



**Annex A: Commissioning for Quality
and Innovation (CQUIN) 2015/16
Guidance Templates for use with the
NHS Standard Contract 2015/16**

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Commissioning Strategy

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1 Publication template for CQUIN variations

This template should be completed when commissioners and providers agree to vary from national CQUIN goals or rules and submitted to: e.cquin@nhs.net

BACKGROUND	
Overview	<i>Summary of and rationale for the service change that will be supported by varying the national CQUIN goals or rules. Justify the new approach and explain how it is in patients' best interests.</i>
Link to local variation of national price	<i>Is this related to a variation in national price? If Yes, which one? (refer to the unique reference number of the price variation).</i>
National goals affected	<i>National CQUIN goals affected</i>
National rules affected	<i>CQUIN rules affected</i>
Commissioner(s)	<i>Commissioner(s) party to the agreement</i>
Provider(s)	<i>Provider(s) party to the agreement</i>
Estimated value	<i>An estimate of the expected financial impact of the variation for the commissioner and provider, relative to the impact of a standard CQUIN scheme.</i>
Proposed duration	<i>Number of years, including frequency of any planned reviews.</i> <i>Note: The duration of any CQUIN variation should not exceed (but may be less than) the duration of the overall contract within which it is agreed.</i> <i>Note: Commissioner and provider will need to agree how they will handle any future changes to CQUIN rules for multi-year schemes, e.g. what happens if the total % available for CQUIN goes up or down.</i>
Impact	<ul style="list-style-type: none"> • <i>How will the new approach impact the quality of care patients receive?</i> • <i>What quality metrics are being monitored?</i> • <i>Are there associated operational risks? How are these being managed?</i> • <i>How will the new approach be evaluated?</i> • <i>How will the variation create a more effective incentive for the provider(s) to achieve the desired outcomes for patients?</i>
Start date of agreement	<i>Date agreement begins</i>
End date of agreement	<i>Date agreement ends</i>
Contact	<i>Email address in case of follow up enquiries</i>

2 National CQUIN Goals for 2015/16

2.1 Indicator 1 Acute Kidney Injury Template

ACUTE KIDNEY INJURY (AKI) IMPROVEMENT GOAL SPECIFICATION	
Indicator number	1
Indicator name	Acute Kidney Injury
Indicator weighting	To be agreed locally (minimum 0.25%)
Description of indicator	<p>This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below.</p> <p>This CQUIN is relevant to acute hospital providers who accept emergency admissions; whilst AKI is also a clinical concern in specialist hospital providers, the volume of cases will not provide a sufficient sample size for this CQUIN.</p>
Numerator	<p>The numerator is the count of completed key items found in the discharge summaries of patients with AKI detected through the pathology laboratory information management system (LIMS), and who have survived to discharge, using calendar month of discharge for each monthly sample. Where 25 or fewer patient records meet these criteria, all the relevant records should be reviewed. If more than 25 patient records meet these criteria, a random sample [see Note A] of 25 sets of patient records should be reviewed. Requirements in discharge summary are:</p> <ol style="list-style-type: none"> 1. Stage of AKI (a key aspect of AKI diagnosis); 2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment); 3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care); 4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care). <p>Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.</p>
Denominator	Where 25 or fewer patient records have AKI

	<p>detected through the pathology laboratory information management system (LIMS), and who have survived to discharge in each monthly sample, the denominator is $N \times 4$ (where N equals all patient records meeting that criteria) i.e. review of four items in each of N discharge summaries.</p> <p>If more than 25 patient records meet these criteria, a random sample [see Note A] of 25 sets of patient records should be reviewed., and the denominator will equal 100 i.e. review of four items in each of 25 discharge summaries.</p>
<p>Rationale for inclusion</p>	<p>The AKI Programme is addressing all parts of the patient pathway. This CQUIN focusses on the recovery and follow up elements of the pathway which are both important elements given over 50% of AKI is currently occurring in primary care.</p> <p>Improving the provision of information to GPs at the time of discharge will start to develop the knowledge base of GPs on AKI and will also positively impact on readmission rates for patients with AKI.</p> <p>Availability of the information required on discharge for <u>compliance</u> with the CQUIN will be dependent on the patients having received appropriate diagnosis and medication review during their admission.</p> <p>It is recognised that early treatment and effective risk assessment are also important in managing patients with AKI in secondary care but clinical resources regarding best practice are not yet available to support clinicians. These are currently being developed as part of the AKI programme.</p>
<p>Data source</p>	<p>Provider audit discharge summaries from patients identified by the laboratory as having AKI on current admission (using the national algorithm as defined in NHS England Patient Safety Alert ‘Standardising the early detection of AKI’ http://www.england.nhs.uk/2014/06/09/psa-aki/) and who have survived to discharge. Data source = discharge summary for episode of care.</p> <p>Audit to be undertaken by clinical staff.</p>

	<p>100 elements to be reviewed each month; four for each of the 25 patient records (or 4 items for each relevant patient record where the total of relevant patient records is less than 25).</p> <p>An application to the Burden Advice and Assessment Service (BAAS) has been made to request approval for quarterly totals to be submitted via UNIFY.</p>
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly. The quarterly score is produced by averaging the three monthly scores i.e. sum the numerator data across the 3 months and then divide by the sum of the denominator data for the 3 months of the quarter.
Baseline period/date	Q1
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Q4
Final indicator value (payment threshold)	See below
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See below Evidence: Summary of monthly discharge summary audit.
Final indicator reporting date	20 days after the end of Q4
Are there rules for any agreed in-year milestones that result in payment?	See below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes; see below Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.

Rules for in year payment and partial payment		
Quarter 1	10% of whole-year AKI CQUIN value awarded if the audit is established and results that can serve as a baseline for improvement	
Quarter 2	20% of whole-year AKI CQUIN value awarded if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1	
Quarter 3	20% of whole-year AKI CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.	
Quarter 4	Maximum of 50% of whole-year AKI CQUIN value available based on the following thresholds:	
	49.9% or less of required key items included in discharge summaries	No payment
	50.0% to 69.9% of required key items included in discharge summaries	10% of whole-year AKI CQUIN value
	70.0% to 79.9% of required key items included in discharge summaries	20% of whole-year AKI CQUIN value
	80.0% to 89.9% of required key items included in discharge summaries	35% of whole-year AKI CQUIN value
	90.0% or above of required key items included in discharge summaries	50% of whole-year AKI CQUIN value

Local data collection advice

See the specification above for data source and numbers required in each monthly audit.

Note A: method for identifying random samples

Trusts should select ONE of the following methods and maintain this method throughout the 2015/16 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.

