NHS
Bury
Clinical Commissioning Group

# Meeting: Primary Care Commissioning Committee

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|---|---|---|---|
| **Meeting Date** | 26 September 2018 | **Action** | Consider |
| **Item No.** | 9 | **Confidential** | No |
| **Title** | Quality in Primary Care Phase 2 Underperformance Analysis | | |
| **Presented By** | Rachele Schofield, Primary Care Manager | | |
| **Author** | Rachele Schofield, Primary Care Manager | | |
| **Clinical Lead** | Dr Jeff Schryer, NHS Bury CCG Chair & Clinical Lead for Primary Care | | |

## Executive Summary

Primary Care Commissioning Committee where presented with the performance outturn for Phase 2 of the Quality in Primary Care Contract (commissioned between 1 April 2017 and the 31 March 2018) in May 2018. The following paper has been written to provide further analysis at the request of the Committee for those Standards within the Contract that demonstrated the highest pockets of underperformance across Practices in Bury and to offer recommendations to improve performance in Phase 3 of the Contract.

## Recommendations

The PCCC are asked to receive the review as presented.

## Links to CCG Strategic Objectives

| | |
|---|---|
| To encourage people so that they want to, and do, take responsibility for their own health and well-being. | ☒ |
| To drive and support system wide transformation. | ☐ |
| To commission joined-up health and social care for people in Bury through a Single Commissioning Framework. | ☐ |
| To achieve financial sustainability for the Bury health and social care economy. | ☒ |
| To support the Locality Care Alliance to deliver high quality services in line with commissioner intentions. | ☐ |
| To be a high-performing, well-run and respected organisation with an empowered workforce | ☐ |

Does this report seek to address any of the risks included on the Governing Body Assurance Framework? If yes, state which risk below:

GBAF *[Insert Risk Number and Detail Here]*

| Implications | | | | | | |
|---|---|---|---|---|---|---|
| Are there any quality, safeguarding or patient experience implications? | Yes | ☐ | No | ☒ | N/A | ☐ |
| | | | | | | |
| Has any engagement (clinical, stakeholder or public/patient) been undertaken in relation to this report? | Yes | ☒ | No | ☐ | N/A | ☐ |
| *Clinical engagement and Practice engagement* | | | | | | |
| Have any departments/organisations who will be affected been consulted ? | Yes | ☐ | No | ☐ | N/A | ☒ |
| | | | | | | |
| Are there any conflicts of interest arising from the proposal or decision being requested? | Yes | ☐ | No | ☒ | N/A | ☐ |
| | | | | | | |
| Are there any financial Implications? | Yes | ☐ | No | ☒ | N/A | ☐ |
| | | | | | | |
| Has a Equality, Privacy or Quality Impact Assessment been completed? | Yes | ☐ | No | ☐ | N/A | ☒ |
| Is a Equality, Privacy or Quality Impact Assessment required? | Yes | ☐ | No | ☐ | N/A | ☒ |
| Are there any associated risks including Conflicts of Interest? | Yes | ☐ | No | ☐ | N/A | ☒ |
| Are the risks on the CCG's risk register? | Yes | ☐ | No | ☐ | N/A | ☒ |
| *If you have ticked yes provide details here. If you are unsure seek advice from Lynne Byers, Email - lynnebyers@nhs.net about the risk register.* | | | | | | |

| Governance and Reporting | | |
|---|---|---|
| **Meeting** | **Date** | **Outcome** |
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| | | |

## Quality in Primary Care Phase 2 Underperformance Analysis

## 1. Introduction

1.1 Primary Care Commissioning Committee where presented with the performance outturn for Phase 2 of the Quality in Primary Care Contract (commissioned between 1 April 2017 and the 31 March 2018) in May 2018. The following paper has been written to provide further analysis at the request of the Committee for those Standards within the Contract that demonstrated the highest pockets of underperformance across Practices in Bury and to offer recommendations to improve performance in Phase 3 of the Contract.

## 2. Background

2.1 On the whole Bury CCG are delighted with Practice performance across Phase 2 of the Quality in Primary Care Contract. The Contract was significantly larger in content and more challenging in terms of delivery during 2017/2018 with a greater number of Key Performance Indictors (KPIs) to achieve hence the increased investment.

