NHS Somerset CCG Providers CQUIN 2019/20

Introduction

A total of 1.25 % is available for CQUINs in 2019/20, with a corresponding increase in core prices, allowing more certainty around funding to invest in agreed local priorities.

CQUIN for 2019/20 will highlight evidence based good practice that is already being rolled out across the country, drawing attention through the scheme to the benefits for patients and providers, and in doing so allow those benefits to be spread more rapidly.

The payment rules for indicators within the CCG scheme have been simplified, allowing greater transparency over performance and earnings, based on achievement between lower and upper adoption goals for each supported intervention.

This document features the revisions made by NHS England to the CQUIN Indicator Specification (April 2019) as summarised below and available here.

The 2019/20 CCG CQUIN schemes comprise indicators, aligned to 4 key areas, in support of the Long Term Plan. 11 elements of good practice have been highlighted across all provider types (acute, mental health, community, ambulance etc.) with a maximum of 5 supported methods applicable to any one provider.

Prevention of Ill Health	Mental Health	Patient Safety	Best Practice Pathways
1- Antimicrobial Resistance: Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery 2 - Staff Flu Vaccinations 3 - Alcohol and Tobacco: Screening & Brief Advice	4 - Improved Discharge Follow Up 5 - Improved Data Quality and Reporting: Data Quality Maturity Index & Interventions 6 - IAPT: Use of Anxiety Disorder Specific Measures	7 - Three High Impact Actions to Prevent Hospital Falls 8 - Community Inserted PICC Lines Secured Using a SecurAcath Device	9 - Stroke 6 Month Reviews 10 - Ambulance Patient Data at Scene: Assurance & Demonstration 11 - Same Day Emergency Care – Pulmonary Embolus/ Tachycardia/ Community Acquired Pneumonia

Summary of CQUIN Indicator Schemes 2019/20

Summary of schemes relevant to Somerset Partnership (other providers and Care Homes included for information)

		Som Par	YDH	T&S	Care UK	Care Homes
Prevention of Ill Health						
1	Antimicrobial Resistance (AMR) Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery (Antibiotic Prophylaxis Orthopaedic Surgery for Care UK)	✓	✓	✓	✓	
2	Staff Flu Vaccinations and Wellbeing	✓	✓	✓	✓	✓
3	Alcohol and Tobacco (A&T) Screening & Brief Advice					
Mental Health						
4	72hr follow up post discharge	✓				
5	Data Quality Maturity Index & Interventions					
6	Use of Anxiety Disorder Specific Measures in IAPT					
Patient Safety						
7	Three high impact actions to prevent Hospital Falls	✓	✓	✓		
8	Community Placed PICC lines secured using a SecurAcath device					
Best Practice Pathways						
9	Six Month Reviews for Stroke Survivors					
10	Ambulance -Access to Patient Information at Scene Assurance & Demonstration					
11	Same Day Emergency Care (SDEC) Pulmonary Embolus, Tachycardia with Atrial Fibrillation, Community Acquired Pneumonia		✓	✓		
12	Ambulatory Care Attendance				✓	

Key

Local Variations (yellow)
Not applicable (grey)

CQUIN Table 2: Summary of Indicators

Indicator Number	Indicator Description	% of CQUIN scheme available	Financial value of Indicator (£)
1a	Antimicrobial Resistance: Lower Urinary Tract Infections in Older People	0.3125%	
1b	Antimicrobial Resistance: Antibiotic Prophylaxis in colorectal surgery (Orthopaedic Surgery for Care UK)		
2a	Staff Flu Vaccinations	0.3125%	
2b	Staff Wellbeing: Access to counselling, physio and wellbeing support		
3a	Alcohol and Tobacco: Screening		
3b	Alcohol and Tobacco: Tobacco Brief Advice		
3c	Alcohol and Tobacco: Alcohol Brief Advice		
4	Mental Health: 72hr follow up post discharge	0.3125%	
5a	Mental Health Data: Data Quality Maturity Index		
5b	Mental Health Data: Interventions		
6	Mental Health: Use of Anxiety Disorder Specific Measures in IAPT		
7	Three high impact actions to prevent Hospital Falls	0.3125%	
8	Community Placed PICC lines secured using a SecurAcath device		
9	Six Month Reviews for Stroke Survivors		
10a	Ambulance -Access to Patient Information at Scene: Assurance		
10b	Ambulance -Access to Patient Information at Scene: Demonstration		
11a	SDEC –Pulmonary Embolus		
11b	SDEC –Tachycardia with Atrial Fibrillation		
11c	SDEC –Community Acquired Pneumonia		
12	Ambulatory Care Attendance		

CQUIN Table 3: Reporting Schedule

The key dates in relation to the reporting of CQUIN evidence are shown below to assist in ensuring an accurate record of achievement each quarter.

