Commissioning for Quality and Innovation (CQUIN)

CCG indicator specifications for 2020-2021

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NHS England and NHS Improvement – Working together for the NHS

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Contents

1. Introduction

The 2020/21 CCG CQUIN scheme contains 17 indicators, aligned to the 4 key areas as illustrated below. Each scheme should be valued at 1.25% of the applicable NHS Standard Contract's Actual Annual Value (AAV).

This Annex sets out the technical specification for each of the indicators in the scheme outlining how each indicator will be measured, how performance will be assessed and paid, as well as links to relevant supporting documents. This document should be read in conjunction with the CQUIN 2020/21 Guidance, which provides information on the rationale for each CQUIN and details of the scheme's structure and value.

Prevention of ill health	Mental health	Patient safety	Best practice pathways
•Appropriate antibiotic prescribing for UTI in adults aged 16+	•Use of anxiety disorder specific measures in IAPT	•Recording of NEWS2 score, escalation time and response time for critical care admissions	•Treatment of community acquired pneumonia in line with BTS Care Bundle
•Cirrhosis and fibrosis tests for alcohol dependent patients	•Outcome measurement across specified mental health services	•Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	•Rapid rule out protocol for ED patients with suspected acute myocardial infraction (excluding STEMI)
•Malnutrition screening	•Biopsychosocial assessments by MH liaison services	•Assessment, diagnosis and treatment of lower leg wounds	•Adherence to evidence based interventions clinical criteria
•Oral health assessments		•Assessment and documentation of pressure ulcer risk	•Access to patient information at scene
•Staff flu vaccinations			•Data security protection toolkit compliance, and access to NHS mail

2. Applicable indicators and values

The following table shows how the supported methods and interventions are relevant to the providers of different services.

Acute	Mental health	Community	Care homes	Ambulance
Recording of NEWS2 score, escalation time and response time for critical care admissions	Use of anxiety disorder specific measures in IAPT	Assessment, diagnosis and treatment of lower leg wounds	Oral health assessments	Access to patient information at scene
Treatment of community acquired pneumonia in line with BTS care bundle	Outcome measurement across specified mental health services	Malnutrition screening	Malnutrition screening	Staff flu vaccinations
Appropriate antibiotic prescribing for UTI in adults aged 16+	Biopsychosocial assessments by MH liaison services	Assessment and documentation of pressure ulcer risk	Assessment and documentation of pressure ulcer risk	
Cirrhosis and fibrosis tests for alcohol dependent patients	Cirrhosis tests for alcohol dependent patients	Staff flu vaccinations	Data security protection toolkit compliance, and access to NHS mail (also applicable to CCG commissioned domiciliary care providers)	
Rapid rule out protocol for ED patients with suspected acute myocardial infraction (Excluding STEMI)	Staff flu vaccinations			
Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery				
Adherence to evidence based interventions clinical criteria				
Staff flu vaccinations				

- All national indicators must be adopted where the relevant services are in scope for each contract, and their value should be equally weighted across the CQUIN funding available. This means if there are 5 indicators relevant for a provider, each would be worth 0.25% (ensuring the scheme is worth 1.25% of the AAV in total). Where fewer than three national indicators are readily applicable to a particular contract, CCGs may offer additional local CQUIN indicators (of appropriate number and complexity, proportionate to the scale of the contract);

- Where more than 8 indicators apply to a given contract, the commissioners and providers should agree the most relevant 8 indicators across the services in scope for each contract, with each indicator attracting the same value within the contract. (See CQUIN 2020/21 Guidance for further detail on agreeing CQUIN schemes).

2. Applicable indicators and values

All indicators must be equally weighted within the scheme. By default, achievement on each indicator is based on a single measure. There are 2 indicators where performance will be calculated by reference to two separate measures, as outlined in the table below. In both cases the sub-parts individually will be worth 50% of the total indicator value.

Indicator	Value (%)
CCG7: Outcome measurement across specified mental health services[1] (MH providers only)	**100%**
CCG7a: Routine outcome monitoring in children and young people's (CYP) and perinatal mental health services	50%
CCG7b: Routine outcome monitoring in community mental health services	50%
CCG17: Data security and NHS mail (care home and domiciliary care providers only)	**100%**
CCG17a: Data security protection toolkit compliance	50%
CCG17b: Reported access to NHS mail	50%

[1] For providers who are contracted for services that don't make them eligible for both CCG7a and CCG7b, then whichever of the two that they are eligible for would carry a value of 100%.

3. Payment – summary of key information included in each indicator specification

This section sets out the information included in each indicator's specification, designed to set out the precise rules for calculating compliance. These will be explained in more detail, with some illustrative examples over the coming slides.

1. Period in scope

The quarters in 2020/21 in which CQUIN compliance must be measured are outlined in the 'Scope' section of each indicator's specification under the heading 'Period'; they are identified as:

i. Green: quarters in scope; and,
ii. Red: quarters out of scope.

2. Basis for performance

Percentage performance will be calculated in one of the ways outlined below. This information is detailed within the 'Data reporting & performance' section of each indicator's specification under the heading 'Performance basis'.

i. **Quarterly:** at the end of each quarter. This will be the majority of indicators. For example, cirrhosis tests for alcohol dependent patients.
ii. **Whole period:** at the scheme end using data for the period in scope. For example, staff flu vaccinations.

