NHS
Sheffield Clinical Commissioning Group

Monitoring the effectiveness of the movement of resources from secondary to primary/community care - Update

Governing Body meeting

3 October 2013

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Key messages

- The CCG needs to be able to demonstrate that the movement of services from secondary care to primary / community care, and its beneficial impact on the health of the Sheffield population, is clear.
- The overall health and social care system is very complex and undergoing continual change and is subject to many parallel projects / interventions. There is general acknowledgement (Right First Time (RFT) experience) that it is almost impossible to determine the direct cause and effect of specific schemes on the overall system.
- A paper was presented to the 4 July meeting of the Governing Body outlining an approach to monitoring progress in the movement of services.

Assurance Framework (AF)

Risk Reference (RR) Number: RR Ref 903 (Healthcare Closer to Home)

How does this paper provide assurance to the Governing Body that the risk is being addressed?: This is a proposal to monitor the shift of resources from secondary care to primary /community care (ie closer to home)

Is this an existing or additional control?: Potential to become an additional control

Equality/Diversity Impact

Has an equality impact assessment been undertaken? NO

Which of the 9 Protected Characteristics does it have an impact on?
The proposed monitoring is intended as a high level view only – there may be the potential to drill some of the monitoring measures down to Age / Gender / Ethnicity

Public and Patient Engagement

None planned at this stage

Recommendations

The Governing Body is asked to note progress to date

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1. Purpose

The CCG has, in line with national policy, expressed a clear objective to be able to demonstrate the movement of services from secondary care to primary / community care. Given the more emergent data flows in primary and community care, the CCG needs to be clear about the measurement of such a move and its beneficial impact on the health of the Sheffield population.

The CCG also wishes to be able to demonstrate this success to the public in simple understandable terms.

2. Introduction

A paper was presented to the 4 July meeting of the Governing Body outlining an approach to monitoring progress in the movement of services.

This paper gives a summary of progress to date.

3. Progress

3.1. Health and Wellbeing Strategy Outcomes

The recently issued "Sheffield Outcomes Framework for Joint Health and Wellbeing Strategy" identifies a list of indicators to be used to jointly monitor the progress of Health Outcomes for the city.
See Appendix 1 for the indicators used in the Outcome Framework

3.2. Right First Time – Performance Dashboard

A dashboard has been in development for the Right First Time Project Board over some months – the first draft is due to be presented to the October Right First Time Board meeting
See Appendix 2 for "Draft headline indicators for RFT performance monitoring"

3.3. Patient Experience measures

The first release of Friends and Family Test data has become available – however, the CCG recognises that this metric alone will provide little empirical evidence about service quality

3.4. System changes

Note – the impact of changes to commissioner of specialised activity have yet to be fully agreed and understood – this impacts the emergency admissions data and enabling the comparison of like for like
Note – there was a delay in access to some data whilst the Impact of the new NHS and Information Governance rules took effect

3.5. Next Steps

We will be looking to see how we can ensure consistent reporting across the three areas of monitoring for the Health and Wellbeing Board, Right First Time, and the shift from secondary to primary are consistent.

4. Questions for Governing Body

The Governing Body is asked to note the progress to date.

Paper prepared by Mark Wilkinson, Head of Informatics

On behalf of Ian Atkinson, Accountable Officer, and Dr Tim Moorhead, CCG Chair

23 September 2013

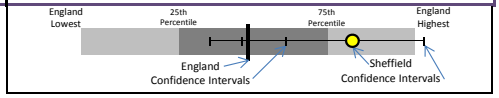
Sheffield Outcomes Framework for Joint Health and Wellbeing Strategy

The table and chart below shows how the health of people for Sheffield compares with England. The average rate for England is shown as the vertical black line, which is always at the centre of the chart. The confidence intervals for England are shown in grey where they are available / applicable.
A red circle implies that Sheffield is significantly worse than England for that indicator; a green circle indicates that it is significantly better. A white circle is shown where confidence intervals were not available but may still indicate an important health problem.

