Developing the use of World Class Commissioning Tools

ASSIST – 23rd September 2008

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Introduction to the Commissioning Business Service

Regional Context for Commissioning

Commissioning Life Cycle – Tools and Methodologies

Information to Support Commissioners and Providers

CBS Development Roadmap

Questions
Commissioning Business Service – www.gmcbs.co.uk

We provide NHS based specialist support to improve the commissioning of health services

Corporate Services

Business Intelligence

Collaborative Commissioning

Procurement & Market Management

Contracting & Performance Management

Welcome to our website

We provide NHS based specialist support to improve the commissioning of health services

This website will give you information about the role of the Commissioning Business Service and our vision of health care in the North West.

The Commissioning of health services is the core business of a Primary Care Trust ensuring that healthcare requirements of its population are met through the provision of a range of high quality services.

We have an extensive range of healthcare commissioning products and services on offer to help develop your commissioning needs and tailor any service requirement to your individual business whether at practice base or collaborative level.

If you have any questions or queries about what is happening to commissioning health services in your area, you can put your question to us by contacting us by telephone on 01581 212 6000 or by making use of our contact page.

We have five key areas which you can visit individually for specific information but please don’t forget we are all working for the same team to deliver quality products and services that meet effectively the needs of our customers.

We hope you enjoy visiting our site and please let us know your thoughts and views on what we can improve or change by visiting the feedback survey on the contact page.
Regional Context for Commissioning

WCC Competencies
6. Manage knowledge and assess needs
10. Manage the local health system
11. Make sound financial investments

Healthier Horizons for the NHS North West
“The stark reality is that the North West lags behind the rest of England in terms of the health of it’s population”

Advancing Quality
“aims to prove that by improving quality, Readmission rates will be reduced Complications in procedures will decline Time patients spend in hospital slashed”
Regional Context for Commissioning – Programs

Greater Manchester Acute Stroke Reconfiguration

Downs Syndrome & Abdominal Aortic Aneurysm Screening Programs

Clinical Assessment and Treatment Service (CATS)

Local Delivery Plans for Collaboratively Commissioned Services
Feed in to the overall Process for Investment and Reform (PIR)

Capacity for Dermatology Clinical Pathways

NHS Technology Adoption Centre – Impact of new technologies
CBS Integrated Commissioning Offering

CBS integrated commissioning offering framework, aligned to support WCC assurance and delivery

Commissioning Data
- Business Intelligence System Reporting (CBS BII)
- Underpinning PCT Health Economy Data Infrastructure

Planning Services
- Planning Services - System Reform (CBS CSS)
- JSNA and Strategic Plan Support

Procuring Services
- Market Management System Reform Lever (CBS PMM)
- Procurement Surveys / Third Sector Engagement

Service Management
- System Management Performance Assurance (CBS CPA)
- Systems Management Platform

Wcc 1 locally led NHS
- Underpinning PCT Health Economy Data Infrastructure

Wcc 2 Work with community partners
- JSNA and Strategic Plan Support

Wcc 3 Engage Patients/Public
- Planning Services - System Reform (CBS CSS)

Wcc 4 Clinical Collaboration
- Procurement Surveys / Third Sector Engagement

Wcc 5 Manage Knowledge & Assess Needs
- Health Needs Assessment

Wcc 6 Prioritise Investment
- Provider Mapping with L.A. Collaborative Commissioning

Wcc 7 Stimulate the market
- Systems Management Platform

Wcc 8 Promote Improvement & Investment
- JSNA and Strategic Plan Support

Wcc 9 Secure Procurement Skills
- Health Needs Assessment

Wcc 10 Manage the Health System
- Market Capability Assessments & Adoption Hub Support

Wcc11 Make Sound Financial Investments
- Tendering/Contracting Skills & Systems OJEU Processes

Additional services:
- Contract Forecasting Analysis
- Business Case Development
- Service Cost Projections – Market Intelligence
- Clinical KPI’s & outcome/output reports
- Contract Management Reporting / Reconciliations / Review
- Financial Modelling & accounting analysis
- Contract Development Terms & Conditions
- Financial modelling & forecasting
- Contract KPI Development
- Contract PMI currency Development
- Market Mapping / EOI Service Strategies
- Market Capability Assessments & Adoption Hub Support
- Tendering/Contracting Skills & Systems OJEU Processes
- Provider Market benchmarking Local Pricing Reviews
- Collaboration between services
Figure 1.8 Schematic presentation of the main elements in health economics

Source: Williams (1987)
Commissioning Life Cycle – Tools and Methodologies

Business Intelligence Unit – Product Lifecycle

Detailed view of:

- ConQuest Contract Document Management (CDM)
- Scenario Generator (Scenario Planning)
- Combined Model (Health Needs Analysis)
- CBS MedInsight (International Benchmarks)
Developing the use of World Class Commissioning Tools
Commissioning Cycle Activities – BI Holistic View

CBS
BIU
Business Intelligence Team
Service Lines

Data Acquisition & Warehousing
- Data Set Identification
- Commissioning
- Data Set design
- TIS data warehouse
- Pseudonymised Data Service

Data Benchmarking & Analysis
- TIS Analyser Benchmarking

Risk Stratification Analysis
- PARR ++
- Combined Model
- CBS MedInsight

Scenario Planning & Service Design
- Map of Medicine
- Scenario Generator

System Management Reporting
- Choose & Book
- Bravo Solution Award

Contract Monitoring
- CorQuest Contract Management
- CorQuest Contract Performance Management

Paul Davies
Strategic Information Manager

Andy Whilow
Data Acquisition Administrator

Lesley Kitchen
Business Systems Analyst

Information Analyst Team Leader

Abbey Law
Analyst

Matrika Randu
Analyst

Nancy Prospero
Analyst

Developers

Commissioning Cycle Activities supported by holistic approach for all CBS teams, Business Intelligence, Procurement & Market Management, and Contract & Performance Management
Levels of Commissioning Overseen by PCT

- GP / PbC Commissioning & Procurement (CP)
- PCT (CP)
- Assc. PCT (CP)
- NW SCT (CP)
- SHA Rules
- PCT Management of Integrated System levels for Procurements

- Value of services per contract
- Financial Risk to the Commissioner
- Risk pressures to PCTs of CP influenced by each level
- Service Performance Risk
- High
- Low
- High

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ConQuest Contract Document Management (CDM) Tool

Easy, customised access via secure NHS network

CBS hosted service for development, maintenance and management of documentation for all contract types.
Already in use by majority of GM PCTs
Facilitates the full contracting life cycle, providing:
- A complete audit trail of contract versions
- Payment and financial schedules
- Control of contract variations and meeting minutes
- Bespoke contract structure hierarchy with local account codes and cost centres
- Mapping to NHS reference data
- Access to reports

Each subscribing organisation has access to:
- Local Helpdesk Support (9am-4pm, Mon – Fri)
- Information analysts to resolve data/report queries
- Bespoke one to one, group instruction sessions and train the trainer programmes
- Active user group to inform rapid development cycle
ConQuest CDM Features

Each subscribing organisation has online access to their own contracts and those for which they are an Associate

provides Contracting and Finance teams access to carefully shared online management information to answer key business questions e.g.:

• What is the total value of all of our contracts?
• What is the value of our contracts with Provider x?
• How many contracts are within their notice period?
• What is the value of all of our contracts for the financial year xx/xx?
ConQuest CDM – Flexible Reporting

Reporting integrated into the TIS Analyser, a Business Intelligence (BI) tool that delivers sophisticated analysis and benchmarking capability directly to the desktops of health professionals. Access to both pre-configured and bespoke management information.
Integration with Contract Performance Monitoring (CPM)

Streamlined contract monitoring data processing, distribution to associates

Validated, shared whole-provider balanced view of performance

Advance production of ‘Indicative Bill’

Automated exception alerting
Scenario Planning – Scenario Generator

It is a tool that gives you the ability to model scenarios based upon local population, prevalence of disease and pathways of care, and to simulate their operation to:

- make more informed strategic decisions and planning choices
- optimise throughput, end-to-end transaction time, cost reduction and resource utilisation
- anticipate effects that changes to a particular model of care might have upon a whole healthcare system and that might otherwise have been overlooked
- better understand the response of the health system to changes in population, disease prevalence, service capacity, configuration and demand
Scenario Planning – Scenario Generator

The objectives of the tool:

• It can help to take you beyond a process map into potential impacts of implementation

• It aids understanding of complex systems

• You might discover unanticipated consequences of a plan

• It should help to inform decisions

BUT

• Simulation won’t tell you the answer, but it will help you ask better questions

• It will only be as good as the data you put in, but it will help you make sense of that data

• All models are wrong, but some are useful

• It will not be an accurate predictor of events, but it might be better to be “broadly right than precisely wrong”
Scenario Generator – Functional Model

- Population
- Demographic weighting
- Prevalence

Events
- Mental Health
- Urgent
- Planned
- Maternity

Whole system model

Scenarios
- Referral patterns
- Capacity
- Duration

Simulation results

Service points, flows & waits

Pathway models

Constrained resources
Scenario Generator – Knee Pain Care Pathway
Originally developed by Health Dialog in collaboration with the King’s Fund and the DH, the Combined Predictive Model can help NHS organisation to

• Identify patients at risk of re-admission across a population.

