



Public Health  
England

**NHS**  
RightCare

# Commissioning for Value Long term conditions pack

NHS Vale of York CCG  
December 2016



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# Foreword

*“The Commissioning for Value packs and the 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**

# Your Long Term Conditions pack

This pack contains data on a number of Long Term Condition (LTC) disease areas and elements of care. The pack is split by stages along a LTC pathway and enables your local health economy to look at that element (such as detection or prescribing) across multiple disease areas. A summary matrix which shows your CCG's position across all these is shown on page 9. Where possible we have also included relevant case studies, tools and guidance.

This pack contains a number of new indicators not included in the previous packs. These are shown as charts throughout the pack.

The information contained in this pack is personalised for your CCG and should be used to help support discussions about long term conditions care in your local health economy, to improve the value and utilisation of resources.

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. When commissioning services CCGs should take into account the duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities, duties under the Health and Social Care Act 2012. Service design and communications should be appropriate and accessible to meet the needs of diverse communities.

Previous Commissioning for Value packs and supporting information can be found on the NHS RightCare website at [www.england.nhs.uk/rightcare](http://www.england.nhs.uk/rightcare)

# 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.

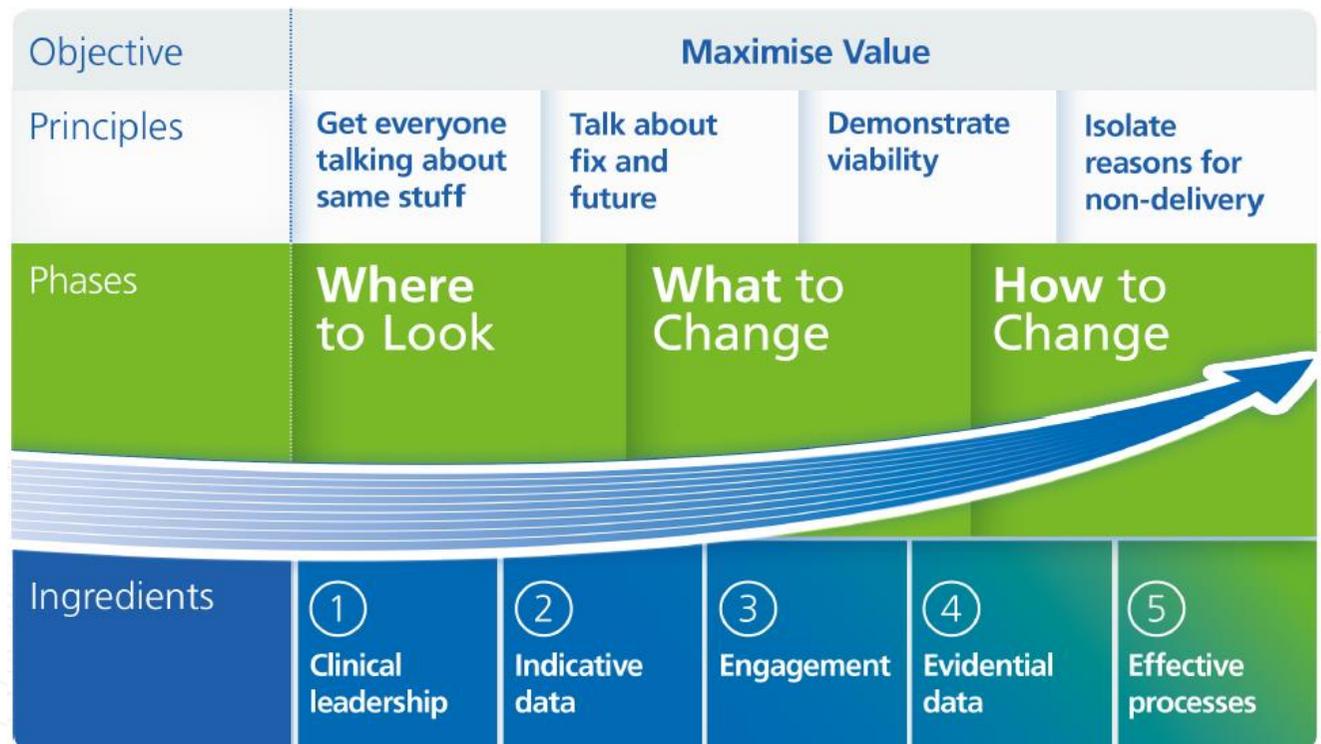
NHS England has committed significant funding to rolling out the RightCare approach. By December 2016 all CCGs will be working with a RightCare Delivery Partner.

# 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*.



# 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:

- West Leicestershire
- Lincolnshire West
- East Riding of Yorkshire
- Bath and North East Somerset
- South Worcestershire
- Guildford and Waverley
- West Cheshire
- North East Essex
- South Warwickshire
- Canterbury and Coastal

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.

## Multi-pathways on a page

Pathways on a page for 19 different clinical programme areas were included in the Where to Look packs produced for each CCG in October 2016. Many refer to Long Term Conditions, but rather than replicate them here, CCGs and local health economies are able to view them by downloading their packs at <https://www.england.nhs.uk/rightcare/intel/cfv/data-packs/>

The matrix on the following page shows an 'at a glance' position for each CCG for all the LTC areas covered in this pack against each of those clinical programmes. The CCG is compared to the average of the five best/lowest CCGs in their similar 10.

The matrix is colour coded to help you see if your CCG has 'better' (**green**) or 'worse' (**red**) values than your peers across the range of indicators within each disease programme and LTC area. If your CCG has 'better' or 'worse' performance but it is not statistically significant, it will be coloured **amber**. It will also be coloured **amber** if performance is balanced (for example, one green and one red indicator). These 'better' or 'worse' judgements are 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. These sections will have a ▲ or ▼ arrow indicating whether the value is higher or lower than the peer group.

The indicators which have been mapped into the matrix and methodology are shown in the Annex.

# Multi-Pathways on a page

	Prevention & Public Health	Estimated Prevalence	Detection	Primary Care Management	Self Care	Prescribing	Elective	Non-Elective	Step-up/ Step-down	Rehab	Outcome	End of Life
Breast Cancer	Red	Yellow	Green	Red	White	Blue ▲	Blue ▲	Yellow	Red	Yellow	Yellow	Red
Lower GI Cancer	Red	Red	Yellow	Red	White	White	Blue ▲	Yellow	Red	Yellow	Red	Red
Lung Cancer	Red	Red	Yellow	Red	White	White	Blue ▲	Red	Red	Yellow	Red	Red
Neurological	White	White	White	Red	Red	Blue ▲	Blue ▲	Red	Red	Red	Red	Red
Serious Mental Illness	Red	Red	White	Red	Green	Blue ▼	White	Red	Red	White	Red	White
Common mental health disorders	Red	Red	Red	Red	Red	Blue ▼	White	White	White	White	Red	White
Dementia	Red	Yellow	Red	Red	Red	Blue ▲	White	Yellow	Red	Red	Red	Red
CHD	Red	Green	Yellow	Red	Red	Blue ▲	Blue ▲	Red	Red	Red	Red	Red
Stroke	Red	Yellow	Yellow	Red	Red	Blue ▲	Blue ▼	Red	Red	Yellow	Yellow	Red
Diabetes	Red	Green	Red	Red	Red	Blue ▼	White	Yellow	Red	Red	Red	White
Renal	Red	Yellow	Yellow	Red	Red	Blue ▲	Blue ▲	Green	Red	Red	Yellow	Red
COPD	Red	Red	Red	Red	Red	Blue ▲	White	Red	Red	Red	Red	Red
Asthma	Red	White	White	Red	Red	Blue ▲	White	Yellow	Red	Red	Yellow	White
Musculoskeletal	Red	Yellow	Blue ▲	Red	Red	Blue ▲	Blue ▲	Red	Red	Yellow	Red	White
Frailty	Red	White	Blue ▼	Red	Red	White	White	Red	Red	Red	Yellow	Red
Multiple Conditions	Red	White	White	Red	Red	White	White	White	Red	Yellow	Red	Red

# Mental health indicators

We recognise that mental health is not necessarily a long term condition, and that many people are able to go on to experience a meaningful recovery from an episode of poor mental health. However, we have chosen to highlight variation in relation to services for people with mental health conditions as part of this pack.

Including mental health conditions, both common mental health disorders such as depression and anxiety, as well as severe mental illness (SMI) such as psychosis and schizophrenia, within this pack is intended to support commissioners to:

- **Apply the same NHS RightCare methodology to reducing unwarranted variation in mental health services**
- **Consider primary care management and supporting self care for people with mental health problems\***. Recognising that life expectancy of people with SMI, such as schizophrenia and bi polar is reduced by an average of 15–20 years mainly due to preventable physical illness, improving physical health care services and encouraging self-care for this cohort is a key priority for commissioners and a key priority of the Five Year Forward View for Mental Health
- **Consider the importance of addressing mental health need within other long term condition pathways\*\*** including early access to psychological services and integrated psychological services

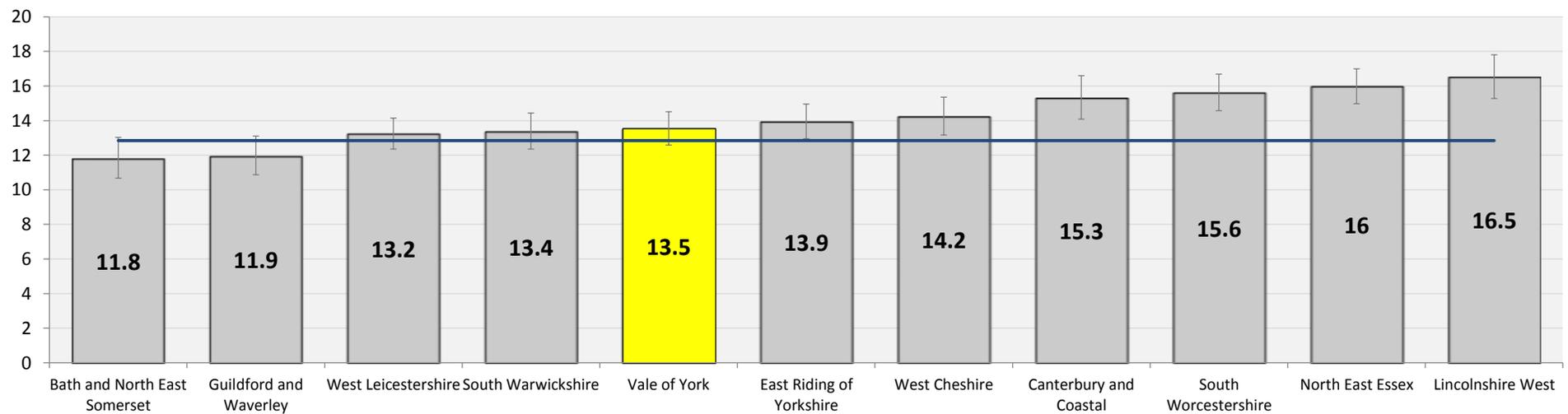
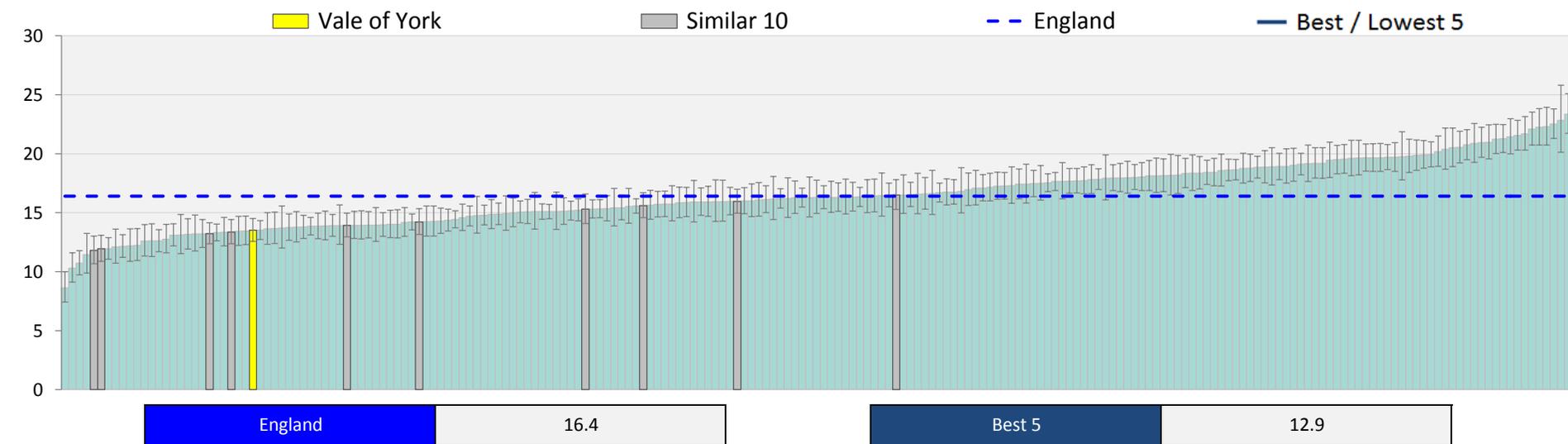
\*Further guidance on how CCGs can address premature mortality for people with SMI will be issued early in 2017

\*\*Commissioners should also consider the interface between LTC and mental health for children and young people, as similar variation in relation to services exists.

# Prevention

# The percentage of people aged 18+ who are self-reported occasional or regular smokers

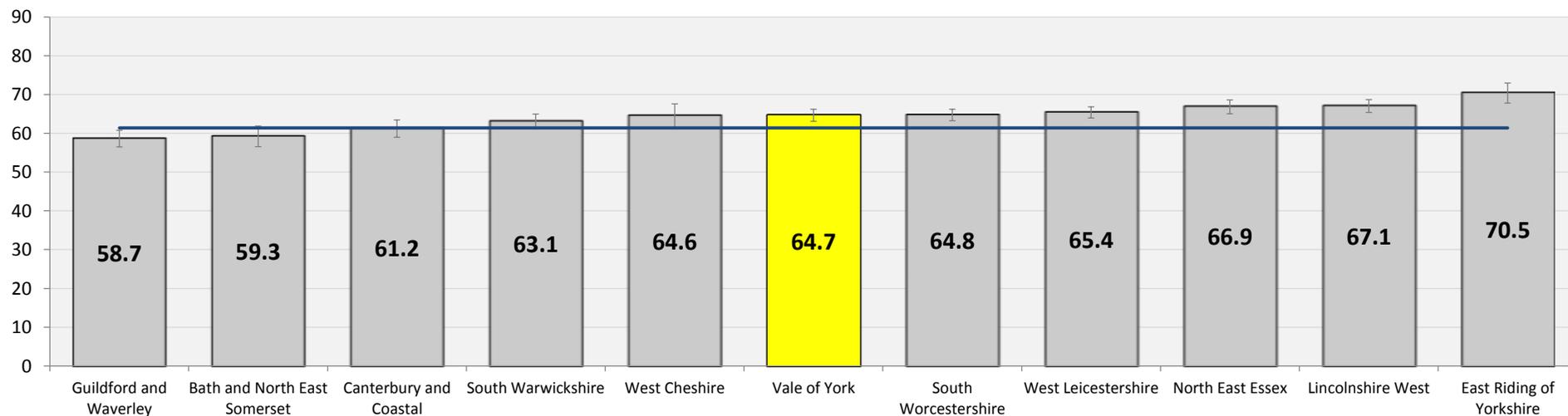
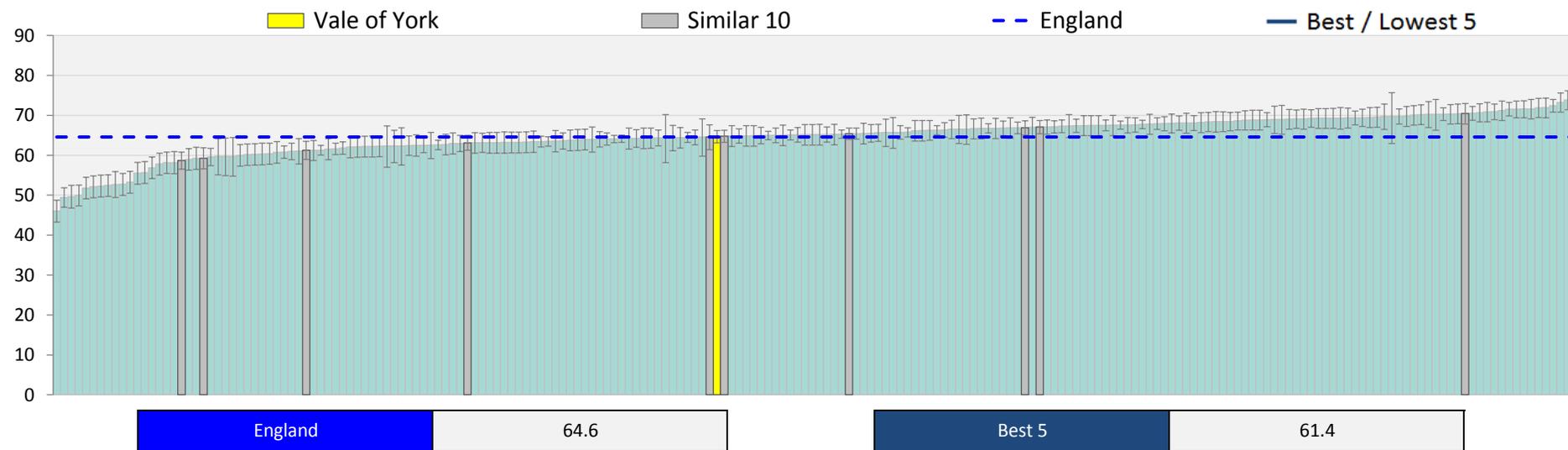
1890 Ppl. (NSS)



Definition: The percentage of people aged 18+ who are self-reported occasional or regular smokers  
 Source: General Practice Patient Survey (GPPS)  
 Year: July 2016

# Percentage of adults classified as overweight or obese (estimated prevalence)

9621 Ppl.



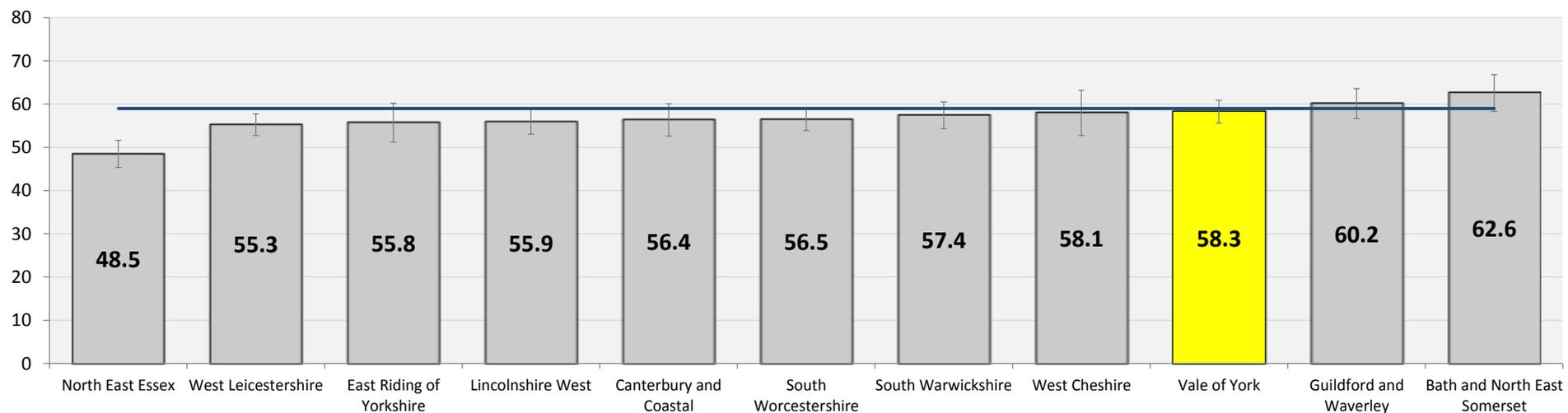
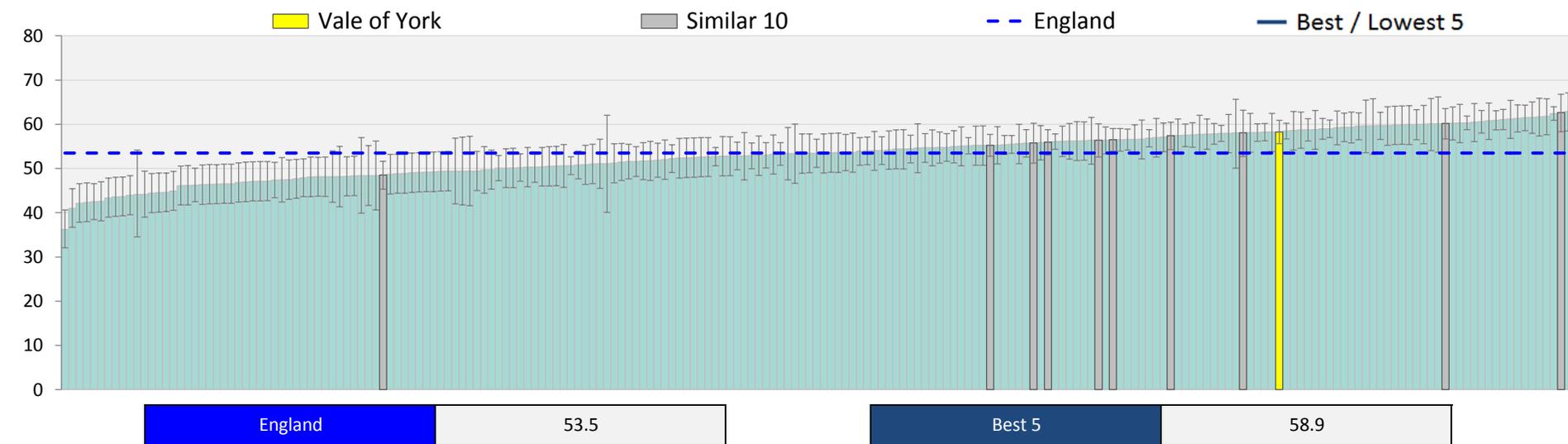
Definition: Percentage of adults classified as overweight or obese (estimated prevalence)

Source: Active People Survey, Sport England, Fingertips, Public Health England

Year: 2012-14

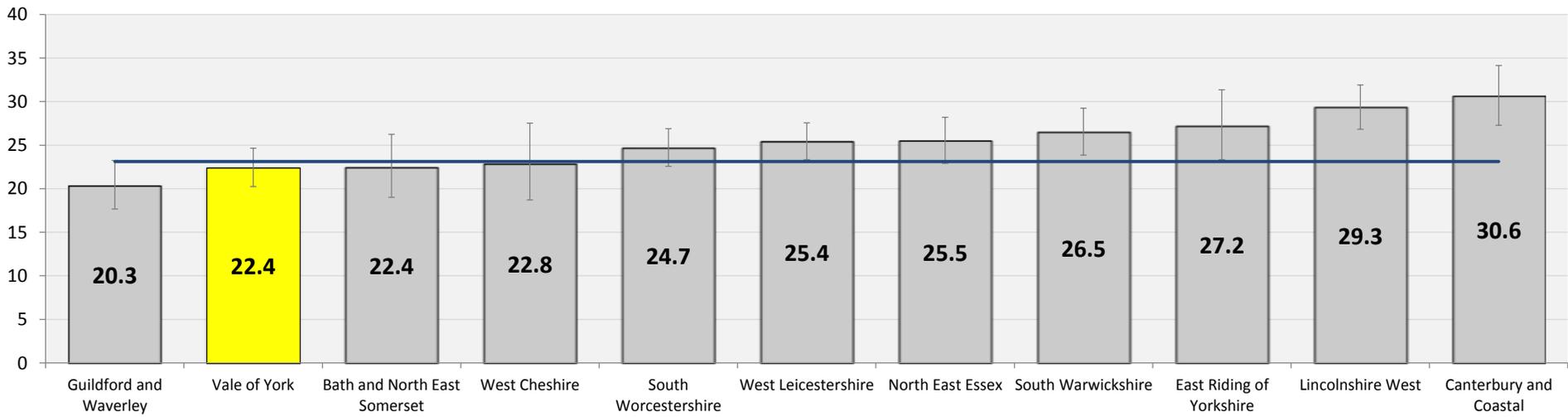
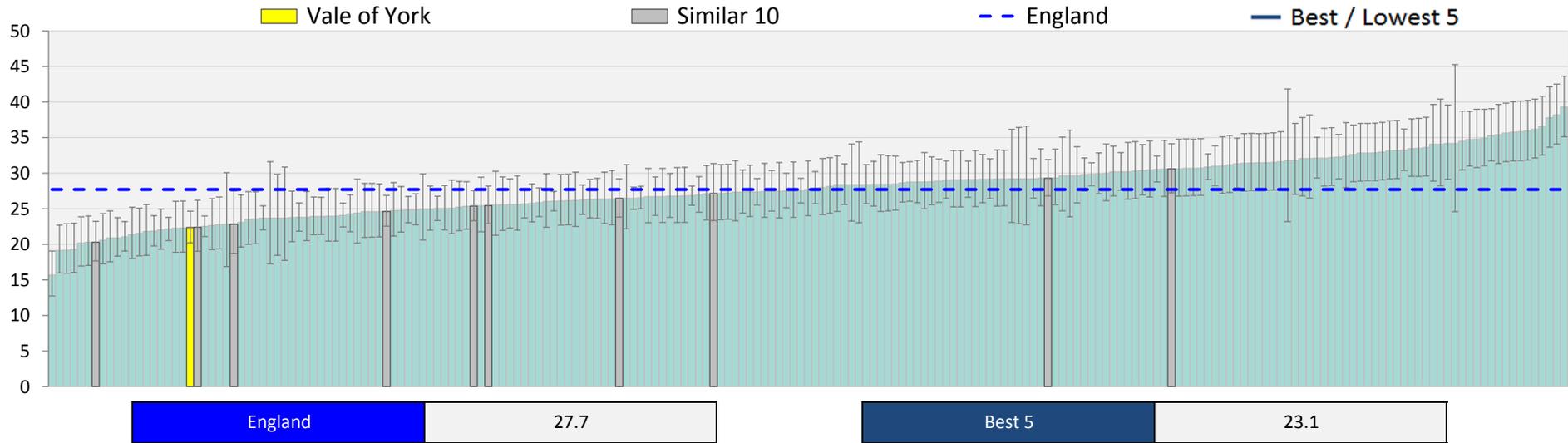
# Proportion of the population meeting the recommended '5 a day' on a usual day

2006 Ppl. (NSS)



Definition: Proportion of the population meeting the recommended '5 a day' on a usual day  
 Source: Active People Survey, Sport England, Fingertips, Public Health England  
 Year: 2014

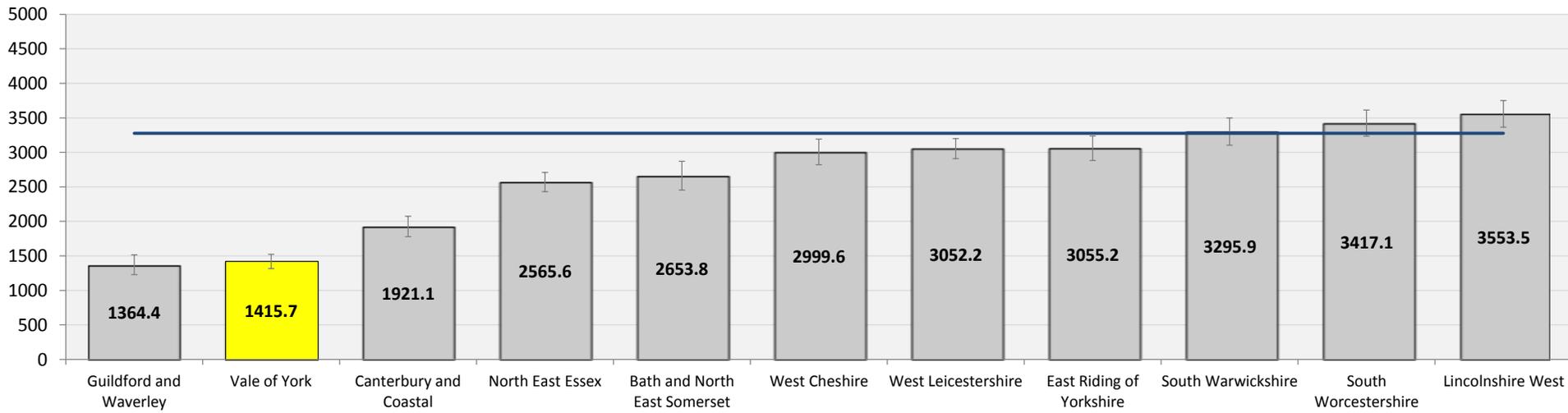
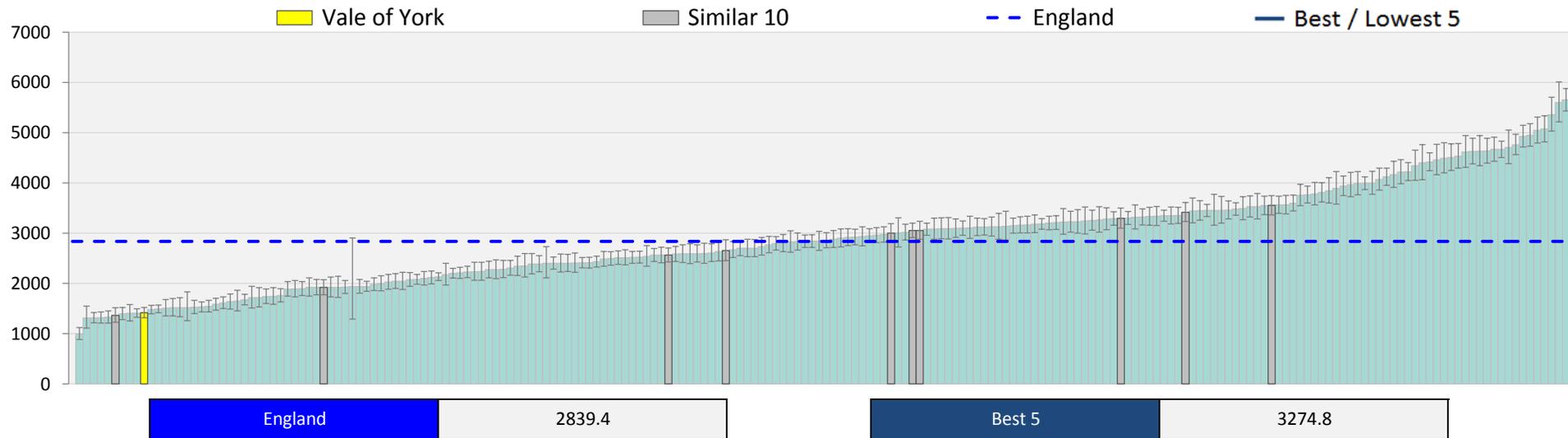
# The percentage of physically inactive adults



Definition: The percentage of physically inactive adults  
 Source: Active People Survey, Sport England, Fingertips, Public Health England  
 Year: 2014

# Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+

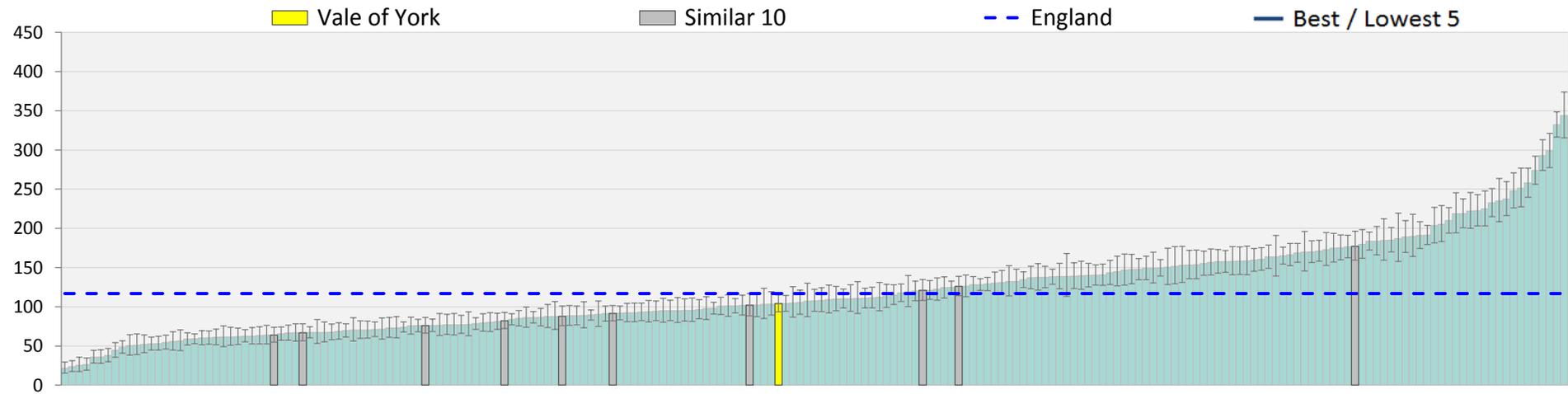
934 Ppl.



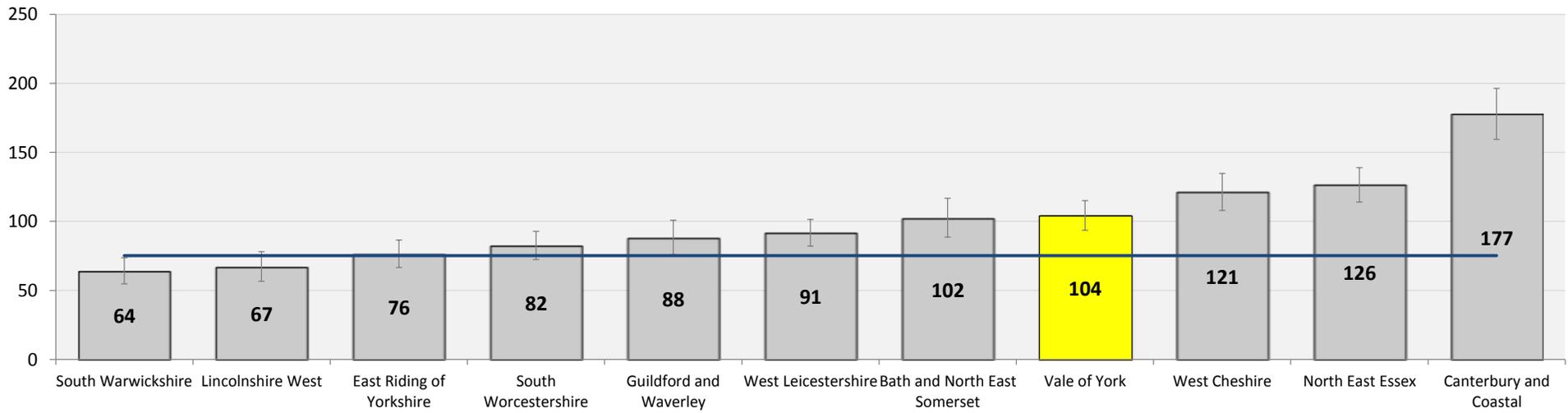
Definition: Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+  
 Source: <http://www.tobacoprofiles.info/tobacco-control>  
 Year: 2014/15

# Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population

**101 Adm.**



England	117.0	Best 5	75.0
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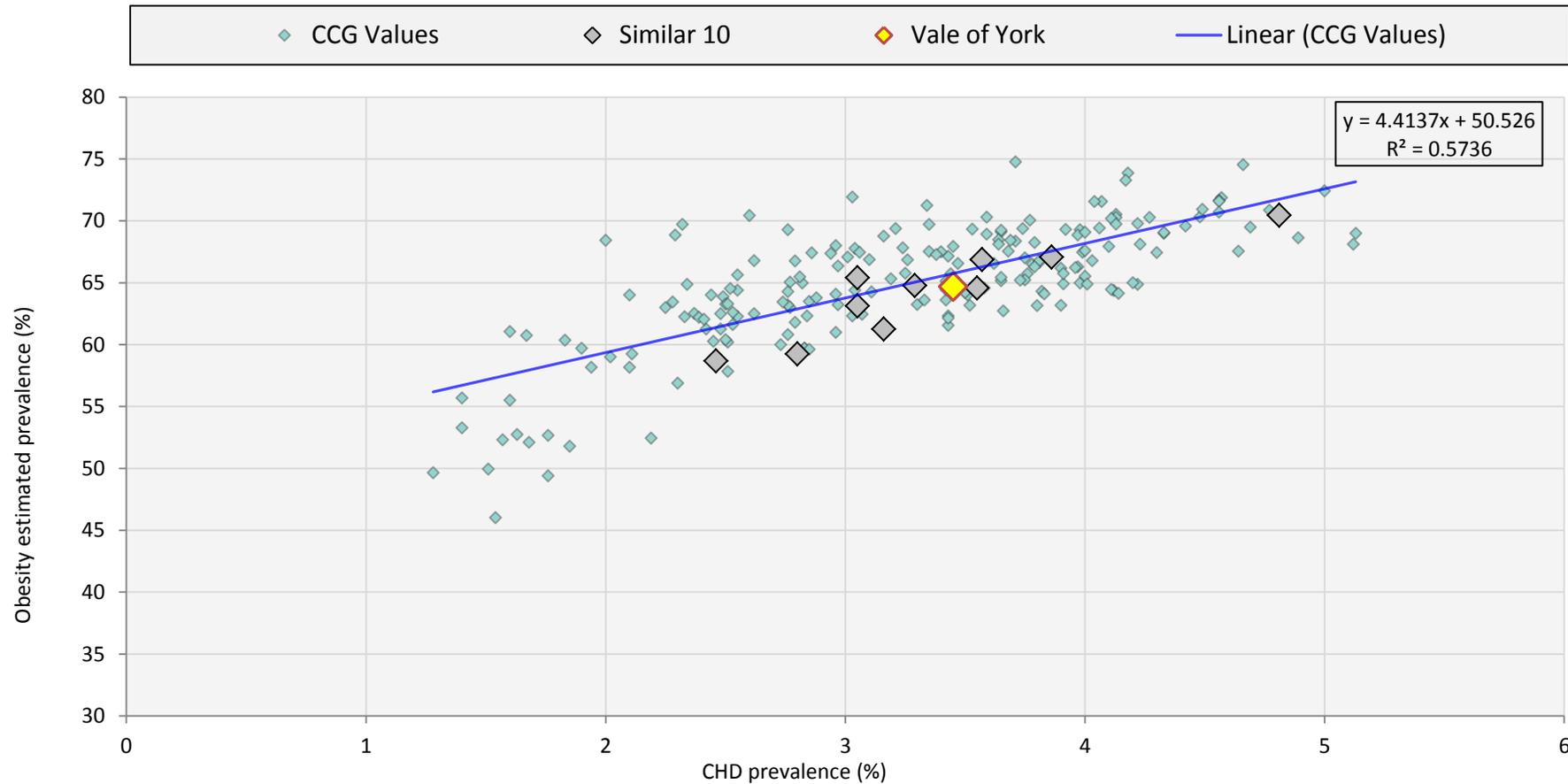


Definition: Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population  
 Source: NHS Digital  
 Year: 2015 (Provisional)

# Prevention scatter plot

The Commissioning for Value Explorer Tool allows the comparison of two indicators, the diagram below is an example. This is an invaluable tool to enable users to assess how one indicator relates to another. The similar 10 can be highlighted too. It is important to remember that correlations do not imply causation but the relationships can help target where to look. The explorer tool is available here:

<http://www.england.nhs.uk/resources/resources-for-ccqs/comm-for-value/>



# Prevention: Guidance

## Local health and care planning: Menu of preventative interventions

Public Health England has worked with partners to identify preventative actions that can improve people's health, support quality improvement and potentially save the NHS and the wider system money. This menu details interventions that are estimated to give a return on investment (ROI) and can demonstrate cost-savings to the health and care system over a five year period. The document aims to support local planning processes and can be used to inform local commissioning strategies and plans. It follows publication of the NHS shared planning guidance and the CQUIN scheme for 2017 to 2019. The menu is a refresh to an earlier version and has been updated with new modelling information and links to new ROI tools. It is based on best available evidence and data. The menu can be found at: <https://www.gov.uk/government/publications/local-health-and-care-planning-menu-of-preventative-interventions>

## Optimal Value Pathway for CVD prevention

NHS RightCare recently published an optimal value pathway on cardio-vascular disease prevention. It has been developed in close collaboration with clinicians, Public Health England, Royal Colleges, NICE and other stakeholders. The aim is to provide local health economies with a high-level overarching national case for change; a best practice pathway; and best practice case studies for elements of the pathway. It can be found at: <https://www.england.nhs.uk/rightcare/intel/cfv/cvd-pathway/>

# Prevention case study: Increasing smoking cessation referrals in Portsmouth



## The background

Smoking costs the National Health Service (NHS) in England approximately £2bn a year for treating diseases caused by smoking. This includes the costs of hospital admissions, GP consultations and prescriptions. The government also pays for sickness/invalidity benefits, widows' pensions and other social security benefits for dependants.

A standardised method of identifying and referring hospital patients to 'stop smoking' support does not exist across England. As such there is no systematic and robust means of identifying and referring smokers to relevant support mechanisms.

## The approach – streamlined secondary care system

The Streamlined Secondary Care System is a whole hospital approach to 'stop smoking' support for patients. The system includes an innovative electronic referral system that is incorporated within the existing hospital IT system. The approach ensures that there is a straightforward and efficient method for referring smokers on to their local stop smoking service. It focuses on implementing systems that support staff to deliver 'Very Brief Advice' (VBA) and electronically refer patients. The electronic referral system sorts patients by their postcode to ensure that they are automatically referred to the correct local 'stop smoking service'. The system also includes an online training programme that provides the necessary knowledge required to deliver VBA in the hospital setting. The system was piloted in the Queen Alexandra Hospital within Portsmouth Hospitals NHS Trust for three months from November 2011 to February 2012.

Continued on the next page...

# Prevention case study: Increasing smoking cessation referrals in Portsmouth



## The outcomes

In total there were 187 referrals made via the 'Referral Management System' (RMS) and 330 referrals made overall by all referral methods. This equates to a total increase of 602% when compared to the 47 referrals made during the same period in the previous year.

Prior to the pilot, 55 members of staff were reported as being trained to deliver 'Very Brief Advice' (VBA) by the local stop smoking services. From 1st September 2011 staff were asked to complete the online VBA training developed for the pilot. This resulted in a 415% increase in the number of staff trained to give VBA to patients via the online training programme.

The simplicity of the Streamlined Secondary Care System has proven to effectively increase the identification and referral of hospital patients into local stop smoking support.

## Key benefits of the approach include:

- A simple and time efficient referral system that is easily incorporated within existing day-to-day practice
- An effective, accessible and measurable online VBA training programme
- A system that enables stop smoking services to respond quickly and efficiently to referred patients
- A whole hospital approach that stimulates progress towards providing a supportive environment for patients to stop smoking

The project report detailing the outcomes of the Streamlined Secondary Care System introduced at Portsmouth can be found at:

<http://www.ncsct.co.uk/usr/pub/ncsct-streamlined-secondary-care-final-report.pdf>

There is also a link to the National Centre for Smoking Cessation & Training (NCSCT) which provides support to organisations conducting smoking cessation interventions: [http://www.ncsct.co.uk/publication\\_introducing-the-ncsct.php](http://www.ncsct.co.uk/publication_introducing-the-ncsct.php)

# Prevention: Best practice and tools

## **The National Centre for Smoking Cessation and Training (NCSCT)**

The NCSCT is a community interest company established to support the delivery of smoking cessation interventions provided by local stop smoking services. The company delivers effective evidence-based tobacco control programmes to 'stop smoking' practitioners and other health care professionals.

Online and face-to-face training courses and modules are available via the NCSCT website which also contains a range of other resources. The NCSCT also offers support services, specifically around smoking cessation in secondary care, independent service reviews and programme management.

NCSCT online training and assessment programmes are free of charge and are available to all from their website. For more information please visit: <http://www.ncsct.co.uk/>

## **CQUIN scheme for 2017-2019**

A new Commissioning for Quality and Innovation (CQUIN) indicator has been added for 2017-2019 for Preventing ill health by risky behaviours – alcohol and tobacco. For more information please visit:

<https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/> (Chapter 9 of the specification document).

# Prevention case study: East Sussex Making Every Contact Count (MECC)

## The background

*East Sussex Better Together* (ESBT) is a 150-week programme to develop a fully integrated health and social care system in East Sussex by 2018. It aims to deliver against the aspirations set out in the Five Year Forward View. As part of this the team has put in place a system-wide prevention programme; with Making Every Contact Count (MECC) a key component.

A pilot funded by NHS Hastings and Rother CCG - and developed in conjunction with East Sussex County Council (ESCC) public health - started at East Sussex Healthcare NHS Trust's (ESHT) Conquest Hospital site in 2015/16 to develop and test ways of rolling out the approach. Following the success of the pilot, plans are in now place to roll out MECC across the whole health and social care workforce.

## The approach

MECC encourages all those who have contact with the public, through health or care services, to use these opportunities to talk about health and wellbeing. It encourages health and social care staff to have brief conversations, during routine interactions, on how people might make positive changes, such as stopping smoking, eating more healthily or exercising more.

The MECC programme brings together health care providers, commissioners, public health experts and clinicians to design and implement a programme that embeds prevention in the role of every member of staff. This has led to the setting up of a MECC project team, commissioning of bespoke training and a roll out programme with key specialities.

Continued on the next page...

# Prevention case study: East Sussex Making Every Contact Count (MECC)

## Challenges

- Challenges in engaging some clinical specialities
- Staff unable to attend due to service pressures
- Developing referral pathways and referral data transfer systems

## Results and key learning

Over 315 staff have completed MECC training across nine specialities. Feedback from participants has been overwhelmingly positive, with 98% reporting they felt better equipped to have healthy lifestyle conversations. Key elements for success include:

- Senior level buy in across organisations
- Dedicated staff time to co-ordinate the programme
- Utilising the evidence base to create persuasive arguments for change
- Capturing positive feedback from clinicians helps build the case in healthcare settings

## Next steps

Through continuous feedback and evaluation the programme adapts and changes to meet the needs of each cohort of participants.

MECC will be incorporated as a component of ESHT's 'health promoting hospitals' model, which will change the environment that shapes staff and patient decisions. It will also be incorporated into Connecting4You - a programme in the west of the county.

Continued on the next page...

# Prevention case study: East Sussex Making Every Contact Count (MECC)

## More information

For more information about this case study please email [richard.watson6@nhs.net](mailto:richard.watson6@nhs.net) or [peter.aston@eastsussex.gov.uk](mailto:peter.aston@eastsussex.gov.uk)

## The evidence base

MECC practical tools:

<https://www.gov.uk/government/publications/making-every-contact-count-mecc-practical-resources>

NICE guidelines:

<https://www.nice.org.uk/guidance/ph49>

## MECC requirement in the standard contract

The NHS Standard Contract requires providers to develop and maintain an organisational plan for making every contact count, in accordance with MECC principles and guidance (standard condition SC8). For more information please visit: <https://www.england.nhs.uk/wp-content/uploads/2016/04/2-nhs-fill-length-1617-scs-apr16.pdf> (see page 11)

# Prevention: Case studies

## Alcohol care teams

A consultant-led, multi-disciplinary Alcohol Care Team (ACT) in Bolton saved 2,000 alcohol-related bed days and reduced readmissions by 3%. In Alexandra Hospital an external evaluation showed a 43% reduction (from 3,814 to 2,155) in A&E attendances alone, a year after the introduction of a small Alcohol Care Team.

For more information please visit:

[http://www.boltonft.nhs.uk/wp-content/uploads/2012/12/bics\\_alcoholteam\\_qipp\\_11.pdf](http://www.boltonft.nhs.uk/wp-content/uploads/2012/12/bics_alcoholteam_qipp_11.pdf)

## Weight management

Birmingham's Lighten Up service saw a reduction in body weight by 5.6% in 3 months and 5.1% in 12 months (2011). The average cost for each service user was £68 a year, and savings were made by reducing - by nearly half - the number of avoidable referrals.

For more information please visit:

[http://nhfshare.heartforum.org.uk/RMAssets/Casestudies/SouthBham\\_lighten\\_up.pdf](http://nhfshare.heartforum.org.uk/RMAssets/Casestudies/SouthBham_lighten_up.pdf)

# Loneliness

# Loneliness and social isolation

Isolation and loneliness can have a negative impact on people's health. 12% or over a million people in England aged 65 and over are persistently or chronically lonely.\*

- Social isolation and loneliness can increase risk of mortality by a quarter <http://pps.sagepub.com/content/10/2/227.abstract> or <http://ow.ly/ibgN305LPwU>
- Loneliness has strong associations with, and may be an independent or synergistic risk factor for depression <http://psycnet.apa.org/journals/pag/21/1/140/>
- In addition it is linked adversely to hypertension, impaired sleep and impaired cognition in older people <http://onlinelibrary.wiley.com/doi/10.1002/gps.2054/full>
- Loneliness may follow a number of trajectories including being a long established attribute, late onset or decreasing <http://ow.ly/QI4o305LPBU>

\* Marmot, M., Oldfield, Z., Clemens, S., Blake, M., Phelps, A., Nazroo, J., Steptoe, A., Rogers, N., Banks, J., Oskala, A. (2016). English Longitudinal Study of Ageing: Waves 0-7, 1998-2015. [data collection]. 25th Edition. UK Data Service. SN: 5050, <http://dx.doi.org/10.5255/UKDA-SN-5050-12>. Figures extrapolated to national population using latest ONS Populations Estimates

# Loneliness and social isolation

- People with a high degree of loneliness are twice as likely, compared to those with a low degree of loneliness, to develop Alzheimer's disease \*
- Loneliness can be as harmful for health as smoking 15 cigarettes per day \*\*
- Educational and social activity group interventions that target specific groups and in which older people are active participants can alleviate social isolation and loneliness among older people <http://ow.ly/vfiu305LPIk> or <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-11-647>
- A higher proportion of those aged 80 and over reported feeling lonely when compared to other age groups (46% compared to the average of 34% for all aged 52 and over) [http://ons.gov.uk/ons/dcp171766\\_304939.pdf](http://ons.gov.uk/ons/dcp171766_304939.pdf)  
Given the increased likelihood of frailty in older people, the home can become detrimental to health.

\* Loneliness and risk of Alzheimer disease. Wilson RS, Krueger KR, Arnold SE, Schneider JA, Kelly JF, Barnes LL, et al. Arch Gen Psychiatry 2007 Feb; 64(2):234-240

\*\* Social relationships and mortality risk: a meta-analytic review. Holt-Lunstad J, Smith TB, Layton JB. PLoS Med 2010;7(7)

# Loneliness and social isolation

CCGs and Local Authorities should consider working together to routinely identify vulnerable older people with frailty using the electronic frailty index or through other local networks who are living alone or socially isolated. These individuals should be offered access to social activity group interventions in which they can actively participate.

CCGs and Local Authorities should consider working together at the neighbourhood level, to understand and build on existing community capacity and assets to recognise and respond to individual needs and circumstances. In particular they should consider pooling resources, and intelligence across organisations and developing new partnerships may increase the benefits for those who are hard to reach or isolated, for example through working with their local Fire and Rescue Service to use Safe and Well Visits to support older people.

Local Authorities should consider addressing loneliness as an outcome measure of council strategies including the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS) <http://ow.ly/JEAA305LQkC>

# Multimorbidity and frailty

Around one in four people have two or more long-term conditions or 'multimorbidity'. This rises to two thirds of people aged 65 years or over.\* Multimorbidity is associated with higher mortality, adverse drug events and greater use of unplanned care.\*\*

CCGs and GPs should optimise care for adults with multimorbidity and/or frailty in line with NICE Guideline 56, including by considering treatment burden (polypharmacy and multiple appointments), patient goals and preparing an individualised management plan (or care plan) which includes how they access urgent care.

The guideline sets out which people are most likely to benefit from an approach to care that takes account of multimorbidity, how they can be identified and what the care involves. It recommends using a validated tool such as the electronic Frailty Index, PEONY or QAdmissions, and, if available in primary care, electronic health records to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admission or admission to care homes.

The NICE Guideline is available at: <https://www.nice.org.uk/guidance/ng56>

\*[http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60240-2.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60240-2.pdf)

\*\*[http://www.bmj.com/lookup/ijlink?linkType=FULL&journalCode=bmj&resid=354/sep21\\_16/i4843&atom=%2Fbmj%2F354%2Fbmj.i5195.atom](http://www.bmj.com/lookup/ijlink?linkType=FULL&journalCode=bmj&resid=354/sep21_16/i4843&atom=%2Fbmj%2F354%2Fbmj.i5195.atom)

# Unhealthy and unsuitable homes

The home is the primary 'health setting' for most people throughout life. There are risks to physical and mental health associated with living in a cold, damp, hazardous home, that does not meet the household's needs, and/or does not provide a sense of security.

One in five homes in England do not meet a 'decent' standard. It is estimated that the cost to the NHS of all homes with significant hazards in England is £2.0bn in first year treatment costs alone: excess cold and falls present the greatest hazards.\*

- There is a clear link between excess winter deaths and cold homes, cardiovascular disease, and respiratory illness, and also increases in falls and injuries  
<https://www.nice.org.uk/guidance/ng6> and  
<https://www.gov.uk/government/publications/cold-weather-plan-cwp-for-england>
- Falls as a consequence of the home can result in physical injury and can also contribute to health deterioration, particularly in older people  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/15810/142631.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/15810/142631.pdf)
- Unhealthy, unsuitable and unstable housing can have an impact on mental health and wellbeing, for example contributing to social isolation <http://www.cieh-housing-and-health-resource.co.uk/mental-health-and-housing/key-issues/>

\* Nichol, S, Roys, M, Garrett, H (2015) The cost of poor housing to the NHS, BRE.  
<https://www.bre.co.uk/filelibrary/pdf/87741-Cost-of-Poor-Housing-Briefing-Paper-v3.pdf>

# Unhealthy and unsuitable homes

The health of the following populations is particularly vulnerable to living in an unhealthy, unsuitable or unstable home:

- People with cardiovascular conditions
- People with respiratory conditions (in particular, chronic obstructive pulmonary disease and childhood asthma)
- People with mental health conditions
- People with disabilities
- Older people (65 and older)
- Households with young children (from new-born to school age)
- Pregnant women
- People on a low income
- People who spend a lot of time at home eg, carers

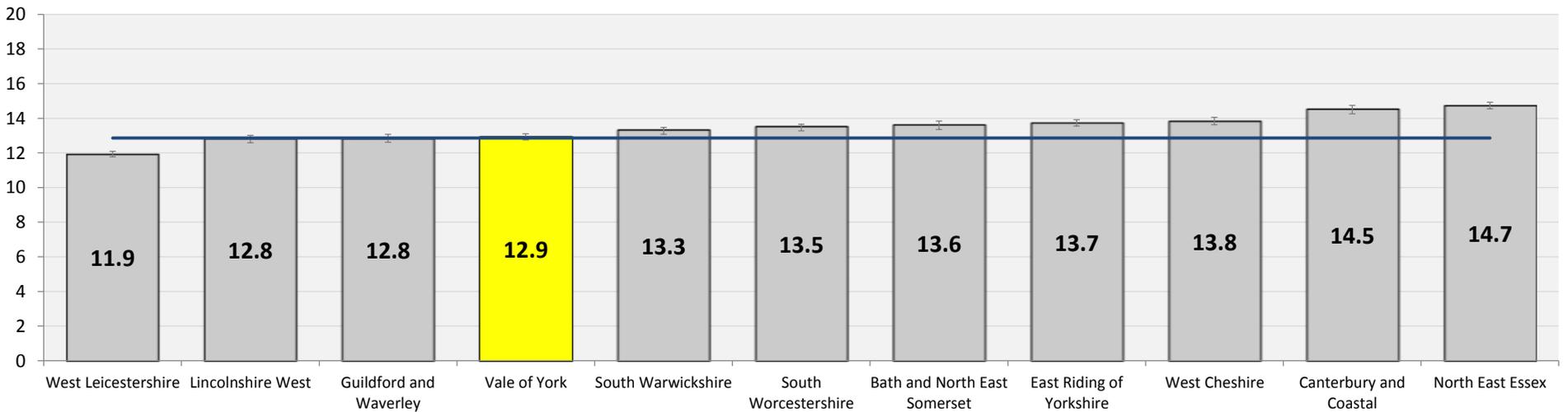
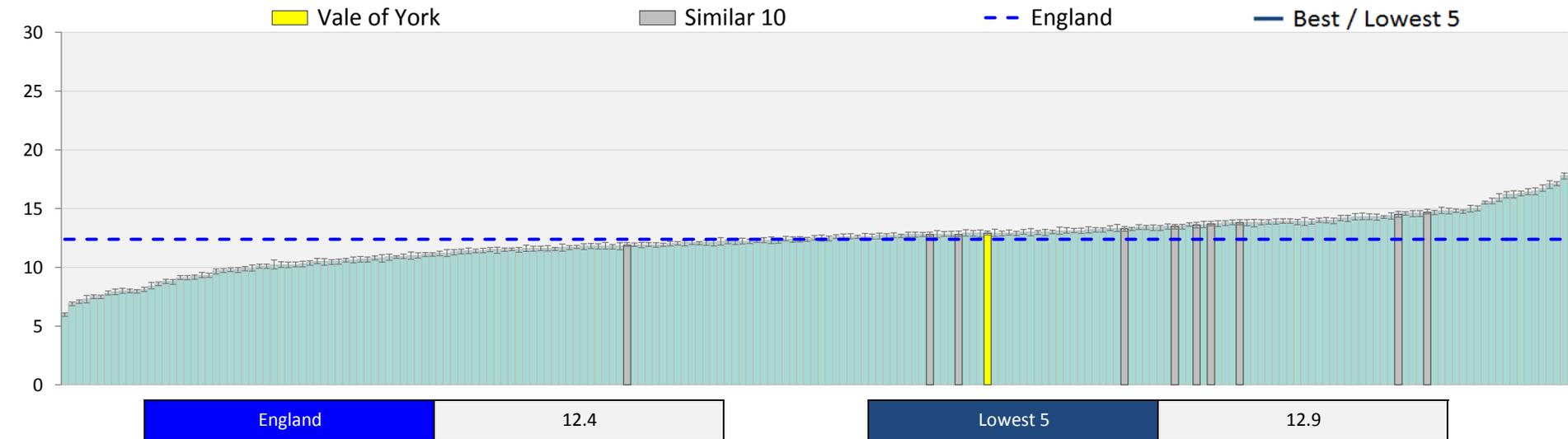
References as per previous page.

# Unhealthy and unsuitable homes

CCGs and Local Authorities should consider working together to routinely identify people at risk and offer access to integrated services and interventions which can enable the home environment to be a healthy one, and in doing so, reduce hospital admissions, length of stay, delayed discharge, readmission rates and ultimately improve outcomes, particularly by promoting equality. <http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-health-and-housing.pdf> and <https://www.gov.uk/government/collections/housing-for-health>

CCGs, Local Authorities and other partners to the Health and Wellbeing Board should consider the home and health relationship in conducting the Joint Strategic Needs Assessment (JSNA) and incorporate relevant actions in the Joint Health and Wellbeing Strategy (JHWS) and all other relevant local commissioning for improved health and wellbeing <https://www.gov.uk/government/collections/housing-for-health>

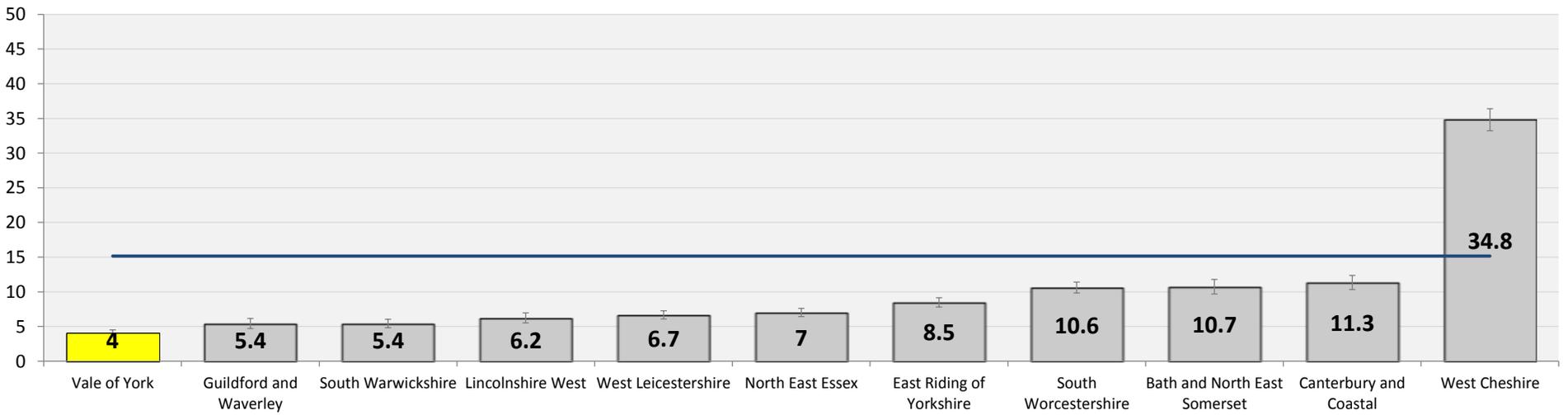
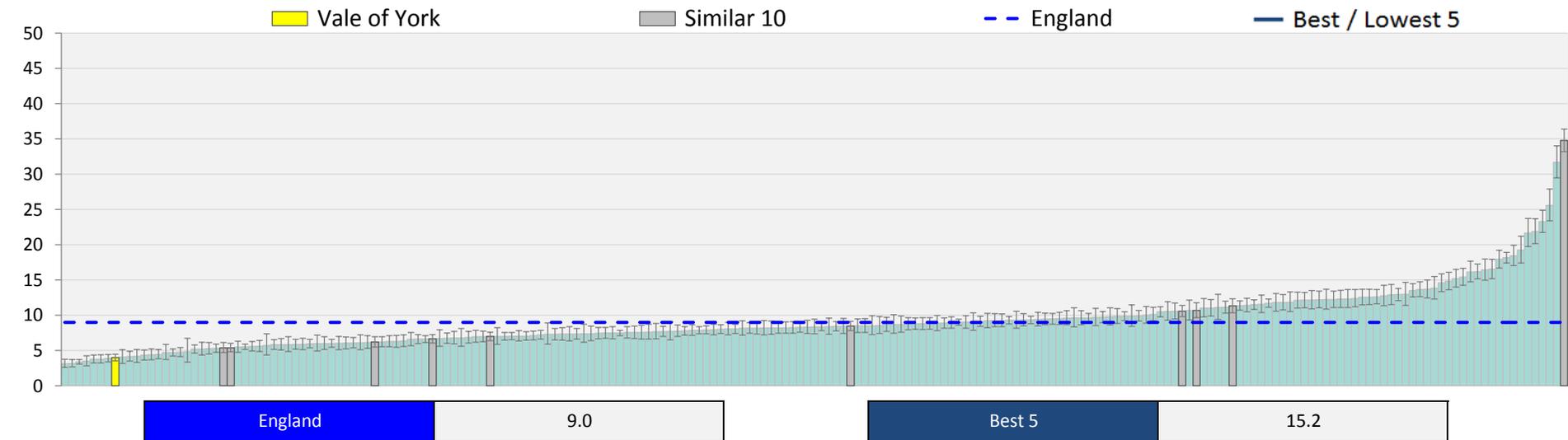
# The percentage of people aged 65+ living alone



Definition: The percentage of people aged 65+ living alone  
 Source: ONS Census  
 Year: 2011

# Rate of IAPT referrals per 1000 population (65+)

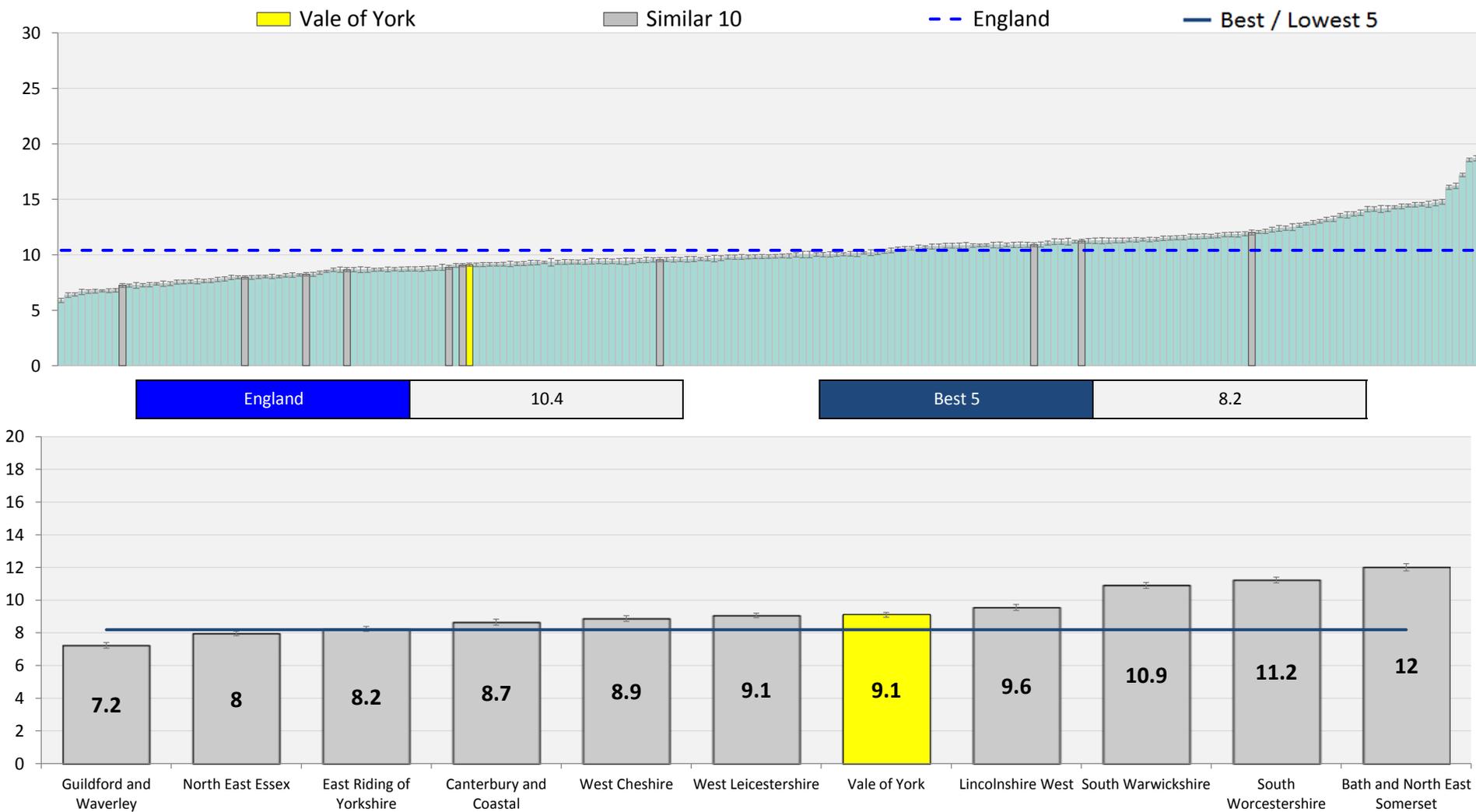
N/A



Definition: Rate of IAPT referrals per 1000 population (65+)  
 Source: Improving Access to Psychological Therapies Dataset Annual Reports, HSCIC  
 Year: 2015/16

# The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology

1315 H.Holds

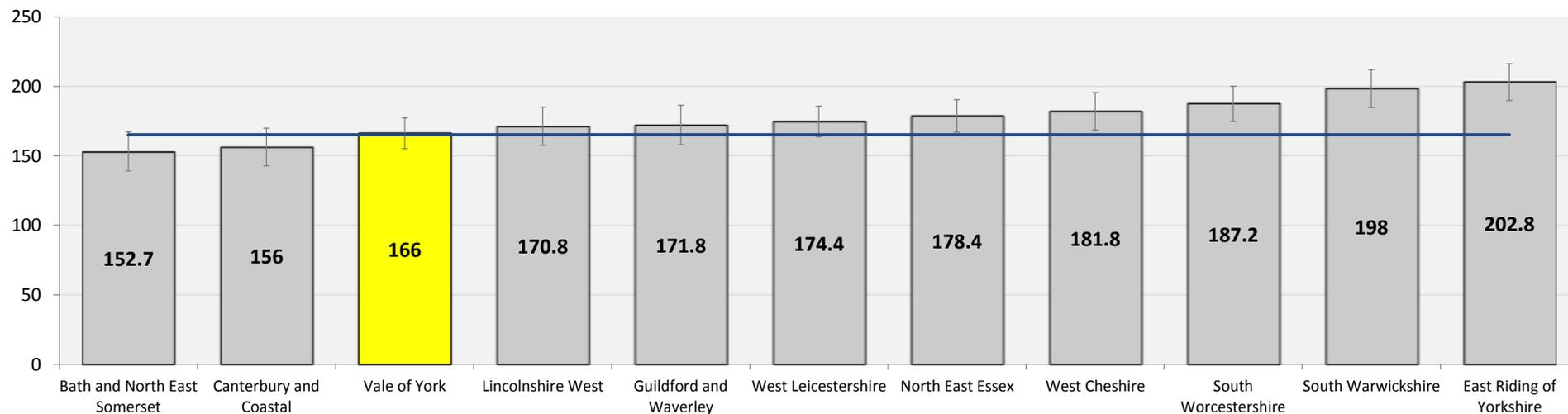
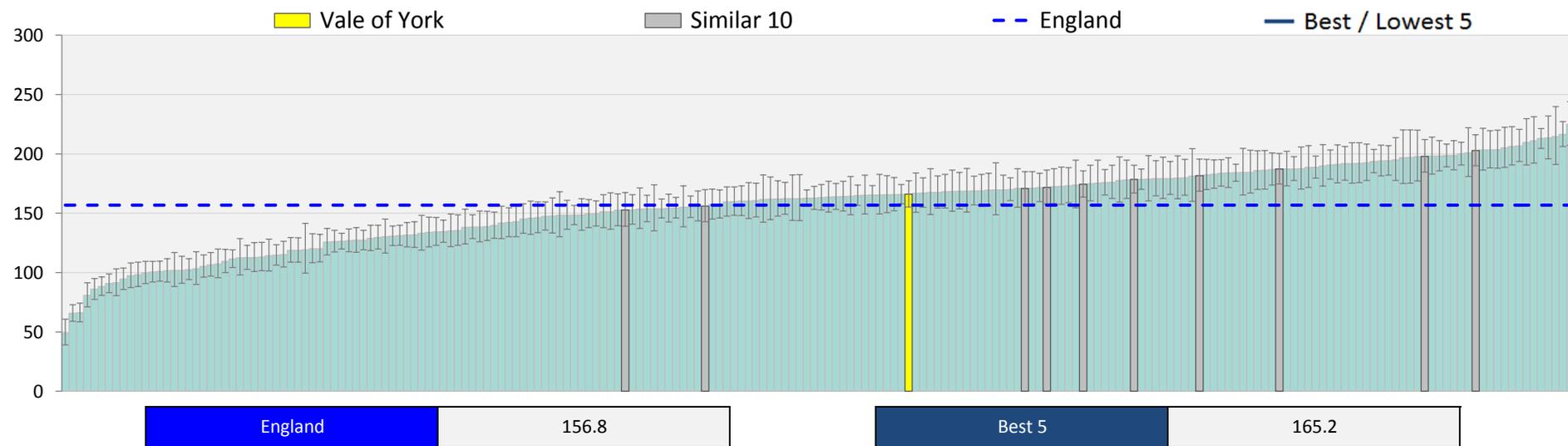


Definition: The percentage of households that experience fuel poverty based on the "Low income, high cost" methodology  
 Source: Department of Energy and Climate Change (DECC), Fingertips, Public Health England  
 Year: 2013

