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**Mental Health**

**Local CQUIN Templates 2016/17**



**Mental Health: Local CQUIN Templates 2016/17**

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# 11. Depression in Older People

| **Indicator** |
| --- |
| **Indicator name** | Improved screening, assessment and further clinical investigation of depression in older people |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to the indicator:1. Proportion of patients aged 75 and over admitted to hospital with either known depression OR to whom screening for depression is applied;
2. Proportion of patients aged 75 and over with known depression OR identified as potentially having depression, and who are appropriately assessed;

Proportion of patients aged 75 and over who are appropriately assessed with a positive or inconclusive diagnosis of depression, and who are subsequently given appropriate care |
| **Numerator** | ScreenThe number of patients aged 75 years and over with known depression or to whom depression screening is applied following admission to hospitalAssess The number of those patients aged 75 years and over with known depression or identified as potentially having depression who are appropriately assessed DetermineThe proportion of those patients aged 75 years and over appropriately assessed who have a positive or inconclusive diagnosis of depression who are, or will be, given further appropriate care |
| **Denominator** | ScreenThe number of patients aged 75 years and over admitted to hospitalAssessThe number of those patients aged 75 years and over with known depression or identified as potentially having depression following the screening DetermineThe proportion of those patients aged 75 years and over appropriately assessed who have a positive or inconclusive diagnosis of depression |
| **Rationale for inclusion** | The rationale for a depression CQUIN in older people is threefold: * It fulfils a pressing clinical need (1), aligns with the current drive for parity of esteem and fits with the extant work of the Mental Health Taskforce (2);
* it builds on the successful dementia CQUIN, providing a bridgehead for the understanding of mental health problems of older people to staff in general hospitals;
* it adds value to current discussions on liaison services for older people in general hospitals – general adult services have tended to marginalise the elderly (for example, the Joint Commissioning Panel for Mental Health commissioning advice and liaison service provision made little mention the needs of older people, 3).

The dementia CQUIN has been hugely successful in raising the profile of dementia in the General Hospital. Similar issues around recognition and treatment pertain to depression. The proposal is that the depression in older people CQUIN follows the same lines of: * **Screening** for depression (by asking a single question to raise awareness among clinicians),
* **Assessing** the presence of depression (using a simple 10 item or 15 item questionnaire which can be self-administered) and then
* **Determining** the next clinical steps (which could be a referral back to the general practitioner for reassessment once the physical illness has resolved, referral to a hospital psychiatry liaison teams for an assessment and follow-up, commencement of medication or referral to IAPT).

Identifying depression in older people during their stay in hospital will ensure that people have a more positive experience and improved outcomes from their stay in hospital. It will also ensure that they receive the required support which will then lower their chances of developing physical conditions that are associated with depression. Therefore, there will be savings across the health and social care sector.Equality Act 2010 states that there should ‘equal treatment in access to public services, regardless of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, race, religion or belief, sex, and sexual orientation. Therefore it is important to prohibit age discrimination in the provision of good mental health services. |
| **Data source** | A census audit of patient notes |
| **Frequency of data collection** | Annual |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Annual |
| **Baseline period/date** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Baseline value** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Final indicator period/date (on which payment is based)** | Q3 Audit |
| **Final indicator value (payment threshold)** | 90% in each of the three component indicators |
| **Final indicator reporting date** | Q4 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see below. 40% of total CQUIN funding available for achievement of milestones |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see below. 60% of total CQUIN funding available for performance against the three metrics. |
| **EXIT Route** | To be agreed locally |

## 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** | Review and develop Protocols for Screening, Assessment and Pathways for Depression in Older Adults. | End Q1 | 10% |
| **Quarter 2** | Protocols for Screening, Assessment and Pathways for Depression in Older Adults are in use | End Q2 | 10% |
| **Quarter 3** | Undertake Audit | End Q3 | 10% |
| **Quarter 4** | Review outcome of the Audit, develop an action plan and implement; results of audit and report on action plan to be shared with commissioners | End Q4 | 10% |

##

## Rules for Partial Achievement at Final Indicator Period/ Date

**Note:** Each of the metrics (screen, assess, and determine) are worth 20% of the total CQUIN scheme so that achievement of 90% or more in all three metrics will earn the maximum 60% of the CQUIN scheme.

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 90% and above | 60% |
| 75-89% | 45% |
| 50-74% | 30% |
| 33-49% | 15% |
| <33% | 0% |

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# 12. Mental health of people with long term conditions

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| --- |
| **Indicator name** | Improvement of screening for common mental health disorders among inpatient admissions of people with long-term conditions (LTCs) |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to the indicator:1. Proportion of patients admitted to hospital with an LTC and known depression OR to whom depression screening is applied;
2. Proportion of patients with known depression OR identified as potentially having depression, who are appropriately assessed;
3. Proportion of appropriately assessed LTC patients with a positive or inconclusive diagnosis of depression, who are subsequently given further appropriate care
 |
| **Numerator** | ScreenThe number of service users with LTC and known depression or to whom depression screening is applied following admission to hospitalAssess The number of service users with LTC and with known depression or identified as potentially having depression who are appropriately assessed DetermineThe number of patients of service users with LTC appropriately assessed who have a positive or inconclusive diagnosis of depression who are, or will be, given further appropriate care  |
|  **Denominator** | ScreenThe number of service users admitted to hospital with LTC Assess The number of service users with LTC and with known depression or identified as potentially having depression DetermineThe number of patients of service users with LTC and appropriately assessed who have a positive or inconclusive diagnosis of depressionNote that it is envisaged that this CQUIN will be targeted at admissions, but extension to outpatient settings would be highly beneficial to service users. |
| **Rationale for inclusion** | People with a diagnosis of a long-term condition (LTC) such as type 2 diabetes mellitus (T2DM), coronary heart disease (CHD), asthma and chronic obstructive pulmonary disease (COPD), or who have medically unexplained symptoms (MUS) are more frequent users of the health care system than those without these health problems[[1]](#footnote-1) and often have associated psychological and mental health problems such as anxiety and depression[[2]](#footnote-2). The outcome of medical illnesses is adversely affected by psychological morbidity. However, as indicated by a qualitative study[[3]](#footnote-3) anxiety and depression tend to be normalised in people with long-term conditions, and are thus less likely to be detected and treated.NICE CG91: *Depression in adults with a chronic physical health problem* notes that practitioners should be aware that patients with a chronic physical health problem are at a high risk of depression, particularly if they have functional impairment, underlying the guidance on effective case identification and recognition, and on risk assessment and monitoring. In support of this level of need, this CQUIN requires providers to:* **Screen** for depression (by asking a single question to raise awareness among clinicians),
* **Assess** the presence of depression where initial screening is indicative of need (using a simple 10 item or 15 item questionnaire which can be self-administered) and then
* **Determine** the next clinical steps (which could be a referral back to the general practitioner for reassessment once the physical illness has resolved, referral to a hospital psychiatry liaison teams for an assessment and follow-up, commencement of medication or referral to IAPT).

