NHS RightCare

Commissioning for Value Where to Look pack

Cornwall and the Isles of Scilly - STP area

December 2016

Public Health England

NHS Improvement

NHS England

Contents

Introduction to your Where to Look pack

What's in this pack?

This pack contains data from the CCG Commissioning for Value Where to Look packs, published in October 2016, collated at STP footprint level.

The data in this pack includes headline opportunities, improvement opportunity tables and slides showing how CCGs in each STP differ from their peers.

An STP opportunity is the sum of all the equivalent opportunities of the CCGs in that area. They do not include negative opportunities or those which are statistically insignificant.

Why your STP area should review it

The information contained in this pack is personalised for each STP footprint area and can be used to help support local discussions about prioritisation to improve the value and utilisation of resources.

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

Legal duties

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

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

Supporting the STP process

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

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

In the meantime, CCGs and local health economies will still be able to use the 2016 focus packs for further investigations as an indication of what to change. Unless a CCG has taken action along a particular pathway, their relative position is unlikely to have altered.

NHS RightCare and Getting it Right First Time (GIRFT)

NHS RightCare and GIRFT are complementary programmes and should be used together to support the delivery of population healthcare improvement and financial sustainability.

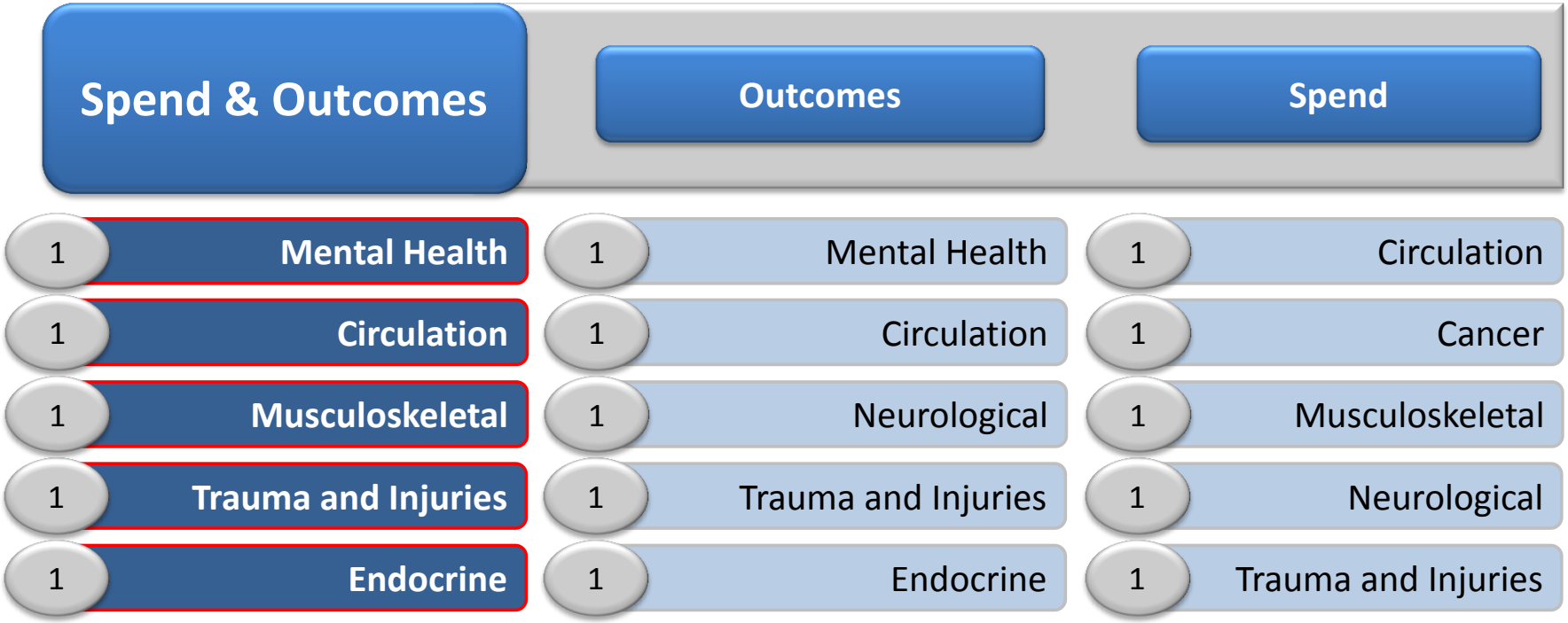
NHS RightCare's Commissioning for Value workstream supports improvement across systems by focusing on pathways of care from primary prevention to end of life care. Whilst supporting improvement in terms of access to and outcomes from the acute sector, Commissioning for Value has not focused in detail on hospital care. GIRFT provides detailed insight into variation in the acute system in a way that has not been available before. As such NHS RightCare and GIRFT collectively provide clinical improvement insight across the entire health care system.

In 2017 NHS RightCare and GIRFT will be working closely together to support STPs and their local health economies. This will begin with a complementary set of analysis on orthopaedic pathways.

This pack supports STP thinking on this collective agenda, including by highlighting opportunities for improvement such as by coordinating the reallocation of capacity in the acute system, something that can only be achieved together. See pages 9 and 10.

Headline opportunity areas for Cornwall and the Isles of Scilly

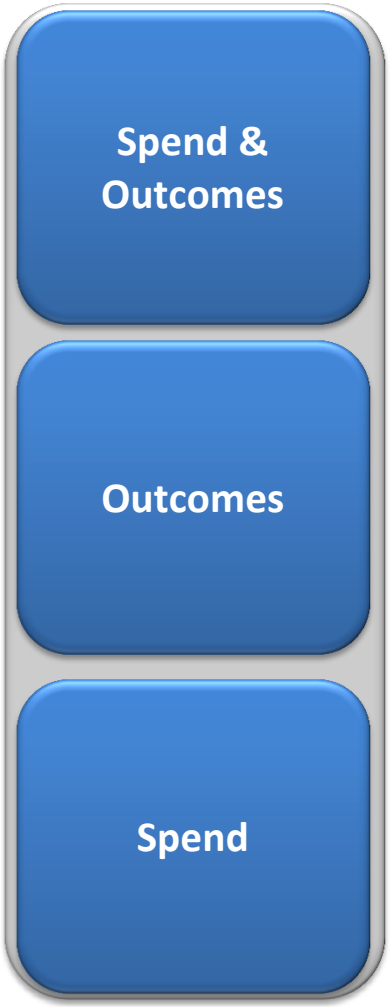
The number in the grey circles below represents how many CCGs within Cornwall and the Isles of Scilly share a particular opportunity area out of 1 CCGs within the STP



These headline lists are based on the contributing CCGs which form the STP. The figure in the grey circle represents the number of times each programme appears in each individual CCG headline list. This is simply the number of CCGs in the STP with a common programme as a headline opportunity. It does not factor in the relative scale of each of the opportunities for this ranking. E.g. an STP with six CCGs may have all six CCGs with a cancer spend opportunity totalling £3m. In this example, cancer would rank above respiratory which appears in the list for five CCGs but has a total opportunity of £4m. This can be explored further in the detailed sections of this pack.

