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**Urgent and Emergency Care**

**Local CQUIN Templates 2016/17**

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**Urgent and Emergency Care: Local CQUIN Templates 2016/17**

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# 28. NHS 111 referrals

| **Indicator** | |
| --- | --- |
| **Indicator name** | Reducing inappropriate NHS 111 referrals to 999 and A&E |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are three parts to this scheme:   1. The percentage of NHS 111 calls triaged that end with an inappropriate 999 referral; 2. The percentage of dispositions to A&E where type of A&E is captured   The percentage of NHS 111 calls triaged that end in a type 1 or 2 A&E disposition. |
| **Numerator** | Inappropriate 999 referrals  Number of 111 calls triaged that end with a 999 referral  Type of A&E  Number of dispositions to A&E where type of A&E is captured (where type is 1, 2, 3 or 4).  Type 1 or 2 A&E disposition  Number of 111 calls triaged that end in a type 1 or 2 A&E disposition |
| **Denominator** | Inappropriate 999 referrals  Number of 111 calls triaged  Type of A&E  Number of dispositions to A&E  Type 1 or 2 A&E disposition  Number of 111 calls triaged |
| **Rationale for inclusion** | The strategic direction as set out in the Five Year Forward View, and the Urgent and Emergency Care Review, is that UEC services are configured with the aim of managing patients with urgent care needs closer to home rather than in a hospital (A&E or inpatient) setting.  This CQUIN scheme will help realise that strategic aim for patients triaged through NHS 111, specifically that referrals to 999 and A&E are only made when most appropriate. Two of the three components directly link payment to reductions in such referrals. The third encourages improved data capture of dispositions for service improvement, quality of the Directory of Services (DOS) as well as to inform a basis for payment of the CQUIN.  A reduction in the level of parts 1 and 3 suggest patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time. |
| **Data source** | Inappropriate 999 referrals  NHS 111 Minimum Dataset, NHS England <http://www.england.nhs.uk/statistics/category/statistics/nhs-111-statistics/>  Type of A&E  Data source will need to be developed locally as the disposition categories in the NHS 111 dataset don’t identify the type of A&E.  Type 1 or 2 A&E disposition  Data source will need to be developed locally as the disposition categories in the NHS 111 dataset don’t identify the type of A&E. The denominator can be sourced from the NHS 111 Minimum Dataset |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | 111 Providers |
| **Frequency of reporting to commissioner** | To be agreed locally |
| **Baseline period/date** | 2015/16 |
| **Baseline value** | To be agreed locally using nationally available data. |
| **Final indicator period/date (on which payment is based)** | 2016/17 |
| **Final indicator value (payment threshold)** | To be agreed locally for each of the three parts. |
| **Final indicator reporting date** | May 2017 |
| **Are there rules for any agreed in-year milestones that result in payment?** | While these should be agreed locally, it is suggested that establishment of the data source for parts 2 and 3 is rewarded in-year. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | To be completed 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

* Any changes to the use of 111 services locally, for example its use as a gateway to access GP out of hours, may change the proportion of ambulance and ED dispositions. Any such changes should be taken into account when setting local levels of improvement.
* It is essential that patients continue to be referred to whichever urgent and emergency care service is identified as being most clinically appropriate to their needs. Local audits of 111 call outcomes and clinical review of adverse events should be considered to ensure that patients are being referred appropriately.

There is greater use of urgent and emergency care services on bank holidays compared to other days. There are two Easter weekends in 2015-16 but only one in 2016/17. Local areas may need to take this into account.

