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"The Commissioning for Value packs and the RightCare programme place the NHS at the forefront of addressing unwarranted variation in care. I know that professionals - doctors, nurses, allied health professionals - and the managers who support their endeavours, all want to deliver the best possible care in the most effective way. We all assume we do so.

What Commissioning for Value does is shine an honest light on what we are doing. The RightCare approach then gives us a methodology for quality improvement, led by clinicians. It not only improves quality but also makes best use of the taxpayers’ pound ensuring the NHS continues to be one of the best value health and care systems in the world."

Professor Sir Bruce Keogh
National Medical Director, NHS England
The RightCare Programme includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners.

The approach has been tested and proven successful in recent years in a number of different health economies. As a programme that focusses relentlessly on value, increasing quality and releasing funds for further innovation, it has particular resonance.

NHS England has committed significant funding to rolling out the RightCare approach to all CCGs over the next two years. In order to provide close support to CCGs and ensure successful implementation, this will happen in three waves.

Each Regional Director has selected a cohort of CCGs to be involved in Wave One, this totals 65 across England. These CCGs will receive early access to RightCare Delivery Partner support from January 2016.


We’ll be supporting all CCGs in making the most of the RightCare approach regardless of whether they are involved in Wave One – this will commence at regional workshops: [http://www.rightcare.nhs.uk/index.php/programme/regional-launch-events-janfeb-2016/](http://www.rightcare.nhs.uk/index.php/programme/regional-launch-events-janfeb-2016/) in January and February 2016. These will be promoted via the CCG bulletin and the RightCare email updates. All CCGs are encouraged to register.
RightCare, together with the New Care Models, support the vision set out in the Five Year Forward View [https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf](https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf) with its focus on the transformation of healthcare services to drive improvements in quality and efficiency.

RightCare and Commissioning for Value support the new NHS shared planning guidance: [https://www.england.nhs.uk/deliver-forward-view/](https://www.england.nhs.uk/deliver-forward-view/) for 2016/17 which emphasises the importance of improving outcomes: better health for the whole population, reduced inequalities, increased quality of care for all patients, and better value for the taxpayer.
Supporting the 2016/17 planning guidance

This pack is being released to coincide with the recently issued NHS Shared Planning Guidance: https://www.england.nhs.uk/deliver-forward-view/.

Commissioners will take the opportunity to draw on the Atlas of Variation and this document, and take into account our plans to roll RightCare out to all CCGs over the next two years, in developing their planning submissions.

“The data and evidence available through tools such as Commissioning for Value will help commissioners make the most important decisions in delivering concrete and sustainable clinical and financial benefits across the NHS. We expect that the roll-out of the RightCare programme will drive up the quality of care while contributing significantly to meeting the efficiency challenge set out in the Five Year Forward View.”

Paul Baumann
Chief Financial Officer, NHS England
Introduction: Welcome to your refreshed data pack

This pack builds on earlier Commissioning for Value packs and updates the data from three previous sets of information:

- The original data packs from October 2013
- The Pathway on a Page packs from November 2014
- The complex patients information in the Integrated Care packs from February 2015 (restated for completeness, not refreshed)

The information contained in these slides, and the accompanying online tools, is personalised for your CCG and should be used to help support local discussion about prioritisation to improve the value and utilisation of resources.

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

NHS England, Public Health England and CCGs have legal duties under the Health and Social Care Act 2012 with regard to reducing health inequalities. One of the main focuses for the Commissioning for Value series has always been reducing variation in outcomes. Commissioners should continue to use these packs and the supporting tools to drive local action to reduce inequalities in access to services and in the health outcomes achieved.

All the previous packs and supporting information can be found on the Commissioning for Value pages: [https://www.england.nhs.uk/comm-for-value/](https://www.england.nhs.uk/comm-for-value/) on the NHS England website.
Commissioning for Value is a partnership between NHS England, Public Health England and NHS RightCare. It provides the first phase of the RightCare approach – where to look.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement. Value opportunities exist where a health economy is an outlier and will most likely yield the greatest improvement to clinical pathways and policies.

Phases two and three then move on to explore What to Change and How to Change. During 2016 RightCare will expand its work with CCGs and work with them on these phases. More information about this is included at the start of this pack.
What is Commissioning for Value?

The Commissioning for Value work programme originated during 2013/14 in response to requests from clinical commissioning groups (CCGs) that they would like support to help them identify the opportunities for change with most impact. It is a partnership between NHS England, Public Health England and NHS RightCare and the initial work was an integral part of the planning approach for CCGs.

