

World Class Commissioning Health Outcomes and Commissioning Assurance Process

Purpose of the Report:

The purpose of this report is to inform the Board on Year 2 of the World Class Commissioning Assurance and the work that is currently on going around predictive modelling for our Health Outcomes. The report also highlights some of challenges and the key initiatives that we would need to put in place or are already working on in order to deliver this ambitious and wide-ranging population health improvement programme.

Introduction:

World Class Commissioning (WCC) is an ambitious programme jointly developed by the Department of Health and wider health and care community and is aimed at delivering outstanding performance in the way we commission health and care services.

WCC will have a direct impact on the health and well-being of the population, driving improvements in patient outcomes, and ensuring the NHS remains one of the most progressive and high-performing health systems in the world.

WCC will help us to invest wisely in better services that are more closely matched to local needs thereby improving health and well-being and reducing health inequalities across the community - adding life to years and years to life.

The Assurance System:

The delivery of the WCC vision takes place within a commissioning assurance system. This system is locally managed by strategic health authorities and is designed to help PCTs identify areas of development and work towards filling gaps in their capabilities as they move towards becoming world class commissioners.

The assurance system is comprised of reviewing 3 key domains:

- Health Outcomes
- Competencies, and
- Governance

Health outcomes are about measuring health gain and quality in health care and ratings are assigned based on the PCT's ability to deliver key health outcomes.

NHS BEN & WCC Assurance:

NHS BEN selected 10 health outcomes to focus on as part of gaining a World Class Commissioner status. These outcomes were chosen based on our priorities as outlined in the Strategic Plan, Local Area Agreements (LAA) and NHS Vital Signs. Our WCC outcomes are ambitious goals and go beyond our commitments to targets and the national indicators adopted within the Vital Signs and LAA.

We were assessed for the first time last year in relation to our progress against these WCC outcomes and competencies and performed at a very high level being in the top three of the 152 PCTs nationwide.

The assurance report particularly commended our strengths in innovation and improvement, productive partnerships and clinical engagement. It also provided insight and guidance into areas that we can look to improve. Based on that feedback we now have included Infant Mortality Rate as one of our health outcomes as it closely aligns with the strategic intent of the PCT and the needs of the population we serve.

The second annual assurance cycle (Year 2) will take place next year and we are now required to submit stretch targets for the coming 5 years for the 11 health outcomes that we have selected.

The trajectories for these outcomes have already been developed and have been formally signed-off by the WCC Programme Board. In addition, the Non-Executive Directors have received the copy of the main document which will shortly be available on the PCT's website as well.

NHS BEN WCC Health Outcomes:

Table 1 gives a detailed account of trajectories for our health outcomes that we would need to achieve in order to meet our WCC targets. Table 1 also highlights the rationale for aspiration along with its likely impact on population health. As is apparent these are quite ambitious targets compared to the current level we are at, and thus require concerted efforts on part of all – PCT, Acute Trusts, City Council etc - involved in delivering them. These trajectories have already been submitted to SHA for review and feedback before final submission to Department of Health in January 2010.

Table 2 lists the impact of health outcomes on other key national/local targets and a few major actions/initiatives that we would need to implement to see progressive and sustained improvements in line with trajectories shown in Table 1.

