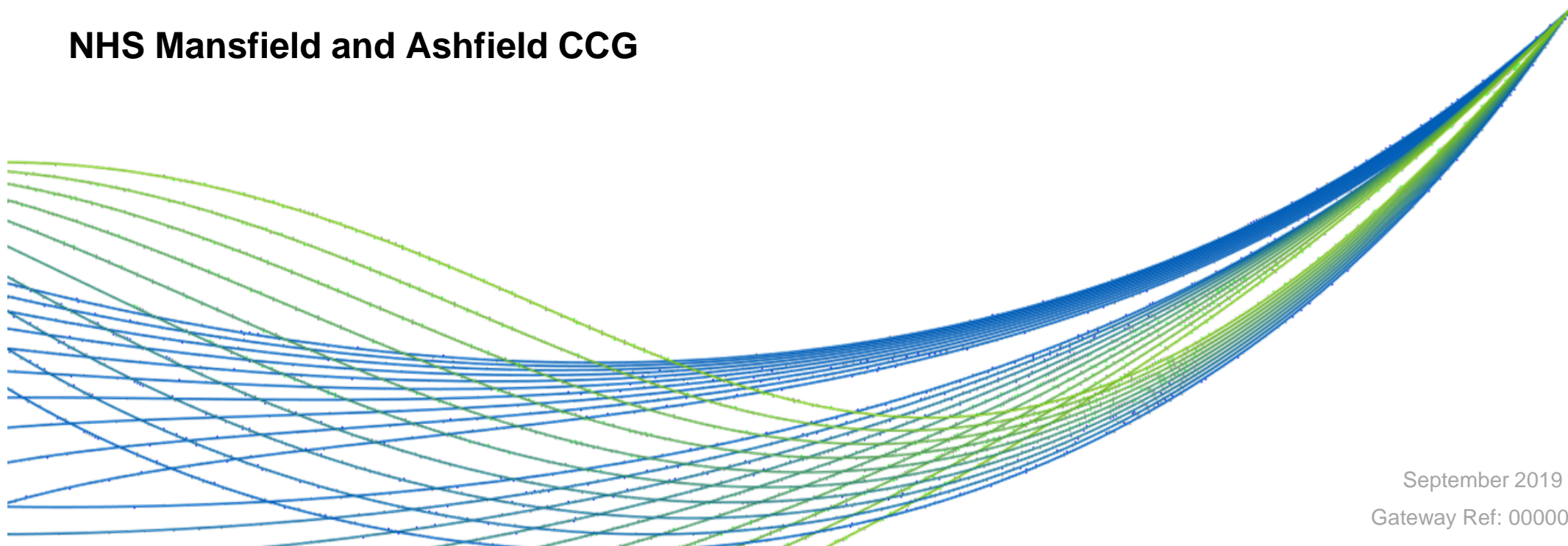


# RightCare

## Where to Look data pack

**NHS Mansfield and Ashfield CCG**



# Contents

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# The RightCare programme

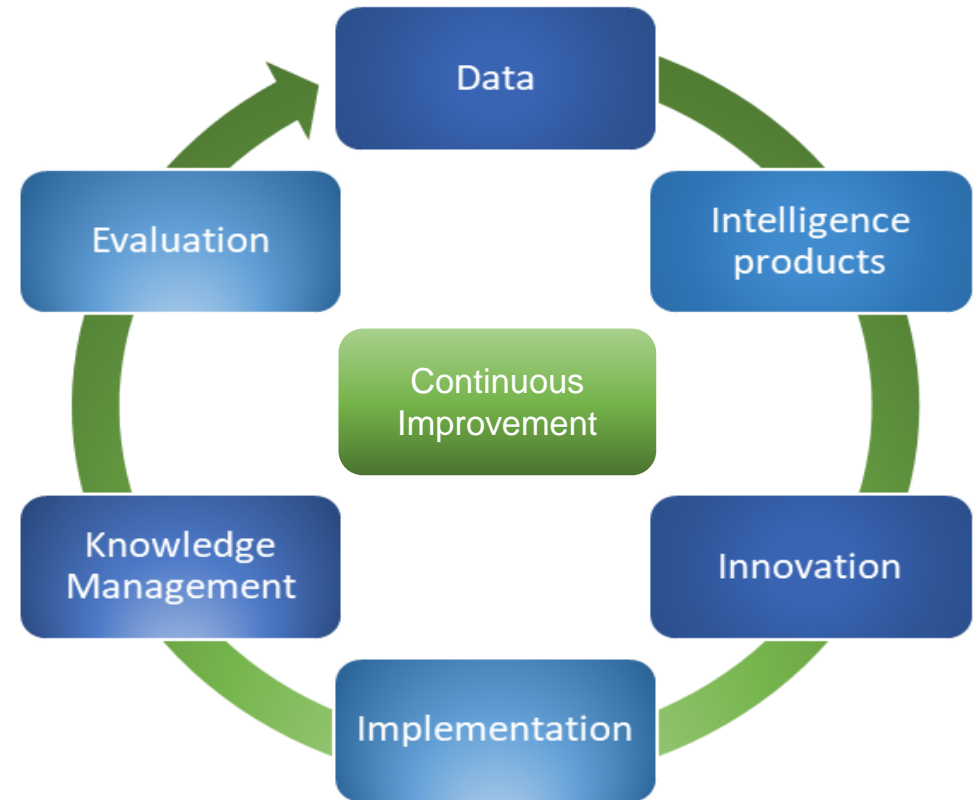
RightCare delivers on the NHS Long Term Plan commitment to reduce unwarranted variation. It highlights opportunities for system quality improvement for patients and provides resources that enable sustainable transformational change.

RightCare is a national programme of NHS England and NHS Improvement. It is structured around a regional operating model which allows for system support, based on local needs. By driving maximum impact at the point of delivery, key ambitions of the Long Term Plan are realised.

Each region has a full RightCare team consisting of Delivery Partners, analysts and project management, all available for system support. In addition to professional hands-on work with health systems, the teams can also access a wealth of RightCare data and resources to identify and act on opportunities for improvement.

The RightCare team has worked with systems on improvement programmes on many priority pathways, covering a wide range of conditions. They work locally with all systems to present a diagnosis of data and evidence across that population.

As most health conditions are linked to demographic factors such as deprivation and age, RightCare's methodology is based on systems comparisons to their closest peers and demographically similar geographies. This is to provide realistic comparisons, taking into account the need for healthcare of different populations. For example, deprived populations will have much higher rates of admissions and worse health outcomes for conditions such as Respiratory, CVD, Cancer, Diabetes, etc. By comparing 10 demographically similar systems, comparisons are fair and meaningful. For more information on the similar 10 methodology, please see page 6.



RightCare process diagram



“The RightCare Intelligence resources and the wider NHS RightCare approach place the NHS at the forefront of addressing unwarranted variation in care, improving patient outcomes and making our resources go as far as possible. RightCare has a bank of evidence regarding what works, what’s replicable to share with systems and to scale up across the country. RightCare works in partnership with health systems to make improvements in patient outcomes by identifying opportunities and priorities, leading to improvements in spend.

“These Intelligence packs shine a light on what we are doing across the country, identifying areas of greatest opportunity. The RightCare approach uses a systematic methodology for quality improvement, led by clinicians, for the benefit of all. This amazing resource allows all health professionals, managers and their partner organisations to explore the information and use it to support local discussions to agree a starting point for change. In this way we can deliver the best possible care in the most effective way for our patients.”

**Professor Nick Harding, Senior Clinical Advisor, RightCare**

## Here are seven suggestions of things you could do next with your RightCare Where to Look pack:

1. Discuss next steps with your local NHS Delivery Partner
2. Explore your pack and get to know your way around it – the tables, charts and key summaries in your pack all help put your area’s data into context.
3. See how you compare with your peers – look at the data to see how you compare with the 10 CCG areas most like yours, not just your neighbouring CCGs.
4. Get everyone talking about the same things – these packs are for the whole organisations to share across all professional groups and wider stakeholders, including providers.
5. Use the identified variation to stimulate improvement and challenge complacency – use these variations to drive conversations about what and how change is initiated, agreed and prioritised for implementation.
6. Use the pack as a catalyst to design optimal care – involve all stakeholders to talk about the ‘fix and future’ and work out what good looks like.
7. Identify who needs to be involved – identify who needs to be informed, engaged or consulted for the best chance of successful change.

# Understanding the data

The data in this pack shows how systems differ from their peers. They do not include negative opportunities or those which are not statistically significant.

This pack contains programme level indicators to show system level performance across the nine main programme areas that are presented by RightCare. There are charts to show how systems are performing in quality and outcome indicators across these programmes, compared to the best or lowest five of their similar 10 CCGs. The pathways look across detection, primary care, condition management and outcomes to create a full picture of CCG performance in this treatment area.

The data is pulled together from a number of reliable data sets, including:

- Secondary User Services (SUS) data, National Clinical Data Repository
- NHS Business Services Authority, ePACT2 dashboard
- Quality and Outcomes Framework
- NHS Digital, Fingertips
- PROMs
- Audit
- National charity organisations

## New content

Several updates have been made to this pack since the previous publication to allow further detailed interpretation of the data presented:

- Outpatient and long stay patients: This pack contains long stay and outpatient attendances data which has not been presented previously. This allows an increased focus on primary care intervention.
- Quality and outcome charts: The opportunity table in previous Where to Look packs has now been replaced by programme specific outcomes charts, showing a more detailed overview of opportunities across the CCG.
- New pathways: Includes pathways for heart failure, influenza and groin hernia.

# Similar 10 methodology

As most health conditions are linked to demographic factors such as deprivation and age, RightCare compares systems to their closest demographically similar peers. This is to provide realistic comparisons, taking into account the need for healthcare of different populations. Deprived populations will have much higher rates of admissions and worse health outcomes for conditions such as respiratory, cardiovascular disease, cancer and diabetes. By comparing 10 demographically similar CCGs, ensures that comparisons are fair and meaningful.

For some CCGs the similar 10 has changed slightly for 2018/19 using new data, new sets of variables, a small methodology change and the reconfiguration of systems. Please see the table below for the variables and percentage weightings used in the similar 10.

Variable (year of data)	Percentage weighting
Index of Multiple Deprivation (2015)	25%
The total population registered with CCGs' practices (2018)	15%
Percentage of population age 18 to 39 (2018)	10%
Percentage of population age 65 to 84 (2018)	10%
Percentage of population age 85+ (2018)	10%
Percentage of population who live in Rural areas (2018)	15%
Percentage of people who said they are White (non-British) (2016-18)	3%
Percentage of people who said they are of Mixed ethnic origin (2016-18)	3%
Percentage of people who said they are of Asian ethnic origin (2016-18)	3%
Percentage of people who said they are of Black ethnic origin (2016-18)	3%
Percentage of people who said they are of Arab or Other ethnic origin (2016-18)	3%

## Your 10 similar CCGs are:

- NHS St Helens CCG
- NHS North East Lincolnshire CCG
- NHS Rotherham CCG
- NHS South Sefton CCG
- NHS Tameside and Glossop CCG
- NHS Sunderland CCG
- NHS South Tyneside CCG
- NHS Barnsley CCG
- NHS Southend CCG
- NHS Halton CCG

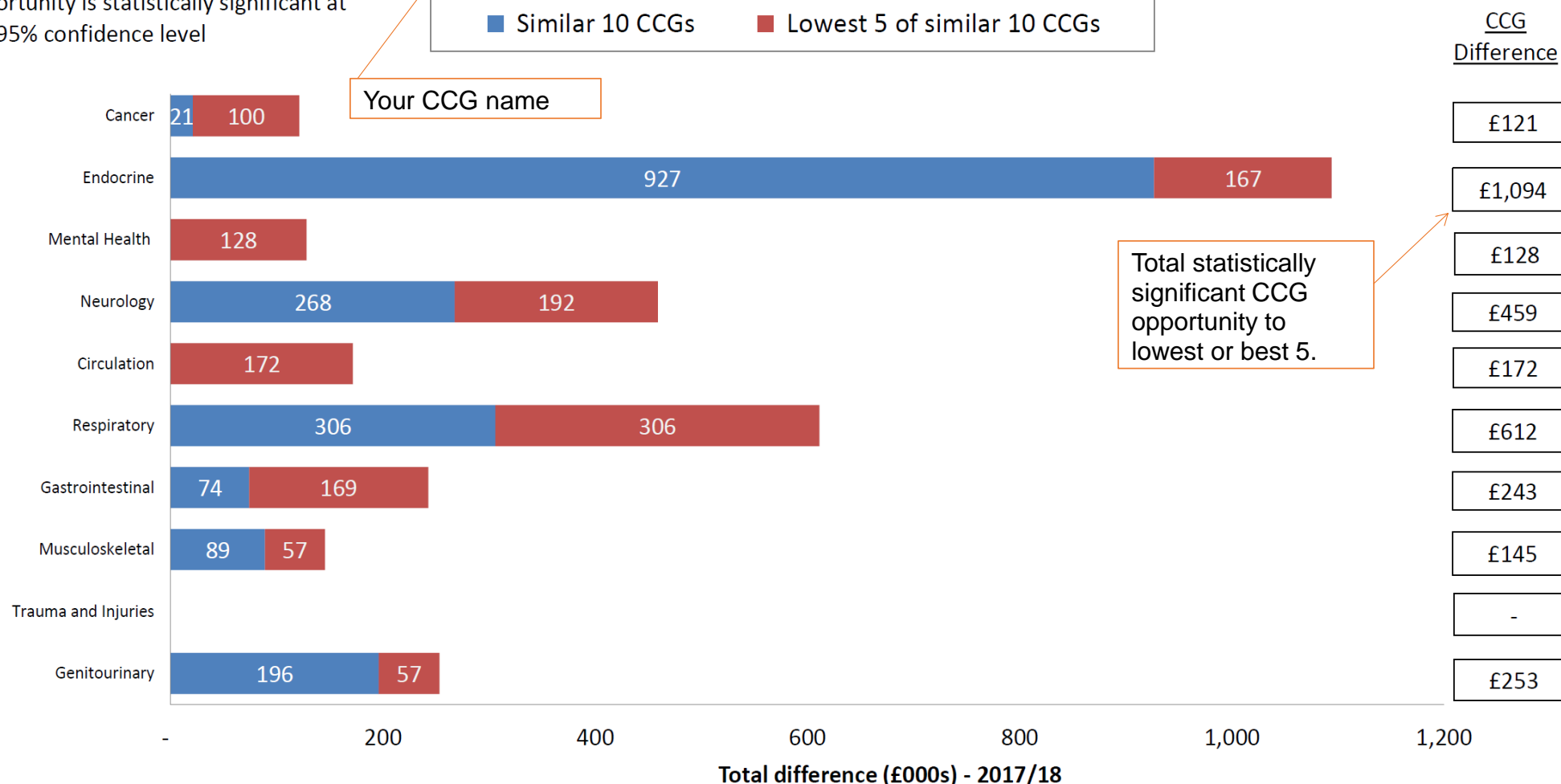
# Interpreting CCG opportunity charts

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

If Crawley CCG performed at the average of its:

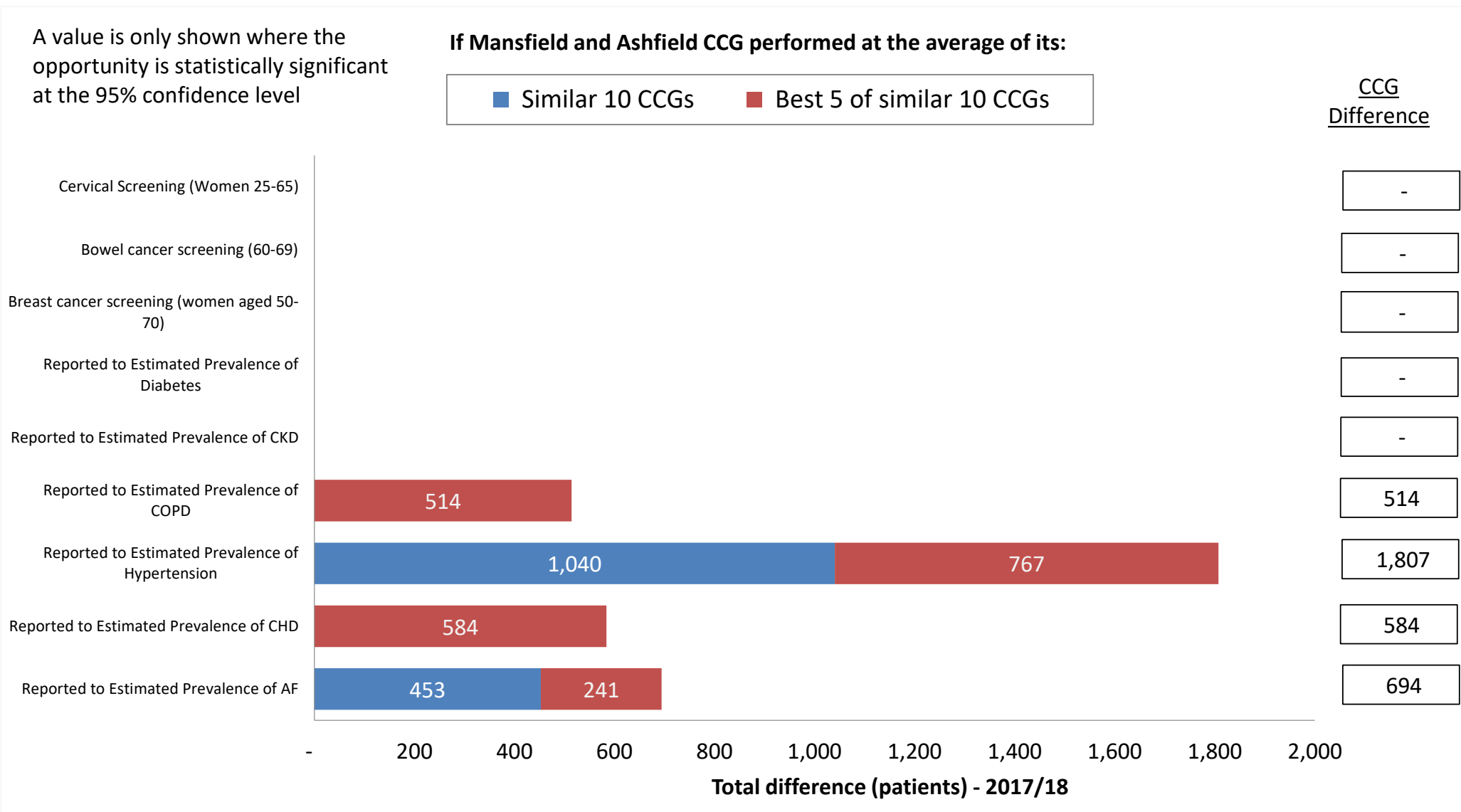
■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs

Your CCG name



The CCG opportunity chart above shows the total statistically significant opportunity for a range of indicators comparing the CCG to the average of its similar 10 CCGs and the average of its lowest or best 5 CCGs for that indicator. The blue portion of the bar shows the opportunity for the CCG compared to its similar 10 CCGs in that programme. The red portion of the bar shows the additional opportunity for the CCG if the CCG performed at the rate of the lowest or best 5 of its similar 10 CCGs. The white box at the end of the row then shows a summed total opportunity.

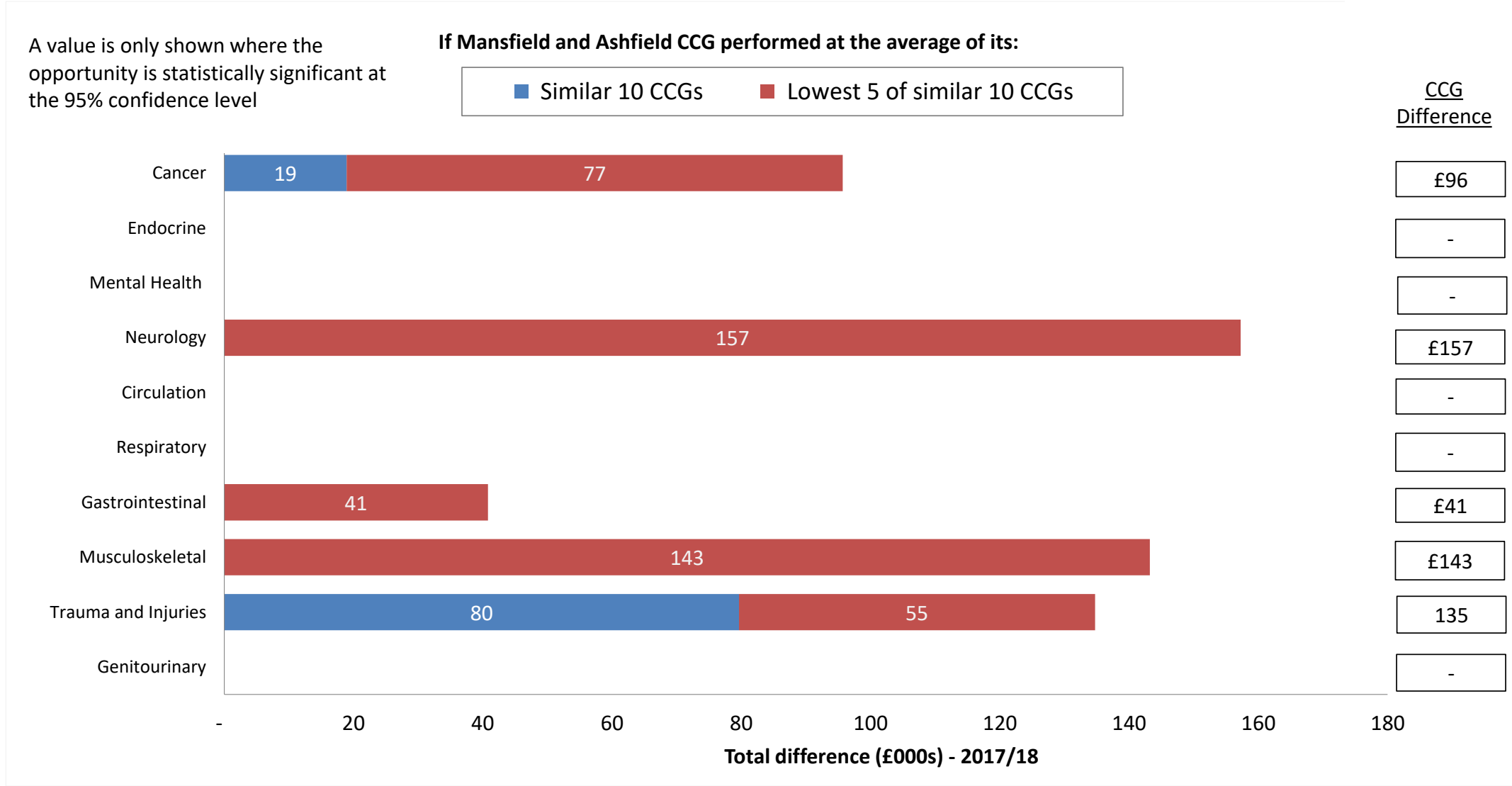
# How different are we on detection?



See page 54 for additional guidance on indicators.

**Source(s):** Modelled prevalence estimates (PHE) compared to QOF recorded prevalence (NHS Digital)  
NHS Cancer Screening Programme, Public Health England (PHE), Fingertips Cancer Services

# How different are we on spend on primary care prescribing?



For the prescribing data above, each individual BNF chemical is mapped to a Programme Budget Category and aggregated to form a programme total. The indicators have been standardised using the unrounded ASTRO-PU weightings. Please note that Endocrine prescribing captures not just diabetes but all endocrine, metabolic and nutrition prescribing. A more detailed breakdown of these opportunities is available from regional analysts.

