Health and Wellbeing Board
21 March 2014

Quality Premium

Responsible Officer Julie Davies
Email: Julie.Davies@shropshireccg.nhs.uk Tel: Fax:

1. Summary

1.1 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 NHS England has sought to design the quality premium to ensure that it:

- rewards CCGs for improved outcomes from the services they commission against the main objectives of the NHS Outcomes Framework and the CCG Outcomes Indicator Set, i.e. reducing premature mortality, enhancing quality of life for people with long-term conditions, helping recovery after acute illness or injury, improving patient experience, and ensuring patient safety;
- sets broad overarching objectives as far as possible, leaving CCGs to determine with health and wellbeing partners what specific local priorities they will need to pursue to achieve improvements in these areas;
- promotes reductions in health inequalities and recognises the different starting points of CCGs: all of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully the level of improvement to be achieved,
- further promotes local priority-setting by highlighting the importance of local approaches reflecting joint health and wellbeing strategies;
- underlines the importance of maintaining patients' rights and pledges under the NHS Constitution.

1.3 The CCG is required identify 5 local and national measures that will reflect improvement in quality (discussed below) and to work with Health and Wellbeing Boards in each area identify a further local measure that should be based on local priorities identified in joint health and wellbeing strategies (15 per cent of quality premium).

2. Recommendations

The Health & Wellbeing board is asked to support the following recommendations:

i) Measure 1 Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people **- that the minimum further reduction of 3.2% is set for this target.**

ii) Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set **- that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.**

iii) Measure 5 Improved reporting of medication-related safety incidents - **that the local providers chosen are Shrewsbury & Telford Hospitals Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital and Shropshire Community Trust. The increase in reported incidents related to medication is to be set at 10% for all providers.**

iv) Measure 6 The local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England is - **People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme. The target is a 20% increase in the number of this type of patient who is referred in year for a programme over and above the baseline measured for 2013/14.**

v) Quarterly progress against all these measures will be taken formally to the Health & Well Being Executive with an exception report sent to the Health & Well-being Board for information.

REPORT

3. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 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**.

3.2 Risk - A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money1 during 2014/15; or

b) incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or

c) incurs a qualified audit report in respect of 2014/15.

4. Financial Implications

4.1 The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation for 2014/15 and in addition to its running costs allowance.)

5. Background

5.1 NHS England has published a number of documents to support planning for 2014/15 and beyond. These are

- "Everyone Counts: Planning for patients 2014/15 to 2018/19;
- The CCG outcomes indicator set 2014/15: At a glance & technical guidance
- Quality Premium: 2014/15 guidance for CCGs

5.2 The quality premium that could be paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

1. **Reducing potential years of lives lost through causes considered amenable to healthcare and including addressing locally agreed priorities for reducing premature mortality** (15 per cent of quality premium);

2. **Improving access to psychological therapies (IAPT)** (15 per cent of quality premium);

3. **Reducing avoidable emergency admissions** (25 per cent of quality premium);

4. **Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator** (15 per cent of quality premium);

5. **Improving the reporting of medication-related safety incidents in a locally selected measure** (15 per cent of quality premium);

6. **A further local measure that should be based on local priorities identified in joint health and wellbeing strategies** (15 per cent of quality premium).

5.3 All of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully, the level of improvement to be achieved. These, together with the additional local measure, should be agreed by individual CCGs with their Health and Wellbeing Board and with the relevant NHS England area team.

5.4 The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs.

5.5 **N.B.** There is no requirement to agree the target improvement for IAPT as the CCG is not achieving 13% or greater by 31st March 2014 and therefore the target required in 2014/15 is set nationally at 15% by 31st March 2015.

5.6 A discussion paper was brought to the green paper meeting in February (Appendix A) outlining the detail behind these individual measures to inform the board and for the board to discuss options for the local measure. This paper is the result of those discussions and makes the following recommendations to the board.

5.7 Recommendations - explained

5.7.1 Measure 1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

Latest data shows that Shropshire is within the best quartile for this measure and therefore it is recommended ***that the minimum further reduction of 3.2% is set for this target.*** This would mean an actual target of 1897.96 (2012 baseline of 1960.7) It should be noted however that as this measure is based on death registrations and is to be achieved between the calendar years 2013 and 2014 the work of the CCG combined with colleagues in the local authority may have minimal impact on the achievement of this target in the short- medium term.

5.7.2 Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set

The CCG recommends ***that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.*** This is based on the work already undertaken by the CCG with Shrewsbury & Telford Hospitals Trust to improve responses linked to A&E which was a particular area of poor performance in 2013/14. The CCG has plans in place with all its providers to both address issues that were identified in this year's friends & family test and to further roll out the test in 2014/15.

5.7.3 Measure 5. Improved reporting of medication-related safety incidents

NHS England patient safety and nursing teams have committed to developing a Safety Thermometer for medications in order to measure improvement locally and also to meet the requirements of the NHS Outcomes Framework which requires the NHS to focus on a small number of key outcomes that must be measured across the country. One such improvement area indicator will cover 'incidence of medication errors causing serious harm'. The H&WB board agreed in February that the national medication safety thermometer should be used as the basis for this measure to avoid duplication and make the best use of resources available.

