Taunton and Somerset NHS Foundation Trust CQUINS 2015/16

CQUIN Table 1: Summary of Goals

	Goal Name	Description of Goal	Goal weighting (% of CQUIN scheme available)	Expected financial value of Goal (£000)	Quality Domain (Safety, Effectiveness Patient Experience or Innovation)
1	Acute Kidney Injury	To focus on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items	0,25%		
2	Sepsis	This CQUIN is focussed on incentivising the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies. It is important to note is not aimed at incentivising sepsis screening for all emergency patients, as there are clinical reasons why screening is unnecessary or misleading in some patient groups.	0.25%		
3	Dementia & Delirium	To support the identification of patients with dementia and delirium, alone and in combination alongside other medical conditions. It aims to prompt appropriate referral, follow up, and effective communication between providers and general practice, through the introduction of a care plan on discharge; after the patient is discharged from hospital or community services following an episode of emergency unplanned care.	0.25%		Safety/ Patient Experience
4	To decrease the proportion of avoidable emergency admissions to hospital (UEC).	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital	0.60%		Effectiveness
5	Reduction in harm	Reduction in prevalence of pressure ulcers	0.25%		Safety
6	Seamless Care for Older people	To deliver seamless care for frail older people, with an increased focus on targeted prevention, supporting people to remain independent and in preventing social isolation.	0.6%		Safety/ Patient Experience/ effectiveness
7	Transition arrangements children to adult services	Informing and developing a generic approach to the transition of children and young people (CYP) to adult services	0.3%		Safety/ Patient Experience/ effectiveness
		Totals:	**2.50%**		

CQUIN Table 2: Summary of Indicators

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
1	1	Acute Kidney Injury	0,25%	
2	2	Sepsis Screening	0.125	
		Sepsis Antibiotic Administration	0.125	
3	3.1	Dementia and Delirium: Find, Assess, Investigate and Refer	(60% of 0.25)	
	3.2	Dementia and Delirium: Staff training	(10% of 0.25)	
	3.3	Dementia and Delirium: Carer support	(30% of 0.25)	
4	4a	Reducing the proportion of avoidable emergency admissions to hospital.	0.50%	
	4b	Improving diagnosis rates of patients with mental health needs at A&E	0.10	
5	5	Pressure Ulcer Prevention: Reduction in Prevalence	0.25%	
6	6	Frailty (See milestones)	O.6%	
		Totals:	**2.5%**	

ACUTE KIDNEY INJURY (AKI) IMPROVEMENT GOAL SPECIFICATION	
Indicator number	1
Indicator name	Acute Kidney Injury
Indicator weighting	To be agreed locally (minimum 0.25%)
Description of indicator	This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge, measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below. This CQUIN is relevant to acute hospital providers who accept emergency admissions; whilst AKI is also a clinical concern in specialist hospital providers, the volume of cases will not provide a sufficient sample size for this CQUIN.
Numerator	The numerator is the count of completed key items found in the discharge summaries of patients with AKI detected through the pathology laboratory information management system (LIMS), and who have survived to discharge, using calendar month of discharge for each monthly sample. Where 25 or fewer patient records meet these criteria, all the relevant records should be reviewed. If more than 25 patient records meet these criteria, a random sample [see Note A] of 25 sets of patient records should be reviewed. Requirements in discharge summary are: 1. Stage of AKI (a key aspect of AKI diagnosis); 2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment); 3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care); 4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care). Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.
Denominator	Where 25 or fewer patient records have AKI detected through the pathology laboratory information management system (LIMS), and who have survived to discharge in each monthly sample, the denominator is N x 4 (where N equals all patient records meeting that criteria) i.e. review of four items in each of N discharge summaries. If more than 25 patient records meet these criteria, a random sample [see Note A] of 25 sets of patient records should be reviewed., and the denominator will equal 100 i.e. review of four items in each of 25 discharge summaries.
Rationale for inclusion	The AKI Programme is addressing all parts of the patient pathway. This CQUIN focusses on the recovery and follow up elements of the pathway which are both important elements given over 50% of AKI is currently occurring in primary care.

	Improving the provision of information to GPs at the time of discharge will start to develop the knowledge base of GPs on AKI and will also positively impact on readmission rates for patients with AKI. Availability of the information required on discharge for compliance with the CQUIN will be dependent on the patients having received appropriate diagnosis and medication review during their admission. It is recognised that early treatment and effective risk assessment are also important in managing patients with AKI in secondary care but clinical resources regarding best practice are not yet available to support clinicians. These are currently being developed as part of the AKI programme.
Data source	Provider audit discharge summaries from patients identified by the laboratory as having AKI on current admission (using the national algorithm as defined in NHS England Patient Safety Alert 'Standardising the early detection of AKI' http://www.england.nhs.uk/2014/06/09/psa-aki/) and who have survived to discharge. Data source = discharge summary for episode of care. Audit to be undertaken by clinical staff. 100 elements to be reviewed each month; four for each of the 25 patient records (or 4 items for each relevant patient record where the total of relevant patient records is less than 25). A BAAS application has been made to request approval for quarterly totals to be submitted via UNIFY.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly. The quarterly score is produced by averaging the three monthly scores i.e. sum the numerator data across the 3 months and then divide by the sum of the denominator data for the 3 months of the quarter.
Baseline period/date	Q1
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Q4
Final indicator value (payment threshold)	See below

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See below Evidence: Summary of monthly discharge summary audit.
Final indicator reporting date	20 days after the end of Q4
Are there rules for any agreed in-year milestones that result in payment?	See below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes; see below Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.

