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Commissioning for Quality and Innovation (CQUIN) scheme for 2022/23

Annex: Indicator specifications

Version 1.4, 14 October 2022

Changes from version 1.3 have been highlighted in yellow

Contents

Introduction

Background

1. This document is an annex to the CQUIN guidance document and sets out both the relevant technical information for the clinical quality indicators, as well as technical guidance to support the implementation and operation of the scheme, such as how to calculate performance and payment.

2. The first section of this document will set out how performance is assessed for each indicator and show how to identify, interpret and use the information contained within the individual indicator specifications.

3. The document then provides technical specifications for each of the indicators. It also contains routes to access further support from clinical policy teams.

4. This document should be read alongside the CQUIN guidance document.

CCG/ICB scheme

5. There are 15 indicators in the 2022/23 clinical commissioning group (CCG)/ integrated care board (ICB) CQUIN scheme. Table 1 (overleaf) shows how these are relevant to the providers of different services.

6. All national indicators (capped at the five most important, where more than five apply) must be adopted where the relevant services are in scope for each contract (see the section on scheme rules in the CQUIN guidance document for more detail on agreeing a CQUIN scheme).

7. All indicators should be equally weighted within the scheme. By default, achievement on each indicator is based on a single measure. There is one indicator where performance is calculated by reference to two separate measures. This is CCG10 – routine outcome measurement across specified mental health services. Here, the sub parts CCG10a and CCG10b will be worth 50% of the total indicator value.

Table 1: Indicators by service type

Acute		Mental Health	Community	Ambulance
Flu vaccinations for frontline healthcare workers	Screening and treatment of pre-operative anaemia for high blood loss surgeries	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers
Compliance with timed diagnostic pathways for cancer services	Cirrhosis and fibrosis tests for alcohol dependent patients	Cirrhosis and fibrosis tests for alcohol dependent patients	Malnutrition screening in the community	
Appropriate antibiotic prescribing for UTI in adults aged 16+	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Outcome measurement across specified mental health services	Assessment, diagnosis and treatment of lower leg wounds	
Recording of NEWS 2 score, escalation time and response time for critical care admissions	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Use of anxiety disorder specific measures in IAPT	Assessment and documentation of pressure ulcer risk	
Treatment of patients with confirmed Community Acquired Pneumonia in accordance with BTS Care bundle		Biopsychosocial assessments by mental health liaison services		

Understanding performance

Monitoring performance

8. The CQUIN scheme contains a mandatory set of reporting requirements (see guidance for details) for core indicators that will be used for performance monitoring and local payment reconciliation purposes.

9. Some of these indicators will be measured using routinely collected national data. Others will require local data to be submitted to the national CQUIN collection.

10. The 'Data Reporting & Performance' section of each indicator's specification will confirm the relevant source details, eg 'quarterly submission via National CQUIN collection' or 'routine submission to the Mental Health Services Data Set'. Links to routinely collected data will also be included where applicable, as well as estimates for the frequency and timing of data.

11. In addition, national CQUIN reporting will bring together the data from the different sources in order to support performance monitoring and payment reconciliation by both CCG/ICB commissioners and NHS England.

12. The next section provides more information about the approaches to collecting and submitting data to the national CQUIN collection. Where available, clinical audit professionals within each service should be contacted to assist with undertaking the approaches detailed below.

Collecting quarterly data

13. One of the following approaches will be applicable for each indicator:

    i. Where a list of records matching both the denominator and the numerator can be identified and extracted from systems (eg PAS, EPR or other local systems), and performance assessed without the need for case note auditing then all records must be used to calculate performance for each quarter in scope.

    ii. Where a list of records (broadly or exactly) matching the denominator can be identified (eg from PAS, EPR or other local systems), but not the numerator, then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and

random sampling should be used to obtain this sample from case notes. See section 2.3.

iii. In exceptional circumstances, where neither the denominator nor the numerator can be readily identified then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and quota sampling should be used to obtain this sample from case notes. See section 2.4.

14. The approach of using random sampling where possible, in combination with the requirement to review 100 records each quarter (or all records where fewer than 100 exist) is designed to minimise collection burden, while ensuring measurement is representative of a provider's true performance.

Collecting quarterly data: random sampling methods

Option 1: true randomisation

15. Using this method, every record matching the denominator needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (eg http://www.random.org/) is used, with 1 and x setting the lower and upper bounds. Within these bounds, the random number generator is then used to identify 100 records.

For example, with 1,000 records, 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; eg 7, 77, 999, 452, 128… These are the chosen records for auditing.

Option 2: systematic sampling

16. Using this method, 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 does not have any clinical significance (eg acuity). For example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/100, 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, 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.

17. In instances where local systems cannot provide an exact list of records matching the denominator (eg 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.

Collecting quarterly data: quota sampling

18. 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.

19. 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:

    i. **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.

    ii. **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 100 records have been identified.

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

Data collection and reporting

20. In 2022/23 we will be collecting CQUIN data via a national collection for all indicators where an existing data flow does not already exist. The timetable for the quarterly national data submissions is set out below:

	Portal opens	Portal closes
Quarter 1	1 July 2022	25 August 2022
Quarter 2	3 October 2022	27 November 2022
Quarter 3	3 January 2023	27 February 2023
Quarter 4	3 April 2023	28 May 2023

21. Details of how to register for the data collection are set out below.

i. Navigate to NHS England Applications (https://apps.model.nhs.uk).

ii. If you already have an account (also known as an Okta account), then log in. If you do not have account, then navigate to https://apps.model.nhs.uk/register to register.

iii. You will receive an email asking you to activate your account by setting a password. When you have done this, log in via https://apps.model.nhs.uk.

iv. Once logged in, request access to 'CQUIN 22/23 data collection'. You will receive an email once your request is approved, normally within 48hrs.

v. Once approved, navigate to NHS England Applications, click the link for 'CQUIN 22/23 data collection' to confirm that you can access the collection.

