National CQUIN Goals for 2015/16

1.1 Indicator 1 Acute Kidney Injury Template

ACUTE KIDNEY INJURY (AKI) IMPROVEMENT GOAL SPECIFICATION	
Indicator number	1
Indicator name	Acute Kidney Injury
Indicator weighting	0.29%
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 included in discharge summaries	*35% of whole-year AKI CQUIN value*
	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.

1.2 Indicator

2 Sepsis Templates

The indicator has two parts - 2a and 2b. 2a must be completed before 2b is implemented. It is expected that 2a will be in place from Q1 and 2b added in Q2.

2a Sepsis Screening

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2a
Indicator name	Sepsis Screening
Indicator weighting	0.165%
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.
Da333ta 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 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.

2b Sepsis Antibiotic Administration

SEPSIS IMPROVEMENT GOAL SPECIFICATION	
Indicator number	2b
Indicator name	Sepsis Antibiotic Administration
Indicator weighting	0.165%
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 CQUIN value available based on the following thresholds:		Maximum 20% of whole-year sepsis 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	*5% of whole-*	*50.0% to 69.9% of*	*5% of whole-*

	eligible patients screened	*year sepsis CQUIN value*	*eligible patients received antibiotics*	*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 triage)	Tick column below for all other cases, including those where time of arrival and/or time of antibiotic administration is 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*

1.3 Indicator 3 Dementia and Delirium Templates

The indicator has three parts - 3a, 3b and 3c.

3a Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3a
Indicator name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator weighting	0.19%
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; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; 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. 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; 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; • Analysis of 2014 CQUIN data returns indicate that the numbers of patients required for the provider audit per CCG would be too small to be sampled, hence a census is preferable. Commissioners will be able to submit this data to UNIFY.

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 (a census), 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). A BAAS application has been made to establish the commissioner data collection. CCGs will be updated via the CCG bulletin.
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 (on which payment is based)	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 (including evidence to be supplied to commissioner)	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 that result in payment?	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	0.065%
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 (including evidence to be supplied to commissioner)	Rules to be agreed locally

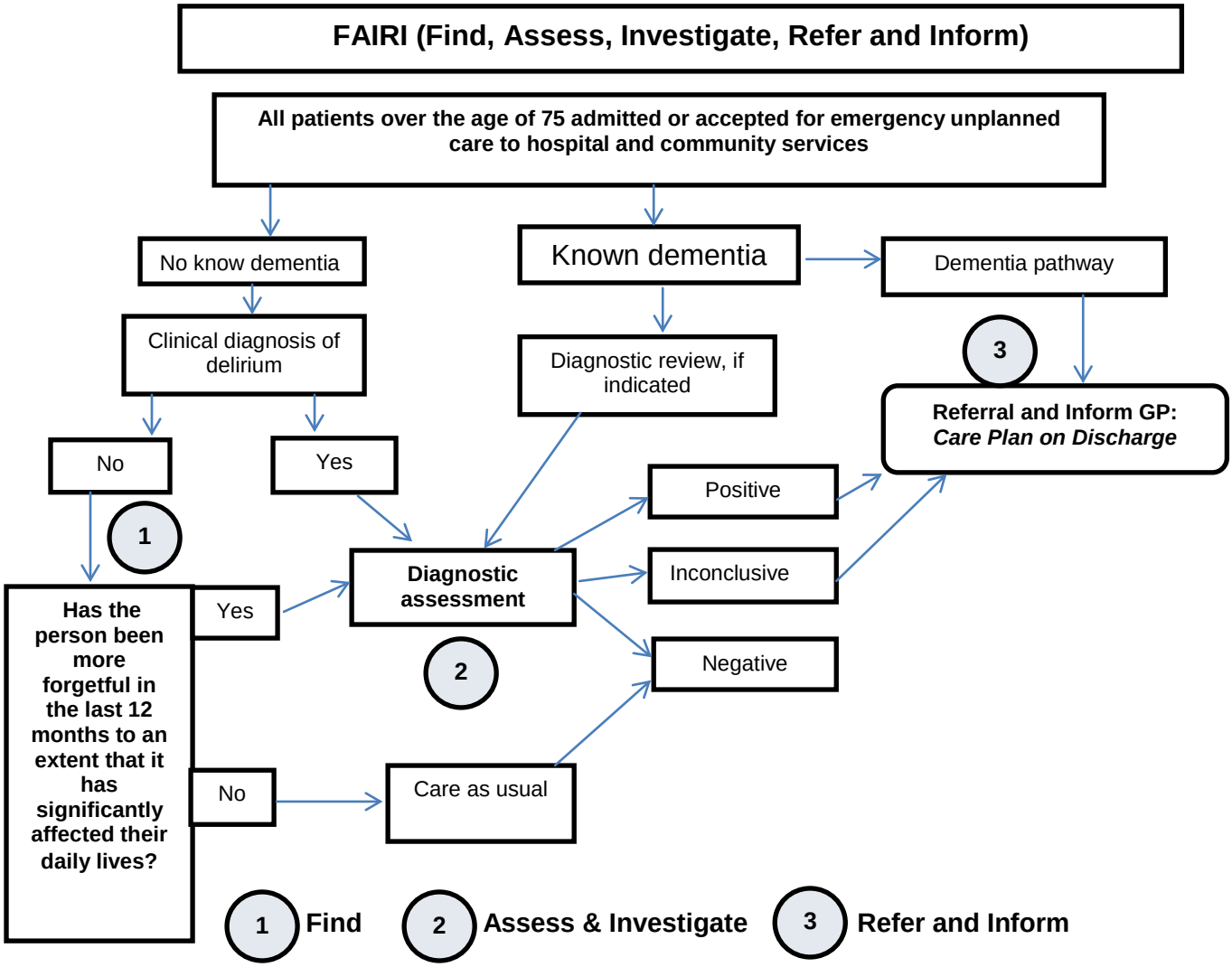
Final indicator reporting date	March 2016
Are there rules for any agreed in –year milestone that result in payment?	To be agreed locally
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally

3c Supporting Carers

DEMENTIA AND DELIRIUM IMPROVEMENT GOAL SPECIFICATION	
Indicator number	3c
Indicator name	Supporting Carers
Indicator weighting	0.115%
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



1.4 Indicator 7 Urgent and Emergency Care Menu Templates

Indicator 7 Reducing the proportion of avoidable emergency admissions to hospital

UEC: REDUCING THE PROPORTION OF AVOIDABLE EMERGENCY ADMISSIONS TO HOSPITAL IMPROVEMENT GOAL SPECIFICATION	
Indicator number	7
Indicator name	Reducing the proportion of avoidable emergency admissions to hospital via a surgical hot clinic
Indicator weighting	0.5%
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.
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.
Data source	Hospital Episodes Statistics/SUS
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15
Baseline value	To be agreed locally using nationally available data
Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	To be agreed locally
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	To be agreed locally

Final indicator reporting date	May 2016
Are there rules for any agreed in-year milestones that result in payment?	Yes as below
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 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.

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	To establish the surgical hot clinic service at CRHFT To review the pilot results and establish and agree a baseline position with commissioners To work with commissioners to set the rate of improvement for 2015/2016 and the frequency of reporting	July 2015 May 2015 May 2015	
Quarter 2	To report against the agreed rate of improvement and targets as agreed in Q1		
Quarter 3	To report against the agreed rate of improvement and targets as agreed in Q1		
Quarter 4	To report against the agreed rate of improvement and targets as agreed in Q1 To produce a final report on the effectiveness of the service against required targets Final report to include an element of patient feedback / experience on the service provided		

Indicator 7 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.

2 Local CQUIN Template

Indicator	
Indicator number	1
Indicator name	Open and Honest care: driving improvements
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	To demonstrates CRH's Boards commitment to the seven principles of the Board Compact. To publish open and honest care reports monthly for the population to view and staff to own
Numerator	N/A
Denominator	N/A
Rationale for inclusion	NHS England's commitment to making more information available about the quality of care in the NHS. This initiative is a central part of NHS England's ambition to ensure every patient gets high-quality care, and to build improved services for the future The open and honest program – Nursing strategy: Compassion in practice: Action Area 3. Open and Honest Care: Driving Improvement. 2012 Compassion in practice – two years on 2014 To improve patient care through sharing and understanding of information on quality of care in an open, honest, accessible and easily understandable manner

Data source	NHS Safety Thermometer Information on healthcare associated infection, (MRSA and C Diff) Pressure ulcers Falls causing moderate or greater harm Information on staff experience Information on patient experience including Friends and Family Test A patient story An improvement story describing what the trust has learnt and what improvements they are making. Never Events
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly receipt of report
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	As per milestones
Final indicator value (payment threshold)	As per milestones
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment?	As per milestones
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No *Final quarter 4 payment will be based on a checkpoint position measured mid February 2016 to allow for payment pre the end of the financial year

