Technical Guidance Annex B
Information on Quality Premium

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1 Background

The Quality Premium (QP) scheme is about rewarding Clinical Commissioning Groups (CCGs) for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

As in previous years, it is important that we retain a focus on the fundamentals of everyday commissioning. These include delivery of the NHS Constitution commitments on Referral to Treatment (RTT) Times, A&E, ambulance and cancer waiting times; adhering to quality regulatory standards, and delivering financial balance. The QP scheme will view CCG performance in the planning submissions round on the national and local priorities as well as on the fundamentals of commissioning to recognised standards.

2 Value

Under the National Health Service Act 2006 (as amended by the Health and Social Care 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.

In keeping with previous years, the maximum QP payment for a CCG is expressed as £5 per head of population, calculated using the same methodology as for CCG running costs, and made as a programme allocation. (This is in addition to a CCG's main financial allocation and in addition to its running costs allowance.)

3 Composition of the Quality Premium Scheme

This is a two year Quality Premium scheme. The QP paid to CCGs in 2018/19 and 2019/20 reflects the quality of the health services commissioned by them in 2017/18 and 2018/19. The QP award will be based on measures that cover a combination of national and local priorities, and on delivery of the gateway tests, as described below.

3.1 National and Local Indicators

There are five national measures and in total these are worth 85% of the QP (full details are set out in Appendix 1):

#	Indicator Name	Weighting
1	Early Cancer Diagnosis	17%
2	GP Access and Experience	17%
3	Continuing Healthcare	17%
4	Mental Health	17%
5	Bloodstream Infections	17%

CCGs can select one local indicator which will be worth 15% of the QP. The indicator should be selected from the RightCare suite of indicators – as set out in the Commissioning for Value packs, focussing on an area of unwarranted variation locally which offers the potential for CCGs to drive improvement.

The level of improvement needed to trigger the reward will be agreed locally between the CCG and NHS England regional team, ensuring that this is robust and offers a stretching ambition.

CCGs will be required to submit their locally agreed indicator definition and level of improvement (as agreed with the Regional Team) early in 2017 via UNIFY.

3.2 Quality Gateway

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 that:

- a local provider has been subject to enforcement action by the Care Quality Commission; or
- a local provider has been flagged as a quality compliance risk and/or have requirements in place around breaches of provider licence conditions; or
- a local provider has been subject to enforcement action based on a quality risk; and
- it has been identified through NHS England's assessment of the CCG, in respect of the quality and governance elements of the Improvement and Assessment Framework, that the CCG is not considered to be making an appropriate, proportionate response with its partners to resolve the above quality failure; and
- this continues to be the position for the CCG at the end of year assessment.

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.

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

3.3 Financial Gateway

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:

- in the view of NHS England, during the relevant financial year the CCG has not operated in a manner that is consistent with the obligations and principles set out in Managing Public Money[1]; or
- the CCG ends the relevant financial year with an adverse variance against the planned surplus, breakeven or deficit financial position[2], or requires unplanned financial support to avoid being in this position; or
- it receives a qualified audit report in respect of the relevant financial year.

[1] https://www.gov.uk/government/publications/managing-public-money
[2] CCGs are measured against all delegated budgets

3.4 NHS Constitution Gateway

As in previous years, a CCG may have its quality premium award reduced via the NHS Constitution gateway. In 2017/18, some providers will continue to have agreed bespoke trajectories, as part of the operation of the Sustainability and Transformation Fund, for delivery of RTT, four hour A&E, 62 day cancer waits and Red 1 ambulance response times. On this basis, the CCG gateway test in respect of these measures will be adjusted to reflect these differential requirements.

NHS Constitution requirement	Reduction to Quality Premium
Maximum 18 weeks from referral to treatment - incomplete standard	25%
Maximum four hour waits in A&E departments standard	25%
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	25%
Maximum 8 minute response for Category A (Red 1) ambulance calls	25%

In keeping with the need to keep the quality premium and CCG assessment processes well aligned, it is important to ensure alignment between the payment of the quality premium and the NHS Constitution Gateway. Should the measures in the NHS Constitution be updated, as occurred with RTT, or expectations around the operation of the Sustainability and Transformation Fund change, NHS England may amend the above criteria in order to maintain alignment.