Table 1: 5 Year Trajectory for WCC Health Outcomes

Outcomes	Metric Description	Outcome also a Vital Sign or LAA Target	Current Level	Improvement Aspiration (5 Years)					Rationale for Aspiration & Impact on Population Health
				2010/11	2011/12	2012/13	2013/14	2014/15	
Health inequalities (Males)	Slope index of inequality for life expectancy at birth at Lower Super Output Area	LAA	9.6	7.48	6.42	5.36	4.3	3.24	We aspire to having no health inequalities in BEN. We already have the least inequalities gap amongst the Core Cities but seek to reduce the inequalities within the PCT. Thus by 2018 someone from the most deprived area can expect to live as long and well as someone from the least deprived does now.
Health inequalities (Females)			7.0	5.46	4.69	3.92	3.15	2.38	
Life expectancy (Males)	Life expectancy at birth (years)	VSB01 LAA	75.9	76.5	76.8	77.1	77.4	77.7	Our life expectancy is currently below the national average as well as below some of the Core Cities and peer PCTs in the ONS Cluster. So we aspire to tackle premature mortality especially targeting the major killers thereby adding extra years of life each year.
Life expectancy (Females)			80.4	80.8	81.0	81.2	81.4	81.6	
Infant mortality	Mortality rate per 1,000 live births in <1 year old	New for Year 2 Assurance Process	8.8	7.3	6.8	6.3	5.8	5.3	We have a third highest infant mortality rate in the country, which is 83% higher than the national average. Likewise we have a higher rate compared to other Core Cities and ONS Cluster. Also local modelling suggests that infant mortality is a leading contributor to the life expectancy gap accounting for 15% and 25% of the difference from the national average in males and females respectively. Hence we aspire to bring our IMR at par with the current national average by 2015. This will save at least 27 additional babies in infancy in 5 years and then every year after that.
Under 18 conception rate	Under 18 conception rate per 1000 females, aged 15-17	VSB08 LAA	47.00	34.12	30.21	26.30	25.39	24.48	Teenage pregnancy is a key issue in health inequalities and a significant cause of social exclusion. Under 18 conceptions in BEN are high compared to the SHA, some of the Core Cities and National averages with some BEN wards having a very high rate. Eight of BEN's 17 wards appear in Birmingham's top 20 highest rate wards for teenage pregnancy. As a result some wards had more than 20 babies born to teenage mothers last year. Areas with higher under 18 years conception rates generally also have

									raised levels of deprivation, poor educational attainment and disengagement at school across the PCT. Nationally, infant mortality rate is 60% higher for teenage mothers and they have 3 times the rate of post-natal depression compared to older mothers and a higher risk of poor mental health for 3 years after the birth. Hence, we seek to reduce this rate and aspire to having no more than 8 babies born each year to teenage mums in any BEN ward by 2012/13 and further reductions afterwards. This metric provides a good opportunity to partnership working and reducing inequalities.
Infants breastfed	Percentage of infants breastfed at 6-8 weeks	VSB11	30.70	42.42	47.75	53.07	58.39	63.71	Historically BEN's rates have improved but still remain well below the rates of some of our ONS cluster PCTs and many of the Core Cities. Breastfeeding has an important contribution in reducing infant mortality and health inequalities. Breastfed babies are less likely to: have allergies; get childhood diabetes; get respiratory-tract or middle-ear infections and get gastroenteritis. Mother is less likely to develop ovarian and breast cancer. So we aspire to increase our initiation rates to 85% by 2018, providing natural protection against illness and future obesity.
Smoking quitters	Quit rate per 100,000 population aged 16 and over	VSB05 LAA	1158	1591	2029	2210	2209	2099	Our current smoking prevalence is around 25% which is higher than our ONS Cluster PCTs and many of the Core Cities. In addition, some of the more deprived wards in BEN have significantly higher prevalence and at the same time the smoking population in these wards is not making full use of the cessation services. Smoking is a major cause of morbidity and mortality in PCT residents. Smoking is the major risk factor behind coronary heart disease, stroke, respiratory diseases and cancers – all major killers for the PCT population. Thus reducing the prevalence of smoking can have significant impact on life expectancy and health inequalities and that's why we aspire to have the lowest smoking prevalence of any core city by 2018 where only 15% of people will be putting themselves at risk.
Percentage of stroke admissions given a brain scan	Percentage of stroke admissions given a brain scan within 24	VSA14	46.5	60.8	67.9	75.0	79.0	83.0	In BEN, we expect to see an increase in the number of people affected by stroke by the year 2020 due to factors like increasing age, smoking, obesity, deprivation, and a significant ethnic minority. Stroke causes substantial morbidity, with around 50% of individuals suffering a stroke