Period	Reminder date	Submission target date
2019/20 Q1 1April-30June	29 July 2019	5 August 2019
2019/20 Q2 1Jul-30Sept	29 October 2019	5 November 2019
2019/20 Q3 1Oct-31Dec	29 January 2020	5 February 2020
2019/20 Q4 1Jan-31Mar	29 April 2020	5 May 2020

1. Antimicrobial Resistance (AMR)

There are two parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 1a	Antimicrobial Resistance: Lower Urinary Tract Infections in Older People	50% of 0.3125% (0.15625%)
CQUIN 1b	Antimicrobial Resistance: Antibiotic Prophylaxis in colorectal surgery	50% of 0.3125% (0.15625%)

Indicator 1a Antimicrobial Resistance: Lower Urinary Tract Infections in Older People

Indicator 1a	
Indicator name	1a Antimicrobial Resistance: Lower Urinary Tract Infections in Older People
Local Variations	No local variation applies to this CQUIN
Indicator weighting	50% of 0.3125% (0.15625%)
Description of indicator	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment. Exclusions: Recurrent UTI (See NICE guidance NG112) where management is antibiotic prophylaxis, pyelonephritis, catheter associated UTI, sepsis.
Numerator	Of the denominator, the number where the 4 audit criteria for diagnosis and treatment following PHE UTI diagnostic and NICE guidance (NG109) are met and recorded: 1. Diagnosis of lower UTI based on documented clinical signs or symptoms 2. Diagnosis excludes use of urine dip stick 3. Empirical antibiotic prescribed following NICE Guideline (NG109) 4. Urine sample sent to microbiology
Denominator	Total number of antibiotic prescriptions for all patients, aged 65+, with a diagnosis of Lower Urinary Tract Infection (ICD-10 codes: N39.0 and N30.0. ED code 27. SNOMED code 68226007).
Rationale for inclusion	In support of a major Long Term Plan priority of antimicrobial resistance and stewardship, four steps outlined for UTI will bring reduced inappropriate antibiotic prescribing, improved diagnosis (reducing the use of urine dip stick tests) and improved treatment and management of patients with UTI. Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay.
Data source	Data should be submitted to PHE via the online submission portal. An auditing tool is available in supporting guidance. Data will be made publicly available on the PHE Fingertips AMR Portal

Indicator 1a	
	approximately 9 weeks after each reporting period.
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 1 – June 2019 Quarter 2 – September 2019 Quarter 3 – December 2019 Quarter 4 – March 2020
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date	Quarter 4 – March 2020
Final indicator value	90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.
Final indicator reporting date	As soon as possible after Q4 2019/20
Are there milestones that result in payment?	N/A
Are there any rules for partial achievement	Yes – See Payment Calculation and Rules for Partial Achievement
2019/20 Local Variations	None required

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥90%	100% of Q4 reward
≥60% and <90%	(Performance % – 60%) / (90% – 60%) of Q4 reward
<60%	0%

Indicator 1b Antimicrobial Resistance: Antibiotic Prophylaxis in colorectal surgery

Indicator 1b	
Indicator name	1b Antimicrobial Resistance: Antibiotic Prophylaxis in Colorectal Surgery
Local Variation	A local variation applies to CareUK for this CQUIN
Indicator weighting (% of CQUIN scheme available)	50% of 0.3125% (0.15625%)
Description of indicator	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.
Numerator	Of the denominator, the number of prophylactic single dose antibiotic prescriptions that meet the NICE Guidance (NG125) regarding the choice of antibiotic.
Denominator	Total number of audited antibiotic prescriptions for inpatients, aged 18+, undergoing surgical prophylaxis for elective colorectal surgery (relevant procedural coding will be available in supporting guidance).
Rationale for inclusion	In support of a major Long Term Plan priority of antimicrobial resistance and stewardship. Implementing NICE guidance for Surgical Prophylaxis will reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines. Improvement is expected to deliver safer patient care, increase effective antibiotic use, which is expected to improve both patient mortality and length of stay.
Data source	Data should be submitted to PHE via the online submission portal. An auditing tool will be available in the supporting guidance. See further information about auditing below. Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each reporting period.
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 1 – June 2019 Quarter 2 – September 2019 Quarter 3 – December 2019 Quarter 4 – March 2020
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	Quarter 4 – March 2020

