East London Foundation Trust Quality Schedule 2019/20

A. Local Quality Requirements

SQPR ref	Quality Requirement	Threshold	Method of Measurement	Consequences of Breach	Timing of application of consequence	Applicable Service Specification	CCG Briefing
LQR1	Percentage of patients on CPA with a written copy of the care plan in date and reviewed annually (12 months) including those placed under S117	≥95%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR2a	Annual Audit of patients on CPA including those placed under S117,with an up-to-date written copy of the care plan shared with GPs	≥95%	Service Quality Performance Report	As set out in GC9	Annual	All	
LQR2b	Annual Audit of patients on CPA including those placed under S117,with an up-to-date written copy of the care plan shared with Carers	≥95%	Service Quality Performance Report	As set out in GC9	Annual	All	
LQR2c	Annual Audit of patients on CPA including those placed under S117,with an up-to-date written copy of the care plan shared with drug and alcohol services	≥95%	Service Quality Performance Report	As set out in GC9	Annual	All	
LQR3	Percentage of service users placed out of area (outside of ELFT services) through the contract will have a named link person	≥90%	Service Quality Performance Report	As set out in GC9	Monthly	Out of Area	

East London Foundation Trust Quality Schedule 2019/20

SQPR ref	Quality Requirement	Threshold	Method of Measurement	Consequences of Breach	Timing of application of consequence	Applicable Service Specification	CCG Briefing
LQR4	Percentage of service users placed out of area (outside of ELFT services) have a regular review. (*To be reported 1month in arrears)*	≥90%	Service Quality Performance Report	As set out in GC9	Monthly	Out of Area	
LQR5	Percentage of patients (Adult CMHT and MHCOP) referred to CMHTs starting treatment within 28 days from referral ((excluding dementia and memory clinic)	95%	Service Quality Performance Report to include performance activity against agreed waiting times	As set out in GC9	Monthly	CMHT/MHCOP	
LQR6	Percentage of responses received from patient experience questionnaire for inpatients on discharge and on the community teams caseload	25%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR7	Review of CMHT pathway to come in Q1 Quality report to include referral process, time from first to second appointment (CPA and non) and how other service such as Total Wellbeing are signposted.	95%	Quarter one Quality Report – subsequent reviews may be scheduled if there are concerns	As set out in GC9	Q1 Quality Report	CMHT	
LQR8	Percentage of notifications of discharge within 7 days of every inpatient spell sent to GP electronically (where available) to include diagnosis, medication information about HCAIs – in line with current recording process	95%	Service Quality Performance Report Report to include electronically sent	As set out in GC9	Monthly	Inpatient	
LQR9	Outpatient letter to be sent to the GP following outpatient attendance within 7 operational days.	55% by the end of Q1 and 65% by the end of Q4 2019/20	Service Quality Performance Report and 6 monthly, with narrative	As set out in GC9	Monthly	Outpatient	

LQR10	Final reports and action plans for all serious incidents will be submitted within 60 operational days in line with national policy	100%	Each final report and action plan submitted via silutonccg@nhs.net	As set out in GC9	Monthly	All	
LQR11	National Safety Alerts actioned within identified time scales	100%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR12	Agency use	< 10%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR13	Proportion of all clinical posts filled by agency staff	<10%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR14	Staff turnover rates	2.5%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR15	Percentage Sickness Absence rate for all staff groups	5%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR16	Delayed Transfer of Care	<7.5%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR17	Re-admissions within 28 days	<7.5%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR18	Percentage of all patients discharged in reporting period who are identified as requiring CRHTT support, and are then discharged with CRHTT support (including those patients who have been on home leave)	95%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR19	Percentage of MH service users on CPA	Percentage	Service Quality Performance Report	As set out in GC9	Monthly	CMHT and CRHTT and EIS	
LQR20	Number of Adult and Older Adult CPA patients that have been						

	identified as requiring one-to-one contact						
LQR21	Percentage of Adult and Older Adult patients that have been identified as requiring one-to-one contact (25a) who are receiving one-to-one contact.	95% with exception reporting	Service Quality Performance Report & Quarterly Quality Report	As set out in GC9	Monthly	Adult/Older Adult	
LQR22	Adult and Older Community Caseload seen within last 6 months, not on CPA (face to face or telephone contact)	90%	Monthly Service Quality Performance Report & Quarterly Quality Report	As set out in GC9	Monthly	Adult/Older Adult	
LQR23	Proportion of Adult service users on CPA with a recording of Employment Status	95%	Service Quality Performance Report	As set out in GC9	Monthly - RiO	Adult	
LQR24	Proportion of Adult and Older adult service users on CPA with a recording of Accommodation Status	95%	Service Quality Performance Report	As set out in GC9	Monthly - RiO	Adult	
LQR25	Percentage of patients where outcome tools are used in assessment and treatment (HoNOS)	90%	Service Quality Performance Report	As set out in GC9	Monthly - RiO		
LQR26	Adult and Older Adult DNA of booked appointments for (First Appointments)	12%	Service Quality Performance Report	As set out in GC9	Monthly	Adult/MHCOP	
LQR27	Adult and Older Adult DNA of booked appointments for (Follow Up Appointments)	10% by end of Q4	Service Quality Performance Report	As set out in GC9	Monthly	Adult/MHCOP	
LQR28	People with dementia: Review of the MAS pathway and GP Communications to be presented to the CCG.	95%	Quarter two Quality Report	As set out in GC9	Quarter Two	Al=	
LQR29	Number of service users requiring an interpreter	Number	Service Quality Performance Report	As set out in GC9	Monthly	All services	
LQR30	Review of ELFTs accessible information and reasonable adjustments made to allow service users to engage and fully participate		Quality Reports	As set out in GC9	Q2 and Q4	All services	

	in services. This will include all protected characteristics including language, LD, Dementia etc..						
LQR31	Percentage of service users detained under the Mental Health Act from BAME communities	Percentage	Service Quality Performance Report and Quality Report	As set out in GC9	Monthly		
LQR32	Mandatory Training Adult Safeguarding Percentage of staff who have received safeguarding training at the appropriate level as specified in the Safeguarding: Roles and Competencies for Health Care Staff (Intercollegiate Document, 2018). As per safeguarding spec		Quarterly Quality Report	Jointly agreed action plan if performance falls below trajectory to achieve end of year threshold to be provided within 20 working days of quarter end	Quarterly quality reports on in year progress, with end of year assurance of compliance with Intercollegiate / NHSE Document Training requirements via Quarterly Quality report Percentage to be reported as a whole and also broken down by professional group e.g. Doctors, nurses AHP's	All	
LQR33	Percentage of staff who have received Prevent Training in line with the NHSE Prevent Training and Competencies Framework. (2017), and the Adult Safeguarding; Roles and Competencies for Health Care Staff. Intercollegiate Documents (2018)	85% of all staff have received basic Prevent awareness.	Service Quality Performance Report and Quarterly Quality Report	Jointly agreed action plan if performance falls below trajectory to achieve end of year threshold to be provided within 20	Quarterly quality reports on in year progress, with Q3/ end of year assurance of compliance with the NHSE	All	

		85% of identified appropriate staff have received Health WRAP3training in line with the NHSE Prevent competencies framework 2017.		working days of quarter end	Training requirements Quarterly via SQPR Quarterly Quality report Percentage to be reported as a whole and also -broken down by professional group e.g. Doctors, nurses AHP's - Prevent awareness		
LQR34	During admission, patients to be offered written information about their psychotropic medication. Acceptance or refusal of written information must be documented. This can be done by any member of the healthcare team (admission)	80%	Service Quality Performance Report	As set out in GC9	Monthly		
LQR35	During admission, patients will be offered a one-to-one discussion with a pharmacist or pharmacy technician about their medication. Acceptance or refusal of one-to-one discussion must be documented (during stay)	80%	Service Quality Performance Report	As set out in GC9	Monthly		
LQR36	All inpatients are offered face-to-face discharge counselling. This should be with a pharmacist or a pharmacy technician, or a trained member of the healthcare team. The counselling would involve working through a discharge checklist.	End of Q1 target: 20% End of Q2 target: 40% End of Q3 target: 60%	Service Quality Performance Report	As set out in GC9	Monthly	Inpatient	

	Acceptance or refusal of discharge checklist. Acceptance or refusal of discharge counselling must be documented (discharge).	End of Q4 target: 80%					

LQR37	Proportion of staff with all mandatory training completed	90% by end of Q1 for all staff.	Service Quality Performance Report	As set out in GC9	Monthly	All	**NB:** To reach 90% by the end of Q1 and to maintain that level of performance.
LQR38	Proportion of staff who have received annual appraisal with past 12 months	End of Q1 60% End of Q2 80% End of Q3 85% End of Q4 90%	Service Quality Performance Report	As set out in GC9	Monthly	All	
LQR39	% vacancy rate	12.5%	Service Quality Performance Report	As set out in GC9	Monthly	All	

CAMHS Local Quality Indicators:

SQPR ref	Quality Requirement	Threshold	Method of Measurement	Consequences of Breach	Timing of application of consequence	Applicable Service Specification	CCG Brief
LQR40	Percentage of children and young people (CYP) on active caseload with a personalised care plan in place	90%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	

LQR41	Commissioners to be informed of **ALL** children (under 18 years) placed on an adult inpatient ward within 24hrs	Number with Exception Reporting	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR42	Percentage of CAMHS referrals assessed within 12 weeks of referral	100% with Exception Reporting	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR43	CAMHS assessment outcome and discharge letter to be sent to the GP following outpatient attendance within 10 operational days	95%	Service Quality Performance Report and Quarterly Quality Report	As set out in GC9	Monthly and Quarterly Audit	CAMHS	
LQR44	All Children Not Brought are followed up and action taken (missed appointment), (This includes Adults not attending an appointment for the child)	100%	Service Quality Performance Report	As set out in GC9	6 monthly audit in Quarters 1 and 3	CAMHS	
LQR45	All Children Not Brought for children's services are followed up and action taken for LAC including informing social worker (missed appointment)- (This includes Adults not attending an appointment for the child)	100%	Service Quality Performance Report	As set out in GC9	6 monthly audit in Quarters 1 and 3	CAMHS	
LQR46	Percentage of CAMHS workforce who have undertaken mandatory training	90% rolling to 92% by Q4	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR47	CAMHS (First Appointments) Was not brought (formally DNA)	12%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR48	CAMHS (Follow Up Appointments) Was not brought (formally DNA)	10%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR49	The number of young people who have transitioned out of the sending service in question during the reporting period.	Number	Service Quality Performance Report	As set out in GC9	Quarterly	CAMHS	

LQR50	Case Note Audit of all the young people who have transitioned out of the service during the reporting period.	100%	Service Quality Performance Report	As set out in GC9	Quarterly Audit reported in Quality Report with Narrative and Outcomes a transition plan which must include: personal transition goals, jointly agreed with the young person.	CAMHS	
LQR51	Group work, percentage of attendees reporting satisfaction/problem reduction:	75% rolling to 95% by Q4	Service Quality Performance Report	As set out in GC9	Quarterly	CAMHS	
LQR52	Number of children over the age of 13 referred for ASD assessment started and seen within 12 weeks.		Service Quality Performance Report	As set out in GC9	Quarterly	CAMHS	
LQR53	Early Help activity report and commentary about this provision needs to be included in the CAMHS quality report.		Quarterly Quality Report	As set out in GC9	Quarterly	CAMHS	
LQR54	CYPIAPT Commentary- high level commentary in relation to how the FIM CYIAPT allocation has been utilised (£84K)		Quarterly Quality Report	As set out in GC9	Quarterly	CAMHS	
LQR55	Single Point of Access- activity report and commentary as how this is developing to be included in the CAMHS quality report		Quarterly Quality Report	As set out in GC9	Quarterly	CAMHS	
LQR56	Schools development workers- activity report and commentary to be included in the CAMHS quality report		Quarterly Quality Report	As set out in GC9	Quarterly	CAMHS	
ELFT National Outcome Metrics: CYP MHSDS Outcome Metrics please use the link below: Recording Outcome Measures for CYPMH v5							

CYP-Report • Outcome Rating Scale (ORS) / Child Outcome Rating Scale (CORS) • Clinical Outcomes in Routine Evaluation 10 (CORE-10) • Generalised Anxiety Disorder 7 (GAD-7) • Patient Health Questionnaire (PHQ-9) • Revised Children's Anxiety and Depression Scale (RCADS): Depression, Generalised Anxiety, Obsessions/Compulsions, Panic, Social Phobia, Separation Anxiety scores. • Strengths and Difficulties Questionnaires (SDQ): Conduct, Emotional Symptoms, Hyperactivity, and Impact scores.				**Parent-Report** • Revised Children's Anxiety and Depression Scale (RCADS): Depression, Generalised Anxiety, Obsessions/Compulsions, Panic, Social Phobia, Separation Anxiety scores. • Strengths and Difficulties Questionnaires (SDQ): Conduct, Emotional Symptoms, Hyperactivity, and Impact scores.			
SQPR ref	**Quality Requirement**	**Threshold**	**Method of Measurement**	**Consequences of Breach**	**Timing of application of consequence**	**Applicable Service Specification**	
CYP IAPT PROM (rated by child) - All closed CYP referrals, with at least direct two contacts. Paired measure can be one of any following (whichever is clinical relevant at time point of data collection).							
LQR57a	No of CYP/PA completing a CYP IAPT measure at assessment (T1)	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR57b	No of CYP/PA had at least one paired score	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR58	% CYP of showing an improvement	50%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR59a	No of LAC CYP/PA completing a CYP IAPT measure at assessment (T1)	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR59b	No of LAC CYP/PA had at least one paired score	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR60	% of LAC CYP of showing an improvement	50%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR61a	No of CYP/PA completing a CYP IAPT measure at assessment (T1)	Number		As set out in GC9	Monthly	CAMHS	
LQR61b	No of CYP/PA had at least one paired score	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	

LQR62	% CYP of showing an improvement	50%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR63a	No of LAC CYP/PA completing a CYP IAPT measure at assessment (T1)	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR63b	No of LAC CYP/PA had at least one paired score	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR64	% of LAC CYP of showing an improvement	50%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
CYP IAPT CROM (rated by clinician) - All closed CYP referrals, with at least direct two contacts							
LQR65a	No of CYP having CGAS (Children's Global Assessment Scale) score recorded at assessment (T1)	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR65b	No of CYP/PA had Paired C_GAS	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR66	% of CYP showing improvement in CGAS score	80%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR67a	No of LAC CYP having CGAS (Children's Global Assessment Scale) score recorded at assessment (T1)	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR67b	No of LAC CYP/PA had Paired C_GAS	Number	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR68	% of LAC CYP showing improvement in CGAS score	80%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
CYP IAPT PREM - All closed CYP referrals, with at least direct two contacts.							
LQR69	% of experience of service questionnaires completed by CYP/PA	50%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	

LQR70	% of CYP/PA recommend the service	95%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR71	% of CYP/PA who are happy with the service	95%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR72	% of experience of service questionnaires completed by LAC CYP/PA	35%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR73	% of LAC CYP/PA recommend the service	85%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR74	% of LAC CYP/PA who are happy with the service	85%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR75	% of Referral identifying a goal	85%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	
LQR76	ELFT Routine Outcome Measures" (ROMS) to be implemented across the CAMHS service as part of the implementation of the CYP IAPT programme.	100%	Service Quality Performance Report	As set out in GC9	Monthly	CAMHS	

ELFT National Access Metrics

	Description	Threshold	Method of Measurement		Timing of application of consequence	Applicable Service Specification	**2019/20 amendments discussions**	National Definition

MHSDS	The number of new children and young people aged under 18 receiving treatment from NHS funded community services in the reporting period	Luton CAMHS Contribute toward Luton CCG Trajectory	Service Quality Performance Report		Monthly	CAMHS	**New**	National Metric 1A: This is a count of new patients who had their first 2 contacts following a referral: • Age is ≤0-17y 364 days at first contact. The second contact can be after the 18th Birthday. • A new individual can be counted only once in the entire reporting period.
MHSDS	Total number of individual children and young people aged under 18 receiving treatment by NHS funded community services in the reporting period.	Luton CAMHS Contribute toward Luton CCG Trajectory	Service Quality Performance Report		Monthly	CAMHS	**New**	National Metric 2A: • Treatment is defined as 2 contacts with no time limit. • Age is ≤0-17y 364 days at first contact. The second contact can be after the 18th Birthday. • An individual can be counted only once in a financial year

East London Foundation Trust Quality Schedule 2019/20

Quality Framework reporting requirements

The quality requirements below will be reported in the quarterly reports for the contractual quarterly quality meetings 2019/20.