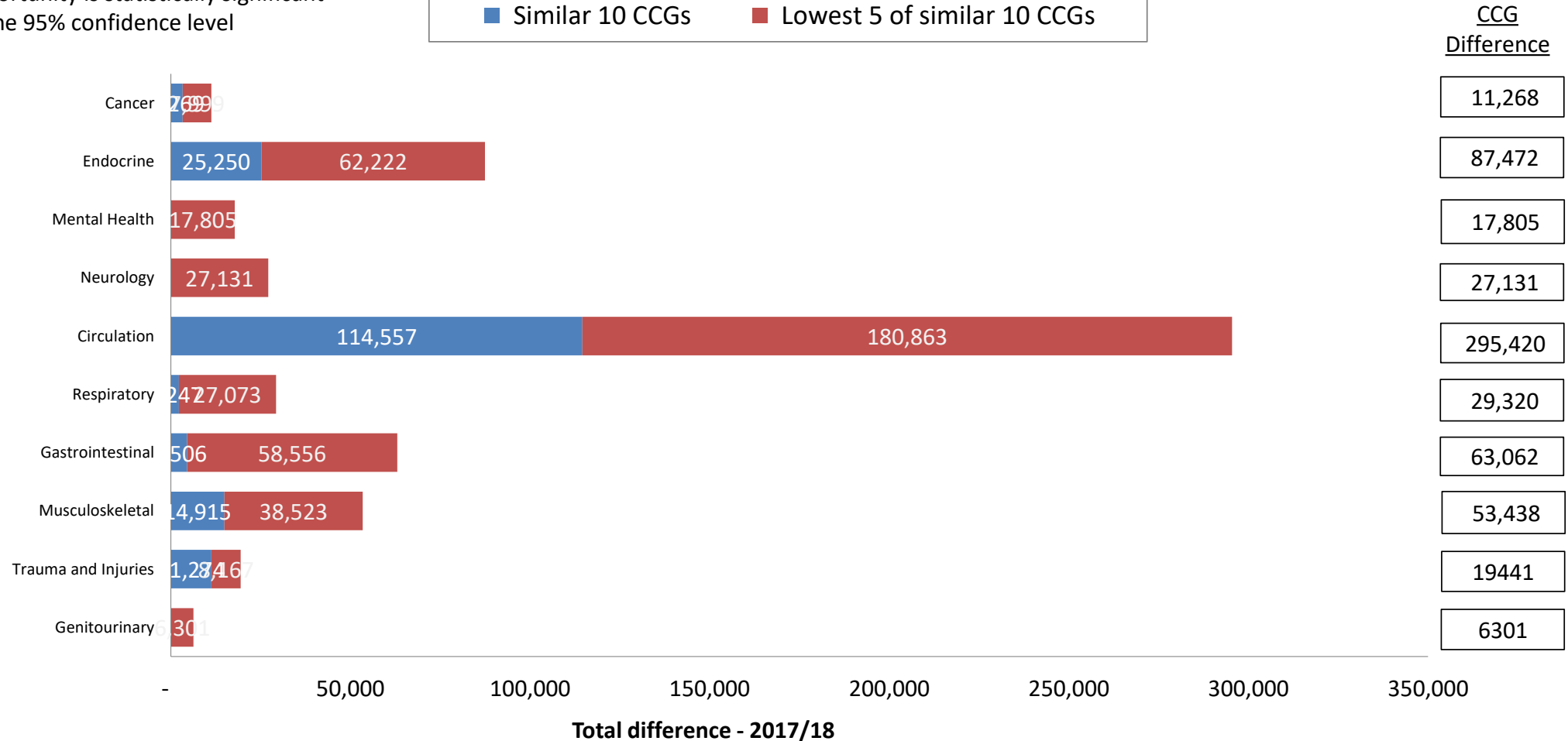
# How different are we on primary care prescribing items?

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Lowest 5 of similar 10 CCGs



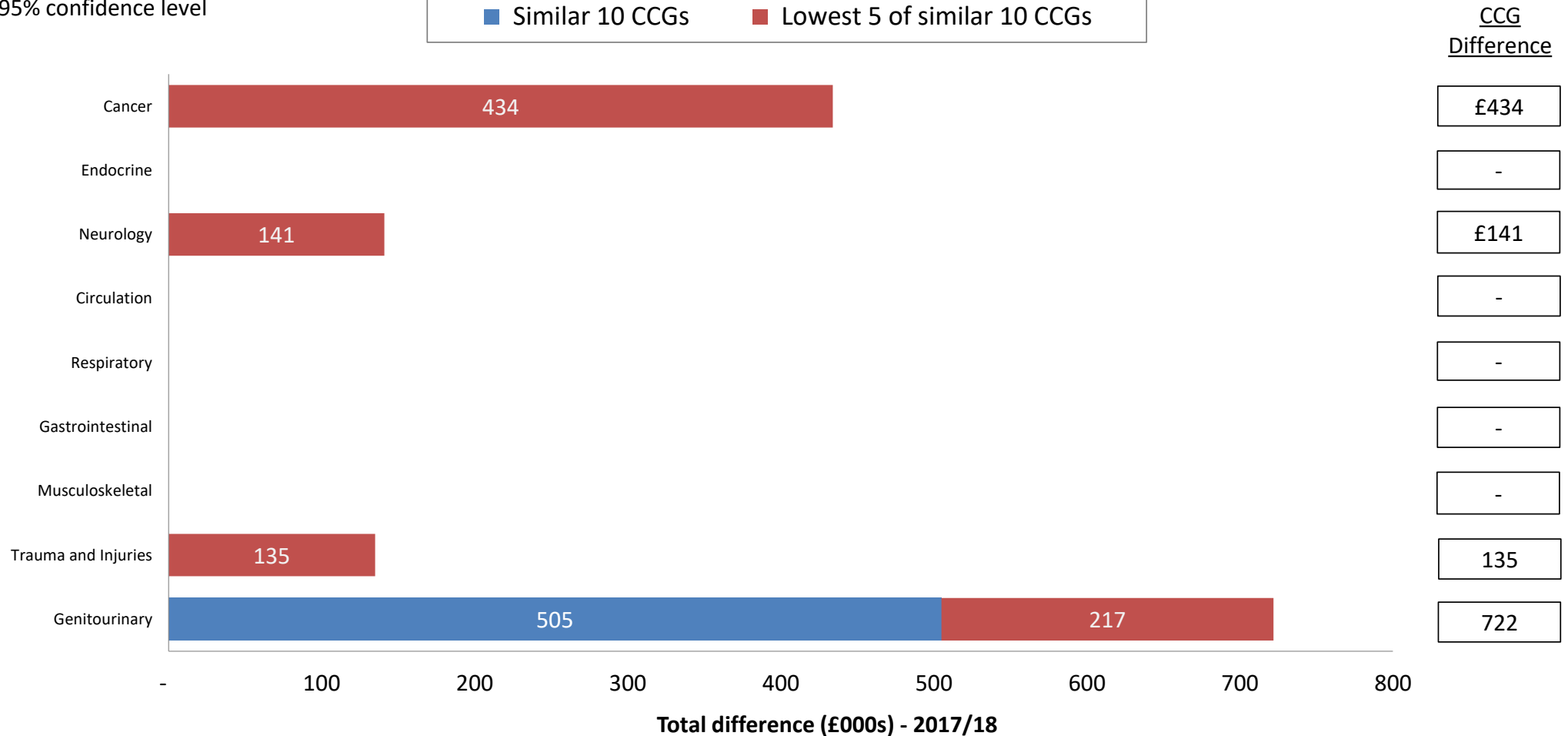
For the prescribing data above, each individual BNF chemical is mapped to a Programme Budget Category and aggregated to form a programme total. The indicators have been standardised using the unrounded ASTRO-PU weightings. Please note that Endocrine prescribing captures not just diabetes but all endocrine, metabolic and nutrition prescribing. A more detailed breakdown of these opportunities is available from regional analysts.

# How different are we on spend on elective admissions?

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs



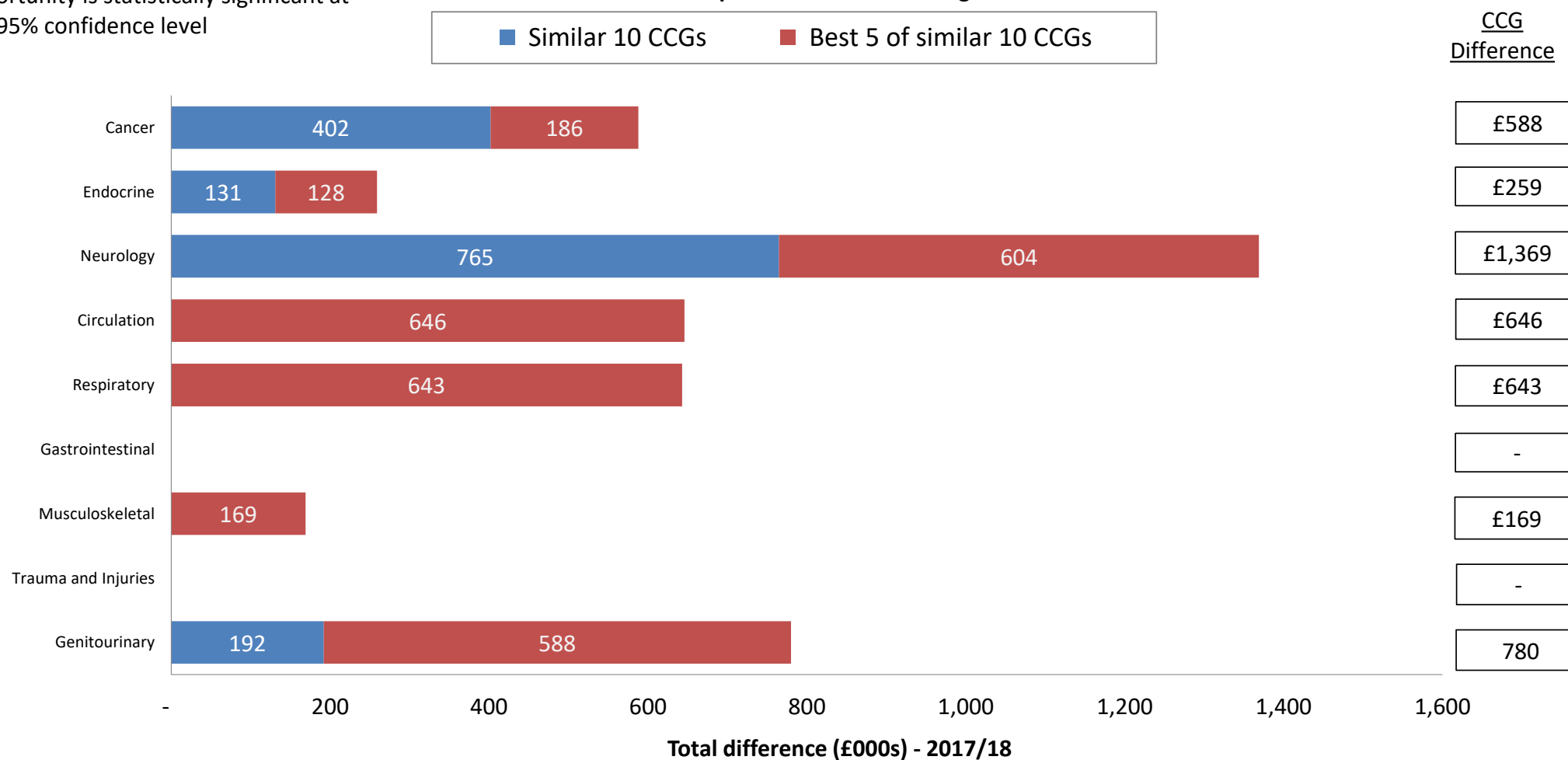
The calculations in this slide are based on admissions for any primary care diagnoses that fall under the listed conditions (based on Programme Budgeting classification). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

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

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



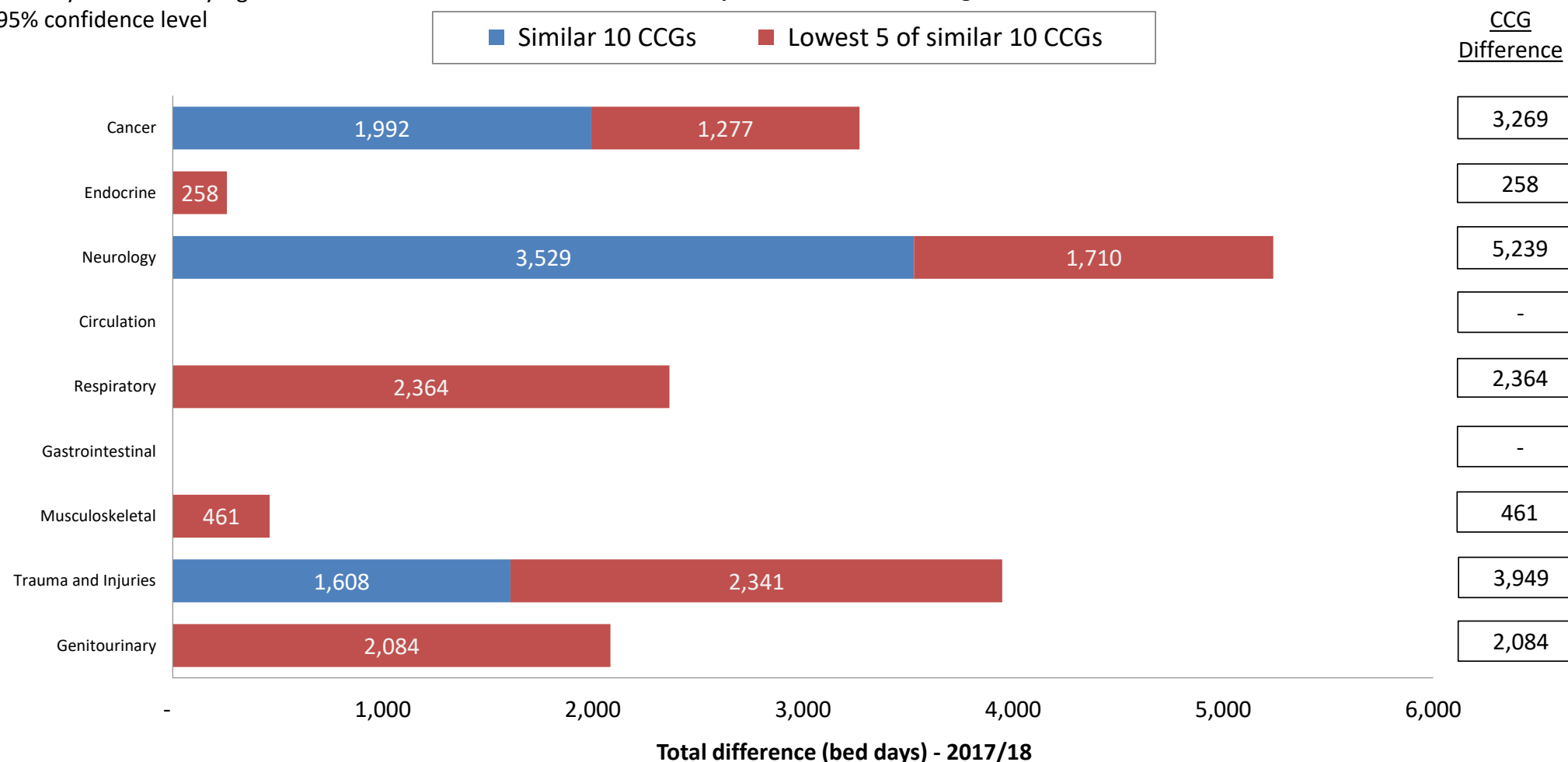
The calculations in this slide are based on admission for any primary care diagnoses that fall under the listed conditions (based on Programme Budgeting classifications). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning expenditure.

# How different are we on bed days?

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

**If Mansfield and Ashfield CCG performed at the average of its:**

■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs



The calculations in this slide are based on admission for any primary care diagnoses that fall under the listed conditions (based on Programme Budgeting classifications which are in based on the World Health Organisation's International Classification of Diseases). These figures are a combination of elective and non-elective admissions.

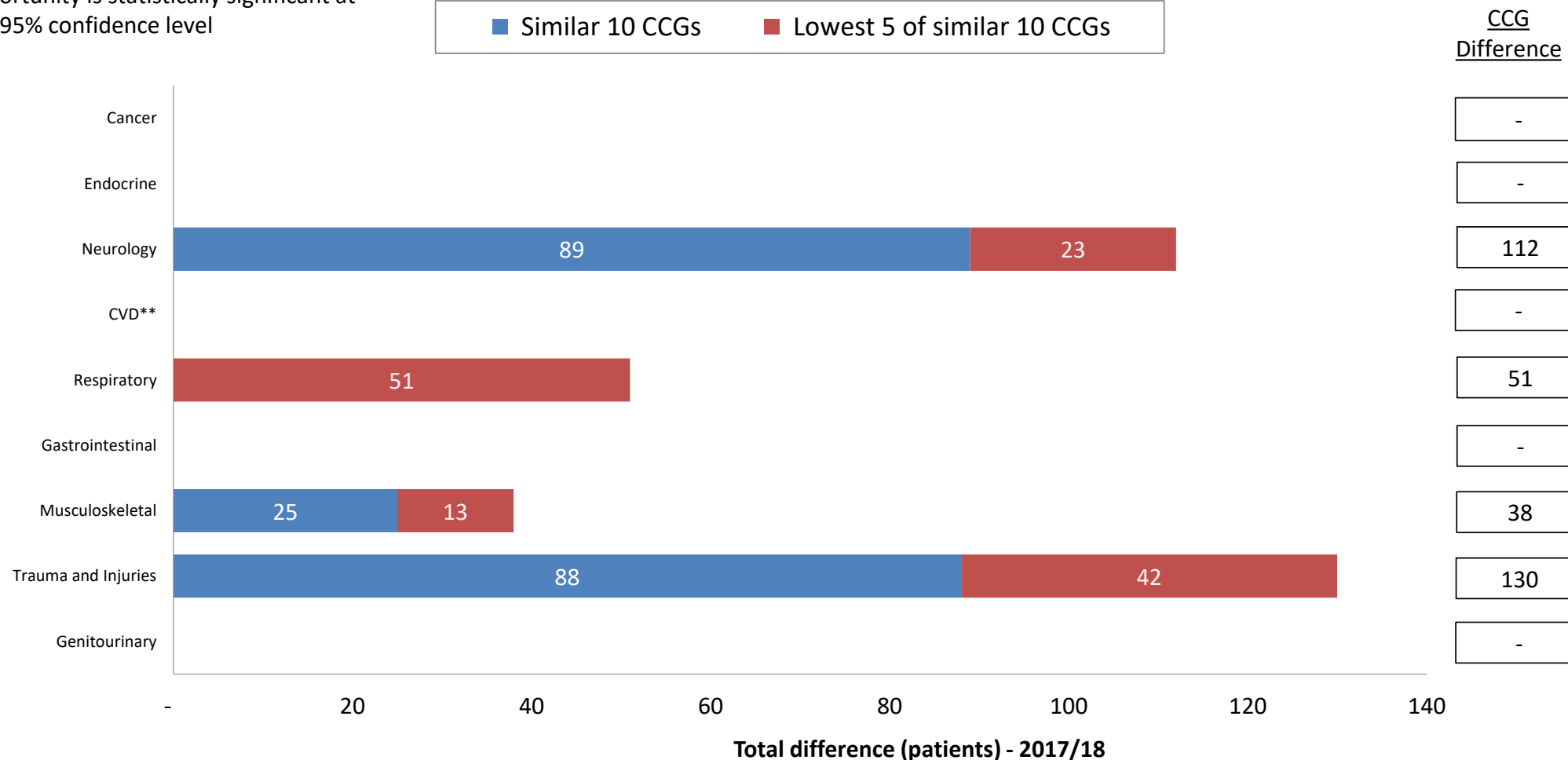
# How different are we on long stay patients\*?

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Lowest 5 of similar 10 CCGs



\*Long stay patients are defined as having a hospital admission 21 days or longer.

\*\*Please note the highlighted indicator is looking at CVD long stay patients, rather than just circulation. This captures patients across circulation, diabetes and renal.

# SUS+ outpatient treatment function codes (TFC) CCG activity

The following slides show SUS+ CCG outpatient activity for the outpatient treatment function codes (TFC) of most relevance to this Programme Budgeting Category. Only those TFCs classed as 'specific acute' have been included, and only where there is sufficient activity nationally.

Indirectly age-sex standardised rates of **attended** outpatient appointments for that TFC are shown – this includes both attended new (first) and follow-up appointments. Potential opportunities are provided by comparing each CCG's rate to the average activity rates of its lowest 5 similar CCGs; as for primary care prescribing and elective inpatient admissions, local interpretation is required to determine whether higher or lower rates of outpatient appointments for the TFC are appropriate.

There is likely to be significant variation nationally in how attended appointments are allocated to TFCs, particularly to the general surgery and general medicine TFCs. These TFCs are included in the NHS RightCare Where to Look pack as they do not align with a specific programme.

# How different are we on outpatient attendances?

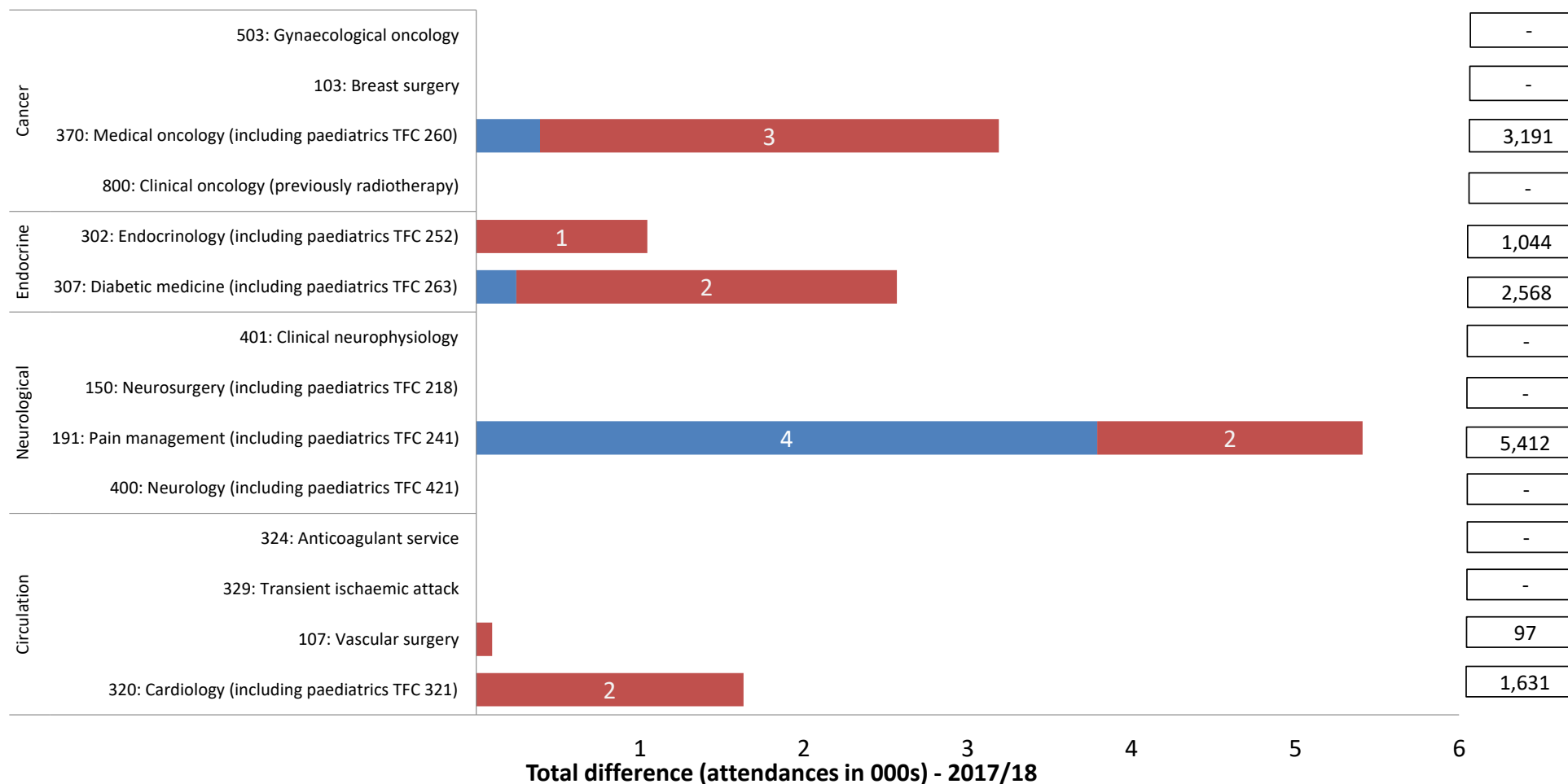
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If NHS Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Lowest 5 of Similar 10 CCGs

CCG  
Difference



Please note that indicators are shown in thousands on the chart, with full opportunities in the total CCG difference cell.