	Rules for in year payment and partial payment	
Quarter 1	10% of whole-year AKI CQUIN value awarded if the audit is established and results that can serve as a baseline for improvement	
Quarter 2	20% of whole-year AKI CQUIN value awarded if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1	
Quarter 3	20% of whole-year AKI CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.	
Quarter 4	Maximum of 50% of whole-year AKI CQUIN value available based on the following thresholds:	
	49.9% or less of required key items included in discharge summaries	*No payment*
	50.0% to 69.9% of of required key items included in discharge summaries	*10% of whole-year AKI CQUIN value*
	70.0% to 79.9% of required key items included in discharge summaries	*20% of whole-year AKI CQUIN value*
	80.0% to 89.9% of required key items	*35% of whole-year AKI CQUIN value*

	included in discharge summaries	
	90.0% or above of required key items included in discharge summaries	*50% of whole-year AKI CQUIN value*

Local data collection advice

See the specification above for data source and numbers required in each monthly audit.

Note A: method for identifying random samples

Trusts should select ONE of the following methods and maintain this method throughout the 2015/16 year of data collection:

1. True randomisation: review the nth patient's notes where n is generated by a random number generator or table (e.g. http://www.random.org/) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. http://www.random.org/.
2. Pseudo-randomisation: Review the first X patients' notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

Suggested format for local data collection				
	Tick column below if **stage of AKI** is recorded in discharge letter	Tick column below if information on **medicines review** having been undertaken is recorded in discharge letter	Tick column below if **type of blood tests** required on discharge for monitoring are recorded in discharge letter	Tick column below if **frequency of blood tests** required on discharge for monitoring are recorded in discharge letter
1.				
2.				
3.				
4.				
5.				
Etc.				
Totals	**Column A total**	**Column B total**	**Column C total**	**Column D total**
CQUIN calculation Column A+ B + C +D totals = numerator total Number of records reviewed x 4 = denominator total Percentage) CQUIN achievement = numerator ÷ denominator x 100				

Additional guidance notes for data collection

Additional guidance Column A (Stage of AKI)

The discharge summary should include a statement that provides:

AKI stage (1, 2 or 3) as defined by the national definition (see http://www.england.nhs.uk/2014/06/09/psa-aki/)

E.g. AKI Stage 3 - The highest recorded stage during an inpatient episode should be recorded.

Additional guidance Column B (Medication review)
For all medications that have been discontinued during an episode of AKI there should be clear documentation as to whether the medication/s was stopped due to AKI and also whether it can be restarted. E.g. *"RAMIPRIL 10 mg discontinued due to AKI. Can be restarted after clinical review" OR "OMEPRAZOLE 20 mg discontinued due to AKI. Not to be restarted (see summary)".*

Any form of wording is acceptable IF it gives a clear indication when and how the medication can be resumed OR explicitly points to a situation where the drug has directly caused renal inflammation and therefore should never be restarted. Simply stating that a medication has been discontinued without a reason or without a statement about potential restarting (e.g. *"SPIRONLACTONE 50 mg discontinued"*) would not allow a point in Column B.

If multiple medications are discontinued, please not a point would only be given in Column B if information on whether or not to restart medication was provided for ALL discontinued medications.

If no medications have been discontinued, only wording that makes it clear that medication review has taken place would be needed for a point.

Additional guidance Column C (Type of blood tests) and Column D (Frequency of blood tests)
For column C there should be a clear statement detailing the type of blood tests to be requested and for Column D a clear statement of when they should be requested. This may be contained within the clinical summary text. It should also be clear who is to perform the request.

For example, points would be awarded for: *"U&Es and FBC should be rechecked on [date] and weekly thereafter until review in the Nephrology clinic in 4 weeks. We would be grateful it the GP practice could arrange the tests and contact us on xxxxx-788249 if there are concerns."* OR *"Biochemistry checks will be organised 1 week prior to the OPA 24/1/2015 by the hospital. The patient has the necessary forms."*
No points would be awarded for C if phrasing is only a non-specific *"Please check bloods"*

No points would be awarded in Column D if no clear statement is given on timing of blood tests.

Data submission

A BAAS application has been made to request approval for quarterly totals to be submitted via UNIFY.

To minimise burden, the data submission proposed is a simple percentage total each quarter - see the improvement specification above for advice on calculating quarterly average from monthly audits of discharge summaries.

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2a
Indicator name	Sepsis Screening
Indicator weighting	To be agreed locally (2a and 2b minimum 0.25%)
Description of indicator	This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. This CQUIN is focussed on incentivising the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies. It is important to note 2a is not aimed at incentivising sepsis screening for all emergency patients, as there are clinical reasons why screening is unnecessary or misleading in some patient groups. This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.
Numerator	The CQUIN requires an established local protocol that defines which emergency patients require sepsis screening. Detail on key content of the protocol is outlined below [Note A], but local adaptation will be needed to reflect the types of Early Warning Score in local use for children and adults. The numerator for 2a (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis. Screening for sepsis must be carried out using an appropriate tool [Note B].
Denominator	The denominator for (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies and who require screening for sepsis according to the agreed local protocol.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.
Data source	Provider audit of a random sample [see Note C] of 50 sets of patient records per month. The following rules should be used: 1. Discard from sample all patients who do NOT require sepsis

	screening according to locally agreed protocol [see Note A]. Number now remaining in sample becomes denominator. 2. Of the remaining patients who required sepsis screening, record the proportion who were screened for sepsis as part of the admission process = counts towards numerator total. 3. All other cases = does not count towards numerator total. Data source = sample drawn from all patient records where the patient presented at emergency departments and other units that directly admit emergencies and WAS NOT in 'minors' stream of ED using calendar month of date of admission/attendance. Audit undertaken by nursing staff but consultant advice sought if needed. A BAAS application has been made to request approval for the quarterly data totals to be submitted via UNIFY.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q1 for 2a (screening)
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	For rules of calculation see below. All quarterly figures to be a simple average of the three individual months' percentage completed. Evidence: Summary of that quarter's monthly audits.
Final indicator reporting date	20 days after the end of the quarter.
Are there rules for any agreed in-year milestones that result in	Yes, see below

payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see below Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.

