# 1. Improving staff health and wellbeing

There are three parts to this CQUIN indicator.

| National CQUIN | Indicator | Indicator weighting (% of CQUIN scheme available) |
|---|---|---|
| CQUIN 1a | Improvement of health and wellbeing of NHS staff | 33.3% of 0.25% (0.0834%) |
| CQUIN 1b | Healthy food for NHS staff, visitors and patients | 33.3% of 0.25% (0.0833%) |
| CQUIN 1c | Improving the uptake of flu vaccinations for front line staff within Providers | 33.3% of 0.25% (0.0833%) |

### Indicator 1a Improvement of health and wellbeing of NHS staff

| Indicator 1a | |
|---|---|
| **Indicator name** | Indicator 1a: Improvement of staff health and wellbeing |
| **Indicator weighting (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0834%) |
| **Description of indicator** | Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, MSK and stress. The two questions do not have to be pre-selected before the staff survey results, with 50% of the value of this indicator relating to performance in one question and the remaining 50% of the value relating to performance in a second question.<br><br>Year 1 (17/18)<br>The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey.<br><br>Year 2 (18/19)<br>The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey.<br><br>1. **Question 9a**: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer “yes, definitely” compared to baseline staff survey results or achieve 45% of staff surveyed answering “yes, definitely”.<br>2. **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the answer “no” compared to baseline staff survey results or achieve 85% of staff surveyed answering “no”.<br>3. **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? |

| Indicator 1a | |
|---|---|
| | Providers will be expected to achieve an improvement of 5% points in the answer “no” compared to baseline staff survey results or achieve 75% of staff surveyed answering “no”. |
| **Numerator** | NHS staff survey results for the Provider<br><br>Year 1<br>**Question 9a:** 2017 number of responses of “yes, definitely”<br>**Question 9b:** 2017 number of responses of “no”<br>**Question 9c:** 2017 number of responses of “no”<br>Year 2<br>**Question 9a:** 2018 number of responses of “yes, definitely”<br>**Question 9b:** 2018 number of responses of “no”<br>**Question 9c:** 2018 number of responses of “no” |
| **Denominator** | NHS staff survey results for the Provider<br><br>Year 1<br>**Question 9a**: 2017 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*)<br>**Question 9b:** 2017 Total number of responses (*Yes/No*)<br>**Question 9c:** 2017 Total number of responses (*Yes/No*)<br>Year 2<br>**Question 9a**: 2018 Total number of responses (*Yes, definitely/ Yes, to some extent/ No*)<br>**Question 9b:** 2018 Total number of responses (*Yes/No*)**Question 9c:** 2018 Total number of responses (*Yes/No*) |
| **Rationale for inclusion** | The Health & Wellbeing CQUIN introduced in 2016 encourages providers to improve their role as an employer in looking after employees health and wellbeing. Part of this scheme provided the option to introduce schemes focussing on mental health, physical activity and MSK – many of which are being introduced during the second half of 2016-17. The focus of this element of the CQUIN will shift from the introduction of schemes to measuring the impact that staff perceive from the changes – via improvements to the health and wellbeing questions within the NHS staff survey.<br><br>Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. This figure excludes the cost of agency staff to fill in gaps, as well as the cost of treatment. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.<br><br>The Five Year Forward View made a commitment ‘to |

| Indicator 1a | |
|---|---|
| | ensure the NHS as an employer sets a national example in the support it offers its own staff to stay healthy'. A key part of improving health and wellbeing for staff is giving them the opportunity to access schemes and initiatives that promote physical activity, provide them with mental health support and rapid access to physiotherapy where required. The role of board and clinical leadership in creating an environment where health and wellbeing of staff is actively promoted and encouraged. |
| **Data source** | The NHS Annual Staff survey<br><br>**Question 9a**: Does your organisation take positive action on health and well-being? *Yes, definitely/ Yes, to some extent/ No* response.<br>**Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? *Yes/No* response.<br>**Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? *Yes/No* response. |
| **Frequency of data collection** | Annual release of staff survey results |
| **Organisation responsible for data collection** | National NHS staff survey co-ordination centre |
| **Frequency of reporting to commissioner** | On the publication of 2017 (year 1) & 2018 (year 2) staff survey – expected to be released in February 2018 & 2019 respectively |
| **Baseline period/date** | Year 1 - 2015 staff survey – released in 2016<br>Year 2 – 2016 staff survey- released in 2017 |
| **Baseline value** | Individual trust performance against each staff survey question |
| **Final indicator period/date (on which payment is based)** | Year 1 - Quarter 4, 2017/18<br>Year 2 – Quarter 4 2018/19 |
| **Final indicator value (payment threshold)** | Achievement of the 5% point improvement in 2 of the 3 questions in the staff survey results |
| **Final indicator reporting date** | Year 1 – Publication of 2017 staff survey – expected in February 2018<br>Year 2 – Publication of 2018 staff survey – expected in February 2019 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes |

## Rules for partial achievement of indicator 1a

The partial payment structure below will be applied to each question individually. For instance, a 5% point improvement in question 9a and a 3% improvement in 9b would result in 75% payment of this indicator calculated by:

1.) Question 9a – 50% indicator weighting x 100% payment for achieving 5% improvement = 50%
2.) Question 9b – 50% indicator weighting x 50% payment for achieving 3% improvement = 25%

**Total = 50%+25% = 75%**

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| Less than 3% point improvement | 0% payment of weighting associated to staff survey results |
| 3% point (or above) and less than 4% improvement | 50% payment of weighting associated to staff survey results |
| 4% point (or above) and less than 5% improvement | 75% payment of weighting associated to staff survey results |
| 5% point or greater improvement or achievement of uptake target | 100% payment of weighting associated to staff survey results |

## Indicator 1b Healthy food for NHS staff, visitors and patients

| Indicator 1b | |
|---|---|
| **Indicator name** | Indicator 1b: Healthy food for NHS staff, visitors and patients |
| **Indicator weighting (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0833%) |
| **Description of indicator** | Providers will be expected to build on the 2016/17 CQUIN by:<br><br>Firstly, maintaining the four changes that were required in the 2016/17 CQUIN in both 2017/18 & 2018/19<br><br>a.) The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)[1].<br>The following are common definitions and examples of price promotions:<br>1. Discounted price: providing the same quantity of a product for a reduced price (pence off deal);<br>2. Multi-buy discounting: for example buy **one** get **one** free;<br>3. Free item provided with a purchase (whereby the free item cannot be a product classified as HFSS);<br>4. Price pack or bonus pack deal (for example 50% for free); and<br>5. Meal deals (In 2016/17 this only applied to drinks sold in meal deals. In 2017/18 onwards no HFSS products will be able to be sold through meal deals).<br><br>b.) The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS);<br>The following are common definitions and examples of advertisements:<br>1. Checkout counter dividers<br>2. Floor graphics<br>3. End of aisle signage<br>4. Posters and banners<br>c.) The banning of sugary drinks and foods high in fat, sugar or salt (HFSS) from checkouts;<br>The following are common definitions and examples of checkouts;<br>1. Points of purchase including checkouts and self-checkouts<br>2. Areas immediately behind the checkout<br>and;<br><br>d.) Ensuring that healthy options are available at any |

