NHS Commissioning Board

Quality Premium: 2013/14 guidance for CCGs

Draft – December 2012

THE NHS CONSTITUTION
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Quality Premium:

2013/14 guidance for CCGs

First published: December 2012

This document is in draft form pending regulations (governing payments in respect of quality) that are expected to come into force in April 2013. We do not anticipate any substantive changes to the document. However, a final version will be published in April 2013

Contents

Executive summary

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.

2. The quality premium paid to CCGs in 2014/15 – to reflect the quality of the health services commissioned by them in 2013/14 – will be based on four national measures and three local measures.

3. The national measures, all of which are based on measures in the NHS Outcomes Framework, will be:
    - reducing potential years of lives lost through amenable mortality (12.5% of quality premium): the overarching objective for Domain 1 of the NHS Outcomes Framework;

    - reducing avoidable emergency admissions (25% of quality premium): a composite measure drawn from four measures in Domains 2 and 3 of the NHS Outcomes Framework;

    - ensuring roll-out of the Friends and Family Test and improving patient experience of hospital services (12.5% of quality premium), based on one of the overarching objectives for Domain 4 of the NHS Outcomes Framework;

    - preventing healthcare associated infections (12.5% of quality premium), based on one of the objectives for Domain 5 of the NHS Outcomes Framework.

4. The three local measures, which should be based on local priorities identified in joint health and wellbeing strategies, will be agreed between individual CCGs and the area teams of the NHS Commissioning Board (NHS CB).

5. The NHS CB will reserve the right not to make any payment where there is a serious quality failure during 2013/14.

6. Subject to regulations due to be made and laid in Parliament early in the New Year:
    - it will be a pre-qualifying criterion for any payment that a CCG manages within its total resources envelope for 2013/14 and does not exceed the agreed level of surplus drawdown

    - the total payment for a CCG (based on its performance against the four national measures and three national measures) 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 62-day waits from urgent GP referral to first definitive treatment for cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

7. The total financial envelope for the quality premium will be announced in the New Year. This will be on top of a CCG's main financial allocation for 2014/15 and on top of its £25 per head running costs allowance.

8. The regulations will set out the purposes for which CCGs will be able to spend their payments.

9. This document has the status of draft guidance until it is revised to reflect the content of the regulations and published as final.

Background

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

11. The design of the quality premium will evolve from year to year. Following engagement with CCGs and other organisations, the NHS CB has sought to design the 2013/14 quality premium in ways that:

    - promote improvements against the main objectives of the NHS Outcomes Framework, ie reducing premature mortality, enhancing quality of life for people with long-term conditions, ensuring swift recovery after acute illness or injury, improving patient experience, and ensuring patient safety
    - set 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
    - promote reductions in health inequalities and recognise the different starting points of CCGs, with a predominant focus on rewarding CCGs for improvements against those starting positions rather than having to achieve the same absolute standard of performance - the only exception to this being the MRSA element of the Domain 5 criteria.
    - further promote local priority-setting by having three measures that reflect joint health and wellbeing strategies
    - underline the importance of maintaining patients' rights and pledges under the NHS Constitution

National measures

Domain of NHS OF	Domain 1: preventing people from dying prematurely
Quality premium measure	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people
Rationale	The overall aim of Domain 1 is to reduce premature mortality. This aim is shared between the NHS and public health frameworks. The contribution that can be delivered by the NHS is best measured by potential years of life lost from causes considered amenable to healthcare. CCGs will be able to determine which aspects of premature mortality are of greatest relevance in their local population. In order to reduce premature mortality within the population, CCGs will need to address the physical health needs of people with mental health conditions and learning disabilities.