2b Sepsis Antibiotic Administration

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2b
Indicator name	Sepsis Antibiotic Administration
Indicator weighting	To be agreed locally (2a and 2b minimum 0.25%)
Description of indicator	This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. 2b relies on administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies. This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.
Numerator	The numerator is the number of patients who present to emergency departments and other wards/units that directly admit emergencies with severe sepsis, Red Flag Sepsis or Septic Shock (as identified retrospectively via case note review of patients with clinical codes for sepsis) and who received intravenous antibiotics within 1 hour of presenting.
Denominator	The denominator is the total number of patients sampled for case note review who, in the view of the reviewer, had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock on presentation at emergency departments and other units that directly admit emergencies, or would have had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock if they had been assessed according to best practice (early warning score and sepsis screening) and therefore should have been administered i/v

	antibiotics within an hour of presentation.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.
Data source	Provider audit of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41). Where 30 or fewer patient records include these codes, all the relevant records should be reviewed. If more than 30 patient records include these codes, a random sample [see Note C] of 30 sets of patient records should be reviewed. This should be a separate audit to 2a. The following rules should be used: 1. Discard from sample: • If there is clear evidence severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the trust's care; • Or if there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile); • Or if an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies. Number now remaining in sample becomes denominator. 2. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of triage) = counts towards numerator total. 3. All other cases, including those where time of arrival and/or time of antibiotic administration is unclear = does not count towards numerator total. Data source = random sample [see Note C] drawn from all patient records where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) using calendar month of date of discharge or death. Audit undertaken by consultant staff.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q2

Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	For rules of calculation see below. All quarterly figures to be a simple average of the three individual months' percentage completed. Evidence: Summary of that quarter's monthly audits.
Final indicator reporting date	20 days after the end of the quarter.
Are there rules for any agreed in-year milestones that result in payment?	Yes, see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see below Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.

	Rules for in year payment and partial payment	
	2a (screening)	**2b (antibiotic administration)**
Quarter 1	10% of whole-year sepsis CQUIN value awarded if appropriate local sepsis protocol and screening tool are in use and baseline data collection established	N/A
Quarter 2	10% of whole-year sepsis CQUIN value awarded if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1	10% of whole-year sepsis CQUIN value awarded if baseline data collection established
Quarter 3	10% of whole-year sepsis CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination	20% of whole-year sepsis CQUIN value awarded if locally agreed Q3 target of improvement from baseline achieved. Q3 target must be set as soon as possible after Q2 ends using data from Q2
Quarter 4	Maximum of 20% of whole-year sepsis	Maximum 20% of whole-year sepsis

	CQUIN value available based on the following thresholds:		CQUIN value available based on the following thresholds:	
	49.9% or less of eligible patients screened	*No payment*	*49.9% or less of eligible patients received antibiotics*	*No payment*
	50.0% to 69.9% of eligible patients screened	*5% of whole-year sepsis CQUIN value*	*50.0% to 69.9% of eligible patients received antibiotics*	*5% of whole-year sepsis CQUIN value*
	70.0% to 79.9% of eligible patients screened	*10% of whole-year sepsis CQUIN value*	*70.0% to 79.9% of eligible patients received antibiotics*	*10% of whole-year sepsis CQUIN value*
	80.0% to 89.9% of eligible patients screened	*15% of whole-year sepsis CQUIN value*	*80.0% to 89.9% of eligible patients received antibiotics*	*15% of whole-year sepsis CQUIN value*
	90.0% or above of eligible patients screened	*20% of whole-year sepsis CQUIN value*	*90.0% or above of eligible patients received antibiotics*	*20% of whole-year sepsis CQUIN value*

Note A: key components of local protocol

Providers should be mindful of the College of Emergency Medicine endorsed tools at http://sepsistrust.org/info-for-professionals/clinical-toolkits/ or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at http://ccforum.com/content/supplementary/cc11895-s2.pdf

Likely components of local protocol on when sepsis screening should be undertaken would include:

- Screening for selected patients in 'majors' streams of emergency departments;
- Exclusion of trauma patients who are likely to have 'false positives' in sepsis screening;
- Making clear that sepsis screening should be triggered by thresholds in adult and paediatric early warning scores. For example, if NEWS is in use without any local adaptation, sepsis screening would be recommended for an aggregate score of 5 or more, or a 'red' score of 3 for any single parameter;
- Pragmatic exclusions, such as no need to screen if a sepsis diagnosis is immediately made without need to screen;
- Special circumstances when sepsis screening is inappropriate, such as with patients not for active treatment;
- Consideration of any vulnerable groups that may require special arrangements to ensure the possibility of sepsis is considered (e.g. children with disabilities).

Providers should be mindful of forthcoming sepsis clinical guidelines from NICE and amend their local protocol in light of interim or final guidance from NICE.

Note B: appropriate tools for sepsis screening

Tools used should be either the College of Emergency Medicine endorsed tools at http://sepsistrust.org/info-for-professionals/clinical-toolkits/ or equivalents that conform to the International Consensus Definitions modified by the Surviving Sepsis Campaign on recognition and diagnosis of sepsis available at http://ccforum.com/content/supplementary/cc11895-s2.pdf.

Providers should be mindful of forthcoming sepsis clinical guidelines from NICE and amend their local tool in light of interim or final guidance from NICE

Note C: method for identifying random samples

Trusts should select ONE of the following methods and maintain this method throughout the 2015/16 year of data collection:

1. True randomisation: review the nth patient's notes where n is generated by a random number generator or table (e.g. http://www.random.org/) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. http://www.random.org/.
2. Pseudo-randomisation: Review the first X patients' notes where the day within the date of birth is based on some sequence e.g. start with patients born on the 1st of the month, move to 2nd, then 3rd, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

Suggested format for local data collection
2a (sepsis screening)

	Tick column below if the patient DID NOT NEED sepsis screening according to local protocol	Tick column below if the patient NEEDED sepsis screening according to local protocol and RECEIVED sepsis screening	Tick column below if the patient NEEDED sepsis screening according to local protocol but DID NOT receive sepsis screening
1.			
2.			
3.			
4.			
5.			
Etc.			
Totals	**Column A total**	**Column B total**	**Column C total**

