National CQUIN Goals for 2016/17

1 NHS Staff health and wellbeing

Note on CQUIN indicator

There are 3 parts to this CQUIN indicator:

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)	Value (£)
CQUIN 1a	Introduction of health and wellbeing initiatives	33.3% of 0.75% (0.25%)	
CQUIN 1b	Healthy food for NHS staff, visitors and patients	33.3% of 0.75% (0.25%)	
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	33.3% of 0.75% (0.25%)	

1a. Introduction of Health and Wellbeing Initiatives

Indicator	
Indicator name	Introduction of health and wellbeing initiatives- **Option B**
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	The introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. Providers should develop a plan and ensure the implementation against this plan. This plan will be subject to peer review (further guidance will be issue on the peer review aspect in the next 4-6 weeks). This should cover the following three areas; a) Introducing a range of **physical activity schemes** for staff. Providers would be expected to offer physical activity schemes with an emphasis on promoting active travel, building physical activity into working hours and reducing sedentary behaviour. They could also introduce physical activity sessions for staff which could include a range of physical activities such as; team sports, fitness classes, running clubs and team challenges. b) Improving **access to physiotherapy services** for staff. A fast track physiotherapy service for staff suffering from musculoskeletal (MSK) issues to ensure staff who are referred via GPs or Occupational Health can access it in a timely manner without delay; and c) Introducing a range of **mental health initiatives** for staff. Providers would be expected to offer support to staff such as, but not restricted to; stress management courses, line management training, mindfulness courses, counselling services including sleep counselling and mental health first aid training;
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Estimates from Public Health England put the cost to the NHS of staff

Indicator	
	absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. The *Five Year Forward View* made a commitment 'to ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. This CQUIN builds on this promise and the developments made across England during the past year through some of the work being undertaken within NHS England's Healthy Workforce Programme to help promote health and wellbeing for NHS staff and improve the support that is available for them in order for them to remain healthy & well. A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged.
Data source	Local implementation plan
Frequency of data collection	Quarter 1 – once Quarter 4 – once
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 1 – once Quarter 4 – once
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	Quarter 4, 2016/17
Final indicator value (payment threshold)	Introducing the agreed initiatives as set out in their plan
Final indicator reporting date	Introducing the agreed initiatives as set out in their plan
Are there rules for any agreed in-year milestones that result in payment?	Yes see milestone requirements below.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	N/A

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	Providers should have developed a plan to introduce and actively promote the three initiatives that is peer reviewed and signed off.	July 2016	20% of the indicator weighting for part 1a
Quarter 4	Providers should have implemented their initiatives (as agreed in their signed off plan) and actively promoted these services to staff to encourage uptake of initiatives.	March 31 2017	80% of the indicator weighting for part 1a

Supporting Guidance and References

https://www.nice.org.uk/guidance/ng13

Supplementary guidance on the health and wellbeing initiatives will be provided during the next 4-6 weeks.

1b. Healthy food for NHS staff, visitors and patients

Indicator	
Indicator name	Healthy food for NHS staff, visitors and patients
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	**Part a** Providers will be expected achieve a step-change in the health of the food offered on their premises in 2016/17, including: a. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS)[1]. The majority of HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets; b. The banning of advertisement on NHS premises of sugary drinks and foods high in fat, sugar and salt (HFSS); c. The banning of sugary drinks and foods high in fat, sugar and salt (HFSS) from checkouts; and

[1] The Nutrient Profiling Model can be used to differentiate these foods while encouraging the promotion of healthier alternatives. https://www.gov.uk/government/publications/the-nutrient-profiling-model

	d. Ensuring that healthy options are available at any point including for those staff working night shifts. CQUIN funds will be paid on delivering the four outcomes above. In many cases providers will be able to achieve these objectives by renegotiating or adjusting existing contracts. **Part b** Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink. The data collected will include the following; the name of the franchise holder, food supplier, type of outlet, start and end dates of existing contracts, remaining length of time on existing contract, value of contract and any other relevant contract clauses. It should also include any available data on sales volumes of sugar sweetened beverages (SSBs).
Numerator	N/A
Denominator	N/A
Rationale for inclusion	PHE's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals.
Data source	**Quarter 1** The responses to the proposed questions below will form part of a national data collection. Providers will submit the responses via UNIFY following locally agreed sign off process by the commissioner. 1) Name of franchise holder 2) Name of supplier or vendor(s) 3) Type of sales outlet (restaurant, café,

