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# Commissioning for Quality and Innovation (CQUIN): 2022/23

## Guidance

Version 1.2, 17 March 2022

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# Introduction

1. The last two years have been unprecedented for the NHS. The COVID-19 pandemic has presented a unique set of challenges and required innovative new ways of working to provide an effective response.
2. As part of that response, the NHS adopted special payment arrangements for 2020/21 and 2021/22, removed the requirement for trusts to sign formal contracts and disapplied financial sanctions for failure to achieve national standards. The Commissioning for Quality and Innovation (CQUIN) financial incentive scheme was also suspended for the entire period.
3. To support the NHS to achieve its recovery priorities, CQUIN is being reintroduced from 2022/23.
4. This document sets out the requirements for all providers of healthcare services that are commissioned under an NHS Standard Contract (full-length or shorter-form version) and are within the scope of the Aligned Payment and Incentives (API) rules, as set out in the [National Tariff and Payment System](#). These requirements take effect from 1 April 2022.
5. Under the Health and Care Bill, it is proposed that integrated care boards (ICBs) will be established to replace clinical commissioning groups (CCGs). At time of publication the Bill has not completed its passage through Parliament; so where necessary, this guidance document refers to 'CCG/ICB-commissioned services' rather than 'CCG' or 'ICB' commissioned services.

# Summary of approach

6. We (NHS England and NHS Improvement) have identified a small number of core clinical priority areas, where improvement is expected across 2022/23. In general, these are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery and where there is a clear need to support reductions in clinical variation between providers.
7. The CQUIN design criteria have been retained, ensuring a continued focus on specific evidence-based improvements, rather than on complicated and burdensome change. These criteria require that indicators in the scheme:
  - highlight proven, standard operational delivery methods
  - support implementation of relatively simple interventions
  - form part of wider national delivery goals that already exist, thereby not adding new cost pressures
  - are explicitly supported by wider national implementation programmes
  - command stakeholder support.
8. Each clinical process or method included in the scheme has been tested with a range of providers to ensure it is deliverable in the way described, that complexity is removed, and that learning from existing implementation has been incorporated.
9. All clinical processes and methods are already being adopted nationally. Their inclusion in CQUIN is to draw attention to their benefits, and to harness the experience of existing adopters to accelerate uptake. In each case, national support from clinical programmes is in place to help providers deliver the improvements and build them into normal clinical practice. See [Indicator Specifications](#) for information on how to access this support.
10. It is important that the NHS can monitor and nationally report a standard set of performance data for these areas. For some indicators, performance information is already flowing through existing national reporting systems. For others, providers will be required to report uptake as set out in the data collection and reporting section of the [CQUIN Indicator Specifications](#).

11. The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) will only be earnable on the five most important indicators for each contract, as agreed by commissioners. Regardless of this local decision on financial incentivisation, all providers in scope for CQUIN, as described within the API rules will be required (as mandated by NHS Digital through information standards notices and/or approved collections) to report their performance against all indicators to the relevant national bodies where they deliver the relevant services, irrespective of whether the indicator is included within their CQUIN scheme. Performance data will be made widely available to systems, and providers will be given access to information about their absolute and relative performance on each indicator, enabling support to be targeted to areas where it is most needed.

## Quality indicators

### CCG/ICB scheme

12. These are the clinical priority areas highlighted for adoption. Comprehensive instructions concerning the specific indicators are contained within the [Indicator Specification document](#) but are summarised below:

<b>CCG1: Staff flu vaccinations</b>	
<p><b>Applicability:</b> Acute, Community, Mental Health, Ambulance</p> <p><b>CQUIN goal:</b> 70% to 90%</p> <p><b>Supporting ref:</b> NICE NG103<sup>1</sup></p>	<p>Staff flu vaccinations are critical in reducing the spread of flu during winter months; therefore protecting those in clinical risk groups and reducing the risk of contracting both flu and COVID-19 at the same time and the associated worse outcomes, and reducing staff absence and the risk for the overall safe running of NHS services.</p> <p>Section 1.7 of NICE guideline NG103 makes recommendations for increasing the uptake of vaccination amongst healthcare staff. From 2021, the green book has made clear that this should include non-clinical staff who have contact with patients.</p>

