NHS England

Commissioning for Quality and Innovation (CQUIN)

Guidance for 2015/16

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Commissioning for Quality and Innovation (CQUIN) Guidance for 2015/16

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1 Introduction

This guidance sets out the Commissioning for Quality and Innovation (CQUIN) scheme for 2015/16, which, where appropriate (see section below), is to be offered by NHS commissioners to providers of healthcare services commissioned under an NHS Standard Contract.

For CQUINs 2015/16 is an evolutionary year: it offers an opportunity to consolidate efforts on national goals from the previous year's scheme whilst also shifting the focus on to new national goals.

The Five Year Forward View (FYFV) has set out the vision for promoting well-being and preventing ill health. A key element of our work going forward will be to align incentives with the reform of payment approaches and contracts. We will work with partners and the system to ensure that future incentive schemes are designed to help drive the changes required.

This document comprises the following:

- Description of when national CQUIN scheme is to be made available by commissioners;
- National CQUIN goals for 2015/16;
- Local CQUIN goals and indicators;
- Processes for agreeing the CQUIN scheme;
- Annex A: The technical guidance to support the national goals.

2 Availability/Applicability of National CQUIN Scheme

The 2015/16 CQUIN scheme is available to providers which have chosen the *enhanced alternative* - the Enhanced Tariff Option (ETO) for the full year 2015/16. The value of the scheme offered will be 2.5% of Actual Contract Value, as defined in the 2015/16 NHS Standard Contract where providers have chosen the ETO option. The percentage value earned will be dependant on provider performance.

Neither the national nor local elements of the 2015/16 CQUIN scheme will be available for the whole of 2015/16 where a provider has not chosen the ETO. Note that this will be the case in the context of both new 2015/16 contracts and contracts awarded before 31 March 2015 and continuing beyond that date. Where a multi-year local CQUIN scheme has been agreed, the parties to the contract may agree to reflect that local scheme in a Local Incentive Scheme by variation to their contract, but CQUIN funding will not be available to fund that scheme.

3 National CQUIN Goals for 2015/16

Given the financial challenges facing the NHS in 2015/16, and the need to continue delivering high quality care for our patients, the national goals seek to incentivise quality and efficiency. The 2015/16 scheme is structured so that the national goals reward transformation across care pathways that cut across different providers.

To support the national priorities we have set a scheme that focuses on:

- The physical health of patients.
- The mental health and wellbeing of patients.
- Enabling care to be provided closer to home for those that need access to urgent and emergency care.

The National Scheme is as follows:

- Two of the current national indicators will remain in place, with limited updating; these cover improving dementia and delirium care and improving the physical health care of patients with mental health conditions;
- Two new indicators will be introduced, one on the care of patients with acute kidney injury, the other on the identification and early treatment of sepsis;
- There will also be a new national CQUIN theme on improving urgent and emergency care across local health communities, commissioners will select one or more indicators locally from a menu of options;
- As planned, the other national CQUIN indicators in 2014/15 covering the safety thermometer and the friends and family test will instead be covered from 2015/16 by new requirements within the NHS Standard Contract.

Fig 1: 2015/16 National CQUIN Goals

Indicator Area	Indicator Number	Indicator Description	Suggested Weighting
Physical Health: Acute Kidney Injury	1	The percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items: 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).	0.25%
Physical Health: Sepsis	2	Two part indicator: • 2a: 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. • 2b: 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	0.25%

		1 hour of presenting.	
Mental Health: Dementia	3	Three part indicator: • 3a: 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. • 3b: To ensure that appropriate dementia training is available to staff through a locally determined training programme. • 3c: To ensure that carers of people with dementia and delirium feel adequately supported.	0.25%
Mental Health: Improving Physical Healthcare for Patients with Severe Mental Illness (SMI)	4	Two part indicator: • 4a: Cardio Metabolic Assessment and treatment for Patients with psychoses. • 4b: Communication with General Practitioners.	0.25%
UEC Menu	5	Three part indicator: • 5a: A reduction in the proportion of NHS 111 calls that end in an inappropriate 999 referral. • 5b: 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). • 5c: Proportion of NHS 111 calls that end in an inappropriate type 1 or type 2 A&E referral.	0.5% (Weighting for each indicator to be agreed locally).
UEC Menu	6	• 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.	
UEC Menu	7	• Reducing the proportion of avoidable emergency admissions to hospital.	

UEC Menu	8	Two part indicator • 8a:Improving recording of diagnosis in A&E • 8b: Reduction in A&E MH re-attendances	

3.1 Coverage and value of national goals

Minimum values for the national elements of CQUIN in 2015/16 are set out in the fig.1 – commissioners may place a higher percentage of CQUIN against these national elements if they choose. In summary:

- The four national indicators will each be worth at least 0.25% (that is, one tenth of the overall CQUIN value each).
- The UEC menu will be worth at least 0.5% (that is, one fifth of the overall CQUIN value).

Some examples of what this will mean in practice for different providers are set out in fig 2. This assumes that the minimum values are applied by commissioners.

