HEALTH AND WELLBEING BOARD

30 JUNE 2015

QUALITY PREMIUM

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Summary

This paper outlines the composition and application of the Quality Premium during 2015/16, and also sets out the proposal for the selection of indicators for NHS Medway CCG for measurement in 2015/16 as submitted to NHS England on 14 May 2015.

1. Budget and Policy Framework

1.1 The quality premium sits outside the Council's policy and budget framework.

1.2 The approval of the Health and Wellbeing Board is required for the measures proposed for the Quality Premium as detailed in the national guidance http://www.england.nhs.uk/ccg-ois/qual-prem/

2. Background

2.1 The national guidance was released on 31 March 2015 and CCGs were required to detail the measures they will select for the Quality Premium by 14 May 2015 as part of its final submission of overarching planning returns to NHS England.

2.2 NHS England asked for confirmation of Health and Wellbeing Board approval of these measures on the 14 May. Since the timescales precluded this due to there being no formal meeting and the local elections taking place, the measures were submitted and the CCG informed NHS England (NHSE) that approval would be sought at the June meeting of the Health and Wellbeing Board. The measures selected were shared and discussed with the Director of Public Health prior to the 14 May submission.

2.3 Full detail can be found in the report attached at Appendix 1.

3. Quality Premium Measures

3.1 The final quality premium paid to CCGs, paid in 2016/17, based on the quality of services commissioned by them in 2015/16, will be based on measures that cover a combination of national and local priorities. These are:

- **Reducing potential years of life** lost through causes considered amenable to healthcare (mandated and 10% of available quality premium).

- **Urgent and emergency care** (30% of the quality premium). CCGs are able to choose from a menu of measures in conjunction with their Health and Well Being Board and local NHSE Area team. One or several measures can be used and the CCG has the ability to decide what proportion of the 30% is attributable to each measure.

- **Mental Health** (30% of the quality premium). CCGs are able to choose from a menu of measures in conjunction with their Health and Well Being Board and local NHSE team. One or several measures can be used and the CCG has the ability to decide what proportion of the 30% is attributable to each measure.

- **Improving antibiotic prescribing in primary and secondary care** (10% of the quality premium).

- **Two local measures (20% of the quality premium, 10% for each measure).** These should reflect local priorities identified in joint health and wellbeing strategies and be based on indicators within the CCG Outcomes Indicator Set (Appendix 2). Should no measures be suitable from the CCG Outcomes Indicators the CCG and partners can choose alternative measures. The level of improvement will need to be agreed by the local NHSE team.

4. Selected NHS Medway Quality Premium Measures

4.1 NHS Medway has submitted the following measures for its local priorities and options from the urgent care and mental health menus:

Local Priority 1: Increased access to Spirometry testing services in primary care (10%)

Local Priority 2: Reduction in acquired and unacquired Grade 2 and above pressure ulcers, as reported in the Safety Thermometer (10%)

4.2 **Urgent Care Menu**: Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends and bank holidays (30%)

4.3 **Mental Health Menu**:
Increase in the proportion of adults in contact with secondary mental health services who are in paid employment (15%)

Reduction in the number of people with severe mental illness who are currently smokers (10%)

5. Risk management

Risk	Description	Action to avoid or mitigate risk	Risk rating
Failure to achieve key national targets linked to Quality Premium	Reputational risk to Local Health and Social Care Economy of non-achievement of quality premium qualifying targets.	Performance management of elective and non-elective performance. Regular reporting and monitoring of national and local quality premium targets.	High

6. Financial implications

6.1 As per 2014/15 a CCG will have its quality premium reduced if the providers it commissions from do not meet NHS Constitution requirements. The impact for NHS Medway sees the available Quality Premium payment reduce from a maximum £1.5m to £0.29m due to the current performance challenges at Medway Foundation Trust.

7. Legal Implications

7.1 Quality Premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities (The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (SI 2013/474)).

7.2 As part of developing their local improvement plans for each Quality Premium measure, CCG's would benefit from completing an equality and health inequalities analysis (National Health Service Act 2006 (as amended by the Health and Social Act 2012). Failure to do so could result in a challenge by way of Judicial Review.

8. Recommendation

8.1 The Board is asked to review and endorse the quality premium measures adopted from the Urgent Care and Mental Health menus and those selected for the two local priorities.