22. If you have any questions about registration, please get in touch via e.cquin@nhs.net.

23. Below are the indicators which will be subject to this national CQUIN collection.

	Indicator description
CCG3	Recording of NEWS 2 score, escalation time and response time for critical care admissions
CCG4	Compliance with timed diagnostic pathways for cancer services
CCG5	Treatment of patients with confirmed community acquired pneumonia in accordance with BTS Care bundle
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery
CCG8	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients
CCG12	Biopsychosocial assessments by MH liaison services
CCG13	Malnutrition screening in the community
CCG14	Assessment, diagnosis and treatment of lower leg wounds
CCG15	Assessment and documentation of pressure ulcer risk

24. All providers commissioned to deliver the services to which these indicators apply will be required (as mandated by NHS Digital through information standards notices and/or approved collections) to report their performance via the national collection. This 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.

Summary of key information included in each indicator specification

Period in scope

25. The quarters in which compliance must be measured are outlined in the 'Scope' section of each indicator's specification. Most indicators will be measured across all four quarters. However, occasionally compliance will only be measured for part of this period (for example, staff flu vaccinations, which are measured in quarters 3 and 4 of the financial year, in line with the national vaccination timetable).

Basis for performance

26. Percentage performance will be calculated in one of the ways outlined below. This information is detailed within the 'Data reporting and performance' section of each indicator's specification.

    i. **Quarterly**: at the end of each quarter. This will be the majority of indicators. For example, cirrhosis tests for alcohol dependent patients.

    ii. **Whole period**: at the scheme end using data for the period in scope. For example, staff flu vaccinations.

Basis for payment

27. For all indicators, payment will be based on a performance assessment undertaken at the end of the scheme. Payment will be calculated in one of two ways that are outlined below. This information is detailed within the 'Payment basis' section of each indicator's specification under the heading 'Calculation'.

    iii. **Quarterly average %**: Payment will be based on the average percentage performance across the period in scope, calculated separately for each quarter. Each quarter's performance will therefore contribute equally to payment. This will apply for most indicators.

    iv. **Whole period %**: Payment will be based on the percentage performance across the period in scope, using one calculation for the whole period at the scheme end.

Payment and thresholds

28. 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. 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 Calculating Payment section for more information.

Calculating payment

Step 1: identifying performance

29. Payment will be based on the entirety of the relevant period. For most indicators this is Q1-Q4 in 2022/3. For a typical indicator with periods Q1 to Q4 in scope, the performance will be calculated by averaging the four quarterly performance figures (average of 1/4s) to produce the scheme performance for the indicator – see below:

Quarterly monitoring												Scheme performance
Q1			Q2			Q3			Q4			
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Performance (%)
25	100	25	35	100	35	45	100	45	55	100	55	(25+35+45+55)/4 = 40

30. In the example below, the period in scope is Q2 to Q4, so here we calculate the average performance across three quarters only (average of 1/3s):

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

Step 2: comparing to thresholds

31. Payment will reward providers based on how their performance falls between each indicator's minimum and maximum thresholds, using the following formula:

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

32. 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 payment begins to be earned – and payment is awarded proportionately based on where performance lands between the 'minimum' and 'maximum' threshold. The table overleaf shows some examples to illustrate this process more clearly:

	Threshold			Calculation	Potential 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

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 earnings of 69% of the payment available (69% of £100,000 = £69,000).

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 £100,000 = £100,000.

In-year payment and end-of-year reconciliation

33. The 1.25% value will be paid in full to the provider in advance in monthly instalments as part of the expected annual contract value to reflect assumed attainment of the CQUIN indicators. An assessment of actual performance should take place at the end of the year. If, following the end-of-year assessment, actual CQUIN indicator attainment is below the maximum threshold, payments will be deducted from the provider as part of the variations to the fixed payment.

34. The example below shows a scenario where the provider achieved a performance level which meant they had earned 81% of the potential value of £100,000 (81% of £100,000 = £81,000):

Example	Potential 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	

35. In this example, the commissioner has paid the provider the full indicator value of £100k as part of the fixed payment. The provider actually earned £81,000, so the commissioner would adjust the fixed payment to reflect this £19,000 overpayment.

Indicator specifications

36. This next section details the individual technical specifications, along with routes to access additional support for each of the individual indicators contained within both the CCG/ICB and PSS schemes.

CCG1: Flu vaccinations for frontline healthcare workers

Description	Achieving 90% uptake of flu vaccinations by frontline staff with patient contact.	
Numerator	Of the denominator, those who receive their flu vaccination.	
Denominator	Total number of frontline healthcare workers (HCWs) between 1 September 2022 and 28 February 2023, in line with the widened definition of frontline HCWs used during the 2021/22 flu season, which includes non-clinical staff who have contact with patients.	
Exclusions	• Staff working in an office with no patient contact • Social care workers • Staff out of the providers for the whole of the flu vaccination period (eg maternity leave, long term sickness	
Data reporting and performance	Monthly provider submission (between September and March) to UKHSA via ImmForm. Data will be made publicly available approximately six weeks after each quarter. Performance basis: Whole Period. Quarterly reporting not suitable due to cumulative nature of measure. See the section on *Calculating Payment* (above) for details about the basis for performance and payment	
Scope	Services: Acute, community, mental health, ambulance.	Period: Quarters three and four only
Payment basis	Minimum: 70% Maximum: 90%	Calculation: Whole period %
Lead contact	c19vaccination.dephospital@nhs.net	