Fig 2: Application of CQUIN Based on Provider Type

Acute hospital services	**Mental health services**
• The national indicators on sepsis, acute kidney injury and dementia will apply, each with a value of 0.25%, totalling 0.75% • A further 0.5% will be available through the UEC theme • Up to 1.25% will be available for local indicators	• The national indicator on physical health assessment of patients with severe mental illness will apply, with a value of 0.25% • A further 0.5% will be available through the UEC menu • Up to 1.75% will be available for local indicators
Community or emergency ambulance services	**Elective hospital care**
• 0.5% will be available through the UEC theme • 0.25% will be available for dementia and delirium (community services only) • Up to 1.75% will be available for local indicators	• Up to 2.5% will be available for local indicators

4 Description of National CQUIN Goals

This section describes the goal and rationale for each indicator along with further reading. Annex A sets out the detailed descriptors which once agreed can be included in Schedule 4E of the provider's NHS Standard Contract.

4.1 Physical Health

Indicator 1 Acute Kidney Injury (AKI)

Goal	To improve the follow up and recovery for individuals who have sustained AKI, reducing the risks of readmission, re-establishing medication for other long term conditions and improving follow up of episodes of AKI which is associated with increased cardiovascular risk in the long term.
Rationale	AKI is a sudden reduction in kidney function. It is not a physical injury to the kidney and usually occurs without symptoms. In England over half a million people sustain AKI every year with AKI affecting 5-15% of all hospital admissions [1]. As well as being common, AKI is harmful and often preventable, thus representing a major patient safety challenge for health care. At times of intercurrent illness (e.g. sepsis) elderly patients and those with chronic conditions (heart failure, diabetes, chronic kidney disease (CKD)) are vulnerable to AKI. AKI enhances the severity of underlying illness, increasing the risk of death; mortality rates of hospitalised patients with AKI are at least 20-33% and AKI is responsible for 40,000 excess deaths every year [1]. Patients with AKI are also subject to longer, more complex hospital stays with increased utilisation of health care resource. A recent economic analysis put the annual cost of AKI in England at >£1billion [1]. Personal recovery may be incomplete and AKI contributes to long term conditions, reducing quality of life metrics and driving the development and progression of CKD. The latter elevates cardiovascular disease risk and end stage renal failure requiring dialysis [2]. Lifetime costs of post-discharge care for AKI patients from 2010-11 was estimated at £179million [1]. There is evidence that care processes can be improved to provide better outcomes. The 2009 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Report demonstrated that a significant component of harm arises from poor standards of AKI care with limited access to specialist care and guidance. In particular there was delayed diagnosis of AKI resulting in lack of treatment [3]. Studies are beginning to emerge showing that improvements in basic care lead to better patient outcomes [4]. AKI has therefore been identified as a major patient safety priority by national and international organisations. NHS England has

	commenced a national AKI Programme within the Patient Safety domain. To improve detection, NHS England have issued a level 3 safety alert to standardise the definition and reporting of AKI within pathology departments (http://www.england.nhs.uk/2014/06/09/psa-aki/). NICE guidance CG169 was issued in 2013 to improve management of AKI.

References

1. Kerr M, Bedford M, Matthews B, O'Donoghue D. The economic impact of acute kidney injury in England. Nephrol Dial Transplant. 2014;29(7):1362-8.
2. Coca SG, Singanamala S, Parikh CR. Chronic kidney disease after acute kidney injury: a systematic review and meta-analysis. Kidney Int. 2012;81(5):442-8.
3. Stewart JM. Adding insult to injury: a review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (acute renal failure). London: National Confidential Enquiry into Patient Outcome and Death, 2009.
4. Balasubramanian G, Al-Aly Z, Moiz A, Rauchman M, Zhang Z, Gopalakrishnan R, Balasubramanian S, El-Achkar TM. Early nephrologist involvement in hospital-acquired acute kidney injury: a pilot study. Am J Kidney Dis. 2011; 57(2):228-34.

Indicator 2 Sepsis

Goal	Providers are expected 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.[1].
Rationale	Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 35,000 deaths attributed to sepsis annually. [2], [3], [4]. Sepsis is almost unique among acute conditions in that it affects all age groups.Two recent reports by the Parliamentary and Health Service Ombudsman highlighted problems in the detection and treatment of sepsis. [5], [6]. Problems in achieving consistent recognition and rapid treatment are thought to contribute to the number of preventable deaths from sepsis. In response, NHS England has established a CQUIN to explicitly tackle these issues. Sepsis is a key priority for NHS England which, in September 2014, issued a Patient Safety Alert [7] to signpost clinicians in the ambulance service, primary and community services and secondary care to a set of resources developed by the UK Sepsis Trust, and

	others, to support the prompt recognition and initiation of treatments for all patients suspected of having sepsis. Sepsis is an important topic that is included in the list of potential areas for the Patient Safety Collaborative to address. It is estimated that the reliable delivery of basic elements of sepsis care could save up to 11,000 lives a year and £150 million annually. [8]. The 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 (MAU) or an acute ward. We recognise that good treatment of sepsis that develops in ward-based patients is important; however, clinical advice and practicality of implementation supported focusing this CQUIN initially on those who present to healthcare with sepsis. While a range of actions are recommended for rapid implementation when a patient presents with sepsis (referred to as the 'Sepsis Six'), rapid administration of antibiotics is the single most crucial action that can prevent deaths from sepsis and can be relatively easily measured and reported on.

