Commissioning for Quality and Innovation (CQUIN)

CCG Indicator Specifications for 2019-2020

Publishing Approval Reference Number **000050**

NHS England and NHS Improvement – Working together for the NHS

February 2020

Contents

1. Introduction

The 2019/20 CCG CQUIN scheme contains 11 indicators, aligned to the 4 key areas as illustrated below. This Annex sets out the technical specification for each of the indicators in the scheme outlining how each indicator will be measured, how performance will be assessed and paid, as well as links to relevant supporting documents. This document should be read in conjunction with the 2019/20 CQUIN Guidance, which provides information on the rationale for each CQUIN and details of the scheme's structure and value.

Prevention of Ill Health	Mental Health	Patient Safety	Best Practice Pathways
• Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery	• Improved Discharge Follow Up	• Three High Impact Actions to Prevent Hospital Falls	• Stroke 6 Month Reviews
• Staff Flu Vaccinations	• Improved Data Quality and Reporting – Data Quality Maturity Index & Interventions	• Community Placed PICC Lines Secured Using a SecurAcath Device	• Ambulance Patient Data at Scene – Assurance & Demonstration
• Alcohol and Tobacco – Screening & Brief Advice	• IAPT – Use of Anxiety Disorder Specific Measures		• Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

2. Indicator Values

The majority of CQUINs are comprised of a single indicator that is used to measure performance and against which 100% of payment will be determined. There are 5 CQUINs that contain sub-parts with payment values spread across these sub parts as outlined in the table below.

Indicator	Value (%)
CCG1: Antimicrobial Resistance (AMR)*	**100**
CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	50
CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery	50
CCG3: Alcohol and Tobacco (A&T)	**100**
CCG3a: Alcohol and Tobacco - Screening	33
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	33
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	33
CCG5: Mental Health Data:	**100**
CCG5a: Mental Health Data: Data Quality Maturity Index	50
CCG5b: Mental Health Data: Interventions	50
CCG10: Ambulance - Access to Patient Information at Scene	**100**
CCG10a: Ambulance - Access to Patient Information at Scene (Assurance)	75
CCG10b: Ambulance - Access to Patient Information at Scene (Demonstration)	25
CCG11: Same Day Emergency Care (SDEC)	**100**
CCG11a: SDEC – Pulmonary Embolus	33
CCG11b: SDEC – Tachycardia with Atrial Fibrillation	33
CCG11c: SDEC – Community Acquired Pneumonia	33

* For providers where CCG1b is not in scope then CCG1a will carry 100% value.

3. Payment – based on cumulative performance at the end of the scheme

The process for calculating performance and payment in this year's CQUIN scheme has been simplified. Here are the key principles. These will be explained in more detail, with some illustrative examples over the coming slides.

1. **For all indicators this year, payment will be based on a performance assessment undertaken at the end of the scheme.**

2. **For most indicators, this payment assessment will be based on the sum of four quarters' data, with data collected at the end of each quarter. For some indicators Q1 or Q2 performance has been exempted from this calculation.**
    - To work out payment, it is usually the case that you take the sum of the relevant quarterly numerators and express that as a proportion of the sum of the relevant quarterly denominators. This will give you a '%' and that is your performance.
    - For some indicators, for example those related to the MHSDS, performance will be calculated automatically by the Mental Health Team at the year end, though for monitoring purposes, information will be available at more regular intervals to commissioners and providers throughout the year.
    - For staff flu, the calculation is as per previous years, based on the number of front line staff, therefore multiple regular calculations will not be required.

3. **Partial payment thresholds have been removed. Instead, there is simply one lower and one upper threshold for each indicator. Payment is determined by reference to these thresholds. Where the upper threshold is reached based on the year end assessment, 100% of payment will be earned; where it drops below the lower threshold, 0% would be earned. Payment is graduated between the two thresholds evenly.**

4. **NHS England does not mandate a specific approach to paying CQUIN monies to providers during the year in advance of the final payment assessment. Many CCGs, for example, will choose to pay providers a regular instalment based on expected earnings requiring this to be reconciled on the basis of actual performance.**

3a. Payment: Thresholds and relevant quarters

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for each indicator during the applicable period (payment basis). The table below summarises the relevant thresholds and payment basis that will be used for each of the indicators within the scheme. **Assessment should take place at the end of the scheme and calculated according to the method outlined in Payments: calculating payments.**

