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

Contents

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	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 Placed 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

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

NHS

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%.

Example	Thresholds		Performance	Calculation	Payment
	Min	Max			
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%

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

NHS

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

NHS

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

NHS

CCG1: Antimicrobial Resistance

CCG2: Staff Flu Vaccinations   13

CCG3: Alcohol and Tobacco

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

NHS

Services in scope
Acute

Payment levels
Minimum: 60%

Maximum: 90%

Scope: | Q1 | Q2 | Q3 | Q4 |

Accessing support
Policy Lead

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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

NHS

Services in scope
Acute who perform elective colorectal surgery

Payment levels
Minimum: 60%

Maximum: 90%

Scope: | Q1 | Q2 | Q3 | Q4 |

Accessing support
Policy Lead

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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

NHS

Services in scope
Acute, Community, Mental Health, Ambulance

Payment levels
Minimum: 60%

Maximum: 80%

Scope: | Q1 | Q2 | Q3 | Q4 |

Accessing support
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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

NHS

Services in scope
Acute, Community, Mental Health

Payment levels
Minimum: 40%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support
Policy Lead

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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

NHS

Services in scope
Acute, Community, Mental Health

Payment levels
Minimum: 50%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support
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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

NHS

Services in scope
Acute, Community, Mental Health

Payment levels
Minimum: 50%

Maximum: 90%

Scope: Q1 Q2 Q3 Q4

Accessing support
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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

NHS

www.nhs.uk

CCG4: 72hr follow up post discharge

NHS

Services in scope
Mental Health

Payment levels
Minimum: 50%

Maximum: 80%

Scope: `Q1` `Q2` `Q3` `Q4`

Accessing support
Policy Lead

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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

NHS

Services in scope
Mental Health (MH trusts only)

Payment levels
Minimum: 90%

Maximum: 95%

Scope: Q1 Q2 Q3 Q4

Accessing support
Policy Lead
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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
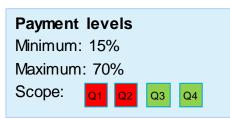
Data Items
The MHSDS Data items included in the DQMI are outlined in the Changes to the DQMI.

CCG5b: Mental Health Data Quality: Interventions

NHS

Services in scope
Mental Health (MH trusts only)

Payment levels
Minimum: 15%

Maximum: 70%

Scope: Q1 Q2 Q3 Q4

Accessing support
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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

NHS

Services in scope
IAPT Services

Payment levels
Minimum: 30%

Maximum: 65%

Scope: Q1 Q2 Q3 Q4

Accessing support
Policy Lead

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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

NHS

CCG7: Three high impact actions to prevent Hospital Falls

NHS

Services in scope
Acute, Community

Payment levels
Minimum: 25%

Maximum: 80%

Scope: Q1 Q2 Q3 Q4

Accessing support
Policy Lead

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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

NHS

Services in scope
Community

Payment levels
Minimum: 70%

Maximum: 85%

Scope: | Q1 | Q2 | Q3 | Q4 |

Accessing support
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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

NHS

CCG9: Six Month Reviews for Stroke Survivors

NHS

Services in scope
Community with stroke rehabilitation

Payment levels
Minimum: 35%

Maximum: 55%

Scope: | Q1 | Q2 | Q3 | Q4 |

Accessing support
Policy Lead

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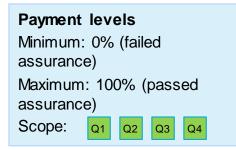
Exclusions
- Died whilst on the stroke care pathway (SSNAP database variable M2.4).
- 6 month reviews that took place before 4 months or after 8 months of the stroke.

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

NHS

Services in scope
Ambulance

Payment levels
Minimum: 0% (failed assurance)

Maximum: 100% (passed assurance)

Scope: Q1 Q2 Q3 Q4

Accessing support
Policy Lead

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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)

NHS

Services in scope
Ambulance

Payment levels
Minimum: 0%

Maximum: 5%

Scope: [Q1] [Q2] [Q3] [Q4]

Accessing support
Policy Lead

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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

NHS

Services in scope

Acute with Type 1 Emergency Department

Payment levels

Minimum: 50%

Maximum: 75%

Scope: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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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: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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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: Q1 Q2 Q3 Q4

Accessing support

Policy Lead

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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.