2.2 However, when analysing performance across each standard, it was clear that there were 3 distinct areas which require further exploration as follows:

- Standard 2 - To improve health outcomes for patients with mental illness, those with learning disabilities and military veterans
- Standard 6 - Improving Outcomes for People with a Long Term Condition
- Standard 8 – Improving Outcomes in Childhood Asthma

## 3 Standard 2 - To improve health outcomes for patients with mental illness, those with learning disabilities and military veterans

3.1 Standard 2 was not commissioned as part of Phase 1, therefore 2017/18 was the first opportunity practices had to work towards these KPIs. Practices performed well against the KPIs for Military Veterans, patients with Cognitive Impairment and Learning Disabilities but performed less well against targets for patients on the Serious Mental Illness (SMI) register:

| KPIs | % of Practices Achieving 17/18 |
|---|---|
| **Physical and Mental Health of those on SMI register:** | |
| 90% 0f patients on SMI register to receive a Care Plan (use template as per Standard 9) | 57% |
| 90% of patients on SMI register with Cholesterol measured April 2017-March 18 | 23% |
| 100% of patients with SMI and cholesterol (who are eligible)have a QRisk2 score recorded April 2017 – March 2018 | 37% |
| 90% of patients on SMI register with BP measured April 2017 March 2018. | 63% |
| 90% of patients on SMI register with Weight measured April 2017 March 2018 | 37% |
| 50% of patients with as QRisk2 score > 10% on a statin | 73% |

3.2 As part of our analysis, we asked the Clinical Lead for Mental Health for a view and reached out to practices that had performed well against Standard 2 however, at the time of writing this paper, we have not received any feedback.

3.3 The analysis of this standard noted the variance in % achievement between each intervention despite the presumption that these would all be carried out within the same consultation. A recent Mersey Internal Audit Agency (MIAA) audit highlighted that in fact interventions e.g. cholesterol check, BP, weight were being recorded opportunistically and included those carried out within other clinical settings.

3.4 We have sought clinical guidance to determine if the health interventions contained in Standard 2 do need to be carried out at the same time in a GP setting or if results from external clinics can be documented on the care plan to ensure its completion. We have been advised that health interventions undertaken in another clinical setting can be recorded provided the procedure was conducted within a 3 month period. This has been added to the Phase 3 Contract Variation (CV001).

3.5 Despite the underperformance seen in Phase 2, it is felt that practices have achieved a solid base on which to build and performance will increase as we progress in to year 2 of delivery against the SMI indicators. This view is supported when looking at the QoF data for 2016/2017 (Appendix 1) which show Bury CCG as the top performing CCG in GM, achieving consistently against QoF mental health targets in year. Please note that, at the time of writing this paper, 2017/18 QoF data is not available for comparison..

## 4 Standard 6 - Improving Outcomes for People with a Long Term Condition

4.1 Standard 6 was not commissioned as part of Phase 1 therefore 2017/18 was the first opportunity practices had to work towards these KPIs. Overall performance against Diabetes within Standard 6 was the least favourable within the Contract. Two Practices excelled by achieving 100% across all 8 care processes and a further 3 practices achieved 100% in some, but not all, areas:

| KPIs | % of Practices Achieving 17/18 |
|---|---|
| **Diabetes:** | |
| 100% of Adult Patients diagnosed as having type 2 diabetes have received all 8 care processes (exception reporting where required in line with QoF). The 9th Care Process - Retinal screening has been removed from the requirements of this year's contract | 6% |
| Patients with Type 2 Diabetes with a BMI check since 1/4/17 | 10% |
| Patients with Type 2 Diabetes with a BP check since 1/4/17 | 13% |
| Patients with Type 2 Diabetes with a HbA1c check since 1/4/17 | 13% |
| Patients with Type 2 Diabetes with a Serum Creatinine check since 1/4/17 | 10% |
| Patients with Type 2 Diabetes with a Urine Albumin check since 1/4/17 | 10% |

| | |
|---|---|
| Patients with Type 2 Diabetes with a Cholesterol check since 1/4/17 | 10% |
| Patients with Type 2 Diabetes with foot examination recorded since 1/4/17, or with valid exception | 10% |
| Patients with Type 2 Diabetes with smoking status recorded since 1/4/17, or latest status is Never Smoked | 7% |

4.2 As part of our analysis to better understand Phase 2 performance, we asked practices who had achieved against Standard 6 for their feedback which was received as follows:

**Birches Medical Centre -** *"Historically The Birches Medical Centre did not perform very well on diabetes management and we were lagging behind our peers.*