Indicator	Pay levels(%)	Payment basis	Indicator	Pay levels(%)	Payment basis
CCG1a: AMR– Lower Urinary Tract Infections in Older People	60 - 90	Q2-4	CCG6: Use of Anxiety Disorder Specific Measures in IAPT	30 - 65	Q2-4
CCG1b: AMR– Antibiotic Prophylaxis in colorectal surgery	60 - 90	Q1-4	CCG7: Three high impact actions to prevent Hospital Falls	25 - 80	Q2-4
CCG2: Staff Flu Vaccinations	60 - 80	Q4	CCG8: PICC lines secured using a SecurAcath device	70 - 85	Q1-4
CCG3a: A&T- Screening	40 - 80	Q1-4	CCG9: Stroke 6 Month Reviews	35 - 55	Q1-4
CCG3b: A&T– Tobacco Brief Advice	50 - 90	Q1-4	CCG10a: Ambulance - (Assurance)	0 - 100	Q1-4
CCG3c: A&T– Alcohol Brief Advice	50 - 90	Q1-4	CCG10b: Ambulance - (Demonstration)	0 - 5	Q3-4
CCG4: 72hr follow up post discharge	50 - 80	Q3-4	CCG11a: SDEC – Pulmonary Embolus	50 - 75	Q1-4
CCG5a: Mental Health Data: Data Quality Maturity Index	90 - 95	Q2-4	CCG11b: SDEC – Tachycardia with Atrial Fibrillation	50 - 75	Q1-4
CCG5b: Mental Health Data: Interventions	15 - 70	Q3-4	CCG11c: SDEC – Community Acquired Pneumonia	50 - 75	Q1-4

3b. Payments: Calculating Performance

Whilst monitoring will take place on a quarterly basis, performance will be based on the entirety of the relevant period.

- For the majority of indicators, this is usually the whole year (see 'Payment Basis' column on Slide 6).
- For a typical scheme that applies to the entire year, the performance will be calculated by adding together the four numerators and denominators submitted and expressing that as a percentage to get a total figure for the year.
- In the example below, 160 is 40% of 400, so the overall performance figure is 40%

Quarterly monitoring												Scheme Performance		
Q1			Q2			Q3			Q4					
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)
25	100	25	35	100	35	45	100	45	55	100	55	160	400	40

- In the example below, performance was on the basis of Q2 – Q4, so here we add together the three numerators and express that as a proportion of the sum of the three denominators.
- 155 is 52% of 300, so the performance figure is 52%

Quarterly monitoring												Scheme Performance		
Q1			Q2			Q3			Q4					
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)
N/A	N/A	N/A	25	100	25	55	100	55	75	100	75	155	300	52

3b. Payments: Calculating Payment

The previous slide explained how to arrive at the overall performance result for the indicators, but how does that relate to the actual CQUIN payment that a provider will earn? Payment in this year's scheme will reward providers based on their performance falling between each indicator's minimum and maximum thresholds, using the following formula.

Payment calculation: (Performance – Min) / (Max – Min) = Payment value

Quite simply, all of the indicators have a target performance level that we refer to as 'max' on all of the indicator specifications. There is also a 'min' level – this is the level at which some level of payment begins to be earned – and this payment is awarded proportionately based on where performance lands between the 'min' and 'max' threshold. Here are some examples to illustrate this process more clearly.

- **Example 1**: Here, the performance level that the provider has achieved is 40%. This is below the 'min' threshold of 50% so no payment has been earned.

- **Example 2:** Here, the performance level that the provider has achieved is 63%. This is between the 'min' (25%) and 'max' (80%) thresholds and the calculation shows us that this equates to an earning of 69% of the payment available (**69% of £100k = £69k**).

- **Example 3:** Here, the performance level that the provider has achieved is 72%. This is above the 'max' threshold of 70% so the provider earns the full potential amount associated with that indicator. Payment is capped at 100% so **100% of £100k = £100k**.

	Threshold			Calculation	Potential CQUIN indicator Value	Payment		
Exam-ple	Min (%)	Max (%)	Perform-ance	*(Performance – Min) / (Max – Min) = Payment value*		%	Calculation (£)	£
1	50	90	40%	(40% - 50%) / (90% - 50%) = -25%	£100k	0%	100k x 0% = 0	0k
2	25	80	63%	(63% - 25%) / (80% - 25%) = 69%	£100k	69%	100k x 69% = 69	69k
3	30	70	72%	(72% - 30%) / (70% - 30%) = 105%	£100k	100%	100k x 100% = 100	100k

3b. Payments: Reconciling Payment

NHS England do not mandate a specific approach to paying CQUIN monies to providers. Many CCGs, for example, will choose to pay a regular amount throughout the year, this is fine. In all instances though, **the assessment of actual performance should take place at the end of the year and any over/ under payment should be reconciled on the basis of actual performance**.

