



NHS RightCare Commissioning for Value Focus Pack

Musculoskeletal conditions;
trauma and injuries
May 2016

- Introduction: Welcome to your focus pack
- NHS RightCare
- Why act?
- Commissioning for Value
- A clinical perspective
- Your most similar CCGs
- Your data
 - Pathways on a page
 - Spend and activity
 - Opportunities
 - Further analysis
- Next steps and actions
- Further support and information
- Useful links
- Annexes

Introduction: Welcome to your focus pack

3

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.

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.

“ 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 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.

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

8

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

9

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:

- Wandsworth
- Islington
- City and Hackney
- Merton
- Lambeth
- Southwark
- Waltham Forest
- Ealing
- Camden
- Brent

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:

- Mixed communities in Inner London

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.

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.

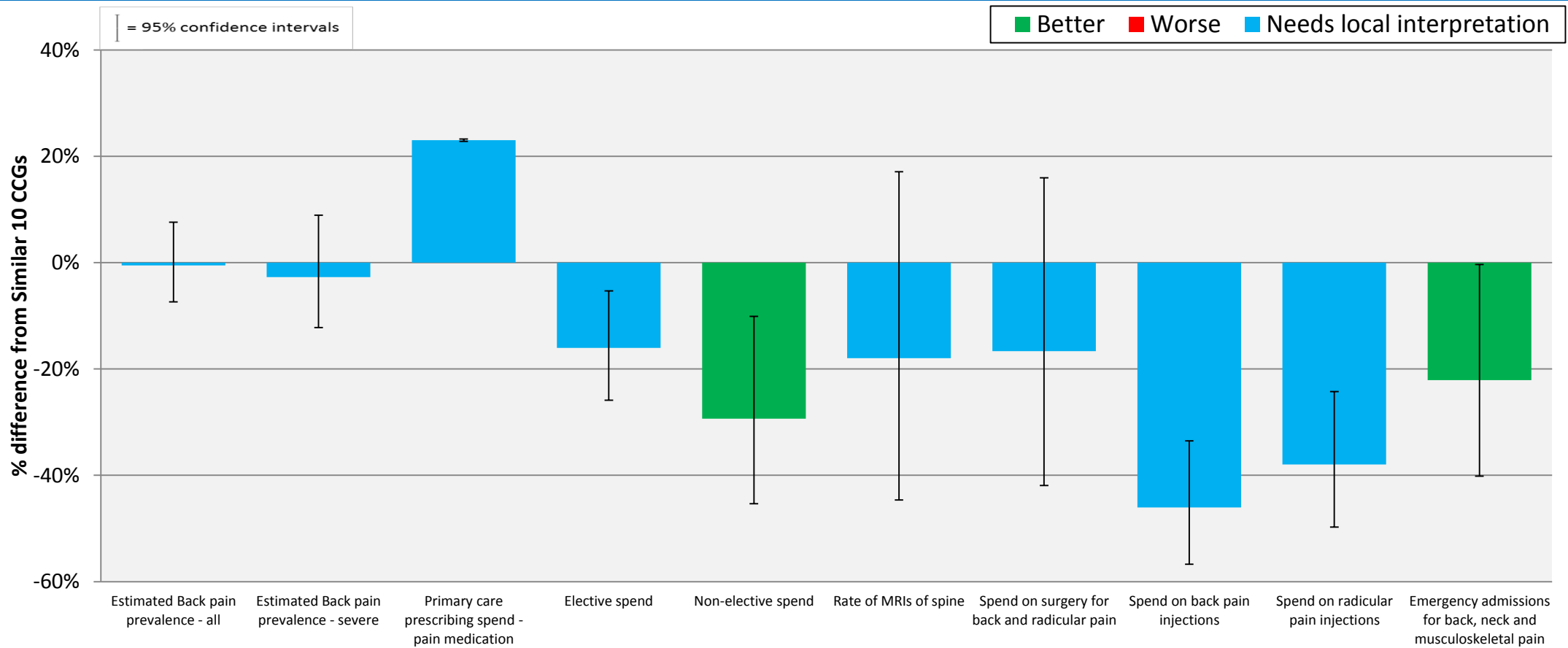
The intention of these pathways is not to provide a definitive view on priorities but to help commissioners explore potential opportunities. These help commissioners to understand how performance in one part of the pathway may affect outcomes further along the pathway. Each indicator is shown as the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

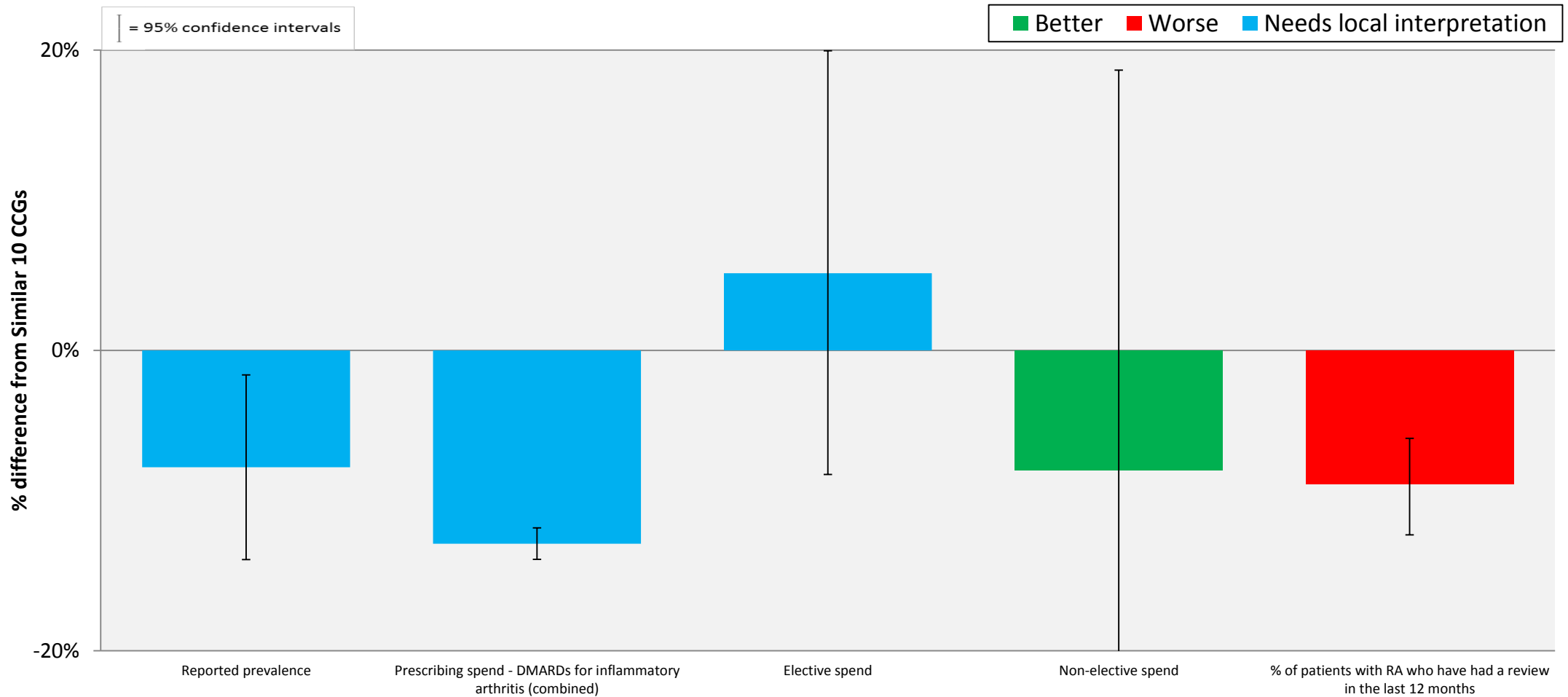
Back, Neck and MSK Pain Pathway

12



NICE Guidance:

<http://pathways.nice.org.uk/pathways/low-back-pain-early-management>

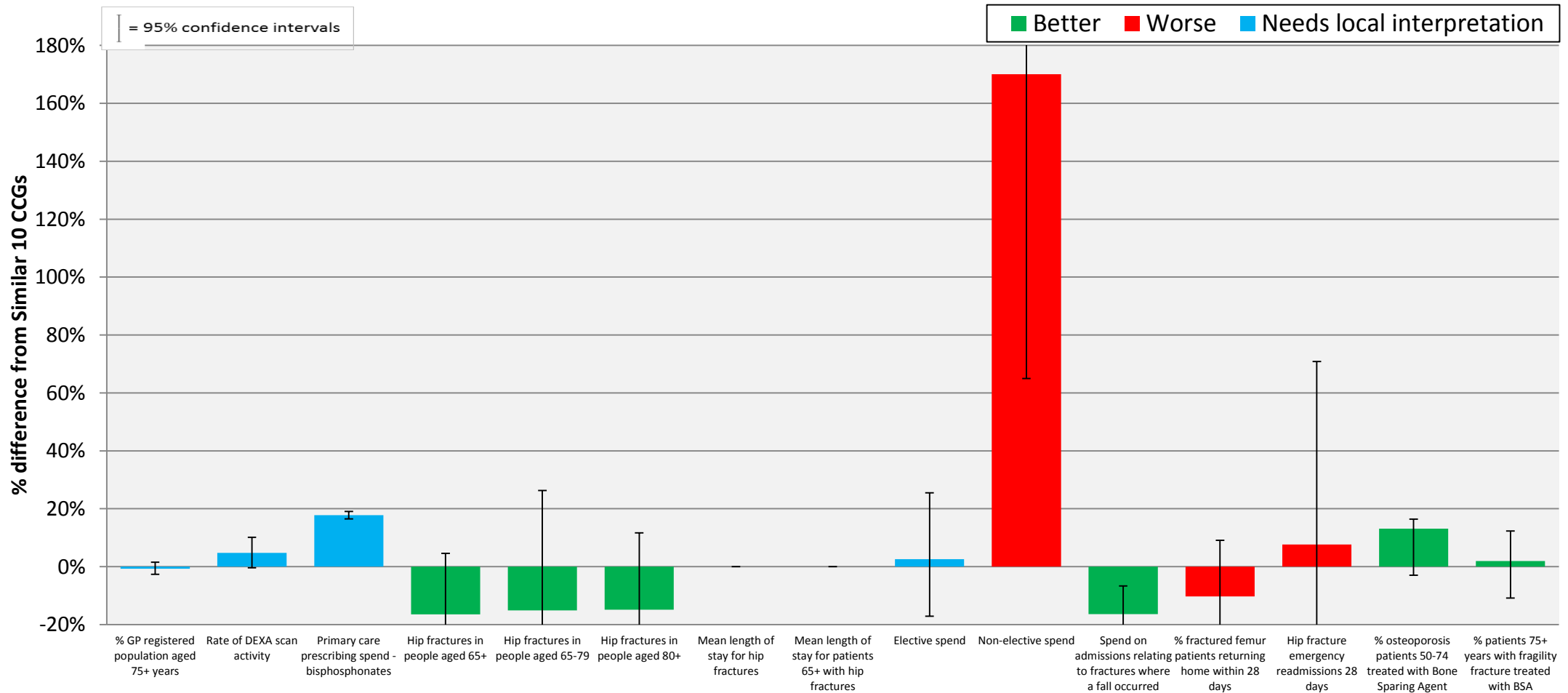


NICE Guidance:

<http://pathways.nice.org.uk/pathways/rheumatoid-arthritis>

Osteoporosis and fragility fractures Pathway

14

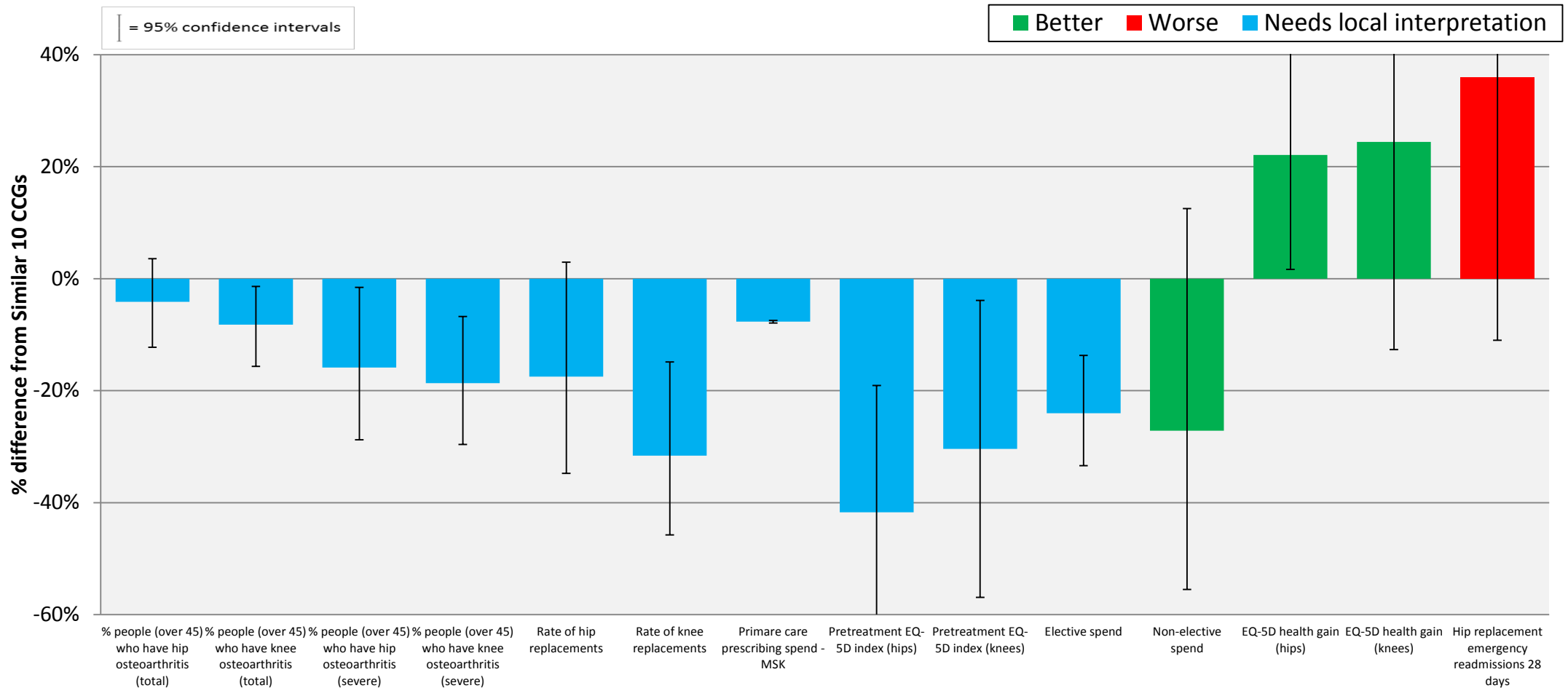


NICE Guidance:

<http://pathways.nice.org.uk/pathways/osteoporosis>

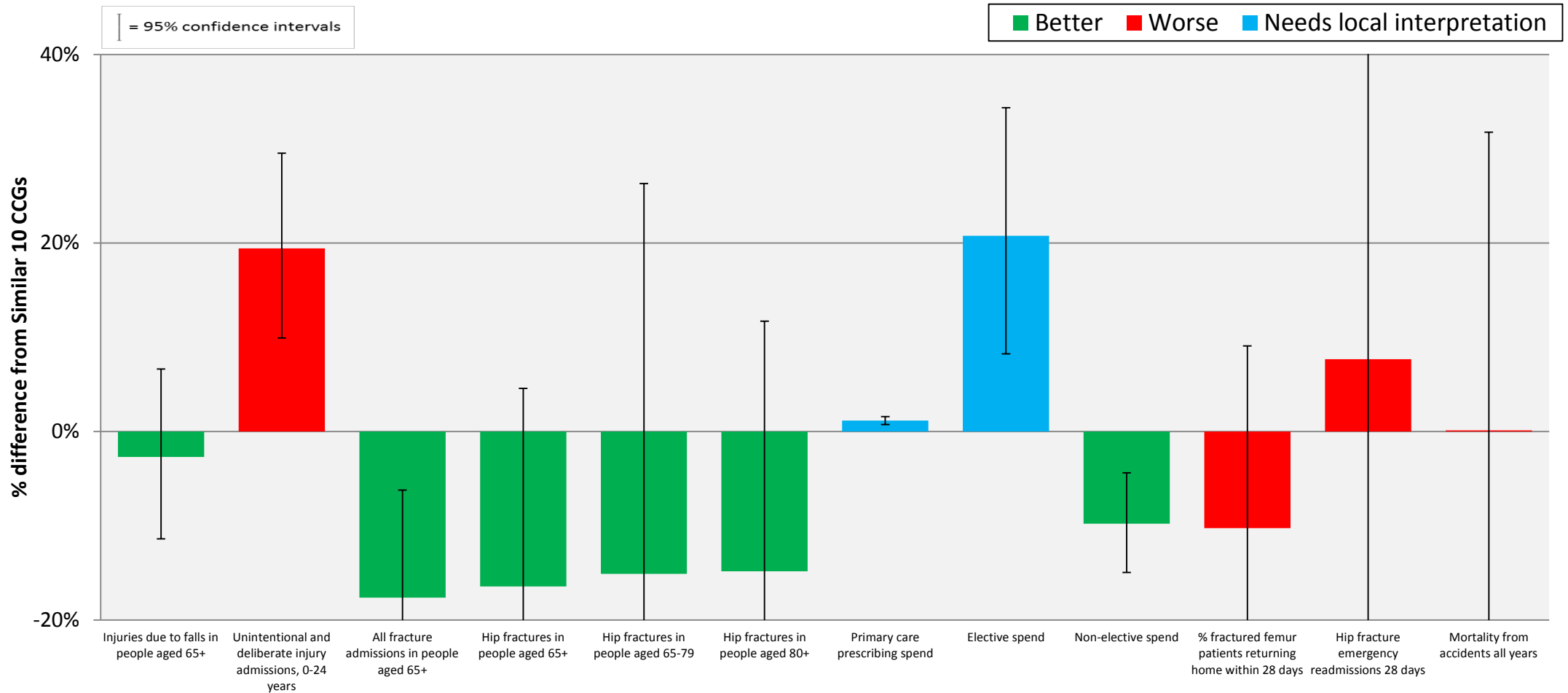
Osteoarthritis Pathway

15



NICE Guidance:

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



NICE Guidance:

<http://pathways.nice.org.uk/pathways/trauma>

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.