Commissioning for Value is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the Commissioning for Value programme can help clinicians and commissioners transform the way care is delivered for their patients and populations and reduce variation in health inequalities.

Commissioning for Value is not intended to be a prescriptive approach for commissioners, rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations. It also supports CCGs to meet their legal duties to have regard to reduce health inequalities.
Why act?

We’ve worked with diverse health economies in recent years that have adopted the RightCare approach. Examples of the population healthcare and system impact of adopting the RightCare approach include:

- 1000s more people at risk of or already with Type 2 diabetes detected and being supported with their primary and secondary prevention (Bradford City and Bradford Districts CCGs)
- 36% reduction in GP referrals to acute MSK services via a locally-run triage system using locally derived protocols (Ashford CCG)
- Significant reductions in unplanned activity amongst people with complex care needs via proactive primary care (Slough CCG)
- 30% reduction in COPD emergency activity from a full pathway redesign (Hardwick CCG)
- 98% reduction in calls from frequent callers via enhanced integrated care and pathway navigation (Blackpool CCG)

Please see the RightCare casebooks: [http://www.rightcare.nhs.uk/](http://www.rightcare.nhs.uk/) for more information.
Your most similar CCGs

Your CCG is clustered with 10 CCGs who have the most similar population. This comparator group is used to identify realistic opportunities to improve health and healthcare for the CCG population. You may find it a powerful improvement tool to compare your opportunities with those of your similar CCGs as part of Phase 1 of the process set out earlier in the pack. By doing so, it may be possible to identify those CCGs which appear to have much better opportunities for populations with similar demographics against both your similar 10 CCGs and the average of the best five performers in the similar CCGs.

The analysis is based on a comparison with your most similar CCGs which are:

- NHS Basildon and Brentwood CCG
- NHS North Hampshire CCG
- NHS Bedfordshire CCG
- NHS Mid Essex CCG
- NHS Chiltern CCG
- NHS South Worcestershire CCG
- NHS South Cheshire CCG
- NHS Calderdale CCG
- NHS Ashford CCG
- NHS Vale Royal CCG

To help you understand more about how your most similar 10 CCGs are calculated, the Similar 10 Explorer Tool is available on the NHS England website: [https://www.england.nhs.uk/comm-for-value/](https://www.england.nhs.uk/comm-for-value/). This tool allows you to view similarity across all the individual demographics used to calculate your most similar 10 CCGs. You can also customise your similar 10 cluster group by weighting towards a desired demographic factor.
Where to look Step 1: Data refresh from the 2013 packs

The Commissioning for Value approach begins with a review of indicative data across the 10 highest spending programmes of care to highlight the top priorities (opportunities) for transformation and improvement.

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

The following slides help identify the ‘where to look’ opportunities to improve value. They contain a range of improvement opportunities across a number of key programme areas to help CCGs identify where local health economies can prioritise ‘where to look’. They do not seek to provide phases 2 (‘what to change’) and 3 (‘how to change’) of the overall approach.

The opportunities that follow in the next few slides outline the potential improvements (in terms of both reduced expenditure and lives saved) if the CCG were to perform at the average of the similar 10 and best five of the similar 10 as outlined in the previous slide.
These formulas should be double checked during the QA process to ensure correct output.

Headline opportunity areas for your health economy

Spend & Outcomes

- Respiratory
- Circulation
- Genito Urinary
- Musculoskeletal
- Cancer

Outcomes

- Genito Urinary
- Musculoskeletal
- Circulation
- Endocrine
- Respiratory

Spend

- Respiratory
- Circulation
- Cancer
- Neurological
- Endocrine

A note on the methodology used to calculate your headline opportunities is available on our website: https://www.england.nhs.uk/comm-for-value/

NHS West Essex CCG
What are the potential lives saved per year?

A value is only shown where the opportunity is statistically significant.

Potential Lives Saved Per Year
If this CCG performed at the average of:

- Similar 10 CCGs
- Best 5 of similar 10 CCGs

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Lives Saved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>27</td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Circulation</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td>13</td>
</tr>
<tr>
<td>Gastro Intestinal</td>
<td></td>
</tr>
<tr>
<td>Trauma and Injuries</td>
<td></td>
</tr>
</tbody>
</table>

To note: Lives saved only includes programmes where mortality outcome have been considered appropriate.
What are the potential savings on elective admissions?

A value is only shown where the opportunity is statistically significant.

