Public Health England

NHS England

NHS RightCare Commissioning for Value Focus Pack

Musculoskeletal conditions; trauma and injuries

May 2016

RightCare

NHS Barking and Dagenham CCG

OFFICIAL

Gateway ref: 04943

Contents

Introduction: Welcome to your focus pack

Welcome to your focus pack on musculoskeletal conditions; and trauma and injuries. The information contained in this pack is personalised for your CCG and should be used to support local discussions and inform a more in-depth analysis around MSK and trauma services. There is a page of useful links at the end and there is a video guide to the pack too.

Each of these focus packs provides detailed information on the opportunities to improve in the highest spending programmes previously covered by Commissioning for Value packs. They include a wider range of outcomes measures and information on the most common procedures and diagnoses for the condition in question.

By using this information, together with local intelligence and reports such as your Joint Strategic Needs Assessment, your CCG will be able to ensure its plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes, resource allocation and reducing inequalities.

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

NHS RightCare

The primary objective for NHS RightCare is to maximise value:

- the value that the patient derives from their own care and treatment
- the value the whole population derives from the investment in their healthcare

The approach has been tested and proven successful in recent years in a number of different health economies. The programme focusses on improving population value including improving outcomes, quality, and releasing capacity and resources for future investment.

To build on the success and value of the RightCare programme, NHS England and Public Health England are taking forward the RightCare approach to ensure it becomes embedded in the new commissioning and public health agendas for the NHS. It is now referenced in the Mandate to NHS England, the NHS Planning Guidance, the CCG Improvement and Assessment Framework and the Quality Premium for 2016/17.

The RightCare programme includes the Commissioning for Value packs and tools, the NHS Atlas series and a number of casebooks. NHS England has committed significant funding to rolling out the RightCare approach to all CCGs over the next two years. Wave 1 has 65 CCGs and these are now receiving early support from one of ten RightCare Delivery Partners. The remaining CCGs are in Wave 2 and will receive support from an expanded team of Delivery Partners later in 2016.

Why act?

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

Professor Sir Bruce Keogh
National Medical Director, NHS England

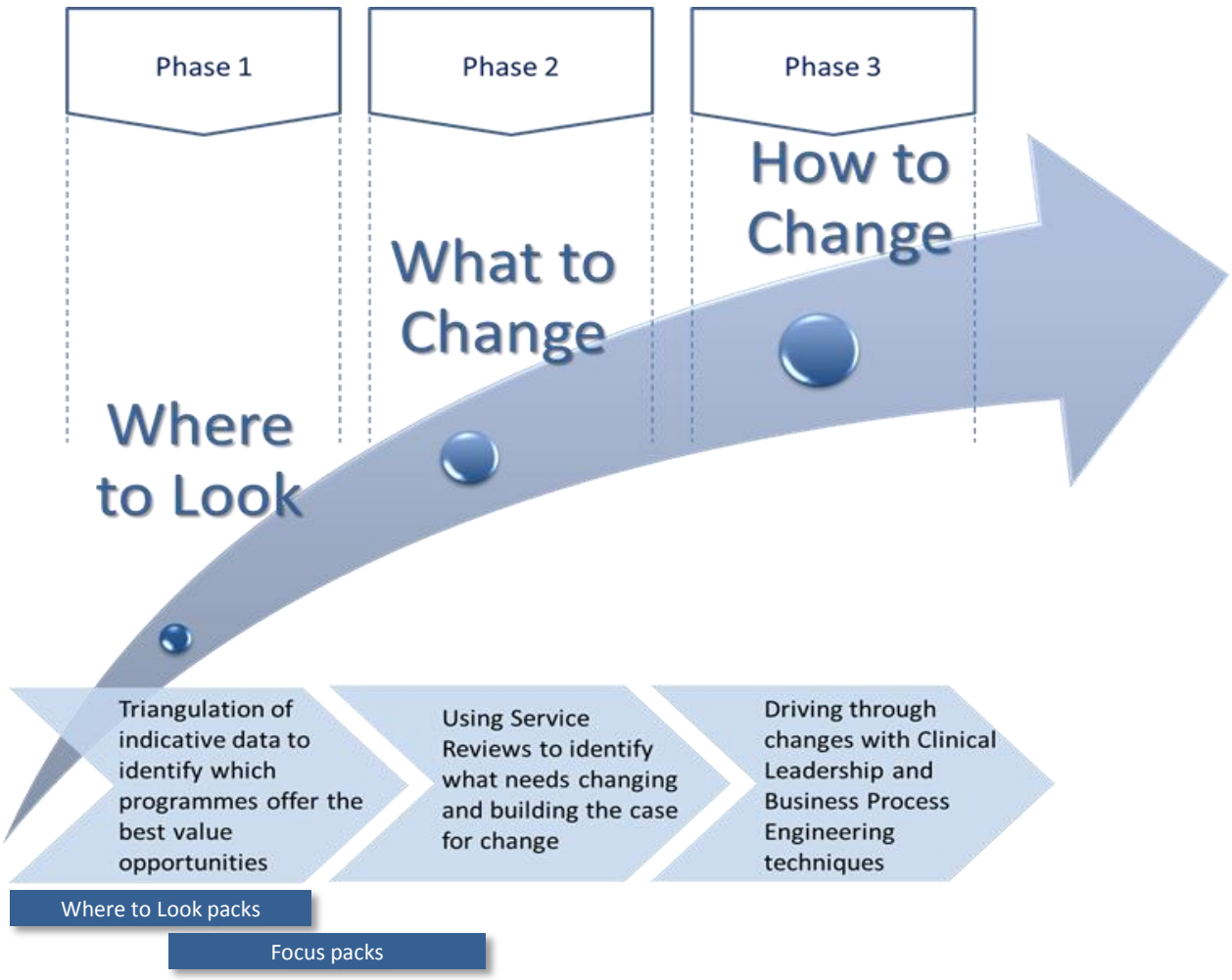
“ The data and evidence available through tools such as Commissioning for Value will help commissioners make the most important decisions in delivering concrete and sustainable clinical and financial benefits across the NHS. We expect that the roll-out of the RightCare programme will drive up the quality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

Paul Baumann
Chief Financial Officer, NHS England

“ In society more years are lived with musculoskeletal disability than any other long term condition. The Commissioning for Value packs provide the basis for healthcare communities to start to identify priorities and address inequalities to better deliver value to local populations and transform the lives of individuals living with musculoskeletal conditions. ”

Professor Peter Kay
National Clinical Director for Musculoskeletal Services, NHS England

Commissioning for Value



Commissioning for Value is a partnership between NHS England and Public Health England. The *Where to Look* packs produced in January 2016 support the first phase of the NHS RightCare approach.

The *Where to Look* packs begin with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement for your CCG.

These focus packs help CCGs to begin work on phase two *What to Change* by using indicative data along a pathway to identify improvement opportunities.

MSK disorders: A clinical perspective

Value in healthcare is concerned with both improving quality and length of life.

Musculoskeletal disorders (back and neck pain, osteoarthritis and rheumatoid arthritis) account for about a quarter of the years lived with disability in England. They result in pain and physical inactivity which are recognised risk factors for developing other long-term conditions such as depression, cardiovascular conditions and some cancers. They also cause a considerable burden to social and informal care as both the prevalence and severity of these disorders increase with age.

Investment in elective activity cannot be interpreted as poor or good value without further investigation. There is now high quality routine data available to evaluate outcomes for the most common elective procedures, hip and knee replacements, using the National Joint Registry (NJR) and Patient Reported Outcome Measures (PROMs) data. This data is now being extended to cover other elective joint replacement procedures such as elbow, shoulder and ankle. More information about PROMs is available in Annex C.

The National Improving Spinal Care (NISC) Project is currently underway to implement NICE / Map of Medicine guidance for the management of low back and radicular pain. Injections for back pain (particularly lumbar facet joint injections) are increasing in activity year on year in the absence of strong clinical and cost-effectiveness evidence. Injections for back pain were not recommended by NICE guidance CG88 for pain up to twelve months duration. In the consultation phase of the updated NICE guidance in May 2016, this was extended to all durations. High activity should be investigated to identify if patients are being managed according to NICE / Map of Medicine guidance and the NISC Project.

Hip and knee activity: Investigating further

There is strong evidence that hip and knee replacements are extremely cost-effective interventions when warranted by clinical need and patient preference. This can be tested at a local level by comparing activity rates with Patient Reported Outcome Measures (PROMs) data. See slides 60 and 61. Low rates may mean that population value could be improved by an increase in activity. High rates should only be interpreted as an opportunity to reduce activity after further investigation.

Rates of hip and knee replacements should be reviewed alongside prevalence estimates of severe hip and knee osteoarthritis.

Rates should also be reviewed alongside pre-treatment and health gain Oxford hip and knee scores and EQ-5D quality of life scores.

CCGs should identify with their main providers of hip and knee replacements whether they meet the requirements of the Best Practice Tariff which requires providers to have at least 50% participation in the PROMs programme and not to be an outlier in case-mix adjusted health gain as measured by the Oxford hip and knee scores. Additionally, providers should have at least 75% of all cases recorded on the NJR to ensure that there is ongoing surveillance of implant survivorship and that providers with high revision rates are identified.

RightCare Shared Decision Making aids are available for osteoarthritis of both the hip and knee:

http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-hip/my-decision/
http://sdm.rightcare.nhs.uk/pda/osteoarthritis-of-the-knee/

Your most similar CCGs

Your CCG is compared to the 10 most demographically similar CCGs. This is used to identify realistic opportunities to improve health and healthcare for your population. The analysis in this pack is based on a comparison with your most similar CCGs which are:

- Greenwich
- Waltham Forest
- Enfield
- Luton
- Croydon
- Haringey
- Slough
- North Manchester
- Birmingham South and Central
- Sandwell and West Birmingham

To help you understand more about how your most similar 10 CCGs are calculated, the Similar 10 Explorer Tool is available on the NHS England website. This tool allows you to view similarity across all the individual demographics used to calculate your most similar 10 CCGs. You can also customise your similar 10 cluster group by weighting towards a desired demographic factor.

In addition to the similar 10, there are CCG cluster groups which have been constructed using the same variables (eg deprivation) as the similar 10. This larger cluster group is used in the opportunity tables, represented by a green triangle. Your CCG is in the following cluster group:

- Deprived urban areas with younger people and ethnic diversity, particularly Black

Your data

This focus pack presents analysis of a wide range of indicators focussing on spend, activity, quality and outcomes. The indicators have been chosen with advice from national clinical leads and other key stakeholders including Arthritis Research UK, the National Osteoporosis Society and the North East Quality Observatory Service.

The data in this pack are the latest available*. The charts identify the metadata for each indicator and the full metadata set will be available on the Commissioning for Value pages of the NHS England website shortly. Data quality has been assessed and only indicators which are sufficiently robust have been included in the pack.

The data are presented as an exploration, starting with the pathways on a page, then moving to elective and non-elective spend, admissions, prescribing and procedures.

Should you have any queries about the indicators or the data, please refer to the contact details on the 'further information and support' page at the end of this pack.

*As the spend indicators have been updated since the publication of the 2016 refreshed 'Where to look' packs, figures for spend rates and potential opportunities may differ slightly from those packs.

Pathways on a page

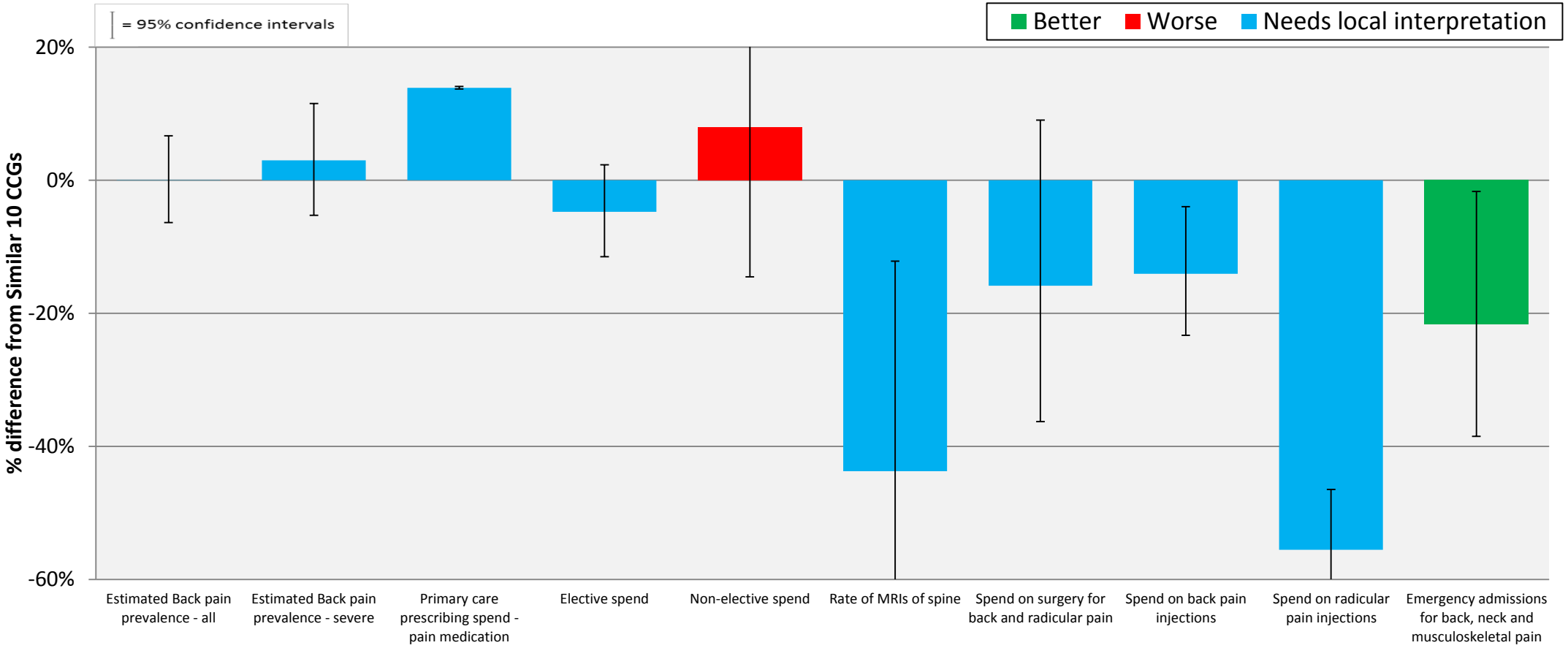
The musculoskeletal pathway in the refreshed 'where to look' 2016 packs has been replaced here by four individual MSK pathways. The majority of indicators in the previous MSK pathway now appear in the new osteoarthritis pathway. The trauma and injuries pathway remains the same; however the spend data has been updated.

The intention of these pathways is not to provide a definitive view on priorities but to help commissioners explore potential opportunities. These help commissioners to understand how performance in one part of the pathway may affect outcomes further along the pathway. Each indicator is shown as the percentage difference from the average of your 10 most similar CCGs.

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 (blue) is used where it is not possible to make this judgement. For example low prevalence may reflect that a CCG truly does have fewer patients with a certain condition, but it may reflect that other CCGs have better processes in place to identify and record prevalence in primary care. **Blue indicators could show significant opportunities for improvement.**

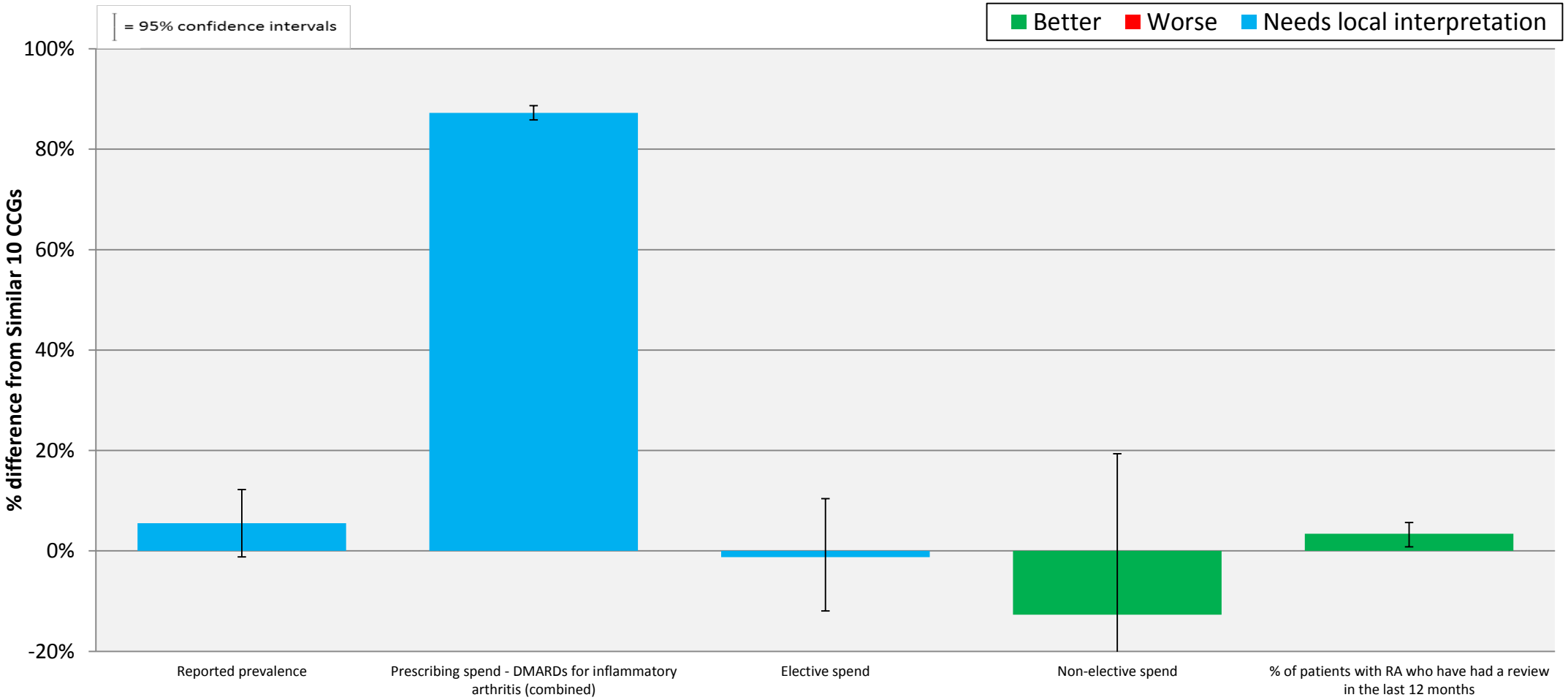
Even where an indicator is green there may still be an opportunity to improve. The programme opportunity tables, starting on page 64, identify the opportunities that exist for your CCG to improve to a level which matches the average of the best five of your similar 10 CCG group. Please note: The variation from the average of the similar 10 CCGs is statistically significant for those indicators where the confidence intervals do not cross the 0% axis.

Back, Neck and MSK Pain Pathway



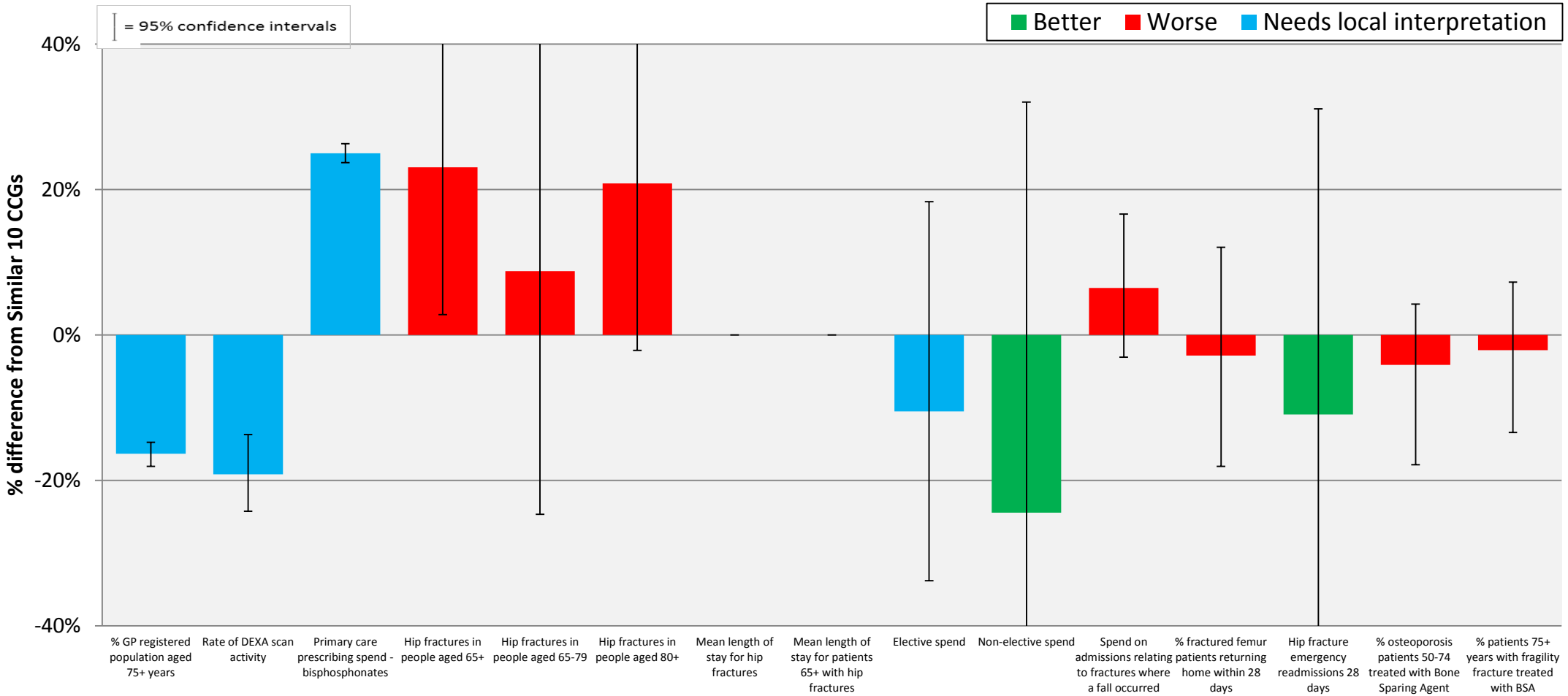
NICE Guidance:
http://pathways.nice.org.uk/pathways/low-back-pain-early-management

Rheumatoid and inflammatory arthritis Pathway



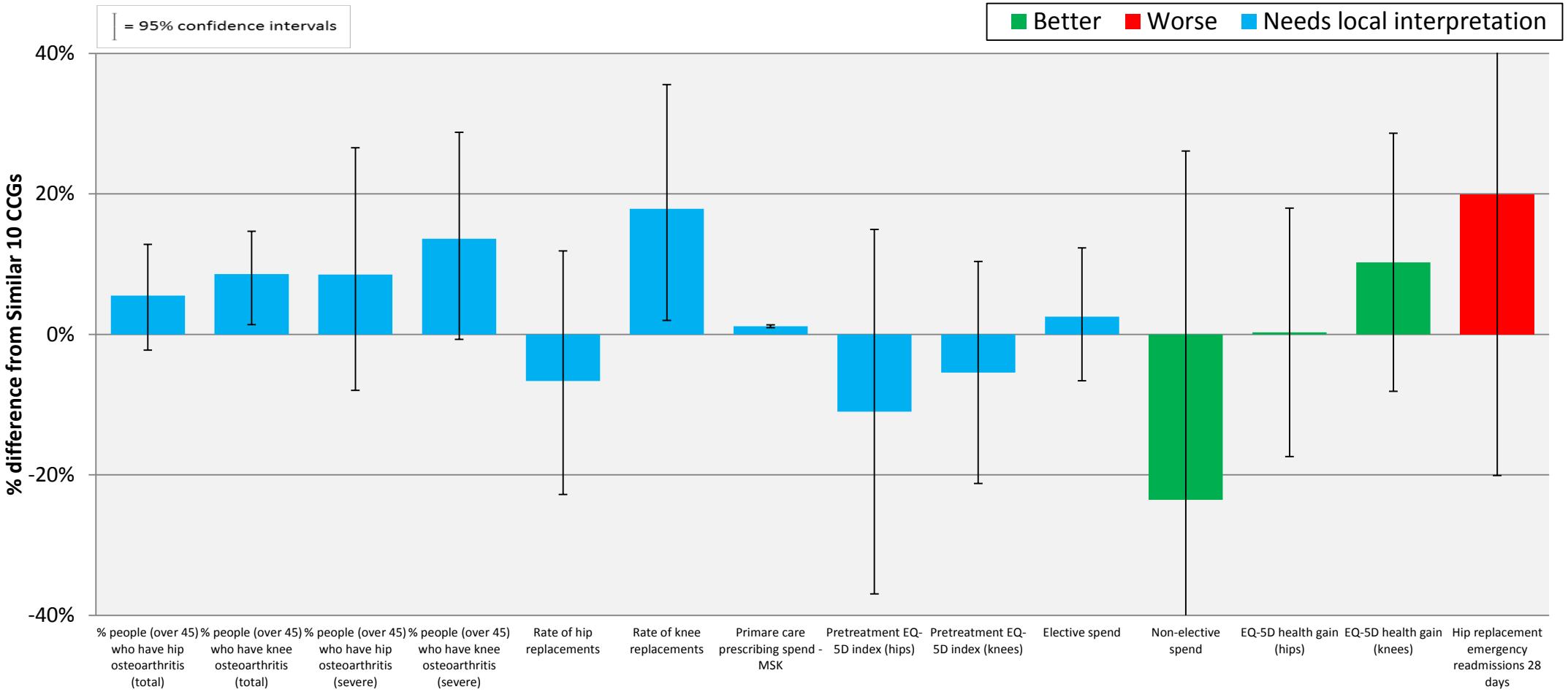
NICE Guidance:
http://pathways.nice.org.uk/pathways/rheumatoid-arthritis

Osteoporosis and fragility fractures Pathway



NICE Guidance:
http://pathways.nice.org.uk/pathways/osteoporosis

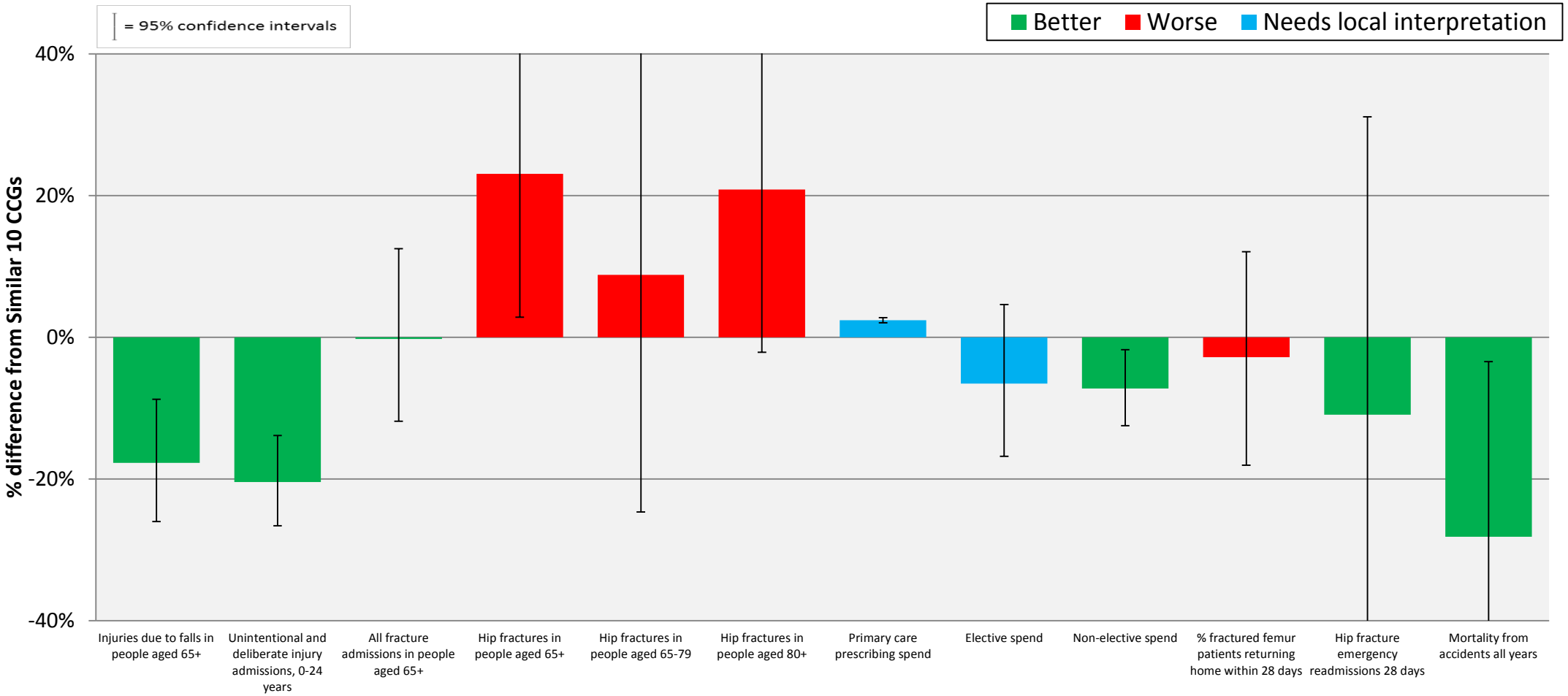
Osteoarthritis Pathway



NICE Guidance:

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

Trauma & Injuries Pathway



NICE Guidance:
http://pathways.nice.org.uk/pathways/trauma

Spend and activity

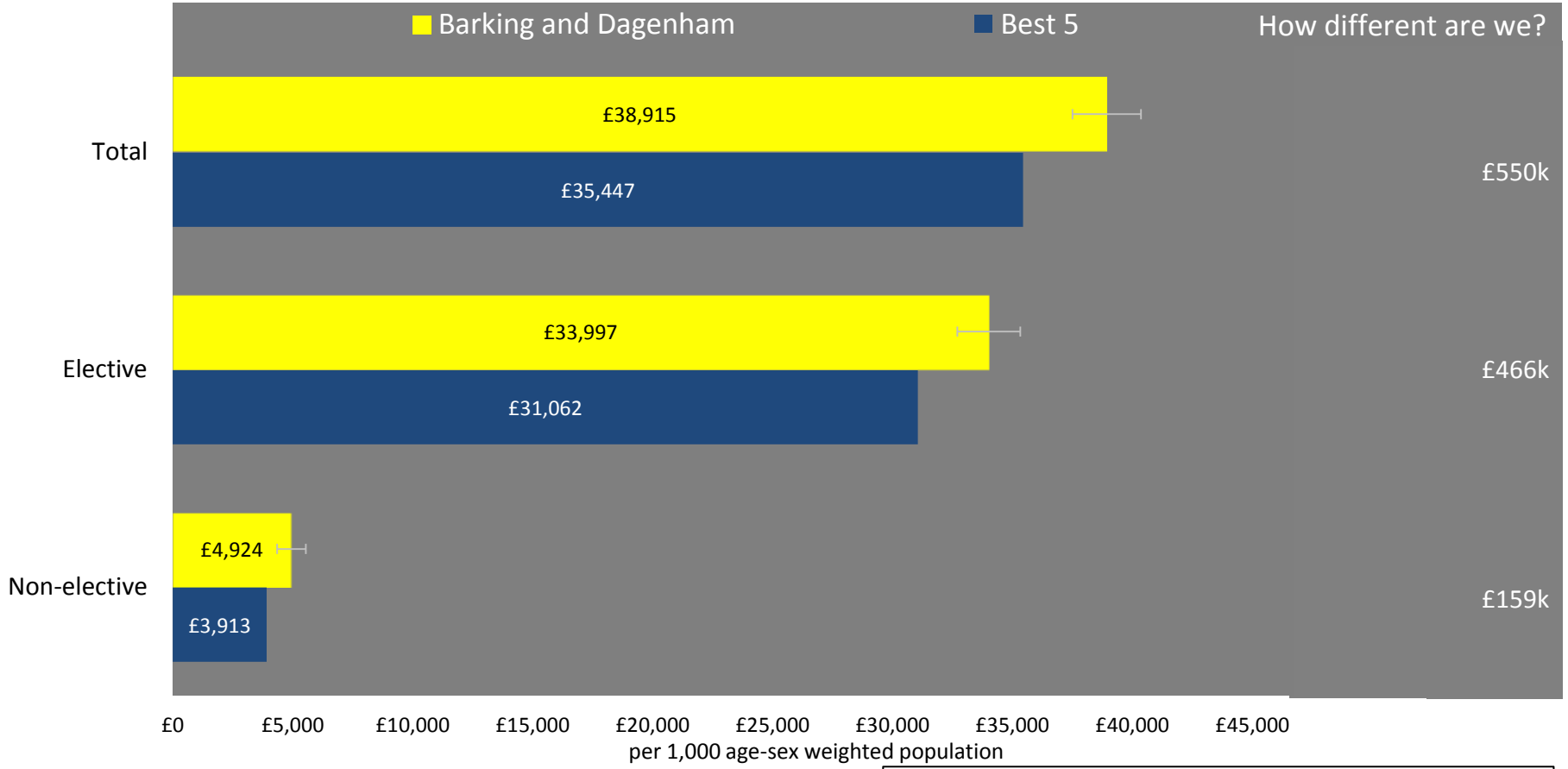
The intention of the following pages is to provide a more in-depth view of the spend and activity for the clinical areas included in this pack compared to your 10 most similar CCGs. The charts show the rate for your CCG (yellow bar), the average of the best five comparator (blue bar) and also the absolute difference (the 'how different are we?' column). They should be used to explore key lines of enquiry to identify potential opportunities for improvement.

The opportunity tables, starting on page 64, identify the best CCG in your similar 10, who you may want to contact – either directly, or through your Delivery Partner if you are in a Wave 1 CCG.

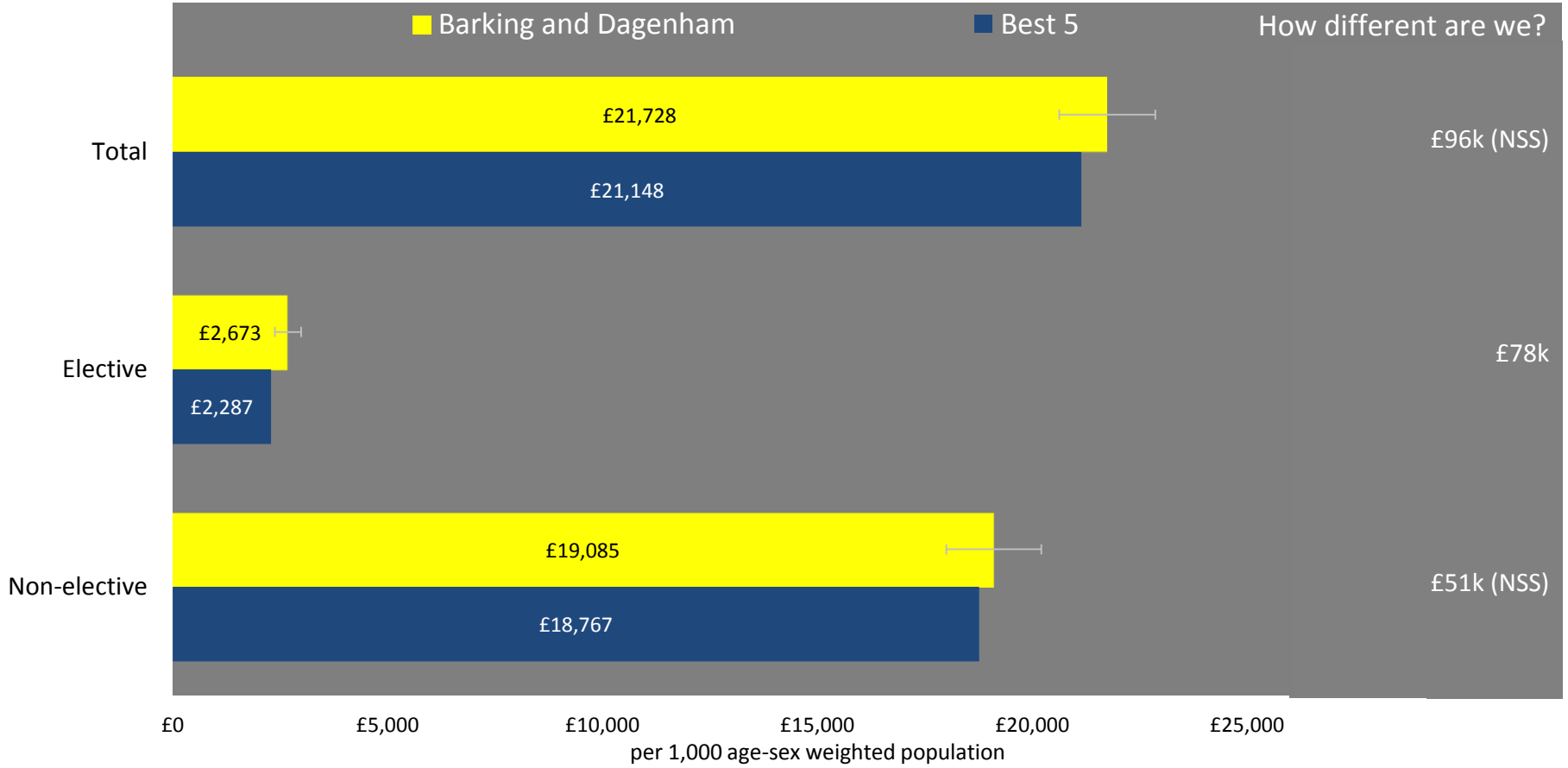
Prescribing and procedures groups and single interventions have been chosen to reflect highest spend. National Clinical Directors and other expert stakeholders have advised on the chemical groupings of drugs used to treat certain conditions within a pathway. Similarly they have advised on procedure grouping. Annex A gives details of those groupings.

For some indicators, the difference between the value for your CCG and the Best 5 is marked as Not Statistically Significant (NSS). This means that we cannot say with confidence (statistically defined as >95% confidence) that any difference between your CCG and the Best 5 is not simply due to chance. Values for these cases have been included in order to provide detailed information for use in considering whether to explore an area further.

Musculoskeletal - Spend



Trauma & Injuries - Spend

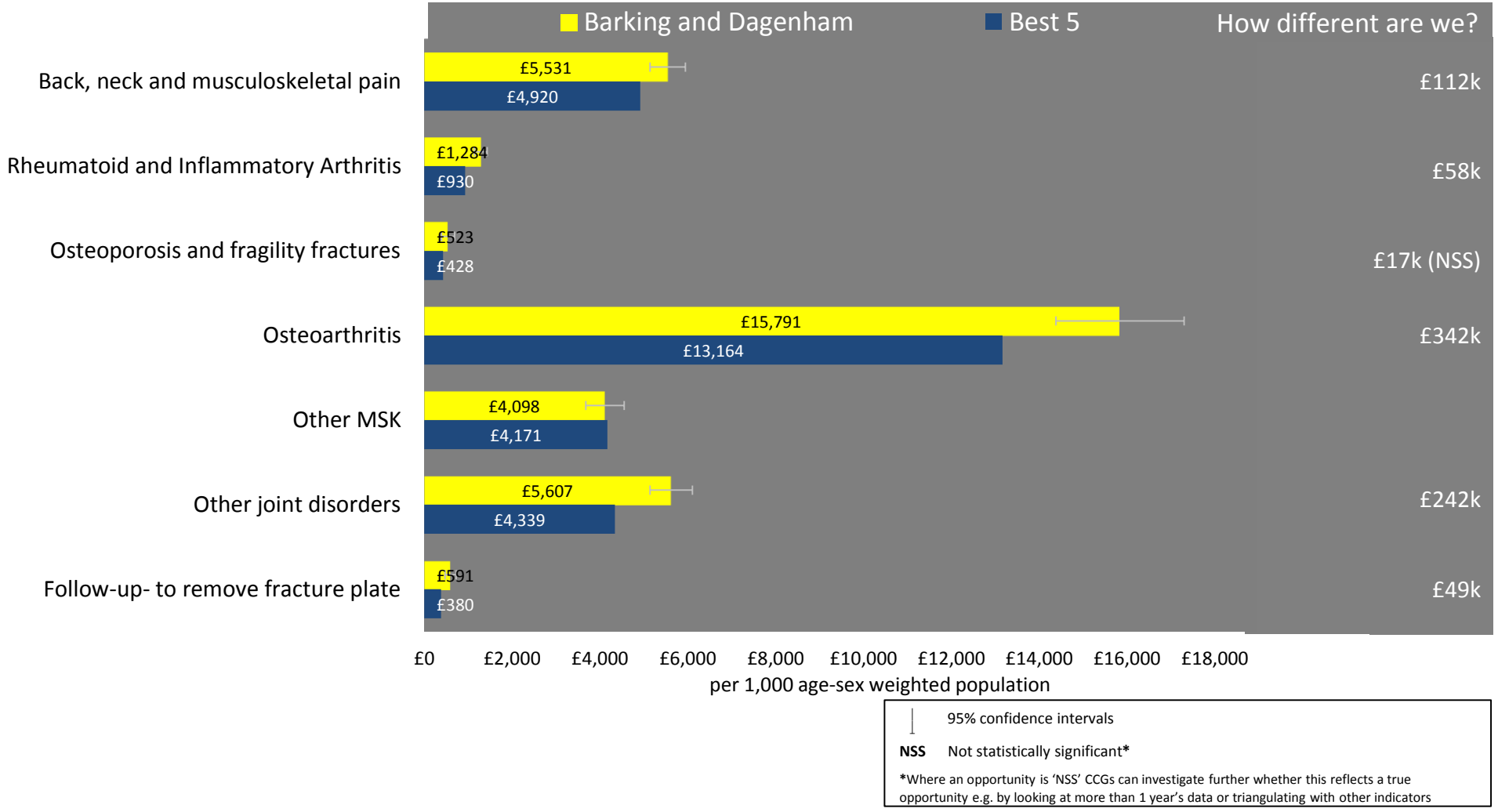


95% confidence intervals

NSS Not statistically significant*

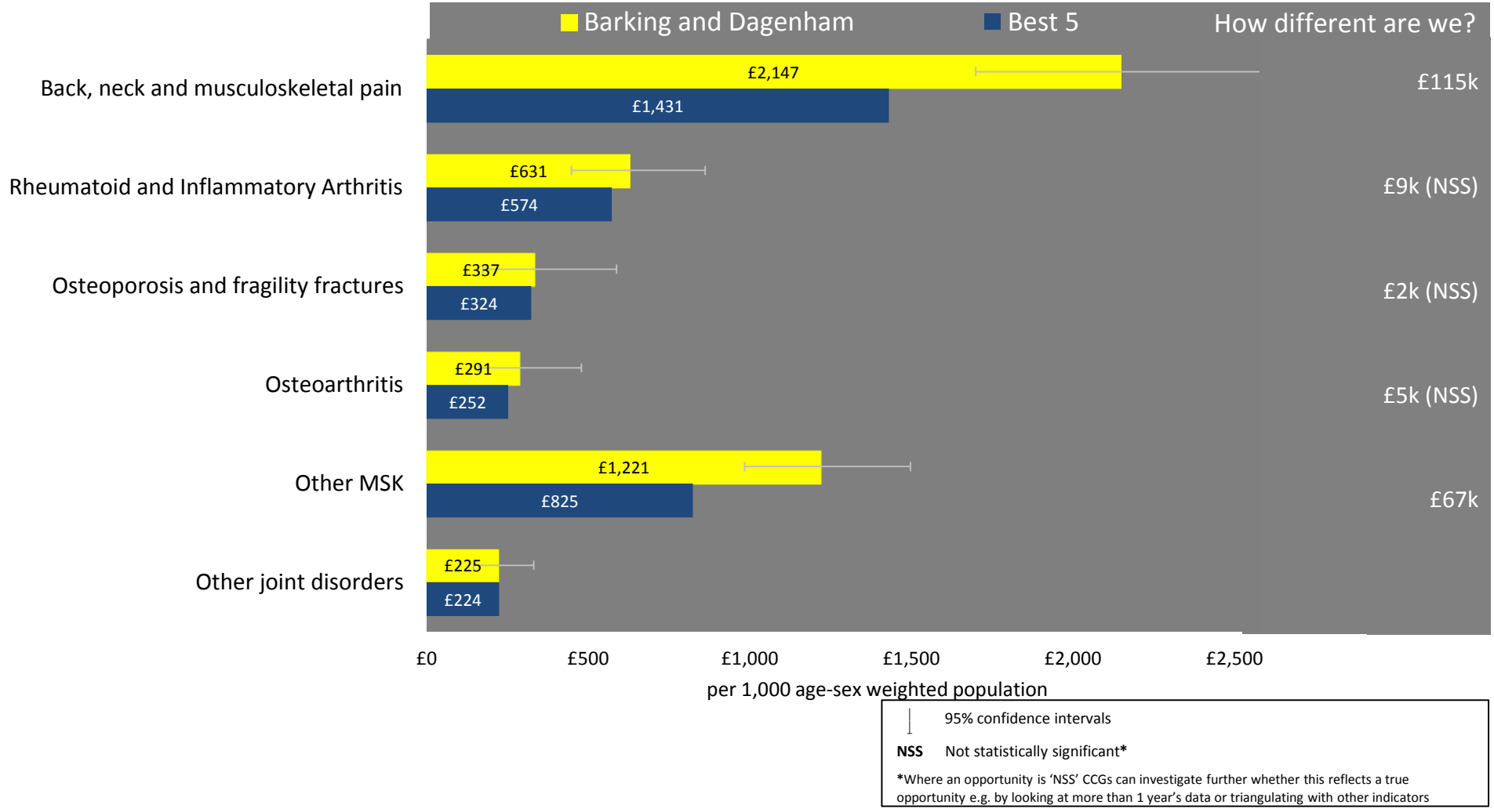
*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

MSK - Elective Spend
Condition Groups

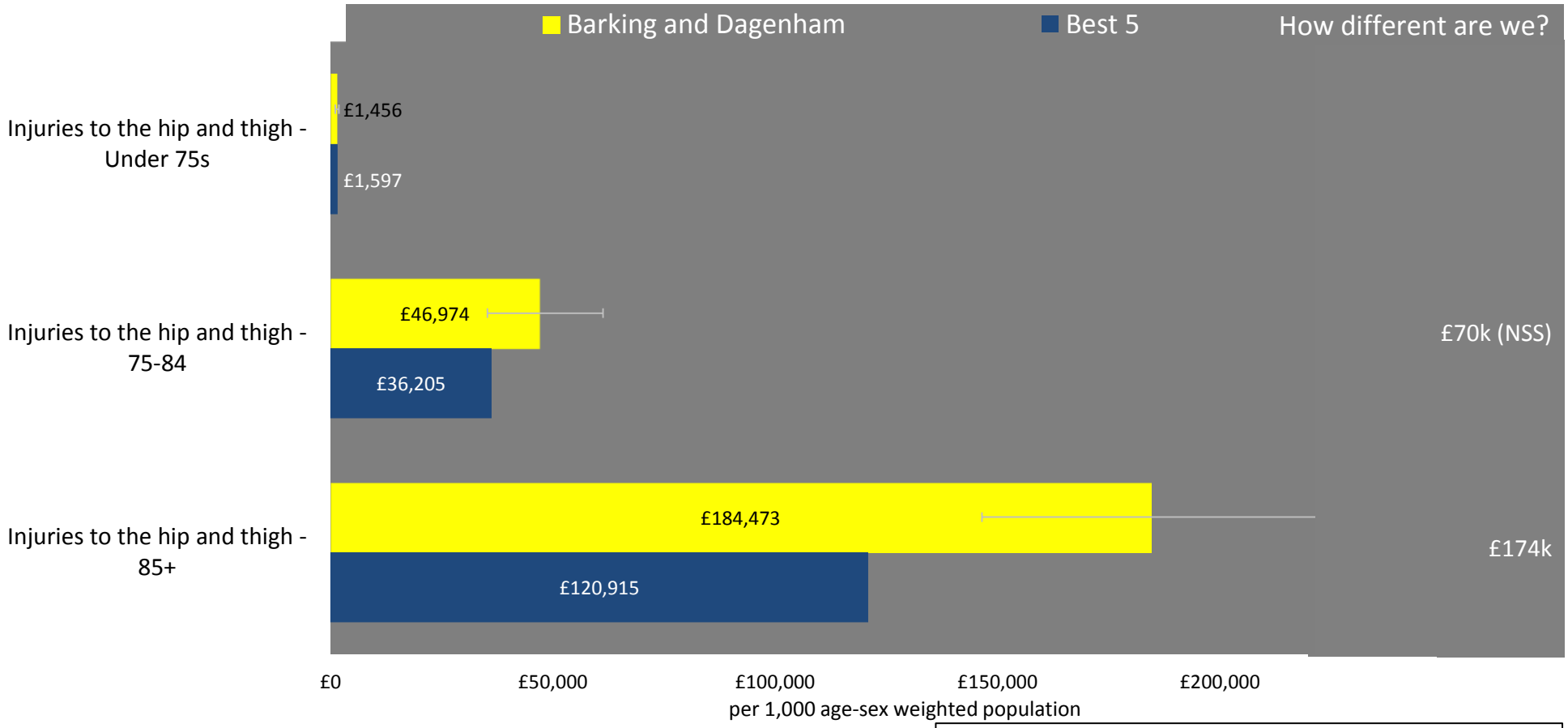


MSK - Non-Elective Spend

Condition Groups



Trauma Spend - Injuries to the hip and thigh



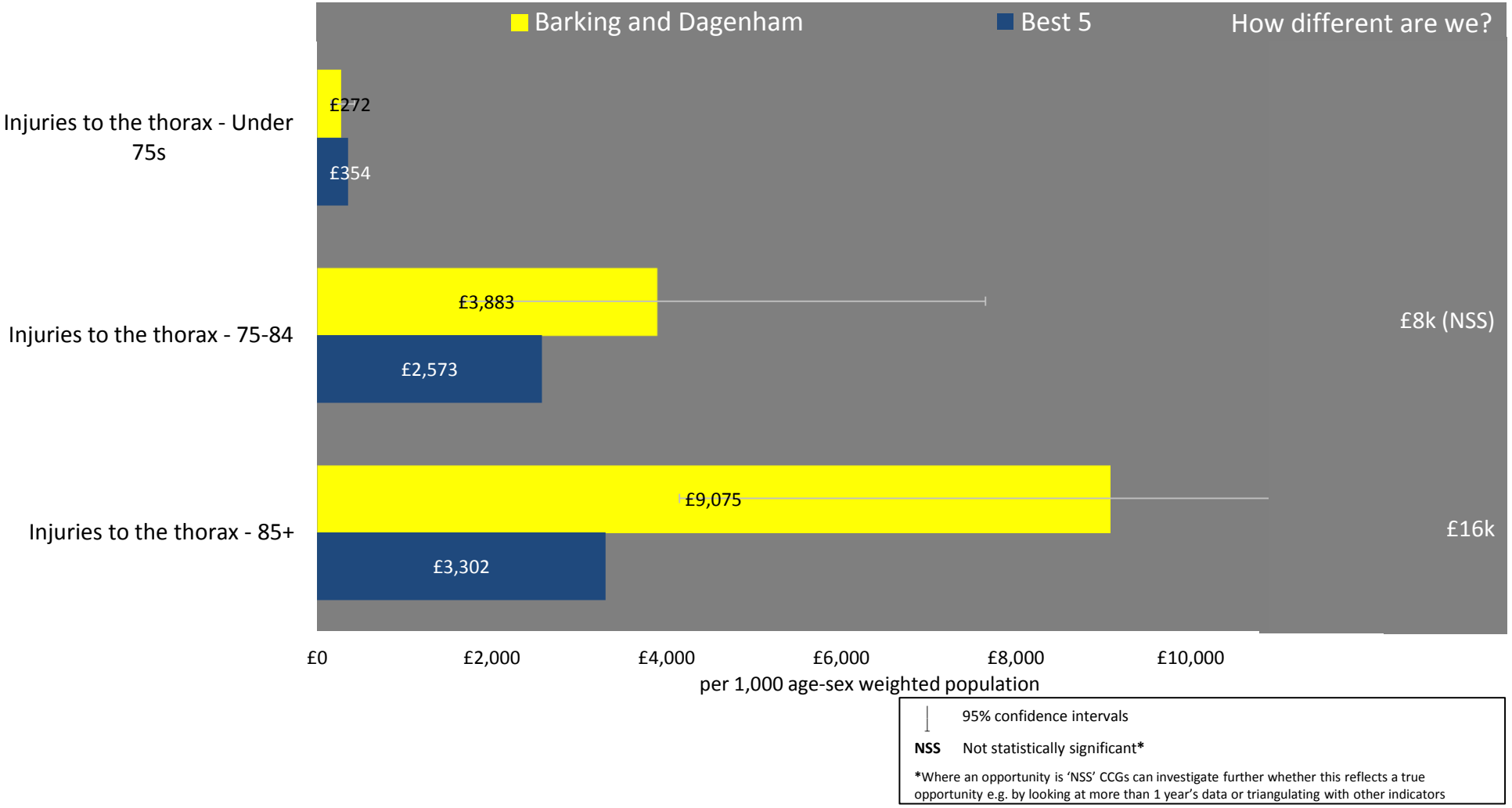
Please note: Spend on Trauma and Injuries (slides 22-29) includes spend for both elective and non-elective admissions.

95% confidence intervals

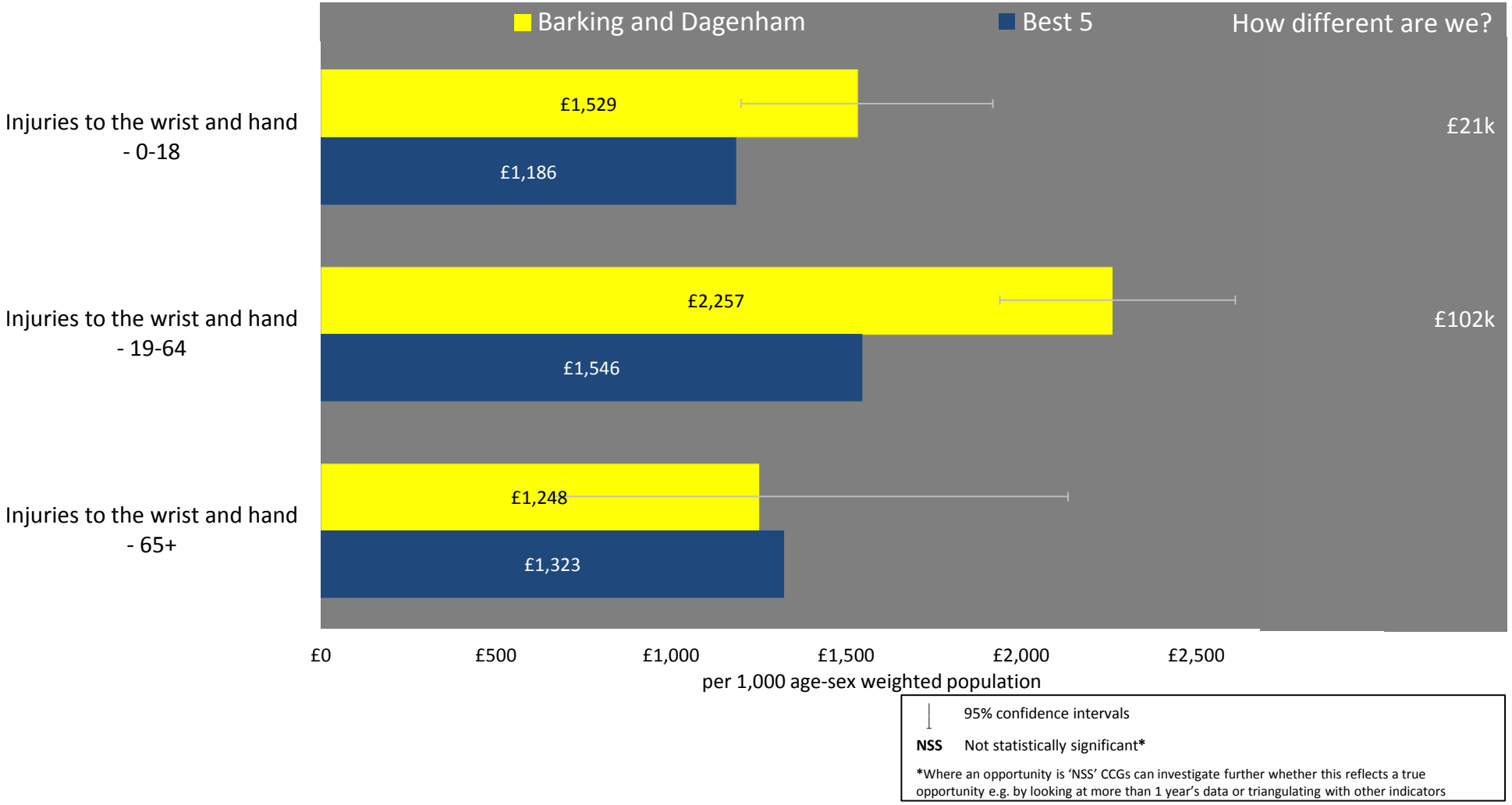
NSS Not statistically significant*

*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

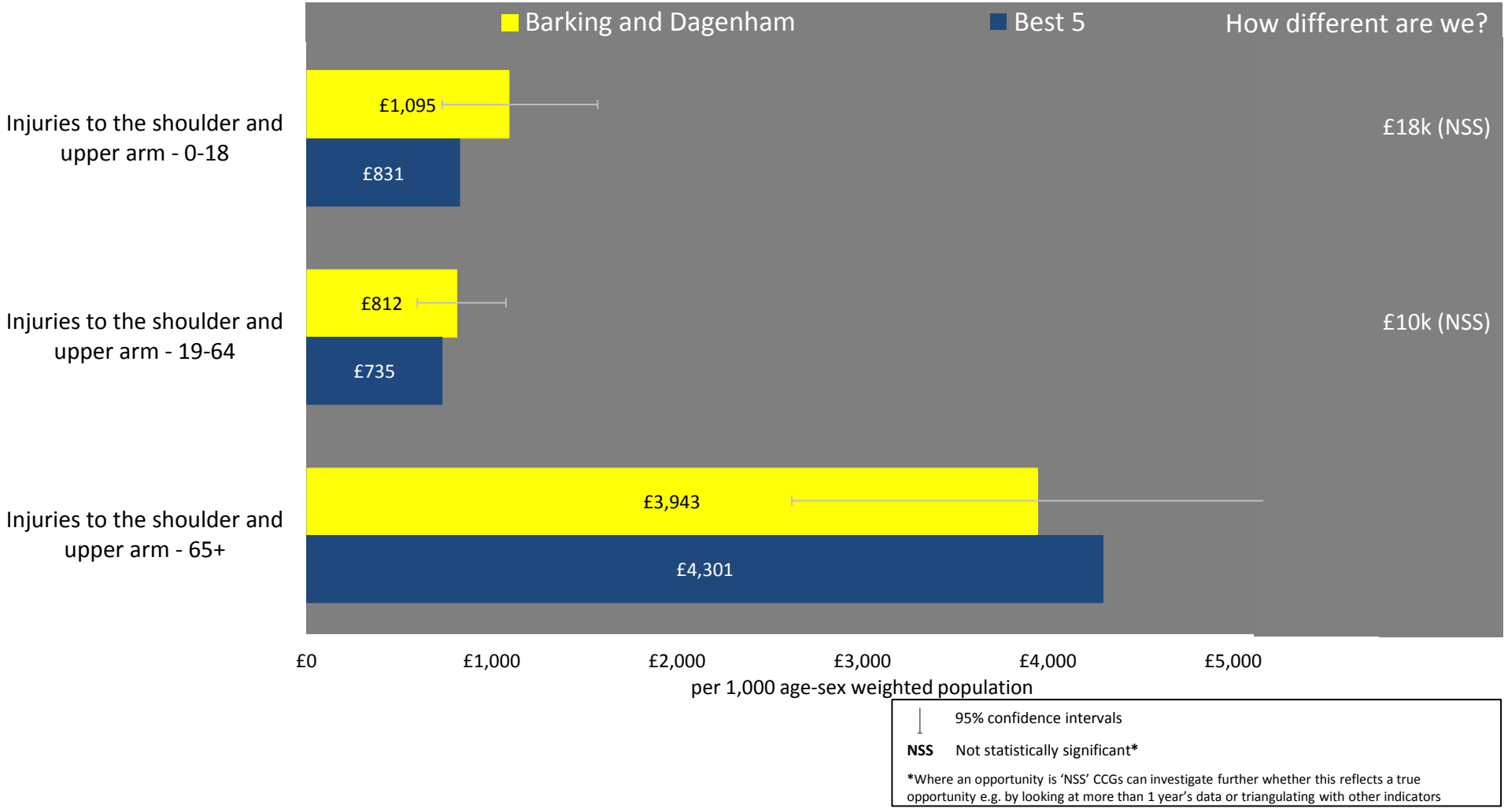
Trauma Spend - Injuries to the thorax



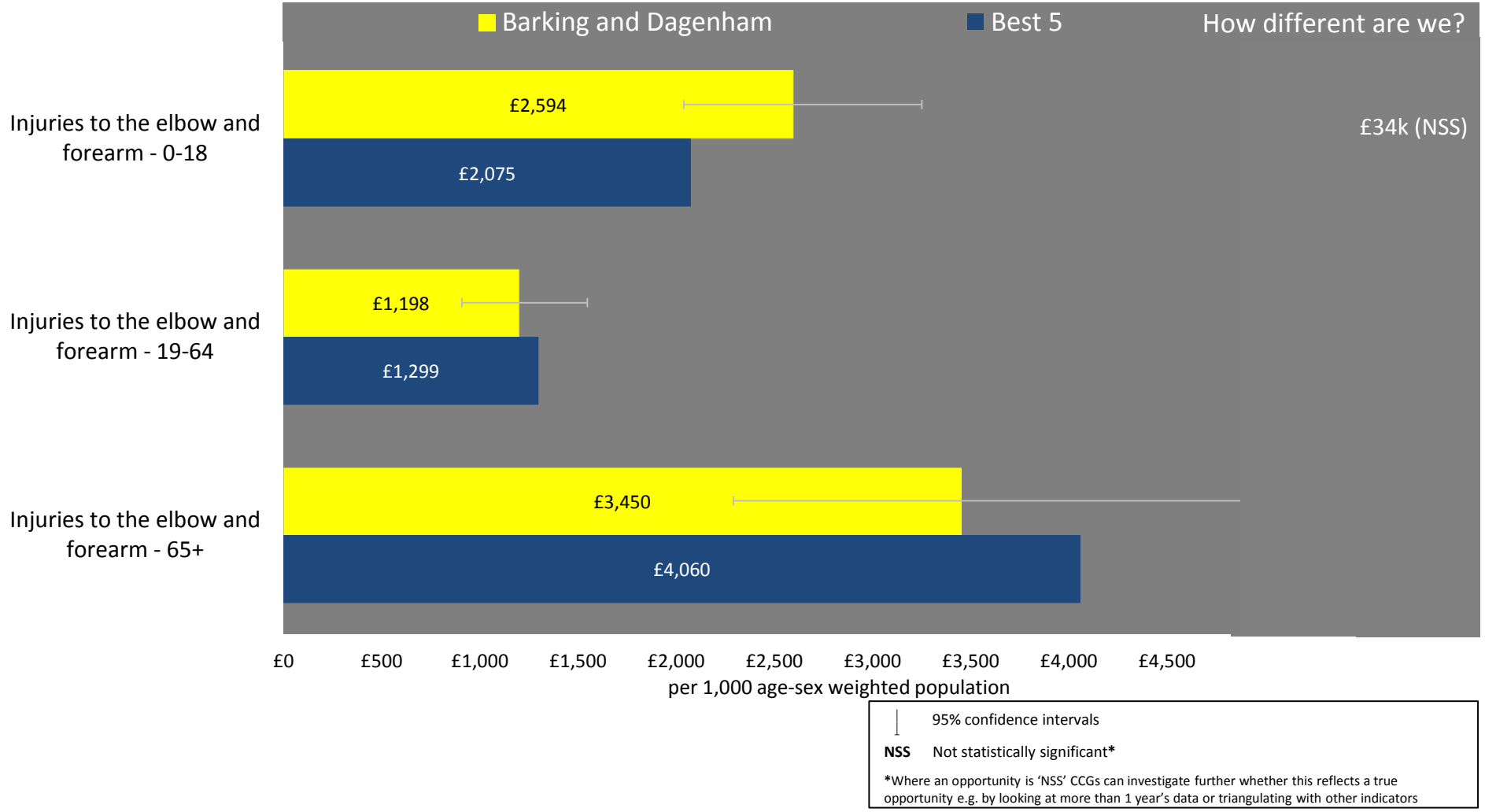
Trauma Spend - Injuries to the wrist and hand



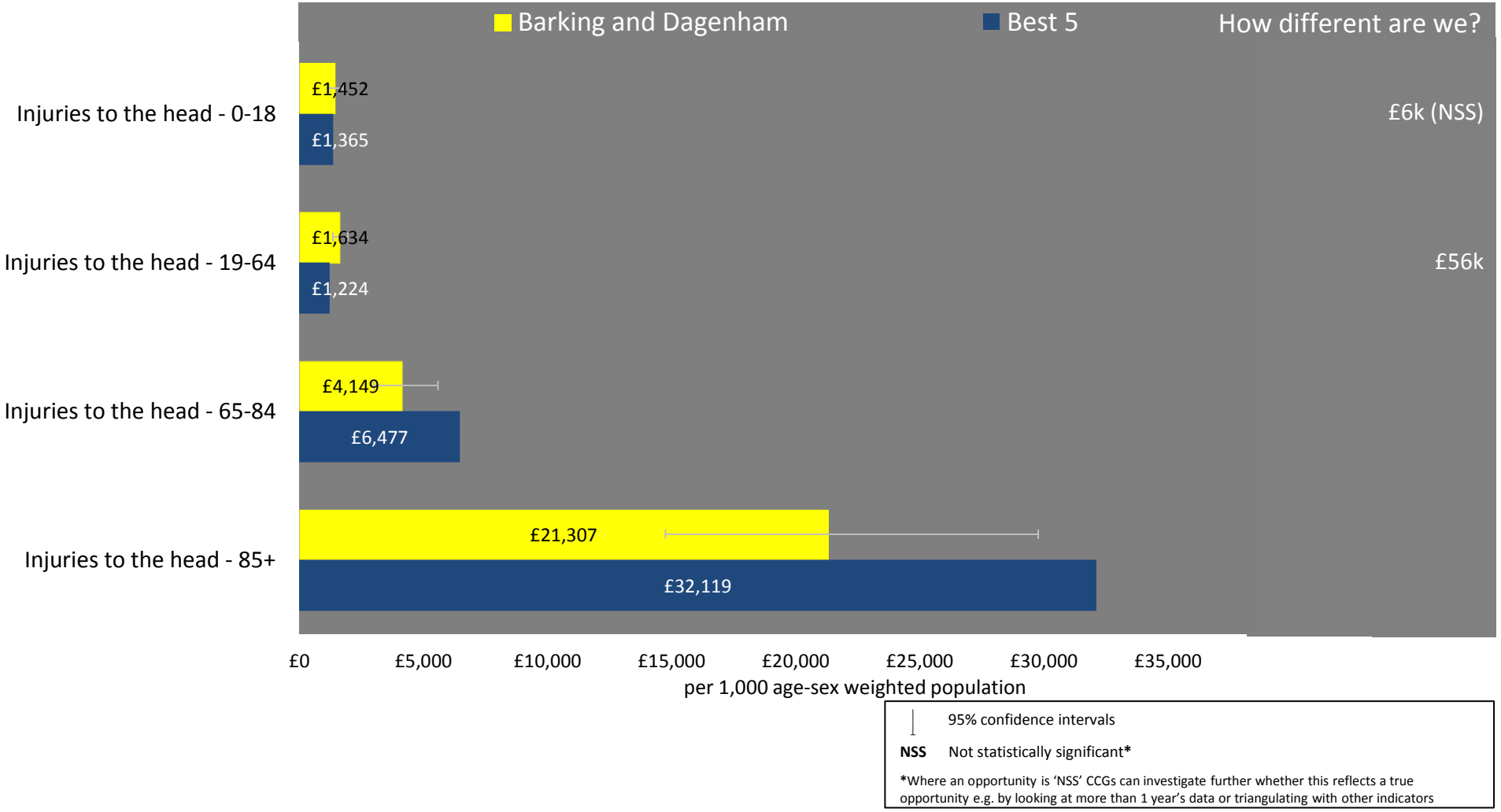
Trauma Spend - Injuries to the shoulder and upper arm



