

**AGENDA ITEM: 8**

<h1>Governing Body</h1>	<h1>REPORT</h1>
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<b>Subject</b>	Integrated Quality, Safety and Performance Report
<b>Date</b>	Thursday, 6 <sup>th</sup> July 2017
<b>Author</b>	Carol Davies – Head of Performance
<b>Lead Director</b>	Anne Murray – Director of Nursing & Quality Donna Derby – Director of Commissioning & Performance

**Executive Summary**  
 This report shows the latest position across a range of national and local indicators and includes analysis of the performance and identifies remedial action being taken to improve delivery and subsequently improving the services and health outcomes for the population of Bedfordshire.

Where applicable graphs are included to show performance across the top 6 acute providers together with performance for the CCG.

A further update has been included on the concerns raised regarding Milton Park which provides services for people with autism, mental health and learning disabilities following a meeting held on 15<sup>th</sup> June 2017.

The report also includes the financial progress against the 2016/17 Quality Premium. This scheme is to reward CCGs for improvements in the quality of services that are commissioned. The scheme incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services.

The Quality Premium for 2017/18 and 2018/19 is a 2 year scheme and the report includes the detail of the indicators and the corresponding Quality Premium value. A dashboard and commentary showing progress of the indicators is included.

**Recommendation**  
 The Committee is asked to review and note the contents of the report and to recommend any further action.

**Links to the business and risks**

<b>Relevant Strategic Objectives (please mark in bold)</b>		
Making sure that care is high quality, safe and sustainable, that it improves health outcomes and wellbeing and	Using the statutory framework with best practice governance and transparency principles to be fully	

provides a good patient experience.	accountable to our population in commissioning and operating as a part of the wider health system	
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<b>Links to Board Assurance Framework / Corporate Risk Register</b>	<i>Risks are identified and included in the Commissioning Directorate Risk Register. Risks with a residual overall score greater than 15 are escalated to the Corporate Risk Register.</i>
<b>Details of additional risks associated with this paper (may include NHS England Assurance Framework / NHS Constitution)</b>	<i>This paper outlines risks to the NHS Constitution and includes mitigating actions.</i>
<b>Financial Implications / impact</b>	<i>This report includes an update against the latest financial position for the 2016/17 &amp; 2017/18 Quality Premium. This update is also reported to the Finance and Performance Committee.</i>
<b>Legal Implications / impact</b>	<i>Patients have a right to treatment under the NHS Constitution and this report provides an update on performance against these indicators.</i>
<b>Partnership work / public engagement implications / impact</b>	<i>Not applicable</i>
<b>Committees / groups where this has been discussed before</b>	<i>Regular updates are presented and discussed at the Quality Operational meetings, Finance and Performance Committee, Integrated Commissioning and Quality Committee and Governing Body.</i>
<b>Other options available and their pros and cons</b>	<i>Not applicable</i>
<b>Background papers</b>	<i>Regular monthly updates</i>

# 1.NHS CONSTITUTIONAL INDICATORS 2017/18 - CCG

Performance Against NHS Constitutional Pledges						Q1 16/17				Q2 16/17				Q3 16/17				Q4 16/17			
KPI Code	BCCG Indicator Level	Plan	Latest Data	Reporting Period	YTD	Trend	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18			
E.B.6	Cancer 2 week waits following urgent GP referral for suspected cancer	93%	94.53%	Apr-17	95.18%	*↓	🟢	🟢	🟢	🟢											
E.B.7	Cancer 2 week waits - Breast Symptomatic where cancer not initially suspected	93%	94.25%	Apr-17	94.85%	*↓	🟢	🟢	🟢	🟢											
E.B.8	Cancer 31 day - 1st definitive treatment from diagnosis	96%	95.45%	Apr-17	97.73%	*↓	🟢	🟢	🟢	🟢											
E.B.9	Cancer 31 day - Subsequent treatment for cancer - Surgery	94%	100.00%	Apr-17	96.77%	*↑	🟢	🟢	🟢	🟢											
E.B.10	Cancer 31 day - Subsequent treatment for cancer - Drugs	98%	100.00%	Apr-17	99.46%	*↑	🟢	🟢	🟢	🟢											
E.B.11	Cancer 31 day - Subsequent treatment - Radiotherapy	94%	91.18%	Apr-17	95.67%	*↓	🟢	🟢	🟢	🟢											
E.B.12	Cancer 62 days - 1st treatment following an urgent GP referral	85%	84.91%	Apr-17	81.67%	*↑	🟡	🟡	🟡	🟡											
E.B.13	Cancer 62 days - 1st treatment following referral from Screening Service	90%	100.00%	Apr-17	91.18%	*↔	🔴	🟢	🟢	🟢											
E.B.14	Cancer 62 days - 1st treatment following consultants decision to upgrade		100.00%	Apr-17	93.65%	*↑															
E.B.15.i	Ambulance Category A - Red 1 ( immediate life threatening and most time critical) response arriving within 8 mins - commissioner	75%	78.91%	Apr-17	78.91%	↑	🟡	🟢	🟢	🟢											
E.B.15.ii	Ambulance Category A - Red 2 (life threatening and less time critical than Red 1) response arriving within 8 mins - commissioner	75%	69.11%	Apr-17	69.11%	↓	🔴	🔴	🟡	🔴											
E.B.16	Ambulance Category A ambulance arrival within 19 mins - commissioner	95%	94.77%	Apr-17	94.77%	↓	🟡	🟢	🟢	🟢											
E.B.S.3	CPA follow up within 7 days of discharge from psychiatric in-patient care	95%	98.40%	Q4 16/17	96.83%	↓	🟢	🟢	🟢	🟢											
E.B.1	18 week Referral to Treatment for completed admitted patients	90%	83.58%	Apr-17	83.58%	↑															
E.B.2	18 week Referral to Treatment for completed non admitted patients	95%	90.83%	Apr-17	90.83%	↓															
E.B.3	18 week Referral to Treatment - Incomplete pathway	92%	92.38%	Apr-17	92.38%	↓	🟢	🟢	🟢	🟢											
E.B.S.4.i	52 week referral for completed admitted pathways	0	1	Apr-17	1	↑															
E.B.S.4.ii	52 week referral for completed non-admitted pathways	0	19	Apr-17	19	↓															
E.B.S.4.iii	52 week referral for incomplete pathways	0	0	Apr-17	0	↑	🔴	🔴	🔴	🔴											
E.B.4	Diagnostic tests - % of patients waiting 6 wks or more	99%	99.24%	Apr-17	99.24%	↓	🟢	🟢	🟢	🟢											
E.B.5	A&E 4 hour wait (7 Providers)	95%	95.47%	Apr-17	95.47%	↑	🟡	🟡	🟡	🟡											
E.B.S.1	Mixed-sex accommodation breaches	0	0	Apr-17	0	↑	🟢	🟢	🟢	🟡											
E.B.S.2	Cancelled operations on or after day of admission and not offered another date within 28 days	0	1	Q4 16/17	14	↑	🔴	🔴	🔴	🔴											
E.B.S.6	Urgent Operations cancelled for a second time	0	0	Apr-17	0	↔	🟢	🟢	🟢	🟢											

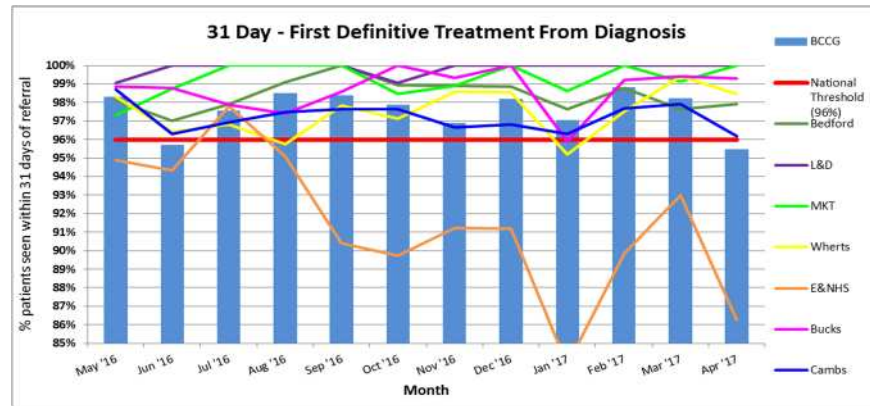
Please note that data is ragged Green if an indicator has been achieved or over-achieved, Amber if it has under-achieved within 5% of the achievement level and Red if it has under-achieved over the 5% threshold. The trend arrows indicate whether performance against the previous month / quarter is showing an improved, worsened or equal position. The colour of the arrows relate to the above ragging for the latest reported period. \* Cancer Year to Date position reflects validated Qtr. 4 and the trend arrow reflects previous month position.