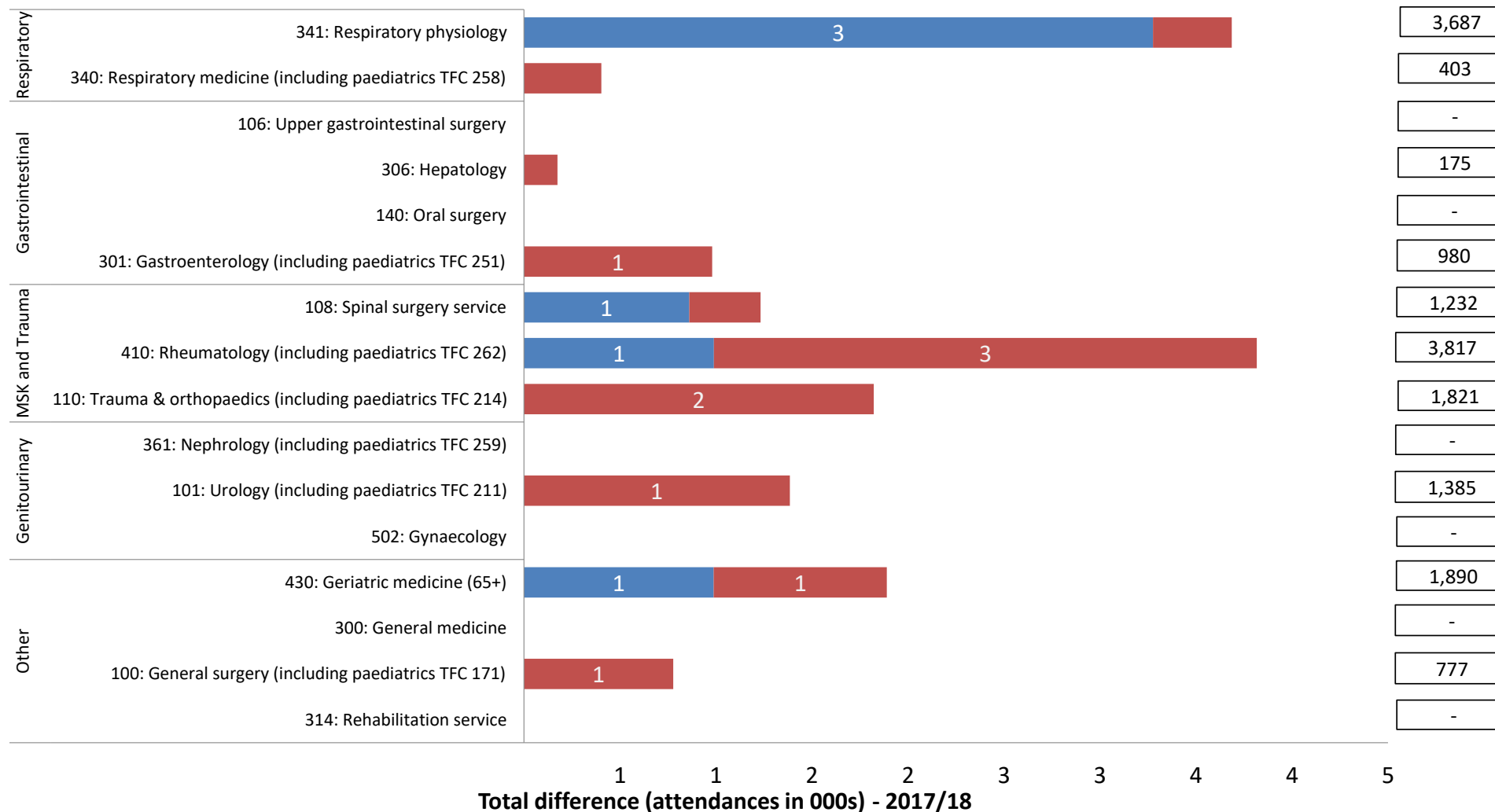
# How different are we on outpatient attendances?

If NHS Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Lowest 5 of similar 10 CCGs

CCG  
Difference



Please note that indicators are shown in thousands on the chart, with full opportunities in the total CCG difference cell.

**Source(s):** National Commissioning Data Repository – Hospital Admissions Databases,  
SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 23/08/18

The following slides look at outcome indicators across programmes. These show how a CCG is performing across outcomes, built on comparing each CCG to its best 5 similar CCGs.

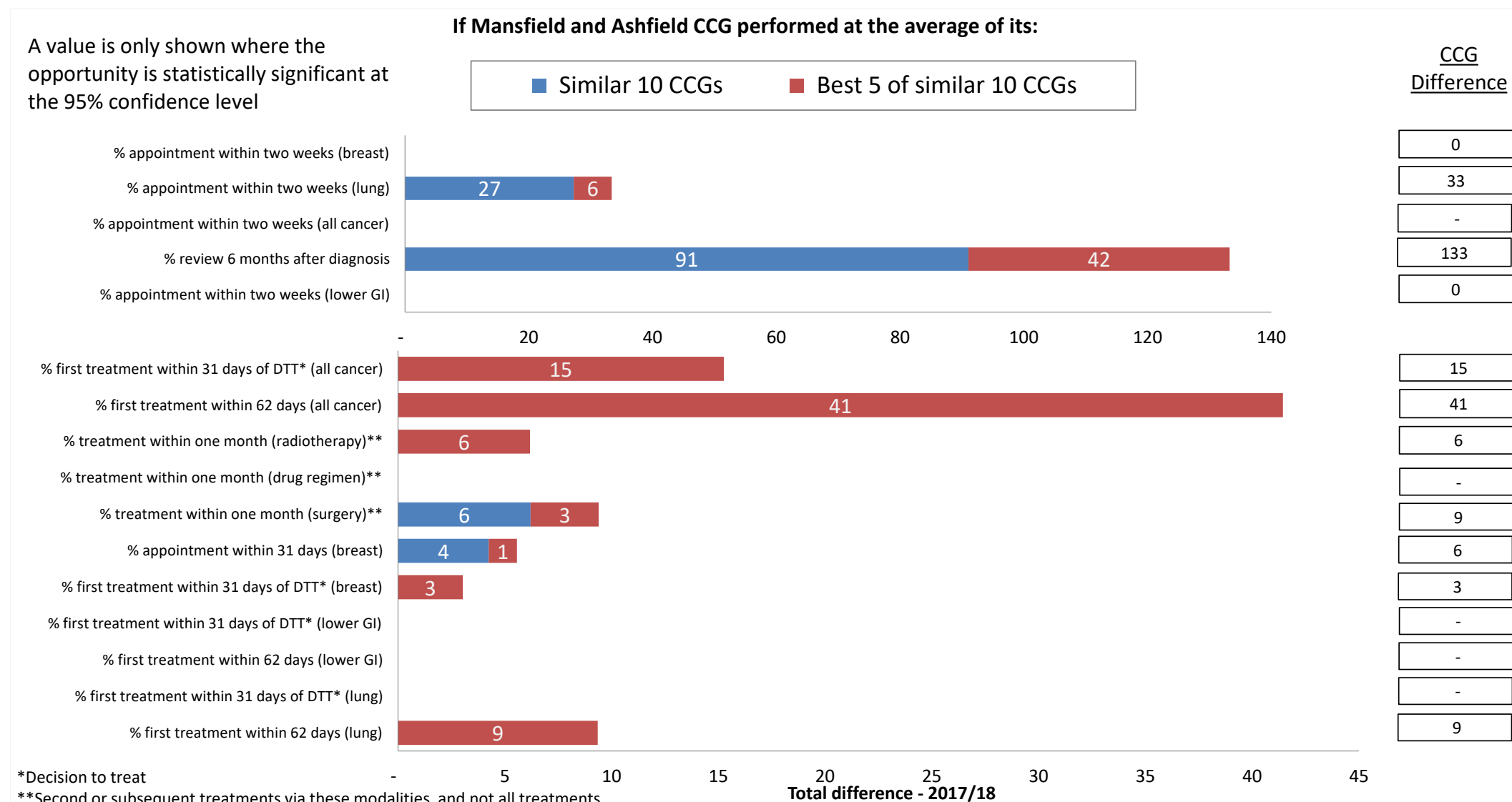
Previously these quality and outcome opportunities were presented in the form of a CCG opportunity table, but the following charts allow a more detailed breakdown of this data.

All data shown is from 2017/18, unless caveated otherwise where this data was not available. These indicators show opportunities in a range of units; for any given indicator the units will match those of the numerator, for example patients, referrals or admissions.

## Mortality data

The mortality indicators included in this latest data pack were restricted due to the limited availability of accurate, up to date, CCG level mortality data. NHS RightCare and NHS England are currently in communication with other NHS agencies and the Office for National Statistics (ONS) to source the latest mortality data to populate our remaining mortality indicators. We intend to add these to the accompanying dataset when this data becomes available.

# How different are we on cancer quality and outcome indicators?



Please note that due to the size of the opportunities some indicators are presented on their own axes to avoid scaling down the opportunities presented in the other indicators.

See page 54 for additional guidance on indicators.

**Source(s):** NHS England Cancer Waiting Times Database,  
PHE Fingertips Cancer Services,  
Quality and Outcomes Framework (QOF), NHS Digital

# How different are we on mental health quality and outcome indicators?

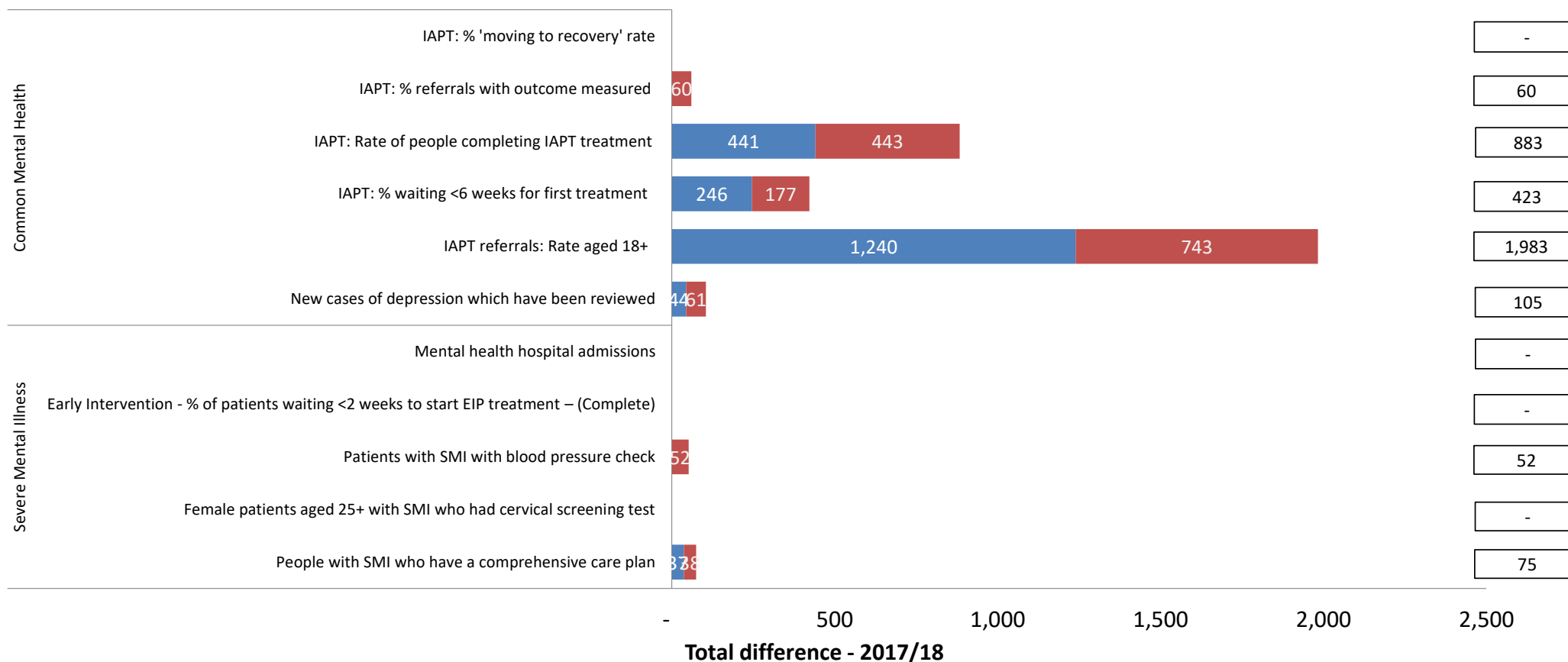
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If Mansfield and Ashfield CCG performed at the average of its:

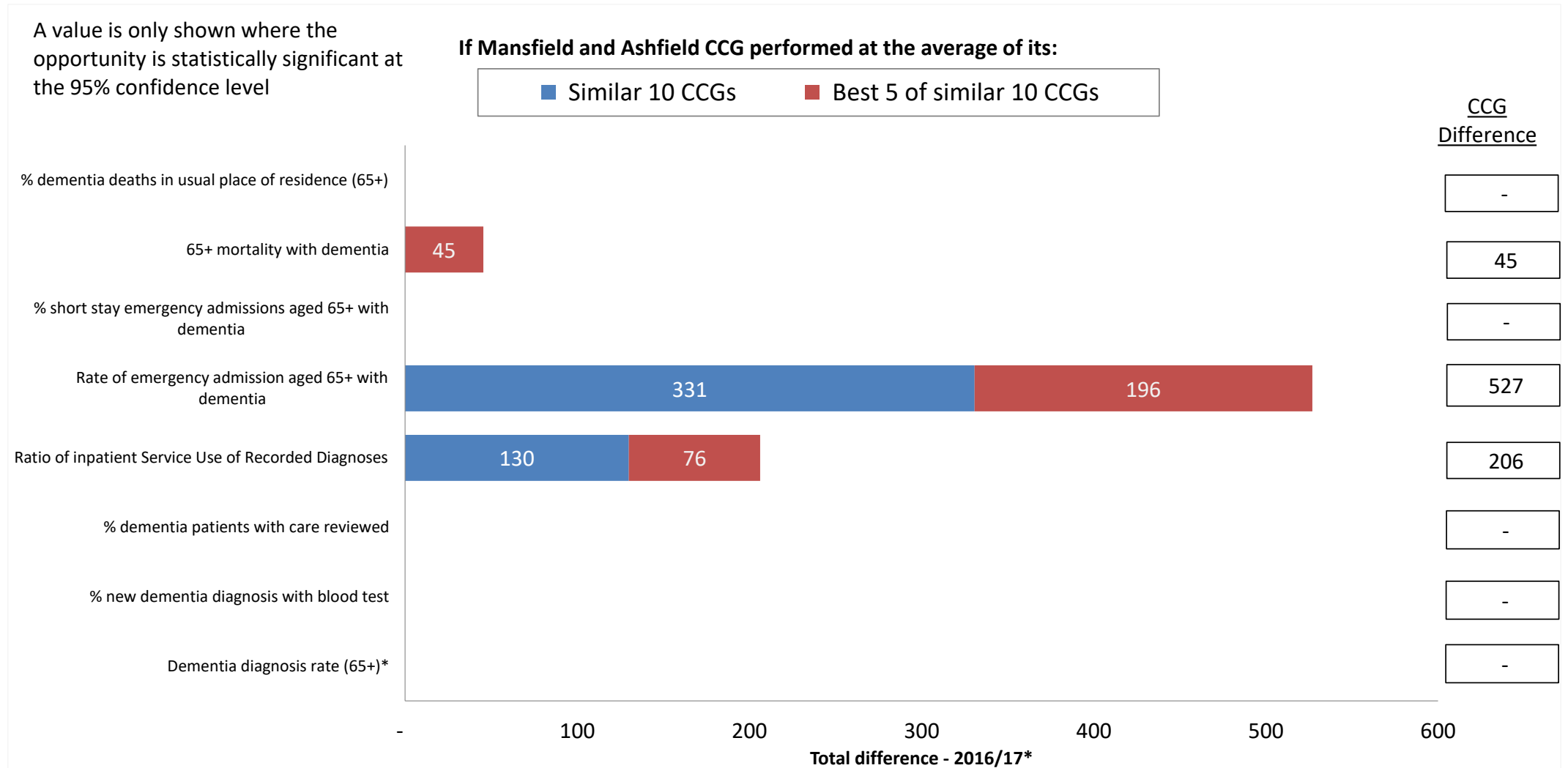
■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

CCG  
Difference



# How different are we on dementia quality and outcome indicators?



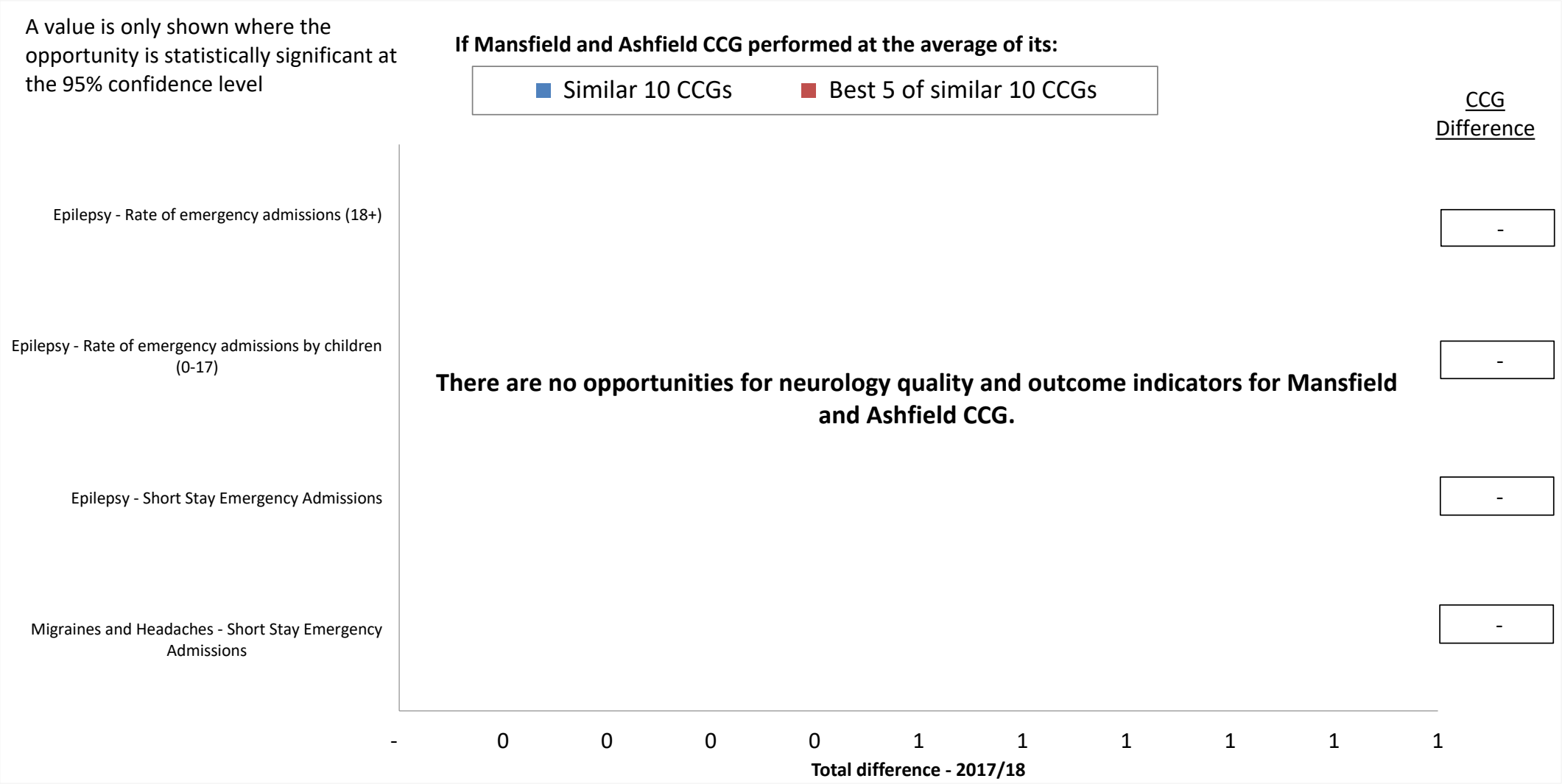
Please note that scale of opportunities will vary due to CCG size.

\*All data from 2016/17 except 'Dementia diagnosis rate 65+' (Nov 2018), '% new dementia diagnosis with blood test' (2017/18) and '% dementia patients with care reviewed' (2017/18).

See page 54 for additional guidance on indicators.