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	Agreement from the Board to the Board Compact Development of SOP Sign up to the programme Develop webpage Mock report for approval via committee's – to include patient and public comments and involvement Distribution plans to be decided to include website, wards, staff and patients	July 15	
Quarter 2	Report developed for each month, uploaded to website by 23rd each month and sent to NHS England Commencing with an upload in July for June data.	November 15	
Quarter 3	Report developed for each month, uploaded to website by 23rd each month and sent to NHS England	January 16	
Quarter 4	Report developed for each month, uploaded to website by 23rd each month and sent to NHS England. Evaluation Report to be presented to QAG highlighting improvements in quality of care, and including feedback on the report from patients and staff	April 16	

Rules for partial achievement at final indicator period/date

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value

Indicator	
Indicator number	2
Indicator name	EDD & Discharge
Indicator weighting (% of CQUIN scheme available)	025%
Description of indicator	To Understand the delays between estimated discharge date (EDD) and actual discharge date (ADD) To record a timely EDD for all patients, which has been assigned by a Senior decision maker To provide a means of effectively communicating to all patients (and carer's) their EDD, what's happening today, tomorrow and at discharge (For example - Ticket Home system) To provide an effective tool that can monitor progression of EDD to ADD and capture the causes of delayed EDD. To analyse the causes of EDD delays to inform service improvement opportunities
Numerator	Number of patients with EDD
Denominator	Total Number of in patients
Rationale for inclusion	To understand the reasons for actual discharge delays, and therefore enable them to be addressed To work to ensure that all patients are cared for in the right place, at the right time, by the right staff 21st Century Joined Up Care programme To assist discharge communication with patients and families To maximise effectiveness of acute bed usage To focus all professionals involved in the discharge process on proactive, timely discharge planning and commissioning requirements

Data source	Update reports on policy implementation and communication. CQUIN report to commissioners
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	Q4 2014/15
Baseline value	As per data from Q4 2014/15
Final indicator period/date (on which payment is based)	As per milestones
Final indicator value (payment threshold)	As per milestones
Final indicator reporting date	April 2015*
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?	No *Final quarter 4 payment will be based on a checkpoint position measured mid February 2016 to allow for payment pre the end of the financial year

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	Trust policy to be developed that describes the EDD requirements and accountability. Communication plan to launch policy across the trust outlining anticipated benefits. To develop a means of effectively communicating to all patients (and carer's) their EDD, what's happening today, tomorrow and at discharge (For example - Ticket Home system) Data Quality Improvement plan for OpenWard system Undertake a baseline assessment of EDD from Q4 2014/15 Trust leads for project to be nominated to facilitate roll out		
Quarter 2	Update of policy communication plan and data quality plan – for the Quarter Data to be shared on percentage compliance against all aspects of the Trust policy as a baseline position Evidence of communication plan, to launch policy, taking place throughout the Trust which will include clinical staff across a variety of grades. Evidence of improving communication to patients and carers their pathway to achieving EDD Ongoing work with Cader to develop OpenWard system functionality to automate collection of data		

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 3	Update of policy communication plan and data quality plan – for the Quarter Quarterly report on rationales for delays in achieving EDD Compliance against key outcomes described in policy on an agreed regular basis – to be agreed once data collections systems are in place Evidence of ongoing improvements to the project with remedial action plans when off trajectory EDD data - % of patients with EDD monthly data submission Evidence of ongoing improvements in communication to patients and carers their pathway to achieving EDD Ongoing work with Cader to develop OpenWard system functionality to automate collection of data		
Quarter 4	Update of policy, communication plan and data quality plan – for the Quarter Final report on project to include improvement plan for 2016/17 to address findings of CQUIN programme Data to be shared on percentage compliance against all aspects of the Trust policy as agreed EDD data - % of patients with EDD monthly data submission Evidence improvements in communication plan of EDD to patients and carers		

Indicator	
Indicator number	3
Indicator name	Compassion and Culture
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	Provider engagement with the agenda of compassion and culture across the organisation and delivery of a focused work programme aimed at improving patient care
Numerator	N/A
Denominator	N/A
Rationale for inclusion	This work reflects the national agenda for the provision of care and can be referenced to – Everyone Counts: Planning for patients 2014/15 – 2018/19 (2013) Fundamental elements of commissioning plans p29 elements -13,15,16 & 17 are all relevant The Francis Report (2013) – Compassion & Care was one of the 5 main areas of response NHS Confederation (2012) Delivering Dignity, focuses on the elderly and the need for compassion NHS England (2012) Compassion in Practice, the 6 C's To build on the work of the 2014/15 CQUIN on Compassion and Culture
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	April 2015-March 2016

