WSHT CQUIN Pack 2013/14

Nationally Mandated Requirements (0.5%):

1. Friends and Family
2. National Safety Thermometer
3. Dementia
4. VTE

Innovation for Health and Wealth (0.5%)

5. Delivery of High Impact Innovations

Regionally Mandated Requirements

6. SEC wide Enhancing Quality program (0.5%)

Locally Mandated Requirements (1.0%)

7. Musculoskeletal Care Service redesign
8. Improving delivery of Accountable Lead Provider arrangements.
9. Locally determined CQUIN

Goals and Indicators

Goal No.	Description of goal	Quality Domain(s) [1]	Indicator name	National or Regional indicator [2]	Indicator weighting on total contract value
1	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.	Patient experience	Friends and Family Test	Nationally mandated	0.125%
2	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter	Safety	NHS Safety Thermometer	Nationally mandated	0.125%
3	Improve awareness and diagnosis of dementia, using risk assessment, in an acute hospital setting	Safety, effectiveness and patient experience	Dementia screening	Nationally mandated	0.125%
4	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	VTE risk assessment	Nationally mandated	0.125%
5	Providers will develop and deliver an IHW implementation plan for the high impact actions relevant to their services.	Safety, experience and effectiveness	Implementing the Innovation, Health and Wealth (IHW) high impact innovations	Nationally mandated	0.5%

[1] Safety / Effectiveness / Experience / Innovation
[2] Nationally mandated / Regionally mandated/ Regionally suggested/ No

6	Improve performance against established baseline of the Acute patient specific pathways as part of the Enhancing Quality Programme.	Safety and Effectiveness	Acute patient specific pathway process development in line with SHA requirements	Regionally Mandated	0.5%
7	Musculoskeletal Care Service redesign	Safety and Effectiveness	Redesign and delivery of new MSK pathways	Locally Mandated	0.33%
8	One Call One Team	Safety and Effectiveness	Improving delivery of Accountable Lead Provider arrangements.	Locally Mandated	0.33%
9	Locally agreed CQUIN	tbc	tbc	Locally Mandated	0.34%

National CQUINS Applicable to WSHT Contract based on wording from final (February 2013) CQUIN guidance.

Goal No.	Description of goal	Quality Domain(s) [3]	Indicator name	National or Regional indicator [4]	Indicator weighting on total contract value
1.1	Friends and family: phased expansion	Patient experience	Friends and family: phased expansion	National CQUIN	0.0375%
1.2	Friends and family: Increased response rate	Patient experience	Friends and family: Increased response rate	National CQUIN	0.05%
1.3	Friends and family: Improved performance on staff test	Patient experience	Friends and family: Improved performance on staff test	National CQUIN	0.0375%
2.1	NHS Safety thermometer – Data collection – *Not appropriate*	NA	NA	NA	0%
2.2	NHS Safety thermometer – Improvement target	Safety	To be agreed	National CQUIN	0.125%
3.1	Dementia – Find, Assess, Investigate and Refer	Effectiveness	Dementia – Find, Assess, Investigate and Refer	National CQUIN	*0.1125%*
3.2	Dementia – Clinical Leadership	Effectiveness / Innovation	Dementia – Clinical Leadership	National CQUIN	*0.0125%*
3.3	Dementia Supporting carers – covered by HII indicator	NA	NA	NA	0%
4.1	VTE – Risk assessment	Safety / Effectiveness	VTE – Risk assessment	National CQUIN	0.125% (including RCA indicator)

[3] Safety / Effectiveness / Experience / Innovation
[4] Nationally mandated / Regionally mandated/ Regionally suggested/ No

4.2	VTE – Root cause analysis	Safety	VTE – Root cause analysis	National CQUIN	Included in above

FRIENDS AND FAMILY TEST: PHASED EXPANSION

Indicator number	1.1
Indicator name	Friends and Family Test - Phased expansion
Indicator weighting (% of CQUIN scheme available)	*0.0375% of contract value*
Description of indicator	Phased expansion
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Local provider response to local commissioners
Frequency of data collection	Check on implementation at end of October 2013 and end of March 2013
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Six monthly
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	Achieving both October 2013 and March 2014 milestones
Final indicator value (payment threshold)	Full delivery of the nationally set milestones
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Provider to demonstrate to commissioner that milestones have been met
Final indicator reporting date	Response from providers to commissioners in April 2014
Are there rules for any agreed in-year milestones that result in payment?	Needs to be full implementation for payment
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Set out above

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)**
End of October 2013	Delivery of Friends and Family roll-out for maternity services	End of October 2013	Stage 1 of the 30% element of the CQUIN

FRIENDS AND FAMILY TEST: INCREASED RESPONSE RATE

Indicator number	1.2
Indicator name	Friends and Family Test – Increased Response Rate
Indicator weighting (% of CQUIN scheme available)	*0.05% of contract value*
Description of indicator	Increased response rate
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Provider submission via UNIFY data collection system
Frequency of data collection	Monthly return
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	Q1 in 2013/14
Baseline value	The response rate (which must be at least 15%)
Final indicator period/date (on which payment is based)	Q4
Final indicator value (payment threshold)	Provider achieving an increase in response rate that improves on Q1 and is 20% or over
Final indicator reporting date	Data available by end of April 2014 (for Q4)
Are there rules for any agreed in-year milestones that result in payment?	Not applicable as year end
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Set out above

FRIENDS AND FAMILY TEST – IMPROVED PERFORMANCE ON STAFF TEST

Indicator number	1.3
Indicator name	Friends and Family Test - Improved Performance on the Staff Friends and Family Test
Indicator weighting (% of CQUIN scheme available)	*0.0375% of contract value*
Description of indicator	Improved performance or remaining in the top quartile on the staff Friends and Family Test
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme
Data source	Publication of annual staff survey through Staff Survey Co-

	ordinating Centre (Picker UK)
Frequency of data collection	Annual staff survey (collected in autumn and reporting in February the following year)
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Annually
Baseline period/date	2012/13 annual staff survey
Baseline value	Provider score in 2012/13 staff survey
Final indicator period/date (on which payment is based)	2013/14 survey results
Final indicator value (payment threshold)	Provider having a better result in 2013/14 compared with 2012/13, or remaining in the top quartile
Final indicator reporting date	Published in February 2014 for 2013/14 survey results
Are there rules for any agreed in-year milestones that result in payment?	Not applicable as year end
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Set out above

NHS SAFETY THERMOMETER

Indicator number	2.2
Indicator name	NHS Safety Thermometer – Improvement
Indicator weighting (% of CQUIN scheme available)	*0.125% of contract value*
Description of indicator	*The safety thermometer was successfully rolled out at WSHT during 2012/13 according to the agreed trajectory. WSHT compare favourably against national benchmarks. Data collection will continue throughout 2013/14.* *This metric will focus on identifying and reducing the number of genuinely avoidable falls.* *The local flag field on the safety thermometer tool will be used to identify patients who fell where the fall was considered to be avoidable. This information will be reviewed alongside the routine root cause analyses carried out on patients suffering harm from falls and total % of patients with falls assessments carried out (as reported to the Trust Board monthly) to drive improvements beyond national medians.* *An exact definition of 'avoidable' will be agreed shortly but is likely to be based on compliance with the falls care bundle.*
Numerator	
Denominator	Total number of patients surveyed on the day
Rationale for inclusion	National CQUIN scheme
Data source	Provider submission to the Information Centre which publishes the data at http://www.ic.nhs.uk/services/nhs-safety-thermometer
Frequency of data collection	One day per month *(in line with national schedule)*
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	Median of six consecutive monthly data points up to 31 March 2013
Baseline value	Median of local data to be agreed..
Final indicator period/date (on which payment is based)	Payment is split into quarterly periods with 25% of the total annual available payment being available in each quarterly month period.
Final indicator value (payment threshold)	*Quarter 1 payment on agreement of baseline value-no tolerance* *Q2,3,4:Achievement of 95% or greater of the improvement goal (shown* *through special cause) followed by maintenance of* *that goal for the second 6 month period will trigger*

