NHS Rotherham CCG Governing Body – December 2014

CHIEF OFFICER'S REPORT

Contact Details:			
Lead Director:	**Chris Edwards**	Lead Officer:	n/a
Job Title:	**CCG Chief Officer**	Job Title:	n/a

Purpose

This report informs the Governing Body about national/local developments in the past month.

Crisis Care Concordat South Yorkshire Declaration

The Concordat is a shared agreed statement signed by key stakeholder organisations, including CCGs, Mental Health Providers, Local Authorities, Police and Ambulance services. It details what needs to happen when people in mental health crisis need help. It is arranged around:

- Access to support before the crisis
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crisis

The CCG supports the signing of the South Yorkshire Crisis Care Concordat along with all partners and organisations. (***Att 1***)

Winter Pressures LES

The Governing Body is asked to note the attached LES which was issued to practices on the 13th November 2014. This has been agreed by the Operational Executive and a lay member. (***Att 2***)

Commissioning for Value Pack

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 most impactful opportunities for change. NHS England has taken a pathway approach to identify areas which we compare more or less favourably to peers CCGs. The data pack will inform our Commissioning Plan. (***Att 3***)

Ofsted Report

Rotherham Council has fully accepted an Ofsted report, which describes its services for children and young people as "inadequate".

The report, which was published on the 19th November 2014 follows an Ofsted inspection of the Council's services for children in need of help and protection, looked after children and care leavers.

Ofsted also inspected Rotherham's multi-agency Local Safeguarding Children's Board, and concluded that the arrangements in place to evaluate the work of the local authority, to safeguard children and promote their welfare are also inadequate.

Rotherham CCG is currently analysing the report and will develop an action plan to improve health services that were found wanting within the report. The action plan will be presented at the next Governing Body meeting.

Extraordinary Meeting - Governing Body

In order to be able to sign of the accounts for 204/15 it is recommended that we have an extraordinary meeting of the Governing Body following AQuA to take place at 11.30am on Friday 22nd May 2014.

Communications Update

- The winter communications campaign encouraging patients to get the right care, first time by making the right choice of service for their illness or injury. Advertising, radio and print, has started and materials are being distributed throughout December, including at the front of A&E and in supermarkets.

- We recently undertook an assessment process for CCG of the Year, following our shortlisting in the HSJ Awards. The process included a 3 hour site visit by two judges and a 10 minute presentation at the HSJ head office. The result was announced on Wednesday 19th November, unfortunately we were unsuccessful and Tower Hamlets CCG won the award for best CCG.

- A Communications and Engagement Plan for 2015/16 has been drafted and will come to Governing Body for approval in January.

- Media training has been undertaken with key staff and some executive GPs, focussing priority areas for the CCG. The individuals will be used as spokespeople at appropriate times in the future.

- A stakeholder awareness event has been organised for the Working Together programme at the New York Stadium, Rotherham on Tuesday 16th December 2014. Invites have been sent to relevant stakeholders.

- The November edition of the Healthwatch newsletter is attached. ***(Att 4)***

Recommendation

The Governing Body is asked to ***note*** the Chief Officer's Report.

Crisis Care Concordat
Mental Health

Att 1

Declaration statement

The 2014 South Yorkshire Declaration on improving outcomes for people experiencing mental health crisis [date of Declaration or of this DRAFT]

We, as partner organisations in South Yorkshire, will work together to put in place the principles of the national Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in South Yorkshire by putting in place, reviewing and regularly updating locally agreed action plans.

This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in South Yorkshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

We, the organisations listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in South Yorkshire.

Who should sign a local Declaration?

Many local organisations want to support the Declaration because of their commitment to improve mental health care and may want to make a specific contribution within the action plan for continuous improvements.

In addition, certain organisations have a formal (statutory) responsibility and/or a professional duty of care regarding people presenting in mental health crisis:

- Clinical Commissioning Groups
- NHS England Local Area teams (primary care commissioners)
- Commissioners of social services
- The Police Service
- Police and Crime Commissioners
- The Ambulance Service
- NHS providers of Urgent and Emergency Care (Emergency Departments within local hospitals)
- Public / independent providers of NHS funded mental health services
- Public / independent providers of substance misuse services

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe

Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

NHS Rotherham Clinical Commissioning Group

NHS Standard Contract - SCHEDULE 2 – THE SERVICES

Winter Pressures LES 2014/15 v4

Service Specification No.	GP5
Service	Additional Opening Hours in General Practice
Commissioner Lead	Dr Jason Page, Commissioning Executive
Provider Lead	As signed
Period	Monday 10th November 2014 to Saturday 7th March 2015
Date of Review	Not applicable – fixed term contract

1. Population Needs

1.1 National/local context and evidence base

Most Practices keep several 'same day' appointments back for patients that require an urgent appointment. However, when these slots are taken the only option Practices have is to add patients as extras into an already fully booked clinic either at the start or end of the session, direct patients to the Walk in Centre, or ask the patients to wait and be seen the next day.

Evidence suggests that rather than attending the Walk in Centre, patients migrate to A&E with inappropriate conditions. A&E staff insist that all patients will be seen if they attend the department, incurring an A&E costs to the CCG. A&E is receiving an influx of patients after GP surgeries close, from 18:30 to 22:00.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	N/A
Domain 2	Enhancing quality of life for people with long-term conditions	N/A
Domain 3	Helping people to recover from episodes of ill-health or following injury	Yes
Domain 4	Ensuring people have a positive experience of care	Yes
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	Yes

3. Scope

3.1 Aims and objectives of service

The aim of the LES is for the CCG to provide additional funding in the form of winter pressures monies to enable Practices to remain open after core hours. Participation is optional.

3.2 Service description/care pathway

The following criteria must be followed in order to qualify for additional funding:

3.2.1 The clinics must be in addition to those provided as extended hours commissioned under the Extended Hours DES from NHS England.

3.2.2 The clinics must be provided after core hours between 18:30 and 20:00

3.2.3 Appointments must be booked on the day after 13:00, and be for

acute patients only.

3.2.4 Practices must be able to demonstrate that all standard clinics are still taking place and that the clinics create additional capacity. 20% of participating practices will be chosen at random and must submit evidence of normal activity and additional activity as requested by the Quality Assurance Team to verify this.

3.2.5 Patients must receive 10 minute appointments, and they must be GP appointments.

3.2.6 Each patient who attends should be given a patient participation questionnaire provided in appendix 1 asking the patients what they would have done if this appointment had not been available e.g. gone to A&E, self-care etc. Practices will be responsible for ensuring these are completed, collating them, and for returning all responses to the CCG. We would expect to see a minimum of 50% of patients who use the additional clinics returning a questionnaire.

3.2.7 There is no cap on the amount of additional clinic time each practice can provide.

3.2.8 The CCG will fund the clinics at a rate of £120 per hour.

3.2.9 As this is a pilot, the CCG will review both the capacity provided and the take-up of appointments each month, and reserves the right to withdraw or reduce the service if it is underutilised.

3.2.10 On signing the contract, each participating practice will be asked to give an indication of what they intend to provide.

3.2.11 This agreement can be terminated by either party at any point by giving 3 months written notice.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

Not applicable.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

Not applicable.

4.3 Applicable local standards

As detailed above in service description/care pathway.

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements

In order to qualify for payment the practice must complete a monthly data return to the CCG. This will be requested by the Quality Assurance Team via Survey Monkey and will include the following data items as a minimum:

- Dates and times (start and finish) of clinics held in previous calendar month
- Total number of patients seen in each clinic.
- Total number of patients who DNA'd in each clinic.

5.2 Applicable CQUIN goals

Not applicable.

Winter Pressures LES 2014/15

6. Practice information and signatures

6.1 Practice Information

Please supply the following information as part of your indication that your practice wishes to participate in the LES.

Planned hours of additional clinics per week: _____

6.2 Signatures

On behalf of:	**On behalf of:** NHS Rotherham CCG
Name:	**Name:** Chris Edwards
Signature:	**Signature:**
Date:	**Date:**

Please return this original copy by post in the envelope enclosed to:

Quality Assurance Team
Rotherham CCG
Oak House
Moorhead Way
Bramley
S66 1YY

NHS
Rotherham
Clinical Commissioning Group

PATIENT QUESTIONNAIRE

Practice Code: **Practice Name:**

During winter more people need more appointments. Your appointment today was in an extra clinic to make sure more people can be seen quickly. We would be grateful if you could answer a couple of questions.

Please tick your answer.

1. How urgently did you feel you needed to be seen by a doctor today?

☐ Needed to be seen today
☐ Preferred to be seen today
☐ Could have been seen another day

2. If this appointment hadn't been available, what would you have done?

☐ Nothing
☐ Gone to the local pharmacy
☐ Gone to A&E
☐ Waited for an appointment
☐ Gone to the Walk in Centre
☐ Other (please comment) _____

3. Following this appointment will you:

☐ Follow the GP advice / treatment
☐ Seek further advice / treatment from A&E
☐ Seek further advice / treatment from Pharmacy
☐ Seek further advice / treatment from Walk in Centre
☐ Nothing
☐ Other (please comment) _____

4. What is the age of the patient?

☐ 5 and under
☐ 6-16
☐ 17-25
☐ 26-40
☐ 41-60
☐ 61-74
☐ 75 and over

5. Do you have daily commitments between 8am and 6pm?

☐ Yes
☐ No

6. Please leave any other comments about this appointment:

_____

_____

_____

_____

_____

Public Health England

RightCare

NHS England

Commissioning for Value: Pathways on a page

NHS Rotherham CCG

November 2014

OFFICIAL Publications Gateway Ref: 02449

Contents

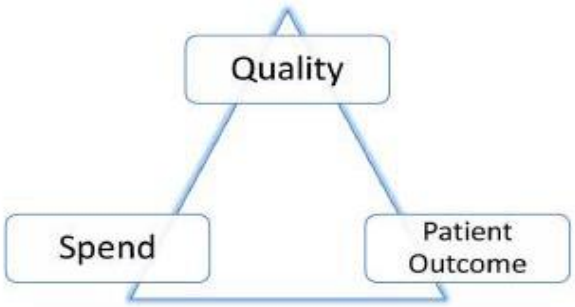
Introduction: What is Commissioning for Value?

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 most impactful opportunities for change. It is a partnership between NHS England, Public Health England and NHS Right Care 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.

