



Using the Commissioning for Quality and Innovation (CQUIN) payment framework

Guidance on new national goals for 2012-13

Using the Commissioning for Quality and Innovation (CQUIN) payment framework

DH INFORMATION READER BOX

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Executive summary

Two new national CQUIN goals have been introduced for use in 2012/13. This short guidance is designed to assist commissioners and providers in including the CQUINs in contracts.

More detailed guidance on the use of the Safety Thermometer, delivery of 'harm free' care and learning from the pilot phase of the project will be available shortly via www.harmfreecare.org and <http://www.ic.nhs.uk/services/nhs-safety-thermometer>

Dementia goal

The goal of the Dementia CQUIN is to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital.

NHS Safety Thermometer goal

The goal of the NHS Safety Thermometer CQUIN is to incentivise the measurement of harm from pressure ulcers, falls, urinary tract infections in patients with catheters and VTE, using the NHS Safety thermometer. This will help fulfil commitments made to publish outcomes data on pressure ulcers in the NHS Outcomes Framework and contribute more widely to the Government's Transparency Agenda. Crucially measurement and publication supports work to deliver improved quality of care.

Actions to achieve the goals

Providers will want to ensure that:

- For the NHS Safety Thermometer, clinical staff understand the reason for the data collection and are able to record pressure ulcers (and the other three outcomes) accurately and are able to act on their findings to intervene; to treat and prevent harm
- For dementia, clinical staff understand the reason for the data collection and are able to record the finding, assessment and investigation, and referral accurately and are able to act on their findings to intervene to treat and care.
- They set up data collection systems which integrate with daily work flows, for example at a clinical handover or safety huddle to maximise learning and minimise the data collection burden.
- For the NHS Safety Thermometer, use their local data collection to ensure that all patient groups are reviewed rather than focussing on 'easy to reach' groups.
- For dementia, use their local data collection to ensure that all patients aged 75 and over are identified, assessed and referred as appropriate.

Chapter 1 - Dementia

Introduction

Dementia is a significant challenge for the NHS with an estimated 25% of acute beds occupied by people with dementia, their length of stay is longer than people without dementia and they are often subject to delays on leaving hospital. Whilst work is underway to improve the nature of outcome data, the process measure of dementia risk assessment will set an effective foundation for appropriate management of patients allowing significant improvements in the quality of care and substantial savings in terms of shorter lengths of stay.

Dementia affects an estimated 670,000 people in England, and the costs across health and social care and wider society are estimated to be £19 billion – both figures are set to rise with the ageing of the population. Currently only around 42% of people with dementia in England have a formal diagnosis despite the fact that timely diagnosis can greatly improve the quality of life of the person with dementia by preventing crises (and thus care home and hospital emergency admission) and offering support to carers (who are invariably under stress).

There is no cure for dementia, and its commonest cause is Alzheimer's disease, although current treatments can provide relief of symptoms. Antipsychotic drugs are prescribed to control agitation and aggression. An estimated 180,000 people, in the UK, with dementia are given these medications, resulting in 1800 excess deaths and 1600 excess strokes per year.

It is estimated that 25% of general hospital beds in the NHS are occupied by people with dementia, rising to 40% or even higher in certain groups such as elderly care wards or in people with hip fractures.

The presence of dementia is associated with longer lengths of stay, delayed discharges, readmissions and inter-ward transfers. Many admissions are because of ambulatory conditions (about 40%) such as urinary tract or respiratory infections, which can be managed in the community.

Dementia is often not coded, particularly when it is not considered the 'primary' reason for admission. As a result, the numbers of people with dementia in hospital is significantly underestimated. Two thirds of people with dementia have a superimposed delirium, associated with increased mortality.

People with dementia in hospital can present with a variety of symptoms ranging from being mildly disorientated to more severe symptoms of agitation, restlessness, shouting and wandering which can cause significant disruption. This latter group often gets labelled as being 'in the wrong place', usually resulting in referral to old age psychiatry liaison services.

The Dementia CQUIN payment will be triggered in three stages: the case finding of 90% of all patients aged 75 and over following admission to hospital, using the dementia case finding question and identification of all those with delirium and dementia, the diagnostic assessment and investigation of 90% of those patients who have been assessed as 'at-risk' of dementia from the dementia case finding question and presence of delirium, and the referral of 90% of those for specialist diagnosis of dementia and appropriate follow up.

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The dementia data collection is a new collection and will commence, through UNIFY2 from April 2012.

Further information

a range of further resources are available on dementia care in hospital, including;

NHS Confederation Report - Acute Awareness

<http://www.nhsconfed.org/Publications/reports/Pages/Dementia-report-Acute-awareness.aspx>

Alzheimer's Society - Counting the Cost

http://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=356

CCQI Audit of Dementia in the General Hospital

<http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/dementia/nationalauditofdementia.aspx>

Dementia Commissioning Pack

<http://dementia.dh.gov.uk/dementia-commissioning-pack/commissioning-pack-resources-antipsychotics/>

Alzheimer's Society agitation guidelines

http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1163&categoryID=200294

Chapter 2 - National Dementia CQUIN: Quick Guide

The aspiration of the dementia CQUIN is to develop the system within acute trust which incentivises the identification of patients with dementia and other causes of impaired cognition alongside their other medical conditions and to prompt appropriate referral and follow up after they leave hospital. Currently around 40% of patients over 75 admitted to general hospitals have dementia with only half having prior diagnosis. Hospitalisation can give an opportunity to ensure proper diagnostic assessment but also that whilst in hospital and on discharge reasonable adjustments are made in their care to take into account their dementia. The more systematic identification of patients with cognitive impairment is also likely to improve the detection of delirium, depression etc and give opportunities to manage them better. The pathway is summarised below and has three parts: Find, Assess and Investigate, Refer (FAIR)

Stage 1

Find: Identify all patients with a diagnosis of dementia. These patients do not move to stage 2 and 3 but should have a diagnostic review if clinically indicated. Patients with a clinical diagnosis of delirium would move straight to stage 2. Patients with neither, ask the “awareness question” (asking the patient or another such as family or professional caregiver) “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 has to be completed with 72 hours of admission.