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	full payment of the CQUIN. *A sliding scale of payment for partial achievement of the improvement goal will also operate so that improvement from baseline performance (shown through special cause) that does not fully meet the target is still rewarded to some extent:* *achievement of 80-95% of target = 40% payment* *achievement of 60-79% of target = 30% payment* *achievement of 40-59% of target = 20% payment* *achievement of 20-39% of target = 10% payment* *achievement of <20% of target = 0% payment.*
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	*NA*
Final indicator reporting date	NHS Safety Thermometer data for March 2014 will be available on 15 April 2014
Are there rules for any agreed in-year milestones that result in payment?	The CQUIN goal will have been met if all of the following parameters are met: There is evidence of special cause variation of the median value from the agreed baseline; the reset median value is stably maintained for six consecutive months or improved further; the difference in the median values from the baseline to the reset value is equivalent to the agreed improvement goal Performance against the improvement CQUIN goal will need to be reviewed separately for each 6 month
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

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	*Initiate use of the local flag field to collect data on avoidable falls to establish baseline*	*As per national thermometer submission guidance*	*25%*

Q2	*Continue data collection of avoidable falls to establish baseline*	*As per national thermometer submission guidance*	*25%*
Q3	*Reduction against baseline*	*As per national thermometer submission guidance*	*25%*
Q4	*Reduction against baseline*	*As per national thermometer submission guidance*	*25%*

DEMENTIA – FIND, ASSESS, INVESTIGATE & REFER

Indicator number	3.1
Indicator name	Dementia – Find, Assess, Investigate and Refer
Indicator weighting (% of CQUIN scheme available)	*0.1125% of contract value*
Description of indicator	The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services
Numerator	1) Number of patients >75 admitted as an emergency who are reported as having: known diagnosis of dementia or clinical diagnosis of delirium, or who have been asked the dementia case finding question 2) Number of above patients reported as having had a diagnostic assessment including investigations 3) Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners
Denominator	1) Number of patients >75 admitted as an emergency, with length of stay >72 hours, excluding those for whom the case finding question cannot be completed for clinical reasons (eg coma) 2) Number of above patients with clinical diagnosis of delirium or who answered positively on the dementia case finding question 3) Number of above patients who underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive
Rationale for inclusion	National CQUIN scheme
Data source	UNIFY 2
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 2013 – March 2014
Final indicator value (payment threshold)	90%
Rules for calculation of payment due at final indicator period/date	Provider has achieved an average of 90% or greater in each of the elements of the indicator each month for any three

(including evidence to be supplied to commissioner)	consecutive months in the first year
Final indicator reporting date	March 2014
Are there rules for any agreed in-year milestones that result in payment?	Commissioners may wish to make this CQUIN payment on a quarterly basis, based on provider performance for that quarter
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

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)**
Each quarter	90% against each of the three elements of the indicator in that month	20 days after that quarter	1/12th

DEMENTIA – CLINICAL LEADERSHIP

Indicator number	3.2
Indicator name	Dementia – Clinical Leadership
Indicator weighting (% of CQUIN scheme available)	*0.0125% of contract value*
Description of indicator	Named lead clinician for dementia and appropriate training for staff
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	National CQUIN scheme.
Data source	Provider
Frequency of data collection	Annual
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Twice (pre-April 2013, March 2014)
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2013 – March 2014
Final indicator value (payment threshold)	Not applicable
Rules for calculation of payment due at final indicator period/date	Provider must confirm named lead clinician and the planned training programme (to be determined locally) for dementia for

(including evidence to be supplied to commissioner)	the coming year. Payment will be made at the end of the year, provided the planned training programme has been undertaken.
Final indicator reporting date	March 2014
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

VTE RISK ASSESSMENT

Indicator number	4.1
Indicator name	VTE Risk Assessment
Indicator weighting (% of CQUIN scheme available)	*0.125% of contract value* ***including RCA indicator***
Description of indicator	% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool
Numerator	Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with the published guidance http://www.vteprevention-nhsengland.org.uk
Denominator	Number of adults who were admitted as inpatients (includes day cases, maternity and transfers both elective and non-elective admissions)
Rationale for inclusion	National CQUIN scheme.
Data source	*Sema Helix PAS (this may change in-year), submission to Unify 2*
Frequency of data collection	*Continuous*
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Monthly
Baseline period/date	Not applicable
Baseline value	Not applicable
Final indicator period/date (on which payment is based)	April 2013 – March 2014
Final indicator value (payment threshold)	95%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	All payments must be based on (1) achievement of at least 95% (or a higher local target) and (2) achievement of the quarterly target for root cause analyses of hospital associated thrombosis, as reported to the commissioner
Final indicator reporting date	20 working days after the end of each month (deadline for Unify2 submission)
Are there rules for any agreed in-year milestones that result in payment?	*CQUIN payment on a quarterly basis, based on provider performance for that quarter*
Are there any rules for partial achievement of the indicator at the final indicator period/date?	No

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)
Each quarter	Achievement of agreed target for both risk assessment and root cause analysis for each month during that quarter	20 days after that quarter	25%

VTE ROOT CAUSE ANALYSIS

Indicator number	4.2
Indicator name	VTE Root Cause Analyses
Indicator weighting (% of CQUIN scheme available)	Included in risk assessment indicator (4.1)
Description of indicator	The number of root cause analyses carried out on cases of hospital associated thrombosis
Numerator	*a) root cause analyses of fatal cases of HAT* *b) root causes analyses of all cases of HAT*
Denominator	*a) all fatal cases of HAT identified* *b) cases of HAT identified*
Rationale for inclusion	National CQUIN scheme
Data source	*Root cause analyses carried out (cases identified through Datix incidents and imaging, supported by clinical coding)*
Frequency of data collection	*Quarterly*
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	*Quarterly*
Baseline period/date	*2012/13*
Baseline value	*35 RCAs carried out*
Final indicator period/date (on which payment is based)	April 2013 – March 2014
Final indicator value (payment threshold)	*Q1 Improve identification and processes* *Q2 100% of fatal cases* *Q3 100% of fatal cases and 50% of all cases* *Q4 100% of fatal cases and 75% of all cases*
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	

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	*Improve identification and processes.*	*20 days after that quarter*	*25%*
Q2	*Q2 100% of fatal cases*	*20 days after that quarter*	*25%*
Q3	*Q3 100% of fatal cases and 50% of all cases*	*20 days after that quarter*	*25%*
Q4	*Q4 100% of fatal cases and 75% of all cases*	*20 days after that quarter*	*25%*

High Impact Innovations

5.1 3 Million Lives "Trusts to set a trajectory for 2013/14 for increasing planned use of telehealth/telecare technologies",		
Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
ALL Providers to:		
1.1 Baseline set	1.1 Establish a baseline of projects already implemented using telehealth/telecare products, stating numbers of patients who are affected to date, at March 2013.	By 31st May 2013
1.2 Trajectory	1.2 Set out a quarterly trajectory for increasing the use of telehealth/telecare technologies during 2013/14 to achieve an increase by number of patients affected/using telehealth/telecare technologies by March 2014	By 31st May 2013
1.3 Reporting	1.3 Set out a quarterly reporting system for showing the impact of telehealth/care technologies in impacting patient care (monitoring changes in hospital admissions, patient health crises, patient confidence and satisfaction, medical call-outs etc).	By 31st May 2013
1.4 Plan	1.4 Presentation of a plan for achieving the trajectory during 2013/14 to achieve the increase in telehealth/telecare technologies *(NB: Plan to include: target volume per quarter, baseline of telehealth/telecare usage in March 2013, trajectory, actions to achieve trajectory*	By 31st May 2013
Title of Activity	**Description of Activity - level to be achieved**	**Delivered by**
1.5 Monitoring	1.5 Q2 & Q3 & Q4 Collect telehealth/telecare usage data and report quarterly against trajectory in plan, by volume of patients affected	On-going
1.6 Collaboratives	1.6 Participate in 3 Million Lives collaborative events as hosted by AHSN HII team by having at	On-going