4 Calculation and use of Quality Premium payments

The maximum QP 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 and in addition to its running costs allowance.)

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. Where a CCG has failed to meet the requirements of the quality or financial gateways set out above, it will not receive a QP payment except where NHS England exercises its discretion with respect to the quality gateway.

Where a CCG does not deliver the identified patient rights and pledges on waiting times, or any bespoke trajectories towards these (in the case of CCGs who commission from providers in receipt of the Sustainability and Transformation Fund (STF)), a reduction for each relevant NHS Constitution measure will be made to the QP payment.

It is planned that CCGs will be advised of the level of their QP award in quarter 3 of the following financial year. In order to maximise its ability to make the most effective

use of the payment within 2018/19 and 2019/20, 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.

QP payments can only be used for the purposes set out in regulations[3]. These state that QP 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 their ability to access health services or the outcomes achieved.

CCGs may utilise the QP 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[4] to publish an explanation of how it has spent a QP payment.

[3] The National Health Service (Clinical Commissioning Groups-Payments in Respect of Quality) Regulations 2013 (S.I. 2013/474)
[4] Section 223K(7) of the NHS Act 2006

Appendix 1: Quality Premium measures

Quality premium measure	Cancers diagnosed at early stage
Threshold	To earn this portion of the quality premium, CCGs will need to either: 1. Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) that are diagnosed at stages 1 and 2 in the 2017 calendar year compared to the 2016 calendar year. For year 2 (2018/19) this will be the 2018 calendar year compared to the 2017 calendar year. Or 2. Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) that are diagnosed at stages 1 and 2 in the 2017 calendar year. For year 2 (2018/19) this will be the 2018 calendar year. Note: In year 2 the denominator may be amended to exclude cancer of unknown stage, this will require an amendment to the thresholds.
Value	17% of quality premium.
Rationale	Cancer survival rates in England have never been higher, but we know that we often lag behind the highest performing countries in the world in international comparisons. We also know that the earlier cancer is diagnosed, the more likely it is to be successfully treated, and survival rates can be dramatically improved. The independent cancer taskforce, in their report *Achieving World-Class Cancer Outcomes*, published in July 2015, set an ambition for the NHS that 62% of all cancers with known stage at diagnosis would be diagnosed at stages 1 and 2 by 2020. Achieving this target will require every CCG to focus on and make significant improvement in early stage diagnoses. Specific public health interventions, such as screening programmes and public information campaigns can aim to improve rates of early diagnosis. Supporting clinicians to spot cancers earlier and greater GP access to diagnostic and specialist advice were outlined in the Five Year Forward View as key planks of improving our diagnostic strategies. In addition, NICE published new guidance on appropriate referral for suspected cancer in 2015, which lowered the threshold of risk for symptoms suggestive of cancer to trigger an urgent referral for suspected cancer to 3%, with the aim of diagnosing more cancers at an early stage. An indicator on the proportion of cancers diagnosed at an early stage is therefore a useful measure for assessing improvement in early diagnosis and ultimately cancer survival. Improving cancer survival is one of the three key ambitions outline in *Achieving World-*

	Class Cancer Outcomes. Thresholds have been set based on levels of improvement previously seen amongst high-performing CCGs and felt to be achievable for the majority of CCGs.
Technical definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour*) **Numerator:** Cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour* **Denominator:** All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour* *invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin.
Data source	Cancer Analysis System, National Cancer Registry, Public Health England
Published Frequency & Timeliness	Data will be a rolling window of one year's worth of data. The data will be lagged by 12 months.