## 1.1 Cancer

There are 8 national cancer waiting time indicators with nationally set thresholds together with 1 additional indicator - 62 day 1st treatment following a consultant decision to upgrade. There is no national threshold for upgrade however data is available at CCG level and will continue to be included on the performance dashboard for information.

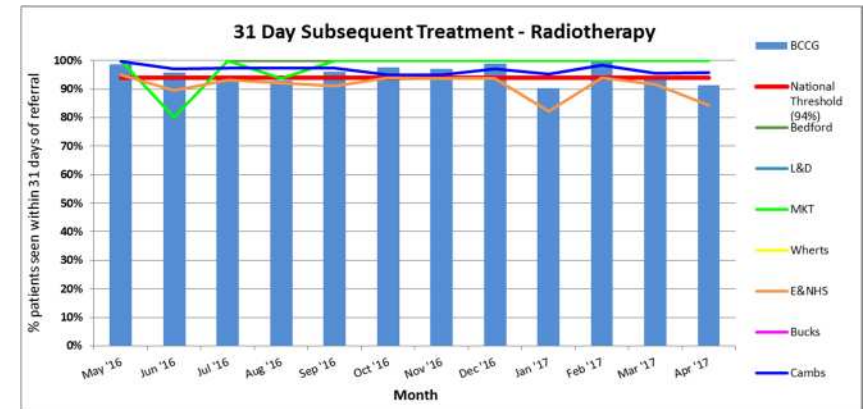
In April the CCG achieved 5 of the 8 key national cancer indicators. 31 day first treatment following diagnosis, 31 day subsequent treatment for radiotherapy and 62 day first treatment following an urgent GP referral all underachieved.

### 31 day 1st definitive treatment following diagnosis – 95.45%



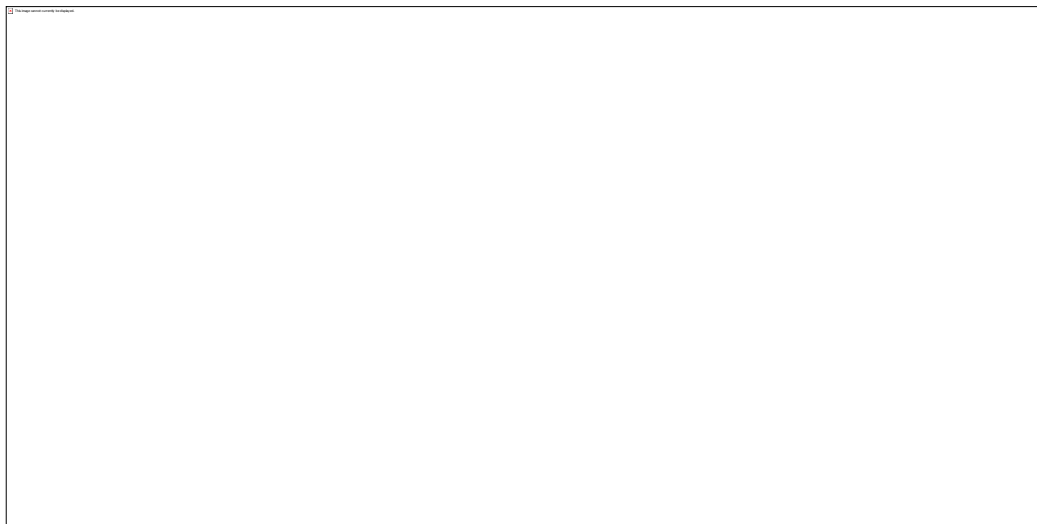
Of the 176 patients seen on this pathway 8 were outside the 31 day threshold, 5 of which were at East & North Herts, 2 at Bedford and 1 Cambridge. 5 breaches were due to capacity issues, 1 patient choice, 1 provider delay and 1 medical delay.

### 31 day subsequent treatment for radiotherapy – 91.18%



Of the 68 patients seen on this pathway 6 were outside the 31 day threshold, 5 at East and North Hertfordshire and 1 at Cambridge. 2 of the breaches were due to capacity issues, 2 patient choice, 1 provider delay and 1 complex pathway.

## 62 Day First Treatment following an Urgent GP Referral – 84.91%



As part of the NHS Improvement and NHS England regional cancer recovery plan a number of actions have been agreed across the region in relation to the reporting and review of long waiting patients. All acute Trusts and CCGs have been asked to routinely report the number of 62+ day and 104+ day breaches along with outcomes and learning themes to Governing Body meetings.

There were 3 104+ day breaches in April. 2 of these were at Luton & Dunstable/East and North Herts on the Urology pathway and the patients started treatment on days 105 and 111. The third breach was at East & North Herts also on the Urology pathway and the patient started treatment on day 112. All patients received active and effective treatment despite having co-morbidities.

Of the 106 patients seen on the pathway 16 breached the threshold. 6 of the breaches were at Bedford Hospital, 3 at Luton & Dunstable, 3 at East & North Herts and 1 each at Cambridge, Buckinghamshire, Milton Keynes and North West Anglia NHS Foundation Trust. 6 of the breaches were due to provider delays, 4 due to late referrals, 4 were complex cases and 2 were due to capacity issues.

Bedford Hospital have an improvement plan in order to deliver against the national threshold Key ongoing issues are around geographical complexities, imaging capacity, access for radiotherapy, complex patients and long delays at tertiary centres for prostate and lung patients.

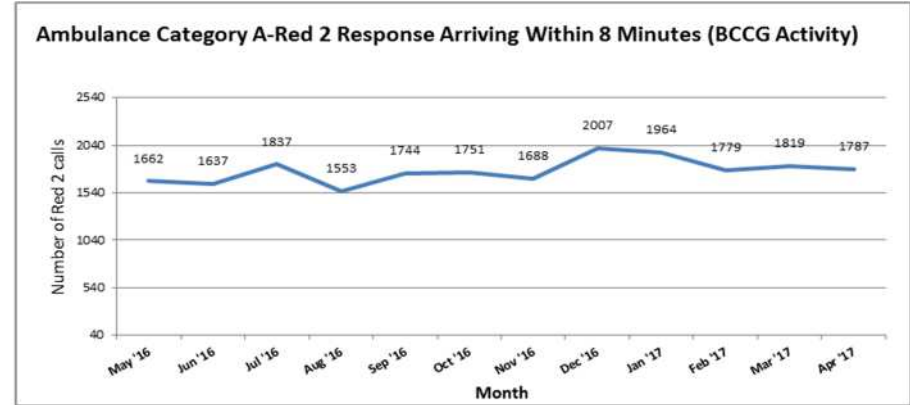
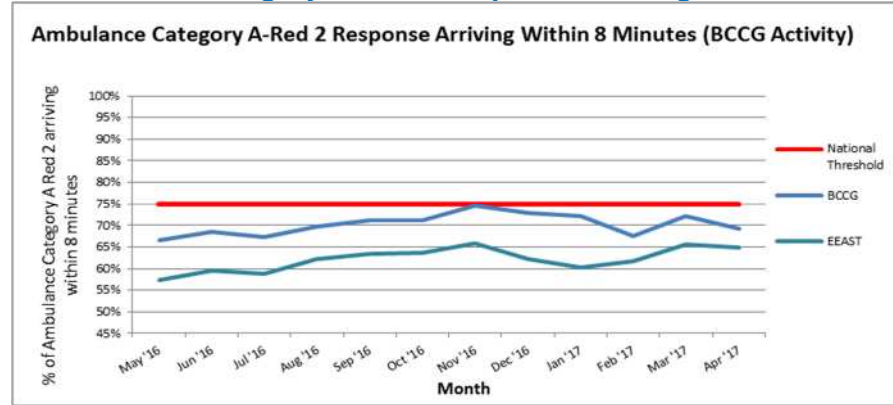
There are a number of actions that are being taken to improve performance:

- Ongoing clinical review of GP referrals to determine appropriateness and quality of referral completed
- National radiotherapy review underway with Bedfordshire specific issues raised with NHSE Specialist Commissioning undertaking further analysis on treatment pathways and performance data at tertiary centres.
- CCG monthly Cancer Improvement Group in place with management leads from Bedford and Luton & Dunstable which monitors performance, review of recovery plans, early warning signs and review of long waiters.