Final indicator value (payment threshold)	
Final indicator reporting date	April 2015*
Are there rules for any agreed in-year milestones that result in payment?	Yes, Milestones as below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, Milestones as 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	Provider to ensure an Executive lead is involved in the project – name to be provided Provider to develop an action plan to promote the key areas for 2015 compassionate care program 1. Embed #hellomyname is……..across the trust 2. Making patient feedback part of everyday practice and demonstrating that feedback obtained has improved experience 3. Improve communication for patients and carer's during discharge Action plan to contain SMART objectives which are agreed with the relevant NDCCG Head of Quality by the end of Q1	End June 2015	
Quarter 2	Progress against action plan and compliance with timescales initially agreed on it to be provided		
Quarter 3	Progress against action plan and compliance with timescales initially agreed on it to be provided		

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 4	Final report to evidence completion of action plan and compliance with timescales initially agreed on it to be provided Final report to include details of overall improvements and patient feedback in relation to the compassion agenda and 3 key areas of work.		

Rules for partial achievement at final indicator period/date

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value

Indicator	
Indicator number	4
Indicator name	Complaints Management
Indicator weighting (% of CQUIN scheme available)	0.25
Description of indicator	To improve the handling of complaints across CRHFT The Provider will take part in one external peer review of patient complaints, which will involve the submission of completed complaint files to be reviewed by a panel against the Patients Association Good Practice Standards on complaints handling The provider will develop an improvement plan from the results of the 2014/15 Patients Association peer review panel results and internal audits to address areas of concern and ensure learning across the organisation The provider will register with and use the national Patient Association survey and benchmarking to measure performance and improvements. Feedback from the survey, peer review and any patient feedback will be shared with the Quality Assurance Committee, at divisional level and at the NDCCG PESC meeting
Numerator	N/A
Denominator	N/A

Rationale for inclusion	Continuation of 2014/15 CQUIN To ensure recommendations from the 2014/15 complaints Peer review process are addressed by the provider National publications (Clwyd & Hart 2013) have demonstrated the NHS management of complaints requires improvement. Good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of care at provider organisations. It provides a tangible and measurable reflection of the organisations commitment to an open and responsive safety culture. As part of the Health Foundation funded 'Speaking Up' project the Patients Association has been developing tools aimed at improving the quality of complaints handling. They have developed and piloted a complainant survey and a peer review process to provide qualitative and quantitative feedback, highlighting areas of positive performance and areas for improvement.
Data source	2014/15 Patient Association peer review report Patients association survey data Local complaints feedback and audit information
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	N/A
Baseline value	As per data sources above
Final indicator period/date (on which payment is based)	As per milestones
Final indicator value (payment threshold)	
Final indicator reporting date	April 2015*
Are there rules for any agreed in-year milestones that result in payment?	Yes as per milestones below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes as per milestones 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	The provider will develop an improvement plan from the results of the 2014/15 Patients Association peer review panel results and internal audits to address areas of concern and ensure learning across the organization. Action plan will be agreed with the appropriate NDCCG Head of Quality.	April 2015	
	The provider will register with and use the national Patient Association survey and benchmarking to measure performance and improvements.	April 2015	
	Feedback from the survey, peer review and any patient feedback will be shared with the Board, at divisional level and at the NDCCG PESC meeting	End Q1	
Quarter 2	The provider will submit an updated improvement plan to the commissioners evidencing progress to date and timely completion of all objectives for the end of Q2		
	The provider will report results of the Patient Association survey and benchmarking to commissioners		
	Feedback from the survey, peer review and any patient feedback will be shared with the Board, at divisional level and at the NDCCG PESC meeting		

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 3	The Provider will take part in an external peer review of patient complaints, which will involve the submission of completed complaint files to be reviewed by a panel against the Patients Association Good Practice Standards on complaints handling The provider will submit an updated improvement plan to the commissioners evidencing progress to date and timely completion of all objectives for the end of Q3 The provider will report results of the Patient Association survey and benchmarking to commissioners Feedback from the survey, peer review and any patient feedback will be shared with the Board, at divisional level and at the NDCCG PESC meeting		
Quarter 4	The provider will submit an updated improvement plan to the commissioners evidencing progress to date and timely completion of all objectives for the end of Q4 The provider will report results of the Patient Association survey and benchmarking to commissioners Feedback from the survey, peer review and any patient feedback will be shared with the Board, at divisional level and at the NDCCG PESC meeting The provider will complete a final report showing progress in all areas in relation to complaints including feedback from the Q3 Peer review process and direct patient feedback.		