	vending, shop/store, trolley service) 4) Start date of existing supplier contract 5) End date of existing supplier contract 6) Remaining length of contract (time to expiration) with external supplier(s) 7) Total contract value 8) Value of contract for the financial year 2015/16 9) Profit share agreements that are in addition to the contract value (percentage of profit that is received by the NHS Provider from the supplier) 10) Free text box: Contract break clauses 11) Volume of Sugar Sweetened Beverages sold **Quarter 4** 1) Question: Have you changed your food supplier during 2016/17(Yes/ No) If yes who is your new food supplier?
Frequency of data collection	End of Quarter 1- once only End of Quarter 4- once only
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	End of Quarter 1 End of Quarter 4
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Quarter 4, 2016/17
Final indicator value (payment threshold)	To be determined locally
Final indicator reporting date	As soon as possible after Q4 2016/17
Are there rules for any agreed in-year milestones that result in payment?	Yes see -milestones requirements 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 collection of the 11 data points outlined in **part b.)** and the submission via unify	July 2016	20% of the indicator weighting for part b
Quarter 4	To be paid on delivering the four outcomes outlined in **part a.)**	March 31 2017	80% of the indicator weighting for part a

Rules for partial achievement

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
0 out of 4 changes introduced	No payment
1 out of 4 changes introduced	25% payment of milestone weighting part a.)
2 out of 4 changes introduced	50% payment of milestone weighting part a.)
3 out of 4 changes introduced	75% payment of milestone weighting part a.)
All 4 changes introduced	100% payment of milestone weighting part a.)

Supporting Guidance and References

https://www.gov.uk/government/publications/sugar-reduction-from-evidence-into-action

1c. Improving the Uptake of Flu Vaccinations for Front Line Clinical Staff

Indicator	
Indicator name	Improving the uptake of flu vaccinations for frontline clinical staff
Indicator weighting (% of CQUIN scheme available)	33.3% of 0.75% (0.25%)
Description of indicator	Achieving an uptake of flu vaccinations by frontline clinical staff of 75%
Numerator	Number of front line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by December 31 2016
Denominator	Total number of front line healthcare workers (permanently contracted staff and fixed term contracts)
Rationale for inclusion	Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season- a much higher incidence than expected in the general population. Influenza is also a highly transmissible infection. The patient population

Indicator	
	found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected. The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association.
Data source	Providers to submit cumulative data monthly over four months on the ImmForm website
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	December 2016
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	December 2016
Final indicator value (payment threshold)	A 75% uptake of the flu vaccination
Final indicator reporting date	As soon as possible after Q4 2016/17
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?	Yes - see partial payment section

Rules for partial achievement

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
64% or less	No payment
65% - 74% uptake of flu vaccinations	50% payment
75% or above	100% payment

Supporting Guidance and References

Practical guidance and support for Providers will be provided by the beginning of March to help support them with the introduction of the initiatives & to help them promote uptake. However, NHS Employers already offer campaign advice for Providers.

http://www.nhsemployers.org/campaigns/flu-fighter/nhs-flu-fighter

2 Timely identification and treatment of Sepsis

Note on CQUIN indicator

There are 2 parts to this CQUIN indicator:

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)	Value (£)
CQUIN 2a	Timely identification and treatment for sepsis in emergency departments	50% of 0.25% (0.125%)	
CQUIN 2b	Timely identification and treatment for sepsis in acute inpatient settings	50% of 0.25% (0.125%)	

2a. Timely identification and treatment for Sepsis in emergency departments

Indicator	
Indicator name	Timely identification and treatment for sepsis in emergency departments
Indicator weighting (% of CQUIN scheme available)	50% of 0.25% (0.125%)
Description of indicator	There are two parts to this indicator: • The percentage of patients who met the criteria for sepsis screening and were screened for sepsis • The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. The two indicators apply to adults and child 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.
Numerator	**Screening** 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. The ED screening element of 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 [4.1], but local adaptation will be needed to reflect the types of Early Warning Score in local use for children and adults. Screening for sepsis must be carried out using an appropriate tool. **Initiation of treatment and day 3 review** The number of patients sampled for case note review who: • present to ED and other wards/units that directly admit emergencies with Red Flag Sepsis or Septic Shock for whom a decision to treat with intravenous antibiotics is made, and these are administered, both within 1 hour of presenting and; • an empiric antibiotics review is carried out by a competent decision