Supporting documents

NICE guideline NG103, Flu vaccination: increasing uptake

ImmForm guidance

2021/22 flu and COVID-19 letter to trusts

Green Book – Chapter 19

JCVI guidance on co-administration

Vaccine uptake guidance and the latest coverage data

CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+

Description	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	
Numerator	Of the denominator, the cases where all the following actions were applied: 1. Documented diagnosis of specific UTI based on clinical signs and symptoms 2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all catheter associated UTI (CAUTI) 3. Empirical antibiotic regimen prescribed following NICE/local guidelines 4. Urine sample sent to microbiology as per NICE requirement 5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.	
Denominator	Total number of antibiotic prescriptions for patients aged 16+, with a primary or secondary diagnosis of Urinary Tract Infection in A&E, and in-patient care. (SNOMED codes (A&E): 68566005, 700372006, 45816000, 4009004, 422747000; ICD-10 codes (Inpatient): N12X, N10X, N39.0, T83.5)	
Exclusions	Patients prescribed antibiotic prophylaxis for the treatment of recurrent UTI; pregnant women; chronic tubulo-interstitial nephritis.	
Data reporting and performance	Data should be submitted quarterly to UKHSA via the online submission portal. An auditing tool will be available in supporting guidance. See the section on *Understanding Performance* (above) for details about auditing. Data will be made publicly available on the UKHSA Fingertips AMR Portal approximately 9 weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 40% Maximum: 60%	Calculation: Quarterly average %
Lead contact	Kieran Hand kieran.hand@nhs.net	

Supporting documents

FutureNHS site for Appropriate antibiotic prescribing for UTI in adults aged 16+ CQUIN (contact policy lead for access)

NICE guideline NG109, Lower UTI

NICE guideline NG111, Pyelonephritis (acute): antimicrobial prescribing

NICE guideline NG113, UTI (catheter associated): antimicrobial prescribing

NICE Quality Standard QS90, UTI in adults

Public Health England (UKHSA) UTI Diagnostic Guidance

Infectious Disease Society of America CAUTI Guideline

European Association of Urology (EAU) Guidelines, Urological infections

UKHSA Fingertips AMR portal

CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

Description	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	
Numerator	Of the denominator, the number where the following are all recorded in clinical notes at time of admission to the critical care unit: • NEWS2 score; and, • The time and date of escalation (T0); and, • The time and date of response by appropriate clinician (T1)[1]	
Denominator	All unplanned critical care unit admissions from non-critical care wards (CCADMITYPE = 01, CCSORCLOC = 03) of patients aged 18+.	
Exclusions	Pregnant women, end of life patients.	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute trusts with a critical care facility	Period: All quarters
Payment basis	Minimum: 20% Maximum: 60%	Calculation: Quarterly average %
Lead contact	Nicola Spencer: nicola.spencer7@nhs.net	

Supporting documents

Deterioration Future NHS Collaboration Platform (contact policy lead for access)

NICE clinical guideline CG50, Acutely ill adults in hospital

NICE guideline NG165, COVID-19 rapid guideline

NICE quality standard QS161, Sepsis

Royal College of Physicians (RCP) London guidance

RCP London additional implementation guidance

[1] As defined in the accompanying support documents

CCG4: Compliance with timed diagnostic pathways for cancer services

Description	Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways.	
Numerator	Of the denominator, those where the rapid assessment and diagnostic pathways were delivered in accordance with the technical support guidance.	
Denominator	Total number of referrals where TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE = [Suspected Lung Cancer, Suspected urological cancers (excluding testicular) where CANCER SUB-TYPE = Prostate, Suspected upper gastrointestinal cancers where CANCER SUB-TYPE = OG, Suspected lower gastrointestinal cancers] and PRIORITY TYPE = [Two Week Wait] or consultant upgrade	
Exclusions	Prostate – patients for whom MRI indicates biopsy not required Lung – patients for whom CT indicates clinic not required Targeted lung health check patients Upper and lower gastrointestinal – patients who are not clinically appropriate to go straight to test	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 55% Maximum: 65%	Calculation: Quarterly average %
Lead contact	Sehrish Hussain Sehrish.Hussain2@nhs.net	

Supporting documents

Future NHS Cancer Faster Diagnosis Standard area (including Technical support guidance) (contact policy lead for access)

Rapid cancer diagnostic and assessment pathways

CCG5: Treatment of community acquired pneumonia in line with BTS care bundle

Description	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	
Numerator	Of the denominator, the number of patients where the following actions were taken: 1. Perform a chest x-ray within 4 hours of hospital arrival time. 2. Pneumonia severity score (CURB65) calculated and documented in the medical notes during the ED and/or acute medical clerking. 3. Receive antibiotics within 4 hours of hospital arrival time. 4. Antibiotic prescription is concordant with severity score, subject to clinical judgement, and in line with local guidelines.	
Denominator	Total number of admissions of patients aged 18+, admitted from the usual place of residence (ADMISORC=19) with a primary diagnosis of pneumonia (ICD10 codes: J13-18).	
Exclusions	Patients Discharged from hospital within previous 10 days of the current admission for pneumonia; patients admitted within previous 8 weeks of the current admission under the treatment function code for medical oncology (370), clinical oncology (800), or clinical haematology (303).	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 45% Maximum: 70%	Calculation: Quarterly average %
Lead contact	Mark Dinsdale england.clinicalpolicy@nhs.net	

Supporting documents

Respiratory disease future NHS platform (contact policy lead for access)