3. Payment – summary of key information included in each indicator specification

3. Basis for payment

For all indicators, payment will be based on a performance assessment undertaken at the end of the scheme. Payment will be calculated in one of two ways that are outlined below. This information is detailed within the 'Payment basis' section of each indicator's specification under the heading 'Calculation'.

i. **Quarterly average %:** Payment will be based on the average % performance across the period in scope, calculated separately for each quarter. Each quarter's performance will therefore contribute equally to payment. This will apply for the majority of indicators. For example, Cirrhosis Tests for Alcohol Dependent Patients.
ii. **Whole period %:** Payment will be based on the average of % performance across the period in scope, using one calculation for the whole period at the scheme end. For example, Staff Flu Vaccinations.

4. Payment & thresholds:

As in the 2019/20 scheme, there is one lower and one upper threshold for each indicator. This information is detailed within the 'Payment basis' section of each indicator's specification under the heading 'Minimum' for the minimum threshold and 'Maximum' for the maximum threshold. Payment is determined by reference to these thresholds. Where the upper threshold is reached, 100% of payment will be earned. No payment will be earned until performance is above the lower threshold. Payment should be graduated between the two thresholds evenly. See Section 3a and 3b for more information.

3a. Indicator payment: thresholds and relevant quarters

Payment will be based on each provider's uptake of the identified method or process, by reference to the minimum and maximum thresholds for each indicator during the applicable period (payment basis). The table below summarises the relevant thresholds and payment basis that will be used for each of the indicators within the scheme. **Assessment should take place at the end of the scheme and calculated according to the method outlined in section 3b.**

Indicator	Pay basis(%)	Period in scope	Indicator	Pay basis(%)	Period in scope
CCG1: Appropriate antibiotic prescribing for UTI in adults aged 16+	40 - 60	Q1-4	**CCG10**: Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery	45 – 60	Q1-4
CCG2: Cirrhosis and fibrosis tests for alcohol dependent patients	20 - 35	Q1-4	**CCG11**: Assessment, diagnosis and treatment of lower leg wounds	25 - 50	Q1-4
CCG3: Malnutrition screening	50 - 70	Q1-4	**CCG12**: Assessment and documentation of pressure ulcer risk	40 - 60	Q1-4
CCG4: Oral health assessments	30 - 50	Q1-4	**CCG13**: Treatment of community acquired pneumonia in line with BTS care bundle	45 - 70	Q1-4
CCG5: Staff flu vaccinations	70 - 90	Q3-4	**CCG14**: Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)	40 - 60	Q1-4
CCG6: Use of anxiety disorder specific measures in IAPT	35 - 65	Q1-4	**CCG15**: Adherence to evidence based interventions (EBI) clinical criteria	60 - 80	Q2-4
CCG7: Outcome measurement across specified mental health services *7a: CYP and perinatal mental health services* *7b: Community mental health services*	10 - 40	Q1-4	**CCG16**: Access to patient information at scene	0-5	Q1-4
CCG8: Biopsychosocial assessments by MH liaison services	60 - 80	Q1-4	**CCG17:** Data security and NHS mail *17a: Data security protection toolkit compliance* *17b: Reported access to NHS mail*	0-100	Q1-4
CCG9: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	20 - 60	Q1-4			

3b. Calculating payment: step 1 – identifying performance

Performance will be based on the entirety of the relevant period.

- For the majority of indicators, this is usually the whole year (see 'Period in scope' column on Slide 8).
- For a typical scheme with periods Q1 to Q4 in scope, the performance will be calculated by averaging the four quarterly performance figures (average of 1/4s) to produce the scheme performance for the indicator.

Quarterly monitoring												Scheme performance
Q1			Q2			Q3			Q4			
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Performance (%)
25	100	25	35	100	35	45	100	45	55	100	55	(25+35+45+55)/4 = 40

- In the example below, the period in scope is Q2 to Q4, so here we calculate the average performance across three quarters only (average of 1/4s).

Quarterly monitoring												Scheme performance
Q1			Q2			Q3			Q4			
Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Num	Den	Perf (%)	Performance (%)
N/A	N/A	N/A	25	100	25	55	100	55	75	100	75	(25+55+75)/3 = 52%

3b. Calculating payment: step 2 – comparing to thresholds

The previous slide explained how to arrive at the overall performance result for the indicators, but how does that relate to the actual CQUIN payment that a provider will earn? Payment will reward providers based on their performance falling between each indicator's minimum and maximum thresholds, using the following formula.

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

Each indicator has a target performance level that we refer to as 'maximum' on the indicator specifications. There is also a 'minimum' level – this is the level of achievement after which some level of CQUIN payment begins to be earned – and payment is awarded proportionately based on where performance lands between the 'minimum' and 'maximum' threshold. Here are some examples to illustrate this process more clearly.

- **Example 1**: Here, the performance level that the provider has achieved is 40%. This is below the 'minimum' threshold of 50% so no payment has been earned.
- **Example 2:** Here, the performance level that the provider has achieved is 63%. This is between the 'minimum' (25%) and 'maximum' (80%) thresholds and the calculation shows us that this equates to an earning of 69% of the payment available (**69% of £100k = £69k**).
- **Example 3:** Here, the performance level that the provider has achieved is 72%. This is above the 'maximum' threshold of 70% so the provider earns the full potential amount associated with that indicator. Payment is capped at 100% so **100% of £100k = £100k**.