## 1.2 Ambulance Response Times

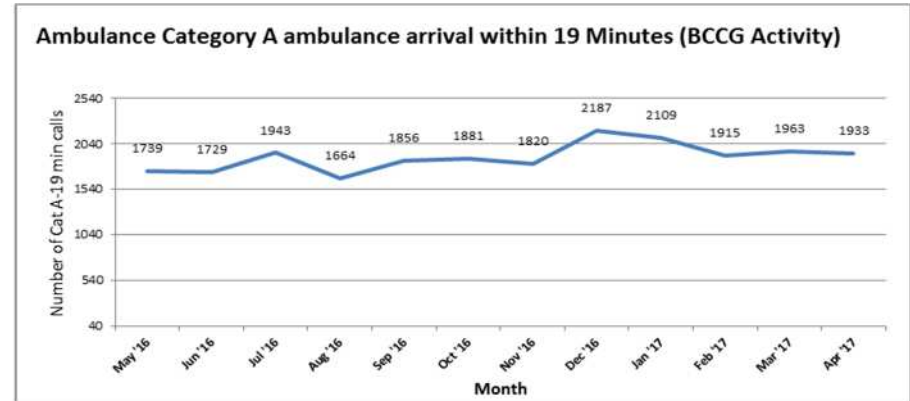
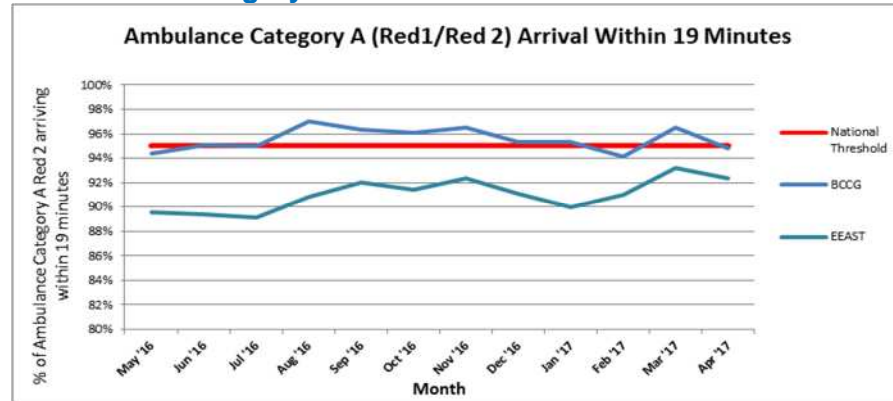
In April the CCG underachieved against Category A Red 2 8 minute and Category A 19 minutes responses. All response targets were underachieved for EEAST – East of England Ambulance Service.

### Ambulance - Category A Red 2 response arriving within 8 minutes – 69.11%



For Cat A Red 2 8 minutes there were 1787 responses of which 1235 arrived within 8 minutes. There was a 6% decrease in activity (112) and there was also a 5% (76) increase in the achievement of the 8 min threshold. Activity per day was marginally up compared to March (approximately 1 call a day) but performance has deteriorated from 72.07% in March to 69.11% in April. Compared to the same period last year there is a 6.75% increase in Red 2 activity and there has been a 21.44% increase in compliant responses compared to 12 months ago.

### Ambulance Category A ambulance arrival within 19 minutes – 94.77%



For Cat A 19 minutes there were 1933 response of which 1832 arrived within 19 minutes. There was a 1.5% decrease in activity (30) and in the number of patients achieving 3% (61) the 19 minute threshold. Both the CCG and EEAST saw a decline in performance and failed to achieve the 95% standard. There was a 1.71% drop in compliant responses compared to previous month.

## Ambulance Performance Update

The main reason for the above underperformance is due to local ambulances being diverted across the region as a result of ambulance delays at Watford General Hospital (WGT). A recovery action plan is in place with WGT and this is monitored by NHS England and NHS Improvement.

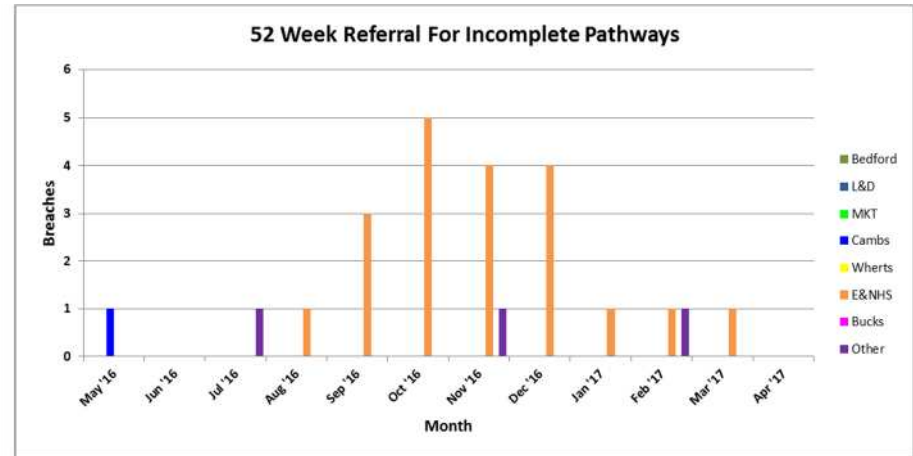
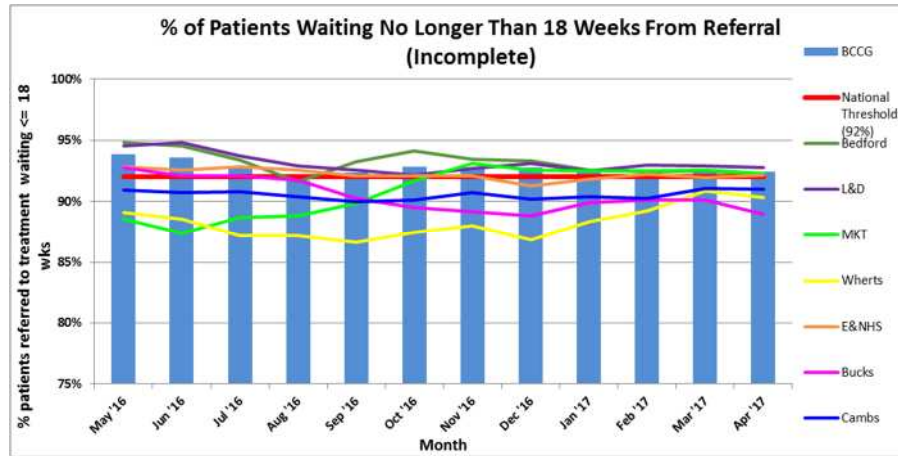
As outlined in the Bedfordshire Urgent and Emergency Care Strategy, the integration of services is imperative to the successful provision of urgent and emergency care for patients across the Bedfordshire system. In line with the national direction, and in support of STP delivery, the A&E Delivery Board continues to focus on this approach for local programmes during 2017/18 and 2018/19.

One of the 7 key priorities is Ambulance. This priority aims to deliver a more equitable and clinically focused response for patients along with faster recognition of life threatening conditions. This will include telephone advice (Hear & Treat), treatment on scene (See & Treat), and conveyance to hospital or use of alternative pathways. Local trajectories for Hear & Treat and See & Treat have been agreed. In support of this priority EEAST are involved with 2 elements of the Ambulance Response Programme (ARP); Nature of Care – a pre-triage set of questions to identify those patients in need of the fastest response and Dispatch on Disposition – dispatch of the most clinically appropriate vehicle to each patient within a timeframe that meets their clinical need.

As part of the Urgent and Emergency Care delivery work, new protocols will be worked up for the care/residential homes with the aim of reducing the current level of calls. There has been an ongoing issue around the volume of activity from these homes. One of the projects going forward will be to work with EEAST care / residential homes to develop and embed these protocols.

A further area of concern that will form part of the Urgent and Emergency Care delivery work is the high level of GP Urgent calls. Work is ongoing with EEAST to develop a comprehensive dataset to identify which practices have the highest volume of calls. The CCG will then work with those practices to identify the reasons and put in mitigating actions to lower activity. The timing of these calls is also an issue with the majority of the calls coming in between 1 and 9pm. In some cases this will result in an influx of ambulances arriving at the hospital at the same time putting pressure on the ambulance trust, the emergency department, the 4hr wait measure and patient flow.

