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**National CQUIN Templates 2016/17**

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**National CQUIN Templates 2016/17**

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# NHS Staff health and wellbeing

**Note on CQUIN indicator**

**There are 3 parts to this CQUIN indicator:**

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| CQUIN 1a | Introduction of health and wellbeing initiatives (Two options only one to be selected) | 33.3% of 0.75% (0.25%) |  |
| CQUIN 1b | Healthy food for NHS staff, visitors and patients | 33.3% of 0.75% (0.25%) |  |
| CQUIN 1c | Improving the uptake of flu vaccinations for front line staff within Providers | 33.3% of 0.75% (0.25%) |  |

**1a. Introduction of Health and Wellbeing Initiatives**

| **Indicator** | |
| --- | --- |
| Indicator name | Introduction of health and wellbeing initiatives- **Option A** |
| Indicator weighting  (% of CQUIN scheme available) | 33.3% of 0.75% (0.25%) |
| Description of indicator | Commissioners and Providers should choose between Option A or Option B  Achieving a 5 percentage point improvement in each of the 3 staff survey questions on health and wellbeing, MSK and stress.  Providers will be expected to achieve an improvement of 5% compared to 2015 staff survey results for each of the three questions in the NHS Annual Staff survey outlined below.   1. **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response. 2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response. 3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response. |
| Numerator | NHS staff survey results for the Provider  **Question 9a**: 2016 combined percentage of staff who have answered “yes, definitely” or “yes, to some extent”  **Question 9b:** 2016 percentage of staff who have answered yes  **Question 9c:** 2016 percentage of staff who have answered yes |
| Denominator | NHS staff survey results for the Provider  **Question 9a**: 2015 combined percentage of staff who have answered “yes, definitely” or “yes, to some extent”  **Question 9b:** 2015 percentage of staff who have answered yes  **Question 9c:** 2015 percentage of staff who have answered yes |
| Rationale for inclusion | Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.  The *Five Year Forward View* made a commitment ‘to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy’. This CQUIN builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England’s Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well.  A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged. |
| Data source | The NHS Annual Staff survey.  **Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response.  **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response.  **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response. |
| Frequency of data collection | Annual release of staff survey results |
| Organisation responsible for data collection | National NHS staff survey co-ordination centre |
| Frequency of reporting to commissioner | Publication of 2016 staff survey |
| Baseline period/date | 2015 staff survey data |
| Baseline value | Individual trust performance against each staff survey question |
| Final indicator period/date (on which payment is based) | Quarter 4, 2016/17 |
| Final indicator value (payment threshold) | Achievement of the 5% improvement in staff survey results |
| Final indicator reporting date | Publication of 2016 staff survey – February 2016 |
| Are there rules for any agreed in-year milestones that result in payment? | Yes see milestone requirements below. |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | N/A |

**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 4 | Providers should have achieved the following improvements in staff survey scores based on a baseline of 2015 staff survey results;  **Question 9a**: A 5% increase in “Yes, definitely” and “Yes, to some extent” based on 2015 performance  **Question 9b:** A 5% increase in “No” responses based on 2015 performance  **Question 9c:** A 5% increase in “No” responses based on 2015 performance | March 31 2017 | 100% of the indicator weighting for part 1a |

**Rules for partial achievement**

Partial achievement rules relate to the performance achieved for each question. Only if you have achieved 5% or more for each of the question can you access 100% of the payment for part 1a i.e. 33% of the overall amount available for the CQUIN (0.75%).

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 1% improvement or less | No payment of weighting associated to staff survey results |
| 2% improvement | 25% payment of weighting associated to staff survey results |
| 3% improvement | 50% payment of weighting associated to staff survey results |
| 4% improvement | 75% payment of weighting associated to staff survey results |
| 5% improvement | 100% payment of weighting associated to staff survey results |

**Supporting Guidance and References**

[**https://www.nice.org.uk/guidance/ng13**](https://www.nice.org.uk/guidance/ng13)

Supplementary guidance on the health and wellbeing initiatives will be provided during the next 4-6 weeks.

**1a. Introduction of Health and Wellbeing Initiatives**

| **Indicator** | |
| --- | --- |
| Indicator name | Introduction of health and wellbeing initiatives- **Option B** |
| Indicator weighting  (% of CQUIN scheme available) | 33.3% of 0.75% (0.25%) |
| Description of indicator | Commissioners and Providers should choose between Option A or Option B  The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues.  Providers should develop a plan and ensure the implementation against this plan. This plan will be subject to peer review (further guidance will be issue on the peer review aspect in the next 4-6 weeks). This should cover the following three areas;   1. Introducing a range of **physical activity schemes** for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. 2. Improving **access to physiotherapy services** for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and 3. Introducing a range of **mental health initiatives** for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training; |
| Numerator | N/A |
| Denominator | N/A |
| Rationale for inclusion | Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.  The *Five Year Forward View* made a commitment ‘to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy’. This CQUIN builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England’s Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well.  A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged. |
| Data source | Local implementation plan |
| Frequency of data collection | Quarter 1 – once  Quarter 4 - once |
| Organisation responsible for data collection | Provider |
| Frequency of reporting to commissioner | Quarter 1 – once  Quarter 4 - once |
| Baseline period/date | N/A |
| Baseline value | N/A |
| Final indicator period/date (on which payment is based) | Quarter 4, 2016/17 |
| Final indicator value (payment threshold) | Introducing the agreed initiatives as set out in their plan |
| Final indicator reporting date | Introducing the agreed initiatives as set out in their plan |
| Are there rules for any agreed in-year milestones that result in payment? | Yes see milestone requirements below. |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | N/A |