# Estimated Prevalence

# Incidence of breast cancer per 100,000 population (all ages)

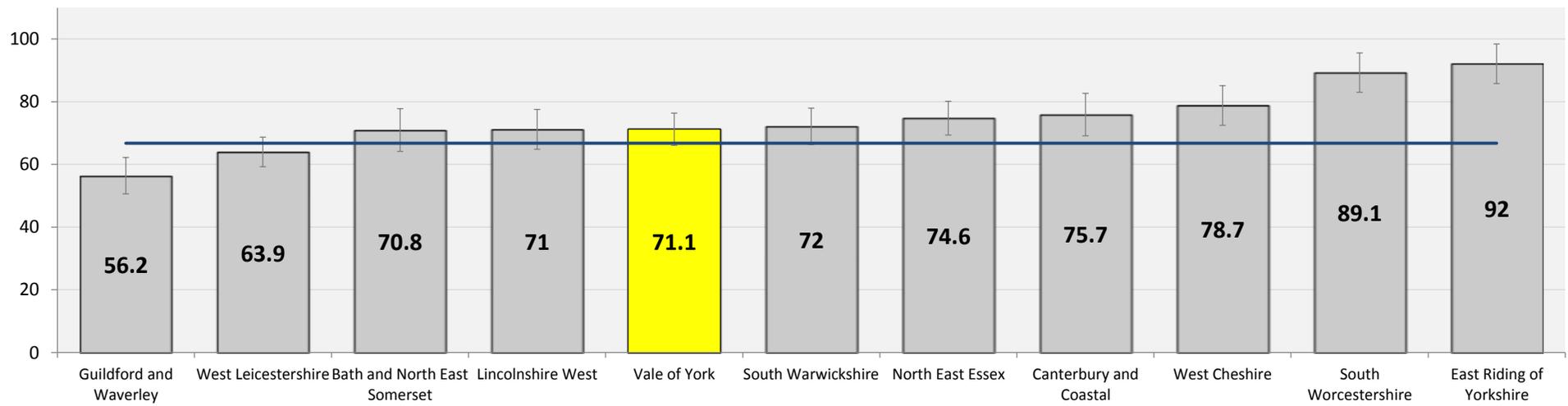
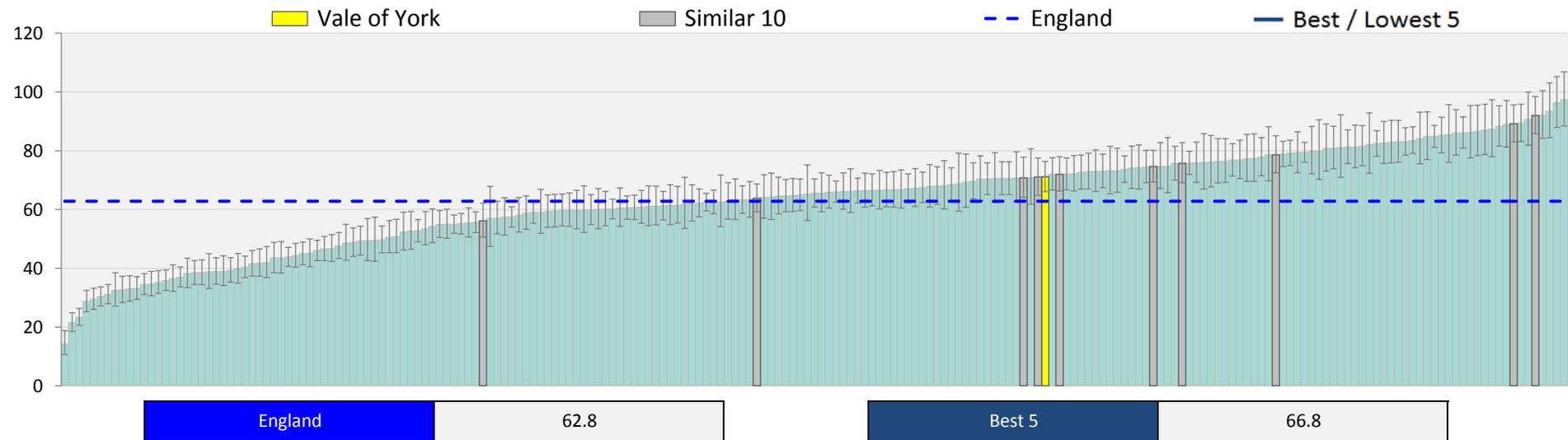
2 Ppl. (NSS)



Definition: Incidence of breast cancer per 100,000 population (all ages)  
 Source: <https://www.cancerdata.nhs.uk/dashboard/breast.html#>  
 Year: 2012-14

# Incidence of colorectal cancer per 100,000 population (all ages)

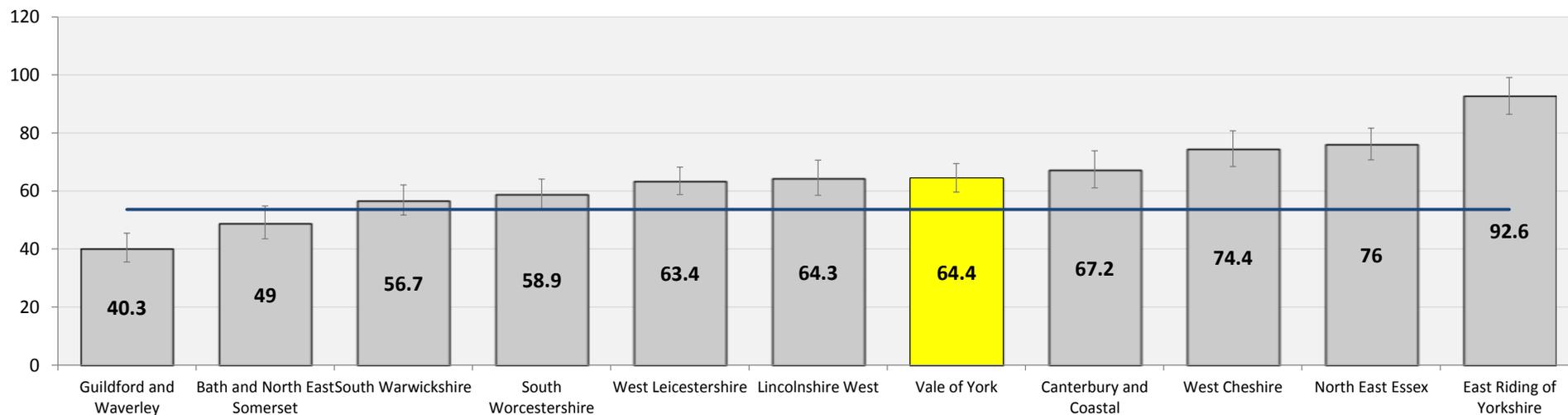
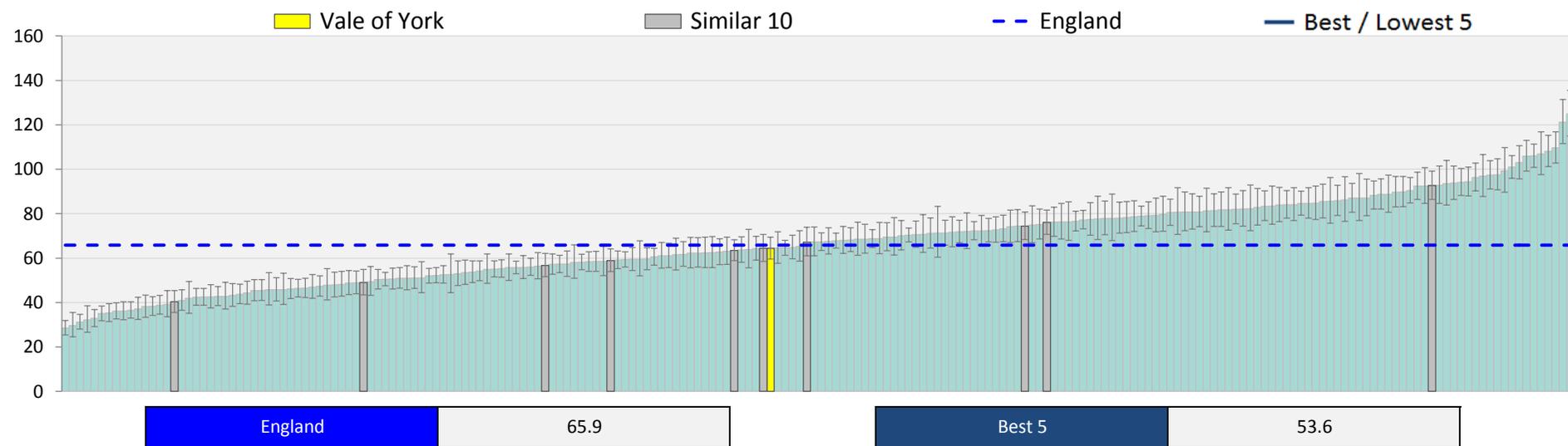
15 Ppl. (NSS)



Definition: Incidence of colorectal cancer per 100,000 population (all ages)  
 Source: <https://www.cancerdata.nhs.uk/dashboard/colorectal.html#>  
 Year: 2012-14

# Incidence of lung cancer per 100,000 population (all ages)

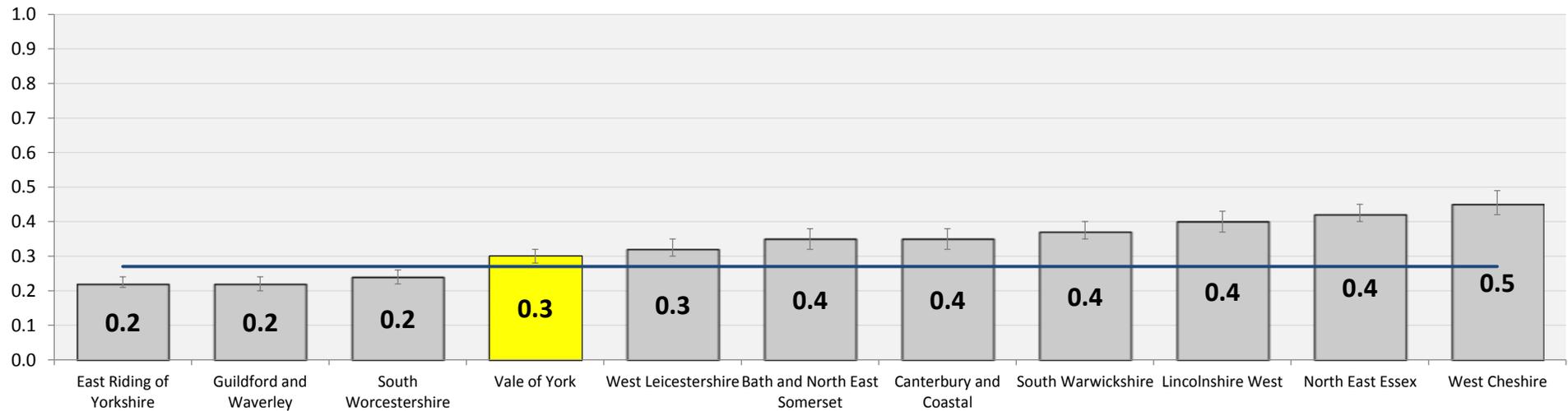
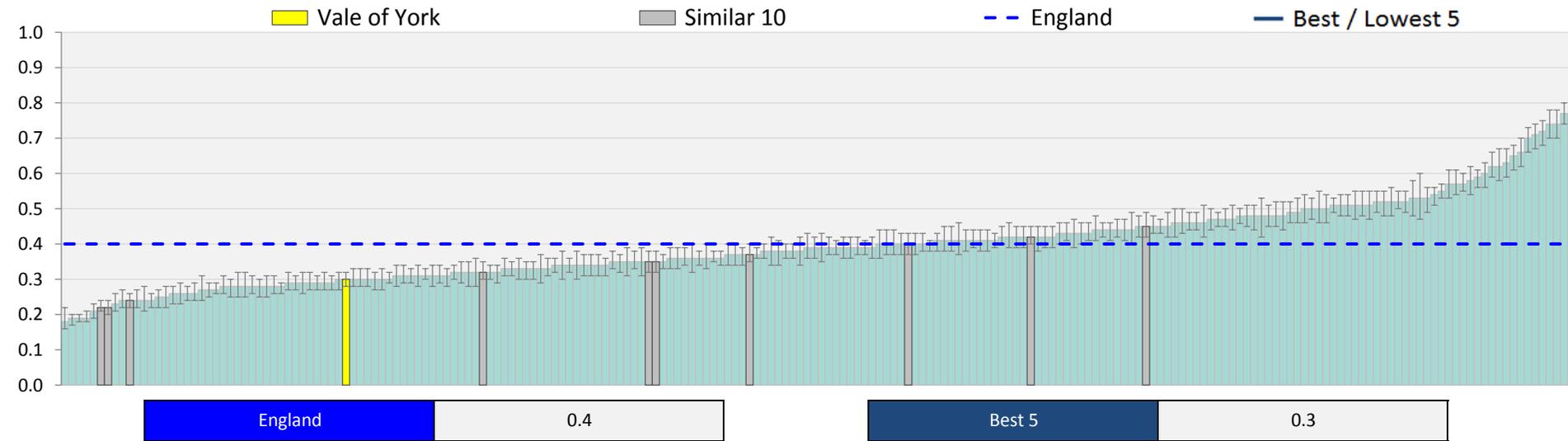
**37 Ppl.**



Definition: Incidence of lung cancer per 100,000 population (all ages)  
 Source: <https://www.cancerdata.nhs.uk/dashboard/lung.html#>  
 Year: 2012-14

# Psychotic disorder: Estimated % of people aged 16+

**86 Ppl.**



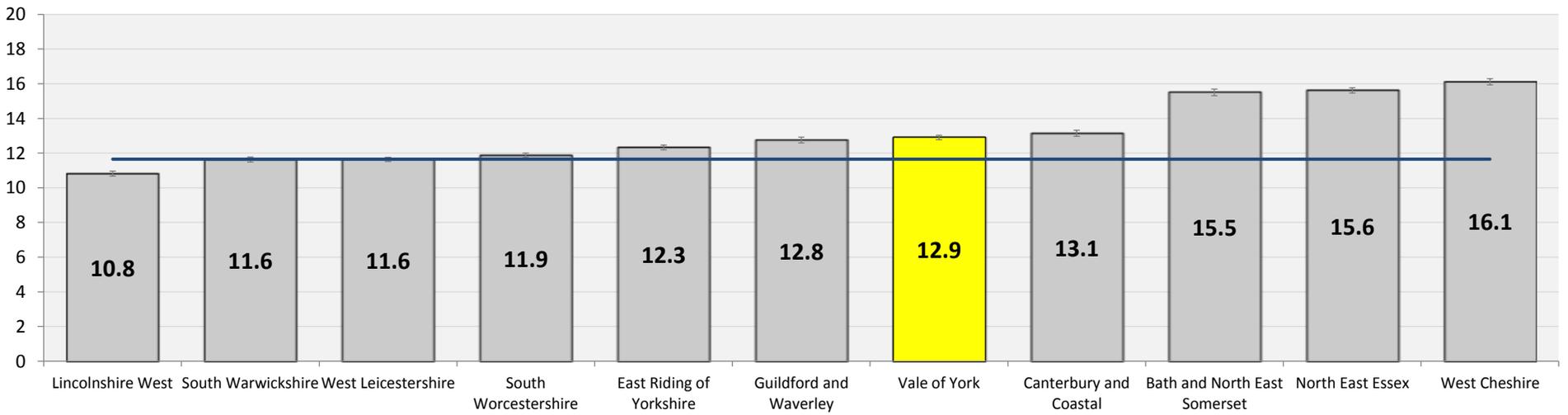
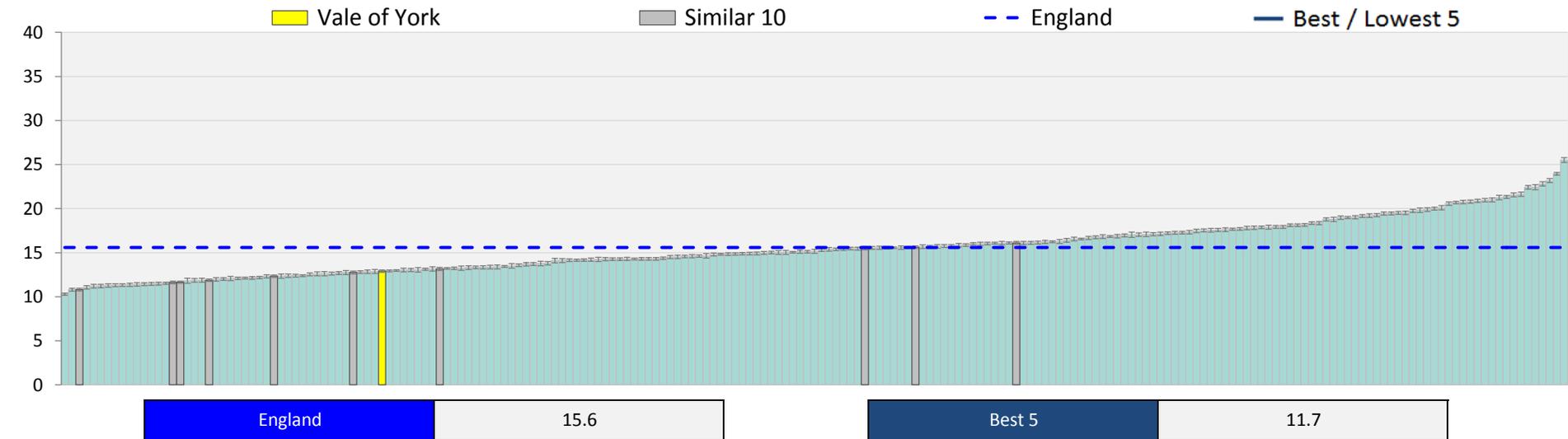
Definition: Psychotic disorder: Estimated % of people aged 16+

Source: Adult Psychiatric Morbidity Survey (APMS 2007), NHS Digital. Fingertips, PHE- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2012

# Estimated prevalence of CMHD aged 16-74 (%)

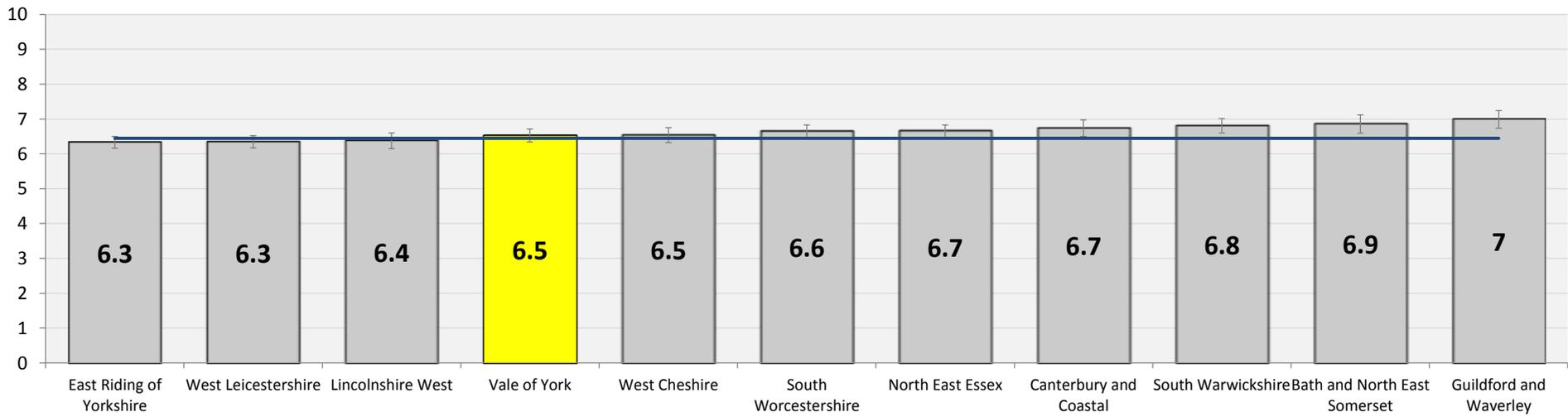
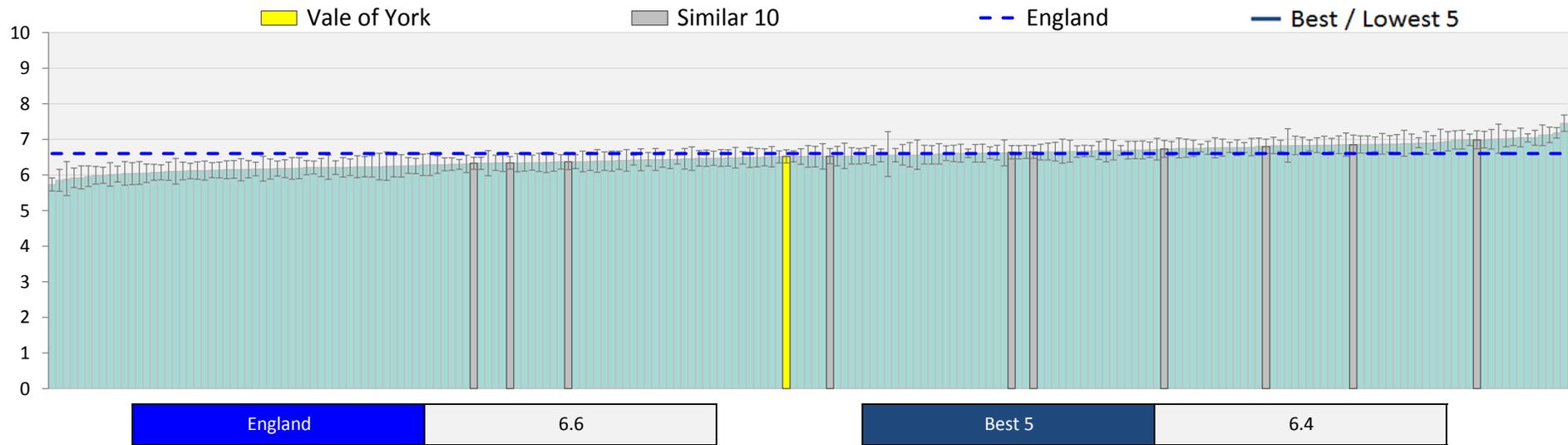
**3216 Ppl.**



Definition: Estimated prevalence of CMHD aged 16-74 (%)  
 Source: NEPHO. Fingertips, PHE- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: 2014/15

# Dementia: Estimated prevalence (%) (65+)

54 Ppl. (NSS)



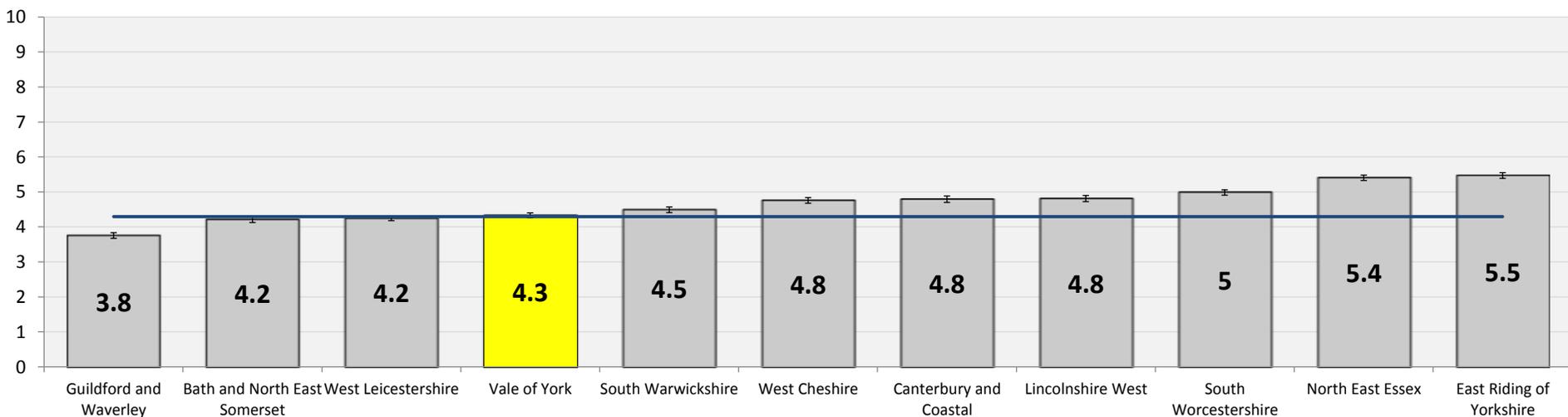
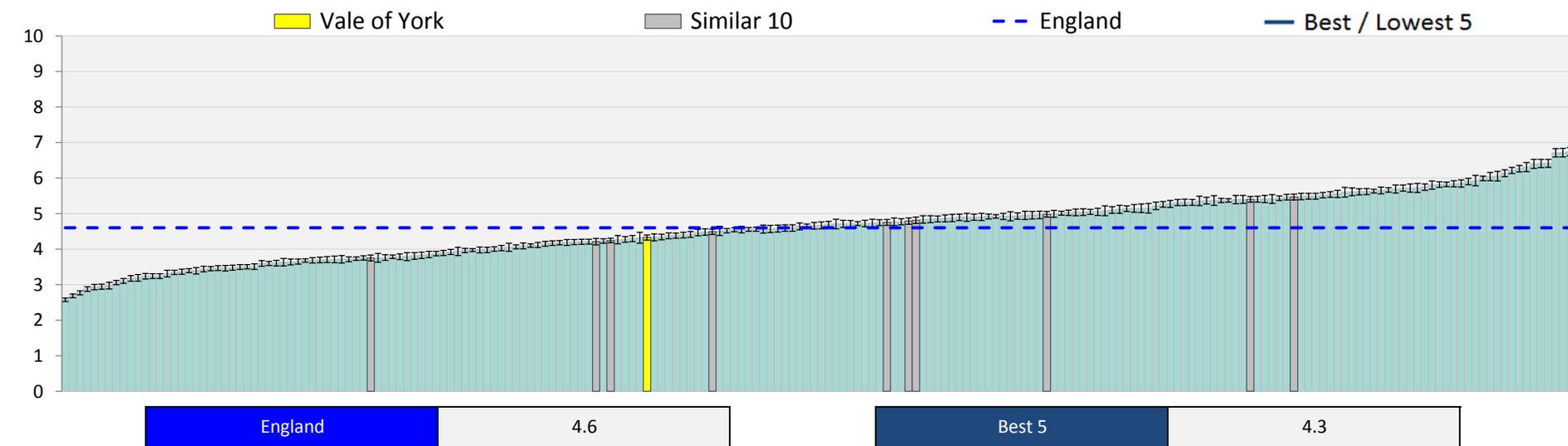
Definition: Dementia: Estimated prevalence (%) (65+)

Source: NHS Digital, Dementia diagnosis monthly workbook- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: Aug-16 (2015)

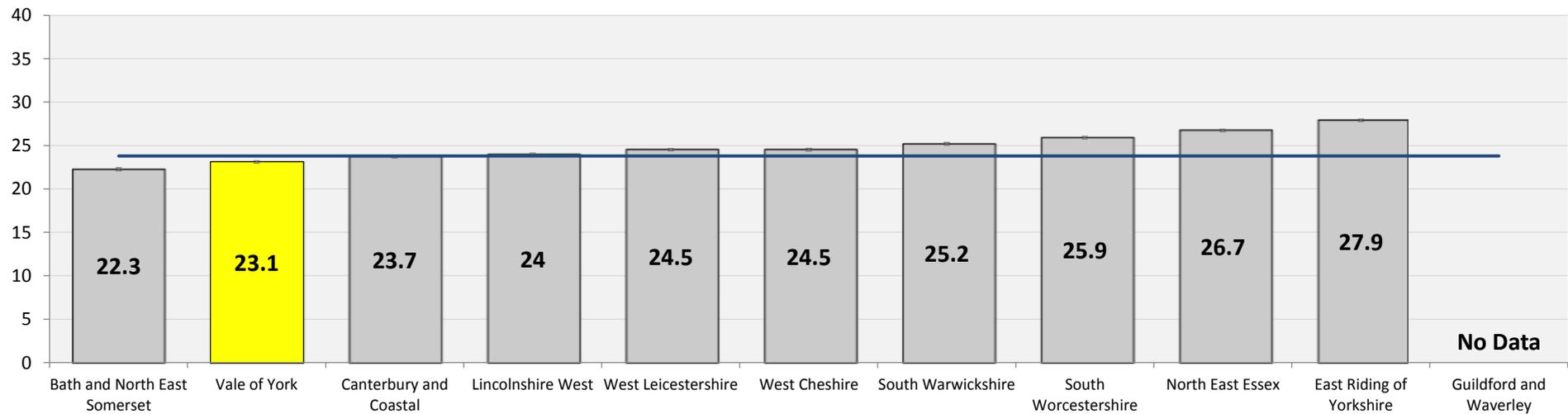
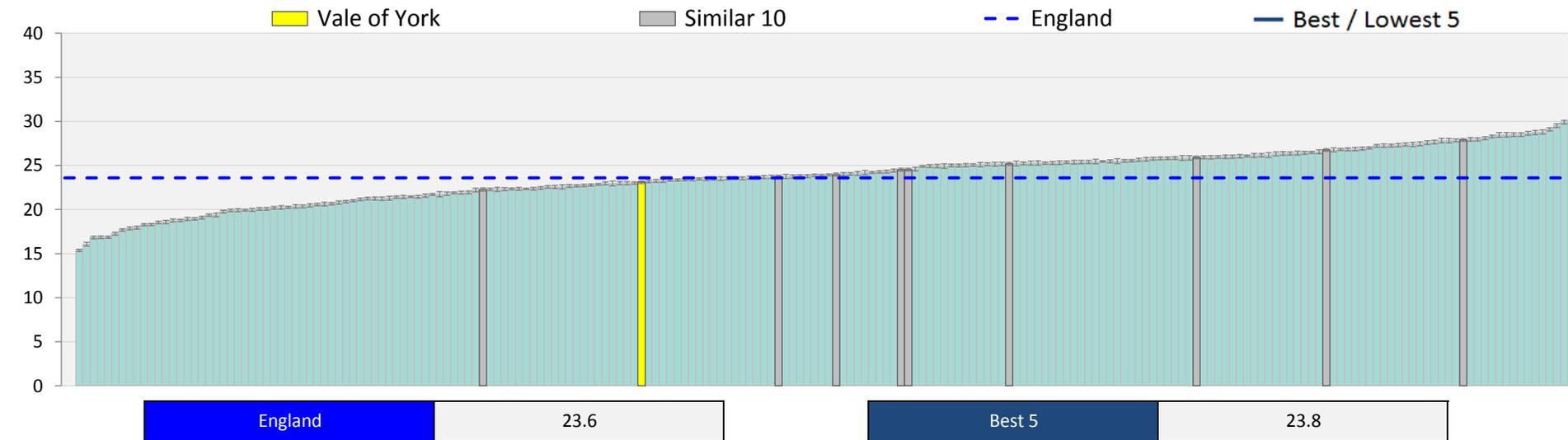
# Estimated CHD prevalence (%)

128 Ppl. (NSS)



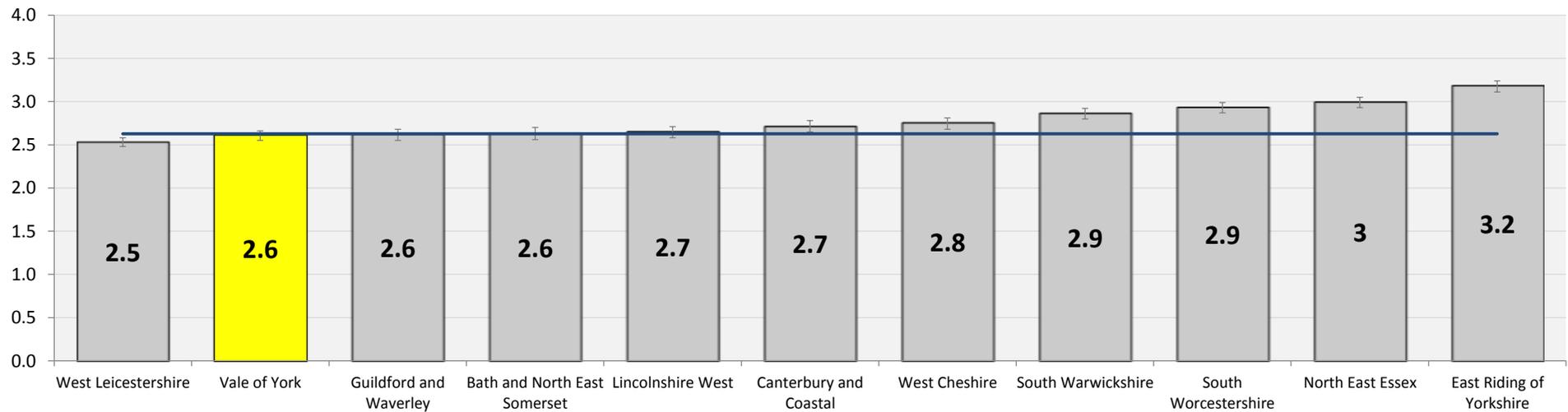
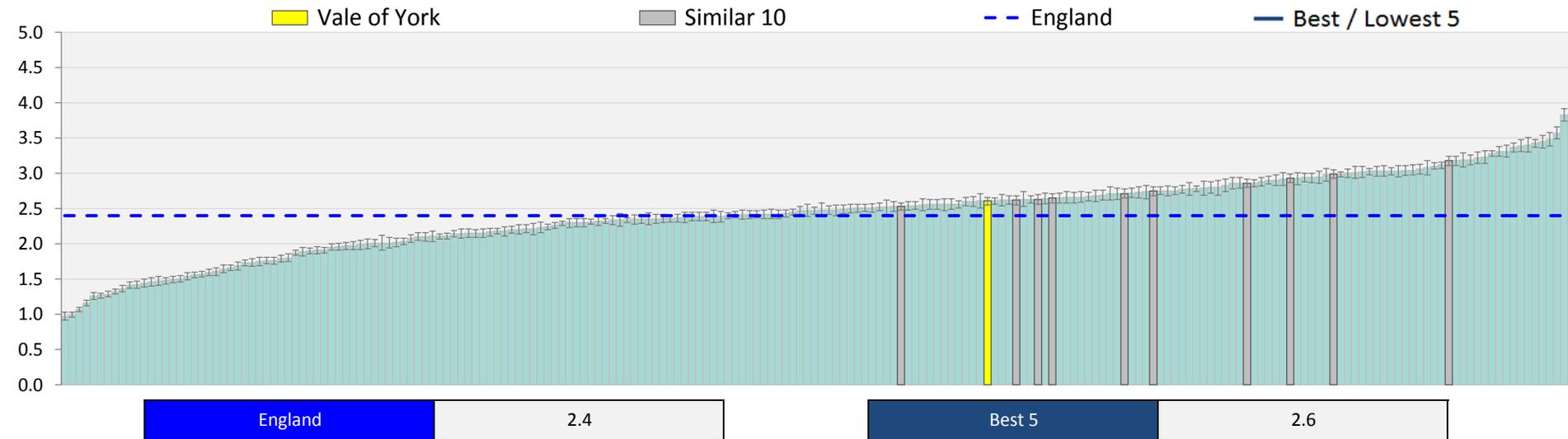
Definition: Estimated CHD prevalence (%)  
 Source: Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: 2011

## Estimated Hypertension Prevalence (%)



Definition: Estimated Hypertension Prevalence (%)  
 Source: Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: 2014

# Estimated prevalence of Atrial Fibrillation (%)

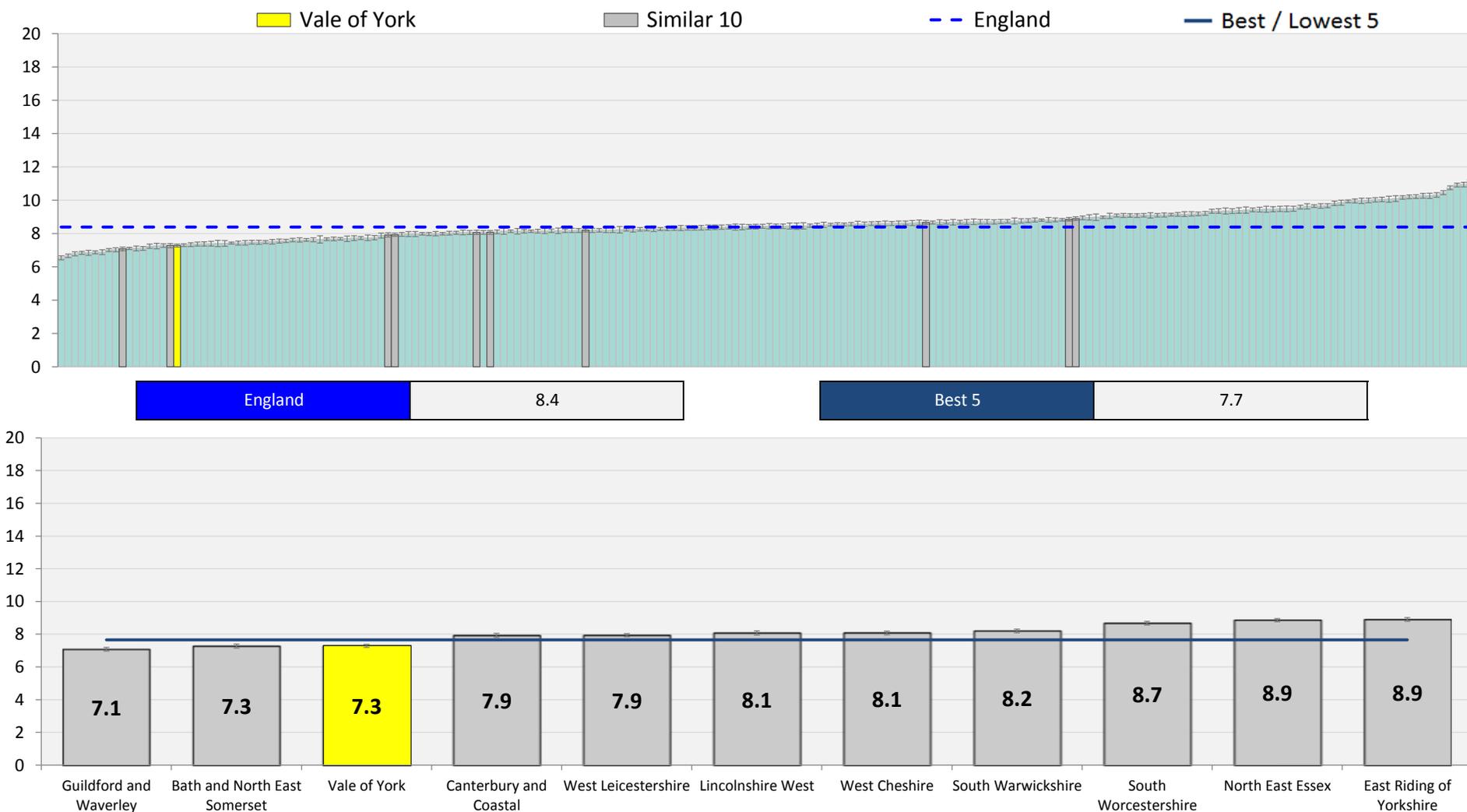


Definition: Estimated prevalence of Atrial Fibrillation (%)

Source: Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2013/14

## Diabetes: estimated prevalence (16+) (%)



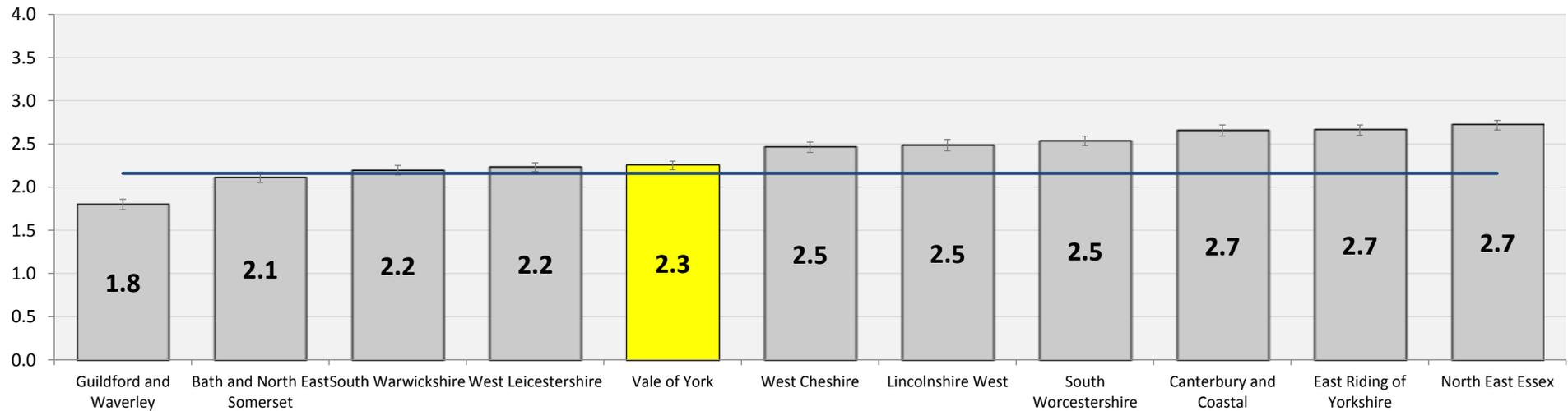
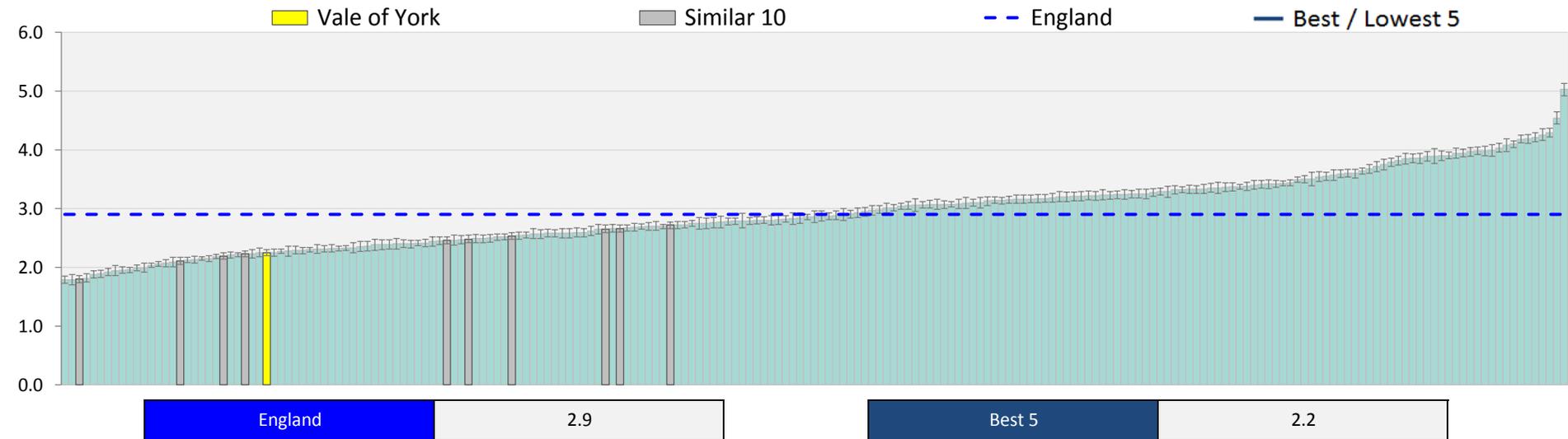
Definition: Diabetes: estimated prevalence (16+) (%)

Source: Diabetes, Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2014/15

# COPD estimated Prevalence (%)

310 Ppl.



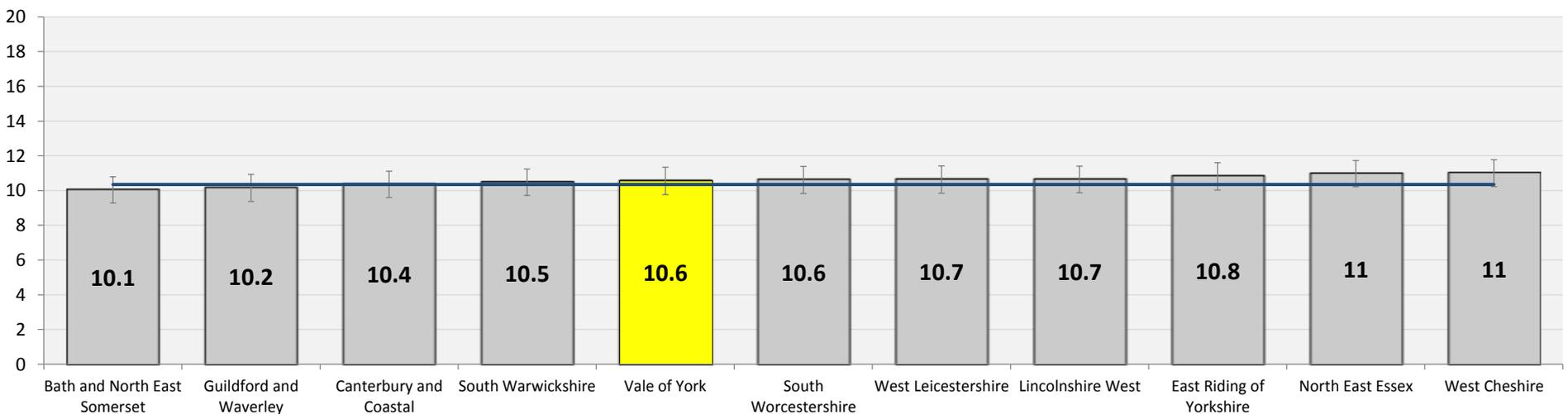
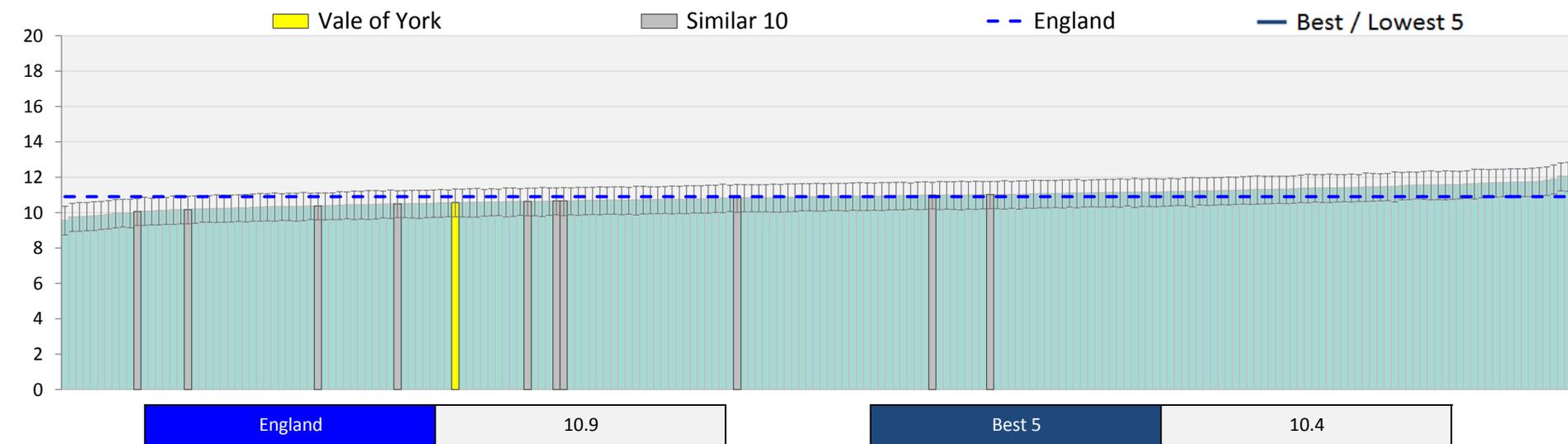
Definition: COPD estimated Prevalence (%)

Source: Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2011

# The percentage of people (over 45) who have hip osteoarthritis (total)

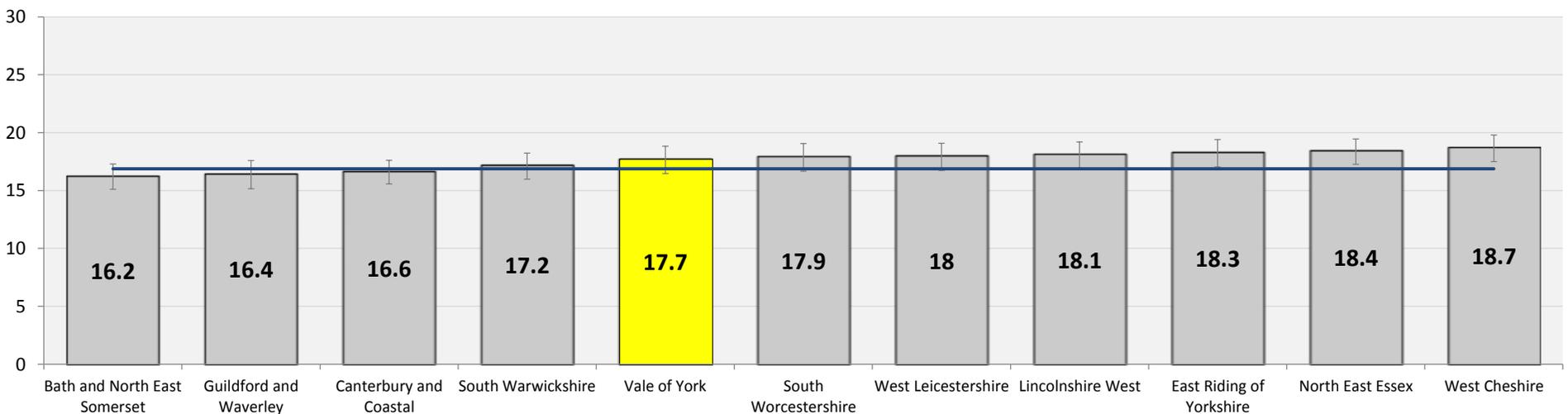
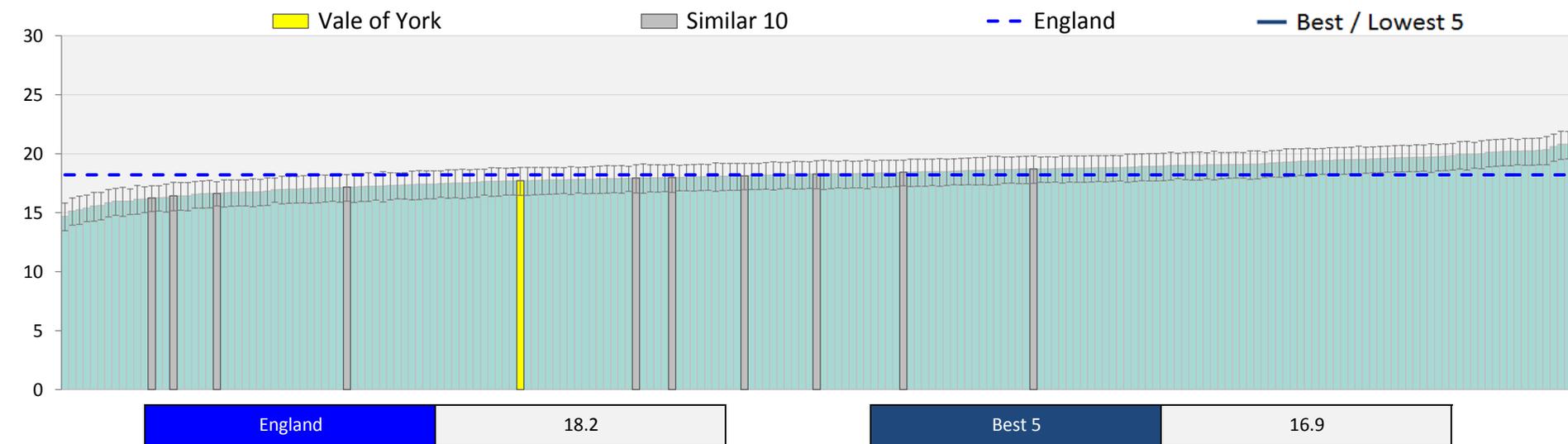
348 Ppl. (NSS)



Definition: The percentage of people (over 45) who have hip osteoarthritis (total)  
 Source: <http://www.arthritisresearchuk.org/mskcalculator>  
 Year: 2012/13

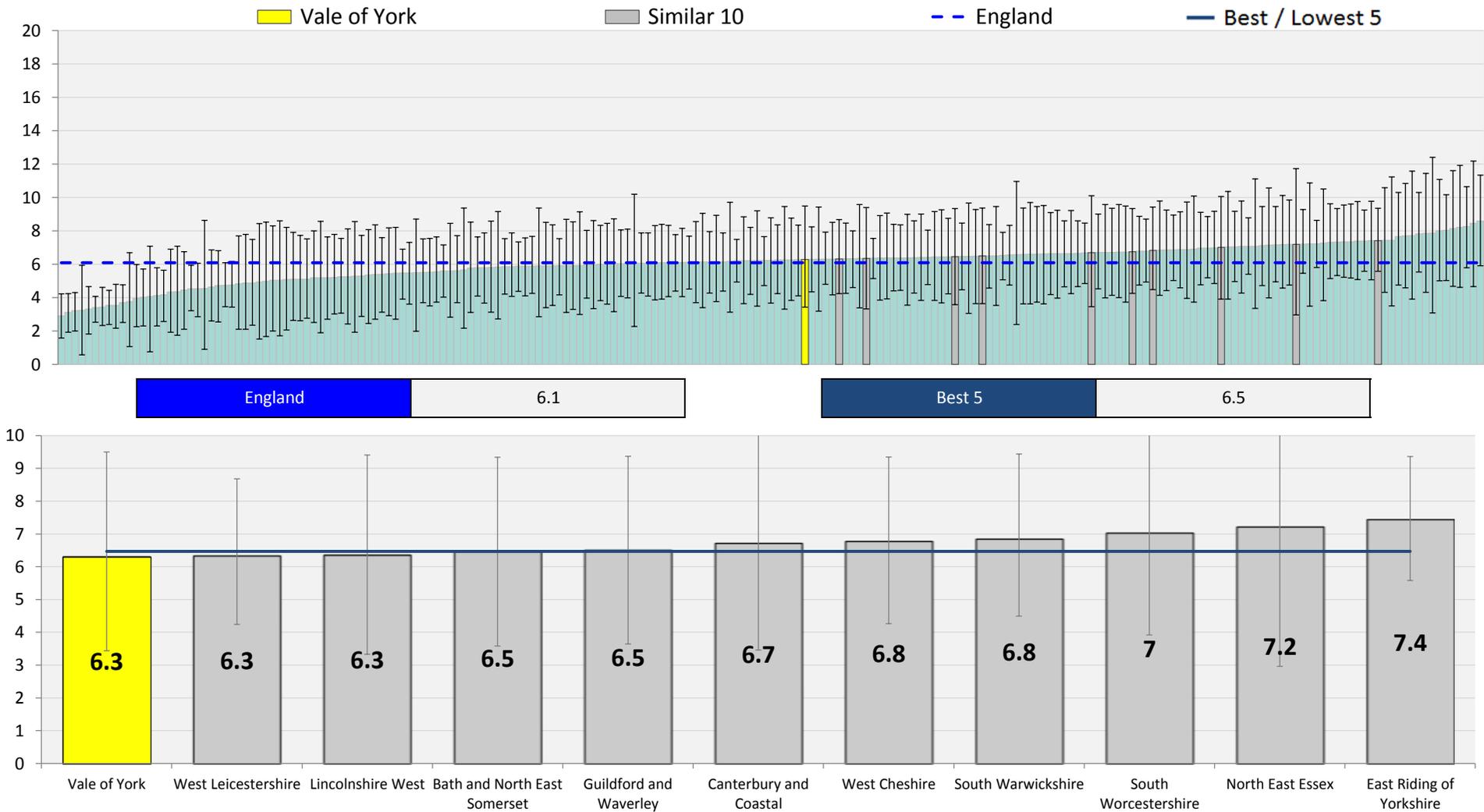
# The percentage of people (over 45) who have knee osteoarthritis (total)

1259 Ppl. (NSS)



Definition: The percentage of people (over 45) who have knee osteoarthritis (total)  
 Source: <http://www.arthritisresearchuk.org/mskcalculator>  
 Year: 2012/13

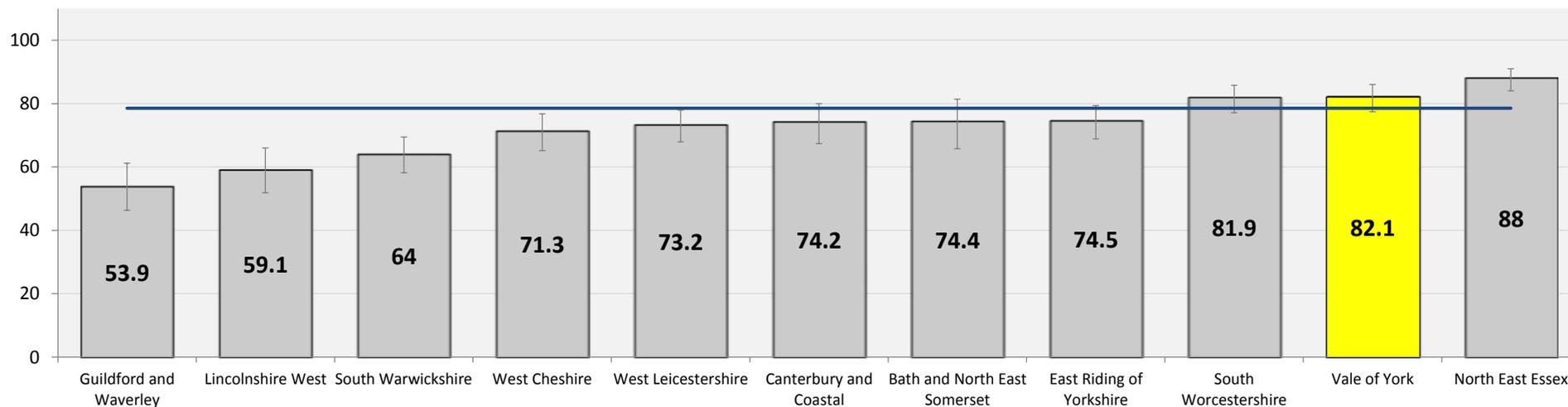
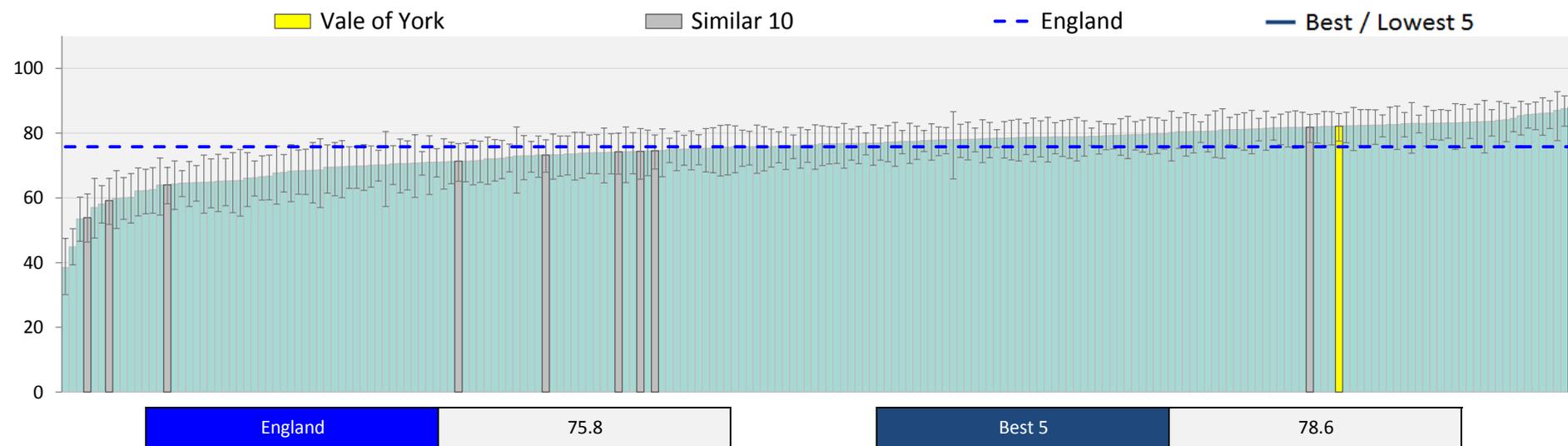
# Chronic Kidney Disease (CKD) Estimated Prevalence (%)



Definition: Chronic Kidney Disease (CKD) Estimated Prevalence (%)  
 Source: Fingertips, Public Health England  
 Year: 2012/13

# Detection

## The percentage of breast cancers detected at an early stage (1 or 2)

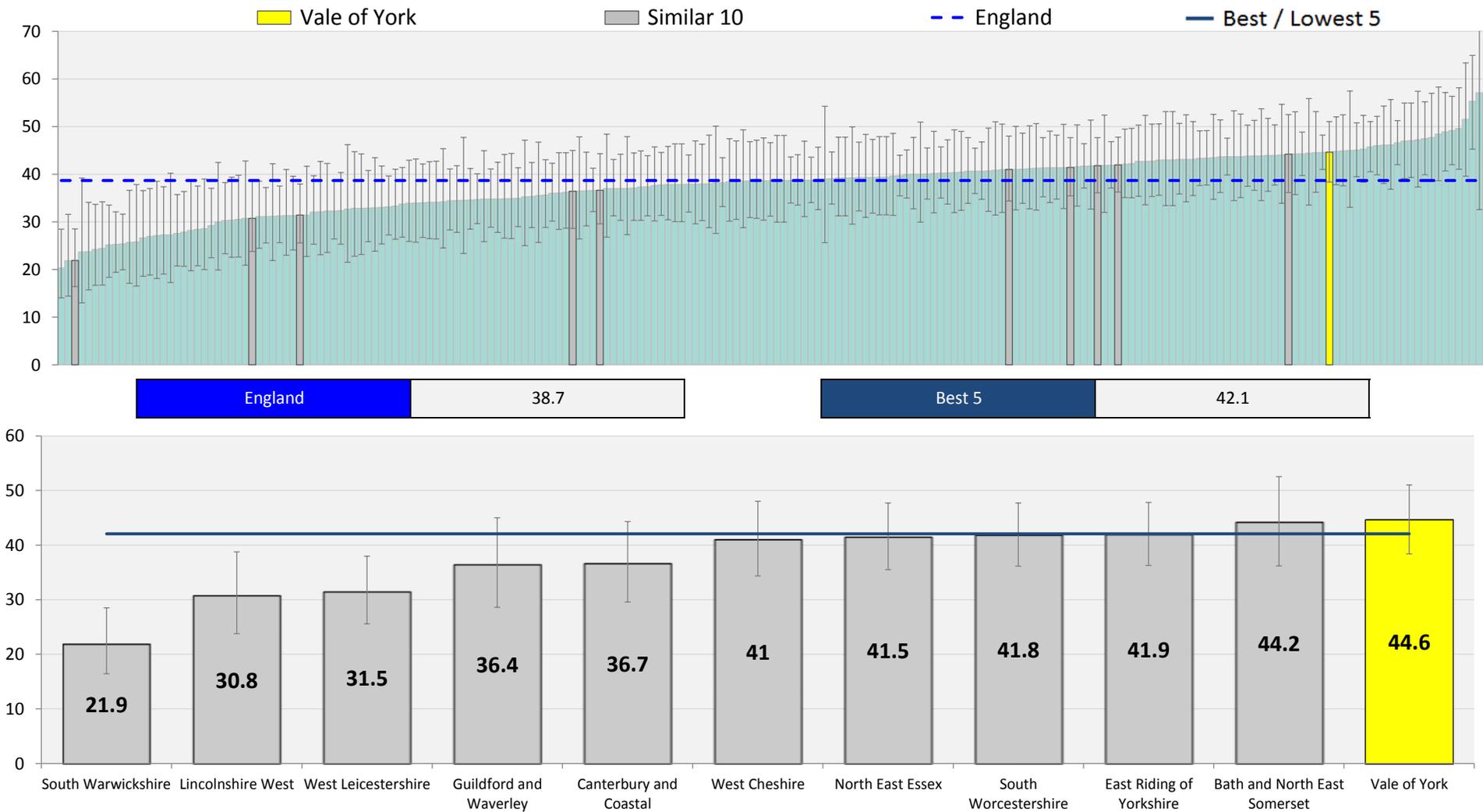


Definition: The percentage of breast cancers detected at an early stage (1 or 2)

Source: <https://www.cancerdata.nhs.uk/dashboard/breast.html#>

Year: 2014

## The percentage of colorectal cancers detected at an early stage (1 or 2)

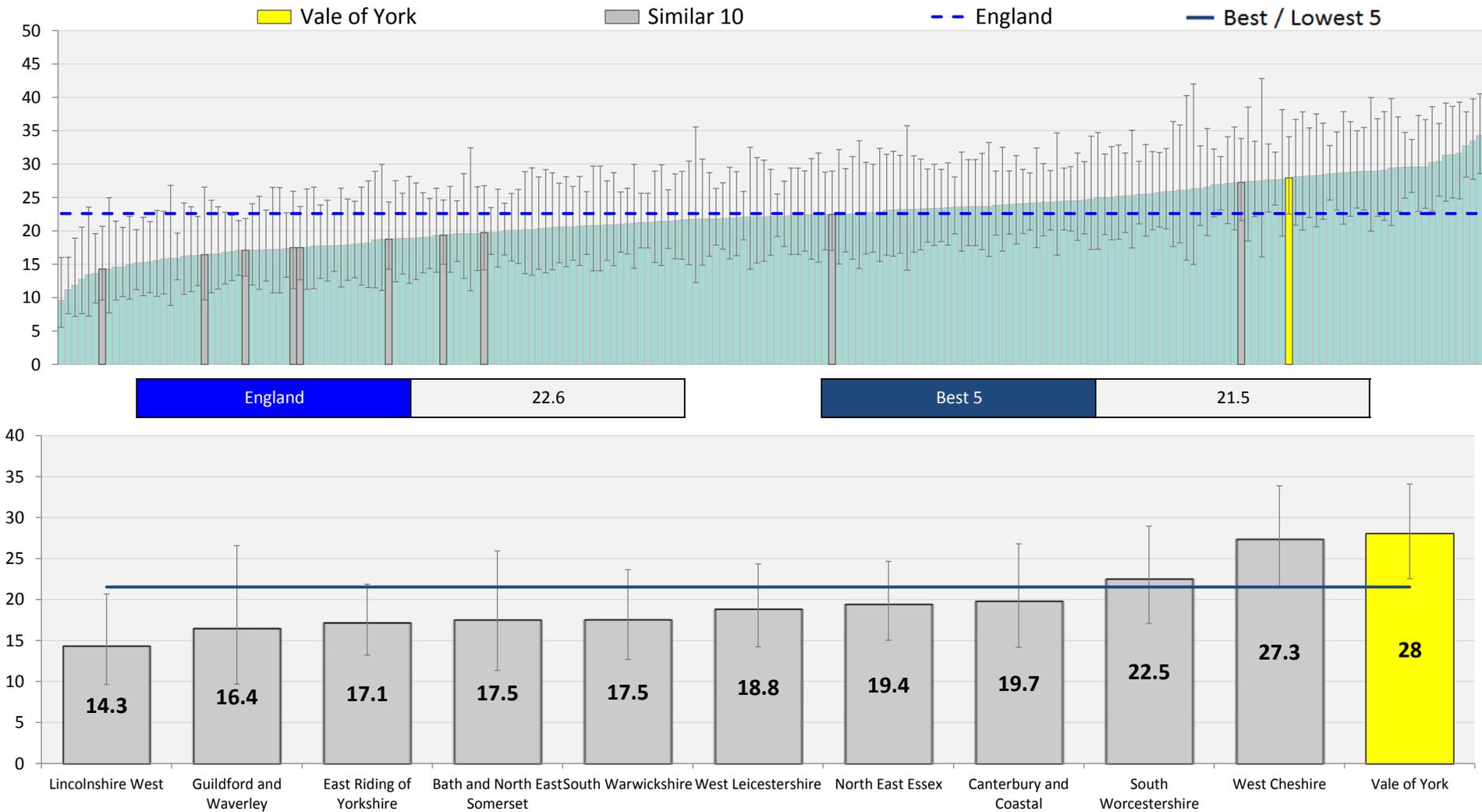


Definition: The percentage of colorectal cancers detected at an early stage (1 or 2)

Source: <https://www.cancerdata.nhs.uk/dashboard/colorectal.html#>

Year: 2014

## The percentage of lung cancers detected at an early stage (1 or 2)



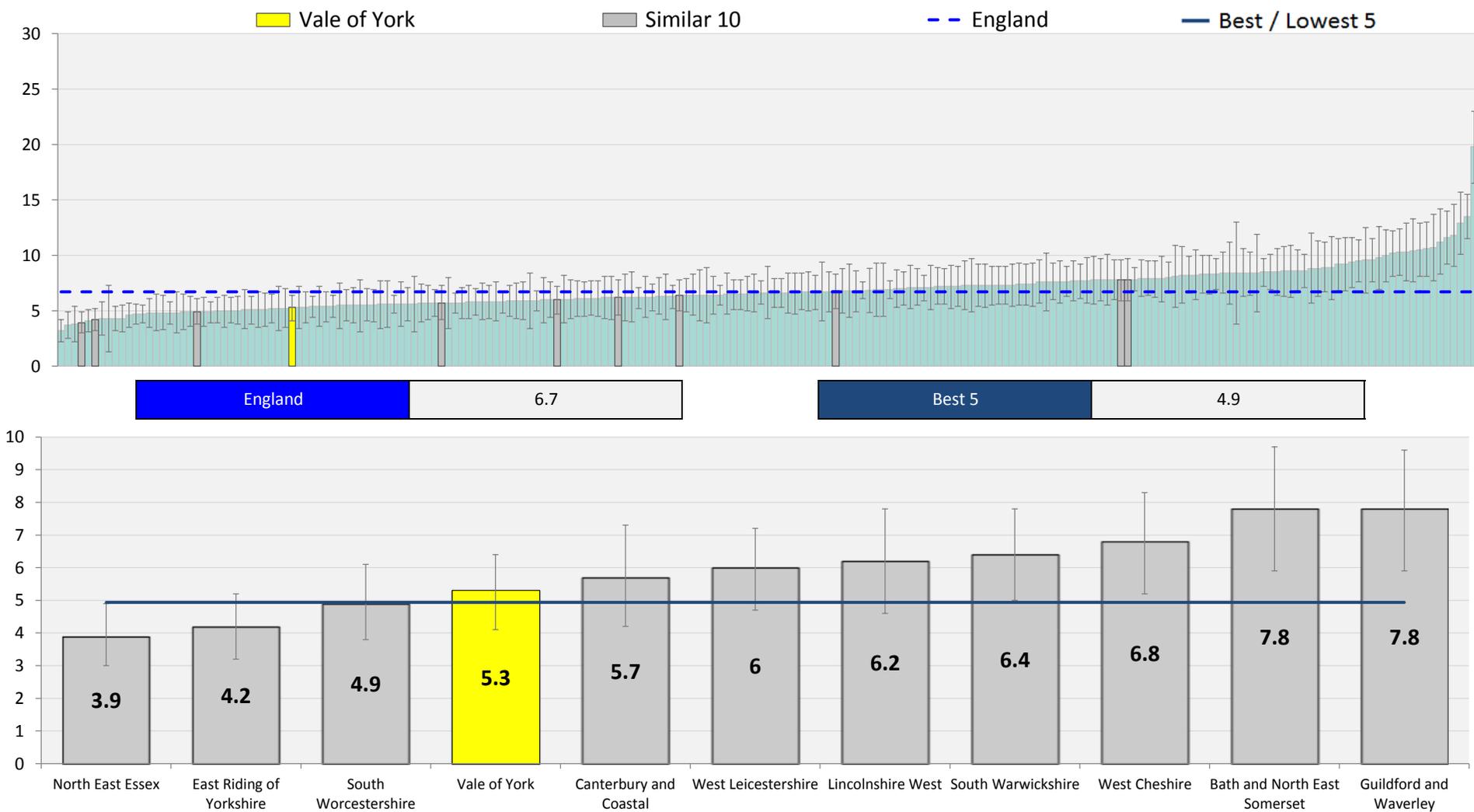
Definition: The percentage of lung cancers detected at an early stage (1 or 2)

