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Commissioning for Value: Integrated care pathways

NHS North West Surrey CCG

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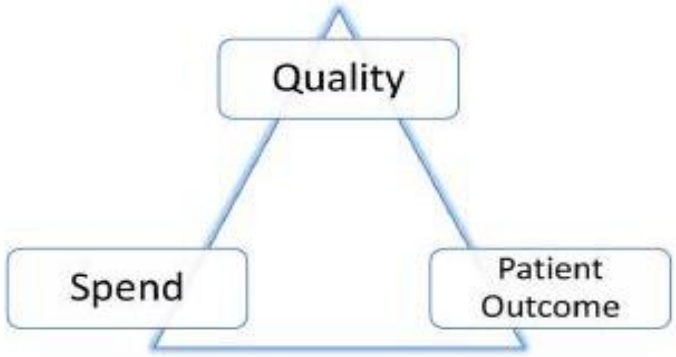
Introduction: What is Commissioning for Value?

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 opportunities for change with most impact. 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 partners, providing suggestions on where to look to help them deliver improvement and the best value to their populations.



Elements of value

Supporting planning and transformation

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

These packs support the vision set out in the recently published **Five Year Forward View** http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf with its focus on the transformation of healthcare services to drive quality and efficiency.

They also support the planning guidance for 2015/16. The **Forward View into action: planning for 2015/16** http://www.england.nhs.uk/wp-content/uploads/2014/12/forward-view-plning.pdf which emphasises the importance of improving outcomes: Better health for the whole population; Increased quality of care for all patients, and; Better value for the taxpayer.

Commissioning for Value helps to support local discussion about prioritisation and utilisation of resources. By using the information contained in these integrated care packs and associated tools, CCGs will be able to ensure their plans focus on the opportunities which have the potential to provide the biggest improvements in health outcomes and resource utilisation.

The Integrated Care pack

This Integrated Care pack is the latest in a series of Commissioning for Value support packs for CCGs.

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 of the NHS Right Care approach.

In November 2014 we published the Pathway on a Page packs which showed a more detailed look at these areas by providing a wider range of key indicators, the latest published data, and presenting them along the lines of a pathway that patients may experience for different conditions. Both sets of the previous packs can be seen at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/.

The new Integrated Care packs seek 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, as is occurring in Wigan Borough CCG.

The National Clinical Directors, Intelligence Networks and third sector organisations have helped to develop the pathways.

Why act: Patient case study – Long Term Conditions

Paul Adams is a typical patient in a typical CCG. The following story is seen across the country in many long term condition pathways. Journey one tells of a standard care pathway. Journey two tells of a pathway that has been commissioned for value.

Journey One

- At the age of 45, and after 2 years of increased urinary frequency and loss of energy, Paul goes to his GP. The GP performs tests, confirms diabetes and seeks to manage with diet, exercise and pills. This leads to 6 visits to the practice nurse and 6 laboratory tests per year.
- Paul knows that he is supposed to manage his diet better but is not sure how to do this and does not want to keep bothering the GP and the practice nurse.
- By the age of 50, Paul has given up smoking but continues to drink. His left leg is beginning to hurt. His GP prescribed insulin a year ago and now refers him for outpatient diabetic and vascular support.
- At 52, Paul's condition has deteriorated further. He has to have his leg amputated and he now has renal and heart problems. His vision is also deteriorating rapidly. He is a classic complex care patient.

This version of Paul's patient journey costs £49,000 at 2014/15 prices…

Why act: Patient case study – Long Term Conditions

If Paul Adams' CCG had adopted Commissioning for Value principles and reformed their diabetes and other long term conditions pathways, what might Paul's patient journey have looked like?

Journey Two

- The NHS Health Check identifies Paul's condition one year earlier, at the age of 44 and case management begins…
- Paul is referred to specialist clinics for advice on diet and exercise and he has this refreshed every 2 years. He is also referred to a stop smoking clinic and successfully quits
- Paul has a care plan and optimal medication and retinopathy screening begins 18 months earlier
- He is supported in his self management via the Desmond Programme and a local Diabetes Patient Support Group

Journey One cost £49k and managed Paul's deterioration

Journey Two costs £9k and keeps Paul well

Integrated care data slides

The following slides present information on a range of areas where CCGs and Local Authorities (LAs) need to work together to deliver integrated services to deliver the best possible outcomes for patients;

- **Maternity and Early Years Pathway** (for any LA that has more than a 10% share of the CCG's population) – shows performance on a range of indicators compared to the average of the ten most similar LAs.
- **Inpatient expenditure for 0-4 year olds** - shows CCG expenditure broken down by the healthcare programmes with the highest spend for admissions covered by the Payment by Results mandatory tariff compared to the ten most similar CCGs.
- **Substance Misuse and Mental Health Pathway** (for any LA that has more than a 10% share of the CCG's population) – shows performance on a range of indicators compared to the average of the ten most similar LAs.
- **Dementia and Long Term Conditions Pathway** – shows CCG performance on a range of indicators compared to the average of the ten most similar CCGs. Dementia and Long Term Conditions (LTCs) are on the same pathway because risk reduction factors for dementia are similar to those for other LTCs.
- **Inpatient expenditure for 75+ year olds** - shows CCG expenditure broken down by the healthcare programmes with the highest spend for admissions covered by the Payment by Results mandatory tariff compared to the ten most similar CCGs.
- **Analysis of the CCGs' most complex patients** (the 2% of patients that the CCG spends the most on for inpatient admissions covered by the Payment by Results mandatory tariff) – includes information on the number of admissions, age profile and healthcare conditions for inpatient admissions and outpatient and A&E attendances.

How to interpret the pathways on a page

Amongst the following slides, key indicators are presented for 3 pathways; Maternity and Early Years, Substance Misuse & Mental Health and Dementia & Long Term Conditions. The format of the pathways is the same as presented in the 2014 version of the packs. Each indicator is shown as the percentage difference from the average of the 10 CCGs/LAs most similar to you.

The indicators are colour coded to help you see if your CCG/LA 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/LA truly does have fewer patients with a certain condition, but it may reflect that other CCGs/LAs have better processes in place to identify and record prevalence in primary care.

To note, the variation from the average of the similar 10 CCGs/LAs 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 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.

