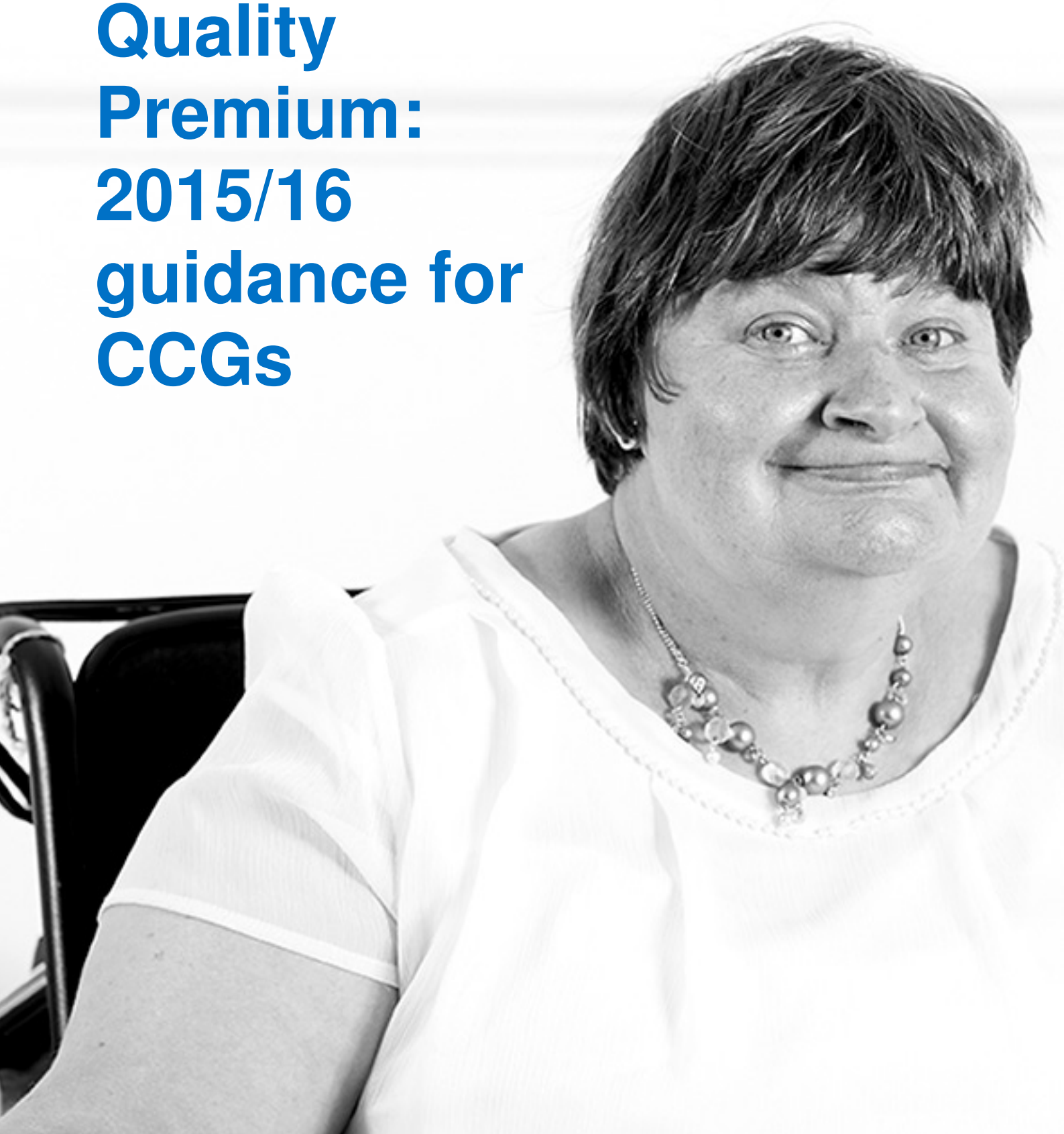
NHS England

Quality Premium: 2015/16 guidance for CCGs



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Quality Premium
2015/16 Guidance for CCGs

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NHS Constitutional measures table updated to reflect RTT changes - page 9
Worked example table updated to reflect RTT changes - page 11
Appendix 2 - NHS Constitution requirements amended to remove RTT admitted and non-admitted text, RTT incomplete measure increased to 30% – page 27

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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 reductions in inequalities in access and in health outcomes.