<sup>1</sup> <https://www.nice.org.uk/guidance/ng103>

<b>CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+</b>	
<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 40% to 60%</p> <p><b>Supporting ref:</b> NICE NG109<sup>2</sup> NICE NG111<sup>3</sup> NICE NG113<sup>4</sup> NICE QS90<sup>5</sup></p>	<p>NICE guidance sets out steps to follow around the correct prescribing of antibiotics for urinary tract infections. These steps require no complex changes or additional investment, and improve diagnosis and management, reduce treatment failure, and reduce the risk of bacteraemia and associated length of stay.</p> <p>In 2019, there were over 175,000 admissions where a UTI was the primary diagnosis at a cost to the system of over £450m. A third of all UTI admissions have a length of stay &gt; 7 days. UTI is a leading cause of healthcare associated Gram-negative bloodstream infections. Improving the management of acute UTI in adults will reduce deterioration and associated length of stay, releasing bed capacity to support NHS recovery activity.</p>

<b>CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions</b>	
<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 20% to 60%</p> <p><b>Supporting ref:</b> NICE CG50<sup>6</sup> Royal College of Physicians (RCP) London guidance<sup>7</sup></p>	<p>The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration, the importance of which has been emphasised during the pandemic. This measure would incentivise adherence to evidence-based steps in the identification and recording of deterioration, enabling swifter response, which will reduce the rate of cardiac arrest and the rate of preventable deaths in England.</p> <p>As many as 20,000 deaths in hospitals each year could be preventable and this CQUIN aims to reduce that figure by 4,000. Deterioration is linked to 90% of NHS bed days. Reducing the need for higher levels of care will free up capacity particularly in ICU by avoiding admissions and reducing lengths of stay, both of which are significant factors in the NHS's recovery efforts.</p>

<sup>2</sup> <https://www.nice.org.uk/guidance/ng109>

<sup>3</sup> <https://www.nice.org.uk/guidance/ng111>

<sup>4</sup> <https://www.nice.org.uk/guidance/ng113>

<sup>5</sup> <https://www.nice.org.uk/guidance/qs90>

<sup>6</sup> <https://www.nice.org.uk/guidance/cg50>

<sup>7</sup> <https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2>

#### CCG4: Compliance with timed diagnostic pathways for cancer services

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 55% to 65%</p> <p><b>Supporting ref:</b> Rapid cancer diagnostic and assessment pathways<sup>8</sup></p>	<p>Faster diagnosis is proven to improve clinical outcomes: patients are more likely to receive successful treatment when diagnosed earlier. This indicator sets out key elements of the timed pathways for colorectal, lung, oesophago-gastric and prostate cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis.</p> <p>There is currently a lack of focus on the pathways. In many cases the required diagnostic tests and actions are currently happening, but not within the required timeframes and in some cases possibly not in the right order, making achievement of faster diagnosis standards less likely.</p>
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#### CCG5: Treatment of community acquired pneumonia in line with BTS care bundle

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 45% to 70%</p> <p><b>Supporting ref:</b> BTS CAP Care Bundle<sup>9</sup> NICE Guideline NG138<sup>10</sup></p>	<p>The British Thoracic Society care bundle sets out the discrete steps that providers need to follow to improve care for patients with community acquired pneumonia. It requires no additional training or investment to implement, will reduce 30-day mortality, length of stay (potentially by as much as one day), and improve patient experience. It is also aligned with NICE guidance on anti-microbial prescribing for community-acquired pneumonia (NG138).</p> <p>Adherence to the CAP Care Bundle as set out in this CQUIN will help to lessen the national burden that pneumonia places on acute providers, which is currently associated with a spend of £765m and has a mortality of around 29,000 individuals each year. The recently published Getting It Right First Time (GIRFT) report for respiratory (Reports - Getting It Right First Time - GIRFT) found that only three trusts in the country reported using CAP bundles 75-100% of the time. Improving pneumonia care is a key output of the GIRFT report with eight recommendations, one of which is the use of care bundles that the CQUIN will support.</p>
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<sup>8</sup> <https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/>

