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**Physical Health**

**Local CQUIN Templates 2016/17**

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

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Contents

[21. Frailty Identification and Care Planning 5](#_Toc446331260)

[22. Faecal Incontinence 12](#_Toc446331264)

[23. Urinary Incontinence 16](#_Toc446331267)

[24. Acute Kidney Injury 20](#_Toc446331271)

[25. Cancer 62 Day Waits 31](#_Toc446331275)

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# 21. Frailty Identification and Care Planning

| **Indicator** | |
| --- | --- |
| **Indicator name** | Promote a system of timely identification and proactive management of frailty in community, mental health and acute providers |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | Percentage of people aged 75 and over screened for frailty syndrome on presentation, frailty severity grade recorded, Comprehensive Geriatric Assessment initiated, discharge summaries to GPs and development of care plans where appropriate according to patient’s needs |
| **Numerator** | There are five metrics for this scheme with the numerators defined as:   1. Number of patients aged 75 and above with a frailty syndrome who are screened for frailty on presentation. 2. Number of patients aged 75 and over who screen positive for frailty have severity grade recorded in patient notes 3. Number of people aged 75 and above who screen positive for moderate or severe frailty who have a personalised care and support plan in place 4. Number of people aged 75 and over who screen positive for moderate or severe frailty for whom Comprehensive Geriatric Assessment has been initiated with information on this shared with their GP.   Number of patients aged 75 and above who screen positive for frailty who are provided with planned personalised care plans according to moderately- severity needs |
| **Denominator** | The corresponding denominators are:   1. Number of patients aged 75 and above with a frailty syndrome who are admitted. 2. Number of patients aged 75 and over who screen positive for frailty 3. Number of people aged 75 and above who screen positive for moderate or severe frailty 4. Number of people aged 75 and over who screen positive for moderate or severe frailty   Number of patients aged 75 and above who are screen positive for frailty. |
| **Rationale for inclusion** | Frailty is a frequent condition with an exponential increase with age.[[1]](#footnote-1) From about 10% in the population aged over 60, to 25% or more in those aged 80 and older.[[2]](#footnote-2) Older people living with frailty are the highest users of services across health and social care and have the highest levels of unplanned admissions to hospital. Older people (in this case aged over >85) occupied 7 million emergency bed days in 12/13 (NHS England, 2015) compared to, for example, the population under the age of 40 occupied 1 million emergency bed days in 12/13. Yet we know that between 20% and 30% of hospital admissions in this group could be prevented by proactive case finding, frailty assessment, care planning and use of services outside of hospital (Mytton et al 2012).[[3]](#footnote-3)  The problem we face is that people with frailty are currently either not reliably identified or identified only when advanced frailty has developed. This leads to missed opportunities to mitigate the preventative components of frailty, to instigate proactive care models such as personalised care and support planning, and/or target geriatric resources. |
| **Data source** | A clinical record audit of a representative sample of patients aged 75 and over who had a frailty syndrome (see further guidance).  Existing GP Practice Read Codes are available to ‘flag’ people diagnosed with frailty. This information would contribute to case finding systems and care planning for practice population at risk of unplanned admission. |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Q1 2016/17 |
| **Baseline value** | To be determined by baseline audit |
| **Final indicator period/date (on which payment is based)** | Q4 2016/17 |
| **Final indicator value (payment threshold)** | The final indicator values for payment are to be agreed locally, and will represent an achievable but stretching level of improvement from the baseline to what should be 95% or above achievement of each of the indicators. |
| **Final indicator reporting date** | To be agreed locally |
| **Are there rules for any agreed in-year milestones that result in payment?** | To be agreed locally |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | To be agreed locally |
| **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

Broadly there are 5 frailty syndromes and encountering one of these should raise suspicion that the individual concerned has frailty. However, it is possible to have any of these problems without frailty and sometimes there can be a very straightforward explanation for the problem.