Providers will be required to develop a Depression in those with LTC Policy and a clear Action Plan/ Strategy with specified targets and milestones by a date in 2016/17.  |
| **Data source** | A census audit of patient notes |
| **Frequency of data collection** | Annual |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Annual |
| **Baseline period/date** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Baseline value** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Final indicator period/date (on which payment is based)** | Q3 Audit |
| **Final indicator value (payment threshold)** | 90% in each of the three component indicators |
| **Final indicator reporting date** | Q4 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see below. 40% of total CQUIN funding available for achievement of milestones |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see below. 60% of total CQUIN funding available for performance against the three metrics. |
| **EXIT Route** |  |

##

## 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** | Review and develop Protocols for Screening, Assessment and Pathways for Depression in Older Adults. | End Q1 | 10% |
| **Quarter 2** | Protocols for Screening, Assessment and Pathways for Depression in Older Adults are in use | End Q2 | 10% |
| **Quarter 3** | Undertake Audit | End Q3 | 10% |
| **Quarter 4** | Review outcome of the Audit, develop an action plan and implement; results of audit and report on action plan to be shared with commissioners | End Q4 | 10% |

##

## Rules for Partial Achievement at Final Indicator Period/ Date

**Note:** Each of the metrics (screen, assess, and determine) are worth 20% of the total CQUIN scheme so that achievement of 90% or more in all three metrics will earn the maximum 60% of the CQUIN scheme.

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 90% and above | 60% |
| 75-89% | 45% |
| 50-74% | 30% |
| 33-49% | 15% |
| <33% | 0% |

##

## Supporting Guidance and References

Qualitative studies have demonstrated that overwhelming anxiety at times of crisis, worry about the illness, and impaired coping lead to use of health care services[[4]](#footnote-4). A number of studies have also shown that depression is associated with increased health care utilisation, medical costs, disability and frequent use of the accident and emergency department[[5]](#footnote-5).

Chronic physical health problems have a major impact on patients and their families, health services, and the economy[[6]](#footnote-6). Depression is twice as common in people with a LTC, such as T2DM, as in the general adult population[[7]](#footnote-7). Psychological problems lead to poorer self-care in LTCs, with potentially serious consequences; for example, if a diabetic patient’s glycaemic regulation is impaired[[8]](#footnote-8).

Although not directly providing evidence on how to recognise or assess depression in patients with chronic physical health problems, a meta-analysis by Pinquart and Duberstein (2010)[[9]](#footnote-9) of 76 prospective studies involving over 160,000 patients with cancer showed that 91% of the bivariate associations between depression and mortality, and 90.5% of the multivariate analyses that controlled for confounding variables, reported a relative risk of more than 1.0. This finding supports the rationale for NICE CG91 guidance by demonstrating that a diagnosis of depression and elevated level of depressive symptoms are predictive of increased mortality in patients with cancer. The authors suggested that consideration could be given to screening for depression as part of cancer treatment. Although screening was not a focus of this meta-analysis, the conclusion is consistent with the recommendation to screen for psychological distress in the NICE guidance on cancer services ‘Improving supportive and palliative care for adults with cancer’.

There is much good evidence on the impact of mental health problems on physical health, viz:

* Mental health problems interact with physical health and can trigger or severely exacerbate other conditions. For example, depression has been associated with a four-fold increase in the risk of heart disease[[10]](#footnote-10) and a three-and-a-half-fold increase in mortality rates after heart attack[[11]](#footnote-11)

* Between 12 and 18 per cent of all NHS expenditure on long-term conditions is estimated to be linked to mental health problems[[12]](#footnote-12)
* Across a range of conditions, each patient with co-morbid depression costs health services between 30 and 140 per cent more than equivalent patients without depression[[13]](#footnote-13)
* Unidentifi­ed mental health problems often underlie ‘medically unexplained symptoms’, which cost the NHS around £3 billion each year and cause significant distress to patients[[14]](#footnote-14)

The Kings Fund has identified improving the management of patients with both physical and mental health needs as being one of the top ten priorities for commissioners in transforming health care systems.

1. (Carney 2001; Naessens 2005; Schrire 1986).
2. Moussavi *et al*, 2007; Patten *et al*, 2008
3. Coventry and colleagues (2011),
4. (Olsson & Hansagi 2001).
5. Lusignan S et al., 2012).
6. (Wilson *et al*, 2005).
7. (Moussavi *et al*, 2007; Patten *et al*, 2008).
8. McKellar *et al*, 2004).
9. **Key reference** Pinquart M, Duberstein PR (2010) Depression and cancer mortality: a meta-analysis. Psychological Medicine 40: 1797–1810 Full text: www.ncbi.nlm.nih.gov/pmc/articles/PMC2935927/pdf/nihms203992.pdf
10. (Osborn et al 2007)
11. (Lesperance et al 2002).
12. (Naylor et al 2012).
13. (Welch et al 2009; Melek and Norris 2008).
14. (Bermingham *et al* 2010).

# 13. CAMHS Transition

|  |
| --- |
| **Indicator name** | Improvement of patient & carer involvement, experience and outcomes in transitions out of Child and Adolescent Mental Health Services (CAMHS). |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are five parts to the indicator:1. Proportion of service users in transition with a named case worker;
2. Proportion of service users in transition whose personalised care plan demonstrably outlines the discharge process;
3. Proportion of GPs (or other referrers) who have been informed that patients are in transition, or in the process of being discharged;
4. Proportion of service users in transition with complete discharge plans;

Proportion of service users in transition offered the opportunity of participating in the CQUIN survey |
| **Numerator** | 1. Number of service users with a named worker during the transition process
2. Number of service users experiencing transition whose personalised care plan outlines the transition / discharge process – providers able to demonstrate that Transition/Discharge plans are in place for all service users going through transition or discharge and that these have been developed and shared with the young person
3. Number of GPs/referrer who have been informed that patients are in transition / discharge
4. Number of service users with complete transition / discharge plans, including problem description / diagnosis / Thrive category
5. Number of service users offered to take part in the survey
 |
|  **Denominator** | 1, 2, 4 and 5: All service users in transition 3: All GPs/referrers who have patients that are in transition  |
| **Rationale for inclusion** | In general transition out of Child and Adolescent Mental Health Services (CAMHS) is poorly planned, poorly executed, and poorly experienced. There are enormous risks for young people disengaging or being lost in the transition process, at this vulnerable point in their development as they leave secondary education, move towards more independent living, gain legal responsibility for their choices and lose those parts of their support network that are only available within child and adolescent services.Therefore, to improve CAMHS caseload management with respect to transition, and improve patient and carer involvement, experience and outcomes with regard to transition between services, this indicator will serve to incentivise providers to collaborate and integrate across the boundary that arbitrarily separates childhood and adolescence from adulthood.Transition is defined as physical movement from one service in one business division within the Trust to another, or to an external provider. In the case of CAMHS it is young people who are being discharged from CAMHS, to either Adult Mental Health services (AMH) or who will not need secondary mental health services and who become the responsibility of their GP following discharge. |
| **Data source** | Provider |
| **Frequency of data collection** | Annual |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Annual |
| **Baseline period/date** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Baseline value** | Not applicable as payment to be based on absolute performance not performance relative to a baseline |
| **Final indicator period/date (on which payment is based)** | Q3 Audit |
| **Final indicator value (payment threshold)** | 75% in each of the five metrics |
| **Final indicator reporting date** | End Q4 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – See below. 50% of total CQUIN funding available for achievement of milestones |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – See below. 50% of total CQUIN funding available for performance against the five metrics. |
| **EXIT Route** | To be agreed locally |