Indicator 1b	
Final indicator value (payment threshold)	90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.
Final indicator reporting date	As soon as possible after Q4 2019/20
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement?	Yes – See Payment Calculation and Rules for Partial Achievement
2019/20 Local Variations	Variation for CareUK required

Collecting quarterly data

There are two broad sources for the CQUIN indicator data:

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

For published data, the data source has been identified and links provided to allow ready access to the data.

Indicators that require data submission to the national CQUIN collection are identified by the source being the 'national CQUIN collection'. This will require supplying data on a quarterly basis by auditing relevant records, such as case notes.

It is recommended that, where available, (clinical) audit professionals within each service are contacted to assist with selecting from the approaches detailed below and to ensure local protocols are met.

Approach to auditing

In circumstances where there is no established national data that includes both numerator and denominator, then audits (sampling) of records is required to allow performance monitoring and assessment. The auditing approach will be determined by the ability to identify the population of interest (sampling frame) from electronic or paper case notes. A minimum sample of 30 records meeting the criteria is required from each quarter. Where the total cohort is less than 30 patients then all records should be audited. If information can be provided readily for all relevant records, it should be provided in preference to auditing.

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

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

Defined sampling frame
If all cases can be readily identified (i.e. those in the denominator) via searchable electronic patient records or via paper case notes then quarterly audits of a minimum, **random** sample of 30 records meeting the criteria are required. An example might be where all cases notes in a given department are relevant.

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

1. **True randomisation:** every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (e.g. http://www.random.org/) is used with 1 and x setting the lower and upper bounds. 30 cases are then identified using the random number generator from within these bounds.

2. **Quasi-randomisation**: every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x but only after the cases have been ordered in a way that doesn't have any clinical significance, for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/30, so that every 'i'th case will be selected after the first case has been randomly generated between 1 and i.

For example, for a sampling frame of 300 cases, i=300/30 =10. So the first case will be randomly selected between 1 and 10 and then the 10th case from this will be used. For example, cases 7, 17, 27, 37, 47… will be chosen.

Undefined sampling frame
If the sampling frame (i.e. the denominator) cannot be fully identified via searchable electronic patient records or via paper case notes, but instead requires reviewing each set of case notes, then it may not be feasible to use random sampling methods. Instead a quarterly audit by **Quota** sampling 30 records is required. Quota sampling is a non- random approach to case selection, where case notes are systematically searched to identify those that match the denominator. The approach is convenient and requires additional care to ensure the sample is representative. Below are examples of how quota sampling could be implemented by trusts. We acknowledge that the individual circumstances of each trust will determine the exact approach adopted. Quota sampling should ideally be avoided in preference for a random approach (see above).

Example quota sampling methods:

- **Patient ID**: If case notes are ordered purely by a randomly assigned patient ID then case notes can be searched consecutively from any position until 30 cases are identified.

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

identified, and then repeating for each subsequent day of the quarter. This can then be repeated from day 1 until 30 records have been identified.

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

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥90%	100% of Q4 reward
≥60% and <90%	(Performance % – 60%) / (90% – 60%) of Q4 reward
<60%	0%

Supporting Guidance and References

Explicit support provided by NHS I AMR Project Lead via Webinars, regional network support as well as an online support page complete with useful guidance and toolkits.

The NHS I Resources page will be updated with CQUIN specific content.

Urinary Tract Infections

- Antimicrobial Resistance – Urinary Tract Infections supporting guidance
- PHE UTI Diagnosis Guideline
- NICE Guidance NG109

Surgical Prophylaxis

- Antimicrobial Resistance – Surgical Antibiotic Prophylaxis supporting guidance
- NHSI/PHE audit tool
- NICE Guidance NG125

Policy Lead

Elizabeth Beech
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2. Staff Flu Vaccinations and Wellbeing

There are two parts to this CQUIN indicator.

