Western Sussex Hospitals NHS
NHS Foundation Trust

Commissioning for Quality and Innovation (CQUIN) Schemes for 2015/16

Goal No.	Indicator Name	Contract
1	Acute Kidney Injury	CWS CCG Contract - National CQUIN
2a 2b	Sepsis Screening Sepsis Antibiotic Administration	CWS CCG Contract - National CQUIN
3a 3b 3c	Dementia – Find, Assess and Refer Dementia – Staff Training Dementia – Supporting Carers	CWS CCG Contract - National CQUIN
4	Urgent and Emergency Care – Reducing the Proportion of Avoidable Emergency Admissions to Hospital	CWS CCG Contract - National CQUIN
5	Seven Day Services	CWS CCG Contract – Local CQUIN
6	Improved care for Inpatients with Dementia	CWS CCG Contract – Local CQUIN
7	Supporting Patients during End of Life Care	CWS CCG Contract – Local CQUIN
8	Mental Capacity Assessment	CWS CCG Contract – Local CQUIN
9	Medicine Safety Thermometer	CWS CCG Contract – Local CQUIN
10	Ward Accreditation	CWS CCG Contract – Local CQUIN
D16A D16B D16C	Increase Effectiveness of Rehabilitation after Critical Illness by completing rehabilitation assessment 24 hours after admission Increase Effectiveness of Rehabilitation on discharge from Critical Care Increase Effectiveness of Rehabilitation after Critical Illness by implementing rehabilitation prescription on discharge	NHSE Contract
	Two year outcomes for infants <30 weeks gestation	NHSE Contract
	Bowel Screening	WSCC Contract
	Breast Screening	WSCC Contract
	Diabetic Eye Screening	WSCC Contract
	Community Dermatology	CWS AQP Contract

Key

CWS CCG **Coastal West Sussex Clinical Commissioning Group**
NHSE **NHS England (Specialist Services Contract)**
WSCC **West Sussex County Council (Public Health Contract)**
AQP **Any Qualified Provider**

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

	Improving the provision of information to GPs at the time of discharge will start to develop the knowledge base of GPs on AKI and will also positively impact on readmission rates for patients with AKI. Availability of the information required on discharge for compliance with the CQUIN will be dependent on the patients having received appropriate diagnosis and medication review during their admission. It is recognised that early treatment and effective risk assessment are also important in managing patients with AKI in secondary care but clinical resources regarding best practice are not yet available to support clinicians. These are currently being developed as part of the AKI programme.
Data source	Provider audit discharge summaries from patients identified by the laboratory as having AKI on current admission (using the national algorithm as defined in NHS England Patient Safety Alert 'Standardising the early detection of AKI' http://www.england.nhs.uk/2014/06/09/psa-aki/) and who have survived to discharge. Data source = discharge summary for episode of care. Audit to be undertaken by clinical staff. 100 elements to be reviewed each month; four for each of the 25 patient records (or 4 items for each relevant patient record where the total of relevant patient records is less than 25). A BAAS application has been made to request approval for quarterly totals to be submitted via UNIFY.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly. The quarterly score is produced by averaging the three monthly scores i.e. sum the numerator data across the 3 months and then divide by the sum of the denominator data for the 3 months of the quarter.
Baseline period/date	Q1
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Q4
Final indicator value (payment threshold)	See below
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See below Evidence: Summary of monthly discharge summary audit.
Final indicator reporting date	20 days after the end of Q4

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

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Audit is established and results that can serve as a baseline for improvement	31 Jul 15	10%
Quarter 2	locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1	31 Oct 15	20%
Quarter 3	locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination.	31 Jan 16	20%
Quarter 4	Achievement of required key items in discharge summaries, subject to partial achievement rules in table below	30 Apr 16	50%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
49.9% or less of required key items included in discharge summaries	No payment
50.0% to 69.9% of required key items included in discharge summaries	10% of whole-year AKI CQUIN value
70.0% to 79.9% of required key items included in discharge summaries	20% of whole-year AKI CQUIN value
80.0% to 89.9% of required key items included in discharge summaries	35% of whole-year AKI CQUIN value
90.0% or above of required key items included in discharge summaries	50% of whole-year AKI CQUIN value

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

Goal name	Physical Health - Sepsis Screening
Indicator number	2a
Indicator name	**Sepsis Screening**
Indicator weighting (% of CQUIN scheme available)	0.125% (2a and 2b total 0.25%)
Description of indicator	This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. This CQUIN is focussed on incentivising the screening of a specified group of adult and child patients in emergency departments and other units that directly admit emergencies. It is important to note 2a is not aimed at incentivising sepsis screening for all emergency patients, as there are clinical reasons why screening is unnecessary or misleading in some patient groups. This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.
Numerator	The CQUIN requires an established local protocol that defines which emergency patients require sepsis screening. Detail on key content of the protocol is outlined below [Note A], but local adaptation will be needed to reflect the types of Early Warning Score in local use for children and adults. The numerator for 2a (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies who met the criteria of the local protocol and were screened for sepsis. Screening for sepsis must be carried out using an appropriate tool [Note B].
Denominator	The denominator for (screening) is the total number of patients presenting to emergency departments and other units that directly admit emergencies and who require screening for sepsis according to the agreed local protocol.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought

	to contribute to the number of preventable deaths from sepsis.
Data source	Provider audit of a random sample [see Note C] of 50 sets of patient records per month. The following rules should be used: 1. Discard from sample all patients who do NOT require sepsis screening according to locally agreed protocol [see Note A]. Number now remaining in sample becomes denominator. 2. Of the remaining patients who required sepsis screening, record the proportion who were screened for sepsis as part of the admission process = counts towards numerator total. 3. All other cases = does not count towards numerator total. Data source = sample drawn from all patient records where the patient presented at emergency departments and other units that directly admit emergencies and WAS NOT in 'minors' stream of ED using calendar month of date of admission/attendance. Audit undertaken by nursing staff but consultant advice sought if needed. A BAAS application has been made to request approval for the quarterly data totals to be submitted via UNIFY.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q1 for 2a (screening)
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	For rules of calculation see below. All quarterly figures to be a simple average of the three individual months' percentage completed. Evidence: Summary of that quarter's monthly audits.
Final indicator reporting date	20 days after the end of the quarter.
Are there rules for any agreed in-year milestones that result in payment	Yes, see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see below Q2 and Q3 targets should be locally set so as to reward genuine attempts to improve performance when providers are starting from a low base.