# 29. Mental health patients re-attendance in A&E

| **Indicator** | |
| --- | --- |
| **Indicator name** | Improving the coding of diagnoses and re-attendance rates of patients with mental health needs at A&E |
| **Indicator weighting  (% of CQUIN scheme available)** | To be agreed locally |
| **Description of indicator** | There are two parts to this scheme, with part 2 dependent on part 1 being satisfactorily achieved:   1. Percentage of records of A&E attendances within the last month with a valid diagnosis code 2. The rate of re-attendances at A&E within 7 days following attendance, where the diagnosis identified is mental health-related |
| **Numerator** | Part 1 – Diagnosis recording  Number of records with a valid diagnosis code (either A&E 2 digit diagnosis code or 3 digit ICD-10 code - for this purpose, codes 38 “Diagnosis not classifiable” and R69 “Unknown and unspecified causes of morbidity” will be classed as invalid.)  Part 2 – Rate of re-attendances  The number of times a re-attendance occurred (for any reason at any A&E) within 7 days following attendances specified in the denominator. See separate technical specification below. |
| **Denominator** | Part 1 – Diagnosis recording  All records of A&E attendances within the last month  Part 2 – Rate of re-attendances  Number of attendances at A&E where the diagnosis identified is MH. Commissioners should determine locally what codes to use to define MH depending on local data quality and recording but should include psychosis and adult poisoning as a minimum. See technical specification below. |
| **Rationale for inclusion** | Despite provision put in place to support the level of need, it is clear that A&E services act as a substitute for more appropriate settings for many people with mental ill health who are not well engaged with mental health services or GPs. This indicator has been developed to incentivise better data recording, improved relapse prevention and crisis care plans for those already known to services, and improved care pathways across providers - including timely communication between acute trusts and mental health providers.  Acute Trusts will need to improve diagnosis recording in the A&E HES data set, so that there is a valid diagnosis code for at least 85% of records, including for mental health and alcohol related reasons for attendance.  Once recording has improved providers (acute trusts and mental health trusts) should collaborate to reduce the rate of re-attendances to A&E within 7 days following an attendance at A&E related to an acute mental health condition. |
| **Data source** | Hospital Episodes Statistics |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Acute trust |
| **Frequency of reporting to commissioner** | To be agreed locally |
| **Baseline period/date** | Part 1 – baseline period is 2015/16  Part 2 – to be agreed locally depending on when part 1 is met. The baseline period will need to include at least 500 MH A&E attendances (see note below) and therefore is likely to cover at least one quarter. |
| **Baseline value** | To be agreed locally using nationally available data for both parts of the scheme. |
| **Final indicator period/date (on which payment is based)** | Part 1 - the data completeness specified should be met for at least one month’s data before the payment is made, and the level of completeness should be maintained throughout 2016-17. |
| **Final indicator value (payment threshold)** | To be agreed locally, including the split between parts one and two. |
| **Final indicator reporting date** | May 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?** | While these should be agreed locally, it is suggested that for part 1 at least 85% of records should have a valid diagnosis code. |
| **EXIT Route** | While these should be agreed locally, it is suggested that for part 1 at least 85% of records should have a valid diagnosis code. |

## 

## 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

Providers with less than 500 MH A&E attendances in the baseline period should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 500 MH A&E attendances.

The reason for including this criterion is that where the number of MH A&E attendances is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.

Technical specification

Part 1: For the data quality component, the first 2 and 3 digits of the raw DIAG\_01 field in HES will be matched against a list of valid 2 character A&E diagnosis codes and valid ICD-10 codes.

Part 2 : For the re-attendance component, all patients with an A&E 2 character diagnosis of 14 or 35 or with an ICD-10 diagnosis in the range F00-F99, G30, T36-T51 or X40-X49 should be included within the denominator. The numerator is then the number of these patients who re-attend ANY A&E for ANY reason within 7 days (inclusive) of the attendance in the denominator.