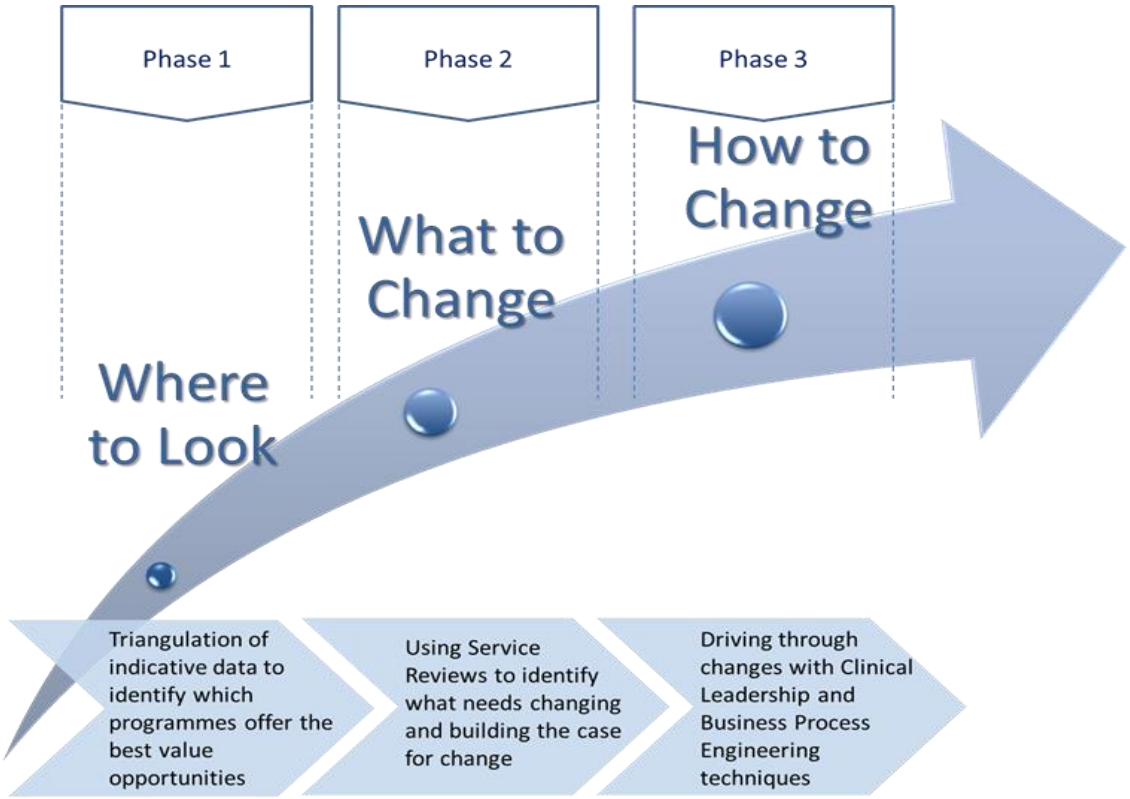
By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the Commissioning for Value programme can help clinicians and commissioners transform the way care is delivered for their patients and populations.

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 area teams, providing suggestions on where to look to help them deliver improvement and the best value to their populations.



Elements of value

The Commissioning for Value approach



The Commissioning for Value approach is to identify value opportunities by looking at clinical programmes, as opposed to organisational or management structures and boundaries. Value opportunities exist where a health economy is an outlier and therefore will most likely yield the greatest improvement to clinical pathways and policies.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement.

Phases two and three then move on to explore *What to Change* and *How to Change*.

Supporting planning and transformation

The healthcare system is facing the challenges of increasing demand and limited resources. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

The forthcoming planning guidance for 2015/16 will emphasise the importance of Commissioning for Value to help support local discussion about prioritisation and utilisation of resources. By using the information contained in these latest packs and enhanced tools, CCGs will be able to ensure their plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes and resource utilisation.

The packs also support the vision set out in the recently published Five Year Forward View with its focus on the transformation of healthcare services to drive quality and efficiency.

Why act?

The benefits from using the Commissioning for Value approach and packs are beginning to be realised across the country. A number of CCGs have already seen improvements in financial and quality outcomes for their populations.

CCGs are using the Commissioning for Value approach to shift spend and improve processes	• Achieved turnaround (Warrington CCG) • Clinically led annual QIPP planning and delivery (Wigan Borough CCG) • Clinical leaders driving change (Vale of York CCG) • Galvanising commissioners in a growing number of health economies (30+ CCGs and growing)
CCGs are using the Commissioning for Value approach to achieve financial stability, eg in West Cheshire CCG	• Yr 1: 'Came from behind' - Implemented system mid year • Yr 2: 'Delivered as went along' - Began at year start, achieved by end • Yr 3: 'Planned ahead' - Began before year, over- achieved • Yr 4: 'Ahead of the curve' - 20% of QIPP delivered by start • Yr 5: 'Total focus on quality'
It's not just about the money. West Cheshire CCG saw quality improvements in just one year	• A&E attendances & admissions, elective & non-elective activity, outpatient firsts & follow-ups all decreased • Outcomes and quality improved • Integration occurred across health sectors and with social care

More information about some of the Commissioning for Value which has already taken place across the country can be seen in the 'Learning from others' section of this pack.

The Pathways on a Page pack

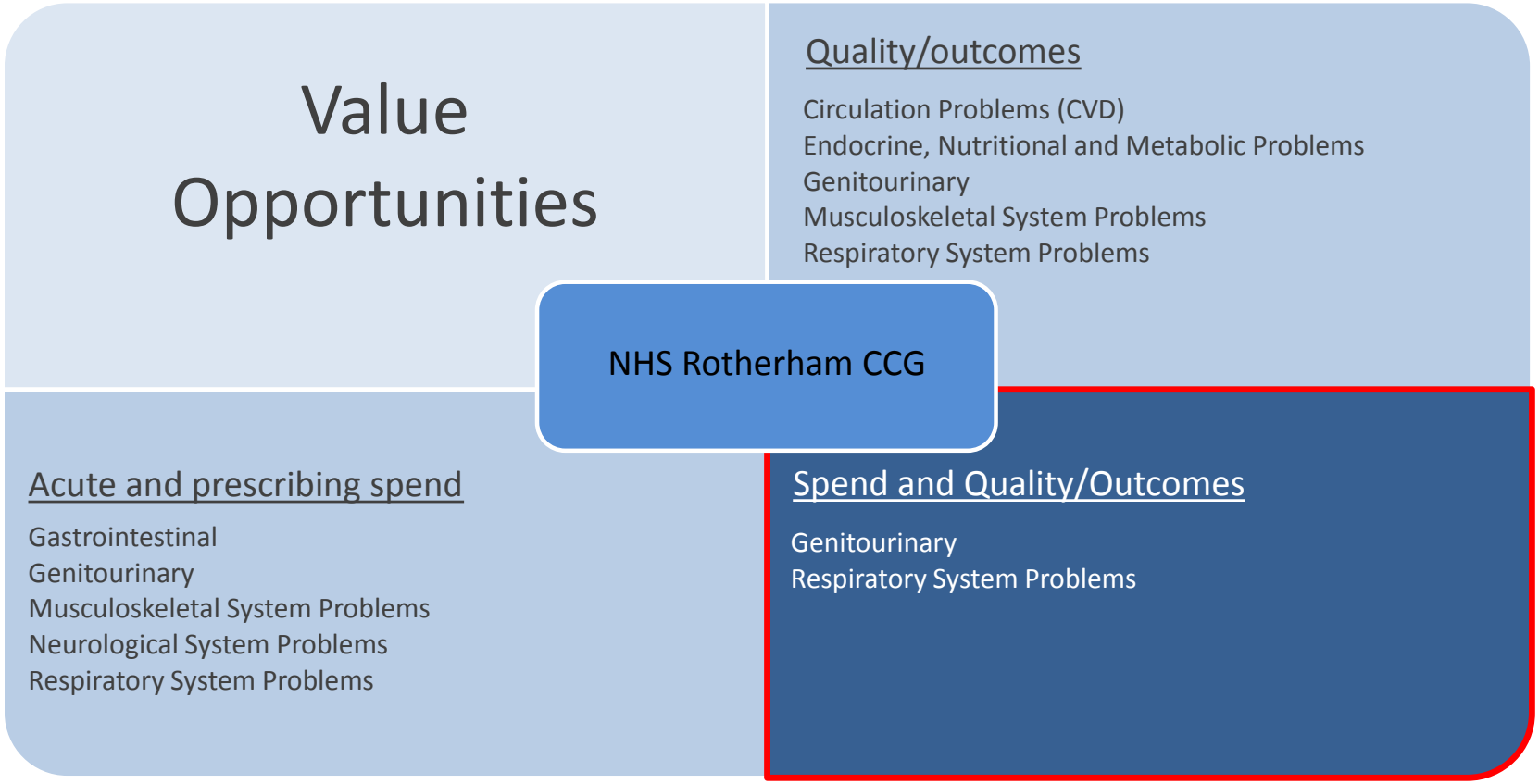
This ‘Pathways on a Page’ pack is the second in a series of Commissioning for Value support packs for CCGs. The National Clinical Directors and Intelligence Networks have helped to develop the pathways.

The first packs - released in October 2013 - contained information on a range of improvement opportunities to help each CCG identify where its local health economy could focus its efforts – the ‘where to look’ phase. Those packs can be seen at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/. The next page shows the areas identified as those where your CCG could potentially make the greatest improvements in terms of spend and quality/outcomes.

This pack provides a more detailed look at these areas by providing a wider range of key indicators, using the latest published data, and presenting them along the lines of a pathway that patients may experience for different conditions. Alongside the areas highlighted last year, CCGs may wish to use the 13 pathways in this pack to complement that identification of improvement opportunities. CCGs may find that exploring the pathway in more detail in this way helps to identify new opportunities to prioritise as part of the planning process. Please note that pathways are not included for gastro-intestinal and neurological problems at this stage; additional indicators for these will be added to the Commissioning for Value tool in due course.

As with the original packs, the intention of these pathways is not to provide a definitive view on priorities but to help commissioners explore potential opportunities. These packs 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. Page 26 provides further information on starting a deep dive.

Headlines for your health economy



Public Health England

RightCare

NHS England

How to interpret your pathways on a page

On the following pages a selection of key indicators are presented following the patient pathway from left to right. Each indicator 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, high prevalence may reflect that a CCG does truly have more patients with a certain condition, but it may reflect that the CCG has better processes in place to identify and record prevalence in primary care, or that registers have not been audited recently.

The original packs presented potential opportunities compared to the best performing five CCGs out of the similar ten. For presentational reasons these pathways on a page show performance compared to the average of the similar ten CCGs. This means that 'better' (green) means better than average and that improvement is still required to become 'good'. Commissioners are encouraged to consider how to achieve the level of the best performing CCGs and the interactive tool and deep dive process allows users to explore this in more detail.

In the original pack, higher spend on prescribing and elective admissions was included as a potential improvement opportunity. In this pack they are coloured blue because spending more in these areas might be a result of a specific strategy to identify and treat patients earlier, which may lead to lower spend on non-elective admissions and better outcomes for patients. Local investigation and interpretation is key to determining the opportunity to improve in these areas. In other words, CCGs should not discount any potential opportunities identified in the first pack for prescribing and elective admissions – these should still be explored, but it is important to consider the pathway as a whole and not individual elements separately.

Commissioners should work with local clinicians and public health colleagues to interpret these pathways.

How to interpret your pathways on a page (continued)

CCGs may also find it a powerful improvement tool to compare their pathways with those of their similar CCGs. By doing so, it may be possible to identify those CCGs which appear to have much better pathways for populations with similar demographics.