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:

    - **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).

3. 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[1] during 2015/16; or

    b) 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; or

    c) incurs a qualified audit report in respect of 2015/16.

4. NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/16.

[1] https://www.gov.uk/government/publications/managing-public-money

5. 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.

6. 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 2015/16 and in addition to its running costs allowance).

7. Regulations[2] set out that quality premium payments should be used in ways that improve quality of care or health outcomes and/or reduce health inequalities.

Background

8. 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 CCGs to reflect the quality of services that they commission, the associated health outcomes and reductions in inequalities.

9. 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.

10. Specific communities, or individuals with similar specific needs, may be disproportionately represented within the groups relevant to each Quality Premium measure. In developing their improvement plans for each measure,

[2] The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (S.I. 2013/474)

CCGs should consider their knowledge of their local population and whether there are specific communities or patient groups for whom a bespoke focus may be appropriate. CCGs should consider whether specific engagement is required with relevant communities or patient groups in order to inform the approaches to be taken. As part of developing their local improvement plans for each Quality Premium measure, CCGs would benefit from completing an equality and health inequalities analysis.

Composition of quality premium

11. 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 measures that cover a combination of national and local priorities. These are:

- **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** (20 per cent of quality premium-10 per cent for each measure). These should reflect local priorities identified in joint health and wellbeing strategies. They should 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. The levels of improvement needed to trigger the reward should be agreed between the CCG, the Health and Wellbeing Board and the local NHS England team.

12. The local measures should not duplicate the national measures described in Appendix 1, including individual components of composite national measures, nor should they duplicate the NHS Constitution measures set out in Appendix 2. They should reflect services that CCGs are responsible for commissioning, or are commissioning jointly with other organisations. They may include aggregate or composite indicators.

13. Full details of the quality premium measures are set out in Appendix 1.

Quality gateway

14. CCGs are responsible for the quality of the care and treatment that they commission on behalf of their population. NHS England reserves the right not to make any quality premium payments to a CCG in cases of serious quality failure, 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 2015/16 end of year assessment.

15. As an alternative to withholding the quality premium in the circumstances above, NHS England may, at its discretion, make the quality premium available to the relevant CCG if the CCG agrees to use the quality premium payment to help resolve the serious quality failure.

16. It is important that the quality premium and assurance processes are well aligned. Should the assurance process criteria with respect to quality failure change during 2015/16, NHS England may amend the above criteria in order to maintain alignment with it, including if assurance criteria are introduced to identify quality failures within CCGs.

Financial gateway

17. Effective use of public resources should be seen as an integral part of securing high-quality services. A CCG will not receive a quality premium if:

    a) in the view of NHS England, during 2015/16 the CCG has not operated in a manner that is consistent with the obligations and principles set out in Managing Public Money[3]; or

[3] Ibid

b) 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; or

c) it receives a qualified audit report in respect of 2015/16.

NHS Constitution measures

18. 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 -92% Incomplete standard*	30%
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%

* This measure is now focussed solely on the Incomplete standard, reflecting the changes made to the NHS Constitution RTT standard in June 2015.

Calculation and use of quality premium payments

19. 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 2015/16 and in addition to its running costs allowance.)

20. For each measure where the identified quality threshold is achieved, the CCG will be eligible for the indicated percentage of the overall funding available to it.

21. Where a CCG has failed to meet the requirements of the quality or financial gateways set out in paragraphs 14-17 above, it will not receive a quality premium payment except where NHS England exercises its discretion with respect to the quality gateway as set out in paragraph 15 above.

