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Guidance

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Introduction

1. This document sets out the Commissioning for Quality and Innovation (CQUIN) indicators and metrics, to be used as part of calculating the annual payment for NHS trusts and Foundation Trusts under the NHS Payment Scheme (NHSPS) aligned payment and incentive (API) rules from 1 April 2023 (subject to the result of the consultation on the proposed 2023/25 NHSPS).

Summary of approach

2. NHS England have identified a small number of clinical priority areas, where improvement is expected across 2023/24. Many of these are short-term clinical improvements that have been selected due to their ongoing importance in the context of COVID-19 recovery.

3. 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.

4. 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.

5. 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 the CQUIN Indicator Specifications for information on how to access this support.

6. 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.

Quality indicators

7. These are the clinical priority areas highlighted for adoption. Comprehensive instructions concerning the specific indicators are contained within the CQUIN Indicator Specifications document but are summarised below:

CQUIN01: Staff flu vaccinations	
Applicability: Acute, Specialised Acute, Community, Mental Health, Specialised Mental Health, Ambulance **CQUIN goal:** 75% to 80% **Supporting ref:** NICE NG103[1]	Staff flu vaccinations are critical in reducing the spread of flu during winter months; 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. The proportion of patient-facing NHS staff accessing seasonal flu vaccinations declined dramatically in the 2021/22 flu season and it is important that we do all we can to reverse this to protect staff and patients. Section 1.7 of NICE guideline NG103 makes recommendations for increasing the uptake of vaccination amongst healthcare staff. The green book is clear that this should include non-clinical staff who have contact with patients.

CQUIN02: Supporting patients to drink, eat and mobilise after surgery	
Applicability: Acute, Specialised Acute **CQUIN goal:** 70% to 80% **Supporting ref:** Perioperative quality improvement programme (PQIP) report 3[2]	Ensuring that patients drink, eat and mobilise ('DrEaM') as soon as possible after surgery is an element of the NHS's enhanced recovery programme that helps to prevent post-operative blood clots and respiratory complications and that should result in an average 37.5% reduction in length of stay for patients who dream in the first 24 hours after surgery. This indicator featured in the 2022/23 CQUIN scheme and has been updated for 2023/24 to include a more comprehensive range of procedures and to ensure that the thresholds continue to be stretching, but achievable.

[1] https://www.nice.org.uk/guidance/ng103
[2] https://pqip.org.uk/FilesUploaded/PQIP-Annual-Report_2021.pdf

CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria	
Applicability: Acute **CQUIN goal:** 60% to 40% (NB lower % = more compliant) **Supporting ref:** NICE NG15[3]	There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity to support recovery from the COVID-19 pandemic; reducing exposure to broad-spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections. This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

CQUIN04: Compliance with timed diagnostic pathways for cancer services	
Applicability: Acute **CQUIN goal:** 35% to 55% **Supporting ref:** Rapid cancer diagnostic and assessment pathways[4]	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, prostate, head & neck and gynaecological cancers, which have been identified by a clinical expert group as crucial to achieving faster diagnosis targets. There is currently a lack of focus on the pathways. In many cases the required diagnostic tests and actions are 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.

CQUIN05: Identification and response to frailty in emergency departments	
Applicability: Acute **CQUIN goal:** 10% to 30% **Supporting ref:** SDEC guide to frailty[5]	There are well-evidenced links between frailty and adverse health outcomes including deconditioning, malnutrition and irreversible cognitive decline which may all lead to increased health and care requirements. Early identification of frailty can mitigate some of these risks. Under the NHS Long Term Plan, every acute hospital with a Type 1 Emergency Department (ED) was asked to provide acute frailty services for at least 70 hours a week. Patients with grades of frailty CFS 6 or above should be assessed for frailty associated syndromes via a comprehensive geriatric assessment and/or be referred to the acute frailty service.

[3] https://www.nice.org.uk/guidance/ng15
[4] https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/
[5] https://www.england.nhs.uk/wp-content/uploads/2021/02/SDEC_guide_frailty_May_2019_update.pdf

CQUIN06: Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	
Applicability: Acute **CQUIN goal:** 0.5% to 1.5% **Supporting ref:** NICE NG5[6]	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. 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 are supported by 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 have access to the service) where they are readmitted.

CQUIN07: Recording of and appropriate response to NEWS2 score for unplanned critical care admissions	
Applicability: Acute **CQUIN goal:** 10% to 30% **Supporting ref:** NICE CG50[7] Royal College of Physicians (RCP) London guidance[8]	The NEWS2 protocol is the RCP and NHS-endorsed best practice for spotting the signs of deterioration and ensuring a timely response, the importance of which has been emphasised during the pandemic. This measure incentivises adherence to evidence-based steps in the identification, recording and timely response to deterioration, which will reduce the rate of preventable deaths and ICU admissions in England. As many as 4,900 deaths in hospitals each year could be preventable and this CQUIN aims to reduce that figure by c.1,000. 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.