	Quality Requirement	Threshold or detail	Method of Measurement	Monitoring Method	CCG Brief
QR01	All inpatients will have their observations completed, assessed and acted upon in line with Trust Guidance (Early recognition and treatment of deterioration)	100% compliance	Narrative in Quarterly Quality Report	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR02	Annual thematic review of all unexpected deaths of patients under mental health services or discharged back to primary care within 30 days (SI to be reported immediately in line with SI requirements)	100%	Submit in Quarter 1 of each year a 12 month review of all unexpected deaths split by service	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR03	Commissioners to be informed when there are no mental health beds available		Quarterly Quality Report to contain where service users went, how many there were, if it was because of lack of beds or other reasons and how long they were there or have been there at time of reporting.	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR04	Carry out an annual review of all patients subject to Section 117 after care to include a review of Section 117 entitlement		To be added to Quality Meeting Agenda once a year to discuss section 117, which could lead to a summary being added to the following Quarters Quality Report.	To be discussed at the Quality Meeting and potentially included in the Quarterly Quality Report	
QR05	Provider will comply with NHS best practice in relation to workforce, recruitment and retention		Quarterly submission of workforce data (including staff numbers, sickness, turnover and vacancies)	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	A proposal has been made to ELFT to include 'SMART' for all action plan requests.

			via Quarterly Quality Meetings, with narrative around areas of concern. Risk assessment of vacancy rates and SMART action plan to address areas of concern – this will be a verbal briefing at Quarterly Quality Meetings		No formal response has been received.
QR06	Progress reporting	Quality Accounts CQUIN CQC inspections and monitoring reports	Audit, reports, evidence	Quarterly Quality Meeting if no current or on-going concerns identified by routine Quality monitoring or outside agencies.	
QR07	Aggregation/Triangulation of complaints/serious incidents/incidents/staffing data	Risk register Service changes	Nationally recommended tools, processes and guidance	Quarterly Quality Meeting if no current or on-going concerns identified by routine Quality monitoring or outside agencies.	
QR08	Implementation of NICE Guidance where applicable. Identification of gaps and mitigating actions.	Compliance	Audit, Policy, Pathway development	Gap analysis and mitigating actions to be reported at Quarterly Quality Meetings	
QR09	All complaints (formal and informal) to be reviewed and acted upon in line with national NHS regulations and requirements. 19	100%	Service Quality Performance Report of the number of complaints. Quarterly thematic report to be included in the Quarterly Quality Report identifying types, locations and causes of complaints, with actions to address issues identified Action plan to be developed and agreed with commissioner to address any failure to reach 95%	Quarterly Quality Meeting if no current or on-going concerns identified by routine Quality monitoring or outside agencies.	A proposal has been made to ELFT to include both Formal and Informal complaints within this requirement. No formal response has been received.
QR10	Evidence of improvement in patient experience.	Improvement from previous survey results	Results from all surveys (local, national, ad hoc) relating to patient experience to be shared with Commissioners including analysis of findings and detailed SMART action	Quarterly Quality Meeting if no current or on-going concerns identified by routine Quality monitoring or outside agencies.	

			plans, to be included in the Quarterly Quality Report		
QR11	Provider will ensure robust processes are in place to ensure safe prescribing, dispensing, preparation and administration of medicines including compliance with Patient Safety Alerts in relation to safe medication practice		Quarterly detailed report of medication patient safety incidents (to include type of error, medication type, level of harm, team and speciality, with evidence of investigation and actions implemented to improve patient safety and learning via Quarterly Quality Meeting Quarterly audit of compliance with Controlled Drug Practice with action plan to be developed and implemented to address issues identified Evidence of response to compliance with patient safety notices in relation to safe medication practice to be submitted by deadline date on safety notice Annual self-assessment and quarterly audit of compliance through Local Implementation Network report Number of medication incidents uploaded to the NRLS as evidenced by the Trusts Datix Incident Reporting System.	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR12	Implementation of any nationally recommended safer staffing tools including evidence of Board assurance of follow-up actions and publication of staffing levels		Link to be added to Quarterly Quality Report and will be reviewed.	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	

QR13	Mandatory Training – if below target then further information to be provided in Quarterly Quality Report	95% of eligible staff (excluding long-term sick, maternity leave) split into different teams	Data submission in the Quarterly Quality Report, to include numbers and percentages and if lower than target the staff groups are not trained.	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR14	Safeguarding Concerns Progress report on discussions of children's safeguarding and a joint forum, highlighting any escalation areas.	As per Safeguarding specifications split for different units/teams	As per Safeguarding specifications, breakdown of type of alert submitted in Quarterly Quality Report	To be included in the Quarterly Quality Report and discussed at the Quality Meeting	
QR15	Annual schedule of audits and quarterly audit dashboard	Annual Audit schedule, Quarterly Dashboard	Submission in the Quarterly Quality Report	Quarterly Update in Quality Meeting	
QR16	Provider will publish quality accounts in the appropriate timescales outlined in Gateway Reference 000931. Quality accounts to be in an accessible format	100%	Quarterly exception report on delivery of actions outlined in Quality Account Annual publication of Quality Account by date specified by Department of Health Provider will submit timescale for review and sign off of Quality Account in Q1 and include commissioner comments in final report	Quarterly Quality Meeting	
QR17	EIP progress reports to include: • Number of Adults with Psychosis or Schizophrenia (Schiz) offered CBTp • Number of Family members of adults with Psychosis or Schiz offered family intervention • Number of Adults with Schiz that have not responded adequately to treatment with at	Numbers and narrative	Quarterly progress report to be submitted within the Quarterly Quality Report Areas which cannot be measured will be included in narrative in the Quarterly Quality Report	Quarterly Quality Meeting	

	least 2 antipsychotics drugs are offered Clozapine. • Number of Adults with Psychosis or Schiz who wish to find or return to work are offered supported employment programmes. • Number of Adults with Psychosis or Schiz who have specific and comprehensive physical health assessments (Dr Anthea Robinson, Luton CCG Clinical Director can help design) • Number of Adults with Psychosis or Schiz who are offered combined healthy eating and physical activity programmes • Number of Adults with Psychosis or Schiz who are offered personalised support to stop smoking • Number of Carers of adults with Psychosis or Schiz offered carer focused support and education programmes				
QR18	Carers Report – to include results of carers survey	Numbers and narrative		Quarterly Quality Meeting	
QR19	Numbers of detained service users who leave inpatient facility without the knowledge or permission of clinical staff. Themes, trends and information split by ward.	Numbers and narrative	Provided in Quarterly Quality Report.	Quarterly Quality Meeting	
QR20	QI project progress reports to be included as appendices	Narrative report	Quarterly – members of QI project teams to be invited to attend some Quality Meetings.	Quarterly Quality Meeting	
QR21	Report on compliance and actions within the Trust Seclusion Policy and Trust Restraint Policy	Numbers and narrative	Numbers and narrative provided in the Quarterly Quality Report.	Quarterly Quality Meeting	
QR22	Winter Plan contained within the Business Continuity Plan to be sent as an appendix	Narrative	Annual	Quarterly Quality Meeting	
QR23	Narrative regarding teaching sessions delivered by psychiatric liaison team, to include what has been delivered, to who and when.	Narrative	Annual – Quarter 4	Quarterly Quality Meeting	

QR24	Narrative and breakdown per BAME community of service users detained under the Mental Health Act from BAME communities	Narrative	Annual – Quarter 4	Quarterly Quality Meeting	
QR25	Narrative and break down per Service of : Adult service users on CPA with a recording of Employment Status, Accommodation Status and Older Adult service users on CPA with a recording of Accommodation Status.	Narrative	Annual – Quarter 3	Quarterly Quality Meeting	
QR26	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis or ARMS (at risk mental state) who wait more than two weeks to start a NICE-recommended package of care.	Narrative	Quarterly Quality Report. Quarterly update re. What was offered to those outside the 2 weeks or when after 2 weeks did they get it.	Quarterly Quality Meeting	

Commissioning for Quality and Innovation (CQUIN)

CCG Indicator Specifications for 2019-2020

Publishing Approval Reference Number **000050**

NHS England and NHS Improvement – Working together for the NHS

March 2019

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1 Introduction

The 2019/20 CCG CQUIN scheme contains 11 indicators, aligned to the 4 key areas as illustrated below. This Annex sets out the technical specification for each of the indicators in the scheme outlining how each indicator will be measured, how performance will be assessed and paid, as well as links to relevant supporting documents. This document should be read in conjunction with the 2019/20 CQUIN Guidance, which provides information on the rationale for each CQUIN and details of the scheme's structure and value.

Prevention of Ill Health

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening & Brief Advice

Mental Health

- Improved Discharge Follow Up
- Improved Data Quality and Reporting – Data Quality Maturity Index & Interventions
- IAPT – Use of Anxiety Disorder Specific Measures

Patient Safety

- Three High Impact Actions to Prevent Hospital Falls
- Community Placed PICC Lines Secured Using a SecurAcath Device

Best Practice Pathways

- Stroke 6 Month Reviews
- Ambulance Patient Data at Scene – Assurance & Demonstration
- Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

2. Indicator Values

The majority of CQUINs are comprised of a single indicator that is used to measure performance and against which 100% of payment will be determined. There are 5 CQUINs that contain sub-parts with payment values spread across these sub parts as outlined in the table below.

Indicator	Value (%)
CCG1: Antimicrobial Resistance (AMR)*	**100**
CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People	50
CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in colorectal surgery	50
CCG3: Alcohol and Tobacco (A&T)	**100**
CCG3a: Alcohol and Tobacco - Screening	33
CCG3b: Alcohol and Tobacco – Tobacco Brief Advice	33
CCG3c: Alcohol and Tobacco – Alcohol Brief Advice	33
CCG5: Mental Health Data:	**100**
CCG5a: Mental Health Data: Data Quality Maturity Index	50
CCG5b: Mental Health Data: Interventions	50
CCG10: Ambulance - Access to Patient Information at Scene	**100**
CCG10a: Ambulance - Access to Patient Information at Scene (Assurance)	75
CCG10b: Ambulance - Access to Patient Information at Scene (Demonstration)	25
CCG11: Same Day Emergency Care (SDEC)	**100**
CCG11a: SDEC – Pulmonary Embolus	33
CCG11b: SDEC – Tachycardia with Atrial Fibrillation	33
CCG11c: SDEC – Community Acquired Pneumonia	33

* For providers where CCG1b is not in scope then CCG1a will carry 100% value.

3a. Payment: Thresholds and Periods

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for each Indicator during the applicable period (Payment basis). The table below summarises the relevant thresholds and payment basis that will be used for each of the indicators within the scheme. Assessment should take place at the end of the scheme and calculated according to the method outlined in Payments: calculating payments.

Indicator	Pay levels(%)	Payment basis	Indicator	Pay levels(%)	Payment basis
CCG1a: AMR– Lower Urinary Tract Infections in Older People	60 - 90	Q1-4	CCG6: Use of Anxiety Disorder Specific Measures in IAPT	30 - 65	Q2-4
CCG1b: AMR– Antibiotic Prophylaxis in colorectal surgery	60 - 90	Q1-4	CCG7: Three high impact actions to prevent Hospital Falls	25 - 80	Q1-4
CCG2: Staff Flu Vaccinations	60 - 80	Q1-4	CCG8: PICC lines secured using a SecurAcath device	70 - 85	Q1-4
CCG3a: A&T- Screening	40 - 80	Q1-4	CCG9: Stroke 6 Month Reviews	35 - 55	Q1-4
CCG3b: A&T– Tobacco Brief Advice	50 - 90	Q1-4	CCG10a: Ambulance - (Assurance)	0 - 100	Q1-4
CCG3c: A&T– Alcohol Brief Advice	50 - 90	Q1-4	CCG10b: Ambulance - (Demonstration)	0 - 5	Q3-4
CCG4: 72hr follow up post discharge	50 - 80	Q3-4	CCG11a: SDEC – Pulmonary Embolus	50 - 75	Q1-4
CCG5a: Mental Health Data: Data Quality Maturity Index	90 - 95	Q2-4	CCG11b: SDEC – Tachycardia with Atrial Fibrillation	50 - 75	Q1-4
CCG5b: Mental Health Data: Interventions	15 - 70	Q3-4	CCG11c: SDEC – Community Acquired Pneumonia	50 - 75	Q1-4

3b. Payments: Calculating Payments

Payment in this year's scheme will reward providers based on their performance falling between each indicator's minimum and maximum thresholds, using the following formula:

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

Examples – see table:

- **Example 1:** If performance is at or below the minimum threshold, the payment achieved will be 0%.
- **Example 2:** Should performance lie somewhere between the minimum and maximum providers will be rewarded proportionately. In the example 2 below, the provider earns 51% of the CQUIN's value based on their performance over the reporting period.
- **Example 3:** If performance reaches or exceeds the maximum threshold, the payment achieved is capped at 100%.

	Thresholds				
Example	**Min**	**Max**	**Performance**	**Calculation**	**Payment**
1	50%	90%	40%	(40% - 50%) / (90% - 50%) = -25%	0%
2	25%	80%	53%	(53% - 25%) / (80% - 25%) = 51%	51%
3	30%	70%	72%	(72% - 30%) / (70% - 30%) = 105%	100%

4. Understanding Performance

4a Monitoring performance

There are two broad sources for the CQUIN indicator data:

- existing published data that are readily available; and
- data that will be collected via a national CQUIN collection.

For each indicator, quarterly data will be available from one of these sources in order to allow performance monitoring by both commissioners and NHS England. The detail about each source is set out in the 'Data Source(s) & Reporting' section of each indicator's specification. For published data, the data source has been identified and links provided to allow ready access to the data – for example Flu vaccinations data. Indicators that require data submission to the national CQUIN collection are identified by the source being the 'national CQUIN collection'. With the exception of CCG10b: Ambulance - (Demonstration) this will require supplying data on a quarterly basis by auditing relevant records, such as case notes.

The next section provides more information about the auditing approaches to be adopted. It is recommended that, where available, (clinical) audit professionals within each service are contacted to assist with selecting from the approaches detailed below and to ensure local protocols are met.

4b Collecting quarterly data: approach to auditing

In circumstances where there is no established national data that includes both numerator and denominator, then **audits** (sampling) of records is required to allow performance monitoring and assessment. The auditing approach will be determined by the ability to identify the population of interest (sampling frame) from electronic or paper case notes. A minimum sample of 100 records meeting the criteria are required from each quarter. Where the total cohort is less than 100 patients then all records should be audited. If information can be provided readily for all relevant records, it should be provided in preference to auditing.

One hundred records has been chosen as a balance between burden and robust measuring of performance – smaller sample sizes would result in greater uncertainty about performance and potentially payments that do not accurately reflect true performance.

4. Understanding Performance

4b Collecting quarterly data: standard approach to auditing cont….

One of the approaches detailed in sections 4c and 4d should be chosen and maintained, based on the CQUIN and local circumstances of the trust. Where possible a defined sampling frame should be established to allow auditing of the indicator.

4c Collecting quarterly data: defined sampling frame.

If all cases can be readily identified (i.e. those in the denominator) via searchable electronic patient records or via paper case notes then quarterly audits of a minimum, **random** sample of 100 records meeting the criteria are required. An example might be where all cases notes in a given department are relevant.

Trusts must select ONE of the following methods of random sampling and maintain this method throughout the scheme:

1) **True randomisation:** every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (e.g. http://www.random.org/) is used with 1 and x setting the lower and upper bounds. 100 cases are then identified using the random number generator from within these bounds.

2) **Quasi-randomisation**: every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x but only after the cases have been ordered in a way that doesn't have any clinical significance, for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/100, so that every 'i'th case will be selected after the first case has been randomly generated between 1 and i.

For example, for a sampling frame of 1,000 cases, i=1,000/100 =10. So the first case will be randomly selected between 1 and 10 and then the 10th case from this will be used. For example. cases 7, 17, 27, 37, 47… will be chosen.

4. Understanding Performance

4d Collecting quarterly data: undefined sampling frame.

If the sampling frame (i.e. the denominator) cannot be fully identified via searchable electronic patient records or via paper case notes, but instead requires reviewing each set of case notes, then it may not be feasible to use random sampling methods. Instead a quarterly audit by **Quota** sampling 100 records is required. Quota sampling is a non-random approach to case selection, where case notes are systematically searched to identify those that match the denominator. The approach is convenient and requires additional care to ensure the sample is representative. Below are examples of how quota sampling could be implemented by trusts. We acknowledge that the individual circumstances of each trust will determine the exact approach adopted. Quota sampling should ideally be avoided in preference for a random approach (see section 4c).

Example quota sampling methods:

- **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.

- **Chronological:** If cases are chronologically ordered then case notes should be selected in a way that ensures the period is well represented. For example, searching through cases from day 1 of the quarter until a case 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.

Similarly, where cases are categorised or split into groups (e.g. by consultant specialty or ward) then auditing should take this in to account in order to best ensure the sample is representative. For example, if cases are relevant from across several wards, then it is important that cases from each ward form part of the sample.