Suggested format for local data collection				
	Tick column below if stage of AKI is recorded in discharge letter	Tick column below if information on medicines review having been undertaken is recorded in discharge letter	Tick column below if type of blood tests required on discharge for monitoring are recorded in discharge letter	Tick column below if frequency of blood tests required on discharge for monitoring are recorded in discharge letter
1.				
2.				
3.				
4.				
5.				
Etc.				
Totals	Column A total	Column B total	Column C total	Column D total
CQUIN calculation				
Column A+ B + C +D totals = numerator total				
Number of records reviewed x 4 = denominator total				
Percentage) CQUIN achievement = numerator ÷ denominator x 100				

Additional guidance notes for data collection

Additional guidance Column A (Stage of AKI)

The discharge summary should include a statement that provides: AKI stage (1, 2 or 3) as defined by the national definition (see <http://www.england.nhs.uk/2014/06/09/psa-aki/>)

E.g. AKI Stage 3 - The highest recorded stage during an inpatient episode should be recorded.

Additional guidance Column B (Medication review)

For all medications that have been discontinued during an episode of AKI there should be clear documentation as to whether the medication/s was stopped due to AKI and also whether it can be restarted. E.g. *“RAMIPRIL 10 mg discontinued due to AKI. Can be restarted after clinical review”* OR *“OMEPRAZOLE 20 mg discontinued due to AKI. Not to be restarted (see summary)”*.

Any form of wording is acceptable IF it gives a clear indication when and how the medication can be resumed OR explicitly points to a situation where the drug has directly caused renal inflammation and therefore should never be restarted. Simply stating that a medication has been discontinued without a reason or without a statement about potential restarting (e.g. *“SPIRONLACTONE 50 mg discontinued”*) would not allow a point in Column B.

If multiple medications are discontinued, please not a point would only be given in Column B if information on whether or not to restart medication was provided for ALL discontinued medications.

If no medications have been discontinued, only wording that makes it clear that medication review has taken place would be needed for a point.

Additional guidance Column C (Type of blood tests) and Column D (Frequency of blood tests)

For column C there should be a clear statement detailing the type of blood tests to be requested and for Column D a clear statement of when they should be requested.

This may be contained within the clinical summary text. It should also be clear who is to perform the request.

For example, points would be awarded for: *“U&Es and FBC should be rechecked on [date] and weekly thereafter until review in the Nephrology clinic in 4 weeks. We would be grateful if the GP practice could arrange the tests and contact us on xxxxx-788249 if there are concerns.”* OR *“Biochemistry checks will be organised 1 week prior to the OPA 24/1/2015 by the hospital. The patient has the necessary forms.”*
No points would be awarded for C if phrasing is only a non-specific *“Please check bloods”*

No points would be awarded in Column D if no clear statement is given on timing of blood tests.

Data submission

A BAAS application has been made to request approval for quarterly totals to be submitted via UNIFY.

To minimise burden, the data submission proposed is a simple percentage total each quarter - see the improvement specification above for advice on calculating quarterly average from monthly audits of discharge summaries.

2.2 Indicator 2 Sepsis Templates

The indicator has two parts - 2a and 2b. 2a must be completed before 2b is implemented. It is expected that 2a will be in place from Q1 and 2b added in Q2.

2a Sepsis Screening

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2a
Indicator name	Sepsis Screening
Indicator weighting	To be agreed locally (2a and 2b minimum 0.25%)
Description of indicator	<p>This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward.</p> <p>It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.</p> <p>This CQUIN is focussed on incentivising the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies. It is important to note 2a is not aimed at incentivising sepsis screening for all emergency patients, as there are clinical reasons why screening is unnecessary or misleading in some patient groups.</p> <p>This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.</p>
Numerator	<p>The CQUIN requires an established local protocol that defines which emergency patients require sepsis screening. Detail on key content of the protocol is outlined below [Note A], but local adaptation will be needed to reflect the types of Early Warning Score in local use for children and adults. The numerator for 2a (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis.</p> <p>Screening for sepsis must be carried out using an appropriate tool [Note B].</p>
Denominator	The denominator for (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies and who require screening for sepsis

	according to the agreed local protocol.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.
Data source	<p>Provider audit of a random sample [see Note C] of 50 sets of patient records per month. The following rules should be used:</p> <ol style="list-style-type: none"> 1. Discard from sample all patients who do NOT require sepsis screening according to locally agreed protocol [see Note A]. Number now remaining in sample becomes denominator. 2. Of the remaining patients who required sepsis screening, record the proportion who were screened for sepsis as part of the admission process = counts towards numerator total. 3. All other cases = does not count towards numerator total. <p>Data source = sample drawn from all patient records where the patient presented at emergency departments and other units that directly admit emergencies and WAS NOT in 'minors' stream of ED using calendar month of date of admission/attendance.</p> <p>Audit undertaken by nursing staff but consultant advice sought if needed.</p> <p>A BAAS application has been made to request approval for the quarterly data totals to be submitted via UNIFY.</p>
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q1 for 2a (screening)
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	<p>For rules of calculation see below.</p> <p>All quarterly figures to be a simple average of the three individual months' percentage completed.</p> <p>Evidence: Summary of that quarter's monthly audits.</p>
Final indicator reporting date	20 days after the end of the quarter.
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?	<p>Yes, see below</p> <p>Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.</p>

2b Sepsis Antibiotic Administration

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2b
Indicator name	Sepsis Antibiotic Administration
Indicator weighting	To be agreed locally (2a and 2b minimum 0.25%)
Description of indicator	<p>This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.</p> <p>2b relies on administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies.</p> <p>This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.</p>
Numerator	The numerator is the number of patients who present to emergency departments and other wards/units that directly admit emergencies with severe sepsis, Red Flag Sepsis or Septic Shock (as identified retrospectively via case note review of patients with clinical codes for sepsis) and who received intravenous antibiotics within 1 hour of presenting.
Denominator	The denominator is the total number of patients sampled for case note review who, in the view of the reviewer, had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock on presentation at emergency departments and other units that directly admit emergencies, or would have had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock if they had been assessed according to best practice (early warning score and sepsis screening) and therefore should have been administered i/v antibiotics within an hour of presentation.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.
Data source	Provider audit of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41). Where 30 or fewer patient records include these codes, all the relevant records should be reviewed. If more than 30 patient records

	<p>include these codes, a random sample [see Note C] of 30 sets of patient records should be reviewed.</p> <p>This should be a separate audit to 2a.</p> <p>The following rules should be used:</p> <ol style="list-style-type: none"> 1. Discard from sample: <ul style="list-style-type: none"> • If there is clear evidence severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the trust's care; • Or if there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile); • Or if an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies. <p>Number now remaining in sample becomes denominator.</p> <ol style="list-style-type: none"> 2. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of triage) = counts towards numerator total. 3. All other cases, including those where time of arrival and/or time of antibiotic administration is unclear = does not count towards numerator total. <p>Data source = random sample [see Note C] drawn from all patient records where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) using calendar month of date of discharge or death.</p> <p>Audit undertaken by consultant staff.</p>
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q2
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	<p>For rules of calculation see below.</p> <p>All quarterly figures to be a simple average of the three individual months' percentage completed.</p> <p>Evidence: Summary of that quarter's monthly audits.</p>
Final indicator reporting date	20 days after the end of the quarter.
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?	<p>Yes, see below</p> <p>Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.</p>

