Commissioning for Quality and Innovation (CQUIN)

PSS indicator specifications for 2020-2021

Annex document to the CQUIN Core Guidance Document

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NHS England and NHS Improvement – Working together for the NHS

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Contents

1. Introduction

The 2020/21 PSS CQUIN scheme contains nine indicators, five indicators for acute providers, and four indicators for mental health providers.

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 CQUIN Core Guidance Document, which provides information on the rationale for each CQUIN and details of the scheme's structure and value.

Acute Providers	Mental health providers
PSS1: Hep C elimination	PSS2: Managing a healthy weight in adult secure MH services
PSS6: Antifungal stewardship	PSS3: CAMHS needs formulations in Tier 4 settings
PSS7: Paediatric movement therapy	PSS4: D/deaf communications assessments in CAMHS and adult inpatient services
PSS8: Severe asthma	PSS5: Routine outcome monitoring in perinatal inpatient services
PSS9: Shared decision making	

2. Applicable Indicators and Values

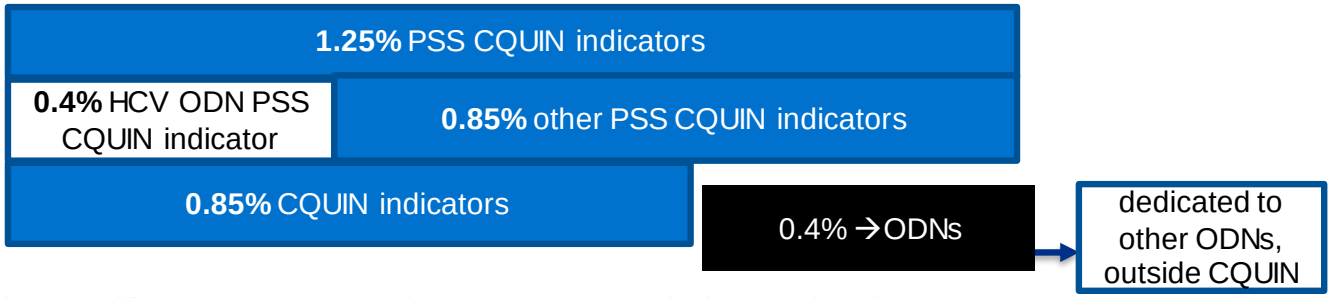
2.a. Value of CQUIN packages

For the PSS scheme, as in previous years, a portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of hepatitis C, ODN leads for hepatitis C will, alongside mental health providers, continue to be eligible for a higher PSS CQUIN allocation when compared to other acute providers of specialised services. Consequently, for HEP C ODN leads, and MH providers the PSS CQUIN scheme is worth a maximum of 1.25%, and for other acute providers it will be worth a maximum of 0.85%.

Mental health providers:

HCV lead providers:

Other acute providers:



Commissioners will offer a provider-specific PSS CQUIN package at a sum equivalent to the above percentage of planned CQUIN-applicable contract value.

2.b. Combining indicators

Commissioners will include **all** applicable indicators within PSS CQUIN packages.

The value of the "Achieving Hepatitis C Elimination" will be set at 0.4 % (out of the total 1.25% CQUIN package for the HCV ODN hosts). For all other indicators, each indicator's CQUIN value should be equally weighted across the CQUIN funding available (0.85% for acute providers, 1.25% for MH providers).

The Hepatitis C Elimination indicator is, however, subject to a minimum value of £330,000. Where this value is greater than 0.4%, the remaining funding available for other acute indicators will be necessarily reduced to ensure the CQUIN package still sums to 1.25%.

2. Applicable Indicators and Values

2.c. Performance measurement

By default, achievement on each indicator is based on a single measure. There are 2 indicators where performance will be calculated by reference to two separate measures, as outlined in the table below. In both cases the sub-parts individually will be worth 50% of the total indicator value. The Shared Decision Making indicator (PSS9) will be measured on the improvement seen in scores between baseline and follow up collection, or maintenance of a good score.

