South Tees Hospitals NHS
NHS Foundation Trust

Meeting / Committee:	Board of Directors	**Meeting Date:**	26 June 2012

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision	Assurance	Information x

Title:	CQUIN measures for 2012/13

Purpose:	The purpose of this report is to inform the Board of the CQUIN measures agreed for 2012/13 and to highlight the current risks to delivery and the actions in place to address these risks.

Summary:	The paper provides information on the CQUIN measures for the acute, community and specialist commissioned services for 2012/13. The overall financial risk is largely mitigated by the block contract arrangement for the NHS Tees contracts. However, there is income linked to CQUIN for the North Yorkshire and Specialist Commissioner services and delivery of the 2012/13 targets will be subject to contract performance management review. There are a number of measures where there are known to be significant risks to delivery and these are described in the report Some of the CQUIN measures for 2012/13 are likely to be carried forward into 2013/14 and it is therefore important to establish a robust position in this year.

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Recommendation:	The Board of Directors is asked to receive the report and note the risks and the actions planned to address these, a further update will be provide following analysis of the quarter 1 data

Implications (mark with x in appropriate column(s)	Legal	Financial x	Clinical x	Strategic	Risk & Assurance

CQUIN 2012/13

1.0 Introduction

The CQUIN measures for 2012/13 have been agreed with NHS Tees and the specialist commissioners. North Yorkshire commissioners have indicated that they will adopt a subset of the measures agreed with NHS Tees.

The purpose of this paper is to give an overview of the CQUIN measures, estimate the risks associated with each measure and describe progress with the actions needed to deliver the targets. The detailed list of measures and the quarterly milestones is included in appendix 1.

2.0 Risks to delivery

The Operating Framework states that for all standard contracts in 2012/13, the amount that providers can earn through CQUIN schemes will be increased to 2.5% on top of actual outturn value, for STHFT this would amount to c. £11.4m, however as there is a block contract arrangement in place for Tees there is no financial risk associated with failure to deliver the CQUIN measures specified in the Tees contract though the organisation will still be held to account through the contract performance management process. The element of the CQUIN income linked to the North Yorkshire contract is likely to be around £1.5m, at the moment it is unknown how they will weight each individual measure. The CQUIN measures for specialist commissioned services are linked to £1.5m income.

The table below shows the list of acute CQUIN measure and highlights those where there are known to be risks to delivery. The Community CQUIN scheme is felt to be low risk overall so is not listed in detail in the table (see appendix 1 for detail of each measure).

Theme	Risk	Value
Acute Services		
National VTE	Low	Tees Block Contract. NYY TBC
National Dementia	High	
Safety thermometer	Low	
National Patient Experience	Low	
Local Patient Experience	Low	
You're welcome	Low	
EWS	Medium	
Discharge	High	
Stroke	Low	
Heart Failure	Low	
Sepsis	Medium	
Breastfeeding	Low	
Smoking	High	
Learning Disabilities	Low	

Theme	Risk	Value
Best interest decision	Low	
COPD	Low	
Diabetes	Low	
Medicines Reconciliation	High	
GRACE	Low	
Pressure ulcers	Low	
Community Services	**Overall low risk with possible exception of safety thermometer in community nursing.**	Tees Block Contract. NYY TBC
Specialist Commissioner Services		
VTE	Low	£75K
Patient Experience	Low	£75K
Diagnosis of dementia	High	£75K
Safety Thermometer	Low	£75K
Quality Dashboard	High	£299k
Cardiac	Low	£180k
Renal Dialysis	Low	£180K
Cancer	Low	£180K
NIC	Medium	£180K
Spinal	Low	£180K

3.0 Further information on high risk measures

3.1 Dementia

The national dementia CQUIN applies to non-elective patients over the age of 75 who have a length of stay of more than 72 hours. The CQUIN consists of three parts:

- Stage 1 - Patients who do not already have a diagnosis of dementia are asked the dementia screening question –"have you/has the patient been more forgetful in the past 12 months to the extent that it has significantly affected your/their daily life", this must be undertaken within 72 hours of admission. If the answer is yes then patients move to stage 2. Patients with a clinical diagnosis of delirium are not asked the screening question and move directly to stage 2.
- Stage 2 - Carry out a diagnostic assessment including investigations to determine whether the presence of a dementia is possible. We will be using the Abbreviated Mental Test Score which is already in use in the organisation. Patients with a score of 7 or less should move to stage 3.
- Stage 3 – referral for specialist diagnosis.

