REPORT TO: Health and Wellbeing Board

Date of Meeting:
Report of: Simon Whitehouse, Chief Executive NHS South Cheshire CCG
Subject/Title: Quality Premium 2015-16

1 Report Summary

1.1 This paper provides the Health and Wellbeing Board with an overview of the Quality Premium 2015/16 national measures.

1.2 This paper provides a summary of the national guidance for the Quality Premium 2015/16 (published 27th April 2015).

1.3 This paper seeks final support of the national measures and the two local priorities that NHS South Cheshire CCG has selected for 2015-16.

2 Recommendations

2.1 The Health and Wellbeing Board are asked to support and approve the final CCG Quality Premium measures and local priorities for 2015-16.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board are asked to support and approve the proposed Quality Premium 201/16 national measures and two local priorities as recommended by the Governing Body of NHS South Cheshire CCG.

3.2 CCG rationale and recommendations for support and approval are illustrated in appendix one.

4.0 Background and Options

4.1 Composition of Quality Premium 2015/16 National Measures and Local Priorities - The national guidance for the Quality Premium 2015/16 was published on 27th April 2015.

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

National Quality Premium Measure 2015/16		**Value**
Reducing potential years of life lost		10%
Urgent and emergency care menu		30%
Mental Health menu		30%
Improving antibiotic prescribing		10%
Local Quality Premium Measure		
Local QP 1	To be approved by Governing Body and Health and Wellbeing Boards	10%
Local QP 2	To be approved by Governing Body and Health and Wellbeing Boards	10%

- **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);

- **Urgent and emergency care** - a menu of 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.

- **Mental health** - a menu of 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.

- **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

- **Two local measures** which should be based on local priorities such as

those identified in joint health and wellbeing strategies (20 per cent of quality premium-10 per cent for each measure).

a. Penalties **-** A CCG will have its quality premium reduced if the providers from whom it commissions services do not meet the NHS Constitution requirements for the following patient rights or pledges:

NHS Constitution requirement	**Reduction to Quality Premium**
Maximum 18 weeks from referral to treatment, comprising: • 90% Completed Admitted standard; • 95% Completed Non-admitted standard; • 92% Incomplete standard	30% total, (comprising 10% for each standard, separately assessed)
Maximum four hour waits in A&E departments-95% standard	30%
Maximum 14 day wait from an urgent GP referral for suspected cancer-93% standard	20%
Maximum 8 minutes responses for Category A (Red 1) ambulance calls-75% standard	20%

b. **Local Measures** - As per the national guidance the local priorities will reflect the local health and wellbeing strategies (and the JSNA) and will be based on indicators from the CCG Outcomes Indicator Set (unless the CCG and the relevant Health and Wellbeing Board and local NHS England team mutually agree that no indicators on this list are appropriate for measuring improvement in the identified local priorities).

c. The levels of improvement needed to trigger the reward will be agreed between the CCG, the Health and Wellbeing Board and the local NHS England team.

d. The local measures will not duplicate the national measures, including individual components of composite national measures, nor will they duplicate the NHS Constitution measures. They will reflect services that the CCGs are responsible for commissioning, or are commissioning jointly with other organisations. They may include aggregate or composite indicators.

5 Access to Information

The background papers relating to this report can be inspected by contacting the report writer:

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Appendix One - Quality Premium 2015/16 - NHS South Cheshire CCG

CCGs are required to include their choice of urgent and emergency care indicators (plus targets), choice of mental health indicators and target for reducing potential years of lives lost through causes considered amenable to healthcare.

Reducing Potential years of lives lost through causes considered amendable to healthcare

Level of Ambition	Rationale
Percentage Reduction of 1.2% NB Percentage reduction should be no less than 1.2% (Nationally set)	Male life expectancy in the South Cheshire CCG area has increased by almost two years since 2007 (and has overtaken England). However, life expectancy for women in the South Cheshire CCG area has only increased by half a year over the same period of time. Differences in male life expectancy have been reducing over the last four years but differences in female life expectancy have been growing wider. The widening in female life expectancy is entirely due to high death rates among women in the Crewe LAP, where life expectancy is significantly lower than the national average and also has not made any improvements for several years. Female life expectancy in the Congleton and Wilmslow LAPs is higher than in Crewe, but these areas have also not improved over time. There have been gains in female life expectancy in all the other LAP areas.Male life expectancy has been increasing in all the LAP areas except Wilmslow. Women in the Crewe LAP have 53% higher mortality from “all other causes”, 31% higher circulatory mortality and 20% higher cancer mortality than the Cheshire East average. Men in the Macclesfield LAP have 23% higher cancer mortality than the Cheshire East average. Men in the Crewe LAP have 28% higher mortality from “all other causes” and 24% higher circulatory mortality than the Cheshire East average