CQUIN calculation

Column A total is discarded from the sample and does not count towards numerator or denominator
Column B total is the numerator total
[Column B total + Column C total] = denominator total
Percentage Part 1 (sepsis screening) CQUIN achievement = (B ÷ [B+C]) x 100

2b (Antibiotic administration)

	Tick column below if antibiotics within an hour of admission were NOT indicated*	Tick column below if antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of	Tick column below for all other cases, including those where time of arrival and/or time of antibiotic administration is

		triage)	unclear
1.			
2.			
3.			
4.			
5.			
Etc.			
Totals	**Column A total:**	**Column B total:**	**Column C total:**

CQUIN calculation

Column A total is discarded from the sample and does not count towards numerator or denominator

Column B total is the numerator total

[Column B total + Column C total] = denominator total

Percentage Part 2 (antibiotic administration) CQUIN achievement = (B ÷ [B+C]) x 100

**** Antibiotics within one hour would NOT be indicated if:***

- *there is clear evidence severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the trust's care*
- *there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile)*
- *an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies*

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3a
Indicator name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): • 3a = 60% of total funding
Description of Indicator	3a: i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services (Find); ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed (Assess and Investigate) NOTE: Indicator 3a(iii) is only applicable to the providers who are responsible for the diagnosis and will produce the initial integrated care plan for the patient. Other providers who are not responsible for diagnosis and care plan generation should agree an exemption with their Commissioner who will subsequently record N/A in UNIFY; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP.(Refer /Infrom) Each patient's emergency, unplanned episode of care can be included only once in each indicator but not necessarily in the same month, as the identification, assessment and *care plan on discharge* stages may take place in different months. Each patient's emergency, unplanned episode of care is to be viewed from the patient's perspective. If a patient is admitted to provider A and transfers to provider B during their episode of care, the patient's length of stay must be determined from the time of admission to provider A. Emergency unplanned care is defined as an emergency admission to hospital or urgent referral to community services which provide an alternative to hospital admission (with a response time within 24 hours). For example, intermediate care, rapid response and step up care services/teams. Care may be provided in a variety of settings including the patients' usual place of residence.
Numerator	3a: i. Numbers of patients over 75 years old admitted or accepted for emergency unplanned care to hospital or community services, who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for

	whom the case finding question cannot be completed for clinical reasons (e.g. coma); ii. Numbers of above patients reported as having a diagnostic assessment including investigation; NOTE: Indicator 3a(iii) is only applicable to the providers who are responsible for the diagnosis and will produce the initial integrated care plan for the patient. Other providers who are not responsible for diagnosis and care plan generation should agree an exemption with their Commissioner who will subsequently record N/A in UNIFY; ** iii. Numbers of above patients who have a *plan of care on discharge* that is shared with general practice. The detail of the *plan of care* is to be locally determined but should include as a minimum: • A diagnosis and READ code; • Current cognitive function and recommendations for re – testing; • A plan to modify/ stop any anti psychotics or sedative drugs (within 3 weeks); • Recommendations for patients with delirium in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction • Recommendations for further assessment or onward referral in line with locally agreed care pathways; • A comprehensive communication plan to include all professionals/services involved; • Recommendations for liaison and communication if the usual place of residence is a care home or for carers; • Any further information to enable general practice to update plans of care for existing patients with a diagnosis of dementia; • Providers will be responsible for carrying out and demonstrating to their commissioner that they have completed a local audit. Providers must conduct audits that are of a sufficiently large number of the people identified, assessed and referred to satisfy their commissioner that a robust audit has been conducted. Providers should ensure that the sample size of the audit is sufficiently large to be robust. Particular care should be taken to ensure that the sample is a random selection of cases eligible to be audited. **
Denominator	3a: i. Numbers of patients over 75 years of age admitted or accepted for emergency unplanned care to hospital or community services, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinic reasons (e.g. coma); ii. Numbers of above patients with a clinical diagnosis of dementia and a new assessment is indicated or who have answered positively on the dementia case finding question; iii. Number of above patients who have an

	existing/known/already recorded diagnosis of dementia or underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data Source	UNIFY2 and local audits 3a (i & ii) Providers must collect and submit data on: • The total number of patients aged 75 and over, admitted or accepted for emergency unplanned care to hospital or community services and stayed more than 72 hours; • Of these, how many a) were asked the dementia case finding question; or b) had a clinical diagnosis of delirium using locally developed protocols in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction; or c) had a known diagnosis of dementia; • Of those with a clinical diagnosis of delirium or who answered positively on the dementia case finding question, how many underwent a diagnostic assessment. 3a (iii) Commissioners must collect and submit data on a provider audit of all the patients notes from each provider where the patient underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive The commissioner should report aggregated data including all providers on: • the number of patients who underwent a diagnostic assessment for dementia on whom the outcome was either positive or inconclusive (denominator); • the number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners who have a *care plan on discharge* which complies with the criteria set out in this guidance for existing patients and for newly diagnosed (numerator).
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider 3a (i & ii) Commissioner 3a (iii)
Frequency of reporting to commissioner	Monthly
Baseline period/date	NA
Baseline value	NA
Final indicator period/data	April 2015 – March 2016
Final indicator value (payment threshold	90% (see below for the specific rules to be applied to the payment)

Rules for calculation of payment due at final indicator period/date	. Acute providers to achieve: • 90% or more for parts i & ii of the indicator at the end of each quarter. • 90% or more for part iii for the whole of quarter 4.
Final indicator reporting date	March 2016
Are there rules for any agreed in –year milestone	Yes
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NO

3b Staff Training

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3b
Indicator name	Staff Training
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): • 3b = 10% of total funding
Description of Indicator	To ensure that appropriate dementia training is available to staff through a locally determined training programme.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data Source	Training programme to be determined locally. To ensure that appropriate dementia training is available to all staff. It is recommended that the commissioning and delivery of the training programme is a collaborative effort across the local health and care economy (including care homes). Commissioners will need to agree local audit processes for the training programme but should include quarterly reports to Provider Boards of :