Indicator	
	maker by day 3 of them being prescribed
Denominator	**<u>Screening</u>** Total number of patients presenting to emergency departments and other units that directly admit emergencies who were appropriate for screening for Sepsis on the basis of the above-mentioned local protocol. **<u>Initiation of treatment and day 3 review</u>** Total number of patients sampled for case note review who, in the view of the reviewer, • had recorded evidence of Red Flag Sepsis or Septic Shock on presentation at ED and other units that directly admit emergencies, or; • would have had recorded evidence of 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 intravenous antibiotics within 60 minutes of presentation.
Rationale for inclusion	Sepsis is a common and potentially life-threatening condition where the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 32,000 deaths in England attributed to Sepsis annually. Of these some estimates suggest 11,000 could have been prevented. The Parliamentary and Health Service Ombudsman (PHSO) published Time to Act in 2013 which found that recurring shortcomings in relation to the Sepsis management included: • failure to recognize the severity of the illness • inadequate first-line treatment with fluids and antibiotics • delays in administering first-line treatment • delay in source control of infection • delay in senior medical input An avoidable death of a 3 year old, also published by the PHSO in 2014 highlighted the need to improve care and pathways for patients with Sepsis. The Secretary of State announced a number of measures to improve the recognition and treatment of Sepsis in January 2015. The NCEPOD Just Say Sepsis! report also made a number of recommendations about the need for better identification and treatment of Sepsis . Problems in achieving consistent recognition and rapid treatment of Sepsis are currently thought to drive the number of preventable deaths. It is the failure to recognise the severity of the illness, or to recognise that the illness is Sepsis, until the condition has reached a state of rapid onset and consequential patient deterioration, that plays a significant role in its effects. This measure is aimed at incentivising systematic screening for Sepsis of

Indicator	
	appropriate patients in emergency departments (EDs) and in acute inpatient hospital services together with, where Sepsis is identified, timely and appropriate treatment and cessation of treatment. It 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. The local protocol (see below) should make clear which patients should be screened. This CQUIN is relevant to: a) ED element-acute hospital providers who accept emergency admissions and have one or more Emergency Departments Inpatient element-providers of acute hospital inpatient services.
Data source	**<u>Screening</u>** Provider audit of a random sample of patient records per month drawn from EDs and other units that directly admit emergencies, and where the patient WAS NOT in a 'minors' stream of ED, using calendar month of date of admission/attendance for the ED part of the scheme. The following exclusions should be applied: 1. Discard from sample all patients who do NOT require Sepsis screening according to the locally agreed protocol. 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 = do not count towards numerator total. The number of patient records randomly sampled should be sufficient to identify at least 50 patient records per month where use of the screening tool would have been appropriate i.e. to sample a larger number of patient records until at least 50 records are identified where use of the screening tool would have been appropriate. Where use of the tool would have been appropriate for fewer than 50 of the patient records, all the relevant records should be reviewed. The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions. **<u>Initiation of treatment and day 3 review</u>** Provider audit of a random sample of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) and using calendar month of date of discharge or death with the sample drawn from EDs and other units that directly admit emergencies, and where the patient WAS NOT in a 'minors' stream of ED, using calendar month of date of admission/attendance. The following rules should be used: 1. Discard from sample: • If there is clear evidence Red Flag Sepsis or Septic Shock was NOT present on admission to the provider's care; • Or if there is clear evidence of a decision NOT to actively treat

Indicator	
	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. The number of patient records randomly sampled should be sufficient to identify at least 30 patient records per month with clinical codes indicating sepsis, i.e. to sample a larger number of patient records until at least 30 records are identified with such codes. Where fewer than 30 patient records include such codes, all the relevant records should be reviewed. Assessment of the CQUIN measure per quarter will be based on the average position from the total number of records assessed from the above process in the relevant quarter. The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions. 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	Q4 2015/16
Baseline value	See section on payments
Final indicator period/date (on which payment is based)	See section on payments
Final indicator value (payment threshold)	See section on payments below for full information • Screening – national thresholds have been set for payment based on absolute performance levels. • Treatment and review – payment to be based on locally agreed levels of improvement for each quarter
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Yes – see payment section below
Final indicator	Q4, 2016/17

Indicator	
reporting date	
Are there rules for any agreed in-year milestones that result in payment?	Yes – see payment section below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see payment section below
EXIT Route	To be determined locally