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

| Indicator 1b | |
|---|---|
| | point including for those staff working night shifts. We will share best practice examples and will work nationally with food suppliers throughout the next year to help develop a set of solutions to tackle this issue.<br><br>Secondly, introducing three new changes to food and drink provision:<br><br>In Year One (2017/18)<br><br>a.) 70% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).<br><br>b.) 60% of confectionery and sweets do not exceed 250 kcal.<br><br>c.) At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g2<br><br>In Year two (2018/19):<br>The same three areas will be kept but a further shift in percentages will be required<br><br>a.) 80% of drinks lines stocked must be sugar free (less than 5 grams of sugar per 100ml). In addition to the usual definition of SSBs it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk based drinks (with sugar content of over 10grams per 100ml).<br><br>b.) 80% of confectionery and sweets do not exceed 250 kcal.<br><br>c.) At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g3 |
| **Numerator** | N/A |
| **Denominator** | N/A |
| **Rationale for inclusion** | Any Provider who does not sell food or drink on their site will not be eligible for the CQUIN. In these cases the weighting |

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419245/balanced-scorecard-annotated-march2015.pdf

| Indicator 1b | |
|---|---|
| | for this part (1b) will be added equally to parts 1a and 1c.<br><br>PHE's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight. Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay and obesity and its health consequences. Consumption of sugar and sugar sweetened drinks. It is important for the NHS to start leading the way on tackling some of these issues, starting with the food and drink that is provided & promoted in hospitals.<br><br>NHS England will continue with their work at a national level with the major food suppliers on NHS premises to ensure that NHS providers are supported to take action across all food and drink outlets on their premises. |
| **Data source** | Provider data source |
| **Frequency of data collection** | End of Quarter 4 |
| **Organisation responsible for data collection** | Evidence should be provided that shows a substantive change has been moved in shifting to healthier products<br>• Reduction in % of sugar/salt products displayed:<br>• Increase in healthier alternatives<br>• Avoidance of overt promotion<br>However the exact detail of reporting should be agreed locally so that it can be adapted to the local situation (for instance it may differ depending on the scale and types of outlets on premises).<br><br>Each provider must evidence to commissioners that they have maintained the changes in 2016/17 and introduced the 2017/18 changes by providing at least the following evidence:<br>• A signed document between the NHS Trust and any external food supplier committing to keeping the changes<br>• Evidence for improvements provided to a public facing board meeting |
| **Frequency of reporting to commissioner** | End of Quarter 4 |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Year 1 - End of Q4 2017/18<br>Year 2 - End of Q4 2018/19 |
| **Final indicator value** | To be determined locally |

| Indicator 1b | |
|---|---|
| **(payment threshold)** | |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **Are there rules for any agreed in-year milestones that result in payment?** | No |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes |

## Rules for partial achievement of indicator 1b

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| 2017/18 - 2016/17 changes maintained<br>2018/19 - 2016/17 changes maintained | 50% payment |
| 2017/18 - Year 1 changes introduced<br>2018/19 - Year 2 changes introduced | 50 % payment |
| 2017/18 - 2016/17 changes maintained and Year 1 changes introduced<br><br>2018/19 – 2016/17 changes maintained and Year 2 changes introduced | 100% payment |

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

| Indicator 1c | |
|---|---|
| **Indicator name** | Improving the uptake of flu vaccinations for frontline clinical staff within Providers. |
| **Indicator weighting (% of CQUIN scheme available)** | 33.3% of 0.25% (0.0833%) |
| **Description of indicator** | Year 1 - Achieving an uptake of flu vaccinations by frontline clinical staff of 70%<br>Year 2 - Achieving an uptake of flu vaccinations by frontline clinical staff of 75% |
| **Numerator** | Number of front line healthcare workers (permanent staff and those on fixed contracts) who have received their flu vaccination by February 28th 2018.<br><br>If organisations believe a significant proportion of staff are receiving their flu vaccines from other providers, they can include this in their returns if they wish to create an auditable scheme to demonstrate it. |
| **Denominator** | Total number of front line healthcare workers [4] |
| **Rationale for inclusion** | Frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during winter months when some of their patients will be infected. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season - a much higher incidence than expected in the general population.<br><br>Influenza is also a highly transmissible infection. The patient population found in hospital is much more vulnerable to severe effects. Healthcare workers may transmit illness to patients even if they are mildly infected.<br><br>The green book recommends that healthcare workers directly involved in patient care are vaccinated annually. It is also encouraged by the General Medical Council and by the British Medical Association.<br><br>Specifically the green book states “Employers need to be able to demonstrate that an effective employee immunisation programme is in place, and they have an obligation to arrange and pay for this service. It is recommended that immunisation programmes are managed by occupational health services with appropriately qualified specialists. This chapter deals primarily with the immunisation of healthcare and laboratory staff; other occupations are covered in the relevant chapters.”[5] |
| **Data source** | Providers to submit cumulative data monthly on the |

[4] Please see appendix A for definitions of frontline healthcare workers Seasonal influenza vaccine uptake HCWs 2015-16 Annual Report

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147882/Green-Book-Chapter-12.pdf

| Indicator 1c | |
|---|---|
| | ImmForm website |
| **Frequency of data collection** | Monthly |
| **Organisation responsible for data collection** | Provider |
| **Frequency of reporting to commissioner** | Year 1 -March 2018<br>Year 2 -March 2019 |
| **Baseline period/date** | N/A |
| **Baseline value** | N/A |
| **Final indicator period/date (on which payment is based)** | Year 1-March 2018<br>Year 2-March 2019 |
| **Final indicator value (payment threshold)** | Year 1 – A 70% uptake of flu vaccinations by frontline healthcare workers<br>Year 2 - A 75% uptake of the flu vaccinations by frontline healthcare workers |
| **Final indicator reporting date** | As soon as possible after Q4 2017/18 |
| **Are there rules for any agreed in-year milestones that result in payment?** | N/A |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes - see partial payment section |

### Rules for partial achievement of indicator 1c – Year 1

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| 50% or less | No payment |
| 50% up to 60% | 25% payment |
| 60% up to 65% | 50% payment |
| 65% up to 70% | 75% payment |
| 70% or above | 100% payment |

### Rules for partial achievement of indicator 1c – Year 2

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| 50% or less | No payment |
| 50% up to 60% | 25% payment |
| 60% up to 65% | 50% payment |
| 65% up to 75% uptake | 75% payment |