<sup>9</sup> <https://www.brit-thoracic.org.uk/quality-improvement/clinical-resources/adult-community-acquired-pneumonia/>

<sup>10</sup> <https://www.nice.org.uk/guidance/ng138>

### CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery

<p><b>Applicability:</b> Acute (relevant surgical wards)</p> <p><b>CQUIN goal:</b> 45% to 60%</p> <p><b>Supporting ref:</b> NICE NG24<sup>11</sup></p>	<p>There is detailed NICE guidance setting out the requirements to offer iron before surgery to patients with iron-deficiency anaemia. This indicator draws attention to the importance of screening and treatment in line with that guidance and drives more consistent delivery of standard clinical practice.</p> <p>Improved compliance would reduce blood transfusion rate for major blood loss surgeries, reducing the occurrence of patient safety risks associated with blood transfusion including fluid overload, infection and incorrect blood transfusions being given. Overall, it is estimated that consistent uptake of screening to 60% would deliver savings of around £3m associated with units of blood being saved due to lower transfusion rates, reductions in critical care periods, saved bed days and reductions in admission rates.</p>
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### CCG7: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 0.5% to 1.5%</p> <p><b>Supporting ref:</b> NICE NG5<sup>12</sup></p>	<p>NICE NG5 recommends that medicines-related communication systems should be in place when patients move from one care setting to another and the act of reconciling medicines should happen within one week of the patient being discharged.</p> <p>This indicator directly incentivises acute trusts to make a referral into the NHS Discharge Medicines Service, which is compliant with the minimum quality requirements described in the NHS DMS Toolkit. Patients who receive this service are less likely to be readmitted (5.8% vs 16% at 30 days), and spend fewer days in hospital (7.2 days on average compared to 13.1 for patients who did not receive the service) where they are readmitted.</p>
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<sup>11</sup> <https://www.nice.org.uk/Guidance/ng24>

<sup>12</sup> <https://www.nice.org.uk/guidance/ng5>



<b>CCG8: Supporting patients to drink, eat and mobilise after surgery</b>	
<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 60% to 70%</p> <p><b>Supporting ref:</b> Perioperative quality improvement programme (PQIP) report 3<sup>13</sup></p>	<p>Ensuring that patients Drink, Eat and Mobilise ('DrEaMing') as soon as possible after surgery is a key element of the NHS's enhanced recovery programme, helping to prevent post-operative blood clots and respiratory complications resulting in an average 37.5% reduction in length of stay.</p>

<b>CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients</b>	
<p><b>Applicability:</b> Acute, Mental Health</p> <p><b>CQUIN goal:</b> 20% to 35%</p> <p><b>Supporting ref:</b> NICE NG49<sup>14</sup> NICE NG50<sup>15</sup></p>	<p>NICE Guidance recommends that people who are alcohol dependent should receive a test for fibrosis and cirrhosis. This proposal aims to support the consistent delivery of that pathway of care and it can be delivered without additional investment or training, and within existing pathways.</p> <p>In 2016/17, more than 50,000 liver admissions were unplanned and avoidable and this is increasing. An evaluation in 2019 found that there were 223 unplanned admissions for patients with alcohol-related liver disease (ArLD) compared to 263 in 2020, an absolute increase of 18%. This CQUIN will increase the number of early liver disease diagnoses, which will change patient behaviour, allow for more effective treatment and better prospects of recovery, supporting a reduction in the burden that liver disease places on the NHS. A UK early diagnosis study found that 39% of cirrhosis patients were abstinent at 30 day follow up, and had a 72% long term survival compared with 44% for those drinking at 30 days.</p> <p>A recent ONS report indicates that currently England has the highest rates of alcoholic liver disease deaths since records began. This trajectory is almost certainly due to increased alcohol consumption during the pandemic and patients waiting longer before presenting in healthcare settings. This increase is unprecedented and, though clearly linked to pandemic restrictions, it is against a background of a 43% increase since 2001.</p>