2b. Timely identification and treatment for Sepsis in acute inpatient settings

Indicator	
Indicator name	Timely identification and treatment for sepsis in acute inpatient settings
Indicator weighting (% of CQUIN scheme available)	50% of 0.25% (0.125%)
Description of indicator	There are two parts to this indicator: • The percentage of patients who met the criteria for sepsis screening and were screened for sepsis • The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock and were administered intravenous antibiotics within the appropriate timeframe and had an empiric review within three days of the prescribing of antibiotics. The two indicators apply to adults and child patients who are acute hospital inpatients
Numerator	**Screening** Total number of patients sampled for case note review who were admitted to the provider's acute inpatient services that met the criteria of the local protocol and were screened for sepsis. The inpatient screening element of the CQUIN requires an established local protocol that defines which inpatients require sepsis screening. Detail on key content of the protocol is outlined below but local adaptation will be needed to reflect the types of scoring systems in local use for children and for adults. Screening for sepsis must be carried out using an appropriate tool [4.2] **Initiation of treatment and day 3 review** The total number of patients sampled for case note review: a) where a patient is newly admitted, for whom in the course of their admission a decision to treat with intravenous antibiotics is made by a competent decision-maker, and these are administered, both within 60 minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified. b) where a patient is an existing inpatient, for whom a decision to treat with intravenous antibiotics, or to change the type of antibiotics previously prescribed, is made by a competent decision-maker, and these are administered, both within 90

Indicator	
	minutes of the possibility that the patient has Red Flag Sepsis or Septic Shock was identified. AND (for both of the above categories): • an empiric antibiotics review is carried out by a competent decision maker by day 3 of them being prescribed
Denominator	**<u>Screening</u>** Total number of patients admitted to the provider's acute inpatient services who were appropriate for screening for Sepsis on the basis of the above mentioned local protocol. **<u>Initiation of treatment and day 3 review</u>** The total number of patients admitted to acute inpatient services sampled for case note review who, in the view of the reviewer, • had recorded evidence of Red Flag Sepsis or Septic Shock during their inpatient stay, or; • would have had recorded evidence of Red Flag Sepsis or Septic Shock if they had been assessed according to best practice and therefore should have been administered intravenous antibiotics within 60 minutes of presentation (90 minutes for existing inpatients).
Rationale for inclusion	As per the rationale described for the Emergency Department part of the CQUIN.
Data source	**<u>Screening</u>** Provider audit of a random sample of patient records per month drawn from all inpatient records. The following exclusions should be applied: 1. Discard from sample all patients who do NOT require Sepsis screening according to the locally agreed protocol. 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 or in the course of their inpatient stay = counts towards numerator total. 3. All other cases = do not count towards numerator total. The number of patient records randomly sampled should be sufficient to identify at least 50 patient records per month where use of the screening tool would have been appropriate i.e. to sample a larger number of patient records until at least 50 records are identified where use of the screening tool would have been appropriate. Where use of the tool would have been appropriate for fewer than 50 of the patient records, all the relevant records should be reviewed. The sampling method used should seek to ensure that a cross-section of appropriate wards are represented in the sample. The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions. **<u>Initiation of treatment and day 3 review</u>** Provider audit of a random sample of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) and using calendar month of date of discharge or death with the sample drawn

Indicator	
	from all inpatient records. The following rules should be used: 1. Discard from sample: • If there is clear evidence Red Flag Sepsis or Septic Shock was NOT present during the inpatient stay; • Or if there is clear evidence of a decision NOT to actively treat Sepsis recorded in the first hour after the possibility that the patient has Sepsis was identified (e.g. advance directive, treatment futile); Number now remaining in sample becomes denominator. 2. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ADMISSION = counts towards numerator total. 3. All other cases, including those where time of identification of Sepsis and/or time of antibiotic administration is unclear = does not count towards numerator total. The number of patient records randomly sampled should be sufficient to identify at least 30 patient records per month with clinical codes indicating sepsis, i.e. to sample a larger number of patient records until at least 30 records are identified with such codes. Where fewer than 30 patient records include such codes, all the relevant records should be reviewed. Assessment of the CQUIN measure per quarter will be based on the average position from the total number of records assessed from the above process in the relevant quarter. The data for children and for adults should be separately identified, although assessment of achievement will be based on the combined child and adult positions. 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	Q1 2016/17
Baseline value	See section on payments
Final indicator period/date (on which payment is based)	See section on payments
Final indicator value (payment threshold)	See section on payments for full information • Screening – payment to be based on establishing the baseline, achieving locally agreed levels of improvement over that baseline for Q2 and Q3, and then achievement of nationally set absolute levels of performance in Q4 • Treatment and review – payment to be based on establishing the baseline, achieving locally agreed levels of improvement over that baseline for Q2 and Q3, and then achievement of nationally set absolute levels of performance in Q4

Indicator	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See section on payments.
Final indicator reporting date	Q4, 2016/17
Are there rules for any agreed in-year milestones that result in payment?	Yes – see payment section below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see payment section below
EXIT Route	To be determined locally

Rules for in-year payments

Emergency Department Setting

Quarter	Screening		Treatment and day 3 review
Q1	Payment based on % of eligible patients (based on local protocol) screened:		15% if locally agreed Q1 target achieved.
	Less than 50.0%:	No payment	
	50.0%-89.9%:	5.0%	
	90.0% or above:	10%	
Q2	As Q1		15% of if locally agreed Q2 target achieved.
Q3	As Q1		15% if locally agreed Q3 target achieved.
Q4	As Q1		15% if locally agreed Q4 target achieved.
Full year – % of indicator weighting available	**40% (max)**		**60% (max)**

Acute Inpatient Setting

Quarter	Inpatient screening	Inpatient antibiotic administration and day 3 review.
Q1	10% if appropriate local Sepsis protocol and screening tool are in use and baseline data collection established.	15% if baseline data collection established.
Q2	10% if locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible	15% if locally agreed Q2 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.

