CCG Commissioners around Sussex Community Trust CQUIN 2013/14

Community Provider Sussex Community Trust

Pre-CQUIN Qualifying Criteria: Delivery of at least 50% of agreed High Impact Innovations from Innovation for Health & Wealth

- For SCT this will mean achievement of two of the three programmes from 12/13.

Individual Achievement by Provider

1. Nationally Mandated Requirements (0.125%):

a) i) Safety Thermometer – pressure ulcers
ii) Safety Thermometer – Safety Express (Local)

2. Regionally Mandated Requirements

SEC wide Enhancing Quality program (0.3%)

- Heart Failure – stretch on 12/13 target

3. Locally Mandated Requirements (2.075%)

a) VTE (0.3%)
b) Friends and Family Test (0.4%)

c) Dementia (0.3%)
d) HII (0.3%)

e) Advance Care Planning (0.375%)
g) Shared Decision Making (0.4%)

Goal No.	Description of goal	Quality Domain(s) [1]	Indicator name	National or Regional indicator [2]	Indicator weighting on total contract value
1a(i) (ii)	Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter Implementation of the Safety Express	Safety	NHS Safety Thermometer	Nationally mandated	0.125%
2	Improve performance against established baseline of the heart failure pathways as part of the Enhancing Quality Programme.	Safety and Effectiveness	Acute patient specific pathway process development in line with SHA requirements	Regionally Mandated	0.3%
3a	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	95% VTE risk assessment	Locally mandated	0.3%
3b	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.	Patient experience	Friends and Family Test	Locally mandated	0.4%
3c	Improve awareness and diagnosis of dementia, using risk assessment, in the community hospital setting	Safety, effectiveness and patient experience	Dementia screening	Locally mandated	0.3%
3d	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	Locally mandated	0.3%

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

3e	Advanced Care Planning (ACP) - % of EOLC patients offered an ACP and associated preferences of care and place of death recorded	Patient Experience	Advance Care Planning	Locally mandated	0.375%
3f	Shared Decision Making	Effectiveness and patient experience	Patient involvement through the use of patient decision aids for patients with osteo arthritis for treatment of hip and knee	Locally mandated	0.4%

Indicator 1a – Safety Thermometer

Description of goal – what do you want to achieve?	This CQUIN incentivises the collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument (developed as part of the QIPP Safe Care national work stream) to survey all relevant patients in all relevant NHS providers in England on a monthly basis Detailed information on the appropriate patients and relevant settings for use of the NHS Safety Thermometer are defined in the NHS Safety Thermometer guidance for use[3]. The intention is for all NHS-funded providers, across community, mental health, acute and residential and nursing care, including NHS-funded independent sector providers, to use the Safety Thermometer, apart from where exceptions apply, as detailed in the guidance. This will allow nationally consistent data to be collected and published as well as facilitating local improvement activity. Where providers already have in place existing data collections that duplicate the measures in the tool, commissioners should use this CQUIN to incentivise transition to the safety thermometer tool to ensure data is produced that is consistent with the national collection. Use of the Safety Thermometer will be mandatory in 2013/14. Where organisations are already submitting full data for the safety thermometer and there is no room for further improvement, commissioners should consider increasing the proportion of CQUIN payments available for the other national CQUIN goals.
Description of indicator – how will achievement be measured?	This CQUIN will require monthly surveying all appropriate patients (as defined in the NHS Safety Thermometer guidance) to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE). Experience to date suggests data is best collected at the point of care by healthcare professionals (in accordance with guidance) using a point prevalence survey method (one day per month), entered into the instrument by administrative staff and aggregated at organisation level by performance teams or other suitable staff. Data should be submitted to the Information Centre quarterly. A completed Safety Thermometer survey for all relevant patients must be included for each month in the relevant quarter's submission to trigger payment.
Numerator	(i) Number of teams submitting safety thermometer data http://harmfreecare.org/wp-content/uploads/2012/06/NHS-ST-CQUIN-2012.pdf (ii) Implementation of the SCT Safety Express tool
Denominator	(i)Number of teams required to submit safety thermometer data Numerator = The number of patients recorded as having a category 2-4 pressure ulcer acquired in the provider's care as measured using the Safety Express tool. (ii) Implementation of the Safety Express Tool and monitoring of usage from Q2 onwards
Rationale for inclusion	Participation in data collection using the NHS Safety Thermometer is an important preparatory step for NHS-funded provider organisations in reducing harm. Incentivising use of the NHS Safety Thermometer will increase the participation in this data collection, establish a national baseline of

[3] Further guidance on the application of the Safety Thermometer, including appropriate settings for use and when it is clinically appropriate to exclude particular patients from the survey, will follow shortly.