### 1.3 18 Week Referral to Treatment (RTT) (including 52+ week breaches) – 92.38%



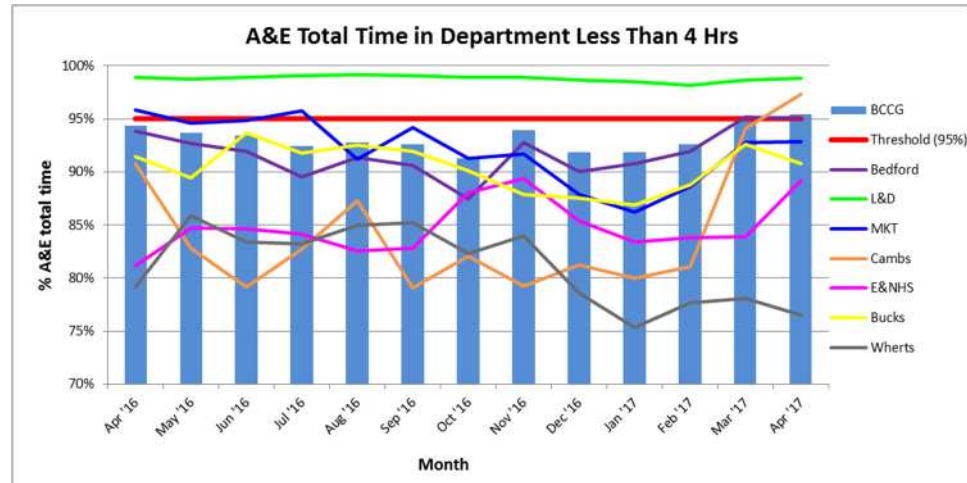
In April the CCG achieved the national threshold for the incomplete pathway with 92.38% however this is a slightly worsening position on March. There were 6 specialties which underachieved; General Surgery at 89.9%, Ophthalmology at 84.69%, Trauma and Orthopaedics (T&O) at 86.52%, Urology 91.76%, Cardiothoracic Surgery at 83.33% and Urology at 91.76%. The CCG has 1922 patients on the incomplete pathway who have breached 18+ weeks. Bedford (944), Luton & Dunstable (363), East & North Hertfordshire (104), Milton Keynes (82), Buckinghamshire (121), Cambridge (125) and Others (183). Of the CCG's top 6 providers Bedford, Luton & Dunstable, East & North Herts and Milton Keynes achieved the aggregate threshold. The number of 18+ breaches rose in April to 1922 from 1845 in March.

Bedford Hospital achieved at an aggregate level for BCCG patients however 4 specialties were underachieved (number of 18+ week breaches in brackets): General Surgery (34), Neurology (81), Trauma and Orthopaedics (83), Ophthalmology (510). The main area of pressure continues to be in Ophthalmology and a recovery plan is in place with an expectation that the threshold will be achieved in September. The Trust has also raised a concern around capacity in Neurology due to an increase in GP referrals. The CCG is working in partnership with the Trust to review disease specific pathways for Neurology to determine opportunities for service provision and management of increasing demand. Bedford have signalled an early warning on Dermatology RTT due to rising demand, this is particularly relevant as the current Community Dermatology Service is transferring from Optum to the Trust from 1st August 2017 on an 18 month pilot period. The CCG is actively working with the Trust to ensure mitigating actions are in place and the new service makes the best use of available resources.

#### 52+ Week Breaches

In April there were no 52+ week breaches reported for the CCG.

## 1.4 A&E – 4 hour wait – 95.47%



The CCG is measured on performance at the main 7 acute providers. In April the CCG achieved the 95% national threshold with 95.47%.

Bedford Hospital – 95.02%  
 Luton & Dunstable – 98.8%  
 East & North Herts – 89.24%  
 Cambridge – 97.32%  
 Buckinghamshire – 90.75%  
 Milton Keynes – 92.9%  
 North West Anglia (Hinchingbrooke) – 87.7%

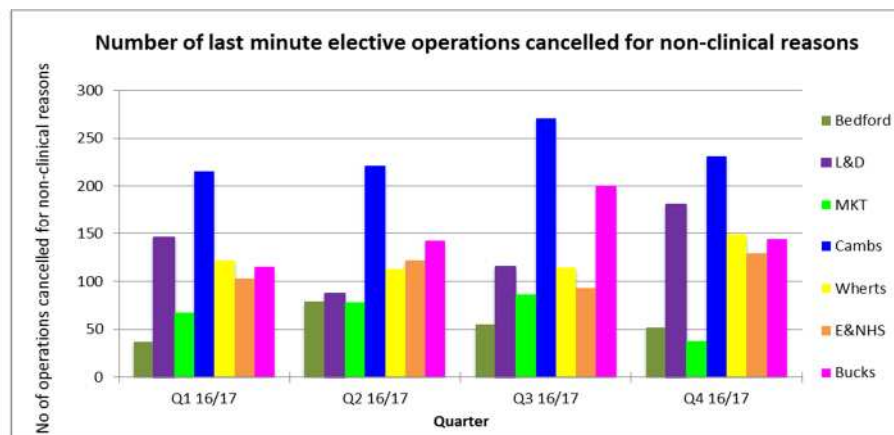
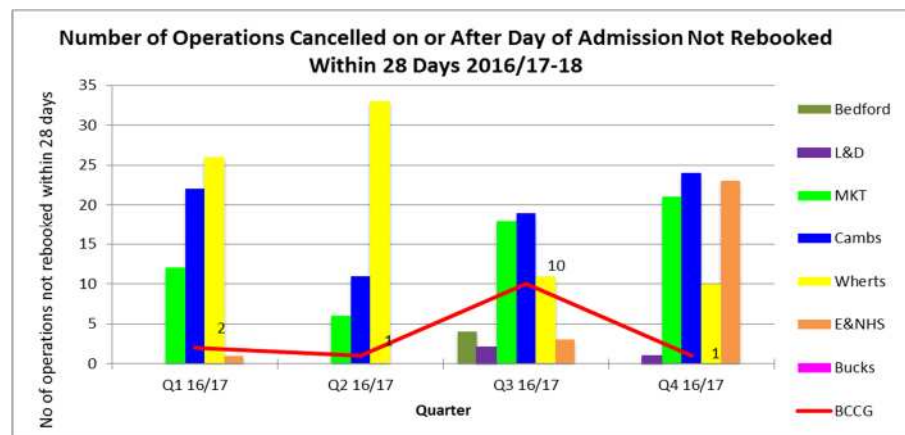
Following the release of the Next Steps Five Year Forward View, the key requirements and the Urgent & Emergency Care Delivery Plan were presented to the Bedford A&E Delivery Board in May. To support the delivery of the national requirements an operational plan is in development with key partner organisations which will form a 'living part' of the Urgent and Emergency Care Strategy.

In June, the Bedford A&E Delivery Board agreed that in order for the requirements set out in the 7 key elements and the 8 high impact changes to be delivered that a new A&E Delivery Board Operational Group will be set up to meet monthly to monitor and review the Operational Plan and report back to A&E Delivery Board partners, summarising monthly position on achievement against the national mandate for 17/18. This will be effective from July 2017.

The Integrated Urgent Care service went live on 30<sup>th</sup> March across Bedfordshire and Luton bringing together 111 and Out of hours services, along with a Clinical Advisory Service. This means that patients who call 111 who are identified as needing further assessment and/or treatment for a non-life threatening condition will received this via an appropriate clinician as part of the same call.

The CCG has now awarded the Urgent Primary Care Service (UPCS) contract which will commence on 1<sup>st</sup> September 2017. This service will provide patients with the most appropriate care for their urgent primary care needs with the aim of reducing the number of inappropriate attendances at Bedford Hospital Emergency Department

## 1.5 Elective Operations cancelled on or after day of admission for non-clinical reasons not been rebooked within 28 days



BCCG Patients					
Provider	Q1	Q2	Q3	Q4	Q4 Trust Wide Breaches
Bedford	0	0	4	0	0
Buckinghamshire	0	0	0	0	0
Cambridge	1	0	3	1	24
East & North Herts	0	0	0	Awaiting confirmation	23
Luton & Dunstable	0	0	0	0	1
Milton Keynes	1	1	3	0	21
West Hertfordshire	0	0	0	0	10

In Quarter 4 the CCG has had confirmation that there has been 1 patient who had their elective operations cancelled on or after day of admission and not rebooked within 28 days. This patient has now been treated.

The breach was at Cambridge and the Trust have confirmed this was a colorectal patient cancelled on the day on 24<sup>th</sup> January due to bed shortages resulting from emergency care pressures. The patient was rescheduled as soon as possible in accordance with clinical priority and was treated on 3<sup>rd</sup> March 2017. As this was a secondary surgery as part of an ongoing treatment plan it was not clinically appropriate to offer an alternative provider for this patient.

The CCG are still awaiting confirmation from East & North Herts as to whether any of the 23 breaches at the Trust were Bedfordshire patients.

