



Public Health
England

Commissioning for value focus pack

Clinical commissioning group:
NHS MILTON KEYNES CCG

Focus area:
Cardiovascular disease (CVD) pathway

Version 2
June 2014



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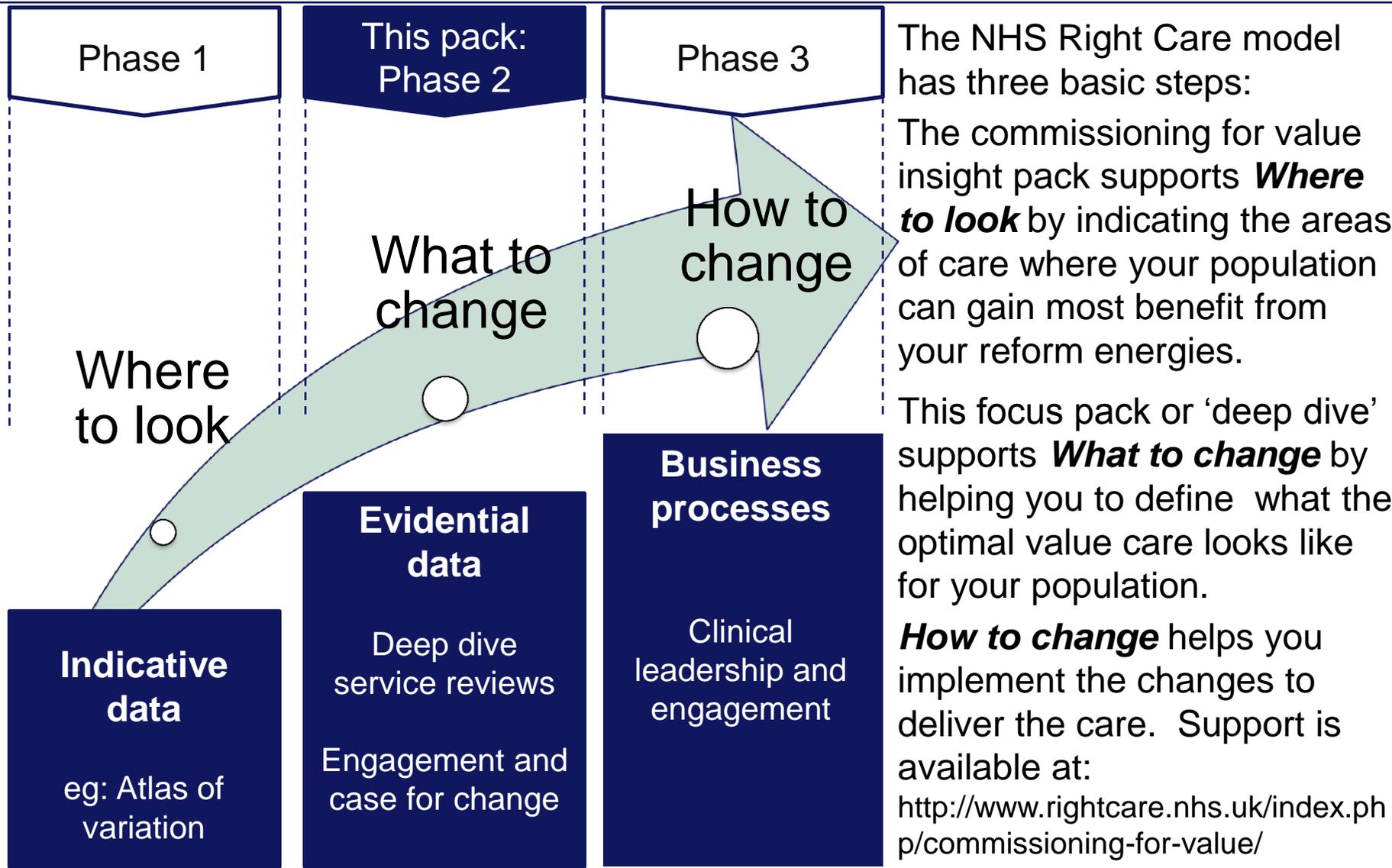