**Source(s):** Quality and Outcomes Framework (QOF), NHS Digital

# How different are we on neurology quality and outcome indicators?

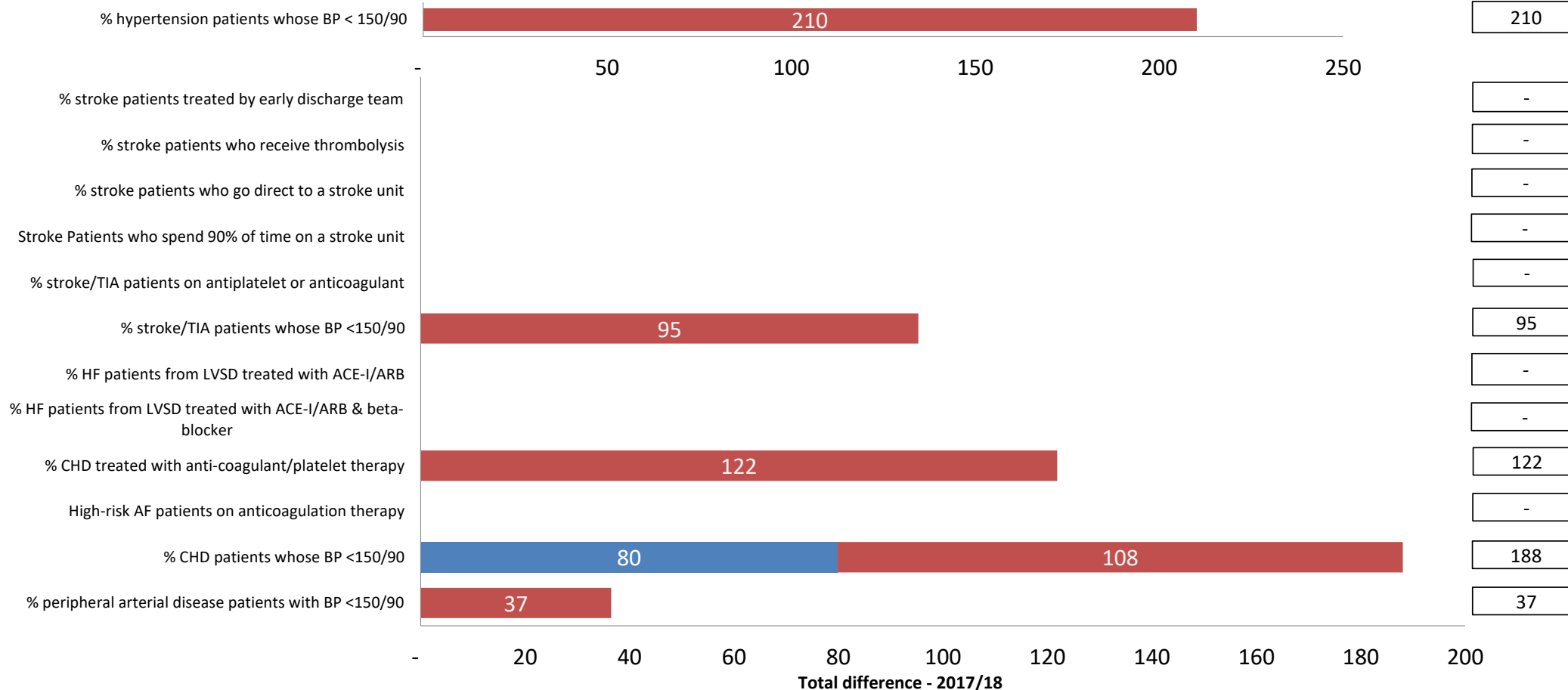


# How different are we on circulation quality and outcome indicators?

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



Please note that due to the size of the opportunities for '% hypertension patients whose BP <150/90' this indicator is presented on its own axes to avoid scaling down the opportunities presented in the other indicators.

See page 54 for additional guidance on indicators.

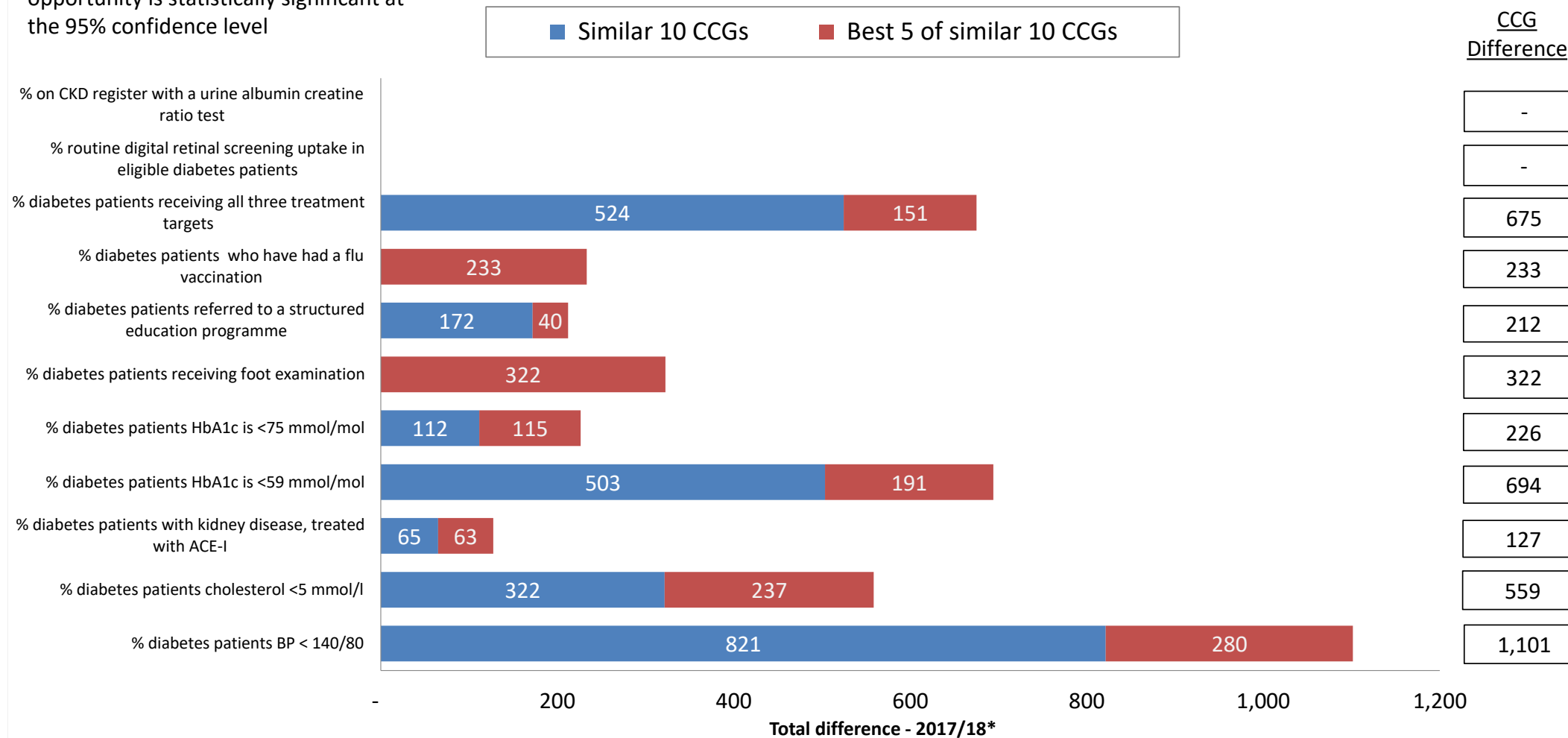
**Source(s):** CCG Outcomes Indicator Set (OIS), Royal College of Physicians Sentinel Stroke National Audit Programme SSNAP Key Indicators, Quality and

# How different are we on endocrine quality and outcome indicators?

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

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs



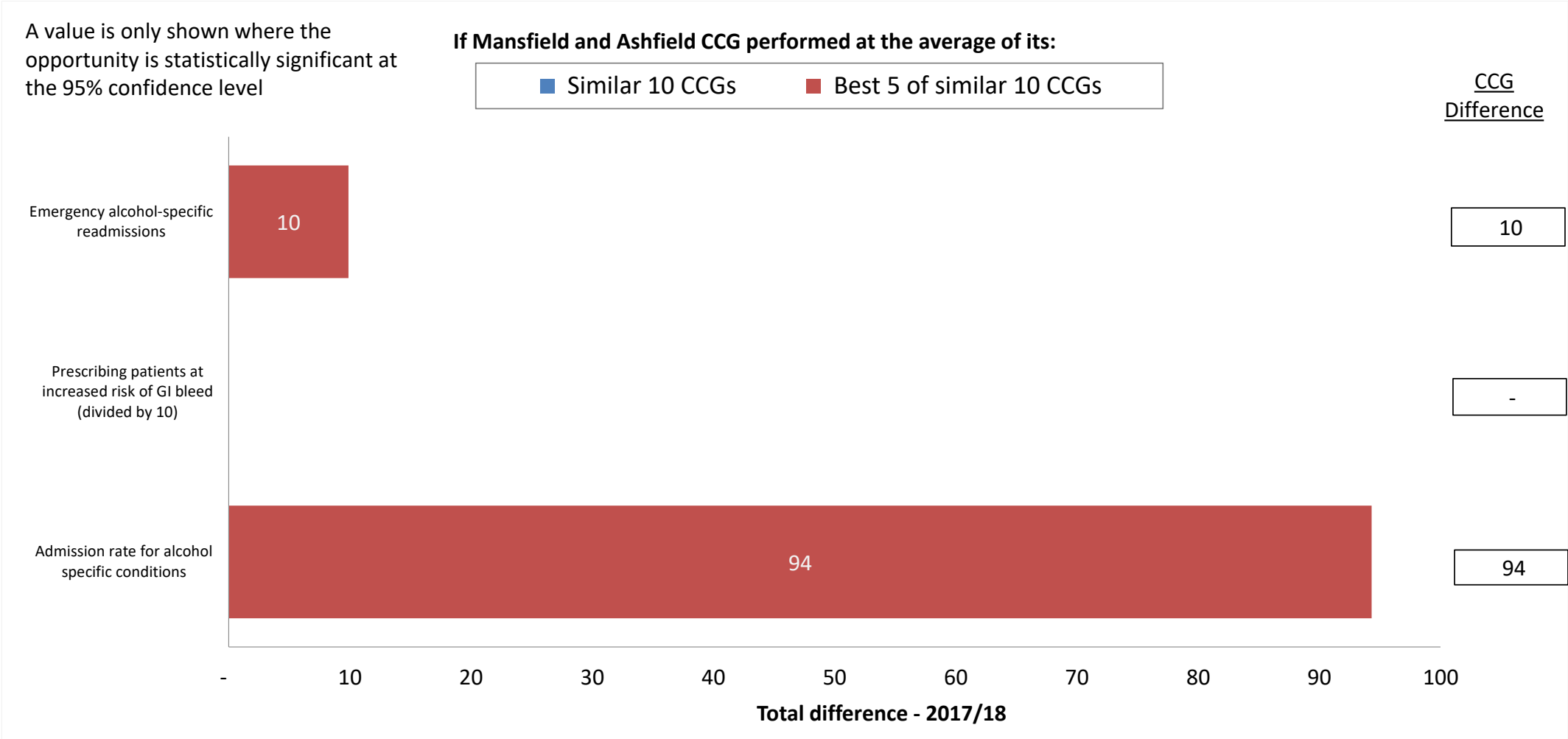
\*All data from 2017/18 except '% diabetes patients receiving all three treatment targets' (2016/17), '% routine digital retinal screening uptake in eligible diabetes patients' (2016/17) and '% on CKD register with a urine albumin creatine ratio test' (2016/17).

Please note that the quality and outcomes indicators for endocrine primarily focus on diabetes outcomes.

See page 54 for additional guidance on indicators.

Source(s): Quality and Outcomes Framework (QOF), NHS Digital, National Diabetes Audit (NDA), NHS Digital

# How different are we on gastrointestinal quality and outcome indicators? RightCare



Please note that the indicator 'Prescribing patients at increase risk of GI bleed' is shown in tens on the chart, with full opportunities in the total CCG difference cell.

# How different are we on respiratory quality and outcome indicators?

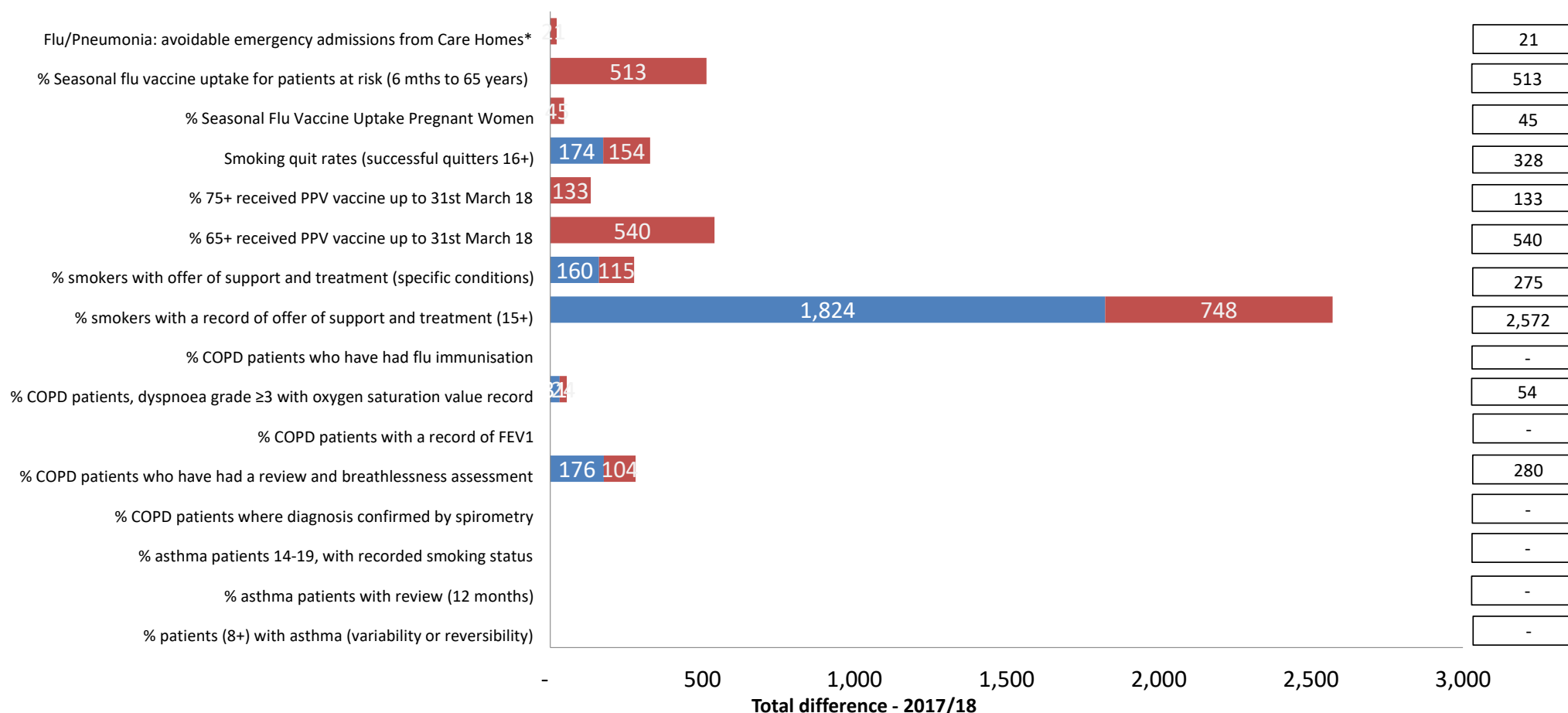
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

CCG  
Difference



\* This indicator is compared to the Enhanced Health in Care Home peer group rather than the standard RightCare similar 10.

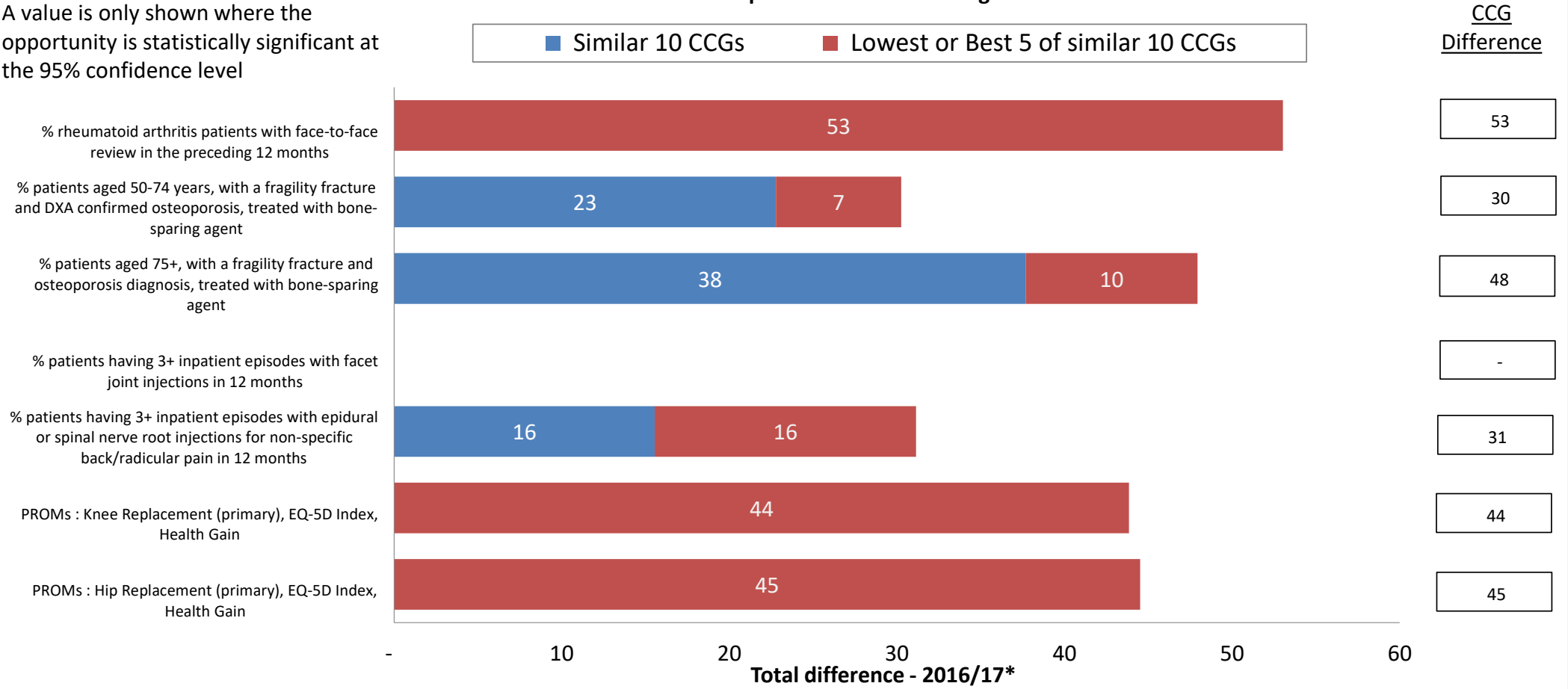
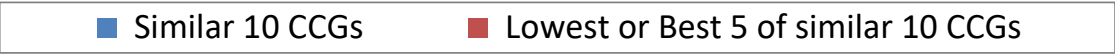
See page 54 for additional guidance on indicators.

**Source(s):** Risk Factors Intelligence Team, Public Health England (PHE), NHS Digital, Annual Population Survey, Office for National Statistics (ONS), Quality and Outcomes Framework (QOF)

# How different are we on musculoskeletal quality and outcome indicators?

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

If Mansfield and Ashfield CCG performed at the average of its:



The health gain data should be considered together with case-mix adjusted health gain and other PROMs scores. The opportunity is in QALYs (quality adjusted life years) which accounts for both the quality of life improvement (in PROMs score) and its likely duration in years.

The bone-sparing agent indicators only consider patients on GP registers who have fragility fractures and an osteoporosis diagnosis. There may be many more patients with osteoporosis.

\* All data is from 2016/17 except '% patients aged 75+, with a fragility fracture and osteoporosis diagnosis, treated with bone-sparing agent', '% patients aged 50-74 years, with a fragility fracture and DXA confirmed osteoporosis, treated with bone-sparing agent' and '% rheumatoid arthritis patients with face-to-face review in the preceding 12 months' which are all from 2017/18.

See page 54 for additional guidance on indicators.

**Source(s):** Quality and Outcomes Framework (QOF), NHS Digital  
National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart)  
- correct as of extract 03/12/18  
Patient Reported Outcome Measures (PROMs), NHS Digital

# How different are we on trauma and injuries quality and outcome indicators?

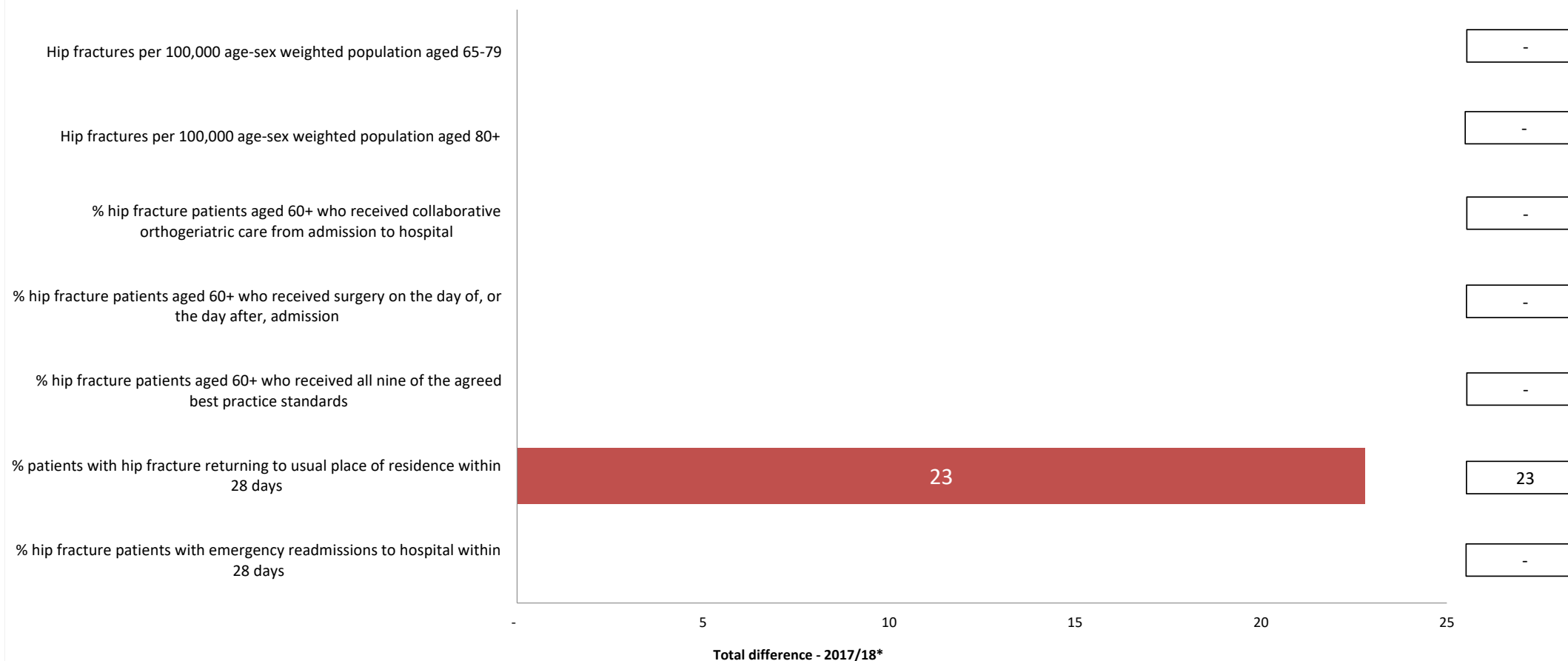
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Lowest or Best 5 of similar 10 CCGs

CCG  
Difference



\*All data is from 2017/18 except for '% hip fracture patients aged 60+ who received all nine of the agreed best practice standards', '% hip fracture patients aged 60+ who received surgery on the day of, or the day after, admission' and '% hip fracture patients aged 60+ who received collaborative orthogeriatric care from admission to hospital' which is from 2016.

See page 54 for additional guidance on indicators.