References

1. Royal College of Physicians (2014) Acute Care Toolkit 9: Sepsis https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_9_sepsis.pdf.
2. Vincent JL, Sakr Y, Sprung CL et al. Sepsis in European intensive care units: results of the SOAP study. Critical Care Medicine 2006; 34: 344–53.
3. Hall MJ, Williams SN, DeFrances CJ, et al.: Inpatient care for septicemia or sepsis: A challenge for patients and hospitals. NCHS data brief Hyattsville, MD: National Center for Health Statistics 2011; 62.
4. The Intensive Care National Audit and Research Centre (2006).
5. Parliamentary and Health Service Ombudsman (2013): TIME TO ACT. Severe sepsis: rapid diagnosis and treatment saves lives. [Online]. Available online at: http://www.ombudsman.org.uk/time-to-act.
6. Parliamentary and Health Service Ombudsman (2014): An avoidable death of a three-year-old child from sepsis: A report by the Health Service Ombudsman for England on an investigation into a complaint from Mr and Mrs Morrish about The Cricketfield Surgery, NHS Direct, Devon Doctors Ltd, South Devon Healthcare NHS Foundation Trust and NHS Devon Plymouth and Torbay Cluster. [Online]. Available online at: http://www.ombudsman.org.uk/reports-and-consultations/reports/health.
7. NHS England (2014) Patient Safety Alert Stage Two: Resources to support the prompt recognition of sepsis and the rapid initiation of treatment http://www.england.nhs.uk/wp-content/uploads/2014/09/psa-sepsis.pdf.
8. Esteban et al. Critical Care Medicine. 2007; 35(5):1284-1289.

Supporting information

- A variety of sepsis tools, including a sepsis screening tool and the sepsis six are available at http://sepsistrust.org/info-for-professionals/resources-for-professionals/
- Equivalent screening tools that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis are available at http://ccforum.com/content/supplementary/cc11895-s2.pdf

4.2 Mental Health and Physical Wellbeing

Indicator 3 Dementia and Delirium

Goal	To support the identification of patients with dementia and delirium, alone and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice, through the introduction of a care plan on discharge; after the patient is discharged from hospital or community services following an episode of emergency unplanned care.
Rationale	850,000 people live with dementia (caused by diseases that damage the brain) in the UK. [1] and this number is set to increase. Dementia costs the UK 26.3 billion a year [1]. Delirium is a common and serious illness in people in hospital or long-term care (nursing or residential care). However, it can be prevented and treated if dealt with urgently. The CQUIN has been developed in line with the NHS England ambition to sustain improvement in timely assessment, diagnosis and support for people with dementia and delirium and the recent Care Quality Commission report [2]. It extends the previous CQUIN by supporting improved communication between providers and general practice for new and existing patients; as well as extending the coverage to community trusts.

References

1. http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2761
2. Care Quality Commission – Cracks in the Pathway
   http://www.cqc.org.uk/content/cracks-pathway

Supporting information

- NHS Confederation Report - Acute Awareness
  http://www.nhsconfed.org/Publications/reports/Pages/Dementia-report-Acute-awareness.aspx
- Alzheimer's Society - Counting the Cost
  http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356
- CCQI Audit of Dementia in the General Hospital
  http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/dementia/nationalauditofdementia.aspx
- Alzheimer’s Society agitation guidelines
  http://www.alzheimers.org.uk/site/scripts/services_info.php?serviceID=126

Indicator 4 Improving Physical Healthcare to Reduce Premature Mortality in People with Severe Mental Illness (SMI)

Goal	To ensure that service users with SMI have comprehensive cardio metabolic risk assessments, the necessary treatments and the results are recorded and shared appropriately with the patient and the treating clinical teams. Patients with SMI for the purpose of this CQUIN are all patients with psychoses, including schizophrenia, in all types of inpatient units commissioned from all sectors, and the community early intervention psychosis services.
Rationale	There is an excess of over 40,000 deaths, which could be reduced if SMI patients received the same healthcare interventions as the general population. [1]. NHS England has committed to reduce the 15 to 20 year premature mortality in people with psychosis and improve their safety through improved assessment, treatment and communication between clinicians. There are robust national NICE and professional standards of care for people with psychoses. NICE Health Technology Assessments (HTAs), NICE guidelines and Quality Standards provide clear standards. However, the 2012 Schizophrenia Commission, and the National Audit of Schizophrenia 2012, which audited a community CPA sample of over 5,000 service users, found that less than 29 % of patients receive the basic annual physical health checks and ongoing monitoring support. The recently published second round of the national audit of schizophrenia (NAS 2, 2014) confirms that standards are improving slowly to 33% being assessed and with variable levels of responsive treatment instituted. This CQUIN supports and facilitates closer working relationships between specialist mental health providers and primary care through the routine use of the NHS numbers, the sharing of physical and mental health diagnoses and treatments, communicated between the specialist mental health clinicians and the person's GP, and with the service user. It has the capacity to lead to reductions in relapse, crisis presentations, avoidable admissions and length of stay through addressing the impact of untreated physical morbidity on recovery. In 2015/ 2016, this CQUIN in essence, remains similar to the 2014/2015 CQUIN, but has additional, proven effective implementation methods embedded. This decision was reached, having examined the evidence of the current national baseline from the National Audit of Schizophrenia 2014 (NAS) and the current evidence of implementation of the 2014/15 CQUIN, consulted with an expert reference group, and reviewed the successful implementation approaches of the top performing providers in the NAS. Most commissioners and providers consulted, fed back that services are now beginning to make real progress in putting in place the necessary infrastructures and training for successful

	implementation, and that consistency of the CQUIN would enable more rapid progress.