1.7 Trajectories	least 1 attendee at the 3Million Lives collaborative 1.7 To be set April 13	Notes sent in previous spreadsheet

5.2 Intra-Operative Fluid Management "Acute providers to demonstrate that 2013/14 trajectories for the technology are in place which are consistent with NTAC guidance."		
Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
ACUTE Providers to:		
2.1 Target volumes of procedures	2.1 Determine target volumes of procedures performed from the NTAC OPCS code list in 2011/12 (NB: AHSN team to provide to trusts)	By 31st May 2013
2.2 Establish a baseline	2.2 Establish a baseline of numbers of procedures (not operations, as one operation may involve more than one procedure code) where IOFM is already being used per month up to March 2013 to determine current status at start of year as a proportion against the target volume as above (NB: can include procedures not on the NTAC OPCS list).	31st May 2013:
2.3 Set out a monthly trajectory	2.3 Set out a monthly trajectory for increasing the use of IOFM during 2013/14 to achieve at least **50%** TBC by volume against the NTAC-OPCS target volume of listed procedures per month by March 2014 (NB: can include procedures not on the NTAC OPCS list).	31st May 2013:
2.4 Presentation of a plan	2.4 Presentation of a plan for achieving the trajectory during 2013/14 to achieve at least **50%** TBC of target volume of procedures having IOFM used during procedure by March 2014, measured by proportion per month, and then increase the following years *(NB: Plan to include: target volume, baseline of IOFM usage in March 2013, trajectory, actions to achieve trajectory)*	31st May 2013:

Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
2.5 Enter IOFM usage data on the KSS monitoring tool	2.5 Q2 & Q3 & Q4, Collect IOFM usage data and enter in to the KSS agreed monitoring system to track volumes against trajectory monthly	April 2013 – March 2014
2.6 Trajectories	2.6 To be set following baseline M12 2012/13 plan Q1 20% to Q4 50%	

5.4 International & Commercial Activity		
Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
All providers to: 4.1 Plan	4.1 Provide a copy of their organisation's plan for exploiting Intellectual Property. Within their plan they must describe how Intellectual Property originating from within their organisation will be exploited. WSHT are completing this and will adopt policy in in collaboration with Academic Health Science Network	1st September 2013

5.5. Digital First Trusts should "establish a 2012/13 baseline and a trajectory for improvement to reduce inappropriate face-to-face contact"		
Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
ALL Providers to:		
5.1 Baseline set	5.1 Establish a baseline of projects already implemented using digital products, stating numbers of transactions to date, at March 2013	By 31st May 2013
5.2 Review and determine which of the 10 digital areas are relevant	5.2 Review and determine which of the 10 digital areas are relevant	By 31st May 2013
5.3 Trajectory	5.3 Set out a quarterly trajectory with the % increase to be agreed when baseline available	By 31st May 2013
5.4 Plan	5.4 Presentation of a plan for achieving the trajectory during 2013/14 to achieve the increase in digital technologies *(NB: Plan to include: target volume of transactions per quarter, list of which of the 10 digital areas are relevant, baseline of digital usage in March 2013, trajectory, actions to achieve trajectory)*	By 31st May 2013
5.5 Monitoring	5.5 Q2 & Q3 & Q4 Collect digital usage data and report quarterly against trajectory in plan, by volume of transactions	Ongoing
5.6 Collaboratives.	5.6 Participate in Digital First collaborative events as hosted by AHSN HII team.	Ongoing
5.7 Identification of which of the 10 areas are relevant – WSHT		

5.6. Dementia Carers Trusts should "demonstrate that plans have been put in place to ensure that for every person admitted to hospital, where there is a diagnosis of dementia, their carer is signposted to relevant advice and receives relevant information to help and support them",		
Title of Activity	**Description of Activity – level to be achieved**	**Delivered by**
Acute, Mental Health providers to:		
6.1 Baseline	6.1 set out a baseline of the volumes of dementia patients admitted per annum/month in 2012/13 to indicate volumes of carers requiring signposting support	By 31st May 2013
6.2 Plan	6.2 Set out a plan that includes methods to be used for signposting carers, action plan for implementing signposting activities during 2013/14, method for monitoring/auditing the provision of signposting information to all carers of patients admitted with dementia.	By 31st May 2013
6.3 Monitoring	6.3 Q2 & Q3 & Q4 Collect carer signposting provision data and report quarterly as a proportion of carers given signposting, against volumes of dementia cases admitted	Ongoing
6.4 Collaboratives	6.4 Participate in Dementia Carers collaborative events as hosted by AHSN HII team.	Ongoing

This is based on the draft version 1.9 of the EQ Document. Thresholds for improvement measures are not yet available.

Goal No.	Description of goal	Quality Domain(s) [5]	Indicator name	National or Regional indicator [6]	Indicator weighting on total contract value
6.1	Establish robust Acute Kidney Injury data capture	Effectiveness	Establish robust Acute Kidney Injury data capture	Regional CQUIN	0.05% of contract value (10% EQ)
6.2	Establish robust #NOF and hip and knee data capture	Effectiveness	Establish robust #NOF and hip and knee data capture	Regional CQUIN	0.05% of contract value (10% EQ)
6.3	Improvement in heart failure scores	Effectiveness	Improvement in heart failure scores	Regional CQUIN	0.05% of contract value (10% EQ)
6.4	Improvement in pneumonia scores	Effectiveness	Improvement in pneumonia scores	Regional CQUIN	0.05% of contract value (10% EQ)
6.5	Establish robust COPD data capture	Effectiveness	Establish robust COPD data capture	Regional CQUIN	0.05% of contract value (10% EQ)
6.6	Improved performance scores for Hip and Knee ERP	Effectiveness / Innovation	Improved performance scores for Hip and Knee ERP	Regional CQUIN	0.05% of contract value (10% EQ)
6.7	Improved performance for Colorectal ERP	Effectiveness / Innovation	Improved performance for Colorectal	Regional CQUIN	0.035% of contract value (7%

[5] Safety / Effectiveness / Experience / Innovation
[6] Nationally mandated / Regionally mandated / Regionally suggested/ No

			ERP		EQ)
6.8	Improved performance scores for Gynaecology ERP	Effectiveness / Innovation	Improved performance scores for Gynaecology ERP	Regional CQUIN	0.04% of contract value (8% EQ)
6.9	Joint working on heart-failure readmissions	Effectiveness / Innovation	Joint working on heart-failure readmissions	Regional CQUIN	0.025% of contract value (5% EQ)
6.10	Baseline data for hip and knee replacement and heart failure patient experience	Patient experience	Baseline data for hip and knee replacement and heart failure patient experience	Regional CQUIN	0.025% of contract value (5% EQ)
6.11	Capture data on anti-psychotic drugs	Effectiveness / Safety	Capture data on anti-psychotic drugs	Regional CQUIN	0.025% of contract value (5% EQ)
6.12	Participate in data quality audit	Effectiveness	Participate in data quality audit	Regional CQUIN	0.025% of contract value (5% EQ)
6.13	Engage in EQ shared learning opportunities	Innovation	Engage in EQ shared learning opportunities	Regional CQUIN	0.025% of contract value (5% EQ)

Indicator number	6.1
Indicator name	Establish robust Acute Kidney Injury data capture
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Establish robust processes to capture patient data which initiates baseline information in the Acute Kidney Injury (AKIN 3 Population) pathway while ensuring timely, accurate and complete data submission into the information system. Baseline in Composite Quality Score (CQS) Provide information at agreed time to ensure information is accessible & ensure patient information is 95% complete. **Measure** • For trusts currently are unable to identify AKI patients to develop process for identifying the AKI patient population • Develop systematic approach which enables patient data to be captured • Collate baseline data in preparation for demonstrable improvement • Prerequisites a) SUS/data transferred to external partner according to timetable b) 95% data completeness in Quality Tool. **Assurance** • EQ&R Committees • Programme Team
Numerator	Establish baseline
Denominator	NA
Rationale for inclusion	Establish baseline
Data source	EQ data collection
Frequency of data collection	Monthly
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly

Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014
Final indicator value (payment threshold)	Establish baseline
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	NA
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.2
Indicator name	Establish robust #NOF and hip and knee data capture
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Establish robust process to capture patient data which initiates baseline information for fracture neck of femur in the Hip & Knee EQ pathway while ensuring timely, accurate and complete data submission into the information systems. a) Establish #NOF pathway • Participate in the development of the denominator population • Participate in the development of appropriate measures Set baseline score for #NOF Establish Composite Quality Score (CQS) baseline Provide information at agreed time to ensure information is accessible & ensure patient information is 95% complete. Agree clinical measures that add value to the system **Measure** • Develop systematic approach which enables patient data to be captured • Collate baseline data in preparation for demonstrable improvement Prerequisites – data transferred to according to timetable **Assurance** • EQ&R Committees • Programme Team
Numerator	Establish baseline
Denominator	NA
Rationale for inclusion	Establish baseline
Data source	EQ data collection
Frequency of data collection	Reporting monthly Apr 2013 – Mar 2014
Organisation responsible for data collection	WSHT
Frequency of reporting to	Reports to Commissioning Teams Quarterly

commissioner	
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014
Final indicator value (payment threshold)	Establish baseline
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	NA
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.3
Indicator name	Improvement in heart failure scores
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Achieve improved performance scores for Heart Failure pathway while ensuring timely, accurate and complete data submission into the information system. Improvement in Appropriate Care Score (ACS) Provide information at agreed time to ensure information is accessible & ensure patient information is 95% complete. **Measure** • Improvement in pathway – see detailed % improvement banding for individual Trusts (partial achievement included). • Prerequisites – a) SUS/data transferred to external partner according to timetable b) 95% data completeness in Quality Tool. **Assurance:** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	Number of patients with appropriate care bundles (i.e. each element appropriate for that patient)
Denominator	Total number of eligible patients
Rationale for inclusion	Evidence based.
Data source	EQ data collection
Frequency of data collection	Reporting monthly Apr 2013 – Mar 2014 (discharge months (January 2013 to December 2013)
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Calendar year 2012 (tbc)
Baseline value	TbC
Final indicator period/date (on which payment is based)	January 2013 to December 2013

Final indicator value (payment threshold)	Threshold TbC
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Threshold TbC
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Threshold TbC

Indicator number	6.4
Indicator name	Improvement in pneumonia scores
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Achieve improved performance scores for Pneumonia (BTS Care Bundle) pathway while ensuring timely, accurate and complete data submission into the information system. Improvement in Appropriate Care Score (ACS) Provide information at agreed time to ensure information is accessible & ensure patient information is 95% complete. Establish revised pathway to co-inside with BTS care bundle approach and transition during 13/14. **Measure** • Improvement in pathway – see detailed % improvement banding for individual Trusts (partial achievement included). • Prerequisites – a) SUS/data transferred to external partner according to timetable b) 95% data completeness in Quality Tool. • Establish revised pathway to align with BTS care bundle approach and transition during 13/14.
Numerator	Number of patients with appropriate care bundles (i.e. each element appropriate for that patient)
Denominator	Total number of eligible patients
Rationale for inclusion	Evidence based
Data source	EQ data collection
Frequency of data collection	Reporting monthly Apr 2013 – Mar 2014 (discharge months (January 2013 to December 2013)
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	Calendar year 2012 (tbc)
Baseline value	TbC
Final indicator period/date (on which payment is based)	January 2013 to December 2013

Final indicator value (payment threshold)	Threshold TbC
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Threshold TbC
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Threshold TbC

Indicator number	6.5
Indicator name	Establish robust COPD data capture
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Develop robust process to capture patient data which initiates baseline information for the new COPD pathway while ensuring timely, accurate and complete data submission into the information system. Baseline in Composite Quality Score (CQS) Provide information at agreed time to ensure information is accessible & ensure patient information is 95% complete. Align with BTS care bundle **Measure** • Develop systematic approach which enables patient data to be captured • Collate baseline data in preparation for demonstrable improvement in the • Prerequisites – a) SUS/data transferred to external partner according to timetable b) 95% data completeness in Quality Tool. **Assurance** • EQ&R Committees • Programme Team
Numerator	Establish baseline
Denominator	NA
Rationale for inclusion	Establish baseline
Data source	EQ data collection
Frequency of data collection	Report monthly Apr 2013 – Mar 2014
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014

Final indicator value (payment threshold)	Establish baseline
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	As above
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.6
Indicator name	Improved performance scores for Hip and Knee ERP
Indicator weighting (% of CQUIN scheme available)	0.05% of contract value (10% EQ)
Description of indicator	Achieve improved performance scores for Hip & Knee ER pathway while ensuring timely, accurate and complete data submission into the information system. (Hip & knee pathway to include any elective procedures no longer covered in EQ and measures) Focus on improving the percentage of clinically selected and agreed measures within the data set 85% (tba) of patients recorded in ERP data set compared with SUS data CQS scoring system to be applied **Measure** • Improvement in pathway – see detailed % improvement banding for individual Trusts. • Prerequisites – a) data transferred to ER according to timetable b) 85% of patients recorded compared with SUS **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	CQS scoring
Denominator	NA
Rationale for inclusion	Evidence based
Data source	WSHT data collection (+ SUS)
Frequency of data collection	Monthly (Apr 2013 to Mar 2014)
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	TbC
Baseline value	TbC
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014 (TbC)

Final indicator value (payment threshold)	Threshold TbC
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Threshold TbC
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Threshold TbC

Indicator number	6.7
Indicator name	Improved performance for Colorectal ERP
Indicator weighting (% of CQUIN scheme available)	0.035% of contract value (7% EQ)
Description of indicator	Achieve improved performance scores against set baseline for ERP Colorectal pathway while ensuring timely, accurate and complete data submission into the minimum data set. (Pathway includes both benign and malignant cases) Focus on improving the percentage of clinically selected and agreed measures within the data set 85% of patients recorded in minimum data set compared with SUS data CQS scoring system to be applied **Measure** • Improvement in pathway – see detailed % improvement banding for individual Trusts. • Prerequisites – a) data transferred to ER according to timetable b) 85% of patients recorded compared with SUS **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	CQS scoring
Denominator	NA
Rationale for inclusion	Evidence based
Data source	ERP data collection
Frequency of data collection	Monthly (Apr 2013 to Mar 2014)
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	TbC
Baseline value	TbC
Final indicator period/date (on	Apr 2013 to Mar 2014 (TbC)

which payment is based)	
Final indicator value (payment threshold)	Threshold TbC
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Threshold TbC
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Threshold TbC

Indicator number	6.8
Indicator name	Improved performance scores for Gynaecology ERP
Indicator weighting (% of CQUIN scheme available)	0.04% of contract value (8% EQ)
Description of indicator	Achieve improved performance scores against set baseline for ERP Gynaecology pathway while ensuring timely, accurate and complete data submission into the minimum data set. (Pathway includes both benign and malignant cases) Focus on improving the percentage of clinically selected and agreed measures within the data set 85% of patients recorded in minimum data set compared with SUS data CQS scoring system to be applied **Measure** • Improvement in pathway – see detailed % improvement banding for individual Trusts. • Prerequisites – • a) data transferred to ER according to timetable b) 85% of patients recorded compared with SUS **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	CQS scoring
Denominator	NA
Rationale for inclusion	Evidence based
Data source	ERP data collection
Frequency of data collection	Monthly
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	TbC
Baseline value	TbC
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014 (TbC)

Final indicator value (payment threshold)	Threshold TbC
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	Threshold TbC
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Threshold TbC

