017/18)   1. 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). 2. 60% of confectionery and sweets do not exceed 250 kcal. 3. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g[[2]](#footnote-2)   In Year two (2018/19):  The same three areas will be kept but a further shift in percentages will be required   1. 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml). 2. 80% of confectionery and sweets do not exceed 250 kcal. 3. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g[[3]](#footnote-3) |
| **Numerator** | N/A |
| **Denominator** | N/A |
| **Rationale for inclusion** | Any Provider who does not sell food or drink on their site will not be eligible for the CQUIN. In these cases the weighting for this part (1b) will be added equally to parts 1a and 1c.  PHE’s report “Sugar reduction – The evidence for action” published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals.  NHS England will continue with their work at a national level with the major food suppliers on NHS premises to ensure that NHS providers are supported to take action across all food and drink outlets on their premises. |
| **Data source** | Provider data source |
| **Frequency of data collection** | End of Quarter 4 |
| **Organisation responsible for data collection** | Evidence should be provided that shows a substantive change has been moved in shifting to healthier products   * Reduction in % of sugar/salt products displayed: * Increase in healthier alternatives * Avoidance of overt promotion   However the exact detail of reporting should be agreed locally so that it can be adapted to the local situation (for instance it may differ depending on the scale and types of outlets on premises).  Each provider must evidence to commissioners that they have maintained the changes in 2016/17 and introduced the 2017/18 changes by providing at least the following evidence:   * A signed document between the NHS Trust and any external food supplier committing to keeping the changes * Evidence for improvements provided to a public facing board meeting |
| **Frequency of reporting to commissioner** | End of Quarter 4 |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Year 1 - End of Q4 2017/18  Year 2 - End of Q4 2018/19 |
| **Final indicator value (payment threshold)** | To be determined locally |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **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?** | Yes |

#### Rules for partial achievement of indicator 1b

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 2017/18 - 2016/17 changes maintained  2018/19 - 2016/17 changes maintained | 50% payment |
| 2017/18 - Year 1 changes introduced  2018/19 - Year 2 changes introduced | 50 % payment |
| 2017/18 - 2016/17 changes maintained and Year 1 changes introduced  2018/19 – 2016/17 changes maintained and Year 2  changes introduced | 100% payment |

#### Indicator 1c Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff

| **Indicator 1c** | |
| --- | --- |
| **Indicator name** | Improving the uptake of flu vaccinations for frontline clinical staff within Providers. |
| **Indicator weighting  (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0833%) |
| **Description of indicator** | Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70%  Year 2 - Achieving an uptake of flu vaccinations by frontline clinical staff of 75% |
| **Numerator** | Number of front line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by February 28th 2018.  If organisations believe a significant proportion of staff are receiving their flu vaccines from other providers, they can include this in their returns if they wish to create an auditable scheme to demonstrate it. |
| **Denominator** | Total number of front line healthcare workers [[4]](#footnote-4) |
| **Rationale for inclusion** | Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - a much higher incidence than expected in the general population.  Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.  The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association.  Specifically the green book states “Employers need to be able to demonstrate that an effective employee immunisation programme is in place, and they have an obligation to arrange and pay for this service. It is recommended that immunisation programmes are managed by occupational health services with appropriately qualified specialists. This chapter deals primarily with the immunisation of healthcare and laboratory staff; other occupations are covered in the relevant chapters.”[[5]](#footnote-5) |
| **Data source** | Providers to submit cumulative data monthly on the ImmForm website |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Year 1 -March 2018  Year 2 -March 2019 |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Year 1-March 2018  Year 2-March 2019 |
| **Final indicator value (payment threshold)** | Year 1 – A 70% uptake of flu vaccinations by frontline healthcare workers  Year 2 - A 75% uptake of the flu vaccinations by frontline healthcare workers |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes - see partial payment section |

#### Rules for partial achievement of indicator 1c – Year 1

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 50% or less | No payment |
| 50% up to 60% | 25% payment |
| 60% up to 65% | 50% payment |
| 65% up to 70% | 75% payment |
| 70% or above | 100% payment |

#### Rules for partial achievement of indicator 1c – Year 2

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 50% or less | No payment |
| 50% up to 60% | 25% payment |
| 60% up to 65% | 50% payment |
| 65% up to 75% uptake | 75% payment |
| 75% or above | 100% payment |

#### Supporting Guidance and References

Practical guidance and support for Providers will be provided by the beginning of March to help support them with the introduction of the initiatives & to help them promote uptake. However, NHS Employers already offer campaign advice for Providers.

<http://www.nhsemployers.org/campaigns/flu-fighter/nhs-flu-fighter>

# Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)

There are four parts to this CQUIN indicator.

|  |  |  |
| --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** |
| CQUIN 2a | Timely identification of sepsis in emergency departments and acute inpatient settings | 25% of 0.25% (0.0625%) |
| CQUIN 2b | Timely treatment for sepsis in emergency departments and acute inpatient settings | 25% of 0.25% (0.0625%) |
| CQUIN 2c | Antibiotic review | 25% of 0.25% (0.0625%) |
| CQUIN 2d | Reduction in antibiotic consumption per 1,000 admissions | 25% of 0.25% (0.0625%) |

#### Indicator 2a Timely identification of sepsis in emergency departments and acute inpatient settings

| **Indicator 2a** | |
| --- | --- |
| **Indicator name** | Timely identification of patients with sepsis in emergency departments and acute inpatient settings |
| **Indicator weighting  (% of CQUIN scheme available)** | 25% of 0.25% (0.0625%) |
| **Description of indicator** | The percentage of patients who met the criteria for sepsis screening and were screened for sepsis  The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards.  This applies in 17/18 and 18/19. |
| **Numerator** | Total number of patients presenting to emergency departments and other units that directly admit emergencies, and acute inpatients services who met the criteria of the local protocol on Early Warning Scores (usually NEWS greater than or equal to 3) (excluding those where an alternative diagnosis is clinically more likely, e.g. major trauma) and were screened for sepsis. |
| **Denominator** | Total number of patients presenting to emergency departments and acute inpatient services and other units that directly admit emergencies who were appropriate for screening for Sepsis on the basis of the above-mentioned local protocol. |
| **Rationale for inclusion** | The purpose of this CQUIN proposal is to embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics.  Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000[[6]](#footnote-6) deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented.  NICE published its first guidance on sepsis in July 2016. The proposed CQUIN is an opportunity for us to encourage provider organisations to follow NICE guidance to improve sepsis management.  In 2015/16 there was a national sepsis CQUIN that appears to have raised the rate of screening for sepsis among ED admissions from 52% to 80%, and the rate of prompt antibiotic administration for people in this group with severe sepsis from 57% in Q3 to 64%.  In 2016/17 this CQUIN was extended to also include inpatients who deteriorate due to sepsis. It is too early to yet measure the impact of this; however it has been viewed favourably by clinicians and quality improvement teams who recognise the importance of prompt identification and management of the deteriorating patient as a means of reducing avoidable mortality in hospitals.  In addition in 2016/7 there is a CQUIN on antimicrobial resistance (AMR) that aims to reduce both total and inappropriate antibiotic usage in hospitals. This is really important since AMR has increased significantly in recent years and the CMO believes it is a major risk for healthcare; without reversal of the trend we may find we have no drugs to treat serious infections in the future.  Both sepsis and AMR CQUINs in 2016/7 include the requirement that a competent clinician reviews the antibiotic prescription within three days of commencement to determine if it is still needed, and if so, if the appropriate antibiotic is being used.  The teams working on sepsis and on AMR in NHS England and NHS Improvement believe that the issues of sepsis and AMR are complementary and that developing and implementing a joint CQUIN will support a coherent approach within provider organisations, towards reducing the impact of serious infections. |
| **Data source** | A minimum of 50 records per month after exclusions for ED and a separate 50 minimum after exclusions for Inpatients. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Year 1 - Q4 2016/17  Year 2 - Q4 2017/18 |
| **Baseline value** | See section on payments |
| **Final indicator period/date (on which payment is based)** | See section on payments |
| **Final indicator value (payment threshold)** | See section on payments below for full information  Screening – national thresholds have been set for payment based on absolute performance levels. |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Yes – see payment section below |
| **Final indicator reporting date** | Year 1 - As soon as possible after Q4 2017/18  Year 2 - As soon as possible after Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see payment section below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see payment section below |
| **EXIT Route** | To be determined locally |

#### Rules for in-year payments for indicator 2a in 17/18 and 18/19

**Emergency Department and Acute Inpatient Settings**

| **Quarter** | **Timely identification and screening** | |
| --- | --- | --- |
| Q1 | Payment based on % of eligible patients (based on local protocol) screened: | |
| **Less than 50.0%:** | No payment |
| **50.0%-89.9%:** | 5.0% |
| **90.0% or above:** | 12.5% |
| Q2 | As Q1 | |
| Q3 | As Q1 | |
| Q4 | As Q1 | |
| **Full year – % of indicator weighting available** | **(max)** | |

#### Supporting Guidance and References

**Key Components of Local Protocols**

Following the publication of the NICE guidance in 2016 on *Sepsis: recognition, diagnosis and early management* [NG51] providers should ensure their protocols follow this guidance

<https://www.nice.org.uk/guidance/ng51>

Providers should be mindful of the tools to support screening and management of Sepsis at <http://sepsistrust.org/clinical-toolkit>.

**Appropriate tools for sepsis screening**

Tools used should be either those produced in conjunction with relevant professional bodies at: <http://sepsistrust.org/clinical-toolkit> or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at <http://ccforum.com/content/supplementary/cc11895-s2.pdf>.

There are other examples of tools for suitable use in inpatient services at: <http://sepsistrust.org/professional/professional-resources/>

**Method for identifying random samples**

Trusts should select ONE of the following methods and maintain this method throughout the 2017/18 year of data collection:

1. True randomisation: review the nth patient’s notes where n is generated by a random number generator or table (e.g. <http://www.random.org/>) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. <http://www.random.org/>.
2. Pseudo-randomisation: Review the first X patients’ notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

This should be repeated in 2018/19.

#### Suggested Format for Local Data Collection

**Sepsis Screening in Emergency Departments**

**N.B.** These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total** | **Column B total** | **Column C total** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |

**Sepsis Screening in Inpatient Services**

**N.B.** These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total** | **Column B total** | **Column C total** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |

#### Indicator 2b Timely treatment of sepsis in emergency departments and acute inpatient settings

| **Indicator 2b** | |
| --- | --- |
| **Indicator name** | Timely treatment of sepsis in emergency departments and acute inpatient settings |
| **Indicator weighting  (% of CQUIN scheme available)** | 25% of 0.25% (0.625%) |
| **Description of indicator** | The percentage of patients who were found to have sepsis in sample 2a and received IV antibiotics within 1 hour.  The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. |
| **Numerator** | Total number of patients found to have sepsis in emergency departments and acute inpatient services in sample 2a who received IV antibiotics within 1 hour of the diagnosis of sepsis. |
| **Denominator** | The total number of patients from the sample in the numerator in 2a who were diagnosed with sepsis. |
| **Rationale for inclusion** | Prompt treatment of sepsis reduces the mortality and the morbidity associated with this condition. |
| **Data source** | The records identified in the numerator of sample 2a |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Year 1 - Q4 2016/17  Year 2 – Q4 2017/18 |
| **Baseline value** | See section on payments |
| **Final indicator period/date (on which payment is based)** | See section on payments |
| **Final indicator value (payment threshold)** | See section on payments below for full information  Screening – national thresholds have been set for payment based on absolute performance levels. |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Yes – see payment section below |
| **Final indicator reporting date** | Year 1 - As soon as possible after Q4 2017/18  Year 2 - As soon as possible after Q4 2017/18 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see payment section below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see payment section below |
| **EXIT Route** | To be determined locally |

#### Rules for in-year payments for indicator 2b in 17/18 and 18/19

**Emergency Department and Acute Inpatient Settings**

| **Quarter** | **Timely treatment** | |
| --- | --- | --- |
| Q1 | Payment based on % of patients with sepsis treated within 1 hour (based on those identified in sample 2a) | |
| **Less than 50.0%:** | No payment |
| **50.0%-89.9%:** | 5.0% |
| **90.0% or above:** | 12.5% |
| Q2 | As Q1 | |
| Q3 | As Q1 | |
| Q4 | As Q1 | |
| **Full year – % of indicator weighting available** | **(max)** | |

#### Supporting Guidance and References

**Key Components of Local Protocols**

Following the publication of the NICE guidance in 2016 on *Sepsis: recognition, diagnosis and early management* [NG51] providers should ensure their protocols follow this guidance

<https://www.nice.org.uk/guidance/ng51>

Providers should be mindful of the tools to support screening and management of Sepsis at <http://sepsistrust.org/clinical-toolkit>.

**Appropriate tools for sepsis screening**

Tools used should be either those produced in conjunction with relevant professional bodies at: <http://sepsistrust.org/clinical-toolkit> or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at <http://ccforum.com/content/supplementary/cc11895-s2.pdf>.

There are other examples of tools for suitable use in inpatient services at: <http://sepsistrust.org/professional/professional-resources/>

#### Suggested Format for Local Data Collection

**Sepsis treatment in Emergency Departments and acute inpatient settings**

**N.B.** These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

This table can be combined with the tables in indicator 2a.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening** | **Tick column below if the patient was diagnosed with sepsis and received IV antibiotics within 1 hour of diagnosis** | **Tick column below if the patient was diagnosed with sepsis and did not receive IV antibiotics within 1 hour of diagnosis** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total** | **Column B total** | **Column C total** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 1 (sepsis treatment) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |

#### Indicator 2c Antibiotic review

| **Indicator 2c** | |
| --- | --- |
| **Indicator name** | Assessment of clinical **antibiotic review** between 24-72 hours of patients with sepsis who are still inpatients at 72 hours. |
| **Indicator weighting  (% of CQUIN scheme available)** | 25% of 0.25% (0.0625%) |
| **Description of indicator** | Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours  Appropriate clinical review by either:   * Infection (infectious diseases/ clinical microbiologist) senior doctor * Infection pharmacist * Senior member of clinical team   With the proportions of antibiotic outcomes in each group submitted, assessed by the following parameters: started on sepsis antibiotic treatment pathway and alive and still an / in-patients at time of review:   * If no blood cultures were not sent or blood cultures negative at 24-72 hours, a clinical review documenting why antibiotics need to be continued by describing the clinical syndrome, antibiotic choice based on syndrome, local IV to oral switch guidelines, and duration defined * If blood cultures were sent and positive by 24-72 hours, clinical review should document these results, ensure the narrowest spectrum antibiotic treatment is prescribed following local IV to oral switch guidelines AND duration defined   It would be expected that the documented outcome of this review will be recorded as follows:   * Stop * IV to oral switch * OPAT (Outpatient Parenteral Antibiotic Therapy) * Continue with new review date * Continue no new review date * Change antibiotic with Escalation to broader spectrum antibiotic * Change antibiotic with de-escalation to a narrower spectrum antibiotic * Change antibiotic e.g. to narrower/broader spectrum or as a result of blood culture results |
| **Numerator** | Number of antibiotic prescriptions reviewed within 72 hours |
| **Denominator** | Number of antibiotic prescriptions included in the sample |
| **Rationale for inclusion** | Rationale is as per part 2a |
| **Data source** | Local audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Based on achievement in each quarter within 2017/18 |
| **Final indicator value (payment threshold)** | Based on achievement in each quarter within 2017/18 – see milestones section |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes, see milestones section |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No |
| **EXIT Route** | To be determined locally |

#### Milestones for indicator 2c

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| Quarter 1 | Perform an empiric review for at least 25% of cases in the sample | End Q1 | 25% of 0.0625% (0.015625%) |
| Quarter 2 | Perform an empiric review for at least 50% of cases in the sample | End Q2 | 25% of 0.0625% (0.015625%) |
| Quarter 3 | Perform an empiric review for at least 75% of cases in the sample | End Q3 | 25% of 0.0625% (0.015625%) |
| Quarter 4 | Perform an empiric review for at least 90% of cases in the sample | End Q4 | 25% of 0.0625% (0.015625%) |

#### Indicator 2d Reduction in antibiotic consumption per 1,000 admissions

| **Indicator 2d** | |
| --- | --- |
| **Indicator name** | Reduction in antibiotic consumption per 1,000 admissions |
| **Indicator weighting  (% of CQUIN scheme available)** | 25% of 0.25% (0.0625%) |
| **Description of indicator** | There are three parts to this indicator.  1. Total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions  2. Total usage (for both in-patients and out-patients) of carbapenem per 1,000 admissions  3. Total usage (for both in-patients and out-patients) of piperacillin-tazobactam per 1,000 admissions |
| **Numerator** | Total antibiotic consumption as measured by Defined Daily Dose (DDD)  Total consumption of carbapenem as measured by Defined Daily Dose (DDD)  Total consumption of piperacillin-tazobactam as measured by Defined Daily Dose (DDD) |
| **Denominator** | Total admissions divided by 1,000 |
| **Rationale for inclusion** | Rationale is as per part 2a and 2b |
| **Data source** | Acute trusts would submit their own antibiotic consumption data to PHE with admission statistics taken from Hospital Episode Statistics (HES).  Antibiotic consumption data would be available for commissioners to review via AMR Fingertips. |
| **Frequency of data collection** | Antibiotic consumption data should be submitted quarterly to PHE |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Annual |
| **Baseline period/date** | January 2016-December 2016 |
| **Baseline value** | As per the validated prescription data in 2013/14 |
| **Final indicator period/date (on which payment is based)** | 2017/18 |
| **Final indicator value (payment threshold)** | Each of the indicators is worth 33% of part d  Reductions would be required as follows:  1% reduction for those trusts with 2016 consumption indicators below 2013/14 median value, or  2% reduction for those trusts with 2016 consumption indicators above 2013/14 median value |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **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 |
| **EXIT Route** | To be determined locally |

# Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)

There are two parts to this CQUIN indicator.