<table>
<tr><td>Quarter</td><td colspan="2">Inpatient screening</td><td colspan="2">Inpatient antibiotic administration and day 3 review.</td></tr>
<tr><td></td><td colspan="2">after Q1 ends using data from Q1.</td><td colspan="2"></td></tr>
<tr><td>Q3</td><td colspan="2">10% if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.</td><td colspan="2">15% if locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.</td></tr>
<tr><td rowspan="4">Q4</td><td colspan="2">Payment based on the following thresholds of eligible patients screened:</td><td colspan="2">Maximum of 15% available based on the following thresholds of eligible patients received antibiotics:</td></tr>
<tr><td>Less than 50.0%:</td><td>No payment</td><td>Less than 50.0%:</td><td>No payment</td></tr>
<tr><td>50.0%-89.9%:</td><td>5%</td><td>50.0%-89.9%:</td><td>5.0%</td></tr>
<tr><td>90.0% or above:</td><td>10%</td><td>90.0% or above:</td><td>15%</td></tr>
<tr><td>Full year – % of indicator weighting available</td><td colspan="2">40% (max)</td><td colspan="2">60% (max)</td></tr>
</table>

Supporting Guidance and References

Key Components of Local Protocols

Providers should be mindful of the tools to support screening and management of Sepsis at http://sepsistrust.org/clinical-toolkit. (This includes tools to support emergency departments, acute medical units, general wards and other settings) 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 (for the ED measure);
- Exclusion of trauma patients who are likely to have ‘false positives’ in sepsis screening;
- Separate and appropriate protocols for EDs and for inpatients
- 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;
- Provision for including where a patient has other indications that they may have Red Flag Sepsis or Septic Shock (i.e. clear indications of infection, unexplained deterioration)

- Inclusion of 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.

Appropriate Tools for Sepsis Screening

Tools used should be either those produced in conjunction with relevant professional bodies at: http://sepsistrust.org/clinical-toolkit 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.

There are other examples of tools for suitable use in inpatient services at: http://sepsistrust.org/professional/professional-resources/

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

Method for Identifying Random Samples

Trusts should select ONE of the following methods and maintain this method throughout the 2016/7 year of data collection:

1. True randomisation: review the n^{th} 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 1^{st} of the month, move to 2^{nd}, then 3^{rd}, 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

Sepsis Screening in Emergency Departments
N.B. These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

	Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol	Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening	Tick column below if the patient NEEDED sepsis screening according to the 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

Antibiotic Administration in Emergency Departments

N.B. These could be separately collated for adults and for children and then then stated as a final total (although also setting out the adult and child totals) totalled into a final table).

	Tick column below if antibiotics within 60 minutes of admission were NOT indicated*	**Tick column below if antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVA, together with an empiric antibiotics review within 3 days)**	**Tick column below for all other cases, including those where time of arrival and/or time of antibiotic administration and/or an empiric antibiotics review within 3 days 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 60 minutes would NOT be indicated if:***

- *there is clear evidence 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 or (in the case of inpatients PRIOR to admission)*

Sepsis Screening in Inpatient Services

N.B. These could be separately collated for adults and for children and then stated as a final total (although also setting out the adult and child totals)

	Tick column below if the patient DID NOT NEED sepsis screening according to the local protocol	**Tick column below if the patient NEEDED sepsis screening according to the local protocol and RECEIVED sepsis screening**	**Tick column below if the patient NEEDED sepsis screening according to the 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

Antibiotic Administration in Inpatient Services

N.B. These could be separately collated for adults and for children and then totalled into a final table.