# 30. 999 calls resulting in transportation to A&E

| **Indicator** | |
| --- | --- |
| **Indicator name** | A reduction in the rate per 100,000 population of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E Department. |
| **Indicator weighting  (% of CQUIN scheme available)** |  |
| **Description of indicator** | Rate of ambulance transportations to type 1 and type 2 A&E per 100,000 population. |
| **Numerator** | Number of ambulance interventions that end in transportation to type 1 or type 2 A&E. |
| **Denominator** | Resident population / 100,000 |
| **Rationale for inclusion** | The first stage report of Professor Sir Bruce Keogh’s review of Urgent and Emergency Care (the “Review”) described the untapped potential of English ambulance services, and the need to expedite the ongoing transformation of these services from a transport to a treatment role. As a result of these changes the ambulance service will become a community-based provider of mobile urgent and emergency healthcare, fully integrated within Urgent and Emergency Care Networks. This indicator incentivises managing care closer to home and a reduction in the rate of ambulance 999 calls that result in conveyance to A&E. At present the majority of patients who dial 999 are attended by an ambulance clinician. Many of these are then transported to an A&E Department despite the fact that this may not be the best place to meet the patient’s needs.  It is proposed that a number of pathways are used as an alternative to the current default conveyance to Accident and Emergency (A&E). Commissioners should utilise Urgent Care Centres, staffed by a multi-disciplinary team, and ensure that these accept patients conveyed to them by ambulance under agreed protocols and care pathways: other alternative care pathways are described later in the document. Other pathways are an alternative to conveyance of any kind, for selected patients contacting the 999 service: these include “hear and treat” and “see and treat”.  A reduction in the level of this indicator suggests patients with emergency care needs are treated in the right place, with the right facilities and expertise, at the right time.  The introduction of enhanced training and protocols for ambulance clinicians, better data sharing across the system, improved clinical support and advice to the ambulance service from a range of healthcare professionals in clinical hubs and/or the provision of alternative care pathways would all be expected to have a positive impact on this indicator. |
| **Data source** | **Numerator:**  “All emergency calls that receive a face-to-face response from the ambulance service”  minus  “Patients discharged, after treatment at the scene or onward referral to an alternative care pathway, and those with a patient journey to a destination other than Type 1 or 2 A&E”.  Ambulance Quality Indicators, NHS England www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators  ***Denominator:***  Population estimates for Ambulance trusts will be made available by NHS England by the end of January, based upon Office for National Statistics estimates. In the meantime Ambulance trusts can use locally available estimates. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Ambulance Trusts |
| **Frequency of reporting to commissioner** | To be agreed locally |
| **Baseline period/date** | 2015-16 |
| **Baseline value** | To be agreed locally using nationally available data. |
| **Final indicator period/date (on which payment is based)** | 2016-17 |
| **Final indicator value (payment threshold)** | The final indicator value needs to be calculated locally based on the methodology set out below.   * Project the number of calls to 999 assuming a linear trend using historic data and population estimates from Office for National Statistics (ONS)\* * Project the proportion of calls that will result in conveyances based on moving from the current baseline to the projected target for 2020/21 (The level of the target is still to be agreed and will be made known but we are currently working with a figure of 40%). * Convert the percentage of calls that will result in conveyances projected for 2016-17 into the number of conveyances using the projected number of calls and calculate the CQUIN indicator which is the number of conveyances per 100,000 population. This is the target value for the 2016-17 CQUIN.   \* Population projections available in the CQUIN Indicators spreadsheet  Using the above methodology at a National level with a target of 40% of calls resulting in conveyances by 2020/21 implies, on average, all local areas reducing their rate of conveyances to Type 1 and Type 2 ED by around 5% in 2016/17.  Further information about the basis for this approach can be found at the end of the template.  In areas where the ambition is already met a target of performance in 2016/17 should be set locally. |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | To be agreed locally |
| **Final indicator reporting date** | April 2017 |
| **Are there rules for any agreed in-year milestones that result in payment?** |  |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes see section on partial payment rules |
| **EXIT Route** | To be determined 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 | No payment |
| 50.0% to 69.9% | 25% payment |
| 70.0% to 79.9% | 50% payment |
| 80.0% to 89.9% | 75% payment |
| 90.0% or above | 100% payment |

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## Supporting Guidance and References

**Issues to be considered locally**

* Any changes to the availability of services locally, for example a new UCC being available, may change the rate of transportation to type 1 and type 2 A&E. Any such changes should be taken into account when setting levels of improvement.
* It is essential that patients continue to be conveyed or referred to whichever emergency care setting is deemed most clinically appropriate, including type 1 and type 2 A&E departments where these are best suited to the patient’s needs. Local audits of non-transported patients and clinical review of adverse events should be considered to ensure that patients are being treated or transported appropriately.
* There is greater use of urgent and emergency care services on bank holidays compared to other days. Local areas may need to take this into account.

**Interventions and evidence base**

It is clear that the intention is that inappropriate conveyances to ED should be minimised. This in general means that the lower the measure the better, However it is essential that patients continue to be conveyed or referred to whichever emergency care setting is deemed most clinically appropriate, including type 1 and type 2 A&E departments where these are best suited to the patient’s needs.

NHS England has developed [clinical models for ambulance services](http://www.nhs.uk/NHSEngland/keogh-review/Documents/UECR-ambulance-guidance-FV.PDF) which focus on increasing hear and treat and see and treat, in addition to guidance on improving referral pathways, which are available [here.](http://www.nhs.uk/NHSEngland/keogh-review/Documents/improving-referral-pathways-v1-FINAL.PDF) To enable this, the following should be considered by commissioners and Urgent and Emergency Care Networks:

* Access to an urgent care clinical advice hub (further information available in [Commissioning Standards for Integrated Urgent Care](https://www.england.nhs.uk/wp-content/uploads/2015/10/integrtd-urgnt-care-comms-standrds-oct15.pdf).
* Ambulance systems to be able to access the NHS Number. From our recent NHS Number survey, Ambulance Trusts remain the care settings with lowest usage of NHS Number. There is a need for Ambulance systems to be able to retrieve it as an underpinning requirement for wider data sharing.
* Ambulance settings to be able to access Summary Care Record (as a constant option), i.e. as an option that is always available and so can be relied on where local solutions don’t exist or can complement local solutions. Providers and clinicians to have option to use either the SCR and/or alternative detailed record solutions to provide direct patient care. SCR to be available for those patients presenting for care who would not have a detailed care record to view.
* Sharing of discharge summaries across care settings (e.g. acute to community, mental health and not just GP) where these meet the standards set by the Academy of Royal Colleges.
* Use of electronic means for sharing transfers of care (such as discharge, care plans) between care settings.
* Implementation of electronic discharge summaries using Interoperability Toolkit (ITK electronic discharge) specifications
* Implementation of existing interoperability standards for sharing clinical correspondence (ITK clinical correspondence specification).
* Access to advice from primary care, and specialist advice from hospital and community based specialists.

* Development of advanced and/or specialist paramedics including mental health triage specialists.
* Commissioning of new care pathways (e.g. elderly falls, alcohol intoxication) to avoid transportation to hospital.
* Increased mental capacity assessments for those at end of life or with long term conditions so that the person has an advance decision plan which gives them the choice to remain at home with family, rather than be brought to hospital.
* Access to special patient notes/care/crisis plans / advance decisions or directives.

**Basis of the methodology for determining the final indicator value**

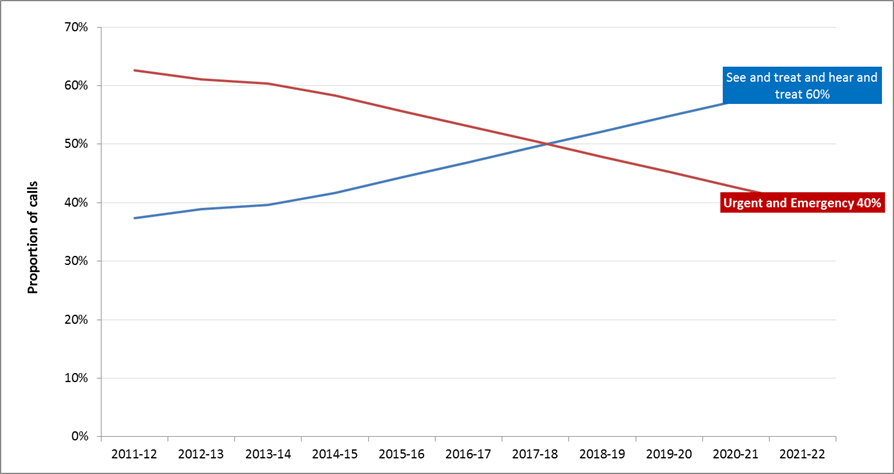
The PEEP modelling report 2015 was developed as part of the Paramedic Education and Training Steering Group’s review of the PEEP Report (2013)[[1]](#footnote-1) recommendations. It provides the direction for development of the profession and develops a plan for ensuring that paramedics can develop the skills required to continue providing high quality care. However further work will be done in the new year to revisit these assumptions, Once agreed these revised assumptions should be used as a basis for setting targets for improvement in 2016/17 at Ambulance Trust level. Set out below is a description of how these revised assumptions will be used to achieve this using the estimate from the PEEP modelling report 2015 for illustration.The PEEP modelling report 2015 set out a future desired activity split, where the urgent and emergency rows below reflect conveyances to ED and future levels are for 2021/22:

|  | **Current % share of activity**6 | **Future desired % share of activity** |
| --- | --- | --- |
| **Hear and treat** | 9 | 20 |
| **See and treat** | 34 | 40 |
| **Urgent** | 17 | 10 |
| **Emergency** | 40 | 30 |

The chart below shows at a national level how we might expect conveyances to ED for urgent and emergency and see and treat and hear and treat to change over time compared to the current position to meet these desired outcomes.

We have assumed the following:

1. The PEEP report assumptions for 2021/22 (currently 40%, 10% for Urgent plus 30% for Emergency) and a linear trajectory towards them
2. Call rate projected from ONS population



1. <https://www.collegeofparamedics.co.uk/downloads/PEEP-Report.pdf> [↑](#footnote-ref-1)