1. Falls (e.g. collapse, legs gave way, ‘found lying on floor’).
2. Immobility (e.g. sudden change in mobility, ‘gone off legs’ ‘stuck in toilet’).
3. Delirium (e.g. acute confusion, ’muddledness’, sudden worsening of confusion in someone with previous dementia or known memory loss).
4. Incontinence (e.g. change in continence – new onset or worsening of urine or faecal incontinence).
5. Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants).

More information on recognising frailty can be found on the British Geriatric Society’s website: http://www.bgs.org.uk/index.php/recognise-frailty-syndrome

Read codes for frailty

CTV3 (e.g. SystmOne)

* XaRB3 - Personal care plan offered
* XaRDz - Offer of personal care plan accepted

Byte (e.g. EMIS,VISION)

* 9NS5. - Personal care plan offered
* 8CMF. -Offer of personal care plan accepted

Frailty read codes

* CTV3
* X76Ao | Frailty
* XabdY | Mild frailty
* Xabdb | Moderate frailty
* Xabdd | Severe frailty

Read V2

* 2Jd. | Frailty
* 2Jd0. | Mild frailty
* 2Jd1. | Moderate frailty
* 2Jd2. | Severe frailty

SNOMED CT concepts for frailty:

* All linked to the concept 248279007 | Frailty (finding):
* 925791000000100 | Mild frailty (finding)
* 925831000000107 | Moderate frailty (finding)
* 925861000000102 | Severe frailty (finding)

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# 22. Faecal Incontinence

| **Indicator** | |
| --- | --- |
| **Indicator name** | Improving faecal incontinence care by identifying contributing factors of faecal incontinence with baseline assessment and providing initial management plan |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | Percentage of hospital inpatients identified with faecal incontinence who have baseline assessment, offered advice, support and choice of products to help deal with bowel control problems and have an initial management plan |
| **Numerator** | There are three parts to this scheme:   1. Number of patients with faecal incontinence who have baseline assessment which includes medical history, physical examination (including anorectal examination) and medication review and questions about diet and how the bowel problems affect their day-to-day life. 2. Number of patients with faecal incontinence who are offered advice, support and a choice of products (such as pads, plugs, skincare products and disposable gloves) to help them deal with bowel control problems   Number of patients with faecal incontinence who have an initial management plan that covers any specific conditions causing the incontinence, and diet, bowel habit, toilet access and medication. Interventions may include addressing specific conditions causing the incontinence and addressing diet, bowel habit, toilet access and medication needs |
| **Denominator** | The denominator is the same for all three parts and is defined as:  Number of hospital inpatients, who report or who are identified as having faecal incontinence. |
| **Rationale for inclusion** | Faecal incontinence may have different underlying causes and contributing factors. There is a risk that healthcare professionals could make assumptions that faecal incontinence is related to a pre-existing condition or disability (such as a neurological condition or cognitive impairment) without carrying out a full assessment. Faecal incontinence may have different contributing factors in people with the same long-term condition. A baseline assessment that takes account of the individual person, rather than assuming incontinence is related to a pre-existing condition, is therefore essential. Correct identification of contributing factors will promote better access to care and ensure that appropriate management can be planned and lead to the biggest improvements in quality of life for people with faecal incontinence. |
| **Data source** | Locally developed audit of a suitable set of notes from a representative sample. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Q1 2016/17 |
| **Baseline value** | To be determined from baseline audit |
| **Final indicator period/date (on which payment is based)** | End 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?** | To be agreed locally |
| **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:

NICE CG 49: Faecal incontinence in adults: management

<http://www.nice.org.uk/guidance/cg49>

# 23. Urinary Incontinence

| **Indicator** | |
| --- | --- |
| **Indicator name** | Urinary Incontinence |
| **Indicator weighting  (% of CQUIN scheme available)** | Increased assessment, treatment and management for inpatients aged 75 and over with urinary incontinence. |
| **Description of indicator** | To be agreed locally |
| **Numerator** | There are four parts to this scheme:   1. Percentage of patients 75 and over who screened positive for urinary incontinence who had a continence assessment that included: (i) urine test to exclude infection; (ii) fluid intake and output chart (iii) post void bladder scan 2. Percentage of patients 75 and over who screened positive for urinary incontinence who receive ongoing treatment related to urinary incontinence 3. Percentage of patients 75 and over who screened positive for urinary incontinence who have incontinence associated dermatitis.   Percentage of patients 75 and over who screened positive for urinary incontinence who have continence assessment, treatment and referral plan shared with patient and carer where relevant |
| **Denominator** | The numerators for the four parts of the scheme are defined as:   1. Number of patients aged 75 and over who screened positive for urinary incontinence who had a continence assessment that included: (i) urine test to exclude infection; (ii) fluid intake and output chart (iii) post void bladder scan 2. Number of patients aged 75 and over who screened positive for urinary incontinence who receive ongoing treatment related to urinary incontinence 3. Number of patients aged 75 and over who screened positive for urinary incontinence who have incontinence associated dermatitis.   Number of patients aged 75 and over who screened positive for urinary incontinence who have continence assessment, treatment and referral plan shared with patient and carer where relevant |
| **Rationale for inclusion** | The denominator is the same for all four parts of the scheme and is defined as:  Number of patients aged 75 and over who screened positive for urinary incontinence  The screening question should be: Do you have problems with getting to the toilet?” |
| **Data source** | It is estimated that urinary incontinence affects 1 in 3 women aged 18+ and lower urinary tract symptoms (LUTS) affects 2.7% of men aged 18 and over and 35% of men over 60 years old . Despite continence problems being relatively common, people are often embarrassed and reluctant to discuss their incontinence and therefore detection in the community can be difficult. However, 80% of continence problems are treatable and the low cost of conservative treatments is offset by the reduced need for containment products, surgery and social care.  Designated continence leads should be identified to ensure accountability for CQUIN delivery. The purpose of this CQUIN is to improve continence care across the acute and community boundaries (especially important for at risk patients such as those with dementia) and the designated leads will use the data to optimise integrated care. |
| **Frequency of data collection** | Locally developed audit of a suitable set of notes from a representative sample. |
| **Organisation responsible for data collection** | Monthly |
| **Frequency of reporting to commissioner** | Provider |
| **Baseline period/date** | Quarterly |
| **Baseline value** | Q1 2016-17 |
| **Final indicator period/date (on which payment is based)** | To be determined from baseline audit. |
| **Final indicator value (payment threshold)** | Q4 2016/17 |
| **Final indicator reporting date** | To be agreed locally that represents a stretching but achievable rate of improvement from baseline. |
| **Are there rules for any agreed in-year milestones that result in payment?** | To be agreed locally |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | To be agreed locally |
| **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)** |
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| 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**