Stage 2

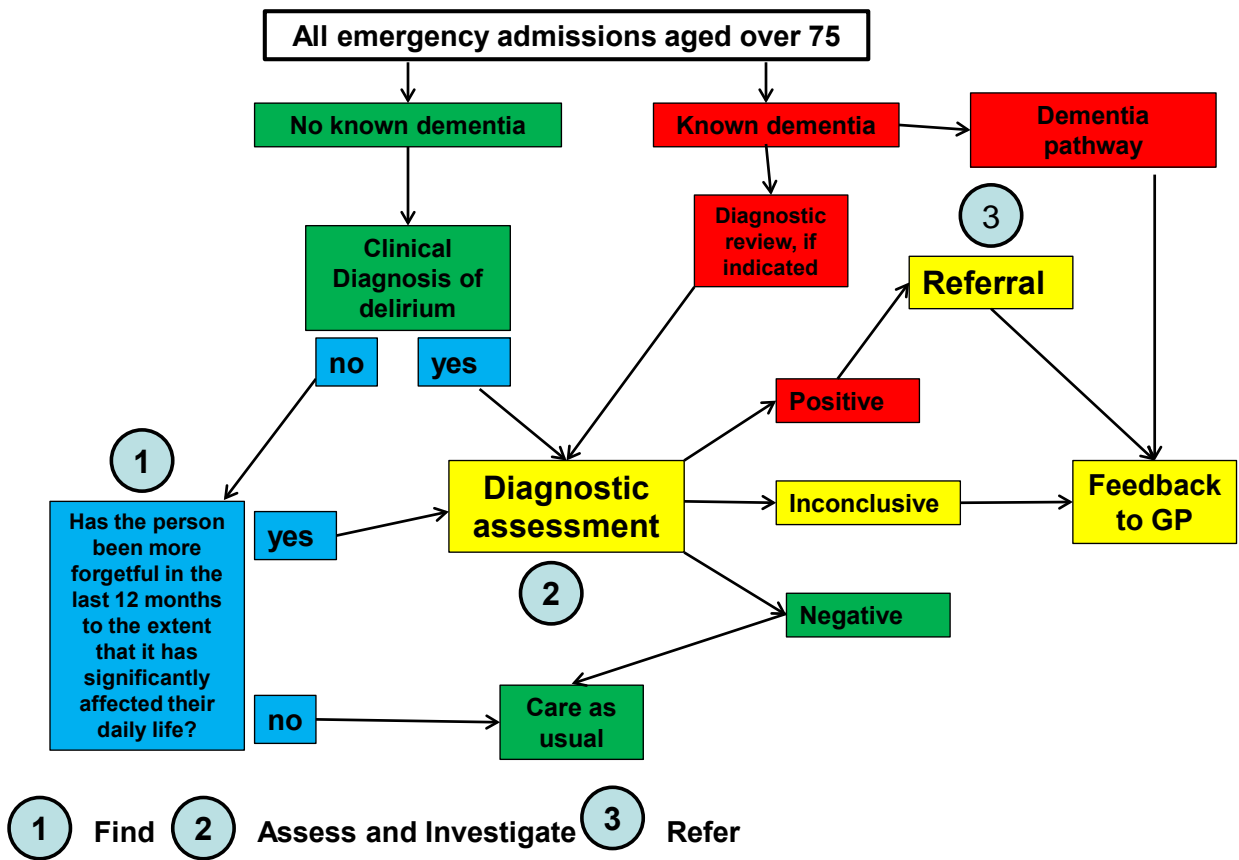
Assess and Investigate: carry out a diagnostic assessment including investigations to determine whether the presence of a dementia is possible.

Stage 3

Referral: for specialist diagnostic assessment by a clinician with appropriate skill or training. This could be to an old age psychiatry liaison team and the person assessed in hospital or it could be referral to a memory clinic or referral to the GP to alert that an assessment had raised the possibility of the presence of dementia. In addition, depending on local services, the patient can be seen as inpatient or outpatient by a geriatrician, nurse specialist/nurse consultant, general physician with interest in dementia, clinical psychologist or neurologist. Some initial diagnostic assessments will be made by specialists working in the acute hospital but so long as there is a clear documented plan for post-discharge formal diagnostic assessment, the CQUIN can be paid.

The CQUIN payment is triggered by 90% compliance in each of the three stages (divided equally) in any three consecutive months in the first year. Day cases, patients with a length of stay of less than 72 hours, transfers, and elective admissions will not be included in year 1.

Dementia CQUIN: FAIR (Find, Assess and Investigate, Refer)



Chapter 3 - Dementia Frequently Asked Questions

Why has a National Dementia CQUIN been developed?

There is widespread concern about the care of people with dementia in the general hospital setting. One in four adult general hospital beds is occupied by someone with dementia (though routine clinical coding underestimates this). People with dementia stay in hospital an average of seven extra days compared to patients with similar primary diagnoses but no dementia. Forty percent of people over 75 admitted acutely to hospital have dementia alongside their other conditions and half of these have not been diagnosed before admission. Many older people in hospital also have cognitive impairment from other causes including delirium or depression – conditions which are often poorly recognised and under-treated.

There are three key reasons to encourage better identification of patients in hospital with dementia:

- a) People with dementia require very specific approaches to their care, communication, environment and clinical treatment. There are many excellent examples of services to improve the care of older people with dementia and which improve their outcomes and experiences. The starting point in making these “reasonable adjustments” in care is to ensure that we identify people with dementia during their hospital admission. We also know that good comprehensive geriatric assessment for older patients has a range of benefits and that this includes proper assessment of cognition.
- b) Many patients in hospital also have cognitive impairment which may be due to causes other than dementia such as depression or delirium. Dementia is a risk factor for developing delirium. Identifying all patients with cognitive impairment will improve the detection of delirium – in line with NICE guidance and our ability to prevent it and our detection of other reversible problems such as depression.
- c) Admission to hospital (often at a time of crisis and for older people in vulnerable situations with complex needs) provides an opportunity to detect people with dementia and to ensure that they are then referred for appropriate diagnostic assessment, treatment and support in the community after discharge from hospital rather than an acute admission being a “missed opportunity”.

The National Dementia CQUIN presents one opportunity to focus on practice in this area, to raise the profile of dementia care in general hospitals and improve post discharge support, by facilitating recognition and best care, following on from the success of venous thromboembolism (VTE). Modelled on the successful VTE risk assessment, it was felt that a dementia diagnostic assessment was appropriate. The aspiration is fairly simple – to use a system lever such as the national CQUIN to raise the profile of dementia and, like VTE, to get it owned by the whole system, i.e. it is not the purview of specialist old age psychiatry liaison teams or geriatricians with a special interest.

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Early diagnosis is a key part of the national dementia strategy. Dementia is a long - term condition and it is in the interests of patients and health professionals to ensure that patients with dementia are known to the system and supported to prevent deterioration and remain at home.

How will payment be triggered?

The CQUIN payment will split into “thirds” and awarded separately for each indicator (i.e., dementia case finding, initial short diagnostic assessment and investigation, referral for specialist diagnosis) that achieves the 90% target

Do all 3 indicators need to be completed within 72 hours of admission?

No. It is only indicator 1, dementia case finding, that needs to be completed within 72 hours of admission. Indicator 2 and 3 can be completed anytime during the admission up to the point of discharge.