Value	12.5% of quality premium
Threshold	To earn this portion of the quality premium, the potential years of life lost (adjusted for sex and age) from amenable mortality for a CCG population will need to reduce by at least 3.2% between 2013 and 2014 This is based on the 10-year average annual reduction in potential years of life lost from amenable mortality
Technical definition	Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The concept of 'amenable' mortality generally relates to deaths under age 75, due to the difficulty in determining cause of death in older people who often have multiple morbidities. The Office for National Statistics (ONS) produces mortality data by cause, which excludes deaths under 28 days (for which cause of death is not classified by ICD-10 codes). These indicators therefore relate to deaths between 28 days and 74 years of age inclusive. See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further detail, including details of the ICD-10 codes included in this measure.

Domain of NHS OF	Domain 2: Enhancing quality of life for people with long term conditions Domain 3: Helping people to recover from episodes of ill health or following injury
Quality premium measure	Avoidable emergency admissions Composite measure of: • unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) • unplanned hospitalisation for asthma, diabetes and epilepsy in children • emergency admissions for acute conditions that should not usually require hospital admission (adults) • emergency admissions for children with lower respiratory tract infection.

Rationale	Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the NHS improve the quality of care and reduce the frequency and necessity for emergency admissions. About a third of avoidable admissions are for people with a secondary diagnosis relating to mental health. Progress in reducing emergency admissions is likely to need a strong focus on improving the physical health of people with mental health conditions.
Value	25% of quality premium
Threshold	To earn this portion of the quality premium, there will need to be a reduction or a zero per cent change in emergency admissions for these conditions for a CCG population between 2013/14 and 2014/15. The NHS CB may apply an adjustment for CCGs with the highest baseline levels of emergency admissions. Details of any adjustment will be published in the New Year.
Technical definition	The NHS Outcome Framework contains four indicators measuring emergency admissions for those conditions (sometimes referred to as 'ambulatory care sensitive conditions') that could usually have been avoided through better management in primary or community care. These are indicators 2.3i and 2.3ii focusing on chronic (ie long term) conditions and indicators 3a and 3.2 focusing on acute conditions. For the purpose of the quality premium these complementary measures are being combined to create a single composite measure. See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details, including details of the ICD-10 codes included in this measure.

Domain of NHS OF	Domain 4: ensuring that people have a positive experience of care

Quality premium measure	1. Roll-out of Friends and Family Test A CCG's local providers deliver the nationally agreed roll-out plan to the national timetable – maternity services by the end of October 2013 and additional services (to be defined) by the end of March 2014. 2. Patient experience for acute inpatient care and A&E services, as measured by the Friends and Family Test
Rationale	The Friends and Family Test is a simple, comparable test which, when combined with follow-up questions, provides a mechanism to identify poor performance and encourage staff to make improvements where services do not live up to the expectations of patients. This leads to a more positive experience of care for patients. The comparability of the data (through the use of a standardised question and methodology) will allow commissioners to understand overarching levels of patient experience for the services that they commission.
Value	12.5% of quality premium
Threshold	To earn this portion of the quality premium, there will need to be: 1) assurance that all relevant local providers of services commissioned by a CCG have delivered the nationally agreed roll-out plan to the national timetable 2) an improvement in average FFT scores for acute inpatient care and A&E services between Q1 2013/14 and Q1 2014/15 for acute hospitals that serve a CCG's population.
Technical definition	Details of central reporting will be specified in separate technical guidance, to be published in due course. The current position is that providers should not compromise anonymity of patient responses by asking for CCG identifying information such as postcode. The expectation is that aggregate responses will be attributed to CCGs using other centrally available data. See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions* for further details.

Domain of NHS OF	Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm
Quality premium measure	1) Incidence of MRSA bacteraemia 2) Incidence of Clostridium difficile (C. difficile)

Rationale	Although the NHS has made significant improvement in recent years in reducing MRSA bloodstream infections and C. difficile infections, the rates of reductions in these infections have been greater in the acute sector than for community onset cases (such as those acquired in care homes). Around half the numbers of MRSA and C. difficile infections are now community-onset cases. CCGs will have a pivotal role to play in driving further improvements in reduction of healthcare associated infections.
Value	12.5% of quality premium
Threshold	A CCG will earn this portion of the quality premium if: • there are no cases of MRSA bacteraemia for the CCG's population; and • C. difficile cases are at or below defined thresholds for CCGs.
Technical definition	C. difficile objectives are included in the *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions*. Data on C. difficile infections by CCG will be published monthly.