within 24 hours	hours									being reliant on others for daily routine activities. Thus early interventions can significantly improve the outcome thereby having an effect on life expectancy and health inequalities and that's why we aspire to provide a brain scan within 24 hours to at least 75% of people admitted to hospital with stroke by 2012 with further gradual improvements in the later years.
Delayed transfers of care	Rate of delayed transfers of care per 100,000 population (age 18 and over)	VSC10 LAA	17.73	11.23	8.09	6.59	5.09	3.59		BEN's rate is high compared to the ONS Cluster PCTs and highest amongst the Core Cities. As a consequence of DToC patients are likely to suffer adverse consequences like anxiety and discomfort to more serious and longer-lasting physical and psychological harm. DToC may deprive someone in greater need of hospital facility adversely affecting NHS' ability to deal with elective and emergency cases. And also lead to the PCT bearing the financial consequences of the delay. As this indicator highlights the ability of the whole system to ensure appropriate discharge from hospital for the entire adult population, so we aspire to reduce DToC in order to improve the effectiveness of the interface between health and social care services. It also closely aligns with the End of Life and Intermediate care strategies.
CHD mortality	Directly standardised mortality rate per 100,000 standard population for all CHD mortality, all ages	LAA	111.63	97.29	92.51	87.73	82.95	78.17		CHD mortality rate in BEN is significantly above the national, cluster and Core Cities averages. CHD is a leading cause of premature death and accounts for the largest part of the health inequalities in PCT residents. This metric provides the PCT with a means of bringing greater focus on primary prevention and proactive management of high risk people in the primary care environment. That's why we aspire to reduce the mortality rate by 30% by 2014/15 (from a 2005-07 baseline) by finding an additional 1000 people most at risk of CHD each year from 2009 and shall ensure that they receive effective treatment and support to stay healthy.
Proportion of all deaths that occur at home	Proportion of all deaths that occur at home	VSC15 LAA	18.42	32.17	42.94	53.7	58.7	63.7		We chose this metric as it is pivotal to the personalisation of care and the promotion of patient choice. Over 60% of people polled expressed a desire to choose their place of death. National research suggests that patients don't want to die 'alone and in hospital', but peacefully and with dignity at home with friends and family by their side. Despite the good

									level of end of life services, the rating is low in BEN compared to other Core Cities. So we aspire to enhance our EoL services so that people will exercise choice at all stages of their illness and 70% of people realise their preference to die at home with support (taking into account the care homes/hospice deaths) by 2012 with further improvements in later years as highlighted in the aspiration targets. This metric will also allow us to demonstrate world class partnership credentials by working with neighbouring PCTs and the City Council and free up capacity in the system.
Patient satisfaction (Locally selected outcome)	Average of 5 indicators from GP Patient Survey (Telephone access, 48 hour access to GP, Advance appointment booking, Appointment with specific GP, Satisfaction with opening hours)	VSA06	80	85	90	95	96	97	We have chosen this metric because it reflects our prioritisation of patient access and will provide us an opportunity to demonstrate world class performance at the key point of access to primary care. It is a composite metric comprised of five elements of access to primary care as per GP patient survey. We aspire to have highly satisfied patients among all the Core Cities and ONS Cluster PCTs with over 95% rating the local health services as excellent by 2012 and further improvements in the subsequent years as outlined in the improvement aspiration targets.

Table 2: Impact of WCC Outcomes on Other Targets and Major Actions required to Achieve the Outcomes

WCC Outcomes	Impact of Improvement		Current Challenges & Major Actions /Initiatives to Support the Improvement of Outcomes and Achievement of Targets
	On Other WCC Outcomes	On Other Key Targets/Indicators	
Health inequalities (Males)	Life expectancy Infant Mortality Under 18 conception rate Smoking quitters CHD mortality Patient satisfaction	NI 55, 56: Obesity in primary school age children in Reception & Year 6 NI 122: Mortality rate from all cancers at ages under 75 NI 123: Stopping smoking NI 137: Healthy life expectancy at age 65 PSA 18: Promote better health and wellbeing for all	<ol style="list-style-type: none"> 1. Engagement with those most at risk in the treatment and lifestyle programmes. 2. Supporting and monitoring GP long term conditions management 3. Introducing the national health check programme 4. Reducing smoking prevalence 5. Improving attendance at the cancer screening programmes
Health inequalities (Females)			
Life expectancy (Males)	Proportion of all deaths that occur at home	Vital Sign - VSB01 NI 137: Healthy life expectancy at age 65 PSA 17: Tackle poverty and promote greater independence and wellbeing in later life PSA 18: Promote better health and wellbeing for all	
Life expectancy (Females)			
Infant mortality	Life expectancy Health inequalities	NI 137: Healthy life expectancy at age 65 NI 120: All-age all cause mortality rate PSA 12: Improve the health and wellbeing of children and young people	
Under 18 conception rate	Health inequalities Life expectancy Infant mortality	Vital Sign - VSB08 NI 112: Under 18 conception rate NI 113: Prevalence of Chlamydia in under 25 year olds (weak impact)	<ol style="list-style-type: none"> 1. Targeting schools with highest incidence of teenage pregnancy 2. Increasing sexual health services and long acting contraception 3. Targeting young women who are not in mainstream education "looked after children" 4. Increasing access and teen friendly contraceptive services in primary care
Infants breastfed	Health inequalities Life expectancy	Vital Sign - VSB11 NI 53: Prevalence of breast-feeding at 6-8 wks from birth PSA 12: Improve the health and wellbeing of children and young people	<ol style="list-style-type: none"> 1. Working with UNICEF to achieve baby-friendly status 2. Extending breastfeeding peer support programme, including ongoing breastfeeding support and improving engagement with antenatal and postnatal women 3. Increasing education regarding the value of breastfeeding