	performance on the four harms and provide information on the range of performance. This will allow the establishment of quality improvement aims for year two (further details to follow) and contribute to the provision of data required for the Outcomes Framework and Government Transparency Agenda. The intention is that further improvement goals relating to outcomes measured by the Safety Thermometer will be incentivised in future years.
Data source	Data is from two primary sources according to the NHS Safety Thermometer guidance: a physical examination of the patient (including a conversation with them or their carer) and nursing / medical records (including pharmacy records). Provider submission to the Information Centre which publishes the data at http://www.ic.nhs.uk/services/nhs-safety-thermometer
Frequency of collection	Data will be collated locally using the NHS Safety Thermometer tool on a single day per month (day to be determined locally in each provider). This monthly data will be uploaded by each provider to the NHS Information Centre on a quarterly basis (ie data representing the 3 constituent months in a single quarter uploaded to the IC quarterly) Further information will be provided in due course on how to submit data. From Q2, improvement data for pressure ulcers will be collected by the Safety Express Tool
Organisation responsible for data collection	NHS Provider
Frequency of reporting to commissioner	Quarterly - reporting use of NHS Safety Thermometer will be through direct submission of the data to the Information Centre. The commissioner will use the data published by the Information Centre to review performance for each relevant Quarter. For the improvement target, quarterly reports to the commissioner
Baseline period / date	Not applicable.
Baseline value	(i) Currently 43 units collecting data of at least 10 patients on the required measurement day – 95% achievement
Final indicator period / date (on which payment is based)	Q4 2013/14
Final indicator value (threshold on which payment is based)	(i) 50% for retaining the 95% achievement of all participating units quarterly (ii)50% for achieving the following trajectory Q1: introduce safety express database across all teams Q2:set base line for SCT acquired pressure ulcers By then end of Q4: improve on Q2 base line
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	(i)95% achievement of 43 units (ii) Q4 target to be set at Q2
Final indicator reporting date	30 working days after the end of the period
Rules for any agreed in-year milestones that result	As above

in payment	
Rules for partial achievement of indicator at year-end	N/A
Rules for delayed achievement against final indicator period/date and/or in-year milestones	N/A

Indicator 2 – Enhancing Quality

	Patient Quality Outcomes - Heart Failure
1	Reduction in Complications
2	Reduction in Re-admissions
3	Reduction in Hospital Admissions (per 1000 admits)
4	Reduction in Mortality
5	Reduction in length of Stay

Stretch target on 2012/13 baseline from SHA April 2013

Indicator 3a. – VTE

Indicator name	VTE Risk Assessment
Indicator weighting (% of CQUIN scheme available)	0.3% of contract value including RCA indicator>
Description of indicator	95% 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	Local CQUIN scheme.
Data source	Monthly report
Frequency of data collection	Monthly
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 deleted reference to Unify
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
Rules for any agreed in-year milestones that result in payment	No in year milestones. Payment relates to compliance position at 31 March 2014
Rules for delayed achievement against final indicator period/date and/or in-year milestones	1 month tolerance

VTE – ROOT CAUSE ANALYSES	
Indicator name	VTE Root Cause Analyses
Description of indicator	The number of root cause analyses carried out on cases of hospital associated thrombosis
Numerator (dependant on M12 2012/13 audit)	Locally agreed numerator, considering the total number of VTE reported through local systems for identification of VTE and root cause analysis, taking into account advice and guidance at http://www.vteprevention-nhsengland.org.uk> Demonstrate process for capture of community-acquired DVT for SCT patients by Q1
Denominator	Locally agreed denominator, considering the total number of VTE reported through local systems for identification of VTE and root cause analysis, taking into account advice and guidance at http://www.vteprevention-nhsengland.org.uk>
Rationale for inclusion	Local CQUIN scheme
Data source	Quarterly report
Frequency of data collection	Quarterly
Organisation responsible for data collection	Provider
Frequency of reporting to commissioner	Quarterly
Baseline period/date	M12 2012/13
Baseline value	TBC
Final indicator period/date (on which payment is based)	April 2013 – March 2014
Final indicator value (payment threshold)	TBC
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?	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