**Source(s):** National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - correct as of extract 03/12/18

National Hip Fracture Database (NHFD), CCG Outcomes Indicator Set, NHS Digital

NHS Mansfield and Ashfield CCG

# How different are we on maternity quality and outcome indicators?

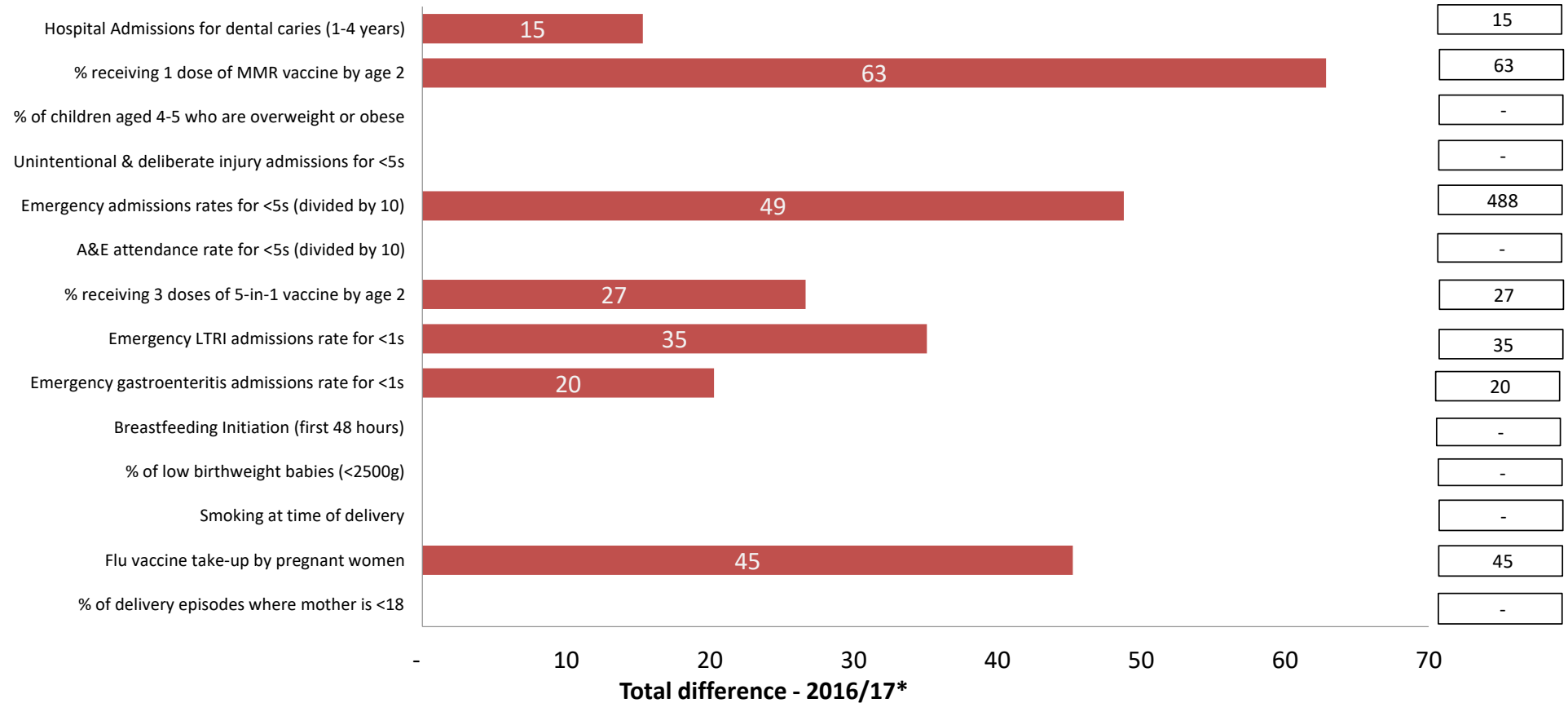
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If Mansfield and Ashfield CCG performed at the average of its:

■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

CCG  
Difference



Please note that indicators 'A&E attendance rates' and 'Emergency admission rates' are shown in hundreds on the chart, with full opportunities in the total CCG difference cell.

\* All data is from 2016/17 except for 'Flu vaccine take-up by pregnant women' (September 2017 - January 2018).

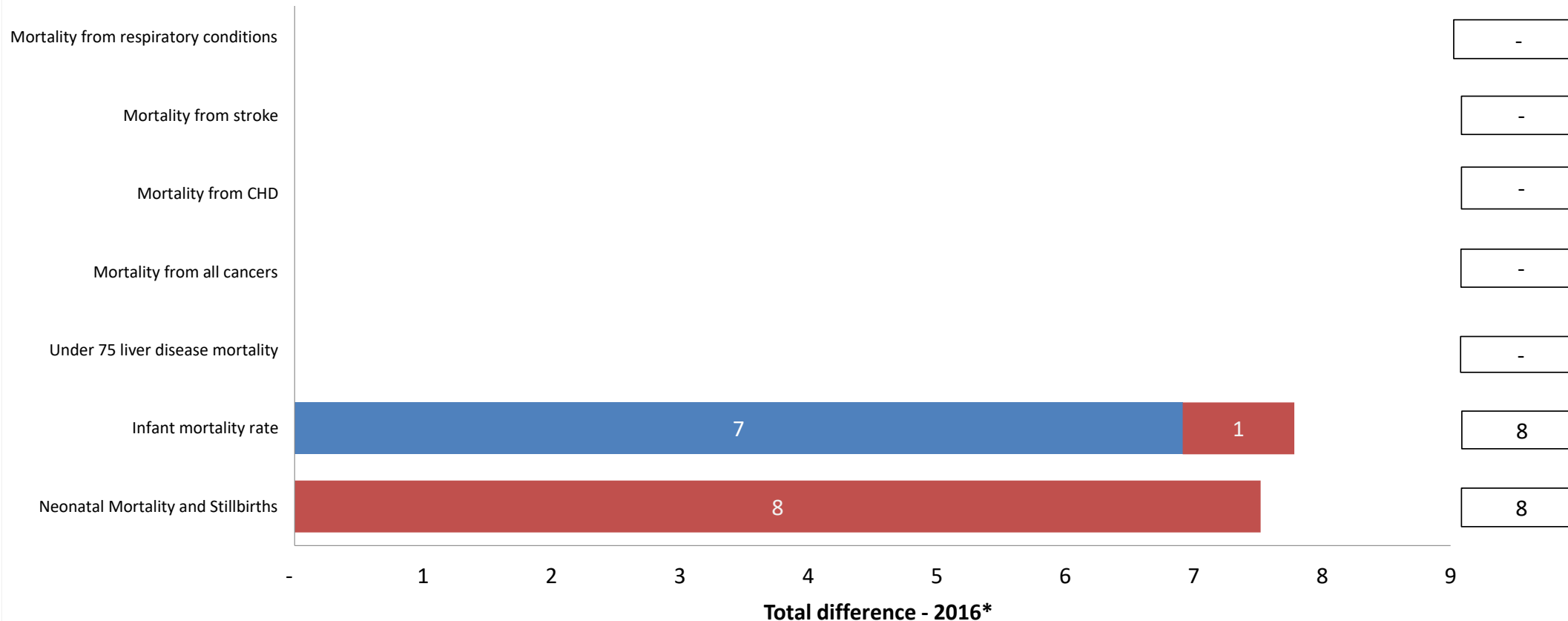
# How different are we on mortality indicators?

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

If Mansfield and Ashfield CCG performed at the average of its:



CCG  
Difference



The mortality data presented above uses the latest published information available from Public Health England and NHS Digital. As the data comes from different sources there is inconsistency in the years covered. The potential lives saved are calculated as annual potential opportunities and are only shown where statistically significant. Lives saved only include programmes where mortality outcomes have been considered appropriate.

\*All data is from 2016 except for 'Infant mortality rate', 'Mortality from CHD' and 'Mortality from stroke' which is from 2014-16.

## Pathways on a Page charts

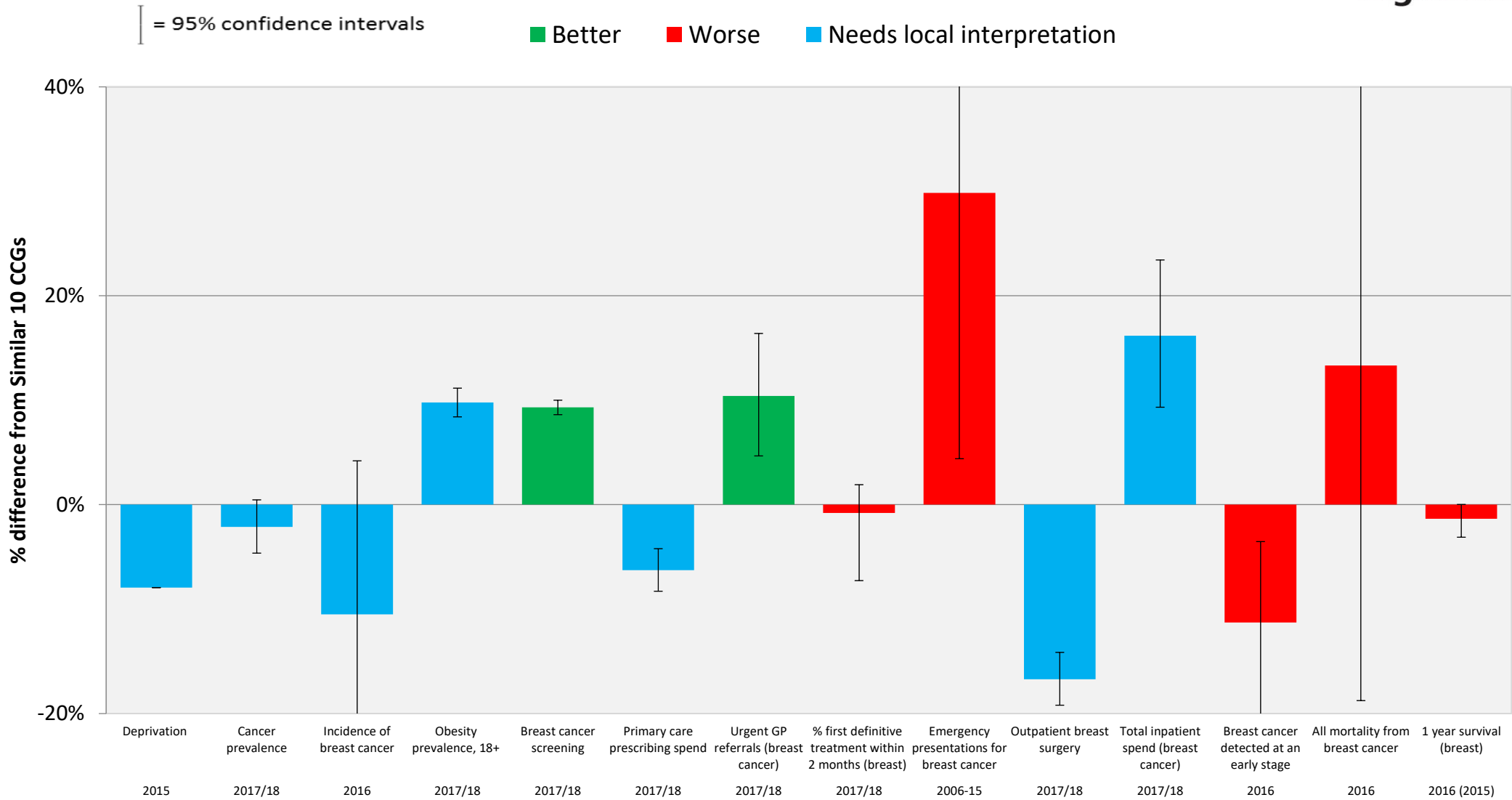
The following slides provide a more detailed look at the 22 'Pathways on a page' for each CCG, by providing a wider range of key indicators for different conditions.

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.

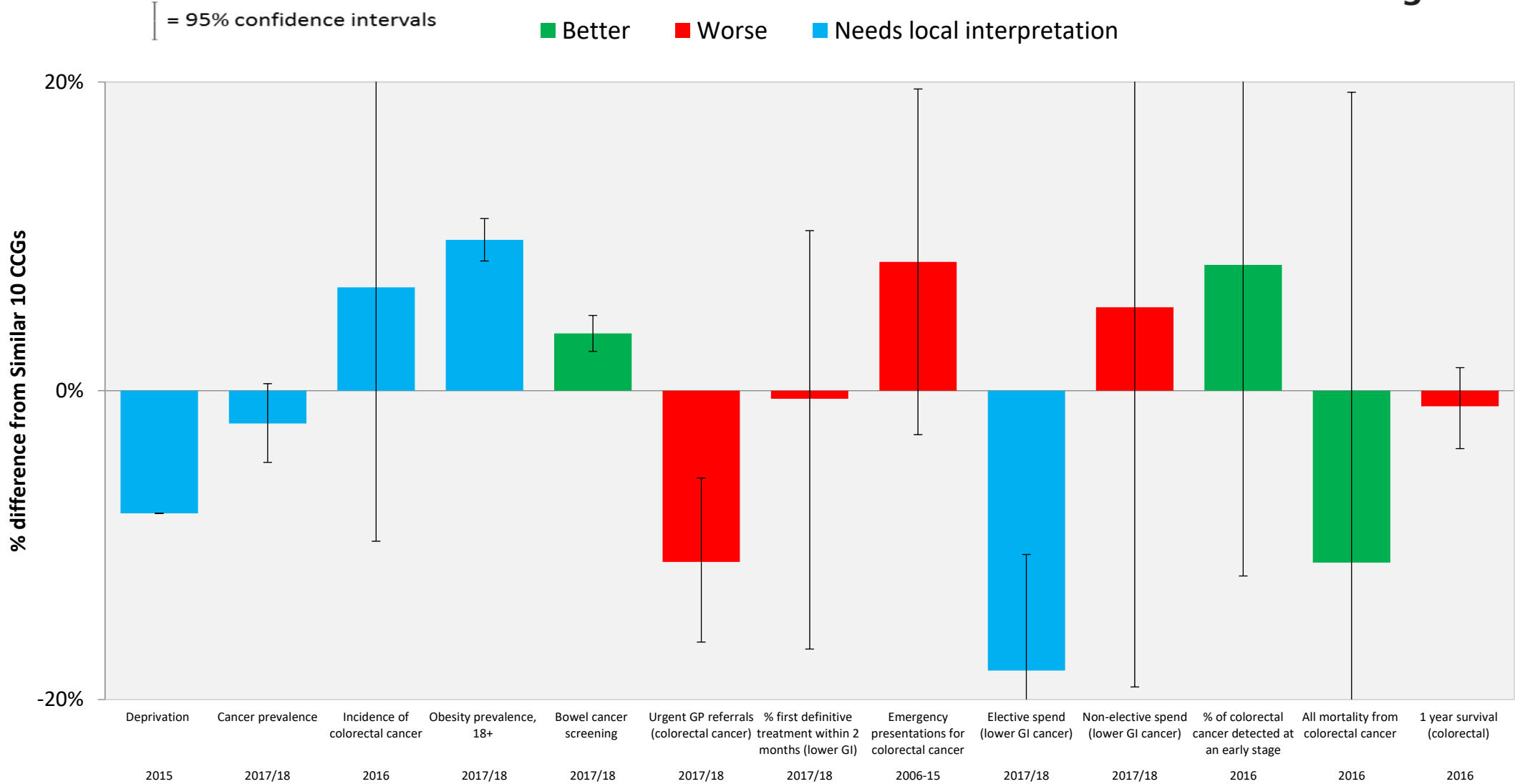
Each indicator on these pathways is shown as the percentage difference from the average of the 10 CCGs most similar to you.