- NHS Tameside and Glossop CCG
- NHS Hartlepool and Stockton-on-Tees CCG
- NHS Barnsley CCG
- NHS St Helens CCG
- NHS Wakefield CCG
- NHS Wigan Borough CCG
- NHS Wirral CCG
- NHS Stoke on Trent CCG
- NHS Doncaster CCG
- NHS Halton CCG

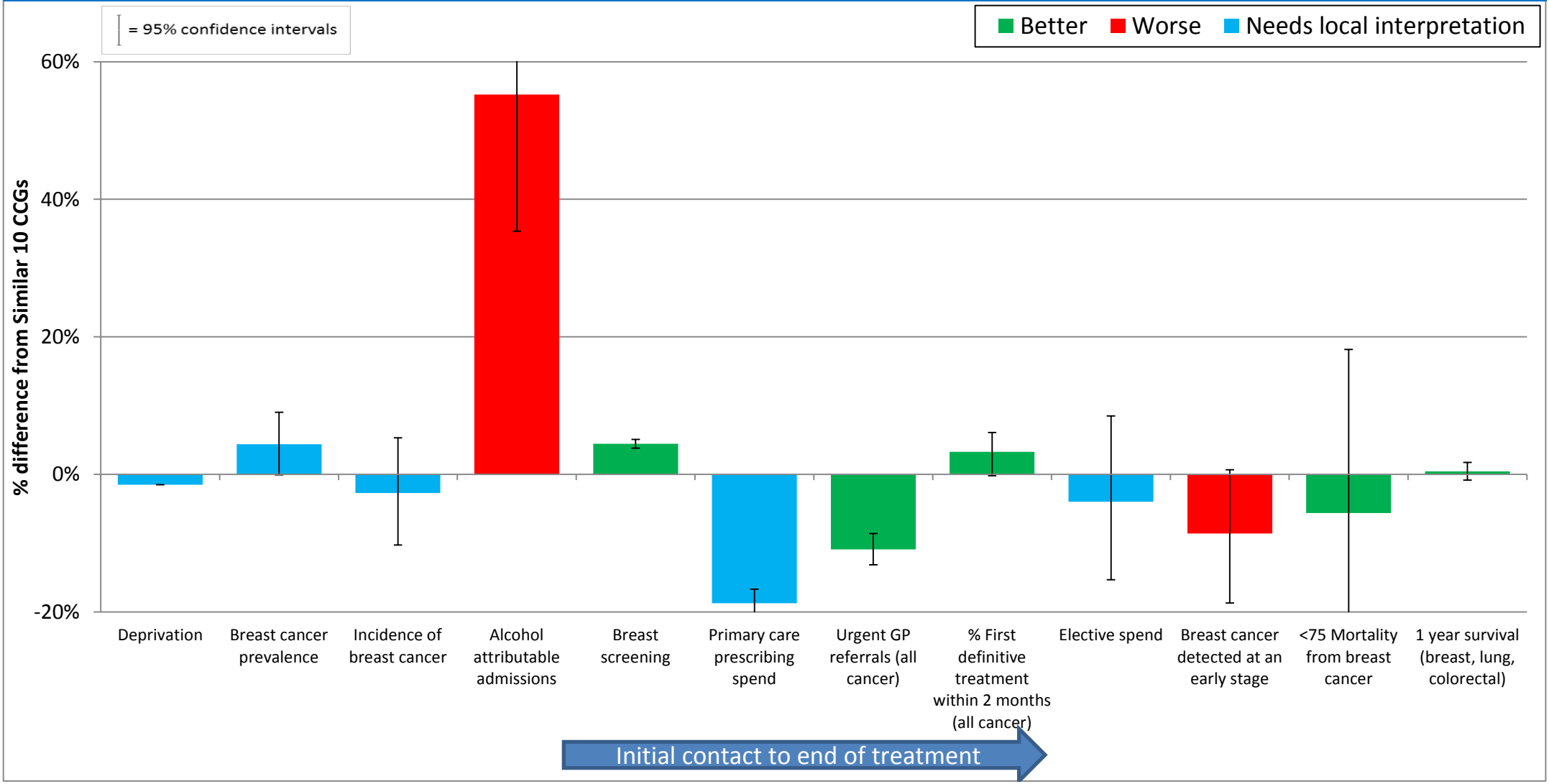
To enable a detailed understanding of the indicators, metadata will be published at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/ shortly, but longer descriptions of the indicators are available in the annex at the end of this pack.

Links to the NICE guidance are included for each pathway. All the pathways can be accessed at: http://pathways.nice.org.uk

Public Health England has also provided support packs to help CCGs understand variations across their cardiovascular (CVD) care pathway and get better value from their CVD services. These packs are available at http://www.yhpho.org.uk/default.aspx?RID=199884

Breast cancer pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/familial-breast-cancer
http://pathways.nice.org.uk/pathways/early-and-locally-advanced-breast-cancer
http://pathways.nice.org.uk/pathways/advanced-breast-cancer