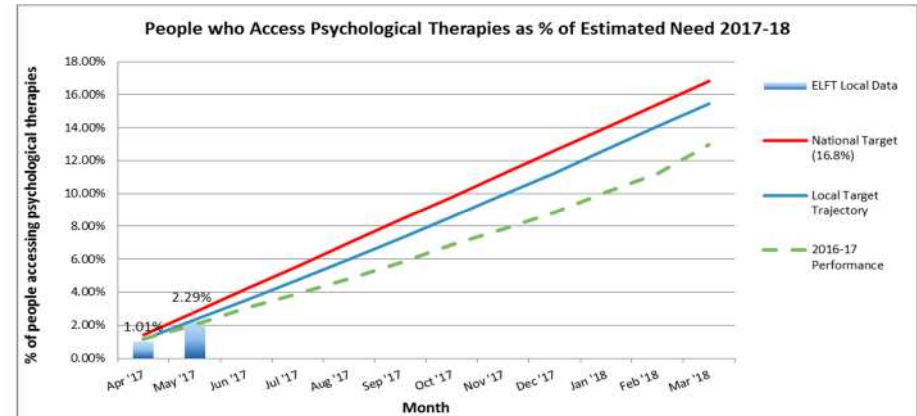
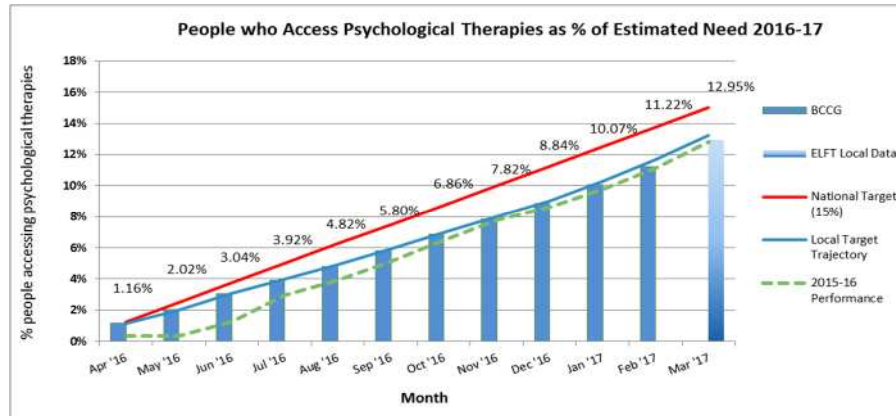
## 2. ADDITIONAL QUALITY INDICATORS WITH EXCEPTIONS

Additional Quality Indicators														
KPI Code	Indicators	Plan	Latest Data	Reporting Period	YTD	Trend	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
E.A.3	IAPT - access rate	15%	1.16%	Feb-17	11.22%	↓	🟡	🟡	🔴					
E.A.S.2	IAPT - people who completed treatment and are moving to recovery	50%	53.66%	Feb-17	48.67%	↑	🟢	🟡	🔴					
E.H.1_A1	% people referred to IAPT programme treated within 6 weeks of referral	75%	95.92%	Feb-17	65.08%	↑	🔴	🔴	🟢					
E.H.1_A2	% people referred to IAPT programme treated within 18 weeks of referral	95%	100.00%	Feb-17	91.63%	↔	🔴	🟡	🟢					
E.A.S.1	Estimated diagnosis rate for people with dementia - Primary Care	67%	59.77%	Apr-17	59.77%	↓	🔴	🔴	🔴	🔴				
E.A.S.4	Number of MRSA incidents	0	0	Apr-17	0	↑	🟢	🟢	🔴	🔴				
E.A.S.5	Number of C-Difficile incidents	73	6	Apr-17	6	↓	🟢	🔴	🔴	🟢				

Please note that data is ragged Green if an indicator has been achieved or over-achieved, Amber if it has under-achieved within 5% of the achievement level and Red if it has under-achieved over the 5% threshold. The trend arrows indicate whether performance against the previous month / quarter is showing an improved, worsened or equal position. The colour of the arrows relate to the above ragging for the latest reported period.

For IAPT indicators the dashboard above reflects the latest national performance. More current local data is included in the IAPT reporting.

## 2.1 Improving Access to Psychological Therapies – Entering Treatment – 2.29% (Local data)



In response to a Contract Performance Notice East London Foundation Trust (ELFT) agreed a revised trajectory of 13.20% to be achieved by 2016/17 year end. Local data from the Trust shows an achievement of 13.21% however there are a number of discrepancies between the local and national datasets. The above chart is based on national data April 2016 - February 2017 and local data for March 2017 and this shows performance at 12.95% however once national data for March is available this achievement could reduce as national figures are always lower than local figures for the following reasons :

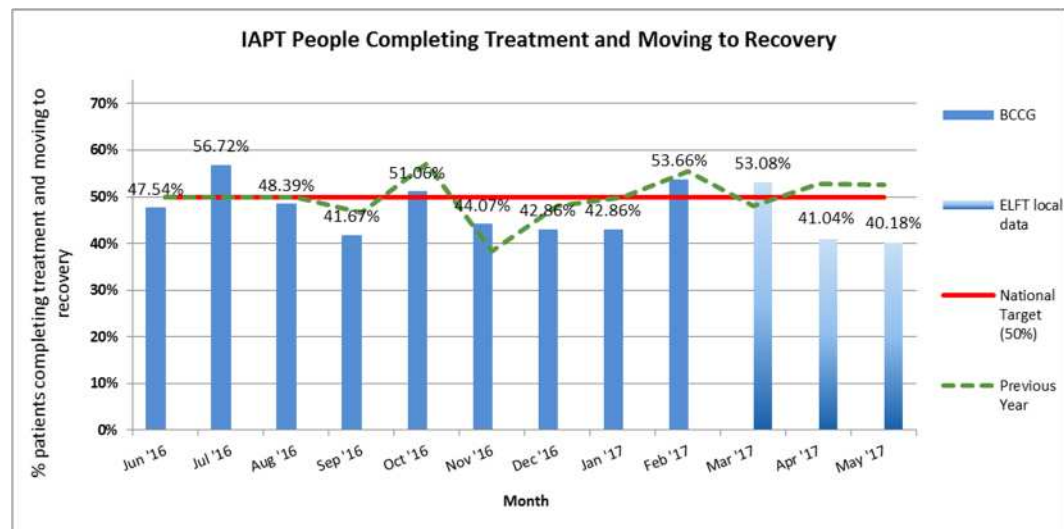
- The national data is rounded up and down to the nearest 5 so will in effect never match the local data.
- Patients can opt out of their data being flowed to the national data, so any performance related to these group would not show in the published data.
- There are a very small number of cases that are decoupled due to errors in recording or errors in processing due to the method of data pseudonymisation.

In 2017/18 the national threshold rises from 15% to 16.8% and following discussion with ELFT the current plan has been set to achieve 15.45%. Monthly thresholds are in place to deliver against the 15.45% however April saw 1.01% of patients entering treatment which is under the agreed threshold for the month of 1.17%. The two bank holidays in the month have contributed to the drop in referrals into the service. Latest local data for May is showing 1.28% giving a year to date position of 2.29% against the agreed threshold of 2.34%.

The CCG Musculoskeletal Services now includes a pathway into the Wellbeing Service and referrals are being monitored through both contracts. The CCG diabetes services are currently being redesigned and work to scope psychology requirements within the contract is underway to link in the Wellbeing Service. The IAPT Provider has already met with the current Diabetes Service to promote referrals to psychological therapies.

The Wellbeing Service with support from CCG Commissioners continue to promote the service across the County working with Acute Hospitals, Community Services, Local Authorities and Voluntary Sector Services.

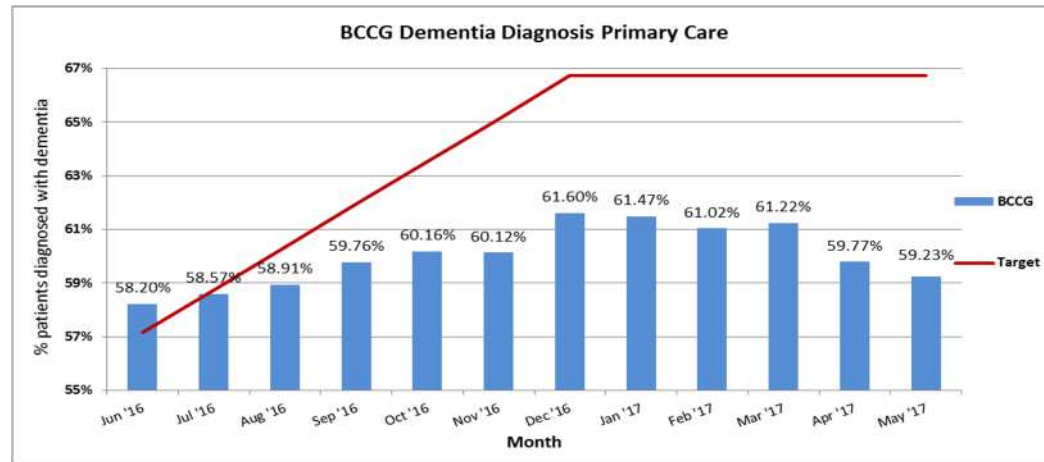
## 2.2 Improving Access to Psychological Therapies – Moving to Recovery 40.18% - (local data)



There has been a deterioration in moving to recovery since April and this has been raised with ELFT who have confirmed that a number of strategies have been put in place to focus on improving the recovery within the service:

- Patients are requesting 1:1 treatment, which does not utilise the stepped care model which promotes recovery. The service is working hard to encourage referrers to focus on methods of treatment such as Computerised Cognitive Behaviour Therapy (CCBT), webinars, guided self-help and group programmes.
- The service is reviewing the management structures and implementing protocols to ensure that all cases are discussed before discharge to ensure that patients have had maximum benefit from the service.
- The service is revisiting the group strategy and is recruiting to a group lead who will coordinate and supervise the group program. Group Cognitive Behaviour Therapy (CBT) can be as effective as individual CBT and the service will encourage clients to access treatment and recovery groups such as mindfulness.
- The service is currently undergoing training in delivering group work to improve outcomes and will have a supportive supervision structure in place.
- The service is also examining the dropout rate and is analysing the waiting times to first treatment. One identified intervention would be the implementation of an early group treatment to help reduce drop outs by engaging clients in treatment within a few days of triage.