5a. CQUIN Indicators: Prevention of Ill Health

CCG1: Antimicrobial Resistance

CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People 11

CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery 12

CCG2: Staff Flu Vaccinations 13

CCG3: Alcohol and Tobacco

CCG3a: Alcohol and Tobacco - Screening 14

CCG3b: Alcohol and Tobacco – Tobacco Brief Advice 15

CCG3c: Alcohol and Tobacco – Alcohol Brief Advice 16

CCG1a: Antimicrobial Resistance – Lower Urinary Tract Infections in Older People

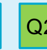
Services in scope

Acute

Payment levels

Minimum: 60%

Maximum: 90%

Scope:  Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Elizabeth Beech

Elizabeth.beech@nhs.net

Supporting Documents

Antimicrobial Resistance – Urinary Tract Infections supporting guidance (to be updated after 1st March 2019)

PHE UTI Diagnosis Guideline

NICE Guidance NG109

Data Source(s) & Reporting

Data should be submitted quarterly to PHE via the online submission portal. An auditing tool will be available in supporting guidance. See sections 4b-d for details about auditing.

Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.

Description

Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

Numerator

Of the denominator, the number where the 4 audit criteria for diagnosis and treatment following PHE UTI diagnostic and NICE guidance (NG109) are met and recorded:

1. Diagnosis of lower UTI based on documented clinical signs or symptoms
2. Diagnosis excludes use of urine dip stick
3. Empirical antibiotic prescribed following NICE Guideline (NG109)
4. Urine sample sent to microbiology

Denominator

Total number of antibiotic prescriptions for all patients, aged 65+, with a diagnosis of lower Urinary Tract Infection*

*relevant procedural coding will be available in supporting guidance.

Exclusions

Recurrent UTI (See NICE guidance NG112) where management is antibiotic prophylaxis, pyelonephritis, catheter associated UTI

CCG1b: Antimicrobial Resistance – Antibiotic Prophylaxis in Colorectal Surgery

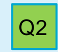
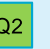
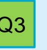
Services in scope

Acute who perform elective colorectal surgery

Payment levels

Minimum: 60%

Maximum: 90%

Scope:   

Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Elizabeth Beech

Elizabeth.beech@nhs.net

Supporting Documents

Antimicrobial Resistance – Surgical Antibiotic Prophylaxis supporting guidance(to be updated after 1st March 2019)

NHSI/PHE audit tool

NICE Guidance CG74

Data Source(s) & Reporting

Data should be submitted quarterly to PHE via the online submission portal. An auditing tool will be available in the supporting guidance. See sections 4b-d for details about auditing.

Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.

Description

Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.

Numerator

Of the denominator, the number of prophylactic single dose antibiotic prescriptions that meet the NICE CG74 guidance regarding the choice of antibiotic.

Denominator

Total number of audited antibiotic prescriptions for inpatients, aged 18+, undergoing surgical prophylaxis for elective colorectal surgery*

*relevant procedural coding will be available in supporting guidance.

CCG2: Staff Flu Vaccinations

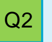
Services in scope

Acute, Community, Mental Health, Ambulance

Payment levels

Minimum: 60%

Maximum: 80%

Scope: 

Accessing support

Policy Lead

Doug Gilbert

Douglas.gilbert1@nhs.net

Supporting Documents

ImmForm Guidance

Green Book

NICE guidance NG103

Data source(s) & Reporting

Monthly Provider submission (between September and February) to PHE via ImmForm. See: Guidance

Data will be made publicly available approximately 6 weeks after each quarter.

Description

Achieving an 80% uptake of flu vaccinations by frontline clinical staff.

Numerator

Total number of front line healthcare workers who have received their flu vaccination between 1 September 2019 and February 28th 2020.

Denominator

Total number of front line healthcare workers.

Exclusions

- Staff working in an office with no patient contact
- Social care workers
- Staff out of the Trust for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)

CCG3a: Alcohol and Tobacco - Screening

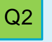
Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 40%

Maximum: 80%

Scope: Q1  Q2 Q3 Q4

Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.

Numerator

Of the denominator, those screened for both smoking and alcohol risk status and the results recorded in patient's record.

Denominator

All *unique patients, aged 18+ who are admitted to an inpatient ward for at least one night (i.e. length of stay equal to or greater than one).

*Unique is defined as a non-repeat admission of a patient during the duration of the CQUIN who has not already received the intervention within the period of the CQUIN.

Exclusions

Maternity inpatients (exclude where 'Epitype'=2,3,4,5 or 6).

CCG3b: Alcohol and Tobacco – Tobacco Brief Advice

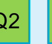
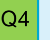
Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope:  

Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of identified smokers given brief advice.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme - including an offer of Nicotine Replacement Therapy (whether or not this offer had been taken up).

Denominator

All eligible patients who have been recorded as smokers during screening.

CCG3c: Alcohol and Tobacco – Alcohol Brief Advice

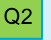
Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope: Q1  Q2 Q3 Q4

Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme, or offered a specialist referral if the patient is potentially alcohol dependent.

Denominator

All eligible patients who have been recorded as drinking above the low risk levels.

5b. CQUIN Indicators: Mental Health

CCG4: 72hr follow up post discharge 18

CCG5: Mental Health Data 19

CCG5a: Mental Health Data: Data Quality Maturity Index 19

CCG5b: Mental Health Data: Interventions 20

CCG6: Use of Anxiety Disorder Specific Measures in IAPT 21

CCG4: 72hr follow up post discharge

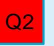
Services in scope

Mental Health

Payment levels

Minimum: 50%

Maximum: 80%

Scope: 

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

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.

Description

Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge from a CCG commissioned service.

Numerator

Of the denominator, those who have a follow up within 72hrs (commencing the day after discharge).

Denominator

Number of people discharged from a CCG commissioned adult mental health inpatient setting.

Exclusions

Details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

CCG5a: Mental Health Data Quality: MHSDS Data Quality Maturity Index

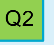
Services in scope

Mental Health (MH trusts only)

Payment levels

Minimum: 90%

Maximum: 95%

Scope: 

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

Routine provider submission to the Mental Health Services Data Set (MHSDS).

The MHSDS monthly data quality reports include granular provider level data on the data items included in the MHSDS DQMI. Published MHSDS data

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.

Description

Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI).

Indicator

The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS. The full definition and DQMI data reports can be found at: DQMI webpage

Data Items

The MHSDS Data items included in the DQMI are outlined in the Changes to the DQMI.

CCG5b: Mental Health Data Quality: Interventions

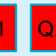
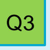
Services in scope

Mental Health (MH trusts only)

Payment levels

Minimum: 15%

Maximum: 70%

Scope:  Q1 Q2  Q3 Q4

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

NHS Digital SNOMED CT Browser

MH SNOMED Website

Specific Pathway Guidance on SNOMED CT Intervention Codes

Data Source(s) & Reporting

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.

Description

Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.

Numerator

Of the denominator, the referrals with at least one intervention* (SNOMED CT procedure code) recorded between the referral start date and the end of the reporting period.

Denominator

The number of referrals that receive their second attended contact in Q3-4 2019/20.

*A condition of this CQUIN is that providers demonstrate a range of interventions over the course of Q3 – Q4. Any provider who is found to be only using one intervention code will receive no payment.

CCG6: Use of Anxiety Disorder Specific Measures in IAPT

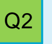
Services in scope

IAPT Services

Payment levels

Minimum: 30%

Maximum: 65%

Scope: Q1  Q2 Q3 Q4

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

IAPT manual

Data Source(s) & Reporting

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' FutureNHS Collaboration Platform.

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*, where the course of treatment was finished and where there were at least two attended treatment appointments.

*This includes 6 disorders: Obsessive Compulsive Disorder, Social Phobias, Health Anxiety, Agoraphobia, Post Traumatic Stress Disorder, Panic Disorder

5c. CQUIN Indicators: Patient Safety

CCG7: Three high impact actions to prevent Hospital Falls 23

CCG8: Community Placed PICC lines secured using a SecurAcath device 24

CCG7: Three high impact actions to prevent Hospital Falls

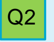
Services in scope

Acute, Community

Payment levels

Minimum: 25%

Maximum: 80%

Scope: Q1  Q2 Q3 Q4

Accessing support

Policy Lead

Julie Windsor

patientsafety.enquiries@nhs.net

jwindsor@nhs.net

Supporting Documents

Falls Prevention Resources

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 80% of older inpatients receiving key falls prevention actions

Numerator

Number of patients from the denominator where all three specified falls prevention actions are met and recorded:

1. Lying and standing blood pressure recorded at least once.
2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).
3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

Denominator

Admitted patients aged over 65 years, with length of stay at least 48 hours.

Exclusions

- Patients who were bedfast and/or hoist dependant throughout their stay.
- Patients who die during their hospital stay.

CCG8: Community Placed PICC lines secured using a SecurAcath device

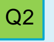
Services in scope

Community

Payment levels

Minimum: 70%

Maximum: 85%

Scope: 

Accessing support

Policy Lead

Stephanie Heath

england.innovation@nhs.net

Supporting Documents

NICE guidance on SecurAcath for securing percutaneous catheters - MTG34

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 85% of community- placed peripherally inserted central catheters (PICC) lines secured using a SecurAcath device.

Numerator

Of the denominator, the number of Patients with a PICC line secured by a SecurAcath device.

Denominator

Patients with a PICC line inserted within a community setting and in place for more than 15 days.

Exclusions

- Patients sensitive to nickel.
- Peripherally inserted central catheters in place for 15 days or less.

Note

This CQUIN **does not** incentivise a change of securing device to PICC lines after the patient is discharged to the community.

5d. CQUIN Indicators: Best Practice Pathways

CCG9: Six Month Reviews for Stroke Survivors 26

CCG10: Ambulance - Access to Patient Information at Scene

CCG10a: Ambulance - Access to Patient Information at Scene (Assurance) 27

CCG10b: Ambulance - Access to Patient Information at Scene (Demonstration) 28

CCG11: Same Day Emergency Care

CCG11a: SDEC – Pulmonary Embolus 29

CCG11b: SDEC – Tachycardia with Atrial Fibrillation 30

CCG11c: SDEC – Community Acquired Pneumonia 31

CCG9: Six Month Reviews for Stroke Survivors

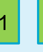
Services in scope

Community with stroke rehabilitation

Payment levels

Minimum: 35%

Maximum: 55%

Scope: 

Accessing support

Policy Lead

National Stroke Programme Team

england.clinicalpolicy@nhs.net

Supporting Documents

Implementation guidance

SSNAP Guidance

Data Source(s) & Reporting

Data provided to the Sentinel Stroke National Audit Programme (SSNAP). See Guidance and Published data

Description

Achieving 55% of eligible stroke survivors receiving a six month follow up within 4-8 months of their stroke.

Numerator:

Number in the denominator who had a six month follow-up within 4 – 8 months of their stroke. (SSNAP database variable M2.2).

Denominator:

Number of patients due for follow-up based on when the patient was admitted or when the follow-up was completed (SSNAP database variable M1.1).

Exclusions

- Died whilst on the stroke care pathway (SSNAP database variable M2.4).
- 6 month reviews that took place before 4 months or after 8 months of the stroke.

CCG10a: Ambulance - Access to Patient Information at Scene (Assurance)

Services in scope

Ambulance

Payment levels

Minimum: 0% (failed assurance)

Maximum: 100% (passed assurance)

Scope:

Accessing support

Policy Lead

Claire Joss

england.ambulance@nhs.net

Supporting Documents

Ambulance CQUIN Guidance Workspace

(Please email UECP-manager@future.nhs.uk to request access.)

Data Source(s) & Reporting

Quarterly reporting about the number of providers that have successfully completed the NHS Digital assurance process for enabling access tor patient information on scene, by ambulance crews, as reported by NHS Digital.

Description

Achievement of NHS Digital's assurance process for enabling access to patient information on scene, by ambulance crews via one of the four nationally agreed approaches:

a) SCRa Portal – a standalone web viewer, on the Spine web portal – controlled by smart card
b) SCR 1-Click - Patient contextual click- launches the SCRa from within an existing application.
    - Known providers; Servelec RiO and Lorenzo (CSC)
c) Commercial Spine Mini Service Providers
    - Known providers; Quicksilva and Intersystems
d) Direct Spine Integration by System Suppliers
    - Known providers; Adastra (Advanced Health and Care), CLEO (CLEOsystems24), Web (EMIS), Symphony (Ascribe), SystmOne (TPP)

Known suppliers for each route have been identified however other suppliers may exist or enter the market during the lifetime of this CQUIN.

CCG10b: Ambulance - Access to Patient Information at Scene (Demonstration)

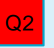
Services in scope

Ambulance

Payment levels

Minimum: 0%

Maximum: 5%

Scope: Q1  Q2 Q3 Q4

Accessing support

Policy Lead

Claire Joss

england.ambulance@nhs.net

Supporting Documents

Ambulance statistics

Ambulance Quality Indicators

Data Source(s) & Reporting

Quarterly submission via National CQUIN collection from trust's operational systems.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 5% of face to face incidents resulting in patient data being accessed by ambulance staff on scene.

Numerator

Of the denominator, the number of incidents with a face to face response, during which the ambulance staff on scene accessed the patient's record.

Denominator:

Total count of incidents with a face to face response as defined in Ambulance Systems indicator (item A56).

CCG11a: SDEC – Pulmonary Embolus

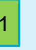
Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope:  Q1 Q2 Q3 Q4

Accessing support

Policy Lead

Rachel Vokes

nhsi.sdeccquinsupport@nhs.net

Supporting Documents

NICE Guidance CG144

Ambulatory Emergency Care Directory (6th Edition)

BTS Guidance for the outpatient management of PE

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4b-d for details about auditing. An auditing tool will be available to aid collection: Auditing tool. Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, those managed in a same day setting, as set out in NICE Guidance CG144, and discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+ with a primary diagnosis of pulmonary embolus*, whose case notes indicate that same day care is clinically appropriate**.

*ICD-10 codes: I260, I269, R071, R091. SNOMED codes: 59282003)

**Clinically appropriate criteria:

- No history of cancer
- No history of chronic cardiopulmonary (heart failure or chronic lung) disease
- Pulse less than 110 beats/ min
- Systolic Blood Pressure greater than 100mmHg
- Oxygen saturation level (arterial) greater than 90%

CCG11b: SDEC – Tachycardia with Atrial Fibrillation

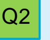
Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope: 

Accessing support

Policy Lead

Rachel Vokes

nhsi.sdeccquinsupport@nhs.net

Supporting Documents

NICE Guidance CG180

Ambulatory Emergency Care Directory (6th Edition)

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4b-d for details about auditing. An auditing tool will be available to aid collection: Auditing tool. Data will be made available approximately 6 weeks after each quarter.

Description:

Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, the number of patients who are managed in a same day setting, as set out in NICE Guidance CG180, and are discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+, with a primary diagnosis of atrial fibrillation*, whose case notes indicate that same day care is clinically appropriate**.

*ICD-10 codes: I440-1,I444-7,I450-9 (excl I457),I471,I479-84,I489,I491-2,I494-5,I498-9,R000,R002,R008. SNOMED codes: 49436004)

**Clinically appropriate criteria:

- No chest pain
- Systolic blood pressure greater than 100 mmHg

Exclusions

Supraventricular tachycardia, postural orthostatic tachycardic syndrome

CCG11c: SDEC – Community Acquired Pneumonia

Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope:

Accessing support

Policy Lead

Rachel Vokes

nhsi.sdeccquinsupport@nhs.net

Supporting Documents

NICE Guidance CG191

Ambulatory Emergency Care Directory (6th Edition)

Data Source(s) & Reporting

Quarterly case note audit submitted via National CQUIN collection – see sections 4b-d for details about auditing. An auditing tool will be available to aid collection: Auditing tool. Data will be made available approximately 6 weeks after each quarter.

Description

Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting where clinically appropriate.

Numerator

Of the denominator, the number of patients who are managed in a same day setting, as set out in NICE Guidance CG191, and are discharged to usual place of residence on the same day as attendance/admission.

Denominator

Total number of patients attending A&E, aged 18+, with a primary diagnosis of pneumonia*, whose case notes indicate that same day care is clinically appropriate**.

*ICD-10 codes: J100,J110,J120-3,J128-9,J13-14X,J153-60,J168,J170-1,J178,J180-1,J188-9,J200-9,J22X. SNOMED codes: 278516003, 233604007, 50417007)

**Clinically appropriate criteria:

- No confusion (Mini Mental Test score greater than 8)
- Respiratory Rate less than 30 / min
- Blood pressure greater than 90 / 60 mmHg

Version Control

Date	Update
7th March 2019	Initial Publication
8th March 2019	p24 PICC Lines – Note added to confirm community inserted PICC lines only.