Quality Premium measure	Overall experience of making a GP appointment
Threshold	To earn this portion of the quality premium, CCGs will need to demonstrate in the July 2018 publication, either: • Achieve a level of 85% of respondents who said they had a good experience of making an appointment, or; • A 3 percentage point increase from July 2017 publication on the percentage of respondents who said they had a good experience of making an appointment.
Value	17% of quality premium.
Rationale	The GP Patient Survey (GPPS) seeks the views of 2.4 million people every year about their experience of GP services and results are published at GP practice level. The survey gives patients the opportunity to provide feedback on a number of aspects of their experience of their GP practice, and provides a rich source of quantitative data on patients' experiences of the access and quality of care they receive. Access to GP services, and, in particular, the ease of making an appointment is a key measure of patient experience, and affects the wider healthcare system as patients who find it difficult to access GP services may seek care through emergency services inappropriately. Q18 ("Overall, how would you describe your experience of making an appointment?") of the GP Patient Survey (GPPS) is the "litmus test" indicator in this regard. Attaching a quality premium payment will also ensure that the profile and importance of insight about patient experience is underlined and it will incentivise the wider system to review and learn from the findings of the GPPS.

Technical definition	Question 18: Overall, how would you describe your experience of making an appointment? • Very good • Fairly good • Neither good nor poor • Fairly poor • Very poor **Numerator:** the weighted number of people answering 'very good' or 'fairly good' to question 18 of the GP Patient Survey. This is expressed as $\Sigma_k(wt\_new_k)$ where k = 1, …, p which are all respondents who answer question 18 with either answering 'very good' or 'fairly good' . **Denominator**: the total weighted number of people who answer question 18 of the GP Patient Survey. This is expressed as $\Sigma_j(wt\_newj)$ where j = 1, …, q which are all respondents who answer question 18 **Weighting** A weight is applied to construct the indicator. The GP Patient Survey includes a weight for non-response bias (wt_new). This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who actually complete the questionnaire. The non-response weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GP Patient Survey. Further information on the current weighting scheme can be found in the survey's technical annex.
Data source	Data for this indicator is from the GP Patient Survey. This survey is commissioned by NHS England and is conducted by the independent survey organisation Ipsos MORI.
Published Frequency & Timeliness	Publication will be in July representing data collection from January to March.

Quality Premium measure	NHS Continuing Healthcare
Threshold	This is a two part indicator: Part a) worth 50% To achieve the Quality Premium for this part, CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility) Part b) worth 50% To achieve the Quality Premium for this part, CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.
Value	17% of quality premium.

Rationale	Part a) The time that elapses between the Checklist (or, where no Checklist is used, other notification of potential eligibility) being received by the CCG and the funding decision being made should, in most cases, not exceed 28 days. CCGs should make all reasonable efforts to ensure the required information or participation is made available within 28 days. This should include developing protocols with services likely to be regularly involved in NHS Continuing Healthcare eligibility processes that reflect the need for information or participation within 28 days. Where the CCG commissions the service from which information or participation is regularly required, it may be appropriate to consider placing such expectations within the specification for the relevant service. Part b) It is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's long-term needs are clearer, and for NHS-funded services to be provided in the interim. This might include therapy and/or rehabilitation, if that could make a difference to the potential further recovery of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. It should always be borne in mind that assessment of eligibility that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential. This could be because, with appropriate support, that individual has the potential to recover further in the near future. It could also be because it is difficult to make an accurate assessment of an individual's needs while they are in an acute services environment. Anyone who carries out an assessment of eligibility for NHS continuing healthcare should always consider whether there is further potential for rehabilitation and for independence to be regained, and how the outcome of any treatment or medication may affect ongoing needs. In order to address this issue and ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few months. It might also include intermediate care or an interim package of support in an individual's own home or in a care home. In such situations, assessment of eligibility for NHS Continuing Healthcare should usually be deferred until an accurate assessment of future needs can be made. The interim services (or appropriate alternative interim services if needs change) should continue in place until the determination of eligibility for NHS continuing healthcare has taken place. There must be no gap in the provision of appropriate support to meet the individual's needs.

