



Public Health
England

NHS

RightCare

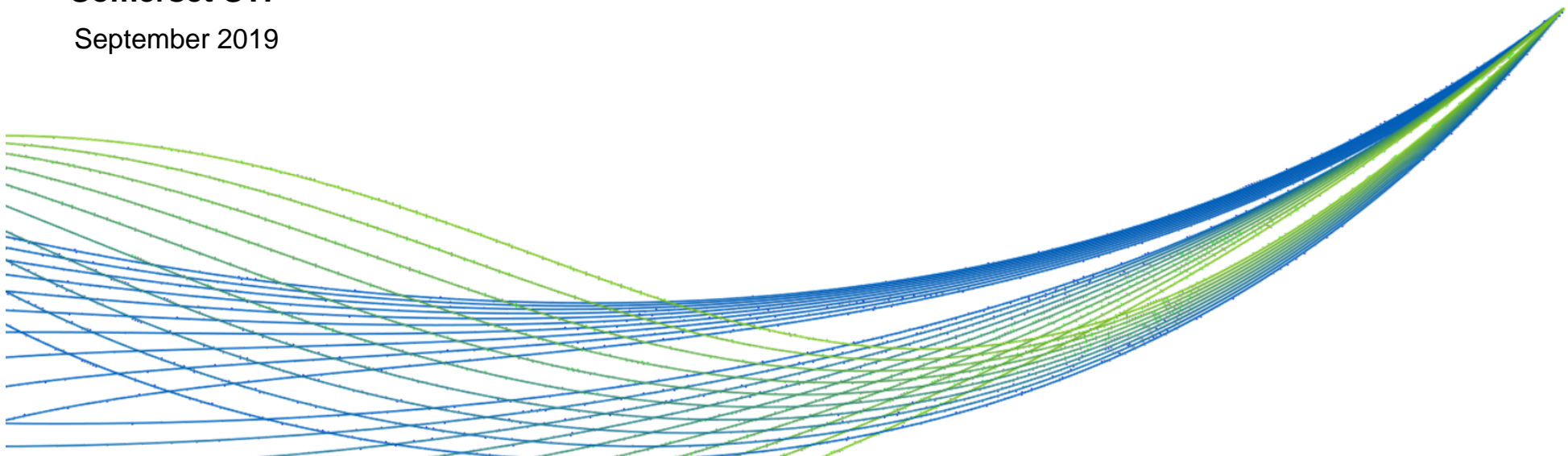
RightCare

Where to Look data pack

STP data (including CCG breakdown)

Somerset STP

September 2019



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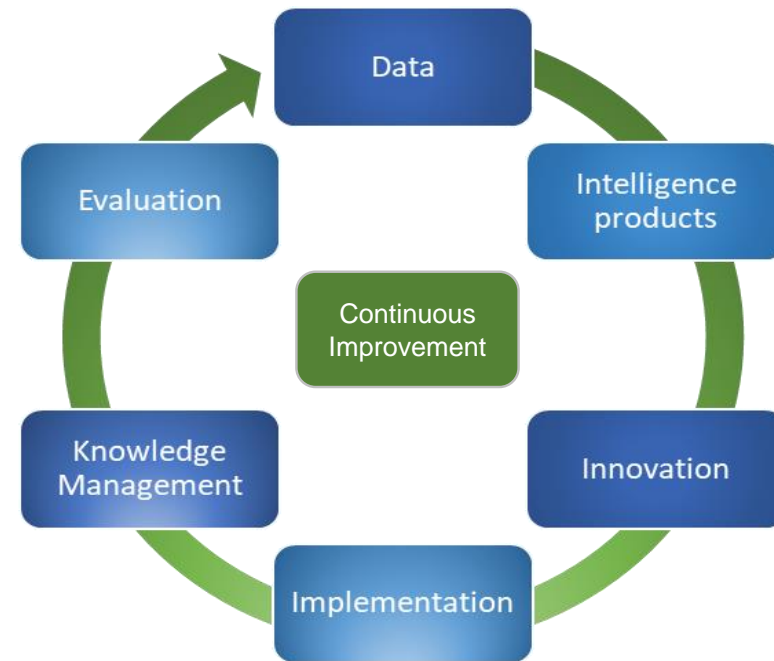
The RightCare programme

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

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 includes headline opportunities, improvement opportunity tables and slides showing how systems 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.

This pack contains programme level indicators to show system level performance across the nine main programme areas that are presented by NHS RightCare. There are also charts to show how systems are performing in quality and outcomes indicators across these programmes, compared to the best or lowest five of their similar 10 CCGs. As well as these comparison charts, there are also grid charts demonstrating CCG performance along treatment pathways, designed to show opportunities for programme improvement on a wider scale. These 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:

- CCG opportunity charts: Previously in STP level packs, the data was not shown at CCG level at any point. In this pack, for each STP level opportunity chart there is a corresponding CCG level chart to show how opportunities are split across the CCGs within the STP.
- 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 STP and its CCGs.
- 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%

Somerset STP - Similar 10 CCG Groups

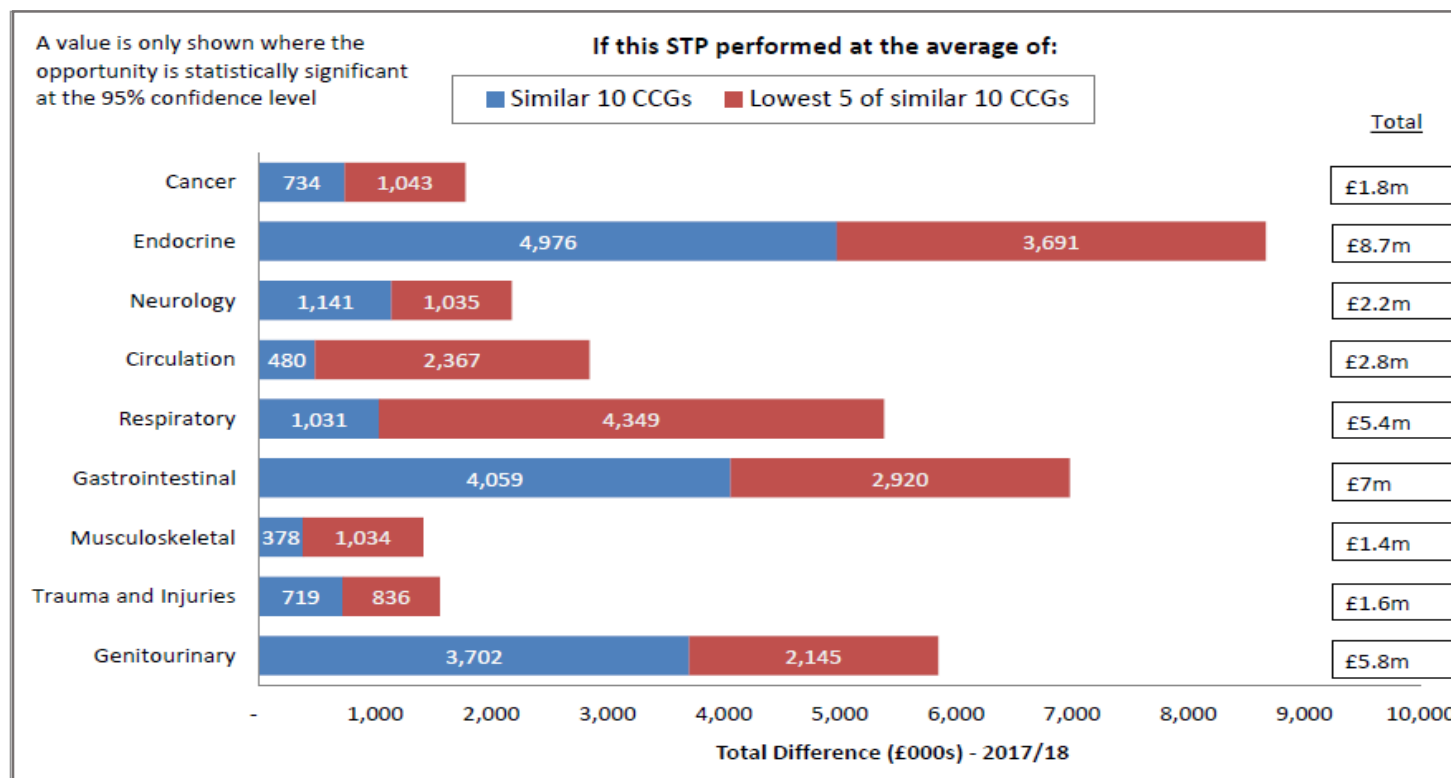


CCG within STP	Similar CCG 1	Similar CCG 2	Similar CCG 3	Similar CCG 4	Similar CCG 5	Similar CCG 6	Similar CCG 7	Similar CCG 8	Similar CCG 9	Similar CCG 10
NHS Somerset CCG	Wiltshire	Ipswich and East Suffolk	Kernow	Gloucestershire	Coastal West Sussex	Shropshire	Dorset	Northumberland	South Worcestershire	Morecambe Bay

The above table shows the Similar 10 CCGs for each of the CCGs within this STP, with Similar CCG 1 being the most similar to the original CCG.

Interpreting STP Opportunity Charts

How different are we on spend on primary care prescribing?

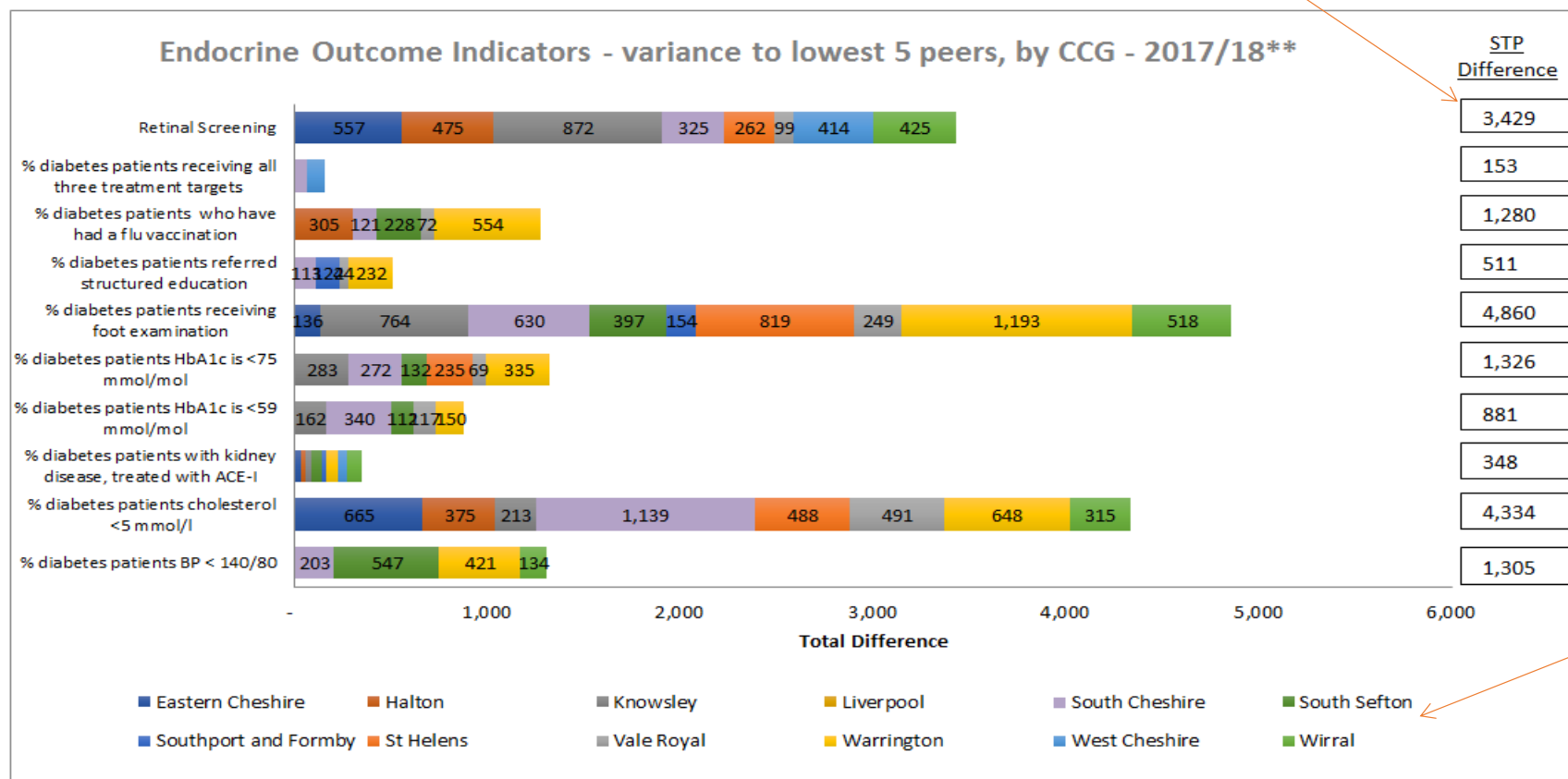


Total Statistically Significant STP Opportunity to Lowest or Best 5.

The STP Opportunity Chart above shows the total statistically significant opportunity for a range of indicators comparing each CCG in the STP to the average of its Similar 10 CCGs and the average of its Lowest or Best 5 CCGs in that indicator. The blue portion of the bar shows the cumulative opportunity for each of the CCGs in this STP compared to their Similar 10 CCGs in that programme. The red portion of the bar shows the additional opportunity for the STP if each CCG performed at the rate of the Lowest or Best 5 of their Similar 10 CCG. The white box at the end of the row then shows a summed total opportunity.

Interpreting the CCGs in STP Opportunity Charts

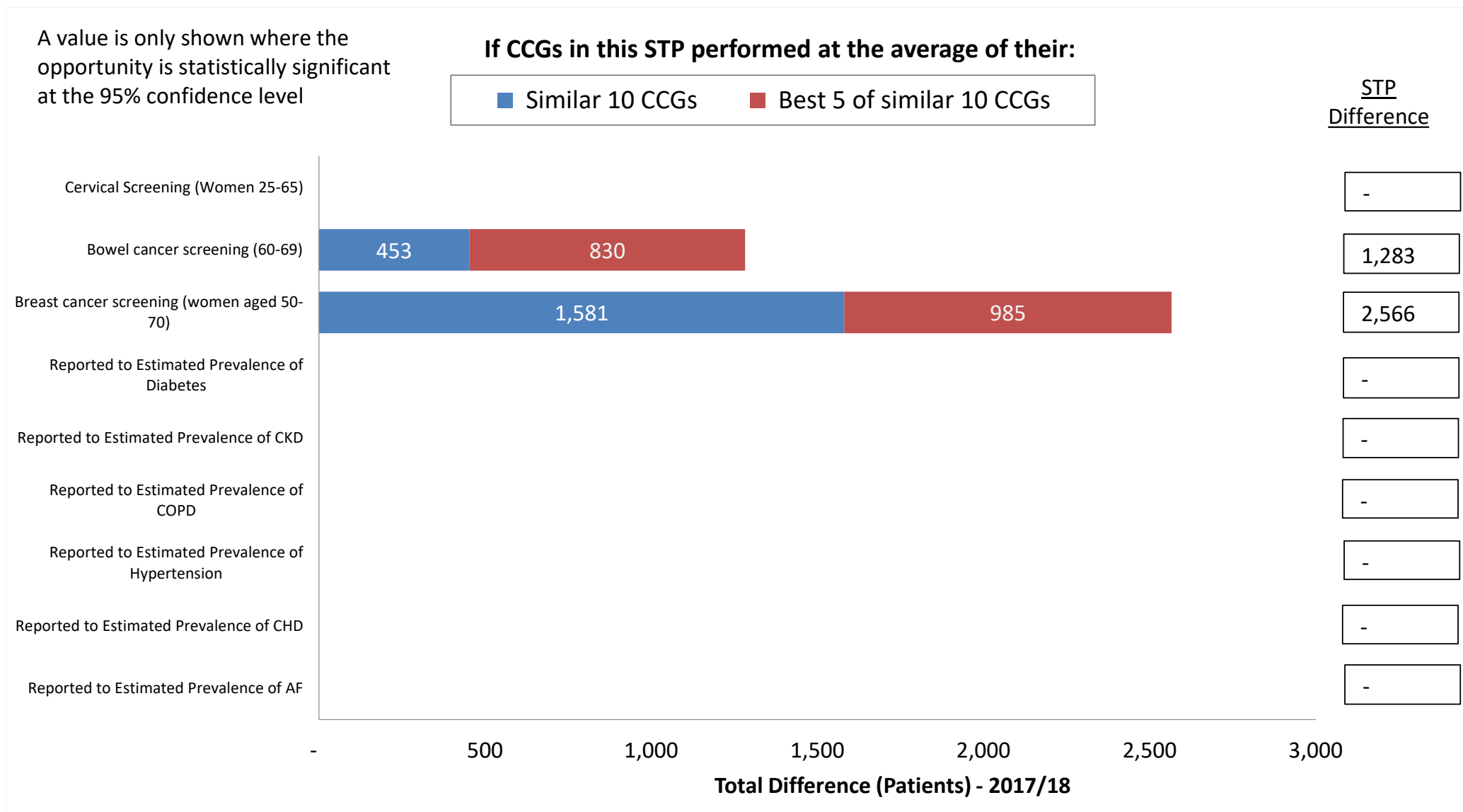
Total Statistically Significant STP Opportunity to Lowest or Best 5.



Key of CCGs:
Read across the first row, then the second row, etc.

The CCGs in STP Opportunity Chart above shows the statistically significant opportunity for a range of indicators for each CCG within an STP, to the average of their Lowest or Best 5 CCGs in that indicator. Each different coloured section of the bar represents a different CCG within this STP and the opportunity that each CCG has to its lowest five is labelled on the bar. The white box at the end of the row then shows a summed total opportunity for the STP for that programme. Note that for some indicators with small opportunity values the data labels are removed for clarity, for example in the '% diabetes patients receiving all three treatment targets' indicator above. The full data for these values is available from your regional RightCare team or Delivery Partner.

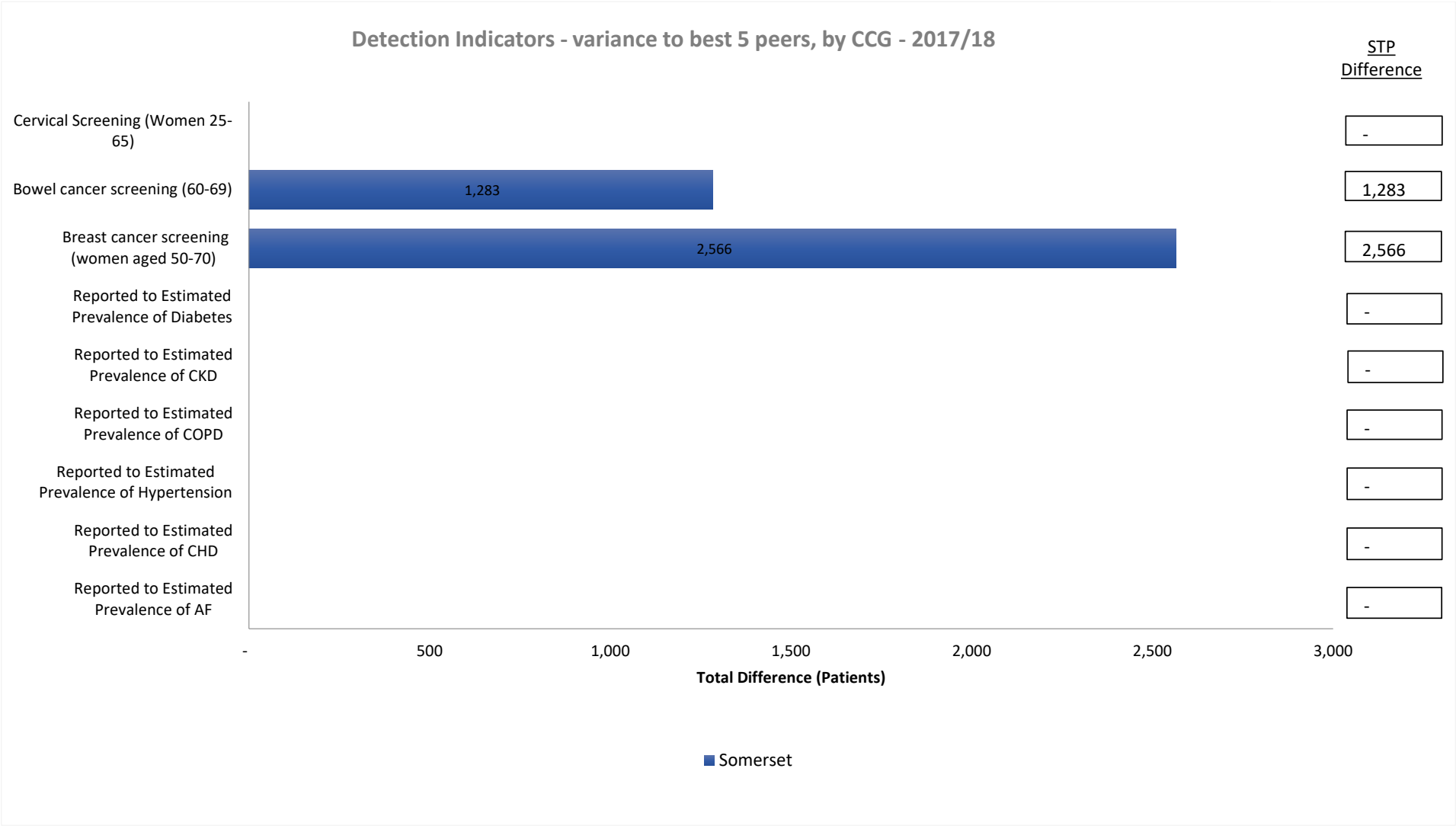
How different are we on detection?



See Page 78 Annex for additional guidance on indicators

Source: 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 detection?

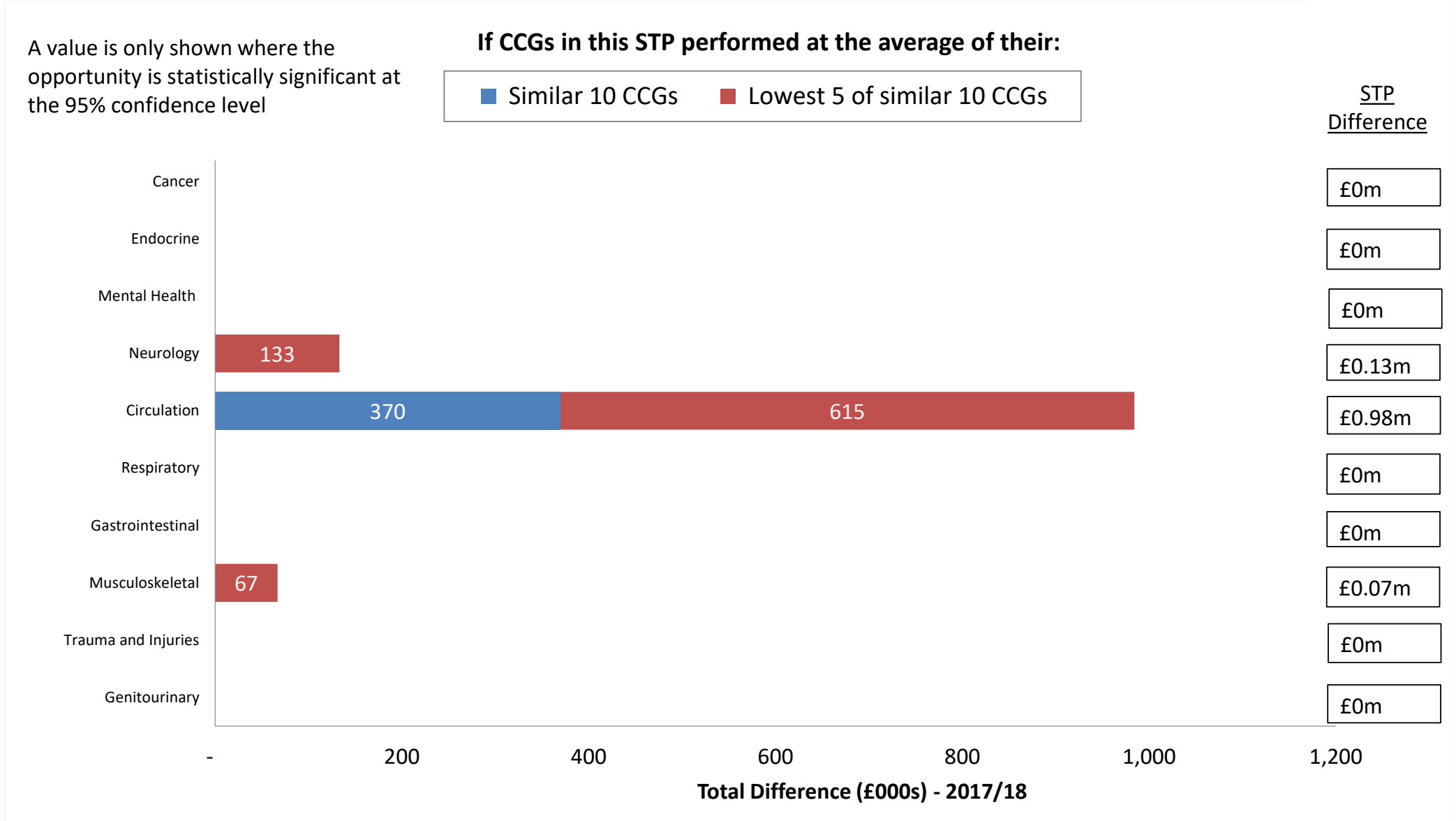


Please note that scale of opportunities will vary due to CCG size.