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| 75% or above | 100% payment |

## Supporting Guidance and References

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

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

## Indicator 8b – Community Trusts

**Please see individual Indicators**

## - 9 Preventing ill health by risky behaviours – alcohol and tobacco

There are five parts to this CQUIN indicator.

| National CQUIN | Indicator | Indicator weighting (% of CQUIN scheme available) |
|---|---|---|
| CQUIN 9 - Tobacco | 9a Tobacco screening | 5% of 0.25% (0.0125%) |
| | 9b Tobacco brief advice | 20% of 0.25% (0.05%) |
| | 9c Tobacco referral and medication offer | 25% of 0.25% (0.0625%) |
| CQUIN 9 – Alcohol | 9d Alcohol screening | 25% of 0.25% (0.0625%) |
| | 9e Alcohol brief advice or referral | 25% of 0.25% (0.0625%) |

### Indicator 9a Tobacco screening

| Indicator 9a | |
|---|---|
| **Indicator name** | Tobacco screening |
| **Indicator weighting (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 5% of 0.25% (0.0125%).<br><br>*(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)* |
| **Description of indicator** | Percentage of unique adult patients who are screened for smoking status AND whose results are recorded. |
| **Numerator** | Number of **unique, adult patients** who are **admitted** and **screened for smoking status** and results are recorded in patient's record during this quarter:<br>• **unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN;<br>• **adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN;<br>• **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the CQUIN for improving physical healthcare in people with severe mental health illness ('PSMI');<br>• the "**screened for smoking status**" element of |

| Indicator 9a | |
|---|---|
| | this indicator requires the standard protocol for screening smokers in secondary care as per NICE guidance PH48 to be implemented. Detail on the required actions from healthcare professionals can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and<br>• the "**recorded in patient's record**" element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. |
| **Denominator** | All **unique, adult patients** who are **admitted** during this quarter:<br>• **unique** is defined as a non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN;<br>• **adult patient** is defined as patients of at least 18 years of age; and<br>• **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). |
| **Rationale for inclusion** | **Context**<br>This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.<br><br>**The burden of smoking**<br>Smoking is estimated to cost £13.8bn to society (£2bn on the NHS through hospital admissions, £7.5bn through lost productivity, £1.1bn in social care). Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness, 33% of tobacco is consumed by people with mental health problems.[6] Smoking is the single largest cause of health inequalities[7]. |

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf
[7] http://www.sciencedirect.com/science/article/pii/S0140673606689757

| Indicator 9a | |
|---|---|
| | A Cochrane Review[8] shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis. Inpatient smoking cessation leads to a reduced rate of wound infections, improved wound healing and increased rate of bone healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates among patients who want to quit and take up a referral to stop smoking services are between 15% and 20%, compared to 3% to 4% amongst those without a referral.[9]<br><br>**The status quo nationally**<br>Coverage of advice and referral interventions for smokers are patchy. Currently in secondary care, some patients may be asked if they smoke, but not all, and not at every admission, e.g. less than half of smokers admitted to hospital receive very brief advice to stop as an inpatient. For those patients that have been identified as a smoker, this is no guarantee that they will then be given an effective stop smoking intervention and referral to evidence based smoking cessation support. Currently, only 1.5% of smokers in acute hospital settings go onto make a quit attempt with stop smoking services.<br><br>**The financial case**<br>Modelling of the tobacco component of the CQUIN suggests that it could reduce costs through fewer admissions and improved health of smokers and passive smokers; resulting in net savings of £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy each year over 4 years. This is a conservative estimate accounting for the reduced cost of hospital admissions only. |
| Data source | **Provider audit of patient records, submitted to CCGs on a quarterly basis:**<br><br>We propose that:<br>• Providers with searchable electronic patient records audit **all patient records**.<br>• Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**.<br><br>**The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months. |

[8] Rigotti N, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients.Cochrane Database of Systematic Reviews 2007; Issue3.Art.No.:CD001837.DOI:10.1002/14651858.CD001837.pub2

[9] http://www.ncsct.co.uk/usr/pub/Briefing%208.pdf

| Indicator 9a | |
|---|---|
| | **The following exclusion criteria** should be applied:<br><br>1. All patients below 18 years of age<br>2. All in-patients in maternity wards<br>3. All A&E attendances that do not lead to in-patient admissions<br>4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention.<br><br>**For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B.<br><br>**The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance and insight teams.<br><br>**Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff[10]. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.<br><br>Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.<br><br>Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which** | Quarter 4 FY 18/19. |

[10] Note that staff and healthcare professionals are used interchangeably throughout this document. The intention is to ensure that the intervention is delivered by the most appropriate healthcare professionals and is not restricted to one particular professional group. Providers will be best placed to judge who in their organisations should deliver.

| Indicator 9a | |
|---|---|
| **payment is based)** | |
| **Final indicator value (payment threshold)** | **90%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.<br><br>**Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.<br><br>**Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below |

## Indicator 9b Tobacco brief advice

| Indicator 9b | |
|---|---|
| **Indicator name** | Tobacco brief advice |
| **Indicator weighting (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 20% of 0.25% (0.05%).<br><br>*(NB: this applies for Q2 onwards, different reward structure for Q1,see 'rules for in-year payment' section below).* |
| **Description of indicator** | Percentage of unique patients who smoke AND are given very brief advice |
| **Numerator** | Number of **eligible patients** who are **given brief advice** during this quarter:<br>• **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a); and<br>• the "**given very brief advice**" element of this indicator requires healthcare professionals to provide brief advice message and this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate. See Annex A for further details. |
| **Denominator** | All **eligible patients** during this quarter:<br>• **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 9a). |
| **Rationale for inclusion** | Please refer to this section in 9a. |
| **Data source** | Please refer to this section in 9a. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.<br><br>Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.<br><br>Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which** | Quarter 4 FY 18/19. |

| Indicator 9b | |
|---|---|
| **payment is based)** | |
| **Final indicator value (payment threshold)** | **90%**<br>(NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme) |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.<br><br>**Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.<br><br>**Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

## Indicator 9c Tobacco referral and medication offer

| Indicator 9c | |
|---|---|
| **Indicator name** | Tobacco referral and medication offer |
| **Indicator weighting (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%).<br><br>*(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)* |
| **Description of indicator** | Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication. |
| **Numerator** | Number of **eligible patients** who are **referred** to specialist services and **offered stop smoking medication** during this quarter:<br>• **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 1a);<br>• the "**referred**" element of this indicator requires healthcare professionals to refer patients (not just signposting) to stop smoking services (these could be e.g. Local Authority funded Local Stop Smoking Services or lifestyle service in the community; in-house services in hospital; or within GP practices or pharmacies) and this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the National Centre for smoking Cessation and Training website (NCSCT). Secondary mental health providers in particular may want to build on the Lester tool as appropriate. See Annex A for further details; and<br>• the "**offered stop smoking medication**" element of this indicator requires healthcare professionals to offer medication (where this is medically appropriate and possible) and this to be recorded in the patient's record in a clear and consistent way. This should be accompanied where relevant by behavioural support as per NICE guidance. Secondary mental health providers in particular may want to build on the Lester tool as appropriate. |
| **Denominator** | All **eligible patients** during this quarter:<br>• **Eligible patients** are defined as patients who have been recorded as smokers during screening (in 9a) |
| **Rationale for inclusion** | Please refer to this section in 9a. |
| **Data source** | Please refer to this section in 9a. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.<br><br>Note that the data that is required for the audits are patient case notes which are to be updated by staff |

| Indicator 9c | |
|---|---|
| | whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.<br><br>Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **30%**<br>(NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.<br><br>**Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.<br><br>**Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