<sup>13</sup> [https://pqip.org.uk/FilesUploaded/PQIP-Annual-Report\\_2021.pdf](https://pqip.org.uk/FilesUploaded/PQIP-Annual-Report_2021.pdf)

<sup>14</sup> <https://www.nice.org.uk/guidance/ng49>

<sup>15</sup> <https://www.nice.org.uk/guidance/ng50>

<b>CCG10: Outcome measurement across specified mental health services</b>	
<p><b>Applicability:</b> All MH providers with adult community mental health, CYP and perinatal MH services.</p> <p><b>CQUIN goal:</b> 10% to 40%</p> <p><b>Supporting ref:</b> Perinatal Mental Health Outcomes Implementation manual<sup>16</sup> NHS Community Mental Health Framework for Adults and Older Adults<sup>17</sup></p>	<p>The delivery of the mental health programme and the commitments in the NHS Long Term Plan outline that mental health elements of delivery and transformation plans should be “outcome-focused, data-driven strategic commissioning which demonstrates an understanding of local health inequalities and their impact on service delivery and transformation”.</p> <p>The use of outcomes measures helps monitor and improve effectiveness, efficiency and quality of the service offered to its service users, to ultimately monitor the impact/benefit people receive from mental health services. This also contributes to wider goals around improved recording and evaluation of interventions in the NHS Long Term Plan.</p>

<b>CCG11: Use of anxiety disorder specific measures in IAPT</b>	
<p><b>Applicability:</b> IAPT services</p> <p><b>CQUIN goal:</b> 55% to 65%</p> <p><b>Supporting ref:</b> The Improving Access to Psychological Therapies (IAPT) Manual<sup>18</sup></p>	<p>The IAPT Manual details the importance of a clinician ensuring that the appropriate outcome measure has been selected during the assessment process, with patients being treated for a specific anxiety disorder having paired scores recorded on the specific Anxiety Disorder Specific Measure (ADSM). This ensures patients receive the most appropriate therapy and safeguards against inappropriate early discharge and adverse consequences.</p>

<sup>16</sup> <https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-routine-outcome-monitoring-in-specialist-mental-health-services.pdf>

<sup>17</sup> <https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>

<sup>18</sup> <https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/>

<b>CCG12: Biopsychosocial assessments by MH liaison services</b>	
<p><b>Applicability:</b> Mental health liaison teams</p> <p><b>CQUIN goal:</b> 60% to 80%</p> <p><b>Supporting ref:</b> NICE CG133<sup>19</sup></p>	<p>NICE CG133 recommends mental health liaison services undertake comprehensive biopsychosocial assessments for people who have presented to emergency departments due to self-harm. Research suggests that only 53% of people who self-harm and present to emergency departments receive a biopsychosocial assessment by specialist mental health staff. This indicator directly incentivises these assessments to take place and for them to meet a minimum set of quality criteria.</p>

<b>CCG13: Malnutrition screening in the community</b>	
<p><b>Applicability:</b> Community hospital inpatients</p> <p><b>CQUIN goal:</b> 50% to 70%</p> <p><b>Supporting ref:</b> NICE QS24<sup>20</sup> NICE NG32<sup>21</sup></p>	<p>Malnutrition is a common clinical and public health problem in England, which is found in all care settings, all disease categories, and individuals of all ages. In 2011/12 The National Institute for Health Research estimated the cost of malnutrition to be £19.6 billion in England. It is estimated to affect 5% of the adult population in England and is expected to increase with the aging population. This indicator builds on work carried out through the nutrition improvement collaboratives and supports simple screening for malnutrition using a validated tool, such as 'The Malnutrition Universal Screening Tool'. Improved screening is expected to support prevention, identification and treatment, enabling potentially significant reductions in both the clinical and economic burden of malnutrition, linked to associated increased admissions and LOS in hospital.</p>

