Preventing ill health by risky behaviours – alcohol and tobacco

There are five parts to this CQUIN indicator.

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

Indicator 9a Tobacco screening

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

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

Indicator 9a	
	(£2bn on the NHS through hospital admissions, £7.5bn through lost productivity, £1.1bn in social care). Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness, 33% of tobacco is consumed by people with mental health problems.[1] Smoking is the single largest cause of health inequalities[2.] A Cochrane Review[3] shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis. Inpatient smoking cessation leads to a reduced rate of wound infections, improved wound healing and increased rate of bone healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates among patients who want to quit and take up a referral to stop smoking services are between 15% and 20%, compared to 3% to 4% amongst those without a referral.[4] **The status quo nationally** Coverage of advice and referral interventions for smokers are patchy. Currently in secondary care, some patients may be asked if they smoke, but not all, and not at every admission, e.g. less than half of smokers admitted to hospital receive very brief advice to stop as an inpatient. For those patients that have been identified as a smoker, this is no guarantee that they will then be given an effective stop smoking intervention and referral to evidence based smoking cessation support. Currently, only 1.5% of smokers in acute hospital settings go onto make a quit attempt with stop smoking services. **The financial case** Modelling of the tobacco component of the CQUIN suggests that it could reduce costs through fewer admissions and improved health of smokers and passive smokers; resulting in net savings of £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy each year over 4 years. This is a conservative estimate accounting for the reduced cost of hospital admissions only.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf
[2] http://www.sciencedirect.com/science/article/pii/S0140673606689757
[3] Rigotti N, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients.Cochrane Database of Systematic Reviews 2007; Issue3.Art.No.:CD001837.DOI:10.1002/14651858.CD001837.pub2
[4] http://www.ncsct.co.uk/usr/pub/Briefing%208.pdf

Indicator 9a	
Data source	**Provider audit of patient records, submitted to CCGs on a quarterly basis:** We propose that: • Providers with searchable electronic patient records audit **all patient records**. • Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**. **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months. **The following exclusion criteria** should be applied: 1. All patients below 18 years of age 2. All in-patients in maternity wards 3. All A&E attendances that do not lead to in-patient admissions 4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention. **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B. **The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance and insight teams. **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff[5].

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

Indicator 9a	
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that the data that is required for the audits are patient case notes which are to be updated by staff whenever relevant.
Organisation responsible for data collection	**Provider**.
Frequency of reporting to commissioner	**Quarterly**. Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well.
Baseline period/date	Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 18/19.
Final indicator value (payment threshold)	**90%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme).
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below

Indicator 9b Tobacco brief advice

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

Indicator 9b	
Baseline period/date	Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 18/19.
Final indicator value (payment threshold)	**90%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme)
Final indicator reporting date	As soon as possible after Q4 2018/19
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

Indicator 9c Tobacco referral and medication offer

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

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

Indicator 9d Alcohol screening

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

Indicator 9d	
	quarter: • **unique** is defined as non-repeat admission of a patient during the duration of the CQUIN (i.e. FY 17/18 and 18/19) who has not already received the intervention within the period of the CQUIN • **adult patient** is defined as patients of at least 18 years of age; and • **admitted** is defined as admitted to an inpatient ward for at least one night (i.e. Length of stay equal to or greater than one) **excluding** any admissions to maternity wards (i.e. admissions to maternity wards not in scope of this CQUIN).
Rationale for inclusion	**Context** This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the FYFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN. **The burden of excessive alcohol consumption** In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK CMOs' lower-risk guideline and increase their risk of alcohol-related ill health. [6] Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries.[7] There are nearly 22,500 alcohol-attributable deaths per year.[8] Out of c3.7m admissions[9], c333,000 were admissions where an alcohol-related disease, injury or condition was the primary diagnosis or there was an alcohol-related external cause. These alcohol-related admissions are 32% higher than in 2004/05.[10] Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose

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

Indicator 9d	
	alcohol misuse causes ill health – this is the group for which IBA is the most effective. Identification and Brief Advice (IBA) results in recipients reducing their weekly drinking by c12%. Because alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health. **The status quo nationally** Currently, IBA delivery in secondary care is patchy and nowhere near the optimal large scale delivery required to significantly impact on population health. It is strongest where there are strong Making Every Contact Counts (MECC) initiatives that include alcohol IBA and where there are well-resourced alcohol care teams that train other staff. **The financial case** Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers. The successful delivery of the CQUIN is estimated to bring about a reduction of weekly alcohol consumption of 12%, which could result in net savings of c£27 per patient receiving alcohol brief advice each year over 4 years, from reduced alcohol-related hospital admissions following improvements in morbidity. (NB: these figures are taken from unpublished modelling conducted by Sheffield University using data derived from the latest Cochrane review of brief advice in primary care.[11])
Data source	**Provider audit of patient records, submitted to CCGs on a quarterly basis:** We propose that: • Providers with searchable electronic patient records audit **all patient records**. • Providers that do not have searchable electronic patient records conduct audits of a **random sample of patient records**. **The case notes in scope** of the audit are of all completed emergency and elective admissions (ie all inpatient admissions) with Length of Stay equal to or bigger than 1 day over the last three months. **The following exclusion criteria** should be applied:

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

Indicator 9d	
	1. All patients below 18 years of age 2. All in-patients in maternity wards 3. All A&E attendances that do not lead to in-patient admissions 4. All repeat admissions during the duration of the CQUIN (i.e. FY 17/18 and 18/19) of patients who have already received the intervention. **For audits based on samples** of the eligible patient records, it is suggested that they identify a random sample, an appropriate sample size and an appropriate method for conducting the review. Additional guidance on sampling is provided in Annex B. **The sampling method** used should seek to ensure that a cross-section of appropriate wards are represented in the sample. Audits to be undertaken by provider performance and insight teams. **Patient records should be clear and consistent** in the way that the individual components of the CQUIN actions are recorded to enable uniform collection across the provider. It is the responsibility of providers to identify the most effective way of recording the required information and communicating this to relevant staff.
Frequency of data collection	**Quarterly**. Data to be collected ahead of quarterly audit. Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well.
Organisation responsible for data collection	**Provider**.
Frequency of reporting to commissioner	**Quarterly**. Note that to enable national audits, providers will simultaneously submit this data to NHS England via UNIFY on a quarterly basis as well.
Baseline period/date	Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 18/19.
Final indicator value (payment threshold)	**50%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme).

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

Indicator 9e Alcohol brief advice or referral

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

Indicator 9e	
	practitioners whenever relevant.
Organisation responsible for data collection	**Provider**.
Frequency of reporting to commissioner	**Quarterly**. Note that to enable national audits, providers are required to simultaneously submit audit data to NHS England via UNIFY on a quarterly basis as well.
Baseline period/date	Baseline to be identified and set during Q1 of the CQUIN (i.e. Q1 of FY 17/18); see *Milestones* below.
Baseline value	To be determined locally, based on baseline setting exercise in Q1; see *Milestones* below.
Final indicator period/date (on which payment is based)	Quarter 4 FY 18/19.
Final indicator value (payment threshold)	**80%** (NB: – this might be reviewed for 18/19 in light of learning from the first year of the scheme)
Final indicator reporting date	As soon as possible after Q4 2018/19.
Are there rules for any agreed in-year milestones that result in payment?	Yes. **Quarter 1** – payment is available for achieving three milestones at the end of Q1, namely a) completing an information systems audit; b) training staff to deliver brief advice and c) collect baseline data. Payment is split equally between a), b) and c), for more detail see *Milestones* below. **Quarter 2 and onwards** – payment is available for high (i.e. to target performance) or improving performance across the indicators; performance data will be submitted on a quarterly basis by providers to commissioners who will reward payment.
Are there any rules for partial achievement of the indicator at the final indicator period/date?	Yes – see *Rules for partial achievement* below.

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

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

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

For Acute Providers this means that they will be rewarded in

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

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
End Q1	Completed information systems audit This milestone requires each provider to undertake an audit its existing information systems. This audit needs to set out: 1. what the proposed mechanisms for collecting the required data for the indicators are / will for the respective provider 2. what (if any) changes have been made to the data capturing arrangements / information in order to enable the quarterly case note audits 3. the proposed approach for conducting the quarterly case note audits (this should include details on potential data quality issues and any other risks; and set out mitigating actions for these to ensure that the case note audits yield accurate data on performance)	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	The audit needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the audit meets the requirements set out above. Full payment of the CQUIN should be provided for audits that address all the requirements set out above. Audits that do not address all requirements will not attract payment.		
End Q1	**Completed brief advice training for relevant staff** This milestone requires each provider to establish and implement a brief advice training plan for relevant health professionals who are expected to provide brief advice. Providers will demonstrate achievement of this milestone by drafting a report which needs to contain details on: 1. **A status quo capacity assessment** (i.e. identification of who the relevant health professionals are to deliver brief advice and an assessment of the existing skills of those relevant health professionals to deliver brief advice) 2. **Who** is in scope to receive the training (ie based on the capacity assessment, identify individual or groups of health professionals who would require training; and clinical leader(s) to act as ward or hospital "champions") 3. **What** the training entails (ie what components are included in the training, how is it sourced and who is to deliver	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	the training incl the method of delivery) 4. **How** effective the training has been (ie assessment of how effective the training was through e.g. Self-assessment of participants after training completion) 5. **When** the training has been delivered (ie training schedule and what groups were trained when; what processes are in place to deliver training for new starters; what process is in place to ensure that training is refreshed; it is expected that the majority of the training is completed by the end of Q1 but where this is not possible, plans for future training are required). The report needs to be shared with the commissioner by the reporting deadline (31 July 2017). Commissioners are responsible for ensuring that the report meets the requirements set out above. Full payment of the CQUIN should be provided for reports that address all the 5 requirements set out above. Reports that do not address all requirements will not attract payment.		
End Q1	**Collected relevant data to establish baseline for all indicators** This milestone requires each provider to collect the required data for each indicator of the CQUIN to establish a baseline performance level. Full payment of the CQUIN should be awarded to those organisations that	31 July 2017	33% of Q1 CQUIN funds

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	can establish a credible baseline level of performance across all indicators. Where baseline data is not available for all of the indicators, no payment will be made. Note that in exceptional cases where providers may not be able to establish baseline data in Q1, they may – following agreement with providers – be able to establish their baseline in Q2 in order to participate in future quarters of the CQUIN.		

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

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

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

Annex A – Supplementary Guidance

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

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

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

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

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

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

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

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

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