The CQUIN payment is triggered by 90% compliance in each of the three stages (divided equally) in any three consecutive months, it is unlikely that we will be in a position to achieve this prior to the end of Q3 so would need to deliver and sustain 90% throughout Q4.

Currently the documentation to support this measure is being incorporated into the falls risk assessment and the core assessment document. The falls documentation has been fully piloted and is ready to be rolled out. The core assessment document is still being piloted.

The reporting of this measure is through the national reporting system UNIFY2 and requires a full dataset not a sample. There are no unused fields on the CAMIS system, if this data is to be captured on CAMIS it will have to be recorded in the same field that is currently used to record VTE risk assessments.

The process of recording and capturing the data is to be piloted on wards 11, 12 and 37 where a high number of patients who meet the criteria for this CQUIN are currently admitted. The pilot will run through July and following evaluation it is hoped to roll this out to the whole trust in September.

3.2 Early Warning Score

This measure is judged to be a medium risk as the trust made progress during 2011/12 but failed to achieve the target.

3.2 Discharge

There are two parts to this CQUIN:

- Improve the quality of discharge summaries – this is a significant challenge for a number of reasons including definitions of what is required, limited IT functionality and time pressures on medical staff.
- Ensure that all complex discharge patients have a completed discharge checklist - audits have shown that compliance with the use of the discharge checklist is variable across the trust. A new discharge checklist has been developed and it is hoped that this will improve compliance.

3.3 Sepsis

The organisation has been keen to include a CQUIN measure relating to sepsis for a number of years but there have not been the resources to reliably capture the data. There is currently a sepsis specialist nurse who is undertaking audits across the trust and the CQUIN for 2012/13 is to measure the number of patients with an infection or an EWS of >3 who have a sepsis screening tool completed. This is judged to be a risk as collection of the data is dependent on a single handed practitioner.

3.4 Smoking

This CQUIN requires the documentation of smoking status in the patient's notes and recording of a brief intervention in patients who smoke. Audits have shown that the recording of this information is poor. There is no field on CAMIS to capture this data and the only record is in the notes. The commissioners are keen that we can demonstrate that patients who smoke are offered a brief intervention and have pushed for a CQUIN relating to smoking for the last three years. The new core assessment document includes a section to record smoking and will be audited to set a baseline and agree an improvement target. This is judged to be a risk because consistency of clinical documentation is an area of concern and the core assessment document is not yet rolled out.

3.5 Medicines reconciliation

This CQUIN is focussed on the AAU and is carried forward from 2011/12 as the target was not met. It was hoped that the summary care record would improve the accuracy of medicines histories in AAU but this has been found to be unreliable. The AAU pharmacist continues to support and educate staff particularly the junior doctors.

3.6 NORSCORE Quality Dashboards.

The CQUIN measures for specialist commissioner services were agreed nationally for 2012/13 and these include a requirement for all relevant services to populate a template (quality dashboard) quarterly with quality metrics. Some of this data is already held on trust systems but much of it is not and requires new data collections to be set up. The commissioners are to issue data books giving detailed definitions of the measures but these have not yet been received and so it is difficult to ensure that adequate preparations for reporting are being made. There is a significant amount of work involved in collecting this data and most of the divisions involved have expressed concerns that they do not have the resources to do this. A piece of work is currently in progress to scope out what information is already collected, where it is held and what the gaps are.

3.7 Neonatal Intensive Care

There are two NORSCORE CQUIN measures relating to neonatal intensive care:

- To achieve a 95% screening rate for retinopathy of prematurity.
- To increase the percentage of preterm babies who are fed on mother's breast milk at discharge.