Reference

1. Shukla H and Watson S (2013) A Tale of two populations (personal communication, October 2013).

Supporting Information

- The Bradford Tool http://www.nhsiq.nhs.uk/media/2484208/bradford_mental_illness_-_final_updated.pdf
- The Lester Tool http://www.rcpsych.ac.uk/pdf/RCP_11049_Positive%20Cardiometabolic%20Health%20chart-%20website.pdf
- Cardiovascular Outcome Strategy https://www.gov.uk/government/publications/improving-cardiovascular-disease-outcomes-strategy
- ICD coding web link http://apps.who.int/classifications/icd10/browse/2010/en
- NICE schizophrenia guideline 2009 http://guidance.nice.org.uk/CG82
- National Audit of Schizophrenia standards for 2013/14 http://www.rcpsych.ac.uk/pdf/NAS%20standards%20and%20outcome%20indicators%20for%20round%202%20FINAL.pdf
- National Audit of Schizophrenia (NAS) report http://www.rcpsych.ac.uk/pdf/NAS%20report%20-%20What%20you%20need%20to%20know%20FINAL.pdf
- Schizophrenia Commission report http://www.schizophreniacommission.org.uk/the-report/
- Rethink Innovation Network http://www.rethink.org/about-us/the-schizophrenia-commission/innovation-network
- The Royal Colleges in collaboration have produced the following templates for ideal discharge summaries:
  - Mental Health discharge summary: http://www.rcpsych.ac.uk/mediacentre/pressreleases2012/dischargesummary.aspx
  - http://www.rcplondon.ac.uk/sites/default/files/documents/discharge-summary_2012_final.pdf
- Department of Health. Refocusing the Care Programme Approach: Policy and Positive Practice Guidance. London: Department of Health (2008) http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf
- Mental Health Partnerships website http://mentalhealthpartnerships.com/

4.3 Urgent and Emergency Care Menu

In line with the objectives of the Urgent and Emergency Care Review, this CQUIN aims to incentivise an “increase in the number of patients with urgent and emergency care needs who are managed close to home, rather than in a hospital (A&E or inpatient) setting”. This goal can be achieved by action on a range of pathways including NHS 111, ambulances, community services and acute care. Key to delivery against all four indicators is free flow of information that enables providers to work effectively together.

There is no single measure that captures this goal; instead, we are allowing local flexibility as to which indicators within the overall objective are selected, and how these indicators are addressed. Commissioners will be able to consider the best mix of indicators to suit local commissioning plans to incentivise improvement, in discussion with providers.

The UEC menu consists of four indicators as follows:

5. Reducing inappropriate NHS 111 referrals to 999 and A&E:
    a) Reduction in the proportion of NHS 111 calls that end in an inappropriate 999 referral;
    b) Improve recording of A&E dispositions in NHS111;
    c) A reduction in the proportion of NHS 111 calls that end in an inappropriate type 1 or type 2 A&E referral.
6. A reduction in the rate of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department.
7. Reducing the proportion of avoidable emergency admissions to hospital.
8. Improving diagnoses and re attendance rates of patients with mental health needs at A&E:
    a) An improvement in diagnosis recording in the A&E HES data set of mental health presentations so that there is a valid diagnosis code for at least 85% of records;
    b) A reduction in the rate of mental health re-attendances at A&E.

The total weighting for the menu is 0.5%. However commissioners can choose one or more indicator and determine the weighting for each of the chosen indicators equating to a minimum total weighting of 0.5%.

In reference to indicator 5 we note that a number of NHS 111 providers will not be eligible for this CQUIN as they will not be commissioned under the NHS Standard Contract. In those cases we would urge commissioners to consider using the indicator as part of their local incentives schemes.

The following section details the types of interventions commissioners may consider implementing to support delivery of each indicator. This is not an exhaustive list of interventions and the assumption is that a number of these interventions will already be in place or in the process of being commissioned.

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

Goals	To reduce the proportion of NHS 111 calls that end in an inappropriate 999 referral. Improve recording of A&E dispositions in NHS 111. To reduce the proportion of NHS 111 calls that end in an inappropriate type 1 or type 2 A&E referral.
Rationale	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. The introduction of clinical hubs or similar clinical advice, better data sharing across the system (including special patient notes (SPNs) and care plans) and/or the provision of alternative care pathways would all be expected to have a positive impact on this indicator.
How	The following interventions may help to support delivery of this