See Page 78 Annex for additional guidance on indicators

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

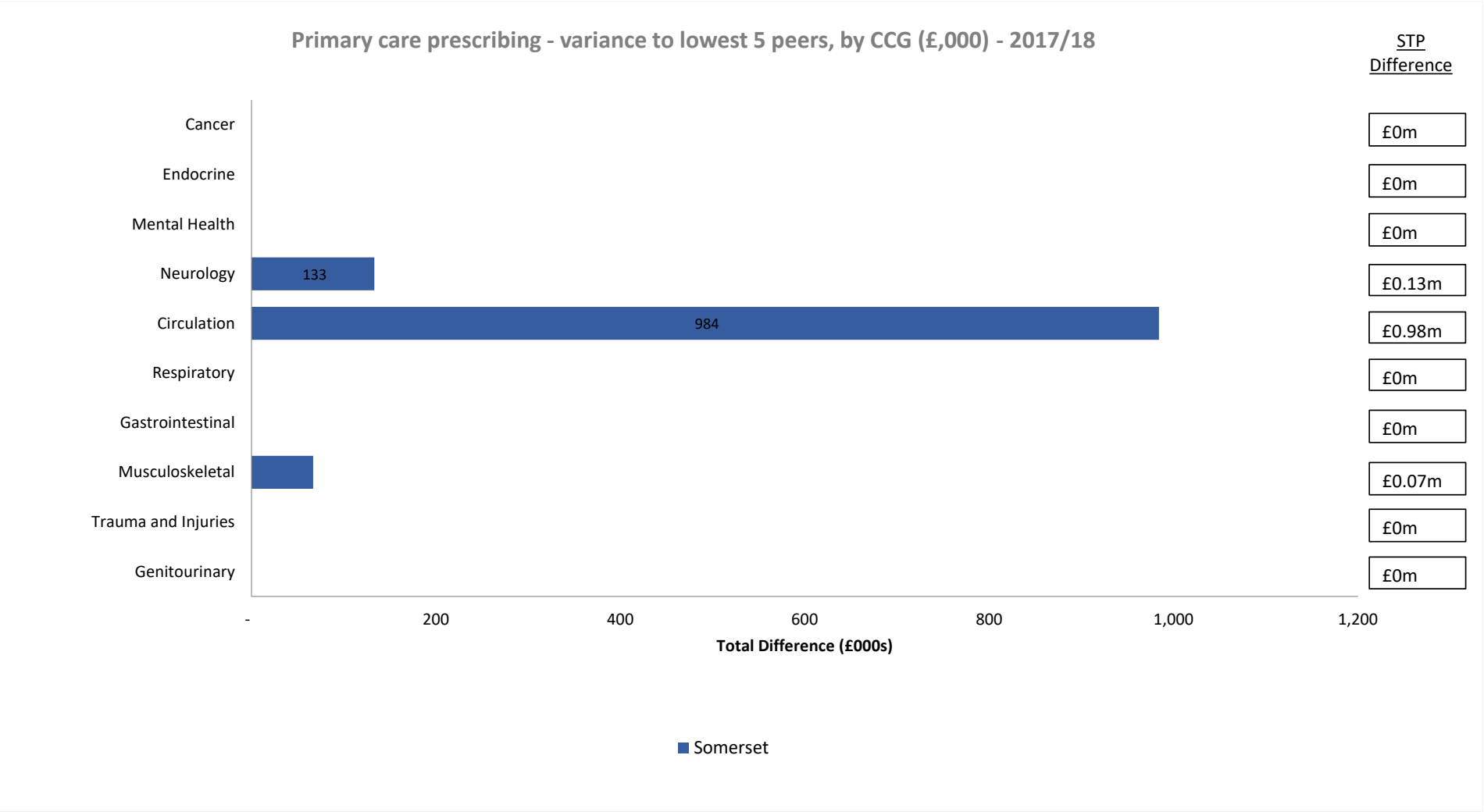
How different are we on spend on primary care prescribing?



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.

Source: Net Ingredient Cost data from ePACT, NHS Business Services Authority

How different are we on primary care prescribing spend?



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

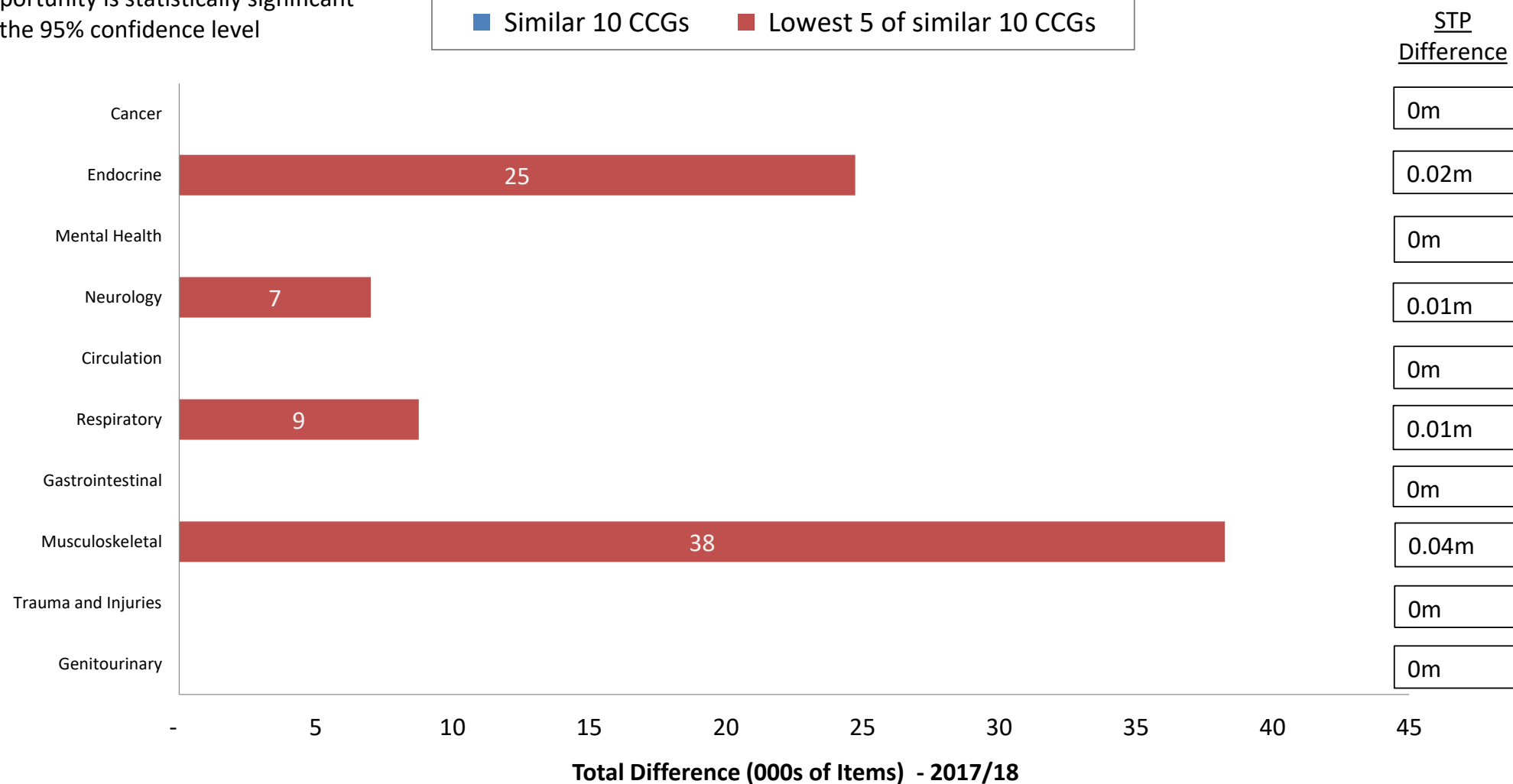
Please note that in certain instances the prescribing data will be influenced by factors such as shared care arrangements, direct procurement and prescribing that has been restricted to an acute setting. These factors will vary by CCG and therefore the quantified differences (calculated to “similar” CCGs) should be viewed within this context. Please speak to your medicines management team for further information on interpreting the prescribing data for your CCG, as some variation may in fact be warranted.

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 CCGs in this STP performed at the average of their:

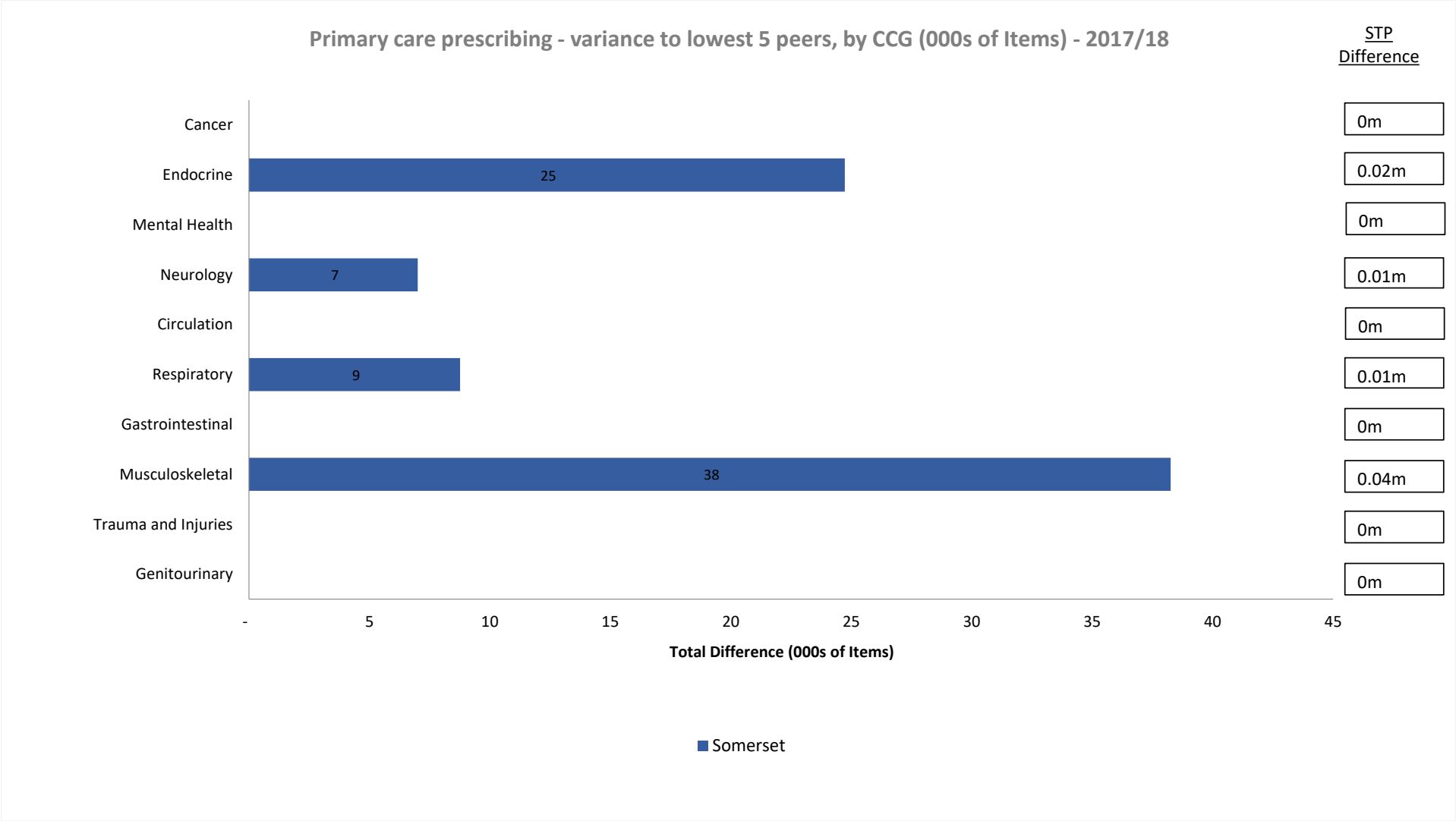
■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs



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.

Source: Items data from ePACT, NHS Business Services Authority

How different are we on primary care prescribing items?



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

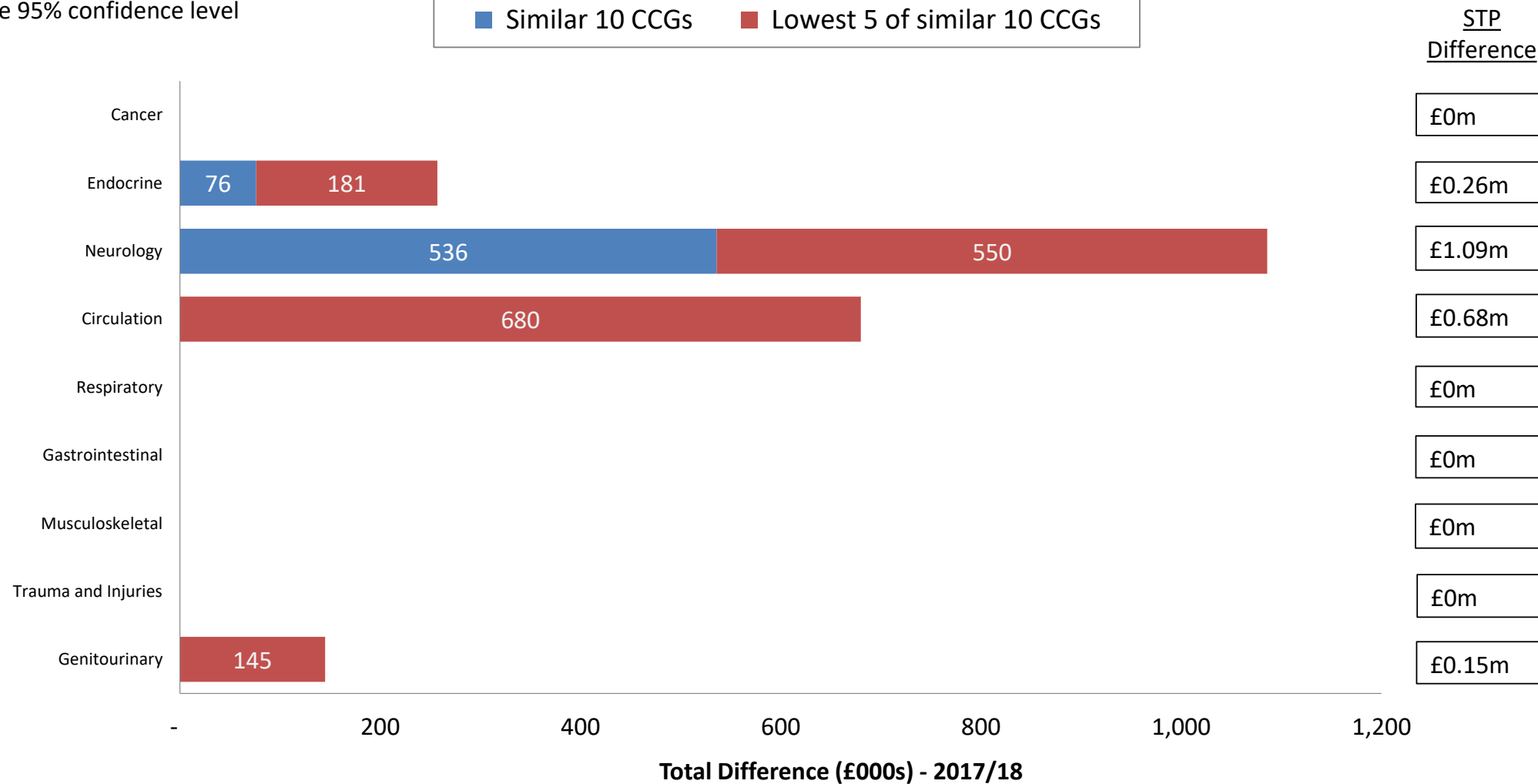
Please note that in certain instances the prescribing data will be influenced by factors such as shared care arrangements, direct procurement and prescribing that has been restricted to an acute setting. These factors will vary by CCG and therefore the quantified differences (calculated to “similar” CCGs) should be viewed within this context. Please speak to your medicines management team for further information on interpreting the prescribing data for your CCG, as some variation may in fact be warranted.

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 CCGs in this STP performed at the average of their:

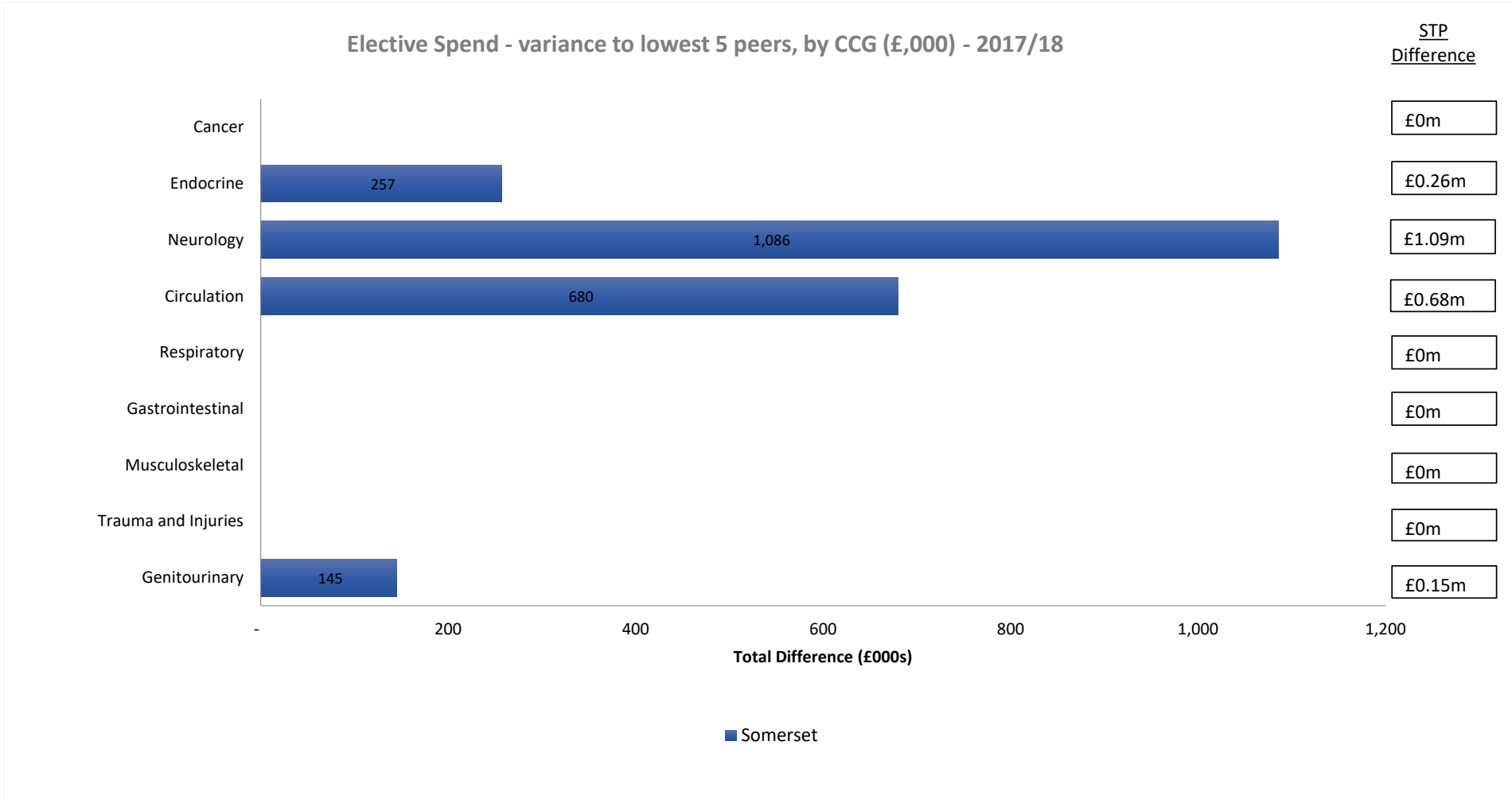
■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs



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.

Source: National Commissioning Data Repository – Hospital Admissions Databases,
SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 15/08/18

How different are we on elective spend?



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

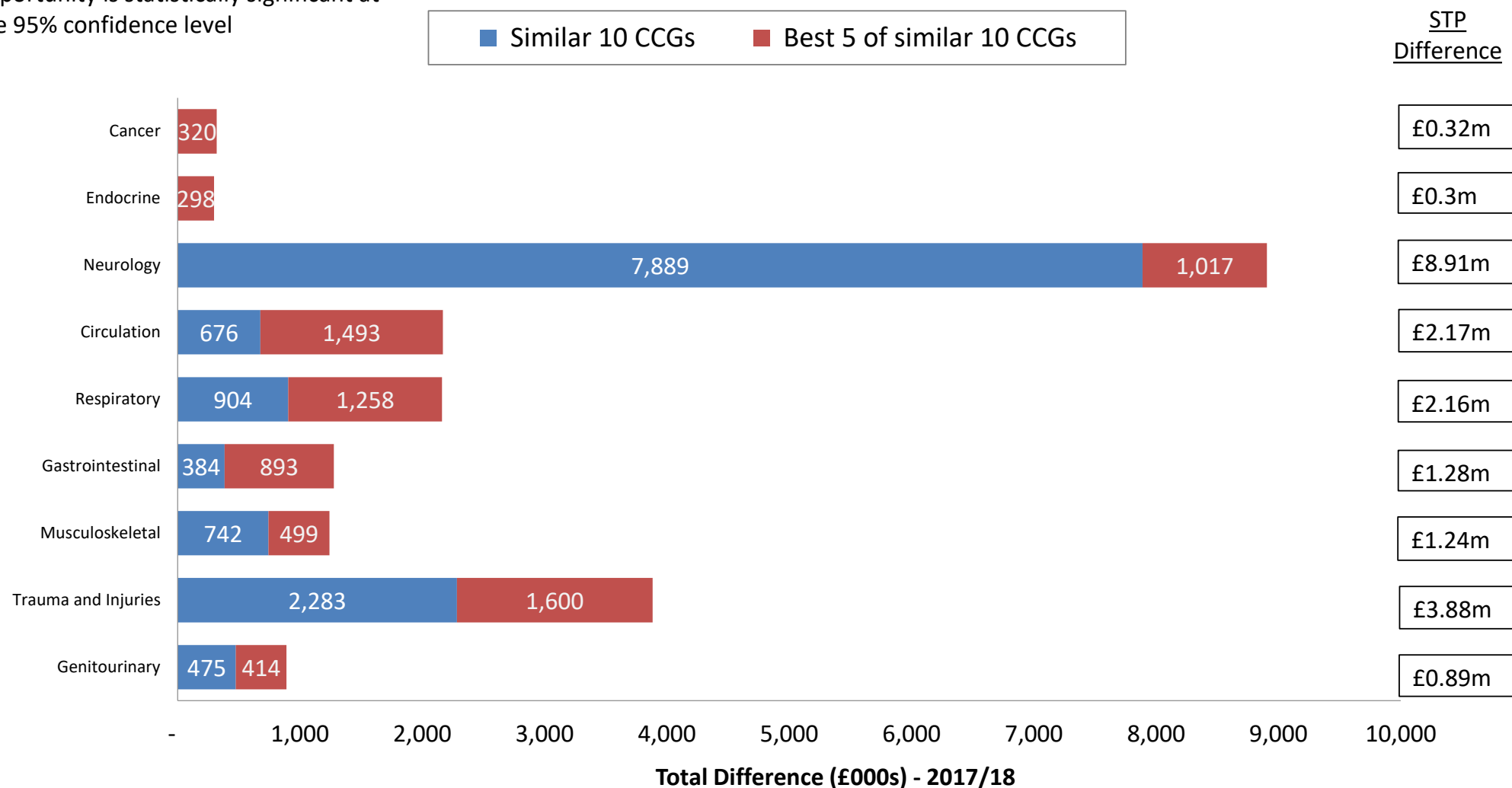
Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 15/08/18

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 CCGs in this STP performed at the average of their:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs

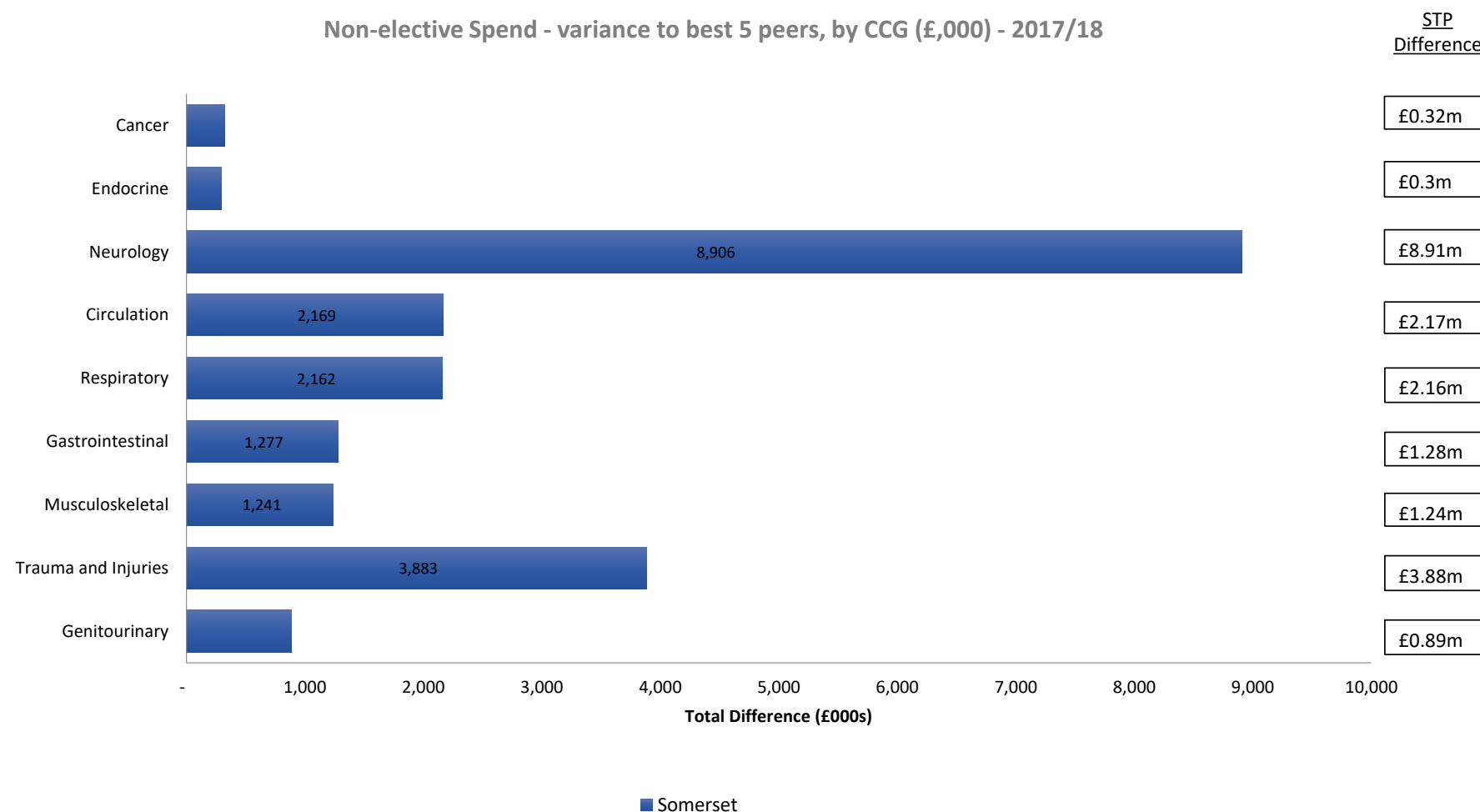


The calculations in this slide are based on admission for any primary care diagnoses that fall under the listed conditions (based on Programme Budgeting classifications). This only includes expenditure on admissions covered by the mandatory payment by results tariff and includes NHS England Direct Commissioning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

Source: National Commissioning Data Repository – Hospital Admissions Databases,
SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 15/08/18

How different are we on non-elective spend?

Non-elective Spend - variance to best 5 peers, by CCG (£,000) - 2017/18



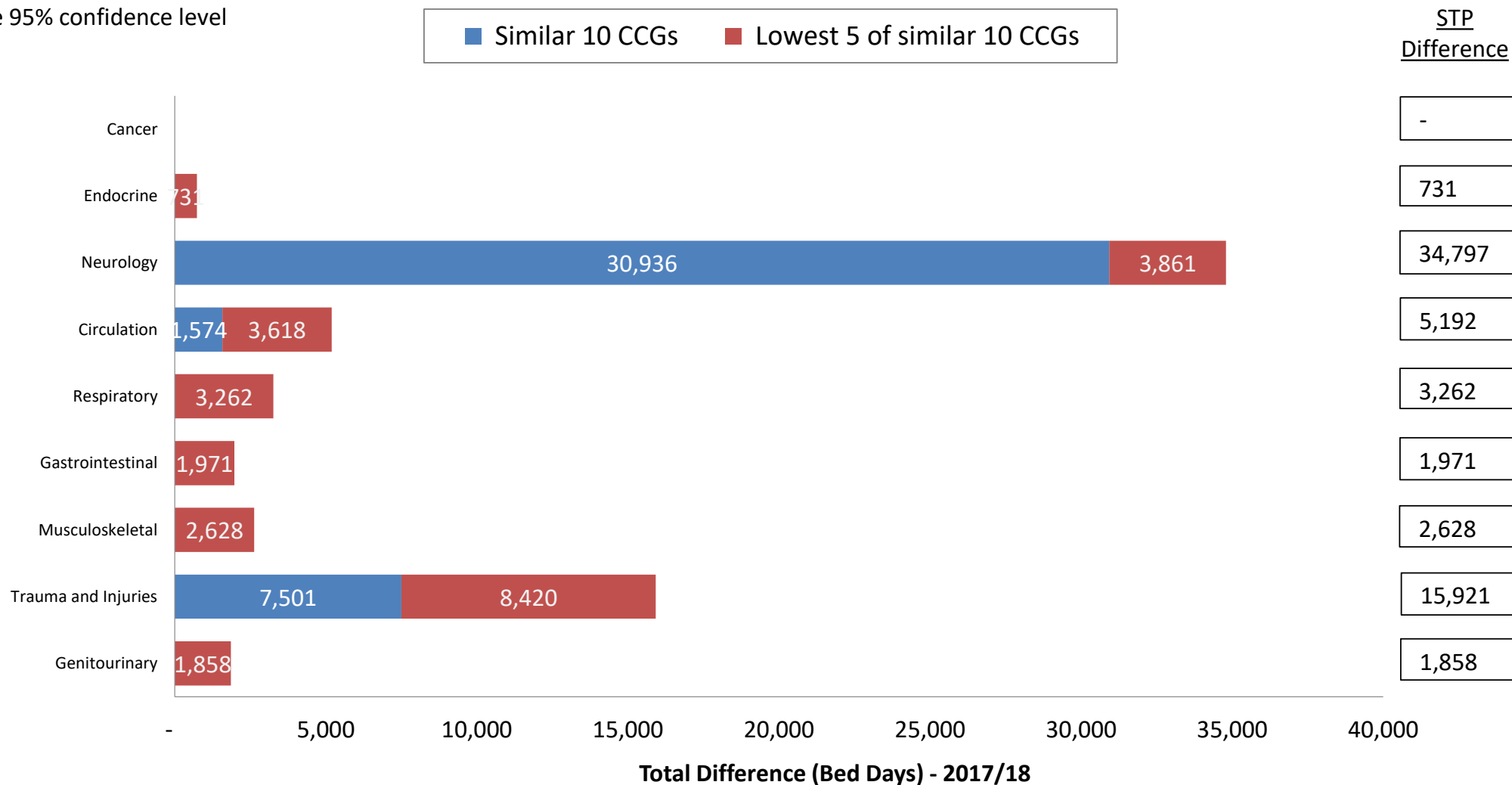
Please note that scale of opportunities will vary due to CCG size.

How different are we on bed days?

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

If CCGs in this STP performed at the average of their:

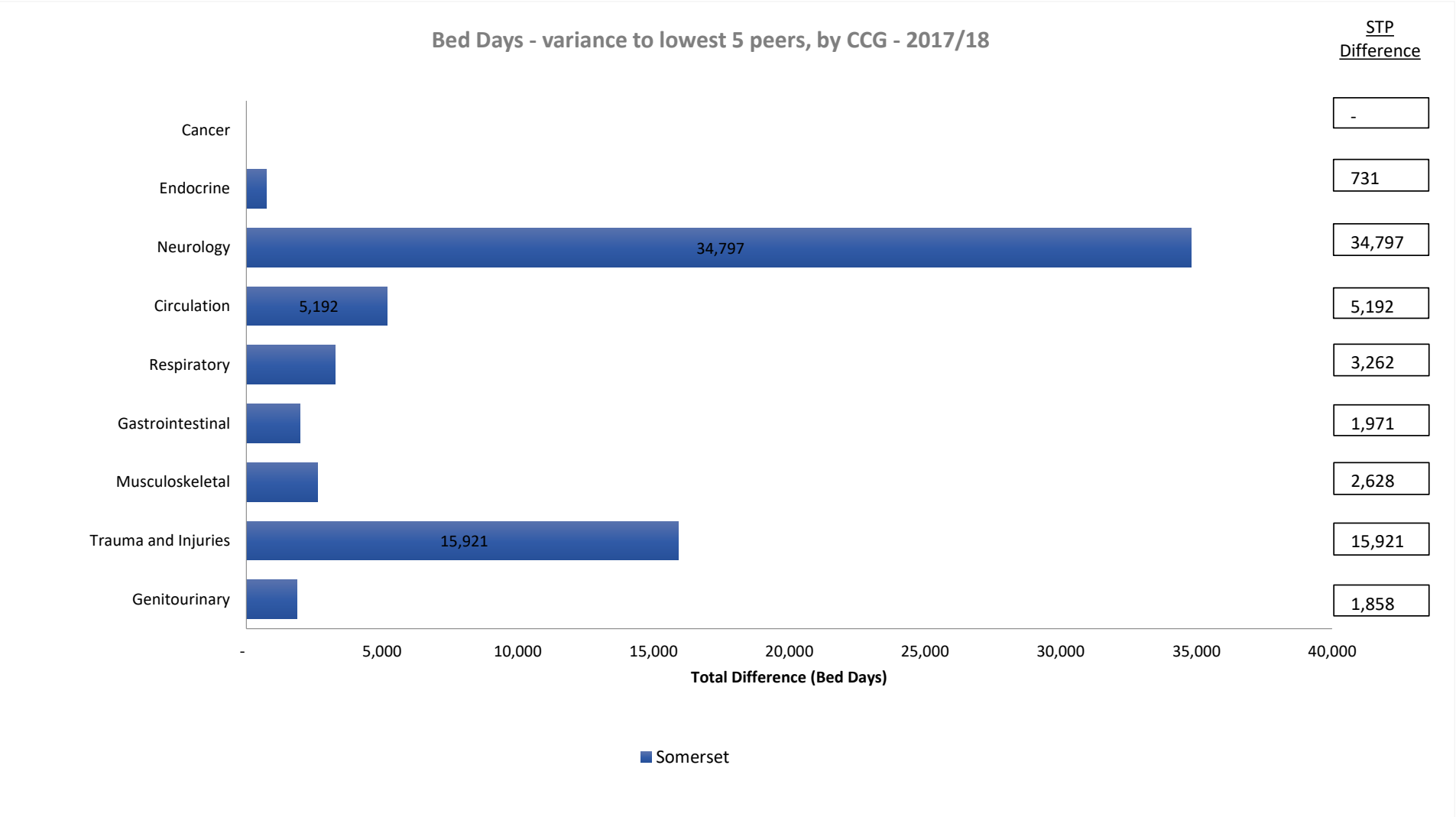
■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs



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.

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 15/08/18

How different are we on bed days?



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

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - Correct as of extract 15/08/18

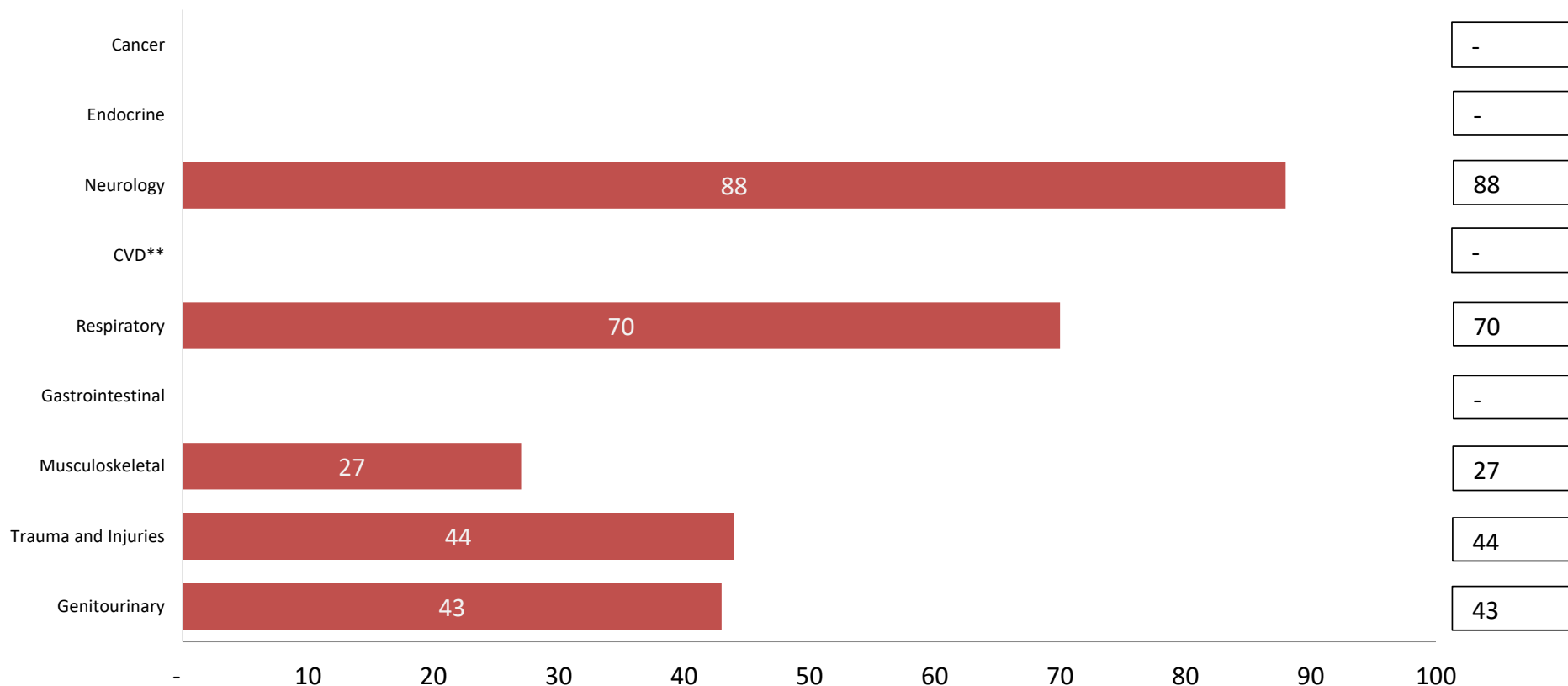
How different are we on long stay patients*?

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

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs ■ Lowest 5 of similar 10 CCGs

STP
Difference

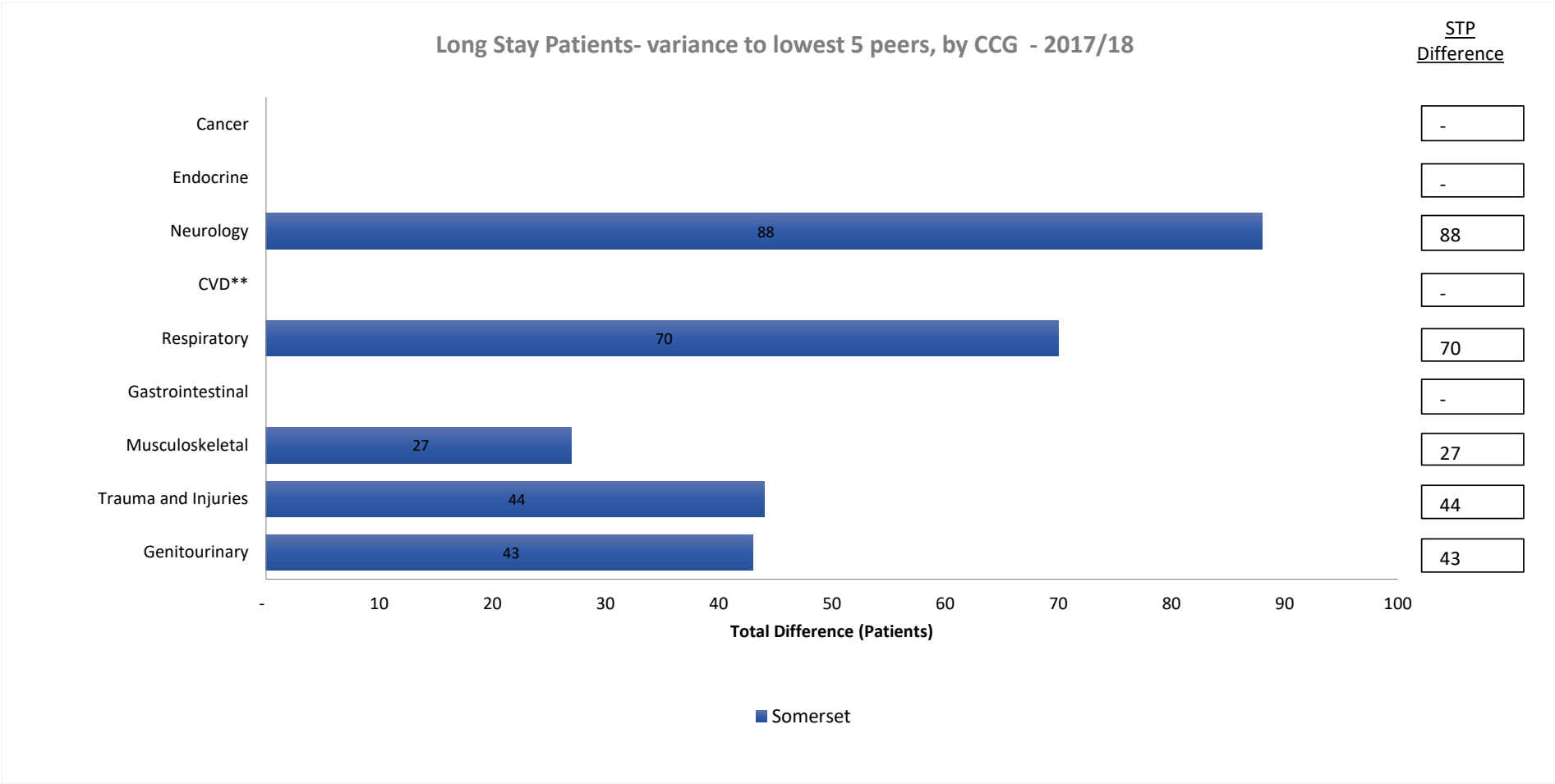


*Long Stay Patients are defined as having a hospital admission 21 days or longer.

Total Difference (Patients) - 2017/18

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

How different are we on long stay patients*?



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

*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.

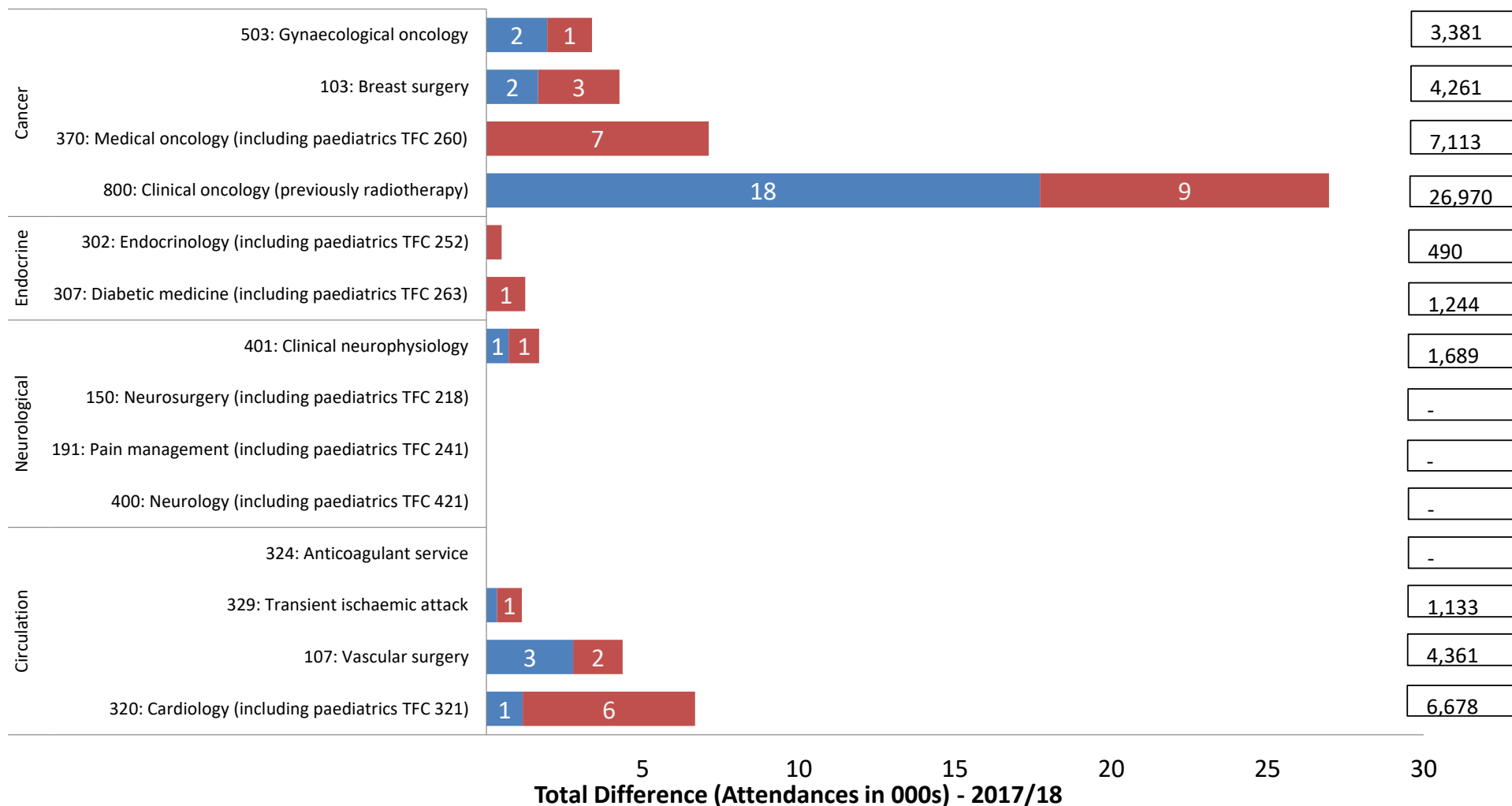
How different are we on outpatient attendances?

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

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs ■ Lowest 5 of Similar CCGs

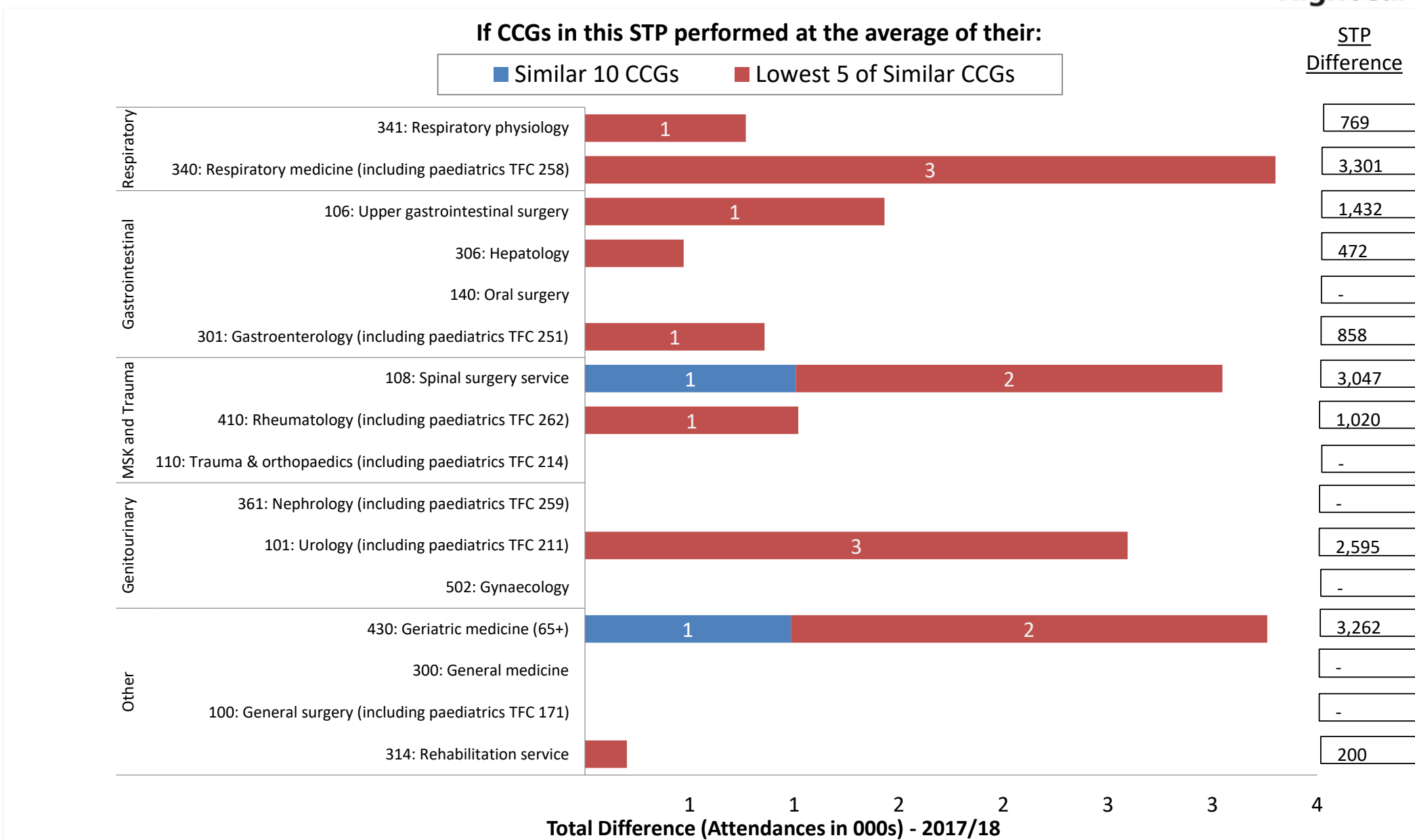
STP
Difference



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

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

How different are we on outpatient attendances?