So, how is any reconciliation requirement assessed?

The two examples below show scenarios where regular CQUIN payments have been paid throughout the year against an indicator, where the provider achieved a performance level which meant they had earned 81% of the potential CQUIN value of £100k (**81% of £100k = £81k**)

- **Example 1**: The CCG has made four quarterly payments of £25k, totalling £100k. The provider actually earned £81k, so the CCG has **overpaid by £19k**.

- **Example 2**: The CCG has made two payments of £25k, totalling £50k. The provider actually earned £81k, so the CCG has **underpaid by £31k**.

Example	Potential CQUIN Indicator Value	In-year Payments (£,000)					End of Scheme Perfor-mance (%)	Due based on Perfor-mance (£,000)	Reconciliation		
		Q1	Q2	Q3	Q4	Total			Calculation (+ve = overpaid, -ve = underpaid	Amount overpaid	Amount underpaid
1	**£100k**	25	25	25	25	100	81%	£81k	100 – 81 = 19	£19k	
2	**£100k**		25		25	50	81%	£81k	50 – 81 = -31		£31k

4.i. Understanding Performance

4.i.a. Monitoring performance

There are two broad sources for the CQUIN indicator data:

- existing published data that are readily available; and
- data that will be collected via a national CQUIN collection.

For each indicator, quarterly data will be available from one of these sources in order to allow performance monitoring by both commissioners and NHS England. The detail about each source is set out in the 'Data Source(s) & Reporting' section of each indicator's specification. For published data, the data source has been identified and links provided to allow ready access to the data – for example Flu vaccinations data. Indicators that require data submission to the national CQUIN collection are identified by the source being the 'national CQUIN collection'. With the exception of CCG10b: Ambulance - (Demonstration) this will require supplying data on a quarterly basis by auditing relevant records, such as case notes.

The next section provides more information about the auditing approaches to be adopted. It is recommended that, where available, (clinical) audit professionals within each service are contacted to assist with selecting from the approaches detailed below and to ensure local protocols are met.

4.i.b. Collecting quarterly data: approach to auditing

In circumstances where both numerator and denominator data are locally available via searchable electronic patient records, then all patient records (that match the denominator) should be audited for performance monitoring and assessment. Otherwise, sampling of records will be required to allow performance monitoring and assessment. The auditing approach will be determined by the ability to identify the population of interest (sampling frame) from electronic or paper case notes. A minimum sample of 100 records meeting the criteria are required from each quarter. Where the total cohort is less than 100 patients then all records should be audited. If information can be provided readily for all relevant records, it should be provided in preference to auditing.

One hundred records has been chosen as a balance between burden and robust measuring of performance – smaller sample sizes would result in greater uncertainty about performance and potentially payments that do not accurately reflect true performance.

4.i. Understanding Performance

4.i.b. Collecting quarterly data: standard approach to auditing cont….

One of the approaches detailed in sections 4c and 4d should be chosen and maintained, based on the CQUIN and local circumstances of the trust. Where possible a defined sampling frame should be established to allow auditing of the indicator.

4.i.c. Collecting quarterly data: defined sampling frame.

If all cases can be readily identified (i.e. those in the denominator) via searchable electronic patient records or via paper case notes then quarterly audits of a minimum, **random** sample of 100 records meeting the criteria are required. An example might be where all cases notes in a given department are relevant.

Trusts must select ONE of the following methods of random sampling and maintain this method throughout the scheme:

1) **True randomisation:** every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (e.g. http://www.random.org/) is used with 1 and x setting the lower and upper bounds. 100 cases are then identified using the random number generator from within these bounds.

2) **Quasi-randomisation**: every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x but only after the cases have been ordered in a way that doesn't have any clinical significance, for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/100, so that every 'i'th case will be selected after the first case has been randomly generated between 1 and i.

For example, for a sampling frame of 1,000 cases, i=1,000/100 =10. So the first case will be randomly selected between 1 and 10 and then the 10th case from this will be used. For example. cases 7, 17, 27, 37, 47… will be chosen.

4.i. Understanding Performance

4.i.d. Collecting quarterly data: undefined sampling frame.