Which CCGs in Cornwall and the Isles of Scilly - STP share headline opportunity areas?

NHS RightCare



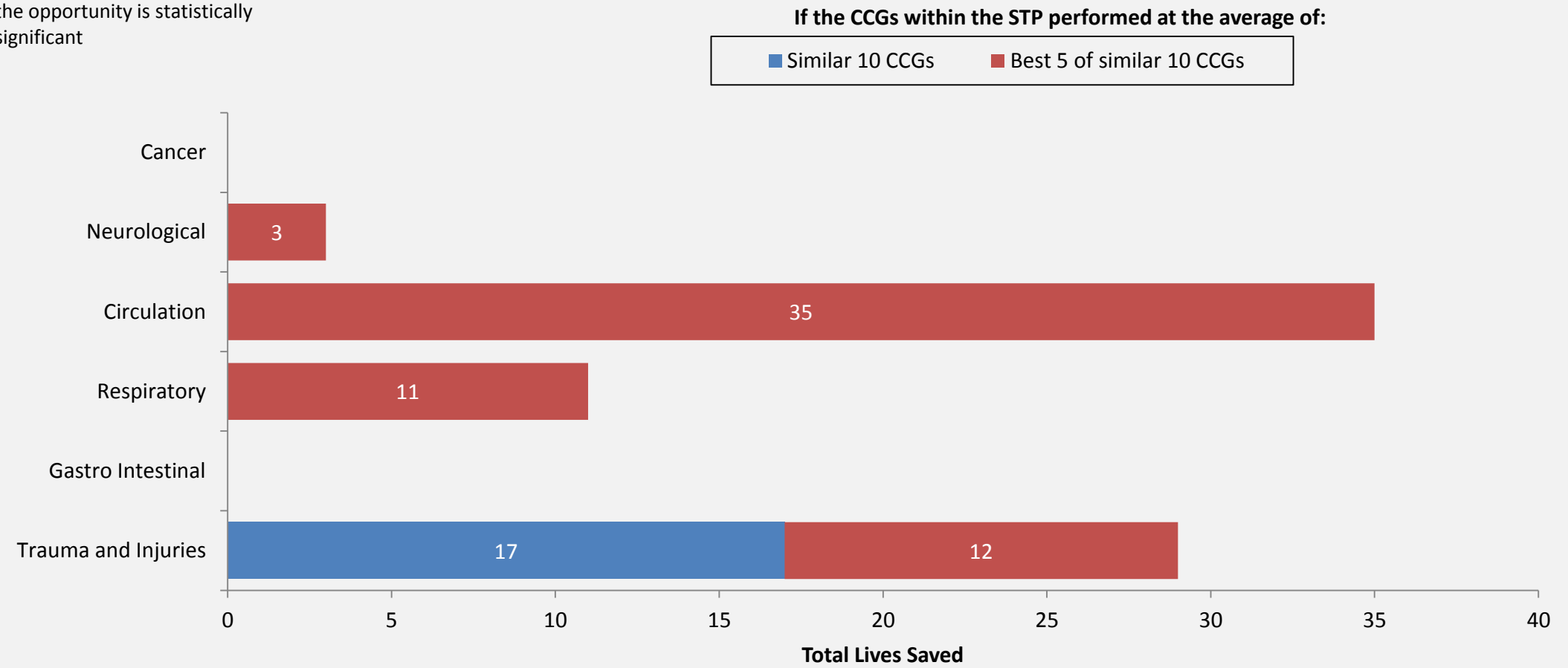
Mental Health	Kernow
Circulation	Kernow
Musculoskeletal	Kernow
Trauma and Injuries	Kernow
Endocrine	Kernow

Mental Health	Kernow
Circulation	Kernow
Neurological	Kernow
Trauma and Injuries	Kernow
Endocrine	Kernow

Circulation	Kernow
Cancer	Kernow
Musculoskeletal	Kernow
Neurological	Kernow
Trauma and Injuries	Kernow

What are the potential lives saved per year?

A value is only shown where the opportunity is statistically significant



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

Coordinating the re-allocation of capacity

Improving a population healthcare system to become high value and optimal requires significant change.

It requires change in the practices and perspectives of all of the professions, people and partners engaged in the system. It requires change in how we engage with individual patients and how we engage with our local communities, so that we inform and then seek to understand their perspectives and their preferences. It requires change in how we operate and think about our organisational structures, plans and asset models. And, most importantly of all, it requires us to embrace, collectively and individually, the need to make these changes.

Variation data, as contained in the suite of Commissioning for Value packs, highlights that in every health system in England, there exists a significant volume of overuse alongside significant underuse. Overuse leads to waste and harm. Underuse leads to a failure to prevent disease and inequity. Reducing both leads to a better and more sustainable system. In order to do this well, we must work together to coordinate the re-allocation of capacity from unwarranted activity to warranted activity, wherever in the system that may be.