The CCG recommends that the local providers chosen for this measure ***are Shrewsbury & Telford Hospitals Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital and Shropshire Community Trust. The increase in reported incidents related to medication is to be set at 10% for all providers.*** This is included in the quality schedules in the contracts for 2014/15 subject to final agreement. The specific areas chosen within the medication safety thermometer for increased reporting are those based on the drugs ,which if doses are missed, may cause the most harm.

5.7.4 Measure 6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

The following measure is recommended to the H&WB Board following the discussion of the short list presented in February.

People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme. The target is a 20% increase in the number of this type of patient who is referred in year for a programme over and above the baseline measured for 2013/14.

This is a key component of high quality care for people with COPD and is in line with our priorities relating to improving care for people with long term conditions, specifically COPD which is a CCG priority for 2014/15. There is an issue with selecting this measure as the national technical guidance says the in-year data won't be available until June 2015. However we believe we can measure this locally via our GP practices and the Community Trust who provide the rehab programme. We are currently working with the

CCG Practice Support Team to establish the baseline for 2013/14 via our GP practices whilst obtaining this year's referral data for pulmonary rehabilitation programmes into the local community trust and will be aiming for a 20% improvement on that baseline during 2014/15.

Quarterly progress against all these measures will be taken to the Health & Well Being Executive with an exception report sent to the Health & Well-being Board for information.

6. Additional Information

7. Conclusions

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) Karen Calder
Local Member
Appendices

APPENDIX A – HWBB Discussion Paper - February 2014

Quality Premium Measure Arrangements for Clinical Commissioning Groups in 2014/15

Background

NHS England has published a number of documents to support planning for 2014/15 and beyond. These are

- "Everyone Counts: Planning for patients 2014/15 to 2018/19;
- The CCG outcomes indicator set 2014/15: At a glance & technical guidance
- Quality Premium: 2014/15 guidance for CCGs

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities. These are:

7. **Reducing potential years of lives lost through causes considered amenable to healthcare and including addressing locally agreed priorities for reducing premature mortality** (15 per cent of quality premium);
8. **Improving access to psychological therapies (IAPT)** (15 per cent of quality premium);
9. **Reducing avoidable emergency admissions** (25 per cent of quality premium);
10. **Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator** (15 per cent of quality premium);
11. **Improving the reporting of medication-related safety incidents in a locally selected measure** (15 per cent of quality premium);
12. **A further local measure that should be based on local priorities identified in joint health and wellbeing strategies** (15 per cent of quality premium).

All of the measures except avoidable emergency admissions include the ability for CCGs and local partners to set either partially or fully, the level of improvement to be achieved. These, together with the additional local measure, should be agreed by individual CCGs with their Health and Wellbeing Board and with the relevant NHS England area team.

A CCG will not receive a quality premium if it:

a) is not considered to have operated in a manner that is consistent with Managing Public Money during 2014/15; or
b) incurs an unplanned deficit during 2014/15, or requires unplanned financial support to avoid being in this position; or
c) incurs a qualified audit report in respect of 2014/15.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2014/15 i.e. where it is identified through the CCG assurance process that:

a) a local provider has been subject to enforcement action by the Care Quality Commission; or
b) a local provider has been flagged as a quality compliance risk by Monitor and/or have requirements in place around breaches of provider licence conditions; or
c) a local provider has been subject to enforcement action by the NHS Trust Development Authority based on a quality risk and

i) it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the assurance framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and

ii) this continues to be the position for the CCG at the 2014/15 end of year assessment.

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments,(c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

The maximum quality premium payment for a CCG will be expressed as £5 per head of population, calculated using the same methodology as for CCG running costs. (This is in addition to a CCG's main financial allocation for 2014/15 and in addition to its running costs allowance.)

Areas where the CCG need H&WB Board agreement

The following elements of the quality premium measures require agreement by the local Health & Well Being Board:-

1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

Agree with Health and Wellbeing Board partners and with the relevant NHS England area team the percentage reduction in the potential years of life lost (adjusted for sex and age) from amenable mortality for the CCG population to be achieved between the 2013 and 2014 calendar year. This should be no less than 3.2% and based on the Directly Standardised Rate

4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set

To earn this portion of the quality premium the CCG must have agreed plans with providers to address specific issues identified from the 2013/14 FFT and deliver those plans. The number of negative responses received via the FFT for local providers must reduce between Q1 and Q4 of 2014/15. The CCG must also have assurance that providers are taking appropriate action in response to their FFT feedback and ensure providers are rolling out FFT by the end of 2014/15. The CCG Director of Nursing, Quality, Patient Safety and Experience has confirmed that these plans and processes of assurance are in place for next year.

In addition there is an improved average score achieved between 2013/14 and 2014/15 for one of the patient improvement indicators set out in the CCG Outcomes Indicator Set with the specific indicator agreed by the CCG with the Health and Wellbeing Board, the NHS England area team and the relevant local providers. CCGs should be assured that NHS providers have plans in place to reduce the proportion of people reporting a poor experience of care in line with the locally set level of ambition.

