**REPORT FROM SOUTH READING CLINICAL COMMISSIONING GROUP (SRCCG) & NORTH & WEST READING CLINICAL COMMISSIONING GROUP (NWRCCG)**

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| **TO:** | **HEALTH AND WELLBEING BOARD** | | |
| **DATE:** | **17th July 2014** | **AGENDA ITEM:** | **7** |
| **TITLE:** | **SOUTH READING & NORTH & WEST READING QUALITY PREMIUM TARGETS 2015/16** | | |
| **LEADS:** | **DR ISHAK NADEEM** | **TEL:** | **0118 921 3827** |
| | **DR ANDY CIECIERSKI** | | **0118 982 2917** |
| **JOB TITLE:** | **CHAIR, SOUTH READING CCG** | **E-MAIL:** | **ishak.nadeem@nhs.net** |
| | **CHAIR, NORTH & WEST CCG** | | **aciecierski@nhs.net** |

## 1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

Under the National Health Service Act 2006 (as amended by the Health and Social Act 2012), NHS England has the power to make payments to Clinical Commissioning Groups (CCGs) to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities. 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.

The Quality Premium measures agreed 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 that cover a combination of national and one local priority. 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.

**RECOMMENDED ACTION**

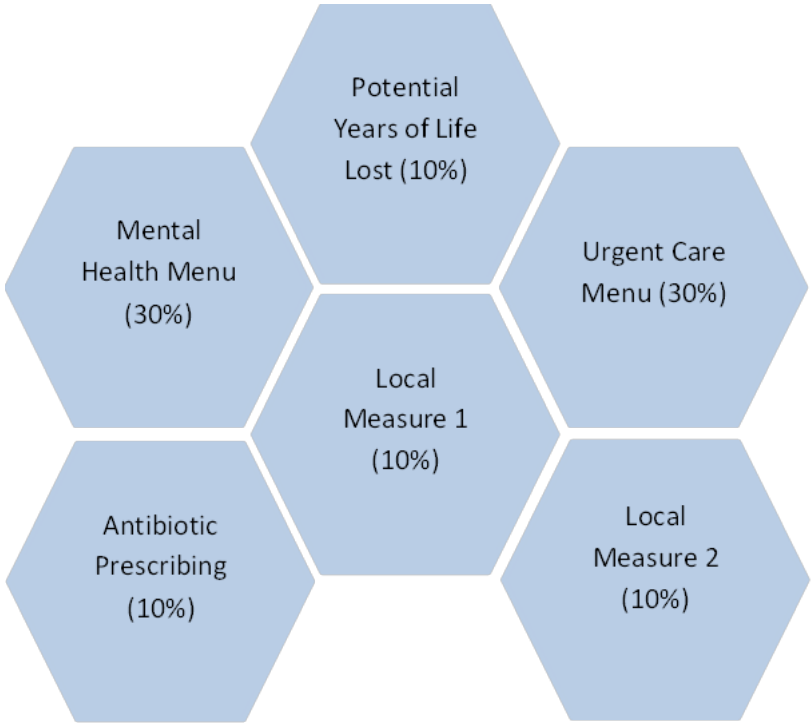
**To note and agree the following quality premium measure targets set for North & West Reading CCG and South Reading CCG for 2015/16:**

1. **Weekend discharge indicator is picked for the whole 30% of the urgent and emergency care measure (NWRCCG & SRCCG);**
2. **The paid employment indicator is picked for the whole 30% of the mental health measure (NWRCCG & SRCCG);**
3. **Increase referrals to Eat 4 Health (SRCCG);**
4. **Increase referrals to alcohol service IRIS (SRCCG);**
5. **Increase in the number of carers identified by GP practices (NWRCCG);**
6. **Increase in uptake of bowel cancer screening. (NWRCCG).**

## 2. POLICY CONTEXT

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.

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.




### 2.1. Urgent and Emergency Care Quality Premium Indicator

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.

*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.

*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 |

*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.

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

## 2.2. Mental Health Quality Premium Indicator

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.

*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%

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%.

*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.

*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.

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.

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

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.

<u>Recommendation</u>

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

## 3. Local Quality Premium Indicators (South Reading CCG)

As part of NHS England guidance, CCG local targets should be chosen from an area of local concern i.e. they should reflect the local priorities identified in joint health and wellbeing strategies. As part of the exercise to address areas of greatest health need within South Reading CCG, a number of data sets were used to understand where the Quality Premium could be focussed. These have been linked back to the Health and Wellbeing strategy for Reading. The methodology for this decision is described in 3.2 below.

### 3.1 Our population

The population of South Reading is different to its neighbouring CCGs. It is an inner city area serving University students with different health needs and a younger population profile compared to other parts of the country. Life Expectancy is lower than the England average and

the area has significant pockets of deprivation. Some of our neighbourhoods are in the 20% most deprived areas in the country including Whitley, Church, Norcot and Redlands.