Coordinating the re-allocation of capacity

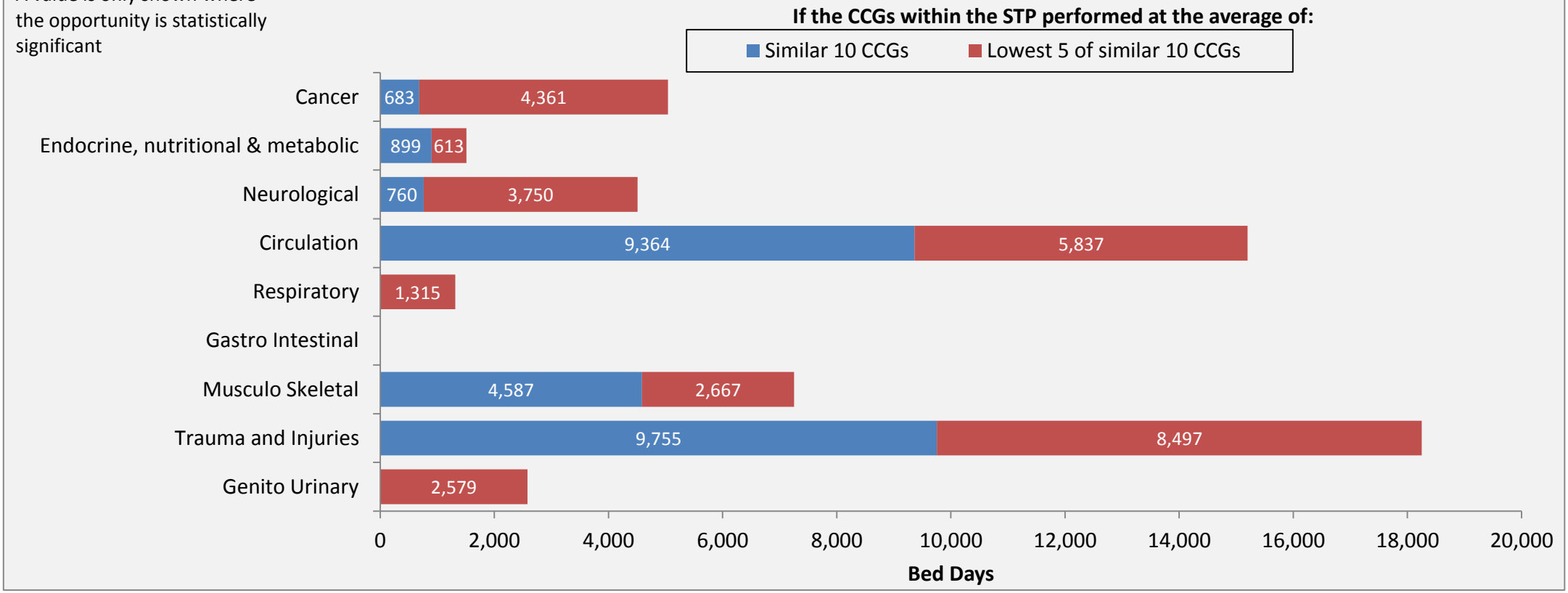
The next page highlights the potential overuse in bed days for your STP area, as implied by variation data for each of your constituent health economies. STP areas are able to use this information to focus on the opportunity to free up bed capacity, and ask the questions ‘Is this current bed use adding value?’ and ‘Where might we better use this capacity and resource?’.

In turn this will allow for discussion and consensus to be reached on where beds add more value if re-allocated for different use. It also allows for discussion and consensus on what current capacity a system could avoid the need for, if resources were re-allocated for non-bed use, to deliver optimal clinical pathways and systems. Avoiding the need for capacity, in this way, is a key component of delivering a sustainable healthcare system.

Fully integrated care is very likely to be a key part of these discussions. Identifying together ‘Where to Look’ and then designing optimal pathways and systems, that is, ‘What to Change’, by collectively answering the question ‘What would we look like if we were doing the very best for our population?’, is the optimal means of achieving this.

How different are we on bed days?

A value is only shown where the opportunity is statistically significant



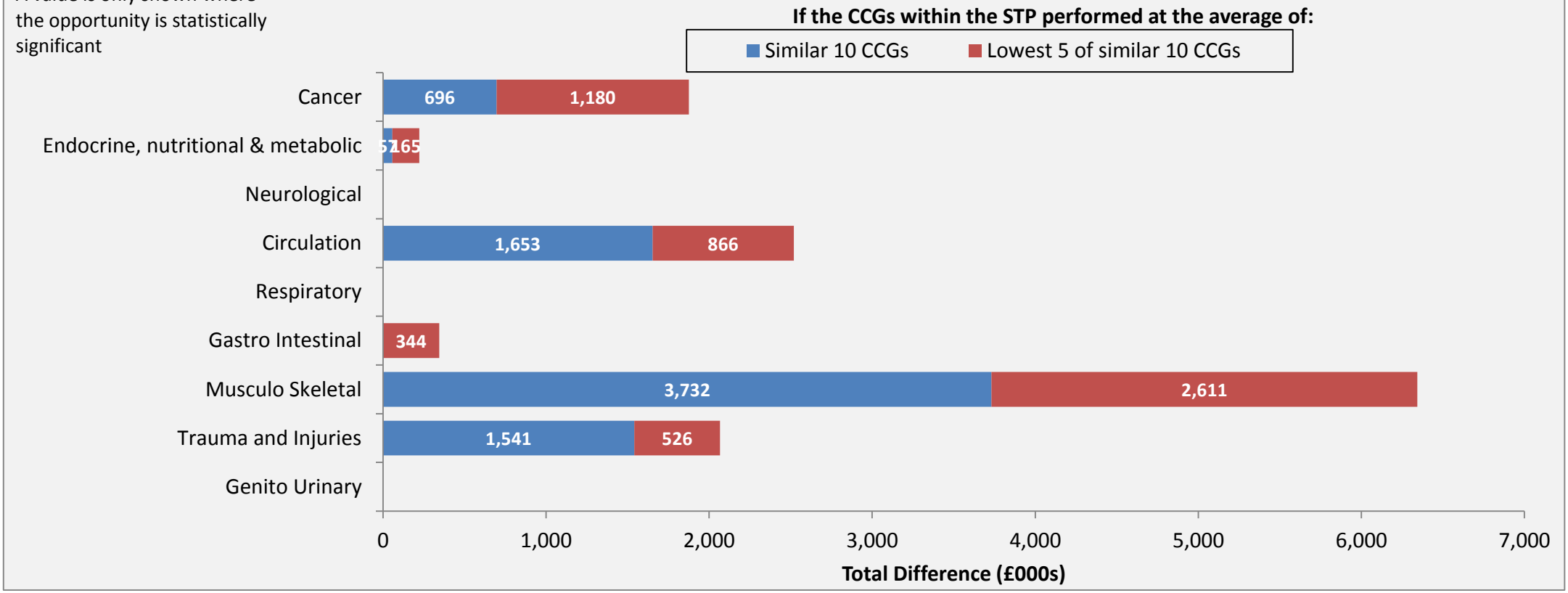
The bed days data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

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

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

How different are we on spend on elective admissions?