• Stratify the health needs of the whole population according to different risk segments.

• Assist commissioners to put appropriate interventions in place for the right patients in time to provide them with a relevant care package.

• Reduce unnecessary emergency admissions hence making significant savings.
Combined Model – Salford PCT Risk Stratification

Population= 157,917 (37 Practices)

**Population Average Utilisation**
Emergency Admits = 113 per 1000
OP = 920 per 1000
A&E = 305 per 1000

**Very High Risk Users – 0.5% (789)**
Emergency Admits = 16.8 x Average
OP = 7.6 x Average
A&E = 7.9 x Average

**High Risk Users – 0.5% - 5% (8,686)**
Emergency Admits = 4.4 x Average
OP = 4.7 x Average
A&E = 2.5 x Average

**Moderate Risk Users – 6% - 20% (23,687)**
Emergency Admits = 1.7 x Average
OP = 1.9 x Average
A&E = 1.3 x Average

**Low Risk Users – 21% - 100% (124,755)**
Emergency Admits = 0.5 x Average
OP = 0.5 x Average
A&E = 0.8 x Average
The very high risk patients combined with the high risk patients (less than 6% of population-9,475) have a significant usage rate compared to the average population accounting for:

- 32.7% of total Inpatient visits
- 29.4% of total Outpatient visits.
The moderate risk patients also have significant usage rate compared to the average population with nearly twice the number of inpatient and outpatient appointments.

- 27% of total Inpatient cost.
- 30% of total Outpatient cost.

Interventions such as self-supported care can help to manage the condition of patients in this segment, preventing them from moving up the risk pyramid.
High prevalence of Asthma, Hypertension and Coronary Artery Disease amongst the top 10,000 patients segment.

Higher rate of more than 1 LTC in the high end of the pyramid.
There is relatively high prevalence of impactable long term conditions in the moderate risk segment and if managed effectively can help to avoid patients moving up the risk pyramid. For example, hypertension prevalence in this group is 10% compared with 5% in the overall population.

Patients in the moderate risk segment are more than twice as likely to have poly-pharmacy utilisation of five-to-nine different drugs over a 90 day period.
There is relatively high prevalence of impactable long term conditions in the moderate risk segment and if managed effectively can help to avoid patients moving up the risk pyramid. For example, hypertension prevalence in this group is 10% compared with 5% in the overall population.
## Combined Model – Salford PCT Risk Stratification

### Utilisation

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<thead>
<tr>
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<tbody>
<tr>
<td>Very High</td>
<td>1,492</td>
<td>5,573</td>
<td>1,907</td>
</tr>
<tr>
<td>High</td>
<td>4,310</td>
<td>37,215</td>
<td>6,638</td>
</tr>
<tr>
<td>Moderate</td>
<td>4,321</td>
<td>42,937</td>
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<td>7,649</td>
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<tr>
<td>Total</td>
<td>17,772</td>
<td>145,353</td>
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### Percentage Utilisation

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PARR++ and the Combined Predictive Model identify different patients even at high risk levels.

Out of top 1000 identified by PARR++ and CPM, 351 patients were identified by both tools.
Evaluation at Whole System Level – Actuarial Techniques

Key elements:

- Financially focussed
- Long term outcomes – usually 5 years +
- Future is based on historical experience analysis, with adjustments for known differences and poor data
- Sensitivity testing on assumptions
- Can involve sophisticated statistics (but not totally necessary)
- Marries pragmatism and theory to create solutions which can be implemented
Evaluation at Whole System Level – Actuarial Techniques

Modelling the potential value from moving to best practice rather than average practice

Involves:

• Having appropriate consistent benchmarks
• Adjusting benchmarks for local demographics and population differences
• Adjusting appropriately for trends
• Calculating potential savings from avoided admissions/avoided beddays
Milliman has large international healthcare databases used to populate benchmark modelling tools.

Milliman creates a range of benchmark levels. The highest level is by Health Cost Guideline (HCG) category. HCGs are an international standard method, developed by Milliman, to aggregate healthcare services and count utilisation.

Additionally detailed benchmarks are available by more detailed service categories, such as aggregated by HRG rollups or procedure codes.

Milliman customises the benchmarks to the specific population being analysed.