*We decided to tackle this systemically and in year 2016/17 we took wide analysis of constraining factors preventing practice to perform better. Then we translated this into action; For example our lead diabetes nurse accessed additional training, she also did independent prescriber course to allow her higher level of independence in pharmacological management and "all in one" approach. She is now supported by another nurse who also gained skills on diabetes management.*

*We made 3 stages improvement plan and stuck to it. We updated/created new diabetes protocol and followed it. We created dedicated "diabetes team" (nurse, GP, HA and admin staff member) who work together using clear protocols/set of competences/clinical pathways and communicate on regular basis. When we recall patients for diabetic reviews we give them set day and time of appointment rather than asking them to book in themselves. If they DNA staff member will phone them to make sure they are being re-booked etc. We read code retinal screenings and DNAs- again a dedicated staff member is responsible for this and she will be chasing up DNAs.*

*We started this work very early in the year 2017/18 as we were aware of amount of work ahead of us and large number of patients we needed to review. This gave us enough time to chase up those who were stubborn to respond and exempt those who refused to be seen (very few did).*

*Our goal was to improve management of our diabetic patients; GM standard achievement was just side benefit."*

**Huntley Mount Medical Centre -** *Happy to share how we did it (lots of hard work, restricting prescriptions to two weeks and then one week, Pract Pharm and Nurses calling, and then GP contacts). The admin team were amazing. I posted sample bottles to some patients. The prob is that the investment doesn't justify the return, that's where it may not be sustainable... happy to discuss.*

4.3 The CCG were aware of the challenge that faced Practices by asking for 100% achievement across a range of indicators rather than reward for individual delivery however we recognised that in order for patients to receive the best possible outcomes all of the 8 care processes should be offered and completed.

4.4 We challenge the practice perspective that the work involved in achieving the Diabetes targets in Phase 2 perhaps did not justify the return on investment. Providers must consider the contract value as a whole rather than just specific KPI reward payments.

4.5 The CCG will expect performance to increase as we progress into year 2 of delivery against the Diabetes indicators, a view which is supported by QoF data for 2016/2017 (Appendix 2) which shows Bury CCG as the top performing CCG in GM, performing strongly against diabetes targets in year and a view which is mirrored when reviewing the National Diabetes Audit (NDA) data in 2016/2017 which showed the CCG average for Bury across the 8 care processes to be 57.5%.

4.6 Within Phase 3 of the contract this target has been reduced to 70%. This is stretch on attainment from the NDA but ensures practices are not disengaged by the unrealistic expectation of 100% achievement.

## 5 Standard 8 – Improving Outcomes in Childhood Asthma

5.1 Whilst the percentage of Practices achieving ≥65% flu uptake (all children aged 2-3) increased by 8% from 2016/17 to 2017/18 and 100% of Practices have an identified Asthma Lead (maintained since Phase 1), there has been a decrease in achievement across all other KPIs within this Standard between Phase 1 (2017/18) and Phase 2 (2017/18):

| KPIs | % of Practices Achieving 17/18 | % of Practices Achieving 16/17 | Trend |
|---|---|---|---|
| Attendance at asthma education sessions and feedback learning to all practices (at least annual) | 93% | 100% | ↓ |
| • ≥75% of children on the register who are on a preventer inhaler have been reviewed within the last 12mths | 87% | 100% | ↓ |
| • ≥75% of children on the register who are on a preventer inhaler with a personalised action plan in place in last 12m | 77% | 97% | ↓ |
| • ≥75% of children on the register who are on a preventer inhaler have completed the ACT as part of the review process in last 12m | 77% | 94% | ↓ |
| • ≥75% of children on the register who are on a preventer inhaler have undergone training/assessment of inhaler technique in last 12m | 80% | 97% | ↓ |
| ≥65% flu uptake (all children aged 2-3) | 27% | 19% | ↑ |

5.2 Despite the downturn in performance between Phase 1 and Phase 2, QoF data for 2016/2017 (Appendix 3) demonstrates the strong position Bury CCG is in across GM, performing consistently against asthma targets in year. It should be recognised that Phase 2 only allowed for a small element of exception reporting for this cohort of patients, noting that QoF allowed greater flexibility with regards to its exception reporting parameters.