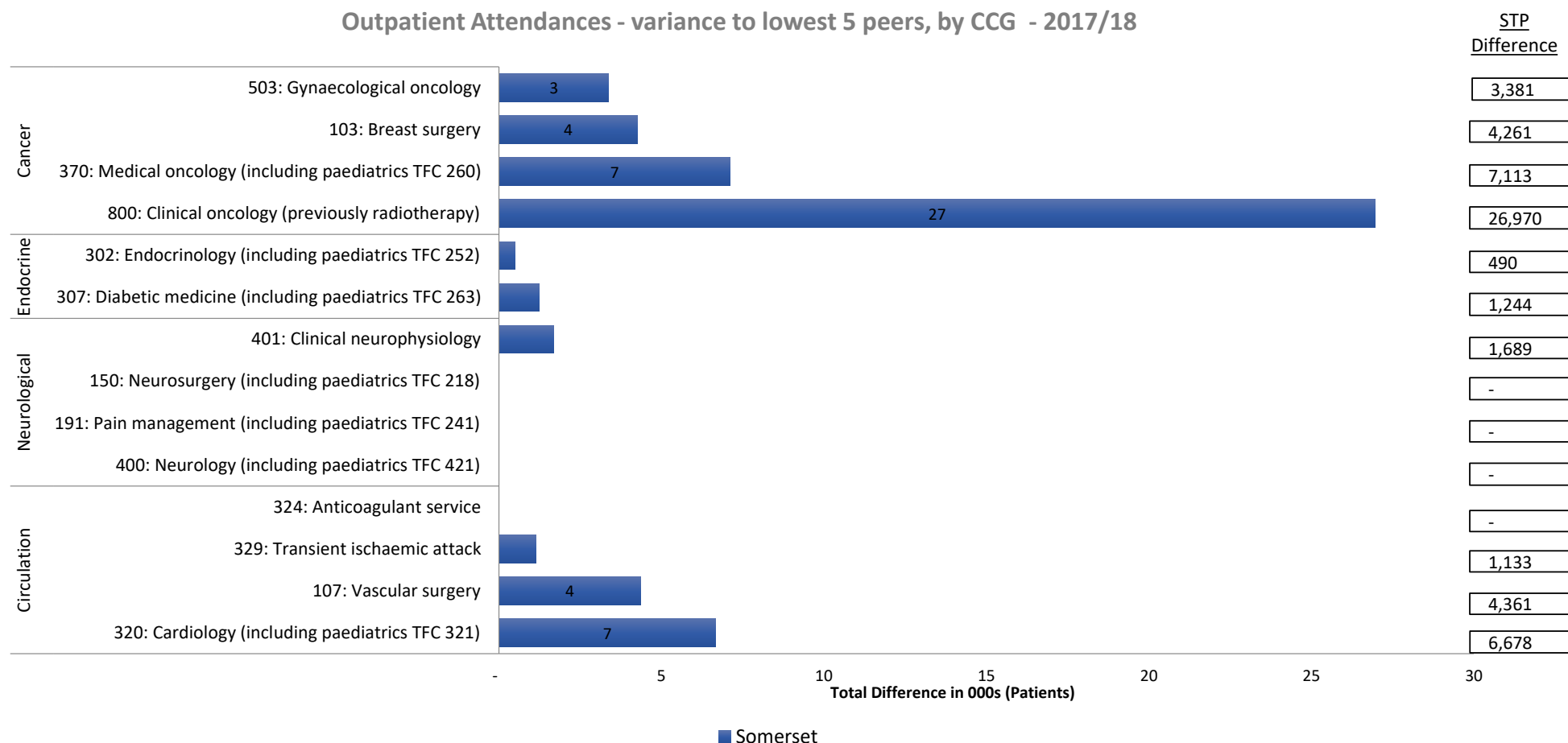


Please also note that indicators are shown in thousands on the chart, with full opportunities in the total STP difference cell.

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

How different are we on outpatient attendances?

Outpatient Attendances - variance to lowest 5 peers, by CCG - 2017/18



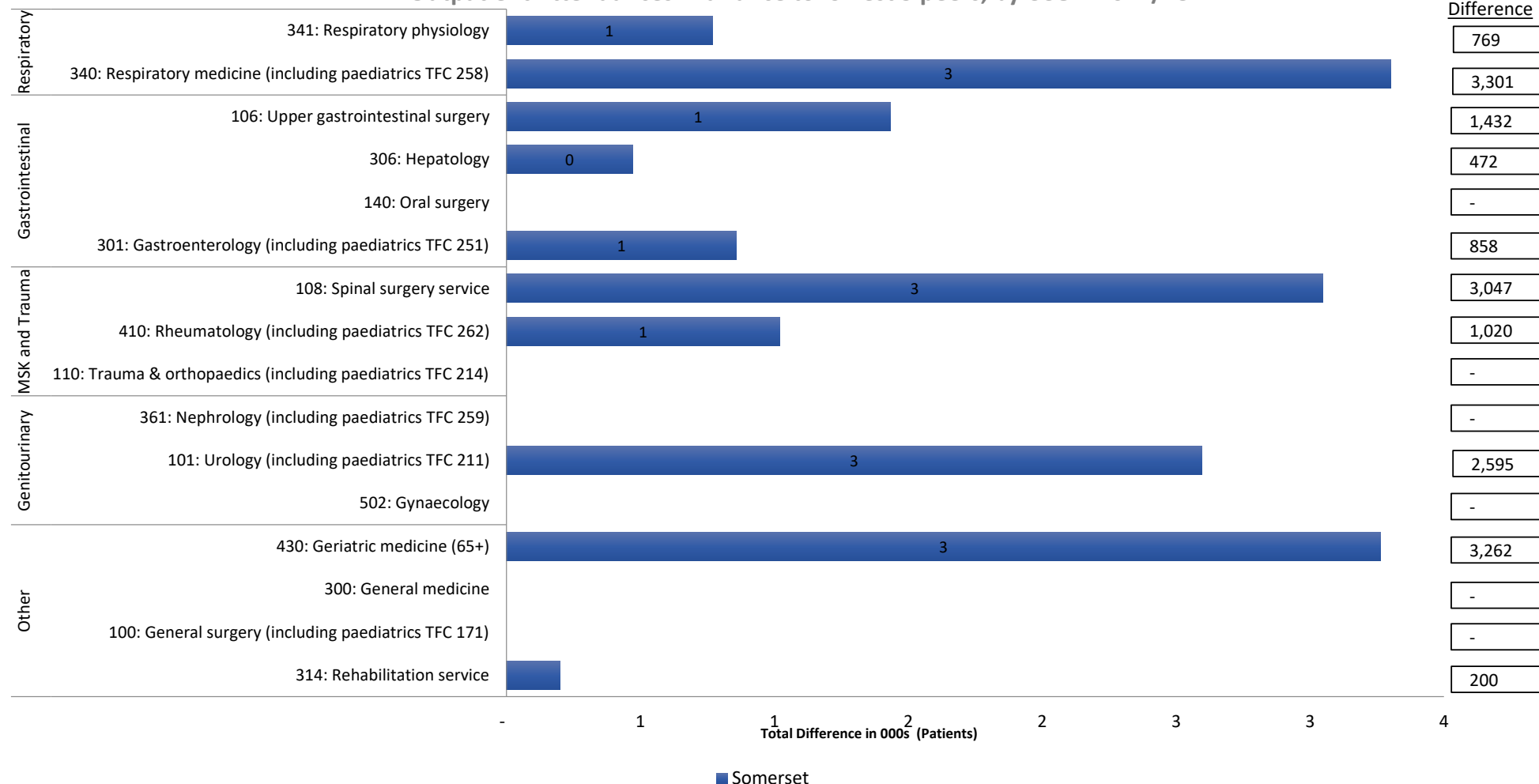
Please note that scale of opportunities will vary due to CCG size. Please also note that indicators are shown in thousands on the chart, with full opportunities in the total STP difference cell.

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart)

Somerset STP

How different are we on outpatient attendances?

Outpatient Attendances - variance to lowest 5 peers, by CCG - 2017/18



Please note that scale of opportunities will vary due to CCG size. Please also note that indicators are shown in thousands on the chart, with full opportunities in the total STP difference cell.

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart)

Somerset STP

Quality and Outcomes Opportunities

The following slides look at outcome indicators across programmes, both at cumulative STP level and opportunities within specific CCGs. These show how an STP is performing across outcomes built on comparing each of its CCGs to its Best 5 Similar CCGs.

Previously these quality and outcome opportunities were presented in the form of a cumulative STP 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

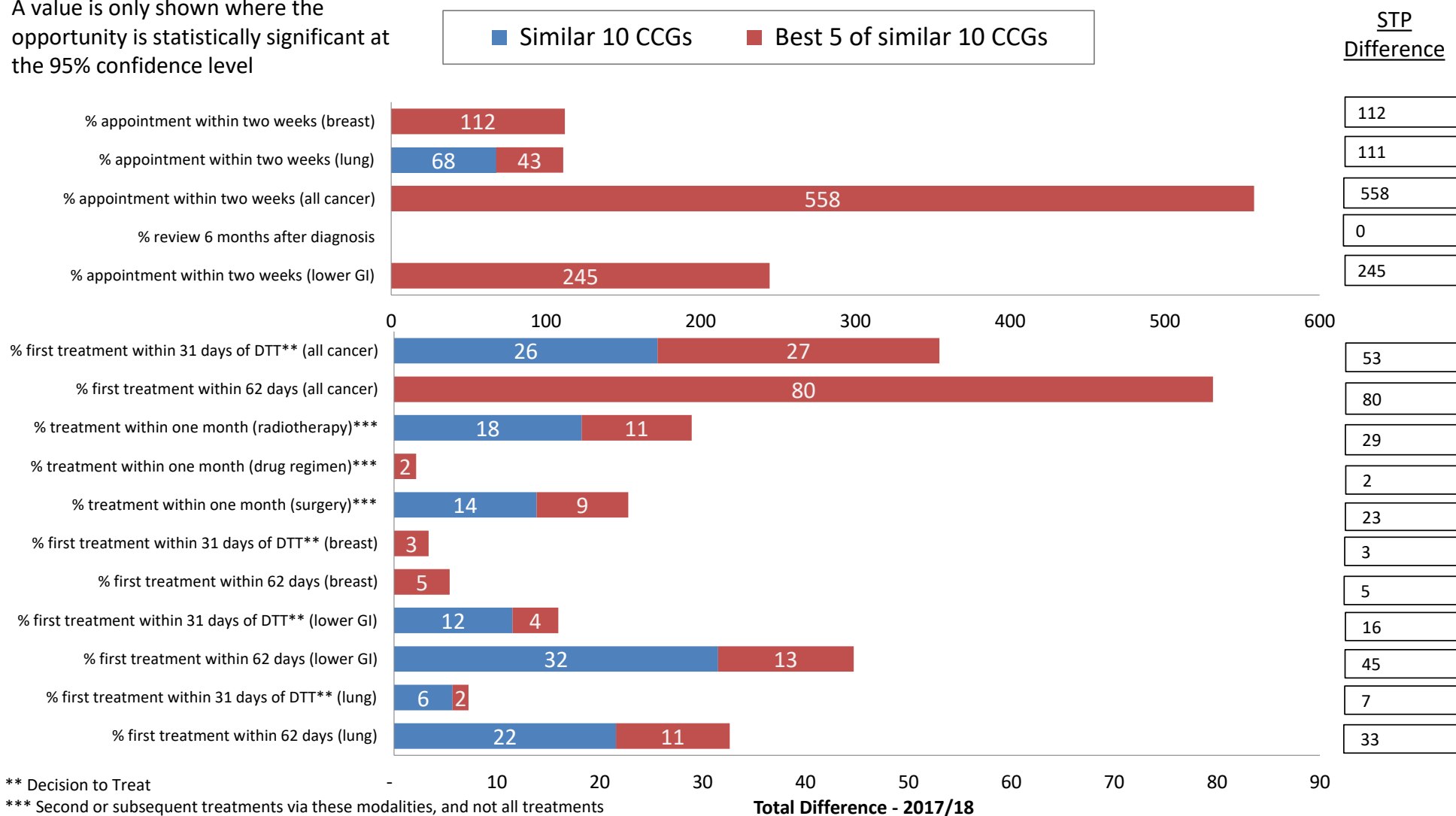
The mortality indicators included in this latest data pack were restricted due to the limited availability of accurate, up to date, CCG level mortality data. NHS RightCare and NHS England are currently in communication with other NHS agencies and the Office for National Statistics (ONS) to source the 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?

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs

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



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.

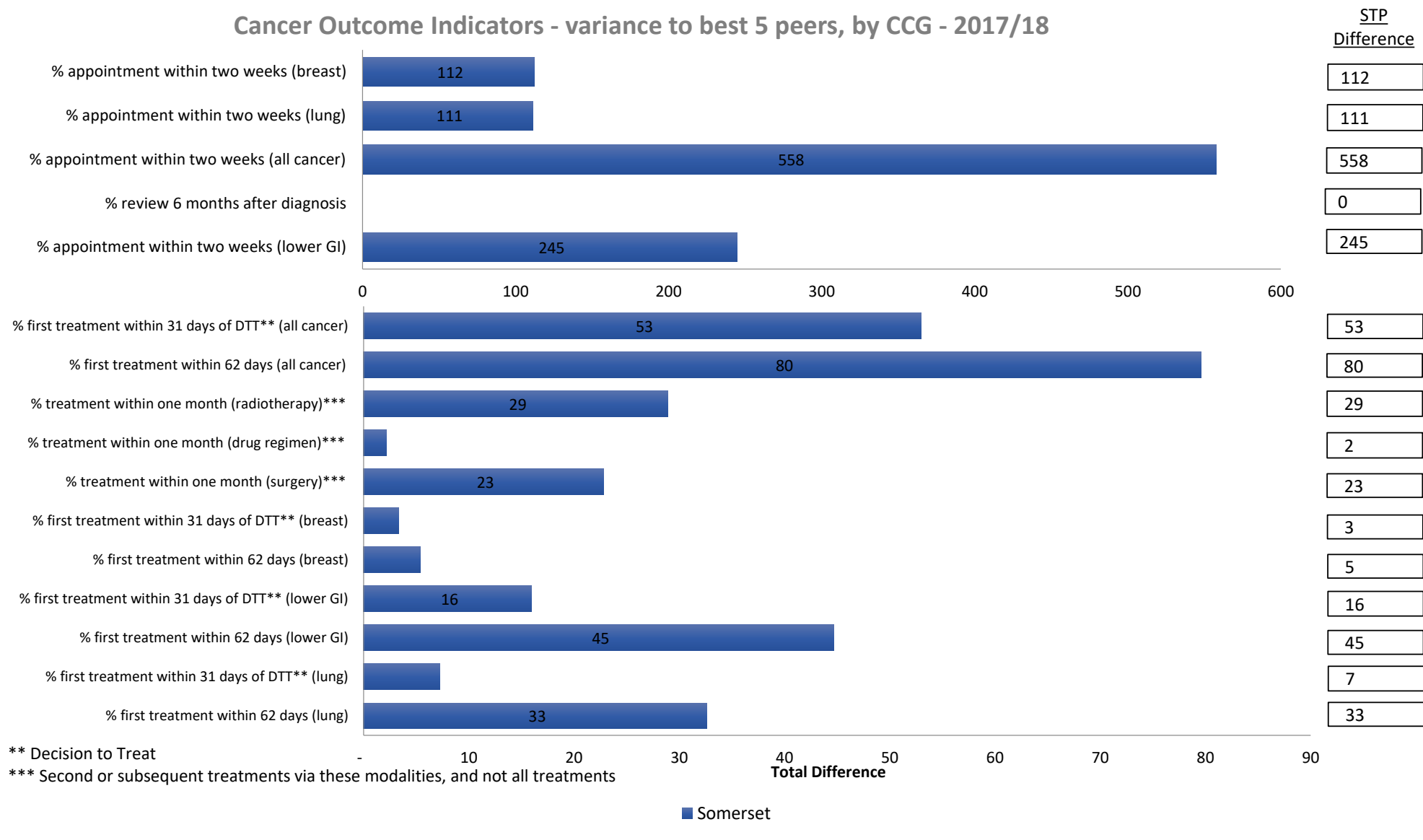
Sources: NHS England Cancer Waiting Times Database,
PHE Fingertips Cancer Services,
Quality and Outcomes Framework (QOF), NHS Digital

*See Page 78 Annex for additional guidance on indicators

Somerset STP

How different are we on cancer quality and outcome indicators?

Cancer Outcome Indicators - variance to best 5 peers, by CCG - 2017/18



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.

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

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

*See Page 78 Annex for additional guidance on indicators
Somerset STP

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

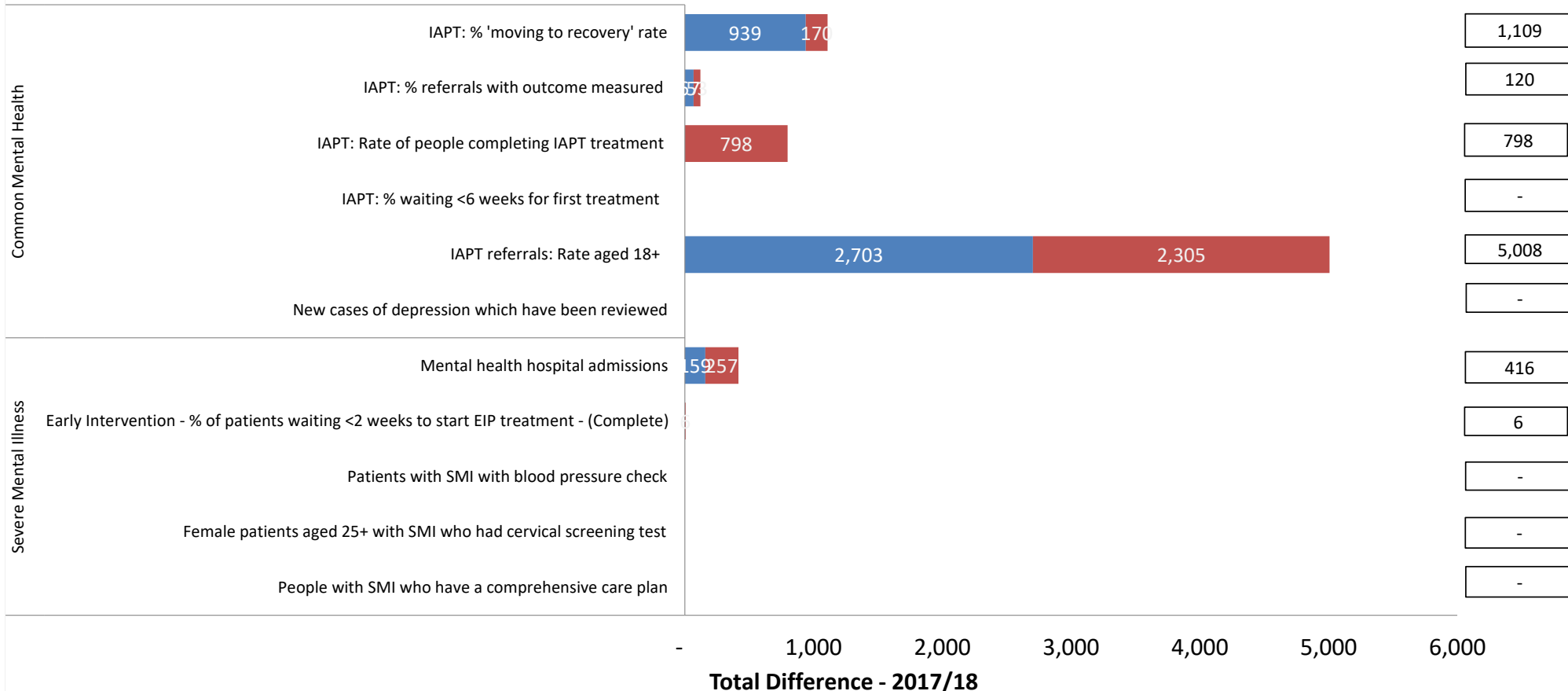
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If CCGs in this STP performed at the average of their:

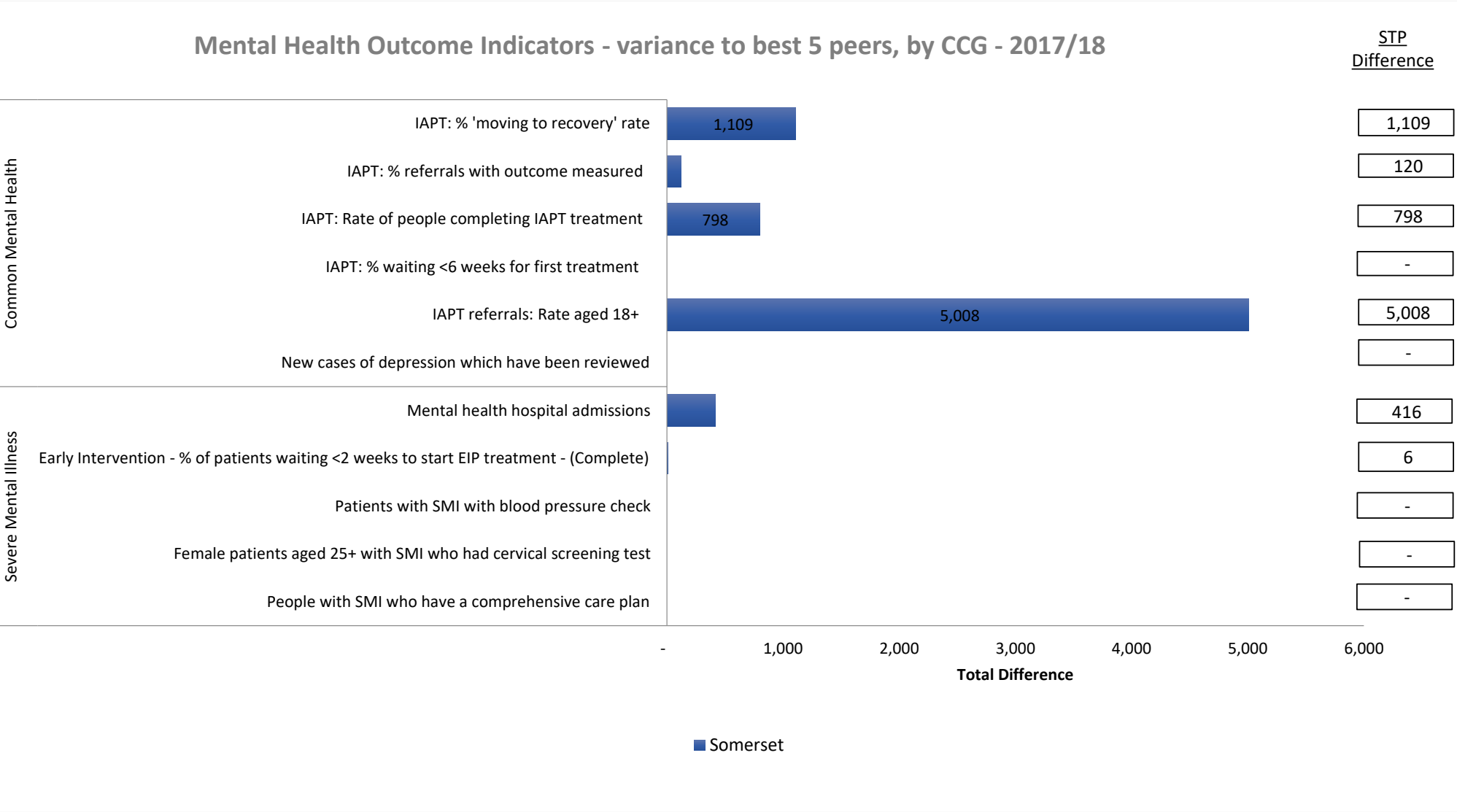
■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