Urgent and Emergency Care

Indicator	Proportion	Level of	Rationale

	of 30%	ambition	
Avoidable emergency admissions Composite measure of: a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); b) unplanned hospitalisation for asthma, diabetes and epilepsy in children; c) emergency admissions for acute conditions that should not usually require hospital admission (all ages); d) emergency admissions for children with lower respiratory tract infection.	15%	Zero per cent change in emergency admissions for these conditions for our CCG population over the 4 yrs. - 2012/13 to 2015/16	We have chosen to focus on this measure as it remains high on the agenda of our Health and Wellbeing Board strategic plans. It aligns to our CCG strategic objectives to transform our urgent care system and will support our local ambitions to reduce hospital admissions. We have a number of commissioning intentions that contribute to this measure during the year. The measure supports JSNA findings as summarised below: Crewe has high rates of adult smoking and more pregnant women smoke at the time of delivery than the England average. Children in Crewe have higher rates of respiratory admissions and asthma than elsewhere in South Cheshire. We have acted quickly to look into the reasons why children are being admitted to hospital, and are working closely with the specialist children's service at Mid Cheshire Hospitals Trust to develop alternatives to hospital admission and improve primary care clinical pathways for children with chronic respiratory disease and develop community-based alternatives in the early stages of the clinical pathway. Smokers with asthma have poorer control of their condition with a higher frequency of asthma attacks than non-smokers. Locally, emergency admissions to hospital for asthma seem to reflect this. We have significantly worse emergency admission rates (per 100 patients on the asthma register) compared to the England average (2.5% vs

			1.8%). Compared to its peers within the ONS Cluster of Prospering Smaller Towns, NHS South Cheshire CCG has the worst rates of emergency admission for asthma (55th out of 55).
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	15%	Zero % change in 2015-16	We have chosen to focus on this measure as it aligns to programmes of work regarding integrated working with social care and the development of 7 day services. This also aligns with HWWB strategy and will capture planned commissioning activity relating to intermediate care and transitional care. This measure also supports JSNA findings.

Mental Health

Indicator	Proportion	Level of ambition	Rationale

	of 30%		
Reduction in the number of patients attending an A&E department for a mental health-related needs 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.	10%	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	This supports our parity of esteem agenda for mental health, and supports our intentions to ensure the same quality markers and targets for waits are equal to that for physical illness. There is work underway this year within primary care mental health services to seek to support people within the community requiring A&E services. We are seeking to improve the clinical coding in A&E regarding mental health presentations which we hope will improve the quality of care for these patients, allowing analysis of right place right time and the development of our liaison services.
Reduction in the number of people with severe mental illness who are currently smokers	20%	2% reduction from baseline April 14/15 Baseline = the number of practice based registered smokers and who also are registered as having a severe mental health illness.	We would like to focus the Quality Premium on this measure as our JSNA findings highlight health inequalities for this population. If we can improve our health education messages to this hard to engage group they will reap great rewards in terms of both length of life for people with severe mental illness and the quality of life.

Improved antibiotic prescribing in primary and secondary care

Indicator	Level of ambition (Targets are set by NHS England)	Rationale (Targets are set by NHS England)
Reduction in the number of antibiotic prescribed in primary care	Reduction in the number of antibiotics prescribed in primary care by 1% (or	The target is to reduce from 1.242 to 1.239 items per STAR PU

	greater) from each CCG's 2013/14 value.	
Reduction in the proportion of broad spectrum antibiotics prescribed in primary care	Number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question	The target is to reduce from 13.1 to 12.1%
Secondary care providers validating their total antibiotic prescription data	MCHFT to complete the validation audit (request this via the Quality Schedule to the contract)	PHE Audit tool provided to Acute Trusts

Local Measures – NHS South Cheshire CCG

QP No	Name of QP	Rationale

C1.19	**Lung Cancer – record stage at diagnosis** **Target:** NB: We will assess this indicator in the context of stage of lung cancer at diagnosis and route of presentation to lung cancer diagnosis The data source is the Somerset cancer system. Baseline data Proportion of patients that received best supportive care Palliative care) for lung cancer: 2013 - 33% 2014 - 29% Proportion of patients	This has been selected as a local priority measure by NHS South Cheshire CCG Clinical Commissioning Executive and approved by the Governing Body (4th June). **The measure and its subsequent work seek to improve the known health inequalities as highlighted within the East Cheshire Joint Strategic Needs Assessment (JSNA):** Around 28% of deaths in Cheshire East are due to cancer, making it the most common cause of death. The three most commonly occurring cancers among men in Cheshire East in 2009 were prostate (292), large bowel (151) and lung (140). Among women, the top three cancers were breast (323), large bowel (116) and lung (106). The main killers were lung cancer, upper gastrointestinal cancer (oesophagus, stomach and pancreas), colorectal cancer and haematological cancers (leukaemia, lymphoma). The JSNA recommends the following actions to reduce this health inequality: • Diagnose more cancers early by raising public awareness and encouraging participation in cancer screening programmes • Minimise delay in investigation and referral for specialist assessment • Accurate staging of disease so that treatment is appropriate to the spread of disease • Use of effective new treatments approved by the National Institute for Health and Clinical Excellence (NICE) • Multidisciplinary teams (MDTs) improve delivery of care for patients **This measure and its subsequent work seek to contribute to the Cheshire East Health and Wellbeing Strategy (2014-16).** *'Outcome two - Working and living well…* *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.'* *'Reducing the incidence of cancer'.*