## 2.3 Dementia Diagnosis Rate – 59.23%



In 2017/18 there has been a change in the way the prevalence figure is calculated moving away from the Office of National Statistics resident population figure and is now calculated using the GP registered population figures. This data will fluctuate during the course of the year and is likely to be different each month which will make it more difficult to monitor progress against this national indicator. In April there were 2948 patients aged 65+ who had a diagnosis for dementia against a GP registered population of 4932. The number of patients with a diagnosis reduced in May down to 2932 however there was a rise in the GP registered population to 4950 which gives a May position of 59.23%.

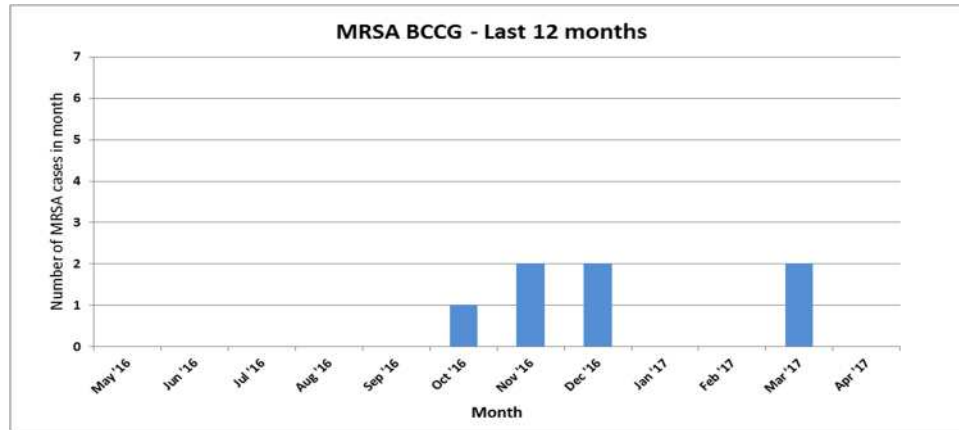
The new referral form for GPs to refer to the memory assessment service (MAS) is now complete and has been tested by the CCG GP clinical lead. The aim is to make it easier for GPs to refer to the memory assessment service.

There has been an increase in the number of people coming out of the MAS with a diagnosis of Mild Cognitive Impairment (MCI) rather than a diagnosis of dementia. The CCG convened a meeting with ELFT on the 6th April to discuss a mechanism to formalise the follow up of (MCI) patients as a proportion of those diagnosed with a MCI will go on to develop a dementia. There is a significantly higher risk if the patient has a long term condition.

The shared care protocol currently in place would need to be reviewed and the CCG clinical lead is arranging visits with the CCG localities to advance this piece of work.

The CCG is researching a screening tool for healthcare professionals to identify the earliest signs of clinically relevant memory impairment and to differentiate this from depression. This tool will either reassure patients or ensure they are referred for further investigations in a timely manner. The CCG has held an initial telephone conference with CANTAB and have invited them to demonstrate the technology.

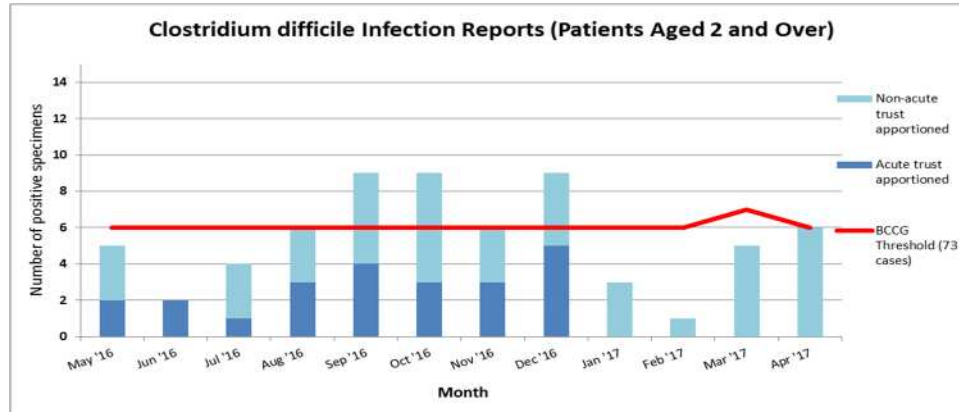
## 2.4 MRSA



The CCG has had zero cases of MRSA reported in April. However one case has been reported in May at Watford General Hospital. This has been initially assigned as Third Party.

All cases of MRSA bacteraemia are finally assigned following a full post infection review and if no lapse in care is identified the CCG can request that the case is assigned to third party. The case remains on the CCG figures for the year but is apportioned to third party – no lapse in care.

## 2.5 Clostridium Difficile



In April there were 6 cases reported against the threshold of 6 for the month. All cases were non-acute apportioned.

Bedford Hospital had 1 case in April against a year end ceiling of 10 and Luton & Dunstable have had 2 cases against a year end ceiling of 6.

## 2.6 Milton Park

Milton Park located within Bedfordshire, provides services for people with autism, mental health and learning disabilities and has for considerable time had low level safeguarding concerns reported, however recently a number have been raised to safeguarding investigation. As the host CCG there is a requirement to collate any information of concern, and share this with NHSE and the funding authorities commissioning placements at the service however the CCG is not responsible for monitoring the service on behalf of other commissioners. BCCG regularly updates NHSE and the concerns are also reported and discussed at the Quality Surveillance Group. The Care Quality Commission (CQC) has inspected the service and noted some improvements however overall the service remains inadequate.

Due to an increased level of concern being raised by BCCG, a risk summit took place on 20<sup>th</sup> February 2017 and the action plan that was already in place in response to the CQC inspection findings has been combined to include the actions from the risk summit. A further NHSE Oversight Group took place on 3 April 2017 with clear actions for Milton Park to complete. The action plan is monitored through the NHSE Oversight Group and shared with the CCG. A further meeting was held on 15<sup>th</sup> June to review and establish revised processes for managing information of concern and safeguarding alerts. Regular meetings have been set up to monitor this which includes a review of safeguarding alerts to identify themes and trends. Overall there is a notable improvement in the communication and transparency from within the provider who are very open to support from, and working with, partner agencies to drive change and quality improvements within the service.

BCCG continue to act as the coordinating CCG, but with revised governance arrangements between the service and placing commissioners to enable more comprehensive overview.

### 3. QUALITY PREMIUM 2016/17

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. The Quality Premium is based on the measures outlined below and cover a combination of national and local priorities agreed in partnership with both Health and Wellbeing Boards. It is important to note that a CCG will not be eligible for any payment if it is not considered to have operated in a manner that is consistent with Managing Public Money or ends the financial year with an adverse variance against planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position or incurs a qualified audit report. It should be noted however that the CCG is duty bound to work towards achieving the measures and will be monitored against their achievement.

Bedfordshire CCG Quality Premium Dashboard											
CCG Quality Premium (Potential Funding)					£2,223,565						
Forecast CCG Quality Premium (iii)					£333,535						
Additions		(Eligible QP funding)			£667,070						
Deductions		(from Eligible QP funding)			£333,535						
Quality Premium Indicators 16/17				% of Quality Premium available if Indicator is achieved		Plan	Latest Data	Reporting Period	YTD	Trend	
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. The Quality Premium for 2016/17 will be based on the measures outlined below and cover a combination of national and local priorities agreed in partnership with both Health and Wellbeing Boards.											
National Indicators - Additions				Weighting	Value	Eligible					
New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed				20%	£444,713		60.00%	58.50%	2014		
Increase in the proportion of GP referrals made by e-referrals - March 2017 performance to exceed March 2016 performance by 20 percentage points (March 2016 - 16.46%)				20%	£444,713		36.46%	24.33%	Mar-17	↑	
Overall experience of making a GP appointment - Improvement on July 2016 survey result (75.25%)				20%	£444,713		78.38%	75.25%	Jul-16		
Reduction in the number of antibiotics prescribed in primary care				5%	£111,178	£111,178	<=1.161	1.086	Mar-17	↑	
Reduction in the proportion of broad spectrum antibiotics prescribed in primary care				5%	£111,178	£111,178	<=10	8.9	Mar-17	↔	
Local Indicators - Additions							Plan	Latest Data	Reporting Period	YTD	Trend
Mental health admissions to secondary mental health services.				10%	£222,357	£222,357	995	62	Mar-17	979	↑
Emergency admission rate for children with asthma per 100,000 population aged 0-18 years				10%	£222,357	£222,357	144	11.35	Mar-17	123.85	↓
Emergency admissions to hospital for people aged 75 years and over with length of stay under 24 hours per 100,000 population aged >75				10%	£222,357		4740	497.0	Mar-17	6154.8	↑
The 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				% Deductions if indicator is underachieved			Plan	Latest Data	Reporting Period	YTD	Trend
18 week Referral to Treatment - Incomplete pathway *				25% of Eligible Additions	£0		92%	92.42%	Mar-17	92.76%	↑
A&E 4 hour wait (7 Providers) *				25% of Eligible Additions	-£166,767		95%	94.98%	Mar-17	92.98%	↑
Cancer 2 week waits following urgent GP referral for suspected cancer *				25% of Eligible Additions	£0		93%	96.14%	Mar-17	95.18%	↓
Ambulance Category A - Red 1 response arriving within 8 mins - EEAST *				25% of Eligible Additions	-£166,767		75%	72.34%	Mar-17	68.84%	↑