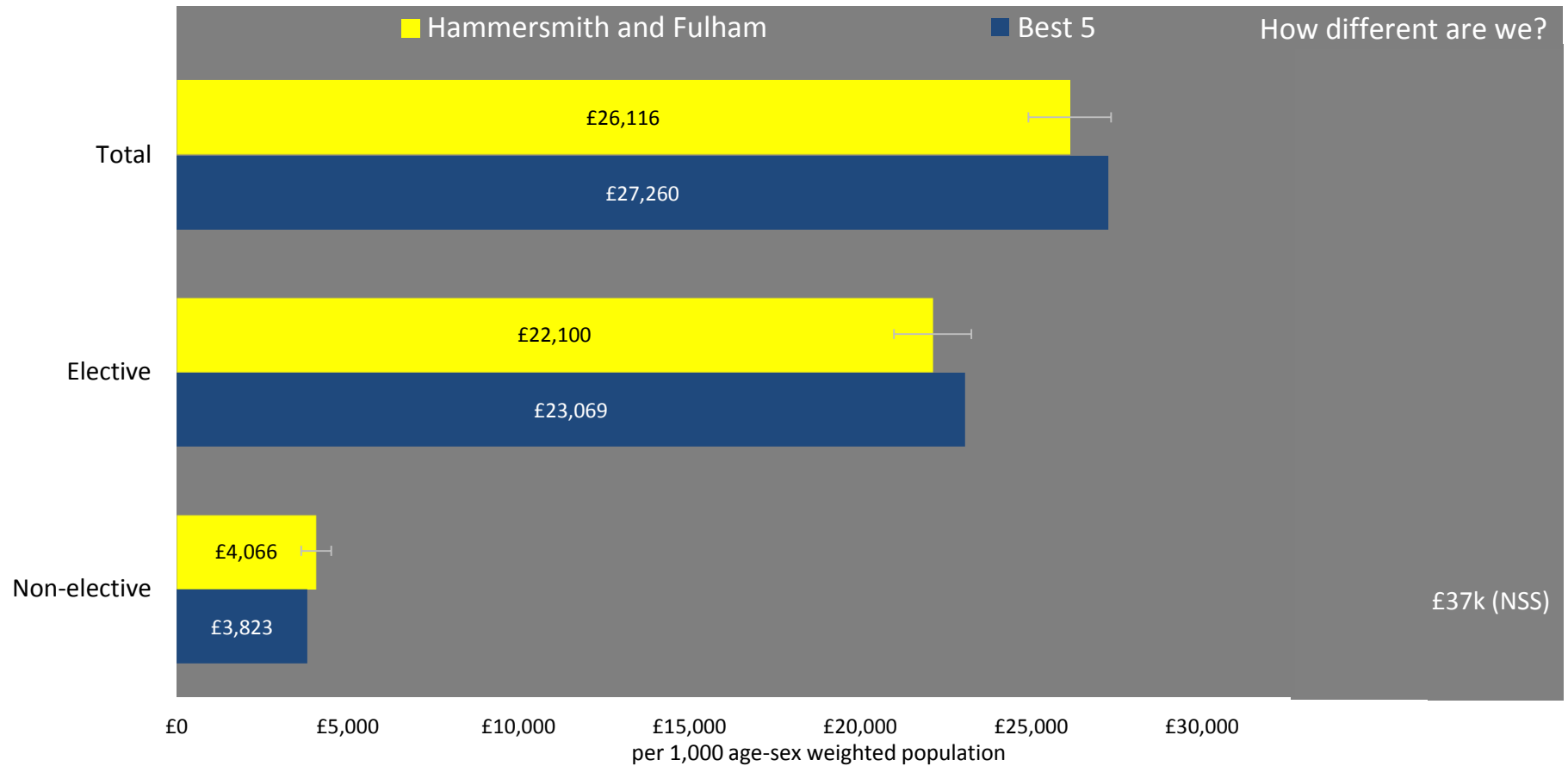
The opportunity tables, starting on page 64, identify the best CCG in your similar 10, who you may want to contact – either directly, or through your Delivery Partner if you are in a Wave 1 CCG.