- Ideally, factors such as age and gender, coverage considerations and geography are used to customise the benchmarks.
- This enables a more comparable benchmark to be reported to actuals.
Milliman creates three levels of benchmarks; Loosely Managed, Moderately Managed and Well Managed.

The HRG rollup benchmarks reflect “world class commissioning” benchmarks, eg they are international best practice.

Milliman hasn’t created customised HCG Benchmarks for non-inpatient categories, due to time constraints.
Medical and Maternity Days/1000 utilisation are high compared to benchmarks

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Actual Days/1000</th>
<th>Loosely Managed Benchmark Days/1000</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical HRGs</td>
<td>709.54</td>
<td>312.87</td>
<td>127%</td>
</tr>
<tr>
<td>Surgical HRGs</td>
<td>208.92</td>
<td>168.26</td>
<td>24%</td>
</tr>
<tr>
<td>Maternity HRGs</td>
<td>48.01</td>
<td>23.39</td>
<td>105%</td>
</tr>
<tr>
<td>Psychiatric HRGs</td>
<td>88.99</td>
<td>77.29</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>1055.46</td>
<td>581.80</td>
<td>81%</td>
</tr>
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</table>
Medical and Maternity Admits/1000 utilisation is high compared to benchmarks

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<td></td>
<td>Admits/1000</td>
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<td>%</td>
</tr>
<tr>
<td>Medical HRGs</td>
<td>132.78</td>
<td>64.25</td>
<td>107%</td>
</tr>
<tr>
<td>Surgical HRGs</td>
<td>42.80</td>
<td>31.83</td>
<td>34%</td>
</tr>
<tr>
<td>Maternity HRGS</td>
<td>22.14</td>
<td>8.79</td>
<td>152%</td>
</tr>
<tr>
<td>Psychiatric HRGs</td>
<td>3.87</td>
<td>8.44</td>
<td>-54%</td>
</tr>
<tr>
<td>Total</td>
<td>201.59</td>
<td>113.30</td>
<td>78%</td>
</tr>
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</table>
Psychiatric ALOS are high compared to loosely managed benchmarks

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Actual (ALOS)</th>
<th>Loosely Managed Benchmark (ALOS)</th>
<th>Variance %</th>
</tr>
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<tbody>
<tr>
<td>Medical HRGs</td>
<td>5.34</td>
<td>4.87</td>
<td>10%</td>
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<tr>
<td>Maternity HRGs</td>
<td>2.17</td>
<td>2.66</td>
<td>-18%</td>
</tr>
<tr>
<td>Psychiatric HRGs</td>
<td>23.01</td>
<td>9.16</td>
<td>151%</td>
</tr>
<tr>
<td>Total</td>
<td>31.40</td>
<td>21.98</td>
<td>61%</td>
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</table>
Most savings are concentrated in several HRG Rollups.

Top 10 Medical HRG Rollups by Days Savings and variations in Admits and ALOS (2007 service dates)
CBS MedInsight – Pilot Conclusions

• Opportunities for improvement were identified during the pilot:

Comparisons to world class commissioning benchmarks identified a significant number of inpatient admits and days that could potentially be avoided.

Utilisation Trends should be monitored, there have been an increase in specific care categories, such as day cases.

On the technology side:

NHS data is sufficient to support actuarially-based analysis.

More value would be realised if community data primary care and pharmacy data were included for a fuller population view.

In particular, predictive models and disease-based models require primary care data to give good results.
Information to Support Commissioners and Providers

Detailed view of:

- CBS Shared Data Warehouse
- Minimum Data Sets
  - PACs/RIS
  - Community Activity
Sources of Data and Information

Health Care Providers
- GP Practice
- Pharmacy
- Ambulance Service
- Out of Hours Services
- Community Services
- 3rd Sector
- Mental Health Provider
- Acute Provider
- IS Provider

Commissioning
- PbC Clusters
- Primary Care Trusts
- Specialist Services

Policy / Guidelines / Strategy
- Department of Health
- Information Centre for Health & Social Care
- National Library for Health
- National Screening Committee
- NHS Purchasing & Supply Agency
- Collaborative Procurement HUB
- Professional Websites
- Strategic Health Authority
- NHS Strategic Tracing Service
- Nat Institute for Health & Clinical Excellence
- Healthcare Commission
- NHS Institute for Innovation & Improvement
- Patients
- Kings Fund
- Office of National Statistics
- Connecting for Health
- Public Health Observatories
- Clinical/Professional Networks
- Local Authority
- Clinical Interest Groups
- Royal Colleges
CBS Data Infrastructure