	Threshold			Calculation	Potential CQUIN indicator value	Payment		
Exam-ple	Min (%)	Max (%)	Perform-ance	*(Performance – Min) / (Max – Min) = Payment value*		%	Calculation (£)	£
1	50	90	40%	(40% - 50%) / (90% - 50%) = -25%	£100k	0%	100k x 0% = 0	0k
2	25	80	63%	(63% - 25%) / (80% - 25%) = 69%	£100k	69%	100k x 69% = 69	69k
3	30	70	72%	(72% - 30%) / (70% - 30%) = 105%	£100k	100%	100k x 100% = 100	100k

3c. In-year payment and end of year reconciliation

NHS England and Improvement does not mandate a specific approach to paying CQUIN monies to providers in advance of a final CQUIN earnings calculation being made at the year end. Many CCGs, for example, will choose to pay a regular amount throughout the year. In all instances though, **the assessment of actual performance should take place at the end of the year and any over/ under payment should be reconciled on the basis of actual performance**.

So, how is any reconciliation requirement assessed?

The two examples below show scenarios where regular CQUIN payments have been paid throughout the year against an indicator, where the provider achieved a performance level which meant they had earned 81% of the potential CQUIN value of £100k (**81% of £100k = £81k**).

- **Example 1**: The CCG has made four quarterly payments of £25k, totalling £100k. The provider actually earned £81k, so the CCG has **overpaid by £19k**.
- **Example 2**: The CCG has made two payments of £25k, totalling £50k. The provider actually earned £81k, so the CCG has **underpaid by £31k**.

Example	Potential CQUIN indicator value	In-year payments (£,000)					End of scheme perfor-mance (%)	Due based on perfor-mance (£,000)	Reconciliation		
		Q1	Q2	Q3	Q4	Total			Calculation (+ve = overpaid, -ve = underpaid	Amount overpaid	Amount underpaid
1	**£100k**	25	25	25	25	100	81%	£81k	100 – 81 = 19	£19k	
2	**£100k**		25		25	50	81%	£81k	50 – 81 = -31		£31k

4.i. Understanding performance

4.i.a. Monitoring performance

There are two broad sources for the CQUIN indicator data:

- Routinely collected national data; and
- Local data which must be submitted to a national CQUIN collection.

The 'Data Reporting & Performance' section of each indicator's specification will confirm the source details e.g. 'quarterly submission via National CQUIN collection' or 'routine submission to the Mental Health Services Data Set'. Links to routinely collected data will also be included where applicable, as well as estimates for the frequency and timing of data.

In addition, national CQUIN reporting will bring together the data from the different sources in order to support performance monitoring by both commissioners and NHS England.

The next section provides more information about the approaches to submitting data to the national CQUIN collection. Where available, clinical audit professionals within each service should be contacted to assist with undertaking the approaches detailed below.

4.i.b. Collecting quarterly data

One of the following approaches will be applicable for each indicator:

1. Where a list of records **matching both the denominator and the numerator** can be identified and extracted from systems (e.g. PAS, EPR or other local systems), and performance assessed without the need for case note auditing then all records must be used to calculate performance for each quarter in scope.
2. Where a list of records (broadly or exactly) **matching the denominator** can be identified (e.g. from PAS, EPR or other local systems), but **not the numerator**, then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and **random sampling** should be used to obtain this sample from case notes. See section 4.i.c.
3. In exceptional circumstances, where neither the denominator nor the numerator can be readily identified then a minimum sample of 100 records (or all records where there are less than 100 records) are required from each quarter, and **quota sampling** should be used to obtain this sample from case notes. See section 4.i.d.

4.i. Understanding performance

4.i.b. Collecting quarterly data

The approach of using random sampling where possible, in combination with the requirement to review 100 records each quarter (or all records where fewer than 100 exist) is designed to minimise collection burden, whilst ensuring measurement is representative of a provider's true performance.

4.i.c. Collecting quarterly data: random sampling methods

1) **True randomisation:** every record matching the denominator needs to be assigned a unique reference number consecutively from 1 to x. Then a random number generator (e.g. http://www.random.org/) is used with 1 and x setting the lower and upper bounds. 100 records are then identified using the random number generator from within these bounds.

For example, with 1,000 records, x=1,000. Number each record from 1 to 1,000. Randomly generate numbers using a random number generator until 100 numbers between 1 and 1,000 are generated e.g. 7, 77, 999, 452, 128… These are the chosen records for auditing.

2) **Systematic sampling**: every record matching the denominator needs to be assigned a unique reference number consecutively from 1 to x but only after the records have been ordered in a way that doesn't have any clinical significance (e.g. acuity), for example, using the electronic patient ID number. A repeat interval 'i' is then calculated by i=x/100, so that every 'i'th record will be selected after the first record has been randomly generated between 1 and i.

For example, with 1,000 records, i=1,000/100 =10. So the first record will be randomly selected between 1 and 10 and then the 10th record from this will be used. For example. record 7, 17, 27, 37, 47… will be chosen for auditing.

In instances where local systems cannot provide an exact list of records matching the denominator (e.g. unable to apply the 'exclusions' shown in the indicator specification), then the above methods can still be used although some records may end up being discounted when reviewing the case notes. Either the method should be repeated until 100 records are identified or more than 100 random records can be generated at the start to allow for the need to discount cases that do not meet the denominator.

4.i. Understanding performance

4.i.d. Collecting quarterly data: quota sampling

Quota sampling is a non-random approach to case selection, where case notes are systematically searched to identify those that match the denominator. Even with care this method can lead to samples that poorly represent a provider's true performance, and **should be avoided** if at all possible and must be used only after **consulting with clinical audit colleagues**.

The case note system adopted locally is crucial in determining how best to apply quota sampling in order to ensure a representative sample is obtained:

- **Patient ID**: If case notes are ordered purely by a randomly assigned patient ID then case notes can be searched consecutively from any position until 100 cases are identified.