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Background papers

None

Appendices

Appendix 1 - Composition of the Quality Premium 2015/16
Appendix 2 – Outcomes Framework

Appendix 1

NHS
Medway
Clinical Commissioning Group

Composition of the Quality Premium 2015/16 and Proposed NHS Medway CCG measures

1. Purpose

The purpose of this document is to summarise the composition and application of the Quality Premium during 2015/16, and also to set out a proposal for the selection of indicators for NHS Medway CCG for measurement in 2015/16.

2. Background

Under the National Service Act 2006, NHS England has the power to make payments to CCGs to reflect the quality of services they commission, the associated health outcomes and reductions in inequalities.

2015/16 provides CCGs with more flexibility to determine their own local measures with health and wellbeing partners and recognises different CCG starting points; all measures except one include the ability for CCGs and local partners to set either partially of fully the level of improvement needed.

National guidance was released on 31 March 2015 and CCGs were required to detail the measures they will select for the Quality Premium by 14 May 2015 as part of its final submission of overarching planning returns to NHS England. At this stage it is purely an indication of the measures to be used rather than defining the rates of improvement.

3. Composition of the Quality Premium

The maximum quality premium payment for a CCG is expressed as £5 per head of population, and is in addition to both the CCG's main financial allocation for 2015/16 and its running cost allowance.

As per 2014/15 a CCG will have its quality premium reduced if the providers it commissions from do not meet NHS Constitution requirements as set out in the following table. The table also acts as an illustrative example of the potential funding available to NHS Medway CCG based on known current and forecast performance.

NHS Constitution Requirement	Reduction to Quality Premium (if standard failed)	Measure Forecast Achievement in 2015/16	Adjustment to Funding	Available Quality Premium
Maximum Quality Premium based on £5 per head of population (291,452 as at January 2015)				**£ 1,457,260**
Maximum 18 weeks from referral to treatment, comprising of:	30% total			
- 90% completed admitted standard		N	-£ 145,726	£ 1,311,534
- 95% completed non-admitted standard	(10% for each standard)	N	-£ 145,726	£ 1,165,808
- 92% incomplete standard		N	-£ 145,726	£ 1,020,082
Maximum four hour waits in A&E departments - 95% standard	30%	N	-£ 437,178	£ 582,904
Maximum 14 day wait from an urgent GP referral for suspected cancer - 93% standard	20%	N	-£ 291,452	£ 291,452
Maximum 8 minutes response for Category A (Red 1) ambulance calls - 75% standard	20%	Y	£ -	£ 291,452
Net Forecast Quality Premium Funding Available				**£ 291,452**

The final quality premium paid to CCGs, paid in 2016/17, based on the quality of services commissioned by them in 2015/16, will be based on measures that cover a combination of national and local priorities. These are:

- **Reducing potential years of life lost through causes considered amenable to healthcare** (mandated and 10% of available quality premium).

- **Urgent and emergency care** (30% of the quality premium). CCGs are able to choose from a menu of measures in conjunction with their Health and Well Being Board and local NHSE Area team. One or several measures can be used and the CCG has the ability to decide what proportion of the 30% is attributable to each measure.

- **Mental Health** (30% of the quality premium). CCGs are able to choose from a menu of measures in conjunction with their Health and Well Being Board and local NHSE team. One or several measures can be used and the CCG has the ability to decide what proportion of the 30% is attributable to each measure.

- **Improving antibiotic prescribing in primary and secondary care** (10% of the quality premium).

- **Two local measures** (20% of the quality premium, 10% for each measure). These should reflect local priorities identified in joint health and wellbeing strategies and be based on indicators within the CCG Outcomes Indicator Set (Appendix 2). Should no measures be suitable from the CCG Outcomes Indicators the CCG and partners can choose alternative measures. The level of improvement will need to be agreed by the local NHSE team.

4. Quality and Financial Gateways

As per previous years the CCG will not receive a quality premium if there is a serious quality failure during 2015/16 or if the CCG has not shown an effective use of public resources, as identified in the CCG assurance process.

Measurement will be against the following criteria:

- A local provider has been subject to enforcement action by the CQC, or has been flagged as a quality compliance risk by Monitor, or has been subject to enforcement action by the Trust Development Agency (TDA) based on a quality risk, and, it is considered through the NHSE assessment of the CCG that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the quality failure and this continues to be the position at the end of 2015/16.