Datasets from Acutes & Care trusts
- Datasets from DH
- ONS Datasets
- Referral Datasets
- Local Datasets

Supporting Datasets
- Index of Multiple Deprivation
- QOF National Data
- Mortality (GM only)
- Choose and Book

Datasets from DH
- GP Registered Population
- Diagnostic Tests
- Births (GM only)

ONS Datasets
- ONS Resident Population
- 18 weeks RTT

Referral Datasets
- Referral

Local Datasets
- Ambulance Incidents (GM Only) NW as of Nov 08
- Community Data (part GM only)
- PACS/RIS data (as of April 09)

Legend Key
- Aggregate Data
- Patient Level
- Monthly Update
- Quarterly Update
- BiAnnual Update
- Yearly Update
- As Available

All datasets cover the Northwest NHS area unless otherwise indicated
Possible CDS Flows in Greater Manchester
The bar chart (bottom left) shows the % of initially coded CDS records (episode start dates) per banding (time range) and per SHA (national level).

- The target for organisations to submit this data within the first week of the episode occurring is 30% by the end of June 08 and 50% by the end of September.

**Summary:**

- The bar chart on the right clearly highlights an issue with the timeliness of the CDS weekly submission of the No. of records (Episode Start Dates).
- Very low submission rates in the first 3 bandings compared with the latter bandings.
- The dotted lines highlight areas of improvement of what SHA’s should be aiming for.

-In many cases SHA’s 1st submission of weekly data against the target was 7 - 13 days after the initial episode had started.

-The NW SHA (Q31) performance was in proportion with the other SHA’s.
The bar chart below shows the % of comprehensively coded APC CDS records per banding across the SHA’s. The data was extracted and configured as of the 24th July 2008.

- The target by the end of June 08 is 80% and 100% by the end of September 08.

- the NW SHA has met the June 08 target of 80% for the ‘previous month’ banding.

Note – It is important to take into consideration the following rule when interpreting the graph below – APC CDS records are to be submitted 20 working days at month end of which the month of activity relates to. Hence the ‘current month’ banding is not a true reflection as the extract run date in this instance is 24th July 2008.
Community Activity – DQ reporting and Benchmarking

IPM (iSoft Patient Manager) relates to the community patient admin system also referred to as Lorenzo. The CBS support community data reporting for those PCT’s currently submitting their data. 2 example reports are shown below.

Main areas of concern:
- High occurrences of contacts with incorrect referral speciality (see bar chart below) and appointments with an incorrect referral speciality. Data quality must improve around this area as it is a clinical risk.
- High % of Appointment Outcomes Not Specified (not including Cancelled Appointments).

Other areas of improvement:
- Contact Outcomes not specified
- Appointment arrival times are null for arrived patients
- Appointment departure time is null for arrived patients.
Minimum Data Sets – RIS Case Study

- support the ‘NW PACs Strategy’
  - Promoting and improving the use of Management Information
  - Promoting clinical safety
  - Promoting a Local Health Community view of RIS/PACS

- understand workflow for diagnostics

- present a common view for providers and commissioners
## Minimum Data Sets – RIS Case Study

<table>
<thead>
<tr>
<th>Requirements from initial meeting</th>
<th>Current status</th>
<th>Data issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnaround times</td>
<td>✔</td>
<td>Query written but took too long to run</td>
</tr>
<tr>
<td>DNAs and cancellations</td>
<td>No data</td>
<td>Excludes requests not completed</td>
</tr>
<tr>
<td>Demand</td>
<td>✔</td>
<td>Need separate extracts for each stage of workflow</td>
</tr>
<tr>
<td>Attrition profiles</td>
<td>No data</td>
<td>Applies to any data we can acquire</td>
</tr>
<tr>
<td>Data quality</td>
<td>?</td>
<td></td>
</tr>
</tbody>
</table>
Minimum Data Sets – RIS Case Study
Minimum Data Sets – RIS Case Study

- Align future work with the Strategic Reporting Solution (SRS) to be delivered by NPfIT
- Extend scope to monitor Clinical Safety Incidents
  - Diagnostic test not performed
  - Dictional locks
  - Dictated but not typed
- Link reporting to NW PACS/RIS Portal
- Define commissioning requirements/views
- Extend pilot to NW organisations
- Utilise the Statistical Scheduler for data extraction
- Push for managed data service from CSC
Agenda

Introduction to the Commissioning Business Service
Regional Context for Commissioning
Commissioning Life Cycle – Tools and Methodologies
Information to Support Commissioners and Providers
CBS Development Roadmap
Questions
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