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/

Most similar CCGs

Your most similar CCGs are:

- NHS Surrey Downs CCG
- NHS Bromley CCG
- NHS Mid Essex CCG
- NHS South Gloucestershire CCG
- NHS Chiltern CCG
- NHS Basildon and Brentwood CCG
- NHS Swindon CCG
- NHS Horsham and Mid Sussex CCG
- NHS North Hampshire CCG
- NHS East Surrey CCG

Most similar LAs

Your LA(s) is/are: **Surrey**

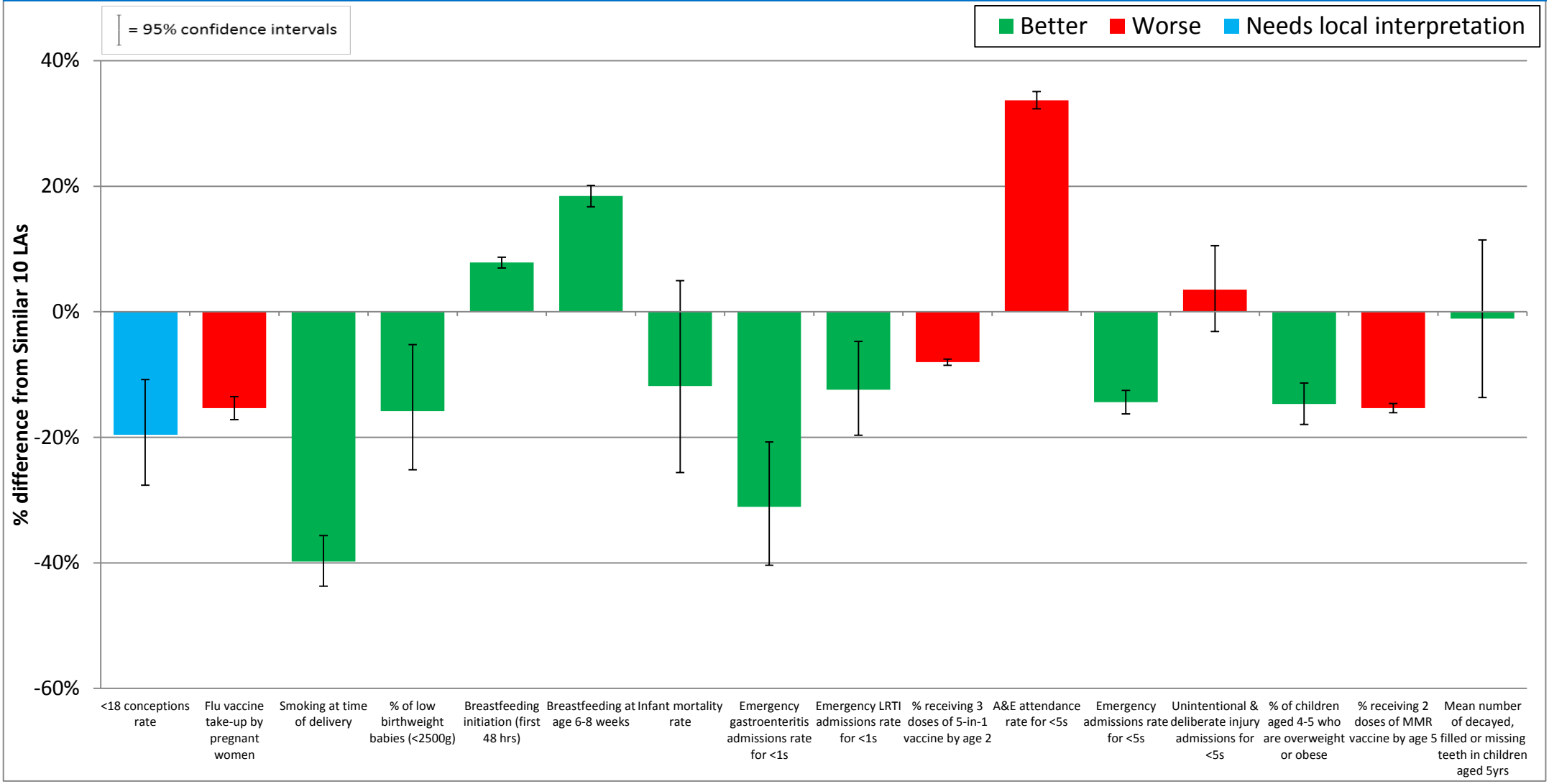
99% Population contribution

The most similar LAs to:
Surrey

- Hertfordshire
- Hampshire
- Essex
- Kent
- West Sussex
- Oxfordshire
- Leicestershire
- Cambridgeshire
- Staffordshire
- Suffolk

Maternity and Early Years pathway

Surrey



Further Information Links:

NICE Pathways on: 'Smoking', 'Maternal and child nutrition', 'Diarrhoea and vomiting', 'Immunisation for children ' and 'Unintentional injuries among under 15s'

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

https://sustain.sharepoint.com/Documents/HCP%20Integrated%20Com%20and%20Del%20toolkit%20final.pdf

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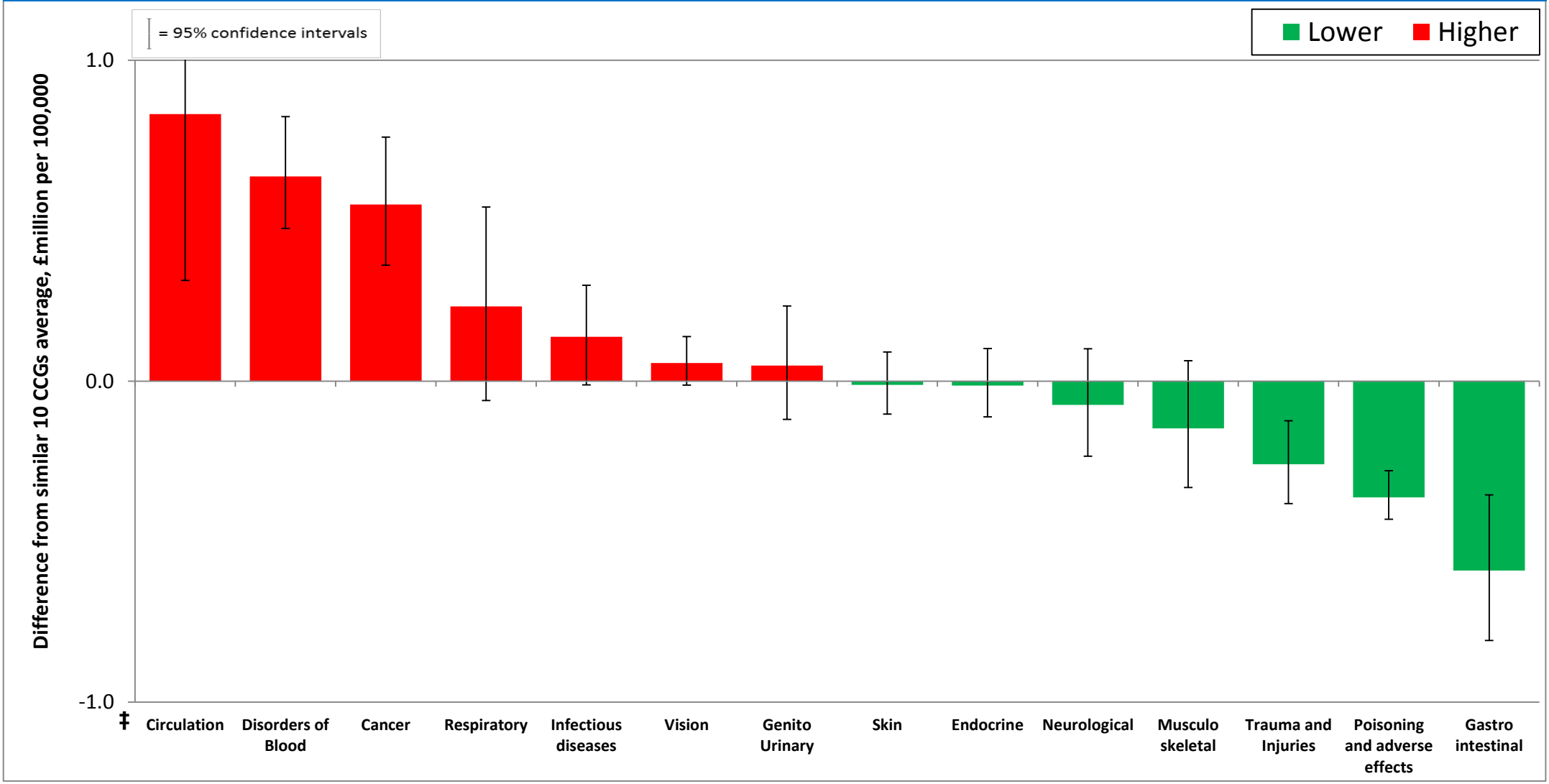
Inpatient spend for those aged under 5