BTS CAP Care Bundle

NICE Guideline NG138, pneumonia (community-acquired): antimicrobial prescribing

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

Description	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE guideline NG24.	
Numerator	Of the denominator, all patients for whom the following actions were applied prior to the procedure: • Haemoglobin (Hb) measured at pre-op assessment, or reviewed and recorded if test results were already available • If anaemia present, have serum ferritin level tested • If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron); or refer to back to primary care for treatment where an existing local pathway is in place.	
Denominator	Total patients who had pre-operative assessment, prior to an elective inpatient admission, with a primary procedure in the following groups: Coronary Artery Bypass Graft, Cardiac Valve Procedures, Colorectal Resection, Cystectomy, Hysterectomy, Primary Hip Replacement, Hip Replacement Revision, Primary Knee Replacement, Knee Replacement Revision, Nephrectomy. OPCS procedure codes are provided in the pre-operative anaemia management CQUIN code table. Both the pre-operative assessment and the elective inpatient admission must take place between 01/04/2022 and 31/03/2023.	
Exclusions	None	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute (relevant surgical wards)	Period: All quarters
Payment basis	Minimum: 45% Maximum: 60%	Calculation: Quarterly average %
Lead contact	Matthew Barker m.barker1@nhs.net	

Supporting documents

The pre-operative anaemia management CQUIN code table is available from the GIRFT website

NICE Guideline NG24, blood transfusion

2016 Audit of Patient Blood Management in adults undergoing elective, scheduled surgery

CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service

Description	Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message.	
Numerator	Of the denominator, the number of patients, where a referral was made within 48 hours following a patient discharge via secure electronic message which included: • Patient's demographic details (including their hospital medical record number) • The medicines being used by the patient at discharge (including prescribed, over-the-counter and specialist medicines) • Any changes to medicines (including medicines started or stopped, or dosage changes) and documented reason for the change • Contact details for the referring clinician or hospital department • Hospital's Organisation Data Service (ODS) code or trust name.	
Denominator	Total number of patients who are discharged from hospital on clinical advice or with clinical consent.	
Exclusions	Maternity Patients with a length of stay <24 hours	
Data reporting and performance	Monthly report from NHSBSA dataset, which will be made available to providers for checking and (where necessary) challenge. Performance basis: Whole period. Data is submitted to NHSBSA by pharmacies on completion of the service, therefore the denominator (taken from SUS datasets) is restricted to discharges taking place more than six weeks before the end of the 22/23 year. This supports 'whole period', rather than 'quarterly' performance assessment.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 0.5% Maximum: 1.5%	Calculation: Whole period
Lead contact	Wasim Baqir, wasim.baqir@nhs.net	

Supporting documents

NICE guideline NG5, Medicines optimisation, March 2015

NHS DMS toolkit

CCG8: Supporting patients to drink, eat and mobilise after surgery

Description	Ensuring that 70% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	
Numerator	Of the denominator, admissions where, within 24 hours of surgery ending, the patient was supported to drink, eat and mobilise by the following actions being taken: • Documented order and provision of the patient with free fluids • Documented order and provision of food, which may include oral soft nutrition or any other food • Documented order and provision of assistance to support an awake patient to mobilise from bed to chair	
Denominator	Total elective inpatient admissions with a primary procedure in the following groups: colorectal resection, cystectomy, nephrectomy, hysterectomy, primary hip replacement, primary knee replacement, revision hip replacement, revision knee replacement and liver resection. See supporting coding guidance for OPCS codes.	
Exclusions	Admissions where the patient was sedated for the 24h after surgery ended.	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 60% Maximum: 70%	Calculation: Quarterly average %
Lead contact	Matthew Barker m.barker1@nhs.net	

Supporting documents

Supporting guidance on the GIRFT website

The Perioperative Quality Improvement Programme (PQIP) Report 3

GIRFT National Report: anaesthesia and peri-operative medicine

NICE NG180, Perioperative care in adults

Raising the Standards: RCoA quality improvement compendium: Postoperative care

CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients

Description	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	
Numerator	Of the denominator, those who have an order or referral for elastography or an effective blood test,[2] to diagnose cirrhosis or advanced liver fibrosis.	
Denominator	Total number of unique inpatients (with at least one-night stay) aged 16+ who have a primary or secondary diagnosis of alcohol dependence (ICD-10 codes F10.2-F10.6).	
Exclusions	Inpatients who have a primary or secondary diagnosis of cirrhosis or advanced liver fibrosis (ICD-10 codes: I81.0, I82.0, I85.0-I85.9, K70.3, K70.4, K71.7, K72.1-K72.9, K74.4-74.6, K76.6, K76.7). Patients who have received elastography or an effective blood test, to diagnose cirrhosis or advanced liver fibrosis in the prior 12 months.	
Data reporting & performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Acute, Mental Health	Period: All quarters
Payment Basis	Minimum: 20% Maximum: 35%	Calculation: Quarterly average %
Lead contact	Alice Rose O'Connell, alice.oconnell@nhs.net	

Supporting documents

FutureNHS collaboration platform - prevention (contact policy lead for access)

Alcohol and drug misuse prevention and treatment guidance

NICE guideline NG49, Non-alcoholic fatty liver disease (NAFLD)

NICE guideline NG50, Cirrhosis in over 16s

[2] Algorithms of serum fibrosis markers that can stage liver fibrosis/cirrhosis accurately, for example the Enhanced Liver Fibrosis Test (ELF, patented) or the Liver Traffic Light Test (LTLT, not patented)