5. Improved reporting of medication-related safety incidents

A CCG will earn this portion of the quality premium if:

• it agrees a specified increased level of reporting of medication errors from specified local providers for the period between Q4, 2013/14 and Q4, 2014/15; and

• these providers achieve the specified increase.

The local measure may include improved levels of reporting from primary care.

The measure should be agreed by the CCG with its local Health and Wellbeing Board and the NHS England area team.

Where the same provider is a local provider (see below), for more than one CCG, those CCGs may wish to jointly agree an increased level of reporting with that provider.

6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

This should reflect priorities within the local Joint Health and Wellbeing Strategy, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities. The local measure should be based on an indicator from the 2014/15 CCG Outcomes Indicator Set issued by NHS England, unless the CCG, the relevant Health and Wellbeing Board and the NHS England area team mutually agree that no indicators on this list are appropriate for measuring improvement in the identified local priorities. The 2014/15 CCG Outcomes Indicator Set is attached as Appendix A
The local measure should not duplicate the other quality premium measures described above, including individual components of composite measures, nor should it duplicate the NHS Constitution measures set out below. It should reflect services that CCGs are responsible for commissioning or that they commission jointly with other organisations. It may, if a CCG and its Health and Wellbeing Board so wish, include aggregate or composite indicators.
N.B. There is no requirement to agree the target improvement for IAPT as the CCG is not achieving 13% or greater by 31st March 2014 and therefore the target required in 2014/15 is set nationally at 15% by 31st March 2015.
Recommendations
Measure 1. Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people
Latest data shows that Shropshire is within the best quartile for this measure and therefore it is recommended ***that the minimum further reduction of 3.2% is set for this target.*** This would mean an actual target of 1897.96 (2012 baseline of 1960.7) It should be noted however that as this measure is based on death registrations and is to be achieved between the calendar years 2013 and 2014 there is virtually nothing the CCG can still do to directly impact on the achievement of this target.
Measure 4. Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set
The CCG recommends ***that the indicator chosen is the one for acute inpatient and A&E and that the percentage improvement in 2014/15 should be 5% to take the target average score for positive responses from 75% in 13/14 to 80% in 2014/15.*** This is based on the work already undertaken by the CCG with SaTH to improve responses linked to A&E.

Measure 5. Improved reporting of medication-related safety incidents

The CCG recommends ***that the local providers chosen are SaTH & RJAH and we await the national guidance for the Medication Safety Thermometer and link our local improvement to that identified within the national target***. If the H&WB Board are in agreement with this approach, the detail of this will be included in the final paper coming to the Board in March for formal approval.
Measure 6. Further local measure agreed by each CCG with their local Health and Wellbeing Board and with NHS England

The following three measures are recommended to the H&WB Board as a short list for the local measure:-

a) People with COPD and Medical Research Council Dyspnoea Scale >= 3 referred to a pulmonary rehabilitation programme.

This is a key component of high quality care for people with COPD and is in line with our priorities relating to improving care for people with long term conditions, specifically COPD which is a CCG priority for 2014/15. There is an issue with selecting this measure as the national technical guidance says the in-year data won't be available until June 2015 but we are currently exploring with the CSU whether we can measure this locally via our GP practices and the Community Trust

who provide the rehab programme. If the monitoring can be arranged this would be our preferred option.

b) Care Coordination

The Community and Care Coordinator Project in Shropshire is a key strand of our long term conditions strategy and our Frail and Complex work. It is also intended to be part of our Better Care Fund work. This would be a local measure not identified within the national outcomes framework that could either record:-

i) The increase in the number of patients who had their care coordinated vs the number measured in 12/13 or

ii) The increase in the referrals to the voluntary sector from the care coordinators

Either of these measures is a step towards monitoring the expected reduction in the dependency on statutory bodies for the care required by the elderly to maintain their independence. This could be the basis for a crucial indicator for the future assessment of the impact of the Better Care Fund. If the H&WB Board consider this to be of sufficient importance the CCG will work with its CSU to confirm the actual position for 12/13 as the baseline and support the collection of the data in 14/15 to demonstrate the level of improvement. If the H&WB Board are in agreement with this approach and we secure the support of the NHS England local area team, the detail of this measure will be included in the final paper coming to the Board in March for formal approval.

c) Estimated diagnosis rate for people with dementia.

Dementia is a key priority for Shropshire and is highlighted in both the local JSNA and our H&WB priorities. The latest information available for this metric show that in 2012/13, the estimated diagnosis rate was 43.3%. There is a national target to deliver 67% by the end of March 2015. This equates to an increase of 1,259 diagnoses between April 2013 and end of March 2015.This is a significant increase on currently levels of performance (total of 2197 diagnoses at the end of March 2013) and the CCG believes this is too high risk for inclusion as a quality premium measure. The CCG will continue to work with its health and wellbeing partners to get as close to this target as possible during 2014/15.