Indicator 3b – Friends and Family Test

Description of indicator	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. Community hospital providers will need to ensure that they can provide Friends and Family scores from 1 April 2013 at the latest that meets the national guidance. Commissioners will need to be assured that their hospital providers are on track to have fully implemented the Friends and Family Test from 1 April 2013 Commissioners and providers will need to put in place implementation plans for rolling out the Friends and Family Test to other areas during 2013/14. SUPPORTING INFORMATION: National Friends and Family Guidance published by the Department of Health is available at http://www.dh.gov.uk/health/2012/10/guidance-nhs-fft/
Numerator	N/A
Denominator	N/A
Rationale for inclusion	The Friends and Family Test will provide timely, granular feedback from patients about their experience.
Data source and frequency of collection	1. Two one-off returns from providers to local commissioners on the position at end of October 2013 and March 2014. 2. Providers of NHS funded services will provide monthly data on Friends and Family Test results via monthly reporting 3. Annual Staff Survey.
Organisation responsible for data collection	NHS Trust
Frequency of reporting to commissioner	As above
Baseline period / date	N/A N/A Improvement on previous year's score
Baseline value	N/A N/A

	Improvement on previous year's score
Final indicator period / date (on which payment is based)	31st March 2014
Final indicator value (payment threshold)	1. 30 per cent of the funding for phased expansion: NHS providers will need to deliver the nationally agreed roll-out plan if available for Community. If not local target that all inpatients to be asked as of 1st April and UTC and MIUs from 1 October 2013 2. 50 per cent of the funding for increasing the response rate in the community inpatient and MIU/UTC areas by Oct 13 Baseline will be Q1 for inpatients and the marked improvement by Q4 and baseline for UTC/MIU Q3 with improvement by Q4 3. 20 per cent of the funding for increasing the score of the Friends and Family Test question within the 2013/14 staff survey compared with 2012/13 survey results.
Final indicator reporting date	31st March 2014
Rules for partial achievement of indicator at year-end	N/A
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	N/A

Indicator 3c – Dementia Screening

DEMENTIA – ASSESS, INVESTIGATE & REFER	
Indicator name	Dementia –Assess, Investigate and Refer
Indicator weighting (% of CQUIN scheme available)	0.3%
Description of indicator	The proportion of all step-up admissions aged 65 and over who are appropriately assessed, and the number referred on to specialist services
Numerator	1) Number of above patients reported as having had a diagnostic assessment including investigations requested within 5 days 2) Number of above patients referred for further diagnostic advice in line with local pathways agreed with commissioners or GP informed 3) Report on but exclude patients who refuse to participate and other exclusions as per national guidelines
Denominator	1) Number of above step up patients aged 65 and over discharged within the reporting month
Rationale for inclusion	Local CQUIN scheme
Data source	Report
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 (including evidence to be supplied to commissioner)	Provider has achieved incrementally to 90% or greater by beginning Q4 and remains above 90%
Final indicator reporting date	March 2014
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?	No

DEMENTIA – CLINICAL LEADERSHIP	
Indicator name	Dementia – Clinical Leadership
Description of indicator	Named lead clinician for dementia and

	appropriate training for staff
Numerator	Not applicable
Denominator	Not applicable
Rationale for inclusion	Local 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 (including evidence to be supplied to commissioner)	Provider must confirm named lead clinician and the planned training programme around the improvement in the management and support of patients with Dementia and their carers. 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

Indicator 3d

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 30th April 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 30th April 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 30th April 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 30th April 2013
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 Collaborative	1.6 Participate in 3 Million Lives collaborative events as hosted by AHSN HII team by having at least 1 attendee at the 3Million Lives collaborative	On-going
1.7 Targets	1.7 Part 1 – Improvement on current usage (60%) of telehealth in the North of the county: Retain current usage of telehealth as deemed appropriate. Propose alternative project for the use of telehealth by the end of Q2 and monitor against milestones Q3 and Q4 Implementation on BHC if Commissioners agree to purchase items. Part 2 – Email out to patients pilot in CWS to be reviewed at 6 months and if successful to be rolled out across SCT	

3. Child in a Chair in a day

Trusts should "review the provision of wheelchair services to ensure outcomes similar to those achieved by the best-performing providers of mobility services for children",

Title of Activity	Description of Activity – level to be achieved	Delivered by
Community/Acute providers to:		
3.1 Baseline	3.1 Review and report on children's wheelchair service provision as at March 2013, as a baseline, including speed of referral to wheelchair service, to assessment for wheelchair, to wheelchair provision. This to be set out as total volume of referral each month, plus; numbers/proportion who were assessed within 1 day, 3 days, 1 week, > 1 week from referral; numbers/proportion who received their wheelchair within 1 day, 3 days, 1 week, 2 weeks, 4 weeks, > 4 weeks from referral.	By 30th April 2013
3.2 Plan	3.2 Set out a plan for improving the provision of wheelchairs during 2013/14, with target improvement in speed of assessment and wheelchair provision from referral by March 2014, as compared to baseline in March 2013. Plan to include baseline, targets of improvement, and methods for monitoring the provision of wheelchairs and the speed of chair provision	By 30th April 2013
3.3 Monitoring	3.3 Collect wheelchair provision data and report 3 monthly against target speed of chair provision and baseline	Ongoing
3.4 Collaborative	3.4 Participate in Child in a Chair collaborative events as hosted by AHSN HII team.	Ongoing
3.5 Targets	3.5 Stretch target for standard chairs dependant on M12 audit of current position	