About the packs

- This focus pack or deep dive looks at an agreed programme area (CVD) to understand variation and improve the value of commissioned services across the pathway.
- Commissioning for value insight packs were produced for every CCG in autumn 2013 by Public Health England (PHE), NHS England and NHS Right Care. These packs identified programme areas with potential opportunities for improving outcome, quality and efficiency at clinical commissioning group (CCG) level for the ten areas of programme expenditure with the highest spend. These are available at:
www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
- This CVD focus pack is available in two formats:
 - a downloadable PDF providing national benchmarked data for heart and stroke together with a summary of key messages: www.ncvin.org.uk/
 - an unbranded PowerPoint slide set that is available to CCGs on request to add additional local information and comment. Email the National cardiovascular intelligence network (NCVIN) to ask for a pack:
ncvin@phe.gov.uk



What and how to change



The NHS Right Care model has three basic steps:

The commissioning for value insight pack supports **Where to look** by indicating the areas of care where your population can gain most benefit from your reform energies.

This focus pack or 'deep dive' supports **What to change** by helping you to define what the optimal value care looks like for your population.

How to change helps you implement the changes to deliver the care. Support is available at:

<http://www.rightcare.nhs.uk/index.php/commissioning-for-value/>



Methodology used to produce this pack

Analysed a wide range of indicators from across the pathway focussing on spend, quality and outcomes

- Identified 'cluster groups' of 10 CCGs with similar characteristics to the CCG (see slide 21)
- Analysed wide range of national data to identify indicators where the CCG is below a benchmark value equal to the average of the top 5 CCGs in its cluster group for that indicator and thus has an opportunity to improve
- Identified indicators where the CCG is in the worst quintile (1 of the worst 2 CCGs) within its cluster for that indicator (see slide 22 for more information on methodology)

Identified key opportunities for value improvement and quantified potential impact

- Quantified opportunity for the CCG if indicators below the benchmark were moved to the benchmark
- Quantification does not mean that the 'saving' or improvement can actually be made but may answer the question 'Is it going to be worth focussing on this area?'

Identified evidence based guidance, quality standards and performance metrics for people providing and commissioning health, public health and social care services for the prevention and management of CVD related conditions. For more information see slide 15



Summary: overarching messages

Overarching messages

Public health focus on prevention; specifically smoking prevalence in patients with a long term condition and binge drinking

Significant benefit to patients if improvement to primary care management indicators were made

High numbers of admissions for: CHD emergency admissions, heart failure emergency admissions



Summary:

prevention and prevalence

Prevention

4 out of 5 prevention indicators are worse than the benchmark.

2 indicators are in the worst quintile.

The % of patients registered with a GP with a LTC who smoke is in the worst quintile. If the CCG were to reach the benchmark then there would be 1,897 fewer patients who smoke.

Binge drinking is in the worst quintile. If the CCG were to reach the benchmark then there would be 10,511 fewer binge drinkers.

Prevalence*

3 out of 3 of the observed to expected prevalence ratios are worse than the benchmark.

The prevalence in 2 disease groups out of 7 are higher than the benchmark.

*These packs use two types of prevalence indicator. The observed prevalence diagnosed on practice registers and the ratio of observed to expected prevalence. The expected prevalence is a modelled estimate of total prevalence (diagnosed and undiagnosed) which uses the characteristics of the population to estimate the expected total prevalence of disease in that population. A low ratio may indicate a higher level of undiagnosed cases of disease and therefore unmet need.



Summary: primary care

Primary care

20 out of 20 primary care indicators are worse than the benchmark.

QOF indicators have been used but exceptions have been included in the denominator.

The following 9 indicators are in the worst quintile, the potential benefits based on hitting the benchmark are shown in brackets:

- % of patients with hypertension BP is 150/90 or less (1,750 more people)

- % of patients with hypertension record of BP (1,178 more people)

- % patients with CHD whose last BP reading is 150/90 or less (216 more people)

- % CHD patients record of aspirin (173 more people)

- % AF patients stroke risk assessed using CHADS2 (138 more people)

- % of patients with stroke/TIA last BP is 150/90 or less (118 more people)

- % of new stroke/TIA patients referred further investigation (48 more people)

- AF & CHADS2 score of 1, % anti-coagulation drug therapy (27 more people)

- % stroke patients record of an anti-platelet agent taken (18 more people)



Summary: secondary care

Secondary care

50 out of 62 secondary care indicators are worse than the benchmark.