Will we have to hit the 90% target consistently from April 2012 to be paid?

To allow providers to implement local plans for delivering the CQUIN goal, the CQUIN will be paid to any trust that achieves the target for 3 consecutive months during year 1. This means the provider must achieve 90% each month for three consecutive months, rather than as an average across three months.

Will we have to achieve all three indicators in the same consecutive three months or can we earn payment by achieving each of the three indicators in separate three month periods?

The goal is based on ensuring a sequential course of action takes place for each patient i.e. case finding, diagnostic assessment and referral. Therefore, essential components of the indicator are the setting up of robust systems to ensure that the initial case finding and subsequent assessment and onward referral takes place for all those within the identified cohorts.

Payment for indicator one will be based on the achievement of 90% or above for a consecutive three month period. Payment for indicators two and three can only be achieved if indicator one is above 90% and the target of 90% for these two indicators is achieved for three consecutive months. This means that the provider will need to ensure that systems are in place by 31st December at the very latest to be able to earn the full 100% CQUIN payment during the 2012/13 contract year, as no payment will be awarded for indicators two and three if indicator 1 is below 90%.

Which patients does this CQUIN apply to?

All patients aged 75 and above admitted as an emergency including those with a diagnosis of dementia. Those with a confirmed diagnosis of dementia will not need a repeat diagnostic assessment unless clinically indicated but will count towards the CQUIN target for indicator 1. Day cases, patients with a length of stay of less than 72 hours, transfers, and elective admissions will not be included – this will be reviewed after year 1.

What are the components of the assessment?

There are three parts summarised in the accompanying Quick Guide essentially: FAIR (Find, Assess and Investigate, Refer). The single question will be used to find people who may be at risk, a short diagnostic assessment including initial investigations will then be carried out, followed by a referral to services if appropriate. Those scoring positively on the initial case finding question would be invited to undertake a dementia diagnostic assessment. Those who score positively on the diagnostic assessment would be referred for specialist diagnosis or further follow up. There are therefore 3 indicators to the CQUIN:

Indicator 1: Dementia case finding

Numerator: Number of patients admitted aged 75 and above who are asked the case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia.

Denominator: Number of patients aged 75 and above, who were admitted as inpatients in an emergency, minus the exclusions (day cases, patients with a length of stay of less than 72 hours, transfers, and elective admissions will not be included – this will be reviewed after year 1- see FAQ 8 'Which patients will be excluded' for full list).

Indicator 2: Diagnostic assessment for dementia

Numerator: Number of patients admitted aged 75 and above, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium and who do not fall into exemption categories (see below), reported as having had a dementia diagnostic assessment including investigations.

Denominator: Number of patients aged 75 and above admitted as inpatients, who have scored positively on the case finding question, or who have a clinical diagnosis of delirium.

Indicator 3: Referral for specialist diagnosis

Numerator: Number of patients admitted aged 75 and above who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") who are referred on for further diagnostic advice and/or further follow up.

Denominator: Number of patients aged 75 and above admitted as inpatients who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive").

Summary of indicators (N: numerator; D: denominator. 90% compliance for each)

Indicator 1: Find

N: Number of patients with a clinical diagnosis of delirium + number of patients asked the question + number of people with a diagnosis of dementia

D: Emergency admissions over the age of 75 (minus exclusions)

Indicator 2: Assess and investigate

N: Number of patients having the diagnostic assessment

D: Number of people with a clinical diagnosis of delirium + number of patients answering positively to the question

Indicator 3: Refer

N: Number of patients being referred on for further assessment and investigation or to their GP for follow up

D: Number of patients in whom the diagnostic assessment is “positive” or “inconclusive”

Numerical example

A ward has 100 admissions of people over the age of 75 in one particular month. 15 are known to have dementia (ie 85 people admitted not known to have a diagnosis of dementia).

A further 20 patients have a clinical diagnosis of delirium on admission.

60 patients are asked the question of whom 35 say yes.

Of the 20 patients with delirium and the 35 who say yes to the question 50 have the diagnostic assessment.

Of this group, there are 40 in whom the assessment is regarded as being “positive” or “inconclusive”.

37 of this group are referred on for further advice.

Stage 1: Numerator: 20 plus 60 plus 15

Denominator: 100

Stage 2: Numerator: 50

Denominator: 20 plus 35

Stage 3: Numerator: 37

Denominator: 40

Which patients will be excluded?

Those for whom the case finding question cannot be completed within 72 hours of admission for reasons of coma, critical illness, severe speech and language difficulties, sensory impairment, lack of translator, family or professional care giver. If the patient has a known diagnosis of dementia, this should be clearly documented and this will contribute towards the CQUIN target for indicator1. They do not however need to go onto to the “assess and investigate” and “refer” stages, though reasonable adjustments should still be made to their care and discharge planning.

Patients discharged with palliative care needs or significant loss of function in whom specialist referral for memory problems is inappropriate.

Re-admissions and frequent attenders without a diagnosis of dementia will be excluded provided there is evidence of these patients having been thorough the FAIR process within the last 6 months.

All the above patients will be excluded from the denominator population if the clearly documented according to predefined criteria.

reason for inability to carry out assessment within 72 hours of admission is

Why is the CQUIN only for over 75s and why is it only for emergency admissions?

For the first year of the CQUIN, we are following the model successfully used for the VTE

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CQUIN, and we are targeting the group of people most at risk of being undiagnosed for dementia, and thus most at risk of experiencing poor care in hospital. In subsequent years we will look at other age groups and admission types.

What constitutes a diagnosis of dementia?

Patients who have dementia documented on their GP records or who have been assessed and diagnosed in a memory clinic are considered to have a formal diagnosis of dementia.

The patient has cognitive impairment but it is unclear whether this is delirium, dementia, co morbid delirium and dementia, or depression.

If the patient has a diagnosis of delirium on admission they do not need to be asked the dementia case finding question and should progress directly to stages 2 and 3. Whilst delirium often resolves rapidly as the patient recovers from their acute illness, it can at times persist beyond the acute phase making assessment for dementia difficult. Additionally, depression can present with symptoms of memory loss akin to those of dementia. In these situations, if the patient is deemed fit for discharge and any underlying cause of persisting delirium has been ruled out it is appropriate for the patient to be followed by the GP following discharge. This should be within a time period long enough to allow full recovery from residual delirium and an accurate assessment of cognitive function and depression. The term delirium rather than “acute confusion” has been used to ensure alignment with the NICE delirium guidelines and to prompt appropriate clinical assessment.

Do both the patient and relatives/cares need to be involved in answering the case finding and diagnostic assessment questions?