**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 should have developed a plan to introduce and actively promote the three initiatives that is peer reviewed and signed off. | July 2016 | 20% of the indicator weighting for part 1a |
| Quarter 4 | Providers should have implemented their initiatives (as agreed in their signed off plan) and actively promoted these services to staff to encourage uptake of initiatives. | March 31 2017 | 80% of the indicator weighting for part 1a |

**Supporting Guidance and References**

[**https://www.nice.org.uk/guidance/ng13**](https://www.nice.org.uk/guidance/ng13)

Supplementary guidance on the health and wellbeing initiatives will be provided during the next 4-6 weeks.

**1b. Healthy food for NHS staff, visitors and patients**

|  |  |
| --- | --- |
| **Indicator** | |
| Indicator name | Healthy food for NHS staff, visitors and patients |
| Indicator weighting  (% of CQUIN scheme available) | 33.3% of 0.75% (0.25%) |
| Description of indicator | **Part a**  Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17, including:   1. The banning of price promotionson sugary drinks and foods high in fat, sugar and salt (HFSS)[[1]](#footnote-1). The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets; 2. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); 3. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and 4. Ensuring that healthy options are available at any point including for those staff working night shifts.   CQUIN funds will be paid on delivering the four outcomes above. In many cases providers will be able to achieve these objectives by renegotiating or adjusting existing contracts.  **Part b**  Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink.  The data collected will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs). |
| Numerator | N/A |
| Denominator | N/A |
| Rationale for inclusion | PHE’s report “Sugar reduction – The evidence for action” published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals. |
| Data source | **Quarter 1**  The responses to the proposed questions below will form part of a national data collection. Providers will submit the responses via UNIFY following locally agreed sign off process by the commissioner.   1. Name of franchise holder 2. Name of supplier or vendor(s) 3. Type of sales outlet (restaurant, café, vending, shop/store, trolley service) 4. Start date of existing supplier contract 5. End date of existing supplier contract 6. Remaining length of contract (time to expiration) with external supplier(s) 7. Total contract value 8. Value of contract for the financial year 2015/16 9. Profit share agreements that are in addition to the contract value (percentage of profit that is received by the NHS Provider from the supplier) 10. Free text box: Contract break clauses 11. Volume of Sugar Sweetened Beverages sold   **Quarter 4**   1. Question: Have you changed your food supplier during 2016/17(Yes/ No) If yes who is your new food supplier? |
| Frequency of data collection | End of Quarter 1- once only  End of Quarter 4- once only |
| Organisation responsible for data collection | Provider |
| Frequency of reporting to commissioner | End of Quarter 1  End of Quarter 4 |
| Baseline period/date | Not applicable |
| Baseline value | Not applicable |
| Final indicator period/date (on which payment is based) | Quarter 4, 2016/17 |
| Final indicator value (payment threshold) | To be determined locally |
| 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 see -milestones requirements below. |

**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 | The collection of the 11 data points outlined in **part b.)** and the submission via unify | July 2016 | 20% of the indicator weighting for part b |
| Quarter 4 | To be paid on delivering the four outcomes outlined in **part a.)** | March 31 2017 | 80% of the indicator weighting for part a |

**Rules for partial achievement**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 0 out of 4 changes introduced | No payment |
| 1 out of 4 changes introduced | 25% payment of milestone weighting part a.) |
| 2 out of 4 changes introduced | 50% payment of milestone weighting part a.) |
| 3 out of 4 changes introduced | 75% payment of milestone weighting part a.) |
| All 4 changes introduced | 100% payment of milestone weighting part a.) |

**Supporting Guidance and References**

[*https://www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action*](https://www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action)

**1c. Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff**

| **Indicator** | |
| --- | --- |
| Indicator name | Improving the uptake of flu vaccinations for frontline clinical staff |
| Indicator weighting  (% of CQUIN scheme available) | 33.3% of 0.75% (0.25%) |
| Description of indicator | Achieving an uptake of flu vaccinations by frontline clinical staff of 75% |
| Numerator | Number of front line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by December 31 2016 |
| Denominator | Total number of front line healthcare workers (permanently contracted staff and fixed term contracts) |
| Rationale for inclusion | Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season- a much higher incidence than expected in the general population.  Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.  The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association. |
| Data source | Providers to submit cumulative data monthly over four months on the ImmForm website |
| Frequency of data collection | Monthly |
| Organisation responsible for data collection | Provider |
| Frequency of reporting to commissioner | December 2016 |
| Baseline period/date | N/A |
| Baseline value | N/A |
| Final indicator period/date (on which payment is based) | December 2016 |
| Final indicator value (payment threshold) | A 75% uptake of the flu vaccination |
| 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? | N/A |
| Are there any rules for partial achievement of the indicator at the final indicator period/date? | Yes - see partial payment section |

**Rules for partial achievement**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 64% or less | No payment |
| 65% - 74% uptake of flu vaccinations | 50% payment |
| 75% or above | 100% payment |