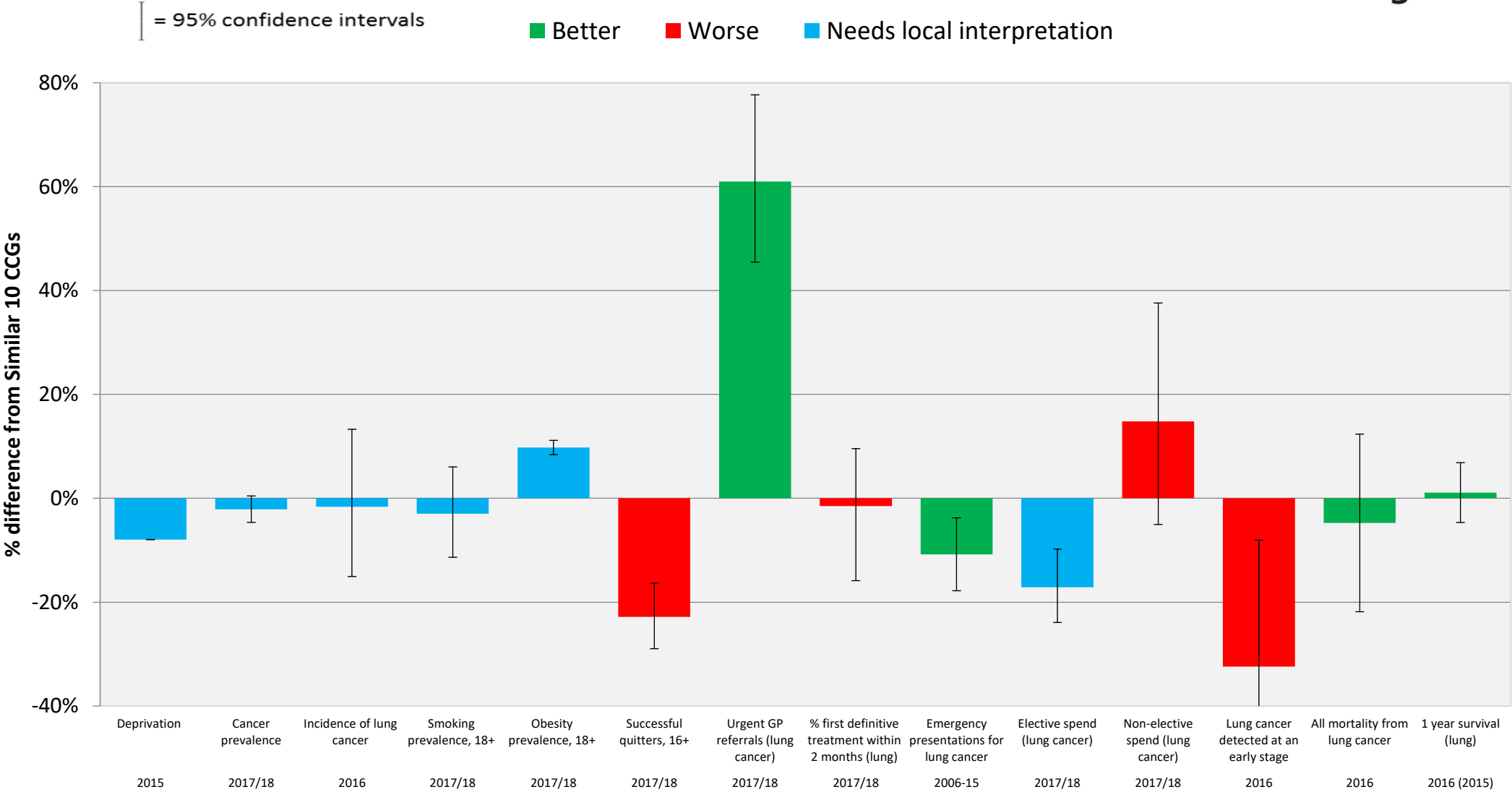
# Breast cancer pathway



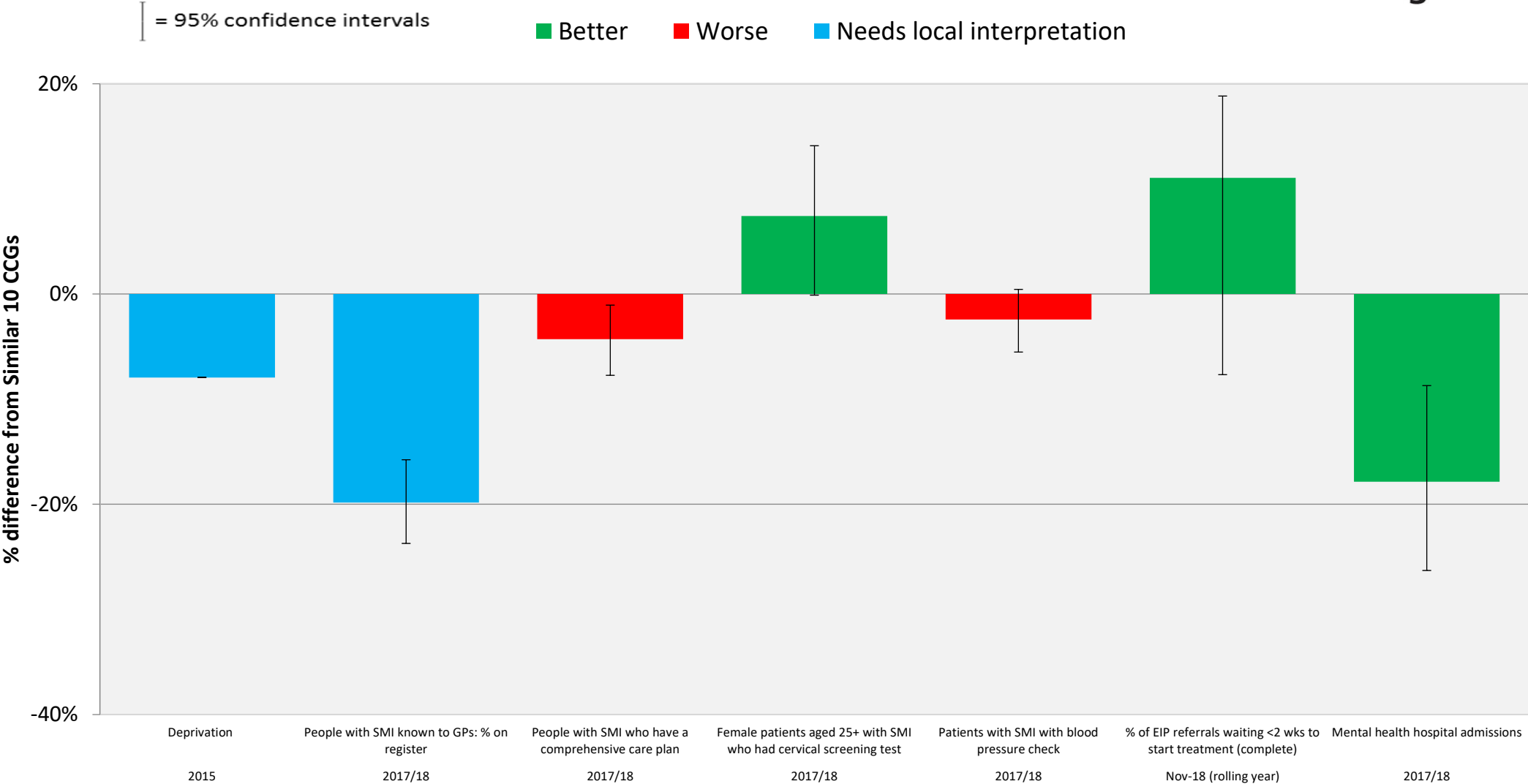
# Lower gastrointestinal cancer pathway



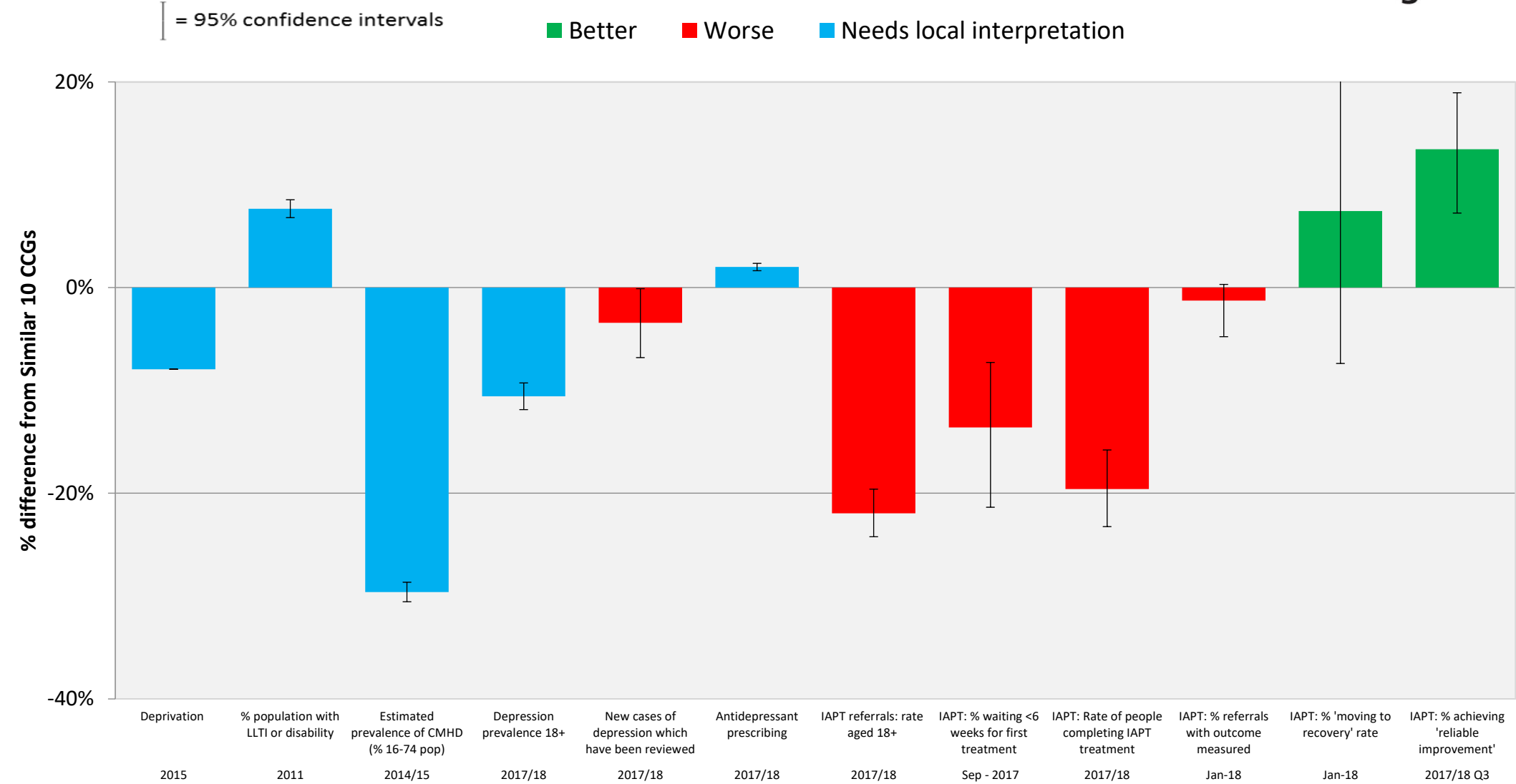
# Lung cancer pathway



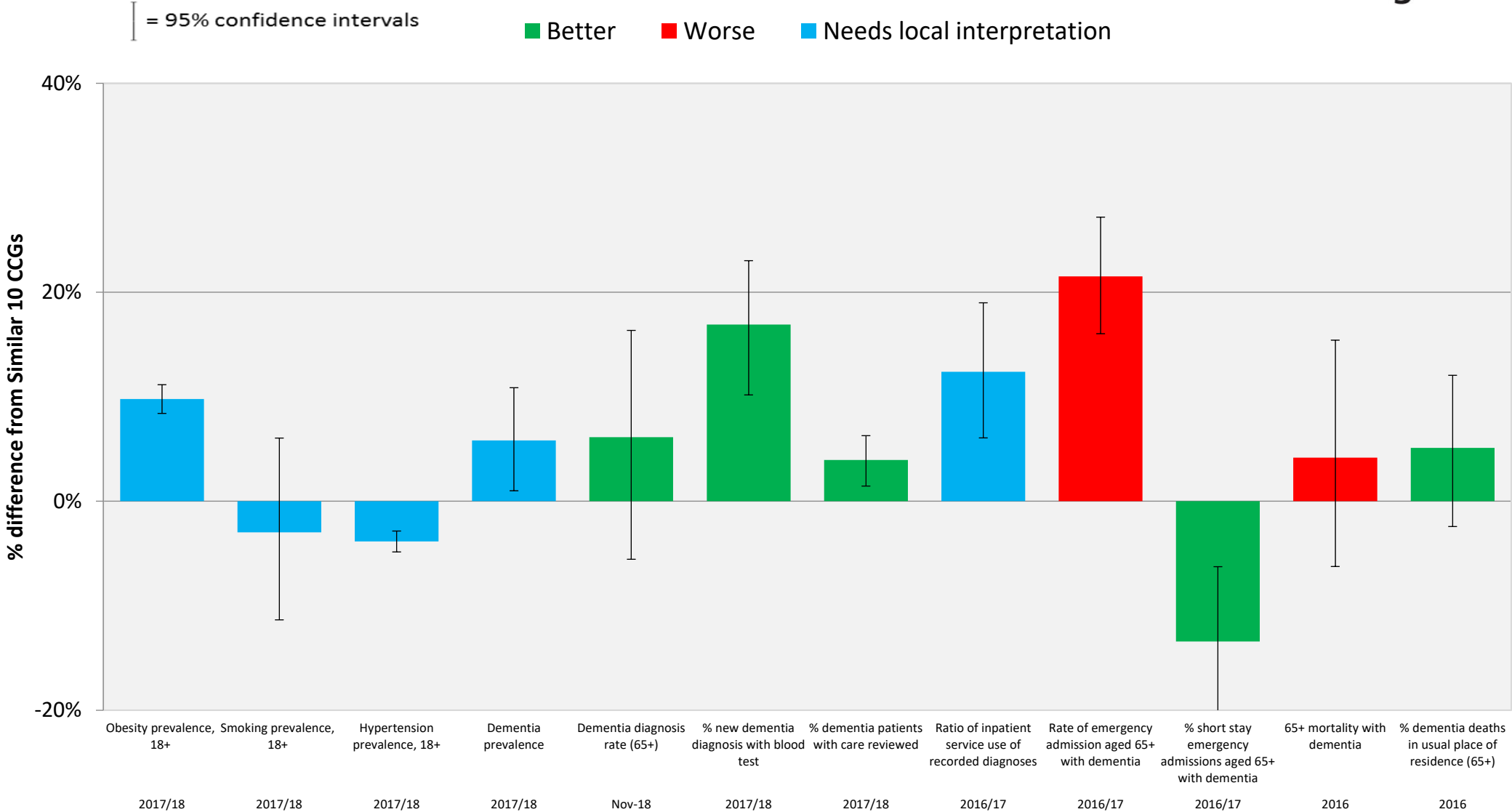
# Severe mental illness pathway



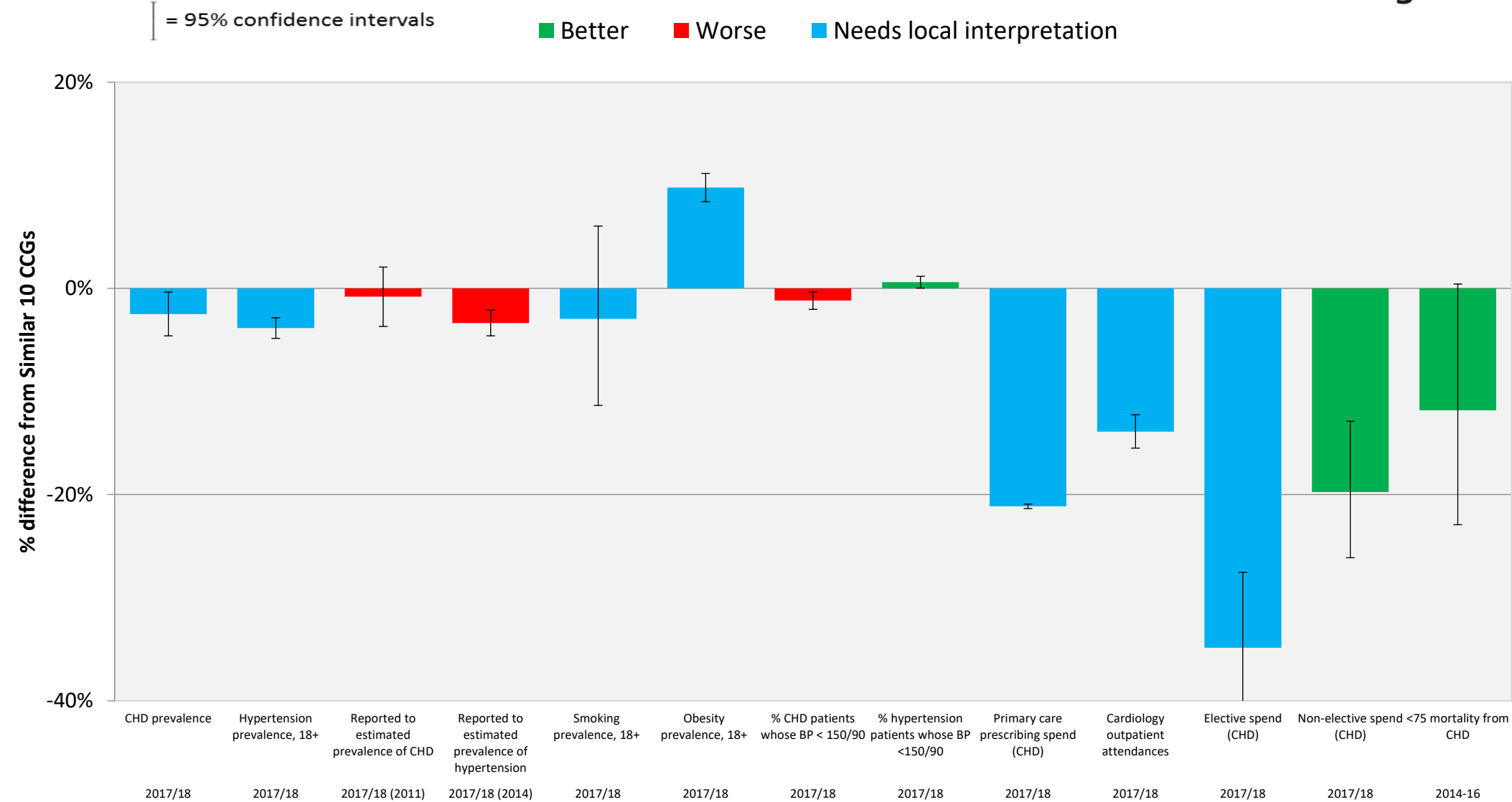
# Common mental health disorder pathway



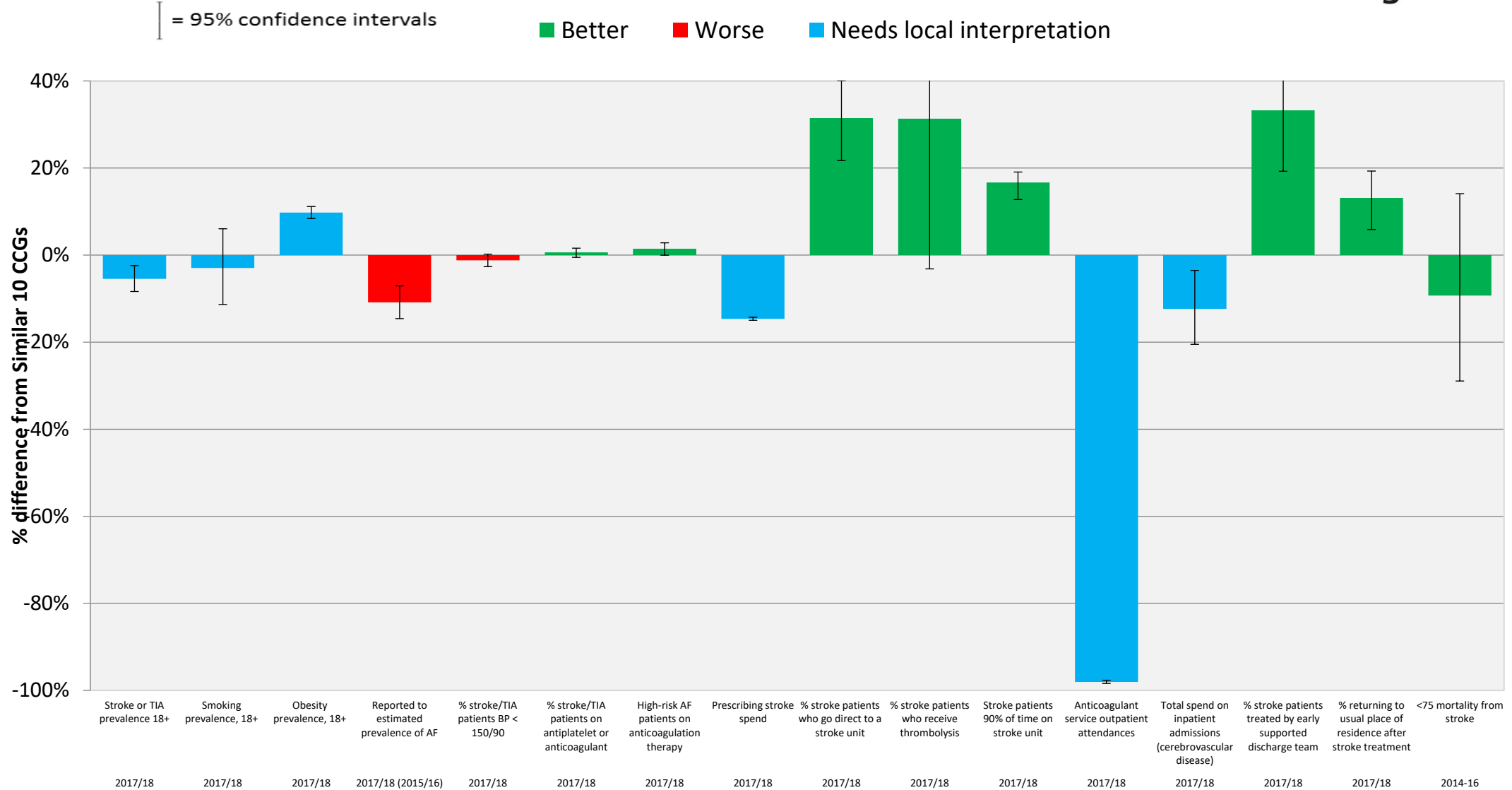
# Dementia pathway



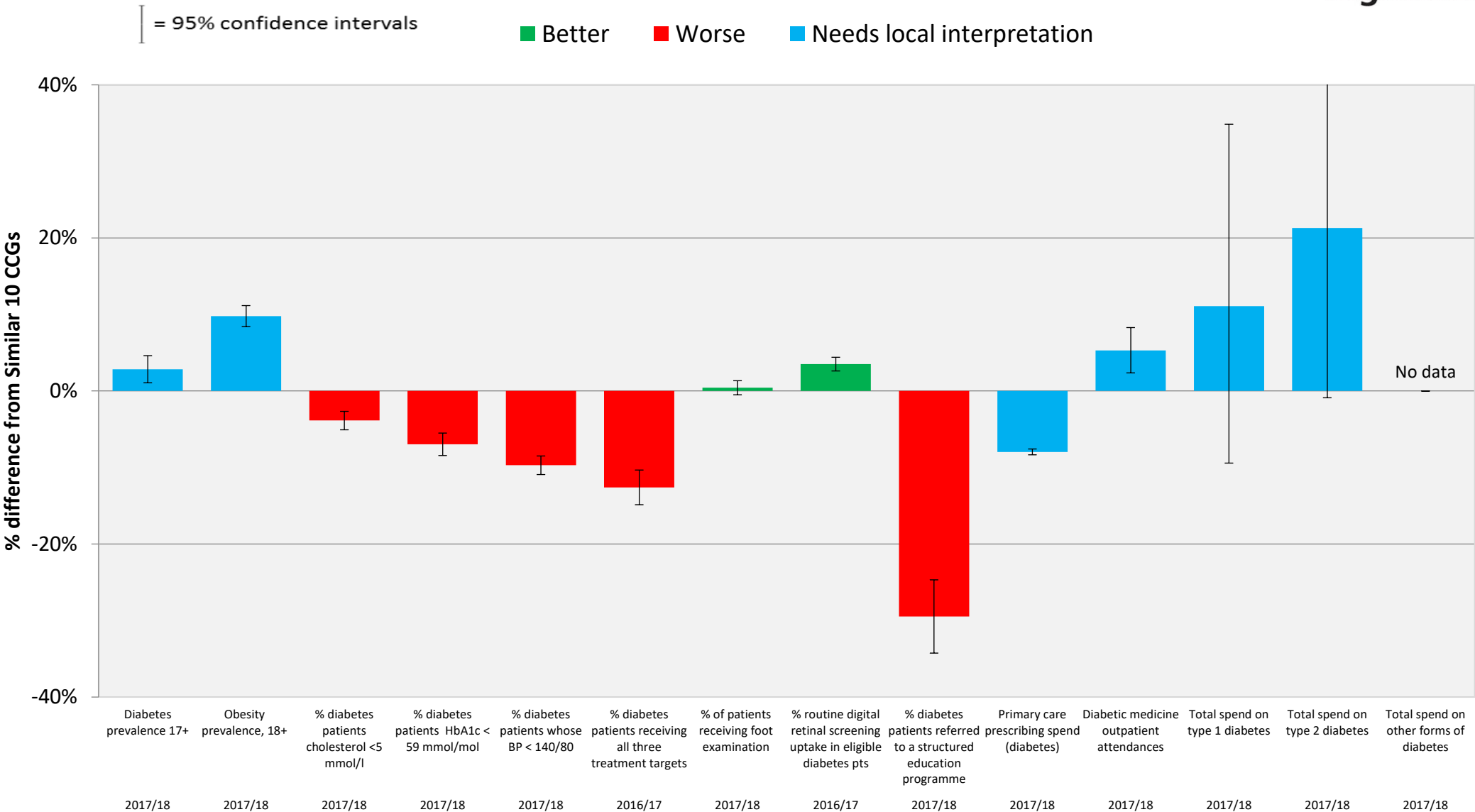
