



Public Health
England

NHS
RightCare

Commissioning for Value Where to Look pack

NHS Tameside and Glossop CCG
January 2017



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Foreword

“ The Commissioning for Value packs and the NHS RightCare programme place the NHS at the forefront of addressing unwarranted variation in care. I know that professionals - doctors, nurses, allied health professionals - and the managers who support their endeavours, all want to deliver the best possible care in the most effective way. We all assume we do so.

What Commissioning for Value does is shine an honest light on what we are doing. The RightCare approach then gives us a methodology for quality improvement, led by clinicians. It not only improves quality but also makes best use of the taxpayers' pound ensuring the NHS continues to be one of the best value health and care systems in the world.”

Professor Sir Bruce Keogh
National Medical Director, NHS England

Introduction to your Where to Look pack

What's in this pack?

This pack is a refresh of the Commissioning for Value Where to Look packs, published in January 2016.

Updates here include:

- Expenditure data is from 2015/16. Outcome data is the latest available at the time of publication
- An additional three pathways on a page for gastro-intestinal
- Complex patients analysis has been updated using 2015/16 data

Why your CCG should review it

This pack is specific to your CCG. The information in the pack and the accompanying online tools should be used to help support local discussion about prioritisation to improve both the utilisation of resources and value for the population.

By using this information each CCG will be able to ensure its plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities.

Your legal duties

NHS England, Public Health England and CCGs have legal duties under the Health and Social Care Act 2012 with regard to reducing health inequalities; and for promoting equality under the Equality Act 2010.

One of the main focuses for the Commissioning for Value series has always been reducing variation in outcomes. Commissioners should continue to use these packs and the supporting tools to drive local action to reduce inequalities in access to services and in the health outcomes achieved.

The NHS RightCare programme



The NHS RightCare programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners.

The approach has been tested and proven successful in recent years in a number of different health economies. As a programme it focuses relentlessly on value, increasing quality and releasing funds for reallocation to address future demand.

NHS England has committed significant funding to rolling out the RightCare approach. By January 2017 all CCGs will be working with an NHS RightCare Delivery Partner.

For more information visit: <https://www.england.nhs.uk/rightcare>

Supporting the STP process

This pack has been refreshed to align with the new Sustainability and Transformation Planning (STP) process. Local service leaders in every part of England are working together for the first time on shared plans to transform health and care in the diverse communities they serve.

Commissioning for Value (CfV) supports CCGs and STP footprint areas by providing the most up to date data available. Expenditure data is from 2015/16. Outcomes data is the latest available at time of publication. The time period for each pathway on a page indicator is included on the chart. In addition the key indicators from the seven focus packs (originally published in April/May 2016) will be refreshed in the CfV online tools in early 2017.

NHS RightCare and Commissioning for Value

Commissioning for Value is a partnership between NHS RightCare and Public Health England. It provides the first phase of the NHS RightCare approach – Where to Look.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies.

Phases two and three then move on to explore *What to Change* and *How to Change*.



What is Commissioning for Value?

The Commissioning for Value (CfV) work programme originated during 2013/14 in response to requests from clinical commissioning groups (CCGs) that they would like support to help them identify the opportunities for change with most impact for their populations.

Commissioning for Value is designed to identify priority programmes which offer the best opportunities to improve healthcare; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the CfV programme can help clinicians and commissioners transform the way care is delivered for their patients and populations and reduce variation in health inequalities.

Commissioning for Value is not intended to be a prescriptive approach for commissioners, rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations.

Previous CfV packs and supporting information can be found on the CfV pages on the NHS RightCare website.

Why act?

We've worked with a number of health economies in recent years that have adopted the NHS RightCare approach, and since January 2016 our Delivery Partners have been working with 65 CCGs across England. Examples of the population healthcare and system impact of adopting the NHS RightCare approach include:

- 1000s more people at risk of or already with Type 2 diabetes detected and being supported with their primary and secondary prevention (Bradford City and Bradford Districts CCGs)
- 30% reduction in referrals to secondary care MSK services via a locally-run triage system, with annual savings of £1m (Ashford CCG)
- Significant reductions in unplanned activity amongst a large cohort of people with complex care needs via proactive primary care (Slough CCG)
- 30% reduction in COPD emergency activity from a full pathway redesign (Hardwick CCG)
- 89% reduction in 999 calls from groups of frequent callers via enhanced integrated care and pathway navigation (Blackpool CCG)

For more information please see the NHS RightCare casebooks at:

<https://www.england.nhs.uk/rightcare/intel/cfv/casebooks/>

Your most similar CCGs

Your CCG is compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for your population. The analysis in this pack is based on a comparison with your most similar CCGs which are:

- NHS Rotherham CCG
- NHS Stoke on Trent CCG
- NHS Bury CCG
- NHS Wakefield CCG
- NHS Hartlepool and Stockton-On-Tees CCG
- NHS Barnsley CCG
- NHS St Helens CCG
- NHS Halton CCG
- NHS South Tees CCG
- NHS Telford and Wrekin CCG

To help you understand more about how your most similar 10 CCGs are calculated, the Similar 10 Explorer Tool is available on the NHS England website. This tool allows you to view similarity across all the individual demographics used to calculate your most similar 10 CCGs. You can also customise your similar 10 cluster group by weighting towards a desired demographic factor.

There has been a change to a small number of CCG similar 10 groups since the January 2016 pack to reflect a reduction in the number of CCGs nationally and a refresh of the demographic variable data used to calculate the similar 10. The group in this pack is the same as that in the focus packs.

Where to Look: Step 1

The Commissioning for Value approach begins with a review of indicative data across the 10 highest spending programmes of care to highlight the top priorities (opportunities) for transformation and improvement.

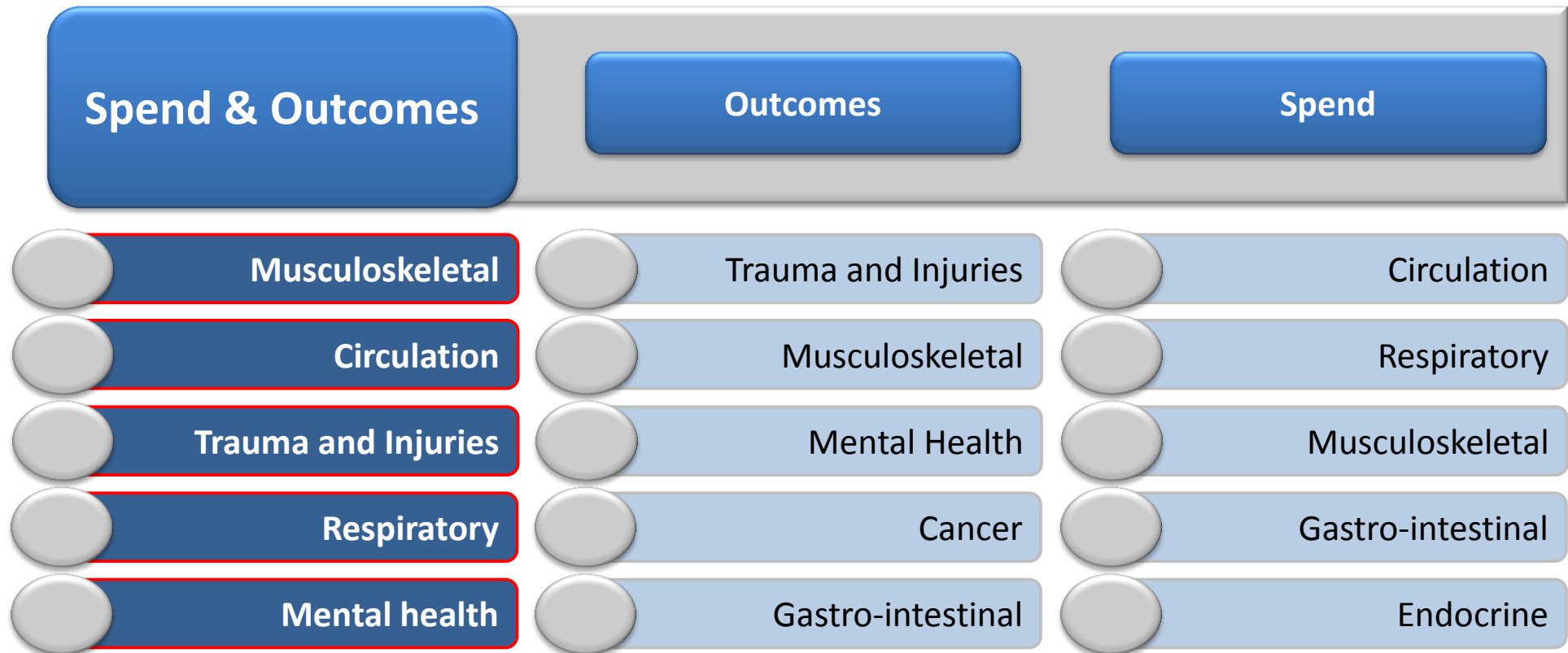
This pack begins the process for you by offering a triangulation of nationally-held data that indicates where CCGs may gain the highest value healthcare improvement.

The following slides help identify the 'where to look' opportunities to improve value. They contain a range of improvement opportunities across a number of key programme areas to help CCGs identify the priority programmes to focus on for improvement. They do not seek to provide phases 2 ('what to change') and 3 ('how to change') of the overall approach.

The opportunities that follow in the next few slides outline the potential improvements (in terms of both reduced expenditure and lives saved) if the CCG were to perform at the average of the similar 10 and best five of the similar 10 as outlined in the previous slide.

Please note that CCGs should not seek to add up all the spend opportunities in the pack (eg in prescribing or non-elective care) to find total potential savings. Each programme of care is shown as a pathway and the pathway needs to be looked at as a whole. For example, in order to reduce spending for non-elective activity within CVD, it may be necessary to increase resources in primary care prevention or prescribing. This should result in better value and a net reduction in costs, but will not be equivalent to the total sum of all savings opportunities.

Headline opportunity areas for your health economy

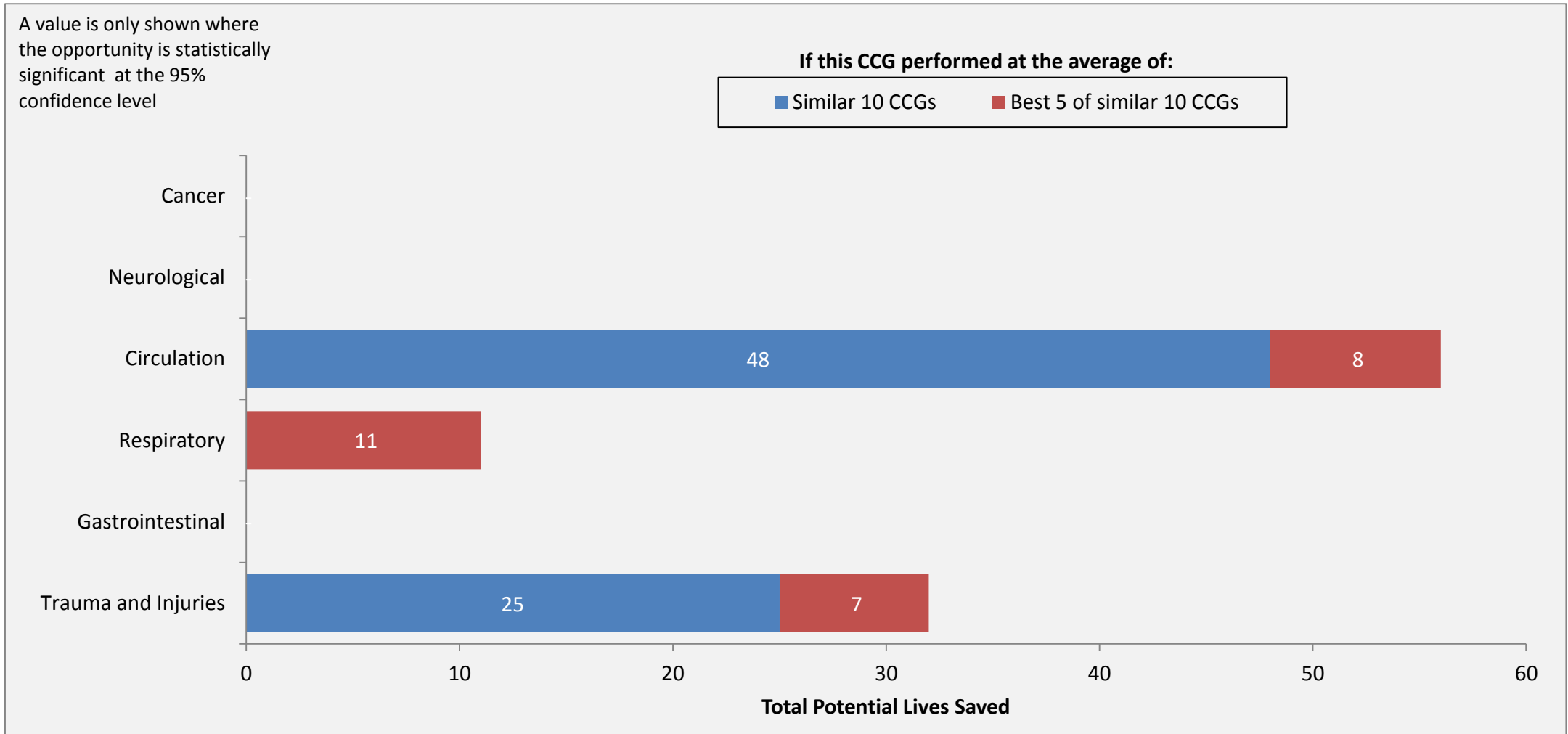


Where there has been a change to your improvement opportunities from the January 2016 pack this could have been caused by actual improvement or deterioration in your own CCG or peer CCG performance or the robustness and timing of local data. If your local opportunities have changed significantly and you would like to investigate the reasons for this further, please contact your Delivery Partner or england.healthinvestmentnetwork@nhs.net.

You can also request the methodology used to calculate your headline opportunities from this e-mail address : england.healthinvestmentnetwork@nhs.net.

What are the potential lives saved per year?

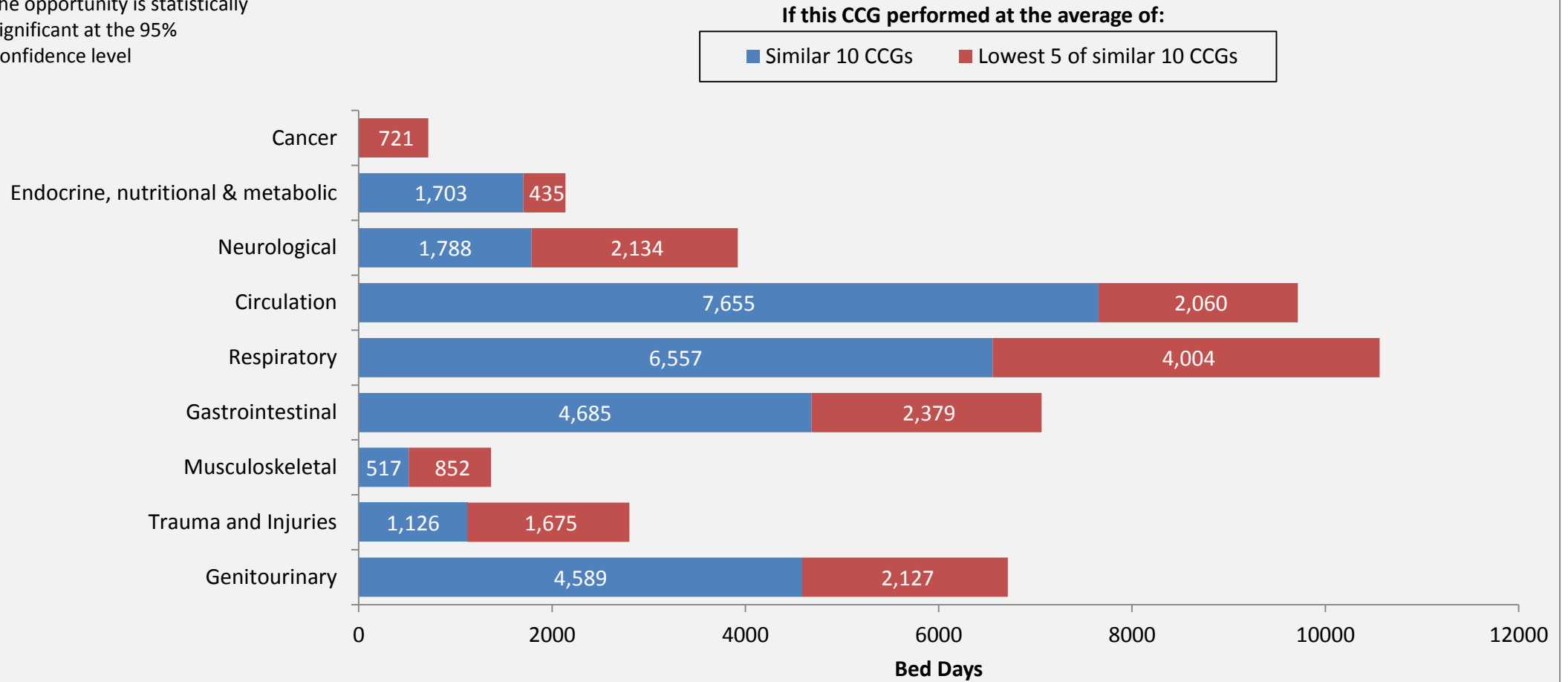
A value is only shown where the opportunity is statistically significant at the 95% confidence level



The mortality data presented above uses Primary Care Mortality Database (PCMD) and is from 2012 to 2014. The potential lives saved opportunities are calculated on a yearly basis and are only shown where statistically significant. Lives saved only includes programmes where mortality outcomes have been considered appropriate.