**Supporting Guidance and References**

*Practical guidance and support for Providers will be provided by the beginning of March to help support them with the introduction of the initiatives & to help them promote uptake. However, NHS Employers already offer campaign advice for Providers.*

[*http://www.nhsemployers.org/campaigns/flu-fighter/nhs-flu-fighter*](http://www.nhsemployers.org/campaigns/flu-fighter/nhs-flu-fighter)

# Timely identification and treatment of Sepsis

**Note on CQUIN indicator**

**There are 2 parts to this CQUIN indicator:**

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| CQUIN 2a | Timely identification and treatment for sepsis in emergency departments | 50% of 0.25% (0.125%) |  |
| CQUIN 2b | Timely identification and treatment for sepsis in acute inpatient settings | 50% of 0.25% (0.125%) |  |

**2a. Timely identification and treatment for Sepsis in emergency departments**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Timely identification and treatment for sepsis in emergency departments |
| **Indicator weighting  (% of CQUIN scheme available)** | 50% of 0.25% (0.125%) |
| **Description of indicator** | There are two parts to this indicator:   * The percentage of patients who met the criteria for sepsis screening and were screened for sepsis * The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics.   The two indicators apply to adults and child patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. |
| **Numerator** | **Screening**  Total number of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis.  The ED screening element of the CQUIN requires an established local protocol that defines which emergency patients require sepsis screening. Detail on key content of the protocol is outlined below [4.1], but local adaptation will be needed to reflect the types of Early Warning Score in local use for children and adults.  Screening for sepsis must be carried out using an appropriate tool.  **Initiation of treatment and day 3 review**  The number of patients sampled for case note review who:   * + present to ED and other wards/units that directly admit emergencies with Red Flag Sepsis or Septic Shock for whom a decision to treat with intravenous antibiotics is made, and these are administered, both within 1 hour of presenting and;   + an empiric antibiotics review is carried out by a competent decision maker by day 3 of them being prescribed |
| **Denominator** | **Screening**  Total number of patients presenting to emergency departments and other units that directly admit emergencies who were appropriate for screening for Sepsis on the basis of the above-mentioned local protocol.  **Initiation of treatment and day 3 review**  Total number of patients sampled for case note review who, in the view of the reviewer,   * had recorded evidence of Red Flag Sepsis or Septic Shock on presentation at ED and other units that directly admit emergencies, or; * would have had recorded evidence of Red Flag Sepsis or Septic Shock if they had been assessed according to best practice (early warning score and Sepsis screening) and therefore should have been administered intravenous antibiotics within 60 minutes of presentation. |
| **Rationale for inclusion** | Sepsis is a common and potentially life-threatening condition where the body’s immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these some estimates suggest 11,000 could have been prevented.  The Parliamentary and Health Service Ombudsman (PHSO) published Time to Act in 2013 which found that recurring shortcomings in relation to the Sepsis management included:   * failure to recognize the severity of the illness * inadequate first-line treatment with fluids and antibiotics * delays in administering first-line treatment * delay in source control of infection * delay in senior medical input   An avoidable death of a 3 year old, also published by the PHSO in 2014 highlighted the need to improve care and pathways for patients with Sepsis. The Secretary of State announced a number of measures to improve the recognition and treatment of Sepsis in January 2015. The NCEPOD Just Say Sepsis! report also made a number of recommendations about the need for better identification and treatment of Sepsis .  Problems in achieving consistent recognition and rapid treatment of Sepsis are currently thought to drive the number of preventable deaths. It is the failure to recognise the severity of the illness, or to recognise that the illness is Sepsis, until the condition has reached a state of rapid onset and consequential patient deterioration, that plays a significant role in its effects.  This measure is aimed at incentivising systematic screening for Sepsis of appropriate patients in emergency departments (EDs) and in acute inpatient hospital services together with, where Sepsis is identified, timely and appropriate treatment and cessation of treatment. It is not aimed at incentivising sepsis screening for all emergency patients, as there are clinical reasons why screening is unnecessary or misleading in some patient groups. The local protocol (see below) should make clear which patients should be screened.  This CQUIN is relevant to:   1. ED element-acute hospital providers who accept emergency admissions and have one or more Emergency Departments   Inpatient element-providers of acute hospital inpatient services. |
| **Data source** | **Screening**  Provider audit of a random sample of patient records per month drawn from EDs and other units that directly admit emergencies, and where the patient WAS NOT in a ‘minors’ stream of ED, using calendar month of date of admission/attendance for the ED part of the scheme.    The following exclusions should be applied:   1. Discard from sample all patients who do NOT require Sepsis screening according to the locally agreed protocol. Number now remaining in sample becomes denominator. 2. Of the remaining patients who required Sepsis screening, record the proportion who were screened for Sepsis as part of the admission process = counts towards numerator total. 3. All other cases = do not count towards numerator total.   The number of patient records randomly sampled should be sufficient to identify at least 50 patient records per month where use of the screening tool would have been appropriate i.e. to sample a larger number of patient records until at least 50 records are identified where use of the screening tool would have been appropriate. Where use of the tool would have been appropriate for fewer than 50 of the patient records, all the relevant records should be reviewed.  The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions.  **Initiation of treatment and day 3 review**  Provider audit of a random sample of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) and using calendar month of date of discharge or death with the sample drawn from EDs and other units that directly admit emergencies, and where the patient WAS NOT in a ‘minors’ stream of ED, using calendar month of date of admission/attendance.  The following rules should be used:   1. Discard from sample:  * If there is clear evidence Red Flag Sepsis or Septic Shock was NOT present on admission to the provider’s care; * Or if there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile); * Or if an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies.   Number now remaining in sample becomes denominator.   1. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of triage) = counts towards numerator total. 2. All other cases, including those where time of arrival and/or time of antibiotic administration is unclear = does not count towards numerator total.   The number of patient records randomly sampled should be sufficient to identify at least 30 patient records per month with clinical codes indicating sepsis. i.e. to sample a larger number of patient records until at least 30 records are identified with such codes. Where fewer than 30 patient records include such codes, all the relevant records should be reviewed.  Assessment of the CQUIN measure per quarter will be based on the average position from the total number of records assessed from the above process in the relevant quarter.  The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions.  Audit undertaken by consultant staff. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | Q4 2015/16 |
| **Baseline value** | See section on payments |
| **Final indicator period/date (on which payment is based)** | See section on payments |
| **Final indicator value (payment threshold)** | See section on payments below for full information   * Screening – national thresholds have been set for payment based on absolute performance levels. * Treatment and review – payment to be based on locally agreed levels of improvement for each quarter |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Yes – see payment section below |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see payment section below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see payment section below |
| **EXIT Route** | To be determined locally |