### 3.2 Review of the data sources

The CCG reviewed the following data sets as part of the review to identify areas of concern: Outcomes Indicator Set, bench marking data compared to CCGs with similar demographics and local intelligence from Programme Boards.
Following a review of these data sources, the areas the CCG is an outlier are as follows:

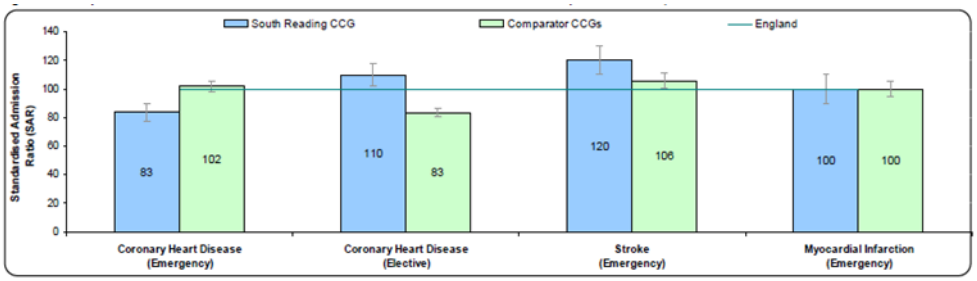
- Ischaemic Heart Disease/Stroke
- Liver Disease
- Obesity

The following data sources show how the CCG benchmarks compared to Local Authority comparator groups and the rest of England:

**Circulatory disease**
Circulatory Diseases - Under 75 Mortality per 100,000 Population ,

| | Reading | | |
|---|---|---|---|
| | Under 75 mortality rate per 100,000 population | Compared to LA comparator group | Compared to all England LAs |
| Heart disease and stroke | 91 | Worse than average | Worst quartile |
| Heart disease | 51 | Worse than average | Worse than average |
| Stroke | 17 | Worse than average | Worse than average |

The Emergency admission ratio for Coronary Heart Disease was significantly lower than the national benchmark and comparators CCGs. However elective admissions for Coronary Heart Disease and emergency admissions for stroke were significantly higher.




**Obesity**
The National Child Measurement Programme (NCMP) measures the prevalence of obesity in 4-5 year olds (Reception) and 10-11 year olds (Year 6). Figure 9 shows that South Reading CCG's prevalence is higher than the England average for both age-groups.

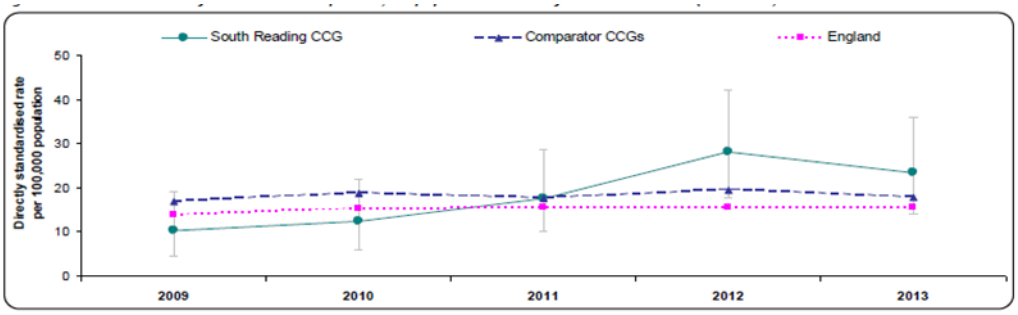
| | | South Reading CCG Prevalence | England Prevalence |
|---|---|---|---|
| Reception (aged 4 to 5) | *Overweight (including obesity)* | 25.4% | 22.2% |
| | *Obesity* | 12.1% | 9.3% |
| Year 6 (aged 10 to 11) | *Overweight (including obesity)* | 37.1% | 33.3% |
| | *Obesity* | 21.3% | 18.9% |

**Liver Disease**

Under 75 Mortality per 100,000 Population

| | Reading | | |
|---|---|---|---|
| | Under 75 mortality rate per 100,000 population | Compared to LA comparator group | Compared to all England LAs |
| **Liver disease** | 25 | Worst quartile | Worst quartile |

In 2013 21 people aged under 75 died from liver disease. Here you can see the mortality rate over a 5 year period for all people aged under 75.




### 3.3 Quality Premium target for 2015/16

In summary, in response to areas where we have the greatest need in t South Reading CCG the Quality Premium targets for 2015/16 are recommended as:

| Local Measure | CCG target | Impact | Aligns to HWB goal |
|---|---|---|---|
| **1. Increase referrals to Eat 4 Health** | Increase GP referrals from 139 to 250 by 31 March 2016 (80% increase) | Allows us to tackle Obesity and its related impact on other conditions such as Diabetes and Cardiovascular Disease | Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities<br><br>Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups |
| **2. Increase referrals to alcohol service IRIS** | Increase GP referrals from 25 to 150 by 31 March 2016 (500% increase) | Allows us to support Berkshrie West wide programmes e.g. QIPP schemes to tackle rising problem in our local area | Goal Four – Promote health-enabling behaviours & lifestyle tailored to the differing needs of communities |

These proposed targets have been discussed by South Reading CCG Council of Practices at their meetings on 8 April and 13 May and GPs have agreed this approach for 2015/16.

## 4. Local Quality Premium Indicators (North & West Reading CCG)

As stated in Section 3 above, CCG local quality premium targets should focus on an area identified as a local priority for the CCG. At its meeting in April 2015 the Health and Wellbeing Board was presented with North & West Reading CCG's refreshed priorities for 2015/16. These included working with partners to identify and address gaps in local GP services to support carers and to reduce the potential years of life lost per 1,000 population from neoplasms compared to the CCG comparator group. The CCG's Quality Premium indicators reflect these two focus areas.

### 4.1 Quality Premium Indicator - to address gaps in local GP services to support carers

In response to the work commissioned by Public Health Reading 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 by supporting goals one and three as follows:

| Goal One – Promote and protect the health of all communities particularly those disadvantaged | Goal Three – Reduce the impact of long term conditions with approaches focused on specific groups |
|---|---|
| Objective 2 - Ensure effective support is available to vulnerable and BME groups to protect their own health. | Objective 3 - Build on and strengthen the quality and amount of support available to adult and young carers in Reading |

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

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 by supporting goal one as follows:

| **Goal One – Promote and protect the health of all communities particularly those disadvantaged** |
|---|
| Objective 3 - Increase awareness and uptake of Immunisation and Screening programmes |