## Indicator 9d Alcohol screening

| Indicator 9d | |
|---|---|
| **Indicator name** | Alcohol screening |
| **Indicator weighting (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%)**.**<br><br>*(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)* |
| **Description of indicator** | Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems |
| **Numerator** | Number of **unique, adult patients** who are **admitted** and **screened for alcohol consumption** and results are **recorded in patient's record** during this quarter:<br>• **unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (ie FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN;<br>• **adult patient** is defined as patients of at least 18 years of age for the purpose of this CQUIN;<br>• **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). NB: screening should take place at a time that is clinically appropriate for the patient. For example, >7 days for patients with severe mental health illness as set out in the PSMI CQUIN;<br>• the "**screened for alcohol consumption**" element of this indicator requires the standard protocol for alcohol screening in secondary care as per NICE guidance to be implemented. Detail on the required actions from staff can be found on the NICE website. Secondary mental health providers in particular may want to build on the Lester tool to include an appropriate alcohol component (which is also encouraged by the PSMI CQUIN). See Annex A for further details; and<br>• the "**recorded in patient's record**" element of this indicator requires the delivery of the standard protocol as described above and the outcome to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. |
| **Denominator** | All **unique, adult patients** who are **admitted** during this quarter:<br>• **unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (i.e. FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN |

| Indicator 9d | |
|---|---|
| | • **adult patient** is defined as patients of at least 18 years of age; and<br>• **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN). |
| **Rationale for inclusion** | **Context**<br>This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.<br><br>**The burden of excessive alcohol consumption**<br>In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK CMOs' lower-risk guideline and increase their risk of alcohol-related ill health. [11] Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries.[12] There are nearly 22,500 alcohol-attributable deaths per year.[13] Out of c3.7m admissions[14], c333,000 were admissions where an alcohol-related disease, injury or condition was the primary diagnosis or there was an alcohol-related external cause. These alcohol-related admissions are 32% higher than in 2004/05.[15]<br><br>Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health – this is the group for which IBA is the most effective. Identification and Brief Advice (IBA) results in recipients reducing their weekly drinking by c12%. Because alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health.<br><br>**The status quo nationally**<br>Currently, IBA delivery in secondary care is patchy and nowhere near the optimal large scale delivery required to significantly impact on population health. It is strongest |

[11] http://digital.nhs.uk/catalogue/PUB16076
[12] http://www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch6-Alc-cons.pdf
[13] Public Health England (2016), Local Alcohol Profiles for England. Available at: http://fingertips.phe.org.uk/profile/local-alcohol-profiles
[14] Admissions to acute, acute &community and acute specialist providers in 2014/15, excluding maternity and below 18s, based on HES data
[15] Statistics on Alcohol, England, 2016 (NHS Digital, 2016)

| Indicator 9d | |
|---|---|
| | where there are strong Making Every Contact Counts (MECC) initiatives that include alcohol IBA and where there are well-resourced alcohol care teams that train other staff.<br><br>**The financial case**<br>Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers. The successful delivery of the CQUIN is estimated to bring about a reduction of weekly alcohol consumption of 12%, which could result in net savings of c£27 per patient receiving alcohol brief advice each year over 4 years, from reduced alcohol-related hospital admissions following improvements in morbidity. (NB: these figures are taken from unpublished modelling conducted by Sheffield University using data derived from the latest Cochrane review of brief advice in primary care.[16]) |
| **Data source** | **Provider audit of patient records, submitted to CCGs on a quarterly basis:**<br><br>We propose that:<br>• Providers with searchable electronic patient records audit **all patient records**.<br>• Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**.<br><br>**The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months.<br><br>**The following exclusion criteria** should be applied:<br><br>1. All patients below 18 years of age<br>2. All in-patients in maternity wards<br>3. All A&E attendances that do not lead to in-patient admissions<br>4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention.<br><br>**For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B.<br><br>**The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance |

[16] Kaner EFS, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane database Syst Rev Online. Wiley Online Library; 2007; 4(2):CD004148.

| Indicator 9d | |
|---|---|
| | and insight teams.<br><br>**Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.<br><br>Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of reporting to commissioner** | **Quarterly**.<br><br>Note that to enable national audits, providers will simultaneously submit this data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **50%**<br>(NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme). |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.<br><br>**Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.<br><br>**Quarter 2 and onwards** – payment is available for high (ie to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

## Indicator 9e Alcohol brief advice or referral

| Indicator 9e | |
|---|---|
| **Indicator name** | Alcohol brief advice or referral |
| **Indicator weighting (% of CQUIN scheme available)** | Achievement of target for this indicator attracts 25% of 0.25% (0.0625%).<br>*(NB: this applies for Q2 onwards, different reward structure for Q1, see 'rules for in-year payment' section below)* |
| **Description of indicator** | Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral. |
| **Numerator** | Number of **eligible patients** who are **given brief advice** or referred to specialist alcohol services during this quarter:<br>• **Eligible patients**are defined as patients who have been recorded as drinking above the lower risk levels during screening (in 2a);<br>• the "**given brief advice**" element of this indicator requires the healthcare professional to provide a brief advice message and this to be recorded in the patient's record in a clear and consistent way. It is the responsibility of providers to identify the most effective way of recording this information. Detail on the required actions from staff can be found on the NICE website. See Annex A for further details;<br>• the "**offered a specialist referral where relevant**" element of this indicator is only required in instances where screening indicates potential alcohol dependence and is instead of brief advice provision. It requires the health professional to offer a referral (not just signposting) for specialist alcohol assessment by the hospital alcohol care team or a local community alcohol treatment service and this to be recorded in the patient's record in a clear and consistent way. Detail on the required actions from staff can be found on the NICE website. See Annex A for further details. |
| **Denominator** | All **eligible patients** during this quarter:<br>• **Eligible patients** are defined as patients who have been recorded as drinking above the lower risk limits during screening (in 9d). |
| **Rationale for inclusion** | Please refer to this section in 9d. |
| **Data source** | Please refer to this section in 9d. |
| **Frequency of data collection** | **Quarterly**. Data to be collected ahead of quarterly audit.<br><br>Note that the data that is required for the audits are patient case notes which are to be updated by health practitioners whenever relevant. |
| **Organisation responsible for data collection** | **Provider**. |
| **Frequency of** | **Quarterly**. |

| | |
|---|---|
| **reporting to commissioner** | Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well. |
| **Baseline period/date** | Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below. |
| **Baseline value** | To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below. |
| **Final indicator period/date (on which payment is based)** | Quarter 4 FY 18/19. |
| **Final indicator value (payment threshold)** | **80%**<br>(NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme) |
| **Final indicator reporting date** | As soon as possible after Q4 2018/19. |
| **Are there rules for any agreed in-year milestones that result in payment?** | Yes.<br><br>**Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below.<br><br>**Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see *Rules for partial achievement* below. |