Commissioning for Quality and Innovation (CQUIN)

Guidance for 2019-2020

Publishing Approval Reference Number **000050**

NHS England and NHS Improvement – Working together for the NHS

March 2019

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1.0 Introduction

- This document provides the guidance for the Commissioning for Quality and Innovation (CQUIN) scheme for 2019/20. It sets out details of both the CCG and Prescribed Specialised Services (PSS) schemes.
- From 1 April 2019, both the CCG and PSS schemes are being reduced in value to 1.25% with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities. A maximum of **5 indicators** will be prescribed nationally for each contract.
- We have recognised that in past schemes CQUIN has attracted criticism for requiring significant cost to implement due to the inclusion of new or complex goals, setting outcome based targets which impose unfairly distributed burden on providers, or require action which is outside the control of a single organisation.
- In response to this, we are taking a radically different approach to CQUIN in 2019/20. Instead of setting new goals CQUIN will simply highlight evidence based good practice that is already being rolled out across the country, drawing attention through the scheme to the benefits for patients and providers, and in doing so allow those benefits to be spread more rapidly. Those measures from the 2018/19 scheme that have been widely recognised as bureaucratic or burdensome have been removed.
- CQUIN is being given fresh clinical momentum, whilst prioritising simplicity and deliverability. Proposals were tested to ensure chosen indicators focus on 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; and command stakeholder support. Broad clinical consensus exists over each included method, following wide engagement with national programmes to select from existing interventions in support of the Long Term Plan.
- Alongside this new approach to the selection of areas for CQUIN, the payment rules for indicators within the CCG scheme have been simplified, allowing greater transparency over performance and earnings, based on achievement between lower and upper adoption goals for each supported intervention. The specifications which accompany this main guidance set out the full details.
- 2019/20 is the first year of this new approach, and we intend to refine and improve the process from 2020. To ensure wide engagement, we will establish a national CQUIN Advisory Group to oversee the development of a future pipeline of indicators which will be attractive to providers and deliver clear benefits to patients. This group will bring together clinical leadership alongside commissioner and provider stakeholders.

2.0 Overview of quality and safety indicators

2.0 Overview of quality and safety indicators

Both the 2019/20 CCG and PSS CQUIN schemes comprise indicators, aligned to 4 key areas, in support of the Long Term Plan. Specific indicator breakdowns are provided in the following slides.

2.0 Overview of quality and safety indicators

2.1 CCG Scheme

The CCG CQUIN scheme highlights the below repeatable methods and interventions selected from current delivery goals, aligned under four priority areas. All have been reviewed to ensure they are in line with current routine clinical practice, simple and straightforward to implement, with national programme teams providing practical tools, training and support to implement where required.

11 elements of good practice have been highlighted across all provider types – acute, mental health, community, ambulance etc. - with a maximum of **5 supported methods** applicable to any one provider.

Prevention of Ill Health	Mental Health	Patient Safety	Best Practice Pathways
• Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery • Staff Flu Vaccinations • Alcohol and Tobacco – Screening & Brief Advice	• Improved Discharge Follow Up • Improved Data Quality and Reporting – Data Quality Maturity Index & Interventions • IAPT – Use of Anxiety Disorder Specific Measures	• Three High Impact Actions to Prevent Hospital Falls • Community Inserted PICC Lines Secured Using a SecurAcath Device	• Stroke 6 Month Reviews • Ambulance Patient Data at Scene – Assurance & Demonstration • Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

Detailed specifications can be found here.

2.0 There will be a maximum of five CCG indicators for each contract

2.1 CCG Scheme

The following table shows how the supported methods and interventions are relevant to different provider types. More information on each is contained in section 3.0.

National indicators must be used where relevant, however where insufficient national indicators are available, CCGs should offer local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract). The total value of indicators should be equal to 1.25%.

Acute	Community	Mental Health	Ambulance
Staff Flu Vaccinations	Staff Flu Vaccinations	Staff Flu Vaccinations	Staff Flu Vaccinations (0.25%)
Alcohol and Tobacco Brief Advice	Alcohol and Tobacco Brief Advice	Alcohol and Tobacco Brief Advice	Access to Patient Information – Assurance Process (0.5%)
Three High Impact Actions to Prevent Hospital Falls	Three High Impact Actions to Prevent Hospital Falls	72hr Follow Up Post Discharge	Access to Patient Information – Demonstration (0.25%)
Antimicrobial Resistance – Urinary Tract Infections and Antibiotic Prophylaxis for Elective Colorectal Surgery	PICC Lines Secured Using a SecurAcath Device	Improved Data Quality and Reporting	+ Locally Determined Indicator (0.25%)
Same Day Emergency Care – Pulmonary Embolus/ Tachycardia with Atrial Fibrillation/ Pneumonia	Stroke 6 Month Reviews	Use of Anxiety Disorder Specific Measures in IAPT	

2.0 Overview of quality and safety indicators

2.2 PSS Scheme

PSS areas included within CQUIN have been simplified in line with the approach taken to the CCG scheme. The design of the scheme has been streamlined since September, with significantly fewer national indicators than currently. The larger indicators (those upon which the bulk of the PSS CQUIN funding will be earned), are extensions of 2017/19 indicators, and seek to build upon success. All indicators support clear well proven steps to ensure benefits are fully realised.

Prevention of Ill Health

- Medicines Optimisation and Stewardship
- Towards Hep C Elimination
- Cystic Fibrosis Supporting Self Management

Mental Health

- Healthy Weight in Adult Secure MH Services
- Addressing CAMHS T4 Staff Training Needs
- D/deaf MH Communication Assessment

Patient Safety

- Clinical Utilisation Review: Avoiding Inappropriate Hospital Stays
- Severe Asthma Specialised Care Review
- Immunoglobulin Stewardship
- Spinal Surgery

Best Practice Pathways

- Promoting Transplantation
- Enabling Thrombectomy
- Rethinking Conversations: Personalising Care for Long Term Condition Patients
- Cirrhosis Care Bundle
- Paediatric Movement Therapies

Detailed specifications can be found here

3.0 CCG Scheme

Highlighted good practice selected for inclusion

3.1 Prevention of Ill Health

Highlighted action/ method	Benefit delivered	Support and information
CCG1: Adherence to national antibiotic guidance in treatment of Lower Urinary Tract Infections in older people and antibiotic prophylaxis in elective colorectal surgery **Applicability:** to all Acute Hospitals providing UTI treatment and elective colorectal surgery. **CQUIN goal**: 60%-90% **Supporting ref:** NICE guidance NG109 NICE guidance CG74 PHE UTI Guidance	• In support of a major Long Term Plan priority of antimicrobial resistance and stewardship, four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI. • Implementing NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines. • Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay.	• Explicit support provided by NHS I AMR Project Lead via Webinars, regional network support as well as an online support page complete with useful guidance and toolkits. • The NHS I Resources page will be updated with CQUIN specific content from March 2019. • Contact Elizabeth Beech at: Elizabeth.beech@nhs.net
CCG2: Achieving an 80% uptake of flu vaccinations by frontline clinical staff **Applicability:** to all NHS providers with frontline staff. **CQUIN goal**: 60-80% **Supporting ref:** NICE guidance NG103	• Staff flu vaccinations are a crucial lever for reducing the spread of flu during winter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.	• Delivery supported by NHS I lead, with ImmForm Guidance and a seasonal campaign to drive awareness. Green Book also contains published guidance. • Contact Doug Gilbert at: Douglas.gilbert1@nhs.net
CCG3: Screening and brief advice for tobacco and alcohol use in inpatient settings **Applicability:** All Acute, Community and MH providers **CQUIN goal:** Screening 40-80% Brief Advice 50-90% **Supporting ref:** NICE guidance PH24, PH45 and PH48	• Screening and brief advice is expected to result in 170k tobacco users and 60k at risk alcohol users receiving brief advice, a key component of their path to cessation. • A reduced version of 2018/19 CQUIN indicator, this is already being delivered strongly across the country, and is part of an ongoing programme to deliver the Long Term Plan.	• E-Learning programme available for training needs along with additional published Guidance and information. • Contact Don Lavoie at: Don.Lavoie@phe.gov.uk

3.2 Mental Health

Highlighted action / method	Benefit delivered	Support and information
CCG4: Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge **Applicability:** All Mental Health trusts **CQUIN goal**: 50 – 80% (Q3-4 only) **Supporting ref:** At present, NICE Guidance NG53 references the national standard of a 7 day follow up, however recent findings from The National Confidential Inquiry into Suicide and Safety in Mental Health evidences the need for a 3 day follow up	• 72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge. • By completing follow up in 3 days providers support the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge. • This activity will increase focus on improving the overall quality of support post discharge.	• Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below. • Contact Belinda Yeldon at: England.MHCQUIN@nhs.net.

CCG5: Improving the quality and breadth of data submitted to the Mental Health Services Dataset
Applicability: All Mental Health trusts
CQUIN goal: DQMI 90 – 95% (Q2-4 only) Interventions 15 – 70% (Q3-4 only)
Supporting ref: Information Standards Notice MHSDS DQMI
	• Accurate data is a key enabler for improvement in MH services and is underpinned by the Long Term Plan. Improving mental health data quality and ensuring providers record interventions consistently using SNOMED CT will enable:
	  • The system to use data in a more efficient and reliable way, ensuring that patients receive appropriate treatment.
	  • Patients and clinicians to make informed decisions about treatment options.
	  • The retirement of costly and burdensome duplicate data collections and local flows.
		• Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.
		• DQMI specific information also available along with a document outlining Changes to the DQMI.
		• Contact Belinda Yeldon at: England.MHCQUIN@nhs.net

CCG6: Achieving 65% of referrals finishing a course of treatment which had paired scores recorded in the specified Anxiety Disorder Specific Measure
Applicability: All MH providers with IAPT services
CQUIN goal: 30 – 65% (Q2-4 only)
Supporting ref: IAPT manual
	• As detailed in the IAPT Manual, the use of specific anxiety disorder measures will:
	  • Reduce inappropriate early discharge.
	  • Safeguard patients against serious clinical problems being missed.
	  • Give clinicians access to critical information to guide the patient's therapy.
	  • Ensure that patients are benefiting from the most appropriate therapy.
	  • Allow clinicians to focus on relieving the symptoms that most distress the patient.
		• Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.
		• MH curriculum also already updated.
		• Contact Belinda Yeldon at: England.MHCQUIN@nhs.net

3.3 Patient Safety

Highlighted action / method	Benefit delivered	Support and information
CCG7: Achieving 80% of older inpatients receiving key falls prevention actions **Applicability:** all Acute Trusts and Community Hospitals **CQUIN goal:** 25 – 80% **Supporting ref:** NICE Clinical Guidance CG161 and NICE Quality Standard QS86	• Taking these three key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs. 1. Lying and standing blood pressure to be recorded 2. No hypnotics or anxiolytics to be given during stay OR rationale documented 3. Mobility assessment and walking aid to be provided if required. • For a typical medium sized acute provider this would equate to around 250 fewer falls, including four fewer hip fractures and brain injuries.	• Provided by NHS I Patient Safety Team via e-learning and various online quality improvement resources all available via the link below. • NHS Improvement falls prevention resources • Contact Julie Windsor at: patientsafety.enquiries@nhs.net
CCG8: Achieving 85% of peripherally inserted central catheters (PICC) lines secured using a SecurAcath device **Applicability:** all Community providers **CQUIN goal**: 70 – 85% **Supporting ref:** NICE Medtech Guidance MTG34	• Used as a replacement for adhesive securement devices. Unlike adhesive securement devices, SecurAcath does not need changing and this has significant cost and patient benefits (lowering the chance of complications caused by movement to the catheter when it is unsecured).	• Support will come from the Innovation, Research and Life Sciences Team as well as the AHSNs • NICE guidance on SecurAcath for securing percutaneous catheters • Contact Stephanie Heath at: england.innovation@nhs.net

3.4 Best Practice Pathways

Highlighted action / method	Benefit delivered	Support and information
CCG9: SSNAP six-month review for all discharged stroke patients **Applicability:** to all community service providers of stroke rehabilitation **CQUIN goal:** 35 – 55% **Supporting ref:** NICE Clinical Guidance CG162	• Improved stroke rehabilitation is a key pillar of the stroke improvement landscape and a commitment in the Long Term Plan. The 6 month assessments have been highlighted as the most fundamental part of that work and the strongest ask from stroke survivors. • The 6 month reviews also provide an opportunity for enhanced personalisation of care through identification of further support needs e.g. through social prescribing.	• The NHSE Stroke team are available for implementation support and online resources and the GIRFT clinical leads will also be prioritising Rehabilitation throughout 2019/20. • SSNAP Guidance • Contact the mailbox at: england.clinicalpolicy@nhs.net
CCG10: Ensure access to patient data at scene, in line with nationally prescribed approaches **Applicability:** to all ambulance providers **CQUIN goal:** 100% passed assurance and 5% records accessed at scene **Supporting ref:** UEC Assurance Statement	• Digital maturity is one of the major short term goals in the Ambulance Digital Strategy and a priority in the Long Term Plan, borne out of the recommendations in the Lord Carter Report. This will support clinical decision making and in turn will lead to improved outcomes for patients and a safe reduction in avoidable ambulance conveyance. • Support from NHS England and NHS Digital already committed to ensuring remaining providers can deliver during 2019/20.	• Guidance available on the Urgent and Emergency care Future NHS Platform with additional support from NHS Digital. • Additional guidance on Ambulance Quality Indicators. • Contact Claire Joss at: england.ambulance@nhs.net
CCG11: Eligible patients to be managed in a same day setting for Pulmonary Embolus / Tachycardia / Community Acquired Pneumonia patients **Applicability:** Acute providers with Type 1 ED **CQUIN goal:** 50 – 75% **Supporting ref:** NICE Guidance CG144, CG191 & CG180	• These three conditions are all from the top 10 conditions with which patients present in a SDEC setting. Each have been selected due to focus on a limited set of clear actions to be taken by providers. Improved same day treatment will reduce pressure on hospital beds, improving length of stay and patient experience. • The rollout of Same Day Emergency Care is one of the commitments from the Long Term Plan.	• Available via the Ambulatory Emergency Care Network as well as via NHS Improvement. • Ambulatory Emergency Care Directory (6th Edition). • BTS Guidance for the outpatient management of PE. • Contact Rachel Vokes at: nhsi.sdeccquinsupport@nhs.net

4.0 Specialised Services Scheme

Highlighted good practice selected for inclusion

4.1 Prevention of Ill Health

Highlighted action / method

PSS1: Medicines Optimisation and Stewardship

Applicability: to all Acute providers with High Cost Drugs payments > £0.5m, especially those with >£5m.
Principal CQUIN goals: 75%-95% existing patients on best value medicines; adoption of antifungal audits.
Supporting ref: Carter Review

Benefit delivered

- The medicines optimisation programme that this indicator supports is delivering cost savings of hundreds of millions.
- Using these techniques also to address over-use of antifungals will enable the NHS to play its part in stemming the worldwide build-up of resistance to antifungals (a WHO priority). This will protect neutropenic patients and others at risk of invasive fungal infections.

Support and information

- Available from the specialised commissioning national team (with a named lead) together with a network of regional pharmacy leads.
- Support Contacts: Suzy.heafield@nhs.net and Malcolm.qualie@nhs.net

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PSS2: Towards Hep C Elimination

Applicability: to 23 HCV Operational Delivery Network hosts.
CQUIN goal: 11,200 treated patients nationally.
Supporting ref: NICE guidance PH43, NICE Guidance re. Direct Acting Antivirals

- Improving treatment of diagnosed patients, and increasing rates of testing and diagnosis, followed by treatment with the new NICE-approved treatments.
- Each patient treated reduces others' risk of infection.
- This indicator is designed to contribute to the UK target of elimination of HCV by 2025.

- National support available from HCV Programme Manager, HCV National Clinical Lead, Pharmacy, Finance.
- Support Contacts: helen.bennett18@nhs.net and g.r.foster@qmul.ac.uk
- Contact mailbox at: england.hepc-enquiries@nhs.net

PSS3: Cystic Fibrosis Supporting Self Management

Applicability: to all participating Adult Cystic Fibrosis Centres in England.
CQUIN goal: to recruit 50% to 75% of patients with chronic pseudomonas to the self-management programme.
Supporting ref: Tappenden et al, PharmacoEconomics 2017; 35:647–659

- Supports changes in clinician and patient behaviour that will transform Cystic Fibrosis care from a clinician led reactive hospital based rescue service to patient led community based prevention.
- Self-management approach, supported as it is by electronic tracking, also minimises waste by enabling just in time drug delivery guided by actual adherence data.