No, information from either source is enough but it is best practice to include both. Informant history is especially helpful when trying to differentiate between delirium and dementia but it is acknowledged that this is not always possible.

Who can the patient be referred to for specialist diagnosis?

The idea is that if a person potentially has a dementia, then a referral should be made for further assessment. This could be to an old age psychiatry liaison team and the person assessed in hospital or it could be referral to a memory clinic or referral to the GP to alert that an assessment had raised the possibility of the presence of dementia. In addition, depending on local services, the patient can be seen as inpatient or outpatient by a geriatrician, nurse specialist/nurse consultant, general physician with interest in dementia, clinical psychologist or neurologist. Some initial diagnostic assessments will be made by specialists working in the acute hospital but so long as there is a clear plan for post-discharge formal diagnostic assessment documented the CQUIN for this indicator can be paid. For those with a diagnosis of dementia on admission it is best practice to inform the mental health team about the admission by sending a copy of the discharge letter or requesting the GP to do so.

It is important as part of the dementia CQUIN that all of the actions are ultimately within the control of the hospital. It would be inappropriate, for example, to make the hospital accountable or responsible for the local authority provision in a particular area.

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Where is the money going to come from?

The money for the dementia CQUIN goal is part of the funding that providers can earn as a quality incentive. This is paid in addition to the annual value of their contract- the payment is calculated on the basis of 2.5% of actual outturn value of the contract for 2012 \13. This means that where all four national CQUIN goals are applicable to a provider, the value of the payment for achievement of the dementia CQUIN will be calculated as 0.125 % of the actual contract value.

How will the process be coordinated?

Trusts will submit data to commissioners on a monthly basis via UNIFY2-the NHS online data collection portal. Whilst this is a national CQUIN, commissioners and providers will need to locally agree the terms of the contract and ensure that appropriate data collection arrangements are in place. Each trust/hospital is responsible for assuring quality control of the process.

Does the CQUIN apply to independent sector providers?

No. The CQUIN is only applicable to NHS trusts currently however this may be reviewed after year 1.

If we are already using a local screening question/ assessment tool, can we continue to use this instead of the national one?

Yes, local modifications are appropriate in agreement with the commissioners as long as basic data set for attainment of CQUIN target is gathered and the medical director signs off the local diagnostic assessment tool to ensure it aligns with national tool.

How was the question developed?

It was a question that simply reflected what seemed to be important seems to have traction and face validity with clinicians who work in the area. The idea was inspired by the Single Question to Identify Delirium (SQUID). People with dementia should be identified on admission and in those people over 75 not known to have without dementia, a question is asked: *“Has the person been more forgetful in the last 12 months to the extent that it has significantly affected their daily life?”* The question was chosen, as much as an awareness raising, rather than formal screening, question. It is a question that any member of the clinical team can ask and it can be addressed to the person in hospital, their families or the GP.

“Forgetful” was chosen instead of *“loss of memory”*, the reference to *“significantly”* is in keeping with the standard definition of dementia and *‘been’* was better than *‘become’* just in case people had not significantly changed over the last 12 months, but were already significantly impaired.

Will this not mean the need for many old age psychiatry liaison teams, which are not available at the moment?

The proposal is not in terms of diagnosing dementia, but to raise the profile and identifying those who may have dementia. There will never be enough old age psychiatry liaison teams to

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assess, diagnose and manage people with dementia in the general hospital. We propose that patients can be referred to a wide range of professionals depending on local arrangements - please see question regarding referral.

Will you not just be raising anxiety unnecessarily?

Only if the process is done badly. If the right support and care is given there is no reason that anxieties will be raised. Doing nothing is not an option, and the national dementia CQUIN presents a unique opportunity to improve the care of people with dementia. NICE guidance, standards in the Royal College of Psychiatrists' dementia in the general hospital audit, and in the NHS Confederation Report, "acute awareness: improving hospital care for people with dementia" already set out the importance of identifying inpatients with dementia as part of improving their care. There is also a clear evidence base for comprehensive geriatric assessment which has proven benefits for older patients and part of this is adequate assessment of cognition. Whilst most hospitals formalise this by including scores such as Abbreviated Mental Test

Scores on hospital admission proformas, we know from national audits that adequate assessment of cognition and history of cognitive impairment is still happening very patchily.

Will we be told how to do the initial short diagnostic assessment?

We will be providing guidance about what a short diagnostic assessment would look like which people will choose to use if they want to or not. However, it may be that local groups would rather make up their own and ideally, it should provoke a close relationship between the local memory service and the hospital to work out what is the best for patients.

Will GPs be overwhelmed on a Monday morning with large numbers of older people coming to see them, saying that they have been told they might have dementia over the weekend and what is the GP going to do about it?

The numbers of people involved are not that big and even if the diagnosis rates went up substantially the numbers for each practice would be relatively manageable. It would be up to GPs and clinical commissioning groups to ensure that there is local provision of appropriate services for people with dementia. Help from organisations such as the Alzheimer's Society will be important.

Will there be training available for this?

With one in four hospital beds being occupied by someone with dementia, and better hospital care of people with dementia being a priority in the NHS operating framework, it is in the interests of trusts to provide dementia training including training on implementation of the CQUIN. There is already a clear standard that every trust should have a named lead dementia clinician.

What about the assessment of the use of anti-psychotic drugs?

The morbidity and mortality associated with the use of antipsychotics in dementia is now widely accepted. If a person is suspected of having dementia and is on one of these medications then a clinical review should take place and the dementia assessment process is the ideal situation for this to occur. Antipsychotics may sometimes be appropriate in the management of patients with delirium or psychosis and in line with NICE guidance. Less commonly, they may be entirely appropriate for short periods in someone with dementia and severe behavioural and psychological symptoms of dementia (BPSD) not controlled by other non-pharmacological

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approaches. Hospitals should audit and reduce their antipsychotic use regularly, have pathways for management of delirium and BPSD and flag all antipsychotics appearing on prescriptions for take home medications to prompt clinicians to review the indication We suggest that all patients on antipsychotics for longer than 7 days have a risk assessment carried out in order to aid the decision regarding continuation Please see the antipsychotics initiation and review clinical support tool, available as part of the DH dementia commissioning pack and the Alzheimer Society agitation guidelines for more information.

<http://dementia.dh.gov.uk/dementia-commissioning-pack/commissioning-pack-resources-antipsychotics/>

http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=1163&categoryID=200294

Will this process not be a huge burden to the NHS?

It is not the process in itself that is putting strain on the NHS, it is the needs of people with dementia in the hospital system that is badly managed. By improving recognition and improving the management, people will go on the right care pathway and, as with many other conditions there will be a halo effect improving the recognition of dementia and its better treatment. The aspiration is that, ultimately, avoiding the unnecessary admission of a person with dementia to hospital and facilitating their discharge will be achieved.