CCG10a: Routine outcome monitoring in CYP and perinatal mental health services

Description	Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice.	
Numerator	Of the denominator, those referrals where the same outcome measure[3] has been used at least twice.	
Denominator	All closed MH referrals that lasted more than two weeks, and open referrals that have been open at least six months, with at least two contacts in the financial year, where the individual was under 18 (0-17) on the date of referral, or was referred to a perinatal service.	
Exclusions	N/A	
Data reporting and performance	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' future NHS collaboration platform. Performance basis: Whole period.	
Scope	Services: Mental health services delivering: • care to under 18s (0-17) • specialist perinatal	Period: All quarters [Note: we will only be counting open referrals in the Q4 reporting period to avoid double-counting]
Payment basis	Minimum: 10% Maximum: 40%	Calculation: Whole period
Lead contact	Silvia Davey England.MHCQUIN@nhs.net	

Supporting documents

Mental Health Future NHS Collaboration Platform (contact policy lead for access)

Mental Health Services Data Set (MHSDS)

Perinatal Mental Health Outcomes Implementation manual

MHSDS technical output specification

[3] Acceptable outcome measures can be found in the MHSDS technical output specification (version 5, as of October 2021) https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

CCG10b: Routine outcome monitoring in community mental health services

Description	Achieving 40% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. In order to meet the requirements of this indicator, Patient Reported Outcome Measures (PROMs) data will need to be submitted (either in combination with Clinician Reported Outcome Measures (CROMs), or only PROMs) as part of the numerator for this CQUIN during the financial year.	
Numerator	Of the denominator, those referrals where the same outcome[4] measure has been used at least twice, and by Q4 where paired PROMs have been submitted by the organisation during the financial year.	
Denominator	All closed referrals that lasted more than 2 weeks, and open referrals that have been open at least six months, where the individual was aged 18 or over on the date of referral, with at least two contacts with select CMHS teams during the financial year.	
Exclusions	N/A	
Data reporting and performance	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. Performance basis: Whole period.	
Scope	Services: Adult community mental health services (CMHS)[5]	Period: All quarters [Note: we will only be counting open referrals in the Q4 reporting period to avoid double-counting]
Payment basis	Minimum: 10% Maximum: 40%	Calculation: Whole period
Lead contact	Silvia Davey England.MHCQUIN@nhs.net	

Supporting documents

Mental Health Future NHS Collaboration Platform (contact policy lead for access)

Mental Health Services Data Set (MHSDS)

MHSDS technical output specification

NHS Community Mental Health Framework for Adults and Older Adults

[4] Acceptable outcome measures can be found in the MHSDS technical output specification (version 5, as of October 2021) https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/mental-health-services-data-set/tools-and-guidance

[5] Selected teams include: Crisis resolution team/home treatment team, crisis resolution team, Home treatment service, Primary care mental health service, Community mental health team – Functional, community mental health team – organic, assertive outreach team, rehabilitation and recovery service, general psychiatric service, psychotherapy service, psychological therapy service (non IAPT), personality disorder service, eating disorders/dietetics service

CCG11: Use of anxiety disorder specific measures in IAPT

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,[6] where the course of treatment was finished and where there were at least two attended treatment appointments in the financial year.	
Exclusions	N/A	
Data reporting and performance	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' Future NHS Collaboration Platform. Performance basis: Quarterly.	
Scope	Services: IAPT services.	Period: All quarters
Payment basis	Minimum: 55% Maximum: 65%	Calculation: Quarterly average %
Lead contact	Silvia Davey England.MHCQUIN@nhs.net	

Supporting documents

Mental Health Future NHS Collaboration Platform (contact policy lead for access)

The Improving Access to Psychological Therapies (IAPT) Manual

The Improving Access to Psychological Therapies (IAPT) Dataset

[6] This includes ten disorders: obsessive compulsive disorder, social phobias, health anxiety, agoraphobia, post-traumatic stress disorder, panic disorder, body dysmorphic disorder, irritable bowel syndrome, chronic fatigue syndrome, medically unexplained symptoms not otherwise specified

CCG12: Biopsychosocial assessments by MH liaison services

Description	Achieving 80% of self-harm[7] referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	
Numerator	Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with Section 1.3 of CG133 including: • Assessment of needs • Risk assessment • Developing an integrated care and risk management plan[8]	
Denominator	The total referrals for self-harm to liaison psychiatry.	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via national CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Mental health liaison teams	Period: All quarters
Payment basis	Minimum: 60% Maximum: 80%	Calculation: Quarterly average %
Lead contact	Silvia Davey England.MHCQUIN@nhs.net	

Supporting documents

Mental Health Future NHS Collaboration Platform (contact policy lead for access)

NICE clinical guideline CG16, Self-harm in over 8s: short-term management

NICE clinical guideline CG133, Self-harm in over 8s: long-term management

NICE quality standard QS34, Self-harm

NICE/NHS England guidance on liaison mental health services for adults/older adults

HQIP assessment of clinical risk in mental health services

[7] The term 'self-harm' for this CQUIN is defined as in the NICE guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This excludes harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself. Please see Mental Health CQUIN Future NHS Collaboration Platform for further information about identifying codes for self-harm referrals in local data sets

[8] NHS Personalised care and support planning describes best practice for care planning: https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/

CCG13: Malnutrition screening in the community

Please note that this specification was amended on 16/03/2022 and is now only applicable to community hospital inpatients

Description	Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	
Numerator	Of the denominator, those where the following actions were taken within 24 hrs of admission (or by 1 June 2022 for those admitted prior to 1 April 2022) and then repeated at least every 30 days of the patient spell: 1. A malnutrition risk screening using a validated tool, such as The Malnutrition Universal Screening Tool (MUST) that measures all the items below, with each documented in the management care plan: • Body mass index (BMI) • Percentage unintentional weight loss • The time duration over which weight loss has occurred • The likelihood of future impaired nutrient intake. 2. All people who are identified as malnourished or at risk of malnutrition have a management care plan that aims to meet their complete nutritional requirements. 3. There is evidence of all actions or goals within the management care plan being acted upon.	
Denominator	All community hospital spells with a length of stay greater than 24 hours for patients aged 18+. This includes community hospital stays starting before 1 April 2022 and those unfinished by 31 March 2023.	
Exclusions	Hospital spells where the admission was before 1 April 2022 and the discharge was before 1 June 2022.	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly. Due to requirement for frequent screening, performance should be assessed after the quarter finishes to ensure screening continuity for longer term patients.	
Scope	Services: Community hospital inpatients	Period: All quarters
Payment basis	Minimum: 50% Maximum: 70%	Calculation: Quarterly average %
Lead contact	Alex Thompson, england.ageingwell@nhs.net	