##

## 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** | Review and develop a Safe Transition and Discharge Protocol for CAMHS and implement.Develop and report baselines of a user and carer survey, to be agreed with Commissioners, with a response rate of at least 40%, that will evaluate: * % of service users and carers who were involved in the transition planning process
* % of service users and carers who are satisfied with the transition planning process
* % of service users and carers who perceive their agreed outcomes ( documented in the personalised care plan) were met

% of service users that know who their key worker is and how to contact them  | End of Q1 | 12.5% |
| **Quarter 2** | Implement Safe Transition and Discharge Protocol | End Q2 | 12.5% |
| **Quarter 3** | Undertake Audit of the protocols with the audit to include further collection of carer and user experience.  | End Q3 | 12.5% |
| **Quarter 4** | Review outcome of the Audit, develop an action plan and implement; results of audit and report on action plan to be shared with commissioners | End Q4 | 12.5% |

##

## Rules for Partial Achievement at Final Indicator Period/ Date

**Note:** Each of the five metrics are worth 10% of the total CQUIN scheme so that achievement of 75% or more in all five metrics will earn the maximum 50% of the CQUIN scheme.

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 75% and above | 50.0% |
| 66-74% | 37.5% |
| 50-65% | 25.0% |
| 33-49% | 12.5% |
| <33% | 0% |

##

## Supporting Guidance and References

Evidence suggests that young people are currently poorly served by mental health services[[15]](#footnote-15). Young people aged under 25s are underrepresented in adult services, therefore services are failing to engage young people, at the time that their disorders may be most effectively treated.

At the heart of this issue, there are recognised problems with transition from services commissioned to provide support for service users up to the age of 18 to those commissioned to provide for individuals aged 18 and over, where the availability and offer of support, is often wildly different from that which may have been received up to the point of transition.

The transition from CAMHS to adult mental health services is a critical point for young people with complex needs, and should be supported by a robust and ‘coordinated multi-agency approach’ to transition planning - repeatedly identified as the key to a successful transition - and this process is further strengthened by early and effective planning, and putting the young person at the centre of the process to help them prepare for transfer to adult services. In spite of this, services are often poorly coordinated. The TRACK study[[16]](#footnote-16) shows that transitions for young people at the age of 18 are poorly managed resulting in only 4% of young people receiving an ‘ideal transition’.

**The issues** can be summarised as follows:

* **Different thresholds:** To get any service from AMHS the threshold in terms of severity of illness is higher than CAMHS so many young people are locked out from receiving a service. For some, their illness has to reach crisis point before they receive a service from AMHS with the effect that their entry to services is more traumatic and more costly to the young person, family and to services than it would have been had their needs been met earlier.
* **Gaps in care:** When young people are no longer eligible for CAMHS there is often a period of no support as they wait to access AMHS services and are put back on waiting lists. For some young people this can result in never making the transition.
* **Postcode lottery:** The transition from CAMHS to AMHS is subject to extreme local variation, with some young people making the transfer to adult services at 16, some at 16 if not in school or 18 if in school, and some at 18, and many not transferring at all but disappearing into a void with long term consequences for their mental health and well-being.  A [recent study](http://wrap.warwick.ac.uk/201/) of transitions in London found only 4% of young people reported a good transition, with many disappearing from services.
* **Communication:** Poor communication between CAMHS and AMHS often leads to repeated assessments, new staff to deal with and new psychiatrists/psychologists to build relationships with. This means young people are often not getting the right help when they need it.
* **Negative perceptions:** Differences between the service location and style of the two services alienates many young people who end up slipping off the radar of services. CAMHS and AMHS still report that they do not understand each other, with both perceiving the other in a negative light which affects the service’s abilities to work together to meet the needs of young people and families

Further, CAMHS are uniquely placed to ensure that on discharge, GPs and other professionals who have on going responsibility for the young people have the information and knowledge they need to make decisions in the future including known information about other health, care, and third sector services that may be helpful.

# 14. Avoidable Mental Health Act Detentions

| **Indicator** |
| --- |
| **Indicator name** | Safely Reducing Avoidable Repeat Detentions under the Mental Health Act |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | Providers will be assessed against quarterly implementation of governance-focused indicators which are:1. Routine reporting on and review of the use of the Mental Health Act, in order to identify those detained with the most frequency
2. Retrospective root-cause analysis of the 50 most frequently detained service users
3. Focus groups with detained service users and their supporters, to seek recommendations on safe and appropriate alternatives to care
4. Enhanced care reviews of service users repeatedly detained.
 |
| **Numerator** | Not applicable as the scheme is based on achievement of milestones |
| **Denominator** | Not applicable as the scheme is based on achievement of milestones |
| **Rationale for inclusion** | The aim of this CQUIN scheme is to safely reduce the level of repeat detentions made under the Mental Health Act (MHA) 1983. Providers will achieve this by implementing governance arrangements and protocols to enable better understanding of demographics of those subject to repeat detentions, and the reasons for those repeat detentions |
| **Data source** | Provider reports |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Provider to submit board-level report outlining progress towards implementation |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Quarterly reward schedule in line with agreed milestones |
| **Final indicator value (payment threshold)** | N/A |
| **Final indicator reporting date** | Quarterly reward schedule in line with agreed milestones |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | N/A |
| **EXIT Route** | To be agreed locally |

## 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** | Routine governance reports on the use of the MH act in all communities were reported and reviewed to identify those who had been detained 1-3. 4-6. 7-10 above 10 times in a 2 year period: | End Q1 + 2-4 weeks (30/07/20xx) | 25 |
| **Quarter 2** | Root cause Analysis Retrospective review of the top 50 who had been frequently detained: through CQC care pathway review methodology of individual semi structured interviews, undertaken by SU researchers, to identify the root causes of the mental ill health, help seeking behaviours in crisis and elective care, the pathway into care, the interventions offered and person, and their families attitudes to current models of healthcare provision and recommendations for change. | End Q2 + 2-4 weeks (31/10/20xx) | 25 |
| **Quarter 3** | Focus groups of 10 service users who had been detained, and their families, supporters and community leaders (where appropriate) to seek their recommendations on safe (for the person and for their community) appropriate alternatives to care, where these were felt appropriate. | End Q3 + 2-4 weeks (31/01/20xx) | 25 |
| **Quarter 4** | Enhanced care review of 10 of those who had been repeatedly detained, to assess and plan safe feasible alternatives to prevent avoidable detentions. It is very likely that these reviews and responsive least restrictive care plans will require inputs from the patient and family, multi-disciplinary and multi-agency that can best respond to the identified biopsychosocial needs. . | End Q4 + 2-4 weeks (30/04/20xx) | 25 |

## 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** |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

## Supporting Guidance and References

In future years or, to stretch performance in Year 1, the CQUIN could additionally include:

* achievement of the National best practice standards of assessment under the Mental Health Act
* achievement in peer accreditation network for best standards achievement

Evidence on rate of detentions

The February 2014 monthly summary of the Mental Health Minimum Dataset included a special feature on detention rates based on 2012-13 data, an extract of the summary is pasted below:

<http://www.hscic.gov.uk/catalogue/PUB14125>

* The rate of detention was 74.8 people per 100,000 of the population, or approximately one person in 1,300 people.
* The rate of short term orders was 40.2 people per 100,000 of the population, or approximately one in 2,500 people.
* The rate of detention was highest for the 75 and over age group at 99.0 people per 100,000 of the population, the highest for any adult age group.
* The rate of short term orders was highest for the 25-34 year age group at 58.1 people per 100,000 of the population.
* The rate of detention for people from the Black and Black British ethnic group, 250.3 people per 100,000 of the population, was around 3 times higher than for the White ethnic group (62.9 per 100,000 of the population).
* 13.4 per cent of people who were subject to a detention were detained more than once in the year.
* 16.8 per cent of people who were subject to a short term order had more than one short term order in the year

References and further reading

Overview of the Mental Health Act (1983) by Mind:

<http://www.mind.org.uk/information-support/legal-rights/mental-health-act/?gclid=CJDSpaz-8ccCFUyNGwod25IAuA#.VfRcVKHTX4h>

# 15. Discharge Planning

| **Indicator** |
| --- |
| **Indicator name** | Mental Health Discharge Planning |
| **Indicator weighting (% of CQUIN scheme available)** |  |
| **Description of indicator** | There are two parts to the indicator:1. Proportion of admitted patients with a ward census completed daily for the duration of their stay;
2. Proportion of discharged patients with care plans meeting pre-agreed criteria
 |
| **Numerator** | 1. Number of patients that have had their ward census fully completed every day for their length of stay.(ward census to be developed as part of the CQUIN in Q1) 2. Number of care plans meeting the agreed criteria |
| **Denominator** | 1.Total number of patients admitted over the same time period as above2. Total Number of patients discharged |
| **Rationale for inclusion** | The focus is to develop integrated systems and processes to ensure continuity of care across in-patient and community settings, delivering a collaborative plan of care and treatment, including that discharge planning commences on admission and continues in the community.The plan of care and treatment* involves the MDT and patients and carers
* needs of patients are identified and met to support early discharge
* enables the patient to be supported and maintained in the community
 |
| **Data source** | PROVIDER |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | PROVIDER |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Not applicable |
| **Baseline value** | Average Length of stay per ward at Q4 13/14 as reported in the in-patient dashboard |
| **Final indicator period/date (on which payment is based)** | 31 March 2016 |
| **Final indicator value (payment threshold)** | See table |
| **Final indicator reporting date** | 31 March 2016 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes, quarterly; see table below |
| **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 | 1. PROVIDER to work with LA practitioners and managers to ensure consistent implementation of PROVIDER policies and procedures to manage the patients from admission to discharge and maintenance in the community.
2. Provide a report to commissioners detailing the process, outcomes and resultant action plan that have developed in order to respond to point 1 above (ensure consistent implementation of PROVIDER policies and procedures to manage the patients from admission to discharge and maintenance in the community.)
3. Develop a ward Census proforma capturing relevant detail including admissions date planned discharge, delayed discharge

Present the findings of the patient census pilot, review and adapt the tool and agree a way forward with commissioners to respond to the CQUIN requirements. |  | 25% |
| Quarter 2 | 1. PROVIDER to work with LA practitioners and managers to ensure consistent implementation of PROVIDER policies and procedures to manage the patients from admission to discharge and maintenance in the community.

To include: Implementation of Daily Ward Patient Census And MDT discharge care plan1. Each ward will review the Daily Ward Patient Census on all patients, every day (7 days a week) ensuring that each ward has fully completed relevant fields for 80% of patients. ( See appendix 1 for Daily Ward Patient Census that identifies the fields for completion )
2. To provide a quarterly ward census report evidencing that each ward has completed relevant fields for 80% of patients. This report will also include a review and analyses of the data held in the ward census to better understand the LOS and delayed discharge of patients and identify potential blocks in the system and lessons learned.
3. PROVIDER will Audit 20 patients per ward per quarter\* to provide evidence that a written copy of the **discharge plan** has been shared with 80% patients (and or carer) and MDT’s and must include ( where applicable);
4. Involvement of patients or carers in discharge planning
5. Patient is given timely notification of discharge and this is documented in the notes
6. The care and rehabilitation to be provided
7. Name of the care coordinator (if required)
8. Action to be taken if there is a crisis, signs of relapse or is the patient fails to attend for treatment
9. The date of the first follow up appointment (CPA review or other review date) which is recorded in the notes and communicated to the patient and members of the MDT.

\* where there are less than 20 patients discharged in the quarter, the maximum number discharged will be audited and accompanied with an explanation. |  | 25% |
| Quarter 3 | 1. PROVIDER to work with LA practitioners and managers to ensure consistent implementation of PROVIDER policies and procedures to manage the patients from admission to discharge and maintenance in the community.

To include: Implementation of Daily Ward Patient Census And MDT discharge care plan1. Each ward will review the Daily Ward Patient Census on all patients, every day (7 days a week) ensuring that each ward has fully completed relevant fields for 80% of patients. ( See appendix1 for Daily Ward Patient Census that identifies the fields for completion )
 |  | 25% |
| Quarter 4 | 1. PROVIDER to work with LA practitioners and managers to ensure consistent implementation of PROVIDER policies and procedures to manage the patients from admission to discharge and maintenance in the community.

To include: Implementation of Daily Ward Patient Census And MDT discharge care plan1. Each ward will review the Daily Ward Patient Census on all patients, every day (7 days a week) ensuring that each ward has fully completed relevant fields for 90% of patients. ( See appendix1 for Daily Ward Patient Census that identifies the fields for completion )
2. To provide a quarterly ward census report evidencing that each ward has completed relevant fields for 90% of patients. This report will also include a review and analyses of the data held in the ward census to better understand the LOS and delayed discharge of patients and identify potential blocks in the system and lessons learned.
3. PROVIDER will Audit 20 patients per ward per quarter\* to provide evidence that a written copy of the **discharge plan** has been shared with 90% patients (and or carer) and MDT’s and must include ( where applicable);
4. Involvement of patients or carers in discharge planning
5. Patient is given timely notification of discharge and this is documented in the notes
6. The care and rehabilitation to be provided
7. Name of the care coordinator (if required)
8. Action to be taken if there is a crisis, signs of relapse or is the patient fails to attend for treatment
9. The date of the first follow up appointment (CPA review or other review date) which is recorded in the notes and communicated to the patient and members of the MDT

\* where there are less than 20 patients discharged in the quarter, the maximum number |  | 30% |

##

## 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** |
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## Supporting Guidance and References

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# 16. Dementia Discharge Summaries

| **Indicator** |
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| **Indicator name** | Improving discharge summaries with follow-up recommendations for people with dementia or delirium |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | The proportion of patients (any age) who on admission have a known diagnosis of dementia or delirium, AND patients aged 75 and over who, following an episode of care with a length of stay over 72 hours, who have been identified with dementia or delirium, who have a discharge summary including follow up recommendations that is shared with the patient’s GP. |
| **Numerator** | 1. Number of patients (any age) who on admission have a known diagnosis of dementia or delirium and who have a discharge summary including follow up recommendations that is shared with the patient’s GP
2. Number of patients aged 75 and over, following an episode of care with a length of stay over 72 hours, who have been identified with dementia or delirium, and who have a discharge summary including follow up recommendations that is shared with the patient’s GP.