- Confidence intervals not available
- Sheffield is statistically WORSE than England
- " " " THE SAME as "
- " " " BETTER than "

Outcome		Indicator	Date of Data	England	Sheffield	Sheffield Trend	England Worst	Spine Chart	England Best
Healthy and Successful City	1	Children in Poverty (HMRC) (all children), %	2010	20.60	24.20	↑	48.60		2.40
	2	Gross income (annual), £	2012	21,794	19,818	↓	15,174		39,665
	3	Long Term unemployment, aged 16-64, %	2013	1.00	1.50	↓	3.40		0.10
	4	16-18 year olds not in education, employment or training (NEETS), %	2012	5.80	7.70	↑	10.50		0.30
	5	Foundation stage Profile attainment: Achieving 78+ points, %	2011/12	64.0	63.0	↑	51.0		78.0
	6	Achieving GCSE 5A*-C inc. Eng. & Maths, %	2011/12	59.4	55.6	↑	40.9		86.4
	7	Homelessness Acceptances (unintentionally homeless and in priority need), per 1,000 households	2012/13	2.37	5.03	↑	11.36		0.03
	8	Air Pollution: mortality attributable to particulate air pollution, %	2010	5.60	5.50	N/A	9.00		3.20
Health and Wellbeing Improving	9	Life Expectancy at Birth Male, Years	2009-2011	78.8	78.4	↑	73.8		83.0
	10	Life Expectancy at Birth Female, Years	2009-2011	82.8	82.1	↑	79.3		86.4
	11	Under 75 all cause mortality (three year), DASR per 100,000 population	2009-2011	268	285	N/A	466		170
	12	Infant Mortality Rate (three year), per 1,000 live births	2009-2011	4.40	5.10	↓	8.00		0.00
	13	% of Adults (18+) with Depression, %	2011/12	11.68	12.27	→	20.29		4.75
	14	Adult smoking prevalence from the Integrated Household Survey (age 18+), %	2011/12	20.0	21.6	→	29.3		13.8
	15	Children in Year 6 (age 10-11) Overweight and obese, %	2011/12	33.9	33.6	↑	43.1		26.6
	16	Alcohol attributable hospital admissions, DASR per 100,000 population	2011/12	1,974	1,722	↑	3,557		934
	17	Breastfeeding prevalence at 6-8 weeks after birth, %	2012/13	47.2	49.5	↓	17.5		83.3
Health Inequalities	18	Slope Index of Inequality for Life Expectancy Male, Years of life	2006-2010	8.90	10.70	↑	16.90		3.10
	19	Slope of Index Inequality for Life Expectancy Female, Years of life	2006-2010	5.90	7.70	↓	11.60		1.20
	20	Excess Winter Deaths, %	2008-2011	19.10	17.60	↓	61.11		-0.45
	21	Excess Under 75 year old mortality in Adults with Serious Mental Illness, DASR per 100,000 population	2010/11	921	988	↑	1,863		210
Care and Support When Needed	22	Patient experience of primary care - good access to GP services, %	2011/12	79.1	75.4	N/A	64.3		87.4
	23	A&E Attendances per 1,000 population, per 1,000	2011/12	309	321	↓	742		176
	24	Emergency admissions for acute conditions that should not usually require hospital admissions (all age), DASR per 100,000	2011/12	1,131	1,141	↓	2,101		249
	25	Antenatal assessment under 13 weeks	2011/12	70.70	46.50	↑	3.10		90.30
	26	Proportion of people using social care who receive self directed support, and those receiving direct payments, %	2011/12	43.00	54.20	N/A	3.90		90.60
	27	People using adult social care who have control over their daily life, %	2011/12	75.1	76.2	N/A	62.5		82.7
	28	Older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services, %	2011/12	82.7	86.2	N/A	56.9		100.0
	29	Permanent Admissions to nursing/residential care, %	2011/12	19.10	4.30	N/A	67.10		3.30
	30	Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population, %	2011/12	9.68	3.42	N/A	30.60		0.50

Sheffield value is WORSE than previous time period ↓
" " " BETTER " " " " ↑
" " " the SAME as " " " " →