Indicator	Value (%)
PSS5: Routine outcome monitoring in perinatal inpatient services (MH providers only)	**100%**
PSS5a: Paired clinician rated outcome scores reported	50%
PSS5b: Paired patient rated outcome scores reported	50%
PSS8: Severe asthma (acute providers only)	**100%**
PSS8a: Existing patients entered onto the registry	50%
PSS8b: New patients entered onto the registry	50%

2.d. Local CQUINs

Where there is a shortfall of applicable national PSS CQUIN indicators, NHS England commissioners may construct local CQUIN indicators as part of a package.

Local CQUINs may be region-specific or continuation of 2019/20 national CQUINs. Example specifications are included for two indicators in this pack, see slide 25.

3. Payment

Summary of key information included in each indicator specification

This section sets out the information included in each indicator's specification, designed to set out the precise rules for calculating compliance. These will be explained in more detail, with some illustrative examples over the coming slides.

Period in scope

The quarters in 2020/21 in which CQUIN compliance must be measured are outlined in the 'Scope' section of each indicator's specification under the heading 'Period'; they are identified as:

i. **Green:** quarters in scope; and,
ii. **Red:** quarters out of scope.

Basis for payment

For all indicators, payment will be based on a performance assessment undertaken at the end of the scheme. Unless otherwise stated, payment will be based on a **quarterly average i.e.** on the average % performance across the period in scope, calculated separately for each quarter. Each quarter's performance will therefore contribute equally to payment. For PSS8a, payment will be based on the average of % performance across the period in scope, using one calculation for the whole period at the scheme end.

Payment and thresholds

There is one lower and one upper threshold for each indicator. This information is detailed within the 'Payment basis' section of each indicator's specification under the heading 'Minimum' for the minimum threshold and 'Maximum' for the maximum threshold. Payment is determined by reference to these thresholds. Where the upper threshold is reached, 100% of payment will be earned. No payment will be earned until performance is above the lower threshold. Payment should be graduated between the two thresholds evenly. See Section 3a and 3b for more information.

3a. Payment: Thresholds and Relevant Quarters

Payment will be based on each provider's uptake of the identified method or process, by reference to 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 section 3b.**

Indicator	Pay basis (%)	Period in scope	Indicator	Pay basis (%)	Period in scope
PSS1: Hep C elimination	40 - 90	Q1-4	PSS2: Managing a healthy weight in adult secure MH services	75 - 90	Q3-4
PSS6: Antifungal stewardship	75 - 90	Q2-4	PSS3: CAMHS needs formulations in Tier 4 settings	50 - 80	Q2-4
PSS7: Paediatric movement therapy	40 - 66	Q3-4	PSS4: D/deaf communications assessments in CAMHS and adult inpatient services	100	Q1-4
PSS8: Severe asthma PSS8a: PSS8b:	 40 - 50 60 - 80	 Q1-4 Q1-4	PSS5: Routine outcome monitoring in perinatal inpatient services PSS5a: PSS5b:	 75 - 95 35 - 55	 Q2-4 Q2-4
PSS9: Shared decision making		Q2, Q4			

3b. Calculating Payment: Step 1 – Identifying Performance

Performance will be based on the entirety of the relevant period.

- For a scheme with periods Q1 to Q4 in scope, the performance will be calculated by averaging the four quarterly performance figures to produce the scheme performance for the indicator, for example:

Quarterly monitoring												Scheme performance
Q1			Q2			Q3			Q4			
Num-erator	Denom-inator	Perfor-mance (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Annual Performance (%)
25	100	25	35	100	35	45	100	45	55	100	55	(25+35+45+55)/4 = 40

- In the example below, the period in scope is Q2 to Q4, so here we calculate the average performance across three quarters only.