Indicator number	6.9
Indicator name	Joint working on heart-failure readmissions
Indicator weighting (% of CQUIN scheme available)	0.025% of contract value (5% EQ)
Description of indicator	Heart Failure readmissions - initiate integrated/joint working between Acute and Community which will benefit patients across acute and community boundaries with an aim to reduce readmissions. Instigate root cause analysis investigation of Heart Failure re-admissions Instigate and attend integrated/joint workshops Develop an action plan with acute providers and work towards developing and initiating processes that mitigate against Heart Failure re admissions **Measure** • Develop a joint action plan with an aim to reduce the number of Heart Failure related re-admissions **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	NA
Denominator	NA
Rationale for inclusion	To support joint working
Data source	Joint action plan
Frequency of data collection	Quarterly
Organisation responsible for data collection	Shared responsibility (WSHT, Community and Commissioning)
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Q4
Final indicator value (payment threshold)	See above
Rules for calculation of	NA

payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.10
Indicator name	Baseline data for hip and knee replacement and heart failure patient experience
Indicator weighting (% of CQUIN scheme available)	0.025% of contract value (5% EQ)
Description of indicator	Establish the baseline data for the Patient Experience measure for Hip & Knee Replacement & Heart Failure patients. **Hip & Knee –** move from pilot (target start date 1 Jan 2013) to full roll-out of patient experience measure (using ER "elective" population) around information, communication/understanding, involvement through introduction of a bespoke post-discharge patient survey. Work towards establishing a baseline from which to measure improvement against at an organisation level. Also look to triangulate data at high level with clinical effectiveness data & PROMs data. Contribute to collaboration between Trusts around establishing process/feeding back results. **Heart Failure –** Full roll out target start date 1 Jan 2013. Minimum participation 20% of total EQ population. Establish baseline from which to measure improvement against at an organisation level. Contribute to collaboration between Trusts around establishing process/feeding back results with special attention to integration between Acute & Community Trusts. Look to triangulate data with clinical effectiveness measures around information/involvement, discharge and transfer of care. Benchmarking opportunities only at high level once baseline of patients established. Not able to set improvement targets at this time. Participate in workshops/webinars **Measure** • Develop a baseline in the Patient Experience measure for Hip & Knee replacement and Heart Failure patients. **Assurance**

	• EQ&R Committees • Programme Team • Commissioning Teams
Numerator	Develop baseline
Denominator	NA
Rationale for inclusion	To improve experience in these pathways
Data source	Experience data collection
Frequency of data collection	Quarterly
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	NA
Final indicator value (payment threshold)	See above
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	See above
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.11
Indicator name	Capture data on anti-psychotic drugs
Indicator weighting (% of CQUIN scheme available)	0.025% of contract value (5% EQ)
Description of indicator	Capture data for the anti-psychotic prescribing measure within the National Dementia data set. Supply data to EQ For all patients with a diagnosis of dementia discharged on APD's have written instructions to the GP requesting a medication review within 3 months **Measure** • Achieve 95% compliance with the medication review request **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	Patients with a diagnosis of dementia discharged on APD's with written instructions to the GP requesting a medication review within 3 months
Denominator	Patients with a diagnosis of dementia discharged on APD's
Rationale for inclusion	Ensure clinically appropriate use of APDs
Data source	WSHT data collection
Frequency of data collection	Monthly
Organisation responsible for data collection	WSTH
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2014
Final indicator value (payment threshold)	95%
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	NA
Final indicator reporting date	Q4

Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Indicator number	6.12
Indicator name	Participate in data quality audit
Indicator weighting (% of CQUIN scheme available)	0.025% of contract value (5% EQ)
Description of indicator	Participate in data quality assurance audits (including Peer Review for ERP) Data quality assurance audits to be carried out and reported to EQ Information Committee **Measure** • Participate in Trust EQ audits as per approved audit process **Assurance** • EQ&R Committees • Programme Team • Commissioning Teams
Numerator	NA
Denominator	NA
Rationale for inclusion	Ensure robustness of ERP / EQ data collection
Data source	Audit
Frequency of data collection	Annual
Organisation responsible for data collection	EQ programme
Frequency of reporting to commissioner	Annual
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	TbC
Final indicator value (payment threshold)	Participation in audit
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	NA
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA

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

Indicator number	6.13
Indicator name	Engage in EQ shared learning opportunities
Indicator weighting (% of CQUIN scheme available)	0.025% of contract value (5% EQ)
Description of indicator	Successfully engage in shared learning opportunities demonstrated by maintaining EQ Lead structure and Trust contribution in EQ programme:- ***Clinical Lead*** • *Attendance at EQ Clinical Reference Group or by teleconferences/webex when indicated by EQ team* *Attendance at Collaboratives* ***Trust Improvement Teams*** • *Support clinical lead in collaborative learning process.* ***Programme Lead*** • *Attendance at Programme Lead meetings or by webinars teleconferences/webex when indicated by EQ team* • *Assist the Data Quality Assurance process* ***Data Management Lead*** • *Attendance at EQ Information Committee or by teleconferences/webex when indicated by EQ team* ***Communication Lead and/or Patient Experience Representative*** • *Attendance at EQ Communications, Engagement, Patient Experience & Shared Decision Making Committee meetings or teleconferences/webex when indicated by EQ team* 70% engagement in to EQ Programmes (Includes attendance for all EQ pathways) **Measure** • 70%+ engagement in shared learning opportunities • Trust representation at shared learning opportunities **Assurance** • EQ&R Committees

	• Programme Team • Commissioning Teams
Numerator	Shared learning opportunities with WSHT representation or engagement
Denominator	Total shared learning opportunities across all pathways
Rationale for inclusion	
Data source	EQ reports
Frequency of data collection	Quarterly
Organisation responsible for data collection	EQ Programme Team
Frequency of reporting to commissioner	Quarterly
Baseline period/date	NA
Baseline value	NA
Final indicator period/date (on which payment is based)	Apr 2013 to Mar 2013
Final indicator value (payment threshold)	70% engagement in to EQ Programmes (Includes attendance for all EQ pathways)
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	NA
Final indicator reporting date	Q4
Are there rules for any agreed in-year milestones that result in payment?	NA
Are there any rules for partial achievement of the indicator at the final indicator period/date?	NA

Locally Mandated Requirements

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
7.	Redesign and delivery of new pathways musculoskeletal services	Safety Quality	7.a	New threshold/pathways for Carpal Tunnel Syndrome	Locally suggested	0.0825% of contract value

Description of indicator	Development and implementation of new treatment thresholds and care pathways for Carpal Tunnel Syndrome (CTS).
Numerator	N/A
Denominator	N/A
Rationale for inclusion	CCG believes that more CTS patients are treated surgically than is indicated elsewhere and are seeking to identify and implement thresholds and pathways, for all commissioned acute providers to adhere to. WSHT will be required to manage treatment for CWS patients with CTS according to these thresholds and pathways.
Data source and frequency of collection	Presentation of a plan outlining the implementation of the thresholds and pathways at WSHT to CWS CCG WSHT Care Pathway audit results
Organisation responsible for data collection	WSHT Clinical Audit department The process and specification for the clinical audit will be agreed jointly by CWS CCG and WSHT and anonymised audit data shared, in line with the Data Protection Act
Frequency of reporting to commissioner	Quarterly, 6W after quarter end
Baseline period / date	N/A
Baseline value	
Final indicator period / date (on which payment is based)	Q1-Q4 2013/14
Final indicator value (payment threshold)	£TBC