See page 2 for definitions of indicators

v0.4, 26th July 2013

Outcome		Indicator Definitions
Healthy and Successful City	1	**Children in Poverty (HMRC) (all children), %** PHOF Indicator 1.1. % of Children in "Poverty": The proportion of children living in families in receipt of out of work benefits or in receipt of tax credits where their reported income is less than 60 per cent of median income. Dependent children are defined as all children aged <16 and those aged 16-19 not married or in a civil partnership, living with parents and in full-time non-advanced education or unwaged government training. Denominator is the total number of children receiving Child Benefit. NOTE: the local authority definition is slightly different to the national level definition of % children in relative poverty (living in households where income is less than 60% of median household income before housing costs). Used to be National indicator 116.
	2	**Gross income (annual), £** Average gross annual income of employees on adult rates who have been in the same job for more than a year.
	3	**Long Term unemployment, aged 16-64, %** The percentage of 16-64 year olds who are claiming JSA for longer than 12 months. As measured by ONS in March of each year.
	4	**16-18 year olds not in education, employment or training (NEETS), %** PHOF 1.5. The percentage of 16 to 18 year olds who are not in education, employment or training (NEET). The estimated number of 16-18 year olds not in education, employment or training divided by the total number of 16-18 year olds known to the local authority whose activity is either not in education, employment or training (NEET), or in education, employment or training (EET). This uses the average proportion of 16-18 year olds NEET between November and January each year. These figures are collected by local authorities, and cannot be compared with the DfE estimate of young people NEET which uses different definitions.
	5	**Foundation stage Profile attainment: Achieving 78+ points, %** % of children who achieve at least 78 points across the Early Years Foundation Stage with at least 6 in each of the scales in Personal, Social and Emotional Development and Communication, Language and Literacy for schools each Local Authority Area. Note that figures are sum of schools in each Local Authority, rather than children resident in that Local Authority. Was National Indicator 72.
	6	**Achieving GCSE 5A*-C inc. Eng. & Maths, %** Percentage of pupils at the end of Key Stage 4 in LEA maintained schools at the end of the academic year achieving 5 or more GCSEs at grades A*-C or equivalent including English and maths, at end of Key Stage 4.
	7	**Homelessness Acceptances (unintentionally homeless and in priority need), per 1,000 households** PHOF Indicator 1.15i. Crude rate of statutory homeless households per 1,000 estimated total households. Number of households who are eligible, unintentionally homeless and in priority need, for which the local authority accepts responsibility for securing accommodation.
	8	**Air Pollution: mortality attributable to particulate air pollution, %** PHOF Indicator 3.1. The indicator is an estimated proportion. It represents the estimated annual mortality attributable to air pollution in the population aged 30+, as a proportion of total deaths of those aged 30+. Mortality burden associated with long-term exposure to anthropogenic (human-made)particulate air pollution (measured as fine particulate matter, PM2.5) at current levels.
Health and Wellbeing Improving	9	**Life Expectancy at Birth Male, Years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	10	**Life Expectancy at Birth Female, Years** PHOF Indicator 0.1i. Life expectancy at birth. Calculated using deaths at all ages, from all causes, registered in the respective calendar years.
	11	**Under 75 all cause mortality (three year), DASR per 100,000 population** Directly age-standardised mortality from all cause in persons less than 75 years in the respective calendar years, per 1000,000 population. Standardised using the European Standard Population.
	12	**Infant Mortality Rate (three year), per 1,000 live births** PHOF Indicator 3.1. Crude mortality rate of infants aged under 1 year per 1000 live births
	13	**% of Adults (18+) with Depression, %** The percentage of patients aged 18 and over with depression, as recorded on practice disease registers. Sheffield value is for PCT. (Note the range is of PCTs)
	14	**Adult smoking prevalence from the Integrated Household Survey (age 18+), %** PHOF Indicator 2.14. Prevalence of smoking among persons aged 18 years and over from the Integrrated Household Survey.
	15	**Children in Year 6 (age 10-11) Overweight and obese, %** PHOF Indicator 2.6ii. Proportion of children aged 10-11 (Year 6) classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
	16	**Alcohol attributable hospital admissions, DASR per 100,000 population** PHOF 2.18. Hospital Admission episodes for alcohol-attributable conditions (previously NI39): All ages, Directly age standarised rates per 100,000 population
	17	**Breastfeeding prevalence at 6-8 weeks after birth, %** PHOF Indicator 2.2 ii. Percentage of infants who are totally or partially breastfed at 6-8 week check. Babies with unknown feeding status at 6-8 weeks are excluded from the numerator and denominator.
Health Inequalities are Reducing	18	**Slope Index of Inequality for Life Expectancy Male, Years of life** The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area.
	19	**Slope of Index Inequality for Life Expectancy Female, Years of life** The Slope Index of Inequality (SII) of life expectancy at birth within each English upper tier local authority based on local deprivation deciles of LSOA (LA level). The SII is a deprivation-based inequalities measure that can be applied to any indicator and has been approved by the NHS Sheffield Director of Public Health as the standard inequalities measure to be used for Public Health indicators. It represents the gap in indicator values between the most deprived and least deprived people in a given area.