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	appropriate local sepsis protocol and screening tool are in use and baseline data collection established	31 Jul 15	10%
Quarter 2	locally agreed Q2 target of improvement from baseline achieved. Q2 target must be set as soon as possible after Q1 ends using data from Q1	31 Oct 15	10%
Quarter 3	locally agreed Q3 target of improvement from baseline achieved. This can be based on Q1 and/or Q2 performance according to local determination	31 Jan 16	10%
Quarter 4	subject to partial achievement rules in table below	30 Apr 16	20%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
49.9% or less of eligible patients screened	No payment
50.0% to 69.9% of eligible patients screened	5% of whole-year sepsis CQUIN value
70.0% to 79.9% of eligible patients screened	10% of whole-year sepsis CQUIN value
80.0% to 89.9% of eligible patients screened	15% of whole-year sepsis CQUIN value
90.0% or above of eligible patients screened	20% of whole-year sepsis CQUIN value

Goal name	Physical Health - Sepsis Antibiotic Administration
Indicator number	2b
Indicator name	**Sepsis Antibiotic Administration**
Indicator weighting (% of CQUIN scheme available)	0.125% (2a and 2b total 0.25%)
Description of indicator	This CQUIN focusses on patients arriving in the hospital via the Emergency Department (ED) or by direct emergency admission to any other unit (e.g. Medical Assessment Unit) or acute ward. It seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. 2b relies on administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies. This CQUIN is relevant to acute hospital providers who accept emergency admissions and have one or more Emergency Departments.
Numerator	The numerator is the number of patients who present to emergency departments and other wards/units that directly admit emergencies with severe sepsis, Red Flag Sepsis or Septic Shock (as identified retrospectively via case note review of patients with clinical codes for sepsis) and who received intravenous antibiotics within 1 hour of presenting.
Denominator	The denominator is the total number of patients sampled for case note review who, in the view of the reviewer, had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock on presentation at emergency departments and other units that directly admit emergencies, or would have had recorded evidence of severe sepsis, Red Flag Sepsis or Septic Shock if they had been assessed according to best practice (early warning score and sepsis screening) and therefore should have been administered i/v antibiotics within an hour of presentation.
Rationale for inclusion	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.
Data source	Provider audit of patient records per month where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41). Where 30 or fewer patient records include these codes, all the relevant records should be reviewed. If more than 30 patient records include these codes, a random sample [see Note C] of 30 sets of patient records should be reviewed.

	This should be a separate audit to 2a. The following rules should be used: 1. Discard from sample: • If there is clear evidence severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the trust's care; • Or if there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile); • Or if an appropriate antibiotic was given PRIOR to arrival at the emergency department or other units that directly admit emergencies. Number now remaining in sample becomes denominator. 2. If antibiotics clearly recorded as GIVEN within 60 minutes or less of recorded time of ARRIVAL (not time of triage) = counts towards numerator total. 3. All other cases, including those where time of arrival and/or time of antibiotic administration is unclear = does not count towards numerator total. Data source = random sample [see Note C] drawn from all patient records where clinical codes indicate sepsis (currently ICD-10 codes A40 and A41) using calendar month of date of discharge or death. Audit undertaken by consultant staff.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q2
Baseline value	To be locally identified immediately following the first quarter of each data collection using data from that quarter.
Final indicator period/date (on which payment is based)	Proportion of value allocated to each quarter – see details below.
Final indicator value (payment threshold)	Proportion of value allocated to each quarter – see details below.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	For rules of calculation see below. All quarterly figures to be a simple average of the three individual months' percentage completed. Evidence: Summary of that quarter's monthly audits.
Final indicator reporting date	20 days after the end of the quarter.

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

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	N/A	31 Jul 15	0%
Quarter 2	baseline data collection established	31 Oct 15	10%
Quarter 3	locally agreed Q3 target of improvement from baseline achieved. Q3 target must be set as soon as possible after Q2 ends using data from Q2	31 Jan 16	20%
Quarter 4	subject to partial achievement rules in table below	30 Apr 16	20%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Final indicator value (payment threshold)	% of CQUIN scheme available
49.9% or less of eligible patients screened	No payment
50.0% to 69.9% of eligible patients screened	5% of whole-year sepsis CQUIN value
70.0% to 79.9% of eligible patients screened	10% of whole-year sepsis CQUIN value
80.0% to 89.9% of eligible patients screened	15% of whole-year sepsis CQUIN value

Goal name	Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)
Indicator number	3a
Indicator name	**Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)**
Indicator weighting (% of CQUIN scheme available)	0.15% (60% of 0.25%)
Description of indicator	i. The proportion of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to either hospital or community services; ii. The proportion of those identified as potentially having dementia or delirium who are appropriately assessed; iii. The proportion of those identified, assessed and referred for further diagnostic advice in line with local pathways agreed with commissioners, who have a written care plan on discharge which is shared with the patient's GP. Each patient's emergency, unplanned episode of care can be included only once in each indicator but not necessarily in the same month, as the identification, assessment and *care plan on discharge* stages may take place in different months. Each patient's emergency, unplanned episode of care is to be viewed from the patient's perspective. If a patient is admitted to provider A and transfers to provider B during their episode of care, the patient's length of stay must be determined from the time of admission to provider A. Emergency unplanned care is defined as an emergency admission to hospital or urgent referral to community services which provide an alternative to hospital admission (with a response time within 24 hours). For example, intermediate care, rapid response and step up care services/teams. Care may be provided in a variety of settings including the patients' usual place of residence.
Numerator	i. Numbers of patients over 75 years old admitted or accepted for emergency unplanned care to hospital or community services, who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question, excluding those for whom the case finding question cannot be completed for clinical reasons (e.g. coma); ii. Numbers of above patients reported as having a diagnostic assessment including investigation; iii. Numbers of above patients who have a *plan of care on discharge* that is shared with general practice. The detail of the *plan of care* is to be locally determined but should include as a minimum: • A diagnosis and READ code; • Current cognitive function and recommendations for re – testing;

	• A plan to modify/ stop any anti psychotics or sedative drugs (within 3 weeks); • Recommendations for patients with delirium in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction • Recommendations for further assessment or onward referral in line with locally agreed care pathways; • A comprehensive communication plan to include all professionals/services involved; • Recommendations for liaison and communication if the usual place of residence is a care home or for carers; • Any further information to enable general practice to update plans of care for existing patients with a diagnosis of dementia; Analysis of 2014 CQUIN data returns indicate that the numbers of patients required for the provider audit per CCG would be too small to be sampled, hence a census is preferable. Commissioners will be able to submit this data to UNIFY.
Denominator	i. Numbers of patients over 75 years of age admitted or accepted for emergency unplanned care to hospital or community services, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinic reasons (e.g. coma); ii. Numbers of above patients with a clinical diagnosis of dementia and a new assessment is indicated or who have answered positively on the dementia case finding question; iii. Number of above patients who have an existing/known/already recorded diagnosis of dementia or underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive.
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	UNIFY2 and local audits (i & ii) - Providers must collect and submit data on: • The total number of patients aged 75 and over, admitted or accepted for emergency unplanned care to hospital or community services and stayed more than 72 hours; • Of these, how many a) were asked the dementia case finding question; or b) had a clinical diagnosis of delirium using locally developed protocols in line with NICE Delirium Quality Standards 4 and 5 https://www.nice.org.uk/guidance/qs63/chapter/introduction; or c) had a known diagnosis of dementia; • Of those with a clinical diagnosis of delirium or who answered positively on the dementia case finding question, how many underwent a diagnostic assessment. (iii) - Commissioners must collect and submit data on a provider audit of all the patients notes from each provider (a census), where the patient underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive

	The commissioner should report aggregated data including all providers on: • the number of patients who underwent a diagnostic assessment for dementia on whom the outcome was either positive or inconclusive (denominator); • the number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners who have a *care plan on discharge* which complies with the criteria set out in this guidance for existing patients and for newly diagnosed (numerator).
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider - (i & ii) Commissioner - (iii)
Frequency of reporting to commissioner	Monthly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	90%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider achieves target value or more for parts i and ii of the indicator at the end of each Quarter; Provider achieves target value or more for part iii of the indicator for the whole of Quarter 4.
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	Yes
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Provider achieves 90% or more for parts i and ii of the indicator at the end of each Quarter; Joint development with CCG Commissioners and other relevant partners/providers of a revised Plan of Care on Discharge to be shared with General Practice.	31 Jul 15	25% of 3a element
Quarter 2	Provider achieves 90% or more for parts i and ii of the indicator at the end of each Quarter;	31 Oct 15	25% of 3a element
Quarter 3	Provider achieves 90% or more for parts i and ii of the indicator at the end of each Quarter;	31 Jan 16	25% of 3a element
Quarter 4	Provider achieves 90% or more for parts i and ii of the indicator at the end of each Quarter; Provider achieves 90% or more for part iii of the indicator for the whole of Quarter 4	30 Apr 16	25% of 3a element
		Total	100%

Goal name	Dementia and Delirium - Staff Training
Indicator number	3b
Indicator name	**Dementia and Delirium - Staff Training**
Indicator weighting (% of CQUIN scheme available)	0.025% (10% of 0.25%)
Description of indicator	To ensure that appropriate dementia training is available to staff through a locally determined training programme.
Numerator	Number of staff suitable to receive appropriate dementia training who have received such training.
Denominator	Number of staff suitable to receive appropriate dementia training who are required to undertake mandatory refresher training during Quarters 2 to 4.
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	Training programme to be determined locally. To ensure that appropriate dementia training is available to all staff. It is recommended that the commissioning and delivery of the training programme is a collaborative effort across the local health and care economy (including care homes). Commissioners will need to agree local audit processes for the training programme but should include quarterly reports comprising: • Numbers of staff who have completed the training; • Overall percentage of staff training within each provider.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	85% of all staff identified in training plan shall have completed the training by 31 March 2016 (target to be in line with Trust target for mandatory training).
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Evidence of performance against planned training programme and target achieved.
Final indicator reporting date	April 2016
Are there rules for any agreed in-year milestones that result in payment	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Not applicable		
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Less than 5% below of Trust target	75%
Greater than 5% below of Trust target	0%

Goal name	Dementia and Delirium - Supporting Carers
Indicator number	3c
Indicator name	**Dementia and Delirium - Supporting Carers**
Indicator weighting (% of CQUIN scheme available)	0.075% (30% of 0.25%)
Description of indicator	Ensure carers of people with dementia and delirium feel adequately supported.
Numerator	NA
Denominator	NA
Rationale for inclusion	This indicator forms part of the national CQUIN which aims to incentivise providers to improve care for patients with dementia or delirium during episodes of emergency unplanned care.
Data source	Carer survey - Commissioners and providers will need to agree on the content of the survey and local processes for surveying carers of people with dementia and delirium which should cover the whole health and social care economy. The findings of the survey to presented biannually to the Provider Board.
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Biannual
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	April 2015 – March 2016
Final indicator value (payment threshold)	NA
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider must demonstrate that they have undertaken a monthly audit of carers of people with dementia to test whether they feel supported and reported the results to the Board.
Final indicator reporting date	March 2016
Are there rules for any agreed in-year milestones that result in payment	To be agreed locally - No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	To be agreed locally - No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	Not applicable		
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Urgent and Emergency Care – Reducing the Proportion of Avoidable Emergency Admissions to Hospital
Indicator number	4
Indicator name	**Urgent and Emergency Care – Reducing the Proportion of Avoidable Emergency Admissions to Hospital**
Indicator weighting (% of CQUIN scheme available)	0.50%
Description of indicator	To decrease the proportion of avoidable emergency admissions to hospital. To enable the planning and introduction of schemes to reduce avoidable emergency admissions, a comprehensive review of historical information will be designed and conducted, identifying the clinical cohorts that avoidable admissions fall under. This review will then inform a programme of work to address the identified patient groups, with an action plan and estimated impact. The plan will then be put into action, and will be programme managed throughout the year, with an on-going review of impact vs expected impact.
Numerator	n/a
Denominator	n/a
Rationale for inclusion	To ensure that patients with ambulatory care sensitive and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital. The introduction of community based preventative measures and/or improved ambulatory care services at the hospital "front door" would both be expected to have a positive impact on this indicator.
Data source	Hospital Episodes Statistics/SUS
Frequency of data collection	Monthly
Organisation responsible for data collection	Acute trust
Frequency of reporting to commissioner	To be agreed locally
Baseline period/date	2014-15
Baseline value	To be agreed locally using nationally available data
Final indicator period/date (on which payment is based)	2015-16
Final indicator value (payment threshold)	To be agreed locally at Q2, including weighting of scheme between national target areas and local improvement initiatives
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Evidence of achievement of agreed milestones
Final indicator reporting date	16 May 2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes, see table below

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	A review of the historical/baseline admissions using the methodology outlined in the CQUIN documentation, including (where available) benchmarking. This will give an understanding of the number of potentially avoidable admissions and the various clinical cohorts into which they fall. This will include consideration of the age and frailty of the patient group and external factors such as provision of services in the community e.g. Discharge to Assess project, to identify ways to reduce ambulatory care sensitive conditions being seen in an urgent care setting. This will be evidenced by a written report presented to commissioners.	31 Jul 15	25%
Quarter 2	The definition of a programme of work to address key patient groups identified in the Q1 review. This will be evidenced in the form of an action plan, with delivery dates and the estimated impact upon each patient cohort (after taking into account any historical growth).	31 Oct 15	25%
Quarter 3	Achievement of milestones outlined at Q2	31 Jan 16	25%
Quarter 4	Achievement of milestones outlined at Q2, achieving target levels of avoidable emergency admissions to hospital as agreed, conditions as outlined in the Technical Specification (referenced below) and agreed during Q2	30 Apr 16	25%
		Total	100%

Technical Specification for Indicator to Reduce the Proportion of Avoidable Emergency Admissions to Hospital

This measure is based on the admissions for diagnoses measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care and which are reflected in four NHS Outcomes Framework indicators:
2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions;
2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s;
3a Emergency admissions for acute conditions that should not usually require hospital admission;
3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs).

The review in Q1 will identify which of the conditions outlined above are appropriate for targeting based on the opportunity and ability to influence (agreed between trust and CCG).