Final indicator reporting date	**Milestones to be achieved** • Payment will be in respect of achievment of the following milestones • The Q1 milestones will be judged to have been achieved on presentation of a reasonable plan outlining the implementation of the thresholds and pathways at WSHT to CWS CCG Clinical lead by 7th June 2013 (ready to be proposed to the next CWS Clinical Commissioning Business meeting) • Once instructions are given by CWS over the pathway to be adopted by WSHT then all subsequent new referrals will be managed by WSHT according to the pathway instructed. Payment of the CQUIN will be based upon adherence to the pathway. In the event a patient is excluded for sound clinical reasons from the pathway they will be assumed to be compliant. All exclusions will be audited and the results made available to the CCG on a monthly basis. • Prior Authorisation will be sought for any patients for whom the pathway / thresholds are thought unsuitable for any individual patient. Patients with Prior Authorisation or direct instruction to proceed will be assumed to have complied with the pathway. CWS will receive feedback where direct instructions are given to proceed to surgical intervention by GPs. • WSHT will undertake a clinical audit of all completed CTS pathways quarterly and demonstrate compliance with the pathways agreed.
Rules for partial achievement of indicator at year-end	Implementation plan presented by 18th June – no tolerance. Q2, Q3, Q4 paid on audited quarterly compliance against pathways Over 90% compliance with pathway – 100% CQUIN payable Over 80% compliance with pathway – 75% of CQUIN payable. Over 70% compliance with pathway – 50% of CQUIN payable. Below 70% - no CQUIN payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	TBA

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Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
7	Redesign and delivery of new pathways for Knee Arthroscopies	Safety Quality	7b	New pathways for Knee Arthroscopies	Locally suggested	0.0825% of contract value

Description of indicator	Development and implementation of new treatment thresholds and care pathways for knee pain.
Numerator	
Denominator	
Rationale for inclusion	CCG believes that more patients received diagnostic arthroscopies than is indicated elsewhere and are seeking to identify and implement thresholds and pathways, for all commissioned acute providers to adhere to. WSHT will be required to manage treatment for CWS patients with knee pain according to these thresholds and pathways.
Data source and frequency of collection	Presentation of a plan outlining the implementation of the thresholds and pathways at WSHT to CWS CCG WSHT Care Pathway audit results
Organisation responsible for data collection	WSHT Clinical Audit department The process and specification for the clinical audit will be agreed jointly by CWS CCG and WSHT and anonymised audit data shared, in line with the Data Protection Act
Frequency of reporting to commissioner	Quarterly, 6W after quarter end
Baseline period / date	N/A
Baseline value	
Final indicator period / date (on which payment is based)	Q1-Q4 2013/14
Final indicator value (payment threshold)	£TBC

Final indicator reporting date	**Milestones to be achieved** Q1 and Q2 payment will be in respect of achievement of the following milestones • The Q1 milestones will be judged to have been achieved on presentation of a reasonable plan outlining the implementation of the thresholds and pathways at WSHT to CWS CCG to CWS Clinical lead by 7th June 2013 (ready to be proposed to the next CWS Clinical Commissioning Business meeting) • Once instructions are given by CWS over the pathway to be adopted by WSHT then all subsequent new referrals will be managed by WSHT according to the pathway instructed. Payment of the CQUIN will be based upon adherence to the pathway. In the event a patient is excluded for sound clinical reasons from the pathway they will be assumed to be compliant. All exclusions will be audited and the results made available to the CCG on a monthly basis. • Prior Authorisation will be sought for any patients for whom the pathway / thresholds are thought unsuitable for any individual patient. Patients with Prior Authorisation or direct instruction to proceed will be assumed to have complied with the pathway. CWS will receive feedback where direct instructions are given to proceed to surgical intervention by GPs. • WSHT will undertake a clinical audit of all completed knee arthroscopy pathways quarterly and demonstrate compliance with the pathways agreed.
Rules for partial achievement of indicator at year-end	Implementation plan presentation by 18th June – no tolerance. Q2, Q3, Q4 paid on audited quarterly compliance against pathways Over 90% compliance with pathway – 100% CQUIN payable Over 80% compliance with pathway – 75% of CQUIN payable. Over 70% compliance with pathway – 50% of CQUIN payable. Below 70% - no CQUIN payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	TBA

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
7	Redesign and delivery of new pathways for Knee Replacements	Safety Quality	7c	New pathways for Knee Replacements	Locally suggested	0.0825% of contract value

Description of indicator	Development and implementation of new treatment thresholds and care pathways for knee pain.
Numerator	
Denominator	
Rationale for inclusion	CCG believes that more patients receive total knee replacement than is indicated elsewhere and are seeking to identify and implement thresholds and pathways, for all commissioned acute providers to adhere to. WSHT will be required to manage treatment for CWS patients needing knee replacement according to these thresholds and pathways.
Data source and frequency of collection	Presentation of options to CWS WSHT Care Pathway audit results
Organisation responsible for data collection	WSHT Clinical Audit department The process and specification for the clinical audit will be agreed jointly by CWS CCG and WSHT and anonymised audit data shared, in line with the Data Protection Act
Frequency of reporting to commissioner	Quarterly, 6W after quarter end
Baseline period / date	N/A
Baseline value	
Final indicator period / date (on which payment is based)	Q1-Q4 2013/14
Final indicator value (payment threshold)	£ TBC

Final indicator reporting date	**Milestones to be achieved** Payment will be in respect of achievement of the following milestones : • The Q1 milestones will be judged to have been achieved if the treatment pathway proposals plan is presented to CWS Clinical lead by 30 June 2013 (ready to be proposed to the next CWS Clinical Commissioning Business meeting)

	• Once instructions are given by CWS over the pathway to be adopted by WSHT then all subsequent new referrals will be managed by WSHT according to the pathway instructed. Payment of the CQUIN will be based upon adherence to the pathway. . In the event a patient is excluded for sound clinical reasons from the pathway they will be assumed to be compliant. All exclusions will be audited and the results made available to the CCG on a monthly basis. • Prior Authorisation will be sought for any patients for which the pathway / thresholds are thought unsuitable for any individual patient. Patients with Prior Authorisation or direct instruction to proceed will be assumed to have complied with the pathway. CWS will receive feedback where direct instructions are given to proceed to surgical intervention by GPs. • WSHT will undertake a clinical audit of all completed hip replacement pathways quarterly once instructed and demonstrate compliance with the pathways agreed.
Rules for partial achievement of indicator at year-end	Options presentation by 7th July – no tolerance. Q2, Q3, Q4 paid on audited quarterly compliance against pathways Over 90% compliance with pathway – 100% CQUIN payable Over 80% compliance with pathway – 75% of CQUIN payable. Over 70% compliance with pathway – 50% of CQUIN payable. Below 70% - no CQUIN payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	TBA

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
7	Redesign and delivery of new pathways for Total Hip Replacements	Safety Quality	7d	New pathways for total hip replacements	Locally suggested	0.0825% of contract value

Description of indicator	Development and implementation of new treatment thresholds and care pathways for hip pain.
Numerator	
Denominator	
Rationale for inclusion	CCG believes that more patients receive hip replacement than is indicated elsewhere and are seeking to identify and implement thresholds and pathways, for all commissioned acute providers to adhere to. WSHT will be required to manage treatment for CWS patients needing hip replacement according to these thresholds and pathways.
Data source and frequency of collection	Presentation of options to CWS WSHT Care Pathway audit results
Organisation responsible for data collection	WSHT Clinical Audit department The process and specification for the clinical audit will be agreed jointly by CWS CCG and WSHT and anonymised audit data shared, in line with the Data Protection Act
Frequency of reporting to commissioner	Quarterly, 6W after quarter end
Baseline period / date	N/A
Baseline value	
Final indicator period / date (on which payment is based)	Q1-Q4 2013/14
Final indicator value (payment threshold)	£TBC