	20	**Excess Winter Deaths, %** The ratio (5) of extra deaths from all causes that occur in the winter months compared to the average of the number of non-winter deaths of the same period. (Public Health Outcome Framework Indicator 4.15). This indicator measures excess winter deaths expressed as the EWD Index, in order that comparisons can be made easily between different geographies. It indicates whether there are higher than expected deaths in the winter compared to the rest of the year. The year runs from August to July. Winter months are December to March, Non-Winter months are August to November and April to July.
	21	**Excess Under 75 year old mortality in Adults with Serious Mental Illness, DASR per 100,000 population** PHOF Indicator 4.9 and NHSOF Indicator 4.5. The mortality rate in the mental health population is directly standardised to the national population. This is then compared to the national rate. The mental health population is defined as anyone who has been in contact with the secondary mental care services in the current financial year or in ether of the two previous financial years who is alive at the beginning of the current financial year. The mental health rate is directly standardised by age and sex to the England population.
Care and Support When Needed	22	**Patient experience of primary care - good access to GP services, %** NHSOF Indicator 4.4i. The percentage of GP patient survey respondents who said they had a good experience of making an appointment. Data for this indicator is from the GP Patient Survey. July 2011 to March 2012. Sheffield value is for PCT. (Note the range is of PCTs)
	23	**A&E Attendances per 1,000 population, per 1,000** The rate in terms of activity per 1000 population for A&E attendances. Based on registered population. England rate is adjusted at source and cannot be used as comparator, England figure is 'sum(standardised rate x population) / sum(population)'.
	24	**Emergency admissions for acute conditions that should not usually require hospital admissions (all age), DASR per 100,000** CCG OIS Indicator 3.1. Data is at CCG level. Total number of emergency admissions episodes for people of all ages* where acute conditions that should not usually require hospital admission was the primary diagnosis. The indicator will show information on the number of emergency admissions per 100,000 population. This indicator has been indirectly age and sex standardised. The number of finished and unfinished continuous inpatient (CIP) spells, excluding transfers, for patients with an emergency method of admission and with any of the following primary diagnoses (DIAG_01in the 1st episode of the spell, ICD 10 codes) in the respective financial year. Indirectly age standardised per 100,000 population for area
	25	**Antenatal assessment under 13 weeks** CCG OIS Indicator 1.13. Data is at CCG level. Number of women in the relevant CCG population who have seen a midwife or a maternity healthcare professional for health and social care assessment of needs, risks and choices by 12 weeks and 6 days of pregnancy
	26	**Proportion of people using social care who receive self directed support, and those receiving direct payments, %** SCOF Indicator 1C.
	27	**People using adult social care who have control over their daily life, %** Measure 1B uses responses to question 3a in the Adult Social Care Survey which asks services uses how much control they have over their daily lives. The measure is calculated as the proportion of respondents who say they have as much control as they want or adequate control, or who respond that they can make all the choices they want in response to the easy read version of the question which asks how much control the service user has in their life. It is expressed as a percentage of all service users who gave a valid response to question 3a.
	28	**Older people (65+) still at home 91 days after discharge from hospital into re-ablement/rehabilitation services, %** NHSOF Indicator 3.6.i . The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator. The collection of the denominator will be between 1 October 2011 and 31 December 2011, with a 91-day follow-up for each case included in the denominator to populate the numerator i.e. the numerator will be collected from 1 January 2012 to 31 March 2012.
	29	**Permanent Admissions to nursing/residential care, %** People counted as a permanent admission should include: • Residents where the local authority makes any contribution to the costs of care, no matter how trivial the amount and irrespective of how the balance of these costs are met; • Supported residents in: o Local authority staffed care homes for residential care; o Independent sector care homes for residential care; and, o Registered care homes for nursing care. o Residential or nursing care which is of a permanent nature and where the intention is that the spell of care should not be ended by a set date. For people classified as permanent residents, the care home would be regarded as their normal place of residence. Where a person who is normally resident in a care home is temporarily absent at 31 March 2011 (e.g. through temporary hospitalisation) and the local authority is still providing financial support for that placement, the person should be included in the numerator. Trial periods in residential or nursing care homes where the intention is that the stay will become permanent should be counted as permanent. Whether a resident or admission is counted as permanent or temporary depends on the intention of the authority making the placement.
	30	**Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population, %** A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.