Technical definition	Part a) In 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility) This applies to new referrals and not reviews of existing NHS CHC cases or Previously Unassessed Periods of Care cases. **Elapsed time calculation:** **Clock starts:** 28 days referral time starts from the date the CCG receives any type of recorded decision that full consideration for NHS CHC is required i.e. a positive checklist or other notification of potential eligibility **Clock stops:** At the date the CCG makes a decision on eligibility. **Numerator:** Number of NHS CHC eligibility decisions where the CCG makes a decision within 28 days of receiving any type of recorded decision that full consideration for NHS CHC is required i.e. a positive checklist or other notification of potential eligibility (N.B. will always be a subset of the denominator figure) **Denominator:** Total number of NHS CHC eligibility decisions made within the financial year (sum of quarterly data) This will then provide a percentage of NHS CHC referrals that have been completed within 28 days The collection method uses both in-built data validations at point of entry and data quality checking post collection. The data collection is accompanied by guidance and definitions Part b) **Numerator:** Number of full comprehensive NHS CHC assessments completed whilst the individual was in an acute hospital in the relevant financial year (sum of quarterly data) **Denominator:** Total number of full NHS CHC assessments completed in the financial year (sum of quarterly data) This will then provide a percentage of full NHS CHC assessments that were completed in an acute hospital in the relevant financial year (sum of quarterly data). The collection method uses both in-built data validations at point of entry and data quality checking post collection. The data collection is accompanied by guidance and definitions.
Data source	NHS England NHS CHC report (the collection is presently covered by BAAS approval until 30th June 2018).

Published Frequency & Timeliness	Quarterly data collection to begin Q1 1718 Not currently published. Data available 55 working days after quarter end e.g. quarter 1 data will be available in quarter 2.

Quality premium measure	**Mental Health** This Quality Premium measure consists of three discrete indicators from which one will be chosen based upon the inequality most pertinent to a given CCG a) Out of area placements (OAPs) b) Equity of Access and outcomes in to IAPT services c) Improve inequitable rates of access to Children & Young People's Mental Health Services The CCG and NHSE Regional Team will agree the indicator most pertinent to the CCG. Only one element will be applied to a given CCG and so each element will be worth 100% of the Quality Premium payment available for this indicator.
Threshold	Each element of the quality premium has specific thresholds as follows: **Part a) OAPs:** a reduction in the number of inappropriate adult OAPs for non-specialist adult acute care. Total number of bed days relating to out of area placements to have reduced by 33% of the baseline number as at 1 April 2017. *NB – during 2017/18 this measure refers to adult acute, older adult acute and PICU beds only. In future years there is likely to be an expectation to reduce OAPs for all CCG-commissioned beds (e.g. Rehabilitation).* *A national definition of OAPs is included in guidance.* **Part b) Equity of Access and outcomes in IAPT services** 1. Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller. And 2. Proportion of people accessing IAPT services aged 65+; to increase to at least 50% of the proportion of adults aged 65+ in the local population or by at least 33%, whichever is greater in 2017/18; to increase to at least 70% of the proportion of adults aged 65+ in the local population, or by an additional 33% in 2018/19, whichever is greater. It is required that both elements must be met in order to meet this

	indicator. **Part c) Improved Access to Children & Young People's Mental Health Services** The required performance in 2017/18 is whichever is the greater of: 1. at least a 14% increase in the number of individual children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 based on 2016/17 baseline 2. the increase in activity necessary to enable 32% of children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 Similar tests will apply in 2018/19.
Value	17% of the Quality Premium CCGs and their NHS England Regional Teams will agree the indicator to be applied to that CCG, based upon the inequality most pertinent to that CCG.
Rationale	*The Five Year Forward View for Mental Health* placed a particular focus on tackling inequalities. Addressing this, a mandatory Mental Health element of the Quality Premium will focus on a number of key inequalities, allowing for the targeting of particular needs pertinent to local health economies and enabling CCGs to draw together resources in order to address local priorities. The quality premium will provide significant incentive for CCGs and their local partners to collaborate in pursuit of improvements in the quality of mental health outcomes. Based on NHS England's interpretation of a CCG's most pertinent needs in this area, this element of QP will be addressed against one of the following inequalities: **a) OAPs** People requiring acute mental health care should always receive evidence based treatment, close to home and in the least restrictive setting. Unfortunately we know that too many acutely unwell people, who require inpatient care, are sent far away from their friends and families at this time when they are particularly vulnerable. Evidence shows that people receiving care out of area have far worse outcomes than those receiving care locally and have a far higher