# 24. Acute Kidney Injury

| **Indicator** | |
| --- | --- |
| **Indicator name** | Improving AKI diagnosis and treatment in hospital and care planning to monitor kidney function after discharge |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below.  This CQUIN is relevant to acute hospital providers who accept emergency admissions; whilst AKI is also a clinical concern in some specialist hospital providers, the volume of cases may not provide a sufficient sample size for this CQUIN. |
| **Numerator** | Count of completed key items found in the discharge summaries of patients with AKI detected through the pathology laboratory information management system (LIMS), and who have survived to discharge, using calendar month of discharge for each monthly sample.  Requirements in discharge summary are:  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)  Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100. |
| **Denominator** | Total number of discharge items which is calculated by multiplying the number of patients in the sample by 4. For sample size of 25 patients the denominator will total 100. |
| **Rationale for inclusion** | AKI has 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, in partnership with stakeholder organisations including the UK Renal Registry.  To improve outcomes from AKI requires a systematic approach. This has been led by the Think Kidneys programme and requires work to improve risk assessment for AKI, provide timely recognition of AKI, to ensure reliable treatment and to enhance recovery.  This CQUIN is designed to improve the recovery of individuals with AKI and to ensure appropriate follow up to minimise short and long term consequences.  The impact of the CQUIN is designed to ensure secondary care teams communicate information about AKI to primary care and mutually determine a follow up plan to evaluate kidney function and re-establish medication for other long term conditions. Coding of episodes of AKI in GP records will improve risk assessment in the community and the more reliable follow up of individuals following AKI will reduce readmission rates and allow better management of CKD. It is increasing recognised that CKD and AKI are interlinked conditions, resulting in harm through end stage renal failure, premature cardiovascular death and increased risk of death if AKI complicates illness. |
| **Data source** | Provider audit discharge summaries from patients identified by the laboratory as having AKI on current admission (using the national algorithm as defined in NHS England Patient Safety Alert ‘Standardising the early detection of AKI’ http://www.england.nhs.uk/2014/06/09/psa-aki/ ) and who have survived to discharge.  Data source = discharge summary for episode of care.  Audit to be undertaken by clinical staff.  Recommended size of audit is 25 patients. Where 25 or fewer patient records meet these criteria, all the relevant records should be reviewed. If more than 25 patient records meet these criteria, a random sample [see Note A] of 25 sets of patient records should be reviewed. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly. The quarterly score is produced by averaging the three monthly scores i.e. sum the numerator data across the 3 months and then divide by the sum of the denominator data for the 3 months of the quarter. |
| **Baseline period/date** | As this is the second year of the CQUIN there will not be a baseline period and standard thresholds apply. |
| **Baseline value** | Moving into the second year the total amount of funding available for the CQUIN should be divided equally across the four quarters i.e 25% of funding available for each quarter. |
| **Final indicator period/date (on which payment is based)** | Each quarter of 2016/17 |
| **Final indicator value (payment threshold)** | See partial payment section  Reporting dates are 30 days after the end of each quarter. |
| **Final indicator reporting date** | 30 days after the end of Q4 |
| **Are there rules for any agreed in-year milestones that result in payment?** | No |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes |
| **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** |
| --- | --- |
| 49.9% or less of required key items included in discharge summaries | No payment |
| 50.0% to 69.9% of required key items included in discharge summaries | 20% of whole AKI CQUIN value for the quarter |
| 70.0% to 79.9% of required key items included in discharge summaries | 40% of whole AKI CQUIN value for the quarter |
| 80.0% to 89.9% of required key items included in discharge summaries | 70% of whole AKI CQUIN value for the quarter |
| 90.0% or above of required key items included in discharge summaries | 100% of whole AKI CQUIN value for the quarter |

## Supporting Guidance and References

**Draft format for local data collection**

|  | Tick column below if **stage of AKI** is recorded in discharge letter | Tick column below if information on **medicines review** having been undertaken is recorded in discharge letter | Tick column below if **type of blood tests** required on discharge for monitoring are recorded in discharge letter | Tick column below if **frequency of blood tests** required on discharge for monitoring are recorded in discharge letter |
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| **Totals** | **Column A total** | **Column B total** | **Column C total** | **Column D total** |
| **CQuin calculation**  Column A+ B + C +D totals = numerator total  Number of records reviewed x 4 = denominator total  Percentage) CQuIN achievement = numerator ÷ denominator x 100 | | | | |

Guidance notes for data collection.

Column A Stage of AKI

The discharge summary should include a statement that provides

AKI stage (1, 2 or 3) as defined by the national definition (see LINK TO SAFETY ALERT) plus the date on which this recorded and the primary cause

e.g. AKI Stage 3 15th December 2012 Bladder outflow obstruction

The highest recorded stage during an inpatient episode should be recorded. A point should be awarded for completion of all elements, so AKI Stage x on its own is not sufficient.

Column B Medication review

For all medications that have been discontinued during an episode of AKI there should be clear documentation as to whether the medications were stopped due to AKI and also whether it can be restarted.

e.g. RAMIPRIL 10 mg discontinued due to AKI . Can be restarted after clinical review

or OMEPRAZOLE 20 mg discontinued due to AKI. Not to be restarted (see summary)

The dialogue is free text but should give a clear indication when and how the medication can be resumed. The latter case for example points to a situation where the drug has directly caused renal inflammation (TIN) and therefore should never be restarted. Simply stating that a medication has been discontinued without a reason or without a statement about potential restarting would not score a point.

e.g. SPIRONLACTONE 50 mg discontinued

Column C Follow up blood tests and Column D frequency

For column C and D there should be a clear statement detailing the type of blood tests to be requested and when they should be requested. This may be contained within the clinical summary text. It should also be clear who is to perform the request.