4. International & Commercial Activity

Title of Activity	Description of Activity – level to be achieved	Delivered by
All providers to:		
4.1 Plan	4.2 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.	1st September 2013

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	Delivered by

	achieved	
ALL Providers to:		
5.3 Baseline set	5.3 Establish a baseline of projects already implemented using digital products, stating numbers of transactions to date, at March 2013	By 30th April 2013
5.4 Review and determine which of the 10 digital areas are relevant	5.4 Review and determine which of the 10 digital areas are relevant – a) appointment reminders and b) mobile working in the community	By 30th April 2013
5.5 Trajectory	5.5 Set out a quarterly trajectory with the % increase to be agreed when baseline available	By 30th April 2013
5.6 Plan	5.6 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 30th April 2013
5.7 Monitoring	5.7 Q2 & Q3 & Q4 Collect digital usage data and report quarterly against trajectory in plan, by volume of transactions	Ongoing
5.8 Collaborative	5.8 Participate in Digital First collaborative events as hosted by AHSN HII team.	Ongoing
5.9 Targets.	5.9 SCT to identify relevant Digital Areas	

Indicator 3e – Advance Care Plans

Description of indicator	To improve the experience for end of life care patients by offering them an opportunity to discuss and complete an advance care plan (ACP). The health care professional can assist in completing the ACP if the patient prefers that approach. The provider will agree and introduce an agreed format for an advance care plan during Quarter 1. The provider will set up and roll out training on advance care plans to be supported by the end of life care facilitators during Quarters 1 and 2. This will include them working alongside community nursing staff with patients. Teams will start to report the number of end of life care patients offered an ACP from Quarter 2, commencing with the specialist palliative care teams and rolling out to other community teams through the year. The roll out will be linked to the roll out of System One which can capture this information
Numerator	Number of teams offering advance care plans to patients
Denominator	Number of teams that have migrated to System One
Rationale for inclusion	Clinical Commissioning Groups and the provider have agreed that Advance Care Plans improve patient experience by offering personalised care that is agreed with the patient, including the preferred place of care for their death
Data source and frequency of collection	1. Quarterly reports on progress by the provider 2. Quarterly monitoring on numbers of patients with ACPs commencing at the end of Q2
Organisation responsible for data collection	NHS Trust
Frequency of reporting to commissioner	As above
Baseline period / date	N/A
Baseline value	N/A
Final indicator period / date (on which payment is based)	31st March 2014
Final indicator value (payment threshold)	1. 30 per cent of the funding for agreeing and implementing a format for the Advance Care Plan during Quarter 1

	2. 30 per cent of the funding for setting up and rolling out a training programme during Quarters 1 and 2 3. 40 per cent of the funding for setting up reporting: • Specialist palliative care team by the end of Q2 • Community nursing teams in NWS by the end of Q3 • All SCT community nursing teams where System One has been rolled out by the end of Q4
Final indicator reporting date	31st March 2014
Rules for partial achievement of indicator at year-end	33% of indicator 3 for each sub target achieved
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	N/A

Indicator 3f - Shared Decision Making

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. Shared decision making forms part of a national work stream in the DH Quality Innovation Productivity and Prevention programme (QIPP).
Numerator	N/A
Denominator	
Rationale for inclusion	38 Patient Decision Aids (PDAs) have been created, designed to help patients understand and consider the pros and cons of possible treatment options and to encourage communication between them and their healthcare professionals. The PDAs feature evidence-based information, images, diagrams and animations. Patient Decision Aids are specially designed information resources that help people make decisions about difficult healthcare options Relevant PDAs are: O/E hip and knee in terms of physio For 2013/14 it is agreed that the Trust will focus on the introduction of OA HIP and Knee patients
Data source	Monthly report from Provider Trust on usage of PDAs
Frequency of data collection	Monthly
Organisation responsible for data collection	Provider Trust
Frequency of reporting to commissioner	Monthly
Baseline period/date	N/A
Baseline value	N/A
Final indicator period/date (on which payment is based)	M12 2013/14
Final indicator value (payment threshold)	TBC

Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	By end Q1 Trust to set up systems for implementation, including recording and setting of targets for the rest of the financial year. Q2 tbc% of relevant patients having SDM Q3 tbc% Q4 tbc%
Final indicator reporting date	M12 2013/14
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