5.3 Following feedback from practices, including Clinical Leads, the CCG have adopted the QoF exception reporting criteria for Phase 3 which we believe will ensure those

patients who are true exceptions are documented and removed from the final performance calculation which will give a more accurate year end performance figure.

5.4 As part of our analysis of Phase 2 performance, we asked the Clinical Lead for Asthma for a view on Phase 2 wider performance however, at the time of writing this paper, we had not received a response. We also reached out to practices that had performed well against Standard 8, one responded as follows:

**Fairfax Medical Practice** - *I think the area you are mainly referring to is attaining the childhood flu target and we did this by actively contacting parents via phone, letter, SMS, email to encourage them to bring in their children. In addition, all clinicians and staff were on board with this, with the view that whenever these children were in the surgery with a parent, family member or for themselves, to actively encourage the parents to get their child vaccinated. This seemed to work very well. With regards getting the children in for their asthma reviews, again it was a multidisciplinary approach to encouraging the families of children to come in for their review with either the nurse or the pharmacist.*

5.5 We have listened to General Practice and noted the challenges faced when achieving this KPI. We have also considered the Association Governing Group AGG ratified GM Standards which state the requirement on general practice to "Increase the uptake of flu immunisations of eligible children (incrementally year on year). Taking this feedback on board, we have reduced the KPI achievement for childhood flu from 65% to 50%. Given this reduction, we expect the upward trend in performance to continue into 2018/19, satisfying both the local and GM expectation whilst ensuring herd immunity and continued quality of care.

## 6 Phase 2 Disputes

6.1 Following the release of year end performance data for Phase 2 of the Quality in Primary Care Contract, and despite the pockets of underperformance seen, the Primary Care Team only received 18 disputes raised by 7 Practices, covering 7 Standards focusing on 11 contractual KPIs. Following Stage 1 feedback to practices, only one has requested their dispute be heard by formal dispute panel**.**

6.2 50% of the disputes received were against the Standards discussed in this paper, however, 44% of those were not upheld at Stage 1 of the process and none of these progressed to formal dispute panel reinforcing the CCG's positive position in the continued commissioning of these Standards in Phase 3:

| Standard | KPI | No of Disputes | Stage 1 Outcome |
|---|---|---|---|
| **Standard 2 - To improve health outcomes for patients with mental illness, those with learning disabilities and military veterans** | Patients on the Practice LD Register aged ≥14 have undergone a health check within the last 12mths | **1** | Upheld |
| | 90% of patients on SMI register with Cholesterol measured Apr 2017-Mar 18 | **1** | Upheld |
| | Practices' dementia diagnosis rates should be 75% of their predicted prevalence or higher | **1** | Upheld |
| **Standard 6 - Improving Outcomes for People with a Long Term Condition** | 100% of Adult Patients diagnosed as having type 2 diabetes have received all 8 care processes (exception reporting where required in line with QoF). The 9th Care Process - Retinal screening has been removed from the | **4** | Not Upheld<br>Not Upheld<br>Upheld |

| | | | |
|---|---|---|---|
| | requirements of this year's contract | | Upheld |
| | 80% of patients who had an MI in 16/17 to have received an echo within 12 months of the MI | **1** | Not Upheld |
| **Standard 8 – Improving Outcomes in Childhood Asthma** | 65% Flu uptake (all children 2-3) | **1** | Not Upheld |

6.3 In contrast, the Primary Care Team received 22 disputes from 18 Practices at the end of Phase 1, a smaller contract focusing on only 5 Standards. This reinforces practice understanding of the contract and justifies the CCG's investment in Outcomes Manager which has enabled practices to view live data ensuring more effective planning whilst providing the CCG with a mechanism for accurate data extraction to evidence performance, leaving a much smaller margin for contest. We will continue to build on this in Phase 3 to ensure a further reduction in disputes received.

## 7 Associated Risks

7.1 The main risk within the Quality in Primary Care Contract is that we may commission unattainable targets which are too challenging for practices to achieve, causing them to disengage in the process. To mitigate against this, we will measure performance against targets across each quarter, ensuring sufficient incremental progress has been made at each juncture.

7.2 Where the data shows that insufficient progress to target has been made, we will engage with Practices, offering support and guidance as appropriate to ensure they are able to achieve the targets set. We will also take that opportunity to remind Practices of their contractual obligations, whilst reinforcing the CCGs financial position with regard to recouping payments where the data supports that practices are not actively pursuing target achievement or engaging in the contract delivery process.