Potential Elective Savings
If this CCG performed at the average of:

- Similar 10 CCGs
- Best 5 of similar 10 CCGs

<table>
<thead>
<tr>
<th>Category</th>
<th>Potential Savings (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>564</td>
</tr>
<tr>
<td>Endocrine, nutritional &amp; metabolic</td>
<td>108</td>
</tr>
<tr>
<td>Neurological</td>
<td>125</td>
</tr>
<tr>
<td>Circulation</td>
<td>329</td>
</tr>
<tr>
<td>Respiratory</td>
<td>402</td>
</tr>
<tr>
<td>Gastro Intestinal</td>
<td>653</td>
</tr>
<tr>
<td>Musculo Skeletal</td>
<td>774</td>
</tr>
<tr>
<td>Trauma and Injuries</td>
<td>193</td>
</tr>
<tr>
<td>Genito Urinary</td>
<td>197</td>
</tr>
</tbody>
</table>

NHS West Essex CCG
What are the potential savings on non-elective admissions?

A value is only shown where the opportunity is statistically significant.

**Potential Non-Elective Savings**

If this CCG performed at the average of:

<table>
<thead>
<tr>
<th>Category</th>
<th>Similar 10 CCGs</th>
<th>Best 5 of similar 10 CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>170</td>
<td>768</td>
</tr>
<tr>
<td>Endocrine, nutritional &amp; metabolic</td>
<td>84</td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td>172</td>
<td>638</td>
</tr>
<tr>
<td>Circulation</td>
<td>489</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td>638</td>
</tr>
<tr>
<td>Gastro Intestinal</td>
<td>366</td>
<td></td>
</tr>
<tr>
<td>Musculo Skeletal</td>
<td>116</td>
<td>118</td>
</tr>
<tr>
<td>Trauma and Injuries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genito Urinary</td>
<td>355</td>
<td></td>
</tr>
</tbody>
</table>
What are the potential savings on prescribing?

Analyses by RightCare. More detailed analyses of prescribing data, outlier practices, and time trends can be produced rapidly using the following resource:

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>Spend</th>
<th>£000</th>
<th>Quality</th>
<th>No. of patients, life-years, referrals, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer &amp; Tumours</strong></td>
<td>• Spend on elective and day-case admissions</td>
<td>1,019</td>
<td>• Females aged 50-70 screened for breast cancer in last 36 months</td>
<td>1,965</td>
</tr>
<tr>
<td></td>
<td>• Spend on non-elective admissions</td>
<td>170</td>
<td>• Mortality from all cancers under 75 years</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>• Spend on primary prescribing</td>
<td>124</td>
<td>• Mortality from lung cancer under 75 years</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mortality from breast cancer under 75 years</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Receiving 1st definitive treatment within 2 months of urgent GP referral</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Successful quitters, 16+</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Bowel cancer screening</td>
<td>859</td>
</tr>
<tr>
<td><strong>Circulation Problems (CVD)</strong></td>
<td>• Spend on elective and day-case admissions</td>
<td>643</td>
<td>• Reported to estimated prevalence of hypertension</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>• Spend on non-elective admissions</td>
<td>489</td>
<td>• TIA cases with a higher risk who are treated within 24 hours</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>• Spend on primary prescribing</td>
<td>295</td>
<td>• Stroke patients spending 90% of their time on stroke unit</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mortality from acute MI under 75 years</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Patients with CHD whose last blood pressure reading is 150/90 or less</td>
<td>289</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Patients with CHD whose last measured cholesterol is 5 mmol/l or less</td>
<td>541</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % hypertension patients whose BP &lt; 150/90</td>
<td>1,049</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % stroke/TIA patients whose BP &lt; 150/90</td>
<td>193</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % stroke/TIA patients cholesterol &lt; 5 mmol/l</td>
<td>186</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Emergency readmissions within 28 days</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % patients returning home after treatment</td>
<td>25</td>
</tr>
<tr>
<td><strong>Endocrine, Nutritional and Metabolic Problems</strong></td>
<td>• Spend on elective and day-case admissions</td>
<td>195</td>
<td>• % diabetes patients cholesterol &lt; 5 mmol/l</td>
<td>919</td>
</tr>
<tr>
<td></td>
<td>• Spend on non-elective admissions</td>
<td>84</td>
<td>• % diabetes patients HbA1c is 64 mmol/mol</td>
<td>934</td>
</tr>
<tr>
<td></td>
<td>• Spend on primary prescribing</td>
<td>931</td>
<td>• % diabetes patients whose BP &lt; 150/90</td>
<td>656</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % patients receiving 8 care processes</td>
<td>1,629</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Retinal screening</td>
<td>756</td>
</tr>
</tbody>
</table>
This table presents opportunities for quality improvement and financial savings for a range of programme areas. These are based on comparing NHS West Essex CCG to the best 5 amongst a peer group of 10.