A value is only shown where the opportunity is statistically significant



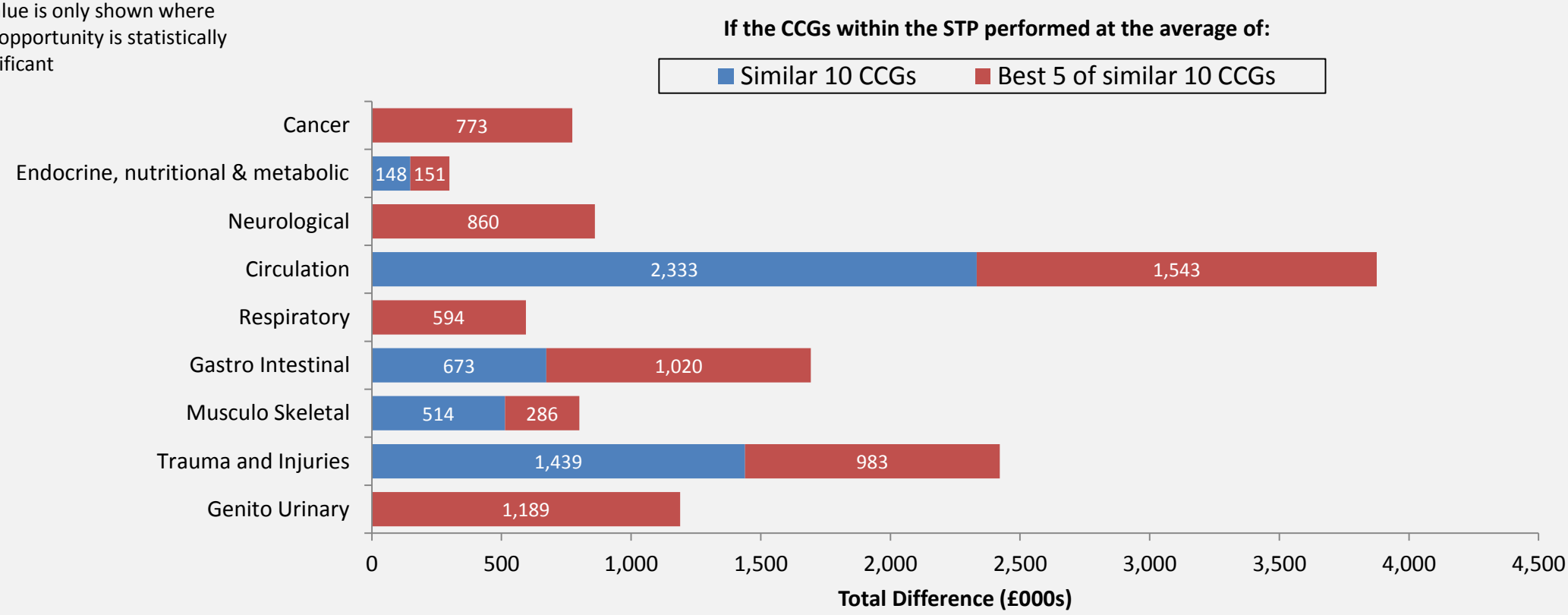
The spend data presented above uses Secondary User Services Extract Mart (SUS SEM) and is from financial year 2015/16.

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

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

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

A value is only shown where the opportunity is statistically significant



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

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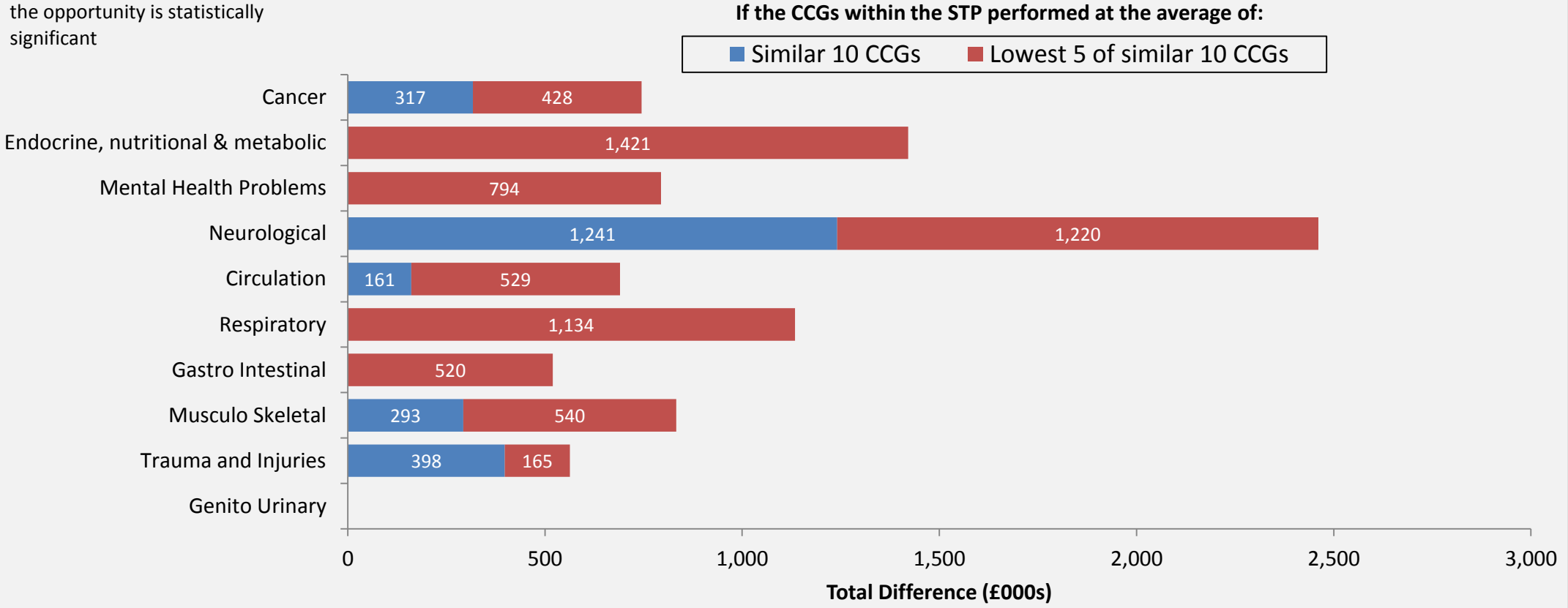
How different are we on spend on primary care prescribing?

A value is only shown where the opportunity is statistically significant



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

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

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Cancer & Tumours	• Spend on elective and day-case admissions	1,876	• Cancer and Tumours - Rate of bed days	5,044
	• Spend on non-elective admissions	773	• % first definitive treatment within 2 months (all cancer)	46
	• Spend on primary care prescribing	744	• Bowel cancer screening	2,209
			• Lower GI cancer detected at an early stage	27
			• Mortality from all cancers all ages	42

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Circulation Problems (CVD)	• Spend on elective and day-case admissions	2,520	• Circulation - Rate of bed days	15,201
	• Spend on non-elective admissions	3,876	• Mortality from all circulatory diseases under 75 years	35
	• Spend on primary care prescribing	690	• Reported to estimated prevalence of CHD	4,619
			• Reported to estimated prevalence of hypertension	10,432
			• Patients with CHD whose cholesterol < 5 mmol/l	179
			• Patients with hypertension whose BP < 150/90	714
			• Mortality from CHD under 75 years	25
			• Mortality from acute MI under 75 years	9
			• Patients with stroke/TIA whose BP < 150/90	231
			• Stroke patients spending 90% of their time on stroke unit	203
			• Emergency readmissions within 28 days for stroke patients	14
			• % patients returning home after treatment	401
			• Mortality from stroke under 75 years	12
			• Reported to estimated prevalence of AF	547
			• Patients who go direct to a stroke unit (quarter)	85
Endocrine, Nutritional and Metabolic Problems	• Spend on elective and day-case admissions	222	• Endocrine - Rate of bed days	1,512
	• Spend on non-elective admissions	299	• % diabetes patients whose HbA1c is <59 mmol/mol	1,762
	• Spend on primary care prescribing	1,421	• % diabetes patients whose blood pressure is <140/80	290
			• % of diabetes patients receiving all three treatment targets	767
			• % patients receiving foot examination	1,468
			• Retinal screening	1,882
			• % diabetes patients attending structured education	425