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

18



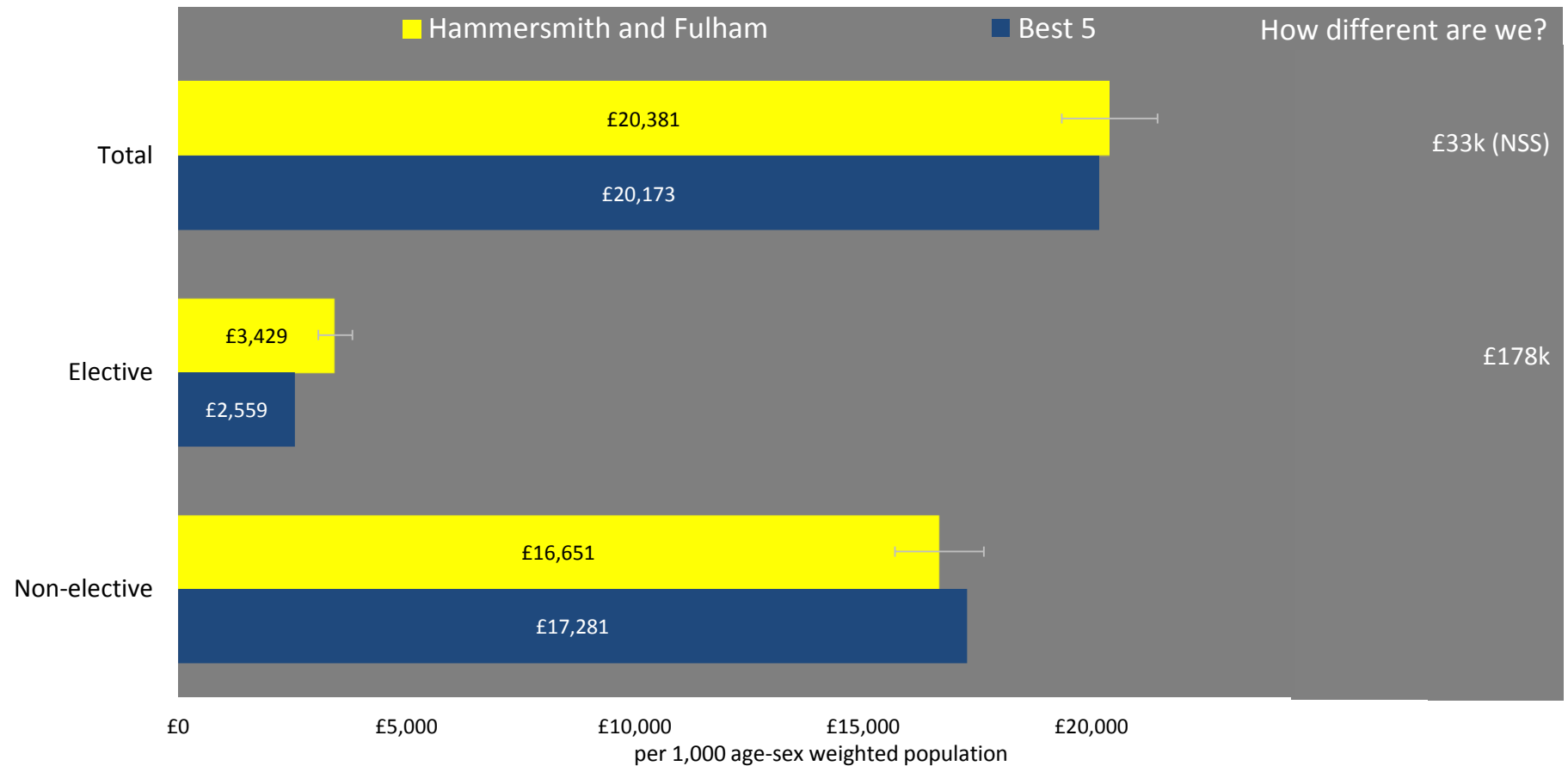
95% confidence intervals

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 & Injuries - Spend

19



95% confidence intervals

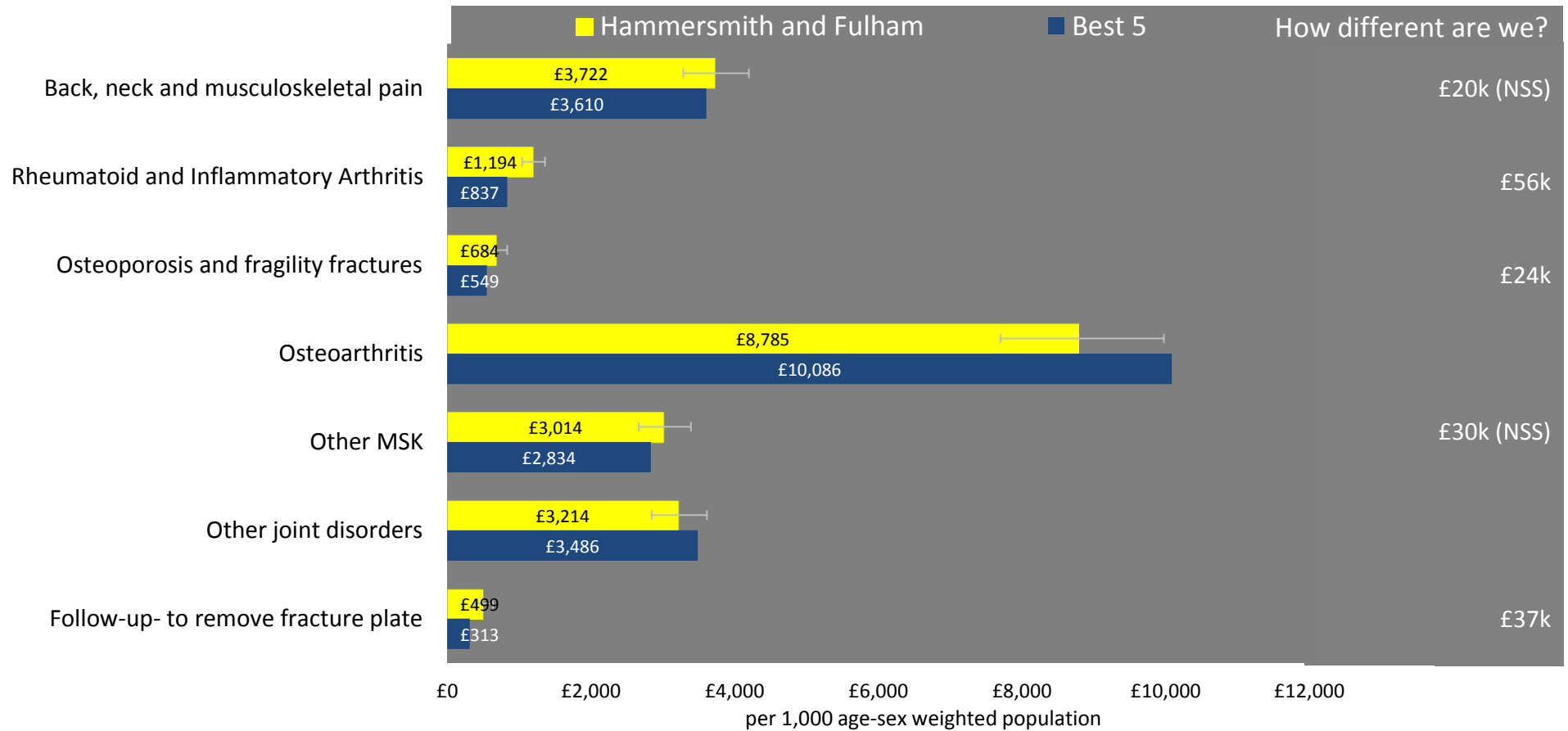
NSS Not statistically significant*

*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

20



95% confidence intervals

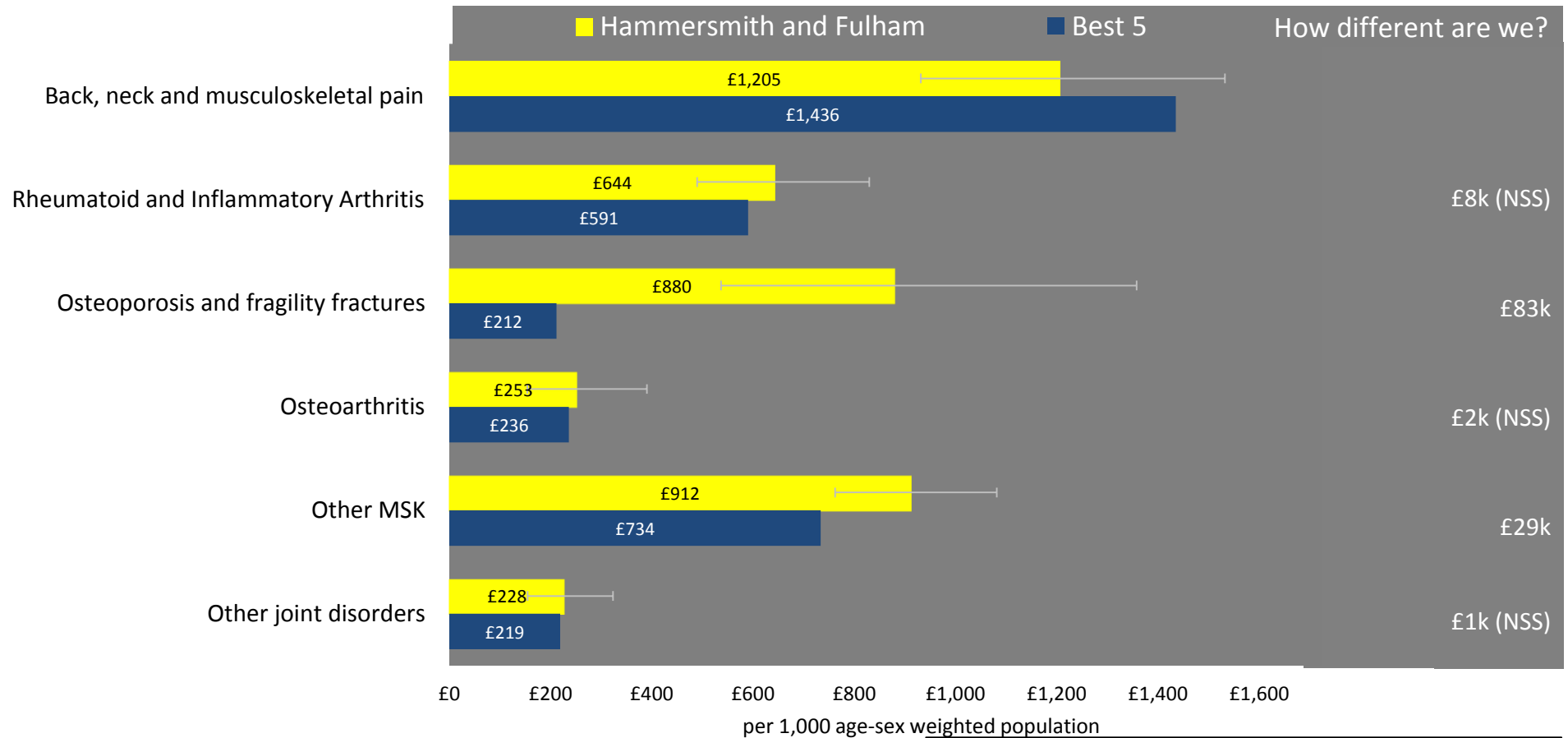
NSS Not statistically significant*

*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 - Non-Elective Spend

Condition Groups

21



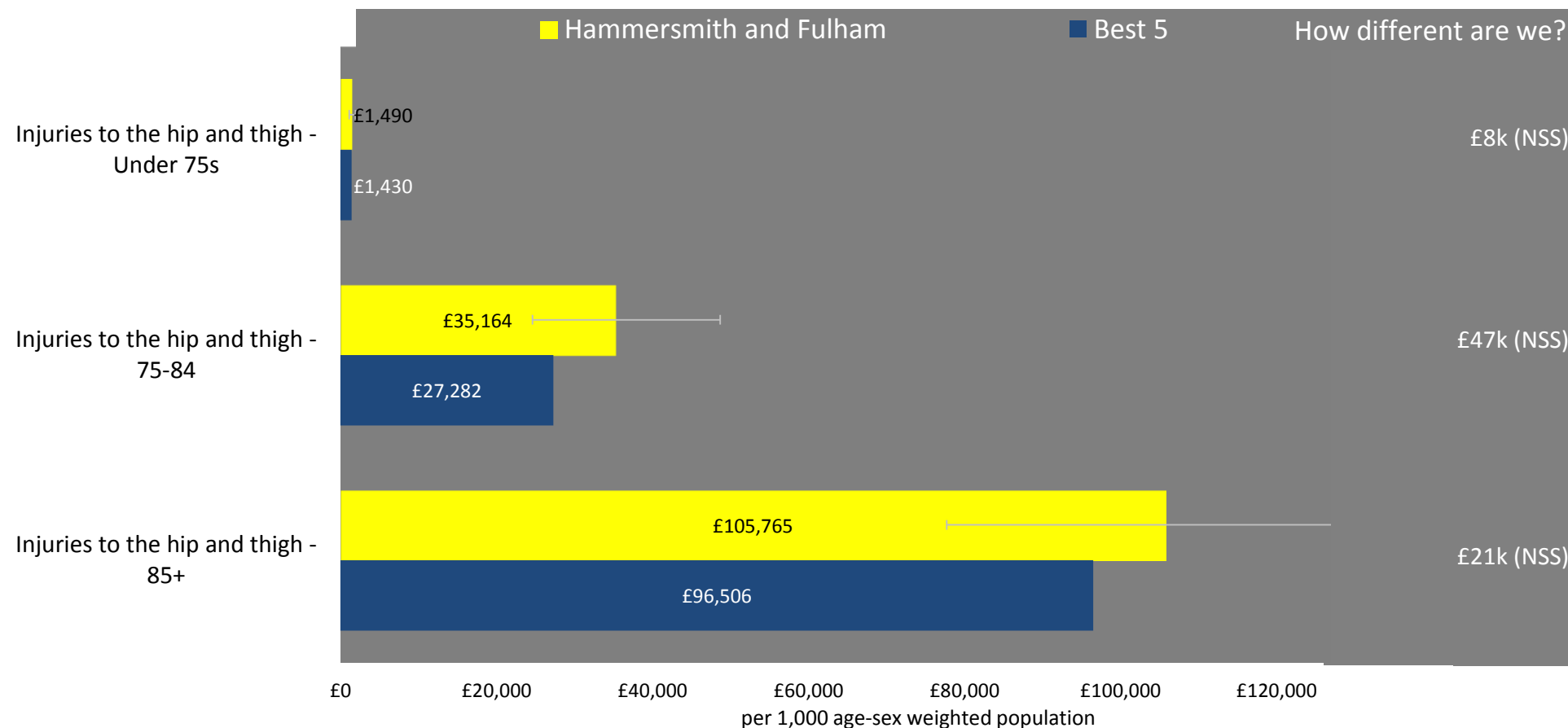
95% confidence intervals

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 hip and thigh

22

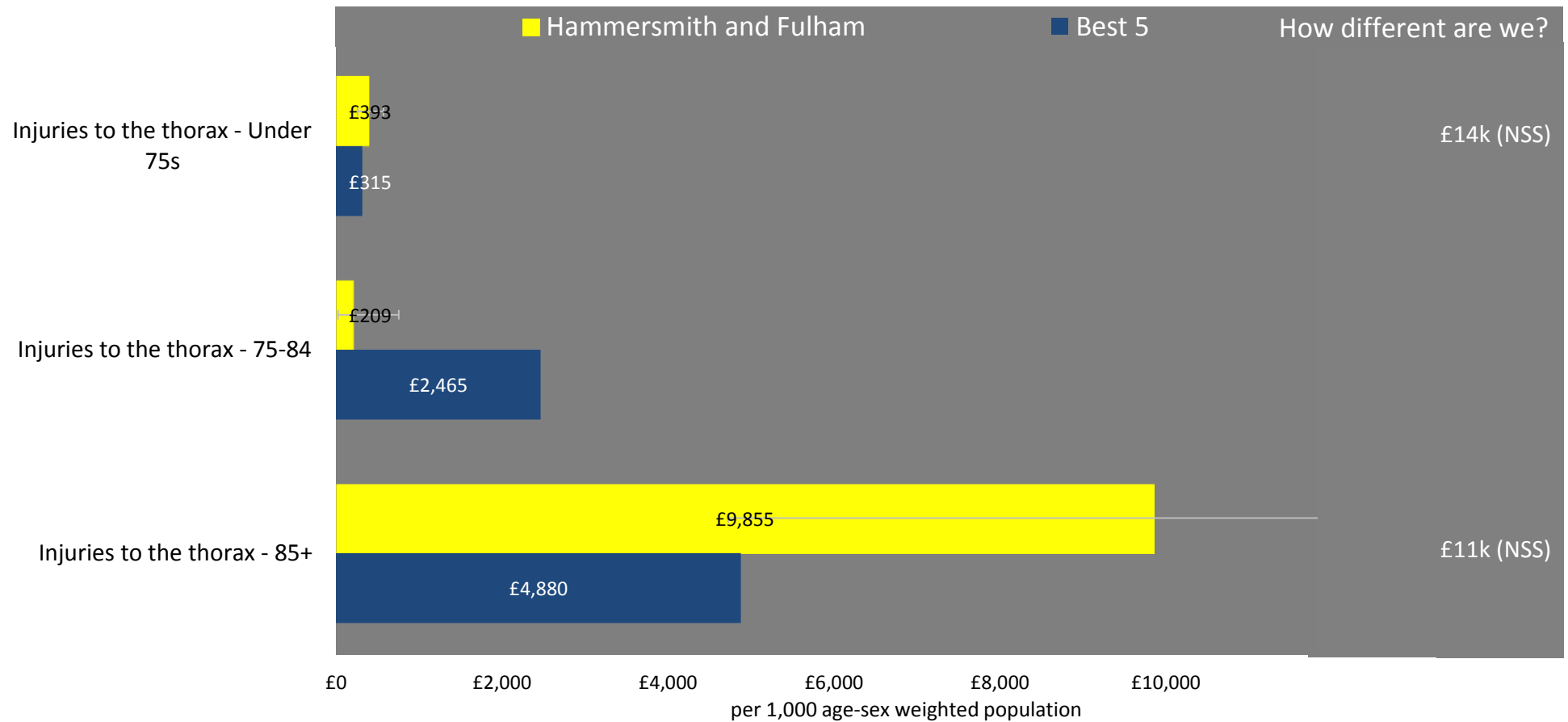


Please note: Spend on Trauma and Injuries (slides 22-29) includes spend for both elective and non-elective admissions.