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>Spend</th>
<th>£000</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td>• Spend on elective and day-case admissions</td>
<td>653</td>
<td>• Emergency admissions for alcohol related liver disease</td>
</tr>
<tr>
<td></td>
<td>• Spend on non-elective admissions</td>
<td>366</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td>• Spend on elective and day-case admissions</td>
<td>197</td>
<td>• Patients on CKD register with a BP of 140/85 or less</td>
</tr>
<tr>
<td></td>
<td>• Spend on non-elective admissions</td>
<td>355</td>
<td>• Patients on CKD register treated with an ACE-i or ARB</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reported to estimated prevalence of CKD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Creatinine ratio test used in last 12 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % home dialysis undertaken</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % of patients on RRT who have a transplant</td>
</tr>
<tr>
<td>Maternity &amp; Reproductive Health</td>
<td>• Spend on primary prescribing</td>
<td>36</td>
<td>• Teenage conceptions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Flu vaccine take-up by pregnant women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Breastfeeding initiation (first 48 hrs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % receiving 3 doses of 5-in-1 vaccine by age 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % of children aged 4-5 who are overweight or obese</td>
</tr>
<tr>
<td>Mental Health Problems</td>
<td></td>
<td></td>
<td>• Emergency hospital admissions for self harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Reported to estimated prevalence of dementia (%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Assessment of severity of depression at outset</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Access to IAPT services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IAPT referrals with a wait &lt;28days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Completion of IAPT treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IAPT: % 'moving to recovery' rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• IAPT: % achieving 'reliable improvement'</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• People on CPA in employment</td>
</tr>
<tr>
<td>Musculoskeletal System Problems</td>
<td>• Spend on elective and day-case admissions</td>
<td>774</td>
<td>• Knee replacement, EQ-5D index, average health gain</td>
</tr>
<tr>
<td>(Excludes Trauma)</td>
<td>• Spend on non-elective admissions</td>
<td>235</td>
<td>• % osteoporosis patients 50-74 treated with Bone Sparing Agent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• % patients 75+ years with fragility fracture treated with BSA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Hip replacement emergency readmissions 28 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tbody>
</table>
## Improvement and saving opportunities

This table presents opportunities for quality improvement and financial savings for a range of programme areas. These are based on comparing NHS West Essex CCG to the best 5 amongst a peer group of 10.

<table>
<thead>
<tr>
<th>Disease Area</th>
<th>Spend</th>
<th>£000</th>
<th>Quality</th>
<th>No. of patients, life-years, referrals, etc.</th>
</tr>
</thead>
</table>
| Neurological System Problems | • Spend on elective and day-case admissions  
• Spend on non-elective admissions  
• Spend on primary prescribing                                      | 125  | 940  
153                                                                                       |                                               |
| Respiratory System Problems  | • Spend on elective and day-case admissions  
• Spend on non-elective admissions  
• Spend on primary prescribing                                      | 568  | 638  
905                                                                                       | 8  
553  
5  
188  
288                                                                                   |
| Trauma & Injuries           | • Spend on elective and day-case admissions  
• Spend on primary prescribing                                      | 348  | 144                                                                                       | 274  
22                                                                                   |
Where to look Step 2: Data refresh from the 'Pathway on a Page' packs

The following slides provide a more detailed look at 14 'Pathways on a page' (adding Maternity at CCG level) by providing a wider range of key indicators for different conditions. Having reviewed the priority programmes identified in Step 1, Step 2 allows you to explore the opportunities in those programmes at condition level.

The intention of these pathways is not to provide a definitive view on priorities, but to help commissioners explore potential opportunities. These slides help commissioners to understand how performance in one part of the pathway may affect outcomes further along the pathway. This is a simplified version of a ‘focus pack’ or ‘deep dive’ and we encourage commissioners to use the full process for pathways that appear to offer the greatest areas for improvement.

Each indicator of these 14 pathways is shown as the percentage difference from the average of the 10 CCGs most similar to you.

The indicators are colour coded to help you see if your CCG has ‘better’ (green) or ‘worse’ (red) values than your peers. This is not always clear-cut, so ‘needs local interpretation’ (blue) is used where it is not possible to make this judgement. For example, low prevalence may reflect that a CCG truly does have fewer patients with a certain condition, but it may reflect that other CCGs have better processes in place to identify and record prevalence in primary care.

Please note: The variation from the average of the similar 10 CCGs is statistically significant for those indicators where the confidence intervals do not cross the 0% axis.

