Title of Report:	**CCG Quality Premium**
Report to be considered by:	The Health and Wellbeing Board
Date of Meeting:	30th July 2015

Purpose of Report:

To inform the Board of the Quality Premium Scheme, and to highlight the two local indicators that the CCG have elected to achieve which align with the local Health & Wellbeing strategy

Recommended Action:

None

When decisions of the Health and Wellbeing Board impact on the finances or general operation of the Council, recommendations of the Board must be referred up to the Executive for final determination and decision.		
Will the recommendation require the matter to be referred to the Council's Executive for final determination?	Yes: ☐	No: x

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No x**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☐
• Does the policy relate to an area with known inequalities?	☐	☐
Outcome Where one or more 'Yes' boxes are ticked, the item is relevant to equality. In this instance please give details of how the item impacts upon the equality streams under the executive report section as outlined.		

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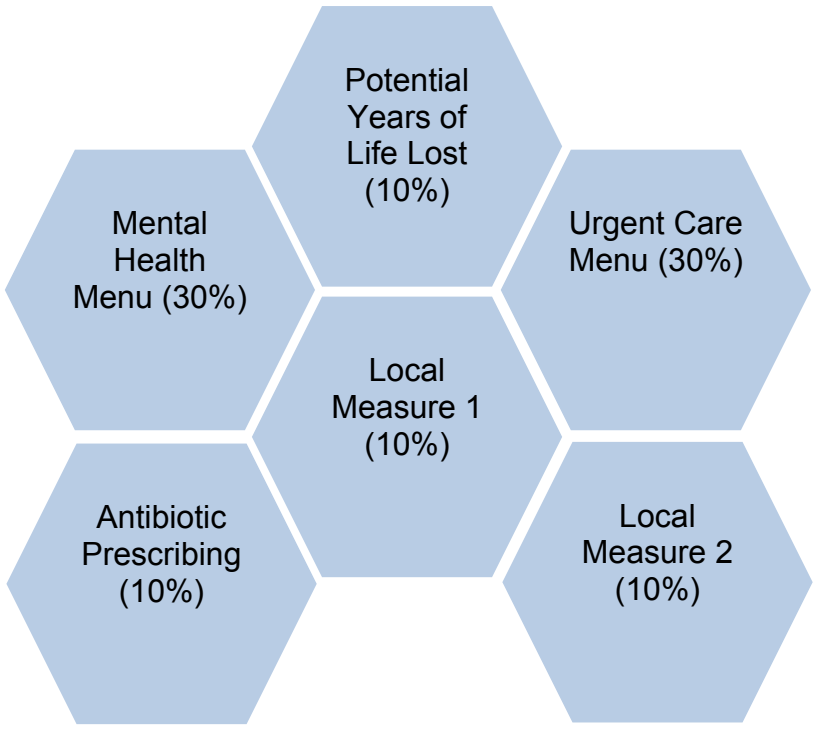
Executive Report

1. Introduction

1.1 NHS England has produced "Quality Premium Guidance" for CCGs for 2015/16. The Quality Premium is intended to reward Clinical Commissioning Groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

1.2 The Quality Premium measures agreed and achieved in 2015/16 will be paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – and will be based on six measures (depicted below) that cover a combination of national and local priorities. Some of these measures are required to be signed off by the Health and Wellbeing Board. This paper outlines the measures and the targets that have been set by the individual CCGs that require such sign off.



2. Urgent and Emergency Care Quality Premium Indicator

2.1 There is a menu of 3 measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

2.2 Avoidable Emergency Admissions Composite Measure

The CCGs are all very high performers on non-elective activity where benchmarked against CCGs across the South Central and Nationally. Taking this into account along with the work that is already being done within the Better Care Fund and CCG

QIPP schemes to manage non elective activity, it is recommended that this indicator is not selected.