- Implementation team based in Sheffield are available to ensure that providers and commissioners are fully supported with the implementation and benefits realisation.
- Support Contact: martin.wildman@sth.nhs.uk

4.2 Mental Health

Highlighted action / method	Benefit delivered	Support and information
PSS4: Healthy Weight in Adult Secure MH Services **Applicability:** to all providers of Adult Secure Mental Health Services **CQUIN goals**: healthy service environment, healthy lifestyle choices for their patients, assessed through monitoring of activity, obesity and wellbeing. **Supporting ref:** NICE Guidance CG189, NICE Guidance PH53, NICE Quality Standard QS111	• Substantial consequential cost savings for the health and social care system by tackling obesity rates among service users. • Contributing to earlier recovery.	• A national task and finish group has been established. Reference material and guidance is provided. • Support Contact: Louise.Davies10@nhs.net • rajesh.moholkar@nhs.net • Mehdi.Veisi@beh-mht.nhs.uk • joanna.brook-tanker@dhuft.nhs.uk
PSS5: Addressing CAMHS T4 Staff Trainings Needs **Applicability:** to all provides of CAMHS inpatient services **CQUIN goal**: all care staff to have capability to deliver psychologically informed care. **Supporting ref:** embedded in indicator specification.	• Reduction in unwarranted variation in access, delivery of effective treatment modalities, and patient outcomes in Tier 4 service settings (inpatient and community). • Ensuring clinically appropriate lengths of stay.	• Support to be available via the HEE local provider collaboratives, which are already established nationally. • Support Contact: LouiseDoughty@nhs.net • Tim.Atkin@lancashirecare.nhs.uk
PSS6: D/deaf MH Communication Assessment **Applicability:** to providers of specialised MH services for the D/deaf **CQUIN goal**: Communication Profiles completed for >25% of existing patients by end of Q4, and for all new admissions in previous quarter. **Supporting ref:** embedded in indicator specification.	• Enabling better assessment of communication needs of D/deaf people, expediting access to effective treatment.	• Reference material and guidance is provided. • Providers will be supported by the Deaf Advisory Group, a subgroup of the Specialised MH CRG. • Support Contact: Victoria.Man@nhs.net • alexanderhamilton@nhs.net

4.3 Patient Safety

Highlighted action / method	Benefit delivered	Support and information
PSS7: Clinical Utilisation Review: Avoiding Inappropriate Hospital Stays **Applicability:** to all Acute providers currently implementing the CUR project, and any (including MH providers) wishing now to join the project. **CQUIN goal**: reduction of 250k inappropriate bed-days nationally. **Supporting ref:** from CUR programme support.	• CUR provides information to providers enabling them to identify reasons for inappropriate bed use, and to take action. • This activity is in direct support of the Long Term Plan goals to “improve performance at getting people home without unnecessary delay..,reducing risk of harm to patients from physical and cognitive deconditioning complications”	• National CUR Programme Team which supports Quarterly CUR Learning Networks • Commissioning CUR Learning Networks, a CUR extranet • Support Contact: h.heywood@nhs.net
PSS8: Severe Asthma – Specialised Care Review **Applicability:** to severe asthma specialist centres. **CQUIN goal**: 80% - 100% new patients started on a biologic are discussed by an MDT **Supporting ref:** NICE Guidance TA278	• Patient outcomes will be improved as significant variation in prescribing and management of severe asthma is addressed, in line with Long Term Plan 1.34. • Through Multi-Disciplinary Team (MDT) oversight of high cost biologics use, one third of current spend could be avoided.	• Project Manager for the related Improving Value scheme • National Respiratory Clinical Reference Group • Support Contacts: alannah.thornton1@nhs.net and Kathy.blacker@nhs.net
PSS9: Immunoglobulin Stewardship **Applicability:** to all selected Immunoglobulin Assessment Panel hosts. **CQUIN goal**: 80%-100% of new patients, 65% existing patients reviewed by Panel **Supporting ref:** Immunoglobulin Use Clinical Guidelines	• Manage immunoglobulin use, ensuring appropriateness of use, dose, frequency and outcome monitoring. • Protect supply issues with immunoglobulin.	• Immunoglobulin Project group and regional implementation and pharmacy leads. • Support Contact: Robcoster@nhs.net and england.immunoglobulin@nhs.net
PSS10: Spinal Surgery **Applicability:** to all specialist spinal centres. **CQUIN goal**: MDT oversight of all specialised surgery. **Supporting ref:** NICE Guidance: spinal & back conditions	• Reduce inappropriate surgery. • Reduce substantial variation in practice across England. • Cut waiting lists and save litigation costs.	• Available from the CRG Chair and Lead Commissioner • Support Contacts: jacquiekemp@nhs.net and David.Stockdale1@nhs.net

4.4 Best Practice Pathways

Highlighted action / method	Benefit delivered	Support and information
PSS11: Promoting Transplantation **Applicability:** to all transplantation centres. **CQUIN goal**: significantly reduced live donor work-up times and organ decline rates **Supporting ref:** https://www.nhsbt.nhs.uk/tot2020/	• Improving donation and utilisation rates results and increased survival rates for recipients. Should also reduce demand for renal dialysis and for high cost interim devices. • Meeting National targets for Kidney, Liver, Heart and Lung transplantation (Taking Organ Donation to 2020).	• The NHS BT Clinical Leads and Living Kidney Donor Strategy Implementation Group (SIG). • Support Contacts: sarah.watson23@nhs.net and jon.gulliver@nhs.net
PSS12: Enabling Thrombectomy **Applicability:** to up to ten thrombectomy providers with capacity to provide training. **CQUIN goal**: nationally, 20 additional interventionists **Supporting ref:** NHS E Mech. Thrombectomy policy.	• "Expanding mechanical thrombectomy – from 1% to 10% of stroke patients – will allow 1,600 more people to be independent after their stroke each year." Long Term Plan 3.75	• The NHS E thrombectomy programme team. • Support Contacts: freddie.drew@nhs.net and jacquiekemp@nhs.net
PSS13: Rethinking Conversations: Personalising Care for Long Term Condition Patients **Applicability:** to (1) providers making progress with '17/19 CQUINs GE2 PAM, GE5 SDM, CA1 ESC; (2) others with patient groups likely to benefit. **CQUIN goal**: increased % of patients receiving timely supported conversations and support for goal achievement **Supporting ref:** NHS E: Universal Personalised Care	• "We will support and help train staff to have the conversations which help patients make the decisions that are right for them." Long Term Plan 1.37. • Supports consideration and access to alternative treatment options, including patient-activation and enhanced supportive care options.	• Available from NHSE Personalised Care Team • Support Contacts: donald.franklin@nhs.net alf.collins@nhs.net jonathan.berry2@nhs.net,
PSS14: Cirrhosis Care Bundle **Applicability:** to HPB specialist providers in a position to network non-specialist partners. **CQUIN goal**: completion of cirrhosis bundle in >50% of patients with decompensated cirrhosis **Supporting ref:** Cirrhosis Care Bundle	• This bundle should reduce mortality (given a 25% higher rate of in-hospital deaths for similar cohort of patients who are treated in non-specialised centres). Also will reduce variation in care and treatment in non-specialised hospitals. • The care bundle has been shown to reduce length of stay by 3-5 days.	• Available from the CRG, with National mailbox • Support Contact: g.r.foster@qmul.ac.uk
PSS15: Paediatric Movement Therapies **Applicability:** to all 17 named centres, who are coordinating care across regions. **CQUIN goal**: MDT assessment for 80% new patients within 18 weeks of referral, with CPIP assessment; regular assessments with follow up interventions **Supporting ref:** NICE Guidance CG145 & NG 62	• To replace ineffective traditional forms of practice; to match efforts to improve interventions in Scotland and in Sweden that have seen significant falls in hip displacement requiring costly surgery. • Anticipated cost saving from reduced surgery of £6 million pa across England. • Patient benefit (and system cost-savings) from prevented deformity and pain.	• Paediatric Neurosciences CRG chair, and from Lead Commissioner • Support Contact: charlie.fairhurst@gstt.nhs.uk

5.0 Scheme eligibility and value

5.0 Scheme Eligibility and Value

5.1 Eligibility

Any provider of healthcare services commissioned under an NHS Standard Contract (full-length or shorter-form version) is eligible for CQUIN. This is inclusive of the independent sector e.g. care homes and the third sector.

5.2 CCG CQUIN scheme values

Depending on provider performance, for CCG contracts, the CQUIN scheme is worth a maximum of 1.25%, payable in addition to the Actual Annual Value (AAV). There continues to be a differential approach to the percentage allocated to CQUIN for specialised services; see section 5.3, pg. 21. The AAV (for both CCG and PSS schemes) is the aggregate of all payments made to the provider for services delivered under the specific contract during the contract year, not including CQUIN and other incentive payments, and after any deductions or withholdings), subject to certain exclusions (see section 6.1 Rules).

The 1.25% payable for the CCG CQUIN scheme, depending on performance is to be split as follows:

- Each national indicator has a minimum weighting of 0.25%, with the exception of providers (typically smaller, non-NHS) to whom some of the national indicators don't readily apply. In those cases, CCGs should offer additional local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract). There should be **no more than five indicators** in total for each contract.

- For providers whose range of services would make them eligible for more than five indicators e.g. those who carry out both acute and community services, the five acute specific indicators should be prioritised, each attracting 0.25%.

- For providers whose range of services would make them eligible for more than five indicators but the acute indicators do not apply e.g. community and mental health services, by mutual agreement the commissioner and provider will be expected to agree the five national indicators most relevant to their service. These should be equally weighted at 0.25%.

As confirmed in the NHS Operational and Contracting guidance 2019/20, where the total value of CQUIN has not been earned, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

5.0 Scheme Eligibility and Value

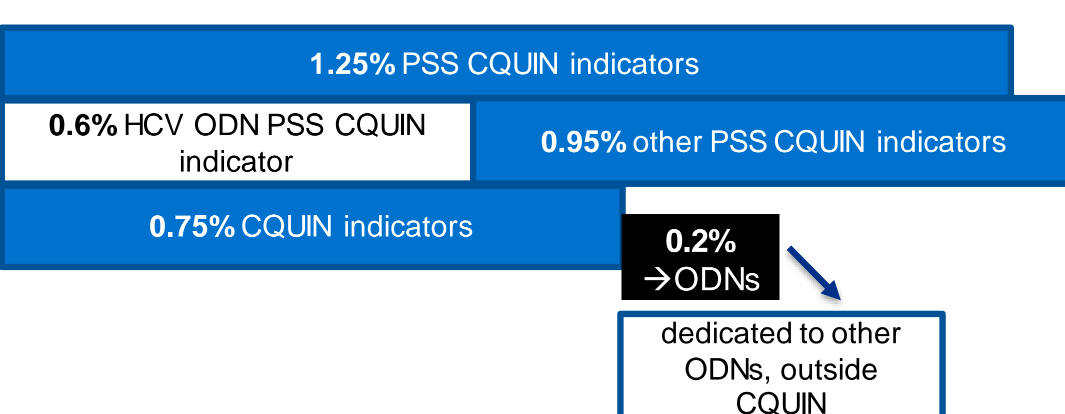
5.3 PSS CQUIN Scheme Values

For the PSS scheme, as in previous years, a portion of the CQUIN monies will be dedicated to sustain and expand the work of Operational Delivery Networks (ODNs) in ensuring consistency of care quality across the country. In addition, recognising the ongoing commitment to the elimination of Hepatitis C, ODN leads for Hepatitis C will, alongside mental health providers, continue to be eligible for a higher PSS CQUIN allocation when compared to other acute providers of specialised services. Consequently, for HEP C ODN leads, the PSS CQUIN scheme is worth a maximum of 1.55% payable in addition to the Actual Annual Value (AAV). For MH providers the PSS CQUIN scheme is worth a maximum of 1.25%, and for other Acute providers it will be worth a maximum of 0.75%.

Mental Health Providers:

HCV Lead Providers:

Other Acute Providers:



Commissioners will offer a provider-specific PSS CQUIN package at a sum equivalent to the above percentage of planned CQUIN-applicable contract value. The CQUIN payment offered for each scheme will be based on the payment mechanism in the CQUIN contract template and is not for local negotiation, although where provider and commissioner agree that a greater or lesser scope or scale of improvement is appropriate, the individual scheme value adjusts.

Commissioners will include **up to five national indicators** within PSS CQUIN packages where applicable, and where CQUIN funding within the PSS contract for that provider allows. Where there is a shortfall of applicable national PSS CQUIN indicators, NHS England commissioners may construct local CQUIN indicators as part of the package of five. Additional indicators may be included only by mutual agreement.

6.0 Rules and guidance

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.1 Rules

This guidance applies to commissioners and providers using the NHS Standard Contract in 2019-2020. The CCG indicators are not mandatory for inclusion in CQUIN schemes in contracts where NHS England is the sole commissioner. Our intention is to make challenging but realistic CQUIN schemes available for providers; we expect that a high proportion of commissioner CQUIN funding will be earned. The following established rules (1-11) should govern the approach to establishing the CQUIN scheme locally:

Rule	Detail
1	A scheme must be offered to each provider which provides healthcare services under the NHS Standard Contract (but see notes on non-contract activity (section 6.8, pg. 27) and low-value contracts (section 6.6, pg. 27).
2	There should be one scheme per contract, offered by the co-ordinating commissioner to the provider. (See note on arrangements for agreeing schemes among the commissioners who are party to a contract (section 6.2, pg. 25).
3	The commissioner may offer a combined scheme to a number of related providers or may seek to align the content of separate schemes across different providers.
4	The maximum value of the scheme – the maximum amount which a provider can earn under it – will be the percentage specified in sections 5.2, pg. 20 and 5.3, pg. 21 of the Actual Annual Value of the contract as defined in the NHS Standard Contract 2019/20, subject to certain exclusions, see rule 5.
5	The exclusions, on the value of which CQUIN is not payable, are: a) (For the avoidance of doubt) any payments made to providers from the 2019/20 Provider and Sustainability Fund; b) High cost drugs, devices and listed procedures (available at: https://improvement.nhs.uk/resources/national-tariff-1920-consultation/) and all other items for which the commissioner makes payment on a "pass-through" basis to the provider (that is, where the commissioner simply meets the actual cost to the provider of a specific drug or product, for example); and c) The value of all services delivered by the provider under the relevant contract to Chargeable Overseas Visitors (as defined in the NHS Standard Contract), regardless of any contribution on account paid by any commissioner in respect of those services. However, services delivered to any Chargeable Overseas Visitor is still contract activity under that contract, and so must be included in calculations in relation to national or local CQUIN indicators.

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.1 Rules continued…

Rule	Detail
6	Funding paid to providers under the scheme is non-recurrent.
7	Discussion between the commissioner and provider (or groups of providers) on the content of each scheme is encouraged, but in the end it is for the commissioner to determine, within the framework of this guidance, the priorities and focus for each scheme.
8	The scheme offered to each provider must be in accordance with this guidance and must give the provider a realistic expectation of earning a high proportion of the percentage available. Further detail on the process for proposal and agreement of schemes is set out in section 6.2, pg.25 – 6.10, pg.28.
9	Each scheme must be recorded in the Schedule 4D 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.
10	Payment to the provider must be based on the provider's achievement of the agreed objectives within the scheme, in line with the detailed arrangements set out in this guidance and in the NHS Standard Contract.
11	Any disputes about schemes which have been agreed and recorded within contracts should be resolved in accordance with the dispute resolution mechanism set out in the NHS Standard Contract.

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.2 Agreement between commissioners

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 (http://www.england.nhs.uk/nhs-standard-contract/). 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.

6.3 Updating CQUIN schemes in multi-year contracts

There will be situations where existing contracts remain in place for 2019/20. The terms of the NHS Standard Contract are clear that any CQUIN scheme must be in accordance with national CQUIN guidance and we therefore expect that commissioners and providers will agree appropriate changes to the CQUIN schedules in their local contracts to reflect this updated National CQUIN guidance and will implement those changes, by 31 March 2019, as part of a wider Variation to their contracts. This Variation will need to enact the reduction in the value of CQUIN from 2.5% to 1.25%, with the necessary offsetting increase in any Local Prices and in the (pre-CQUIN) Expected Annual Contract Value. Updating of CQUIN schemes to reflect this national guidance should be straightforward and should not lead to disputes.

6.4 Offer and agreement between commissioners and providers (new contracts)

For 2019/20, commissioners and providers will in most cases be seeking to agree a new contract to take effect on 1 April 2019. Where this is the case, then – in line with rule 7 – it is important to be clear about how they should engage on any content of the 2019/20 CQUIN scheme which is to be locally agreed – and what happens if they are unable to reach agreement:

- Commissioners will wish to engage with providers, or groups of similar providers, at the earliest opportunity, in order to discuss proposals for CQUIN schemes.