National CQUIN	Indicator	Indicator weighting (% of CQUIN scheme available)
CQUIN 2a	Staff Flu Vaccinations	50% of 0.3125% (0.15625%)
CQUIN 2b	Staff Wellbeing: Access to counselling, physio and wellbeing support	50% of 0.3125% (0.15625%)

Indicator 2a Staff Flu Vaccinations

Indicator 2a	
Indicator name	2a Staff Flu Vaccinations
Local Variation	No local variation applies to this CQUIN
Indicator weighting (% of CQUIN scheme available)	50% of 0.3125% (0.15625%)
Description of indicator	Achieving an 80% uptake of flu vaccinations by frontline clinical staff. Exclusions: • Staff working in an office with no patient contact • Social care workers • Staff out of the Trust for the whole of the flu vaccination period (e.g. maternity leave, long term sickness)
Numerator	Total number of front line healthcare workers who have received their flu vaccination between 1 September 2019 and February 28th 2020.
Denominator	Total number of front line healthcare workers.
Rationale for inclusion	Staff flu vaccinations are a crucial lever for reducing the spread of flu during w inter months, where it can have a significant impact on the health of patients, staff, their families and the overall safe running of NHS services.
Data source	Monthly Provider submission (between September and February) to PHE via ImmForm. See: Guidance Data will be made publicly available approximately 6 weeks after each quarter.
Frequency of data collection	Monthly (between September and February)
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 3 – December 2019 Quarter 4 – March 2020
Baseline period/date	N/A

Indicator 2a	
Baseline value	N/A
Final indicator period/date (on which payment is based)	Quarter 4 – March 2020
Final indicator value (payment threshold)	An 80% uptake of the flu vaccinations by frontline clinical staff
Rules for calculation of payment due at final indicator period/date	See Payment Calculation and Rules for Partial Achievement
Final indicator reporting date	As soon as possible after Q4 2019/20
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement	Yes – see Payment Calculation and Rules for Partial Achievement
2019/20 Local Variations	None required

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥80%	100% of Q4 reward
≥60% and <80%	(Performance % – 60%) / (80% – 60%) of Q4 reward
<60%	0%

Supporting Guidance and References

Delivery supported by NHS I lead, with ImmForm Guidance and a seasonal campaign to drive awareness. Green Book also contains published guidance.

NICE guidance NG103

Policy Lead
Doug Gilbert Douglas.gilbert1@nhs.net

Indicator 2b Staff Wellbeing: Access to counselling, physio and wellbeing support

<table>
<tr><th colspan="2">Indicator 2b</th></tr>
<tr><td>Indicator name</td><td>Staff Wellbeing: Access to counselling, physio and wellbeing support</td></tr>
<tr><td>Local Variation</td><td>Local Variation required for all providers</td></tr>
<tr><td>Indicator weighting (% of CQUIN scheme available)</td><td>50% of 0.3125% (0.15625%)</td></tr>
<tr><td>Description of indicator</td><td>Achieving 5% of staff completing Wellbeing Champion training. Wellbeing Champions include staff trained as/in Mental Health First Aiders, Health Champions, Making Every Contact Count (MECC), Coach to Lead, Mental Health Awareness for Managers, Wellbeing Ambassadors.
(See validation requirements for Training Courses below)</td></tr>
<tr><td>Numerator</td><td>Number of Staff who completed validated Wellbeing Champion training between 1 April 2019 and 31 March 2020.</td></tr>
<tr><td>Denominator</td><td>Total number of staff.</td></tr>
<tr><td>Rationale for inclusion</td><td>There is a significant cost to the NHS of staff absence due to poor health. Evidence from staff survey and mental health studies shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and clinical outcomes for patients.

Linked to the commitments made in the Five Year Forward View around offering support to staff staying healthy, providers are encouraged to improve their role as an employer in looking after employee's health and wellbeing. The 'Staff Health and Wellbeing Framework' sets out the support that health care organisations should provide to their staff in order to promote health and wellbeing. The framework focuses on:
• Organisational enablers as the essential leadership, structural and cultural building blocks for improving staff health and wellbeing.
• Health interventions that focus support for staff in core health areas.