	indicator: • Ensuring that every clinician is aware of the need to use the NHS number in all communications to enable safe information sharing. • Access to primary care information through Summary Care Record (SCR) as a constant option i.e. as an option that is always available so can be relied on where local solutions don't exist or this can complement local solutions. • Where available, local solutions that provide additional detail to the SCR of patient information required for urgent care (e.g. Lancashire Core Personal Profile). Providers and clinicians to have option to use either the SCR and/or alternative detailed record solutions to provide direct patient care. SCR to be available for those patients presenting for care who would not have a detailed care record to view. • Development of a composite urgent care clinical advice hub with 24/7 access to a range of relevant expertise and services e.g. mental health, dental, pharmacy, GP both in and out of hours, paramedic, hospital specialists, alcohol and drug services, social care, housing etc. • Improved training and feedback for NHS 111 clinical and non-clinical staff, for example in relation to probing techniques. • Review of existing dispositions / local Directory of Services (DOS) to identify where a lack of services leads to a default ED disposition, and the establishment of services to address this need. • Targeted clinical advice for certain types of call (e.g. patients with Special Patient Notes (SPNs) or care plans / co-morbidities). • Promote broader range of service selection by NHS 111 providers, including monitoring of service selection. • ITK (Interoperability Toolkit) integration between providers to inform the next place of care following NHS 111 assessment, allowing an ED to understand who is referred by NHS 111 and allow the patient journey to be mapped. • Use of electronic means for sharing transfers of care (such as discharge, care plans) between care settings: • Implementation of electronic discharge summaries using Interoperability Toolkit (ITK electronic discharge) specifications; • Implementation of existing interoperability standards for sharing clinical correspondence (ITK clinical correspondence specification). • Reporting to commissioners the level of 'ED Catch all' (were no other services are available) to enable commissioning of wider service offer. • Digital solutions that prevent and reduce acute presentation, including biometric data monitoring. • Connection to the digital online platform, which will offer an online symptom assessment facility to patients and where

	required will offer connection through to the service required following assessment. We recognise that NHS 111 may not differentiate between all types of A&E referral, and so it is difficult to nationally incentivise a reduction in inappropriate referrals to Type 1& 2 A&E. We would encourage local initiatives to capture disposition (and referral) to type 1 and 2 A&E separately from type 3 and 4, whilst improving the quality of the local DOS. Once data collection is stronger, local measures can be taken to reduce inappropriate referrals to Type 1 and 2 A&Es. Local incentives should be considered to encourage this. A mechanism to address data locally is suggested below: **Fig 3: Improving DOS profiles** Within the DOS profiles, DOS leads identify ED type in the name of the service as it appears in returns, e.g. Anytown Medical Centre Emergency Department (TYPE 1); Othertown Hospital A&E department (TYPE 3). Once coding is improved, 111 service providers can then be targeted to provide, and monitor, training for staff to enable understanding of the issues, the differences and the rationale and require them to offer any ED flagged as type 1 and 2 as a last resort where clinically appropriate and where practical for the patient. The case mix of new callers to NHS 111 is difficult to predict and is likely to vary from area to area depending on local actions to promote NHS 111. This cannot be controlled in the specification of a national measure; however the proposed measure will allow local areas to take account of any anticipated local service changes when setting improvement measures. Commissioners should consider bank holiday variations between 2014/15 and 2015/6 (i.e. two Easter weekends in 2015/16) where a greater use of NHS 111 services is always anticipated. NHS 111 services must continue to refer people to ambulance services, EDs or mental health referral assessment units, including healthcare based section 136 units when that is the most appropriate clinical course of action.

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

Goal	To reduce the rate of 999 calls that result in transportation to a type 1 or type 2 A&E Department.
Rationale	To ensure that patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time. However 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.
How	The introduction of enhanced physical, mental health and addiction training and protocols for ambulance clinicians, consistent use of the NHS number for all patients, 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. This may include: • Ambulance systems to be able to access the NHS Number. From our recent NHS Number survey, Ambulance Trusts remain the care settings with lowest usage of NHS Number. There is a need for Ambulance systems to be able to retrieve it as an underpinning for wider data sharing. • Ambulance settings to be able to access SCR (as a constant option), i.e. as an option that is always available so can be relied on where local solutions don't exist or can complement local solutions. Providers and clinicians to have option to use either the SCR and/or alternative detailed record solutions to provide direct patient care. SCR to be available for those patients presenting for care who would not have a detailed care record to view. • Sharing of discharge summaries across care settings (e.g. acute to community, mental health and not just GP) where these meet the standards set by the Academy of Royal Colleges. • Use of electronic means for sharing transfers of care (such as discharge, care plans) between care settings. • Implementation of electronic discharge summaries using Interoperability Toolkit (ITK electronic discharge) specifications • Implementation of existing interoperability standards for sharing clinical correspondence (ITK clinical correspondence specification). • Access to advice from primary care, and specialist advice from hospital and community based specialists. • Access to an urgent care clinical advice hub (as above). • Development of advanced and/or specialist paramedics including mental health triage specialists. • Commissioning of new care pathways (e.g. elderly falls, alcohol

	intoxication) to avoid transportation to hospital. • Increased mental capacity assessments for those at end of life or with long term conditions so that the person has an advance decision plan which gives them the choice to remain at home with family, rather than be brought to hospital. • Access to special patient notes/care/crisis plans / advance decisions or directives.

Indicator 7 Reducing the Proportion of Avoidable Emergency Admissions to Hospital

