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Commissioning for Quality and Innovation (CQUIN) scheme for 2023/24

Annex: Indicator specifications

Version 1.1, 6 January 2023

Changes from version 1 have been highlighted in yellow

Contents

Introduction

Background

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

2. The first section of this document sets out how performance is assessed for each indicator and shows 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, including routes to access further support from clinical policy teams.

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

Indicators

5. There are 17 indicators in the 2023/24 CQUIN scheme. Table 1 below 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 up to three separate measures. This is CQUIN15 – routine outcome measurement across specified mental health services. Here, the indicator value is split equally between sub parts CQUIN15a, CQUIN15b and CQUIN15c. Where a provider is not commissioned to provide all three services in scope of the indicator, the indicator value should be split equally between those services[1] that are commissioned.

[1] Please note that for the purposes of this CQUIN only, children and young peoples' (CYP) and community perinatal mental health services are treated as one 'service'.

Table 1: Applicability of indicators by service type

Acute	Specialised Acute	Mental Health	Specialised Mental Health	Community	Ambulance
Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers	Flu vaccinations for frontline healthcare workers
Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Outcome measurement across specified mental health services	Outcome measurement across specified mental health services	Assessment and documentation of pressure ulcer risk	
Prompt switching of intravenous to oral antimicrobial treatment	Achieving the national standard of patients with chronic limb threatening ischaemia undergoing revascularisation within 5 days of admission	Reducing the need for the use of restrictive practices in adult inpatient/ older adult MH settings	Reducing the need for the use of restrictive practices in CYPMH inpatient settings	Assessment, diagnosis and treatment of lower leg wounds	
Compliance with timed diagnostic pathways for cancer services	Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres			Malnutrition screening in the community	
Identification and response to frailty in	Treatment of non-small-cell lung cancer (stage I or II) in line				

Acute	Specialised Acute	Mental Health	Specialised Mental Health	Community	Ambulance
emergency departments	with the national optimal lung cancer pathway				
Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	Improving the quality of shared decision-making conversations				
Recording of and response to NEWS2 score for unplanned critical care admissions					
Assessment and documentation of pressure ulcer risk					

Understanding performance

Monitoring performance

8. The CQUIN scheme contains a mandatory set of reporting requirements (see guidance for details) for indicators that are 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 or commissioners as specified.

10. The 'Data Reporting & Performance' section of each indicator's specification gives the relevant details, eg 'quarterly submission via National CQUIN collection' or 'routine submission to the Mental Health Services Data Set'. Links to routinely collected data are also 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 ICB commissioners and NHS England. More information about how to access this data will be made available in due course.

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 paragraphs 15-17 for information on random sampling.

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 paragraphs 18-19 for information on quota sampling.

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 2023/24 we will be collecting CQUIN data via a national collection for all indicators, other than PSS-only indicators, where an existing data flow cannot be used. The timetable for national data collection and release of dashboards will be notified in due course.

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 23/24 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 23/24 data collection' to confirm that you can access the collection.

22. Please note that the portal's only function is for providers to submit their own data – it will not be possible for another organisation (such as an ICB commissioner or regional team) to view a provider's data via the portal. 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
CQUIN02	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
CQUIN04	Compliance with timed diagnostic pathways for cancer services
CQUIN05	Identification and response to frailty in emergency departments
CQUIN07	Recording of and response to NEWS2 score for unplanned critical care admissions
CQUIN12	Assessment and documentation of pressure ulcer risk
CQUIN13	Assessment, diagnosis and treatment of lower leg wounds
CQUIN14	Malnutrition screening in the community

24. All providers commissioned to deliver the services to which these indicators apply will be required (as mandated by NHS England 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, seasonal flu vaccinations for frontline healthcare workers (HCWs), 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 approach for the majority of indicators. For example, compliance with timed diagnostic pathways for cancer services.

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

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 or exceeded, 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 2023/24. 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 and information regarding specific indicators.

