Public Health England

NHS RightCare

Commissioning for Value Where to Look pack

NHS Trafford CCG

January 2017

OFFICIAL

Gateway ref: 06345

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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 Solihull CCG
- NHS Stockport CCG
- NHS Southend CCG
- NHS Bury CCG
- NHS Warrington CCG
- NHS Havering CCG
- NHS Dudley CCG
- NHS Redditch and Bromsgrove CCG
- NHS Basildon and Brentwood CCG
- NHS Swindon 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.

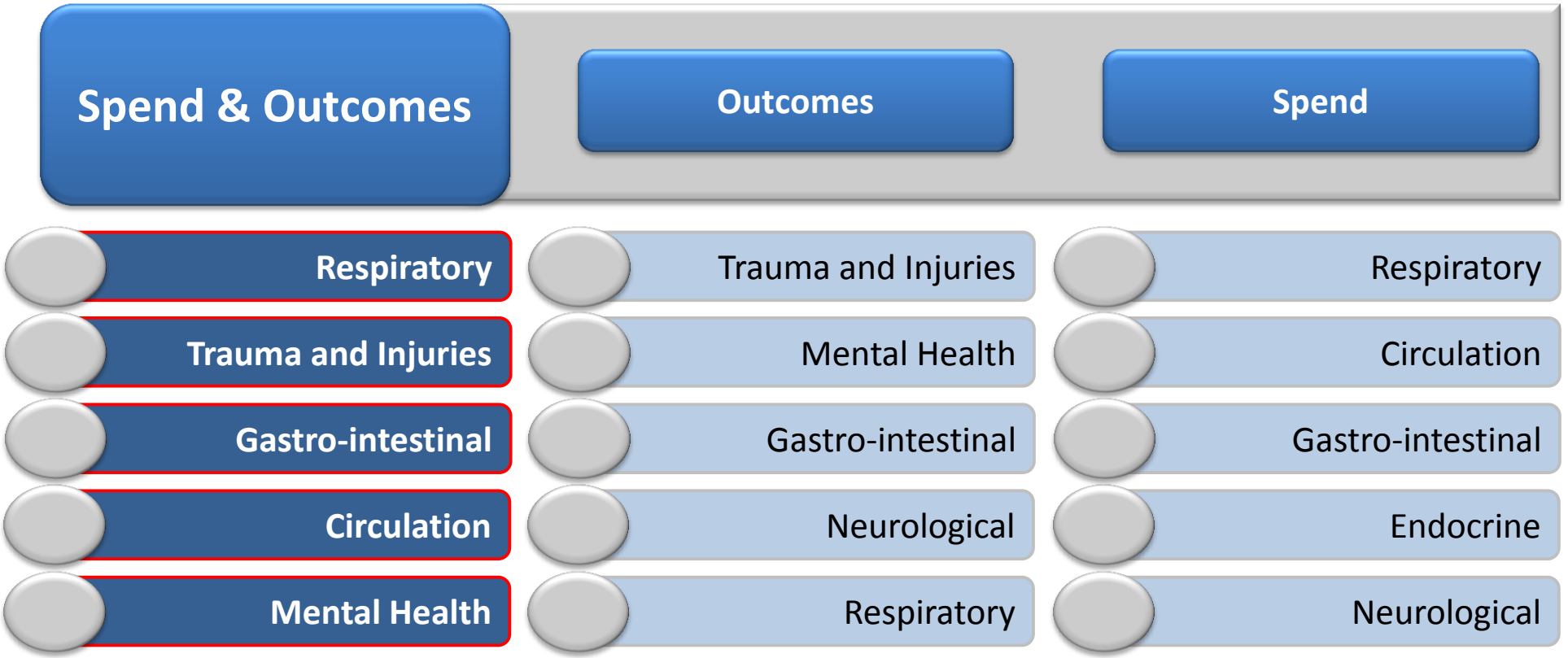
This pack begins the process for you by offering a triangulation of nationally-held data that indicates where CCGs may gain the highest value healthcare improvement.

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

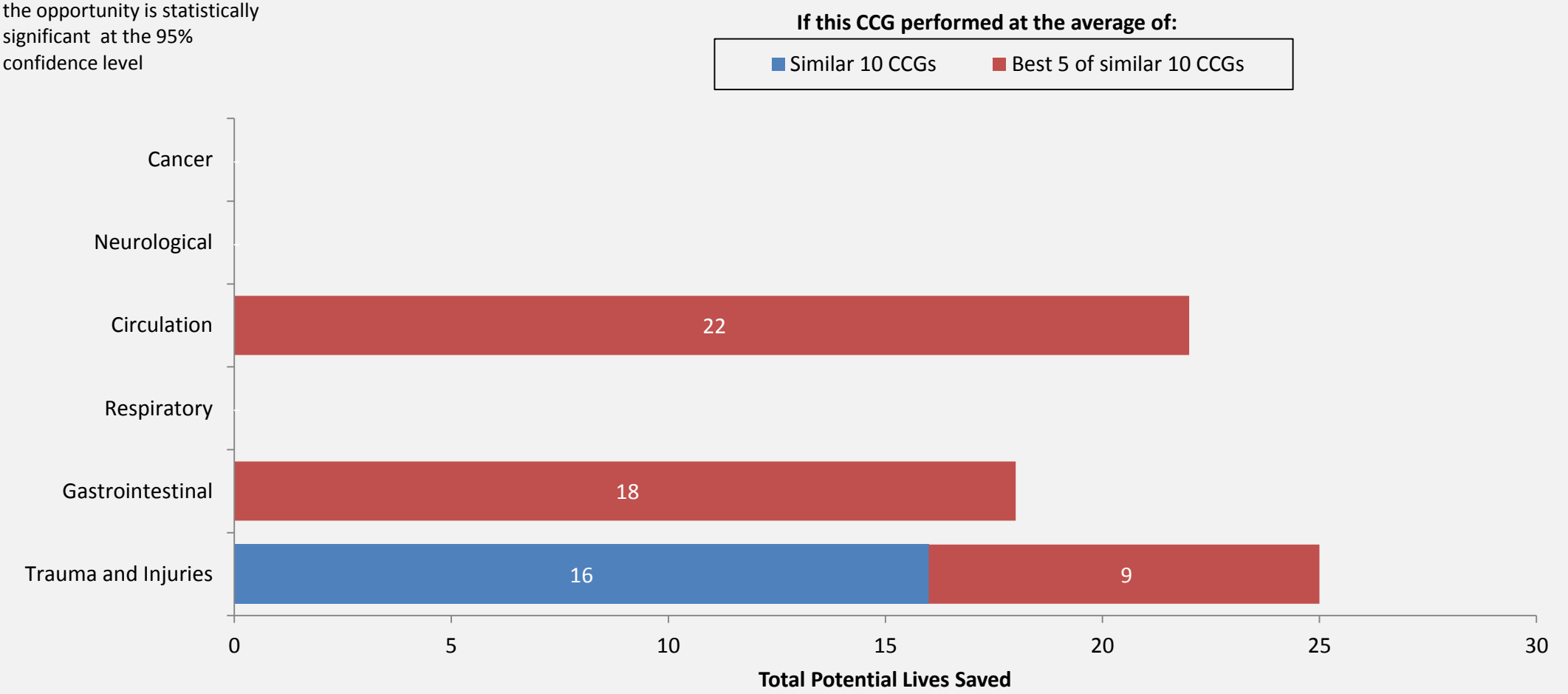


Where there has been a change to your improvement opportunities from the January 2016 pack this could have been caused by actual improvement or deterioration in your own CCG or peer CCG performance or the robustness and timing of local data
If your local opportunities have changed significantly and you 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?

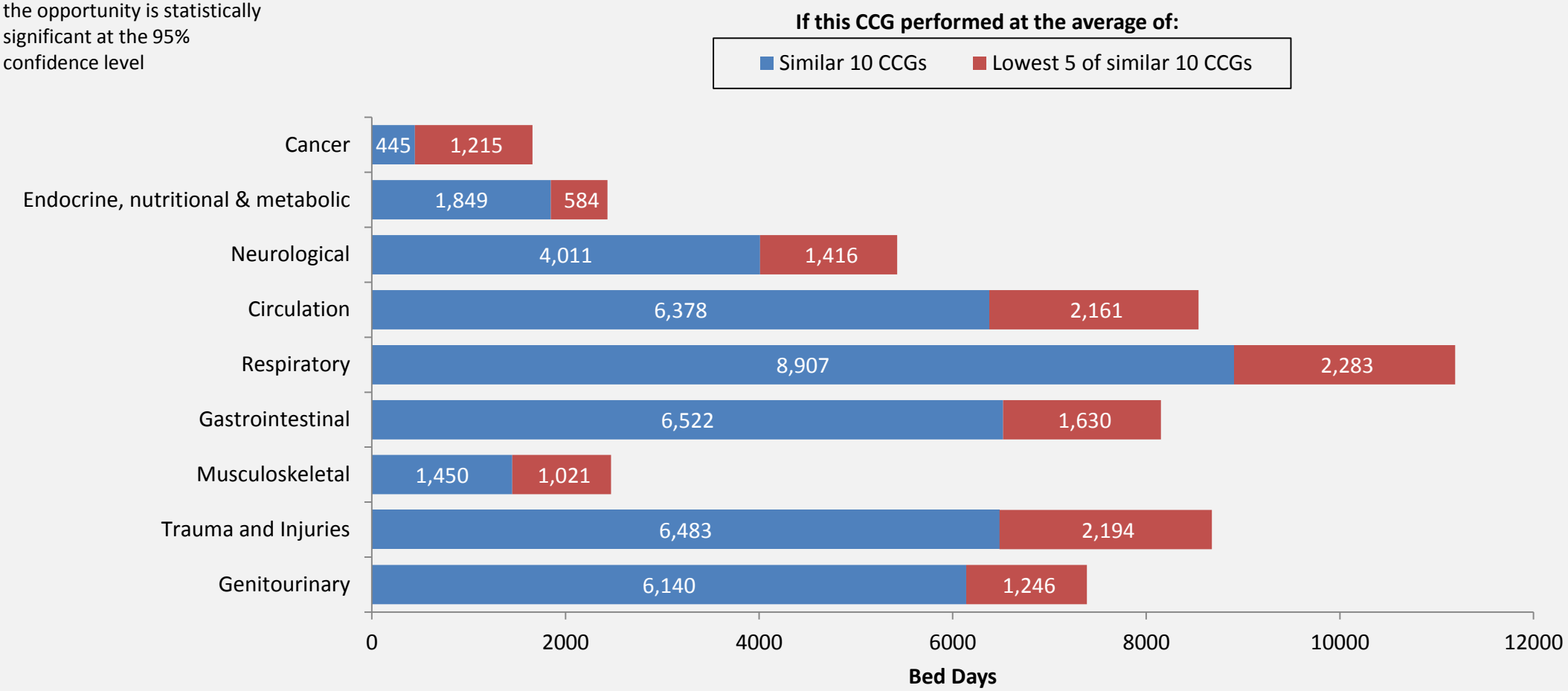
A value is only shown where the opportunity is statistically significant at the 95% confidence level



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 appropria te.

How different are we on bed days?

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



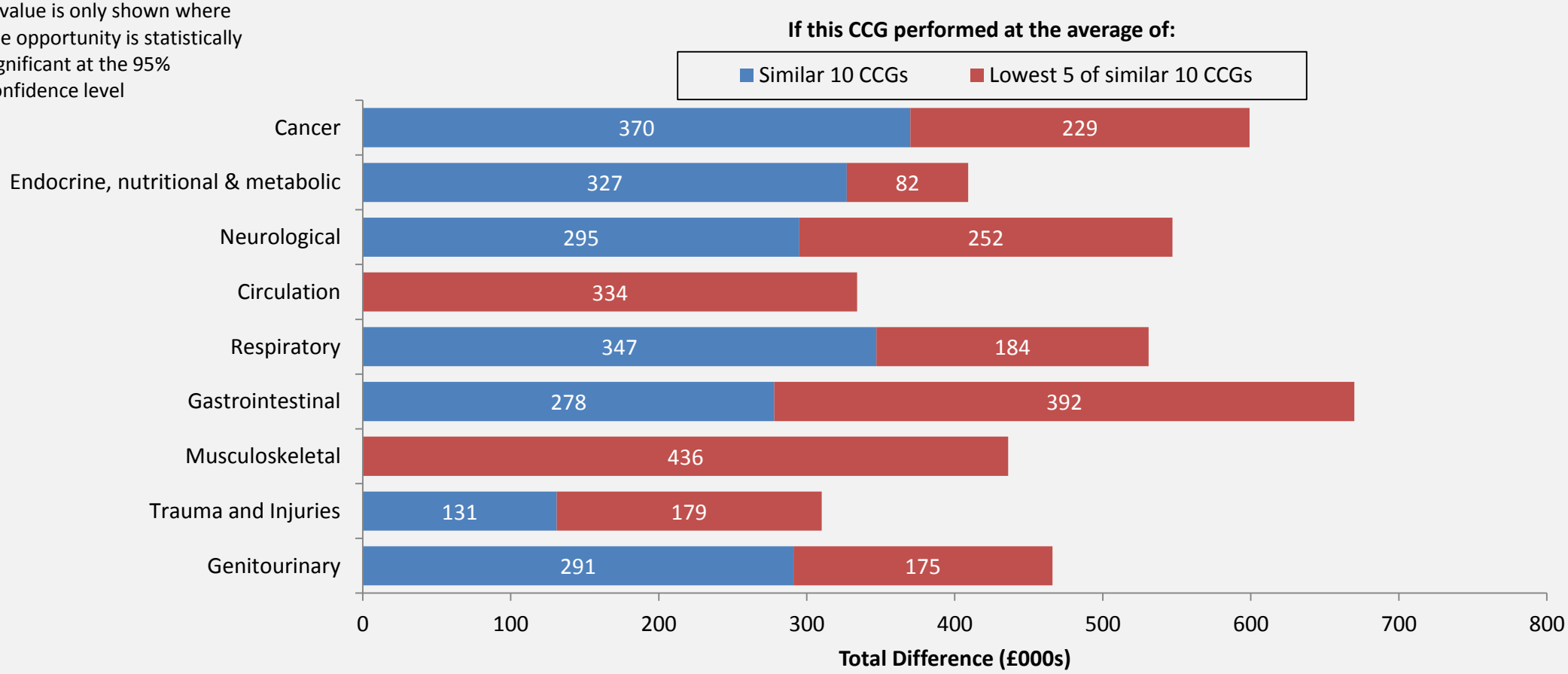
The bed days data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

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 (includin g 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?