<b>CCG14: Assessment, diagnosis and treatment of lower leg wounds</b>	
<p><b>Applicability:</b> Community nursing</p> <p><b>CQUIN goal:</b> 25% to 50%</p> <p><b>Supporting ref:</b> NICE CG147<sup>22</sup> NICE CG168<sup>23</sup></p>	<p>NICE guidance has existed since 2012 on the appropriate treatment of lower leg wounds, and work by the national wound care strategy programme has been supporting roll out of good practice since 2016.</p> <p>It is estimated that approximately 1.5% of the adult population in the UK is affected by active lower limb ulceration (73,000 patients) and yet less than a quarter receive appropriate assessment and treatment. This unwarranted variation of care and the under use of evidence-based best practice results in sub-optimal healing rates and increased NHS spend.</p>

<sup>19</sup> <https://www.nice.org.uk/guidance/cg133>

<sup>20</sup> <https://www.nice.org.uk/guidance/gs24/resources/nutrition-support-in-adults-pdf-2098545777349>

<sup>21</sup> <https://www.nice.org.uk/guidance/cg32/resources/nutrition-support-for-adults-oral-nutrition-support-enteral-tube-feeding-and-parenteral-nutrition-pdf-975383198917>

<sup>22</sup> <https://www.nice.org.uk/guidance/cg147>

<sup>23</sup> <https://www.nice.org.uk/guidance/cg168>

<b>CCG15: Assessment and documentation of pressure ulcer risk</b>	
<p><b>Applicability:</b> Community hospital inpatients</p> <p><b>CQUIN goal:</b> 40% to 60%</p> <p><b>Supporting ref:</b> NICE CG179<sup>24</sup> NICE QS89<sup>25</sup></p>	<p>NICE clinical guideline CG179 sets out clear best practice for assessing the risk of pressure ulcer development and acting upon any risks identified. It is fully aligned with the recently republished NPIAP (National pressure injury advisory panel) international clinical practice guidelines.</p> <p>Inclusion in CQUIN is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for community hospital patients</p>

## Specialised Services (PSS) scheme

13. The set of clinical priority areas highlighted for adoption are summarised below. Please consult the [indicator specifications](#) for detailed information on the actions being incentivised by each indicator and how the targets are constructed.

<b>PSS1: Achievement of revascularisation standards for lower limb Ischaemia</b>	
<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 40% to 60%</p> <p><b>Supporting ref:</b> Peripheral Arterial Disease Quality Improvement Framework (PAD-QIF)<sup>26</sup></p>	<p>Following guidance published by the Vascular Society to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia and in turn reduce length of stay, in-hospital mortality rates, readmissions and amputation rates. Estimated annual savings are £12 million.</p> <p>The 2021 National Vascular Registry Annual Report included estimates that patients with chronic limb threatening ischaemia (CLTI) undergoing open surgical revascularisation within 5 days of admission had a median length of stay (Los) of 9 days, while people waiting more than 5 days for a procedure had median LoS of 21 days.</p>

<sup>24</sup> <https://www.nice.org.uk/guidance/cg179>

<sup>25</sup> <https://www.nice.org.uk/guidance/qs89>

<sup>26</sup> <https://www.vsqip.org.uk/resources/quality-improvement/quality-improvement-lower-limb-ischaemia/>

**PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery**

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 65% to 75%</p> <p><b>Supporting ref:</b> NICE NG197<sup>27</sup> GMC Guidance<sup>28</sup></p>	<p>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 about both their clinical condition and the consequences of the current pandemic.</p> <p>SDM enables health professionals to comply with the post-Montgomery legal requirement to take “reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments”.</p> <p>SDM is not new; many of the policy and legal drivers have been in place for many years prior to COVID-19, but in 2021 the case for change is more compelling than ever. This is backed up by two highly significant regulatory publications that were published since the onset of the pandemic – the NICE Guideline on Shared Decision Making and the GMC Guidance on decision making and consent.</p>
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**PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres**