How different are we on bed days?

A value is only shown where the opportunity is statistically significant at the 95% confidence level

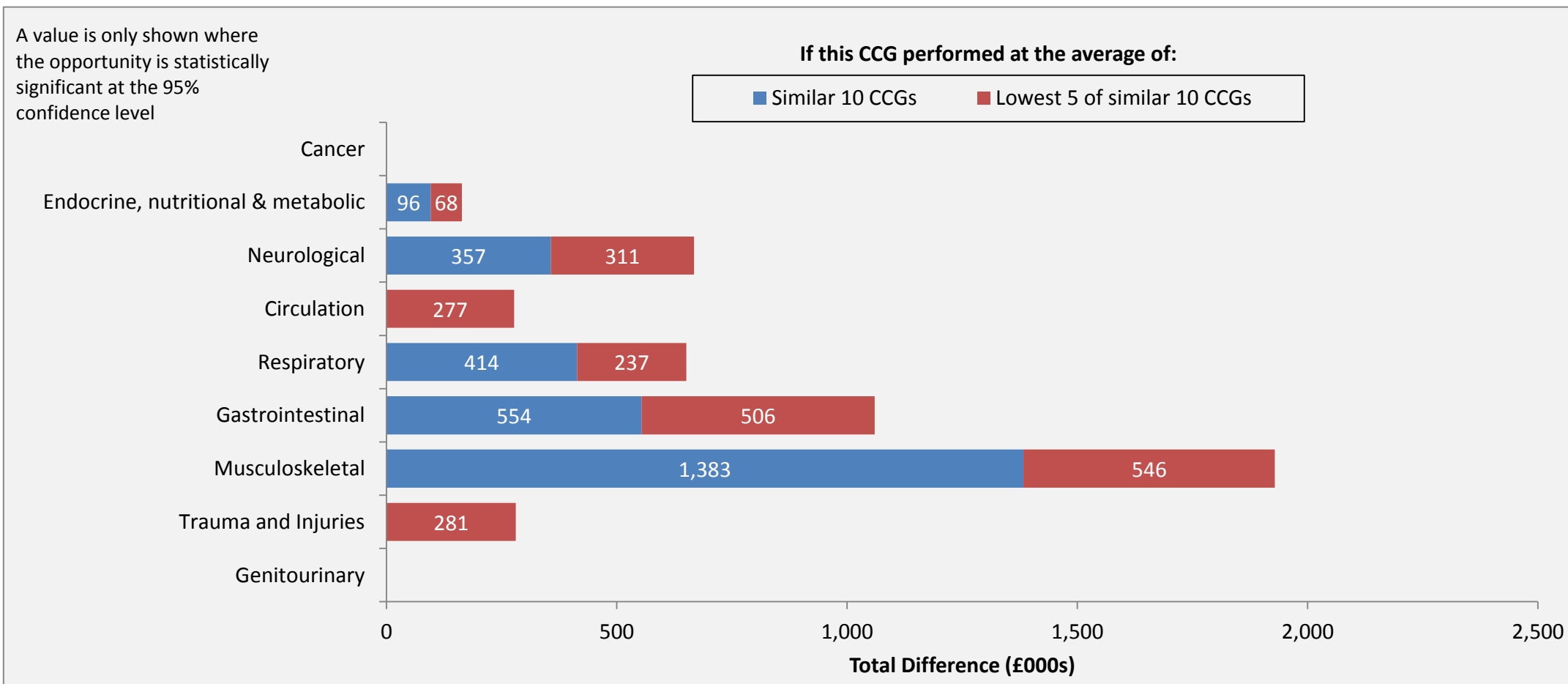


The bed days data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on admissions for any primary diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning activity. These figures are a combination of elective and non-elective admissions.

Length of stay is derived from admission and discharge date. Spells that have the same admission and discharge date (including planned day cases) have a length of stay in SUS as zero. These have been recoded as a length of stay of 1 day in order to capture the impact of these admissions on total bed days for a CCGs.

How different are we on spend on elective admissions?



The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

The calculations in this slide are based on expenditure on admissions for any primary diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

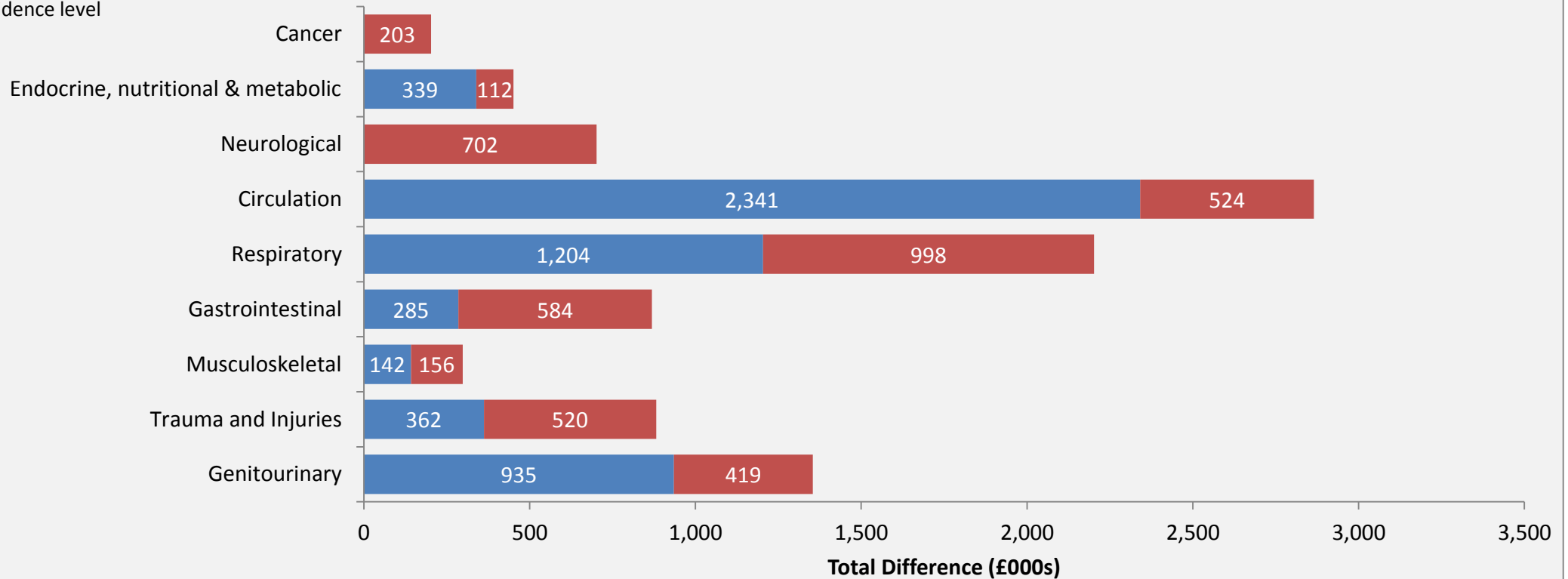
CCGs can explore this expenditure in more detail using the Commissioning for Value Focus Packs. For example, Neurological expenditure contains Chronic Pain, and the focus pack breaks this down by different types of Pain. CCGs should consider whether these admissions should be considered alongside other programmes e.g. CVD, Gastrointestinal, Musculoskeletal problems.

How different are we on spend on non-elective admissions?

A value is only shown where the opportunity is statistically significant at the 95% confidence level

If this CCG performed at the average of:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

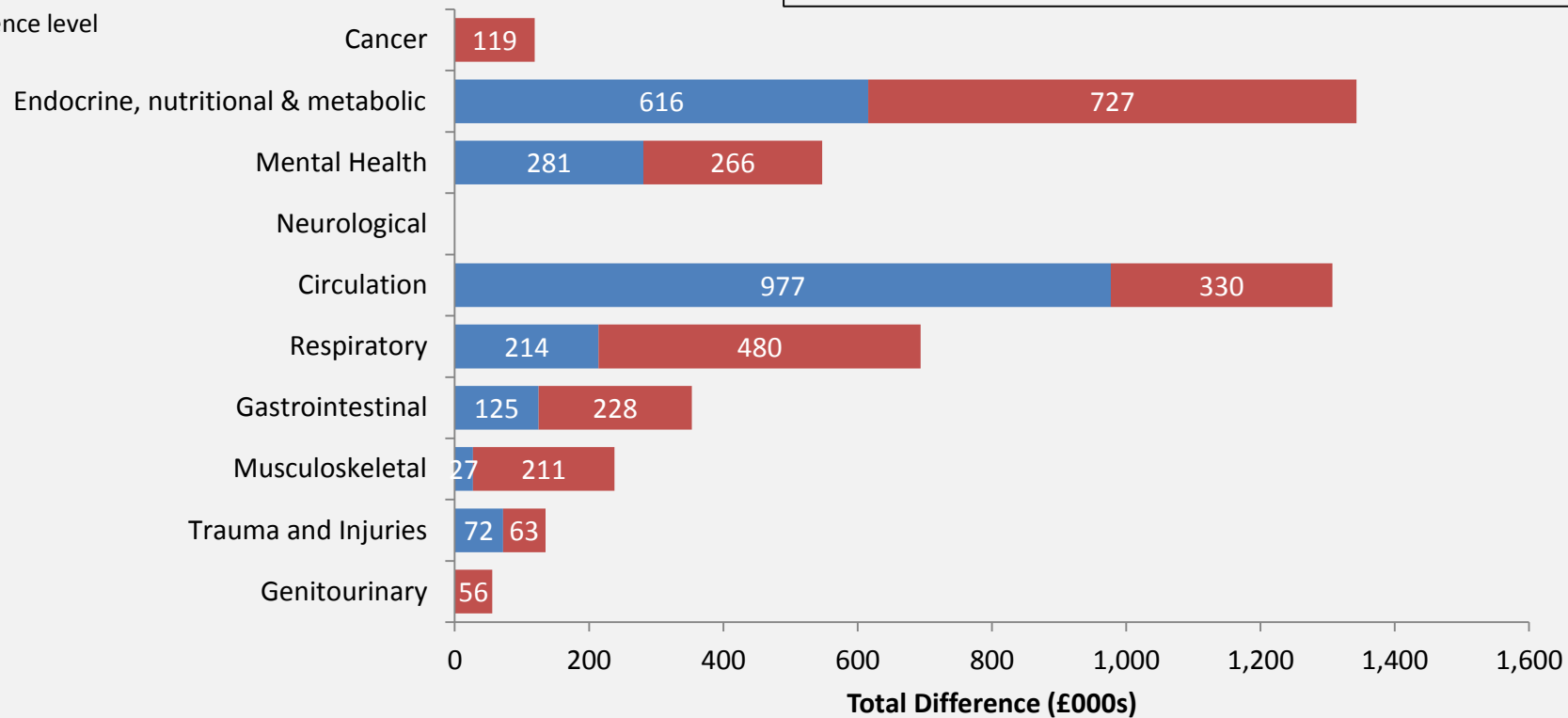
The calculations in this slide are based on expenditure on admissions for any primary diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in turn based on the World Health Organisation's International Classification of Diseases). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

CCGs can explore this expenditure in more detail using the Commissioning for Value Focus Packs. For example, Neurological expenditure contains Chronic Pain, and the focus pack breaks this down by different types of Pain. CCGs should consider whether these admissions should be considered alongside other programmes e.g. CVD, Gastrointestinal, Musculoskeletal problems.

How different are we on spend on primary care prescribing?

A value is only shown where the opportunity is statistically significant at the 95% confidence level

If this CCG performed at the average of:



The prescribing data presented above uses Net Ingredient Cost (NIC) from ePact.com provided by the NHS Business Services Authority and is from financial year 2015/16. Each individual BNF chemical is mapped to a Programme Budget Category and aggregated to form a programme total. The indicators have been standardised using the ASTRO-PU weightings. Opportunities have been shown to the CCGs similar 10 and the lowest 5 CCGs. Prescribing opportunities are for local interpretation and should be viewed in conjunction with the individual disease pathways.

More detailed analyses of prescribing data, outlier practices, and time trends can be produced rapidly using the following resource: <http://www.OpenPrescribing.net>

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Cancer & Tumours	<ul style="list-style-type: none"> • Spend on non-elective admissions • Spend on primary care prescribing 	203 119	<ul style="list-style-type: none"> • Cancer and Tumours - Rate of bed days • Breast cancer screening • Bowel cancer screening • Lower GI cancer detected at an early stage • Mortality from colorectal cancer under 75 years • Successful quitters, 16+ • Mortality from lung cancer under 75 years • Mortality from all cancers all ages 	721 2,945 1,321 13 10 643 19 47
Circulation Problems (CVD)	<ul style="list-style-type: none"> • Spend on elective and day-case admissions • Spend on non-elective admissions • Spend on primary care prescribing 	277 2,864 1,307	<ul style="list-style-type: none"> • Circulation - Rate of bed days • Mortality from all circulatory diseases under 75 years • Reported to estimated prevalence of CHD • Reported to estimated prevalence of hypertension • Mortality from CHD under 75 years • Stroke patients spending 90% of their time on stroke unit • Emergency readmissions within 28 days for stroke patients • % patients returning home after treatment • Mortality from stroke under 75 years • Reported to estimated prevalence of AF • Stroke patients treated by early supported discharge team (quarter) 	9,715 56 530 952 51 61 6 35 9 477 9

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Endocrine, Nutritional and Metabolic Problems	<ul style="list-style-type: none"> • Spend on elective and day-case admissions • Spend on non-elective admissions • Spend on primary care prescribing 	164 451 1,344	<ul style="list-style-type: none"> • Endocrine - Rate of bed days • % diabetes patients whose cholesterol < 5 mmol/l • % patients receiving foot examination • Retinal screening • % diabetes patients referred to structured education 	2,138 293 264 665 108
Gastrointestinal	<ul style="list-style-type: none"> • Spend on elective and day-case admissions • Spend on non-elective admissions • Spend on primary care prescribing 	1,060 868 353	<ul style="list-style-type: none"> • Gastro - Rate of bed days • Mortality for liver disease under 75 years • % 6+ week waits for a gastroscopy (4 month snapshots) • Alcohol specific hospital admissions • Emergency admissions for alcoholic liver disease condition (19+) • Reported Clostridium difficile cases • % 6+ week waits for a colonoscopy (4 month snapshots) • Rate of emergency colonoscopies • Emergency admissions for gastroenteritis (0-4) • Emergency admissions for gastroenteritis (5+) 	7,064 12 85 249 69 35 61 9 43 75