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

23. It is planned that CCGs will be advised of the level of their quality premium award early in quarter 3 in the 2016/17 financial year. In order to maximise its ability to make the most effective use of the payment within 2016/17, each CCG should consider making plans for use of the payment in advance of this date, so that these plans can be implemented as soon as the level of award is confirmed.

24. Quality premium payments can only be used for the purposes set out in regulations[4]. These state that quality premium payments should be used by CCGs to secure improvement in:

    a) the quality of health services; or

    b) the outcomes achieved from the provision of health services; or

    c) reducing inequalities between patients in terms of their ability to access health services or the outcomes achieved.

25. 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.

26. Each CCG is required[5] to publish an explanation of how it has spent a quality premium payment.

27. A worked example of a quality premium calculation is set out overleaf.

[4] Ibid

[5] Section 223K(7) of the NHS Act 2006

Worked example of quality premium calculation (for illustration only)

- a CCG has a population of 160,000
- the CCG satisfies the financial and quality gateways for 2015/16
- the CCG achieves all the national measures with the exception of improving antibiotic prescribing
- the CCG does not achieve one of its local measures
- the CCG meets four out of the six NHS Constitution measures.

Measure	Percentage of quality premium	Potential value for illustrative CCG	Measure achieved	Eligible quality premium funding
Reducing potential years of life lost	10%	£80,000	Y	£80,000
Urgent and emergency care menu	30%	£240,000	Y	£240,000
Mental health menu	30%	£240,000	Y	£240,000
Improving antibiotic prescribing	10%	£80,000	N	£0
Local measure 1	10%	£80,000	Y	£80,000
Local measure 2	10%	£80,000	N	£0
TOTAL	**100%**	**£800,000**		**£640,000**

NHS Constitution rights and pledges	Measure achieved	Adjustment to funding	Quality premium funding
RTT-incomplete	Y	-	
A&E waits	Y	-	
Cancer waits – 14 days	Y	-	
Category A Red 1 ambulance calls	N	20%	- £128,000
Total adjustment			- £128,000
NET TOTAL PAYABLE			**£512,000**

Appendix 1: Quality premium measures

Reducing premature mortality

Quality premium measure	**Reduce potential years of life lost (PYLL) from causes considered amenable to healthcare over time**
Threshold	To earn this portion of the quality premium, CCGs will need to: a) agree with Health and Wellbeing Board partners and with the relevant local NHS England team the average trend percentage reduction in the potential years of life lost (standardised for sex and age) from amenable mortality for the CCG population to be achieved over the period between the 2012 and 2015 calendar years. This should be no less than 1.2%; b) demonstrate that, in developing the reduction to be achieved and its plans to deliver it, the CCG and its partners have taken into account: i) the local causes of premature mortality for those living in areas of deprivation; ii) other relevant needs set out in the local joint health and wellbeing strategy; c) achieve the planned reduction.
Value	10% of quality premium.
Rationale	Reducing premature mortality is an aim that 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. CCGs will have the most significant impact in reducing premature mortality by determining which contributing factors are of greatest impact to their local population, particularly taking into account the causes of premature mortality for those who live in areas of deprivation and/or are from socially excluded groups.
Technical definition	A CCG will receive this part of the quality premium if the annualised trend in the Directly Standardised Rate of PYLL from amenable causes over the period 2012 to 2015 is at least as low as the level of reduction agreed by the CCG with its Health and Wellbeing Board and NHS England, and if its plans to do so have taken into account the local causes of premature mortality for those living in areas of deprivation and other relevant needs set out in the local health and wellbeing strategy.

	Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare". 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. 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. Issues are considered further in the ONS publication *Avoidable mortality in England and Wales*[6]. The list of ICD-10 codes is included in Appendix 3. The methodology for calculating the PYLL rate uses the average age-specific period life expectancy for each five-year age band for the relevant calendar year as the age to which a person in that age band who died from one of the amenable causes might have been expected to live in the presence of timely and effective health care. The age-specific period life expectancy is different for each calendar year, and will be published alongside the data. These age-specific life expectancies are used to weight the number of deaths in that age band to give the number of years of life lost for that age band. The total number of years of life lost are calculated for each age band. These are directly standardised against an England standard population based on ONS estimates for each year and expressed as a rate per 100,000 populations. The deaths are allocated to each CCG based on the GP of registration from the Primary Care Mortality Database (PCMD). Where no GP practice code is recorded in the PCMD, the CCG of responsibility is derived using the home postcode of the individual and the CCG of geographical responsibility according to the NHS Postcode Directory. The data will be supplied and calculated by the Information Centre for Health and Social Care. Baseline data for 2014 will be available in summer 2015. Outcome data for 2015 will be available in summer 2016.

[6] http://www.ons.gov.uk/ons/dcp171778_362295.pdf

	The trend is based on the log-linear Least Squares regression over the 4 years using the formula trend= e^{β} where $\ln(PYLL_{year})=\alpha+\beta year$ This will be illustrated in the baseline publication.

Urgent and emergency care

Quality premium measure	**Avoidable emergency admissions** **Composite measure of:** **a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults);** **b) unplanned hospitalisation for asthma, diabetes and epilepsy in children;** **c) emergency admissions for acute conditions that should not usually require hospital admission (adults);** **d) emergency admissions for children with lower respiratory tract infection.**
Threshold	To earn this portion of the quality premium, there will need to be either: a) a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16 ; or b) the Indirectly Standardised Rate of admissions in 2015/16 at less than 1,000 per 100,000 population.
Value	As part of urgent and emergency care menu, overall worth 30% of the Quality Premium
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.
Technical definition	This measure is based on the admissions for diagnoses 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 and which are reflected in four NHS Outcomes Framework indicators: • 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions; • 2.3ii Unplanned hospitalisation for asthma, diabetes and

	epilepsy in under 19s; • 3a Emergency admissions for acute conditions that should not usually require hospital admission; • 3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs). A CCG will receive this part of the quality premium if: • There is a reduction, or a zero per cent change, in the annualised trended change in the Indirectly Standardised Rate of emergency admissions for these conditions over the 4 years 2012/13 to 2015/16 ; OR the Indirectly Standardised Rate of admissions in 2015/16 is less than 1,000 per 100,000 population. The data are extracted from the Hospital Episode Statistics (HES) system. The admissions for each CCG are based on the GP practice recorded in HES. Where no GP practice code is recorded, the CCG of responsibility is derived using the home postcode of the individual and the CCG of geographical responsibility according to the NHS Postcode Directory. The ICD-10 diagnoses that are included are listed in Appendix 4, along with the other parameters used in the HES query. The rate will be Indirectly Standardised using the England rate in each year. The trend is based on the log-linear Least Squares regression over the 4 years using the formula trend= e^{β} where $\ln(PYLL_{year})=\alpha+\beta year$ This will be illustrated in the baseline publication. Baseline data for 2014/15 will be available in summer 2015. Outcome data for 2015/16 will be available in summer 2016.

Quality premium measure	**Delayed transfers of care which are an NHS responsibility**
Threshold	The total number of delayed days caused by delayed transfers of care in 2015/16 should be less than the number in 2014/15
Value	As part of urgent and emergency care menu, overall worth 30% of the Quality Premium
Rationale	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer of adults from hospitals is an important marker of effective joint working of local partners.
Technical definition	Average delayed transfers of care (delayed days) per 100,000 population, attributable to the NHS, per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Measure:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* The number will be attributed from Local Authority level using the proportion of each CCGs' registered population that are resident in each LA. *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month. Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-englandand-wales/index.html) Frequency: Numerator collected monthly. (Denominator annual) Timing: 2 month lag. Baseline: 2014/15 total