**2b. Timely identification and treatment for Sepsis in acute inpatient settings**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Timely identification and treatment for sepsis in acute inpatient settings |
| **Indicator weighting  (% of CQUIN scheme available)** | 50% of 0.25% (0.125%) |
| **Description of indicator** | There are two parts to this indicator:   * The percentage of patients who met the criteria for sepsis screening and were screened for sepsis * The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics.   The two indicators apply to adults and child patients who are acute hospital inpatients |
| **Numerator** | **Screening**  Total number of patients sampled for case note review who were admitted to the provider’s acute inpatient services that met the criteria of the local protocol and were screened for sepsis.  The inpatient screening element of the CQUIN requires an established local protocol that defines which inpatients require sepsis screening. Detail on key content of the protocol is outlined below but local adaptation will be needed to reflect the types of scoring systems in local use for children and for adults.  Screening for sepsis must be carried out using an appropriate tool [4.2]  **Initiation of treatment and day 3 review**  The total number of patients sampled for case note review:   1. where a patient is newly admitted, for whom in the course of their admission a decision to treat with intravenous antibiotics is made by a competent decision-maker, and these are administered, both within 60 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified. 2. where a patient is an existing inpatient, for whom a decision to treat with intravenous antibiotics, or to change the type of antibiotics previously prescribed, is made by a competent decision-maker, and these are administered, both within 90 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified.   AND (for both of the above categories):   * an empiric antibiotics review is carried out by a competent decision maker by day 3 of them being prescribed |
| **Denominator** | **Screening**  Total number of patients admitted to the provider’s acute inpatient services who were appropriate for screening for Sepsis on the basis of the above mentioned local protocol.  **Initiation of treatment and day 3 review**  The total number of patients admitted to acute inpatient services sampled for case note review who, in the view of the reviewer,   * had recorded evidence of Red Flag Sepsis or Septic Shock during their inpatient stay, or; * would have had recorded evidence of Red Flag Sepsis or Septic Shock if they had been assessed according to best practice and therefore should have been administered intravenous antibiotics within 60 minutes of presentation (90 minutes for existing inpatients). |
| **Rationale for inclusion** | As per the rationale described for the Emergency Department part of the CQUIN. |
| **Data source** | **Screening**  Provider audit of a random sample of patient records per month drawn from all inpatient records. The following exclusions should be applied:   1. Discard from sample all patients who do NOT require Sepsis screening according to the locally agreed protocol. Number now remaining in sample becomes denominator. 2. Of the remaining patients who required Sepsis screening, record the proportion who were screened for Sepsis as part of the admission process or in the course of their inpatient stay = counts towards numerator total. 3. All other cases = do not count towards numerator total.   The number of patient records randomly sampled should be sufficient to identify at least 50 patient records per month where use of the screening tool would have been appropriate i.e. to sample a larger number of patient records until at least 50 records are identified where use of the screening tool would have been appropriate. Where use of the tool would have been appropriate for fewer than 50 of the patient records, all the relevant records should be reviewed.  The sampling method used should seek to ensure that a cross-section of appropriate wards are represented in the sample.  The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions.  **Initiation of treatment and day 3 review**  Provider audit of a random sample of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) and using calendar month of date of discharge or death with the sample drawn from all inpatient records.  The following rules should be used:  1. Discard from sample:  • If there is clear evidence Red Flag Sepsis or Septic Shock was NOT present during the inpatient stay;  • Or if there is clear evidence of a decision NOT to actively treat Sepsis recorded in the first hour after the possibility that the patient has Sepsis was identified (e.g. advance directive, treatment futile);  Number now remaining in sample becomes denominator.  2. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ADMISSION= counts towards numerator total.  3. All other cases, including those where time of identification of Sepsis and/or time of antibiotic administration is unclear = does not count towards numerator total.  The number of patient records randomly sampled should be sufficient to identify at least 30 patient records per month with clinical codes indicating sepsis. i.e. to sample a larger number of patient records until at least 30 records are identified with such codes. Where fewer than 30 patient records include such codes, all the relevant records should be reviewed.  Assessment of the CQUIN measure per quarter will be based on the average position from the total number of records assessed from the above process in the relevant quarter.  The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions.  Audit undertaken by consultant staff. |
| **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** | See section on payments |
| **Final indicator period/date (on which payment is based)** | See section on payments |
| **Final indicator value (payment threshold)** | See section on payments for full information   * Screening – payment to be based on establishing the baseline, achieving locally agreed levels of improvement over that baseline for Q2 and Q3, and then achievement of nationally set absolute levels of performance in Q4 * Treatment and review – payment to be based on establishing the baseline, achieving locally agreed levels of improvement over that baseline for Q2 and Q3, and then achievement of nationally set absolute levels of performance in Q4 |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | See section on payments. |
| **Final indicator reporting date** | Q4, 2016/17 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes – see payment section below |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see payment section below |
| **EXIT Route** | To be determined locally |