			4. Improving data recording
Smoking quitters	Health inequalities Life expectancy Infant Mortality	Vital Sign - VSB05 NI 123: Stopping smoking NI 120: All-age all cause mortality rate NI 121: Mortality rate from all circulatory diseases at ages under 75 NI 122: Mortality rate from all cancers at ages under 75 NI 137: Healthy life expectancy (HLE) at age 65 PSA 18: Promote better health and wellbeing for all	1. Continuing through multi staged approach to support smoking quitters through primary care, pharmacies, NRT by Post and specialist cessation services 2. Increasing access and uptake in target deprived groups 3. Marketing and engagement to encourage people to quit and remain quit (reducing relapse rate) and reducing take-up by youth 4. Improving follow-up of smokers at 52 weeks
Percentage of stroke admissions given a brain scan within 24 hours	Health inequalities Life expectancy Delayed transfers of care	Vital Sign - VSA14 NI 124: People with a long-term condition supported to be independent and in control of their condition PSA 18: Promote better health and wellbeing for all PSA 19: Ensure better care for all	1. Achieving 20 quality markers as set out in the National Stroke strategy 2. Reducing the number of pathway steps against identified baseline timescales 3. Full implementation of NHS BEN's Stroke strategy
Delayed transfers of care	Health inequalities Proportion of all deaths that occur at home	Vital Sign - VSC10 NI 131: Delayed transfers of care NI 132: Timeliness of social care assessment (all adults)	1. Urgent need to look into the shortage of community care services including those for dementia and extra care sheltered housing with City Council 2. Developing appropriate service prioritisation criteria with City Council that includes younger adults
CHD mortality	Health inequalities Life expectancy Smoking quitters Patient satisfaction	NI 120: All-age all cause mortality rate NI 137: Healthy life expectancy at age 65 PSA 18: Promote better health and wellbeing for all	1. Engagement with those most at risk in the treatment and lifestyle programmes esp Stop Smoking 2. Supporting and monitoring GP CHD management 3. Introducing the national health check programme
Proportion of all deaths that occur at home	Patient satisfaction	Vital Sign - VSC15 NI 129: End of life care – access to appropriate care enabling people to be able to choose to die at home NI 128: User reported measure of respect and dignity in their treatment NI 140: Fair treatment by local services	1. Reducing hospital admission rates for patients on the GSF Register 2. Sustained achievement of Service KPIs
Patient satisfaction	Health Inequalities	Vital Sign - VSA06 NI 128: User reported measure of respect and dignity in their treatment NI 124: People with a long-term condition supported to be independent and in control of their condition PSA 19: Ensure better care for all	1. Improving GP practice telephone access 2. Extending the surgery opening times 3. Improving communication with the patients esp around purpose of any medicine being prescribed and its potential side-effects

Table 3 gives a graphical overview of our WCC outcomes' trajectories in comparison to Vital Signs, LAA Targets, peer PCTs in our Office for National Statistics (ONS) cluster, and Core Cities.¹ The graphs show our current position alongside the current best level of achievement by any of our peer PCTs in ONS Cluster and Core Cities. They also highlight what we should have achieved as part of our LAA and Vital Signs targets where relevant because not all the WCC health outcomes are LAA and/or Vital Signs targets.

Keeping in view our current level/performance, we still have a long way to go before achieving the World Class Commissioner status but we are on right track as we have achieved gradual improvements in most of these outcomes in the previous years.