Quality premium measure	**Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.**
Threshold	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
Value	As part of urgent and emergency care menu, overall worth 30% of the Quality Premium
Rationale	Having a lower number of patients discharged at weekends and bank holidays can be an indicator that patients who are otherwise ready for discharge are inappropriately remaining in hospital. It is an indicator of the availability of seven day services to support discharge.
Technical definition	The source of the data is Hospital Episode Statistics. A discharge is counted where the Finished Discharge Episode flag equals 1 and the admission method does not begin with 1 (is not an elective admission) and the patient classification equals 1 (is an ordinary admission). There are a total of 365 days in 2014/15 of which 112 are weekends or public holidays. In 2015/16 there are 366 days of which 114 are weekend or bank holidays. **Numerator**: discharges (as defined above) that occur at a weekend or bank holiday **Denominator**: discharges (as defined above) that occur on any day The CCG that each discharge is assigned to is based on the CCG_RESPONSIBILITY field in HES.

Mental health

Quality premium measure	**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.**
Threshold	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, or is over 95%
Value	As part of the mental health menu, overall worth 30% of the Quality Premium
Rationale	Patients attending A&E with mental health needs can form a disproportionately large part of the number of patients who wait more than four hours to be treated and discharged, or admitted. A reduction in this number is an indicator of mental health needs having parity of esteem with physical health needs, together with being an indicator of appropriate services to meet these needs being in place.
Technical definition	For the data quality component, the first 2 and 3 digits of the raw DIAG_01 field in HES will be matched against a list of valid 2 character A&E diagnosis codes and valid ICD-10 codes. The proportion of all attendances where the CCG is listed as the responsible CCG must be greater than or equal to 90%. For the 4 hour waiting component, the DEPDUR field (time in minutes from arrival to departure) is used. The proportion of valid A&E attendances with a valid DEPDUR less than or equal to 240 compared to all attendances with a valid DEPDUR is used to calculate the proportion waiting less than 4 hours. The diagnosis included are those with an A&E 2 character diagnosis of 14 or 35 or with an ICD-10 diagnosis in the range F00-F99, G30, T36-T51 or X40-X49.

Quality premium measure	**Reduction in the number of people with severe mental illness who are currently smokers**
Threshold	A reduction in the percentage of people with severe mental illness who are current smokers
Value	As part of the mental health menu, overall worth 30% of the Quality Premium
Rationale	Smoking is the most important cause of preventable ill health and premature death in the UK. It has been reported that deaths from smoking-related diseases are twice as high among people with schizophrenia. The indicator will support reduction in smoking rates in people with serious mental illness (SMI), and should lead to action that will result in improved outcomes.
Technical definition	The indicator is measured as the percentage of people who are current smokers out of people with SMI identified on GP systems, given by CCG, based on GP data extracted by GPES. Numerator: Of the people in the denominator, the number who are identified as current smokers. Denominator: The number of people on the GP list with a diagnosis of SMI, where it is appropriate for the care component to be carried out. Patients identified for this indicator have one or more of the diagnosis codes for schizophrenia, bipolar affective disorder or other psychoses in their electronic health record and their latest mental health diagnosis is not in remission. The measure is based on a comparison of the percentage between 31 March 2015 and 31 March 2016.