Goal	To decrease the proportion of avoidable emergency admissions to hospital.
Rationale	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital.
How	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. This may include: • Ensuring access to primary care information through the SCR. • Where available, access to local solutions that provide additional patient information to the SCR and/or crisis care plans and /or advance decision plan required for urgent care. • Use of electronic means for sharing transfers of care (such as discharge, care plans) between care settings. • Implementation of electronic discharge summaries using Interoperability Toolkit (ITK electronic discharge) specifications. • Implementation of existing interoperability standards for sharing clinical correspondence (ITK clinical correspondence specification). • Improved staffing, facilities and training for staff working in ambulatory emergency care facilities, and/or the development of new service models. • Development of a composite urgent care clinical advice hub with 24/7 access to a range of relevant expertise and services e.g. mental health, dental, pharmacy, GP both in and out of hours, paramedic, hospital specialists, alcohol and drug services, social care, housing etc. • Enhanced community support / discharge arrangements. • Crisis home treatment teams and liaison mental health teams of sufficient capacity and capability to meet the needs of the population. • Availability of mental health referral assessment units including healthcare based section 136 suite provision. • Access to day treatment services, crisis and respite houses for people known to have repeat crises and where brief spells in alternatives to hospital beds would be beneficial. • Access to hospital and community based specialist advice for

	physical and mental health 24/7. • For Ambulatory Care Units and mental health trust services, hospital front door or community based, timely access to diagnostics such as blood testing, ECG, x-ray, ultrasound, CT and MRI. • Multidisciplinary teams, including physiotherapy, occupational therapy, social work, community mental health nurse, alcohol specialists etc. • Considering dedicated retrieval and transfer home transport (Abingdon model). 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 at what level improvement should be set.

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

Goal	To improve recording of diagnosis in A&E and a reduction in the rate of mental health re-attendances at A&E.
Rationale	This indicator has been developed to incentivise better data recording, improved relapse prevention and crisis care plans for those already known to services, and improved care pathways across providers - including timely communication between acute trusts and mental health providers.
How	Acute Trusts will need to improve diagnosis recording in the A&E HES data set, so that there is a valid diagnosis code for at least 85% of records, including for mental health and alcohol related reasons for attendance. Once recording has improved providers (acute trusts and mental health trusts) should collaborate to reduce the rate of re-attendances in A&E within 7 days following an attendance at A&E related to an acute mental health condition. We recognise that the most commonly used diagnosis coding framework in A&E is less specific than ICD10, and therefore limits the identification of MH diagnoses. Accordingly we have limited the specification at a national level to psychosis, and adult poisoning, which can be viewed as index conditions that have a higher rate of recording. We are aware of ongoing initiatives to improve data quality; as improvements take place in coding locally we would encourage local areas, where practical, to identify alcohol and other

	MH related diagnoses such as self-harm to include in the CQUIN. The time over which the second part of the CQUIN (reducing re attendance rates) applies will need to be agreed locally and would be dependent on when in the reporting year data quality reaches an acceptable level. The following interventions may support delivery of this two part indicator: • Improved, co-produced (with the patient) relapse prevention care plans for known patients on the CPA (Care Programme Approach), which agree safe community alternatives to A&E. • Improved availability of 24/7 crisis home treatment teams and other crisis response services, to provide early effective intervention. • Improved availability of 24/7 liaison mental health team in A&E with enhanced responsiveness and senior input (there is a robust evidence base that this reduces re attendances, admissions and length of stay). • Ensuring A&E staff receive training in mental health awareness, assessment and signposting to liaison mental health teams, including basic biopsychosocial self-harm assessments as described in NICE guidance (NICE self-harm CG16). • Access to relevant information through SCR and local systems to share relevant data. • Increased use of NHS number to support data sharing and data interoperability. • Use of electronic means for sharing transfers of care (such as discharge, care plans) between care settings. • Implementation of electronic discharge summaries using Interoperability Toolkit (ITK electronic discharge) specifications; • Implementation of existing interoperability standards for sharing clinical correspondence (ITK clinical correspondence specification). • Development of new mental health facilities for assessment in A&E and in community settings. • Ensuring NHS 111 has access to Special Patient Notes relating to Mental Health crisis and other information as required. The national indicators covering UEC as well as Dementia and Delirium require the sharing of discharge summaries across different providers. It should be noted that as per the NHS Standard Contract, the sharing of discharge summaries or Post Event Messages between NHS Trusts, NHS Foundation Trusts and GP will by October 2015 only be done using electronic channels.

5 Local CQUINs

As noted at section 2 above, neither national nor local CQUINs will be available unless the provider has opted for the ETO for 2015/16. Where the provider has opted for the ETO, the percentage available for local CQUINs will be dependant on the values applied to the national indicators and the type of provider (see fig 2). The percentage is to be agreed between commissioner and provider in line with section 6 (or, in the context of a competitive procurement, determined by the commissioner).

The number and content of local CQUIN schemes is entirely for local agreement. However, we recommend designing a scheme with a small number of indicators linked to high impact changes as opposed to a large number of indicators covering a wide range of conditions.

As in previous years we have made available a CQUIN pick list. This consists of a range of indictors that have been prepopulated. The purpose of this pick list is to aid commissioners by saving time and effort locally in developing local indicators for inclusion in the CQUIN scheme.

The CQUIN pick list can be accessed at http://www.england.nhs.uk/nhs-standard-contract/15-16/.

Commissioners may wish to consider developing local CQUINs in the following areas:

- Electronic discharge summaries[1]
- 7 Day Services
- Friends and Family Test response or local improvement
- Pressure ulcer reduction
- Actions in response to Winterbourne View

Supporting information

1. The National Information Board's recent publication, Personalised Health and Care 2020 Using Data and Technology to Transform Outcomes for Patients and Citizens, sets out an ambitious agenda for the transition to a fully digital NHS (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/376886/NHS_England_NIB_report.pdf). Commissioners should also look to use SDIPs as a means of encouraging rapid progress within and between providers towards the adoption of modern interoperable clinical information systems.