	Tick column below if any of the following are not indicated: a) a decision to treat with intravenous antibiotics is made by a competent decision-maker, and antibiotics GIVEN within 60 minutes (for new admissions) or 90 minutes (for existing inpatients) of potential sepsis being identified via use of the local protocol and tool. b) an empiric review takes place by day 3 of the antibiotics being prescribed.	**Tick column below if all of the following are indicated:** a) a decision to treat with intravenous antibiotics is made by a competent decision-maker, and antibiotics GIVEN within 60 minutes (for new admissions) or 90 minutes (for existing inpatients) of potential sepsis being identified via use of the local protocol and tool. b) an empiric review takes place by day 3 of the antibiotics being prescribed.	**Tick column below for all other cases:** including those where time of identification of potential sepsis and/or time of decision to treat and/or antibiotic administration and/or empiric antibiotics review within 3 days are 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 60 minutes would NOT be indicated if:*** • *there is clear evidence 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 or (in the case of inpatients PRIOR to admission)*

3 Antimicrobial Resistance and Antimicrobial Stewardship

Note on CQUIN scheme

There are 2 parts to this CQUIN:

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)	Value
CQUIN 3a	Reduction in antibiotic consumption per 1,000 admissions	80% of 0.25% (0.20%)	
CQUIN 3b	Empiric review of antibiotic prescriptions	20% of 0.25% (0.05%)	

3a. Reduction in antibiotic consumption

Indicator name	Reduction in antibiotic consumption per 1,000 admissions
Indicator weighting (% of CQUIN scheme available)	80% of 0.25% (0.20%)
Description of indicator	There are three parts to this indicator. 1. Total antibiotic consumption per 1,000 admissions 2. Total consumption of carbapenem per 1,000 admissions 3. Total consumption of piperacillin-tazobactam per 1,000 admissions
Numerator	Total antibiotic consumption as measured by Defined Daily Dose (DDD) Total consumption of carbapenem as measured by Defined Daily Dose (DDD) Total consumption of piperacillin-tazobactam as measured by Defined Daily Dose (DDD)
Denominator	Total admissions divided by 1,000
Rationale for inclusion	Antimicrobial resistance (AMR) has risen alarmingly over the last 40 years and inappropriate and overuse of antimicrobials is a key driver. The number of new classes of antimicrobials coming to the market has reduced

	in recent years and between 2010 and 2013, total antibiotic prescribing in England increased by 6%. This leaves the prospect of reduced treatment options when antimicrobials are life-saving and standard surgical procedures could become riskier with widespread antimicrobial resistance. An AMR CQUIN aims to reduce total antibiotic consumption measured as defined daily doses (DDDs) per 1000 admissions as well as to obtain evidence of antibiotic review within 72 hours of commencing an antibiotic. The CQUIN has two parts, the first aimed at reducing total antibiotic consumption and certain broad-spectrum antibiotics and the second focussed on antimicrobial stewardship and ensuring antibiotic review within 72 hours.
Data source	Acute trusts would submit their own antibiotic consumption data to PHE and evidence of 72 hour antibiotic review to the commissioners with admission statistics taken from Hospital Episode Statistics (HES). Antibiotic consumption data would be available for commissioners to review via a dedicated website. Antibiotic review data would be submitted from the provider to the commissioners directly to monitor progress.
Frequency of data collection	Data will be collected quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Annual
Baseline period/date	2013/14
Baseline value	As per the validated prescription data in 2013/14
Final indicator period/date (on which payment is based)	2016/17
Final indicator value (payment threshold)	Each of the indicators is worth 25% of part 3a with an additional 25% to be paid for submission of consumption data to PHE for years: 2014/15 to 2016/17 Reduction of 1% or more in total antibiotic consumption against the baseline Reduction of 1% or more in carbapenem against the baseline Reduction of 1% or more in piperacillin-tazobactam against the baseline
Final indicator reporting date	As soon as possible after Q4 2016/17
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
EXIT Route	To be determined locally

3b. Empiric review of antibiotic prescriptions

Indicator name	Empiric review of antibiotic prescriptions
Indicator weighting (% of CQUIN scheme available)	20% of 0.25% (0.05%)
Description of indicator	Percentage of antibiotic prescriptions reviewed within 72 hours
Numerator	Number of antibiotic prescriptions reviewed within 72 hours
Denominator	Number of antibiotic prescriptions included in the sample
Rationale for inclusion	Rationale is as per part 1
Data source	Local audit of a minimum of 50 antibiotic prescriptions taken from a representative sample across sites and wards.
Frequency of data collection	Monthly
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)	Based on achievement in each quarter within 2016/17
Final indicator value (payment threshold)	Based on achievement in each quarter within 2016/17 – see milestones section
Final indicator reporting date	As soon as possible after Q4 2016/17
Are there rules for any agreed in-year milestones that result in payment?	Yes - see milestones section
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No
EXIT Route	To be determined locally

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	Perform an empiric review for at least 25% of cases in the sample	End Q1	25% of 0.05% (0.0125%)
Quarter 2	Perform an empiric review for at least 50% of cases in the sample	End Q2	25% of 0.05% (0.0125%)