Quality premium measure	**Increase in the proportion of adults in contact with secondary mental health services who are in paid employment**.
Threshold	An increase in the percentage of people in contact with mental Services (as measured in the MHMDS) who are in paid employment.; OR a reduction in the gap between people in contact with mental services (as measured in the MHMDS) who are in paid employment and the employment rate of the general population.
Value	As part of the mental health menu, overall worth 30% of the Quality Premium
Rationale	Participation in paid employment is an indicator of recovery, and of the degree to which wider outcomes for individuals are being addressed, as well as having therapeutic value in itself.
Technical definition	Data source: Mental Health Minimum Data Set Numerator: Of people in the denominator, the number recorded as being in employment at their most recent assessment, formal review or other multi-disciplinary care planning meeting. The measure is focused on 'paid' employment, to be clear that voluntary work is to be excluded for the purposes of this measure Denominator: The number of working age adults aged 18 to 69 who have received secondary mental health services at any point during the quarter. The measure is based on a comparison of the proportion within paid employment between Q4, 2014/15 and Q4, 2015/16. For the comparison with employment rate of the general population, ONS Labour Market Statistics at Local Authority level will be attributed to the CCG.

Quality premium measure	**Improvement in the health related quality of life for people with a long term mental health condition**
Threshold	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
Value	As part of the mental health menu, overall worth 30% of the Quality Premium
Rationale	The indicator supports identification of the degree to which wider health and quality of life needs of individuals with a long term mental health condition are being addressed for all equitably across the social gradient.
Technical definition	The measure is based on the average weighted health status (EQ-5D) score for adults with a long-term condition, given by CCG. Data source: GP Patient Survey, CCG OIS <u>People with a long term mental health condition(A)</u>: Numerator: The sum of weighted EQ-5D scores for all responses from people who identify themselves as having a long-term mental health condition. Denominator: The sum of all weighted responses from people who identify themselves as having a long-term mental health condition. <u>People with any long term condition (B)</u>: Numerator: The sum of weighted EQ-5D scores for all responses from people who identify themselves as having a long-term condition. Denominator: The sum of all weighted responses from people who identify themselves as having a long-term condition. The measure is based on a comparison of B minus A between 2014/15 and 2015/16. Data availability: 2014/15-September 2015 2015/16-September 2016

Patient safety

Quality premium measure	**Improved antibiotic prescribing in primary and secondary care** This is a composite Quality Premium consisting of three parts: Part a) reduction in the number of antibiotics prescribed in primary care Part b) reduction in the proportion of broad spectrum antibiotics prescribed in primary care Part c) secondary care providers validating their total antibiotic prescription data
Threshold	The three parts of the quality premium have specific thresholds as follows: Part a) reduction in the number of antibiotics prescribed in primary care by 1% (or greater) from each CCG's 2013/14 value. Individual practice reduction to be agreed by the CCG with each practice. Part b) 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 Part c) 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

Value	The value of the Quality Premium will be differentially weighted as follows: Part a) reduction in the number of antibiotics prescribed in primary care will be worth 50% of the total quality premium payment Part b) reduction in the number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care will be worth 30% of the total quality premium payment Part c) secondary care providers validating their total antibiotic prescribing data will be worth 20% of the total quality premium payment
Rationale	Evidence suggests that antibiotic resistance is driven by over-using antibiotics and prescribing them inappropriately. Keeping levels of antibacterial prescribing low, by only prescribing antibiotics when appropriate, will help reduce the spread of the antibacterial resistance that can be a serious threat to patients who have infections that do not respond to antimicrobial drugs. Broad spectrum antibiotics, such as co-amoxiclav, cephalosporins and quinolones, need to be reserved to treat resistant disease and should generally be used only when standard antibiotics are ineffective. In addition, without having a clear validated dataset, benchmarking across hospitals is not possible.

Technical definition	**Part a) reduction in the number of antibiotics prescribed in primary care by 1% or greater. Individual practice reduction to be decided by the CCG.** **Numerator:** Number of prescription items for antibacterial drugs (BNF 5.1) within the CCG **Denominator:** Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PUs) http://www.hscic.gov.uk/prescribing/measures **Prescribing Data** This information can be obtained from the Information Services Portal (ISP) provided by NHS Business Services Authority which covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. http://www.nhsbsa.nhs.uk/PrescriptionServices/3607.aspx For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within ISP **Part b)** 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 below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question **Numerator:** Number of prescription items for BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) within the CCG **Denominator:** Number of antibiotic prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 prescribed within the CCG **Prescribing Data** Prescribing information can be obtained from the electronic Prescribing Analysis and CosT tool (ePACT) system provided by NHS Business Services Authority which covers prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. http://www.nhsbsa.nhs.uk/3230.aspx