- **Chronological:** If case notes are chronologically ordered then these should be selected in a way that ensures the time period is well represented. For example, searching through case notes from day 1 of the quarter until a case matching the denominator is identified, and then repeating for each subsequent day of the quarter. This can then be repeated from day 1 until 100 records have been identified.

- **Clinical:** In addition, if case notes are categorised clinically, or split across clinical settings (e.g. wards) that are all relevant to the CQUIN then, similarly, case notes should be searched consecutively from each category or setting. This may need to be combined with chronological approaches above.

4.ii. Data collection and reporting

4.ii.a. National CQUIN data collection

For the 2020/21 CQUIN scheme we will be collecting CQUIN data via a national collection for all indicators where an existing data flow does not already exist. Specific details will be updated and communicated in due course. Below are the indicators which will be included in the national collection, with the Q1 collection to commence in July 2020.

CCG2	Cirrhosis and fibrosis tests for alcohol dependent patients
CCG3	Malnutrition screening
CCG4	Oral health assessments
CCG8	Biopsychosocial assessments by MH liaison services
CCG9	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
CCG10	Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery
CCG11	Assessment, diagnosis and treatment of lower leg wounds
CCG12	Assessment and documentation of pressure ulcer risk
CCG13	Treatment of community acquired pneumonia in line with BTS care bundle
CCG14	Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)
CCG15	Adherence to evidence based interventions (EBI) clinical criteria
CCG16	Access to patient information at scene

Compliance with the national collection is a contractual requirement, and is vital in ensuring there is transparent data on performance across the country, allowing providers and commissioners to understand their comparative progress in delivering the areas set out in the scheme. It will further allow us to provide regular updates to regions, alongside national policy and clinical teams, helping to direct support as needed. More information will be made available in due course.

5a. CQUIN indicators: prevention of ill health

CCG1: Appropriate antibiotic prescribing for UTI in adults aged 16+

Scope

Services: Acute (all surgical wards)

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 40%

Maximum: 60%

Calculation: Quarterly average %

Accessing support

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Supporting documents

Antimicrobial Resistance – Urinary Tract Infections supporting guidance

PHE UTI Diagnostic Guidance

IDSA CAUTI Guideline

EAU Guideline

NICE Lower UTI NG109

NICE Pyelonephritis (acute) NG 111

NICE UTI (catheter associated) NG 113

NICE Quality Standard QS90

Data reporting & performance

Data should be submitted quarterly to PHE via the online submission portal. An auditing tool will be available in supporting guidance. See sections 4b-d for details about auditing.

Data will be made publicly available on the PHE Fingertips AMR Portal approximately 9 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.

Numerator

Of the denominator, the cases where all the following actions were applied:

1. Documented diagnosis of specific UTI based on clinical signs and symptoms;
2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all Catheter Associated UTI (CAUTI);
3. Empirical antibiotic regimen prescribed following NICE / local guidelines;
4. Urine sample sent to microbiology as per NICE requirement; and,
5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record:

Denominator

Total number of antibiotic prescriptions for patients aged 16+, with a primary or secondary diagnosis of Urinary Tract Infection in A&E, and in-patient care. (SNOMED codes (A&E): 68566005, 700372006, 45816000; ICD-10 codes (Inpatient): N12X, N10X, N39.0, T83.5)

Exclusions

Patients prescribed antibiotic prophylaxis for the treatment of recurrent UTI; pregnant women; chronic tubulo-interstitial nephritis.

CCG2: Cirrhosis and fibrosis tests for alcohol dependent patients

Scope

Services: Acute, Mental health

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 20%

Maximum: 35%

Calculation: Quarterly average %

Accessing support

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Supporting documents

Additional supporting guidance will be available here

NICE Guideline NG50

NICE Guideline NG49

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 35% of all unique inpatients (with at least one-night stay) with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.

Numerator

Of the denominator, those who have an order or referral for transient elastography (TE) or an effective[1] blood test, to diagnose cirrhosis or advanced liver fibrosis.

Denominator

Total number of inpatients (with at least one-night stay) who have a primary or secondary diagnosis of alcohol dependence (ICD-10 codes F10.2-F10.6).

Exclusions

- Inpatients who have a primary or secondary diagnosis of cirrhosis or advanced liver fibrosis (ICD-10 codes: I81.0, I82.0, I85.0-I85.9, K70.3, K70.4, K71.7, K72.1-K72.9, K74.4-74.6, K76.6, K76.7).
- Patients who have received a transient elastography (TE) or an effective1 blood test, to diagnose cirrhosis or advanced liver fibrosis in the prior 12 months.

[1] Algorithms of serum fibrosis markers that can stage liver fibrosis/cirrhosis accurately, for example the Enhanced Liver Fibrosis Test (ELF, patented) or the Southampton Traffic Light Test (STLT, not patented). Full details of appropriate tests are provided in the supporting document *Implementation guidance*.

CCG3: Malnutrition screening

Scope

Services: Community hospital inpatients & NHS funded residents in care homes

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 50%

Maximum: 70%

Calculation: Quarterly average %

Accessing support

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Supporting documents

Supporting documents will be available on the Ageing Well Future NHS Collaboration Platform. For access please contact policy lead

Nutrition support in adults: NICE QS24

The Malnutrition Universal Screening Tool (MUST)

Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition CG32

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. Due to requirement for frequent screening, performance should be assessed after the quarter finishes to ensure screening continuity for longer term patients and care home residents. See section 3. for details about the basis for performance and payment.

Description

Achieving 70% of community hospital inpatients, or NHS-commissioned residents in care homes aged 18+, having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1&2), with evidence of actions against identified risks.