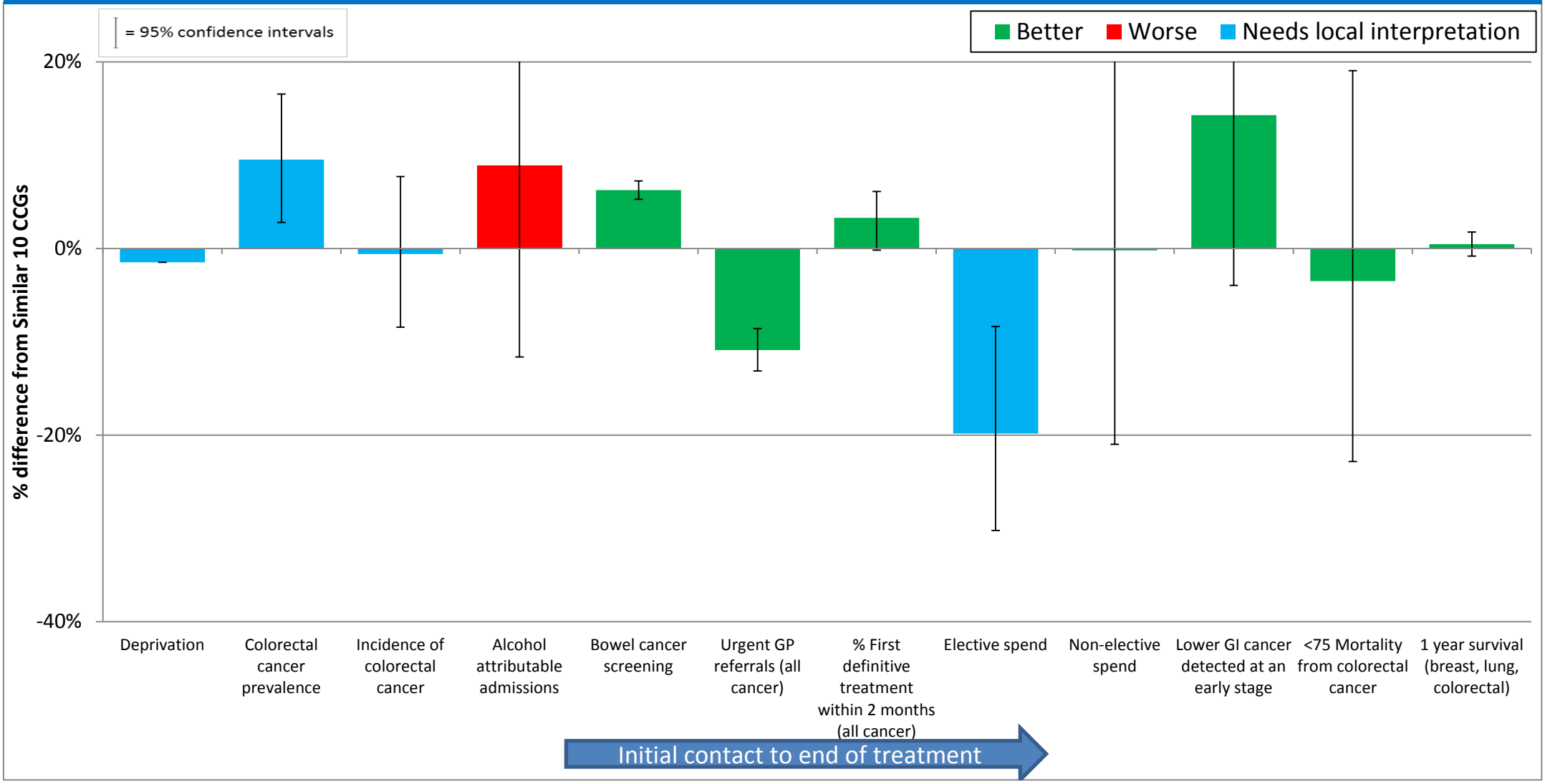
Public Health England

RightCare

NHS England

Lower gastrointestinal cancer pathway

NHS Rotherham CCG



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

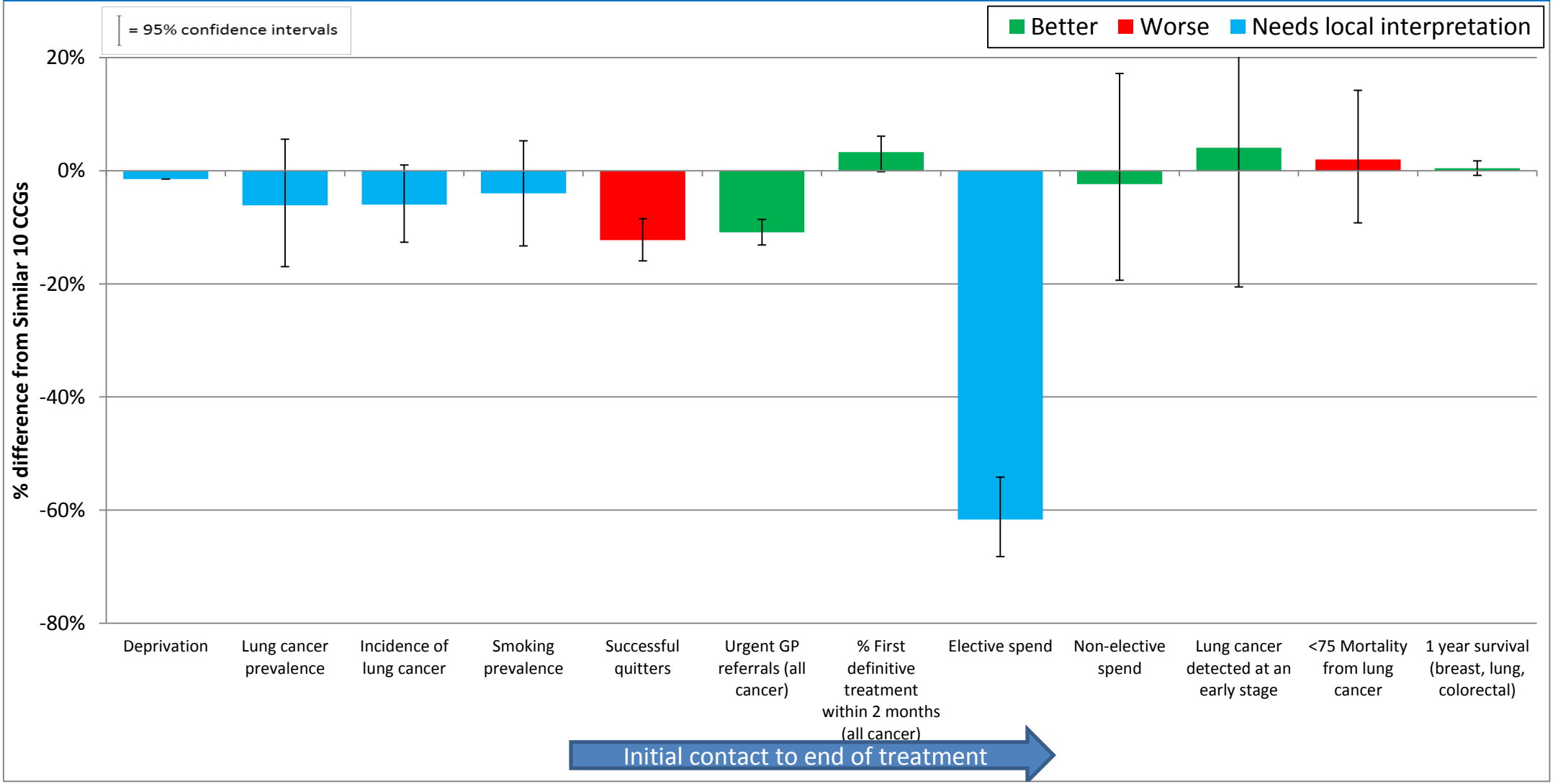
Public Health England

RightCare

NHS England

Lung cancer pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/lung-cancer

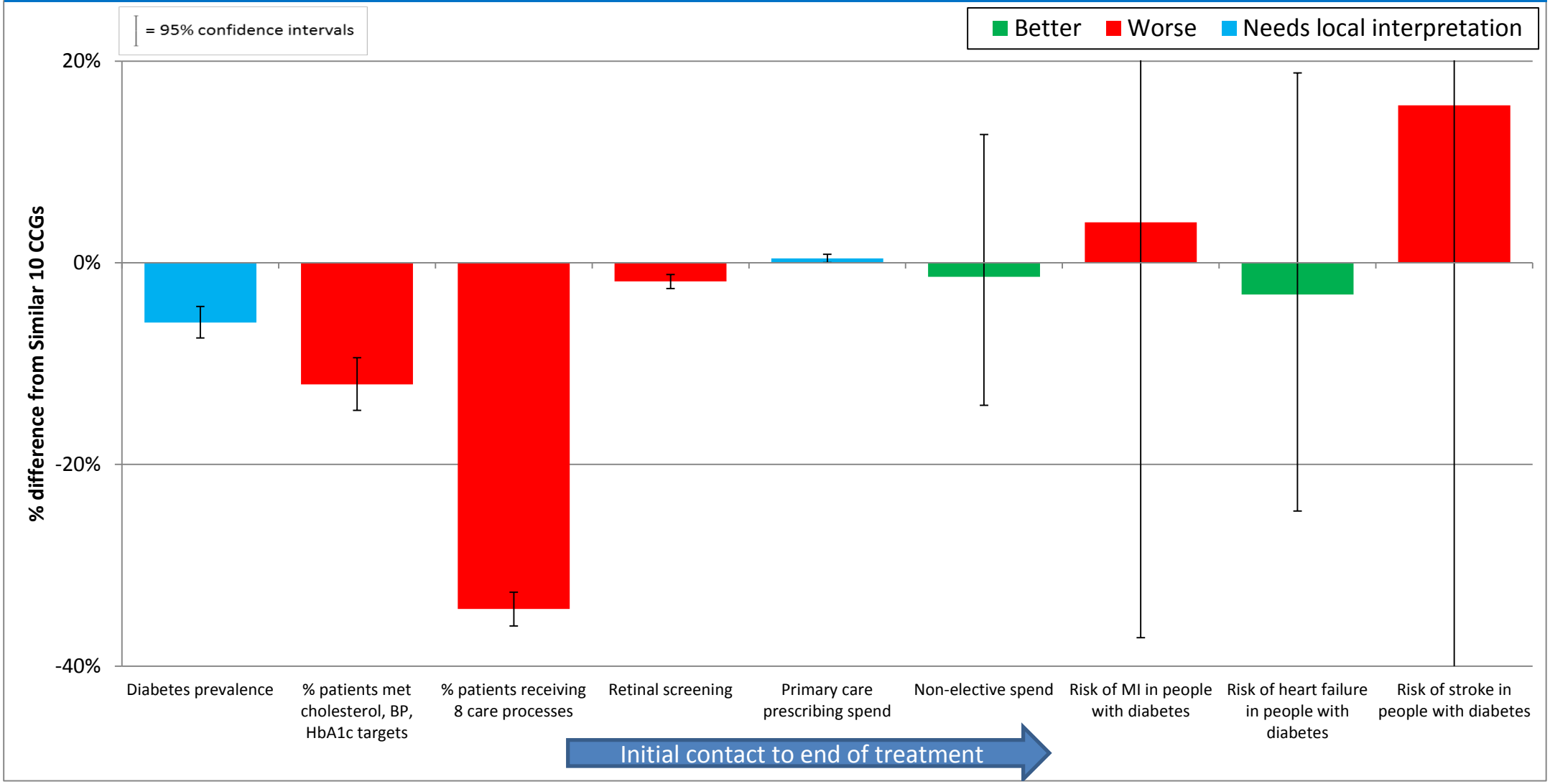
Public Health England

RightCare

NHS England

Diabetes pathway

NHS Rotherham CCG



NICE guidance:

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

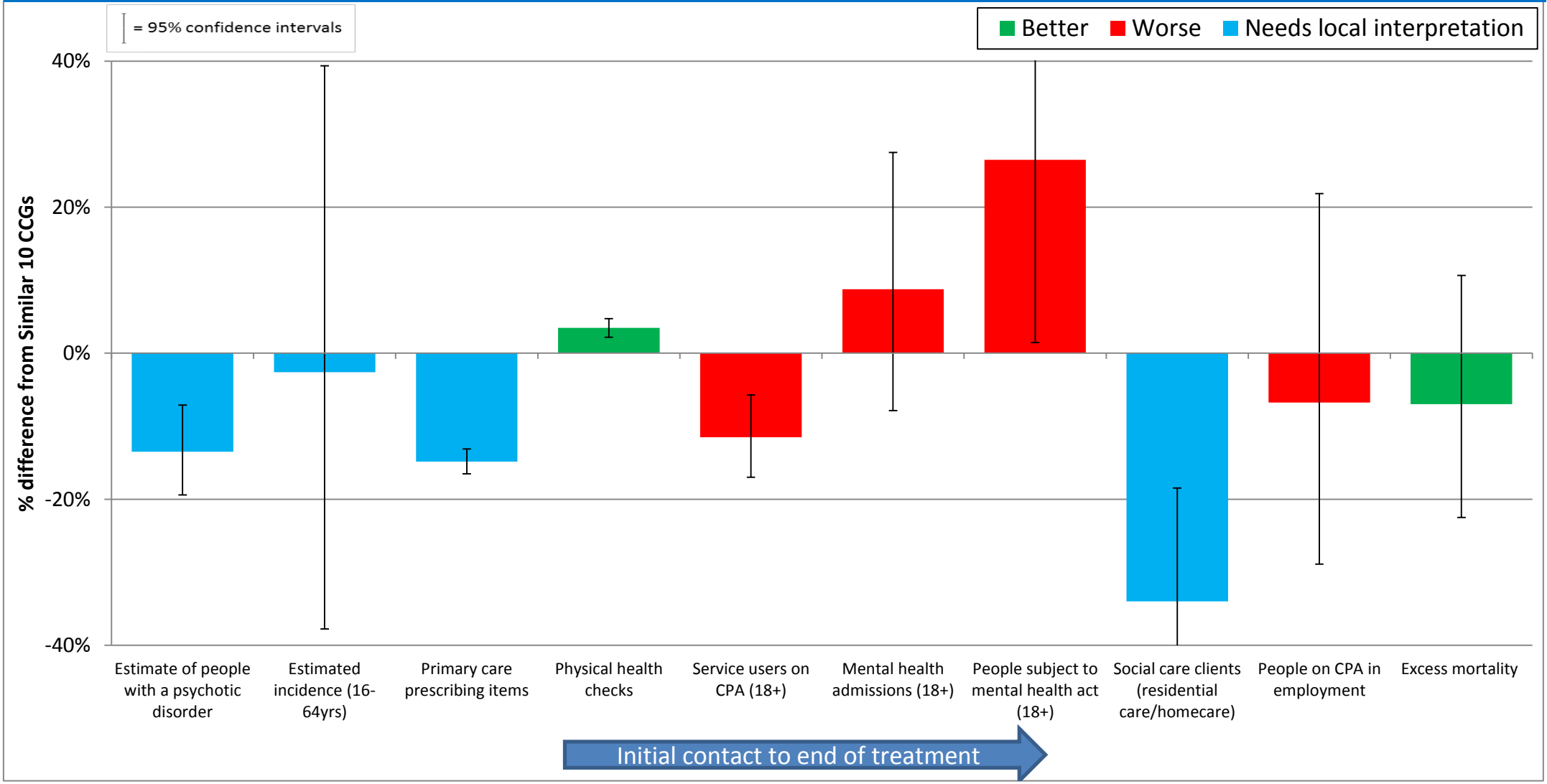
Public Health England

RightCare

NHS England

Psychosis pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia

Other important psychosis indicators omitted for data quality issues:

http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/

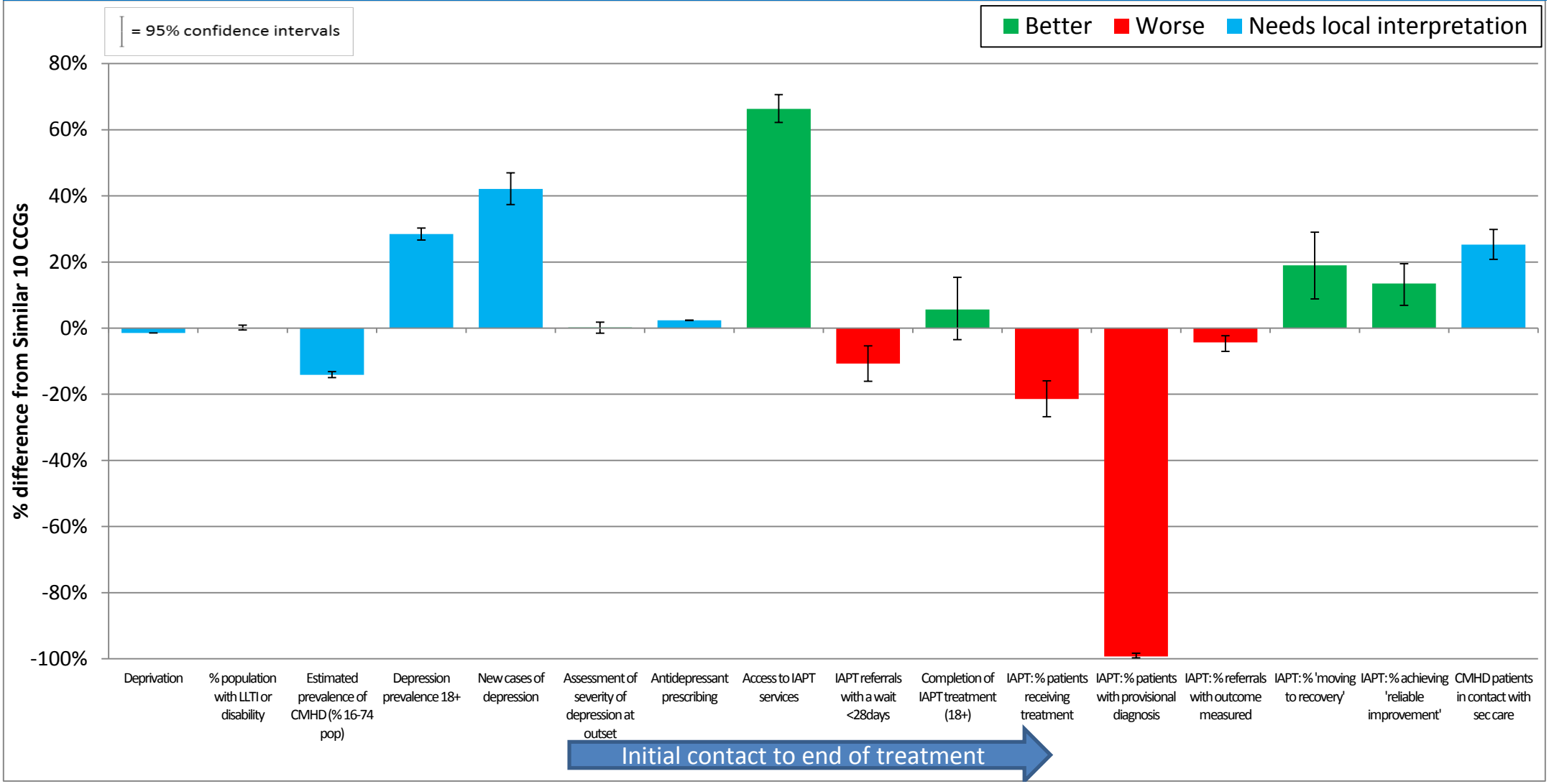
Public Health England

RightCare

NHS England

Common mental health disorder pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care