Source: <https://www.cancerdata.nhs.uk/dashboard/lung.html#>

Year: 2014

# Routes to diagnosis - emergency presentations for breast cancer - DSR per 100,000 population

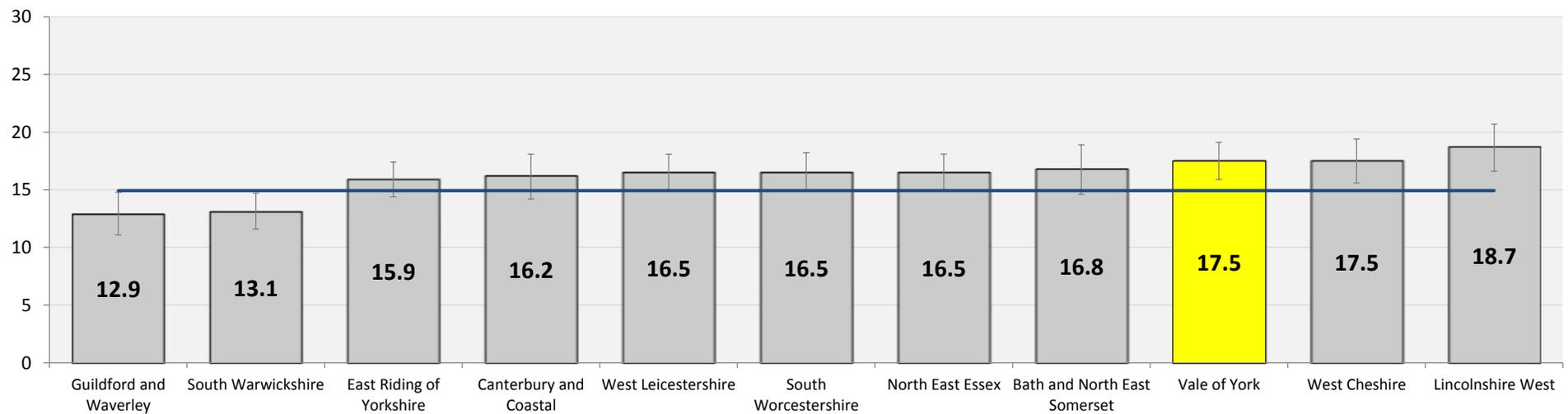
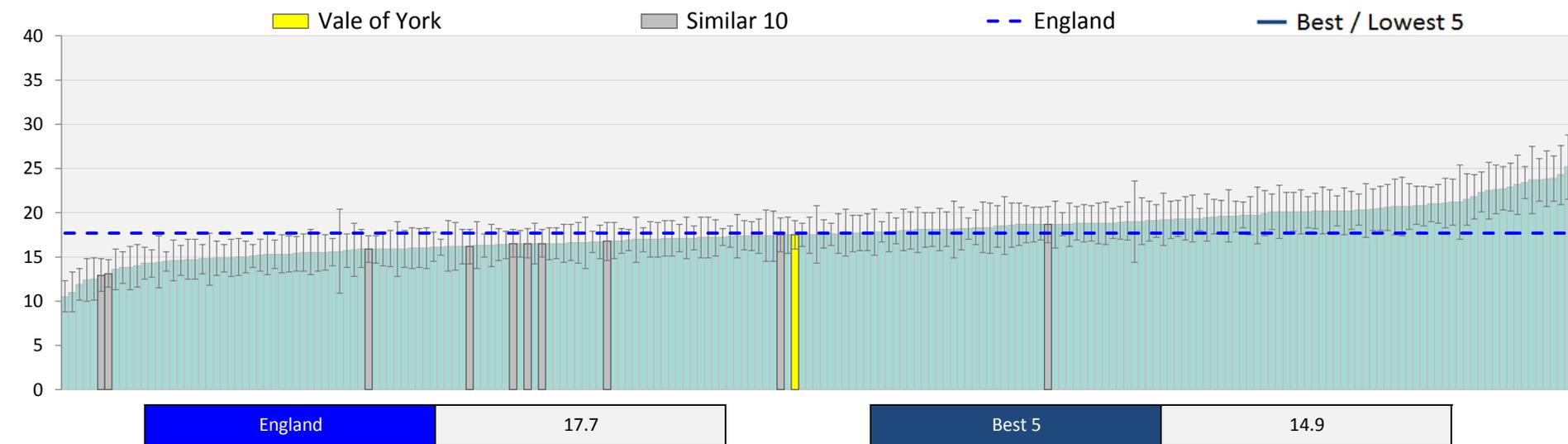
**N/A**



Definition: Routes to diagnosis - emergency presentations for breast cancer - DSR per 100,000 population  
 Source: Hospital Episode Statistics (HES), The National Cancer Intelligence Network  
 Year: 2006-2013

# Routes to diagnosis - emergency presentations for colorectal cancer - DSR per 100,000 population

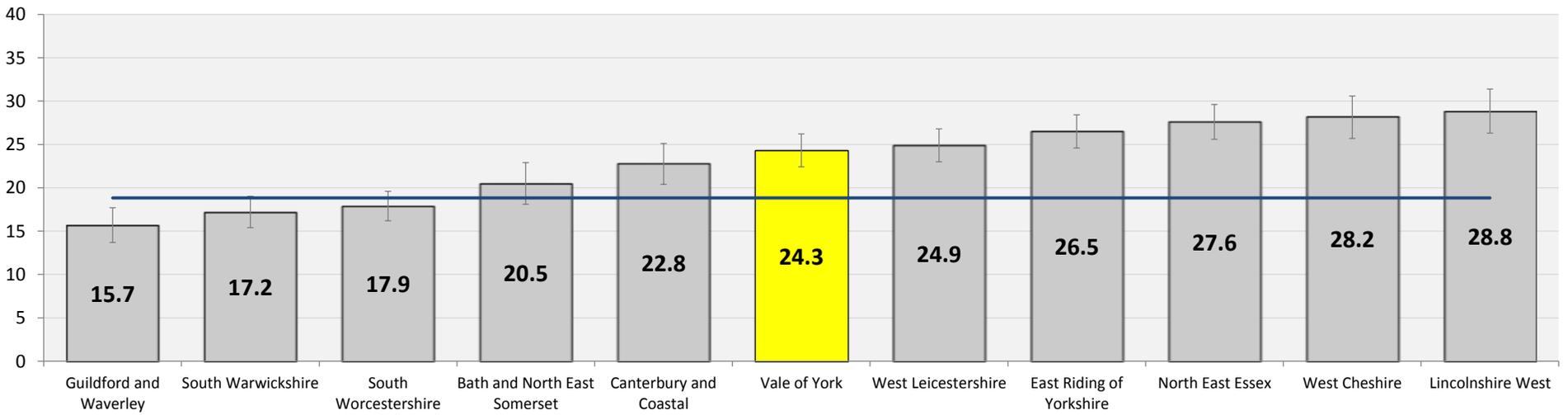
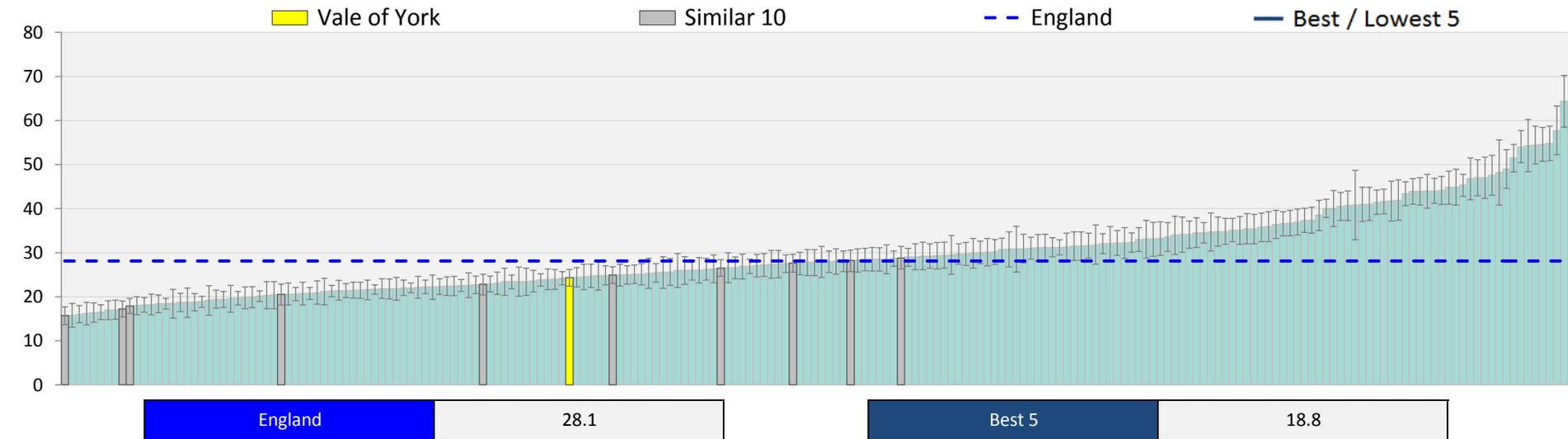
N/A



Definition: Routes to diagnosis - emergency presentations for colorectal cancer - DSR per 100,000 population  
 Source: Hospital Episode Statistics (HES), The National Cancer Intelligence Network  
 Year: 2006-2013

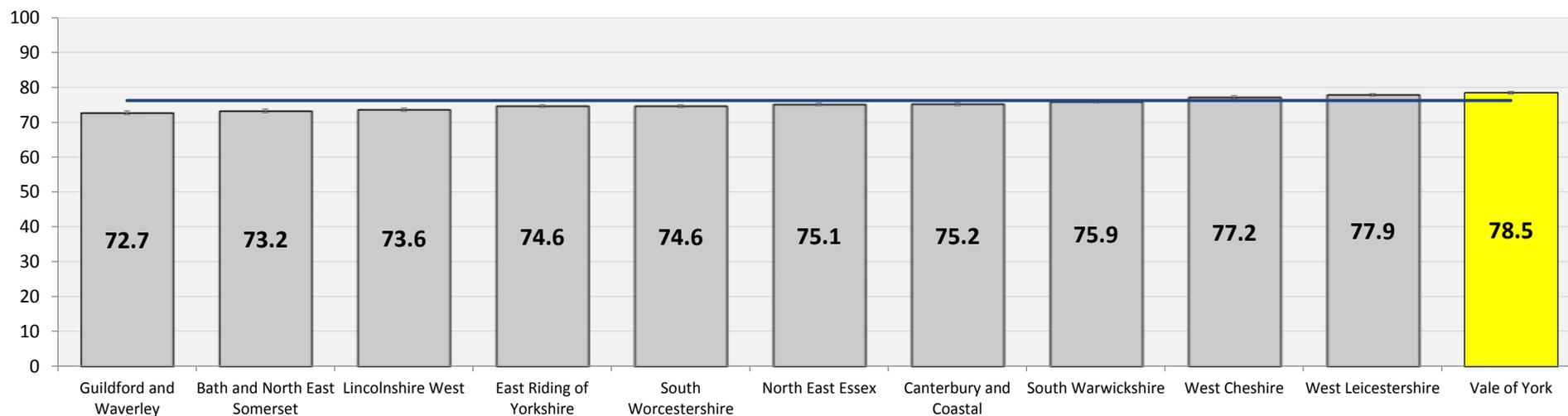
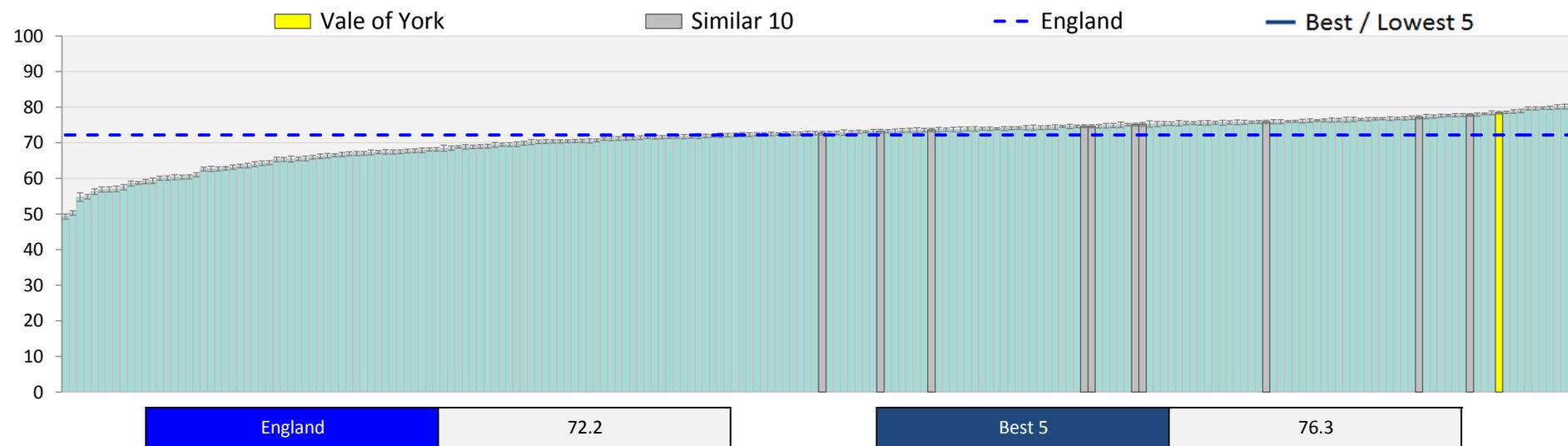
# Routes to diagnosis - emergency presentations for lung cancer - DSR per 100,000 population

**N/A**



Definition: Routes to diagnosis - emergency presentations for lung cancer - DSR per 100,000 population  
 Source: Hospital Episode Statistics (HES), The National Cancer Intelligence Network  
 Year: 2006-2013

## The percentage of women aged 50 - 70 who were screened for breast cancer in last three years

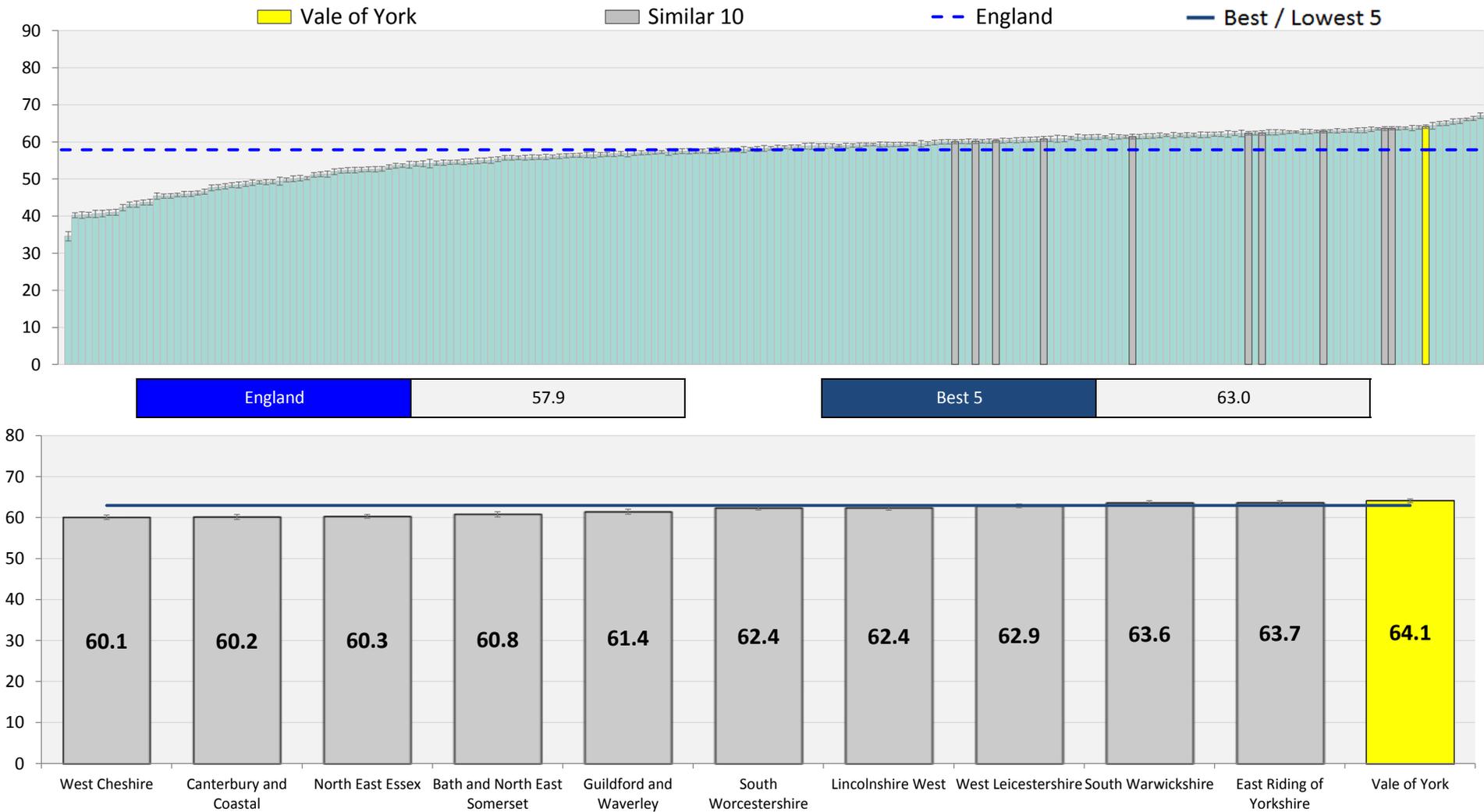


Definition: The percentage of women aged 50 - 70 who were screened for breast cancer in last three years

Source: <https://www.cancerdata.nhs.uk/dashboard/breast.html#>

Year: 2014/15

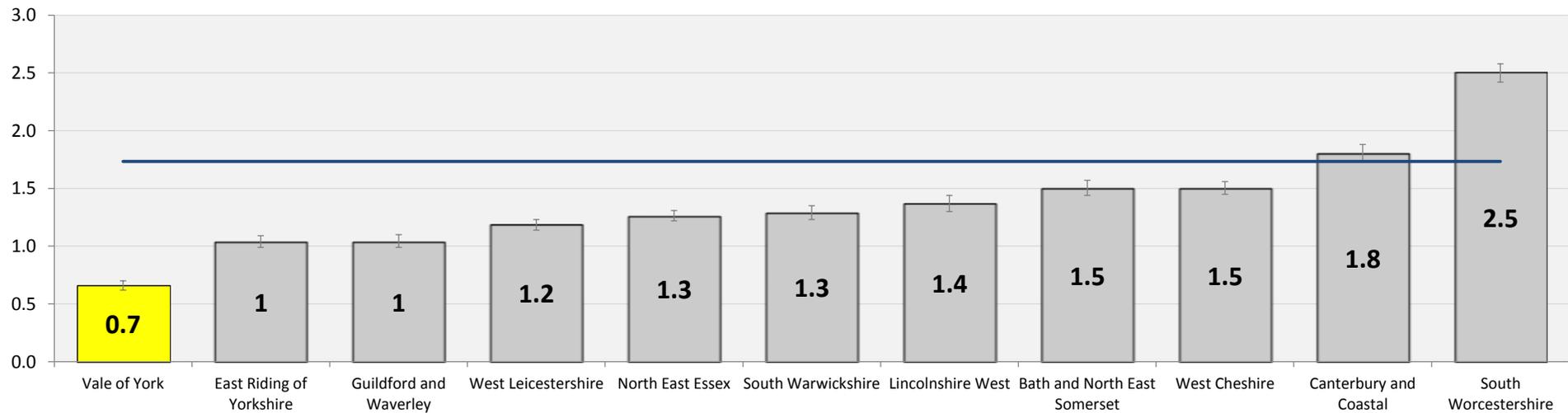
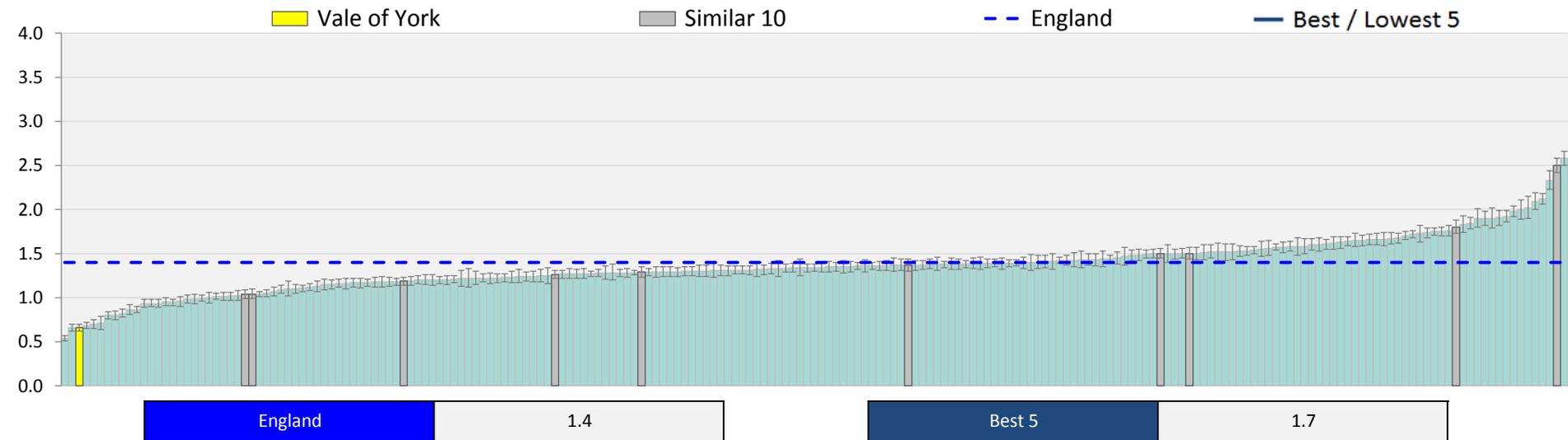
# The percentage of people aged 60-69 who were screened for bowel cancer in the previous 30 months



Definition: The percentage of people aged 60-69 who were screened for bowel cancer in the previous 30 months  
 Source: <https://www.cancertoolkit.co.uk>  
 Year: 2014/15

# Access to IAPT services: People entering IAPT as % of those estimated to have anxiety/depression (6 months)

2014 Ppl.



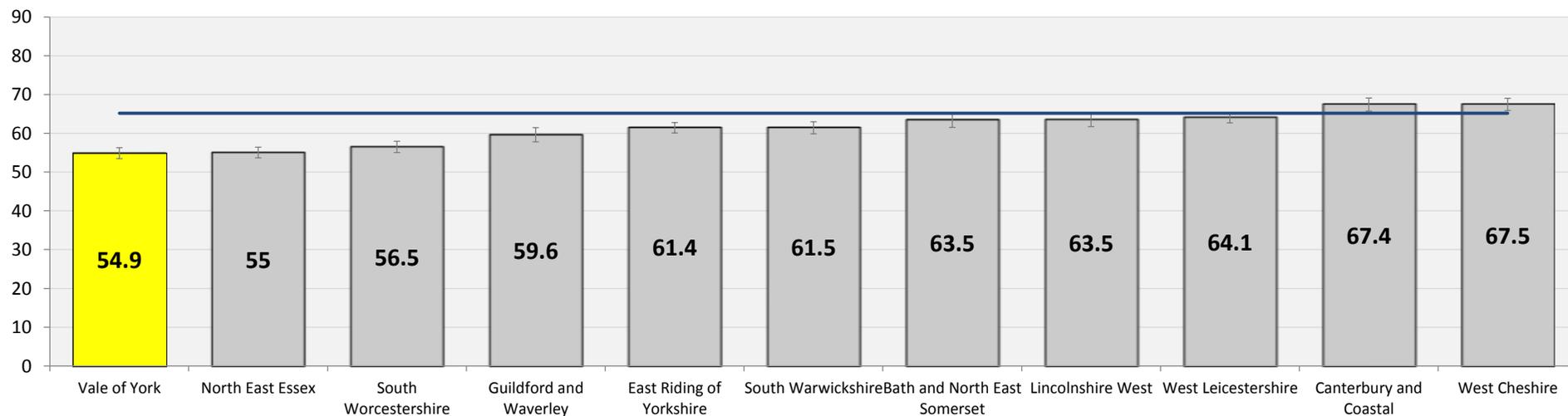
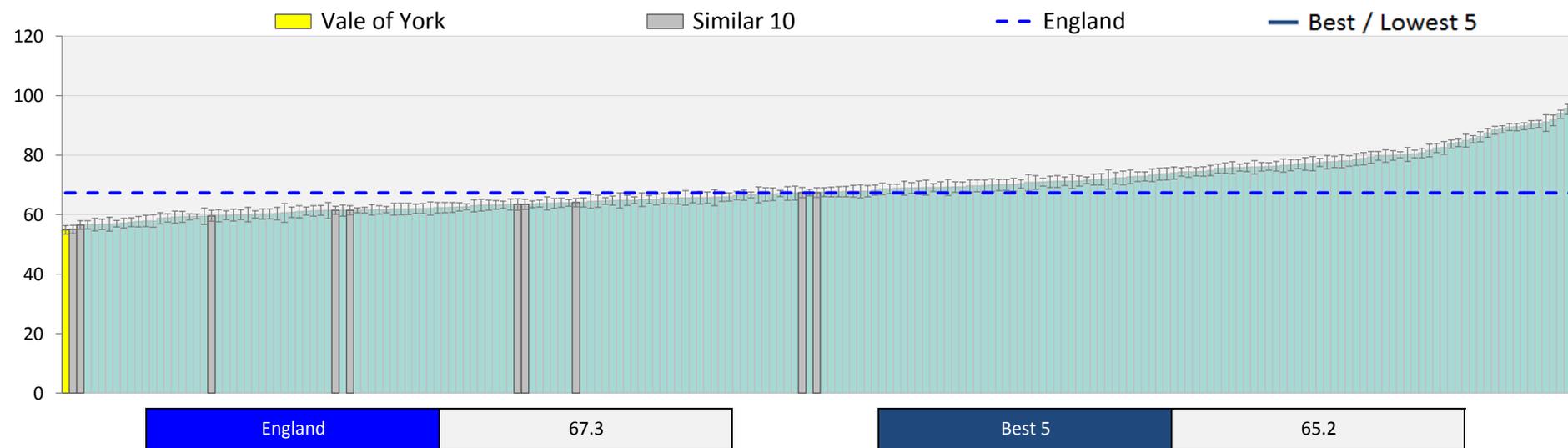
Definition: Access to IAPT services: People entering IAPT as % of those estimated to have anxiety/depression (6 months)

Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PH

Year: Oct-Mar 2016

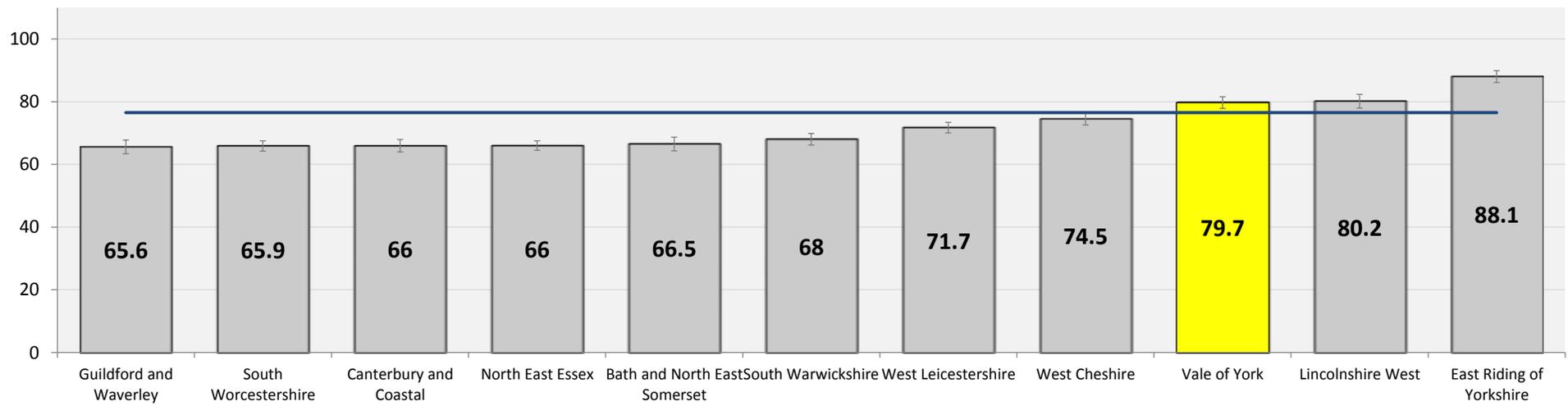
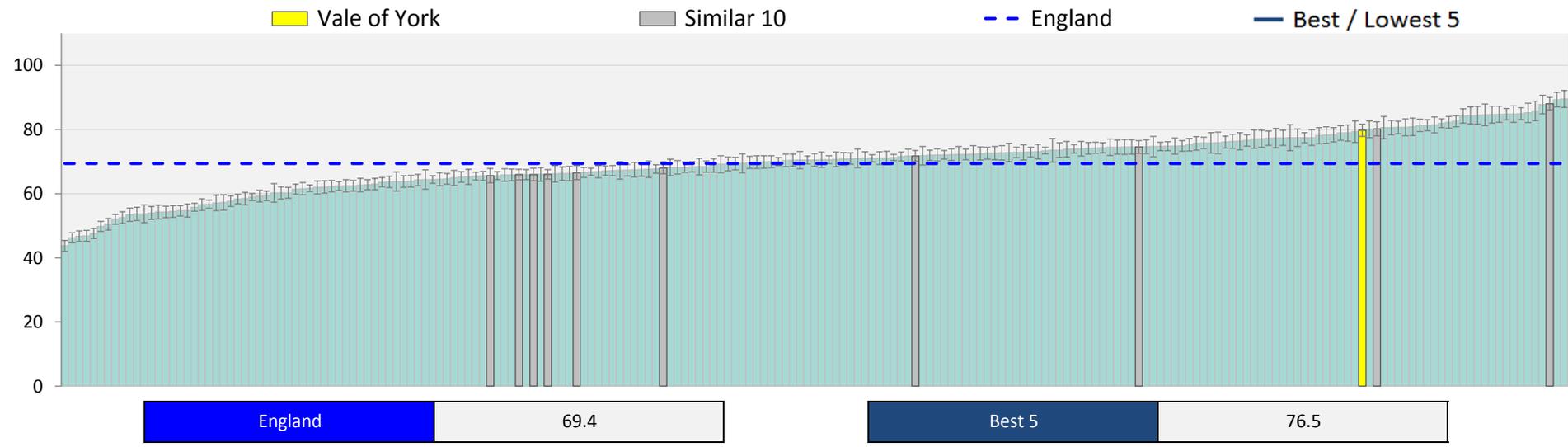
# Dementia diagnosis rate: Reported to Estimated prevalence (%) (65+)

468 Ppl.



Definition: Dementia diagnosis rate: Reported to Estimated prevalence (%) (65+)  
 Source: NHS Digital, Dementia diagnosis monthly workbook- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: Aug-16

## Reported to Estimated prevalence of CHD (%)



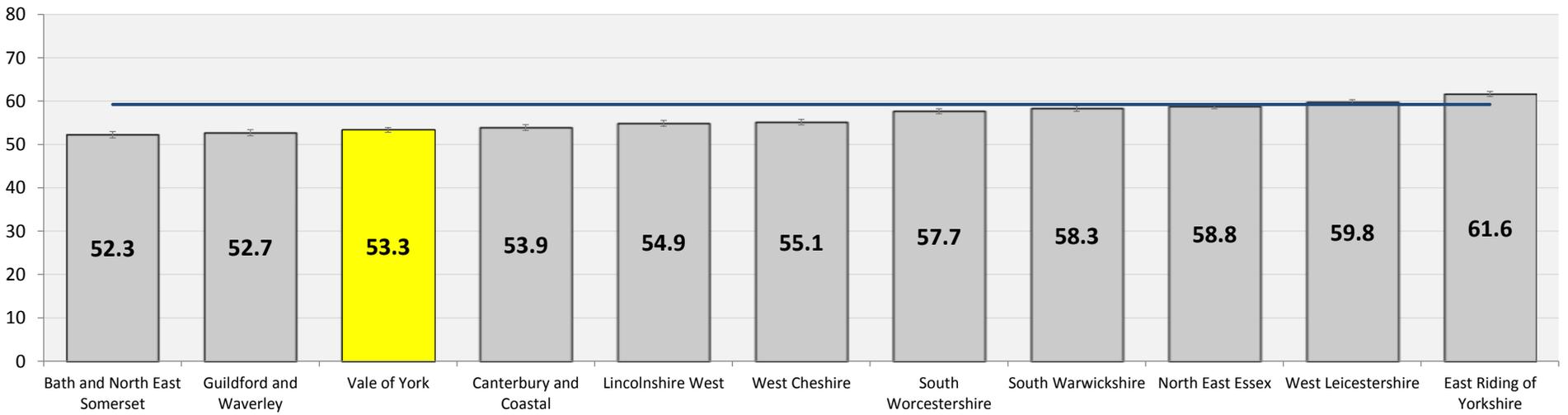
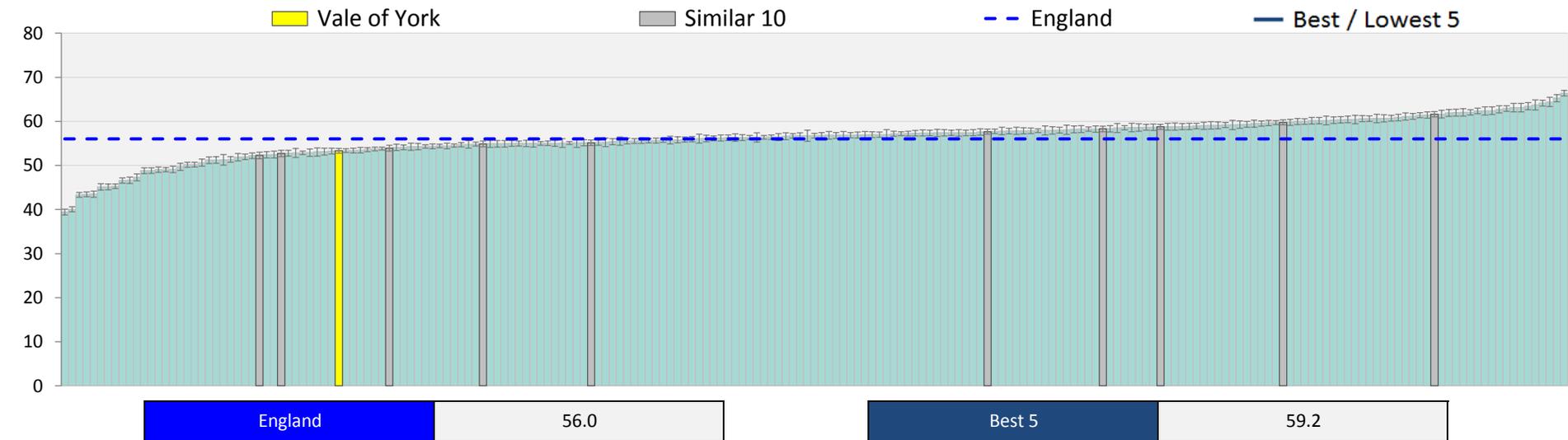
Definition: Reported to Estimated prevalence of CHD (%)

Source: QOF, [www.apho.org.uk/diseaseprevalencemodels](http://www.apho.org.uk/diseaseprevalencemodels)- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2015/16 (2011)

# Reported to Estimated prevalence of Hypertension (%)

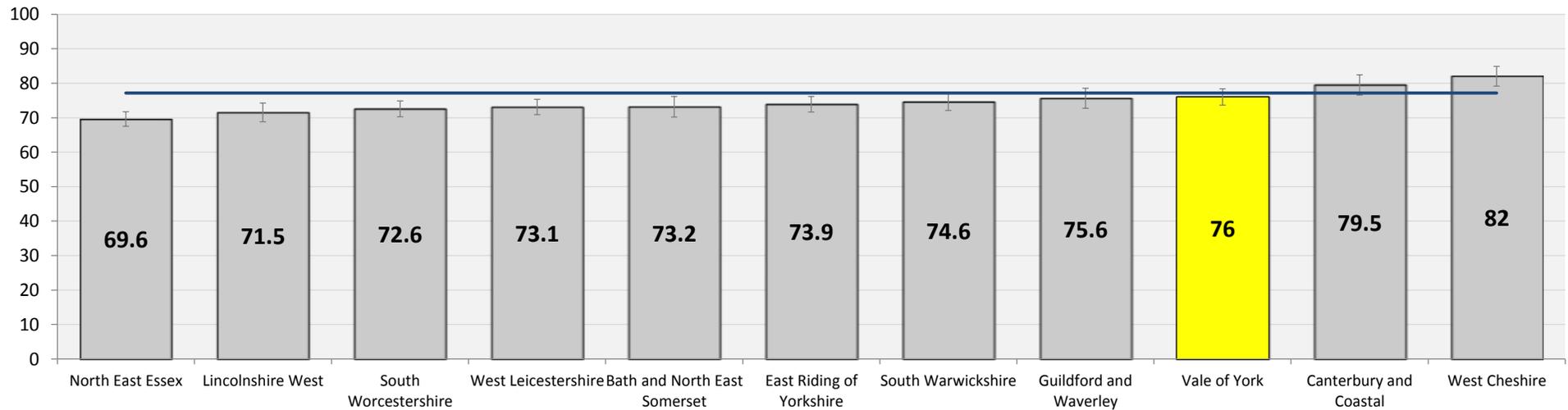
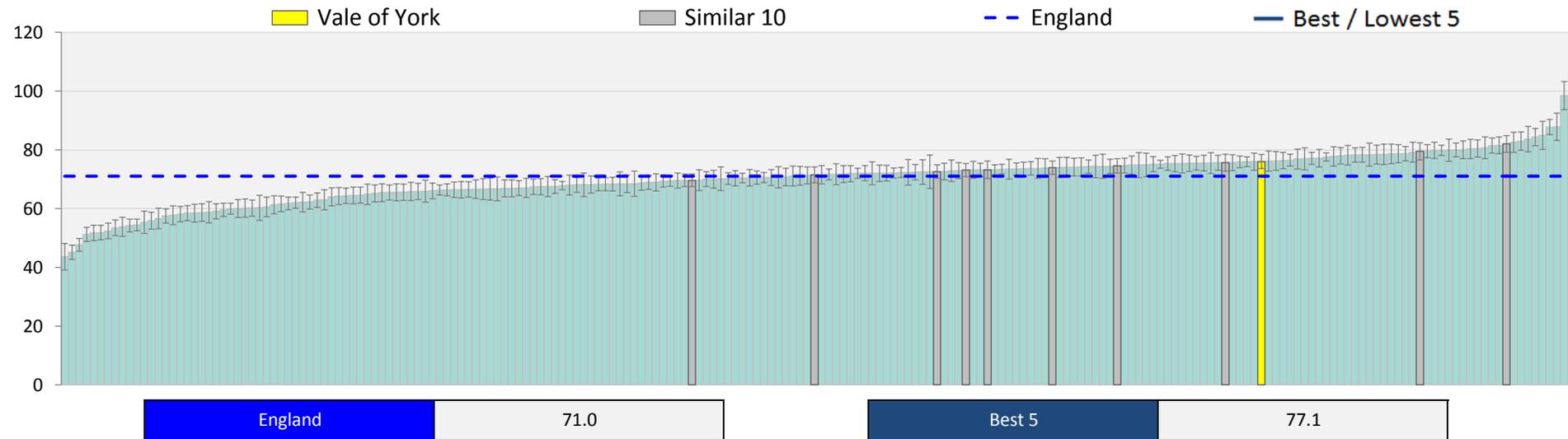
5142 Ppl.



Definition: Reported to Estimated prevalence of Hypertension (%)  
 Source: QOF, www.apho.org.uk/diseaseprevalencemodels- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: 2015/16 (2011)

# Reported to Estimated prevalence of Atrial Fibrillation

116 Ppl. (NSS)



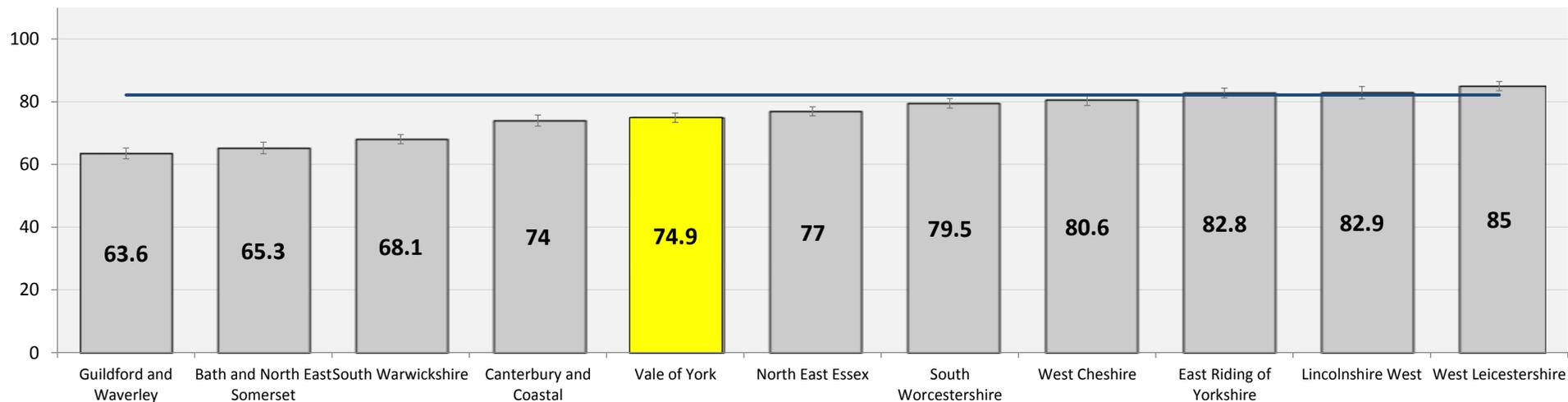
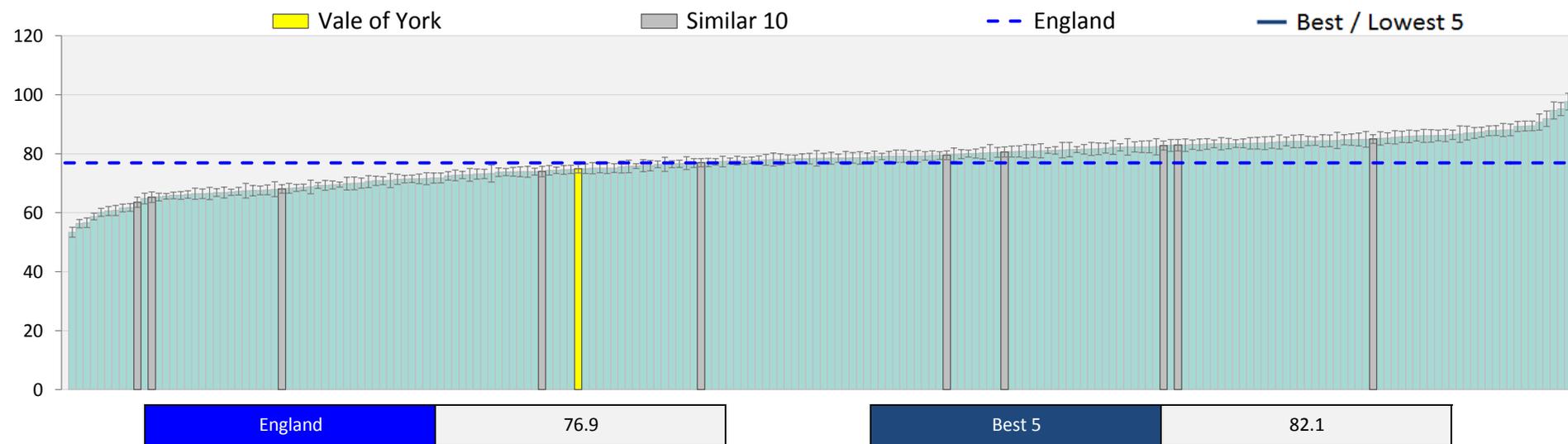
Definition: Reported to Estimated prevalence of Atrial Fibrillation

Source: QOF, [www.apho.org.uk/diseaseprevalencemodels](http://www.apho.org.uk/diseaseprevalencemodels)- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

Year: 2015/16 (2013/14)

# Diabetes: Observed prevalence compared to Estimated prevalence in adults (%)

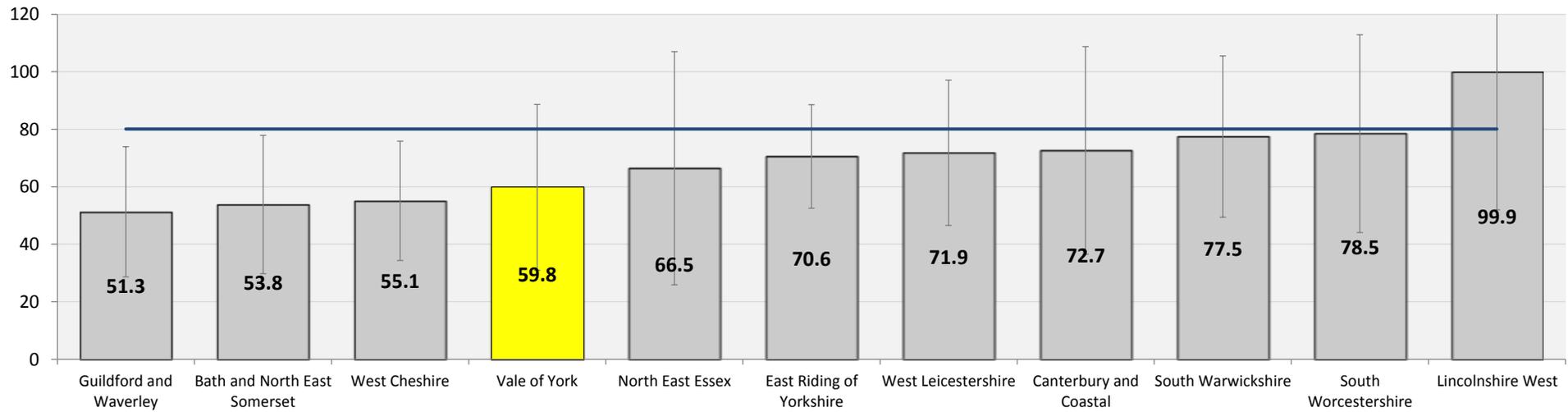
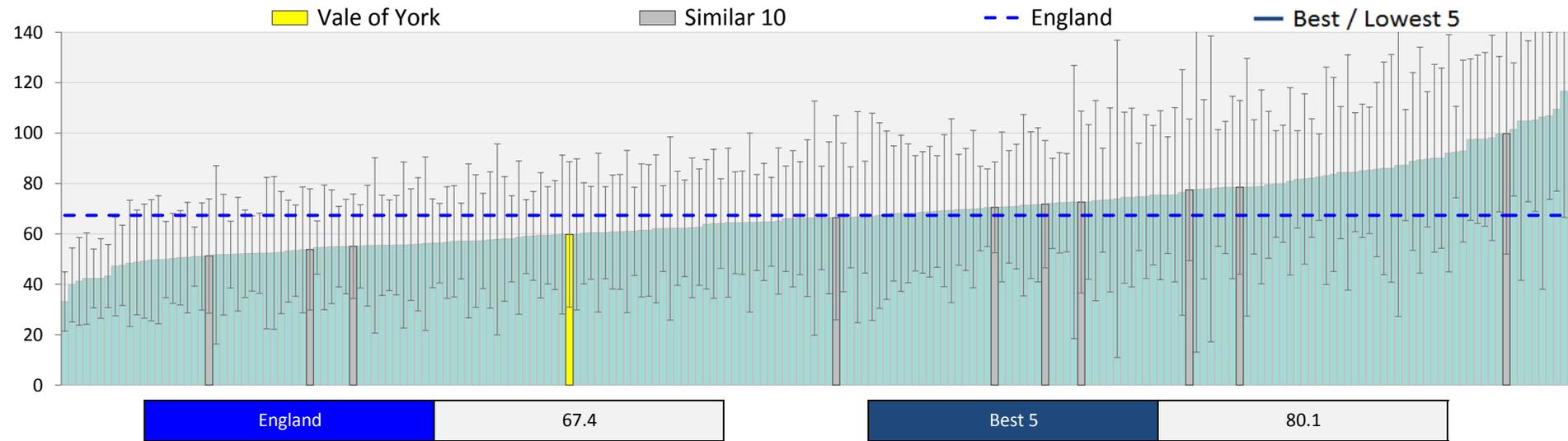
1539 Ppl.



Definition: Diabetes: Observed prevalence compared to Estimated prevalence in adults (%)  
 Source: Fingertips, Public Health England- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017  
 Year: 2015/16 (2014/15)

# Reported to Estimated prevalence of CKD (%)

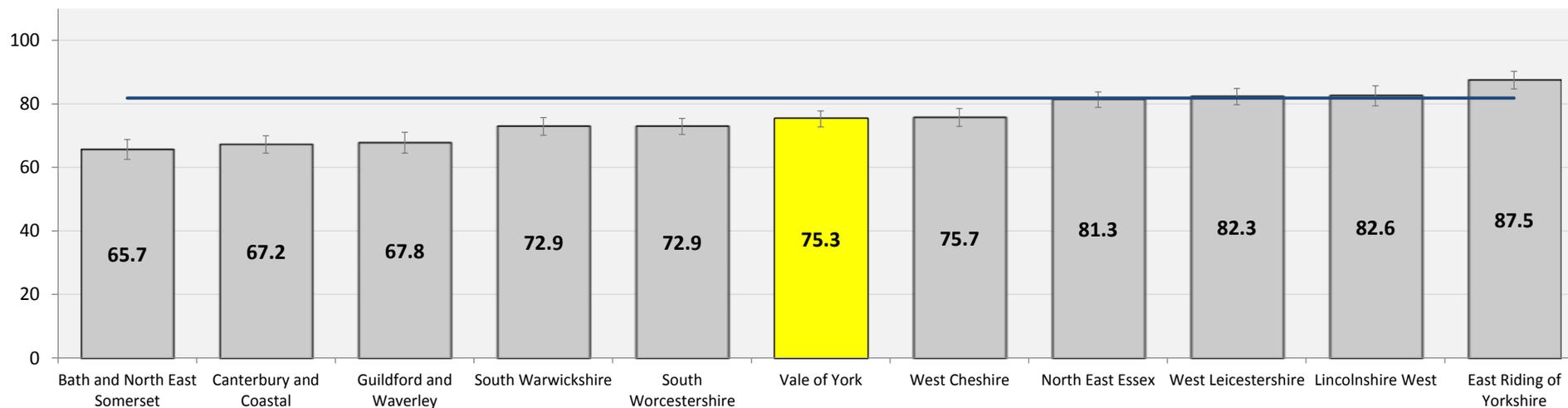
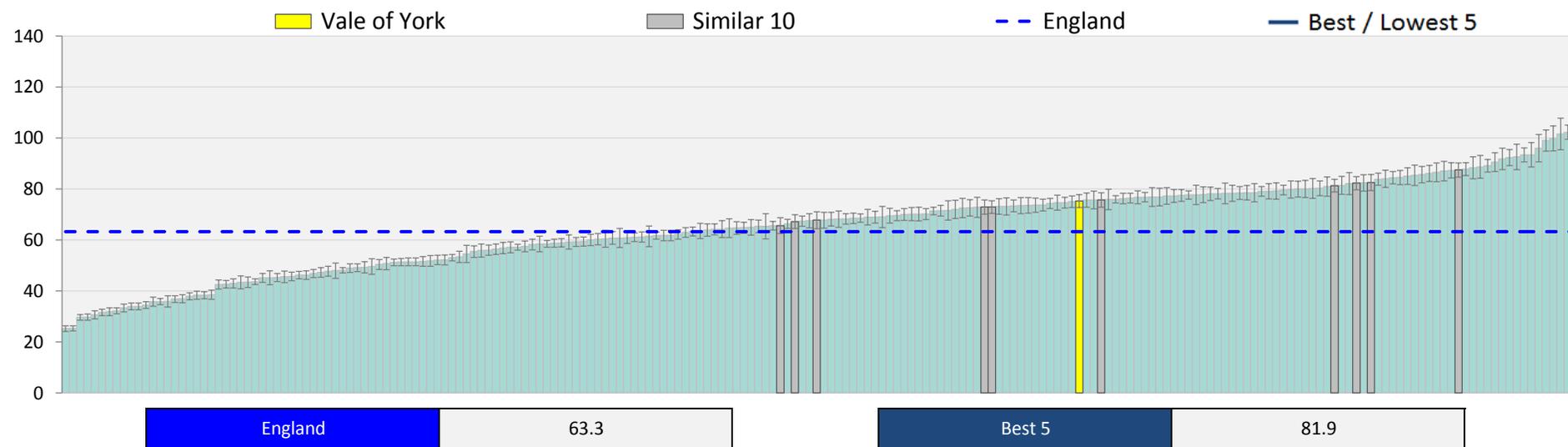
3668 Ppl. (NSS)



Definition: Reported to Estimated prevalence of CKD (%)  
 Source: QOF, NHS Digital  
 Year: 2015/16 (2012/13)

## Reported to Estimated prevalence of COPD (%)

534 Ppl.

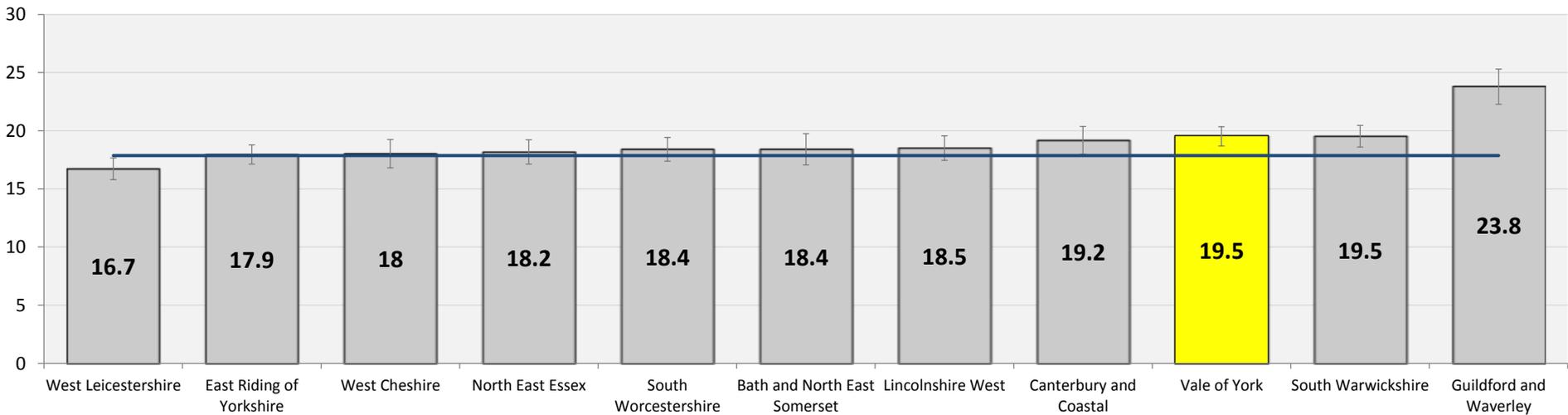
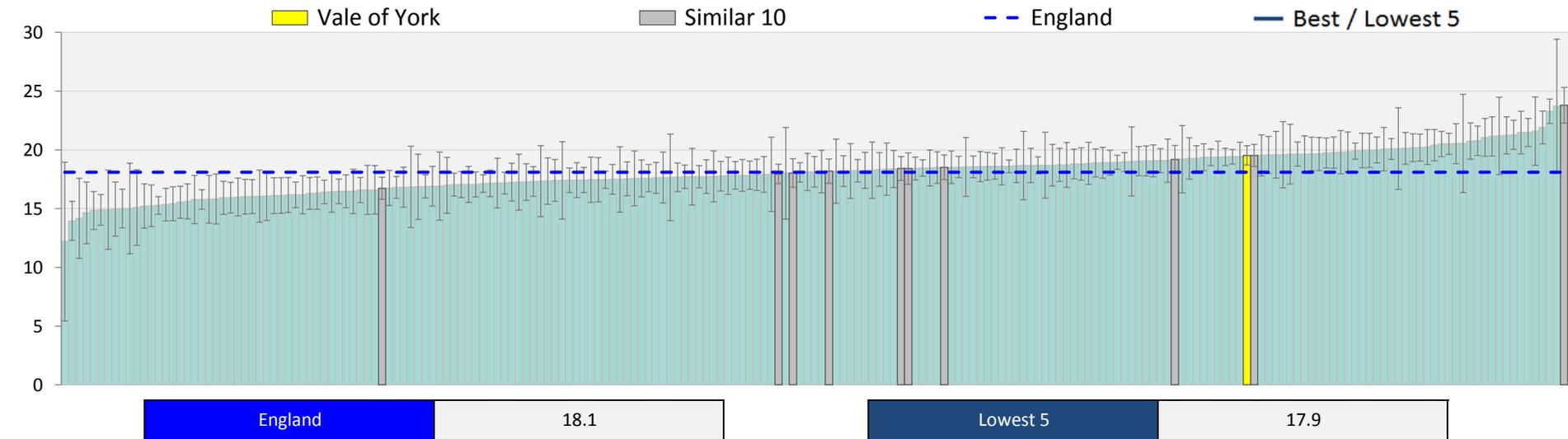


Definition: Reported to Estimated prevalence of COPD (%)

Source: <http://www.NHS Digital.gov.uk/catalogue/PUB18887>, <http://www.erpho.org.uk/inhale.aspx>- CIs were calculated by the RightCare team and are underestimates. PHE will provide CIs in 2017

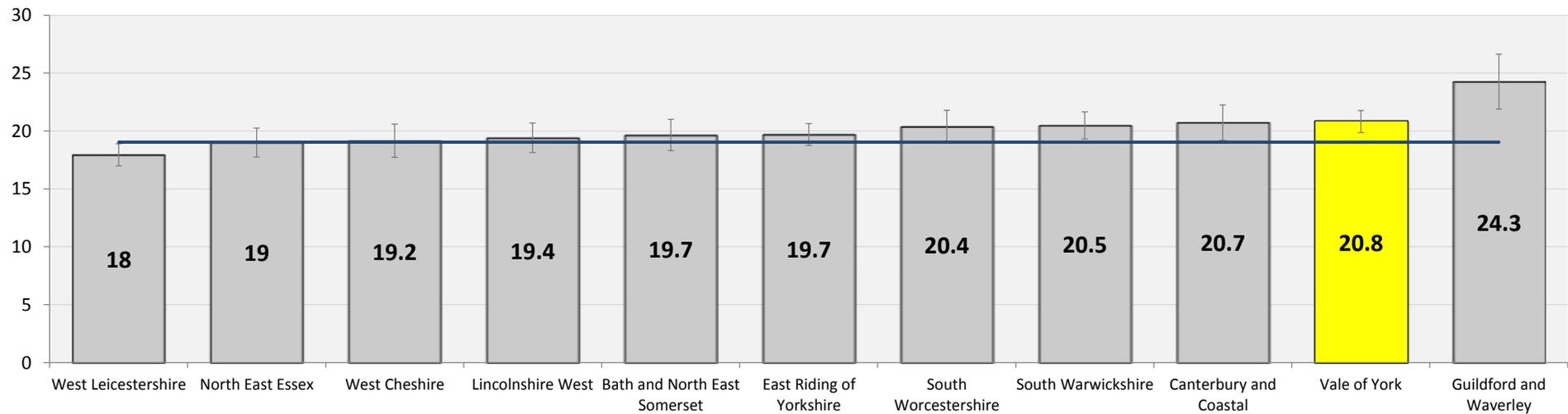
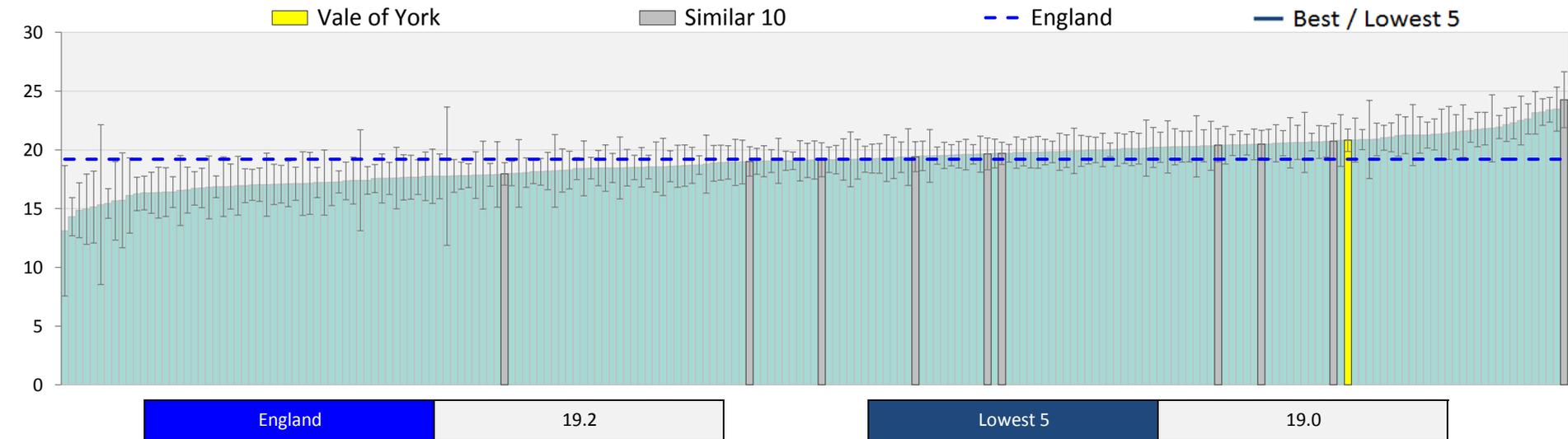
Year: 2015/16 (2011)

# Pre-op, Oxford Score, Hip



Definition: Pre-op, Oxford Score, Hip  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16

# Pre-op, Oxford Score, Knee

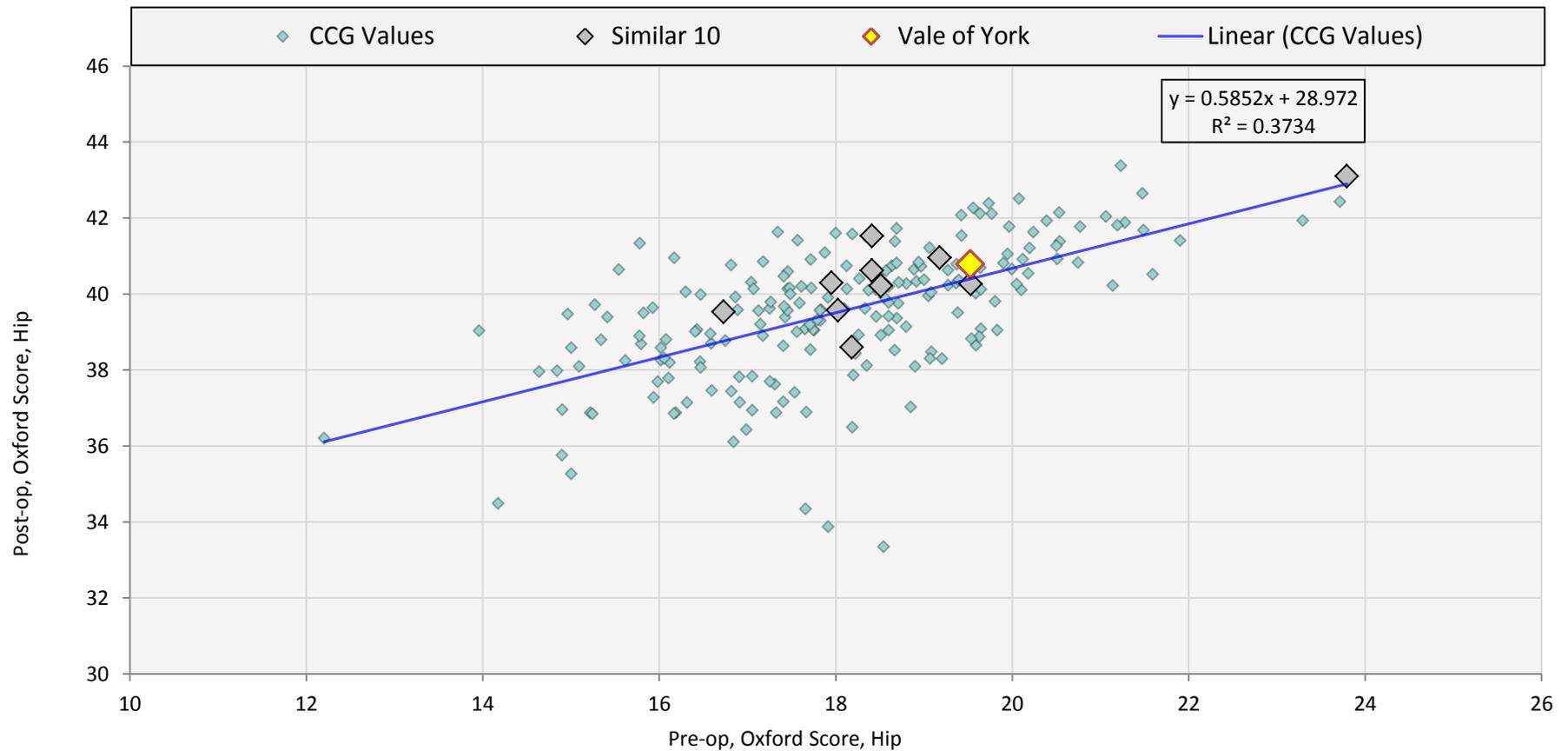


Definition: Pre-op, Oxford Score, Knee  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16

# Detection scatter plot

The Commissioning for Value Explorer Tool allows the comparison of two indicators, the diagram below is an example. This is an invaluable tool to enable users to assess how one indicator relates to another. The similar 10 can be highlighted too. It is important to remember that correlations do not imply causation but the relationships can help target where to look. The explorer tool is available here:

<http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>



# Detection case study: Diabetes in Slough

## The background

The prevalence of type 2 diabetes in the UK is rising due to increasing levels of obesity and an aging population. 80% of the costs of treating type 2 diabetes are spent on avoidable complications including heart attack, stroke, renal disease, blindness and amputations.

In 2013 the prevalence of diagnosed cases of type 2 diabetes was approximately 6%, however in Slough it was 8% - corresponding to over 8,600 people. In addition there was estimated to be around 1,400 more people with undiagnosed diabetes.

Type 2 diabetes is significantly more common in people of South Asian and Afro-Caribbean descent. Slough's population includes 40% of South Asian and 9% of Afro-Caribbean descent.

## The research

A designated leadership team began with the NHS RightCare 'where to look' stage – comparing national data, similar 10 CCGs and the Thames Valley strategic clinical network. This showed potential opportunities to improve the quality of care and value for money.

Local intelligence then suggested that there was a significant gap in services for the South Asian population, plus a wide variation in prevalence and measurement of diabetes patients between practices.

Continued on the next page...

# Detection case study: Diabetes in Slough

## The approach

Two main areas of action were taken:

- Direct, culturally sensitive engagement with the South Asian population who either had type 2 diabetes or risk factors for developing it. A lifestyle intervention programme delivered interactive group education sessions over 7 weeks
- A programme of education to upskill the healthcare professionals in the GP practices in Slough through a clinical mentorship programme

## Outcomes and learning

- Patients in each of the practices now have a key contact for advice on managing their diabetes
- There are clear pathways for patients and primary care health professionals
- Patient participation groups have been set up to provide support and encourage self-management
- Demonstrable improvement in the detection and control of diabetes across Slough

The learning from the project also included a focus on CCG leadership and engagement of all stakeholders in the local health economy / system of care.

## More information

For more information about this case study please visit [https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/09/Casebook\\_Slough-CCG\\_Diabetes-Care.pdf](https://www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/09/Casebook_Slough-CCG_Diabetes-Care.pdf)

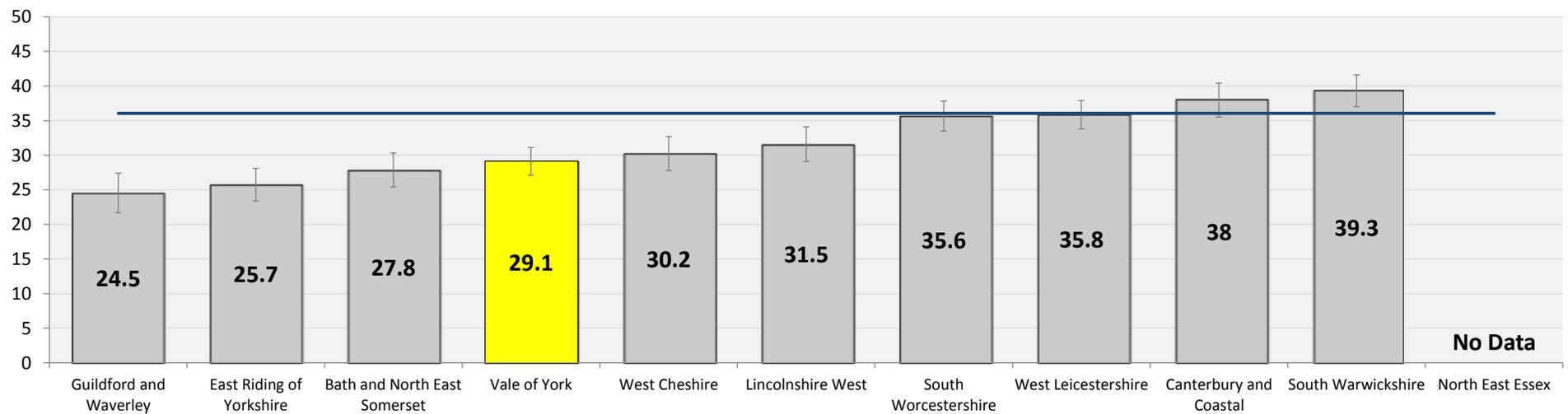
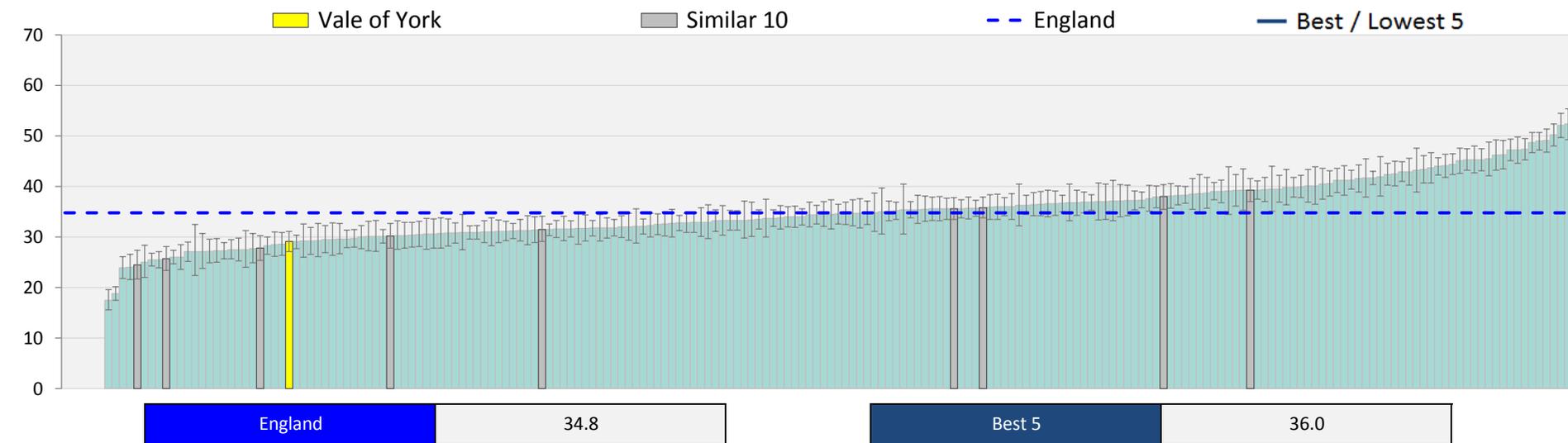
# Primary Care Management

Please note the indicators in this section cover multiple conditions. A more comprehensive set of indicators covering primary care management is included in the focus packs:

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

# Physical health checks for patients with SMI: Summary score (average of the 6 physical health check indicators)

**141 Pats.**



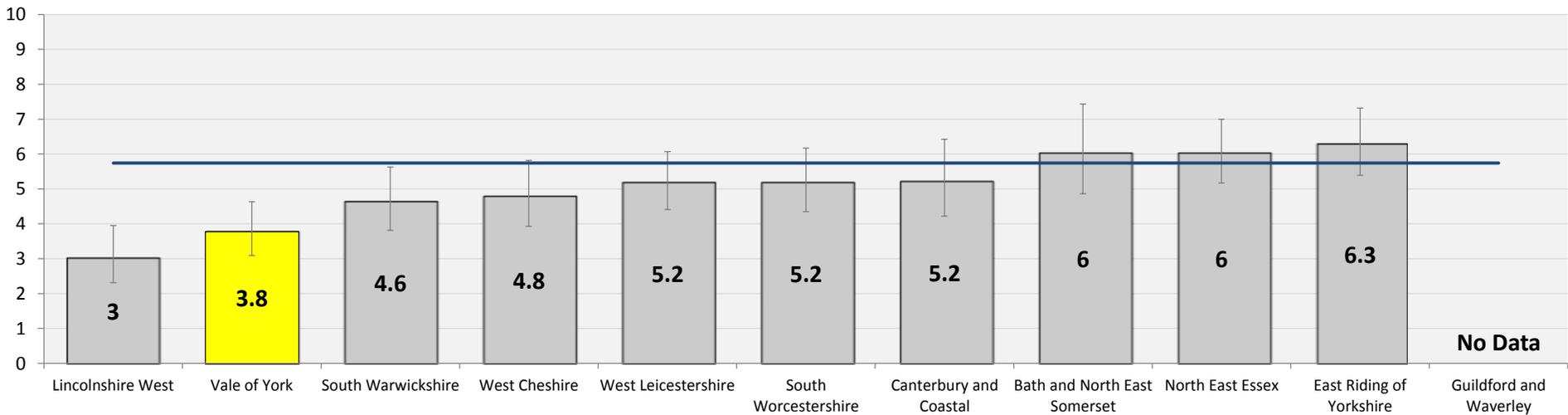
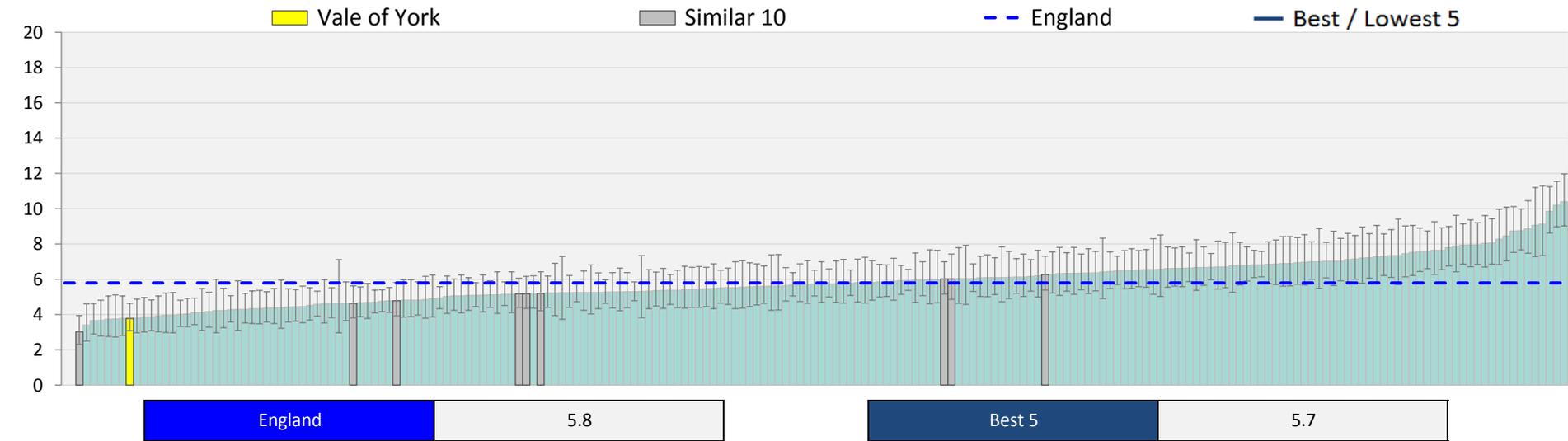
Definition: Physical health checks for patients with SMI: Summary score (average of the 6 physical health check indicators)

Source: CCG OIS, NHS Digital.

