Health and Wellbeing Board Review of the Surrey CCGs Quality Measure (2014/16 Operation Plans) - Two areas to be reviewed by Board Members:

- Do the Quality Measure's align with the Health and Wellbeing Strategy Priorities?
- Are the Quality Measure stretches (baseline v target) challenging enough?

CCG	Local Quality Measure	Baseline	Target	Stretch	Health and Wellbeing Strategy Priorities				
					Mental Health	Children & YP	Older Adults	Prevention	Safeguarding
East Surrey	GP OOH patient satisfaction	30%	80%	50%			√ (reduction in A&E attendances and emergency admissions)		
Surrey Downs	Dementia diagnosis	48% but population set to rise by 5%	67% to maintain baseline target	5%	√		√		√
Guildford & Waverley	Frail elderly advanced care planning	0%	80%	80%			√	√	√
North West Surrey	Alcohol identification and intervention in new registrations	Current baseline 0% 5% population changes GP (1150)	33% (380) patients to receive intervention	33%	√		√	√	√
Surrey Heath	GP patient assessments on admission to nursing homes	0%	75%	75%			√	√	√
NE Hants & Farnham	Diabetes patients receiving all 8 core processes	68%	72.5%	3%				√	

Further actions: All CCGs to put Quality Measures into plain language for sharing with patient's and stakeholders and to include an explanation of the measures and the stretch and how they will improve outcomes for patients.

North East Hampshire & Farnham Clinical Commissioning Group

We will increase the percentage of patients diagnosed with diabetes who receive all eight (NICE recommended) key care processes from 68% to 72.5% during 2014/15.

The eight key care processes for diabetes are important assessments and tests that should be conducted each year as part of patients' ongoing care and monitoring of their condition. These processes are carried out by the patient's key healthcare professional who manages their condition, usually a primary care clinician such as a GP or Practice Nurse. The key care processes are defined as:

1. Measuring the patient's Body Mass Index (assessment)
2. Measuring the patient's Blood Pressure (assessment)
3. Reviewing the patient's risk of foot complications (assessment)
4. Recording a patient's smoking status (assessment)
5. Measuring the patient's HbA1c (test)
6. Measuring the patient's serum creatinine (test)
7. Measuring the patient's serum cholesterol (test)
8. Measuring the patient's urine albumin: creatinine ratio (test)

The reason for conducting the key care processes is to monitor the patient's condition, allowing the healthcare professional to detect any changes or deterioration, which can be proactively managed through implementing early interventions. These interventions can assist in stabilising the patient's condition and prevent or slow down further deterioration which can lead to serious complications later in life.

All local GP Practices have committed to deliver the eight key care processes with the emphasis on strengthening the positive longer term outcomes for patients diagnosed with diabetes.

Surrey Downs CCG

Dementia screening initiative leading to earlier diagnosis

With an ageing population and an estimated 4,000 people living with dementia in the Surrey Downs area alone, in July 2013 we launched an innovative project to improve early diagnosis and support for people living with dementia in the local area.

Based on similar initiatives that have worked well in other parts of the country, we teamed up with Surrey and Borders Partnership Foundation NHS Trust to introduce a new team of specialist community nurses who are now screening those most at risk.

As part of the initiative we invite people over the age of 65 years to have a memory test. The test can't give a dementia diagnosis but if issues are identified we refer people on to other services to understand what the problem is and whether it is dementia or caused by another underlying health issue.

Since we first launched the service we have screened over 800 people. Just under one in five of those who have taken part have been referred on to other services for further investigation so early signs suggest the project is already making a real difference in helping to identify memory problems sooner.

East Surrey CCG

The objective of this quality measure is to reduce the number of people reporting very bad experience of out of hours care. For East Surrey CCG this is significant when considering performance in this area both nationally and against comparator CCGs as evidenced by the "Level of Ambition Tool".

The measure to be used will be ascertained by way of survey, and will be the average number of positive responses per 100 patients. The baseline figure of 30% was determined from the "Level of Ambition Tool" used as part of the strategic planning process.
The improvement from 30% to 80% will be challenging, however, the CCG is confident of achieving this as we have procured a new service with constant monitoring of the provider through Key Performance Indicators (KPIs) relating to quality of service that will drive improved patient experience. Examples include:

- The % of times where the summary care records of patients were accessed either before, or during, the consultation.
- The % of patients who wait longer than 30 minutes running from the time of their scheduled appointment booked by 111.
- The % of times incoming calls from other local community OOH services are answered within 20 seconds
- The % of incoming referrals which, after a consultation, result in an admission per base & CCG

Guildford and Waverley CCG

The objective is to provide anticipatory care plans for the number of people on the district nurse caseload who are at the end of their life to improve the quality and co-ordination of people's care.
The target is 80% of the district nurse caseload and the baseline is 0%.

North West Surrey CCG

Alcohol identification and intervention in new registrations

- GPs are asked to get new patients registering with their practice to complete a simple questionnaire which gives scores against a number of key questions which assesses how often they drink alcohol and how much and whether this fits a profile which means they are likely to develop long term health problems as a result.

- If patients score above a particular level then they will offer the patient a brief discussion to help them understand the risk they are taking and the long term impact and gives advice on how they can reduce their drinking and sources of support available to them if they would like more help.
- By following this approach we are looking to try and identify more of the higher risk patients than we have done in the past and make sure that we offer them positive help to reduce their risk of serious long term damage to their health.

Surrey Heath CCG

Improving the quality of general practice initial assessment and documentation for patients on admission to nursing homes

Surrey Heath CCG currently has 452 nursing home residents. An assessment form has been developed to help GPs easily identify risk factors which would contribute to the likelihood of a hospital admission and improve dementia diagnosis rates, and support patients preference for their preferred place of death. The review will include a falls assessment and medication review. In addition to improving the quality of care to patients through the development of a personalised care plan early after the patient's admission it will enable better communication between nursing home staff, patients and families and GPs . The aim is to have at least 75% completion rate of these forms for all registered patients by 31st March 2015.