

2019/20 PSS CQUIN Scheme

Indicator Template

[Section B to be completed before insertion in contracts.]

PSS4 Healthy Weight in Adult Secure Mental Health Services

Indicator Name	Achieving Healthy Weight in Adult Secure MH Services
A. SUMMARY of Indicator	
Indicator Sponsors (with email address)	Louise.Davies10@nhs.net rajesh.moholkar@nhs.net Mehdi.Veisi@beh-mht.nhs.uk joanna.brook-tanker@dhuft.nhs.uk
Improving Value Reference	N/A
Duration	2 years (subject to review after 1 year)
CCG Complementarity	N/A
<p>Problem to be addressed (maximum 150 words): <i>[Briefly characterise the shortfall in quality or efficiency that the indicator is designed to address; detailed evidence should be placed in section D1]</i> Causes of obesity for patients in adult secure services are complex with interlinked drivers going beyond just eating habits and physical activity levels and may relate to the physical effects of pharmacological treatment interventions. Developing a service environment and a systems approach to healthy lifestyles that takes account of these complexities and the particular needs of patients is likely to make it easier for patients to achieve and maintain healthy weight during admission and beyond.</p>	
<p>Change sought: <i>[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4.]</i> The indicator has 3 strategic goals</p> <ul style="list-style-type: none"> • To deliver a healthy service environment in adult secure services regardless of security level • To promote and increase healthy lifestyle choices including increased physical activity (in line with expectations set out in NHS England guidance) and healthier eating in all patients in adult secure services • To ensure continuity in approach and promotion of good practice across high, medium and low secure services 	
<p>Specifically: Providers will demonstrate that they</p> <ul style="list-style-type: none"> • Understand why change is required in each service • Can identify the scale and nature of change needed in each service • Can devise an effective change programme and outcome metrics to deliver the action needed in each service • Have robust corporate and service commitment to change with the underpinning governance, communication and involvement systems, processes and structures needed to underpin programme design, delivery and oversight 	

- Can evaluate and understand the outcomes of the service change programme revising it as needed in response

See appendix for guidance on understanding and delivering the change needed.

B. CONTRACT SPECIFIC INFORMATION (for completion locally, using guidance in sections C below)

B1.Provider (see Section C1 for applicability rules)	<i>[Insert name of provider]</i>
B2. Provider Specific Duration. What will be the first Year of Indicator for this provider, and how many years are covered by this contract?	2019/20 2020/21 <i>[Adjust locally]</i> One/two years <i>[Adjust locally]</i>
B3.Indicator Target Payment (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN indicator should achieve payment of: Target Value: <i>[Add locally ££s]</i>

B4. Payment Triggers.

The triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the indicator, are set out in Section C4.

Relevant provider-specific variation, if any, is set out in this table.

[Adjust table as required for this indicator – or delete if no provider-specific information is required.]

Provider specific triggers	2019/20	2020/21
Trigger 1:		
Trigger 2:		

B5. Information Requirements

Obligations under the indicator to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.

Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. <i>[Vary if necessary.]</i>
B6. In Year Payment Phasing & Profiling	
Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.	
<i>[Specify variation of this approach if required]</i>	

C. INDICATOR SPECIFICATION GUIDE: STEP CHANGE INDICATORS		
C1. Providers to whom Applicable		
Nature of Adoption Ambition:	All providers of adult secure services	
List of Providers for whom Indicator is Applicable (NOT EXHAUSTIVE)	2Gether NHS FT Avon & Wilts Partnership Trust Barnet, Enfield & Haringey MH T Birmingham & Solihull MH FT Black Country Partnership FT Bradford District Care NHS FT Bramley Health Cambridgeshire & Peterborough FT Central & North West London FT Cheshire & Wirral Partnership FT Cornwall FT Coventry & Warwickshire Partnership Trust Cygnet Healthcare Derbyshire NHS FT Devon Partnership Trust Dorset Healthcare University FT East London FT Elysium Healthcare Essex Partnership University FT Greater Manchester MH FT Hertfordshire Partnership FT Humber NHS FT Inmind Ltd Kent & Medway Partnership Trust Lancashire Care FT Leeds & York Partnership FT Leicestershire Partnership T Lincolnshire FT Livewell Southwest Ludlow Street Healthcare	Midlands Partnership NHS FT Newbridge Care Systems Norfolk & Suffolk NHS FT North East London NHS FT North West Boroughs NHS FT Northamptonshire NHS FT Northumberland Tyne & Wear FT Nottinghamshire Healthcare FT Oxford Health FT Oxleas NHS FT Partnerships in Care Ltd Priory Group Ltd Pennine Care FT Riverside Healthcare Ltd Rotherham & Doncaster Healthcare FT St Andrews Healthcare St George Healthcare Group St. Magnus Sheffield Health & Social Care FT Somerset Partnership FT Southern Health NHS FT South London & Maudsley FT South West London & St George's MH Trust South West Yorkshire Partnership FT Southern Health FT Sussex Partnership FT Tees Esk & Wear Valley FT The Huntercombe Group The Retreat Hospital West London MH Trust