Recommendations:

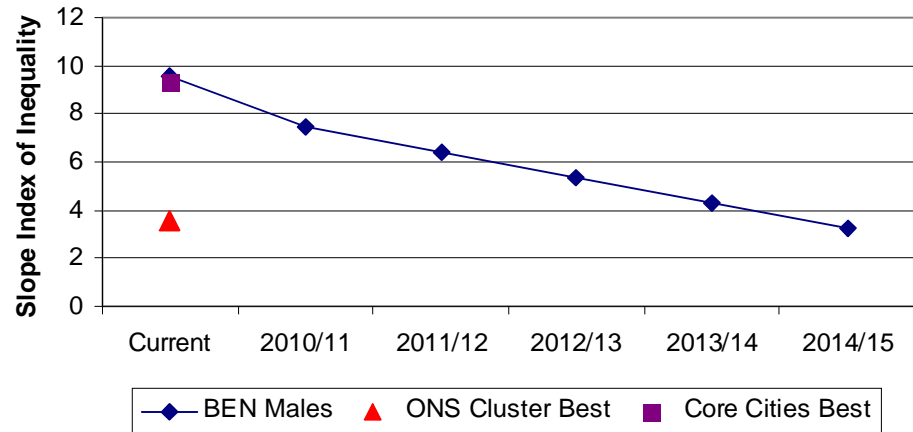
The Board members are requested to:

- Note the predictive modelling for Year 2 of the assurance process, and
- Support the team in implementing the actions outlined in this report, in our Strategic Plan and other series of reports around these outcomes already been presented in previous Board meetings.

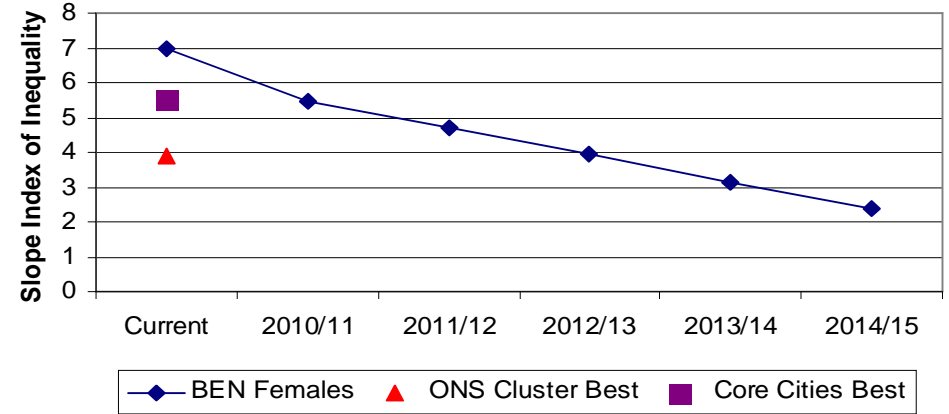
¹ Cluster is a group of similar PCTs as defined by the ONS and BEN falls in the 'Centres with Industry' group. Core Cities include: Birmingham, Bristol, Leeds, Liverpool, Manchester, Newcastle, Nottingham, Sheffield.

Table 3: WCC Trajectory & Comparison with ONS Cluster, Core Cities, Vital Sign Targets & LAA Targets