Appendix 2: NHS Constitution requirements

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 and calculation method	Achieved for at least 92% of patients over the course of the 2015/16 year. The position for 2015/16 will be measured from the incomplete Referral to Treatment (RTT) pathway snapshots (patients waiting to start consultant-led treatment at month end) in the monthly RTT returns from April 2015 to March 2016. The waiting time standard that at least 92% of patients are waiting within 18 weeks should be achieved on average for the year. This will be calculated by summing the numerators (patients waiting within 18 weeks) from each month end and then dividing by the sum of all the denominators (patients waiting) from each month end.
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 2015/16 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	30%

Patient right or pledge	Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department.
Threshold and calculation method	Achieved for at least 95% of patients over the course of the 2015/16 year. The position for 2015/16 will be measured from Weekly Situation Reports (sitreps) and will consist of data for all types of A&E across 52 weeks of sitreps from week ending 6 April 2015 to week ending 29 March 2016. The number of attendances (numerator) and number of 4 hour waits (denominator) will then be used to calculate an overall percentage for the year.
Attribution to CCG	Data will be mapped from providers to CCGs using a mapping derived from Hospital Episode Statistics figures. This calculates what proportion of each provider can be attributed to a given CCG. Any activity that is under 1% of the trust's overall activity will be ignored in this mapping. The mapping will be updated at regular intervals, with the

	latest mapping being used to cover the whole period. Only organisations submitting on HES will have their activity mapped to CCGs. Therefore, any type 3 units that do not submit on HES will not have their sitrep data allocated to any CCG.
Technical guidance	See 2015/16 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	30%

Patient right or pledge	Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer.
Threshold and calculation method	Achieved for at least 93% of patients over the course of the 2015/16 year. This will be calculated by summing data for the four quarters of 2015/16 to produce one annual figure against which the CCG will be assessed. As the patient is only reported in the period they are treated irrespective of when their pathway of care started, quarters can be added together.
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 2015/16 planning guidance technical definitions
Reduction in Quality Premium for non-achievement	20%

Patient right or pledge	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 2015/16 year. The percentage will be calculated by summing the numerator (the number of Red 1 calls resulting in an emergency response arriving at the scene of the incident within 8 minutes) over the 12 months April 2015 to March 2016 and also summing the denominator (the number of Red 1 calls resulting in an emergency response arriving at the scene of the incident) over the same period. The percentage will then be calculated using the usual numerator/denominator method for the whole year.
Attribution to CCG	Each CCG will be judged by the performance of the ambulance trust that serves its geographic area.
Technical guidance	See 2015/16 planning guidance technical definitions.
Reduction in Quality Premium for non-achievement	20%

Appendix 3: Amenable causes of mortality included in measure 1

ICD-10 Codes	Condition group and cause	**Ages included**
Infections		
A15–A19, B90	Tuberculosis	0–74
A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03	Selected invasive bacterial and protozoal infections	0–74
B17.1, B18.2	Hepatitis C	0-74
B20-B24	HIV/AIDS	All
Neoplasms		
C18–C21	Malignant neoplasm of colon and rectum	0–74
C43	Malignant melanoma of skin	0–74
C50	Malignant neoplasm of breast	0–74
C53	Malignant neoplasm of cervix uteri	0–74
C67	Malignant neoplasm of bladder	0–74
C73	Malignant neoplasm of thyroid gland	0–74
C81	Hodgkin's disease	0–74
C91, C92.0	Leukaemia	0–44
D10–D36	Benign neoplasms	0–74
Nutritional, endocrine and metabolic		
E10–E14	Diabetes mellitus	0–49
Neurological disorders		
G40–G41	Epilepsy and status epilepticus	0–74
Cardiovascular diseases (CVD)		
I01–I09	Rheumatic and other valvular heart disease	0–74
I10–I15	Hypertensive diseases	0–74
I20–I25	Ischaemic heart disease	0–74
I60–I69	Cerebrovascular diseases	0–74
Respiratory diseases		
J09–J11	Influenza (including swine flu)	0–74
J12–J18	Pneumonia	0–74
J45– J46	Asthma	0–74
Digestive disorders		
K25–K28	Gastric and duodenal ulcer	0–74
K35–K38, K40–K46, K80–K83, K85,K86.1-K86.9, K91.5	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia	0–74
Genitourinary disorders		
N00–N07, N17–N19,	Nephritis and nephrosis	0–74