	incidence of suicide. Furthermore, OAPs are far more costly to provide which means that public funding is not being used to best effect. This is, of course, unacceptable, and *Implementing the Five Year Forward View for Mental Health* agreed to the Mental Health Taskforce recommendation that inappropriate OAPs for non-specialist acute mental health care should be eliminated. Some areas have already achieved this ambition, but there are still high levels of variation across the country. This is why OAPs are being included as a measure in the Quality Premium. **b) Equity of Access and outcomes in IAPT services** Improving access is a priority in the Five Year Forward View for Mental Health: by 2020/21 at least 25% of people with common mental health conditions should access services each year. In parallel, quality should be maintained and developed; including meeting existing waiting times and recovery standards, and improving access and outcomes for all adults. We know that people from Black, Asian and minority ethnic (BAME) communities can experience poorer outcomes from services than people who identify themselves as White British. In the most recently available national data (Quarter 4 2015/16) the recovery rates for people from Black Asian and minority ethnic groups were as much as 13.6 percentage points lower than the rate for people identified as White British. In addition, older people are under-represented in services, not accessing them as readily as people who are under 65 years of age. The percentage of over 65s completing a course of treatment is around 7% nationally, which is lower than the equivalent proportion of the adult population at approximately 13%. Service providers and commissioners should be taking action to ensure equity of access to and outcomes from IAPT services to people irrespective of any protected characteristics (as defined under the Equalities Act 2010) in line with their Public Sector Equalities Duties (PSED). They must also pay due regard to the need to reduce health inequalities between patients in access to and outcomes from IAPT services. There are examples of good practice in making IAPT services serve their whole population equally, and improving access for older people and outcomes for people from Black and Minority Ethnic groups is a

	good step towards this goal. **c) Improved rates of access to Children & Young People's Mental Health services** Children and young people are a priority group for mental health promotion and prevention, and *the Five Year Forward View for Mental Health* calls for *the Future in Mind* recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. One in ten children has a diagnosable mental health disorder. This can range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour. Despite recognition that early intervention can be highly cost effective, a significant treatment gap persists. The last UK epidemiological study suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. Compounding this, data from the NHS benchmarking network and recent audits year on year reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems. This indicator seeks to address this inequitable treatment gap by improving access. Addressing the difficulties in accessing the help they need NHSE has committed to helping at least 70,000 more children and young people each year to access high-quality, evidence based mental health care when they need it by 2020/21. An increase of 14% accessing treatment is consistent with the national real terms improvement required to move 12 months ahead of the national trajectory, set out in *Implementing the Five Year Forward View for Mental Health*.
Technical definition	**a) OAPs –** a 33% or greater reduction in OAPS is required to receive the QP

	Numerator: Total number of bed days people sent inappropriately out of area as at year end 31 March 2018 **Denominator**: Total number of bed days people sent inappropriately out of area as at baseline defined by CCGs at year end **Source**: CAP collection on OAPs, due to be reporting from December 2016, MHSDS, Unify **b) IAPT Access** – satisfactory performance against both components required to receive the QP There are two components of the IAPT indicator, which is applicable in both 2017/18 and 2018/19, enabling both short and medium term improvement activity: **i.** **BAME Access:** Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller. **Numerator:** Number of people from BAME groups reaching recovery **Denominator:** Number of people from BAME groups completing treatment. **Source:** IAPT MDS, aggregated information necessary for this calculation to be available quarterly from December 2016. **ii.** **Older People's Access**: For 17/18 the proportion of people accessing IAPT services aged 65+ to increase to at least 50% of the proportion of adults aged 65+ in the local population, or by at least 33%, whichever is greater; for 18/19 the proportion of people accessing IAPT services aged 65+ to increase to at least 70% of the proportion of adults aged 65+ in the local population, or by an additional 33%, whichever is greater. **Numerator:** number of people entering treatment to IAPT Services aged 65+ as a proportion of total number of people entering treatment to IAPT Services **Denominator:** Total number of people aged 65+ in the local population. **Source:** IAPT MDS, aggregated information necessary for this calculation to be available quarterly from December 2016.