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

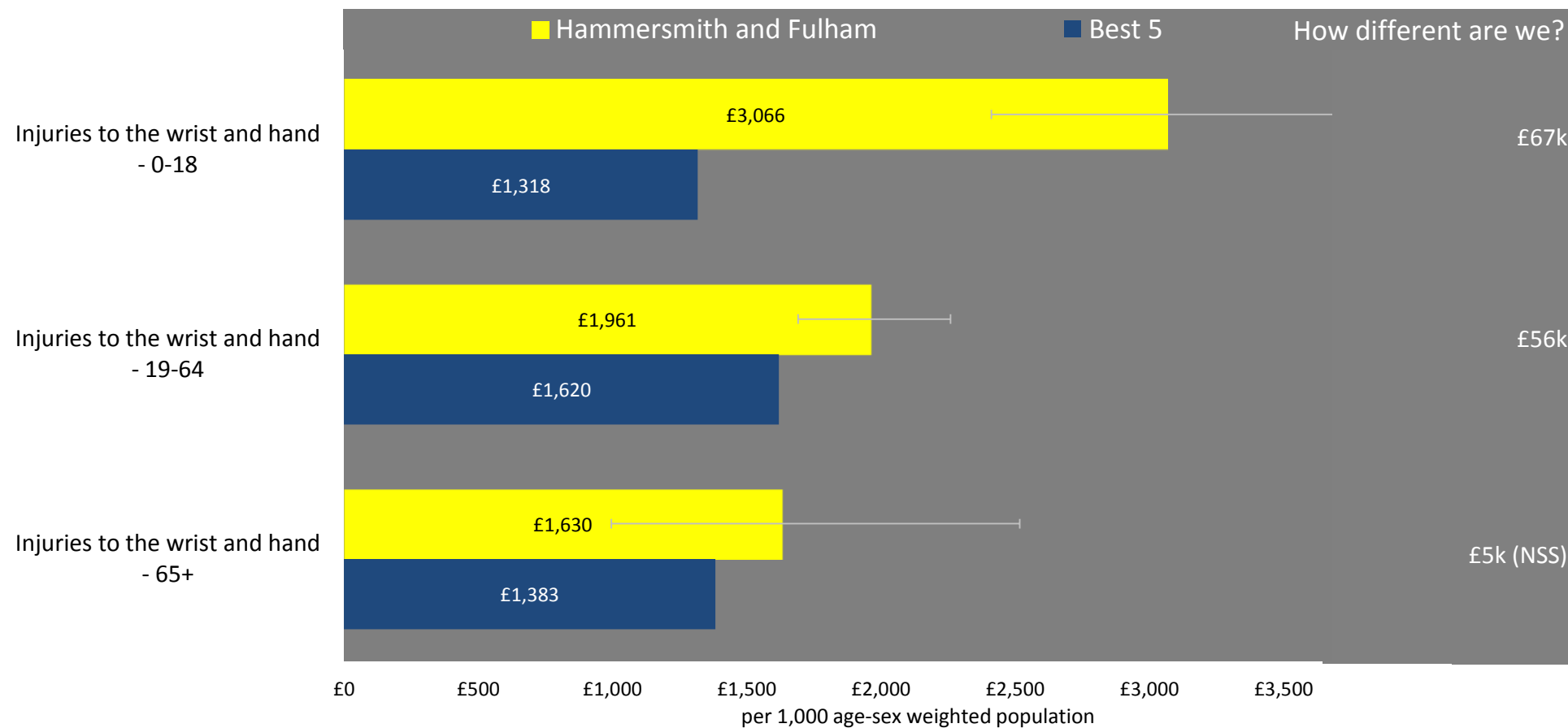
23



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 wrist and hand

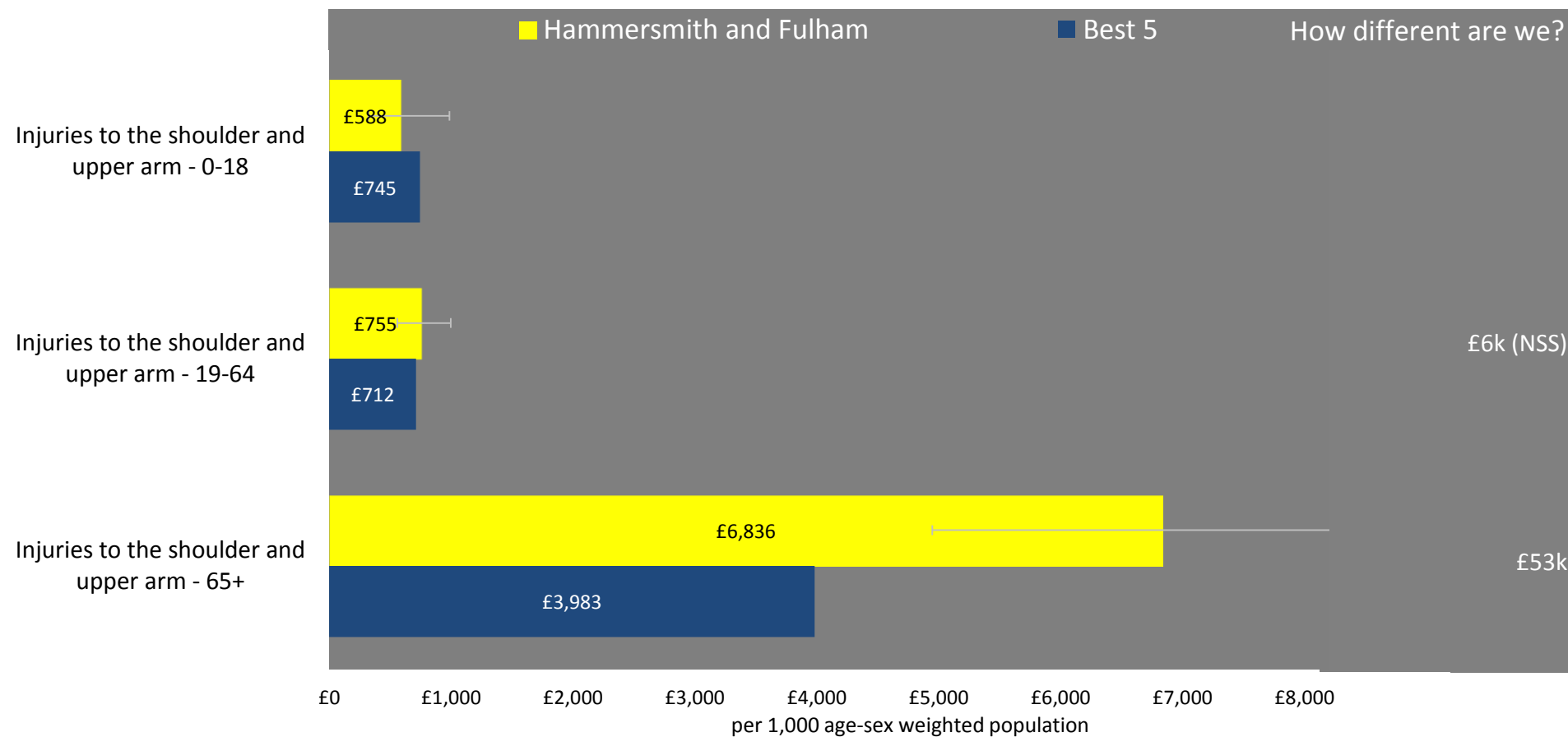
24



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 shoulder and upper arm

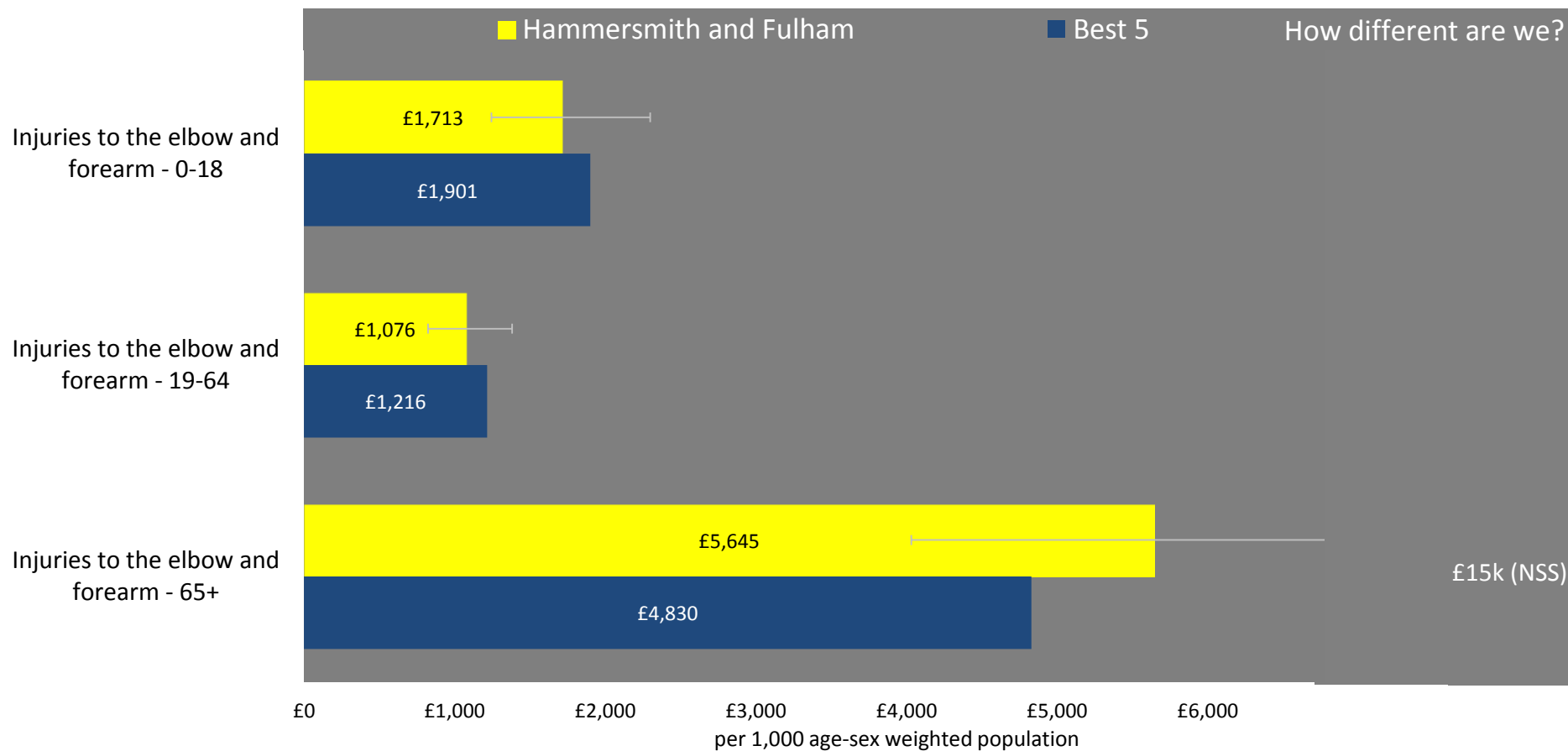
25



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 elbow and forearm

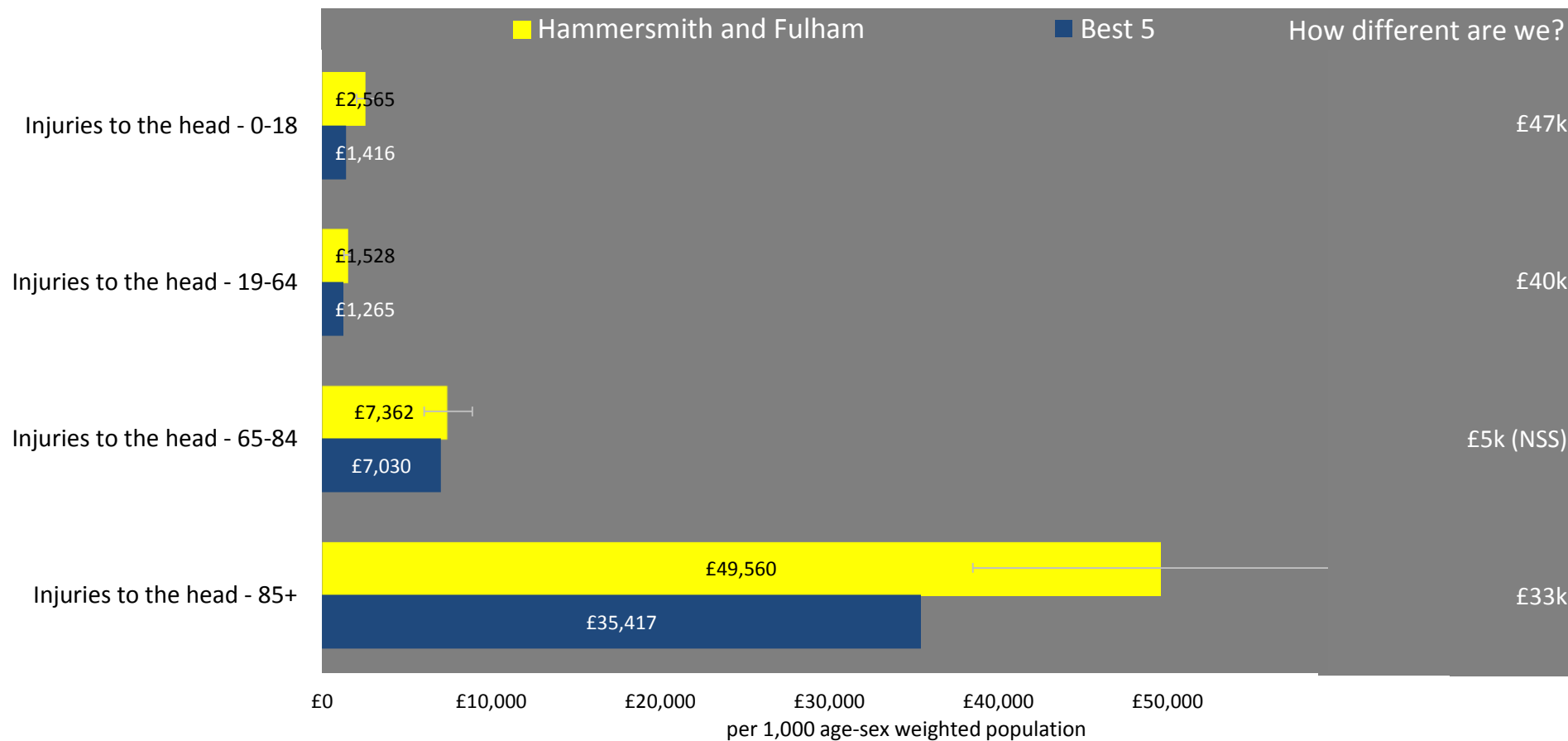
26



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 head

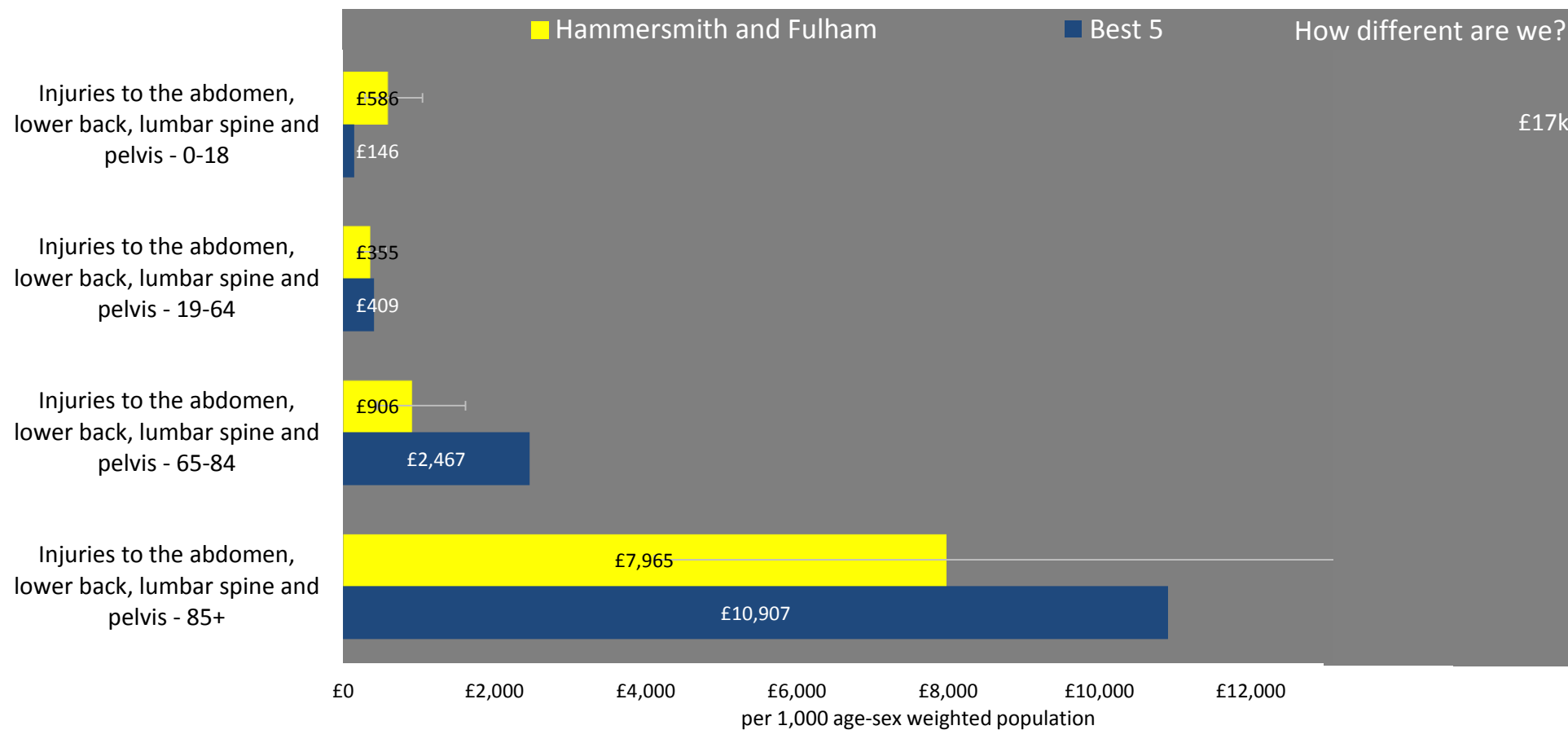
27



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 abdomen, lower back, lumbar spine and pelvis

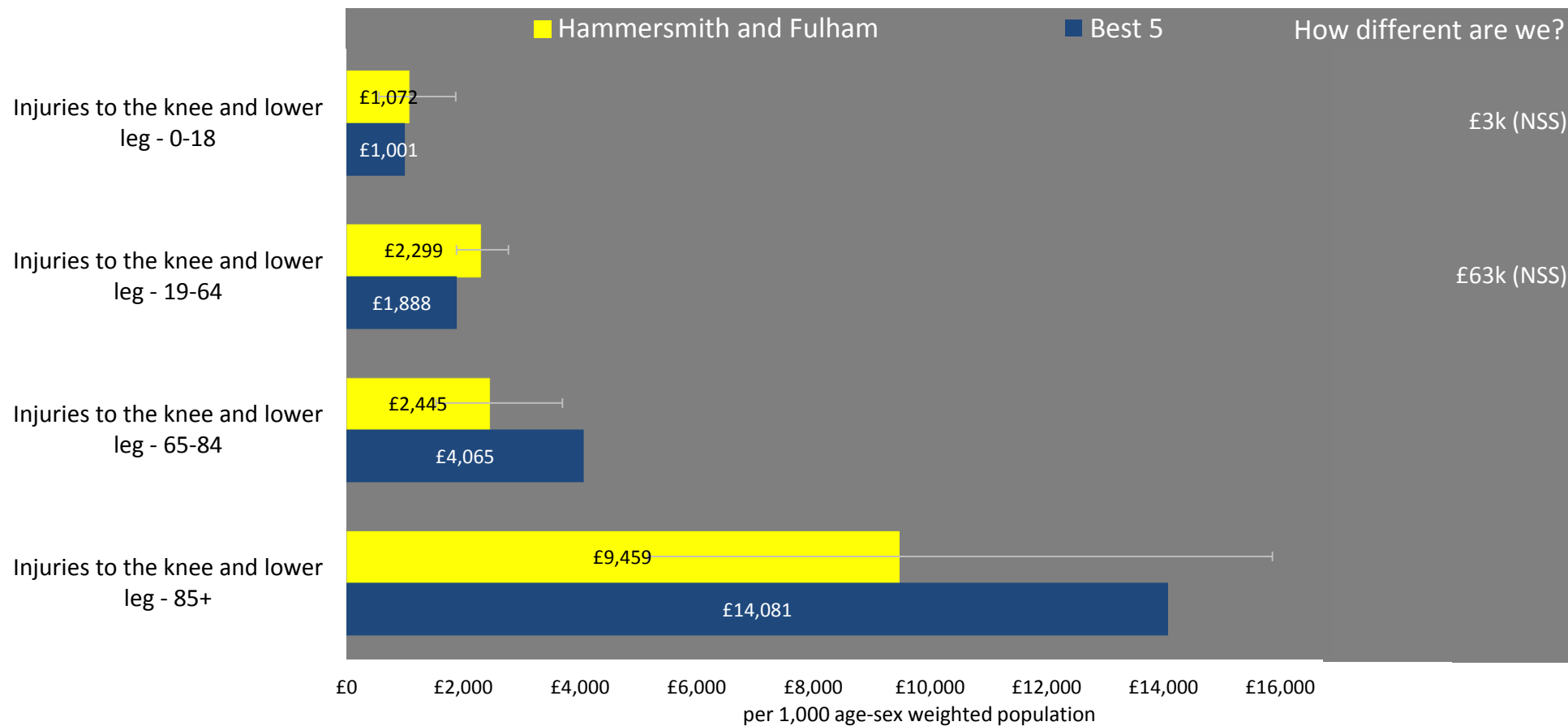
28



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 knee and lower leg

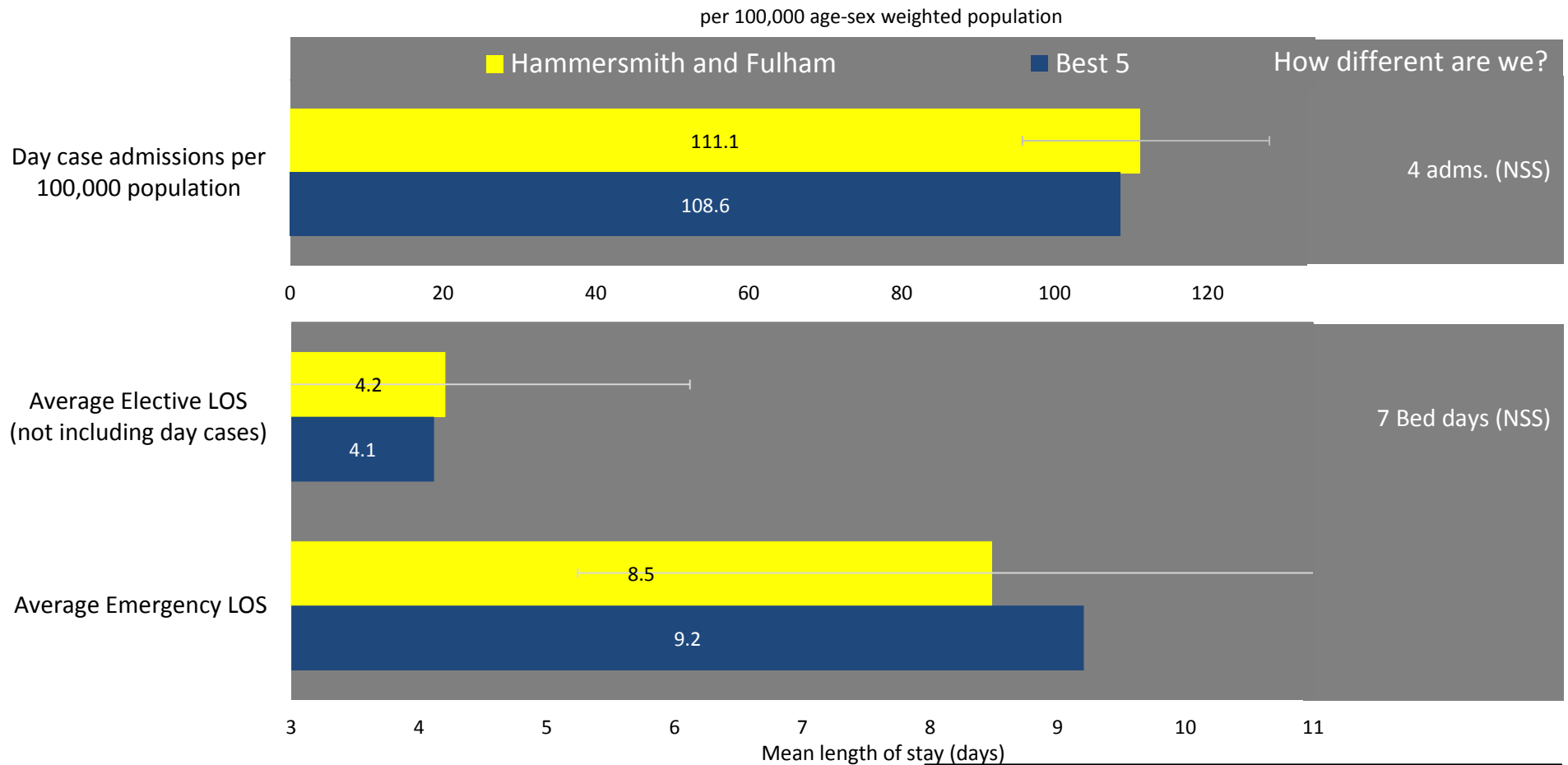
29



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 admissions - Back, neck and musculoskeletal pain