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Genitourinary	<ul style="list-style-type: none"> • Spend on non-elective admissions • Spend on primary care prescribing 	1,355 56	<ul style="list-style-type: none"> • Genitourinary - Rate of bed days • Reported to estimated prevalence of CKD 	6,716 2,773
Maternity & Reproductive Health			<ul style="list-style-type: none"> • Emergency LRTI admissions rate for <1s • A&E attendance rate for <5s • Emergency admissions rate for <5s • Unintentional & deliberate injury admissions for <5s • % of children aged 4-5 who are overweight or obese 	43 1,579 621 82 48

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Mental Health Problems	<ul style="list-style-type: none"> Spend on primary care prescribing 	547	<ul style="list-style-type: none"> Physical health checks for patients with SMI Mental health hospital admissions People subject to mental health act (quarter) New cases of depression which have been reviewed Assessment of severity of depression at outset Completion of IAPT treatment (quarter) IAPT: % referrals with outcome measured (6 months) IAPT: % 'moving to recovery' rate (quarter) IAPT: % achieving 'reliable improvement' (quarter) Emergency hospital admissions for self harm Excess under 75 mortality rate in adults with serious mental illness Mortality with dementia, 65+ % adults on CPA in settled accommodation (end of quarter snapshot) % dementia deaths in usual place of residence (65+) % short stay emergency admissions aged 65+ with dementia Dementia diagnosis rate (65+) % of EIP referrals waiting >2 wks to start treatment (Incomplete) (5m) % of EIP referrals waiting <2 wks to start treatment (Complete) (5m) IAPT: % waiting <6 weeks for first treatment (6 month snapshots) Rate of emergency admissions aged 65+ with dementia 	<ul style="list-style-type: none"> 132 78 27 129 68 184 18 80 30 214 29 105 440 65 65 378 12 11 467 570

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Musculoskeletal System Problems (Excludes Trauma)	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions Spend on primary care prescribing Spend on admissions relating to fractures where a fall occurred 	1,929 298 238 483	<ul style="list-style-type: none"> MSK - Rate of bed days Hip replacement, EQ-5D Index, average health gain Knee replacement, EQ-5D Index, average health gain Hip replacement emergency readmissions 28 days Hip fractures in people aged 65+ Hip fractures in people aged 65-79 Hip fractures in people aged 80+ Hip fracture emergency readmissions 28 days 	1,369 50 47 5 38 13 32 14
Neurological System Problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions 	668 702	<ul style="list-style-type: none"> Neurological - Rate of bed days Patients with epilepsy on drug treatment and convulsion free, 18+ 	3,922 81
Respiratory System Problems	<ul style="list-style-type: none"> Spend on elective and day-case admissions Spend on non-elective admissions Spend on primary care prescribing 	651 2,202 693	<ul style="list-style-type: none"> Respiratory - Rate of bed days Mortality from bronchitis, emphysema and COPD under 75 years Reported to estimated prevalence of COPD % of COPD patients with a record of FEV1 % asthma patients with review (12 months) Emergency admission rate for children with asthma, 0-19yrs % of COPD patients with a diagnosis confirmed by spirometry 	10,561 11 2,252 308 155 71 67

Note: 'Spend on admissions relating to fractures where a fall occurred' is a sub-set of Trauma and Injuries non-elective spend and is not included in the spend for overall MSK non-elective admissions. This indicator as well as 'Rates of hip fractures', 'Emergency readmissions to hospital within 28 days for patients: hip fractures' and '% patients returning to usual place of residence following hospital treatment for fractured femur' may appear in the improvement opportunities table for both Trauma & Injuries and MSK table. This is due to them being in the Trauma & Injury pathway as well as the Osteoporosis pathway. Opportunities for these five indicators have only contributed to the headline; 'Spend', 'Outcomes' (and hence 'Spend and Outcomes') for MSK only.

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Tameside and Glossop CCG to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant at the 95% confidence level.

Disease Area	Spend	£000	Quality	Quantified Opportunity
Trauma & Injuries	<ul style="list-style-type: none"> • Spend on elective and day-case admissions • Spend on non-elective admissions • Spend on primary care prescribing • Spend on admissions relating to fractures where a fall occurred 	281 882 135 483	<ul style="list-style-type: none"> • Trauma and injuries - Rate of bed days • Mortality from accidents all ages • Injuries due to falls in people aged 65+ • Unintentional and deliberate injury admissions, 0-24yrs • All fracture admissions in people aged 65+ • Hip fractures in people aged 65+ • Hip fractures in people aged 65-79 • Hip fractures in people aged 80+ • Hip fracture emergency readmissions 28 days 	2,801 32 201 269 78 38 13 32 14

Where to Look: Step 2

The following pages provide a more detailed look at 19 'Pathways on a page' by providing a wider range of key indicators for different conditions. Having reviewed the priority programmes identified in step 1 (pages 12-23), local health economies can explore the opportunities in those programmes at condition level by using step 2 (pages 26-44).

The intention of these pathways is not to provide a definitive view, but to help commissioners explore potential opportunities. These slides help to understand how performance in one part of the pathway may affect outcomes further along the pathway. This is a simplified version of a 'focus pack' or 'deep dive' and we encourage commissioners to use the full process for pathways that appear to offer the greatest areas for improvement. Focus packs for each CCG for the highest spending programmes are available on the NHS RightCare website.

Each indicator of these pathways is shown as the percentage difference from the average of the 10 CCGs most similar to you.

Where to Look: Step 2



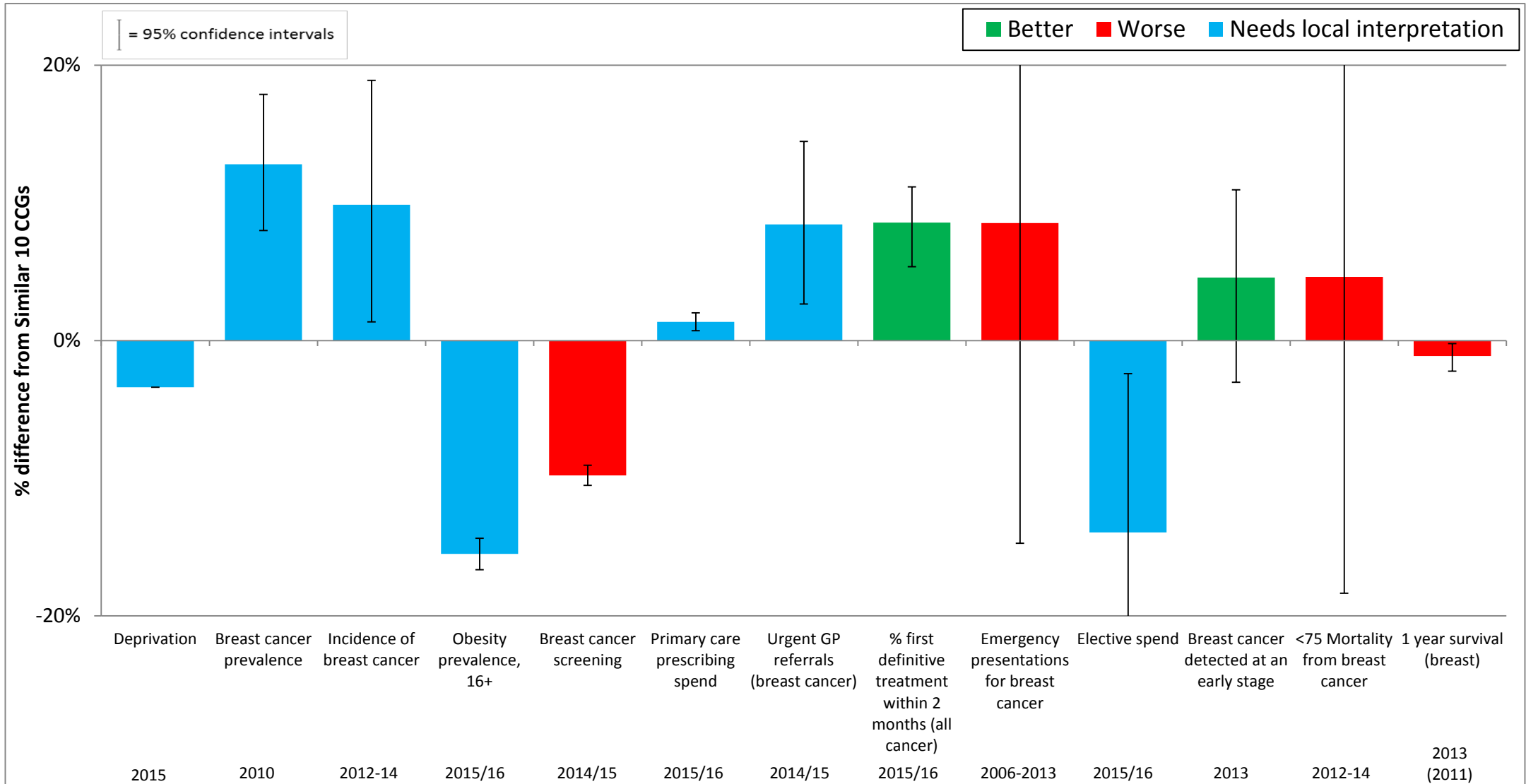
RightCare

The indicators are colour coded to help you see if your CCG has 'better' (**green**) or 'worse' (**red**) values than your peers. This is not always clear-cut, so 'needs local interpretation' (**blue**) is used where it is not possible to make this judgement. For example, low prevalence may reflect that a CCG truly does have fewer patients with a certain condition, but it may reflect that other CCGs have better processes in place to identify and record prevalence in primary care.

Please note: The variation from the average of the similar 10 CCGs is statistically significant at the 95% confidence level for those indicators where the confidence intervals do not cross the 0% axis.

Commissioners should work with local clinicians and public health colleagues to interpret these pathways. It is recommended that you look at packs for your similar CCG group. By doing so, it may be possible to identify those CCGs which appear to have much better pathways for populations with similar demographics.

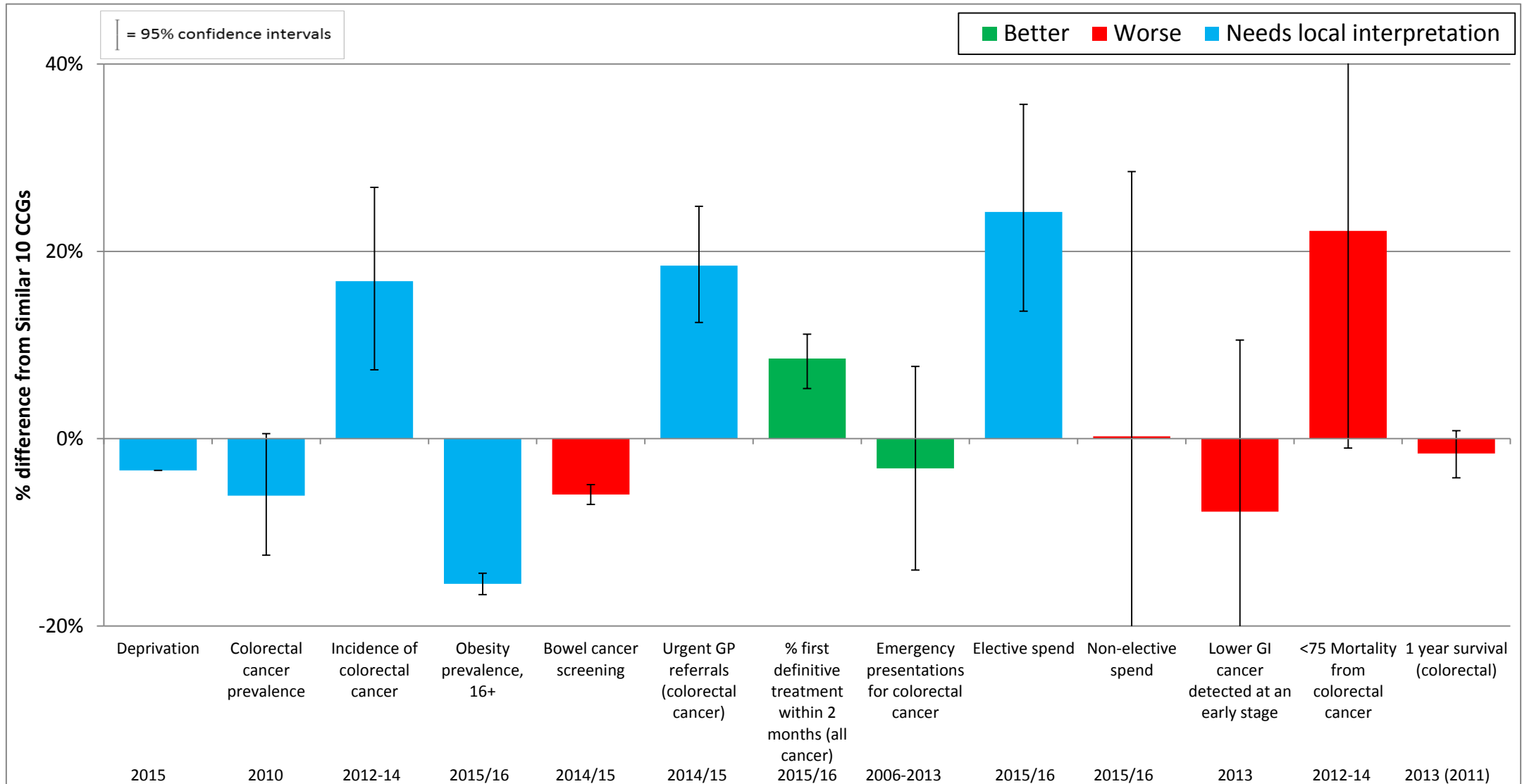
Breast cancer pathway



NICE guidance:

- <http://pathways.nice.org.uk/pathways/familial-breast-cancer>
- <http://pathways.nice.org.uk/pathways/early-and-locally-advanced-breast-cancer>
- <http://pathways.nice.org.uk/pathways/advanced-breast-cancer>

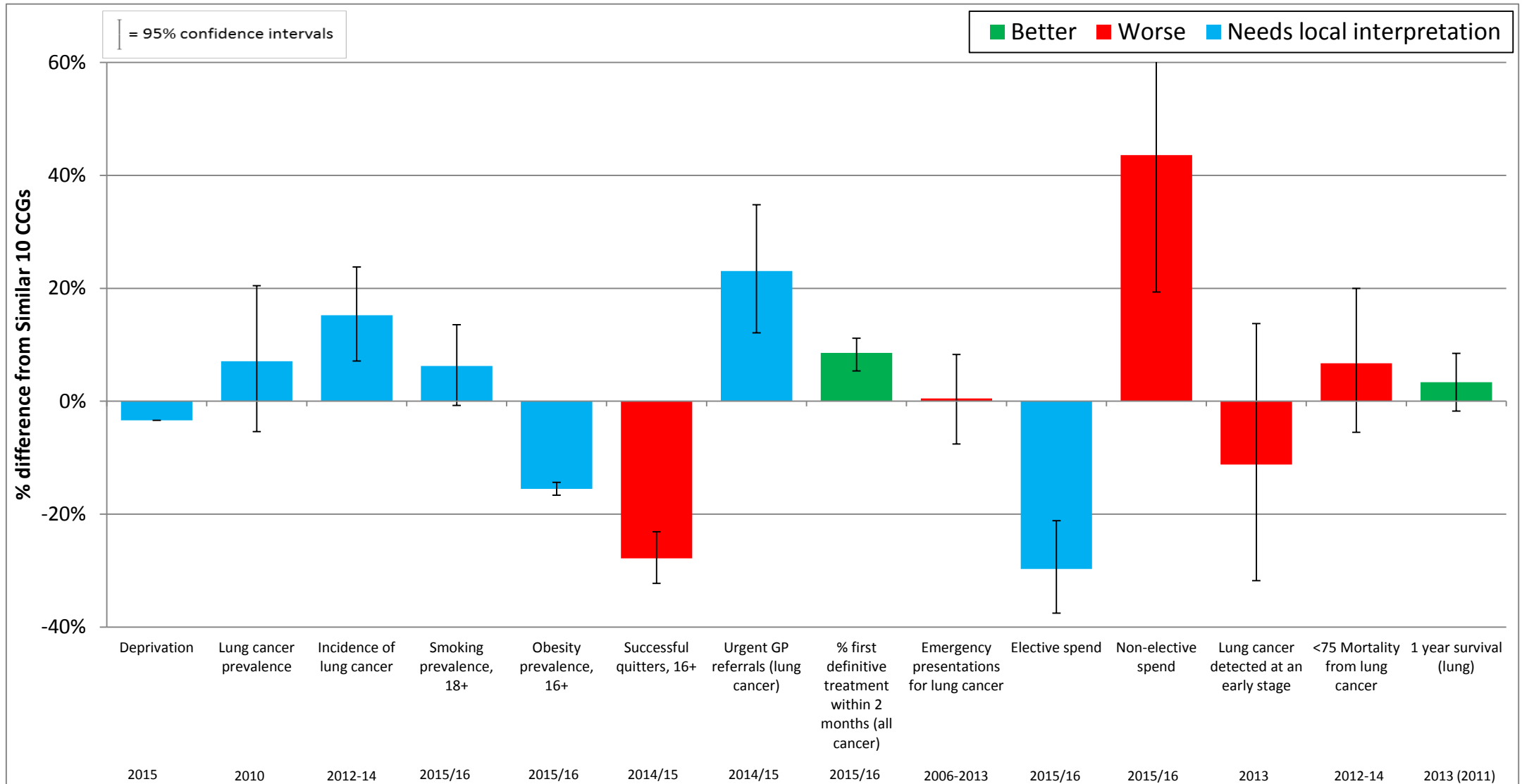
Lower gastro-intestinal cancer pathway



NICE guidance:

- <http://pathways.nice.org.uk/pathways/colorectal-cancer>
- <http://pathways.nice.org.uk/pathways/colonoscopic-surveillance>
- <http://pathways.nice.org.uk/pathways/gastrointestinal-conditions>

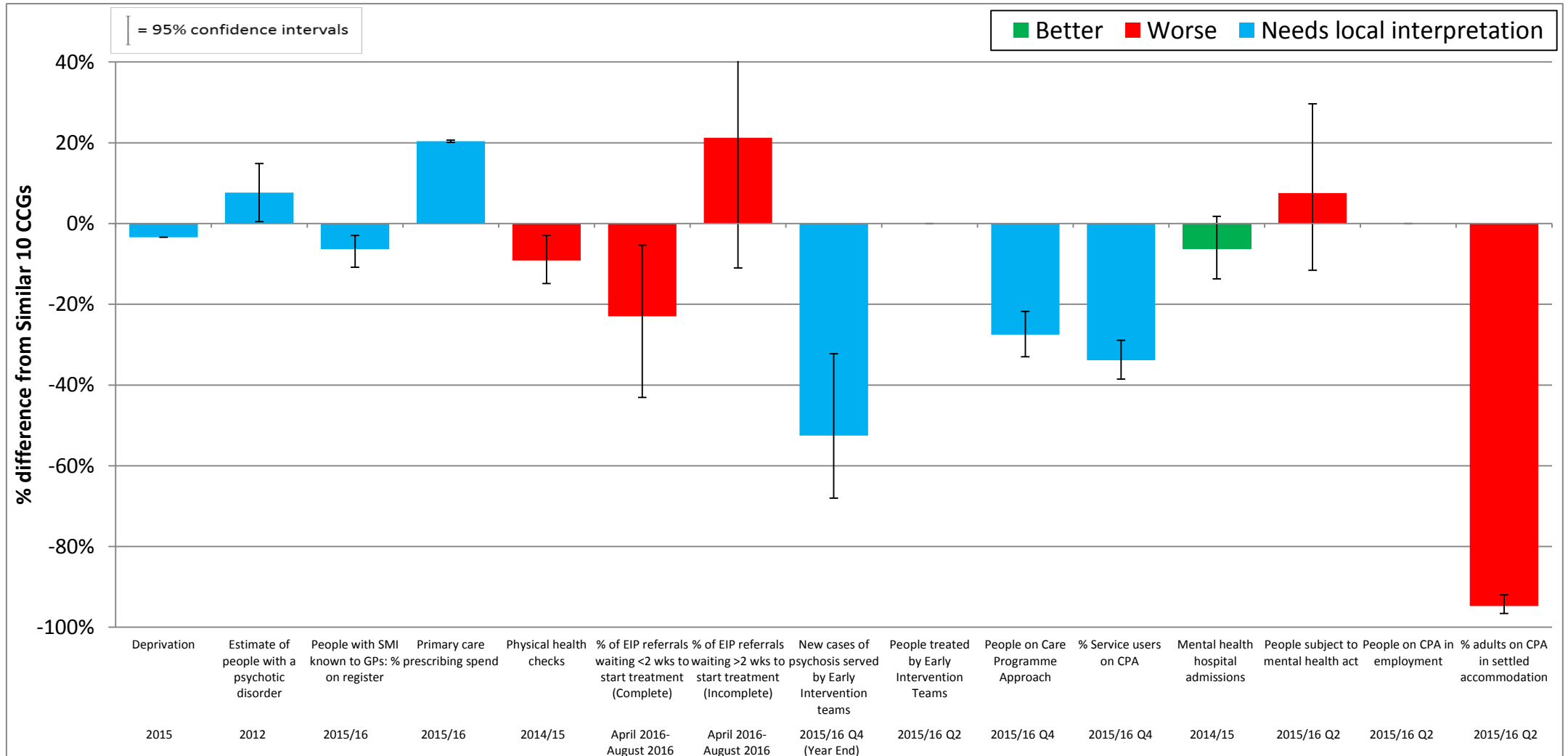
Lung cancer pathway



NICE guidance:

<http://pathways.nice.org.uk/pathways/lung-cancer>

Severe Mental Illness pathway



NICE guidance: <http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia>

Further Information Links:

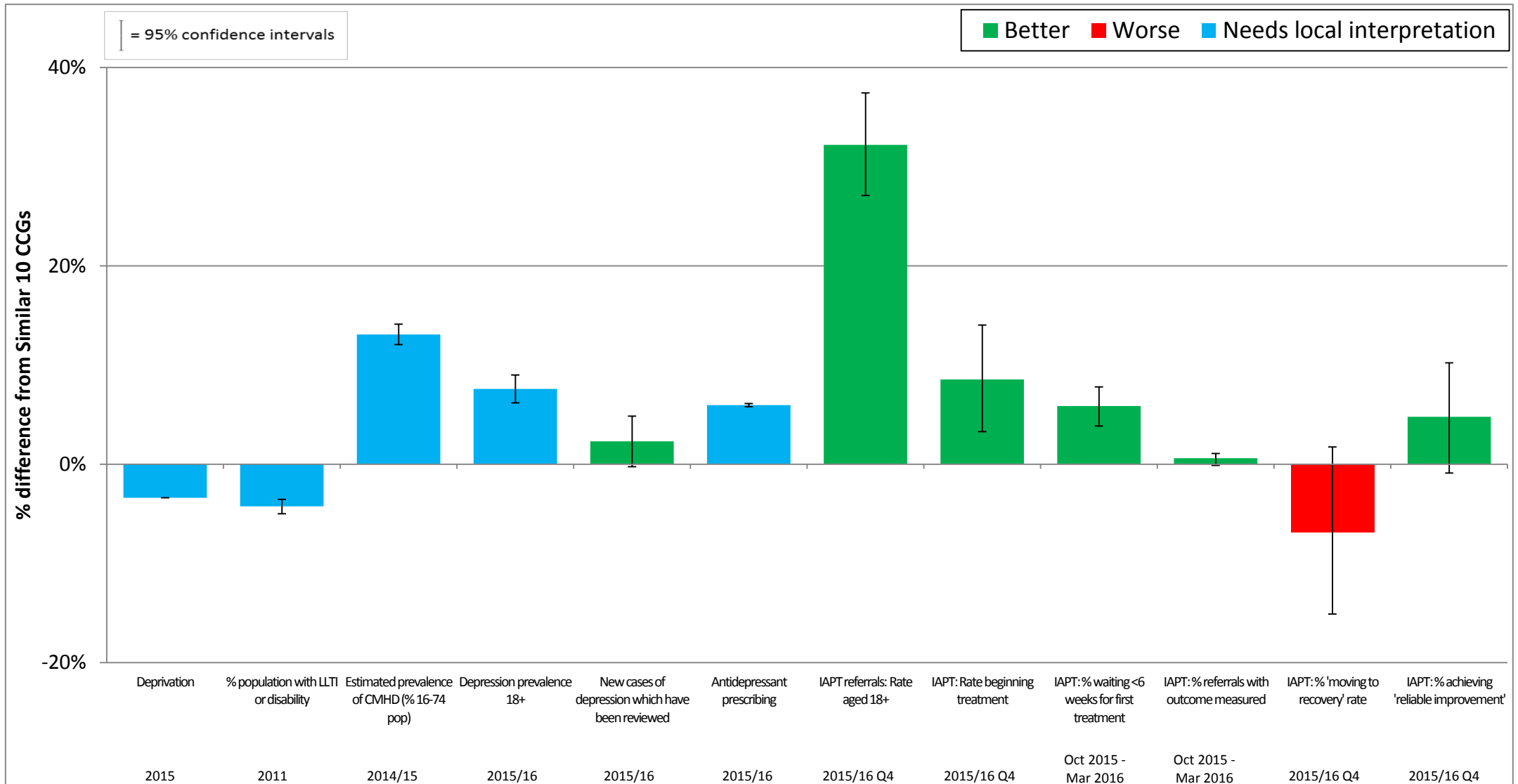
<http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/>

EIP (Early intervention in psychosis) Complete pathways – this shows the %age of patients waiting less than 2 weeks to start treatment out of all those who have started treatment.

EIP Incomplete pathways – this shows the %age of patients waiting more than 2 weeks out of all those who are yet to start treatment.

<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/04/eip-guidance.pdf>

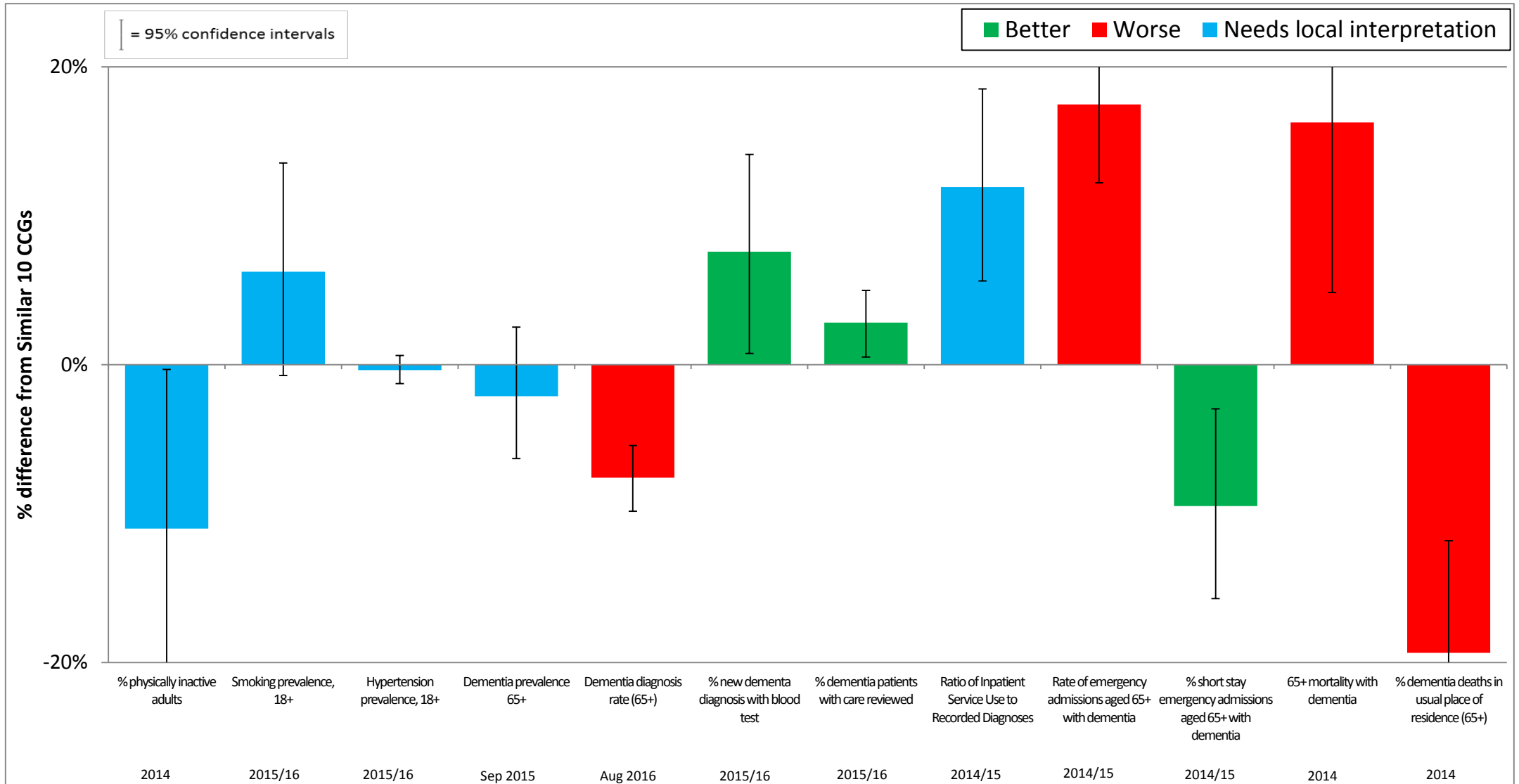
Common mental health disorder pathway



NICE guidance:

<http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care>

Dementia pathway

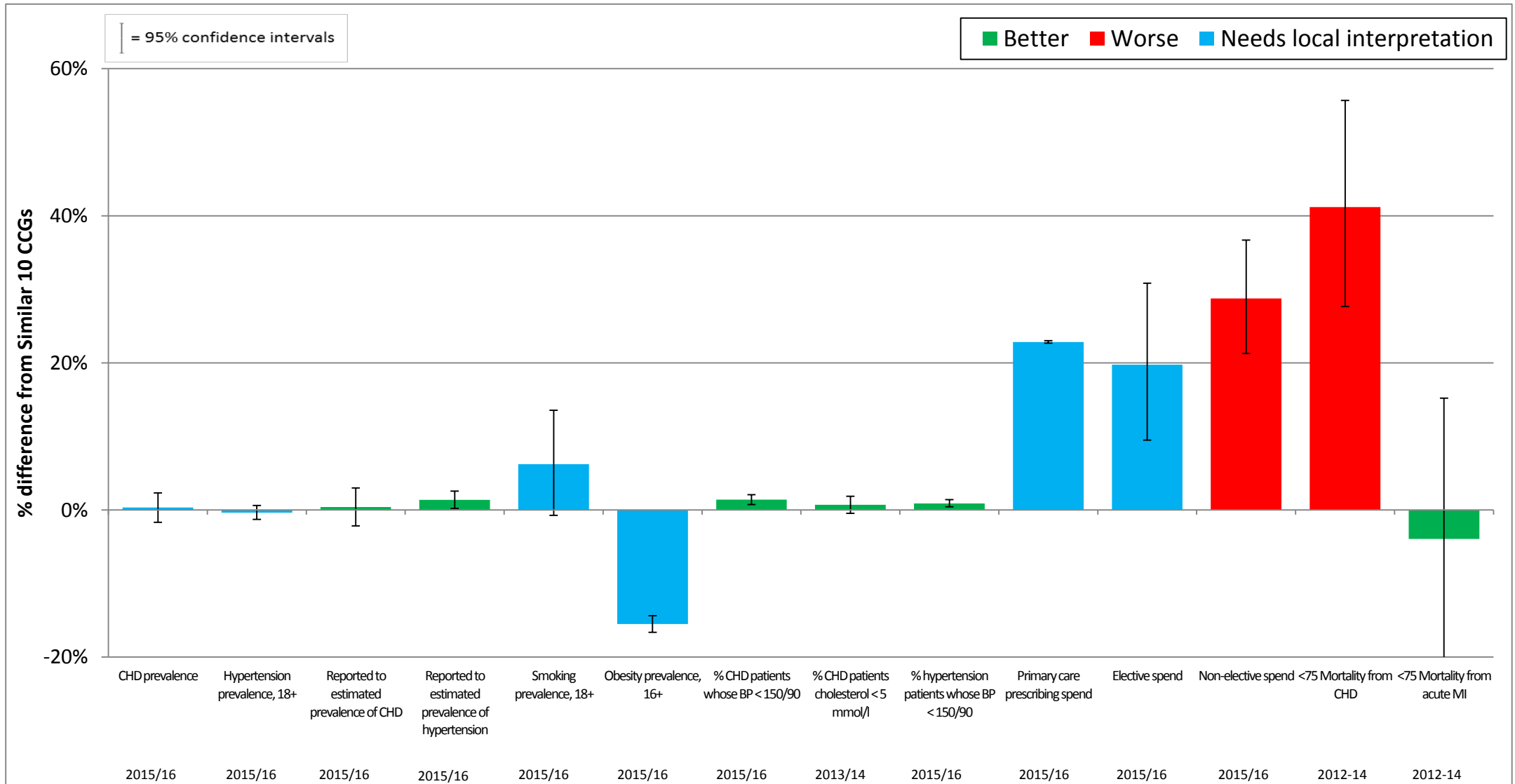


NICE guidance:

<http://pathways.nice.org.uk/pathways/dementia>

<https://pathways.nice.org.uk/pathways/dementia-disability-and-frailty-in-later-life-mid-life-approaches-to-delay-or-prevent-onset>

Heart disease pathway



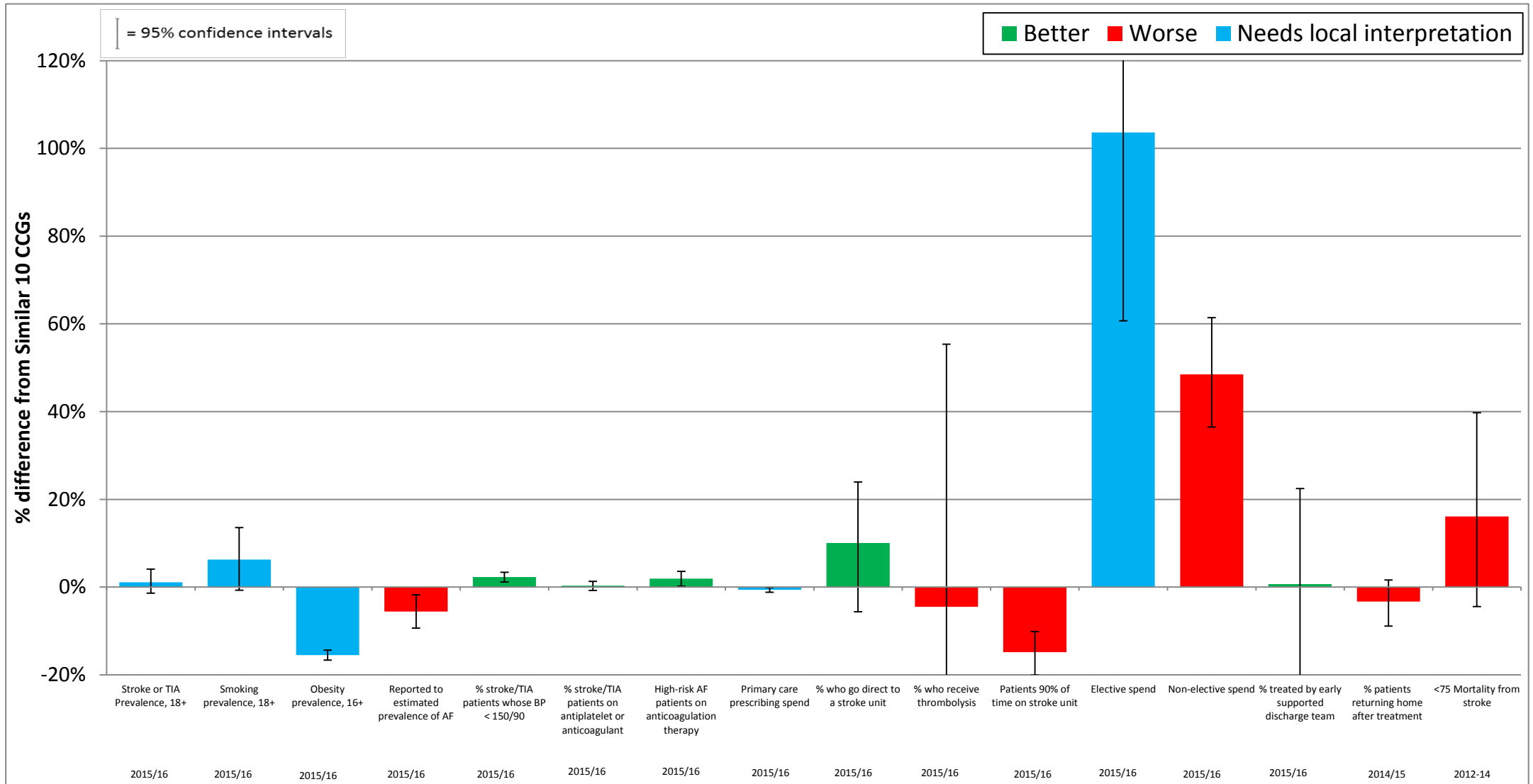
NICE Pathways on: Hypertension, Cardiovascular Disease and Smoking

<http://pathways.nice.org.uk/>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-ht.aspx>

Stroke pathway



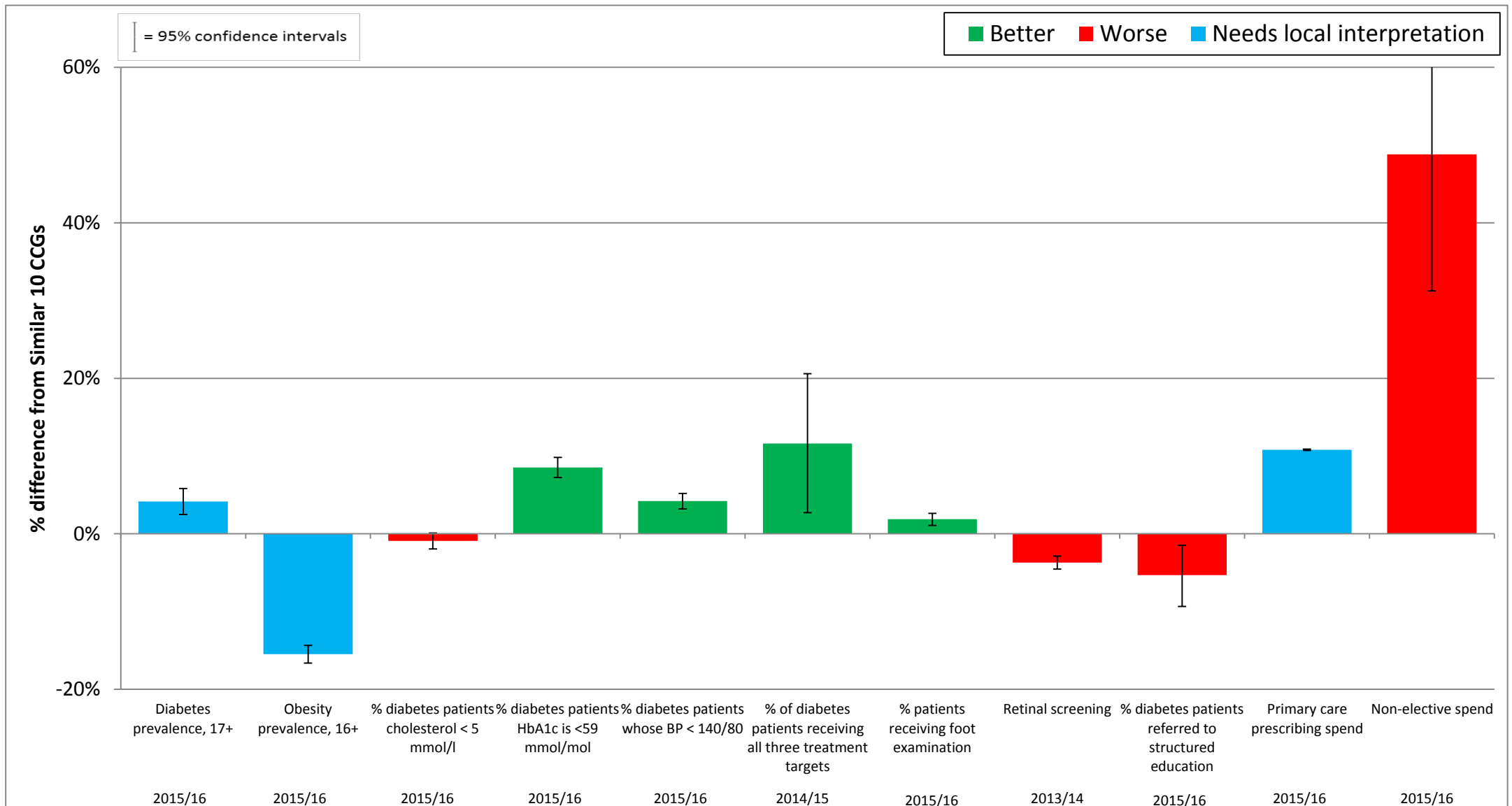
NICE guidance: <http://pathways.nice.org.uk/pathways/stroke>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-af/grasp-af.aspx>

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/warfarin-patient-safety.aspx>

Diabetes pathway



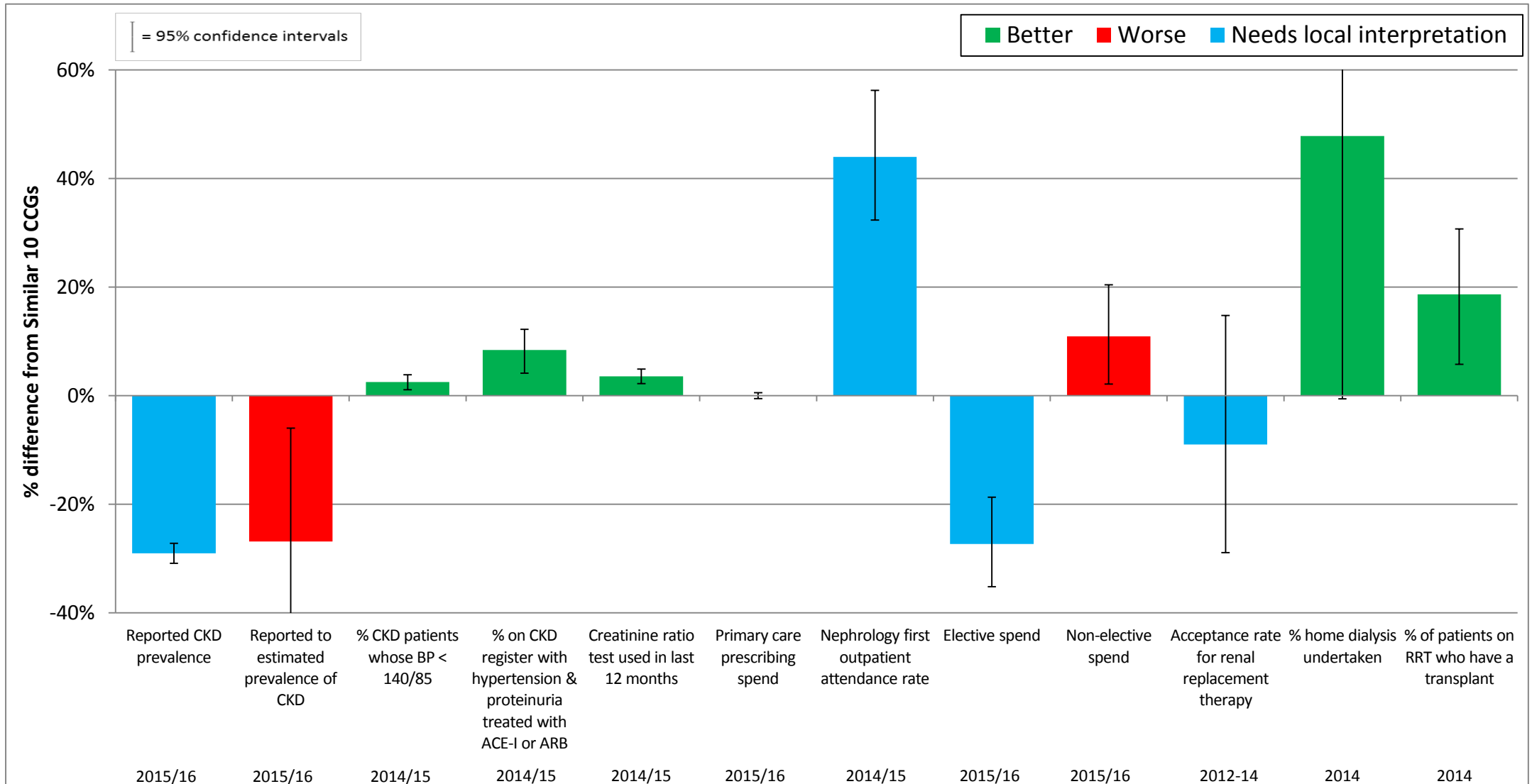
NICE guidance:

<http://pathways.nice.org.uk/pathways/diabetes>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/diabetes-care.aspx>

Renal pathway

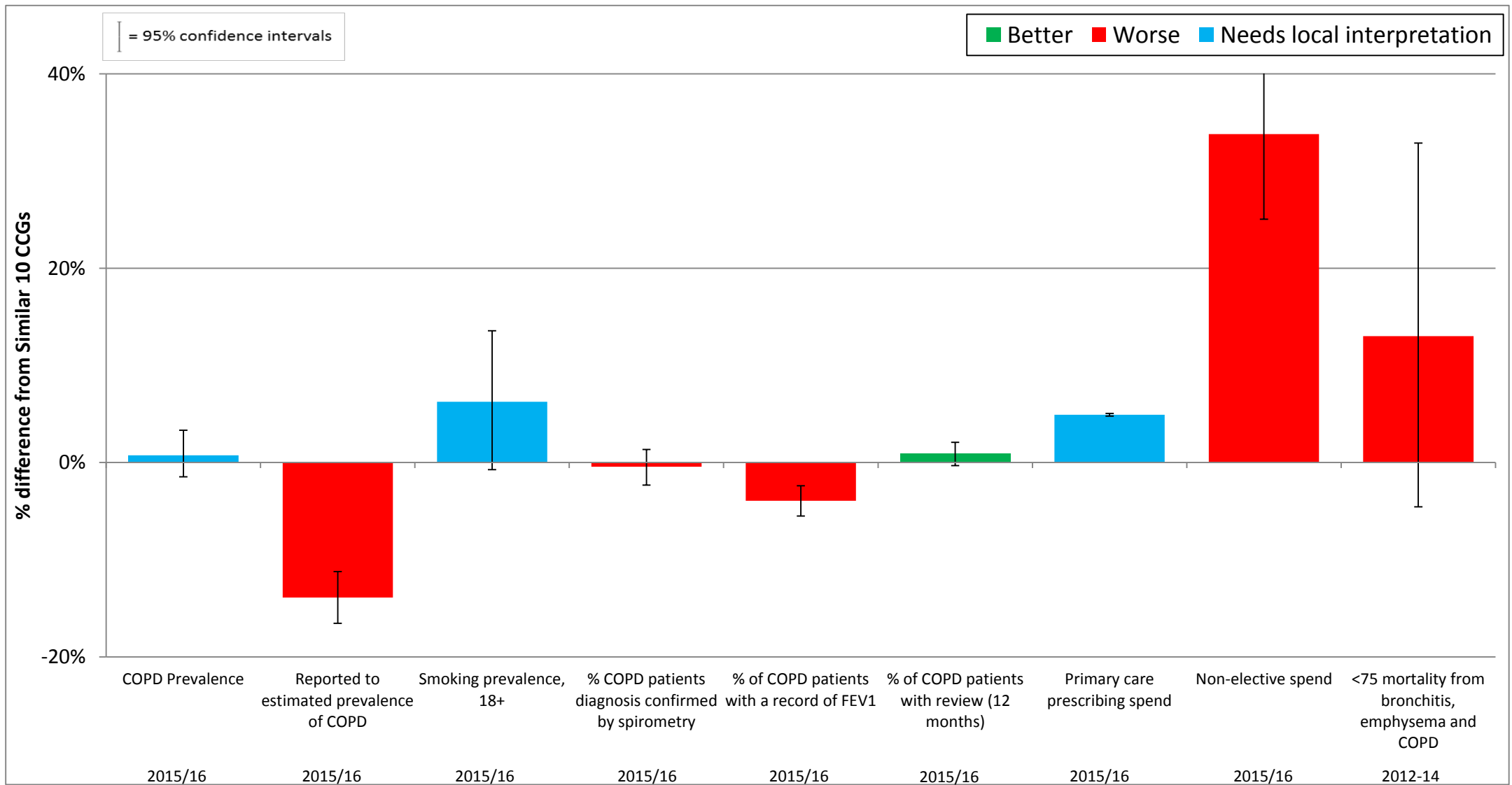


NICE guidance:

<http://pathways.nice.org.uk/pathways/chronic-kidney-disease>

<http://pathways.nice.org.uk/pathways/acute-kidney-injury>

COPD pathway



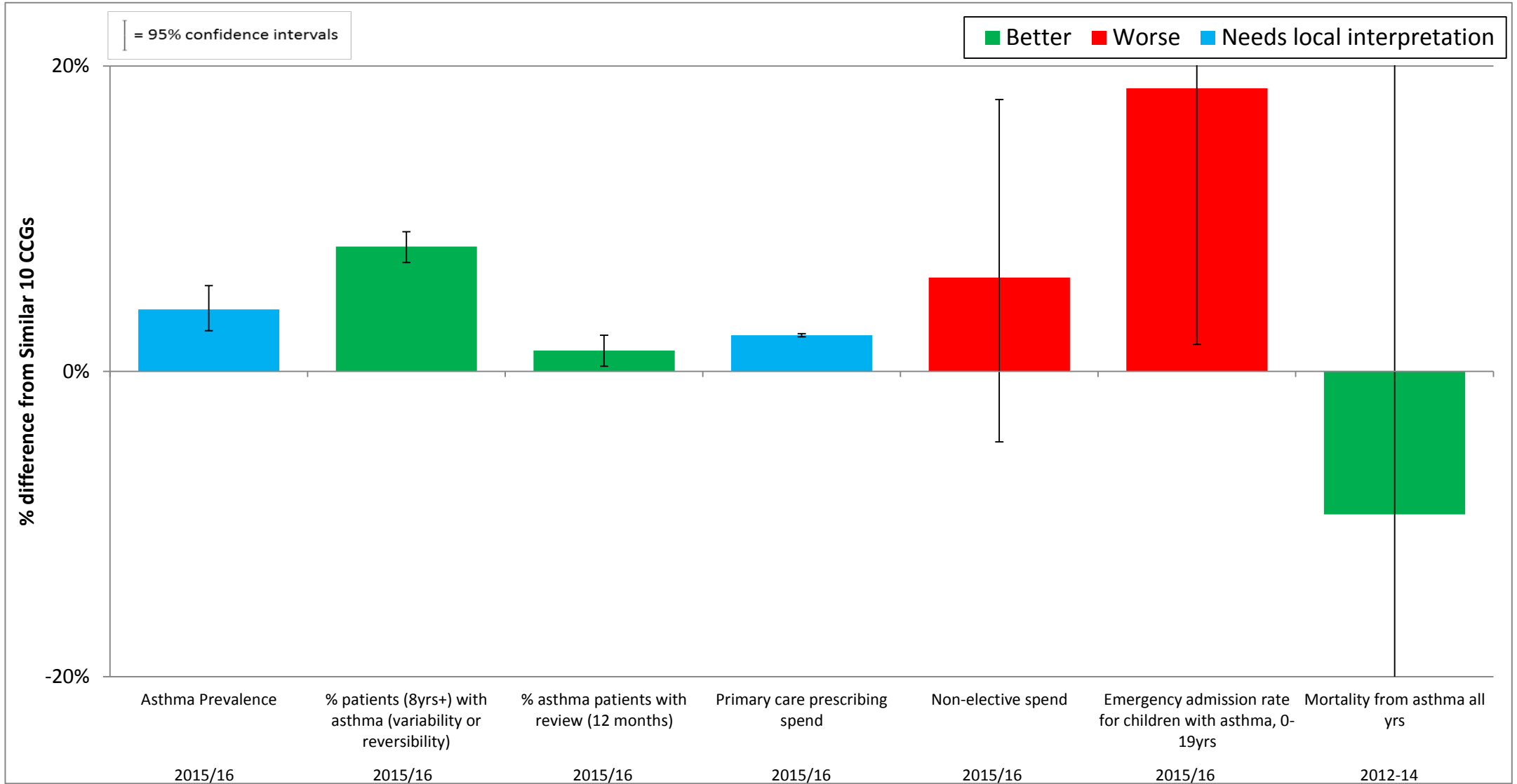
NICE guidance:

<http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-copd.aspx>

Asthma pathway



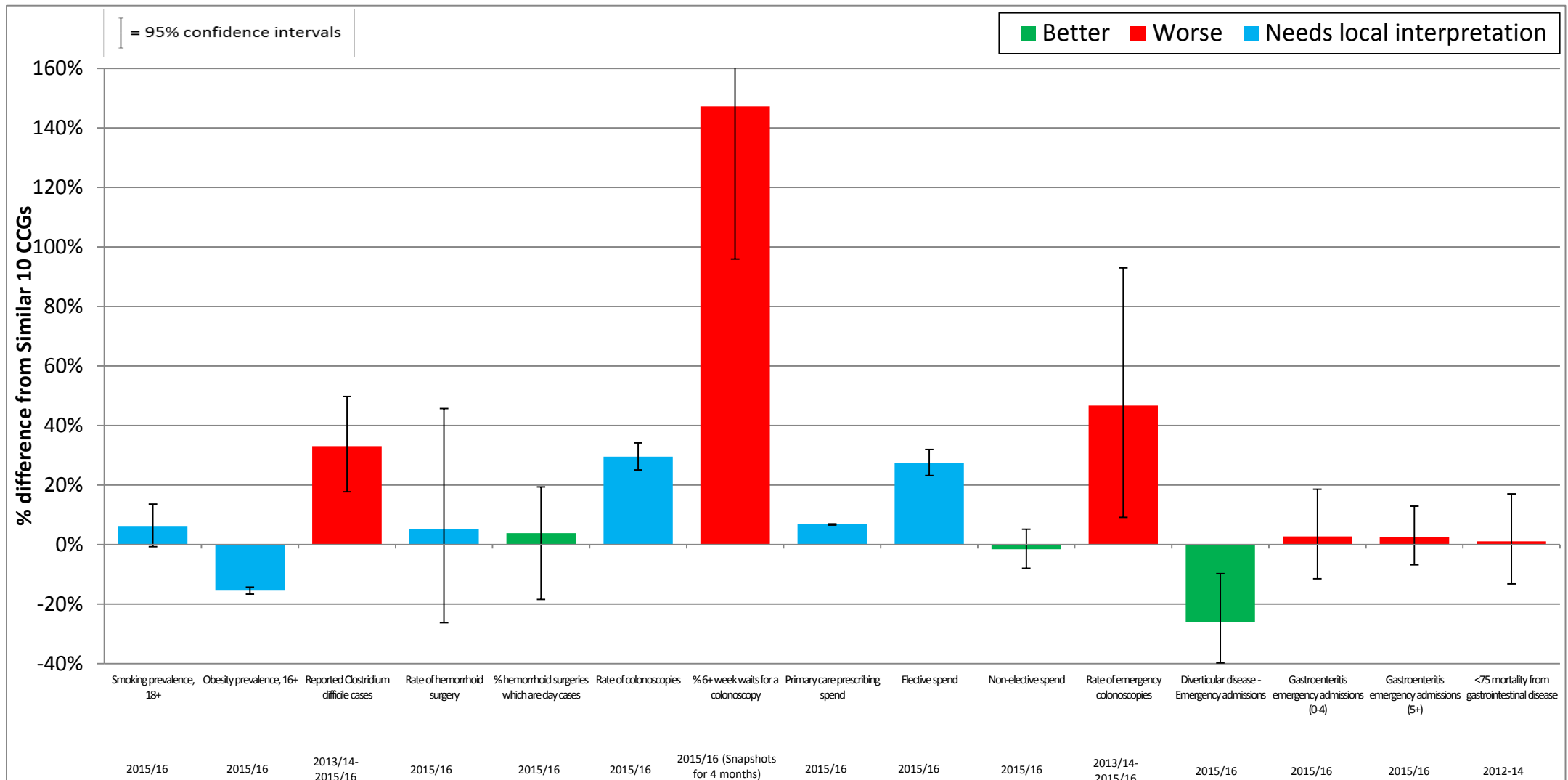
NICE guidance:

<http://pathways.nice.org.uk/pathways/asthma>

PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/asthma.aspx>

Lower gastrointestinal pathway

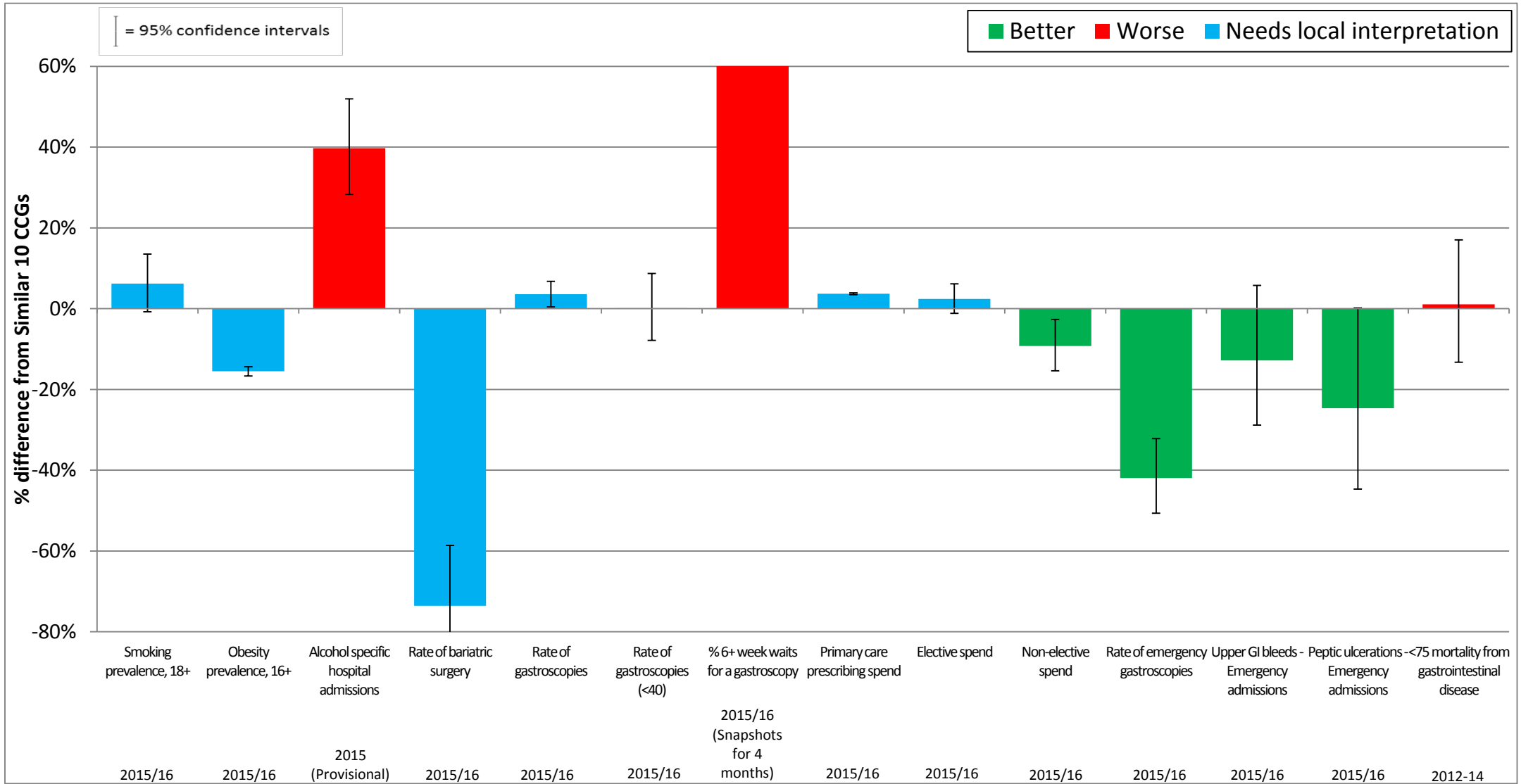


Note: It is anticipated that emergency admissions for Diverticular Disease of Intestine will increasingly be treated with drainage rate lines, with a gradual decrease in resection rates lines. CCGs are advised to examine their procedure rates and how they can move towards performing more resections.

Colonoscopies are one of 15 key diagnostic tests which the NHS Constitution states less than 1% of patients should wait more than 6 weeks for. CCGs which achieve good performance compared to their peers may still be missing this target. CCGs are therefore advised to examine their waiting list times in greater detail, which are available at:

<https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/>

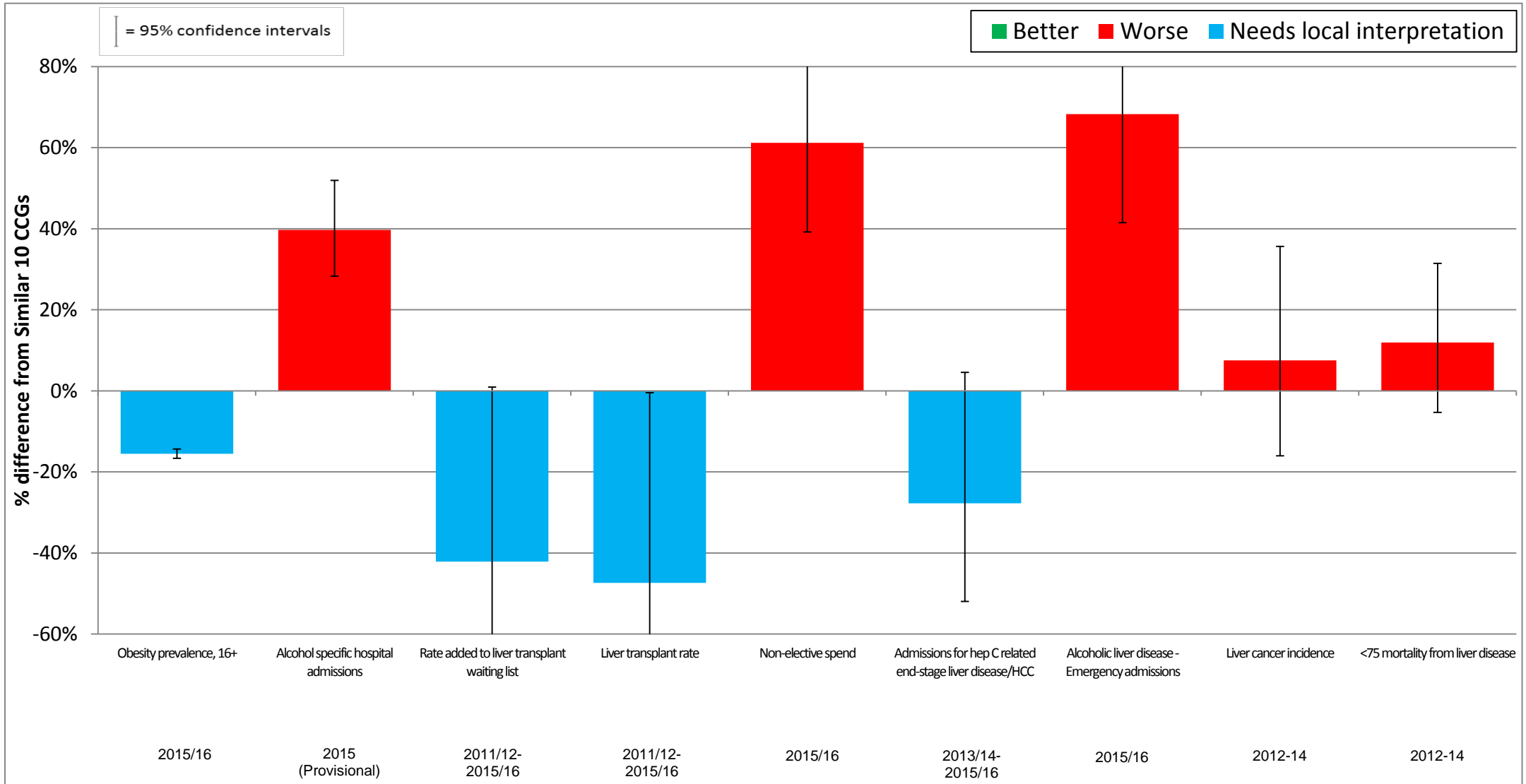
Upper gastrointestinal pathway



Note: Gastroscopies are one of 15 key diagnostic tests which the NHS Constitution states less than 1% of patients should wait more than 6 weeks for. CCGs which achieve good performance compared to their peers still may be missing this target. CCGs are therefore advised to examine their waiting list times in greater detail, which are available at:

<https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/>

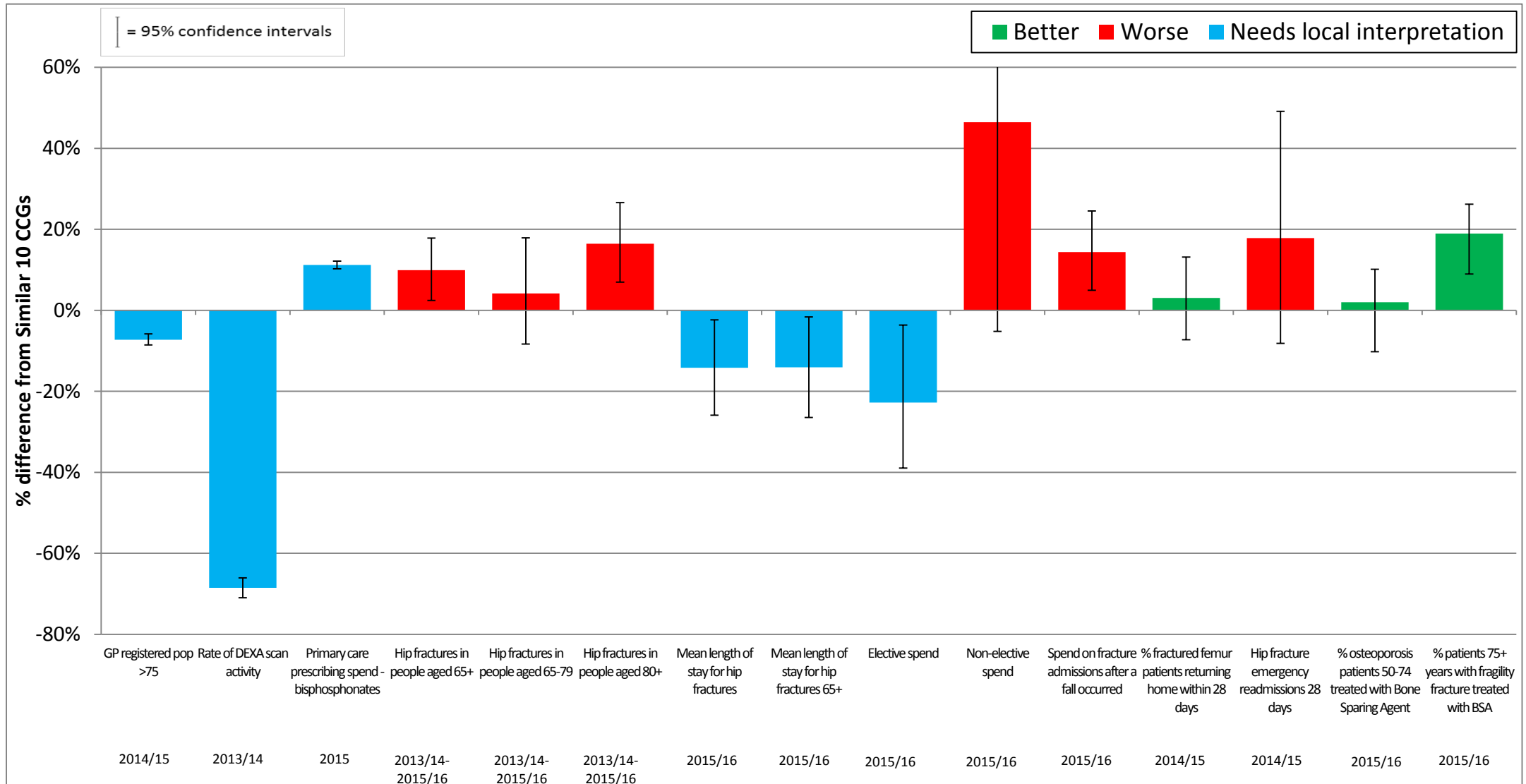
Liver disease pathway



Note: Variation in hospital testing practices for Hepatitis will influence the extent to which Hep C related end stage liver disease/hepatocellular carcinoma admissions are reported. CCGs are therefore advised to examine how hospital testing practices for Hepatitis may be affecting reported admission rates.

Many cases of liver cancer are linked to cirrhosis. Cirrhosis is commonly caused by heavy and harmful drinking, hepatitis C and the build-up of fat inside the tissue of the liver. Liver cancer incidence therefore is related to a number of other indicators listed in the pathway.

Osteoporosis and fragility fractures pathway



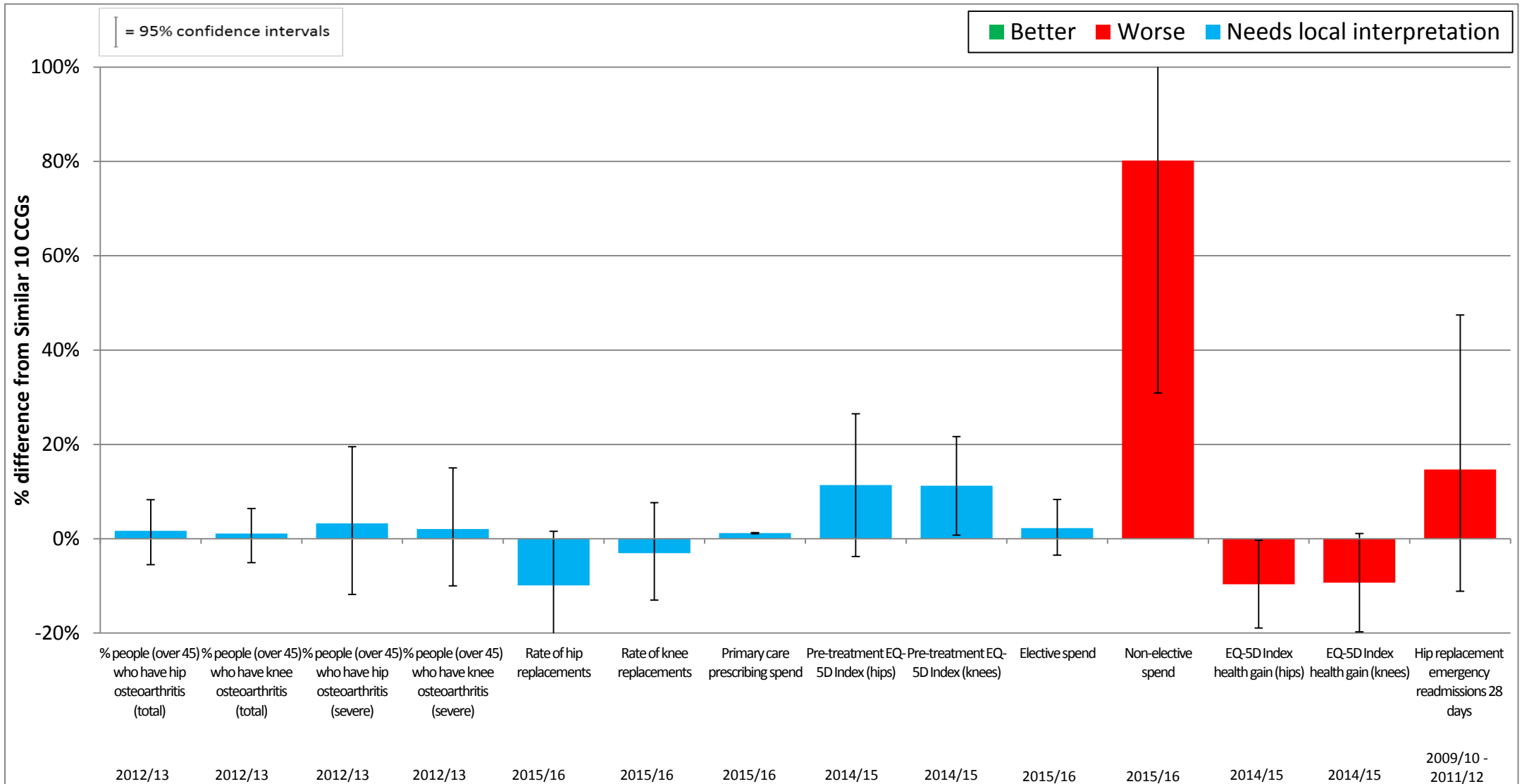
NICE guidance:

<http://pathways.nice.org.uk/pathways/musculoskeletal-conditions>

Arthritis Research UK Musculoskeletal calculator:

<http://www.arthritisresearchuk.org/mskcalculator>

Osteoarthritis pathway



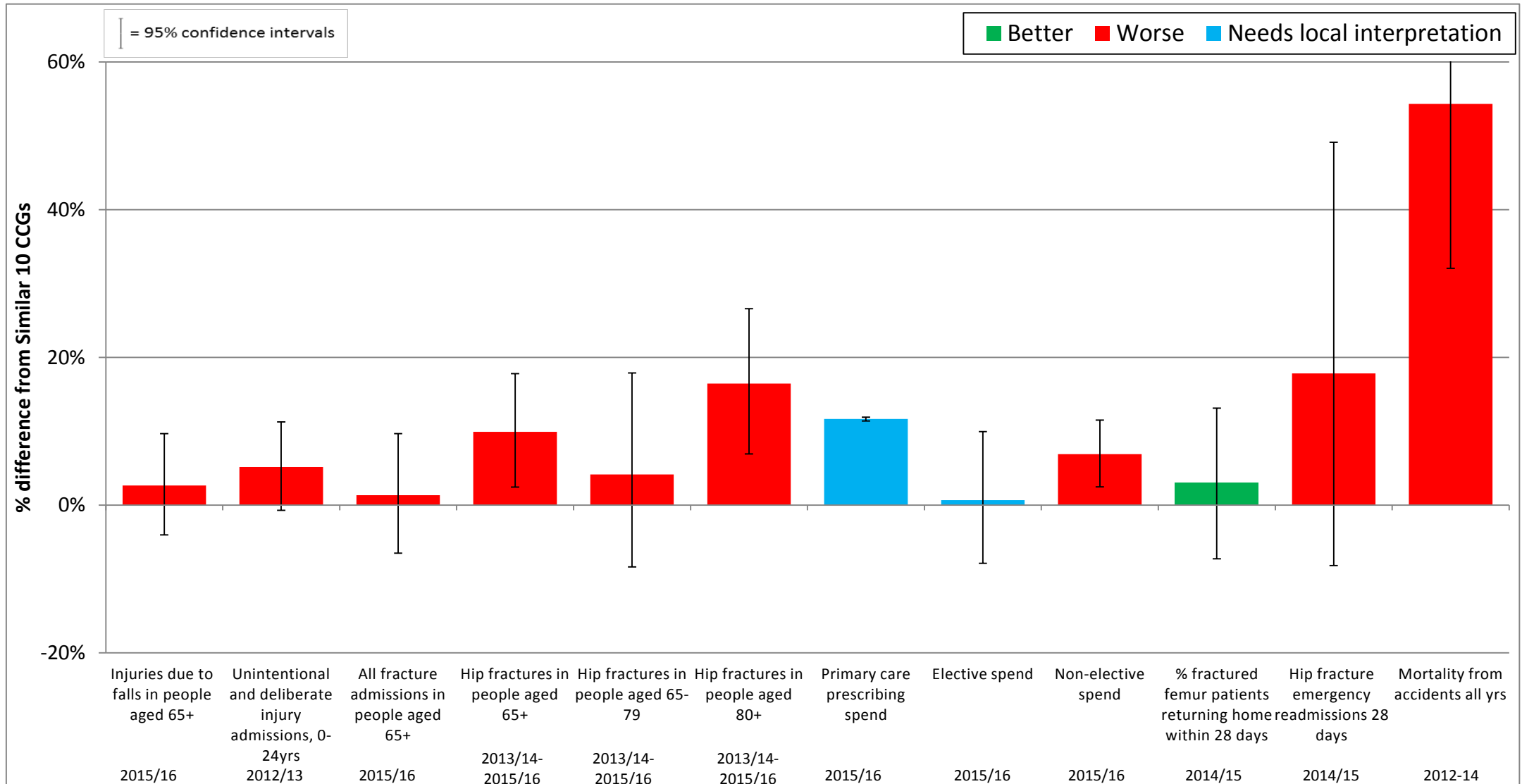
NICE guidance:

<http://pathways.nice.org.uk/pathways/musculoskeletal-conditions>

Arthritis Research UK Musculoskeletal calculator:

<http://www.arthritisresearchuk.org/mskcalculator>

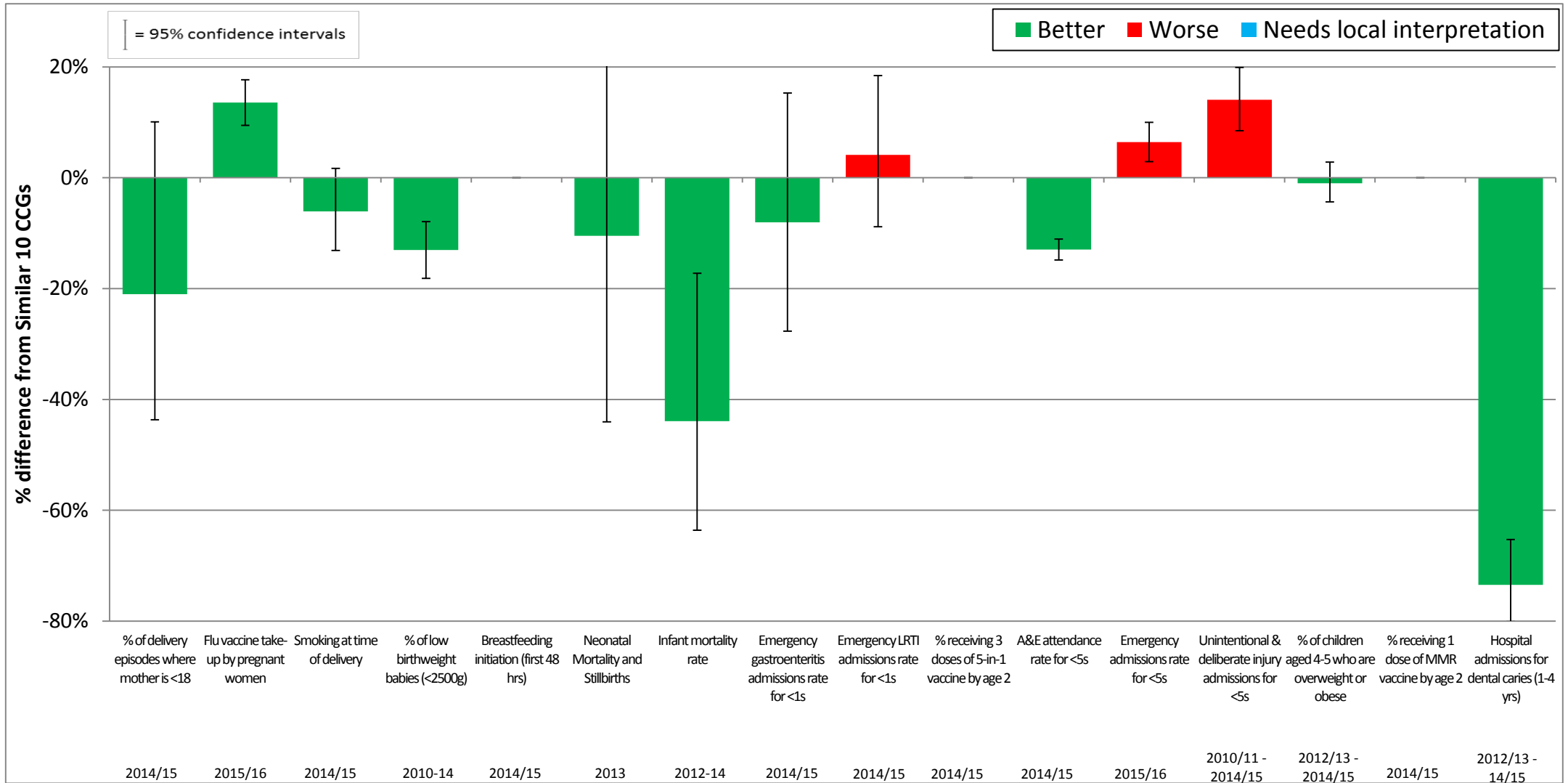
Trauma and injury pathway



NICE guidance:

- <http://pathways.nice.org.uk/pathways/falls-in-older-people>
- <http://pathways.nice.org.uk/pathways/unintentional-injuries-among-under-15s>
- <http://pathways.nice.org.uk/pathways/hip-fracture>

Maternity and early years pathway



NICE Pathways on: 'Smoking', 'Maternal and child nutrition', 'Diarrhoea and vomiting', 'Immunisation for children' and 'Unintentional injuries among under 15s'

<http://pathways.nice.org.uk/>

Further Information Link:

<https://sustain.sharepoint.com/Documents/HCP%20Integrated%20Com%20and%20Del%20toolkit%20final.pdf>

Where to Look: Step 3

The Integrated Care packs (2015) sought to show the extent to which complex patients use resources across programmes of care and the urgent care system. This can support local discussions on the health and systems impact if this cohort of the population were managed via integrated care planning and supported self-management arrangements. The National Clinical Directors, Intelligence Networks and third sector organisations helped to develop the pathways.