Local measures

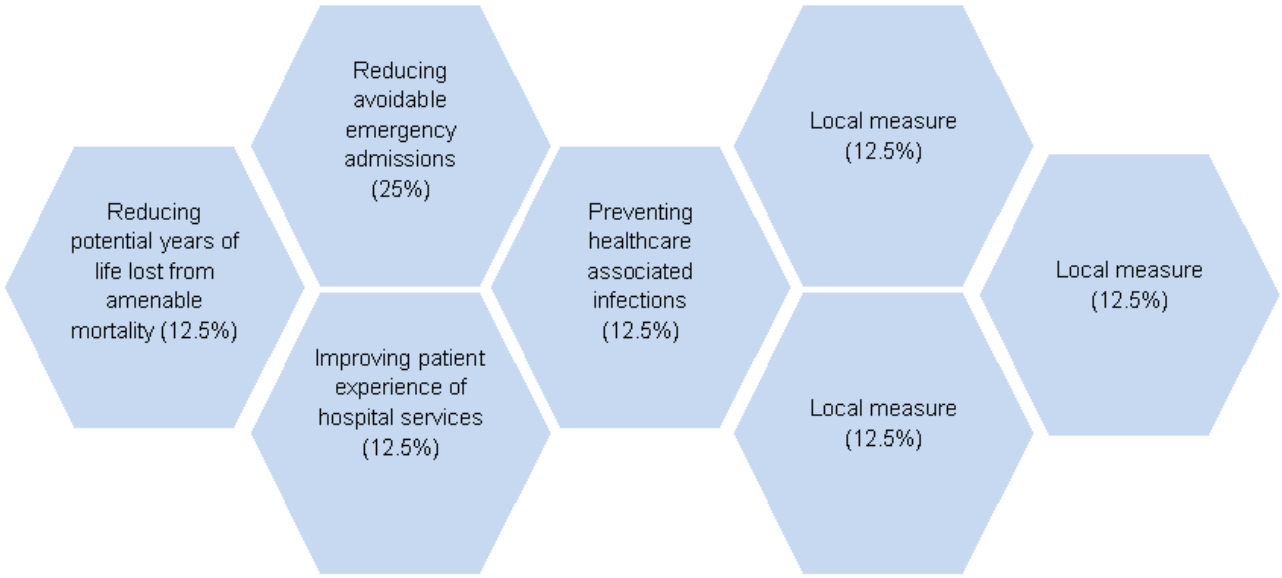
12. The quality premium will also include three locally identified measures.

13. Each CCG should agree these measures with the NHS Commissioning Board after consideration with Health and Wellbeing Boards and key stakeholders, especially patients and local community representatives.

14. These measures should focus on local issues and priorities, especially where the outcomes are poor compared to others and where improvement in these areas will contribute to reducing health inequalities.

15. Each measure should be based on robust data and the improvement needed to trigger the reward should be expressly agreed between the CCG and the NHS CB Area Team. Where there is concern about the validity of data, the measures identified in the CCG Outcomes Indicator Set should be used as a default.

Overall distribution of quality reward



Serious quality failure

16. CCGs will be responsible for the quality of the care and treatment that they commission on behalf of their population. The NHS CB will reserve the right not to make any quality premium payments to a CCG in cases of serious quality failure, ie where the Care Quality Commission judges that a provider is in serious breach of its registration requirements.

17. In such circumstances and when deciding whether or not to withhold payment, the NHS CB will want to understand the steps that the CCG has taken to monitor the quality of the care it has commissioned and the action it has taken, in collaboration with other parts of the system, should serious concerns about quality be identified.