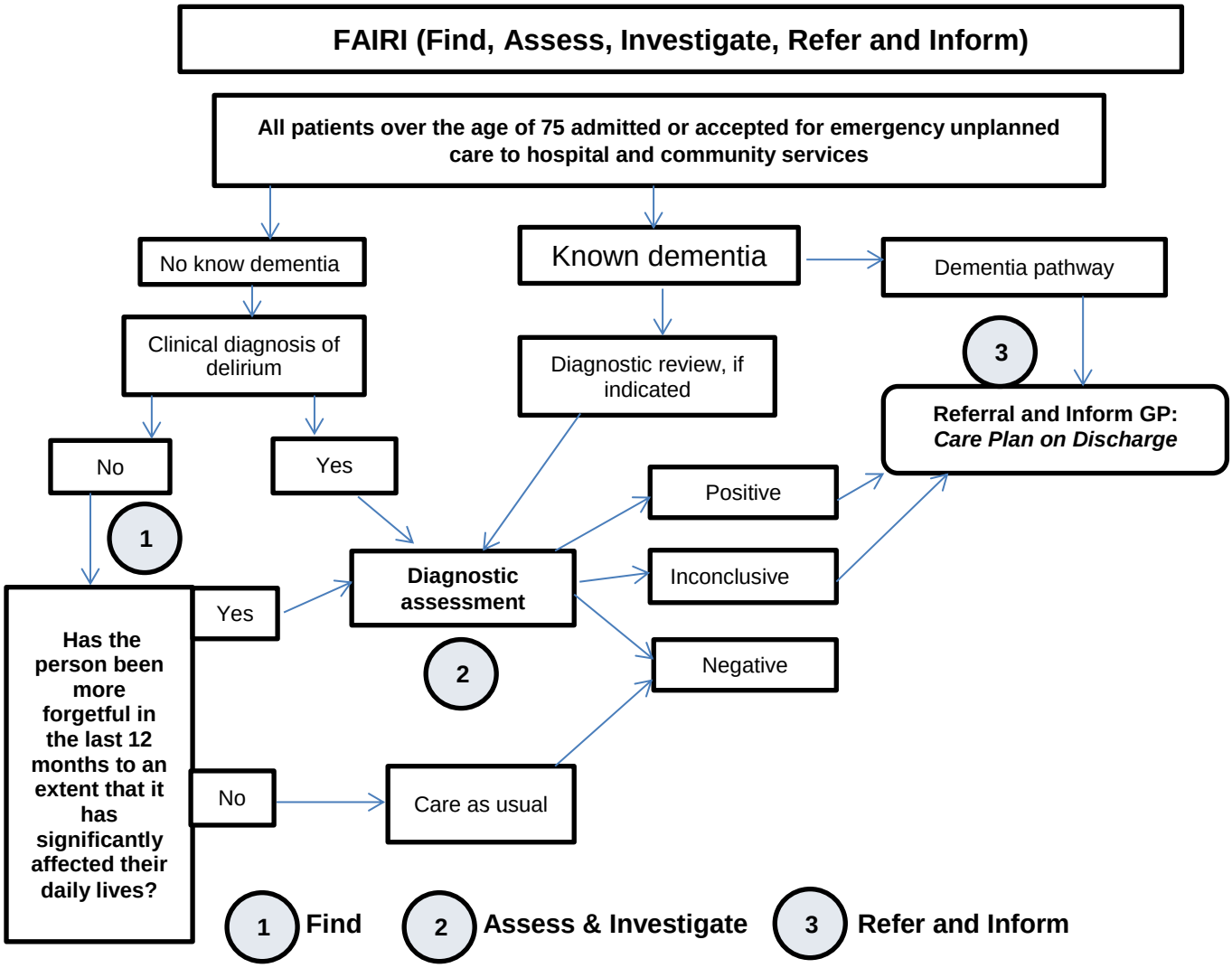
	• Numbers of staff who have completed the training; • Overall percentage of staff training within each provider.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly reports to the provider board
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/data (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold	To be agreed locally
Rules for calculation of payment due at final indicator period/date	Rules to be agreed locally (including evidence to be supplied to commissioner)
Final indicator reporting date	March 2016
Are there rules for any agreed in –year milestone that result in payment?	To be agreed locally
Are there any rules for partial achievement	To be agreed locally

3b Supporting Carers

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3c
Indicator name	Supporting Carers
Indicator weighting	3a, 3b and 3c total weighting be agreed locally (suggested minimum of 0.25%): • 3c = 30% of total funding
Description of Indicator	Ensure carers of people with dementia and delirium feel adequately supported.
Numerator	NA
Denominator	NA

Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data Source	Carer survey - Commissioners and providers will need to agree on the content of the survey and local processes for surveying carers of people with dementia and delirium which should cover the whole health and social care economy. The findings of the survey to presented biannually to the Provider Board.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Biannual
Baseline period/date	NA
Baseline value	NA
Final indicator period/data (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold	NA
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Rules to be agreed locally.
Final indicator reporting date	March 2016
Are there rules for any agreed in –year milestone that result in payment?	To be agreed locally
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally

Fig 1: Dementia FAIRI Flow chart


FAIRI (Find, Assess, Investigate, Refer and Inform)
All patients over the age of 75 admitted or accepted for emergency unplanned care to hospital and community services
No know dementia
Known dementia
Dementia pathway
Clinical diagnosis of delirium
Diagnostic review, if indicated
3
Referral and Inform GP: Care Plan on Discharge
No
Yes
1
Positive
Diagnostic assessment
Inconclusive
Has the person been more forgetful in the last 12 months to an extent that it has significantly affected their daily lives?
Yes
2
Negative
No
Care as usual
1 Find
2 Assess & Investigate
3 Refer and Inform