Supporting documents

Discharge and Community services (formerly Ageing Well) Future NHS Collaboration Platform (contact policy lead for access)

NICE quality standard QS24, Nutrition support in adults

NICE clinical guideline CG32, Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition

The Malnutrition Universal Screening Tool (MUST), August 2016

CCG14: Assessment, diagnosis and treatment of lower leg wounds

Description	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.	
Numerator	Of the denominator, the number where the following audit criteria for diagnosis and treatment are met within 28 days of referral to service or, for a patient already receiving care from that service, within 28 days of a non-healing leg wound being identified and recorded: • Documentation of a full leg wound assessment that meets the minimum requirements described in *Lower Limb Assessment Essential Criteria*. • Patients with a leg wound with an adequate arterial supply (ABPI ≥ 0.8-1.3) and where no other condition that contra-indicates compression therapy is suspected, treated with a minimum of 40mmHg compression therapy. • Patients diagnosed with a leg ulcer documented as having been referred (or a request being made for referral) to vascular services for assessment for surgical interventions.	
Denominator	Total number of patients treated in the community nursing service with a wound on their lower leg (originating between the knee and the malleolus).	
Exclusions	N/A	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly.	
Scope	Services: Community nursing patients	Period: All quarters
Payment basis	Minimum: 25% Maximum: 50%	Calculation: Quarterly average %
Lead contact	Una Adderley, National Wound Care Strategy Programme, NatWoundStrat@yhahsn.com	

Supporting documents

National wound care strategy programme CQUIN page (includes FAQs and data collection tools)

NICE clinical guideline CG147, Peripheral arterial disease

NICE clinical guideline CG168, Varicose veins

National Wound Care Strategy programme: lower limb assessment essential criteria

SIGN guideline 120, Management of chronic venous leg ulcers, August 2010

CCG15: Assessment and documentation of pressure ulcer risk

Description	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	
Numerator	Of the denominator, those where the following actions were taken within 24 hours of admission (or by 1 June 2022 for those admitted prior to 1st April 2022) and then repeated at least every 30 days of the patient spell: 1. A pressure ulcer risk assessment (within 6hrs) using a validated scale, such as Waterlow, Purpose T, or Braden, that assesses all of: i. Mobility; ii. Skin; iii. Nutritional status; iv. Continence; v. Sensory perception. 2. Has an individualised care plan[9] which includes all of: i. Risk and skin assessment outcomes; ii. Recommendations about pressure relief at specific at-risk sites; iii. Mobility and need to reposition the patient; iv. Comorbidities; v. Patient preference. 3. Actions to manage the risks identified by the pressure ulcer risk assessment are documented by clinical staff.	
Denominator	All community hospital spells (including those starting before 1 April 2022 and those unfinished by 31 March 2023), for patients aged 18+ with length of stay greater than 24 hours.	
Exclusions	Hospital spells where the admission was before 1 April 2022 and the discharge was before 1 June 2022.	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on *Understanding Performance* (above) for details about auditing as well as data collection and reporting. Data will be made available approximately six weeks after each quarter. Performance basis: Quarterly. Due to requirement for frequent screening, performance should be assessed after the quarter finishes to ensure screening continuity for longer term patients.	
Scope	Services: Community hospital inpatients	Period: All quarters
Payment basis	Minimum: 40% Maximum: 60%	Calculation: Quarterly average %
Lead contact	Una Adderley, National Wound Care Strategy Programme, NatWoundStrat@yhahsn.com	

Supporting documents

National wound care strategy programme CQUIN page (includes FAQs and data collection tools)

NICE clinical guideline CG179, Pressure ulcers: prevention and management

NICE quality standard QS89, Pressure ulcers

[9] NHS Personalised care and support planning describes best practice for care planning: https://www.england.nhs.uk/ourwork/patient-participation/patient-centred/planning/

PSS1: Achievement of revascularisation standards for lower limb Ischaemia

Description and Objective	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.	
Indicator	The proportion of patients that have a diagnosis of chronic limb threatening ischaemia (CLTI) that undergo revascularisation (improve blood supply to prevent leg amputation) either open, endovascular or combined within 5 days of a non-elective admission to vascular provider units.	
Numerator	Number of patients that have a diagnosis of CLTI that undergo revascularisation either open, endovascular or combined within 5 days of a non-elective admission to vascular provider units.	
Denominator	The total number of patients with a diagnosis of CLTI that undergo revascularisation either open endovascular or combined after non-elective admission to vascular provider units.	
Exclusions	None	
Data reporting and performance	Quarterly reports to be provided from National Vascular Registry (NVR) on the Vascular Services Quality Improvement Programme website (www.vsqip.org.uk) in a special NHS organisational data viewer page for lower limb revascularisation. Annual validated assessment provided by the NVR with case ascertainment to be measured against Hospital Episode Statistics (HES)	
Scope	All 87 providers of vascular services for lower limb arterial disease in England	Period: Quarters 1 to 4
Payment Basis	Minimum: 40% Maximum: 60%	Calculation: Quarterly
Lead contact	Kathy Blacker, Lead Commissioner – Vascular Disease CRG, NHSEI Specialised Commissioning Kathy.Blacker@nhs.net	