Year: 2014/15

# The percentage of patients with a long term condition who have a written care plan

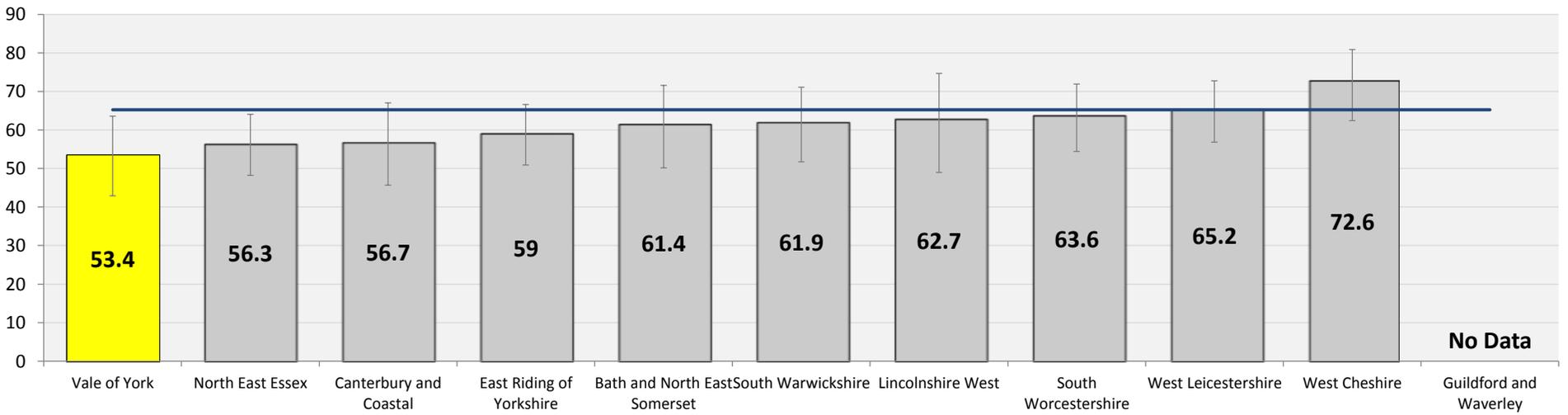
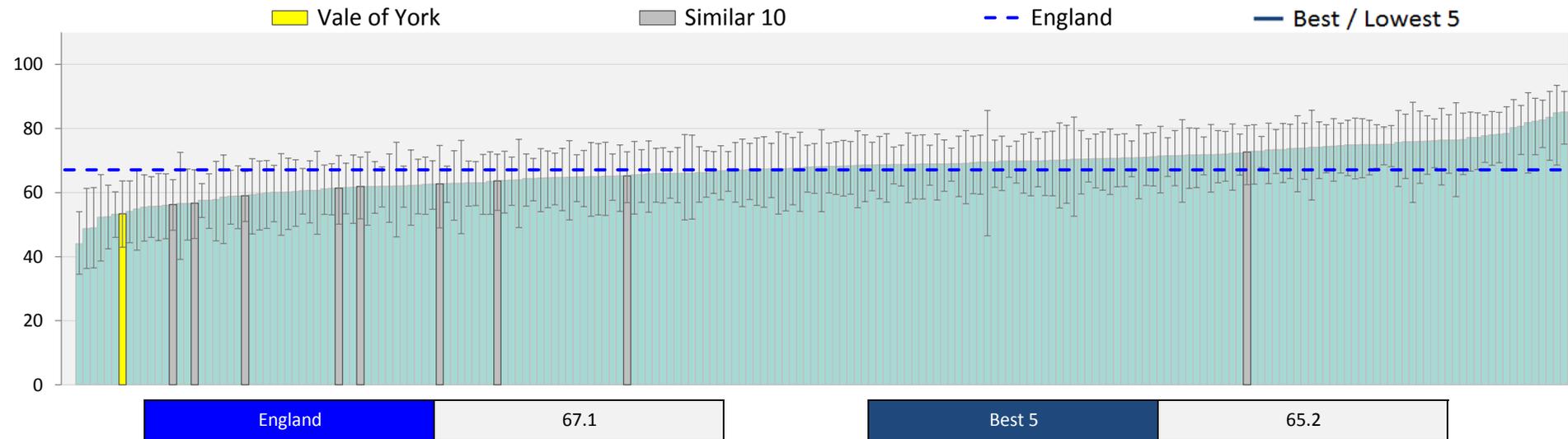
**N/A**



Definition: The percentage of patients with a long term condition who have a written care plan  
 Source: General Practice Patient Survey (GPPS)  
 Year: 2015/16

# The percentage of patients with a long term condition who use their written care plan

**N/A**



Definition: The percentage of patients with a long term condition who use their written care plan  
 Source: General Practice Patient Survey (GPPS)  
 Year: 2015/16

# Primary care case study: STarT back care and fracture liaison service in Sussex

## STarT Back Tool

The STarT Back Tool is a simple prognostic questionnaire that helps clinicians identify modifiable risk factors (biomedical, psychological and social) for back pain disability. The tool is being trialled in two GP practices in Brighton, embedded in electronic patient records it uses read codes to trigger the launch of the questionnaire. The score is automatically calculated and populates a letter, stratifying the patient into a low, medium or high risk category. This letter is then sent to the relevant service. The tool has been shown to support more effective referrals and reduce GP consultations.

## Fracture Liaison Service

Sussex MSK Partnership works closely with primary care to provide care closer to home using shared care protocols to safely monitor Disease Modifying agents used to treat inflammatory arthritis. There is also a nurse-led primary care fracture liaison service in Crawley. The main objective of the Fracture Liaison Service (FLS) is to ensure that patients at highest risk of future fracture are identified and that they receive appropriate evaluation and treatment, based on national guidelines of care. FLS case finds patients and accepts referrals for high risk patients. A consultation aims to assess fracture risk, provide information and support regarding lifestyle, falls risk, and initiate treatment where needed. Follow up at 3 and 12 months is provided for patients on osteoporosis medications. A large percentage of high risk patients are elderly with reduced mobility. Crawley FLS provides care close to home with monthly clinics at each GP locality.

## More information

For more information please visit: <http://www.sussexmskpartnershipcentral.co.uk>

## Primary care case study: Recognition of early inflammatory arthritis in Oldham

Local GP referral times in Oldham are shorter than the national average. In the second year of the National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis, 40% of patients were referred within three days of presentation to their GP, compared with 20% nationally. This had improved from 30% in the first year of the audit following a series of GP education events (led by Pennine MSK Partnership working with the CCG) and local strategies to raise awareness of the importance of early referral to improve patient outcomes. Effective triage and workforce planning also ensures that the majority of patients are seen within three weeks of referral in accordance with NICE quality standards. The percentage of patients seen locally within three weeks of referral across the two years of the audit ranged between 72% and 58%, in comparison with 37% nationally.

Early access to specialist services means that 77% of patients were able to commence disease modifying drugs within six weeks of diagnosis compared with 68% nationally. Early access to combination treatment is crucial to improve pain, maintain function, aid work retention, and protect joints from irreversible damage in early disease. Higher numbers of specialist nurses have been shown to be associated with greater achievement of this quality standard and nurse-led clinics provide high quality cost-effective care and facilitate treating to target within the context of shared decision making.

### More information

For more information about this case study please contact: [alan.nye@nhs.net](mailto:alan.nye@nhs.net)

# Primary Care: Resources

## Improving outcomes and value in musculoskeletal conditions

Early diagnosis and treatment of group 1 (inflammatory) conditions e.g. rheumatoid arthritis:

- In the UK over 400,000 people have rheumatoid arthritis. It strikes at any age, needing lifelong specialist treatment
- Severe painful, disabling joint inflammation and damage; 40% are not working within five years of onset
- Biologic drugs cost £7-10k annually if conventional therapy (£500/year) ineffective
- Urgent diagnosis and intensive treatment improves outcomes, and reduced need for biologic drugs
- Minority of patients receive national care standard: GP to specialist review three weeks; treatment within six weeks
- Dedicated Early Arthritis Clinics improve quality of care and reduce costs

Arthritis Research UK: Data and statistics

<http://www.arthritisresearchuk.org/arthritis-information/data-and-statistics.aspx>

National Audit Office: Services for people with rheumatoid arthritis

<https://www.nao.org.uk/report/services-for-people-with-rheumatoid-arthritis/>

HQIP Rheumatoid and Early Inflammatory Arthritis 2nd Annual Report 2016

<http://www.hqip.org.uk/resources/rheumatoid-and-early-inflammatory-arthritis-2016/>

Arthritis Research UK: Public health

<http://www.arthritisresearchuk.org/policy-and-public-affairs/public-health.aspx>

# Primary care management tools: GRASP

The GRASP suite is a series of three free audit tools, which can help general practices in England case-find and audit their management of patients with some of the most prevalent long term conditions. These conditions currently include:

- Atrial fibrillation (GRASP-AF)
- Chronic obstructive pulmonary disease (GRASP-COPD)
- Heart failure (GRASP-HF)

The tools were co-developed by the NHS in partnership between the NHS England Sustainable Improvement team (formerly NHS Improving Quality) and the developers PRIMIS who are based at the University of Nottingham.

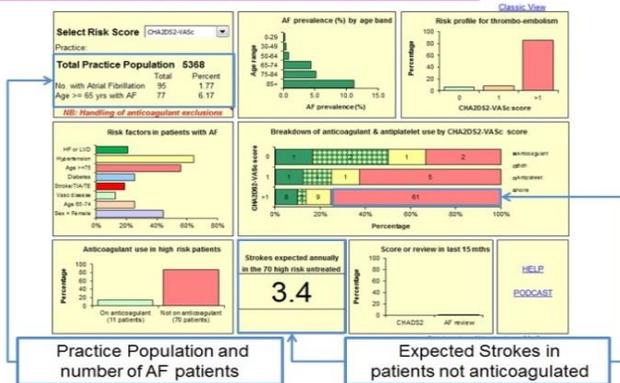
The GRASP suite:

- Is aligned to current NICE clinical guidelines
- Includes 'case finders' to help identify possibly undiagnosed patients
- Provides a comprehensive, highly visual 'dashboard' of key data for each condition
- Generates patient lists to help GPs identify and prioritise those patients who would benefit from review
- Links results to NHS Outcomes Framework Domain 1 (preventing people from dying prematurely) and Domain 2 (enhancing quality of life with people with long term conditions). Can be expanded to cover other conditions in future.

Practices can upload pseudonymised data to a secure online database for benchmarking purposes and allows practices to work together to improve care across their CCG or STP footprint. No patient identifiable data is uploaded

# Primary care management tools: GRASP

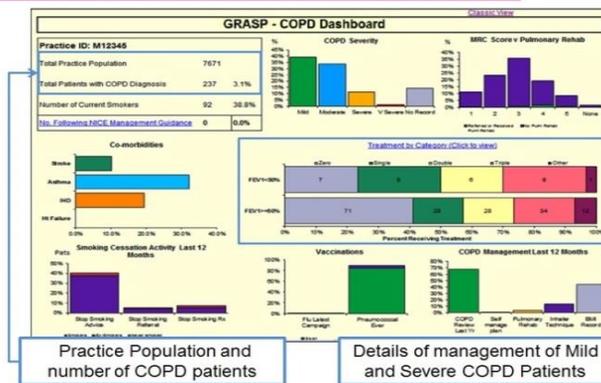
GRASP-AF Practice Overview Dashboard



Practice Population and number of AF patients

Expected Strokes in patients not anticoagulated

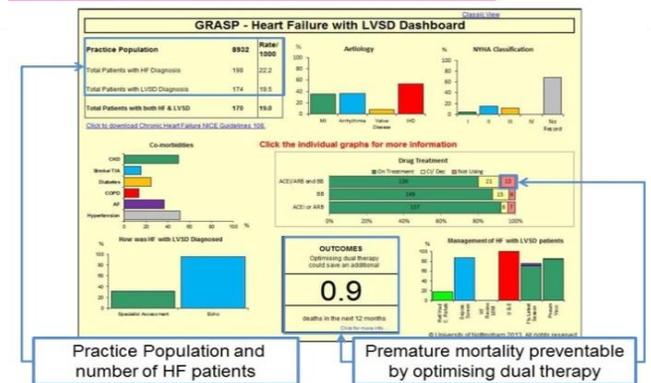
GRASP-COPD Practice Overview Dashboard



Practice Population and number of COPD patients

Details of management of Mild and Severe COPD Patients

GRASP-HF Practice Overview Dashboard



Practice Population and number of HF patients

Premature mortality preventable by optimising dual therapy

## GRASP-AF

This tool assists GP practices to interrogate their clinical data, enabling them to improve the management and care of patients with atrial fibrillation (AF) and to reduce their risk of stroke through appropriate intervention with anticoagulation

## GRASP-COPD

This tool assists GPs with COPD patients by including a case finder to identify patients and enables practices to audit their management of patients with COPD and check a patient's severity against how they are currently being treated.

## GRASP-HF

This tool helps GP practices improve the management and care of patients with heart failure with left ventricular systolic dysfunction (LVSD). The tool also assists with case finding activity, helping practices to establish more accurate prevalence rates within the practice population.

# Primary care management tools: GRASP

GRASP can help practices and CCGs to:

- Improve the quality of care for people with atrial fibrillation, heart failure and COPD, both within individual practices and across CCG or STP footprints
- Save lives and improve quality of life by facilitating earlier intervention and better management
- Avoid costly hospital admissions and readmissions
- Improve practice efficiency by enabling practices to prioritise individual patients for review and target resources effectively
- Maximise Quality and Outcomes Framework (QOF) attainment and support any local quality improvement schemes
- Keep pace with current best practice guidelines and standards.

NHS England's Sustainable Improvement team is partnering with NHS RightCare's Delivery Partners, to roll out the GRASP Suite of tools across all CCGs in line with all Sustainability and Transformation Plans, beginning in late 2016. Working in this way gives a practical solution to practices who have identified AF, COPD or Heart Failure as priority areas using the Commissioning for Value packs, allowing them to identify patients at greatest risk or where maximum benefits can be obtained.

The GRASP suite of tools can be found at:

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

For more information contact Nick Hodgetts, Sustainable Improvement Team on 07788 158655.

# Self Care

# Self care: Introduction

Care for people with long-term conditions (LTCs) forms a significant part of the health and social care system. However, the actual proportion of time that a person with a LTC spends with a health professional is very small compared to the time they spend managing their own care. 35% of the population of people living with LTCs have low or very low levels of knowledge, skills and confidence to self care, in order to manage their health and wellbeing and live independently. This is often defined as having a low level of 'activation'\*. These people tend to develop more LTCs, have a poorer quality of life, make more unwarranted use of public services and cost more to public services, than people at higher levels of activation.

Care services can play a key role in helping people to build their knowledge, skills and confidence, and to access services and support networks in their local communities such as self-management education programmes, coaching, peer support and group activities. This requires both changes in the services that are commissioned locally, and a different relationship between care providers and people living with long-term conditions and their carers, where personalised care and support planning can help identify how to achieve the outcomes that are important to individuals and what support they need in order to manage their health and wellbeing.

\*Gilbert H & Hibbard J for Kings Fund (2014), *Supporting People to Manage Their Health*

# Self care: Key actions for CCGs

Key actions for CCGs to undertake to ensure people with LTCs feel supported to self-care and manage their health and wellbeing include:

- Identifying the services and resources in your local area, building relationships with voluntary and community services and commissioning a menu of options to support self care, including structured self-management education programmes, health coaching, peer support, group activities, and asset-based community support.
- Establishing criteria and methodology for cohort identification of people with LTCs with low levels of knowledge, skills and confidence who would benefit from additional support.
- Ensuring providers are facilitating personalised care and support planning conversations with people with LTCs and their carers to discuss what is important to them and what support they need in order to help build their knowledge, skills and confidence. Care professionals may need additional training and support.
- Commissioning active signposting or social prescription service to help people access support in their local areas.

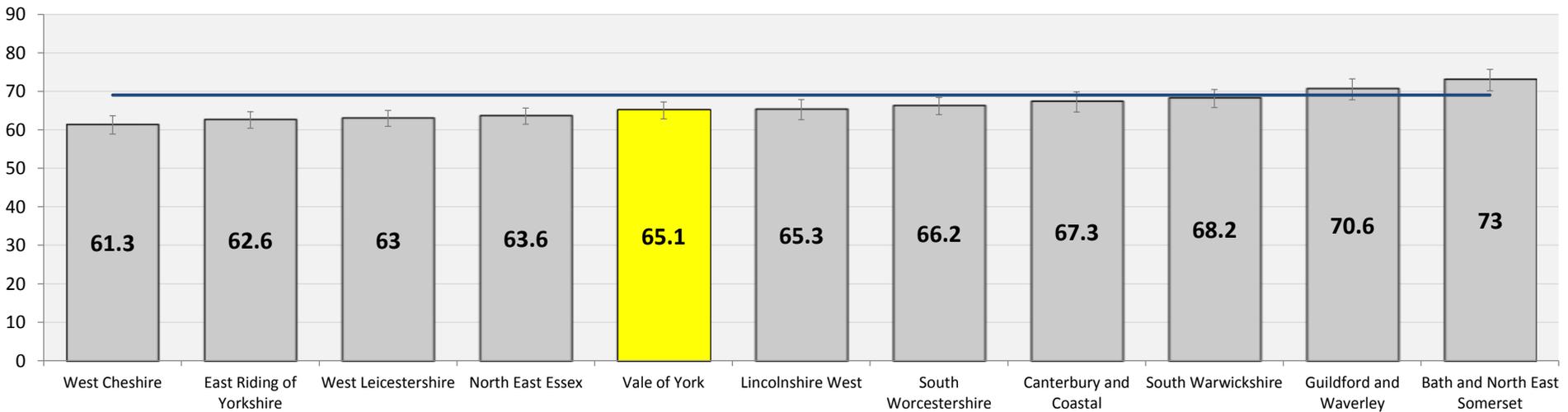
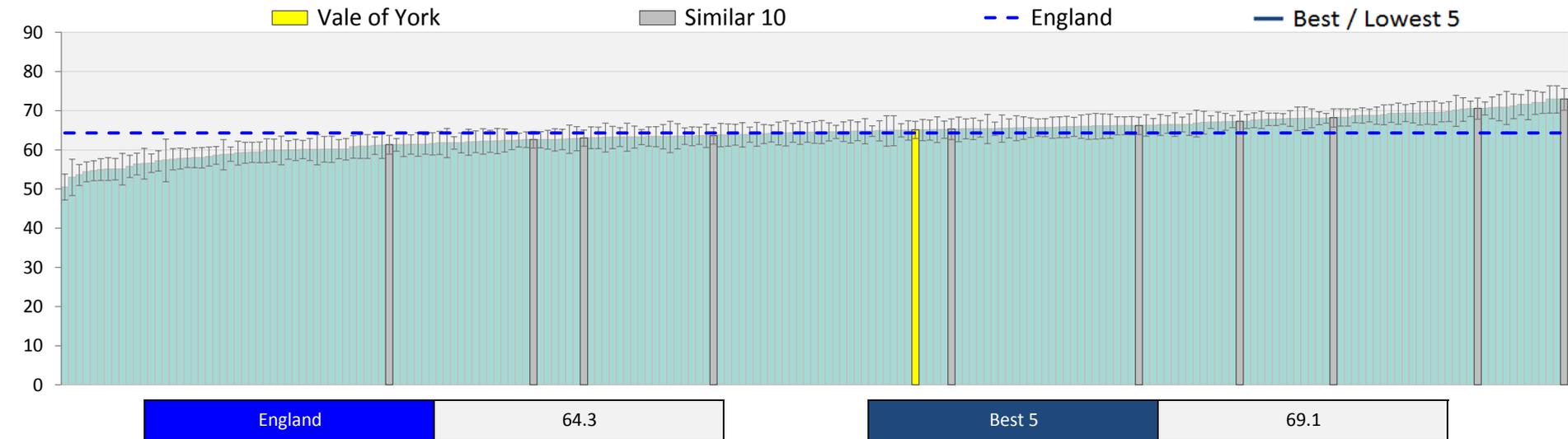
The following question from the GP Patient Survey is used to assess CCG performance in supporting people to self-care:

*In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)?*

Additionally, CCGs may have their own processes for measuring improvements in people's knowledge, skills and confidence, such as by using the Patient Activation Measure.

# The percentage of people who feel supported to manage their condition

N/A



Definition: The percentage of people who feel supported to manage their condition  
 Source: NHS Digital, Confidence Intervals have been calculated by the RightCare team and will be underestimate  
 Year: 2015/16

# Self care case study: Rotherham Social Prescribing Model

## Context and background

Rotherham borough has a population of 250,000 with a mixture of urban and rural areas. Rotherham is an ex-mining community with high levels of deprivation and health inequalities, with above average numbers of the population living with long term conditions. The area has significantly higher levels of ambulatory care sensitive hospital admissions than other similar populations, and 20% of the spend is on these conditions. Over 30% of emergency hospital admissions are for people aged over 65. Some of the local challenges are attributed to:

- poor integration of health and social care services
- lack of alternative levels of care

## Solution

Social prescribing is an approach that links patients in primary care with non-medical support in the community. Voluntary Action Rotherham, on behalf of NHS Rotherham CCG, co-ordinates a social prescribing scheme which particularly focuses on secondary prevention, commissioning services that will prevent worsening health for those people with existing LTCs, and thus reduce costly interventions in specialist care.

By connecting people with a range of voluntary and community sector-led interventions, such as exercise/mobility activities, community transport, befriending and peer mentoring and carer's respite, the scheme aims to lead to improved social and clinical outcomes for people with long term conditions and their carers; more cost-effective use of NHS and social care resources and to the development of a wider, more diverse range of local community services.

Continued on the next page...

# Self care case study: Rotherham Social Prescribing Model

## Participants

Participants are identified by GP surgeries using a risk stratification tool. Advisers discuss patients at risk of unplanned hospital admission within the integrated case management teams and patients identified as needing non-clinical means of support to improve their health and wellbeing are referred to the social prescribing scheme. Advisers then carry out a home visit to undertake a guided conversation to help patients identify what areas of their lives they would like to change/improve.

The services they connect people to are provided through contracts with a range of local voluntary and community sector organisations. Where the main providers are not able to meet a particular need or goal, advisers may spot-purchase more appropriate solutions.

## Outcomes

An evaluation by the Centre for Regional Economic and Social Research at Sheffield Hallam University (Sep 2012 - Mar 2015 data) found that the service had positive social and economic impacts:

- After 3-4 months, 82 per cent of people experienced positive change in at least one social outcome area.
- The value of service users' wellbeing outcomes were estimated between £0.57m - £0.62m in the first year following engagement with the scheme - greater than the costs of delivering the service.
- Non-elective inpatient episodes reduced by 7%; non-elective inpatient spells reduced by 11%; Accident and Emergency attendances reduced by 17%
- The estimated total NHS costs avoided between 2012-15 were more than half a million pounds. An initial return on investment of 43p for each £1 invested.

## More information

For more information about this case study please contact: [linda.jarrold@varotherham.org.uk](mailto:linda.jarrold@varotherham.org.uk) or visit <http://ow.ly/sUpw305LQtV>

# Self care: Tools and resources

## Realising the Value

Nesta and the Health Foundation are working together on Realising the Value – supporting people to have the knowledge, skills and confidence to play take an active role in managing their own health.

There are many good examples of how the health and care system is already doing this. For example, recognising the importance of people supporting their peers to stay as well as possible or coaching to help people set the health-related goals that are important to them.

Realising the Value is not about inventing new approaches, it's about strengthening the case for change, identifying evidence-based approaches that engage people in their own health and care, and developing tools to support implementation across the NHS and local communities.

Tools, resources and reports can all be found at: <http://www.nesta.org>

Continued on the next page...

# Self care: Tools and resources

## Patient activation

Patient activation' describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions. The Patient Activation Measure (PAM) is a tool that enables healthcare professionals to measure a patient's activation level.

For details on Patient Activation and the Patient Activation Measure visit:

<https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/>

## Personal health budgets

Personal health budgets enable people with long term conditions or disabilities to better manage their health, improving quality of life, while reducing the use of reactive NHS services such as A&E, GPs or hospital admissions. They empower people to plan care and support that works for them, allowing them to meet their health needs in ways that may not be possible in traditional NHS services.

For more information on personal health budgets visit [www.england.nhs.uk/healthbudgets](http://www.england.nhs.uk/healthbudgets)

# Self care: Tools and resources

## Personalised care and support planning

Personalised care and support planning is a process whereby care professionals and people with LTCs and their carers work together to clarify and understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing. They agree goals, identify support needs, develop and implement action plans, and monitor progress.

For more details:

NHS England handbook on personalised care and support planning

<https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/>

TLAP Personalised care and support planning tool <http://www.thinklocalactpersonal.org.uk/personalised-care-and-support-planning-tool/>

# Self care: Resources

## Improving outcomes and value in musculoskeletal conditions

Information about group 2 (musculoskeletal pain) conditions e.g. osteoarthritis, back pain

- 8.75 million people in the UK have sought osteoarthritis treatment; 5.5 million with severe chronic back pain
- Half of people aged 65 and over with any long-term condition also have painful MSK condition
- Unless pain is addressed, people with LTC who also have arthritis will not be able to realise the benefits
- By meeting needs of people with osteoarthritis/back pain, physical activity programmes maximise impact
- Appropriate physical activity reduces pain and disability from osteoarthritis and back pain
- ESCAPE-pain is a twice-weekly, six-week group rehabilitation programme for people with lower limb osteoarthritis, combining education with a progressive exercise regimen, endorsed by NICE
- People report significant pain reduction, and improvements in function, quality of life, mood
- Evidence supports benefits are maintained 30 months post participation
- Costs lower than usual physio, reduces health-care/medication use, delays/avoids surgery
- Savings estimated at £1000-2000k per participant per year

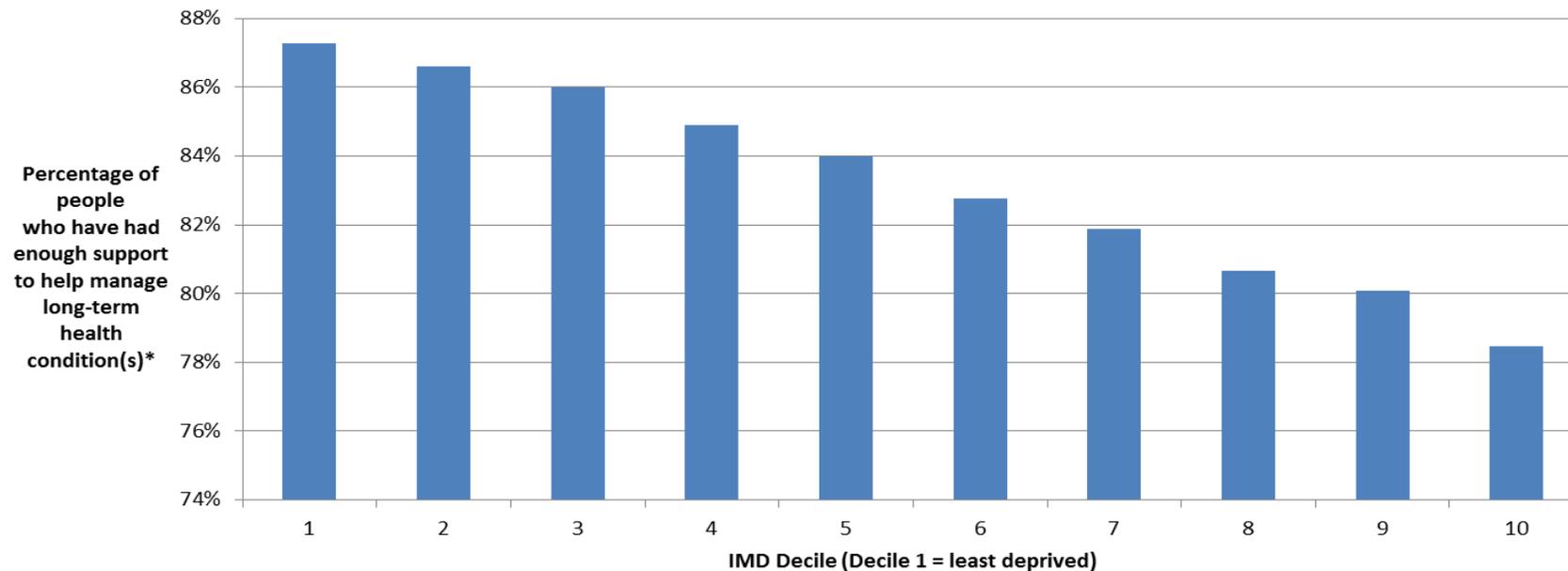
NICE guideline on osteoarthritis: care and management

<https://www.nice.org.uk/guidance/cg177?unlid=2021539962016101582430>

Enabling Self-management and Coping with Arthritic Pain using Exercise (ESCAPE-pain)

<http://www.escape-pain.org/>

# Self care and deprivation



\*Contains aggregated data collected from Jul-Sept 2015 and Jan-Mar 2016

The chart above uses practice level data. It shows that there is a negative correlation between deprivation and the proportion of people who feel supported to manage their condition. This indicates that people in more deprived areas are less likely to feel supported to manage their condition.

Therefore, even if you are a good performing CCG it is possible that patients in more deprived areas do not feel as supported as those in areas with less deprivation.

NHS RightCare is producing practice packs in early 2017 which will allow CCGs to explore practice level variation on a range of information.

# Primary Care Prescribing

# Prescribing case study: Bradford's Healthy Hearts

## The background

Bradford Districts CCG has the seventh worst cardiovascular disease mortality rate under 75 in England (over 28% of deaths). Around 14% of the population have hypertension and more than 21,000 have high cholesterol levels.

Set up to tackle one of Bradford's leading causes of death, *Bradford's Healthy Hearts (BHH)* is an ambitious joint initiative of the 40 practices that form Bradford Districts CCG. By 2020 *BHH* aims to reduce cardiovascular events by 10% - the equivalent of 150 strokes and 340 heart attacks. Changes to prescribing is a key factor

## The approach

Fully owned at CCG and practice level, BHH has strong links with secondary care consultants, nurses and pharmacists. Plus regular engagement and education sessions with the public and practice staff. Practices have nominated champions, upskilled to support the campaign and as enablers to practice engagement. To support already busy GPs working with a target population of 350,000 people, relentlessly efficient and innovative use has been made of information technology, ensuring the best use of time and resources. Time and care has been taken to safely design IT approaches which benefit patients and practices alike.

The campaign has taken a population approach, for example by sending out letters to 13,000 patients advising them of treatment change and a campaign website [www.bradfordshealthyhearts.co.uk](http://www.bradfordshealthyhearts.co.uk) to provide links to video and other supportive information. This approach has enabled shifts in treatment for large numbers of patients within three months.

Continued on the next page...

# Prescribing case study: Bradford's Healthy Hearts

## Activity

During 2015/16, BHH has:

- identified over 7,000 people with more than a 10% risk of stroke and started them on statins, and a further 6,000 were switched to a more effective statin, to reduce their cholesterol levels
- worked to prevent strokes for people with an abnormal heart rhythm (atrial fibrillation), with almost 1,000 people starting blood-thinning therapy to reduce their risk
- started a programme to improve blood pressure control for 38,000 patients with high blood pressure

## Outcomes

In just over a year, BHH has enabled 17,000 interventions to take place with a minimum of additional work from practices, and associated cost savings. The approach taken is easily transferrable to other areas of quality improvement, such as respiratory.

Bradford's Healthy Hearts has been recognised nationally, including the 2015 BMJ Leadership Award, 2015 General Practice Awards - general practice team of the year and clinical team of the year – cardiovascular.

## More information

For more information about this case study please visit <http://www.bradfordshealthyhearts.co.uk/>

# Medicines optimisation

NHS RightCare and partners are helping local health economies develop patient-focused approaches to maximise value from medicines. This requires a holistic approach and partnership between patients and clinicians.

Medicines optimisation looks beyond the cost of medicines to the value they deliver, recognising medicines are an investment in improved patient outcomes. It is about ensuring the right patients, get the right choice of medicines, at the right time, and are supported to take them.

With support from partners, the NHS RightCare team is aligning guidance, tools and techniques with the three phases of 'Where to Look, What to Change and How to Change'. The alignment will include:

- making connections across the system to realise the benefits of medicines optimisation.
- developing metrics to illustrate areas of variation for localities to investigate and use in order to drive population healthcare improvement.

The aim is to help ensure that medicines are optimised across pathways of care to help patients make the most of their medicines and take their personal preferences into account.

## Medicines optimisation case study: Neuropathic pain

### The background

Working across Eastbourne, Hailsham & Seaford CCG and Hastings and Rother CCG, the medicines management team sought to improve quality and efficiency of prescribing for neuropathic pain, whilst reducing variation in prescribing behaviour between GP practices. The NHS RightCare Commissioning for Value focus pack for Neurology had identified significant variation in prescribing and shown that spend on pregabalin prescribing in both CCGs was much higher than expected based on comparisons to the similar 10 CCGs.

### The approach

All locally available pain services were mapped. The model of care provided by each service was identified and the views of clinicians working within each setting were sought. Any currently available care or referral pathways were identified, along with national or local clinical guidelines for pain management (with a focus on neuropathic pain in particular). An extensive primary care data collection exercise was undertaken to identify the drivers for inappropriate and overuse of pregabalin within the health economy.

A strategy to reduce inappropriate initiation of pregabalin was developed in tandem with a programme of patient centred structured pain management reviews in primary care. This work stream was supported by educational events and was incentivised through the Prescribing Support Scheme.

Continued on the next page...

# Medicines optimisation case study: Neuropathic pain

## Key success factors

Clinical leadership; Engagement; Sharing best practice between clinicians

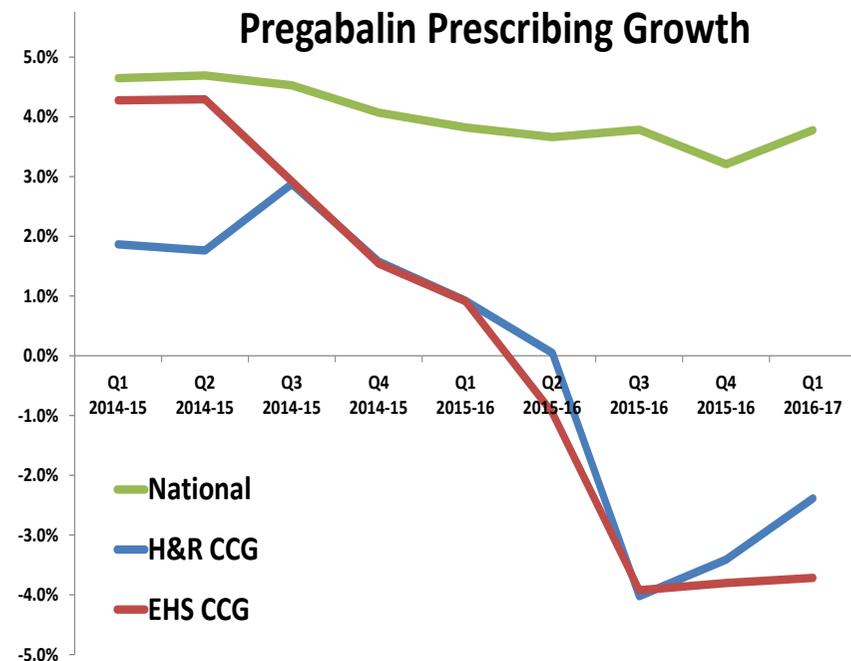
## Outcomes

The majority of GP practices in the two CCGs undertook primary care reviews (82% overall) and rates of withdrawal from pregabalin treatment were higher than expected, ranging from 12% to 64% between GP practices. All practices that engaged with the project reduced their pregabalin prescribing, regardless of the volume of pregabalin prescribed at baseline. A significant reduction in volume of prescribing has been demonstrated in both CCGs (see chart).

Estimated annual savings from this project are approximately £395k across both CCGs. The savings made through a reduction in pregabalin prescribing will enable more effective investment in primary care to improve health outcomes for local people

## Patient story

“There was no negative impact on Mr H’s chronic pain. He has lost weight and reported feeling much better with more energy for life. Since the trial withdrawal he has also stopped narcotic analgesia and started working again.”



# Medicines optimisation: Guidance

NHS RightCare information on medicines optimisation

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

NHS England information on medicines optimisation

<https://www.england.nhs.uk/ourwork/pe/mo-dash/background/>

*Medicines Optimisation: Helping patients to make the most of medicines. Good practice guidance for healthcare professionals in England* (May 2013) A publication from the Royal Pharmaceutical Society working with NHS England, patient groups, other Royal Colleges and the Association of British Pharmaceutical Industry

<http://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf>

NICE guideline on Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes

<https://www.nice.org.uk/guidance/ng5>

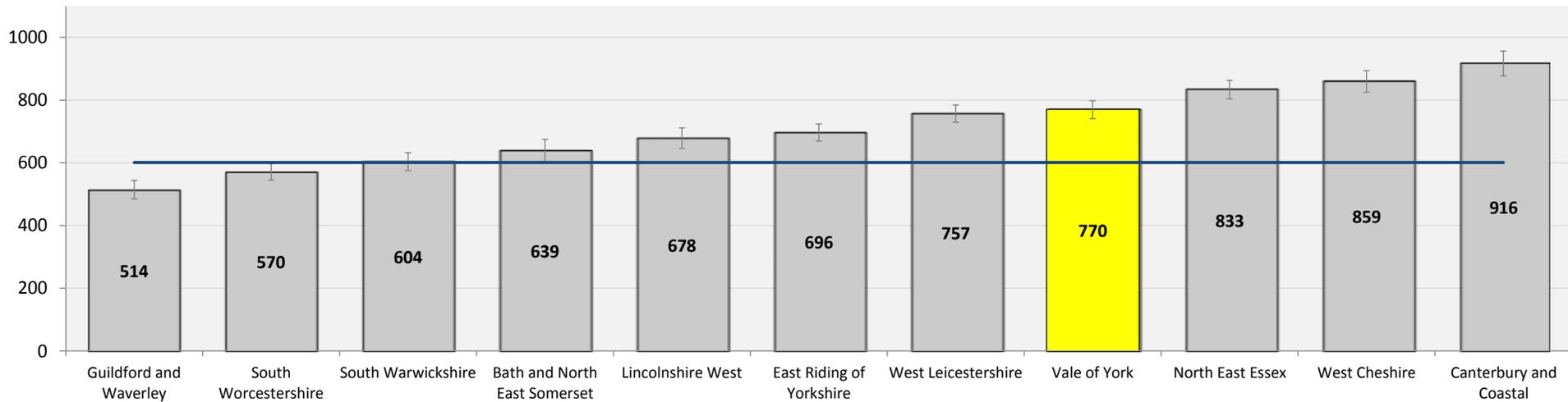
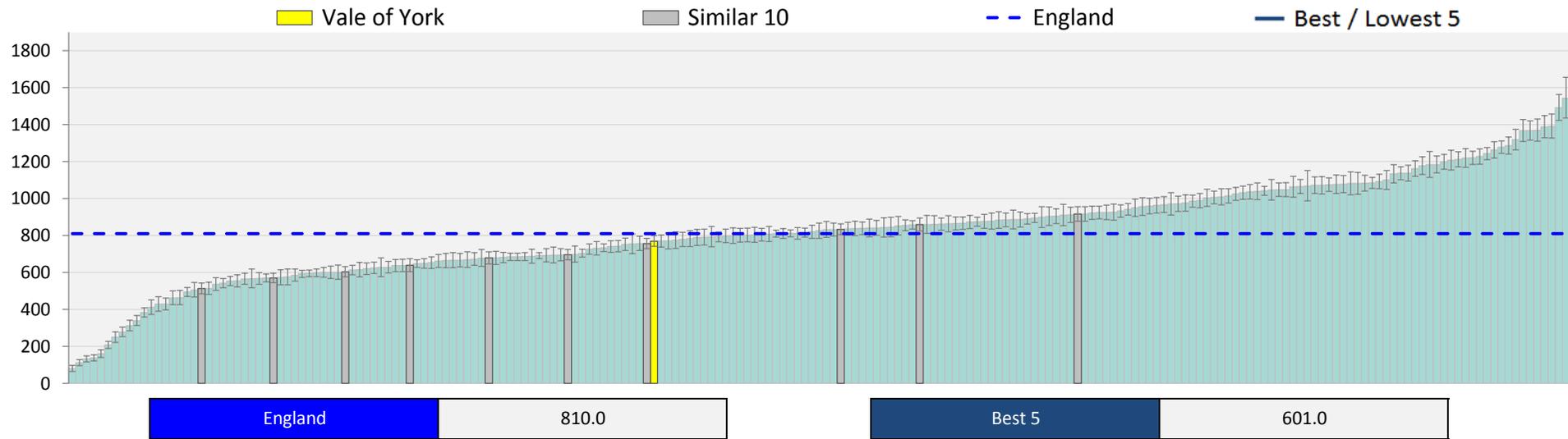
Primary Care Commissioning (PCC) Commissioning medicines optimisation services from community pharmacy: Guidance for commissioners (October 2016)

<http://www.pcc-cic.org.uk/article/guidance-commissioning-medicines-optimisation-services-community-pharmacy>

# Intermediate Care Step Up/ Step Down

# Unplanned hospitalisation for chronic ambulatory care sensitive conditions

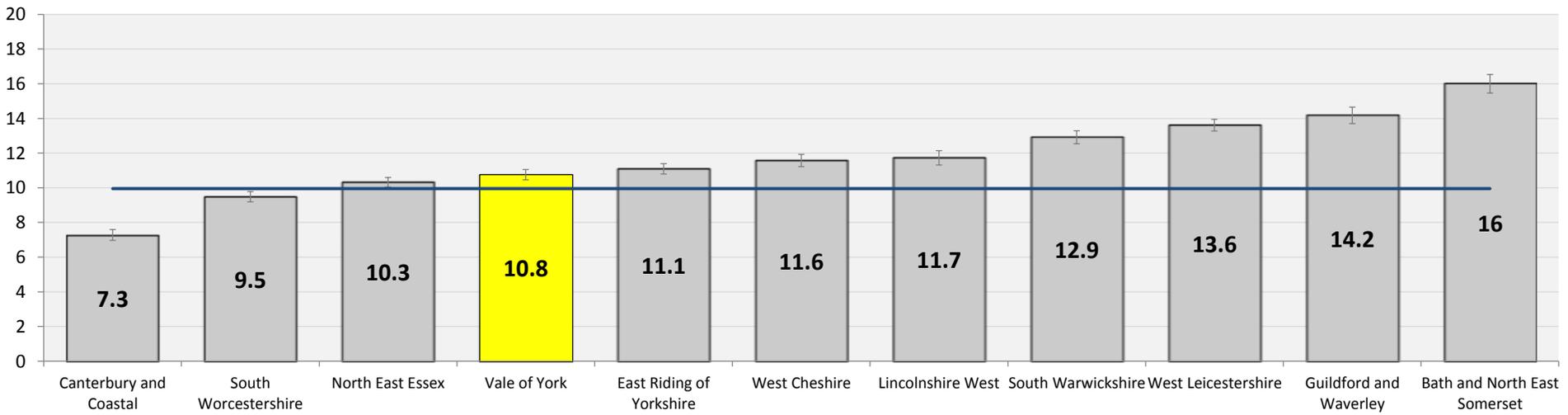
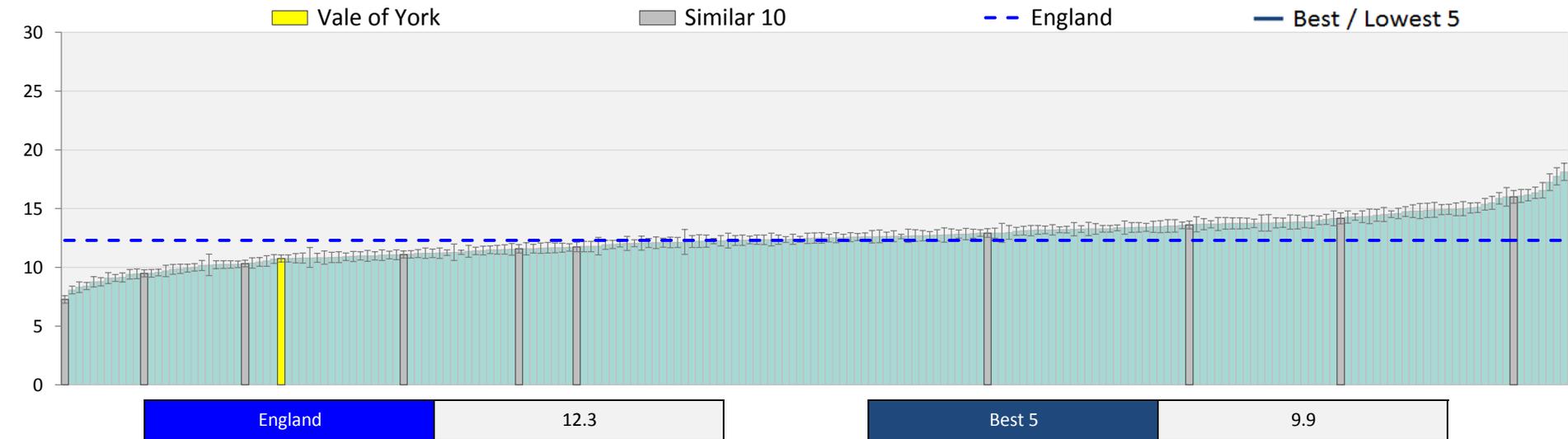
**593 Adm.**



Definition: Unplanned hospitalisation for chronic ambulatory care sensitive conditions  
 Source: NHS Digital  
 Year: 2015/16 (Provisional)

# Proportion of people aged >65 in hospital for ten days or more

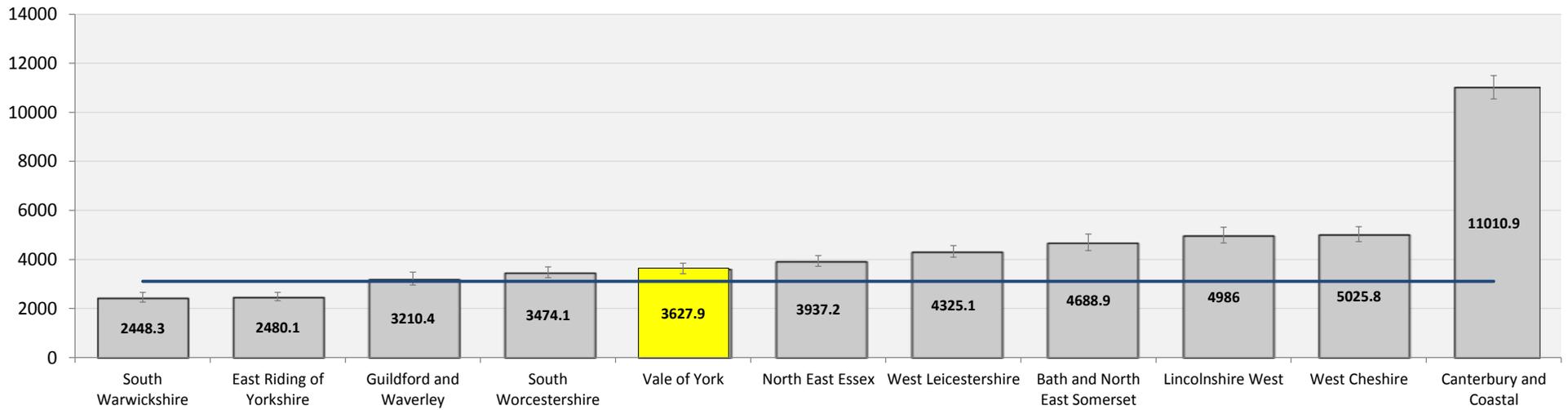
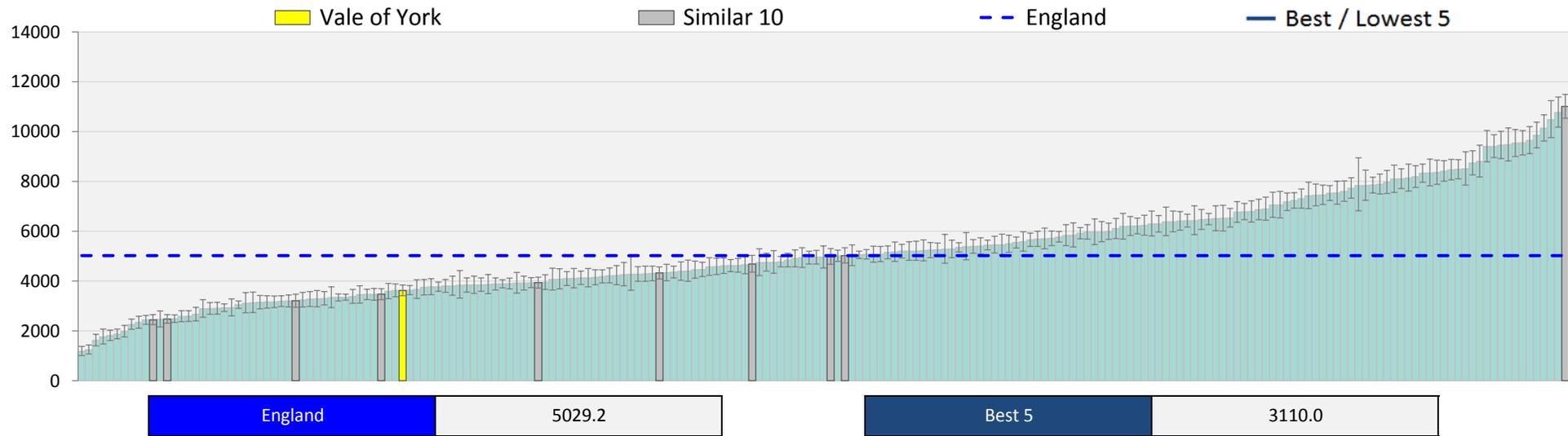
**333 Ppl.**



Definition: Proportion of people aged >65 in hospital for ten days or more (the % of people out of those aged 65+ who have an admissions for ten days or more)  
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)  
 Year: 2015/16

# Rate of emergency admissions aged 75+ with a stay of <24 hrs per 100,000 pop

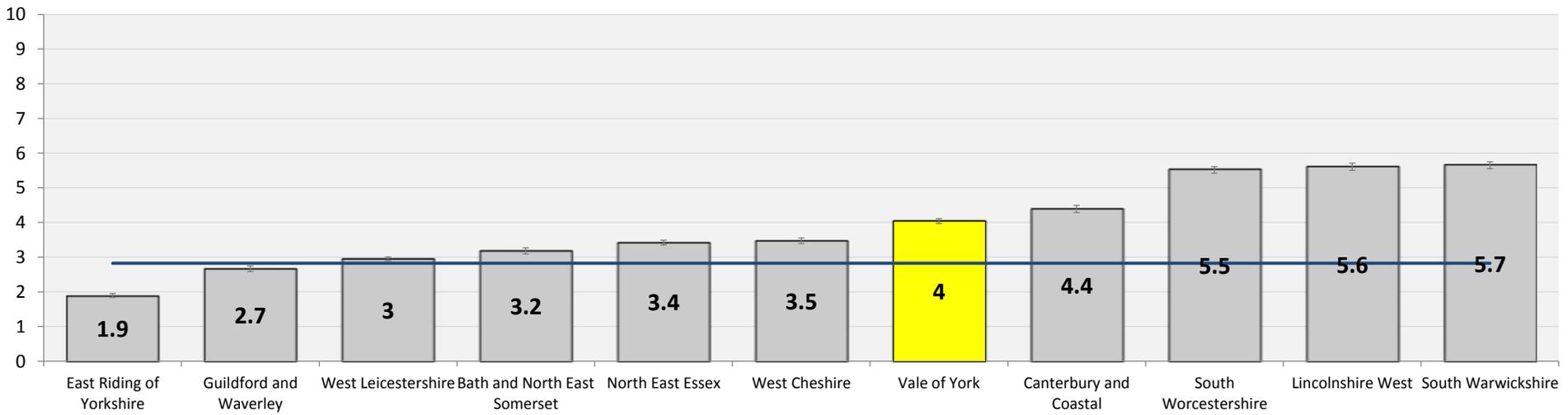
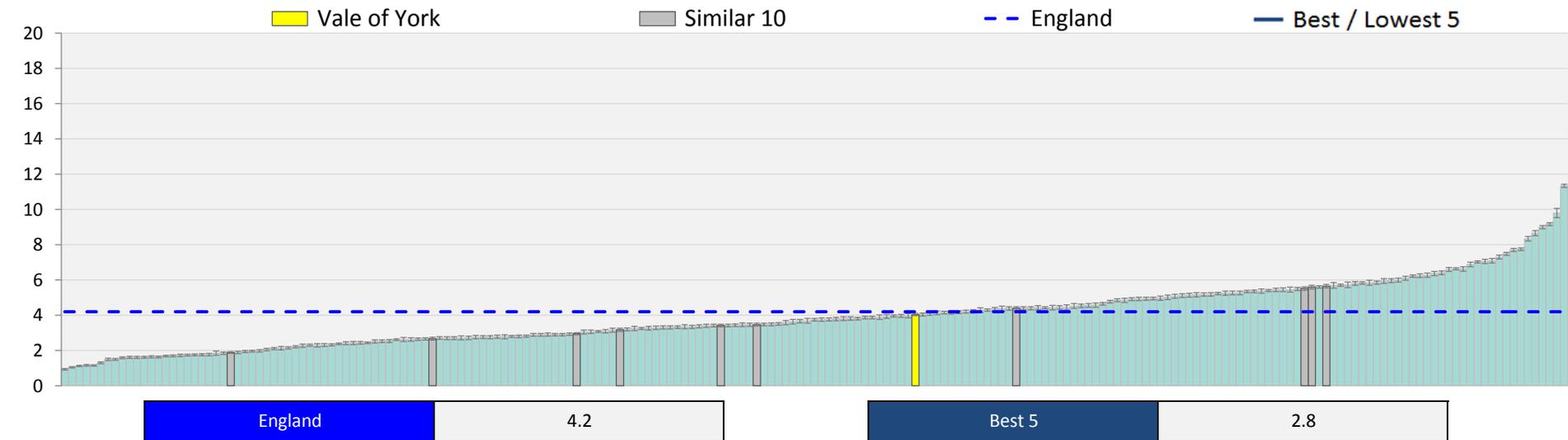
155 Adm.



Definition: Rate of emergency admissions aged 75+ with a stay of <24 hrs per 100,000 pop  
 Source: PHE, HES, NHS Digital  
 Year: 2012/13

# Rate of patients with delayed transfers of care (%)

**3484 Pats.**



Definition: Rate of patients with delayed transfers of care (%)  
 Source: NHS England  
 Year: 2014/15

# Intermediate care case study: Home from Hospital

## The background

Carers Resource established the Home from Hospital project to support patients identified as 'high risk of re-admission without support'. The project is funded by Bradford City, Bradford Districts and Airedale CCGs. It is for adults who live in Bradford, Airedale and Wharfedale who are being discharged home and need extra support. It supports a range of people including people living alone, people worried about how they will cope and people with a long term condition including dementia.

## The service

The service includes a home visit to discuss any concerns and immediate needs the person may have and the following:

- a basic hamper
- weekly visits and calls for up to six weeks
- liaising with health and social care professionals
- help to access appropriate benefits
- help to organise ongoing support eg domiciliary services and befriending

## Evaluation

Evaluation has shown that the service reduces anxiety, increases confidence and happiness, increases self care, increases choice and control and enables appropriate use of health and care services. Patients report feeling equal or better than before being admitted to hospital.

## More information

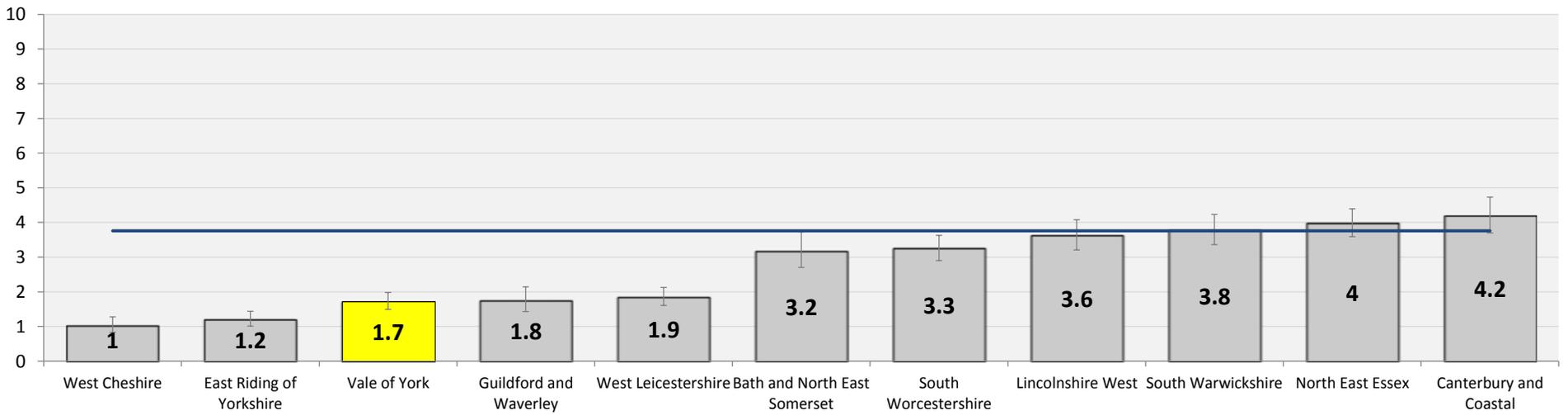
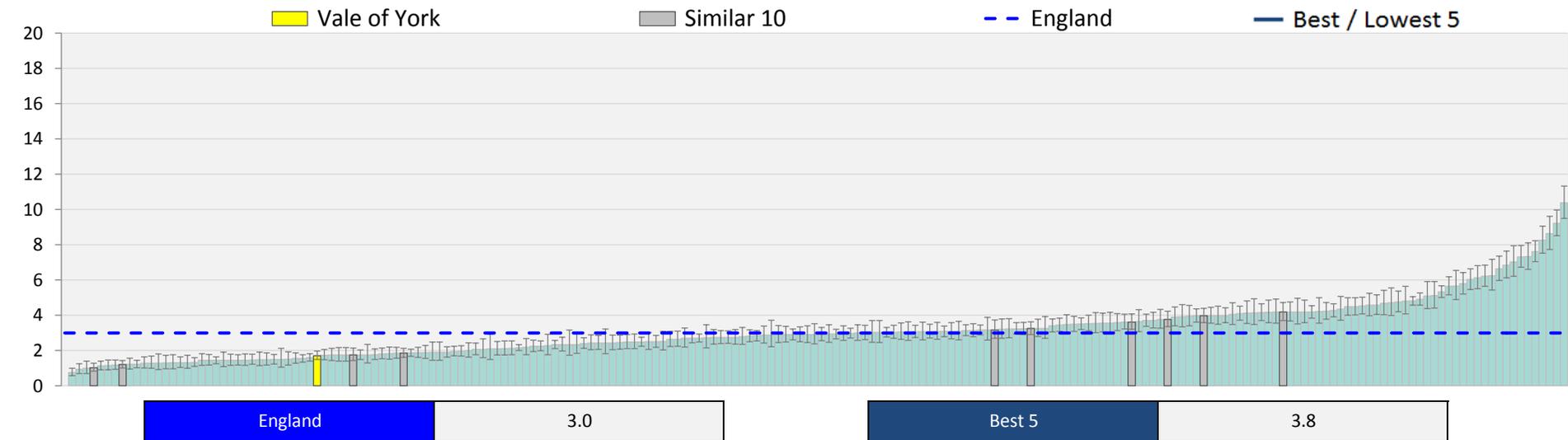
For more information about this case study please visit:

<http://www.carersresource.org/news/home-from-hospital-scheme-bradford-airedale/>

# Rehabilitation

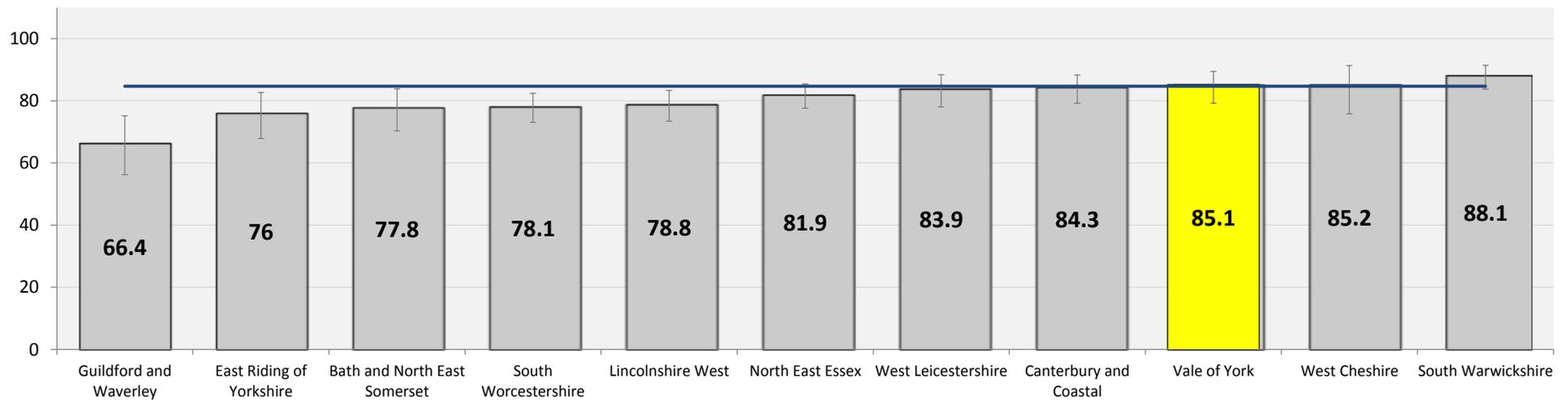
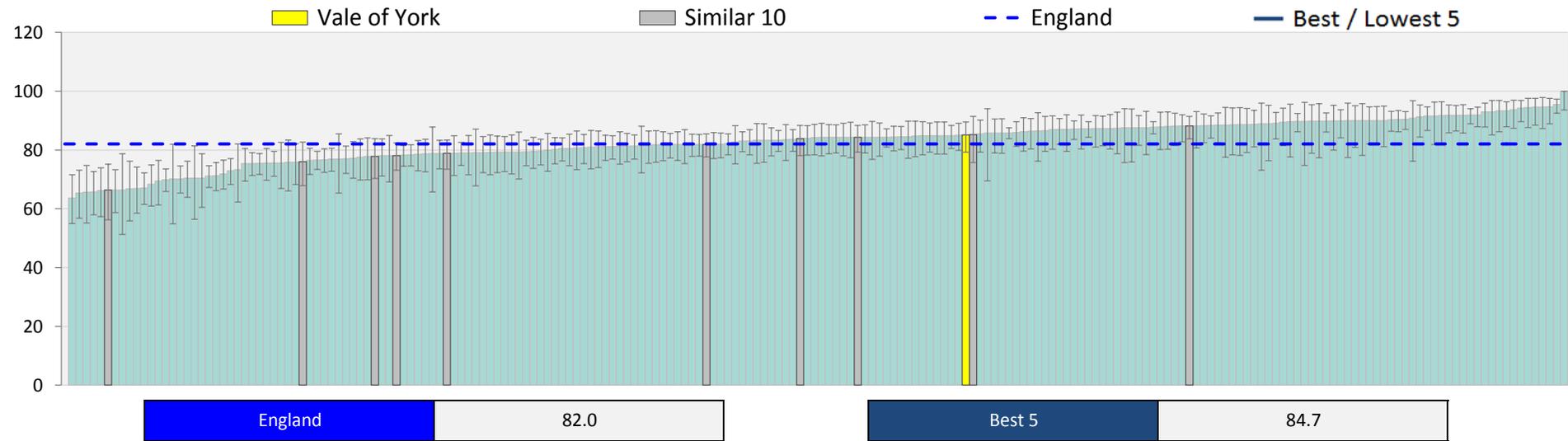
# The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital

220 Pats.



Definition: The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital  
 Source: NHS Digital  
 Year: 2014/15

# The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services



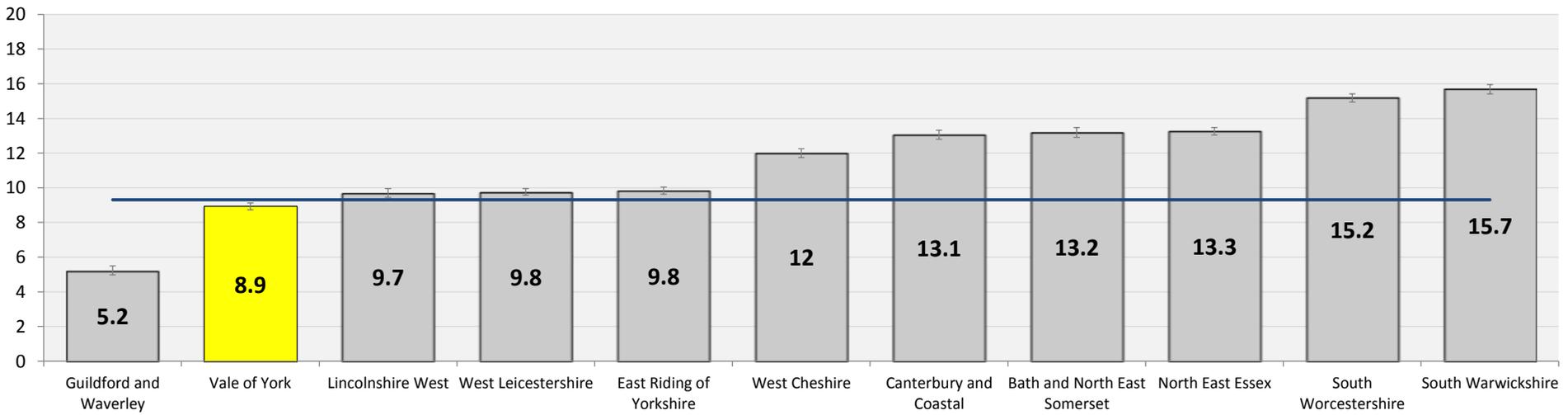
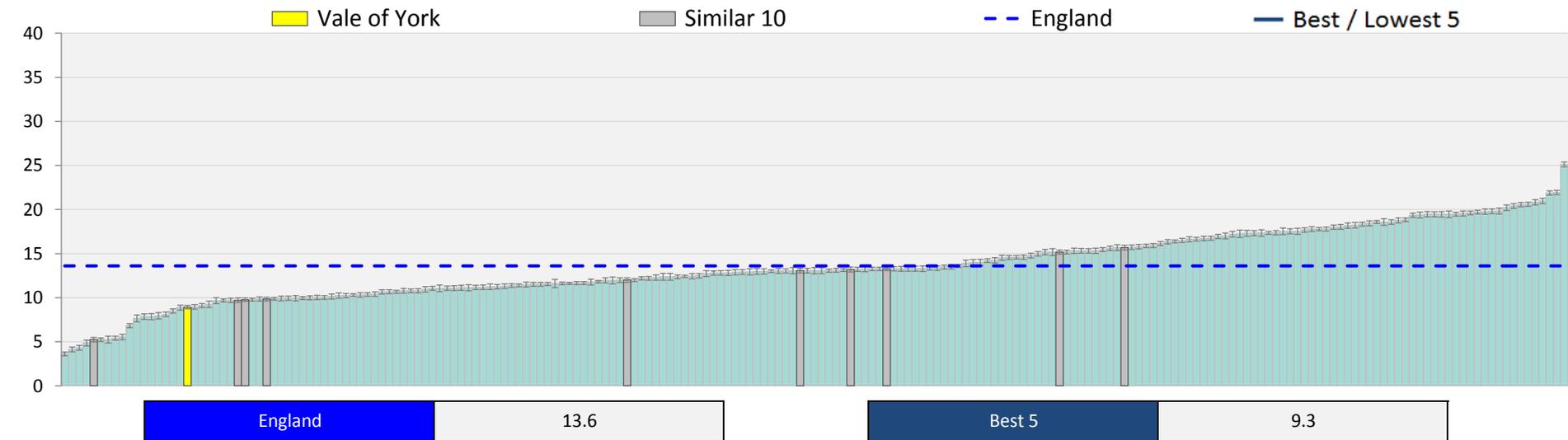
Definition: The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

Source: NHS Digital

Year: 2014/15

# Difference in the employment rate between those with a long-term health condition and all those of working age

N/A



Definition: Difference in the employment rate between those with a long-term health condition and all those of working age  
 Source: NHS Digital, ONS  
 Year: 2016 Q1

## Rehabilitation case study: Sandwell and West Birmingham Hospitals Integrated Care Services (iCares)

### The issue

The Trust's adult / Long Term Conditions community rehab service was facing a 60% increase in demand, increasingly complex caseloads and a call for year on year cost savings.

There were numerous teams (with associated variation and duplication in activity), multiple access points, inter-team referrals, long waits, and lots of paperwork.

### The solution

Looked at the evidence base, audited data, engaged with staff and patients, consulted with unions then redesigned the service to:

- open seven days a week, 8am – 8pm
- respond to patients' clinical needs, not based on diagnosis or location
- be an integrated locality care team, treating patients holistically
- Join up all aspects of care: Self-management; Routine; Specialist; and Urgent

### Outcomes

- Wait for rehab and reablement dropped from 40 days to an average of 16 days
- Bed occupancy increased from 85% to 93%
- 92% of patients return home from nursing home based IMC beds in under 6 weeks
- 93% of patients would recommend the service to friends and family

Continued on the next page...

## Rehabilitation case study: Sandwell and West Birmingham Hospitals Integrated Care Services (iCares)

### It works because...

- New model is based on clinical need - not geography, age, or diagnosis
- It has a broad reach – from pre-diagnosis to death
- The depth of expertise of the staff - nurses, therapists and other professionals are co-located

### Feedback

Positive feedback from service users

92% of staff report feeling involved and motivated at work

### Learning

Key points of learning include:

- Have a focus on the outcomes
- Use the evidence base
- Keep communicating and ask for help
- Tolerate differences
- The workforce are the key to change and momentum
- Use the power of data and patient stories

### More information

For more information about this case study please email [sandwell.icares@nhs.net](mailto:sandwell.icares@nhs.net)

# Rehabilitation case study: Tele-wound care in Bradford

## The background

Chronic wounds are a significant burden to patients, and wound care is costly to the NHS. The incidence of wounds tends to increase with age and many wound care patients are nursing home residents. A study was carried out in Bradford in 2013 to look at the effectiveness of tele-health to enhance wound care for nursing home patients.