UEC: REDUCING THE PROPORTION OF AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL IMPROVEMENT GOAL SPECIFICATION	
Indicator number	4 a
Indicator name	Reducing the proportion of avoidable emergency admissions to hospital.
Indicator weighting	To be agreed locally.
Description of indicator	Avoidable emergency admissions as a proportion of all emergency admissions.
Numerator	Number of avoidable emergency admissions (as defined by the technical specification for indicator 7). a) Increase in zero LOS with no overnight stay in patients with an ambulatory case sensitive admission.
Denominator	Number of all emergency admissions
Rationale for inclusion	The indicator has been developed to ensure that patients with ambulatory care sensitive conditions and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. The introduction of community based preventative measures and/or improved ambulatory care services at the hospital "front door" would both be expected to have a positive impact on this indicator. Emergency Ambulatory Care sensitive conditions as defined by the KINGS Fund as chronic conditions for which it is possible to prevent acute exacerbations and reduce the need for hospital admission through active management
Data source	Hospital Episodes Statistics/SUS
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	Monthly
Baseline period/date	2014-15
Baseline value	a) LOS with no overnight stay in patients with an ambulatory case sensitive admission.
Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	a) 4% increase in zero length of stay, with no overnight stay, for emergency admission with an ambulatory case sensitive

	condition.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Full payment released provided planned ward reconfigurations in the Duchess Building, to provide greater capacity for the acutely ill and older patients take place during the year. This will include the development of the OPAL unit and Ambulatory Care Centre.
Final indicator reporting date	16 May 2016
Are there rules for any agreed in-year milestones that result in payment?	no
Are there any rules for partial achievement of the indicator at the final indicator period/date?	None
Exclusions	Providers with less than 1,000 total emergency admissions in 2014-15 should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 1,000 total emergency admissions. The reason for including this criterion is that where the number of emergency admissions is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.
Issues to take into consideration when setting local levels of improvement	Reconfiguration of services locally, such as opening or closing of A&E departments, is likely to have an impact on the number of avoidable emergency admissions. This should be taken into account when looking at local data to set a rate of improvement. If reconfiguration of services is planned during 2015-16 this should be taken into consideration when deciding whether to adopt this CQUIN, and what level of improvement it should be set at.

Indicator 4a Technical Specification

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as ‘ambulatory care sensitive conditions’) that

could usually have been avoided through better management in primary or community care and which are reflected in four NHS Outcomes Framework indicators:

2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions;

2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s;

3a Emergency admissions for acute conditions that should not usually require hospital admission;

3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs).

The data are extracted from the Hospital Episode Statistics (HES) system.

The ICD-10 diagnoses that are included are listed below, along with the other parameters used in the HES query.

Specification of HES query for avoidable emergency admissions

1 Field Name ADMIMETH is equal to the following: 21, 22, 23, 24, 28

(Rationale: This restricts the data to emergency admissions only.)

2 Field Name EPISTAT is equal to the following: 1 or 3

(Rationale: This includes both finished and unfinished hospital episodes.)

3 Field Name ADMIDATE Limited to admissions within the relevant financial year.

(Rationale: Data are presented annually with an admission date within the financial year of interest.)

4 Field Name SEX is equal to the following: 1 or 2

(Rationale: Data are for the sum of males and females and exclude the small number of records where sex was unknown or unspecified.)

5 Field Name EPIORDER is equal to: 1

(Rationale: This restricts the data to the first emergency admission in a hospital spell.)

6 Field Name ADMISORC is not equal to: 51, 52, 53

(Rationale: This excludes transfers.)

7 Field Name EPITYPE is equal to: 1

(Rationale: This restricts the data to general episodes (excludes birth, delivery and mental health episodes).)

8 Field Name CLASSPAT is equal to: 1

(Rationale: This restricts the data to ordinary admissions (excludes day case and maternity admissions)).

9a Field Name 4 CHAR PRIMARY DIAGNOSIS CODE (DIAG_01) is any of (a) to (q) are true AND Field Name STARTAGE is between 1-120 or >7000.

a) DIAG_01 is equal to any of: B18.0, B18.1. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).

b) DIAG_01 is equal to any of: J45, J46X

c) DIAG_01 is equal to any of: I11.0, I50, J81X, I13.0. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71

d) DIAG_01 is equal to any of: E10, E11, E12, E13, E14

e) DIAG_01 is equal to any of: J20, J41, J42X, J43, J44, J47X. J20 only with second diagnosis of J41, J42, J43, J44, J47

f) DIAG_01 is equal to any of: I20, I25. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X0, X1, X2, X4, X5

g) DIAG_01 is equal to any of: D50.1, D50.8, D50.9, D51, D52

h) DIAG_01 is equal to any of: I10X, I11.9. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71

i) DIAG_01 is equal to any of: G40, G41, F00, F01, F02, F03, I48X

j) DIAG_01 is equal to any of: J10, J11, J13X, J14, J15.3, J15.4, J15.7, J15.9, J16.8, J18.1, J18.8, A36, A37, B05, B06, B16.1, B16.9, B26, M01.4. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).

k) DIAG_01 is equal to any of: I24.0, I24.8, I24.9. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X0, X1, X2, X4, X5.

l) DIAG_01 is equal to any of: E86, K52, A02.0, A04, A05.9, A07.2, A08, A09.

m) DIAG_01 is equal to any of: N10, N11, N12, N13.6, N15.9, N39.0, N30.0, N30.8, N30.9.

n) DIAG_01 is equal to any of: K25.0-K25.2, K25.4-K25.6, K26.0-K26.2, K26.4-K26.6, K27.0-K27.2, K27.4-K27.6, K28.0-K28.2, K28.4-K28.6, K20, K21.

o) DIAG_01 is equal to any of: L03, L04, L08.0, L08.8, L08.9, L88, L98.0, I89.1, L01, L02. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S1, S2, S3, S41, S42, S43, S44, S45, S48, S49, T, V, W, X0, X1, X2, X4, X5. S47 is allowed if by itself.

p) DIAG_01 is equal to any of: H66, H67, J02, J03, J06, J31.2, J04.0.

h) DIAG_01 is equal to any of: A69.0, K02, K03, K04, K05, K06, K08, K09.8, K09.9, K12, K13.

q) DIAG_01 is equal to any of: R56, O15, G25.3.