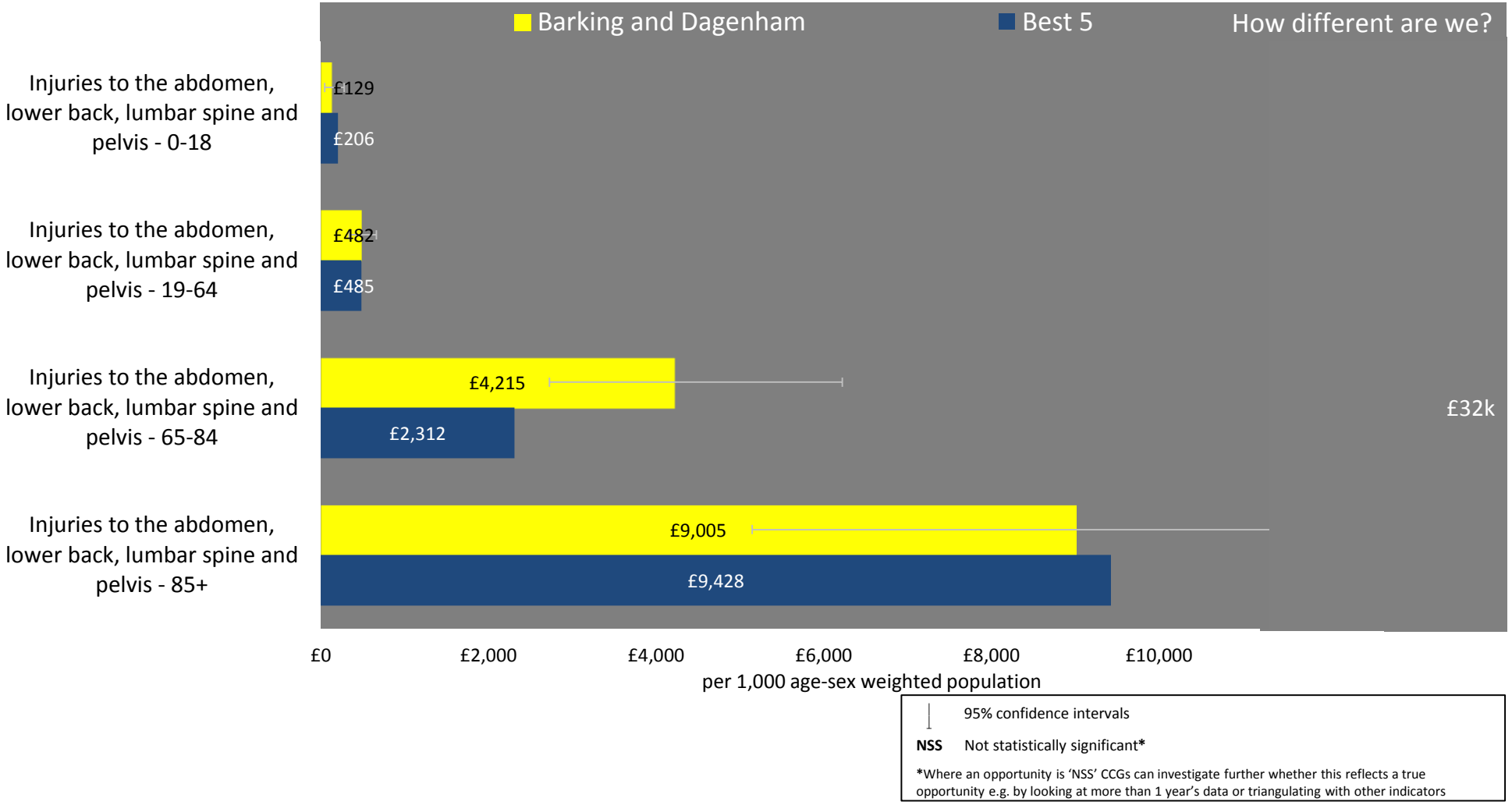
Trauma Spend - Injuries to the elbow and forearm



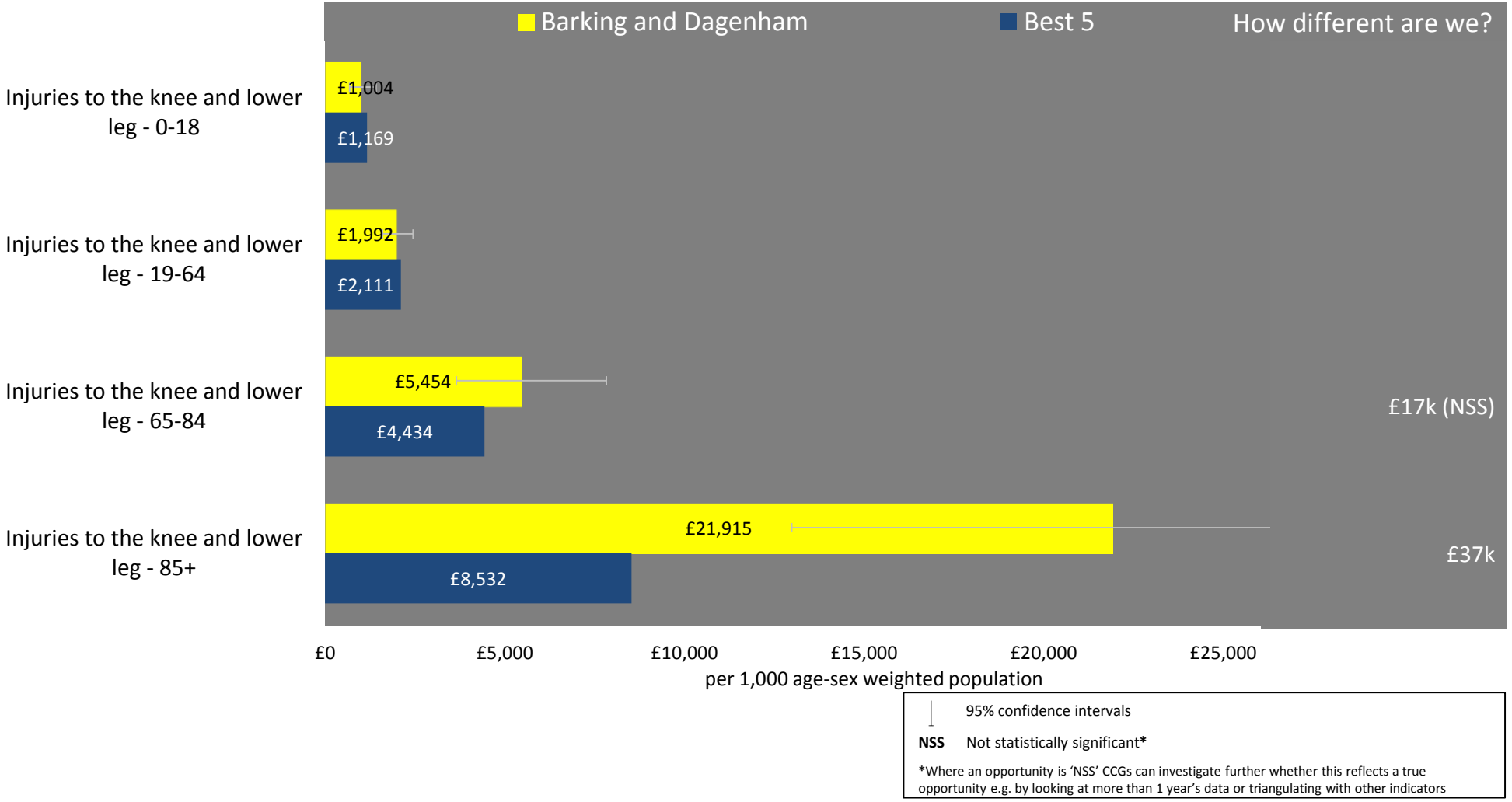
Trauma Spend - Injuries to the head



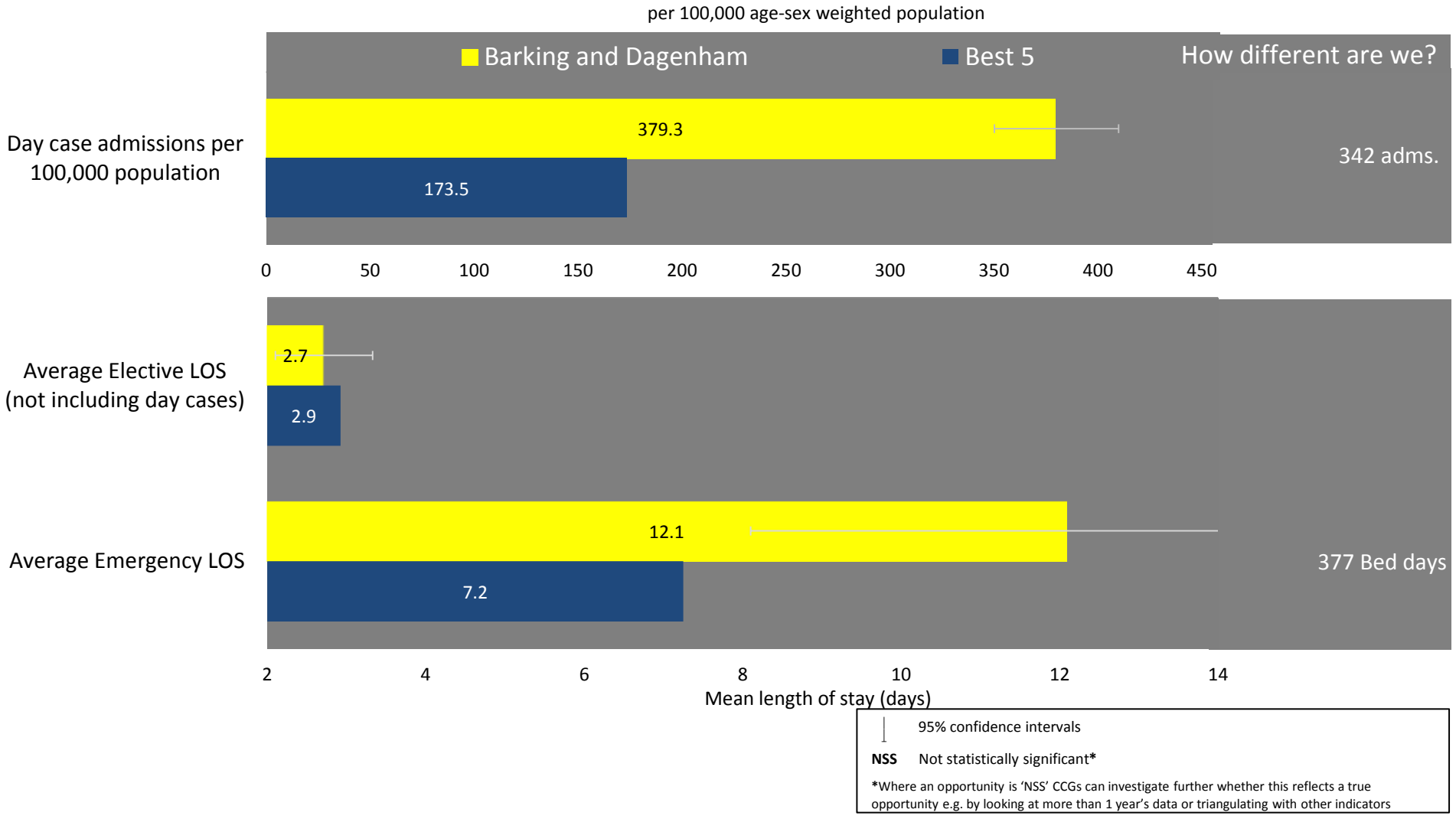
Trauma Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis



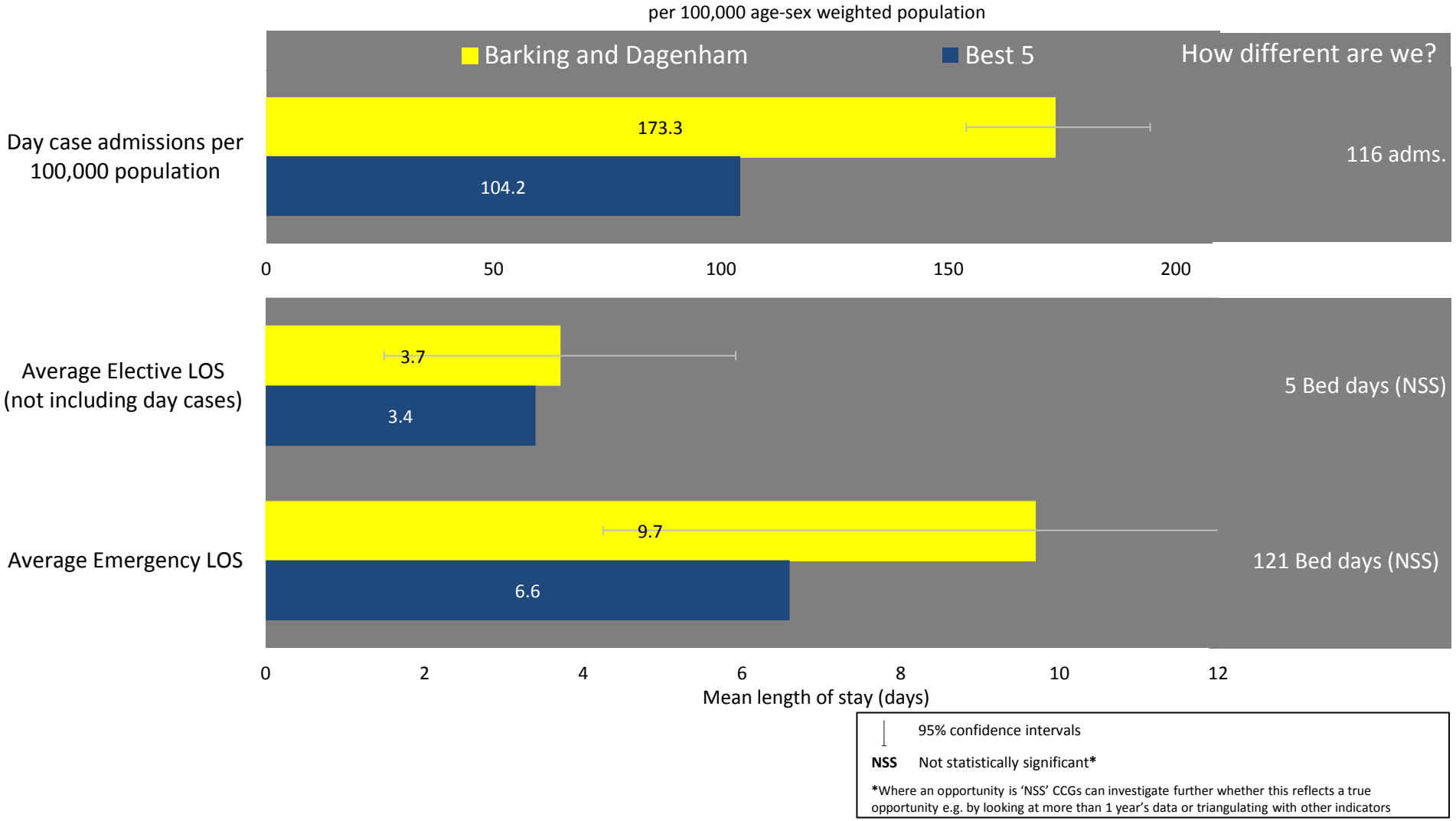
Trauma Spend - Injuries to the knee and lower leg



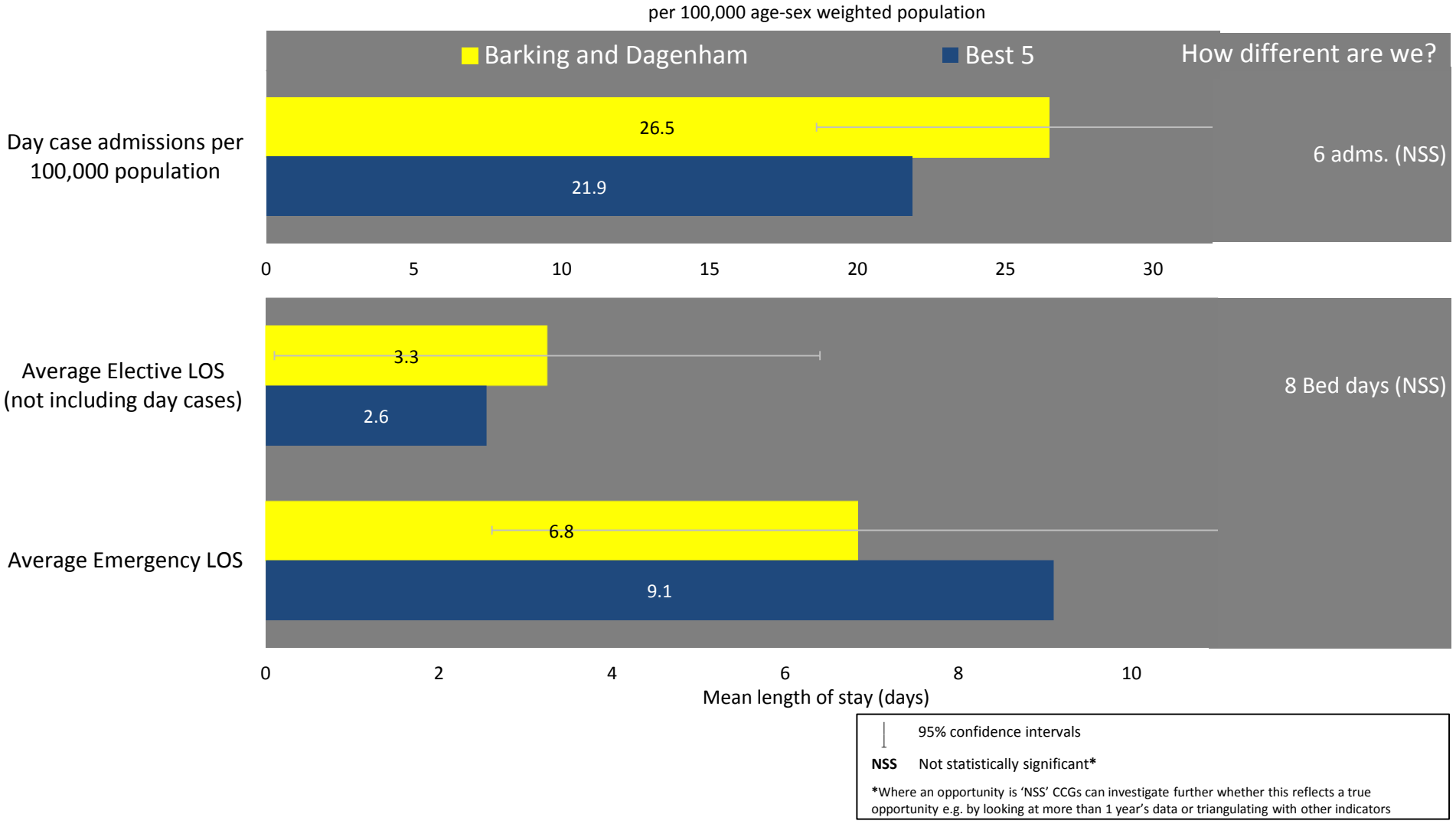
MSK admissions - Back, neck and musculoskeletal pain



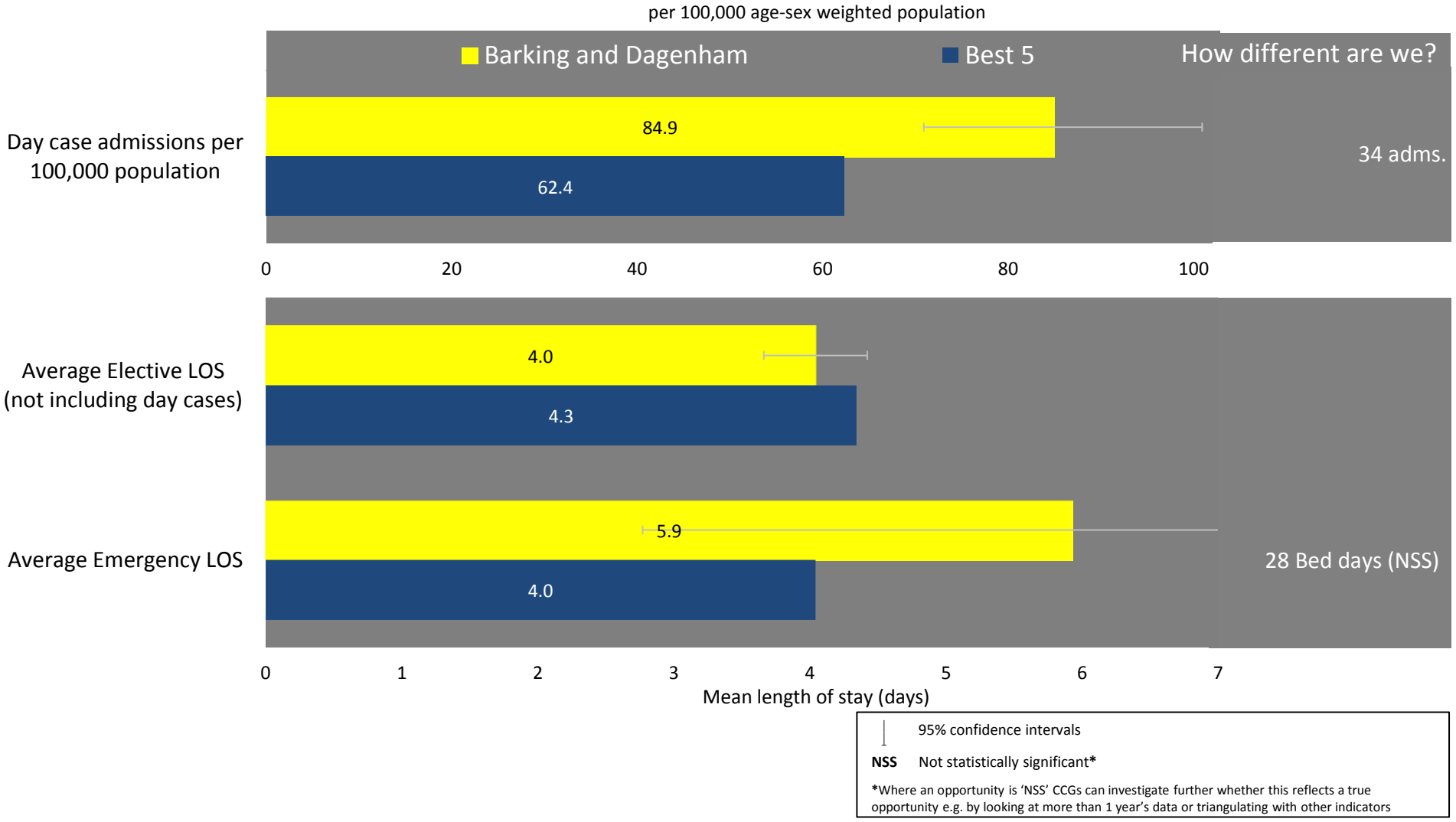
MSK admissions - Rheumatoid and Inflammatory arthritis



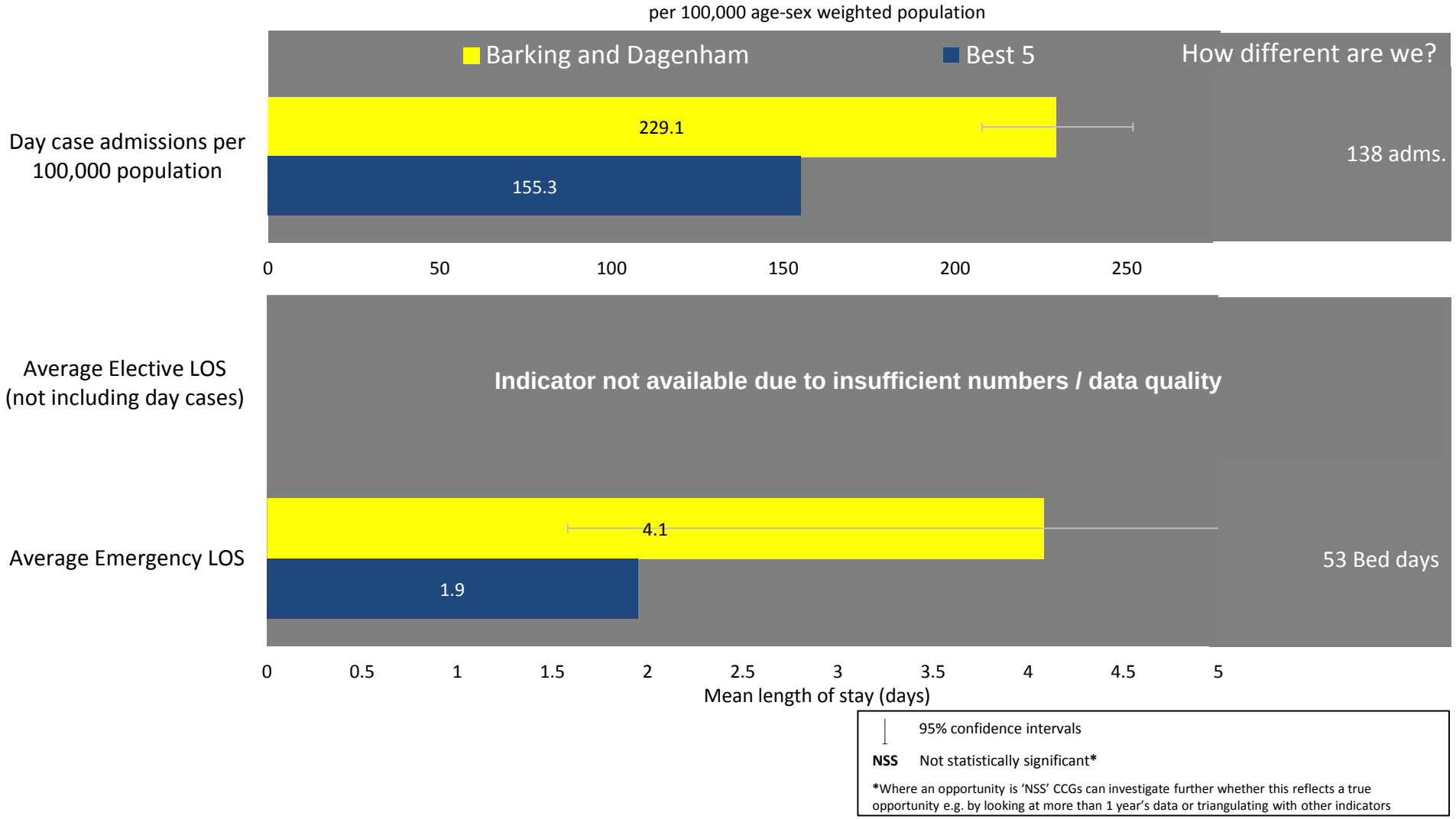
MSK admissions - Osteoporosis and fragility fractures



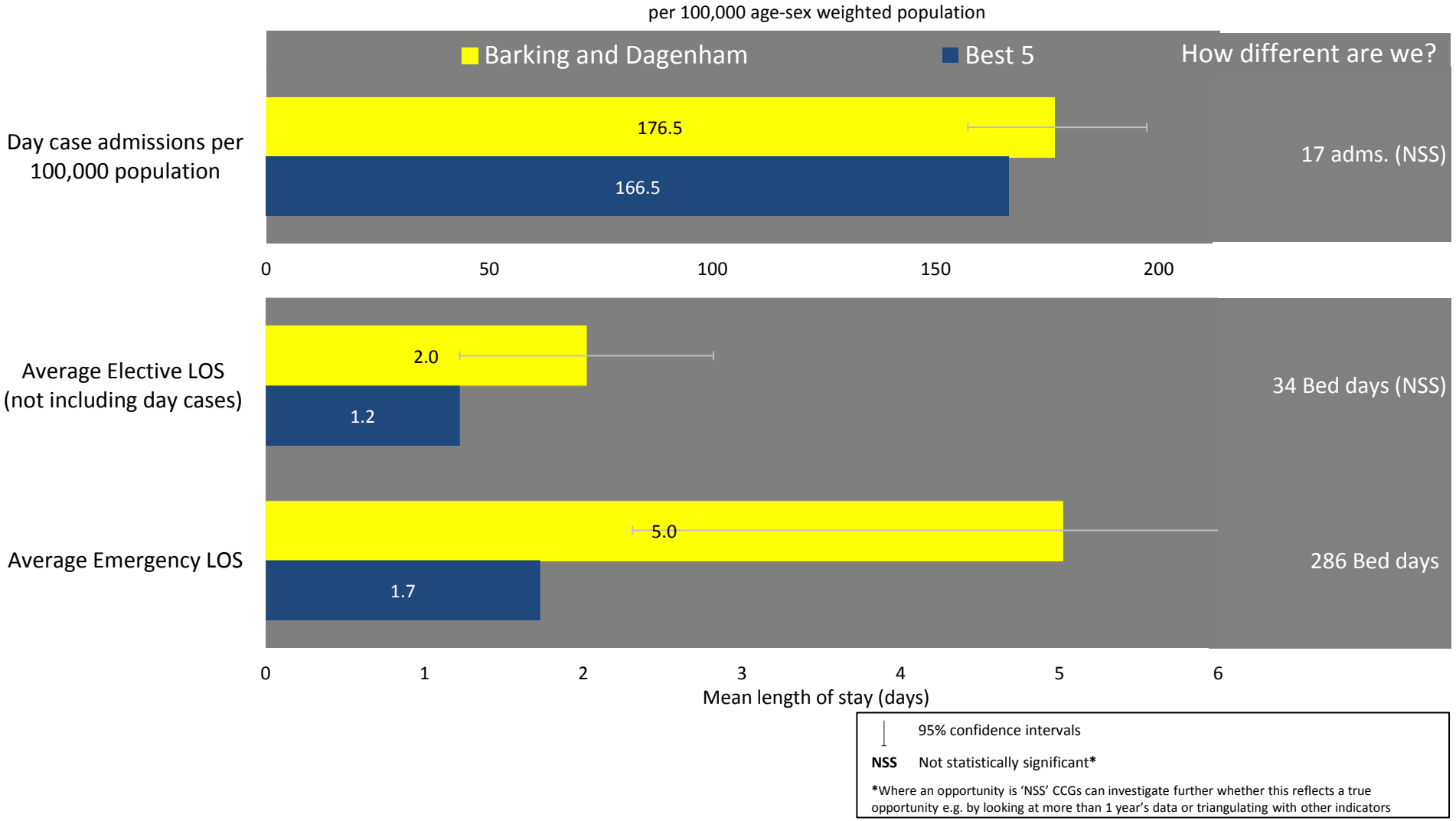
MSK admissions - Osteoarthritis



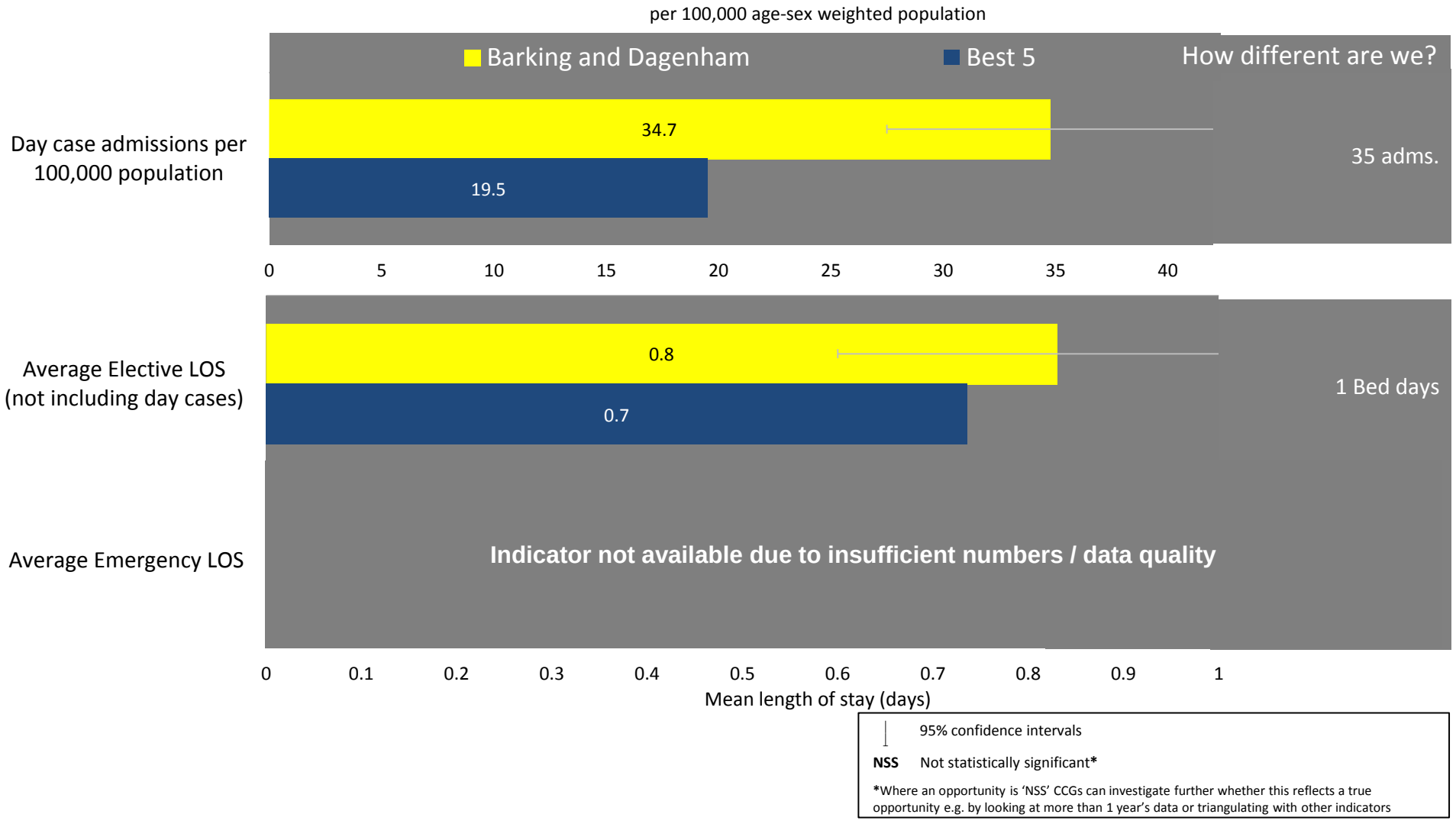
MSK admissions - Other joint disorders



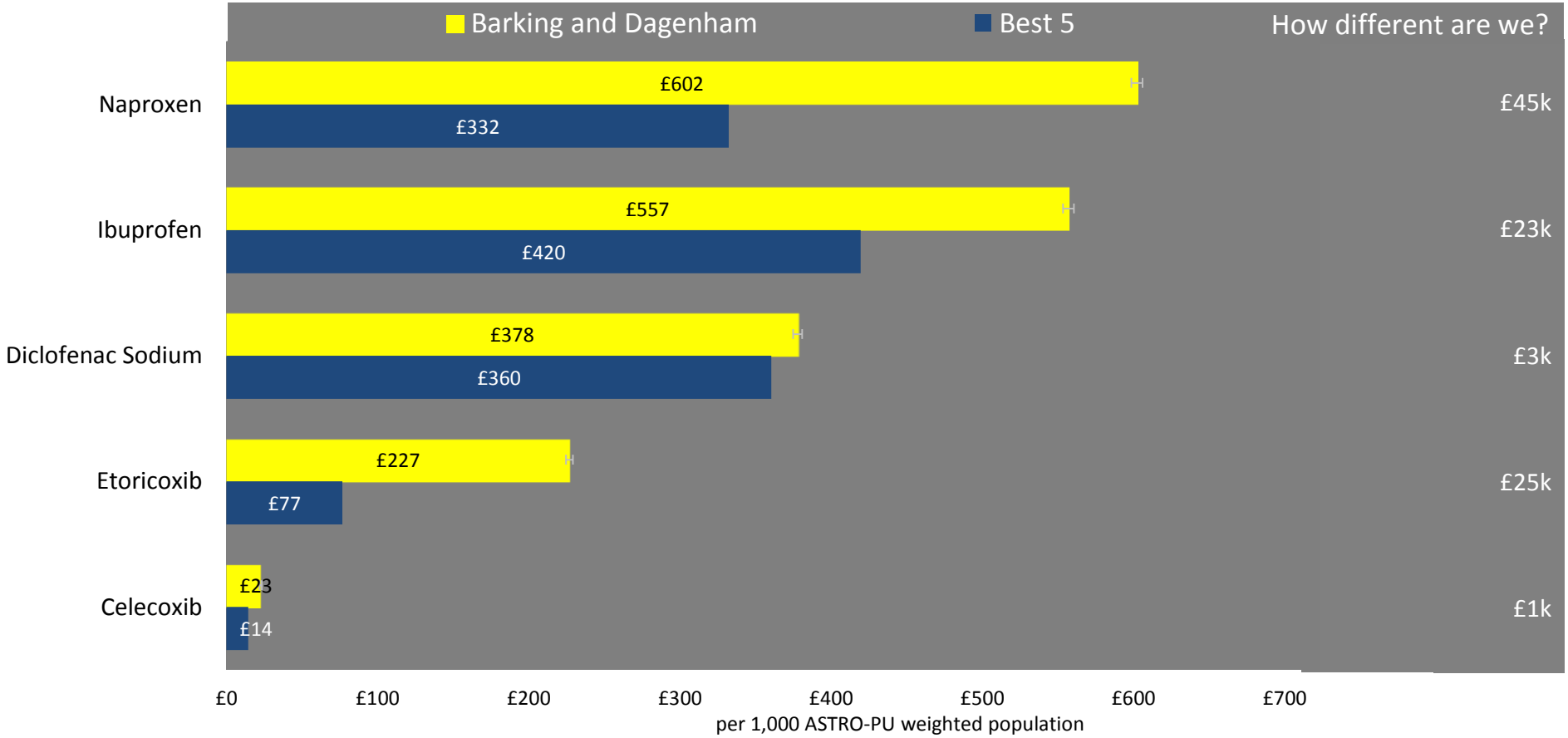
MSK admissions - Other MSK conditions



MSK admissions - Removal of fracture plates



Primary Care Prescribing Spend
Nonsteroidal anti-inflammatory drugs (NSAIDs) treating inflammation and pain



Medicines Optimisation Dashboard: https://www.england.nhs.uk/ourwork/pe/mo-dash/

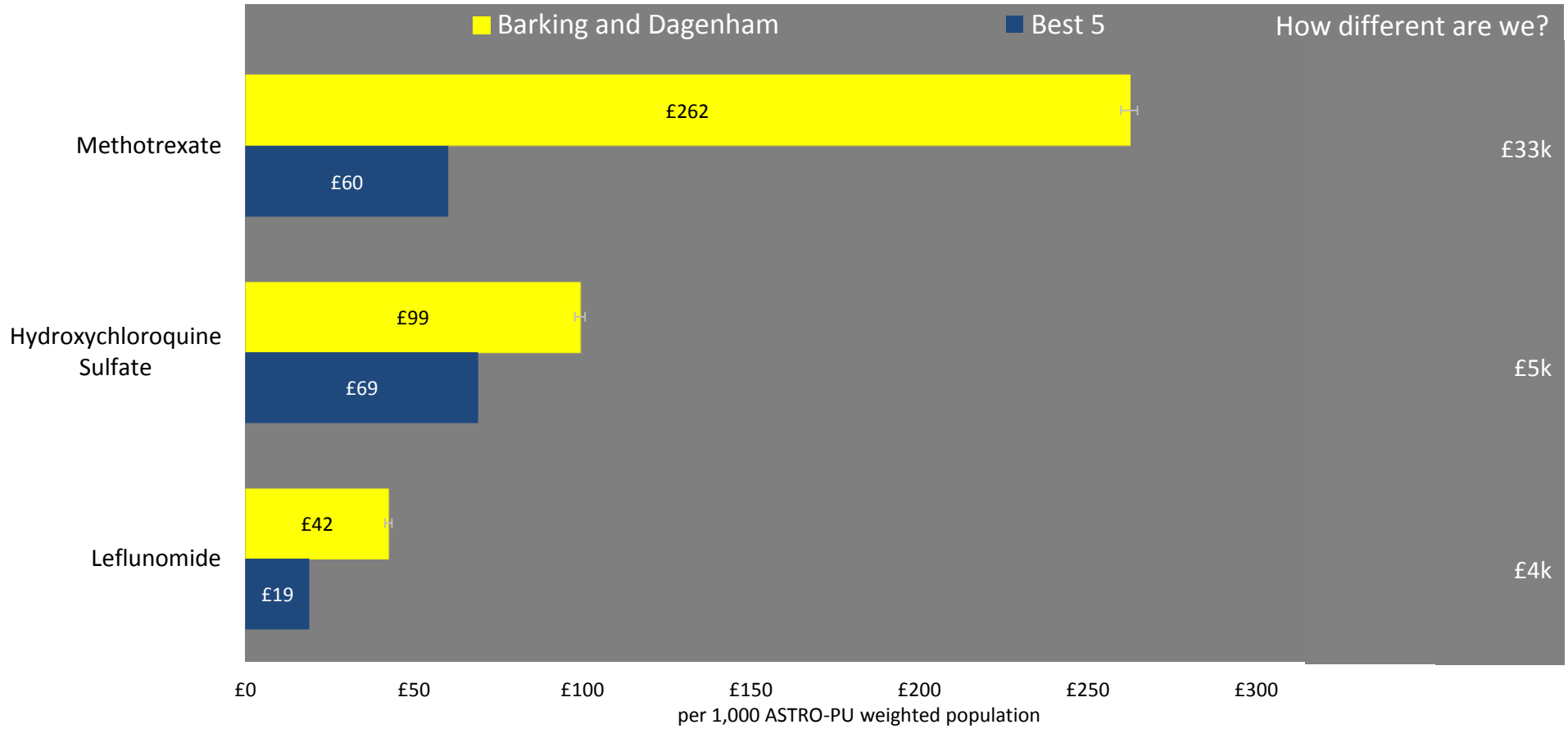
Innovation Scorecard: https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/

95% confidence intervals

NSS Not statistically significant*

*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

Primary Care Prescribing Spend
Disease-modifying antirheumatic drugs (DMARDs) for inflammatory arthritis



Medicines Optimisation Dashboard: https://www.england.nhs.uk/ourwork/pe/mo-dash/

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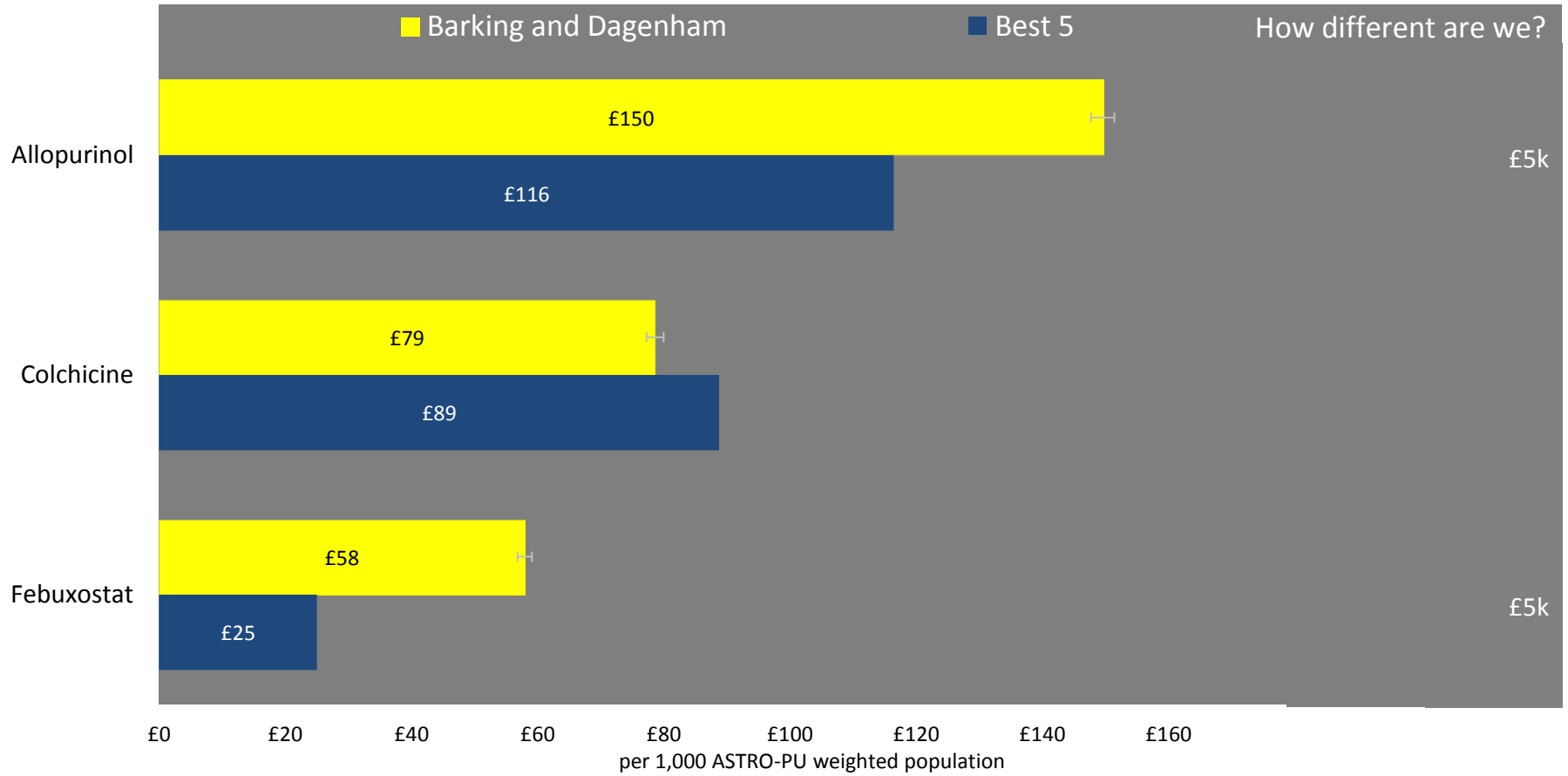
Primary Care Prescribing Spend - Gout therapies



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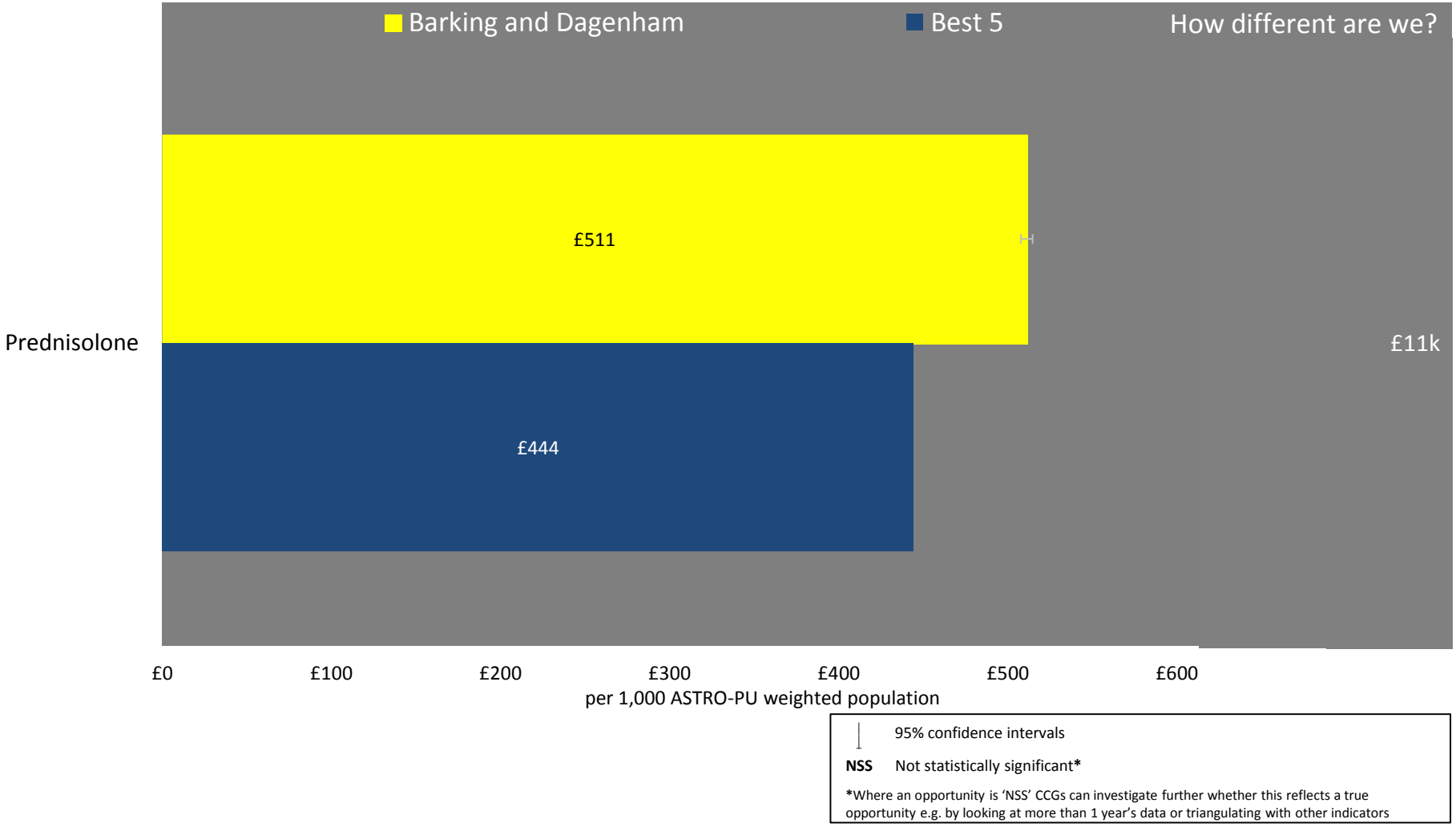
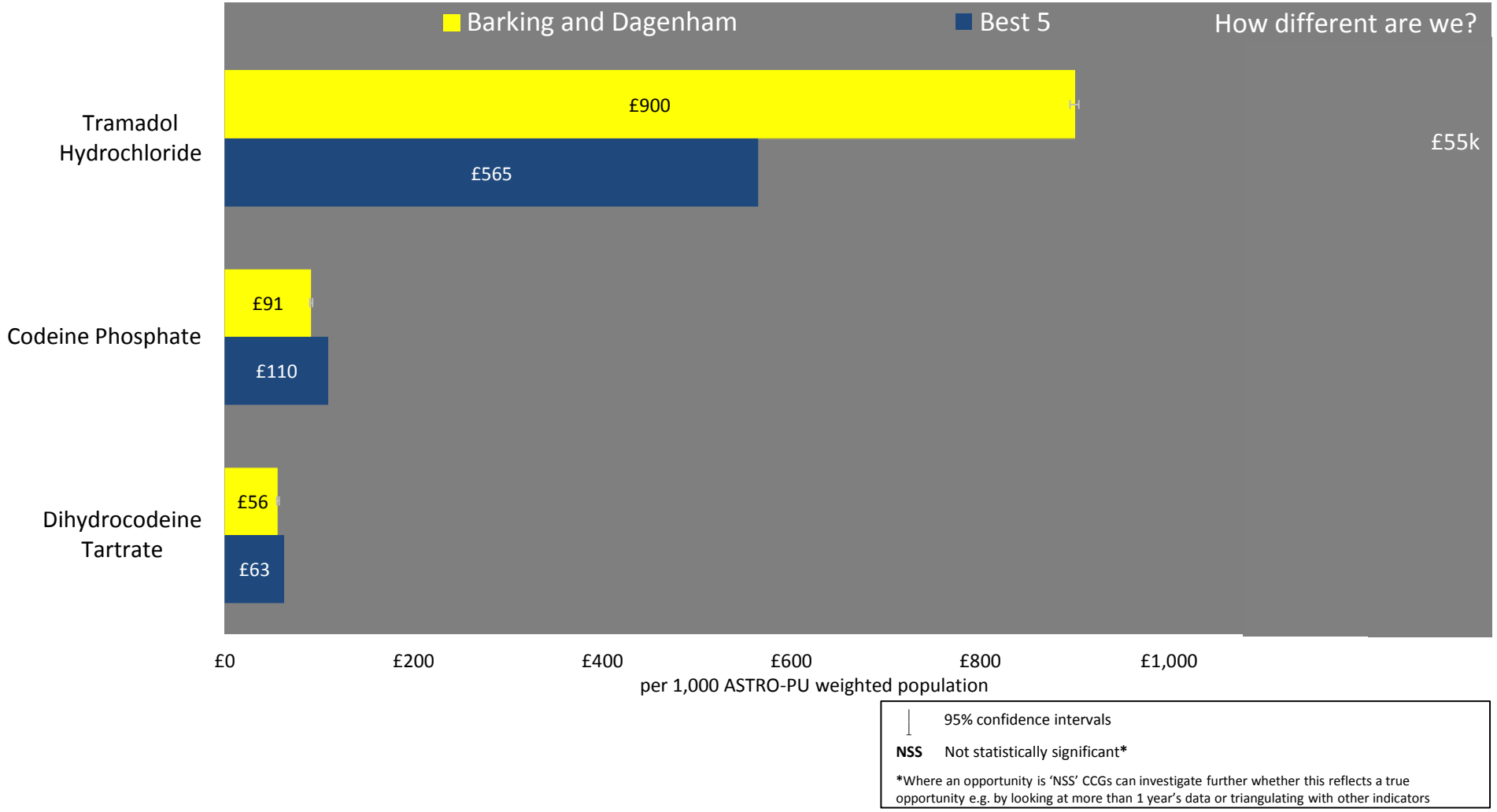
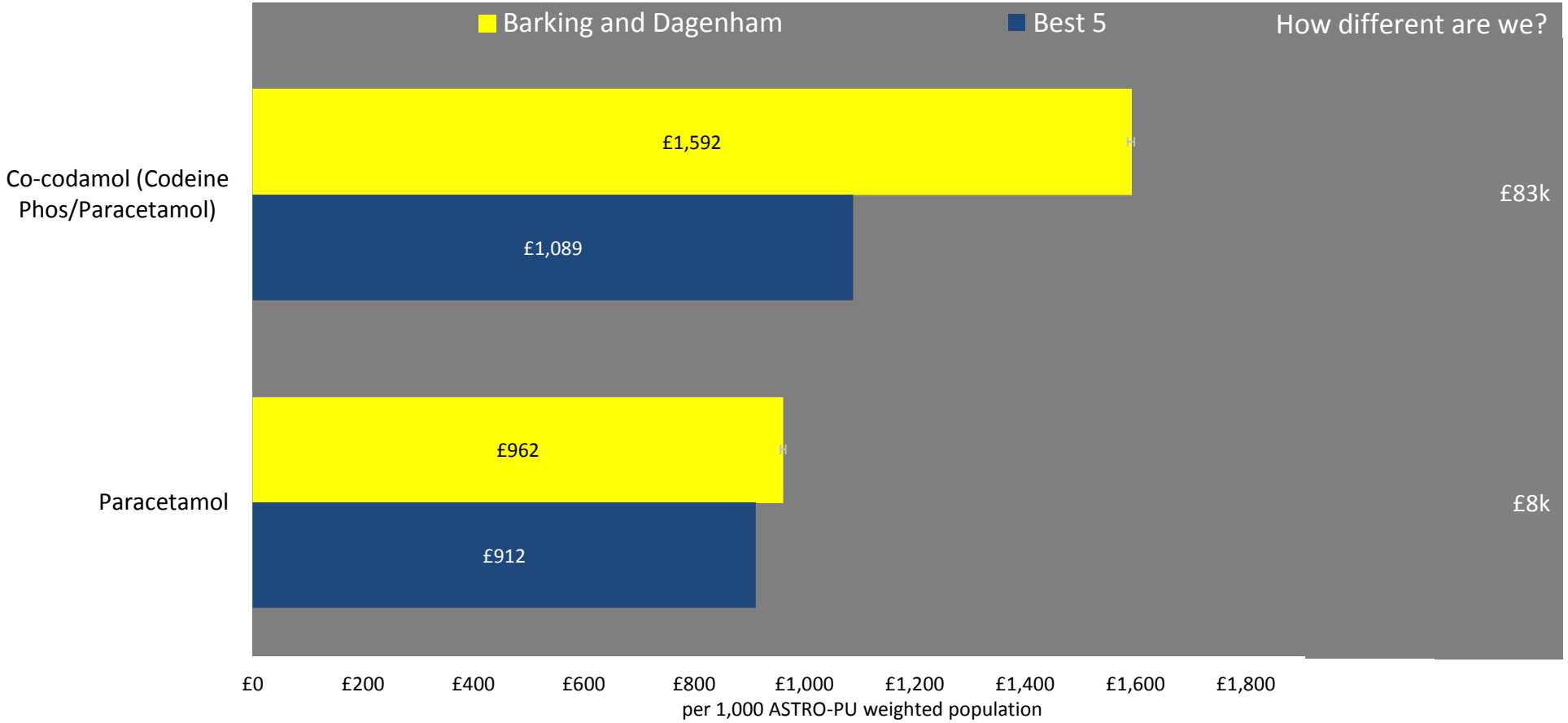
Primary Care Prescribing Spend - Glucocorticoids used in rheumatic disease



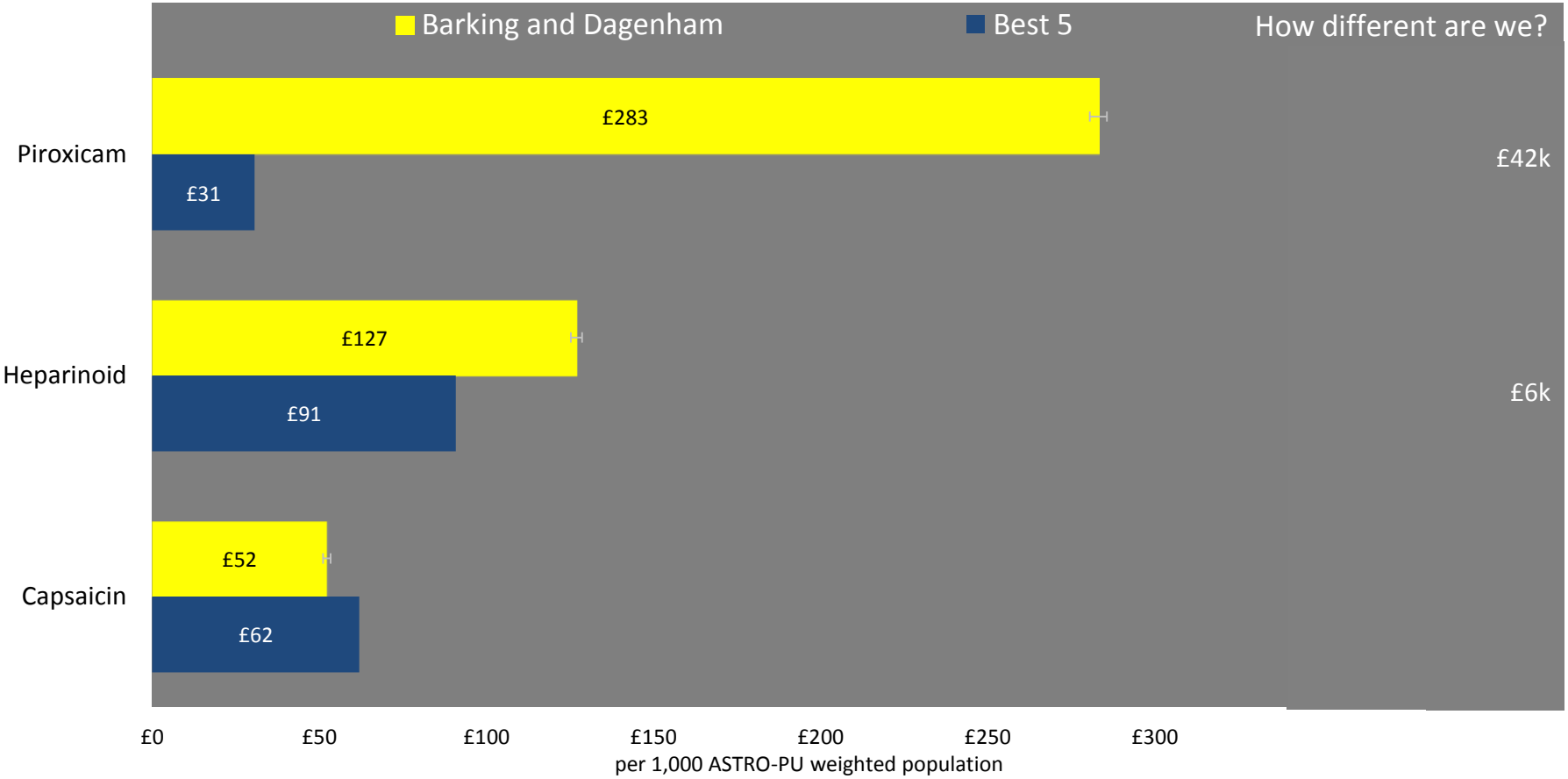
Primary Care Prescribing Spend - Opioid analgesics



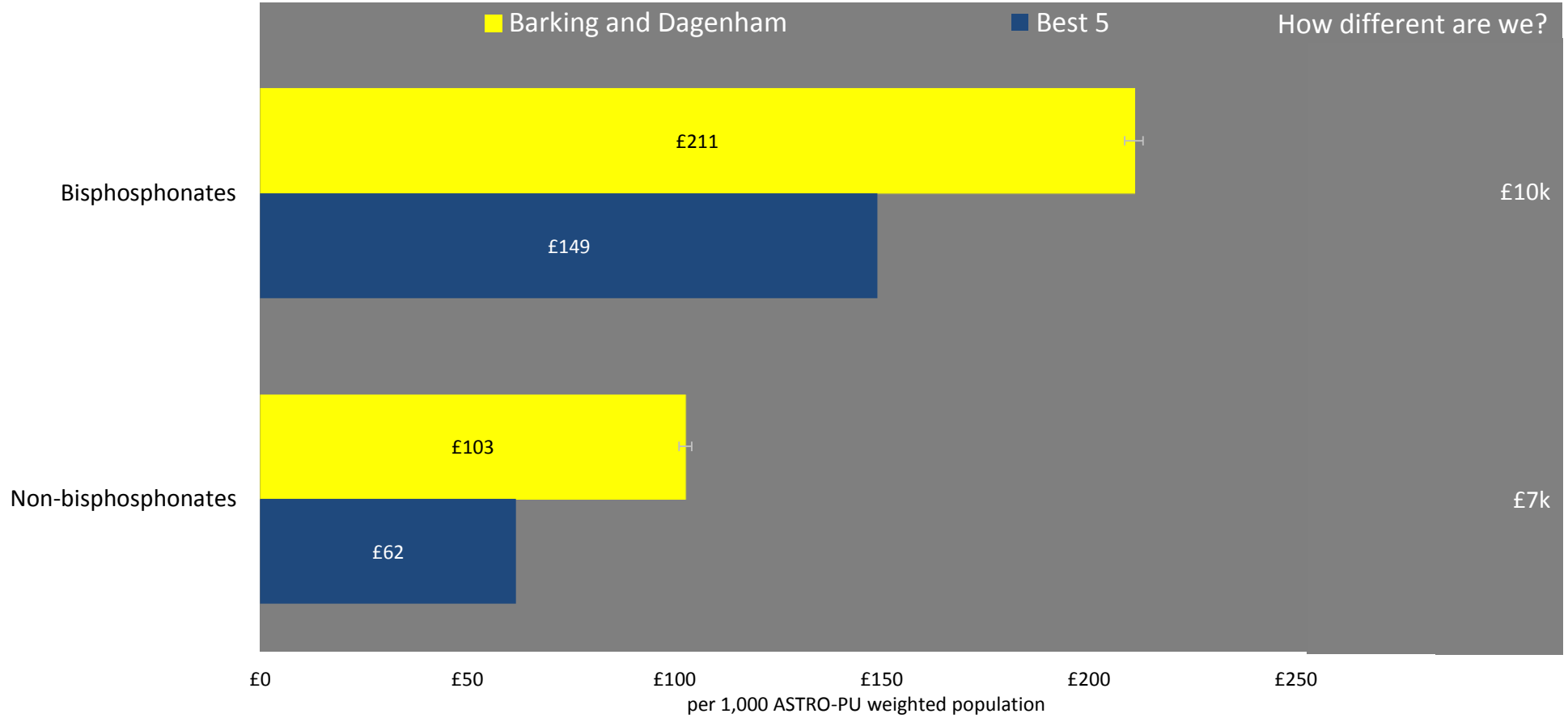
Primary Care Prescribing Spend - Non-Opioid analgesics



Primary Care Prescribing Spend - Other high spend MSK

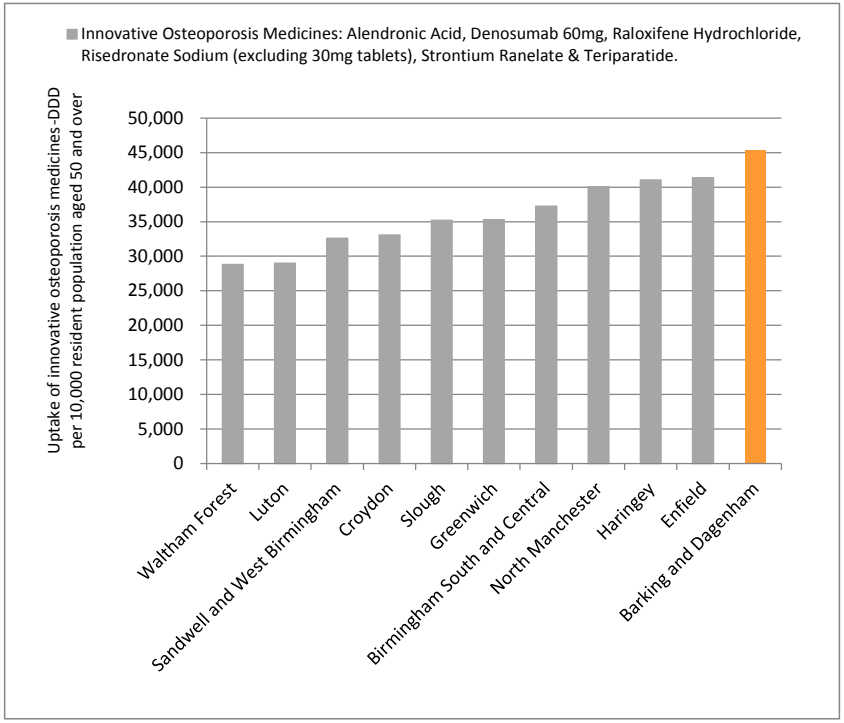


Primary Care Prescribing Spend - Osteoporosis drugs



Osteoporosis Innovative Medicines

Does this CCG have appropriate uptake of innovative osteoporosis medicines?