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| **CQUIN 3a** | Improving physical healthcare to reduce premature mortality in people with SMI:  Cardio metabolic assessment and treatment for patients with psychoses | 80% of 0.25% (0.20%) |  |
| **CQUIN 3b** | Improving physical healthcare to reduce premature mortality in people with SMI:  Collaborating with primary care clinicians | 20% of 0.25% (0.05%) |  |

#### Indicator 3a Cardio metabolic assessment and treatment for patients with psychoses

| **Indicator 3a** | |
| --- | --- |
| **Indicator name** | Cardio metabolic assessment and treatment for patients with psychoses |
| **Indicator weighting  (% of CQUIN scheme available)** | 80% of 0.25% (0.20%) |
| **Description of indicators** | **For 2017/18**  To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas:   1. Inpatient wards. 2. All community based mental health services for people with mental illness (patients on CPA), excluding EIP services. 3. Early intervention in psychosis (EIP) services.   **And in addition, for 2018/19**  To demonstrate positive outcomes in relation to BMI and smoking cessation for patients in early intervention in psychosis (EIP) services. |
| **Numerator** | **For 2017/18**  The number of patients in the defined audit sample who have both:   1. a completed assessment for each of the cardio-metabolic parameters with results documented in the patient’s electronic care record held by the secondary care provider. 2. a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.   **For 2018/19**  For **inpatient wards** and **community mental health services** same as for 2017/18.  For **early intervention in psychosis** services, same as for 2017/18 **plus**   * **EIP BMI outcome indicator**   The number of patients in the defined audit sample who have not exceeded a 7% weight gain since their baseline weight measurement prior to starting on anti-psychotic medication.     * **EIP Smoking cessation outcome indicator**   The number of patients in the defined audit sample who have stopped smoking |
| **Denominator** | **For 2017/18**  **Inpatients**  The sample must be limited to patients who have been admitted to the ward for at least 7 days. Inpatients with an admission of less than 7 days are excluded.  **Patients on CPA in all community based mental health services**  The sample must be limited to patients who have been on the team caseload for a minimum of 12 months.  **Early intervention in psychosis services**  The sample must be as per the annual CCQI EIP Network self-assessment specification.  *As per Implementing the Five Year Forward View for Mental Health (https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf) the NHS England planning guidance (*[*https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf*](https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf)*) and the NHSI Single Oversight Framework (*[*https://improvement.nhs.uk/uploads/documents/Single\_Oversight\_Framework\_published\_30\_September\_2016.pdf*](https://improvement.nhs.uk/uploads/documents/Single_Oversight_Framework_published_30_September_2016.pdf)*), all EIP services are expected to take part in the EIP Network, a quality assessment and improvement scheme administered by the Royal College of Psychiatrists College Centre for Quality Improvement, CCQI (*[*http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/earlyinterventionpsychosis.aspx*](http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/earlyinterventionpsychosis.aspx)*). This includes specific review of the quality of physical health care provided to people on the EIP caseload in line with the requirements of this CQUIN scheme.*  **For 2018/19**  For **inpatient wards** and **community mental health services** same as for 2017/18.  For **early intervention in psychosis** services, same as for 2017/18 **plus**   * **EIP BMI outcome indicator**   The number of patients experiencing a first episode of psychosis (not those classed as having an At Risk Mental State) who have been taking anti-psychotic medication for between at least 6 and 12 months.   * **EIP Smoking cessation outcome indicator**   The sample must be limited to patients who were identified in the 2017/18 sample as being at risk as per the red zone of the Lester Tool for smoking. |
| **Rationale for inclusion** | **Background**  People with severe mental illness (SMI) are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.  Early Intervention in Psychosis Services  Since 1 April 2016, the access and waiting time standard for early intervention in psychosis (EIP) services has required that more than 50% of people experiencing first episode psychosis commence treatment with a NICE-approved care package within two weeks of referral. The standard is targeted at people aged 14-65 in line with NICE recommendations. In response to the recommendation of the Mental Health Taskforce, NHS England has committed to ensuring that, by 2020/21, the standard will be extended to reach at least 60% of people experiencing first episode psychosis.  To understand the baseline picture in terms of access to NICE-recommended interventions, NHS England commissioned the Healthcare Quality Improvement Partnership (HQIP) to undertake a baseline audit of EIP service provision. The sampling period spanned the period July 2014 to December 2014 and was published on 5 July 2016. Access to high quality physical healthcare assessment and interventions is one of the key requirements of the NICE Quality Standard but the audit finding was that screening for all seven physical health measures took place in only 22% of cases sampled (range of 0%-82%) and all indicated interventions were offered in only 13% of cases sampled (range of 0-64%).Improving access to high quality physical healthcare in EIP services is particularly crucial to improving longer term physical health care outcomes for people with psychosis and a specific focus on EIP services within this CQUIN scheme is therefore necessary.  Physical health SMI CQUIN  This CQUIN builds on the developments across England over the last 3 years to improve physical health care for people with severe mental illness (SMI) in order to reduce premature mortality in this patient group. The number of cardio metabolic assessments completed and interventions offered substantially increased between 2014/15 and 2015/16 and there was an increase in compliance with the CQUIN requirements. By continuing the CQUIN, providers have an opportunity to continue to build on progress made and ensure systems are in place to embed learning and sustain good practice.  The aim is to ensure that patients with SMI receive comprehensive cardio metabolic risk assessments and have access to the necessary treatments/interventions. The results are to be recorded in the patient’s electronic care record (held by the secondary mental health provider) and shared appropriately with the patient, the treating clinical team and partners in primary care.  Patients with SMI for the purpose of this CQUIN are all patients with psychosis, including schizophrenia (see additional notes below), in all types of inpatient units and community settings commissioned from all sectors.  The cardio metabolic parameters, based on the Lester Tool, for this CQUIN are as follows:   * Smoking status; * Lifestyle (including exercise, diet alcohol and drugs); * Body Mass Index; * Blood pressure; * Glucose regulation (preferably HbA1c or fasting plasma glucose. Random plasma glucose as appropriate); * Blood lipids.   Previously EIP services were audited in the PSMI CQUIN. With the access and waiting time standard and subsequent work, as of 2016/17 EIP services are required to complete an annual self-assessment tool (<http://www.rcpsych.ac.uk/pdf/EIPN%20Self%20Assessment%20Tool.pdf>) which includes completing a physical health review at start of treatment (baseline), at 3 months and then annually (or 6 monthly for young people) unless a physical abnormality arises. This includes the cardio metabolic parameters based within the Lester Tool. With data already collected through the CCQI EIP self-assessment tool, the CQUIN will draw upon this information to help calculate the CQUIN indicator above for 2017/18 and 2018/19.  BMI and smoking outcomes in EIP services  In order to provide stretch upon previous year’s requirements, for 18/19 this CQUIN scheme will develop to include a focus upon achieving outcomes in relation to BMI and smoking rates within EIP services. These are two of the parameters that, if positively impacted, have most potential to reduce premature mortality.   * The BMI outcome indicator is applicable to EIP services where 35% or more patients should gain no more than 7% body weight in the first year of taking antipsychotic medication. * The smoking outcome indicator is applicable to EIP services where 10% or more patients who were previously identified as in the Red Zone for smoking on the Lester Tool should have stopped smoking.   This CQUIN is part of a suite of incentives that trusts will be working with, and a number of these incentives will be complementary. The Preventing ill health by risky behaviours – alcohol and tobacco CQUIN indicator also includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status and alcohol use.  NHS England and Public Health England have taken steps to ensure alignment between the CQUIN indicators and so this presents an opportunity for providers to build on the practice incentivised through this indicator. It is therefore expected that providers will develop synergies across their work in delivering CQUINs to maximise the opportunities and reduce cost duplication and strengthen efforts in this area. |
| **Data source** | Internal mental health provider sample submitted to national audit provider for the CQUIN (for inpatient and community mental health services).  Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network (for EIP services). |
| **Frequency of data collection** | Annual |
| **Organisation responsible for data collection** | Mental health provider |
| **Frequency of reporting to commissioner** | Results of national audit and EIP quality assessment expected to be available by Quarter 4 for reporting to commissioners (2017/18 and 2018/19).  Additional direct reporting to commissioners locally in Quarters 2, 3 and 4. |
| **Baseline period/date** | Not applicable |
| **Baseline value** | Not applicable |
| **Final indicator period/date (on which payment is based)** | Data for national audit of inpatient and community based mental health services expected to be collected and submitted to national audit provider during Quarter 3 of both 2017/18 and 2018/19. Results to be available in Quarter 4.  Data for EIP services expected to be collected and submitted to CCQI during Quarter 2 of both 2017/18 and 2018/19. Results to be available by Quarter 4. |
| **Final indicator value (payment threshold)** | **Thresholds for payment:**  **For 17/18**   1. Inpatients – 90% 2. Community mental health services (patients on CPA) - 65% 3. Early intervention in psychosis services – 90%   **For 18/19**   1. Inpatients – 90% 2. Community mental health services (patients on CPA) - 75% 3. Early intervention in psychosis services – 90%   BMI outcome indicator – 35%  Smoking outcome indicator – 10% |
| **Final indicator reporting date** | 30 March 2018 and 29 March 2019 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes - see below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes - see below (excludes BMI and smoking outcome indicators) |

#### Milestones for indicator 3a

**2017/18**

| **Date/period milestone relates to 2017/18** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1 17/18** | 1. Ensure sustainable and high quality training programme in place for all relevant clinical staff caring for people with SMI. Training should cover processes for assessing, documenting and acting on cardio metabolic risk factors. Clinical staff training plan should have been fully implemented and all relevant clinical staff trained by the end of Q1. (Assessed locally by commissioners) 2. Ensure clear pathways for interventions and signposting for all cardio-metabolic risk factors:  * Smoking cessation * Lifestyle (including exercise, diet alcohol and drugs) * Obesity * Hypertension * Diabetes * High cholesterol   Clear pathways should be in place and have been disseminated to all clinical teams by the end of Q1. (Assessed locally by commissioners)   1. Ensure that the electronic care record system has been developed and is being used effectively for collection of physical health assessment and interventions data. (Assessed locally by commissioners). | July 2017 | 30% of indicator weighting for part 3a (10% for each of I, ii and iii). |
| **Quarter 4 17/18** | Results of national audit across inpatient and community mental health services and of EIP self-assessment scheme published. (See sliding scales below for payment details).  Evidence of systematic feedback on performance to clinical teams (Assessed locally by commissioners). | April 2018 | 70% of indicator weighting for part 3a, made up of:  20% (Inpatient services)  20% (EIP services)  30% (Community teams) |

**2018/19**

| **Date/period milestone relates to 2018/19** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1 18/19** | 1. Ensure physical health training programme is built into mandatory training procedures and:  * All staff who should have been trained have received initial training * New starters in relevant roles are trained * Relevant staff receive refresher training  1. Continue to ensure clear pathways for interventions and signposting for all cardio-metabolic risk factors:  * Smoking cessation * Lifestyle (including exercise, diet alcohol and drugs) * Obesity * Hypertension * Diabetes * High cholesterol   (Assessed locally by commissioners)   1. Complete internal audit to provide assurance that physical health assessment and interventions data are being recorded appropriately on the electronic care record. (Assessed locally by commissioners). | July 2018 | 10% of indicator weighting for part 3a |
| **Quarter 4 18/19** | Results of national audit across inpatient and community mental health services and of EIP self-assessment scheme published. (See sliding scales below for payment details).  Evidence of systematic feedback on performance to clinical teams (Assessed locally by commissioners).  Results of audit across EIP services for achieving BMI outcome indicator – at least 35% of patients should gain no more than 7% body weight in the first year of taking antipsychotic medication.  Results of audit across EIP services for achieving EIP smoking outcome indicator – at least 10% of patients who were previously in the Red Zone for smoking on the Lester Tool have stopped smoking. | April 2019 | 90% of indicator weighting for part 3a, made up of:  20% (Inpatient services)  40% (Community teams)  20% (EIP services)  5% (EIP BMI indicator)  5% (EIP Smoking indicator) |

#### Rules for partial achievement of indicator 3a

**Inpatient services & Early Intervention Psychosis Services (excluding BMI and smoking outcome indicators for which there is no partial achievement threshold)**

**For 2017/18 and 2018/19**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 49.9% or less | No payment |
| 50.0% to 69.9% | 25% payment |
| 70.0% to 79.9% | 50% payment |
| 80.0% to 89.9% | 75% payment |
| 90.0% or above | 100% payment |

**Community Mental Health Services**

**For 2017/18**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 34.9% or less | No payment |
| 35.0% to 44.9% | 25% payment |
| 45.0% to 54.9% | 50% payment |
| 55.0% to 64.9% | 75% payment |
| 65.0% or above | 100% payment |

**For 2018/19**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 44.9% or less | No payment |
| 45.0% to 54.9% | 25% payment |
| 55.0% to 64.9% | 50% payment |
| 65.0% to 74.9% | 75% payment |
| 75.0% or above | 100% payment |