The following slides include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that your CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2015/16. Nationally the most common conditions of admissions for complex patients are circulation; cancer; and gastro-intestinal problems.

Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients who will require the most treatment across the health and care system. **However it is not possible to include analysis on mental health patients as they are not captured fully in these datasets.**

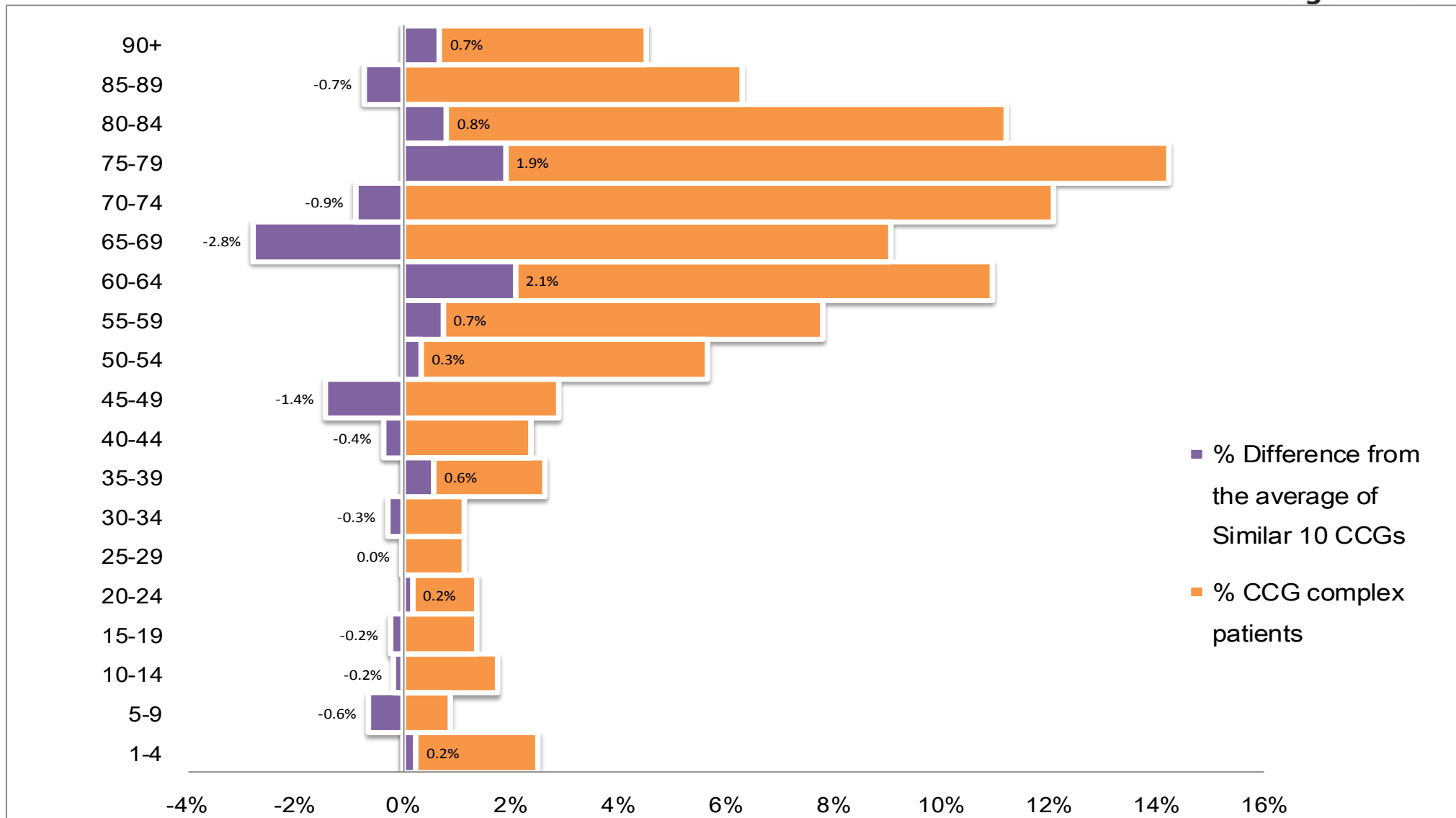
Nationally:

- These complex patients comprise **16%** of spend on inpatient admissions
- The average complex patient has seven admissions per year for three different conditions (based on programme budget categories)
- **61%** of these complex patients are aged 65 and over
- **38%** of these complex patients are aged 75 and over
- **14%** of these complex patients are aged 85 and over

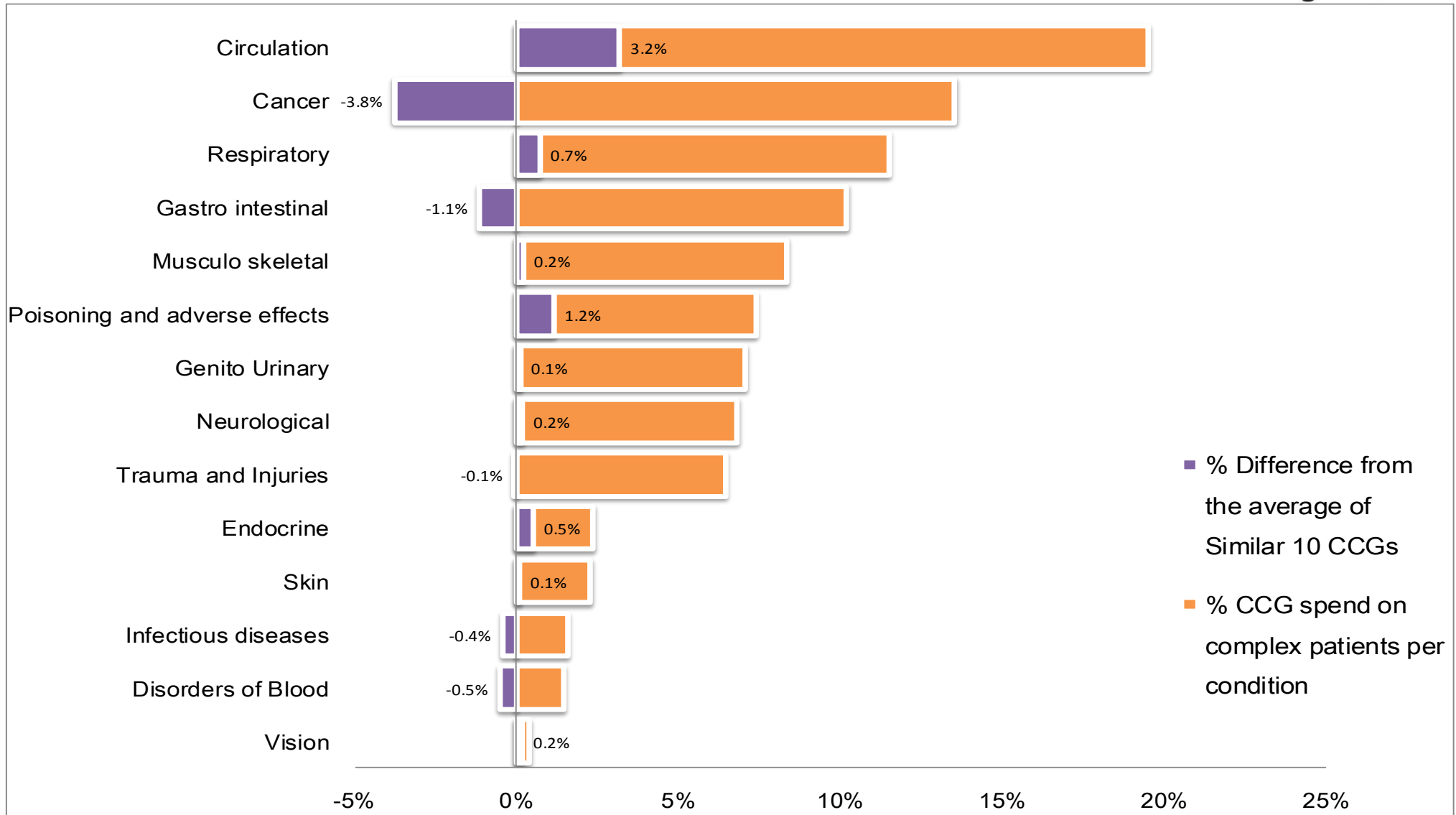
Complex patients - Age Profile

2% Most Complex Patients (16.4% of CCG Spend)				
Age	Number of complex patients	Mean Number of Admissions	Mean Number of Different Conditions	Total Spend (£000s)
1-4	20	14.1	2.70	£ 727
5-9	7	5.6	2.71	£ 163
10-14	14	6.3	1.93	£ 341
15-19	11	5.8	1.91	£ 307
20-24	11	8.6	2.55	£ 231
25-29	9	10.1	3.78	£ 184
30-34	9	2.7	2.00	£ 160
35-39	21	7.5	2.81	£ 465
40-44	19	7.8	2.32	£ 453
45-49	23	5.0	2.70	£ 484
50-54	45	5.2	2.49	£ 890
55-59	62	7.1	2.76	£ 1,389
60-64	87	5.9	2.77	£ 1,744
65-69	72	6.4	3.01	£ 1,338
70-74	96	6.3	2.97	£ 1,906
75-79	113	5.6	2.99	£ 2,281
80-84	89	5.7	3.08	£ 1,720
85-89	50	4.6	2.98	£ 973
90+	36	3.8	2.67	£ 669
TOTAL	794	6.1	2.83	£ 16,424

Complex patients - Age Profile



Complex patients - Spend Profile



Complex patients - Co-morbidities

Of the 264 patients admitted for Circulation, 68 patients were admitted for a Gastro intestinal condition and 68 patients were admitted for a Neurological condition.

*For more details on how to interpret the following table, please refer to the last slide of this pack "Complex Patients - How to interpret co-morbidities table"

Main conditions	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3	Co-morbidity 4	Co-morbidity 5
Circulation	Gastro intestinal	Neurological	Respiratory	Genito Urinary	Poisoning and adverse effects
264 patients	68	68	66	52	36
Gastro intestinal	Circulation	Respiratory	Genito Urinary	Neurological	Cancer
240 patients	68	67	65	53	54
Respiratory	Gastro intestinal	Circulation	Neurological	Genito Urinary	Cancer
230 patients	67	66	57	51	48
Cancer	Gastro intestinal	Respiratory	Genito Urinary	Poisoning and adverse effects	Circulation
187 patients	54	48	39	43	31
Genito Urinary	Gastro intestinal	Circulation	Respiratory	Neurological	Cancer
183 patients	65	52	51	45	39

Next steps and actions

Local health economies can take the following steps now:

- Identify the priority programmes and complex patients in your locality and compare against current improvement activity and plans
- Look at the focus packs on the NHS RightCare website for those areas which are a priority for your locality
- Engage with clinicians and other local stakeholders, including public health teams in local authorities and commissioning support organisations and explore the priority opportunities further using local data
- Ensure planning round submissions, and returns for the CCG Improvement and Assessment Framework reflect the opportunities identified
- Discuss the opportunities highlighted in this pack as part of the STP planning process and consider STP wide action where appropriate
- Revisit the NHS RightCare website regularly as new content, including updates to tools to support the use of the Commissioning for Value packs, is regularly added
- Discuss next steps with your Delivery Partner (please note all CCGs will have a Delivery Partner assigned to them by January 2017)

Further support and information



The Commissioning for Value benchmarking tool, explorer tool, full details of all the data used, and links to other useful tools are available on the NHS RightCare website. Links are shown on the next page.

The NHS RightCare website also offers resources to support CCGs in adopting the Commissioning for Value approach. These include:

- Focus packs for the highest spending programmes covered in this pack
- Online videos and 'how to' guides
- Case studies with learning from other CCGs

If you have any questions or require any further information or support you can email the Commissioning for Value support team direct at: england.healthinvestmentnetwork@nhs.net

Useful links

NHS RightCare website:

<https://www.england.nhs.uk/rightcare>

Commissioning for Value packs and products:

<https://www.england.nhs.uk/rightcare/intel/cfv/>

NHS RightCare casebooks:

<https://www.england.nhs.uk/rightcare/intel/cfv/casebooks/>

Commissioning for Value Similar 10 Explorer Tool:

<https://www.england.nhs.uk/wp-content/uploads/2016/01/cfv-16-similar-10-explr-tool.xlsm>

Five Year Forward View:

<https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

NHS shared planning guidance for 2017/18 - 2018/19

<https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/>

CCG Improvement and Assessment Framework

<https://www.england.nhs.uk/commissioning/ccg-auth/>

Annex: How to interpret the complex patients co-morbidities table

This slide provides insight into how to interpret the co-morbidities table.

The three different factors which make up this table are the main condition, co-morbidity and the number of patients.

	Main conditions	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3	Co-morbidity 4	Co-morbidity 5
1st	Gastro intestinal	Neurological	Genito Urinary	Poisoning and adverse effects	Circulation	Cancer
	161 patients	48	48	48	41	34
2nd	Circulation	Respiratory	Gastro intestinal	Genito Urinary	Neurological	Poisoning and adverse effects
	178 patients	52	41	36	26	28

Interpreting main conditions

Main conditions are ranked by the number of different conditions (based on programme budgeting subcategories) that patients are admitted for. This ranking may be different if based on the number of patients that have had an admission for each condition. For example, this CCG has 161 patients who were admitted to hospital for Gastro Intestinal problems, but 40 of these patients had admissions for two different Gastro Intestinal subcategories (e.g. Lower Gastro Intestinal and Upper Gastro Intestinal) so the total number of conditions that the ranking is based on is 201. This CCG has 178 patients who were admitted for Circulation problems, but only 15 of these patients had admissions for two different Circulation subcategories (e.g. Coronary Heart Disease and Cerebrovascular Disease) so the total number of conditions that the ranking is based on is 193. Therefore, Gastro Intestinal is shown as the 1st main condition.

Interpreting co-morbidities

Co-morbidities are ranked by the number of different conditions (based on programme budgeting subcategories) that patients are admitted for. This ranking may be different if based on the number of patients that have had an admission for each condition. Of the 178 patients who were admitted to hospital for Circulation problems, 26 patients also had 40 Neurological admissions (for two different Neurological subcategories). Of the 178 patients who were admitted to hospital for Circulation problems, 28 patients also had 28 admissions for Poisoning and adverse effects. Therefore, Neurological is shown as the 4th co-morbidity for Circulation followed by Poisoning and adverse effects.