- In the view of NHSE the CCG has not operated in a manner that is consistent with the principles set out in Managing Public Money; or ends the financial year with an adverse variance against the planned surplus, breakeven or deficit position, or requires unplanned financial support.

- It receives a qualified audit report in respect of 2015/16.

NHS England may make the quality premium available if the CCG agrees to use the payment to help resolve the serious quality failure.

5. CCG Use of the Quality Premium Payment

For each measure where it is identified the threshold is achieved, the CCG will be eligible for the indicated percentage of the overall funding available to it.

Quality premium payments can only be used to secure improvement in:

- The quality of health services
- The outcomes achieved from the provision of health services
- Reducing inequalities between patients in terms of their access to health services or the outcomes achieved.

Each CCG will be required to publish an explanation of how it has spent the quality premium payment.

It is planned that the CCG will be advised of its level of quality premium payment in the third quarter of 2016/17. As such the CCG will need to plan how it is likely to spend its payment in advance of this date as the funding will need to be spent within the 2016/17 financial year.

6. Proposal for the Selection of NHS Medway Quality Premium Measures

The following table sets out the measures that NHS Medway CCG proposes to use as its selected quality premium measures for both the local priorities and available options from the urgent care and mental health menus.

These have been submitted as part of the CCGs final NHSE planning submission on 14th May 2015. A rationale has been given for each measure, however it should be noted that due to the late publication of the guidance and the inability at this stage to further influence provider Commissioning for Quality and Innovation (CQUINs) payments framework and

community contracts, pragmatism has been used to identify measures that are within current work programmes and that have readily available data sources.

Quality Premium Menu	Indicator	NHS Medway QP Measure?	Proposed Indicator Weighting	Rationale
Urgent and Emergency Care	Avoidable emergency admissions Composite measure of: a. unplanned hospitilsation for chronic ambulatory care sensitive conditions (adult) b. unplanned hospitilsation for asthma, diabetes and epilepsy in childen c. emergency admissions for acute conditions that should not usually require emergency admission d. emergency admissions for children with lower respiratory tract infection	No	0%	Fits with current CCG strategy within urgent care pathway development with Medway Foundation Trust, and known areas of improvement. However difficult to monitor and impact in these defined areas.
	Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends and bank holidays	Yes	30%	Fits with current CCG strategy within urgent care pathway development with Medway Foundation Trust, and known areas of improvement
	Delayed Transfers of Care which are NHS responsibility	No	0%	Known issue regarding data quality and capture of DTOCs at MFT. Current review looking at coding of NHS or Social Care responsibility and so any baseline measure would be inaccurate.

Quality Premium Menu	Indicator	NHS Medway QP Measure?	Proposed Indicator Weighting	Rationale
Mental Health	Increase in the proportion of adults in contact with secondary mental health services who are in paid employment	Yes	15%	Already a measure within the KMPT KPIs and so levers to drive improvements exist and data is available.
	Reduction in the number of patients attending an A&E dept, for mental health related needs who wait more than 4 hours to be treated and discharged or admitted. Combined with defined improvement of diagnosis coding of patients attending A&E.	No	0%	Current coding at MFT poor, and those patients traiged to MedOCC from the Emergency Deptartment do not get coded at present. Secondary diagnosis coding measures already falls behind 90% target.
	Reduction in the number of people with severe mental illness who are currently smokers	Yes	15%	Baseline assessment indicates that the Quit Positive Scheme will impact suffficiently to influence improvement in this measure.
Local Measures	Increased access to Spirometry testing services in primary care	Yes	10%	This is not within the CCG Outcomes Indicator set, but is already an established priority. Fits within the CCG wide objective of improving COPD diagnosis and early treatment. Practices have already been engaged in this initiative and funding is included in the 2015/16 GP Practice Community Contracts
	Reduction in acquired and unacquired Grade 2 and above pressure ulcers, as reported in the Safety Thermometer	Yes	10%	This is not within the CCG Outcomes Indicator set, but is already an established priority and part of a collaborative CQUIN within the MFT and MCH contracts to reduce uninformed pressure ulcers

7. Next Steps

The Health and Wellbeing Board is requested to review and endorse the quality premium measures adopted from the Urgent Care and Mental Health menus and those selected for the two local priorities.

Due to local elections there has been no formal mechanism to receive approval prior to submission to NHS England. For the 14th May submission the measures were reviewed at the CCG Executive Team meeting and shared with the Director of Public Health to ensure that measures are aligned to priorities. The proposal has since been reviewed and supported through the CCG Commissioning Committee on 20th May 2015.