**Rules for in-year payments**

**Emergency Department Setting**

| **Quarter** | **Screening** | | **Treatment and day 3 review** |
| --- | --- | --- | --- |
| Q1 | Payment based on % of eligible patients (based on local protocol) screened: | | 15% if locally agreed Q1 target achieved. |
| **Less than 50.0%:** | No payment |
| **50.0%-89.9%:** | 5.0% |
| **90.0% or above:** | 10% |
| Q2 | As Q1 | | 15% of if locally agreed Q2 target achieved. |
| Q3 | As Q1 | | 15% if locally agreed Q3 target achieved. |
| Q4 | As Q1 | | 15% if locally agreed Q4 target achieved. |
| **Full year – % of indicator weighting available** | **40% (max)** | | **60% (max)** |

**Acute Inpatient Setting**

| **Quarter** | **Inpatient screening** | | **Inpatient antibiotic administration and day 3 review.** | |
| --- | --- | --- | --- | --- |
| Q1 | 10% if appropriate local Sepsis protocol and screening tool are in use and baseline data collection established. | | 15% if baseline data collection established. | |
| Q2 | 10% if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1. | | 15% if locally agreed Q2 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination. | |
| Q3 | 10% if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination. | | 15% if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination. | |
| Q4 | Payment based on the following thresholds of eligible patients screened: | | Maximum of 15% available based on the following thresholds of eligible patients received antibiotics: | |
| **Less than 50.0%:** | No payment | **Less than 50.0%:** | No payment |
| **50.0%-89.9%:** | 5% | **50.0%-89.9%:** | 5.0% |
| **90.0% or above:** | 10% | **90.0% or above:** | 15% |
| **Full year – % of indicator weighting available** | **40% (max)** | | **60% (max)** | |

**Supporting Guidance and References**

**Key Components of Local Protocols**

Providers should be mindful of the tools to support screening and management of Sepsis at <http://sepsistrust.org/clinical-toolkit>. (This includes tools to support emergency departments, acute medical units, general wards and other settings.) or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at <http://ccforum.com/content/supplementary/cc11895-s2.pdf>.

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

* Screening for selected patients in ‘majors’ streams of emergency departments (for the ED measure) ;
* Exclusion of trauma patients who are likely to have ‘false positives’ in sepsis screening;
* Separate and appropriate protocols for EDs and for inpatients
* Making clear that sepsis screening should be triggered by thresholds in adult and paediatric early warning scores. For example, if NEWS is in use without any local adaptation, sepsis screening would be recommended for an aggregate score of 5 or more, or a ‘red’ score of 3 for any single parameter;
* Provision for including where a patient has other indications that they may have Red Flag Sepsis or Septic Shock (i.e. clear indications of infection, unexplained deterioration)
* Inclusion of no need to screen if a sepsis diagnosis is immediately made without need to screen;
* Special circumstances when sepsis screening is inappropriate, such as with patients not for active treatment;
* Consideration of any vulnerable groups that may require special arrangements to ensure the possibility of sepsis is considered (e.g. children with disabilities).

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

**Appropriate Tools for Sepsis Screening**

Tools used should be either those produced in conjunction with relevant professional bodies at: <http://sepsistrust.org/clinical-toolkit> or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at <http://ccforum.com/content/supplementary/cc11895-s2.pdf>.

There are other examples of tools for suitable use in inpatient services at: <http://sepsistrust.org/professional/professional-resources/>

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

**Method for Identifying Random Samples**

Trusts should select ONE of the following methods and maintain this method throughout the 2016/7 year of data collection:

1. True randomisation: review the nth patient’s notes where n is generated by a random number generator or table (e.g. <http://www.random.org/>) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. <http://www.random.org/>.
2. Pseudo-randomisation: Review the first X patients’ notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

**Suggested Format for Local Data Collection**

**Sepsis Screening in Emergency Departments**

**N.B.** These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total** | **Column B total** | **Column C total** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |

**Antibiotic Administration in Emergency Departments**

**N.B.** These could be separately collated for adults and for children and then then stated as a final total (although also setting out the adult and child totals) totalled into a final table).