Chapter 4 - Dementia Diagnostic Assessment

Step 1 - Find			
Does the patient already have a formal diagnosis of dementia? Yes - Dementia Care pathway with reasonable adjustments as appropriate No - Clinical Diagnosis of delirium on admission? Yes -move to step 2 and 3 No –Ask the question. Has the person been more forgetful in the past 12 months, to the extent that it has significantly affected their daily life? (ask patient/relative/carer) Yes -move to step 2 and 3; No - continue with usual care			
Step 2- Assess and investigate			
Questions for patient (AMTS)	Score 1 if correct	Clinical History	
		Questions to consider (ask patient/relative/carer)	
1.Age		When did the memory problems begin?	
2.Date of Birth			
3.Repeat 42 West Street	N/A	How did the memory problems begin i.e., acute/gradual?	
4.Year			
5.Time(nearest hour		Has there been any worsening of the memory problem or is it stable?	
6.Name of hospital		Other relevant information :	
7.Recognise 2 people (e.g. Dr, Nurse)			
8. Year world war 2 ended (1945)		Examination and investigations	
9.Who is the monarch (Elizabeth)		Complete physical examination	Yes No
10.Count backwards from 20		Investigation to consider: B12, Folate, TFTs, Calcium, CRP, haematology, U&E and LFTs	Yes No
11. Recall 42 West street		Review medication, in particular antipsychotics	Yes No
Total out of 10 ≤8 consider dementia			
Step 3 -Refer			
Clinical impression of suspected dementia (other conditions particularly delirium excluded): Depending on local protocol refer to: memory services, GP, liaison psychiatry (see FAQs for examples of professionals to whom to refer)		Inconclusive/unable to exclude resolving delirium on discharge: Request GP to re-assess and refer as appropriate following discharge	

Chapter 5 - NHS Safety Thermometer

Background

- International and English epidemiological research demonstrates that overall 10-12% of all patients suffer from pressure ulcers (7% for category 2-4 pressure ulcers), a substantial proportion of which can be avoided. The gap between the best and worst performers is substantial and simple, inexpensive nursing interventions can dramatically reduce prevalence. The burden is known to be disproportionately experienced by older people and more vulnerable patients in community settings.
- Pressure ulcers have been identified by the Chief Nursing Officer and NHS Medical Director as a key quality issue for the NHS and an area in which more systematic and robust data is needed in order to help drive improvements in care. A DH policy task and finish group was commissioned in September 2011 to explore publication of a relevant set of pressure ulcer data with a view to developing a programme of work to support NHS Providers in making improvements in this area, as well as supporting the NHS Outcomes Framework and Government Transparency agenda.
- The question of which data set(s) to publish was not straightforward given the variable quality of the current data available for pressure ulcer prevalence and incidence, principally derived from National Reporting and Learning System and Hospital Episode Statistics. These data sets tell a particular story but are thought to not reflect the true incidence of pressure ulcers in the NHS.
- However, the current piloting of the NHS Safety Thermometer as part of the QIPP Safe Care workstream highlighted the benefits of this data collection and the additional detail and accuracy it could provide in relation to pressure ulcer prevalence. The policy group therefore recommended the publication of HES and NRLS data and that data should also be published from the NHS Safety Thermometer on a national basis. To support spread of data collection using the NHS Safety Thermometer, a national CQUIN goal was devised for inclusion in the NHS Standard Contract.
- The NHS Safety Thermometer measures the proportion of patients with a pressure ulcer (category II-IV of any origin) using a point estimate methodology (on one day per month) in all patients receiving NHS funded healthcare. It also measures 3 other common 'harms'; harm from falls, urinary tract infections in patients with catheters and new VTE, and introduces the concept of 'harm free' care where patients are assessed for the absence of all 4 'harms'.
- The NHS Safety Thermometer has been developed and tested by NHS frontline teams participating in the Energising for Excellence and QIPP Safe Care programme (Safety Express) over a one-year development period. It has received scrutiny during its design and development from global content and improvement experts who have met to review and develop the instrument.

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- The NHS Safety thermometer has therefore been selected for incentivisation as a national measurement instrument for pressure ulcers because:
 - Clinically, it is well known that patients who suffer pressure ulcers are vulnerable and susceptible to other preventable complications [4]. It is these patients for whom the burden, dependency and cost of suffering is greatest.
 - Attempts to reduce the prevalence pressure ulcers could lead to unintended consequences in other common complications and it is important to ensure that pressure ulcer reductions are not having a detrimental impact in other areas. For example, there may be a misguided perception that pressure ulcers can be reduced by the insertion of urinary catheters and an increase in the use of catheters and urinary infection could go unnoticed unless this is measured at the same time as pressure ulcers.
 - The NHS Safety thermometer measures four high-volume patient safety issues (pressure ulcers, falls in care, urinary infection in patients with catheters and new VTE treatment). It contains clinically valid and pragmatic operational definitions for each focus area, which means it can be used across a range of settings. It gives a timely summary of results which can be used for teams in their improvement work and the data collected are easy to aggregate at the micro- (ward), meso- (organisation, cluster or region) or macro-system (national).
 - The instrument is efficient; a pilot of the instrument by 170 NHS providers has confirmed that the survey, which is completed by frontline healthcare professionals, takes less than 10 minutes per patient (significantly less in the case of experienced users) and it fits within the daily work flow of frontline clinicians, for example at handover or regular rounds.
- Case studies exploring how the NHS Safety Thermometer can be used to improve patient care are available from www.harmfreecare.org

How will Safety Thermometer achievement be measured

- For the NHS Safety Thermometer, CQUIN payment will be triggered by submission of 3 consecutive months' worth of survey data covering a single quarter, provided each of the 3 surveys reflects data for 100% of appropriate patients.
- For a guide to which patients, cohorts and services are considered appropriate to be surveyed using the Safety Thermometer, in particular inclusions and exclusions, please see annex A. This in essence sets out which services and patients the CQUIN is relevant to. Practical application of these exclusions in the identification of the number of beds eligible for inclusion in the safety thermometer, which can in turn be used as the denominator for the CQUIN, can be seen in Annex B.
- Where organisations feel they have identified an additional cohort or set of patients for whom surveying with the NHS Safety Thermometer is inappropriate (i.e. should be excluded from the survey) a process will be put in place which will allow the organisation to submit the details, and their rationale for, the proposed exclusion. This will be

reviewed by an expert professional reference group who will reach agreement whether or not the proposed exclusion is to be incorporated into the existing NHS Safety Thermometer guidance. The initial proposal for how this process will work can be seen in Annex C. The process uses a template, for consistency of application, which ensures a record of all proposed exclusions is kept for reference and incorporation into FAQs and/or additional guidance. The initial proposal for this template can be seen in Annex D.