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Gastrointestinal	• Spend on elective and day-case admissions	344	• Alcohol specific hospital admissions	419
	• Spend on non-elective admissions	1,693	• Emergency admissions for alcoholic liver disease condition (19+)	59
	• Spend on primary care prescribing	520	• Rate of emergency gastroscopies	133
			• Emergency admissions for Upper GI bleeds	35
			• Emergency admissions for Peptic Ulcerations	33
			• Reported Clostridium difficile cases	25
			• % 6+ week waits for a colonoscopy (4 month snapshots)	29
			• Emergency admissions for gastroenteritis (0-4)	100
Genitourinary	• Spend on non-elective admissions	1,189	• Genitourinary - Rate of bed days	2,579
			• Patients on CKD register with a BP of 140/85 or less	482
			• Patients on CKD register treated with an ACE-1 or ARB	146

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Maternity & Reproductive Health			• Flu vaccine take-up by pregnant women	429
			• Smoking at time of delivery	180
			• Infant mortality rate	9
			• Emergency LRTI admissions rate for <1s	64
			• % receiving 3 doses of 5-in-1 vaccine by age 2	267
			• A&E attendance rate for <5s	1,182
			• Emergency admissions rate for <5s	938
			• Unintentional & deliberate injury admissions for <5s	61
			• % of children aged 4-5 who are overweight or obese	180
			• % receiving 1 dose of MMR vaccine by age 2	296
Mental Health Problems (all)	• Spend on primary care prescribing	794	• Mortality from suicide and injury undetermined all ages	11
			• People with mental illness and or disability in settled accomodation	377

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Mental Health Problems (common)			• New cases of depression which have been reviewed	183
			• Assessment of severity of depression at outset	766
			• IAPT referrals with a wait <28days (quarter)	275
			• IAPT: % referrals with outcome measured (6 months)	145
			• IAPT: % 'moving to recovery' rate (quarter)	234
			• IAPT: % achieving 'reliable improvement' (quarter)	109
			• Emergency hospital admissions for self harm	300
Mental Health Problems (severe)			• Physical health checks for patients with SMI	126
			• % Service users on CPA (end of quarter snapshot)	2,955
			• People subject to mental health act (quarter)	47
			• People on CPA in employment (end of quarter snapshot)	150
			• % adults on CPA in settled accommodation (end of quarter snapshot)	452
			• % of EIP referrals waiting >2 wks to start treatment (Incomplete) (5m)	16
			• % of EIP referrals waiting <2 wks to start treatment (Complete) (5m)	13

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Mental Health Problems (dementia)			• % short stay emergency admissions aged 65+ with dementia	186
			• % new dementa diagnosis with blood test	42
			• Dementia diagnosis rate (65+)	690
			• % of dementia patients with care reviewed	112
Musculoskeletal System Problems (Excludes Trauma)	• Spend on elective and day-case admissions	6,343	• MSK - Rate of bed days	7,254
	• Spend on non-elective admissions	800	• % osteoporosis patients 50-74 treated with Bone Sparing Agent	14
	• Spend on primary care prescribing	833	• % patients 75+ years with fragility fracture treated with BSA	24
	• Spend on admissions relating to fractures where a fall occurred	351	• Hip replacement, EQ-5D Index, average health gain	256
			• Knee replacement, EQ-5D Index, average health gain	95
			• Hip fractures in people aged 65+	44
			• Hip fractures in people aged 80+	49
			• % fractured femur patients returning home within 28 days	192
Neurological System Problems	• Spend on non-elective admissions	860	• Neurological - Rate of bed days	4,510
	• Spend on primary care prescribing	2,461	• Mortality from epilepsy under 75 years	3
			• Patients with epilepsy on drug treatment and convulsion free, 18+	405

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

Improvement opportunities

This table presents opportunities for quality improvement and spend differences for a range of programme areas. These are based on comparing the CCGs within Cornwall and the Isles of Scilly STP to the best / lowest 5 CCGs. A quantified unit is only shown when the opportunity is statistically significant.

Disease Area	Spend	£000	Quality	No. of patients, life-years, referrals, etc.
Respiratory System Problems	• Spend on non-elective admissions	594	• Respiratory - Rate of bed days	1,315
	• Spend on primary care prescribing	1,134	• Mortality from bronchitis, emphysema and COPD under 75 years	11
			• Reported to estimated prevalence of COPD	2,666
			• % of COPD patients with a record of FEV1	124
			• % of COPD patients with review (12 months)	87
			• % asthma patients with review (12 months)	913
			• Emergency admission rate for children with asthma, 0-19yrs	37
Trauma & Injuries	• Spend on elective and day-case admissions	2,067	• Trauma and injuries - Rate of bed days	18,252
	• Spend on non-elective admissions	2,422	• Mortality from accidents all ages	29
	• Spend on primary care prescribing	563	• Injuries due to falls in people aged 65+	100
	• Spend on admissions relating to fractures where a fall occurred	351	• Unintentional and deliberate injury admissions, 0-24yrs	430
			• All fracture admissions in people aged 65+	683
			• Hip fractures in people aged 65+	44
			• Hip fractures in people aged 80+	49
			• % fractured femur patients returning home within 28 days	192

How to read your STP pathways

The following slides provide a more detailed look at 19 'Pathways on a page' for each CCG within the STP.

The intention of these pathways is not to provide a definitive view, but to help commissioners explore potential opportunities. These slides help to understand how performance in one part of the pathway may affect outcomes further along the pathway.

Each row in the matrix represents a CCG in your STP area and how it compares to its similar 10 CCGs across that pathway. The similar 10 CCGs are not necessarily in the same STP. These Pathways on a Page allow an STP to examine which programmes have common opportunities for several CCGs across the entire pathway, or for part of a pathway (such as primary care or detection) for several CCGs. Therefore, STPs may find it useful to scan the charts both horizontally and vertically.

The key to the right shows how to interpret the coloured squares and arrows.

The STP opportunities underneath each indicator name sum the CCG opportunities benchmarked against the average of the best 5 CCGs, unlike the coloured squares which benchmark against the average of the similar 10 CCGs.

Opportunities are calculated for all RAG-rated indicators except for the stated exceptions.