Financial gateway

18. A CCG can only earn a quality premium if has improved quality or achieved high standards of quality as assessed by the measures set out above.

19. Subject to regulations, a CCG will not, however, receive a quality premium if it has failed to manage within its total resources envelope or has exceeded the agreed level of surplus drawdown, based on the principle that effective use of public resources should be seen as an integral part of securing high-quality services.

20. The NHS CB may also withhold or reduce a quality premium payment if a CCG does not meet requirements in relation to financial propriety.

NHS Constitution

21. Subject to regulations, 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:

Patient right or pledge	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral
Threshold	Achieved for at least 92% of patients over the course of the 2013/14 year
Attribution to CCG	Data will be available by CCGs as providers will submit data on the basis of the CCG that is responsible for a given patient.
Technical guidance	See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions*

Patient right or pledge	Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department
Threshold	Achieved for at least 95% of patients over the course of the 2013/14 year
Attribution to CCG	Provider A&E performance will be attributed to CCGs on the basis of patient flow data for all providers that are responsible for a significant share of the CCG's A&E activity.
Technical guidance	See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions*

Patient right or pledge	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer
Threshold	Achieved for at least 85% of patients over the course of the 2013/14 year
Attribution to CCG	Data will be available by CCGs as providers will submit data on the basis of the CCG that is responsible for a given patient.
Technical guidance	See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions*

Patient right or pledge	Category A Red 1 ambulance calls resulting in an emergency response arriving within 8 minutes
Threshold	Achieved for at least 75% of patients over the course of the 2013/14 year
Attribution to CCG	Each CCG will be judged by the performance of the ambulance trust that serves its geographic area.
Technical guidance	See *Everyone Counts: Planning for Patients 2013/14 - Technical Definitions*

Calculation of quality premium payments

22. The maximum quality premium payment for a CCG will be expressed as a level of funding (£) per head of population, calculated using the same methodology as for CCG running costs.

23. For each measure (national and local) where the identified quality threshold is achieved the CCG will be eligible for the indicated percentage of the overall funding available to it.

24. Where a CCG has failed to manage within its total resources envelope the CCG will not receive a quality premium payment.

25. Where a CCG does not deliver the identified patient rights and pledges on waiting times, a reduction of 25% for each relevant NHS Constitution measure will be made to the quality premium payment.

26. The quality premium payment will be made in the 2014/15 financial year.

Worked Example

Illustrative assumptions:

- a CCG has a population of 160,000
- value of quality premium is £5[1] per head of population
- the CCG manages within its total resources for 2013/14
- the CCG achieves two of the three local measures
- the CCG achieves all the national measures with the exception of Domain 4
- the CCG meets two out of the four NHS Constitution measures.

Measure	Percentage of quality premium	Value for illustrative CCG	Measure achieved	Eligible quality premium funding[2]
Domain 1	12.5%	£100,000	Y	£100,000
Domains 2 & 3	25%	£200,000	Y	£200,000
Domain 4	12.5%	£100,000	N	£0
Domain 5	12.5%	£100,000	Y	£100,000
Local Measure 1	12.5%	£100,000	Y	£100,000
Local Measure 2	12.5%	£100,000	Y	£100,000
Local Measure 3	12.5%	£100,000	N	£0
TOTAL	**100%**	**£800,000**		**£600,000**

NHS Constitution rights and pledges	Measure achieved	Adjustment to funding	Quality premium funding
Referral to treatment times (18 weeks)	Y	-	
A&E waits	N	25%	- £150,000
Cancer waits – 62 days	Y	-	
Category A Red 1 ambulance calls	N	25%	- £150,000
Total adjustment			- £300,000
REVISED TOTAL			**£300,000**

[1] For illustration purposes only.

[2] Subject to financial gateway and delivery of identified patient rights and pledges

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