NHS North West Surrey CCG



‡ Only those programmes with the highest inpatient spend are included

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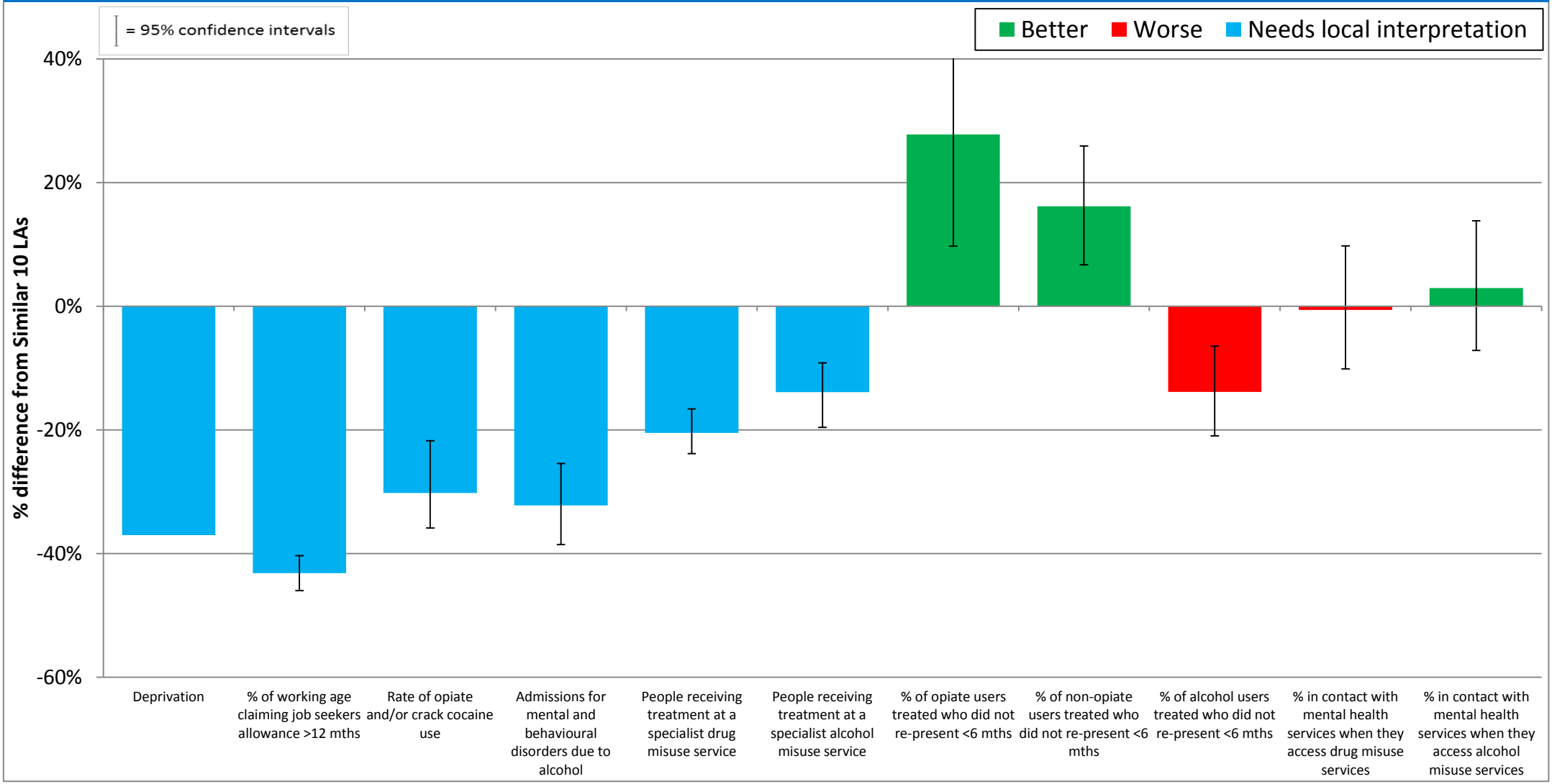
Substance misuse and mental health pathway

Surrey



Further Information Links:

http://pathways.nice.org.uk/pathways/drug-misuse

http://pathways.nice.org.uk/pathways/alcohol-use-disorders

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

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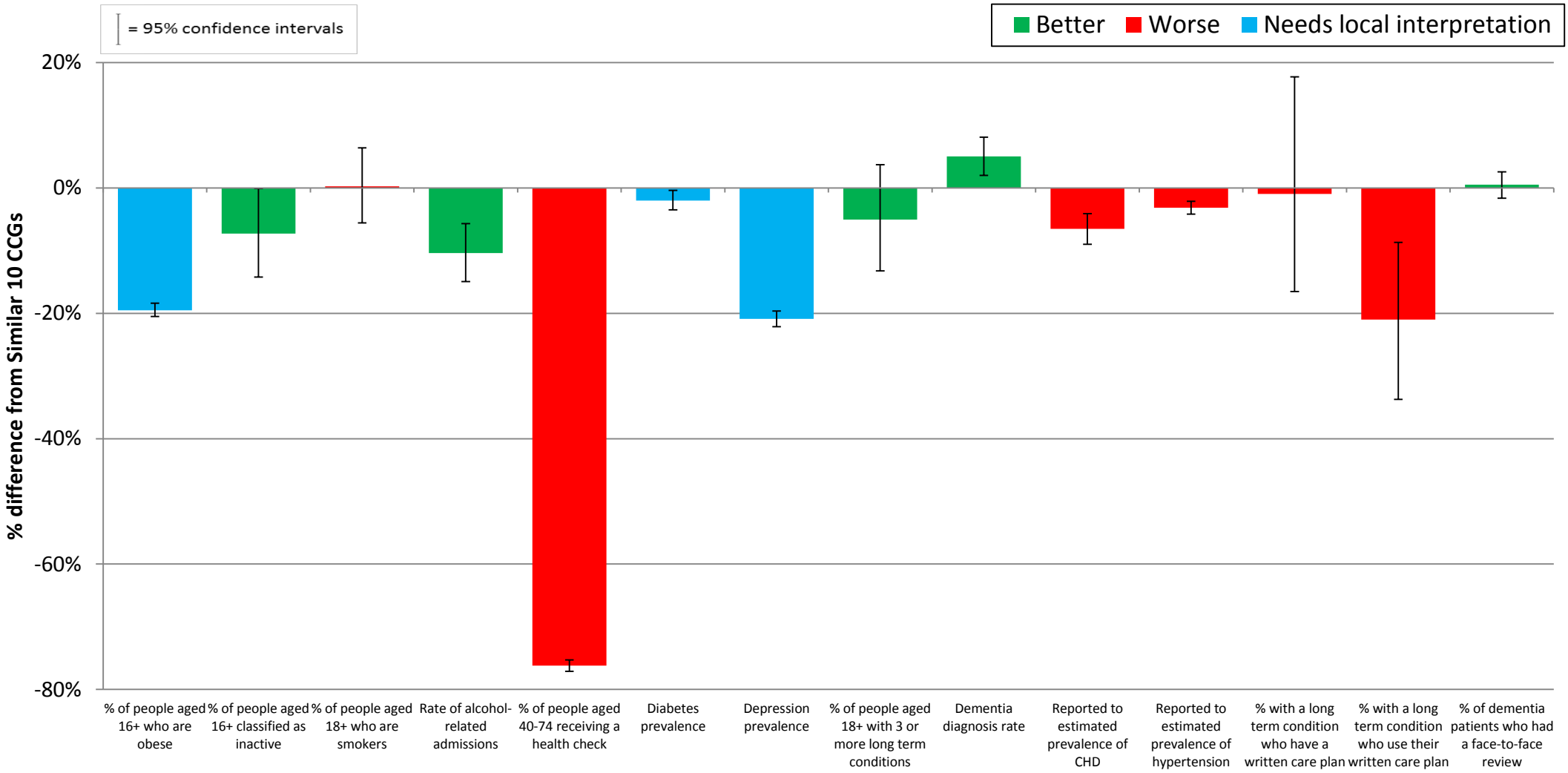
Dementia and LTCs