2.3 Delayed Transfers of Care with NHS Responsibility

The CCG has reviewed the local provider Trusts and a comparison can be seen below. This shows that the annual numbers are very low as these are based on a snapshot position for the last Thursday of every month. Therefore, if there was one or two really bad last Thursdays, the remainder of the year could be put at risk.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Total
RBFT	14	12	21	23	22	22	27	20	14	13	17	205
BHFT	1	0	0	0	2	2	6	4	5	7	7	34
Bucks	22	15	15	11	12	16	15	27	11	18	18	180
OUH	46	65	61	65	74	67	97	77	97	105	87	841

2.4 Non-elective admission patients discharged at the weekend or on a bank holiday

The proportion of patients discharged on a Saturday, Sunday or English Public Holiday should be;

(a) at least 0.5% points higher in 2015/16 than in 2014/15; OR
(b) Greater than 30% in 2015/16

The current baseline position is below 30%, so the aim will be to achieve a 0.5% increase in 2015/16. This fits with the system resilience plans around patient flow and additional community and social care capacity has been commissioned for weekend discharges. RBFT are also working to increase 7 day working in some key areas within the Trust which would also support achievement of this target.

2.5 Recommendation

Therefore, it is recommended that the weekend discharge indicator is picked for the whole 30% of the urgent and emergency care measure.

3. Mental Health Quality Premium Indicator

3.1 There is a menu of 4 measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

3.2 Reduction in the number of patients attending an A&E department for a mental health-related need who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E

a) The proportion of primary diagnosis codes at A&E with a valid 2 character A&E diagnosis or 3 digit ICD-10 code will be at least 90%; AND
b) The proportion of patients with a primary diagnosis of mental health-related needs or poisoning that spend more than 4 hours in A&E is no greater than the average for all patients, or is over 95%

3.3 Currently less than 1% of A&E attendances are coded with a valid diagnosis code on SUS. Therefore it will be difficult to achieve the first part of this indicator. This indicator appears to be an annual assessment and therefore there is no time to achieve the increases required in A&E coding to achieve an annual position of 90%.

3.4 Number of people with severe mental illness who are currently smokers

After discussion with the Mental Health GP lead there are a number of concerns with this indicator. A large proportion of these patients will no longer be under the care of BHFT and therefore this will depend purely on GP patient reviews. It is known that this is a difficult group of patients to attend the GP surgery and they will also be a very resistant group to stop smoking. The feedback loop from BHFT to GP practices would need to be improved to ensure that where a patient is referred to the stop smoking service from BHFT and subsequently stops smoking, the GP is informed to ensure the system record reflects this. Therefore it is felt that although this is the right thing to do for patients; this indicator would be particularly difficult to show an improvement against.

3.5 Increase in the proportion of adults in contact with secondary mental health services who are in paid employment

a) An increase in the percentage of people in contact with mental Services who are in paid employment.; OR
b) a reduction in the gap between people in contact with mental services who are in paid employment and the employment rate of the general population.

3.6 BHFT have a CQUIN in place during 2015/16 which requires an increase in the number of community mental patients who are in purposeful activity, defined as education, training employment or volunteering. This will therefore support the CCG if this is chosen as the quality premium indicator. NHSE has confirmed that we do not need to specify the increase and any increase would be classed as achievement.

3.7 Improvement in the health related quality of life for people with a long term mental health condition

3.8 This indicator would require a reduction in the difference between the health related quality of life for people with any long term conditions compared to those with a mental health long term condition. The data source for this indicator is the GP survey. It is very difficult to directly make an improvement on the survey as we could make a difference for a cohort of patients who then they may not get asked to complete the survey. We've had real problems with year on year variation on the scores for different questions in this survey which could just be natural variation due to the different patients completing the questionnaire. We also normally benchmark well on the survey, making it even harder to improve. Following discussions with the GP Mental Health Lead, it is recommended that this indicator is not selected.

3.9 <u>Recommendation</u>

Therefore, it is recommended that the paid employment indicator is picked for the whole 30% of the mental health measure.

4. Newbury & District CCG Local Quality Premium Indicators

4.1 Local Indicator 1

For 2015/16 the CCG have agreed to train all practice based clinical staff on domestic violence (subject to approval by NHS England) using the Nationally Validated Tool –IRIS (Identification & Referral to Improve Safety).

IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme. Core areas of the programme are training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

IRIS is a collaboration between primary care and third sector organisations specialising in DVA. An advocate educator is linked to general practices and based in a local specialist DVA service. The advocate educator works in partnership with a local clinical lead to co-deliver the training to practices.