#### Indicator 3b Collaboration with primary care clinicians

| **Indicator 3b** | |
| --- | --- |
| **Indicator name** | Collaboration with primary care clinicians. |
| **Indicator weighting  (% of CQUIN scheme available)** | 20% of 0.25% (0.05%) |
| **Description of indicator** | 90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. A local audit of communications should be completed. |
| **Numerator** | The number of patients in the audit sample for whom the mental health provider has provided to the GP\* an up-to-date copy of the patient’s care plan/CPA review letter or a discharge summary which sets out details of all of the following:   * 1. NHS number   2. All primary and secondary mental and physical health diagnoses   3. Medications prescribed and recommendations (including duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication).   4. Ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified, as per the Lester Tool.   5. Care plan or discharge plan   \*To take place within the following time periods:   * Within 48 hours for patients discharged as inpatients * Within 2 weeks for patients on CPA |
| **Denominator** | Patients within the defined audit sample who are subject to the CPA, and who have been under the care of the mental health provider for at least 12 months at the time of the defined audit period. |
| **Rationale for inclusion** | With over 490,000 people with SMI registered with a GP, it is important to ensure a stronger emphasis on collaboration and communication between primary and secondary care. This is necessary given that in the longer term and certainly following discharge from secondary care, people with SMI should be supported to manage their health within primary care.  Appropriate sharing and exchanging of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice. The rationale for this CQUIN is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals.  Building on the developments made across England to improve communications between primary and secondary care, the CQUIN addresses further alignment and collaboration. To do this, responsibilities for conducting physical health checks and the on-going management of physical healthcare should be clearly identified and formalised locally. Electronic systems and infrastructure should continue to evolve to support the transfer of accurate and up to date patient records, making information accessible. By the end of 2016, NHS England plans to publish national best practice to support secondary and primary care in achieving the above. |
| **Data source** | Internal audit undertaken by mental health providers. |
| **Frequency of data collection** | Annual audit |
| **Organisation responsible for data collection** | Mental health provider |
| **Frequency of reporting to commissioner** | Results of local audit required to be reported to local commissioners in Quarter 4 of both 2017/18 and 2018/19. |
| **Baseline period/date** | Not applicable |
| **Baseline value** | Not applicable |
| **Final indicator period/date (on which payment is based)** | Quarter 3 of both 2017/18 and 2018/19. |
| **Final indicator value (payment threshold)** | 90.0% |
| **Final indicator reporting date** | 30 March 2018 and 29 March 2019 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see below |
| **EXIT Route** | To be determined locally |

#### Milestones for indicator 3b

**2017/18**

| **Date/period milestone relates to 2017/18** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 2 17/18** | Identify and develop clear plans for aligning and cross checking SMI QOF and CPA registers. | October 2017 | 20% of indicator weighting for part 3b |
| **Quarter 3 17/18** | Establish a clear shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up.  This should include information on:   * Communication channels locally * Resources contributed to this agenda * Roles and responsibilities, including frequency of follow up annual physical health checks * Sharing and exchanging information regarding physical health of people with SMI, via electronic patient records across secondary and primary interfaces   Audit to be undertaken by provider. | December 2017 | 50% of indicator weighting for part 3b |
| **Quarter 4 17/18** | Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details) Action plan in place for 18/19 based on audit findings. | April 2018 | 30% of indicator weighting for part 3b |

**2018/19**

| **Date/period milestone relates to 2018/19** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Quarter 1 18/19** | Complete alignment of SMI QOF and CPA registers and have system in place for routine reconciliation going forward | July 2018 | 20% of indicator weighting for part 3b |
| **Quarter 2 18/19** | Review progress made in implementing shared care protocol between secondary care provider and primary care regarding physical health checks for people with SMI and the appropriate follow up checks. Agree joint action plan to address outstanding issues. | October 2018 | 50% of indicator weighting for part 3b |
| **Quarter 3 18/19** | Evidence status of interoperability of data and IT systems between secondary and primary care, to facilitate flow of information on physical health issues for people with SMI. Agree joint action plan to address outstanding issues.  Audit to be undertaken by provider. | December 2018 | 10% of indicator weighting for part 3b |
| **Quarter 4 18/19** | Results of local audit required to be reported to local commissioners. (See sliding scale below for payment details). | April 2019 | 20% of indicator weighting for part 3b |

#### Rules for partial achievement of indicator 3b

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 49.9% or less | No payment |
| 50.0% to 69.9% | 25% payment |
| 70.0% to 79.9% | 50% payment |
| 80.0% to 89.9% | 75% payment |
| 90.0% or above | 100% payment |

#### Supporting guidance and references for CQUIN 3a and 3b implementation

* **ICD 10 codes:**

For the purposes of the CQUIN, patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes will be included in the national audit: F10.5, F11.5, F12.5, F13.5, F14.5, F15.5, F16.5, F19.5, F20-29, F30.2, F31.2, F31.5, F32.3 and F33.3.

* **Lester tool:**

[**http://www.rcpsych.ac.uk/pdf/RCP\_11049\_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf**](http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf)

* **NICE resources to support implementation:**
  + NICE guidelines make recommendations about the promotion of physical health in people with psychosis and schizophrenia, and a range of other guidelines are available to improve aspects of physical health including smoking cessation, obesity, glucose regulation, blood lipids, and lifestyle factors.
  + Implementation products (such as baseline assessment tools, NICE pathways, online learning modules, and local practice examples) can be found on the “tools and resources” tab of the guideline; for example <https://www.nice.org.uk/guidance/cg178/resources> which includes access to the Lester Positive Cardio metabolic Health Resource, endorsed by NICE.

# Improving services for people with mental health needs who present to A&E

| **Indicator 4** | |
| --- | --- |
| **Indicator name** | Improving services for people with mental health needs who present to A&E. |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | **For 2017/18:**   1. Reduce by 20% the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.   **For 2018/19:**   1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions.      1. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs[[7]](#footnote-7).   **Mental health and acute hospital providers,** working together and, likely also with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved, integrated service offer, with the result that attendances at A&E are reduced.  The CQUIN has been designed so as to encourage collaboration between providers across the care pathway and as such is to be applied to both acute providers and mental health providers. While it takes account of different responsibilities for providers, performance by both acute and mental health providers will be measured and shared across the pathway, and will affect overall achievement against the CQUIN indicator. All mental health and acute providers subject to the scheme will therefore need to work together to ensure the successful delivery of all milestones and to achieve levels of performance necessary to release full reward.  Successful achievement of the CQUIN is therefore likely to necessitate partnership working and joint governance between CCGs, acute providers, mental health providers and other key local partners. Areas may wish to use existing forums such as A&E Delivery Boards and Urgent and Emergency Care Networks to oversee this process.  Where there are a number of providers fulfilling the acute or mental health provider role for a given locality, their contribution to overall performance for that locality should be weighted in line with their respective levels of commissioned activity for that locality. CCGs will need to determine the allocation of the rewards locally, based on their local geographies, taking into account:   1. the differing provider geographies (e.g. mental health providers may serve populations across the footprints of varying numbers of A&E departments); 2. different arrangements in different areas – for example, some liaison services are provided by mental health trusts and some are provided by acute trusts; and 3. the milestones set out in the CQUIN – the achievement of which are contingent on actions from either mental health providers, acute providers, or both working together; CCGs will therefore need to consider and agree with providers the proportion of the indicators for each year that will be delivered by the acute provider(s), what proportion will be delivered by the MH provider(s), and what by both.   Through this mechanism, the CQUIN is designed to incentivise both acute and mental health providers to contribute to improved services for people with mental health and psychosocial needs who present to A&E.  Year 1 will focus on improving understanding of the complex needs of a small cohort of people who use A&E most intensively. There will be a particular focus on identifying those people within this cohort who may benefit from integrated mental and physical health assessment, care planning and interventions[[8]](#footnote-8). There will also be an intensive focus on improving the quality of coding of primary and secondary mental health needs in A&Es.  Year 2 will seek to maintain the progress of year 1 – or previous years where a reasonable baseline reduction has already been established – for the selected cohort of frequent attenders, but the focus will broaden to deliver a reduction in the number of attendances to A&E for all people with primary mental health needs.  *Year 1*   1. Identify the people who attended each A&E most frequently during 2016/17 (this is likely to be people who would usually attend A&E 10-15 times or more; the cohort will need to be adjusted for attrition[[9]](#footnote-9)). 2. Review this group and identify the sub-cohort of people for whom mental health and psychosocial interventions led by specialist mental health staff would have the greatest impact. The number of people in the cohort will need to be agreed locally between providers and commissioners. It is expected that cohorts will include at least 10-15 people per hospital site. However, where possible, larger cohorts than this are encouraged as the greater the number of people in the cohort, the greater the potential benefits. For large hospitals serving greater populations, commissioners should seek to include larger cohorts in the scheme. Individual hospitals will have their own systems and methods of identification and this cohort’s number of attendances for 2016/17 and number of patients will be recorded to set the baseline; 3. Review and develop a co-produced care plan[[10]](#footnote-10) for each person in this cohort, which includes a focus on preventing avoidable A&E attendances. While a collaborative approach is critical to the successful implementation of this CQUIN scheme, the appointment of a named dedicated clinical lead or leads is likely to be beneficial. Care plans should be made available to A&E departments so that when a named person in the selected cohort does attend A&E, they receive more consistent care that better meets their needs. Care plans should be developed with the individual in question and involve and/or be shared with other relevant partner organisations where appropriate, such as primary care, including as part of the discharge planning process. Consideration should be given to the use of integrated and interoperable electronic care records or the enhanced Summary Care Record as enabling platforms. 4. Strengthen existing / develop new services to support this cohort of people better and offer safe and more therapeutic alternatives to A&E where appropriate. 5. Over one year, reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders, and establish improved services to ensure this reduction is sustainable; 6. Improve the quality of A&E diagnostic coding for mental health needs (primary and secondary), ensuring that coding for the final quarter of the year is complete and accurate; ensure systems are in place to assure quality of mental health diagnostic coding in the A&E HES dataset going forward, including conducting an internal audit of all mental health diagnostic coding to provide assurance of data quality.   *Year 2*   1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions; 2. Reduce total number of attendances to A&E by10% for all people with primary mental health needs.[[11]](#footnote-11) 3. Strengthen existing / develop new services to support people with mental health needs better and offer safe and more therapeutic alternatives to A&E where appropriate. 4. Repeat internal audit of mental health diagnostic coding in A&E to provide assurance of the quality of coding.   The benefits expected from this CQUIN would be:   * Identification of the most intensive users of local emergency physical and mental health services and improved understanding of their health and care needs and joint review / creation of personalised care plans for this cohort; * Reduced healthcare usage, reducing avoidable pressures on emergency departments and GP services; * Improved health and social outcomes for this cohort; * Improved experience of health and care services for this cohort, including reduced stigma through increased staff education and awareness; * Improved data quality and recording of mental health need in emergency departments; * Improved integrated care pathways across providers, including timely communication and collaboration between acute trusts, mental health providers, ambulance services, primary care, social care, public health (drug/alcohol services) and the voluntary sector; and * Joint governance and working between various providers will provide a better picture of local needs and demand, which can inform commissioning. |
| Numerator / Denominator | **For Year 1 (2017/18):**   1. Reduce by 20% the number of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable:   e.g:  **For Year 2 (2018/19):**   1. Sustain the reduction in year 1 of attendances to A&E for those within the selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions - the cohort will need to be adjusted for attrition[[12]](#footnote-12); 2. Reduce total number of attendances to A&E by 10% for all people with primary mental health needs[[13]](#footnote-13);   e.g: |
| **Rationale for inclusion** | People with mental ill health are 3 times more likely to present to A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental ill health. People with known mental ill health are 5 times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical health reasons . This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.  The QualityWatch study also found that people with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14, and that “the high levels of emergency care use by people with mental ill health indicate that they are not having their care well managed and suggest that there are opportunities for planned care (inside and outside of the hospital) to do more. These people are well known to the healthcare system and are having many health encounters”.  Source: <http://www.qualitywatch.org.uk/focus-on/physical-and-mental-health>  Furthermore, a recent systematic review and meta-analysis of studies in the NHS and comparable health systems suggests that approximately one-third to two-thirds of people who attend A&E due to mental ill health have been known to mental health services.  A large majority of the people with most complex needs who attend A&E the most frequently are likely to have significant health needs including physical and mental co-morbidities, and may benefit from assessment and review of care plans with specialist mental health staff, and further interventions from mental health, primary, community, social care, alcohol and substance misuse, and voluntary sector services.  Successful achievement of the CQUIN is therefore likely to necessitate partnership working and joint governance between CCGs, acute providers, mental health providers and other key local partners. Areas may wish to use existing forums such as A&E Delivery Boards and Urgent and Emergency Care Networks to oversee this process.  The CQUIN reward is to be shared between acute and mental health providers. CCGs will need to determine the allocation of the rewards locally, based on their local geographies, taking into account:   * the differing provider geographies (e.g. mental health providers may serve populations across the footprints of varying numbers of A&E departments); * different arrangements in different areas – for example, some liaison services are provided by mental health trusts and some are provided by acute trusts; * the milestones set out in the CQUIN – the achievement of which are contingent on actions from either mental health providers, acute providers, or both working together; CCGs will therefore need to consider and agree with providers the proportion of the indicators for each year that will be delivered by the acute provider(s), what proportion will be delivered by the MH provider(s), and what by both.   The CQUIN is for all ages – and it is for local areas to determine and segment the needs of the selected patient cohorts.  The cohorts of people who could benefit from case management, advance care planning and community interventions to help reduce A&E attendances, might typically include:   * People with primary substance misuse problems but with co-morbid mental health and social needs; * People with long-term conditions (e.g. COPD, diabetes, heart failure, chronic pain syndrome) which have a mental health component that has previously been undetected; * Older people with a combination of multiple and deteriorating physical health problems, frailty, cognitive dysfunction and increasing social need; * People with primarily complex mental health needs including self-harming behaviour, personality disorders, substance misuse; * People with medically unexplained symptoms and resultant intensive health-seeking behaviours; and * People with complex social needs, including e.g. housing, domestic violence, loneliness/social isolation, financial difficulties.   Nationally, coding of primary and secondary mental health needs in A&E is known to require considerable improvement. Anecdotally, we hear that people with mental ill health make considerable use of A&E, often staying there for long periods due to lack of alternatives (with frequent breaches of the 4hr A&E target) even though it is often not the best setting for them. Studies, such as those cited above also point to a considerable amount of undetected underlying mental health need among people presenting primarily for physical health reasons. However, poor coding means that it is not possible to quantify the scale or extent of this. It is in the clear interest of acute and mental health providers to improve the quality of data - not only to improve patient outcomes, but also to be able to demonstrate the true prevalence of mental ill health in A&E, and make the case for improved services.  Central to the CQUIN is the recognition that information sharing practices within the NHS itself and beyond need to improve, particularly for patients with mental health needs, in order to improve their experiences of care and outcomes. The issue of missed opportunities to share information in the interest of patient safety has also been raised by coroners on many different occasions following suicides and other serious incidents, with misplaced concerns about patient confidentiality often cited as a contributory factor. The information sharing practices encouraged by the CQUIN support the Caldicott Review’s assertion that the duty to share information can be as important as the duty to protect patient confidentiality, and that health and social care professionals should have the confidence to share information in the best interests of their patients.[[14]](#footnote-14) [[15]](#footnote-15) Information sharing agreements where they are not already in place should be expedited.[[16]](#footnote-16) |
| **Data source** | A&E HES, Unify2 collection |
| **Frequency of data collection** | Quarterly submissions to commissioners relating to milestones set out below.  Single annual submission to NHS England |
| **Organisation responsible for data collection** | * Acute providers to collect data on cohorts (number of patients, number of attendances). * Quarterly reports to CCGs. * Annual national submission to NHS England. |
| **Frequency of reporting to commissioner** | Quarterly. |
| **Baseline period/date** | 2016/17 |
| **Baseline value** | A&Es to confirm number of people in the selected cohort and to calculate total number of attendances in 2016/17 for the selected cohort (including attendances per patient), and submit to NHS England via Unify2. |
| **Final indicator period/date (on which payment is based)** | Payment schedule as per milestones below. 2 year CQUIN scheme:   * Year 1 payment based on performance during 2017/18. * Year 2 payment based on performance during 2018/19. |
| **Final indicator value (payment threshold)** | Year 1   * 20% reduction in A&E attendances of the selected cohort of frequent attenders to A&E in 2016/17 who would benefit from mental health and psychosocial interventions.   Year 2   * 0% increase in number of A&E attendances of the selected cohort of frequent attenders to A&E in 2017/18 who would benefit from mental health and psychosocial interventions. * 10% reduction in all A&E attendances of people with a primary mental health diagnosis (when comparing Q4 2017/18 to Q4 2018/19). |
| **Final indicator reporting date** | Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes, in the milestones selection below. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes, in the partial achievement section below. |