The episode of care includes all admissions to hospitalsnot just unplanned admissions.**For the purpose of this CQUIN only, a patient is said to be identified as having dementia or delirium if EITHER, they (i) have an existing/known/recorded diagnosis of dementia or clinical diagnosis of delirium OR (ii) underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.**Discharge summary’s follow up plan to contain the following:1. Diagnosis of delirium where this was made and any new diagnosis of dementia during the admission with recommended ICD and READ codes in line with Regional coding guidance.
2. Details of any cognitive tests performed and substantial changes to needs.
3. A plan to modify/stop any anti-psychotics or sedative drugs (within 3 weeks).
4. Details of any referrals already made and any team already involved.
5. Recommendations for further assessment or onward referral in line with locally agreed care pathways.
6. Recommendations for liaison and communication if the usual place of residence is a care home or for carers;
7. Recommendations for patients with delirium in line with NICE Delirium Quality Standards 4 and 5

<https://www.nice.org.uk/guidance/qs63/chapter/introduction>1. Any further information to enable general practice to update care plans for existing patients with a diagnosis of dementia.
 |
| **Denominator** | 1. Number of patients (any age) who on admission have a known diagnosis of dementia or delirium
2. Number of patients aged 75 and over, following an episode of care with a length of stay over 72 hours, who have been identified with dementia or delirium

The episode of care includes all admissions to hospitals not just unplanned admissions. |
| **Rationale for inclusion** | **Goal**To improve the management of dementia and delirium and to prompt appropriate referral, follow up and effective communication between providers and general practice, through the introduction of `follow on recommendations` as part of the discharge planning. **Rationale**850,000 people live with dementia in the UK[[17]](#footnote-17) and this number is set to increase. Dementia costs the UK £26.3 billion a year. Delirium is a common and serious illness in people in hospital or long-term care (nursing or residential care). The CQUIN has been developed in line with the NHS England ambition to sustain improvement in support for people with dementia and delirium and the Care Quality Commission report.[[18]](#footnote-18) |
| **Data source** | Providers will be responsible for carrying out and demonstrating to their commissioner that they have completed a local audit. Providers must conduct audits that are of a sufficiently large number of the people identified, assessed and referred to satisfy their commissioner that a robust audit has been conducted. Providers should ensure that the sample size of the audit is sufficiently large to be robust. Particular care should be taken to ensure that the sample is a random selection of cases eligible to be audited. The audits should also check that the discharge summaries meet the necessary standards.Further information on data collection is provided at the end of the template. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider organisationsThis CQUIN applies to Acute hospital providers. |
| **Frequency of reporting to commissioner** | Monthly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Payments are based on meeting the threshold in each quarter during the year 2016/2017 |
| **Final indicator value (payment threshold)** | 90% or more |
| **Final indicator reporting date** | March 2017 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | To be agreed locally |
| **EXIT Route** | To be agreed locally |

## 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** |
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## Supporting Guidance and References

Background

This CQUIN builds on the work that providers have undertaken as part of the 2015/16 Dementia and Delirium CQUIN, by addressing some of the issues raised in the previous CQUIN and developing it further to encourage further improvements in care.

The 2015/16 CQUIN mandated a discharge care plan for people with dementia and delirium in line with NICE QS 5. This is retained with a simplified description and is named “follow up recommendation”. Many primary care surgeries are introducing care plan templates.

It is important that patients do not have multiple care plans as this may cause confusion. The change in name avoids confusion for patients, carers and health professionals regarding location of the main care plan. The intention is that the follow up recommendation is used by primary care to update the patient’s care plan after discharge.

Data Collection

Providers will be familiar with this process of data collection as part of the Dementia and Delirium CQUIN. However for 2016/17 data collection has extended as follows:

i) to any age with a known diagnosis of dementia of delirium

ii) for all admissions to hospitals not just unplanned admissions.

**For information:**

Part 3a (i and ii) of the 2015/16 Dementia and Delirium CQUIN, that is the Find, Assess and Investigate aspects, will continue to be collected as part of the BAAS approved collection in the Standard Contract.

However, Part 3a iii of the 2015/16 Dementia and Delirium CQUIN is not BAAS approved, so will not continue to be collected in 2016/17. In its place we will substitute the data that was collected for 3a iii for 2014/15.

This means that some of the data will continue to be collected via Unify and available to commissioners. In summary this is as follows:

* 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
1. Were asked the dementia case finding question; or
2. 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

1. 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.
* Of those who received a diagnostic assessment, how many should have been referred on to other services or back to their GP and how many were then referred in accordance with local pathways agreed with commissioners.

**Please note:**

Community service providers are not included in this local CQUIN for 2016/17 as we have very limited information on the performance of these providers for 2015/16. As you will be aware, 2015/16 is the first year that community service providers were included in the national Dementia and Delirium CQUIN, and we cannot yet ascertain how successful the CQUIN has been in incentivising improvements in/by these providers.

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# 17. Dementia: John’s Campaign

| **Indicator** |
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| **Indicator name** | Implementing a policy on welcoming carers and family members of people with dementia according to patient’s needs and not restricted by visiting hours. |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | Supporting carers and family members of people with dementia (all ages), to be welcomed by hospitals according to the patients’ needs and not restricted by visiting hours.  |
| **Numerator** | The number of people who have been identified with dementia (all ages), whose Carer(s) have been provided with information about the hospital’s policy on John’s Campaign. To include planned and unplanned admissions to hospital.**For the purposes of this CQUIN:**A patient is said to be identified as having dementia if EITHER, they (i) have an existing/known/recorded diagnosis of dementia OR (ii) underwent a diagnostic assessment for dementia in whom the outcome was positive. |
|  **Denominator** | The number of people (all ages) who have been identified as having of dementia. To include planned and unplanned admissions to hospital. |
| **Rationale for inclusion** | Historically restrictions have been in place regarding visiting times since the 1950’s though there is no national policy or guidance with regarding to visiting restrictions within the NHS, and each organisation, department or ward can adopt their own visiting times and restrictions.The Francis Inquiry report 2013 discussed the need to review unnecessary restrictions on hospital visiting and added that they should be as open to visitors as would be the patients home.Over a quarter of people accessing acute hospital services are likely to have dementia. Around a fifth of these admissions are related to potentially preventable acute conditions. A new study (July 2015) by PHE’s Dementia Intelligence Network (DIN) shows increased numbers of emergency admissions for people with dementia.Hospital stays are particularly detrimental for people with dementia who experience longer stays and poorer outcomes than the general population. People with dementia may not be able to return home when the acute episode of care is completed, due to further disablement during the hospital stay, which is devastating for them and their families and it has significant cost consequences for the care system.People with dementia are vulnerable and can become distressed and disorientated in unfamiliar surroundings. Their ability to understand and communicate with strangers may be limited. Staff may not be sufficiently trained to understand and respond to the needs of people with dementia Important decisions are often made about the future care of people with dementia at the point that they are admitted to hospital, which may be permanent. These decisions are likely to be influenced by a number of factors but include: a failure to engage with people with dementia in the decision making process; decisions made about balancing risk. Involving a family carer from the moment of admission to hospital until the moment of discharge has been proved to give better quality of care and improved outcomes. The family Carer can provide insight, facilitate communication (and informed consent) and ensure continuity of care. |
| **Data source** | Data will be collected through records maintained on local systems (please refer to Guidance Notes below). |
| **Frequency of data collection** | Survey of carers will be undertaken in line with the requirements of the Standard Contract.Frequency of the data on the proportion of carers who have been provided with information on John’s Campaign policy is to be determined locally. |
| **Organisation responsible for data collection** | Provider organisations - Acute hospital and Mental Health hospital providers. |
| **Frequency of reporting to commissioner** | Survey of carers will be undertaken in line with the requirements of the Standard Contract.Frequency of the data on the proportion of carers who have been provided with information on John’s Campaign policy is to be determined locally. |
| **Baseline period/date** | Q1 2016/17 |
| **Baseline value** | To be determined based on baseline collection in Q1 2016/17 |
| **Final indicator period/date (on which payment is based)** | End of Q4 2016/17 |
| **Final indicator value (payment threshold)** | To be agreed locally based on a stretching but realistic level of improvement from the baseline value. |
| **Final indicator reporting date** | April 2017 |
| **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?** | To be agreed locally |
| **EXIT Route** | To be agreed locally |