▲	CCG is statistically significantly **HIGHER**
▼	CCG is statistically significantly **LOWER**
△	CCG **HIGHER but not statistically significant**
▽	CCG **LOWER but not statistically significant**
◀▶	CCG is equal to benchmark
△	CCG **WORSE/HIGHER but not statistically significant**
▽	CCG **WORSE/LOWER but not statistically significant**
△	CCG **BETTER/HIGHER but not statistically significant**
▽	CCG **BETTER/LOWER but not statistically significant**
◀▶	CCG is equal to benchmark
	CCG is statistically significantly **WORSE**
	CCG is statistically significantly **BETTER**
	CCG has no published data for this indicator or value is suppressed due to small numbers

Breast cancer pathway

	2015	2010	2012-14	2015/16	2014/15	2015/16	2014/15	2015/16	2006-2013	2015/16	2013	2012-14	2013 (2011)
	Deprivation	Breast cancer prevalence	Incidence of breast cancer	Obesity prevalence, 16+	Breast cancer screening	Primary care prescribing spend	Urgent GP referrals (breast cancer)	% first definitive treatment within 2 months (all cancer)	Emergency presentations for breast cancer	Elective spend	Breast cancer detected at an early stage	<75 Mortality from breast cancer	1 year survival (breast)
STP opportunity (to Best 5)								**46 Pats.**					
Kernow	▲	△	▽	▲		▼	▽			▽			

Note: We do not calculate potential opportunities for emergency presentations and one-year survival rates owing to missing information in published data.

Lower gastro-intestinal cancer pathway

	2015	2010	2012-14	2015/16	2014/15	2014/15	2015/16	2006-2013	2015/16	2015/16	2013	2012-14	2013 (2011)
	Deprivation	Colorectal cancer prevalence	Incidence of colorectal cancer	Obesity prevalence, 16+	Bowel cancer screening	Urgent GP referrals (colorectal cancer)	% first definitive treatment within 2 months (all cancer)	Emergency presentations for colorectal cancer	Elective spend	Non-elective spend	Lower GI cancer detected at an early stage	<75 Mortality from colorectal cancer	1 year survival (colorectal)
STP opportunity (to Best 5)					**2,209 Ppl.**		**46 Pats.**			**£126K**	**27 Pats.**		
Kernow	▲	▼	△	▲		▲		▽	▼	△	▽		△

Note: We do not calculate potential opportunities for emergency presentations and one-year survival rates owing to missing information in published data.

Lung cancer pathway

	2015	2010	2012-14	2015/16	2015/16	2014/15	2014/15	2015/16	2006-2013	2015/16	2015/16	2013	2012-14	2013 (2011)
	Deprivation	Lung cancer prevalence	Incidence of lung cancer	Smoking prevalence, 18+	Obesity prevalence, 16+	Successful quitters, 16+	Urgent GP referrals (lung cancer)	% first definitive treatment within 2 months (all cancer)	Emergency presentations for lung cancer	Elective spend	Non-elective spend	Lung cancer detected at an early stage	<75 Mortality from lung cancer	1 year survival (lung)
STP opportunity (to Best 5)								**46 Pats.**			**£242K**			
Kernow	▲	▲	▽	▲	▲		▲		▽	▽	△	△		△

Note: We do not calculate potential opportunities for emergency presentations and one-year survival rates owing to missing information in published data.

Severe mental illness pathway

	2015	2012	2015/16	2015/16	2014/15	April 2016-August 2016	April 2016-August 2016	2015/16 Q4 (Year End)	2015/16 Q2	2015/16 Q4	2015/16 Q4	2014/15	2015/16 Q2	2015/16 Q2	2015/16 Q2
	Deprivation	Estimate of people with a psychotic disorder	People with SMI known to GPs: % on register	Primary care prescribing spend	Physical health checks	% of EIP referrals waiting <2 wks to start treatment (Complete)	% of EIP referrals waiting >2 wks to start treatment (Incomplete)	New cases of psychosis served by Early Intervention teams	People treated by Early Intervention Teams	People on Care Programme Approach	% Service users on CPA	Mental health hospital admissions	People subject to mental health act	People on CPA in employment	% adults on CPA in settled accommodation
STP opportunity (to Best 5)					**126 Pats.**	**13 Pats.**	**16 Pats.**				**2,955 Pats.**		**47 Ppl.**	**150 Ppl.**	**452 Ppl.**
Kernow	▲	▼	▼	▼	△	▽	▽	▲	△	▲	▲		△		

Note: There is variation in the quality of care coordination under CPA, meaning CCGs have not been ranked better/worse than their similar peers for these indicators. However, because it is recommended that more users should be offered CPA support, opportunity figures have been provided for % service users on CPA.

Common mental health disorders pathway

	2015	2011	2014/15	2015/16	2015/16	2015/16	2015/16 Q4	2015/16 Q4	Oct 2015 - Mar 2016	Oct 2015 - Mar 2016	2015/16 Q4	2015/16 Q4
	Deprivation	% population with LLTI or disability	Estimated prevalence of CMHD (% 16-74 pop)	Depression prevalence 18+	New cases of depression which have been reviewed	Antidepressant prescribing	IAPT referrals: Rate aged 18+	IAPT: Rate beginning treatment	IAPT: % waiting <6 weeks for first treatment	IAPT: % referrals with outcome measured	IAPT: % 'moving to recovery' rate	IAPT: % achieving 'reliable improvement'
STP opportunity (to Best 5)					**183 Pats.**					**145 Pats.**	**234 Pats.**	**109 Pats.**
Kernow	▲	▲	▲	▼		▲						△

Note: It isn't possible to robustly calculate an opportunity of number of additional people who should be referred into IAPT.

Dementia pathway

	2014	2015/16	2015/16	Sep 2015	Aug 2016	2015/16	2015/16	2014/15	2014/15	2014/15	2014	2014
	% physically inactive adults	Smoking prevalence, 18+	Hypertension prevalence, 18+	Dementia prevalence 65+	Dementia diagnosis rate (65+)	% new dementa diagnosis with blood test	% dementia patients with care reviewed	Ratio of Inpatient Service Use to Recorded Diagnoses	Rate of emergency admissions aged 65+ with dementia	% short stay emergency admissions aged 65+ with dementia	65+ mortality with dementia	% dementia deaths in usual place of residence (65+)
STP opportunity (to Best 5)					**690 Ppl.**	**42 Pats.**	**112 Pats.**			**186 Adm.**		
Kernow	▽	▲	▼	▼		▽		▼		△	▽	

Heart Disease pathway

	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2013/14	2015/16	2015/16	2015/16	2015/16	2012-14	2012-14
	CHD prevalence	Hypertension prevalence, 18+	Reported to estimated prevalence of CHD	Reported to estimated prevalence of hypertension	Smoking prevalence, 18+	Obesity prevalence, 16+	% CHD patients whose BP < 150/90	% CHD patients cholesterol < 5 mmol/l	% hypertension patients whose BP < 150/90	Primary care prescribing spend	Elective spend	Non-elective spend	<75 Mortality from CHD	<75 Mortality from acute MI
STP opportunity (to Best 5)			**4,619 Ppl.**	**10,432 Ppl.**				**179 Pats.**	**714 Pats.**			**£1180K**	**25 Lives**	**9 Lives**
Kernow	△	▽			▲	▲				▲	▲		△	▽