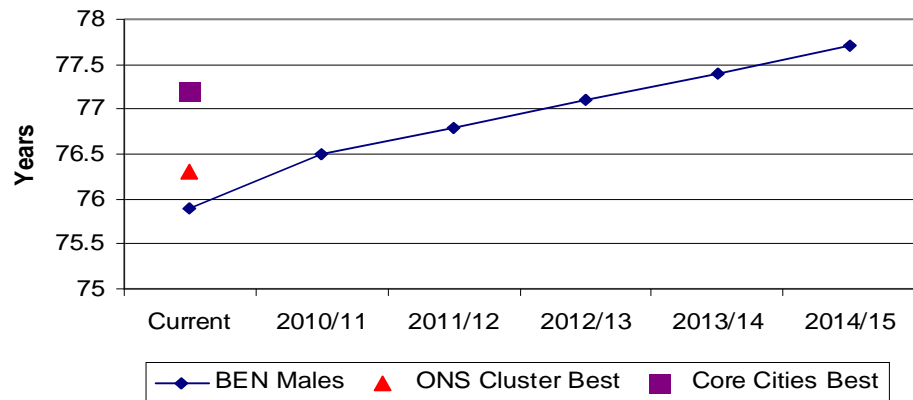
Health Inequalities - Males



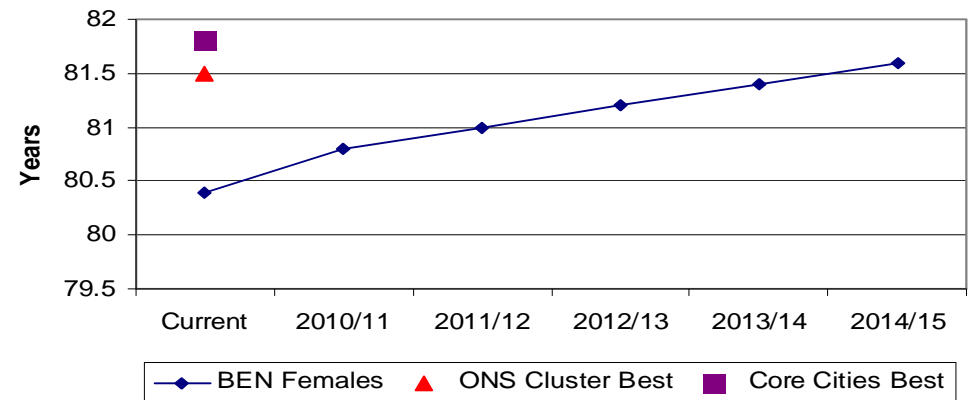
Health Inequalities - Females



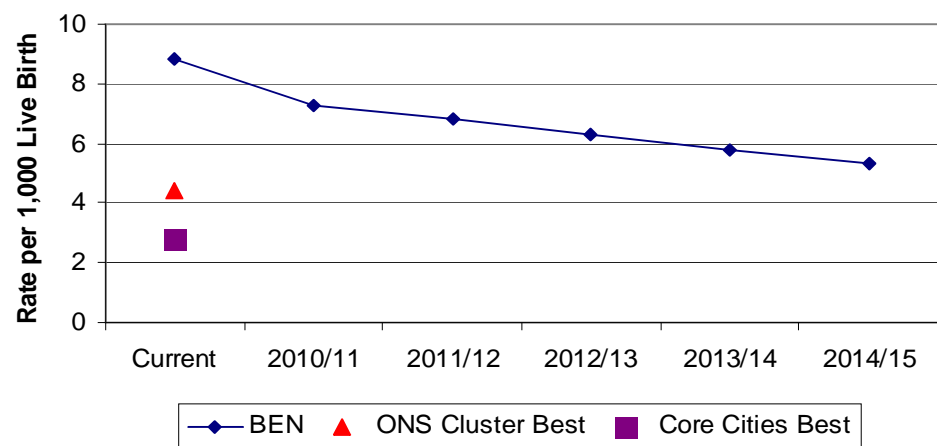
Life Expectancy - Males



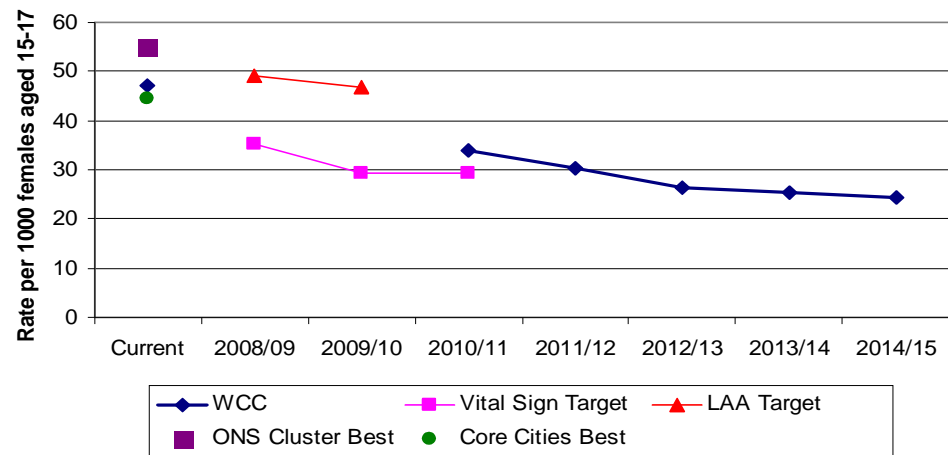
