NHS Bath and North East Somerset Clinical Commissioning Group

Measures of Success 2014/16

Appendix 3a

3 NHS CCG Outcomes Indicator Set (selected) - National Metrics that the NHS have chosen for CCGs to set local ambitions (not in quality premium)

Domain / reference	Description	baseline	Local Ambition 2014 / 15	Local Ambition 2015 / 16	Plans for Delivery
2.1	Improve the health related quality of life for people with long term conditions	77.4 (2012/13)	77.6	77.8	Embed new Community Cluster Team Model, Establish a diabetes pathway group to re-design local services, Develop clinical model for community COPD service
2.11	Recovery following talking therapies for people of all ages	47% (2012/13)	50%	55%	Progress integration of primary care liaison and talking therapies provision
2.13	Estimated diagnosis rate for people with dementia	58% (2012)	60%	67%	Improve diagnosis rates for people with dementia working with primary care and community dementia support workers
4ai	Patient experience of primary care - average number of negative responses per 100 patients	3.8 (2012)	3.7	3.6	Review of community based primary care services, work with practices on support for over 75s, work with practices on extended access through PM Challenge fund
4b	Increase the number of people having a positive experience of hospital care. (Average number of negative responses per 100 patients)	123 (2012)	121	119	Impact of CQUIN schemes. Roll out of Family and Friends Test.
5.4	Incidence of health care associated infection - C. difficile	46 (2013/14 ytd)	tbc	tbc	(Awaiting national setting of target). In 2013/14 the CCG set up a Health Care Acquired Infection (HCAI) collaborative to keep local providers focussed on reducing C.Difficile and other HCAI.

4 Better Care Fund - National Health and Social Care indicators to measure the impact of the Better Care Fund spend, with locally set ambitions and a new local indicator.

Metrics	Description	baseline	Performance for payment in April 2015	Performance for payment in October 2015	Plans for Delivery
1	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	971 (2012/13)	n/a	936	The schemes will all support this metric: * Social care assessments and packages of care can be put in place in a more timely way to avoid the need for care home admissions. In the absence of this service at weekends, when demand for hospital beds can increase, care home placements can be used as a means of expediting discharges. * Integrated Re-ablement assessments and rehabilitation plans can be put in place in a more timely way to enable patients to return home with appropriate support, again avoiding the need for a care home placement. * A broader focus on maintaining and supporting independent living employing a range of approaches including Personal Budgets/Direct Payments as well as community and voluntary sector solutions will alter culture and practice to place less emphasis on residential care. * Accounting for population changes during the reporting period we would expect to make a 3% improvement against this metric.
2	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	86% (120/140) (2012/13)		83% (455/550) (2014/15)	The schemes will support this metric: * Capacity can be focussed on discharge planning and resources mobilised to ensure that discharges are safe, co-ordinated and well supported by other associated services e.g. voluntary sector. * Capacity can be focussed on community re-ablement and resources mobilised to ensure that independent living arrangements are safe, co-ordinated and well supported by other associated services e.g. voluntary sector. * Growth in the service overall and a widening of access criteria is likely to result in a slight drop in current performance (84%) against this metric, however we anticipate that performance will settle at the England average for the baseline year of 83%.
3	Delayed transfers of care from hospital per 100,000 population (average per month)	3.51% (2012/13)	3.02% (04-12/14)	2.62% (01-06/15)	The BCF schemes will support this metric: * A range of schemes will focus attention and effort on reducing length of stay and improving the timeliness of discharges from both acute and community settings. * Re-ablement services which 'push' people out of hospital and effective support which 'pulls' them back into the community will impact positively on length of stay. * Our current trajectory shows significant improvement against this metric since 2012/13 (3.51%) and we would expect, with the application of further resource, to improve this further to the England median of 2.61%.
4	Avoidable emergency admissions (composite measure) (Number per 100,000 people)	1573 (2012/13)	708 (04-09/14)	708 (10/14 - 03/15)	The BCF schemes will support this metric: * Schemes which manage, stabilise and decrease any emerging risks, care and support needs and will impact positively on emergency admissions. * Targeted support to maintain safety and wellbeing at home post discharge will help to boost performance against this metric. * We already perform well on emergency admissions (top quartile) and would therefore expect to see small improvements against this metric with a reduction of around 150.
5	Patient / service user experience	tbc	tbc	tbc	We have chosen to use the national metric once available
6 - Local	Proportion of people beng case managed by the Community Cluster Teams with a personalised care plan and lead accountable professional	TBC	75%	90%	the BCF schemes will support this metric * The establishment of the multi-disciplinary weekly meetings will provide actively integrated working of health and social care services, enabling smoother pathways of care. * This will ensure that a whole range of services are in place to avoid admissions and readmissions, maximising peoples capacity to remain in their own homes. * 2014/15 is the implementation period for the new community cluster service and the targets are set to monitor that each cluster and GP practice are building this new process into their business as usual.

1 National Quality and Safety Standards (selected) - with National targets where available

Reference	Description	Target	2013 /14 year to date		Plans for Delivery
5.3 RUH	Incidence of newly acquired category 2,3 and 4 pressure ulcers	no target	31	n/a	This is measured using the monthly snap shot from the NHS Safety Thermometer. The Median for the RUH for July 2012- January 2014 stands at 0.5%, which is lower (better) than the national median of 1.2% prevalence of patients with newly acquired pressure ulcers. This issue will continue on the Quality agenda for improvement.
Quality 5	Number of Never Events	0	0	G	There have been no never events with the providers where we are lead commissioner this year so far and expect this to continue.
Local 5 RUH	Percentage of all adult inpatients who have had a VTE risk assessment	95%	95%	G	The RUH are meeting their VTE risk assessment trajectory, achieving 96% for Q3 . There is a 1 month data lag.
Quality 11 RUH	WHO Surgical Safety Checklist completed for 100% of procedures	100%	100%	G	The performance has improved across the year at the RUH and is expected to continue at standard.
Quality 13 RUH	Fracture Neck of Femur - % in theatre within 36 hours	80%	81%	G	The RUH performance for this standard needs improved robustness in 2014/15.
CB_A15	Healthcare acquired infection (HCAI) measure - MRSA	0	3	R	HCAI collaborative. Focus on antimicrobial prescribing.