Commissioners should work with local clinicians and public health colleagues to interpret these pathways. It is recommended that you look at packs for your similar CCG group. By doing so, it may be possible to identify those CCGs which appear to have much better pathways for populations with similar demographics.

To enable a detailed understanding of the indicators, metadata will be published shortly on the NHS England website: https://www.england.nhs.uk/comm-for-value/
Breast cancer pathway

NHS West Essex CCG

% difference from Similar 10 CCGs

95% confidence intervals

Better  Worse  Needs local interpretation

Deprivation  Breast cancer prevalence  Incidence of breast cancer  Obesity prevalence, 16+  Breast screening  Primary care prescribing spend  Urgent GP referrals (all cancer)  % First definitive treatment within 2 months (all cancer)  Elective spend  Breast cancer detected at an early stage  <75 Mortality from breast cancer  1 year survival (breast, lung, colorectal)

NICE guidance:
http://pathways.nice.org.uk/pathways/familial-breast-cancer
http://pathways.nice.org.uk/pathways/advanced-breast-cancer
Lower gastrointestinal cancer pathway

NICE guidance:
http://pathways.nice.org.uk/pathways/colorectal-cancer
http://pathways.nice.org.uk/pathways/colonoscopic-surveillance
http://pathways.nice.org.uk/pathways/gastrointestinal-conditions
Lung cancer pathway

NICE guidance:

Deprivation
Lung cancer prevalence
Incidence of lung cancer
Smoking prevalence, 18+
Obesity prevalence, 16+
Successful quitters, 16+
Urgent GP referrals (all cancer)
% First definitive treatment within 2 months (all cancer)
Elective spend
Non-elective spend
Lung cancer detected at an early stage
<75 Mortality from lung cancer
1 year survival (breast, lung, colorectal)
Diabetes pathway

NHS West Essex CCG

- 95% confidence intervals

<table>
<thead>
<tr>
<th>Metric</th>
<th>Better</th>
<th>Worse</th>
<th>Needs local interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>% difference from Similar 10 CCGs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Diabetes prevalence, 17+ prevalence, 16+ % difference from Similar 10 CCGs
- Obesity prevalence, 16+ % difference from Similar 10 CCGs
- % diabetes patients with cholesterol < 5 mmol/l % difference from Similar 10 CCGs
- % diabetes patients with HbA1c > 64 mmol/mol % difference from Similar 10 CCGs
- % diabetes patients whose BP is < 150/90 % difference from Similar 10 CCGs
- % patients receiving 8 care processes % difference from Similar 10 CCGs
- Retinal screening % difference from Similar 10 CCGs
- Primary care prescribing spend % difference from Similar 10 CCGs
- Non-elective spend % difference from Similar 10 CCGs
- Risk of MI in people with diabetes % difference from Similar 10 CCGs
- Risk of heart failure in people with diabetes % difference from Similar 10 CCGs
- Risk of stroke in people with diabetes % difference from Similar 10 CCGs

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

PRIMIS Toolkit:
Psychosis pathway

NHS West Essex CCG

NICE guidance:
http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia
http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/
Common mental health disorder pathway

NICE guidance:

NHS West Essex CCG
Heart disease pathway

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

CHD prevalence
Hypertension prevalence, 18+
Reported to estimated prevalence of CHD
Reported to estimated prevalence of hypertension
Smoking prevalence, 18+
Obesity prevalence, 16+
% CHD patients whose BP < 150/90
% CHD patients cholesterol < 5 mmol/l
% hypertension patients whose BP < 150/90
Primary care prescribing spend
Elective spend
Non-elective spend <75 Mortality from CHD
<75 Mortality from acute MI

% difference from Similar 10 CCGs

95% confidence intervals

PRIMIS Toolkit:

**Stroke pathway**

NHS West Essex CCG

- Stroke or TIA Prevalence, 18+
- Smoking prevalence, 18+
- Obesity prevalence, 16+
- % stroke/TIA patients whose BP < 150/90
- % stroke/TIA patients whose cholesterol < 5 mmol/l
- % stroke/TIA patients on anti-platelet agent
- % AF patients with stroke risk assessment on ASA drug therapy
- Primary care prescribing spend
- TIA cases treated within 24 hours
- % stroke/TIA patients whose BP < 150/90
- % stroke/TIA patients whose cholesterol < 5 mmol/l
- % stroke/TIA patients on anti-platelet agent
- % AF patients with stroke risk assessment on ASA drug therapy
- Primary care prescribing spend
- TIA cases treated within 24 hours
- % patients 90% of Elective spend
- Non-elective spend
- Emergency readmissions within 28 days
- % patients returning home after treatment
- <75 Mortality from stroke