Risk reduction, detection and primary care management

NHS North West Surrey CCG



Further Information Links:

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

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

Click on: 'Topics', 'Population Groups', 'Older People'

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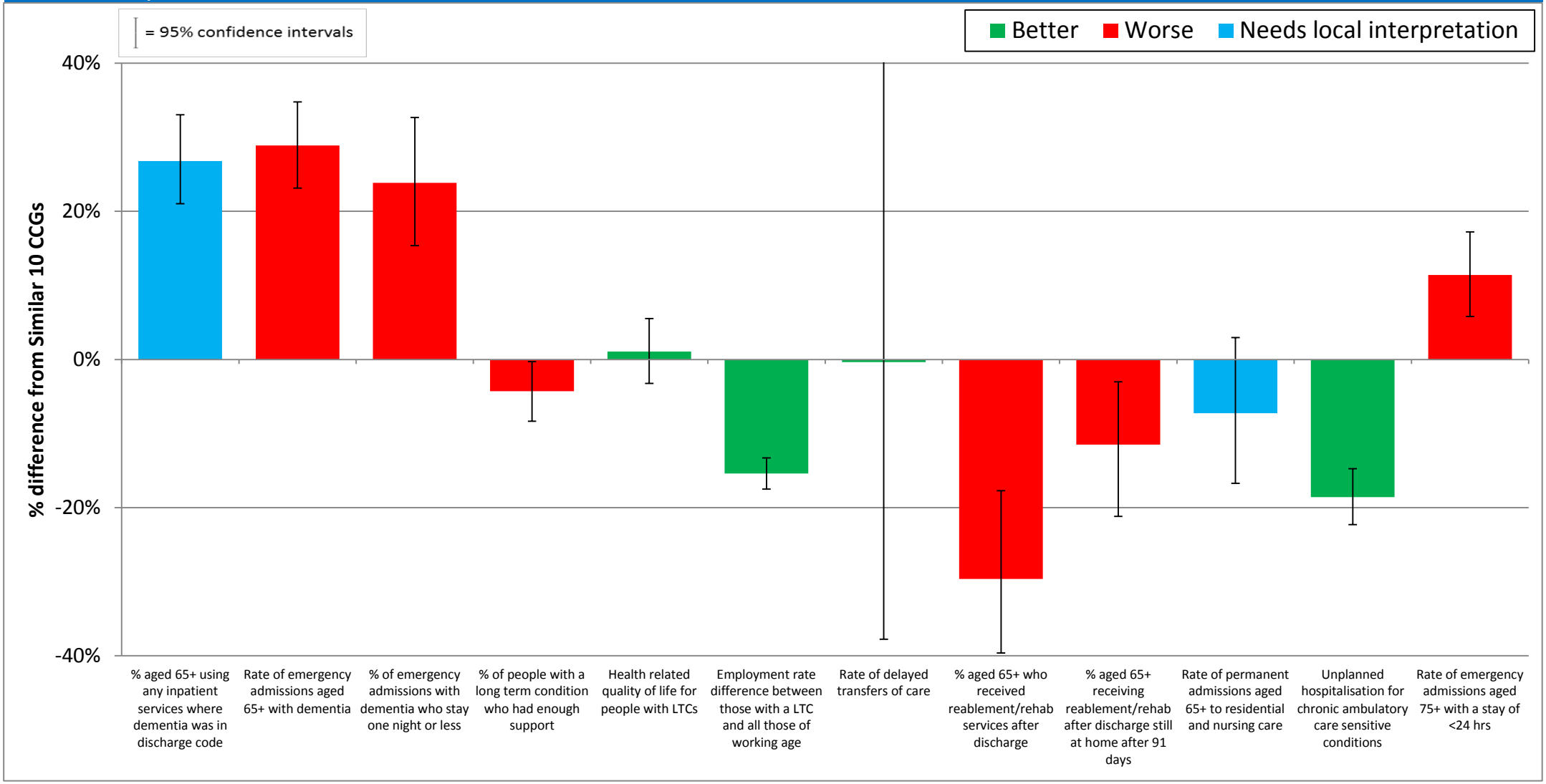
Dementia and LTCs

Secondary care and outcomes

NHS North West Surrey CCG



Further Information Links:

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

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

Click on: 'Topics', 'Population Groups', 'Older People'