#### Milestones for indicator 4

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| Q1 2017/18 | MH trust and acute trust to review most frequent A&E attenders who have attended 10-15 times or more within the last 12 months (i.e. throughout 2016/17).  Local acute and MH providers identify subset of people from most frequent A&E attenders who would benefit from assessment, review, and care planning with specialist mental health staff. Ways in which this can be done could include:   * Clinical review meetings between A&E and liaison mental health clinicians; * Opportunistic assessment by liaison mental health clinicians (i.e. at one of the cohort patient’s next attendances); * Review of case notes.   Once this subset has been identified, the number of patients within it and the number of 2016/17 attendances is recorded to set a baseline.  MH trust and acute trust to assure commissioners that further work has been undertaken with partners (111, ambulance service, police, substance misuse, primary care, etc) to identify whether identified cohort also presenting frequently at other UEC system touch points. | June 2017 | 10% |
| Q2 2017/18 | MH trust and acute trust to work together to identify whether the presentations of the identified cohort were coded appropriately in A&E HES dataset.  Conduct internal audit of A&E mental health coding. On the basis of findings, agree joint data quality improvement plan and arrangements for regular sharing of data regarding people attending A&E. | Sept 2017 | 10% |
| Q2 2017/18 | MH trust, acute trust establish joint governance arrangements to review progress against CQUIN and associated service development plans. | Sept 2017 | 0% |
| Q2 2017/18 | MH trust, acute trust, to work with other key system partners as appropriate/necessary to ensure that:   * Care plans (co-produced with the patient and written in the first person) are in place for each patient in the identified cohort of frequent attenders; * A system is in place to identify new frequent attenders and ensure that care plans are put in place swiftly; * Care plans are shared with other key system partners (with the patient’s permission). | Sept 2017 | 10% |
| Q2 2017/18 | MH trust, acute trust, bringing in other local partners as necessary/appropriate, agree service development plan to support sustained reduction in A&E frequent attendances by people with MH needs. This is likely to include enhancements to:   * Primary care mental health services including IAPT; * Liaison mental health services in the acute hospital; * Community mental health services and community-based crisis mental health services;   This work is likely to need to be undertaken with other partners outside of the NHS, including social care, public health and voluntary sector partners. | Sept 2017 | 20% |
| Q3 2017/18 | MH trust, acute trust review progress against data quality improvement plan and all confirm that systems are in place to ensure that coding of MH need via A&E HES data submissions is complete and accurate, to allow confidence that Q4 submissions are complete and accurate. Assurances provided to CCGs accordingly.  Mental health provider, acute provider to agree formally and assure CCG that they are confident that a robust and sustainable system for coding primary and secondary mental health needs is in place. | Dec 2017 | 10% |
| Q4/2017/18 | 20% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | March 2018 | 40% |
| Q1 2018/19 | Baseline set for total number of A&E attendances in Q4 2017/18 with primary mental health diagnosis.  Providers will need to submit aggregate data via UNIFY to demonstrate performance against the CQUIN. It is likely that the single end of year national UNIFY2 data submission to NHS England will include:   * Total number of A&E attendances of the selected cohort of most frequent attenders in 2016/17 who were identified as potentially benefitting from mental health and psychosocial interventions, and total number of these patients; * Total number of A&E attendances of those within the selected cohort of most frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions, and total number of these patients; * Total number of A&E attendances in Q4 2017/18 of people with a primary mental health diagnosis, and total number of these patients; * Evaluation report of progress against all year 2017/18 milestones (as set out above), signed off by local A&E Delivery Board. | May 2018 | 0% |
| Q3 2018/19 | Repeat internal audit of A&E mental health coding to ensure improvement from year 1 is sustained.  Mental health provider, acute provider to agree formally and assure CCG that they are confident that a robust and sustainable system for coding primary and secondary mental health needs is in place. | Dec 2019 | 10% |
| Q4 2018/19 | Agree plan to mainstream CQUIN work programme to become business as usual going forward. | Jan 2019 | 0% |
| Q4 2018/19 | 0% increase in number of A&E attendances of the selected cohort of frequent attenders. | March 2019 | 10% |
| Q4 2018/19 | 10% reduction in A&E attendances with a primary mental health diagnosis in Q4 of 2018/19 as compared to baseline set in Q4 2017/18. | March 2019 | 80% |
| Q1 2019/20 | National data submission to NHS England via UNIFY2 for total number of A&E attendances during 2018/19 for those within the selected cohort of frequent attenders in 2017/18 who would benefit from mental health and psychosocial interventions.  Evaluation report of 2 year CQUIN submitted. | May 2019 | 0% |

#### Rules for partial achievement of indicator 4

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Year 1 – 15-19.99% reduction in A&E attendances of those within the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 30% (maximum available is 40% for achieving 20%+ reduction) |
| Year 1 – 10-14.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 20% |
| Year 1 – 5-9.99% reduction in A&E attendances of the selected cohort of frequent attenders in 2016/17 who would benefit from mental health and psychosocial interventions. | 10% |
| Year 2 – 5-9.99% reduction in A&E attendances of all people with a primary mental health diagnosis. | 60% (maximum available is 80% for achieving 10%+ reduction) |
| Year 2 – 2.5-4.99% reduction in A&E attendances of all people with a primary mental health diagnosis. | 40% |
| Year 2 – 0-2.49% reduction in A&E attendances of all people with a primary mental health diagnosis. | 20% |

# Offering advice and guidance

| **Indicator 6** | |
| --- | --- |
| **Indicator name** | Offering advice and Guidance (A&G) |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | The scheme requires providers to set up and operate A&G services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. A&G support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative.  A&G in the context of this CQUIN refers to structured, non-urgent, electronic A&G provided via telephone, email, or an online system. CCGs may agree with trusts how the local programme of A&G will operate, and the definition of an A&G response may include:   * Virtual review of test results (e.g. ECG, bloods) and advice on next steps required * Supply of a suggested treatment or management plan to the GP (which may include carrying out further investigations in primary care) * Direct booking of diagnostic test (e.g. endoscopy) * Direct booking of intervention, where indicated * Advice on the appropriate clinic referral (reducing redirected appointments)   Clinical responsibility will remain with the GP accessing the A&G service, unless or until the patient is seen face to face in secondary care.  In areas where A&G services have been trialled to date, clinical haematology, diabetes and endocrinology, cardiology, gastroenterology and nephrology have been found to offer opportunity. Based on treatment function code, these specialties accounted for 12.4% of GP referrals June 2015 – July 2016 (SUS, 1st OP attendances where source is GMP, GDP and GPwSI, based on General and Acute). In the same data, the following specialties accounted for 36.9% of all GP referrals:   * Gynaecology (8%) * Trauma and orthopaedics (7.7%) * ENT (7.4%) * Dermatology (7.3%) * Ophthalmology (6.4%)   A guide will be produced in support of the scheme which sets out the practical steps involved in setting up an A&G service. |
| **Numerator** | A&G coverage: Number of GP referrals to elective outpatient specialties which provide A&G. |
| **Denominator** | Total number of GP referrals to elective outpatient services. |
| **Rationale for inclusion** | The [GP Forward View](https://www.england.nhs.uk/ourwork/gpfv/) set out the need to improve GP access to consultant advice on potential referrals into secondary care. This indicator draws on a number of case studies from around the country where A&G has already begun to be implemented.  In 2016 Winpenny et al[[17]](#footnote-17) reviewed 183 studies published in the last 10 years on interventions in primary care aimed at improving the effectiveness and efficiency of outpatient services, including 8 studies on email or phone requests for specialist advice. They concluded that, *“there is substantial opportunity to reduce the number of patients who are seen in outpatient clinics”*. In a Spanish study evaluating virtual consultation services for endocrinology over the 3 year period 2008 – 2010 88% of virtual consultations (where the specialist reviewed the patient’s clinical history without the patient attending) were resolved without requiring a hospital visit alongside a reduction in inappropriate referrals from 25% to 10% after introduction of the virtual consultation system.[[18]](#footnote-18) An email GP advisory service staffed by Endocrine / Diabetes Specialist Registrars as part of their training commitment found that a formal referral was only suggested in response to 10% of enquiries (although did not draw conclusions about whether the email service ultimately reduced referrals to outpatient clinics.[[19]](#footnote-19))  The design of this CQUIN draws on learning from local areas around the country where A&G services have already been set up. The early outcomes do not yet constitute a robust evidence base on referrals and activity avoided, so have not been generalised into expectations for the wider system, but they do show encouraging early signs.  Asynchronous A&G via ERS or an alternative IT system:   * Leicester and Lincoln: Anecdotal reports that referrals have decreased but no figures to demonstrate this yet. In 2015, 432 A&G requests were responded to, and 68 patients were subsequently referred into the same specialty. No analysis has been done yet on A&G requests that did not result in a referral. * Sandwell and West Birmingham report approximately 25% “supported rejections” of endoscopy referrals * Calderdale and Huddersfield: in 2015, 26% of A&G queries were advised to refer in to secondary care * Morecambe Bay: Evaluated the usage of bespoke A&G system for the period from 10 May 2013 to 31 January 2014:   + GPs reported a reduction of 70 patients who would have been directly referred to OP prior to A&G (39% reduction) * Wandsworth CCG implemented “Kinesis” web-based software for asynchronous and synchronous advice in 2012:   + 74% of queries are answered within 48 hours.   + In 2015/16 Wandsworth GPs sent 3993 requests via Kinesis, 48% of which did not lead to a referral   Synchronous A&G via a telephony system:   * Stockport: Use of the Consultant Connect system for immediate advice from consultants over the telephone. Over the period 22/2/15 – 15/4/16:   + Call connection rate – 76% (and increasing)   + Average call answering time – 40 seconds   + Average call duration – 3 minutes 44 seconds   + Percentage of calls avoiding a hospital outpatient appointment 59% (70% if the request for purely diagnostics is included.) |
| **Data source** | For the purposes of the main indicator denominator, referral data is already captured in the Monthly Activity Return (MAR). For the numerator, providers will need to report on which specialties are covered by A&G services (this is not already collected) and this will be linked to MAR data to quantify performance.  Demand on elective specialties covered by A&G should be tracked locally to provide insight on the impact of the service. |
| **Frequency of data collection** | Quarterly. |
| **Organisation responsible for data collection** | The numerator and denominator will be collected at Provider level. |
| **Frequency of reporting to commissioner** | The provider will meet with Commissioners at least quarterly, initially to review the implementation of the A&G service and then to monitor impact through the main indicator. Providers of all levels participating in the scheme will have an incentive to earn the reward and improve, as the target is expressed as a proportion of local referral volumes. |
| **Baseline period/date** | The target for the main indicator is not relative to a baseline but Q1 2017/18 will provide a picture of A&G coverage prior to CQUIN mobilisation. |
| **Baseline value** | Proportion of GP referrals made to elective outpatient specialties which provide access to A&G services. |
| **Final indicator period/date (on which payment is based)** | Q4 2018/19 |
| **Final indicator value (payment threshold)** | 75% of GP referrals are made to elective outpatient specialties which provide access to A&G services. |
| **Final indicator reporting date** | 30th April 2019 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Payment will be made quarterly over the 2 year scheme, on evidence of milestones in the following table. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes |

#### Milestones for indicator 6

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Q1 2017/18** | * Agree specialties with highest volume of GP referrals for A&G implementation * Agree trajectory for A&G services to cover a group of specialties responsible for at least 35% of GP referrals by Q4 2017/18 * Agree timetable and implementation plan for introduction of A&G to these specialties during the remainder of 2017/18 * Agree local quality standard for provision of A&G, including that 80% of asynchronous responses are provided within 2 working days | 30 July 2017 | 25% of year 1 reward |
| **Q2 2017/18** | * A&G services mobilised for first agreed tranche of specialties in line with implementation plan and trajectory * Local quality standard for provision of A&G finalised * Baseline data for main indicator provided | 31 October 2017 | 25% of year 1 reward |
| **Q3 2017/18** | * A&G services operational for first agreed tranche of specialties * Quality standards for provision of A&G met * Data for main indicatos provided * Timetable, implementation plan and trajectory agreed for rollout of A&G services to cover a group of specialties responsible for at least 75% of GP referrals by Q4 2018/19 | 31 January 2018 | 25% of year 1 reward |
| **Q4 2017/18** | * A&G services operational for specialties covering at least 35% of total GP referrals by start of Q4 and sustained across the quarter * Quality standards for provision of A&G met * Data for main indicator provided | 31 May 2018 | 25% of year 1 reward |
| **Q1 2018/19** | * A&G services introduced in line with Q1 trajectory and implementation plan * Quality standards for provision of A&G met * Data for main indicator provided | 31 July 2018 | 15% of year 2 reward |
| **Q2 2018/19** | * A&G services introduced in line with Q1 trajectory and implementation plan * Quality standards for provision of A&G met * Data for main indicator provided | 31 October 2018 | 15% of year 2 reward |
| **Q3 2018/19** | * A&G services introduced in line with Q1 trajectory and implementation plan * Quality standards for provision of A&G met * Data for main indicator provided | 31 January 2019 | 15% of year 2 reward |
| **Q4 2018/19** | * A&G services in place for a group of specialties responsible for receiving 75% of total GP referrals by start of Q4 and sustained across the quarter * Local quality standards met * Data for main indicator provided | 30 May 2019 | 55% of year 2 reward |

#### Rules for partial achievement of indicator 6

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| **≥35%** | **100% of Q4 2017/18 reward** |
| **30% - <35%** | 80% of Q4 2017/18 reward |
| **25% - <30%** | 60% of Q4 2017/18 reward |
| **20% - <25%** | 40% of Q4 2017/18 reward |
| **≥75%** | **100% of Q4 2018/19 reward** |
| **65% - <75%** | 80% of Q4 2018/19 reward |
| **55% - <65%** | 60% of Q4 2018/19 reward |
| **45% - <55%** | 40% of Q4 2018/19 reward |

# NHS e-Referrals

| **Indicator 7** | |
| --- | --- |
| **Indicator name** | NHS e-Referrals CQUIN |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | This indicator relates to GP referrals to consultant-led 1st outpatient services only and the availability of services and appointments on the NHS e-Referral Service. It is not looking at percentage utilisation of the system.  All providers to publish ALL such services and make ALL of their First Outpatient Appointment slots available on NHS e-Referral Service (e-RS) by 31 March 2018 following the trajectory below.  Undertake required work on their Directory of Services to publish ALL services on the NHS e-Referral Service.  The guidance below sets out the practical steps for delivery in support of this scheme. |
| **Numerator** | For Q1:   1. Submit a baseline plan to deliver Q2, Q3 and Q4 targets.   For Q2 to Q4 providers will be required to evidence that:   1. Services are published and available to receive referrals through NHS e-Referral Service as set out in the Milestones below. The numerator will be the count of published first outpatient services listed on the Directory of Services e-RS extract EBSX05; and 2. Adequate slot polling is taking place to allow patients to book appointments evidenced by a reduction in ‘Appointment Slot Issues’ to a rate of 4% or less. The numerator for this measure will be the number of Appointment Slot Issues received by provider. |
| **Denominator** | To assess that all services are published on the NHS e-Referral Service (e-RS), providers will be required to evidence a definitive list of all services/clinics accepting 1st O/P referrals and details of the e-RS services they are mapped to.  For Q2 – Q4 point i) The denominator will be the number of first outpatient services, which receive GP referrals, as identified in the Q1 baseline plan.  For point ii) it will be the total number of first outpatient bookings received through e-RS. |
| **Rationale for inclusion** | This incentive is designed to encourage a move away from any paper based processes in line with the target for Q4 but recognising that each trust will need to decide how their services are configured and this may include referral only services (further information in the guidance).  For bookable services providers should adjust their e-RS slot polling range, in line with their actual waiting time and based on their available capacity and operating model for each service but ensure a transition away from paper based referrals. |
| **Data source** | e-RS System and Providers. For Q2-Q4 measures detailed above: i. will use data from the Directory of Services e-RS extract EBSX05; and  ii will use the monthly e-RS Appointment Slot Issues report. |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Providers |
| **Frequency of reporting to commissioner** | Monthly |
| **Baseline period/date** | April 2017 |
| **Baseline value** | Varies by Provider |
| **Final indicator period/date (on which payment is based)** | March 2018 |
| **Final indicator value (payment threshold)** | Enabling all referrals into the Provider Trust through e-RS. |
| **Final indicator reporting date** | 31 March 2018 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Quarterly milestones as below. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | As this is a staged CQUIN payments will be made for attainment of the thresholds set out at each quarter.  There will be no payment for partial achievement outside of this staged approach. |