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
90.0% or above	100% payment
80.0% to 89.9%	75% payment
70.0% to 79.9%	50% payment
50.0% to 69.9%	25% payment
49.9% or less	No payment

Goal name	Seven Day Services
Indicator number	5
Indicator name	**Seven Day Services**
Indicator weighting (% of CQUIN scheme available)	0.25%
Description of indicator	Progressive compliance with the 10 clinical standards outlined in the NHS Service Seven Days a Week paper.
Numerator	NA
Denominator	NA
Rationale for inclusion	• Alignment to CCG clinical strategy for Urgent and Proactive Care and Everyone Counts; • Supports condition for access to the Better Care Fund (BCF); Aligned to a 2 year multi-provider implementation plan for progressive whole system compliance with all clinical standards (both standards relating directly to acute services and those requiring multi-agency working with other healthcare providers i.e. SPFT & SCT).
Data source	Report / presentations to commissioners
Frequency of data collection	Quarterly
Organisation responsible for data collection	WSHFT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	n/a
Baseline value	n/a
Final indicator period/date (on which payment is based)	31 Mar 2016
Final indicator value (payment threshold)	Evidence of satisfactory performance against Provider Implementation Plan, as outlined in the milestone payment schedule below.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Evidence of progress against refreshed Provider Implementation Plan (issued Q1 2014/15)
Final indicator reporting date	20 working days after quarter end
Are there rules for any agreed in-year milestones that result in payment	Yes – see milestone table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see table below

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Continue rollout of standard 4: Shift Handovers (including a clinical information platform identifying parameters for the sickest patients) to all ward areas	31 Jul 15	25%
Quarter 2	Review of patient experience for patients admitted out of hours / at weekends (re standard 1) (survey to be repeated in Q2 2015/16) – including evidence of feedback to patients of real-time information about experience for admission in / out of hours (e.g. posters or display screens) ; Continue rollout of standard 4:	31 Oct 15	25%
Quarter 3	Continue rollout of standard 4: Standard 10 (Quality Improvement): Progress update	31 Jan 16	25%
Quarter 4	Standard 2 (time to initial assessment): a full strategic overview and needs assessment of the requirements for delivery of standard 2, including baseline assessment, proposals for robust ongoing monitoring arrangements and worked up business cases for any additional capacity or workforce that would be required to deliver standard 2.	30 Apr 16	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available

Goal name	Improved care for Inpatients with Dementia
Indicator number	6
Indicator name	**Improved care for Inpatients with Dementia**
Indicator weighting (% of CQUIN scheme available)	0.2%
Description of indicator	Continuation and embedding of the structured clinical change programme initiated in 2014/15 ensuring best practice regarding the treatment and optimising patient experience for high risk dementia patients at WSHFT.
Numerator	n/a
Denominator	n/a
Rationale for inclusion	Because of the extreme elderly patient-mix at WSHFT, dementia care is of paramount importance. Delivery of sustained improvements for patients suffering from dementia addresses the following priorities: • Improvement in the quality of care for a vulnerable group of patients; • Alignment to CCG clinical strategy for Urgent and Proactive Care; • Improves patient experience and supports self-management of care; • Reinforcement of need to plan for discharge from point of admission, to include other agencies to facilitate timely discharge e.g. social care and/or community based AHP input. Key Principles for Scheme design: Setting and complying with revised set of standards – developed from the “Knowing Me” project - for improved patient and carer experience in acute hospital setting aimed at improving the overall quality of care offered to patients with Dementia, including improvements in the discharge process, ways of increasing the knowledge of an increasing workforce e.g. staff awareness training and appointment of Dementia champions and reducing unnecessary time spent in a hospital setting.
Data source	Report / presentations to commissioners
Frequency of data collection	Monthly
Organisation responsible for data collection	WSHFT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	n/a
Baseline value	n/a
Final indicator period/date (on which payment is based)	Full year 2015/16
Final indicator value (payment threshold)	Full implementation of Trust Dementia Action Plan - developed from the “Knowing Me” project to include: • Improved linkage with proactive care and the dementia crisis teams to ensure that discharge planning is instigated on

	admission; • Ensuring Knowing Me document is completed; • Continued emphasis on avoiding ward moves for dementia patients not related to the patients' clinical need with the aim of reducing avoidable night-moves to zero.
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Yes, see table below.
Final indicator reporting date	31 April 2016
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	1. All night-time ward moves subject to review by the Dementia Matron and General Manager responsible for co-ordination of the site team to identify whether the patients' condition was considered as part of the decision making process and whether the move could have been avoided. 2. Identification of Dementia Champions for all key wards likely to receive dementia patient. 3. Continuation of 2014/15 measures (Knowing Me audits, Carers survey, use of patient flag for dementia patients / alerts to proactive care).	31 Jul 15	25%
Quarter 2	1. All night-time ward moves subject to review by the Dementia Matron and General Manager responsible for co-ordination of the site team. 2. Roll-out of 'structured mealtimes' for dementia patients to key areas receiving dementia patients (includes staff training, establishing dining areas with tables, engagement of volunteer support). 3. Continuation of 2014/15 measures (Knowing Me audits, Carers survey, use of patient flag for dementia patients / alerts to proactive care).	31 Oct 15	25%
Quarter 3	1. All night-time ward moves subject to review by the Dementia Matron and General Manager responsible for co-ordination of the site team 2. Continuation of 'structured mealtimes' for dementia patients' programme. 3. Roll-out of dementia friendly ward redevelopment (redecoration in dementia colours, pictures of nature, signage) to two further ward areas.	31 Jan 16	25%

	4. Continuation of 2014/15 measures (Knowing Me audits, Carers survey, use of patient flag for dementia patients / alerts to proactive care).		
Quarter 4	1. All night-time ward moves subject to review by the Dementia Matron and General Manager responsible for co-ordination of the site team 2. Continuation of 'structured mealtimes' for dementia patients' programme. 3. Continuation of 2014/15 measures (Knowing Me audits, Carers survey, use of patient flag for dementia patients / alerts to proactive care).	30 Apr 16	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Supporting Patients during End of Life Care(2 year CQUIN)
Indicator number	7
Indicator name	**Supporting Patients during End of Life Care**
Indicator weighting (% of CQUIN scheme available)	0.2%
Description of indicator	Supporting patients by improving consistent levels of identification of those nearing the end of their life (i.e. it is anticipated that they will die within approx. 1 year or weeks / days). Patients who are identified as at end of life (weeks / days) will have an individualised care plan completed. Patients recognised as possibly nearing the end of their life (months or year) will be offered the support to complete an advance care plan, be entered on to the EPaCCS register and details of the ACP uploaded to the universal care plan (when in place). Patient and carer experience will be improved by increased staff knowledge and confidence to communicate about EOL issues and offer support with advance care planning.
Numerator	1. Number of staff who have accessed the *'Care in the last days and hours of life'* training 2. Number of staff who have accessed '*Sage and thyme communications skills'* training 3. Number of patients identified as receiving end of life care who die in hospital and have an individualised care plan 4. Number of patients with Palliative Care Team involvement offered advance care planning
Denominator	1. Number of staff identified in the training plan as being appropriate to receive '*Care in the last days and hours of life'* training 2. Number of staff identified in the training plan as being appropriate to receive '*Sage and thyme communications skills'* training 3. Number of patients identified as receiving end of life care who die in hospital 4. Number of patients with Palliative Care Team involvement that it would have been appropriate to offer advance care planning
Rationale for inclusion	We currently see lower than expected levels of identification of patients at in the last year of life and 90% of the local specialist End of Life Care services are used by those with a diagnosis of cancer, despite cancer being the cause of only 26% of death's locally. Evidence identifies that locality End of Life care electronic registers (EPaCCS) improve care co-ordination and patient/carer experience and NHS IQ state that by 2015 there should be a 70% roll out of EPaCCS across England.