[6] https://www.nice.org.uk/guidance/ng5
[7] https://www.nice.org.uk/guidance/cg50
[8] https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

CQUIN08: Achievement of revascularisation standards for lower limb Ischaemia	
Applicability: Specialised Acute **CQUIN goal:** 45% to 65% **Supporting ref:** Peripheral Arterial Disease Quality Improvement Framework (PAD-QIF)[9]	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 to length of stay, in-hospital mortality rates, readmissions and amputation rates. Estimated annual savings are £12 million. 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.

CQUIN09: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	
Applicability: Specialised Acute **CQUIN goal:** 40% to 75% **Supporting ref:** NICE public health guideline PH43[10]	In support of the NHS England 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. 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 poor health outcomes due to disadvantage. Progress towards the elimination goal is currently jeopardised by failures in timely progression from diagnosis into treatment. Such diagnosed but untreated patient cohorts remain able to communicate the disease to others. Further, the longer the time these vulnerable patients remain without treatment, the more likely they are to be lost to the system altogether or to experience negative impact on their liver condition.

[9] https://www.vsqip.org.uk/resources/quality-improvement/quality-improvement-lower-limb-ischaemia/
[10] https://www.nice.org.uk/guidance/ph43

CQUIN10: Radical treatment for patients with Stage I – II Non Small Cell Lung Cancer	
Applicability: Specialised Acute **CQUIN goal:** 80% to 85% **Supporting ref:** NICE QS17[11] NLCA report[12] GIRFT lung cancer report[13]	Patients given radical (aka curative intent) treatment have a markedly improved survival and reduced mortality compared to no treatment or palliative treatment. NICE QS17 recommends that adults with non-small-cell lung cancer (NSCLC) stage I or II and good performance status have treatment with curative intent. This is also a key recommendation in the national lung cancer audit report and the 2022 national lung GIRFT report. There are a variety of options for treatment with curative intent. This indicator sets out the comprehensive range of treatment modalities that should be considered either individually or in combination. Decisions about treatment options should be taken at cancer multidisciplinary team meetings and involve patients.

CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	
Applicability: Specialised Acute **CQUIN goal:** 65% to 75% **Supporting ref:** NICE NG197[14] GMC Guidance[15]	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 their clinical condition. 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". SDM is not new; many of the policy and legal drivers have been in place for many years, but now the case for change is more compelling than ever. This is backed up by two highly significant regulatory publications – the NICE Guideline on Shared Decision Making and the GMC Guidance on decision making and consent.

[11] https://www.nice.org.uk/guidance/qs17/chapter/Quality-statement-5-Treatment-with-curative-intent
[12] https://www.rcplondon.ac.uk/projects/outputs/nlca-annual-report-2022
[13] https://future.nhs.uk/connect.ti/GIRFTNational/view?objectId=130557605
[14] https://www.nice.org.uk/guidance/ng197
[15] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent

CQUIN12: Assessment and documentation of pressure ulcer risk	
Applicability: Acute; Community hospital inpatients **CQUIN goal:** 70% to 85% **Supporting ref:** NICE CG179[16] NICE QS89[17]	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. This indicator has been expanded for 2022/23 to include inpatients in acute settings as well as community hospitals. This is expected to contribute to reducing the number of pressure ulcers nationally, improving standards of care for patients in both settings.

CQUIN13: Assessment, diagnosis and treatment of lower leg wounds	
Applicability: Community nursing **CQUIN goal:** 25% to 50% **Supporting ref:** NICE CG147[18] NICE CG168[19]	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. 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.

[16] https://www.nice.org.uk/guidance/cg179
[17] https://www.nice.org.uk/guidance/qs89
[18] https://www.nice.org.uk/guidance/cg147
[19] https://www.nice.org.uk/guidance/cg168

CQUIN14: Malnutrition screening in the community	
Applicability: Community hospital inpatients **CQUIN goal:** 70% to 90% **Supporting ref:** NICE QS24[20] NICE NG32[21]	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.

CQUIN15: Outcome measurement across specified mental health services	
Applicability: Adult CMHS; CYP; and perinatal (including inpatient) MH services. **CQUIN goal:** Various (see specifications for details) **Supporting ref:** Perinatal Mental Health Outcomes Implementation manual[22] NHS Community Mental Health Framework for Adults and Older Adults[23]	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". 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.