- We have suggested particular days for providers to carry out the surveys each month in the timetable available from <http://www.ic.nhs.uk/services/nhs-safety-thermometer>. Organisations do not have to use this exact date, although they should undertake the survey on a single day. It could be possible that a patient harm could be double counted if a patient moves between settings, wards or caseloads. To limit the possibility of double counting of patient harms, the organisation should aim to complete the survey within a specific time period, for example on one morning between 9 and 12. Organisations should also consider linking in with other local providers to agree the date and time window in which the survey is carried out to limit the potential for individuals to be double counted as they move between services.
- Arrangements for the payment of CQUIN goals in general are set out in the Guidance on the NHS Standard Contract 2012/13 available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131988. Information on CQUIN schemes is also available from the NHS Institute, at http://www.institute.nhs.uk/commissioning/pct_portal/cquin.html
- For all participating providers of NHS services, compliance with the monthly point estimate survey will be measured through review of the nationally published data available on the Information Centre website. Data from each provider's monthly surveys will be submitted by the provider on a monthly basis to the NHS Information Centre who. The Information Centre will then publish data for all providers that submit. At the most detailed level data does not compromise patient confidentiality. Commissioners should use this data publication to confirm that their relevant providers are submitting data and therefore to inform CQUIN payments.
- Providers with multiple contracts should consider whether it is more appropriate to submit separate data returns for each contracted service, or to submit a single data return for their organisation. This will depend on the size of the data returns for each contracted service and the practicalities of separating out services, or indeed combining services into a single data return where they are distinct. For example a single organisation providing separate mental health and community services under different contracts should consider providing separate returns for each service. This will need to be agreed with their commissioner(s) and each service must be registered separately with the NHS IC to enable separate data submissions.
- A pilot collection of NHS Safety Thermometer data has been in place since September 2010. This has previously been coordinated by the QIPP Safe Care Programme Office. The first publication of pilot data was in November 2011, relating to a sample of wards/ departments / caseloads from volunteer sites and collected between September 2010 and September 2011.

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- From January 2012, the system has switched over to involve direct submission of merged provider-level data to the Information Centre by participating providers. Providers should submit monthly data export files to the Information Centre by emailing them to safetythermometer@ic.nhs.uk (see NHS Safety Thermometer User Guide available at <http://www.ic.nhs.uk/services/nhs-safety-thermometer>). Publication of data will be quarterly in arrears with the first data publication for national data transparency and Outcomes Framework purposes in April 2012. Further guidance on analysing and interpreting data on outcomes will be available from April 2012.
- However, please note that for CQUIN purposes, the first relevant quarter for CQUIN payment is Quarter 2 (July – September 2012), relating to data published in October 2012. This is due to the need to ensure data collection and publication processes are robust prior to any links being made with contractual payments.
- Providers are encouraged to trial the use of the NHS Safety Thermometer as soon as possible during the final quarter of 2011/12 and the first quarter of 2012/13. They should undertake 'dummy' surveys of a small number of wards/care settings and trial submission of data to the Information Centre in order to test their systems and processes for embedding use of the Safety Thermometer in their routine activities. Commissioners should be involved in this process to test their systems for reviewing their providers' data submissions for the purposes of payment prior to commencement of the CQUIN scheme in quarter 2 of 2012/13.

Ensuring all appropriate patients have been surveyed to qualify for the CQUIN payment for the Safety Thermometer

- It is clearly necessary for commissioners to be able to satisfy themselves that a particular provider has submitted data for all appropriate patients for each month in a quarter in order to justify their CQUIN payment. It is equally clear providers need to be able to exercise clinical discretion in applying inclusion and exclusion criteria for use of the measurement tool, and that they should not be expected to account for and justify each exclusion in order to qualify for their CQUIN payment.
- Therefore, it will be for commissioners to determine whether the monthly returns for a particular provider represent a patient survey sample size that is consistent with the expected activity of that particular provider. Commissioners should use their knowledge of their providers' activity based, for example, on the information they have for tariff or other contractual purposes and cross-reference this with the number of sampled patients for each monthly survey as reported via the data published by the Information Centre. They should allow for some exclusions of patients based on the types of activities the provider undertakes.
- There will be no routine national validation of patient survey sample size. However, you will need to provide your commissioner with a statement regarding the coverage of the data, including information (non-identifiable) on those patients that have been included in the data submission and those that have been excluded.
- Commissioners should consider each service they commission via an individual contract separately. The payment of each CQUIN is governed by a specific contract and therefore commissioners should satisfy themselves for each contract they hold with a

provider that the provider has conducted a survey of the expected number of patients. Where it is not practical to separate out the data relevant to each contract from the overall data submitted for a single survey by a provider, it is sufficient for the commissioner to satisfy themselves that the survey was of sufficient size to have included the specific patients that the contract applies to within the overall data collected.

- Commissioners may wish to triangulate this assessment with other commissioners or against the other contracts they hold with the same provider to ensure that the same patients' surveys are not being used to satisfy multiple separate CQUIN requirements.

Care Homes

- Those in the Care Homes sector using the NHS Standard Contract for Care Homes have access to the national CQUIN payment framework and are therefore subject to the national CQUIN goals unless exceptions apply. In the case of the NHS Safety Thermometer CQUIN, this therefore means all Care Homes delivering NHS-commissioned care for residents using the NHS Standard contract qualify for CQUIN payments in relation to the NHS Safety Thermometer if they collect and submit data as required. Please note however that the CQUIN payment calculation must be based on the income the home gets from its NHS-funded care using the standard contract and not their total turnover.
- Where care is provided that is not explicitly funded through a contract agreed with an NHS commissioner and using the NHS Standard Contract for care homes, it is not part of the CQUIN scheme. We would strongly encourage all care homes, regardless of the CQUIN scheme, to utilise the NHS Safety Thermometer to measure harm and improve care. However in the absence of a standard contract (for example where care is jointly funded by a PCT and Local Authority but provided through a Section 75 agreement not a direct contract between the PCT and the Care Home) the CQUIN cannot apply.
- Given the Care Homes Standard Contract for 2011/12 will also be used in 2012/13, the Department is issuing a deed of variation for the Care Homes contract to add any new items mandated through the Operating Framework to existing contracts. This includes reference to the new NHS Safety Thermometer CQUIN goal.