Quarterly monitoring												Scheme performance
Q1			Q2			Q3			Q4			
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Annual Performance (%)
N/A	N/A	N/A	25	100	25	55	100	55	75	100	75	(25+55+75)/3 = 52%

3b. Calculating Payment: Step 2 – Comparing to Thresholds

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 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

Each indicator has a target performance level that we refer to as 'maximum' on the indicator specifications. There is also a 'minimum' level – this is the level of achievement after which some level of CQUIN payment begins to be earned – and payment is awarded proportionately based on where performance lands between the 'minimum' and 'maximum' 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 'minimum' 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 'minimum' (25%) and 'maximum' (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 'maximum' 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 (%)	Perfor-mance	*(Performance – Min) / (Max – Min) = Payment value*		%	Calculation (£k)	£k	Result
1	50	90	40%	(40% - 50%) / (90% - 50%) = -25%	£100k	0%	100k x 0% = 0	0	No payment
2	25	80	63%	(63% - 25%) / (80% - 25%) = 69%	£100k	69%	100k x 69% = 69	69	Partial
3	30	70	72%	(72% - 30%) / (70% - 30%) = 105%	£100k	100%	100k x 100% = 100	100	Full payment

3c. In-year Payment and End-of-year Reconciliation

NHS England and Improvement does not mandate a specific approach to paying CQUIN monies to providers in advance of a final CQUIN earnings calculation being made at the year end. Many commissioners, for example, will choose to pay a regular amount throughout the year. 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 commissioner has made four quarterly payments of £25k, totalling £100k. The provider actually earned £81k, so the commissioner has **overpaid by £19k**.
- **Example 2**: The commissioner has made two payments of £25k, totalling £50k. The provider actually earned £81k, so the commissioner 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. Understanding Performance

4.a. Collecting sample data

Two indicators, PSS2 (Adult Secure Healthy Weight) and PSS6 (Antifungal Stewardship) require audits. The approach of using random sampling where possible is designed to minimise collection burden, whilst ensuring measurement is representative of a provider's true performance.

4.b. Random sampling methods

1) **True randomisation:** every record matching the denominator 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. The desired number of records are then identified using the random number generator from within these bounds.

For example, with 1,000 records, and a sample of 100, x=1,000. Number each record from 1 to 1,000. Randomly generate numbers using a random number generator until 100 numbers between 1 and 1,000 are generated e.g. 7, 77, 999, 452, 128… These are the chosen records for auditing.

2) **Systematic sampling**: every record matching the denominator needs to be assigned a unique reference number consecutively from 1 to x but only after the records have been ordered in a way that doesn't have any clinical significance (e.g. acuity), for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/(the number to be sampled), so that every 'i'th record will be selected after the first record has been randomly generated between 1 and i.

For example, with 1,000 records and a sample of 100, i=1,000/100 =10. So the first record will be randomly selected between 1 and 10 and then the 10th record from this will be used. For example. record 7, 17, 27, 37, 47… will be chosen for auditing.

In instances where local systems cannot provide an exact list of records matching the denominator (e.g. unable to apply the 'exclusions' shown in the indicator specification), then the above methods can still be used although some records may end up being discounted when reviewing the case notes. Either the method should be repeated until 100 records are identified or more than 100 random records can be generated at the start to allow for the need to discount cases that do not meet the denominator.

4. Understanding Performance

4.c. Collecting quarterly data: quota sampling

Quota sampling is a non-random approach to case selection, where case notes are systematically searched to identify those that match the denominator. Even with care this method can lead to samples that poorly represent a provider's true performance, and **should be avoided** if at all possible and must be used only after **consulting with clinical audit colleagues**.

The case note system adopted locally is crucial in determining how best to apply quota sampling in order to ensure a representative sample is obtained:

- **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 the appropriate number of cases are identified.

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

- **Clinical:** In addition, if case notes are categorised clinically, or split across clinical settings (e.g. wards) that are all relevant to the CQUIN then, similarly, case notes should be searched consecutively from each category or setting. This may need to be combined with chronological approaches above.

4.d. Data Collection and Reporting

For the 2020/21 CQUIN scheme we will be collecting CQUIN compliance data quarterly from regional commissioners via a national compliance template by the end of the following quarter (e.g. Q1 compliance data will be collected by the end of Q2). Specific details will be updated and communicated in due course.

This process is vital in ensuring there is transparent data on performance across the country, allowing providers and commissioners to understand their comparative progress in delivering the areas set out in the scheme. It will further allow us to provide regular updates to regions, alongside national policy and clinical teams, helping to direct support as needed.