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	Perform an empiric review for at least 75% of cases in the sample	End Q3	25% of 0.05% (0.0125%)
Quarter 4	Perform an empiric review for at least 90% of cases in the sample	End Q3	25% of 0.05% (0.0125%)

Local CQUIN Goals for 2016/17

1 Frailty (Delirium)

Indicator number	1
Indicator name	Frailty (Delirium)
Indicator weighting	
Description of Indicator	Improvement in the recognition, treatment and prevention of delirium by implementation of a clear care pathway.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Frailty is a frequent condition with an exponential increase with age.[2] From about 10% in the population aged over 60, to 25% or more in those aged 80 and older.[3] Older people living with frailty are the highest users of services across health and social care and have the highest levels of unplanned admissions to hospital. The problem we face is that people with frailty are currently either not reliably identified or identified only when advanced frailty has developed. This leads to missed opportunities to mitigate the preventative components of frailty, to instigate proactive care models such as personalised care and support planning, and/or target geriatric resources. The Trust has a delirium pathway in place and is working across the health community to develop a care pathway. In order to drive improvements this CQUIN focuses on: Recognition – completion of CAM (Confusion Assessment Method) for all patients over 75 presenting with acute confusion (this would include those patients with a diagnosis of dementia who are currently excluded. Need to commence screening for delirium risk for all of those over the age of 75 Treatment - % of patients diagnosed with delirium (identified via coding) who are treated in line with NICE guidance. Monitored via an audit 25 cases per month. Prevention – For patients at risk, nursing care plan reflects prevention measures as per NICE e.g. nutrition and hydration, medication review, etc. Monitored via an audit 25 cases per month. This is a designated 21C Transformation Programme workstream priority.

[2] Garcia-Garcia FJ, Gutierrez Avila G, Alfaro-Acha A, et al; Toledo Study Group. The prevalence of frailty syndrome in an older population from Spain. The Toledo Study for Healthy Aging. J Nutr Health Aging 2011;15:852-6.
[3] Collard RM, Boter H, Schoevers RA, Oude Voshaar RC. Prevalence of frailty in community-dwelling older persons: a systematic review. J Am Geriatr Soc. 2012;60(8):1487-92.

	NHSE Local CQUIN menu guidance – Physical Health Goal number 21 – Frailty identification & care planning.
Data Source	Recognition – To be collected alongside Dementia assessment data by the Older Peoples Team. Treatment and Prevention – monthly audit data.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Quarter 1
Baseline value	N/A
Final indicator period/data (on which payment is based)	As per milestones
Final indicator value (payment threshold	As per milestones
Final indicator reporting date	April 2017
Are there rules for any agreed in –year milestone that result in payment?	As per milestones
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No, payment will be based on timely completion of milestones

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	Development of improvement plan which includes: - Introduction of CAM for all patients over 75 presenting with acute confusion with the target of 90% completion by the end of Q4 - Definition of at risk patients and minimum requirements for nurse care plan - Development of audit process - Roll out of Education strategy to 80% of trained clinical staff by the end of Q4 - Demonstration of reduction in the inappropriate use of antipsychotic medications for delirium by end of Q4. Collection of baseline data. To agree quarterly improvement targets for Q2, Q3 and Q4 with commissioners post receipt of baseline data.	July 16	
Quarter 2	Update on improvement plan and compliance against timescales within it. Submission of target monitoring and audit data.	November 16	

Quarter 3	Update on improvement plan and compliance against timescales within it. Submission of target monitoring and audit data.	January 17	
Quarter 4	Update on improvement plan and compliance against timescales within it. Submission of target monitoring and audit data.	April 17	

2 Carers

Indicator number	2
Indicator name	Carers
Indicator weighting	
Description of Indicator	Development and implementation of an overarching improvement plan for carers including young carers, carers for patients with learning disabilities and John's campaign which is in line with NHS England's commitment to carers published in May 2014.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	The NHS England Commitment to carers recognises that *"carers are a hugely important asset to the NHS. However, too often carers do not receive the recognition and support that they need and deserve from the NHS. We need to do more to help identify, support and recognise their vital roles".* Feedback from carers has highlighted the need to: - Recognise the role of informal carers and respond to their needs to ensure there is continuity of care for those cared for. - Ensure carers are given the choice to be involved in the care of their loved ones, and act as partners in care. - Have clear communication with carers about what they can expect, when and from whom. - Proactively provide relevant carers information & support e.g. referral for assessment, carer's allowance, attendance allowance, NHS transport reimbursement costs. - Ensure that there is carer input into staff awareness training. Involving a family carer from the moment of admission to hospital until the moment of discharge has been proven to give better quality of care and improved outcomes. It is essential to the roll out of the 21C transformation programme and community hubs that Carers' needs are recognised and they are supported. NHSE Local CQUIN menu guidance – Mental Health Goal number 17 – Dementia: Johns Campaign
Data Source	Internal improvement plan and audit data
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Quarter 1