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if antibiotics within 60 minutes of admission were NOT indicated\*** | **Tick column below if antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVA, together with an empiric antibiotics review within 3 days)** | **Tick column below for all other cases, including those where time of arrival and/or time of antibiotic administration and/or an empiric antibiotics review within 3 days is unclear** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total:** | **Column B total:** | **Column C total:** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 2 (antibiotic administration) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |
| ***\* Antibiotics within 60 minutes would NOT be indicated if:***   * *there is clear evidence Red Flag Sepsis or Septic Shock was NOT present on admission to the trust’s care* * *there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile)* * *an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies or (in the case of inpatients PRIOR to admission)* | | | |

**Sepsis Screening in Inpatient Services**

**N.B.** These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening** | **Tick column below if the patient NEEDED sepsis screening according to the local protocol but DID NOT receive sepsis screening** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total** | **Column B total** | **Column C total** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |

**Antibiotic Administration in Inpatient Services**

**N.B.** These could be separately collated for adults and for children and then totalled into a final table.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick column below if any of the following are not indicated:**  a) a decision to treat with intravenous antibiotics is made by a competent decision-maker, and antibiotics GIVEN within 60 minutes (for new admissions) or 90 minutes (for existing inpatients) of potential sepsis being identified via use of the local protocol and tool.  b) an empiric review takes place by day 3 of the antibiotics being prescribed. | **Tick column below if all of the following are indicated:**  a) a decision to treat with intravenous antibiotics is made by a competent decision-maker, and antibiotics GIVEN within 60 minutes (for new admissions) or 90 minutes (for existing inpatients) of potential sepsis being identified via use of the local protocol and tool.  b) an empiric review takes place by day 3 of the antibiotics being prescribed. | **Tick column below for all other cases:**   * including those where time of identification of potential sepsis and/or time of decision to treat and/or antibiotic administration and/or empiric antibiotics review within 3 days are unclear |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |
| Etc. |  |  |  |
| **Totals** | **Column A total:** | **Column B total:** | **Column C total:** |
| **CQUIN calculation**  Column A total is discarded from the sample and does not count towards numerator or denominator  Column B total is the numerator total  [Column B total + Column C total] = denominator total  Percentage Part 2 (antibiotic administration) CQUIN achievement = (B ÷ [B+C]) x 100 | | | |
| ***\* Antibiotics within 60 minutes would NOT be indicated if:***   * *there is clear evidence Red Flag Sepsis or Septic Shock was NOT present on admission to the trust’s care* * *there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile)* * *an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies or (in the case of inpatients PRIOR to admission)* | | | |

# Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI)

**Note on CQUIN indicator**

**There are 2 parts to this CQUIN indicator:**

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value (£)** |
| CQUIN 3a | Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses | 80% of 0.25% (0.20%) |  |
| CQUIN 3b | Communication with General Practitioners | 20% of 0.25% (0.05%) |  |