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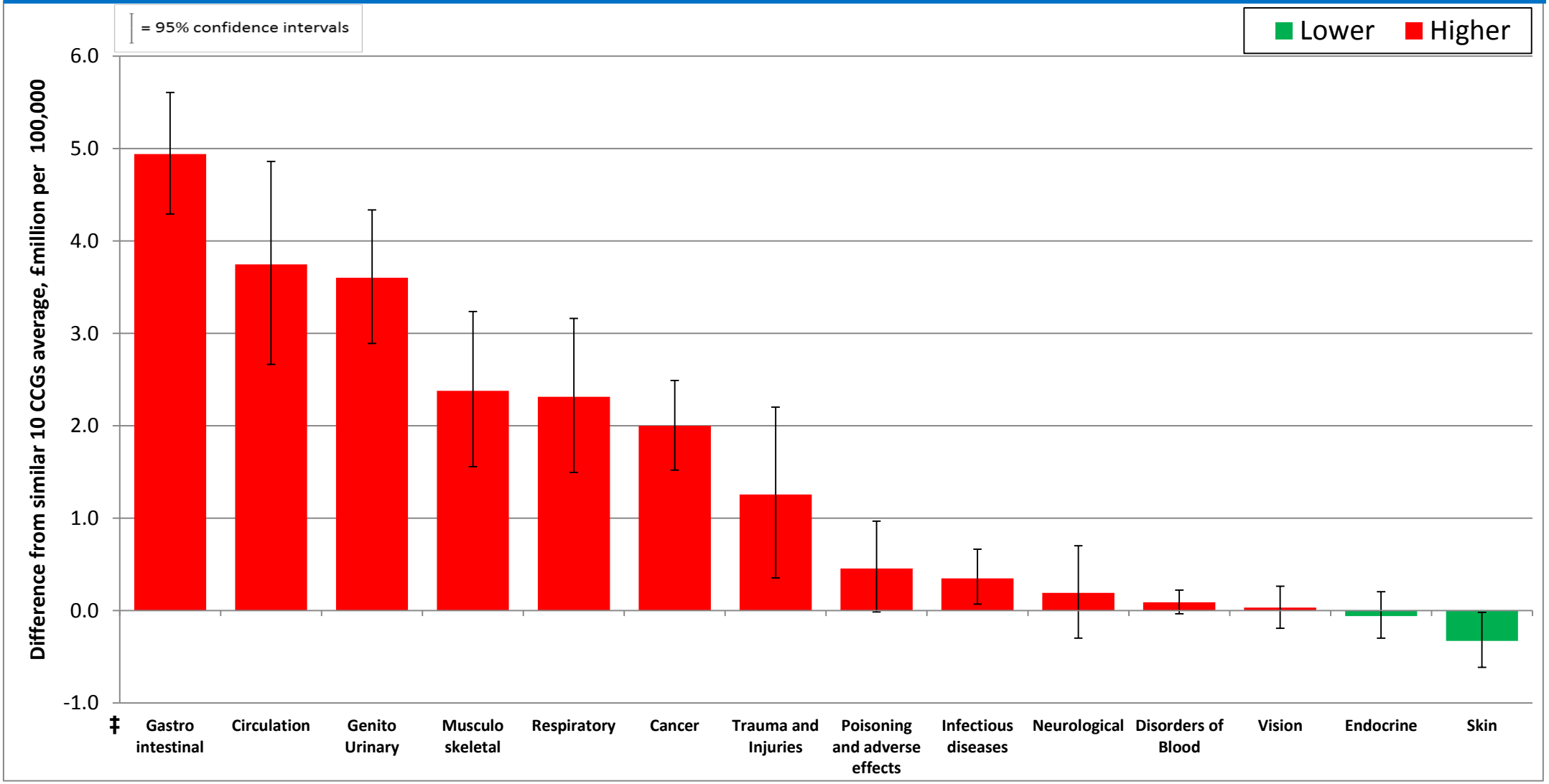
Inpatient spend for those aged 75+

NHS North West Surrey CCG



‡ Only those programmes with the highest inpatient spend are included

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Complex patients: Introduction

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 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 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.

Complex Patients - Age Profile

NHS North West Surrey CCG

2% Most Complex Patients (15.4% of CCG Spend)					
Age	Number of complex patients	Mean Number of Admissions	Mean Number of Different Conditions	Total Spend (£000s)	
0	29	6.7	2.59	£	1,020
1-4	21	11.5	3.43	£	731
5-9	14	26.5	2.79	£	551
10-14	6	4.3	2.00	£	146
15-19	13	6.2	2.15	£	303
20-24	11	12.2	3.73	£	261
25-29	14	8.4	2.79	£	322
30-34	16	9.5	2.38	£	316
35-39	10	4.6	2.00	£	208
40-44	25	6.8	2.88	£	569
45-49	36	9.9	3.08	£	814
50-54	39	6.0	2.36	£	953
55-59	58	9.3	2.90	£	1,437
60-64	54	8.4	3.11	£	1,305
65-69	81	8.1	2.99	£	1,863
70-74	99	5.7	2.84	£	2,159
75-79	148	5.2	2.95	£	3,127
80-84	118	5.4	3.13	£	2,580
85-89	76	4.7	3.08	£	1,546
90+	65	4.5	2.95	£	1,375
TOTAL	933	6.8	2.93	£	21,588

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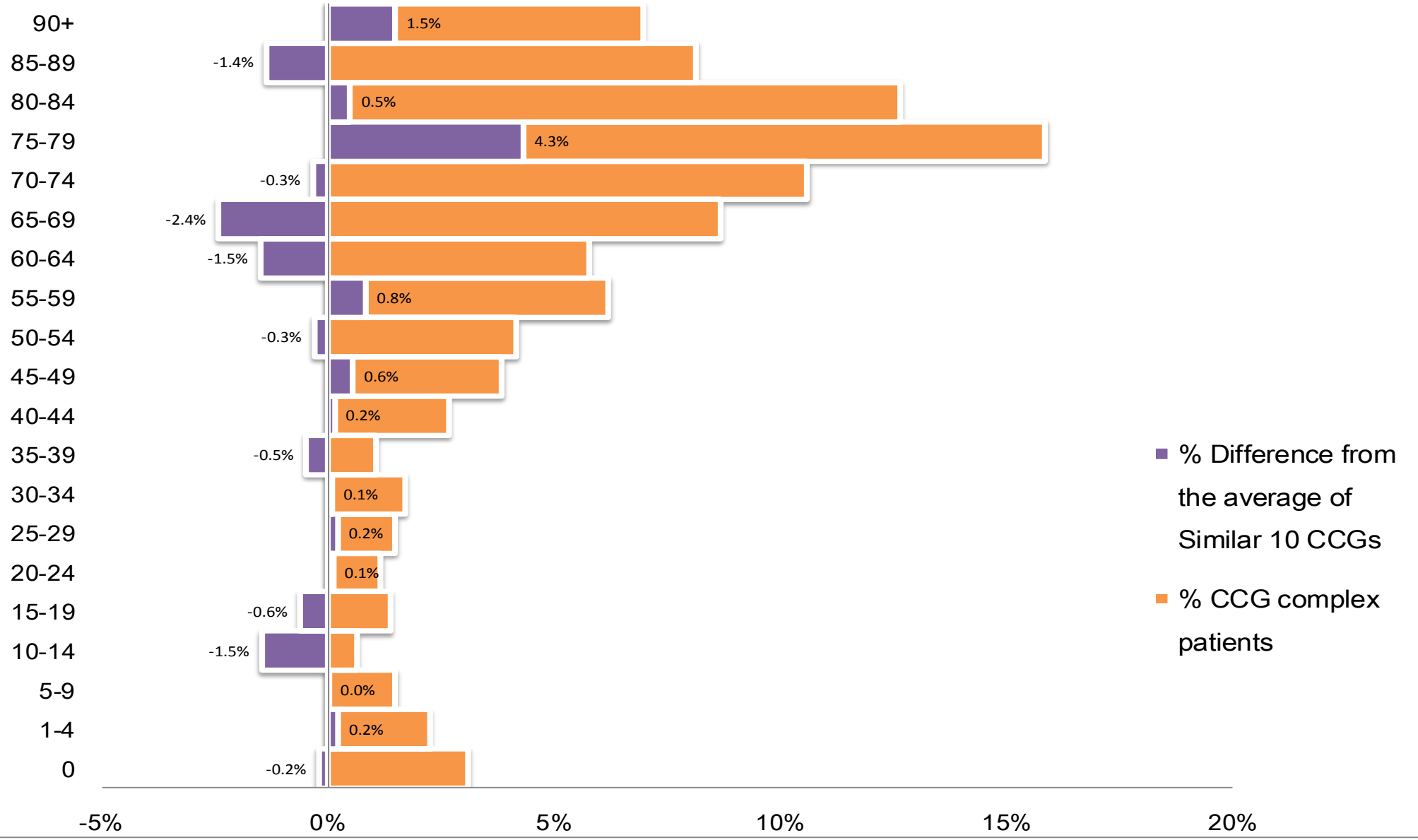
Complex Patients - Age Profile