The risks for this measure relate to the data collection for retinopathy screening as we have been unable to replicate the figures provides by the neonatal network used to set the baseline and increasing breast feeding is a challenging area to influence particularly in this client group, however the percentage increase required is small.

4.0 Summary and conclusion

At the end of quarter 1 the first data collection for CQUIN will provide a better indication of risks of non-delivery. Due to the block contract arrangements the financial risks are reduced however the high risk measures are still linked to income from North Yorkshire and NORSCORE, and for the high risk measures it is likely that this will amount to in excess of £400k.

A programme management arrangement used to support CQUIN in previous years is being applied and actions are in place to address the high risk areas. A further update will be provided following evaluation of the quarter 1 position.

It is proving more difficult to engage staff in the delivery of the CQUIN measures as the financial drivers are not as strong due to the block contract arrangements however, a number of the 2012/13 CQUIN measures will form the basis for more challenging targets next year and it is therefore important that the organisation achieves the best position possible.

Ruth James
Deputy Director of Healthcare Governance and Quality
June 2012.

Appendix 1.

STHFT CQUIN Schemes 2012/13

Acute						
Theme	**Measure**	**Q1**	**Q2**	**Q3**	**Q4**	**Value**
National VTE	Percentage of inpatients with a VTE risk assessment on admission	90%	90%	90%	90%	Tees Block Contract. NYY TBC
	Percentage of patients receiving the correct prophylaxis	90%	90%	90%	95%	Tees Block Contract. NYY TBC
	Report outlining the number of adult inpatient admissions identified as having a hospital acquired VTE, report to highlight causative factors following RCA and any subsequent actions required.	RCA report	Receipt of report	Receipt of report	Receipt of report	Tees Block Contract. NYY TBC
National Dementia	Percentage of patients admitted as an emergency age 75 and over with a LOS >72 hours asked the dementia screening question	90% across 3 consecutive months				Tees Block Contract. NYY TBC
	Percentage of patients that have a positive response to the screening question that have risk assessed for dementia	90% across 3 consecutive months				Tees Block Contract. NYY TBC
	Percentage of patients considered at risk of dementia that are referred for specialist diagnosis	90% across 3 consecutive months				Tees Block Contract. NYY TBC

National Safety Thermometer	Percentage of complete submissions	100% across 3 consecutive months				Tees Block Contract. NYY TBC
National Patient Experience		TBA				Tees Block Contract. NYY TBC
Local Patient Experience	Compliance with work programme					Tees Block Contract. NYY TBC
You're welcome	Achievement of accreditation in Children's OPD and Orthodontic OPD				Scheduled verification visit	Tees Block Contract. NYY TBC
EWS	Percentage of patients who have the frequency of observations prescribed	80%	80%	85%	90%	Tees Block Contract. NYY TBC
	Percentage of patients receiving obs as per prescription	95%	95%	95%	95%	Tees Block Contract. NYY TBC
Discharge	Percentage of patients that have been discharged to a different location to the admission location with a completed discharge checklist	Agree MDS	Baseline	TBA		Tees Block Contract. NYY TBC
	Percentage of patients/carers documented as receiving discharge checklist	Agree MDS	Baseline	TBA		Tees Block Contract. NYY TBC
	Percentage of patients that have been discharged to a community hospital with a completed transfer checklist	Agree MDS	Baseline	TBA		Tees Block Contract. NYY TBC

	Quality of discharge summaries	Share 11/12 report and develop action plan	Report progress against action plan	Report progress against action plan	Re-audit	Tees Block Contract. NYY TBC
Stroke	Early supported discharge	Develop and share implementation plan	Report on progress	Report on progress	Report on progress	Tees Block Contract. NYY TBC
Heart Failure	1. Patient receives input to their management plan from a MDT heart failure team	Baseline	TBA			Tees Block Contract. NYY TBC
	2.Patient receives clinical assessment from a member of the MDT team within 2 weeks of discharge	Baseline	TBA			Tees Block Contract. NYY TBC
	3.Patient has a personalised management plan that is shared	Baseline	TBA			Tees Block Contract. NYY TBC
Sepsis	Percentage of patients with a completed sepsis screening tool that have an infection or have triggered >=3 on the EWS	Baseline	TBA			Tees Block Contract. NYY TBC
Breastfeeding	Continuation of project from 2011/12	Develop action plan and Q1 update	Report on progress against action plan	Report on progress against action plan	Report on progress against action plan	Tees Block Contract. NYY TBC
Smoking	Percentage of patients that have smoking status recorded		Baseline	TBA		Tees Block Contract. NYY TBC