# Heart disease pathway



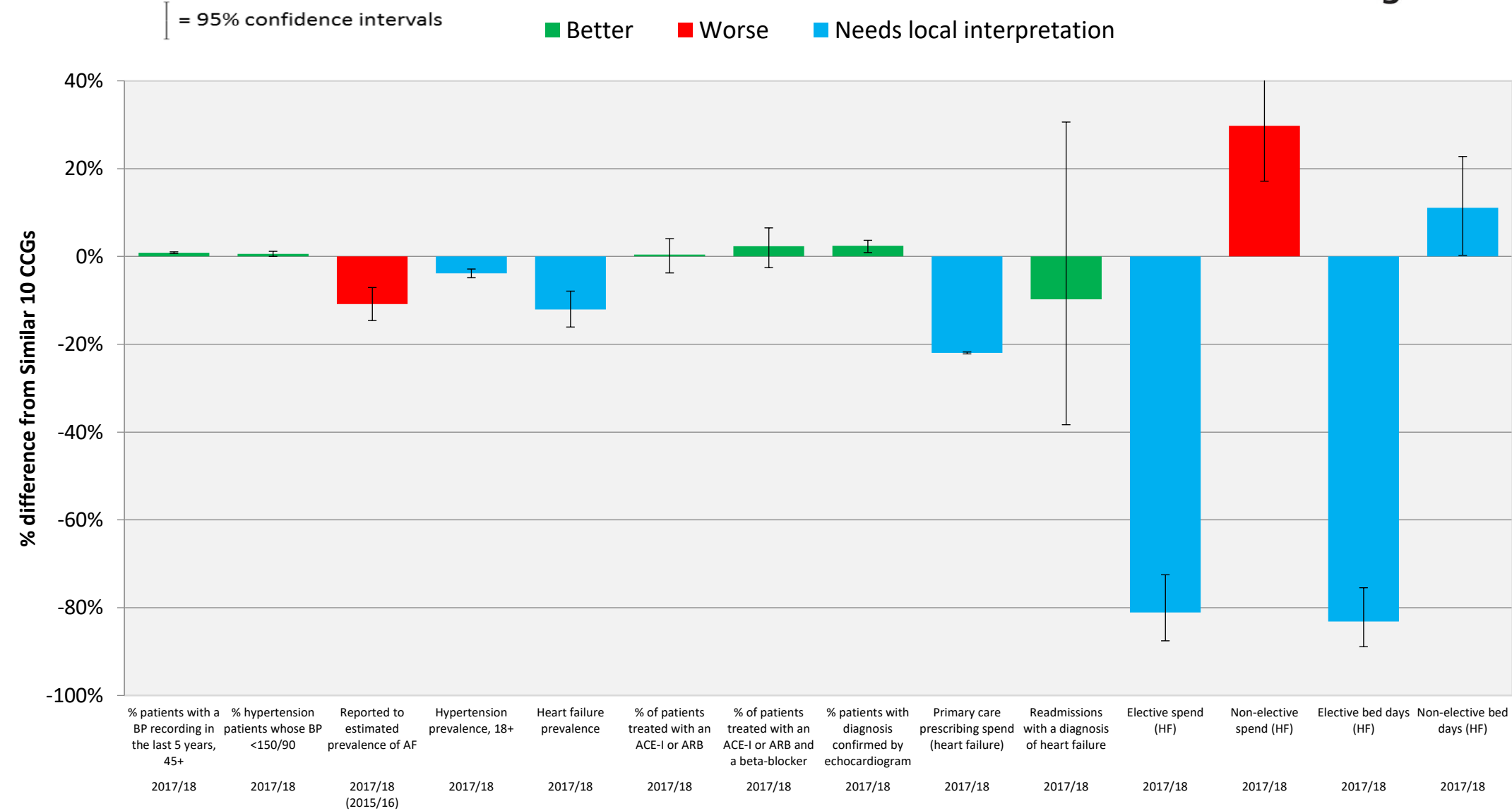
# Stroke pathway



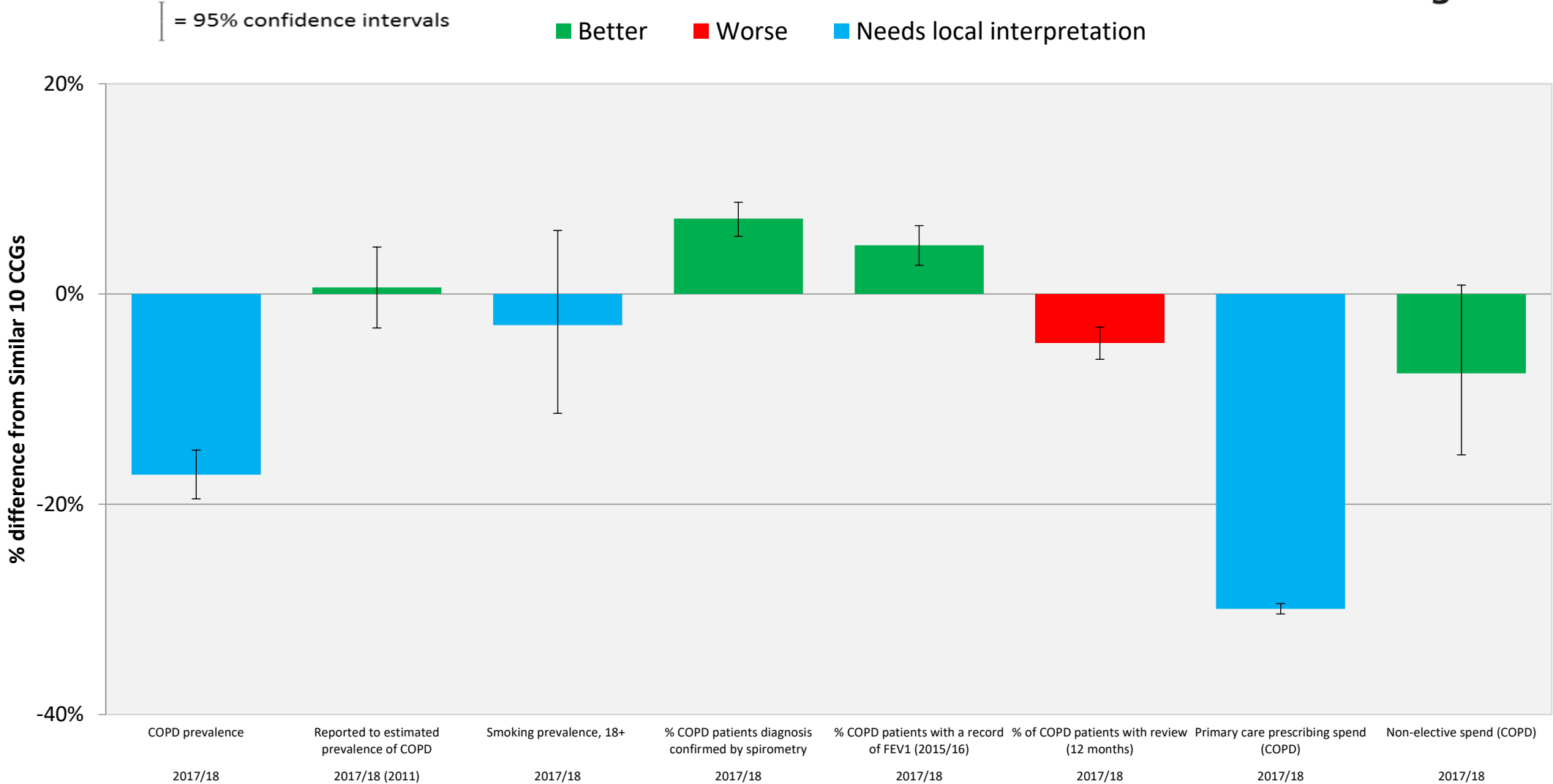
# Diabetes pathway



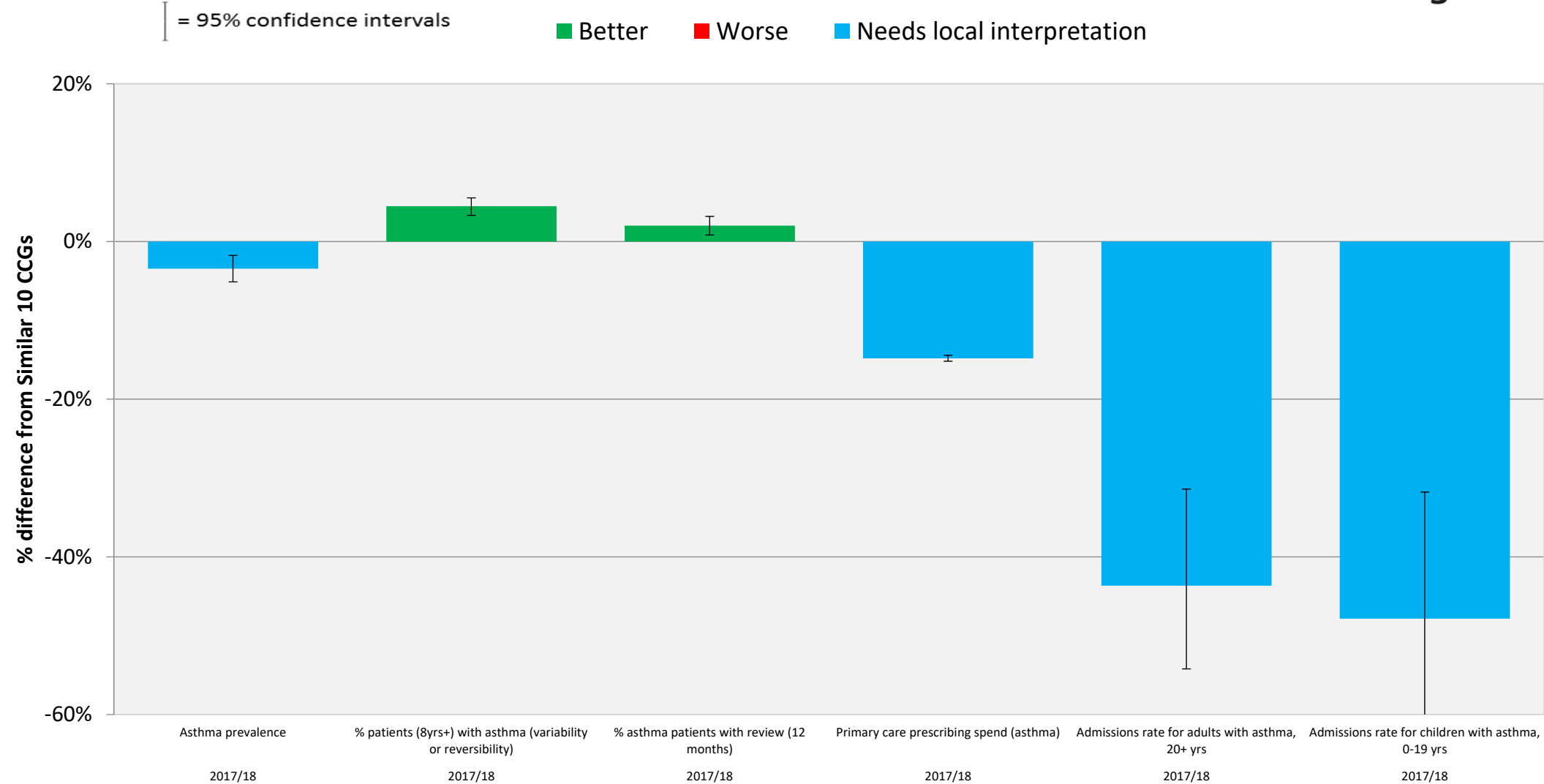
# Heart failure pathway



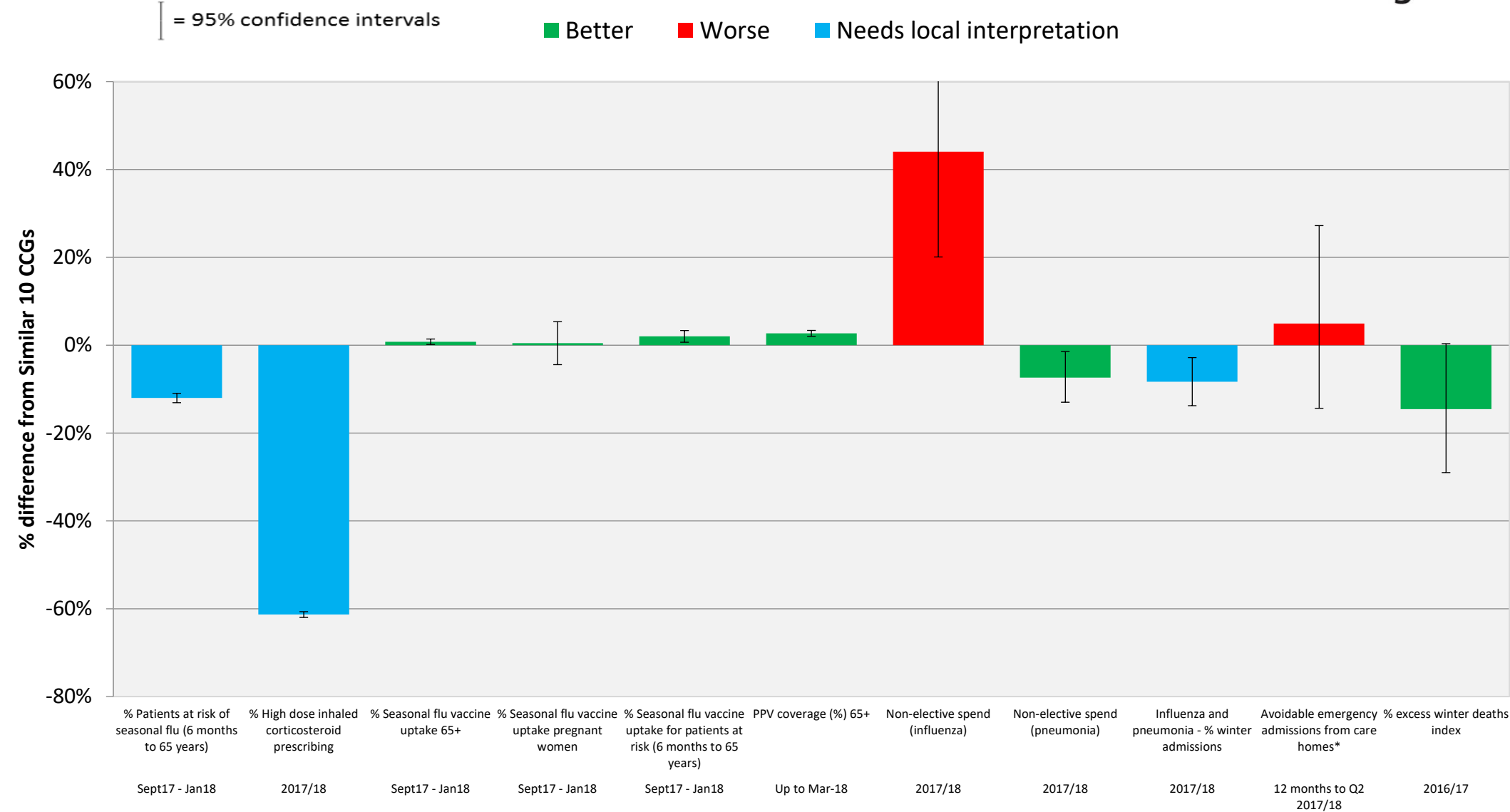
# Chronic obstructive pulmonary disease pathway



# Asthma pathway



# Influenza and pneumonia pathway



\*This indicator is compared to the Enhanced Health in Care Home peer group rather than the standard RightCare similar 10.