## 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 | Providers have a policy or statement that identifies and supports carers and is approved by the Board. Policy or statement to have been developed locally with patient and carer groups. If a Provider has already adopted John’s Campaign then they will notify the commissioner to what extent it has been adopted. Providers have developed an implementation plan to support their policy on John’s Campaign.Provider’s training programme includes their approach to John’s Campaign and awareness of the role of carers. Training to be determined locally but to be included as part of all dementia training and as part of the hospital’s Induction training.Providers have developed and made available information for carers on their approach/commitment to John’s Campaign Provider develops a survey of carers of people with dementia. The Provider will ensure that the impact of John’s Campaign (including carer awareness of the campaign) will be included in the carers survey, required of the Standard Contract.  | End of Q1 |  |
| Quarter 2 |  |  |  |
| Quarter 3 |  |  |  |
| Quarter 4 | Complete the survey and analysis of carers of people with dementia in line with the requirements of the Standard Contract Service Condition 12 and Schedule 6F.  | End of Q4 |  |

## 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** |
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## Supporting Guidance and References

Background

Please note that John’s Campaign currently relates to carers of people with dementia, that is those people that have a recorded diagnosis of dementia on admission; or those patients who underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive[[19]](#footnote-19)

John’s Campaign is asking for the families and carers of people with dementia to have the same rights as the parents of sick children, and be allowed to remain with them in hospital for as many hours as they are needed, and as they are able to give. “Caring can be an exhausting business - we are asking only for the RIGHT for carers to continue to care, not the DUTY”.

There is strong national support for John’s Campaign:

In March 2015, Norman Lamb (Minister of State) and Alistair Burns (National Clinical Director for Dementia, NHS England), wrote to Trusts to ask them to consider supporting John’s Campaign.

“The request is for the carers of people with dementia who are in hospital, to be allowed the option to stay with that person outside of normal visiting hours or even overnight. We are cognisant that this is a practice which hospitals have adopted widely since the early 1990s for the parents of children staying in hospital. We are also conscious that many general hospitals offer accommodation for parents to stay overnight”

A number of Trusts and hospitals have adopted this approach:

* Royal Brighton and Sussex and Bristol University Hospitals both providing outstanding examples of good practice in supporting carers.
* Imperial College Healthcare has introduced a carer’s passport.

Other examples can be found on the John’s Campaign website <http://www.johnscampaign.org.uk/>.

There are resources available to providers and commissioners on the John’s Campaign website that will help with the development and implementation of this local CQUIN. Resources include: an explanation of the campaign; examples of good practice; FAQs; and the March 2015 letter from Norman Lamb and Alistair Burns. <http://www.johnscampaign.org.uk/resources.html>.

Providers may also consider registering their commitment to John’s Campaign on the Observer’s website (currently contains a list of 100 Trusts or hospitals)

<http://www.theguardian.com/society/2015/jul/25/johns-campaign-listing-hospitals-that-welcome-carers>.

Policy/statement on the adoption of John’s Campaign

The policy should clearly set out the provider’s commitment to John’s Campaign including where and how the campaign will be adopted. It is important to involve local groups of patients and carers to ensure that the policy has relevance for the people most directly affected by its recommendations.

Currently adoption is varied across the Trusts and hospitals from individual wards, hospital wide or Trust wide. However, the fundamental drive from John’s Campaign is that carers have access to the person with dementia outside of usual visiting hours.

It may be useful to clearly set out the role of the Carer in hospital; what contribution they may wish to make in continuing to support the person they care for, for example assisting at meal times and supporting them at night. However, John’s Campaign is clear in that there should be no expectation that carers should stay in hospital, it must always be a balance of what the patient’s needs are and what the carers are able to give.

Adoption of John’s Campaign has also extended, in some examples, beyond visiting times to reduced cost of parking and meals/refreshments for carers (linked to the carers passport). Examples are available on the John’s Campaign website.

Training

As part of the Standard Contract 2016/17, providers will be required to ensure that appropriate dementia and delirium training is available to staff through a locally determined training programme, (this formed part of the National Dementia and Delirium CQUIN 2015/16). Providers are asked to include in this training programme their approach to John’s Campaign and the role of carers and to report on this addition to their commissioner in line with General Condition 5.5.

Information for carers

There is no specific requirement for how the information will be available to carers. Different approaches have been used by the Trusts and hospitals that have adopted John’s Campaign. Some examples include:

* Posters on ward doors
* Permanent display of information at hospital entrances
* Information pack.
* Carers Passport to distinguish the Carer from other visitors

Carers Survey

The 2015/16 Dementia CQUIN Part 3c requires provider to undertake a survey of carers for people with dementia, to ensure that they feel adequately supported. From 2016/17 this will be included in the Standard Contract. Providers will be required to ascertain the impact that their adoption of John’s Campaign on Carer satisfaction. The details will be agreed with the commissioner.

Data Source

Acute providers and community service providers (that may include Mental Health Trusts) currently collect some data for this local CQUIN. Currently data on “The number of patients admitted with a known diagnosis of dementia or who have been identified as potentially having dementia who are appropriately assessed”, is collected from Acute and Community Providers as part of Indicator 3 Dementia and Delirium Part 3aii.

A large number of providers are therefore familiar with collecting such data and inputting onto local systems, however, this aspect of data collection may be new to some Mental Health hospital providers. This will be taken forward into the Standard Contract 2016/17.