Uptake of medicines predominantly prescribed in primary care (Defined Daily Doses) 130

	Alendronic Acid	Denosumab 60mg [1]	Raloxifene Hydrochloride	Risedronate Sodium (exclude 30mg tabs)	Strontium Ranelate	Teriparatide [2]	Total
Barking and Dagenham	38,623	156	138	5,825	603	0	45,345
Greenwich	30,276	55	599	3,973	383	0	35,286
Waltham Forest	26,027	82	274	2,129	309	0	28,822
Enfield	37,247	136	328	2,858	788	0	41,357
Luton	25,201	385	168	2,777	484	0	29,014
Croydon	30,327	0	294	2,145	333	0	33,099
Haringey	36,363	235	308	3,143	992	0	41,040
Slough	32,993	0	16	2,029	171	0	35,209
North Manchester	36,658	555	157	2,679	43	0	40,091
Birmingham South and Central	33,992	33	352	2,715	158	0	37,250
Sandwell and West Birmingham	28,967	240	262	2,974	158	0	32,602
Mean of 10 nearest neighbours	31,805	172	276	2,742	382	0	35,377

1. Nationally as much Denosumab is prescribed in secondary care as primary care
2. Teriparatide is predominantly prescribed in secondary care

The chart shows ranked variation in uptake of innovative osteoporosis medicines (TA160, TA161, TA204, TA265) for the CCG (orange bar) and it's ten most similar CCGs (grey bars)

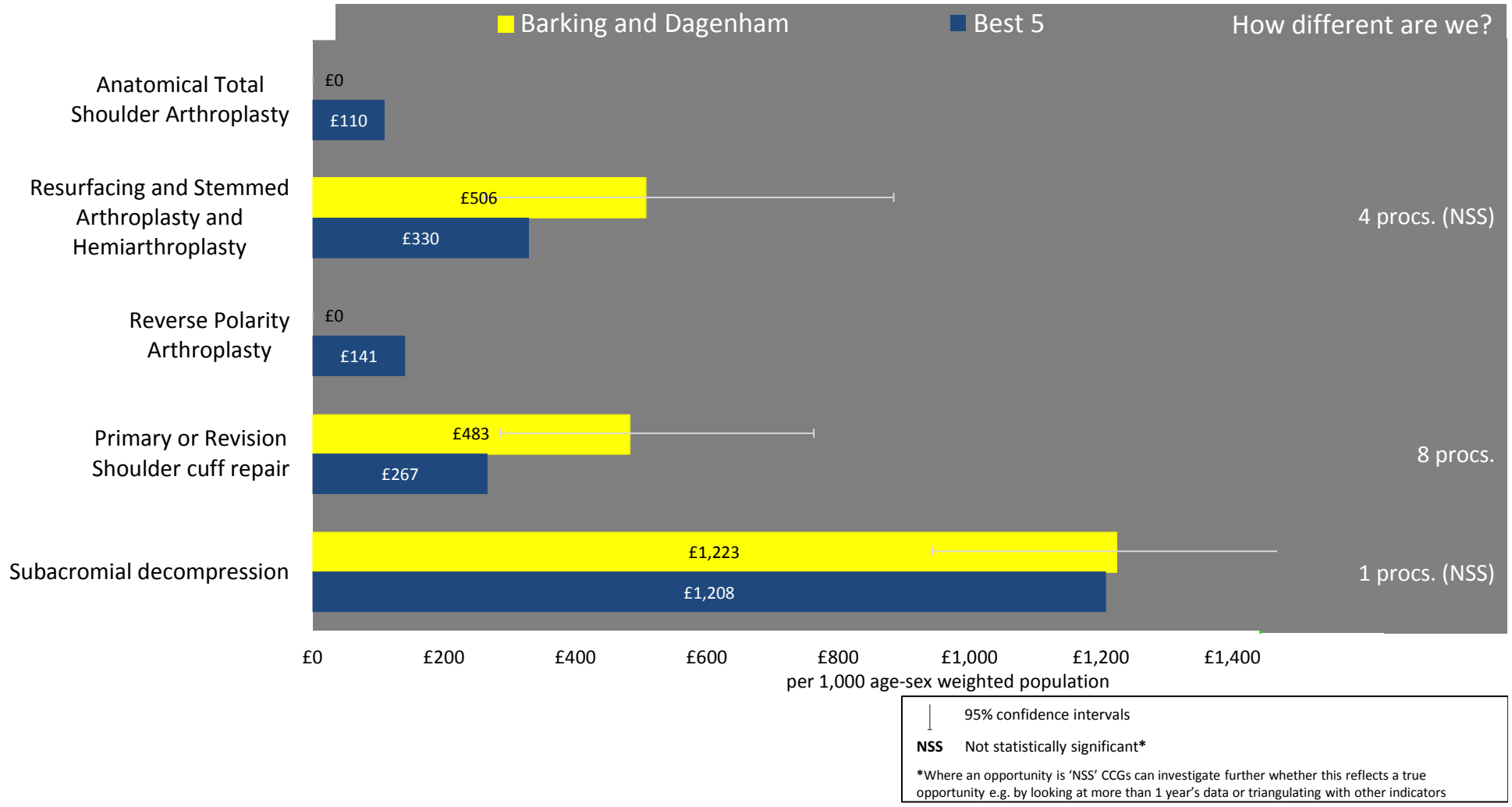
If there is relatively low uptake, taking into consideration relative cost effectiveness of these medicines and other interventions, might there be a case for higher uptake?

If there is relatively high uptake, taking into consideration relative cost effectiveness of these medicines and other interventions might there be a case for lower uptake?

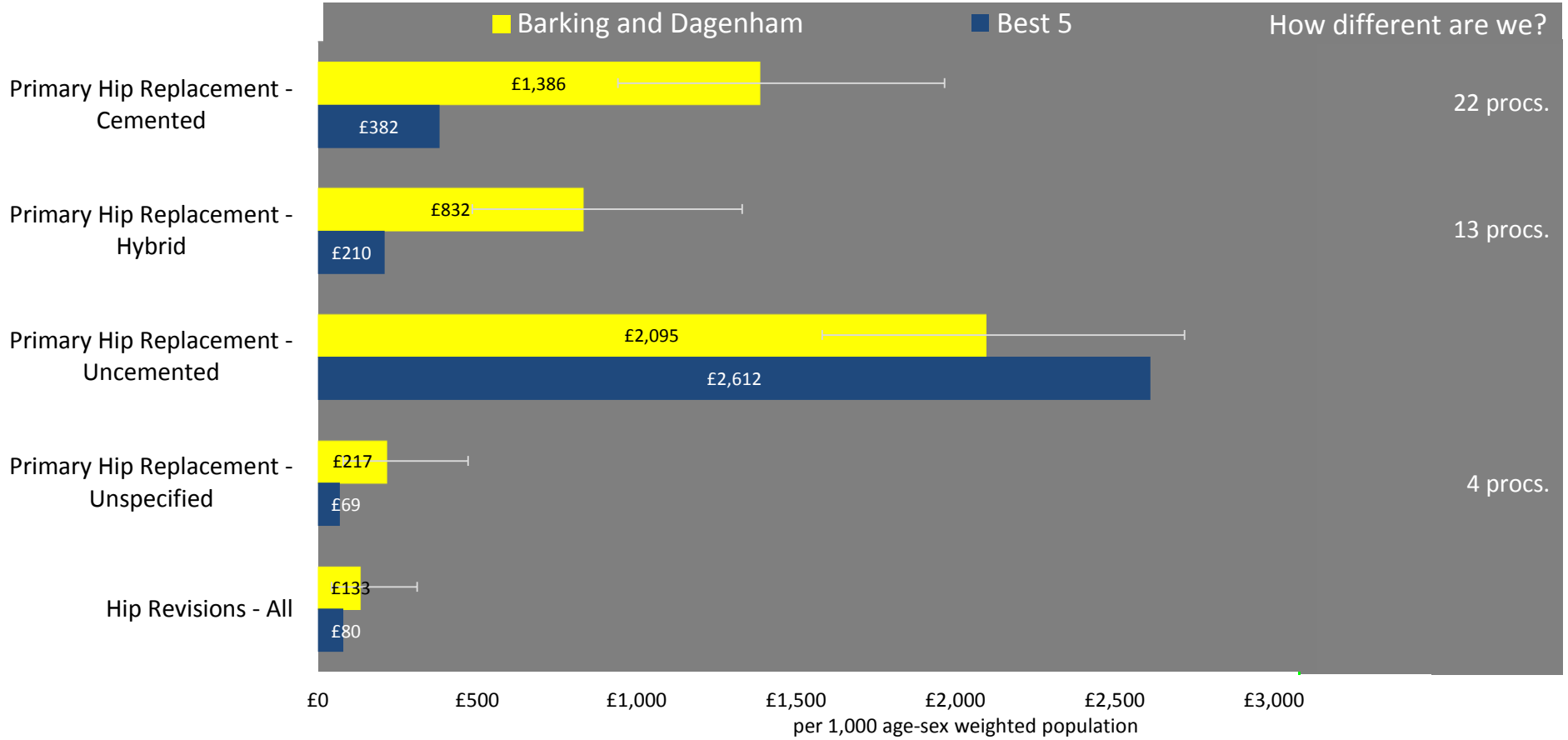
Note: Although uptake data from the innovation scorecard have not been adjusted for demography & disease prevalence, the chart above compares the 10 nearest neighbours. Uptake data is from Q2 2015-2016.

http://www.hscic.gov.uk/catalogue/PUB19259
https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/

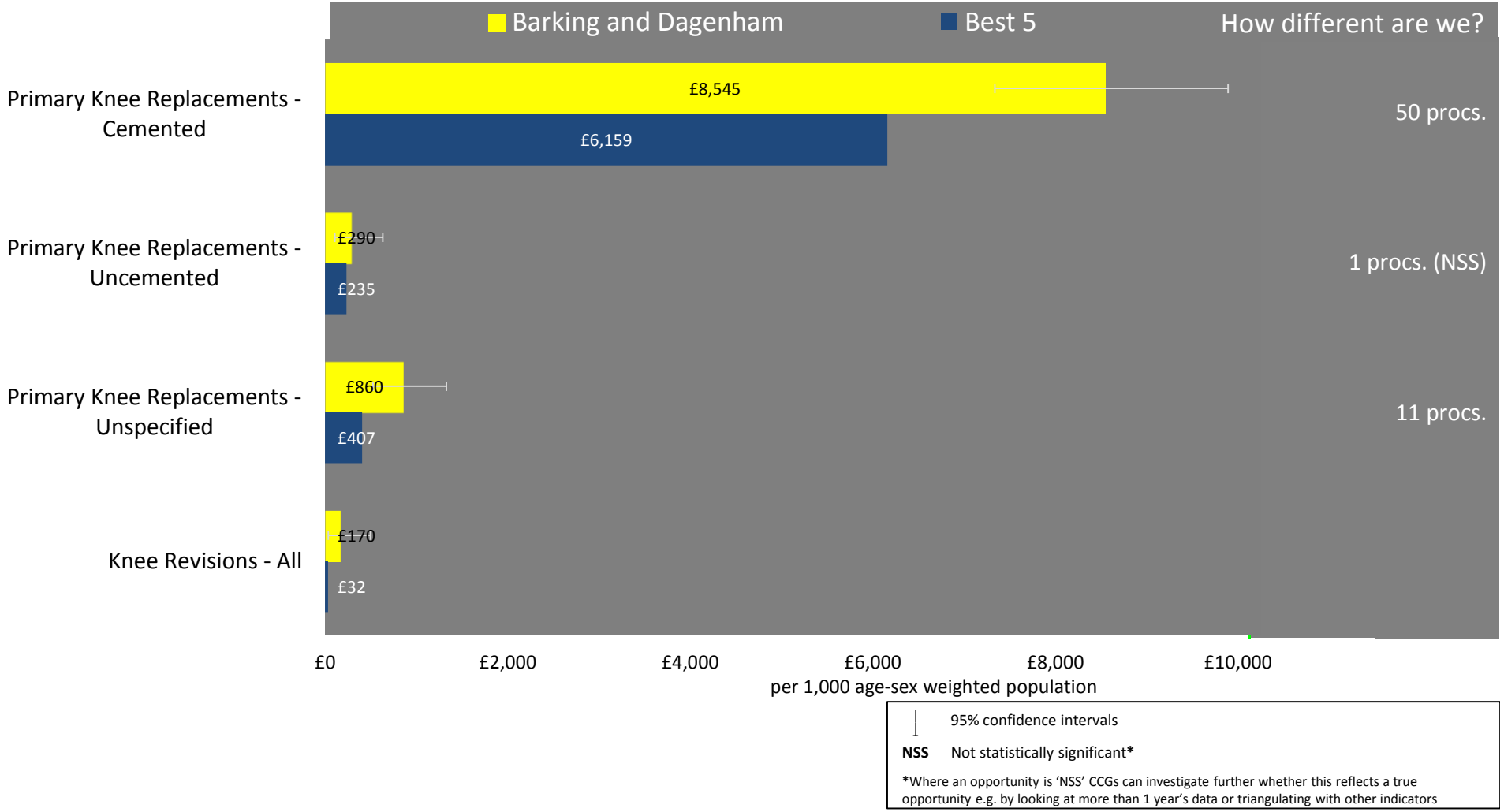
MSK Procedures - Shoulder



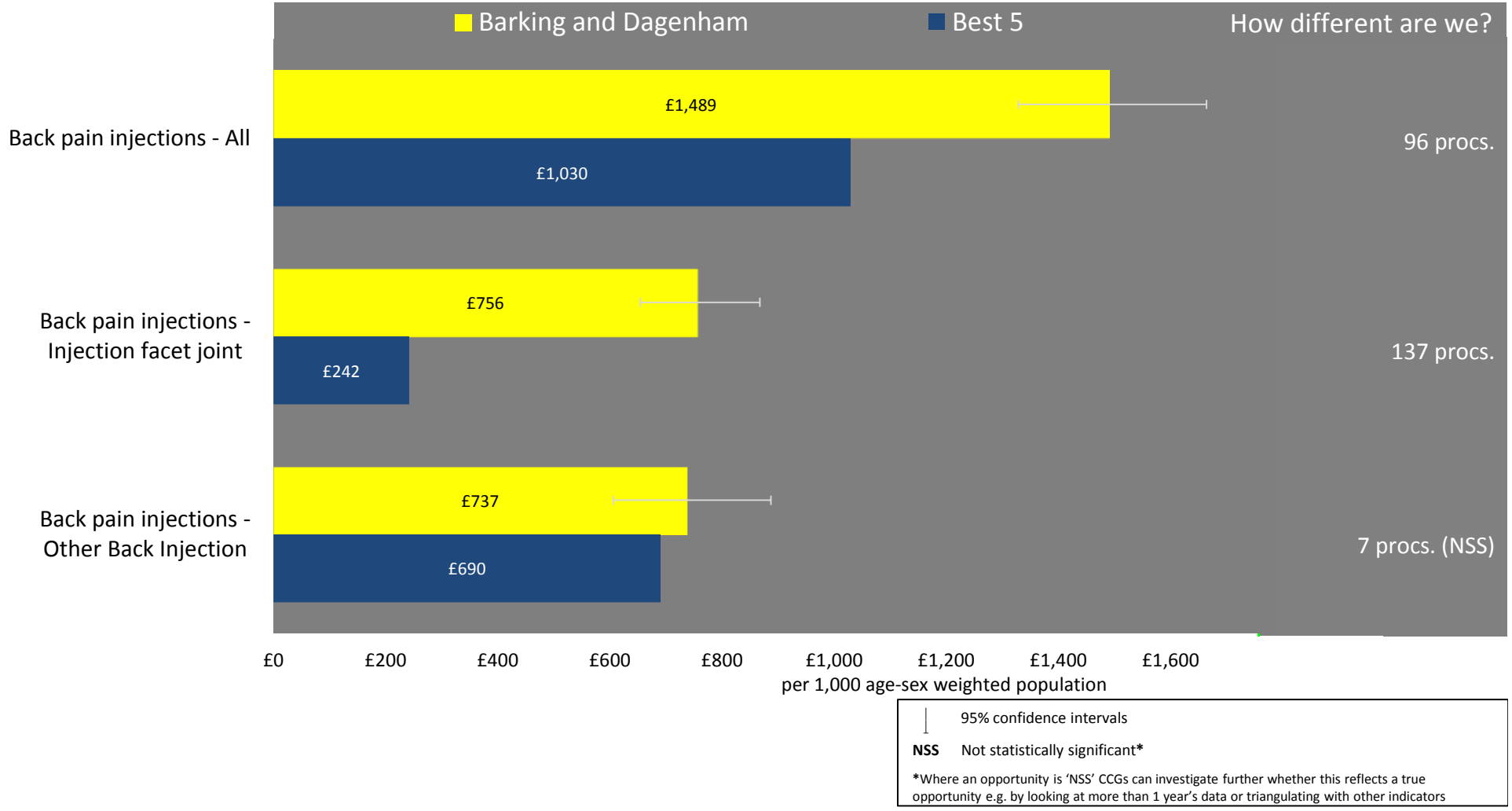
MSK Procedures - Hip replacements



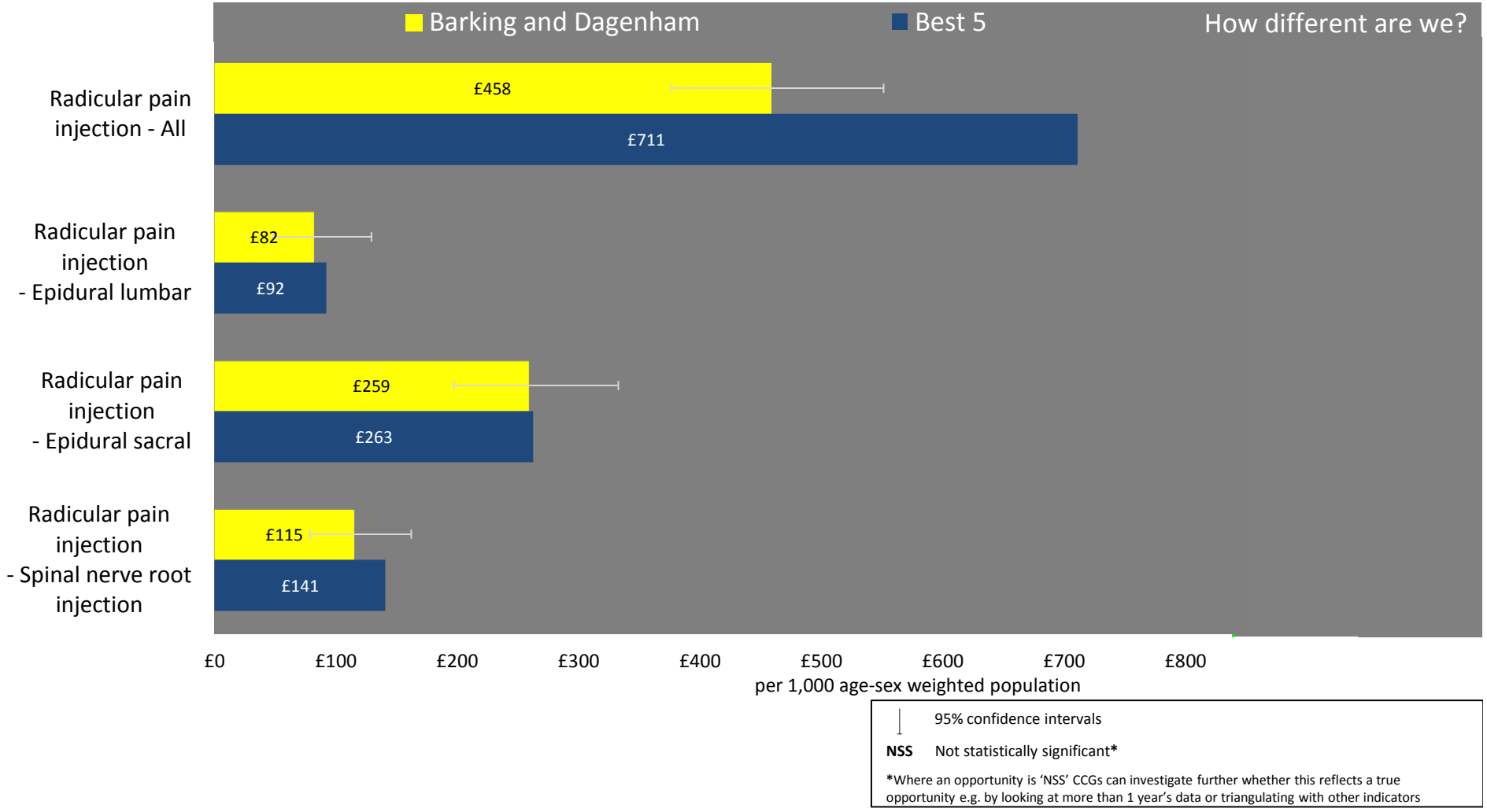
MSK Procedures - Knee replacements



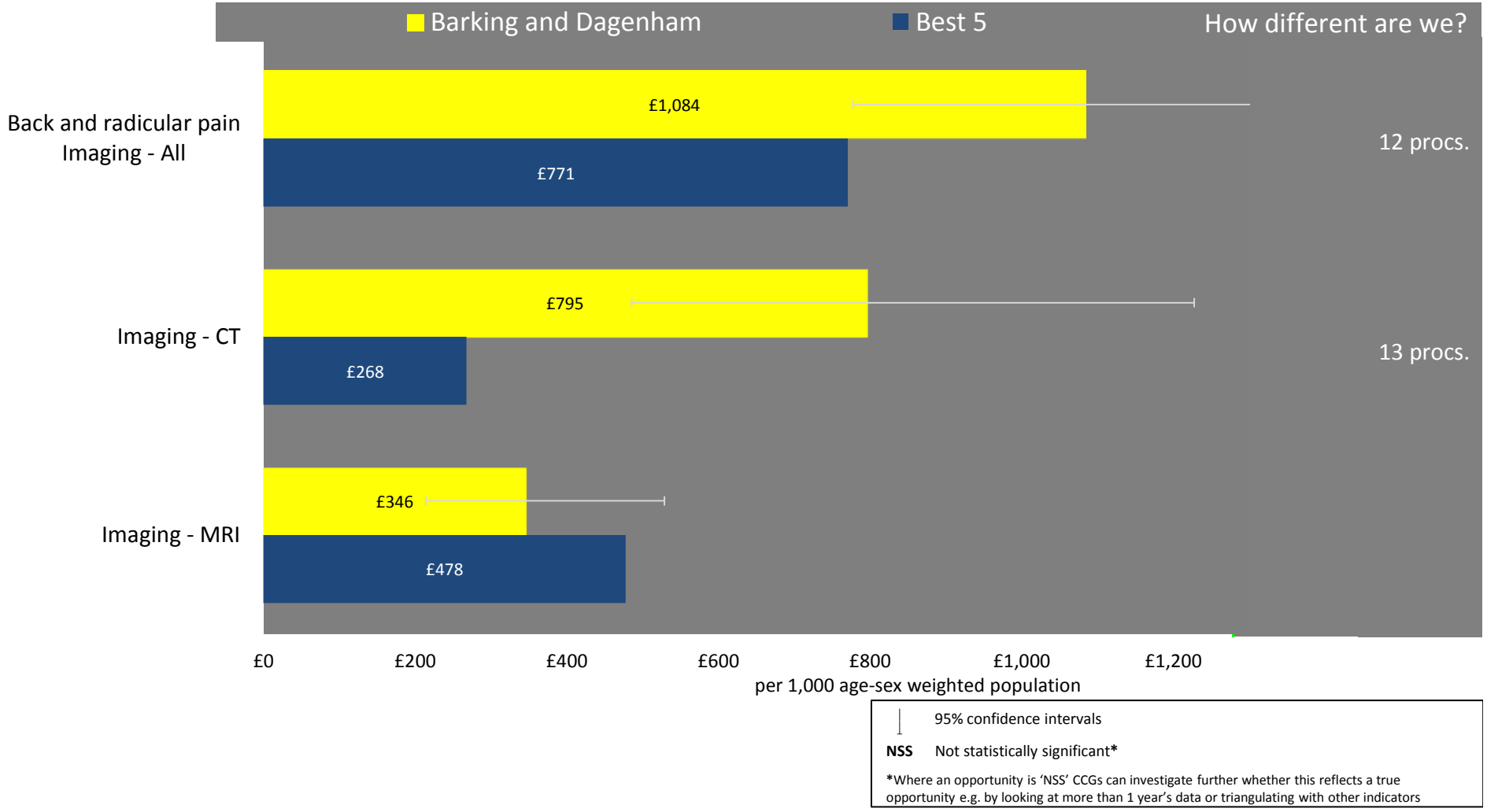
MSK Procedures - Back and radicular pain



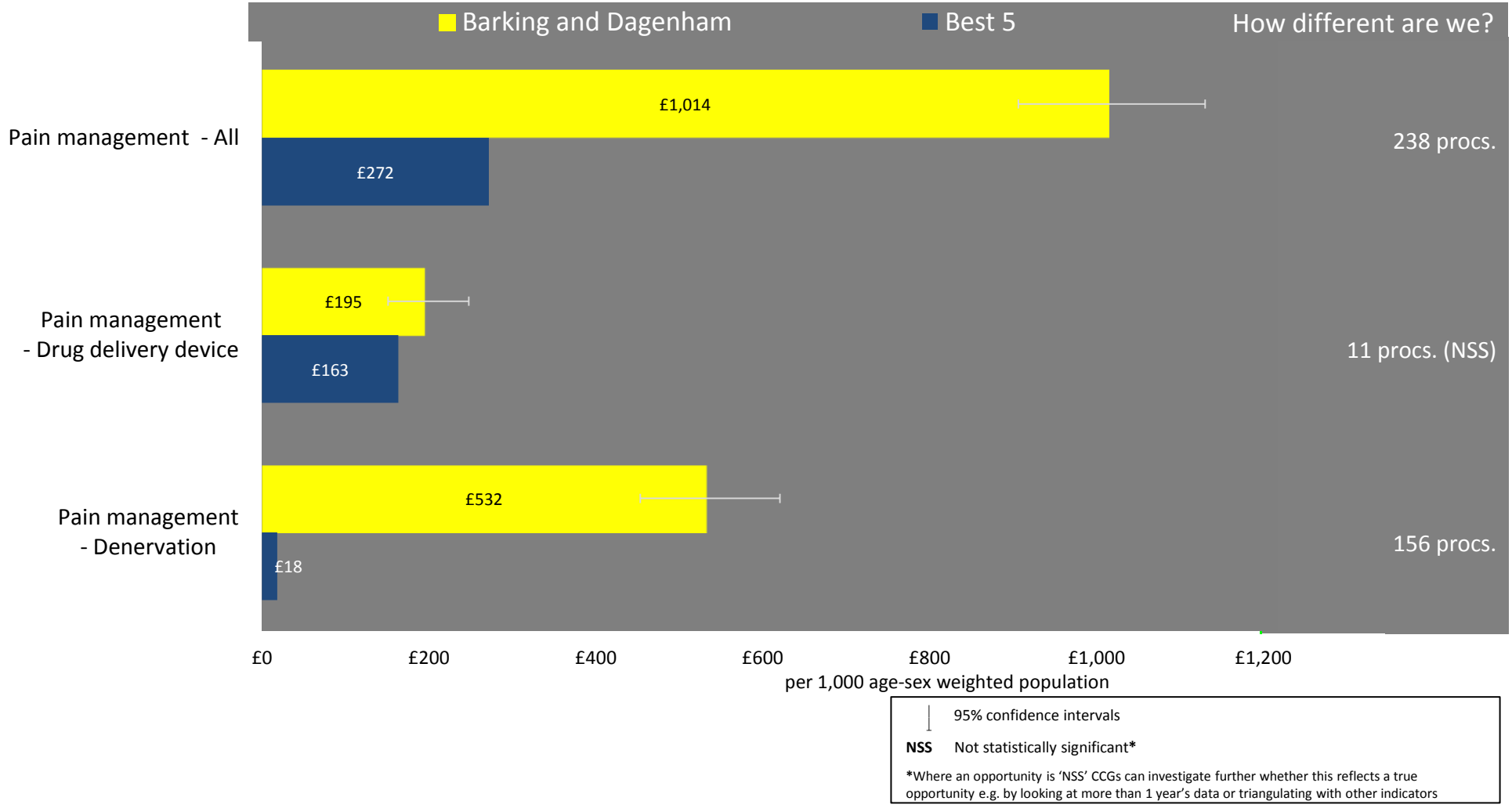
MSK Procedures - Back and radicular pain continued



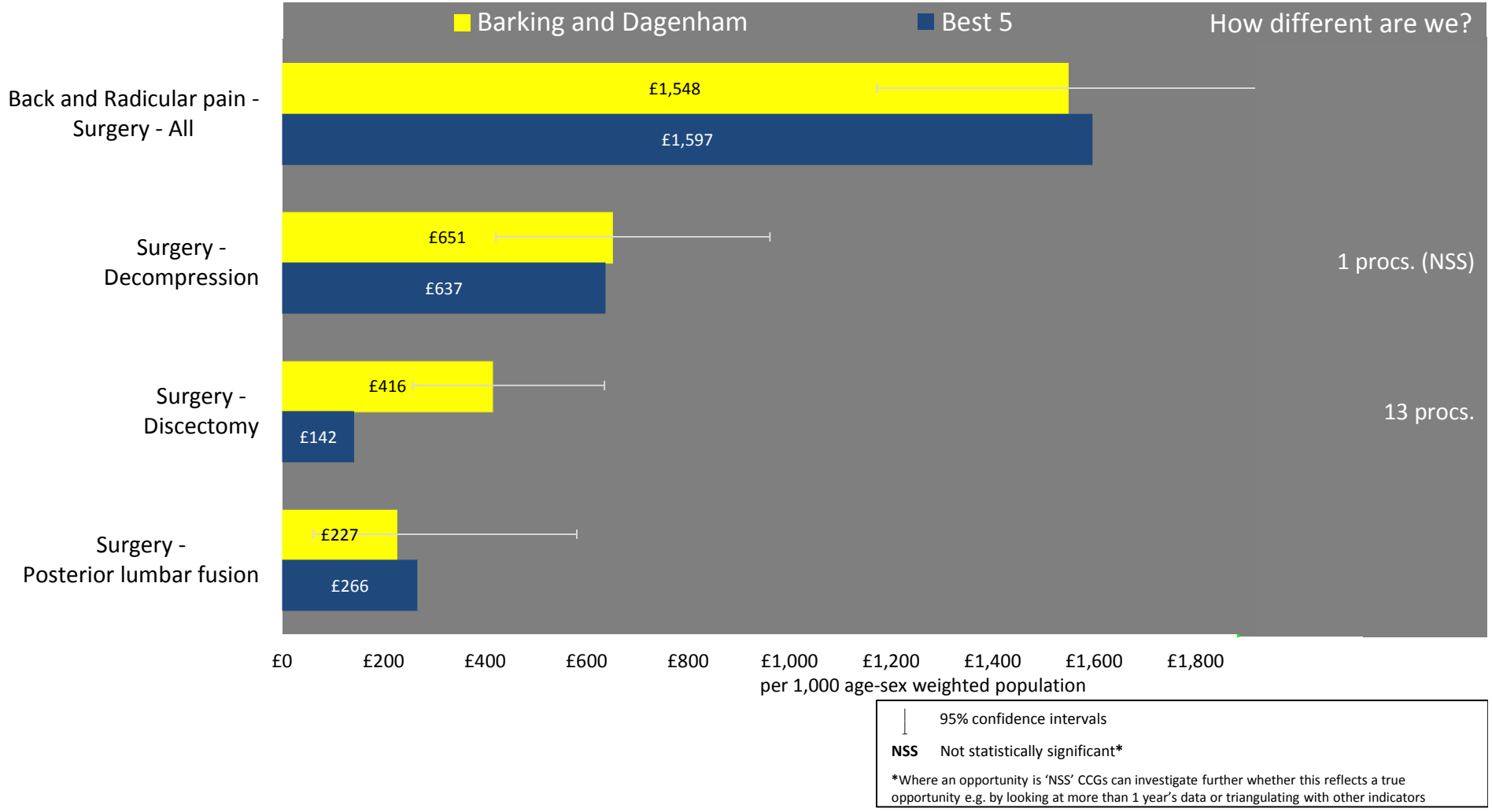
MSK Procedures - Back and radicular pain continued



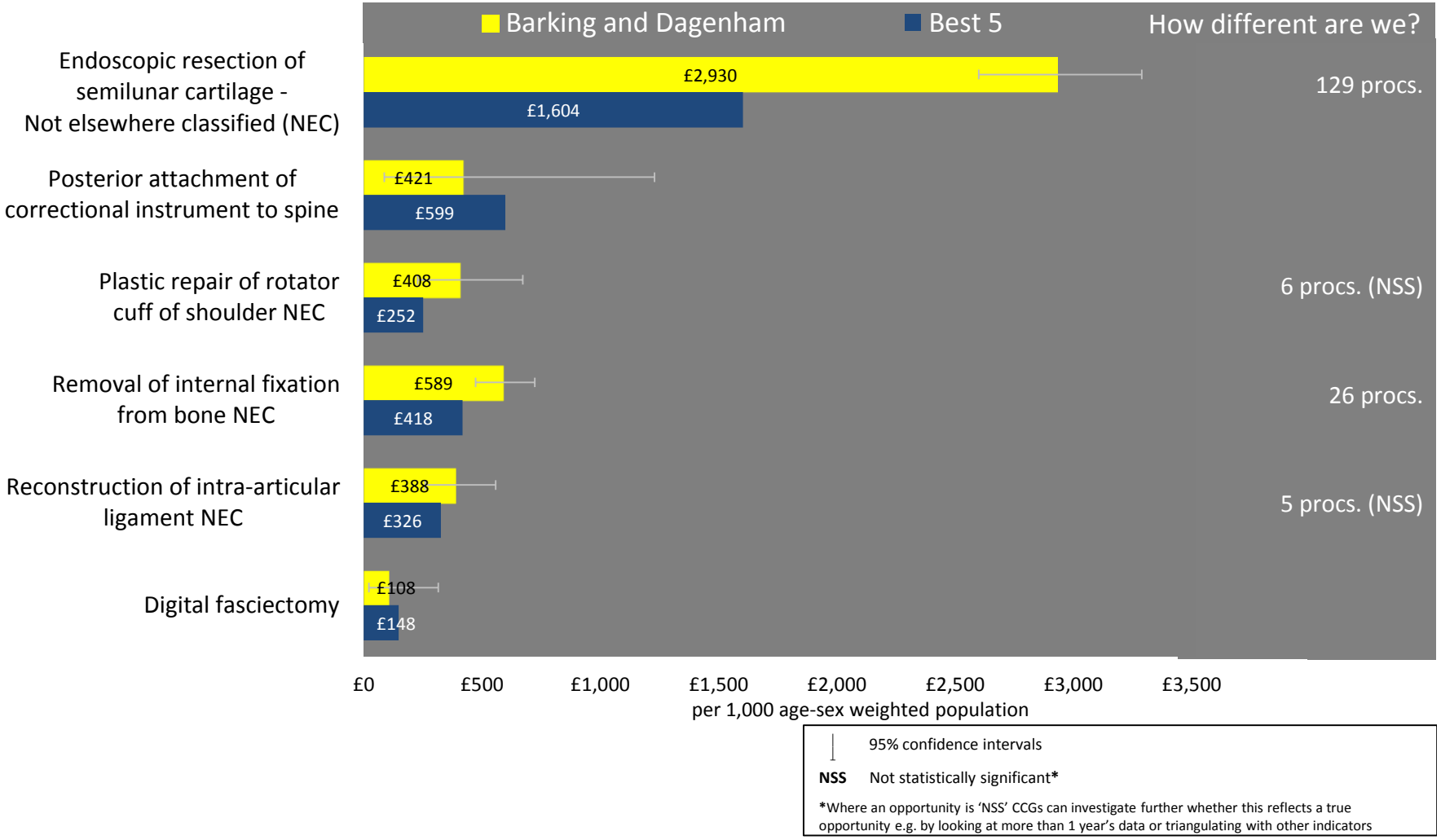
MSK Procedures - Back and radicular pain continued



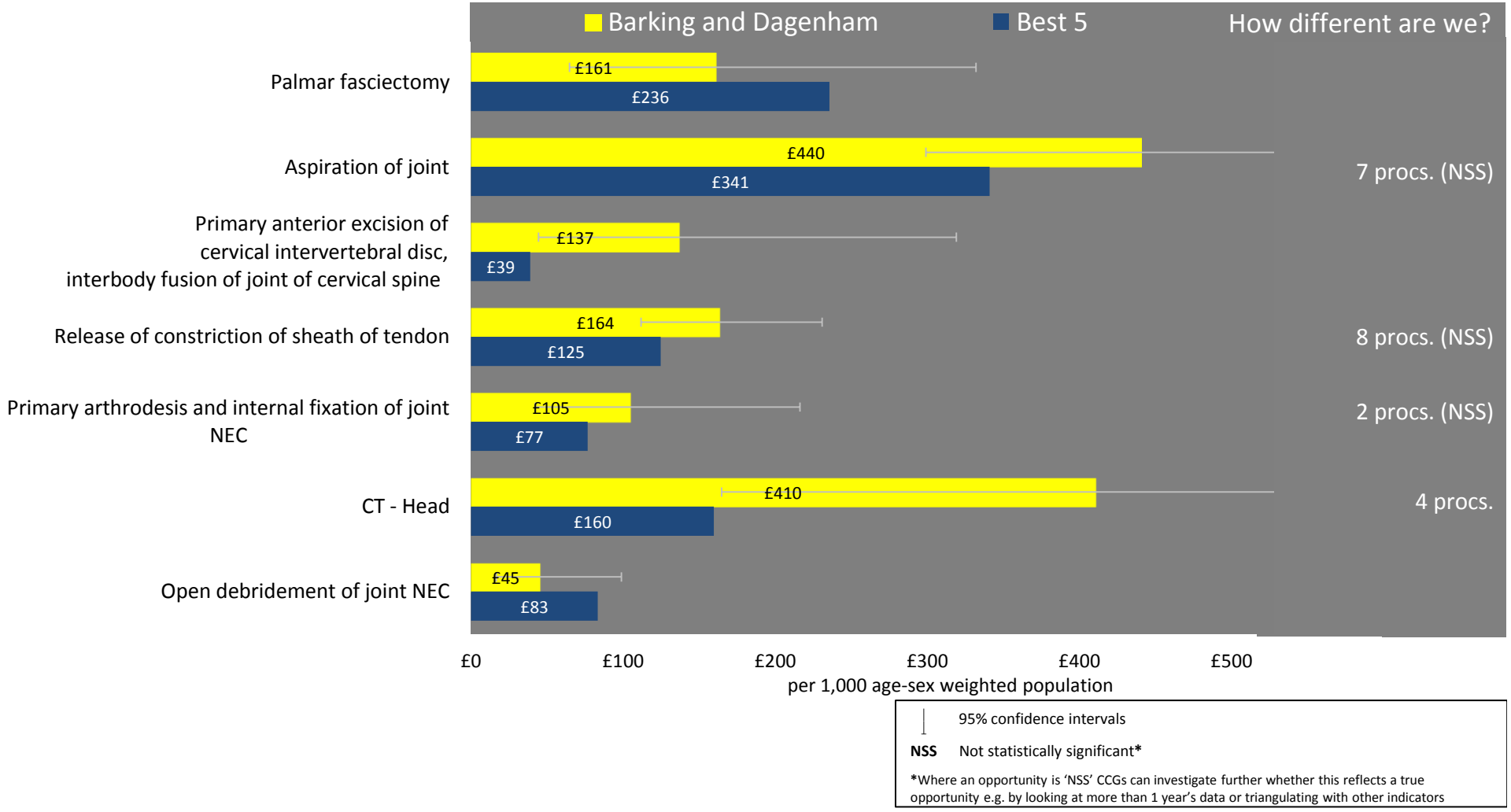
MSK Procedures - Back and radicular pain continued



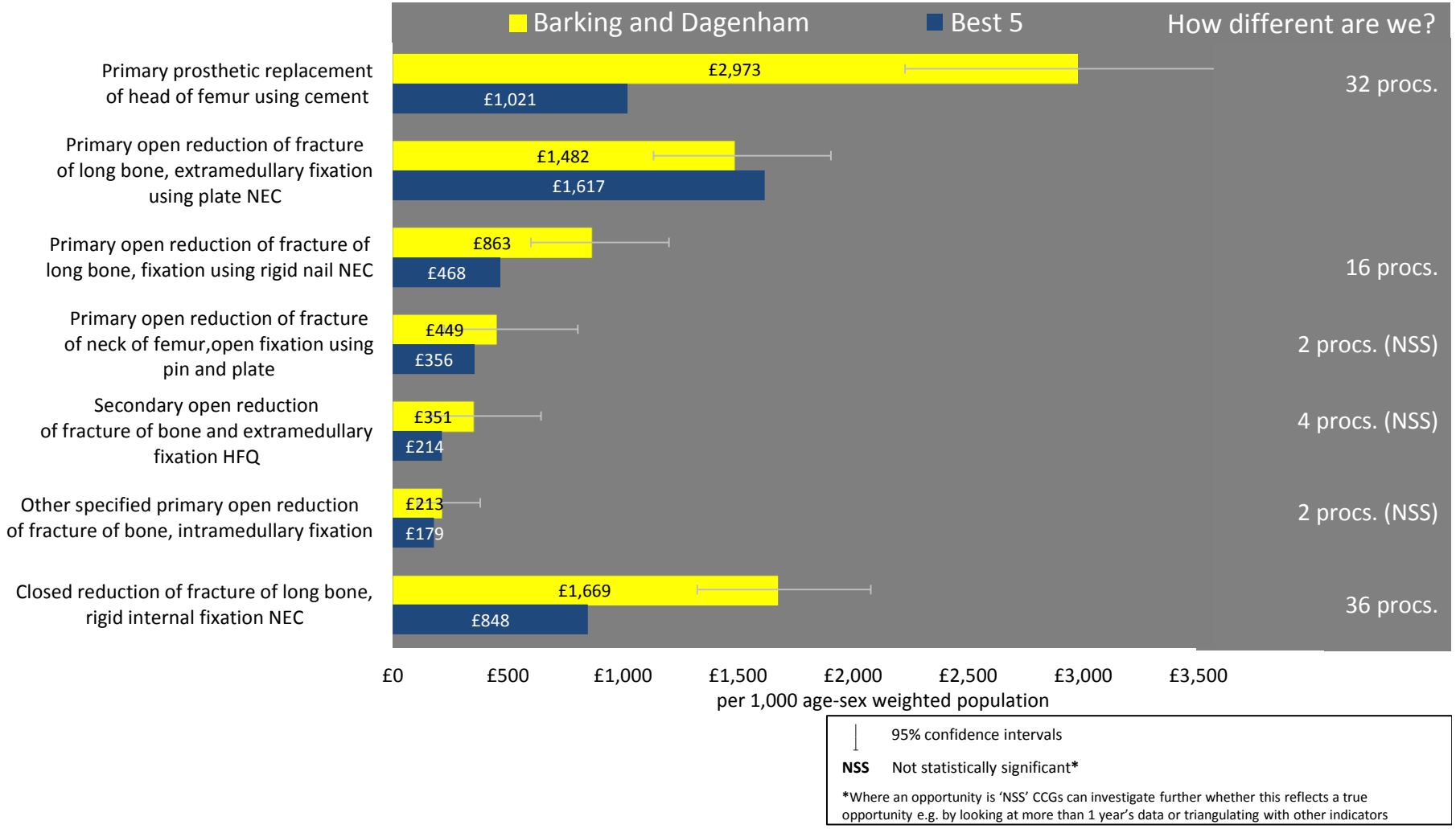
MSK Procedures - Other high spend MSK



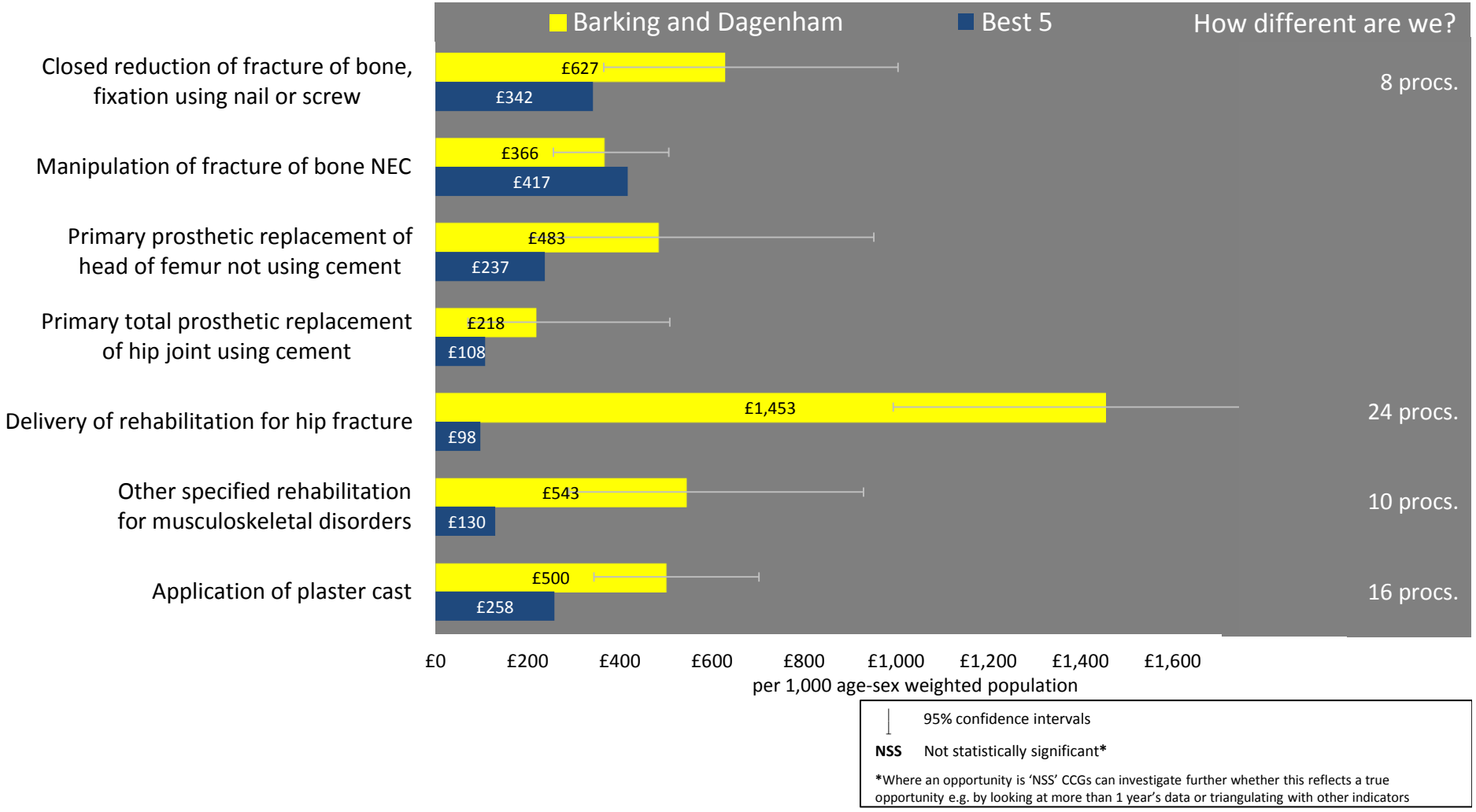
MSK Procedures - Other high spend MSK continued



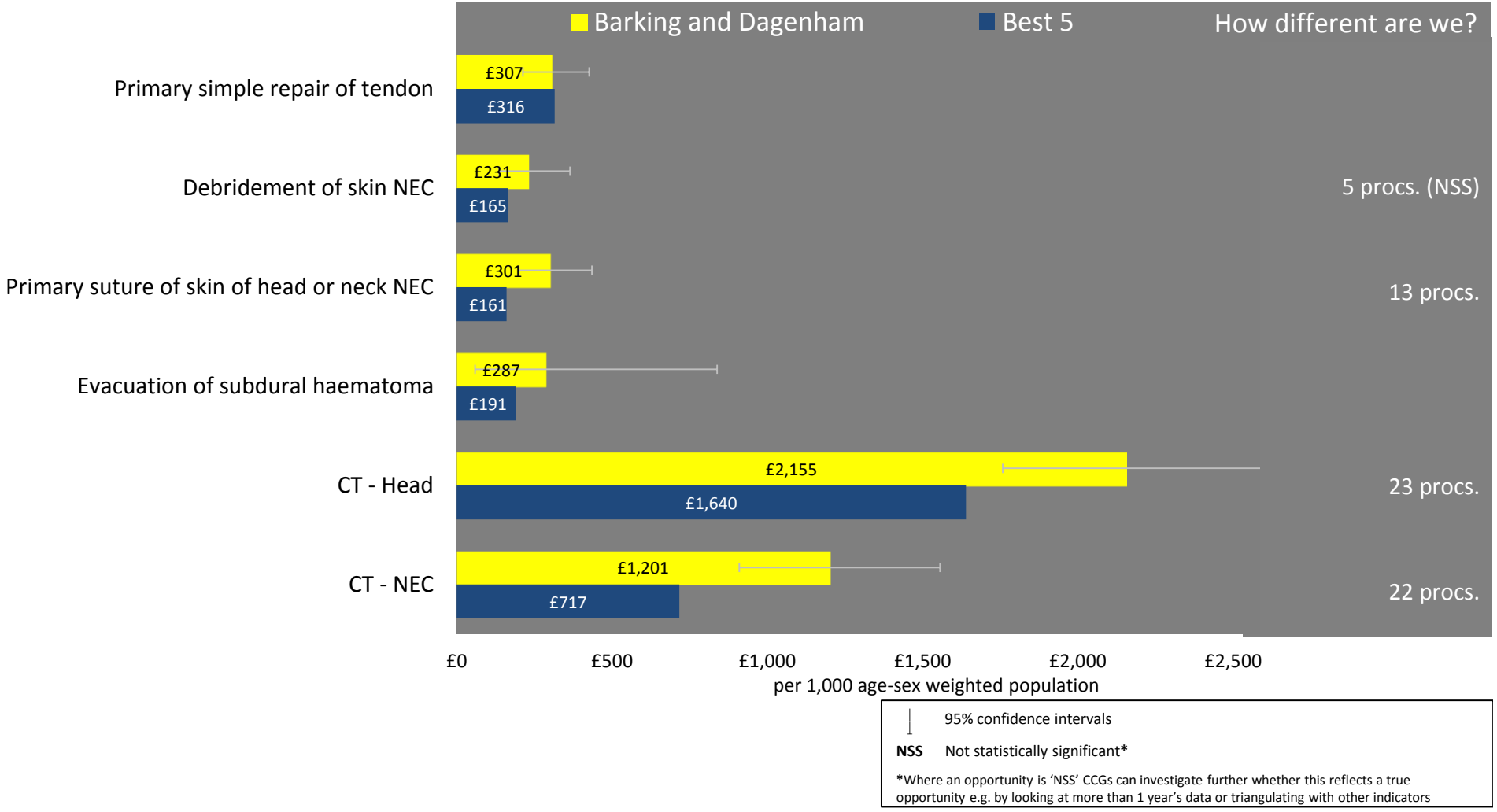
Trauma and injuries - Procedures



Trauma and injuries- Procedures continued



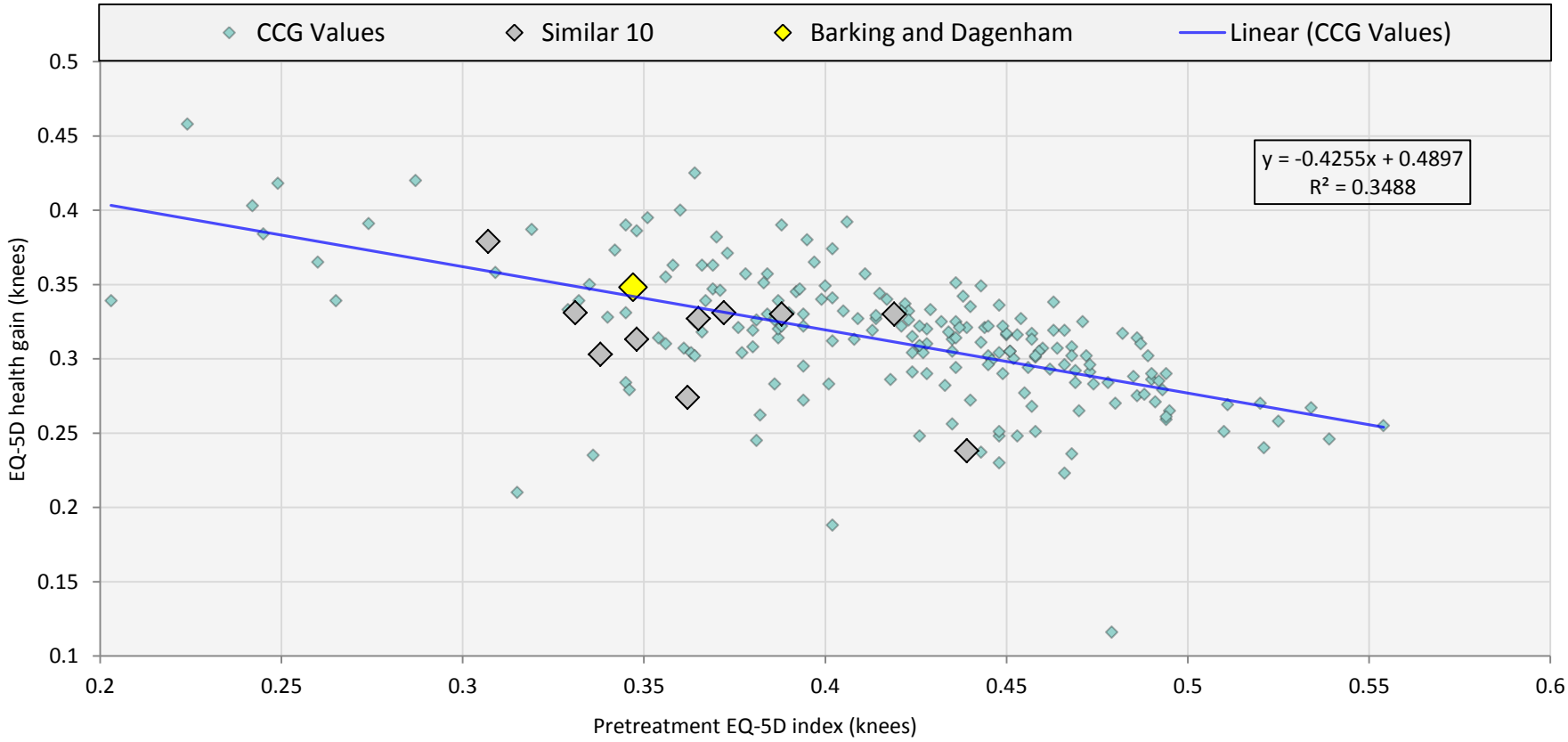
Trauma and injuries - Procedures continued



Scatter Plot Analysis

The Commissioning for Value Explorer Tool allows the comparison of two indicators, the diagram below is an example. This is an invaluable tool to enable users to assess how one indicator relates to another. The similar 10 can be highlighted too. It is important to remember that correlations do not imply causation but the relationships can help target where to look. The explorer tool is available here:

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

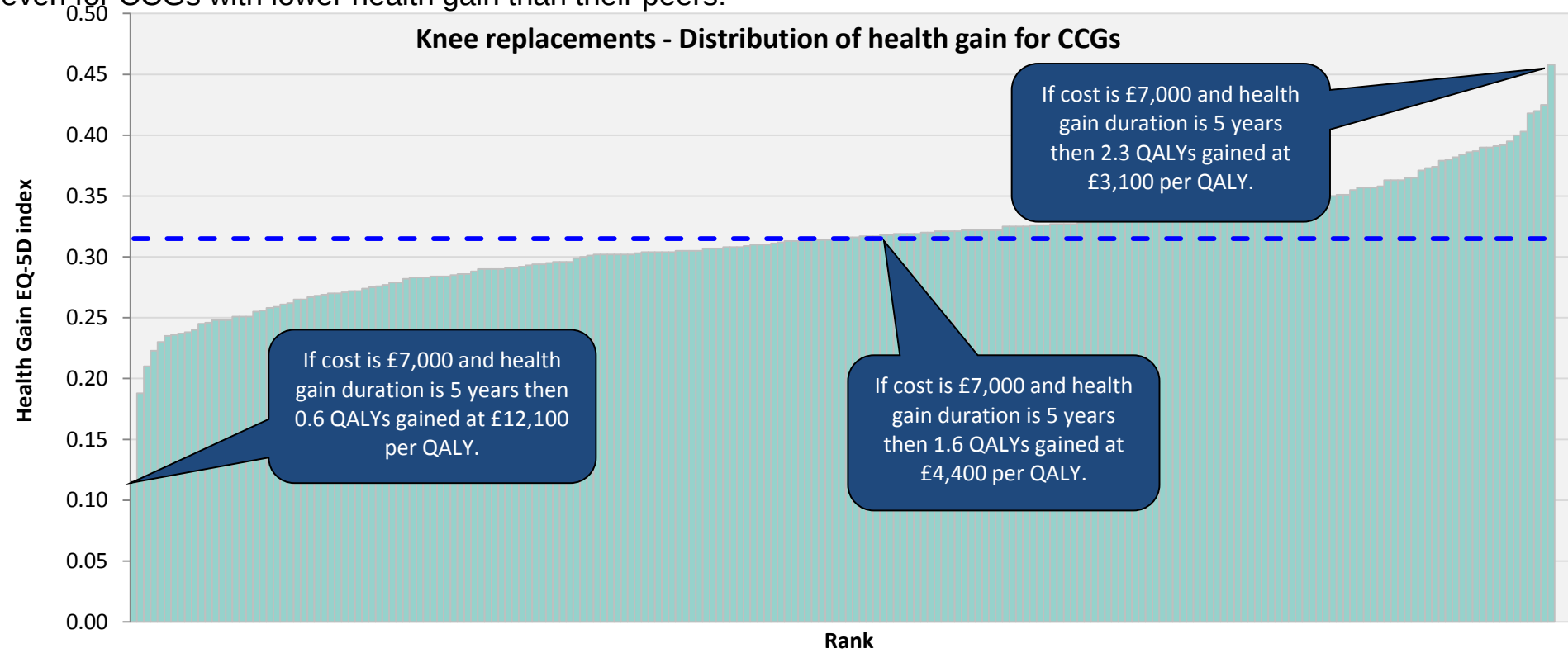


What is the range of health gain for knee replacements across CCGs?

On average knee replacements*;

- provide a large health gain for patients
- are good value for money

even for CCGs with lower health gain than their peers.

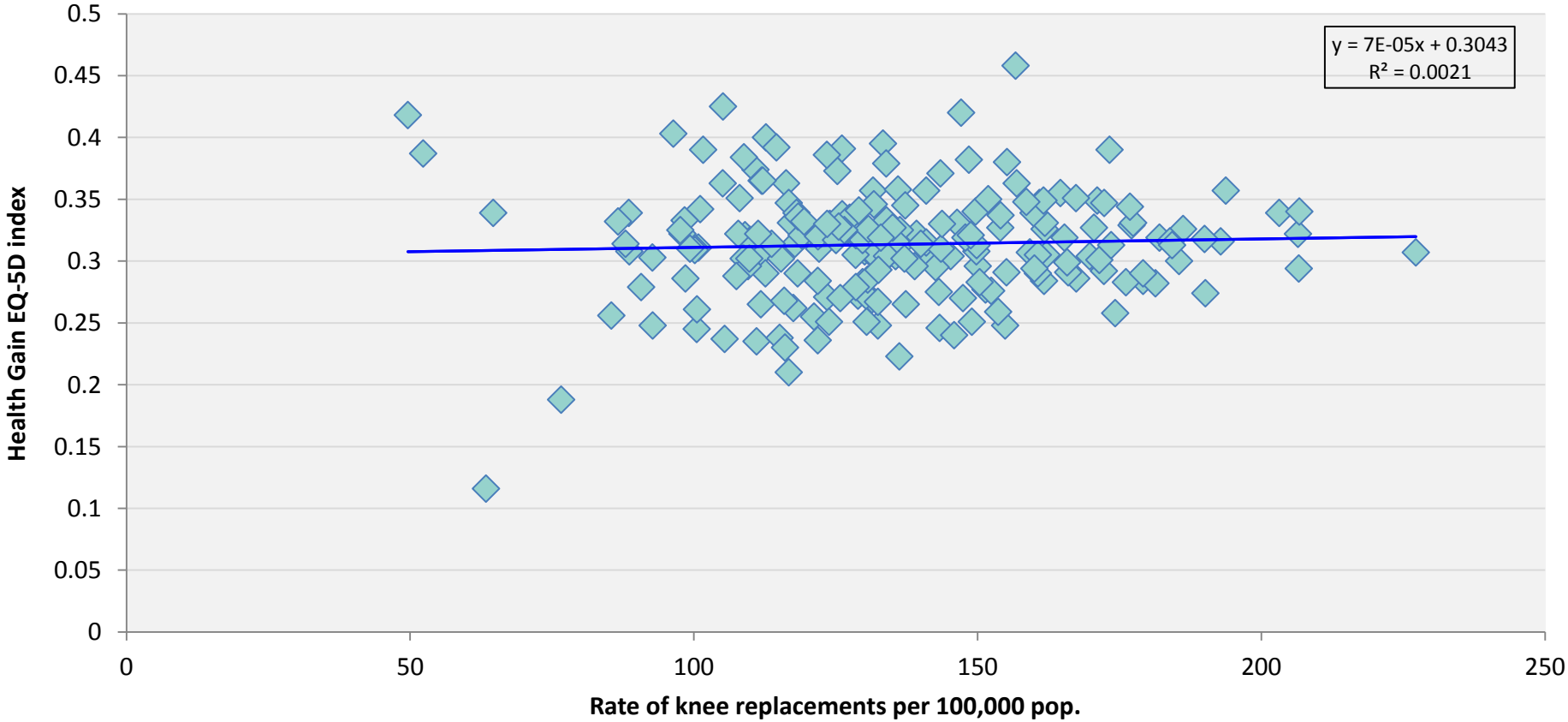


*Similarly for hip replacements except the health gain tends to be larger. The England average EQ-5D Index health gain is 0.437.

Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre, 2014/15

What is the health gain for knee replacements - even if we perform more procedures than our peer CCGs?

CCGs that perform higher rates of knee replacements* tend to get the same large health gain for patients at the same value for money as CCGs that perform lower rates.



*Similarly for hip replacements except the health gain tends to be larger. The England average EQ-5D Index health gain is 0.437.

Opportunity table: Methodology

The opportunity tables present all focus pack indicators for five aspects of the pathway.

- **Risk**
- **Prevalence and detection**
- **Service and quality**
- **Spend**
- **Outcomes**

The width of the spine chart shows the England range. Your CCG is benchmarked against its similar 10 group. The shaded area of the spine chart within the table shows the range for the similar 10 group. Where the CCG is highest or lowest compared with its similar 10 group it is shown as outside that group range. This has been done to clearly show where the CCG is in relation to the similar 10 and the England worst/highest and best/lowest values.

Opportunities have been calculated for all indicators apart from those that relate to recorded prevalence and some risk factors. Where an indicator can be clearly interpreted as worse or better the spine charts show the position of the CCG, the best five average, and the wider cluster best CCG. The opportunity is quantified where the CCG is worse in relation to the Best 5 average.

Where an indicator needs to be locally interpreted (for example elective spend) and the CCG is higher than the average of the 5 CCGs with the lowest values, the opportunity table shows the potential opportunity. By calculating the potential opportunity it is possible to answer the question “Is it worth investigating this further?” The Best 5 average and the cluster best are not shown on the spine chart for these indicators.

Opportunity table: Interpretation

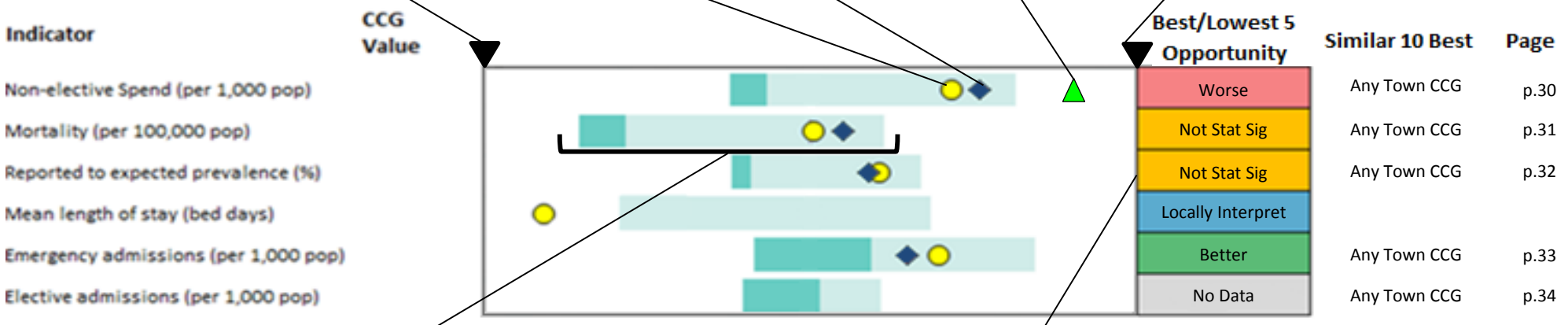
England **Worst**
or
England **Highest**
(for indicators that require Local Interpretation)

Your CCG

Best 5 CCG average

Wider cluster group best CCG‡

England **Best**
or
England **Lowest**
(for indicators that require Local Interpretation)



The shaded area is the range for your similar 10 group. Your CCG is the yellow circle and, as it is not part of the similar 10, it could appear anywhere from England worst/highest to the England best/lowest

The darker green shading shows the worst quintile in the similar 10.

Red = Statistically significantly worse than best 5 & quantified CCG opportunity

Amber & 'amount (NSS)' = Not statistically significant – *worse* than best 5

Amber & 'blank' = Not statistically significant – *better* than best 5

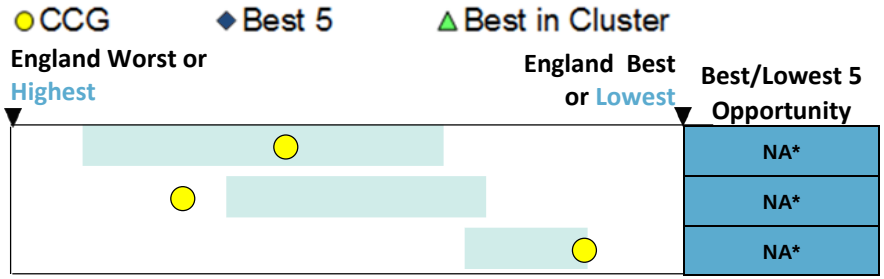
Blue = Indicator is to be locally interpreted and requires contextual information. Potential opportunities are **only** shown where the CCG is **higher** than the best 5. No potential opportunities are calculated for prevalence and some risk factors.

Green = Statistically significantly better than best 5

No Data = No CCG data or data has been supressed due to small numbers

‡ The wider cluster group best CCG is not always in the similar 10. It is included to indicate a 'stretch' target. Your wider CCG cluster group is identified on page 9.

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population



Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Smoking prevalence, 18+	18.8	NA*		
Obesity prevalence, 16+	11.6	NA*		
% GP registered population, 75+	4.3	NA*		

Please note: For smoking and obesity, opportunities are not presented due to difficulties calculating these, rather than because they need local interpretation.