OR

9b Field Name 4 CHAR PRIMARY DIAGNOSIS CODE (DIAG_01) is any of (a) to (b)

AND Field Name STARTAGE is <19 or >7000

a) J45, J46, E10, G40, G41

b) J10.0, J11.0, J11.1, J12.-, J13, J14, J15.-, J16.-, J18.0, J18.1, J18.9, J21.

UEC: IMPROVING DIAGNOSES AND RE ATTENDANCE RATES OF PATIENTS WITH MENTAL HEALTH NEEDS AT A&E IMPROVEMENT GOAL SPECIFICATION	
Indicator number	4b
Indicator name	Improving recording of referral to Crisis Liaison service in A&E
Indicator weighing	To be agreed locally
Description of indicator	To be agreed with acute providers): Where required, improve diagnosis recording in the A&E HES data set so that the proportion of records with valid codes (either A&E 2 digit diagnosis codes or 3 digit ICD-10 codes) is at least 85%. For this purpose, codes 38 “Diagnosis not classifiable” and R69 “Unknown and unspecified causes of morbidity” will be classed as invalid.
Numerator	Number of records with a valid diagnosis code (either A&E 2 digit diagnosis code or 3 digit ICD-10 code - for this purpose, codes 38 “Diagnosis not classifiable” and R69 “Unknown and unspecified causes of morbidity” will be classed as invalid.)
Denominator	All records of A&E attendances within the last month
Rationale for inclusion	This indicator has been developed to incentivise better data recording and encourage improved and timely communication and intervention between acute trusts and mental health providers to improve outcomes for those with MH conditions seeking urgent and emergency care.
Data source	Hospital Episodes Statistics
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	Monthly
Baseline period/date	Q1 2015/16
Baseline value	To be agreed by 30 June 2015 locally using nationally available data.
Final indicator period/date (on which payment is based)	The data completeness specified should be met for at least one month’s data before the payment is made and the level of completeness should be maintained throughout 2015-16.
Final indicator value (payment threshold)	To be agreed locally by 30 June 2015

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally by 30 June 2015
Final indicator reporting date	16 May 2016
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	% of CQUIN scheme available for meeting final indicator value: 49.9% or less No payment 50.0% to 69.9% 25% payment 70.0% to 79.9% 50% payment 80.0% to 89.9% 75% payment 90.0% or above 100% payment
Exclusions	Providers with less than 500 MH A&E attendances in the baseline period should not be included. If CCGs are setting a CQUIN for part of the activity of a provider then the size of that element should exceed 500 MH A&E attendances. The reason for including this criterion is that where the number of MH A&E attendances is small, the change in the rate of the proposed measure will be more susceptible to random variation and may not actually reflect a true change in the level of the measure. The minimum threshold set is designed to mitigate this.

REDUCTION IN PRESSURE ULCER INCIDENCE	
Indicator number	5
Indicator name	Reduction In Pressure Ulcer Incidence
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	To reduce the reported incidence of people with an avoidable healthcare acquired pressure ulcer (Grade 2 and above) in inpatient beds by 50% over a three year period based on out turn for each year: Year 1 (2014/15) 20%; Year 2 (2015/16) 20%; Year 3 2016/17)10%
Numerator	Number of reported of hospital acquired pressure ulcers (ie all Grade 2 and above pressure ulcers appearing after 72h of admission and reported via the incident reporting system)
Denominator	N/A

Rationale for inclusion	It was estimated in 2004 that the NHS spent £2.1bn treating pressure ulcers. These figures are a conservative estimate. 90% of this cost is nursing time. Evidence suggests that between 4 and 10% of patients admitted to UK district hospitals develop a pressure ulcer.
Data source	Monthly analysis of reported incidents reported via risk management systems and quality dashboards
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly report on Quality/CQUIN scorecard to Quality Review Meeting
Baseline period/date	Year 2: Year-end position for 2014/15
Baseline value	155
Final indicator period/date (on which payment is based)	Payment is split into quarterly periods with 25% of the total annual available payment being available for each 3 month period
Final indicator value (payment threshold)	A aspirational target of 20% overall reduction.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Full payment to be released if evidence of actions taken to reduce the reoccurrence of pressure ulcers in the Trust is supplied in quarter 3 by 17 December 2015.
Final indicator reporting date	31 March 2016
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement of the indicator at the final indicator period/date?	See table below

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to Commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Progress against the improvement goal will be reviewed quarterly.	Quarter 1 CQRM	25%
Quarter 2	Progress against the improvement goal will be reviewed quarterly.	Quarter 2 CQRM	25%
Quarter 3	Progress against the improvement goal will be reviewed quarterly.	Quarter 3 CQRM	25%

	Local CQUIN no 6 Seamless Care for Older people		
Quarter 4	A aspirational target of 20% overall reduction. Full payment to be released if evidence of actions taken to reduce the reoccurrence of pressure ulcers in the Trust is supplied in quarter 3 by 17 December 2015.	Quarter 4 CQRM	25%

Description of indicator	The priority for this set of CQUINs is delivering seamless care for frail older people, with an increased focus on targeted prevention, supporting people to remain independent and in preventing social isolation. The aspirational requirements for this CQUIN are for 2015/16 and beyond. The work will involve the implementation of frailty risk stratification when the person enters services, to proactively develop care plans, escalation plans and requires these plans to be shared across Health services. This will link to services that offer Comprehensive Geriatric Assessment for those with high frailty. This will be achieved through: 1. **Developing screening tools to identify frailty;** T&S FT will test, evaluate and agree an appropriate frailty screening tool (Rockwood) for use on patients identified at ED and MAU as requiring admission to hospital during Q1 and will will establish the "cut off" score for the tool above which completion of a Comprehensive Geriatric Assessment adds most value. T&S FT will establish a mechanism for collecting data electronically to build an accurate picture of this frailty cohort to inform development of a frailty service. T&S FT. **2. Completion of Comprehensive Geriatric Assessment (CGA);** T&S FT will complete a CGA on the group of patients in the cohort identified as above who present on a Monday to Friday between 8:30 and 17:30 (the ambition during 2015/16 is to prove the value of this patient care pathway to enable extension to out of hours in the future). T&S FT will complete a CGA for 75% by the end of Q3 and 90% by the end of Q4. 3. **Personalized Care Plan**, Somerset CCG is working with the voluntary sector in the delivery of holistic personalized care planning (PCP) for patients with LTC (initial pilot heart failure) who are discharged from T&S FT. T&S FT will continue to work with community partners to deliver this project In addition, T&S FT will commit to using the learning from this pilot to work with community partners to test the development of peronalized care plans for patients identified as requiring a CGA at admission. This will be based on improvement methodology and PDSA cycles, starting with one patient before scaling up incremently (making changes as required) until all patients who have received a CGA reliably receive a personalized care plan that contains the necessary information for the community services to continue the care.
Numerator	Number of patients in identified cohort receiving a Comprehensive Geriatric Assessment