## Objective

To evaluate the effectiveness of a telehealth system, using digital pen-and-paper technology and a modified smartphone, to remotely monitor and support the effectiveness of wound management in nursing home residents.

## Method

A randomised controlled pilot study was conducted in selected nursing homes in Bradford, which were randomised to either the control or evaluation group. All patients with a wound of any aetiology or severity, resident in the selected nursing homes were considered eligible to participate in the study. Residents in the control homes who had, or developed, a wound during the study period, continued to receive unsupported care directed by the nursing home staff (defined as 'standard care'), while those in the evaluation homes received standard care supported by input from the remote experts.

Continued on the next page...

# Rehabilitation case study: Tele-wound care in Bradford

## Results

Thirty-nine patients with a wound were identified in 16 participating Bradford nursing homes. Analysis of individual patient management pathways suggested that the system provided improved patient outcomes and that it may offer cost savings by improving dressing product selection, decreasing inappropriate onward referral and speeding healing. Despite initial anxiety related to the technology most nursing-home staff found the system of value and many were keen to see the trial continue to form part of routine patient management.

## Conclusion

The current study supports the potential value of telemedicine in wound care and indicates the value that such a system may have to nursing-home staff and patients.

## More information

For more information about this case study please visit [kath.vowden@bthft.nhs.uk](mailto:kath.vowden@bthft.nhs.uk)

# Rehabilitation case study: The East Midlands Academic Health Science Network (EMAHSN) stroke rehabilitation programme

## The background

Stroke is the leading cause of adult disability, with devastating impact particularly when stroke survivors leave hospital and return home. Without community stroke rehabilitation services many stroke survivors face the prospect of a life of unnecessary dependency with additional burden placed upon formal and informal carers.

## The approach

The overall aim of the EMAHSN programme is to facilitate provision of evidence based community stroke services in all regions of the East Midlands. The vision being that all stroke survivors that need it would be able to receive appropriate delivery of specialist stroke rehabilitation in their own home.

A key objectives of the programme is to reduce inequality of care provision to ensure that stroke survivors and their families have greater opportunity to be supported in their recovery journey. Key outputs from the programme facilitated widespread sharing of evidence based best practice models, and were key to ensuring stroke care remains on the local and national agenda.

Continued on the next page...

# Rehabilitation case study: The East Midlands Academic Health Science Network (EMAHSN) stroke rehabilitation programme

## Key outcomes

Mapping East Midlands community stroke service provision and production of regional stroke care pathways for stroke survivors in the East Midlands.

- The development of an evidence based stroke Early Supported Discharge (ESD) service specification and Community Stroke Rehabilitation (CSR) service specification
- Engagement events for East Midlands stroke stakeholders focusing on evidence based community stroke services
- Regionally tailored workshops bringing commissioners and service providers together to address gaps in community stroke services and develop service improvement initiatives
- Development of regional community stroke service directories
- Production of supplementary helpline notes for ESD and CSR

## More information

The EMAHSN website provides detailed information on the stroke rehabilitation initiatives the network developed and implemented.

<http://emaHSN.org.uk/stroke-rehabilitation-projects/reducing-the-burden-of-stroke-in-the-community>

# Rehabilitation: Guidance and tools

NHS England Commissioning Guidance for Rehabilitation

<https://www.england.nhs.uk/ourwork/qual-clin-lead/ahp/improving-rehabilitation/>

Principles and expectations for good adult rehabilitation

<http://www.wessexscn.nhs.uk/about-us/latest-news/rehabilitation-reablement-and-recovery-quality-guidance-document-now-published/>

Allied Health Professions Service Improvement Project

<https://www.gov.uk/government/publications/allied-health-professions-service-improvement-project>

Allied Health Professions Referral to Treatment Guide

<https://www.gov.uk/government/news/allied-health-professionals-referral-to-treatment-data-collection>

The Royal College of Physicians published national guidelines in 2009 on stroke rehabilitation - *Spasticity in adults: Management using botulinum toxin*. These are currently being updated, with a revised version expected in early 2017

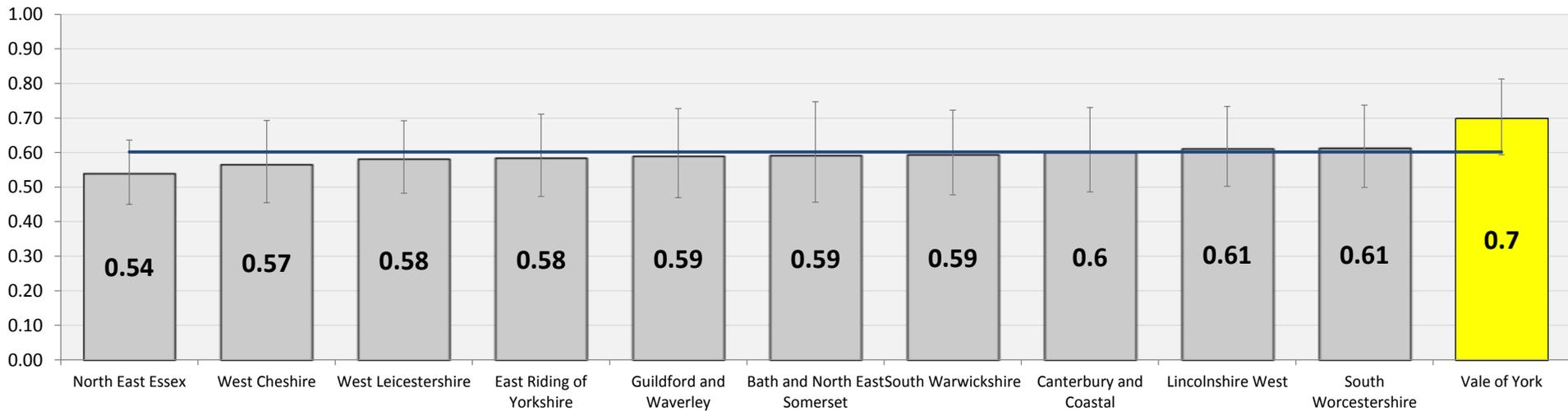
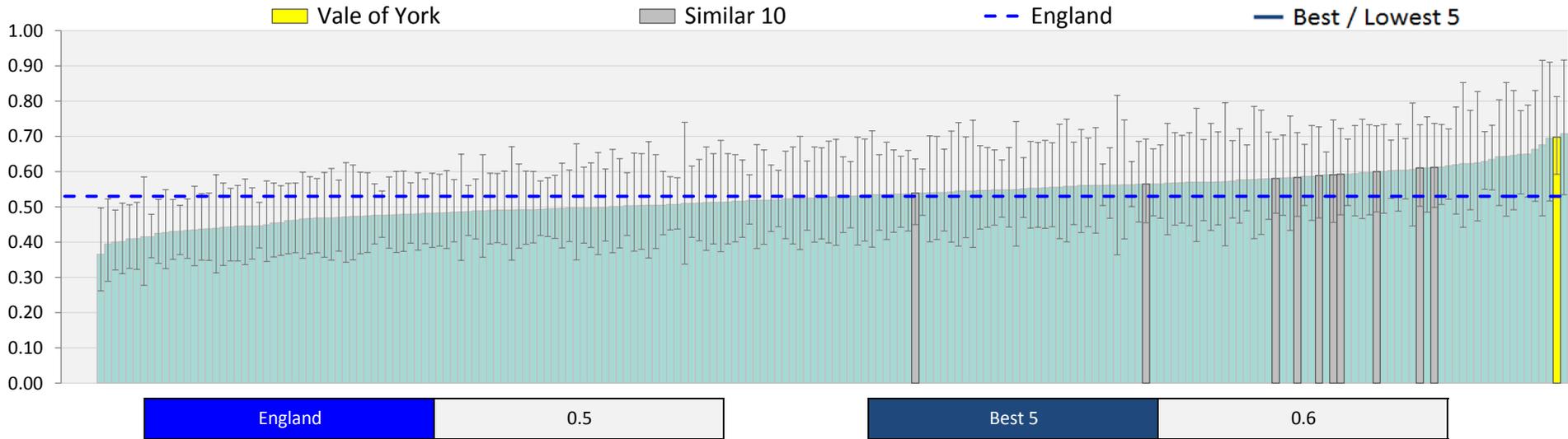
<https://cdn.shopify.com/s/files/1/0924/4392/files/spasticity-in-adults-management-botulinum-toxin.pdf?7537870595093585378>

## Care Outcomes

Please note the indicators in this section cover multiple conditions.  
Other outcome indicators can be found at the end of the annex.

# Health related quality of life people with long term conditions: average score

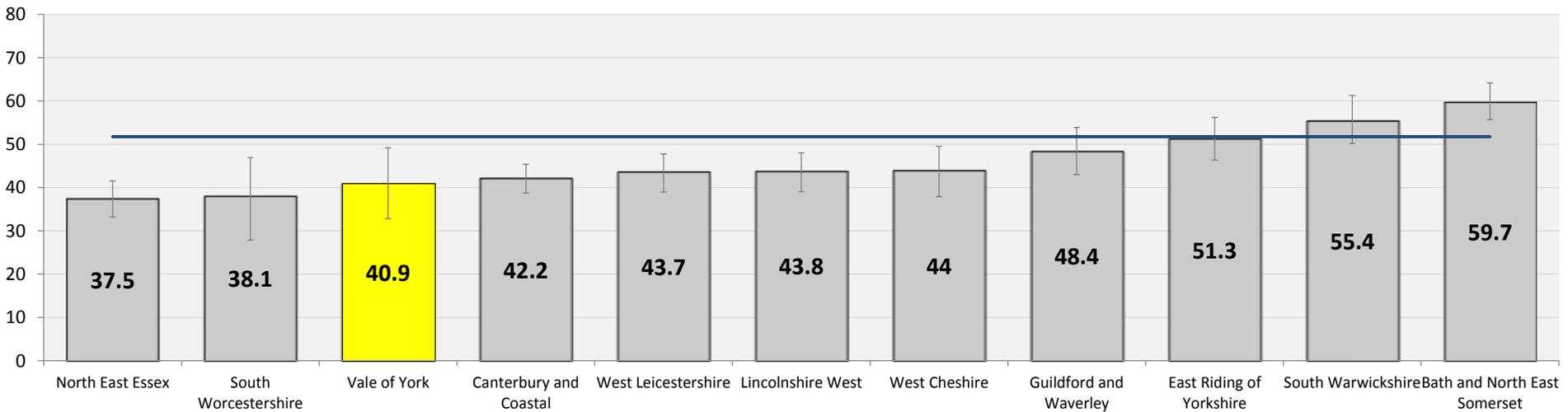
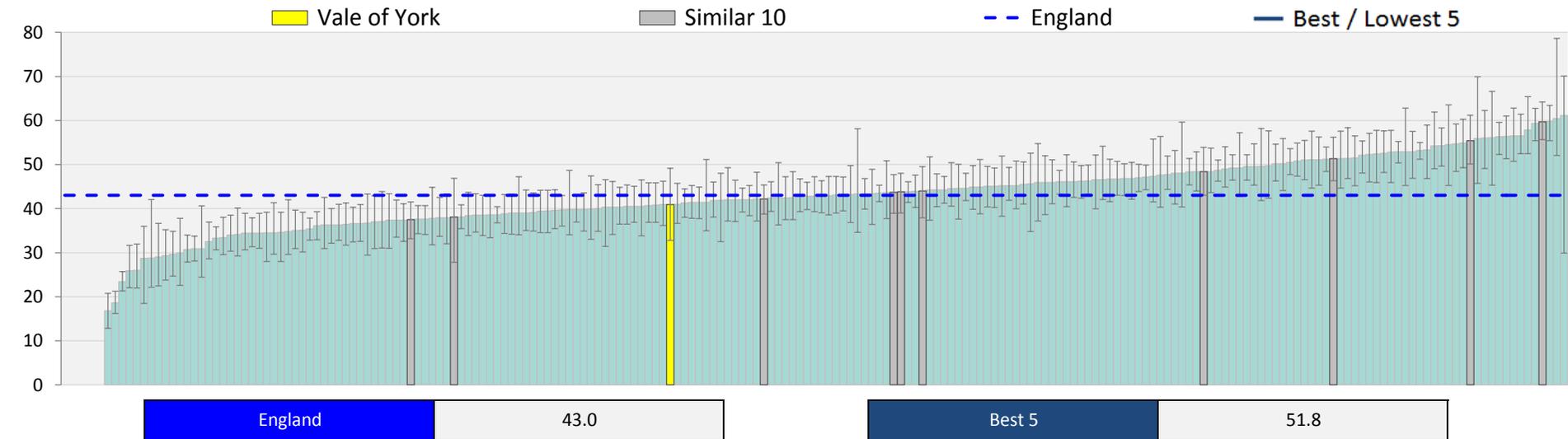
**N/A**



Definition: Health related quality of life people with long term conditions: average score- from EQ-5D  
 Source: NHS Digital, GPPS  
 Year: 2015/16

# % of patients with an LTC who are moving to recovery

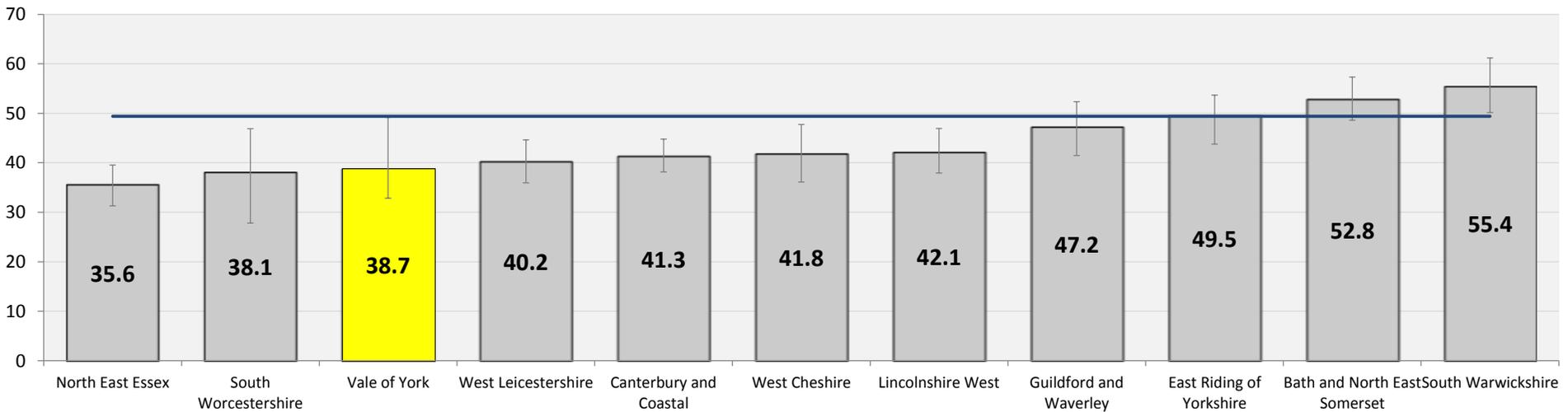
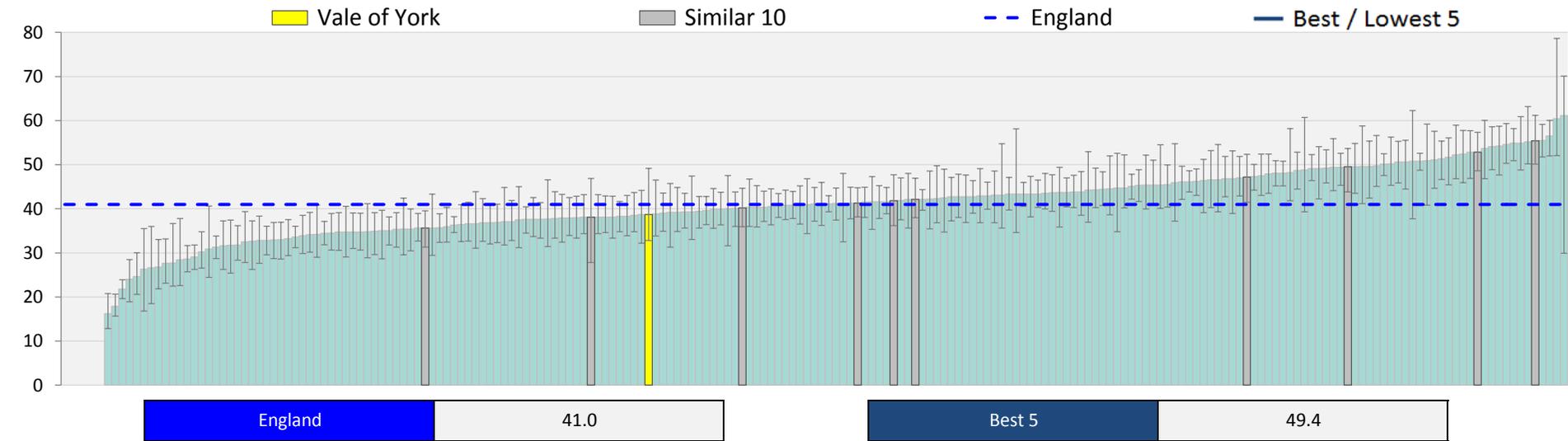
15 Pats.



Definition: % of patients with an LTC who are moving to recovery  
 Source: NHS Digital, Annual Report IAPT  
 Year: 2015/16

# % of patients with an LTC who are achieving reliable recovery

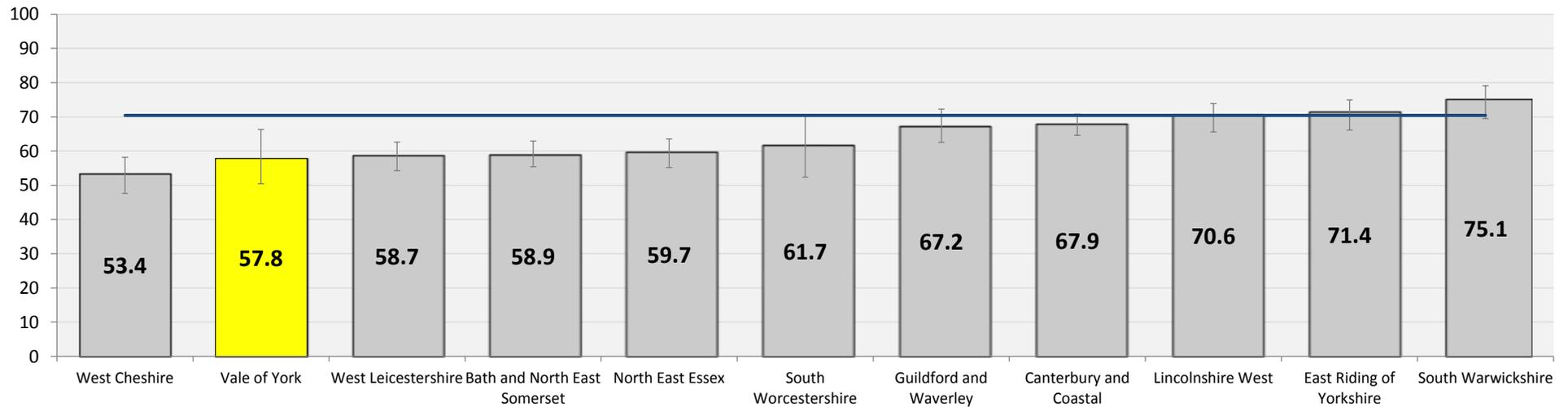
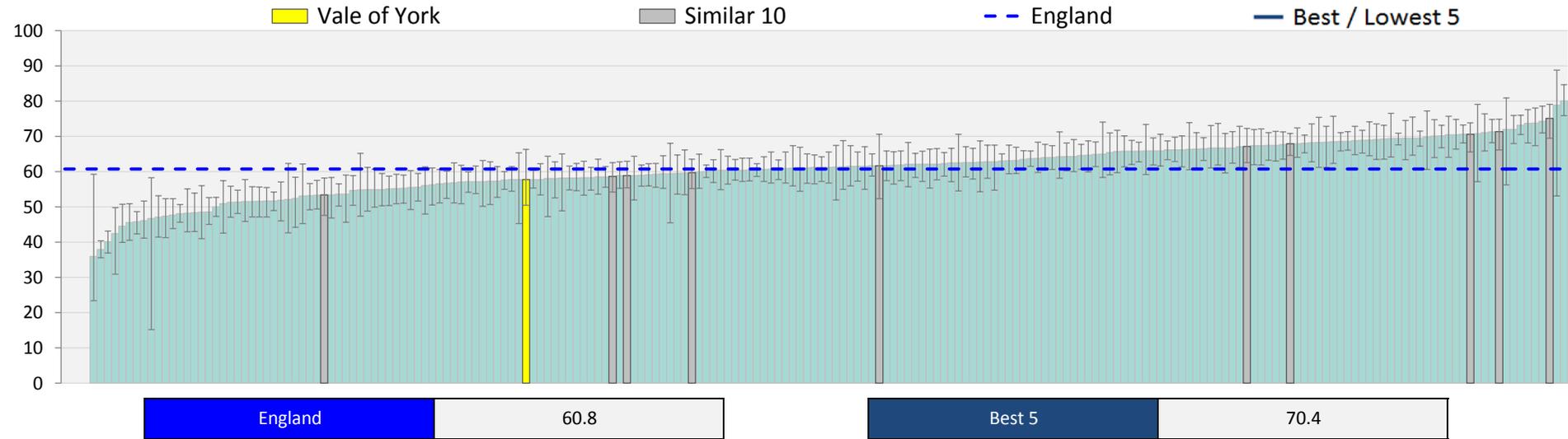
**14 Pats.**



Definition: % of patients with an LTC who are achieving reliable recovery  
 Source: NHS Digital, Annual Report IAPT  
 Year: 2015/16

# % of patients with an LTC who are achieving reliable improvement

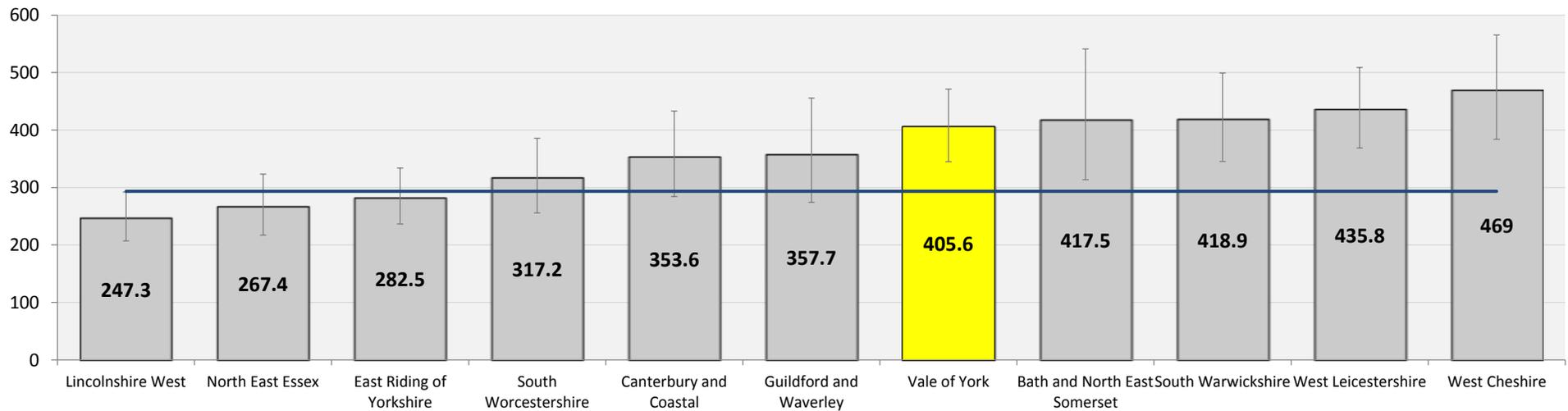
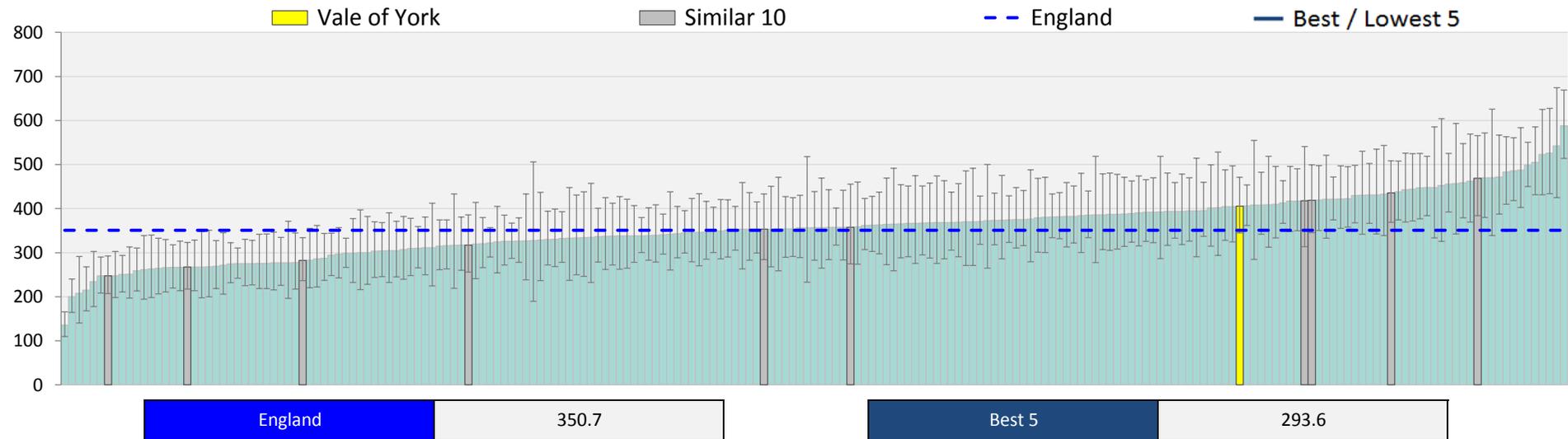
**18 Pats.**



Definition: % of patients with an LTC who are achieving reliable improvement  
 Source: NHS Digital, Annual Report IAPT  
 Year: 2015/16

# <75 Excess Mortality in Adults with SMI

45 Lives

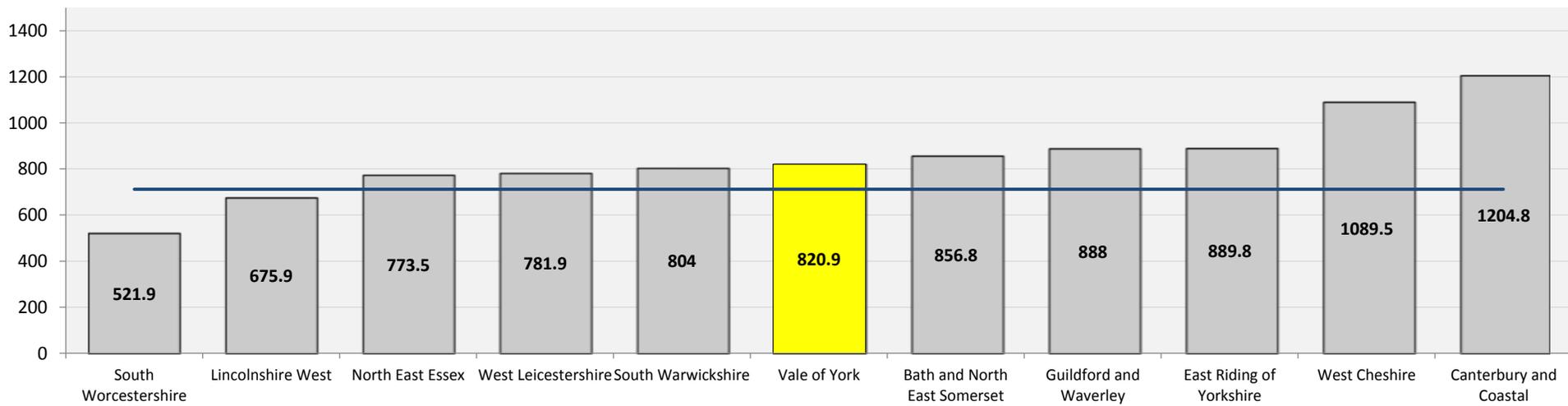
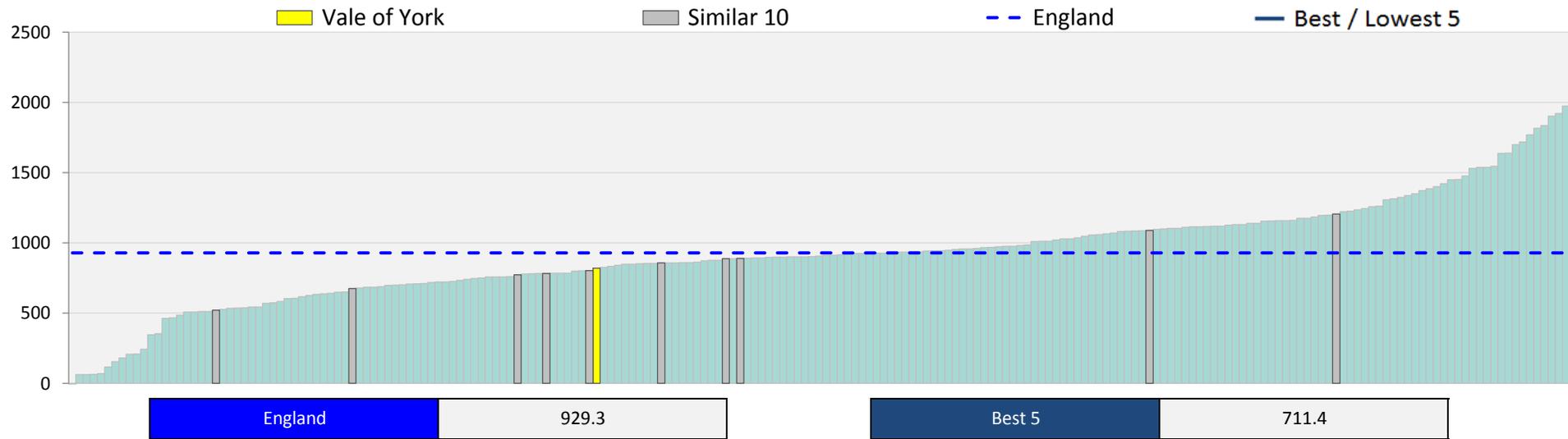


Definition: <75 Excess Mortality in Adults with SMI  
 Source: NCHOD, NHS Digital, Fingertips, PHE  
 Year: 2013/14

# Health Inequalities

# Inequality of unplanned hospitalisation for chronic ambulatory care sensitive conditions

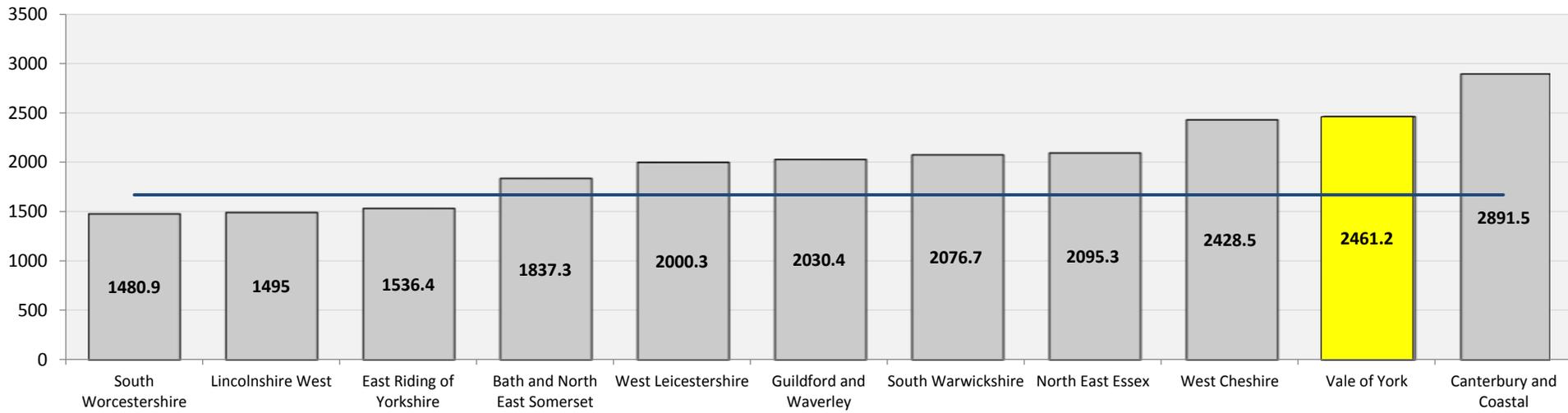
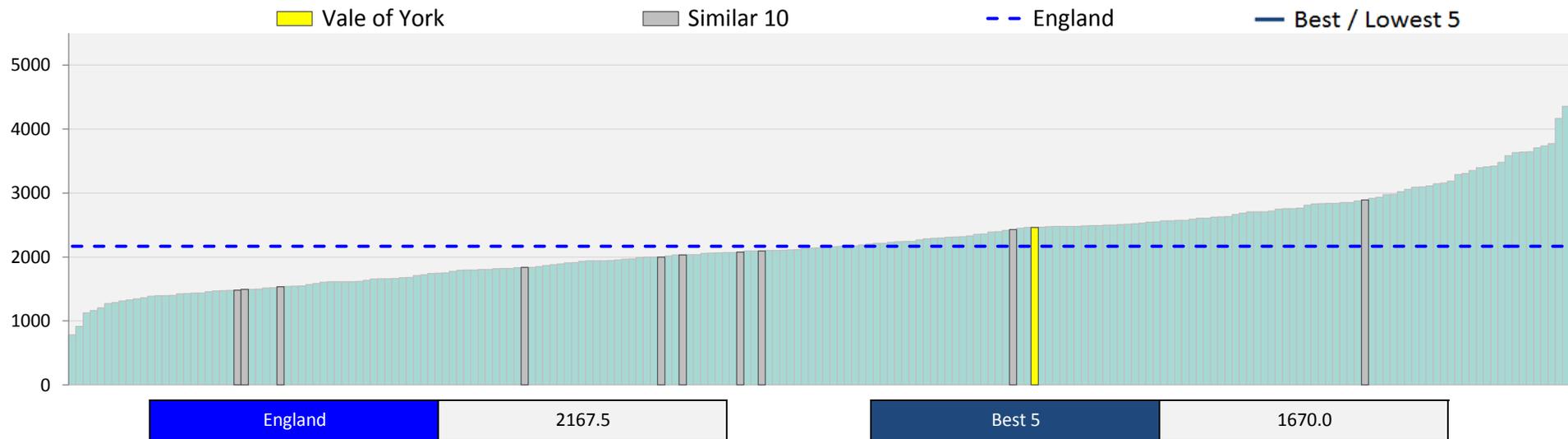
**N/A**



Definition: Inequality of unplanned hospitalisation for chronic ambulatory care sensitive conditions  
 Source: IAF  
 Year: 2015/16

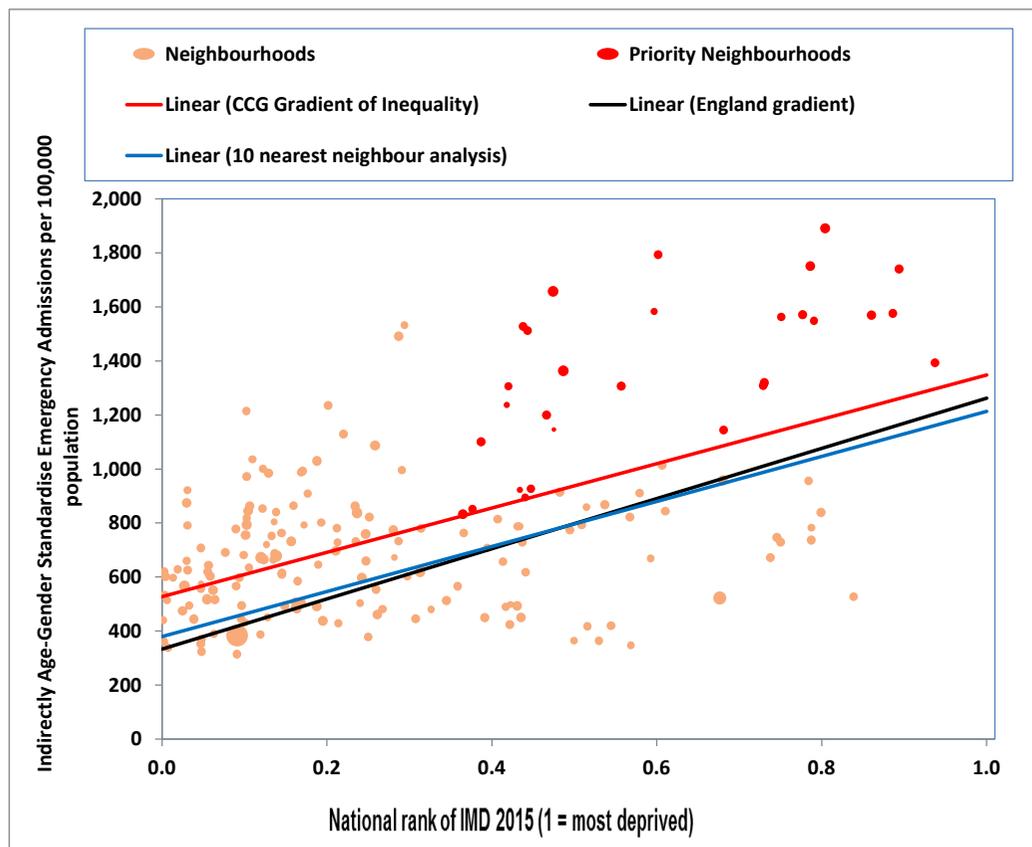
# Inequality of unplanned hospitalisation for urgent care sensitive conditions

**N/A**



Definition: Inequality of unplanned hospitalisation for urgent care sensitive conditions  
 Source: IAF  
 Year: 2015/16

## Priority Neighbourhoods (LSOAs) for Inequality



In the chart to left, the red and orange bubbles represent neighbourhoods (LSOAs) in the CCG. These vary in size in proportion to their population. Nationally there are about 33 thousand Neighbourhoods (LSOAs) with an average population of around 2 thousand. Some LSOAs are split over more than one CCG.

The red line shows the Absolute Gradient of Inequality (AGI) for the CCG. The steeper the line the greater the level of inequality. The black line shows the national AGI. The blue line shows the AGI for the 10 nearest neighbours.

The red bubbles are critical for determining the CCG AGI as they represent priority neighbourhoods ranked in the top half for both Age-Gender Standardised Rates of Emergency Admissions and National Rank of Index of Multiple Deprivation scores that are on or above the red line.

The link below is to a tool for CCGs to explore priority LSOAs  
[http://cgttools.england.nhs.uk/health\\_inequalities/ACSC\\_106a\\_RC\\_HIE\\_Neighbourhoods\\_Tool.xls](http://cgttools.england.nhs.uk/health_inequalities/ACSC_106a_RC_HIE_Neighbourhoods_Tool.xls)

This tool enables alternative partitions of LSOAs between priority and non priority (red and orange bubbles on the chart) and lists data and statistics for priority LSOAs. In line with information governance rules, numbers less than 5 have been suppressed.

Note: AGI data is for Q1-Q4 2015/16.

Sources: HES and population figures provided by NHS Digital re-used with the permission of NHS Digital. All rights reserved.

This AGI Indicator is 106a in the NHSE Improvement and Assessment Framework.

<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/05/technical-annex.pdf>

The data for this indicator can be found at <https://www.england.nhs.uk/ccg-iaf-indicator>

This NHS England report on Challenging Health Inequalities on this and indicator 106b c be found at <https://www.england.nhs.uk/about/gov/equality-hub/challenge-health-inequalities/>

We will shortly provide a RightCare pack which will focus on health inequalities.

# What can be done to address inequality in the CCG?

A large focus on reducing inequality has been on access to primary and hospital care. However inequalities are also present due to other factors i.e. self-care, lifestyle and co-ordination of care. The CCG data should provide insight into local area performance of tackling inequalities. Interventions should be applied with a view of the local population i.e. giving consideration to levels of deprivation within a CCG.

Further research is needed on:

- conditions for particular groups and areas with high admissions
- marginalised groups i.e. Gypsies and Travellers, refugees
- Individual interventions and combined interventions

Does this CCG have any practical examples?  
Has this CCG tried any of the suggested interventions?

Can these suggestions help the CCG to address inequality?

- Social prescribing
- Self management
- Case management
- Integrated primary and secondary care
- Assertive community treatment
- Managed clinical networks
- Medicines optimisation

### Case study: integrated care

Integrated care brings together primary, secondary and community health providers to focus around individual patient needs. Bolton CCG developed an urgent care dashboard which gives real-time information from their local Acute Trust on A&E admissions to GP practices, in a user-friendly format. This enables better understanding of variation in primary care, and the monitoring of individual patients. The dashboard can also be used for case management. One of the first pilot practices in Bolton reported a reduction in A&E attendances by 16.8% while similar practices not taking part saw an increase by just under 4%.

Read more:  
Developing an urgent care dashboard- Yorkshire & Humber AHSN  
Barking and Dagenham, Havering and Redbridge Integrated Care Coalition

### Case study: self management

Self-management is particularly useful for long-term condition i.e. asthma and COPD. Self-management enables patients to understand how they are affected by their condition, and how they can cope with symptoms. Studies have found that the use of telehealth for COPD self-management has reduced visits to accident & emergency. Flo telehealth is an interactive texting services for patients that gives prompts and advise to patients for managing their own health. It also collects patient readings. It is currently use by over 70 health and social care organisations. Flo increases levels of compliance through education and instilling good habits in patients.

Read more:  
Flo Telehealth- West Midlands  
Telehealthcare for COPD

### Case study: social prescribing

Social prescribing encompasses various non-medical interventions including self-help groups, adult learning, gym-based activities and therapy. Social prescribing is particularly useful for those with long-term conditions, which are more common for those living in deprived areas. Rotherham CCG's use of social prescribing reduced demand for urgent hospital care with effective collaboration from voluntary and community organisations. Additionally the average number of A&E attendances reduced by 17%.

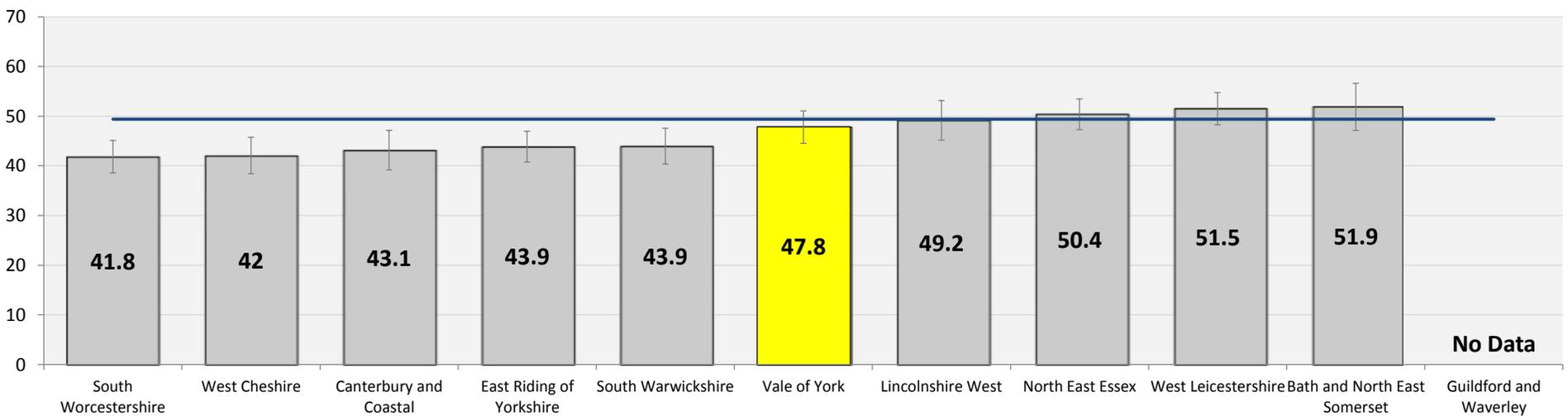
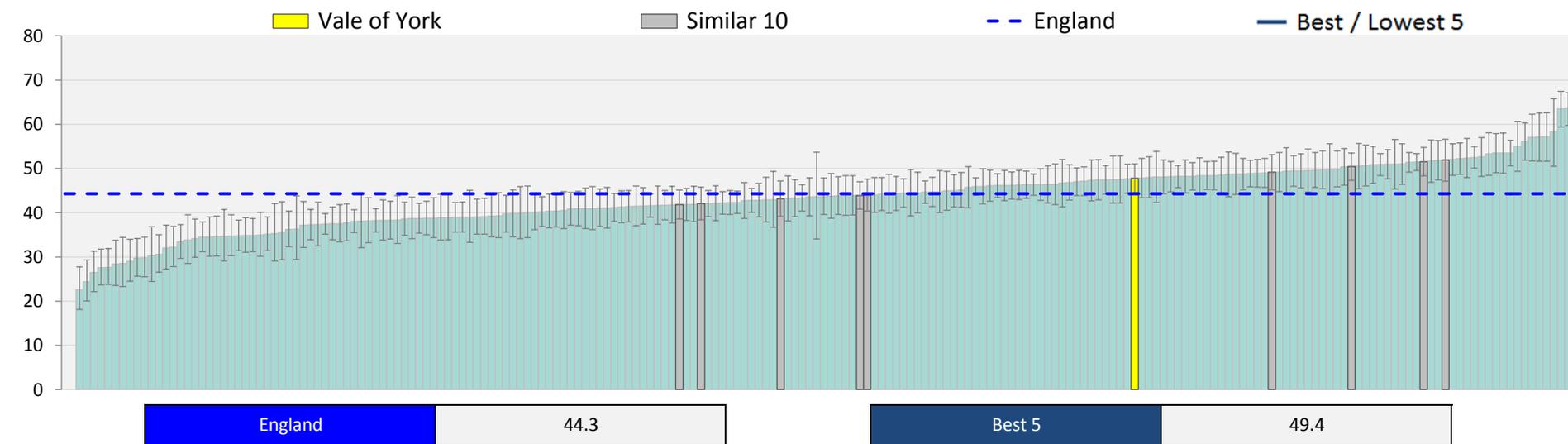
Read more:

- The Rotherham social prescribing service
- Bromley By Bow Centre social prescribing

# End of Life

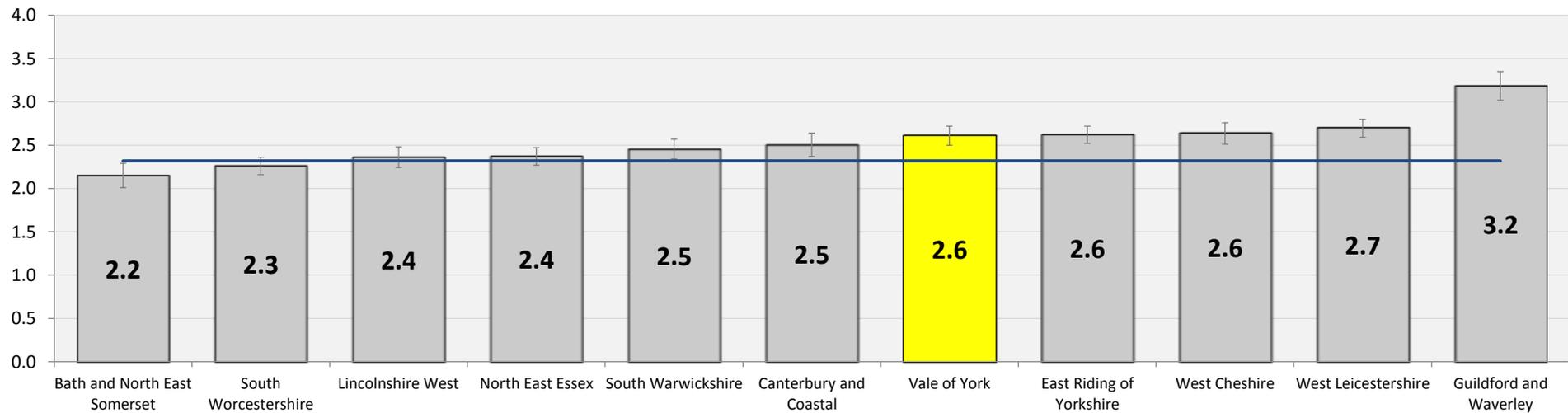
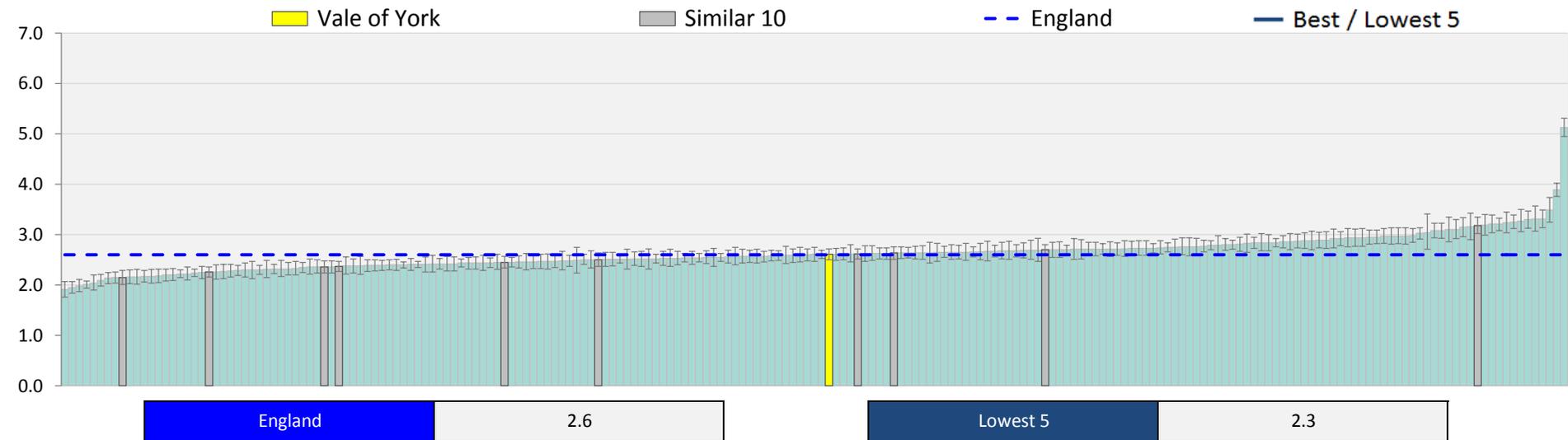
# The percentage of deaths in usual place of residence: people with cancer

14 Pats. (NSS)



Definition: The percentage of deaths in usual place of residence: people with cancer  
 Source: Fingertips, Public Health England  
 Year: 2014

# Cancer: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

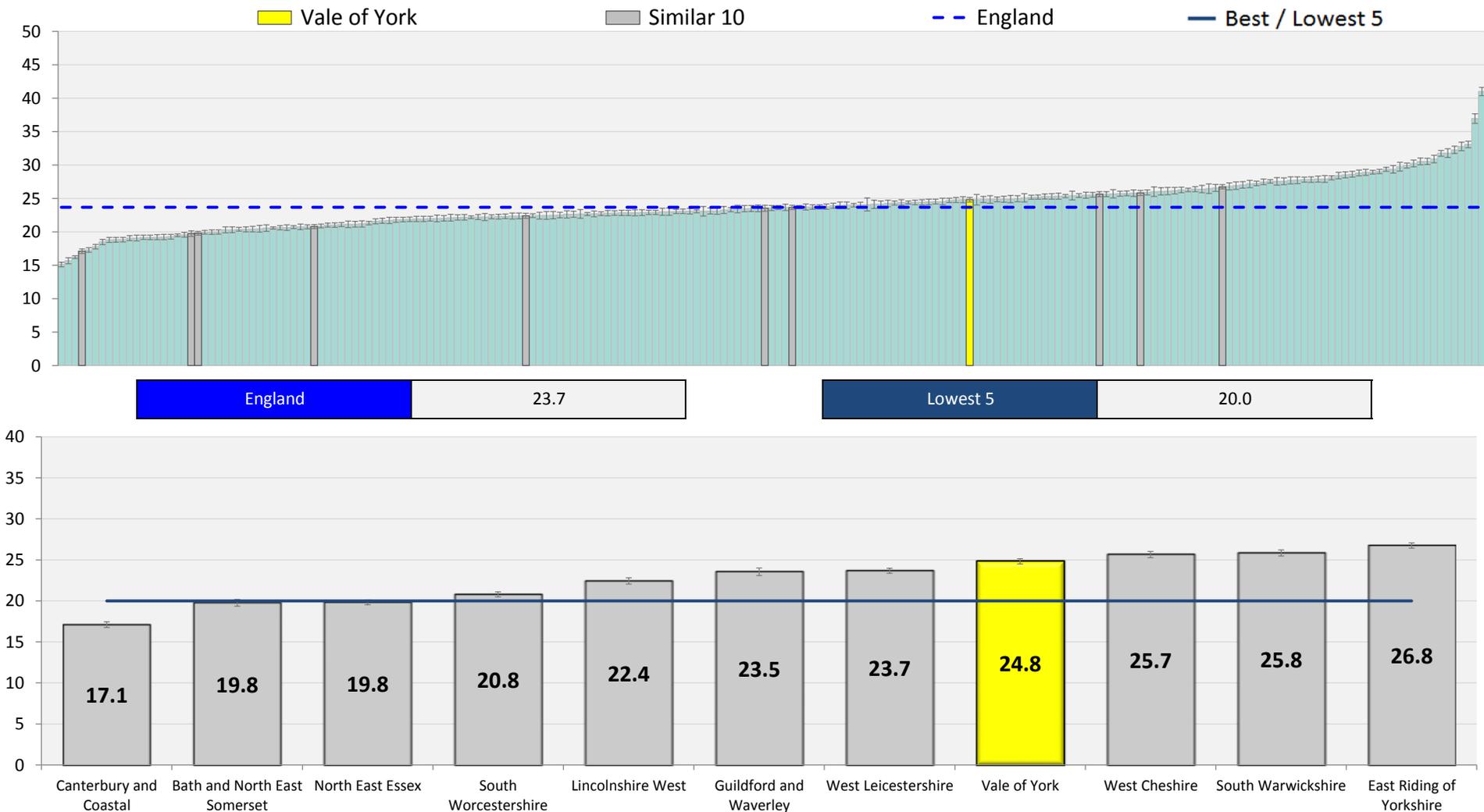


Definition: Cancer: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

## Cancer: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015



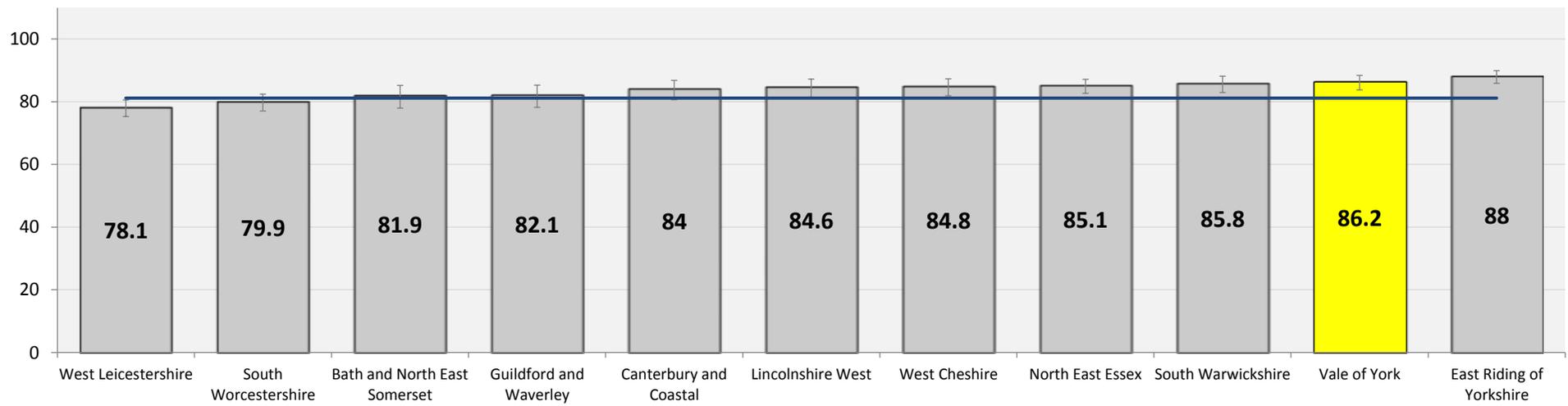
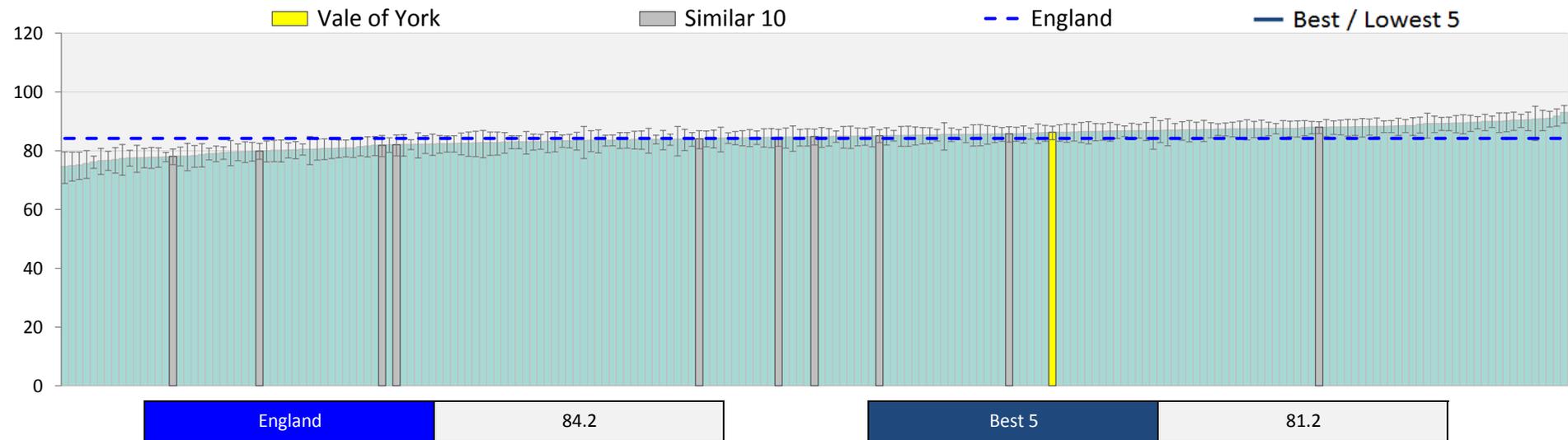
Definition: Cancer: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

# Cancer: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life

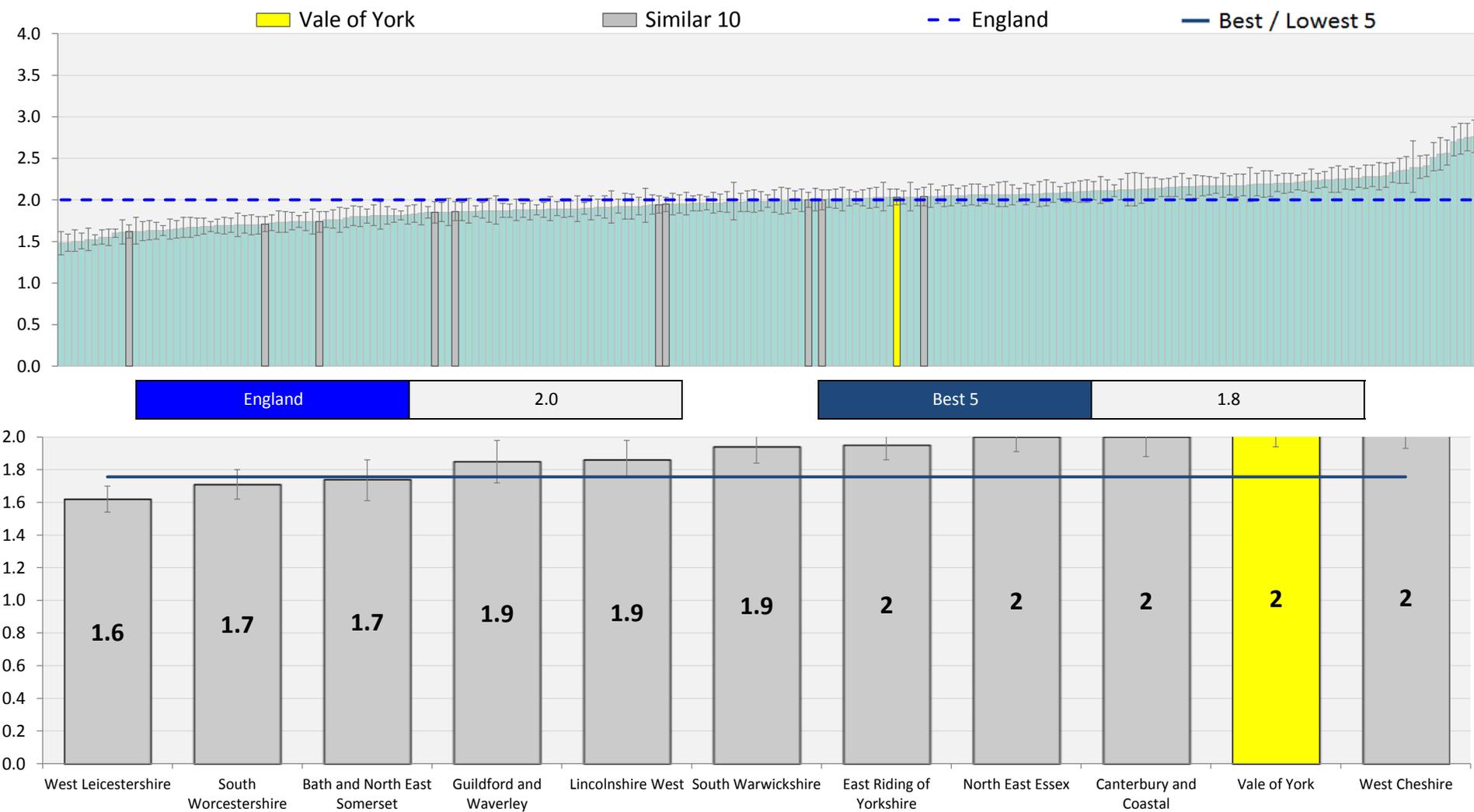
**44 Pats.**



Definition: Cancer: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life  
 Source: PHE, ONS  
 Year: 2013-15

# Cancer: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

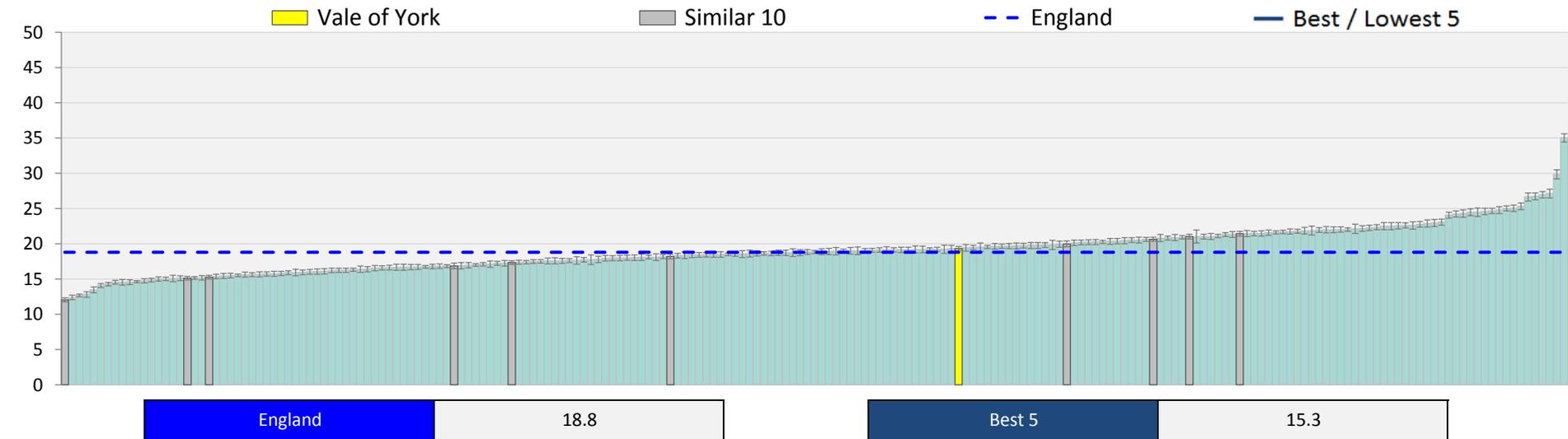
**237 Adm.**



Definition: Cancer: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# Cancer: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

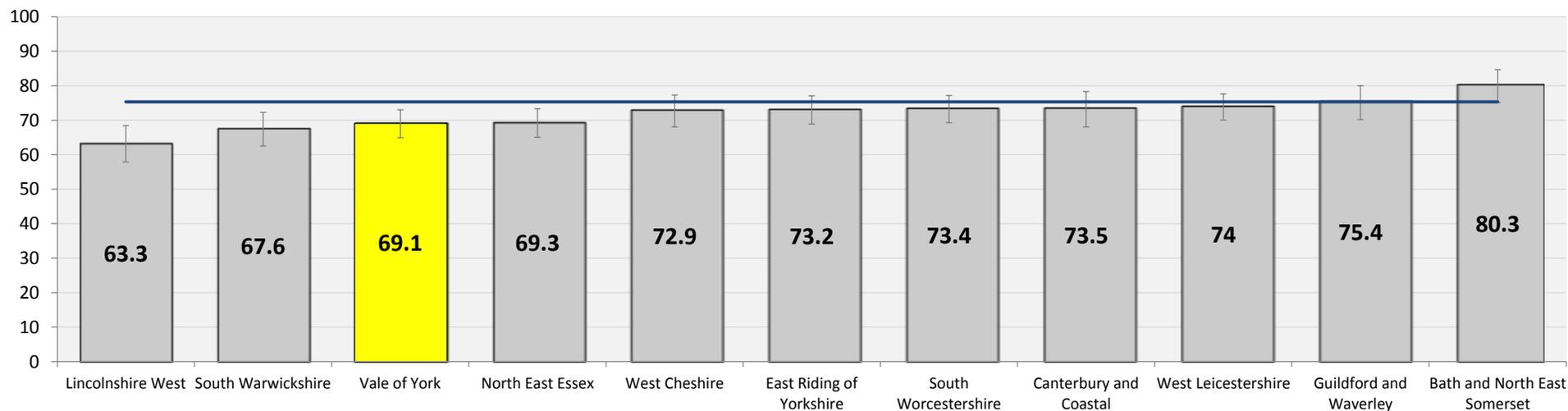
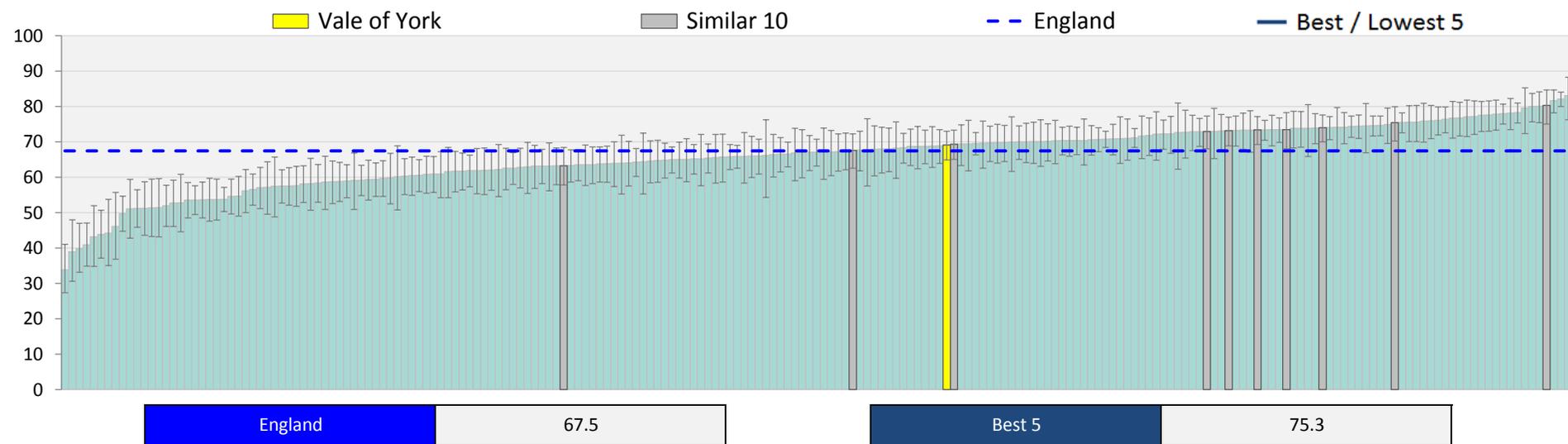
**3476 Days**



Definition: Cancer: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

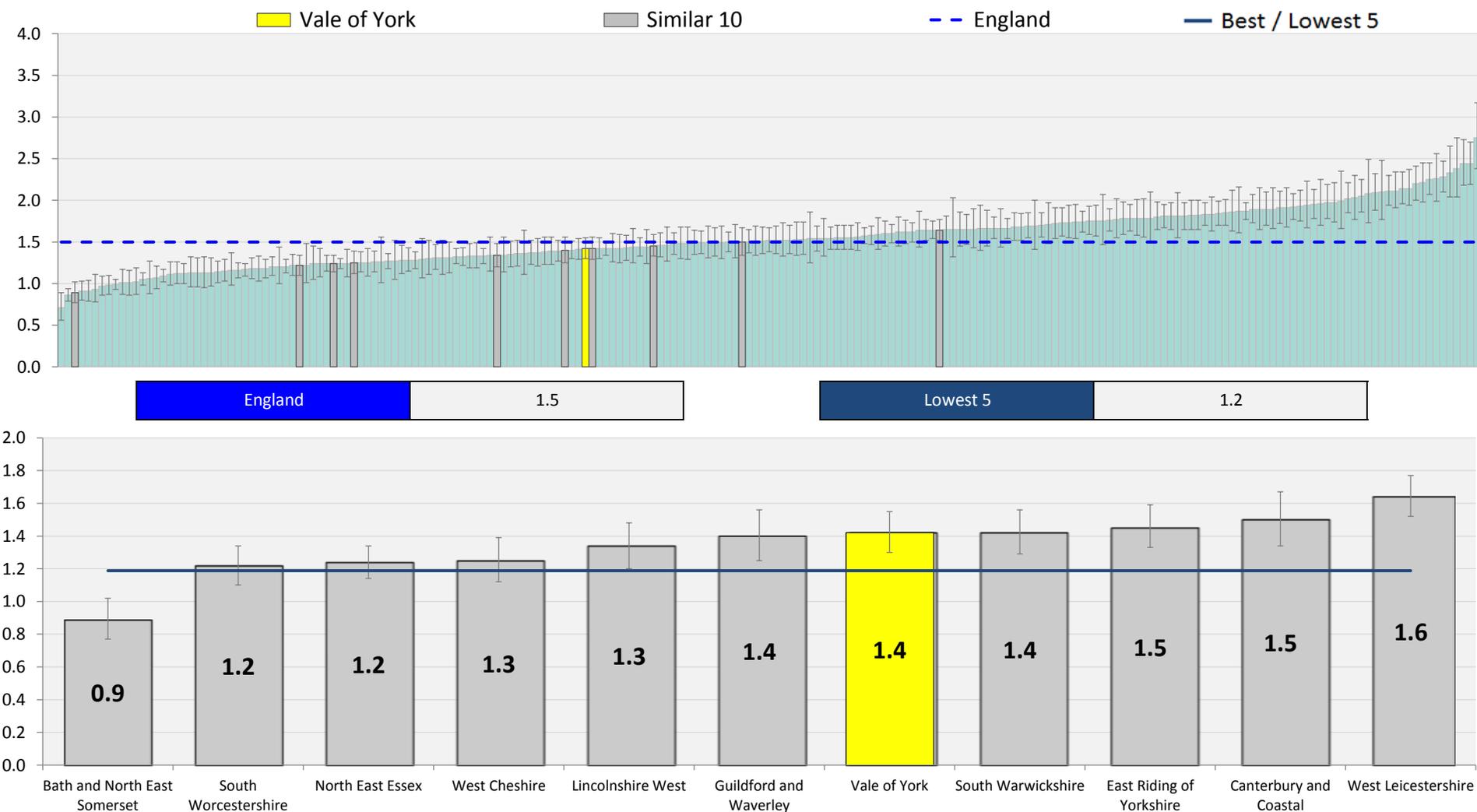
# The percentage of deaths in usual place of residence: people with dementia aged 65+