3 indicators are in the worst quintile. All three are listed below, the potential savings based on hitting the benchmark average are shown in brackets:

- New implantable cardioverter-defibrillator procedures (p) (228 fewer procedures)
- Heart failure male emergency admissions (DSR) (108 fewer admissions)
- CHD female emergency admissions (DSR) (52 fewer admissions)

* (p) = PCT based indicator



Summary: social care

Social care

1 out of 1 social care indicators are worse than the benchmark.
There are no indicators in the worst quintile.



Where does the CCG compare poorly against its cluster group?

Number of Indicators where CCG has room for improvement*	Indicators in the worst quintile versus benchmark group - difference between the CCG and the benchmark, (p) – PCT based indicator	Opportunity - if the CCG were to equal the benchmark
4/5 prevention indicators	% of patients registered with a GP with a LTC who smoke (3.9 % higher) Binge drinking (p) (5.2 % higher)	1,897 patients 10,511 people
3/3 observed to expected prevalence ratios	Stroke ratio (-13.6 % lower)	509 people
20/20 primary care indicators	% AF patients stroke risk assessed using CHADS2 (-5 % lower) AF & CHADS2 score of 1, % anti-coagulation drug therapy (-4.6 % lower) % patients with CHD whose last BP reading is 150/90 or less (-3.4 % lower) % CHD patients record of aspirin (-2.7 % lower) % of patients with hypertension record of BP (-3.7 % lower) % of patients with hypertension BP is 150/90 or less (-5.5 % lower) % of patients with stroke/TIA last BP is 150/90 or less (-4.2 % lower) % stroke patients record of an anti-platelet agent taken (-1 % lower) % of new stroke/TIA patients referred further investigation (-4.9 % lower)	138 people 27 people 216 people 173 people 1,178 people 1,750 people 118 people 18 people 48 people

*below the average of the best 5 CCGs in the cluster group



Where does the CCG compare poorly against its cluster group?

Number of Indicators where CCG has room for improvement*	Indicators in the worst quintile versus benchmark group - difference between the CCG and the benchmark, (p) – PCT based indicator	Opportunity - if the CCG were to equal the benchmark
50/62 secondary care indicators	CHD female emergency admissions (DSR) (40.8 % higher) Heart failure male emergency admissions (DSR) (76 % higher) New implantable cardioverter-defibrillator procedures (p) (148.8 % higher)	52 admissions 108 admissions 228 procedures
1/1 social care indicators	No indicators in the worst quintile	No indicators in the worst quintile

*below the average of the best 5 CCGs in the cluster group



Where to focus: understanding practice variation

- The NCVIN can provide practice level data for CCGs on request: ncvin@phe.gov.uk. This will allow CCGs to better understand practice variation. Practices are clustered with other practices across the country with similar populations. The practice is then compared with the other practices within that cluster for all the indicators where the data is available at practice level.
- This information is not presented routinely in these packs as CCGs will want to use it sensitively as the basis of a discussion with practices to better understand the reasons for variation and the reduction of variation not explained by clinical need.



Where to focus: adding local data

An unbranded power point slide set is available to CCGs on request to add additional local information and comment. These can be requested through the NCVIN: ncvin@phe.gov.uk

CCGs may want to consider adding local intelligence to triangulate with the intelligence in this pack. This may include:

- Up to date intelligence from providers
- Contract monitoring data
- Local prescribing data
- Joint Strategic Needs Assessment (JSNA)
- Preventative activity commissioned by local authorities
- Data on inequalities

Local data can be particularly useful when:

- Testing the size of the opportunities identified from the national data in this pack
- Linking to identified needs of the population
- Testing whether plans introduced since this data was collected have worked
- Testing whether commissioned services are accessed by those in greatest need



Bring it all together:

what works, what could work,
who should we speak to

NICE Guidance, Quality Standards etc

Prevention of cardiovascular disease

Hypertension

Atrial fibrillation

Stroke

Chronic heart failure

Lipid modification

Myocardial infarction with ST segment elevation

Lower limb peripheral arterial disease

Smoking prevention and cessation

Obesity

Physical activity

Contact the NICE field team for support and advice on implementing NICE guidance

The quality and productivity collection provides quality assured examples of improvements across NHS and social care and include cardiovascular and stroke.