NHS North West Surrey CCG



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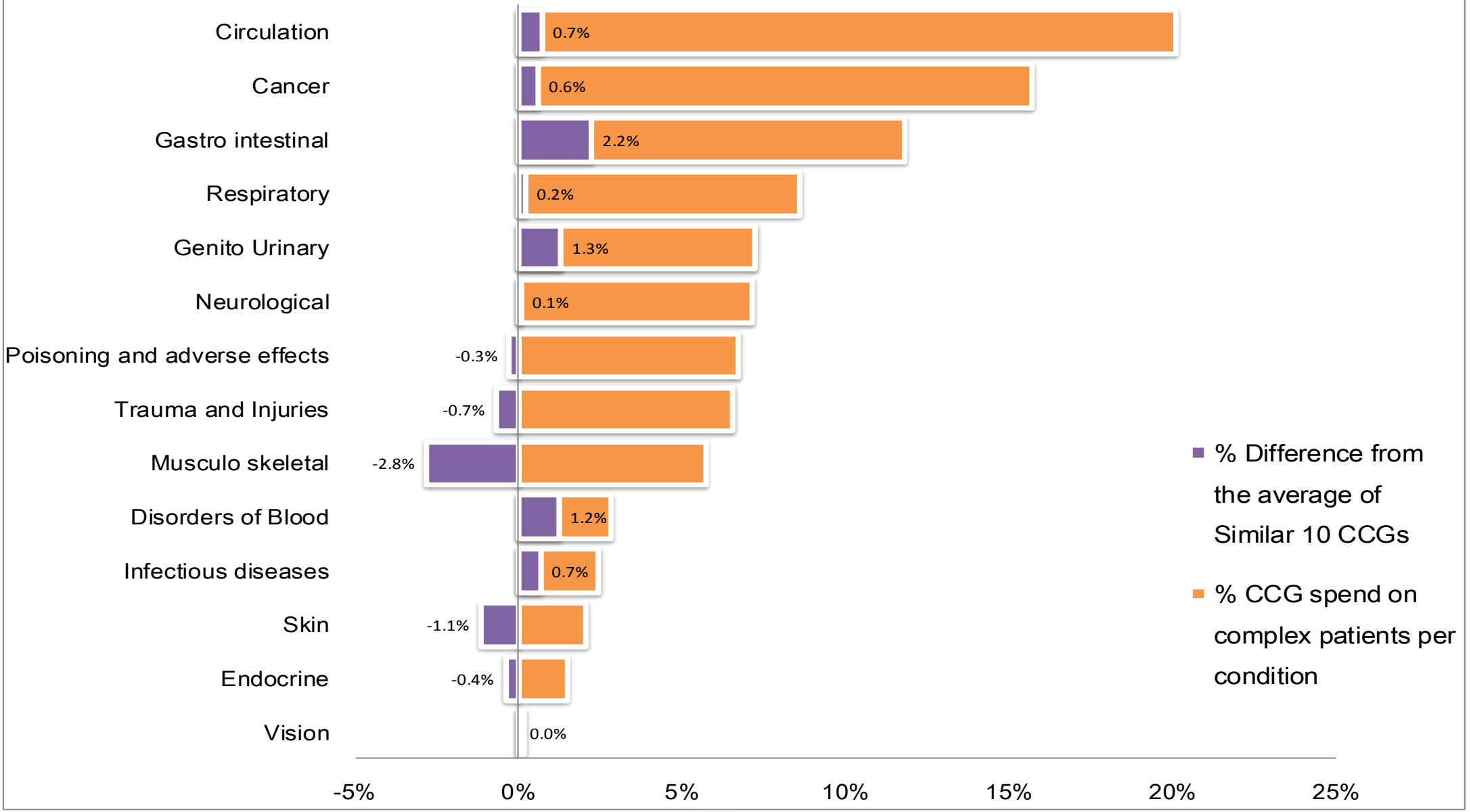
Complex Patients - Spend Profile

NHS North West Surrey CCG



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Complex Patients - Co-morbidities

NHS North West Surrey CCG

Of the 355 patients admitted for Circulation, 96 patients were admitted for a Gastro intestinal condition and 85 patients were admitted for a Genito Urinary 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"**

Main conditions	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3	Co-morbidity 4	Co-morbidity 5
Circulation	Gastro intestinal	Genito Urinary	Respiratory	Neurological	Cancer
355 patients	96	85	78	74	53
Gastro intestinal	Cancer	Circulation	Genito Urinary	Neurological	Respiratory
303 patients	94	96	77	75	75
Cancer	Gastro intestinal	Genito Urinary	Respiratory	Circulation	Neurological
247 patients	94	55	59	53	44
Neurological	Gastro intestinal	Circulation	Genito Urinary	Respiratory	Cancer
245 patients	75	74	74	74	44
Genito Urinary	Circulation	Gastro intestinal	Neurological	Respiratory	Cancer
225 patients	85	77	74	71	55

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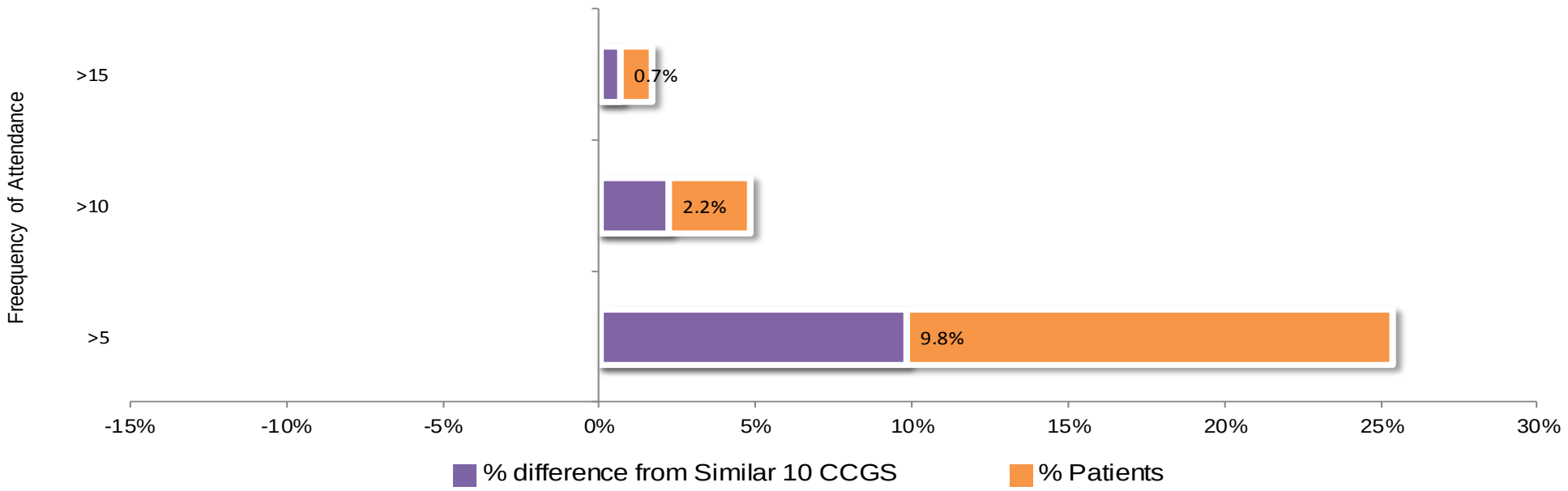
Complex Patients - A & E