Wellbeing Champions within organisations are in an optimal position to improve access to support. These champions are staff that champion emotional wellbeing and positive mental health within the work setting. They drive forward positive change and support for the whole work community and break down stigma and barriers to receiving support.</td></tr>
<tr><td>Data source</td><td>Data should be submitted to Somerset CCG via email.</td></tr>
<tr><td>Frequency of data collection</td><td>Quarterly</td></tr>
<tr><td>Organisation responsible for data collection</td><td>Provider</td></tr>
</table>

Indicator 2b	
Frequency of reporting to commissioner	Quarter 1 – June 2019 Quarter 2 – September 2019 Quarter 3 – December 2019 Quarter 4 – March 2020 See information on reporting requirements below.
Baseline period/date	Total FTE Staff as at April 2019
Baseline value	Number of Staff with Wellbeing Champion training
Final indicator period/date (on which payment is based)	Quarter 4 – March 2020
Final indicator value (payment threshold)	5% of total staff completed validated Wellbeing Champion training.
Rules for calculation of payment due at final indicator period/date	See Payment Calculation and Rules for Partial Achievement
Final indicator reporting date	As soon as possible after Q4 2019/20
Are there rules for any agreed in-year milestones that result in payment?	N/A
Are there any rules for partial achievement?	Yes – See Payment Calculation and Rules for Partial Achievement
2019/20 Local Variations	Local Variation required for all providers

Training Courses

Suitable training courses must be delivered by appropriately trained professionals and course content must be evidence based and include:

- models for understanding and identifying stress and distress and the related strategies and tools to support a person to help themselves
- coaching to develop the skills and attitudes needed to be confident to have wellbeing conversations
- support for implementation of the training such as use of self-help resources and or signposting to appropriate services

Recommended Training

Connect 5 is designed to increase the confidence and skills of front line staff so that they can be most effective in having conversations with the people about mental health and wellbeing, and so help people to manage mental health problems and increase their resilience and mental wellbeing through positive changes.
Connect 5 is a three stage mental health and wellbeing training programme. Everyone trains to deliver all three stages but frontline staff may only need the basic first stage. The different stages are targeted to suit the differing roles and levels of

opportunity that workers and volunteers have to focus on people's stress, distress and difficulties; this ranges from brief wellbeing advice to extended wellbeing intervention.
National pilot evaluation of the Connect 5 cascade training programme: https://www.rsph.org.uk/about-us/news/promising-start-as-connect-5-training-targets-mental-wellbeing-taboo.html
For more info or dates, please contact Louise Finnis (LFinnis@somerset.gov.uk)

Health Champion training (RSPH): www.rsph.org.uk/event/workplace-health-champions.html

Mind Somerset Mental Health Awareness Course for managers: https://www.mindinsomerset.org.uk/training/mental-health-awareness-for-managers/

Reporting Requirements

Period	Data to be Reported
2019/20 Q1	Trusts to share Staff Wellbeing Action Plan and baseline data on number of Wellbeing Champions.
2019/20 Q2	Trusts to provide an updated Staff Wellbeing Action Plan and review of outcomes.
2019/20 Q3	Trusts to share Dashboard data including staff turnover, sickness rate, vacancy rate, staff survey and friends and family test results.
2019/20 Q4	Trusts to provide an updated Staff Wellbeing Action Plan and review of outcomes.

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥5%	100% of Q4 reward
≥0% and <5%	(Performance % – 0%) / (5% – 0%) of Q4 reward
<0%	0%

Supporting Guidance and References

NHS Employers Health and Wellbeing Framework: https://www.nhsemployers.org/your-workforce/retain-and-improve/staff-

experience/health-and-wellbeing/the-way-to-health-and-wellbeing/health-and-wellbeing-framework

Making Every Contact Count (MECC) is an approach to behaviour change that uses the millions of day to day interactions that organisations and people have with other people to support them in making positive changes to their physical and mental health and wellbeing: www.healthysomerset.co.uk/weight/2019/02/27/making-every-contact-count-mecc/

Foresight's 'Mental capital and wellbeing' project:
https://www.gov.uk/government/publications/five-ways-to-mental-wellbeing