Publication of surveys on small numbers of patients

- Publication of data derived from the NHS Safety Thermometer will be at the greatest level of detail possible while balancing the need to maintain patient confidentiality. This means for example that where small numbers of patients are surveyed within identified units/wards/cohorts, full publication of data could result in patient-identifiable information being released. It may therefore be necessary to anonymise or merge such data to protect patients. Where entire services for which a contract applies only include small numbers of patients, it may also be necessary to publish such data only as part of aggregated results covering a number of services in a region, or even nationally. Final decisions on the level of detail that can be published will be taken by the NHS Information Centre. Commissioners should consider the implications of this when agreeing processes for triggering CQUIN payments in relation to services involving very small numbers of patients.

Multiple contracts

- Where organisations are providing services to NHS-funded patients under contracts with multiple commissioners, it is sufficient for each individual commissioner to consider the overall expected activity of the provider and satisfy themselves that the data provided via the Safety Thermometer survey is consistent with this level of activity. There is no need for commissioners to ensure that the specific patients they commission for have been surveyed where this is not straightforward.

Safety Thermometer beyond 2012/13

- Providers and commissioners should note that the intention is for use of the NHS Safety Thermometer to become mandatory from 2013/14. 2012/13 is a transition year in which providers are incentivised to move to using the NHS Safety Thermometer as soon as possible and to submit data for national publication.
- The data submitted over the course of 2012/13 will be used in determining potential quality goals in future years. These may include, for example, incentivising a particular reduction in pressure ulcer prevalence or to reward the level of 'harm free' care as measured by the Safety Thermometer.
- Providers and commissioners should work together to determine quality improvement goals. They should use data collected throughout 2012/13 as a baseline viewed over time and use 'best in class' examples to set improvement goals for 2013/14.

What action is required to define and agree these goals in local provider contracts?

- The commissioner and provider need to complete the relevant CQUIN template(s) within their contracts, ensuring a clear understanding of:
 - Relevant services/contracts to which the CQUINs apply
 - Numerators and denominators
 - Data collection arrangements and timings
 - Payment threshold
 - Payment value
 - Payment schedule

What actions are required to support achievement of these goals during the financial year?

- Providers will want to ensure that:
 - Clinical staff understand the reason for the data collection and are able to record pressure ulcers (and the other three outcomes) accurately and are able to act on their findings to intervene; to treat and prevent harm

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- They set up data collection systems which integrate with daily work flows, for example at a clinical handover or safety huddle to maximise learning and minimise the data collection burden.
- They use their local data collection to ensure that all patient groups are reviewed rather than focussing on 'easy to reach' groups.

Supporting Information

- A range of resources are available to local health economies in using the Safety Thermometer to collect data (including indicator definitions) and more widely in improving the outcomes identified by the NHS Safety Thermometer;
 - Download the NHS safety thermometer at <http://www.ic.nhs.uk/services/nhs-safety-thermometer>
 - Technical Guidance for using the NHS Safety Thermometer is also at <http://www.ic.nhs.uk/services/nhs-safety-thermometer>
 - A series of webex recordings and slides on implementing the NHS Safety Thermometer are available from <http://www.harmfreecare.org/resources/nhsst-10steps/>
 - Wider guidance on how to use the NHS Safety Thermometer as part of a whole programme to reduce harm in NHS care is available from <http://www.harmfreecare.org/>
 - Further guidance will be produced on implementing the NHS Safety Thermometer and setting improvement goals. Any new guidance will be available at the following link <http://www.harmfreecare.org/measurement/nhs-safety-thermometer/>
 - Pressure ulcers: The management of pressure ulcers in primary and secondary care <http://www.nice.org.uk/CG29>
 - The assessment and prevention of falls in older people <http://www.nice.org.uk/CG21>
 - Catheter care: RCN guidance for Nurses http://www.rcn.org.uk/_data/assets/pdf_file/0018/157410/003237.pdf
 - Cost Effective commissioning for continence care <http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf>

Annex A: Inclusions & Exclusions for the NHS Safety Thermometer

This annex outlines the exclusions and inclusion of organisations, cohorts and patients that are currently in place for the data collection associated with the NHS Safety Thermometer.

The CQUIN to incentivise the use of the NHS Safety Thermometer states that '100% of all relevant patients' should be surveyed on the day of audit. 'Relevant patients' are defined for each organisation or service type in columns 2 and 3 as 'inclusions'. There are also a range of exclusions. These are shown for each organisation or service types in columns 4,5 and 6.

The exclusions applied to the NHS Safety Thermometer, at an organisational, cohort and patient level, at this stage are considered areas for development throughout 2012.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Organisation type	Included		Excluded		
	Cohort	Patients	Organisation	Cohort	Patients
Acute hospital	All specialties & services including prison & military services, theatre recovery, critical care units, neonatal intensive care (<i>pressure ulcers only</i>) and postnatal wards, minus specified exclusions (see column 5)	All inpatients on the day of the survey, minus specified exclusions (see column 5)	None	Day cases, outpatients, A&E attendances, well babies, renal dialysis patients, regular day attenders (see notes below)	Specific patients who may not be applicable to be surveyed for each harm are referenced in the definitions guidance which will explain in detail the definition for each harm and the harm free care measure (to be published by the end of March)
Specialist hospitals (inc. orthopaedic, ENT, neurology, paediatrics, women's)	All specialties & services including theatre recovery, critical care units and postnatal wards, minus specified exclusions (see column 4&5)	All inpatients on the day of the survey, minus specified exclusions (see column 5)	Specialist Eye Hospitals	Day cases, outpatients, A&E attendances, neonatal patients, renal dialysis patients, regular day attenders (see notes below)	
Mental health and Learning Disability inpatient facilities	All old age mental health and learning disability specialties & services (see notes below), including any prison services, minus specified exclusions (see column 5)	All inpatients on the day of the survey, minus specified exclusions (see column 5)	None	Outpatients, all specialties not related to old age mental health and learning disabilities (e.g. child and adolescent, forensic, psychotherapy, eating disorders).	
Mental health and Learning Disability community teams	All old age mental health and learning disability specialties & services, including any prison services, minus specified exclusions (see column 5)	All patients seen by the team on the day of the survey, minus specified exclusions (see column 5)	None	Outpatients, all specialties not related to old age mental health and learning disabilities (e.g. child and adolescent, forensic, psychotherapy, eating disorders).	
Community hospital, including social enterprises/CICs providing NHS funded care	All specialties & services including prison & military services, minus specified exclusions (see column 5)	All inpatients on the day of the survey, minus specified exclusions (see column 5)	None	Day cases, outpatients, A&E attendances, neonatal patients, renal dialysis patients, regular day attenders (see notes below)	
Community services, including social enterprises/CICs providing NHS funded care	Community (district) nursing (inc. virtual wards), integrated rehabilitation services, rapid response, prison services, military services, minus specified exclusions (see column 5)	All patients seen by the team on the day of the survey, minus specified exclusions (see column 5)	None	Outpatients (e.g. podiatry, continence, leg ulcer clinics, SLAT), health visiting, school nursing (see notes below)	
Independent sector hospitals providing NHS funded care	All NHS funded specialties & services including prison & military services, minus specified exclusions (see column 5)	All NHS funded inpatients on the day of the survey, minus specified exclusions (see column 5)	None	Day cases, outpatients, A&E attendances, neonatal patients, renal dialysis patients, regular day attenders (see notes below)	
Nursing homes	All NHS funded residents	All NHS funded residents on the day of the survey	None	None	
Ambulance trusts			Ambulance trusts are excluded from NHS Safety Thermometer survey		