6 Agreeing the CQUIN scheme

This national CQUIN guidance applies to commissioners and providers using the NHS Standard Contract in 2015/16. As noted at paragraph 2 above, neither national nor local CQUIN schemes will be offered to a provider which has not chosen the 2015/16 ETO.

The national indicators are not mandatory for inclusion in CQUIN schemes in contracts where NHS England is the sole commissioner, with the exception of the national indicator on improving physical healthcare for people with severe mental

illness. NHS England will separately publish specific indicators for use in its contracts for directly-commissioned services.

Commissioners should plan to make challenging but realistic CQUIN schemes available for providers; we expect that a high proportion of commissioner CQUIN funding will be earned. We recommend that when agreeing local schemes the CQUIN scheme is aligned to the local Quality Premium scheme, particularly in relation to urgent and emergency care, so that commissioners and providers are able to work towards a common set of goals. Within local CQUIN schemes, it is important to state clearly that it is reasonable and legitimate for commissioners to prioritise indicators that focus on quality improvements and also deliver efficiency savings. But CQUIN schemes must not be used to incentivise actions by providers which will in any way damage patient care.

6.1 Established approach

The following established rules should govern the approach to establishing the CQUIN scheme locally:

1. A scheme must be offered to each provider which provides healthcare services under the NHS Standard Contract and has chosen the 2015/16 ETO (but see notes below on non-contract activity and low-value contracts).
2. There should be one scheme per contract, offered by the co-ordinating commissioner to the provider. (See note below on arrangements for agreeing schemes among the commissioners who are party to a contract.)
3. The commissioner may offer a combined scheme to a number of related providers or may seek to align the content of separate schemes across different providers.
4. The maximum value of the scheme – that is, the maximum amount which a provider can earn under it – will be 2.5% of the Actual Annual Value of the contract as defined in the NHS Standard Contract 2015/16 (that is, the aggregate of all payments made to the provider for services delivered under the specific contract during the contract year, not including CQUIN and other incentive payments, and after any deductions or withholdings or set-off), subject to certain exclusions.
5. The exclusions, on the value of which CQUIN is not payable, are:
    - High-cost drugs devices and listed procedures identified in the National Tariff Payment System 2015/16 Annex 7b: High cost drugs, devices and listed procedures (available at: https://www.gov.uk/government/consultations/national-tariff-payment-system-201516-a-consultation-notice) and all other items for which the commissioner make payment on a “pass-through” basis to the provider (that is, where the commissioner simply meets the actual cost to the provider of a specific drug or product, for example); and
    - The value of all services delivered by the provider under the relevant contract to Chargeable Overseas Visitors (as defined in the NHS Standard Contract), regardless of any contribution on account paid by any commissioner in respect of those services. However, services delivered to any Chargeable Overseas Visitor is still contract activity

under that contract, and so must be included in calculations in relation to national or local CQUIN indicators.

6. Funding paid to providers under the scheme is non-recurrent.
7. Discussion between the commissioner and provider (or groups of providers) on the content of each scheme is encouraged, but in the end it is for the commissioner to determine, within the framework of this guidance, the priorities and focus for each scheme.
8. The scheme offered to each provider must be in accordance with this guidance and must give the provider a realistic expectation of earning a high proportion of up to 2.5% available – but must also support achievement of the commissioner's plans to commission high-quality services. Further detail on the process for proposal and agreement of schemes is set out below.
9. Each scheme must be recorded in the Schedule 4E of the local contract (which will be in the form of the NHS Standard Contract). Contracts must set out clearly the proportion of payment associated with each scheme indicator and the basis upon which payment will be made.
10. Actual in-year payment to the provider must be based on the provider's achievement of the agreed objectives within the scheme, in line with the detailed arrangements set out in this guidance and in the NHS Standard Contract.
11. Any disputes about schemes which have been agreed and recorded within contracts should be resolved in accordance with the dispute resolution mechanism set out in the NHS Standard Contract.

6.2 Agreement between commissioners

Where multiple commissioners are proposing to be party to the same contract with a provider, they must identify one of them to act as co-ordinating commissioner and should put in place a Collaborative Commissioning Agreement, setting out governance arrangements for how they will work together. This Agreement can be used to describe how the co-ordinating commissioner will consult and engage with other commissioners to determine the proposed content of the CQUIN scheme to be offered to the provider. (A model Collaborative Commissioning Agreement is available at http://www.england.nhs.uk/nhs-standard-contract/.)

6.3 Offer and agreement between commissioners and provider

In line with rule 7 above, it is important to be clear about how commissioners and providers should engage on the content of the CQUIN scheme – and what happens if they are unable to reach agreement.

- Commissioners will wish to engage with providers, or groups of similar providers, at the earliest opportunity, in order to discuss proposals for CQUIN schemes.
- Where multiple commissioners are party to the same contract with a provider, it is for the co-ordinating commissioner to lead the discussions with the provider on CQUIN.

- The commissioner and provider should make every effort to agree the CQUIN scheme as part of the overall contract, as per the national deadline for agreement.
- Ultimately, where the commissioner has made a reasonable offer of a CQUIN scheme to the provider, in line with the requirements of this guidance and the provider has not accepted it as part of a signed contract (or contract variation) by 31 May 2015:
    - the provider will be entitled to earn CQUIN only in respect of the national indicators applicable to its services and with each indicator attracting up to 0.25% of contract value; and
    - the commissioner will be entitled to withdraw the offer of local CQUIN indicators (including locally-agreed indicators relating to the national menu on urgent and emergency care) and need not make available local CQUIN indicators to that provider for the remainder of that contract year, even if a contract (or contract variation) is subsequently signed.
- In this scenario, the commissioner should ensure that it reduces accordingly any CQUIN payments it makes on account to the provider.