Baseline value	N/A
Final indicator period/data (on which payment is based)	As per milestones
Final indicator value (payment threshold	As per milestones
Final indicator reporting date	April 2017
Are there rules for any agreed in –year milestone that result in payment?	As per milestones
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No, payment will be based on timely completion of milestones

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	Establish a carers working group. Sign-up to the Derbyshire Carers pledge and John's Campaign. Undertake a baseline assessment of processes and mechanisms in place to support Carers across the Trust and wider community and identify good practice elsewhere. Undertake a consultation to identify priorities for carers by linking into existing groups. Develop an improvement plan based on the above assessments, which will include key milestones including: • Multi disciplinary training and awareness • Policy development • Increase in referrals for carers assessments • Information for carers on the standards and commitment to Johns campaign Utilising all of the above information to agree Key standards for Carers which are approved by the Board.	July 16	
Quarter 2	Update on Improvement plan demonstrating improvements and compliance against agreed timescales	November 16	
Quarter 3	Update on Improvement plan demonstrating improvements and compliance against agreed timescales	January 17	
Quarter 4	Update on Improvement plan demonstrating improvements and compliance against agreed timescales Audit of key standards (agreed at end of Q1)	April 17	

3 Maternity

Indicator	
Indicator number	3
Indicator name	Reducing avoidable harm in Maternity Services
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	saving-babies-lives-car-bundle.pdf The Trust will fully implement the *Saving Babies Lives care bundle* and meet the Recommendations for the Improvement of Stillbirth and Bereavement Care in Yorkshire and the Humber. In addition to the care bundle the Trust will participate in the RCOG Each Baby Counts initiative, use the DoH Sands perinatal mortality tool (once available) and adhere to the NICE guidance on diabetes in pregnancy Saving Babies Lives brings together 4 elements of care – 1. Reducing smoking in pregnancy 2. Risk assessment and surveillance for fetal growth restriction 3. Raising awareness of reduced fetal movement 4. Effective fetal monitoring in labour
Numerator	N/A
Denominator	N/A
Rationale for inclusion	The Saving Babies Lives: A care Bundle for reducing stillbirth aims to reduce avoidable harm in maternity care in England and aligns with the Government target to reduce stillbirth by 50% by the year 2030. Local SI reports discussed at QAG (January 2016) have led to support for a local maternity CQUIN to support the Trust to implement national initiatives National commitment to halve the rates of stillbirths, neonatal and maternal deaths and intrapartum brain injuries by 2030 with a 20% reduction by 2020.
Data source	Internal improvement plan, baseline data collection, national benchmarking and audit data
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Quarter 1
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 2017
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, payment will be based on timely completion of milestones

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	Undertake a gap analysis against all of the intervention requirements as laid out in the 4 elements of the Saving babies lives care bundle Collate a baseline data position against all of the required interventions of the 4 elements of the Saving babies lives care bundle including both antepartum and intrapartum data eg – numbers of staff who have undergone CTG training, numbers of SGA babies delivered Ensure all improvements are in line with the recommendations for the Improvement of Stillbirth and Bereavement Care in Yorkshire and the Humber and that these are part of the improvement plan Gap analysis to include position against RCOG Each Baby Counts initiative, use the DoH Sands perinatal mortality tool (once available) and the NICE guidance on diabetes in pregnancy Develop and agree an improvement plan with the CCG based on the above gap analysis, which will reflect the 4 elements of the care bundle and all required interventions and include key milestones, measureable KPIs and audit requirements To carry out a case note audit of a minimum of 10 case note audits every 6 months of selected cases of SGA not detected antenatally and to add findings to the improvement plan	By end of June 2016	
Quarter 2	Update on improvement plan with exception report as required Evidence of achievement of milestones to date, KPIs and audit requirements	November 16	
Quarter 3	Update on improvement plan with exception report as required Evidence of achievement of milestones to date, KPIs and audit requirements To carry out a case note audit of a minimum of 10 case note audits every 6 months of selected cases of SGA not detected antenatally and to add findings to the improvement plan	January 17	
Quarter 4	Evidence of achievement of all improvement plan milestones, KPIs and audit requirements to fully operationalise the Saving Babies Lives care bundle by 1st April 2017.	April 17	