	Percentage of patients with positive smoking status recorded that have been offered a brief intervention		Baseline	TBA		Tees Block Contract. NYY TBC
Learning Disabilities	Percentage of admitted patients flagged as LD that have reasonable adjustments made	Baseline	TBA			Tees Block Contract. NYY TBC
Best interest decision	% of recorded best interest decisions for those with a diagnosis of dementia	Develop an audit tool, agree the method and size of sampling with commissioners	Implement audit in agreed areas, to establish baseline, report findings and recommendations	Develop action/ implementation plan to take forward recommendations from audit report and recommendations	Evidence progress against action plan, interim evaluation of project regarding roll out of audit, improvement targets and mainstreaming best practice	Tees Block Contract. NYY TBC
	% of recorded best interest decisions for those with a diagnosis of learning disabilities					Tees Block Contract. NYY TBC
COPD	Implementation of an improvement plan linked to discharge of COPD patients	Share implementation plan	Report on progress against implementation plan	Report on progress against implementation plan	Report on progress against implementation plan	Tees Block Contract. NYY TBC
Diabetes	Percentage of patients with DKA that are seen by a specialist nurse within 48 hours of admission (unless self discharge or				90%	Tees Block Contract. NYY TBC

	death)					
Meds Reconciliation	Improve accuracy of medicines reconciliation	Develop action plan			Re-audit, no more than 25% inaccuracies	Tees Block Contract. NYY TBC
GRACE	Percentage of patients with acute coronary syndrome admitted to cardiothoracic services that have a recorded GRACE score	90%	90%	90%	90%	Tees Block Contract. NYY TBC
Pressure ulcers	Thematic report on findings from RCA from grade 3&4 pressure ulcers	Receipt of report	Receipt of report	Receipt of report	Receipt of report	Tees Block Contract. NYY TBC
Community						
Theme	**Measure**	**Q1**	**Q2**	**Q3**	**Q4**	**Value**
VTE Risk Assessment	As acute		-			Tees Block Contract. NYY TBC
VTE Prophylaxis	As acute		-	-		Tees Block Contract. NYY TBC
VTE RCA	As acute		-	-		Tees Block Contract. NYY TBC
Safety Thermometer	As acute		-	-		Tees Block Contract. NYY TBC
Local Patient Experience	As acute		-			Tees Block Contract. NYY TBC

Maternal Smokers	i) The number of pregnant women referred to Stop Smoking Services who have a recorded target quit date within Stop Smoking Services ii) The number of pregnant women referred to Stop Smoking Services who have a record of quit status at 4 weeks (i.e. quit, not quit, lost to follow up). Multiple counting should be avoided for women who make more than one quit attempt throughout the duration of pregnancy		-		i) 30% ii) 38%	Tees Block Contract. NYY TBC
Antenatal visits	% of first time mothers women receiving an antenatal contact from a named health visitor	Measure and provide data as to the current levels of contact, identify any improvements that could be made (in conjunction with working party). Report on progress				Tees Block Contract. NYY TBC
Hear by Right	demonstrate a commitment to actively improving the participation of young people at all levels of their service by adopting the hear by right standards		-		Submission of evidence	Tees Block Contract. NYY TBC
Breastfeeding project	The provider will plan and implement an innovative project with a view to increasing local breastfeeding implementation and/ or continuation rates.		-		Provide update against Action Plan	Tees Block Contract. NYY TBC