	that received effective treatment for lung cancer: 2013 - 67% 2014 - 71% Target for the proportion of patients that will receive effective treatment in 2015 - 73%	**This measure and its subsequent work contributes to CCG Strategic and Operational priorities for 2015/16:** This Local Quality Premium measure supports a number of CCG and wider health and care strategies. Along with its strategic objectives NHS South Cheshire CCG have identified six local ambitions. These have been identified through key health inequalities. In South Cheshire we aim to focus our commissioning activities to address the following with regard to lung cancer. As part of our CCG priorities to reduce the premature mortality of our local population we are reviewing our cancer pathways. This will include ensuring the highest quality of care that meets the NICE Improving Outcome Guidance and national performance standards. This review will include moving care closer to home. As part of Mid Cheshire Hospitals Foundation Trust and University Hospitals of North Midlands 'Stronger Together' Programme there is commissioner commitment to review all cancer pathways that currently do not flow to the University Hospitals of North Midlands. This will be led by the specialised commissioning unit and follow a commissioning led process being patient centred, clinically led and outcome focused considering also capable provider and competition rules. The CCG will continue to review the of the whole lung cancer pathway with a focus on survivorship. This will align cancer care reviews, after treatment summaries and holistic needs assessment with a focus on self are/self-management. The CCG will continue to review cancer waiting times and performance against the NICE Improving Outcomes guidance. This measure supports CCG operational objectives and we anticipate it to have an impact on diagnosing lung cancer earlier, so that the number of lung cancers diagnosed as an emergency presentation reduces

		from 21% to 16% by March 2016.
C2.13	**Estimated diagnosis rates of dementia** **Target:** Our target for 2015-16 is 66.7%. The proposed numerator for this is: 1499 The proposed denominator for this is: 2247	This has been selected as a local priority measure by NHS South Cheshire CCG Clinical Commissioning Executive and approved by the Governing Body (4th June). **The measure and its subsequent work seek to improve the known health inequalities as highlighted within the East Cheshire Joint Strategic Needs Assessment (JSNA):** There are estimated to be 4,500 people living with Dementia in east Cheshire over the age of 65. •65% are likely to be women •One in five people over 80 has a form of Dementia. One in 20 people over 65 has a form of Dementia] •There are currently 820,000 people in the UK with Dementia and this costs the UK economy £23 billion a year. •The total number of people with Dementia in the UK is forecast to increase to 940,110 by 2021 and 1,735,087 by 2051, an increase of 38% over the next 15 years and 154% over the next 45 years. Analysis of data indicates that the CCG's actual dementia diagnosis rate is 61.2% and your estimated prevalence for people with dementia is 2263. This identifies an estimated gap of 878 people who may benefit from access to support by way of a dementia diagnosis, and a gap of 124 to achieve the national ambition. The All-Party parliamentary Group on Dementia recommends utilising existing opportunities for identification of people with dementia. It recommends that primary care workers and other health and social care professionals in contact with people with an established risk of dementia, should routinely ask

		questions to identify symptoms of dementia. Many people with dementia have complex needs. These will include a combination of mental, physical and social needs. A recent research study identified that only 5% of patients with dementia have dementia with no other Comorbidities. Cardiovascular conditions and depression are key comorbidities. At the later stages, people can have high levels of dependency and morbidity. (ISNA Dementia Summary 2012). Most people with dementia are over the age of 65 and are also more at risk of discrimination and infringements of their human rights because they may not have the capacity to challenge abuses or to report what has occurred. **This measure and its subsequent work seek to contribute to the Cheshire East Health and Wellbeing Strategy (2014-16).** *'Outcome three - Ageing well…* *Enabling older people to live healthier and more active lives for longer'.* *'Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness)'.* **This measure and its subsequent work contributes to CCG Strategic and Operational priorities for 2015/16:** NHS South CCG has been working with their GP practices to improve rates of diagnosis and ensure that people living with dementia can access the support they need. Throughout 2015/16, practices will be supported to achieve and maintain a high level of diagnosis. Memory Services with Dementia: The CCG have introduced a shared care arrangement for primary and secondary care, to ensure that patients living with dementia and their carers\families are well supported.

		Dementia Services for people at End of Life: The CCG have piloted a dementia end of life service to enhance the quality of experiences from patients, carers and family members Within the Better Care fund plans have been agreed between NHS South Cheshire CCG and Cheshire East Council and adopted by the Health and Well Being Board. The overarching local pioneer programme Connecting Care will provide a structure for the development of these plans. Plans include dementia reablement within integrated community services. Primary care mental health teams: The aim of this project is to develop a new primary care mental health team which will have a focus on improved dementia care and mental health liaison in the community. The aim of an integrated team would be to provide high quality care that result in improved health and wellbeing and a better experience for adults with complex care needs. This will be achieved by joining up mental health and physical health services to focus on individuals in their own homes and community, and reduce the need for emergency care during 2015/16. The team will provide the additional skills and knowledge necessary to manage patients living with dementia, and patients who have a mental health condition as well as a physical health problem. It is envisaged that the team will work closely with GP practices and link with the developing integrated neighbourhood team model.