	Mersey Care NHS Trust	
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C2. Provider Specific Parameters

The indicator requires the following parameters to be set for each provider in advance of contract, to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)

N/A

C3. Calculating the Target Payment for a Provider

The target overall payment for this indicator (the payment if the requirements of the indicator are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

The total value of the scheme is calculated as 1.25% of the baseline value of the provider contract for relevant adult secure services.

Provider payment is split against the scheme triggers in Section C4 below. The % split for each trigger is also set out in Section C4 below.

See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.

C4. Payment Triggers and Partial Achievement Rules

Payment Triggers

The interventions or achievements required for payment under this CQUIN indicator are as follows:

Descriptions	First Year	Second Year
Trigger 1:	Q1 and Q2 Using guidance in appendix, each Provider to <ul style="list-style-type: none"> • Demonstrate robust understanding of why change is needed in each service • Establish baseline service position and identify change required • Develop a co-produced change programme including outcome metrics, delivery mechanisms/approach and resources required to deliver improvements against baseline in each service • Demonstrate corporate and senior service clinical and management team commitment to actions needed and resource requirements • Establish service/organisational governance infrastructure that 	Q1 and Q2 Provider to demonstrate <ul style="list-style-type: none"> • Active implementation of refreshed change programme building on learning from year 1 • Evidence of progress made against programme deliverables including demonstration of changes made at corporate, service and patient level and impact on service baselines • Demonstrate active engagement and involvement in the work of the Adult Secure CRG Healthy Weight Task & Finish Group including its outputs and timeframes for delivery

	<p>includes patient representatives together with the reporting and communication processes needed to oversee and deliver service change programme over years 1 and 2</p> <ul style="list-style-type: none"> • Demonstrate active engagement and involvement in the work of the Adult Secure CRG Healthy Weight Task & Finish Group including its outputs and timeframes for delivery 	
<p>Trigger 2:</p>	<p>Q3 and Q4 Using guidance in the appendix, Provider to demonstrate</p> <ul style="list-style-type: none"> • Active implementation of change programme • Providers to demonstrate they are developing an understanding of what interventions are most likely to drive a healthy weight in this setting considering the advice of dieticians, healthier food provision and uptake (even where this may go beyond normal service requirements as set out in the NHS contract) • Evidence of progress made against programme including demonstration of changes made at corporate, service and patient level and impact on service baselines • Evaluation of impact and refreshed change programme reflecting outcome for implementation from Q1 year 2 • Demonstrate active engagement and involvement in the work of the Adult Secure CRG Healthy Weight Task & Finish Group including its outputs and timeframes for delivery • Annual report by service co-produced with patients, staff and carers/families – reflecting on changes made and impact. Report to contain recommendations for continued action in year 2 	<p>Q3 and Q4 Provider to demonstrate</p> <ul style="list-style-type: none"> • Active implementation of change programme • Evidence of progress made against programme including demonstration of changes made at corporate, service and patient level and impact on service baselines • Demonstrate active engagement and involvement in the work of the Adult Secure CRG Healthy Weight Task & Finish Group including its outputs and timeframes for delivery Final report by service co-produced with patients, staff and carers/families demonstrating impact on service delivery, clinical practice and patient outcomes. • Evidence of corporate and service plan to ensure action and improvement becomes business as usual

Target Payment per Trigger

The following table sets out the Target payment that is payable on achievement of each of the Payment Triggers.

Target Payment per Trigger	First Year of indicator	Second Year
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Trigger 1 (Q1 and Q2)	20% of scheme value	50%
Trigger 2 (Q3 and Q4)	80% of scheme value	50%
TOTAL	100%	100%

Partial achievement rules

Not applicable

Definitions

C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.