CQUIN01: Flu vaccinations for frontline healthcare workers

Description	Achieving 80% 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), including non-clinical staff who have contact with patients, between 1 September 2023 and 28 February 2024.	
Exclusions	• Staff working in an office with no patient contact • Social care workers • Staff not in contact with patients 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, specialised acute, community, mental health, specialised mental health, ambulance	Period: Quarters three and four only
Payment basis	Minimum: 75% Maximum: 80%	Calculation: Whole period %
Lead contact	england.vaccinecentresgroupsupport@nhs.net	

Supporting documents

NICE guideline NG103: Flu vaccination: increasing uptake
ImmForm guidance
National flu immunisation programme 2022 to 2023 letter
Green Book – Chapter 19
JCVI guidance on co-administration
Vaccine uptake guidance and the latest coverage data

CQUIN02: Supporting patients to drink, eat and mobilise (DrEaM) after surgery

Description	Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.	
Numerator	Of the denominator, where the patient: • was discharged without having an overnight stay; • OR was supported to drink, eat and mobilise, which requires: a. provision of the patient with free fluids b. provision of food, which may include oral soft nutrition or any other food, or, only in the case of patients having upper GI or pancreatic surgery, jejunostomy feeding c. provision of assistance by a maximum of one person (if required) to support an awake patient to mobilise from bed to chair • OR , where exemptions apply, was provided with the elements of the care bundle (a-c), that were applicable to the procedure they underwent (See OPCS code guidance for further information)	
Denominator	Total number of elective surgical admissions (inpatient and day case) where the primary procedure was a **major surgical procedure[2]*** from the following specialties: Cranial Neurosurgery; Spinal Surgery; Endocrine Surgery; Breast Surgery; ENT; Oral and Maxillofacial Surgery; General Surgery; Cardiothoracic; Vascular; Urology; Orthopaedics; Gynaecology. (See OPCS code guidance for further information)	
Exclusions	Admissions where the patient was sedated for the 24h after surgery ended, spinal fluid leak; spinal cord injury; airway concerns.	
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. Performance basis: Quarterly.	
Scope	Services: Acute; Specialised Acute	Period: All quarters
Payment basis	Minimum: 70% Maximum: 80%	Calculation: Quarterly average
Lead contact	Matthew Barker m.barker1@nhs.net	

Supporting documents

GIRFT website: DrEaMing CQUIN
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

[2] Major surgery defined using the "restrictive" category in this academic paper: https://academic.oup.com/bja/article-abstract/119/2/249/4049141. Abbott, Fowler et al. 2017 Brit J Anaes. Frequency of surgical treatment and related hospital procedures in the UK: a national ecological study using hospital episode statistics

CQUIN03: Prompt switching of intravenous to oral antibiotic

Description	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	
Numerator	Of the denominator, those who, at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics	
Denominator	Total number of adult inpatients (16+) with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter)	
Exclusions	• Patients in ICU and HDU • Patients treated with intravenous antifungals or antivirals	
Data reporting and performance	Quarterly submission via e-mail to UKHSA. Refer to the AMR Programme Workspace in FutureNHS (link below) for details about auditing, data collection and reporting. Performance basis: Quarterly.	
Scope	Services: Acute, specialised acute	Period: All quarters
Payment basis	Minimum: 60% Maximum: 40% **Please note that for this indicator, a LOWER % = better performance**	Calculation: Quarterly average %
Lead contact	Kieran Hand england.amrprescribingworkstream@nhs.net	

Supporting documents

FutureNHS AMR workspace for supporting documents (inc audit data collection template; indicator-specific guidance; FAQs)

NICE guidance NG15 Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use

National IV-to-oral switch criteria and decision aid

CQUIN04: Compliance with timed diagnostic pathways for cancer services

Description	Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers 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, as defined by the sequence of events and maximum milestone timeframes being achieved, were delivered in accordance with the technical support guidance (see below).	
Denominator	Total number of referrals where TWO WEEK WAIT CANCER OR SYMPTOMATIC BREAST REFERRAL TYPE = [Suspected Lung Cancer, Suspected gynaecological cancers, Suspected head and neck cancers where CANCER SUB-TYPE does not equal Thyroid, Suspected urological cancers (excluding testicular) where CANCER SUB-TYPE = Prostate, Suspected upper gastrointestinal cancers where CANCER SUB-TYPE = OG, Suspected lower gastrointestinal cancers where CANCER SUB-TYPE = Colorectal] and PRIORITY TYPE = [Two Week Wait] or PRIORITY TYPE = [urgent] or [routine] and CONSULTANT UPGRADE DATE is not null and is equal to or less than date of first event in pathway	
Exclusions	• Prostate: patients for whom MRI indicates biopsy not required • Lung: patients for whom CT indicates clinic not required • Targeted lung health check patients • Patients who are not clinically appropriate to go straight to test as determined by local triage protocols	
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. Performance basis: Quarterly	
Scope	Services: Acute	Period: All quarters
Payment basis	Minimum: 35% Maximum: 55%	Calculation: Quarterly average %
Lead contact	Peter Hawkins Peter.Hawkins4@nhs.net	

Supporting documents

FutureNHS Cancer Faster Diagnosis Standard workspace (including Technical support guidance) (contact policy lead for access)

Rapid cancer diagnostic and assessment pathways

CQUIN05: Identification and response to frailty in emergency departments

Description	Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.	