If the sampling frame (i.e. the denominator) cannot be fully identified via searchable electronic patient records or via paper case notes, but instead requires reviewing each set of case notes, then it may not be feasible to use random sampling methods. Instead a quarterly audit by **Quota** sampling 100 records is required. Quota sampling is a non-random approach to case selection, where case notes are systematically searched to identify those that match the denominator. The approach is convenient and requires additional care to ensure the sample is representative. Below are examples of how quota sampling could be implemented by trusts. We acknowledge that the individual circumstances of each trust will determine the exact approach adopted. Quota sampling should ideally be avoided in preference for a random approach (see section 4c).

Example quota sampling methods:

- **Patient ID**: If case notes are ordered purely by a randomly assigned patient ID then case notes can be searched consecutively from any position until 100 cases are identified.

- **Chronological:** If cases are chronologically ordered then case notes should be selected in a way that ensures the period is well represented. For example, searching through cases from day 1 of the quarter until a case is identified, and then repeating for each subsequent day of the quarter. This can then be repeated from day 1 until 100 records have been identified.

Similarly, where cases are categorised or split into groups (e.g. by consultant specialty or ward) then auditing should take this in to account in order to best ensure the sample is representative. For example, if cases are relevant from across several wards, then it is important that cases from each ward form part of the sample.

4.ii. Data Collection and Reporting

For the 2019/20 CQUIN scheme we are undertaking a proof of concept approach to data collection and reporting, working with a new partner, NetSolving and using their Case Capture tool to collect CQUIN data. This will replace the SDCS CQUIN collection previously operated via NHS Digital.

This new approach adheres to the principles of simplicity and effectiveness and is aimed at enhancing the user experience when collecting and monitoring CQUIN performance. The new method should make it easier to upload data and navigate through the site, providing improved system functionality and better-quality data with improved built-in validation checks.

Furthermore, throughout the year, there will be a renewed focus on the provision of improved, flexible reporting on CQUIN performance for providers, regions, CCGs and national teams, offering an ability to understand performance across a range of cohorts. This will all be made available via the Case Capture platform.

Alongside the collection of data for those indicators where there is no existing source (see 4.ii.a.), Case Capture reporting will also include CQUIN data collected via other national sources and will serve as a single location for reviewing CQUIN performance. The importing of this data will be managed centrally. This comprehensive dataset will be the optimal source for the local CQUIN performance reporting required under SC38.5 of the NHS Standard Contract.

In order to provide a complete set of data, drawing in a range of other national sources in the way that has been described above, it is important that each quarter providers identify all CQUIN indicators they are required to deliver, including those that they are directly submitting data for through Case Capture. This will ensure that data for those indicators where data is taken from existing sources is imported accurately and presented alongside the submitted data to present a comprehensive view of performance.

Those providers that have CCG contracts that apply to different services and undertake CCG3a-c & 7 need to supply data for each contract. For example, acute services and community services provided for the same CCG under different contracts will need to supply data against each for CCG7.

4.ii. Data Collection and Reporting

4.ii.a. Indicators that require collection

The CQUIN data that will be collected via this new platform are listed in the table below. The indicator specifications describe the specific data items that will need to be calculated and submitted.

CCG3a	Alcohol and Tobacco - Screening
CCG3b	Alcohol and Tobacco – Tobacco Brief Advice
CCG3c	Alcohol and Tobacco – Alcohol Brief Advice
CCG7	Three high impact actions to prevent Hospital Falls
CCG8	Community Placed PICC lines secured using a SecurAcath device
CCG10b	Ambulance - Access to Patient Information at Scene (Demonstration)
CCG11a	SDEC – Pulmonary Embolus
CCG11b	SDEC – Tachycardia with Atrial Fibrillation
CCG11c	SDEC – Community Acquired Pneumonia

4.ii.b. Collection schedule

The data collection will operate in line with the schedule below:

Submission Window	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Opens	July 15th 2019	October 14th 2019	January 13th 2020	April 13th 2020
Closes	August 16th 2019	November 15th 2019	February 14th 2020	May 15th 2020

4.ii. Data Collection and Reporting

4.ii.c. Access and use

Case Capture is an online tool, accessible 24 hours a day for anyone with an internet connection. All users who had previously been registered for the 2018/19 CQUIN collection will be invited to submit data via Case Capture. These users have been set up with privileges that allow them the ability to invite colleagues to submit data on behalf of the provider.

Newly added users as identified above will receive an email from 'noreply@netsolving.com'. Please follow the prompts in that email to set up your password. Check your spam folder if you cannot find it in your inbox.

If you have not received a registration email and believe that you should, please contact your CQUIN lead to determine whether they are able to add you to Case Capture – information on managing users is provided in section 4.ii.f.