For example, points would be awarded for

U&Es and FBC should be rechecked on [date] and weekly thereafter until review in the Nephrology clinic in 4 weeks. We would be grateful it the GP practice could arrange the tests and contact us on xxxxx-788249 if there are concerns.

Or

Biochemistry checks will be organised 1 week prior to the OPA 24/1/2015 by the hospital. The patient has the necessary forms.

No points would be awarded for C for ‘Please check bloods’ or for an absence of any guidance about timing for D.

Background information

Acute Kidney Injury (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) vulnerable individuals such as the elderly or those with chronic conditions (heart failure, diabetes, chronic kidney disease (CKD) may sustain AKI and complicate their primary health issue. 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].

Whilst many recover the individual’s recovery may be incomplete and there is increasing recognition that incomplete recovery may be prolonged and of high impact. AKI can exacerbate the impact of 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]. To improve outcomes needs action to improve risk assessment, improve diagnosis and detection, ensure reliable treatment and enhance recovery.

AKI has therefore been identified as a major patient safety priority by national and international organisations. For example, NHS England have commenced a national AKI Programme in partnership with the UK Renal Registry within the Patient Safety domain [5]. Guidance has been issued by the National Institute for Health and Care Excellence (NICE) and the UK Renal Association [6,7]. The International Society of Nephrology has launched the ‘0-by-25’ campaign to eliminate avoidable death related to AKI [8]. Avoiding harm related to AKI is one of the 16 key priorities in the public and professional authored ‘Kidney Health, Delivering Excellence Report’ [9].

The pathway of Risk-Detection-Treatment-Recovery for AKI is being addressed by several schemes across the NHS in England. Southern Derbyshire CCG are testing a Risk Tool in conjunction with the acute Trust. 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.

The purpose of this CQUIN is to improve the follow up and recovery for individuals who have sustained AKI. In particular, it will address follow up needs, medication reconciliation and reduce the risks of readmission. Readmission rates following AKI are high and may be triggered by the consequences of AKI itself, such as CKD or CVD events or due to an underlying long condition being destabilised by medication changes [10]. Longer term improved follow up of episodes of AKI can reduce the impact increased cardiovascular risk in the long term, probably mediated by chronic kidney disease [11]

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# 25. Cancer 62 Day Waits

**Note on CQUIN indicator**

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| CQUIN 25a | Urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic) | 80% |  |
| CQUIN 25b | Review of long waiters (>104 days) | 20% |  |

**25a. Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment within 62 Days**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Urgent GP (GMP,GDP or Optometrist) referral for suspected cancer to first treatment within 62 days |
| **Indicator weighting  (% of CQUIN scheme available)** | 80% |
| **Description of indicator** | The proportion of patients receiving first definitive treatment within 62 days of an urgent GP referral for suspected cancer. |
| **Numerator** | Number of patients receiving first definitive treatment for cancer within 62-days following  an urgent GP referral for suspected cancer within a given period, for all  cancers (ICD-10 C00 to C97 and D05) |
| **Denominator** | Total number of patients receiving first definitive treatment for cancer following an urgent  GP (GDP or GMP) referral for suspected cancer within a given period, for all cancers  (ICD-10 C00 to C97 and D05) |
| **Rationale for inclusion** | Ensuring efficient investigation, diagnosis and treatment of cancer is essential to ensuring a positive patient experience and improving cancer outcomes.  The 62 day pathway encompasses the entire patient journey from initial referral by a GP to beginning treatment. It is therefore the most comprehensive of the cancer waiting times standards, and is generally considered the headline indicator of performance on cancer waits.  A revised breach allocation policy will be published by the end of March. Local implementation of this policy should be undertaken as soon as possible, and by October 2016 at the latest, to ensure CQUIN payments accurately reflect provider performance.  Performance on the 62 day standard has not been achieved in a sustainable way. By targeting 62 day cancer waits through the CQUIN scheme we aim to stimulate local focus on delivering this constitutional commitment in a sustainable way during the next year. |
| **Data source** | HSCIC CWT system |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Local Providers who submit to Open Exeter |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Year 2016/17 |
| **Final indicator value (payment threshold)** | 85% in each quarter |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | CWT data report shows that at least 85% of patients referred to a provider received their first definitive treatment within 62 days of an urgent GP referral. |
| **Final indicator reporting date** | As soon as possible after Q4 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – payment is to be based on performance in each quarter |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No. The threshold needs to be met in each period to earn the CQUIN proportion available for that period. |
| **EXIT Route** | To be determined locally |