## Milestones for indicators 9a-9e (Note: these only apply to Q1 of the CQUIN)

**For Community and Mental Health Providers this means** that they will be rewarded in:

a) quarter 1 of FY17/18 for achievement of the three milestones set out below; and
b) quarter 2 (and any subsequent quarters in FY 17/18 and FY 18/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 17/18 and onwards).

**For Acute Providers this means** that they will be rewarded in

a) quarter 1 of FY18/19 for achievement of the three milestones set out below (this is because the CQUIN only applies to Acute providers from FY 18/19 onwards); and
b) quarter 2 of FY 18/19 (and any subsequent quarters in FY 18/19) according to performance across the indicators (partial payment rules set out below apply for Q2 FY 18/19 and onwards).

| 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 Q1** | Completed information systems audit<br><br>This milestone requires each provider to undertake an audit its existing information systems. This audit needs to set out:<br>1. what the proposed mechanisms for collecting the required data for the indicators are / will for the respective provider<br>2. what (if any) changes have been made to the data capturing arrangements / information in order to enable the quarterly case note audits<br>3. the proposed approach for conducting the quarterly case note audits<br>(this should include details on potential data quality issues and any other risks; and set out mitigating actions for these to ensure that the case note audits yield accurate data on performance)<br>The audit needs to be shared with the commissioner by the reporting deadline (31 July 2017).<br>Commissioners are responsible for ensuring that the audit meets the requirements set out above.<br>Full payment of the CQUIN should be provided for audits that address all the requirements set out above.<br>Audits that do not address all requirements will not attract payment. | 31 July 2017 | 33% of Q1 CQUIN funds |
| **End Q1** | **Completed brief advice training for relevant staff**<br>This milestone requires each provider to establish and implement a brief advice training plan for relevant health professionals who are expected to provide brief advice.<br>Providers will demonstrate achievement of this milestone by drafting a report which needs to contain details on:<br>1. **A status quo capacity** | 31 July 2017 | 33% of Q1 CQUIN funds |

| 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) |
|---|---|---|---|
| | **assessment**<br>(i.e. identification of who the relevant health professionals are to deliver brief advice and an assessment of the existing skills of those relevant health professionals to deliver brief advice)<br>2. **Who** is in scope to receive the training<br>(ie based on the capacity assessment, identify individual or groups of health professionals who would require training; and clinical leader(s) to act as ward or hospital "champions")<br>3. **What** the training entails<br>(ie what components are included in the training, how is it sourced and who is to deliver the training incl the method of delivery)<br>4. **How** effective the training has been<br>(ie assessment of how effective the training was through e.g. Self-assessment of participants after training completion)<br>5. **When** the training has been delivered<br>(ie training schedule and what groups were trained when; what processes are in place to deliver training for new starters; what process is in place to ensure that training is refreshed; it is expected that the majority of the training is completed by the end of Q1 but where this is not possible, plans for future training are required).<br><br>The report needs to be shared with the commissioner by the reporting deadline (31 July 2017).<br>Commissioners are responsible for | | |

| 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) |
|---|---|---|---|
| | ensuring that the report meets the requirements set out above. Full payment of the CQUIN should be provided for reports that address all the 5 requirements set out above. Reports that do not address all requirements will not attract payment. | | |
| **End Q1** | **Collected relevant data to establish baseline for all indicators**<br><br>This milestone requires each provider to collect the required data for each indicator of the CQUIN to establish a baseline performance level.<br>Full payment of the CQUIN should be awarded to those organisations that can establish a credible baseline level of performance across all indicators.<br>Where baseline data is not available for all of the indicators, no payment will be made.<br>Note that in exceptional cases where providers may not be able to establish baseline data in Q1, they may – following agreement with providers – be able to establish their baseline in Q2 in order to participate in future quarters of the CQUIN. | 31 July 2017 | 33% of Q1 CQUIN funds |

**Rules for partial achievement of indicator 9a-e (note that these apply from Q2 onwards)**

| | % of CQUIN scheme available for meeting final indicator value | | | | |
|---|---|---|---|---|---|
| **Final indicator value for the partial achievement threshold** | **9a** | **9b** | **9c** | **9d** | **9e** |
| **100%** | **5%** | **20%** | **25%** | **25%** | **25%** |
| **for those achieving below 100% of target / final indicator value** | | | | | |
| 10% point improvement over last Q performance* | **2%** | **10%** | **12%** | **12%** | **12%** |
| 20% point improvement over last Q performance* | **4%** | **15%** | **18%** | **18%** | **18%** |

*Note that following the baseline setting exercise in Q1, a minimum threshold level of activity may be introduced such that improvements only over this minimum threshold would be partially rewarded.

## Annex A – Supplementary Guidance

Supplementary guidance will be issued alongside this final CQUIN guidance document. This supplementary guidance will be targeted at and co-developed by frontline healthcare professionals and contain a comprehensive suite of resources for them to facilitate successful delivery of the CQUIN.

## Annex B – Method for identifying random samples and minimum sample sizes

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

1. True randomisation: review the $n^{th}$ patient's notes where n is generated by a random number generator or table (e.g. http://www.random.org/) and this is repeated until a full sample of notes has been reviewed. These are easy to use and readily available online – e.g. http://www.random.org/.

2. Pseudo-randomisation: Review the first X patients' notes where the day within the date of birth is based on some sequence e.g. start with patients born on the $1^{st}$ of the month, move to $2^{nd}$, then $3^{rd}$, until X patients have been reviewed. X equals the sample size required. Note this must NOT be based on full birthdate as this would skew the sample to particular age groups.

Feedback from analysts and the engagement exercise was received relating to the required sample size for sample-based patient record audits:

3. Due to expected attrition with each step of the interventions (from screening, to brief advice, to referral) and the need to provide robust samples, feedback from stakeholders suggested that a minimum sample size for sample-based audits should be set.

4. The minimum sample size is initially set at 500 case notes per quarter. Those trusts that receive fewer than 500 eligible patients per quarter should audit all eligible patient records. Those trusts that receive more than 500 eligible patients per quarter should ensure that their sample is random and may follow the methods set out above to achieve randomisation.