Numerator

Of the denominator, those where the following actions were taken within 24 hours of admission/ start of residence (or by 1st June 2020 for those admitted/ starting residence prior to 1st April 2020) and then repeated at least every 30 days of the patient spell or care home residence.

1. A malnutrition risk screening using a validated tool, such as The Malnutrition Universal Screening Tool; (MUST) that measures all of the items below, with each documented in the management care plan[1]:
    - Body mass index (BMI);
    - Percentage unintentional weight loss;
    - The time duration over which weight loss has occurred; and,
    - The likelihood of future impaired nutrient intake.
2. All people who are identified as malnourished or at risk of malnutrition have a management care plan that aims to meet their complete nutritional requirements.
3. There is evidence of all actions or goals within the management care plan being acted upon.

Denominator

All community hospital spells (including those starting before 1st April 2020 and those unfinished by 31st March 2021), for patients aged 18+ with length of stay greater than 24 hours and NHS-funded residents in care homes, aged 18+

Exclusions

Hospital spells or care home residence where the admission/start of residence was before 1st April 2020 and the discharge/end of residence was before 1st June 2020.

[1] NHS Personalised care and support planning describes best practice for care planning.

CCG4: Oral health assessments

Scope

Services: NHS funded residents in care homes

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 30%

Maximum: 50%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

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Supporting Documents

Supporting documents will be available on the Ageing Well Future NHS Collaboration Platform. For access please contact policy lead

NICE: oral health for adults in care homes: NG48

NICE: Oral Health assessment tool

NICE: Improving oral health for adults in care homes: A quick guide for care home managers

CQC: Smiling matters: oral health care in care homes

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. Due to requirement for frequent screening, performance should be assessed after the quarter finishes to ensure screening continuity. See section 3 for details about the basis for performance and payment.

Description

Achieving 50% of NHS commissioned residents having an oral health assessment that meets NICE guidance.

Numerator

Of the denominator, those where the following actions were taken within 24 hours of start of residence (or by 1st June 2020 for those starting residence prior to 1st April 2020) and then repeated at least every 30 days of the care home residence:

1. Undertake the oral health assessment and record any actions following the assessment in the resident's personal care plan[1].
2. If the resident has dentures, including partial dentures, record whether they are marked or unmarked in the resident's personal care plan. If unmarked:
    - Provide advice of the importance of marking and record the advice given in the resident's personal care plan.
    - Ask the resident for consent for undertaking denture marking and record this in the resident's personal care plan. If consent is provided:
        - Undertake denture marking and record in resident's personal care plan.
3. Check whether the resident has had a dental check-up in the 12 months prior to the assessment. Record findings in the resident's personal care plan. If the resident has not had a check-up in the 12 months prior to assessment then:
    - Seek the resident's consent in organising a check-up with a dentist. Record in the resident's personal care plan. If consent is provided:
        - Organise a check-up with a dentist, recording this information in their personal care plan.

Denominator

All NHS commissioned residents, aged 18+, who have provided documented consent for undertaking an oral health assessment.

Exclusions

Residents where the start of residence was before 1st April 2020 and the end of residence was before 1st June 2020.

[1] NHS Personalised care and support planning describes best practice for care planning.

CCG5: Staff flu vaccinations

Scope

Services: Acute, community, mental health, ambulance.

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 70%

Maximum: 90%

Calculation: Whole period %

Accessing support

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Supporting documents

ImmForm Guidance

Green Book

NICE Guideline NG103

Data reporting & performance

Monthly provider submission (between September and March) to PHE via ImmForm. See: Guidance

Data will be made publicly available approximately 6 weeks after each quarter.

Performance basis: Whole Period. Quarterly reporting not suitable due to cumulative nature of measure. See section 3 for details about the basis for performance and payment.

Description

Achieving an 90% uptake of flu vaccinations by frontline staff with patient contact.

Numerator

Of the denominator, those who receive their flu vaccination.

Denominator

Total number of front line healthcare workers between 1 September 2020 and February 28th 2021.

Exclusions

- Staff working in an office with no patient contact.
- Social care workers.
- Staff out of the provider for the whole of the flu vaccination period (e.g. maternity leave, long term sickness).

5b. CQUIN indicators: mental health

CCG6: Use of anxiety disorder specific measures in IAPT

Scope

Services: IAPT services

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 35%

Maximum: 65%

Calculation: Quarterly average %

Accessing support

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Supporting documents

Available from the 'Mental Health CQUIN' Future NHS Collaboration Platform. Please email the policy lead above to gain access.

IAPT manual

Data reporting & performance

Routine provider submission to the Improving Access to Psychological Therapies (IAPT) Data Set

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' Future NHS Collaboration Platform.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM).

Numerator

Of the denominator, the referrals that had paired scores recorded on the specified ADSM.

Denominator

The number of referrals with a specific anxiety disorder problem descriptor[1], where the course of treatment was finished and where there were at least two attended treatment appointments in the financial year.

[1] This includes 6 disorders: Obsessive Compulsive Disorder, Social Phobias, Health Anxiety, Agoraphobia, Post Traumatic Stress Disorder, Panic Disorder

CCG7a: Routine outcome monitoring in CYP and perinatal mental health services

Scope

Services: Mental health services delivering:

- care to under 18s
- specialist perinatal

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum:10%

Maximum: 40%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

Sally Milne

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Supporting documents

Available from the 'Mental Health CQUIN' Future NHS Collaboration Platform. Please email the policy lead above to gain access.

Perinatal Mental Health Outcomes Implementation manual

Data reporting & performance

Routine provider submission to the Mental Health Services Data Set (MHSDS)

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental health CQUIN' future NHS collaboration platform.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice.