STP
Difference



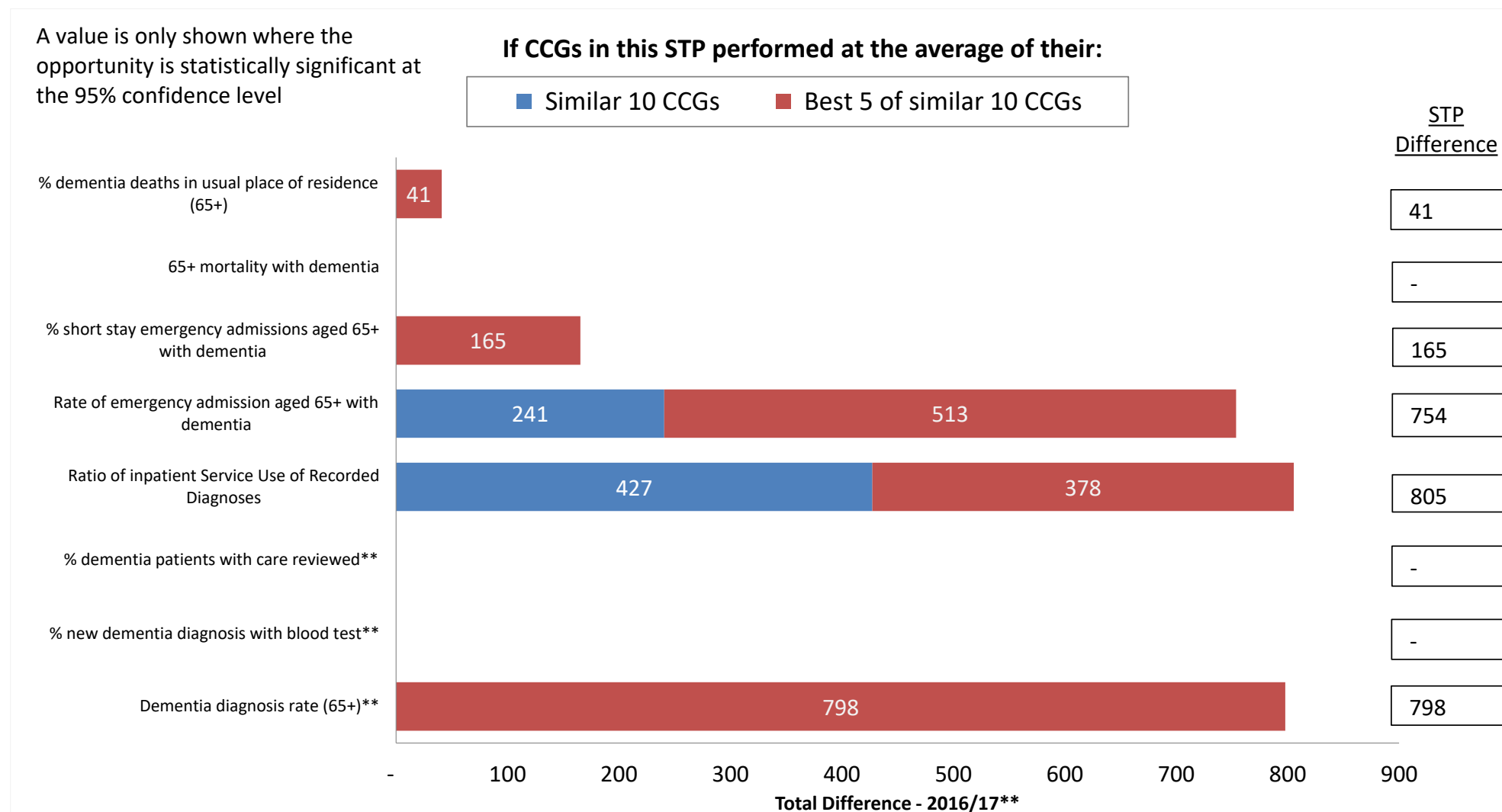
How different are we on mental health quality and outcome indicators?



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

Source: Public Health England (PHE), Clinical Programmes and Patient Insight Analytical Unit

How different are we on dementia quality and outcome indicators?



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

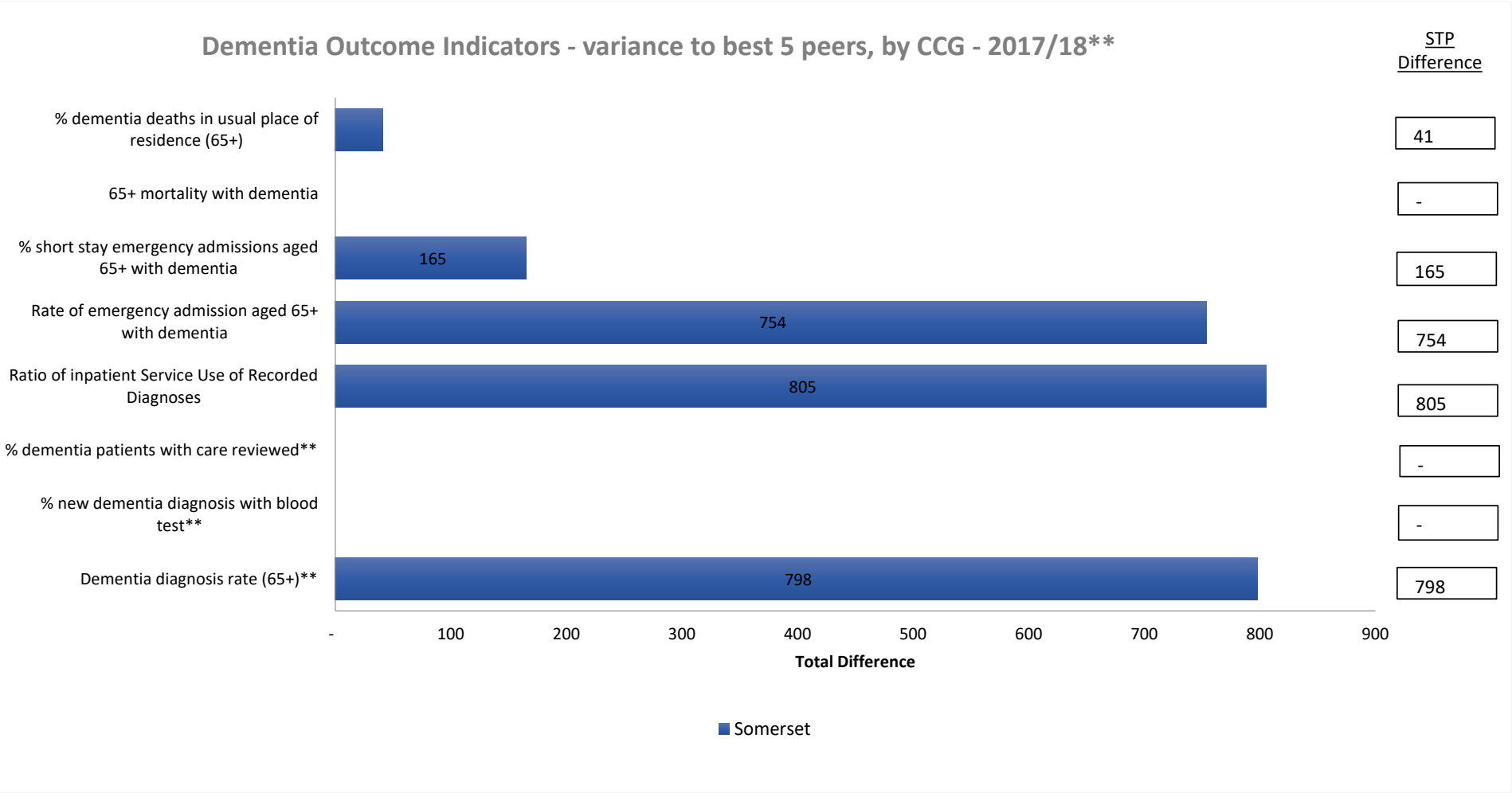
**All data from 2016/17 except 'Dementia diagnosis rate 65+' (Nov 2018), % new dementia diagnosis with blood test (2017/18) and % dementia patients with care reviewed (2017/18).

Sources: Quality and Outcomes Framework (QOF), NHS Digital

*See Page 78 Annex for additional guidance on indicators

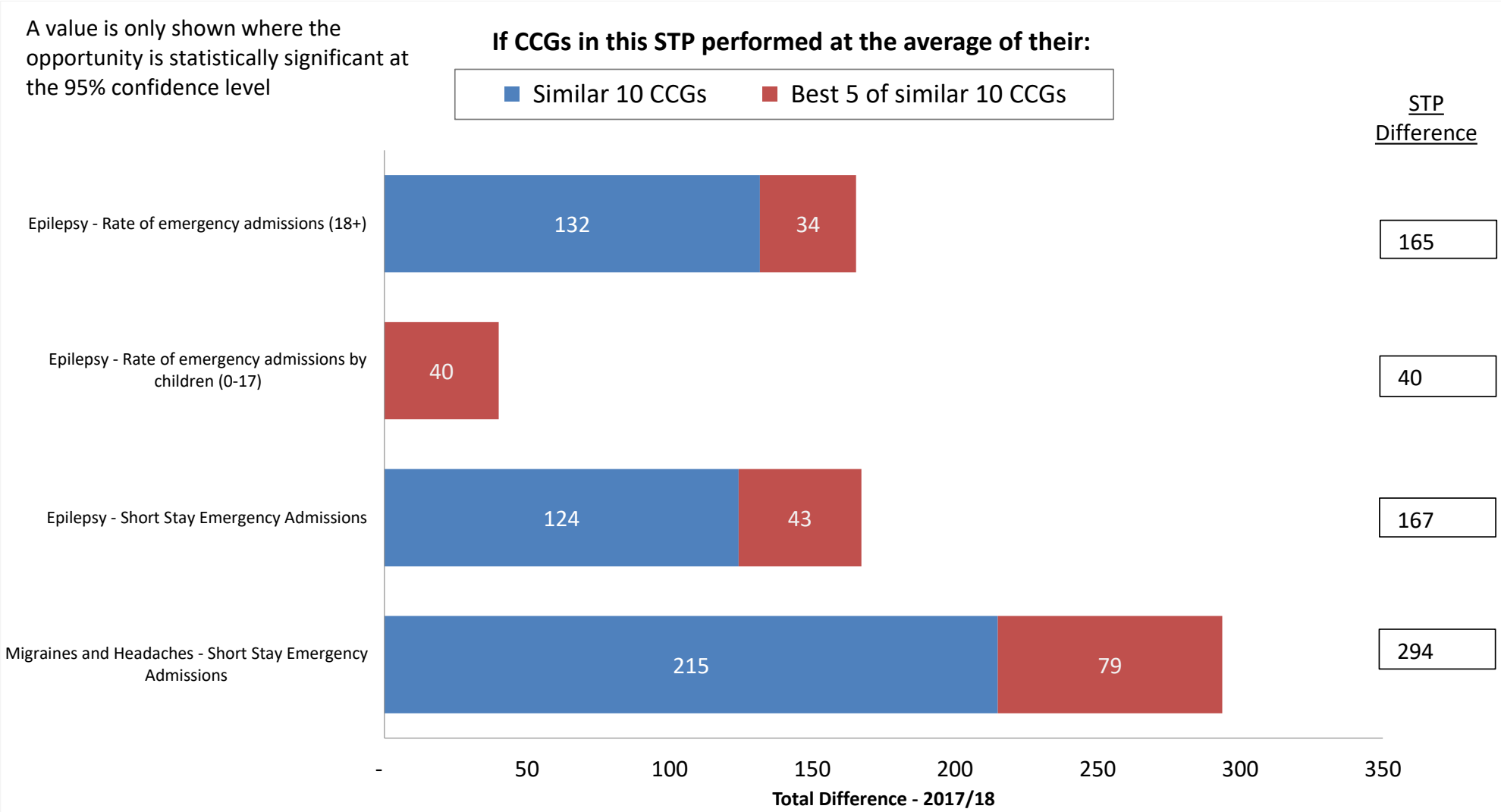
Somerset STP

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).

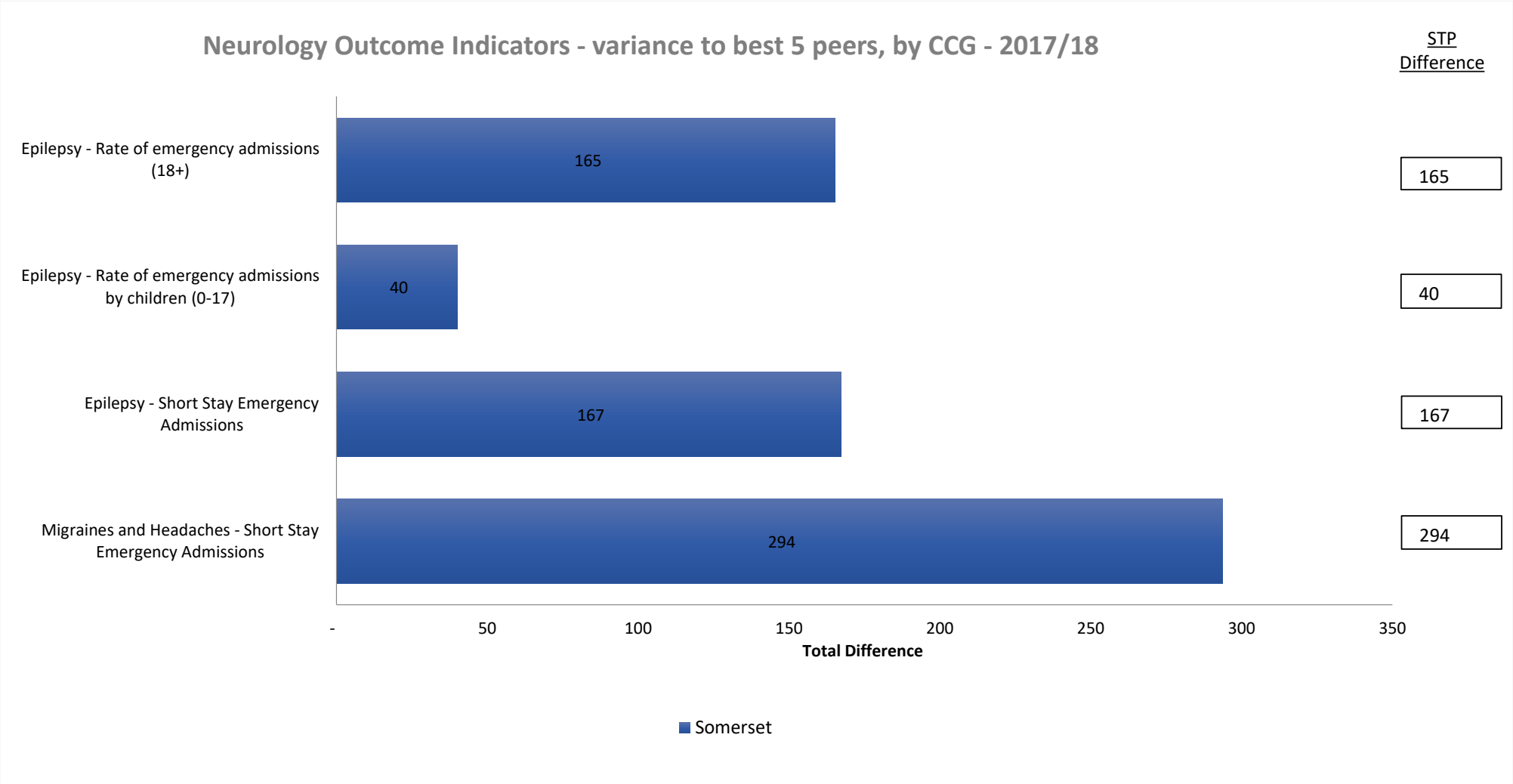
How different are we on neurology quality and outcome indicators?



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

*See Page 78 Annex for additional guidance on indicators
Somerset STP

How different are we on neurology quality and outcome indicators?

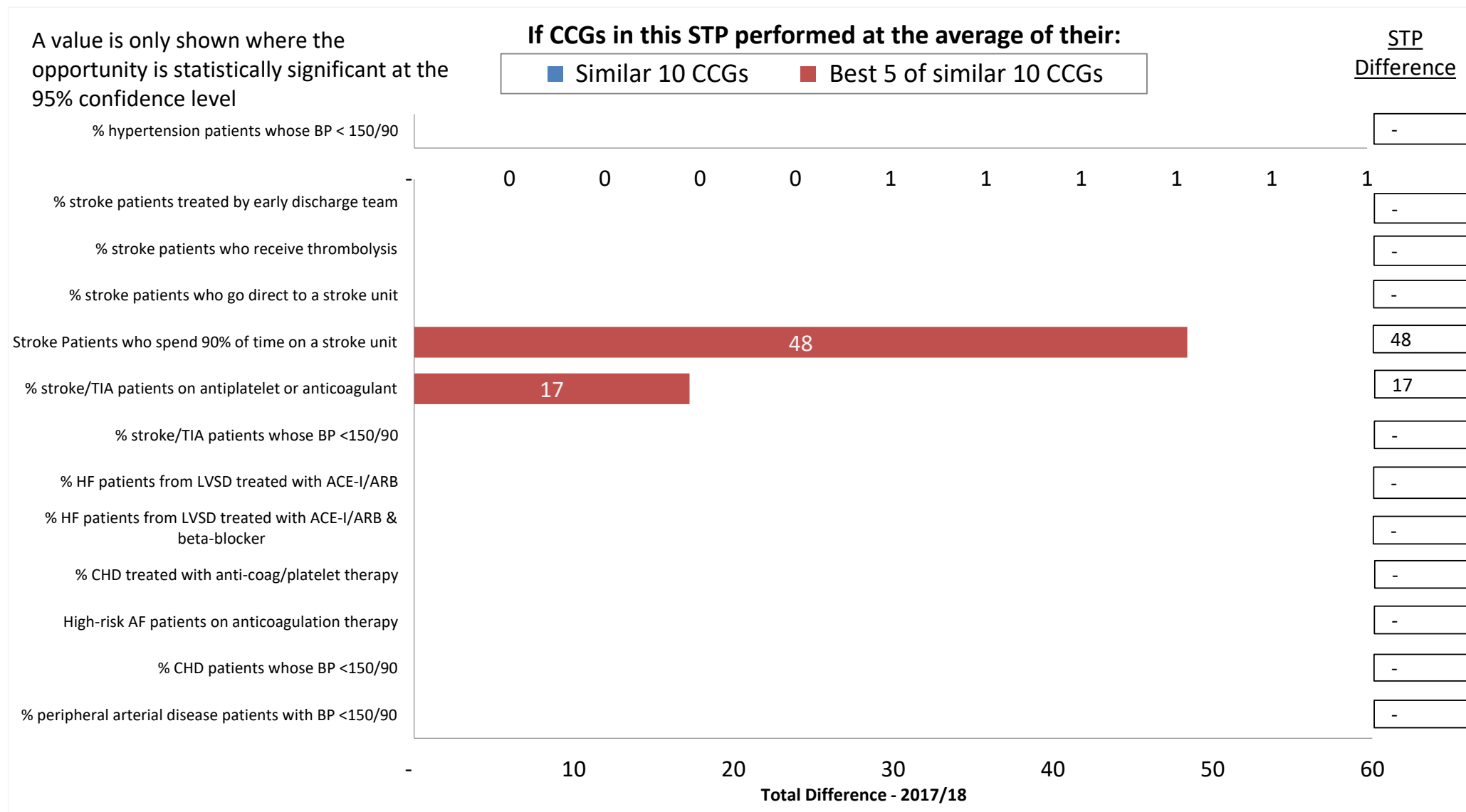


Please note that scale of opportunities will vary due to CCG size.

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

*See Page 78 Annex for additional guidance on indicators

How different are we on circulation quality and outcome indicators?



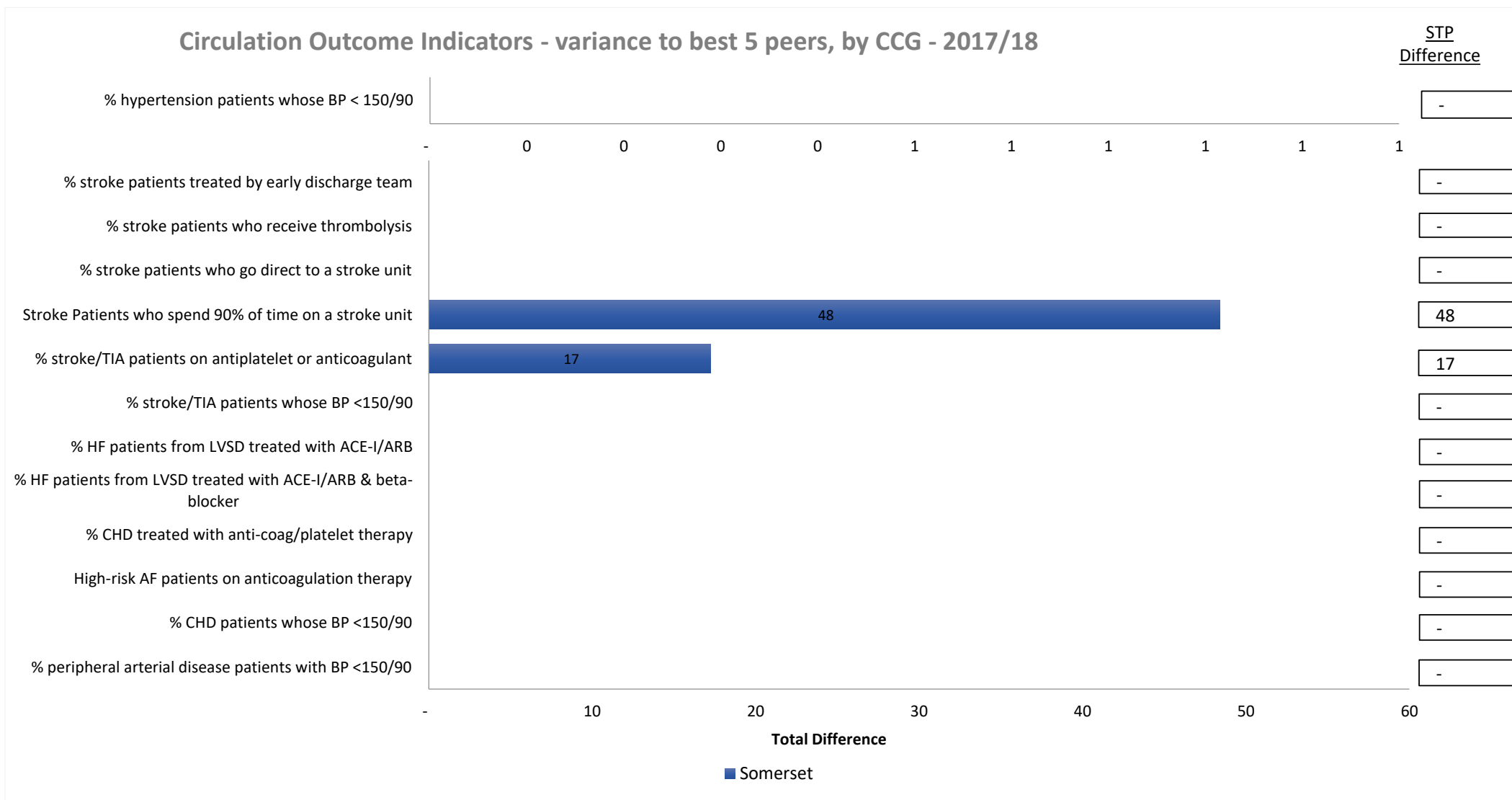
Please note that due to the size of the opportunities for '% hypertension patients whose BP < 150/90' this indicator is presented on its own axes to avoid scaling down the opportunities presented in the other indicators.

Sources: CCG Outcomes Indicator Set (OIS),
Royal College of Physicians Sentinel Stroke National Audit Programme SSNAP Key Indicators,
Quality and Outcomes Framework (QOF), NHS Digital

*See Page 78 Annex for additional guidance on indicators

Somerset STP

How different are we on circulation quality and outcome indicators?



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.