NHS England are currently reviewing the measures and once approved the CCG will need to work up current baselines and suggested improvement targets with both the Health and Wellbeing Board and the local NHS England team.

During 2015/16 the Contracting and Performance Support team will monitor the measures and detail the expected quality premium payment, on a monthly basis so that advanced planning can be undertaken as to how the payment will be spent.

NHS Outcomes Framework 2015/16

at a glance

1 Preventing people from dying prematurely

Overarching indicators

1a Potential years of life lost (PYLL) from causes considered amenable to healthcare
i Adults ii Children and young people
1b Life expectancy at 75
i Males ii Females
1c Neonatal mortality and stillbirths

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4*)
1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7*)
1.3 Under 75 mortality rate from liver disease (PHOF 4.6*)
1.4 Under 75 mortality rate from cancer (PHOF 4.5*)
i One- and ii Five-year survival from all cancers
iii One- and iv Five-year survival from breast, lung and colorectal cancer
v *One- and* vi *Five-year survival from cancers diagnosed at stage 1&2* (PHOF 2.19**)

Reducing premature mortality in people with mental illness
1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9*)
ii *Excess under 75 mortality rate in adults with common mental illness*
iii *Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services* (PHOF 4.10**)

Reducing mortality in children
1.6 i Infant mortality (PHOF 4.1*)
ii Five year survival from all cancers in children

Reducing premature death in people with a learning disability
1.7 *Excess under 60 mortality rate in adults with a learning disability*

2 Enhancing quality of life for people with long-term conditions

Overarching indicators

2 Health-related quality of life for people with long-term conditions (ASCOF 1A**)

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions (ASCOF 1E** & PHOF 1.8*)

Reducing time spent in hospital by people with long-term conditions
2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions
ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (ASCOF 1D**)

Enhancing quality of life for people with mental illness
2.5 i Employment of people with mental illness (ASCOF 1F** & PHOF 1.8**)
ii *Health-related quality of life for people with mental illness* (ASCOF 1A** & PHOF 1.6**)

Enhancing quality of life for people with dementia
2.6 i Estimated diagnosis rate for people with dementia (PHOF 4.16*)
ii *A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life* (ASCOF 2F**)

Improving quality of life for people with multiple long-term conditions
2.7 *Health-related quality of life for people with three or more long-term conditions* (ASCOF 1A**)

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11*)

Improvement Areas

Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures
i *Physical health-related procedures*
ii *Psychological therapies*
iii *Recovery in quality of life for patients with mental illness*

Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *Survival from major trauma*

Improving recovery from stroke
3.4 *Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months*

Improving recovery from fragility fractures
3.5 Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation service (ASCOF 2B[1]*)
ii Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2B[2]*)

Improving Dental Health
3.7 i *Decaying teeth* (PHOF 4.02**)
ii *Tooth extractions in secondary care for children under 10*

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
i GP services
ii GP Out-of-hours services
iii NHS dental services
4b Patient experience of hospital care
4c *Friends and family test*
4d *Patient experience characterised as poor or worse*
i. *Primary care*
ii. *Hospital care*

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii NHS dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Bereaved carers' views on the quality of care in the last 3 months of life

Improving experience of healthcare for people with mental illness
4.7 *Patient experience of community mental health services*

Improving children and young people's experience of healthcare
4.8 *Children and young people's experience of inpatient services*

Improving people's experience of integrated care
4.9 *People's experience of integrated care* (ASCOF 3E**)

5 Treating and caring for people in a safe environment and protecting them from avoidable harm

Overarching indicators

5a *Deaths attributable to problems in healthcare*
5b *Severe harm attributable to problems in healthcare*

Improvement areas

Reducing the incidence of avoidable harm
5.1 Deaths from venous thromboembolism (VTE) related events
5.2 Incidence of healthcare associated infection (HCAI)
i MRSA
ii C. difficile
5.3 *Proportion of patients with category 2, 3 and 4 pressure ulcers*
5.4 Hip fractures from falls during hospital care

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Improving the culture of safety reporting
5.6 Patient safety incidents reported

Alignment with Adult Social Care Outcomes Framework (ASCOF) and/or Public Health Outcomes Framework (PHOF)

* Indicator is shared
** Indicator is complementary

Indicators in italics are in development

Appendix 2