For each Quarter

1. Patient scores on Simple Physical Activity Questionnaire (SPAQ), BMI, and Warwick Edinburgh Mental Wellbeing Score (WEMWS) showing changes over time
2. Number of eligible patients receiving lifestyle intervention programme

Reference information included in the Appendix

Reporting of Achievement against Triggers:

Quarterly report to commissioners as part of contract performance monitoring

Information for Benchmarking:

See above for quarterly requirement metrics

Information Governance:

No patient identifiable information to be used in reporting information

Reporting Template requirement:

None

C6. Supporting Guidance and References

Further details on implementation, and references to documents that will support implementation:

See appendix

D. Indicator Justification and Evaluation

D1. Evidence and Rationale for Inclusion

Evidence Supporting Intervention Sought

Current literature indicates that the lives of people with severe mental illness are 10 to 25 years shorter than the general population. Obesity is one of the most significant modifiable

risk factors for premature mortality and chronic disease in individuals with mental illness (1).

The 2017 Public Health England report identified the extent of obesity in adult secure inpatient units with rates of up to 80% reported compared to the general population around 60%. The report highlighted concerns regarding the propensity of secure settings to operate an “obesogenic” environment, thereby contributing to a higher likelihood of developing physical comorbidities (2).

There is also evidence that increased physical activity is linked to reduced duration of poor mental health. One recent study (3) found a relationship between physical activity and the number of days spent admitted to acute inpatient mental health wards in people with severe mental illness based at four acute mental health wards in Oxfordshire, UK. Mean length of stay (LOS) for patients participating in no sessions, one session, two sessions and three sessions of physical activity per week were 127, 83, 32 and 15 respectively. The difference in LOS for individuals with no sessions vs. one session per week was 44 days. Another recent study (4) of 1.2 million people in the USA found that people who exercise report having 1.5 fewer days of poor mental health a month, compared to people who do not exercise. Both studies are cross-sectional in nature, so do not establish causation, nor do they relate directly to a secure setting; however, they match the existing generic body of longitudinal research showing that regular physical activity is associated with better mental health.

The CQUIN seeks to contribute towards achieving the 5-Year Forward View and Long Term Plan’s (<https://www.longtermplan.nhs.uk/>) prevention agenda. It is based on a whole system approach to healthy bodyweight and is an incremental, evolving process intended for long term delivery. Following the PHE report into obesity in adult secure services published in 2017, Rethink Mental Illness facilitated consultations with service users in secure services through the regional Recovery and Outcomes Groups. Key messages from this process included the need for culture change rather than a single discreet intervention and the need for support for individuals to make significant lifestyle changes.

References:

1. Liu NH, Daumit GL, Dua T, Aquila R, Charlson F, Cuijpers P, Druss B, Dudek K, Freeman M, Fujii C, Gaebel W. “Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas.” *World psychiatry*. 2017 Feb;16(1):30-40.
2. Public Health England (2017). *Working together to address obesity in adult mental health secure units: A systematic review of the evidence and a summary of the implications for practice*. London, UK: Public Health England.
3. Korge J, Nunan D. “Higher participation in physical activity is associated with less use of inpatient mental health services: A cross-sectional study.” *Psychiatry research*. 2018 Jan 1;259:550-3.
4. Chekroud s, et al, “Association between physical exercise and mental health in 1·2 million individuals in the USA between 2011 and 2015: a cross-sectional study.” *The Lancet Psychiatry*, September 2018, [https://doi.org/10.1016/S2215-0366\(18\)30227-X](https://doi.org/10.1016/S2215-0366(18)30227-X)

Rationale of Use of CQUIN incentive

CQUIN as an instrument is justified if net costs beyond normal service requirements are incurred by providers whilst benefits and cost savings accrue to patients and commissioners.

Obesity rates are higher in people with mental illness; individuals with schizophrenia have a 2.8 to 3.5 times higher rate, while those with major depressive disorder or bipolar disorder have a 1.2 to 1.5 increased risk of being obese than the general population (2). Being overweight seriously affects people's quality of life and their health. It increases the risk of metabolic abnormalities (metabolic syndrome) resulting in

- 5-6 times increase in type 2 diabetes,
- 3-6 times increased risk of mortality due to cardiovascular diseases including coronary heart disease, and stroke,
- an increased prevalence of non-alcoholic fatty liver disease and some cancers in individuals with mental illness. (3-6).

Reductions in these factors will benefit patients in secure settings in addition to providers and commissioners of secure services and by extension the wider health system.

D2. Indicator Duration and Exit Route

The appropriate duration of an indicator depends upon how long CQUIN support is required before the change in behaviour sought can be embedded in services specification or otherwise.

This scheme is expected to be delivered as business as usual with requirements reflected in NHS England contract from 2021-22.

D3. Justification of Size of Target Payment

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payment covers costs of establishing the scheme and the associated organisational and service structures, processes and delivery mechanisms including training and equipment requirements.