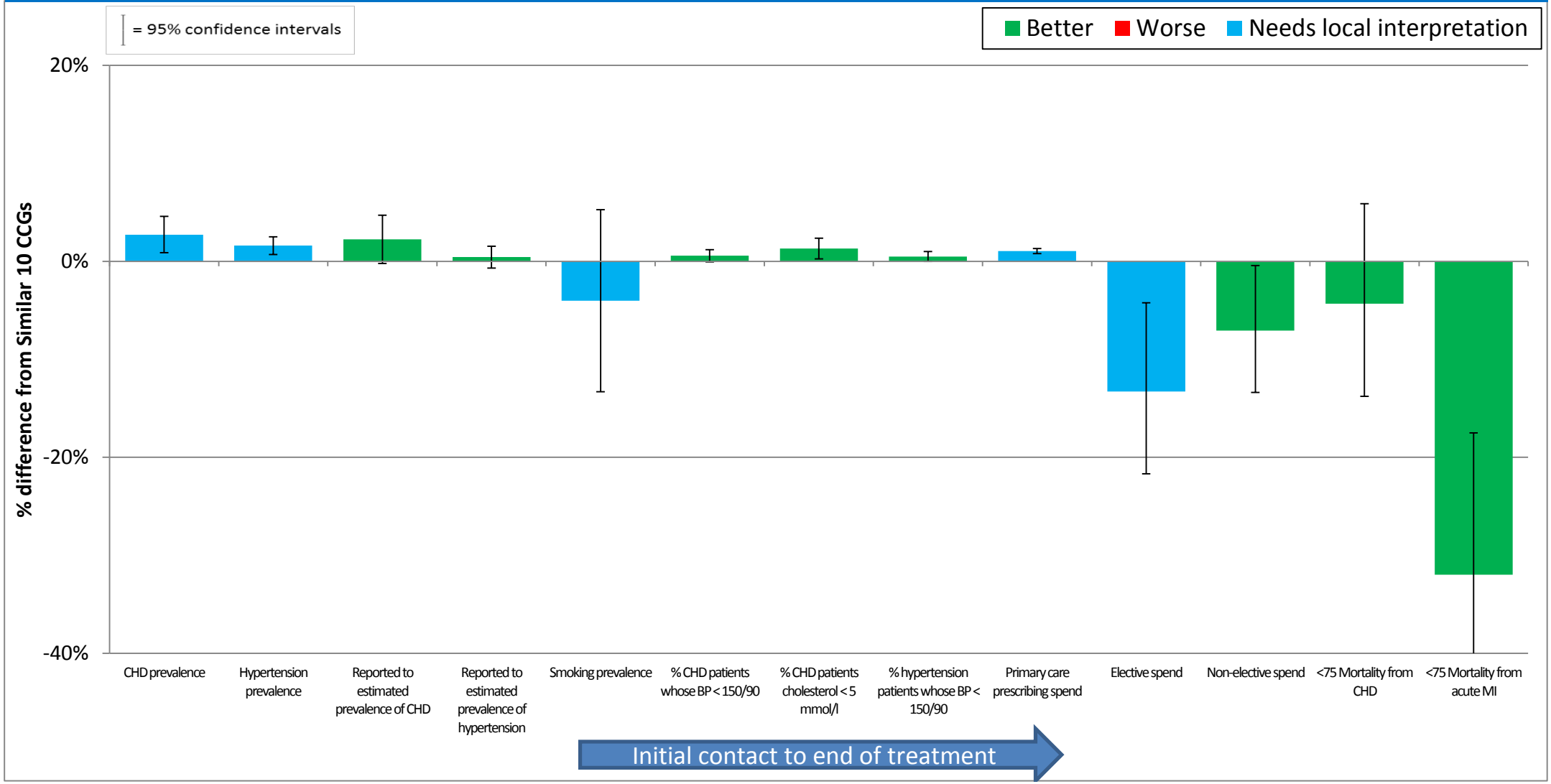
Public Health England

RightCare

NHS England

Heart disease pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/hypertension
http://pathways.nice.org.uk/pathways/cardiovascular-disease-prevention
http://pathways.nice.org.uk/pathways/smoking