#### Milestones for indicator 7

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Q1**  **01/04/2017 to 30/06/2017** | Providers should supply a plan to deliver Q2, Q3 and Q4 targets to include:   * a definitive list of all services/clinics accepting 1st O/P referrals and details of the NHS e-RS services they are mapped to, identifying any gaps to be addressed through this CQUIN. * a trajectory to reduce Appointment Slot Issues to a level of 4%, or less, over Q2, Q3 and Q4. | 01/07/2017 | 25% |
| **Q2**  **01/07/2017 to 30/09/2017** | * 80% of Referrals to 1st O/P Services able to be received through e-RS. * Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1. | 01/10/2017 | 25% |
| **Q3**  **01/10/2017 to 31/12/2017** | * 90% of Referrals to 1st O/P Services able to be received through e-RS. * Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1. | 02/01/2018 | 25% |
| **Q4**  **01/01/2018 to 31/03/2018** | * 100% of Referrals to 1st O/P Services able to be received through e-RS. * Evidence that slot polling ranges for directly bookable services match or exceed waits for paper referrals - details of slot polling ranges (as recorded on EBSX05) and Appointment Slot Issues by service reducing to 4% or less in line with the agreed trajectory set in Q1. | 01/04/2018 | 25% |

#### Rules for partial achievement of indicator 7

**Quarter 2**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieving 50% to 60% of referrals to 1st O/P Services able to be received through e-RS. | 50% of available Q2 scheme |
| Achieving 61% to 70% of referrals to 1st O/P Services able to be received through e-RS. | 60% of available Q2 scheme |
| Achieving 71% to 79% of referrals to 1st O/P Services able to be received through e-RS. | 70% of available Q2 scheme |
| Achieving 80% or above of referrals to 1st O/P Services able to be received through e-RS. | 100% of available Q2 scheme |

**Quarter 3**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieving 61% to 70% of referrals to 1st O/P Services able to be received through e-RS. | 50% of available Q3 scheme |
| Achieving 71% to 80% of referrals to 1st O/P Services able to be received through e-RS. | 60% of available Q3 scheme |
| Achieving 81% to 89% of referrals to 1st O/P Services able to be received through e-RS. | 70% of available Q3 scheme |
| Achieving 90% or above of referrals to 1st O/P Services able to be received through e-RS. | 100% of available Q3 scheme |

**Quarter 4**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieving 71% to 80% of referrals to 1st O/P Services able to be received through e-RS. | 50% of available Q4 scheme |
| Achieving 81% to 90% of referrals to 1st O/P Services able to be received through e-RS. | 60% of available Q4 scheme |
| Achieving 91% to 99% of referrals to 1st O/P Services able to be received through e-RS. | 70% of available Q4 scheme |
| Achieving 100% of referrals to 1st O/P Services able to be received through e-RS. | 100% of available Q4 scheme |

#### Supporting Guidance for e-referrals CQUIN indicator 7

**2017/18 e-Referrals CQUIN Guidance**

This CQUIN has been introduced to:

* support Providers with the transition to receiving all GP referrals through the NHS e-Referral Service, in line with the expectations of the NHS Standard Contract
* reduce the number of patients that experience an ‘Appointment Slot Issue’

There are two main elements to the CQUIN; the availability of services and the availability of appointments.

1. All providers to publish ALL of their services and make ALL of their First Outpatient Appointment slots available on e-RS by 31 March 2018

This element of the CQUIN will require providers to:

* review all of their outpatient clinics
* identify which clinics accept GP referrals for First appointments
* cross reference against available NHS e-Referral Services

Each clinic that accepts GP referrals will need to be mapped to one - or more - NHS e-Referral service. Additionally, the provider will need to ensure that all First Outpatient Appointments within these clinics has been made available to the NHS e-Referral Service (e-RS). Minimising carve out of clinic slots supports better overall Capacity and Demand management. [www.england.nhs.uk/ourwork/demand-and-capacity/](http://www.england.nhs.uk/ourwork/demand-and-capacity/)

Where clinics are identified without appropriate mappings to e-RS, the provider will need to identify existing services to map to, or plan for the creation of additional e-RS services.

To support this, NHS Digital will introduce the concept of ‘referral only’ services to the NHS e-Referral Service in early Q1 2017/18. Referral only services will enable providers to access clinical referral information through e-RS without the need for a booked appointment. This change recognises that, for some services, up front patient booking is not the optimal pathway and may have prevented some services being made available to e-RS to this point. The Provider will be expected to book an appointment for the patient within e-RS after receiving the referral information. Further information on referral only services will be made available by NHS Digital in the coming months.

Providers will then need to submit baseline plans to make all of their services available for referral via e-RS to the following schedule:

* Q2 2017/18: 80% of Referrals to 1st O/P Services able to be received through e-RS.
* Q3 2017/18: 90% of Referrals to 1st O/P Services able to be received through e-RS.
* Q4 2017/18: 100% of Referrals to 1st O/P Services able to be received through e-RS.

**Suggested approach for compiling baseline plans:**

1. Work with IT and/or PAS back office colleagues to identify all consultant-led outpatient clinics that have accepted GP referrals to see patients for their first (new) attendance over the last 12 months.
2. Confirm which e-RS services are mapped to each of the clinics identified in step 1. It may be possible to pull this information directly from the PAS along with the clinic information. Otherwise, a manual check of clinics will be required.
   1. Where a clinic is mapped to e-RS services, ensure that all first outpatient slots within that clinic have been made available to e-RS, or agree a plan to do so that supports the Q2-Q4 availability trajectory
3. Where no clinic mapping to an e-RS service(s) exists, work with clinicians to review the existing Directory of Services to agree whether each clinic can be linked to an existing service, or if a new service needs to be defined and mapped. This may include the use of Referral Only services, if appropriate.
4. The above three steps will identify all clinics that need to be made available to e-RS along with their actual or future e-RS service mappings.
5. Separately, work with Information Team colleagues to analyse GP Referral volumes by specialty, so that you understand which combination of specialties and services need to be made available to achieve the 80% and 90% thresholds at the end of Q2 and Q3 respectively.
6. Taken together, all of this information should enable a Provider to submit a baseline plan to deliver the Q2, Q3 and Q4 trajectory.
7. Adequate slot polling is taking place to allow patients to book appointments evidenced by a reduction in ‘Appointment Slot Issues’ to a rate of 4% or less

An ‘Appointment Slot Issue’ (ASI) occurs when a patient is unable to book their appointment through the NHS e-Referral Service, for one of two reasons. The first is that, in very rare circumstances, a technical issue can prevent an appointment slot from being shown or booked. The second and usual reason is that organisations providing directly bookable services have not made sufficient appointment slots available to e-RS.

As well as inconveniencing and often confusing patients, ASIs cause a number of dis-benefits for providers, including typically costing twice as much to process than when a patient is able to book through e-RS.

Providers need to understand the true wait for a First Outpatient Appointment within each service, and slot polling ranges should be set at (or in excess of) this wait to ensure equity of access. Where true waits exceed usual partial booking windows (typically 6 weeks) this may require the provider to book all of the outpatient waiting list to ensure that all patients are seen ‘in turn’ and to prevent the impression of e-RS referred patients ‘queue jumping’.

Making polling ranges match waiting times is a necessary pre-requisite of moving to an environment where all GP referrals are made through e-RS, as well as being the most effective way of reducing ASIs.

NHS Digital has fully revised its guidance for the effective management of Appointment Slot Issuesand has published a case study on how Cambridge University Hospitals successfully reduced their level of ASIs. Both documents, along with a presentation on the benefits of matching polling ranges to waiting times, are available from the Document Library at [www.digital.nhs.uk/referrals](http://www.digital.nhs.uk/referrals)

Where providers have first outpatient waiting times in excess of those required to deliver sustainable RTT performance, a number of effective capacity and demand tools are available from NHS Improvement <https://improvement.nhs.uk/resources/outpatient-capacity-and-demand-tool/>

or via NHS England [www.england.nhs.uk/ourwork/demand-and-capacity/](http://www.england.nhs.uk/ourwork/demand-and-capacity/)

1. **Supporting proactive and safe discharge**

There are three versions of this CQUIN indicator:

* 8a – Applicable to Acute Trusts
* 8b – Applicable to Community Trusts
* 8c – Applicable to Care Homes

#### Indicator 8a – Acute Trusts

| **Indicator 8a – Acute Trusts** | |
| --- | --- |
| **Indicator name** | Supporting Proactive and Safe Discharge – Acute Providers |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | **Year 1 17/18**   * Part a) 40% of weighting for this measure   Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories   * Part b) 20% of the weighting for this measures (applicable to acute only, with category 1 or 2 A&E departments)   Emergency Care Data Set (ECDS)  Type 1 or 2 A&E providers to have demonstrable and credible planning by the end of Quarter 1, in order to commence timely submission of data from 1st October 2017.  See milestone section for detail of the requirements.  Further information on the ECDS can be found at: <https://www.england.nhs.uk/ourwork/tsd/ec-data-set/>  Where Part b is not applicable to a provider this weighting should be applied to Part a.   * Part c) 40% of weighting for this measure   Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.  **Year 2 18/19**   * Part a) 80% of weighting for this measure   Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.   * Part b) 20% of weighting for this measure   Completion and timely submission of data by provider in line with the collection requirements. See milestone section for detail of the requirements.  Where part b is not applicable to a provider this weighting will be applied to part a. |
| **Numerator** | Year 1  Finished discharge episodes within Q3 and 4 of 2017/18 , discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route  Year 2  Finished discharge episodes within 2018/19 , discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route |
| **Denominator** | Year 1  Finished discharge episodes of patients aged 65+ admitted via non-elective route within Q3 and 4 with a LOS of >2  Year 2  Finished discharge episodes of patients aged 65+ admitted via non-elective route within 18/19 with a LOS of >2 |
| **Rationale for inclusion** | There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people’s needs, and increasing costs to local health economies.  Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[[20]](#footnote-20). For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.  Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess\* pathway to maximum effect, and to understand capacity within community services to support improved discharge.  This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals.  The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).  Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally.  \*Definition of discharge to assess[[21]](#footnote-21):  Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: ‘discharge to assess’, ‘home first’, ‘safely home’, ‘step down’. |
| **Data source** | HES / SUS |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | HES data available via NHS Digital |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Year 1 Q3 and Q4 2016/17 Year 2 2017/18 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** | Year 1 End of 2017/18  Year 2 End of 2018/19 |
| **Final indicator value (payment threshold)** | Year 1 (17/18):   * 2.5% point increase discharge to usual place of residence: across Q3 and Q4 2017/18 OR an increase to 47.5% across Q3 and 4 2017/18   Year 2 (18/19)   * 7.5% point increase in discharge to usual place of residence from baseline 2017/18 baseline to end of 18/19 18 OR an increase from baseline to 50% across quarters in 2018/19   Thresholds for year 2 will be reviewed in line with evidence from 17/18. |
| **Final indicator reporting date** | Discharge to usual place of residence:  Year 1: End of Q4 2017/18  Year 2: End of Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes. See below. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes. See below. |

#### Milestones for indicator 8a – Acute Trusts

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Q2 Year 1**  **Part a)** | i) Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems.  ii) Develop and agree with commissioner a plan, baseline and trajectories which reflect expected impact of implementation of local initiatives to deliver the part b indicator for year 1 and year 2. As part of this agree what proportion of the part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers. | End of Q2 2017/18 | 40% of 100% in Year 1 |
| **Q1 Year 1**  **Part b)**  **Q3 Year 1**  **Part b)** | i) Type 1 or 2 A&E provider has demonstrable and credible planning in place to make the required preparations (e.g. by upgrading IT systems and training staff) so that the Emergency Care Data Set (ECDS) can be collected and returned from 1st October 2017.  ii) Type 1 or 2 A&E provider is returning data at least weekly AND 95% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 95% of patients have a diagnosis. Chief complaint should be any value from the ECDS Chief Complaint code set (SNOMED CT). Diagnosis should be any value from the ECDS diagnosis code set (SNOMED CT). | End of Quarter 1  End of Quarter 3 | 15% of 100% in Year 1  5% of 100% in Year 1 |
| **Q1 Year 2**  **Part b)**  **Q1 Year 2**  **Part b)**  **Q1 Year 2**  **Part b)** | Type 1 or 2 A&E provider is returning data daily AND 99% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 99% of patients have a diagnosis AND 99% of patients have a measure of acuity recorded. Acuity should be any value from the ECDS acuity set  Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number).  Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded. Referral source should be any value from the EDCS referral source set. | End of Q1  End of Q2  End of Q3 | 5%  5%  5% |
| **Q1 Year 2**  **Part b)** | Type 1 or 2 A&E provider is returning data daily AND 100% of patients have both a valid Chief Complaint and a Diagnosis (unless that patient is streamed to another service) so that 100% of patients have a diagnosis AND 100% of patients have a measure of acuity recorded AND 100% of patients record the discharging clinician (using the GMC/NMC/HCPC number) AND 100% of patients have the referral source recorded AND 100% of patients have discharge status recorded. Discharge status should be any value from the EDCS discharge status set. | End of Q4 | 5%  In total 20% of 100% in Year 2 |

#### Rules for partial achievement for indicator 8a – Acute Trusts - Part c)

**This payment will be calculated on the combined total of provider and community contributions not on an individual provider performance.**

**Percentage point increase in discharge to usual place of residence**

**Year 1 (17/18)**

**By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 1.5% point increase | No payment |
| 1.5 up to 1.99% point increase | 50% payment |
| 2 up to 2.49% point increase | 80% payment |
| 2.5% point increase or greater | 100% payment |

**Or**

**Year 1 (17/18)**

**By the end of Q4 47.5% in % of patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 40% | No payment |
| 40% up to 44.9% | 50% payment |
| 45% up to 47.4% | 80% payment |
| 47.5% or greater | 100% payment |

**Year 2 (18/19)**

**By the end of Q4 7.5% point increase from baseline in no. patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 3% point increase | No payment |
| 3 up to 6.49% point increase | 50% of payment |
| 6.5 up to 7.49% point increase | 80% of payment |
| 7.5% point increase | 100% of payment |

**Or**

**Year 2 (18/19)**

**By the end of Q4 50% in % of patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 45% | No payment |
| 45% up to 47.49% | 50% of payment |
| 47.5% up to 49.9% | 80% of payment |
| 50% or greater | 100% of payment |