30



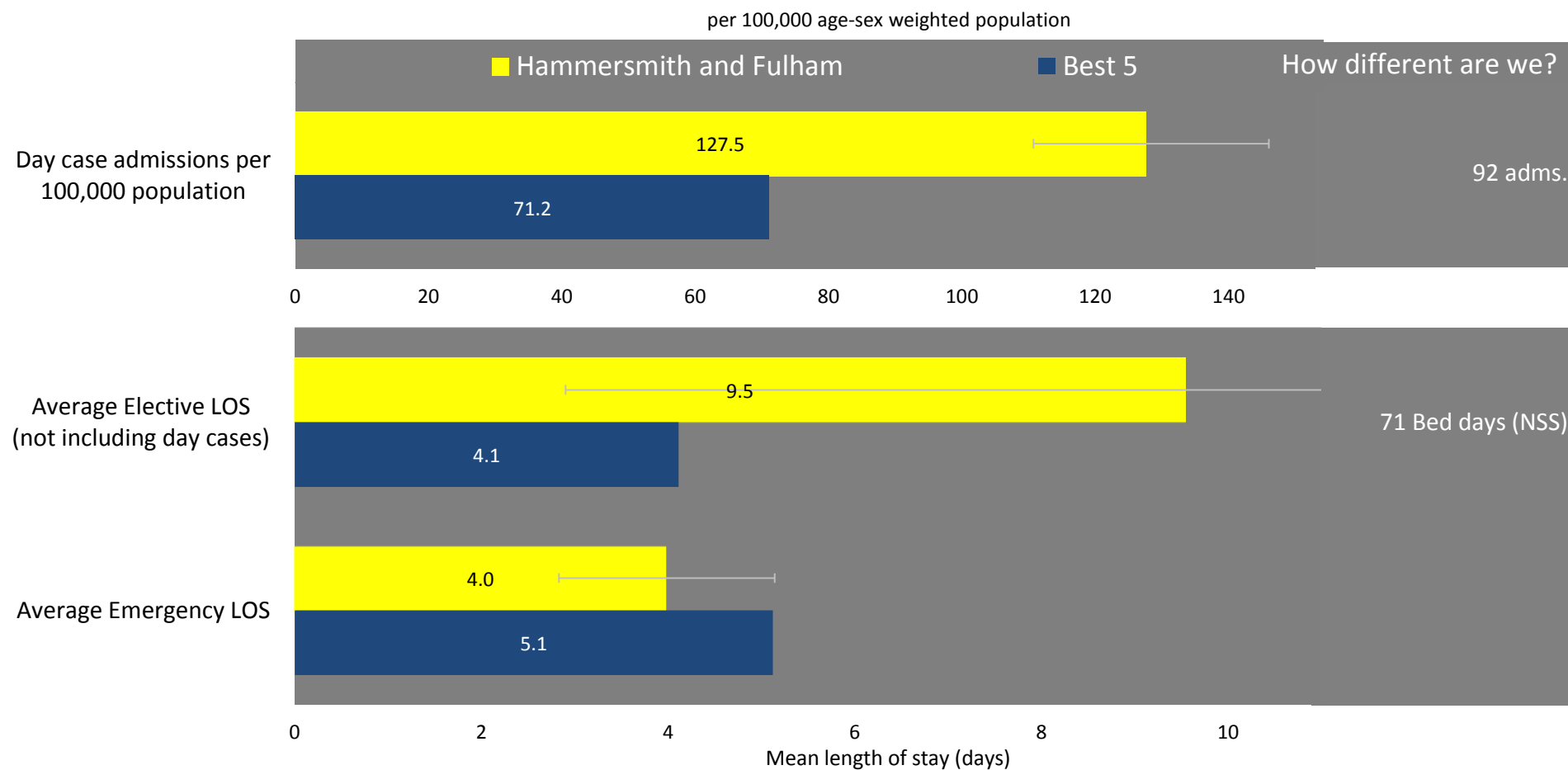
95% confidence intervals

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 admissions - Rheumatoid and Inflammatory arthritis

31



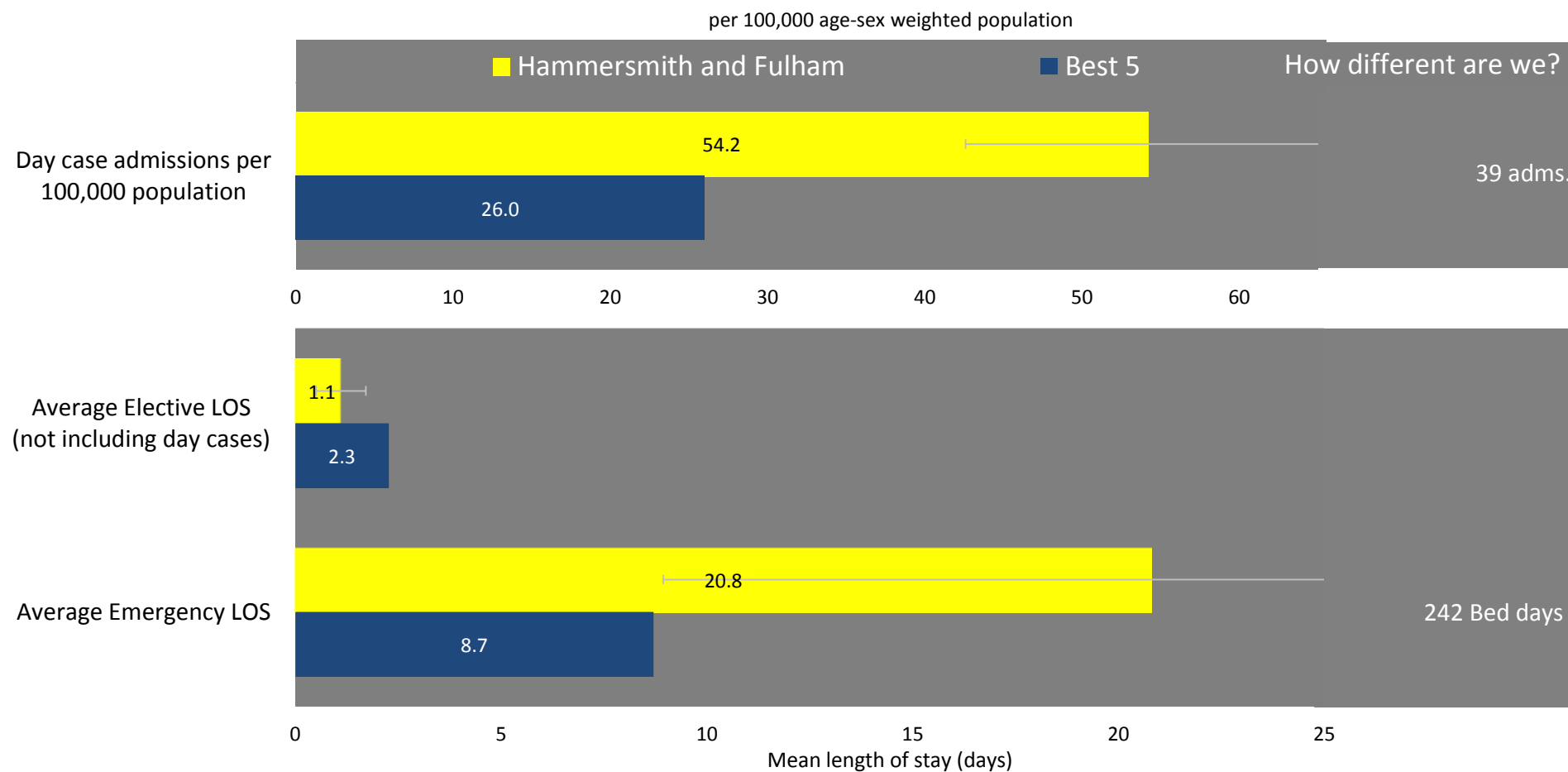
95% confidence intervals

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 admissions - Osteoporosis and fragility fractures

32



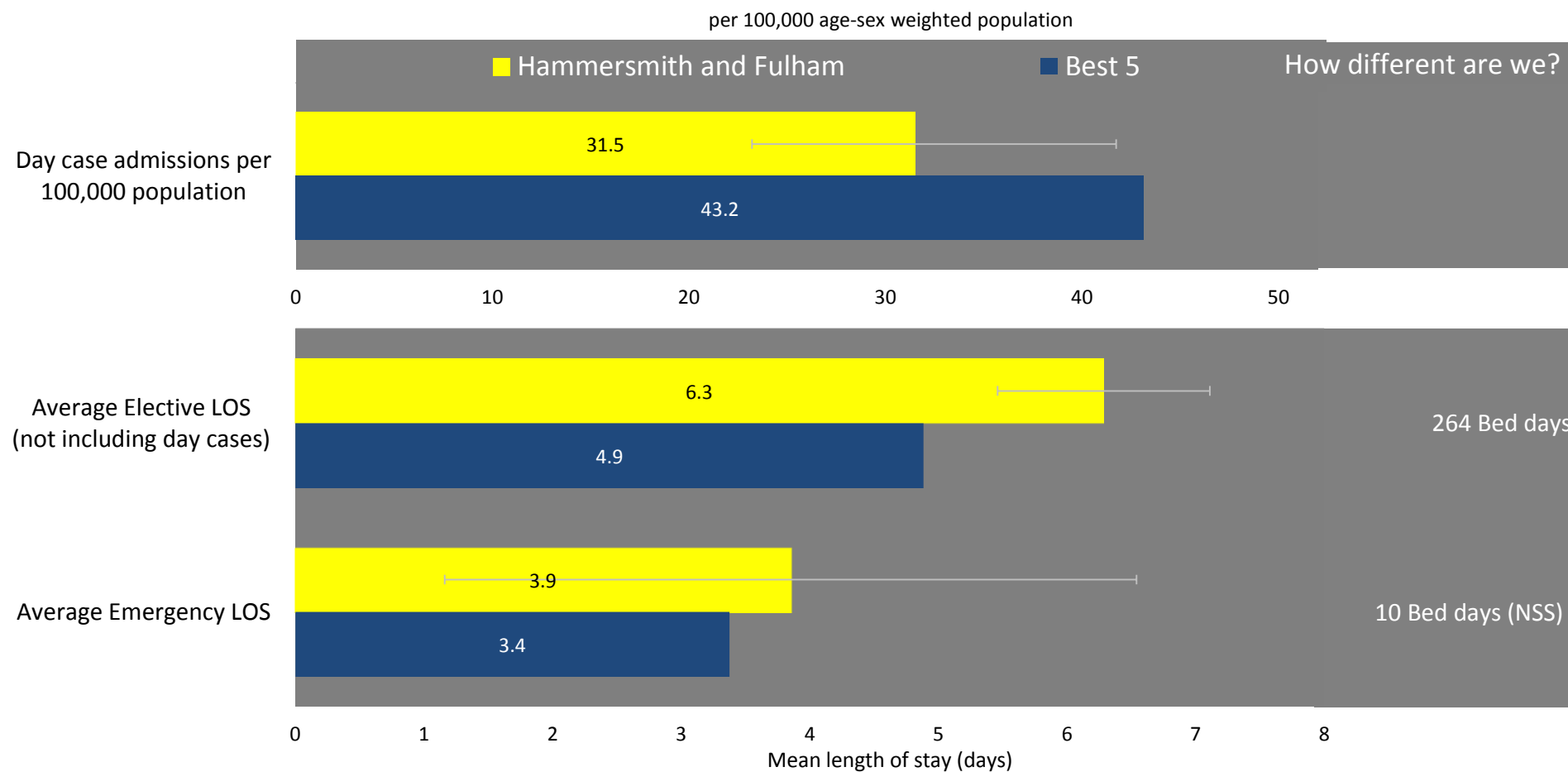
95% confidence intervals

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 admissions - Osteoarthritis

33

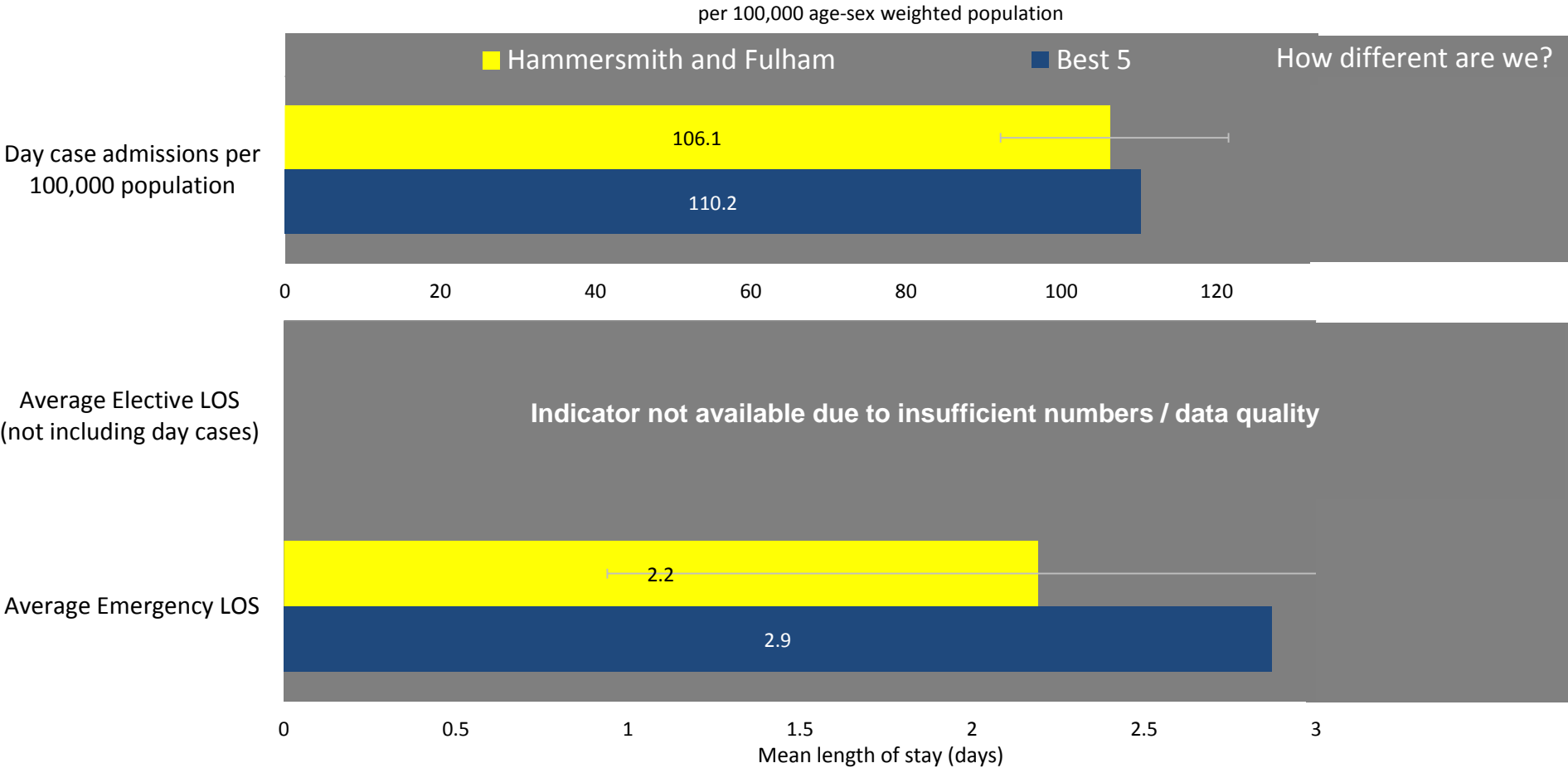


95% confidence intervals

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 admissions - Other joint disorders



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 admissions - Other MSK conditions

35



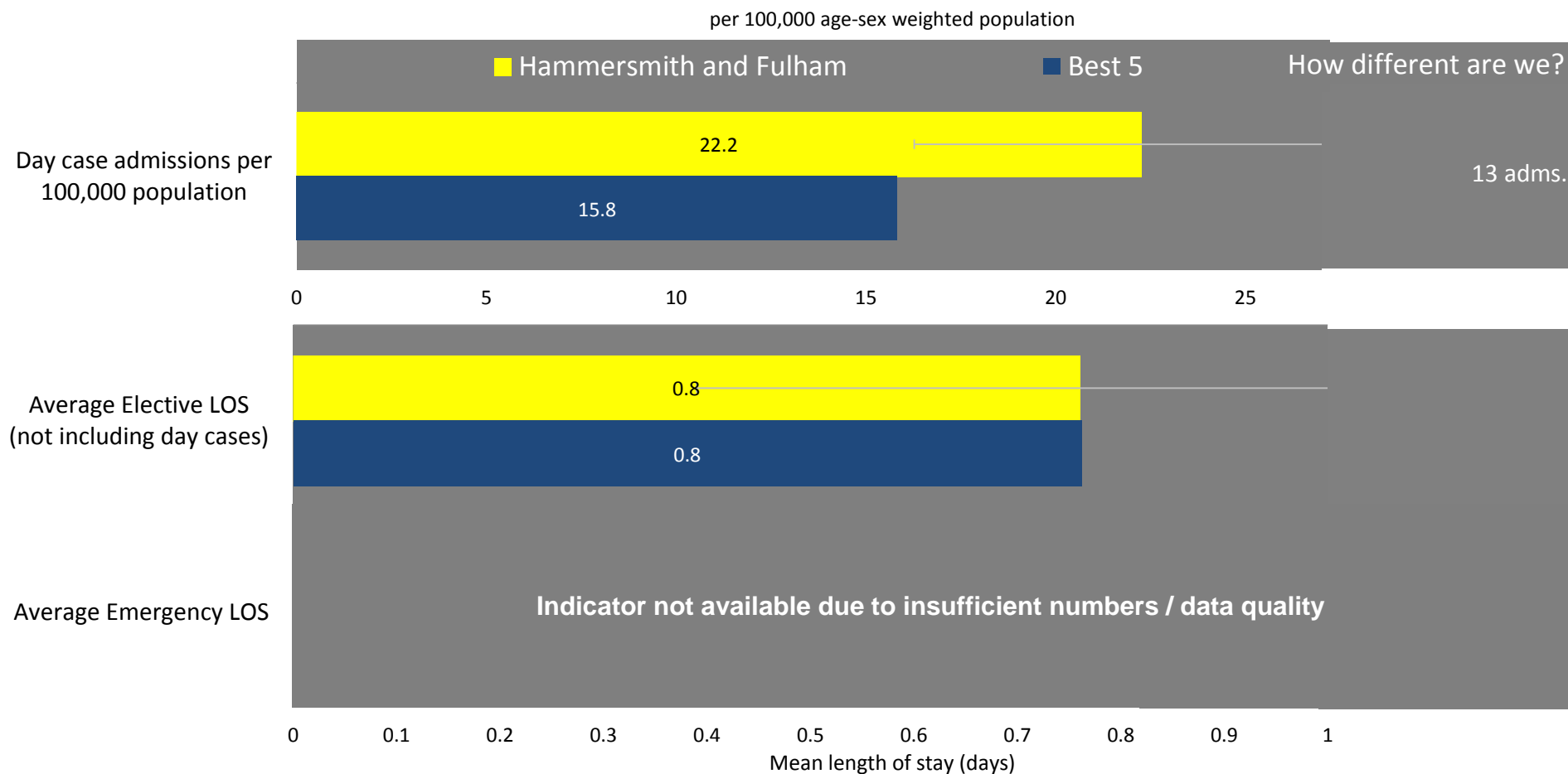
95% confidence intervals

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 admissions - Removal of fracture plates