31 Pats.



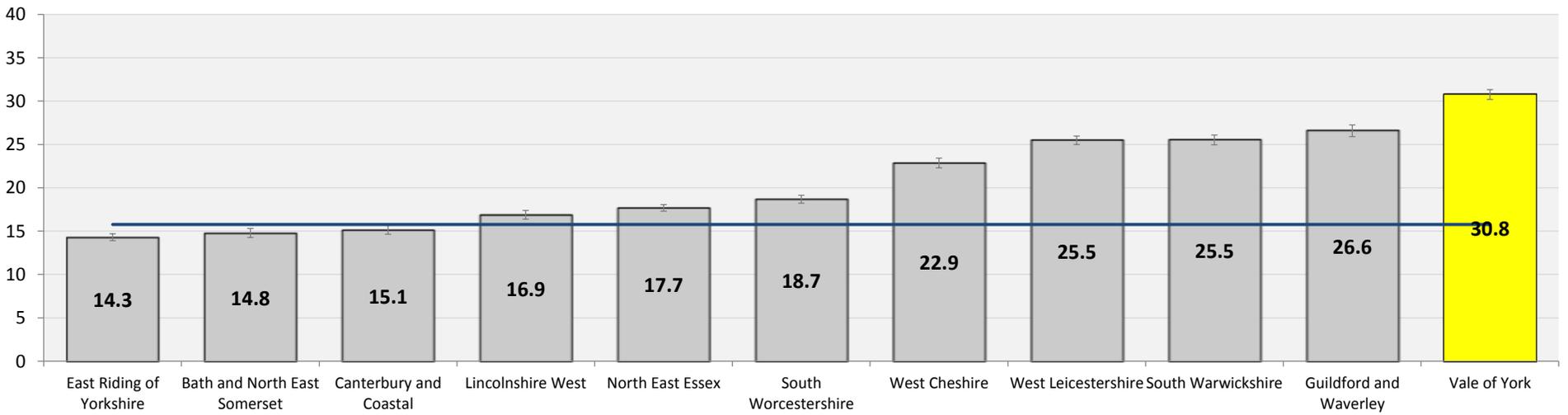
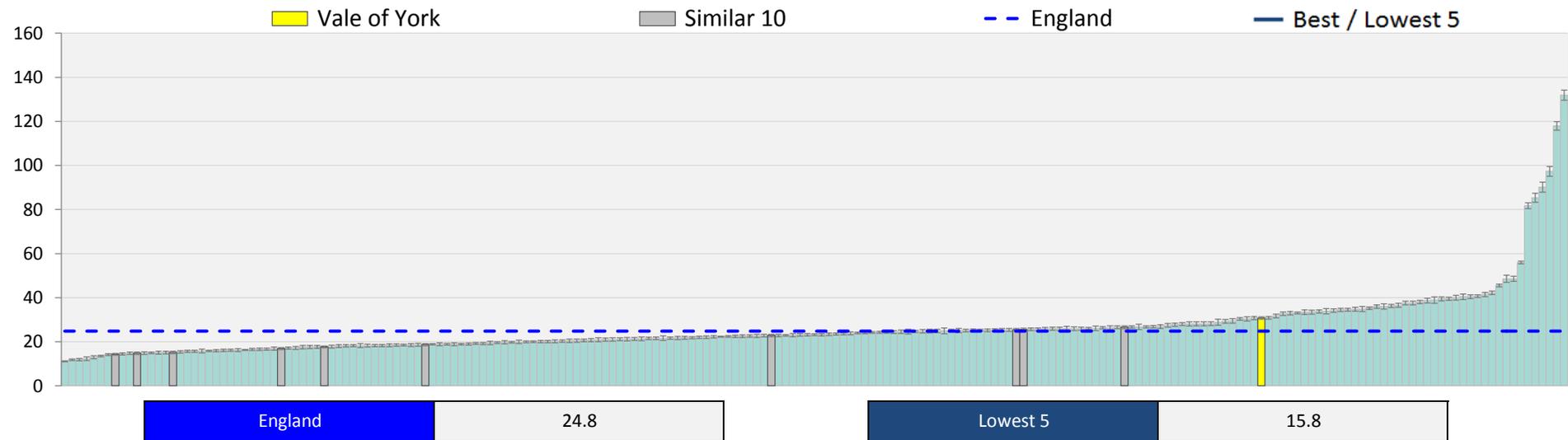
Definition: The percentage of deaths in usual place of residence: people with dementia aged 65+  
 Source: ONS Mortality File, PHE. Fingertips, PHE  
 Year: 2014

# Dementia: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015



Definition: Dementia: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

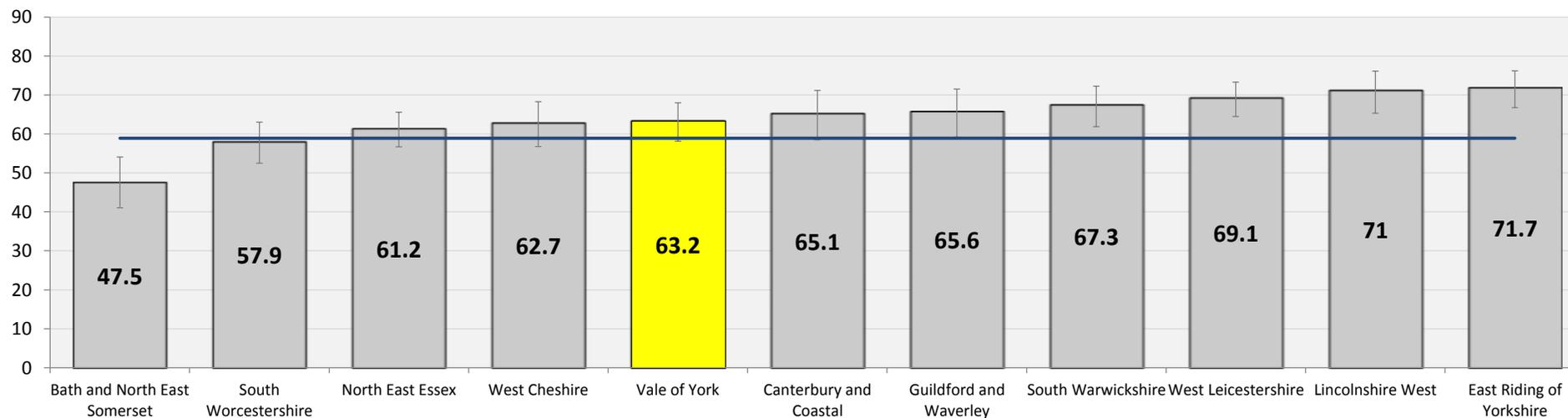
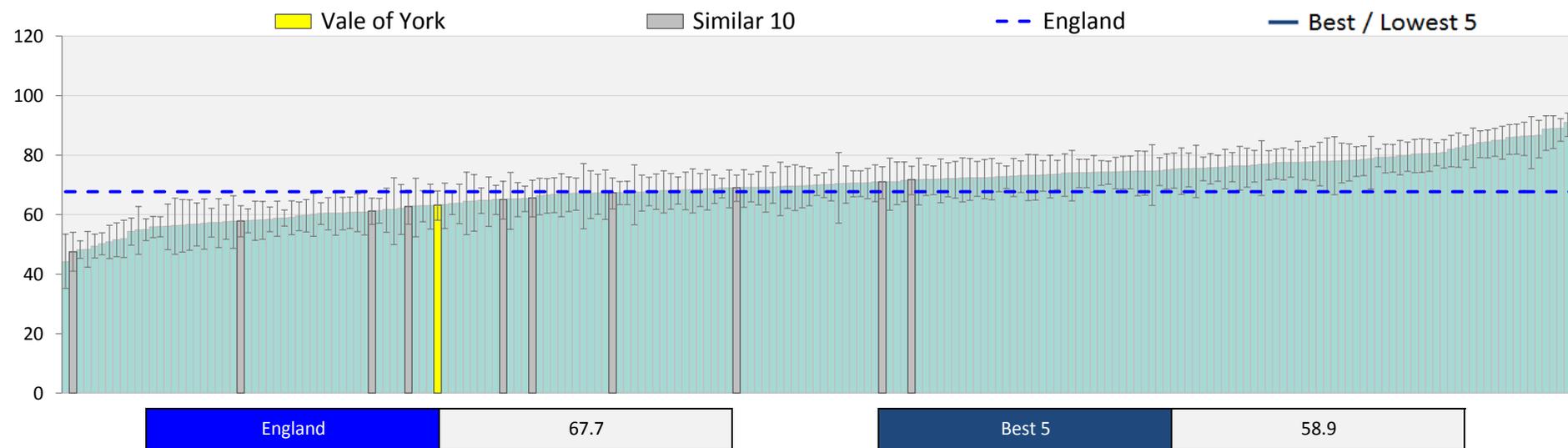
# Dementia: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015



Definition: Dementia: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# Dementia: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life

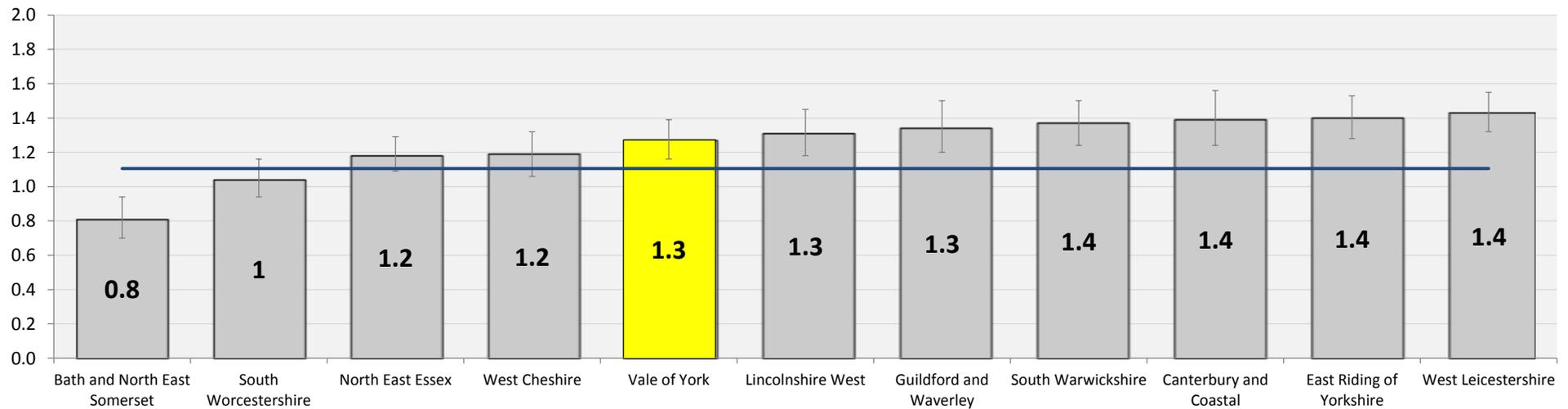
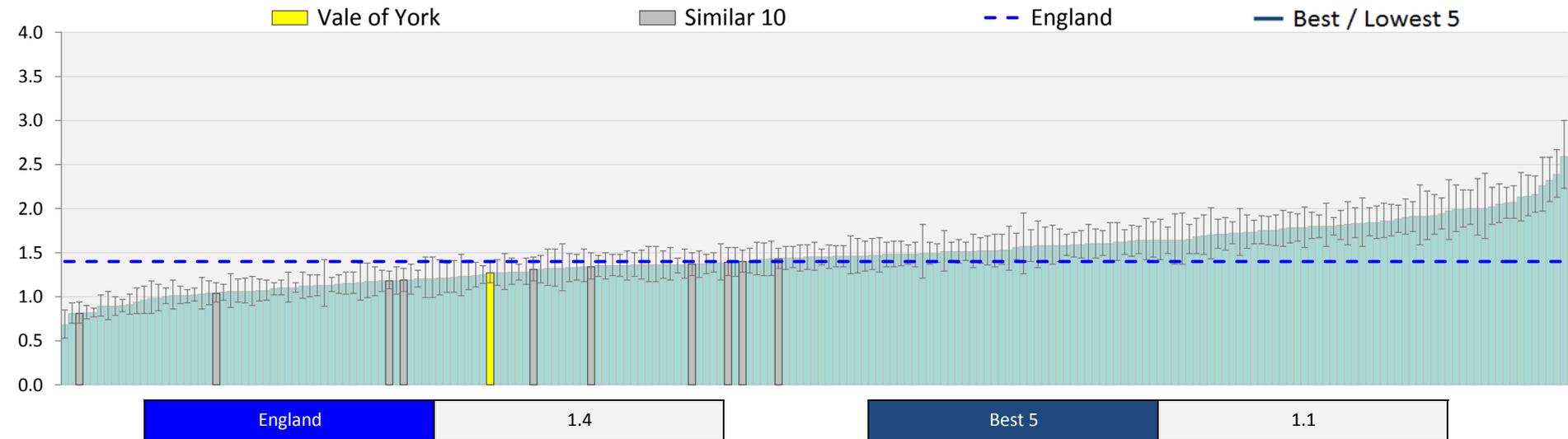
16 Pats. (NSS)



Definition: Dementia: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life  
 Source: PHE, ONS  
 Year: 2013-15

# Dementia: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

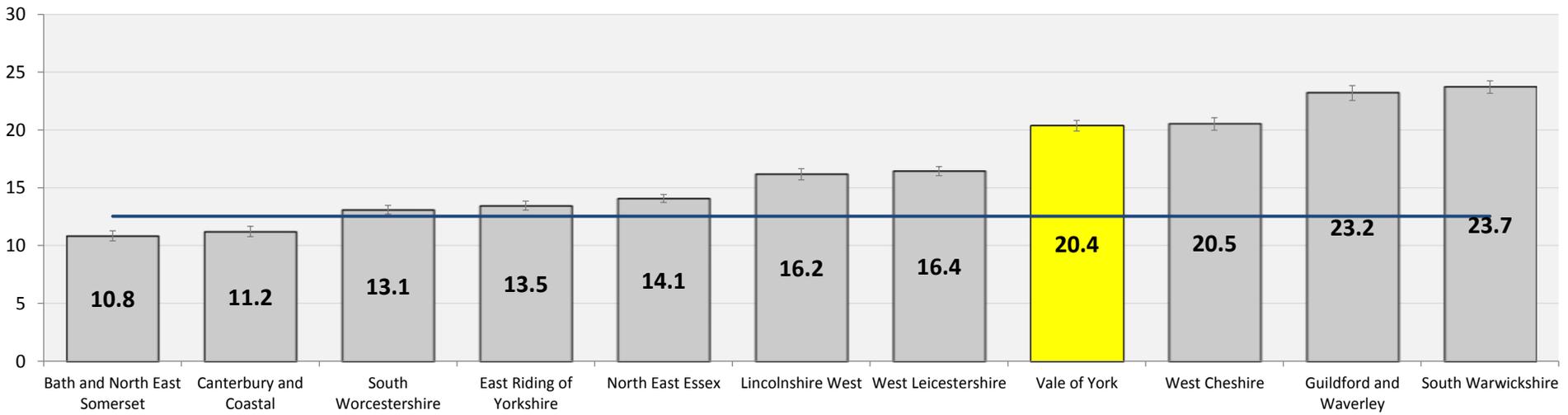
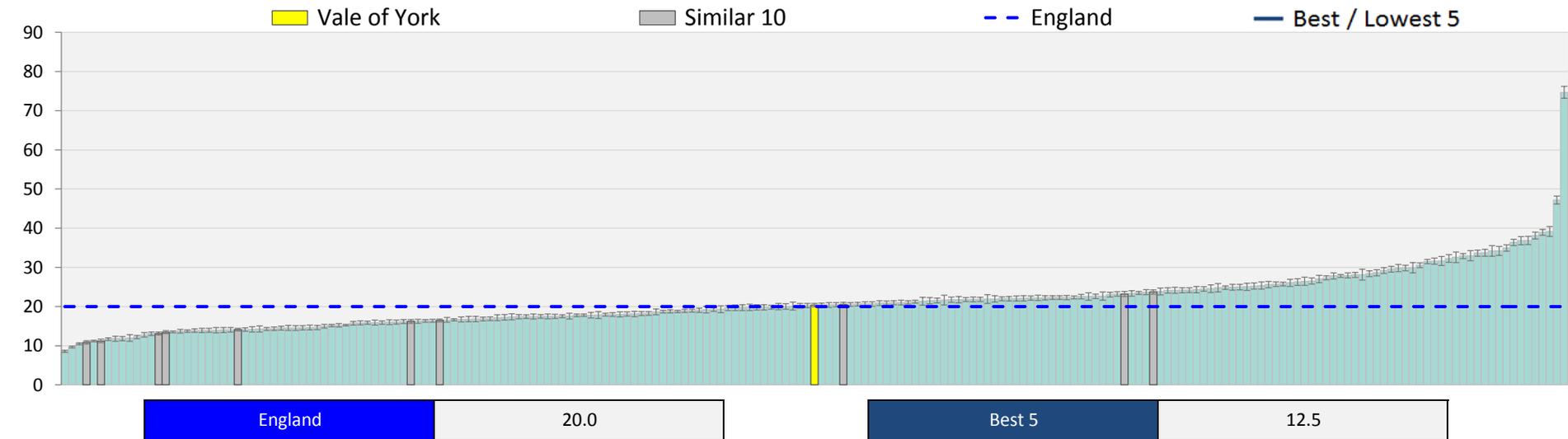
**60 Adm.**



Definition: Dementia: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# Dementia: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

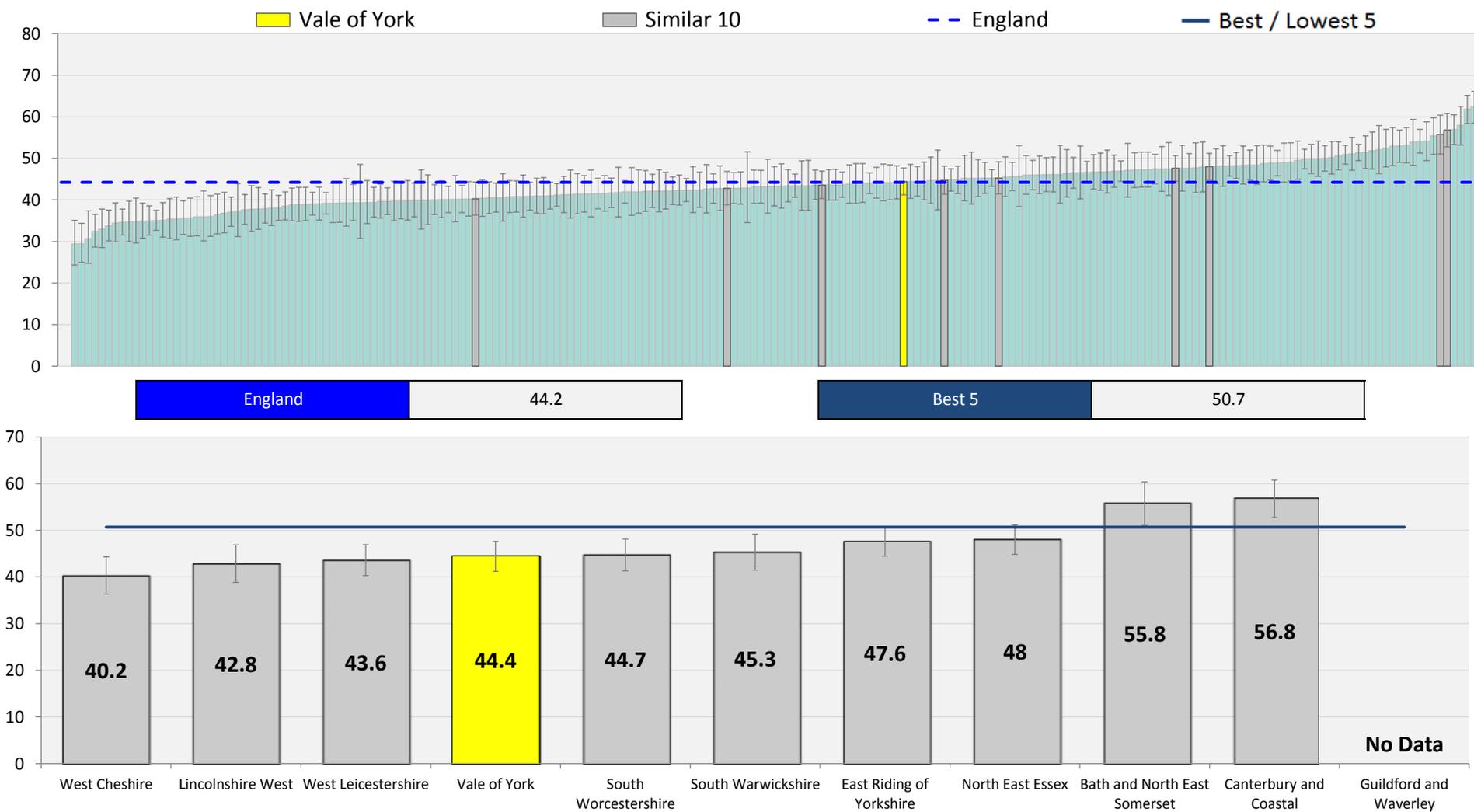
**2868 Days**



Definition: Dementia: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

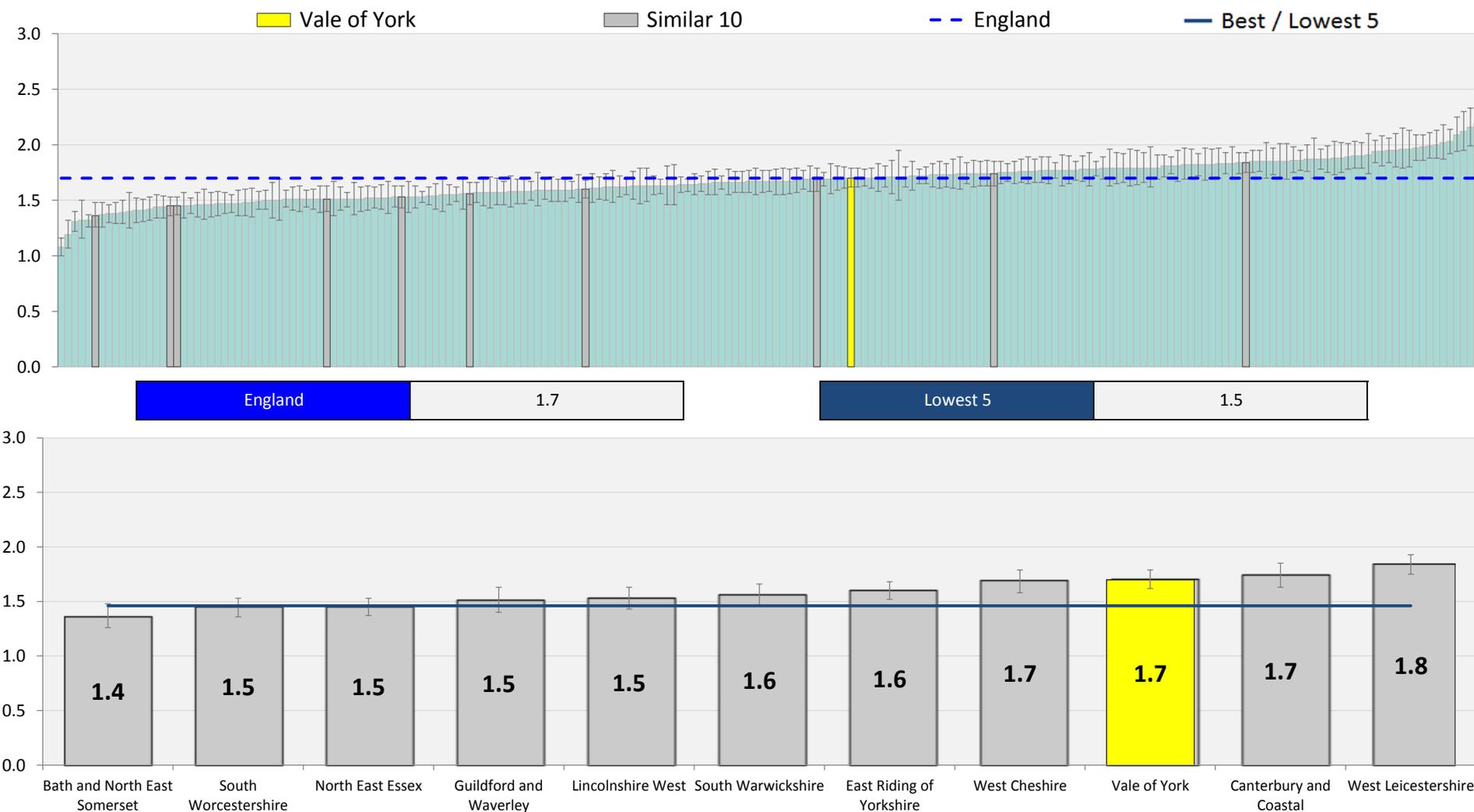
# The percentage of deaths in usual place of residence: people with circulatory diseases

57 Pats.



Definition: The percentage of deaths in usual place of residence: people with circulatory diseases  
 Source: Fingertips, Public Health England  
 Year: 2014

## Circulatory: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

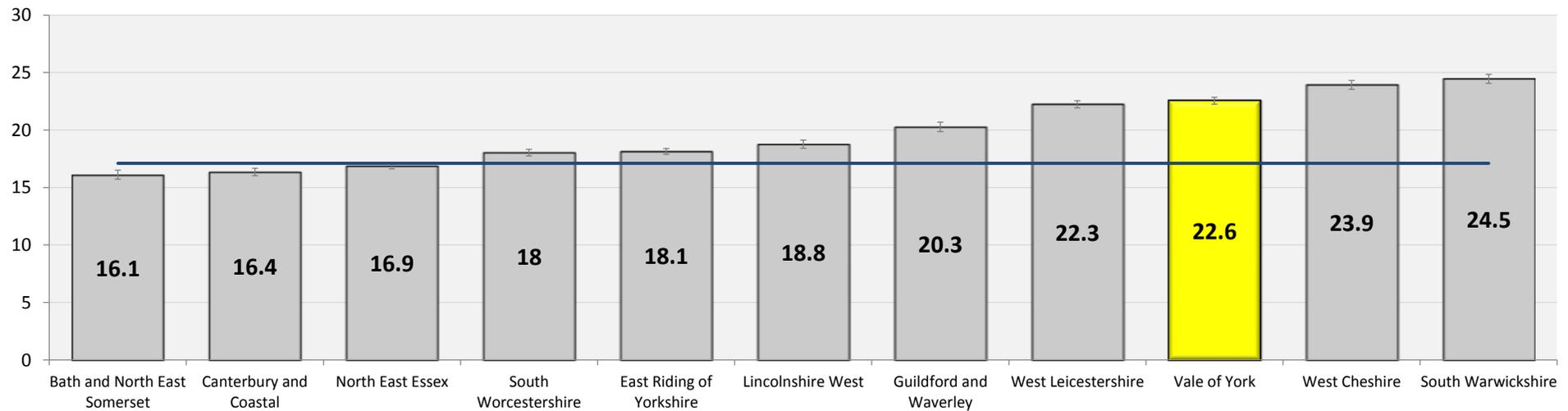
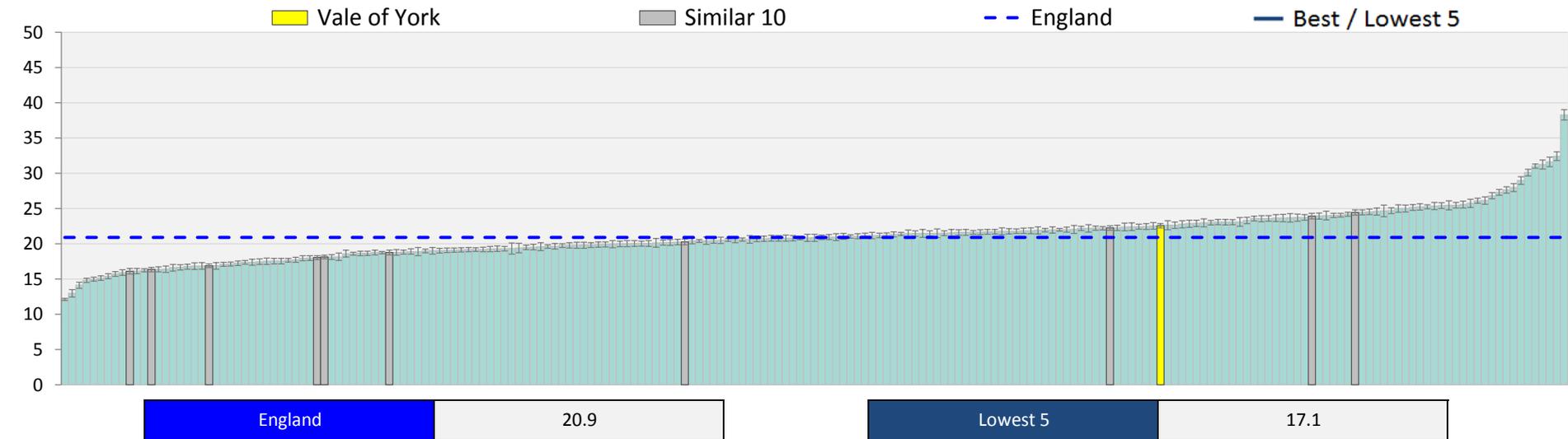


Definition: Circulatory: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

## Circulatory: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015



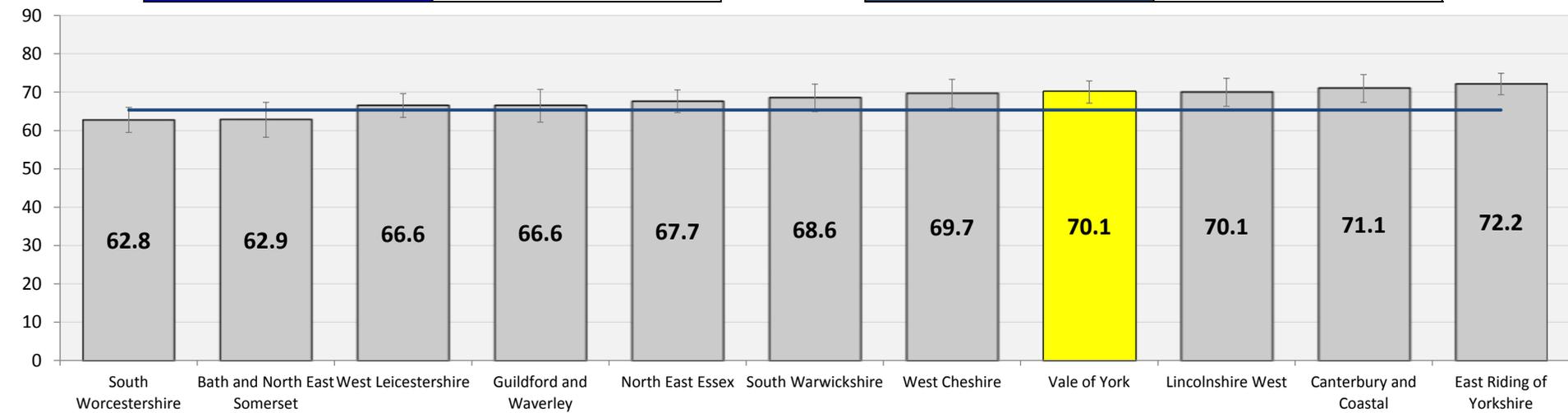
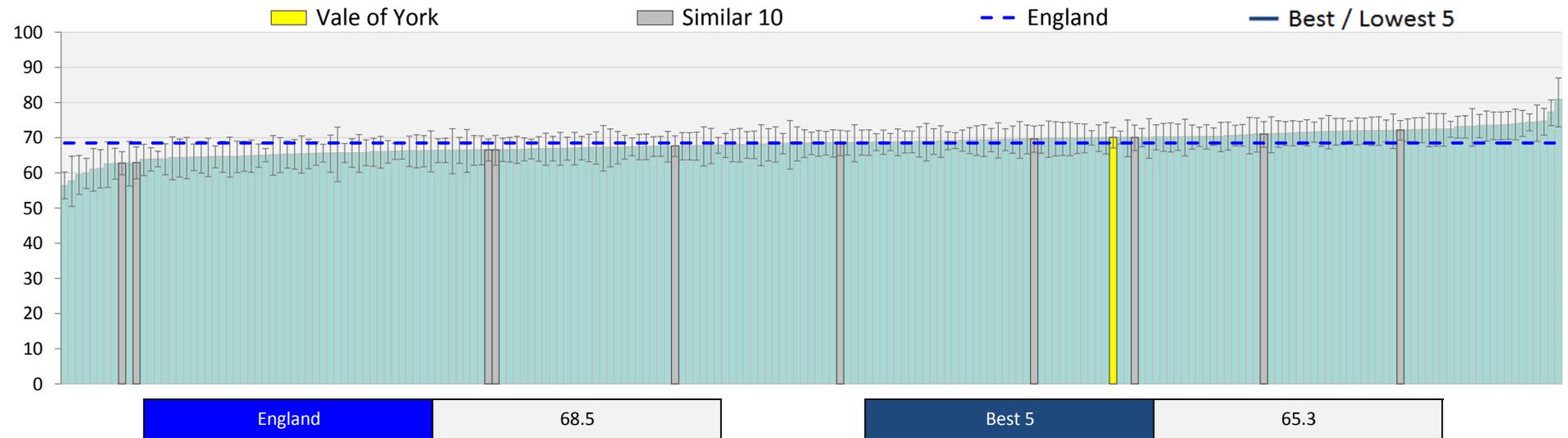
Definition: Circulatory: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

# Circulatory: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life

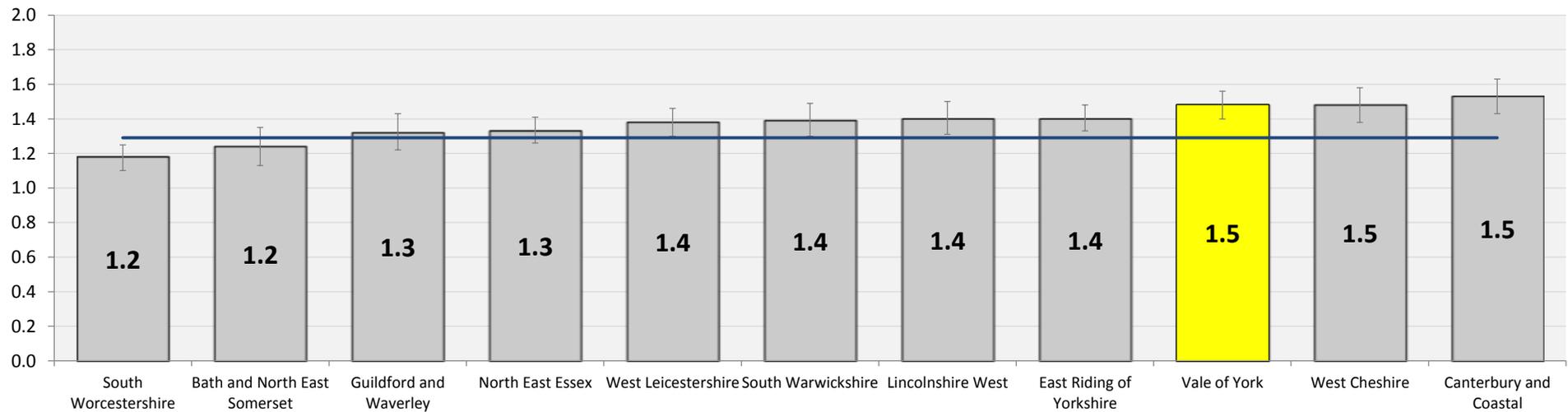
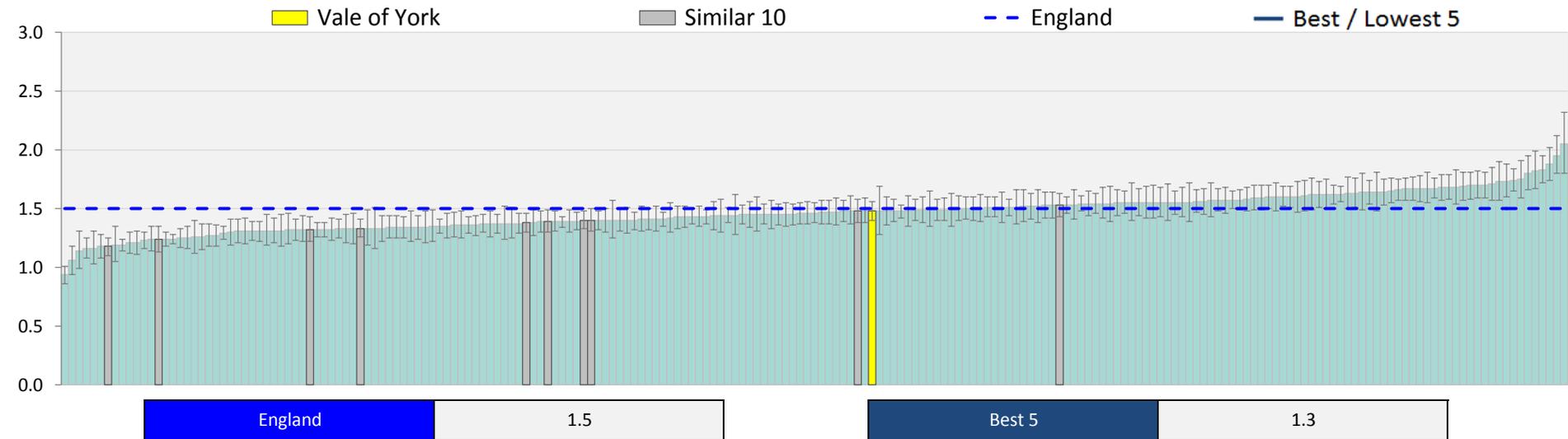
**45 Pats.**



Definition: Circulatory: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life  
 Source: PHE, ONS  
 Year: 2013-15

# Circulatory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

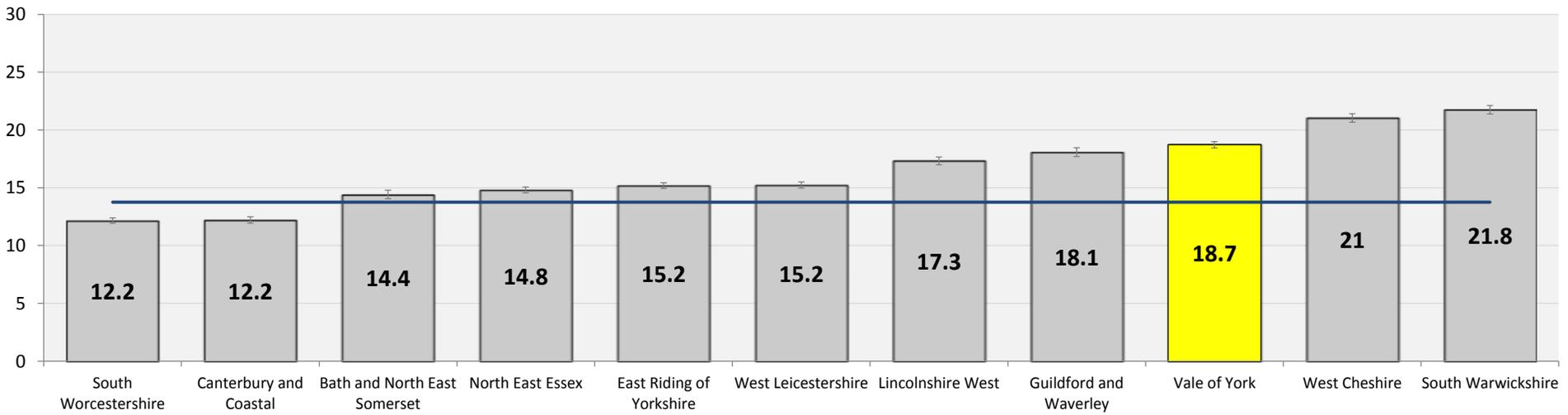
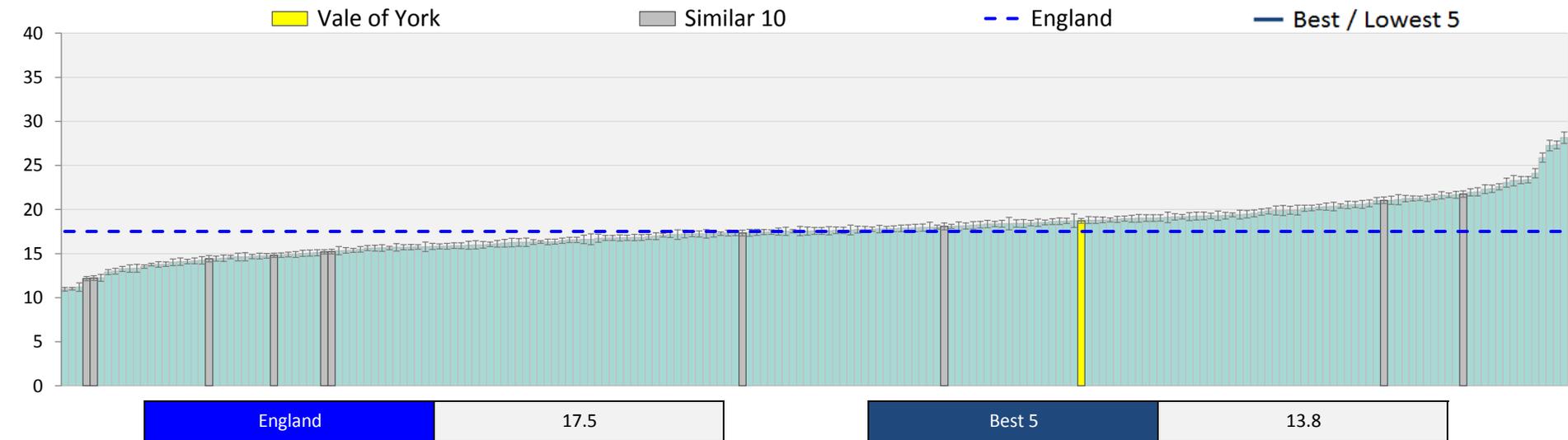
**181 Adm.**



Definition: Circulatory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# Circulatory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

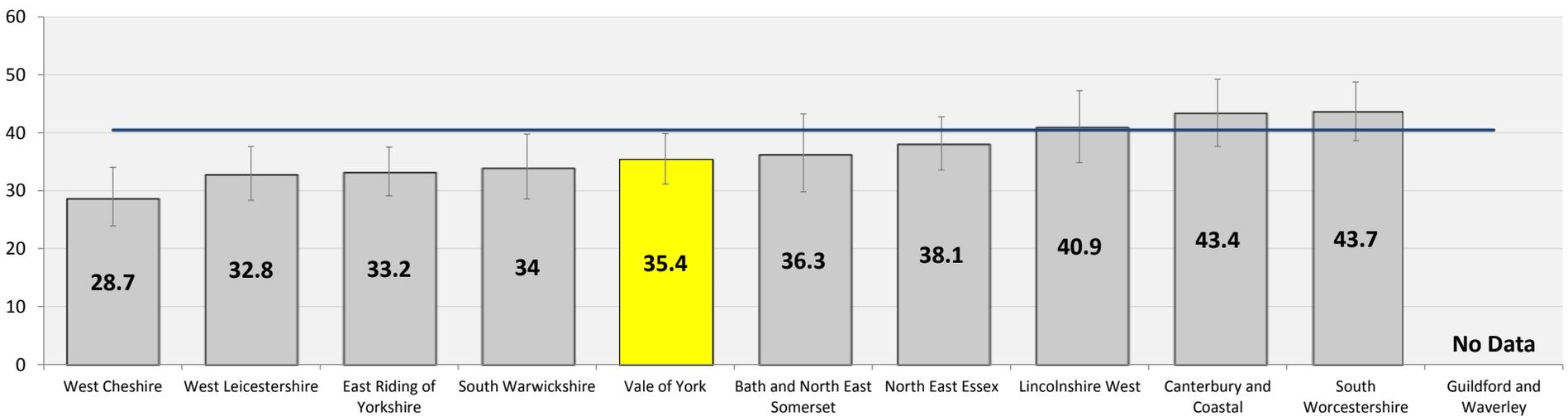
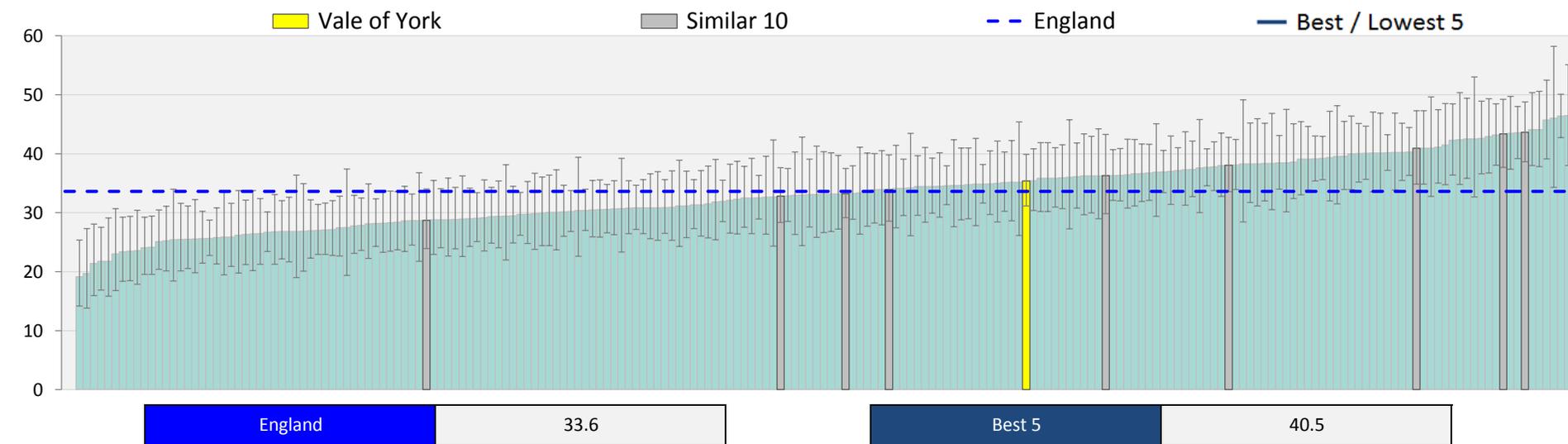
**4736 Days**



Definition: Circulatory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

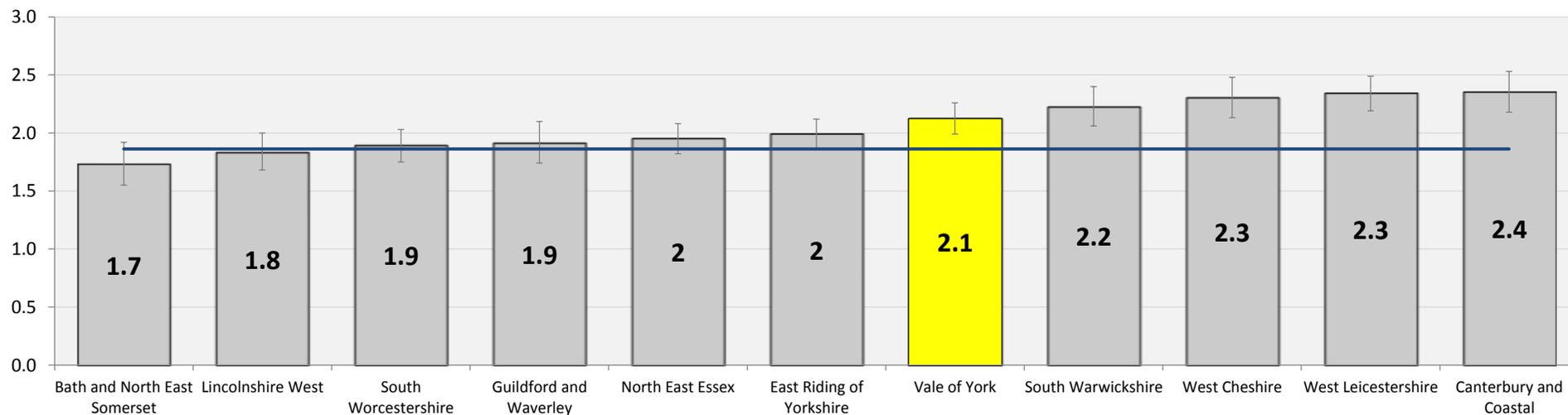
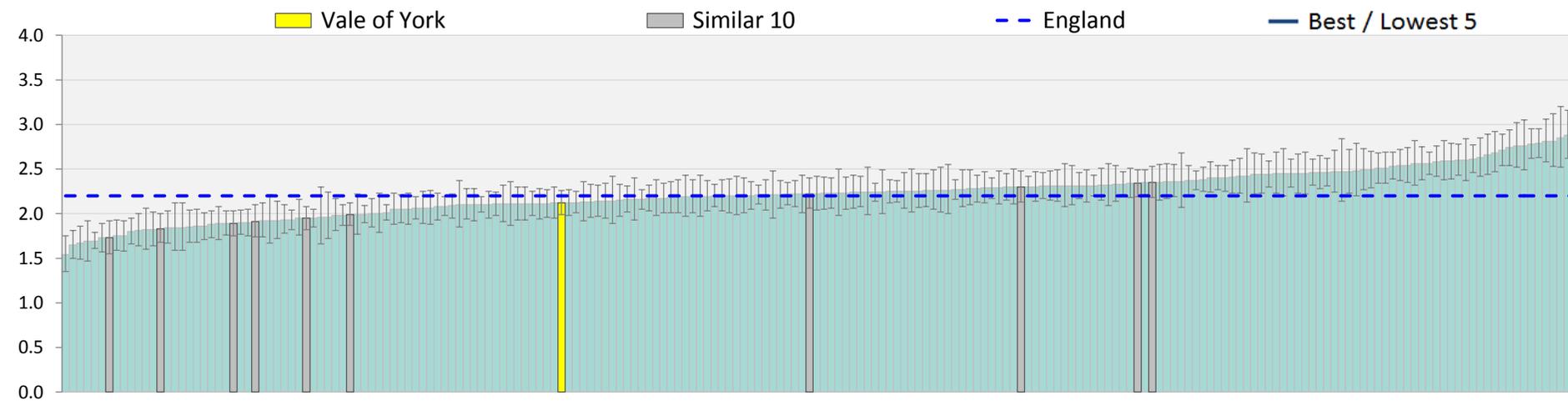
# The percentage of deaths in usual place of residence: people with respiratory diseases

**23 Pats.**



Definition: The percentage of deaths in usual place of residence: people with respiratory diseases  
 Source: Fingertips, Public Health England  
 Year: 2014

# Respiratory: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

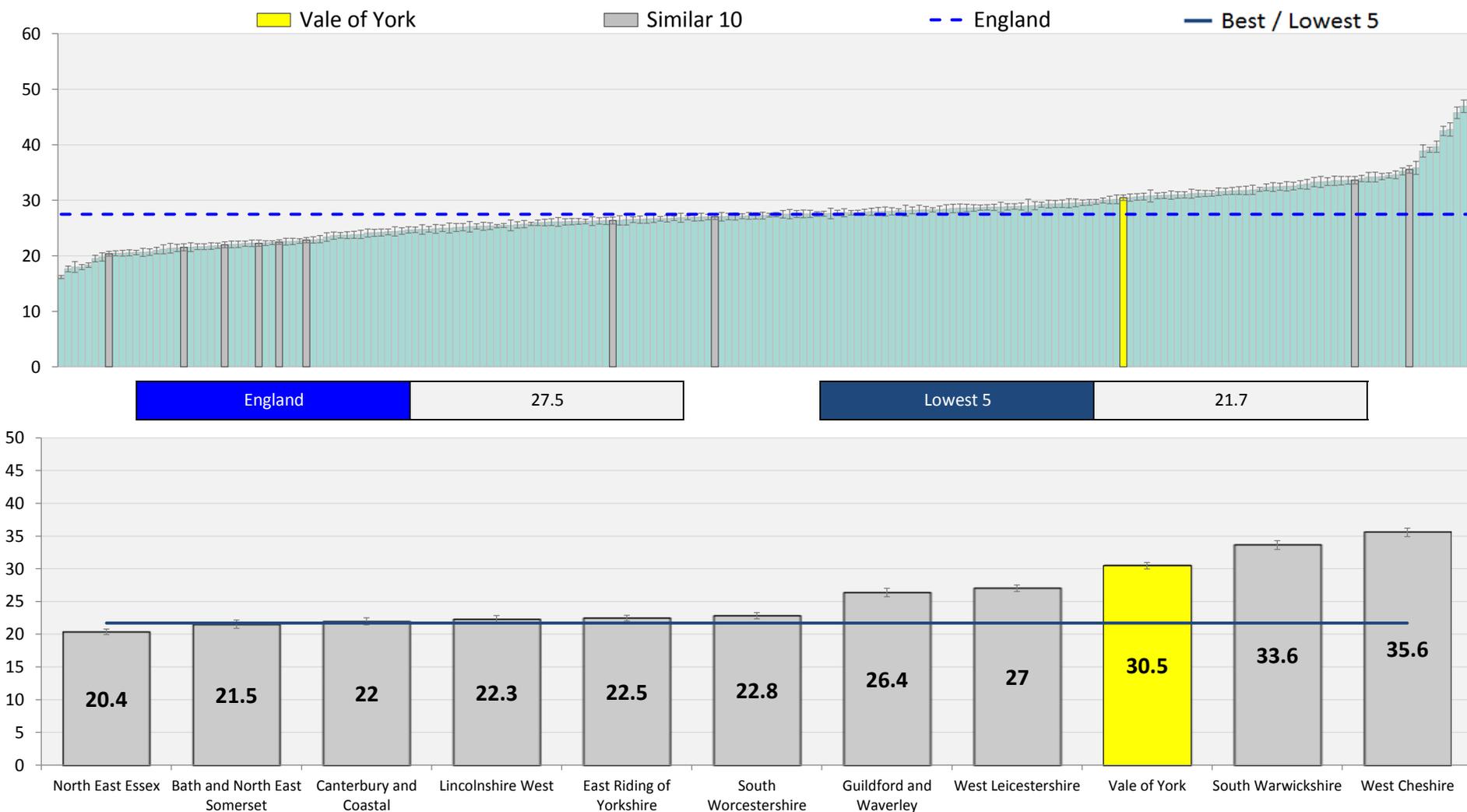


Definition: Respiratory: Average annual number of ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

## Respiratory: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015



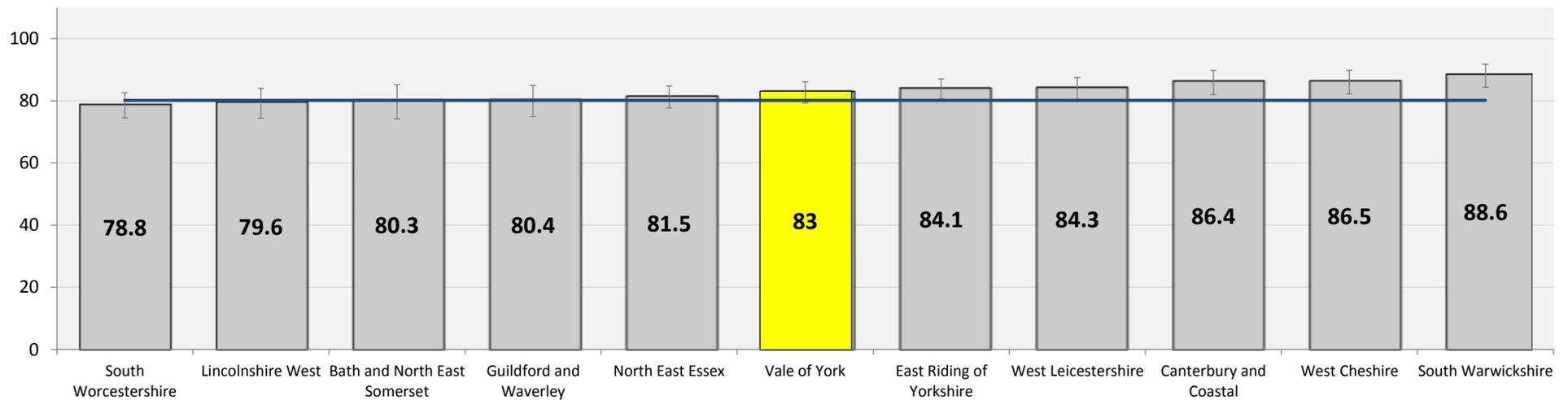
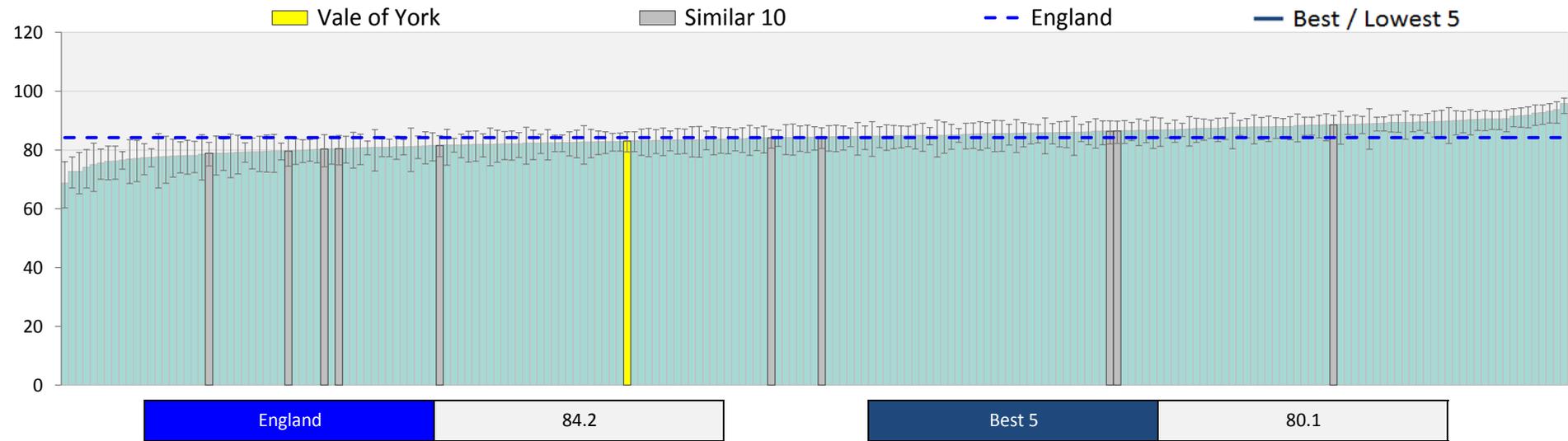
Definition: Respiratory: Average annual number of days (nights) spent in ordinary hospital admissions during the last year of life of CCG residents who died 2013-2015

Source: PHE, ONS

Year: 2013-15

# Respiratory: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life

13 Pats. (NSS)



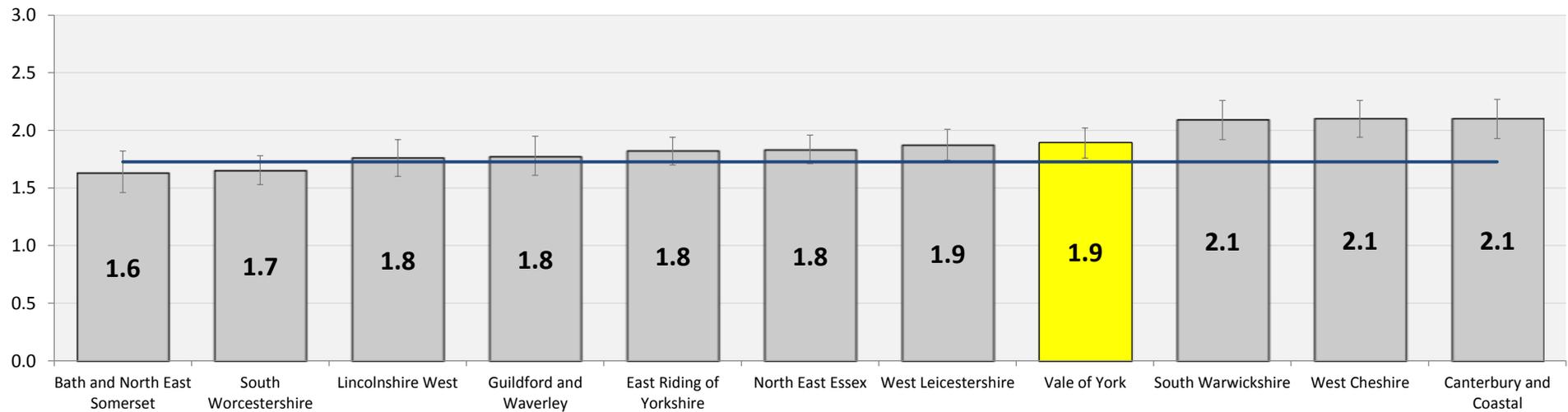
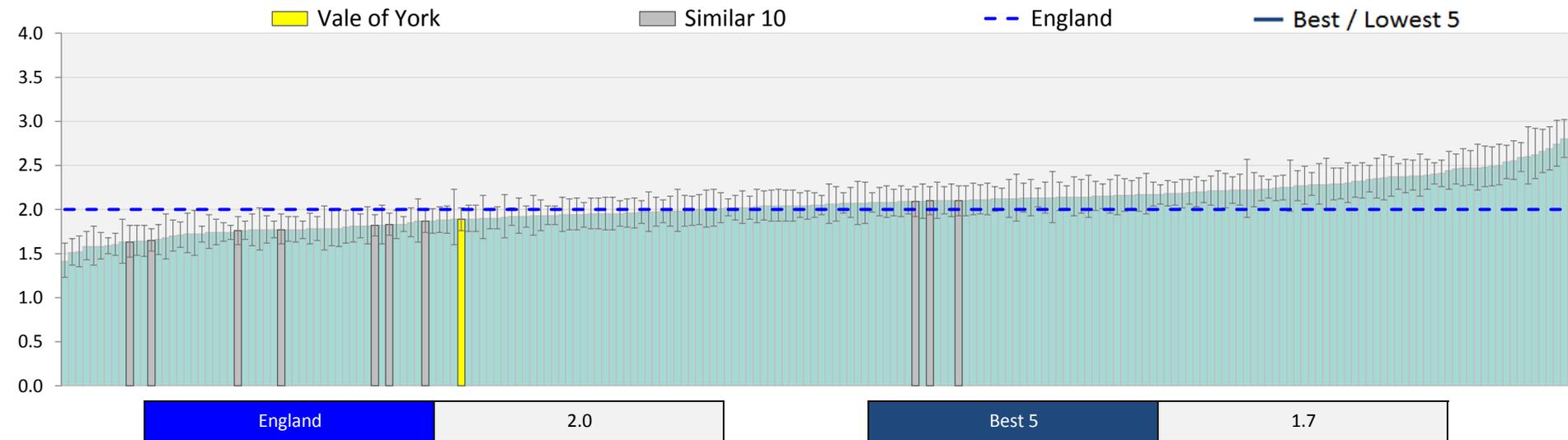
Definition: Respiratory: The percentage of CCG residents who died 2013-2015 with an emergency hospital admission during their last year of life

Source: PHE, ONS

Year: 2013-15

# Respiratory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

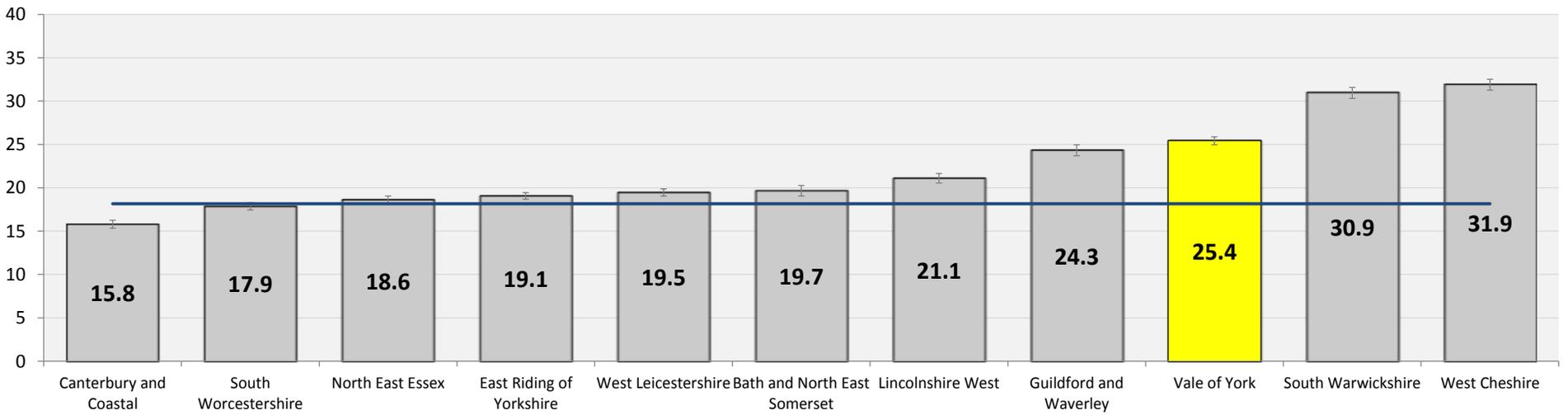
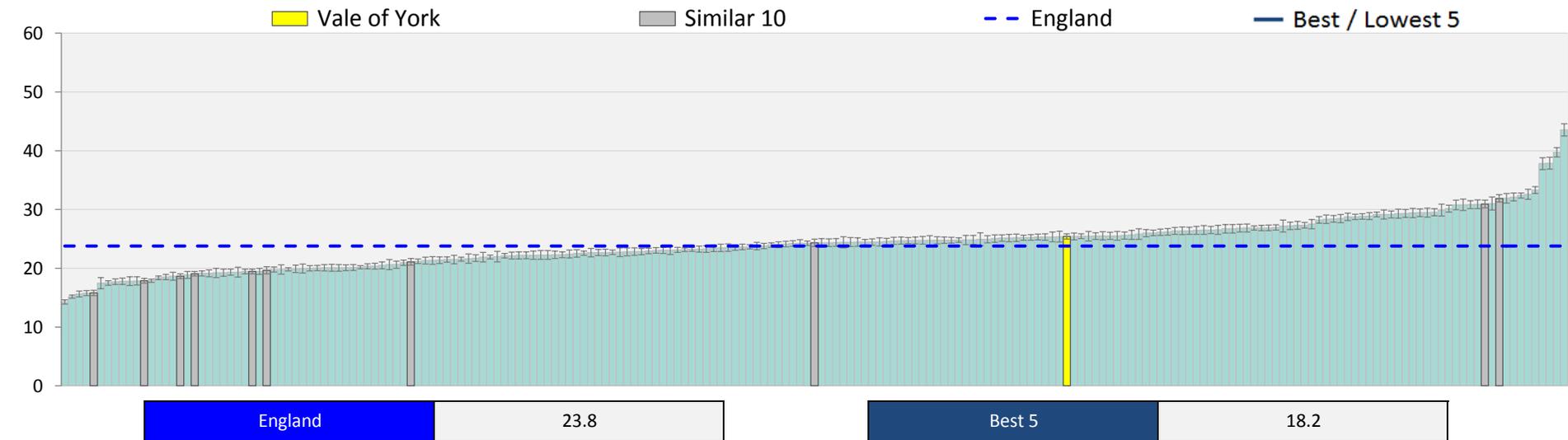
**75 Adm.**



Definition: Respiratory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# Respiratory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

**3321 Days**



Definition: Respiratory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015  
 Source: PHE, ONS  
 Year: 2013-15

# End of life care: Priorities and policy

**Key priorities and policy commitments to support local health economies set their ambitions for end of life care for 2020/21**

## **National strategic priorities for 2020/21**

Significantly improve patient choice in end of life care, including ensuring an increase in the number of people able to die in the place of their choice, including at home (NHS Mandate)

### **Measures of success**

- Increase in people with a life-limiting progressive illness identified as being in the last year of life
- Increase in the number of people offered the opportunity to develop, record and share a personalised care plan
- Interoperable Electronic Palliative Care Co-ordination system (EPaCCS) in place and used across the country by 2020
- Increase in % of people who are cared for and die in their place of choice
- Improvement in patient and carer experience, especially in symptom control, decision-making processes, coordination of care and knowing where and how to access help and advice when needed
- Specialist palliative care advice is accessible 24/7 regardless of care setting
- Increase in % of patients with non malignant disease involved with specialist palliative care

# End of life care: Further info and tools

## Source / tools

- Ambitions for palliative and end of life care: National Framework for local action  
<http://endoflifecareambitions.org.uk/>
- Palliative care coordination implementation guidance  
[http://www.endoflifecare-intelligence.org.uk/resources/publications/implementation\\_guidance](http://www.endoflifecare-intelligence.org.uk/resources/publications/implementation_guidance)
- Specialist Level Palliative Care: Information for commissioners  
<https://www.england.nhs.uk/wp-content/uploads/2016/04/specilst-palliatv-care-comms-guid.pdf>
- Commissioning person centred care: Commissioning toolkit for end of life care  
<https://www.england.nhs.uk/wp-content/uploads/2016/04/nhsiq-comms-eolc-tlkit-.pdf>
  
- Indicator included in the NHS England CCG Improvement and Assessment framework 2016/17  
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/03/ccg-iaf-mar16.pdf>
- Summary Care Record case additional information:  
<http://systems.hscic.gov.uk/scr/additional/carebriefing.pdf> (briefing) and  
<http://systems.hscic.gov.uk/scr/additional/careslides.ppt> (slide pack)
- Knowledge hub for palliative and end of life care. Launch of phase 1 due September 2016 at:  
<http://endoflifecareambitions.org.uk/>

# NHS Continuing Healthcare

The following few pages refer to NHS Continuing Healthcare (NHS CHC). This is a package of ongoing care that is 100% funded solely by the NHS, where the individual has been found to have a 'primary health need' as set out in the National Framework for NHS Continuing Healthcare and NHS-funded nursing care. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness.

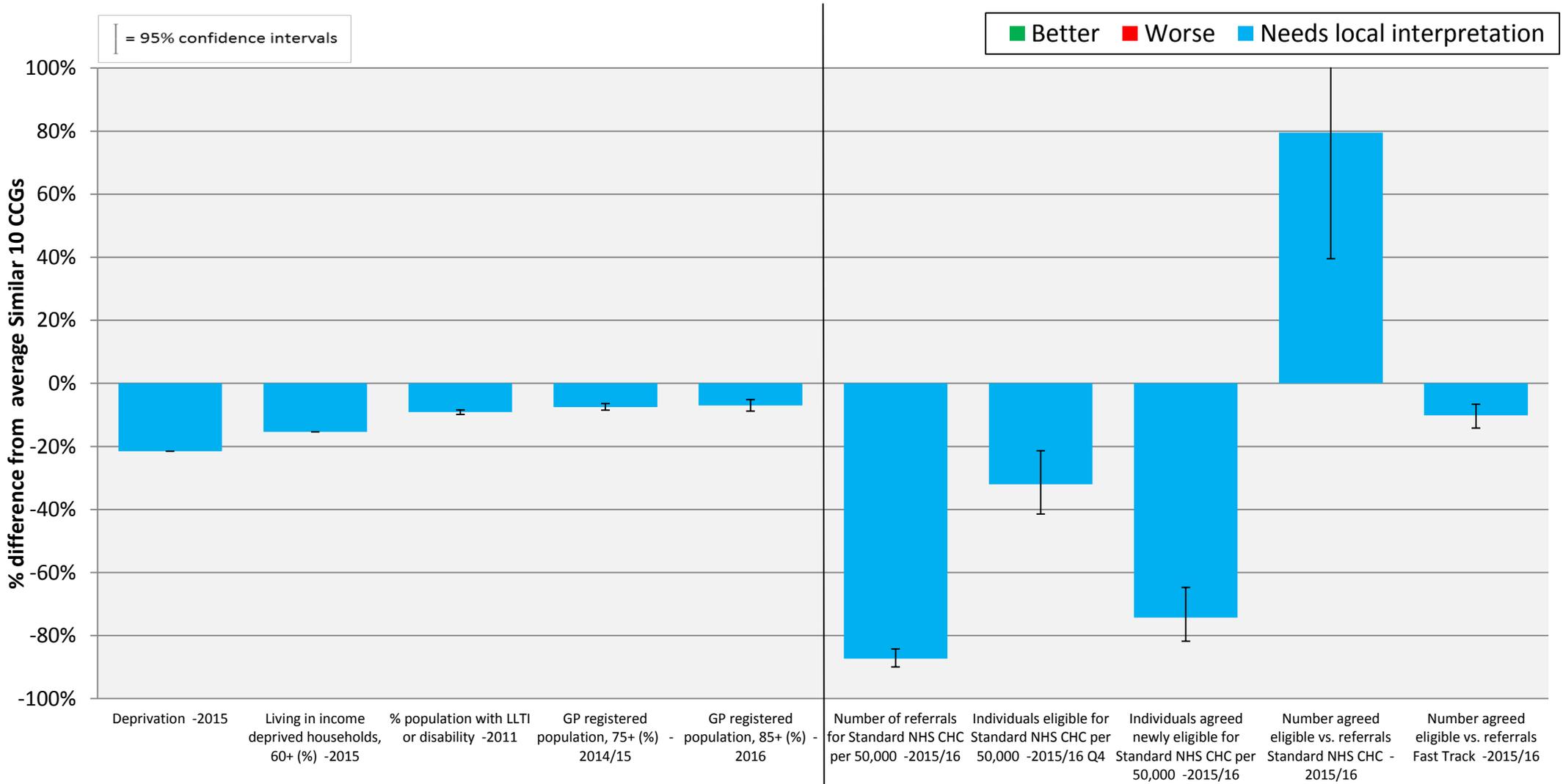
# NHS CHC Pathway

The NHS CHC indicators 'need local interpretation' so are coloured in (blue). It is not possible to make the judgement of whether a higher value is better/worse or a lower value is better/worse.