	It is well documented that lack of staff confidence and skills has a direct effect on the patient and carer experience. A significant number of complaints around the experience at the EOL relate to poor communication.
Data source	EPaCCs Register Training plan and outcomes of training evidence Somerset Register and Palliative Care team records
Frequency of data collection	Monthly
Organisation responsible for data collection	WSHFT palliative care team
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Q1 2015/16
Baseline value	
Final indicator period/date (on which payment is based)	Q4 2015/16
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	WSHFT Palliative Care Team to continue to be involved in the CCG led EOLC Redesign Project which encompasses the implementation of the EPaCCs register. WSHfT to contribute to the first system wide data collection for the EPaCCS register (when in place).
Final indicator reporting date	30 April 2016
Are there rules for any agreed in-year milestones that result in payment	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Q1	Training plan to be developed to identify approach to delivery of training and appropriate cohort of staff to be trained. Percentage of identified staff to receive training over year to be agreed with CCG EOLC managerial and clinical leads Identify baseline and agree quarterly targets for percentage of end of life care patients that are offered individualised care plans and/or advance care planning. Quarterly targets to be agreed with the CCG EOLC managerial and clinical leads.	31 Jul 2015	25%

Q2	Provider to develop an WSHFT EPaCCs implementation plan with timescales Evaluation of the Readmission Avoidance Pilot to understand the impact of these roles in the early identification of those patients admitted to WSHFT who are in the last year / months /weeks / days of life. Evidence of progress against Training Plan.	31 Oct 2015	25%
Q3	Evidence of progress against Training Plan.	31 Jan 2016	25%
Q4	1. Percentage of staff as agreed in Q1 to have completed '*Care in the last days and hours of life'* training 2. Percentage of staff (as agreed in Q1) to have completed '*Sage and thyme communications skills'* training *3.* Percentage of patients (as agreed in Q1) at end of life that die in hospital and have an individualised care plan 4. Percentage of patients *(*as agreed in Q1*)* involved with Palliative Care Team to have been offered support with advance care planning.	30 Apr 2016	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available

Goal name	Mental Capacity Assessment
Indicator number	8
Indicator name	**Mental Capacity Assessment**
Indicator weighting (% of CQUIN scheme available)	0.2%
Description of indicator	To improve quality of care and to include people identified as lacking capacity in decision making about their care, either in a hospital or care setting. To increase compliance with the Mental Capacity Act 2005 in Health environments and to increase Health organisations professional expertise in the area. An audit will take place each quarter to review compliance with Mental Capacity Assessment procedures and action plans will be developed to ensure improvement. The implementation of the action plans will be monitored by the Safeguarding Group.
Numerator	Number of staff suitable to receive appropriate MCA training who have received such training.
Denominator	Number of staff suitable to receive appropriate MCA training identified in the training plan that are required to undertake mandatory refresher training during Quarters 2 to 4.
Rationale for inclusion	The implementation of the Care Act in April 2015, supports the Mental Capacity Act (2005) and the CCG have been given funding from NHS England to deliver training for MCA across the health economy to all professionals as outlined in the MCA act (2005).
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	31 March 2016
Final indicator value (payment threshold)	85% of suitable staff identified in the training plan to have received MCA training (target to be in line with Trust target for mandatory training).
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	In addition, Provider to demonstrate how training has been embedded within the culture and practices of the organisation.
Final indicator reporting date	30 April 16
Are there rules for any agreed in-year milestones that result in payment	Yes, see milestone table below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	• For the organisation to have named leads for the Mental Capacity Act • Develop training plan for identified cohort of staff to complete MCA training within the year 2015/16 • Identify monitoring approach and baseline for DoLs applications and Independent Mental Capacity Advisor (IMCA)consultations • Audit of 10 patients who have had DoLs applications or IMCA consultations to confirm compliance with Mental Capacity Assessment. Action plan to be developed from audit to ensure further improvement with Mental Capacity Assessment.	April 2015 31 Jul 15 31 Jul 15	25%
Quarter 2	• Ongoing monitoring of DoLs applications and IMCA consultations • Evidence of progress against Training Plan • Audit of 10 patients who have had DoLs applications or IMCA consultations to confirm compliance with Mental Capacity Assessment. Action plan to be developed from audit to ensure further improvement with Mental Capacity Assessment.	31 Oct 15	25%
Quarter 3	• Ongoing monitoring of DoLs applications and IMCA consultations • Evidence of progress against Training Plan • Audit of 10 patients who have had DoLs applications or IMCA consultations to confirm compliance with Mental Capacity Assessment. Action plan to be developed from audit to ensure further improvement with Mental Capacity Assessment.	31 Jan 16	25%

Quarter 4	• Provide evidence of that mental capacity awareness has been embedded within the culture and practices of the organisation.
	• 80% of staff identified in training plan to have received MCA training
	• provider to report following information (full year);
	  • Number of DOLs applications
	  • Number of IMCAs consulted
	  • Audit of 10 patients who have had DoLs applications or IMCA consultations to confirm compliance with Mental Capacity Assessment. Action plan to be developed from
		30 Apr 16	25%

	audit to ensure further improvement with Mental Capacity Assessment.		
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Less than 5% below of Trust target	75%
Greater than 5% below of Trust target	0%

Goal name	Medication Safety Thermometer
Indicator number	9
Indicator name	**Medication Safety Thermometer**
Indicator weighting (% of CQUIN scheme available)	0.2%
Description of indicator	Roll out of the Medicine Safety Thermometer during the course of 2015/16 to key wards on both sites at WSHFT. Submission of Medicine Safety Thermometer data nationally. Development of feedback loops internally to wards and clinicians and upwards reporting of performance to the Medicines Optimisation Committee. Note: key to successful uptake and utilisation of the thermometer tool is feedback from the pilot to be undertaken in quarter 1. Currently it is assumed that a small sample of patients will be audited for each participating ward. This will be reviewed as part of the pilot, with the implementation group taking a lead in defining the roll out plan. The Medicine Safety Thermometer is a more in-depth review than the main Patient Safety Thermometer and it is not thought appropriate or desirable to review all patients on all wards every month.
Numerator	Number of wards with data submissions during quarter
Denominator	Total wards as per roll-out plan due to submit data.
Rationale for inclusion	Medication errors remain a significant cause of in-hospital harm nationally and can result in severe harm and in some cases death. The NHS Safety Thermometer has proved a useful tool in monitoring and driving the reduction of harm associated with healthcare in relation to falls, pressure ulcers, UTIs associated with catheters and VTE. The Medication Safety Thermometer is a national initiative, however is currently optional. Implementation during 2015/16 as part of a wider programme to improve medicines management would support the identification of medication errors and improve prescribing practice.
Data source	Report from WSHFT (but Commissioners can confirm submission with national harm-free care team)
Frequency of data collection	Quarterly
Organisation responsible for data collection	WSHFT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Mar 15
Baseline value	0 – Currently no wards using this tool
Final indicator period/date (on which payment is based)	Qtr 4/31 Mar 16
Final indicator value (payment threshold)	Medicines Safety thermometer live on key wards (circa 70% of total wards)