	ONS population data. Compliance is defined as achieving both components. **c) CYP- MH Access** – in order to achieve the QP, the required performance in 2017/18 is whichever is the greater of: 1. at least 14% increase in the number of individual children and young people aged 0-18 with a diagnosable Mental Health condition starting treatment in NHS funded community services when they need it in 2017/18 based on 2016/17 baseline, Or; 2. the increase in activity necessary to enable 32% of children and young people aged 0-18 with a diagnosable MH condition starting treatment in NHS funded community services when they need it in 2017/18 Similar tests will apply in 2018/19 **Numerator:** The number of children and young people aged 0-18 with a diagnosable MH condition starting treatment in NHS funded community services in the reporting period. **Denominator:** Baseline figure for total number of new, individual children and young people 0-18 with a diagnosable MH condition treated by NHS funded community services. **Source:** MHSDS. The expectation is that Q2 MHSDS data for 2016/17 will be multiplied by 4 and included in the planning template to provide an estimated baseline. You will have the opportunity in the data collection template to amend this baseline based Q4 data or local data if it is higher than the Q4 reported baseline.

Quality Premium Measure	**Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups** This Quality Premium measure consists of three parts: Part a) reducing gram negative blood stream infections (BSI) across the whole health economy Part b) reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care Part c) sustained reduction of inappropriate prescribing in primary care The weighting for the 3 measures is as follows: Part A = 45% Part B= 45% Part C= 10%: Part A i) will be worth 35%. Part A ii) will be worth 10%; Part B i) will be worth 22.5% and part B ii) will be worth 22.5%; Part C will be worth 10%. Payment must be considered individually for each component of the QP as each part supports improvement within different areas which individually and collectively support the overarching ambition. This proposal outlines the details for the QP during 2017/18 however the main components of the QP should be maintained during 2018/19 to support a 2 year QP scheme. As outlined below, targets associated with each element will be reviewed so that more specific and ambitious targets can be set for 18/19.
Threshold	**Part a) reduction in the number of gram negative blood stream infections across the whole health economy. The required performance in 2017/18 must be:** i. a 10% reduction (or greater) in all *E coli* BSI reported at CCG level based on 2016 performance data (indicative and final targets will be made available in a following publication). In 2018/19 reduction thresholds will be reviewed against the latest activity to ensure the QP supports the maximum appropriate reduction gains. ii. collection and reporting of a core primary care data set for all E *coli* BSI in Q2-4 2017/18. This will require completion of requisite data through the existing PHE DCS reporting system for E coli BSI and the refined data collection for primary care related aspects. Further details will be available in following publications. Collection and reporting of a core primary care data set for all E coli BSI will continue during 2018/19.

	Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care. The required performance in 2017/18 must be: iii. a 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16) for 2017/18. In 2018/19 reduction thresholds will be reviewed to ensure targets reflect latest activity and maximise appropriate reduction gains. iv. a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) for 2017/18. In 2018/19 reduction thresholds will be reviewed to ensure targets reflect latest activity and maximise appropriate reduction gains. **Part C) sustained reduction of inappropriate prescribing in primary care** i. items per STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU. This threshold will remain during 2018/19.
Value	17% of quality premium
Rationale	Work to develop and deliver this Quality Premium directly responds to the ambitions set by Government following the O'Neill Review on Antimicrobial Resistance (May, 2016). These ambitions include a: • 50% reduction of Gram Negative Bloodstream Infections (GNBSIs) by 2020 • 50% reduction of the number of inappropriate antibiotic prescriptions by 2020 It also enables work (across the ALBs) to support the UK 5 Year AMR Strategy (2013-2018), which states that there are few public health issues of greater importance than antimicrobial resistance (AMR) in terms of impact on society. Infections are increasingly developing that cannot be treated and the rapid spread of multi-drug resistant bacteria means that we could be close to reaching a point where it is not possible to prevent or treat everyday infections or diseases. This work will support the other clinical priority areas, across NHS England and NHS Improvement, particularly through supporting the Sepsis agenda and by informing improvements in community care. It will assist Sustainability and Transformation Planning footprints to develop and deliver Sustainability and Transformation Plans - for which patient safety, and AMR specifically, are included as key priority areas – and local AMR plans (which are being lead and supported by PHE). **Part a) reducing gram negative blood stream infections across the whole health economy** Healthcare-associated Gram-negative bacteraemias (bloodstream

	infections) pose a significant health risk and threat to patient safety. They include infections caused by *Escherichia coli*, and *Pseudomonas aeruginosa.* Rates of bacteraemia caused by GNB vary depending on the bacterial species: • Mandatory surveillance of *Escherichia coli* (*E.coli)* has indicated an alarming rise in rates of *E. coli* bacteraemia (60.4 to 66.2 per 100,000 population from 2012- 2015). • Rates of *Pseudomonas spp*. and *Stenotrophomonas spp*. bacteraemia have decreased steadily. (6.9 to 6.2 per 100,000 and 1.3 to 0.8 per 100,000, respectively, from 2007-2014). • Rates of carbapenemase-producing enterobacteriaceae (CPE) are also increasing within the UK. • Health care acquired infections (HCAIs) associated with multi-drug resistant (MDR) Gram-negative species are of utmost importance due to the difficulties in treatment associated with the limited number of effective antibiotics. E.coli bacteraemia is the largest most prevalent group of GNBSI which supports the QP's focus on these bacteraemia over the next 2 years. The reporting of E.coli BSI is already mandatory (via the PHE DCS system) and this provides data on which to establish a baseline and set reduction targets for 2017/18. Reduction targets should be revised for 2018/19 when (through the work done as part of the 17/18 QP) we will understand where and how greater improvements can be supported. Reduction in other GNBSI should be considered in future years when systems should have been established to capture baseline data. **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care** The age group with the highest rates of E. coli bacteraemia in England were observed amongst the elderly (75 years and over) with 402.9 and 313.5 reports per 100,000 population for males and females respectively. The PHE enhanced data set reported to ARHAI 24-14 (01) for *E coli* BSI (including 3 months of data from 38 acute trusts Nov 2012-Jan 2013, reporting on 891 cases) stated that 50% of cases related to the urogenital tract, and in these 72% occurred in patients >65years, and 64% of patients had reported at least one UTI in the previous 12 months. This supports the focus of this element of the QP. The report states that: *is it clear that a significant proportion of the rise may be due to patients being prescribed inappropriate antibiotics, resulting in relapsing infections. It is important that antimicrobial prescribing is appropriate and effective. However, there remains a difficult balance between the clinical management of UTIs and the empiric prescribing of broad-spectrum antimicrobials due to increasing resistance to narrow spectrum antibiotics which limits available treatment options*. On-going mandatory surveillance continues to identify previous UTIs as a