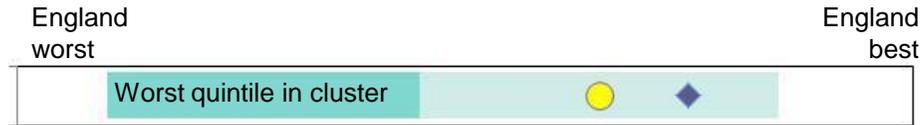
Look at NICE shared learning examples from organisations that have put guidance into practice. Examples include peripheral arterial disease, hypertension and obesity

NICE is recruiting additional members to join its Commissioning reference panel and to support the NICE commissioning programme.

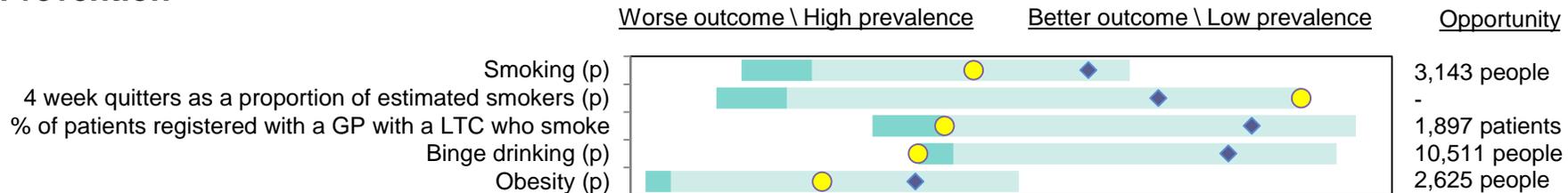


Annex 1: spine charts

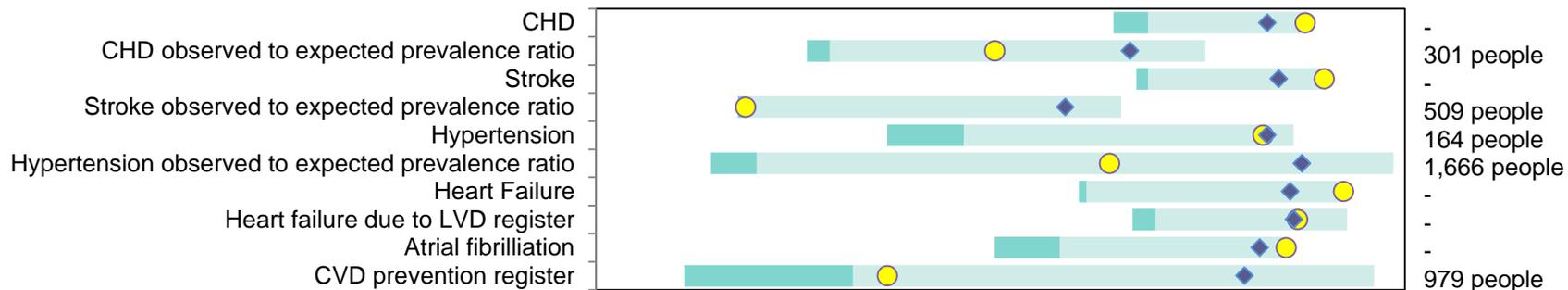
KEY: ● CCG value ◆ Benchmark



Prevention



Prevalence



* (p) = PCT based indicator

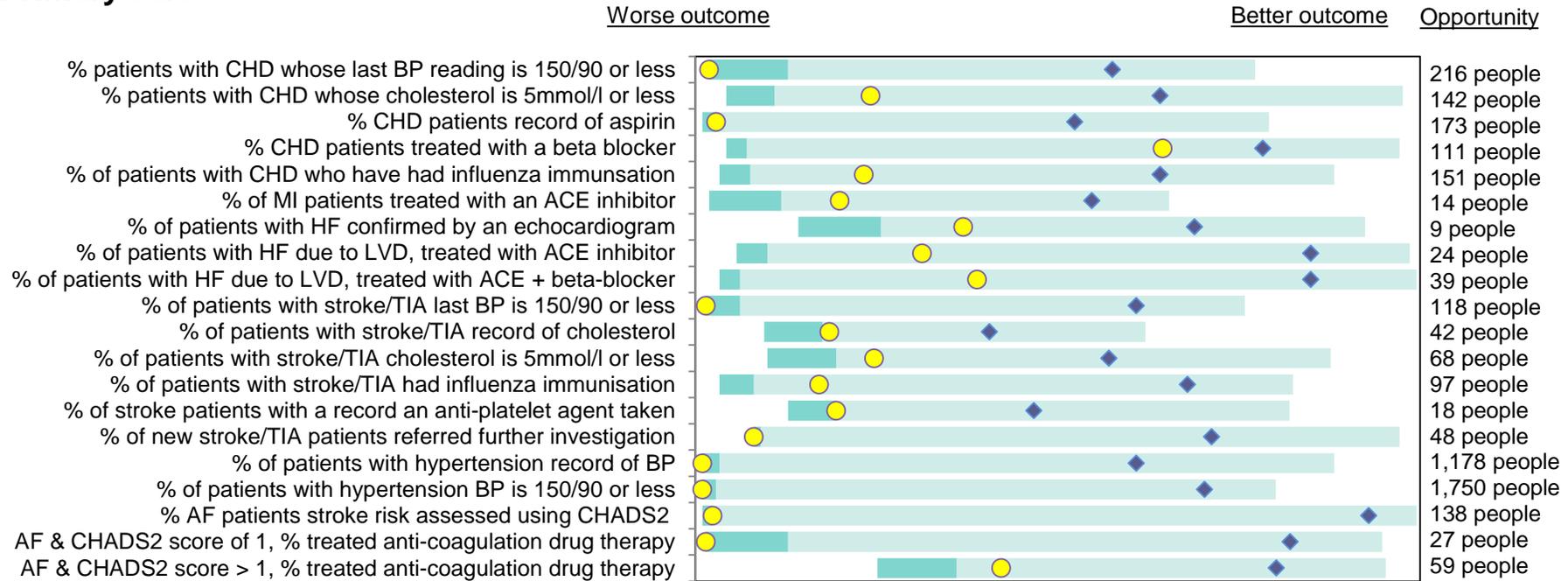
For data sources used, see slide 23



Annex 1: spine charts



Primary care



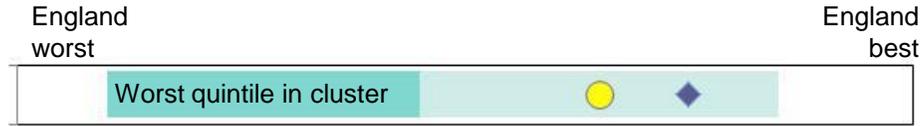
* (p) = PCT based indicator

For data sources used, see slide 23



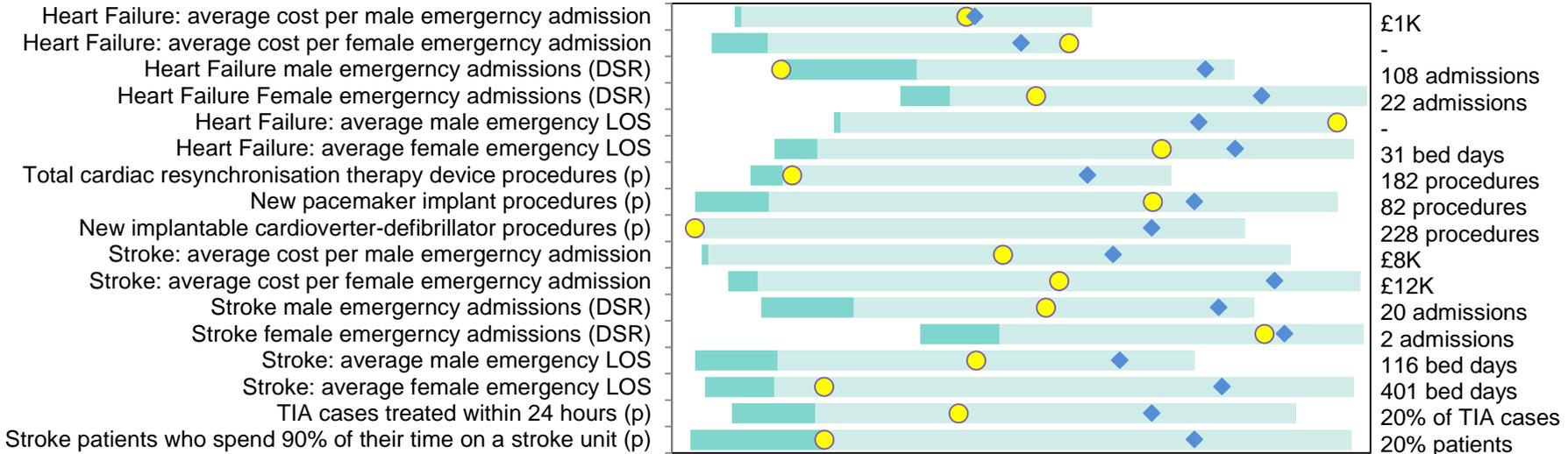
Annex 1: spine charts

KEY: ● CCG value ◆ Benchmark



Secondary care continued

Worse outcome Better outcome Opportunity



Social care



* (p) = PCT based indicator

For data sources used, see slide 23



Annex 2: similar CCGs

The 10 most similar CCGs to NHS MILTON KEYNES CCG are:

NHS THURROCK CCG
NHS CRAWLEY CCG
NHS SWINDON CCG
NHS BRACKNELL AND ASCOT CCG
NHS BARNET CCG
NHS SUTTON CCG
NHS BEXLEY CCG
NHS BROMLEY CCG