Numerator

Of the denominator, those referrals where the same outcome measure[1] has been used at least twice.

Denominator

All closed MH referrals with at least two contacts in the financial year, where the individual was under 18 on the date of referral, or was referred to a perinatal service.

[1] Acceptable outcome measures can be found in the MHSDS technical output specification[2]

[2] Version 5 due to be published in April 2020.

CCG7b: Routine outcome monitoring in community mental health services

Scope

Services: Adult community mental health services (CMHS)

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 10%

Maximum: 40%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

Sally Milne

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Supporting documents

Available from the 'Mental health CQUIN' Future NHS Collaboration Platform. Please email the policy lead above to gain access.

Supported by the National Collaborative Centre for Mental Health (NCCMH) Community MH framework

Data reporting & performance

Routine provider submission to the Mental Health Services Data Set (MHSDS).

Monthly provider level data will be available approx. 12 weeks after each period – details will be provided via the 'Mental Health CQUIN' FutureNHS collaboration platform.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 40% of adults accessing select CMHS, having their outcomes measured at least twice.

Numerator

Of the denominator, those referrals where the same outcome[1] measure has been used at least twice.

Denominator

All closed referrals where the individual was aged 18+ on the date of referral, with at least two contacts with select CMHS teams[2] during the financial year.

[1] Acceptable outcome measures can be found in the MHSDS Technical Output specification[3]

[2] Selected mental health teams includes: Crisis resolution team/home treatment team, crisis resolution team, Home treatment service, Primary care mental health service, Community mental health team – Functional, community mental health team – organic, assertive outreach team, rehabilitation and recovery service, general psychiatric service, psychotherapy service, psychological therapy service (non IAPT), personality disorder service, eating disorders/dietetics service.

[3] Version 5 due to be published in April 2020.

CCG8: Biopsychosocial assessments by MH liaison services

Scope

Services: Mental health liaison teams

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 60%

Maximum: 80%

Calculation: Quarterly average %

Accessing support

NHSE&I policy Lead

Sally Milne

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Supporting Documents

Available from the 'Mental Health CQUIN' Future NHS Collaboration Platform. Please email the policy lead above to gain access.

NICE Guideline CG16

NICE Guideline CG133

NICE Quality Standard QS34

NHSE/NICE Guidance on Liaison Mental Health Services for Adults and Older Adults 2016

HQIP Guideline on Assessment of Clinical Risk in Mental Health Service 2018

Data reporting & performance

Quarterly submission via national CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3. for details about the basis for performance and payment.

Description

Achieving 80% of self-harm[1] referrals receiving a biopsychosocial assessment concordant with NICE guidelines.

Numerator

Of the denominator, those that had evidence of a comprehensive biopsychosocial assessment concordant with Section 1.3 of CG133 including:

- Assessment of needs
- Risk assessment
- Developing an integrated care and risk management plan[2]

Denominator

The total referrals for self-harm[1] to liaison psychiatry

[1] The term self-harm for this CQUIN is defined as in the NICE guideline to refer to any act of self-poisoning or self-injury carried out by an individual irrespective of motivation. This excludes harm to the self arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself. Please see Mental Health CQUIN Future NHS Collaboration Platform for further information about identifying codes for self-harm referrals in local data sets.

[2] NHS Personalised care and support planning describes best practice for care planning.

5c. CQUIN indicators: Patient safety

CCG9: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions

Scope
Services: Acute

Period: Q1 Q2 Q3 Q4

Payment basis
Minimum: 20%
Maximum: 60%
Calculation: Quarterly average %

Accessing support

NHSE&I policy lead
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Supporting documents
Supporting documents will be available on the Deterioration Future NHS Collaboration Platform

NICE Clinical Guideline CG50

RCP London Guidance

Data reporting & performance
Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description
Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.

Numerator
Of the denominator, the number where the following are all recorded in clinical notes at time of admission to the critical care unit:
1. NEWS2 score and,
2. The time and date of escalation (T0)[1]; and,
3. The time and date of response by appropriate clinician (T1)[1].

Denominator
All unplanned critical care unit admissions from non-critical care wards (CCADMITYPE = 01, CCSORCLOC = 03) of patients aged 18+.

Exclusions
Pregnant women, end of life patients.

[1] As defined in the accompanying support documents.

CCG10: Screening and treatment of iron deficiency anaemia in patients listed for major elective blood loss surgery

Scope

Services: Acute (relevant surgical wards)

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 45%

Maximum: 60%

Calculation: Whole period %

Accessing support

NHSE&I policy lead

Matthew Barker

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Supporting documents

NICE Guideline NG24

The pre-operative anaemia management CQUIN code table will be available on the 'associated projects' section of the GIRFT website.

2016 Audit of Patient Blood Management in adults undergoing elective, scheduled surgery

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Whole period. The need to allow for screening to take place 6 weeks prior to the procedure requires the denominator to be restricted to only include procedures taking place more than 6 weeks after the start of the 20/21 year. This restriction supports 'whole period', rather than 'quarterly' performance assessment. See section 3 for details about the basis for performance and payment.

Description

Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE Guideline NG24.

Numerator

Of the denominator, all admissions where the following actions were applied within the 6 week period prior to the procedure:

- Haemoglobin (Hb) measured; and,
- If anaemia present, have serum ferritin level tested; and,
- If diagnosed with iron-deficiency anaemia offered appropriate iron treatment (oral and/or IV iron).