Mental Health Foundation guide:
https://www.mentalhealth.org.uk/our-work/mental-health-workplace

Time to Change champions Campaign:
https://www.time-to-change.org.uk/champions

Skills for Health Core Skills Framework:
http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

Public Health England's Campaign Resource Centre has a multitude of downloadable resources that can be used and shared with employees:
https://campaignresources.phe.gov.uk/resources

Somerset Activity & Sports Partnership Active Workplace offer:
https://www.sasp.co.uk/active-workplace

4. Mental Health: 72hr follow up post discharge

Indicator 4	
Indicator name	Mental Health: 72hr follow up post discharge
Local Variation	No variation required
Indicator weighting (% of CQUIN scheme available)	0.3125%
Description of indicator	Achieving 80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge from a CCG commissioned service. Exclusions: Details will be provided via the ‘Mental Health CQUIN’ FutureNHS Collaboration Platform.
Numerator	Number of people discharged from a CCG commissioned adult mental health inpatient setting who have a follow up within 72hrs (commencing the day after discharge).
Denominator	Number of people discharged from a CCG commissioned adult mental health inpatient setting.
Rationale for inclusion	72 hour follow up is a key part of the work to support the Suicide prevention agenda within the Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge. By completing follow up in 3 days providers support the suicide prevention agenda, ensuring patients have both a timely and w ell- planned discharge. This activity will increase focus on improving the overall quality of support post discharge.
Data source	Routine provider submission to the Mental Health Services Data Set (MHSDS). Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the ‘Mental Health CQUIN’ FutureNHS Collaboration Platform.
Frequency of data collection	Quarter 3 and 4
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 3 – December 2019 Quarter 4 – March 2020
Baseline period/date	N/A
Baseline value	N/A

Indicator 4	
Final indicator period/date (on which payment is based)	Quarter 4 – March 2020
Final indicator value (payment threshold)	80% of adult mental health inpatients receiving a follow-up within 72hrs of discharge
Final indicator reporting date	As soon as possible after Q4 2019/20
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 Payment Calculation and Rules for Partial Achievement
2019/20 Local Variation	No variation required

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥80%	100% of Q4 reward
≥50% and <80%	(Performance % – 50%) / (80% – 50%) of Q4 reward
<50%	0%

Supporting guidance and references

Supporting documents will be available on the MH CQUIN Future NHS Collaboration Platform. For access please contact:

Policy Lead
Belinda Yeldon
England.MHCQUIN@nhs.net

At present, NICE Guidance NG53 references the national standard of a 7 day follow up, however recent findings from The National Confidential Inquiry into Suicide and Safety in Mental Health evidences the need for a 3 day follow up.

7. Three high impact actions to prevent Hospital Falls

<table>
<tr><th colspan="2">Indicator 7</th></tr>
<tr><td>Indicator name</td><td>Three high impact actions to prevent Hospital Falls</td></tr>
<tr><td>Local Variation</td><td>No variation required</td></tr>
<tr><td>Indicator weighting (% of CQUIN scheme available)</td><td>0.3125%</td></tr>
<tr><td>Description of indicator</td><td>Achieving 80% of older inpatients receiving key falls prevention actions.

Exclusions:
• Patients who were bedfast and/or hoist dependant throughout their stay.
• Patients who die during their hospital stay.</td></tr>
<tr><td>Numerator</td><td>Number of patients from the denominator where all three specified falls prevention actions
are met and recorded:
1. Lying and standing blood pressure recorded at least once.
2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).
3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.</td></tr>
<tr><td>Denominator</td><td>Admitted patients aged over 65 years, with length of stay at least 48 hours.</td></tr>
<tr><td>Rationale for inclusion</td><td>Taking these three key actions as part of a comprehensive multidisciplinary falls intervention will result in fewer falls, bringing length of stay improvements and reduced treatment costs.
1. Lying and standing blood pressure to be recorded
2. No hypnotics or anxiolytics to be given during stay OR rationale documented
3. Mobility assessment and walking aid to be provided if required.
For a typical medium sized acute provider this would equate to around 250 fewer falls, including four fewer hip fractures and brain injuries.</td></tr>
<tr><td>Data source</td><td>Quarterly submission via National CQUIN collection – see details about auditing below.