IRIS will be a valuable resource, not only regarding the training itself, but as a trusted point of contact for concerns about Domestic Abuse and what to do if practices hear a disclosure of it in a consultation, or at the front desk.

This aligns with our Health & Wellbeing Strategy priority 1 - **Emotional Wellbeing:** *We will promote emotional wellbeing in children and young people, through prevention, early identification and provision of appropriate services.*

5. Local indicator 2

Eat 4 Health offer a Free 10-week weight management programme to support people in losing weight across the areas of West Berkshire, Wokingham and Reading. The programmes are delivered in group settings and are open to anyone 16 years and above who have a body mass index (BMI) over 25. Sessions are run over 10 consecutive weeks, and each session is split into 2 parts:

- Lifestyle management and healthy eating (45 mins)
- Exercise with qualified exercise instructor (45 mins)

Throughout 2015/16 the CCG would seek to promote and actively refer individuals to the service in sufficient numbers to maximise the utilisation if this service which has been jointly commissioned by the Local Authorities.

This aligns with our Health & Wellbeing Strategy priority 6 - **Healthy weight and physical activity:** We *will maintain or increase the number of people who are a healthy weight, by: promoting physical activity and healthy eating, by providing a range of evidence based weight management interventions and by increasing opportunities for residents to be more physically active.*

6. North & West Reading CCG Local Quality Premium Indicators

6.1 CCG local quality premium targets should focus on an area identified as a local priority for the CCG. North & West Reading CCG have identified the main areas to receive greater focus in 2015/16 as follows:

- Ensuring that all GP practices conduct risk stratification and care planning for patients aged 75 and over (including all care home residents);

- Ensuring that at least 80% of practices provide enhanced access for their patients;

- Implementation of a three year plan to increase walking/cycling via the "Beat the Street" initiative. There will be a specific focus on encouraging those with long term conditions to take part and we aim to ensure that at least 15% of patients with long term conditions will take part in 15/16;

- Increase dementia diagnosis rates from 62.4% to 67% by July 2015;

- Reduce the potential years of life lost per 1,000 population from neoplasms compared to the CCG comparator group by increasing uptake of bowel cancer screening to 62% by the end of December 2015;

- Focus on cardiovascular disease by working closely with Public Health to achieve increased uptake in health checks from 61% to 66% of our eligible population by end of March 2016;

- "Upstream" intervention for patients aged 75 plus. We will work with Age UK Berkshire to pilot a scheme whereby 2 Personal Independence Co-Ordinators will be funded to guide and support patients not currently requiring medical or nursing intervention to help reduce their future dependency on health and social care;

- Working with partners to identify and address gaps in local GP services to support carers.

6.2 The CCG's Quality Premium indicators reflect two of these focus areas; reducing the potential years of life lost from neoplasms by increasing bowel cancer screening rates and increasing the number of carers known to GP practices so that more carers benefit from enhanced support from general practice.

7. Quality Premium Indicator - to address gaps in local GP services to support carers

7.1 In response to work being conducted by partners to identify and address gaps in local GP services to support carers, the CCG plans to increase the number of carers known to GP practices so that more carers benefit from enhanced support from general practice. The Quality Premium target is to increase the number of carers identified by GP practices and included on a register from 1,251 to 2,502 by the end of March 2016; this is a 1% increase in the CCG's population identified as being carers.

This aligns to the Health and Wellbeing strategy priority 8 – *Carers*: *We will promote the health and wellbeing of carers, including young carers.*

8. 4.2 Quality Premium Indicator - to address potential years of life lost from neoplasms

8.1 In response to the CCG having the highest rate of potential years of life lost per 1,000 population for neoplasms compared to the CCG comparator group, we will target one of the major programmes that supports a reduction in this variation, increasing uptake of bowel cancer screening. The Quality Premium target will be to increase uptake of bowel cancer screening from 57.95% (March 14) to 62% by the end of March 2016, this is above the national target of 60%.

This aligns to the Health and Wellbeing strategy priority 7 – *Cardiovascular disease and cancer: We will improve the prevention and early identification of cardiovascular disease and cancer in primary care and community settings through the provision of NHS health checks and screening and ensure the provision of high quality secondary care services.*

9. Equalities

9.1 This item is not relevant to equality.

Appendices

There are no Appendices to this report.