If you believe that nobody within your provider has been granted access to Case Capture and you need to submit data for the CQUINs listed on the previous page, please contact e.cquin@nhs.net with the following information:

1. **Email subject: CQUIN data collection: User Check**
2. **Full name**
3. **Provider name**
4. **Email address**

Once you have been added successfully, your registration email will contain the following:

Link: https://data.casecapture.com/
Username: your email address joe.bloggs@hospital.nhs.uk
Password: Create strong password with numerical and characters.
2 Factor Authentication: When you log-in for the first time you will be sent a 6 digit code to your email, enter this into the box.

4.ii. Data Collection and Reporting

4.ii.d. Submitting data

Submitting data via Case Capture is simple and intuitive.

1. Click ‘edit’ (pencil icon) on the right hand side of the ‘CQUINs study’ to navigate to the record management screen.
2. Within the record management screen click “Add record” to start entering data.
3. You will need to select all of the CQUINs that you are expected to deliver.
4. Ensure all sections are green before completing. You are able to edit it later once it has been saved.
5. Ensure you click ‘Save’ before exiting the data collection.
6. Once you have completed the record and you can see it saved as green in the record management screen, click the padlock button to lock the record, prior to the collection window closing. Once locked you will no longer be able to make any changes to your record so please ensure that you have reviewed and are content with your submission prior to locking your record.

N.B. Only locked records will be considered finalised and used for national reporting. Unlocked records will be considered as draft and not used. For housekeeping, it is recommended that any unused, draft records that are not locked each quarter are deleted.

Please be aware that, whilst FAQs and helpful information (e.g. brief numerator and denominator descriptions) are available within Case Capture, the detailed specifications held within this document and the contacts named within these specifications should be the primary source of information for any questions about specific CQUIN indicators.

4.ii.e. Data Revisions

By exception, revisions can be submitted via Case Capture according to the timetable below. When submitting a revision, the email address of the responsible person in the CCG who has been informed of the revision must be provided. Without this confirmation, a revision is not able to be submitted.

Revisions Window	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Opens	November 25th 2019	February 24th 2020	May 25th 2020	June 8th 2020
Closes	December 6th 2019	March 6th 2020	June 5th 2020	June 19th 2020

4.ii. Data Collection and Reporting

4.ii.f. Managing users

A single user from each provider has privileges that allow them to invite colleagues to submit data on behalf of the provider. This user has ‘Administrator’ privileges within Case Capture.

In order to add an additional user from your provider, “Administrators” must follow the ‘Add User’ link on the landing page. You will need the email address of the user you are wishing to add, and you will need to determine the level of access that this user should have. For example, they may be able to upload data or have access to view reports. We recommend that just one or two individuals per site are provided with ‘Administrator’ privileges.

We recommend that ‘Writer’ access which allows editing of data and ‘Importer’, are limited.

5a. CQUIN Indicators: Prevention of Ill Health

CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People

Services in scope

Acute

Payment levels

Minimum: 60%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Antimicrobial Resistance – Urinary Tract Infections supporting guidance

PHE UTI Diagnosis Guideline

NICE Guidance NG109

Data Source(s) & Reporting

Data should be submitted quarterly to PHE via the online submission portal. An auditing tool will be available in supporting guidance. See sections 4b-d for details about auditing.

Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.

Description

Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

Numerator

Of the denominator, the number where the 4 audit criteria for diagnosis and treatment following PHE UTI diagnostic and NICE guidance (NG109) are met and recorded:

1. Diagnosis of lower UTI based on documented clinical signs or symptoms
2. Diagnosis excludes use of urine dip stick
3. Empirical antibiotic prescribed following NICE Guideline (NG109)
4. Urine sample sent to microbiology

Denominator

Total number of antibiotic prescriptions for all patients, aged 65+, with a diagnosis of lower Urinary Tract Infection (ICD-10 codes: N39.0 and N30.0. ED code 27. SNOMED code 68226007)

Exclusions

Recurrent UTI (See NICE guidance NG112) where management is antibiotic prophylaxis, pyelonephritis, catheter associated UTI, sepsis

CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery

Services in scope
Acute who perform elective colorectal surgery

Payment levels
Minimum: 60%
Maximum: 90%
Scope: Q1 Q2 Q3 Q4

Accessing support

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Supporting Documents
Antimicrobial Resistance – Surgical Antibiotic Prophylaxis supporting guidance

NHSI/PHE audit tool

NICE Guidance NG125

Data Source(s) & Reporting
Data should be submitted quarterly to PHE via the online submission portal. An auditing tool will be available in the supporting guidance. See sections 4b-d for details about auditing.

Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.

Description
Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

Numerator
Of the denominator, the number of prophylactic single dose antibiotic prescriptions that meet the NICE NG125 guidance regarding the choice of antibiotic.

Denominator
Total number of audited antibiotic prescriptions for inpatients, aged 18+, undergoing surgical prophylaxis for elective colorectal surgery*

*relevant procedural coding is detailed in the supporting guidance.

CCG2: Staff Flu Vaccinations

Services in scope

Acute, Community, Mental Health, Ambulance

Payment levels

Minimum: 60%

Maximum: 80%

Scope*: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

ImmForm Guidance

Green Book

NICE guidance NG103

Data source(s) & Reporting

Monthly Provider submission (between September and March) to PHE via ImmForm. See: Guidance

Data will be made publicly available approximately 6 weeks after each quarter.

Description

Achieving an 80% uptake of flu vaccinations by frontline clinical staff.

Numerator

Total number of front line healthcare workers who have received their flu vaccination between 1 September 2019 and February 28th 2020.

Denominator

Total number of front line healthcare workers.

Exclusions

- Staff working in an office with no patient contact
- Social care workers
- Staff out of the Trust for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)

NB. Aside from the target, this CQUIN is exactly the same as in the 17/19 Scheme.

*Achievement of this CQUIN is determined by the total proportion of frontline healthcare workers vaccinated. It is not based on average rates of vaccination across quarters but rather the cumulative rate at the end of the year.

CCG3a: Alcohol and Tobacco - Screening

Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 40%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support

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Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.

Numerator

Of the denominator, those screened for both smoking and alcohol risk status and the results recorded in patient's record.

Denominator

All *unique patients, aged 18+ who are admitted to an inpatient ward for at least one night (i.e. length of stay equal to or greater than one).

*Unique is defined as a non-repeat admission of a patient during the duration of the CQUIN who has not already received the intervention within the period of the CQUIN.

Exclusions

Maternity inpatients (exclude where 'Epitype'=2,3,4,5 or 6).

CCG3b: Alcohol and Tobacco – Tobacco Brief Advice

Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

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Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of identified smokers given brief advice.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme - including an offer of Nicotine Replacement Therapy (whether or not this offer had been taken up).

Denominator

All eligible patients who have been recorded as smokers during screening.

CCG3c: Alcohol and Tobacco – Alcohol Brief Advice

Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

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Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme, or offered a specialist referral if the patient is potentially alcohol dependent.

Denominator

All eligible patients who have been recorded as drinking above the low risk levels.

5b. CQUIN Indicators: Mental Health

CCG4: 72hr follow up post discharge

Services in scope

Mental Health

Payment levels

Minimum: 50%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

Routine provider submission to the Mental Health Services Data Set (MHSDS).

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

Description

Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge from a CCG commissioned service.

Numerator

Of the denominator, those who have a follow up within 72hrs (commencing the day after discharge).

Denominator

Number of people discharged from a CCG commissioned adult mental health inpatient setting.

Exclusions

Details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

CCG5a: Mental Health Data Quality: MHSDS Data Quality Maturity Index

Services in scope

Mental Health (MH trusts only)

Payment levels

Minimum: 90%

Maximum: 95%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

Routine provider submission to the Mental Health Services Data Set (MHSDS).

The MHSDS monthly data quality reports include granular provider level data on the data items included in the MHSDS DQMI. Published MHSDS data

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

Description

Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI).

Indicator

The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS. The full definition and DQMI data reports can be found at: DQMI webpage

Data Items

The MHSDS Data items included in the DQMI are outlined in the Changes to the DQMI.

CCG5b: Mental Health Data Quality: Interventions

Services in scope

Mental Health (MH trusts only)

Payment levels

Minimum: 15%

Maximum: 70%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

NHS Digital SNOMED CT Browser

MH SNOMED Website

Specific Pathway Guidance on SNOMED CT Intervention Codes

Data Source(s) & Reporting

Routine provider submission to the Mental Health Services Data Set (MHSDS).

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

Description

Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded between the referral start date and the end of the reporting period.

Numerator

Of the denominator, the referrals with at least one intervention* (SNOMED CT procedure code) recorded between the referral start date and the end of the reporting period.

Denominator

The number of referrals that receive their second attended contact in Q3-4 2019/20.

*A condition of this CQUIN is that providers demonstrate a range of interventions over the course of Q3 – Q4. Any provider who is found to be only using one intervention code will receive no payment.