5. National bodies will continue to keep issues related to data collection including minimum sample sizes under review. There will also be additional advice for trusts on how they can reduce the administrative burden as part of supplementary guidance.

# 10 Improving the assessment of wounds

| Indicator 10 | |
|---|---|
| **Indicator name** | Improving the assessment of wounds |
| **Indicator weighting (% of CQUIN scheme available)** | 0.25% |
| **Description of indicator** | The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment. |
| **Numerator** | The indicator aims to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks. |
| **Denominator** | Number of patients on the provider's caseload with wounds that have failed to heal for 4 weeks or more following self-care, primary, community or specialist care within Q2 & Q4 2017/18. |
| **Rationale for inclusion** | Research evidence demonstrates that over 30% of chronic wounds identified in the CQUIN as wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines. Guidance on the components of a full wound assessment will be published via the Leading Change adding Value web page early in 2017. Failure to complete a **full** assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal.<br><br>For providers and commissioners the delay in wound healing relates to the resources being consumed inappropriately. Managing patients with wounds and their associated co-morbidities is estimated to cost the NHS £5.3 billion; the average cost of unhealed wounds is more than double that of healed wounds. There is also significant variation in current practice.<br><br>A recent economic evaluation of a wound care pathway for chronic wounds demonstrates that the current pathway experienced by many patients delivers poorer outcomes at greater cost to the commissioner – the study estimates this cost to be approximately 10 times greater.<br><br>Establishing a baseline figure through clinical audit for the number of full wound assessments that are completed in Q2 will enable service providers to review how their service is currently provided and to implement changes that will enable clinical practitioners to undertake full wound assessments |

| Indicator 10 | |
|---|---|
| | for all patients who have wounds that have not healed for 4 weeks or more. The audit should be undertaken on a minimum of 150 patients from the provider caseload of patients who have a wound that has not healed within 4 week of it occurring.<br><br>Increasing the number of patients who have a full assessment of wounds will promote the use of effective treatment based on the outcome of the assessment. |
| **Data source** | Local baseline audit collection of a minimum of 150 patients on the caseload with a wound that has failed to heal within 4 weeks, which will be then, be submitted through a national data collection. |
| **Frequency of data collection** | 6 monthly through a clinical audit undertaken in Q2 and Q4 |
| **Organisation responsible for data collection** | Community Nursing Service Provider |
| **Frequency of reporting to commissioner** | Quarter 1 : Establish Clinical Audit plan<br>Quarter 2: Clinical Audit of wound assessments<br>Quarter3: Improvement Plan<br>Quarter 4: Repeat Clinical Audit |
| **Baseline period/date** | Q2 2017/18 |
| **Baseline value** | To be determined by outcome of Q2 clinical audit undertaken by Community Service provider. |
| **Final indicator period/date (on which payment is based)** | Q4 2017/18 |
| **Final indicator value (payment threshold)** | Payment to be based on establishing the baseline in Q2 and on achieving locally agreed levels of improvement over that baseline for Q4.<br><br>Payment in Year 2 will be based on achievement of nationally set absolute levels of performance in Q2 and Q4. These payments will be developed nationally based on an assessment of national data returns and a further review of the latest evidence. |
| **Final indicator reporting date** | 18 April 2018 to local commissioners with submission to national data base by 30 April 2018 |
| **Are there rules for any agreed in-year milestones that result in payment?** | Completion of Clinical Audit and Improvement plan by end of Q2 and sharing of results with Commissioner and submission to national data collection by 18 November 2017. |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Yes – see table below |

**Milestones for indicator 10**

| 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) |
|---|---|---|---|
| **Q1and 2 2017/18** | Completion of Clinical audit to provide a baseline figure for the number of patients with chronic wounds that have received a full assessment. Full audit report and improvement plan with trajectory to be provided for commissioner. | 30 November 2017 | 50% of year if baseline data collection established and improvement plan agreed. |
| **Q4 2017/18** | Completion of clinical audit to demonstrate an improvement in the number of patients with chronic wound who have received a full wound assessment. | 31May 2018 | Maximum of 50% of year available based on the following achievement of locally agreed levels of improvement in the number of patients with chronic wound who have received a full wound assessment: |
| **Year 2 2018/19** | Achievement of the CQUIN in Year 2 will be based on achievement of nationally set absolute levels of performance in Q2 and Q4. | 30 November 2018 - Q2 audit<br><br>31 May 2019 – Q4 audit | Maximum of 100% of year available based on achievement of nationally set absolute levels of performance in Q2 and Q4. |

## Rules for partial achievement of indicator 10

**Q4 2017/18**

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| Achieved less than 33% of improvement target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

**Q2:2018/19**

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| Achieved less than 33% of target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

**Q4: 2018/19**

| Final indicator value for the partial achievement threshold | % of CQUIN scheme available for meeting final indicator value |
|---|---|
| Achieved less than 33% of target: | No payment |
| 33-99.9% of target: | 15% |
| 100% or above: | 50% |

## References

Guest JF, Ayoub N, McIlwraith T, *et al*. Health economic burden that wounds impose on the National Health Service in the UK. *BMJ Open* 2015;5: e009283. doi:10.1136/ bmjopen-2015-009283

## 11. Personalised care and support planning

| Indicator 11 | |
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| **Indicator name** | Personalised Care and Support Planning |
| **Indicator weighting (% of CQUIN scheme available)** | 0.25% |
| **Rationale** | More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services.<br><br>Changing this situation is not a short-term fix. However there are steps we can take, supported by the CQUIN scheme to incentivise the change in behaviours and methodologies that allow patients to take greater control over their health and wellbeing. A core component is personalised care and support planning which is; a) an intervention that supports people to develop the knowledge, skills and confidence to manage their own health and wellbeing and that leads to the development of a care plan and b) an enabler that supports patients to understand the local support mechanisms that are available to them.<br><br>We envisage that the first year of the CQUIN is an opportunity to introduce the requirement of high quality personalised care and support planning, whilst recognising that not all health systems will have the technological means nor the workforce capabilities of making these happen. In future years there will be a need to increase the expected levels of achievement so that by 2020/21 personalised care and support planning is fully embedded across the service as the norm.<br><br>The Realising the Value report ‘At the heart of health’ describes how personalised care and support planning is a key enabler to allow the proliferation of self-care support packages such as health coaching, peer support and self-management education. In this context it can be seen as the foundation for the behaviour change needed to support improvements in self-care. |
| **Description of indicator** | This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified, the relevant workforce receive appropriate training, and that personalised care and support planning conversations can be incorporated into consultations with patients and carers. The second year |