36



95% confidence intervals

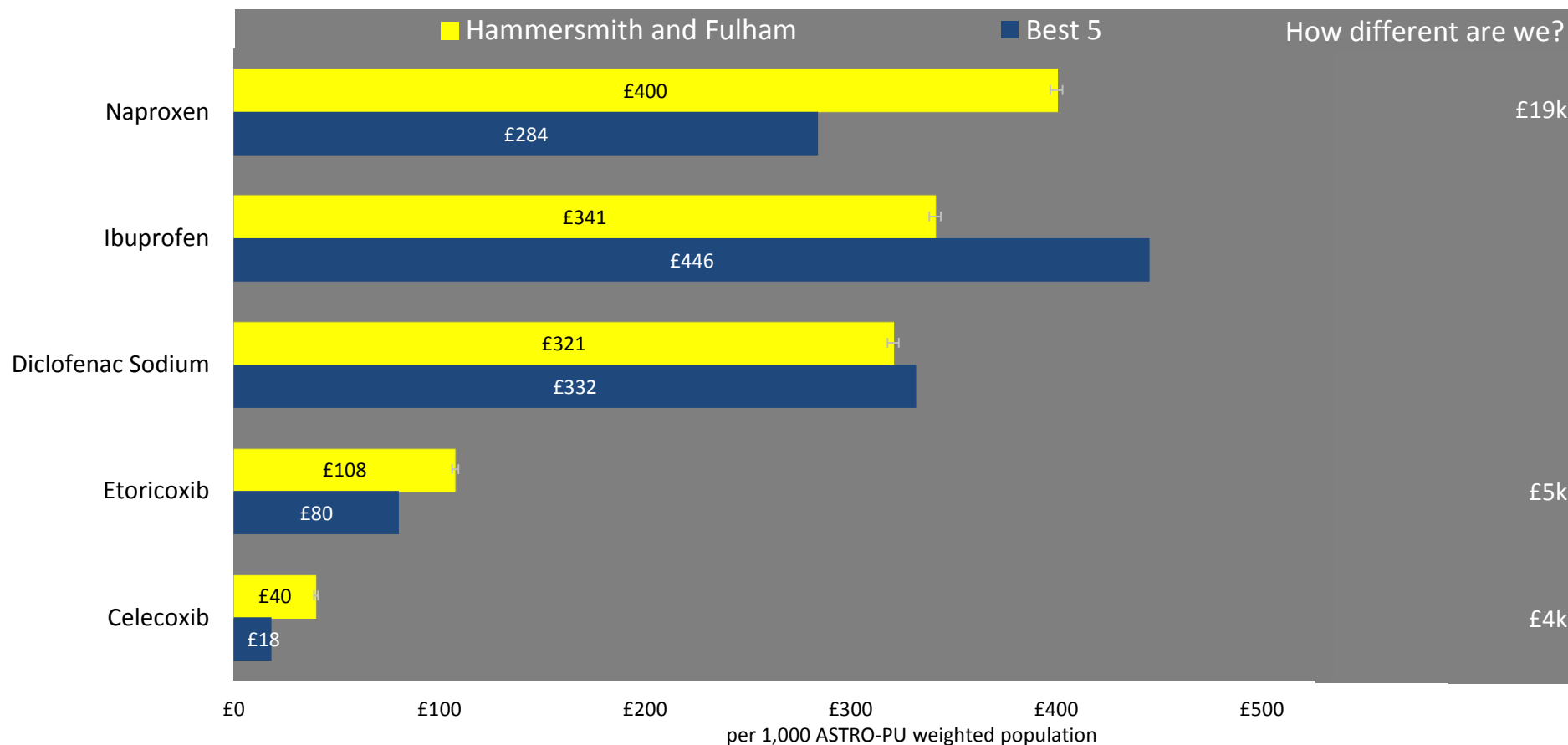
NSS Not statistically significant*

*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

Nonsteroidal anti-inflammatory drugs (NSAIDs) treating inflammation and pain

37



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

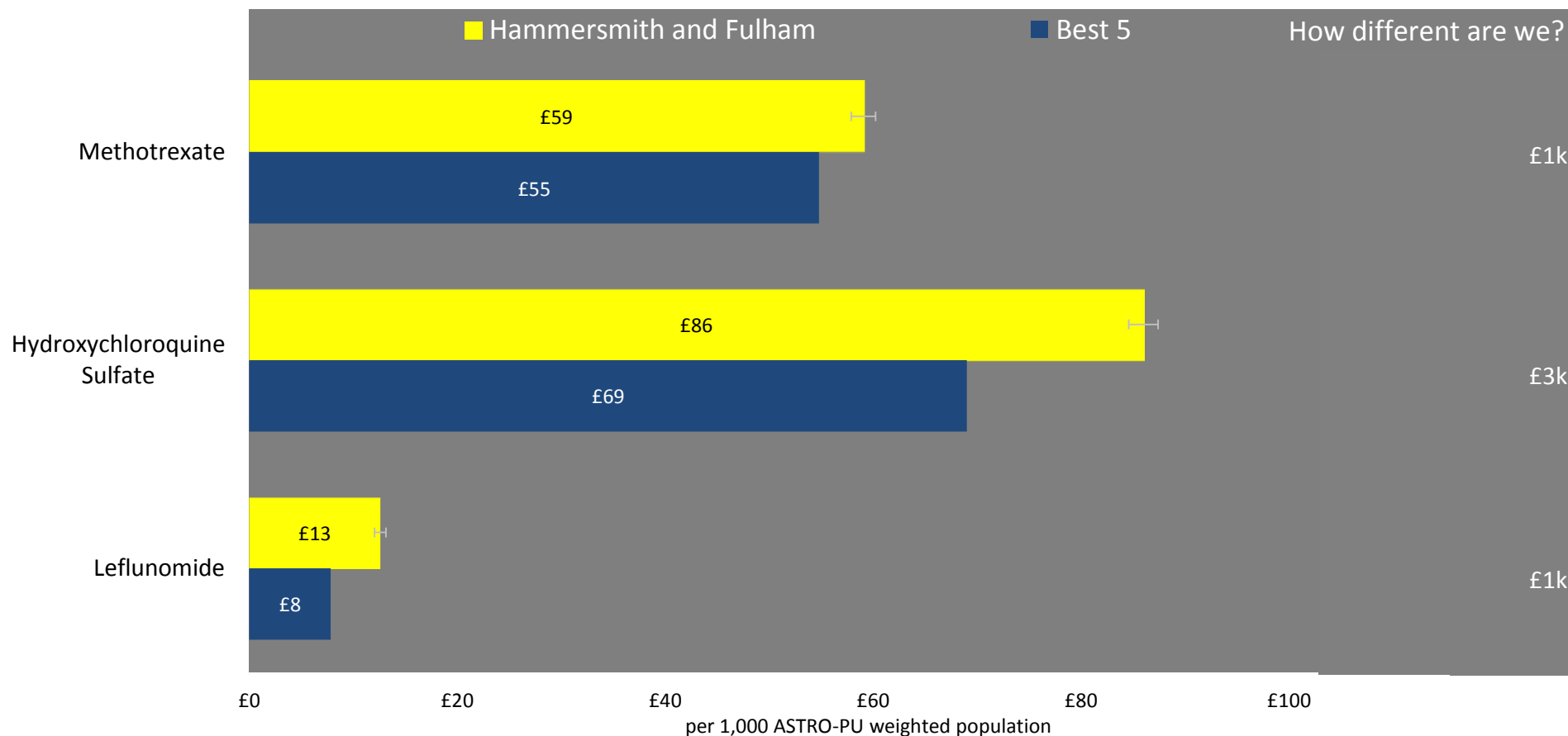
Innovation Scorecard: <https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/>

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

38



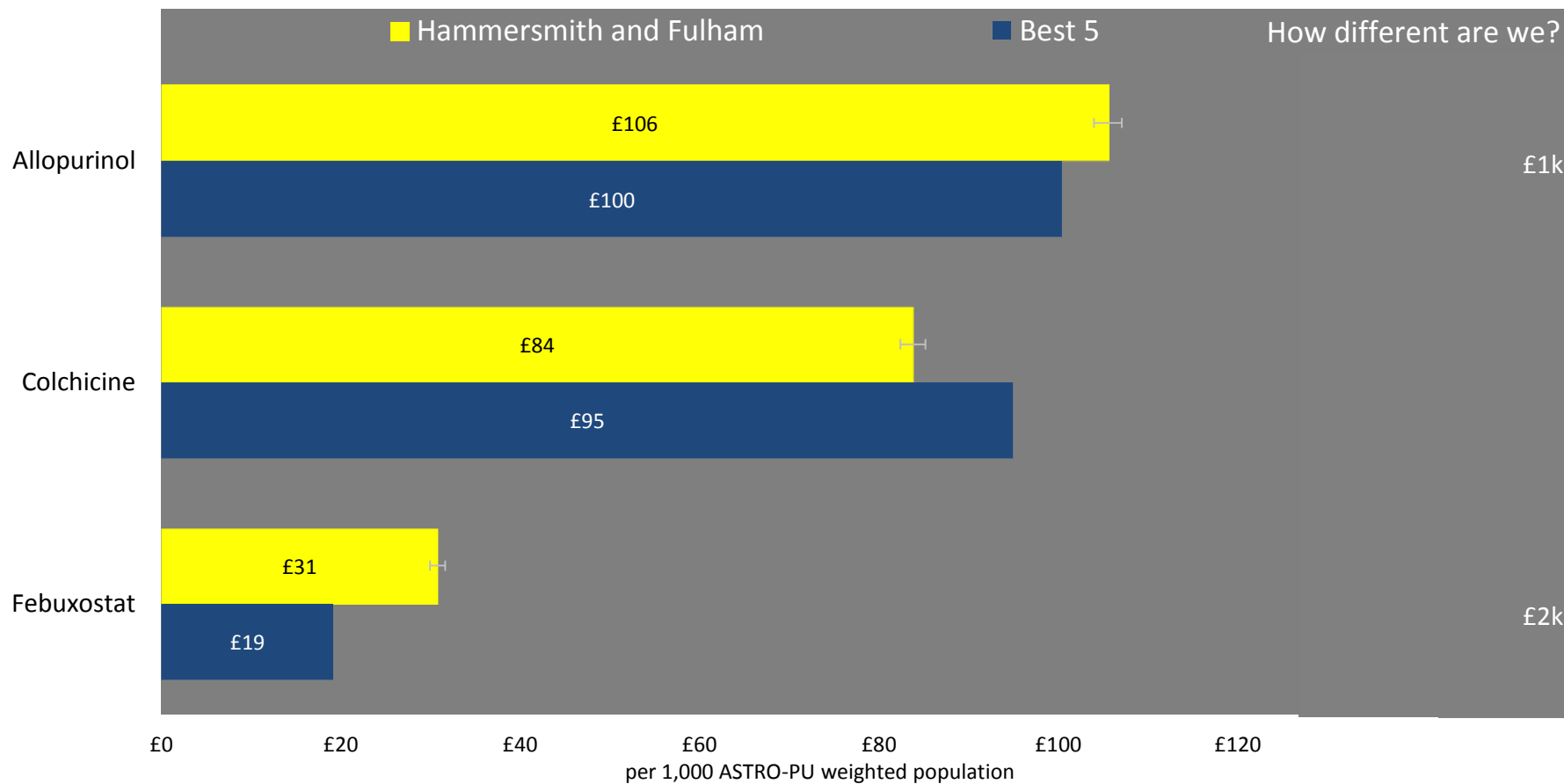
Medicines Optimisation Dashboard: <https://www.england.nhs.uk/ourwork/pe/mo-dash/>

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 - Gout therapies

39



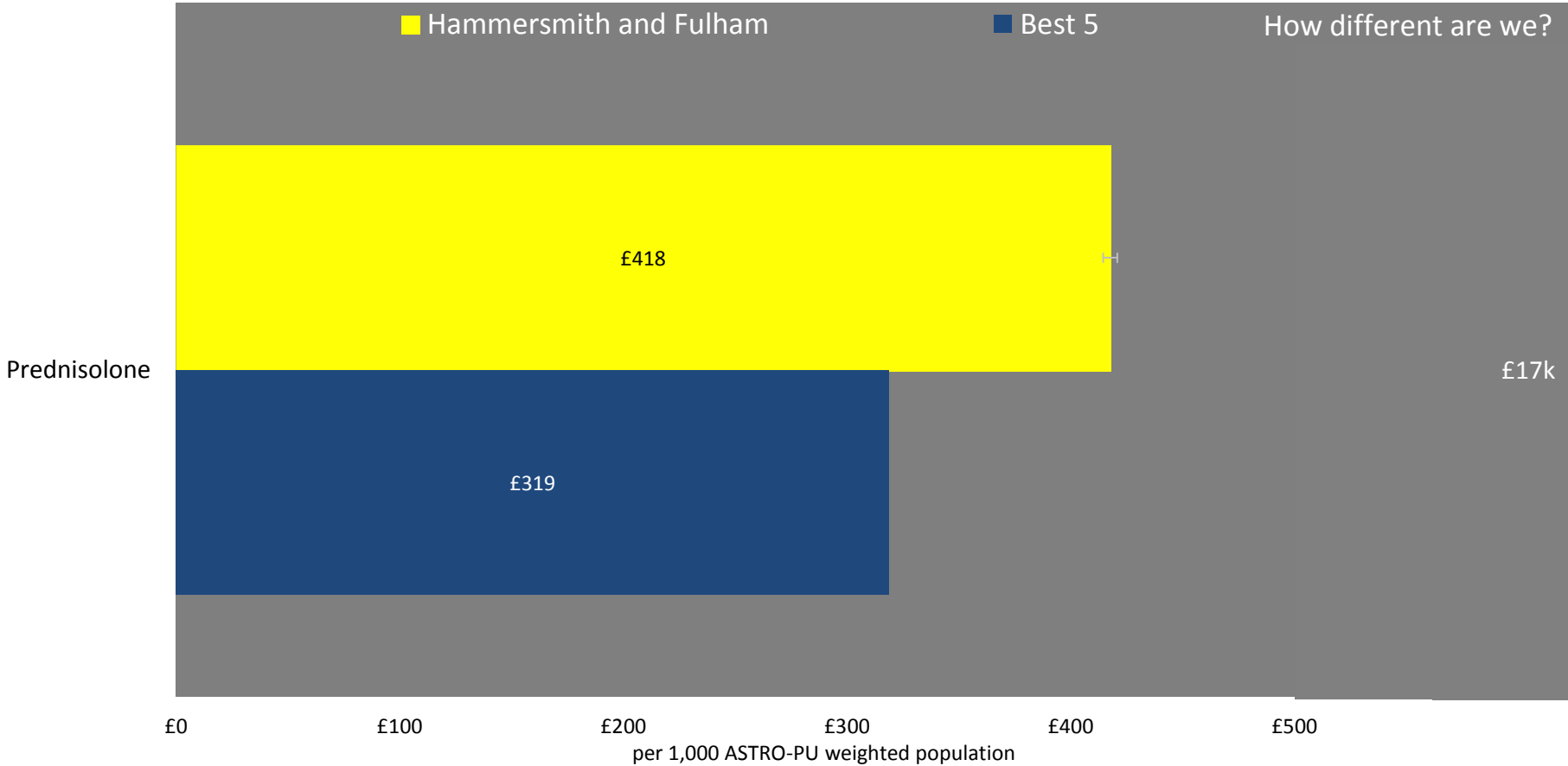
Medicines Optimisation Dashboard: <https://www.england.nhs.uk/ourwork/pe/mo-dash/>