Stroke pathway

	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	Jan-Mar 2016	Jan-Mar 2016	2015/16	2015/16	2015/16	Jan-Mar 2016	2009/10 - 11/12	2014/15	2012-14
	Stroke or TIA Prevalence, 18+	Smoking prevalence, 18+	Obesity prevalence, 16+	Reported to estimated prevalence of AF	% stroke/TIA patients whose BP < 150/90	% stroke/TIA patients on antiplatelet or anticoagulant	High-risk AF patients on anticoagulation therapy	Primary care prescribing spend	% who go direct to a stroke unit	% who receive thrombolysis	Patients 90% of time on stroke unit	Elective spend	Non-elective spend	% treated by early supported discharge team	Emergency readmissions within 28 days	% patients returning home after treatment	<75 Mortality from stroke
STP opportunity (to Best 5)				**547 Ppl.**	**231 Pats.**				**85 Pats.**		**203 Pats.**		**£1528K**		**14 Adm.**	**401 Pats.**	**12 Lives**
Kernow	▲	▲	▲	▽	△			▲		▽		▲			△		△

Diabetes pathway

	2015/16	2015/16	2015/16	2015/16	2015/16	2014/15	2015/16	2013/14	2015/16	2015/16	2015/16
	Diabetes prevalence, 17+	Obesity prevalence, 16+	% diabetes patients cholesterol < 5 mmol/l	% diabetes patients HbA1c is <59 mmol/mol	% diabetes patients whose BP < 140/80	% of diabetes patients receiving all three treatment targets	% patients receiving foot examination	Retinal screening	% diabetes patients attending structured education	Primary care prescribing spend	Non-elective spend
STP opportunity (to Best 5)				**1,762 Pats.**	**290 Pats.**	**767 Pats.**	**1,468 Pats.**	**1,882 Pats.**	**425 Pats.**		**£313K**
Kernow	▼	▲								▼	

Renal pathway

	2015/16	2015/16	2014/15	2014/15	2014/15	2015/16	2014/15	2015/16	2015/16	2012-14	2014	2014
	Reported CKD prevalence	Reported to estimated prevalence of CKD	% CKD patients whose BP < 140/85	% on CKD register with hypertension & proteinuria treated with ACE-I or ARB	Creatinine ratio test used in last 12 months	Primary care prescribing spend	Nephrology first outpatient attendance rate	Elective spend	Non-elective spend	Acceptance rate for renal replacement therapy	% home dialysis undertaken	% of patients on RRT who have a transplant
STP opportunity (to Best 5)			**482 Pats.**	**146 Pats.**					**£548K**			
Kernow	▲	△	△			▼	▼	▼		△	△	△

COPD pathway

	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2012-14
	COPD Prevalence	Reported to estimated prevalence of COPD	Smoking prevalence, 18+	% COPD patients diagnosis confirmed by spirometry	% of COPD patients with a record of FEV1	% of COPD patients with review (12 months)	Primary care prescribing spend	Non-elective spend	<75 mortality from bronchitis, emphysema and COPD
STP opportunity (to Best 5)		**2,666 Ppl.**			**124 Pats.**	**87 Pats.**			**11 Lives**
Kernow									

Asthma pathway

	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2012-14
	Asthma Prevalence	% patients (8yrs+) with asthma (variability or reversibility)	% asthma patients with review (12 months)	Primary care prescribing spend	Non-elective spend	Emergency admission rate for children with asthma, 0-19yrs	Mortality from asthma all yrs
STP opportunity (to Best 5)			**913 Pats.**			**37 Adm.**	
Kernow	△		△	▲		△	▽

Lower gastro-intestinal pathway

	2015/16	2015/16	2013/14-2015/16	2015/16	2015/16	2015/16	2015/16 (Snapshots for 4 months)	2015/16	2015/16	2015/16	2013/14-2015/16	2015/16	2015/16	2015/16	2012-14
	Smoking prevalence, 18+	Obesity prevalence, 16+	Reported Clostridium difficile cases	Rate of hemorrhoid surgery	% hemorrhoid surgeries which are day cases	Rate of colonoscopies	% 6+ week waits for a colonoscopy	Primary care prescribing spend	Elective spend	Non-elective spend	Rate of emergency colonoscopies	Diverticular disease - Emergency admissions	Gastroenteritis emergency admissions (0-4)	Gastroenteritis emergency admissions (5+)	<75 mortality from gastrointestinal disease
STP opportunity (to Best 5)			**25 Cases**				**29 Cases**						**100 Adm.**		
Kernow	▲	▲	△	▼		▼		▼	△						▽

Note: Colonoscopies are one of 15 key diagnostic tests which the NHS Constitution states less than 1% of patients should wait more than 6 weeks for. CCGs which achieve good performance compared to their peers may still be missing this target. CCGs are therefore advised to examine their waiting list times in greater detail, which are available at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

Upper gastro-intestinal pathway

	2015/16	2015/16	2015 (Provisional)	2015/16	2015/16	2015/16	2015/16 (Snapshots for 4 months)	2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2012-14
	Smoking prevalence, 18+	Obesity prevalence, 16+	Alcohol specific hospital admissions	Rate of bariatric surgery	Rate of gastroscopies	Rate of gastroscopies (<40)	% 6+ week waits for a gastroscopy	Primary care prescribing spend	Elective spend	Non-elective spend	Rate of emergency gastroscopies	Upper GI bleeds - Emergency admissions	Peptic ulcerations - Emergency admissions	<75 mortality from gastrointestinal disease
STP opportunity (to Best 5)			**419 Adm.**							**£589K**	**133 Pats.**	**35 Adm.**	**33 Adm.**	
Kernow	▲	▲		▲	▼	▼		▲	▼			△	△	▽

Note: Gastroscopies are one of 15 key diagnostic tests which the NHS Constitution states less than 1% of patients should wait more than 6 weeks for. CCGs which achieve good performance compared to their peers may still be missing this target. CCGs are therefore advised to examine their waiting list times in greater detail, which are available at: https://www.england.nhs.uk/statistics/statistical-work-areas/diagnostics-waiting-times-and-activity/monthly-diagnostics-waiting-times-and-activity/

Liver disease pathway

	2015/16	2015 (Provisional)	2011/12-2015/16	2011/12-2015/16	2015/16	2013/14-2015/16	2015/16	2012-14	2012-14
	Obesity prevalence, 16+	Alcohol specific hospital admissions	Rate added to liver transplant waiting list	Liver transplant rate	Non-elective spend	Admissions for hep C related end-stage liver disease/HCC	Alcoholic liver disease - Emergency admissions	Liver cancer incidence	<75 mortality from liver disease
STP opportunity (to Best 5)		**419 Adm.**			**£439K**		**59 Adm.**		
Kernow	▲		△	△		▲		△	

Note: Many cases of liver cancer are linked to cirrhosis. Cirrhosis is commonly caused by heavy and harmful drinking, hepatit is C and the build-up of fat inside the tissue of the liver. Liver cancer incidence is therefore related to a number of other indicators in the pathway, meaning CCGs have been rat ed better/worse than their similar peers. However, to be consistent with other cancer incidence indicators, a quantified opportunity figure has not been provided.