Rules for in year payment and partial payment				
		2a (screening)	2b (antibiotic administration)	
Quarter 1	10% of whole-year sepsis CQUIN value awarded if appropriate local sepsis protocol and screening tool are in use and baseline data collection established		N/A	
Quarter 2	10% of whole-year sepsis CQUIN value awarded if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1		10% of whole-year sepsis CQUIN value awarded if baseline data collection established	
Quarter 3	10% of whole-year sepsis CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination		20% of whole-year sepsis CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. Q3 target must be set as soon as possible after Q2 ends using data from Q2	
Quarter 4	Maximum of 20% of whole-year sepsis CQUIN value available based on the following thresholds:		Maximum 20% of whole-year sepsis CQUIN value available based on the following thresholds:	
	<i>49.9% or less of eligible patients screened</i>	<i>No payment</i>	<i>49.9% or less of eligible patients received antibiotics</i>	<i>No payment</i>
	<i>50.0% to 69.9% of eligible patients screened</i>	<i>5% of whole-year sepsis CQUIN value</i>	<i>50.0% to 69.9% of eligible patients received antibiotics</i>	<i>5% of whole-year sepsis CQUIN value</i>
	<i>70.0% to 79.9% of eligible patients screened</i>	<i>10% of whole-year sepsis CQUIN value</i>	<i>70.0% to 79.9% of eligible patients received antibiotics</i>	<i>10% of whole-year sepsis CQUIN value</i>
	<i>80.0% to 89.9% of eligible patients screened</i>	<i>15% of whole-year sepsis CQUIN value</i>	<i>80.0% to 89.9% of eligible patients received antibiotics</i>	<i>15% of whole-year sepsis CQUIN value</i>
	<i>90.0% or above of eligible patients screened</i>	<i>20% of whole-year sepsis CQUIN value</i>	<i>90.0% or above of eligible patients received antibiotics</i>	<i>20% of whole-year sepsis CQUIN value</i>

Note A: key components of local protocol

Providers should be mindful of the College of Emergency Medicine endorsed tools at <http://sepsistrust.org/info-for-professionals/clinical-toolkits/> 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>

Likely components of local protocol on when sepsis screening should be undertaken would include:

- Screening for selected patients in ‘majors’ streams of emergency departments;
- Exclusion of trauma patients who are likely to have ‘false positives’ in sepsis screening;

- Making clear that sepsis screening should be triggered by thresholds in adult and paediatric early warning scores. For example, if NEWS is in use without any local adaptation, sepsis screening would be recommended for an aggregate score of 5 or more, or a 'red' score of 3 for any single parameter;
- Pragmatic exclusions, such as no need to screen if a sepsis diagnosis is immediately made without need to screen;
- Special circumstances when sepsis screening is inappropriate, such as with patients not for active treatment;
- Consideration of any vulnerable groups that may require special arrangements to ensure the possibility of sepsis is considered (e.g. children with disabilities).

Providers should be mindful of forthcoming sepsis clinical guidelines from NICE and amend their local protocol in light of interim or final guidance from NICE.

Note B: appropriate tools for sepsis screening

Tools used should be either the College of Emergency Medicine endorsed tools at <http://sepsistrust.org/info-for-professionals/clinical-toolkits/> 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>.

Providers should be mindful of forthcoming sepsis clinical guidelines from NICE and amend their local tool in light of interim or final guidance from NICE

Note C: method for identifying random samples

Trusts should select ONE of the following methods and maintain this method throughout the 2015/16 year of data collection:

1. True randomisation: review the n^{th} 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.

**Suggested format for local data collection
2a (sepsis screening)**

	Tick column below if the patient DID NOT NEED sepsis screening according to local protocol	Tick column below if the patient NEEDED sepsis screening according to local protocol and RECEIVED sepsis screening	Tick column below if the patient NEEDED sepsis screening according to local protocol but DID NOT receive sepsis screening
1.			
2.			
3.			
4.			
5.			
Etc.			
Totals	Column A total	Column B total	Column C total
<p>CQUIN calculation</p> <p>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 = $(B \div [B+C]) \times 100$</p>			

2b (Antibiotic administration)

	Tick column below if antibiotics within an hour of admission were NOT indicated*	Tick column below if antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of triage)	Tick column below for all other cases, including those where time of arrival and/or time of antibiotic administration is unclear
1.			
2.			
3.			
4.			
5.			
Etc.			
Totals	Column A total:	Column B total:	Column C total:
<p>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 2 (antibiotic administration) CQUIN achievement = $(B \div [B+C]) \times 100$</p>			
<p>* Antibiotics within one hour would NOT be indicated if:</p> <ul style="list-style-type: none"> ▪ <i>there is clear evidence severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the trust's care</i> ▪ <i>there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile)</i> ▪ <i>an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies</i> 			

2.3 Indicator 3 Dementia and Delirium Templates

The indicator has three parts - 3a, 3b and 3c.

3a Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3a
Indicator name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): <ul style="list-style-type: none"> • 3a = 60% of total funding
Description of Indicator	<p>3a:</p> <ol style="list-style-type: none"> i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP. <p>Each patient's emergency, unplanned episode of care can be included only once in each indicator but not necessarily in the same month, as the identification, assessment and <i>care plan on discharge</i> stages may take place in different months.</p> <p>Each patient's emergency, unplanned episode of care is to be viewed from the patient's perspective. If a patient is admitted to provider A and transfers to provider B during their episode of care, the patient's length of stay must be determined from the time of admission to provider A.</p> <p>Emergency unplanned care is defined as an emergency admission to hospital or urgent referral to community services which provide an alternative to hospital admission (with a response time within 24 hours). For example, intermediate care, rapid response and step up care services/teams. Care may be provided in a variety of settings including the patients' usual place of residence.</p>
Numerator	<p>3a:</p> <ol style="list-style-type: none"> i. Numbers of patients over 75 years old admitted or accepted for emergency unplanned care to hospital or community services, who are reported as having: known