NHS North West Surrey CCG



ATTENDANCE FREQUENCY	PATIENTS	% PATIENTS	ATTENDANCES	% ATTENDANCES	PATIENT % DIFF TO SIMILAR 10	ATTENDANCE % DIFF TO SIMILAR 10
>5	210	25.4%	1,977	56.2%	9.8%	15.1%
>10	40	4.8%	733	20.8%	2.2%	6.7%
>15	14	1.7%	398	11.3%	0.7%	2.9%
TOTAL	**828**	**100.0%**	**3,520**	**100.0%**		

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

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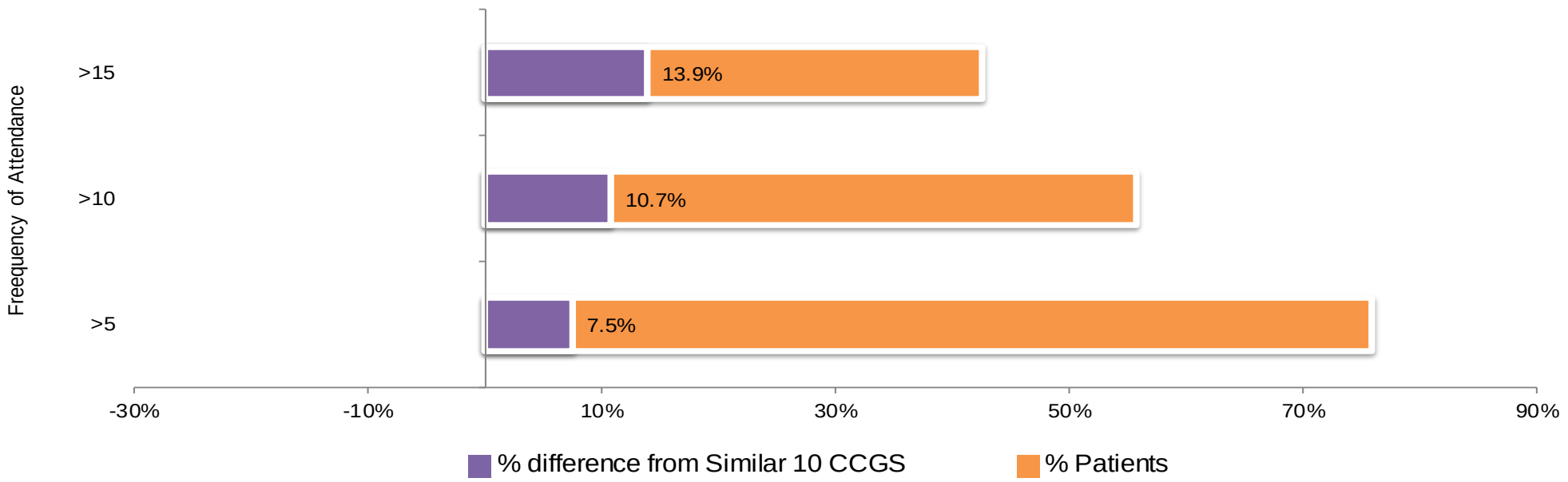
Complex Patients - Outpatients

NHS North West Surrey CCG



ATTENDANCE FREQUENCY	PATIENTS	% PATIENTS	ATTENDANCES	% ATTENDANCES	PATIENT % DIFF TO SIMILAR 10	ATTENDANCE % DIFF TO SIMILAR 10
>5	673	76.0%	14,924	95.9%	7.5%	2.7%
>10	494	55.8%	13,490	86.7%	10.7%	7.2%
>15	377	42.6%	11,992	77.1%	13.9%	13.1%
TOTAL	**886**	**100.0%**	**15,558**	**100.0%**		

‡ TOP 5 CONDITIONS	PATIENTS	% PATIENTS	ATTENDANCES	% ATTENDANCES
Cancer	266	30.0%	2,775	17.8%
General Medicine	287	32.4%	2,282	14.7%
Circulation	366	41.3%	1,726	11.1%
Trauma and Musculoskeletal	243	27.4%	1,160	7.5%
Disorders of Blood	169	19.1%	1,022	6.6%
TOTAL	**886**	**100.0%**	**15,558**	**100.0%**

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.

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Complex Patients Summary - NHS North West Surrey CCG

- 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 Gastro intestinal
  - 63% of these complex patients are aged 65 or over
  - 44% of these complex patients are aged 75 or over
  - 15% of these complex patients are aged 85 or over
- Admissions for 29 children aged under one cost £1 million a year
- 95% of the complex patients also had an outpatient attendance during the year
  - 76% of those patients had more than 5 attendances
  - 43% had more than 15 attendances
  - The average patient had 18 attendances a year
- 89% of the complex patients also had an A & E attendance during the year
  - 25% of those patients had more than 5 attendances
  - 2% had more than 15 attendances
  - The average patient had 4 attendances a year

Complex patients: Case Study – Wigan Borough CCG

- Wigan Borough CCG adopted the RightCare approach in 2012. They identified the need to target their most complex care patients and highest users of services.
- The CCG developed a risk stratification tool, based on the Blackpool model, and localised it for use in Wigan's primary and community care sectors.
- The tool identified the optimal opportunities to improve patient care and well-being for individual high users of NHS services.
- The local GP community embraced the aim of the improvement programme and began to target support to the individuals that the risk tool highlighted.
- As a consequence, **6,000 more residents of Wigan are now actively supported with care plans and case management**. Most of these were previously extensive users of the urgent care part of Wigan's healthcare system.
- The next phase of the programme is to specify the optimal care plan and clinical guidelines to support this. This will ensure that all 6,000, and more in time, always receive the best care possible wherever they are in the system, and reduce unnecessary variation.
- **The above reform can be replicated locally, including primary, community and social care involvement to ensure integration.**

Identifying opportunities to improve population health

CCGs and Local Authorities may wish to consider the following next steps:

Tease out the questions that this pack raises across the health and social care system

- What role could prevention play in improving outcomes?
- Is there evidence of unmet need, e.g. recorded to estimated prevalence indicators, high emergency admissions?
- Are there opportunities for secondary prevention within primary, secondary and social care?
- Do current plans (including Better Care Fund) and service provision take account of these opportunities?
- Is there a role for 'joined up' commissioning across the system or integrated services

Triangulate the intelligence in this pack with other sources

- Look at the pathways on a page packs which will tell you more about the prevention of long term conditions in your CCG
- Look at your Joint Strategic Needs Assessment
- Consider local intelligence about use of commissioned services – for example is the population with greatest need accessing preventative services?

The NHS RightCare approach - Next steps

CCGs may wish to consider the following next steps:

- 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
- 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 at http://ccgtools.england.nhs.uk/cfv/flash/atlas.html and compare your data with that of your peers. Re-visit regularly to explore the updates
- Explore other resources, such as the 'how to' videos, 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 a priority area, use the CVD focus packs at http://www.yhpho.org.uk/default.aspx?RID=199884 otherwise, commission local packs
- 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*

Commissioning for Value workshops

To support CCGs and local partners to use and understand their packs to their maximum benefit, NHS England, NHS Right Care and Public Health England are holding a series of regional workshops throughout March.