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



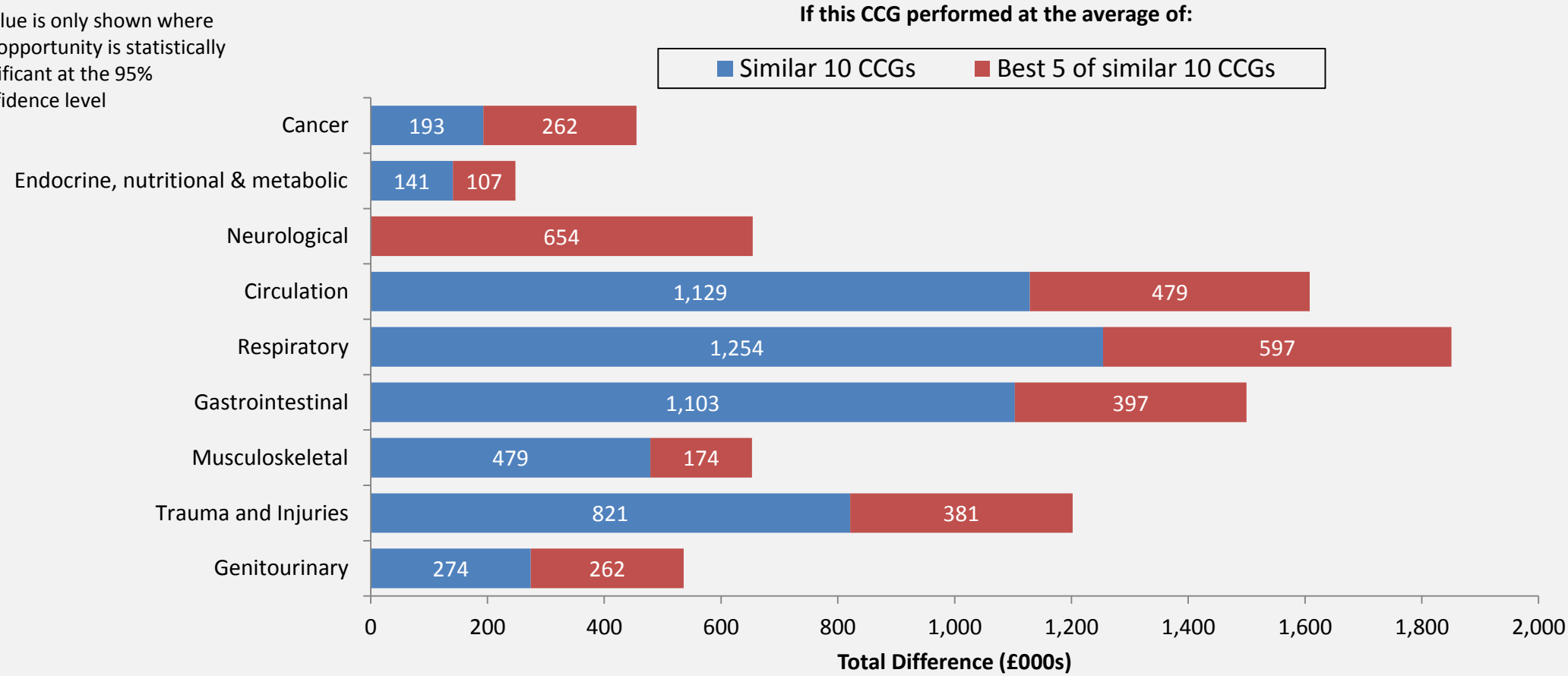
The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

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



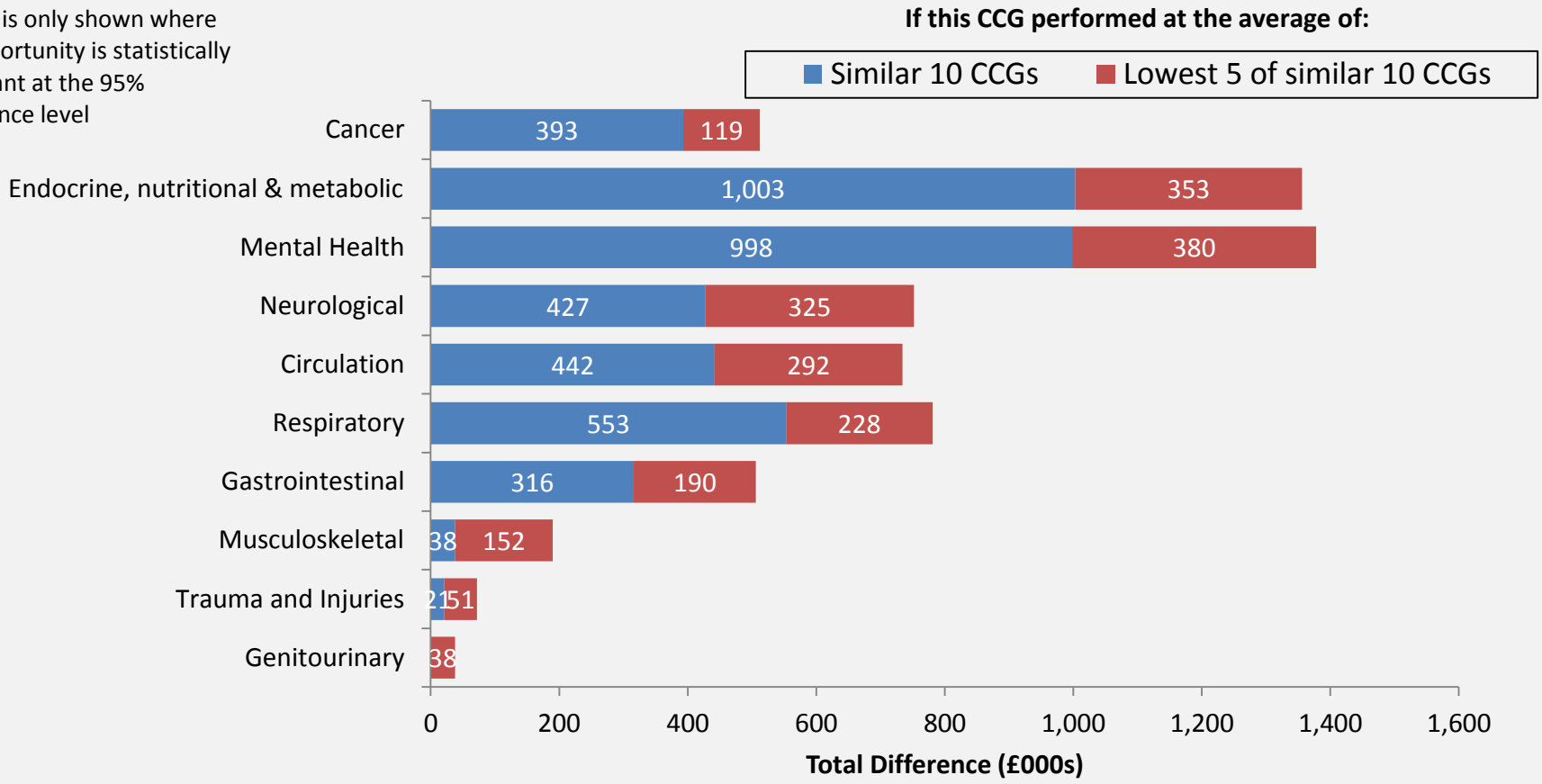
The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

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



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 Trafford 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	• Spend on elective and day-case admissions	599	• Cancer and Tumours - Rate of bed days	1,660
	• Spend on non-elective admissions	455	• Breast cancer screening	1,335
	• Spend on primary care prescribing	512	• Bowel cancer screening	409
			• Mortality from colorectal cancer under 75 years	7
			• Successful quitters, 16+	786
Circulation Problems (CVD)	• Spend on elective and day-case admissions	334	• Circulation - Rate of bed days	8,539
	• Spend on non-elective admissions	1,608	• Mortality from all circulatory diseases under 75 years	22
	• Spend on primary care prescribing	735	• Reported to estimated prevalence of hypertension	2,570
			• Patients with CHD whose BP < 150/90	115
			• Patients with CHD whose cholesterol < 5 mmol/l	99
			• Patients with hypertension whose BP < 150/90	512
			• Mortality from acute MI under 75 years	10
			• Patients with stroke/TIA whose BP < 150/90	52
			• Stroke patients spending 90% of their time on stroke unit	25
			• % patients returning home after treatment	86
			• Mortality from stroke under 75 years	8
			• High-risk AF patients on anticoagulation therapy	127

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Trafford 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	• Spend on elective and day-case admissions	409	• Endocrine - Rate of bed days	2,433
	• Spend on non-elective admissions	248	• % diabetes patients whose cholesterol < 5 mmol/l	369
	• Spend on primary care prescribing	1,355	• % diabetes patients whose HbA1c is <59 mmol/mol	867
			• % diabetes patients whose blood pressure is <140/80	223
			• % of diabetes patients receiving all three treatment targets	274
			• % patients receiving foot examination	226
Gastrointestinal	• Spend on elective and day-case admissions	670	• Gastro - Rate of bed days	8,152
	• Spend on non-elective admissions	1,499	• Mortality from gastrointestinal disease under 75 years	18
	• Spend on primary care prescribing	505	• Mortality for liver disease under 75 years	19
			• % 6+ week waits for a gastroscopy (4 month snapshots)	117
			• Alcohol specific hospital admissions	147
			• Emergency admissions for alcoholic liver disease condition (19+)	21
			• % 6+ week waits for a colonoscopy (4 month snapshots)	70
			• Rate of emergency colonoscopies	9
			• Emergency admissions for diverticular disease	26
			• Emergency admissions for gastroenteritis (0-4)	77
			• Emergency admissions for gastroenteritis (5+)	121

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Trafford 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	• Spend on elective and day-case admissions	466	• Genitourinary - Rate of bed days	7,387
	• Spend on non-elective admissions	536	• Patients on CKD register with a BP of 140/85 or less	85
	• Spend on primary care prescribing	38	• Patients on CKD register treated with an ACE-1 or ARB	29
Maternity & Reproductive Health			• Emergency LRTI admissions rate for <1s	76
			• A&E attendance rate for <5s	2,174
			• Emergency admissions rate for <5s	1,114
			• Unintentional & deliberate injury admissions for <5s	71
			• Hospital admissions for dental caries (1-4 years)	31

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Trafford 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	• Spend on primary care prescribing	1,378	• Physical health checks for patients with SMI	36
			• Mental health hospital admissions	49
			• People subject to mental health act (quarter)	50
			• New cases of depression which have been reviewed	127
			• Assessment of severity of depression at outset	53
			• Completion of IAPT treatment (quarter)	254
			• IAPT: % 'moving to recovery' rate (quarter)	49
			• IAPT: % achieving 'reliable improvement' (quarter)	42
			• Emergency hospital admissions for self harm	101
			• Excess under 75 mortality rate in adults with serious mental illness	29
			• % adults on CPA in settled accommodation (end of quarter snapshot)	98
			• % dementia deaths in usual place of residence (65+)	41
			• % short stay emergency admissions aged 65+ with dementia	106
			• % new dementa diagnosis with blood test	38
			• Dementia diagnosis rate (65+)	97
			• % of EIP referrals waiting >2 wks to start treatment (Incomplete) (5m)	10
			• % of EIP referrals waiting <2 wks to start treatment (Complete) (5m)	9
			• IAPT: % waiting <6 weeks for first treatment (6 month snapshots)	463
			• Rate of emergency admissions aged 65+ with dementia	216

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing NHS Trafford 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)	• Spend on elective and day-case admissions	436	• MSK - Rate of bed days	2,471
	• Spend on non-elective admissions	653	• Hip replacement, EQ-5D Index, average health gain	52
	• Spend on primary care prescribing	190	• Knee replacement, EQ-5D Index, average health gain	63
	• Spend on admissions relating to fractures where a fall occurred	401	• Hip replacement emergency readmissions 28 days	8
			• % fractured femur patients returning home within 28 days	25
Neurological System Problems	• Spend on elective and day-case admissions	547	• Neurological - Rate of bed days	5,426
	• Spend on non-elective admissions	654	• Emergency admission rate for children with epilepsy aged 0–17 years	22
	• Spend on primary care prescribing	752	• Patients with epilepsy on drug treatment and convulsion free, 18+	57
Respiratory System Problems	• Spend on elective and day-case admissions	531	• Respiratory - Rate of bed days	11,190
	• Spend on non-elective admissions	1,852	• Reported to estimated prevalence of COPD	1,591
	• Spend on primary care prescribing	781	• % of COPD patients with a record of FEV1	200
			• % patients (8yrs+) with asthma (variability or reversibility)	93
			• % asthma patients with review (12 months)	197
			• Emergency admission rate for children with asthma, 0-19yrs	81
			• % of COPD patients with a diagnosis confirmed by spirometry	39

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 Trafford 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	• Spend on elective and day-case admissions	310	• Trauma and injuries - Rate of bed days	8,676
	• Spend on non-elective admissions	1,202	• Mortality from accidents all ages	25
	• Spend on primary care prescribing	72	• Injuries due to falls in people aged 65+	167
	• Spend on admissions relating to fractures where a fall occurred	401	• Unintentional and deliberate injury admissions, 0-24yrs	76
			• All fracture admissions in people aged 65+	69
			• % fractured femur patients returning home within 28 days	25

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.