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.4 Offer and agreement between commissioners and providers (new contracts) cont…

- Where multiple commissioners are party to the same contract with a provider, it is for the co-ordinating commissioner to lead the discussions with the provider on CQUIN.
- The commissioner must make a reasonable offer of a CQUIN scheme to the provider.
- Ultimately, where the commissioner has made such an offer and the provider has not accepted it as part of a signed contract by 21 March 2019, the commissioner will be entitled to withdraw the offer of local CQUIN indicators from the percentage specified in sections 5.2, pg.20 and 5.3, pg.21 and need not make available local CQUIN indicators to that provider for the remainder of that contract year, even if a contract is subsequently signed. In this scenario, the commissioner should ensure that it reduces accordingly any CQUIN payments it makes on account to the provider.
- For the avoidance of doubt, the agreed scheme should be recorded in section 4D of the NHS Standard Contract.

6.5 Independent and third sector providers

The CQUIN scheme has been designed to be offered to the full range of providers that deliver services under the NHS Standard Contract. Where national indicators apply, commissioners should aim to ensure scheme compliance by locally contracting for these. Commissioners must explicitly offer the CQUIN to all independent and third sector providers unless they have decided to apply the small value contracts exemption (6.6, pg. 24). The explicit offer of CQUIN also applies to providers commissioned under the NHS Standard Contract on the Any Qualified Provider framework.

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.6 Small-Value Contracts

Providers should have the opportunity to earn CQUIN payments, regardless of how small the value of their contract is. We recognise, however, that it may not always be a good use of time for commissioners and providers to develop and agree detailed schemes for very low-value contracts. At their sole discretion, therefore, commissioners may choose simply to pay the percentage specified in sections 5.2, pg.20 and 5.3, pg. 21 to providers where this value would be non-material, rather than develop a specific scheme. Where they intend to do this, they must make it clear at the outset of their procurement or contract negotiation process, so that providers understand that a separate CQUIN scheme is not to be offered. Within their contracts, they should then:

- Select the appropriate option within the CQUIN Schedule (4D), so that it is clear that the small-value contract exception is being applied; and
- ensure that the Local Prices (Schedule 3A) and the Expected Annual Contract Value (Schedule 3F) are expressed at full value (that is, including any value which would otherwise have been paid as CQUIN), as now required under Service Condition 38.15 of the 2019/20 NHS Standard Contract.

6.7 Joint Commissioning

Where NHS and Local Authority commissioners are jointly commissioning services under the NHS Contract for example care homes but not pooling funds, CQUIN only applies to that healthcare funding part. Local Authority commissioners could choose to match funding to the CQUIN equivalent but this is for local determination.

6.8 CQUIN and Non-Contract Activity

Non-Contract Activity (NCA) billing arrangements are not intended as a routine alternative to formal contracting, but for use where there are small, unpredictable flows of patient activity delivered by a provider which is geographically distant from the commissioner.

As a general principle, CQUIN payments may be earned by a provider on NCA. Subject to the restrictions below, the terms of a provider's CQUIN scheme with its main commissioner for the relevant service will be deemed to apply to any NCA activity it carries out in that service. Providers will need to supply reasonable evidence to NCA commissioners of that scheme and of achievement of incentive goals.

6.0 Rules and Guidance - Agreeing and Implementing a CQUIN Scheme

6.9 Local Incentive Schemes and Services Covered by Local Prices

It is of course possible for commissioners, at their discretion, to offer additional incentives to providers, on top of the main national scheme.

Such schemes should be recorded as Local Incentive Schemes in the relevant schedule of the NHS Standard Contract. If local incentives affect services covered by National Prices, commissioners may need to submit a Local Variation to Monitor, as outlined in the National Tariff Payment System 2019 - 20.

We recognise that, particularly where a competitive procurement approach is being used, commissioners may choose, as an explicit part of setting a local price for a contract, to create a broader local incentive scheme, incorporating the national CQUIN scheme but linking a higher proportion of contract value (above the percentage specified in sections 5.2, pg. 20 and 5.3, pg. 21) to agreed quality and outcome measures, rather than activity levels. This is a legitimate approach, and there is no requirement in this situation for the commissioner to offer a further CQUIN scheme to the provider, on top of the agreed local price. Commissioners should ensure that they make their intended approach clear from the outset of the procurement process.

6.10 CQUIN Earn-ability

Following on from the successfully trialled CQUIN Finance Return in 2018/19, NHS England and NHS Improvement will be seeking to collect in-year information in order to confirm whether CQUIN awards are expected to be earned during 2019/20. Providers and Commissioners will be expected to comply with the requirements of that return. More information will be shared on this in due course.

As confirmed in the NHS Operational and Contracting guidance 2019/20, where the total value of CQUIN has not been earned, the use of the resultant funding will be subject to sign off by the joint NHS England/Improvement regional teams.

Version Control

Date	Update
7th March 2019	Initial Publication
8th March 2019	Section 6.4 (p26) amended

ELFT CQUIN SCHEMES 2019-20

Coordinating Commissioner	Luton Clinical Commissioning Group	Sign Off:	**Provider CEO**	
Associate Commissioner			**Commissioner CEO**	
Total financial value of Scheme				

Goals and Indicators:

Indicator number	**Indicator name**	**Indicator weighting**
CCG2	Staff Flu Vaccinations	0.32%
CCG3a)	Alcohol & Tobacco: Screening	0.10%
CCG 3b)	Alcohol & Tobacco : Tobacco Brief Advice	0.10%
CCG 3c)	Alcohol & Tobacco : Alcohol Brief Advice	0.10%
CCG4)	72hr Follow-Up Post Discharge	0.31%
CCG5a)	Mental Health Data: Data Quality Maturity Index	0.16%
CCG5b)	Mental Health Data: Interventions	0.16%

Highlighted action / method

CCG4: Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge

Applicability: All Mental Health trusts
CQUIN goal: 50 – 80% (Q3-4 only)
Supporting ref: At present, NICE Guidance NG53 references the national standard of a 7 day follow up, however recent findings from The National Confidential Inquiry into Suicide and Safety in Mental Health evidences the need for a 3 day follow up

Benefit delivered

- 72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge.
- By completing follow up in 3 days providers support the suicide prevention agenda, ensuring patients have both a timely and well-planned discharge.
- This activity will increase focus on improving the overall quality of support post discharge.

Support and information

- Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.
- Contact Belinda Yeldon at: England.MHCQUIN@nhs.net.

CCG3: Screening and brief advice for tobacco and alcohol use in inpatient settings

Applicability: All Acute, Community and MH providers
CQUIN goal: Screening 40-80% Brief Advice 50-90%
Supporting ref: NICE guidance PH24, PH45 and PH48

- Screening and brief advice is expected to result in 170k tobacco users and 60k at risk alcohol users receiving brief advice, a key component of their path to cessation.
- A reduced version of 2018/19 CQUIN indicator, this is already being delivered strongly across the country, and is part of an ongoing programme to deliver the Long Term Plan.

- E-Learning programme available for training needs along with additional published Guidance and information.
- Contact Don Lavoie at: Don.Lavoie@phe.gov.uk

Highlighted action / method

Benefit delivered

Support and information

CCG5: Improving the quality and breadth of data submitted to the Mental Health Services Dataset

Applicability: All Mental Health trusts
CQUIN goal: DQMI 90 – 95% (Q2-4 only) Interventions 15 – 70% (Q3-4 only)
Supporting ref: Information Standards Notice MHSDS DQMI

- Accurate data is a key enabler for improvement in MH services and is underpinned by the Long Term Plan. Improving mental health data quality and ensuring providers record interventions consistently using SNOMED CT will enable:
  - The system to use data in a more efficient and reliable way, ensuring that patients receive appropriate treatment.
  - Patients and clinicians to make informed decisions about treatment options.
  - The retirement of costly and burdensome duplicate data collections and local flows.

- Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact the email address below.
- DQMI specific information also available along with a document outlining Changes to the DQMI.
- Contact Belinda Yeldon at: England.MHCQUIN@nhs.net

CCG2: Staff Flu Vaccinations

Services in scope

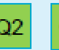
Acute, Community, Mental Health, Ambulance

Payment levels

Minimum: 60%

Maximum: 80%

Scope:



Q4

Accessing support

Policy Lead

Doug Gilbert

Douglas.gilbert1@nhs.net

Supporting Documents

ImmForm Guidance

Green Book

NICE guidance NG103

Data source(s) & Reporting

Monthly Provider submission (between September and February) to PHE via ImmForm. See: Guidance

Data will be made publicly available approximately 6 weeks after each quarter.

Description

Achieving an 80% uptake of flu vaccinations by frontline clinical staff.

Numerator

Total number of front line healthcare workers who have received their flu vaccination between 1 September 2019 and February 28th 2020.

Denominator

Total number of front line healthcare workers.

Exclusions

- Staff working in an office with no patient contact
- Social care workers
- Staff out of the Trust for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)

CCG3a: Alcohol and Tobacco - Screening

Services in scope

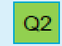
Acute, Community, Mental Health

Payment levels

Minimum: 40%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4



Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use.

Numerator

Of the denominator, those screened for both smoking and alcohol risk status and the results recorded in patient's record.

Denominator

All *unique patients, aged 18+ who are admitted to an inpatient ward for at least one night (i.e. length of stay equal to or greater than one).

*Unique is defined as a non-repeat admission of a patient during the duration of the CQUIN who has not already received the intervention within the period of the CQUIN.

Exclusions

Maternity inpatients (exclude where 'Epitype'=2,3,4,5 or 6).

CCG3b: Alcohol and Tobacco – Tobacco Brief Advice

Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope:

Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of identified smokers given brief advice.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme - including an offer of Nicotine Replacement Therapy (whether or not this offer had been taken up).

Denominator

All eligible patients who have been recorded as smokers during screening.

CCG3c: Alcohol and Tobacco – Alcohol Brief Advice

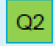
Services in scope

Acute, Community, Mental Health

Payment levels

Minimum: 50%

Maximum: 90%

Scope: Q1


Accessing support

Policy Lead

Don Lavoie

Don.Lavoie@phe.gov.uk

Supporting Documents

Alcohol and Tobacco Brief Interventions E-Learning programme

Guidance and information

Data source(s) & Reporting

Quarterly submission via National CQUIN collection – see sections 4b-d for details about auditing.

Data will be made available approximately 6 weeks after each quarter.

Description

Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.

Numerator

Of the denominator, those who are given brief advice as outlined in the Alcohol and Tobacco Brief Interventions E-learning programme, or offered a specialist referral if the patient is potentially alcohol dependent.

Denominator

All eligible patients who have been recorded as drinking above the low risk levels.

CCG4: 72hr follow up post discharge

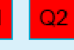
Services in scope

Mental Health

Payment levels

Minimum: 50%

Maximum: 80%

Scope: 

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

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.

Description

Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge from a CCG commissioned service.

Numerator

Of the denominator, those who have a follow up within 72hrs (commencing the day after discharge).

Denominator

Number of people discharged from a CCG commissioned adult mental health inpatient setting.

Exclusions

Details will be provided via the 'Mental Health CQUIN' FutureNHS Collaboration Platform.

CCG5a: Mental Health Data Quality: MHSDS Data Quality Maturity Index

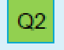
Services in scope

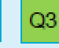
Mental Health (MH trusts only)

Payment levels

Minimum: 90%

Maximum: 95%

Scope: Q1 



Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

Data Source(s) & Reporting

Routine provider submission to the Mental Health Services Data Set (MHSDS).

The MHSDS monthly data quality reports include granular provider level data on the data items included in the MHSDS DQMI. Published MHSDS data

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.

Description

Achieving a score of 95% in the MHSDS Data Quality Maturity Index (DQMI).

Indicator

The MHSDS DQMI score is an overall assessment of data quality for each provider, based on a list of key MHSDS data items. The MHSDS DQMI score is defined as the mean of all the data item scores for percentage valid & complete, multiplied by a coverage score for the MHSDS. The full definition and DQMI data reports can be found at: DQMI webpage

Data Items

The MHSDS Data items included in the DQMI are outlined in the Changes to the DQMI.

CCG5b: Mental Health Data Quality: Interventions

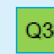
Services in scope

Mental Health (MH trusts only)

Payment levels

Minimum: 15%

Maximum: 70%

Scope: 

Accessing support

Policy Lead

Belinda Yeldon

England.MHCQUIN@nhs.net

Supporting Documents

Available from the 'Mental Health CQUIN' FutureNHS Collaboration Platform. Please email the policy lead above to gain access.

NHS Digital SNOMED CT Browser

MH SNOMED Website

Specific Pathway Guidance on SNOMED CT Intervention Codes

Data Source(s) & Reporting

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.

Description

Achieving 70% of referrals where the second attended contact takes place between Q3-4 with at least one intervention (SNOMED CT procedure code) recorded using between the referral start date and the end of the reporting period.

Numerator

Of the denominator, the referrals with at least one intervention* (SNOMED CT procedure code) recorded between the referral start date and the end of the reporting period.

Denominator

The number of referrals that receive their second attended contact in Q3-4 2019/20.

*A condition of this CQUIN is that providers demonstrate a range of interventions over the course of Q3 – Q4. Any provider who is found to be only using one intervention code will receive no payment.

3a. Payment: Thresholds and Periods

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for each Indicator during the applicable period (Payment basis). The table below summarises the relevant thresholds and payment basis that will be used for each of the indicators within the scheme. Assessment should take place at the end of the scheme and calculated according to the method outlined in Payments: calculating payments.

Indicator	Pay levels(%)	Payment basis
CCG2: Staff Flu Vaccinations	60 - 80	Q1-4
CCG3a: A&T- Screening	40 - 80	Q1-4
CCG3b: A&T– Tobacco Brief Advice	50 - 90	Q1-4
CCG3c: A&T– Alcohol Brief Advice	50 - 90	Q1-4

CCG4: 72hr follow up post discharge	50 - 80	Q3-4
CCG5a: Mental Health Data: Data Quality Maturity Index	90 - 95	Q2-4
CCG5b: Mental Health Data: Interventions	15 - 70	Q3-4

General Principles Applied Throughout Schedule
The principles applied throughout this document are applicable to all Commissioners under the Contract. This includes both the Host Commissioner and all Associate Commissioners under the Contract. However the delivery methods are specific to those Commissioners who use the NHS NEL Commissioning Support Unit services for the receipt and onward delivery of data. For Commissioners outside of the NHS NEL Commissioning Support Unit customer base delivery methods and location for the reports should be specified to the Trust directly. However where the Host Commissioner requests delivery for example via the Data Landing Portal it is expected that all Associate Commissioners will receive the data in the same method, format and timing. The Provider and the Coordinating Commissioner agree to work together to identify and document any data definitions and/or rules to promote understanding and transparency about local approaches to billable activity and/or rules to promote understanding and transparency about local approaches to billable activity and the basis for payment of incentives or penalties with respect to the KPIs, clinical or quality indicators. This will include confirmation of the data quality parameters to be used in the datasets provided. Should either party fail to achieve a deadline (including Reporting Requirements submission deadline), this will be flagged and escalated initially in writing via e-mail to the BI or Contract Lead; the parties shall enter into joint dialogue to agree corrective action being taken; however the Commissioner retains the right to seek contractual redress for failure. Following changes to data sharing agreements bought in collectively between NHS England and NHS Digital this now entitles the Host Clinical Commissioning Group Commissioner for each Provider to receive full Trust wide data for the course of the Contract Period and Data Sharing Agreement. Host Commissioners and their agents (including CSUs and DSCROs) will need to strictly observe the terms of the data sharing agreement in terms of information governance when sharing activity and finance information with Associate Commissioners and therefore Providers should ensure that any concerns around information governance are addressed via the Data Sharing Agreement which should accurately and comprehensively reflect agreements relating to the provision of data to Associate Commissioners by the Host Commissioner As such Commissioners require all submissions made to the Host Clinical Commissioning Group Commissioner to contain patient and aggregate submissions as appropriate covering all patient treatment and Commissioners. This includes all Commissioners and sources of patient treatment including but not limited to: • *NHS England Commissioned activity and financial values,* • *Public Health England Commissioned activity and financial values,* • *Clinical Commissioning Group Commissioned activity and financial values,* • *Local Authority Commissioned activity and financial values,* • *Privately Commissioned activity and financial values* This agreement is being implemented to allow Commissioners to review Trust wide data and assist in monitoring and coordinating delivery of healthcare to the population and health system covered by the Provider, as well as performance across all sources, datasets and submissions. Commissioners expect that all data submissions will be via a common Non-SUS Submission Portal submission standard. Currently this is the NHS Digital Data Landing Portal. This is in line with new information NHS Digital has released that advises wherever possible to avoid submissions of bulk patient identifiable data via NHS.Net systems. Where data submissions are not being made via the NHS Digital Data Landing Portal, unless a specific agreement is reached to the contrary, they should be made NELCSU.DSC-NonAcute@nhs.net.