Numerator	Of the denominator, the number of patients who have a documented assessment against the clinical frailty scale (CFS) with:
	• The result recorded in ECDS
	• Appropriate response where moderate-severe frailty (CFS score of 6 or more) is identified, including:
	  ○ initiation of a comprehensive geriatric assessment (CGA), and/or
	  ○ referral into the acute frailty service (AFS).
	SNOMED codes used to identify the CFS being completed and captured:
	• 1129331000000101 (CFS 1)
	• 1129341000000105 (CFS 2)
	• 1129351000000108 (CFS 3)
	• 1129361000000106 (CFS 4)
	• 1129371000000104 (CFS 5)
	• 1129381000000102 (CFS 6)
	• 1129391000000100 (CFS 7)
	• 1129401000000102 (CFS 8)
	• 1129411000000100 (CFS 9)	

Denominator	Total number of patients attending A&E/SDEC aged 65+	
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. Performance basis: Quarterly.	
Scope	Type 1 acute providers	Period: All quarters
Payment basis	Minimum: 10% Maximum: 30%	Calculation: Quarterly average
Lead contact	Adam Brunning adam.brunning@nhs.net	

Supporting documents

Principles and Characteristics of an Acute Frailty Service for Same Day Emergency Care guidance
SDEC guide to frailty

CQUIN06: 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 Patients with a length of stay <24 hours (including day cases)	
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

CQUIN07: Recording of and response to NEWS2 score for unplanned critical care admissions

Description	Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes.	
Numerator	Of the denominator, the number where: 1. The following are all recorded in clinical notes at time of admission to the critical care unit: • NEWS2 score • The time of deterioration [T -1] (a new and sustained NEWS2 of 5-6 or 7+) • The time of escalation [T0] • The time of clinical response [T1] 2. There is a management plan including at minimum: investigation plan; treatment plan; escalation plan; and review plan, as per NICE CG50 documented in clinical notes 3. The time of the clinical response [T1] was within the RCP guidelines[1] [60 mins for NEWS2 score of 5-6 and 30 mins for a NEWS2 score of 7+]; 4. In patients with a new NEWS2 score of 7 or more and no improvement 60 minutes after the initial clinical response, the time of a senior response [T2] is recorded in clinical notes 5. The time of senior response [T2] (where required) was no more than 60 minutes after the initial clinical response, and within the RCP guidelines[1] with regard to the grade/role of the reviewer.	
Denominator	All unplanned critical care unit admissions from non-critical care wards (CCADMITYPE = 01, CCSORCLOC = 03) and A&E (CCADMITYPE = 01, CCSORCLOC = 05) of patients aged 18+	
Exclusions	• Patients admitted directly to resus (no corridor wait) • Pregnant patients • Patients who are agreed as end of life patients prior to critical care admission	
Data reporting and performance	Quarterly submission via National CQUIN collection. See the section on Understanding Performance for details about auditing, data collection and reporting. Performance basis: Quarterly.	
Scope	Services: Acute trusts with a critical care facility	Period: All quarters
Payment basis	Minimum: 10% Maximum: 30%	Calculation: Quarterly average
Lead contact	Hannah Coyne hannah.coyne@nhs.net	

Supporting documents

Deterioration FutureNHS 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

CQUIN08: 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 to 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	Data to be submitted to the National Vascular Registry within 8 weeks of the end of each quarter. Quarterly reports to be provided from National Vascular Registry (NVR) including a validated assessment against SUS (Secondary Uses Service) data.	
Scope	All 87 providers of vascular services for lower limb arterial disease in England	Period: Quarters 1 to 4
Payment basis	Minimum: 45% Maximum: 65%	Calculation: Quarterly average
Lead contact	Kathy Blacker kathy.blacker@nhs.net	

Supporting documents

Peripheral Arterial Disease Quality Improvement Framework (PAD-QIF)
National Vascular Registry 2022 Annual report
GIRFT Report on Vascular Surgery