5a. CQUIN Indicators: Acute

PSS1: Achieving Hepatitis C Elimination

Services in scope

HCV case finding and treatment, carried out by the 23 lead Hep C centres

Payment levels

Minimum: 40%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

Central Support Team:

england.hepc-enquiries@nhs.net

Data Source(s) & Reporting

Routine provider submissions to Blueteq and the HCV Registry as per 2019/20 Hep C Elimination CQUIN.

Description

Co-ordination of Operational Delivery Networks to work towards Hepatitis C elimination by delivering an out of hospital-based HCV Programme, liaising with stakeholders such as prisons, probation services, community pharmacies, drug and alcohol services, GPs and patient groups to identify, test and engage people living with HCV.

Indicator:

The proportion of patients treated, relative to the 2020/21 run rate

Numerator

The number of patients treated in the area

Denominator

The 2020/21 run rate. The run rate will be set by NHSE/I, to ensure progress is continued to be made towards elimination.

PSS6: Antifungal Stewardship

Services in scope

Those where there is a high use of antifungals for patients with invasive fungal infection

Payment levels

Minimum: 75%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact england.improvingvalue@nhs.net

Supporting Documents

Implementation Pack available from the 2019/20 CQUIN webpages. Additional 2020/21 guidance available on the PSS CQUIN Future NHS Collaboration Platform

Email PSSCQUIN@nhs.net for access

Data Source(s) & Reporting

PHE Fingertips Database. Compliance will be assessed centrally and reports sent to regions. The minimum number of patient records audited is to be 20 patients per quarter. If a Trust has fewer than 20 patients all cases must be audited. Regional commissioners have the discretion to ask larger Trusts to audit more than 20 patients where resources allow, up to a maximum of 30% of total patients receiving an antifungal.

Description

Antifungal stewardship (AFS) teams to carry out patient audits and to address the shortfall in use of key diagnostics that can better target usage of antifungals for patients with invasive fungal infection. AFS teams to involve at least two of the following:

- Antimicrobial pharmacist
- Infectious Diseases consultant
- Clinical microbiologist
- Consultant for intensive care
- Consultant for haematology and/or oncology
- Specialist pharmacist haematology and/or oncology
- Specialist pharmacist intensive care unit

Indicator:

The proportion of patients treated by approved antifungals as per local guidelines and reviewed appropriately by the AFS team within 7 days

Numerator

The number of patients, whose records are audited, who are found to have been treated by approved antifungals as per local guidelines and to have been reviewed appropriately by the AFS team within 7 days

Denominator

Target number of patient records as agreed with the Commissioner, with advice from regional pharmacy leads and the Improving Value Antifungal Stewardship Project Group.

Exclusions

Fluconazole/nystatin, any topical use of antifungals, prophylaxis, patients who received antifungals for thrush / superficial fungal infections.

PSS7: Paediatric Movement Therapy

Services in scope

19 named lead providers of specialised children's services

Payment levels

Minimum: 40%

Maximum: 66%

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact

Charlie.Fairhurst@gstt.nhs.uk

Supporting Documents

Available from the PSS CQUIN Future NHS Collaboration Platform. Email PSSCQUIN@nhs.net for access

Data Source(s) & Reporting

Cerebral Palsy Integrated Pathway (CPIP) Database hosted by Dundee University

Description

To develop networks to support referral pathways, ensuring patients receive a CPIP assessment and that it is entered into the national database.

Although this was a 2019/20 CQUIN, the indicator has been refocussed and is open to 19 named lead providers of specialised children's services including those who did not take part in the 2019/20 Paediatric Movement Therapy CQUIN.

Indicator:

The proportion of Cerebral Palsy patients having received a Cerebral Palsy Integrated Pathway (CPIP) assessment that is entered on the national database

Numerator

The number of Cerebral Palsy patients served by the network, of which the lead specialised provider is the host, having received a CPIP assessment that is entered on the national database

Denominator

The number of eligible Cerebral Palsy paediatric patients. Data to be provided by the CRG.