#### Indicator 8b – Community Trusts

| **Indicator 8b – Community Trusts** | |
| --- | --- |
| **Indicator name** | Supporting Proactive and Safe Discharge – Community Providers |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | **Year 1 17/18**   * Part a) 60% of weighting for this measure   Actions to map existing discharge pathways, roll-out new protocols, collect baseline/trajectories   * Part b) 40% of weighting for this measure   Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% points from baseline (Q3 and Q4 2016/17). Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate.  **Year 2 18/19**   * Part a) 100% of weighting for this measure   Increasing proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission by 7.5% points from 2017/18. Inappropriate, early discharge carries risks to patients and therefore providers and commissioners should carefully monitor readmission rate. |
| **Numerator** | Year 1  Finished discharge episodes within Q3 and 4 of 2017/18 , discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route  Year 2  Finished discharge episodes within 2018/19 , discharged to usual place of residence within 3- 7 days of admission of patients aged 65+ admitted via non-elective route |
| **Denominator** | Year 1  Finished discharge episodes of patients aged 65+ admitted via non-elective route within Q3 and 4 with a LOS of >2  Year 2  Finished discharge episodes of patients aged 65+ admitted via non-elective route within 18/19 with a LOS of >2 |
| **Rationale for inclusion** | There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people’s needs, and increasing costs to local health economies.  Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[[22]](#footnote-22). For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.  Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess\* pathway to maximum effect, and to understand capacity within community services to support improved discharge.  This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals.  The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).  Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally.  \*Definition of discharge to assess[[23]](#footnote-23):  Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: ‘discharge to assess’, ‘home first’, ‘safely home’, ‘step down’. |
| **Data source** | HES / SUS |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | HES data available via NHS Digital |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Year 1 Q3 and Q4 2016/17 Year 2 2017/18 |
| **Baseline value** |  |
| **Final indicator period/date (on which payment is based)** | Year 1 End of 2017/18  Year 2 End of 2018/19 |
| **Final indicator value (payment threshold)** | Year 1 (17/18):   * 2.5% point increase discharge to usual place of residence: across Q3 and Q4 2017/18 OR an increase to 47.5% across Q3 and 4 2017/18   Year 2 (18/19)   * 7.5% point increase in discharge to usual place of residence from baseline 2017/18 baseline to end of 18/19 18 OR an increase from baseline to 50% across quarters in 2018/19   Thresholds for year 2 will be reviewed in line with evidence from 17/18. |
| **Final indicator reporting date** | Discharge to usual place of residence:  Year 1: End of Q4 2017/18  Year 2: End of Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes. See below. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes. See below. |

#### Milestones for indicator 8b – Community Trusts

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Year 1**  **Part a)** | 1. Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out protocols in partnership across local whole-systems. 2. Develop and agree with commissioner a plan, baseline and trajectories which reflect impact of implementation of local initiatives to deliver the Part b indicator for year 1 and year 2. As part of this agree what proportion of the Part b indicator for each year will be delivered by the acute provider and what proportion will be delivered by the community provider. Achievement of part b will require collaboration between acute and community providers. | End of Q2 2017/18 | 60% of 100% in Year 1 |

#### Rules for partial achievement for indicator 8b – Community Trusts – part b)

**This payment will be calculated on the combined total of provider and community contributions not on an individual provider performance.**

**Percentage point increase in discharge to usual place of residence**

**Year 1 (17/18)**

**By the end of Q4 2.5% point increase from baseline in no. patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 1.5% point increase | No payment |
| 1.5 up to 1.99% point increase | 50% payment |
| 2 up to 2.49% point increase | 80% payment |
| 2.5% point increase or greater | 100% payment |

**Or**

**Year 1 (17/18)**

**By the end of Q4 47.5% in % of patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 40% | No payment |
| 40% up to 44.9% | 50% payment |
| 45% up to 47.4% | 80% payment |
| 47.5% or greater | 100% payment |

**Year 2 (18/19)**

**By the end of Q4 7.5% point increase from baseline in no. patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 3% point increase | No payment |
| 3 up to 6.49% point increase | 50% of payment |
| 6.5 up to 7.49% point increase | 80% of payment |
| 7.5% point increase | 100% of payment |

**Or**

**Year 2 (18/19)**

**By the end of Q4 50% in % of patients discharged to usual place of residence**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Less than 45% | No payment |
| 45% up to 47.49% | 50% of payment |
| 47.5% up to 49.9% | 80% of payment |
| 50% or greater | 100% of payment |

#### Indicator 8c – Care Homes

| **Indicator 8c – Care Homes** | |
| --- | --- |
| **Indicator name** | Supporting Proactive and Safe Discharge – Care Homes |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | **Year 1 17/18**  Part a) 60% of weighting for this measure (applicable to acute, community and NHS commissioned care home bed providers).  Actions to map existing discharge pathways and roll-out local protocols.  Part b) 40% of weighting for this measure:   * **Care Home Provider:** Locally agree collection of Patient Experience measure, or PROM for patients discharged to care home through D2A or metrics associated with delivery of part a.   **Year 2 18/19**  Part a) 100% of weighting for this measure:   * **Care Home Provider:** Collection and analysis of locally agreed patient Experience measure or PROM for patients discharged to care home through D2A or metrics agreed as per year one Part a. |
| **Numerator** | N/A |
| **Denominator** | N/A |
| **Rationale for inclusion** | There is a considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures. Delayed discharge has serious impact across health and care systems, reducing the ability of emergency departments to respond to people’s needs, and increasing costs to local health economies.  Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days[[24]](#footnote-24). For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.  Local A&E Delivery Boards are being asked in 2016/17 to implement key initiatives to address some of the major underlying issues causing delayed discharges. This CQUIN builds upon the 2016/17 A&E Plan discharge-specific activity to support systems to streamline discharge pathways, embed and strengthen the discharge to assess\* pathway to maximum effect, and to understand capacity within community services to support improved discharge.  This is a two year CQUIN that works across local health economies that aims to improve discharges for patients across all wards within hospitals.  The desired outcomes will be improvement in patient outcomes, improvement in patient flow, and reduction in delayed discharges (and thus reduction in associated costs).  Although this CQUIN includes a measure using acute data, it is an indicator of how well the whole system works to support timely discharge. Distribution of the CQUIN amount on achievement of the target between acute, community and NHS-commissioned care home beds would need to be determined locally.  \*Definition of discharge to assess[[25]](#footnote-25):  Where people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where possible) or another community setting. This is where assessment for longer -term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. Commonly used terms for this are: ‘discharge to assess’, ‘home first’, ‘safely home’, ‘step down’. |
| **Data source** | Locally determined |
| **Frequency of data collection** | Locally determined |
| **Organisation responsible for data collection** | Locally determined |
| **Frequency of reporting to commissioner** | Locally determined |
| **Baseline period/date** | NA |
| **Baseline value** | NA |
| **Final indicator period/date (on which payment is based)** | Year 1 End of 2017/18  Year 2 End of 2018/19 |
| **Final indicator value (payment threshold)** | **Year 1 (17/18):**  See below table with milestones.  **Year 2 (18/19):**  See below table with milestones. |
| **Final indicator reporting date** | Year 1: End of Q4 2017/18  Year 2: End of Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | NA |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | NA |

#### Milestones for indicator 8c – Care Homes

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Year 1**  **Part a)** | Map and streamline existing discharge pathways across acute, community and NHS-care home providers, and roll-out new protocols in partnership across local whole-systems. | End of Q2 2017/18 | 60% of 100% of Year 1 |
| **Part b)** | Locally agree a patient experience measure or PROM for patients discharged to care home through D2A.  Part b) Care home provider requirement or metrics associated with delivery of Part a. | End of Q4 2017/18 | 40% of 100% of Year 1 |
| **Year 2**  **Part a)** | Collection and analysis of Patient Experience measure or PROM for patients discharged to care home through D2A (Minimum 100 Sample) or metrics associated with delivery of year 1 Part a. | End of Q2 2018/19  End of Q4 2018/19 | 35% of 100% of Year 2  35% of 100% of Year 2 |

1. **Preventing ill health by risky behaviours – alcohol and tobacco**

There are five parts to this CQUIN indicator.

|  |  |  |
| --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** |
| CQUIN 9 - Tobacco | 9a Tobacco screening | 5% of 0.25% (0.0125%) |
|  | 9b Tobacco brief advice | 20% of 0.25% (0.05%) |
|  | 9c Tobacco referral and medication offer | 25% of 0.25% (0.0625%) |
| CQUIN 9 – Alcohol | 9d Alcohol screening | 25% of 0.25% (0.0625%) |
|  | 9e Alcohol brief advice or referral | 25% of 0.25% (0.0625%) |

**Indicator 9a Tobacco screening**

| **Indicator 9a** | |
| --- | --- |
| **Indicator name** | Tobacco screening |
| **Indicator weighting  (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 5% of 0.25% (0.0125%).  *(NB: this applies for Q2 onwards, different reward structure for Q1, see ‘rules for in-year payment’ section below)* |
| **Description of indicator** | Percentage of unique adult patients who are screened for smoking status AND whose results are recorded. |
| **Numerator** | Number of **unique,** **adult** **patients** who are **admitted** and **screened for smoking status** and results are recorded in patient’s record during this quarter:   * **unique** isdefined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN; * **adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN; * **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the CQUIN for improving physical healthcare in people with severe mental health illness (‘PSMI’); * the “**screened for smoking status**” element of this indicator requires the standard protocol for screening smokers in secondary care as per NICE guidance PH48 to be implemented. Detail on the required actions from healthcare professionals can be found on the National Centre for smoking Cessation and Training website ([NCSCT](http://www.ncsct.co.uk/usr/pub/hospitalised-patients.pdf)). Secondary mental health providers in particular may want to build on the [Lester tool](http://www.rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf) as appropriate (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and * the “**recorded in patient’s record**” element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient’s record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. |
| **Denominator** | All **unique,** **adult patients** who are **admitted** during this quarter:   * **unique** isdefined as a non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN; * **adult patient** is defined as patients of at least 18 years of age; and * **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). |
| **Rationale for inclusion** | **Context**  This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View ([5YFV](https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf)), particularly around the need for a ’…radical upgrade in prevention…’ and to ‘…incentivising and supporting healthier behaviour’. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.  **The burden of smoking**  Smoking is estimated to cost £13.8bn to society (£2bn on the NHS through hospital admissions, £7.5bn through lost productivity, £1.1bn in social care). Smoking is England’s biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness, 33% of tobacco is consumed by people with mental health problems.[[26]](#footnote-26) Smoking is the single largest cause of health inequalities[[27]](#footnote-27).  A Cochrane Review[[28]](#footnote-28) shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis. Inpatient smoking cessation leads to a reduced rate of wound infections, improved wound healing and increased rate of bone healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates among patients who want to quit and take up a referral to stop smoking services are between 15% and 20%, compared to 3% to 4% amongst those without a referral.[[29]](#footnote-29)  **The status quo nationally**  Coverage of advice and referral interventions for smokers are patchy. Currently in secondary care, some patients may be asked if they smoke, but not all, and not at every admission, e.g. less than half of smokers admitted to hospital receive very brief advice to stop as an inpatient. For those patients that have been identified as a smoker, this is no guarantee that they will then be given an effective stop smoking intervention and referral to evidence based smoking cessation support. Currently, only 1.5% of smokers in acute hospital settings go onto make a quit attempt with stop smoking services.  **The financial case**  Modelling of the tobacco component of the CQUIN suggests that it could reduce costs through fewer admissions and improved health of smokers and passive smokers; resulting in net savings of £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy each year over 4 years. This is a conservative estimate accounting for the reduced cost of hospital admissions only. |
| Data source | **Provider audit of patient records, submitted to CCGs on a quarterly basis:**  We propose that:   * Providers with searchable electronic patient records audit **all patient records**. * Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**.   **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months.  **The following exclusion criteria** should be applied:   1. All patients below 18 years of age 2. All in-patients in maternity wards 3. All A&E attendances that do not lead to in-patient admissions 4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention.   **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B.  **The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance and insight teams.  **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff[[30]](#footnote-30). |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.  Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.  Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **90%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.  **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.  **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below |

**Indicator 9b Tobacco brief advice**

| **Indicator 9b** | |
| --- | --- |
| **Indicator name** | Tobacco brief advice |
| **Indicator weighting  (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 20% of 0.25% (0.05%).  *(NB: this applies for Q2 onwards, different reward structure for Q1,see ‘rules for in-year payment’ section below).* |
| **Description of indicator** | Percentage of unique patients who smoke AND are given very brief advice |
| **Numerator** | Number of **eligible patients** who are **given brief advice** during this quarter:   * **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a); and * the “**given very brief advice**” element of this indicator requires healthcare professionals to provide brief advice message and this to be recorded in the patient’s record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website ([NCSCT](http://www.ncsct.co.uk/usr/pub/hospitalised-patients.pdf)). Secondary mental health providers in particular may want to build on the [Lester tool](http://www.rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf) as appropriate. See Annex A for further details. |
| **Denominator** | All **eligible patients** during this quarter:   * **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 9a). |
| **Rationale for inclusion** | Please refer to this section in 9a. |
| **Data source** | Please refer to this section in 9a. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.  Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.  Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **90%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme) |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.  **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.  **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

**Indicator 9c Tobacco referral and medication offer**

| **Indicator 9c** | |
| --- | --- |
| **Indicator name** | Tobacco referral and medication offer |
| **Indicator weighting  (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%).  *(NB: this applies for Q2 onwards, different reward structure for Q1, see ‘rules for in-year payment’ section below)* |
| **Description of indicator** | Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. |
| **Numerator** | Number of **eligible patients** who are **referred** to specialistservices and **offered stop smoking medication** during this quarter:   * **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a); * the “**referred**” element of this indicator requires healthcare professionals to refer patients (not just signposting) to stop smoking services (these could be e.g. Local Authority funded Local Stop Smoking Services or lifestyle service in the community; in-house services in hospital; or within GP practices or pharmacies) and this to be recorded in the patient’s record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website ([NCSCT](http://www.ncsct.co.uk/usr/pub/hospitalised-patients.pdf)). Secondary mental health providers in particular may want to build on the [Lester tool](http://www.rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf) as appropriate. See Annex A for further details; and * the “**offered stop smoking medication**” element of this indicator requires healthcare professionals to offer medication (where this is medically appropriate and possible) and this to be recorded in the patient’s record in a clear and consistent way. This should be accompanied where relevant by behavioural support as per NICE guidance. Secondary mental health providers in particular may want to build on the [Lester tool](http://www.rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf) as appropriate. |
| **Denominator** | All **eligible patients** during this quarter:   * **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 9a) |
| **Rationale for inclusion** | Please refer to this section in 9a. |
| **Data source** | Please refer to this section in 9a. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.  Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.  Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **30%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.  **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.  **Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