**3a. Cardio Metabolic assessment and treatment for patients with psychoses**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Cardio metabolic assessment and treatment for patients with psychoses |
| **Indicator weighting  (% of CQUIN scheme available)** | 80% of 0.25% (0.20%) |
| **Description of indicator** | To demonstrate Cardio metabolic Assessment and Treatment for Patients with Psychoses in the following areas:   1. Inpatient Wards 2. Early Intervention Psychosis Services 3. Community Mental Health Services (Patients on CPA) |
| **Numerator** | 1. **Inpatients and Early Intervention Psychosis Services**   Number of patients in defined audit sample who have both:   1. a completed assessment for each of the cardio-metabolic parameters with results documented in the patient’s records 2. a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.   **b) Patients on CPA in Community Mental Health Services**  Number of patients in defined audit sample who have both:   1. a completed assessment for each of the cardio-metabolic parameters with results recorded in the patient’s records 2. ii. a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. |
| **Denominator** | 1. **Inpatients and Early Intervention Psychosis Services**   Inpatients  Number of patients in defined national audit sample – (the sample must be limited to patients who have been admitted to the ward for at least 7 days. Inpatients with an admission of less than 7 days are excluded)  Early Intervention Psychosis Services  Number of patients in defined national audit sample – (the sample must be limited to patients who have been on the team caseload for a minimum of 6 months)   1. **Patients on CPA in Community Mental Health Services**   Number of patients on CPA in defined national audit sample – (the sample must be limited to patients who have been on the team caseload for a minimum of 12 months) |
| **Rationale for inclusion** | This CQUIN builds on the developments made across England on improving physical health care for people with severe mental illness (SMI) in order to reduce premature mortality in this patient group. It gives providers an opportunity to continue building on progress made over the past two years and ensure systems are in place to embed learning and sustain good practice.  The aim is to ensure that patients with SMI have comprehensive cardio metabolic risk assessments, have access to the necessary treatments/interventions and the results are recorded in the patient’s record and shared appropriately with the patient and the treating clinical teams.  Patients with SMI for the purpose of this CQUIN are all patients with psychoses, including schizophrenia (see additional notes below), in all types of inpatient units and community settings commissioned from all sectors.  The cardio metabolic parameters based on the Lester Tool for this CQUIN are as follows:   * Smoking status; * Lifestyle (including exercise, diet alcohol and drugs); * Body Mass Index; * Blood pressure; * Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate); * Blood lipids. |
| **Data source** | Internal provider sample submitted to National Audit provider for the CQUIN. |
| **Frequency of data collection** | Data for national audit expected to be collected and submitted to national audit provider during Quarter 3 of 2016/17 – results to be available in Quarter 4 |
| **Organisation responsible for data collection** | MH Provider |
| **Frequency of reporting to commissioner** | Results of national audit expected to be available for Quarter 4 for reporting to commissioners (April 2017). Additional direct reporting to commissioners locally in Quarters 2, 3 and 4. |
| **Baseline period/date** | Not applicable |
| **Baseline value** | Not applicable |
| **Final indicator period/date (on which payment is based)** | Quarter 4, 2016/17 |
| **Final indicator value (payment threshold)** | 1. Inpatients – 90% 2. Early Intervention Psychosis Services – 90% 3. Community Mental Health Services (Patients on CPA) - 65% |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Quarter 4 audit results demonstrate that for 90% of inpatients, 90% of Early Intervention Psychosis services and 65% of Community Mental Health Services audited, the provider has undertaken an assessment of each of the cardio metabolic parameters below, with the results recorded in the patient's records/care plan/discharge documentation as appropriate, together with a record of associated interventions where indicated (eg smoking cessation programme, lifestyle interventions, medication review, treatment according to NICE guidelines and /or onward referral to another clinician for assessment, diagnosis and treatment)  The parameters are:   * Smoking status; * Lifestyle (including exercise, diet alcohol and drugs); * Body Mass Index; * Blood pressure; * Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate); * Blood lipids. |
| **Final indicator reporting date** | 30 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?** | Yes- see below |
| **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** | **Inpatient Wards and Early Intervention Psychosis Services**   1. Ensure ongoing training programme for clinicians on improving physical health care for patients with SMI (assessed locally by commissioners) 2. Evidence of successful implementation of electronic healthcare records data collection of physical health assessment and measurable outcomes (assessed locally by commissioners) 3. Evidence of routine systematic feedback on performance to clinical teams (assessed locally by commissioners)   **Community Mental Health Services (Patients on CPA)**   1. Establish physical health training plan for community mental health clinicians (assessed locally by commissioners) 2. Identification/development of clear pathways for interventions and signposting for all cardio-metabolic risk factors:  * Smoking cessation * Lifestyle (including exercise, diet alcohol and drugs) * Obesity * Hypertension * Diabetes * High cholesterol   (assessed locally by commissioners) | 31 July 2016 | **20% of indicator weighting for part 3a** |
| **Quarter 2** | Completed pathways in place and disseminated to all clinical teams (assessed locally by commissioners) | October 2016 | **10% of indicator weighting for part 3a** |
| **Quarter 3** | Clinical staff training plan fully implemented (assessed locally by commissioners) | 31 January 2017 | **10% of indicator weighting for part 3a** |
| **Quarter 4** | Results of national audit across both inpatients and Early Intervention Psychosis Services (see sliding scales below for payment details).  Community Mental Health Services - (see sliding scales below for payment details). | April 2017 | **60% of indicator weighting for part 3a in all, made up of:**  30%  30% |

**Rules for partial achievement**

**Inpatients and Early Intervention Psychosis Services**

| **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 |

**Community Mental Health Services**

| **Final indicator value for the partial achievement threshold** | **% of CQUIN scheme available for meeting final indicator value** |
| --- | --- |
| 34.9% or less | No payment |
| 35.0% to 44.9% | 25% payment |
| 45.0% to 54.9% | 50% payment |
| 55.0% to 64.9% | 75% payment |
| 65.0% or above | 100% payment |

**Supporting Guidance and References**

* **ICD 10 codes:** For the purposes of the CQUIN, patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes will be included in the national audit: F10.5, F11.5, F12.5, F13.5, F14.5, F15.5, F16.5, F19.5, F20-29, F30.2, F31.2, F31.5, F32.3 and F33.3
* **Lester tool: http://www.rcpsych.ac.uk/pdf/eversion%20NICE%20Endorsed%20Lester%20UK%20adaptation%20.pdf**

**3b. Communication with General Practitioners**

| **Indicator** | |
| --- | --- |
| **Indicator name** | Communication with General Practitioners |
| **Indicator weighting  (% of CQUIN scheme available)** | 20% of 0.25% (0.05%) |
| **Description of indicator** | 90% of patients to have either an updated CPA ie a care programme approach care plan or a comprehensive discharge summary shared with the GP. A local audit of communications should be completed. |
| **Numerator** | The number of patients in the audit sample for whom the provider has provided to the GP an up-to-date copy of the patient’s care plan/CPA review letter or a discharge summary which sets out details of all of the following:   * 1. NHS number   2. All primary and secondary mental and physical health diagnoses   3. Medications prescribed and recommendations (may include duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication)   4. Ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified   5. Care Plan or discharge plan |
| **Denominator** | A sample of a minimum of 100 patients who are subject to the CPA –and who have been under the care of the provider for at least 12 months at the time of the audit. |
| **Rationale for inclusion** | Appropriate sharing of information between practitioners about diagnosed physical and mental health conditions is essential for safe practice. The rationale for this CQUIN is to ensure essential information needed for safe and effective care of patients who are also seen by secondary care mental health services is communicated to primary care professionals. |
| **Data source** | Internal audit undertaken by providers |
| **Frequency of data collection** | One audit in Quarter 2 |
| **Organisation responsible for data collection** | MH provider |
| **Frequency of reporting to commissioner** | Results of local audit required to be reported to local commissioners in Quarter 3 |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Audit undertaken in Q2, July – September 2016. |
| **Final indicator value (payment threshold)** | 90.0% |
| **Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)** | Quarter 2 audit demonstrates that, for 90% of patients audited during the period, the provider has provided to the GP an up-to-date copy of the patient’s care plan/CPA review letter or a discharge summary which sets out details of all of the following:   1. NHS number 2. All primary and secondary mental and physical health diagnoses 3. Medications prescribed and recommendations (may include duration and/or review, ongoing monitoring requirements, advice on starting, discontinuing or changing medication) 4. Ongoing monitoring and/or treatment needs for cardio-metabolic risk factors identified 5. Care Plan or discharge plan |
| **Final indicator reporting date** | January 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?** | Yes – see below |
| **EXIT Route** | To be determined locally |