Final indicator reporting date	**Milestones to be achieved** Payment will be in respect of achievement of the following milestones • The Q1 milestones will be judged to have been achieved if the treatment pathway proposals plan is presented to CWS Clinical lead by 30 June 2013 (ready to be proposed to the next CWS Clinical Commissioning Business

	meeting) • Once instructions are given by CWS over the pathway to be adopted by WSHT then all subsequent new referrals will be managed by WSHT according to the pathway instructed. Payment of the CQUIN will be based upon adherence to the pathway. . In the event a patient is excluded for sound clinical reasons from the pathway they will be assumed to be compliant. All exclusions will be audited and the results made available to the CCG on a monthly basis. • Prior Authorisation will be sought for any patients for which the pathway / thresholds are thought unsuitable for any individual patient. Patients with Prior Authorisation or direct instruction to proceed will be assumed to have complied with the pathway. CWS will receive feedback where direct instructions are given to proceed to surgical intervention by GPs. • WSHT will undertake a clinical audit of all completed hip replacement pathways quarterly once instructed and demonstrate compliance with the pathways agreed.
Rules for partial achievement of indicator at year-end	Options presentation by 7th July – no tolerance. Q2, Q3, Q4 paid on audited quarterly compliance against pathways Over 90% compliance with pathway – 100% CQUIN payable Over 80% compliance with pathway – 75% of CQUIN payable. Over 70% compliance with pathway – 50% of CQUIN payable. Below 70% - no CQUIN payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	TBA

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
8	To ensure that patients requiring unplanned care are treated in the right place at the right time reducing levels of avoidable hospital admission	Safety Quality	8a	One Call One Team – Ambulatory Care Sensitive Conditions	Locally suggested	0.0825% of contract value

Description of indicator	Raising awareness of locally agreed care pathways for: ▪ Lower limb cellulitis ▪ Community Acquired Pneumonia ▪ DVT ▪ PE and ensuring that all appropriate patients are managed in line with these care pathways and, where suitable alternative services are commissioned and provided in the community, unnecessary admissions to hospital are avoided
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Provide incentives to support change in attitudes towards and the utilisation of agreed care pathways by hospital staff, ensuring that patients who can be better cared for in a community setting have good access to the right services.
Data source and frequency of collection	Provider collected data.
Organisation responsible for data collection	WSHT clinical audit department The process and specification for the clinical audit will be agreed jointly by CWS CCG and WSHT and anonymised audit data shared, in line with the Data Protection Act
Frequency of reporting to commissioner	Quarterly, 6W after quarter end
Baseline period / date	N/A
Baseline value	N/A

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Final indicator period / date (on which payment is based)	Q1: Trust will develop and implement a programme of awareness training to ensure that all relevant staff are aware of agreed care pathways and alternative services commissioned by CCG for patents with agreed ambulatory care sensitive conditions. Trust will develop and agree with CWS CCG a method for recording patients attending with agreed ambulatory care sensitive conditions and compliance with agreed care pathways. In the event a patient is excluded for sound clinical reasons from the pathway they will be assumed to be compliant. All exclusions will be audited and the results made available to the CCG on a monthly basis. Q2, 3 and Q4: Trust will audit compliance with care pathways quarterly, and work with CCG to agreed trajectory for reduction in admissions in agreed ambulatory care sensitive conditions for use as CQUIN for 2014/15
Final indicator value (payment threshold)	N/A
Final indicator reporting date	Report to be provided to CCG no later than 1 month after the end of the relevant quarter
Rules for partial achievement of indicator at year-end	Q1 - - no tolerance Evidence of awareness programme and Agreed method for reporting- The process and specification for the clinical audit and reporting will be agreed jointly by CWS CCG. (It is the expectation of the CCG that this should be achievable in Q1, but where there is good reason for delay and this has been mutually agreed, payment of the Q1 payment will be made on the completion of this requirement. Agreement by the CCG to a revised completion date will not be unreasonably withheld) Q2 Q3, Q4 paid on audited quarterly compliance against pathways Over 90% compliance with pathway – 100% CQUIN payable Over 80% compliance with pathway – 75% of CQUIN payable. Over 70% compliance with pathway – 50% of CQUIN payable. Below 70% - no CQUIN payment
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	

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Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
8	To ensure that patients requiring unplanned care are treated in the right place at the right time reducing levels of avoidable hospital admission	Safety Quality	8b	One Call One Team	Locally suggested	0.0825% of contract value

Description of indicator	To reduce levels of avoidable hospital admissions by promoting the use of One Team clinics for older people presenting to the Trust needing unplanned care.
Numerator	Number of patients arriving in Accident & Emergency and Acute Medical Units for whom a referral to One Team is made
Denominator	Number of patients arriving in Accident & Emergency Departments.
Rationale for inclusion	Provide incentives to support increased use of One Team for suitable patients, ensuring that patients who can be better cared for in a community setting have good access to the right services in a timely fashion.
Data source and frequency of collection	Provider collected data.
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Monthly with Quarterly summary
Baseline period / date	To be established during Q1
Baseline value	To be established during Q1
Final indicator period / date (on which payment is based)	**2013/14**

Final indicator value (payment threshold)	**Q1:** No indicator – performance reported monthly from May 2013. **Q2:** Improvement on baseline. Threshold to be jointly agreed by CCG Clinical Accountable Officer and WSHT Medical Director **Q3:** Improvement on baseline. Threshold to be jointly agreed by CCG Clinical Accountable Officer and WSHT Medical Director **Q4:** Improvement on baseline. Threshold to be jointly agreed by CCG Clinical Accountable Officer and WSHT Medical Director
Final indicator reporting date	Report to be provided to CCG no later than 1 months after the end of the relevant quarter
Rules for partial achievement of indicator at year-end	Split of CQUIN payments to be : 10% of CQUIN paid for full achievement in Q1 30% of CQUIN paid for full achievement in Q2 30% of CQUIN paid for full achievement in Q3 30% of CQUIN paid for full achievement in Q4
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	1 month tolerance

Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
8	"Gainshare" scheme in support of sustaining and improving delivery of One Call One Team.	Safety Quality	8c	One Call One Team- Access to Rapid Access Clinic	Locally suggested	0.0825% of contract value

Description of indicator	Improved access to Rapid Access Clinic
Numerator	Number of patients seen in a Rapid Access Clinic where the patient is seen within 5 working ~~days~~ of referral.
Denominator	Number of patients seen in a Rapid Access Clinic.
Rationale for inclusion	Provide incentives to support improved access to services provided by Community Geriatrician.
Data source and frequency of collection	Provider collected data.
Organisation responsible for data collection	Provider WSHT
Frequency of reporting to commissioner	Monthly with Quarterly summary
Baseline period / date	NA
Baseline value	**NA**
Final indicator period / date (on which payment is based)	31st March 2014
Final indicator value (payment threshold)	**Q1:** No indicator – performance reported monthly. **Q2:** 98%. **Q3:** 98%. **Q4:** 98%. Over 98% achievement of indicator – 100% CQUIN payable Over 95% achievement of indicator– 75% of CQUIN payable. Over 80% achievement indicator– 50% of CQUIN payable. Below 80% - no CQUIN payment

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	Split of CQUIN payments to be : 10% of CQUIN available for payment in Q1 30% of CQUIN available for payment in Q2 30% of CQUIN available for payment in Q3 30% of CQUIN available for payment in Q4
Final indicator reporting date	20 working days after end of period.
Rules for partial achievement of indicator at year-end	There will be no payments of partial achievement of CQUIN.
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	1 month tolerance

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Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
8	To ensure that patients requiring unplanned care are treated in the right place at the right time reducing levels of avoidable hospital admission	Safety Quality	8.d	One Call One Team – Patient Satisfaction	Locally suggested	0.0825% of contract value

Description of indicator	Patient experience of One Call One Team
Numerator	Number of patients surveyed who are satisfied with the quality of services received further to an attendance at a rapid access clinic or treatment by a GP in A+E
Denominator	Number of patients surveyed further to attending a rapid access clinic or treated by a GP in A+E. A statistically significant number of patients to be surveyed will be agreed with CWS.
Rationale for inclusion	CCG and Trust wish to understand patient experience of One Call One Team services, and to ensure that these services are developed in a way that improves patient satisfaction with services as well as avoiding unnecessary admissions to hospital.
Data source and frequency of collection	Provider collected data.
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period / date	Baseline survey to be conducted Q1/Q2 2013/14
Baseline value	To be confirmed
Final indicator period / date (on which payment is based)	Q3 and Q4 2013/14
Final indicator value (payment threshold)	To be confirmed (x% increase on baseline in Q3 and x% increase on Q3 in Q4)