Denominator	Number of patients presenting in ED and MAU between the hours of 08:30 and 17:30, Monday to Friday, who score at or above the "cut off" score on the frailty screening tool (detail to be added)
Rationale for inclusion	Building on the 2014/15 Personalised Care Plan for Patients with identified long term conditions in 2015/16 the focus to ensure people who are frail and at high risk of hospital admission are supported to live at home for as long as possible with their care and support needs provided by an integrated team of professionals. This will reduce emergency admissions and delay the need for long-term care and, in particular, permanent admission to a care home. A consistent system is required to identify people who are frail. This will enable us to target CGA where agreed, agree a nominated key worker, and produce personalised care plans that enable appropriate interventions according to the level of frailty. An agreed set of standards shall be adopted across the health and social care community which shall include a simple referral system for clinicians which gives senior medical input to patients wherever they come to notice - hospital or community. To attempt to assist in reducing the impact of frailty conditions on acute hospitals
Data source	Provider
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	April 2015 – June 2015
Baseline value	
Final indicator period/date (on which payment is based)	July 2015 - March 16
Final indicator value (payment threshold)	Achievement of 90% compliance for CGA for one month in Quarter 4
Final indicator reporting date	20th April 2016

Are there rules for any agreed in-year milestones that result in payment?	Yes –payable upon delivery of items due in Quarterly Meeting:
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Checkpoint Meeting: - Agree frailty screening tool - Agree "cut off" score for frailty screening tool - Agree methodology for collection of data - Evidence of on-going commitment to Test and Learn		25%
Quarter 2	a) Establish service for delivery of CGA and embed measurement processes b) Evidence of commitment to work with community partners to develop personalized care plans for identified cohort.		25%
Quarter 3	a) dAchieve 75% compliance for CGA for patients with a Rockwood score of 7 or more one month in Quarter b) Evidence of initial work with community partners to develop personalized care plans for identified cohort.		25%
Quarter 4	a) Achieve 90% compliance for CGA for one month in Quarter b)Evidence of working with community partners to develop personalized care plans for identified cohort.		25%

	LOCAL 7
Indicator name	**Transition arrangements children to adult services**
Indicator weighting	
Description of indicator	Informing and developing a generic approach to the transition of children and young people (CYP) to adult services. This will be achieved through: 1. **Definition of Cohort;** T&S FT will agree an age range to define various cohorts of patients in transition during Q1. This may identify specific requirements for certain age groups (e.g. Management of DNAs for 18 to 25) or certain conditions if appropriate. **2. Establishment of Trust Wide Group;** T&S FT will establish a Trust wide transition group, overseeing all elements of transition across all conditions, during Q1. 3. **Development of a Generic Transition Policy;** T&S FT will develop a policy to cover key elements of transition (e.g. staff training requirements,access to information, support for transition) across all conditions by the end of Q2. The policy will include agreed method of tracking the agreed cohorts through the transition process. **4. Individualised Transition Plans;** T&S FT will develop processes for delivering individualised transition plans for all conditions as part of policy development. As part of this development, trajectories will be established for all conditions, with a particular focus on the diabetic service. Implementation will start with testing and roll out for the pediatrics diabetes service in Q3.
Numerator	The number of service users on a transition programme. Focus on children known to Diabetic Service and work with Somerset Partnership Continence Service
Denominator	Number of services users who have complex health needs meeting the cohort definition for patients in transition
Rationale for inclusion	The process of maturing from childhood to adulthood is complex for most young people, their parents/carers and the services involved. It is increasingly challenging for those young people with exceptional health care needs due to the complexity of their medical and care needs. Moving from a model of care where healthcare decisions are made by parents/carers to systems where the young person is expected and encouraged to do more for themselves, utilising different services, building new relationships with a range of different professionals can appear daunting. Transferring from child to adult services can bring additional stresses and anxieties to a family. The transition process can be improved by using a range of local resources, teams and professionals to identify the young person's on-going needs and then look at how they can be effectively transferred to within the adult service.

	There is much published evidence around best practice in developing and planning for example form the pond to the Sea http://www.cqc.org.uk/sites/default/files/CuQC_Transition%20Report.pdf . A number of key themes emerge during transition for young people in health which include: a) A trust working group to develop and implement transition policy and pathways. b) A generic framework for transition for all ~~disease~~ condition areas to work towards and within c) Work towards identifying cohort in each ~~disease~~ condition area and begin to improve patient experience.
Data source	Provider
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to Commissioner	Quarterly
Baseline period/date	Q1 2014/ 15
Baseline value	To be confirmed by 30 June 2015
Final indicator period/date	January 2016 – March 2016
Final indicator value (payment threshold)	90% of Diabetic service users on transition programme
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	Achievement of each quarters target attracts 25% of the total value of the scheme (see milestones below)
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Establishment of Trust Wide Group Agreement of cohort definition(s)		5%

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 2	Approval of Trust wide policy on transition Agreement of process for tracking patients in transition Development of process for individualised care plans		5%
Quarter 3	Roll out of individualised plans in diabetes		
Quarter 4	Delivery of target for individual care plans for diabetes Roll out of plans to further conditions		90%