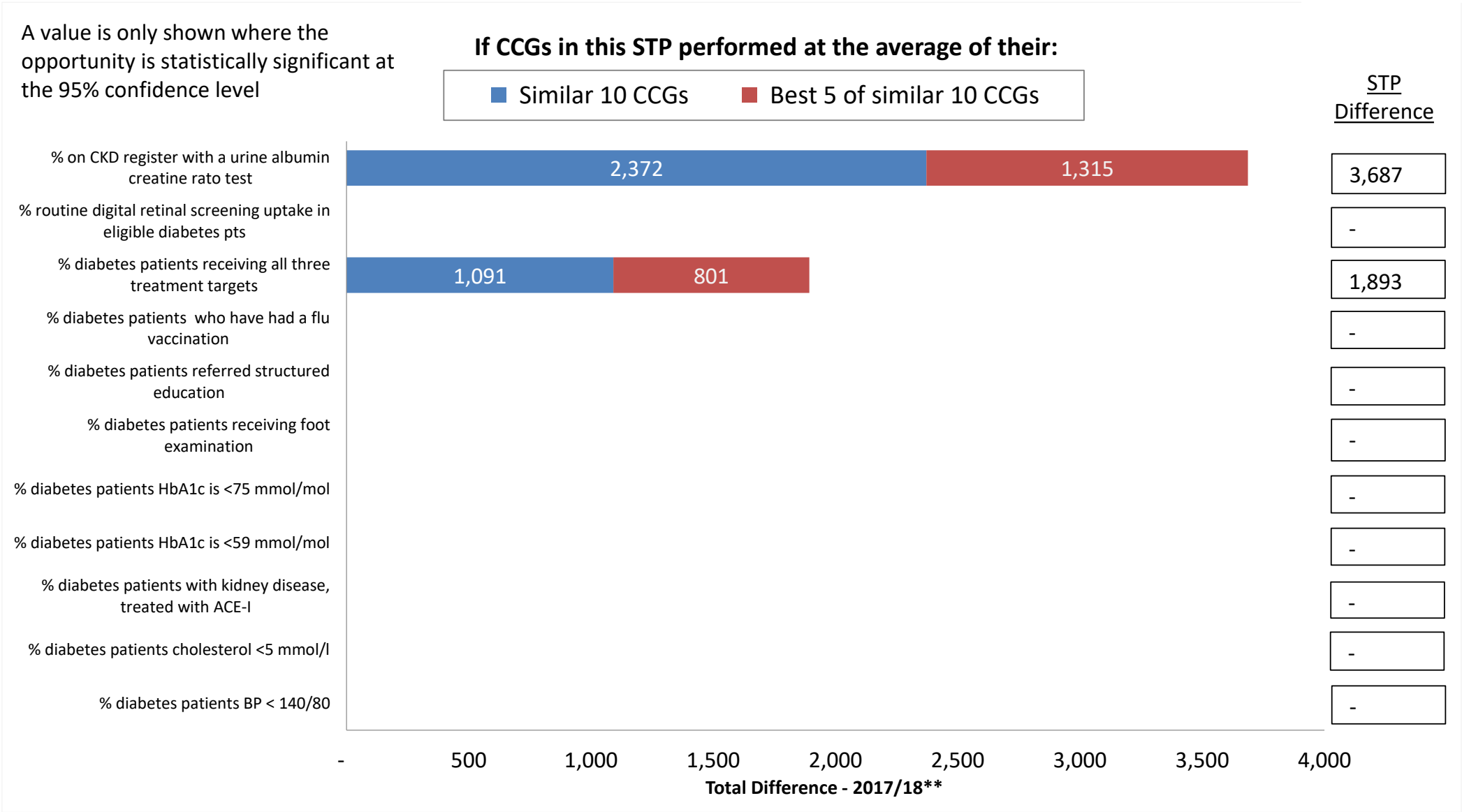
Please note that scale of opportunities will vary due to CCG size.

Sources: CCG Outcomes Indicator Set (OIS),
Royal College of Physicians Sentinel Stroke National Audit Programme SSNAP Key Indicators,
Quality and Outcomes Framework (QOF), NHS Digital

*See Page 78 Annex for additional guidance on indicators

Somerset STP

How different are we on endocrine quality and outcome indicators?



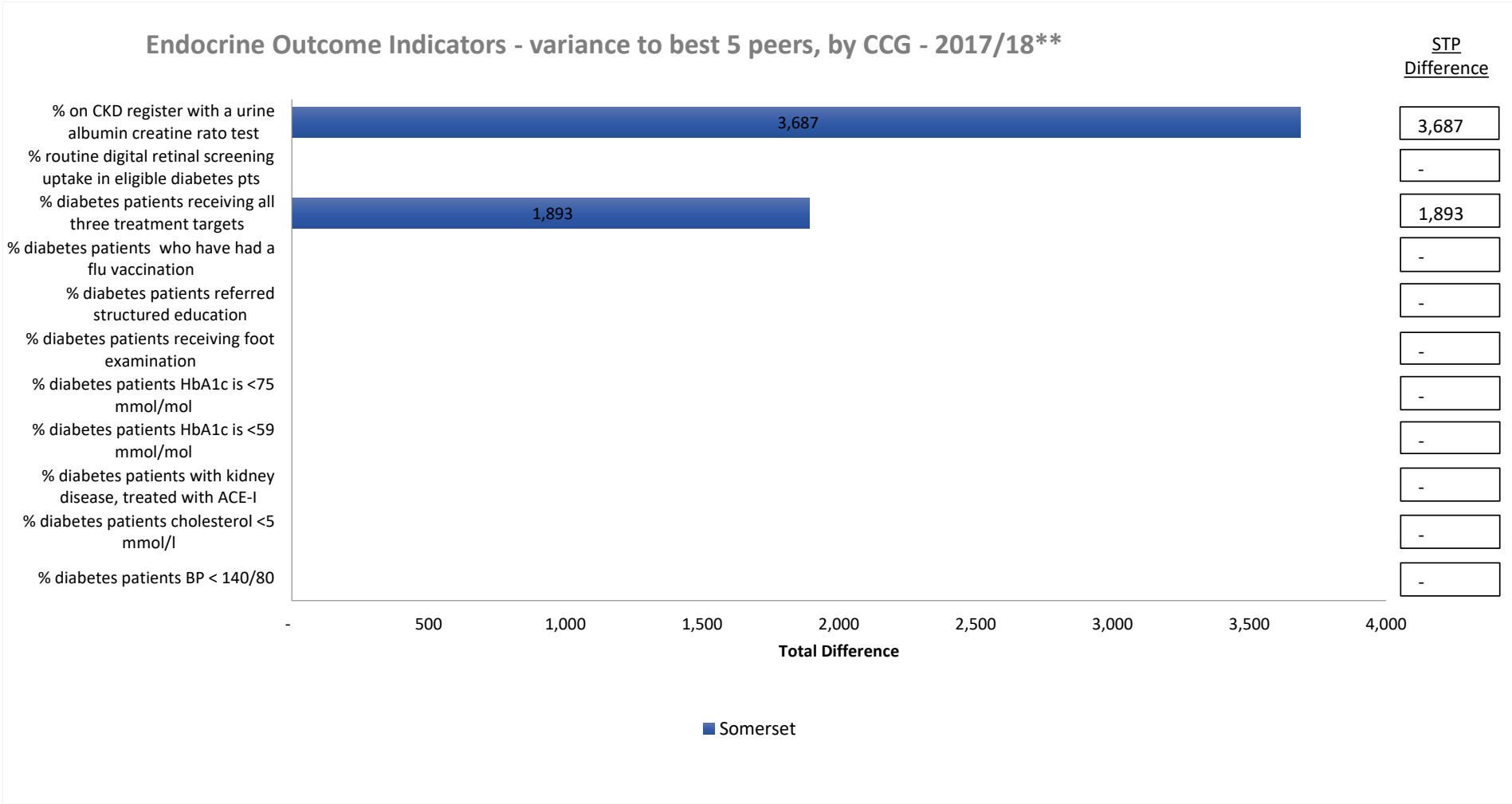
**All data from 2017/18 except '% diabetes patients receiving all three treatment targets' and 'Retinal Screening', '% on CKD register with a urine albumin creatine rato test' (2016/17). Please note that the quality and outcomes indicators for Endocrine primary focus on Diabetes outcomes.

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

*See Page 78 Annex for additional guidance on indicators

Somerset STP

How different are we on endocrine quality and outcome indicators?



Please note that scale of opportunities will vary due to CCG size.
Please note that the quality and outcomes indicators for Encodine primary focus on Diabetes outcomes.

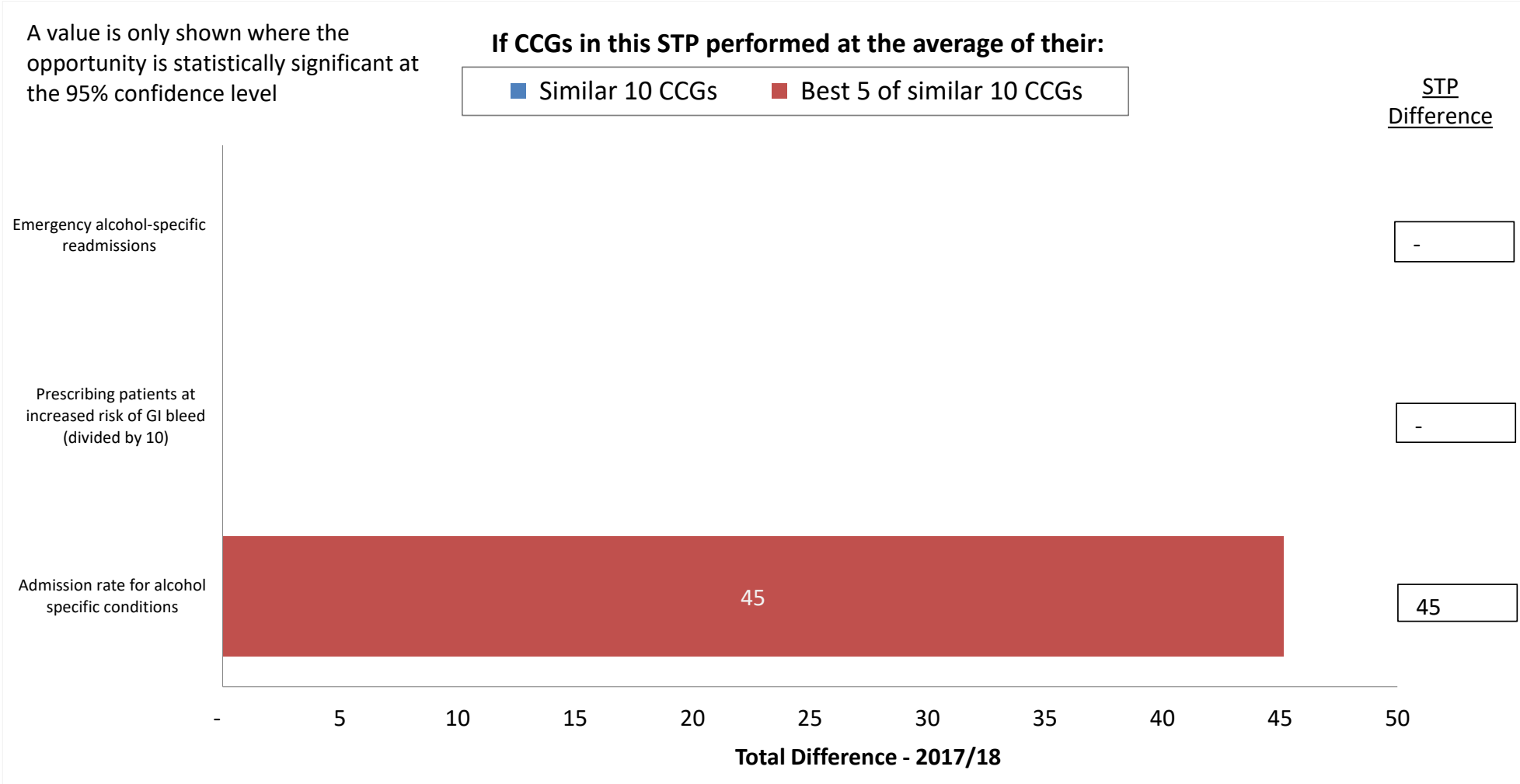
**All data from 2017/18 except '% diabetes patients receiving all three treatment targets' and 'Retinal Screening', '% on CKD register with a urine albumin creatine rato test' (2016/17).
Please note that the quality and outcomes indicators for Encodine primary focus on Diabetes outcomes.

*See Page 78 Annex for additional guidance on indicators

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

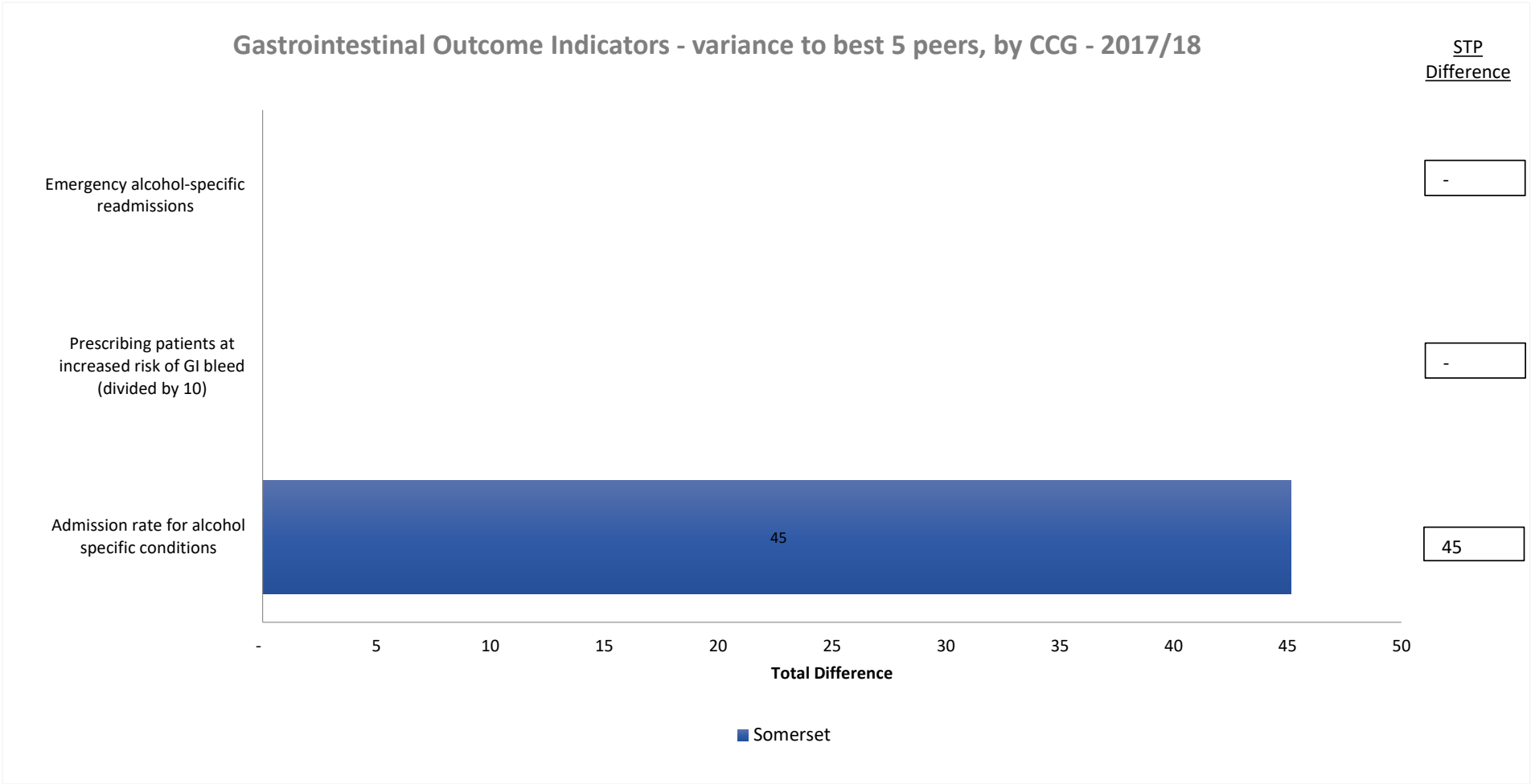
Somerset STP

How different are we on gastrointestinal quality and outcome indicators?



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 STP difference cell.

How different are we on gastrointestinal quality and outcome indicators?



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

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 STP difference cell.

Source: NHS Digital Outcomes Framework

*See Page 78 Annex for additional guidance on indicators

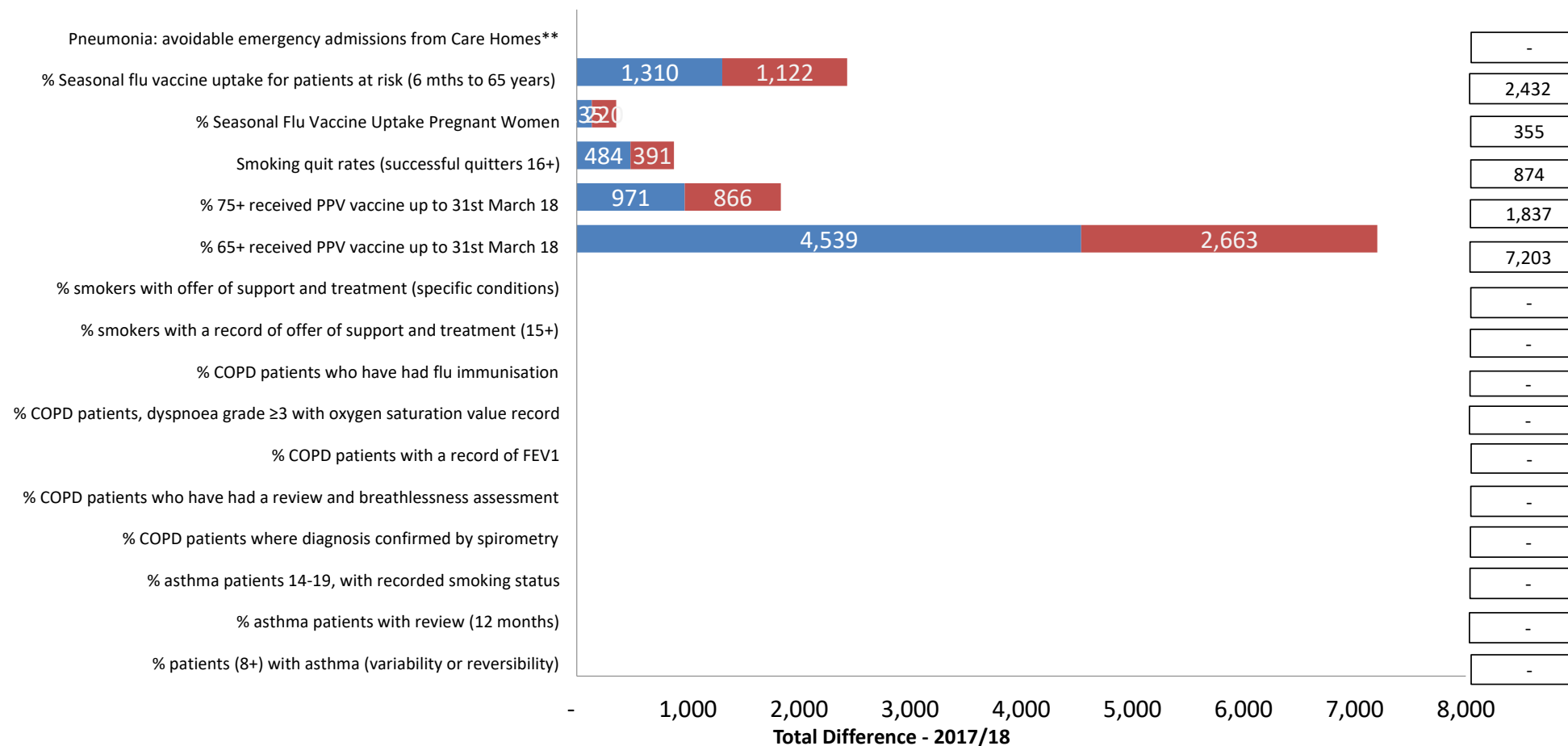
How different are we on respiratory quality and outcome indicators?

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

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs ■ Best 5 of similar 10 CCGs

STP
Difference



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

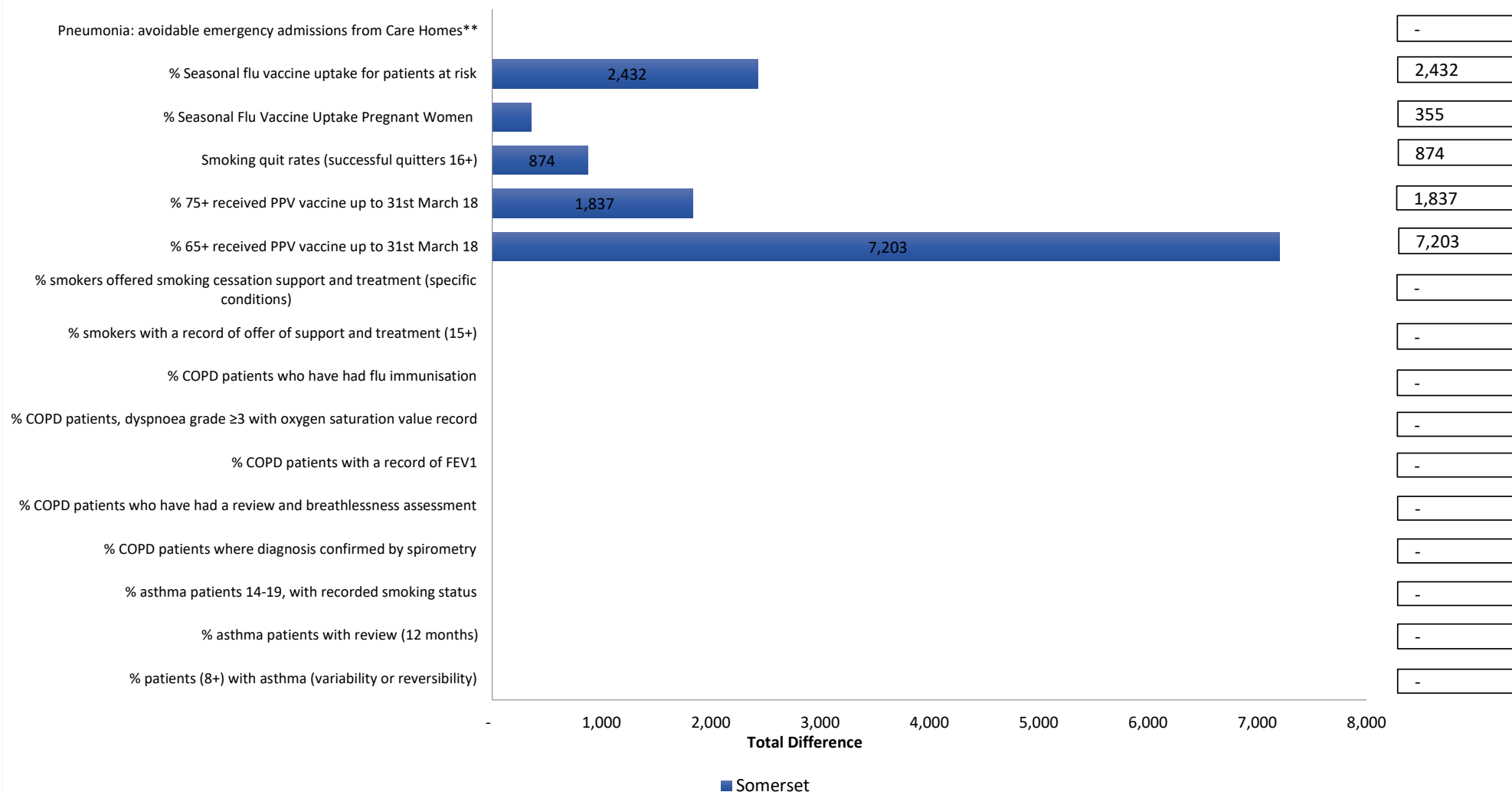
*See Page 78 Annex for additional guidance on indicators

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

Somerset STP

How different are we on respiratory quality and outcome indicators?