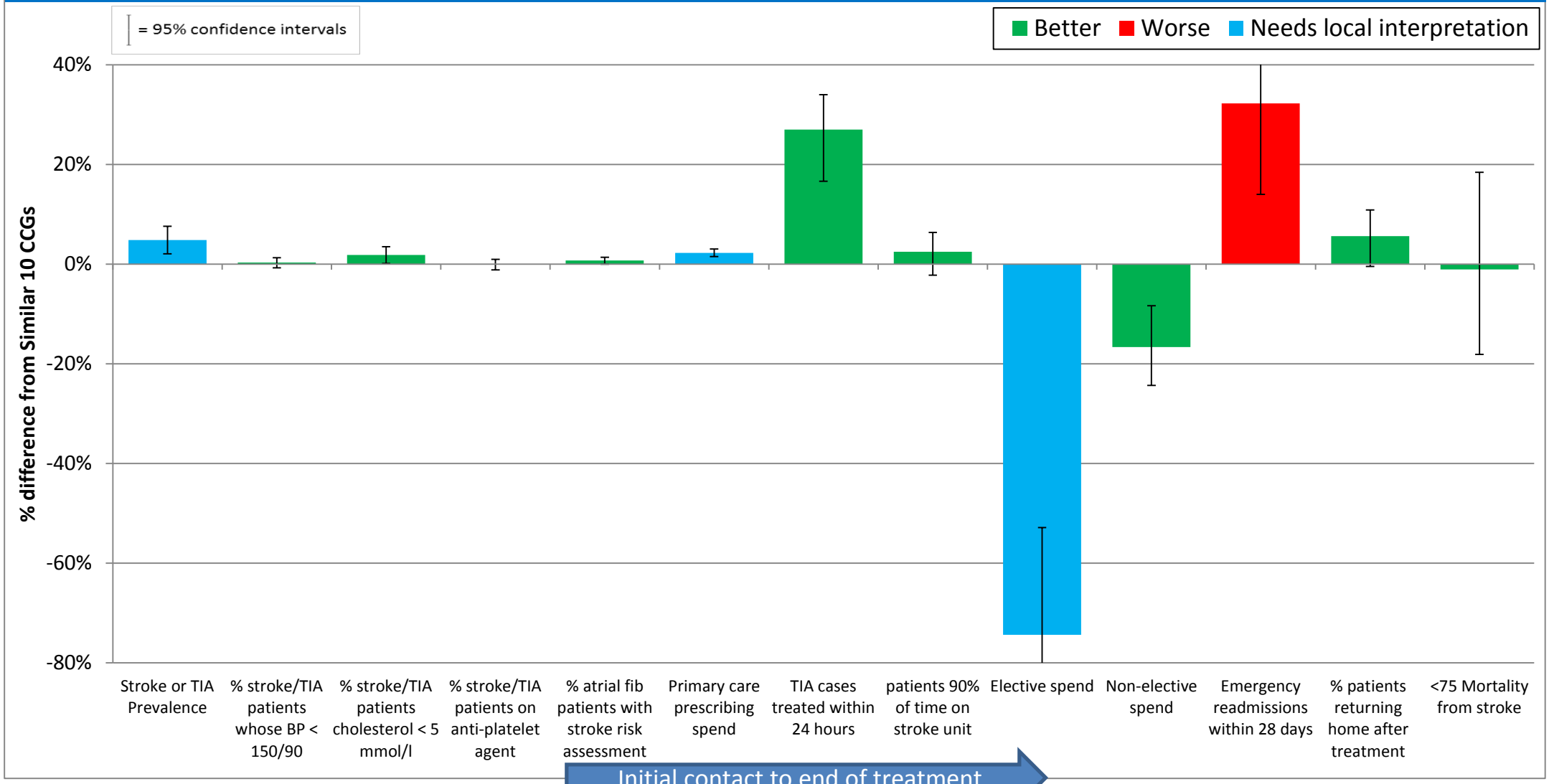
Public Health England

RightCare

NHS England

Stroke pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/stroke

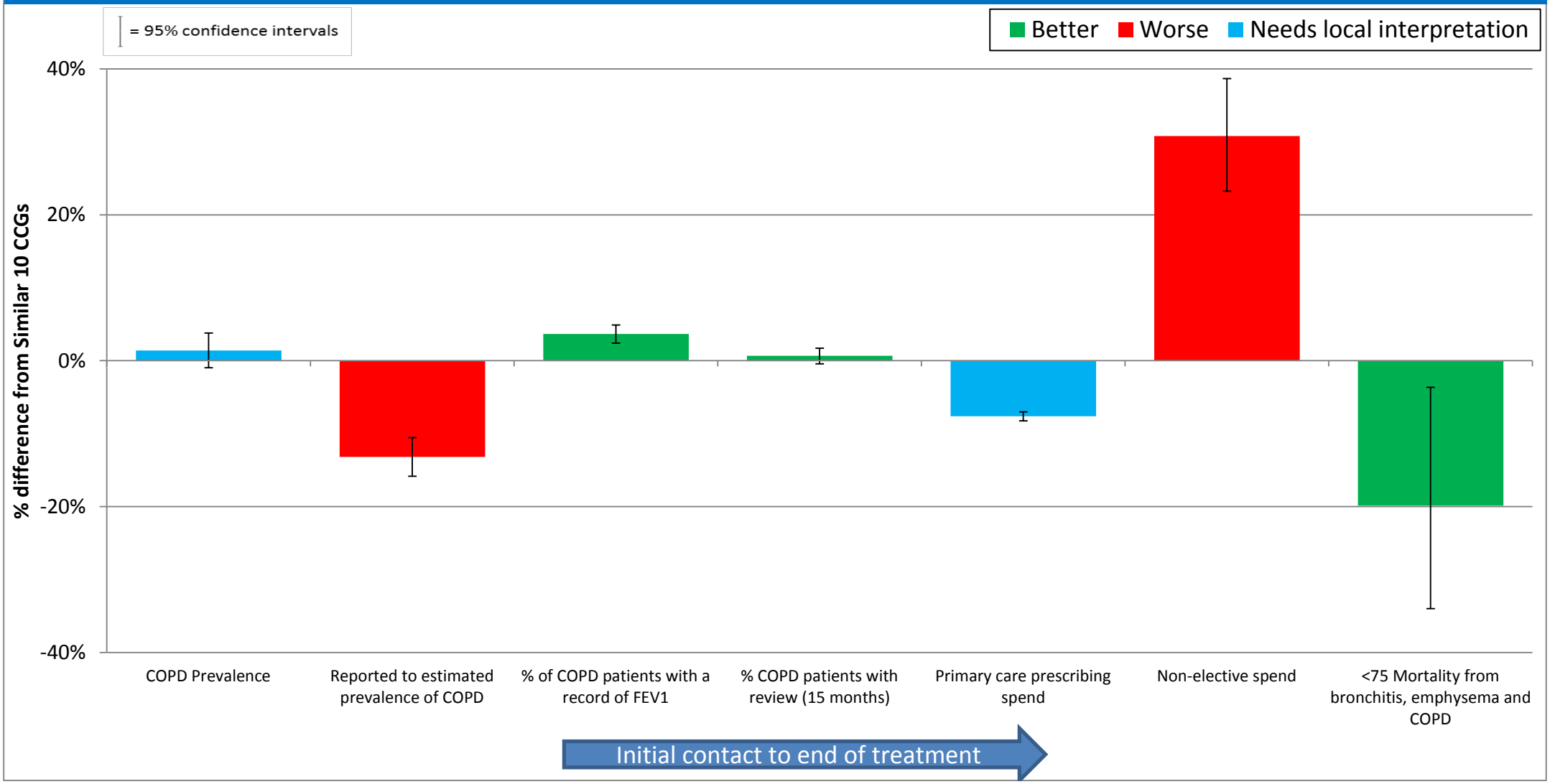
Public Health England

RightCare

NHS England

COPD pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease

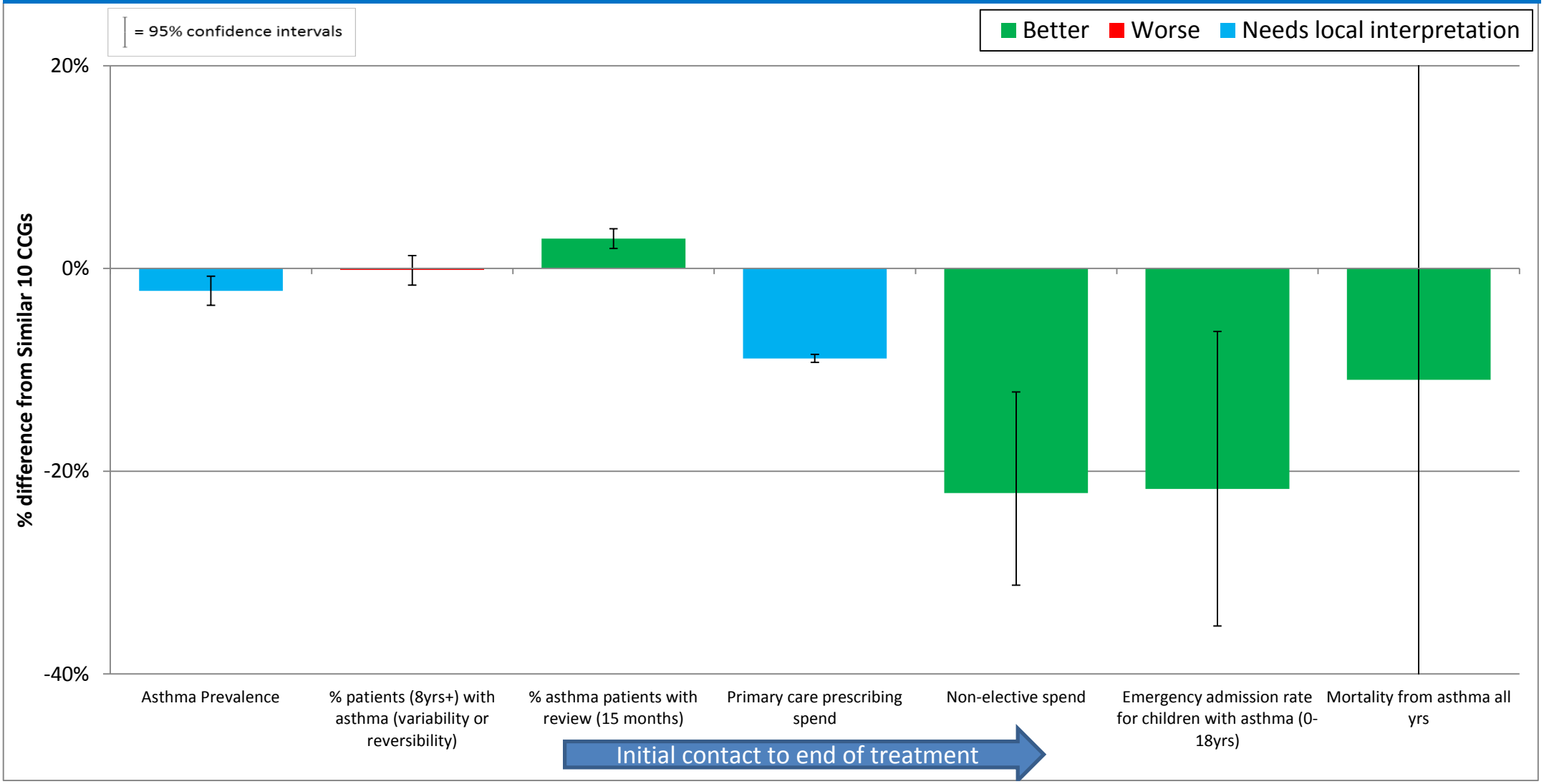
Public Health England

RightCare

NHS England

Asthma pathway

NHS Rotherham CCG



NICE guidance:

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

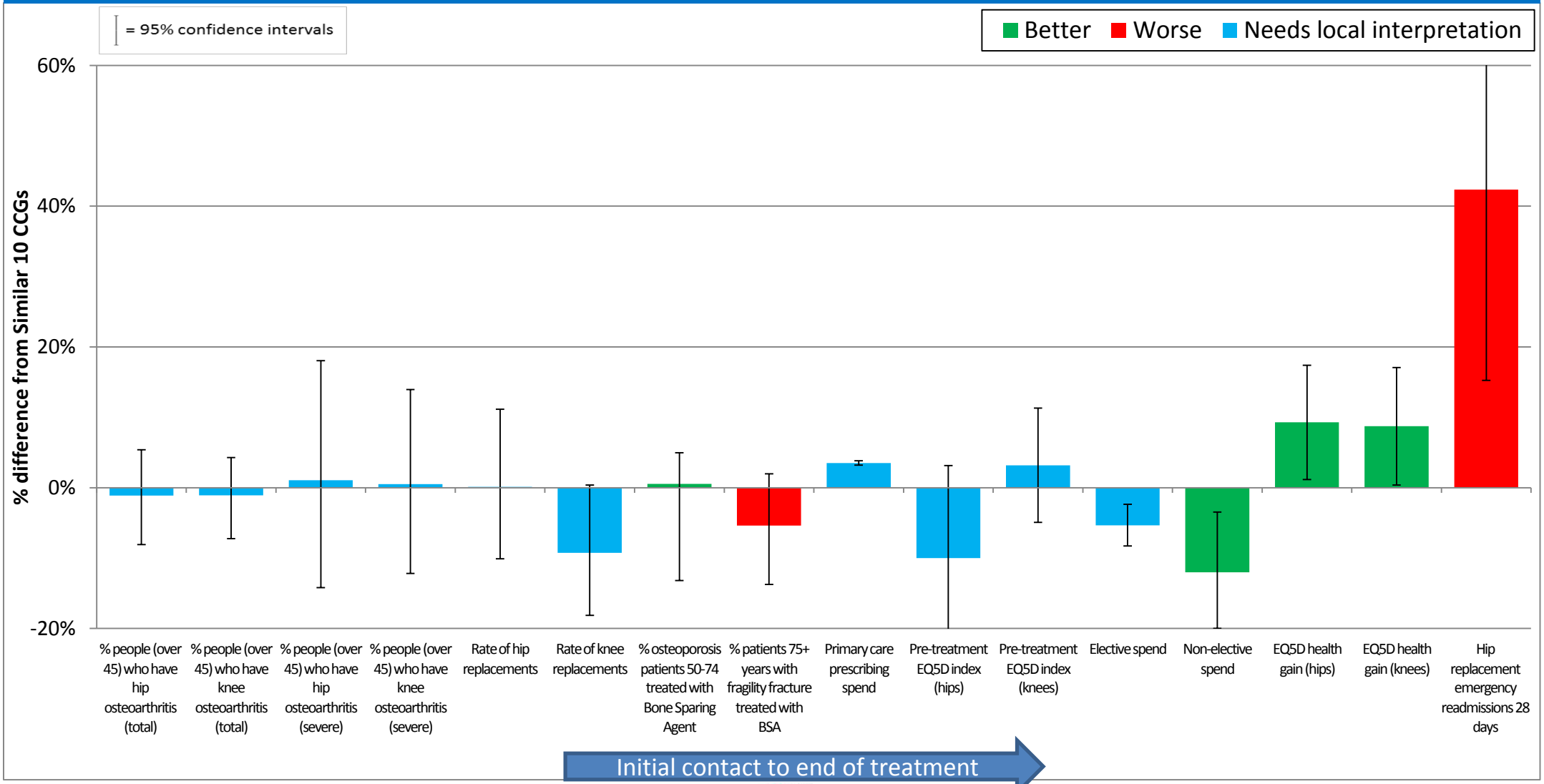
Public Health England

RightCare

NHS England

Musculoskeletal pathway

NHS Rotherham CCG



NICE guidance:

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

Arthritis Research UK Musculoskeletal calculator:

http://www.arthritisresearchuk.org/mskcalculator

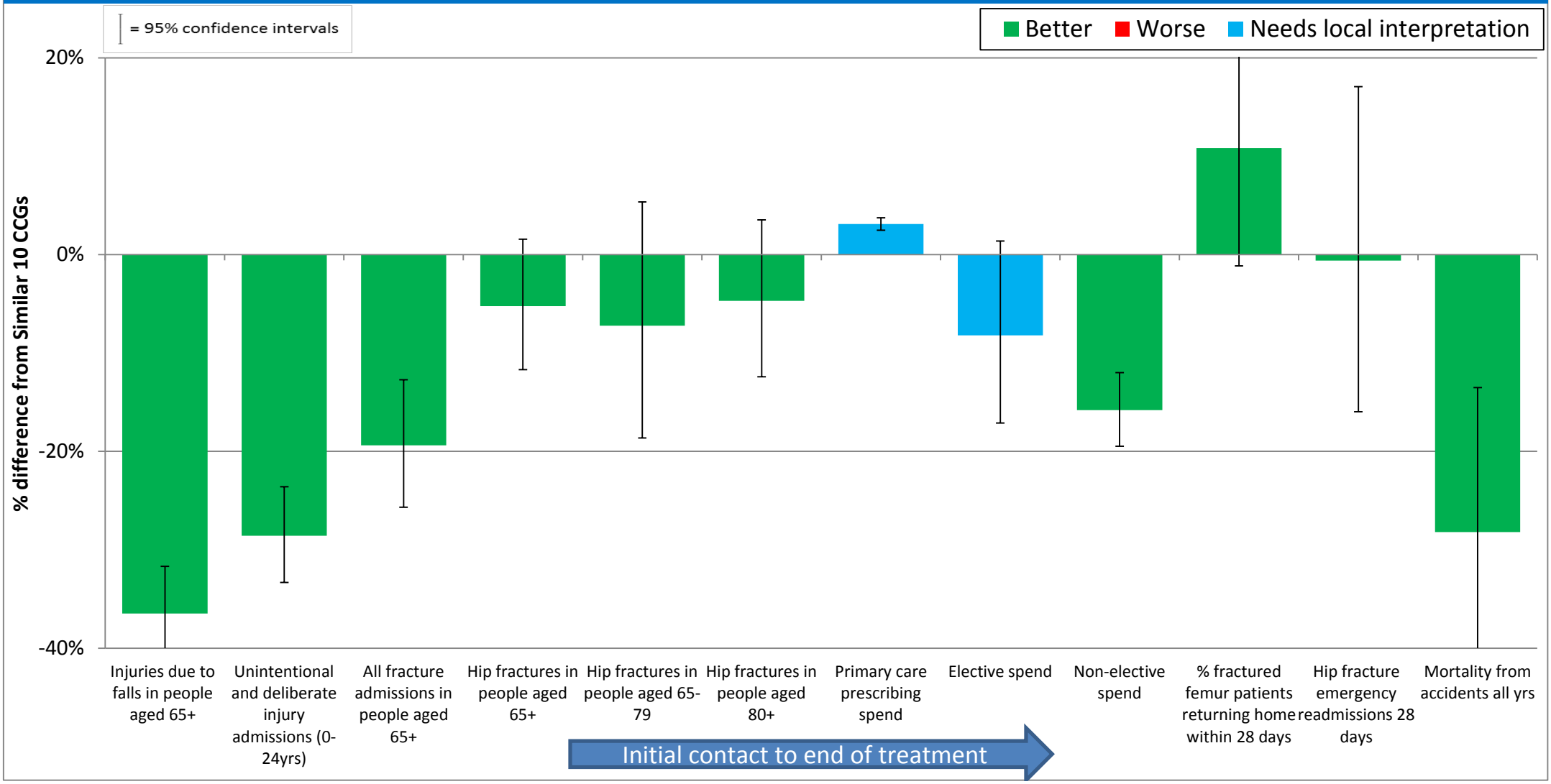
Public Health England

RightCare

NHS England

Trauma and injury pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/falls-in-older-people

http://pathways.nice.org.uk/pathways/unintentional-injuries-among-under-15s

http://pathways.nice.org.uk/pathways/hip-fracture

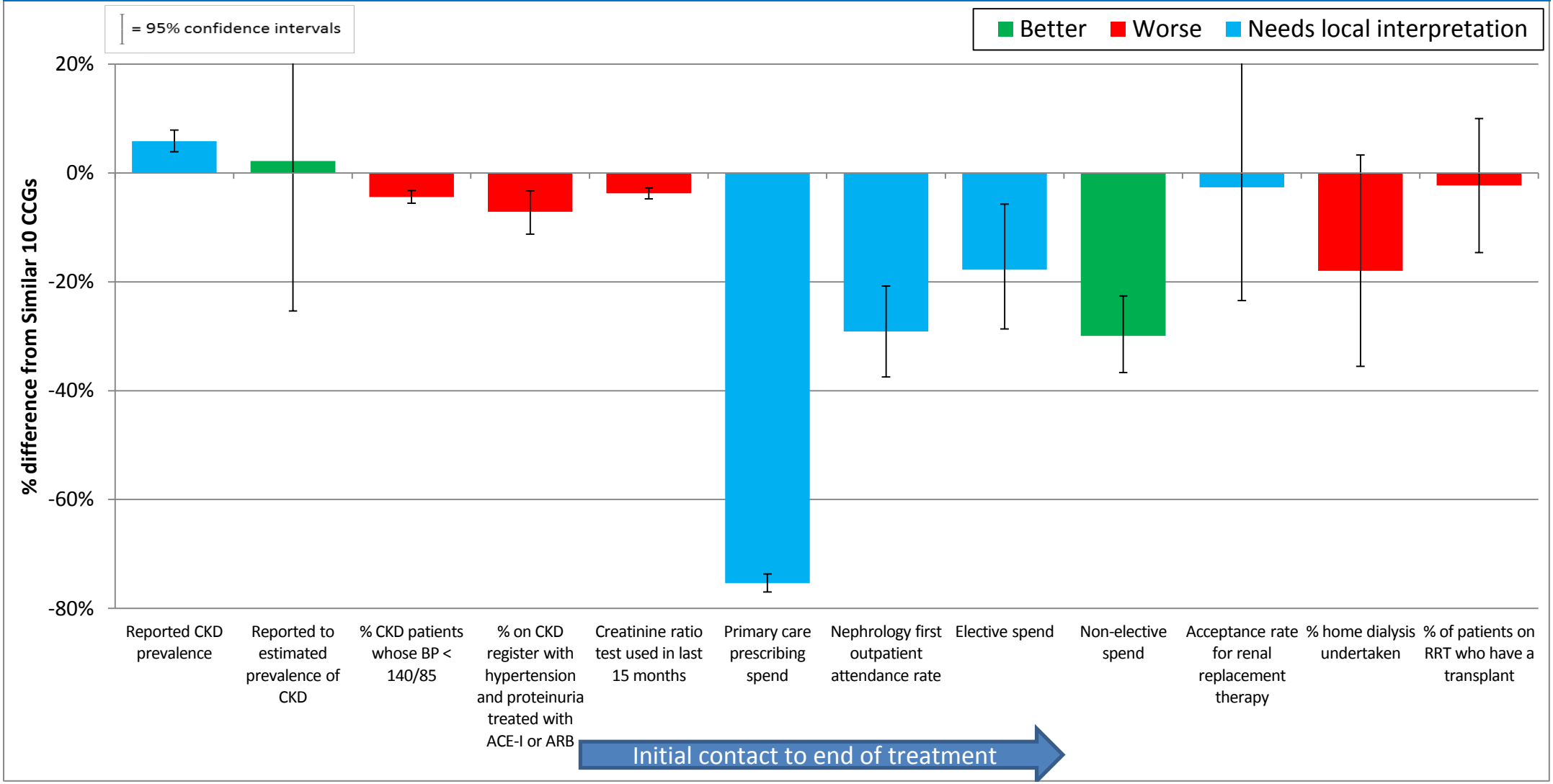
Public Health England

RightCare

NHS England

Renal pathway

NHS Rotherham CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/chronic-kidney-disease

http://pathways.nice.org.uk/pathways/acute-kidney-injury

Public Health England

RightCare

NHS England

Learning from others: 1

Commissioning for Value in Hardwick CCG: From pack to delivery in just seven months

Hardwick CCG received their initial Commissioning for Value pack, adopted the NHS Right Care approach, commissioned a deep dive in to COPD, engaged clinicians to identify improvement opportunities and are now implementing:

- Locally agreed and specified COPD pathway
- Enhanced nebulisers service in primary care
- Primary care COPD audit and support service to implement findings practice by practice
- Improved promotion of self-management
- Improved self-management support
- Enhanced organisation of Breathe Easy Groups (with British Lung Foundation)

In just seven months they have delivered:

- 30% reduction in emergency admissions
- £170,000 saving (just from initial impact – much more to come)

These are summarised examples of what others have done since the first Commissioning for Value pack.
See www.rightcare.nhs.uk/resourcecentre for full case studies.

Learning from others: 2

Commissioning for Value in Slough CCG: Diabetes

"The Right Care methodology has been successfully applied to the management of diabetes in Slough"

Slough CCG

Following primary care pathway reform:

- Of patients with pre-diabetes whose results are available for evaluation, 100% saw a reduction in their HbA1c levels
- Of the patients with type 2 diabetes, 89% saw a reduction in their HbA1c levels
- 15 out of 16 practices showed an increase in the number of patients whose diabetes was controlled
- 15 out of 16 practices saw an increase from 72.25% to 80.06% of patients whose blood pressure was <140/80

Next step: Spread the use of the methodology across whole diabetes system and beyond

These are summarised examples of what others have done since the first Commissioning for Value pack. See www.rightcare.nhs.uk/resourcecentre for full case studies.

Next steps

CCGs may wish to consider the following next steps:

- Identify the priority programmes in your pack 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
- Link with the planning round and discuss at governing body and Health and Wellbeing Board level: Design optimal system – make case – decide – deliver
- Explore the Commissioning for Value online tool and compare your data with that of your peers. Re-visit regularly to explore the updates at http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
- Explore other resources, such as the 'how to' videos, deep dive guide, CVD Intelligence Network focus pack and NICE resources. See the NHS Right Care website at http://www.rightcare.nhs.uk/ for links.
- Commission a deep dive pack. If CVD is your priority area, use the CVD focus packs at http://www.yhpho.org.uk/default.aspx?RID=199884
- Identify local support to move on to phase 2 of the NHS Right Care approach: *What to Change.* Work with local transformation teams to support and deliver service redesign as captured in the principles of phase 3 of the NHS Right Care approach: *How to Change*

Public Health England RightCare NHS England

Coming soon

We will be following up this set of packs with further products from the Commissioning for Value programme over the coming months. These will include:

- A set of Integrated Care packs (March 2015). These packs will include analysis to help commissioners understand how their most complex patients flow through the system and how the characteristics of these patients differ from similar CCGs, for example:
  - How many admissions to hospital the most complex patients have each year and how does this compare to similar CCGs?
  - How does the age structure of the most complex patients compare to similar CCGs?
  - What healthcare conditions do these patients have; what are the most common co-morbidities?
- A series of regional events for CCGs, area teams, CSUs, public health leads and other stakeholders (March 2015). These will take place across the country and help attendees work through their packs, better understand the data, meet CCGs with similar issues and suggest next steps
- New resources on the NHS Right Care resource centre, including new learning videos, casebooks and a handbook on the NHS Right Care approach. Find them at: http://www.rightcare.nhs.uk/
- A compendium Atlas of Variation aimed at reducing unwarranted variation across the main programmes of care (March 2015)
- A handbook on conducting 'deep dives' for prioritised pathways
- Updates to the Commissioning for Value online tools at http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value

Further support and information

The Commissioning for Value benchmarking tool (containing all the data used to create the CCG packs), full details of all the data used, and links to other useful tools are available online at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

The NHS Right Care website offers resources to support CCGs in adopting the Commissioning for Value approach. These include:

- Online videos and 'how to' guides
- Case studies with learning from other CCGs
- Tried and tested process templates
- Advice on how to produce 'deep dive' packs locally

These can be found at: http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

The NHS England Learning Environment which includes a directory of support offers; a case study pinboard; and a peer-to-peer learning exchange can be found at: https://learnenv.england.nhs.uk/

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

Public Health England

RightCare

NHS England

Annex: Full list of indicators

Breast Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Breast Cancer Prevalence (%)
Incidence of breast cancer per 100,000 population (all ages)
Rate of alcohol attributable admissions for breast cancer per 100,000 females aged 15+
% of women aged 50 - 70 screened for breast cancer in last three years
Spend on primary care prescribing for breast cancer per 1,000 weighted population
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for breast cancer per 1,000 population
% of breast cancers detected at an early stage (1 or 2)
Mortality from breast cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Lower Gastro Intestinal Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Colorectal Cancer Prevalence (%)
Incidence of colorectal cancer per 100,000 population (all ages)
Rate of alcohol attributable admissions for colorectal cancer per 100,000 population
% of people aged 60-69 who were screened for bowel cancer in the previous 30 months
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for lower GI cancer per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for lower GI cancer per 1,000 population
% of colorectal cancers detected at an early stage (1 or 2)
Mortality from colorectal cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Lung Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Lung Cancer Prevalence (%)
Incidence of lung cancer per 100,000 population (all ages)
Smoking prevalence (%)
Smoking quit rates (successful quitters), per 100,000 population aged 16+
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for lung cancer per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for lung cancer per 1,000 population
% of lung cancers detected at an early stage (1 or 2)
Mortality from lung cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Annex: Full list of indicators (continued)