**Indicator 9d Alcohol screening**

| **Indicator 9d** | |
| --- | --- |
| **Indicator name** | Alcohol screening |
| **Indicator weighting  (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%)**.**  *(NB: this applies for Q2 onwards, different reward structure for Q1, see ‘rules for in-year payment’ section below)* |
| **Description of indicator** | Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems |
| **Numerator** | Number of **unique,** **adult** **patients** who are **admitted** and **screened for alcohol consumption** and results are **recorded in patient’s record** during this quarter:   * **unique** isdefined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN; * **adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN; * **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the PSMI CQUIN; * the “**screened for alcohol consumption**” element of this indicator requires the standard protocol for alcohol screening in secondary care as per NICE guidance to be implemented. Detail on the required actions from staff can be found on the [NICE website](https://pathways.nice.org.uk/pathways/alcohol-use-disorders#content=view-node%3Anodes-screening&path=view%3A/pathways/alcohol-use-disorders/screening-and-brief-interventions-for-harmful-drinking-and-alcohol-dependence.xml). Secondary mental health providers in particular may want to build on the [Lester tool](http://www.rcpsych.ac.uk/pdf/e-version%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf) to include an appropriate alcohol component (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and * the “**recorded in patient’s record**” element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient’s record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. |
| **Denominator** | All **unique,** **adult patients** who are **admitted** during this quarter:   * **unique** isdefined as non-repeat admission of a patient during the duration of the CQUIN (i.e. FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN * **adult patient** is defined as patients of at least 18 years of age; and * **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). |
| **Rationale for inclusion** | **Context**  This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View ([5YFV](https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf)), particularly around the need for a ’…radical upgrade in prevention…’ and to ‘…incentivising and supporting healthier behaviour’. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.  **The burden of excessive alcohol consumption**  In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK CMOs’ lower-risk guideline and increase their risk of alcohol-related ill health. [[31]](#footnote-31) Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries.[[32]](#footnote-32) There are nearly 22,500 alcohol-attributable deaths per year.[[33]](#footnote-33) Out of c3.7m admissions[[34]](#footnote-34), c333,000 were admissions where an alcohol-related disease, injury or condition was the primary diagnosis or there was an alcohol-related external cause. These alcohol-related admissions are 32% higher than in 2004/05.[[35]](#footnote-35)  Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health – this is the group for which IBA is the most effective. Identification and Brief Advice (IBA) results in recipients reducing their weekly drinking by c12%. Because alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health.  **The status quo nationally**  Currently, IBA delivery in secondary care is patchy and nowhere near the optimal large scale delivery required to significantly impact on population health. It is strongest where there are strong Making Every Contact Counts (MECC) initiatives that include alcohol IBA and where there are well-resourced alcohol care teams that train other staff.  **The financial case**  Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers. The successful delivery of the CQUIN is estimated to bring about a reduction of weekly alcohol consumption of 12%, which could result in net savings of c£27 per patient receiving alcohol brief advice each year over 4 years, from reduced alcohol-related hospital admissions following improvements in morbidity. (NB: these figures are taken from unpublished modelling conducted by Sheffield University using data derived from the latest Cochrane review of brief advice in primary care.[[36]](#footnote-36)) |
| **Data source** | **Provider audit of patient records, submitted to CCGs on a quarterly basis:**  We propose that:   * Providers with searchable electronic patient records audit **all patient records**. * Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**.   **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months.  **The following exclusion criteria** should be applied:   1. All patients below 18 years of age 2. All in-patients in maternity wards 3. All A&E attendances that do not lead to in-patient admissions 4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention.   **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B.  **The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance and insight teams.  **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.  Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.  Note that to enable national audits, providers will simultaneously submit this data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **50%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.  **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.  **Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

**Indicator 9e Alcohol brief advice or referral**

| **Indicator 9e** | |
| --- | --- |
| **Indicator name** | Alcohol brief advice or referral |
| **Indicator weighting  (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%).  *(NB: this applies for Q2 onwards, different reward structure for Q1, see ‘rules for in-year payment’ section below)* |
| **Description of indicator** | Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. |
| **Numerator** | Number of **eligible patients** who are **given brief advice** or referred to specialist alcohol services during this quarter:   * **Eligible patients**are defined as patients who have been recorded as drinking above the lower risk levels during screening (in 2a); * the “**given brief advice**” element of this indicator requires the healthcare professional to provide a brief advice message and this to be recorded in the patient’s record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the [NICE website](https://pathways.nice.org.uk/pathways/alcohol-use-disorders#content=view-node%3Anodes-screening&path=view%3A/pathways/alcohol-use-disorders/screening-and-brief-interventions-for-harmful-drinking-and-alcohol-dependence.xml). See Annex A for further details; * the “**offered a specialist referral where relevant**” element of this indicator is only required in instances where screening indicates potential alcohol dependence and is instead of brief advice provision. It requires the health professional to offer a referral (not just signposting) for specialist alcohol assessment by the hospital alcohol care team or a local community alcohol treatment service and this to be recorded in the patient’s record in a clear and consistent way. Detail on the required actions from staff can be found on the [NICE website](https://pathways.nice.org.uk/pathways/alcohol-use-disorders#content=view-node%3Anodes-screening&path=view%3A/pathways/alcohol-use-disorders/screening-and-brief-interventions-for-harmful-drinking-and-alcohol-dependence.xml). See Annex A for further details. |
| **Denominator** | All **eligible patients** during this quarter:   * **Eligible patients** are defined as patients who have been recorded as drinking above the lower risk limits during screening (in 9d). |
| **Rationale for inclusion** | Please refer to this section in 9d. |
| **Data source** | Please refer to this section in 9d. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.  Note that the data that is required for the audits are patient case notes which are to be updated by health practitioners whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.  Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **80%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme) |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.  **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.  **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

**Milestones for indicators 9a-9e (Note: these only apply to Q1 of the CQUIN)**

**For Community and Mental Health Providers this means** that they will be rewarded in:

1. quarter 1 of FY17/18 for achievement of the three milestones set out below; and
2. quarter 2 (and any subsequent quarters in FY 17/18 and FY 18/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 17/18 and onwards).

**For Acute Providers this means** that they will be rewarded in

1. quarter 1 of FY18/19 for achievement of the three milestones set out below (this is because the CQUIN only applies to Acute providers from FY 18/19 onwards); and
2. quarter 2 of FY 18/19 (and any subsequent quarters in FY 18/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 18/19 and onwards).

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **End Q1** | Completed information systems audit  This milestone requires each provider to undertake an audit its existing information systems. This audit needs to set out:   1. what the proposed mechanisms for collecting the required data for the indicators are / will for the respective provider 2. what (if any) changes have been made to the data capturing arrangements / information in order to enable the quarterly case note audits 3. the proposed approach for conducting the quarterly case note audits (this should include details on potential data quality issues and any other risks; and set out mitigating actions for these to ensure that the case note audits yield accurate data on performance)   The audit needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the audit meets the requirements set out above.  Full payment of the CQUIN should be provided for audits that address all the requirements set out above. Audits that do not address all requirements will not attract payment. | 31 July 2017 | 33% of Q1 CQUIN funds |
| **End Q1** | **Completed brief advice training for relevant staff**  This milestone requires each provider to establish and implement a brief advice training plan for relevant health professionals who are expected to provide brief advice. Providers will demonstrate achievement of this milestone by drafting a report which needs to contain details on:   1. **A status quo capacity assessment**  (i.e. identification of who the relevant health professionals are to deliver brief advice and an assessment of the existing skills of those relevant health professionals to deliver brief advice) 2. **Who** is in scope to receive the training  (ie based on the capacity assessment, identify individual or groups of health professionals who would require training; and clinical leader(s) to act as ward or hospital “champions”) 3. **What** the training entails  (ie what components are included in the training, how is it sourced and who is to deliver the training incl the method of delivery) 4. **How** effective the training has been (ie assessment of how effective the training was through e.g. Self-assessment of participants after training completion) 5. **When** the training has been delivered  (ie training schedule and what groups were trained when; what processes are in place to deliver training for new starters; what process is in place to ensure that training is refreshed; it is expected that the majority of the training is completed by the end of Q1 but where this is not possible, plans for future training are required).     The report needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the report meets the requirements set out above. Full payment of the CQUIN should be provided for reports that address all the 5 requirements set out above. Reports that do not address all requirements will not attract payment. | 31 July 2017 | 33% of Q1 CQUIN funds |
| **End Q1** | **Collected relevant data to establish baseline for all indicators**  This milestone requires each provider to collect the required data for each indicator of the CQUIN to establish a baseline performance level.  Full payment of the CQUIN should be awarded to those organisations that can establish a credible baseline level of performance across all indicators. Where baseline data is not available for all of the indicators, no payment will be made.  Note that in exceptional cases where providers may not be able to establish baseline data in Q1, they may – following agreement with providers – be able to establish their baseline in Q2 in order to participate in future quarters of the CQUIN. | 31 July 2017 | 33% of Q1 CQUIN funds |

**Rules for partial achievement of indicator 9a-e (note that these apply from Q2 onwards)**

|  | **% of CQUIN scheme available for meeting final indicator value** | | | | |
| --- | --- | --- | --- | --- | --- |
| **Final indicator value for the partial**  **achievement threshold** | **9a** | **9b** | **9c** | **9d** | **9e** |
| **100%** | **5%** | **20%** | **25%** | **25%** | **25%** |
| **for those achieving below 100% of target / final indicator value** |  | | | | |
| 10% point improvement over last Q performance\* | **2%** | **10%** | **12%** | **12%** | **12%** |
| 20% point improvement over last Q performance\* | **4%** | **15%** | **18%** | **18%** | **18%** |

\*Note that following the baseline setting exercise in Q1, a minimum threshold level of activity may be introduced such that improvements only over this minimum threshold would be partially rewarded.

**Annex A – Supplementary Guidance**

Supplementary guidance will be issued alongside this final CQUIN guidance document. This supplementary guidance will be targeted at and co-developed by frontline healthcare professionals and contain a comprehensive suite of resources for them to facilitate successful delivery of the CQUIN.

**Annex B – Method for identifying random samples and minimum sample sizes**

Trusts should select ONE of the following methods and maintain this method throughout the 2016/7 year of data collection:

1. True randomisation: review the nth patient’s notes where n is generated by a random number generator or table (e.g. <http://www.random.org/>) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. <http://www.random.org/>.
2. Pseudo-randomisation: Review the first X patients’ notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

Feedback from analysts and the engagement exercise was received relating to the required sample size for sample-based patient record audits:

1. Due to expected attrition with each step of the interventions (from screening, to brief advice, to referral) and the need to provide robust samples, feedback from stakeholders suggested that a minimum sample size for sample-based audits should be set.
2. The minimum sample size is initially set at 500 case notes per quarter. Those trusts that receive fewer than 500 eligible patients per quarter should audit all eligible patient records. Those trusts that receive more than 500 eligible patients per quarter should ensure that their sample is random and may follow the methods set out above to achieve randomisation.
3. National bodies will continue to keep issues related to data collection including minimum sample sizes under review. There will also be additional advice for trusts on how they can reduce the administrative burden as part of supplementary guidance.
4. **Improving the assessment of wounds**

| **Indicator 10** | |
| --- | --- |
| **Indicator name** | Improving the assessment of wounds |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment. |
| **Numerator** | The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks. |
| **Denominator** | Number of patients on the provider’s caseload with wounds that have failed to heal for 4 weeks or more following self-care, primary, community or specialist care within Q2 & Q4 2017/18. |
| **Rationale for inclusion** | Research evidence demonstrates that over 30% of chronic wounds identified in the CQUIN as wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines. Guidance on the components of a full wound assessment will be published via the Leading Change adding Value web page early in 2017.  Failure to complete a **full** assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal.  For providers and commissioners the delay in wound healing relates to the resources being consumed inappropriately. Managing patients with wounds and their associated co-morbidities is estimated to cost the NHS £5.3 billion; the average cost of unhealed wounds is more than double that of healed wounds. There is also significant variation in current practice.  A recent economic evaluation of a wound care pathway for chronic wounds demonstrates that the current pathway experienced by many patients delivers poorer outcomes at greater cost to the commissioner – the study estimates this cost to be approximately 10 times greater.  Establishing a baseline figure through clinical audit for the number of full wound assessments that are completed in Q2 will enable service providers to review how their service is currently provided and to implement changes that will enable clinical practitioners to undertake full wound assessments for all patients who have wounds that have not healed for 4 weeks or more. The audit should be undertaken on a minimum of 150 patients from the provider caseload of patients who have a wound that has not healed within 4 week of it occurring.  Increasing the number of patients who have a full assessment of wounds will promote the use of effective treatment based on the outcome of the assessment. |
| **Data source** | Local baseline audit collection of a minimum of 150 patients on the caseload with a wound that has failed to heal within 4 weeks, which will be then, be submitted through a national data collection. |
| **Frequency of data collection** | 6 monthly through a clinical audit undertaken in Q2 and Q4 |
| **Organisation responsible for data collection** | Community Nursing Service Provider |
| **Frequency of reporting to commissioner** | Quarter 1 : Establish Clinical Audit plan  Quarter 2: Clinical Audit of wound assessments  Quarter3: Improvement Plan  Quarter 4: Repeat Clinical Audit |
| **Baseline period/date** | Q2 2017/18 |
| **Baseline value** | To be determined by outcome of Q2 clinical audit undertaken by Community Service provider. |
| **Final indicator period/date (on which payment is based)** | Q4 2017/18 |
| **Final indicator value (payment threshold)** | Payment to be based on establishing the baseline in Q2 and on achieving locally agreed levels of improvement over that baseline for Q4.  Payment in Year 2 will be based on achievement of nationally set absolute levels of performance in Q2 and Q4. These payments will be developed nationally based on an assessment of national data returns and a further review of the latest evidence. |
| **Final indicator reporting date** | 18 April 2018 to local commissioners with submission to national data base by 30 April 2018 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Completion of Clinical Audit and Improvement plan by end of Q2 and sharing of results with Commissioner and submission to national data collection by 18 November 2017. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see table below |

**Milestones for indicator 10**

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Q1and 2 2017/18** | Completion of Clinical audit to provide a baseline figure for the number of patients with chronic wounds that have received a full assessment. Full audit report and improvement plan with trajectory to be provided for commissioner. | 30 November 2017 | 50% of year if baseline data collection established and improvement plan agreed. |
| **Q4 2017/18** | Completion of clinical audit to demonstrate an improvement in the number of patients with chronic wound who have received a full wound assessment. | 31May 2018 | Maximum of 50% of year available based on the following achievement of locally agreed levels of improvement in the number of patients with chronic wound who have received a full wound assessment: |
| **Year 2 2018/19** | Achievement of the CQUIN in Year 2 will be based on achievement of nationally set absolute levels of performance in Q2 and Q4. | 30 November 2018 - Q2 audit  31 May 2019 – Q4 audit | Maximum of 100% of year available based on achievement of nationally set absolute levels of performance in Q2 and Q4. |

#### Rules for partial achievement of indicator 10

**Q4 2017/18**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieved less than 33% of improvement target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

**Q2:2018/19**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieved less than 33% of target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

**Q4: 2018/19**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| Achieved less than 33% of target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

**References**

Guest JF, Ayoub N, McIlwraith T, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 2015;5: e009283. doi:10.1136/ bmjopen-2015-009283