**Rules for partial achievement**

| **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 |

# Antimicrobial Resistance and Antimicrobial Stewardship

**Note on CQUIN scheme**

**There are 2 parts to this CQUIN:**

|  |  |  |  |
| --- | --- | --- | --- |
| **National CQUIN** | **Indicator** | **Indicator weighting (% of CQUIN scheme available)** | **Value** |
| CQUIN 4a | Reduction in antibiotic consumption per 1,000 admissions | 80% of 0.25% (0.20%) |  |
| CQUIN 4b | Empiric review of antibiotic prescriptions | 20% of 0.25% (0.05%) |  |

**4a. Reduction in antibiotic consumption**

|  | |
| --- | --- |
| **Indicator name** | Reduction in antibiotic consumption per 1,000 admissions |
| **Indicator weighting  (% of CQUIN scheme available)** | 80% of 0.25% (0.20%) |
| **Description of indicator** | There are three parts to this indicator.   1. Total antibiotic consumption per 1,000 admissions 2. Total consumption of carbapenem per 1,000 admissions 3. Total consumption of piperacillin-tazobactam per 1,000 admissions |
| **Numerator** | Total antibiotic consumption as measured by Defined Daily Dose (DDD)  Total consumption of carbapenem as measured by Defined Daily Dose (DDD)  Total consumption of piperacillin-tazobactam as measured by Defined Daily Dose (DDD) |
| **Denominator** | Total admissions divided by 1,000 |
| **Rationale for inclusion** | Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming to the market has reduced in recent years and between 2010 and 2013, total antibiotic prescribing in England increased by 6%. This leaves the prospect of reduced treatment options when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance.  An AMR CQUIN aims to reduce total antibiotic consumption measured as defined daily doses (DDDs) per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focussed on antimicrobial stewardship and ensuring antibiotic review within 72 hours. |
| **Data source** | Acute trusts would submit their own antibiotic consumption data to PHE and evidence of 72 hour antibiotic review to the commissioners with admission statistics taken from Hospital Episode Statistics (HES).  Antibiotic consumption data would be available for commissioners to review via a dedicated website. Antibiotic review data would be submitted from the provider to the commissioners directly to monitor progress. |
| **Frequency of data collection** | Data will be collected quarterly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Annual |
| **Baseline period/date** | 2013/14 |
| **Baseline value** | As per the validated prescription data in 2013/14 |
| **Final indicator period/date (on which payment is based)** | 2016/17 |
| **Final indicator value (payment threshold)** | Each of the indicators is worth 25% of part 4a with an additional 25% to be paid for submission of consumption data to PHE for years: 2014/15 to 2016/17  Reduction of 1% or more in total antibiotic consumption against the baseline  Reduction of 1% or more in carbapenem against the baseline  Reduction of 1% or more in piperacillin-tazobactam against the baseline |
| **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?** | No |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No |
| **EXIT Route** | To be determined locally |

**4b. Empiric review of antibiotic prescriptions**

|  | |
| --- | --- |
| **Indicator name** | Empiric review of antibiotic prescriptions |
| **Indicator weighting  (% of CQUIN scheme available)** | 20% of 0.25% (0.05%) |
| **Description of indicator** | Percentage of antibiotic prescriptions reviewed within 72 hours |
| **Numerator** | Number of antibiotic prescriptions reviewed within 72 hours |
| **Denominator** | Number of antibiotic prescriptions included in the sample |
| **Rationale for inclusion** | Rationale is as per part 4a |
| **Data source** | Local audit of a minimum of 50 antibiotic prescriptions taken from a representative sample across sites and wards. |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Quarterly |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Based on achievement in each quarter within 2016/17 |
| **Final indicator value (payment threshold)** | Based on achievement in each quarter within 2016/17 – see milestones section |
| **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, see milestones section |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | No |
| **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 | Perform an empiric review for at least 25% of cases in the sample | End Q1 | 25% of 0.05% (0.0125%) |
| Quarter 2 | Perform an empiric review for at least 50% of cases in the sample | End Q2 | 25% of 0.05% (0.0125%) |
| Quarter 3 | Perform an empiric review for at least 75% of cases in the sample | End Q3 | 25% of 0.05% (0.0125%) |
| Quarter 4 | Perform an empiric review for at least 90% of cases in the sample | End Q3 | 25% of 0.05% (0.0125%) |

1. The Nutrient Profiling Model can be used to differentiate these foods while encouraging the promotion of healthier alternatives. https://www.gov.uk/government/publications/the-nutrient-profiling-model [↑](#footnote-ref-1)