= 95% confidence intervals

**NHS West Essex CCG**
COPD pathway

NICE guidance:

PRIMIS Toolkit:

COPD Prevalence

Reported to estimated prevalence of COPD
Smoking prevalence, 18+
% of COPD patients with a record of FEV1
% COPD patients with review (12 months)
Primary care prescribing spend
Non-elective spend
<75 Mortality from bronchitis, emphysema and COPD

-20%
0%
20%

= 95% confidence intervals

Better  Worse  Needs local interpretation

NHS West Essex CCG
Asthma pathway

NHS West Essex CCG

% difference from Similar 10 CCGs

% patients (8yrs+) with asthma (variability or reversibility)

% asthma patients with review (12 months)

Primary care prescribing spend

Non-elective spend

Emergency admission rate for children with asthma, 0-18yrs

Mortality from asthma all yrs

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

PRIMIS Toolkit:
http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/asthma.aspx

NHS West Essex CCG

NICE Pathways

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

PRIMIS Toolkit:
http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/asthma.aspx
Musculoskeletal pathway

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

Arthritis Research UK Musculoskeletal calculator:
http://www.arthritisresearchuk.org/mskcalculator
Renal pathway

NICE guidance:
Maternity and early years pathway

NHS West Essex CCG

Further Information Links:
http://pathways.nice.org.uk/
Where to look Step 3: Complex patient analysis from the 2015 'Integrated Care' Packs

The Integrated Care packs sought to demonstrate the extent to which complex patients utilise resources across programmes of care and the urgent care system. This can support local discussions on the health and systems impact if this cohort of the population were managed via integrated care planning and supported self-management arrangements. The National Clinical Directors, Intelligence Networks and third sector organisations helped to develop the pathways.

The following slides include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that your CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2013/14. Nationally the most common conditions of admissions for complex patients are circulation; cancer; and gastro-intestinal problems. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients who will require the most treatment across the health and care system. **However it is not possible to include analysis on mental health patients as they are not captured fully in these datasets.**

NB – the complex patient slides have not been updated from the previous pack.

**Nationally:**
- These complex patients comprise **15%** of spend on inpatient admissions
- The average complex patient has six admissions per year for three different conditions (based on programme budget categories)
- **59%** of these complex patients are aged 65 and over
- **37%** of these complex patients are aged 75 and over
- **13%** of these complex patients are aged 85 and over
- **92%** of these complex patients also had an outpatient appointment during the year. Those patients had 13 attendances a year on average
- **81%** of these complex patients also had an A&E attendance during the year. Those patients had 4 attendances a year on average.
The following slides include analysis on inpatient admissions, outpatient and A&E attendances for the 2% of patients that the CCG spends the most on for inpatient admissions (covered by mandatory tariff) in 2013/14. Nationally, the most common conditions of admissions for complex patients are Circulation, Cancer and Gastrointestinal problems. Whilst this analysis only focuses on secondary care due to availability of data, it is expected that these patients are fairly representative of the type of complex patients that will require the most treatment across the health and social care system. **However, it is not possible to include analysis on mental health patients as they are not captured fully in these datasets.**