Life Expectancy - Females



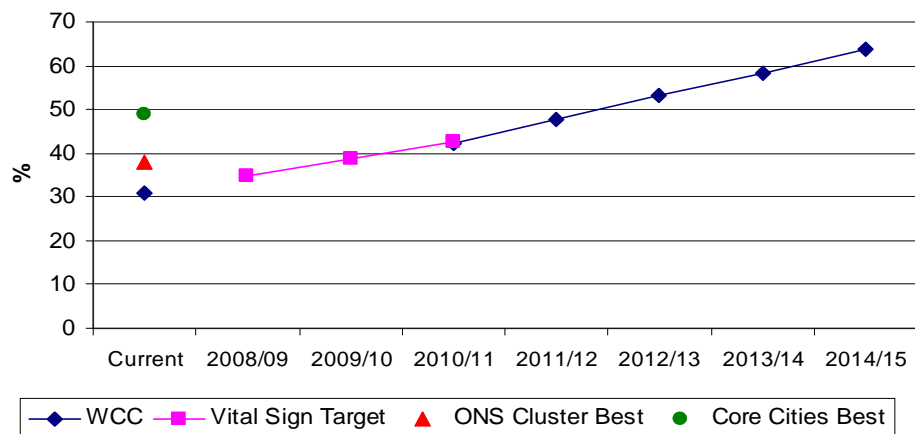
Infant Mortality



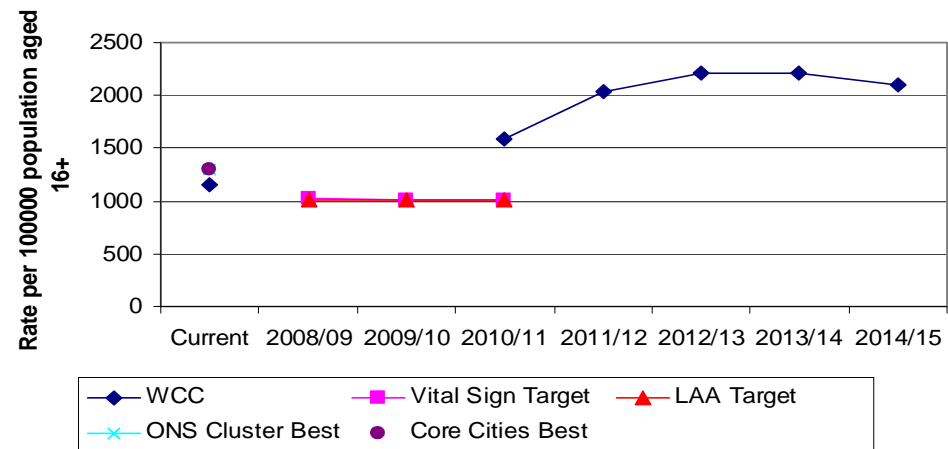
Under 18 Conception Rate



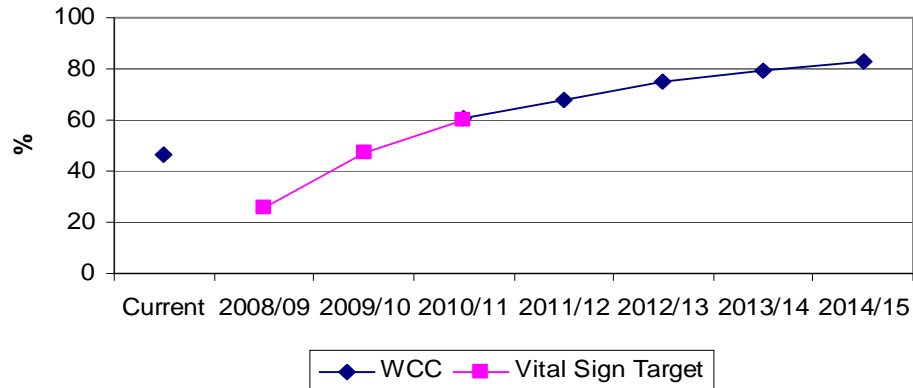
Infant Breastfed at 6-8 Weeks



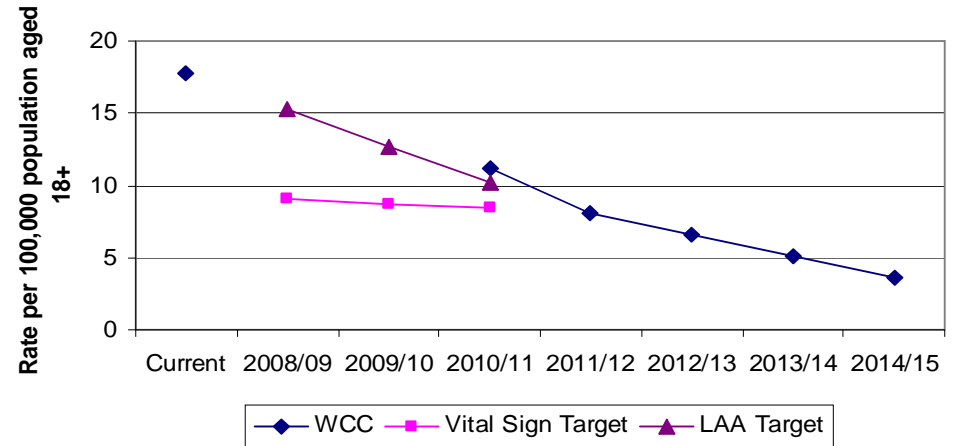