*** No opportunity is calculated for risk and reported prevalence indicators**

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Prevalence and detection

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

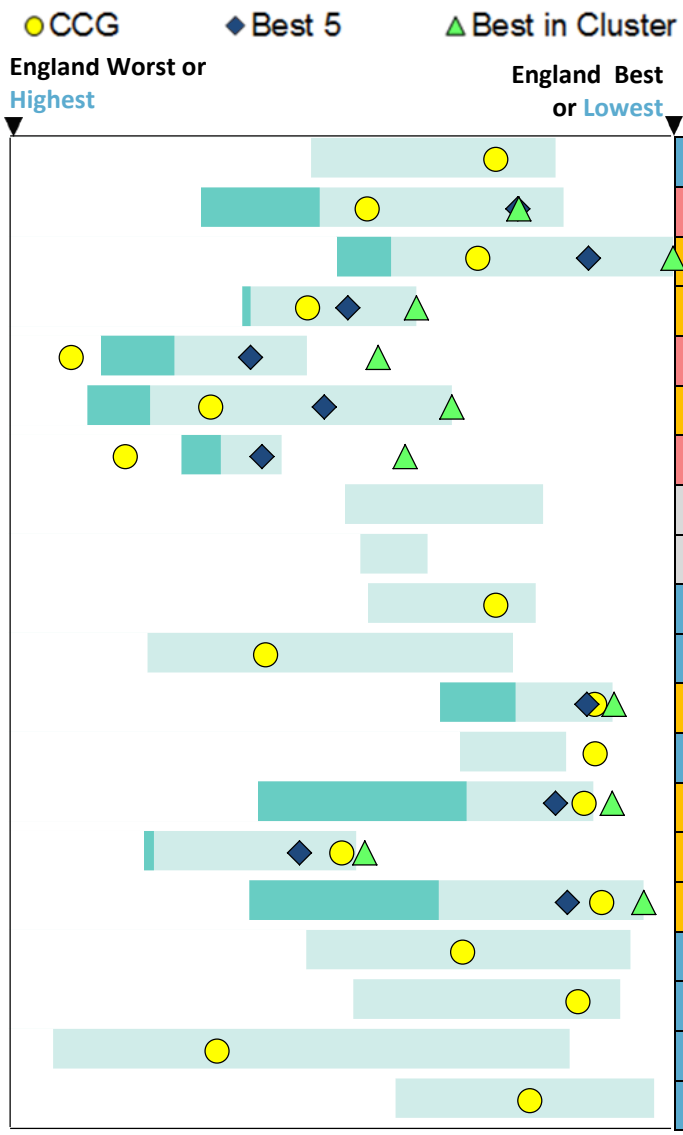
Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
% people (over 45) who have hip osteoarthritis (total)	11.6	NA*		
% people (over 45) who have knee osteoarthritis (total)	19.9	NA*		
% people (over 45) who have hip osteoarthritis (severe)	3.6	NA*		
% people (over 45) who have knee osteoarthritis (severe)	7.2	NA*		
Reported prevalence of rheumatoid and inflammatory arthritis (%)	0.6	NA*		
Estimated Back pain prevalence - all (%)	14.9	NA*		
Estimated Back pain prevalence - severe (%)	9.1	NA*		

*** No opportunity is calculated for risk and reported prevalence indicators**

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Activity and quality

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

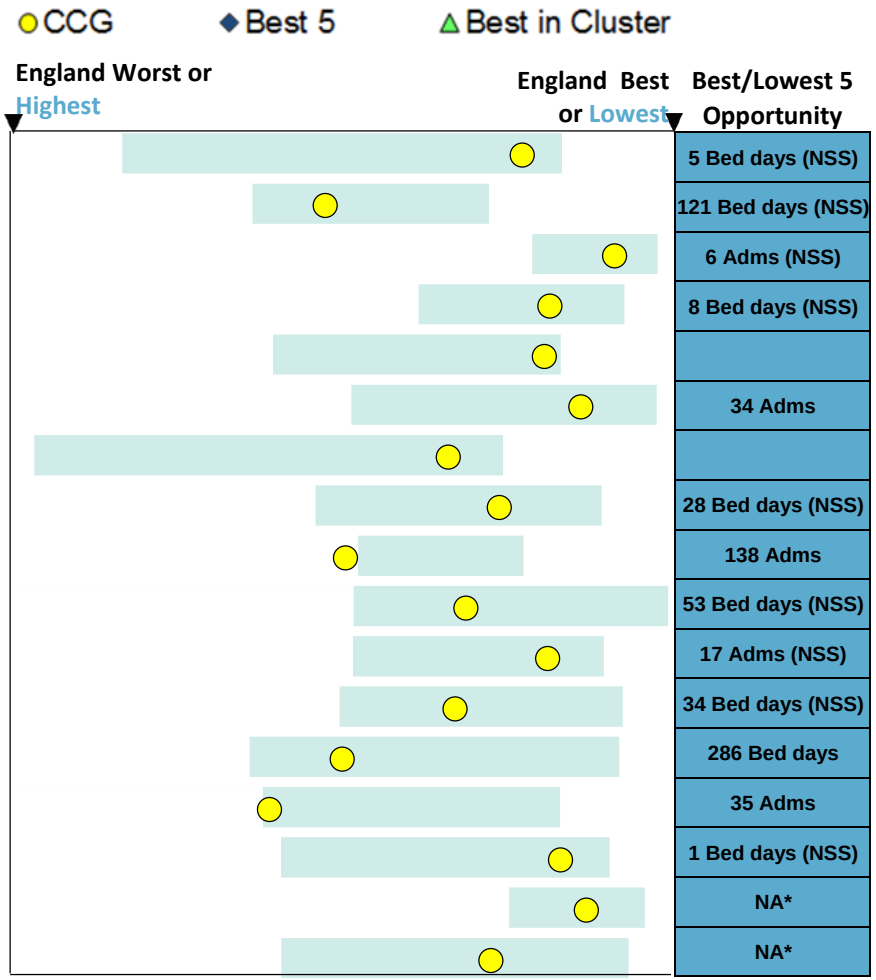


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Rate of DEXA scan activity (*)	4.6	143 Scans		
% osteoporosis patients 50-74 treated with Bone Sparing Agent	84.6	4 Pats	Slough	p.78
% patients 75+ years with fragility fracture treated with BSA	74.0	8 Pats (NSS)	Enfield	p.79
All fracture admissions in people aged 65+ (per 1,000 pop. 65+)	14	22 Adms (NSS)	Waltham Forest	p.80
Hip fractures in people aged 65+ (**)	674	32 Adms	Waltham Forest	p.81
Hip fractures in people aged 65-79 (**)	247	7 Adms (NSS)	Waltham Forest	p.82
Hip fractures in people aged 80+ (**)	1734	20 Adms	Croydon	p.83
Mean length of stay for hip fractures (bed days)	No Data	No Data		
Mean length of stay for patients 65+ with hip fractures (bed days)	No Data	No Data		
Rate of hip replacements (**)	90	8 Pats (NSS)		
Rate of knee replacements (**)	159	53 Pats		
% of patients with RA who have had a review in the last 12 months	88.0		Birmingham South and Central	p.84
Rate of MRIs of spine (**)	11			
Emergency admissions for Back, neck and MSK pain (**)	42		Haringey	p.85
Injuries due to falls in people aged 65+ (**)	1866.0		Luton	p.86
Unintentional and deliberate injury admissions, 0-24 years (**)	83		Enfield	p.87
Back, neck and MSK pain - day case admissions (**)	379.3	342 Adms		
Back, neck and MSK pain - Average LOS - elective (bed days)	2.7			
Back, neck and MSK pain - Average LOS - emergency (bed days)	12.1	377 Bed days		
Rheumatoid & Inflammatory Arthritis - day case admissions (**)	173.3	116 Adms		

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Activity and quality

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population



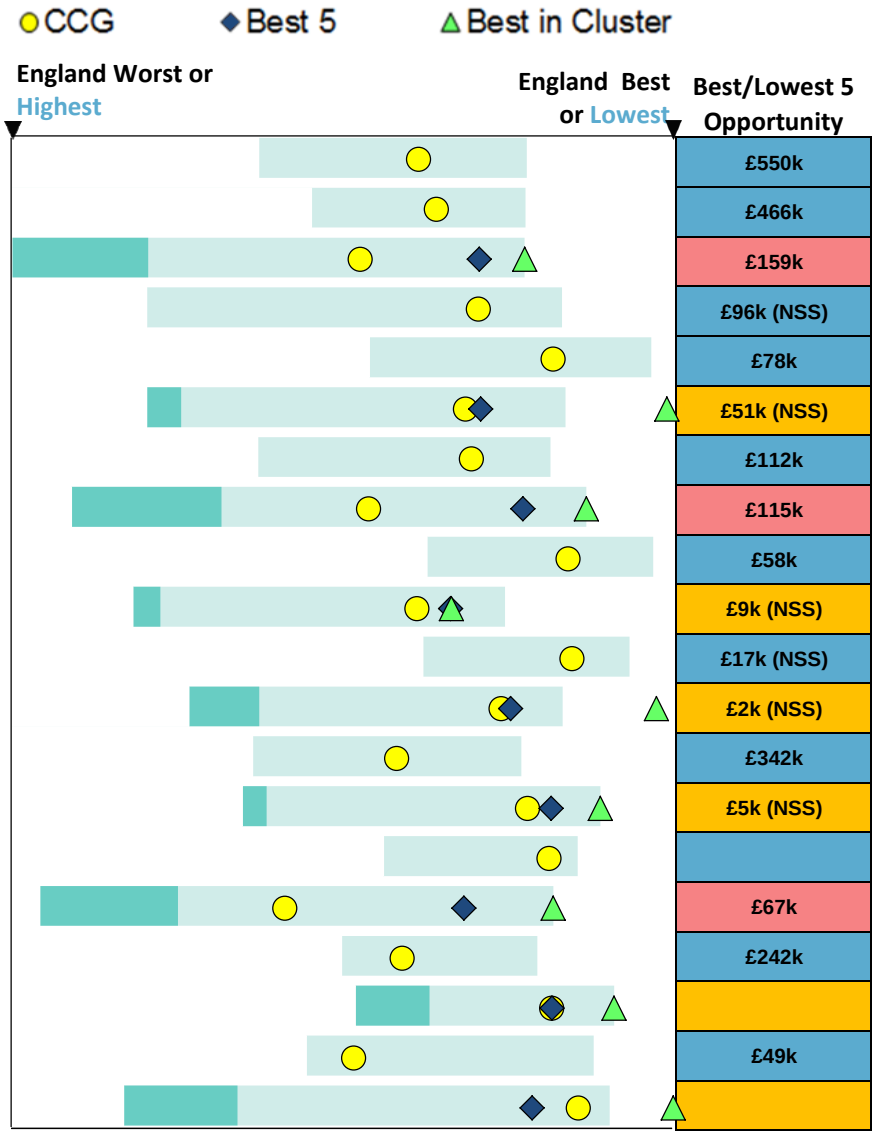
Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Rheumatoid & Inflammatory Arthritis-Average LOS-elective (bed days)	3.7	5 Bed days (NSS)		
Rheumatoid & Inflammatory Arthritis-Average LOS-emergency(bed days)	9.7	121 Bed days (NSS)		
Osteoporosis & fragility fractures - day case admissions (**)	26.5	6 Adms (NSS)		
Osteoporosis & fragility fractures-Average LOS-elective (bed days)	3.3	8 Bed days (NSS)		
Osteoporosis & fragility fractures-Average LOS-emergency (bed days)	6.8			
Osteoarthritis - day case admissions (**)	84.9	34 Adms		
Osteoarthritis - Average LOS - elective (bed days)	4.0			
Osteoarthritis - Average LOS - emergency (bed days)	5.9	28 Bed days (NSS)		
Other joint disorders - day case admissions (**)	229.1	138 Adms		
Other joint disorders - Average LOS - emergency (bed days)	4.1	53 Bed days (NSS)		
Other MSK conditions - day case admissions (**)	176.5	17 Adms (NSS)		
Other MSK conditions - Average LOS - elective (bed days)	2.0	34 Bed days (NSS)		
Other MSK conditions - Average LOS - emergency (bed days)	5.0	286 Bed days		
Follow-up- to remove fracture plate - day case admissions (**)	34.7	35 Adms		
Follow-up- to remove fracture plate-Average LOS-elective (bed days)	0.8	1 Bed days (NSS)		
GP Exception Rate - Rheumatoid Arthritis (%)	5.2	NA*		
GP Exception Rate - Osteoporosis (%)	8.2	NA*		

*** No opportunity is calculated for exception rates**

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

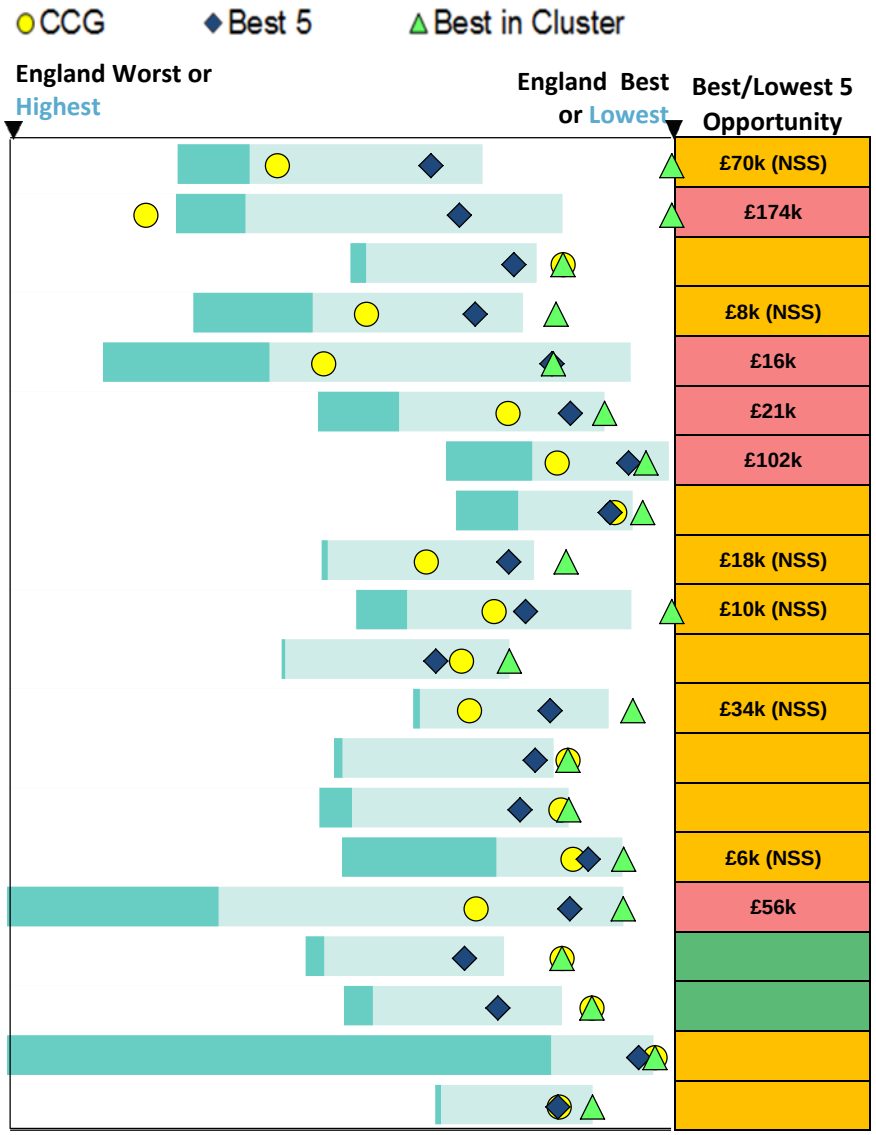


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
MSK - Total (*)	38915	£550k		
MSK - Elective (*)	33997	£466k		
MSK - Non-elective (*)	4924	£159k	Haringey	p.88
Trauma - Total (*)	21728	£96k (NSS)		
Trauma - Elective (*)	2673	£78k		
Trauma - Non-elective (*)	19085	£51k (NSS)	Luton	p.89
Back, neck and MSK pain - elective (*)	5531	£112k		
Back, neck and MSK pain - non-elective (*)	2147	£115k	Haringey	p.90
Rheumatoid and Inflammatory Arthritis - elective (*)	1284	£58k		
Rheumatoid and Inflammatory Arthritis - non-elective (*)	631	£9k (NSS)	Luton	p.91
Osteoporosis and fragility fractures - elective (*)	523	£17k (NSS)		
Osteoporosis and fragility fractures - non-elective (*)	337	£2k (NSS)	Croydon	p.92
Osteoarthritis - elective (*)	15791	£342k		
Osteoarthritis - non-elective (*)	291	£5k (NSS)	Croydon	p.93
Other MSK conditions - elective (*)	4098			
Other MSK conditions - non-elective (*)	1221	£67k	Enfield	p.94
Other joint disorders - elective (*)	5607	£242k		
Other joint disorders - non-elective (*)	225		Enfield	p.95
Follow-up- to remove fracture plate - elective (*)	591	£49k		
Injuries to the hip and thigh - Under 75s (*)	1456		Haringey	p.96

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

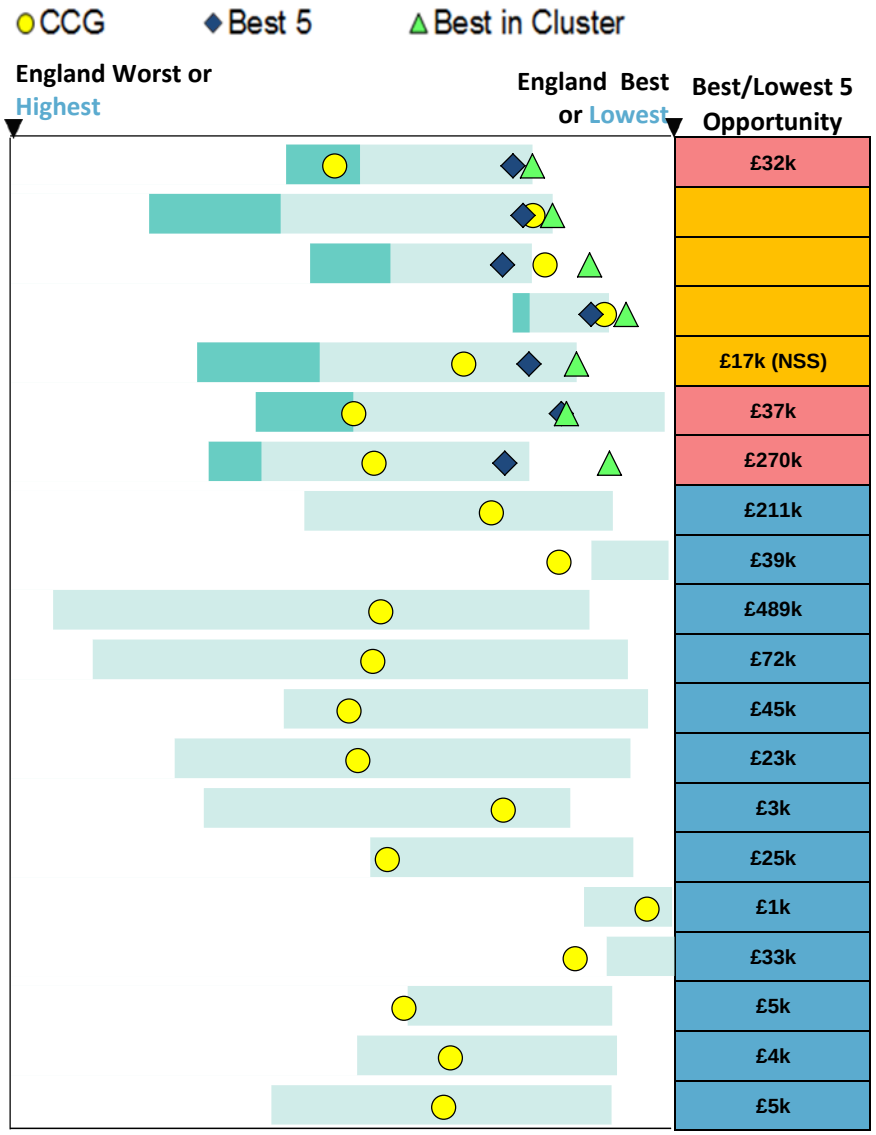


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Injuries to the hip and thigh - 75-84 (*)	46974	£70k (NSS)	Croydon	p.97
Injuries to the hip and thigh - 85+ (*)	184473	£174k	Luton	p.98
Injuries to the thorax - Under 75s (*)	272		Barking and Dagenham	p.99
Injuries to the thorax - 75-84 (*)	3883	£8k (NSS)	Sandwell and West Birmingham	p.100
Injuries to the thorax - 85+ (*)	9075	£16k	North Manchester	p.101
Injuries to the wrist and hand - 0-18 (*)	1529	£21k	Enfield	p.102
Injuries to the wrist and hand - 19-64 (*)	2257	£102k	Luton	p.103
Injuries to the wrist and hand - 65+ (*)	1248		Luton	p.104
Injuries to the shoulder and upper arm - 0-18 (*)	1095	£18k (NSS)	Enfield	p.105
Injuries to the shoulder and upper arm - 19-64 (*)	812	£10k (NSS)	Luton	p.106
Injuries to the shoulder and upper arm - 65+ (*)	3943		Haringey	p.107
Injuries to the elbow and forearm - 0-18 (*)	2594	£34k (NSS)	Waltham Forest	p.108
Injuries to the elbow and forearm - 19-64 (*)	1198		Barking and Dagenham	p.109
Injuries to the elbow and forearm - 65+ (*)	3450		Haringey	p.110
Injuries to the head - 0-18 (*)	1452	£6k (NSS)	Greenwich	p.111
Injuries to the head - 19-64 (*)	1634	£56k	Greenwich	p.112
Injuries to the head - 65-84 (*)	4149		Barking and Dagenham	p.113
Injuries to the head - 85+ (*)	21307		Barking and Dagenham	p.114
Injuries to abdomen,lower back, lumbar spine and pelvis - 0-18 (*)	129		Barking and Dagenham	p.115
Injuries to abdomen,lower back, lumbar spine and pelvis - 19-64 (*)	482		Haringey	p.116

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

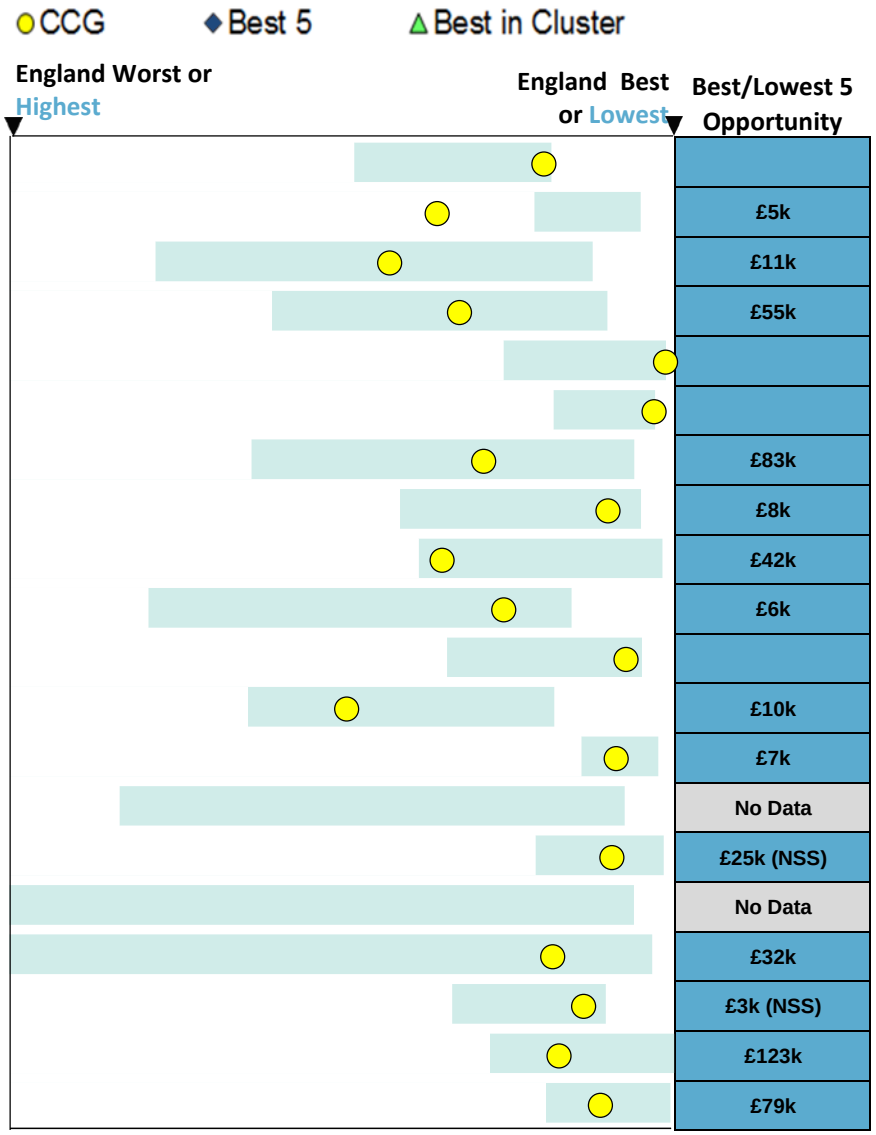


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Injuries to abdomen,lower back, lumbar spine and pelvis - 65-84 (*)	4215	£32k	Enfield	p.117
Injuries to abdomen,lower back, lumbar spine and pelvis - 85+ (*)	9005		Waltham Forest	p.118
Injuries to the knee and lower leg - 0-18 (*)	1004		Barking and Dagenham	p.119
Injuries to the knee and lower leg - 19-64 (*)	1992		Waltham Forest	p.120
Injuries to the knee and lower leg - 65-84 (*)	5454	£17k (NSS)	Greenwich	p.121
Injuries to the knee and lower leg - 85+ (*)	21915	£37k	Slough	p.122
Spend on admissions relating to fractures where a fall occurred (*)	12212	£270k	Luton	p.123
Prescribing spend - MSK (*)	6326	£211k		
Prescribing spend -DMARDs for inflammatory arthritis (combined) (*)	404	£39k		
Prescribing spend - pain medication for MSK** (*)	8947	£489k		
Prescribing spend - Trauma and Injuries (*)	1840	£72k		
Prescribing spend - Naproxen (***)	602	£45k		
Prescribing spend - Ibuprofen (***)	557	£23k		
Prescribing spend - Diclofenac Sodium (***)	378	£3k		
Prescribing spend - Etoricoxib (***)	227	£25k		
Prescribing spend - Celecoxib (***)	23	£1k		
Prescribing spend - Methotrexate (***)	262	£33k		
Prescribing spend - Hydroxychloroquine Sulfate (***)	99	£5k		
Prescribing spend - Leflunomide (***)	42	£4k		
Prescribing spend - Allopurinol (***)	150	£5k		

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

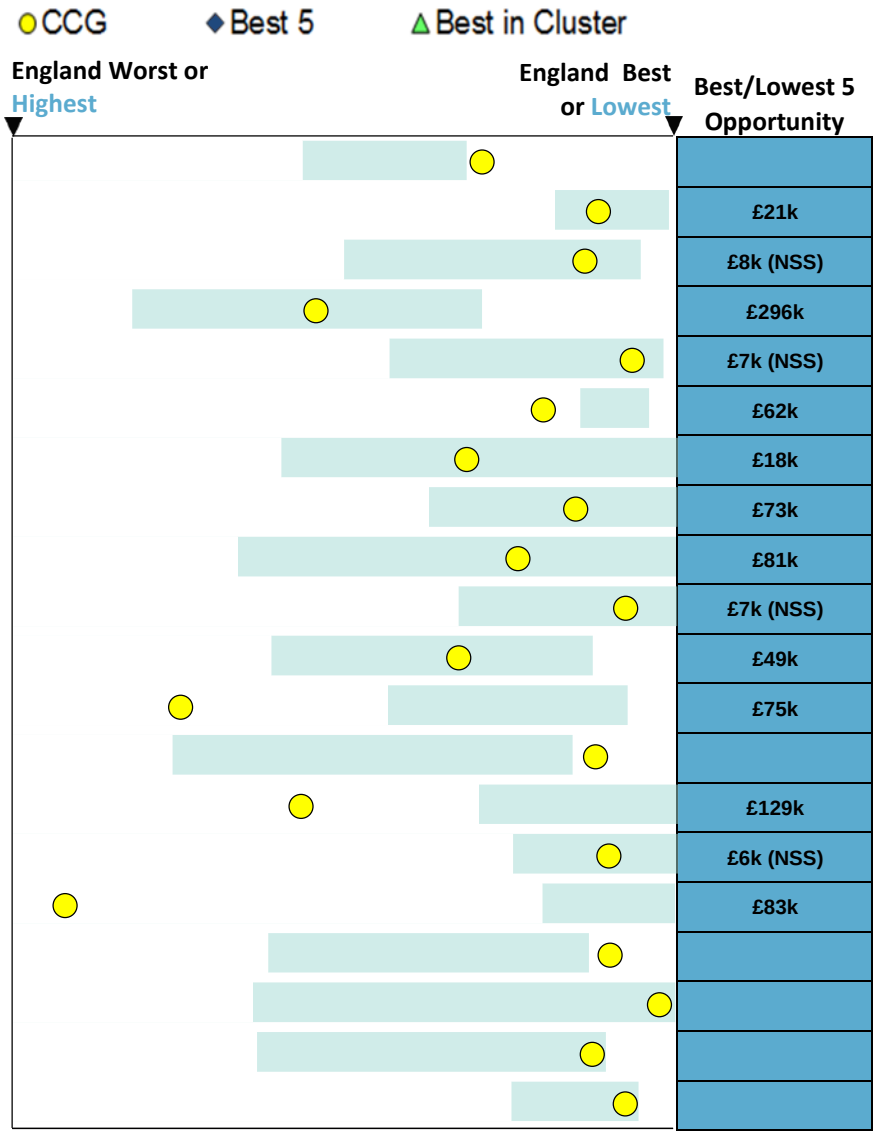


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Prescribing spend - Colchicine (***)	79			
Prescribing spend - Febuxostat (***)	58	£5k		
Prescribing spend - Prednisolone (***)	511	£11k		
Prescribing spend - Tramadol Hydrochloride (***)	900	£55k		
Prescribing spend - Codeine Phosphate (***)	91			
Prescribing spend - Dihydrocodeine Tartrate (***)	56			
Prescribing spend - Co-codamol (Codeine Phos/Paracetamol) (***)	1592	£83k		
Prescribing spend - Paracetamol (***)	962	£8k		
Prescribing spend - Piroxicam (***)	283	£42k		
Prescribing spend - Heparinoid (***)	127	£6k		
Prescribing spend - Capsaicin (***)	52			
Prescribing spend - Bisphosphonates (***)	211	£10k		
Prescribing spend - Non-bisphosphonates (***)	103	£7k		
MSK Proc.- Anatomical Total Shoulder Arthroplasty (*)	No Data	No Data		
MSK Proc.- Resurfacing and Stemmed Arthroplasty/Hemiarthroplasty(*)	506	£25k (NSS)		
MSK Proc.- Reverse Polarity Arthroplasty (*)	No Data	No Data		
MSK Proc.- Primary or Revision Shoulder cuff repair (*)	483	£32k		
MSK Proc.- Subacromial decompression (*)	1223	£3k (NSS)		
MSK Proc.- Primary Hip Replacement - Cemented (*)	1386	£123k		
MSK Proc.- Primary Hip Replacement - Hybrid (*)	832	£79k		

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

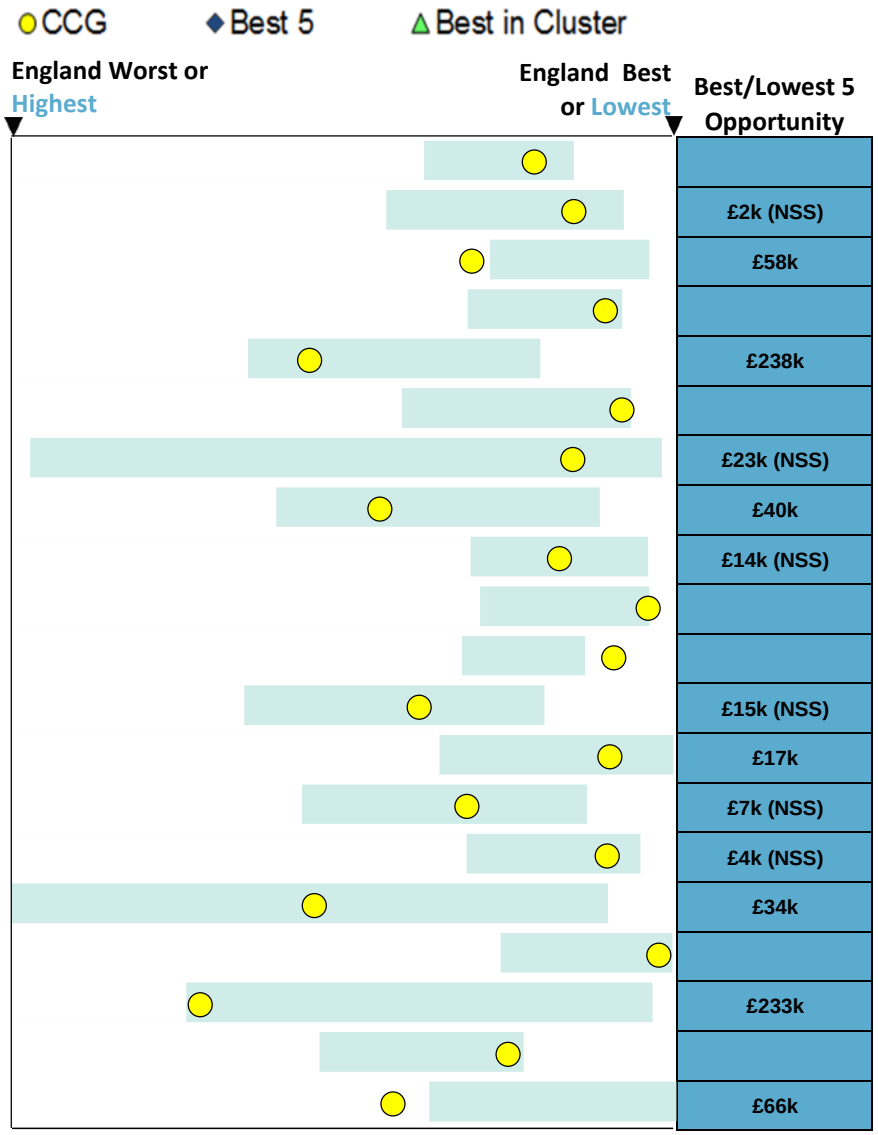


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
MSK Proc.- Primary Hip Replacement - Uncemented (*)	2095			
MSK Proc.- Primary Hip Replacement - Unspecified (*)	217	£21k		
MSK Proc.- Hip Revisions - All(*)	133	£8k (NSS)		
MSK Proc.- Primary Knee Replacements - Cemented (*)	8545	£296k		
MSK Proc.- Primary Knee Replacements - Uncemented (*)	290	£7k (NSS)		
MSK Proc.- Primary Knee Replacements - Unspecified (*)	860	£62k		
MSK Proc.- Knee Revisions - All (*)	170	£18k		
MSK Proc.- Back pain injections - All (*)	1489	£73k		
MSK Proc.- Back pain injections - Injection facet joint (*)	756	£81k		
MSK Proc.- Back pain injections - Other Back Injection (*)	737	£7k (NSS)		
MSK Proc.- Back and radicular pain - Imaging - All (*)	1084	£49k		
MSK Proc.- Imaging - CT (*)	795	£75k		
MSK Proc.- Imaging - MRI (*)	346			
MSK Proc.- Pain management - All (*)	1014	£129k		
MSK Proc.- Pain management - Drug delivery device (*)	195	£6k (NSS)		
MSK Proc.- Pain management - Denervation (*)	532	£83k		
MSK Proc.- Radicular pain injection - All (*)	458			
MSK Proc.- Radicular pain injection - Epidural lumbar (*)	82			
MSK Proc.- Radicular pain injection - Epidural sacral (*)	259			
MSK Proc.- Radicular pain injection- spinal nerve root injection(*)	115			

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

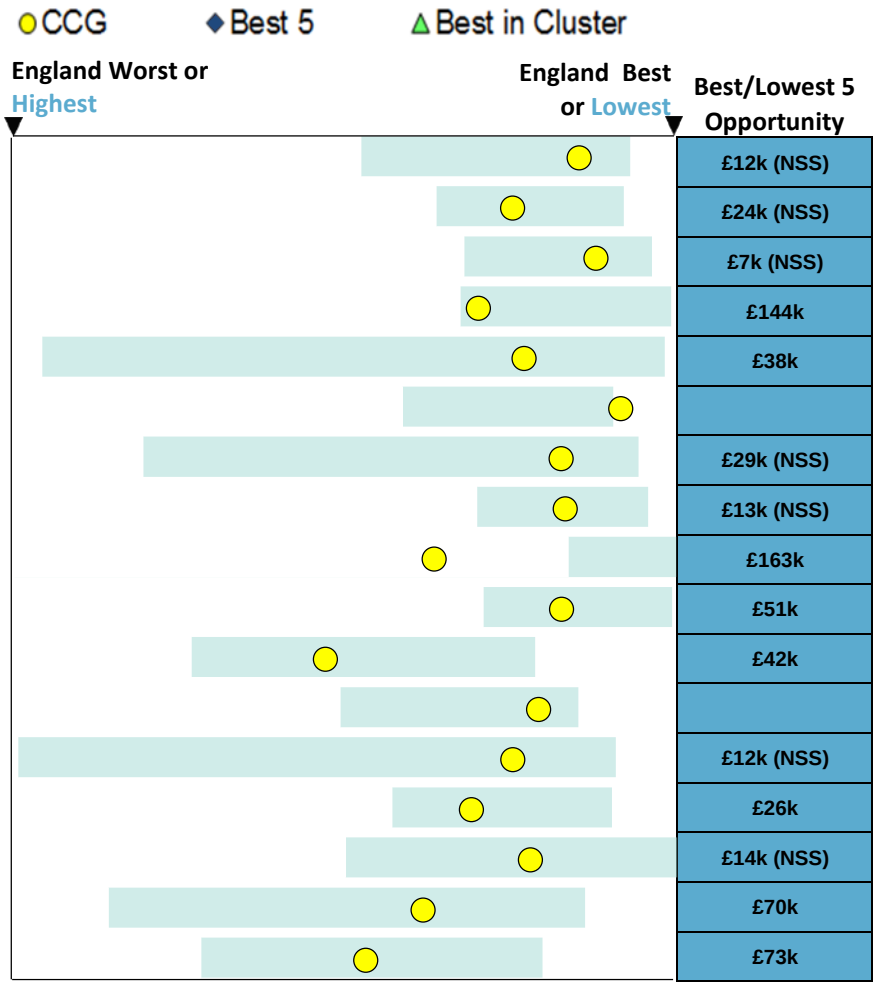


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
MSK Proc.- Back and Radicular pain - Surgery - All (*)	1548			
MSK Proc.- Surgery - Decompression (*)	651	£2k (NSS)		
MSK Proc.- Surgery - Discectomy (*)	416	£58k		
MSK Proc.- Surgery - Posterior lumbar fusion (*)	227			
MSK Proc.- Endoscopic resection of semilunar cartilage NEC (*)	2930	£238k		
MSK Proc.- Posterior attachment of correct. instrument to spine(*)	421			
MSK Proc.- Plastic repair of rotator cuff of shoulder NEC (*)	408	£23k (NSS)		
MSK Proc.- Removal of internal fixation from bone NEC (*)	589	£40k		
MSK Proc.- Reconstruction of intra-articular ligament NEC (*)	388	£14k (NSS)		
MSK Proc.- Digital fasciectomy (*)	108			
MSK Proc.- Palmar fasciectomy (*)	161			
MSK Proc.- Aspiration of joint (*)	440	£15k (NSS)		
MSK Proc.- Excision of cervical disc&fusion of joint of spine(*)	137	£17k		
MSK Proc.- Release of constriction of sheath of tendon (*)	164	£7k (NSS)		
MSK Proc.-Primary arthrodesis and internal fixation of joint NEC(*)	105	£4k (NSS)		
MSK Proc.- CT - Head (*)	410	£34k		
MSK Proc.- Open debridement of joint NEC (*)	45			
T&I Proc.- Prosth. replacement - head of femur-cement (*)	2973	£233k		
T&I Proc.- Open reduction -fracture of long bone& fixation - plate NEC (*)	1482			
T&I Proc.- Open reduction-fracture of long bone &fixation - rigid nail NEC (*)	863	£66k		

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

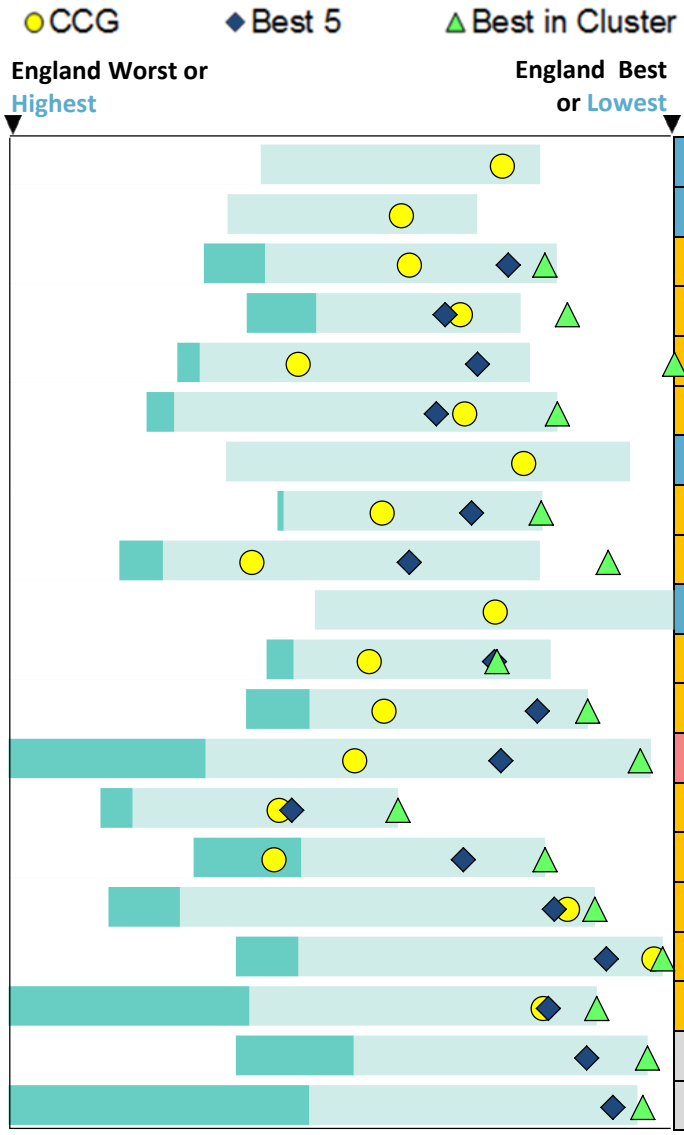


Indicator	CCG Value	Best/Lowest 5 Opportunity	Similar 10 Best	Page
T&I Proc.- Open reduction -fracture of neck of femur and open fixation using pin and plate (*)	449	£12k (NSS)		
T&I Proc.- 2nd open reduction of fracture of bone and extramedullary fixation HFQ (*)	351	£24k (NSS)		
T&I Proc.- Other specified primary open reduction of fracture of bone and intramedullary fixation (*)	213	£7k (NSS)		
T&I Proc.- Closed reduction of fracture of long bone and rigid internal fixation NEC (*)	1669	£144k		
T&I Proc.- Closed reduction of fracture of bone and fixation using nail or screw (*)	627	£38k		
T&I Proc.- Manipulation of fracture of bone NEC (*)	366			
T&I Proc.- Primary prosth. replace. - head of femur-not cement (*)	483	£29k (NSS)		
T&I Proc.- Primary total prosth. replace. - hip joint- cement (*)	218	£13k (NSS)		
T&I Proc.- Delivery of rehabilitation for hip fracture (*)	1453	£163k		
T&I Proc.- Other specified rehabilitation for MSK disorders (*)	543	£51k		
T&I Proc.- Application of plaster cast (*)	500	£42k		
T&I Proc.- Primary simple repair of tendon (*)	307			
T&I Proc.- Debridement of skin NEC (*)	231	£12k (NSS)		
T&I Proc.- Primary suture of skin of head or neck NEC (*)	301	£26k		
T&I Proc.- Evacuation of subdural haematoma (*)	287	£14k (NSS)		
T&I Proc.- CT - Head (*)	2155	£70k		
T&I Proc.- CT - NEC (*)	1201	£73k		

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Outcomes

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population



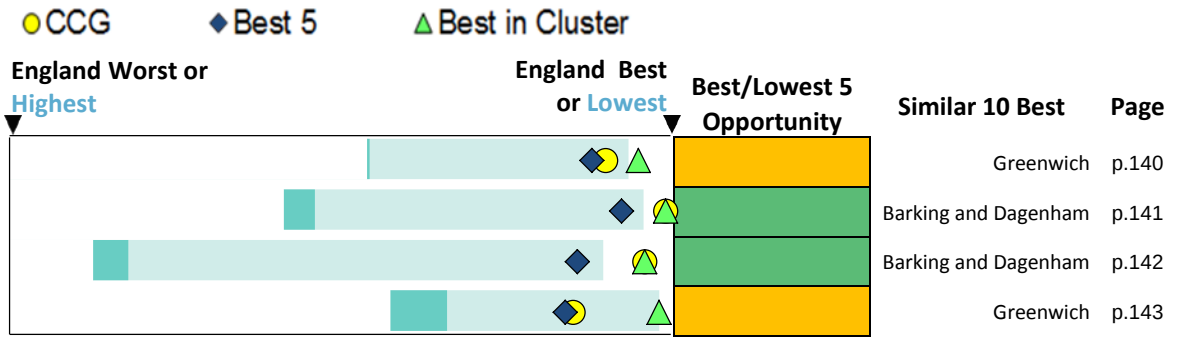
Indicator	CCG Value	Similar 10 Best	Page
Pretreatment EQ-5D index (hips)	0.271		
Pretreatment EQ-5D index (knees)	0.347		
EQ-5D health gain (hips)	0.448	North Manchester	p.124
EQ-5D health gain (knees)	0.348	Luton	p.125
EQ-5D - Hip (primary) - Health gain (casemix adjusted)	0.414	North Manchester	p.126
EQ-5D - Knee (primary) - Health gain (casemix adjusted)	0.324	Waltham Forest	p.127
Oxford score - Hip (primary) - Pre-op	15.9		
Oxford score - Hip (primary) - Health gain	20.5	Birmingham South and Central	p.128
Oxford score - Hip (primary) - Health gain (casemix adjusted)	20.7	Birmingham South and Central	p.129
Oxford score - Knee (primary) - Pre-op	16.8		
Oxford score - Knee (primary) - Health gain	14.7	Luton	p.130
Oxford score - Knee (primary) - Health gain (casemix adjusted)	14.9	Waltham Forest	p.131
% fractured femur patients returning home within 28 days	53.7	Luton	p.132
Hip fracture emergency readmissions 28 days (%)	14.4	Greenwich	p.133
Hip replacement emergency readmissions 28 days (%)	7.0	Enfield	p.134
Mortality from accidents all years (**)	14.0	Enfield	p.135
Mortality - Accidents - Under 75 (**)	5.8	Waltham Forest	p.136
Mortality - Accidents - 75+ (**)	92.5	Greenwich	p.137
Mortality - Falls - Under 75 (**)	No Data	Greenwich	p.138
Mortality - Falls - 75+ (**)	No Data	Luton	p.139

***No opportunity presented for PROMs indicators except EQ-5D index health gain**

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Outcomes

* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population



Indicator	CCG Value	Similar 10 Best	Page
Mortality - all ages - transport accident (**)	1.5	Greenwich	p.140
Life years lost Accidents (all)	217.5	Barking and Dagenham	p.141
Life years lost falls (all)	18.1	Barking and Dagenham	p.142
Life years lost transport (all)	45.6	Greenwich	p.143

Please refer to slide 63 for full guidance on interpretation of this table of opportunities

Further analysis

The following pages provide a further analysis of a range of indicators in the focus pack. The indicators selected are those where we have been able to assign a judgement on whether a lower or higher value is *better* eg a lower value is better for mortality, and a higher value better for case finding.

Top chart:
The opportunity box from the spine chart is shown in the top right of the blue banner. The top chart shows the whole England distribution together with the highlighted Similar 10 group (grey bars) and your CCG (yellow bar). The England average is shown by the dashed blue line. The England value and the Best 5 average values are shown below this chart.

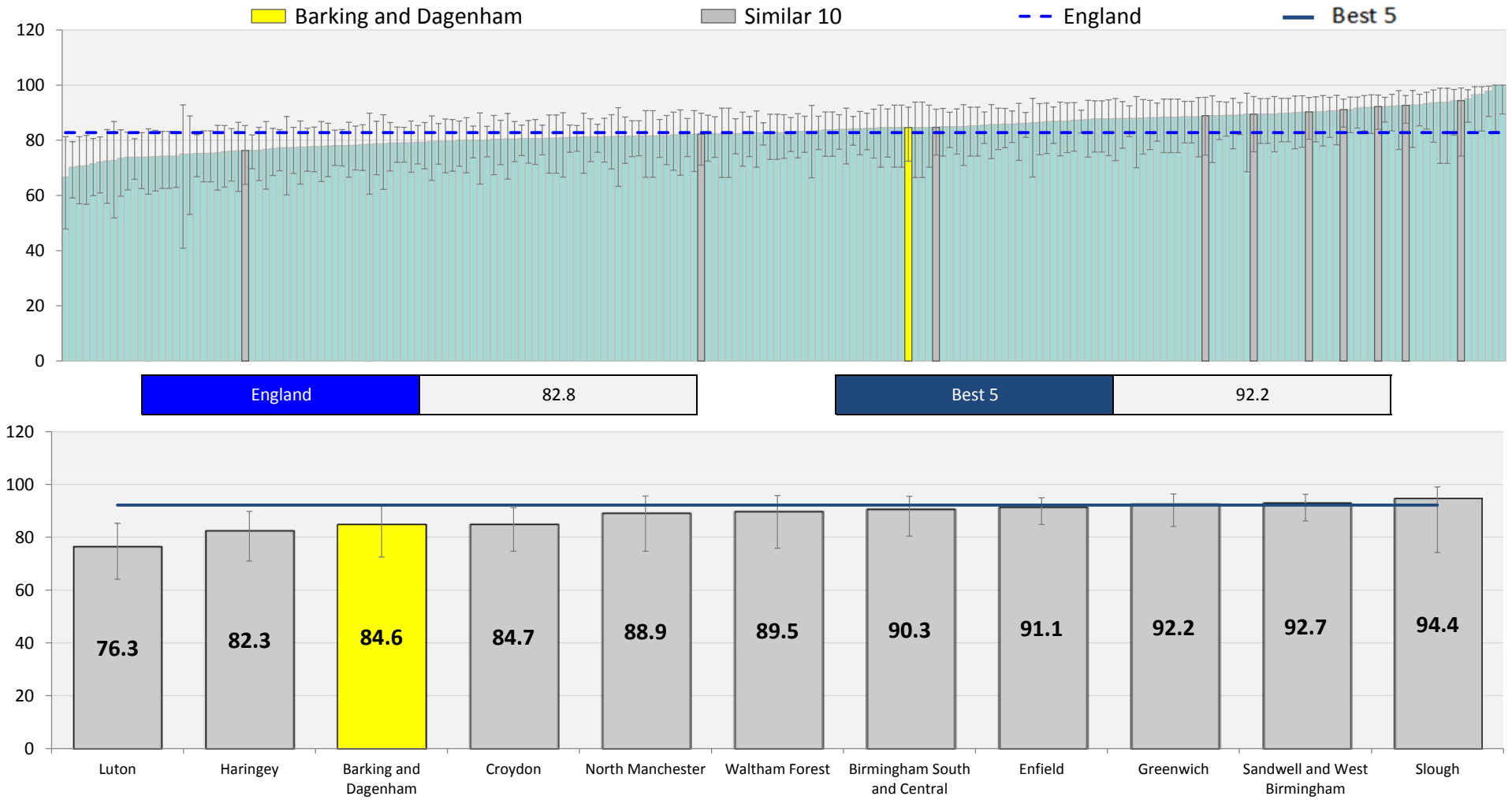
Bottom chart:
Shows your CCG and the Similar 10 group together with their indicator values. The Best 5 CCG average is shown by a dark blue line.

The full indicator name, source and time period are shown at the bottom left.

The analysis presented in the following pages can be replicated for *all* indicators in the focus pack using the Commissioning for Value Focus Pack Tool. The tool is available on the Commissioning for Value web pages. The link is shown on page 147.

% osteoporosis patients 50-74 treated with Bone Sparing Agent

4 Pats



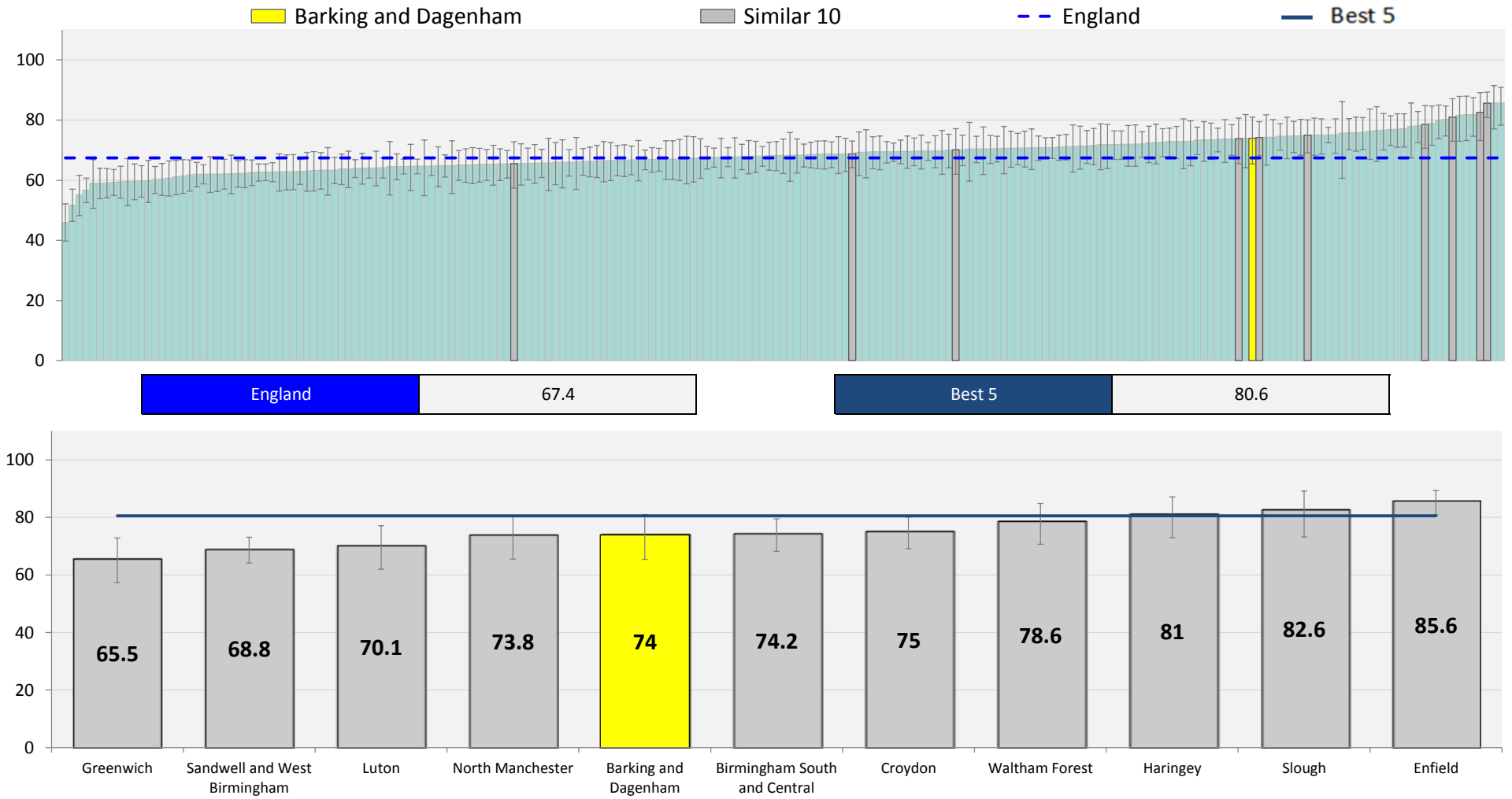
Definition: % of patients aged 50-75 years, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent (OST002)

Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

% patients 75+ years with fragility fracture treated with Bone Sparing Agent

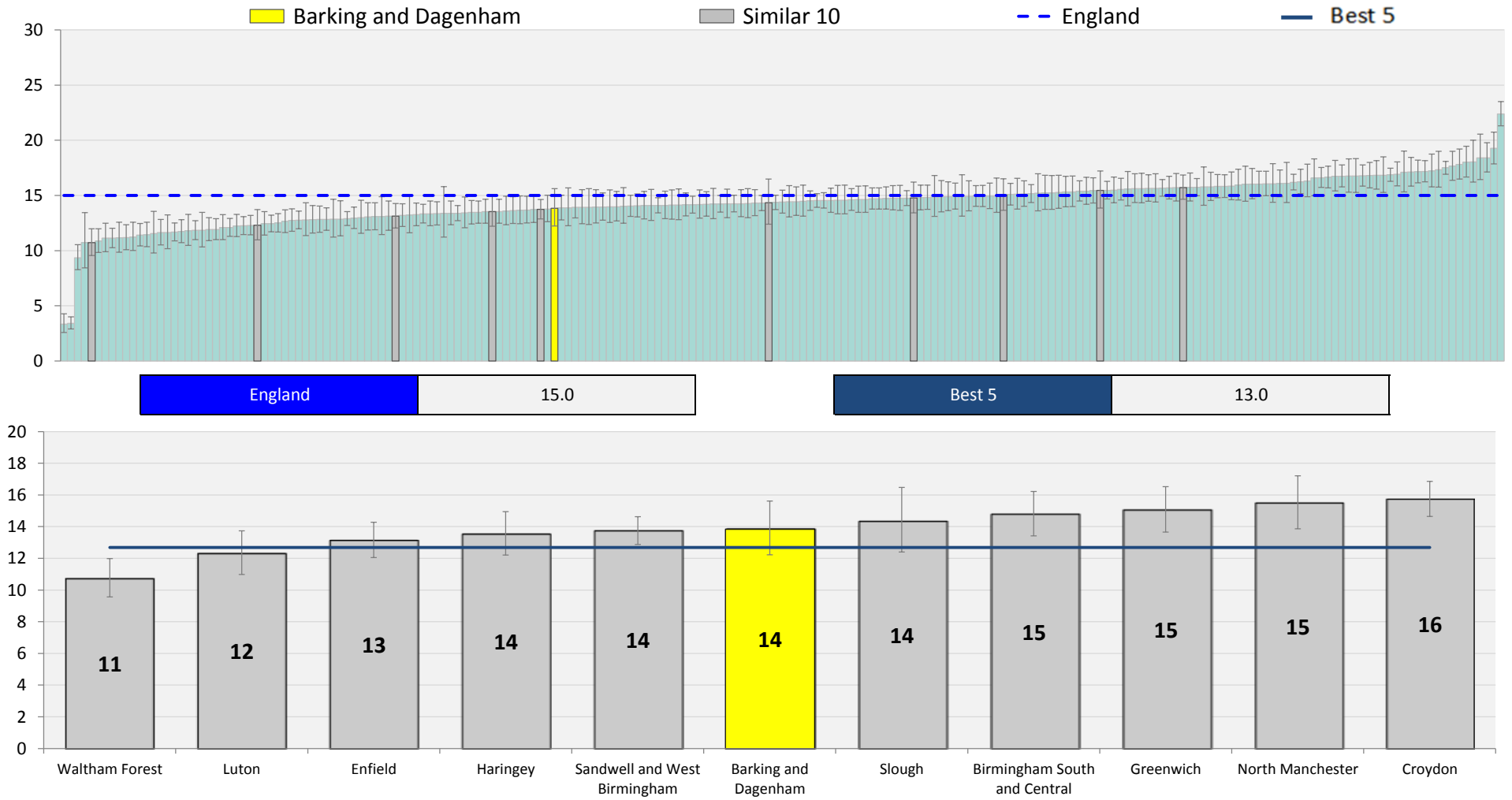
8 Pats (NSS)



Definition: % of patients aged 75+ years with a fragility fracture treated with an appropriate bone-sparing agent (OST03)
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre
Year: 2013/14

Rate of all fracture admissions in people aged 65+ (per 1,000 pop. 65+)

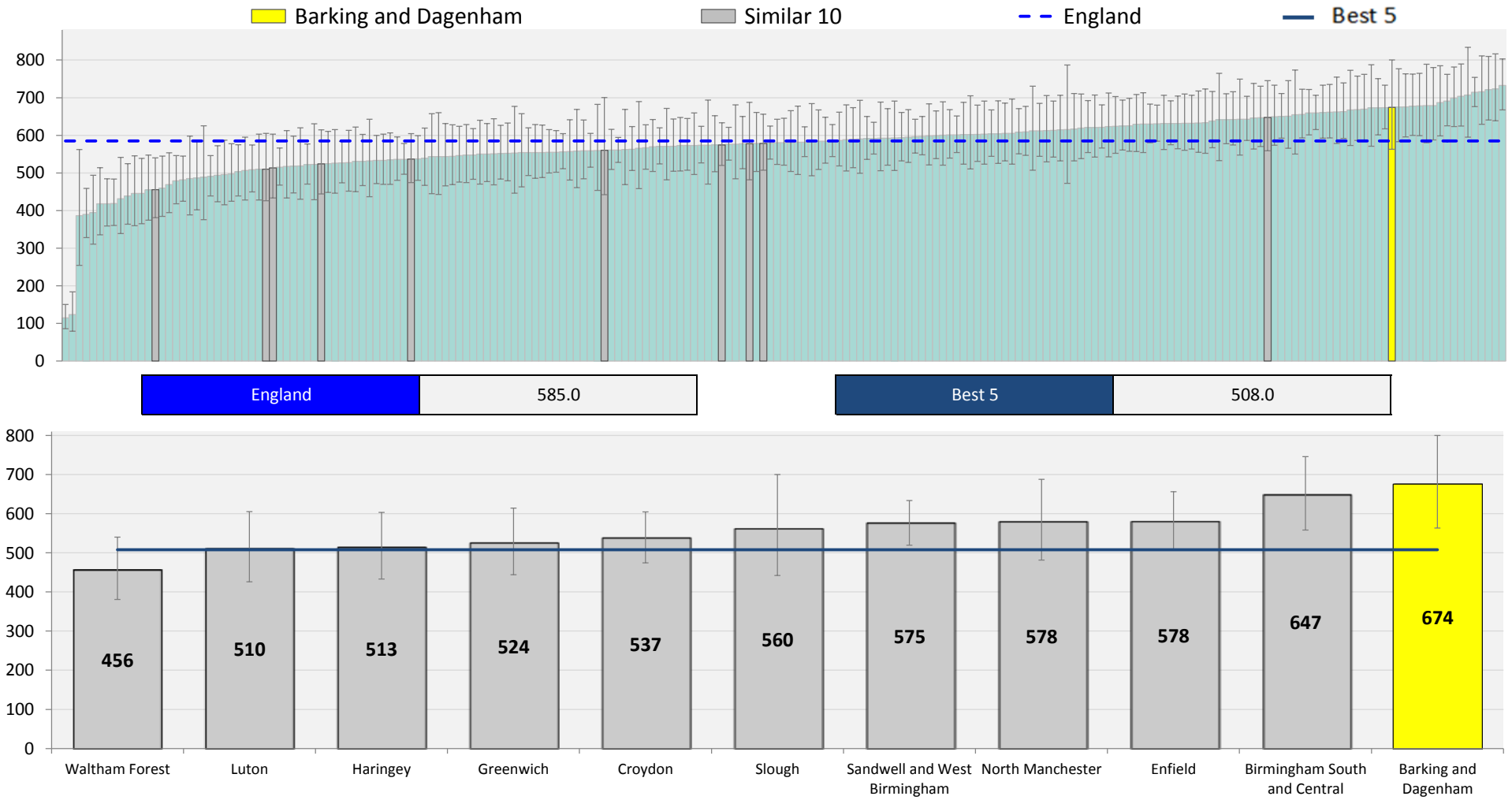
22 Adms (NSS)



Definition: Rate of all fracture admissions per 1,000 population aged 65+
Source: Hospital Episode statistics (HES)
Year: 2014/15

Hip fractures in people aged 65+ (per 100,000 pop)

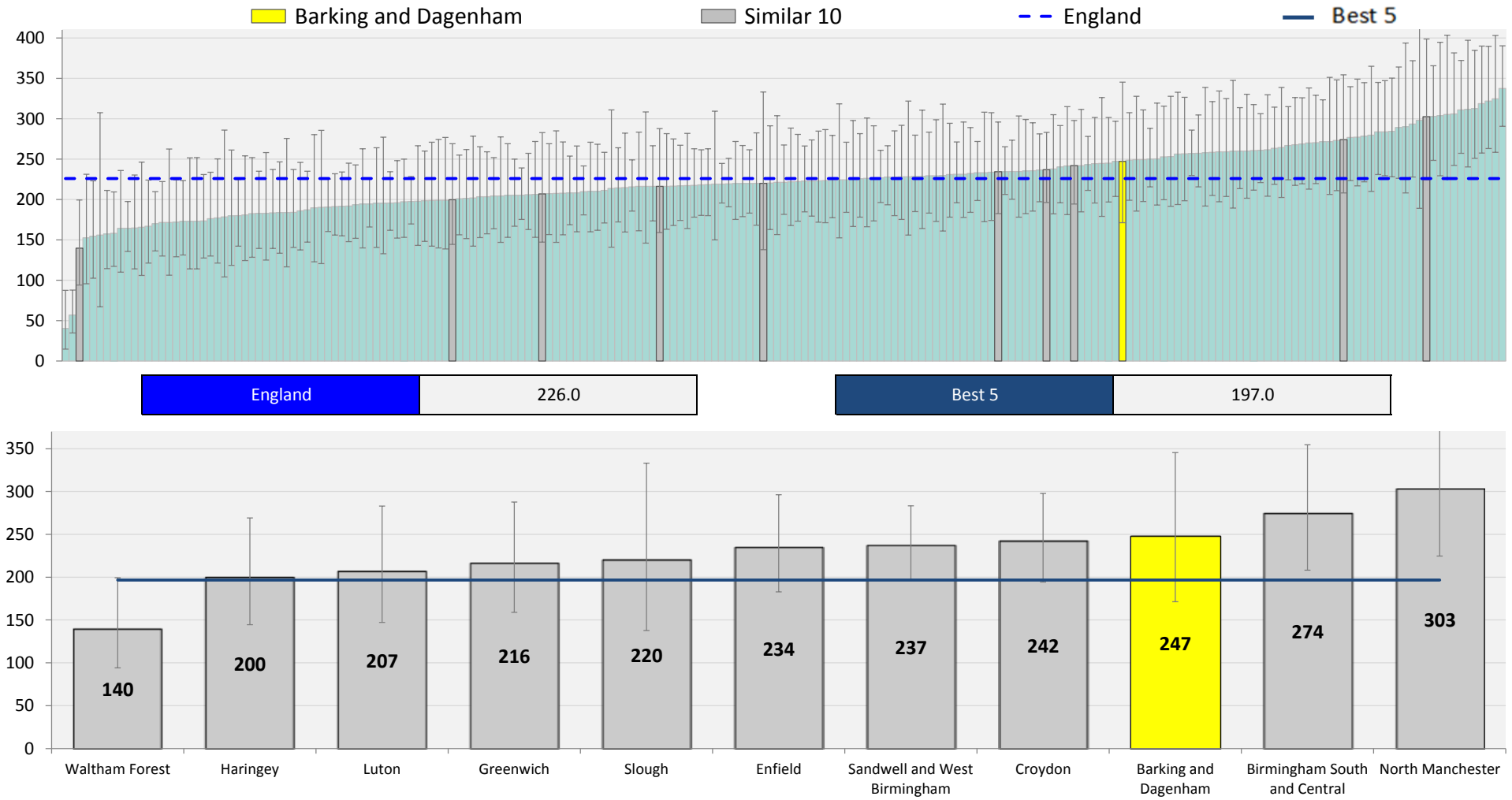
32 Adms



Definition: Hip fractures per 100,000 population aged 65+
Source: Hospital Episode statistics (HES)
Year: 2014/15

Hip fractures in people aged 65-79 (per 100,000 pop)

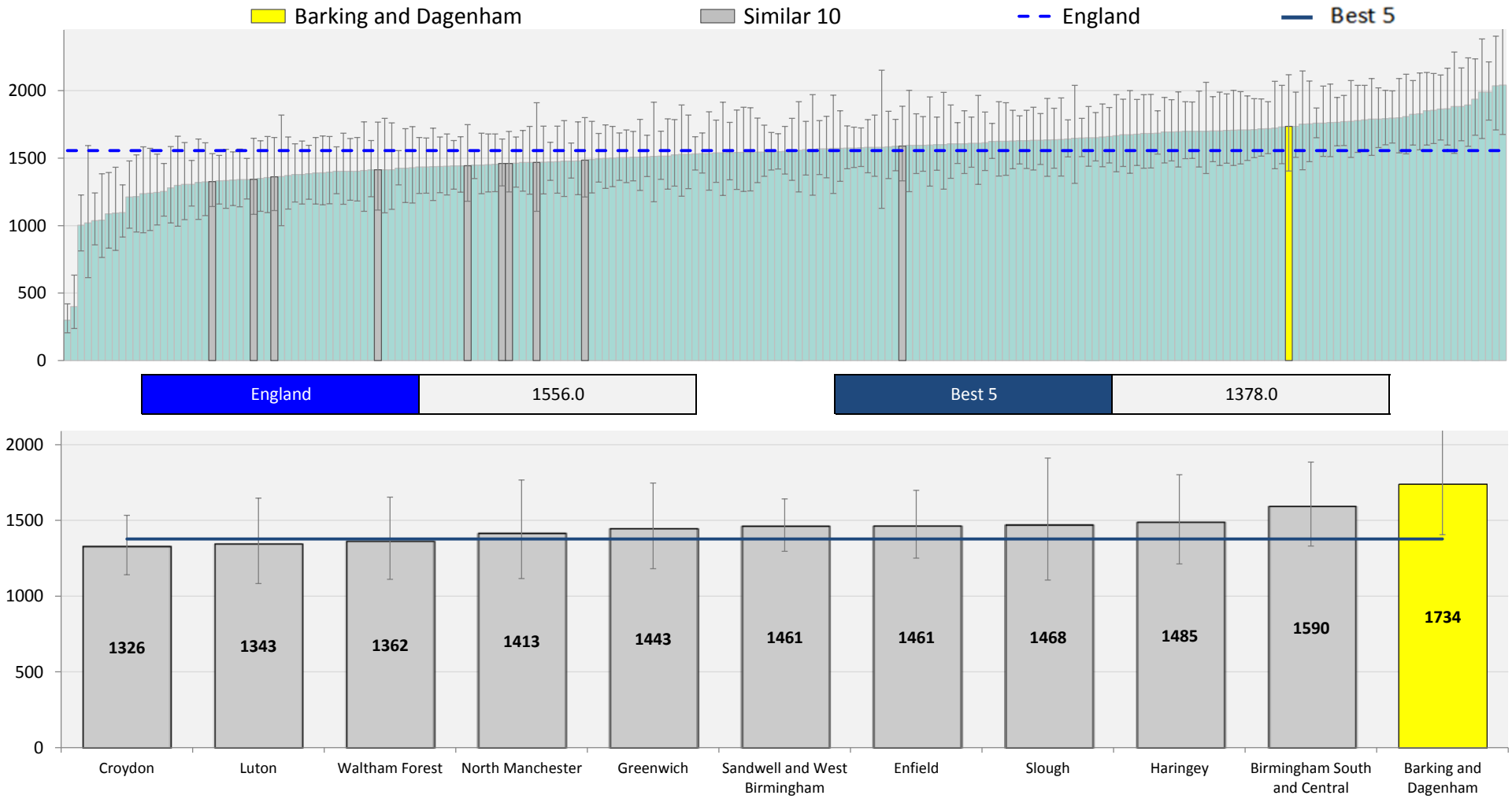
7 Adms (NSS)