Diabetes

Diabetes Prevalence (%)
% of all diabetes patients meeting all three treatment targets (for cholesterol, blood pressure and HbA1c)
% of all diabetes patients receiving eight care processes
% of all diabetes patients having retinal screening in the previous 15 months (DM21)
Spend on primary care prescribing for diabetes per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for diabetes per 1000 population
Additional risk of complication for myocardial infarction among people with diabetes (%)
Additional risk of complication for heart failure among people with diabetes (%)
Additional risk of complication for stroke among people with diabetes (%)

Psychosis

Psychotic Disorder: estimated % of people aged 16+
New cases of psychosis: estimated incidence per 100,000 aged 16-64
GP prescribing of drugs for psychoses and related disorders: items per 1,000 population
Physical health checks for patients with Serious Mental Illness: summary score (average of the 6 physical health check indicators)
The number of people on Care Programme Approach per 100,000 population aged 18+
Mental health admissions to hospital: Rate per 100,000 population aged 18+
The number of people subject to the Mental Health Act per 100,000 population aged 18+
Social care mental health clients in residential care or receiving home care aged 18-64: Rate per 100,000 population
% of people aged 18-69 on Care Program Approach in employment
Excess under 75 mortality in adults with serious mental illness: standardised mortality ratio (%)

Common Mental Health Disorders

Socioeconomic deprivation: overall Index of Multiple Deprivation score
% of the total population with a limiting long term illness or disability
People estimated to have any common mental health disorder: estimated % of population aged 16-74
Depression Prevalence aged 18+ (%)
New cases of depression: adults with a new diagnosis of depression as % of all adults on the GP register
% of new cases of depression in the previous year who had an assessment of severity using an assessment tool validated for use in primary care (DEP06)
Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU
Access to Improving Access to Psychological Therapies (IAPT) services: People entering IAPT services as a % of those estimated to have anxiety/depression
Waiting < 28 days for IAPT: % of referrals (in month) waiting <28 days for first treatment
Completion of IAPT treatment: Rate completing treatment per 100,000 population aged 18+
% of IAPT patients receiving a course of treatment
% of IAPT patients given a provisional diagnosis
% of IAPT referrals with treatment outcome measured
% of people who are "moving to recovery" of those who have completed IAPT treatment
IAPT reliable recovery: % of people who have completed IAPT treatment who achieved "reliable improvement"
The number of people in contact with secondary care for a common mental health condition per 100,000 population aged 18+

Annex: Full list of indicators (continued)

Heart Disease

Coronary Heart Disease (CHD) Prevalence (%)
Hypertension Prevalence (%)
Reported to estimated prevalence of CHD (%)
Reported to estimated prevalence of hypertension (%)
Smoking prevalence (%)
% of patients with CHD whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (CHD 06)
% of patients with CHD whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (CHD 08)
% of patients with hypertension whose last blood pressure reading (as measured within the last 9 months) is 150/90 or less (BP 05)
Spend on primary care prescribing for CHD per 1,000 weighted population
Spend on elective and day-case admissions for CHD per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for CHD per 1000 population
Mortality from CHD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
Mortality from acute MI: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

---

Stroke

Stroke or Transient Ischaemic Attack (TIA) Prevalence (%)
% of patients with stroke or TIA whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (STROKE 06)
% of patients with stroke or TIA whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (STROKE 08)
% of patients with a non-haemorrhagic stroke or TIA with a record that an anti-platelet agent (aspirin etc) or an anti-coagulant is being taken (STROKE 12)
% of patients with atrial fibrilliation in whom the risk of stroke has been assessed using CHADS2 in the previous 15 months (AF 05)
Spend on primary care prescribing for cerebrovascular disease per 1,000 weighted population
% of TIA cases with a higher risk who are treated within 24 hours
% of patients admitted to hospital following a stroke who spend 90% of their time on a stroke unit
Spend on elective and day-case admissions for cerebrovascular disease per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for cerebrovascular disease per 1,000 population
Emergency readmissions to hospital within 28 days for patients: stroke (%)
% of patients returning to usual place of residence following hospital treatment for stroke
Mortality from stroke: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

COPD

Chronic Obstructive Pulmonary Disease (COPD) Prevalence (%)
Reported to estimated prevalence of COPD (%)
% of COPD patients with a record of FEV1 in the preceding 15 months (COPD 10)
% of COPD patients having had a review in the previous 15 months (COPD 13)
Spend on primary care prescribing for Obstructive Airways Disease per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for Obstructive Airways Disease per 1,000 population
Mortality from bronchitis and emphysema and COPD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

Annex: Full list of indicators (continued)

Asthma

Asthma Prevalence (%)
% of patients aged 8 years and over diagnosed as having asthma from 1st April 2006 with measures of variability or reversibility (ASTHMA 08)
% of asthma patients who have had a review in the preceding 15 months (ASTHMA 09)
Spend on primary care prescribing for asthma per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for asthma per 1,000 population
Emergency admission rate for children with asthma per 100,000 population aged 0–18 years
Mortality from asthma: all age directly age-standardised rates (DSR) per 100,000 European Standard Population

---

Musculoskeletal

% of people (over 45) who have hip osteoarthritis (total)
% of people (over 45) who have knee osteoarthritis (total)
% of people (over 45) who have hip osteoarthritis (severe)
% of people (over 45) who have knee osteoarthritis (severe)
Primary hip replacements per 100,000 population
Primary knee replacements per 100,000 population
% of patients aged between 50-74 years with a fragility fracture in whom osteoporosis is confirmed in a DXA scan who are currently treated with an appropriate bone-sparing agent (OST 02)
% of patients aged 75+ years with a fragility fracture scan who are currently treated with an appropriate bone-sparing agent (OST 03)
Spend on primary care prescribing for Musculoskeletal problems per 1,000 weighted population
Pre-treatment EQ-5D Index: hip replacement
Pre-treatment EQ-5D Index: knee replacement
Spend on elective and day-case admissions for Musculoskeletal problems per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for Musculoskeletal problems per 1,000 population
Health Gain EQ-5D Index: hip replacement
Health Gain EQ-5D Index: knee replacement
Emergency readmissions to hospital within 28 days for patients: hip replacements (%)

Trauma & Injury

Injuries due to falls per 100,000 population aged 65+
Hospital admissions caused by unintentional and deliberate injury for those aged 0-24 per 10,000 population
Rate of all fracture admissions per 1,000 population aged 65+
Hip fractures per 100,000 population aged 65+
Hip fractures per 100,000 population aged 65 -79
Hip fractures per 100,000 population aged 80+
Spend on primary care prescribing for Trauma and Injuries per 1,000 weighted population
Spend on elective and day-case admissions for Trauma and Injuries per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for Trauma and Injuries per 1,000 population
% of patients returning to usual place of residence following hospital treatment for fractured femur
Emergency readmissions to hospital within 28 days for patients: hip fractures
Mortality from accidents: all age directly age-standardised rates (DSR) per 100,000 European Standard Population

Annex: Full list of indicators (continued)

Renal

Chronic Kidney Disease (CKD) Prevalence (%)
Reported to estimated prevalence of CKD (%)
% of patients on CKD register, whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less (CKD03)
% of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded) (CKD05)
% of patients on the CKD register with a record of a urine albumin creatinine ratio test in the preceding 15 months (CKD06)
Spend on primary care prescribing for renal problems per 1,000 weighted population
Nephrology first outpatient attendances per 1,000 population
Spend on elective and day-case admissions for renal problems per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for renal problems per 1,000 population
Number of people accepted onto Renal Replacement Therapy per 1,000,000 population
% of people receiving dialysis undertaking dialysis at home
% of patients on Renal Replacement Therapy who have a kidney transplant

healthwatch Rotherham news

Welcome to the Healthwatch Rotherham Newsletter

November 2014

Successes This Month- Focus on Special Inquiry

Healthwatch Rotherham is part of the National Inquiry Panel into unsafe discharge. Sharon, one of our engagement officers, is on the National Special Inquiry Panel set up by Healthwatch England to look at the unsafe discharge issue across England. The purpose of the Special Inquiry is to ensure improvement in national policy and local practice. The panel will look at experiences shared by people discharged from a hospital, care home or secure mental health setting focussing on the experiences of homeless people, those with mental health conditions and older people. The comments collected by Healthwatch Rotherham, as always, were passed on to the services concerned so that they were aware of them.

The impacts at a local level are included below and are all from The Rotherham NHS Foundation Trust:

- The comments made by service users will be used to inform and improve discharge services have been shared with all members of the Trust Patient Experience Group to be passed on to all departments. This is important because it ensures that feedback is shared widely and to a diverse group of staff.
- Each directorate is sharing the comments with matrons and ward sisters from all ward areas.
- A review of nursing admission documentation is undertaken led by the Professional Advisory Forum. This review will ensure that the question **'Do you have anywhere to go following discharge'?** is routinely asked. It is important that all patients are asked about their social circumstances on admission to hospital to avoid repetition of events such as those described in the report.
- The Discharge Policy is reviewed with reference to the Healthwatch report and will ensure that appropriate focus is placed on the social elements of discharge planning.
- The comments provided will be used for next month's patient story to the Board of Directors. Every month the directors hear a story that describes patient experience at the Trust and in October this will focus on discharge planning for vulnerable groups.
- The feedback provided is shared at Team Briefing in November 2014. This is Trust wide communication which means that the key messages shared within your report will be disseminated across the whole organisation.

From The Chair

You will have seen that we have advertised for a Chief Executive Officer. Mel, has taken up an exciting challenge with Sheffield City Council and will leave us in December. The Board is sad to see Mel go but we place on record our thanks to her for all her hard work.

I was delighted to see the annual Healthwatch England report features some of the work performed by Healthwatch Rotherham in the past year. It is pleasing to see that the good work undertaken in Rotherham is getting recognised at a national level.

We also had an excellent turn out for the latest Enter & View training session. Healthwatch relies on its volunteers and it was great to hear we had a lot of new people taking part- thank you.

Naveen

Rotherham Youth Cabinet
Healthwatch features in the Rotherham Youth Cabinet Manifesto 2014-2015. The manifesto has a commitment to work with Healthwatch Rotherham over the coming year. Healthwatch Rotherham is looking forward working with the Rotherham Youth Cabinet.

Promoting NHS Constitution to Children & Young People
Sharon was invited to attend the pilot of a new educational tool to help children and young people understand their rights when using the healthcare system designed by the National Children's Bureau.

Dentist Report
The Healthwatch Rotherham report on access to dentistry in Rotherham will form part of the Rotherham's **first** Oral Health Needs Assessment. The current urgent dental care pathway is being reviewed across Yorkshire and the Humber to ensure that services in place meet patient needs in the most appropriate way. Watch this space as we will be sharing the needs assessment and will be asking for your comments.

More Successes

The Co-Operative pharmacy in Thrybergh, have made the following changes:

- ✔ Medication with similar names have been repositioned and further separated on the shelf to reduce risk.
- ✔ Alert stickers have been placed on dispensary shelving to act as a reminder.
- ✔ Issue discussed at a team meeting
- ✔ Staff have re-read the company operating procedure

01709 71 71 30

info@healthwatchrotherham.org.uk

www.healthwatchrotherham.org.uk

twitter @hwrotherham

facebook www.facebook.com/hwrotherham

If you have any comments about health and social care services in Rotherham, please let us know.

healthwatch Rotherham

33 High Street, Rotherham, S60 1PT
info@healthwatchrotherham.org.uk
01709 717130
www.healthwatchrotherham.org.uk