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

95% confidence intervals

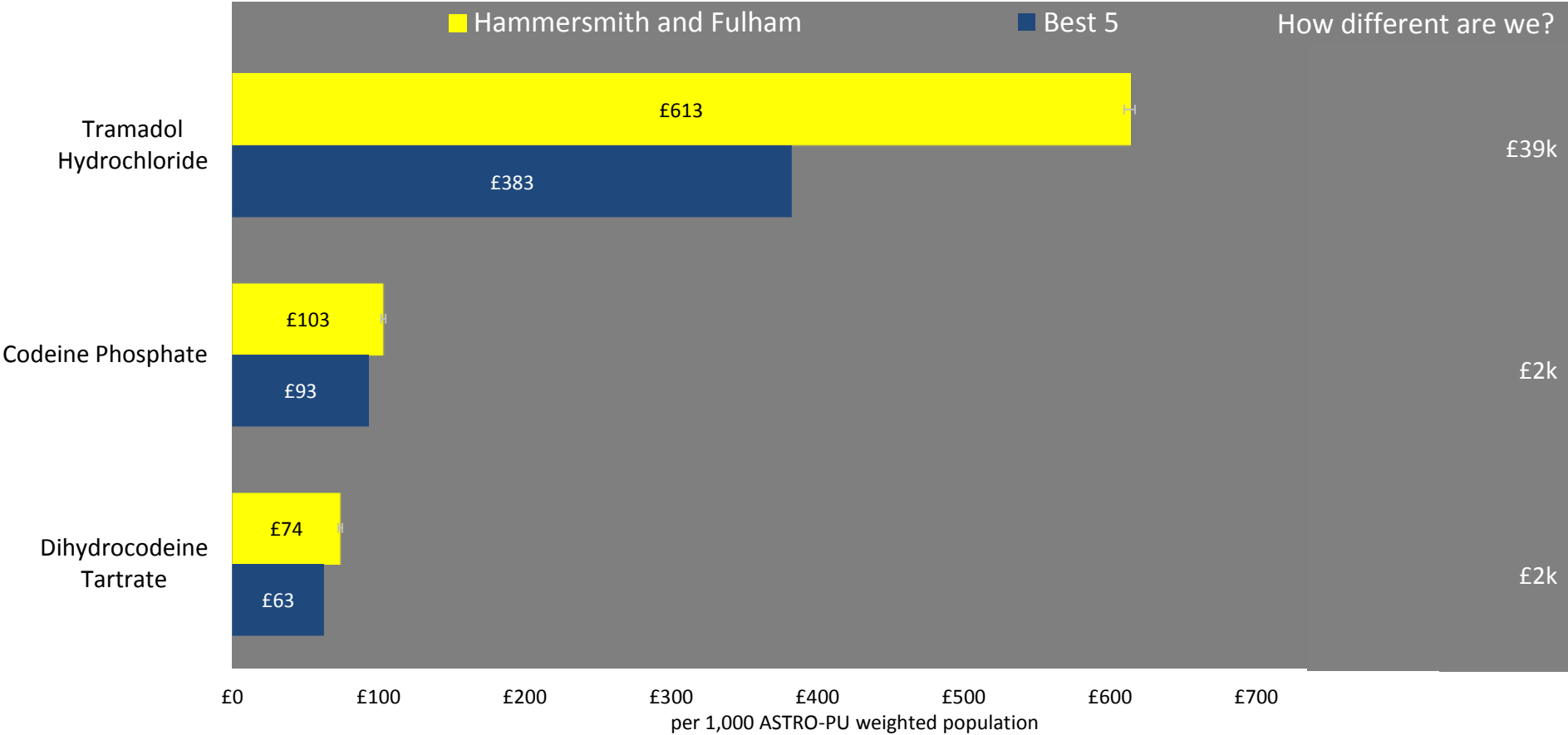
NSS Not statistically significant*

*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



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 - Opioid analgesics

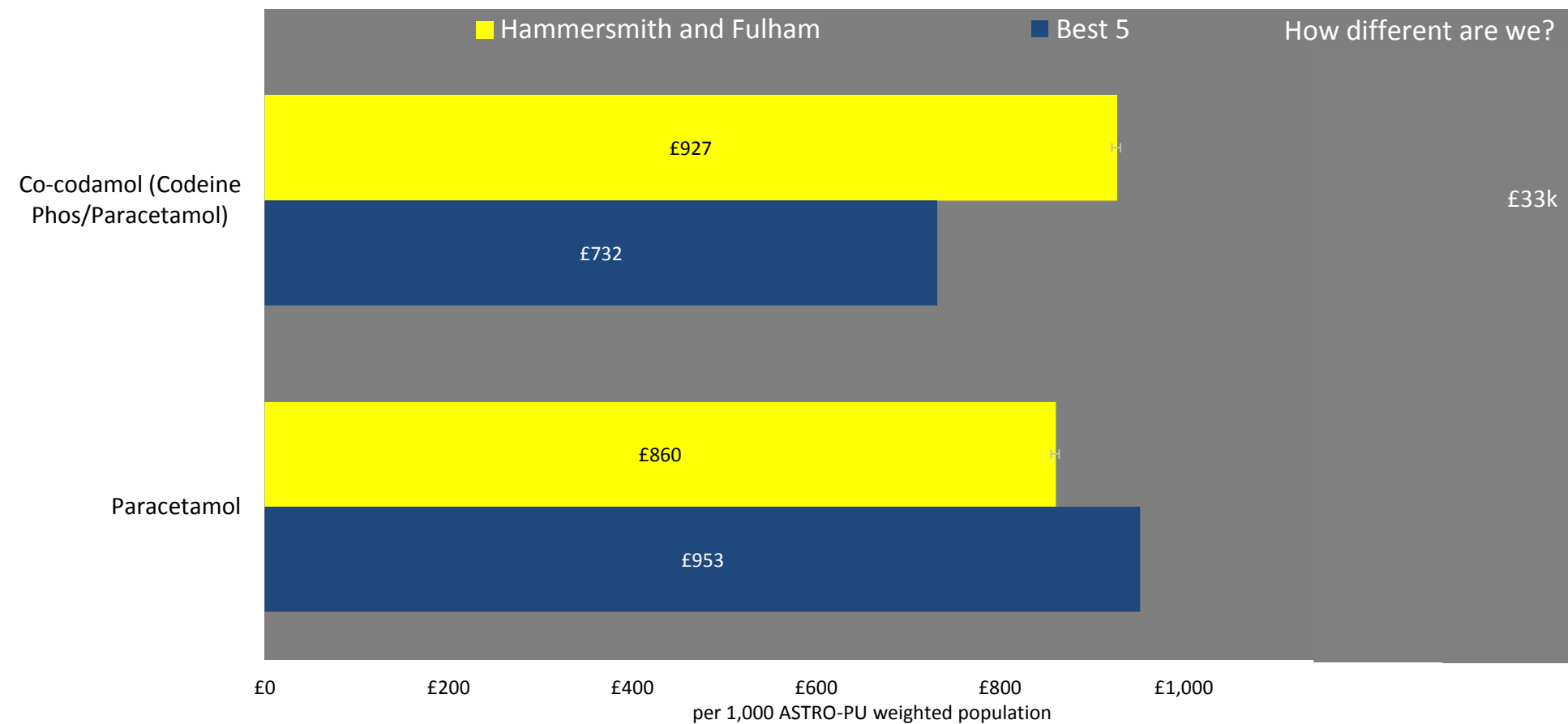


95% confidence intervals

NSS Not statistically significant*

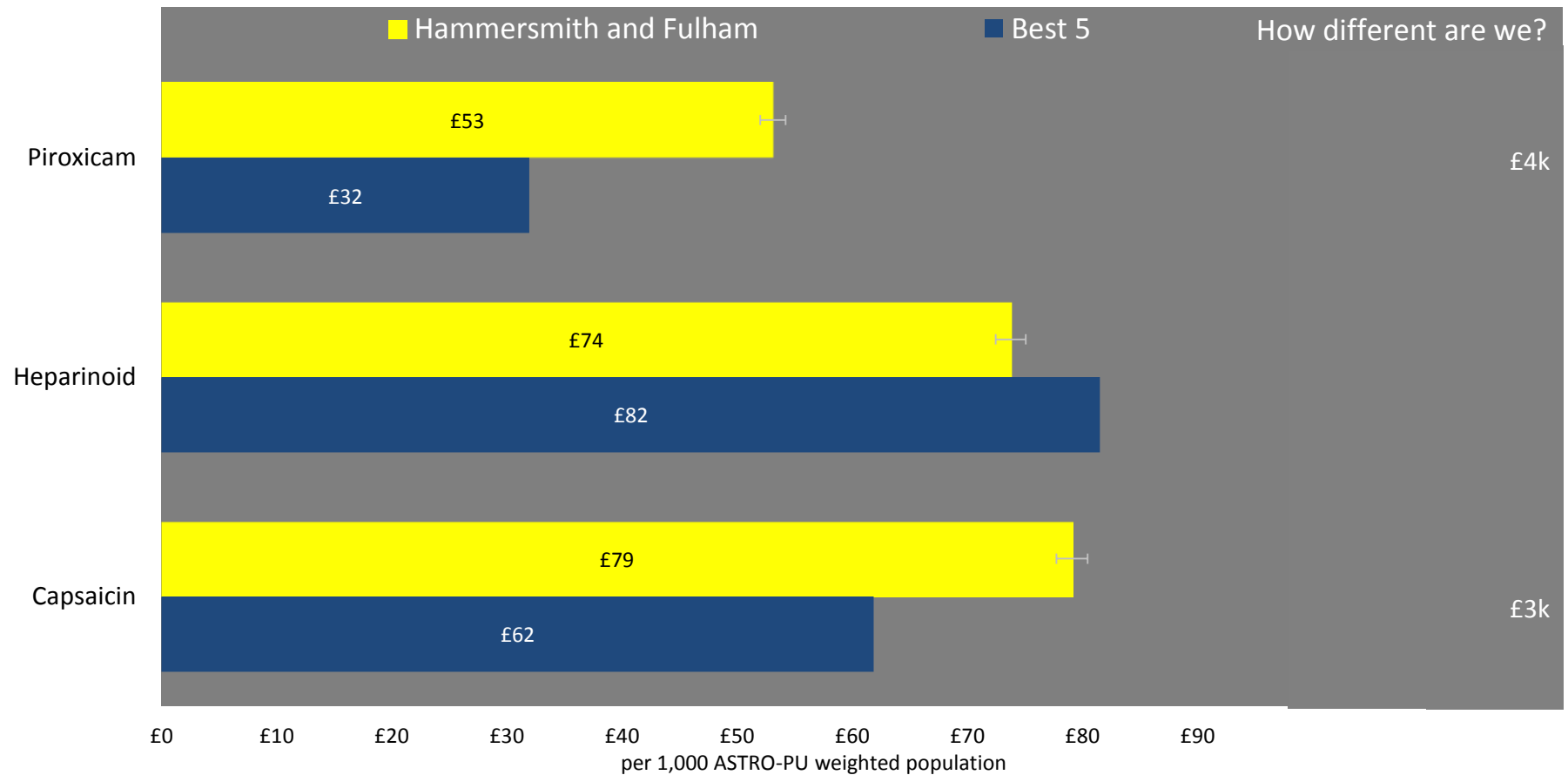
*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

Primary Care Prescribing Spend - Non-Opioid analgesics



Primary Care Prescribing Spend - Other high spend MSK

43

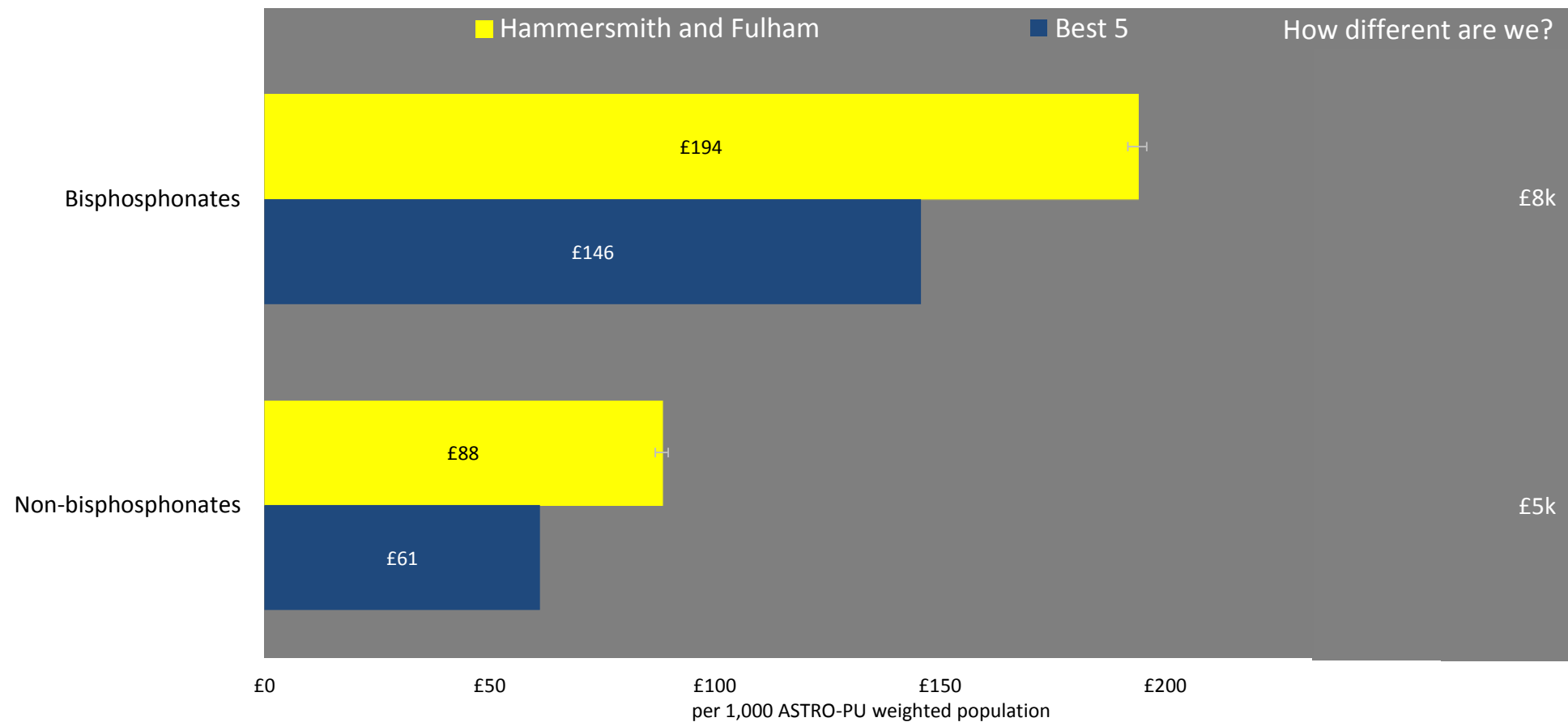


95% confidence intervals

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 - Osteoporosis drugs

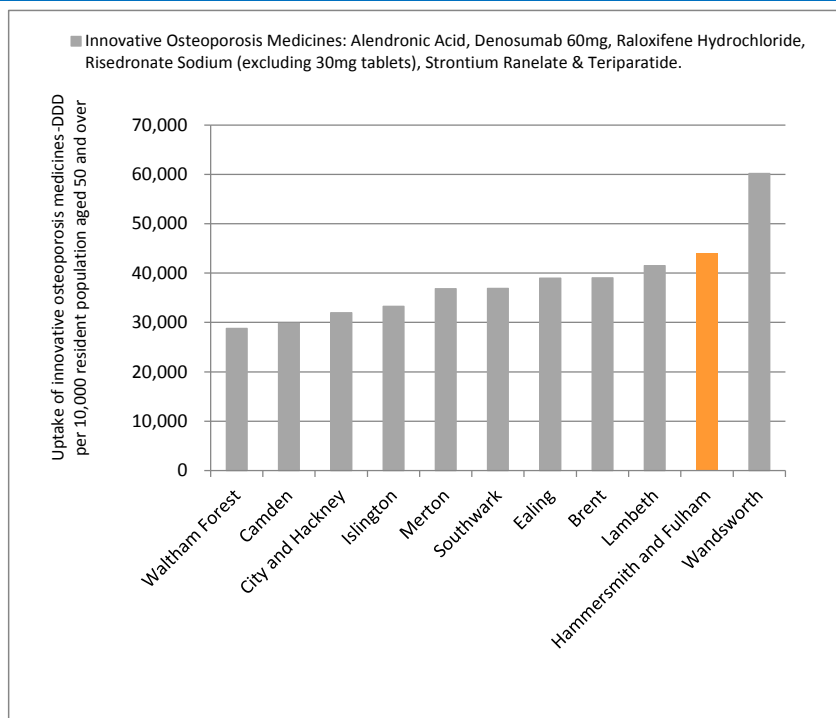


95% confidence intervals
NSS Not statistically significant*
*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

Osteoporosis Innovative Medicines

Does this CCG have appropriate uptake of innovative osteoporosis medicines?