PSS8: Severe Asthma

Services in scope

Named Asthma Centres working with all referring DGHs in each network

Payment levels

Two components, equally weighted:

a. Minimum: 40% of existing patients,
   Maximum: 50% of existing patients
   Payment made on the performance across the whole year
   Scope: Q1 Q2 Q3 Q4

b. Minimum: 60% of new patients;
   Maximum: 80% of new patients
   Payment made on average quarterly performance
   Scope: Q1 Q2 Q3 Q4

Partial payment rules: 50% of payment made on reaching the minimum threshold

Accessing support

Severe asthma toolkit to be published in early 2020/21; Improving Value implementation pack already available on Sharepoint; email england.improvingvalue@nhs.net for access.

Support Contacts: alannah.thornton1@nhs.net and Kathy.blacker@nhs.net

The Severe Asthma Collaborative, supported by the Improving Value Severe Asthma Project Team, will provide updated guidance

Supporting Documents

Available on the PSS CQUIN Future NHS Collaboration Platform. Email PSSCQUIN@nhs.net for access

Data Source(s) & Reporting

Blueteq; Severe Asthma Registry.

Description

Year 2 of the CQUIN scheme supporting the prescribing and management of patients with severe asthma.

Any named specialised asthma centre that did not take part in the 2019/20 severe asthma can still take up the 2020/21 CQUIN.

Indicator:

The proportion of severe asthma patients on biologics who are entered into the Severe Asthma registry, having been discussed within MDT

Numerator

a. The number of patients currently on a biologic who had not been discussed in an MDT, who now have their data entered in the Severe Asthma Registry, having had their eligibility checked through MDT discussion.
b. The number of new patients who have their data entered in the Severe Asthma Registry, having been discussed within MDT

Denominator

a. The number of existing severe asthma patients on biologics not featuring on the Severe Asthma registry
b. The number of new severe asthma patients

Exclusions

Those who do not give consent

PSS9: Shared Decision Making (SDM)

Services in scope

Cancer, cardiovascular and neuroscience pathways involving decision points relating to: ablation for atrial fibrillation and aortic stenosis; cardiac surgery (CABG vs PCI); neurosurgery; early stage lung cancer; palliative chemotherapy; localised prostate cancer; adjuvant use of chemotherapy for colorectal cancer. Additional pathways can be included subject to agreement.

Payment levels

CQUIN payment made on improvement to SDMQ9 mean score between baseline data collection (in Q2) and follow-up data collection (in Q4), OR on maintenance of 75% SDMQ9 score across the two collections (as agreed with the commissioner). Mean score calculated across all applicable pathways.

Scope: Q1 Q2 Q3 Q4

Partial payment made for maintenance of a mean score of between 65% and 75%.

Accessing support

Support will be offered in support of all four pillars of shared decision making: commissioned services, supportive systems and processes, prepared public and trained teams.

Contact england.shareddecisionmaking@nhs.net

Support is also available via the Improving Value Scheme, within which Commissioners can make use of the Business case documentation. Please email jill.lockhart1@nhs.net for access)

Supporting Documents

FAQs and guidance available on the PSS CQUIN Future NHS Collaboration Platform. Please see also:

https://www.england.nhs.uk/shared-decision-making/guidance-and-resources/

- SDM implementation checklist

https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

Data Source(s) & Reporting

Assessment of SDMQ9 questionnaires issued to patients following conversations at key decision points on specified clinical pathways. CollaboRATE questionnaires may be used on agreement with the commissioner if already in operation.

http://www.patient-als-partner.de/media/sdm-q-9_english_version.pdf

http://www.glynelwyn.com/collaborate-measure.html

Description

Achieving high quality shared decision making conversations to support patients to make informed decisions based on available evidence and their personal values and preferences and knowledge of the risks, benefits and consequences of the options available to them

Indicator:

Patient satisfaction with shared decision making conversations at key decision points

Value

The mean score of SDMQ9 responses in Q4 relative to Q2, reported by a cross-section of patients at each data collection, reaching specified decision points within pathways in scope.

An 'improvement' in the mean score refers to a change that is statistically significant. Analytical support will be provided by the national team to assess improvement.

5b. CQUIN indicators: Mental Health

PSS2: Adult Secure Healthy Weight

Services in scope

Adult Secure

Payment levels

Minimum: 75%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact Louise.Davies10@nhs.net

Supporting Documents

Updated guidance on managing a healthy weight in secure settings (forthcoming) .