NHS NORTH EAST HAMPSHIRE AND FARNHAM CCG
NHS DARTFORD, GRAVESHAM AND SWANLEY CCG

For information on the methodology used to calculate the 10 most similar CCGS please go to:

<http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/>



Annex 3:

Statistical methodology

Statistical methodology

The methodology used in this pack consisted of the following steps:

For each indicator:

- Data are ranked within the cluster
- A benchmark value is calculated from the best 5 ranked values
- The opportunity that could be gained if the CCG were to improve to the benchmark value is calculated
- The worst quintile is identified as the worst 2 ranked values
- If the indicator lies in the worst quintile then it is highlighted as a potential area for investigation

This is a non-parametric statistical approach which is designed to be easy to understand and interpret. It is also insensitive to the presence of outlying or extreme values. While the comparison does not necessarily prove statistical significance it does provide a robust indication of the most promising areas for further investigation.



Annex 4: Data sources

Data sources used:

- Quality and Outcomes Framework (QOF), 2012/13, Copyright © 2014, Re-used with the permission of the Health and Social Care Information Centre. All rights reserved
- Modelled estimates of prevalence, December 2011, East of England Public Health Observatory
- Health Survey for England, 2006-08
- Smoking cessation, 2011/12, Copyright © 2012. Health and Social Care Information Centre, Lifestyles Statistics. All rights reserved.
- 2011/12 mid year population estimates, Office for National Statistics (ONS), © Crown Copyright 2014
- Hospital Episode Statistics (HES), 2012/13, Copyright © 2014, Re-used with the permission of The Health and Social Care Information Centre. All rights reserved.
- Cardiac Rhythm Audit, 2010
- Myocardial Infarction National Audit Programme (MINAP), 2010
- The NHS Atlas of Variation in Healthcare, (Right Care) 2011



Annex 5: Glossary

AF	Atrial fibrillation
BP	Blood pressure
CABG	Coronary artery bypass graft
CCG	Clinical Commissioning Group
CHADS2	A method of calculating the risk of stroke in patients with atrial fibrillation (AF)
CHD	Coronary heart disease
CVD	Cardiovascular disease
DSR	Directly standardised rate
LOS	Length of stay
LTC	Long term condition
LVD	Left ventricular dysfunction
QOF	Quality Outcomes Framework
STEMI	Segment elevation myocardial infarction
TIA	Transient ischaemic attack