# 18. Improving Access to Psychological Therapies

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| **Indicator name** | Enhancing Access and Recovery in Improving Access to Psychological Therapies |
| **Indicator weighting (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to the scheme to enhance access and recovery in IAPT. 1. Improving access by adherence to waiting time standardsa) Percentage of service users with common mental health conditions referred to the Improving Access to Psychological Therapies programme treated within:i. 6 weeks of referralii. 18 weeks of referralb) Percentage of service users entering treatment who have a second treatment session within:i. 28 days of first treatment session, ii. 90 days of their first treatment session2. Ensuring equity of Access for disadvantaged groups 1. Ratio between the observed proportion of service users identified as BAME on the caseload and the expected proportion identified as BAME based on local demographics

b) Ratio between the observed proportion of service users aged 65 and over on the caseload and the expected proportion aged 65 and over based on local demographics 3. Improving recoverya) Completion of Milestones to support implementation of appropriate steps taken to ensure optimum recovery rates b) IAPT recovery rate:1. Percentage of service users that had a course of treatment who have moved to recovery
2. No statistically meaningful reduction in number of cases reaching recovery is observed.
 |
| **Numerator** | 1. Improving access by adherence to waiting time standards1. Count of referrals which entered treatment during the sample period waiting:
	1. 42 days or less for first treatment[[20]](#footnote-20)
	2. 126 days or less for first treatment[[21]](#footnote-21);
2. Count of referrals between first and second treatment appointment[[22]](#footnote-22) (where the second treatment appointment occurred within the sample period) waiting over:
	1. 28 days
	2. 90 days

2. Ensuring equity of Access for disadvantaged groups :1. Proportion of service users identified as BAME on the caseload during the sample period[[23]](#footnote-23);
2. Proportion of service users aged 65 and over on the caseload during the sample period [[24]](#footnote-24)
3. Recovery
4. As per milestones laid out below
5. IAPT recovery rate:
	1. Number of referrals with an end date in the sample period that finished a course of treatment where the service user has moved to recovery[[25]](#footnote-25);
	2. Number of closed referrals observed during the sample period having at least two treatment sessions (excluding assessment and follow up)[[26]](#footnote-26)
 |
| **Denominator** | 1. Improving access by adherence to waiting time standards Adherence to Waiting Time Standards:1. Count of referrals with a first treatment[[27]](#footnote-27) appointment (entering treatment) during the sample period
2. Count of referrals with a second treatment[[28]](#footnote-28) appointment during the sample period;

2. Ensuring equity of Access for disadvantaged groups * + 1. Proportion of local population identified as BAME observed during the sample period; AND
		2. Proportion of local population aged 65years and over observed during the sample period;
1. Recovery
	1. As per milestones laid out below
	2. Improving Access to Psychological Therapies (IAPT) Recovery Rate
		1. Number of closed referrals observed during the sample period that had a course of treatment (at least 2 treatment sessions)[[29]](#footnote-29) **LESS**

Number of referrals with an end date in the sample period that finished a course of treatment where the service user was not at caseness at initial assessment[[30]](#footnote-30) * + 1. Number of closed referrals having at least two treatment sessions (excluding assessment and follow up) observed during a baseline period as defined by commissioner[[31]](#footnote-31)
 |
| **Rationale for inclusion** | As IAPT services have matured and been evaluated, a number of key characteristics have emerged which appear critical in terms of assuring quality of delivery and achieving good clinical and other outcomes. This learning, the conclusion of which is that incentivising the delivery of effective, evidence based treatments in a consistent and timely manner will improve clinical recovery rates, forms the basis of this CQUIN indicator.**Access**Timely access to evidence-based care has been identified as of particular importance in improving longer term mental health, physical health and recovery-focused outcomes and in reducing the distress experienced by individuals and their families. As such, this CQUIN supports the continued implementation of the waiting time standard for IAPT, requiring that 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral. Strengthening the assessment of access standards, this CQUIN seeks to ensure that additional measures captured in national reports are drawn upon in order to guard against the introduction of perverse incentives into local commissioning arrangements. Performance against the access standard will therefore be assessed alongside assessment of so-called artificial treatment starts, where service users have an early appointment but are then put on an ‘internal’ waiting list before a full course of treatment starts.**Equality of Access**Equality of Access remains an issue for IAPT services. IAPT Service Providers have largely achieved access requirements by treating those population groups identified as easy to engage with. As a result, It is clear that some disadvantaged groups are disproportionately under-represented among IAPT service users.**Service Users identified as BAME**White British clients make up 85% of IAPT treatment completers who have a known ethnicity. When compared with ONS data and expected prevalence we can conclude that BAME groups are underrepresented on the caseloads of IAPT services.**Service Users Aged 65+**Currently approximately 7% of those who complete a course of treatment are aged 65 or over. ONS data and expected prevalence suggest that approximately 12.5% - 13% of people accessing IAPT services should be aged 65 or over. Addressing the lack of equity experienced by these groups is essential that services, in collaboration with their commissioners, undertake some action to ensure that IAPT services are accessible to those who require them.**Recovery Rates**The NHS mandate commits the IAPT programme to achieving recovery rates of 50%. As well as incentivising the achievement of this standard, this CQUIN incentivises providers to tackle a number of key issues, shown to be determinants of clinical outcome.**Ensuring appropriate treatment dosage**There is widespread variability in the number of sessions delivered during an episode of treatment between providers. Good concordance with NICE clinical guidelines will assure optimum clinical outcomes. Delivery of the appropriate number of sessions over the course of an episode of treatment has been shown to be positively correlated with recovery rates.**Problem Descriptors**Similarly, improved recovery and reliable improvement rates are positively correlated with higher levels of data completeness of problem descriptors. Taking steps to ensure that the needs of service users may be appropriately identified and captured will ensure that the best course of treatment to meet those needs may be effectively determined and acted upon. **Reduced DNA Rates**High rates of disengagement and low rates of attendance will not only put pressure on services, but are also correlated with low rates of recovery. Proactively engaging with hard to reach groups, and taking steps to address poor rates of attendance amongst patient groups is critical to the efficient operation of services.  |
| **Data source** | The IAPT dataset contains the fields required to measure performance against the new standards. All patient activity should continue to be recorded routinely using local IT systems. The IAPT data standard was mandated for central collection from 2011 and requires all IAPT services to submit a monthly extract of activity to the HSCIC for secondary usesIndicators will be published at national, provider and CCG level on the HSCIC website through Monthly IAPT Reports (Monthly CSV File and Quarterly CSV File). |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Providers |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | 2015/16 Q3 data |
| **Baseline value** | TBC |
| **Final indicator period/date (on which payment is based)** | Q3 2016/17Performance against the metrics will be assessed based on data in Q3 i.e. Q3 is the sample period. |
| **Final indicator value (payment threshold)** | 1. Improving access by adherence to waiting time standards – 25% of indicator valuea) Percentage of service users with common mental health conditions referred to the Improving Access to Psychological Therapies programme:i. 75% treated within 6 weeks of referralii. 95% treated within 18 weeks of referralb) Percentage of service users entering treatment who have a second treatment session:i. 75% within 28 days of first treatment session, ii. 95% within 90 days of their first treatment session2. Ensuring equity of Access for disadvantaged groups – 15% of indicator valuea) 80% of the expected number of service users identified as BAME on the caseload b). 80% of the expected number of service users aged 65 and over on the caseload3. Improving recovery – 50% of indicator valuea) Completion of Milestones to support implementation of appropriate steps taken to ensure optimum recovery rates b) IAPT Recovery Rate1. 50% recovery rate
2. No statistically meaningful reduction in number of cases reaching recovery is observed.
 |
| **Final indicator reporting date** | End Q4 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes; Milestones covering appropriate steps taken by providers to tackle key issues shown to be determinants of clinical outcome; see below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Only for 3b – IAPT recovery rate. See partial payments table below |

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## 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 | Board-level sign off of implementation plan to ensure that requirements of CQUIN are met, including: * appropriate steps necessary to ensure that treatments offered are NICE recommended and evidence based, offered in the appropriate dosage by a trained and accredited workforce
* appropriate steps necessary to ensure that the needs of service users may be appropriately identified and captured as problem descriptors;
* proactive management of DNA rate.