Denominator

Total elective inpatient admissions, within the period 13 May 2020 – 31 March 2021, with a primary procedure in the following groups: Coronary Artery Bypass Graft , Cardiac Valve Procedures, Colorectal Resection, Cystectomy, Hysterectomy, Primary Hip Replacement, Hip Replacement Revision, Primary Knee Replacement, Knee Replacement Revision, Nephrectomy, Carotid Artery (open procedure), Other Aortic/Iliac Occlusive Disease (open procedure).

OPCS procedure codes are provided in the pre-operative anaemia management CQUIN code table.

CCG11: Assessment, diagnosis and treatment of lower leg wounds

Scope
Services: Community Nursing

Period: Q1 Q2 Q3 Q4

Payment basis
Minimum: 25%
Maximum: 50%
Calculation: Quarterly average %

Accessing support
Policy lead
Una Adderley
National Wound Care Strategy Programme
una.adderley@yhahsn.com

Supporting documents
NICE Clinical Guideline CG147

NICE Clinical Guideline CG168

SIGN Guideline 120

Additional supporting documents will be available via the Future Collaboration Network for Wound Care. For access please email the contact above.

Data reporting & performance
Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description
Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.

Numerator
Of the denominator, the number where the following audit criteria for diagnosis and treatment are met within 28 days of referral to service or, for a patient already receiving care from that service, within 28 days of a non-healing leg wound being identified and recorded:

1. Documentation of a full leg wound assessment that meets the minimum requirements described in *Lower Limb Assessment Essential Criteria*.
2. Patients with a leg wound with an adequate arterial supply (ABPI $\geq$ 0.8-1.3) and where no other condition that contra-indicates compression therapy is suspected, treated with a minimum of 40mmHg compression therapy.
3. Patients diagnosed with a leg ulcer documented as having been referred (or a request being made for referral) to vascular services for assessment for surgical interventions.

Denominator
Total number of patients treated in the community nursing service with a wound on their lower leg (originating between the knee and the malleolus).

CCG12: Assessment and documentation of pressure ulcer risk

Scope

Services: Community hospital inpatients & NHS funded residents in care homes

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 40%

Maximum: 60%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

Jennie Hall

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Supporting documents

Supporting documents will be available on the Ageing Well Future NHS Collaboration Platform. For access please contact england.ageingwell@nhs.net

Pressure ulcers: Prevention and management – NICE CG179

Pressure Ulcers NICE QS89

NPIAP : Prevention and Treatment of Pressure Ulcers/ Injuries Clinical Practice Guidelines (Nov 2019)

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. Due to requirement for frequent screening, performance should be assessed after the quarter finishes to ensure screening continuity for longer term patients and care home residents. See section 3. for details about the basis for performance and payment.

Description

Achieving 60% of community hospital inpatients or NHS commissioned residents in nursing homes aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

Numerator

Of the denominator, those where the following actions were taken within 24 hours of admission/ start of residence (or by 1st June 2020 for those admitted/ starting residence prior to 1st April 2020) and then repeated at least every 30 days of the patient spell or care home residence:

1. A pressure ulcer risk assessment using a validated scale, such as Waterlow, Purpose T, or Braden, that assesses all of:
   i. Mobility; ii. Skin; iii. Nutritional status; iv. Continence; and, v. Sensory perception.
2. Has an individualised care plan[1] which includes all of:
   i. Risk and skin assessment outcomes; ii. Recommendations about pressure relief at specific at-risk sites; iii. Mobility and need to reposition the patient; iv. Comorbidities; and, v. Patient preference.
3. Actions to manage the risks identified by the pressure ulcer risk assessment are documented by clinical staff.

Denominator

All community hospital spells (including those starting before 1st April 2020 and those unfinished by 31st March 2021), for patients aged 18+ with length of stay greater than 24 hours and NHS-funded residents in care homes, aged 18+.

Exclusions

Hospital spells or care home residence where the admission/start of residence was before 1st April 2020 and the discharge/end of residence was before 1st June 2020.

[1] NHS Personalised care and support planning describes best practice for care planning.

5d. CQUIN indicators: best practice pathways

CCG13: Treatment of community acquired pneumonia in line with BTS care bundle

Scope

Services: Acute

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 45%

Maximum: 70%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

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Supporting documents

Additional supporting guidance will be available here.

BTS CAP Care Bundle

NICE Clinical Guideline CG191

NICE Guideline NG138

Data reporting & performance

Quarterly submission via national CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3. for details about the basis for performance and payment.

Description

Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.

Numerator

Of the denominator, the number of patients where the following actions were taken:

1. Perform a chest x-ray within 4 hours of hospital arrival time.
2. Pneumonia severity score (CURB65) calculated and documented in the medical notes during the ED and/or acute medical clerking.
3. Receive antibiotics within 4 hours of hospital arrival time.
4. Antibiotic prescription is concordant with severity score and in line with CG191 or local guidelines.

Denominator

Total number of admissions of patients aged 18+, admitted from the usual place of residence (ADMISORC=19) with a primary diagnosis of pneumonia (ICD10 codes: J12-18).

Exclusions

- Discharged from hospital within previous 10 days of the current admission for pneumonia.
- Admissions within previous 8 weeks of the current admission for pneumonia under the treatment function code for medical oncology (370), clinical oncology (800), or clinical haematology (303).

CCG14: Rapid rule out protocol for ED patients with suspected acute myocardial infarction (excluding STEMI)

Scope

Services: Acute

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 40%

Maximum: 60%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

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Supporting documents:

Additional supporting guidance will be available here

NICE Diagnostics Guidance DG15

NICE Clinical Guideline CG95

Health Technology Assessment 19(44)

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3. for details about the basis for performance and payment.

Description

Achieving 60% of Emergency Department (ED) admissions with suspected acute myocardial infarction for whom two high-sensitivity troponin tests have been carried out in line with NICE recommendations.