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 60% to 75%</p> <p><b>Supporting ref:</b> NICE guidance PH43<sup>29</sup></p>	<p>In support of the NHS England and NHS Improvement public commitment to achieve hepatitis C elimination ahead of the WHO target of 2030 and be the first country in the world to do so.</p> <p>Supports the NHS Long Term Plan in reducing health inequalities as many of the groups most affected by HCV are not in regular contact with healthcare services and experience significant health inequalities.</p> <p>Increased clinical benefits as direct acting antiviral drugs are well established and have high cure rates.</p> <p>Finding and treating patients who are not aware of their HCV infection improves long term prognosis for patients and prevents onward transmission, additionally supporting prevention.</p>
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<sup>27</sup> <https://www.nice.org.uk/guidance/ng197>

<sup>28</sup> <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent>

<sup>29</sup> <https://www.nice.org.uk/guidance/ph43>

**PSS4: Delivery of Cerebral Palsy Integrated Pathway assessments for cerebral palsy patients in specialised children’s services**

<p><b>Applicability:</b> 18 acute paediatric lead centres</p> <p><b>CQUIN goal:</b> 10% to 60%</p> <p><b>Supporting ref:</b> CPIP UK website<sup>30</sup> NICE guideline CG145<sup>31</sup> NICE guidance NG62<sup>32</sup></p>	<p>To develop networks to support referral pathways, ensuring patients receive a <a href="#">Cerebral Palsy Integrated Pathway (CPIP)</a> assessment and that it is entered into the national database. Early intervention can prevent deformity, pain and need for complex surgery. Cost savings from reductions in surgery are estimated at £6 million per annum. The proposal also aims to ensure equity of access to the pathway for all children with cerebral palsy and avoid geographical variation. There are several thousand children in England who would benefit from specialist multidisciplinary team review.</p> <p>Aligns with The NHS Long Term Plan to provide a commitment to improving the quality of care for children with long-term conditions. Increases the focus on improving children’s lives by ensuring that professionals work together across organisational boundaries.</p>
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**PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines**

<p><b>Applicability:</b> Acute</p> <p><b>CQUIN goal:</b> 74% to 98%</p> <p><b>Supporting ref:</b> FSSA clinical guide to surgical prioritisation<sup>33</sup></p>	<p>The aim of this indicator is to reduce the risks of harm to patients from a combination of: not being categorised and then, should they have been categorised as priority 2 or 3, waiting longer than the clinically advised thresholds of four weeks and twelve weeks respectively.</p> <ul style="list-style-type: none"> <li>• This indicator is in support of the national drive to improve the level of priority categorisation recording.</li> <li>• From a measurement perspective, it focuses on a set of pathways which have been identified as a priority for elective recovery within specialised commissioning, where we know historically there have been long waiting lists and/or waiting lists have been particularly challenged during the pandemic, and where risks of harm to patients are acutely high from exceeding clinical waiting time thresholds.</li> <li>• As at 19/12/21, 6,926, or 39%, of patients waiting to receive treatment in the selected pathways/procedures were recorded in the WLMDS without one or all of a priority categorisation, procedure code and decision to admit date.</li> </ul>
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<sup>30</sup> <https://www.cpipuk.org/>

<sup>31</sup> <https://www.nice.org.uk/guidance/cg145/chapter/1-Guidance#physical-therapy-physiotherapy-and-or-occupational-therapy>

<sup>32</sup> Multidisciplinary care for those with cerebral palsy aged under 25: <https://www.nice.org.uk/guidance/NG62/chapter/Recommendations#multidisciplinary-care>

<sup>33</sup> [https://fssa.org.uk/covid-19\\_documents.aspx](https://fssa.org.uk/covid-19_documents.aspx)