CQUIN09: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres

Description and Objective	Progress towards the NHSE public commitment to achieve hepatitis C elimination ahead of the WHO target of 2030 is currently jeopardised by failures in timely progression from diagnosis into treatment. Time from referral to treatment (RTT) should not exceed 4 weeks (in line with HIV care), but many patients are exceeding this – especially those in addiction services. 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. This CQUIN therefore has a shift in focus relative to the 2022/23 Hep C CQUIN indicator. It is in support of the programme and funding for ODNs to provide the end-to-end care pathway. ODNs are asked to work with partners to generate sufficient capacity to meet the RTT target. 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. The elimination programme also 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 poor health outcomes due to disadvantage, including people who inject drugs, prisoners and migrant communities.	
Indicator	The percentage of patients commencing treatment within 4 weeks of a positive diagnosis of viraemia	
Numerator	The number of patients commencing treatment (prescribed, on Blueteq) within 4 weeks of a positive diagnosis of viraemia	
Denominator	The number of patients commencing treatment	
Exclusions	None	
Data reporting	Blueteq data will be assessed 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: 40% Maximum: 75%	Calculation: Twice during the year
Lead contact	Mark Gillyon-Powell england.hepc-enquiries@nhs.net	

Supporting documents

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

CQUIN10: Treatment of non small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway

Description	Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-1) referred for treatment with curative intent, as per the NICE QS17 recommendation. 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.	
Numerator	Of the denominator, those who were referred for treatment including one or more of the following treatment modalities: • surgery – lobectomy, sublobar resection, bronchoangioplastic surgery, bilobectomy or pneumonectomy • radiotherapy – stereotactic ablative radiotherapy (SABR) or conventional or hyperfractionated radiotherapy • chemoradiotherapy • thermoablative techniques.	
Denominator	Total number of adult patients (aged 18+) diagnosed with NSCLC stage I or II and with good performance status (WHO 0-1) whose treatment is discussed at MDT.	
Exclusions	• Patients diagnosed before 1 April 2023 or after 11 February 2024 • Lung function and CFS that preclude surgery or radical radiotherapy	
Data reporting and performance	Reporting template[3] to be submitted to commissioner each quarter. Performance basis: Quarterly	
Scope	Services: Specialist Acute providers with cancer MDTs	Period: All quarters
Payment basis	Minimum: 80% Maximum: 85%	Calculation: Whole period %
Lead contact	Debbie Robinson deborah.robinson5@nhs.net	

Supporting documents

NICE Quality statement 5: Treatment with curative intent
NLCA report
GIRFT lung cancer report

[3] Template available on the PSS CQUIN FutureNHS platform.

CQUIN11: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery

Description and Objective	Achieving high quality shared decision (SDM) 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. This CQUIN indicator highlights the importance of the NICE Guideline on SDM and the GMC Guidance on Decision Making and Consent, and supports providers to consider their approach to maximise compliance to those regulatory documents. The specific aim of the 2023/24 indicator is to embed the work in 2022/23 to achieve high quality SDM conversations in certain specialised pathways and to support roll-out of that work more widely across organisation. • 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 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 specialised pathways. SDMQ9 is the recommended questionnaire to be used. Alternatively, CollaboRATE can be used. Specified pathways should be agreed with the commissioner and represent an extension of the 2022/23 scheme i.e. reference should be made as to how SDM approaches introduced in 2022/23 will be further embedded (e.g. by action on components of the four pillars of SDM implementation), and/or new specialised pathways should be included with the 2023/24 scheme.	
Numerator	Sum of scores for each question answered by each patient.	
Denominator	Number of responses on included pathways multiplied by the maximum score for each question.	
Exclusions	None	
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. Reporting template to be submitted to commissioner each quarter[4].	
Scope	Acute specialised providers who took part in the 2022/23 SDM CQUIN	Period: Quarters 2 and 4
Payment basis	Minimum: 65% Maximum: 75%	Calculation: Q4
Lead contact	england.psscquin@nhs.net	

Supporting documents

NICE NG197, Shared decision making
GMC Guidance, decision making and consent
NHSEI guidance
SDM Introductory Module from the Personalised Care Institute

[4] 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%. National reporting template available to collate questionnaire scores on the PSS CQUIN FutureNHS platform.