6.4 CQUIN variations

Where commissioners and providers are seeking to radically change or improve services, through innovative contracting and payment models, the national CQUIN rules or national goals may not be appropriate for local circumstances. For example, commissioners and providers may be trying to implement a new service delivery model based on a package of care for a cohort of service users. In this case, an innovative outcome-based payment approach might be more appropriate than the use of separate CQUIN payments to incentivise improvement, or it might best be supported through multi-year CQUINs.

The NHS Standard Contract will permit such variations, provided commissioners and providers apply the following three rules:

1. **The variation is in the best interests of patients**. It will support the development of new and innovative service delivery models which are in the best interests of patients today and in the future. It will create a more effective incentive for the provider(s) to achieve the desired outcomes for patients.
2. **The variation promotes transparency to improve accountability and encourage sharing of best practice**. It must be documented in the NHS Standard Contract using the summary template provided in the accompanying technical guidance for CQUIN 2015/16 and submitted to: e.CQUIN@nhs.net. Submissions will be published. Providers must still use all reasonable endeavours to improve services in line with national CQUIN goals and must continue to collect and submit any mandated data returns.
3. **The variation should be developed through consultation**. Commissioners and providers must engage constructively with each other when seeking to agree variations. This process should involve clinicians, patient groups and other relevant stakeholders where possible. Providers and commissioners should agree short and long-term objectives for service improvement and a

framework for agreeing variations, including the sharing of information and whether other stakeholders will be involved in making decisions on the variation.

CQUIN variations can be agreed between one or more commissioners and one or more providers. CQUIN variations only have effect for the services specified in the agreement and for the parties to that agreement. We encourage agreements by multiple commissioners, or a lead commissioner acting on behalf of multiple commissioners and multiple providers acting to provide integrated care services that benefit patients. Any CQUIN variation should apply at the whole contract level, rather than to individual commissioners only.

6.5 Multiple-year CQUIN schemes

Where commissioners and providers wish to agree CQUIN schemes or CQUIN variations covering multiple years, they may do so. However, such agreements:

- Should not be for a longer period than the duration of the relevant contract.
- Should, for subsequent years, be on a provisional basis, subject to annual confirmation in the light of future national CQUIN guidance.

6.6 CQUIN and non-contract activity

Non-Contract Activity (NCA) billing arrangements are not intended as a routine alternative to formal contracting, but for use where there are small, unpredictable flows of patient activity delivered by a provider which is geographically distant from the commissioner.

As a general principle, CQUIN payments may be earned by a provider on NCA where that provider has opted for the ETO. Subject to the restrictions below, the terms of a provider's CQUIN scheme with its main commissioner for the relevant service will be deemed to apply to any NCA activity it carries out in that service. Providers will need to supply reasonable evidence to NCA commissioners of that scheme and of achievement of incentive goals.

It is important, though, that we do not put in place a perverse incentive for a provider to avoid agreeing contracts with commissioners, on the basis that it will then be easier to earn CQUIN payments. Therefore:

- If a commissioner has made clear to a provider that it wishes to put in place a contract for a flow of activity that could otherwise be handled as NCA and has proposed a CQUIN scheme in line with this guidance; and
- If the provider has refused to agree a contract, relying instead on the NCA approach; then
- The provider will not be entitled to claim any CQUIN payment from the NCA commissioner for that year, other than in respect of national goals and their respective indicators.

(Detailed arrangements for NCA are set out in *Who Pays? Determining responsibility for payments to providers*, which is available at http://www.england.nhs.uk/wp-content/uploads/2014/05/who-pays.pdf.)

6.7 Small-value contracts

Providers on the ETO should have the opportunity to earn CQUIN payments, regardless of how small the value of their contract is. We recognise, however, that it may not always be a good use of time for commissioners and providers to develop and agree detailed schemes for very low-value contracts. At their sole discretion, therefore, commissioners may choose simply to pay up to 2.5% value to providers where this value would be non-material, rather than develop a specific scheme.

6.8 Local Incentive Schemes and services covered by Local Prices

It is of course possible for commissioners, at their discretion, to offer additional incentives to providers, on top of the main national scheme. CCGs may wish, for instance, to use funding they expect to earn through the Quality Premium scheme to offer additional incentives to providers – and this approach is encouraged.

Such schemes should be recorded as Local Incentive Schemes in the relevant schedule of the NHS Standard Contract. If local incentives affect services covered by National Prices, commissioners may need to submit a Local Variation to Monitor, as outlined in the National Tariff Payment System 2015/16.

We recognise that, particularly where a competitive procurement approach is being used, commissioners may choose, as an explicit part of setting a local price for a contract, to create a broader local incentive scheme, incorporating the national CQUIN scheme but linking a higher proportion of contract value (above the 2.5% envisaged) to agreed quality and outcome measures, rather than activity levels. This is a legitimate approach, and there is no requirement in this situation for the commissioner to offer a further 2.5% CQUIN scheme to the provider, on top of the agreed local price. Commissioners should ensure that they make their intended approach clear from the outset of the procurement process.