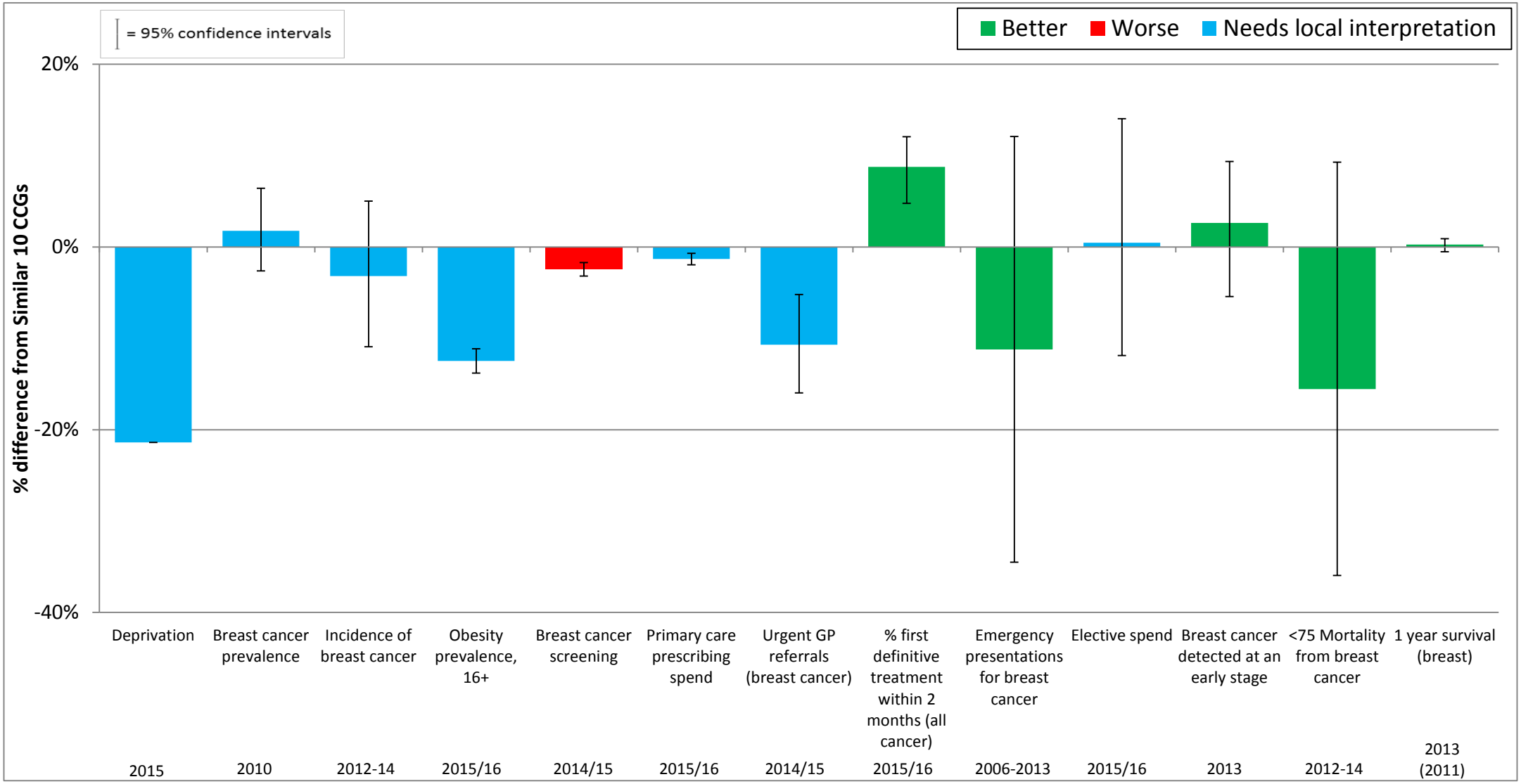
Where to Look: Step 2

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



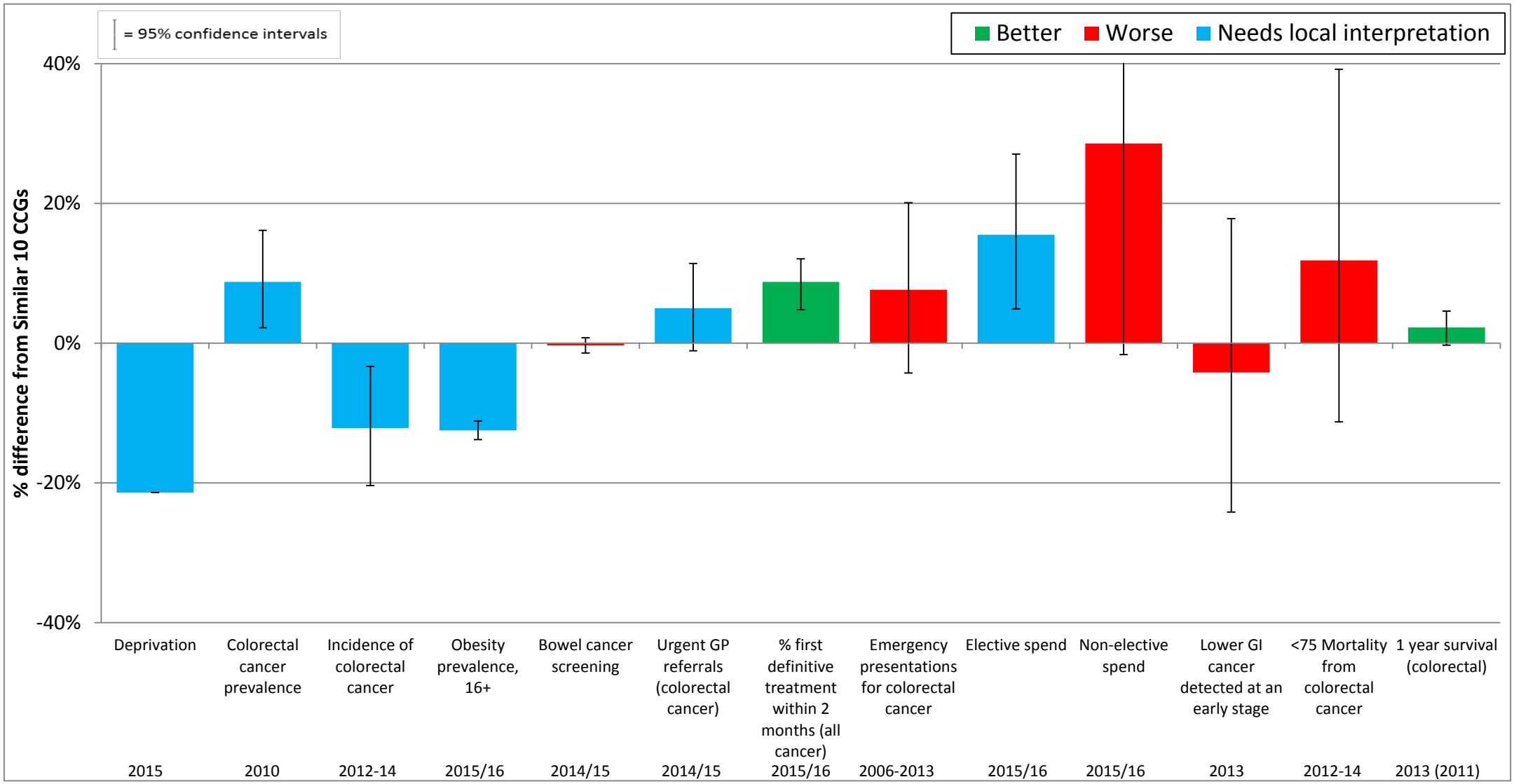
NICE guidance:

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

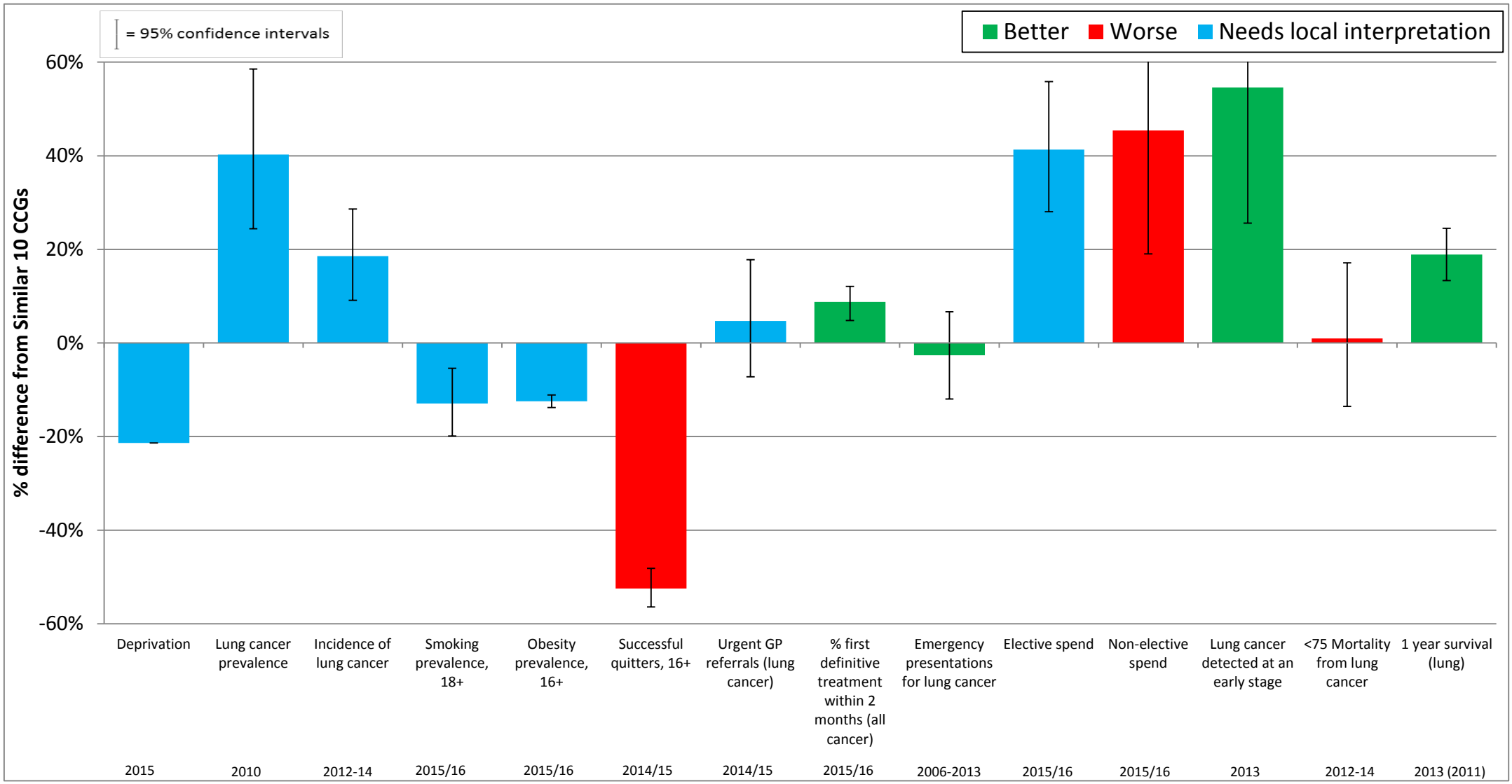
Lower gastro-intestinal cancer pathway



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

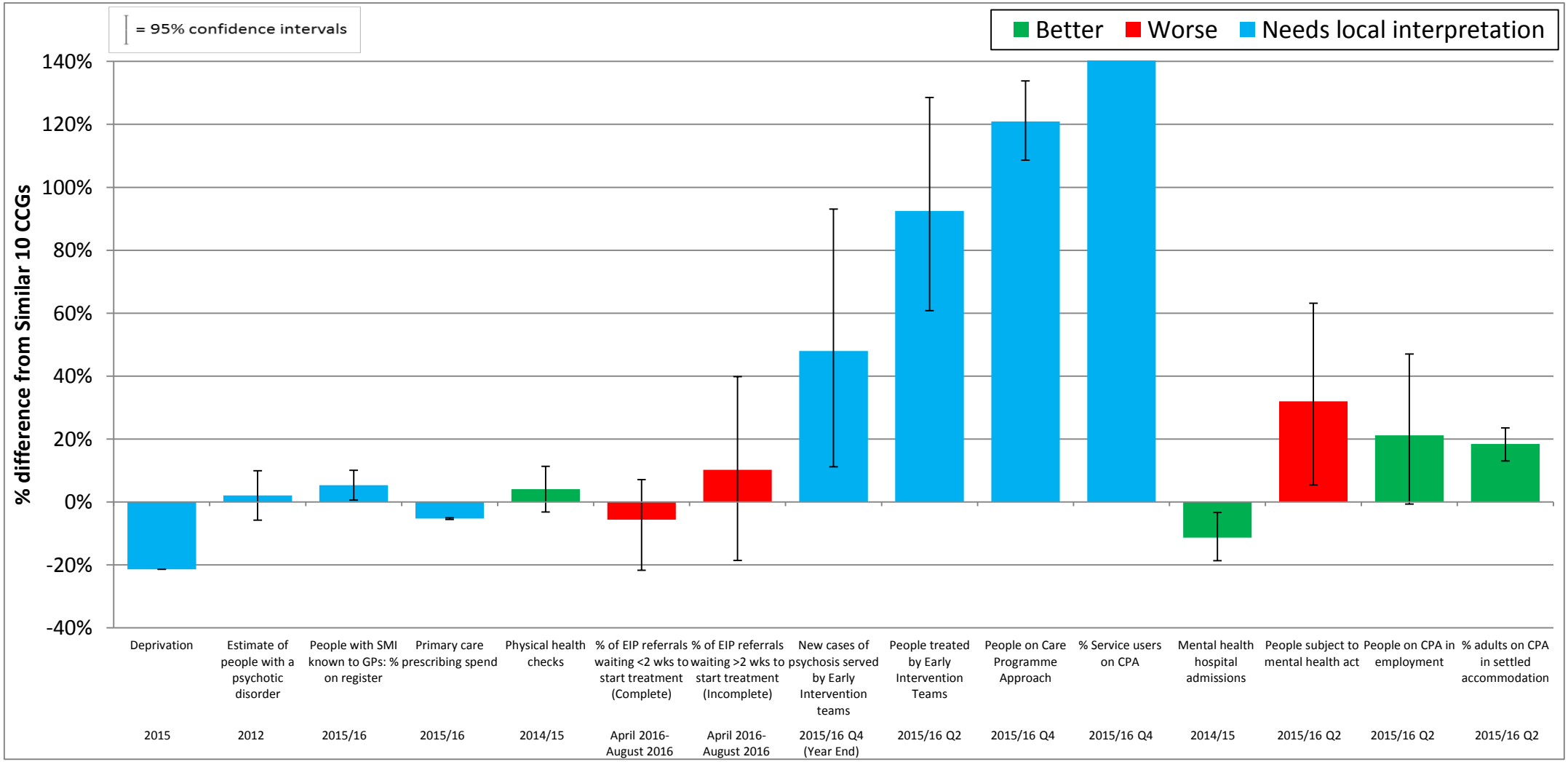
Lung cancer pathway



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:

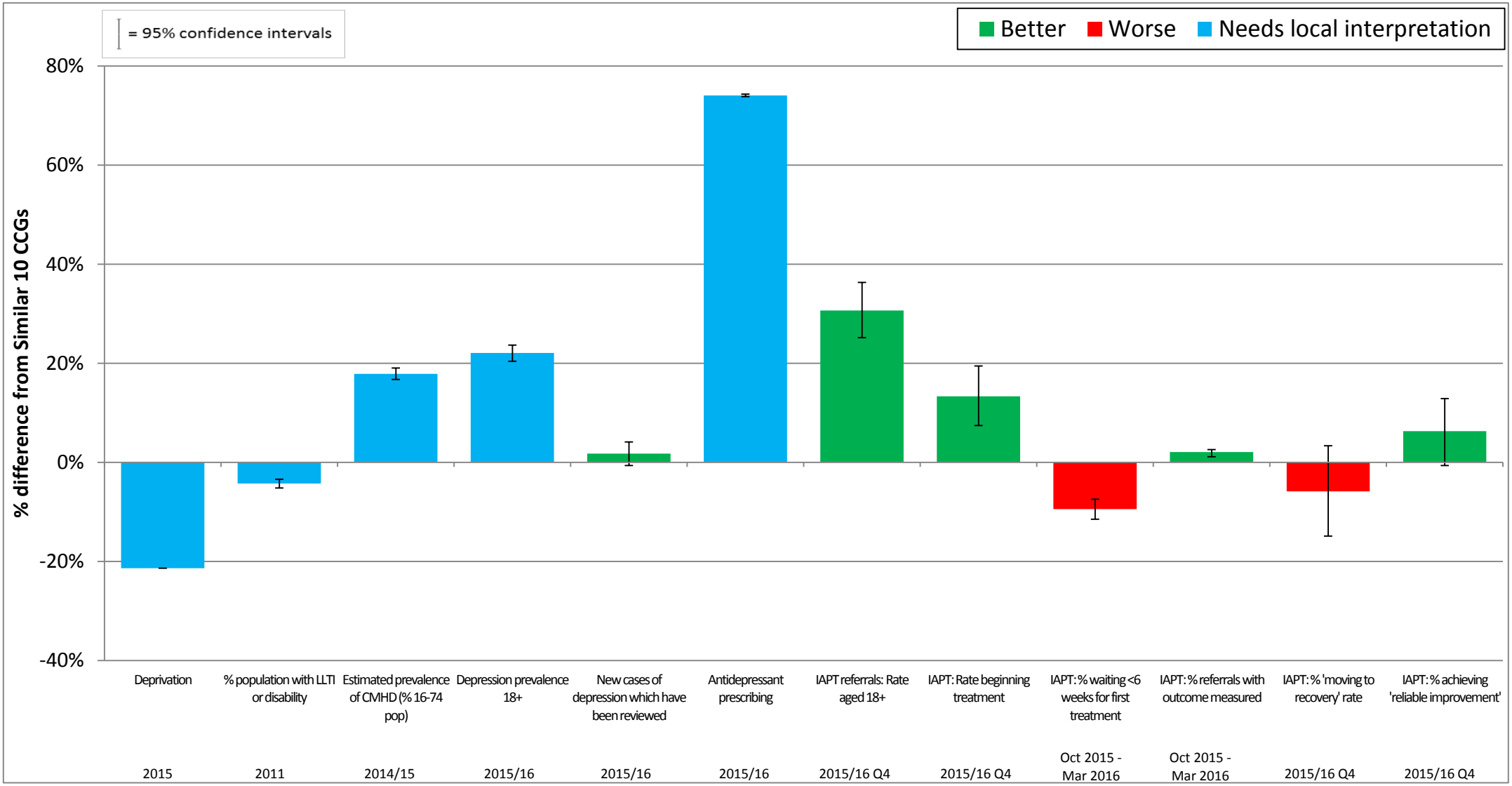
http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/

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

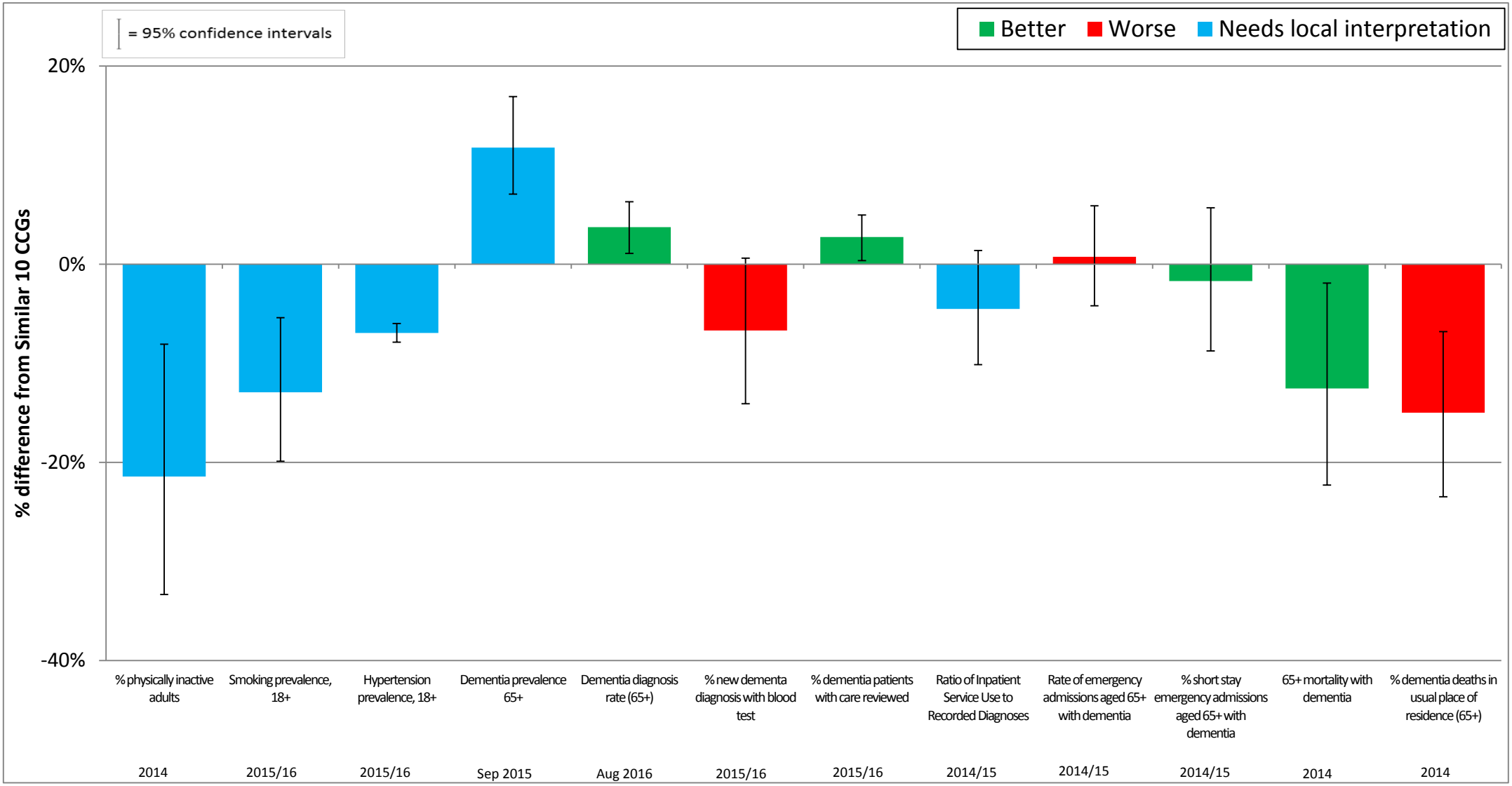
Common mental health disorder pathway



NICE guidance:

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

Dementia pathway

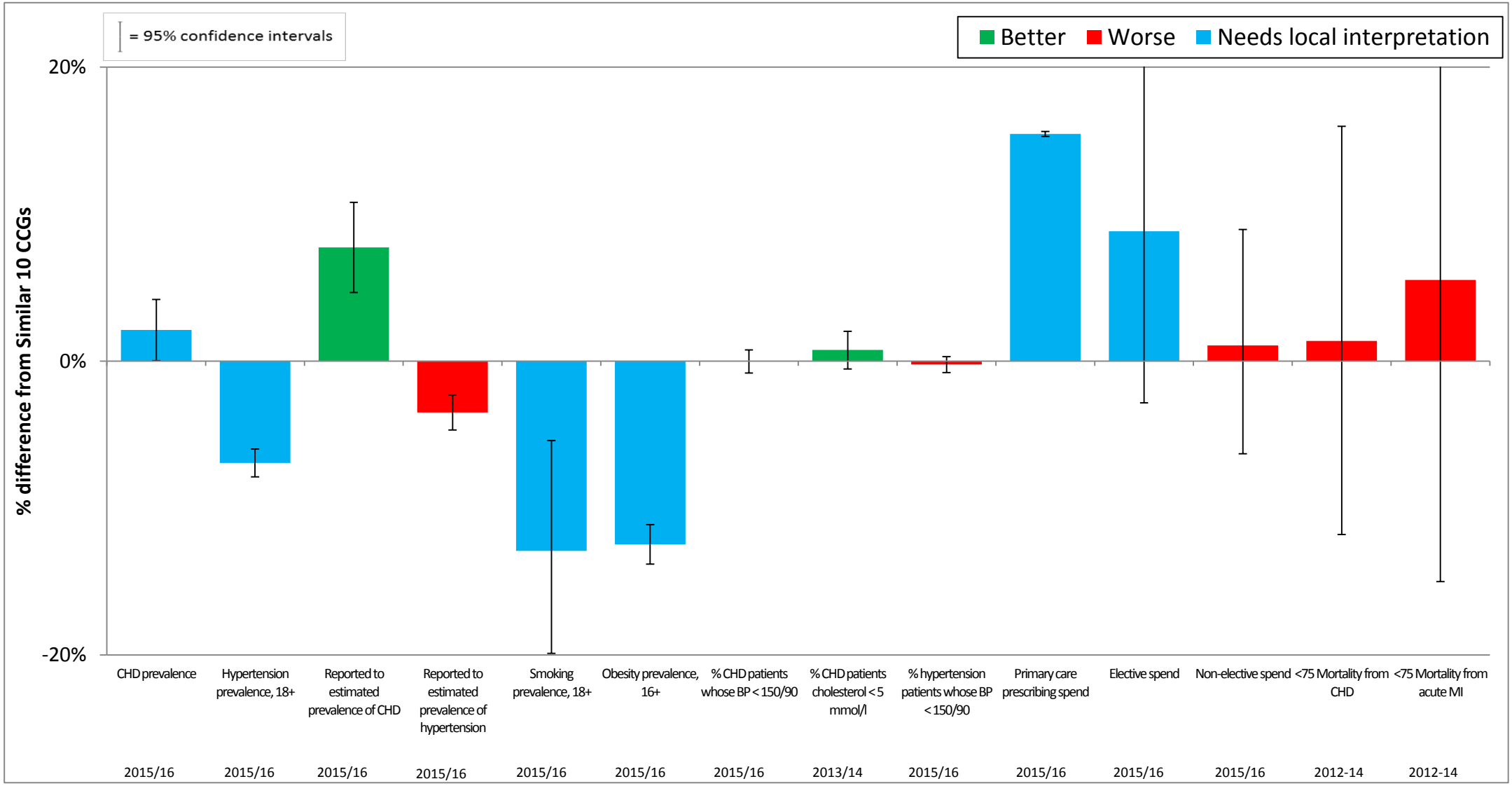


NICE guidance:

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

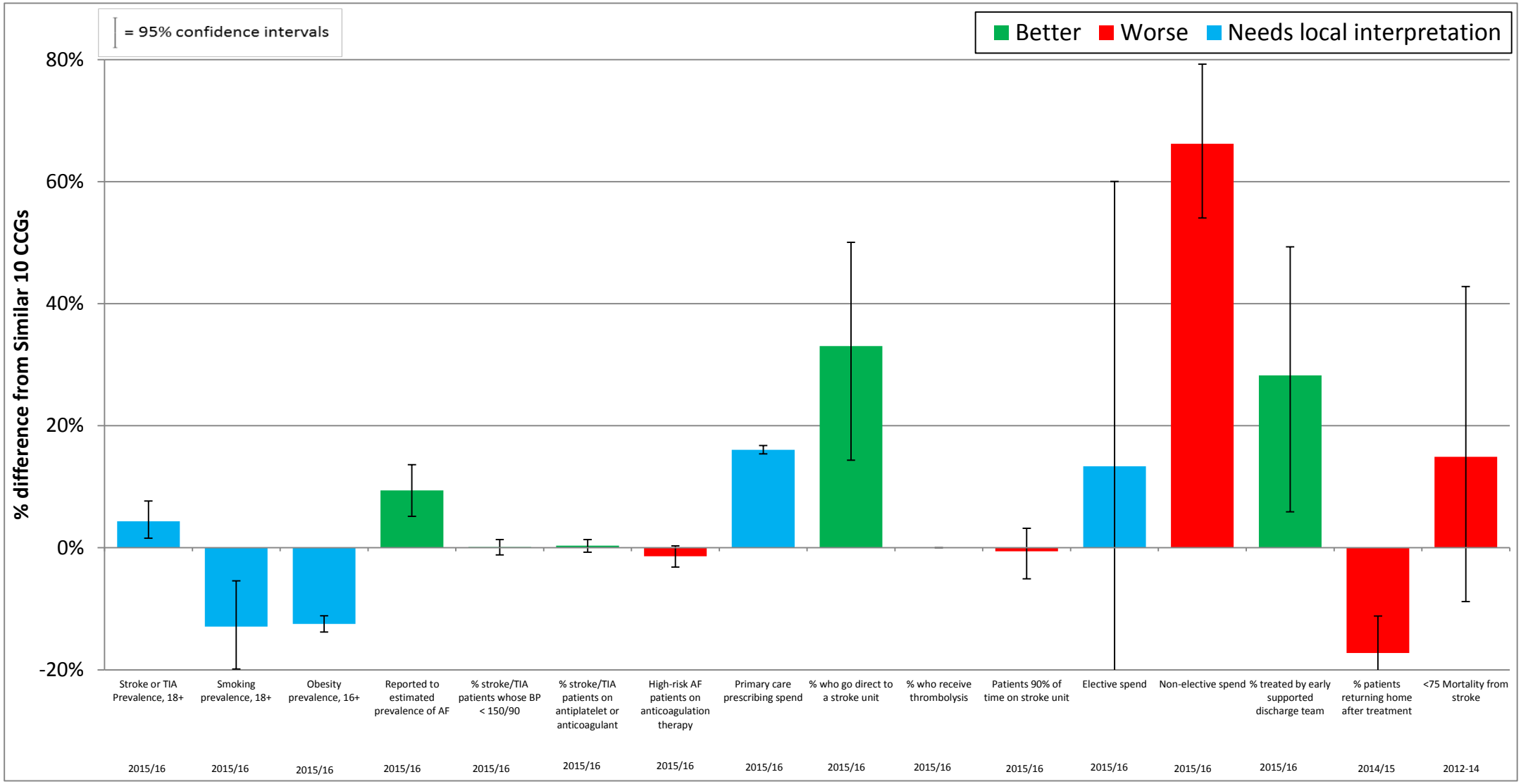


NICE Pathways on: Hypertension, Cardiovascular Disease and Smoking

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

PRIMIS Toolkit:
http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-hf.aspx

Stroke pathway



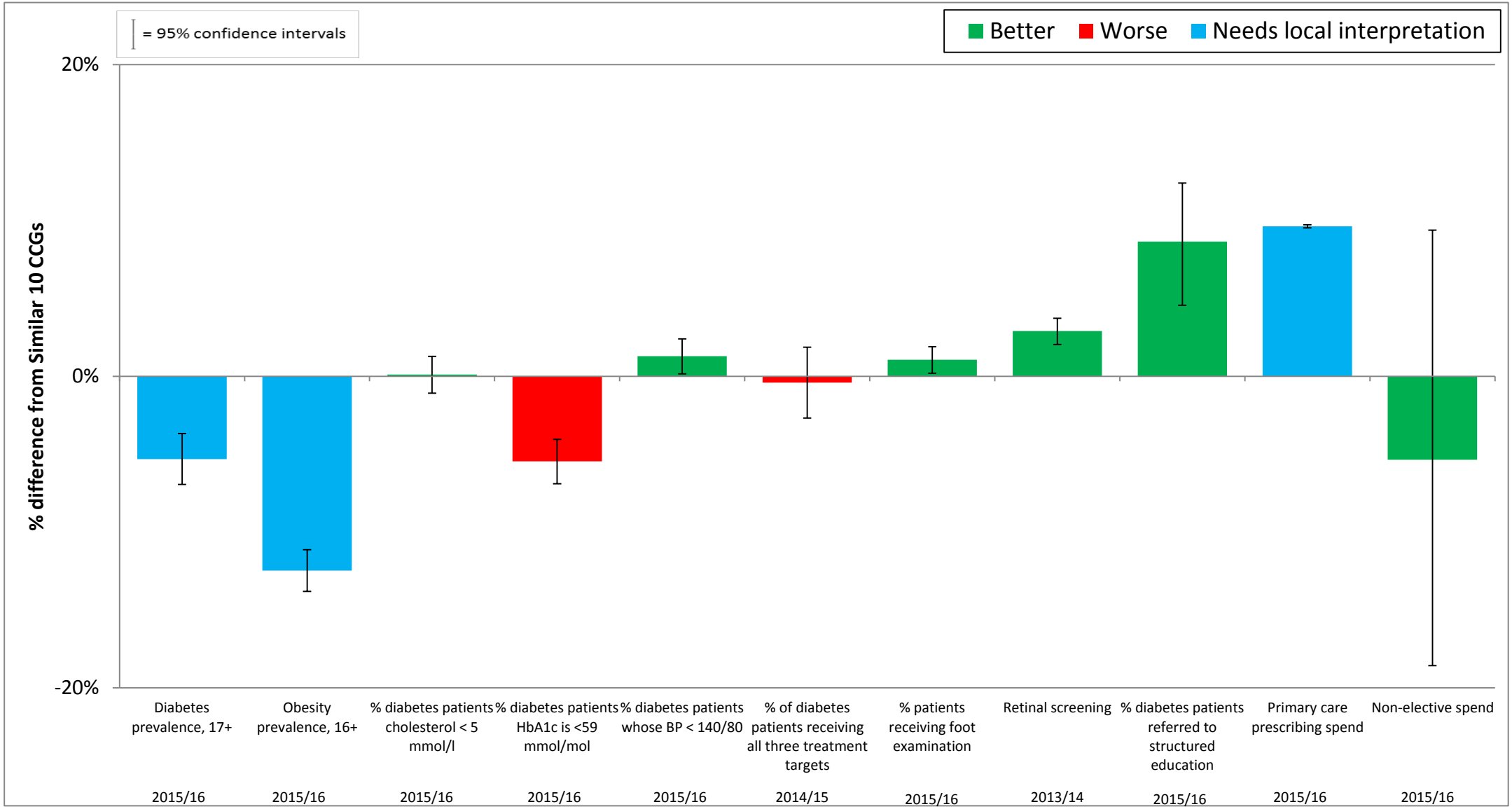
NICE guidance: http://pathways.nice.org.uk/pathways/stroke

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



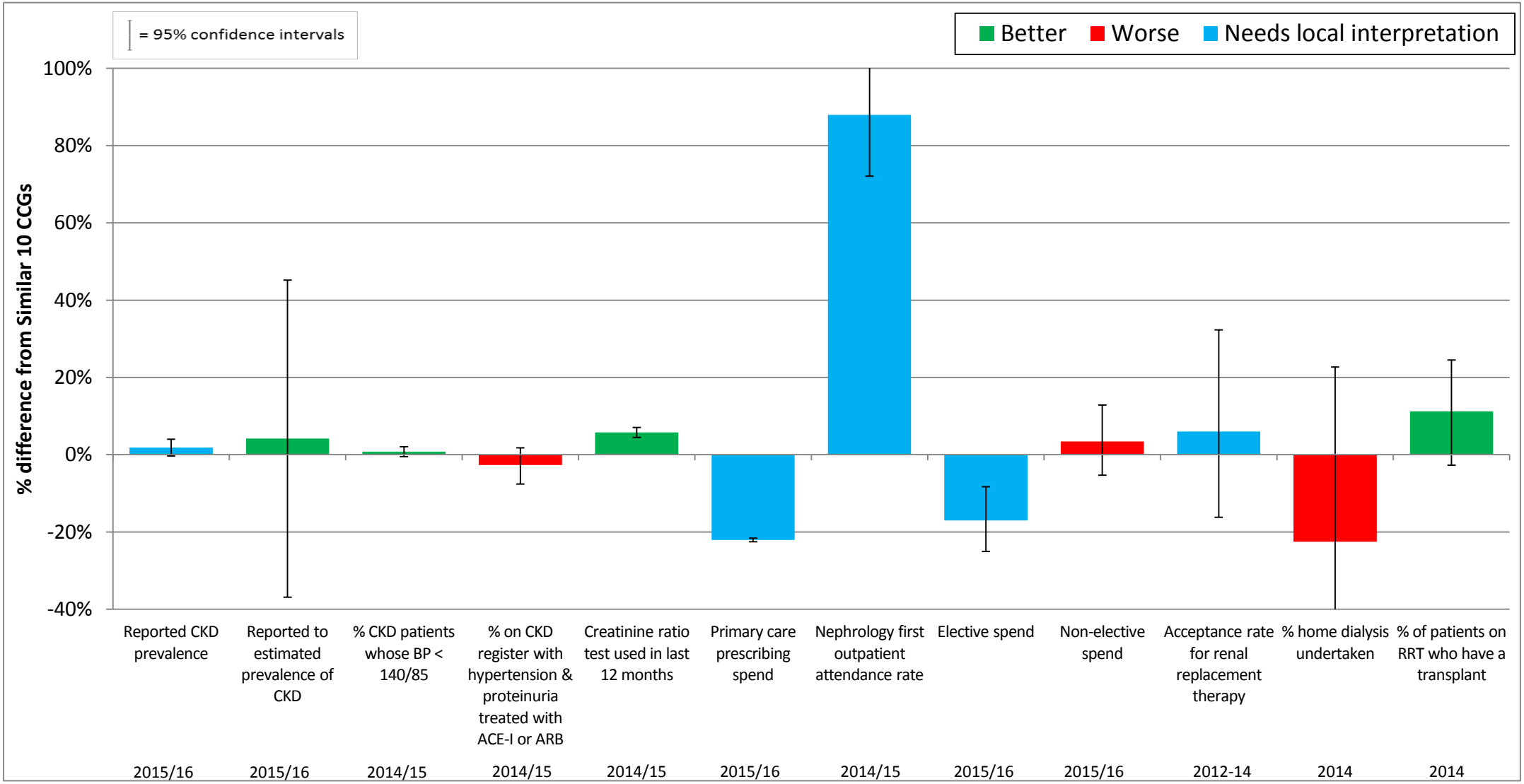
NICE guidance:

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

PRIMIS Toolkit:

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

Renal pathway

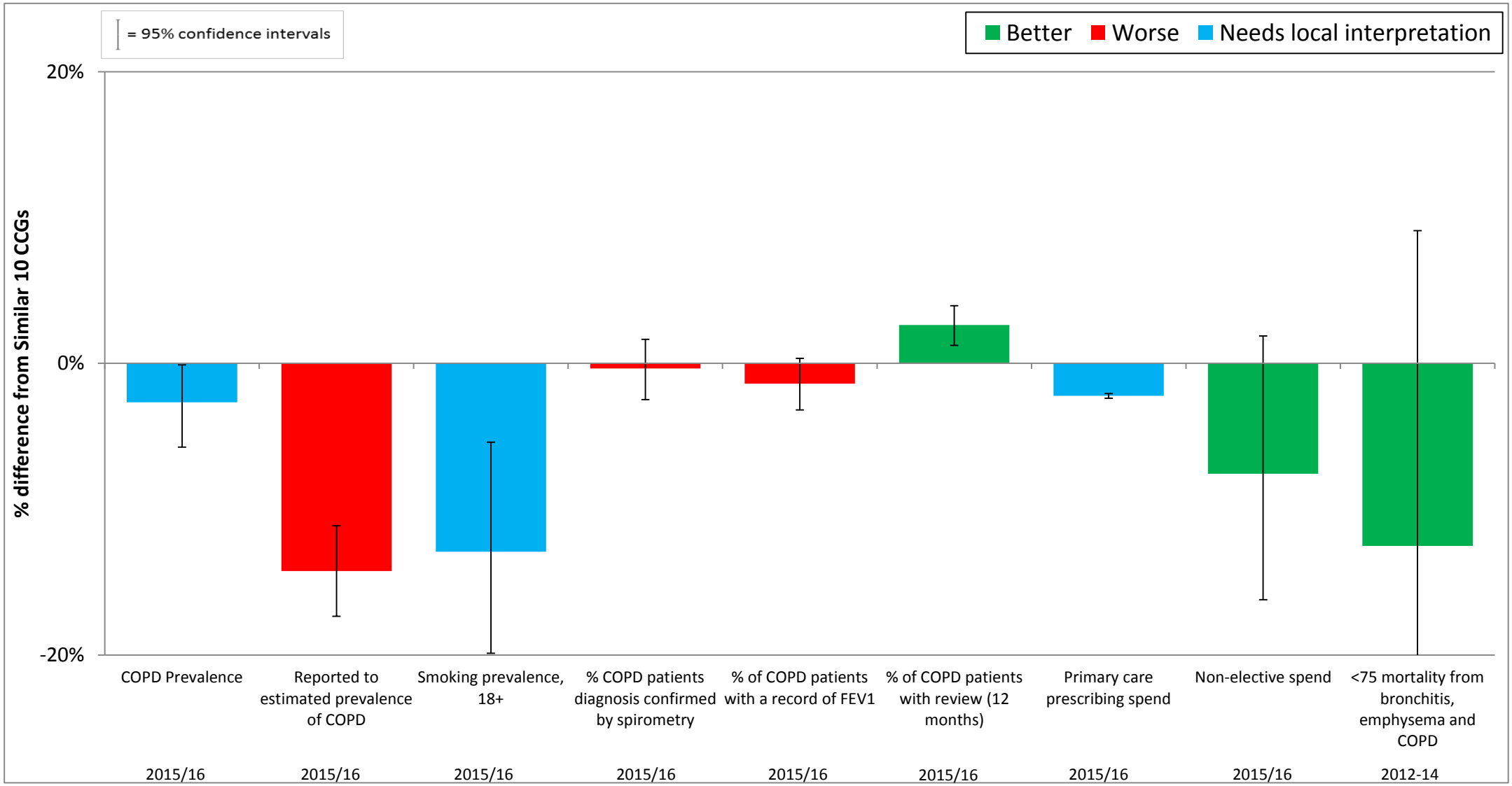


NICE guidance:

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

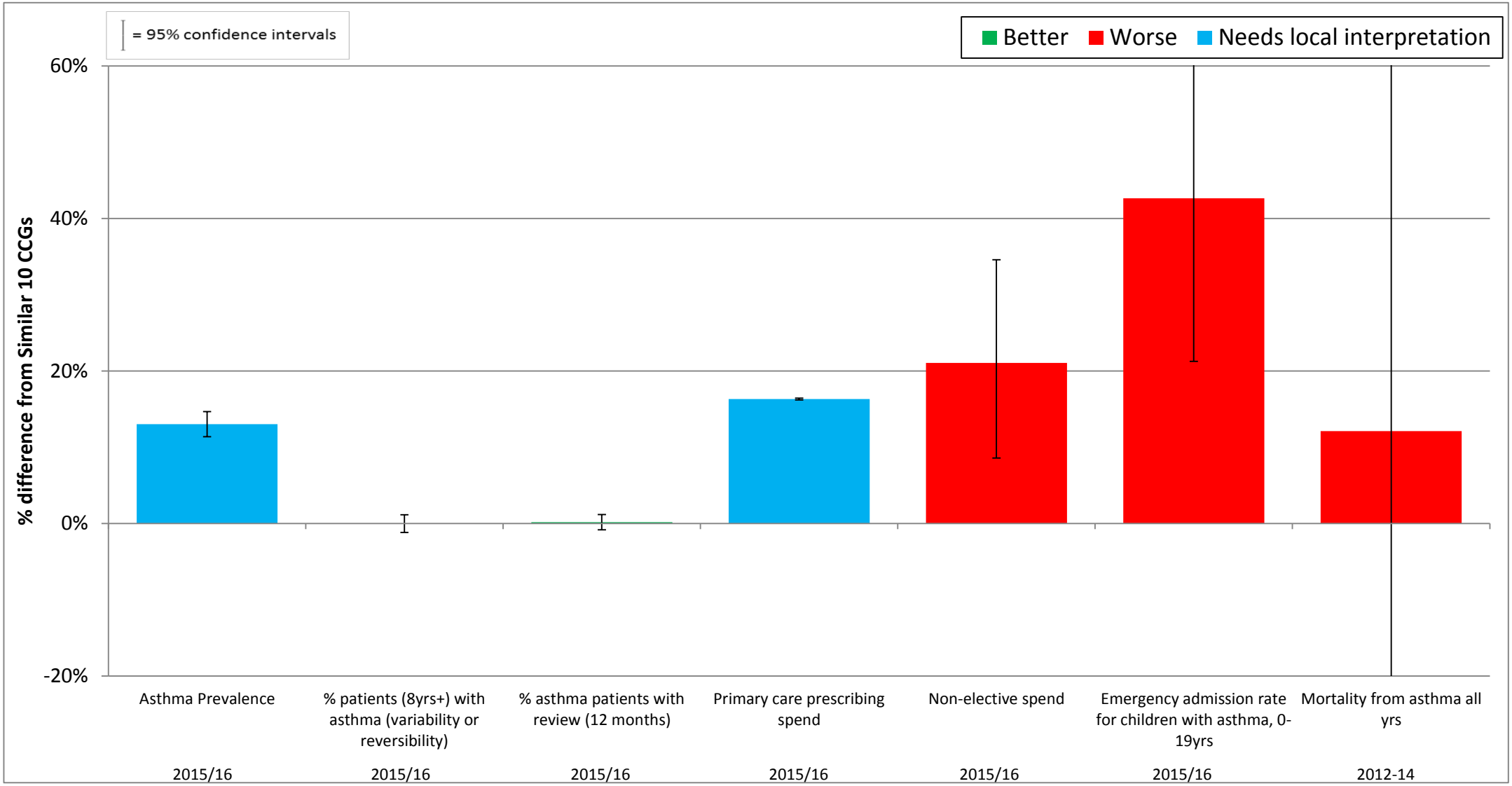
http://pathways.nice.org.uk/pathways/acute-kidney-injury

COPD pathway



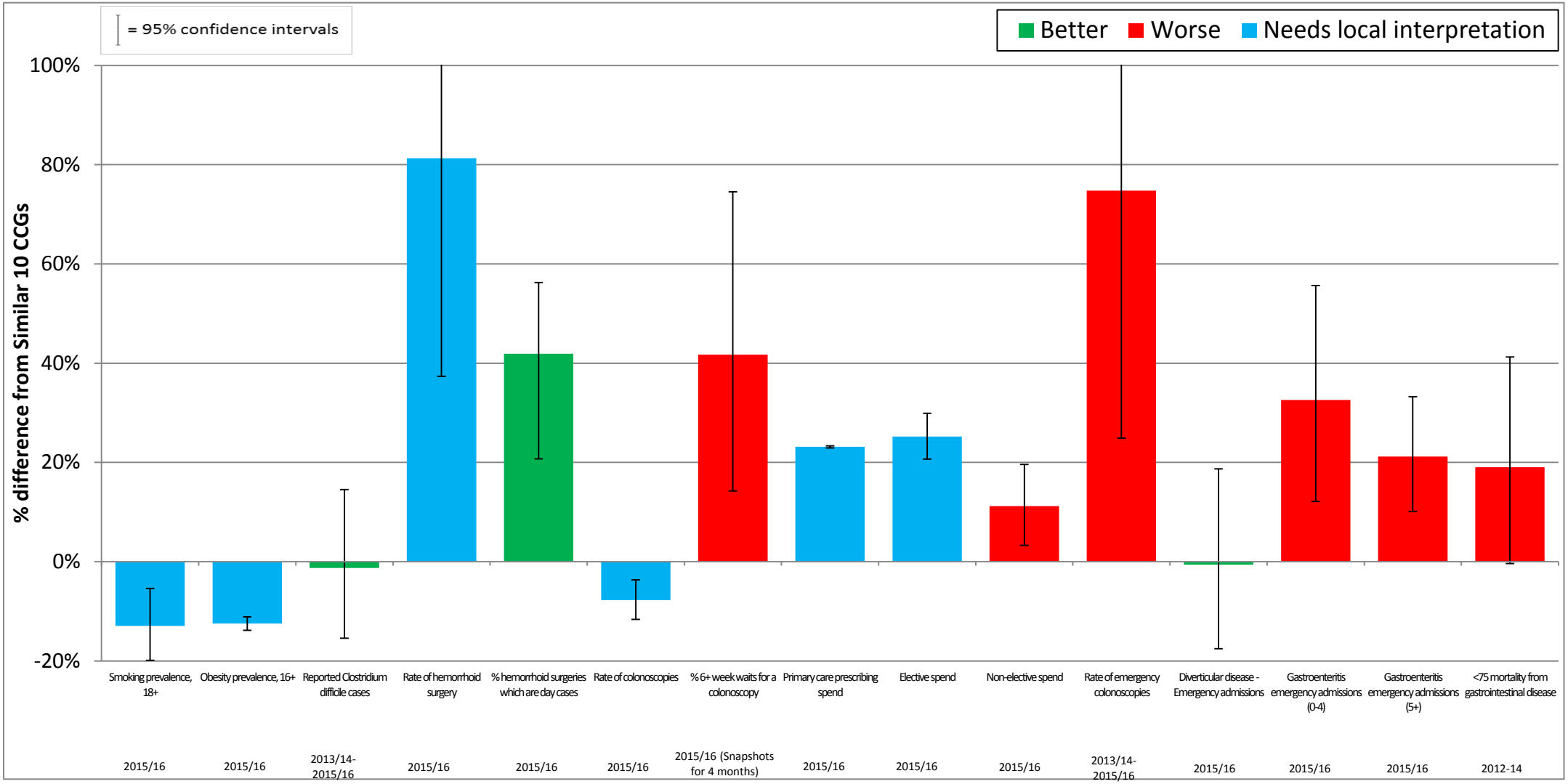
NICE guidance:
http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease
PRIMIS Toolkit:
http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-copd.aspx

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

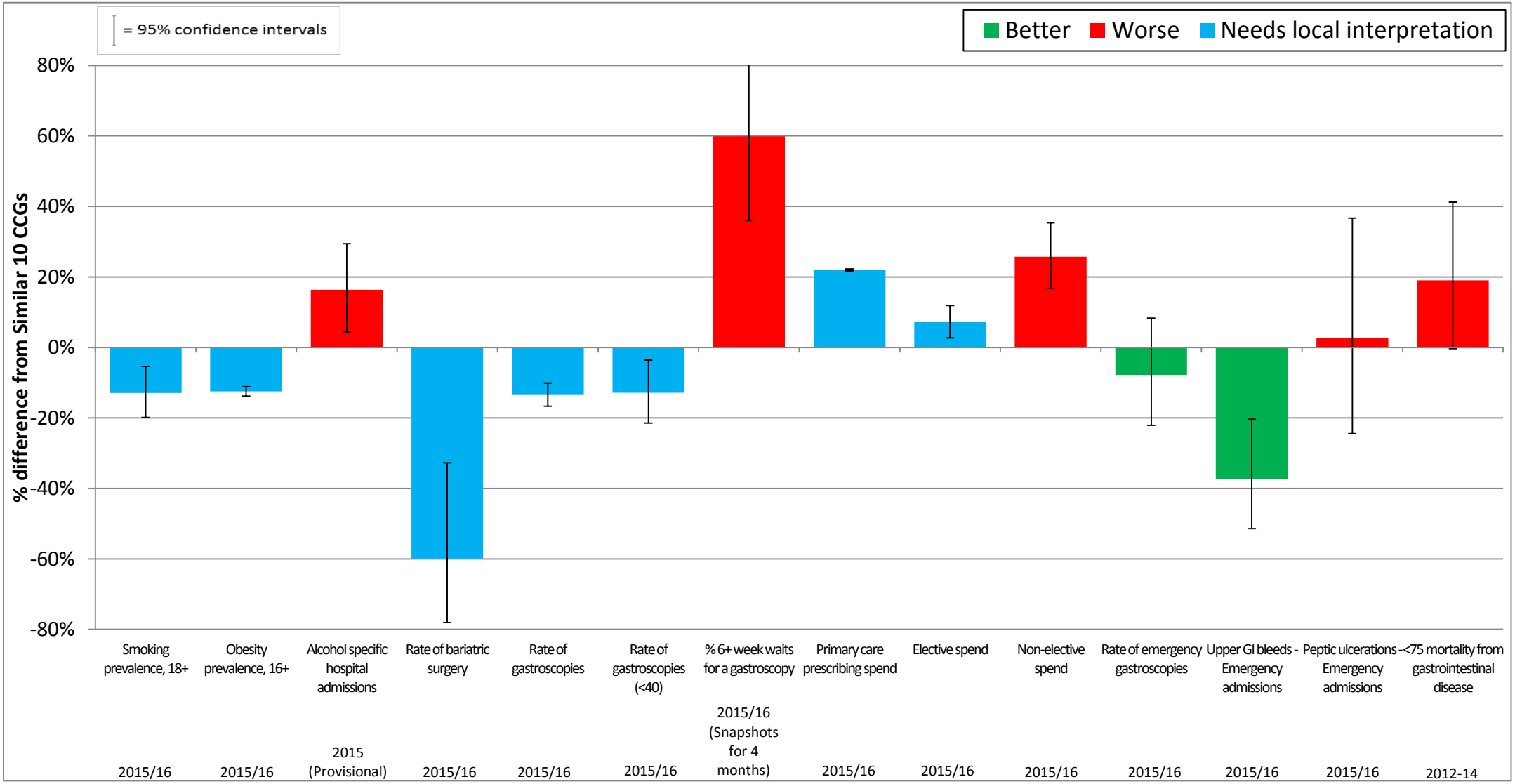


Note: It is anticipated that emergency admissions for Diverticular Disease of Intestine will increasingly be treated with drainage rate lines, with a gradual decrease in resection rates lines. CCGs are advised to examine their procedure rates and how they can move towards performing more resections.