[20] https://www.nice.org.uk/guidance/qs24/resources/nutrition-support-in-adults-pdf-2098545777349
[21] https://www.nice.org.uk/guidance/cg32/resources/nutrition-support-for-adults-oral-nutrition-support-enteral-tube-feeding-and-parenteral-nutrition-pdf-975383198917
[22] https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-routine-outcome-monitoring-in-specialist-mental-health-services.pdf
[23] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

CQUIN16: Reducing the need for the use of restrictive practices in CYPMHS inpatient settings	
Applicability: Tier 4 CYPMHS inpatient services **CQUIN goal:** 70% to 90% **Supporting ref** Reducing restrictive practice (RRP) quality improvement collaborative[24]	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 came into force in 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. 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 builds on the 2022/23 *Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings* indicator by adding the question as to whether a blanket restriction was a precursor to the use of force. 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. The 'reducing restrictive practice (RRP) quality improvement collaborative' tested over 300 change ideas over 18 months, and saw 24 out of 38 wards reporting reductions ranging from 25% to 100% in one or more measure of restrictive practice. Of those 300+ change ideas, 'reduce blanket restrictions and rules' was tested by 23 of the 24 wards (96%) which saw sustained reductions in restrictive interventions.

[24] https://www.rcpsych.ac.uk/improving-care/nccmh/quality-improvement-programmes/MHSIP-reducing-restrictive-practice/reducing-restrictive-practice

CQUIN17: Reducing the need for the use of restrictive practices in adult and older adult inpatient settings	
Applicability: Mental health – adult and older adult inpatient services **CQUIN goal:** 75% to 90% **Supporting ref:** CQC: A focus on restrictive intervention reduction programmes in inpatient mental health services[25] Safewards evaluation report[26]	This indicator builds on the 2022/23 Supporting quality improvement in the use of restrictive practice in Tier 4 CYPMH settings indicator but now looking at adult and older adult inpatient settings 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. 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 came into force in 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. The Statutory Guidance supporting the Act is clear on the need for accurate recording of interventions. High quality data is a crucial building block to allow focus and reflection on the use of restrictive practices and consequently reduce the need for those practices.

[25] https://www.cqc.org.uk/sites/default/files/201701207b_restrictivepractice_resource.pdf
[26] https://www2.health.vic.gov.au/-/media/health/files/collections/research-and-reports/s/safewards-final-evaluation-report.pdf

Scheme rules and additional guidance

Eligibility and value

8. Under the NHS payment system (NHSPS) the rules for the Aligned Payment and Incentive (API) payments for NHS trusts and Foundation Trusts provide that, for contractual relationships with an estimated annual contract value (EACV) of above £10M, if the provider does not achieve the CQUIN metrics published in this guidance, the fixed payment should be decreased as has been agreed in accordance with this guidance. In this guidance we refer to the arrangements between the commissioner and provider as a CQUIN scheme.

9. Commissioners may choose to offer an equivalent to a CQUIN scheme in contracts that are out of scope of the API rules, or have an EACV of less than £10m, where a national CQUIN indicator is relevant. Where the services of the affected provider are covered by local payment arrangements as described in the NHSPS, they can include a financial incentive for delivering a specific quality metric by setting out the agreed arrangement in the Local Prices Schedule of their NHS Standard Contract (Schedule 3C). Where the services of the affected provider are covered by Unit Prices published in the NHSPS, any deduction for failing to achieve the required quality metrics would require a locally agreed adjustment under rule 3 in section 6 of the NHSPS. NHS England's regional specialised services commissioning teams will seek to agree this approach with Independent Sector providers of specialised mental health services, for example; and such providers are encouraged to agree to this, as per section 3.1 of the NHSPS on the payment principles that apply to any local payment arrangements.

10. Please note that within a multi-commissioner contract with a large trust, for example there might be two individual relationships above the £10m threshold to CQUIN, applies; and three with lower value contracts to which CQUIN does not apply.

11. Under the NHS Standard Contract, there should be one scheme which covers the CQUIN applicable relationships within that contract, 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 17-18 below.

12. As was the case in 2022/23, the financial value of CQUIN remains 1.25% of the fixed element of payment. It should be paid in full to the provider, in advance, in monthly instalments as part of the fixed payment. The commissioner will make deductions as part of the variations to the fixed payment for any underperformance against the relevant nationally set CQUIN indicators.

13. The CQUIN financial incentive 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 will be required (as mandated by NHS England 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.

Agreeing and implementing a scheme

14. 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 (but are not mandated to) 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 as mandated by NHS England through information standards notices and/or approved collections, even where these indicators are not included within their CQUIN scheme.

iii. Where NHS England is an associate commissioner to a contract, there must be consideration of the inclusion of any applicable indicators relating to specialised acute services in the CQUIN offer. It is expected that the number of CQUINs dedicated to each area will be roughly proportional to the value of the contract, e.g. where specialised services form a quarter of the contract value, 1 in 4 CQUINs should relate to specialised services.

15. 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 15 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.

16. Funding paid to providers under the scheme is non-recurrent.

17. 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.

18. Each scheme must be recorded in Schedule 3F 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.

19. 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.

20. 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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