Supporting documents

Peripheral Arterial Disease Quality Improvement Framework (PAD-QIF)

National Vascular Registry 2021 Annual report

GIRFT Report on Vascular Surgery

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

Description and Objective	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 with regard to both their clinical condition and the consequences of the current pandemic. • SDM enables health professionals to comply with 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" • SDM is not new; many of the policy and legal drivers have been in place for many years prior to Covid, but in 2022 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 SDM and the GMC Guidance on Decision Making and Consent. • SDM can support the use of more conservative treatment options. Published evidence suggests that when SDM has been introduced in surgical pathways, surgical uptake has reduced by at least 20%.	
Indicator	The level of patient satisfaction with shared decision making conversations – as measured by patient scores on internationally validated patient questionnaires – at key decision points in specified pathways that are priority areas for recovery around managing/reducing waiting lists, unplanned admissions and keeping vulnerable people out of hospital.[10] SDMQ9 is the recommended questionnaire to be used. Alternatively, CollaboRATE can be used.	
Numerator	Sum of scores for each question answered by each patient	
Denominator	Number of patients on included pathways multiplied by the maximum score for each question	
Data reporting and performance	CQUIN achievement contingent on improvement to mean score between baseline data collection (in Q2) and subsequent data collection (in Q4), OR on maintenance of a score of 75% or above across the two collections (as agreed with the commissioner).[11]	
Scope	Acute specialised providers	Period: Quarters 2 and 4
Payment Basis	Minimum: 65% Maximum: 75%	Calculation: Q4
Lead contact	Jonathan Berry, Personalised Care Group, NHSEI Jonathan.berry2@nhs.net	

Supporting documents

NICE NG197, Shared decision making

[10] Specialised acute pathways recommended for inclusion by the national team are:
blood and infection: HIV, haemoglobinopathies and haemophilia, Hep C, primary immune deficiencies, bone marrow transplant; cancer: palliative chemotherapy and Enhanced Supportive Care; cardiology and cardiac surgery; frailty: any specialised service with a focus on improving care of older people in specialised pathways, learning from the work of the Specialised Clinical Frailty Network; neurology and neurosurgery; perioperative services within specialised pathways, including for cardiovascular disease e.g. pre-surgery pathways for AAA and vascular services, aortic dissection and cardiac services; renal disease; severe asthma. Additional pathways can be included subject to agreement. The expectation is that each pathway is included where the patient cohort is greater than 50 patients in order to allow sufficient data to be gathered for CQUIN measurement purposes.

[11] Mean score calculated across all applicable pathways. Different patients may feature in the Q2 and Q4 data collections – it is not expected that the same patients are tracked over time. Partial achievement for maintenance of a mean score of between 65% and 75%. Template available from the national team to collate questionnaire scores. National team will assess scores and confirm whether an improvement in the mean score is one which is statistically significant.

GMC Guidance, decision making and consent
NHSEI guidance
SDM Introductory Module from the Personalised Care Institute

PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres

Description and Objective	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. • In support of the NHSE/I 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. • The wider cost savings and benefits of eliminating Hepatitis C include fewer people requiring liver transplants, and reductions in the numbers of people experiencing liver cirrhosis due to HCV. • 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.	
Indicator	The proportion of patients treated, relative to the 2022/23 run rate	
Numerator	The number of patients treated in the area	
Denominator	The 2022/23 run rate. The run rate will be set by NHSE/I, to ensure progress is continued to be made towards elimination.	
Exclusions	None	
Data reporting and performance	Blueteq data will be assessed twice during the year, by the national team. Data will be validated against the HCV Patient Registry and the HCV Drugs Minimum Dataset.	
Scope	Lead Hep C Centres	Period: Quarters 1 to 4
Payment Basis	Minimum: 60% Maximum: 75%	Calculation: Twice during the year
Lead contact	Mark Gillyon-Powell, Head of Programme - HCV Elimination, NHSEI Mark.Gillyon-Powell@nhs.net	

Supporting documents

NICE guidance PH43, Hepatitis B and C testing: people at risk of infection

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

Description and Objective	To develop networks to support referral pathways, ensuring patients receive a Cerebral Palsy Integrated Pathway (CPIP) 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 £6m 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 MDT review.	
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 in the relevant geographical area of each lead provider and their referring centres – data to be provided by the national team.	
Exclusions	None	
Data reporting and performance	Cerebral Palsy Integrated Dataset, hosted by Dundee University. Patient numbers will be assessed on a quarterly basis by the national team	
Scope	19 Paediatric Lead Centres	Period: Quarters 2 to 4
Payment Basis	Minimum: 10% Maximum: 60%	Calculation: Quarterly
Lead contact	Dr Charlie Fairhurst, Consultant in Paediatric Neurodisability, Head of Paediatric Neurosciences, Evelina London Children's Hospital, CRG Chair Charlie.Fairhurst@gstt.nhs.uk	

Supporting documents

CPIP Manual[12]

NICE guideline CG145, Spasticity in under 19s: management, Section 1.2 Physical therapy (physiotherapy and/or occupational therapy)

NICE guidance on multidisciplinary care for those with cerebral palsy aged under 25

[12] Available from the PSS CQUIN Future NHS Collaboration Platform. Email england.psscquin@nhs.net for access

PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines

Description and Objective	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. • This indicator is in support of the national drive to improve the level of priority categorisation recording[13]. • From a measurement perspective, it focuses on a set of procedures and 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. • 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.	
Indicator	The proportion of patients on admitted pathways for: cardiac surgery; cardiothoracic surgery; neurosurgery; AAA surgery; and within cardiology: TAVI and complex cardiac devices; who receive a priority categorisation - according to the Federation of Surgical Specialty Associations (FSSA) clinical guide to surgical prioritisation or equivalent[14] - that is entered into the waiting list minimum dataset (WLMDS) alongside a decision to admit date and a proposed procedure code[15].	
Numerator	The number of patients[16] on the selected admitted pathways who receive a valid priority categorisation, proposed procedure code and decision to admit date.	
Denominator	The number of patients on the selected admitted pathways.	
Exclusions	None	
Data reporting	Quarterly snapshot of the WLMDS. Reports will be provided by the national team.	
Scope	All providers offering the selected procedures and pathways, irrespective of whether they are currently submitting to WLMDS with the appropriate procedure code.	Period: Quarters 1 to 4
Payment Basis	Minimum: 74% Maximum: 98%	Calculation: Whole period
Lead contact	For waiting list minimum dataset queries please contact england.waitinglistmds@nhs.net. For other queries please contact the NHSEI Specialised Commissioning National Analytics inbox: england.scdata@nhs.net	

[13] See https://future.nhs.uk/connect.ti/ElectiveRecovery/view?objectId=23199920 for more detail

[14] For the specified cardiac surgery and cardiology pathways, the specialised commissioning cardiac CRG guidance on prioritisation of patients should be used. See the PSS CQUIN Future NHS Collaboration Platform for more detail. Email england.psscquin@nhs.net for access

[15] https://fssa.org.uk/covid-19_documents.aspx
For guidance on the relevant procedure codes that will be used for CQUIN measurement, see the PSS CQUIN Future NHS Collaboration Platform.

[16] Both specialised and non-specialised patients within these pathways are subject to this indicator. It should be noted that this indicator does not seek to suggest that any patients being treated within any particular pathways or procedures should be prioritised within waiting list management processes, rather, it asks that all patients are categorised in order to support robust waiting list management processes.

PSS6: Delivery of formulation or review within 6 weeks of admission, as part of a dynamic assessment process for admissions within Tier 4 CYPMH settings

Description and Objective	To maximise health outcomes for all children and young people through: • 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. • 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. This 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 for the c.4,700 admissions per year. The NHSE 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.	
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.	
Data reporting and performance	National reporting template to be completed quarterly	
Scope	Tier 4 hospital and community CYPMHS Settings	Period: Quarters 1 to 4
Payment Basis	Minimum: 50% Maximum: 80%	Calculation: Quarterly
Lead contact	Andrew Simpson, Interim Deputy Head of Mental Health and Lead Commissioner – CAMHS CRG, NHSEI Specialised Commissioning andrew.simpson20@nhs.net	

Supporting documents

Guidance document formulation and review, as part of a dynamic assessment process[17]

[17] Available on the PSS CQUIN Future NHS Collaboration Platform, email england.psscquin@nhs.net for access

PSS7: Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings

Description and Objective	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. 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. 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.	
Indicator	The MHSDS RI CQUIN score. This is an overall assessment of data quality for each provider, based on a list of key MHSDS data items listed. The MHSDS RI CQUIN score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS.[18]	
Numerator	Sum of data item scores for percentage valid and complete for each of the specified fields relating to restrictive interventions, multiplied by a coverage score for the MHSDS	
Denominator	Total number of specified fields relating to restrictive interventions	
Supporting measures	To support achievement, it is recommended that providers develop the following: • Development of an organisation policy on restrictive practice with appropriate adjustments for children and young people • Identification of a process to obtain regular feedback from CYP staff and family/carers following restrictive interventions • Implementation of a case note audit in order to assess data quality (restrictive practice data recorded on MHSDS) and identify contributing factors and themes for a quality improvement programme • Development of a quality improvement programme using evidence based approaches	
Data reporting and performance	Mental Health Services Data Set (MHSDS). Data submitted will undergo secondary analysis and presented in a table available to providers (with overall MHSDS RI score for individual providers) to allow benchmarking and support QI. Data will be reviewed on a quarterly basis by the CRG Spec commissioning (NHSE/I) and by regional commissioners/provider collaboratives.	
Scope	All CAMHS Tier 4 inpatient services	Period: Quarters 1 to 4
Payment Basis	Minimum: 65% Maximum: 80%	Calculation: Quarterly
Lead contact	Andrew Simpson, Interim Deputy Head of Mental Health and Lead Commissioner – CAMHS CRG, NHSEI Specialised Commissioning andrew.simpson20@nhs.net	

[18] For the full definition and data items, please see the detail on the PSS CQUIN Future NHS Collaboration Platform, email england.psscquin@nhs.net for access

PSS8: Outcome measurement in perinatal inpatient services

Description and Objective	Collection and recording of patient-reported and clinician-reported outcome measures. This has the potential to improve outcomes for the 900 - 1,000 patients in the 18 perinatal MH inpatient Mother and Baby Units (MBUs). 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. Outcomes data can also shed light on the effectiveness of interventions being delivered, supporting national objectives around developing the evidence base for specialised services and commissioning for outcomes.	
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.	
Exclusions	None	
Data reporting and performance	Mental Health Services Data Set (MHSDS).	
Scope	All 18 MBUs	Period: Quarters 1 to 4
Payment Basis	Minimum: 75% CROM; 35% PROM Maximum: 95% CROM; 55% PROM 50% weighting on each type of measure	Calculation: Quarterly
Lead contact	Sarah Warmington, Head of Mental Health, NHSEI Specialised Commissioning, and Lead Commissioner – Perinatal CRG s.warmington@nhs.net	

Supporting documents

CORC Implementation manual for routine outcome measurement in perinatal mental health

Framework for Routine Outcome Measures in Perinatal Psychiatry

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