**Please note: The variation from the average of the similar 10 CCGs is statistically significant 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.

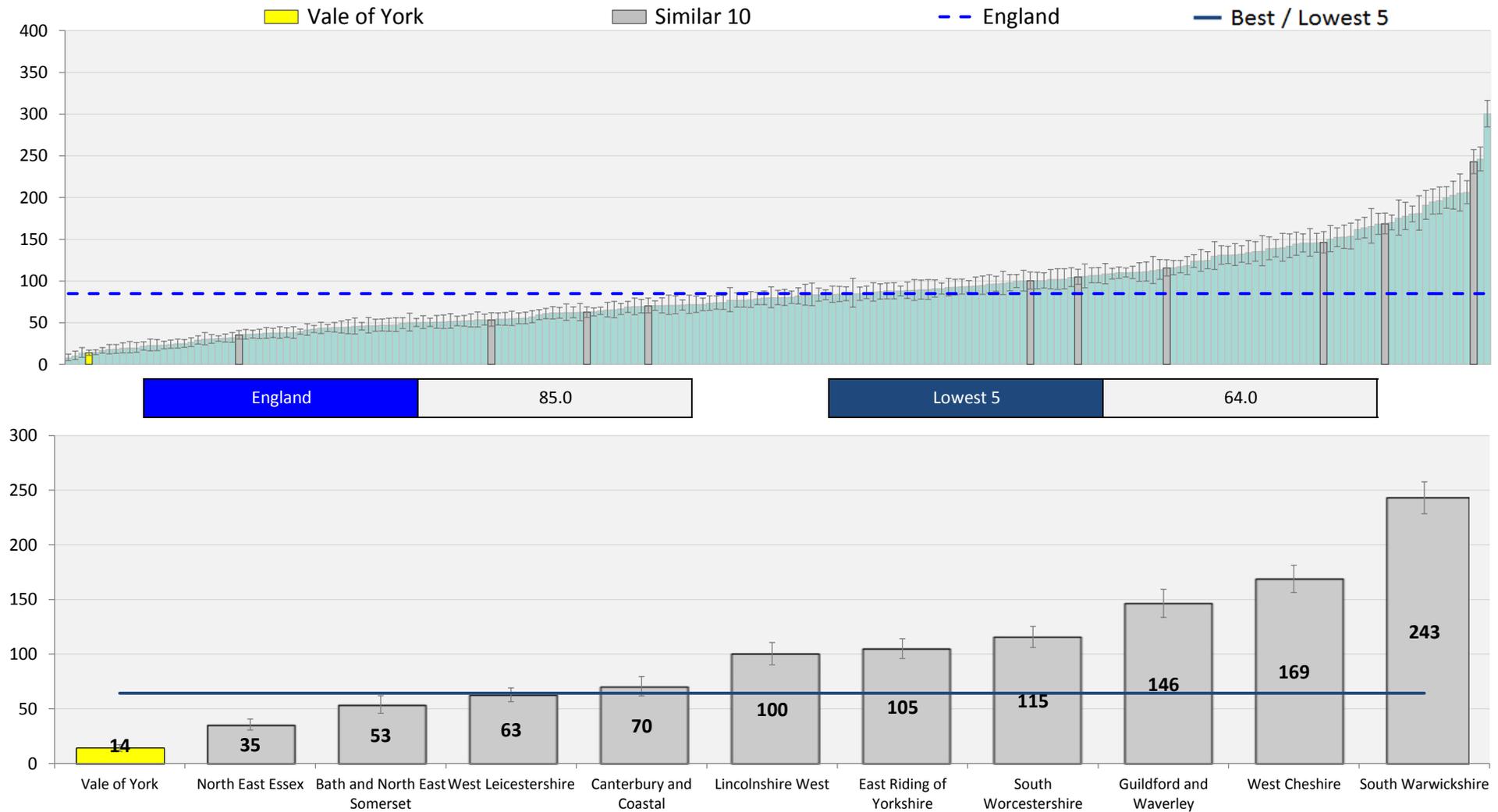
# NHS Continuing Healthcare Pathway



Supplementary information

NHS Continuing Healthcare information

## Number of referrals for Standard NHS CHC (non-fast track) per 50,000

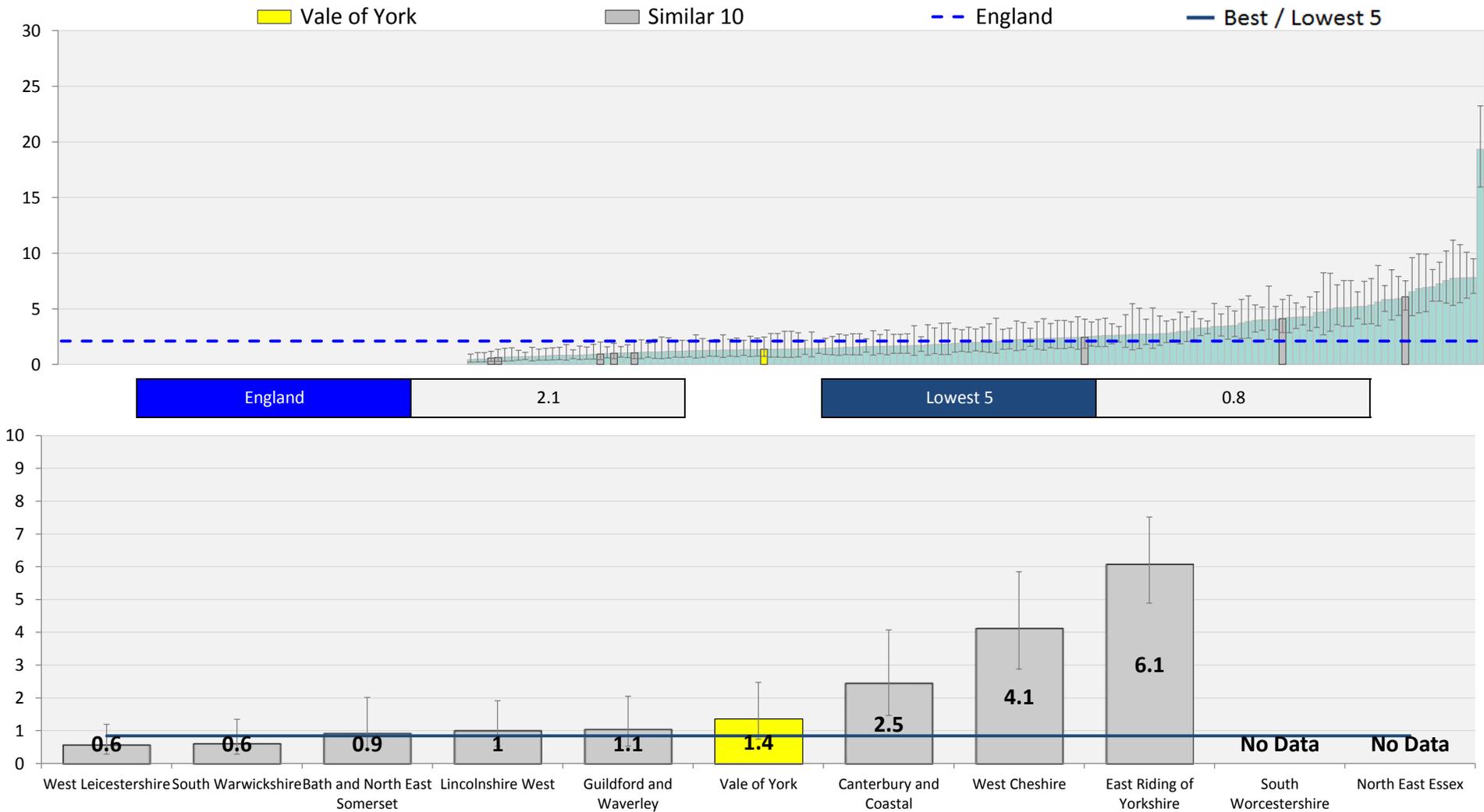


Definition: Number of referrals for Standard NHS CHC (non-fast track) per per 50,000

Source: CHC

Year: 2015/16

## The percentage of NHS CHC with a Personal Health Budget

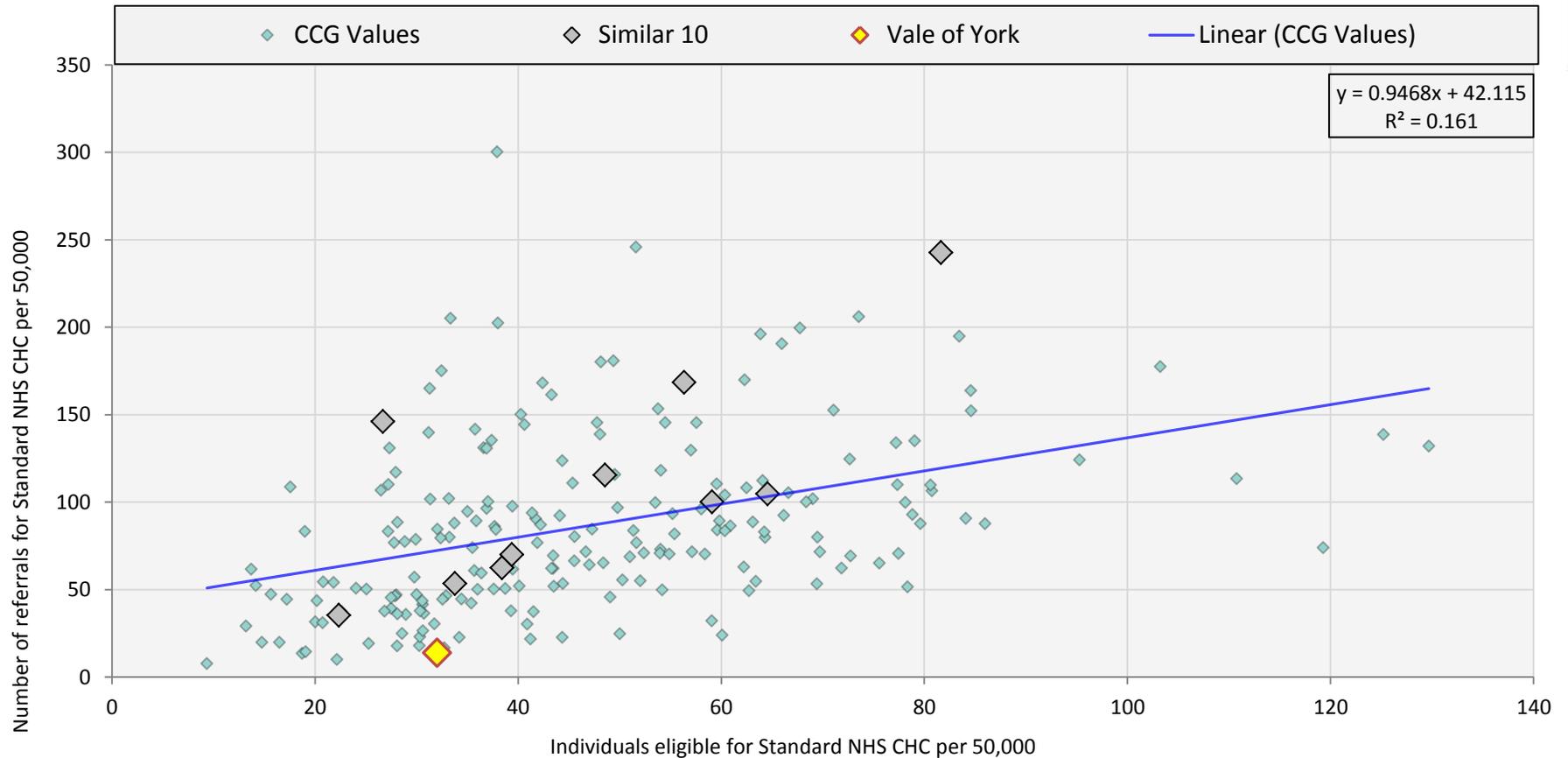


Definition: The percentage of NHS CHC with a Personal Health Budget

Source: CHC

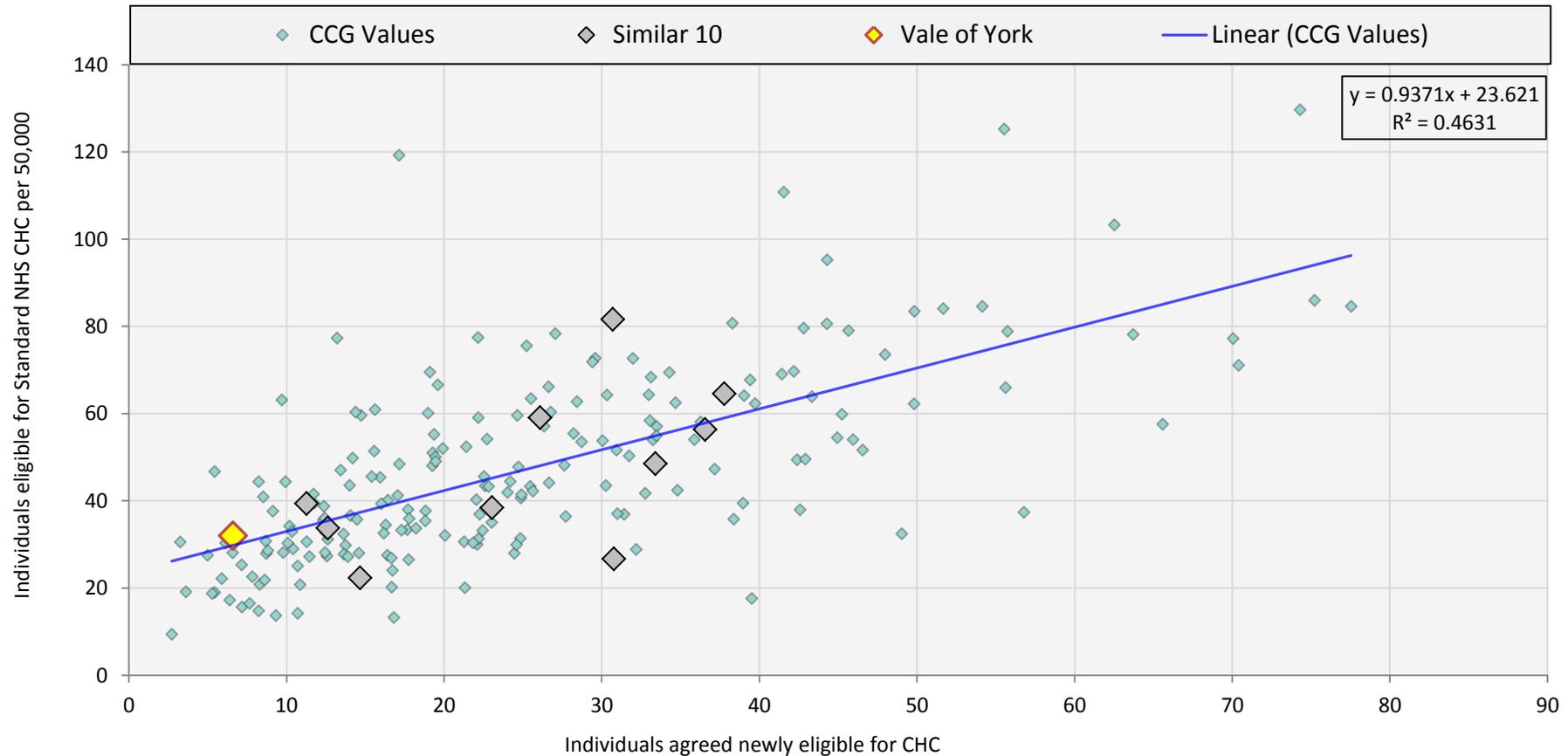
Year: 2015/16

# NHS Continuing Healthcare Scatterplot



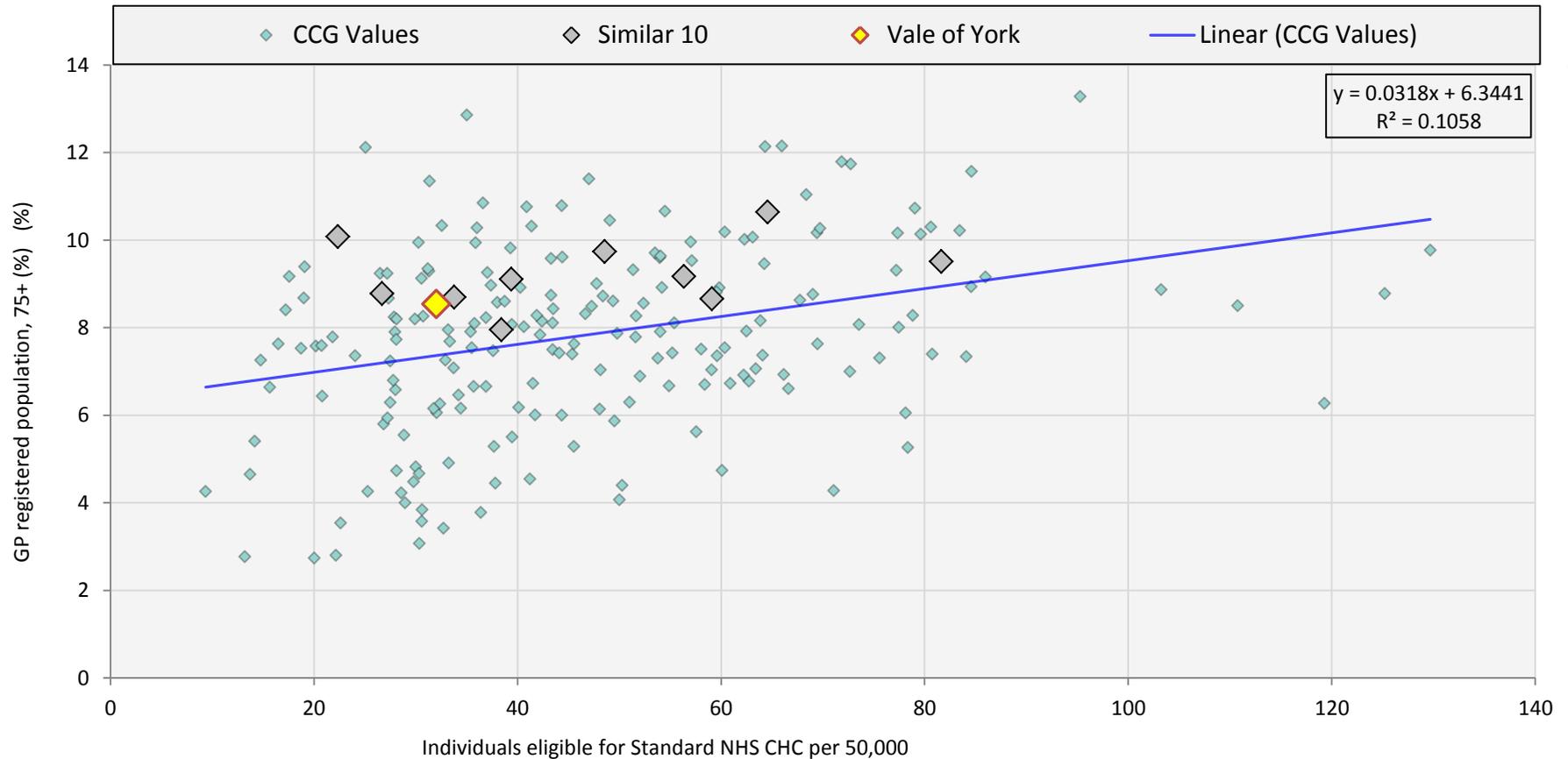
There is a slight positive correlation between referrals and individuals eligible. E.g. if a CCG is above the line this suggests they receive more referrals than would be expected given the number of individuals eligible for CHC

# NHS Continuing Healthcare Scatterplot



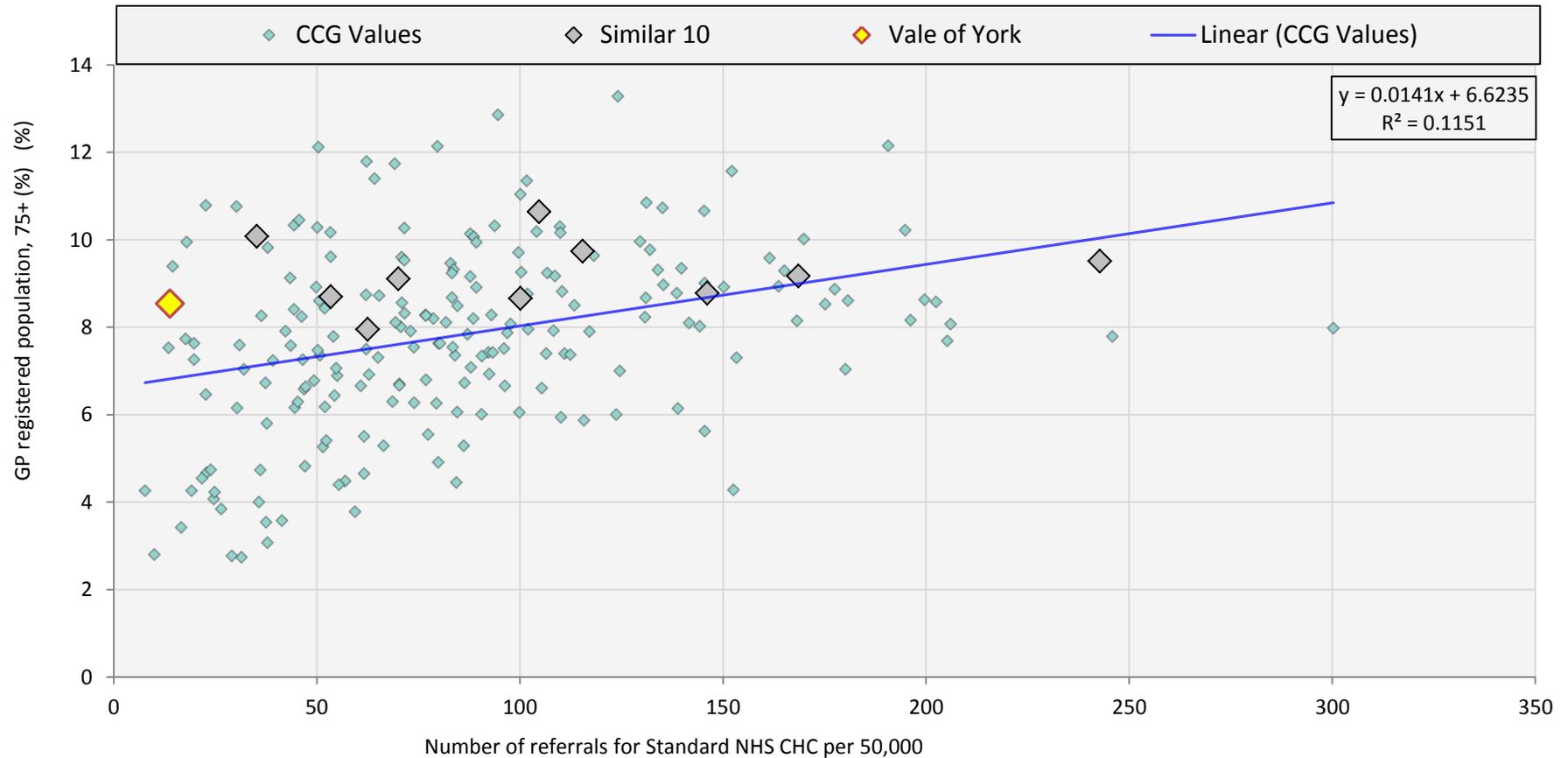
There is a positive correlation between individuals agreed newly eligible and individuals currently eligible. E.g. if a CCG is above the line this suggests that they have more cases eligible than would be expected given the number of newly eligible cases. This may indicate that their existing cases are funded for a longer period of time

# NHS Continuing Healthcare Scatterplot



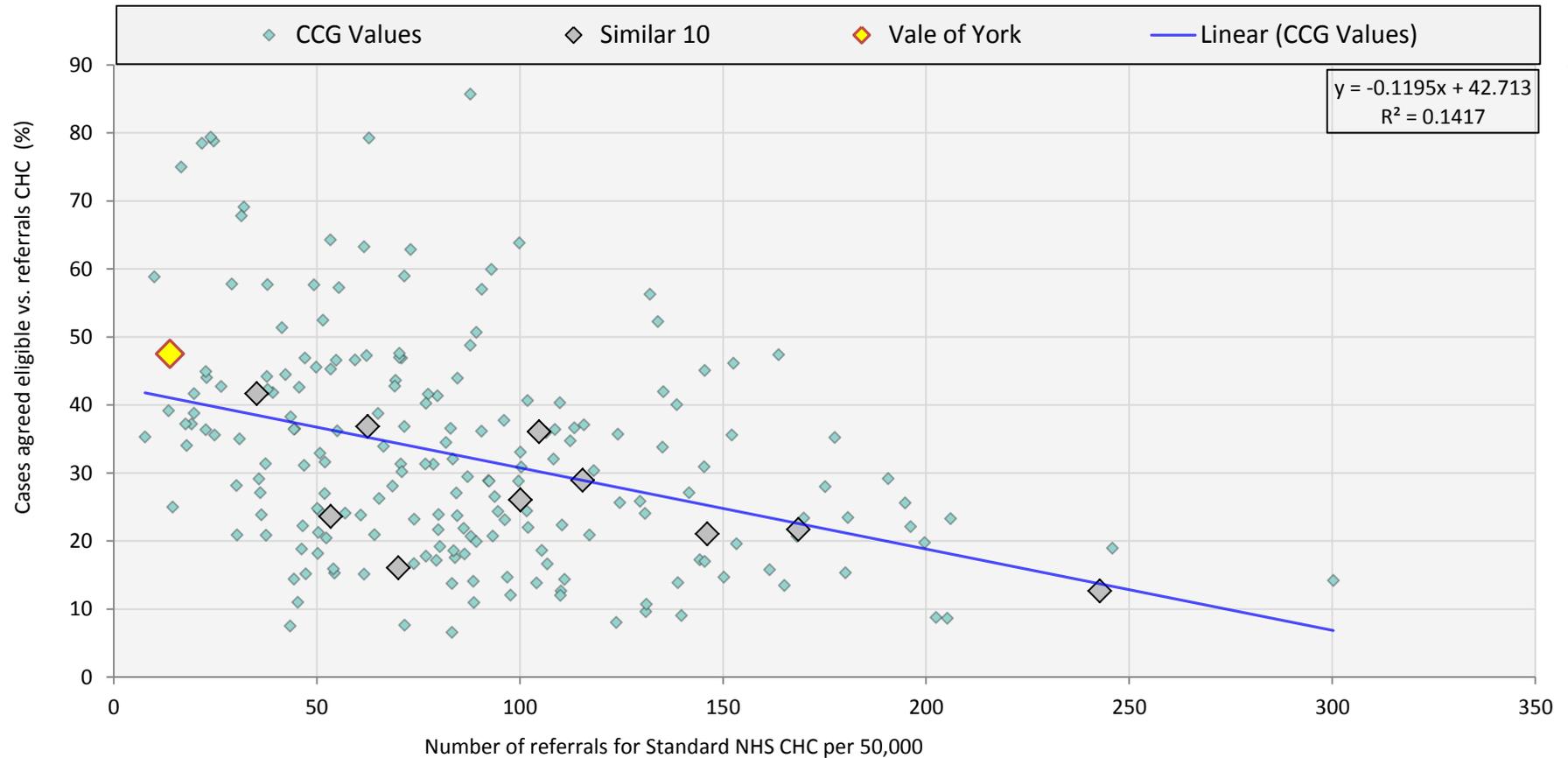
There is a slight positive correlation between numbers eligible and the % GP registered population aged 75+ years. E.g. if a CCG is above the line this suggests they have more eligible cases than would be expected given the age of their population.

# NHS Continuing Healthcare Scatterplot



There is a slight positive correlation between number of referrals and the % GP registered population aged 75+ years. E.g. if a CCG is above the line this suggests they have more referrals than would be expected given the age of their population.

# NHS Continuing Healthcare Scatterplot



There is a negative correlation between 'cases agreed eligible Vs referrals received' and 'number of referrals' i.e. the greater the number of referrals the lower the proportion of cases agreed eligible. E.g. if a CCG is above the line this suggests that they have a higher proportion of cases agreed eligible given their numbers of referrals.

# NHS CHC: Glossary of terms

## **Standard NHS CHC (non Fast Track)**

NHS CHC that is assessed via the standard NHS CHC (non Fast Track) assessment route using the checklist screening tool and / or Decision Support Tool (DST) if a full consideration is required. Decision making on eligibility for NHS CHC should, in most cases, take no longer than 28 days from receipt of a completed Checklist (or, where no Checklist is used, other notification of potential eligibility for NHS CHC). Standard NHS CHC is based on current needs and does not include Previously Unassessed Periods of Care (PUPoCs).

## **Fast track**

NHS CHC that is assessed via the fast track assessment route. The Fast Track tool is used where an appropriate clinician considers that a person should be fast tracked for NHS CHC because that person has a rapidly deteriorating condition and the condition may be entering a terminal phase. The person may need NHS CHC funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care setting). Given the nature of the needs, the time from receipt of the completed Fast Track Pathway Tool to the package being implemented should preferably not exceed 48 hours.

# NHS CHC: Definitions

## **Number of referrals for standard NHS CHC (non Fast Track)**

A referral is any notification which indicates that full consideration for Standard NHS CHC (non Fast Track) is required (eg a positive checklist or DST - whichever is received first).

## **Individuals agreed newly eligible for Standard NHS CHC (non Fast Track)**

The number of people newly meeting the NHS CHC eligibility criteria for any length of period during the year. Activity is counted according to the date cases are agreed eligible.

## **Comparison: Cases agreed eligible v referrals**

The number of cases agreed newly eligible for Standard NHS CHC (non Fast Track) in the quarter as a percentage of the number of referrals for Standard NHS CHC (non Fast Track) in the year.

## **Individuals currently eligible for Standard NHS CHC (non Fast Track)**

The number of people eligible for Standard NHS CHC (non Fast Track) as at the last day of the year.

## **Comparison: Fast tracks agreed eligible v referrals**

The number of individuals agreed newly eligible for Fast Track NHS CHC in the quarter as a percentage of the number of Fast Track referrals (Fast Track tools) received in the year.

# NHS CHC: Supplementary information

The items included in the supplementary information section of the NHS CHC Pathway chart and scatter plots are to provide further context to the NHS CHC Information.

Levels of deprivation, older people living in income deprived households and incidence of Limiting Long-Term Illness or disability are some of the factors which impact levels of health needs in different CCG populations. These may be potential contributors to NHS CHC as NHS CHC is provided to individuals with a primary health need resulting from disability, accident or illness. Information on how these variables are calculated can be found here: <https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>. Please note that some of the variables included in the calculations for the supplementary information may not be specifically relevant to NHS CHC. e.g. The Crime Domain is part of the Index of Multiple Deprivation.

Age is likely to be another relevant factor in levels of NHS CHC. In a sample of individuals eligible for Standard NHS CHC (non Fast Track) during 2013/14 taken from 191 CCGs, 75% were aged 65 and over. It is therefore likely that populations with a greater proportion of elderly people will have higher levels of NHS CHC.

Supplementary information on the percentage of GP registered populations aged 75 and over, and aged 85 and over, is therefore included.

A mandatory PHB data collection is currently being developed by NHS England. The figures within this report have been received from NHS CHC teams and relate only to individuals who have been found eligible for NHS CHC.

# NHS CHC: Supplementary information

The NHS England Continuing HealthCare Strategic Improvement Programme focuses on improving CHC outcomes, through reduced variation leading to sustainable finances. Other associated national programmes which CCGs may be interested in are the Personalisation and Choice programme and the hospital discharge programme. For more information on any of these programmes please contact a representative of NHS England.

# NHS CHC: Data considerations and caveats

The information provided in this pack provides a useful tool for identifying potential unwarranted variation and where to look to further understand the reasons for outlying activity.

There are however a number of different variables that may contribute to variation in NHS CHC activity including (but not limited to) the age dispersion within the local population, variations between geographical areas in terms of their levels of health needs, and the availability of other local services for example step down beds, intermediate care, rehabilitation services, and other CCG community services.

This information therefore provides a starting point only and further detailed query and analysis may be required to understand reasons for any variation.

Much of the data is derived from 'management information', which is information generated during the course of day-to-day business, some key components of which are collected by NHS England to monitor application of the National Framework. As management information these data should not be considered official statistics. All endeavours are made to ensure the data is as accurate as possible however some of the data submitted by CCGs may represent an estimation of activity.

There is currently a voluntary data collection for personal health budgets (PHBs) which is reported by CCG PHB leads to NHS England. As this is voluntary and completed by different teams there may be some differences in the 2 data sets. A mandatory PHB data collection is currently being developed to help resolve this.

# NHS CHC: Data considerations and caveats

Quarterly data may be subject to revision due to the reasons set out in this section and in case of errors made by organisations when submitting data. Revisions are made in publications where they are submitted in time.

Factors impacting data quality include the following:

- Local NHS CHC databases help CCGs record information on their NHS CHC cases and provide data for reporting requirements. However changes to an existing system or implementation of a new system can impact data quality whilst CCGs work to migrate and clean their data. Routine data cleansing and backlogs of information waiting to be input onto systems in times of high workload may also impact data quality.
- In-template validations within the reports that CCGs complete help to improve data quality and minimise incomplete or erroneous entries.
- Additional automated validation checks applied to the data post submission also contribute to improving data quality. Queries arising from the validation checks are raised with the CCGs who provided the data. CCGs are then able to resubmit data or provide NHS England with further explanation of the figures.
- Late notifications from providers on the status of their patients can sometimes mean activity information is later found to be inaccurate after submission deadlines e.g. a given provider may give a CCG late notification that a number of patients included in their activity had passed away before quarter end but not notify them of this until after report deadlines.

# Next steps and actions

Local health economies can take the following steps now:

- Review the multi-pathway (page 9) to identify pathway stages where there is an opportunity to improve across several Long Term Conditions. Don't ignore amber and blue as they may represent opportunities for improvement.
- Look at the focus packs on the NHS RightCare website for those areas which are a priority for your locality
- Consider the additional indicators included in this pack and identify potential improvement areas for further investigation
- 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
- Look at the case studies and supporting information in this pack to help identify 'how to change'
- 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 Autumn 2016)

## 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:

- New 'Where to Look' packs
- Focus packs for the highest spending programmes
- 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](mailto:england.healthinvestmentnetwork@nhs.net)

## Useful links

NHS RightCare website:

[www.england.nhs.uk/rightcare](http://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>

NHS Outcomes Framework: Domain 2

<https://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/>

NHS England Long Term Conditions team

[ENGLAND.longtermconditions@nhs.net](mailto:ENGLAND.longtermconditions@nhs.net)

NHS Continuing Healthcare

<https://www.england.nhs.uk/ourwork/pe/healthcare/>

# Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of our values. Throughout the development of the policies and processes cited in this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to - and outcomes from - healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Guidance for NHS commissioners on Equality and Health Inequalities duties can be found at:

<https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/>

# Annex

This Annex contains the multiple pathway matrix methodology and a table showing how the indicators in the multi pathways on a page (page 9) have been mapped.

It also contains additional care outcome indicators

# Multiple pathway matrix methodology

Key indicators for each clinical programme have been mapped across the pathway as shown in the multiple pathway matrix.

To identify the colour coding, the CCG performance will be scored against the average of the best 5 CCGs. The following scores are then applied for each indicator:

- Where the value is not statistically significant, this is scored **0**.
- If the value is statistically significantly better than the best 5, it is scored **1**.
- If the value is statistically significantly worse than the best 5, it is scored **-1**.

When the score has been calculated for all the indicators within a disease area and care setting, an average of these scores is taken. The following criteria colour code the box:

Where the average score is greater than  $\frac{1}{3}$ , the box will be coloured **green**.

Where the average score is less than  $-\frac{1}{3}$ , the box will be coloured **red**.

Where the average score is between  $-\frac{1}{3}$  and  $\frac{1}{3}$  the box will be coloured **amber**.

An example of the calculation is below, for CCG:

	CCG Value	LCI	UCI	Best 5	Statistically Significant?	Colour	Score
<b>Indicator #1</b>	73.1	72.3	74.0	72.5	No	A	0
<b>Indicator #2</b>	58.0	57.1	59.0	61.6	Yes	R	-1
<b>Average Score</b>	N/A	N/A	N/A	N/A	N/A	N/A	<b>-0.5</b>

If a CCG had **5 amber** indicators and **1 red** indicator, the average score would be -0.17 (-1/6), so it would be coloured **amber**.

If a CCG had **3 green** indicators and **3 red** indicators, the average score would be 0, so it again would be coloured **amber**.

If a CCG had **5 red** indicators and **1 amber** indicator, the average score would be -0.83 (-5/6), so this would be coloured **red**.

# Annex: Multiple Pathway Matrix Indicators [1]

<b>Breast Cancer</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Percentage of adults classified as overweight or obese (estimated prevalence)
	<b>Prevalence</b>	Incidence of breast cancer per 100,000 population (all ages)	Breast Cancer Prevalence (%)	
	<b>Detection</b>	The percentage of women aged 50 - 70 who were screened for breast cancer in last three years	The percentage of breast cancers detected at an early stage (1 or 2)	Routes to diagnosis - emergency presentations for breast cancer - DSR per 100,000 population
	<b>Primary Care Self Care</b>	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis		
	<b>Prescribing</b>	Breast Cancer - Total primary care prescribing spend per 1000 ASTRO-PU population		
	<b>Elective</b>	Breast Cancer - Total elective spend per 1000 population		
	<b>Non-elective</b>	Cancer, Breast - Total non-elective spend on admissions per 1,000 population		
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)		
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Difference in the employment rate between those with a long-term health condition and all those of working age
	<b>Outcomes</b>	Mortality from breast cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	One year cancer survival rate for breast cancer for ages 15-99	
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with cancer	Cancer: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Cancer: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

## Annex: Multiple Pathway Matrix Indicators [2]

<b>Lower GI Cancer</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Percentage of adults classified as overweight or obese (estimated prevalence)
	<b>Prevalence</b>	Incidence of colorectal cancer per 100,000 population (all ages)	Colorectal Cancer Prevalence (%)	
	<b>Detection</b>	The percentage of people aged 60-69 who were screened for bowel cancer in the previous 30 months	The percentage of colorectal cancers detected at an early stage (1 or 2)	Routes to diagnosis - emergency presentations for colorectal cancer - DSR per 100,000 population
	<b>Primary Care</b>	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis		
	<b>Self Care</b>			
	<b>Prescribing</b>			
	<b>Elective</b>	Bowel Cancer- Total elective spend per 1000 age/sex weighted population		
	<b>Non-elective</b>	Bowel Cancer- Total non-elective spend per 1000 age/sex weighted population		
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)		
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over reablement/rehabilitation services	Difference in the employment rate between those with a long-term health condition and all those of working age
	<b>Outcomes</b>	Mortality from colorectal cancer: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard population	One year cancer survival rate for colorectal cancer for ages 15-99	
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with cancer	Cancer: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Cancer: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

# Annex: Multiple Pathway Matrix Indicators [3]

<b>Lung Cancer</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Percentage of adults classified as overweight or obese (estimated prevalence)
	<b>Prevalence</b>	Incidence of lung cancer per 100,000 population (all ages)	Lung Cancer Prevalence (%)	
	<b>Detection</b>	The percentage of lung cancers detected at an early stage (1 or 2)	Routes to diagnosis - emergency presentations for lung cancer - DSR per 100,000 population	
	<b>Primary Care</b>	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis		
	<b>Self Care</b>			
	<b>Prescribing</b>			
	<b>Elective</b>	Lung Cancer - Total elective spend per 1000 age/sex weighted population		
	<b>Non-elective</b>	Lung Cancer - Total non-elective spend per 1000 age/sex weighted population		
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)		
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Difference in the employment rate between those with a long-term health condition and all those of working age
	<b>Outcomes</b>	Mortality from lung cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population	One year cancer survival rate for lung cancer for ages 15-99	
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with cancer	Cancer: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Cancer: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

# Annex: Multiple Pathway Matrix Indicators [4]

<b>Neurological</b>	<b>Prevention</b>		
	<b>Prevalence</b>		
	<b>Detection</b>		
	<b>Primary Care</b>	The percentage of patients aged 18 years and over on drug treatment for epilepsy who have been seizure free for the last 12 months recorded in the preceding 12 months	
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition	
	<b>Prescribing</b>	Neurological - Total primary care prescribing spend per 1000 ASTRO-PU population	
	<b>Elective</b>	Neurological - Total elective spend per 1000 age/sex weighted population	
	<b>Non-elective</b>	Neurological - Total non-elective spend per 1000 age/sex weighted population	
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)	
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
	<b>Outcomes</b>	Mortality from epilepsy: Under 75 directly age-standardised rates (DSR) per 100,000 European Standard population	Emergency admission rate for children with epilepsy per population aged 0–19 years
	<b>End of Life</b>	The percentage of deaths in usual place of residence: Overall	

# Annex: Multiple Pathway Matrix Indicators [5]

<b>Serious Mental Illness</b>	<b>Prevention</b>	Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population					
	<b>Prevalence</b>	Psychotic disorder: Estimated % of people aged 16+	New cases of psychosis: estimated incidence per 100,000 population				
	<b>Detection</b>						
	<b>Primary Care</b>	Physical health checks for patients with SMI: Summary score (average of the 6 physical health check indicators)	The Percentage of SMI patients who have comprehensive care plan	Patients on lithium therapy with levels in therapeutic range: % within preceding 4 months	The percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways		
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition	Service users with crisis plans: % of people in contact with mental health services with a crisis plan in place	% Number of people with crisis plan admitted to hospital			
	<b>Prescribing</b>	Psychoses prescribing per 1000 ASTRO-PU population					
	<b>Elective</b>						
	<b>Non-elective</b>	Rate of admissions for patients aged 18+: Rate per 100,000 population aged 18+					
	<b>Step-up / Step-down</b>	Rate of admissions 18+ those under care of Crisis Resolution/Home Treatment teams	Service users on CPA: % people in contact with MH services who are on care programme approach (end of quarter snapshot)				
	<b>Rehab</b>						
<b>Outcomes</b>	The percentage of people aged 18-69 on care programme approach (CPA) in employment	The number of people subject to the Mental Health Act per 100,000 population aged 18+	The percentage of adults aged 18+ in contact with secondary mental health services (SMHS) who are on the Care Programme Approach (CPA) and are helped into settled accommodation	<75 Excess Mortality in Adults with Serious SMI	Mortality from suicide: All ages Directly age-standardised rates (DSR) per 100,000 European Standard population		
<b>End of Life</b>							

# Annex: Multiple Pathway Matrix Indicators [6]

<b>Common Mental Health Disorders</b>	<b>Prevention</b>	Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population			
	<b>Prevalence</b>	Estimated prevalence of CMHD aged 16-74 (%)			
	<b>Detection</b>	Access to IAPT services: People entering IAPT as % of those estimated to have anxiety/depression			
	<b>Primary Care</b>	IAPT: Waiting <6 weeks to enter treatment (supporting waiting time measure): % of referrals waiting <6 weeks for first treatment	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	IAPT referrals: Rate (quarterly) per 100,000 population aged 18+	Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition			
	<b>Prescribing</b>	Antidepressant prescribing cost per 1000 STAR-PU population			
	<b>Elective</b>				
	<b>Non-elective</b>				
	<b>Step-up / Step-down</b>				
	<b>Rehab</b>				
	<b>Outcomes</b>	Rate of recovery: % of people who are "moving to recovery" of those who have completed IAPT treatment	IAPT reliable recovery: % of people who have completed IAPT treatment who achieved "reliable improvement"		
	<b>End of Life</b>				

# Annex: Multiple Pathway Matrix Indicators [7]

<b>Dementia</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	The percentage of physically inactive adults
	<b>Prevalence</b>	Dementia: Estimated prevalence (%) (65+)		
	<b>Detection</b>	Dementia diagnosis rate: Reported to Estimated prevalence (%) (65+)		
	<b>Primary Care</b>	The percentage of patients who have had their care reviewed in last 12 months (dementia)	Blood tests recorded: Percentage of new dementia diagnosis with blood test recorded 6 months before or after entering onto the register	
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition		
	<b>Prescribing Elective</b>	Primary care prescribing spend per 1,000 ASTRO-PU weighted population - Rivastigmine, Galantamine, & Memantine Hydrochloride		
	<b>Non-elective</b>	Rate of emergency inpatient hospital admissions of people (aged 65+) with a mention of dementia per 100,000 age-standardised resident population		
	<b>Step-up / Step-down</b>	Dementia: short stay emergency admissions (aged 65+)		
	<b>Rehab</b>	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	
	<b>Outcomes</b>	Mortality with dementia: Over 65 Directly age-standardised rates (DSR) per 100,000 population		
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with dementia aged 65+	Dementia: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Dementia: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015

# Annex: Multiple Pathway Matrix Indicators [8]

<b>CHD</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Percentage of adults classified as overweight or obese (estimated prevalence)	Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population
	<b>Prevalence</b>	Estimated CHD prevalence (%)	Estimated Hypertension Prevalence (%)		
	<b>Detection</b>	Reported to Estimated prevalence of CHD (%)	Reported to Estimated prevalence of Hypertension (%)		
	<b>Primary Care</b>	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 or less	Percentage of patients with CHD whose last measured cholesterol (as measured within the last 12 months) is 5mmol/l or less	The percentage of patients with hypertension whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less	
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition			
	<b>Prescribing</b>	Circulation - CHD - Total primary care prescribing spend per 1000 ASTRO-PU population			
	<b>Elective</b>	Circulation - CHD - Total elective spend per 1000 population			
	<b>Non-elective</b>	Circulation - CHD - Total non-elective spend per 1000 population			
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)			
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services		
	<b>Outcomes</b>	Mortality from coronary heart disease: Under 75 directly age-standardised rates (DSR) per 100,000 European Standard population			
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with circulatory diseases	Circulatory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Circulatory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	

# Annex: Multiple Pathway Matrix Indicators [9]

<b>Stroke</b>	<b>Prevention</b>	Reported to Estimated prevalence of Atrial Fibrillation				
	<b>Prevalence</b>	The percentage of patients with stroke or TIA whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less	The percentage of patients with a non-haemorrhagic stroke or TIA with a record that an antiplatelet agent or an anticoagulant is being taken	The Percentage AF with Stroke Assessment on Anti-Coagulation Therapy		
	<b>Detection</b>	The percentage of people who feel supported to manage their condition				
	<b>Primary Care</b>	Circulation - Cerebrovascular Disease - Total primary care prescribing spend per 1000 ASTRO-PU population				
	<b>Self Care</b>	Circulation - Cerebrovascular Disease - Total elective spend per 1000 age/sex weighted population				
	<b>Prescribing</b>	Circulation - Cerebrovascular Disease - Total non-elective spend per 1000 age/sex weighted population				
	<b>Elective</b>	The percentage of patients treated by a stroke skilled Early Supported Discharge team	Rate of patients with delayed transfers of care (%)			
	<b>Non-elective</b>	The percentage of patients admitted to hospital following stroke who spend 90 percent of their time on a stroke unit	The percentage people aged 65 and over who received areablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services		
	<b>Step-up / Step-down</b>	The percentage of applicable patients who go direct to a stroke unit within 4 hours	Emergency readmissions to hospital within 28 days for patients with stroke	The percentage of patients returning to usual place of residence following hospital treatment for stroke	Mortality from stroke: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard population,	The percentage of all stroke patients who receive thrombolysis
	<b>Rehab</b>	The percentage of deaths in usual place of residence: people with circulatory diseases				
	<b>Outcomes</b>	Reported to Estimated prevalence of Atrial Fibrillation				
	<b>End of Life</b>	The percentage of patients with stroke or TIA whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less	The percentage of patients with a non-haemorrhagic stroke or TIA with a record that an antiplatelet agent or an anticoagulant is being taken	The Percentage AF with Stroke Assessment on Anti-Coagulation Therapy		

# Annex: Multiple Pathway Matrix Indicators [10]

<b>Diabetes</b>	<b>Prevention</b>	Proportion of the population meeting the recommended '5 a day' on a usual day	The percentage of physically inactive adults	Percentage of adults classified as overweight or obese (estimated prevalence)			
	<b>Prevalence</b>	Diabetes: estimated prevalence (16+) (%)					
	<b>Detection</b>	Diabetes: Observed prevalence compared to Estimated prevalence in adults (%)					
	<b>Primary Care</b>	The percentage of diabetic patients whose last cholesterol was 5mmol or less	The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol or less (or equivalent test/reference range depending on local laboratory) in the preceding 12 months	The percentage of diabetic patients whose last blood pressure was 140/80 or less	The percentage of all diabetes patients having retinal screening in the previous 12 months	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register	The percentage of all diabetes patients receiving a foot examination
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition					
	<b>Prescribing Elective</b>	Diabetes - Total primary care prescribing spend per 1000 ASTRO-PU population					
	<b>Non-elective</b>	Diabetes - Total non-elective spend per 1000 population					
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)					
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services				
	<b>Outcomes End of Life</b>	The percentage of diabetes patients receiving all three treatment targets					

# Annex: Multiple Pathway Matrix Indicators [11]

<b>Renal</b>	<b>Prevention</b>	Percentage of adults classified as overweight or obese (estimated prevalence)	
	<b>Prevalence</b>	Chronic Kidney Disease (CKD) Estimated Prevalence (%)	
	<b>Detection</b>	Reported to Estimated prevalence of CKD (%)	
	<b>Primary Care</b>	The percentage of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less (CKD002)	The percentage of patients on the CKD register with hypertension and proteinuria who are treated with ACE-I or ARB
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition	
	<b>Prescribing</b>	Genitourinary - Renal problems - Total primary care prescribing spend per 1000 ASTRO-PU population	
	<b>Elective</b>	Genitourinary - Renal problems - Total elective spend per 1000 age/sex weighted population	
	<b>Non-elective</b>	Genitourinary - Renal problems - Total non-elective spend per 1000 age/sex weighted population	
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)	
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
	<b>Outcomes</b>	The percentage of people receiving dialysis undertaking dialysis at home	The percentage of patients on Renal Replacement Therapy who have a kidney transplant
	<b>End of Life</b>	The percentage of deaths in usual place of residence: Overall	

# Annex: Multiple Pathway Matrix Indicators [12]

<b>COPD</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+			
	<b>Prevalence</b>	COPD estimated Prevalence (%)				
	<b>Detection</b>	Reported to Estimated prevalence of COPD (%)				
	<b>Primary Care</b>	The percentage of COPD patients with a record of FeV1 in the preceding 12 months	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (COPD003)	The percentage of patients with COPD and Medical Research Council dyspnoea grade $\geq 3$ at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition				
	<b>Prescribing Elective</b>	Respiratory - Obstructive Airways Disease - Total primary care prescribing spend per 1000 ASTRO-PU population				
	<b>Non-elective</b>	Respiratory - Obstructive airways disease - Total non-elective spend per 1000 age/sex weighted population				
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)				
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			
	<b>Outcomes</b>	Mortality from bronchitis, emphysema and COPD: Under 75 directly age-standardised rates (DSR) per 100,000 European Standard population				
	<b>End of Life</b>	The percentage of deaths in usual place of residence: people with respirator diseases	Respiratory: Average annual number of emergency hospital admissions during the last year of life of CCG residents who died 2013-2015	Respiratory: Average annual number of days (nights) spent in emergency hospital admissions during the last year of life of CCG residents who died 2013-2015		

# Annex: Multiple Pathway Matrix Indicators [13]

<b>Asthma</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+
	<b>Prevalence</b>		
	<b>Detection</b>		
	<b>Primary Care</b>	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or anytime after diagnosis'	The percentage of asthma patients who have had a review in the preceding 12 months
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition	
	<b>Prescribing</b>	Respiratory - Asthma - Total primary care prescribing spend per 1000 ASTRO-PU population	
	<b>Elective</b>		
	<b>Non-elective</b>	Asthma - Total Spend on non-elective admissions per 1,000 population	
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)	
	<b>Rehab</b>	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
	<b>Outcomes</b>	Mortality from asthma: All ages Directly age-standardised rates (DSR) per 100,000 European Standard population	Emergency admission rate for children with asthma per population aged 0–19 years
	<b>End of Life</b>		

# Annex: Multiple Pathway Matrix Indicators [14]

<b>Musculoskeletal</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	The percentage of physically inactive adults	Percentage of adults classified as overweight or obese (estimated prevalence)
	<b>Prevalence</b>	The percentage of people (over 45) who have hip osteoarthritis (total)	The percentage of people (over 45) who have knee osteoarthritis (total)		
	<b>Detection</b>	Rate of DEXA scan activity per 1,000 age/sex weighted population	Pre-op, Oxford Score, Hip	Pre-op, Oxford Score, Knee	
	<b>Primary Care</b>	The percentage of patients aged 50-74 years , with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent (OST002)	The percentage of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent (OST03)	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months (RA002)	
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition			
	<b>Prescribing</b>	Musculoskeletal - Total primary care prescribing spend per 1000 ASTRO-PU population			
	<b>Elective</b>	Musculoskeletal - Total elective spend per 1000 age/sex weighted population			
	<b>Non-elective</b>	Musculoskeletal - Total non-elective spend per 1000 age/sex weighted population			
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)			
	<b>Rehab</b>	Emergency readmissions to hospital within 28 days for patients with hip replacements	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital	Difference in the employment rate between those with a long-term health condition and all those of working age
	<b>Outcomes</b>	Hip replacement, Oxford Score, Health Gain	Knee replacement, Oxford Score, Health Gain	Post-op, Oxford Score, Hip	Post-op, Oxford Score, Knee
	<b>End of Life</b>				

# Annex: Multiple Pathway Matrix Indicators [15]

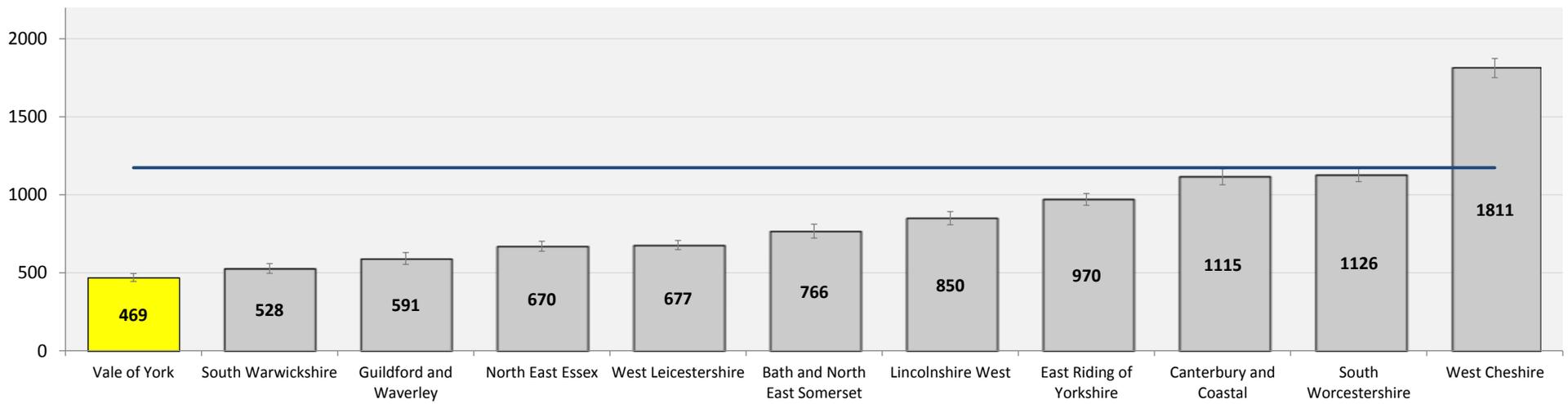
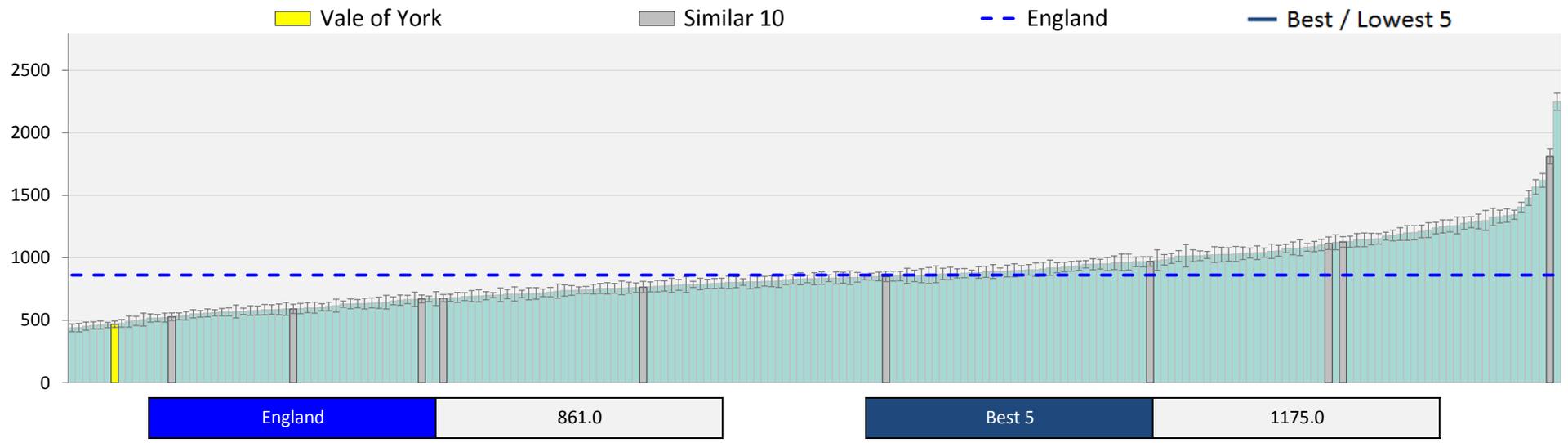
<b>Frailty</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Proportion of the population meeting the recommended '5 a day' on a usual day	The percentage of physically inactive adults	Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population	Percentage of adults classified as overweight or obese (estimated prevalence)
	<b>Prevalence</b>						
	<b>Detection</b>	Rate of DEXA scan activity per 1,000 age/sex weighted population					
	<b>Primary Care</b>	The percentage of patients aged 50-74 years , with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent (OST002)	The percentage of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent (OST03)	The percentage of patients with a long term condition who have a written care plan	The percentage of patients with a long term condition who use their written care plan		
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition					
	<b>Prescribing</b>						
	<b>Elective</b>						
	<b>Non-elective</b>	Hospital admissions for primary diagnosis tendency to fall	Hospital admissions for primary diagnosis syncope and collapse	Hospital admissions for primary diagnosis disorientation			
	<b>Step-up / Step-down</b>	Proportion of people aged >65 in hospital for ten days or more	Injuries due to falls in people aged 65+	Rate of patients with delayed transfers of care (%)	Rate of emergency admissions aged 75+ with a stay of <24 hrs per 100,000 pop		
	<b>Rehab</b>	Emergency readmissions to hospital within 28 days for patients: hip fractures	Percentage of patients returning to usual place of residence following hospital treatment for fractured femur	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital		
	<b>Outcomes</b>	Mortality from falls (75+): Directly age-standardised rates (DSR) per 100,000 European Standard population					
	<b>End of Life</b>	The percentage of deaths in usual place of residence: Overall					

# Annex: Multiple Pathway Matrix Indicators [16]

<b>Multiple Conditions</b>	<b>Prevention</b>	The percentage of people aged 18+ who are self-reported occasional or regular smokers	Smoking quit rates (successful quitters), per 100,000 population aged 16yrs+	Proportion of the population meeting the recommended '5 a day' on a usual day	The percentage of physically inactive adults	Rate of alcohol specific hospital admissions per 100,000 age-sex weighted population	Percentage of adults classified as overweight or obese (estimated prevalence)	
	<b>Prevalence</b>							
	<b>Detection</b>							
	<b>Primary Care</b>	The percentage of patients with a long term condition who use their written care plan	Physical health checks for patients with SMI: Summary score (average of the 6 physical health check indicators)	The percentage of patients with a long term condition who use their written care plan				
	<b>Self Care</b>	The percentage of people who feel supported to manage their condition						
	<b>Prescribing</b>							
	<b>Elective</b>							
	<b>Non-elective</b>							
	<b>Step-up / Step-down</b>	Rate of patients with delayed transfers of care (%)	Rate of emergency admissions aged 75+ with a stay of <24 hrs per 100,000 pop	Proportion of people aged >65 in hospital for ten days or more				
	<b>Rehab</b>	The percentage people aged 65 and over who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Difference in the employment rate between those with a long-term health condition and all those of working age	The percentage people aged 65 and over who received reablement/rehabilitation services after discharge from hospital				
	<b>Outcomes</b>	Unplanned hospitalisation for chronic ambulatory care sensitive conditions						
	<b>End of Life</b>	The percentage of deaths in usual place of residence: Overall						

# IAPT referrals: Rate (quarterly) per 100,000 population aged 18+

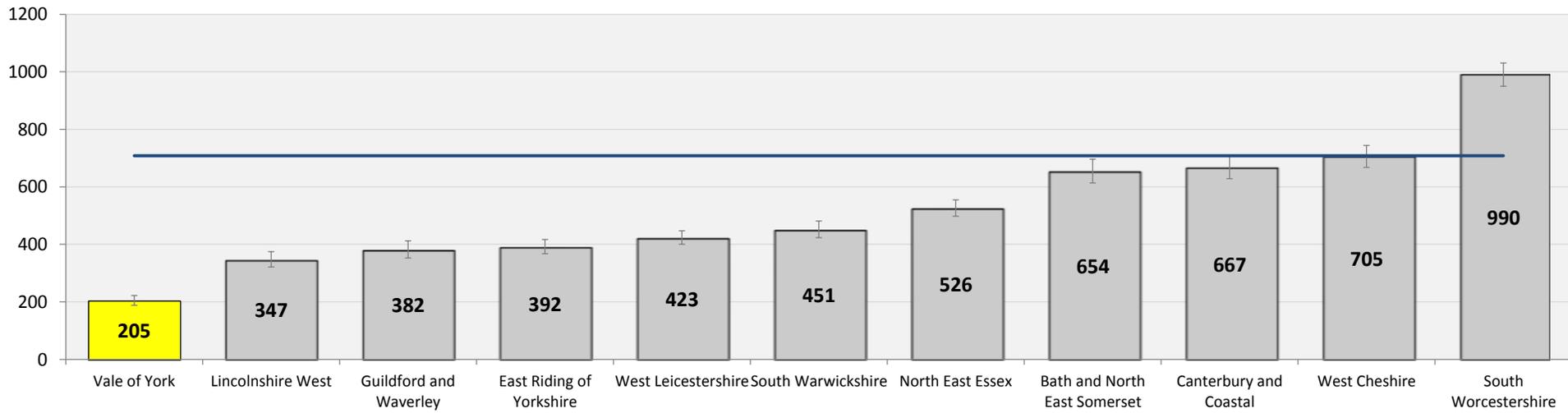
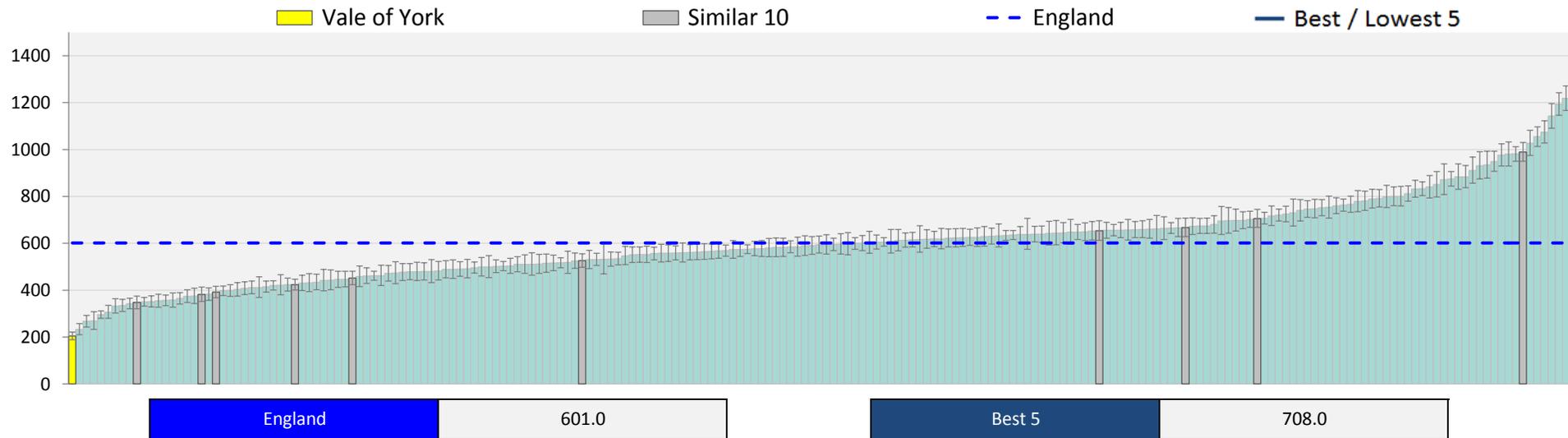
**2019 Pats.**



Definition: IAPT referrals: Rate (quarterly) per 100,000 population aged 18+  
 Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PHE  
 Year: 2015/16 Q4

# Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+

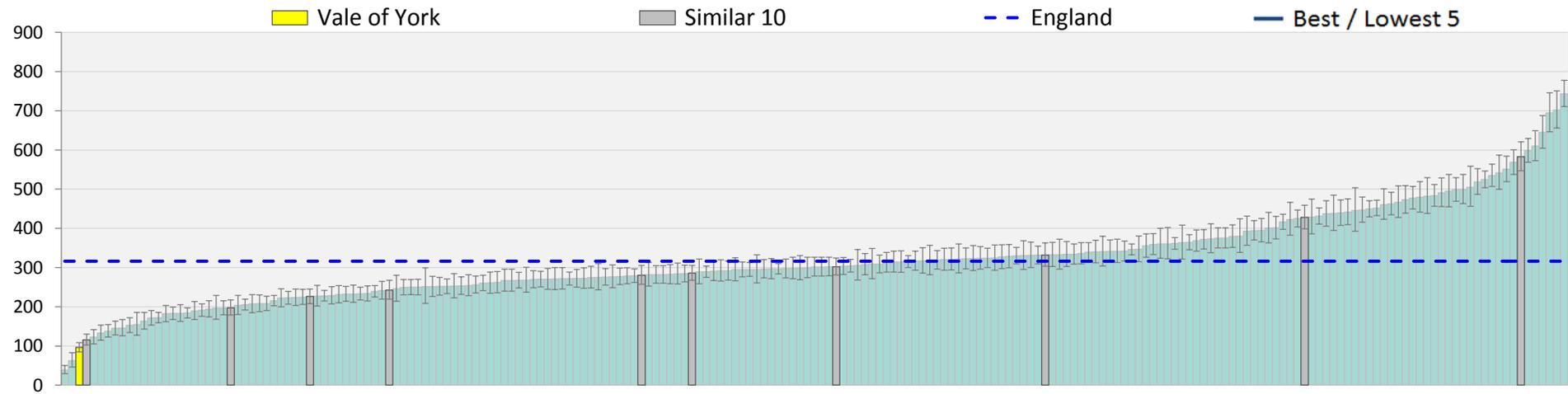
**1441 Pats.**



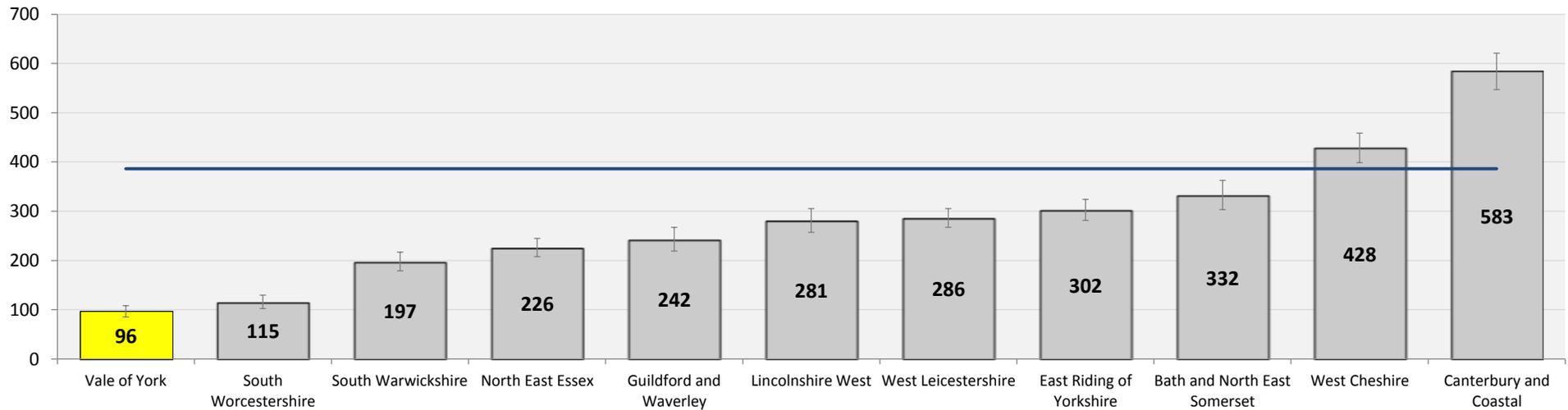
Definition: Entering IAPT treatment: Rate (quarterly) beginning IAPT treatment per 100,000 population aged 18+  
 Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PHE  
 Year: 2015/16 Q4