A. Reporting Requirements

General Principles Applied Throughout Schedule
Commissioners expect that via the NEL Commissioning Support Unit CDT that will form part of the Contract Documentation that this will identify which fields being submitted by the Provider can contain Patient Identifiable Data (PID). It will then be the Providers responsibility to ensure that all submissions of data are consistent and that no submissions occur with PID in fields outside of those highlighted in the CDT document. The CDT document must be completed and shared with the NEL Commissioner Support Unit NELIE Support team (NELCSU.NELIEsupport@nhs.net) by no later than Monday 20 May 2019. Where submission of PID in non PID fields occurs Commissioners, with the assistance of NEL Commissioning Support Unit, will be flagging this as an Information Governance breach as Data Services for Commissioners Regional Offices will only be pseudonymising, anonymising and restricting data flows on fields identified as containing patient identifiable data going forward. The responsibility for resolving these breaches with NHS Digital and the Information Commissioner's Office will then sit with the Provider to undertake. Commissioners expect that all submissions of data to SUS will be completed as net change submissions in the Message Exchange for Social Care and Health (MESH) mechanism as other submission types such as bulk submissions result in sub-optimal performance of SUS. In addition the other submission mechanism of Electronic Data Transfer (EDT) file transfer mechanism will no longer be supported by SUS+ from 1 June 2019 onwards. As the Commissioner and Provider landscape is rapidly changing Commissioners expect that during the Contract Period report definitions and specifications may change. Therefore it is expected that all parties will work collaboratively to discuss, change and implement alterations to reporting requirements during the Contract Period. This will be undertaken with Contract Variations however Commissioners expect that changes to reporting may be agreed in writing (likely via emails) with formal Contract documentation and Local Variations being applied retrospectively so as not to hold up changes to the provision of data or reporting to ensure that Contract documentation is not a blocker to the rapid changes being undertaken across the Health Economy. The Provider will work with the Commissioners on the provision of data to support new models of care (e.g. Integrated Care). This data may be used to support the development or implementation of RAID, CCG QIPP, Better Care Fund, mental health clusters or Outcome Based Commissioning Schemes.

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
National Requirements Reported Nationally						
NCCR 01.	As specified in the DCB Schedule of Approved Collections[1] where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	All	2019/20 Standard NHS Contract
NCCR 02.	Patient Reported Outcome Measures (PROMS)[2] where mandated for and as applicable to the Provider and the Services	As set out in relevant Guidance	As set out in relevant Guidance	As set out in relevant Guidance	All	2019/20 Standard NHS Contract

[1]Published on the NHS Digital website at https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections

[2]Published on the NHS Digital website at https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/patient-reported-outcome-measures-proms

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
National Requirements Reported Locally						
NRRL 01.	**Activity and Finance Report** (note that, if appropriately designed, this report may also serve as the reconciliation account to be sent by the Provider by the First Reconciliation Date under SC36.28, or under SC36.31)	Monthly	For Local Agreement 2019-20 NELCSU Mental Health Infor 2019-20 NELCSU Mental Health Schec MH Data set.xlsx	By no later than the First Reconciliation Date for the month to which it relates, consistent with data submitted to SUS, where applicable 2019-20 NELCSU Mental Health Schec	A, MH	2019/20 Standard NHS Contract
NRRL 02.	**Service Quality Performance Report** detailing performance against Operational Standards, National Quality Requirements, Local Quality Requirements, Never Events and the duty of candour, including, without limitation: a. details of any thresholds that have been breached and any Never Events and breaches in respect of the duty of candour that have occurred; b. details of all requirements satisfied; **c.** details of, and reasons for, any failure to meet requirements; d. the outcome of all Root Cause Analyses and audits performed pursuant to SC22 (Assessment and Treatment for Acute Illness); **e.** report on performance against the HCAI Reduction Plan	Monthly	For Local Agreement	Within 15 Operational Days of the end of the month to which it relates.	All All All A ALL except 111	2019/20 Standard NHS Contract

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
NRRL 03.	**CQUIN Performance Report** and details of progress towards satisfying any Quality Incentive Scheme Indicators, including details of all Quality Incentive Scheme Indicators satisfied or not satisfied	For Local Agreement	For Local Agreement	For Local Agreement	All	2019/20 Standard NHS Contract
NRRL 04.	**NHS Safety Thermometer Report** detailing and analysing: • data collected in relation to each relevant NHS Safety Thermometer; • trends and progress; • Actions to be taken to improve performance.	Monthly, or as agreed locally	For local agreement, according to published NHS Safety Thermometer reporting routes	[For local agreement], according to published NHS Safety Thermometer reporting routes	All (not AM, CS, D, 111, PT, U)	2019/20 Standard NHS Contract
NRRL 05.	**Complaints monitoring report** setting out numbers of complaints received and including analysis of key themes in content of complaints	For local agreement	For local agreement	[For local agreement]	All	2019/20 Standard NHS Contract
NRRL 06.	**Report against performance of Service Development and Improvement Plan (SDIP)**	In accordance with relevant SDIP	In accordance with relevant SDIP	In accordance with relevant SDIP	All	2019/20 Standard NHS Contract
NRRL 07.	**Summary report of all incidents requiring reporting**	Monthly	For Local Agreement	For Local Agreement	All	2019/20 Standard NHS Contract
NRRL 08.	**Data Quality Improvement Plan: report of progress against milestones**	In accordance with the relevant DQIP	In accordance with the relevant DQIP	In accordance with the relevant DQIP	All	2019/20 Standard NHS Contract

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
NRRL 09.	Report and provide monthly data and detailed information relating to violence-related injury resulting in treatment being sought from Staff in A&E departments, urgent care and walk-in centres to the local community safety partnership and the relevant police force, in accordance with applicable Guidance (Information Sharing to Tackle Violence (ISTV)) Initial Standard Specification https://digital.nhs.uk/isce/publication/isb1594	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	A, A+E, U	2019/20 Standard NHS Contract
NRRL 10.	Report on outcome of reviews and evaluations in relation to Staff numbers and skill mix in accordance with GC5.2 (Staff)	Annually (or more frequently if and as required by the Co-ordinating Commissioner from time to time)	For local agreement	For local agreement	All	2019/20 Standard NHS Contract
NRRL 11.	**Report on compliance with the National Workforce Race Equality Standard.**	Annually	For local agreement	For local agreement	All	2019/20 Standard NHS Contract
NRRL 12.	**Specific reports required by NHS England** in relation to Specialised Services and other services directly commissioned by NHS England, as set out at http://www.england.nhs.uk/nhs-standard-contract/ss-reporting (where not otherwise required to be submitted as a national requirement reported centrally or locally)	Monthly	As set out in relevant Guidance	As set out in relevant Guidance	A, A+E, U	2019/20 Standard NHS Contract

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
NRRL 13.	**Report on performance** in reducing Antibiotic Usage in accordance with SC21.4 (Antimicrobial Resistance and Healthcare Associated Infections)	Annually	For local agreement	For local agreement	All	2019/20 Standard NHS Contract
NRRL 14.	**Report on progress** against sustainable development management plan in accordance with SC18.2	Annually	For local agreement	For local agreement	All	2019/20 Standard NHS Contract
Local Requirements Reported Locally						
LRRL 01.	**Improving Access to Psychological Therapies (IAPT) Dataset:** Data relating to Adults aged 18 and above accessing NHS commissioned IAPT services for depression and anxiety in England. The data set does not apply to those providing services to people under 18 years of age.	**Monthly**	PDF 2019-20 NELCSU Mental Health Sche(	**In line with national submission timetable (TBC)**	MH	2019/20 Standard NHS Contract (2019/20 timetable yet to be published but it seems to be different from the MHSDS submission timetable)

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL 02.	**Activity and Finance Report and Associated Patient Level Backing Data:** The Provider shall supply monthly activity and finance monitoring reports on an aggregate level, and evidence all relevant elements of these with reconcilable patient level backing data. The service provider agrees to supply information in line with NELCSUs submission standards and definition criteria regardless of host and associate arrangements. *Key Report Expectations:* • Clustered Dataset • Patient Level Clustered Dataset • HRG level Cost and Volume Dataset • Patient Level Cost and Volume Dataset	**Monthly**	2019-20 NELCSU Mental Health Schec 2019-20 NELCSU Mental Health Schec MH Core - Cluster MDS.xlsx	In line with the attached timetable Aggregate Activity and Finance Reports should be submitted to Commissioners via the Data Landing Portal (DLP)[3] NEL Submission Standards.docx	MH	Local NEL CSU Hosted Reporting Requirements
LRRL 03.	National Freeze (Post-Reconciliation) dates for reconciliation of individual data sets to contract monitoring reports: Notional freeze dates after which the provider will not be able to refresh activity data have been set. This is to ensure that the Provider records all activity relating to all Mental Health services to the required timescales.	Monthly	Refreshed final version of all activity and finance reports, backing data and National dataset submissions	The National freeze (post-reconciliation) dates are detailed in Appendix 1.	MH	Local NEL CSU Hosted Reporting Requirements

[3]Published on the NHS Digital website at https://digital.nhs.uk/services/data-landing-portal

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL 04.	**Statutory Reporting** The Provider must submit data and/or reports to support Commissioners' statutory returns and submissions to NHS England, designated agents of the Department of Health and other relevant bodies. The Provider shall also submit data and/or reports in support of any new statutory requirements which Commissioners may need to meet during the period of this contract. The Provider shall meet deadlines as stipulated by Commissioners to enable data turnaround time before final Commissioner submission.	As per National guidance.	As per National guidance.	As per National guidance.	MH	Local NEL CSU Hosted Reporting Requirements
LRRL 05.	**Non Statutory Reporting** The Provider must submit data and/or reports to the Commissioner to support requests received within the year from the Department of Health, NHS England, designated agents of the Department of Health and other relevant bodies. The Provider shall be expected to meet deadlines as stipulated by the Commissioner where the relevant body has requested that the Commissioner coordinate Provider responses and the commissioner has informed the providers as soon as the commissioner is aware of the request.	As per National guidance.	As per National guidance.	As per National guidance.	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL 06.	**Ad Hoc Information Requests** The provider will support reasonable additional information requests from commissioners not included within the Information Schedule. If whether the request is reasonable is contested then agreement at monthly contract meetings will be sort. All requests to be submitted to the Providers BDU unit.	As relevant to specific request	As relevant to specific request	As relevant to specific request	MH	Local NEL CSU Hosted Reporting Requirements
LRRL 07.	**Waiting Times** For Community Mental Health services where a waiting list exists then the provider will report these to the commissioner.	Monthly	In accordance with national reporting definitions detailed in SQPR Waiting times will cover all GP referred patients and covers the waiting time from referral to first treatment.	As applicable to the Commissioner request. For reports submitted via e-mail, to be cc'd to the relevant coordinating Commissioner contracts lead. Monthly SQPR	MH	Local NEL CSU Hosted Reporting Requirements
LRRL 08.	**Outcome Measures:** The Provider will provide information to support the development and monitoring of outcome measures and related reports. These include CROMS (Clinician Rated Outcome Measures) HoNOS data based on the 4 Factor model, PROMS (Patient Rated Outcome Measures) and where no other PROM is used by a provider SWEMWBS.	As relevant to outcome measure	As agreed between the Provider and the Commissioner through TSG.	As agreed between the Provider and the Commissioner through TSG.	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL 09.	**Psychiatric Liaison Service: Core 24** Where arrangements are in place or are being developed to support PLS, data should be reported in line with local agreement	Monthly	Part of monthly local dataset submission.	15 operational days after the month end. For the coordinating commissioner the report should be e-mailed via NHS mail to **NELCSU.DSC-MH@nhs.net**	MH	Local NEL CSU Hosted Reporting Requirements
LRRL 10.	**New Models of Care** The Provider will work with the Commissioners on the provision of data to support new models of care (e.g. Integrated Care). This data may be used to support the development or implementation of CCG QIPP, Better Care Fund, mental health clusters or Outcome Based Commissioning Schemes.	As relevant to specific request	As relevant to specific request.	As relevant to specific request	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL 11.	**NEL Claims Management Policy;** Validation of Patient Level Data commissioners have appointed NEL to undertake validation of the recording and charging of patient data which forms the basis the Trust's reconciliation account in line with Service Conditions 36.29 and 36.30 and the obligations of Providers within this process are contained in the attached document	Monthly	**NEL Claims Management Policy** NEL CMP RS 20191302.pdf	The service provider will adhere to the TIMETABLE in the Supporting Information Document Appendix 1. The schedule is mandatory, variation is not permitted. Please note that data may also need to be submitted to a HSCIC secure SFTP site, commencing in-year – to be advised. NELCSU is encouraging all providers to submit data via the NELCSU submission porta	All	Local NEL CSU Hosted Reporting Requirements
Quality						
LRRL QR 01.	**Quality Accounts:** The Provider should submit to the Commissioners an annual quality account that reflects national guidance. The provider will develop and work within in-year timescales for review by Commissioners, adding additional information as required by Commissioners.	Annual	Draft report, so that commissioners can comment on next year's priorities and this year's progress	No later than 30 days prior to publication. For Luton CCG send to lccgquality@nhs.net for Bedford CCG send to bccg.contracts@nhs.net	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 02.	**Dashboard of Quality Metrics for Organisational Health:** Data required for the Dashboard of Quality Metrics for Organisational Health will be made available by the Provider if not reported elsewhere. The requirements are currently as below: I. Patient Complaints II. Patient Experience III. Patient Safety Incidents IV. Never Events **V.** Nurse Staffing Ratio per Bed	As per Dashboard of Quality Metrics for Organisational Health requirements	As per Dashboard of Quality Metrics for Organisational Health requirements and as set out in the 2016-17 Safeguarding Quality Specifications (CYP and Adults). K. Safeguarding Policies and Mental Capacity Act Policies i) Number of complaints to be reported through SQPR. ii) Quarterly thematic report to be included in the Quarterly Quality Report (as set out in QR12 of the Quality Schedule).	SQPR and Quarterly Quality Report. For Luton CCG send to lccgquality@nhs.net for Bedford CCG send to **bccg.contracts@nhs.net**	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 03.	**PALS data: To include:** • Number of patient contacts • Type of patient contact • Location • Specialty • Response times • Actions	Quarterly	As provided by the Provider (Provider performance report/SLA)	SQPR and Quarterly Quality Report. For Luton CCG send to lccgquality@nhs.net for Bedford CCG send to **bccg.contracts@nhs.net**	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 04.	**Mixed Sex Accommodation:** Report on performance against mixed sex accommodation and on any breaches: 2.1 Breach location (e.g.: ward) is required 2.2 Any deviation from zero tolerance will require a plan/trajectory to reduce breaches – to be shared with Commissioners	Monthly	As set out in the 2016-17 EMSA Quality Specification. SCHEDULE 2 – THE SERVICES G. Other Local Agreements, Policies and Procedures	SQPR and Quarterly Quality Report. For Luton CCG send to lccgquality@nhs.net for Bedford CCG send to **bccg.contracts@nhs.net**	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 05.	**Serious Incidents:** The Provider will report data on Serious Incidents (SI) on STEIS where they meet the SI threshold (as defined by national guidance) and where the SI affected patients, the Provider will report data to the National Reporting & Learning System (NRLS) and will provide evidence, to Commissioners, of having submitted such reports. Quarterly reports of all SIs will be provided for review at the Quality Monitoring Meeting (QMM) – this will include review of all new and currently open cases. It will also include review of overdue SIs and incidents for which a final report has been submitted to Commissioners but before agreeing closure Commissioners have requested further information. The QMM will review trend analysis of SI categories and trends in contributory factors and root causes. The Quarterly SI Meeting will also review the implementation of actions identified through root cause analysis of SIs, with a particular focus on Never Events.	As per requirement	As set out in the 2019-20 Serious Incidents Quality Specification SCHEDULE 6 – Contract Management, Reporting and Information Requirements. C. Incidents Requiring Reporting Procedure. Monthly status reports must be submitted to the Commissioner via the Service Quality Performance Report (SQPR).	SI numbers to be reported monthly through the Service Quality Performance Report. Where Commissioners have requested further information, a full and complete report to be provided within 10 working days following such request, to be e-mailed to: SILutonCCG@nhs.net	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 06.	**Never Events:** The Provider must report all Never Events in accordance with DH guidance and demonstrate learning from Never Event SIs so that assurance is provided on systems put in place to prevent re-occurrence - Delays in the handover process from East of England Ambulance Service to A&E staff of 1 hour or more must be agreed with the Provider, and the Commissioners informed of the SI - The Commissioners may request additional information relating to these incidents as necessary – following which the Provider should supply a full and complete response within 10 working days.	As per requirement	As set out in the 2019-20 Serious Incidents Quality Specification SCHEDULE 6 – Contract Management, Reporting and Information Requirements. C. Incidents Requiring Reporting Procedure. Monthly status reports must be submitted to the Commissioner via the Service Quality Performance Report (SQPR).	SI numbers to be reported monthly through the Service Quality Performance Report. Where Commissioners have requested further information, a full and complete report to be provided within 10 working days following such request, to be e-mailed to: SILutonCCG@nhs.net	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 07.	**Avoidable Harm:** The Provider will provide a quarterly report on avoidable harm (pressure ulcers, VTE, catheter associated urinary infections and falls) and plans to reduce occurrence for review at Quarterly Monitoring Meeting (QMM)	Quarterly	Reported as part of the Quarterly Quality Meeting	Timing as agreed between the Parties but to fit with Quarterly Quality Meeting dates :	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 08.	**Locally/Nationally identified Quality risks:** Concerns and risks which may impact on the quality or safety of care identified by the Provider should be shared with the Commissioners within 1 working day and/or discussed at the Quarterly Quality Monitoring Meeting. Any concerns or risks that could have an adverse reputational effect on the provider or commissioner and deemed to be of public interest.	Within the timescales as agreed between the Parties	1. Notification via email 2. Notification to be followed up through reference in the quarterly Quality Report and/or discussion at quarterly Quality Monitoring Meeting. 3.Mitigation within 72hours	1. Within 1 working day 2. Quarterly Quality Report	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 09.	**CQC Contact:** The Provider must report to the Commissioners, within 1 working day Within CQC report time frames, any CQC mortality alerts or CQC visits, and share any initial CQC feedback provided along with final full CQC inspection reports and the Provider's response in light of recommendations made.	Within 1 working day Within CQC report time frames of any notification of any alert and or visit	Email to Commissioner	Within 1 working day	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 10.	**Quality Assurance Visits:** The Provider participates in a programme for quality assurance visits. 6 months following each visit made, the Provider will be required to provide a progress report on actions taken against the visit outcome report recommendations. Action plan updates to be reported to the Commissioners through the QMM reporting process.	Following a quality assurance visit and as agreed between the Parties	A copy of visit outcomes and progress report	Timing as agreed between the Parties but to fit with Quality Monitoring Meetings dates	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 11.	**Schedule 5 (of the Act) report (prev. Rule 43 Coroner's Rulings):** The Provider must alert the Commissioners about all rulings and their action plans in light of all recommendations made. Action plan updates to be reported through QMM.	Rulings - as and when necessary. Action plan updates - Monthly	Rulings - as agreed between the Parties Action plan updates – as agreed between the Parties	Rulings - as soon as possible after the ruling has occurred. Action plan updates – to be sent monthly in advance of the Quality Monitoring Meetings.	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 12.	**Safeguarding (children and adults):** The provider will complete the safeguarding reporting requirements as set out in the Safeguarding (CYP and Adult) Specifications. Quarterly submissions to be made via the Quarterly Quality Monitoring Meeting process.	Monthly	As per the agreed Adult and Child Safeguarding Dashboards.	Timing as agreed between the Parties but to fit with the quarterly Quality Monitoring Meetings.	MH	Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 13.	National Institute for Clinical Evidence (NICE) Guidance: The Provider must ensure that they take note of all NICE guidance that is relevant to their services and show evidence, to the Co-ordinating Commissioner: i. that they have complied with responding to NICE technology appraisals ii. Undertake a gap analysis between all relevant guidance and full compliance (including technical appraisals, NICE guidance, NICE standards and indicators) iii. That the services have developed action plans in response to recommendations and iv. also show evidence of action taken	i. Quarterly ii. As and when necessary iii. As and when necessary	As agreed between the Parties	Timing and delivery as agreed between the Parties but to fit with Quality Monitoring Meetings. In quarterly Quality Report.	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 14.	**National Central Alerts System (CAS):** Compliance with the National Central Alerts System (CAS)	Quarterly	In quarterly Quality Report.	Quarterly Quality Report.		Local NEL CSU Hosted Reporting Requirements