Numbers at each event are limited. Please book your place online using the links below.

Each event will bring together CCGs, health and wellbeing boards, local government, public health teams, commissioning support services, intelligence networks, NICE and area teams. The events will:

- give CCGs an opportunity to discuss their pack findings with experts and their local health communities;
- enable delegates to hear from quality and transformation leaders about the benefits of value-based commissioning; and
- showcase real life examples of the Commissioning for Value model delivering improvement and financial sustainability.

The full-day workshops will be held on:

- **Tuesday 10 March in Leeds**. Click http://www.events.england.nhs.uk/all/382 for more information
- **Wednesday 11 March in London**. Click http://www.events.england.nhs.uk/all/383 for more information
- **Tuesday 17 March in Birmingham**. Click http://www.events.england.nhs.uk/all/381 for more information
- **Wednesday 18 March in Basingstoke**. Click http://www.events.england.nhs.uk/all/380 for more information
- **Tuesday 24 March in Manchester**. Click http://www.events.england.nhs.uk/all/384 for more information

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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 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 (coming soon)
- Advice on how to produce 'deep dive' packs locally (coming soon)

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

Annex: Full list of indicators

Maternity and early years

- Conceptions in women aged <18 years per 1,000 females aged 15-17 years
- % of pregnant women vaccinated for flu
- Number of women known to be smokers at time of delivery per 100 maternities
- % of mothers who give their babies breast milk in the first 48 hours after delivery
- % of infants that are totally or partially breastfed at age 6-8 weeks
- Rate of infant deaths aged <1 year per 1,000 live births
- Rate of emergency admissions for gastroenteritis in infants aged <1 year per 10,000 population aged <1 year
- Rate of emergency admissions for respiratory tract infections in infants aged <1 year per 10,000 population aged <1 year
- Children who received 3 doses of DTaP/IPV/Hib vaccine at any time by their second birthday as a % of children reaching age 2 years within the period
- A&E attendance rate per 1,000 population aged 0-4 years
- Rate of emergency admissions per 1,000 population aged 0-4 years
- Rate of hospital admissions caused by unintentional and deliberate injuries in children aged 0-4 years per 10,000 population aged <5 years
- % of children aged 4-5 years classified as overweight or obese
- Children who received 2 doses of MMR vaccine at any time between their first and fifth birthdays as a % of children reaching age 5 years within the period
- The mean number of teeth per child aged 5 years sampled which were either actively decayed or had been filled or extracted due to decay
- % of live births with a gestational age of at least 37 complete weeks and a recorded birth weight who had a recorded birth weight of under 2500g

Inpatient spend for those aged under 5

- **Infectious Diseases**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Cancer**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Disorders of Blood**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Endocrine**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Neurological**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Eye Vision Problems**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Circulatory**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Respiratory**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Gastro Intestinal**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Skin Problems**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Musculoskeletal**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Trauma and Injuries**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Genito Urinary**: Inpatient costs for those aged <5 standardised for age and sex per 100,000 population
- **Poisoning and adverse effects**: Inpatients costs for those aged <5 standardised for age and sex per 100,000 population

Annex: Full list of indicators (continued)

Substance misuse and mental health pathway

- Socioeconomic deprivation: overall Index of Multiple Deprivation score
- % of the working age population that have been claiming job seekers allowance for over 12 months
- Estimated prevalence of opiate and/or crack cocaine users per 1,000 population aged 15-64
- Rate of admissions with a primary diagnosis of a mental or behavioural disorder due to alcohol per 100,000 total population
- Number of individuals who received treatment at a specialist drug misuse service per 100,000 total population
- Number of individuals who received treatment at a specialist alcohol misuse service per 100,000 total population
- % of opiate drug users being treated who left drug treatment successfully and did not re-present to treatment within 6 months
- % of alcohol users being treated who left treatment successfully and did no re-present to treatment within 6 months
- % being treated at alcohol misuse services also receiving treatment from mental health services other than for substance misuse at the time of assessment

Dementia and long term conditions – Risk reduction, detections and primary care management

- % of people registered in a GP practice aged 16+ on the clinical register for obesity
- % of respondents aged 16+, with valid responses to the questions, doing less than the required level of activity to count as physically active
- % of people aged 18+ who are self-reported occasional or regular smokers
- Rate of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause per 100,000 total population
- % of the eligible population, aged 40-74, who have received an NHS Health Check since 1st April 2013
- % of patients aged 17+ with diabetes, as recorded on practice disease registers
- % of patients aged 18+ with depression, as recorded on practice disease registers
- % of people aged 18+ self-reporting experiencing three or more long-term conditions
- The number of people with dementia on GP registers as a % of the estimated number in the population
- Reported prevalence of people with coronary hearth disease (CHD) on GP registers as a % of estimated prevalence
- Reported prevalence of people with hypertension on GP registers as a % of estimate prevalence
- % of people aged 18+ with a long-term condition who report having a written care plan
- % of people aged 18+ with a long-term condition who report using their written care plan to manage their day to day health
- % of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months

Annex: Full list of indicators (continued)

Dementia and long term conditions – Secondary care and outcomes

- % of patients aged 65+ using any inpatient services where dementia was mentioned in the discharge code
- Emergency admissions to hospital of people with dementia (where dementia was mentioned in the discharge code), per 1,000 population aged 65+
- % of emergency admissions of people aged 65+ with dementia (where dementia was mentioned in the discharge code) where the length of stay was of 1 night or less
- % of people aged 18+ with a long-term condition who report that they had enough support from local services to help manage their condition(s)
- Health related quality of life for people with long term conditions: average score
- Difference in the employment rate between those with a long-term health condition and all those of working age
- Delayed transfers of care from hospital per 100,000 population aged 18+
- % of older people (aged 65+) who received reablement/rehabilitation services after discharge from hospital
- % of older people (aged 65+) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
- Permanent admissions of older people (aged 65+) to residential and nursing care homes per 100,000 population aged 65+
- Emergency admissions for chronic ambulatory care sensitive conditions for people of all ages per 100,000 total population
- Emergency admissions to hospital for people aged 75+ with length of stay under 24 hours per 100,000 population aged 75+

Inpatient spend for those aged 75 and over

- **Infectious Diseases**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Cancer**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Disorders of Blood**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Endocrine**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Neurological**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Eye Vision Problems**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Circulatory**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Respiratory**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Gastro Intestinal**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Skin Problems**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Musculoskeletal**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Trauma and Injuries**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Genito Urinary**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population
- **Poisoning and adverse effects**: Inpatient costs for those aged 75+ standardised for age and sex per 100,000 population

Complex Patients - How to interpret 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.

	Main conditions	Co-morbidity 1	Co-morbidity 2	Co-morbidity 3	Co-morbidity 4	Co-morbidity 5
1st	Gastro intestinal	Neurological	Genito Urinary	Poisoning and adverse effects	Circulation	Cancer
	161 patients	48	48	48	41	34
2nd	Circulation	Respiratory	Gastro intestinal	Genito Urinary	Neurological	Poisoning and adverse effects
	178 patients	52	41	36	26	28

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.