# Completion of IAPT treatment: Rate quarterly completing treatment per 100,000 population aged 18+

**830 Pats.**



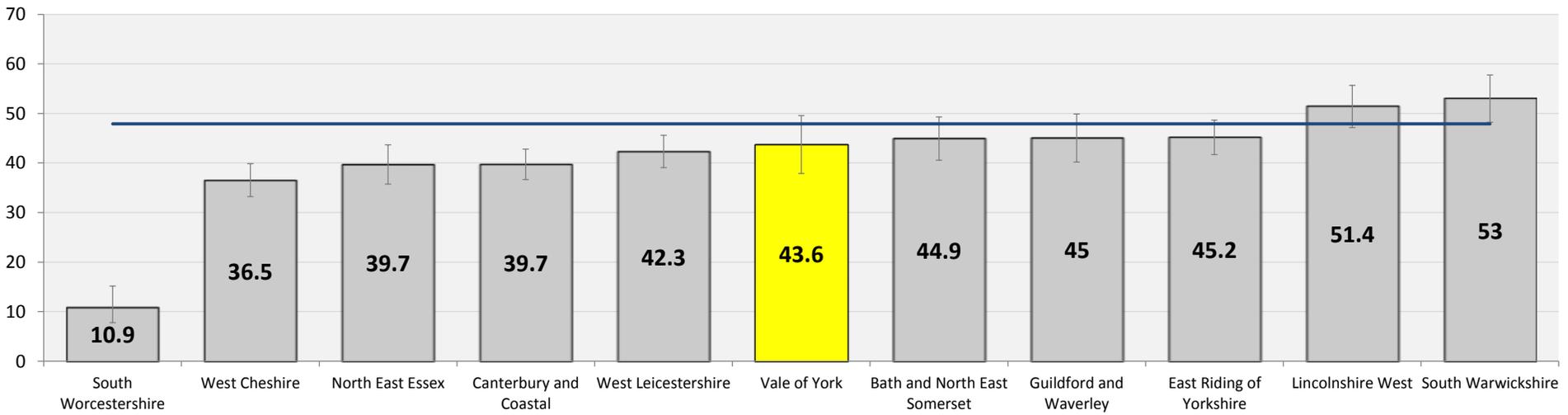
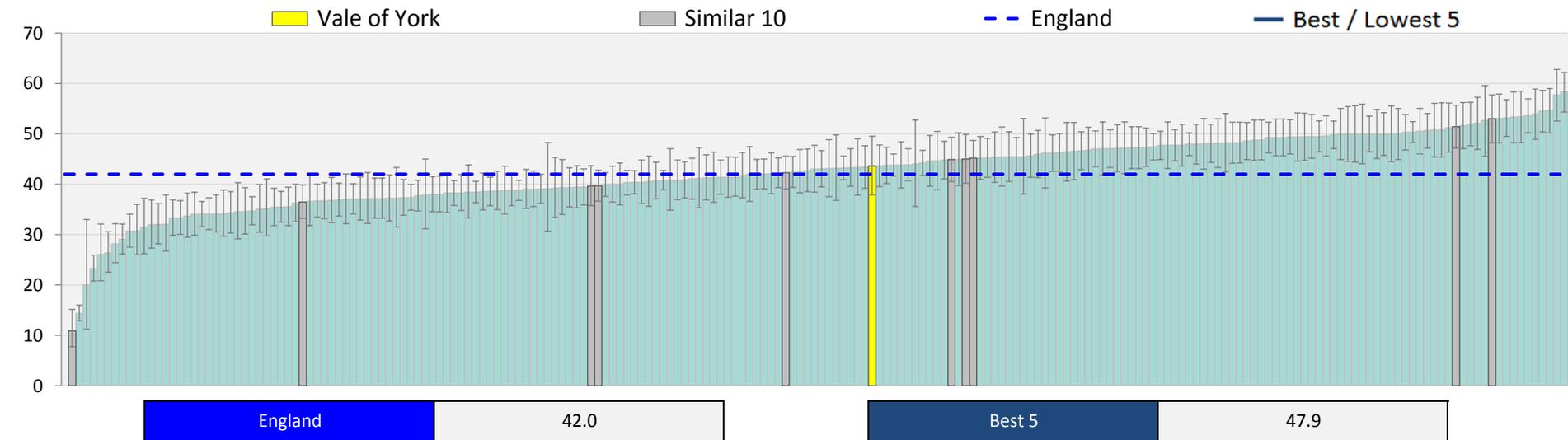
England	316.0	Best 5	386.0
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Definition: Completion of IAPT treatment: Rate quarterly completing treatment per 100,000 population aged 18+  
 Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PHE  
 Year: 2015/16 Q4

# Rate of recovery (quarterly): % of people who are "moving to recovery" of those who have completed IAPT treatment

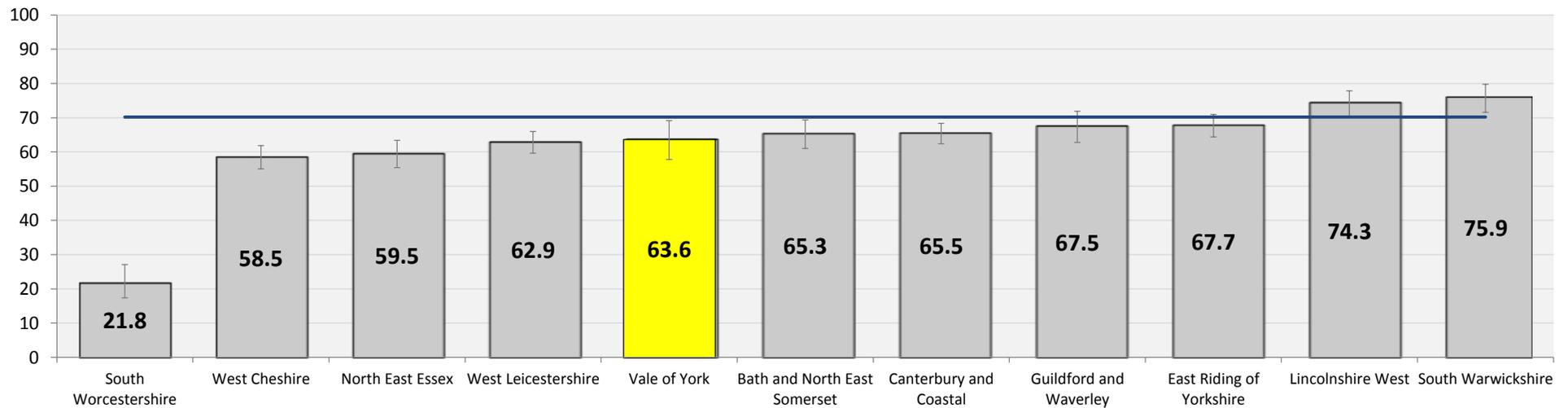
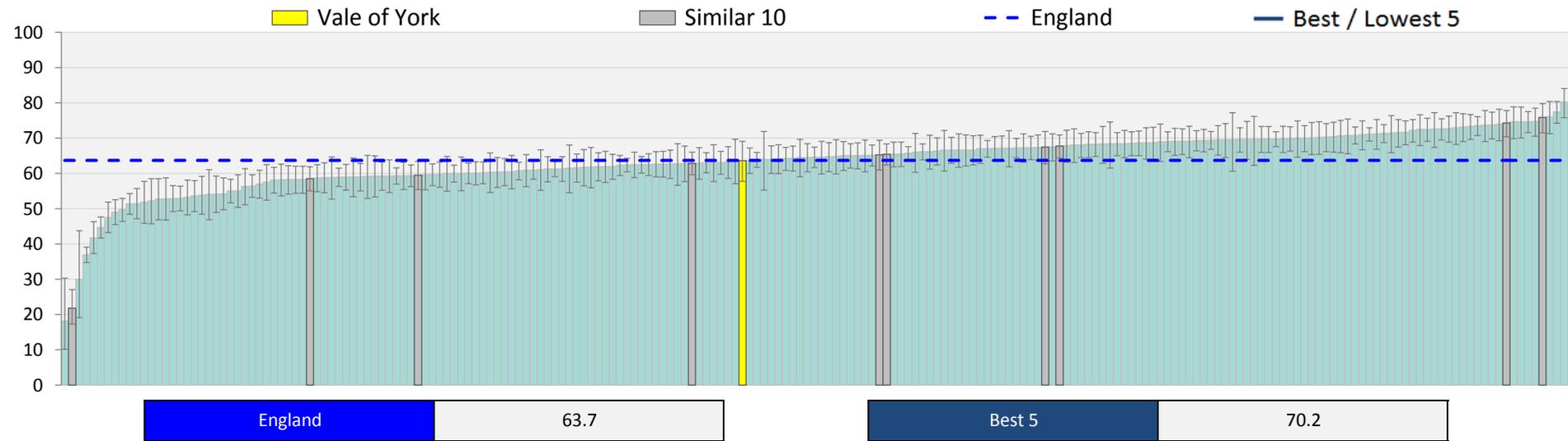
12 Pats. (NSS)



Definition: Rate of recovery (quarterly): % of people who are "moving to recovery" of those who have completed IAPT treatment  
 Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PHE  
 Year: 2015/16 Q4

# IAPT reliable recovery (quarterly): % of people who have completed IAPT treatment who achieved "reliable improvement"

**18 Pats.**



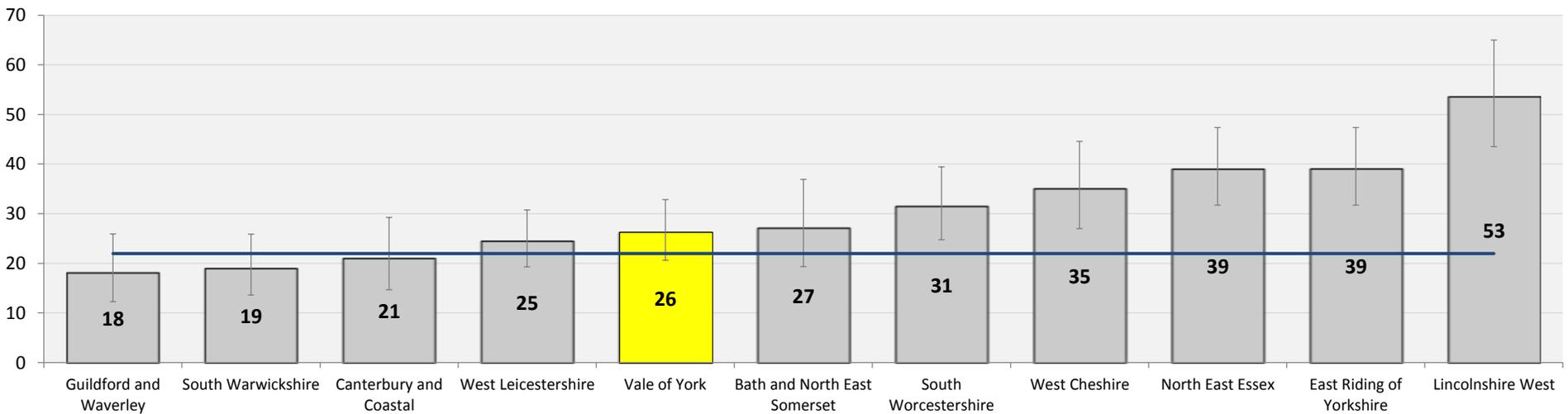
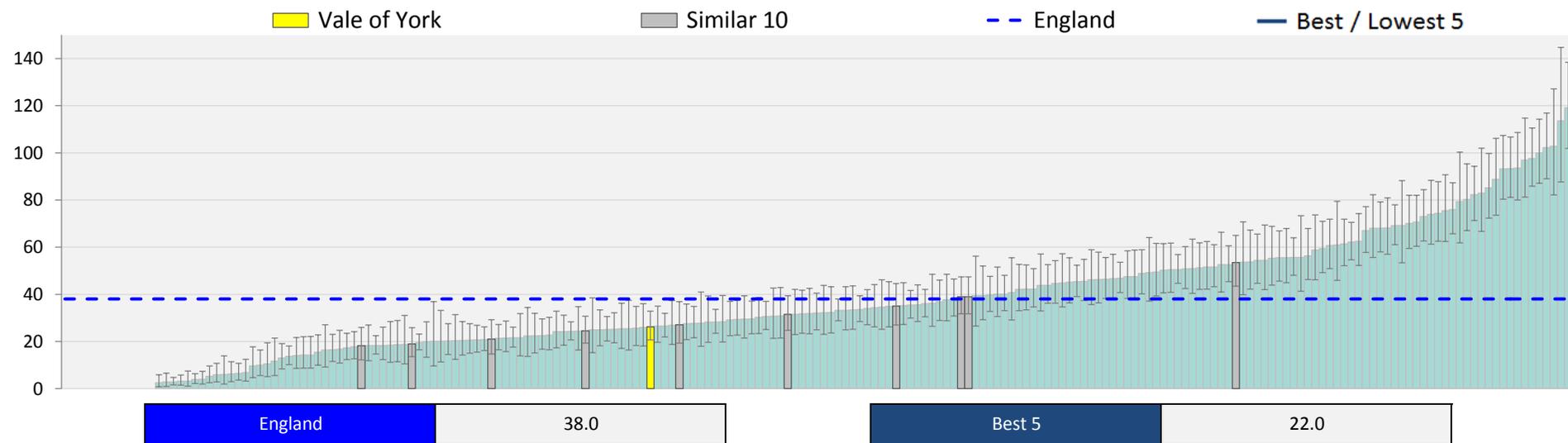
Definition: IAPT reliable recovery (quarterly): % of people who have completed IAPT treatment who achieved "reliable improvement"

Source: Improving Access to Psychological Therapies Dataset Reports, NHS Digital. Fingertips, PHE

Year: 2015/16 Q4

# The number of people subject to the Mental Health Act per 100,000 population aged 18+ (quarterly)

**12 Ppl. (NSS)**



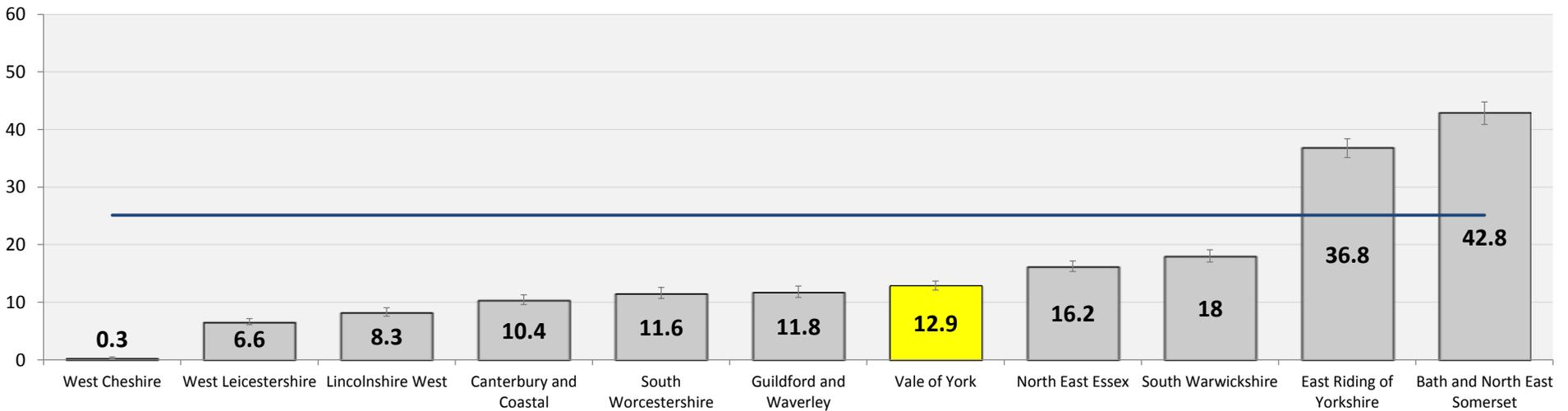
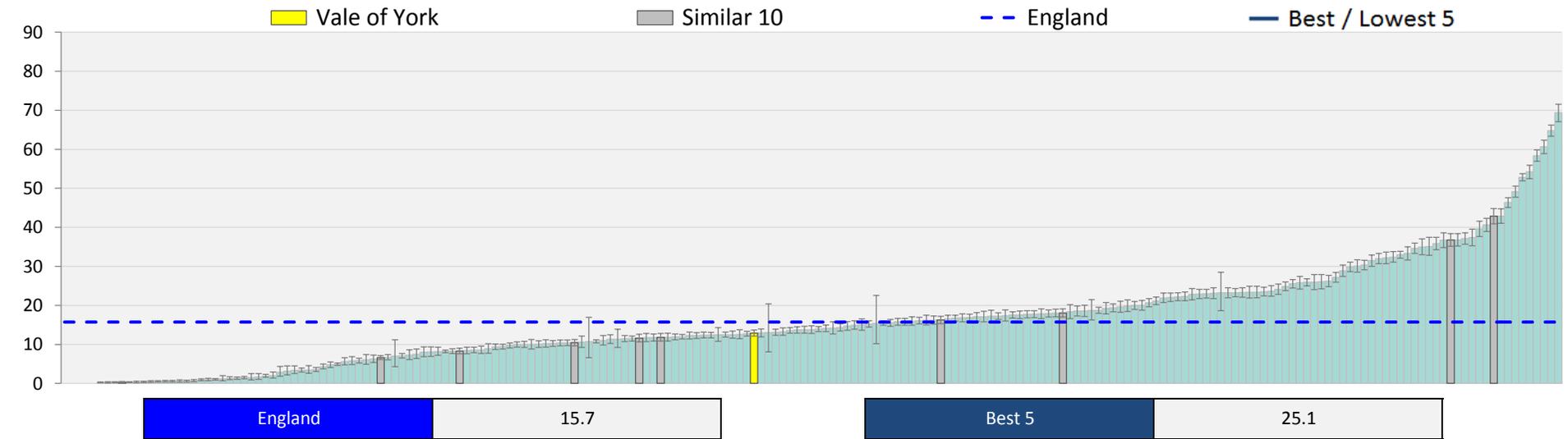
Definition: The number of people subject to the Mental Health Act per 100,000 population aged 18+ (quarterly)

Source: Mental Health Minimum Data Set (MHMDS) Reports, NHS Digital. Fingertips, PHE

Year: 2015/16 Q2

# Service users on CPA: % people in contact with MH services who are on care programme approach (end of quarter snapshot)

**873 Pats.**



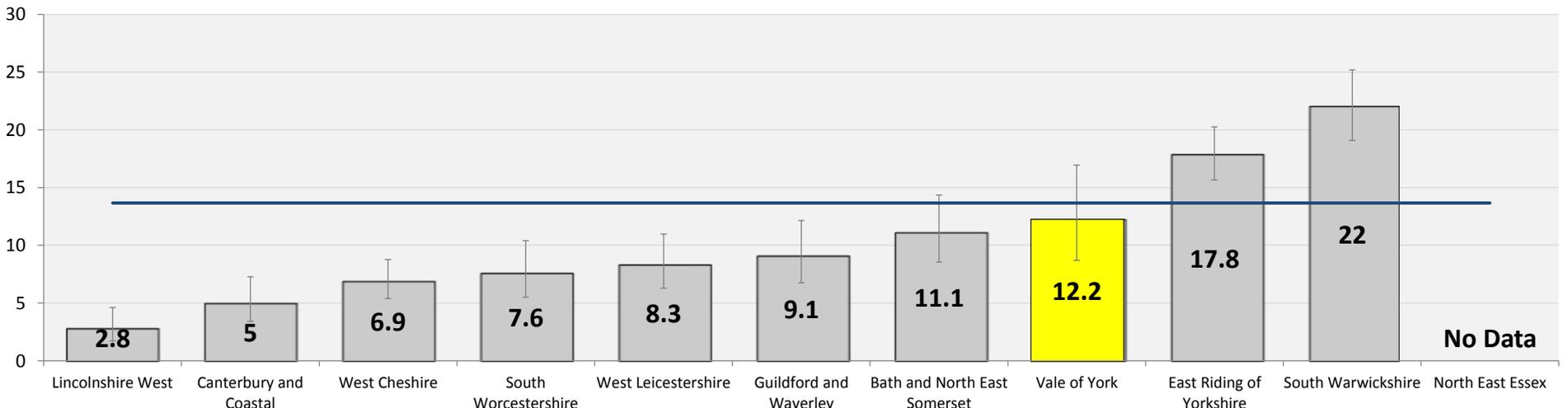
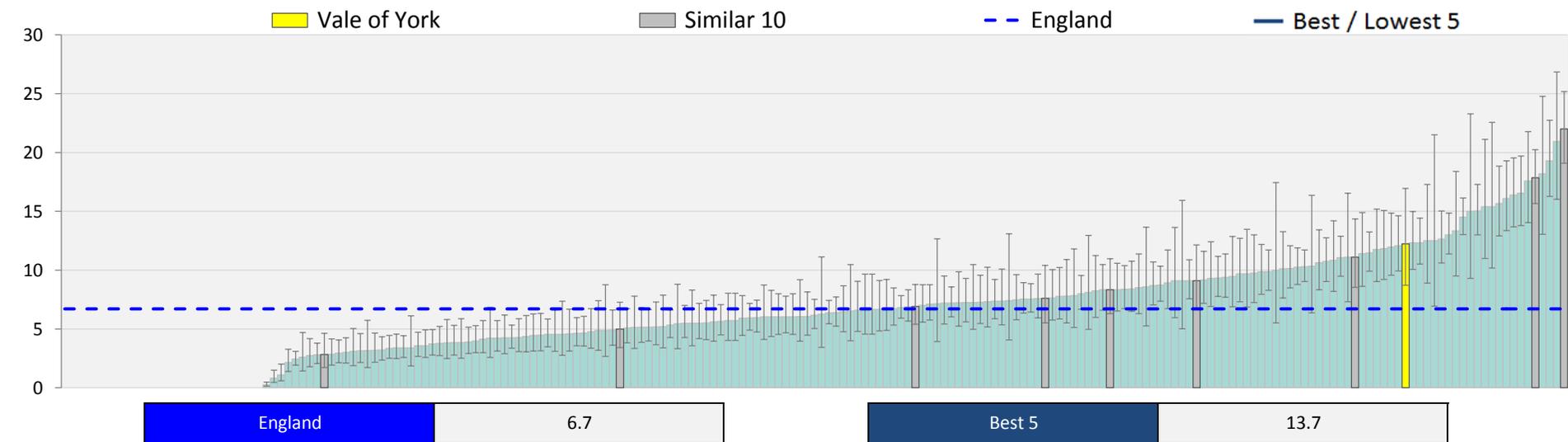
Definition: Service users on CPA: % people in contact with MH services who are on care programme approach (end of quarter snapshot)

Source: Mental Health Minimum Data Set (MHMDS) Reports, NHS Digital. Fingertips, PHE

Year: 2015/16 Q4

# The percentage of people aged 18-69 on care programme approach (CPA) in employment (end of quarter snapshot)

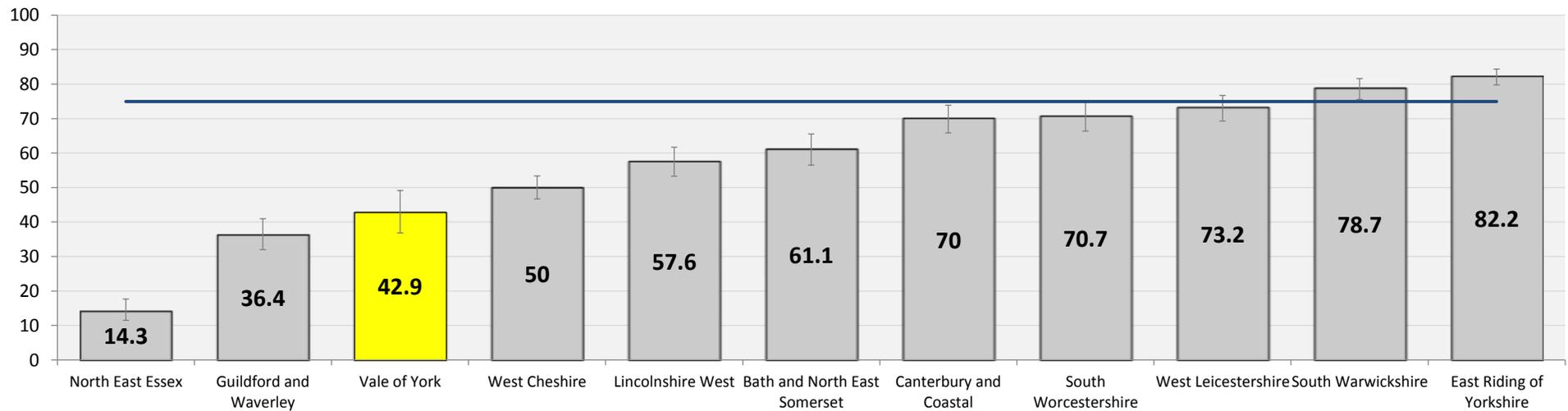
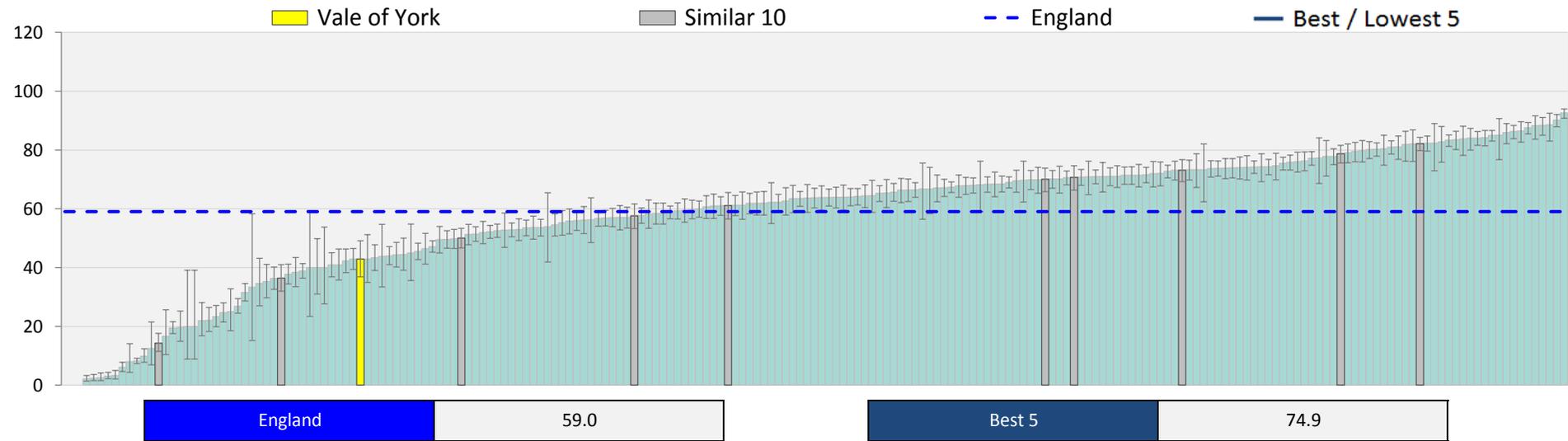
**4 Ppl. (NSS)**



Definition: The percentage of people aged 18-69 on care programme approach (CPA) in employment (end of quarter snapshot)  
 Source: Mental Health Minimum Data Set (MHMDS) Reports, NHS Digital. Fingertips, PHE  
 Year: 2015/16 Q2

The percentage of adults aged 18+ in contact with secondary mental health services (SMHS) who are on the Care Programme Approach (CPA) and are helped into settled accommodation (end of quarter snapshot)

**79 Ppl.**



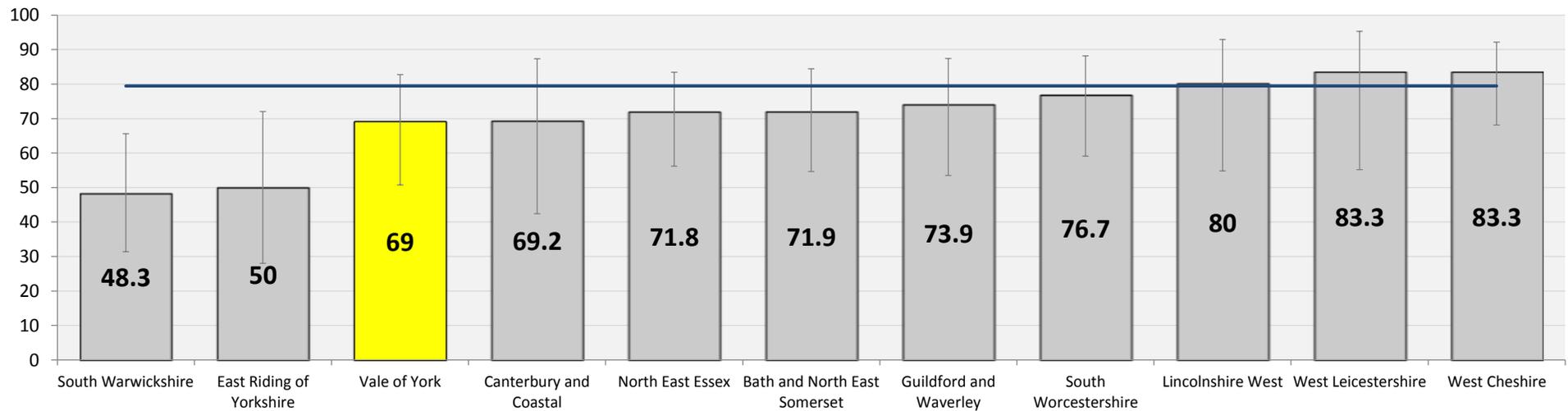
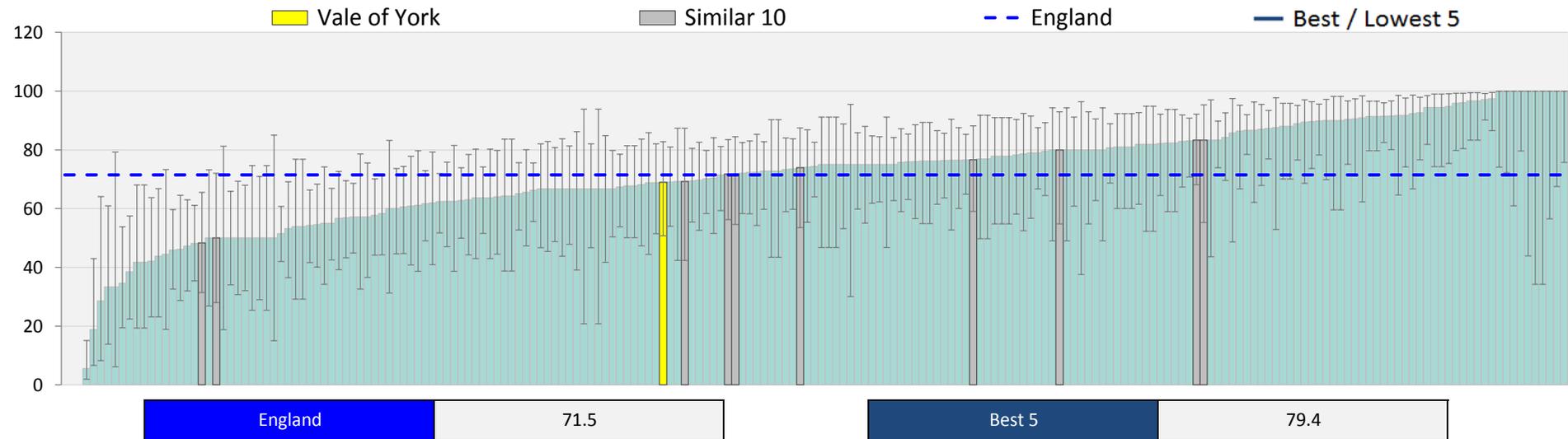
Definition: The percentage of adults aged 18+ in contact with secondary mental health services (SMHS) who are on the Care Programme Approach (CPA) and are helped into settled accommodation (end of quarter snapshot)

Source: Mental Health and Learning Disabilities Statistics (MHLDS), NHS Digital. Fingertips, PHE

Year: 2015/16 Q2

# The percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways (5 months)

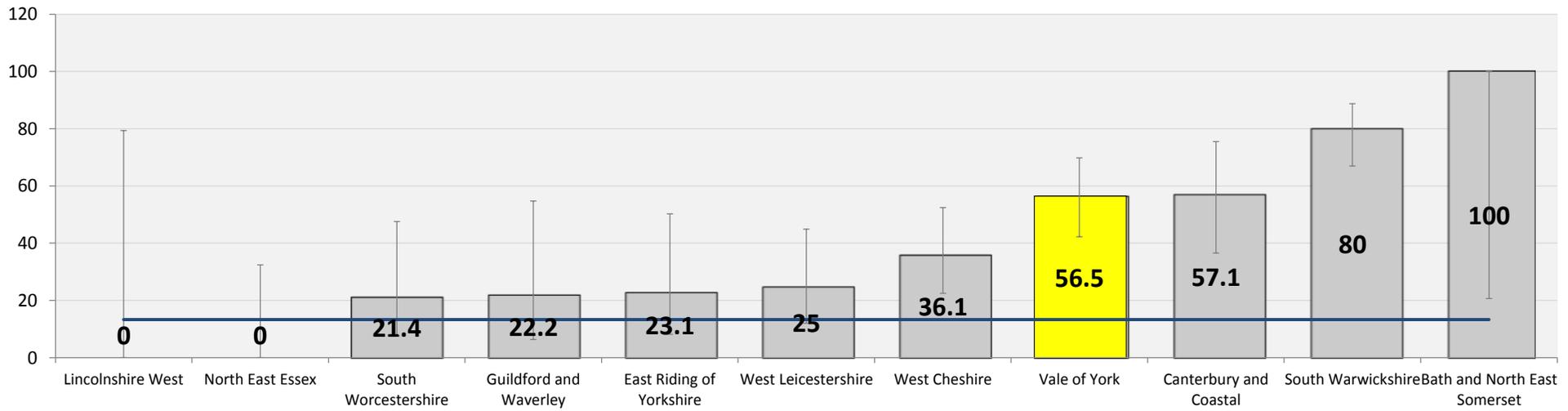
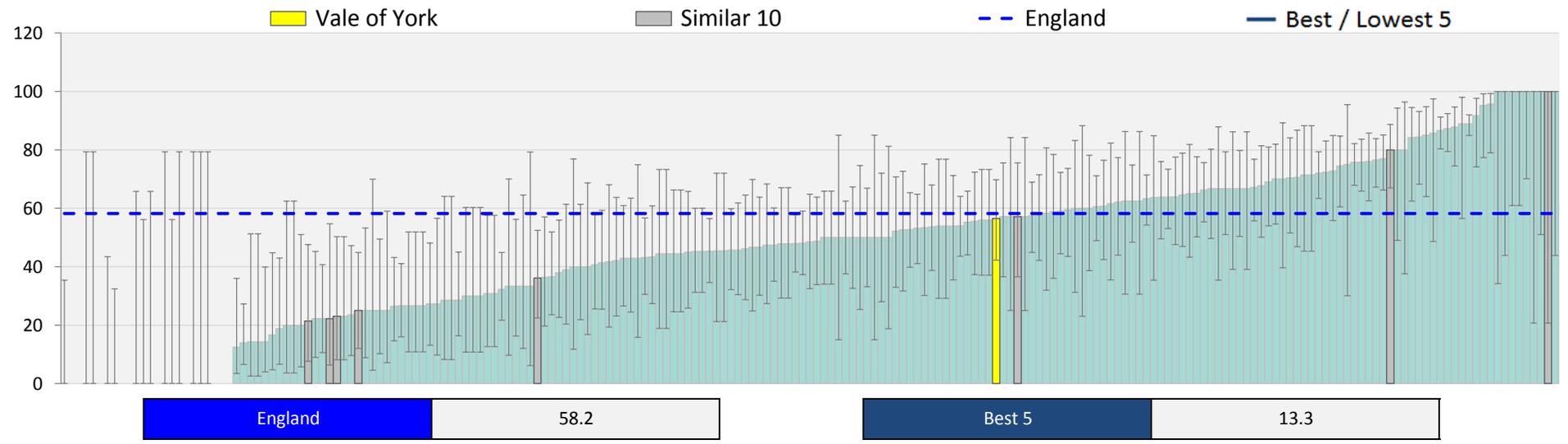
3 Pats. (NSS)



Definition: The percentage of patients waiting less than 2 weeks to start EIP treatment – Percentage of all complete pathways (5 months)  
 Source: NHS England  
 Year: April 2016- August 2016

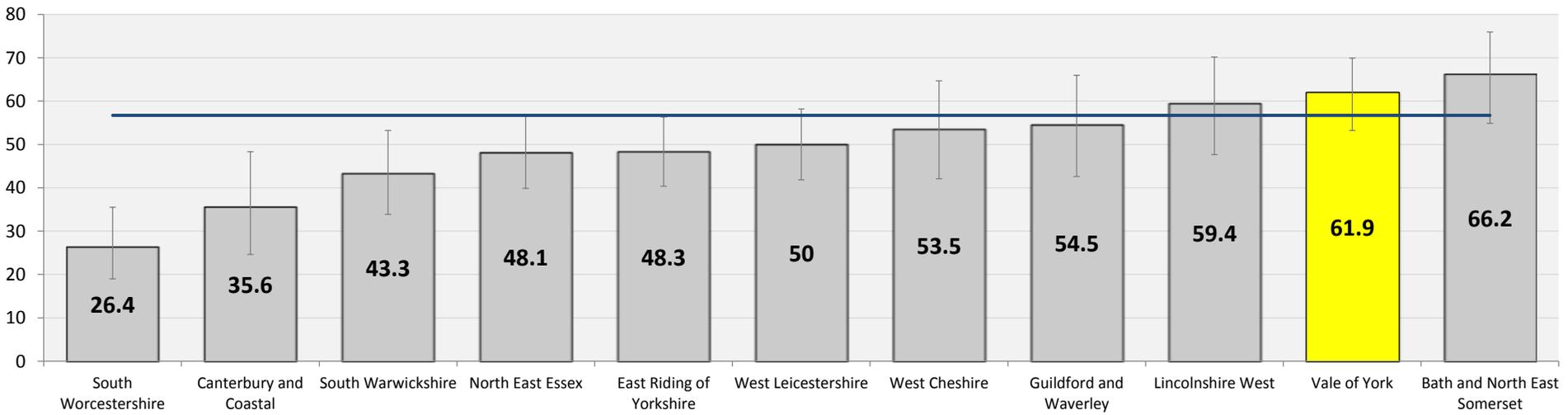
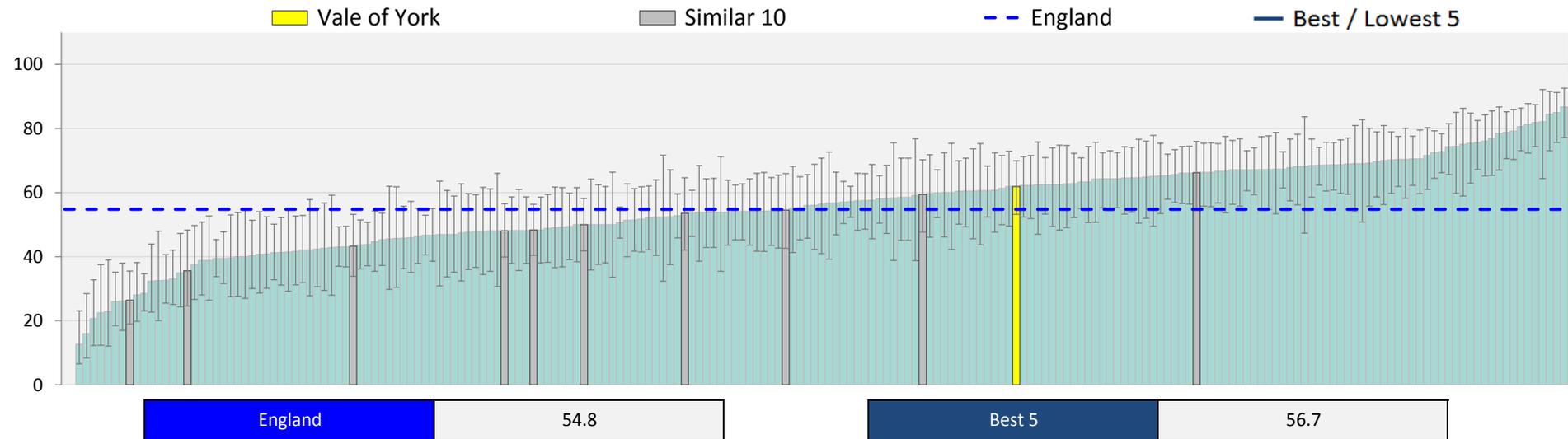
# The percentage of patients waiting more than 2 weeks to start EIP treatment – Percentage of all incomplete pathways (5 months)

**20 Pats.**



Definition: The percentage of patients waiting more than 2 weeks to start EIP treatment – Percentage of all incomplete pathways (5 months)  
 Source: NHS England  
 Year: April 2016- August 2016

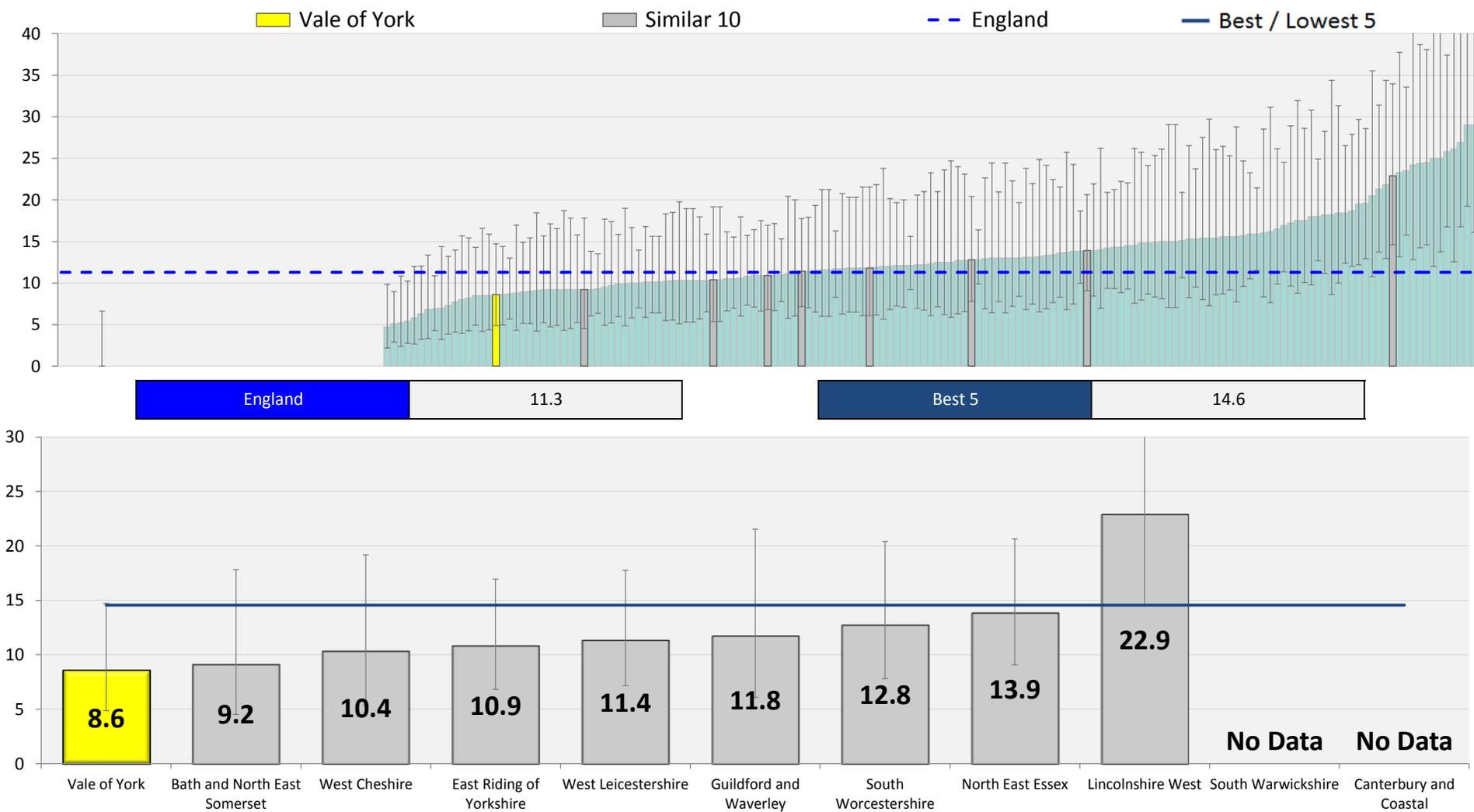
# The percentage of applicable patients who go direct to a stroke unit within 4 hours (quarterly)



Definition: The percentage of applicable patients who go direct to a stroke unit within 4 hours (quarterly)  
 Source: Sentinel Stroke National Audit Programme (SSNAP)  
 Year: Jan-Mar 2016

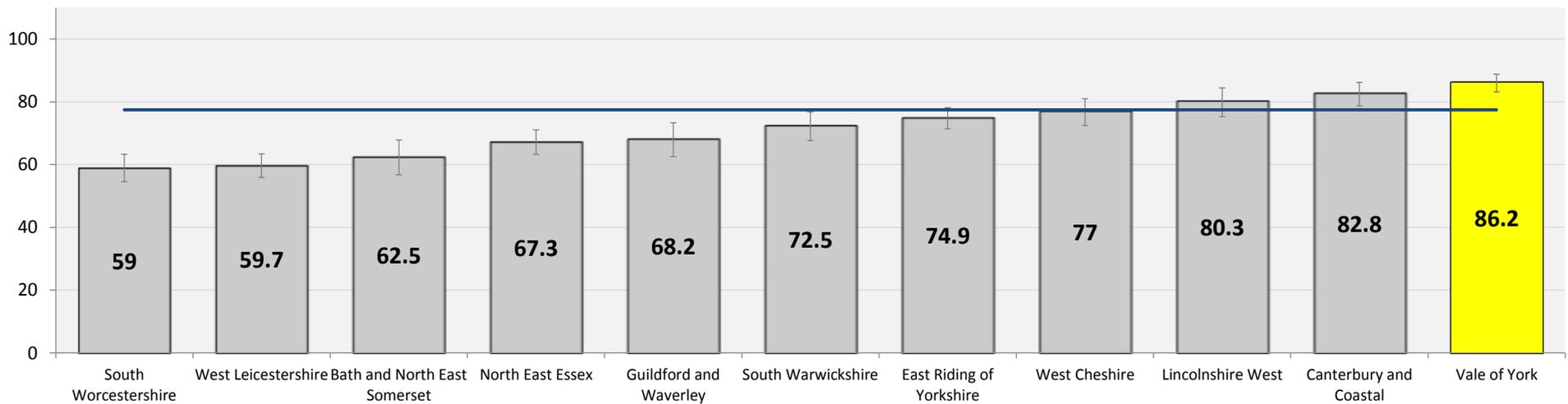
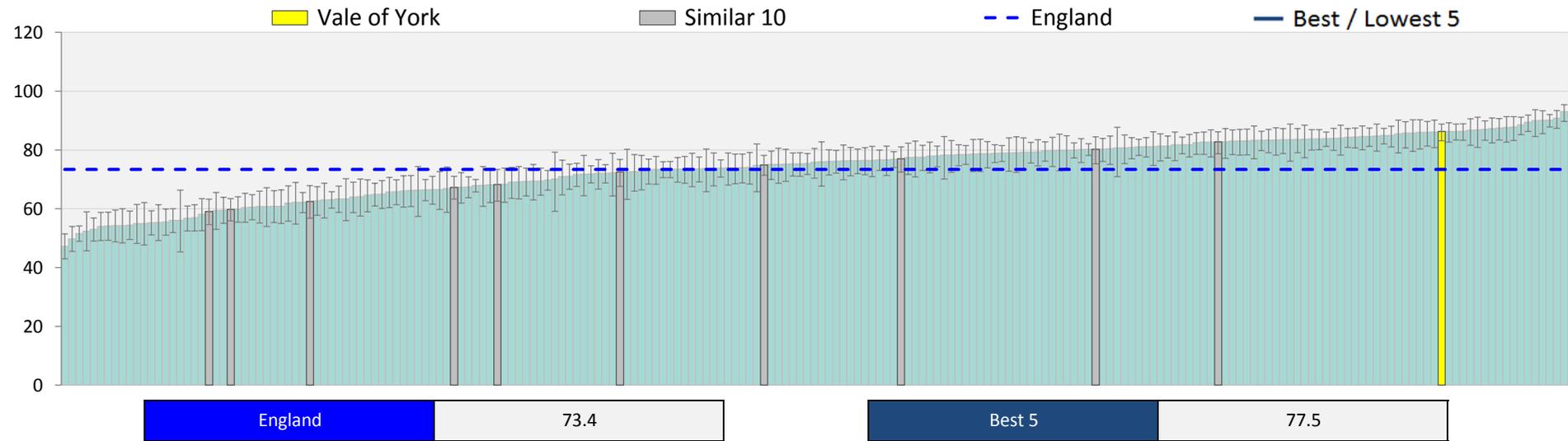
# The percentage of all stroke patients who receive thrombolysis (quarterly)

8 Pats. (NSS)



Definition: The percentage of all stroke patients who receive thrombolysis (quarterly)  
 Source: Sentinel Stroke National Audit Programme (SSNAP)  
 Year: Jan-Mar 2016

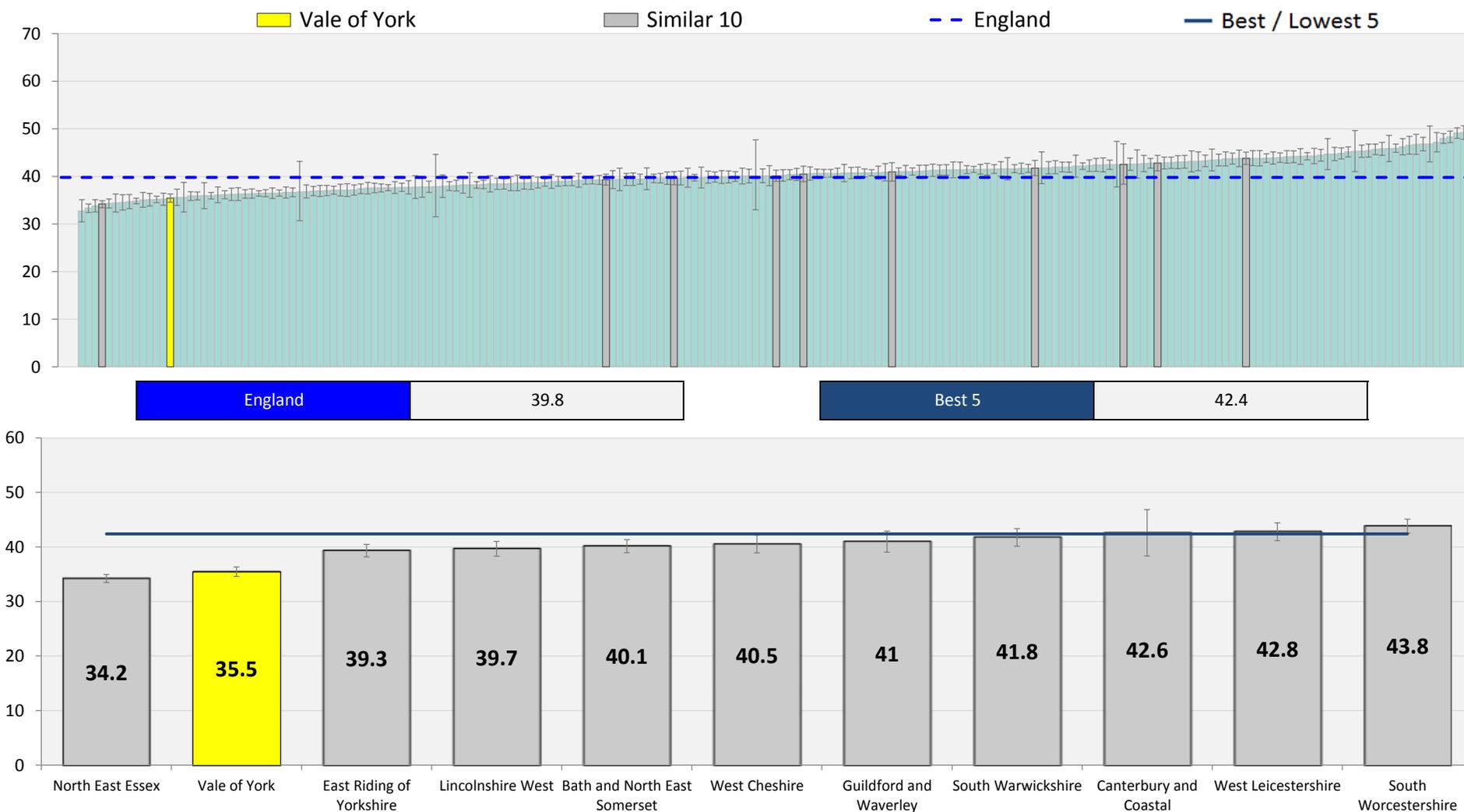
# The percentage of patients returning to usual place of residence following hospital treatment for stroke



Definition: The percentage of patients returning to usual place of residence following hospital treatment for stroke  
 Source: <http://www.NHS Digital.gov.uk/hdis>  
 Year: 2014/15

## The percentage of diabetes patients receiving all three treatment targets

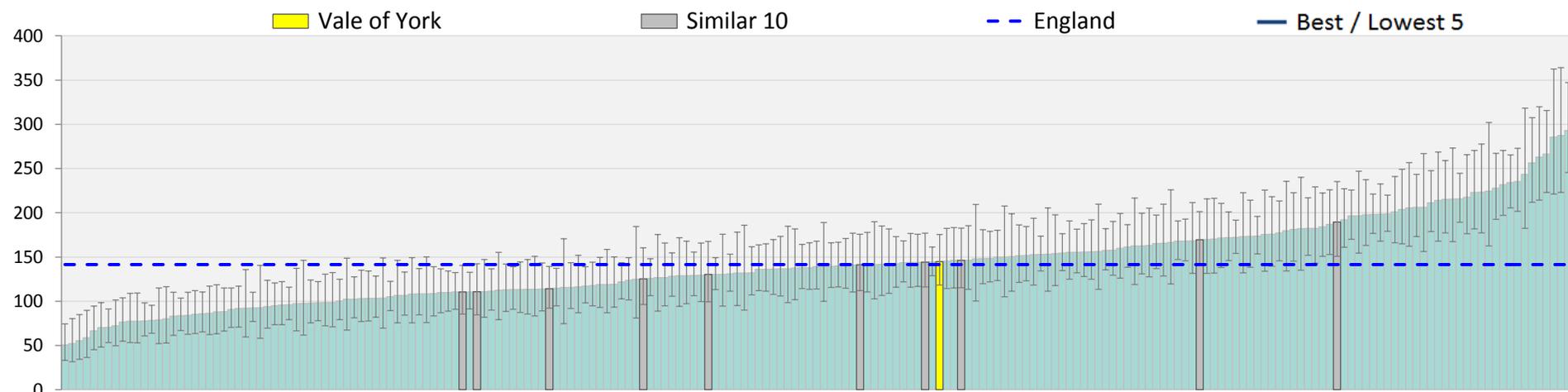
793 Pats.



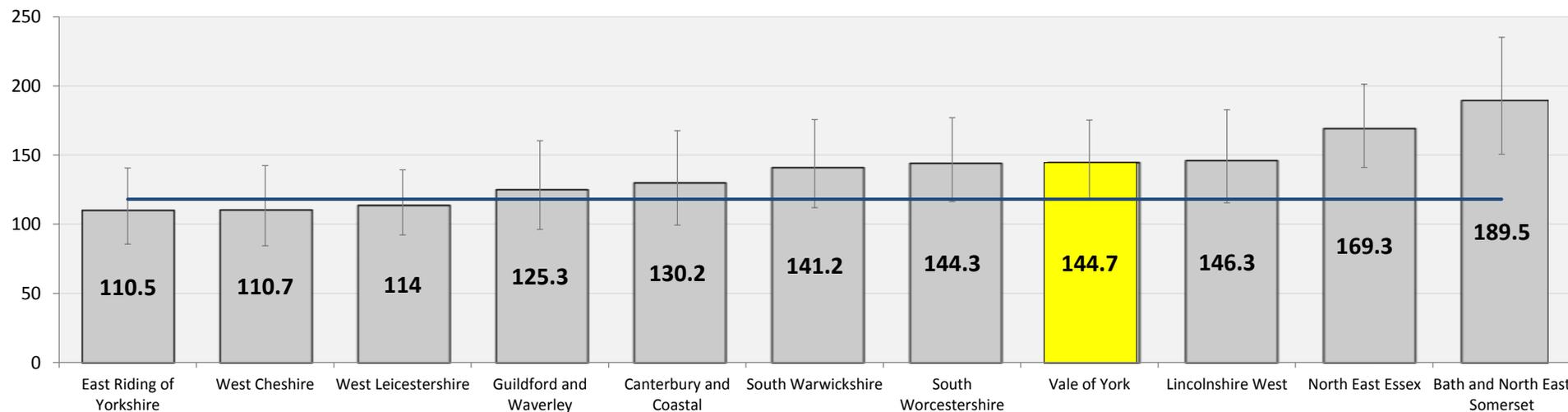
Definition: The percentage of diabetes patients receiving all three treatment targets  
 Source: QOF, NHS Digital  
 Year: 2014/15

# Emergency admission rate for children with epilepsy per population aged 0–19 years

**19 Adm.**



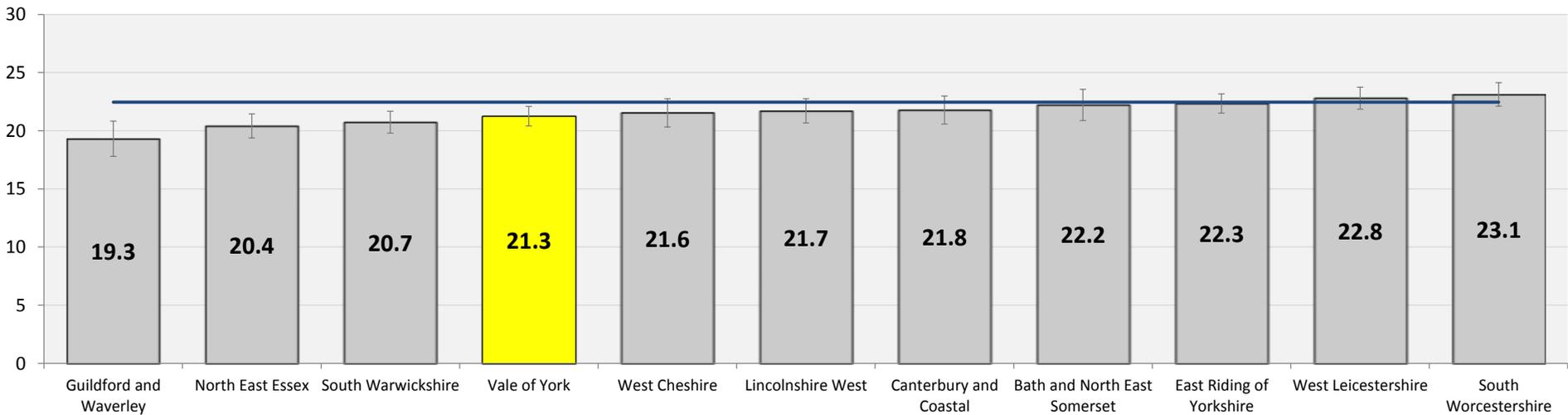
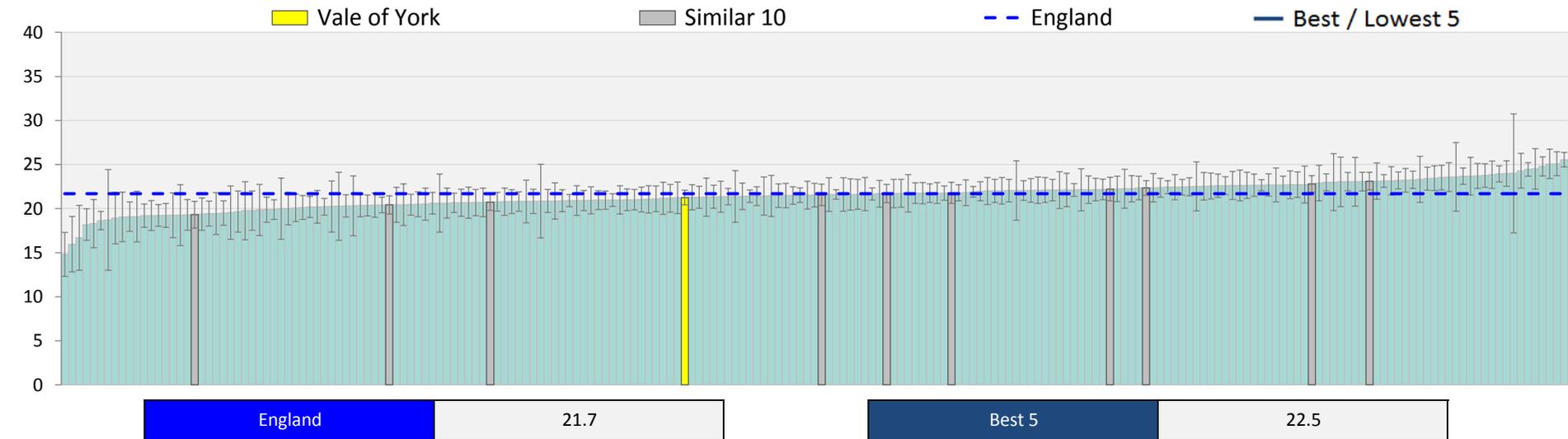
England	141.4	Best 5	118.1
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Definition: Emergency admission rate for children with epilepsy per population aged 0–19 years  
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)  
 Year: 2015/16

# Hip replacement, Oxford Score, Health Gain

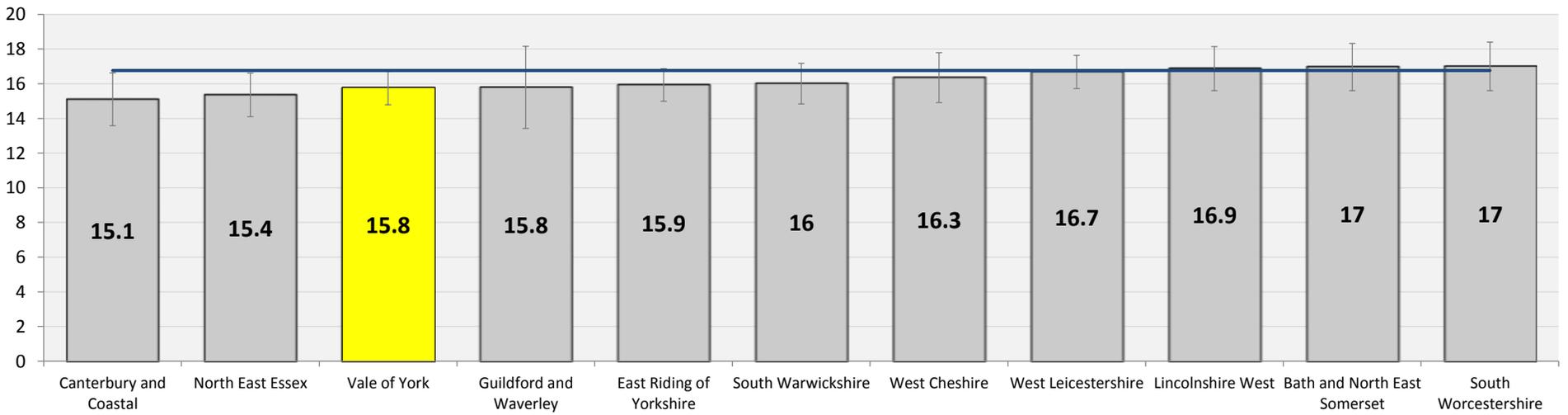
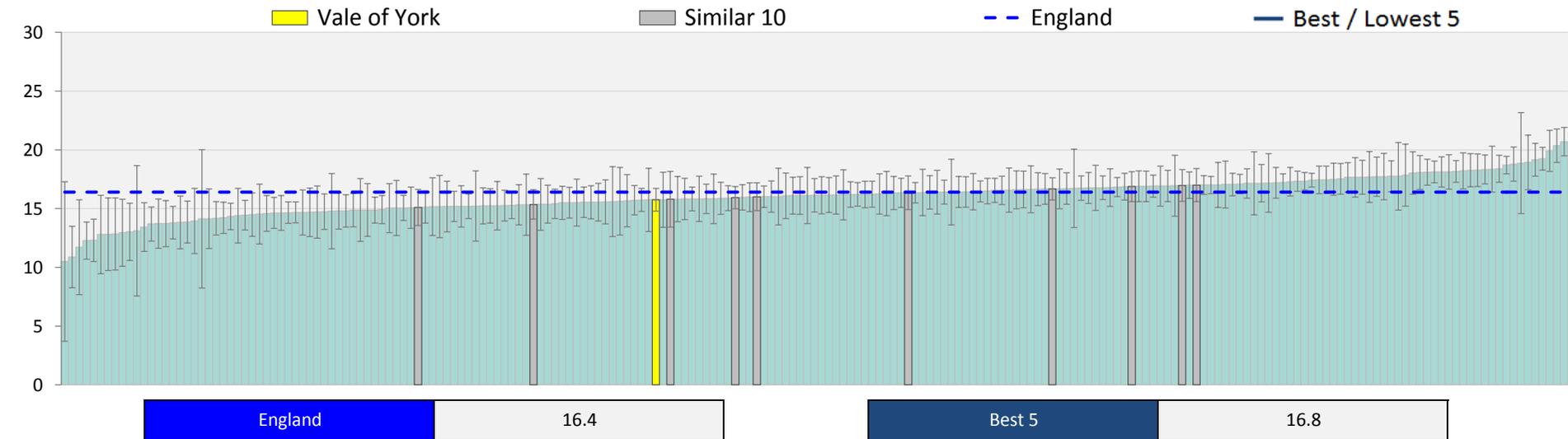
N/A



Definition: Hip replacement, Oxford Score, Health Gain  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16

# Knee replacement, Oxford Score, Health Gain

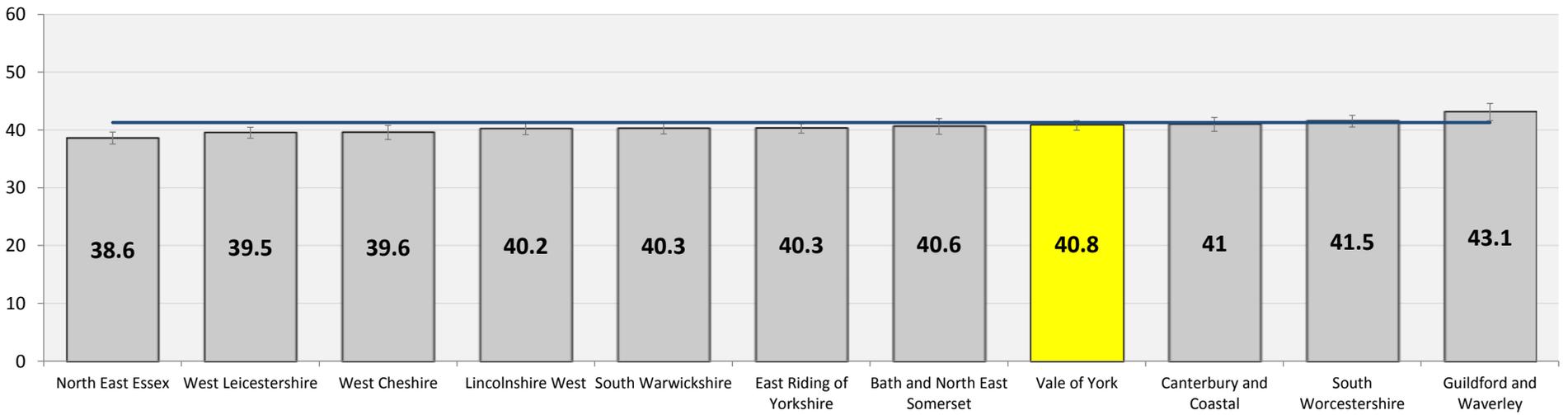
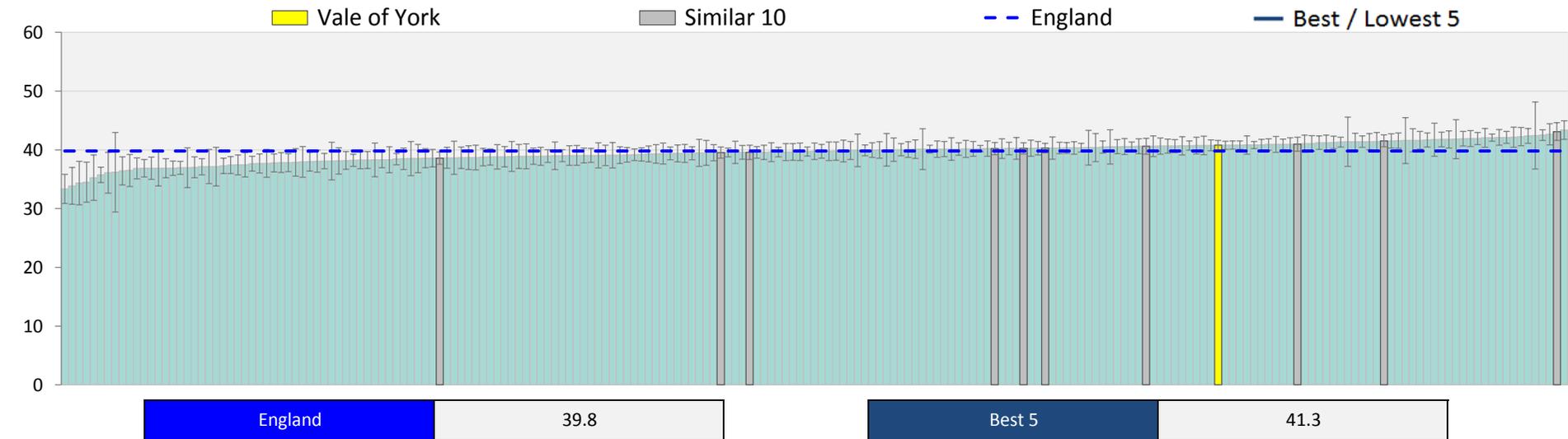
N/A



Definition: Knee replacement, Oxford Score, Health Gain  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16

# Post-op, Oxford Score, Hip

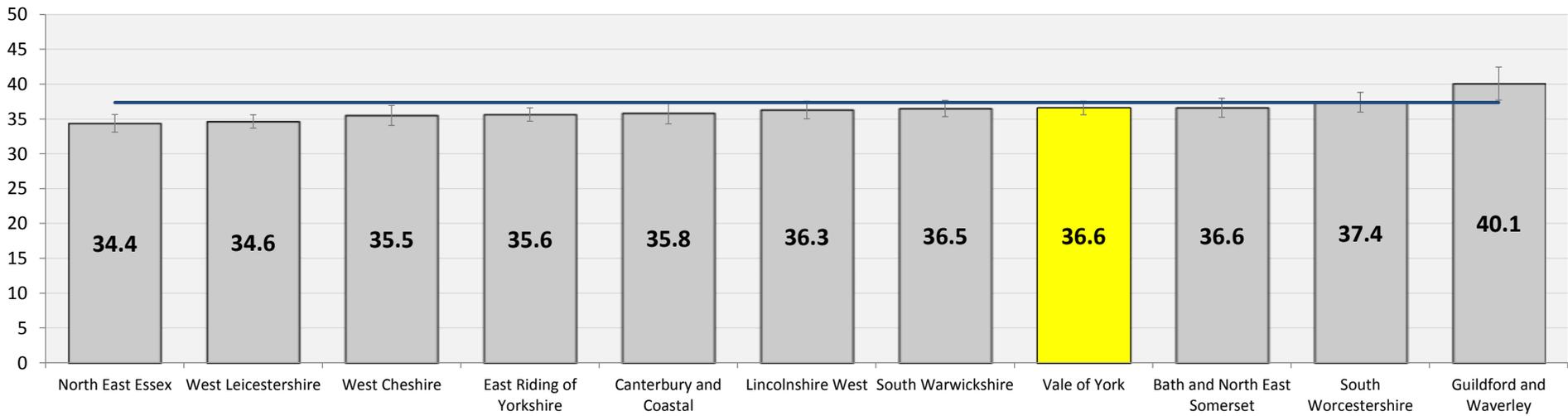
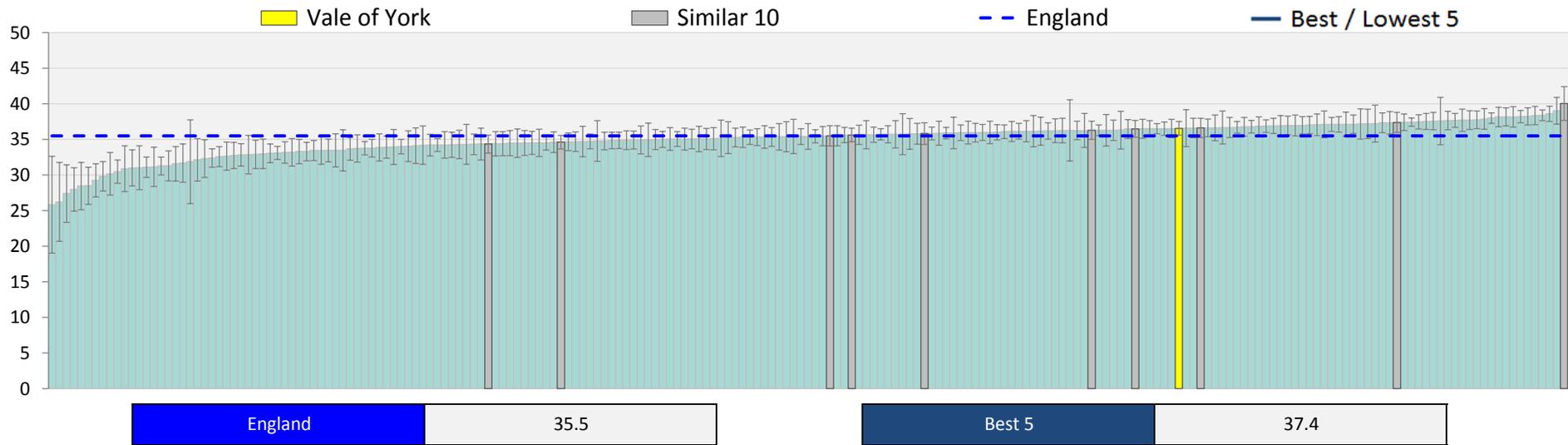
**N/A**



Definition: Post-op, Oxford Score, Hip  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16

# Post-op, Oxford Score, Knee

**N/A**



Definition: Post-op, Oxford Score, Knee  
 Source: Patient Reported Outcome Measures (PROMs), NHS Digital  
 Year: 2015/16