| Indicator 11 | |
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| | will focus more on delivery of personalised care and support planning, the quality of conversations and the impact on individual levels of knowledge, skills and confidence.<br><br>In year one there are three components:<br><br>**Establishing provider systems** to ensure that personalised care and support planning conversations can be incorporated into care delivery and can be recorded as an activity. Also to ensure relevant cohorts of patients who would benefit most from the delivery of personalised care and support planning can be identified on IT systems.<br><br>For the purpose of the CQUIN, personalised care and support planning conversations are defined as:<br><br>• *Conversations between a care professional, a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing.*<br>• *Follow a process of sharing information, identifying support needs, discussing options, contingency planning, setting goals, developing an action plan, and monitoring progress.*<br>• *Consider how to co-ordinate the individual's care across a number of different care settings, linking to other existing care plans, particularly for people with multiple conditions.*<br>• *Consider physical and mental health as well as wider holistic wellbeing.*<br>• *Resulting in an agreed, recorded, document that the patient and carer owns*<br><br>Providers should submit a plan outlining their approach to delivering personalised care and support planning and how this will be recorded as an activity, taking account of the pioneering work of the national Integrated Personal Commissioning team, the latest iteration of the TLAP personalised care and support planning tool[17] and the NHS England handbook on personalised care and support planning[18].<br><br>**Identifying relevant patient populations**. Providers should submit a plan outlining how they will identify the relevant patient population with one or more long-term conditions and with low levels of knowledge, skills and confidence (activation) to manage their health and wellbeing who would benefit from personalised care and support planning. They will need to take into consideration |

[17] http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/
[18] NHS England & Coalition for Collaborative Care (2015) *Personalised care and support planning handbook* - https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/

| Indicator 11 | |
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| | cohorts of patients who may already be participating in personalised care and support planning, for example people with learning disabilities, people with severe mental health issues who are part of the Care Programme Approach, people with complex needs who have personal health budgets or are part of the Integrated Personal Commissioning programme. This may require planning with commissioners and other providers to agree who will lead the care planning process, and also how multi-disciplinary teams can work together.<br><br>To identify the cohort providers should:<br>• Identify those patients with one or more long-term conditions as defined by the GP patient survey. People may be identified on clinical IT systems, for example using ICD10 codes or using risk stratification tools. People may be additionally identified through contact with care professionals as someone who would benefit from personalised support[19].<br><br>Then **conduct a baseline review of patient activation** for those patients with long term conditions identified above. This means:<br>• For those organisations already using the Patient Activation Measure, ensuring that all identified patients and carers have their activation levels recorded[20]; this can be combined to create an organisational score, or<br>• For those organisations not using the Patient Activation Measure, ensuring that all identified patients and carers are asked a local survey using two key questions from the existing GP patient survey (GPPS). Answers to these questions will use the same criteria as the GPPS and be given scores as described below to allow production of an organisational score. These are:<br>○ **Q32** – *In the last six months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?*<br><br>Answering 'yes, definitely' = 1 point, 'yes, to some extent' = 0.5 points. Other answers = 0 points<br>○ **Q33** – *How confident are you that you can manage your own health?*<br><br>Answering 'very confident' = 1 point, 'fairly confident' = 0.5 points. Other answers = 0 points. |

[19] See also NICE guideline on multimorbidity - https://www.nice.org.uk/guidance/ng56
[20] Patient Activation Best Practice Guide (due to be published December 2016)

| Indicator 11 | |
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| | **Following this review of patient activation, the relevant population to be prioritised for personalised care and support planning will be defined as:**<br>• Those with one or more long-term conditions as defined by the GP patient survey[21]; AND<br>• For those organisations already using the Patient Activation Measure those patients assessed at Level 1 or 2 in their activation level; **or**<br>• For those organisations not using the Patient Activation Measure, those patients who score 0 points on the GPPS questions.<br><br>**Ensuring that all relevant provider staff are sufficiently competent** in holding care and support planning discussions with patients and carers, through appropriate training. For the purpose of the CQUIN 'relevant provider staff' can be defined as:<br>• *Those who have allocated time to support the patient and carer to develop their care and support plan; and*<br>• *Have specific expertise or training in support for people with long-term conditions; and*<br>• *Are in a position to be able to liaise with multidisciplinary teams as required to gather information pertinent to the care planning discussion, and to raise issues that are impacting on an individual's care or that need to be considered at an organisational level*<br>• *Are a regular (at least annual) point of contact for the patient and carer*<br><br>Appropriate training is defined as training that:<br>• *Explores the role of care & support planning in empowering patients and carers;*<br>• *Clearly defines the role and expectations of the member of staff and the patient and/or carer;*<br>• *Provides a framework for staff to follow in having structured care and support planning conversations based around what is important to the person living with a long-term condition and their holistic needs, not just their medical needs;*<br>• *Helps staff develop skills in motivational interviewing to help them in encouraging patients and carers to actively participate in planning discussions, and how to tailor their approach based on the individual's levels of knowledge, skills and confidence, and their communication needs; and*<br>• *Helps staff deal with sensitive discussions such as consent, mental capacity, and end of life care*.<br><br>In year two there are two components:<br><br>**Reporting on the number of care and support planning conversations** that take place (with the expectation that at |

[21] Final position to be confirmed prior to April 2017. The current expectation is this will include a broad definition (Long term conditions are health conditions that can't be cured, last a year or longer, impact on a person's life, and may require on-going care and support) and a list of the specific conditions that fall under this definition