**25b. Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Root-cause analysis on all long waiters and a clinical harm review for a positive diagnosis |
| **Indicator weighting  (% of CQUIN scheme available)** | 20% |
| **Description of indicator** | To demonstrate appropriate management and review of long wait cases on the 62-day urgent GP referral to first treatment pathway, in line with the NHS England backstop policy ([see below for further information](#_Supporting_Guidance_and)).   1. Proportion of patients waiting longer than 104 days whose cases have received a root-cause analysis 2. Proportion of patients waiting longer than 104 days whose cases received a root-cause analysis and a confirmed cancer diagnosis who had a clinical harm review. |
| **Numerator** | 1. Number of patients waiting longer than 104 days whose cases have received a root-cause analysis 2. Number of patients waiting longer than 104 days whose cases have received a root-cause analysis and a clinical harm review where there is a confirmed cancer diagnosis. |
| **Denominator** | 1. Total number of patients waiting longer than 104 days from urgent GP referral to definitive treatment. 2. Total number of patients waiting longer than 104 days from urgent GP referral to first definitive treatment where there is a confirmed cancer diagnosis |
| **Rationale for inclusion** | Ensuring efficient investigation, diagnosis and treatment of cancer is essential to ensuring a positive patient experience and improving cancer outcomes.  Roughly 5% of patients wait longer than 104 days from urgent GP referral to first definitive treatment.  Such a lengthy delay to treatment could give time for cancer to significantly progress, increasing the probability of a poor patient outcome.  Whilst there may be legitimate reasons for some of these waits, such a long delay should be expected to trigger a review process, so that providers can understand the causes of these long waits and put in place processes to avoid them in future.  A revised breach allocation policy will be published by the end of March. Local implementation of this policy should be undertaken as soon as possible, and by October 2016 at the latest, to ensure CQUIN payments accurately reflect provider performance. |
| **Data source** | HSCIC CWT system and local data collection |
| **Frequency of data collection** | Quarterly |
| **Organisation responsible for data collection** | Providers |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Performance is assessed quarterly |
| **Final indicator value (payment threshold)** | 100% in each quarter |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Quarterly report shows that 100% of long-wait cases received a root-cause analysis and a clinical harm review where a confirmed cancer diagnosis was made. Evidence that a root-cause analysis or clinical harm review is under way can be considered by commissioners in recognition that these analyses can be time consuming.  Evidence that reviews have taken place should be submitted to the commissioner for review. This should comprise a summary of review findings or progress towards completion of reviews under way. |
| **Final indicator reporting date** | As soon as possible after Q4 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – payment is to be based on performance in each quarter |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No. The threshold needs to be met in each quarter to earn the CQUIN proportion available for that quarter. |
| **EXIT Route** | To be determined locally |

**Rules for in-year payment**

## Payment rules for part a and b

| **Period to which payment relates** | **% of CQUIN scheme available for achieving threshold in each period** |
| --- | --- |
| Q1 | 25% |
| Q2 | 25% |
| Q3 | 25% |
| Q4 | 25% |
| Total | 100% |

**Supporting Guidance and References**

* Further information on Cancer Waiting Times can be found here: <https://www.england.nhs.uk/statistics/category/statistics/provider-waiting-cancer/>
* The ‘backstop policy’ on managing long waiters can be found here: <https://www.england.nhs.uk/wp-content/uploads/2015/11/managing-long-waiting-cancer-patients.pdf>

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