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Achievement of agreed targets
Final indicator reporting date	30 Apr 16
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	1. Pilot on approx 4 wards. 2. Feedback from pilot. 3. Roll-out plan provided to commissioners with milestones for Q2, Q3, Q4	31 Jul 15	25%
Quarter 2	Roll-out to ward areas identified in roll-out plan.	31 Oct 15	25%
Quarter 3	Roll-out to ward areas identified in roll-out plan.	31 Jan 16	25%
Quarter 4	Roll-out to ward areas identified in roll-out plan.	30 Apr 16	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

Goal name	Ward Accreditation
Indicator number	10
Indicator name	**Ward Accreditation**
Indicator weighting (% of CQUIN scheme available)	0.2%
Description of indicator	To launch and undertake the first year of Ward Accreditation Programme supporting the Patient First initiative. The aim is to ensure all wards are delivering excellence across a range of measures, such as patient experience, safeguarding, patient safety, medicines management and nutrition and hydration. The Trust has set a goal of all wards achieving ward accreditation status by 2017.
Numerator	
Denominator	
Rationale for inclusion	Delivering high quality and appropriate care to patients is of paramount importance. The Trust must account for the quality of care it delivers to patients and that care should be evidence based and appropriate to the needs of the patient. Measuring the quality of nursing care delivered by individuals and teams is not easy. This performance framework, based on the Trust's 'We Care' approach to service delivery, incorporates care and compassion standards and key clinical indicators, whilst providing evidence for the Care Quality Commission's fundamental standards. A key element of ward accreditation includes review and understanding ward level performance metrics (incidents, friends and family test data, complaints, metal capacity act training) on a regular basis as part of daily safety huddles. The framework is designed around 14 standards with each one being subdivided into 3 elements; Environment, Care and Leadership. Each standard will correlate to one or more aspects of 'We Care' and this will be denoted on the heading of each standard. The 14 standards are: 1. **Organisation and Management of the Clinical Area.** The clinical area is effectively managed and organized in a way that benefits patients, staff and visitors. 2. **Safeguarding Patients.** Patients feel safe, secure and supported with experiences that promote clear pathways to well-being. 3. **Pain Management.** A pain management plan will be developed with the patient by the medical and nursing team aiming to control the pain with consideration of risks-benefits**.** 4. **Patient Safety.** Patient's vital signs are observed and any deterioration is documented and communicated to medical staff. 5. **Environmental Safety.** The environment is safe for patients,

	staff and visitors. 6. **Nutrition and Hydration.** Patients are enabled to consume food (orally) and fluids which meets their individual needs. 7. **End of Life Care.** Patients have control over their own health care and promote independence. 8. **Medicines Management.** Avoidable patient harm in relation to medicine management will be eliminated. 9. **Person Centered Care.** Every patient is treated as an individual, with compassion all of the time. 10. **Pressure Ulcers.** The condition of the patient's skin will be maintained or improved. 11. **Elimination.** Patient's bladder and bowel needs are met. 12. **Communication.** Patient and carers experience effective communication, sensitive to their individual needs and preferences, which promote high quality care for the patient. (This includes written communication). 13. **Infection Control.** Patients are cared for in a clean environment and staff demonstrate good infection control practice. 14. **Staff Safety**
Data source	Provider report
Frequency of data collection	Quarterly
Organisation responsible for data collection	WSHFT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Mar 15
Baseline value	0 – Currently no wards using this tool
Final indicator period/date (on which payment is based)	Qtr 4/31 Mar 16
Final indicator value (payment threshold)	Achievement of agreed targets in Provider Implementation Plan
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider progress report
Final indicator reporting date	30 Apr 16
Are there rules for any agreed in-year milestones that result in payment	Yes, see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Quarter 1	Submission of Provider Implementation Plan and evidence of progress against Plan.	31 Jul 15	25%
Quarter 2	Evidence of progress against Plan.	31 Oct 15	25%
Quarter 3	Evidence of progress against Plan.	31 Jan 16	25%
Quarter 4	Evidence of progress against Plan.	30 Apr 16	25%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	

CQUIN 2015/16	
Indicator number	D16 A Trauma & Head Scheme 1 Adult Critical Care
Indicator name	**Increase Effectiveness of Rehabilitation after Critical Illness by completion of rehabilitation assessment 24 hrs after admission**
Indicator weighting (% of CQUIN scheme available)	*To be determined by Area Team*
Description of indicator	Completion of an assessment of patient's rehabilitation needs 24hrs after admission to Critical Care.
Numerator	The number of admitted patients to Critical Care recorded as having rehabilitation assessment at 24hrs in Case-mix Programme.
Denominator	All adult patients admitted to Case-mix Programme.
Rationale for inclusion	NICE 83 stipulates 24hr assessment of needs.
Data source	ICNARC CMP
Frequency of data collection	Data will be collected by ICNARC quarterly.
Organisation responsible for data collection	ICNARC and Provider Trust
Frequency of reporting to Commissioner	Quarterly in line with standard CQUIN reporting timelines
Baseline period/date	Q1 & 2 2013/ 2014 data
Baseline value	To be confirmed to Area Team by Provider Trust
Final indicator period/date (on which payment is based)	Q4 2015
Final indicator value (payment threshold)	95% achievement
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to Commissioner)	Data has to be submitted to ICNARC for all patients.
Final indicator reporting date	Q4 flex
Are there rules for any agreed in-year milestones that result in payment	Yes
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No paid on all or nothing basis

Indicator number	D16 B
Indicator name	**Increase Effectiveness of Rehabilitation on discharge from Critical Care**
Indicator weighting (% of CQUIN scheme available)	To be determined by Area Team
Description of indicator	Assessment of rehabilitation needs for all patients on discharge from Critical Care.