Implementation plan to be shared with Commissioners | End Q1 | 5% |
| Quarter 2 | Sustainable delivery of implementation plan to ensure that requirements of CQUIN are met to commence.Progress to be shared with Commissioner; Satisfactory progress to be made towards goals within implementation plan. | Start Q2End Q2 | 5% |
| Quarter 3 | Sample Period for CQUIN metrics | End Q3 | N/A |
| Quarter 4 | Reporting Period for CQUIN metricsProvider Performance against CQUIN Access and Recovery metrics to be assessed in line with CQUIN business rules | End Q4 | 90% |

## 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** |
| --- | --- |
| >50% | 100% |
| 46-49.9% | 75% |
| 43-45.9% | 50% |
| 40-42.9% | 25% |
| <39.9% | 0% |

## Supporting Guidance and References

* <http://www.iapt.nhs.uk/data/>
* <http://www.hscic.gov.uk/iapt>
* <http://www.iapt.nhs.uk/silo/files/measuring-recovery-2014.pdf>
* [http://www.hscic.gov.uk/media/16922/IAPT-Month-Metadata/xls/IAPT-month-metadata.xlsx](https://web.nhs.net/OWA/redir.aspx?SURL=t9bHgubdtRs1kPrHKEcybvbJh2XxP1J_khdckU-6sHSkdv2ZnDPTCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBoAHMAYwBpAGMALgBnAG8AdgAuAHUAawAvAG0AZQBkAGkAYQAvADEANgA5ADIAMgAvAEkAQQBQAFQALQBNAG8AbgB0AGgALQBNAGUAdABhAGQAYQB0AGEALwB4AGwAcwAvAEkAQQBQAFQALQBtAG8AbgB0AGgALQBtAGUAdABhAGQAYQB0AGEALgB4AGwAcwB4AA..&URL=http%3a%2f%2fwww.hscic.gov.uk%2fmedia%2f16922%2fIAPT-Month-Metadata%2fxls%2fIAPT-month-metadata.xlsx)
* [http://www.hscic.gov.uk/media/18182/IAPT-Reporting-FAQs/pdf/Understanding\_and\_replicating\_our\_published\_reports\_-July\_2015\_\_\_v1.2.pdf](https://web.nhs.net/OWA/redir.aspx?SURL=ty5Vmb86bMEMgfwR5OuOEPMF822UF95s7qRxiOwVzfykdv2ZnDPTCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBoAHMAYwBpAGMALgBnAG8AdgAuAHUAawAvAG0AZQBkAGkAYQAvADEAOAAxADgAMgAvAEkAQQBQAFQALQBSAGUAcABvAHIAdABpAG4AZwAtAEYAQQBRAHMALwBwAGQAZgAvAFUAbgBkAGUAcgBzAHQAYQBuAGQAaQBuAGcAXwBhAG4AZABfAHIAZQBwAGwAaQBjAGEAdABpAG4AZwBfAG8AdQByAF8AcAB1AGIAbABpAHMAaABlAGQAXwByAGUAcABvAHIAdABzAF8ALQBKAHUAbAB5AF8AMgAwADEANQBfAF8AXwB2ADEALgAyAC4AcABkAGYA&URL=http%3a%2f%2fwww.hscic.gov.uk%2fmedia%2f18182%2fIAPT-Reporting-FAQs%2fpdf%2fUnderstanding_and_replicating_our_published_reports_-July_2015___v1.2.pdf)
* <http://fingertips.phe.org.uk/>
* http://www.hscic.gov.uk/article/2021/Website-Search?q=title%3ARoutine+Quarterly+Improving+Access+to+Psychological+Therapies+Data+Set+reports+&area=both&size=10&sort=Most+recent
1. (Carney 2001; Naessens 2005; Schrire 1986). [↑](#footnote-ref-1)
2. Moussavi *et al*, 2007; Patten *et al*, 2008 [↑](#footnote-ref-2)
3. Coventry and colleagues (2011), [↑](#footnote-ref-3)
4. (Olsson & Hansagi 2001). [↑](#footnote-ref-4)
5. Lusignan S et al., 2012). [↑](#footnote-ref-5)
6. (Wilson *et al*, 2005). [↑](#footnote-ref-6)
7. (Moussavi *et al*, 2007; Patten *et al*, 2008). [↑](#footnote-ref-7)
8. McKellar *et al*, 2004). [↑](#footnote-ref-8)
9. **Key reference** Pinquart M, Duberstein PR (2010) Depression and cancer mortality: a meta-analysis. Psychological Medicine 40: 1797–1810 Full text: www.ncbi.nlm.nih.gov/pmc/articles/PMC2935927/pdf/nihms203992.pdf [↑](#footnote-ref-9)
10. (Osborn et al 2007) [↑](#footnote-ref-10)
11. (Lesperance et al 2002). [↑](#footnote-ref-11)
12. (Naylor et al 2012). [↑](#footnote-ref-12)
13. (Welch et al 2009; Melek and Norris 2008). [↑](#footnote-ref-13)
14. (Bermingham *et al* 2010). [↑](#footnote-ref-14)
15. (Singh et al, 2010 and Singh, 2009). [↑](#footnote-ref-15)
16. (Singh, 2008) [↑](#footnote-ref-16)
17. <http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2761> [↑](#footnote-ref-17)
18. Care Quality Commission – Cracks in the Pathway. <http://www.cqc.org.uk/content/cracks-pathway> [↑](#footnote-ref-18)
19. Please refer to the 2014/15 and the 2015/16 Dementia CQUIN guidance - <https://www.england.nhs.uk/nhs-standard-contract/15-16//> Respectively. [↑](#footnote-ref-19)
20. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FirstTreatment6Weeks [↑](#footnote-ref-20)
21. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FirstTreatment18Weeks [↑](#footnote-ref-21)
22. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FirstToSecondTreatmentOver28days [↑](#footnote-ref-22)
23. Quarterly CSV File Field Name:VariableA [↑](#footnote-ref-23)
24. Quarterly CSV File Field Name:VariableA [↑](#footnote-ref-24)
25. Quarterly CSVFile Field Name:Recovery [↑](#footnote-ref-25)
26. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FinishedCourseTreatment [↑](#footnote-ref-26)
27. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FirstTreatment [↑](#footnote-ref-27)
28. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name: SecondTreatment [↑](#footnote-ref-28)
29. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FinishedCourseTreatment [↑](#footnote-ref-29)
30. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:NotCaseness [↑](#footnote-ref-30)
31. Monthly Improving Access to Psychological Therapies (IAPT) Reports Field Name:FinishedCourseTreatment [↑](#footnote-ref-31)