1. **Personalised care and support planning**

| **Indicator 11** | |
| --- | --- |
| **Indicator name** | Personalised Care and Support Planning |
| **Indicator weighting  (% of CQUIN scheme available)** | 0.25% |
| **Rationale** | More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services.  Changing this situation is not a short-term fix. However there are steps we can take, supported by the CQUIN scheme to incentivise the change in behaviours and methodologies that allow patients to take greater control over their health and wellbeing. A core component is personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them.  We envisage that the first year of the CQUIN is an opportunity to introduce the requirement of high quality personalised care and support planning, whilst recognising that not all health systems will have the technological means nor the workforce capabilities of making these happen. In future years there will be a need to increase the expected levels of achievement so that by 2020/21 personalised care and support planning is fully embedded across the service as the norm.  The Realising the Value report ‘At the heart of health’ describes how personalised care and support planning is a key enabler to allow the proliferation of self-care support packages such as health coaching, peer support and self-management education. In this context it can be seen as the foundation for the behaviour change needed to support improvements in self-care. |
| **Description of indicator** | This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers. The second year will focus more on delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence.  In year one there are three components:  **Establishing provider systems** to ensure that personalised care and support planning conversations can be incorporated into care delivery and can be recorded as an activity. Also to ensure relevant cohorts of patients who would benefit most from the delivery of personalised care and support planning can be identified on IT systems.  For the purpose of the CQUIN, personalised care and support planning conversations are defined as:   * *Conversations between a care professional, a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing.* * *Follow a process of sharing information, identifying support needs, discussing options, contingency planning, setting goals, developing an action plan, and monitoring progress.* * *Consider how to co-ordinate the individual’s care across a number of different care settings, linking to other existing care plans, particularly for people with multiple conditions.* * *Consider physical and mental health as well as wider holistic wellbeing.* * *Resulting in an agreed, recorded, document that the patient and carer owns*   Providers should submit a plan outlining their approach to delivering personalised care and support planning and how this will be recorded as an activity, taking account of the pioneering work of the national Integrated Personal Commissioning team, the latest iteration of the TLAP personalised care and support planning tool[[37]](#footnote-37) and the NHS England handbook on personalised care and support planning[[38]](#footnote-38).  **Identifying relevant patient populations**. Providers should submit a plan outlining how they will identify the relevant patient population with one or more long-term conditions and with low levels of knowledge, skills and confidence (activation) to manage their health and wellbeing who would benefit from personalised care and support planning. They will need to take into consideration cohorts of patients who may already be participating in personalised care and support planning, for example people with learning disabilities, people with severe mental health issues who are part of the Care Programme Approach, people with complex needs who have personal health budgets or are part of the Integrated Personal Commissioning programme. This may require planning with commissioners and other providers to agree who will lead the care planning process, and also how multi-disciplinary teams can work together.  To identify the cohort providers should:   * Identify those patients with one or more long-term conditions as defined by the GP patient survey. People may be identified on clinical IT systems, for example using ICD10 codes or using risk stratification tools. People may be additionally identified through contact with care professionals as someone who would benefit from personalised support[[39]](#footnote-39).   Then **conduct a baseline review of patient activation** for those patients with long term conditions identified above. This means:   * For those organisations already using the Patient Activation Measure, ensuring that all identified patients and carers have their activation levels recorded[[40]](#footnote-40); this can be combined to create an organisational score, or * For those organisations not using the Patient Activation Measure, ensuring that all identified patients and carers are asked a local survey using two key questions from the existing GP patient survey (GPPS). Answers to these questions will use the same criteria as the GPPS and be given scores as described below to allow production of an organisational score. These are:   + **Q32** – *In the last six months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?*  Answering ‘yes, definitely’ = 1 point, ‘yes, to some extent’ = 0.5 points. Other answers = 0 points   + **Q33** – *How confident are you that you can manage your own health?*   Answering ‘very confident’ = 1 point, ‘fairly confident’ = 0.5 points. Other answers = 0 points.  **Following this review of patient activation, the relevant population to be prioritised for personalised care and support planning will be defined as:**   * Those with one or more long-term conditions as defined by the GP patient survey[[41]](#footnote-41); AND * For those organisations already using the Patient Activation Measure those patients assessed at Level 1 or 2 in their activation level; **or** * For those organisations not using the Patient Activation Measure, those patients who score 0 points on the GPPS questions.   **Ensuring that all relevant provider staff are sufficiently competent** in holding care and support planning discussions with patients and carers, through appropriate training. For the purpose of the CQUIN ‘relevant provider staff’ can be defined as:   * *Those who have allocated time to support the patient and carer to develop their care and support plan; and* * *Have specific expertise or training in support for people with long-term conditions; and* * *Are in a position to be able to liaise with multidisciplinary teams as required to gather information pertinent to the care planning discussion, and to raise issues that are impacting on an individual’s care or that need to be considered at an organisational level* * *Are a regular (at least annual) point of contact for the patient and carer*   Appropriate training is defined as training that:   * *Explores the role of care & support planning in empowering patients and carers;* * *Clearly defines the role and expectations of the member of staff and the patient and/or carer;* * *Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs;* * *Helps staff develop skills in motivational interviewing to help them in encouraging patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual’s levels of knowledge, skills and confidence, and their communication needs; and* * *Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care*.   In year two there are two components:  **Reporting on the number of care and support planning conversations** that take place (with the expectation that at least one conversation takes place for each patient but the number of conversations will vary depending on individual’s needs and levels of knowledge, skills and confidence).  **Conducting a follow up review of patient’s knowledge, skills and confidence** for the identified patient population.  As above, organisations will either need to repeat the process of collecting individual Patient Activation scores using the Patient Activation Measure, or using the questions from the GP patient survey to ascertain levels of confidence and feelings of support. |
| **Numerator**  **Denominator** | **In year one:**   1. Submission of a plan to ensure care & support planning is recorded by providers and how patients will be identified will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted. 2. The provider to identify the number of patients as having one or more LTCs compared to the total number of patients served.  **AND**  For all patients identified as having one or more LTCs, all patients to have a patient activation score recorded.  **AND**   To confirm the final cohort as the number of patients with one more LTCs and who have a low activation level (as described above) 3. The provider to identify the number of staff who have undertaken training in personalised care and support planning   **In year two:**   1. The number of patients from the identified cohort who have undertaken personalised care and support planning conversations 2. Whether there has been an improvement in individual activation levels following personalised care and support planning |
| **Data source** | **Year One:**   1. Community based providers would need to submit a plan via UNIFY outlining their approach to delivering personalised care and support planning to an identified cohort of patients and how they will record this activity in a format that can be aggregated at organisation level (ie local, operational collection can vary, but organisational submission to UNIFY must be consistent) following locally agreed sign off processes by the commissioner 2. Providers would need to identify which patient populations would benefit from personalised care and support planning and should be prioritised, using the list of long term conditions outlined in the GP Patient Survey and the Patient Activation Measure or GP patient survey criteria to assess their level of confidence and perceived support. 3. Providers would need to identify relevant staff (as defined above) and record that they have undertaken training in personalised care and support planning (as defined above). To be submitted via UNIFY following locally agreed sign off processes by the commissioner   **Year Two:**   1. Identify the number of care planning conversations taking place for each of the identified cohort from the previously identified local system. 2. Follow-up use of a survey instrument (the Patient Activation Measure or questions from the GP patient survey) to assess whether the level of patients’ skills, knowledge and confidence to self-manage has improved. |
| **Frequency of data collection** | Annual, noting in-year milestones for year 1 |
| **Organisation responsible for data collection** | This will be the responsibility of individual community providers collecting data via UNIFY |
| **Frequency of reporting to commissioner** | Annual, noting in-year milestones for year 1 |
| **Baseline period/date** | The requirements described are new and baselines to inform Year 2 will be collected during Year 1. |
| **Baseline value** |
| **Final indicator period/date (on which payment is based)** | 31 March 2018 (Year 1) and 31 March 2019 (Year 2) |
| **Final indicator value (payment threshold)** | **In Year One:**   1. 25% of Year One CQUIN value     1. No plan produced = 0% of proportion of CQUIN value    2. Plan produced but recording system not in place = 50% of proportion of CQUIN value    3. Plan produced and recording system put in place = 100% of proportion of CQUIN value 2. 45% of Year One CQUIN value. Comprised of:   **Identifying long term conditions (15% of Year One CQUIN value)**   * 1. Relevant patient cohort not identified or submitted = 0% of proportion of CQUIN value   2. Relevant patient cohort identified and submitted to commissioner = 100% of proportion of CQUIN value  **Undertaking patient activation assessment (30% of Year One CQUIN value)**   3. < 50% of identified cohort have a patient activation assessment = 0% of proportion of CQUIN value   4. 50 to 75% of identified cohort have a patient activation assessment = 50% of proportion of CQUIN value   5. 75% > of identified cohort have a patient activation assessment = 100% of proportion of CQUIN value  1. 30% of Year One CQUIN value     1. No staff identified for training = 0% of proportion of CQUIN value    2. Cohort of staff identified and list submitted to commissioner = 10% of proportion of CQUIN value    3. 33% to 66% of identified staff trained by end of year (including submitted staff list in ‘b’) = 40% of proportion of CQUIN value    4. 66 to 85% of identified staff trained by end of year (including submitted staff list in ‘b’) = 70% of proportion of CQUIN value    5. 85% > of identified staff trained by end of year (including submitted staff list in ‘b’) = 100% of proportion of CQUIN value   **In Year Two:**   1. 50% of Year Two CQUIN value     1. < 50% of identified cohort have evidence of care and support planning conversations as recorded by provider = 0% of proportion of CQUIN value    2. 50 to 75% of identified cohort have evidence of care and support planning conversations as recorded by provider= 50% of CQUIN value    3. 75% > of identified cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value 2. 50% of Year Two CQUIN value     1. < 25% of identified cohort demonstrate an improvement in their patient activation assessment = 0% of proportion of CQUIN value    2. 25 to 50% of identified cohort demonstrate an improvement in their patient activation assessment = 50% proportion of CQUIN value    3. 50% > of identified cohort demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value |
| **Final indicator reporting date** | April 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | In-year milestones for Year 1 will be as follows:  **By end of Q2:**  Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted by the end of the year (yes/no).  **By end of Q3:**  The provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served  **By end of Q4:**   1. The provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning. 2. The provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above)   There are no in-year milestones for Year 2 |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Partial achievement of indicators is covered in the differing percentages of achievement within the ‘final indicator value’ section above. |

**Milestones for indicator 11**

| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| --- | --- | --- | --- |
| **Year 1**  **2017/18** | Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no). | end of Q2 | 25% |
| **Year 1**  **2017/18** | Provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served | end of Q3 | 15% |
| **Year 1**  **2017/18** | Provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning. | end of Q4 | 30% |
| **Year 1**  **2017/18** | Provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above) | end of Q4 | 30% |

**Rules for partial achievement for indicator 11**

The payment details are described in the final indicator value (payment threshold) in the table above.

1. The Nutrient Profiling Model can be used to differentiate these foods while encouraging the promotion of healthier alternatives. <https://www.gov.uk/government/publications/the-nutrient-profiling-model> [↑](#footnote-ref-1)
2. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf> [↑](#footnote-ref-2)
3. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf> [↑](#footnote-ref-3)
4. Please see appendix A for definitions of frontline healthcare workers [Seasonal influenza vaccine uptake HCWs 2015-16 Annual Report](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/544536/Seasonal_influenza_vaccine_uptake_HCWs_2015_16_Annual_Report.pdf) [↑](#footnote-ref-4)
5. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf> [↑](#footnote-ref-5)
6. The incidence, and thus mortality figures, for sepsis were revised in late 2015 following the publication into the public domain of HES data by junior minister Ben Gummer. Mortality in England currently sits at approximately 30% according to the 2015 NCEPOD study 'Just say Sepsis' and to ICNARC. This estimated data therefore lead us to a figure of 36,847 lives claimed annually in England. [↑](#footnote-ref-6)
7. See section below for rules on partial achievement [↑](#footnote-ref-7)
8. Please see ‘rationale’ section below for further detail about selection and segmentation of this cohort [↑](#footnote-ref-8)
9. E.g. due to deaths, relocations out of area etc. [↑](#footnote-ref-9)
10. The care plan may be known by other names, such as an attendance plan or personal support plan. The purpose of the plan is to guide care delivered by staff whenever an identified patient attends A&E, promoting consistency of care that aims to better meet the needs of patients. Involvement of patients and carers in their co-production is essential, and other partner agencies including primary care should be aware of the plans, and have access and contribute to their development as necessary. They should include a patient’s key health and care issues and accompanying management plans, and other relevant information such as the different named professionals involved in their care. [↑](#footnote-ref-10)
11. See section below for rules on partial achievement [↑](#footnote-ref-11)
12. E.g. due to deaths, relocations out of area etc. [↑](#footnote-ref-12)
13. See section below for rules on partial achievement [↑](#footnote-ref-13)
14. Caldicott review: information governance in the health and care system: https://www.gov.uk/government/publications/the-information-governance-review [↑](#footnote-ref-14)
15. NHS England, A Quick Guide to Sharing Patient Information for Urgent & Emergency Care: <http://www.nhs.uk/NHSEngland/keogh-review/Documents/160203-qucik-guide-Sharing-Patient-Information-for-Urgent-Care.pdf> [↑](#footnote-ref-15)
16. The Information Governance Alliance (hosted by NHS Digital) and the Centre of Excellence for Information Sharing have produced helpful resources: <http://systems.digital.nhs.uk/infogov/iga/resources/infosharing> & <http://informationsharing.org.uk/our-work/learning-good-practice/> & <http://informationsharing.org.uk/our-work/resources/> [↑](#footnote-ref-16)
17. ‘Improving the effectiveness and efficiency of outpatient services: a scoping review of interventions at the primary–secondary care interface’, Winpenny et al. 2016, Journal of Health Services Research and Policy [↑](#footnote-ref-17)
18. Oliva, X., Micaló, T., Pérez, S., Jugo, B., Solana, S., Bernades, C., Sanavia, M. and Delgado, C. (2013). Virtual referral system between specialized endocrinological care and primary care. *Endocrinología y Nutrición (English Edition)*, 60(1), pp.4-9. [↑](#footnote-ref-18)
19. Walker, J., Rourke, D., Allen, K., Karavitaki, N., Levy, J. and Wass, J. (2009). An e-mail GP advisory service: a more efficient way of dealing with clinical enquiries. *Br J Hosp Med*, 70(9), pp.532-533. [↑](#footnote-ref-19)
20. National Audit Office, (2016) Discharging Older Patients from Hospital [↑](#footnote-ref-20)
21. Quick Guide: Discharge to assess [www.nhs.uk/quickguide](http://www.nhs.uk/quickguide) [↑](#footnote-ref-21)
22. National Audit Office, (2016) Discharging Older Patients from Hospital [↑](#footnote-ref-22)
23. Quick Guide: Discharge to assess [www.nhs.uk/quickguide](http://www.nhs.uk/quickguide) [↑](#footnote-ref-23)
24. National Audit Office, (2016) Discharging Older Patients from Hospital [↑](#footnote-ref-24)
25. Quick Guide: Discharge to assess [www.nhs.uk/quickguide](http://www.nhs.uk/quickguide) [↑](#footnote-ref-25)
26. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf> [↑](#footnote-ref-26)
27. <http://www.sciencedirect.com/science/article/pii/S0140673606689757> [↑](#footnote-ref-27)
28. Rigotti N, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients.Cochrane Database of Systematic Reviews 2007; Issue3.Art.No.:CD001837.DOI:10.1002/14651858.CD001837.pub2 [↑](#footnote-ref-28)
29. <http://www.ncsct.co.uk/usr/pub/Briefing%208.pdf> [↑](#footnote-ref-29)
30. Note that staff and healthcare professionals are used interchangeably throughout this document. The intention is to ensure that the intervention is delivered by the most appropriate healthcare professionals and is not restricted to one particular professional group. Providers will be best placed to judge who in their organisations should deliver. [↑](#footnote-ref-30)
31. <http://digital.nhs.uk/catalogue/PUB16076> [↑](#footnote-ref-31)
32. <http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch6-Alc-cons.pdf> [↑](#footnote-ref-32)
33. Public Health England (2016), Local Alcohol Profiles for England. Available at: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles> [↑](#footnote-ref-33)
34. Admissions to acute, acute &community and acute specialist providers in 2014/15, excluding maternity and below 18s, based on HES data [↑](#footnote-ref-34)
35. Statistics on Alcohol, England, 2016 (NHS Digital, 2016)​ [↑](#footnote-ref-35)
36. Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane database Syst Rev Online. Wiley Online Library; 2007; 4(2):CD004148. [↑](#footnote-ref-36)
37. <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/> [↑](#footnote-ref-37)
38. NHS England & Coalition for Collaborative Care (2015) *Personalised care and support planning handbook* - <https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/> [↑](#footnote-ref-38)
39. See also NICE guideline on multimorbidity - <https://www.nice.org.uk/guidance/ng56> [↑](#footnote-ref-39)
40. Patient Activation Best Practice Guide (due to be published December 2016) [↑](#footnote-ref-40)
41. Final position to be confirmed prior to April 2017. The current expectation is this will include a broad definition (Long term conditions are health conditions that can’t be cured, last a year or longer, impact on a person’s life, and may require on-going care and support) and a list of the specific conditions that fall under this definition [↑](#footnote-ref-41)