Definition: Hip fractures per 100,000 population aged 65-79
Source: Hospital Episode statistics (HES)
Year: 2014/15

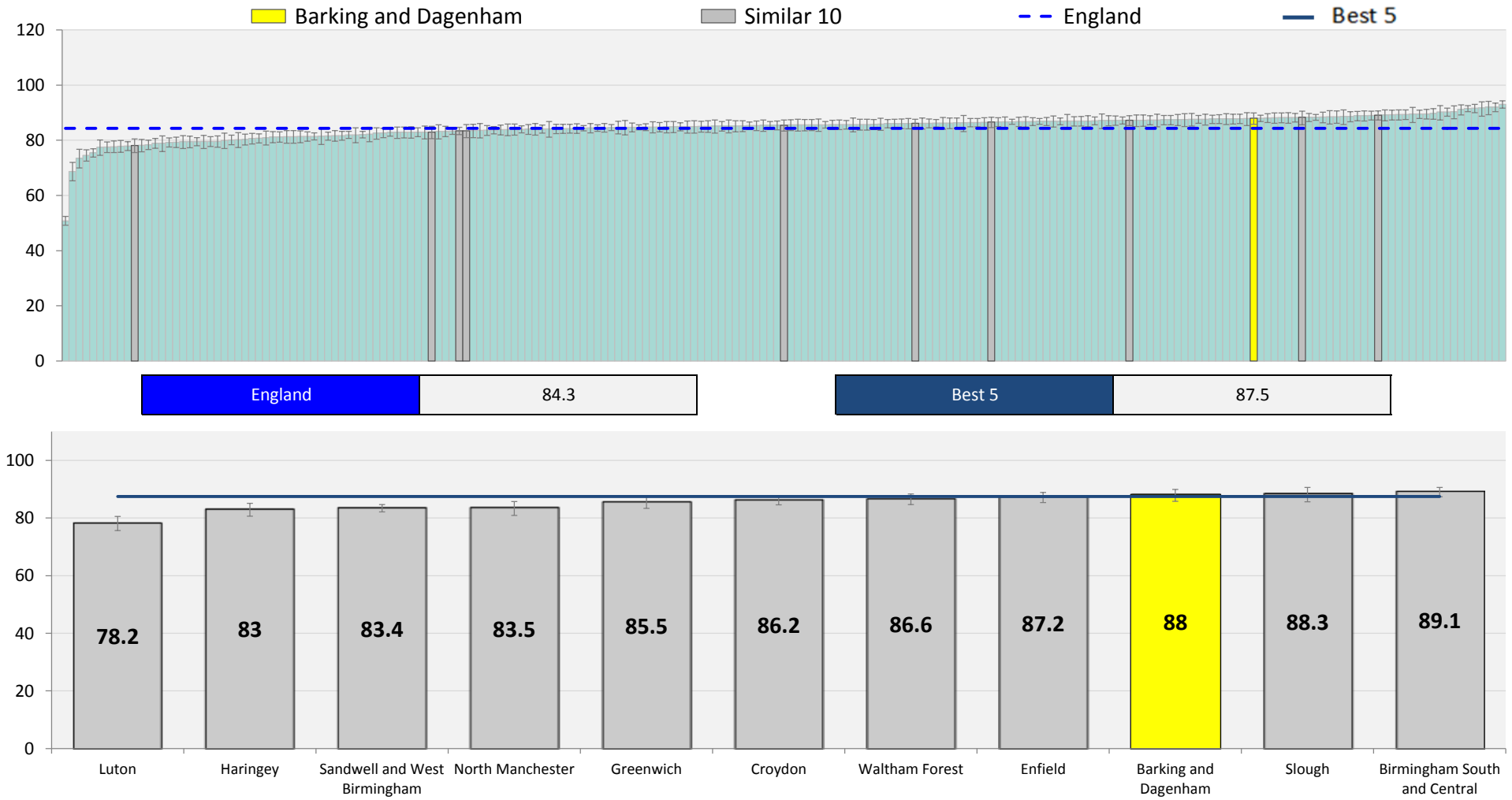
Hip fractures in people aged 80+ (per 100,000 pop)

20 Adms



Definition: Hip fractures per 100,000 population aged 80+
Source: Hospital Episode statistics (HES)
Year: 2014/15

% of patients with Rheumatoid Arthritis who have had a review in the last 12 months

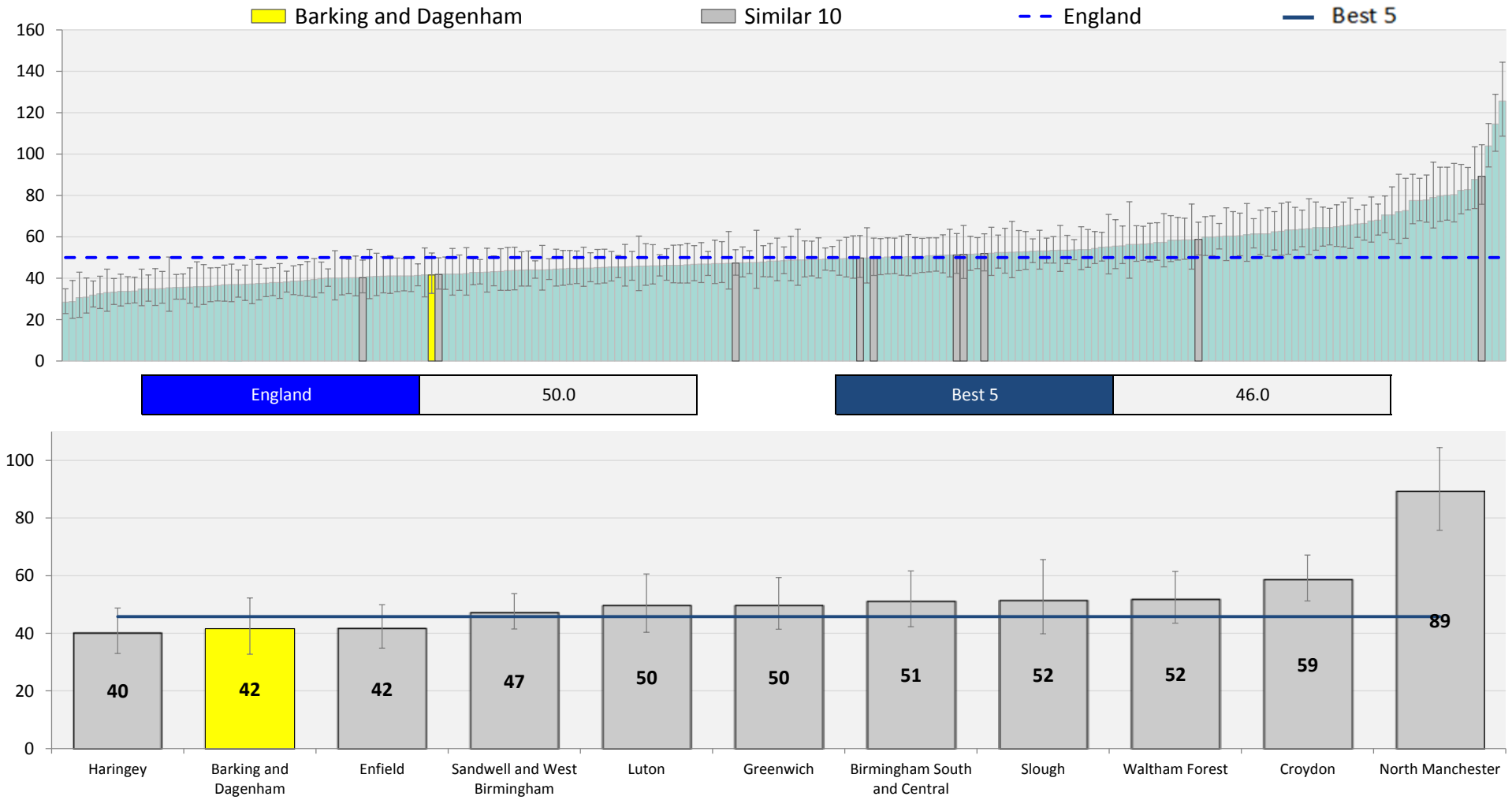


Definition: The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months

Source: Quality and Outcomes Framework, HSCIC

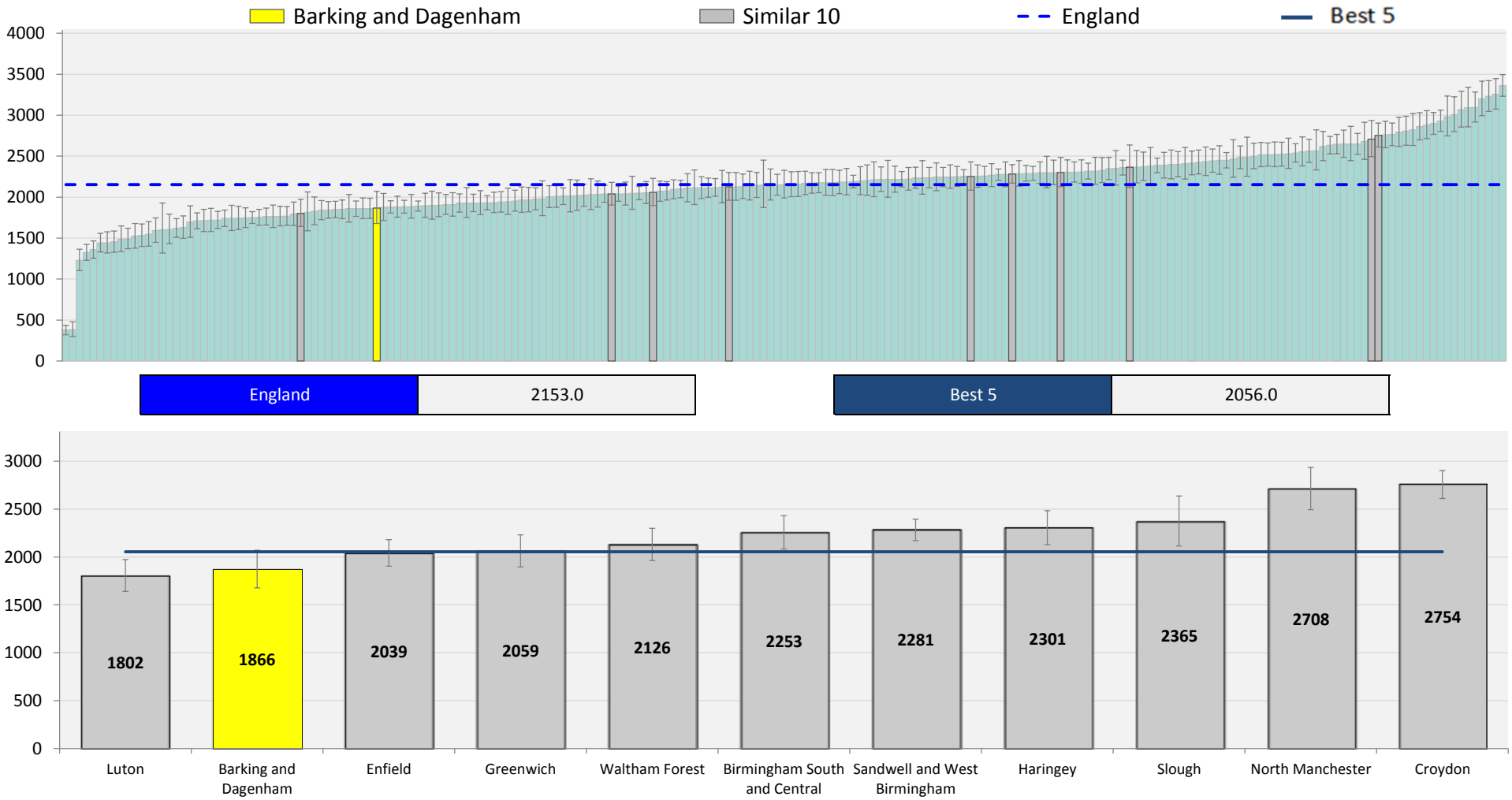
Year: 2014/15

Emergency admissions for Back, neck and MSK pain (per 100,000 pop)



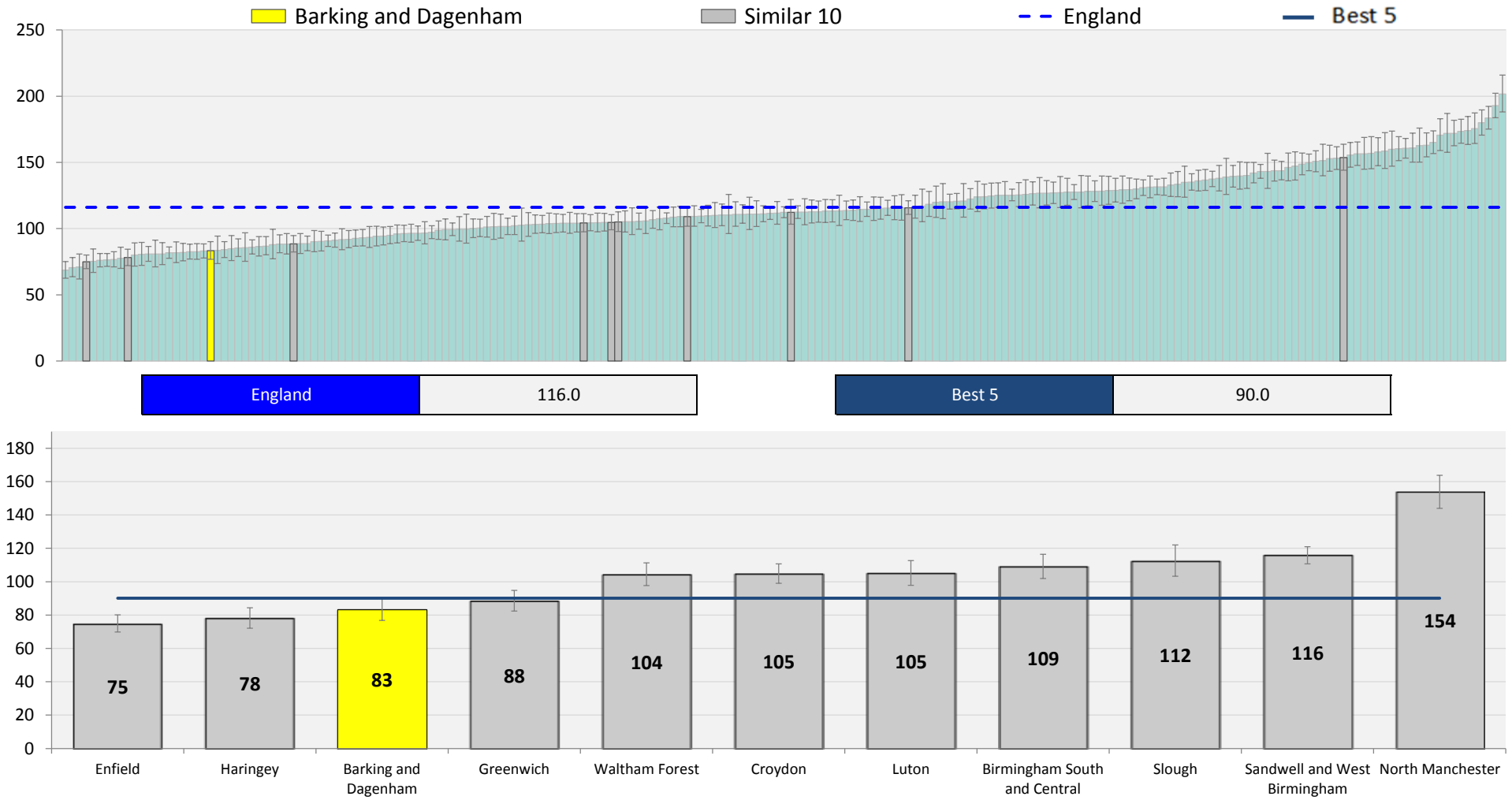
Definition: Number of Emergency admissions for back, neck and musculoskeletal pain per 100,000 Population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries due to falls in people aged 65+ (per 100,000 pop)



Definition: Injuries due to falls per 100,000 population aged 65+
Source: Hospital Episode statistics (HES)
Year: 2014/15

Unintentional and deliberate injury admissions, 0-24 years (per 100,000 pop)



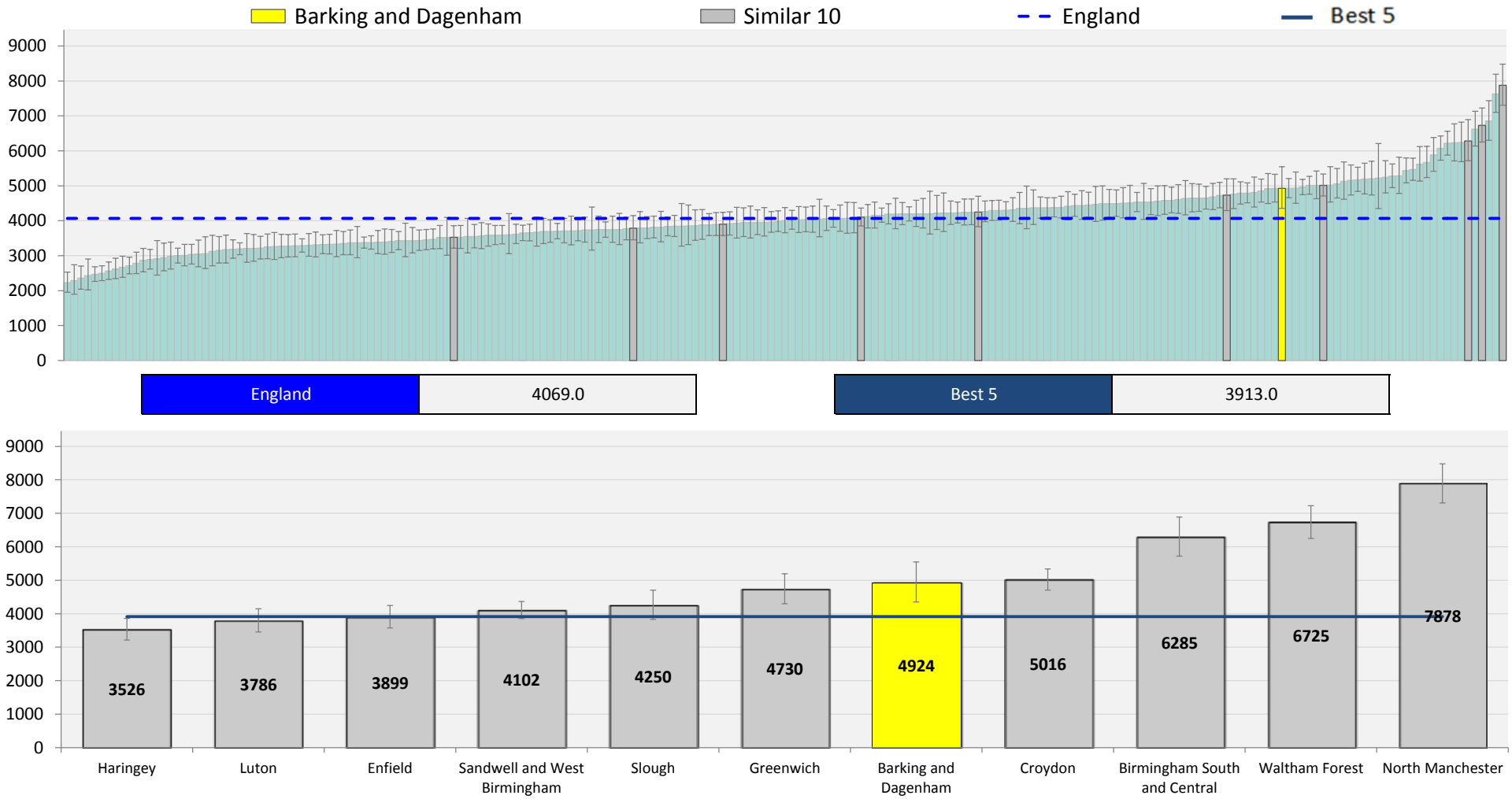
Definition: Hospital admissions caused by unintentional and deliberate injury for those aged 0-24 per 10,000 population

Source: Hospital Episode Statistics (HES), The Health and Social Care Information Centre. Office for National Statistics (ONS). Community Mental Health Profile (CMHP), Fingertips, Public Health England

Year: 2012/13

MSK - Non-elective spend (£ per 1,000 pop)

£159k



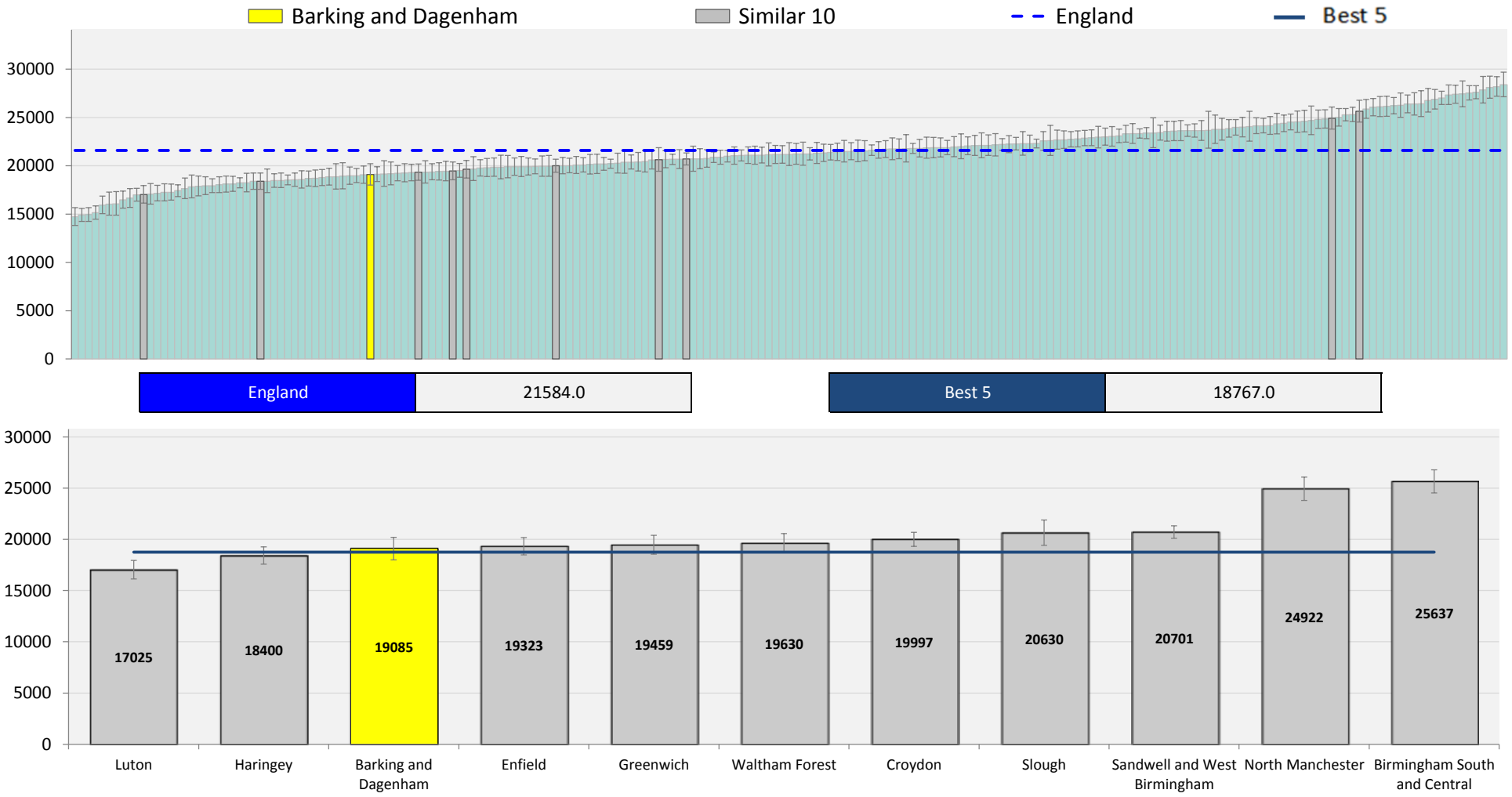
Definition: MSK - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Trauma - Non-elective spend (£ per 1,000 pop)

£51k (NSS)



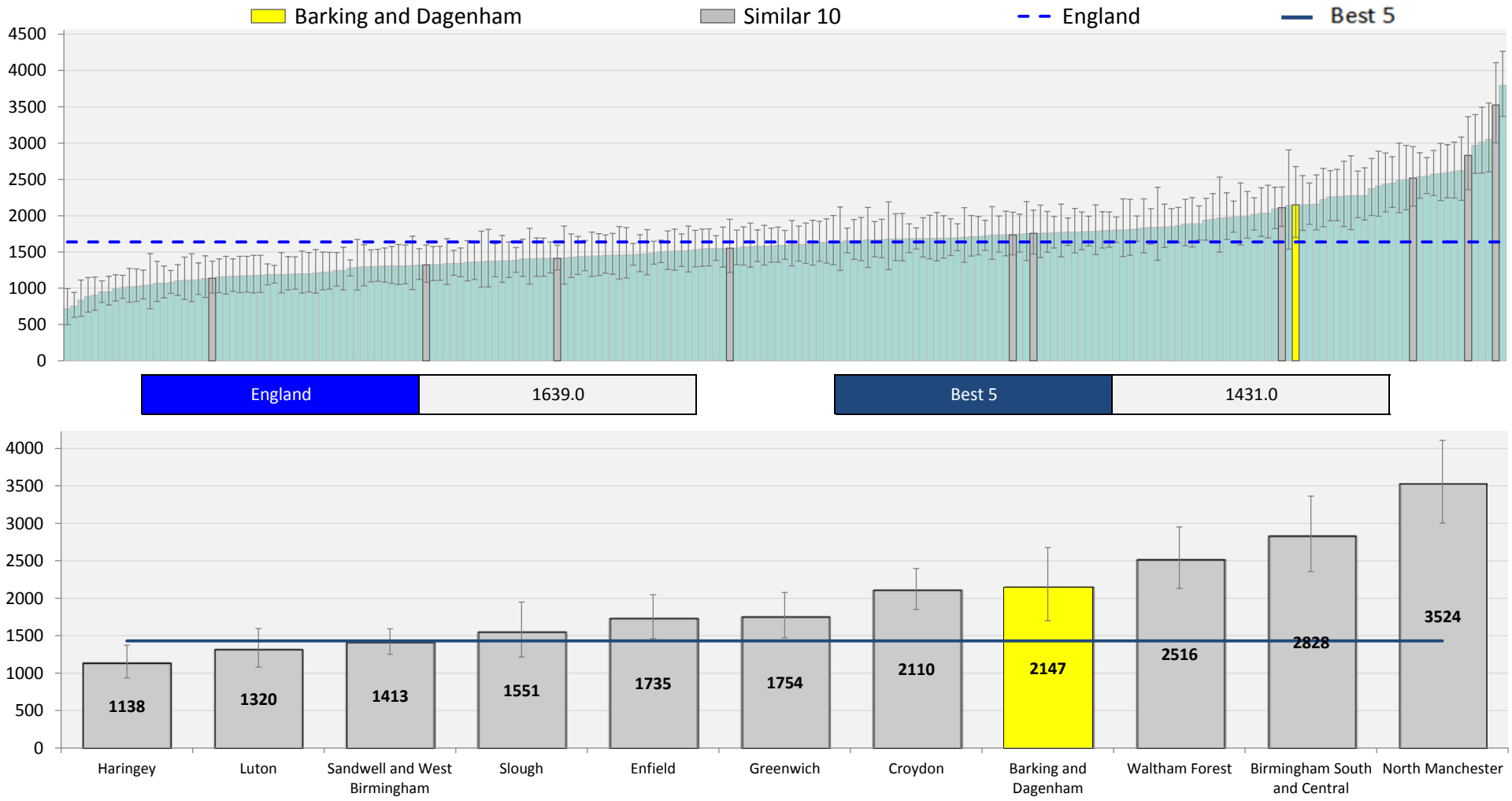
Definition: Trauma and Injuries - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Back, neck and MSK pain - non-elective spend (£ per 1,000 pop)

£115k



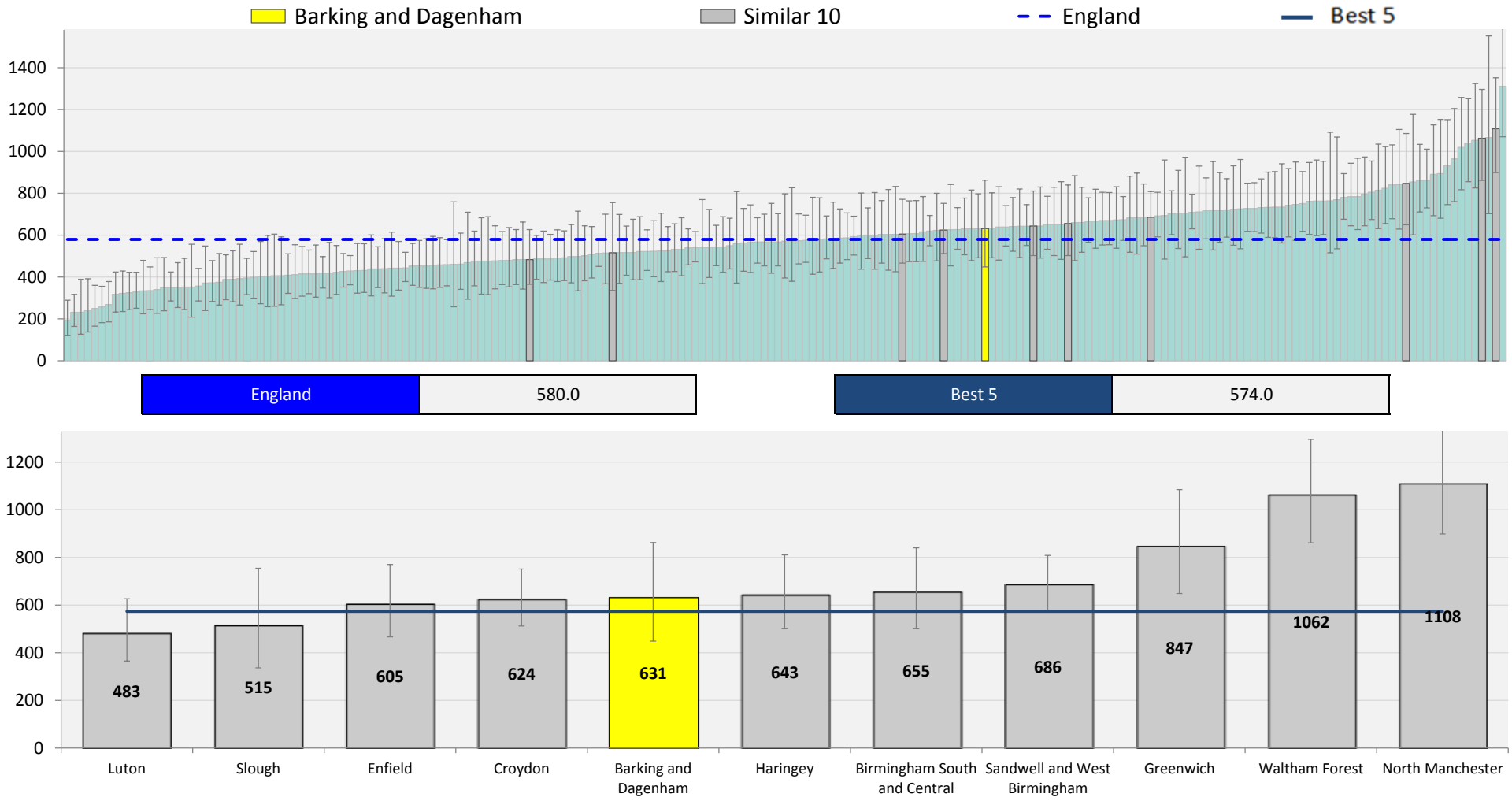
Definition: Back, neck and musculoskeletal pain - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Rheumatoid and Inflammatory Arthritis - non-elective spend (£ per 1,000 pop)

£9k (NSS)



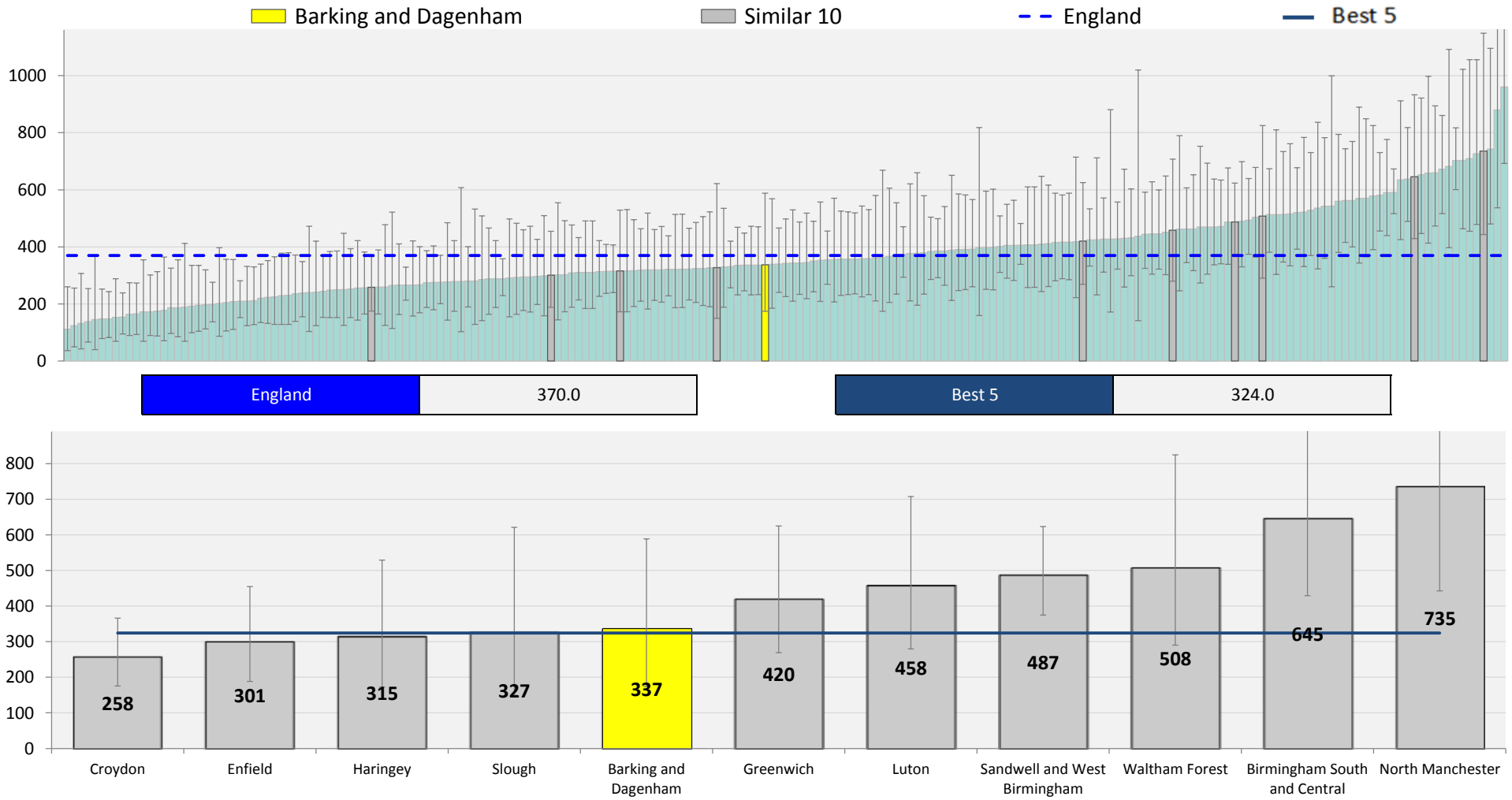
Definition: Rheumatoid and Inflammatory Arthritis - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Osteoporosis and fragility fractures - non-elective spend (£ per 1,000 pop)

£2k (NSS)



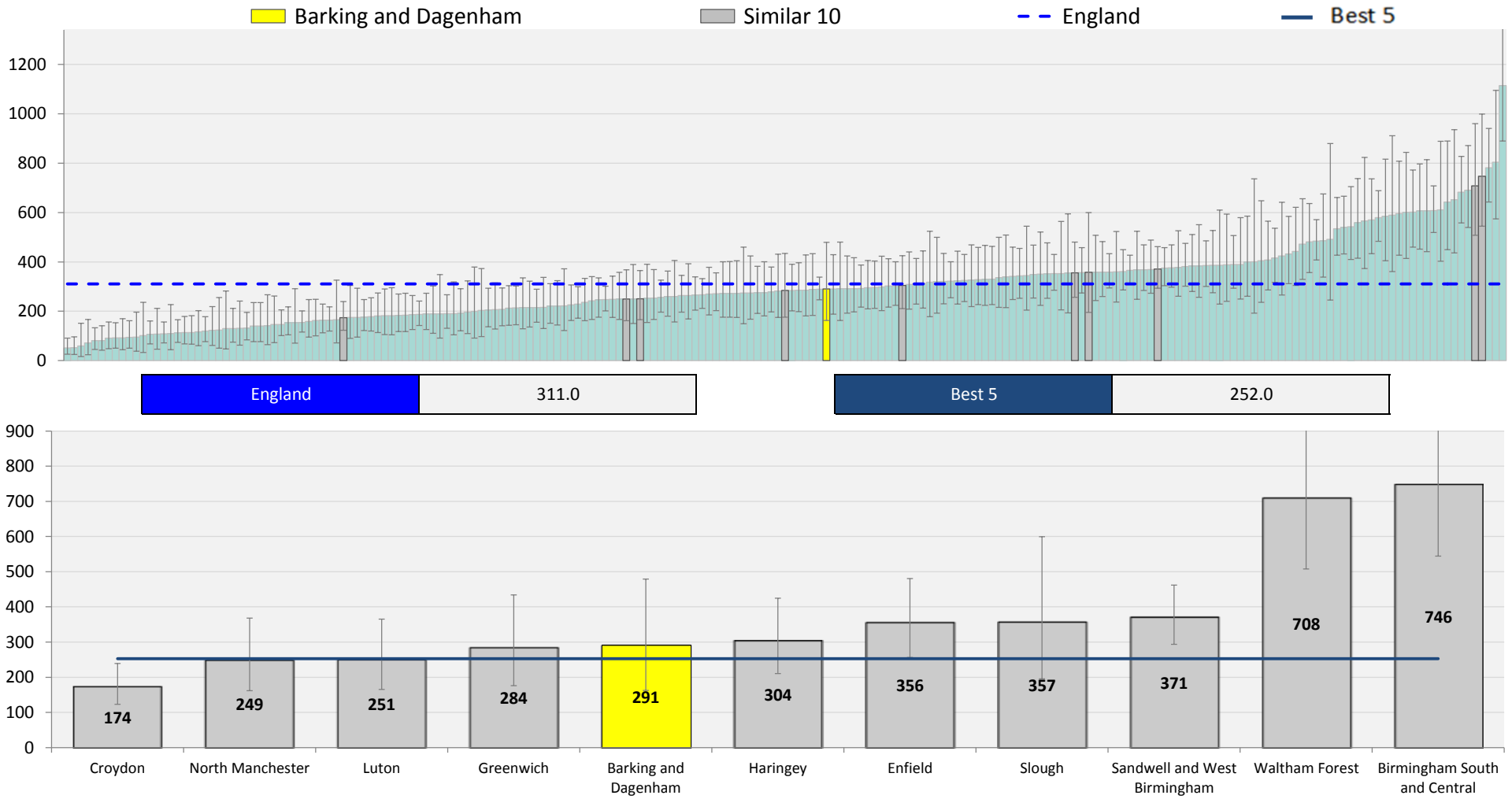
Definition: Osteoporosis and fragility fractures - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Osteoarthritis - non-elective spend (£ per 1,000 pop)

£5k (NSS)



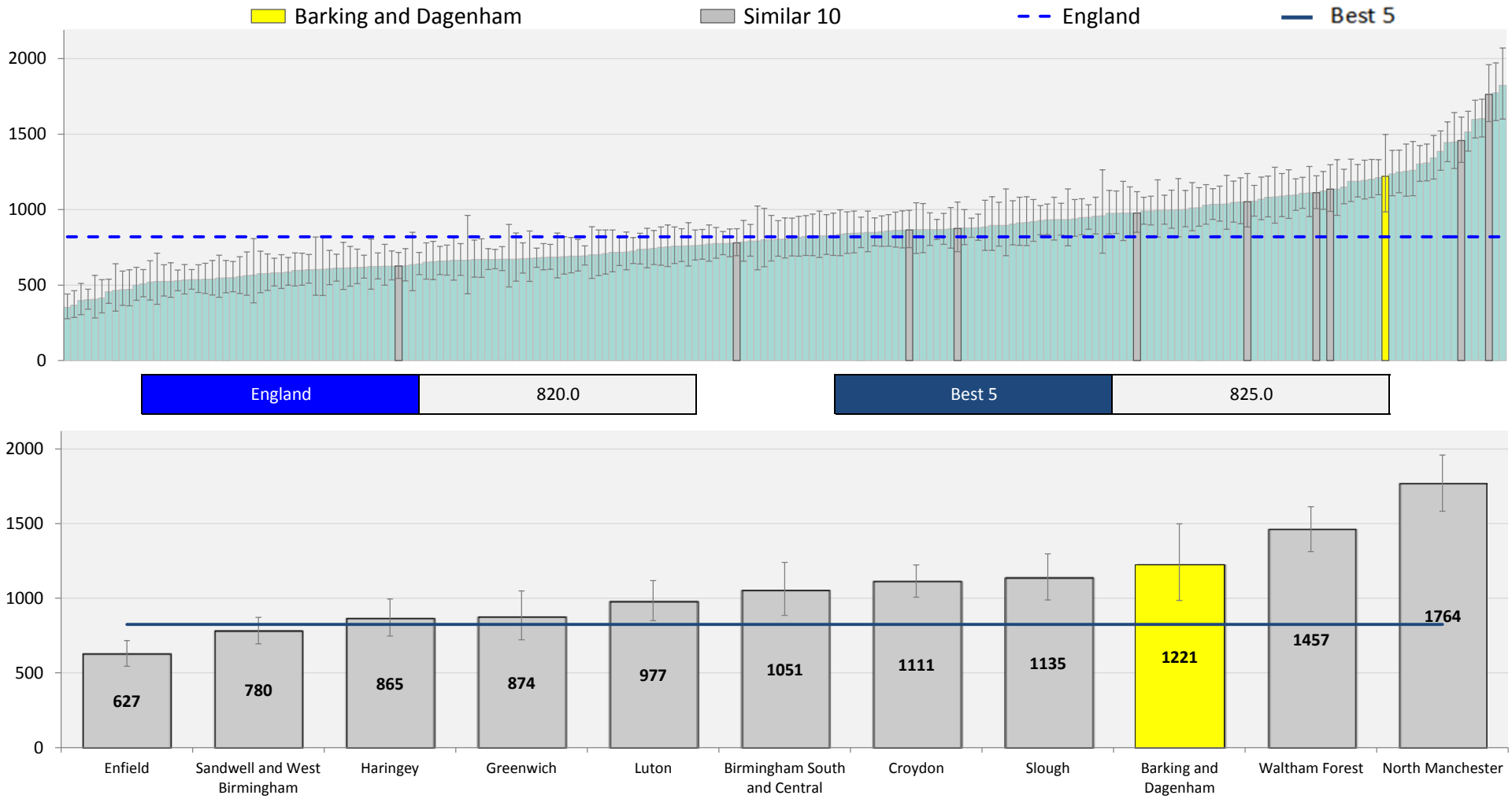
Definition: Osteoarthritis - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Other MSK conditions - non-elective spend (£ per 1,000 pop)

£67k

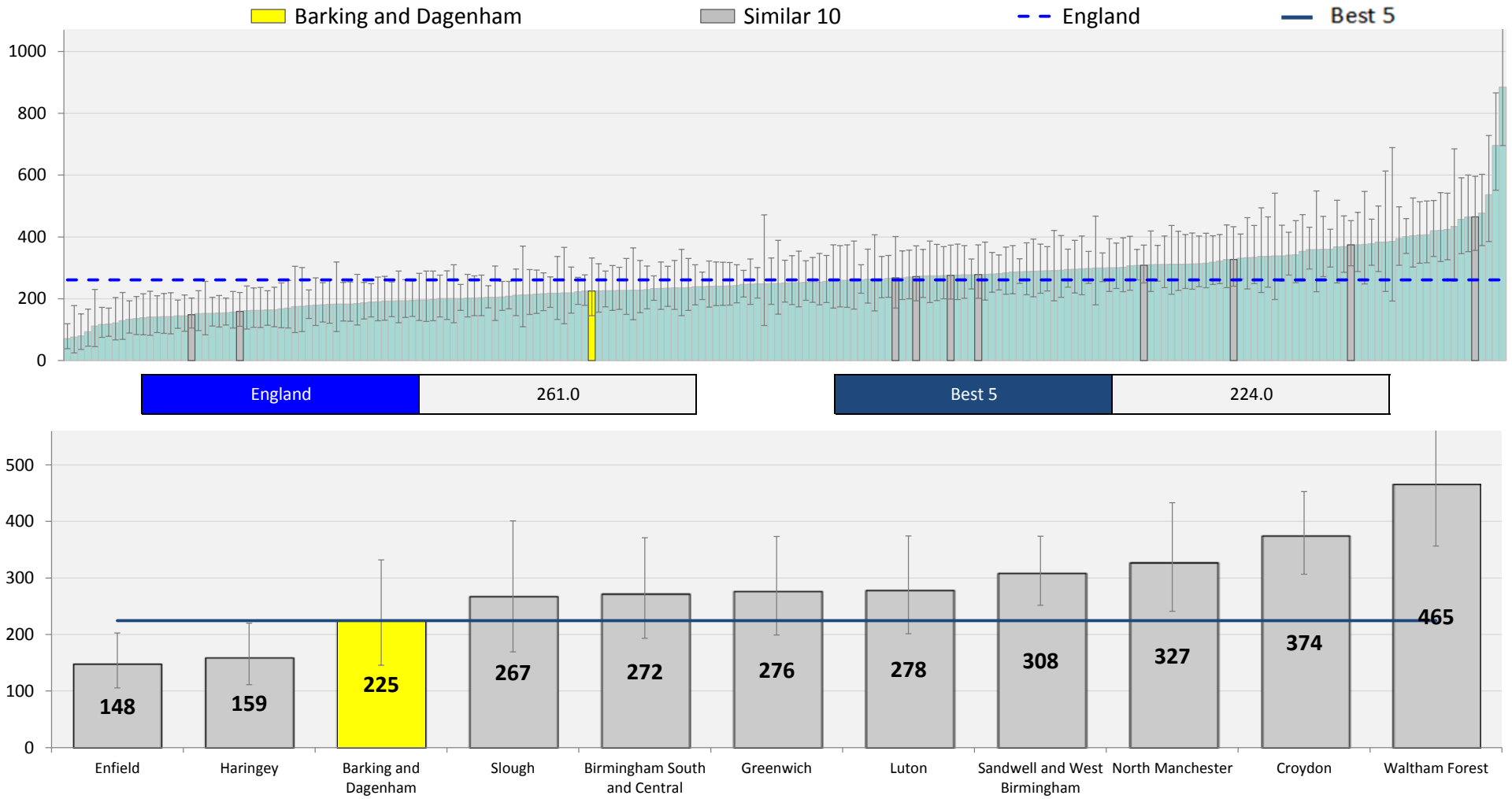


Definition: Other MSK - Total Non-elective spend on admissions per 1,000 population

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

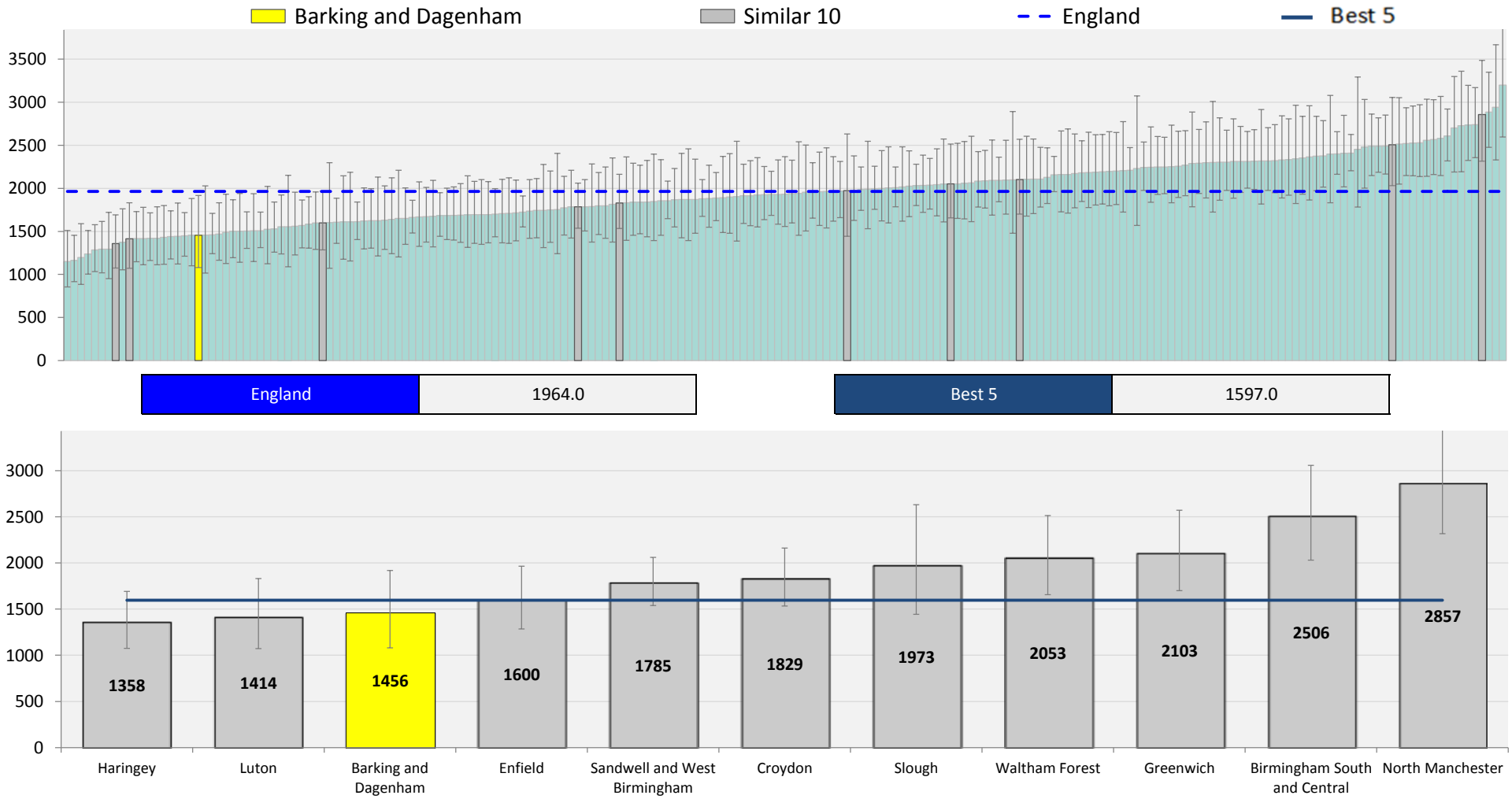
Year: 2014/15

Other joint disorders - non-elective spend (£ per 1,000 pop)



Definition: Other joint disorders (not including osteoarthritis or rheumatoid arthritis) - Total Non-elective spend on admissions per 1,000 population
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

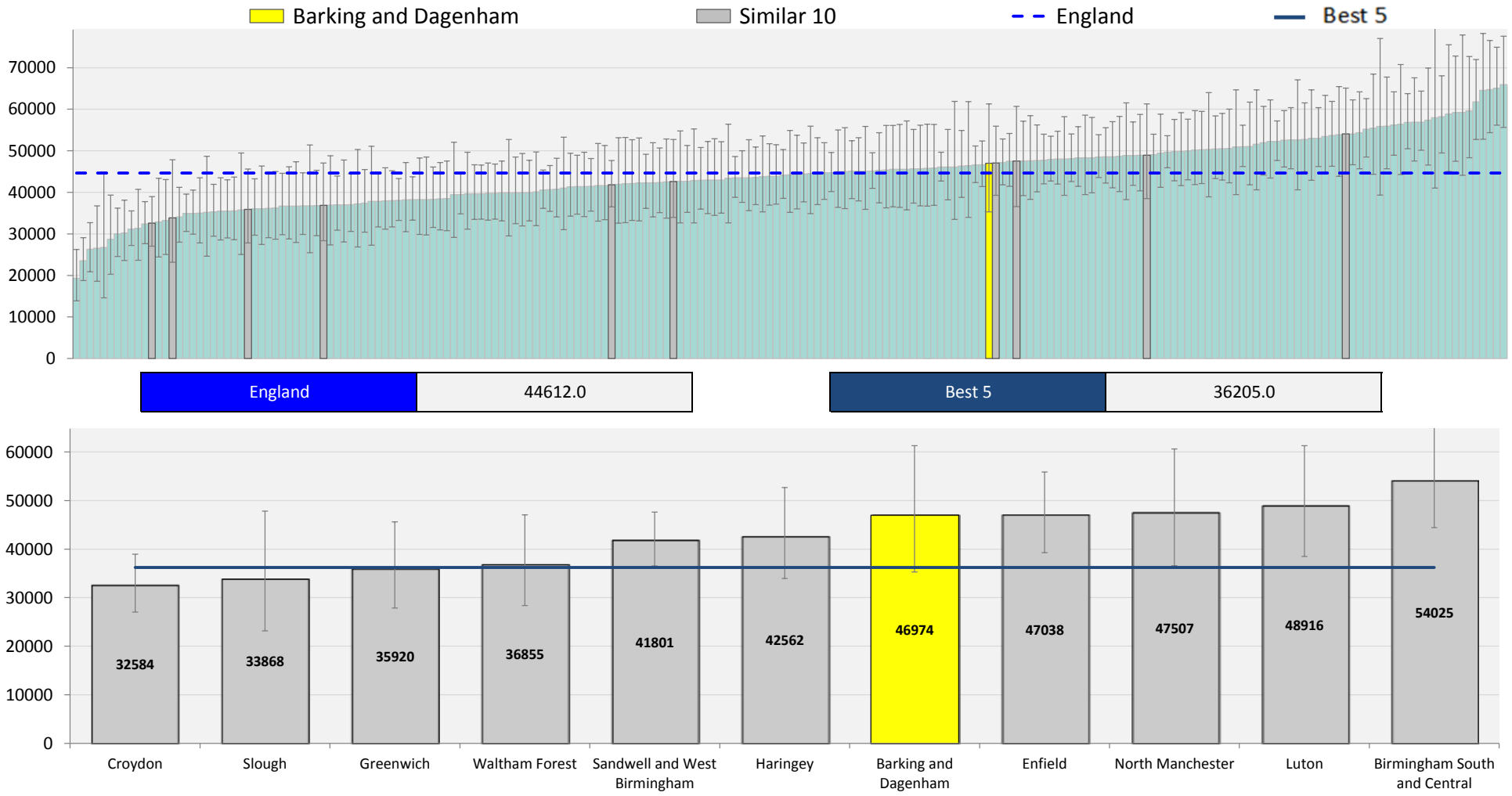
Injuries to the hip and thigh - Under 75s - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to hip and thigh - Under 75s
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the hip and thigh - 75-84 - Spend (£ per 1,000 pop)

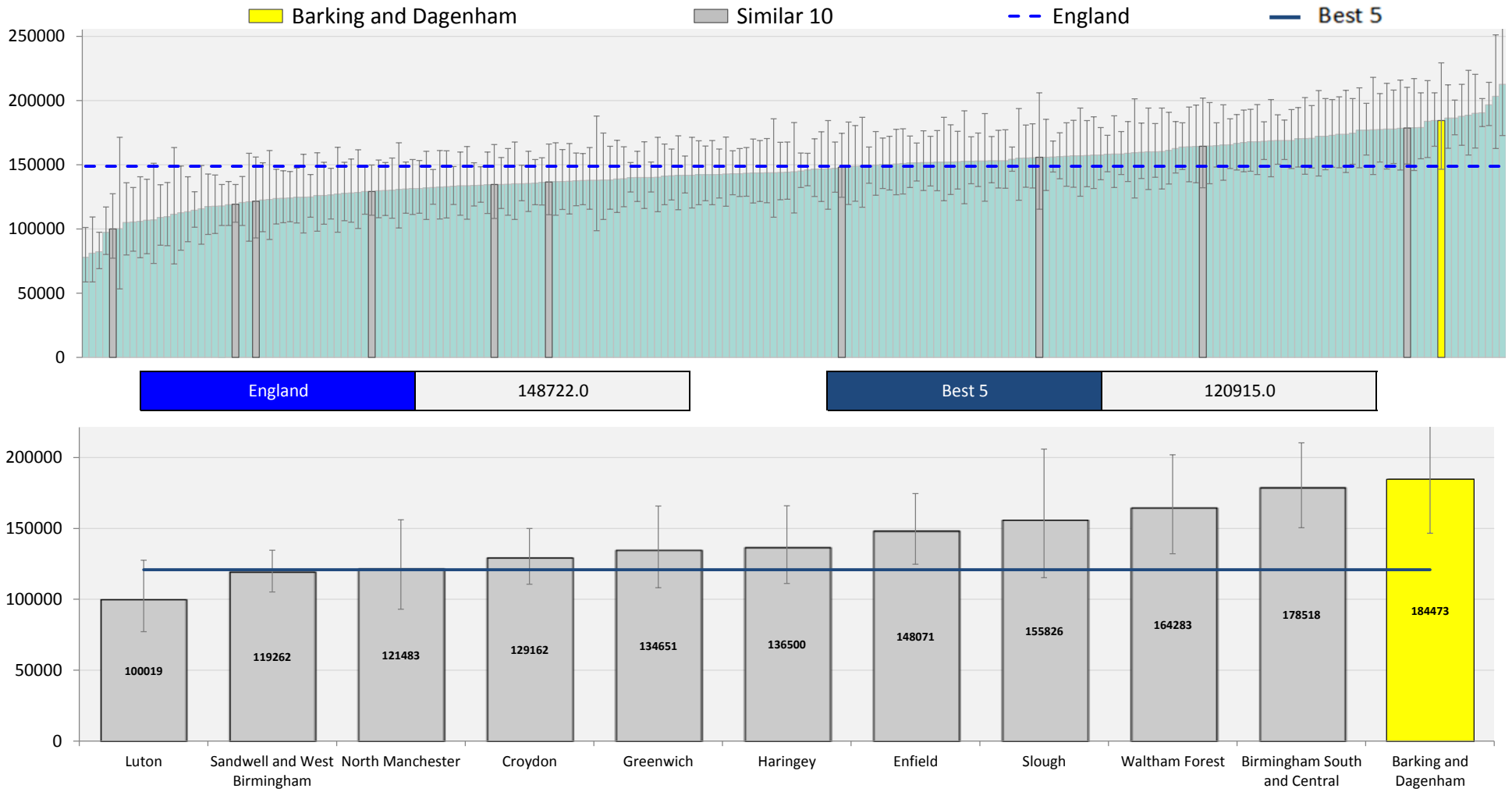
£70k (NSS)



Definition: Spend - Injuries to hip and thigh - 75-84
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the hip and thigh - 85+ - Spend (£ per 1,000 pop)

£174k

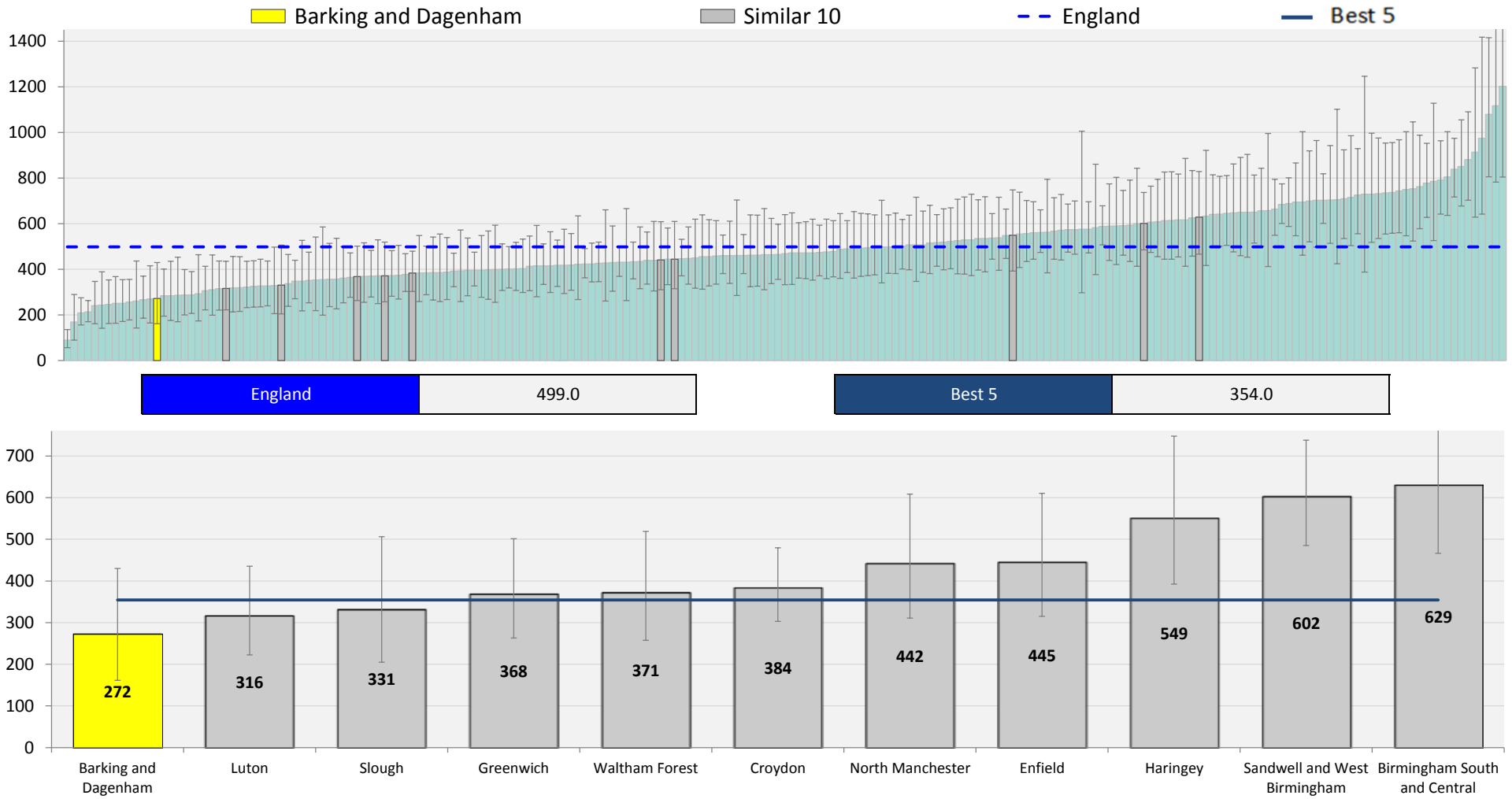


Definition: Spend - Injuries to hip and thigh - 85+

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

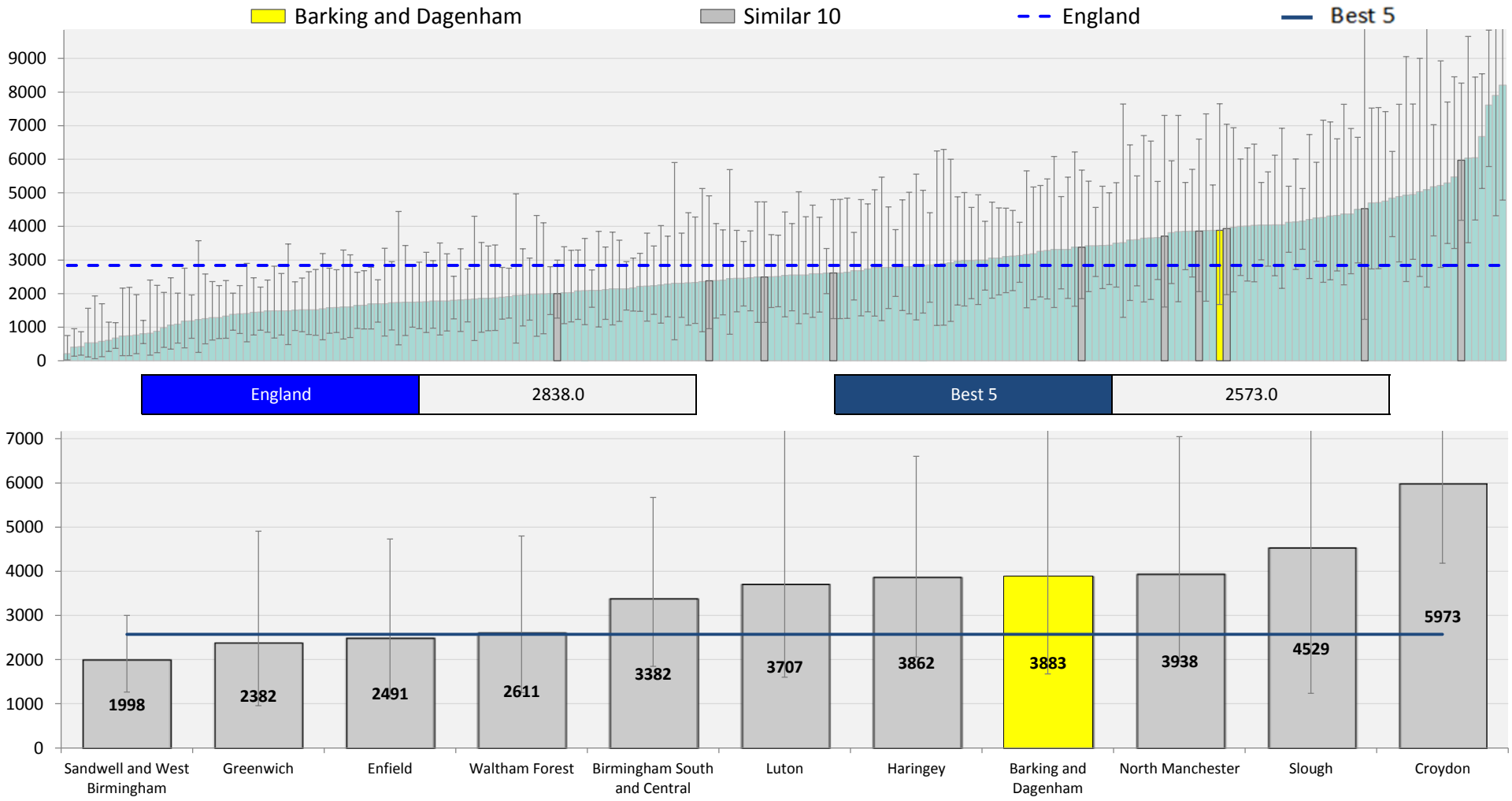
Injuries to the thorax - Under 75s - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to thorax - Under 75s
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the thorax - 75-84 - Spend (£ per 1,000 pop)