CQUIN12: Assessment and documentation of pressure ulcer risk

Description	Achieving 85% of acute and 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 2023 for those admitted prior to 1st April 2023) 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[1] 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 acute and community hospital spells (including those starting before 1 April 2023 and those unfinished by 31 March 2024), for patients aged 18+ admitted to bedded units/wards with length of stay greater than 24 hours.	
Exclusions	Hospital spells where the admission was before 1 April 2023 and the discharge was before 1 June 2023. Patients seen/treated entirely within ED.	
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. 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: Acute and community hospital inpatients	Period: All quarters
Payment basis	Minimum: 70% Maximum: 85%	Calculation: Quarterly average %
Lead contact	Una Adderley NatWoundStrat@yhahsn.com	

Supporting documents

National wound care strategy programme CQUIN page (includes FAQs and data collection tools – please ask policy lead for access)

NICE clinical guideline CG179, Pressure ulcers: prevention and management

NICE quality standard QS89, Pressure ulcers

CQUIN13: 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. Performance basis: Quarterly	
Scope	Services: Community nursing patients	Period: All quarters
Payment basis	Minimum: 25% Maximum: 50%	Calculation: Quarterly average %
Lead contact	Una Adderley NatWoundStrat@yhahsn.com	

Supporting documents

National wound care strategy programme CQUIN page (includes FAQs and data collection tools – please ask policy lead for access)
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

CQUIN14: Malnutrition screening for community hospital inpatients

Description	Achieving 90% 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 2023 for those admitted prior to 1 April 2023) 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 2023 and those unfinished by 31 March 2024.	
Exclusions	Hospital spells where the admission was before 1 April 2023 and the discharge was before 1 June 2023.	
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. 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: 70% Maximum: 90%	Calculation: Quarterly average %
Lead contact	Community Health Services team england.communityservices1@nhs.net	

Supporting documents

Discharge and Community services (formerly Ageing Well) FutureNHS 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

CQUIN15a: Routine outcome monitoring in community mental health services

<table>
<tr><td>Description</td><td colspan="3">Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHSs), having their outcomes measure recorded at least twice. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.</td></tr>
<tr><td>Numerator</td><td colspan="3">Of the denominator, those referrals where the same outcome measure[5] has been used at least twice during the financial year. And separately, those referrals where the same PROM has been used at least twice during the financial year (see ‘Payment basis’ below for details).</td></tr>
<tr><td>Denominator</td><td colspan="3">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.</td></tr>
<tr><td>Exclusions</td><td colspan="3">A number of team types are excluded. See supporting guidance on FutureNHS workspace for full details</td></tr>
<tr><td>Data reporting and performance</td><td colspan="3">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</td></tr>
<tr><td>Scope</td><td colspan="2">Services: Adult community mental health services (CMHS)[6]</td><td>Period: All quarters
[Note: we will only be counting open referrals in the Q4 reporting period to avoid double-counting]</td></tr>
<tr><td>Payment basis</td><td>Paired overall
Min: 20%
Max: 50%</td><td>Paired PROMs
Min: 2%
Max: 10%</td><td>Calculation: Whole period; 50% weighting on each type of measure</td></tr>
<tr><td>Lead contact</td><td colspan="3">Hina Sharma England.MHCQUIN@nhs.net</td></tr>
</table>

Supporting documents

Mental Health FutureNHS 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

[5] Outcomes measures (PROM and CROM) identified as appropriate for use in MH services are listed in the National Clinical Content Repository library that flow to the MHSDS.

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

CQUIN15b: Routine outcome monitoring in CYP and community perinatal mental health services

Description	Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	
Numerator	Of the denominator, those referrals where the same outcome measure[7] 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 outpatient service.	
Exclusions	A number of team types are excluded. See supporting guidance on FutureNHS workspace for full details.	
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: 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	Min: 20% Max: 50%	Calculation: Whole period
Lead contact	Hina Sharma England.MHCQUIN@nhs.net	

Supporting documents

Mental Health FutureNHS Collaboration Platform (contact policy lead for access)
Mental Health Services Data Set (MHSDS)
Perinatal Mental Health Outcomes Implementation manual
MHSDS technical output specification

[7] Acceptable outcomes measures (PROM and CROM) identified as appropriate for use in MH services are listed in the National Clinical Content Repository library that flow to the MHSDS. For list of measures used in CYP see Technical Guidance - Reporting Outcome Measures for CYPMH. For Perinatal see Perinatal Mental Health Outcomes Implementation manual

CQUIN15c: Routine outcome monitoring in inpatient perinatal mental health services