	<p>diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma);</p> <p>ii. Numbers of above patients reported as having a diagnostic assessment including investigation;</p> <p>iii. Numbers of above patients who have a <i>plan of care on discharge</i> that is shared with general practice. The detail of the <i>plan of care</i> is to be locally determined but should include as a minimum:</p> <ul style="list-style-type: none"> • A diagnosis and READ code; • Current cognitive function and recommendations for re – testing; • A plan to modify/ stop any anti psychotics or sedative drugs (within 3 weeks); • Recommendations for patients with delirium in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction • Recommendations for further assessment or onward referral in line with locally agreed care pathways; • A comprehensive communication plan to include all professionals/services involved; • Recommendations for liaison and communication if the usual place of residence is a care home or for carers; • Any further information to enable general practice to update plans of care for existing patients with a diagnosis of dementia; • Analysis of 2014 CQUIN data returns indicate that the numbers of patients required for the provider audit per CCG would be too small to be sampled, hence a census is preferable. Commissioners will be able to submit this data to UNIFY.
Denominator	<p>3a:</p> <p>i. Numbers of patients over 75 years of age admitted or accepted for emergency unplanned care to hospital or community services, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinic reasons (e.g. coma);</p> <p>ii. Numbers of above patients with a clinical diagnosis of dementia and a new assessment is indicated or who have answered positively on the dementia case finding question;</p> <p>iii. Number of above patients who have an existing/known/already recorded diagnosis of dementia or underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.</p>
Rationale for inclusion	<p>This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia</p>

	or delirium during episodes of emergency unplanned care.
Data Source	<p>UNIFY2 and local audits</p> <p>3a (i & ii)</p> <p>Providers must collect and submit data on:</p> <ul style="list-style-type: none"> • The total number of patients aged 75 and over, admitted or accepted for emergency unplanned care to hospital or community services and stayed more than 72 hours; • Of these, how many <ul style="list-style-type: none"> a) were asked the dementia case finding question; or b) had a clinical diagnosis of delirium using locally developed protocols in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction; or c) had a known diagnosis of dementia; • Of those with a clinical diagnosis of delirium or who answered positively on the dementia case finding question, how many underwent a diagnostic assessment. <p>3a (iii)</p> <p>Commissioners must collect and submit data on a provider audit of all the patients notes from each provider (a census), where the patient underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive. The commissioner should report aggregated data including all providers on:</p> <ul style="list-style-type: none"> • the number of patients who underwent a diagnostic assessment for dementia on whom the outcome was either positive or inconclusive (denominator); • the number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners who have a <i>care plan on discharge</i> which complies with the criteria set out in this guidance for existing patients and for newly diagnosed (numerator). <p>A BAAS application has been made to establish the commissioner data collection. CCGs will be updated via the CCG bulletin.</p>
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider 3a (i & ii) Commissioner 3a (iii)
Frequency of reporting to commissioner	Monthly
Baseline period/date	NA
Baseline value	NA

Final indicator period/data (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	90% (see below for the specific rules to be applied to the payment)
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)*	<p>Acute providers to achieve:</p> <ul style="list-style-type: none"> • 90% or more for parts i & ii of the indicator at the end of each quarter. • 90% or more for part iii for the whole of quarter 4. <p>Community service providers achieve:</p> <ul style="list-style-type: none"> • 90% or more for parts i & ii of the indicator from the start of quarter 3. • 90% or more for part iii for the whole of quarter 4.
Final indicator reporting date*	March 2016
Are there rules for any agreed in – year milestone that result in payment?*	To be agreed locally
Are there any rules for partial achievement of the indicator at the final indicator period/date?*	To be agreed locally

* Sections of table revised.

3b Staff Training

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3b
Indicator name	Staff Training
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): <ul style="list-style-type: none"> • 3b = 10% of total funding
Description of Indicator	To ensure that appropriate dementia training is available to staff through a locally determined training programme.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data Source	Training programme to be determined locally. To ensure that appropriate dementia training is available to all staff. It is recommended that the commissioning and delivery of the training programme is a collaborative effort across the local health and care economy (including care homes). Commissioners will need to agree local audit processes for the training programme but should include quarterly reports to Provider Boards of : <ul style="list-style-type: none"> • Numbers of staff who have completed the training; • Overall percentage of staff training within each provider.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly reports to the provider board
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to)	Rules to be agreed locally

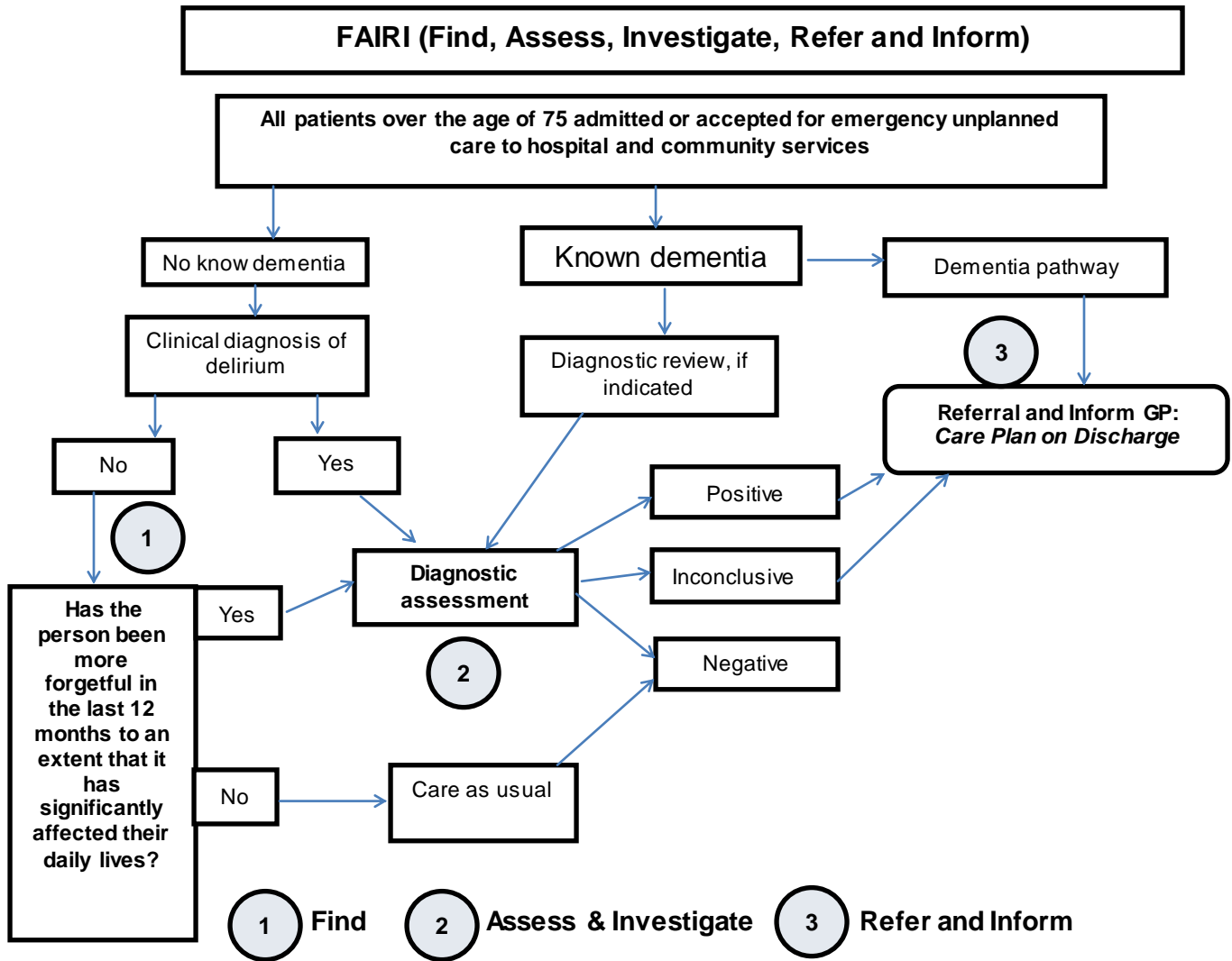
commissioner)	
Final indicator reporting date	March 2016
Are there rules for any agreed in –year milestone that result in payment?	To be agreed locally
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally

3b Supporting Carers

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3c
Indicator name	Supporting Carers
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): <ul style="list-style-type: none"> • 3c = 30% of total funding
Description of Indicator	Ensure carers of people with dementia and delirium feel adequately supported.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data Source	Carer survey - Commissioners and providers will need to agree on the content of the survey and local processes for surveying carers of people with dementia and delirium which should cover the whole health and social care economy. The findings of the survey to presented biannually to the Provider Board.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Biannual
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	NA
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Rules to be agreed locally.
Final indicator reporting date	March 2016
Are there rules for any agreed in –year	To be agreed locally

milestone that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally

Fig 1: Dementia FAIRI Flow chart



2.4 Indicator 4 Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness Templates

This is a two part indicator – 4a & 4b.

4a Cardio Metabolic Assessment and Treatment for Patients with Psychoses

IMPROVING PHYSICAL HEALTHCARE TO REDUCE PREMATURE MORTALITY IN PEOPLE WITH SEVERE MENTAL ILLNESS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	4a
Indicator name	Cardio Metabolic Assessment and Treatment for Patients with Psychoses
Indicator weighting	4a and 4b total weighting be agreed locally (suggested minimum of 0.25%): <ul style="list-style-type: none"> • 4a = 80% of total funding
Description of indicator	To demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in inpatients with psychoses and community patients in Early Intervention psychosis teams.
Numerator	As set out in National Audit of Schizophrenia.
Denominator	As set out in National Audit of Schizophrenia.
Rationale for inclusion	National CQUIN scheme.
Data source	Audit data collected via a national process which will be notified early in 2015
Frequency of data collection	Separate audits for inpatients and EIP, with data expected to be submitted during Quarters 2 and 3 of 2015/16 – results to be available in Quarter 4.
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Audit reporting requirements as set out above. Additional direct reporting to commissioners locally in Quarters 1, 3 and 4.
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	January – March 2016
Final indicator value (payment threshold)	90% (inpatients), 80.0% (EIP)

<p>Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)</p>	<p>Quarter 4 audit results demonstrate that, for 90% of patients audited during the period (inpatients) or for 80% of patients audited during the period (community EIP), the provider has undertaken an assessment of each of the following key cardio metabolic parameters, with the results recorded in the patient's notes/care plan/discharge documentation as appropriate, together with a record of associated interventions (eg smoking cessation programme, lifestyle interventions, medication review, treatment according to NICE guidelines and /or onward referral to another clinician for assessment, diagnosis, and treatment)</p> <p>The parameters are:</p> <ul style="list-style-type: none"> • Smoking status; • Lifestyle (including exercise, diet alcohol and drugs); • Body Mass Index; • Blood pressure; • Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate); • Blood lipids. <p>Provider supplies evidence of systematic feedback on performance to clinical teams.</p>
<p>Final indicator reporting date</p>	<p>30 April 2016</p>
<p>Are there rules for any agreed in-year milestones that result in payment?</p>	<p>Yes – see below</p>
<p>Are there any rules for partial achievement of the indicator at the final indicator period/date?</p>	<p>Yes – see below</p>

Indicator 4a Milestones

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	Implementation plan covering: <ul style="list-style-type: none"> • Board commitment sign-up • identified clinical leadership • detailed project plan • planning for training for all clinical staff • systematic feedback process for individual clinical teams • planning for implementation of electronic healthcare records data collection of physical health assessment and measurable outcomes with a view to going live in 16/17 (assessed locally by commissioners)	31 July 2015	20%
Quarter 2	No milestone		
Quarter 3	Clinical staff training plan fully implemented (assessed locally by commissioners) Electronic recording of outcomes fully implemented	31 January 2016	20%
Quarter 4	Results of national Royal College audit - separate samples for: <ul style="list-style-type: none"> • inpatients • community early intervention patients (See sliding scales below for payment details.) Evidence of systematic feedback on performance to clinical teams (assessed locally by commissioners)	29 April 2016	60% in all, made up of: 30% 20% 10%

Rules for partial achievement at final indicator period/date

The two tables below provide for a sliding scale of payment in relation to the element of the indicator which is payable on the basis of the actual audit results for Quarter 4.

Audit of inpatients

Final indicator value for the partial achievement Q4 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

Audit of community EIP patients

Final indicator value for the partial achievement Q4 threshold	% of CQUIN scheme available for meeting final indicator value
39.9% or less	No payment
40.0% to 59.9%	25% payment
60.0% to 69.9%	50% payment
70.0% to 79.9%	75% payment
80.0% or above	100% payment

4b Communication with General Practitioners

IMPROVING PHYSICAL HEALTHCARE TO REDUCE PREMATURE MORTALITY IN PEOPLE WITH SEVERE MENTAL ILLNESS (SMI) IMPROVEMENT GOAL SPECIFICATION	
Indicator number	4b
Indicator name	Communication with General Practitioners
Indicator weighting	4a & 4b total weighting be agreed locally (suggested minimum of 0.25%): <ul style="list-style-type: none"> • 4b = 20% of total weighting
Description of indicator	<p>90% of patients should have either an updated CPA ie a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications should be completed.</p> <p>Completion of a local audit of communication with patients' GPs, demonstrating that, for 90% of patients audited, an up-to-date care plan and/or discharge summary has been shared with the GP, which meets the standards of the Academy of Royal Colleges and includes NHS number, ICD codes for all primary and secondary mental and physical health diagnoses, medications prescribed and monitoring requirements, physical health conditions and ongoing monitoring and treatment needs and Recovery focussed healthy lifestyle plans.</p>
Numerator	<p>The number of patients in the audit sample for whom the provider has provided to the GP an up-to-date copy of the patient's care plan or a discharge summary which sets out appropriate details of all of the following:</p> <ul style="list-style-type: none"> • NHS number; • All primary and secondary mental and physical health diagnosis, including ICD codes; • Medications prescribed and monitoring requirements; an • Physical health condition and ongoing monitoring and treatment needs; • Recovery focussed healthy lifestyle plans.
Denominator	A sample of a minimum of 100 patients who are subject to the CPA –and who have been under the care of the provider for at least 100 days at the time of the audit.
Rationale for inclusion	National CQUIN scheme
Data source	Local audit
Frequency of data collection	One audit in Quarter 2
Organisation responsible for data collection	Provider