Respiratory Outcome Indicators - variance to best 5 peers, by CCG - 2017/18



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

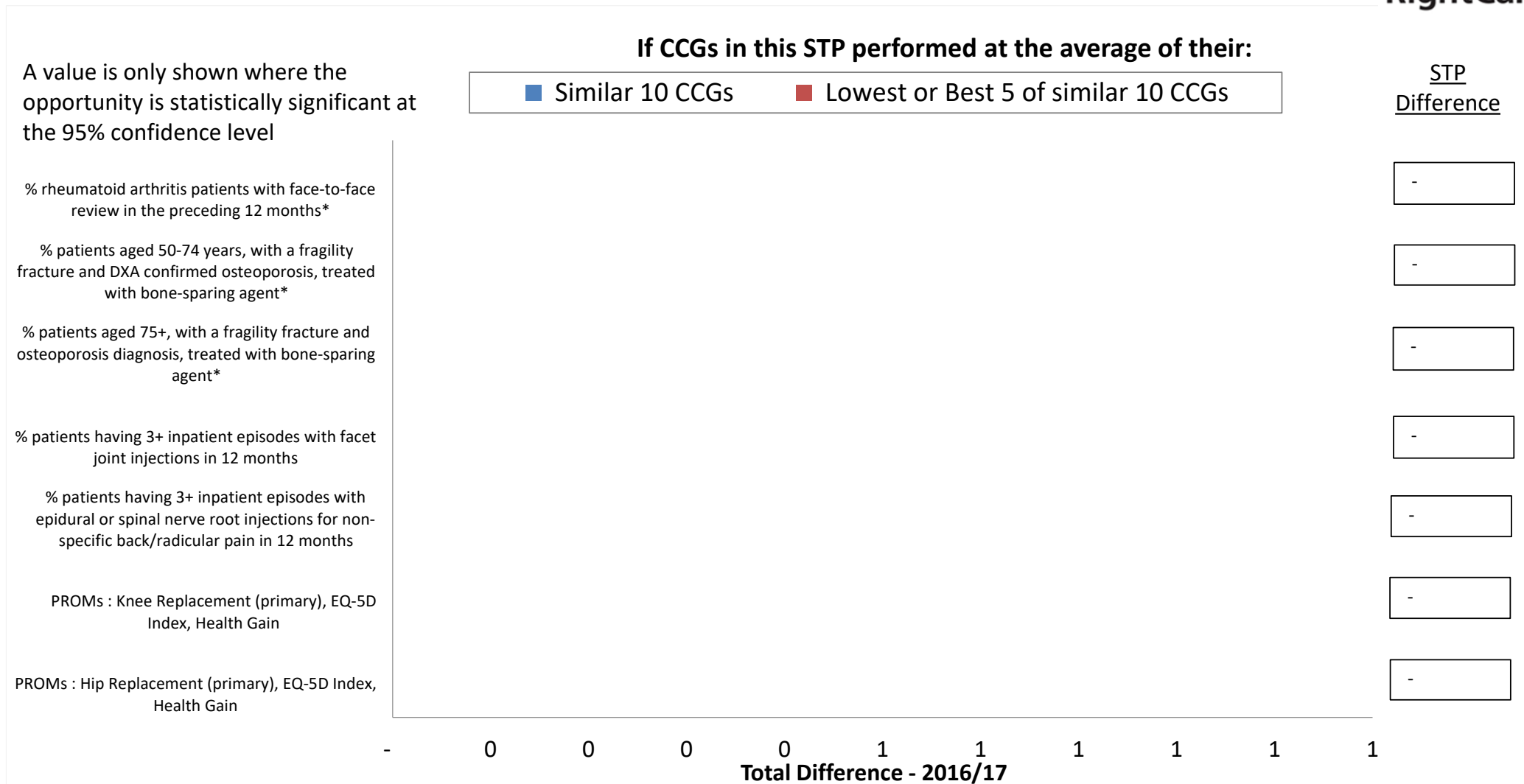
Sources: Risk Factors Intelligence Team, Public Health England (PHE), NHS Digital, Annual Population Survey, Office for National Statistics (ONS), Quality and Outcomes Framework (QOF)

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

*See Page 78 Annex for additional guidance on indicators

Somerset STP

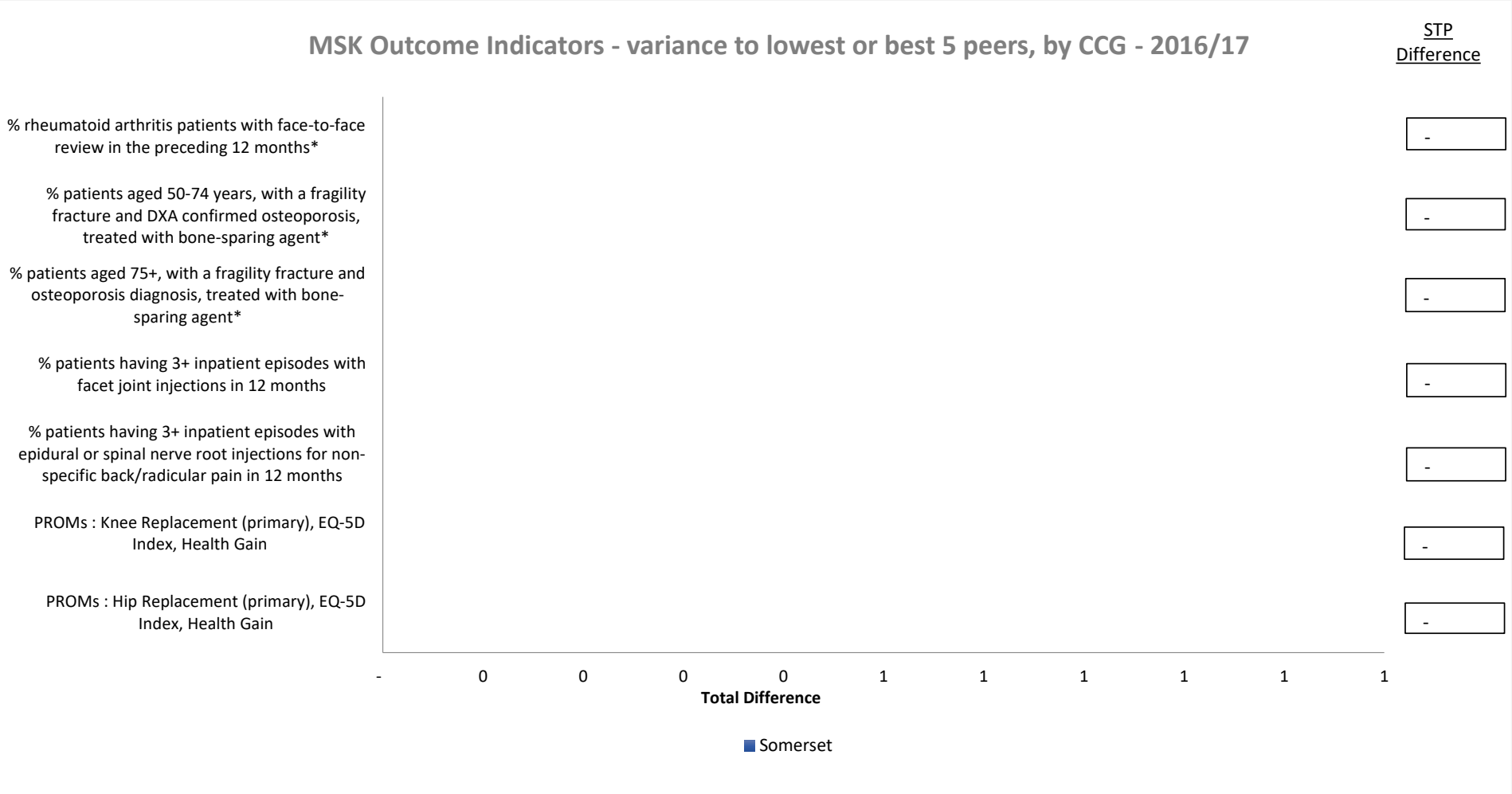
How different are we on musculoskeletal quality and outcome indicators?



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.

How different are we on musculoskeletal quality and outcome indicators?



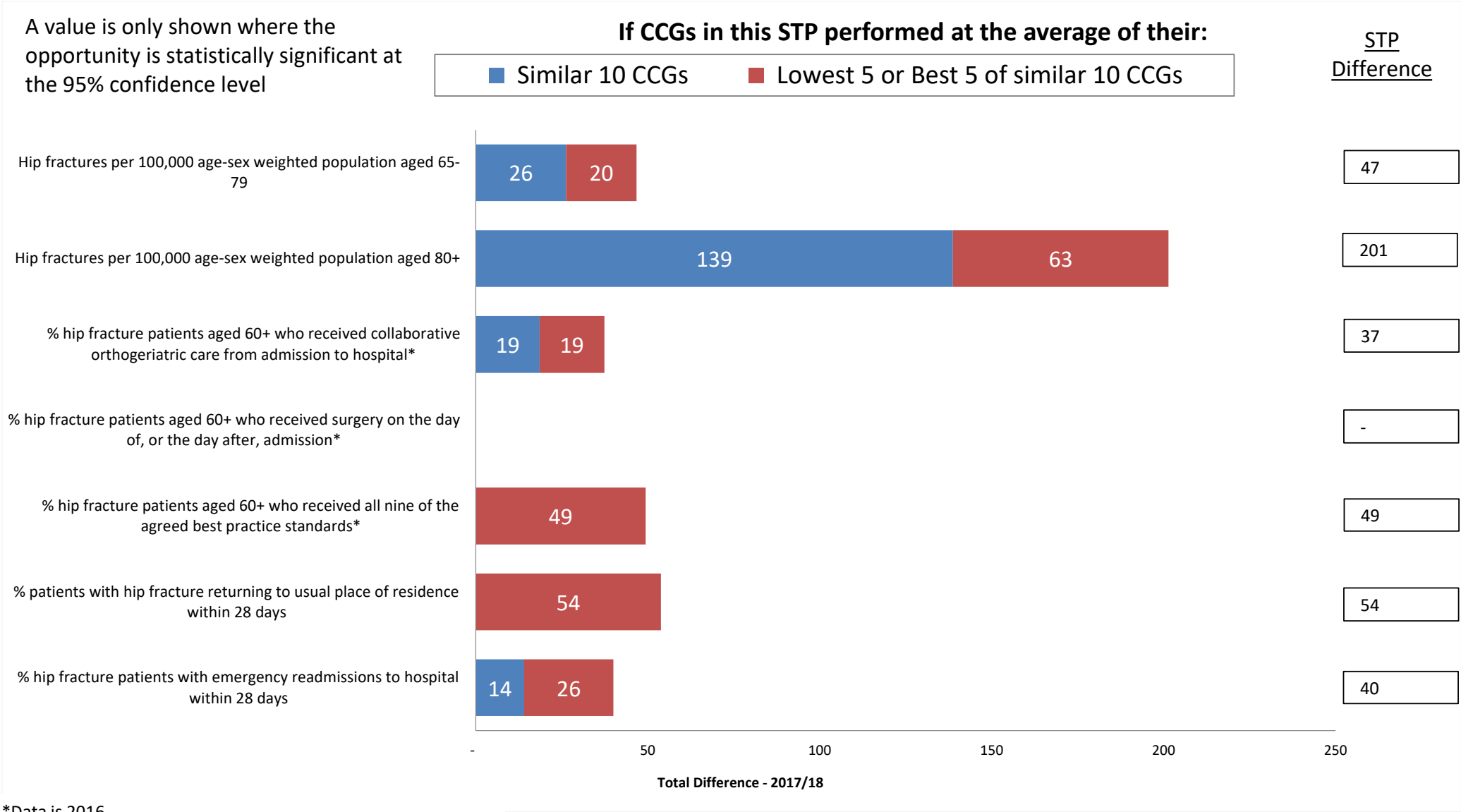
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The bone-sparing agent indicators only consider patients on GP registers who have fragility fractures and an osteoporosis diagnosis. There may be many more patients with osteoporosis.

*Data is 2017/18

Source: 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 3/12/18
Patient Reported Outcome Measures (PROMs), NHS Digital

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

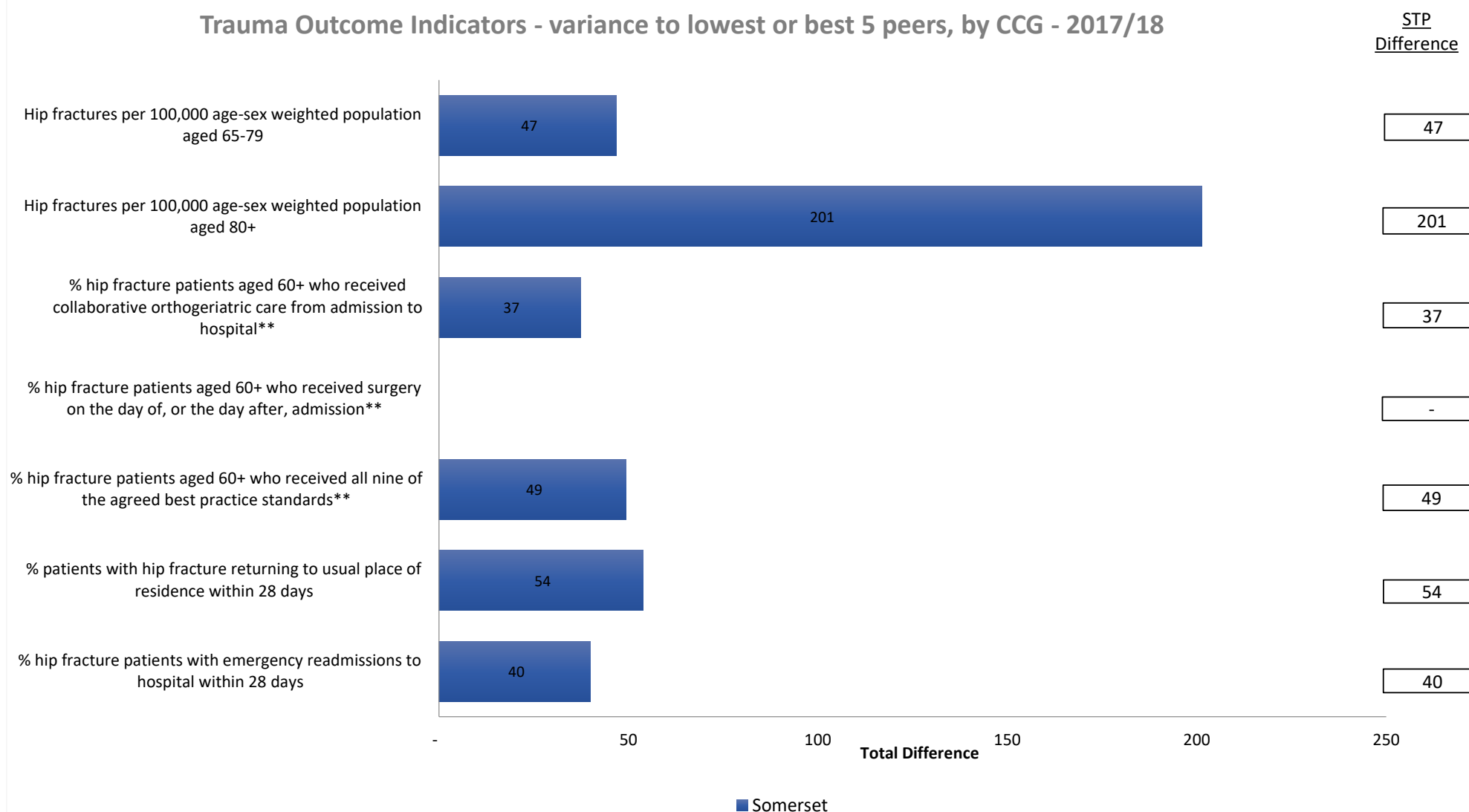


*Data is 2016

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - correct as of extract 3/12/18
National Hip Fracture Database (NHFD), CCG Outcomes Indicator Set, NHS Digital

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

Trauma Outcome Indicators - variance to lowest or best 5 peers, by CCG - 2017/18



*See Page 78 Annex for additional guidance on indicators

**Data is 2017/18

Source: National Commissioning Data Repository – Hospital Admissions Databases, SUS SEM (Secondary Uses Services Standard Extract Mart) - correct as of extract 3/12/18
National Hip Fracture Database (NHFD), CCG Outcomes Indicator Set, NHS Digital

How different are we on maternity quality and outcome indicators?

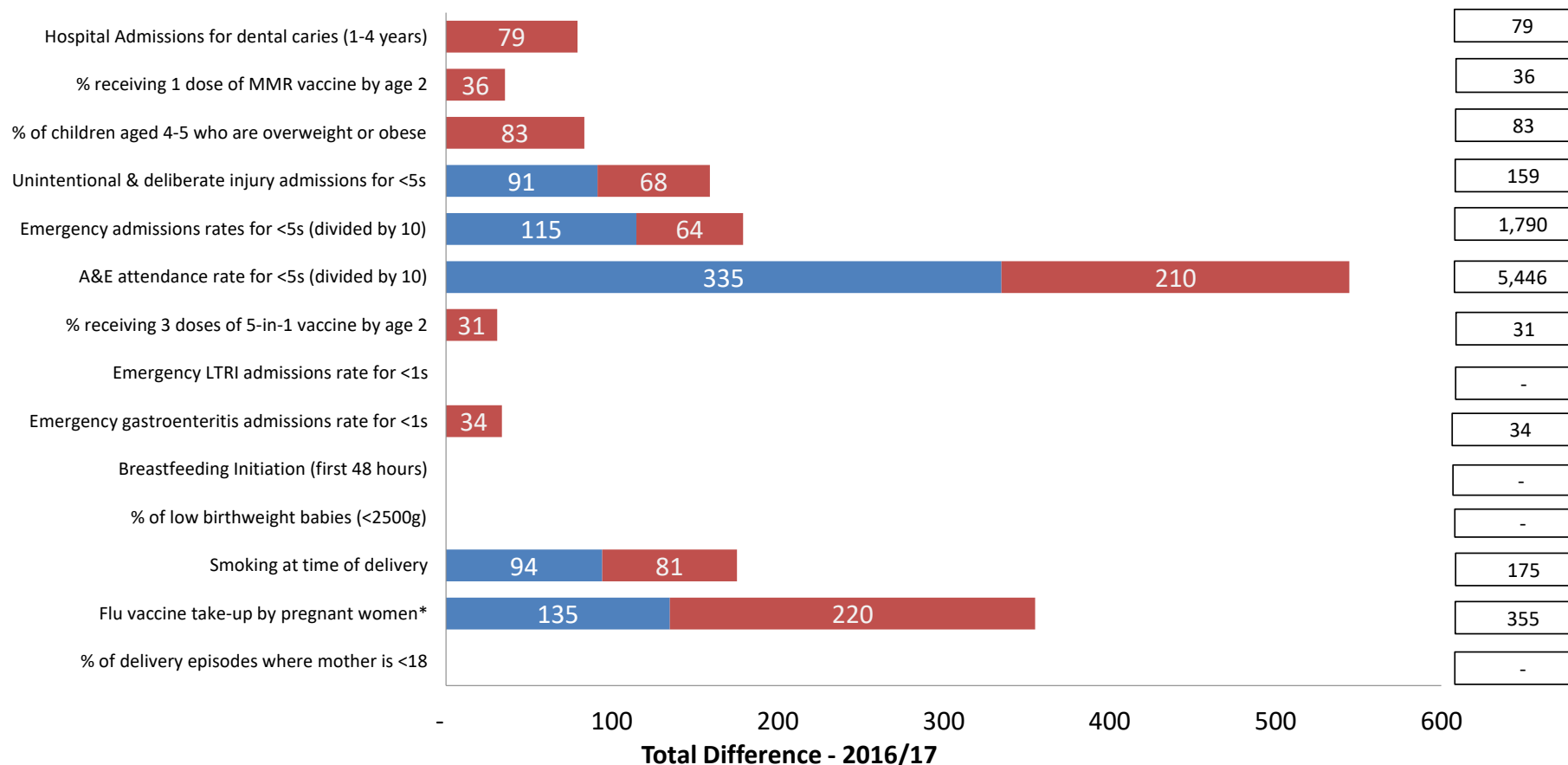
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

STP
Difference



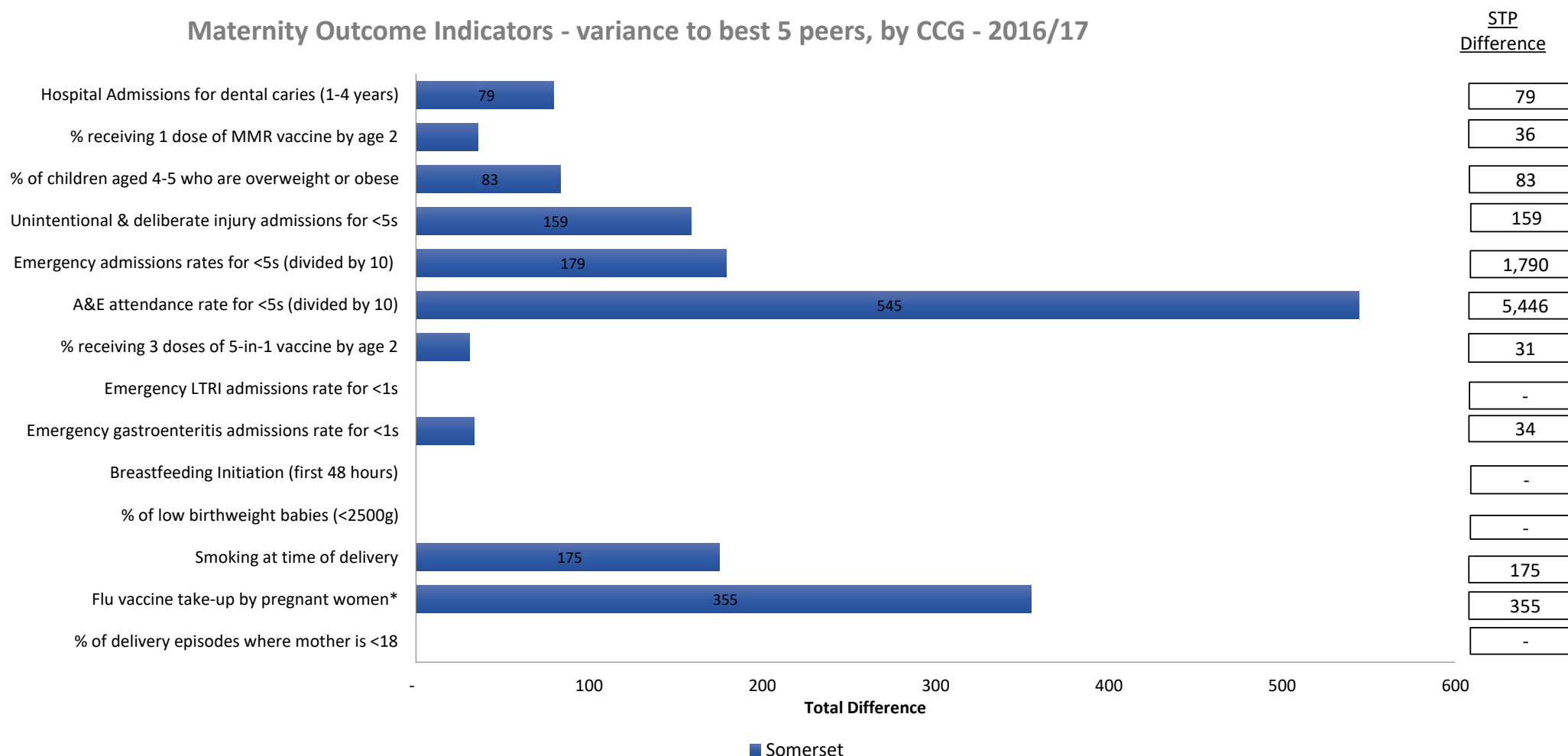
Please note that indicators 'A&E attendance rates' and 'Emergency admission rates' are shown in hundreds on the chart, with full opportunities in the total STP difference cell.

*Data is Sept17 - Jan18

Source: Public Health England (PHE), Clinical Programmes and Patient Insight Analytical Unit

How different are we on maternity quality and outcome indicators?

Maternity Outcome Indicators - variance to best 5 peers, by CCG - 2016/17



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

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 STP difference cell.

*Data is Sept17 - Jan18

Sources: Health England (PHE), NHS Digital, Clinical Programmes and Patient Insight Analytical Unit

How different are we on mortality indicators?