Final indicator reporting date	6 weeks after the end of the quarter in which the data is collected
Rules for partial achievement of indicator at year-end	Achievement of Q3 – 50% of CQUIN paid Achievement of Q4 – 50% of CQUIN paid
Rules for any agreed in-year milestones that result in payment	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	1 month tolerance

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Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
9	Reduced usage of co-amoxiclav	Safety Quality	9.1	Improving antibiotic prescribing		0.11% of contract value

Description of indicator	1) Reviewing antimicrobial prescribing policies and implementing changes to reduce usage of co-amoxiclav. This will be measured using pharmacy data showing overall usage of this drug normalised by numbers of total admissions (presented as usage per 1000 admissions). 2) Undertake quarterly assessment using the Antimicrobial Self Assessment Toolkit (ASAT). Maintain an assessment score at or above baseline value, and enact any milestones generated via assessment.
Numerator	N/A
Denominator	N/A
Rationale for inclusion	Usage of broad spectrum antibiotic agents is one factor associated with development of *C difficile* disease which is a significant issue both in the community and the acute trust within West Sussex
Data source and frequency of collection	WSHT Pharmacy data, monthly
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period / date	January – April 2013 inclusive
Baseline value	£TBC
Final indicator period / date (on which payment is based)	Financial year 2013/14 based on achievement of milestones as below
Final indicator value (payment threshold)	Prescribing (0.055% of contract value) Q1: Review of current antimicrobial guidance, development / approval of new policies and incorporation of necessary changes in formulary. Q2: Agree baseline and agree improvement trajectory and thresholds for antimicrobial prescribing in quarter 3 and 4. The level of expected improvement will be appropriate to the baseline level and the casemix of patients. Q3 & 4: To monitor and achieve reduction in normalised usage of co-amoxiclav ASAT (0.055% of contract value)

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Final indicator reporting date	6 weeks after the end of the quarter in which the data is collected
Rules for partial achievement of indicator at year-end	Prescribing Q1: The completed, revised antimicrobial guidance and related policies will be delivered to the CCG by June 30th Q2: The baseline data will be shared with and agreed between the Head of Medicines Management at WSHT and the CWS CCG prescribing lead by July 15th and an improvement trajectory agreed by August 15th. In the event of

	failure to agree the trajectory the matter will be referred to the Medical Director of WSHT and the Clinical Chief Officer of CWC CCG for agreement. Q3 and Q4: Figure for usage per 1000 admissions derived from outputs from pharmacy data systems and activity data (with source data provided to show the source of calculation). Milestones will be agreed for Q3 and Q4 as above. ASAT Q1 establish baseline value from validated 2012/13 assessment scores Q2 to Q4 < Baseline value: nil payment >Baseline, but less than baseline value plus 2 points: 50% payment >=Baseline plus 2 points, but less than baseline value plus 4 points: : 75% payment >=Baseline value plus 4 points: 100% payment
Rules for any agreed in-year milestones that result in payment	Prescribing Milestones will be agreed for Q3 and Q4 as above. For the improvement trajectory achievement of improvements less than the threshold will be treated as follows: - < 75% of target reduction for that quarter: nil 75-99% reduction: 50% payment ≥100% reduction: 100% payment ASAT Q1: Compliance determined by score of not less than 80 points. Payment of 0.01375% of contract value. Q1: Compliance determined by score of not less than 80 points. Payment of 0.01375% of contract value. Q1: Compliance determined by score of not less than 80 points. Payment of 0.01375% of contract value. Q1: Compliance determined by score of not less than 80 points. Payment of 0.01375% of contract value.
Rules for delayed achievement against final indicator period/date and/or in-year milestones	

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Goal no.	Description of goal	Quality Domain(s)	Indicator number	Indicator name	National or Regional indicator	Indicator weighting
9	Local CQUIN	tbc	9.2	Reduction of outpatient complaints		0.11% of contract value

Description of indicator	Development and roll out of outpatient partial booking, enabling a reduction in patient complaints relating to rescheduling/cancellation.
Numerator	Total patient complaints and enquiries to WSHT PALs service relating to outpatient rescheduling/cancellation.
Denominator	Total outpatient attendances. Consistent with national reporting the rate to be expressed as a standardised rate of contact per 10,000 outpatient attendances.
Rationale for inclusion	Identified area of patient experience concern by both WSHT and commissioners.
Data source and frequency of collection	WSHT Trust Board Quality Report, monthly.
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly
Baseline period / date	2012/13
Baseline value	0.12
Final indicator period / date (on which payment is based)	Q4 2013/14
Final indicator value (payment threshold)	£TBC

Final indicator reporting date	6 weeks after the end of the quarter in which the data is collected
Rules for partial achievement of indicator at year-end	Q1: Identify and procure call handling system for WSHT Outpatient Call Centres. This is an essential enabler for partial booking as existing systems cannot support call volumes partial booking generate. Q2: Roll out revised call handling system, and implement effective partial booking system. Q3: Deliver an aggregate patient contact ratio for Q3 of not greater than 0.11% per 10,000 outpatient attendances Q4: Deliver an aggregate patient contact ratio for Q3 of not greater than 0.10% per 10,000 outpatient attendances. .
Rules for any agreed in-year milestones that result in payment	Q1: No associated payment for compliance Q2: No associated payment for compliance Q3: Compliance triggers 50% payment of CQUIN value Q4: Compliance triggers 50% payment of CQUIN value
Rules for delayed achievement against final indicator period/date and/or in-year milestones	

9	Local CQUIN	Safety Quality	9.3	Assisted feeding		0.11% of contract value

Description of indicator	Increase the percentage of patient surveyed that confirm having assistance with feeding where the need for support is identified by the patient/carer. Achieve an end of year (Q4) compliance score in excess of the national median score of 7.5.
Numerator	Patient surveyed that confirm having assistance with feeding where the need for support was identified by the patient/relative
Denominator	Patient surveyed where the need for feeding assistance is identified
Rationale for inclusion	Comparatively low compliance score in National Inpatient Survey
Data source and frequency of collection	Real Time Patient Survey, collated monthly
Organisation responsible for data collection	WSHT
Frequency of reporting to commissioner	Quarterly. In addition to RTPE information about the number of complaints; PALs contacts incidents etc; number of volunteers trained relating to assisted feeding should be included in this quarterly report.
Baseline period / date	National Inpatient Survey 2012. Q1 for implementation of volunteer training programme; Q2 for roll out to wards.
Baseline value	6.3
Final indicator period / date (on which payment is based)	Q4 2013/14
Final indicator value (payment threshold)	£TBC

Final indicator reporting date	6 weeks after the end of the quarter in which the data is collected
Rules for partial achievement of indicator at year-end	Q1: delivery of Dining companion training programme to volunteer group Q2: Rollout to specified number of wards (to be agreed) on each site Q3: Q4: Roll out of dining companion scheme to all wards across both sites. For the improvement threshold will be treated as follows: - < 7.0, nil payment >=7.0 to <7.25, 50% payment >7.25 to 7.5, 75% payment >7.5, 100% payment
Rules for any agreed in-year milestones that result in payment	
Rules for delayed achievement against final indicator period/date and/or in-year milestones	
Final indicator reporting date	6 weeks after the end of the quarter in which the data is collected
Rules for partial achievement of indicator at year-end	Q1: delivery of Dining companion training programme to volunteer group Q2: Rollout to specified number of wards (to be agreed) on each site Q3: Q4: Roll out of dining companion scheme to all wards across both sites. For the improvement threshold will be treated as follows: - < 7.0, nil payment >=7.0 to <7.25, 50% payment >7.25 to 7.5, 75% payment >7.5, 100% payment
Rules for any agreed in-year milestones that result in payment	
Rules for delayed achievement against final indicator period/date and/or in-year milestones	