Guidance will be provided on what a good passport looks like, along with a national reporting template, on the PSS CQUIN Future NHS Collaboration Platform

Email PSSCQUIN@nhs.net for access. The format of the passport (e.g. paper or digital) is for local agreement.

Data Source(s) & Reporting

Sample audits of a small proportion (15%) of passports to be carried out during Q3 and Q4. An audit support tool will be provided by the CRG.

Quarterly updates and an annual report are requested – for which a national reporting template will be provided

Description

Continuation of the programme to manage a healthy weight in secure settings, as detailed in the (updated, forthcoming) CQUIN guidance, that involves carrying out interventions for service users, workforce, the environment and culture, relating to food, nutrition and physical activity. The focus of the 2020/21 CQUIN, which replaces the 2019/20 scheme, is for service users to have a physical health passport in relation to managing a healthy weight that has been co-designed, details their goals, and that is transferable to other settings.

Indicator:

The proportion of eligible service users with a 'physical health passport' in relation to managing a healthy weight

Numerator

The number of service users with a 'physical health passport' that has been updated at least six monthly in line with CPA and CTR reviews;

plus, for new admissions, the number with a passport in development in preparation for the first CPA at 3 months.

Denominator

All service users

Exclusions

The number for whom it has been documented that such an approach is not suitable

PSS3: CAMHS Tier 4 Needs Formulations

Services in scope

Tier 4 hospital and community CAMHS Settings

Payment levels

Minimum: 50%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact LouiseDoughty@nhs.net

Supporting Documents

Updated CQUIN guidance will be published, to include examples of what good looks like in terms of the formulation process, drawing out implications from formulations on training and service development, and implementing those service changes that have been identified. A national reporting template will also be made available on the PSS CQUIN Future NHS Collaboration Platform

Email PSSCQUIN@nhs.net for access

Data Source(s) & Reporting

National reporting template to be completed quarterly

Description

Follow on from CAMHS Tier 4 Training CQUIN, focussing on formulation and review, as part of a dynamic assessment process, to improve the effectiveness of approaches, methods and interventions delivered in Tier 4 hospital and community settings.

Indicator:

The proportion of inpatients with a formulation or review that has been shared in the appropriate format with the young person, carers and community key workers as part of a dynamic assessment process.

Numerator

The number of inpatients, where it was agreed at the 5 day CPA that formulation is an aim or function of the admission, which have had a formulation or review, or update of existing formulation, within 6 weeks of admission, that is based on the collation of up to date information and understanding from the young person, family and all relevant sources, and that has been shared in the appropriate format with the young person, carers and community key workers as part of a dynamic assessment process.

Denominator

The number of admissions

Exclusions

- All admissions, where formulation is not agreed as an aim or function of the admission, which have had the rationale recorded and is accessible for audit and reporting purposes.
- Discharges without medical authority (DAMA) and out of area repatriations before a formulation could be completed.

PSS4: D/deaf Communications

Services in scope

D/deaf inpatient services in specialised adult and CAMHS mental health services

Payment levels

Minimum: N/A

Maximum: 100%

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact:

s.warmington@nhs.net
alexanderhamilton@nhs.net

Supporting Documents

Available from the CQUIN webpages. and on the PSS CQUIN Future NHS Collaboration Platform

Email PSSCQUIN@nhs.net for access

Data Source(s) & Reporting

Reporting as per the 2019/20 CQUIN via a national reporting template

Description

Year 2 of delivery of communications assessments as detailed in the CQUIN guidance

Indicator:

The proportion of adult and CAMHS service users assessed using the appropriate communication tool

Numerator

The number of adult inpatient service users assessed using the Sunburst Tool;

The number of CAMHS service users assessed using the CAMHS Communication Profile

Denominator

New and existing adult inpatient service users;

New and existing CAMHS service users

PSS5: Outcome Reporting in Perinatal Services

Services in scope

Perinatal Mental Health Inpatient Mother and Baby Units (MBUs)

Payment levels

Two components with equal weighting:

1) Minimum: 75% (CROM)
   Maximum: 95% (CROM)
2) Minimum: 35% (PROM)
   Maximum: 55% (PROM)

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact: amelia.mosley@nhs.net

Supporting Documents

Implementation manual for Routine Outcome Measurement in Perinatal MH (CORC, 2-19) and Framework for Routine Outcome Measures in Perinatal Psychiatry (CR216, RCPsych 2018).