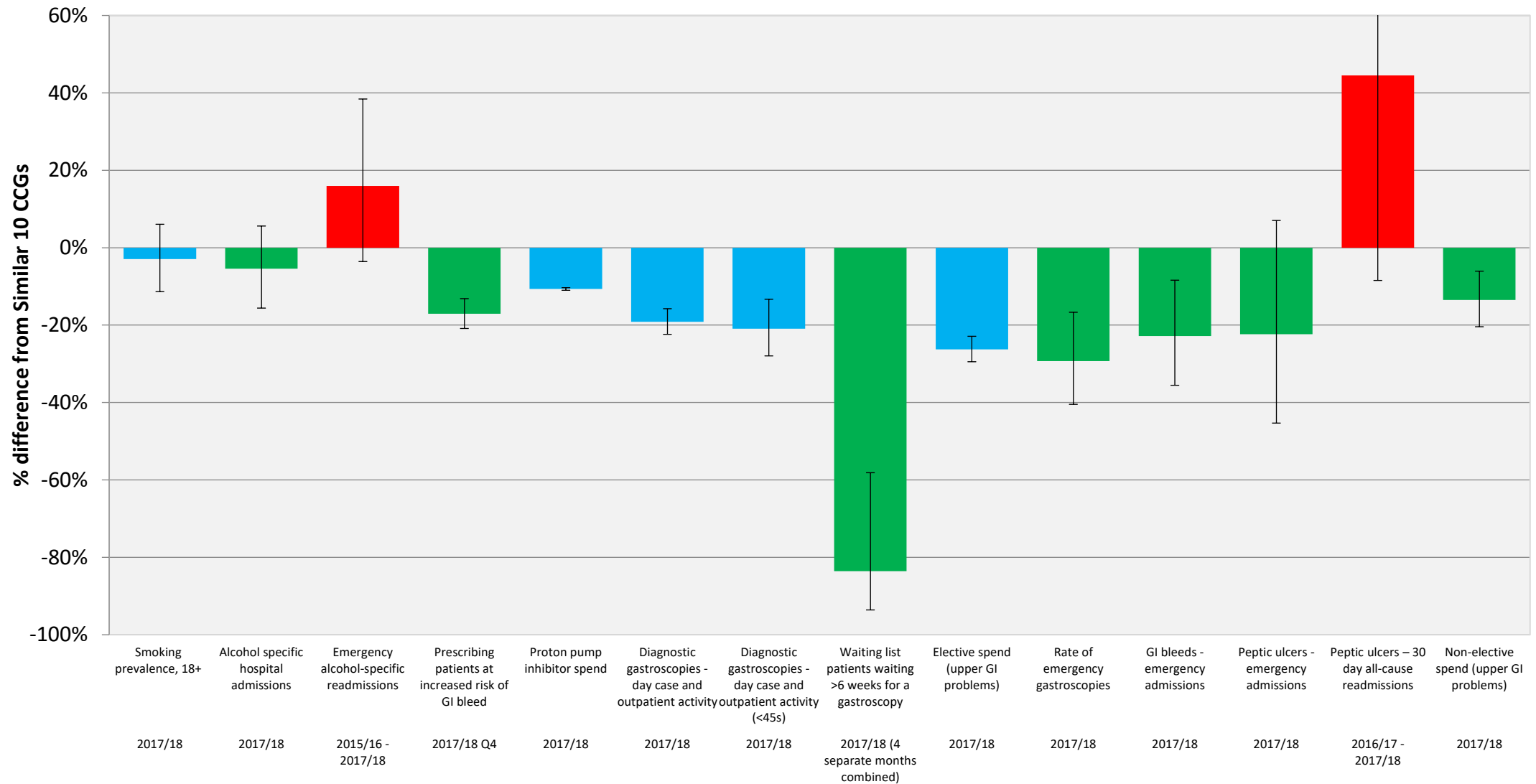
# Upper gastrointestinal pathway

| = 95% confidence intervals

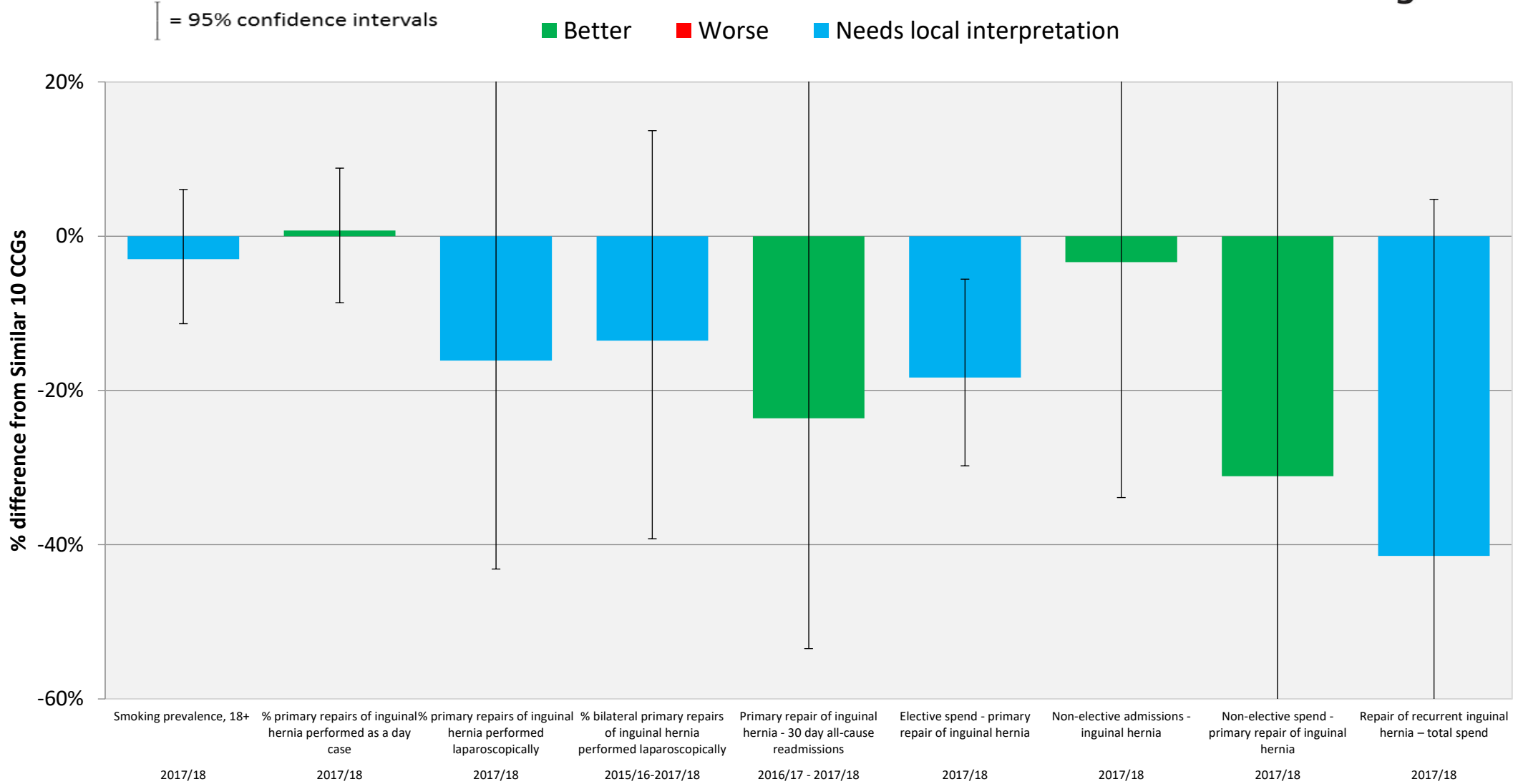
■ Better

■ Worse

■ Needs local interpretation



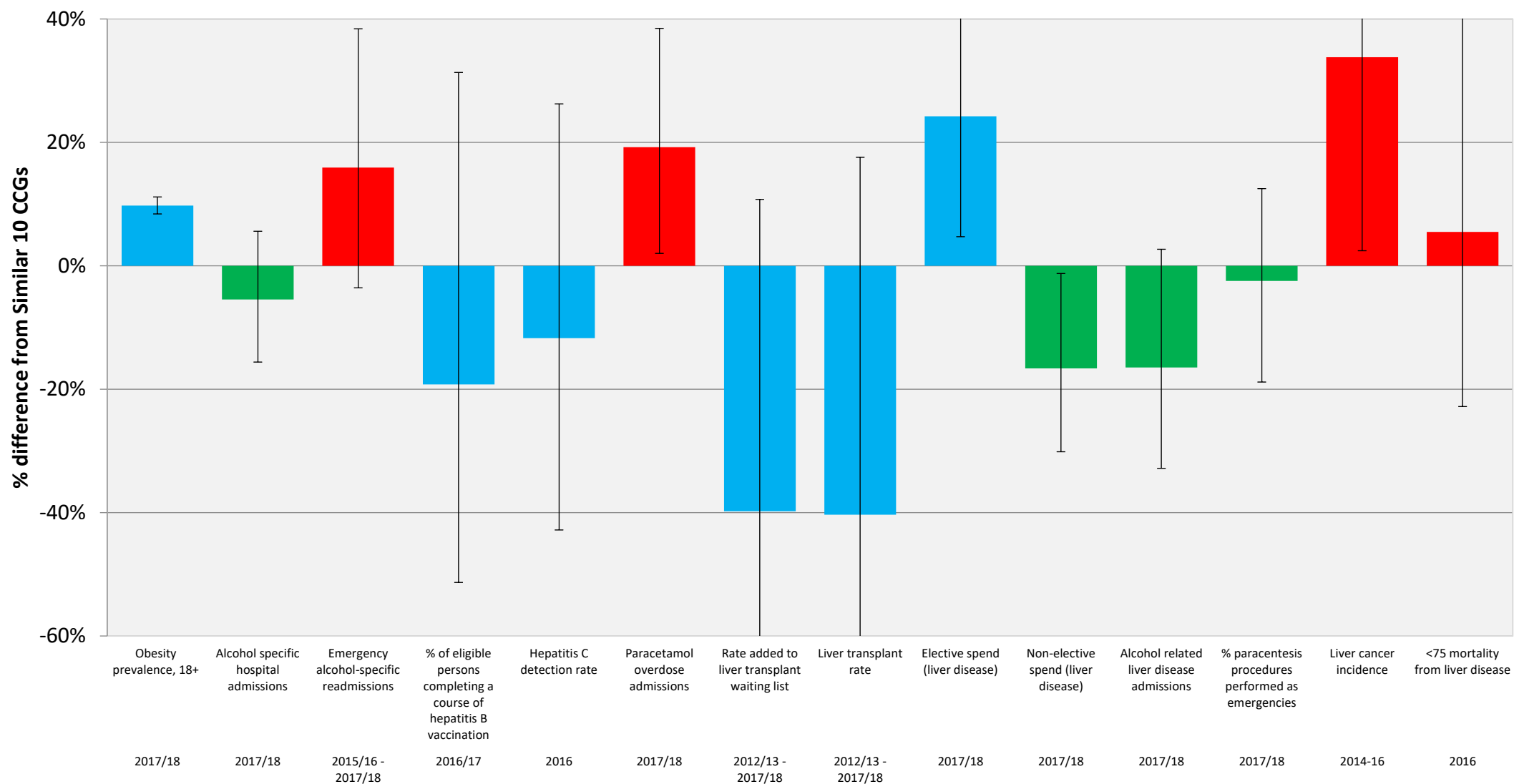
# Groin hernia pathway



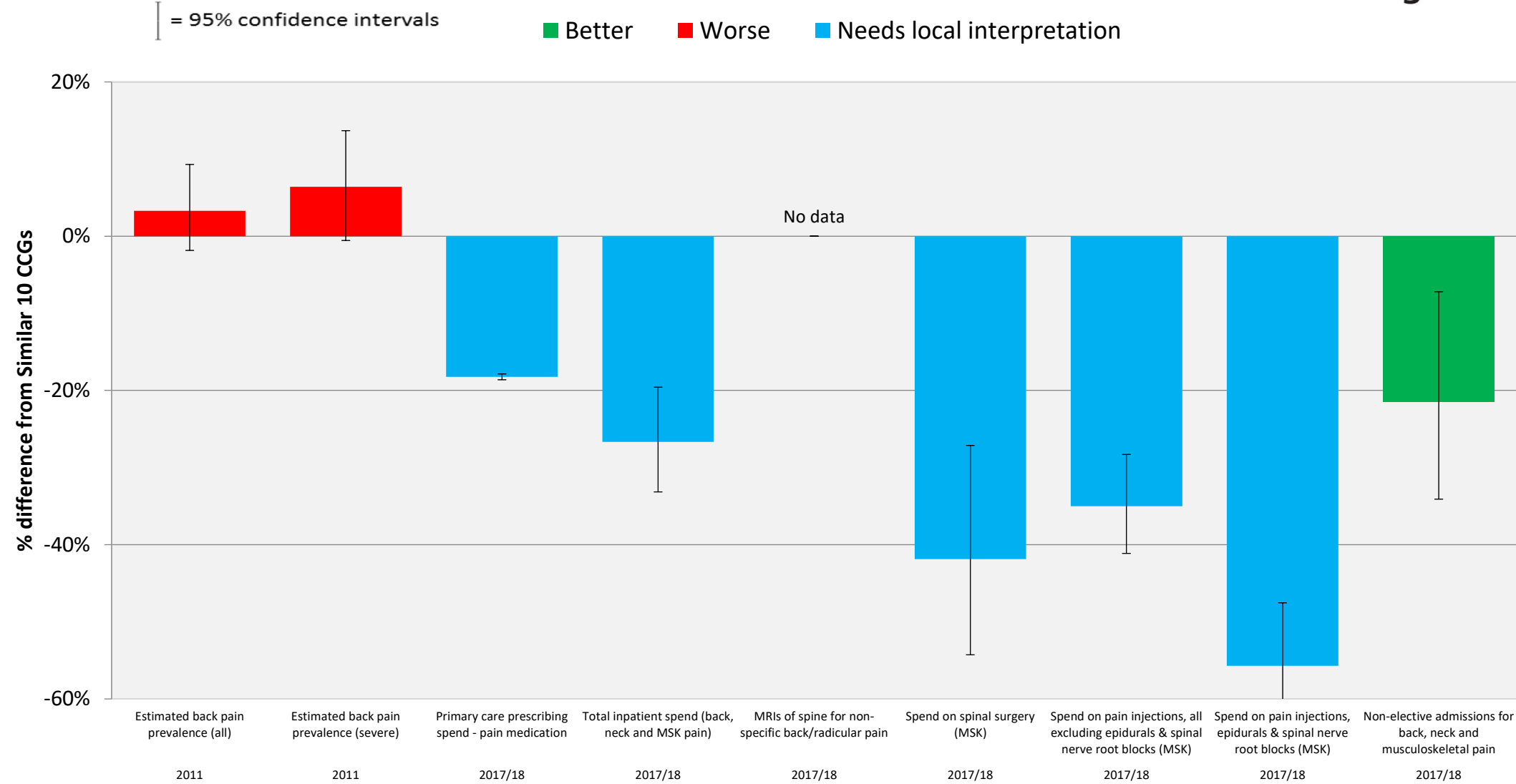
# Liver disease pathway

⌋ = 95% confidence intervals

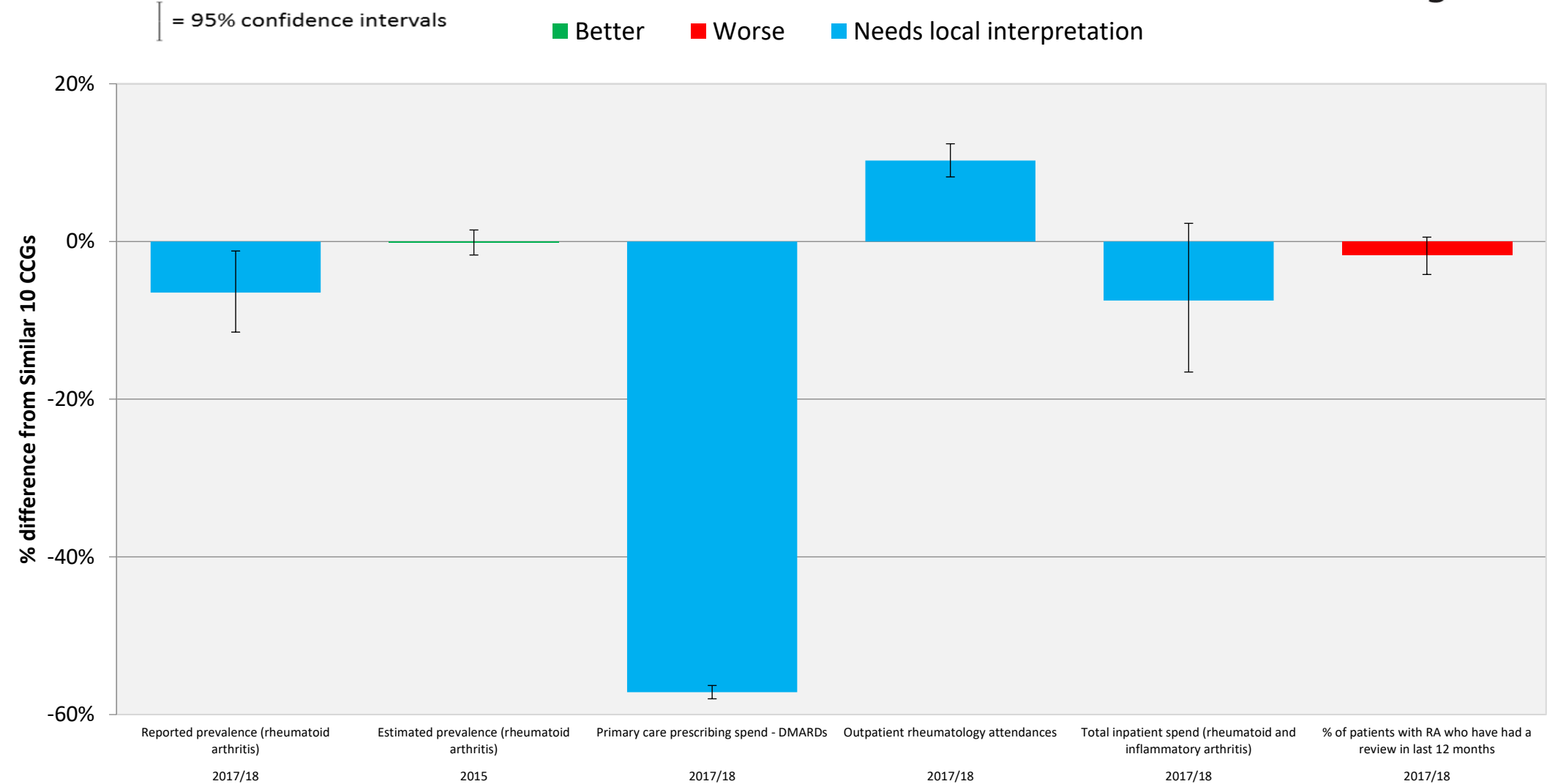
■ Better   ■ Worse   ■ Needs local interpretation



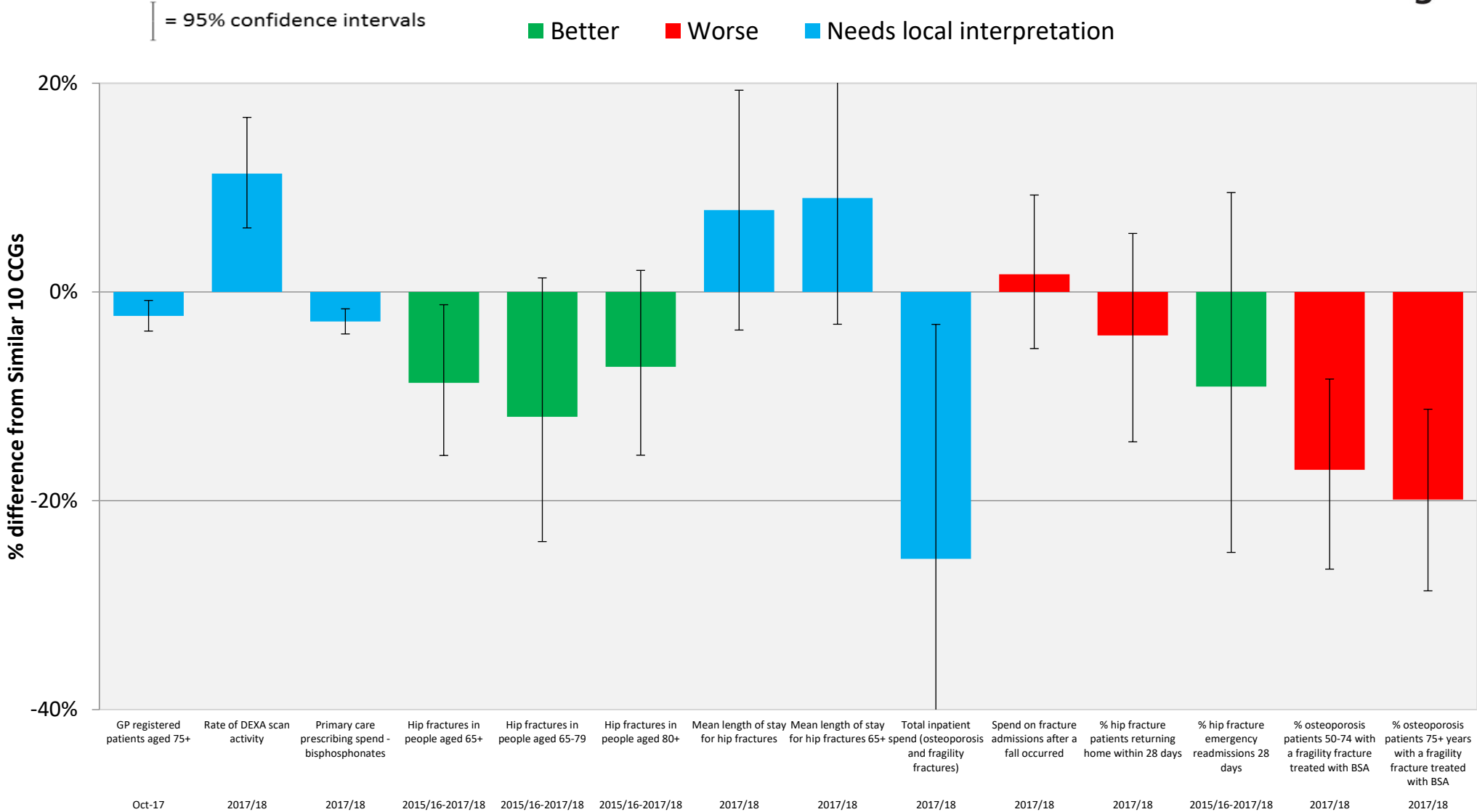
# Back, neck and MSK pain pathway



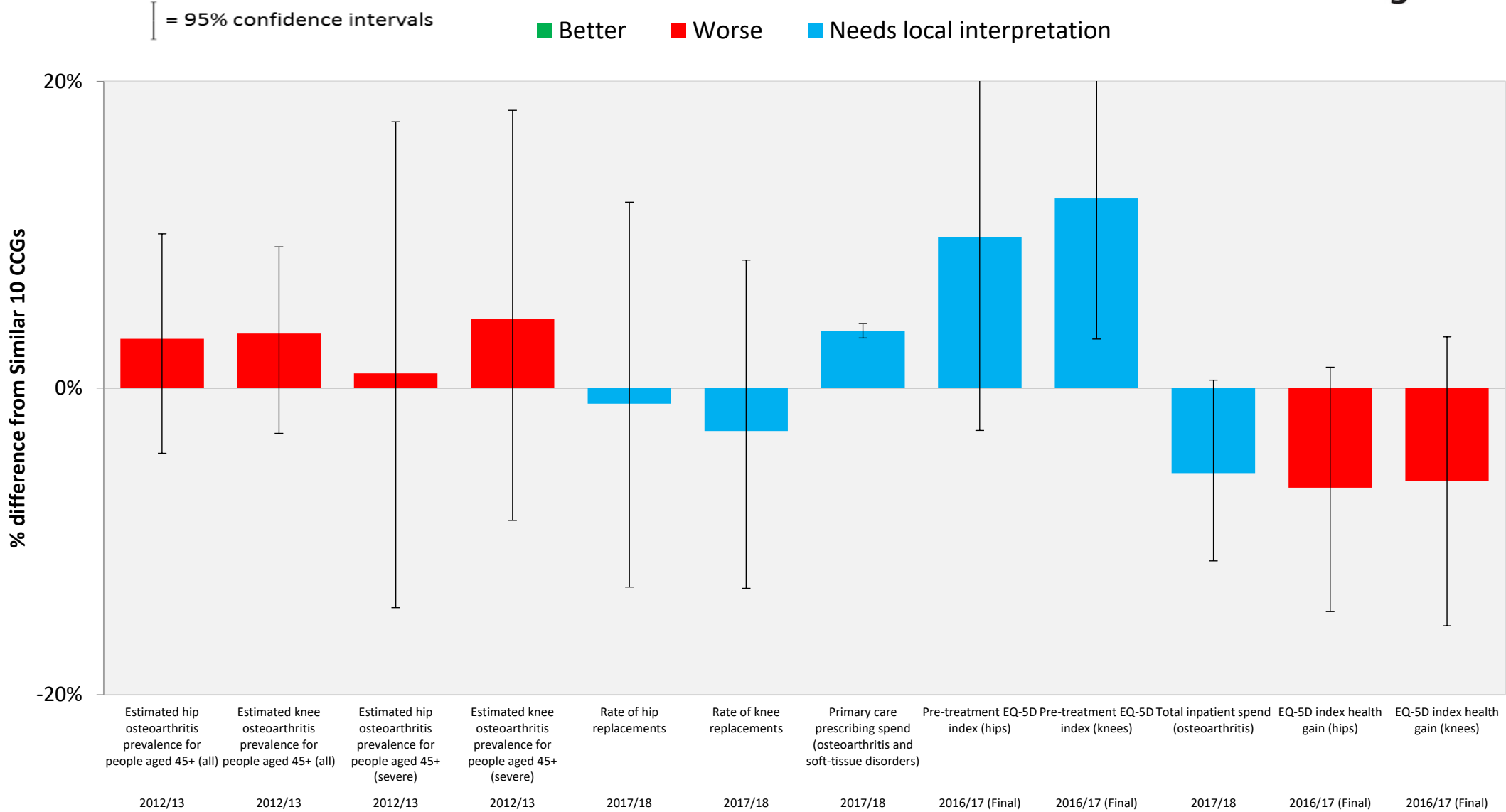
# Rheumatoid and inflammatory arthritis pathway



# Osteoporosis and fragility fractures pathway



# Osteoarthritis pathway



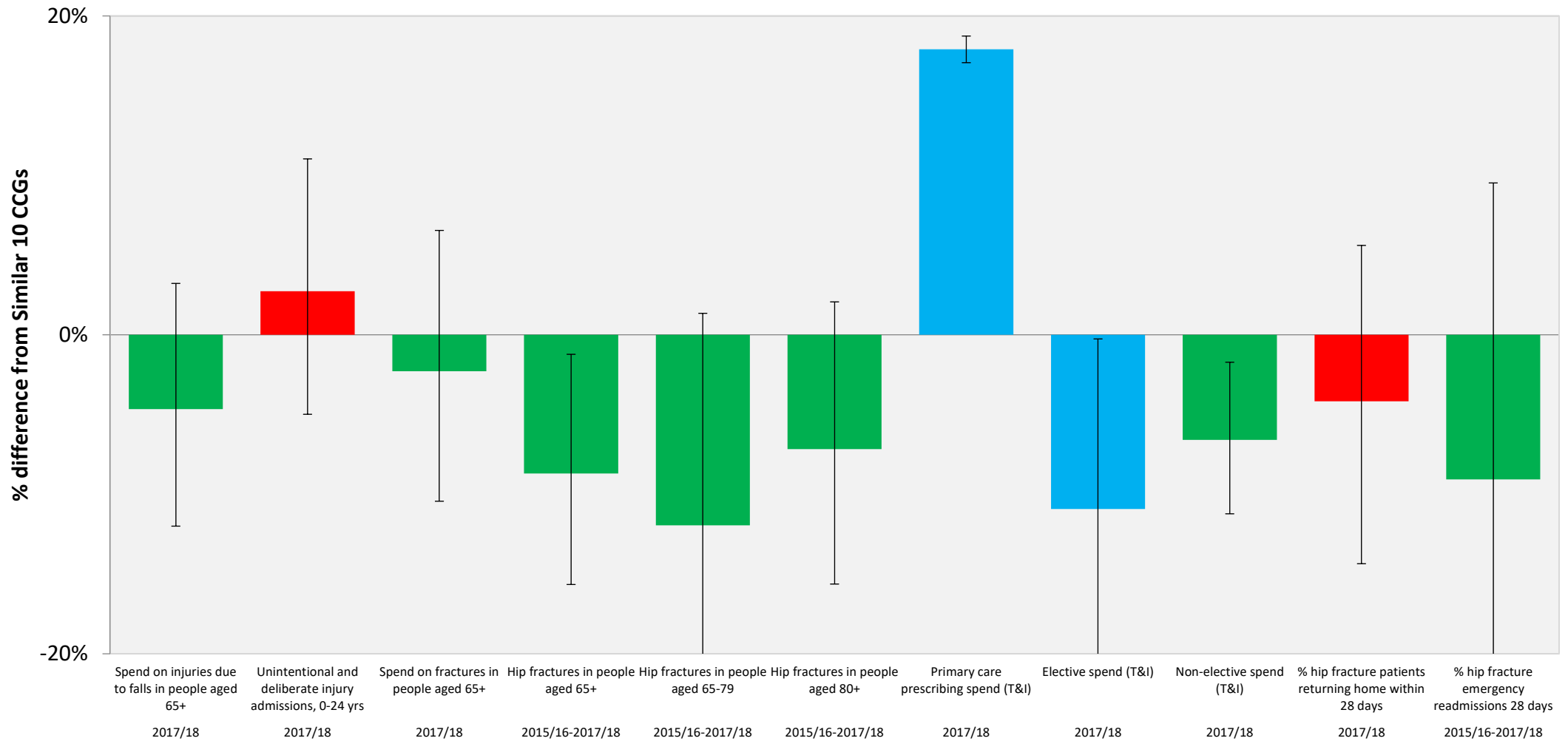
# Trauma and injuries pathway

| = 95% confidence intervals

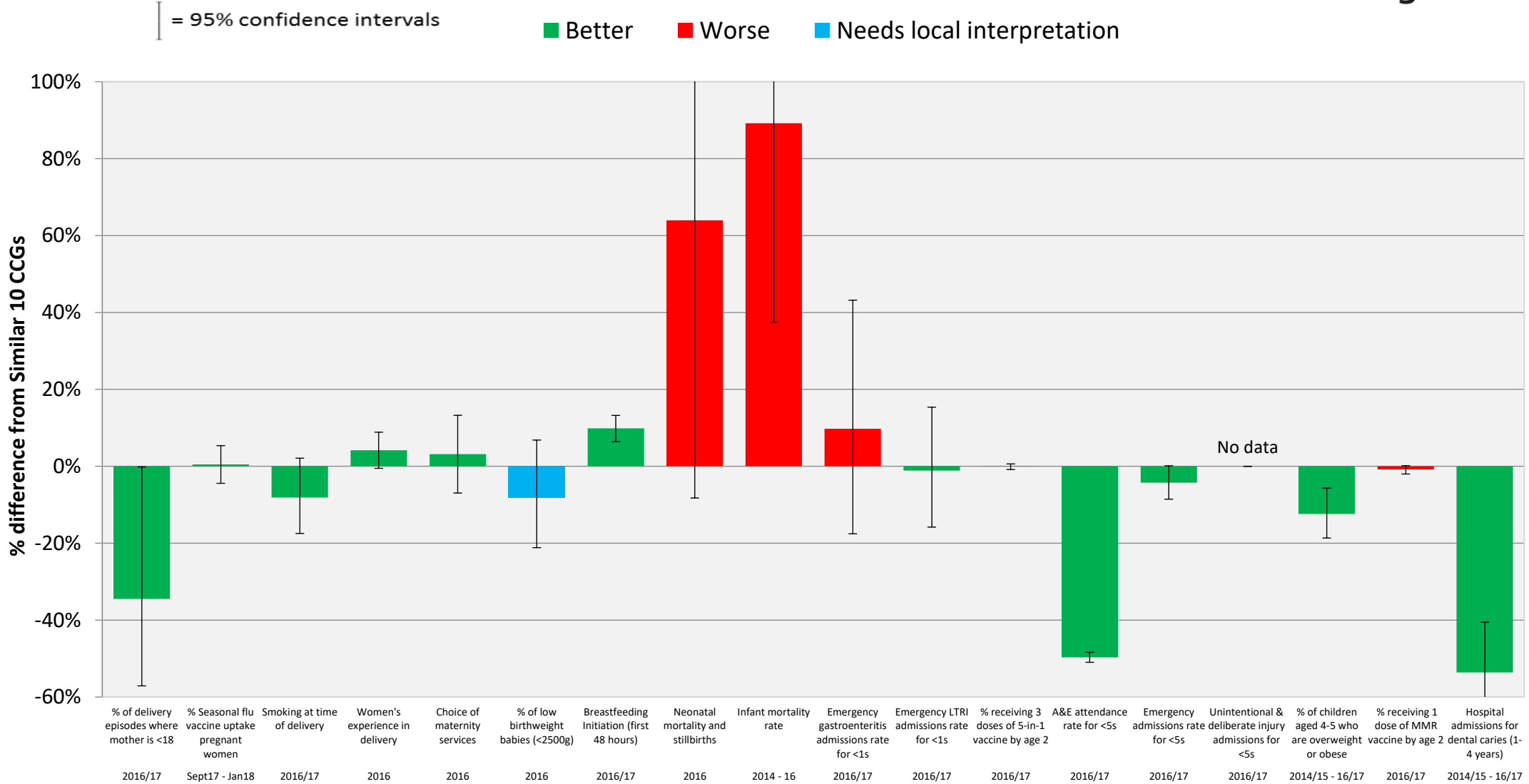
■ Better

■ Worse

■ Needs local interpretation



# Maternity and early years pathway



## 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.

In general where a high CCG value is considered 'worse' then it is calculated using the formula:

$$\text{Potential Opportunity} = (\text{CCG Value} - \text{Benchmark Value}) * \text{Denominator}$$

The denominator is the most suitable population data for that indicator e.g. 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, i.e. 12,000 becomes 12.

The difference between the CCG value and the benchmark is stated as statistically significant when the CCG's 95% confidence intervals do not overlap with the benchmark value.

For FY 2017/18 the decision was made to include more chemicals in the cerebrovascular prescribing indicator than in the equivalent 2016/17 indicator, in order to make it more representative of prescribing to manage cerebrovascular disease in primary care. With the addition of the newly included BNF subchapters (see metadata for detail) the spend on this area has increased significantly across CCGs, therefore this spend is not comparable to previous year's indicator for primary care prescribing on cerebrovascular disease.

## Annex: Additional guidance on the data in this pack

### QOF data suppression:

Please note that the following CCGs have opted out of producing Quality and Outcomes Framework data, and therefore have had their data suppressed for all QOF indicators in this pack:

- Dudley CCG (05C)
- Tower Hamlets CCG (08V)
- Somerset CCG (11X)
- Aylesbury Vale CCG (10Y) - now combined with Chiltern CCG (10H) to form Buckinghamshire CCG (14Y), therefore QOF data is suppressed for both Aylesbury Vale and Chiltern CCGs.

### Methodology of merged CCG data:

Inpatient and prescribing data has been extracted for the new 195 CCG configuration. Quality and outcome indicators are still published at the previous 207 CCG configuration so data for merged CCGs has been aggregated into the new configurations and the confidence intervals have been recalculated.

## Further information

- NHS RightCare tools, methodology and full details of all the data used in this pack are available on the Intelligence pages of the [NHS RightCare website](#).
- If you have any questions about this pack or require any further information and support you can email us directly at [england.healthinvestmentnetwork@nhs.net](mailto:england.healthinvestmentnetwork@nhs.net).
- For more general information about how to use the NHS RightCare approach to get best value for your population, visit the [NHS RightCare website](#), email [rightcare@nhs.net](mailto:rightcare@nhs.net), tweet [@nhsrightcare](#), or follow our [LinkedIn page](#).