Numerator

Of the denominator, those where the time between the first and second high-sensitivity troponin (HST) sample requests is 3.5 hours or less.

Denominator

Total number of A&E attendances aged 18+, presenting with chest pain (Chief Complaint SNOMED = 29857009) and Acuity 2-5[1] who have had two High Sensitivity Troponin sample requests[2].

Exclusions

Any diagnosis of ST segment elevation myocardial infarction (SNOMED = 401303003).

Notes

[1] SNOMED codes: 1064911000000105, 1064901000000108, 1077241000000103, 1077251000000100

[2] EMERGENCY CARE CLINICAL INVESTIGATION = 105000003 (Troponin); to be used in combination with clinical information (e.g. via Integrated Clinical Environment' (ICE) Clinical Systems) in order to identify the number and time of High Sensitivity Troponin sample requests.

CCG15: Adherence to evidence based interventions (EBI) clinical criteria

Scope

Services: Acute

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 60%

Maximum: 80%

Calculation: Quarterly average %

Accessing support

NHSE&I policy lead

Dr Aoife Molloy

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Supporting documents

Additional supporting documents will be available via the Future Collaboration Network for EBI. For access please email the contact above.

Evidence Based Interventions Programme

Data reporting & performance

Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Achieving 80% of Phase 1, Category 2 procedures from the evidence based interventions (EBI) statutory guidance of November 2018 meeting the required criteria for delivery.

Numerator

Of the denominator, the number where the specific requirements set out within the EBI guidance have been followed.

Denominator

All Category 2 procedures (breast reduction, removal of benign skin lesions, grommets for glue ear in children, tonsillectomy for recurrent tonsillitis, haemorrhoid surgery, hysterectomy for heavy menstrual bleeding, chalazia removal, arthroscopic shoulder decompression for subacromial shoulder pain, carpal tunnel syndrome release, dupuytrens contracture release in adults, ganglion excision, trigger finger release in adults, varicose vein interventions) carried out using the codes detailed within appendix 4 of the EBI statutory guidance.

Exclusions

None

CCG16: Access to patient information at scene

Scope
Services: Ambulance

Period: Q1 Q2 Q3 Q4

Payment basis
Minimum: 0%
Maximum: 5%
Calculation: Quarterly average %

Accessing support
NHSE&I policy lead
Claire Joss
england.ambulance@nhs.net

Supporting documents
Ambulance CQUIN Guidance Workspace

Ambulance statistics

Ambulance Quality Indicators

Data reporting & performance
Quarterly submission via National CQUIN collection – see section 4 for details about auditing as well as data collection and reporting. Data will be made available approximately 6 weeks after each quarter.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description
Achieving 5% of face to face incidents resulting in patient data being accessed by ambulance staff on scene.

Numerator
Of the denominator, the number of incidents with a face to face response, during which the ambulance staff on scene accessed the patient's record.

Denominator:
Total count of incidents with a face to face response as defined in Ambulance Systems indicator (item A56).

CCG17a: Data security protection toolkit compliance

Scope

Services: Care homes with NHS funded residents and domiciliary care providers

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 0% (failed assurance)

Maximum: 100% (passed assurance

Calculation: Whole period %

Accessing support

NHSE&I policy lead

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Supporting documents

For access to reporting dashboard on the Future collaboration platform and information about further implementation support email: england.ageingwell@nhs.net

Additional information can be found on the Digital Social Care website

Data reporting & performance

Monthly reporting about the number of providers who have successfully met the data security and protection toolkit (DSPT) Entry Level or higher requirements, as per reporting dashboard produced by the National Ageing well team.

Data will be made available via the 'Enhanced Health in Care Homes' workspace on the future collaboration platform on a monthly basis, approximately 6 weeks after the period ends.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

The data security and protection toolkit (DSPT) is an online self-assessment tool that allows organisations that process health and care data to measure their performance against the National Data Guardian's 10 data security standards.

Achievement of this CQUIN will be on the basis of DSPT status [Column J: Care home and Dom care selection tabs of the reporting dashboard] and compliant providers will have either of the following three statuses within the year 20/21 (Column K: DSPT status date).

- Entry level
- Standards met
- Standards exceeded

No other statuses will be considered compliant with the CQUIN requirements.

CCG17b: Reported access to NHS mail

Scope

Services: Care homes with NHS funded residents and domiciliary care providers

Period: Q1 Q2 Q3 Q4

Payment basis

Minimum: 0% (no reported access)

Maximum: 100% (reported access)

Calculation: Whole period %

Accessing support

NHSE&I policy lead

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Supporting documents

For access to reporting dashboard on the future collaboration platform and information about further implementation support email: england.ageingwell@nhs.net

Additional information can be found on the Digital Social Care website

Data reporting & performance

Monthly reporting about the number of providers who have successfully accessed NHS Mail, as per reporting dashboard produced by the National Ageing well team.

Data will be made available via the enhanced health in care homes workspace on the future collaboration platform on a monthly basis, approximately 6 weeks after the period ends.

Performance basis: Quarterly. See section 3 for details about the basis for performance and payment.

Description

Confirmed access to NHS mail.

Achievement of this CQUIN will be on the basis of NHS mail linked accounts status [Column L: Care home and Dom care selection tabs of the reporting dashboard] and compliant providers will have a status of a whole number equal to or greater than ‘1’.

Providers with a status of ‘0’ or blank are deemed not to have reported access to NHS mail and will therefore not meet the requirements of this CQUIN.

Version control

Date	Update
20 January 2020	Initial Publication