N25-N27		
N13, N20–N21, N35, N40, N99.1	Obstructive uropathy & prostatic hyperplasia	0–74
Maternal & infant		
P00–P96, A33	Complications of perinatal period	All
Q00–Q99	Congenital malformations, deformations and chromosomal anomalies	0–74
Injuries		
Y60–Y69, Y83–Y84	Misadventures to patients during surgical and medical care	All

Appendix 4: Specification of HES query for avoidable emergency admissions measure within the urgent and emergency care menu

1 Field Name ADMIMETH is equal to the following: 21, 22, 23, 24, 28
(Rationale: This restricts the data to emergency admissions only.)

2 Field Name EPISTAT is equal to the following: 1 or 3
(Rationale: This includes both finished and unfinished hospital episodes.)

3 Field Name ADMIDATE Limited to admissions within the relevant financial year.
(Rationale: Data are presented annually with an admission date within the financial year of interest.)

4 Field Name SEX is equal to the following: 1 or 2
(Rationale: Data are for the sum of males and females and exclude the small number of records where sex was unknown or unspecified.)

5 Field Name EPIORDER is equal to: 1
(Rationale: This restricts the data to the first emergency admission in a hospital spell.)

6 Field Name ADMISORC is not equal to: 51, 52, 53
(Rationale: This excludes transfers.)

7 Field Name EPITYPE is equal to: 1
(Rationale: This restricts the data to general episodes (excludes birth, delivery and mental health episodes).)

8 Field Name CLASSPAT is equal to: 1
(Rationale: This restricts the data to ordinary admissions (excludes day case and maternity admissions)).

9a Field Name 4 CHAR PRIMARY DIAGNOSIS CODE (DIAG_01) is any of (a) to (q) are true AND Field Name STARTAGE is between 1-120 or >7000.
a) DIAG_01 is equal to any of: B18.0, B18.1. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).
b) DIAG_01 is equal to any of: J45, J46X
c) DIAG_01 is equal to any of: I11.0, I50, J81X, I13.0. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71
d) DIAG_01 is equal to any of: E10, E11, E12, E13, E14
e) DIAG_01 is equal to any of: J20, J41, J42X, J43, J44, J47X. J20 only with second diagnosis of J41, J42, J43, J44, J47
f) DIAG_01 is equal to any of: I20, I25. OPCS4 codes excluded: A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, V, W, X0, X1, X2, X4, X5
g) DIAG_01 is equal to any of: D50.1, D50.8, D50.9, D51, D52
h) DIAG_01 is equal to any of: I10X, I11.9. OPCS4 codes excluded: K0, K1, K2, K3, K4, K50, K52, K55, K56, K57, K60, K61, K66, K67, K68, K69, K71
i) DIAG_01 is equal to any of: G40, G41, F00, F01, F02, F03, I48X

j) DIAG_01 is equal to any of: J10, J11, J13X, J14, J15.3, J15.4, J15.7, J15.9, J16.8, J18.1, J18.8, A36, A37, B05, B06, B16.1, B16.9, B26, M01.4. Exclude people with a secondary diagnosis of D57 (Sickle-cell disorders).