Description	Achieving 55% of inpatients in specialist perinatal mental health services having the same patient-reported outcomes measure (PROM) recorded at least twice and 95% of patients having the same clinician-reported outcomes measure (CROM) recorded at least twice.		
Numerator	Of the denominator, those patients where the same patient-reported outcome measure (PROM), and those where the same clinician-reported outcome measure (CROM) have each been used at least twice during the inpatient stay. The only outcome measures which will count towards this CQUIN are CROMs: HoNOS, HoNOSCA and PROMs: CORE-OM and CORE-10.		
Denominator	All patients who were discharged from a mother and baby unit (MBU) during the financial year, and those who remain inpatients at the end of the financial year and have been inpatient for at least six months.		
Exclusions	N/A		
Data reporting and performance	Routine provider submission to the Mental Health Services Data Set (MHSDS). Quarterly provider level data will be available approx 12 weeks after each period on the PSS CQUIN FutureNHS platform. Performance basis: Whole period.		
Scope	All 19 MBUs		Period: All quarters
Payment basis	**Paired CROMs** Min: 75% Max: 95%	**Paired PROMs** Min: 35% Max: 55%	Calculation: whole period; 50% weighting on each type of measure
Lead contact	Helen Wilde h.wilde@nhs.net		

Supporting documents

CORC implementation manual for routine outcome measurement in perinatal mental health

Framework for Routine Outcome Measures in Perinatal Psychiatry

CQUIN16: Reducing the need for restrictive practice in CYPMH inpatient 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. GIRFT data shows that the use of force is higher in CYP settings than adult settings and recommends that levels should be no higher in CYP settings. 2022/23 saw a focus within the CQUIN scheme on improving data quality on the recording of restrictive interventions in CYPMH Tier 4 settings. This has provided a high quality baseline from which to build quality improvement plans to respond to the Mental Health Units (Use of Force) Act 2018 by reducing the use of force and ensuring accountability and transparency about the use of force. In 2023/24, teams are now asked to focus on a component of quality improvement plans that has been evaluated as successful to date - a review of blanket interventions - and to include that within their quality improvement approaches. 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. This indicator therefore asks that there is reflection on whether a blanket restriction was a precursor to the use of force every time a restrictive incident is recorded. The work of the collaborative has shown that a focus on reducing the antecedents to the use of harmful restrictive interventions can have a more powerful effect than solely focussing on response or reparation to harmful events that have already taken place. Achievement against this indicator, in conjunction with continued achievement of high quality submissions to the MHSDS restrictive intervention tables, will support providers in meeting one of the requirements of the Act which states that providers are to 'keep records of any use of force on a patient by staff who work in that unit' and that this should include 'details of what led to the use of force'.	
Indicator	The proportion of restrictive incident records which note whether a blanket restriction was a precursor to the use of force.	
Numerator	The number of restrictive incident records which note whether a blanket restriction was a precursor to the use of force	
Denominator	The total number of restrictive incident records, as recorded in the Mental Health Services Dataset (MHSDS).	
Data reporting and performance	Providers are asked to submit a quarterly report to their commissioner or Lead Provider as appropriate, detailing the number of records which meet the requirement, using the national reporting template available on the PSS CQUIN FutureNHS platform.	
Scope	All CYPMH Tier 4 inpatient services	Period: Quarters 2 to 4
Payment basis	Min: 70% Max: 90%	Calculation: Quarterly
Lead contact	Andrew Simpson andrew.simpson20@nhs.net	

Supporting documents:

Mental Health Units (Use of Force) Act 2018: Statutory guidance for NHS organisations in England, and police forces in England and Wales, published 7 December 2021

Shah et al, The mental health safety improvement programme: a national quality improvement collaborative to reduce restrictive practice in England, British Journal of Healthcare Management Vol. 28, No. 5, May 2022

Restraint Reduction Network Blanket Restrictions Toolkit

CQUIN17: Reducing the need for restrictive practice in adult/older adult settings

Description	Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	
Numerator	Of the denominator, those where all required and mandatory data fields are complete adjusted for coverage of both table MHS505 & MHS515 (see supporting guidance on FutureNHS workspace for more information)	
Denominator	Total number of restrictive interventions recorded while a patient is in a mental health adult or older adult inpatient bed during the reporting period.	
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	ICB commissioned adult and older adult inpatient mental health services	Period: Quarters 1 to 4
Payment basis	Min: 75% Max: 90%	Calculation: Quarterly
Lead contact	Ruth Davies england.mhcquin@nhs.net	

Mental Health FutureNHS Collaboration Platform (contact policy lead for access)
Mental Health Services Data Set (MHSDS)
CQC: A focus on restrictive intervention reduction programmes in inpatient mental health services
Safewards evaluation report

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Contact: enquiries@england.nhs.uk

This publication can be made available in a number of alternative formats on request.