**Nationally:**

- These complex patients comprise 15% of spend on inpatient admissions.
- The average complex patient has 6 admissions per year for three different conditions (based on programme budget categories).
- 59% of these complex patients are aged 65 or over
- 37% of these complex patients are aged 75 or over
- 13% of these complex patients are aged 85 or over
- 92% of the complex patients also had an outpatient attendance during the year. Those patients had 13 attendances a year on average.
- 81% of the complex patients also had an A&E attendance during the year. Those patients had 4 attendances a year on average.
<table>
<thead>
<tr>
<th>Age</th>
<th>Number of complex patients</th>
<th>Mean Number of Admissions</th>
<th>Mean Number of Different Conditions</th>
<th>Total Spend (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>36</td>
<td>4.0</td>
<td>2.28</td>
<td>£ 969</td>
</tr>
<tr>
<td>10-14</td>
<td>12</td>
<td>2.8</td>
<td>1.50</td>
<td>£ 445</td>
</tr>
<tr>
<td>15-19</td>
<td>11</td>
<td>10.3</td>
<td>2.55</td>
<td>£ 408</td>
</tr>
<tr>
<td>20-24</td>
<td>8</td>
<td>10.9</td>
<td>1.88</td>
<td>£ 201</td>
</tr>
<tr>
<td>25-29</td>
<td>12</td>
<td>4.9</td>
<td>2.63</td>
<td>£ 147</td>
</tr>
<tr>
<td>30-34</td>
<td>12</td>
<td>9.6</td>
<td>2.25</td>
<td>£ 255</td>
</tr>
<tr>
<td>35-39</td>
<td>13</td>
<td>4.3</td>
<td>2.69</td>
<td>£ 250</td>
</tr>
<tr>
<td>40-44</td>
<td>25</td>
<td>12.7</td>
<td>2.88</td>
<td>£ 766</td>
</tr>
<tr>
<td>45-49</td>
<td>23</td>
<td>5.9</td>
<td>2.70</td>
<td>£ 439</td>
</tr>
<tr>
<td>50-54</td>
<td>34</td>
<td>8.1</td>
<td>3.12</td>
<td>£ 759</td>
</tr>
<tr>
<td>55-59</td>
<td>39</td>
<td>6.9</td>
<td>2.79</td>
<td>£ 829</td>
</tr>
<tr>
<td>60-64</td>
<td>59</td>
<td>7.6</td>
<td>3.24</td>
<td>£ 1,217</td>
</tr>
<tr>
<td>65-69</td>
<td>88</td>
<td>9.4</td>
<td>2.80</td>
<td>£ 1,939</td>
</tr>
<tr>
<td>70-74</td>
<td>91</td>
<td>6.9</td>
<td>3.00</td>
<td>£ 1,911</td>
</tr>
<tr>
<td>75-79</td>
<td>96</td>
<td>5.7</td>
<td>2.85</td>
<td>£ 1,959</td>
</tr>
<tr>
<td>80-84</td>
<td>96</td>
<td>6.0</td>
<td>3.31</td>
<td>£ 1,841</td>
</tr>
<tr>
<td>85-89</td>
<td>83</td>
<td>4.6</td>
<td>2.90</td>
<td>£ 1,623</td>
</tr>
<tr>
<td>90+</td>
<td>52</td>
<td>4.3</td>
<td>2.94</td>
<td>£ 1,054</td>
</tr>
<tr>
<td>TOTAL</td>
<td>806</td>
<td>6.8</td>
<td>2.88</td>
<td>£ 17,750</td>
</tr>
</tbody>
</table>
Of the 243 patients admitted for Gastro intestinal, 88 patients were admitted for a Cancer condition and 67 patients were admitted for a Respiratory condition.

*For more details on how to interpret the following table, please refer to the last slide of this pack "Complex Patients - How to interpret co-morbidities table"*
### Complex Patients - A & E

NHS West Essex CCG

#### Frequency of Attendance

<table>
<thead>
<tr>
<th>Attendance Frequency</th>
<th>Patients</th>
<th>% Patients</th>
<th>Attendances</th>
<th>% Attendances</th>
<th>Patient % Diff to Similar 10</th>
<th>Attendance % Diff to Similar 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;5</td>
<td>147</td>
<td>20.5%</td>
<td>1,190</td>
<td>44.2%</td>
<td>6.7%</td>
<td>6.1%</td>
</tr>
<tr>
<td>&gt;10</td>
<td>20</td>
<td>2.8%</td>
<td>281</td>
<td>10.4%</td>
<td>0.3%</td>
<td>-2.7%</td>
</tr>
<tr>
<td>&gt;15</td>
<td>8</td>
<td>1.1%</td>
<td>139</td>
<td>5.2%</td>
<td>0.1%</td>
<td>-2.4%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>716</td>
<td>100.0%</td>
<td>2,695</td>
<td>100.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- Each attendance frequency band is not exclusive.
- Patients reported with >15 outpatient attendances will also be reported in the >5 attendances band.
- The totals for frequency band will therefore not be equal to the overall total reported.
- * Represents a low number
Complex Patients - Outpatients

NHS West Essex CCG

-1.7%
-2.5%
-2.2%
-30% -10% 10% 30% 50% 70% 90%

Note:
Each attendance frequency band is not exclusive. Patients reported with >15 outpatient attendances will also be reported in the >5 attendances band. The totals for frequency band will therefore not be equal to the overall total reported.
The treatments table shows the top 5 treatments for a CCG based on attendances. The number of patients is not exclusive as 1 patient could attend for multiple different conditions.
* Represents a low number.
‡ Please refer to Commissioning for Value website for details.
• Your average complex patient has 7 inpatient admissions per year across 3 different conditions (based on programme budgeting categories)
  ➢ Your CCG spends most on Circulation, Cancer and Respiratory
  ➢ 63% of these complex patients are aged 65 or over
  ➢ 41% of these complex patients are aged 75 or over
  ➢ 17% of these complex patients are aged 85 or over

• Admissions for 36 children aged under one cost £1 million a year

• 90% of the complex patients also had an outpatient attendance during the year
  ➢ 66% of those patients had more than 5 attendances
  ➢ 24% had more than 15 attendances
  ➢ The average patient had 12 attendances a year

• 89% of the complex patients also had an A & E attendance during the year
  ➢ 21% of those patients had more than 5 attendances
  ➢ 1% had more than 15 attendances
  ➢ The average patient had 4 attendances a year
You may be thinking...