## 8 Recommendations

8.1 The PCCC are asked to

- Receive the review as presented

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September 2018

# Appendices

## Appendix 1

| indicator_code | indicator_desc | Possible | 00V | 00T | 00Y | 01D | 01G | 01W | 01Y | 02A | 02H | 14L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| LD003 | The contractor establishes and maintains a register of patients with learning disabilities | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| MH001 | The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| MH002 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate | 6.0 | 6.0 | 5.6 | 5.5 | 5.6 | 5.2 | 5.9 | 5.4 | 5.7 | 5.8 | 5.5 |
| MH003 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months | 4.0 | 3.8 | 3.8 | 3.8 | 3.8 | 3.7 | 3.8 | 3.7 | 3.8 | 3.8 | 3.8 |
| MH007 | The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months | 4.0 | 3.9 | 3.8 | 3.8 | 3.7 | 3.6 | 3.9 | 3.6 | 3.6 | 3.9 | 3.8 |
| MH008 | The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years | 5.0 | 5.0 | 4.9 | 4.5 | 4.9 | 4.7 | 4.8 | 5.0 | 4.9 | 4.8 | 4.8 |
| MH009 | The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months | 1.0 | 1.0 | 0.8 | 1.0 | 0.9 | 0.9 | 0.9 | 1.0 | 1.0 | 0.8 | 0.9 |
| MH010 | The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months | 2.0 | 1.8 | 1.3 | 1.4 | 1.5 | 1.4 | 1.7 | 1.7 | 1.7 | 1.4 | 1.7 |

## Appendix 2

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DM002 | The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less | 8.0 | 7.9 | 7.4 | 7.4 | 7.6 | 7.3 | 7.8 | 7.5 | 7.6 | 7.7 | 7.5 |
| DM003 | The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less | 10.0 | 9.7 | 9.0 | 8.9 | 9.2 | 8.8 | 9.6 | 9.2 | 9.3 | 9.6 | 9.0 |
| DM004 | The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less | 6.0 | 5.9 | 5.4 | 6.0 | 5.9 | 5.6 | 6.0 | 5.9 | 5.9 | 5.8 | 5.8 |
| DM006 | The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs) | 3.0 | 2.9 | 2.5 | 2.8 | 2.8 | 2.6 | 2.8 | 2.9 | 2.9 | 2.7 | 2.8 |
| DM007 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months | 17.0 | 15.9 | 14.1 | 13.4 | 14.4 | 14.1 | 16.0 | 14.6 | 15.6 | 15.3 | 14.6 |
| DM008 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months | 8.0 | 7.5 | 6.5 | 6.4 | 6.8 | 6.6 | 7.5 | 6.9 | 7.2 | 7.1 | 6.8 |
| DM009 | The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months | 10.0 | 9.4 | 8.3 | 8.4 | 8.7 | 8.3 | 9.4 | 8.7 | 9.1 | 8.8 | 8.7 |
| DM012 | The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months | 4.0 | 3.8 | 3.1 | 3.7 | 3.8 | 3.2 | 3.7 | 3.6 | 3.8 | 3.8 | 3.8 |
| DM014 | The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register | 11.0 | 10.0 | 10.6 | 10.2 | 10.3 | 9.2 | 10.8 | 10.3 | 10.4 | 10.8 | 10.5 |
| DM017 | The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 | 6.0 |
| DM018 | The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March | 8.0 | 2.9 | 2.7 | 2.9 | 2.9 | 2.5 | 2.9 | 2.9 | 3.0 | 2.9 | 2.8 |

## Appendix 3

| indicator_code | indicator_desc | Possible | 00V | 00T | 00Y | 01D | 01G | 01W | 01Y | 02A | 02H | 14L |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **AST001** | The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 | 4.0 |
| **AST002** | The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis | 15.0 | 14.9 | 14.8 | 14.9 | 15.0 | 14.7 | 15.0 | 15.0 | 14.9 | 15.0 | 15.0 |
| **AST003** | The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions | 20.0 | 19.9 | 19.3 | 19.5 | 19.6 | 17.3 | 20.0 | 19.4 | 19.8 | 19.5 | 19.3 |
| **AST004** | The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months | 6.0 | 6.0 | 5.9 | 5.9 | 6.0 | 5.4 | 5.9 | 5.9 | 5.9 | 5.9 | 5.7 |