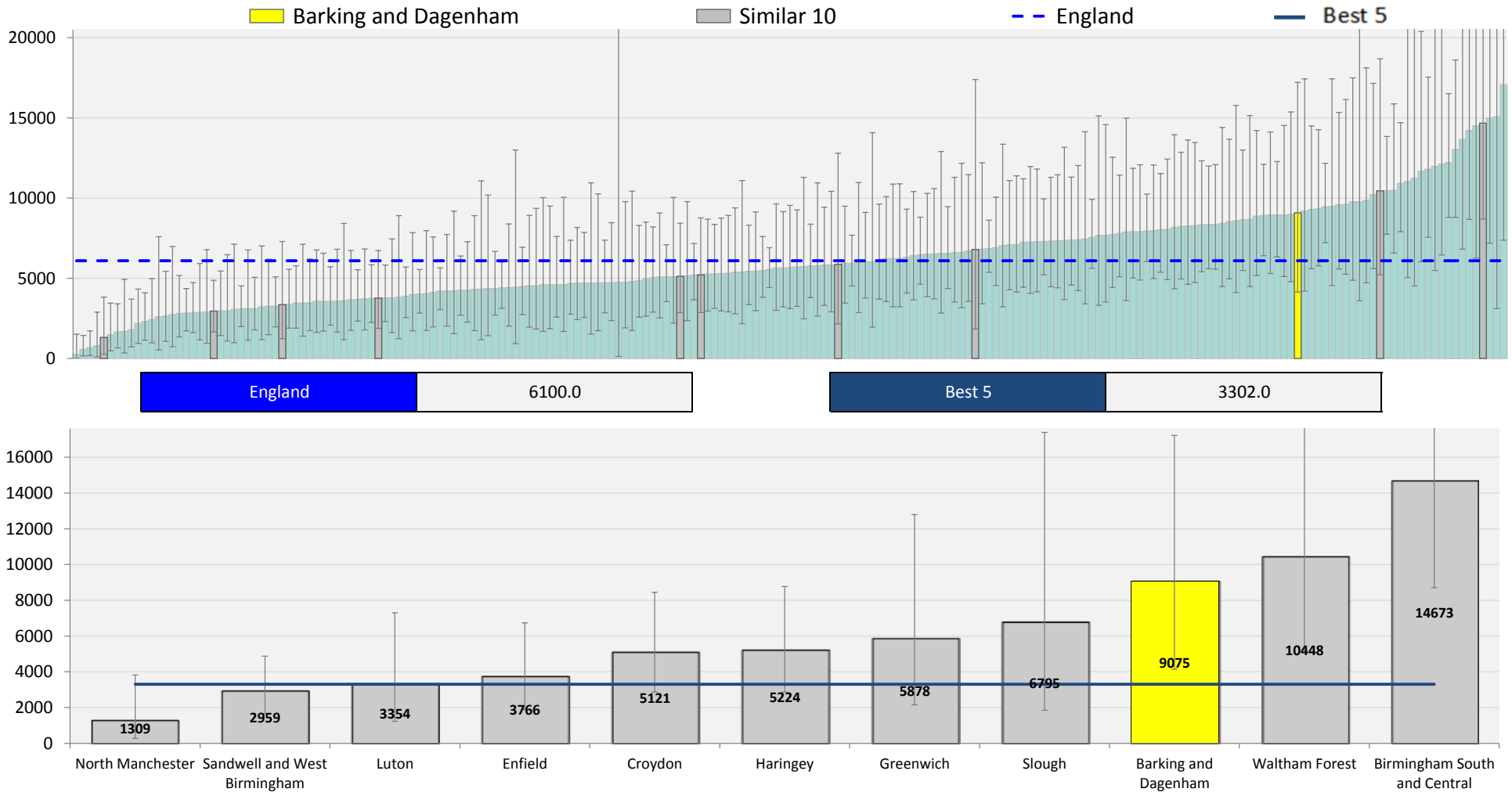
£8k (NSS) | 100



Definition: Spend - Injuries to thorax - 75-84
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the thorax - 85+ - Spend (£ per 1,000 pop)

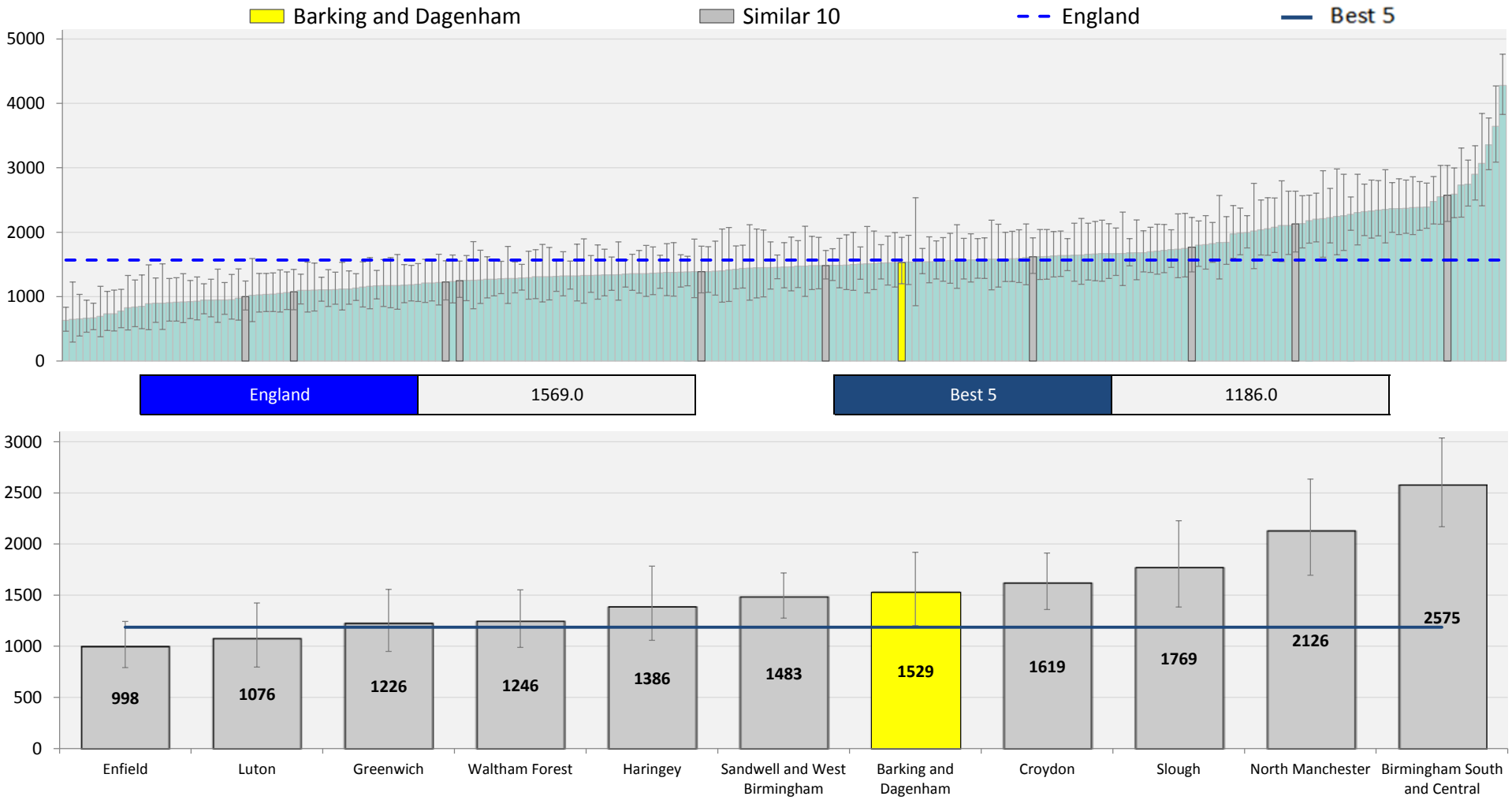
£16k | 101



Definition: Spend - Injuries to thorax - 85+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the wrist and hand - 0-18 - Spend (£ per 1,000 pop)

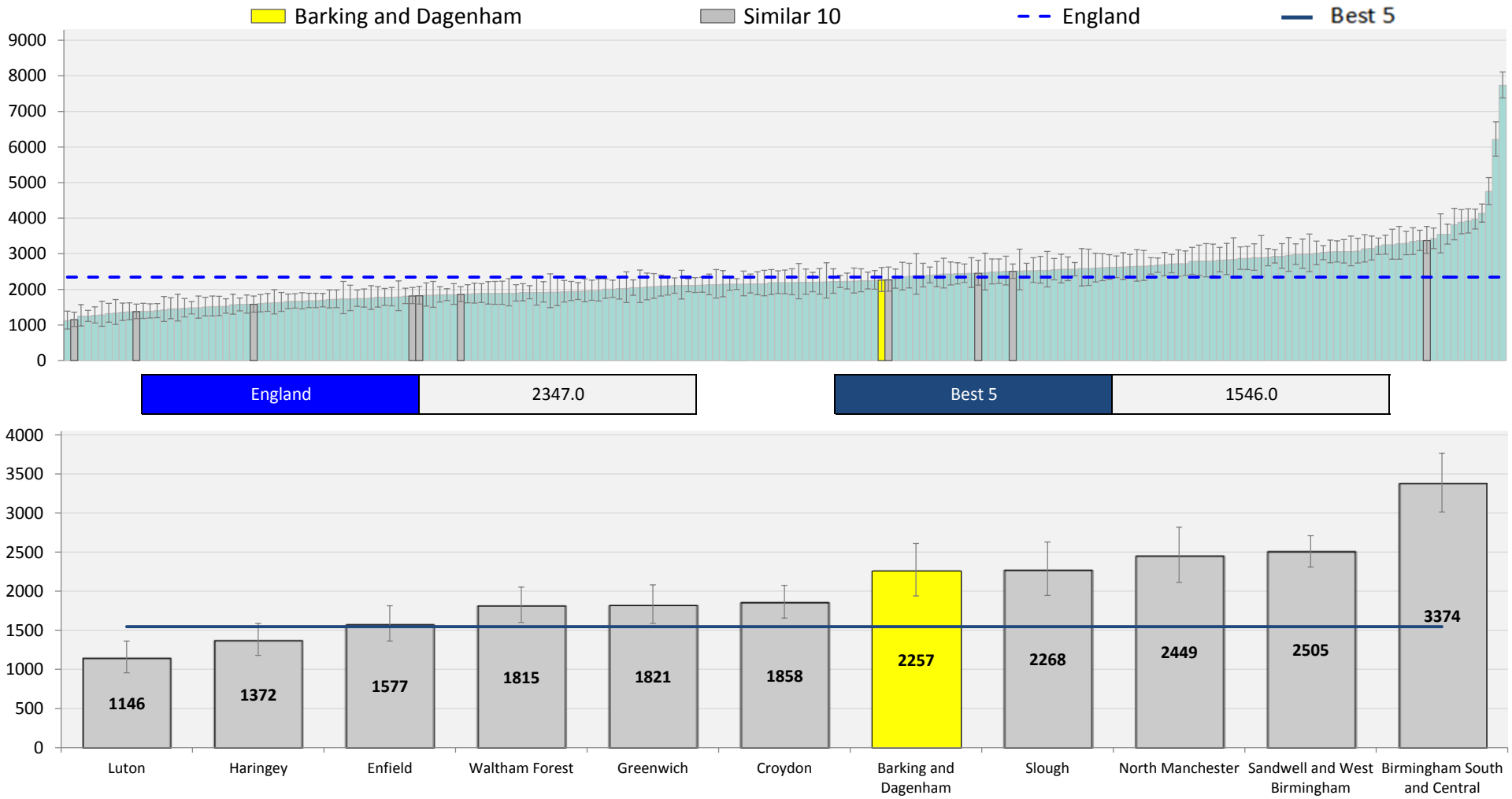
£21k



Definition: Spend - Injuries to wrist and hand - 0-18
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

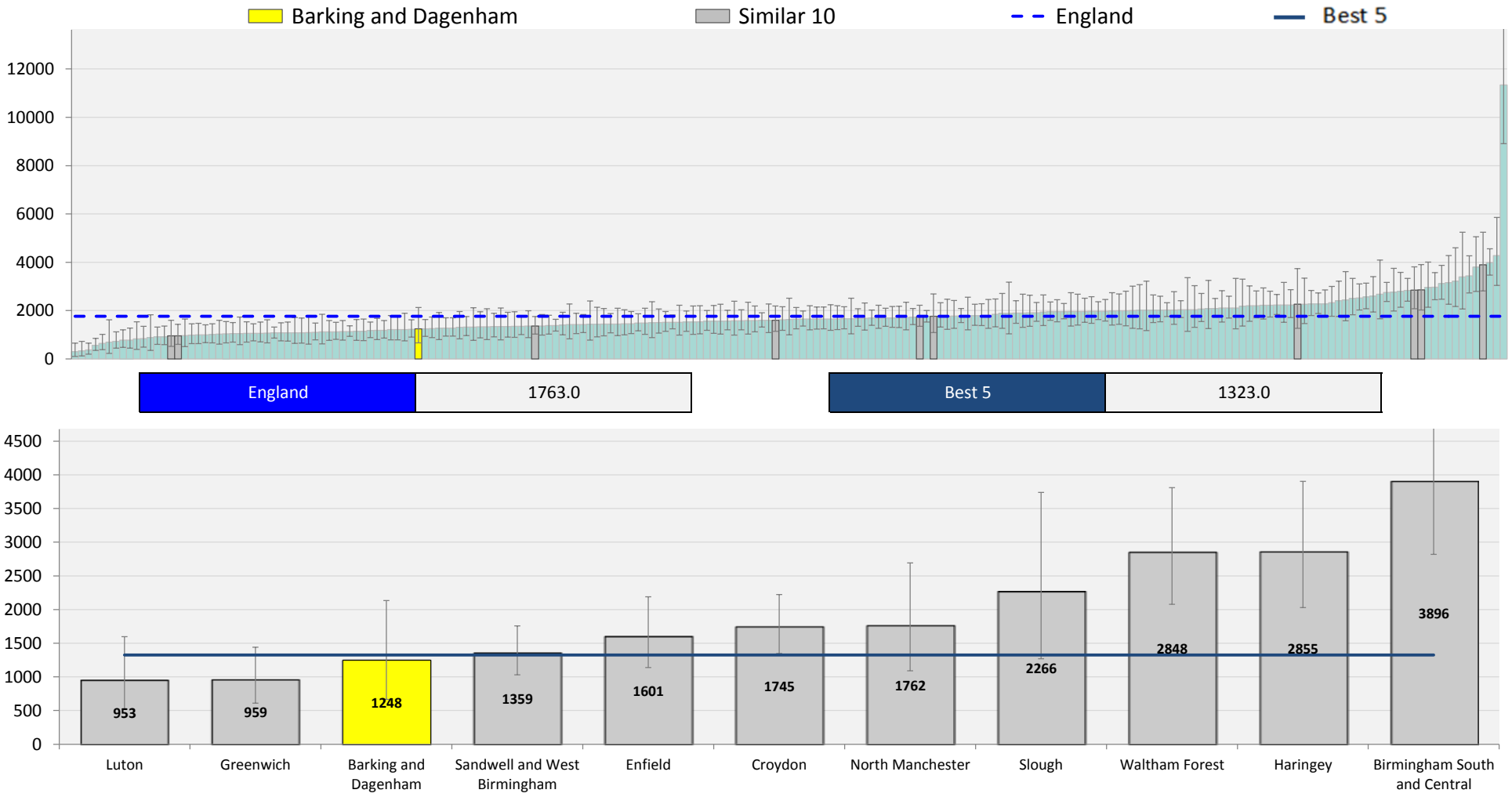
Injuries to the wrist and hand - 19-64 - Spend (£ per 1,000 pop)

£102k | 103



Definition: Spend - Injuries to wrist and hand - 19-64
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

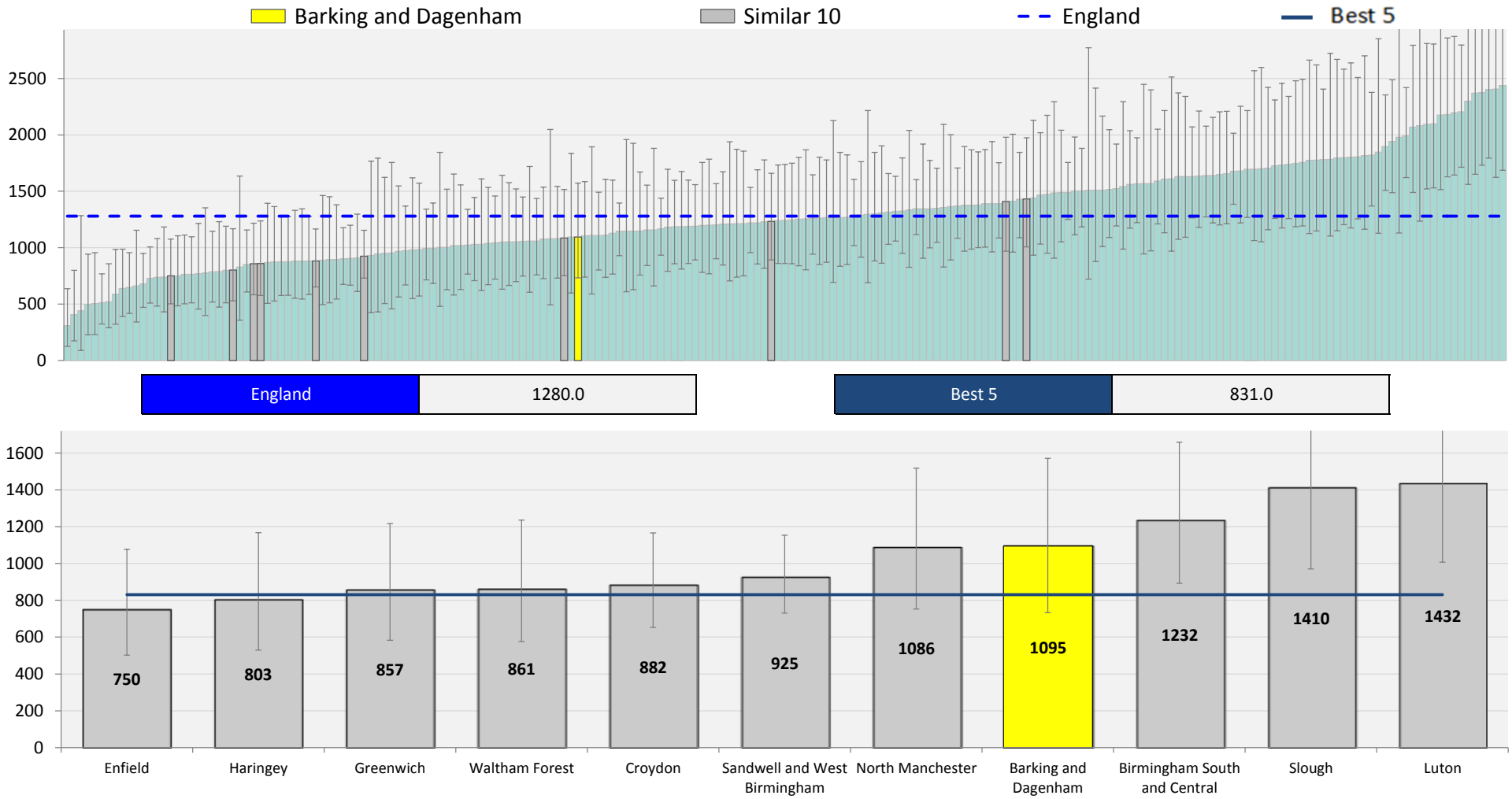
Injuries to the wrist and hand - 65+ - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to wrist and hand - 65+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the shoulder and upper arm - 0-18 - Spend (£ per 1,000 pop)

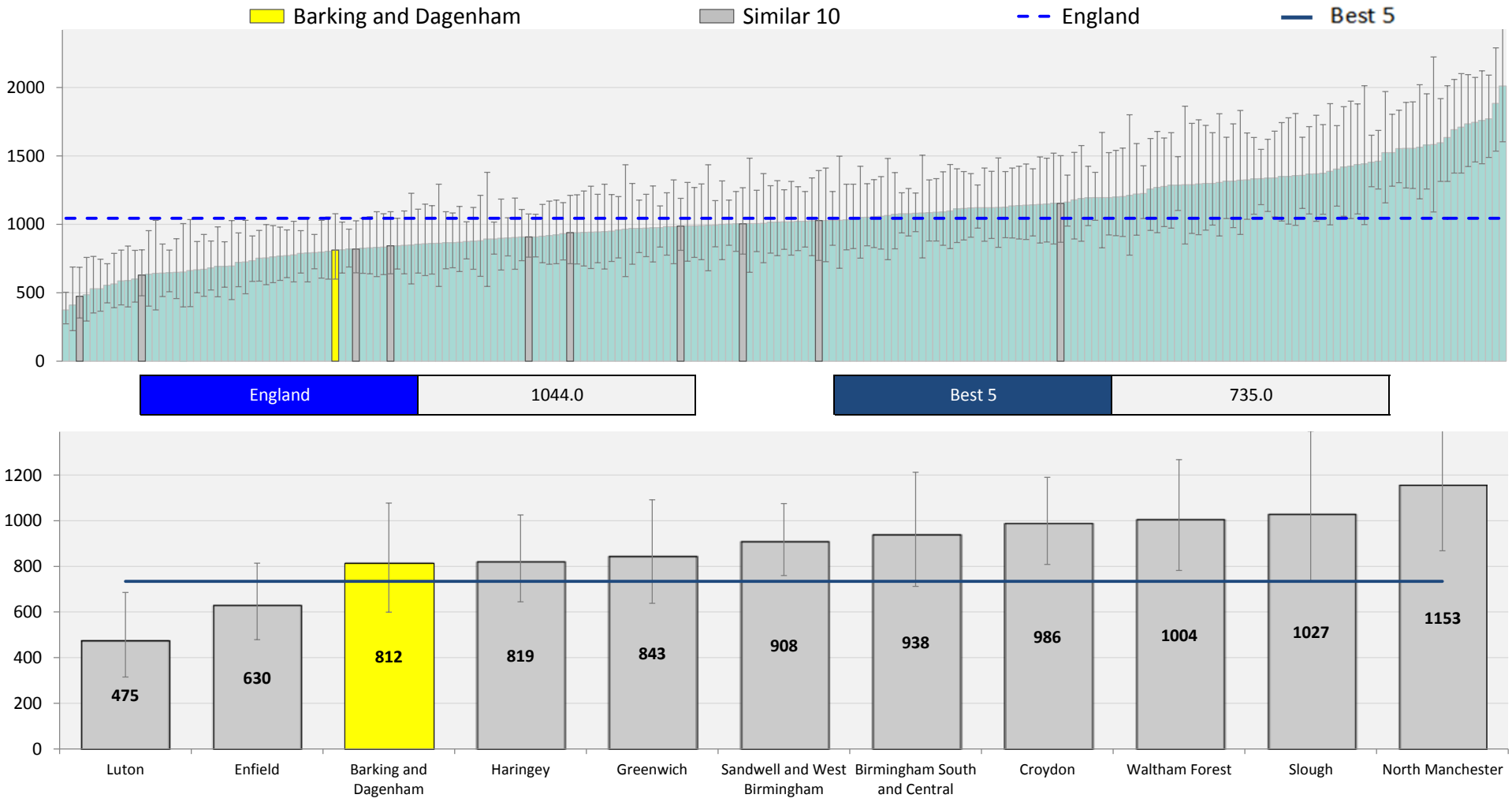
£18k (NSS)



Definition: Spend - Injuries to shoulder and upper arm - 0-18
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the shoulder and upper arm - 19-64 - Spend (£ per 1,000 pop)

£10k (NSS)

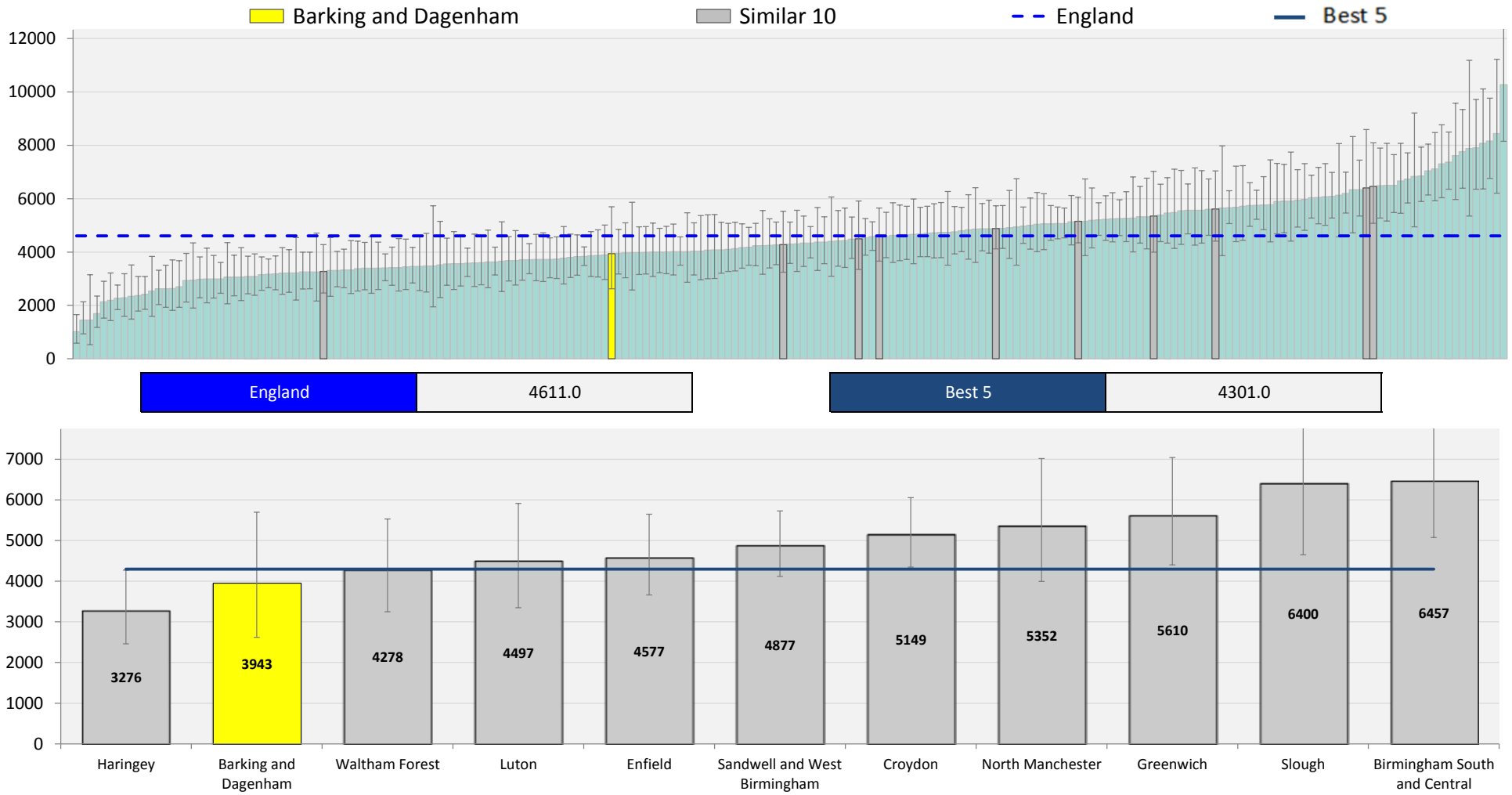


Definition: Spend - Injuries to shoulder and upper arm - 19-64

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

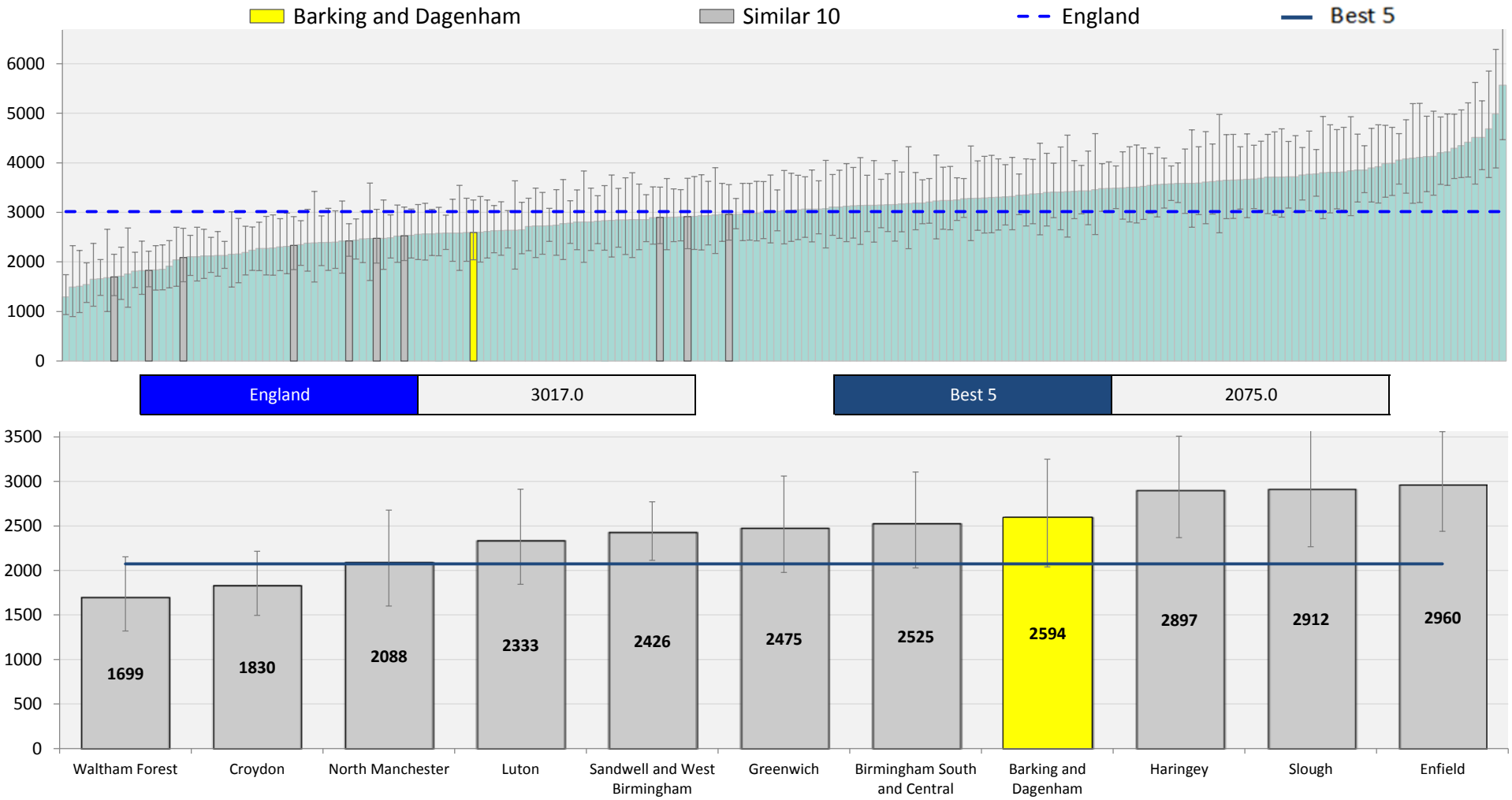
Injuries to the shoulder and upper arm - 65+ - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to shoulder and upper arm - 65+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the elbow and forearm - 0-18 - Spend (£ per 1,000 pop)

£34k (NSS)

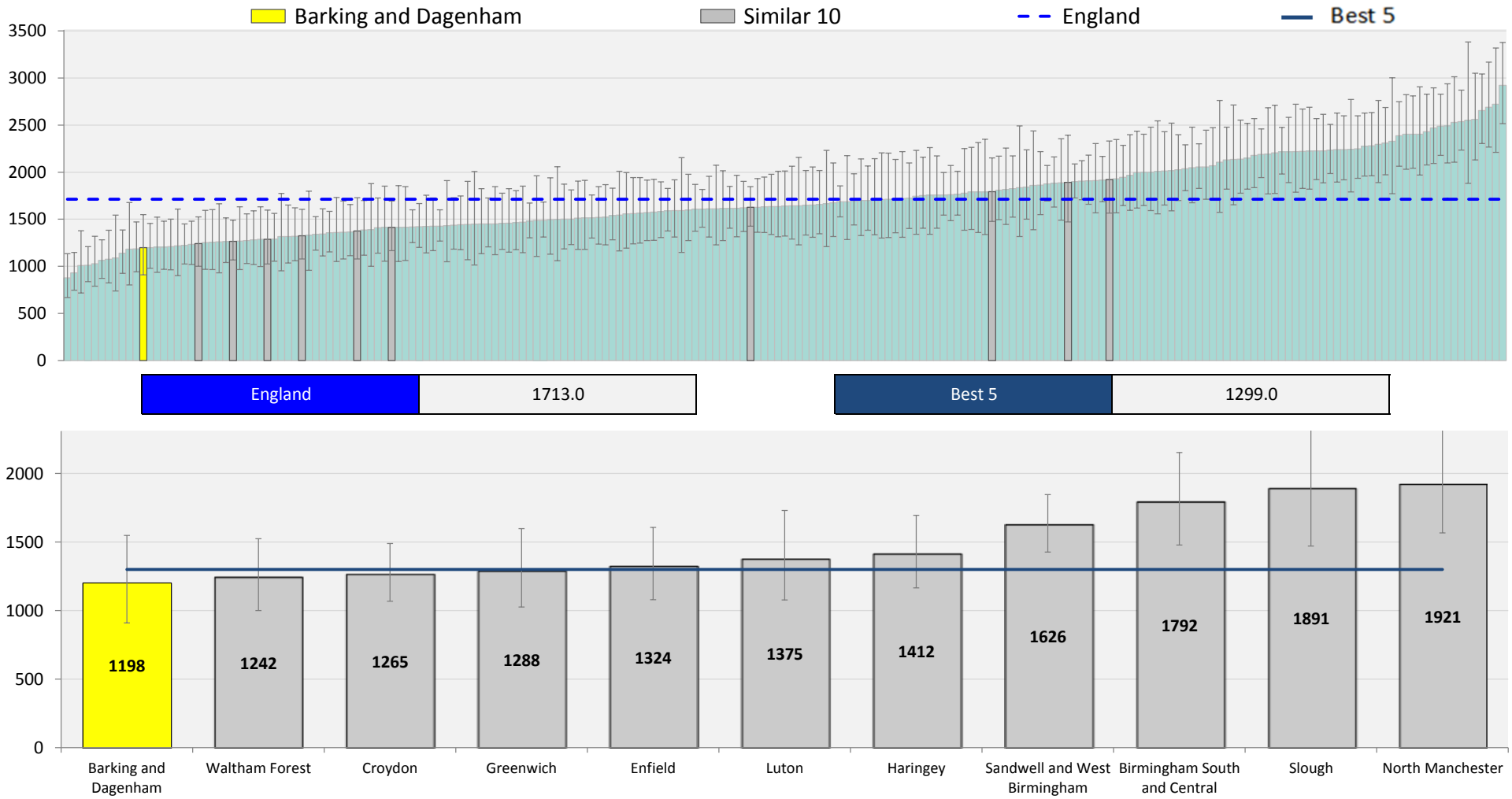


Definition: Spend - Injuries to elbow and forearm - 0-18

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

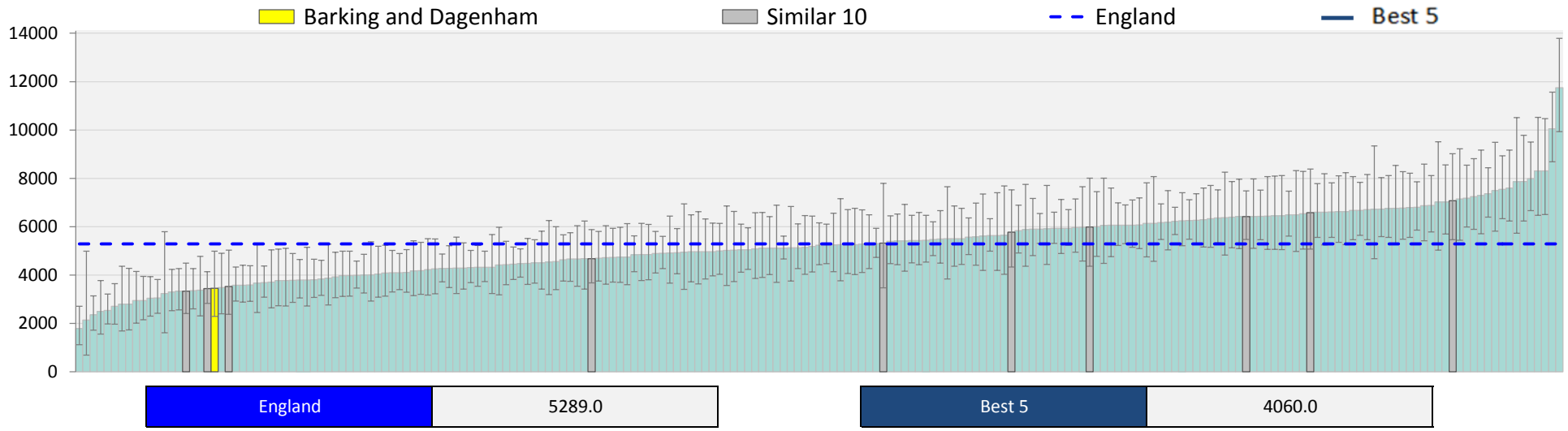
Year: 2014/15

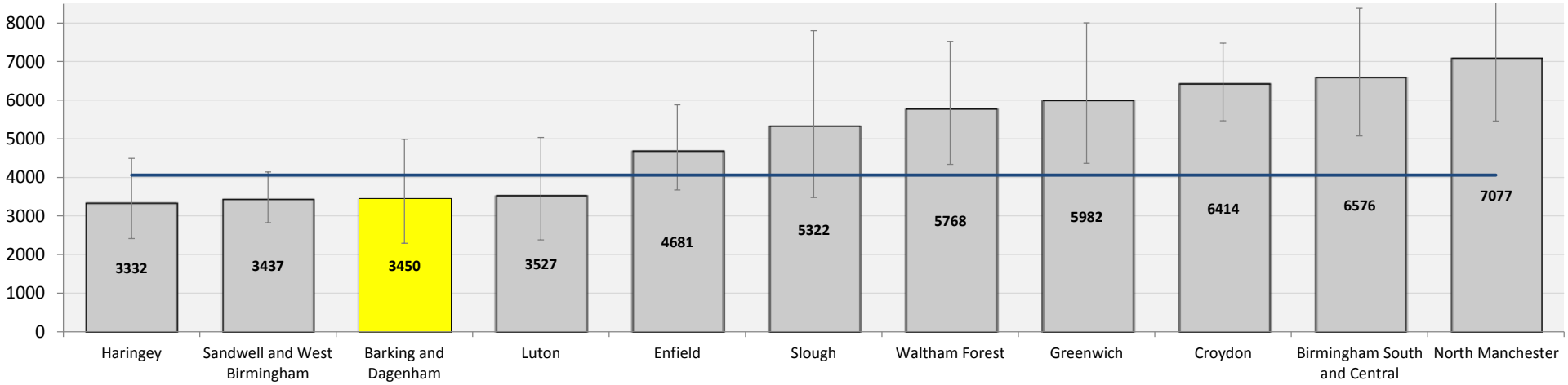
Injuries to the elbow and forearm - 19-64 - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to elbow and forearm - 19-64
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the elbow and forearm - 65+ - Spend (£ per 1,000 pop)





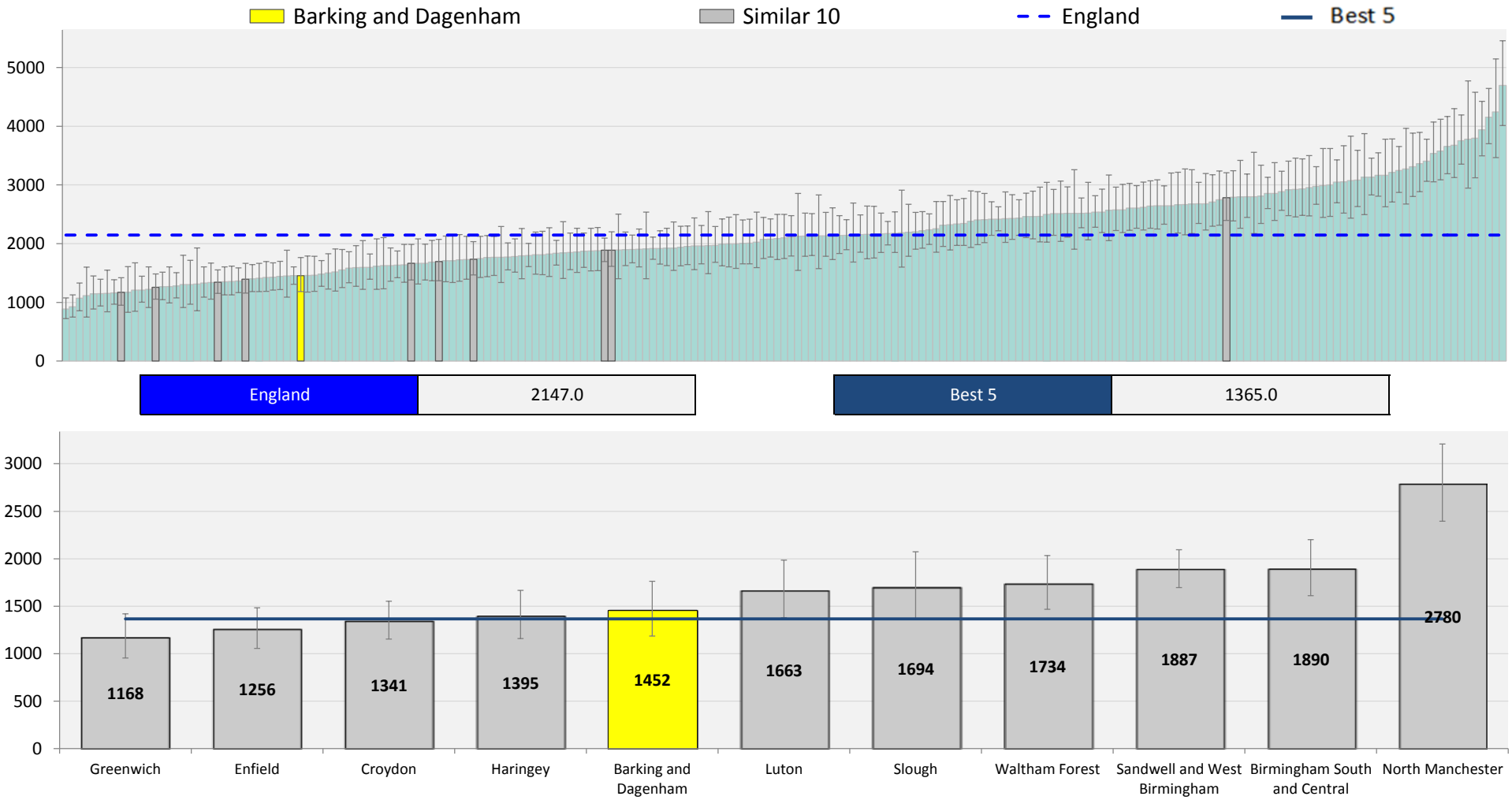
Definition: Spend - Injuries to elbow and forearm - 65+

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

Injuries to the head - 0-18 - Spend (£ per 1,000 pop)

£6k (NSS)



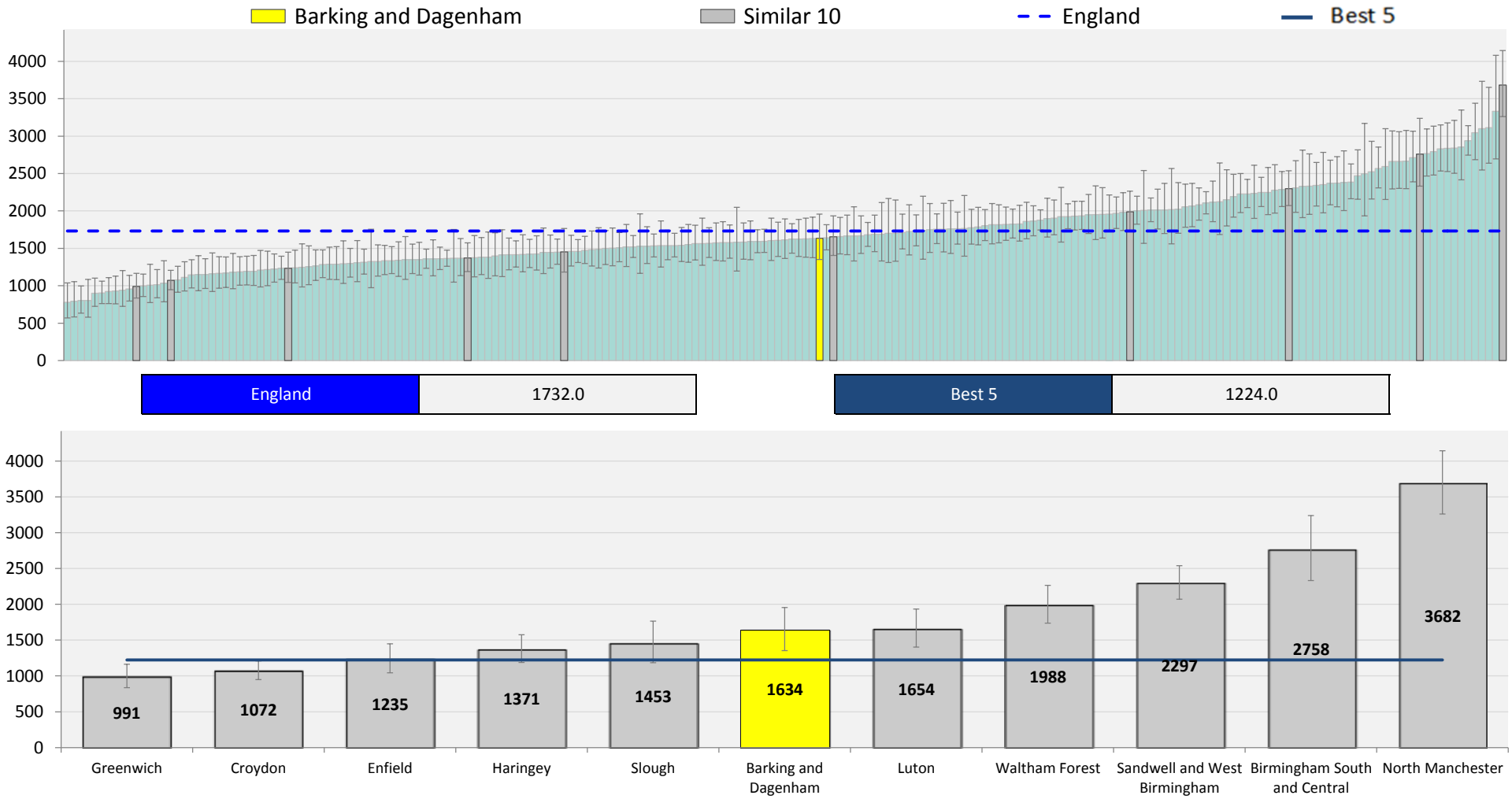
Definition: Spend - Injuries to the head - 0-18

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

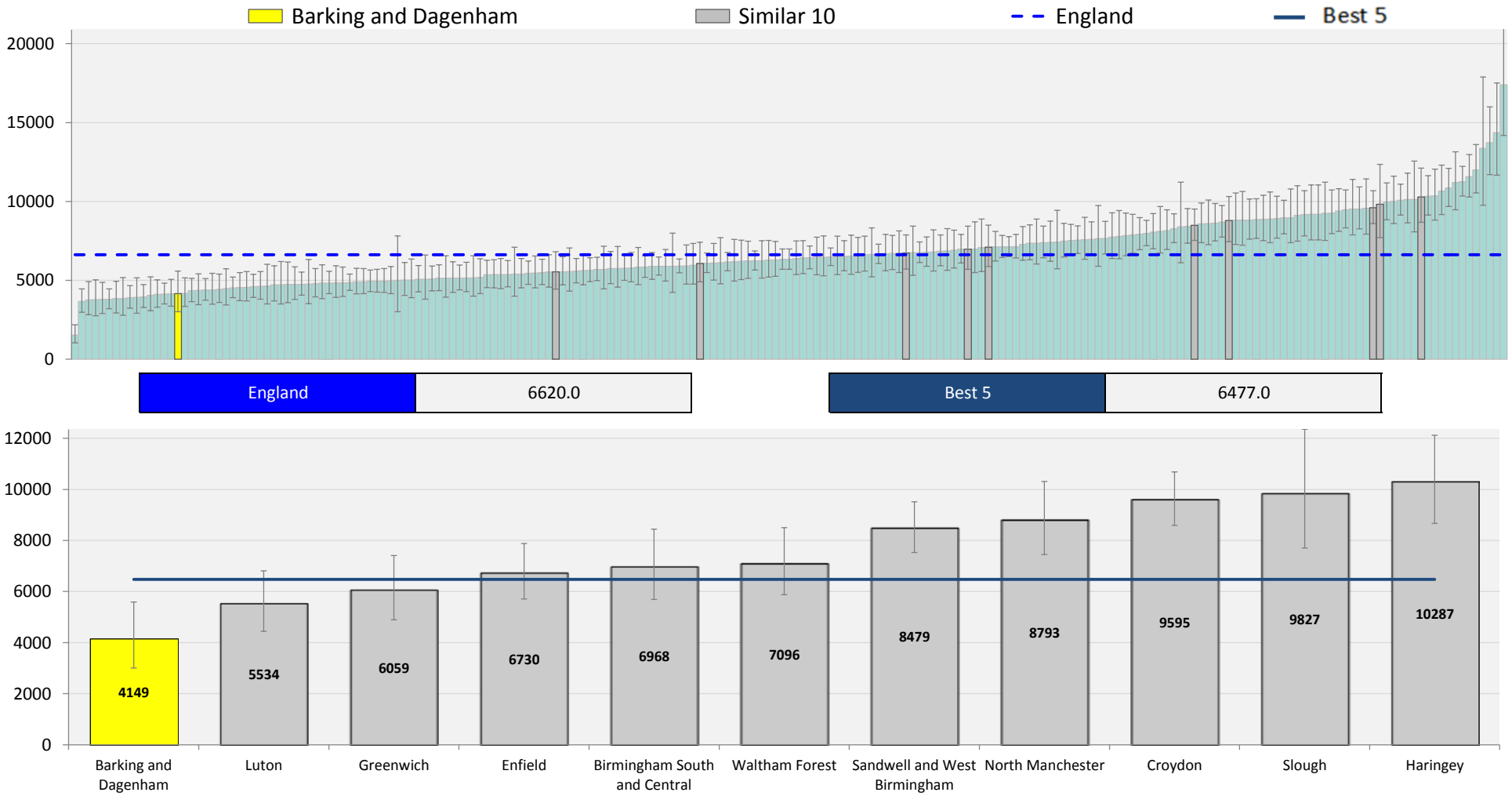
Injuries to the head - 19-64 - Spend (£ per 1,000 pop)

£56k



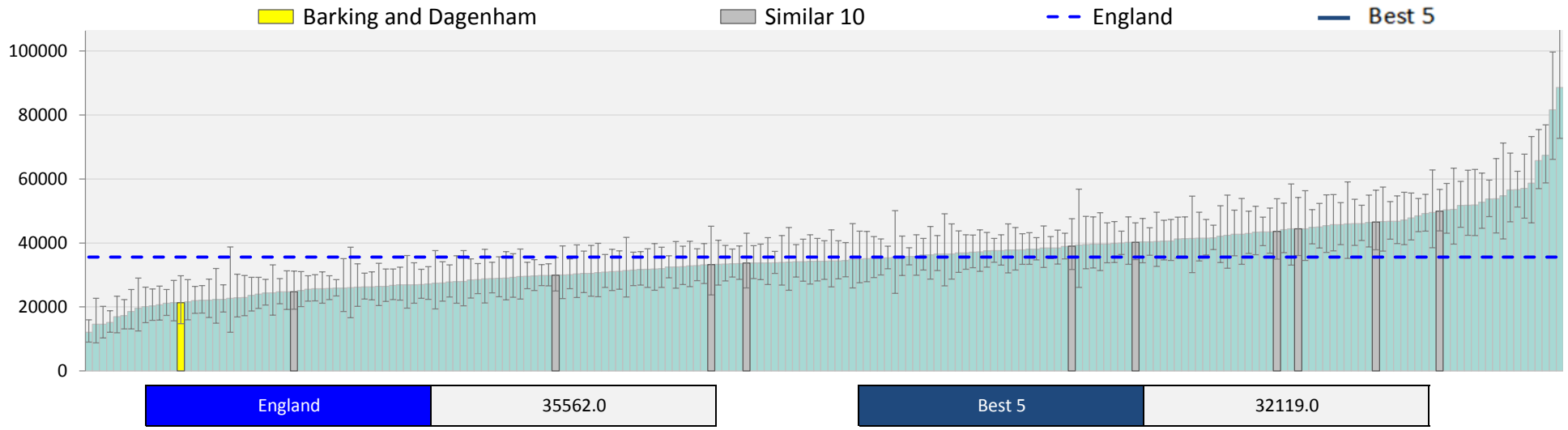
Definition: Spend - Injuries to the head - 19-64
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

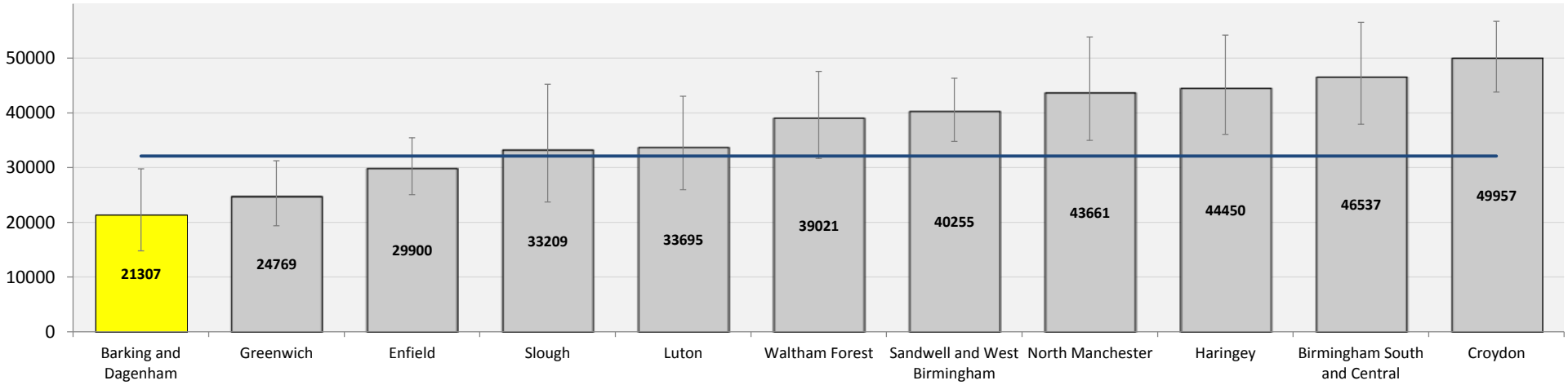
Injuries to the head - 65-84 - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to the head - 65-84
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

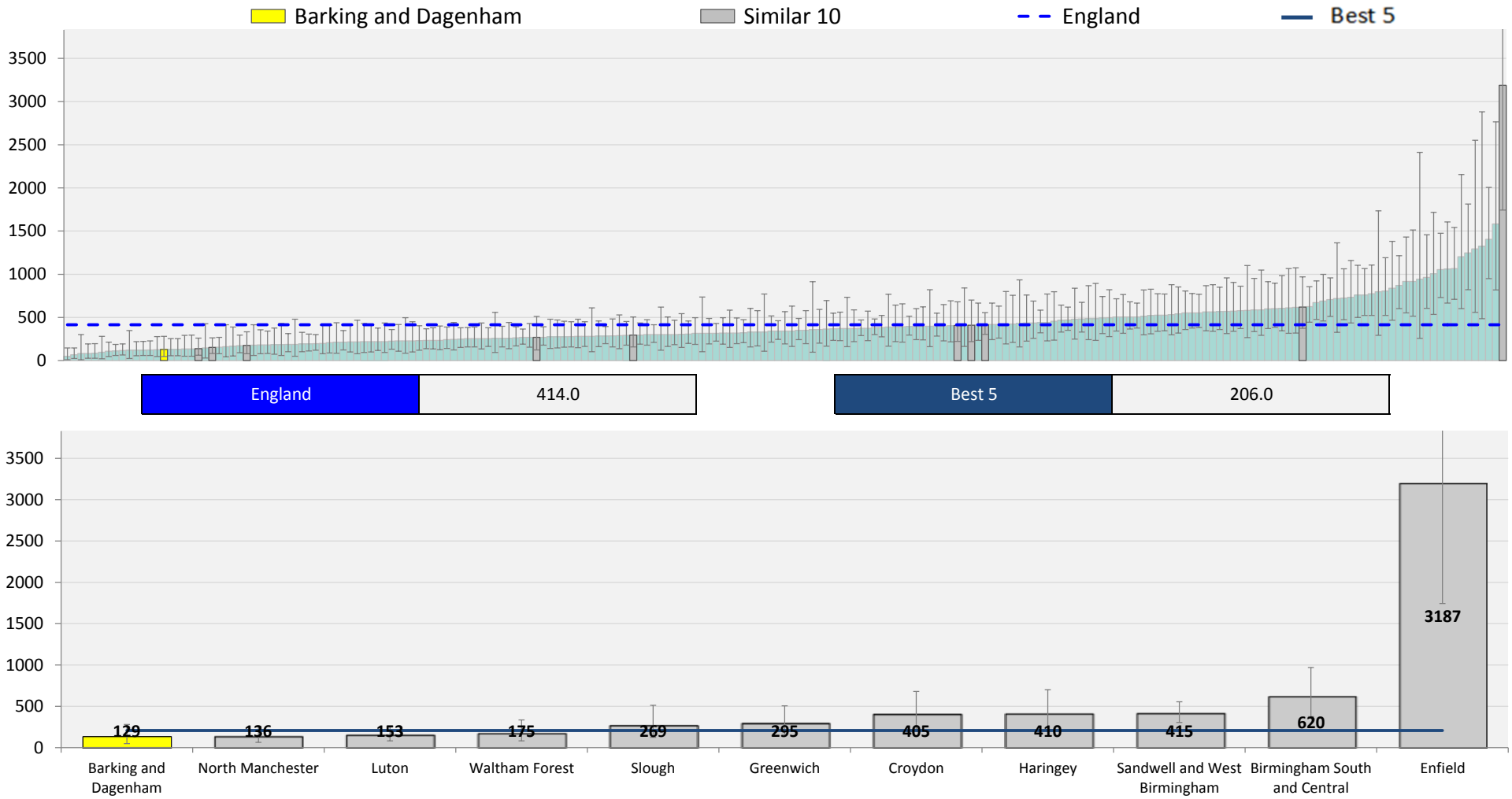
Injuries to the head - 85+ - Spend (£ per 1,000 pop)





Definition: Spend - Injuries to the head - 85+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to abdomen,lower back, lumbar spine and pelvis - 0-18 - Spend (£ per 1,000 pop)

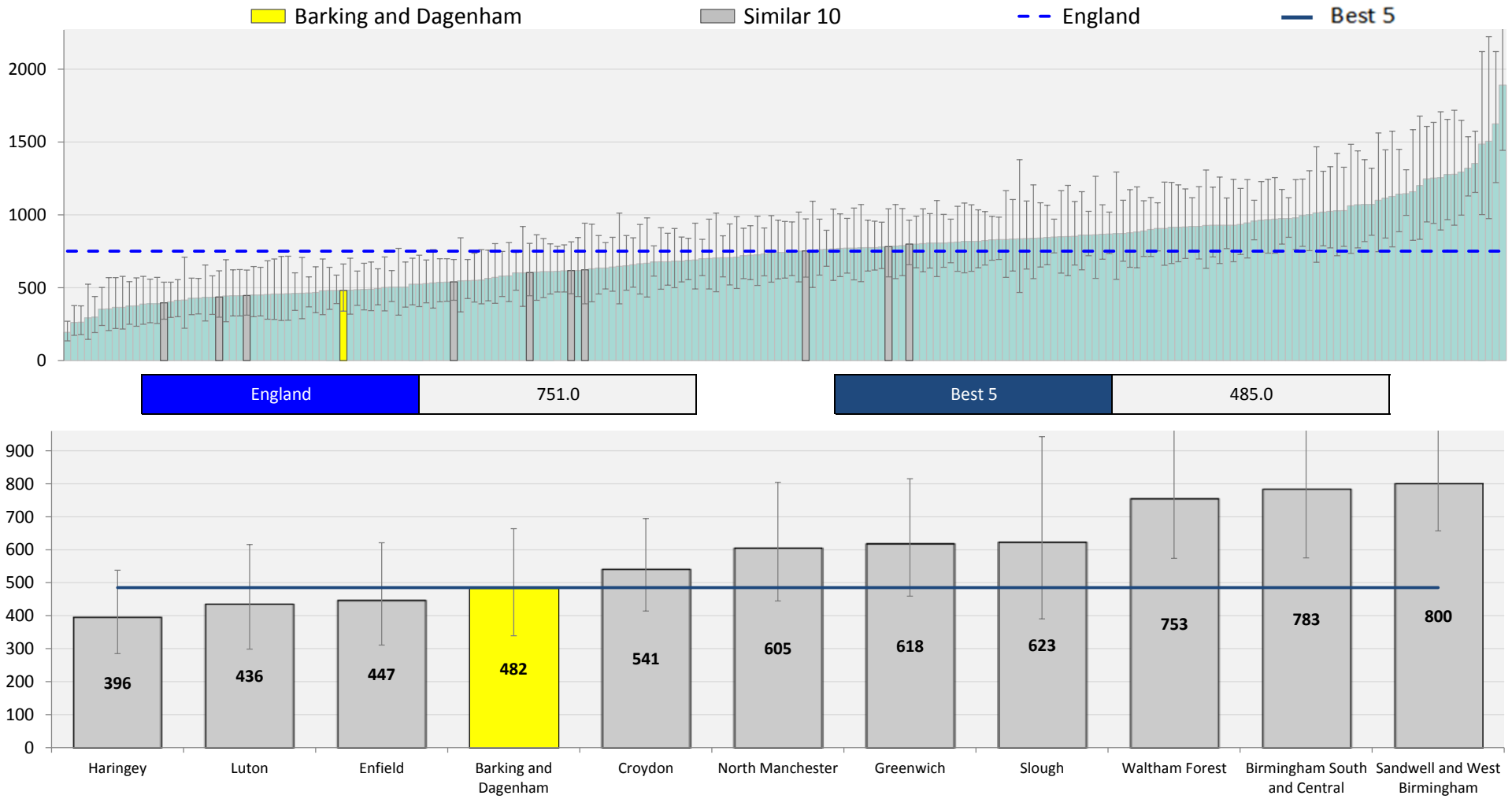


Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 0-18

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

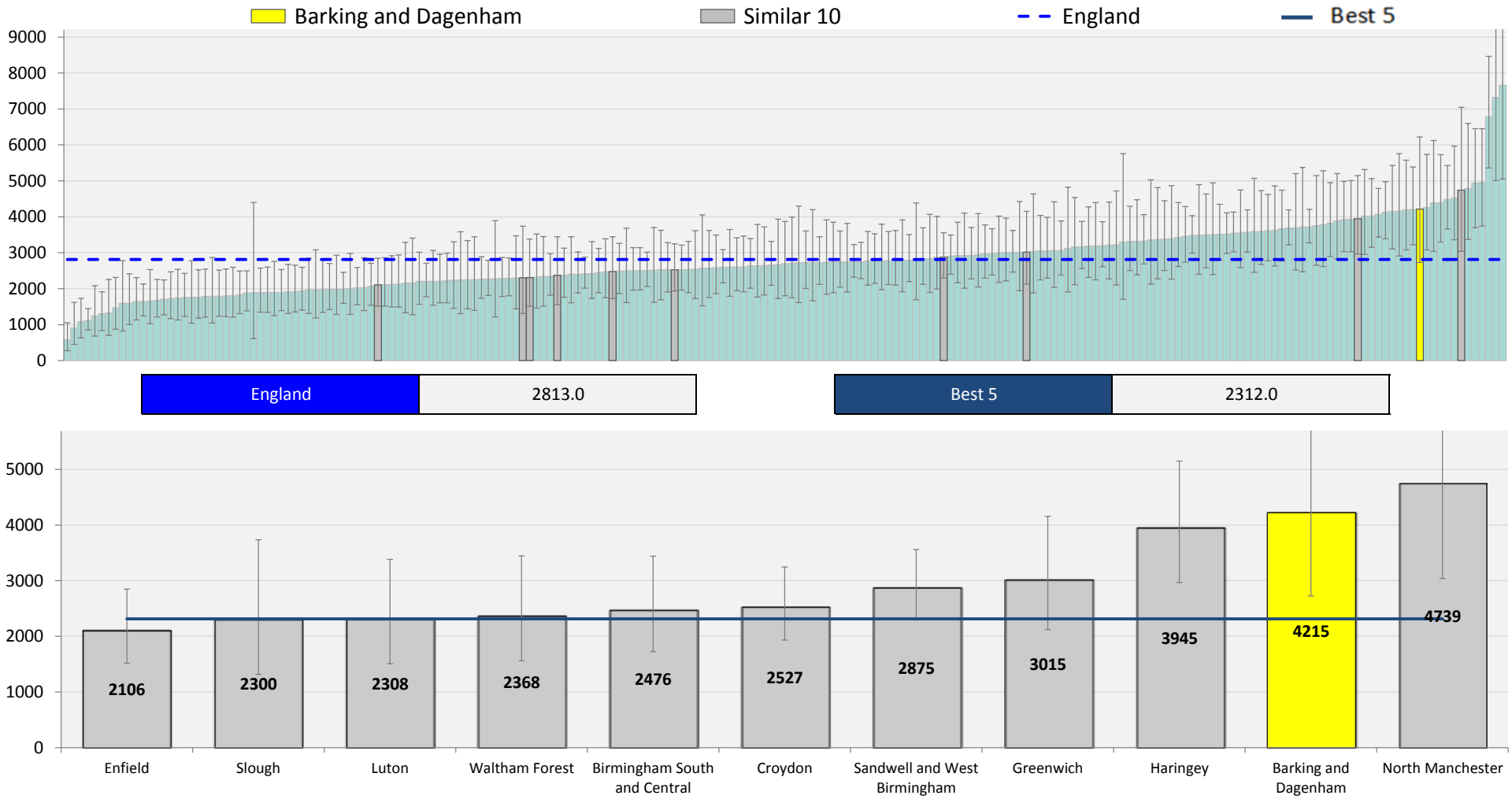
Injuries to abdomen,lower back, lumbar spine and pelvis - 19-64 - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 19-64
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to abdomen,lower back, lumbar spine and pelvis - 65-84 - Spend (£ per 1,000 pop)