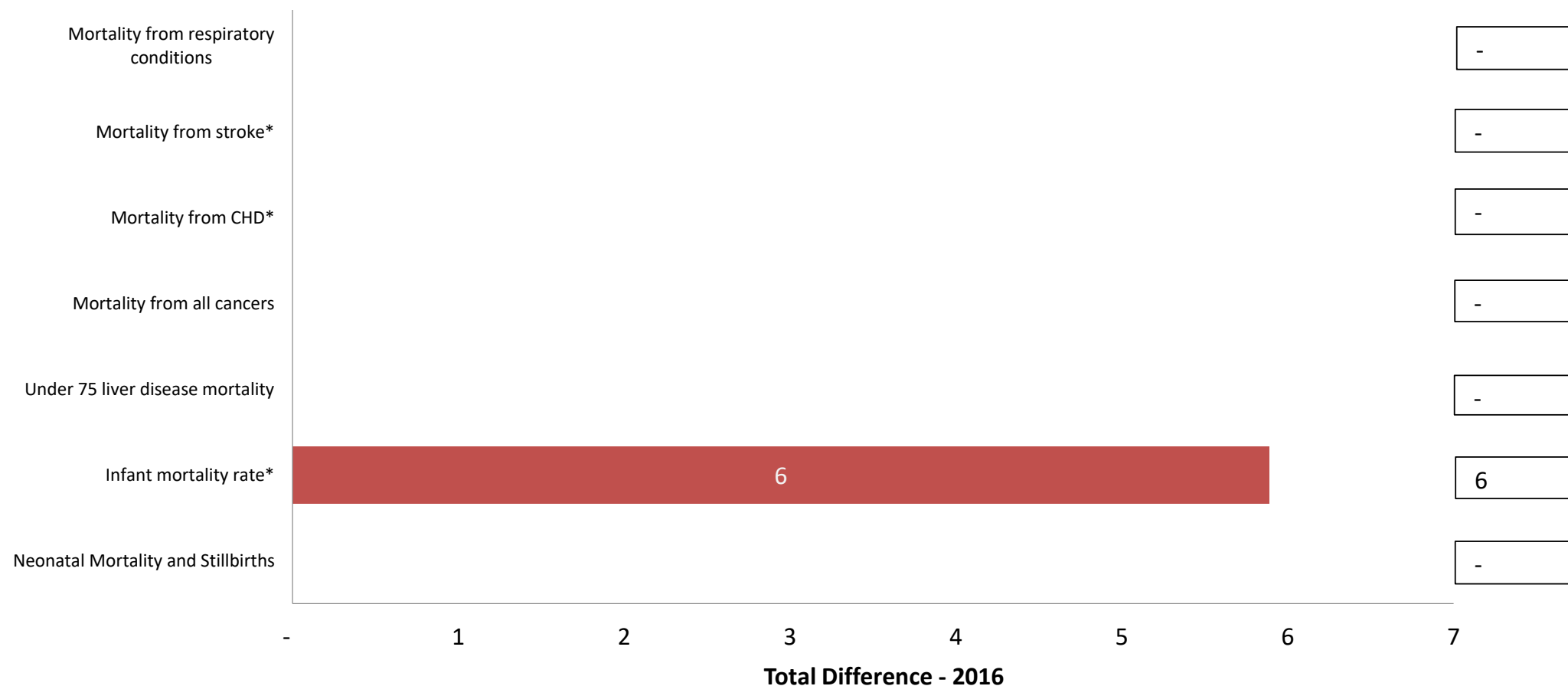
A value is only shown where the opportunity is statistically significant at the 95% confidence level

If CCGs in this STP performed at the average of their:

■ Similar 10 CCGs

■ Best 5 of similar 10 CCGs

STP
Difference

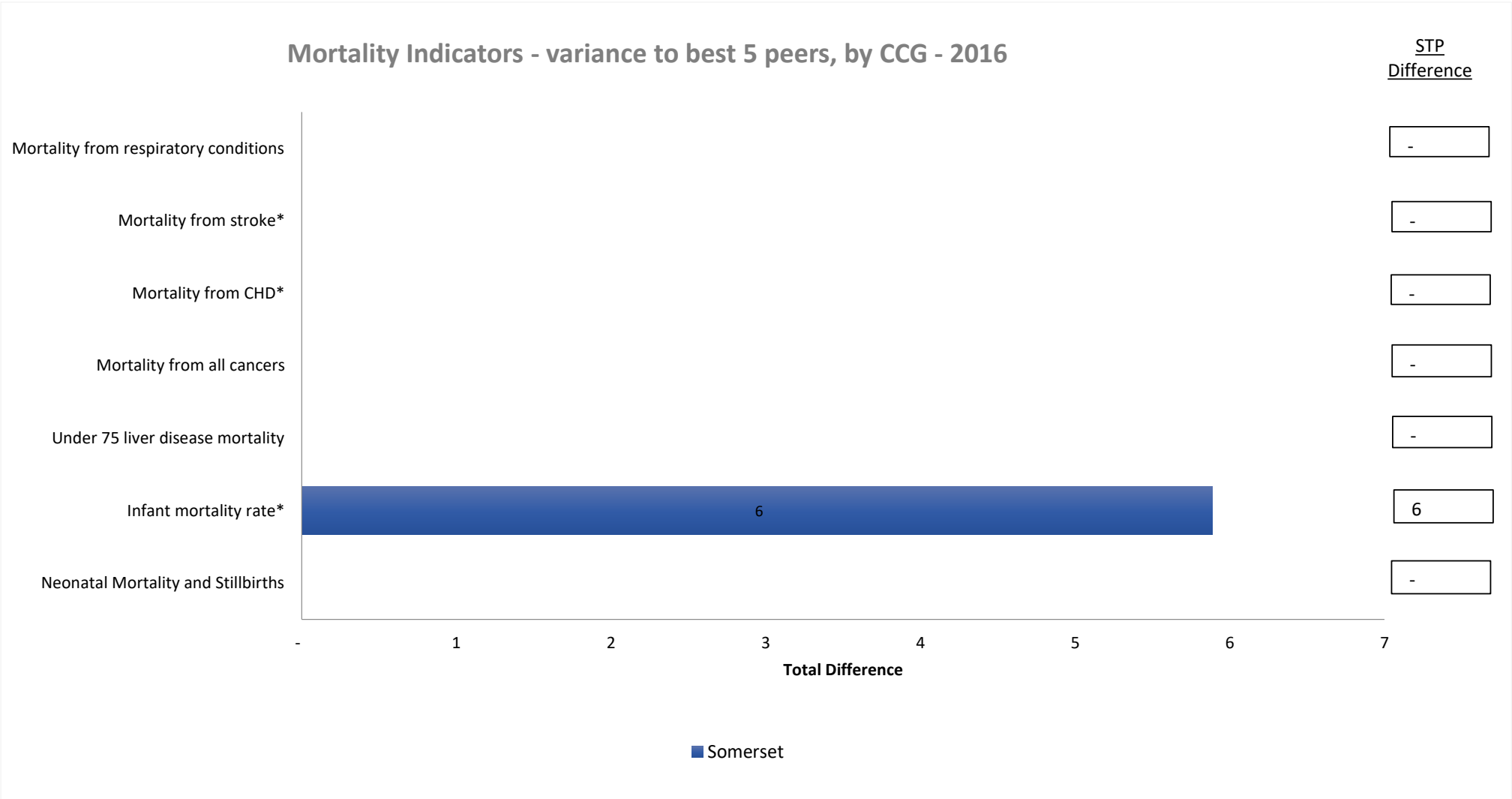


The mortality data presented above uses the latest published information available from Public Health England and NHS Digital. As the data comes from different sources there is inconsistency in the years covered. The potential lives saved are calculated as annual potential opportunities and are only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

* Data is 2014-16

Source: Public Health England, NHS Digital

How different are we on mortality indicators?



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

* Data is 2014-16

Source: Public Health England, NHS Digital

Interpreting STP Pathway on Page

The following slides provide a more detailed look at the 23 '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.













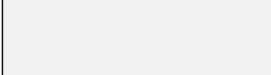
Each row in the matrix represents a CCG in your STP and how it compares to its Similar 10 CCGs across that pathway. The Similar 10 CCGs are not necessarily in the same STP. These Pathways on a Page allow an STP to examine which programmes have common opportunities for several CCGs across the entire pathway, 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 colours squares and arrows.









For CCG level outcomes opportunities please refer to the charts on pages 31 to 56 as a selection of these indicators are displayed there at CCG level.

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-rates 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

	2015	2017/18	2016	2017/18	2017/18	2017/18	2017/18	2017/18	2006-15	2017/18	2017/18	2016	2016	2016 (2015)
	Deprivation	Cancer Prevalence	Incidence of breast cancer	Obesity prevalence, 18+	Breast cancer screening	Primary Care prescribing spend	Urgent GP referrals (breast cancer)*	% first definitive treatment within 2 months (Breast)	Emergency presentations for breast cancer	Outpatient Breast Surgery	Total Inpatient Spend (Breast Cancer)	Breast cancer detected at an early stage	All Mortality from Breast Cancer	1 year survival (breast)
STP opportunity (to Best/Lowest 5)	-	-	-	-	2,566	-	-	5	-	4,261	82	40	-	-
Somerset														

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

*Due to feedback from cancer stakeholders this is higher the better.

Lower GI cancer

	2015	2017/18	2016	2017/18	2017/18	2017/18	2017/18	2006-15	2017/18	2017/18	2016	2016	2016
	Deprivation	Cancer Prevalence	Incidence of colorectal cancer	Obesity prevalence, 18+	Bowel cancer screening	Urgent GP referrals (colorectal cancer)*	% first definitive treatment within 2 months (Lower GI)	Emergency presentations for colorectal cancer	Elective Spend (Lower GI Cancer)	Non-elective Spend (Lower GI Cancer)	% of colorectal cancer detected at an early stage	All Mortality from Colorectal Cancer	1 year survival (colorectal)
STP opportunity (to Best/Lowest 5)	-	-	-	-	1,283	629	45	-	248	-	-	-	-
Somerset													

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

*Due to feedback from cancer stakeholders this is higher the better.



Lung cancer

	2015	2017/18	2016	2017/18	2017/18	2017/18	2017/18	2017/18	2006-15	2017/18	2017/18	2016	2016	2016 (2015)
	Deprivation	Cancer Prevalence	Incidence of lung cancer	Smoking Prevalence, 18+	Obesity prevalence, 18+	Successful quitters, 16+	Urgent GP referrals (lung cancer)*	% first definitive treatment within 2 months (Lung)	Emergency presentations for lung cancer	Elective Spend	Non-elective Spend	Lung cancer detected at an early stage	All Mortality from Lung Cancer	1 year survival (lung)
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	874	-	33	-	72	108	-	-	-
Somerset	▲		▼	▲					▼	▼	▼	▲	▼	

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

*Due to feedback from cancer stakeholders this is higher the better.






Severe mental illness

	2015	2017/18	2017/18	2017/18	2017/18	Nov-18 (rolling year)	2017/18
	Deprivation	People with SMI known to GPs: % on register	People with SMI who have a comprehensive care plan**	Female patients aged 25+ with SMI who had cervical screening test**	Patients with SMI with blood pressure check**	% of EIP referrals waiting <2 wks to start treatment (Complete)	Mental health hospital admissions
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	6	416
Somerset							

**Please note the above SMI indicators are do not include patients with personality disorders.
Indicators relating to CPA and the Mental Health Act are not included in this pathway due to ongoing reviews. Please also note that Mental Health delayed discharges are considerably undercounted nationally.

Somerset STP

Common mental health disorder

	2015	2011	2014/15	2017/18	2017/18	2017/18	2017/18	Sep - 2017	2017/18	Jan-18	Jan-18	2017/18 Q3
	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: % waiting <6 weeks for first treatment	IAPT: Rate of people completing IAPT treatment	IAPT: % referrals with outcome measured	IAPT: % 'moving to recovery' rate	IAPT: % achieving 'reliable improvement'
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	-	5,008	-	798	120	1,109	703
Somerset												

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

Dementia

	2017/18	2017/18	2017/18	2017/18	Nov-18	2017/18	2017/18	2016/17	2016/17	2016/17	2016	2016
	Obesity prevalence, 18+	Smoking Prevalence, 18+	Hypertension prevalence, 18+	Dementia prevalence	Dementia diagnosis rate (65+)	% new dementia diagnosis with blood test	% dementia patients with care reviewed	Ratio of inpatient Service Use of Recorded Diagnoses	Rate of emergency admission 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/Lowest 5)	-	-	-	-	798	-	-	805	754	165	-	41
Somerset		△			▽			△		△		▽

Heart disease

	2017/18	2017/18	2017/18 (2011)	2017/18 (2014)	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2014-16
	CHD Prevalence	Hypertension prevalence, 18+	Reported to Estimate Prevalence of CHD	Reported to Estimate Prevalence of Hypertension	Smoking Prevalence, 18+	Obesity prevalence, 18+	% CHD patients whose BP < 150/90	% hypertension patients whose BP <150/90	Primary Care Prescribing Spend (CHD)	Cardiology Outpatient Attendances	Elective Spend (CHD)	Non-Elective Spend (CHD)	<75 Mortality from CHD
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	-	-	-	-	6,678	-	-	-
Somerset					△				▽	△	▽		

Stroke

	2017/18	2017/18	2017/18	2017/18 (2015/16)	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2014-16
	Stroke or TIA Prevalence 18+	Smoking Prevalence, 18+	Obesity prevalence, 18+	Reported to Estimated Prevalence of AF	% Stroke/TIA patients BP < 150/90	% stroke/TIA patients on antiplatelet or anticoagulant	High-risk AF patients on anticoagulation therapy	Prescribing Stroke Spend*	% stroke patients who go direct to a stroke unit	% stroke patients who receive thrombolysis	Stroke patients 90% of time on stroke unit	Anticoagulant Service Outpatient Attendances	Total Spend on Inpatient Admissions (Cerebrovasc ular Disease)	% stroke patients treated by early supported discharge team	% returning to usual place of residence after stroke treatment	<75 Mortality from Stroke
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	-	-	2,033	-	-	48	-	1,532	-	135	-
Somerset		△						△			▽	▽	△			▽

Diabetes

	2017/18	2017/18	2017/18	2017/18	2017/18	2016/17	2017/18	2016/17	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18
	Diabetes Prevalence 17+	Obesity prevalence, 18+	% diabetes patients cholesterol <5 mmol/l	% diabetes patients HbA1c < 59 mmol/mol	% diabetes patients whose BP < 140/80	% diabetes patients receiving all three treatment targets	% of patients receiving foot examination	% routine digital retinal screening uptake in eligible diabetes pts	% diabetes patients referred to structured education	Primary Care Prescribing Spend (Diabetes)	Diabetic Medicine Outpatient Attendances	Total Spend on Type 1 Diabetes	Total Spend on Type 2 Diabetes	Total Spend on Other Forms of Diabetes
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	1,893	-	-	-	119	1,244	-	137	12
Somerset														

Heart failure












	2017/18	2017/18	2017/18 (2015/16)	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18
	% patients with a BP recording in the last 5 years, 45+	% hypertension patients whose BP <150/90	Reported to Estimated Prevalence of AF	Hypertension prevalence, 18+	Heart Failure Prevalence	% of patients treated with an ACE-I or ARB	% of patients treated with an ACE-I or ARB and a beta- blocker	% patients with diagnosis confirmed by echocardiogra m	Primary Care Prescribing Spend (Heart Failure)	Readmissions with a diagnosis of Heart Failure	Elective Spend (HF)	Non-Elective Spend (HF)	Elective Bed Days (HF)	Non-Elective Bed Days (HF)
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	-	-	-	-	-	-	790	-	2,804
Somerset									▼	▽	▼		▼	▲

Chronic obstructive pulmonary disease (COPD)

	2017/18	2017/18 (2011)	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18
	COPD prevalence	Reported to estimated prevalence of COPD	Smoking Prevalence, 18+	% COPD patients diagnosis confirmed by spirometry	% COPD patients with a record of FEV1 (2015/16)	% of COPD patients with review (12 months)	Primary Care Prescribing Spend (COPD)	Non-elective spend (COPD)
STP opportunity (to Best/Lowest 5)	-	-	-	-	-	-	-	788
Somerset			△				▽	

	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18
	Asthma prevalence	% patients (8yrs+) with asthma (variability or reversibility)	% ashtma patients with review (12 months)	Primary Care Prescribing Spend (Asthma)	Admissions rate for adults with asthma, 20+ yrs	Admissions rate for children with asthma, 0-19 yrs
STP opportunity (to Best/Lowest 5)	-	-	-	-	69	-
Somerset				▼	△	▼

Influenza and pneumonia

	Sept17 - Jan18	2017/18	Sept17 - Jan18	Sept17 - Jan18	Sept17 - Jan18	Up to Mar-18	2017/18	2017/18	2017/18	12 months to Q2 2017/18	2016/17
	% Patients at risk of seasonal flu (6 mths to 65 years)	% High dose inhaled corticosteroid prescribing	% Seasonal flu vaccine uptake 65+	% Seasonal flu vaccine uptake pregnant women	% Seasonal flu vaccine uptake for patients at risk (6 mths to 65 years)	PPV coverage (%) 65+	Non-elective spend (Influenza)	Non-elective spend (Pneumonia)	Influenza and pneumonia - % winter admissions	Pneumonia: Avoidable emergency admissions from care homes	% Excess winter deaths index
STP opportunity (to Best/Lowest 5)	-	-	2,949	355	2,432	7,203	254	1,196	-	-	130
Somerset											









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

	2017/18	2017/18	2015/16 - 2017/18	2017/18 Q4	2017/18	2017/18	2017/18	2017/18 (4 separate months)	2017/18	2017/18	2017/18	2017/18	2016/17 - 2017/18	2017/18
	Smoking Prevalence, 18+	Alcohol specific hospital admissions	Emergency alcohol-specific readmissions	Prescribing patients at increased risk of GI bleed	Proton pump inhibitor spend	Diagnostic gastroscopies - Day case and outpatient activity	Diagnostic gastroscopies - Day case and outpatient activity (<45s)	Waiting list patients waiting >6 weeks for a gastroscopy	Elective spend	Rate of emergency gastroscopies	GI bleeds - Emergency admissions	Peptic ulcers - Emergency admissions	Peptic ulcers - 30 day all-cause readmissions	Non-elective spend
STP opportunity (to Best/Lowest 5)	-	45	-	-	50	-	-	152	-	-	228	-	-	388
Somerset														

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>

Groin hernia

	2017/18	2017/18	2017/18	2015/16-2017/18	2016/17 - 2017/18	2017/18	2017/18	2017/18	2017/18
	Smoking Prevalence, 18+	% primary repairs of inguinal hernia performed as a day case	% primary repairs of inguinal hernia performed laparoscopically	% bilateral primary repairs of inguinal hernia performed laparoscopically	Primary repair of inguinal hernia - 30 day all-cause readmissions	Primary repair of inguinal hernia - Elective spend	Inguinal hernia - Non-elective admissions	Primary repair of inguinal hernia - Non-elective spend	Repair of recurrent inguinal hernia – Total spend
STP opportunity (to Best/Lowest 5)	-	28	-	-	-	93	34	-	-
Somerset									

Liver disease

	2017/18	2017/18	2015/16 - 2017/18	2016/17	2016	2017/18	2012/13 - 2017/18	2012/13 - 2017/18	2017/18	2017/18	2017/18	2017/18	2014-16	2016
	Obesity prevalence, 18+	Alcohol specific hospital admissions	Emergency alcohol-specific readmissions	% of eligible persons completing a course of hepatitis B vaccination	Hepatitis C detection rate	Paracetamol overdose admissions	Rate added to liver transplant waiting list	Liver transplant rate	Elective Spend	Non-Elective Spend	Alcohol related liver disease admissions	% paracentesis procedures performed as emergencies	Liver cancer incidence	<75 mortality from liver disease
STP opportunity (to Best/Lowest 5)	-	45	-	-	-	151	-	-	-	-	-	23	-	-
Somerset			▽	△	▽		▽	▽	▽				△	▽

Note: % of eligible persons completing a course of hepatitis B vaccination and Hepatitis C detection rate indicators have been produced by mapping Local Authority data to CCG level. Elective spend, non-elective spend and mortality indicators align with PHE's definition of Liver Disease, which includes admissions and deaths due to liver cancer. Many cases of liver cancer are linked to cirrhosis. Cirrhosis is commonly caused by heavy and harmful drinking, hepatitis C and the build-up of fat inside the tissue of the liver. Liver cancer incidence is therefore related to a number of other indicators in the pathway, meaning CCGs have been rated better/worse than their similar peers. However, to be consistent with other cancer incidence indicators, a quantified opportunity figure has not been provided.

Back, neck and MSK pain




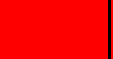
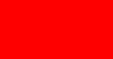
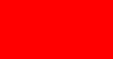





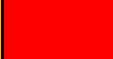


	2011	2011	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18
	Estimated back pain prevalence (all)	Estimated back pain prevalence (severe)	Primary Care prescribing spend - pain medication	Total Inpatient Spend (Back, Neck and MSK pain)	MRIs of spine for non-specific back/radicular pain	Spend on spinal surgery (MSK)	Spend on pain injections, all excluding epidurals & spinal nerve root blocks (MSK)	Spend on pain injections, epidurals & spinal nerve root blocks (MSK)	Non-elective admissions for back, neck and musculoskeletal pain
STP opportunity (to Best/Lowest 5)	6,742	6,791	116	-	-	-	-	-	158
Somerset									

These are inpatient MRIs of spine for non-specific back/radicular pain.
 NICE guidance: <https://pathways.nice.org.uk/pathways/low-back-pain-and-sciatica>
 Versus Arthritis : <https://www.versusarthritis.org/>

Rheumatoid and inflammatory arthritis

	2017/18	2015	2017/18	2017/18	2017/18	2017/18
	Reported Prevalence (Rheumatoid Arthritis)	Estimated Prevalence (Rheumatoid Arthritis)	Primary Care Prescribing Spend - DMARDs	Outpatient Rheumatology Attendances	Total Inpatient Spend (Rheumatoid and Inflammatory Arthritis)	% of patients with RA who have had a review in last 12 months
STP opportunity (to Best/Lowest 5)	-	276	307	1,020	190	-
Somerset			▲	▼	△	

Osteoporosis and fragility fractures













	Oct-17	2017/18	2017/18	2015/16- 2017/18	2015/16- 2017/18	2015/16- 2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2015/16- 2017/18	2017/18	2017/18
	GP Registered Pop aged 75+	Rate of DEXA scan activity	Primary care prescribing spend - bisphosphonate s	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+	Total Inpatient Spend (Osteoporosis and fragility fractures)	Spend on fracture admissions after a fall occurred	% hip fracture patients returning home within 28 days	% hip fracture emergency readmissions 28 days	% osteoporosis patients 50-74 with a fragility fracture treated with BSA	% osteoporosis patients 75+ years with a fragility fracture treated with BSA
STP opportunity (to Best/Lowest 5)	-	-	6	247	47	201	2,241	2,173	200	664	54	40	-	-
Somerset														

DEXA scans are used to confirm diagnosis of osteoporosis, which is an important step to ensuring people at higher risk of fragility fractures are identified and treated. Therefore no opportunity is calculated. The bone-sparing indicators only consider patient on GP registers who have fragility fractures and an osteoporosis diagnosis. There may be many more patients with osteoporosis.

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

Versus Arthritis : <https://www.versusarthritis.org/>

Osteoarthritis





	2012/13	2012/13	2012/13	2012/13	2017/18	2017/18	2017/18	2016/17 (Final)	2016/17 (Final)	2017/18	2016/17 (Final)	2016/17 (Final)
	Estimated hip osteoarthritis prevalence for people aged 45+ (all)	Estimated knee osteoarthritis prevalence for people aged 45+ (all)	Estimated hip osteoarthritis prevalence for people aged 45+ (severe)	Estimated knee osteoarthritis prevalence for people aged 45+ (severe)	Rate of hip replacements	Rate of knee replacements	Primary Care Prescribing Spend (Osteoarthritis and soft-tissue disorders)	Pre-treatment EQ-5D Index (hips)	Pre-treatment EQ-5D Index (knees)	Total Inpatient Spend (Osteoarthritis)	EQ-5D Index health gain (hips)	EQ-5D Index health gain (knees)
STP opportunity (to Best/Lowest 5)	-	-	-	-	226	108	16	-	-	1,630	-	-
Somerset												

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





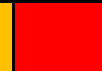









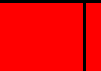



NICE guidance: <http://pathways.nice.org.uk/pathways/osteoporosis>

Versus Arthritis : <https://www.versusarthritis.org/>

Trauma and injuries

	2017/18	2017/18	2017/18	2015/16-2017/18	2015/16-2017/18	2015/16-2017/18	2017/18	2017/18	2017/18	2017/18	2015/16-2017/18
	Spend on injuries due to falls in people aged 65+	Unintentional and deliberate injury admissions, 0-24 yrs	Spend on fractures 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 (T&I)	Elective Spend (T&I)	Non-elective Spend (T&I)	% hip fracture patients returning home within 28 days	% hip fracture emergency readmissions 28 days
STP opportunity (to Best/Lowest 5)	917	634	2,400	247	47	201	-	-	4,032	54	40
Somerset											

Maternity and early years

	2016/17	Sept17 - Jan18	2016/17	2016	2016	2016	2016/17	2016	2014 - 16	2016/17	2016/17	2016/17	2016/17	2016/17	2016/17	2014/15 - 16/17	2016/17	2014/15 - 16/17
	% of delivery episodes where mother is <18	% Seasonal flu vaccine uptake pregnant women	Smoking at time of delivery*	Women's Experience in Delivery	Choice of Maternity Services	% of low birthweight babies (<2500g)*	Breastfeeding Initiation (first 48 hours)	Neonatal Mortality and Stillbirths	Infant mortality rate	Emergency gastroenteritis admissions rate for <1s	Emergency LTRI admissions rate for <1s	% receiving 3 doses of 5 in-1 vaccine by age 2	A&E attendance rate for <5s	Emergency admissions rates 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 years)
STP opportunity (to Best/Lowest 5)	-	355	175	-	-	-	-	-	6	34	-	31	5,446	1,790	159	83	36	79
Somerset																		

*The highlighted indicators contain data published at local authority level which has been mapped to 195 CCG level.

Annex: Additional guidance on the data in this pack



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 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.

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

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.
- 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, tweet [@nhsrightcare](#), or follow our [LinkedIn page](#).