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Notes:	
Term	Definition
Day case	A patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a hospital bed overnight (patient classification code = 2) and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission and included in the NHS Safety Thermometer survey.
Outpatient	An Out-Patient Attendance is an attendance at which a patient is seen by or has contact with (face to face or via telephone/telemedicine) a health care professional, in respect of one referral, in a clinic setting.
A&E attendance	An individual visit by one patient to an Accident and Emergency Department to receive treatment from the accident and emergency service.
Neonatal patients	Babies in care who are 28 days old or less
Dialysis patients	Patients undergoing regular dialysis who should be recorded as a regular day admission (patient classification code = 3)
Old age mental health and learning disability services	Mental health and learning disability services provided to patients generally over the age of 65. Inpatient older people's mental health services would usually be recorded under the treatment function 715 (Old Age Psychiatry).
CICs	Community Interest Companies (CICS) are limited companies created for the use of people who want to conduct a business or other activity for community benefit, and not purely for private advantage.
Regular day attenders	Patients undergoing regular treatments (e.g. chemotherapy) who should be recorded as a regular day admission (patient classification code = 3)
Health visiting	Teams employed to visit people in their homes and give help and advice on health and social welfare, specifically to mothers of preschool children, to the handicapped, and to elderly people.
School nursing	Teams/staff working with school-age children and young people in a range of settings including schools.

Annex B: NHS Safety Thermometer

Worked examples

Hospital Based Leader

In order to get your CQUIN payment you will need to be able to demonstrate the number or eligible beds you have on the day of the survey, the number or patients surveyed and the reasons for any omissions.

All inpatients: All specialities and services, including any prison and/or military services

Except: Day cases, outpatients, A&E attendances, well babies, renal dialysis patients, regular day attenders

Defining your eligible beds (the denominator)	
1.	Get a list of all wards, departments and directorates
2.	Identify locations for in patient care
3.	Create a list of locations and specialities in locations, including a figure of total beds in these locations (NB: local bed managers will be able to help you with this)
4.	Look at the exclusions to determine if any exclusions apply, for example: <ul style="list-style-type: none"> • Well babies • Renal dialysis • Outpatients • A&E • Day cases
5.	Deduct this number to get your total eligible beds; this number should be reviewed quarterly
6.	The total calculated in step 5 will be required each time you conduct the survey. You will also need to provide occupancy of these beds in these locations on the day of the survey (NB: this can be sourced from your PAS system or via your information team)
7.	Assemble data for the number of patients surveyed

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8.	Document the number of patients surveyed and reasons for omissions
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Example: Safety Thermometer Survey 15th January 2012

First Calculation (eligible beds):

Total occupied beds	Total bed exclusions	Reasons for exclusions	Total eligible beds
Insert the number of occupied beds on the day of the survey	Insert the total number of beds excluded	Insert the reason for exclusions	Insert the number of eligible beds after exclusions have been deducted
100	25	10 day cases, 5 renal dialysis, 10 neonates	<u>75</u>

Second Calculation (proportion of eligible patients surveyed):

Actual beds surveyed (patients)	Total beds omitted	Reason for omissions	% completeness
Insert the number of actual beds (patients) surveyed with the Safety Thermometer	Insert the number of eligible beds that were not surveyed	Insert the reason for the omissions	Calculate the number or total eligible beds minus the number of eligible beds omitted with reasons. Divide this number by the number of beds surveyed to get your percentage completeness
65	10	Empty Beds = 8 Patient in another location = 2	75 (total eligible beds) - 10 (total beds omitted) = 65 65/65 = 100%

Community Healthcare Services Leader (District Nursing)

In order to get your CQUIN payment you will need to be able to demonstrate the number or eligible patient appointments you have on the day of the survey, the number or patients surveyed and the reasons for any omissions.

All patients: seen on the day of the survey by community nursing teams (inc. virtual wards)

Except: Outpatients (e.g. podiatry, continence, leg ulcer clinics, SLAT), health visiting, school nursing

Defining your eligible patient cohort (the denominator)	
1.	Assemble the data for numbers of patient contacts undertaken on the day of the survey
2.	Look at the exclusions to determine if there are any exclusions that apply to your service, for example: <ul style="list-style-type: none">• Health visiting• Outpatients• School nursing
3.	Deduct these appointments from the total to get the number of eligible patients
4.	The total calculated in step 3 will be required each time you conduct the survey
5.	Assemble data for the number of patients surveyed
6.	Document the number of patients surveyed and reasons for omissions

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Example: Safety Thermometer Survey 15th January 2012

First Calculation (eligible contacts):

Total contacts	Total excluded contacts	Reasons for exclusions	Total eligible contacts
Insert the number of contacts on the day of the survey	Insert the total number of contacts excluded	Insert the reason for exclusions	Insert the number of eligible contacts after exclusions have been deducted
100	15	15 Health Visiting	85

Second Calculation (proportion of eligible patients surveyed):

Actual contacts surveyed (patients)	Total omissions	Reason for omissions	% completeness
Insert the number of actual contacts (patients) surveyed with the Safety Thermometer	Insert the number of eligible contacts that were not surveyed	Insert the reason for the omissions	Calculate the number or total eligible contacts minus the number of eligible contacts omitted with reasons. Divide this number by the number of contacts (patients) surveyed to get your percentage completeness
83	2	No documentation, patient unable to communicate = 2	85 (total eligible contacts) - 2 (total contact omissions) = 83 83/85= 100%

Annex D: NHS Safety Thermometer Patient Cohort Exclusion Template

Organisation name	
SHA region	
Contact name	
Contact number	
Contact e-mail	
Brief description of patient cohort to be excluded	
Rationale for exclusion	
Estimated number of patients in cohort (based on a single month's Safety Thermometer collection)	
<p>E-mail this form to the NHS QUEST team at Abigail.warren@nhs.net or k.cheema@nhs.net</p> <p>Your request will be reviewed by an expert reference group. The outcome of the review will be advised to you within 6 weeks</p>	
FOR NHS QUEST USE ONLY	
Date received:	
NHS Quest reviewer:	
Date sent to ref group:	
Outcome (accept/reject):	
Date and contact when outcome advised:	