Osteoporosis and fragility fractures pathway

	2014/15	2013/14	2015	2013/14-2015/16	2013/14-2015/16	2013/14-2015/16	2015/16	2015/16	2015/16	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16
	GP registered pop >75	Rate of DEXA scan activity	Primary care prescribing spend - bisphosphonates	Hip fractures in people aged 65+	Hip fractures in people aged 65-79	Hip fractures in people aged 80+	Mean length of stay for hip fractures	Mean length of stay for hip fractures 65+	Elective spend	Non-elective spend	Spend on fracture admissions after a fall occurred	% fractured femur patients returning home within 28 days	Hip fracture emergency readmissions 28 days	% osteoporosis patients 50-74 treated with Bone Sparing Agent	% patients 75+ years with fragility fracture treated with BSA
STP opportunity (to Best 5)				**44 Adm.**		**49 Adm.**				**£112K**	**£351K**	**192 Pats.**		**14 Pats.**	**24 Pats.**
Kernow	▽	▲	▼	▽	△	△	▽	▽	△	△	▽			▽	▽

Osteoarthritis pathway

	2012/13	2012/13	2012/13	2012/13	2015/16	2015/16	2015/16	2014/15	2014/15	2015/16	2015/16	2014/15	2014/15	2009/10 - 11/12
	% people (over 45) who have hip osteoarthritis (total)	% people (over 45) who have knee osteoarthritis (total)	% people (over 45) who have hip osteoarthritis (severe)	% people (over 45) who have knee osteoarthritis (severe)	Rate of hip replacements	Rate of knee replacements	Primary care prescribing spend	Pre-treatment EQ-5D Index (hips)	Pre-treatment EQ-5D Index (knees)	Elective spend	Non-elective spend	EQ-5D Index health gain (hips)	EQ-5D Index health gain (knees)	Hip replacement emergency readmissions 28 days
STP opportunity (to Best 5)											**£145K**	**256 QALYs**	**95 QALYs**	
Kernow	△	△	△	△	▲	▽	▲	▲	▲	▲			▽	

Trauma and injury pathway

	2015/16	2012/13	2015/16	2013/14-2015/16	2013/14-2015/16	2013/14-2015/16	2015/16	2015/16	2015/16	2014/15	2014/15	2012-14
	Injuries due to falls in people aged 65+	Unintentional and deliberate injury admissions, 0-24yrs	All fracture admissions in people aged 65+	Hip fractures in people aged 65+	Hip fractures in people aged 65-79	Hip fractures in people aged 80+	Primary care prescribing spend	Elective spend	Non-elective spend	% fractured femur patients returning home within 28 days	Hip fracture emergency readmissions 28 days	Mortality from accidents all yrs
STP opportunity (to Best 5)	**100 Adm.**	**430 Adm.**	**683 Ppl.**	**44 Adm.**		**49 Adm.**			**£2422K**	**192 Pats.**		**29 Lives**
Kernow				▽	△	△	▲	▲				

Maternity and early years pathway

	2014/15	2015/16	2014/15	2010-14	2014/15	2013	2012-14	2014/15	2014/15	2014/15	2014/15	2015/16	2010/11 - 2014/15	2012/13 - 2014/15	2014/15	2012/13 - 14/15
	% of delivery episodes where mother is <18	Flu vaccine take-up by pregnant women	Smoking at time of delivery	% of low birthweight babies (<2500g)	Breastfeeding initiation (first 48 hrs)	Neonatal Mortality and Stillbirths	Infant mortality rate	Emergency gastroenteritis admissions rate for <1s	Emergency LRTI admissions rate for <1s	% receiving 3 doses of 5-in-1 vaccine by age 2	A&E attendance rate for <5s	Emergency admissions rate for <5s	Unintentional & deliberate injury admissions for <5s	% of children aged 4-5 who are overweight or obese	% receiving 1 dose of MMR vaccine by age 2	Hospital admissions for dental caries (1-4 yrs)
STP opportunity (to Best 5)		**429 Cases**	**180 Cases**				**9 Lives**		**64 Adm.**	**267 Cases**	**1,182 Pats.**	**938 Adm.**	**61 Adm.**	**180 Cases**	**296 Cases**	
Kernow	△			▽		△		▽	△				△			

Next steps and actions

STP areas can take the following steps now:

- Identify the priority programmes in your locality and compare against current improvement activity and plans
- Look at the focus packs on the NHS RightCare website for those areas which are a priority for your locality
- Engage with clinicians and other local stakeholders, including public health teams in local authorities and commissioning support organisations and explore the priority opportunities further using local data
- Refer to the pages on coordinated re-allocation of capacity and discuss the wider opportunities highlighted in this pack as part of the STP planning process and consider STP wide action
- 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 local NHS RightCare Delivery Partner. If you don't know who your Delivery Partner is, please email rightcare@nhs.net

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 local health economies in adopting the Commissioning for Value approach. These include:

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

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

Useful links

NHS RightCare website:
https://www.england.nhs.uk/rightcare

Commissioning for Value packs and products:
https://www.england.nhs.uk/rightcare/intel/cfv/

NHS RightCare casebooks:
https://www.england.nhs.uk/rightcare/resources/

Five Year Forward View:
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS shared planning guidance for 2017/18 - 2018/19:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

How have the potential opportunities been calculated?

The potential opportunity at CCG level highlights the scale of change that would be achieved if the CCG value moved to the benchmark value of the average of the ‘Best 5’ or ‘Lowest 5’ CCGs in its group of similar 10 CCGs.

Generally, where a high CCG value is considered ‘worse’ then it is calculated using the formula:

Potential Opportunity = (CCG Value – Benchmark Value) * Denominator

The denominator is the most suitable population data for that indicator eg CCG registered population, CCG weighted population, CCG patients on disease register etc. The denominator is also scaled to match the Value. So if the CCG Value and Benchmark Value are given in “per 1,000 population” then the denominator is expressed in thousands, ie 12,000 becomes 12.

For an indicator, adding the statistically significant opportunities from the CCG packs gives the opportunity for the STP presented in this pack.

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. All CCGs are now working with an NHS RightCare Delivery Partner. We have also aligned Delivery Partners to STP footprints to better support the system.

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

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.*