Note: The CCG A&E mapping is based on all providers that see 1% or more of CCG patients. For Bedfordshire these providers are Bedford Hospital (94%), Luton & Dunstable Hospital (29%), Cambridge University Hospital (1%), Hinchingbrooke (1%), East & North Herts (8%), Milton Keynes (7%) and Buckinghamshire (3%). Please note the percentage for the CCG should not add up to 100%, the percentage describes the amount of activity attributed to the CCG at that Trust.

The CCG will not be eligible for any payment if it is not considered to have operated in a manner that is consistent with Managing Public Money during 2016/17 or ends the financial year with an adverse variance against planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position or incurs a qualified audit report in respect of 2016/17. It should be noted however that the CCG is duty bound to work towards achieving the measures and will be monitored against their achievement.

#### Quality Premium Additions:

- **New cases of cancer diagnosed at stage 1 and 2** – Threshold is 4 percentage point improvement in 2016 compared to 2015 or >60% diagnosed in 2016. Due to delays in data reporting the latest available published data is 2014 with 2015 data not expected to be released until June 2017. The linear trend is continuing to provide assurance that the threshold will be met.
- **Increase in the proportion of GP referrals made by e-referrals** - Threshold 80% by March 2017 and demonstrate year on year increase or 20 percentage point increase on March 2016. March 2017 data shows that this indicator has not been achieved at year end.
- **Overall experience of making a GP appointment** - Threshold achieve 85% of respondents with a good experience or a 3 percentage point increase from July 2016 for good experience. The latest published data is July 2016 which provides the baseline figure for the 2016/17 target. The GP survey has changed to an annual publication from July 2016 therefore new data will not be available until July 2017. There is therefore a risk that this indicator will not be achieved.
- **Antibiotic prescribing** - Threshold (a) Reduction in antibiotics prescribed in primary care less than 1.161 items per STAR-PU (b) Reduction in broad spectrum antibiotics prescribed in primary care less than 10%. The latest published data is March 2017 and shows the CCG have met this target at year end.
- **Mental health admissions to hospital** - Due to the delay in national data the dashboard above reflects actual numbers of admissions using local provider data. Performance in March achieved against the monthly plan and this gives a year end position of 979 against the Quality Premium threshold of less than 995 which is an achievement at year end.
- **Emergency admission rate for children with asthma** - Baseline is 2015/16 forecast outturn of 160 per 100,000. Latest data available via Mede Analytics is March and this is showing that this indicator has achieved the year-end target.
- **Emergency admissions to hospital for people aged 75 years and over with a length of stay under 24 hours** - Baseline is 2015/16 forecast outturn of 4740 per 100,000. Latest data available via Mede Analytics is March and this shows that this indicator has not achieved at year end.

#### Quality Premium Deductions:

- **18 weeks referral to treatment (Incomplete Pathway)** - Latest published data is March and shows this indicator has been achieved at year end.
- **A&E 4 hour wait (7 providers)** - Latest published data is March and shows an underachievement year to date which may result in a 25% reduction against the achieved quality premium.
- **Cancer 2 week waits following urgent GP referral for suspected cancer** - Latest published data is March and shows this indicator has achieved at year end.
- **75% threshold for Category A (Red 1) 8 minute response for ambulance calls** – Latest data is March and is showing an underachievement year to date which will result in a 25% reduction against the achieve quality premium.

## 4. QUALITY PREMIUM 2017/18

### Bedfordshire CCG Quality Premium Dashboard

CCG Quality Premium (Potential Funding)

£2,249,500

Forecast CCG Quality Premium (iii)

£0

Additions

(Eligible QP funding)

£0

Deductions

(from Eligible QP funding)

£0

Quality Premium Indicators 17/18	% of Quality Premium available if Indicator is achieved			Plan	Latest Data	Reporting Period	YTD	Trend
	Weighting	Value	Eligible					
<b>National Indicators - Additions</b>								
New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed	17%	£382,415		>=60%	58.50%	2014		
Overall experience of making a GP appointment - Improvement on July 2017 survey result (TBC)	17%	£382,415		tbc	75.25%	Jul-16		
<b>Continuing Healthcare - Part A</b> NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (in 80% of cases with a positive NHS CHC Checklist for new referrals)	8.5%	£191,208		>=80%		New collection data not available		
<b>Continuing Healthcare - Part B</b> Less than 15% of all full NHS CHC assessments take place in an acute hospital setting	8.5%	£191,208		<15%		New collection data not available		
<b>Mental Health - Equity of Access and outcomes into IAPT services - BAME</b> 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 smaller	17.0%	£382,415		tbc	42.05%	Apr-17	42.05%	
<b>Mental Health - Equity of Access and outcomes into IAPT services - Older People</b> Proportion of people accessing IAPT services >65 years 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.			tbc	10.61%	Apr-17	10.61%		
<b>Bloodstream infections - Part A i)</b> At least 10% reduction in all E coli BSI reported at CCG level based on 2016 performance data	6.0%	£133,845		223	33	Apr-17	33	
<b>Bloodstream infections - Part A ii)</b> Collection and reporting of core primary care data set for all E coli BSI in Q2 2017/18	1.7%	£38,242				Awaiting confirmation of measurement		
<b>Bloodstream infections - Part B i)</b> At least 10% reduction in the Trimethoprim:Nitrofurantoin prescribing ratio based on CCG baseline data (June15-May16) for 2017/18	3.8%	£86,043		0.687		Available Jul-17		
<b>Bloodstream infections - Part B ii)</b> At least 10% reduction in the number of Tremithoprim items prescribed to patients aged 70 years or greater on baseline data (June15-May16)	3.8%	£86,043		7687.4		Available Jul-17		
<b>Bloodstream infections - Part C</b> Sustained recution of inappropriate prescribing in primary care, items per STAR-PU must be equal of below 1.161 items per STAR-PU	1.7%	£38,242		<=1.161		Available Jul-17		
<b>Local Indicators - Additions</b>				<b>Plan</b>	<b>Latest Data</b>	<b>Reporting Period</b>	<b>YTD</b>	<b>Trend</b>
<b>Right Care - Gastrointestinal</b> Rate of Gastroscopies per 100,000 age-sex weighted population (<40) 5% reduction in the number of elective gastroscopies in 2017/18 for age 19-39 years compared to 2016/17	15%	£337,425		681	57	Apr-17	57	
<b>The 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</b>	% Deductions if indicator is underachieved			<b>Plan</b>	<b>Latest Data</b>	<b>Reporting Period</b>	<b>YTD</b>	<b>Trend</b>
18 week Referral to Treatment - Incomplete pathway *	25% of Eligible Additions	£0		92%	92.38%	Apr-17	92.38%	↓
A&E 4 hour wait (7 Providers) *	25% of Eligible Additions	£0		95%	95.47%	Apr-17	95.47%	↑
Cancer 2 week waits following urgent GP referral for suspected cancer *	25% of Eligible Additions	£0		93%	94.53%	Apr-17	95.18%	↓
Ambulance Category A - Red 1 response arriving within 8 mins - EEASt *	25% of Eligible Additions	£0		75%	73.64%	Apr-17	73.64%	↑

Note: The CCG A&E mapping is based on all providers that see 1% or more of CCG patients. For Bedfordshire these providers are Bedford Hospital (92%), Luton & Dunstable Hospital (29%), Cambridge University Hospital (1%), Hinchingsbrooke (1%), East & North Herts (7%), Milton Keynes (8%) and Buckinghamshire (2%). Please note the percentage for the CCG should not add up to 100%, the percentage describes the amount of activity attributed to the CCG at that Trust.