£32k

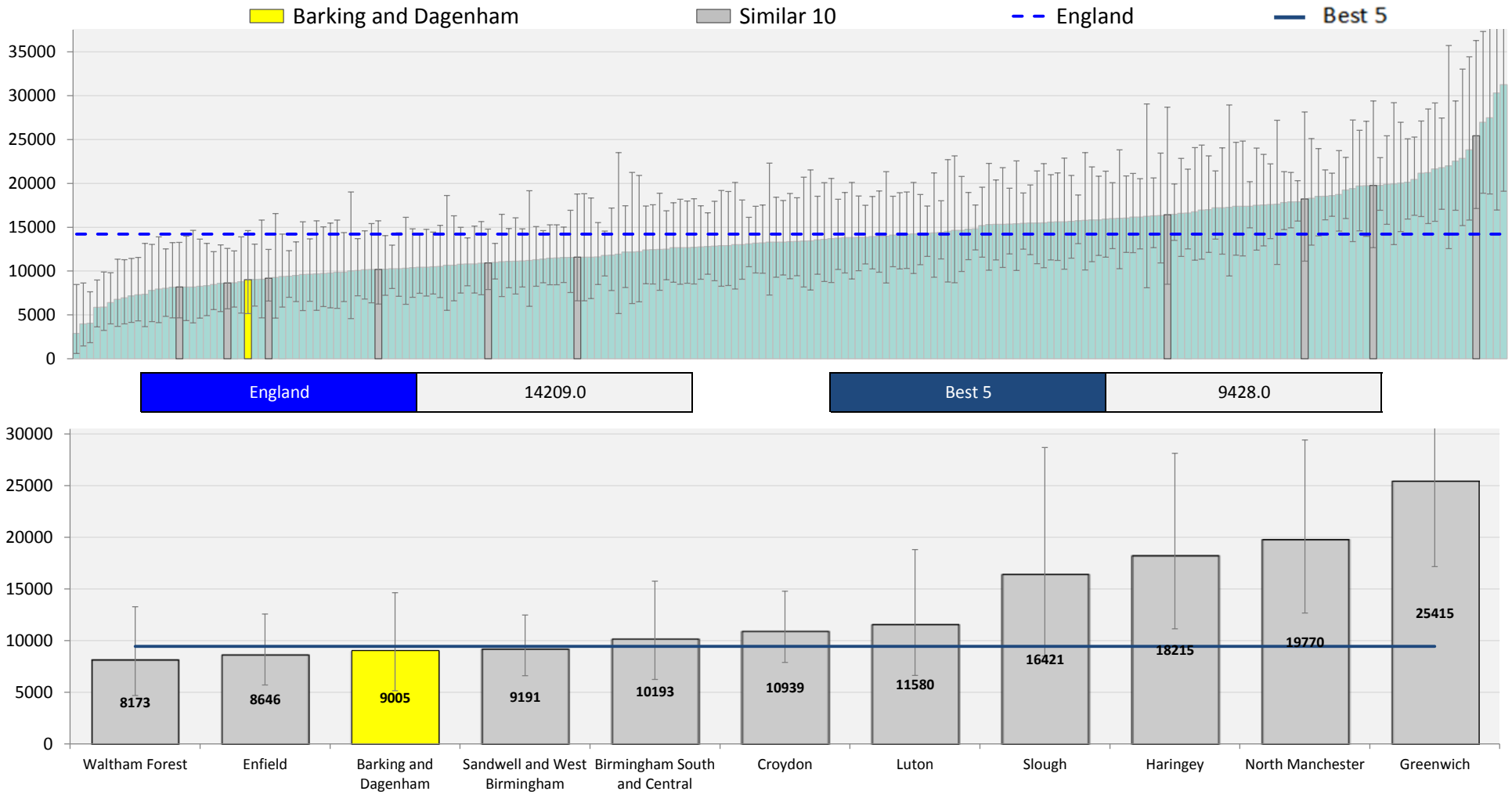


Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 65-84

Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

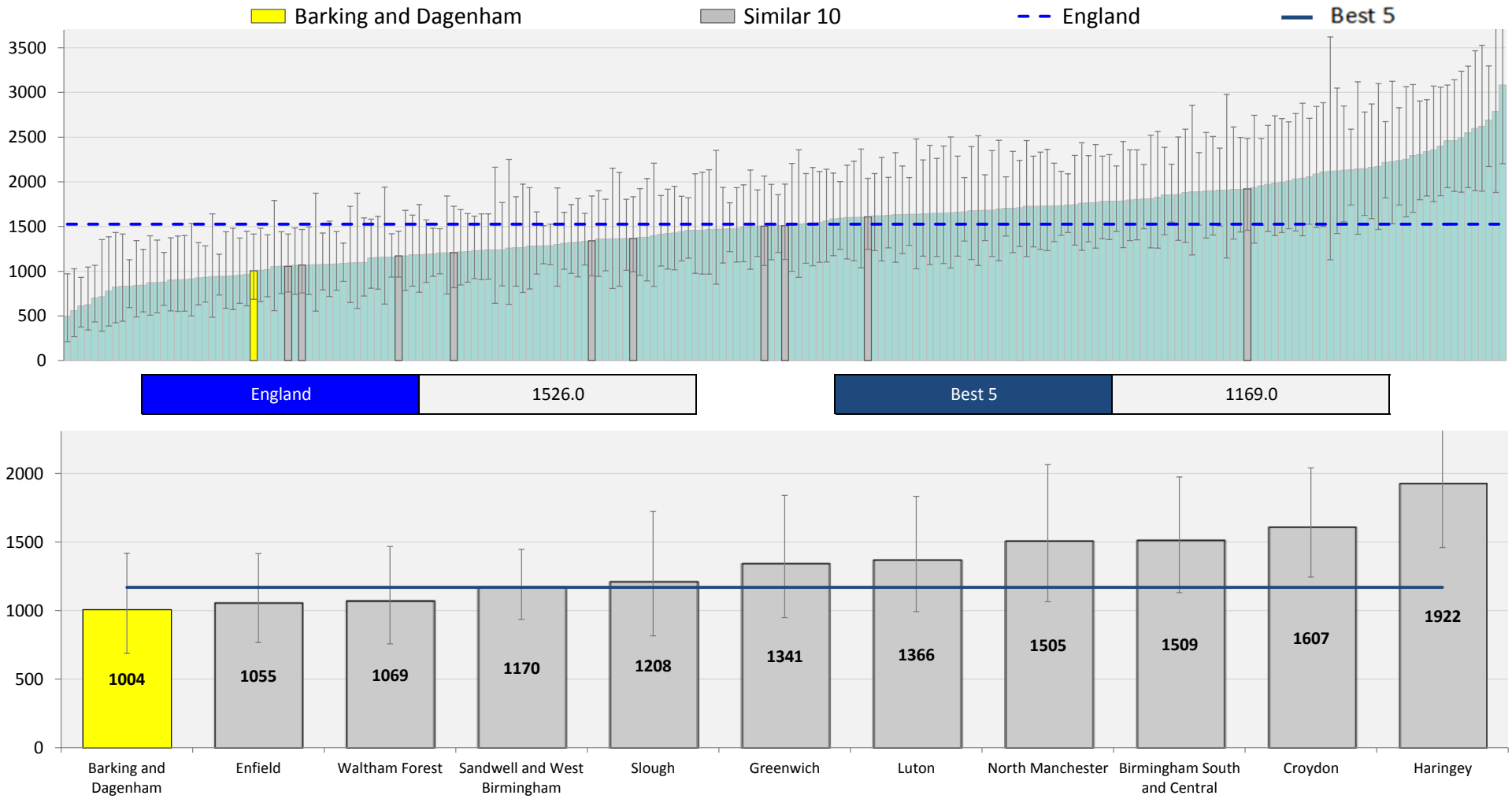
Year: 2014/15

Injuries to abdomen,lower back, lumbar spine and pelvis - 85+ - Spend (£ per 1,000 pop)



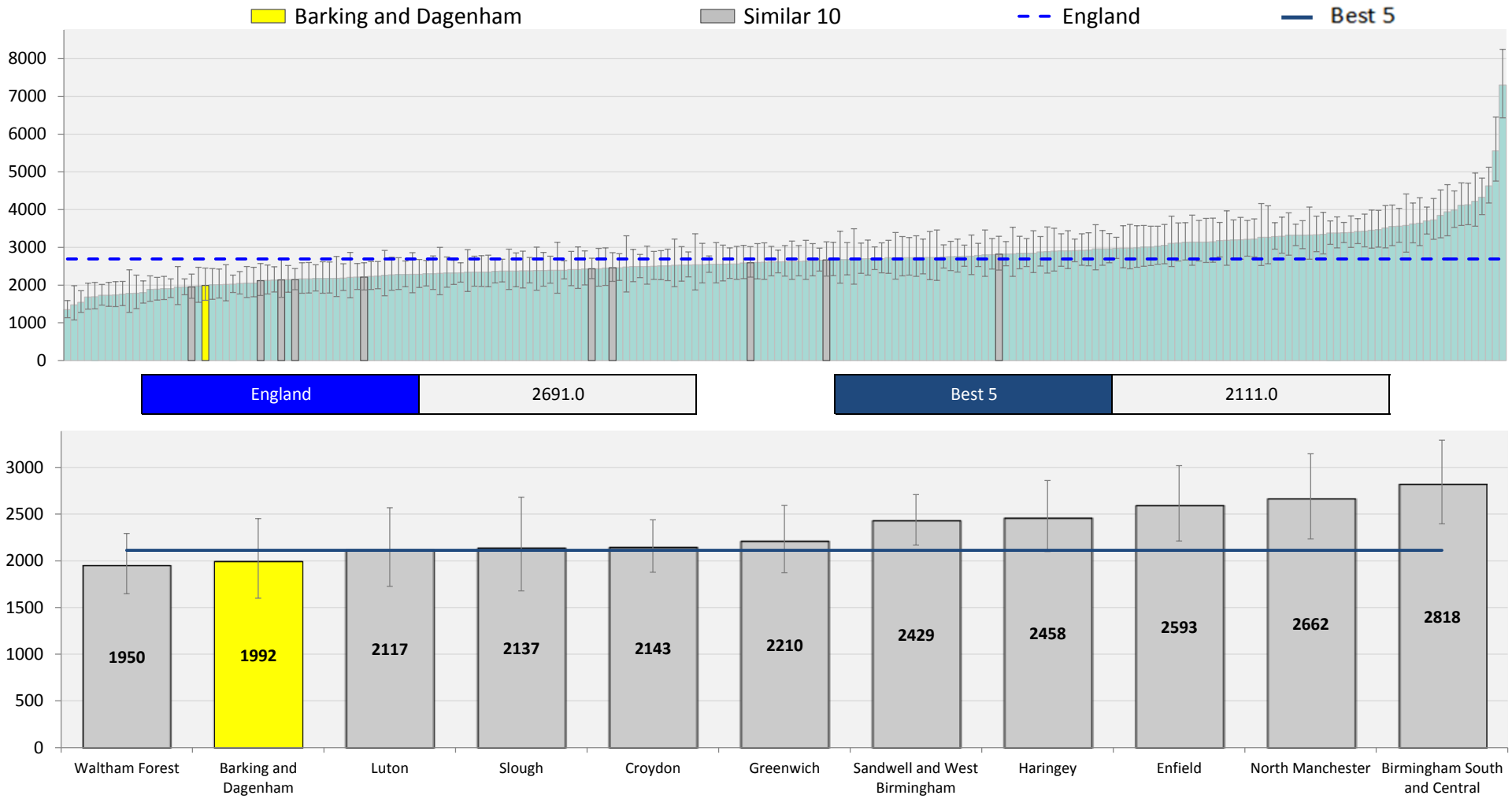
Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 85+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the knee and lower leg - 0-18 - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to the knee and lower leg - 0-18
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

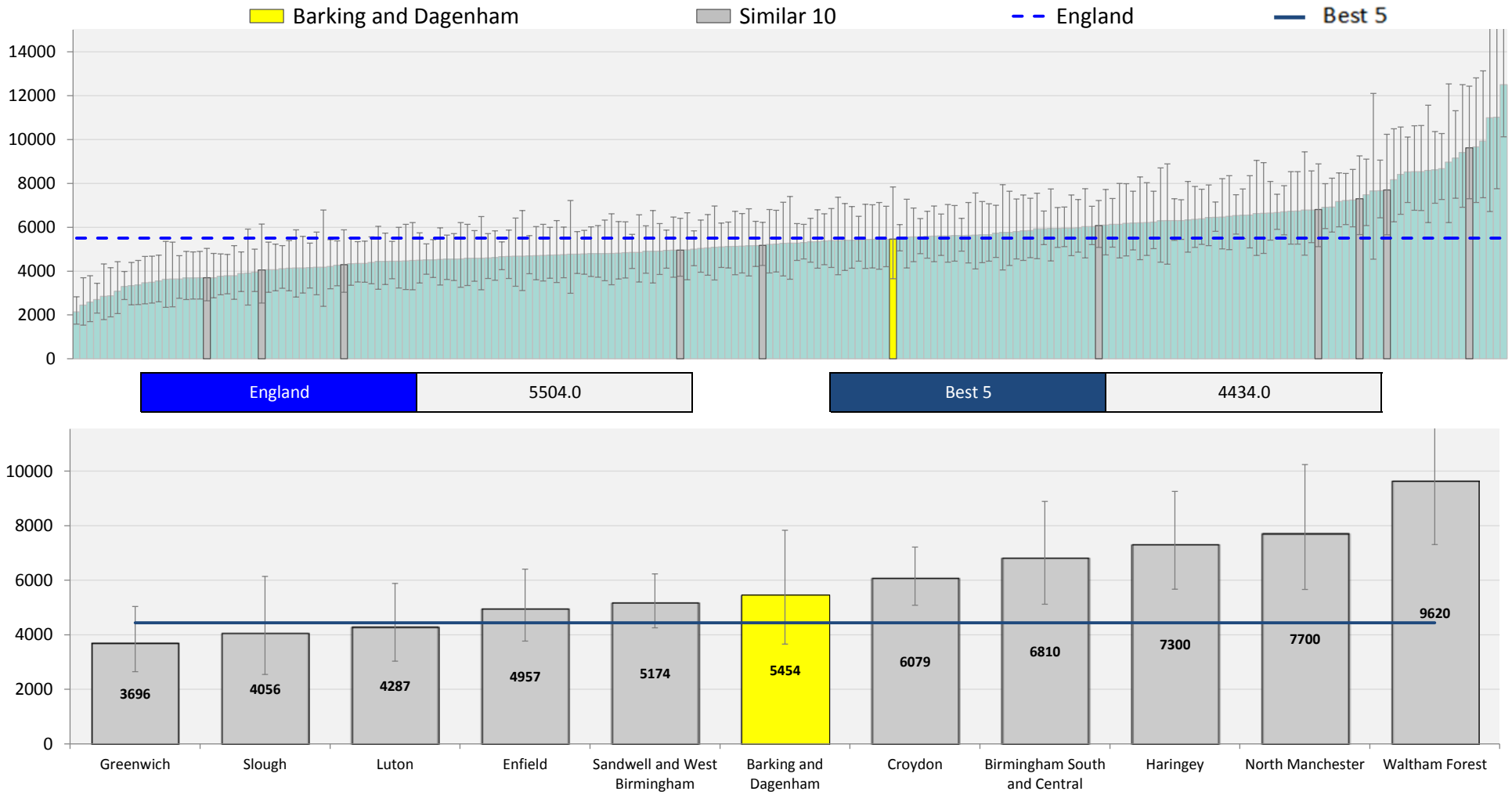
Injuries to the knee and lower leg - 19-64 - Spend (£ per 1,000 pop)



Definition: Spend - Injuries to the knee and lower leg - 19-64
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the knee and lower leg - 65-84 - Spend (£ per 1,000 pop)

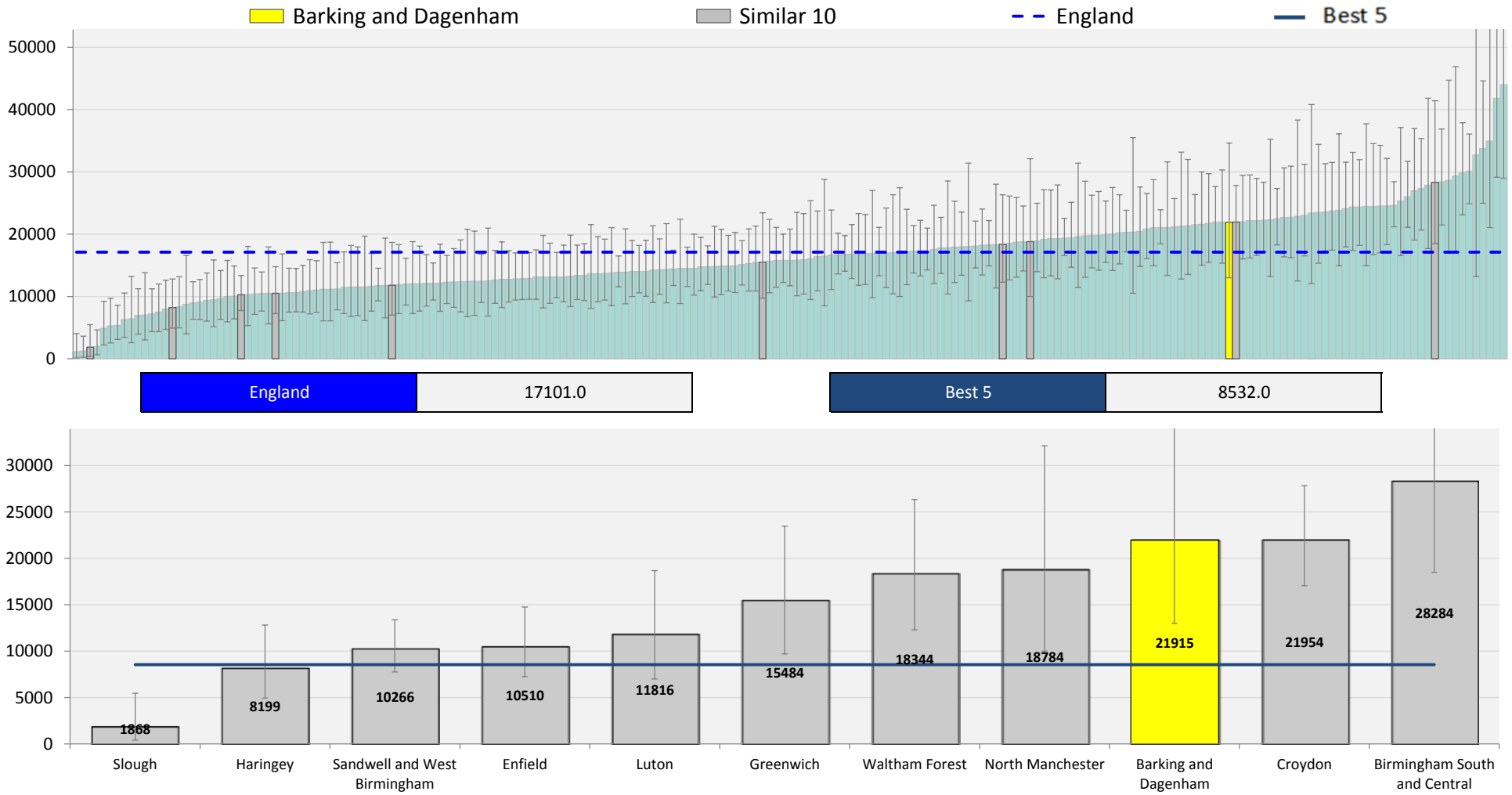
£17k (NSS)



Definition: Spend - Injuries to the knee and lower leg - 65-84
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Injuries to the knee and lower leg - 85+ - Spend (£ per 1,000 pop)

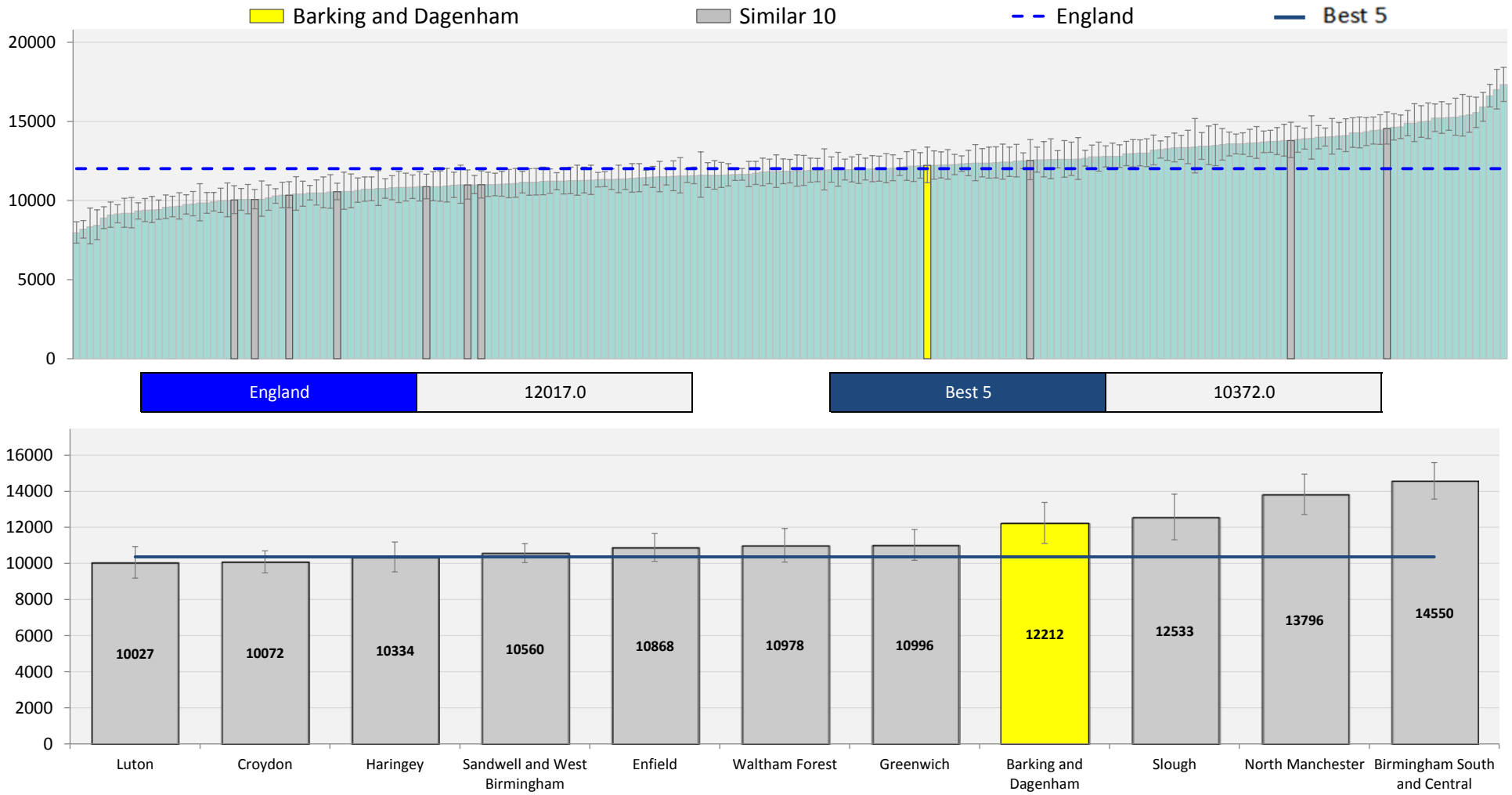
£37k | 122



Definition: Spend - Injuries to the knee and lower leg - 85+
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

Spend on admissions relating to fractures where a fall occurred (£ per 1,000 pop)

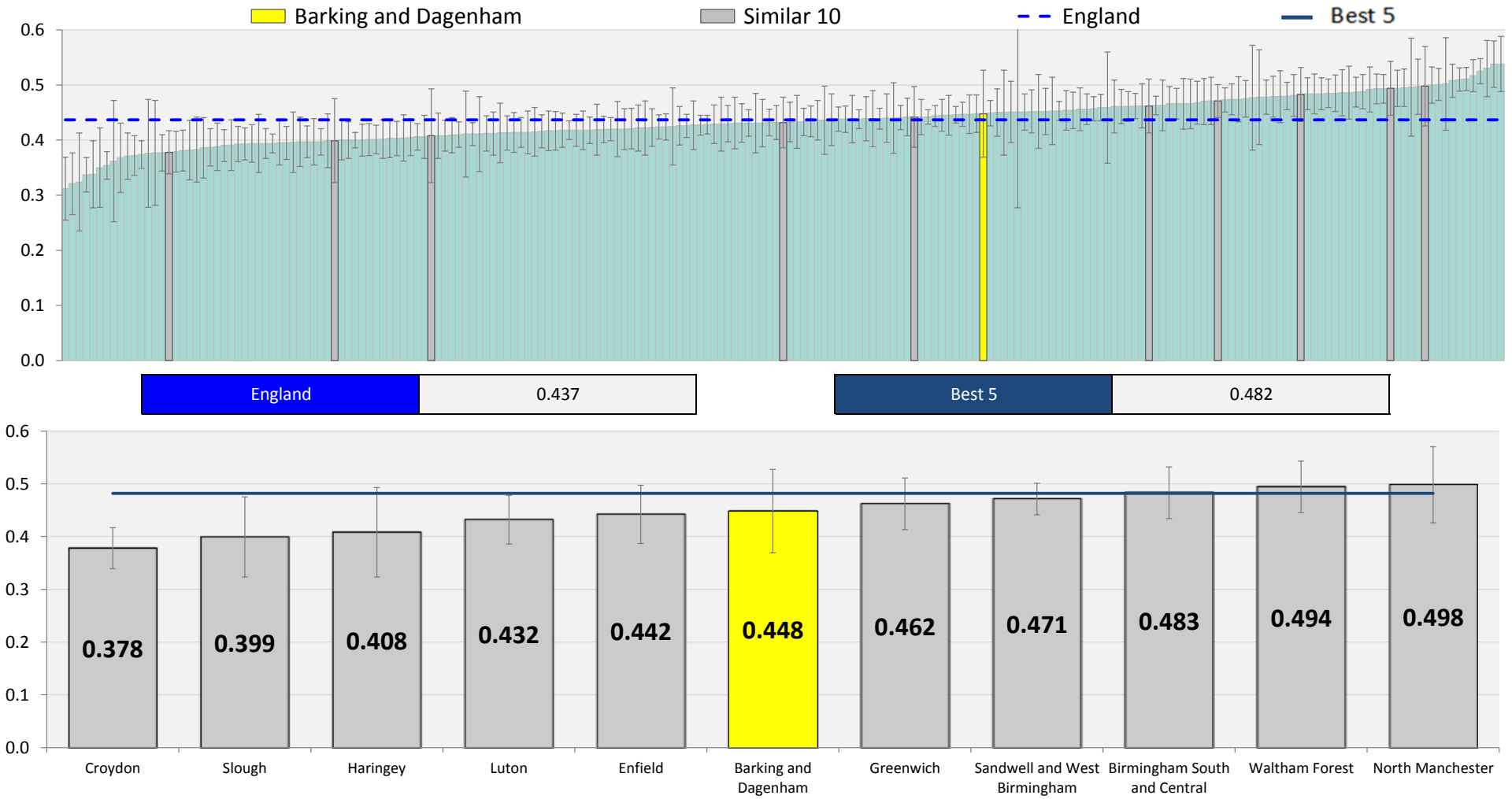
£270k



Definition: Spend on admissions relating to fractures where a fall occurred
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
Year: 2014/15

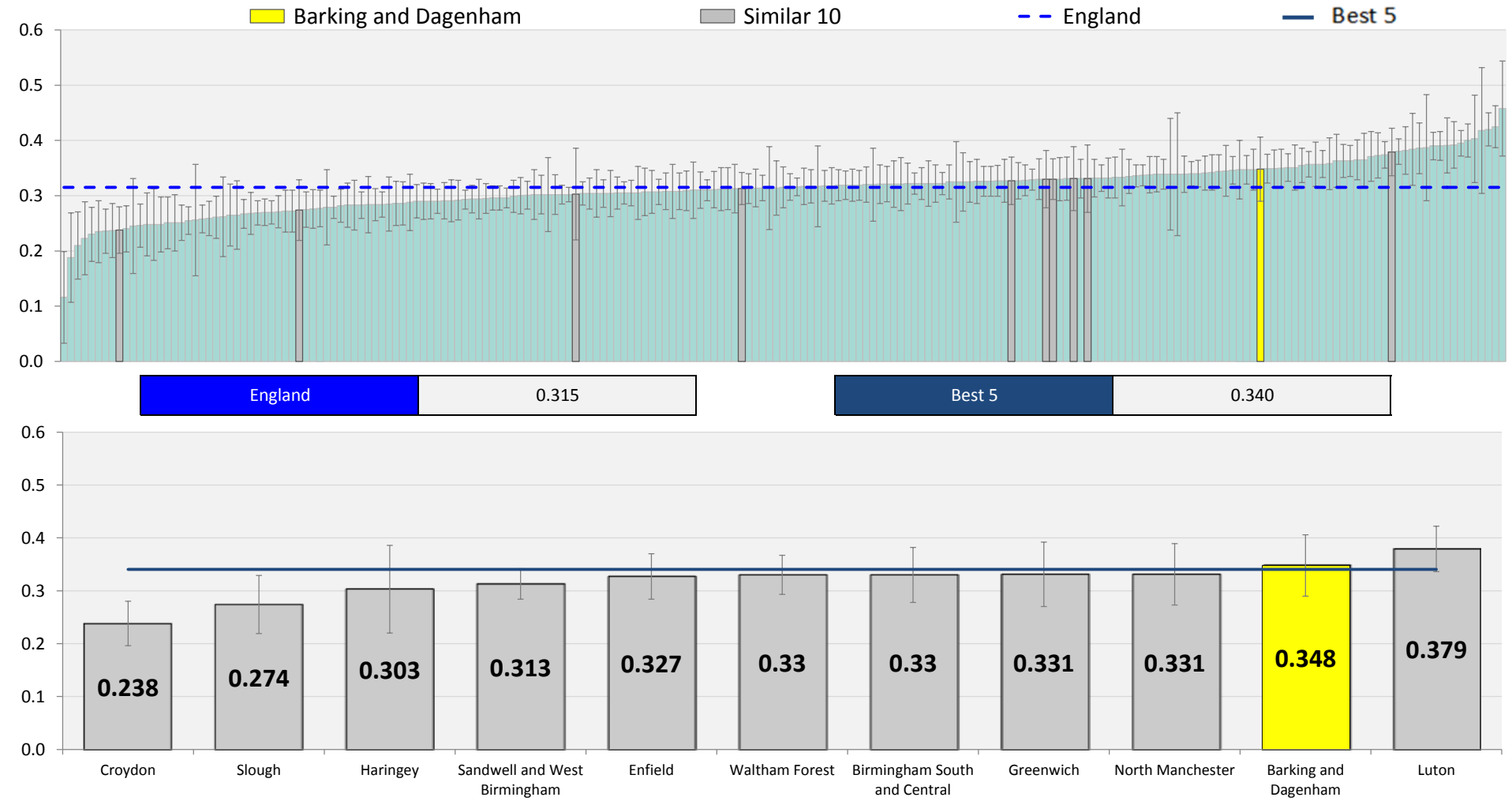
EQ-5D health gain (hips)

6 QALYs (NSS)



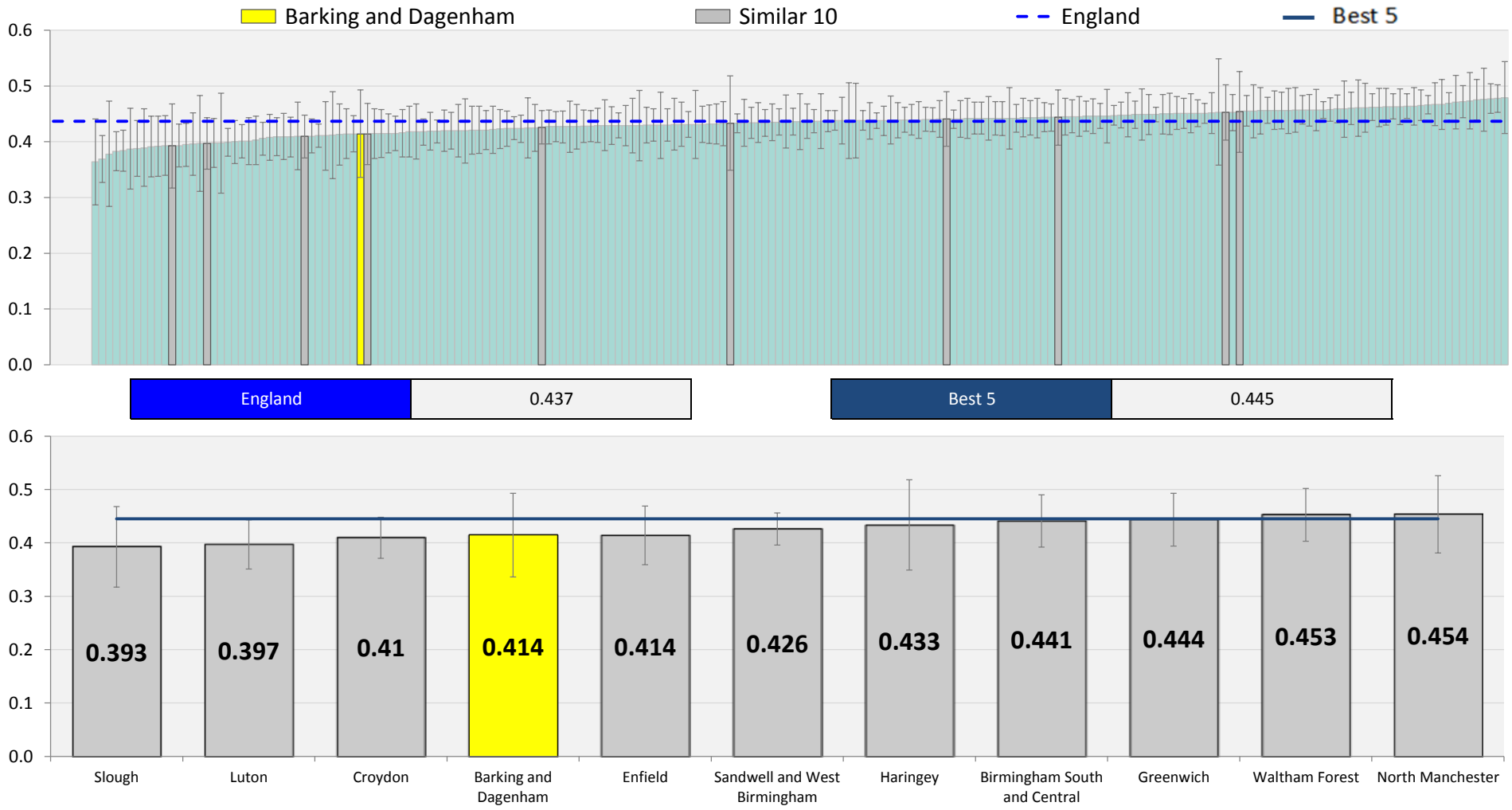
Definition: Hip replacement, EQ-5D, Health Gain
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

EQ-5D health gain (knees)



Definition: Knee replacement, EQ-5D, Health Gain
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

EQ-5D - Hip (primary) - Health gain (casemix adjusted)



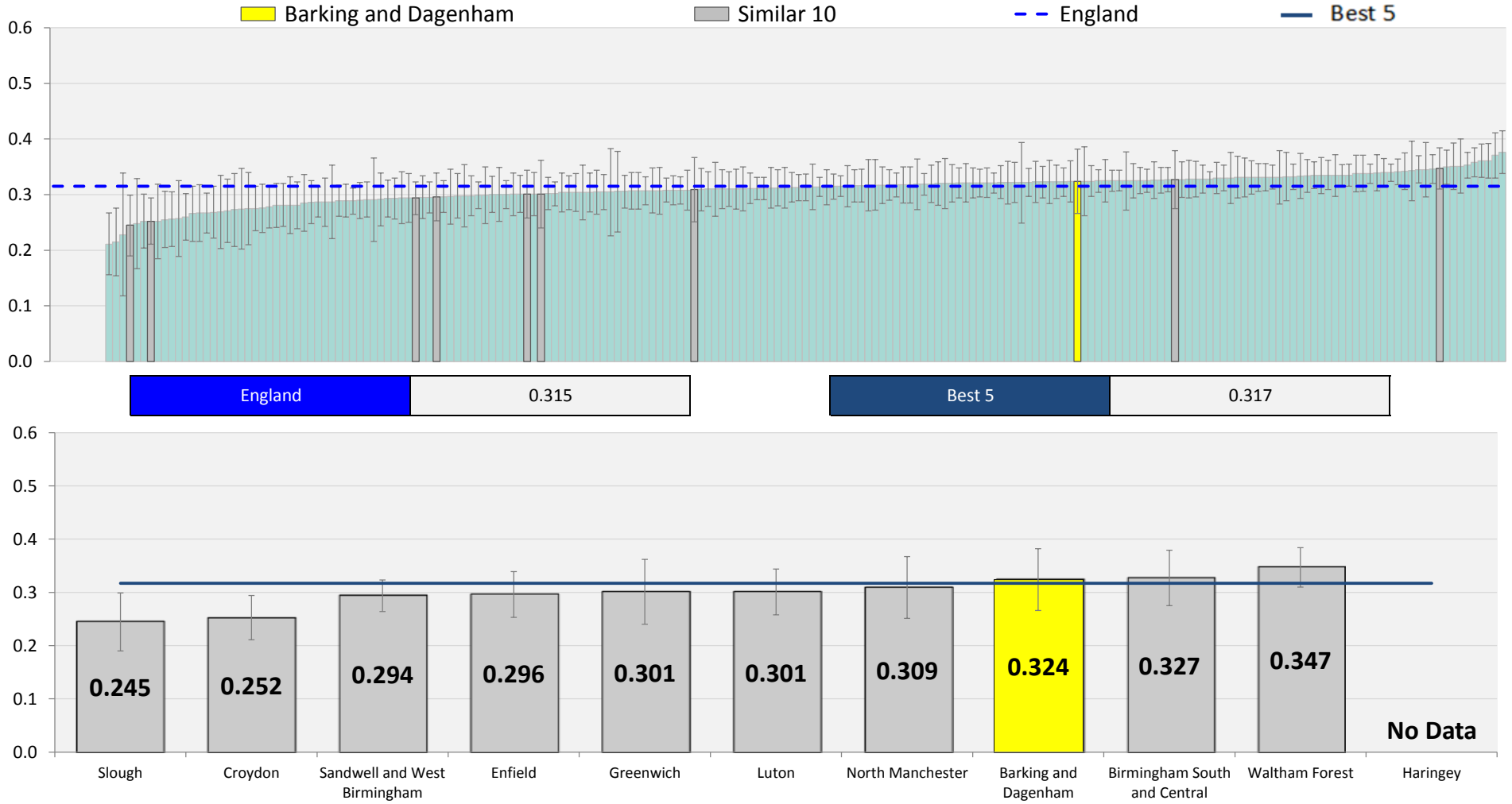
Definition: EQ-5D - Hip (primary) - Health gain (casemix adjusted)

Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre

Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

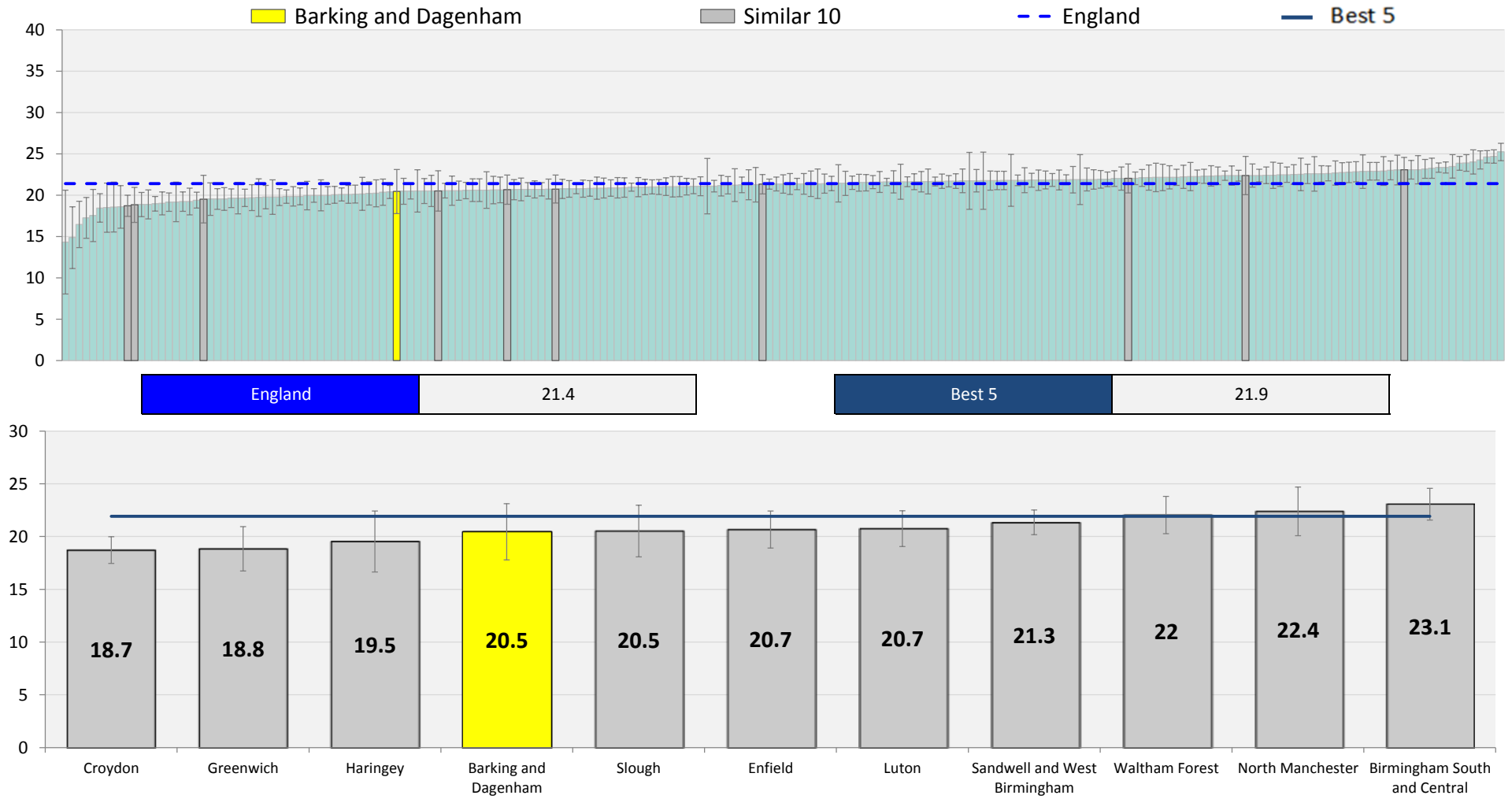
EQ-5D - Knee (primary) - Health gain (casemix adjusted)



Definition: EQ-5D - Knee (primary) - Health gain (casemix adjusted)
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

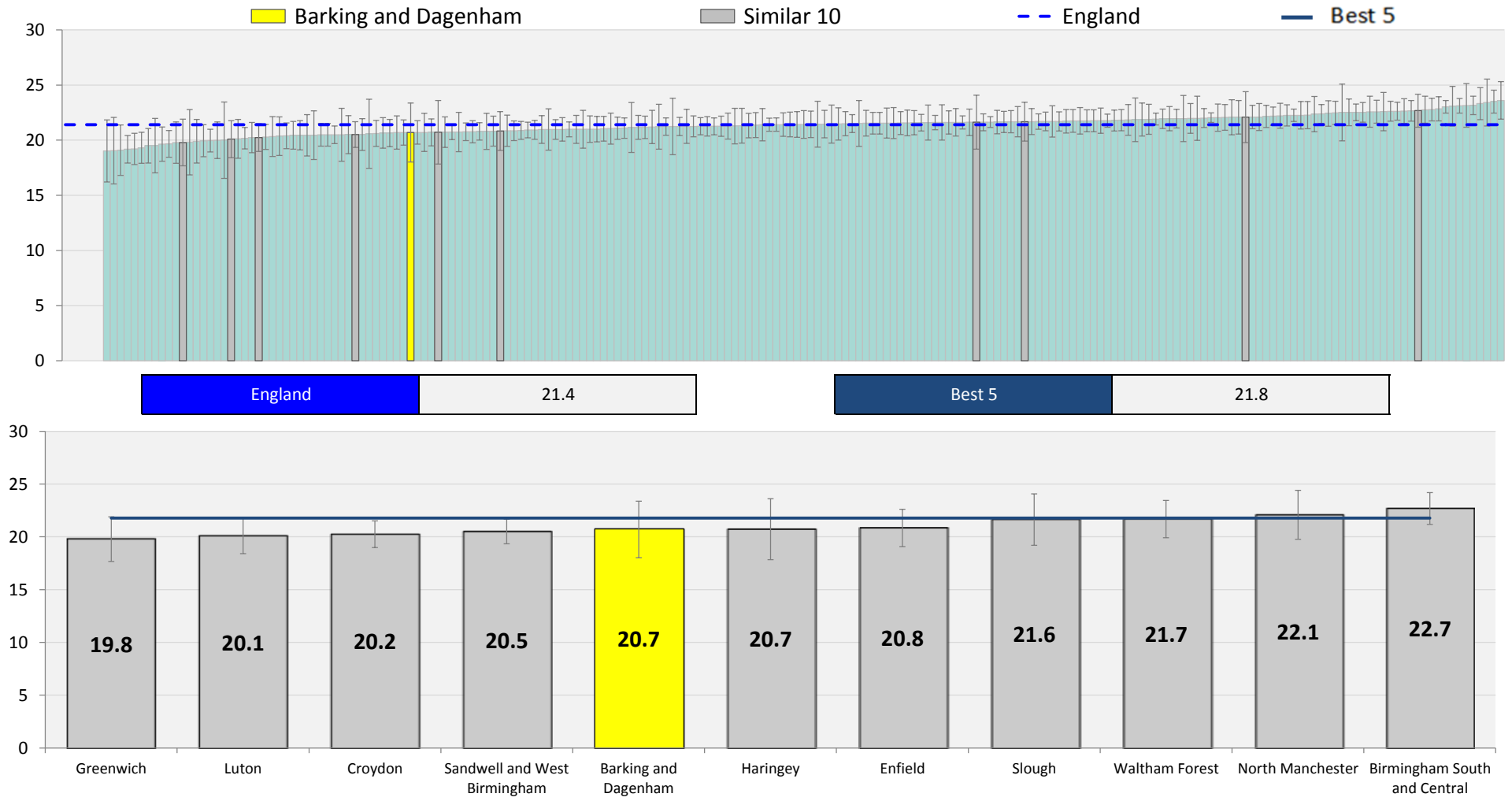
Oxford score - Hip (primary) - Health gain



Definition: Hip replacement, Oxford Hip Score, Health Gain
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

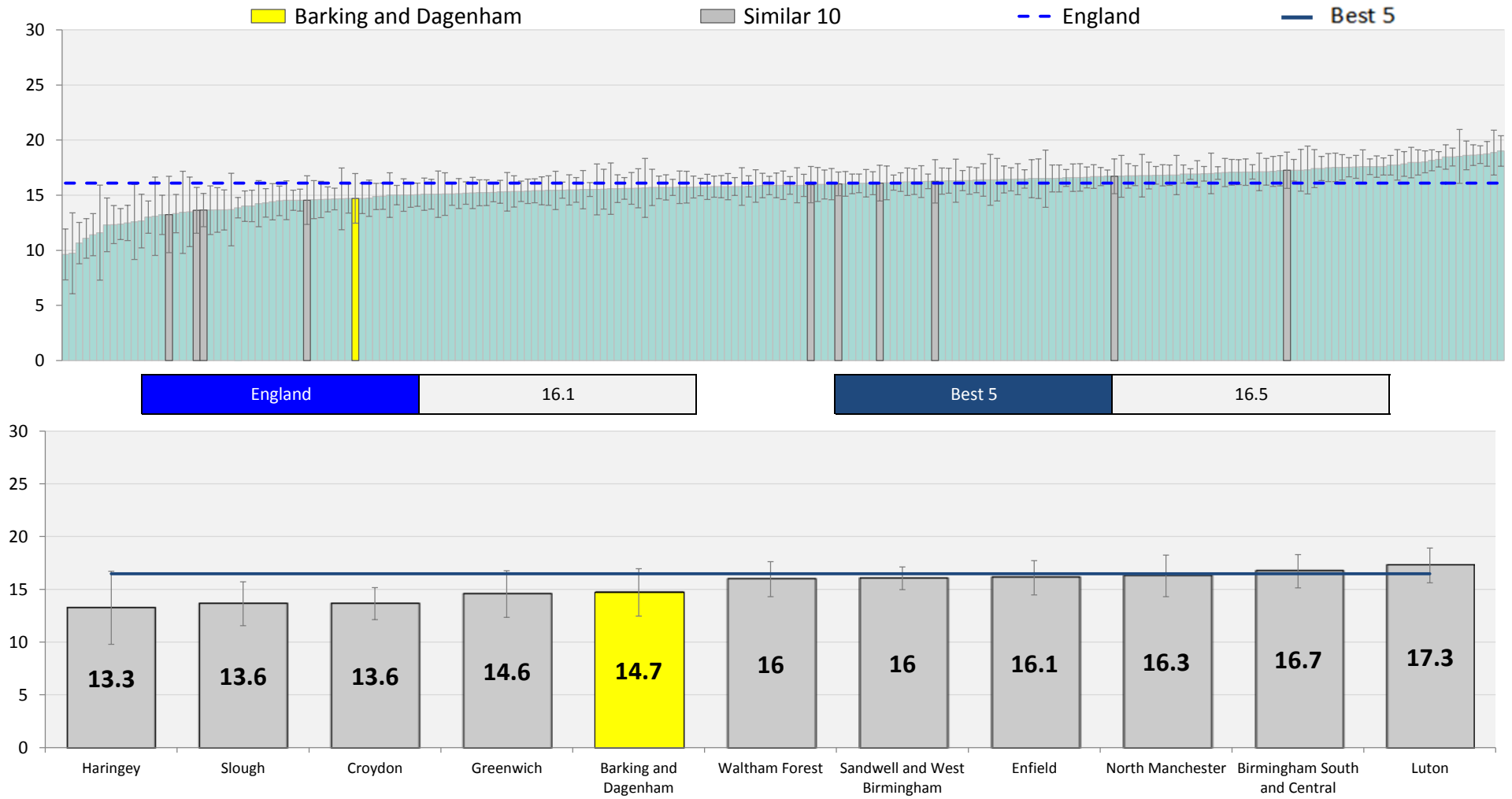
Oxford score - Hip (primary) - Health gain (casemix adjusted)



Definition: Hip replacement, Oxford Hip Score, Health Gain (casemix adjusted)
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

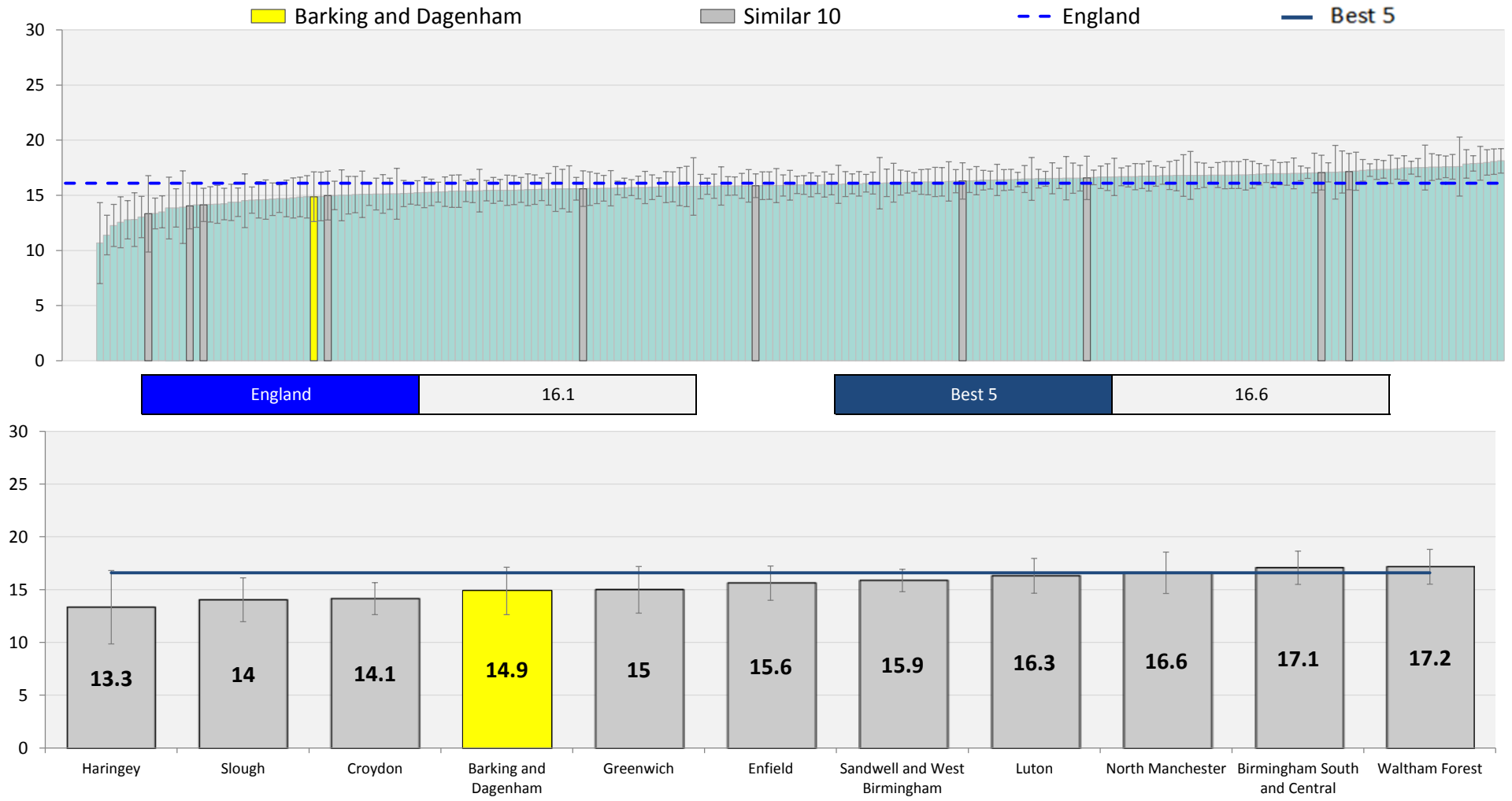
Oxford score - Knee (primary) - Health gain



Definition: Knee replacement, Oxford Knee Score, Health Gain
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

Oxford score - Knee (primary) - Health gain (casemix adjusted)

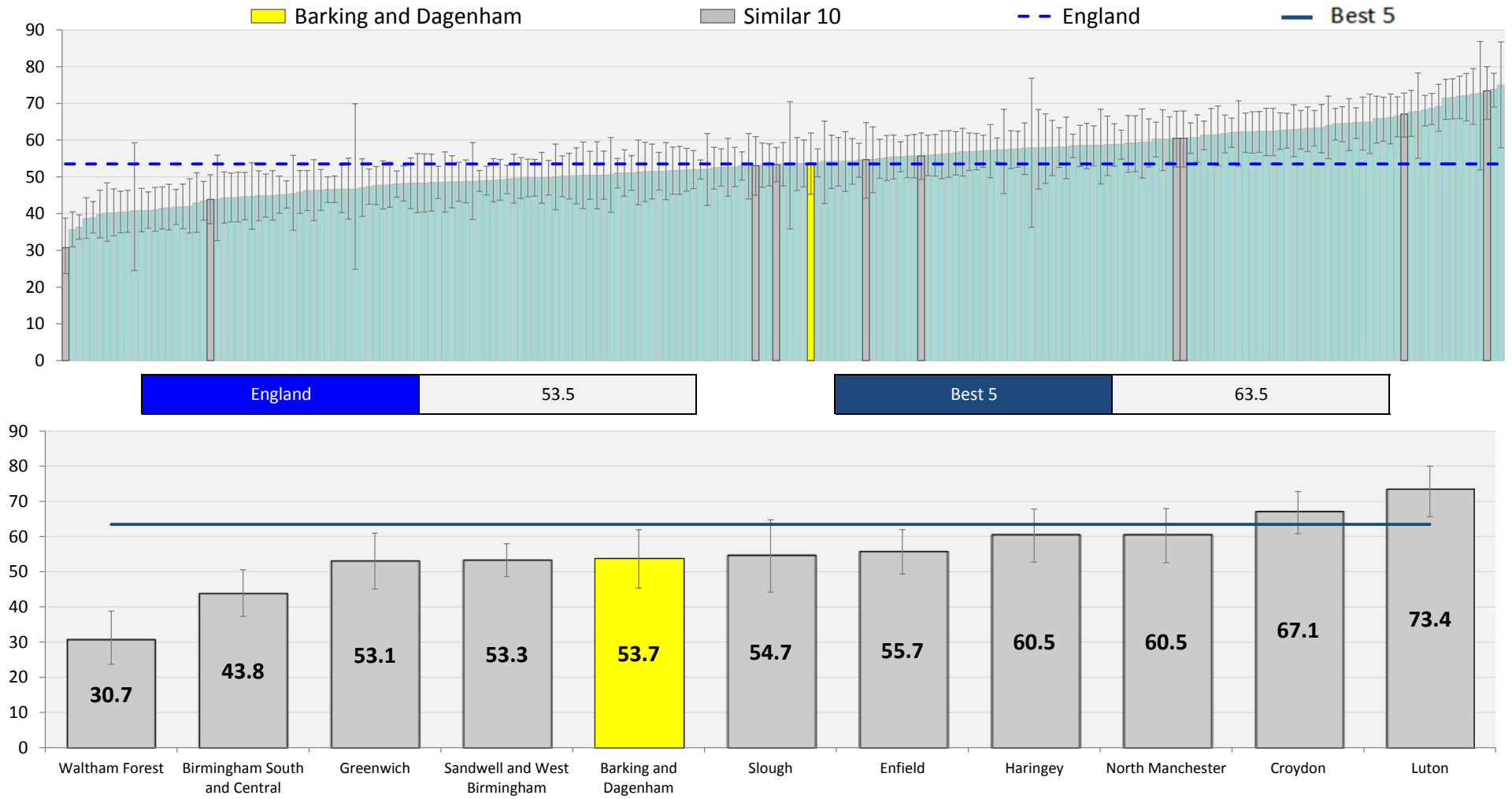


Definition: Oxford Score - Knee (primary) - Health gain (casemix adjusted)
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

No opportunity presented for PROMs indicators except EQ-5D index health gain

% fractured femur patients returning home within 28 days

13 Pats

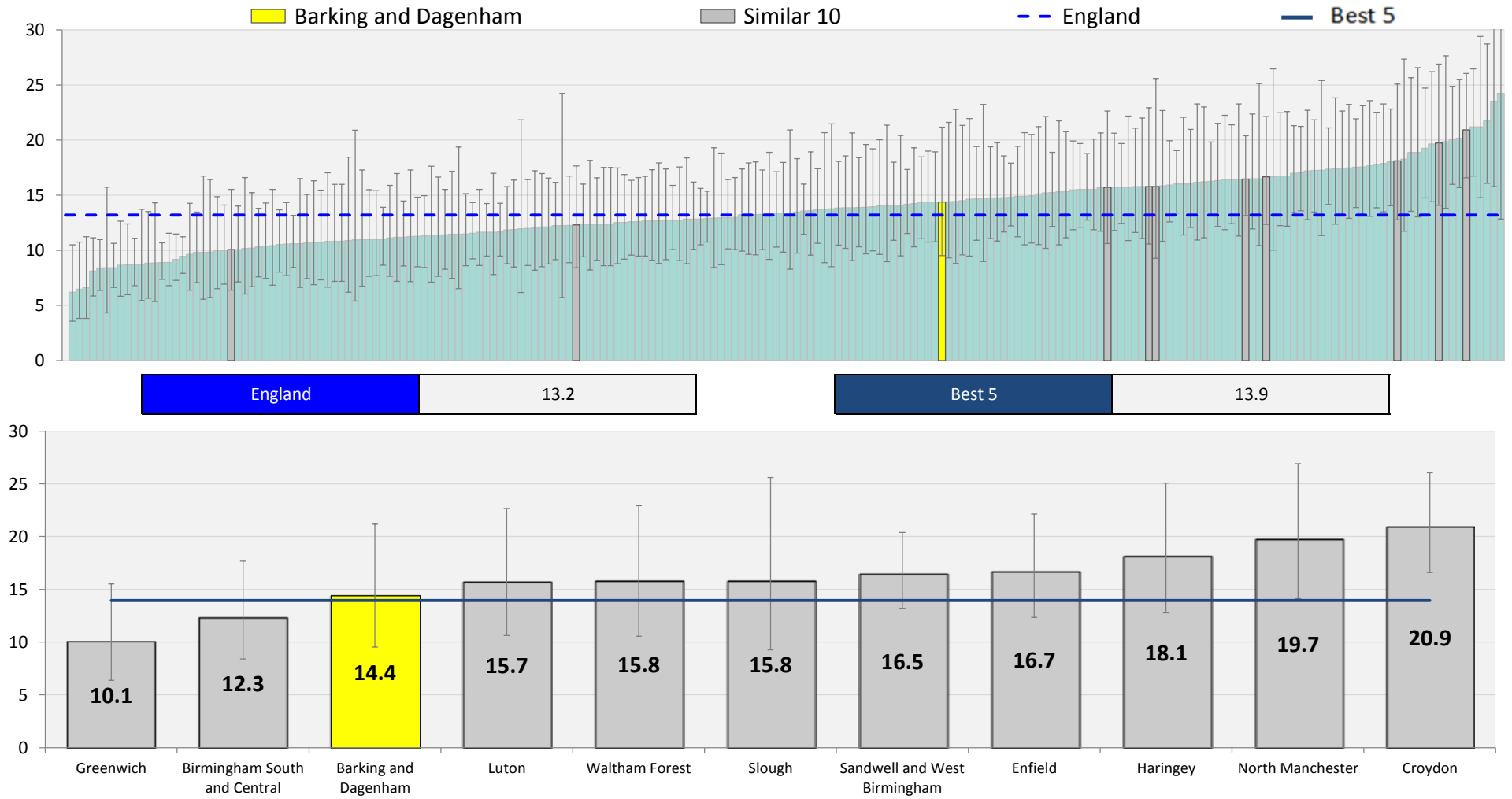


Definition: Percentage of patients returning to usual place of residence following hospital treatment for fractured femur

Source: Hospital Episode statistics (HES)

Year: 2014/15

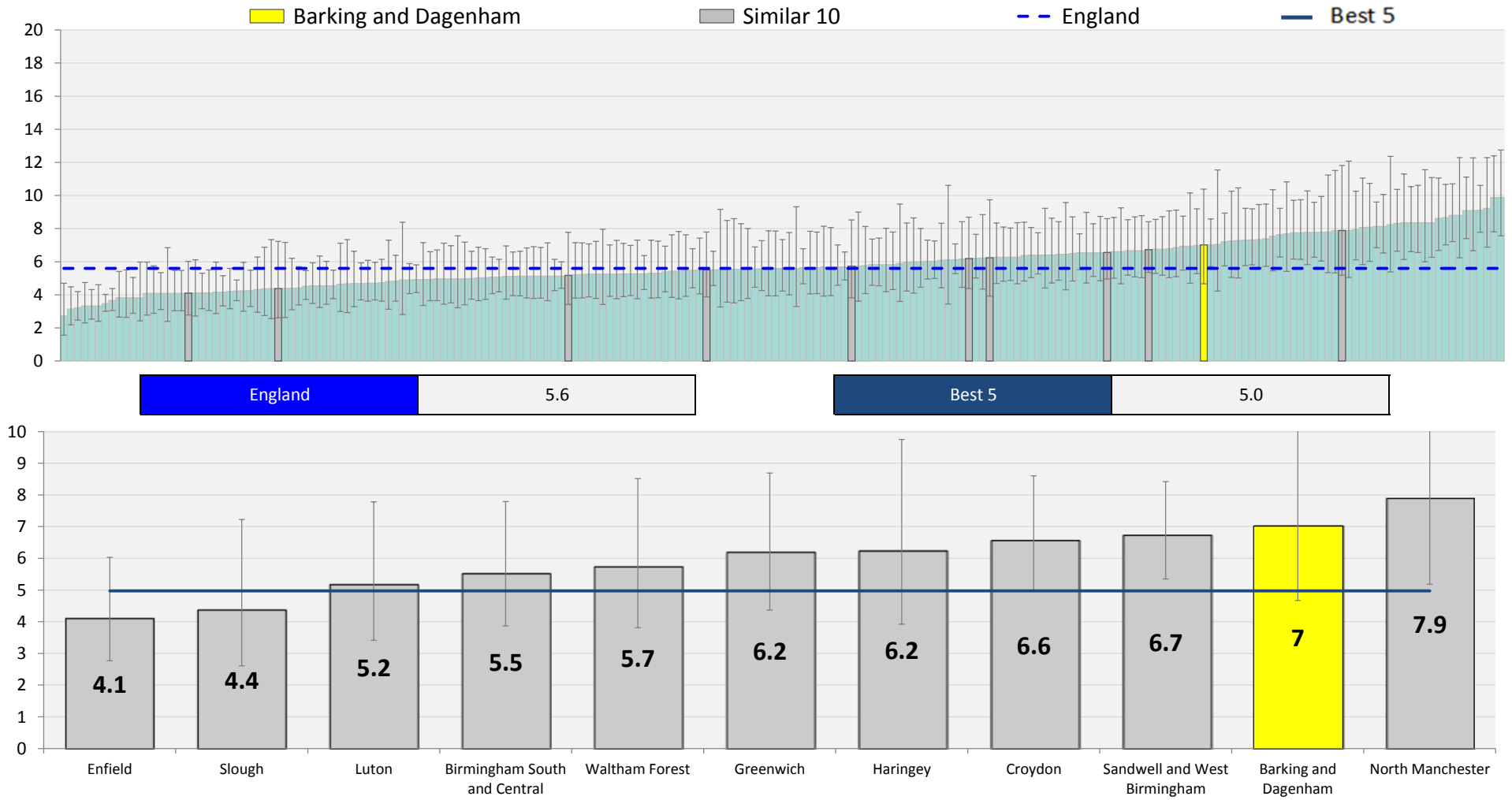
Hip fracture emergency readmissions 28 days (%)



Definition: Emergency readmissions to hospital within 28 days for patients: hip fractures
Source: Hospital Episode statistics (HES)
Year: 2014/15

Hip replacement emergency readmissions 28 days (%)

6 Pats (NSS)

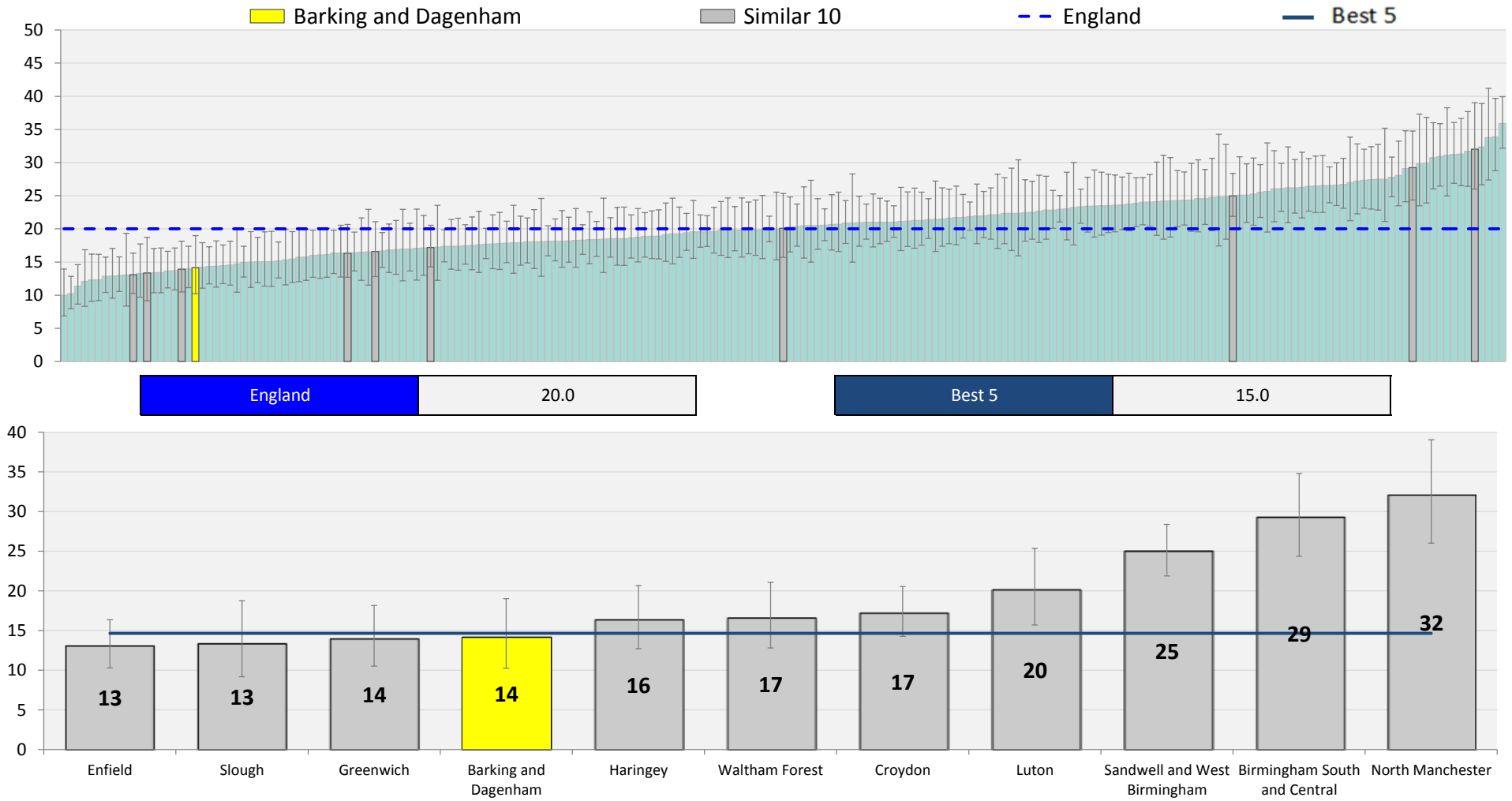


Definition: Emergency readmissions to hospital within 28 days for patients: hip replacements (%)