PHOF = Public Health Outcome Framework
NHSOF = NHS Outcome Framework
CCG = Clinical Commisioning Group

Draft headline indicators for RFT performance monitoring

The following refer to corresponding boxes in strategy map	Measure	Detail	Spilt (where appropriate)
Box A: Health & Wellbeing of people with LTCs	**NHSOF / PHOF indicators of preventable premature mortality**	Overall mortality from causes considered preventable	
		Premature mortality from causes considered preventable:	Cardiovascular
			Respiratory
			Liver
	ASCOF domains: **Enhancing quality of life for people with care and support needs** **Ensuring people have a positive experience of care and support**	Proportion of social care service users who have control over their daily life	
		Social care-related quality of life	
		Overall satisfaction of social care service users with their care and support	
		Delayed discharge from hospital	
		% offered reablement following hospital discharge	
		% still at home 91 days after reablement / rehab following hospital discharge	
Box B: Reduced unnecessary acute bed days	**Sheffield trusts: overall rate of emergency admission (FCEs)**	Emergency admission FCEs	
		Emergency admission bed nights	
		Emergency ACSC admission FCEs	
		Emergency ACSC admission bed nights	
	Sheffield trusts: number of acute bed nights	STH	
		SCH	
		Total STH + SCH	
	Sheffield trusts: ambulatory care sensitive bed nights (CCG Quality premium)	ACSC emergency beds nights (Sheffield definition) and non-ACSC bed nights by month to YTD from April 2007?	
Box C: Effective use of resources	**Operating costs**	Total unscheduled care spend (commissioner) versus plan	
	Measures of effectiveness	Programme budgeting spend (focus on excess spend areas versus benchmark comparators):	Mental health
			Social care
	Incidence of temporary service closures due to hitting capacity limit	As a measure of bottlenecks arising in the care system:	CICS & STIT
			IC beds
Box D: Service user perspective	**Kate Register and team to define**		
Box E: Volume and variation	**Rate variation in ACSC emergency admissions**	FCEs table – rolling 12m total	
		By Locality (? and by GPA)	Central Locality
			HASC Locality
			North Locality
			West Locality
	ACSC emergency admission length of stay	Mean	
	GSM measures	Discharges	
		(midnight?) bed occupancy	
	Transitional care pathway	Intermediate Care - discharges	
		Intermediate Care - average LOS	
		CICS & STIT measure?	
	ACSC admissions with a SMI (placeholder)	?Using ICD10 definition of SMI	
		?Using clients on SHSCT's CPA register	
	Rate of paediatric admissions (placeholder)	Paediatric admissions in under 5s.	
		NHSOF measures:	asthma, diabetes & epilepsy in u19s
			child LRTI admissions
	Rate of readmission	ACSC readmission (any) within 30 days of ACSC discharge	
Box F: Financial	**Cost of emergency hospital admissions**	Total - actual	
		Total - plan	
		ACSCs	
		Non-ACSCs	
	Change in hospital spend versus new investments in community services	Change in emergency hospital admission expenditure since baseline versus new investment (± ROI)	
		Ditto for children's services?	

JSNA = Joint Strategic Needs Assessment
NHSOF = NHS Outcomes Framework
ASCOF = Adult Social Care Outcomes Framework