Scheme costs will vary by provider and individual service reflecting organisational differences for example against a single or multi-site provider, linking the value of the scheme to the value of the contract baseline ensures equity in approach.

D4. Evaluation: Approach, data and resources

Evaluation Approach:

Adult Secure CRG Healthy Weight Task and Finish Group to inform approach to final programme evaluation.

Information for Evaluation	To be determined
Resources for Evaluation	To be determined

Appendix

1. Useful reference material

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/591875/obesity_in_mental_health_secure_units.pdf

<https://www.nice.org.uk/guidance/qs111>

<https://www.england.nhs.uk/sugar-action/>

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/595129/Healthier_and_more_sustainable_GBSF_checklist.pdf

<https://www.gov.uk/government/publications/healthier-and-more-sustainable-catering-a-toolkit-for-serving-food-to-adults>

<https://www.longtermplan.nhs.uk/>

https://www.who.int/mental_health/evidence/guidelines_severe_mental_disorders_web_note_2018/en/

Nice cg189: obesity: identification, assessment and management

<https://www.nice.org.uk/guidance/cg189>

NICE PH53 Weight management: lifestyle services for overweight and obese adults

<https://www.nice.org.uk/guidance/ph53>

PHE, A Guide to Commissioning and Delivering Tier 2 Adult Weight Management Services

<https://www.gov.uk/government/publications/adult-weight-management-services-commission-and-provide>

2. Why change is required

Providers should consider the following when demonstrating their understanding of why change is required in each service, the reference documents in the links above should help in framing the approach.

1. Provider should identify where action needed to improve the obesogenic environment in secure settings, for example:

- Addressing food policies such as food and drink provision; patient access to takeaway meals and shop product selection
- Ensuring that there is access to green space and meaningful activities and that appropriate health promotion equipment is in place.

2. Providers to review their approaches to and resources for health promotion including

- health improvement training so that service staff understand and can confidently support lifestyle change interventions as part of delivering holistic health care. Training would include:
 - Eating healthily and achieving a balanced diet
 - Physical activity
 - Mental wellbeing, such as making use of the NHS Making Every Contact Count programme
- Care and planning approaches are co-produced and tailored to the specific needs of patients considering their gender, physical health conditions and associated risks and medication. Plans may include referral to appropriate weight management services.

3. Ideas to support implementation

Providers may wish to consider

- Establishing a healthy living group (HLG) and a physical health monitoring group (PHMG) comprised of patients, carers and clinical and non-clinical staff accountable to the senior management team
- Establishing each service's baseline for
 - Whole dining experience including: expenditure per head, arrangements for/at/outside of meal times, compliance with mandatory hospital food standards, access to non-hospital food and drink including patient shop, take-aways and use of patient leave and types of pre-packed meals/snacks available including less healthy food and drink choices such as sugar-sweetened drinks, savoury snacks, confectionary and pre-packed products labelled as high in fat, saturated fat, sugar or salt
 - Information and support for carers regarding appropriate choices around food and drink they may bring to the unit and provide on home visits
 - BMI, physical and activity indicators for all patients using the Simple Physical Activity Questionnaire (SPAQ a 5-item clinical tool designed to assess physical activity)
 - patient wellbeing scores using existing tool such as HONOS
- Identifying Physical Activity Champions (experts by experience, carers and staff) to enable patients to get active through combination of 1:1 and/or group support
- Identifying quality metrics measuring but not limited to for example
 - Increases in staff knowledge and confidence.

- Improved level of patient uptake in physical activities and healthy food options as measured by the SPAQ, BMI and wellbeing measures

4. Numerator and denominator for assessing sugary drinks and snacks

In line with GBSF and PHE guidance, baseline audit of menus and stock held in patient shop should measure provision of SSBs, confectionery, sweets and pre-packaged food by the following indicators

- a) SSBs: The numerator is the total volume of sugary drinks sold/provided in litres (based on this criterion). The denominator is the total volume of all drinks sold /available in litres
- b) Confectionery and sweets: The numerator is the total amount of confectionery and sweets packets stocked/available over 250kcal. The denominator is the amount of confectionery and sweet packets stocked/available in total (regardless of caloric content)
- c) Pre-packed food: The numerator is the total amount of prepacked sandwiches and other savoury prepacked stocked /available. The denominator is the total amount of prepacked sandwiches and other savoury snacks not meeting these criteria stocked/available.

5. Physical Activity Guidance from Department of Health for Adults

1. Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.
2. Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or combinations of moderate and vigorous intensity activity.
3. Adults should also undertake physical activity to improve muscle strength on at least two days a week.
4. All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.