**PSS6: Delivery of formulation or review within six weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings**

<p><b>Applicability:</b> Mental health – all specialised CYPMHS providers</p> <p><b>CQUIN goal:</b> 50% to 80%</p>	<p>Aims to maximise health outcomes for all children and young people through:</p> <ul style="list-style-type: none"> <li>• Having a clear process for developing a multidisciplinary team understanding (i.e. a formulation) of (a) the presenting difficulties for a young person, leading to (b) a coherent plan of care, intervention and risk management for within Tier 4 settings, and (c) recommendations for care and intervention post-discharge.</li> <li>• Enhancing all professionals' understanding of the identified present and anticipated future needs of a young person, and therefore the accurate planning of effective services to meet those needs.</li> <li>• Aims to deliver improved effectiveness of and team consistency in approaches, methods and interventions delivered in Tier 4 hospital and community settings; and improved discharge plans and patient outcomes in Tier 4 hospital settings.</li> <li>• The NHS England and NHS Improvement service specification for Tier 4 general CYPMH units explicitly states that a comprehensive formulation is pivotal to the provision of good quality Tier 4 input.</li> <li>• Aligns with the NHS Long Term Plan goals to improve quality of care, and reduce restrictive practices.</li> </ul>
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**PSS7: Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings**

<p><b>Applicability:</b> Mental health – all specialised CYPMHS providers</p> <p><b>CQUIN goal:</b> 65% to 80%</p>	<p>Restrictive interventions are often a major contribution to delaying recovery, and have been linked with causing serious trauma, both physical and psychological, to people who use services and to staff. Data from both NHS Benchmarking (CYPMH, 2019) and GIRFT (2020) suggest consistently that the number of restrictive practice interventions are greater in CYPMH inpatients units in comparison to adults.</p> <p>This indicator will underpin measures that will need to be put in place to implement the Mental Health Units (Use of Force) Act 2018 that will come into force at the start of 2022. The Act, also known as Seni’s Law, is named after Olaseni Lewis, who died as a result of being forcibly restrained whilst he was a voluntary patient in a mental health unit. To support services with implementation, the Government will be publishing the statutory guidance at the same time which will detail how mental health units are expected to meet the requirements of the Act.</p> <p>A number of recent studies have shown that it is possible to achieve significant reductions in the use of restrictive interventions, including an Australian evaluation of the introduction of a ‘Safewards’ model of practical approaches to avoid flashpoints, achieve de-escalation and consolidate into practice alternatives to restrictive interventions. This study was a randomised control trial (RCT) which found a statistically significant higher reduction in the use of seclusion in those units which had introduced the Safewards model compared to those which hadn’t.</p>
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**PSS8: Outcome measurement in perinatal inpatient services**

<p><b>Applicability:</b> Mental health – 18 MBUs</p> <p><b>CQUIN goal:</b> 75% to 95% (CROM) 35% to 55% (PROM)</p> <p><b>Supporting ref:</b> Implementation manual for Routine Outcome Measurement in Perinatal MH<sup>34</sup> (CORC, 2-19)</p>	<p>Outcomes data can shed light on the effectiveness of interventions being delivered, supporting national objectives around developing the evidence base for specialised services and commissioning for outcomes.</p> <p>Access to routine clinical feedback has been demonstrated to improve outcomes for patients. Reviewing of individual outcome measures can aid clinical decision making and have a positive impact on care and treatment.</p> <p>Perinatal mental health is a priority area of focus within the 5 Year Forward View for mental health and within the NHS Long Term Plan. Supports NHS Long Term Plan ambition to improve quality of care.</p>
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<sup>34</sup> <https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-routine-outcome-monitoring-in-specialist-mental-health-services.pdf>