<table>
<tr><th colspan="2">Indicator 11</th></tr>
<tr><td></td><td>least one conversation takes place for each patient but the number of conversations will vary depending on individual's needs and levels of knowledge, skills and confidence).<br><br>Conducting a follow up review of patient's knowledge, skills and confidence for the identified patient population.<br><br>As above, organisations will either need to repeat the process of collecting individual Patient Activation scores using the Patient Activation Measure, or using the questions from the GP patient survey to ascertain levels of confidence and feelings of support.</td></tr>
<tr><td>Numerator<br>Denominator</td><td>In year one:<br><br>1. Submission of a plan to ensure care & support planning is recorded by providers and how patients will be identified will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted.<br><br>2. The provider to identify the number of patients as having one or more LTCs compared to the total number of patients served.<br><br>AND<br><br>For all patients identified as having one or more LTCs, all patients to have a patient activation score recorded.<br><br>AND<br><br>To confirm the final cohort as the number of patients with one more LTCs and who have a low activation level (as described above)<br><br>3. The provider to identify the number of staff who have undertaken training in personalised care and support planning<br><br>$$Indicator = \left[ \frac{Number\ of\ staff\ who\ have\ been\ recorded\ as\ undertaking\ care\ and\ support\ planning\ training}{Total\ number\ of\ staff\ identified\ by\ the\ provider\ as\ caring\ for\ the\ identified\ patient\ cohort} \right] \times 100\%$$<br><br>In year two:<br><br>1. The number of patients from the identified cohort who have undertaken personalised care and support planning conversations</td></tr>
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| Indicator 11 | |
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| | $$Indicator = \left[\frac{Number\ of\ patients\ who\ have\ had\ a\ record\ of\ care\ and\ support\ planning\ conversations}{Total\ number\ of\ patients\ who\ should\ have\ had\ a\ care\ and\ support\ planning\ conversation\ in\ accordance\ with\ the\ agreed\ local\ plan}\right] \times 100\%$$<br><br>2. Whether there has been an improvement in individual activation levels following personalised care and support planning<br><br>$$Indicator = \left[\frac{Difference\ in\ score\ of\ patient\ activation\ \left(\begin{matrix}Score\ of\ patient\ activation\ in\ Year\ 2\ -\\ Score\ of\ patient\ activation\ in\ Year\ 1\end{matrix}\right)}{Score\ of\ patient\ activation\ in\ Year\ 1}\right] \times 100\%$$ |
| **Data source** | **Year One:**<br>1. Community based providers would need to submit a plan via UNIFY outlining their approach to delivering personalised care and support planning to an identified cohort of patients and how they will record this activity in a format that can be aggregated at organisation level (ie local, operational collection can vary, but organisational submission to UNIFY must be consistent) following locally agreed sign off processes by the commissioner<br><br>2. Providers would need to identify which patient populations would benefit from personalised care and support planning and should be prioritised, using the list of long term conditions outlined in the GP Patient Survey and the Patient Activation Measure or GP patient survey criteria to assess their level of confidence and perceived support.<br><br>3. Providers would need to identify relevant staff (as defined above) and record that they have undertaken training in personalised care and support planning (as defined above). To be submitted via UNIFY following locally agreed sign off processes by the commissioner<br><br>**Year Two:**<br>1. Identify the number of care planning conversations taking place for each of the identified cohort from the previously identified local system.<br><br>2. Follow-up use of a survey instrument (the Patient Activation Measure or questions from the GP patient survey) to assess whether the level of patients' skills, knowledge and confidence to self-manage has improved. |
| **Frequency of data collection** | Annual, noting in-year milestones for year 1 |

| Indicator 11 | |
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| **Organisation responsible for data collection** | This will be the responsibility of individual community providers collecting data via UNIFY |
| **Frequency of reporting to commissioner** | Annual, noting in-year milestones for year 1 |
| **Baseline period/date**<br>**Baseline value** | The requirements described are new and baselines to inform Year 2 will be collected during Year 1. |
| **Final indicator period/date (on which payment is based)** | 31 March 2018 (Year 1) and 31 March 2019 (Year 2) |
| **Final indicator value (payment threshold)** | **In Year One:**<br><br>1. 25% of Year One CQUIN value<br><br>a. No plan produced = 0% of proportion of CQUIN value<br>b. Plan produced but recording system not in place = 50% of proportion of CQUIN value<br>c. Plan produced and recording system put in place = 100% of proportion of CQUIN value<br><br>2. 45% of Year One CQUIN value. Comprised of:<br><br>**Identifying long term conditions (15% of Year One CQUIN value)**<br><br>a. Relevant patient cohort not identified or submitted = 0% of proportion of CQUIN value<br>b. Relevant patient cohort identified and submitted to commissioner = 100% of proportion of CQUIN value<br><br>**Undertaking patient activation assessment (30% of Year One CQUIN value)**<br><br>c. < 50% of identified cohort have a patient activation assessment = 0% of proportion of CQUIN value<br>d. 50 to 75% of identified cohort have a patient activation assessment = 50% of proportion of CQUIN value<br>e. 75% > of identified cohort have a patient activation assessment = 100% of proportion of CQUIN value<br><br>3. 30% of Year One CQUIN value<br><br>a. No staff identified for training = 0% of proportion of CQUIN value<br>b. Cohort of staff identified and list submitted to commissioner = 10% of proportion of CQUIN value<br>c. 33% to 66% of identified staff trained by end of year (including submitted staff list in 'b') = 40% of proportion of CQUIN value |

| Indicator 11 | |
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| | d. 66 to 85% of identified staff trained by end of year (including submitted staff list in 'b') = 70% of proportion of CQUIN value<br>e. 85% > of identified staff trained by end of year (including submitted staff list in 'b') = 100% of proportion of CQUIN value<br><br>**In Year Two:**<br><br>1. 50% of Year Two CQUIN value<br><br>a. < 50% of identified cohort have evidence of care and support planning conversations as recorded by provider = 0% of proportion of CQUIN value<br>b. 50 to 75% of identified cohort have evidence of care and support planning conversations as recorded by provider= 50% of CQUIN value<br>c. 75% > of identified cohort have evidence of care and support planning conversations as recorded by provider = 100% of CQUIN value<br><br>2. 50% of Year Two CQUIN value<br><br>a. < 25% of identified cohort demonstrate an improvement in their patient activation assessment = 0% of proportion of CQUIN value<br>b. 25 to 50% of identified cohort demonstrate an improvement in their patient activation assessment = 50% proportion of CQUIN value<br>c. 50% > of identified cohort demonstrate an improvement in their patient activation assessment = 100% of proportion of CQUIN value |
| **Final indicator reporting date** | April 2018/19 |
| **Are there rules for any agreed in-year milestones that result in payment?** | In-year milestones for Year 1 will be as follows:<br><br>**By end of Q2:**<br>Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted by the end of the year (yes/no).<br><br>**By end of Q3:**<br><br>The provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served<br><br>**By end of Q4:**<br><br>1. The provider to confirm what proportion of relevant staff have undertaken training in personalised care |

| Indicator 11 | |
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| | and support planning.<br><br>2. The provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above)<br><br>There are no in-year milestones for Year 2 |
| **Are there any rules for partial achievement of the indicator at the final indicator period/date?** | Partial achievement of indicators is covered in the differing percentages of achievement within the 'final indicator value' section above. |

## Milestones for indicator 11

| 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) |
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| **Year 1 2017/18** | Submission of a plan to ensure care & support planning is recorded by providers will be a yes/no requirement. Likewise local commissioners will need to confirm whether the plan has been received and accepted (yes/no). | end of Q2 | 25% |
| **Year 1 2017/18** | Provider to identify the number of patients as having multiple LTCs and who will be prioritised for personalised care and support planning (establishment of cohort) compared to the total number of patients served | end of Q3 | 15% |
| **Year 1 2017/18** | Provider to confirm what proportion of relevant staff have undertaken training in personalised care and support planning. | end of Q4 | 30% |
| **Year 1 2017/18** | Provider to confirm the number of patients identified for the cohort who have one or more LTCs and have been assessed as having a low activation level (as described above) | end of Q4 | 30% |

## Rules for partial achievement for indicator 11

The payment details are described in the final indicator value (payment threshold) in the table above.