	key risk factor. This indicator would work to increase the appropriate use of nitrofurantoin as 1st line choice for the empirical management of UTI in primary care settings, and support a reduction in inappropriate prescribing of trimethoprim which is reported to have a significantly higher rate of non-susceptibility in 'at risk' groups; these are defined in PHE Management of Infection Guidelines. Prescribing data also demonstrates the variation in prescribing practice across CCGs and further supports the view that this is an area that requires and is amendable to improvement. **Part C) sustained reduction of inappropriate prescribing in primary** This QP also aims to sustain improvements enabled by the previous QP which successfully delivered a reduction in the prescribing of antibiotics (by 7.3%, 2.6 million prescriptions), including board spectrum antibiotics (which reduced from 3.9m prescriptions in 2014-15 to 3.3m the following year) within primary care. CCGs will be expected to ensure items per STAR-PU are equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU.
Technical definition	**Part a) Reducing gram negative blood stream infections across the whole health economy** i. **A reduction target of 10% in all *E.coli* BSI reported at CCG level - independent of the time of onset of BSI**. Baseline rates will be set using 2016 performance data currently captured via the DCS system and published online. Indicative targets will be made available following publication of 2015/16 infection rates in October 2016. Final targets will be made available following the publication of 2016 data in early 2017. Performance will be measured using FY 2017/18 data. Thresholds will be reviewed for 2018/19 as highlighted above. To support the health economy to achieve this reduction CCGs will need to; ii. **Collect and report a core primary care data set for all *E.coli* BSI in Q2-4 2017/18.** This will require completion of requisite data through the existing PHE DCS reporting system for E.coli BSI and the refined data collection for primary care related aspects. Further details will be available in a following publication. CCGs are expected to use Q1 2017/18 to establish a local approach to capture the core primary care data. **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care.** Individual practice reduction to be decided by the CCG. **i. a 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16). This threshold will be reviewed for 2018/19 as highlighted above.**

	Numerator: Number of prescription items for trimethoprim within the CCG **Denominator:** Number of prescription items for nitrofurantoin within the CCG **Prescribing Data** This information can be obtained from the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. *(NB: this system will be moved to a new platform in January 2017 that will include an Antimicrobial dashboard to support this Quality Premium at CCG level)* 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 the CCG data set. Cost centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement) **ii. a 10% reduction (or greater) in the number of trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16) . This threshold will be reviewed for 2018/19 as highlighted above.** **Numerator:** Number of prescription items for trimethoprim with identifiable NHS number and age 70 years or greater within the CCG **Prescribing Data** This information will be obtained from the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. *(NB. this system will be moved to a new platform in January 2017 that will include an Antimicrobial dashboard to support this Quality Premium at CCG level)* 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 the CCG data set. Cost

	centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement). **Part C) sustained reduction of inappropriate prescribing in primary care** i. items/STAR-PU must be equal to or below England 2013/14 mean performance value of 1.161 items per STAR-PU. This threshold will remain during 2018/19 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) **Prescribing Data** This information can be obtained from the Information Services Portal (ISP) or the electronic Prescribing Analysis and CosT tool (ePACT) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. Further information is available on the Information Services Portal. 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. Cost centres that support Vanguard Integrated Urgent Care Hub prescribing may be excluded from the CCG data set (this can be agreed individually with NHS Improvement).
Data source	**Part a) reducing gram negative blood stream infections across the whole health economy** For this part of the QP, data will be taken from PHE DCS system to both collect data for GNBSI and monitor progress on E coli BSI. This will be on the Fingertips AMR Portal **Part b) reduction of inappropriate antibiotic prescribing for UTI in primary care** The NHSBSA ePACT is moving to a new platform, and this will support reporting of prescription patient age data. The AMS dashboard will be

	developed and this will be pre-populated with relevant information for the CCG. Prescribing data for all elements of this part of the QP will be reported by NHS BSA on a monthly basis as a rolling 12 monthly value.
Published Frequency & Timeliness	**Part A:** The number E.coli BSIs are reported at a CCG level by PHE and published quarterly. Information will be available via the Fingertips AMR Portal. **Part B and C:** Prescribing data is reported monthly at a CCG level by NHSBSA Prescription Services. To support GNBSI QP performance monitoring both GNBSI QP antibiotic indicators will be reported monthly (with existing 3 month lag), as a rolling 12 monthly data set at CCG level. This will be presented in the antibiotic monitoring dashboard published on the NHS England QP web page. This follows the existing system to support the current QP activity. In addition the new ePACT platform on Oracle will allow the development of a dashboard to support CCGs to deliver these elements of the QP. This dashboard will also support the CCG IAF AMR indicators in the current AMR QP which will help support sustained QP activity into 2017-19.