Source: Hospital Episode Statistics (HES), The Health and Social Care Information Centre. The Indicator Portal, The Health and Social Care Information Centre

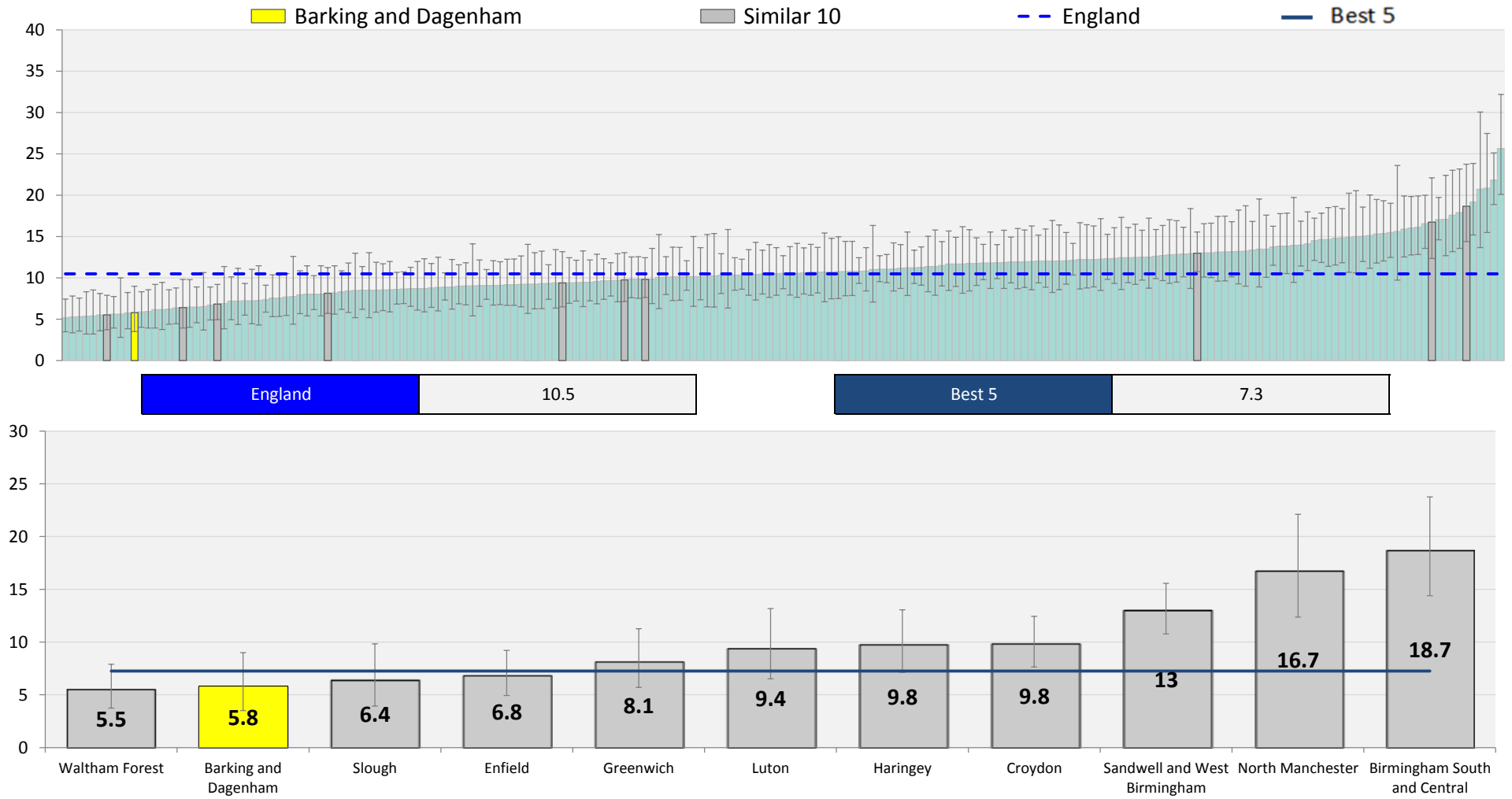
Year: 2009/10-2011/12

Mortality from accidents all years (per 100,000 pop)



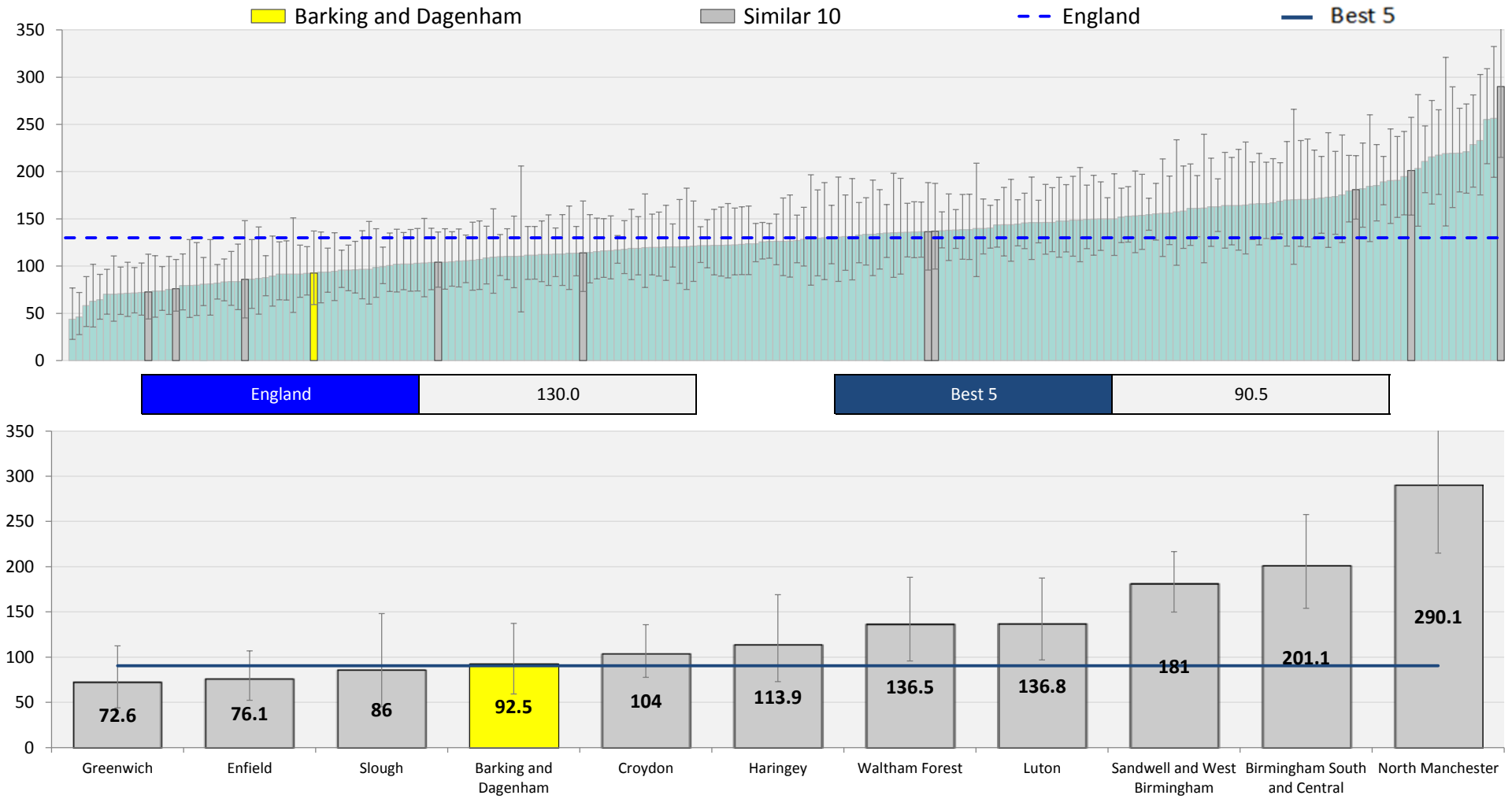
Definition: Mortality from accidents: all age directly age-standardised rates (DSR) per 100,000 European Standard Population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

Mortality - Accidents - Under 75 (per 100,000 pop)



Definition: Mortality from accidents: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

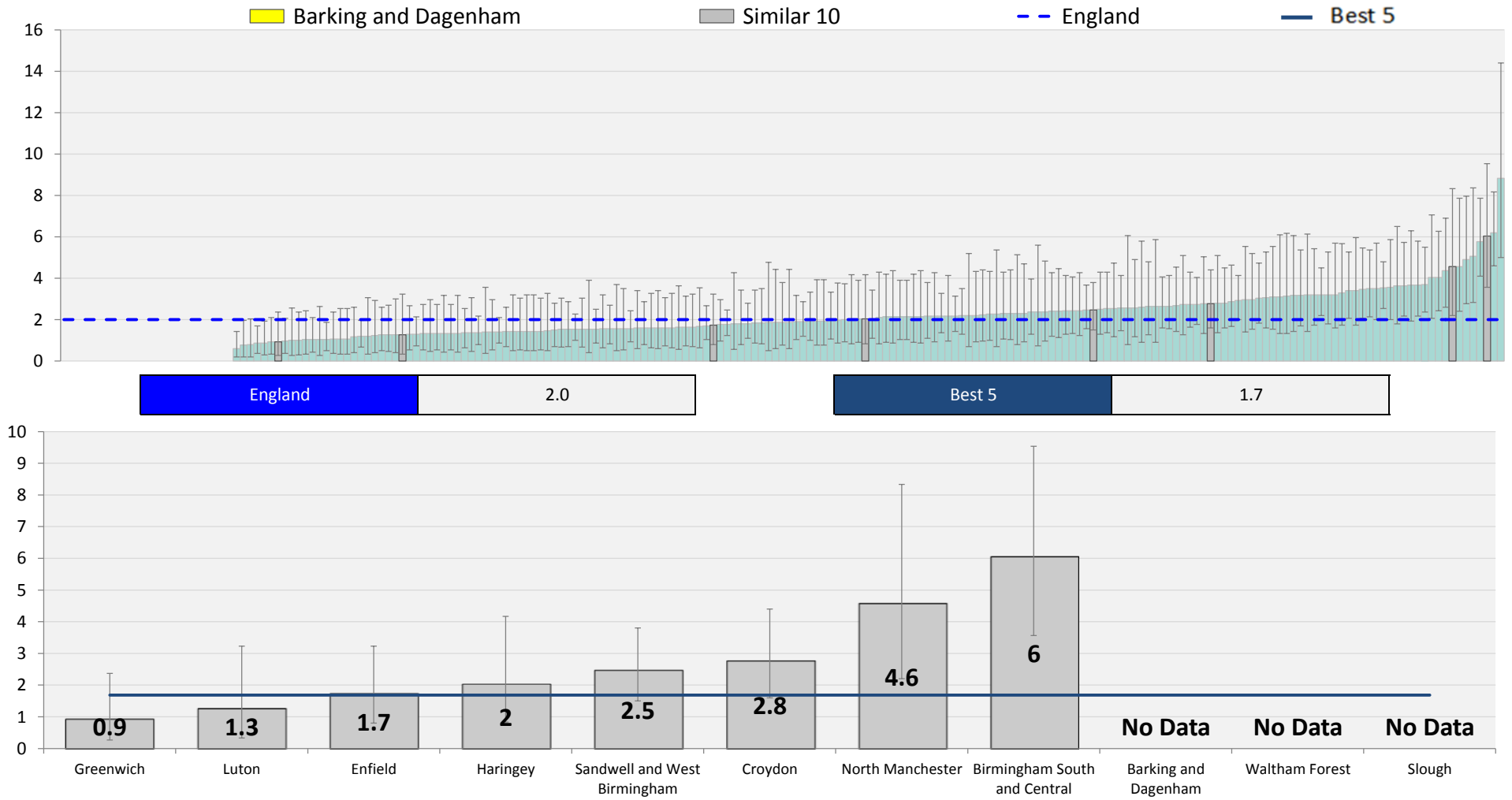
Mortality - Accidents - 75+ (per 100,000 pop)



Definition: Mortality from accidents: 75+ Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

Mortality - Falls - Under 75 (per 100,000 pop)

No Data



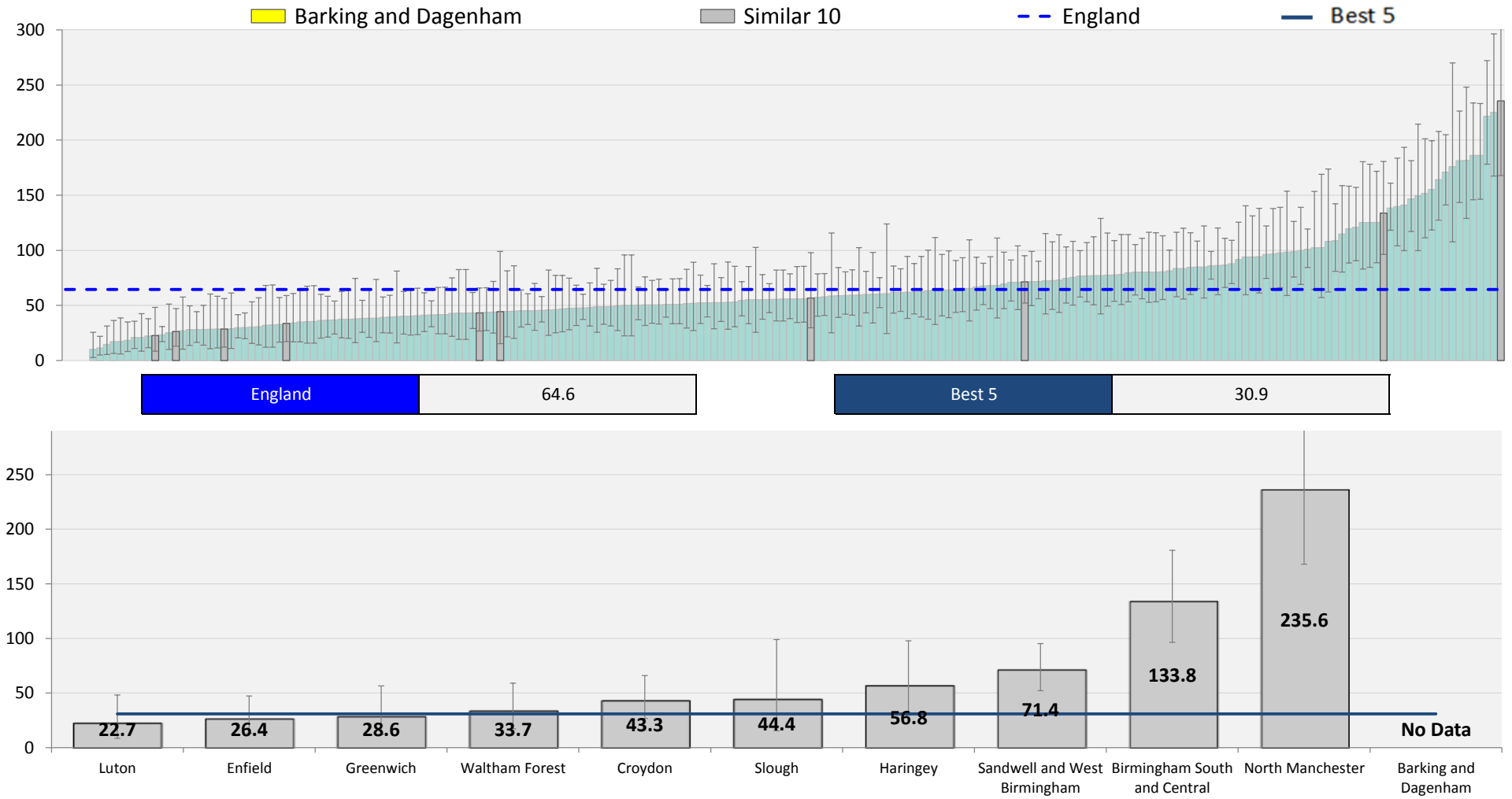
Definition: Mortality from accidental falls: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard population

Source: Primary Care Mortality Database, HSCIC

Year: 2011-13

Mortality - Falls - 75+ (per 100,000 pop)

No Data

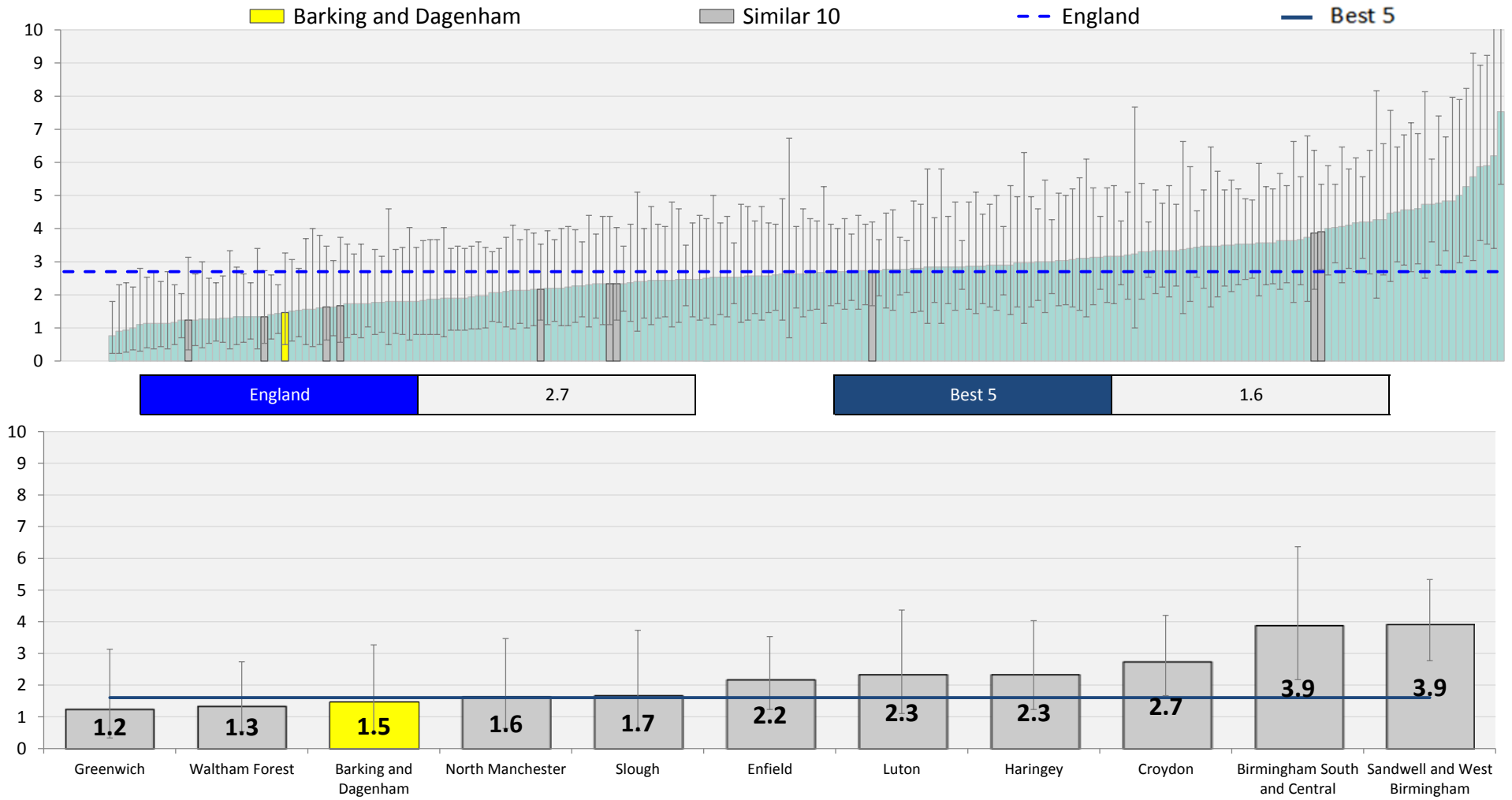


Definition: Mortality from accidental falls: 75+ Directly age-standardised rates (DSR) per 100,000 European Standard population

Source: Primary Care Mortality Database, HSCIC

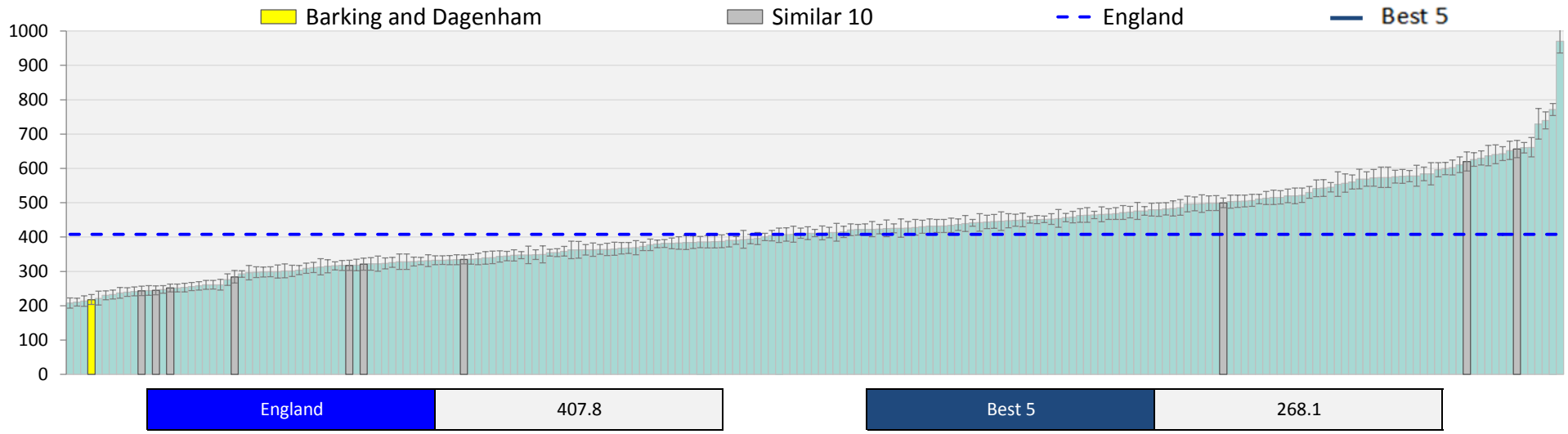
Year: 2011-13

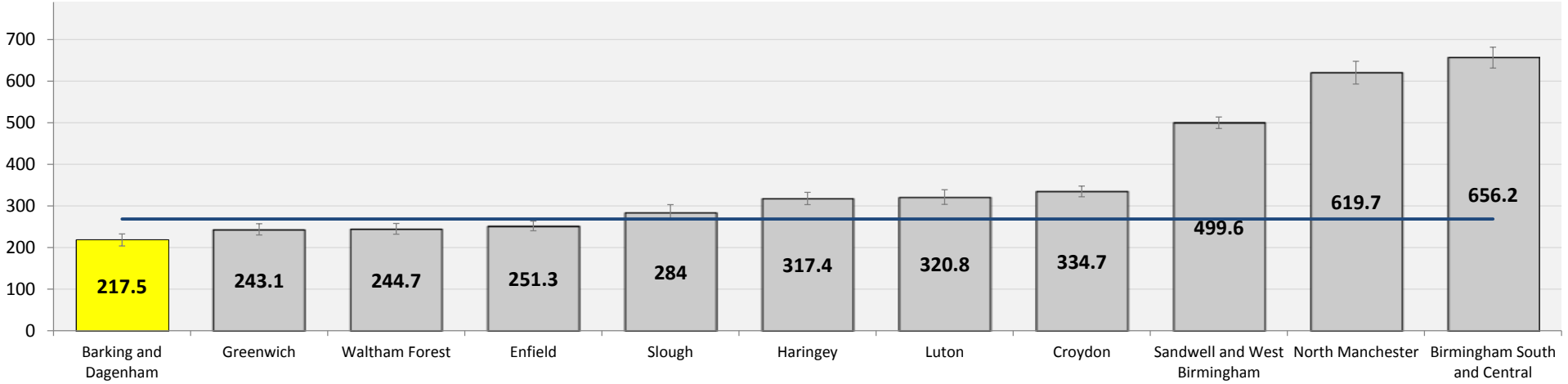
Mortality - all ages - transport accident (per 100,000 pop)



Definition: Mortality from transport accidents: Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

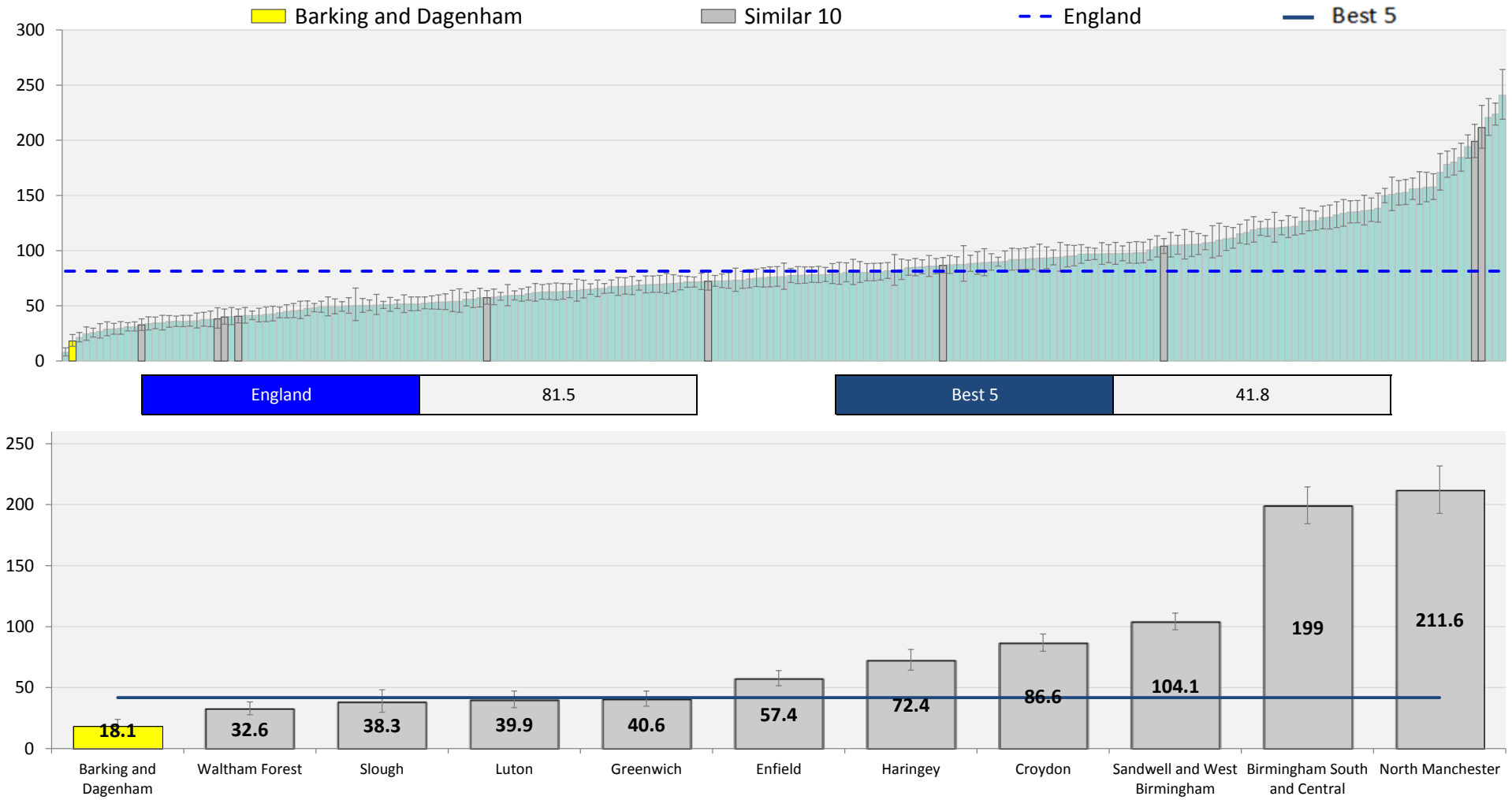
Life years lost Accidents (all)





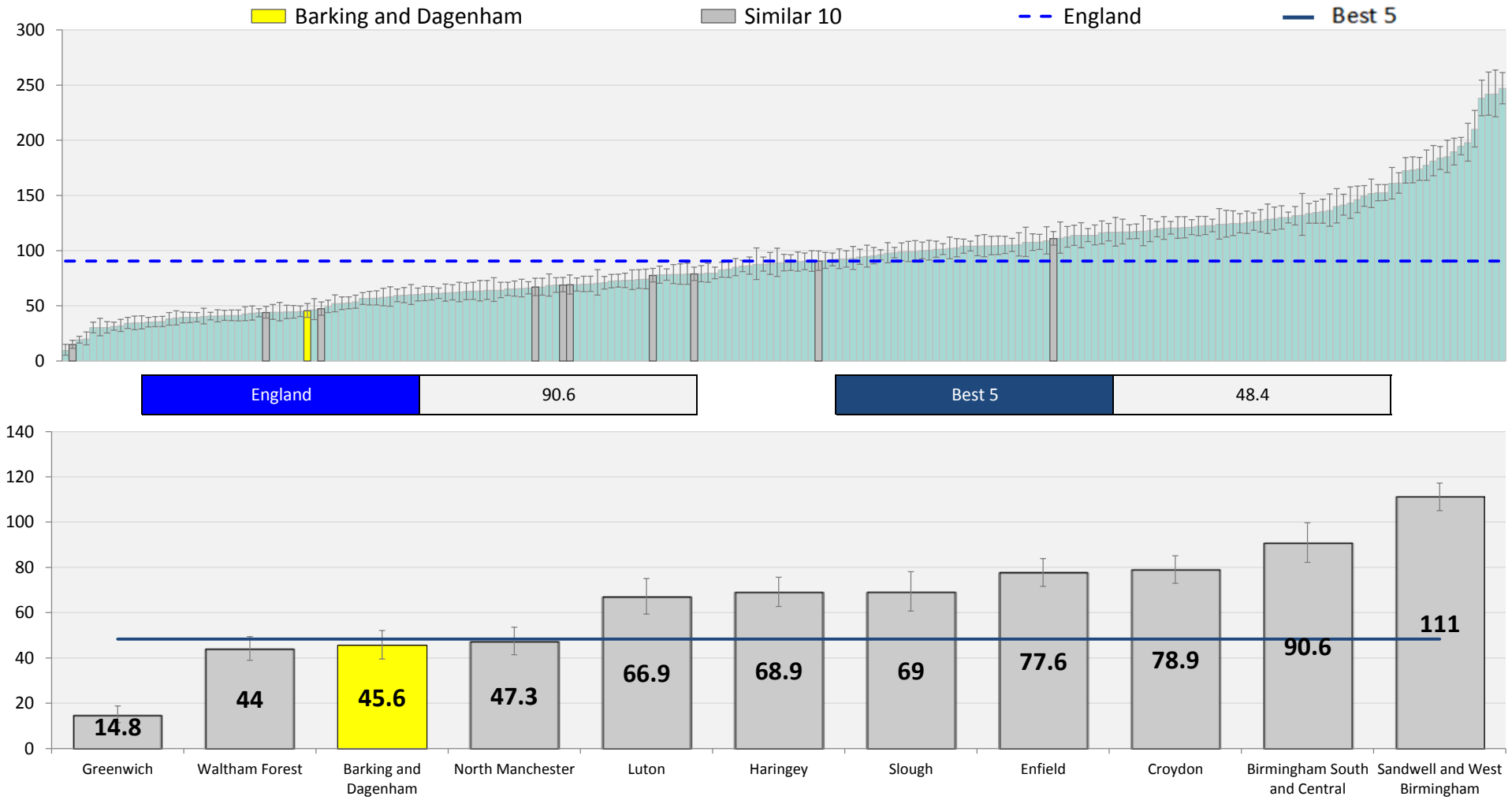
Definition: Years of life lost due to mortality from accidents: Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

Life years lost falls (all)



Definition: Years of life lost due to mortality from accidental falls: Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

Life years lost transport (all)



Definition: Years of life lost due to mortality due to transport accidents: Directly age-standardised rates (DSR) per 100,000 European Standard population
Source: Primary Care Mortality Database, HSCIC
Year: 2011-13

Next steps and actions

Commissioners can take the following actions now:

- Identify the key opportunities for improvement within the pathways included in the MSK, Trauma and Injuries focus pack for your population 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 and explore the opportunities along the pathways further using local data
- Revisit the Commissioning for Value web pages regularly as new content, including updates to tools to support the use of the Commissioning for Value packs, is regularly added
- Watch the focus pack videos, and explore other clinical resources
- Always consider risk factor reduction (e.g. smoking prevalence) as an opportunity to improve population health and reduce disease prevalence
- Discuss the opportunities highlighted in this pack as part of the STP planning process and consider STP wide action where appropriate
- For Wave One CCGs, speak to your Delivery Partner about other practical steps for your locality
- For Wave Two CCGs, start to identify and act to improve the opportunities highlighted

Further support and information

The Commissioning for Value benchmarking tool, explorer tool, full details of all the data used, and links to other useful tools are available on the Commissioning for Value pages of the NHS England website.

The NHS RightCare 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

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

Further surgical resources

There are further resources on key surgical pathways and data available at The Royal College of Surgeons National Surgical Commissioning Centre. All the resources listed below are freely available at the website shown on page 147.

- **Commissioning guides**: have been developed through a NICE accredited process and outline the 'high value' care pathway for a particular surgical complaint. Further information on the development of the commissioning guides is available online. Guides related to MSK conditions include: Painful osteoarthritis of the hip; Painful osteoarthritis of the knee; Subacromial shoulder pain; Painful tingling fingers (carpal and cubital tunnel); and Low back pain
- **Data tools linked to commissioning guides**: use Hospital Episode Statistics (HES). All the tools have been developed with input from a multidisciplinary guideline development group and clinical coders and the technical definitions and guidance on navigating the tools are available to download. The data within these tools should be used as a start of a conversation between commissioners and their providers to examine possible areas for improved efficiency and quality improvement
- **The Quality Dashboards and Procedure Explorer Tool (PET):** There are 30 separate quality dashboards which show quality indicators for surgical procedures commissioned by commissioners. The PET tool shows further detailed information on individual procedures. Data tools for the pathways are:

  - Total Hip replacement and hip resurfacing
  - Knee arthroscopy and osteotomy
  - Rotator cuff revision, subacromial decompression
  - Total or partial knee replacement
  - Carpal and cubital tunnel surgery
  - Facet joint injection/medial branch block

Useful links

Commissioning for Value pages of the NHS England website:
http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

Commissioning for Value Similar 10 Explorer Tool:
https://www.england.nhs.uk/wp-content/uploads/2016/01/cfv-16-similar-10-explr-tool.xlsm

Supporting videos for the CFV focus packs:
https://www.youtube.com/playlist?list=PL6IQwMACXkj1e17bcMvaHuy1gd9XrZT92

NHS RightCare website:
http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

NHS England MSK and Person Centred Care team:
england.longtermconditions@nhs.net

Royal College of Surgeons National Surgical Commissioning Centre:
http://www.rcseng.ac.uk/surgical-commissioning

Continued on the next page

Useful links cont.

Arthritis Research UK:
http://www.arthritisresearchuk.org/

National Osteoporosis Society:
https://www.nos.org.uk/

North East Quality Observatory Service:
http://www.neqos.nhs.uk

National Institute for Health and Care Excellence:
https://www.nice.org.uk/

National Improving Spinal Care Project:
http://ukssb.com/pages/Improving-Spinal-Care-Project/National-Backpain-Pathway.html

Annex A:
Condition and drug groupings

Problems of the musculoskeletal system: Conditions

Condition Group	Programme Budget Category	Primary Diagnosis Code
Back, neck and musculoskeletal pain	15X	Any Primary Diagnosis Code that begins with M40, M41, M42, M43, M46, M47, M48, M49, M50, M51, M52, M53, M54, M86, M87, M88, M89, M90, M91, M92, M93, M94, M95 or M96 and mapped to 15X.
Rheumatoid and Inflammatory Arthritis	15X	Any Primary Diagnosis Code that begins with M00, M01, M02, M03, M05, M06, M07, M08, M09, M10, M11, M12, M13, M14 or M45 and mapped to 15X.
Osteoporosis and fragility fractures	15X	Any Primary Diagnosis Code that begins with M80, M81, M82, M83, M84 or M85 and mapped to 15X.
Osteoarthritis	15X	Any Primary Diagnosis Code that begins with M15, M16, M17, M18 or M19 and mapped to 15X.
Other joint disorders (not including rheumatoid and inflammatory arthritis or osteoarthritis)	15X	Any Primary Diagnosis Code that begins with M20, M21, M22, M23, M24 or M25 and mapped to 15X.
Other MSK	15X	Any Primary Diagnosis Code that begins with M30, M31, M32, M33, M34, M35, M36, M60, M61, M62, M63, M65, M66, M67, M68, M70, M71, M72, M73, M74, M75, M76, M77, M78, M79,M97, M98 or M99 and mapped to 15X.

Programme Budget Category 15X = Problems of the Musculoskeletal System

Problems due to trauma and injuries; Spend groups

Condition Group	Programme Budget Category	Primary Diagnosis Code
Injuries to the hip and thigh	16X	Any Primary Diagnosis Code that begins with S70, S71, S72, S73, S74, S75, S76, S77, S78 or S79 and mapped to 16X.
Injuries to the thorax	16X	Any Primary Diagnosis Code that begins with S20, S21, S22, S23, S24, S25, S26, S27, S28 or S29 and mapped to 16X.
Injuries to the wrist and hand	16X	Any Primary Diagnosis Code that begins with S60, S61, S62, S63, S64, S65, S66, S67, S68 or S69 and mapped to 16X.
Injuries to the shoulder and upper arm	16X	Any Primary Diagnosis Code that begins with S40, S41, S42, S43, S44, S45, S46, S47, S48 or S49 and mapped to 16X.
Injuries to the elbow and forearm	16X	Any Primary Diagnosis Code that begins with S50, S51, S52, S53, S54, S55, S56, S57, S58 or S59 and mapped to 16X.
Injuries to the head	16X	Any Primary Diagnosis Code that begins with S00, S01, S02, S03, S04, S05, S06, S07, S08, S09 and mapped to 16X.
Injuries to the abdomen, lower back, lumbar spine and pelvis	16X	Any Primary Diagnosis Code that begins with S30, S31, S32, S33, S34, S35, S36, S37, S38 or S39 and mapped to 16X.
Injuries to the knee and lower leg	16X	Any Primary Diagnosis Code that begins with S80, S81, S82, S83, S84, S85, S86, S87, S88 or S89 and mapped to 16X.

Programme Budget Category 16X = Problems due to Trauma and Injuries

MSK procedures

Back and radicular pain ICD10 and OPCS4.7 codes

Definitions for low back and radicular pain are based on diagnosis codes (ICD-10) and relevant secondary care procedures codes (OPCS 4.7) were developed by the NEQOS (Liz Lingard, Andrea Brown and Adam Fearing) working with Professor Charles Greenough (National Clinical Director for Spinal Disorders, South Tees NHS Foundation Trust). These codes have been supported by Mr Ashley Cole, Chair of Specialised Spinal Surgery Clinical Reference Group (Consultant Orthopaedic Surgeon, Northern General Hospital and Sheffield Children's Hospital). NEQOS has producing detailed regional CCG and Provider level reports to support the Getting It Right First Time (GIRFT) project and the National Pathfinder Project for Acute Low Back and Radicular Pain. More information is available at: www.neqos.nhs.uk

Hip and Knee Replacement codes

Codes used in this focus pack are consistent with the OPCS4.7 codes published by the NJR. It should be noted that the Hip and Knee replacement codes used by the HSCIC for the PROMs programme are not consistent with the codes used by the National Joint Registry (NJR). These inconsistencies have been discussed with clinical experts from the British Orthopaedic Association and the leads for the national PROMs programme within NHS England and the HSCIC (September 2015) and it was agreed that OPCS4.7 codes published by the NJR should be the accepted standard for all future indicator development. NEQOS produces a bi-annual Provider level Hip and Knee Dashboard that includes process and outcomes indicators. More information is available at: www.neqos.nhs.uk).

Shoulder surgery codes

Development of shoulder replacement and sub-acromial decompression with/without rotator cuff repair indicators was a collaboration between NEQOS (Liz Lingard and Kayoung Goffe) and Orthopaedic Surgeons led by Amar Rangan (National Clinical Director for Shoulder Disorders) with Mike Reed, Jaime Candal-Couto, Simon Jameson, Andreas Hinsche, Sivaraman Balasubramanian, Rajesh Nanda in the North East and Adam Watts, Chris Peach, Matthew Kent Phil Turner, David Johnson in the North West. This work was funded by Orthopaedic Research UK.

MSK procedures: Shoulders

High spend procedures mapped to Programme Budget Code: 15X*

OPCS Procedure Codes for Anatomical Total Shoulder Arthroplasty: O061, O068, O069, O071, O078, O079, O081, O088, O089, W961, W968, W969, W971, W978, W979, W981, W988, W989
OPCS Procedure Codes for Resurfacing and Stemmed Hemiarthroplasty: W494, W504, W515, W581, Z814, W491, W498, W499, W501, W508, W509, W511, W518, W519
OPCS Procedure Codes for Reverse Polarity Arthroplasty: W965, W975, W986
OPCS Procedure Codes for Revision Shoulder cuff repair: T791, T793, T794, T795
OPCS Procedure Code for Subacromial decompression: O291

* Primary procedures where the primary diagnosis for the admission fell within the Programme Budget Category 15X

MSK procedures: Hip and knee replacements

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Codes for Primary Hip Replacement - Cemented: W371, W378, W379, W521
OPCS Procedure Codes for Primary Hip Replacement - Uncemented: W381, W388, W389, W531
OPCS Procedure Codes for Primary Hip Replacement - Unspecified: W391, W399 or ((W541, W581) and (Z843 or Z761 or Z756))
OPCS Procedure Codes for Primary Hip Replacement - Hybrid: W931, W939, W941, W949, W951, W958, W959
OPCS Procedure Codes for Hip Revisions - Total: W370, W372, W373, W374, W380, W382, W383, W384, W392, W393, W394, W395, W462, W472, W482, W522, W523, W532, W533, W542, W543, W544, W572, W574, W582, W932, W933, W940, W942, W943, W952, W953, W954
OPCS Procedure Codes for Primary Knee Replacements – Cemented: W401, W408, W409, W521
OPCS Procedure Codes for Primary Knee Replacements - Uncemented: W411, W418, W419, W531
OPCS Procedure Codes for Primary Knee Replacements - Unspecified: W421, W428, W429 or ((W541, W581) and (Z846 or Z765 or Z845 or Z844 or Z774 or Z787))
OPCS Procedure Codes for Knee Revisions - Total: O180, O182, O183, O184, W400, W402, W403, W404, W410, W412, W413, W414, W420, W422, W423, W424, W425, W522, W523, W532, W533, W542, W543, W544, W553, W564, W574, W582, W603, W613, W641, W642

MSK procedures: Back/Radicular pain injections

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Code	Full procedure description	Procedure type	Procedure group
V544	Injection around spinal facet of spine	Back pain injections	Injection facet joint
W903	Injection of therapeutic substance into joint	Back Pain Injections	Other Back Injection
X375	Intramuscular injection for local action	Back Pain Injections	Other Back Injection
X382	Injection of steroid for local action NEC	Back Pain Injections	Other Back Injection
A521	Therapeutic lumbar epidural injection	Radicular pain injection	Epidural lumbar
A522	Therapeutic sacral epidural injection	Radicular pain injection	Epidural sacral
A528	Other specified therapeutic epidural injection	Radicular pain injection	Epidural (not specified)
A529	Unspecified therapeutic epidural injection	Radicular pain injection	Epidural (not specified)
A577	Injection of therapeutic substance around spinal nerve root	Radicular pain injection	Spinal nerve root injection

MSK procedures: Imaging

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Code	Full procedure description	Procedure group
U054	Computed tomography of spine	CT
U055	Magnetic resonance imaging of spine	MRI
U211	Magnetic resonance imaging NEC	MRI
U212	Computed tomography NEC	CT
V523	Discography of intervertebral disc	Discography

MSK procedures: Pain management

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Code	Full procedure description	Procedure group
A483	Insertion of neurostimulator adjacent to spinal cord	Neurostimulators
A484	Attention to neurostimulator adjacent to spinal cord NEC	Neurostimulators
A485	Reprogramming of neurostimulator adjacent to spinal cord	Neurostimulators
A486	Removal of neurostimulator adjacent to spinal cord	Neurostimulators
A487	Insertion of neurostimulator electrodes into the spinal cord	Neurostimulators
A543	Implantation of intrathecal drug delivery device adjacent to spinal cord	Drug delivery device
A544	Attention to intrathecal drug delivery device adjacent to spinal cord	Drug delivery device
A545	Removal of intrathecal drug delivery device adjacent to spinal cord	Drug delivery device
A572	Rhizotomy of spinal nerve root	Spinal nerve root destruction
A573	Radiofrequency controlled thermal destruction of spinal nerve root	Spinal nerve root destruction
A574	Injection of destructive substance into spinal nerve root	Spinal nerve root destruction
A575	Destruction of spinal nerve root NEC	Spinal nerve root destruction
A705	Electroacupuncture	Acupuncture

MSK procedures: Pain management continued

OPCS Procedure Code	Full procedure description	Procedure group
A706	Acupuncture NEC	Acupuncture
A707	Application of transcutaneous electrical nerve stimulator	TENS
V485	Radiofrequency controlled thermal denervation of spinal facet joint of lumbar vertebra	Denervation
V486	Denervation of spinal facet joint of lumbar vertebra NEC	Denervation
V487	Radiofrequency controlled thermal denervation of spinal facet joint of vertebra NEC	Denervation
V488	Other specified denervation of spinal facet joint of vertebra	Denervation
V489	Unspecified denervation of spinal facet joint of vertebra	Denervation
V623	Primary percutaneous intradiscal radiofrequency thermocoagulation to lumbar intervertebral disc	Radiofrequency thermocoagulation to disc
V628	Other specified primary percutaneous intradiscal radiofrequency thermocoagulation to intervertebral disc	Radiofrequency thermocoagulation to disc
V629	Unspecified primary percutaneous intradiscal radiofrequency thermocoagulation to intervertebral disc	Radiofrequency thermocoagulation to disc
V633	Revisional percutaneous intradiscal radiofrequency thermocoagulation to lumbar intervertebral disc	Radiofrequency thermocoagulation to disc
V638	Other specified revisional percutaneous intradiscal radiofrequency thermocoagulation to intervertebral disc	Radiofrequency thermocoagulation to disc
V639	Unspecified revisional percutaneous intradiscal radiofrequency thermocoagulation to intervertebral disc	Radiofrequency thermocoagulation to disc
X292	Continuous intravenous infusion of therapeutic substance NEC	Drug delivery device

MSK procedures: Surgery

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Codes for Surgery - All: A578, A579, V251, V252, V253, V254, V255, V256, V258, V259, V261, V262, V263, V264, V265, V266, V268, V269, V281, V282, V288, V289, V331, V332, V333, V334, V335, V336, V337, V338, V339, V341, V342, V343, V344, V345, V346, V347, V348, V349, V351, V352, V358, V359, V363, V368, V369, V382, V383, V384, V385, V386, V388, V389, V393, V394, V395, V396, V397, V398, V399, V401, V404, V408, V409, V493, V521, V522, V528, V529, V548, V549, V563, V564, V568, V569, V573, V574, V603, V608, V609, V613, V618, V619, V671, V672, V678, V679, V681, V682, V688, V689
OPCS Procedure Codes for Surgery – Decompression: V252, V254, V255, V256, V258, V259, V603, V608, V609, V671, V672, V678, V679
OPCS Procedure Codes for Surgery - Discectomy: V331, V332, V337, V338, V339, V351, V358, V359
OPCS Procedure Codes for Surgery - Posterior lumbar fusion: V382, V383, V384, V385, V386, V388, V389, V404, V408, V409

MSK procedures: Other high spend MSK

High spend procedures mapped to Programme Budget Code: 15X

OPCS Procedure Code	Full procedure description	Short name in focus packs
W822	Endoscopic resection of semilunar cartilage NEC	Endoscopic resection of semilunar cartilage NEC
V411	Posterior attachment of correctional instrument to spine	Posterior attachment of correctional instrument to spine
T791	Plastic repair of rotator cuff of shoulder NEC	Plastic repair of rotator cuff of shoulder NEC
W283	Removal of internal fixation from bone NEC	Removal of internal fixation from bone NEC
W742	Reconstruction of intra-articular ligament NEC	Reconstruction of intra-articular ligament NEC
T525	Digital fasciectomy	Digital fasciectomy
T521	Palmar fasciectomy	Palmar fasciectomy
W901	Aspiration of joint	Aspiration of joint
V294	Primary anterior excision of cervical intervertebral disc and interbody fusion of joint of cervical spine	Primary anterior excision of cervical intervertebral disc and interbody fusion of joint of cervical spine
T723	Release of constriction of sheath of tendon	Release of constriction of sheath of tendon
W621	Primary arthrodesis and internal fixation of joint NEC	Primary arthrodesis and internal fixation of joint NEC
U051	Computed tomography of head	CT - Head
W802	Open debridement of joint NEC	Open debridement of joint NEC

Trauma and injuries procedures

High spend procedures mapped to Programme Budget Code: 16X

OPCS Procedure Code	Full procedure description	Short name in focus packs
W461	Primary prosthetic replacement of head of femur using cement	Primary prosthetic replacement of head of femur using cement
W201	Primary open reduction of fracture of long bone and extramedullary fixation using plate NEC	Primary open reduction of fracture of long bone and extramedullary fixation using plate NEC
U051	Computed tomography of head	CT - Head
W242	Closed reduction of fracture of long bone and rigid internal fixation NEC	Closed reduction of fracture of long bone and rigid internal fixation NEC
W246	Closed reduction of fracture of bone and fixation using nail or screw	Closed reduction of fracture of bone and fixation using nail or screw
U212	Computed tomography NEC	CT - NEC
W192	Primary open reduction of fracture of long bone and fixation using rigid nail NEC	Primary open reduction of fracture of long bone and fixation using rigid nail NEC
W262	Manipulation of fracture of bone NEC	Manipulation of fracture of bone NEC
W191	Primary open reduction of fracture of neck of femur and open fixation using pin and plate	Primary open reduction of fracture of neck of femur and open fixation using pin and plate
U502	Delivery of rehabilitation for hip fracture	Delivery of rehabilitation for hip fracture
W471	Primary prosthetic replacement of head of femur not using cement	Primary prosthetic replacement of head of femur not using cement
W198	Other specified primary open reduction of fracture of bone and intramedullary fixation	Other specified primary open reduction of fracture of bone and intramedullary fixation
T676	Primary simple repair of tendon	Primary simple repair of tendon
W232	Secondary open reduction of fracture of bone and extramedullary fixation HFQ	Secondary open reduction of fracture of bone and extramedullary fixation HFQ
U508	Other specified rehabilitation for musculoskeletal disorders	Other specified rehabilitation for musculoskeletal disorders
S571	Debridement of skin NEC	Debridement of skin NEC
X481	Application of plaster cast	Application of plaster cast
S411	Primary suture of skin of head or neck NEC	Primary suture of skin of head or neck NEC
W371	Primary total prosthetic replacement of hip joint using cement	Primary total prosthetic replacement of hip joint using cement
A411	Evacuation of subdural haematoma	Evacuation of subdural haematoma

MSK prescribing

Condition drug groups	Chemical level drugs included
Pain medication	Nefopam hydrochloride, Tapentadol Hydrochloride, Tramadol Hydrochloride, Amitriptyline Hydrochloride, Pregabalin, Nortriptyline, Gabapentin, Celecoxib, Diclofenac Potassium, Diclofenac Sodium, Etoricoxib, Ibuprofen, Indometacin, Meloxicam, Naproxen, Capsaicin
Bisphosphonates	Other Calcium Supplement Preps, Other Vitamin D Preps, Alendronic acid, Zoledronic Acid, Ibandronic Acid
Non-bisphosphonates	Calcitriol, Teriparatide, Denosumab, Raloxifene Hydrochloride, Strontium Ranelate

MSK prescribing continued

Individual drugs	BNF Category
Naproxen	Non-steroidal anti-inflammatory drugs
Ibuprofen	Non-steroidal anti-inflammatory drugs
Diclofenac Sodium	Non-steroidal anti-inflammatory drugs
Etoricoxib	Non-steroidal anti-inflammatory drugs
Celecoxib	Non-steroidal anti-inflammatory drugs
Methotrexate	Drugs that suppress the rheumatic disease process
Hydroxychloroquine Sulfate	Drugs that suppress the rheumatic disease process
Leflunomide	Drugs that suppress the rheumatic disease process
Allopurinol	Gout and cytotoxic-induced hyperuricaemia
Colchicine	Gout and cytotoxic-induced hyperuricaemia
Febuxostat	Gout and cytotoxic-induced hyperuricaemia
Prednisolone	Glucocorticoid therapy
Tramadol Hydrochloride	Opioid analgesics
Codeine Phosphate	Opioid analgesics
Dihydrocodeine Tartrate	Opioid analgesics
Co-codamol (Codeine Phos/Paracetamol)	Non-opioid analgesics and compound analgesic preparations
Paracetamol	Non-opioid analgesics and compound analgesic preparations
Piroxicam	Non-steroidal anti-inflammatory drugs
Heparinoid	Parenteral anticoagulants
Capsaicin	Rubefacients, topical NSAIDs, capsaicin, and poultices

SUS SEM code definitions

Admission Method	Admission Method Description
11	11: Waiting list
12	12: Booked
13	13: Planned
21	21: Accident and emergency or dental casualty department of the health care provider
22	22: General practitioner: after a request for immediate admission has been made direct to a hospital provider, i.e. Not through a bed bureau, by a general practitioner or deputy
23	23: Bed bureau
24	24: Consultant clinic, of this or another health care provider
25	25: Admission via mental health crisis resolution team
28	28: Other means, examples are: admitted from the accident and emergency department of another provider where they had not been admitted; transfer of an admitted patient from another hospital provider in an emergency; baby born at home as intended
2A	2A: Accident and emergency department of another provider where the patient had not been admitted
2B	2B: Transfer of an admitted patient from another hospital provider in an emergency
2C	2C: Baby born at home as intended
2D	2D: Other emergency admission
31	31: Admitted ante-partum
32	32: Admitted post-partum
81	81: Transfer of any admitted patient from other hospital provider other than in an emergency
82	82: The birth of a baby in this health care provider
83	83: Baby born outside the health care provider except when born at home as intended.

Patient Classification	Patient Classification Description
1	1: Ordinary admission
2	2: Day case admission

Person Gender Code	Person Gender Description
1	1: Male
2	2: Female

Annex B:
High level metadata

Admissions spend indicators

Analysis	Elective/Non-elective spend analysis
Time Period	2014/15
Age Group	0 – 120
Admissions method	Elective - 11, 12, 13** Non-Elective - 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D, 31, 32, 81, 82, 83** [Total spend indicators includes all elective and non elective admissions method codes]
Patient Classification	Elective - 1, 2** Non-Elective – 1**
Sex	1, 2**
Coding scheme used	Programme Budget Category (PBC), ICD10 Primary Diagnosis Codes
Numerator	Total spend on elective/non-elective admissions based on PBC/condition
Numerator Source	Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart) http://www.hscic.gov.uk/sus
Denominator	Age/Sex Standardised Population. Rate= (Numerator/Denominator) * 1000

**See annex for SUS SEM Code definitions

Secondary User Services Extract Mart (SUS SEM) data is used.
Only patients with a mandatory tariff recorded have been selected.
The fields that were pulled from SUS SEM include:

- CCG code (based on the GP practice code)
- Sex (this field is used for age/sex standardisation)
- Age_Quinary (Age Band)
- Number of spells
- Net_SLA_Payment (the cost before MFF is applied)

The data does not include CCGs which were not found in the official list of CCGs across England.
Age_Quinary field is presented in 5-year age bands (0-4, 5-9, 10-14, etc.) including the “85+” age band for people aged 85 and over. This field is used for age/sex standardisation.
Number of spells field counts all the patients admitted to hospital for a procedure and discharged in the financial year 2014/15 and groups into each age band.
[Patients admitted in 2014/15 but not discharged until 2015/16 will not count towards the spend. A small number of patients admitted in 2013/14 but not discharged until 2014/15 will count towards the spend for 2014/15.]
Net_SLA_Payment field is the cost before Market Forces Factor (MFF) is applied. This field gives spend on elective/non-elective admissions for all patients in the age band in 2014/15.
The number of elective/non-elective admissions were suppressed where it was less than or equal to 5 at CCG level.

Day case admissions indicators

Analysis	Day case admissions analysis
Time Period	2014/15
Age Group	0 – 120
Admissions method	11, 12, 13
Patient Classification	2
Sex	1, 2
Coding scheme used	Programme Budget Category (PBC), ICD10
Numerator	Number of day case admissions based on PBC/condition
Numerator Source	Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart) http://www.hscic.gov.uk/sus
Denominator	Age/Sex Standardised Population. Rate= (Numerator/Denominator) * 100000

Secondary User Services Extract Mart (SUS SEM) data is used.

Only patients with a mandatory tariff recorded have been selected.

The fields that were pulled from SUS SEM include:

- CCG code (based on the GP practice code)
- Sex (this field is used for age/sex standardisation)
- Age_Quinary (Age Band)
- Number of spells

The data does not include CCGs which were not found in the official list of CCGs across England.

Age_Quinary field is presented in 5-year age bands (0-4, 5-9, 10-14, etc.) including the “85+” age band for people aged 85 and over. This field is used for age/sex standardisation.

Number of spells field counts all the day case admissions in 2014/15 and groups into each age band.

The number of day case admissions were suppressed where it was less than or equal to 5 at CCG level.

Emergency admissions indicators

Analysis	Emergency admissions analysis
Time Period	2014/15
Age Group	Children: 0 – 18 Adults: 19 - 120
Admissions method	Emergency - 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D
Patient Classification	1
Sex	1, 2
Coding scheme used	Programme Budget Category (PBC), ICD10
Numerator	Number of emergency admissions based on PBC/condition
Numerator Source	Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart) http://www.hscic.gov.uk/sus
Denominator	Age/Sex Standardised Population. Rate= (Numerator/Denominator) * 100000

Secondary User Services Extract Mart (SUS SEM) data is used.

Only patients with a mandatory tariff recorded have been selected.

The fields that were pulled from SUS SEM include:

- CCG code (based on the GP practice code)
- Sex (this field is used for age/sex standardisation)
- Age_Quinary (Age Band)
- Number of spells

The data does not include CCGs which were not found in the official list of CCGs across England.

Age_Quinary field is presented in 5-year age bands (0-4, 5-9, 10-14, etc.) including the “85+” age band for people aged 85 and over. This field is used for age/sex standardisation.

Number of spells field counts all the emergency admissions in the financial year 2014/15 and groups into each age band.

The number of emergency admissions were suppressed where it was less than or equal to 5 at CCG level.

Length of stay indicators

Analysis	Length of Stay analysis
Time Period	2014/15
Age Group	0 - 120
Admissions method	Elective - 11, 12, 13 Emergency - 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D
Patient Classification	1
Sex	1, 2
Coding scheme used	Programme Budget Category (PBC), ICD10
Numerator	Total number of bed days for elective/emergency admissions based on PBC/condition (not including day cases)
Numerator Source	Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart) http://www.hscic.gov.uk/sus
Denominator	Total number of elective/emergency admissions not including day cases based on PBC/condition.

Secondary User Services Extract Mart (SUS SEM) data is used. Length of Stay data have been extracted at record level.

Only patients with a mandatory tariff recorded have been selected.

Data filtered by Length of Stay less than 180 days.

The fields that were pulled from SUS SEM include:

- APCS_Ident
- CCG code (based on the GP practice code)
- Spell_LoS (Length of Stay)

The data does not include CCGs which were not found in the official list of CCGs across England.

APCS_Ident field was later used to count the number of elective/emergency admissions since the data was extracted at record level.

Spell_LoS field is the spell length of stay derived using Admission Date and Discharge Date.

Standard deviation has been calculated for each CCG in order to calculate confidence intervals using record level data. Length of Stay data was then grouped by CCG to get the total number of bed days (Sum of Spell_LoS field) and total number of elective/emergency admissions (count of APCS_Ident field) for each CCG.

The number of elective/emergency admissions were suppressed where it was less than or equal to 5 at CCG level.

Procedures spend and activity indicators

Analysis	Procedures spend and activity analysis
Time Period	2014/15
Age Group	0 – 120
Admissions method	11, 12, 13, 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D, 31, 32, 81, 82, 83
Patient Classification	1, 2
Sex	1, 2
Coding scheme used	Programme Budget Category (PBC), OPCS
Numerator	Total spend on discharges based on PBC and procedures
Numerator Source	Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart) http://www.hscic.gov.uk/sus
Denominator	Age/Sex Standardised Population. Rate= (Numerator/Denominator) * 1000

Secondary User Services Extract Mart (SUS SEM) data is used.
Only patients with a mandatory tariff recorded have been selected.

For these indicators, spend on a procedure is the total cost of all spells where the procedure listed is the primary procedure in the spell, and where the primary diagnosis for the spell falls under the programme budget category listed. The figure for "How different are we?" converts the CCG's spending rate above the benchmark spending rate into the equivalent number of procedures.

The fields that were pulled from SUS SEM for spend on procedures include:

- CCG code (based on the GP practice code)
- Sex (this field is used for age/sex standardisation)
- Age_Quinary (Age Band)
- Number of spells
- Net_SLA_Payment (the cost before MFF is applied)

The data does not include CCGs which were not found in the official list of CCGs across England.

Age_Quinary field is presented in 5-year age bands (0-4, 5-9, 10-14, etc.) including the "85+" age band for people aged 85 and over. This field is used for age/sex standardisation.
Number of spells field counts all the patients admitted to hospital for a procedure and discharged in the financial year 2014/15 and groups into each age band. [Patients admitted in 2014/15 but not discharged until 2015/16 will not count towards the spend. A small number of patients admitted in 2013/14 but not discharged until 2014/15 will count towards the spend for 2014/15.]
Net_SLA_Payment field is the cost before Market Forces Factor (MFF) is applied. This field gives spend on discharges for all patients in the age band in 2014/15.

The fields that were pulled from SUS SEM for procedures activity include:

- CCG code (based on the GP practice code)
- Number of spells (count s all admissions in 2014/15 and groups by CCG).

The number of admissions/discharges were suppressed where it was less than or equal to 5 at CCG level.

Prescribing spend indicators

Analysis	Prescribing Spend
Time period	January 2015 - December 2015
Numerator	Net Ingredient cost (NIC) of BNF Chemical Substance Net Ingredient cost (NIC) is the basic price of a drug as stated in Part II Clause 8 of the Drug Tariff
Numerator Source	ePACT.net – data provided by the NHS Business Services Authority
Denominator	CCG ASTRO-PU weighted population Age, Sex and Temporary Resident Originated Prescribing Units
Rate	Numerator / Denominator x 1000 (spend rate per 1,000 ASTRO-PU weighted population)

We have presented a range of indicators grouping a selection of BNF chemical substances together and aggregating the total Net Ingredient cost. We have also presented individual BNF chemical spend indicators where the total spend is large enough and where advised by national clinical leads. The indicators have been standardised using the ASTRO-PU weightings and are shown per 1,000 ASTRO-PU population to allow fair comparison between CCGs.

Net Ingredient cost (NIC) is the basic price of a drug as stated in Part II Clause 8 of the Drug Tariff.

ASTRO-PU (Age, Sex and Temporary Resident Originated Prescribing Units) weightings have been used to weights the CCG population for age and sex to allow for better comparison of prescribing patterns. Further information regarding ASTRO-PU populations and other prescribing specific populations can be found at http://www.hscic.gov.uk/prescribing/measures

Annex C:
Additional information on PROMs

Patient Reported Outcome Measures (PROMs)

Patients are asked about their health just before and six months after hip and knee replacement surgery to assess the impact of treatment.

- Pre-op score: health of patient before the operation
- Post-op score: health of patient six months after the operation

Health gain: difference between the post-op and pre-op scores which estimates the effect of the treatment.

Patients answer two different sets of questions about their health:

- The Oxford Hip Score and Oxford Knee Score are based on questions which are specific to the joint.

  E.g. pain in the joint, how painful to stand because of the joint, limping because of the joint etc.

- The EQ-5D Index is based on questions about the overall health of the patient.

  E.g. pain/discomfort, mobility, self-care, usual activities, anxiety/depression.

  The EQ-5D Index concerns overall health, so the same questions are asked for both hip or knee surgery.

The Oxford Score health gain better estimates the impact of the treatment on the patient's joint.
The EQ-5D Index health gain better estimates the impact of the treatment on the patient's overall health.

The Oxford Scores for pre-op and post-op health range from 0 to 48 (with 48 as best).
The EQ-5D Scores for pre-op and post-op health range from -0.59 to 1 (with 1 as best).
Often EQ-5D Index health scores of 1 are referred to as "perfect health" and 0 as being 'equivalent to death'.

PROMs and case-mix adjustment

Patients have characteristics (such as age, sex, co-morbidities) that are beyond the control of the providers but which affect the average health gain that patients receive.

Comparing average health gain scores between providers could be misleading as the case-mix of patients that one provider treats may be different to the case-mix of patients at another provider.

The average case-mix adjusted health gain takes these factors that are beyond the control of the providers into account so providers can be more fairly compared with each other.

The average Oxford Score case-mix adjusted health gain is the best measure for comparing the surgeries between two providers. Commissioners will be interested in these scores and comparisons. It can be useful to understand how different providers are performing and inform the commissioner about the case-mix of their patients.

However, the EQ-5D Index health gain (which has not been case-mix adjusted and is described on the previous page) will be of greater interest to commissioners because this is the actual health gain their patients receive and it considers the wider impact of the treatment on the patient's overall health. Commissioners will also want to compare themselves to others commissioners on this measure too.

The EQ-5D Index health gain is the actual health gain experienced by the patient and so this is the measure to use for value for money calculations. The EQ-5D Index health gain is used to determine the number of QALYs (Quality Adjusted Life Years) that patients receive from treatment and in cost per QALY calculations.

As the EQ-5D Index is a general measure of overall health, it can be used to compare the benefit and value for money of different procedures. The PROMs programme looks at hip and knee replacements, varicose veins and groin hernia procedures.

More information and data on PROMs is available from the website: http://www.hscic.gov.uk/proms

Annex D: Methodology

How have the potential opportunities been calculated?

The potential opportunity highlights the scale of change that would be achieved if the CCG Value moved to the Benchmark Value of the average of the ‘Best 5’ or ‘Lowest 5’ CCGs in its group of similar 10 CCGs.

Generally, where a high CCG Value is considered ‘worse’ then it is calculated using the formula:

Potential Opportunity = (CCG Value – Benchmark Value) * Denominator

The denominator is the most suitable population data for that indicator eg CCG registered population, CCG weighted population, CCG patients on disease register etc. The denominator is also scaled to match the Value. So if the CCG Value and Benchmark Value are given in “per 1,000 population” then the denominator is expressed in thousands, ie 12,000 becomes 12.

For procedures, the potential opportunity can be expressed in pounds, or dividing this by the unit cost then it can be expressed in the equivalent number of procedures.