Frequency of reporting to commissioner	Reports required in respect of Quarter 2.
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Audit undertaken in Q2, July – September 2015.
Final indicator value (payment threshold)	90.0%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	<p>Quarter 2 audit demonstrates that, for 90% of patients audited during the period, the provider has provided to the GP an up-to-date copy of the patient's care plan or a comprehensive discharge summary for patients with no CPA initiated.</p> <p>Quarter 2 audit demonstrates that, for 90% of patients audited during the period, the provider has provided to the GP an up-to-date copy of the patient's care plan, which sets out appropriate details of all of the following:</p> <ul style="list-style-type: none"> • NHS number; • All primary and secondary mental and physical health diagnosis, including ICD codes; • Medications prescribed and monitoring requirements; an • Physical health condition and ongoing monitoring and treatment needs; • Recovery focussed healthy lifestyle plans.
Final indicator reporting date	31 October 2015
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 – see below

Rules for partial achievement at final indicator period/date

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

2.5 Urgent and Emergency Care Menu Templates

Indicator 5 Reducing Inappropriate NHS 111 Referrals to 999 and A&E

This is a three part indicator. 5b will need to be implemented before 5c can commence.

5a A Reduction in the Proportion of NHS 111 Calls Ending in an Inappropriate 999 Referral

UEC: REDUCING INAPPROPRIATE NHS 111 REFERRALS TO 999 AND A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number	5a
Indicator name	A reduction in the proportion of NHS 111 calls ending in an inappropriate 999 referral.
Indicator weighting	To be agreed locally.
Description of indicator	Proportion of NHS 111 calls that end in an inappropriate 999 referral.
Numerator	Number of 111 calls triaged that end with a 999 referral.
Denominator	Number of 111 calls triaged.
Rationale for inclusion	<p>A reduction in the level of this indicator suggests patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time.</p> <p>The indicator has been developed to ensure that patients with physical and mental health problems using NHS 111 receive the most appropriate clinical referral to meet their urgent care needs and receive care close to home whenever it is safe and effective to do so.</p> <p>For the numerator, the MDS Guidance document (on the website below alongside the published data) specifies the number of final dispositions that result in an emergency ambulance being dispatched, and approximately corresponds to Red1+ Red2 and Green1 + Green2 categories.</p> <p>The denominator is the number of 111 calls triaged, because that comes from the same data source as the numerator. It excludes calls quickly terminated by the caller, and calls completed by providing basic information about health services.</p>
Data source	NHS 111 Minimum Dataset, NHS England http://www.england.nhs.uk/statistics/category/statistics/nhs-111-statistics/
Frequency of data	Monthly

collection	
Organisation responsible for data collection	111 Providers
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15
Baseline value	To be agreed locally using nationally available data.
Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally
Final indicator reporting date	May 2016
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	% 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
Issues to take into consideration when setting local levels of improvement:	<ul style="list-style-type: none"> Any changes to the use of 111 services locally, for example its use as a gateway to access GP out of hours, may change the proportion of ambulance and ED dispositions. Any such changes should be taken into account when setting local levels of improvement. It is essential that patients continue to be referred to whichever urgent and emergency care service is identified as being most clinically appropriate to their needs. Local audits of 111 call outcomes and clinical review of adverse events should be considered to ensure that patients are being referred appropriately. There is greater use of urgent and emergency care services on bank holidays compared to other days. There is one Easter weekend in 2014-15 but there are two in 2015-16. Local areas may need to take this into account.

5b Improve Recording Detail of A&E Dispositions in NHS111

UEC: REDUCING INAPPROPRIATE NHS 111 REFERRALS TO 999 AND A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number(s)	5b
Indicator name(s)	Improve recording detail of A&E dispositions in NHS111.
Indicator weighting	To be agreed locally
Description of indicator	<p>Capture of disposition (and referral) to type 1 and 2 A&E separately from type 3 and 4, thereby improving the quality of the Directory of Services (DoS).</p> <p>There is no national data collection to capture data for these measures; local systems will need to be developed if this CQUIN is adopted. Below are some suggestions for the definition of measures that could be put in place locally.</p>
Numerator	Number of dispositions to A&E where type of A&E is captured (where type is 1, 2, 3 or 4).
Denominator	Number of dispositions to A&E.
Rationale for inclusion	<p>A reduction in the level of this indicator suggests patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time.</p> <p>The indicator has been developed to ensure that patients with physical and mental health problems using NHS 111 receive the most appropriate clinical referral to meet their urgent care needs and receive care close to home whenever it is safe and effective to do so.</p>
Data source	To be agreed locally
Frequency of data collection	To be agreed locally
Organisation responsible for data collection	111 Providers
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	To be agreed locally
Baseline value	To be agreed locally
Final indicator period/date (on which payment is based)	To be agreed locally
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to	To be agreed locally

be supplied to commissioner)	
Final indicator reporting date	To be agreed locally
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?	% 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
Issues to take into consideration when setting local levels of improvement:	<ul style="list-style-type: none"> • Any changes to the use of 111 services locally, for example its use as a gateway to access GP out of hours, may change the proportion of ambulance and ED dispositions. Any such changes should be taken into account when setting local levels of improvement. • It is essential that patients continue to be referred to whichever urgent and emergency care service is identified as being most clinically appropriate to their needs. Local audits of 111 call outcomes and clinical review of adverse events should be considered to ensure that patients are being referred appropriately. • There is greater use of urgent and emergency care services on bank holidays compared to other days. There is one Easter weekend in 2014-15 but there are two in 2015-16. Local areas may need to take this into account.

5c A Reduction in the Proportion Of NHS 111 Calls Ending in an Inappropriate Type 1 or Type 2 A&E Referral

UEC: REDUCING INAPPROPRIATE NHS 111 REFERRALS TO 999 AND A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number(s)	5c
Indicator name(s)	A reduction in the proportion of NHS 111 calls ending in an inappropriate type 1 or type 2 A&E referral.
Indicator weighting	To be agreed locally
Description of indicator	Proportion of NHS 111 calls that end in an inappropriate type 1 or type 2 A&E referral. There is no national data collection to capture data for these measures; local systems will need to be developed if this CQUIN is adopted. Below are some suggestions for the definition of measures that could be put in place locally.
Numerator	Number of 111 calls triaged that end in a type 1 or 2 A&E disposition.
Denominator	Number of 111 calls triaged.
Rationale for inclusion	A reduction in the level of this indicator suggests patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time. The indicator has been developed to ensure that patients with physical and mental health problems using NHS 111 receive the most appropriate clinical referral to meet their urgent care needs and receive care close to home whenever it is safe and effective to do so.
Data source	To be agreed locally
Frequency of data collection	To be agreed locally
Organisation responsible for data collection	111 Providers
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	To be agreed locally
Baseline value	To be agreed locally
Final indicator period/date (on which payment is based)	To be agreed locally
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to	To be agreed locally

be supplied to commissioner)	
Final indicator reporting date	To be agreed locally
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?	% 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
Issues to take into consideration when setting local levels of improvement:	<ul style="list-style-type: none"> • Any changes to the use of 111 services locally, for example its use as a gateway to access GP out of hours, may change the proportion of ambulance and ED dispositions. Any such changes should be taken into account when setting local levels of improvement. • It is essential that patients continue to be referred to whichever urgent and emergency care service is identified as being most clinically appropriate to their needs. Local audits of 111 call outcomes and clinical review of adverse events should be considered to ensure that patients are being referred appropriately. • There is greater use of urgent and emergency care services on bank holidays compared to other days. There is one Easter weekend in 2014-15 but there are two in 2015-16. Local areas may need to take this into account.