Smoking Quitters



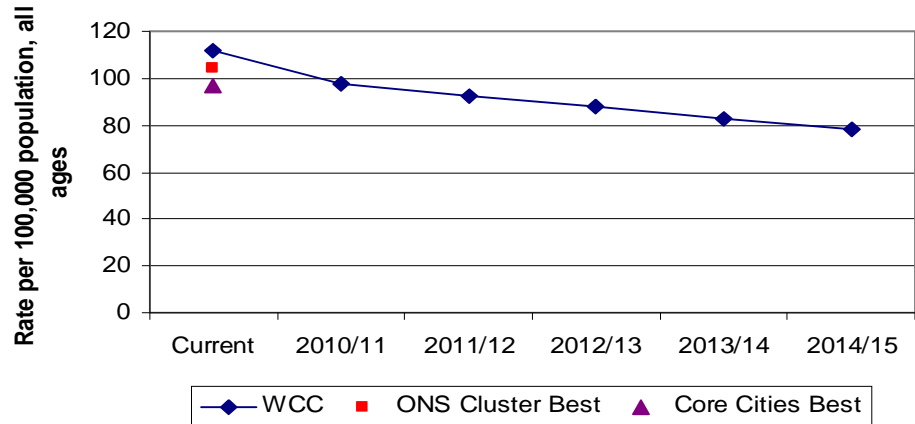
Stroke Admissions given a Brain Scan within 24 Hours



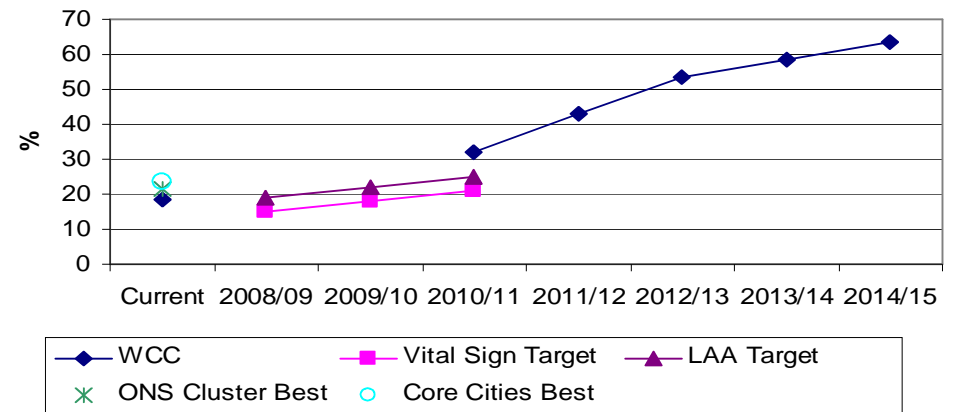
DToC



CHD Mortality



End of Life - Deaths occurring at Home



Patient Satisfaction

