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SUPPLEMENTARY 1

THE HEALTH AND WELLBEING BOARD

Tuesday, 12 May 2015

Agenda Item 14a 2015/16 Quality Premium (Pages 1 - 5)

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HEALTH AND WELLBEING BOARD

12 May 2015

This report is submitted under Agenda Item 14. The Chair will be asked to decide if it can be considered at the meeting under the provisions of Section 100B(4)(b) of the Local Government Act 1972 as a matter of urgency to enable a response to be provided to NHS by 14 May 2015.

Title: 2015/16 Quality Premium	
Report of the Clinical Commissioning Group	
Open Report	**For Decision**
Wards Affected: None	**Key Decision:** No
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Sponsor: Conor Burke, Chief Accountable Officer, Barking and Dagenham Clinical Commissioning Group.	

Summary:

Clinical Commissioning Groups (CCGs) have the opportunity to earn a Quality Premium, which is intended to reward CCGs for improvements in quality of the services they commission and for associated improvements in health outcomes. There are six measures against which the CCG can claim a portion of the Quality Premium Payment the details of which are set out in the report below.

Recommendation(s)

The Health and Wellbeing Board is recommended to:

1. Support the Barking and Dagenham CCG in its response to the NHS in regards to the 2015/16 Quality Premium; and,
2. Approve the measures and trajectories for 2015/16 within that response, as set out in the report below.

Reason(s)

To support the actions of the Health and Wellbeing Strategy through improvements in quality of the services and associated improvements in health outcomes.

1. Introduction and Background

1.1 Clinical Commissioning Groups (CCGs) have the opportunity to earn a Quality Premium which is intended to reward CCGs for improvements in quality of the services they commission and for associated improvements in health outcomes. Guidance on the 2015/16 Quality Premium was published on 27 April 2015. A maximum payment of £5 per head of population is available non-recurrently to CCGs who can demonstrate improvements in a number of measures that cover a combination of national and local priorities. The financial reward is linked to the delivery of NHS Constitution standards and Finance or Quality gateway standards with a proportion of funding withheld if these measures are not achieved. Full achievement of the 15/16 Quality Premium is potentially worth around £1m for Barking and Dagenham CCG.

1.2 The CCG is required to select its Quality Premium measures in conjunction with the Health and Wellbeing Board and inform NHSE of the measures and improvement trajectories by 14 May 2015.

2. Quality Premium Measures and Proposal

2.1 There are six quality premium measures; achievement of each by the CCG in 2015/16 allows the CCG to claim a proportion of the total Quality Premium payment. Two measures are nationally mandated; two measures offer a menu of choices across national priorities and a further two must be chosen from CCG Outcome Indicator Set (CCG OIS) measures

2.2 The CCG is proposing the following quality premium measures for 2015/16. Where the CCG has made local choices measures have been selected which:

- support the key national and local priority to build on the improvements to urgent and emergency care achieved in 2014/15 and to routinely deliver the NHS Constitution standards
- are the areas in which improvement is most attainable and
- are the areas where the CCG can most easily and accurately measure progress.

Measure	Value	Improvement required
Nationally mandated - Reducing potential years of lives lost through causes considered amenable to healthcare (also known as PYLL).	10% of quality premium	Achieve an average per annum percentage reduction in the potential years of life lost (standardised for sex and age) from amenable mortality for the CCG population over the period between the 2012 and 2015 calendar years. This should be no less than 1.2% (NOTE: as part of the 14/15 Operating Plan the CCG set an ambition of 5.4% per annum improvement which will continue to be the CCG improvement target)

Nationally mandated – improving antibiotic prescribing in primary and secondary care	10% of quality premium	**This measure consists of three parts:** Reduction in the number of antibiotics prescribed in primary care by 1% (or greater from each CCG's 2013/14 value). This part accounts for 50% of the 10% Quality Premium payment. Reduction in the number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care, by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion (11.3%) for English CCGs (whichever represents the smallest reduction for the CCG in question). This part accounts for 30% of the 10% Quality Premium payment. Secondary care providers with 10% or more of their activity being commissioned by the relevant CCG have validated their total antibiotic prescribing data as certified by PHE. This part accounts for 20% of the 10% Quality Premium payment.
Urgent and emergency care measure (from menu of choices) – increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays	30% of quality premium	To achieve this measure, the proportion of patients discharged on a Saturday, Sunday or English Public Holiday should be: • at least 0.5% points higher in 2015/16 than in 2014/15; OR • greater than 30% in 2015/16
Mental health measure (from menu of choices) – reduce the number of patients attending an A&E department for 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	30% of quality premium	To achieve this measure: • 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** • 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

Local measure 1 (from CCG OIS) - people who have had a stroke who are admitted to an acute stroke unit within 4 hours of arrival to hospital	10% of quality premium	The CCG shall determine the improvement required to achieve this part of the Quality Premium. The recommendation (based on analysis of available data) is that the CCG should seek a 3% improvement. Achievement is dependent on acute provider performance so it is beneficial for BHR CCGs to have a single agreed improvement required and this is to be communicated to BHRUT.
Local measure 2 (from CCG OIS) - patient experience of hospital care	10% of quality premium	The CCG shall determine the improvement required to achieve this part of the Quality Premium. The recommendation (based on analysis of available data) is that the CCG should seek a 3% improvement. Achievement is dependent on acute provider performance so it is beneficial for BHR CCGs to have a single agreed improvement required and this is to be communicated to BHRUT.

2.3 The full 2015/16 Quality Premium guidance lists the criteria and technical definitions for achievement of each measure; it is available on the NHSE website at this address: http://www.england.nhs.uk/ccg-ois/qual-prem/

3. How might CCGs lose Quality Premium payments?

3.1 A CCG will lose its right to **all** Quality Premium earned in the manner described above if:

- it is not considered to have operated in a manner that is consistent with the obligations and principles set out in 'Managing Public Money' (https://www.gov.uk/government/publications/managing-public-money)
- it ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position
- it receives a qualified audit report in respect of 2015/16

3.2 NHSE also reserves the right not to make any payment where there is a serious quality failure during 2015/16

3.3 A CCG will also have its Quality Premium payment reduced if the providers from whom it commissions services do not meet the NHS Constitution requirement for

the following patient rights or pledges:

- **Maximum 18-week waits from referral to treatment** – failure against which a 30% payment reduction applies (10% reduction for each for the 90% Completed Admitted, 95% Completed Non-Admitted and 92% Incomplete standards; each separately assessed)

- **Maximum four hour waits in A&E departments (95% standard)** – failure against which a 30% payment reduction applies

- **Maximum 14 day wait from a urgent GP referral for suspected cancer (93% standard)** – failure against which a 20% payment reduction applies

- **Maximum 8 minute responses for Category A (Red 1) ambulance calls (75% standard)** – failure against which a 20% payment reduction applies

4. How can CCGs use Quality Premium money?

4.1 Quality premium payments can only be used for the purposes set out in regulations; which state that quality premium payments should be used by CCGs to secure improvement in:

- the quality of health services; or

- the outcomes achieved from the provision of health services; or

- reducing inequalities between patients in terms of access or outcomes achieved

4.2 CCGs may utilise the quality premium payment with other organisations to deliver the improvements above where appropriate wider powers are available for the use of the funding in this manner. Each CCG is required to publish an explanation of how it has spent a quality premium payment.

4.3 The CCG will be advised of the level of their 15/16 Quality Premium award early in quarter 3 in the 2016/17 financial year.

Public Background Papers Used in the Preparation of the Report:
None

List of Appendices:
None

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