# Scheme rules and additional guidance

## Eligibility and value

14. A CQUIN scheme must be offered to each provider which provides healthcare services under the NHS Standard Contract, where indicated in the API rules within the National Tariff Payment System. This was a change that was introduced in 2021/22, though there was no active CQUIN scheme during that period. The change to bring CQUIN within the scope of API rules does have some important consequences, and these are explored below.
15. Unlike in previous years, CQUIN now only applies to those contractual relationships within scope of the API rules. That is, to:
  - i. all CCG-trust relationships within the same ICS
  - ii. all other CCG-provider relationships with an expected annual contract value (EACV) of more than £30m
  - iii. all specialised services commissioned from providers by NHS England, or by a lead provider, where part of a Provider Collaborative.
16. Therefore, please note that within a multi-commissioner contract with a large trust, for example there might be five individual relationships above the £30m threshold to which API, and therefore CQUIN, apply; and five with lower EACVs to which API and CQUIN do not apply.
17. Under the NHS Standard Contract, there should be one scheme which covers the CQUIN applicable relationships, offered by the co-ordinating commissioner, or by NHS England in the case of PSS, to the provider. Where multiple commissioners are proposing to be party to the same contract with a provider, they must identify one of them to act as co-ordinating commissioner and put in place a Collaborative Commissioning Agreement (<https://www.england.nhs.uk/nhs-standard-contract/22-23/>). This agreement can be used to describe the governance arrangements; how the co-ordinating commissioner will consult and engage with other commissioners to determine the proposed content of the CQUIN scheme to be offered to the provider, in accordance with paragraphs 21-22 below.

18. The financial value of CQUIN remains at a reduced value of 1.25%, although now as a proportion of the fixed element of payment. As such, it is no longer additional to the EACV. It should be paid in full to the provider, in advance, in monthly instalments as part of the EACV; but the commissioner will make deductions as part of the variations to the fixed payment for any underperformance, depending on the provider's reported performance against the relevant nationally set CQUIN indicators.

### **Agreeing and implementing a scheme**

19. By default, commissioners and providers should include all relevant quality indicators within their CQUIN scheme. The financial value of each indicator should be equally weighted. So, if there are five indicators relevant for a provider's contract, each would be worth 0.25% (ensuring the scheme is worth 1.25% of the fixed element of payment in total).
  - i. Where fewer than three national indicators relevant for a particular contract, commissioners may offer additional local indicators (of appropriate number and complexity, proportionate to the scale of the contract).
  - ii. We recommend that no more than five indicators are included within a CQUIN scheme and so, where more than five indicators are relevant to a particular provider's services, the co-ordinating commissioner and the provider should agree the most relevant five indicators across the services in scope for each contract, with each indicator attracting the same value within the contract. It should be noted, however, that in all instances, providers that are in scope for CQUIN, in accordance with API rules are required to report their performance against the complete set of relevant national indicators, even where these indicators are not included within their CQUIN scheme.
20. In most cases, it will be straightforward for a commissioner and provider to identify the relevant indicators and to slot them into the contract schedule, in advance of contract signature. But in the situations described in paragraph 19 above, there will be a need for some negotiation, either to identify additional local indicators or to agree which national indicators are the most relevant. In such cases, the onus should be on the co-ordinating commissioner to make a clear proposal to the provider on a timely basis so that, acting in good faith,

the two parties can then reach agreement, with the local contract being completed and signed before the start of the new financial year.

21. Funding paid to providers under the scheme is non-recurrent.
22. The scheme offered to each provider must be in accordance with this guidance and, where local development is required, must give the provider a realistic expectation of earning a high proportion of the percentage available.
23. Each scheme must be recorded in Schedule 3E of the local contract (which will be in the form of the NHS Standard Contract). Contracts must set out clearly the proportion of payment associated with each scheme indicator and the basis upon which payment will be made.
24. The provider must submit local CQUIN performance reports and reconciliation accounts to its co-ordinating commissioner, in accordance with the requirements of Service Condition 38 of the Contract.
25. Any disputes about schemes that have been agreed and recorded within contracts should be resolved in accordance with the dispute resolution mechanism set out in the NHS Standard Contract.

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