Data Source(s) & Reporting

Routine datasets – Mental Health Services Data Set and Specialised Mental Health (bespoke) datasets

Description

Improvement of routine outcome monitoring in Perinatal Mental Health services -

the use of outcome reporting in perinatal mental health services to measure and record clinician- and patient-rated outcome measures, and patient-rated experience measures.

Indicator:

The proportion of women accessing perinatal Mental Health services within Specialised Mother and Baby Units (MBUs) having paired scores recorded on the specific outcome measures required

Numerator

The number of patients admitted to a Mother and Baby Unit where paired (i.e. at least two) outcome scores have been recorded.

Denominator

All patients discharged from a perinatal mental health service.

5c. Example Specifications for Local CQUIN Indicators

Local 1: Cirrhosis Care Bundle

Services in scope

HPB specialist providers, each networked to around ten non-specialist partners.

Data Source(s) & Reporting

Reporting Template – which will need to be updated to reflect the higher target of 75% for the component relating to the proportion of patients for whom there has been completion of the cirrhosis bundle.

Payment

All components / triggers paid on an all or nothing basis.

Scope: Q1 Q2 Q3 Q4

Accessing support

Contact Graham Foster
g.r.foster@qmul.ac.uk

Supporting Documents

CQUIN Indicator document published as part of 2019/20 scheme

Description

Implementation of a management algorithm at admission ('cirrhosis bundle') in conjunction with a written referral pathway, ensuring that all patients with decompensated cirrhosis that require specialist care are offered treated within a specialised liver centre. Second year of 2019/20 national CQUIN

Indicator:

Four components / triggers:

(1) MOUs in place with all network providers (30% of payment)

(2) Outlying clinical practice should have been identified (10%)

(3) Completion of cirrhosis bundle in at least 75% of patients with ecompensated cirrhosis admitted throughout the region (55%)

(4) Payment of £8,000 to the national coordinating centre (5%)

Local 2: Clinical Utilisation Review

Data Source(s) & Reporting

- Monthly CUR Minimum Data set, as set out in the Information Schedule of the standard contract, including Bed Compliment data
- Twice yearly case studies
- Service Improvement Plan

Payment levels

Payment will be made for achievement against the 20/21 benefits realisation target at quarter 4. To support achievement of the target, providers will be expected to:

- Achieve of 85% compliance and above, measured quarterly.
- Produce 2 case studies by Q4
- Produce a service improvement plan to support achievement of the benefits realisation target.

Scope: Q1 Q2 Q3 Q4

Accessing support

Central Support Team:

H.Heywood@nhs.net

Rationale

Commissioners and NHS providers may wish to consider CUR:-

- To understand and address:
  - the **barriers to patient flow including delayed transfers of care;**
  - **inappropriate admissions; and**
  - **long lengths of stay.**
- To support clinicians, managers and commissioners to understand and manage the **clinically appropriate utilisation of beds in real time**, using **clinical evidence-based data**
- To address **QIPP challenges** through implementing an **evidence-based clinical-decision support tool**, identifying opportunities for **service improvement** that result in improvements in **productivity, efficiency and patient outcomes.**

Description

CUR is a clinical decision support software tool that enables clinicians to make objective, evidence-based assessments of whether patients are receiving the **right level of care** in the **right setting**, at the **right time** based on their individual **clinical need**. CUR **improves patient flow**, identifying patients who should **never have been admitted** and demonstrating whether or not patients are **clinically appropriate** for the level of care they are receiving.

Indicator:

The percentage reduction in the number of patients not meeting the criteria for their current level of care (benefits realisation target). Target to be agreed between provider and commissioner, supported by advice from the national CUR team.

Version control

Date	Version	Update
22 January 2020	1	Initial publication on Future NHS Platform
10 February 2020	2	Publication on NHSE/I website. Change to contact email addresses under PSS4 and PSS9; change to quarters in scope for PSS6 and PSS7.