“The data are wrong”
The data are ‘indicative’, they do not need to be 100% robust to indicate that improvement is needed in an area, especially where more than one indicator (triangulation) suggests the same.

“The data are old”
The data are the most recent available. Have you done anything since to improve the pathway? If not, the opportunity remains.

“We’ve already fixed that area”
Great news! Double-check that the reforms have worked and move on to the next priority area identified by the indicators.
Next steps and actions

In addition to joining our workshops in early 2016, commissioners can take practical steps now:

• Identify the priority programmes and complex patients in your locality and compare with current reform activity and improvement plans

• Engage with clinicians and other local stakeholders, including public health teams in local authorities and commissioning support organisations

• Revisit the Commissioning for Value web pages: [https://www.england.nhs.uk/comm-for-value/](https://www.england.nhs.uk/comm-for-value/) regularly as content, including new tools to support use of the Commissioning for Value packs, will be added soon

• Explore other resources, such as the ‘how to’ videos, CVD Intelligence Network focus pack and NICE resources. See the NHS RightCare website for links: [http://www.rightcare.nhs.uk/](http://www.rightcare.nhs.uk/) Ensure planning round submissions reflect the opportunities identified and potential for change

• Engage with the national RightCare team at the regional workshops in January and February

• And (for Wave One CCGs) prepare for action in your local health economy by appointing an SRO to champion this work, plus leads with key responsibility for finance, commissioning, innovation, clinical and primary care
Further support and information

The Commissioning for Value benchmarking tool, full details of all the data used, and links to other useful tools are available on the Commissioning for Value pages of the NHS England website: https://www.england.nhs.uk/comm-for-value/  We will shortly be producing a series of focus packs for CCGs that will provide more detailed information on the opportunities to improve in the eleven highest spending programmes covered by this pack. This will include a wider range of outcomes measures and information on the most common procedures and diagnoses that patients are admitted to hospital for. This will also present information on those GP practices within each CCG that are performing better or worse than similar practices across the country.

The NHS RightCare website offers resources to support CCGs in adopting the Commissioning for Value approach: http://www.rightcare.nhs.uk/ These include:

• Online videos and ‘how to’ guides
• Case studies with learning from other CCGs

If you have any questions or require any further information or support you can email the Commissioning for Value support team direct at: england.healthinvestmentnetwork@nhs.net
Annex: How to interpret the complex patients co-morbidities table

This slide provides insight into how to interpret the co-morbidities table. The three different factors which make up this table are the main condition, co-morbidity and the number of patients.

**Interpreting main conditions**
Main conditions are ranked by the number of different conditions (based on programme budgeting subcategories) that patients are admitted for. This ranking may be different if based on the number of patients that have had an admission for each condition. For example, this CCG has 161 patients who were admitted to hospital for Gastro Intestinal problems, but 40 of these patients had admissions for two different Gastro Intestinal subcategories (e.g. Lower Gastro Intestinal and Upper Gastro Intestinal) so the total number of conditions that the ranking is based on is 201. This CCG has 178 patients who were admitted for Circulation problems, but only 15 of these patients had admissions for two different Circulation subcategories (e.g. Coronary Heart Disease and Cerebrovascular Disease) so the total number of conditions that the ranking is based on is 193. Therefore, Gastro Intestinal is shown as the 1st main condition.

**Interpreting co-morbidities**
Co-morbidities are ranked by the number of different conditions (based on programme budgeting subcategories) that patients are admitted for. This ranking may be different if based on the number of patients that have had an admission for each condition. Of the 178 patients who were admitted to hospital for Circulation problems, 26 patients also had 40 Neurological admissions (for two different Neurological subcategories). Of the 178 patients who were admitted to hospital for Circulation problems, 28 patients also had 28 admissions for Poisoning and adverse effects. Therefore, Neurological is shown as the 4th co-morbidity for Circulation followed by Poisoning and adverse effects.