CCG6: Use of Anxiety Disorder Specific Measures in IAPT

Services in scope

IAPT Services

Payment levels

Minimum: 30%

Maximum: 65%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Belinda Yeldon

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Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

IAPT manual

Data Source(s) & Reporting

Routine provider submission to the Improving Access to Psychological Therapies (IAPT) Data Set

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

Description

Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).

Numerator

Of the denominator, the referrals that had paired scores recorded on the specified ADSM.

Denominator

The number of referrals with a specific anxiety disorder problem descriptor*, where the course of treatment was finished and where there were at least two attended treatment appointments.

*This includes 6 disorders: Obsessive Compulsive Disorder, Social Phobias, Health Anxiety, Agoraphobia, Post Traumatic Stress Disorder, Panic Disorder.

5c. CQUIN Indicators: Patient Safety

CCG7: Three high impact actions to prevent Hospital Falls

Services in scope

Acute, Community

Payment levels

Minimum: 25%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Falls Prevention Resources

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 80% of older inpatients receiving key falls prevention actions

Numerator

Number of patients from the denominator where all three specified falls prevention actions are met and recorded:

1. Lying and standing blood pressure recorded at least once.
2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).
3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

Denominator

Admitted patients aged over 65 years, with length of stay at least 48 hours.

Exclusions

- Patients who were bedfast and/or hoist dependant throughout their stay.
- Patients who die during their hospital stay.

CCG8: Community Placed PICC lines secured using a SecurAcath device

Services in scope

Community

Payment levels

Minimum: 70%

Maximum: 85%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Stephanie Heath

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Supporting Documents

NICE guidance on SecurAcath for securing percutaneous catheters - MTG34

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 85% of community- placed peripherally inserted central catheters (PICC) lines secured using a SecurAcath device.

Numerator

Of the denominator, the number of Patients with a PICC line secured by a SecurAcath device.

Denominator

Patients with a PICC line inserted within a community setting and in place for more than 15 days.

Exclusions

- Patients sensitive to nickel.
- Peripherally inserted central catheters in place for 15 days or less.

Note

This CQUIN **does not** incentivise a change of securing device to PICC lines after the patient is discharged to the community.

5d. CQUIN Indicators: Best Practice Pathways

CCG9: Six Month Reviews for Stroke Survivors

Services in scope

Community with stroke rehabilitation

Data Source(s) & Reporting

Data provided to the Sentinel Stroke National Audit Programme (SSNAP). See Guidance and Published data

Payment levels

Minimum: 35%

Maximum: 55%

Scope: Q1 Q2 Q3 Q4

Description

Achieving 55% of eligible stroke survivors receiving a six month follow up within 4-8 months of their stroke.

Numerator:

Number in the denominator who had a six month follow-up within 4 – 8 months of their stroke. (SSNAP database variable M2.2).

Denominator:

Number of patients due for follow-up based on when the patient was admitted or when the follow-up was completed (SSNAP database variable M1.1).

Exclusions

- Died whilst on the stroke care pathway (SSNAP database variable M2.4).
- 6 month reviews that took place before 4 months or after 8 months of the stroke.

Accessing support

Policy Lead

National Stroke Programme Team

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Supporting Documents

Implementation guidance

SSNAP Guidance

CCG10a: Ambulance - Access to Patient Information at Scene (Assurance)

Services in scope

Ambulance

Payment levels

Minimum: 0% (failed assurance)

Maximum: 100% (passed assurance)

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Claire Joss

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Supporting Documents

Ambulance CQUIN Guidance Workspace

(Please email UECP-manager@future.nhs.uk to request access.)

Data Source(s) & Reporting

Quarterly reporting about the number of providers that have successfully completed the NHS Digital assurance process for enabling access tor patient information on scene, by ambulance crews, as reported by NHS Digital.

Description

Achievement of NHS Digital's assurance process for enabling access to patient information on scene, by ambulance crews via one of the four nationally agreed approaches:

a) SCRa Portal – a standalone web viewer, on the Spine web portal – controlled by smart card

b) SCR 1-Click - Patient contextual click- launches the SCRa from within an existing application.
   - Known providers; Servelec RiO and Lorenzo (CSC)

c) Commercial Spine Mini Service Providers
   - Known providers; Quicksilva and Intersystems

d) Direct Spine Integration by System Suppliers
   - Known providers; Adastra (Advanced Health and Care), CLEO (CLEOsystems24), Web (EMIS), Symphony (Ascribe), SystmOne (TPP)

Known suppliers for each route have been identified however other suppliers may exist or enter the market during the lifetime of this CQUIN.