Indicator 6 Reducing Rates of 999 Calls that Result in Transportation to A&E

UEC: REDUCING RATES OF 999 CALLS THAT RESULT IN TRANSPORTATION TO A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number	6
Indicator name	A reduction in the rate per 100,000 population of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department.
Indicator weighting	To be agreed locally.
Description of indicator	Rate of ambulance transportations to type 1 and type 2 A&E per 100,000 population.
Numerator	Number of ambulance interventions that end in transportation to type 1 or type 2 A&E.
Denominator	Resident population / 100,000
Rationale for inclusion	<p>A reduction in the level of this indicator suggests patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time.</p> <p>The introduction of enhanced training and protocols for ambulance clinicians, better data sharing across the system, improved clinical support and advice to the ambulance service and/or the provision of alternative care pathways would all be expected to have a positive impact on this indicator.</p>
Data source	<p>Numerator: “All emergency calls that receive a face-to-face response from the ambulance service” minus “Patients discharged, after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than Type 1 or 2 A&E”. Ambulance Quality Indicators, NHS England www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators</p> <p>Denominator: Population estimates for Ambulance trusts will be made available by NHS England by the end of January, based upon Office for National Statistics estimates. In the meantime Ambulance trusts can use locally available estimates.</p>
Frequency of data collection	Monthly
Organisation responsible for data collection	Ambulance Trusts
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15
Baseline value	To be agreed locally using nationally available data.

Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	% 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
Issues to take into consideration when setting local levels of improvement	<ul style="list-style-type: none"> Any changes to the availability of services locally, for example a new UCC being available, may change the rate of transportation to type 1 and type 2 A&E. Any such changes should be taken into account when setting local levels of improvement. It is essential that patients continue to be conveyed or referred to whichever emergency care setting is deemed most clinically appropriate, including type 1 and type 2 A&E departments where these are best suited to the patient's needs. Local audits of non-transported patients and clinical review of adverse events should be considered to ensure that patients are being treated or transported appropriately. There is greater use of urgent and emergency care services on bank holidays compared to other days. There is one Easter weekend in 2014-15 but there are two in 2015-16. Local areas may need to take this into account.

Indicator 7 Reducing the Proportion of Avoidable Emergency Admissions to Hospital

UEC: REDUCING THE PROPORTION OF AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL IMPROVEMENT GOAL SPECIFICATION	
Indicator number	7
Indicator name	Reducing the proportion of avoidable emergency admissions to hospital.
Indicator weighting	To be agreed locally.
Description of indicator	Avoidable emergency admissions as a proportion of all emergency admissions.
Numerator	Number of avoidable emergency admissions (as defined by the technical specification for indicator 7).
Denominator	Number of all emergency admissions
Rationale for inclusion	The indicator has been developed to ensure that patients with ambulatory care sensitive conditions and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. The introduction of community based preventative measures and/or improved ambulatory care services at the hospital "front door" would both be expected to have a positive impact on this indicator.
Data source	Hospital Episodes Statistics/SUS
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15
Baseline value	To be agreed locally using nationally available data
Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally
Final indicator reporting date	May 2016
Are there rules for any agreed in-year	

milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	% 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
Exclusions	Providers with less than 1,000 total emergency admissions in 2014-15 should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 1,000 total emergency admissions. The reason for including this criterion is that where the number of emergency admissions is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.
Issues to take into consideration when setting local levels of improvement	Reconfiguration of services locally, such as opening or closing of A&E departments, is likely to have an impact on the number of avoidable emergency admissions. This should be taken into account when looking at local data to set a rate of improvement. If reconfiguration of services is planned during 2015-16 this should be taken into consideration when deciding whether to adopt this CQUIN, and what level of improvement it should be set at.

Indicator 7 Technical Specification

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as ‘ambulatory care sensitive conditions’) that could usually have been avoided through better management in primary or community care and which are reflected in four NHS Outcomes Framework indicators:

2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions;

2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s;

3a Emergency admissions for acute conditions that should not usually require hospital admission;

3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs).

The data are extracted from the Hospital Episode Statistics (HES) system.

The ICD-10 diagnoses that are included are listed below, along with the other parameters used in the HES query.

Specification of HES query for avoidable emergency admissions

1 Field Name ADMIMETH is equal to the following: 21, 22, 23, 24, 28

(Rationale: This restricts the data to emergency admissions only.)

2 Field Name EPISTAT is equal to the following: 1 or 3

(Rationale: This includes both finished and unfinished hospital episodes.)

3 Field Name ADMIDATE Limited to admissions within the relevant financial year.

(Rationale: Data are presented annually with an admission date within the financial year of interest.)

4 Field Name SEX is equal to the following: 1 or 2

(Rationale: Data are for the sum of males and females and exclude the small number of records where sex was unknown or unspecified.)

5 Field Name EPIORDER is equal to: 1

(Rationale: This restricts the data to the first emergency admission in a hospital spell.)

6 Field Name ADMISORC is not equal to: 51, 52, 53

(Rationale: This excludes transfers.)

7 Field Name EPITYPE is equal to: 1

(Rationale: This restricts the data to general episodes (excludes birth, delivery and mental health episodes).)

8 Field Name CLASSPAT is equal to: 1

(Rationale: This restricts the data to ordinary admissions (excludes day case and maternity admissions)).