Numerator	The number of patients who have an assessment recorded at discharge from Critical Care.
Denominator	All survivors in Case-mix Programme.
Rationale for inclusion	NICE 83 identifies the need for the rehabilitation assessment to be repeated on discharge from Critical Care.
Data source	ICNARC CMP
Frequency of data collection	Data will be collected by ICNARC quarterly.
Organisation responsible for data collection	ICNARC and Provider Trust
Frequency of reporting to Commissioner	Quarterly in line with standard CQUIN reporting timelines
Baseline period/date	Q1 & Q2 2013/2014 data
Baseline value	To be confirmed to Area Team by Provider Trust based on Q1 data
Final indicator period/date (on which payment is based)	Q4 2015
Final indicator value (payment threshold)	95% achievement
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to Commissioner)	Data has to be submitted to ICNARC for all patients.
Final indicator reporting date	Q4 flex data
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 paid on all or nothing basis

Indicator number	D16 C
Indicator name	**Increase Effectiveness of Rehabilitation after Critical Illness by implementing rehabilitation prescription on discharge**
Indicator weighting (% of CQUIN scheme available)	To be determined by Area Team
Description of indicator	Implementation of Rehabilitation Prescription for all patients on discharge from Critical Care.
Numerator	Number of patients recorded as having rehabilitation prescription on discharge from Critical Care.
Denominator	Number of survivors at discharge from Critical Care recorded in Case-mix Programme.
Rationale for inclusion	NICE 83 identifies the need for a structured rehabilitation prescription for each patients on discharge from Critical Care.
Data source	ICNARC CMP
Frequency of data collection	Data will be collected by ICNARC quarterly.

Organisation responsible for data collection	ICNARC and Provider Trust
Frequency of reporting to Commissioner	Quarterly in line with standard CQUIN reporting timelines
Baseline period/date	Q1 & Q2 2013/2014 data
Baseline value	To be confirmed to Area Team by Provider Trust based on Q1 data
Final indicator period/date (on which payment is based)	Q4 2015
Final indicator value (payment threshold)	95% achievement
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to Commissioner)	Data has to be submitted to ICNARC for all patients
Final indicator reporting date	Q4 2015
Are there rules for any agreed in-year milestones that result in payment	No
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No all or nothing payment

CQUIN 2015/16	
Indicator number	Women & Children Scheme 1 ACF Template Service specification reference :
Indicator name	**Two Year outcomes for infants <30 weeks gestation**
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	To achieve an improvement in recording of developmental and health outcomes of preterm infants <30 weeks gestation at birth to inform neonatal practice development
Numerator	All infants <30 weeks gestation at birth, discharged home from that Provider who remain alive at 2 years corrected age who have data entered in the Neuromotor, Malformations, Social, Resp/CVS, GI, Renal, Neurology, Auditory, Vision and Communication fields in the BadgerNet 2 year follow up data fields
Denominator	All infants <30 weeks gestation at birth, discharged home from that Provider who remain alive at 2 years corrected age
Rationale for inclusion	Annual and rolling health and developmental outcome data of extreme preterm infants are highly important measures of the quality and effectiveness of neonatal services in addition to providing crucial information for parents of babies admitted
Data source	BadgerNet database or alternative internal data source
Frequency of data collection	Data to be entered from one health and developmental assessment performed at any time between 22 months corrected age and the child's 3rd birthday
Organisation responsible for data collection	Individual Trust
Frequency of reporting to commissioner	Quarterly. Individual children's data should be submitted in the quarter in which their third birthday falls
Baseline period/date	BadgerNet (by Clevermed) or alternative internal data source recordings for 2012/13
Baseline value	
Final indicator period/date (on which payment is based)	Full year 1st April 2015 – 31st March 2016 (year 1), full year 1st April 2016 – 31st March 2017 (year 2), Full year 1st April 2017 – 31st March 2018 (year 3)
Final indicator value (payment threshold)	A minimum target of 40% of eligible babies having data recorded in year 1, 60% in year 2 and 75% in year 3 for full payment
Final indicator reporting date	31st March 2018
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?	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	The Provider must submit the following: Numerator and denominator data for babies <30 weeks gestation discharged home from that Provider whose 3rd birthday falls in that quarter (as per final indicator value)		25% for full data reporting (as per final indicator value)
Quarter 2	The Provider must submit the following: Numerator and denominator data for babies <30 weeks gestation discharged home from that Provider whose 3rd birthday falls in that quarter (as per final indicator value)		25% for full data reporting (as per final indicator value)
Quarter 3	The Provider must submit the following: Numerator and denominator data for babies <30 weeks gestation discharged home from that Provider whose 3rd birthday falls in that quarter (as per final indicator value)		25% for full data reporting (as per final indicator value)
Quarter 4	The Provider must submit the following: Numerator and denominator data for babies <30 weeks gestation discharged home from that Provider whose 3rd birthday falls in that quarter (as per final indicator value)		25% for full data reporting (as per final indicator value)

Provider – Western Sussex Hospitals Trust, Bowel Cancer Screening Service	
Indicator	
Indicator number	
Indicator name	**Bowel Screening**
Indicator weighting (% of CQUIN scheme available)	2.5%
Description of indicator	To undertake a baseline Health Equity Audit and develop an action plan to tackle inequities, focussing on ethnicity, learning difficulties and socioeconomic deprivation
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	In order to address inequalities in uptake, services need to understand the profile of their population, and uptake in different groups. This is the first step to developing an action plan
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider and PHE
Frequency of reporting to commissioner	Quarterly – Initially through Screening and Immunisation Programme Management Board meetings and then reported to the contracting meetings
Baseline period/date	
Baseline value	– with CQUIN
Final indicator period/date (on which payment is based)	To review uptake and outcome of Bowel Screening and its variations in population subgroups by, area and socioeconomic status, ethnicity, age and gender; learning difficulties (not exhaustive other subgroups need to be considered). To work closely with the local Public Health team at the Council, and PHE Screening and Immunisation team to agree the methodology and to access appropriate data related to the population to support the data held by the screening programme as part of the review. To prepare a health inequalities report with a service improvement plan
Final indicator value (payment threshold)	Not Applicable
Final indicator reporting date	30th June 2016 (Presented to next PMB following this date)
Are there rules for any agreed in-year milestones that result in payment?	Please see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Not applicable

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 2	Scope the and develop audit report	At the PMB meeting after the end of Q2 2015/16. Scheduled as an agenda item	
Quarter 3	First draft and update report to contract meeting.	At the PMB meeting after the end of Q3 2015/16. Scheduled as an agenda item	50% of payment
Quarter 4	Present Audit Report. Report should demonstrate any health inequalities identified whilst undertaking the audit, and recommendations and actions to help reduce the inequality gaps which will improve overall uptake.	At the PMB meeting after the end of Q4 2015/16. Scheduled as an agenda item	75% of payment
Quarter 4	Final report and action plan to be tabled at contract meeting.	At the PMB meeting after the end of Q1 2016/17. Scheduled as an agenda item	100% of payment