CCG10b: Ambulance - Access to Patient Information at Scene (Demonstration)

Services in scope

Ambulance

Payment levels

Minimum: 0%

Maximum: 5%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

Ambulance statistics

Ambulance Quality Indicators

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection from trust's operational systems - see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 5% of face to face incidents resulting in patient data being accessed by ambulance staff on scene.

Numerator

Of the denominator, the number of incidents with a face to face response, during which the ambulance staff on scene accessed the patient's record.

Denominator:

Total count of incidents with a face to face response as defined in Ambulance Systems indicator (item A56).

CCG11a: SDEC – Pulmonary Embolus

Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

NICE Guidance CG144

Ambulatory Emergency Care Directory (6th Edition)

BTS Guidance for the outpatient management of PE

SDEC Additional Resources

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting. An auditing tool and FAQs are available to support collection. Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 75% of patients with confirmed pulmonary embolus (PE) being managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, those managed in a same day setting, as set out in NICE Guidance CG144, and discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+ with a primary diagnosis of pulmonary embolus*, whose case notes indicate that same day care is clinically appropriate**.

*ICD-10 codes: I260, I269. SNOMED codes: 59282003

**Clinically appropriate criteria:

- No history of cancer
- No history of chronic cardiopulmonary (heart failure or chronic lung) disease
- Pulse less than 110 beats/ min
- Systolic Blood Pressure greater than 100mmHg
- Oxygen saturation level (arterial) greater than 90%

Exclusions

None

CCG11b: SDEC – Tachycardia with Atrial Fibrillation

Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

NICE Guidance CG180

Ambulatory Emergency Care Directory (6th Edition)

SDEC Additional Resources

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting. An auditing tool and FAQs are available to support collection. Data will be made available approximately 6 weeks after each quarter.

Description:

Achieving 75% of patients with confirmed atrial fibrillation (AF) being managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, the number of patients who are managed in a same day setting, as set out in NICE Guidance CG180, and are discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+, with a primary diagnosis of atrial fibrillation*, whose case notes indicate that same day care is clinically appropriate**.

*ICD-10 codes: I44.0-7, I45.0-9 (excl I457), I47.0, 147.2, I47.9, I48.0-9, I49.1-2, I49.4-5, I49.8-9, R00.0,R00.2,R00.8. SNOMED codes: 49436004

**Clinically appropriate criteria:

- No chest pain
- Systolic blood pressure greater than 100 mmHg

Exclusions

Supraventricular tachycardia, postural orthostatic tachycardic syndrome

CCG11c: SDEC – Community Acquired Pneumonia

Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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Supporting Documents

NICE Guidance CG191

Ambulatory Emergency Care Directory (6th Edition)

SDEC Additional Resources

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4.i. for details about auditing and 4.ii. for details on data collection and reporting. An auditing tool and FAQs are available to support collection. Data will be made available approximately 6 weeks after each quarter.

Description

Patients with confirmed Community Acquired Pneumonia (CAP) should be managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, the number of patients who are managed in a same day setting, as set out in NICE Guidance CG191, and are discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+, with a primary diagnosis of pneumonia*, whose CRB65 score is 0 -1 and whose case notes indicate that same day care is clinically appropriate in accordance with BTS Guidance.

*ICD-10 codes: J10.0-J12.0-3, J12.8-9, J13x, J14x,J15.3-9, J16.0/8, J17.0-1, J17.8, J18.0-1, J18.8-9. SNOMED codes: 278516003, 233604007, 50417007)

Exclusions

None

Version Control

Date	Update
7th March 2019	Initial Publication
8th March 2019	p24 PICC Lines – Note added to confirm community inserted PICC lines only.
8th May 2019	p5-9 – General performance and payment slides expanded for clarity. p10 – 4b Opening sentence clarified. p14-15 – References updated, Diagnosis codes clarified, Sepsis exclusion clarified. p16 – Clarified period in scope. p32-34 – SDEC Additional Resources link added. Spelling mistake amended on p34.
17th June 2019	p32-34 – SDEC FAQs link added. Amended ICD-10 codes.
15th July 2019	p2 – Contents page amended. p13-17 – Data collection and reporting section updated.
12th August 2019	p8 – Payment calculation figure error corrected. p39 – SDEC CAP slide denominator section updated. BTS Guidance link added.
8th October 2019	p6 – Payment basis column amended p19, 31 – Payments scope amended
3rd February 2020	P16 – Data revisions deadline windows amended.