9a Field Name 4 CHAR PRIMARY DIAGNOSIS CODE (DIAG_01) is any of (a) to (q) are true AND Field Name STARTAGE is between 1-120 or >7000.

a) DIAG_01 is equal to any of: B18.0, B18.1. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).

b) DIAG_01 is equal to any of: J45, J46X

c) DIAG_01 is equal to any of: I11.0, I50, J81X, I13.0. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71

d) DIAG_01 is equal to any of: E10, E11, E12, E13, E14

e) DIAG_01 is equal to any of: J20, J41, J42X, J43, J44, J47X. J20 only with second diagnosis of J41, J42, J43, J44, J47

- f) DIAG_01 is equal to any of: I20, I25. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X0, X1, X2, X4, X5
- g) DIAG_01 is equal to any of: D50.1, D50.8, D50.9, D51, D52
- h) DIAG_01 is equal to any of: I10X, I11.9. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71
- i) DIAG_01 is equal to any of: G40, G41, F00, F01, F02, F03, I48X
- j) DIAG_01 is equal to any of: J10, J11, J13X, J14, J15.3, J15.4, J15.7, J15.9, J16.8, J18.1, J18.8, A36, A37, B05, B06, B16.1, B16.9, B26, M01.4. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).
- k) DIAG_01 is equal to any of: I24.0, I24.8, I24.9. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X0, X1, X2, X4, X5.
- l) DIAG_01 is equal to any of: E86, K52, A02.0, A04, A05.9, A07.2, A08, A09.
- m) DIAG_01 is equal to any of: N10, N11, N12, N13.6, N15.9, N39.0, N30.0, N30.8, N30.9.
- n) DIAG_01 is equal to any of: K25.0-K25.2, K25.4-K25.6, K26.0-K26.2, K26.4-K26.6, K27.0-K27.2, K27.4-K27.6, K28.0-K28.2, K28.4-K28.6, K20, K21.
- o) DIAG_01 is equal to any of: L03, L04, L08.0, L08.8, L08.9, L88, L98.0, I89.1, L01, L02. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S1, S2, S3, S41, S42, S43, S44, S45, S48, S49, T, V, W, X0, X1, X2, X4, X5. S47 is allowed if by itself.
- p) DIAG_01 is equal to any of: H66, H67, J02, J03, J06, J31.2, J04.0.
- h) DIAG_01 is equal to any of: A69.0, K02, K03, K04, K05, K06, K08, K09.8, K09.9, K12, K13.
- q) DIAG_01 is equal to any of: R56, O15, G25.3.

OR

9b Field Name 4 CHAR PRIMARY DIAGNOSIS CODE (DIAG_01) is any of (a) to (b)

AND Field Name STARTAGE is <19 or >7000

a) J45, J46, E10, G40, G41

b) J10.0, J11.0, J11.1, J12.-, J13, J14, J15.-, J16.-, J18.0, J18.1, J18.9, J21.

Indicator 8 Improving Diagnoses and Re-attendance Rates of Patients with Mental Health Needs at A&E

This is a two part indicator. Part 8b can only be implemented following completion of part 8a.

8a Improving Recording of Diagnosis in A&E

UEC: IMPROVING DIAGNOSES AND RE ATTENDANCE RATES OF PATIENTS WITH MENTAL HEALTH NEEDS AT A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number	8a
Indicator name	Improving recording of diagnosis in A&E
Indicator weighing	To be agreed locally
Description of indicator	<p>To be agreed with acute providers): Where required, improve diagnosis recording in the A&E HES data set so that the proportion of records with valid codes (either A&E 2 digit diagnosis codes or 3 digit ICD-10 codes) is at least 85%. For this purpose, codes 38 "Diagnosis not classifiable" and R69 "Unknown and unspecified causes of morbidity" will be classed as invalid.</p> <p>Only where 8a is achieved should 8b be addressed. In some local areas 8a will already be achieved.</p> <p>Where trusts have already met 8a, commissioners should recognise this achievement through a reward via CQUIN.</p>
Numerator	Number of records with a valid diagnosis code (either A&E 2 digit diagnosis code or 3 digit ICD-10 code - for this purpose, codes 38 "Diagnosis not classifiable" and R69 "Unknown and unspecified causes of morbidity" will be classed as invalid.)
Denominator	All records of A&E attendances within the last month
Rationale for inclusion	This indicator has been developed to incentivise better data recording and encourage improved and timely communication and intervention between acute trusts and mental health providers to improve outcomes for those with MH conditions seeking urgent and emergency care.
Data source	Hospital Episodes Statistics
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15

Baseline value	To be agreed locally using nationally available data.
Final indicator period/date (on which payment is based)	The data completeness specified should be met for at least one month's data before the payment is made and the level of completeness should be maintained throughout 2015-16.
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally
Final indicator reporting date	May 2016
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?	% 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
Exclusions	Providers with less than 500 MH A&E attendances in the baseline period should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 500 MH A&E attendances. The reason for including this criterion is that where the number of MH A&E attendances is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.

8b Reduction in A&E MH Re-attendances

UEC: IMPROVING DIAGNOSES AND RE ATTENDANCE RATES OF PATIENTS WITH MENTAL HEALTH NEEDS AT A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number	8b
Indicator name	Reduction in A&E MH re-attendances
Indicator weighing	To be agreed locally
Description of indicator	<p>To be agreed with MH providers: Reduce the rate of mental health re-attendances at A&E in 2015/16. The time over which this applies will be agreed locally and will depend on how soon in the reporting year data quality reaches an acceptable level (i.e. part 1 criteria).</p> <p>Only where 8a is achieved should 8b be addressed. In some local areas 8a will already be achieved.</p>
Numerator	The number of times a re-attendance occurred (for any reason at any A&E) within 7 days following attendances specified in the denominator. See technical specification below.
Denominator	Number of attendances at A&E where the diagnosis identified is MH. Commissioners should determine locally what codes to use to define MH depending on local data quality and recording but should include psychosis and adult poisoning as a minimum. See technical specification below.
Rationale for inclusion	This indicator has been developed to incentivise better data recording and encourage improved and timely communication and intervention between acute trusts and mental health providers to improve outcomes for those with MH conditions seeking urgent and emergency care.
Data source	Hospital Episodes Statistics
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	To be agreed locally depending on when 8a is met. The baseline period will need to include at least 500 MH A&E attendances (see note below) and therefore is likely to cover at least one quarter.
Baseline value	To be agreed locally using nationally available data.
Final indicator period/date (on which payment is based)	To be agreed locally. The final period will need to include at least 500 MH A&E attendances (see note below) and therefore is likely to cover at least one quarter.
Final indicator value (payment threshold)	To be agreed locally

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally
Final indicator reporting date	May 2016
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?	% 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
Exclusions	Providers with less than 500 MH A&E attendances in the baseline period should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 500 MH A&E attendances. The reason for including this criterion is that where the number of MH A&E attendances is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.

Indicator 8 Technical Specification

- 8a: For the data quality component, the first 2 and 3 digits of the raw DIAG_01 field in HES will be matched against a list of valid 2 character A&E diagnosis codes and valid ICD-10 codes.
- 8b: For the re-attendance component, all patients with an A&E 2 character diagnosis of 14 or 35 or with an ICD-10 diagnosis in the range F00-F99, G30, T36-T51 or X40-X49 should be included within the denominator. The numerator is then the number of these patients who re-attend ANY A&E for ANY reason within 7 days (inclusive) of the attendance in the denominator.

3 Local CQUIN Template

Indicator	
Indicator number	
Indicator name	
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	
Numerator	
Denominator	
Rationale for inclusion	
Data source	
Frequency of data collection	
Organisation responsible for data collection	
Frequency of reporting to commissioner	
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	
Final indicator value (payment threshold)	
Final indicator reporting date	
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones

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			
Quarter 2			
Quarter 3			
Quarter 4			

Rules for partial achievement at final indicator period/date

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value