Data will be made available approximately 6 weeks after each reporting period.</td></tr>
<tr><td>Frequency of data collection</td><td>Quarterly</td></tr>
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Indicator 7	
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarter 1 – June 2019 Quarter 2 – September 2019 Quarter 3 – December 2019 Quarter 4 – March 2020
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	Quarter 4 – March 2020
Final indicator value (payment threshold)	80% of older inpatients receiving key falls prevention actions.
Final indicator reporting date	As soon as possible after Q4 2019/20
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 Payment Calculation and Rules for Partial Achievement
2019/20 Local Variation	No variation required

Collecting Quarterly Data

There are two broad sources for the CQUIN indicator data:

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

For published data, the data source has been identified and links provided to allow ready access to the data.

Indicators that require data submission to the national CQUIN collection are identified by the source being the 'national CQUIN collection'. This will require supplying data on a quarterly basis by auditing relevant records, such as case notes.

It is recommended that, where available, (clinical) audit professionals within each service are contacted to assist with selecting from the approaches detailed below and to ensure local protocols are met.

Approach to auditing
In circumstances where there is no established national data that includes both numerator and denominator, then audits (sampling) of records is required to allow performance monitoring and assessment. The auditing approach will be determined by the ability to identify the population of interest (sampling frame) from electronic or paper case notes. A minimum sample of 30 records meeting the criteria is required from each quarter. Where the total cohort is less than 30 patients then all records should be audited. If information can be provided readily for all relevant records, it should be provided in preference to auditing.

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

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

Defined sampling frame
If all cases can be readily identified (i.e. those in the denominator) via searchable electronic patient records or via paper case notes then quarterly audits of a minimum, **random** sample of 30 records meeting the criteria are required. An example might be where all cases notes in a given department are relevant.

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

3. **True randomisation:** every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (e.g. http://www.random.org/) is used with 1 and x setting the lower and upper bounds. 30 cases are then identified using the random number generator from within these bounds.

4. **Quasi-randomisation**: every case within the sampling frame needs to be assigned a unique reference number consecutively from 1 to x but only after the cases have been ordered in a way that doesn't have any clinical significance, for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/30, so that every 'i'th case will be selected after the first case has been randomly generated between 1 and i.

For example, for a sampling frame of 300 cases, i=300/30 =10. So the first case will be randomly selected between 1 and 10 and then the 10th case from this will be used. For example, cases 7, 17, 27, 37, 47… will be chosen.

Undefined sampling frame
If the sampling frame (i.e. the denominator) cannot be fully identified via searchable electronic patient records or via paper case notes, but instead requires reviewing each set of case notes, then it may not be feasible to

use random sampling methods. Instead a quarterly audit by **Quota** sampling 30 records is required. Quota sampling is a non- random approach to case selection, where case notes are systematically searched to identify those that match the denominator. The approach is convenient and requires additional care to ensure the sample is representative. Below are examples of how quota sampling could be implemented by trusts. We acknowledge that the individual circumstances of each trust will determine the exact approach adopted. Quota sampling should ideally be avoided in preference for a random approach (see above).

Example quota sampling methods:

- **Patient ID**: If case notes are ordered purely by a randomly assigned patient ID then case notes can be searched consecutively from any position until 30 cases are identified.

- **Chronological:** If cases are chronologically ordered then case notes should be selected in a way that ensures the period is well represented. For example, searching through cases from day 1 of the quarter until a case is identified, and then repeating for each subsequent day of the quarter. This can then be repeated from day 1 until 30 records have been identified.

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

Payment Calculation and Rules for Partial Achievement

Payment in this year's scheme will reward providers based on their performance falling between the minimum and maximum thresholds for the Indicator during the applicable period (Payment basis).

Assessment takes place at the end of the scheme and calculated using the following formula:

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

Final indicator value for the partial achievement threshold	% of CQUIN scheme available for meeting final indicator value
≥80%	100% of Q4 reward
≥25% and <80%	(Performance % – 25%) / (80% – 25%) of Q4 reward
<25%	0%

Support and Information

Provided by NHS I Patient Safety Team via e-learning and various online quality improvement resources all available via the link below.

- NHS Improvement Falls Prevention Resources
- NICE Clinical Guidance CG161
- NICE Quality Standard QS86

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