Provider – Western Sussex Hospitals Trust, Breast Cancer Screening Service	
Indicator	
Indicator number	
Indicator name	**Breast Screening**
Indicator weighting (% of CQUIN scheme available)	2.5%
Description of indicator	To undertake a baseline Health Equity Audit and develop an action plan to tackle inequities, focussing on ethnicity, learning difficulties and socioeconomic deprivation
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	In order to address inequalities in uptake, services need to understand the profile of their population, and uptake in different groups. This is the first step to developing an action plan
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider and PHE
Frequency of reporting to commissioner	Quarterly – Initially through Screening and Immunisation Programme Management Board meetings and then reported to the contracting meetings
Baseline period/date	
Baseline value	– with CQUIN
Final indicator period/date (on which payment is based)	To review uptake and outcome of Breast screening and its variations in population subgroups by, area and socioeconomic status, ethnicity, age and gender; learning difficulties (not exhaustive other subgroups need to be considered). To work closely with the local Public Health team at the Council, and PHE Screening and Immunisation team to agree the methodology and to access appropriate data related to the population to support the data held by the screening programme as part of the review. To prepare a health inequalities report with a service improvement plan
Final indicator value (payment threshold)	Not Applicable
Final indicator reporting date	30th June 2016 (Presented to next PMB following this date)
Are there rules for any agreed in-year milestones that result in payment?	Please see below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Not applicable

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 2	Scope the and develop audit report	At the PMB meeting after the end of Q2 2015/16. Scheduled as an agenda item	
Quarter 3	First draft and update report to contract meeting.	At the PMB meeting after the end of Q3 2015/16. Scheduled as an agenda item	50% of payment
Quarter 4	Present Audit Report. Final report should demonstrate any health inequalities identified whilst undertaking the audit, and recommendations and actions to help reduce the inequality gaps which will improve overall uptake.	At the PMB meeting after the end of Q4 2015/16. Scheduled as an agenda item	75% of payment
Quarter 4	Final report and action plan to be tabled at contract meeting.	At the PMB meeting after the end of Q1 2016/17. Scheduled as an agenda item	100% of payment

Provider – Western Sussex Hospitals Trust, Diabetic Eye Screening Programme	
Indicator	
Indicator number	
Indicator name	**Diabetic Eye Screening Programme**
Indicator weighting (% of CQUIN scheme available)	2.5%
Description of indicator	To undertake a baseline Health Equity Audit and develop an action plan to tackle inequities, focussing on ethnicity, learning difficulties and socioeconomic deprivation
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	In order to address inequalities in uptake, services need to understand the profile of their population, and uptake in different groups. This is the first step to developing an action plan
Data source	Provider
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider and PHE
Frequency of reporting to commissioner	Quarterly – Initially through Screening and Immunisation Programme Management Board meetings and then reported to the contracting meetings
Baseline period/date	
Baseline value	– with
Final indicator period/date (on which payment is based)	To review uptake and outcome of Diabetic Eye Screening Programme and its variations in population subgroups by, area and socioeconomic status, ethnicity, age and gender; learning difficulties (not exhaustive other subgroups need to be considered). To work closely with the local Public Health team at the Council, and PHE Screening and Immunisation team to agree the methodology and to access appropriate data related to the population to support the data held by the screening programme as part of the review. To prepare a health inequalities report with a service improvement plan
Final indicator value (payment threshold)	Not Applicable
Final indicator reporting date	30th June 2016 (Presented to next PMB following this date)
Are there rules for any agreed in-year milestones that result in payment?	Please see below

Are there any rules for partial achievement of the indicator at the final indicator period/date?	Not applicable

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 2	Scope the and develop audit report	At the PMB meeting after the end of Q2 2015/16. Scheduled as an agenda item	
Quarter 3	First draft and update report to contract meeting.	At the PMB meeting after the end of Q3 2015/16. Scheduled as an agenda item	50% of payment
Quarter 4	Present Audit Report. Final report should demonstrate any health inequalities identified whilst undertaking the audit, and recommendations and actions to help reduce the inequality gaps which will improve overall uptake.	At the PMB meeting after the end of Q4 2015/16. Scheduled as an agenda item	75% of payment
Quarter 4	Final report and action plan to be tabled at contract meeting.	At the PMB meeting after the end of Q1 2016/17. Scheduled as an agenda item	100% of payment

Goal name	Shared Decision Making and supporting patients to self-care
Indicator number	
Indicator name	**Community Dermatology: Shared Decision Making and supporting patients to self-care**
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	Shared Decision Making (SDM) is where a patient and clinician jointly engage in the decision making process to choose a treatment, screening option or self-management programme, which is consistent with the patient's values and preferences. Working in partnership with the CCG to support patients to self-care. This may involve the use of effective sign-posting, including to our voluntary sector partners. This may also involve investment in evidence-based approaches such as group-based education for people with specific conditions and/or self-management educational courses.
Numerator	
Denominator	
Rationale for inclusion	Shared decision making forms part of a national work stream in the DH Quality Innovation Productivity and Prevention programme (QIPP). Evidence has shown that the best way to support patients to self-care is through a personalised care plan. A care plan is an agreement between a patient and their health professional (or social services) to help patients to manage their health day to day. It can be a written document or simply a statement recorded in patient notes. The care plan is primarily designed to help the patient and is not restricted in its content, A care plan may include, but is not limited to: • Personal Goals the patient is working towards • Details of clinical tasks, including where patients and clinicians have jointly engaged in the decision making process to choose a treatment • Details of supporting services • Details of any patient anxieties • Emergency contact details • Details of any medication • An eating and/or exercise plan Key principles for the scheme: Development of systems/processes designed to improve the information to which patients have access—not only clinical advice, but also information about their condition and history.

	Development of systems/processes designed to support patients to manage their own health –stay healthy, make informed choices of treatment (SDM) and to managing their condition to avoid complications.
Data source	Data-set
Frequency of data collection	Monthly
Organisation responsible for data collection	All providers
Frequency of reporting to commissioner	Quarterly
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	31st March 2016
Final indicator value (payment threshold)	Development and on-going delivery of a provider plan to evidence and increase the number of patients: • Actively involved in Shared Decision Making prior to treatment. • Actively following their Personal Care Plan. The scheme has an overall aspiration to increase the number of patients actively involved in decisions about their treatment The scheme has an overall aspiration to increase the number of patients actively following a Personalised Care Plan
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Evidence that milestones have been achieved will be provided to commissioners
Final indicator reporting date	30 April 2016
Are there rules for any agreed in-year milestones that result in payment	Yes see table below
Are there any rules for partial achievement of the indicator at the final indicator period/date?	100% of the final indicator value will be available to the provider for the successful delivery of agreed milestones for quarters 1, 2, 3 and 4 in accordance with the table below.

Milestones (only complete if the indicator has in-year milestones)			
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
Qtr 1	N/A		
Qtr 2	N/A		
Qtr 3	Development of a project plan designed to demonstrate how shared decision making and personal care plans can be provided to all patients from the beginning quarter 4. Demonstrate how shared decision making will be implemented and recorded in every appropriate patient consultation. Development of a Personalised Care Plan designed by clinical specialists and shared with the CCG in readiness for implementation from the beginning of quarter 4.	31 January 2016	50%
Qtr 4	Evidence to show that during Q4 30% of patients who undergone treatment were actively involved in shared decision making prior to treatment. Evidence to show that during Q4 30% of patients were provided with a Personal Care Plan.	30 April 2016	50%
		Total	100%

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)	
Final indicator value (payment threshold)	% of CQUIN scheme available
Not applicable	