Reference	Report Name	Reporting Period	Format of Report	Timing and Delivery of Report	Application	Source
LRRL QR 15.	**Quality (Report) Equality and Diversity: To cover the following areas:** 1. Public sector equality duty 2. Workforce race equality indicators 3. Translator and interpreter provision 4. Meeting Religious and Cultural Needs of Service Users 5. Equality analysis (audit) 6. Learning disabilities	Annually	In quarterly Quality Report.	As follows: 1) Quarter 3 (31 days after month end) 2) Quarter 3 3) Quarter 4 4) Quarter 4 5) Trust to allow access Oct-Dec 2016 6)Trust to submit report at end Q4 (30 days after quarter end)	MH	Local NEL CSU Hosted Reporting Requirements
LRRL QR 16.	**Clinical Audits:** i) Annual Clinical Audit plan ii) Clinical audit findings and action plans to address non-conformities	i) Annual ii) Quarterly	i) The provider will submit an annual audit plan and present this at quarterly Quality Monitoring meetings. ii) Clinical audit update shows learning from national and local audits, including drivers for audits and is informed by SIs, incidents and complaints. Forms part of quarterly quality report	i) in Quarter 1. ii) In the quarterly Quality Report.	MH	Local NEL CSU Hosted Reporting Requirements

Appendix 1: SUS, Non-SUS and Claims Management Timetable

SCHEDULE 6 – CONTRACT MANAGEMENT, REPORTING AND INFORMATION REQUIREMENTS

A. Reporting Requirements

						Commissioner C Letter Period		Provider Response Period		Commissioner D Letter Period					
Period No	Period	A	B	B2	C	D	D2	E	E2	F	F2	G	H	H2	I
		NTPS Reconciliation Inclusion Date Provider Submits SUS Reconciliation Data to NHS Digital	Provider Submits Non-SUS Reconciliation Data to Commissioners	WD A-B	NTPS Reconciliation Publication Date SUS Reconciliation Data Available to Commissioners	Commissioners Submits Claims to Provider	WD C-D	Provider Response to Initial Claims	WD D-E	Commissioners Submits Updates to Claims Based on Provider Responses	WD E-F	NTPS Post-Reconciliation Inclusion Date Provider submits SUS Post-Reconciliation Data to NHS Digital	Provider submits Non-SUS Post-Reconciliation Data to Commissioners	WD G-H	NTPS Post-Reconciliation Publication Date SUS Post-Reconciliation Data Available to Commissioners
M01	**Apr 2019**	Mon 20 May 2019	Wed 22 May 2019	2	Fri 24 May 2019	Tue 04 Jun 2019	6	Fri 14 Jun 2019	8	Mon 24 Jun 2019	6	Wed 19 Jun 2019	Fri 21 Jun 2019	2	Tue 25 Jun 2019
M02	**May 2019**	Wed 19 Jun 2019	Fri 21 Jun 2019	2	Tue 25 Jun 2019	Wed 03 Jul 2019	6	Mon 15 Jul 2019	8	Tue 23 Jul 2019	6	Wed 17 Jul 2019	Fri 19 Jul 2019	2	Tue 23 Jul 2019
M03	**Jun 2019**	Wed 17 Jul 2019	Fri 19 Jul 2019	2	Tue 23 Jul 2019	Wed 31 Jul 2019	6	Mon 12 Aug 2019	8	Tue 20 Aug 2019	6	Mon 19 Aug 2019	Wed 21 Aug 2019	2	Fri 23 Aug 2019
M04	**Jul 2019**	Mon 19 Aug 2019	Wed 21 Aug 2019	2	Fri 23 Aug 2019	Tue 03 Sep 2019	6	Fri 13 Sep 2019	8	Mon 23 Sep 2019	6	Wed 18 Sep 2019	Fri 20 Sep 2019	2	Tue 24 Sep 2019
M05	**Aug 2019**	Wed 18 Sep 2019	Fri 20 Sep 2019	2	Tue 24 Sep 2019	Wed 02 Oct 2019	6	Mon 14 Oct 2019	8	Tue 22 Oct 2019	6	Thu 17 Oct 2019	Mon 21 Oct 2019	2	Wed 23 Oct 2019
M06	**Sep 2019**	Thu 17 Oct 2019	Mon 21 Oct 2019	2	Wed 23 Oct 2019	Thu 31 Oct 2019	6	Tue 12 Nov 2019	8	Wed 20 Nov 2019	6	Tue 19 Nov 2019	Thu 21 Nov 2019	2	Mon 25 Nov 2019
M07	**Oct 2019**	Tue 19 Nov 2019	Thu 21 Nov 2019	2	Mon 25 Nov 2019	Tue 03 Dec 2019	6	Fri 13 Dec 2019	8	Mon 23 Dec 2019	6	Tue 17 Dec 2019	Thu 19 Dec 2019	2	Mon 23 Dec 2019
M08	**Nov 2019**	Tue 17 Dec 2019	Thu 19 Dec 2019	2	Mon 23 Dec 2019	Fri 03 Jan 2020	6	Wed 15 Jan 2020	8	Thu 23 Jan 2020	6	Mon 20 Jan 2020	Wed 22 Jan 2020	2	Fri 24 Jan 2020
M09	**Dec 2019**	Mon 20 Jan 2020	Wed 22 Jan 2020	2	Fri 24 Jan 2020	Mon 03 Feb 2020	6	Thu 13 Feb 2020	8	Fri 21 Feb 2020	6	Wed 19 Feb 2020	Fri 21 Feb 2020	2	Tue 25 Feb 2020
M10	**Jan 2020**	Wed 19 Feb 2020	Fri 21 Feb 2020	2	Tue 25 Feb 2020	Wed 04 Mar 2020	6	Mon 16 Mar 2020	8	Tue 24 Mar 2020	6	Wed 18 Mar 2020	Fri 20 Mar 2020	2	Tue 24 Mar 2020
M11	**Feb 2020**	Wed 18 Mar 2020	Fri 20 Mar 2020	2	Tue 24 Mar 2020	Wed 01 Apr 2020	6	Wed 15 Apr 2020	8	Thu 23 Apr 2020	6	Tue 21 Apr 2020	Thu 23 Apr 2020	2	Mon 27 Apr 2020
M12	**Mar 2020**	Tue 21 Apr 2020	Thu 23 Apr 2020	2	Mon 27 Apr 2020	Wed 06 May 2020	6	Mon 18 May 2020	8	Tue 26 May 2020	6	Wed 20 May 2020	Fri 22 May 2020	2	Wed 27 May 2020

Column	Action By	Additional Information
A	Provider	**NTPS Reconciliation Inclusion Date:** The date by which all submissions for the Contract Period covered by this Reconciliation Date must be submitted by the Provider and received to the NHS Digital SUS for inclusion in the SUS NTPS Managed Service Extract, this must be received by NHS Digital SUS before 5pm on this date.
B	Provider	**Provider Submits Non-SUS Reconciliation Data to Commissioners:** The date by which all submissions for the Contract Period covered by this Reconciliation Date must be submitted by the Provider and received to Commissioners for inclusion in Contract Monitoring Process. This must include all datasets including where applicable Aggregate Level, Patient Level and Supplementary datasets as outlined within the Contract for Financial Monitoring purposes.
B2	*None*	*Calculated Field of number of working days between Column A and Column B*
C	Other	**NTPS Reconciliation Publication Date:** The date by which all Provider data submitted to SUS inline with the NTPS Reconciliation Inclusion Date (Column A) will be made available to Commissioners from NHS Digital SUS for the purpose of Contract Monitoring and Claims Management purposes.
D	Commissioner	**Commissioner Submits Claims to Provider:** The date by which NEL Commissioning Support Unit will formally submit any data claims, challenges or queries with the Provider for resolution. *This period is commonly known or referred to as the 'Initial Claims Period' or the 'NEL Commissioning Support Unit C Letter Period'.*
D2	*None*	*Calculated Field of number of working days between Column C and Column D*
E	Provider	**Provider Response to Initial Claims:** The date by which the Provider will formally submit it's response to any data claims, challenges or queries raised with the Provider to attempt to resolve the issues raised. *This period is commonly known or referred to as the 'Provider Response Period'.*
E2	*None*	*Calculated Field of number of working days between Column D and Column E*
F	Commissioner	**Commissioner Submits Updates to Claims Based on Provider Responses:** The date by which NEL Commissioning Support Unit will formally respond to Providers in respect of the responses provided to the challenges. *This period is commonly known or referred to as the 'Commissioner Re-Response Period' or the 'NEL Commissioning Support Unit D Letter Period'.*
F2	*None*	*Calculated Field of number of working days between Column E and Column F*
G	Provider	**NTPS Post-Reconciliation Inclusion Date:** The date by which all submissions for the Contract Period covered by this Post-Reconciliation Date must be submitted by the Provider and received to the NHS Digital SUS for inclusion in the SUS NTPS Managed Service Extract, this must be received by NHS Digital SUS before 5pm on this date.
H	Provider	**Provider Submits Non-SUS Post-Reconciliation Data to Commissioners:** The date by which all submissions for the Contract Period covered by this Post-Reconciliation Date must be submitted by the Provider and received to Commissioners for inclusion in Contract Monitoring Process. This must include all datasets including where applicable Aggregate Level, Patient Level and Supplementary datasets as outlined within the Contract for Financial Monitoring purposes.
H2	*None*	*Calculated Field of number of working days between Column G and Column H*
I	Other	**NTPS Post-Reconciliation Publication Date:** The date by which all Provider data submitted to SUS inline with the NTPS Post-Reconciliation Inclusion Date (Column G) will be made available to Commissioners from NHS Digital SUS for the purpose of Contract Monitoring and Reconciliation purposes.

Columns D, E and F will be subject to change where a Provider does not submit data for either SUS or Non-SUS datasets in line with the dates identified in Columns A, B, G and H

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
National Requirement				
Data Quality Maturity Index: in accordance with SC28.2.7				Clause SC28: Information Requirements
Local Requirement				
DQ 1 – Delivery of a Local Dataset Submission The Trust will implement the new Data Specification as per Schedule 6A Reporting Requirements	Data to be provided in the newly agreed format as per Schedule 6A Reporting Requirements	Monthly data submissions in accordance with the format in the Information Schedule. Monitored and Reviewed at TSG and escalated, as necessary to SPR.	April 2019 data to be reported in new format	Clause SC28: Information Requirements
DQ 2 - Measuring improvement in clinical outcomes, Psychiatric Liaison Service (PLS)	Trust and commissioners to review existing metrics and work towards a short list, which enables effective monitoring of the PLS efficiency and assures an understanding of the true impact on whole system cost savings. Proposed end product is a suite of reporting split into: · A monthly dashboard which will illustrate the activity and performance measures, submitted through monthly performance report. · A quarterly qualitative report, including experience and outcome measures, submitted to the **Quarterly Quality Meeting (QQM).**	Narrative via Quality Meetings.	In line with Core 24 Implementation as per PLS KPI list.	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
	Milestones outlined as follows: DQ 2.1) PLS clinical leads will work with the CSU/CCG to develop a proposed set of thresholds for the agreed metrics. This will be based on current activity and be supported by evidence and sign off by the CCG. DQ 2.2) Consider revising existing metrics and/or including additional metrics so as to ensure reporting requirements to reflect whole system financial impact of PLS. DQ 2.3) Agree set of qualitative measures to meet the reporting requirements for the **Quarterly QRM Reports** so as to report second quarter activity.			
DQ11 - CAMHS	CAMHS Reporting by end of Q2: ELFT RiO System and ELFT Outcomes system are being developed so that outcomes data will be collected in the data warehouse, which will enable outcomes to be reported to commissioners on a regular basis as specified. This work with the third party outcomes contractor has taken much longer than required.	Progress will be monitored through the Technical Subgroup	by end of Q2	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
NHS No	99%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Default values will not be included as valid codes	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Postcode	99%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Commissioner Code	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
Date of Birth	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Start Date	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Default values will not be included as valid codes	1st Reconciliation on 19/20	Clause SC28: Information Requirements
End Date	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Default values will not be included as valid codes	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Ethnicity Code	95%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields.	1st Reconciliation on 19/20	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
		Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well		
General Practice Code	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Local Patient ID	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Activity Actual	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields.	1st Reconciliation on 19/20	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
		Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well		
Data Included in Local Backing Dataset	100%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields. Valid Default values that incorporate the NHS Digital VODIM rules will be included valid codes. The % of these codes will be monitored as well	1st Reconciliation on 19/20	Clause SC28: Information Requirements
Planned Review Date	95%	Monthly from local datasets provided Percentage of total records with valid entries for selected fields.	Tiered trajectory of achievement. Future dates still to be embedded as a process.	Clause SC28: Information Requirements
Crisis Plans	95%	Everyone on CPA to have an agreed Crisis Plan in Place	50% by December 2019. 75% by Feb 2020, 95% by end March 2020	Clause SC28: Information Requirements
Perinatal Mental Health		Develop System wide dashboard for Perinatal Mental Health	Q1 2019/20	Clause SC28: Information Requirements
Mental Health Street Triage		Develop System wide dashboard for Mental Health Street Triage	Q1 2019/20	Clause SC28: Information Requirements

B. Data Quality Improvement Plans

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
Individual Placement Service		Develop System wide dashboard for IPS	Q1 2019/20	Clause SC28: Information Requirements