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:

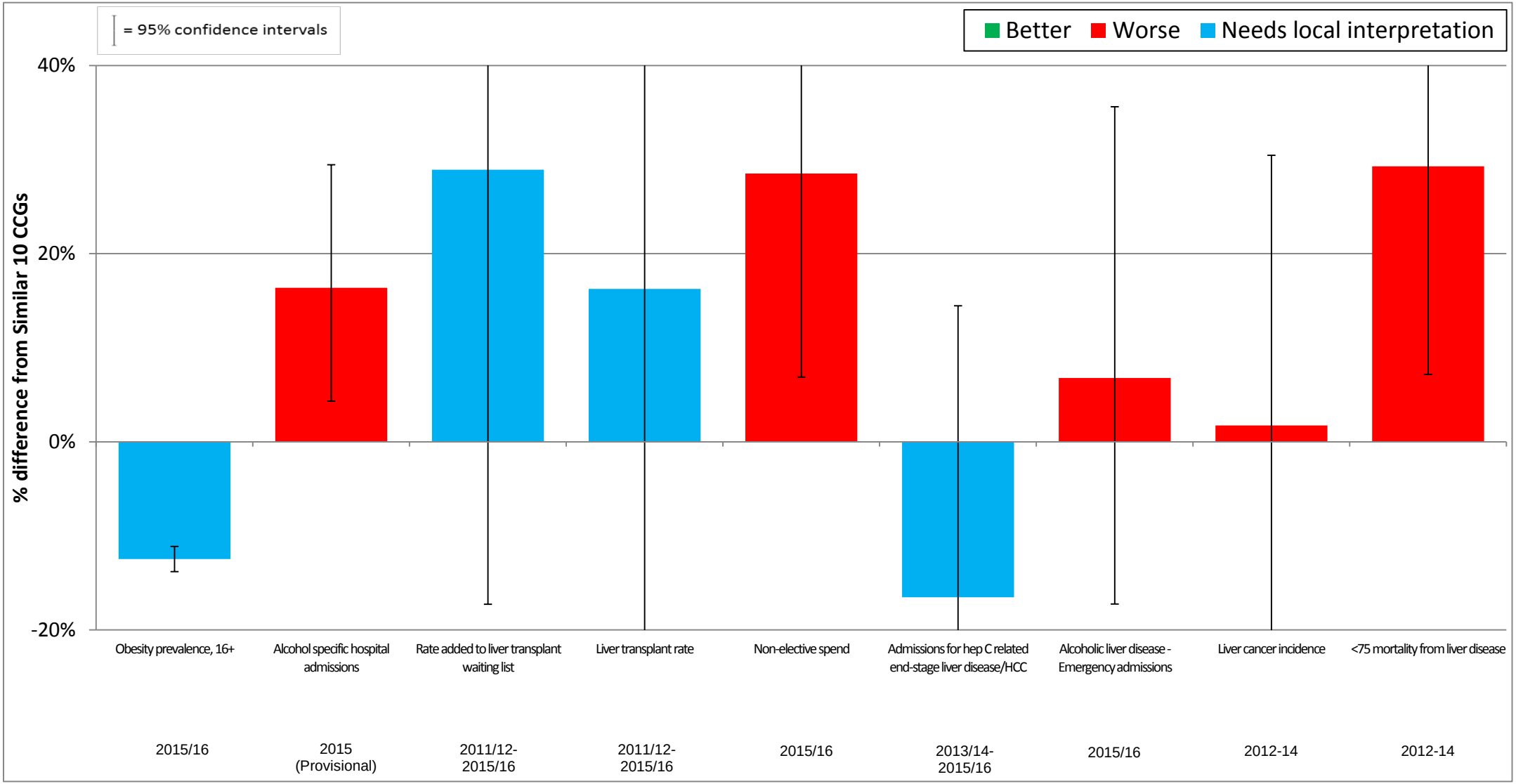
https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

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/

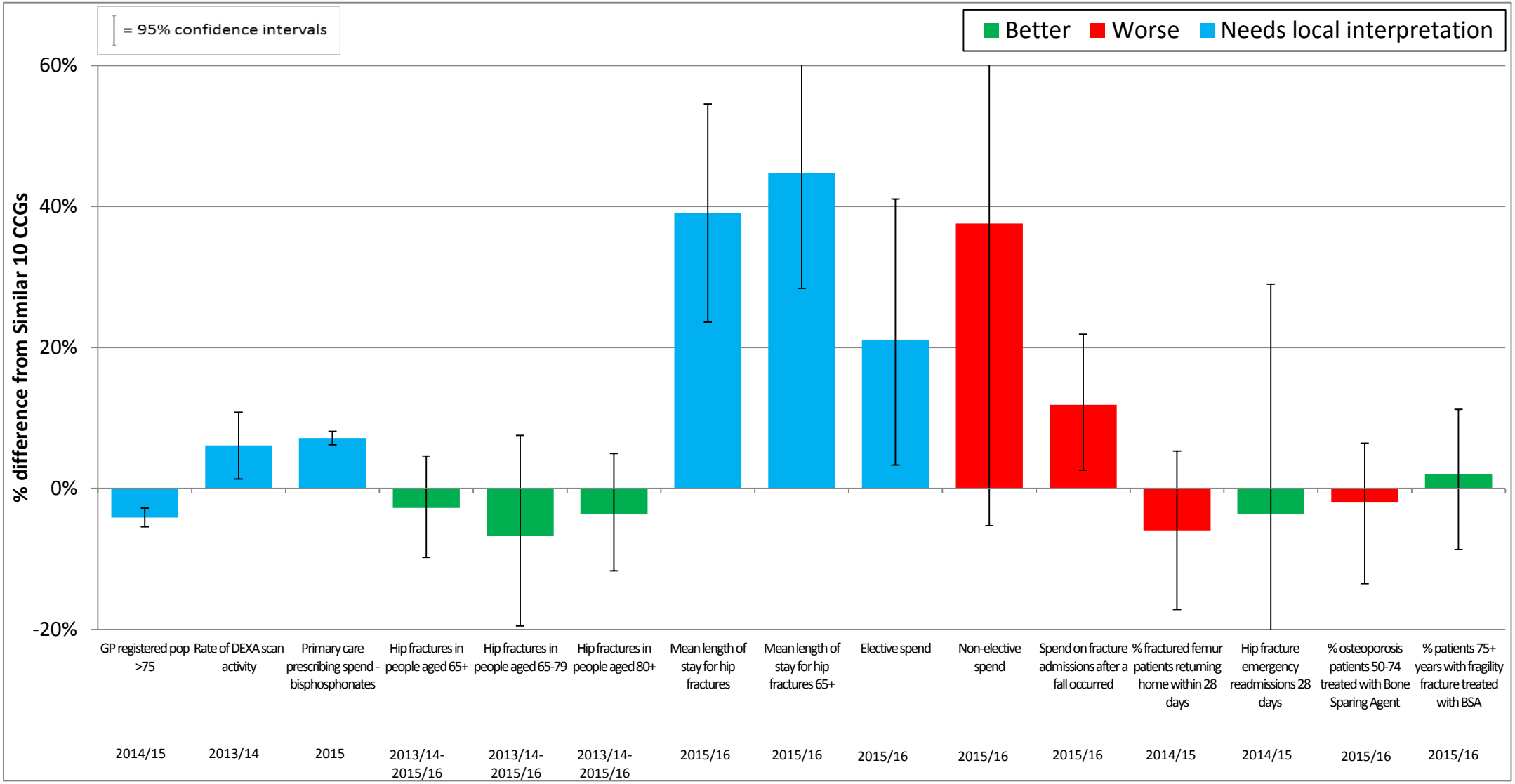
Liver disease pathway



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.

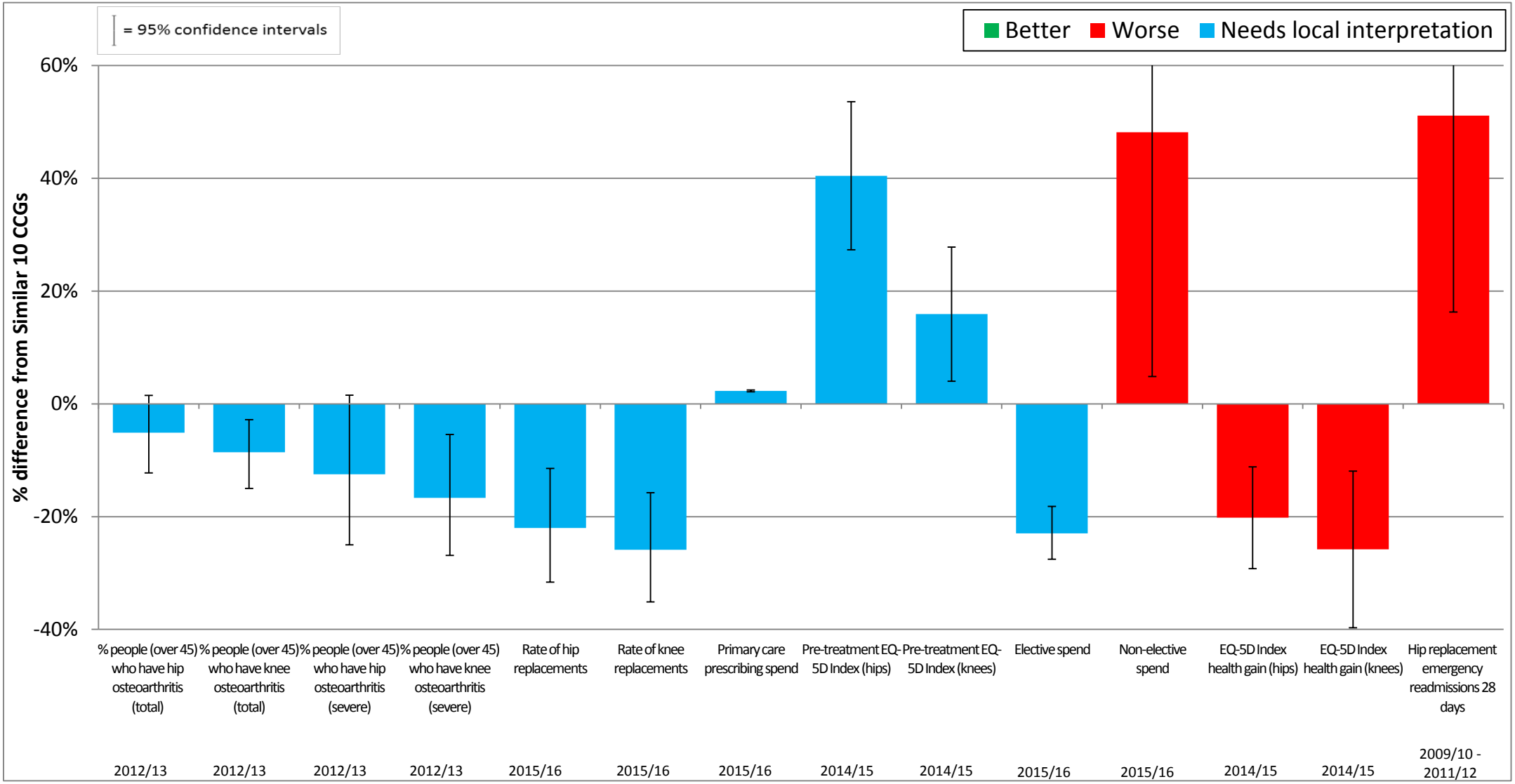
Many cases of liver cancer are linked to cirrhosis. Cirrhosis is commonly caused by heavy and harmful drinking, hepatitis C and the build-up of fat inside the tissue of the liver. Liver cancer incidence therefore is related to a number of other indicators listed in the pathway.

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



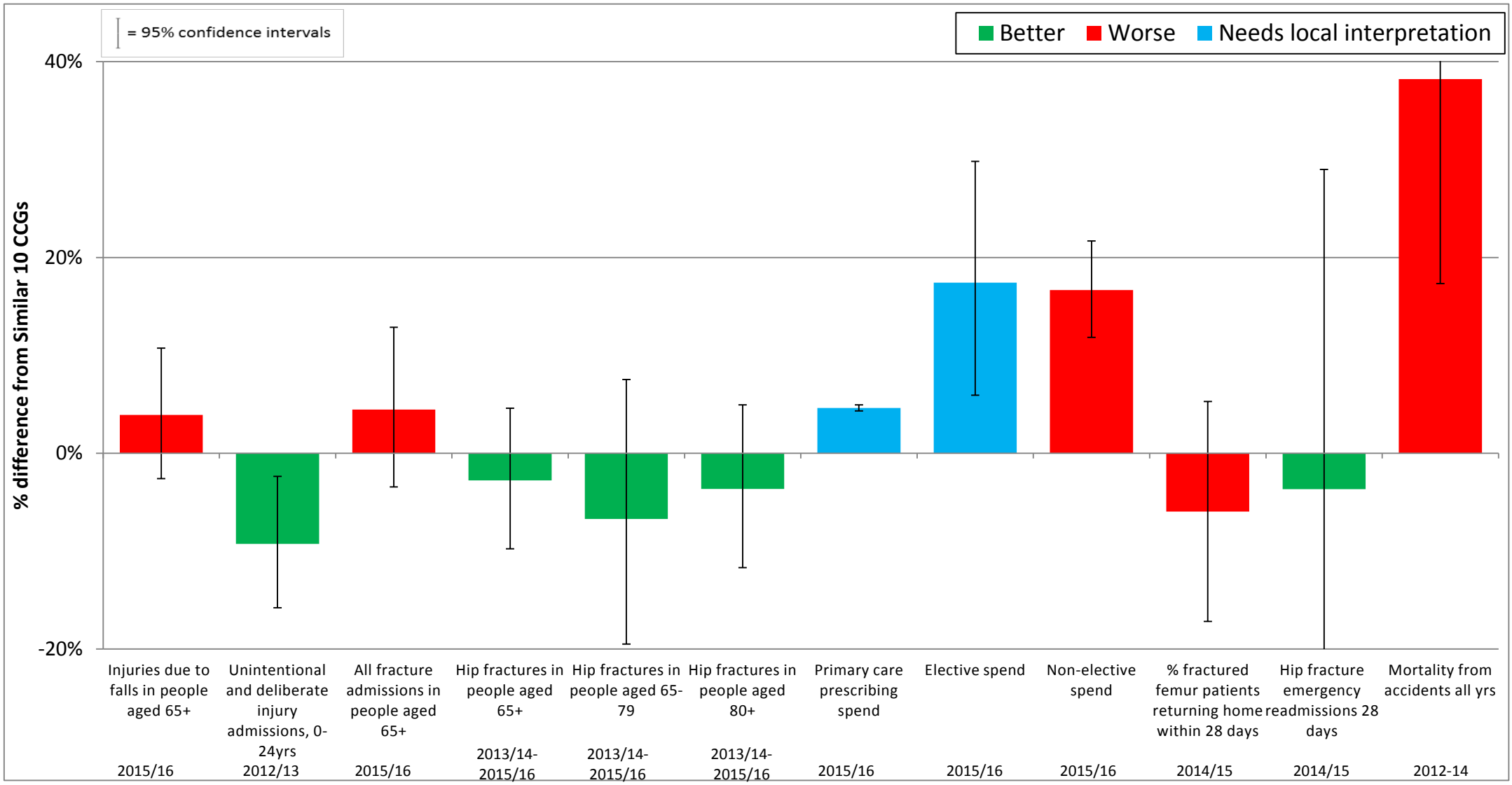
NICE guidance:

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

Arthritis Research UK Musculoskeletal calculator:

http://www.arthritisresearchuk.org/mskcalculator

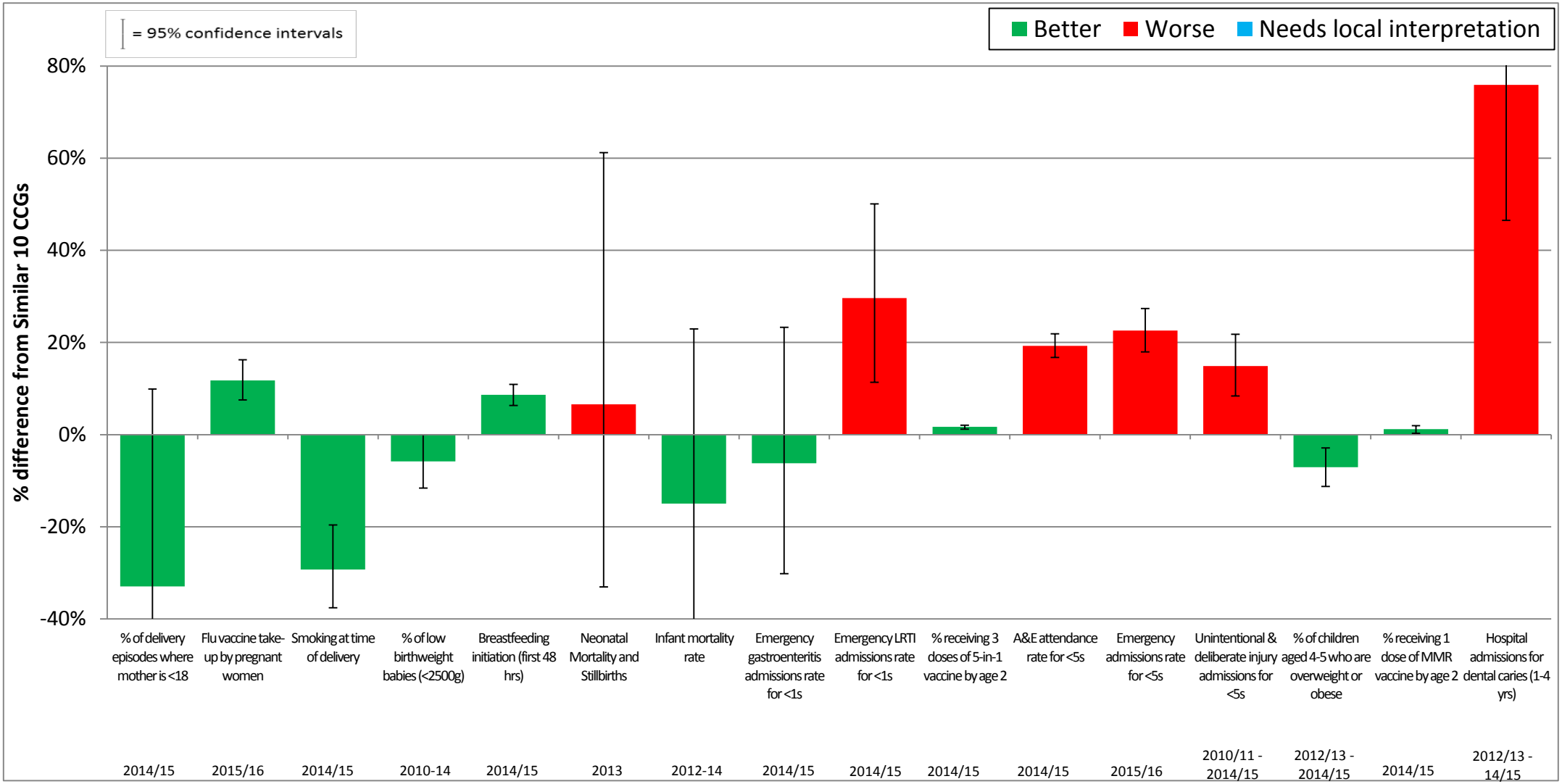
Trauma and injury pathway



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:

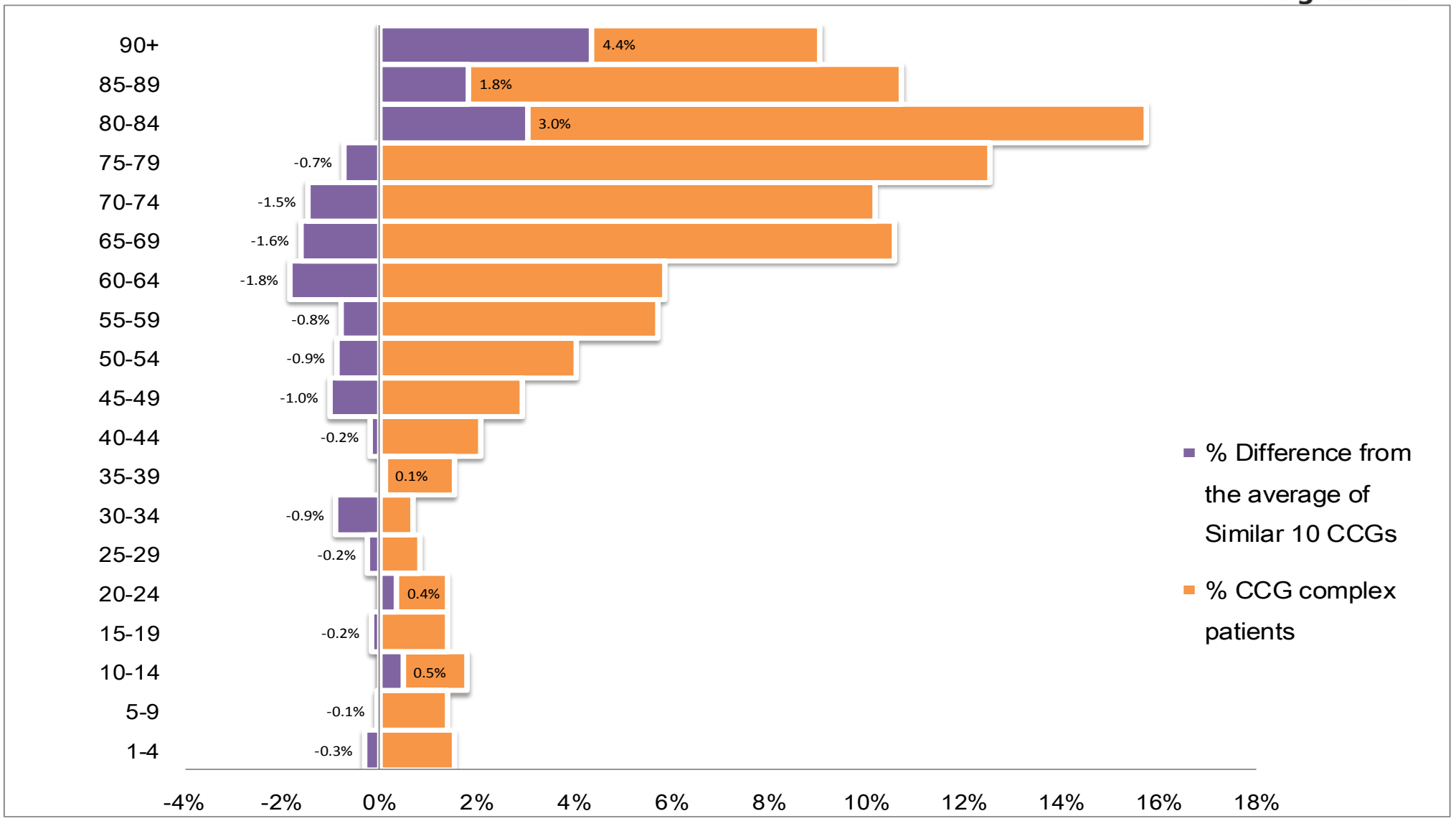
- These complex patients comprise **16%** of spend on inpatient admissions
- The average complex patient has seven admissions per year for three different conditions (based on programme budget categories)
- **61%** of these complex patients are aged 65 and over
- **38%** of these complex patients are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

Complex patients - Age Profile

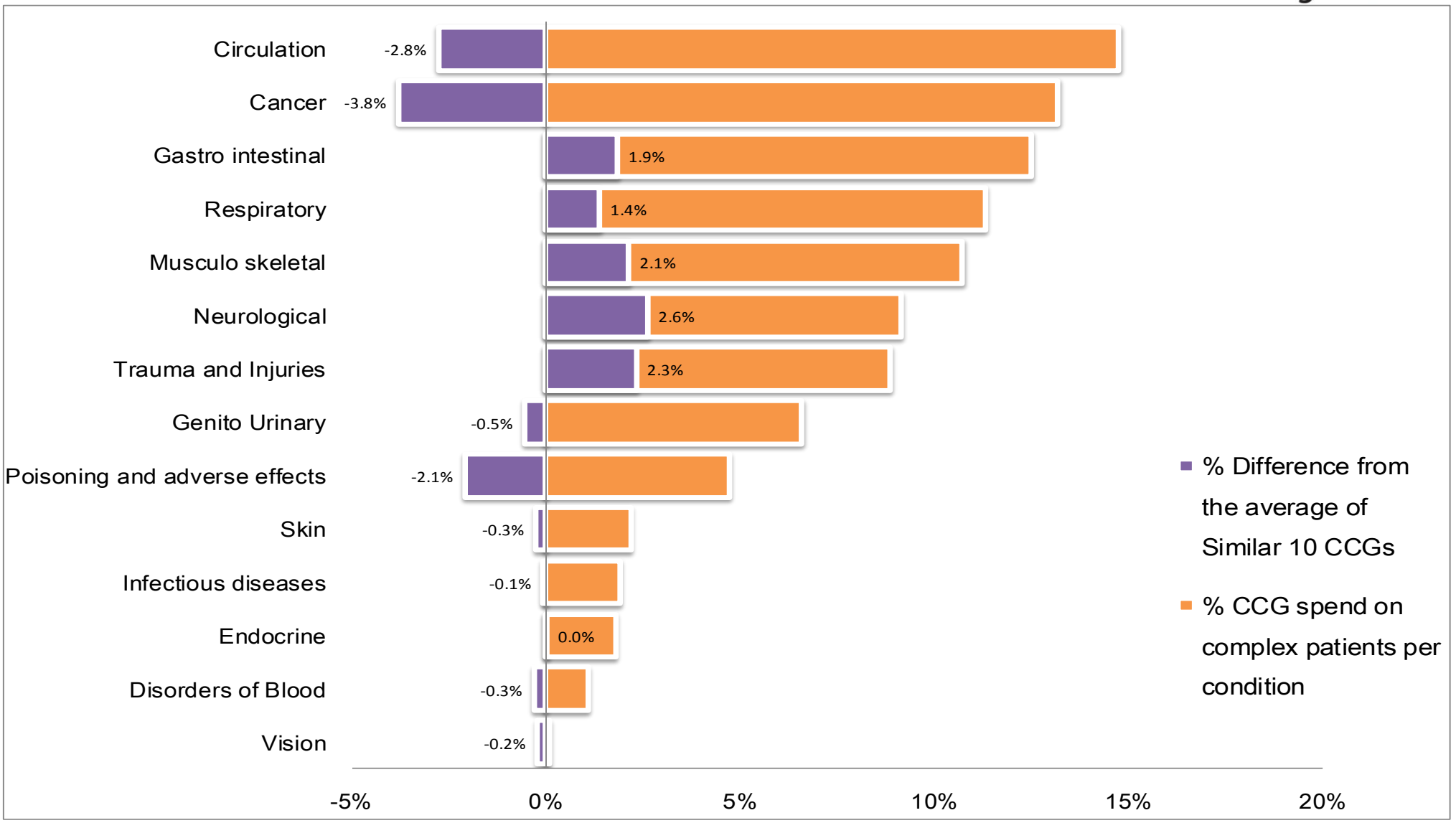
2% Most Complex Patients (16.8% of CCG Spend)					
Age	Number of complex patients	Mean Number of Admissions	Mean Number of Different Conditions		Total Spend (£000s)
1-4	11	13.8	2.64	£	281
5-9	10	9.7	2.20	£	237
10-14	13	9.0	2.08	£	504
15-19	10	6.3	2.00	£	249
20-24	10	6.6	2.00	£	217
25-29	6	4.2	2.67	£	111
30-34	*	16.4	2.20	£	116
35-39	11	7.6	2.82	£	214
40-44	15	10.9	2.20	£	276
45-49	21	4.9	2.86	£	425
50-54	29	10.3	3.28	£	572
55-59	41	7.2	3.07	£	844
60-64	42	4.7	2.60	£	922
65-69	76	8.1	3.16	£	1,664
70-74	73	8.8	3.33	£	1,624
75-79	90	4.7	2.70	£	1,701
80-84	113	4.2	2.74	£	2,195
85-89	77	3.8	2.87	£	1,501
90+	65	3.0	2.38	£	1,210
TOTAL	**723**	**6.1**	**2.78**	**£**	**14,864**

* Represents low number and the total number of complex patients have been adjusted due to suppressed numbers

Complex patients - Age Profile



Complex patients - Spend Profile



Complex patients - Co-morbidities

Of the 213 patients admitted for Gastro intestinal, 63 patients were admitted for a Cancer condition and 60 patients were admitted for a Respiratory 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
Gastro intestinal	Cancer	Respiratory	Circulation	Genito Urinary	Neurological
213 patients	63	60	48	47	51
Circulation	Respiratory	Gastro intestinal	Neurological	Genito Urinary	Cancer
225 patients	63	48	50	45	33
Respiratory	Gastro intestinal	Circulation	Cancer	Neurological	Genito Urinary
203 patients	60	63	50	44	44
Cancer	Gastro intestinal	Respiratory	Genito Urinary	Circulation	Poisoning and adverse effects
169 patients	63	50	37	33	31
Neurological	Gastro intestinal	Circulation	Genito Urinary	Respiratory	Cancer
183 patients	51	50	47	44	28

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.