The CCG will not be eligible for any payment if it is not considered to have operated in a manner that is consistent with Managing Public Money during 2016/17 or ends the financial year with an adverse variance against planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position or incurs a qualified audit report in respect of 2017/18. It should be noted however that the CCG is duty bound to work towards achieving the measures and will be monitored against their achievement

### Quality Premium Additions:

- **New cases of cancer diagnosed at stage 1 and 2** – Threshold is 4 percentage point improvement in 2017 compared to 2016 or >60% diagnosed in 2016. Due to delays in data reporting the latest available published data is 2014 with 2015 data not expected to be released until June 2017. The linear trend is continuing to provide assurance that the threshold will be met.
- **Overall experience of making a GP appointment** - Threshold achieve 85% of respondents with a good experience or a 3 percentage point increase from July 2017 for good experience. July 2017 provides the baseline figure for the 2017/18 target. The GP survey is now an annual publication and therefore new data will not be available until July 2018.
- **NHS Continuing Healthcare**
  - Part A** – NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the checklist (in 80% of cases with a positive NHS CHC checklist for new referrals) – Data will be available 55 working days after the quarter end.
  - Part B** – Less than 15% of all full NHS CHC assessments take place in an acute hospital setting - Data will be available 55 working days after the quarter end.
- **Mental Health – Equity of Access and outcomes into IAPT services – BAME** – Recovery rate of people accessing IAPT services identified as BAME, improvement of least 5 percentage points or to the same level as white British, whichever is smaller. 2017/18 trajectory is in the process of being agreed with ELFT.
- **Mental Health – Equity of Access and outcomes into IAPT services – Older People** – Proportion of people accessing IAPT services >65 years 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. 2017/18 trajectory is in the process of being agreed with ELFT.
- **Bloodstream Infections**
  - Part A (i)** – At least 10% reduction in all E coli BSI reported at CCG level based on 2016 performance data. Threshold for 2017 is 223 or less. April performance is above the plan of 18 cases at 33 cases.
  - Part A (ii)** – Collection and reporting of core primary care data set for all E Coli BSI in Q2 2017/18.
  - Part B (i)** – At least 10% reduction in the Trimethoprim:Nitrofurantoin prescribing ratio based on CCG baseline data (June 15 – May 16). Threshold for 2017/18 is 0.687 or less. National reporting of this indicator will start in July.
  - Part B (ii)** – At least 10% reduction in the number of Trimethoprim items prescribed to patients aged 70 years or greater on baseline data (June 15-May 16). National reporting of this indicator will start in July.
  - Part C - Antibiotic prescribing** - Threshold (a) Reduction in antibiotics prescribed in primary care less than 1.161 items per STAR-PU. National reporting of this indicator will start in July.
- **Rate of gastroscopies per 100,000 age-sex weighted population (<40)** – 5% reduction in the number of elective gastroscopies in 2017/18 for age 19-39 years compared to 2016/17. Threshold for 2017/18 is 681 or less. April performance is showing 57 procedures against the threshold of 53

### Quality Premium Deductions:

- **18 weeks referral to treatment (Incomplete Pathway)** - Latest data is April and shows this indicator is currently achieving the threshold.
- **A&E 4 hour wait (7 providers)** - Latest published data is April and shows this indicator is currently achieving the threshold.
- **Cancer 2 week waits following urgent GP referral for suspected cancer** - Latest data is April and shows this indicator is currently achieving
- **75% threshold for Category A (Red 1) 8 minute response for ambulance calls** – Latest data is April and shows this indicator is currently underachieving the threshold.

## 5. Glossary

A&E	Accident and Emergency	MRSA	Methicillin-Resistant Staphylococcus Aureus bacteraemia
AAU	Acute Assessment Unit	MSSA	Methicillin-Sensitive Staphylococcus Aureus bacteraemia
BBC	Bedford Borough Council	MSA	Mixed Sex Accommodation
BCCG	Bedfordshire Clinical Commissioning Group	MSK	Musculoskeletal
BCF	Better Care Fund	MSOA	Middle Super Output Area
BEDOC	Bedford On Call	NHS	National Health Service
BHT	Bedford Hospital Trust	NHSE	NHS England
CAD	Computer Aided Dispatch (ambulance)	NHSI	NHS Improvement
CBC	Central Bedfordshire Council	NLRS	National Reporting and Learning System
C-Difficile	Clostridium Difficile	OOH	Out Of Hours
CHAT	Comprehensive Health Assessment Tool	OPEL	Operational Pressures Escalation Levels (Urgent Care)
CPA	Care Programme Approach	PBR	Payment By Results
CQC	Care Quality Commission	PEPS	Partnership for Excellence in Palliative Support
CQUIN	Commissioning Quality and Innovation	PHE	Public Health England
CSE	Child Sexual Exploitation	POD	Point Of Delivery
E&NHS	East & North Hertfordshire	PTS	Patient Transport Service
ECIST	Emergency Care Intensive Support Team	RCA	Root Cause Analysis
EEAST	East of England Ambulance Service	RTT	Referral to Treatment
EOL	End of Life	SCAS	South Central Ambulance Service
EOL CCT	End of Life Comfort Care Transport	SCP	Serious Concerns Process
FFT	Friends and Family Test	SEPT	South Essex Partnership Trust
GP	General Practice	SHMI	Summary Hospital level Mortality Indicator
GSF	Gold Standards Framework	SI	Serious Incidents
HALO	Hospital Ambulance Liaison Officer	SPoA	Single Point of Access
HCAI	Healthcare Associated Infections	STEIS	Strategic Executive Information System
IAPT	Improving Access to Psychological Therapies	STF	Sustainability and Transformation Fund
L&D	Luton and Dunstable Hospital	SQPR	Service Quality Performance Report
LA	Local Authority	T&O	Trauma & Orthopaedics
LCCG	Luton Clinical Commissioning Group	TDA	Trust Development Agency
LSCB	Local Safeguarding Children Board	TIA	Transient Ischemic Attack
MASH	Multi Agency Safeguarding Hub	VTE	Venous Thromboembolism
MRI	Magnetic Resonance Imaging	TDA	Trust Development Agency

## 6. Definitions

**Category A (Red 1) 8 Minute Response Time** - Incidents that are immediately life threatening conditions, e.g. cardiac arrest, respiratory arrest, should receive an emergency response within 8 minutes irrespective of location in 75% of cases. This means that for patients with immediately life-threatening conditions, faster response times may improve health outcomes and the patient experience.

**Category A (Red 2) 8 Minute Response Time** - Incidents which may be life-threatening conditions but less time-critical should receive an emergency response within 8 minutes irrespective of location in 75% of cases. This means that for patients with immediately life-threatening conditions, faster response times may improve health outcomes and the patient experience.

**Category A (Red 1 and 2) 19 Minute Transportation Time** - Immediately life-threatening incidents should receive an ambulance response at scene within 19 minutes irrespective of location in 95% of cases. The ability to transport patients with immediately life-threatening conditions in a clinically safe manner may improve their health outcomes and patient experience.

**Ambulance Handover Delays** – The clock starts when the ambulance stops in the patient offloading bay in Accident & Emergency. It then stops when a full clinical handover has taken place, the patient has been transferred onto hospital apparatus and all Ambulance equipment returned to the vehicle allowing the crew to leave the department.

**Ambulance – See and Treat** – Focussed clinical assessment at the patient’s location followed by appropriate treatment, discharge and/or referral. **Hear and Treat** – where it appears that the patient has a less serious condition. A clinician in ambulance control centre has a discussion with patient or carer and will give appropriate healthcare advice. An ambulance response will not necessarily be sent at the time of the call.

**18 Weeks Referral to Treatment – Incomplete pathway** - This applies to patients on a non-urgent consultant led pathway setting a maximum time of 18 weeks from the point of initial referral up to the start of any treatment necessary where it is clinically appropriate. Incomplete pathways are those where patients are still waiting for treatment – national threshold 92%. Pathway consists of 19 Specialities e.g. Dermatology, Gynaecology.

**Cancer 2 Week Wait Following Urgent GP Referral For *Suspected* Cancer** – This indicator relates to all patients that have been urgently referred to an acute trust with *suspected* cancer by their GP having their first outpatient attendance within 14 calendar days.

**Cancer 2 Week Wait for Breast Symptoms where cancer was *not initially suspected*** – This indicator relates to all patients that have been urgently referred to an acute trust for evaluation / investigation of breast symptoms by a primary or secondary care professional having their first outpatient attendance within 14 calendar days. This pathway excludes any patients that have been referred urgently with *suspected* breast cancer.

**Dementia** – This relates to the number of people diagnosed with dementia, expressed as a percentage of the estimated prevalence. The prevalence rate is provided by the Office of National Statistics.