Lung Health Project	Project to roll out to a further 4 more community drop ins in year 2. locations to be determined by Public Health Needs analysis		-		Update on progress against plan, including evaluation of project	Tees Block Contract. NYY TBC
Dementia	To redevelop a more comprehensive Action Plan to work towards implementation of NICE quality standard, focusing on training and use of nationally recommended screening tools		-		Update against Action Plan	Tees Block Contract. NYY TBC
Best Interest Decision	To establish numbers of inpatients across the organisation with a diagnosis of LD or Dementia, from which to establish an appropriate sample size. To develop an audit tool to establish a baseline of best interest decision recording. Agree the method and size of sampling with commissioners.		-		Roll out audit	Tees Block Contract. NYY TBC
Advance Care Plan	The percentage of palliative care patients on a community services case load who have been offered the opportunity to make an advance statement of their future wishes	90%	90%	90%	95%	Tees Block Contract. NYY TBC

Liverpool Care Pathway (LCP)	% of all 'near to death' patients on the caseload who are also on the Care Pathway for the Last Days of Life	90%	93%	95%	95%	Tees Block Contract. NYY TBC
Preferred Place of Care	% of people who die in their place of choice	90%	90%	90%	90%	
Nutrition	Per cent of adult patients (>18 years old) on the community nursing caseload who are screened for risk of under nutrition and if necessary, have an appropriate plan of care i. Screening ii. Action plans		-		i.98% ii. 90%	Tees Block Contract. NYY TBC
Hydration	1. Ensuring that all patients who need to have their fluid balance monitored are being appropriately monitored. 2. Those who are being monitored are receiving the appropriate fluid intake.	Baseline and agree KPIs	-		Achieve improvement indicators	Tees Block Contract. NYY TBC
Falls reduction - stage one screening tool	Stage 1 falls screening tool will be completed at first visit by community nurse for all patients aged 65 and over who have had a fall during the last 12 months	95%	95%	95%	95%	Tees Block Contract. NYY TBC
Falls reduction - Stage two screening tool	No of patients screened and identified as high risk who have had full risk assessment	95%	95%	95%	95%	Tees Block Contract. NYY TBC

Pressure ulcer reduction	i) Number of patients identified as having an in-patient acquired pressure ulcer during point prevalence audit (in accordance with EPUAP scale) ii) thematic analysis of pressure sores reported by community services to identify root causes and potential areas for whole systems improvements		-		<4%	Tees Block Contract. NYY TBC
Community matrons emergency plans	Percentage of long-term condition patients on a Community Matron's caseload with an emergency plan as part of their personal care plan	Review and impleme nt action plan	Report	Report	Report	Tees Block Contract. NYY TBC
NESCG						
Theme	Measure	Target		Value (£K)		
VTE	As acute			75		
Patient Experience	As acute			75		
Diagnosis of dementia	As acute			75		
Safety Thermomete r	As acute			75		
Quality Dashboard	Range of quality measures across NESCG commissioned services.	Provide reports on at least 75% of measures required from Q2 onwards		299		

Cardiac	1. The proportion of patients referred as urgent, to have cardiac surgery as an in-patient (with or without transfer) within 7 days of decision to accept.	To establish baseline Q1 and agree target for Q2-Q4.	180		
Renal Dialysis	An additional 15 patients to commence home therapy dialysis by April 2013. Numbers to comprise either patients receiving peritoneal dialysis (including assisted automated peritoneal dialysis) or patients receiving home haemodialysis	15 additional patients.	180		
Cancer	Increased access to IMRT 20% of all episodes of radiotherapy treatment should be delivered using IMRT	20%	180		
NIC	1. To achieve a 95% screening rate for retinopathy of prematurity 2. To increase the percentage of preterm babies who are fed on mother's breast milk at discharge.	1. 95% by Q4 2. ≥22.4% (baseline 20.2%)	180		

Spinal	1. % of newly injured SCI patients with traumatic injury will receive a face-to-face outreach visit from the SCIC acute outreach team within X days (maximum 7) of the referral. 2. 90% of newly injured SCI patients who are being ventilated for all or part of the day will have a ventilation/ weaning plan agreed with the referring team within X days (maximum 7) of the referral 3.Waiting times for referral to admission for newly injured SCI patients only	1. 90% by Q4 2.90% by Q4 3. Submission of quarterly reports	180		