45



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

142

| | Alendronic Acid | Denosumab 60mg ¹ | Raloxifene Hydrochloride nascent | Sodium (exclude 30mg tabs) | Strontium Ranelate | Teriparatide ² | Total |
|-------------------------------|-----------------|-----------------------------|----------------------------------|----------------------------|--------------------|---------------------------|--------|
| Hammersmith and Fulham | 40,064 | 301 | 316 | 2,729 | 539 | 0 | 43,949 |
| Wandsworth | 54,184 | 109 | 424 | 5,190 | 310 | 0 | 60,218 |
| Islington | 30,664 | 153 | 393 | 1,562 | 487 | 6 | 33,265 |
| City and Hackney | 28,790 | 104 | 218 | 2,285 | 574 | 0 | 31,970 |
| Merton | 32,903 | 98 | 587 | 2,964 | 273 | 0 | 36,824 |
| Lambeth | 38,214 | 28 | 293 | 2,690 | 256 | 0 | 41,480 |
| Southwark | 33,293 | 55 | 192 | 3,199 | 159 | 0 | 36,900 |
| Waltham Forest | 26,027 | 82 | 274 | 2,129 | 309 | 0 | 28,822 |
| Ealing | 35,181 | 137 | 310 | 3,113 | 240 | 0 | 38,982 |
| Camden | 25,647 | 246 | 417 | 2,868 | 659 | 0 | 29,838 |
| Brent | 34,776 | 127 | 462 | 3,207 | 465 | 0 | 39,038 |
| Mean of 10 nearest neighbours | 33,968 | 114 | 357 | 2,921 | 373 | 1 | 37,734 |

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 its 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.

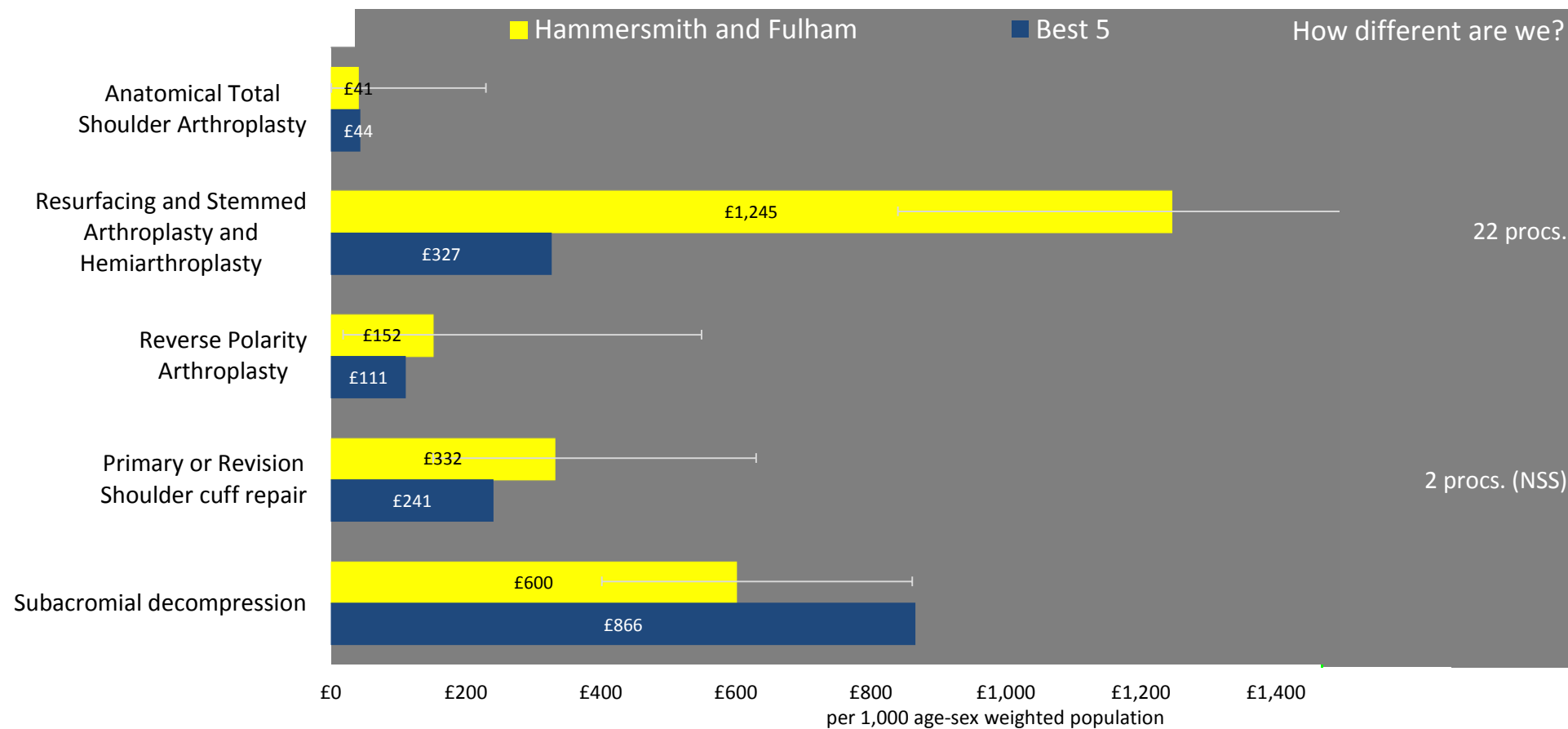
Sources: Innovation Scorecard May 2016, Prescribing and Medicines Team, HSCIC using data from ePACT (NHS Business Services Authority); CCG Resident Population: ONS. Re-used with the permission of the HSCIC. All rights reserved.

<http://www.hscic.gov.uk/catalogue/PUB19259>

<https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/>

MSK Procedures - Shoulder

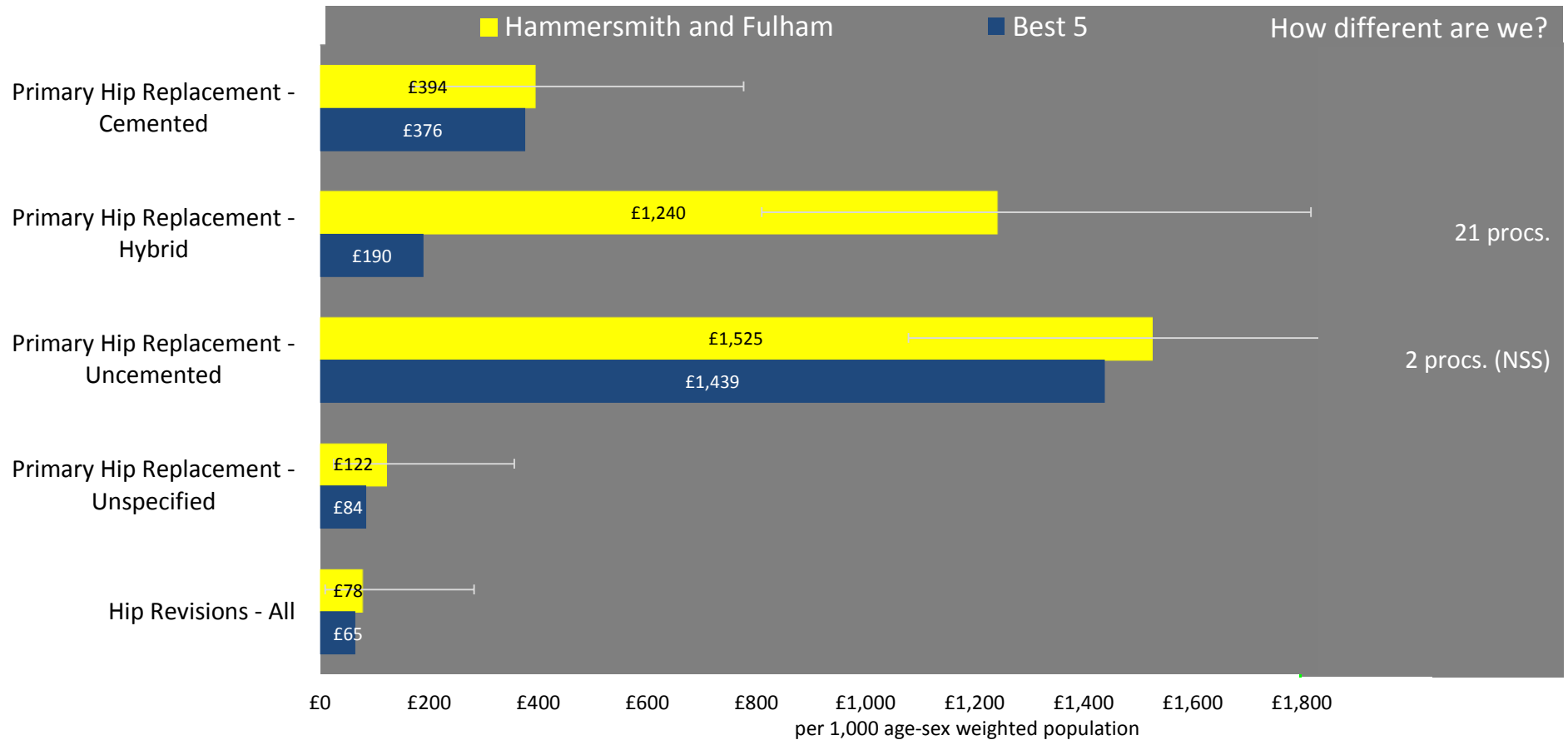
46



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 Procedures - Hip replacements

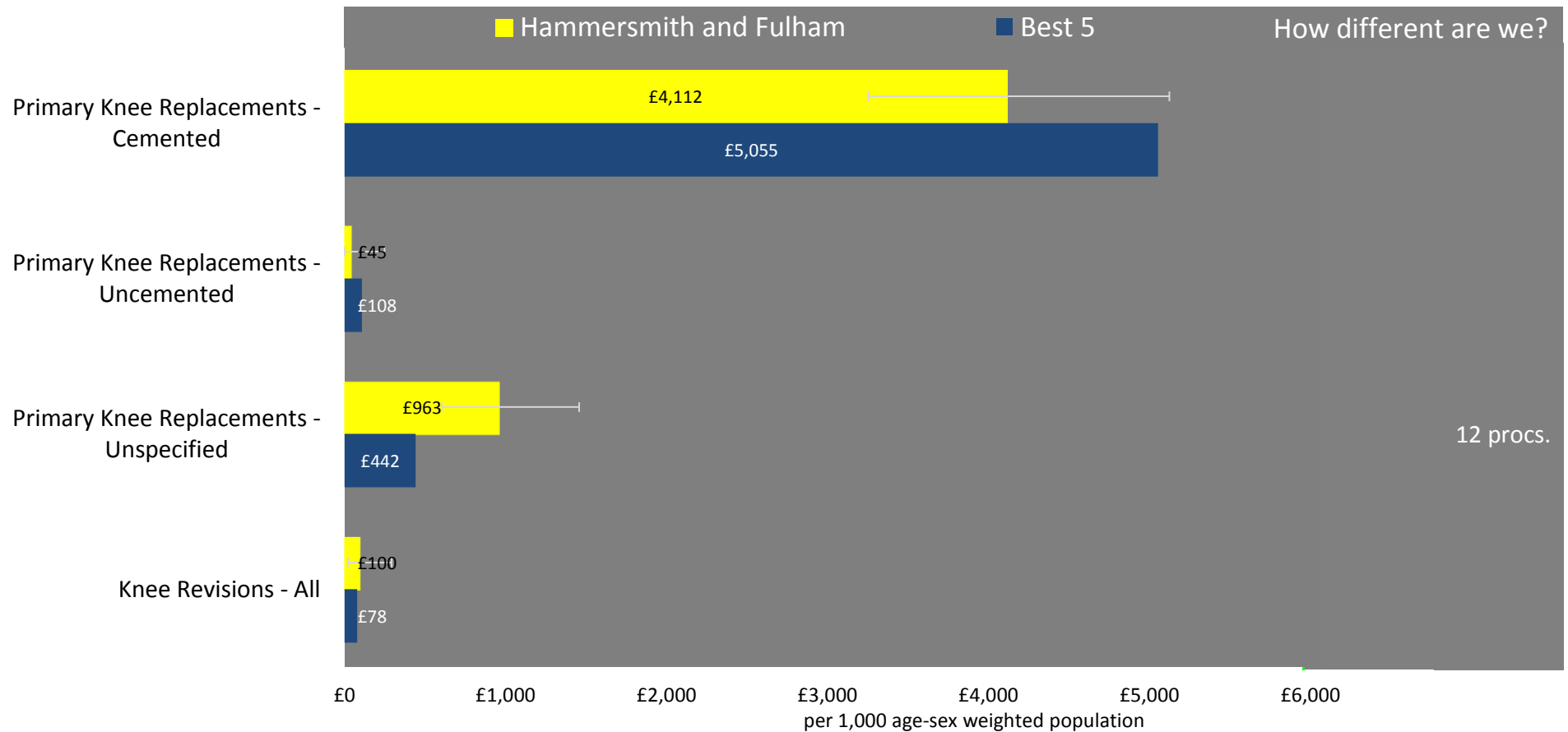
47



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 Procedures - Knee replacements

48



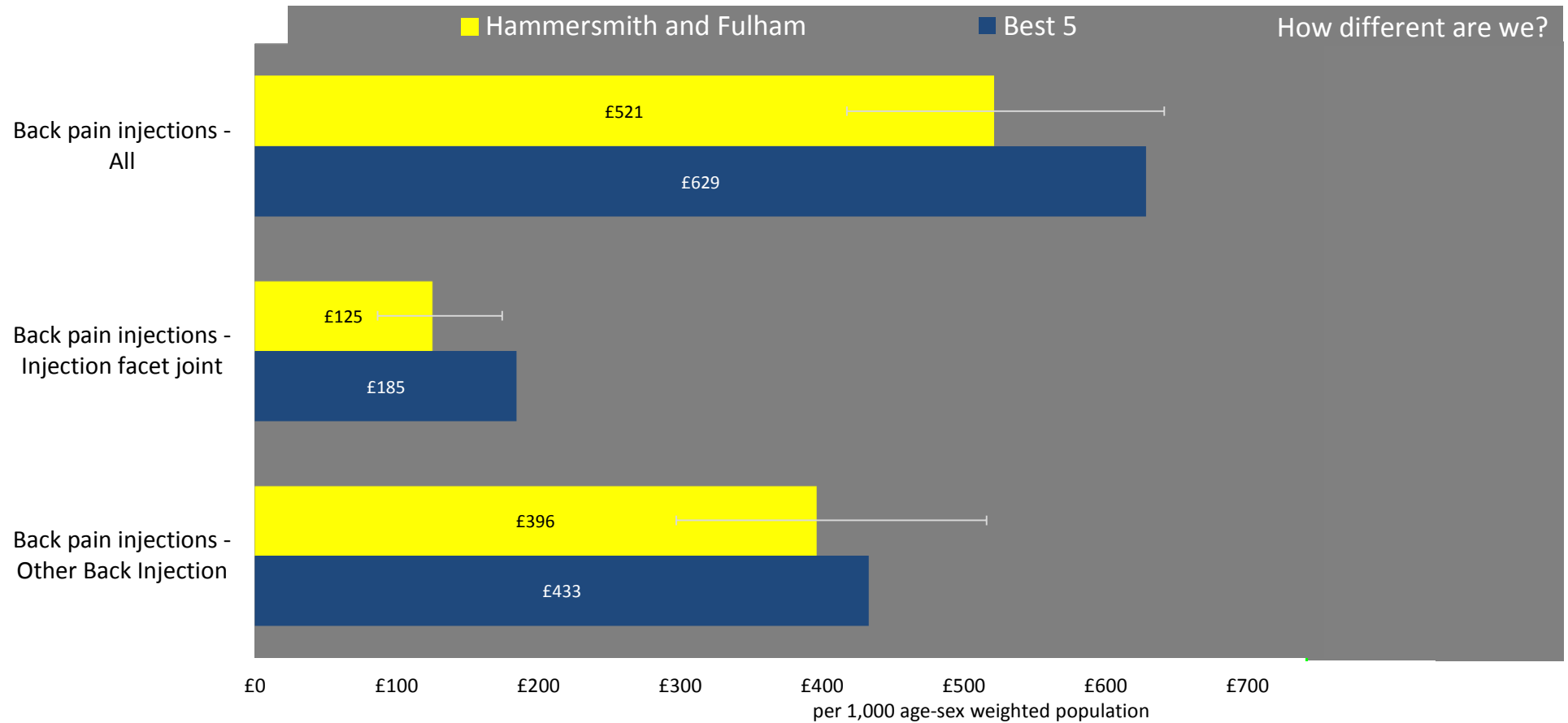
95% confidence intervals

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 Procedures - Back and radicular pain

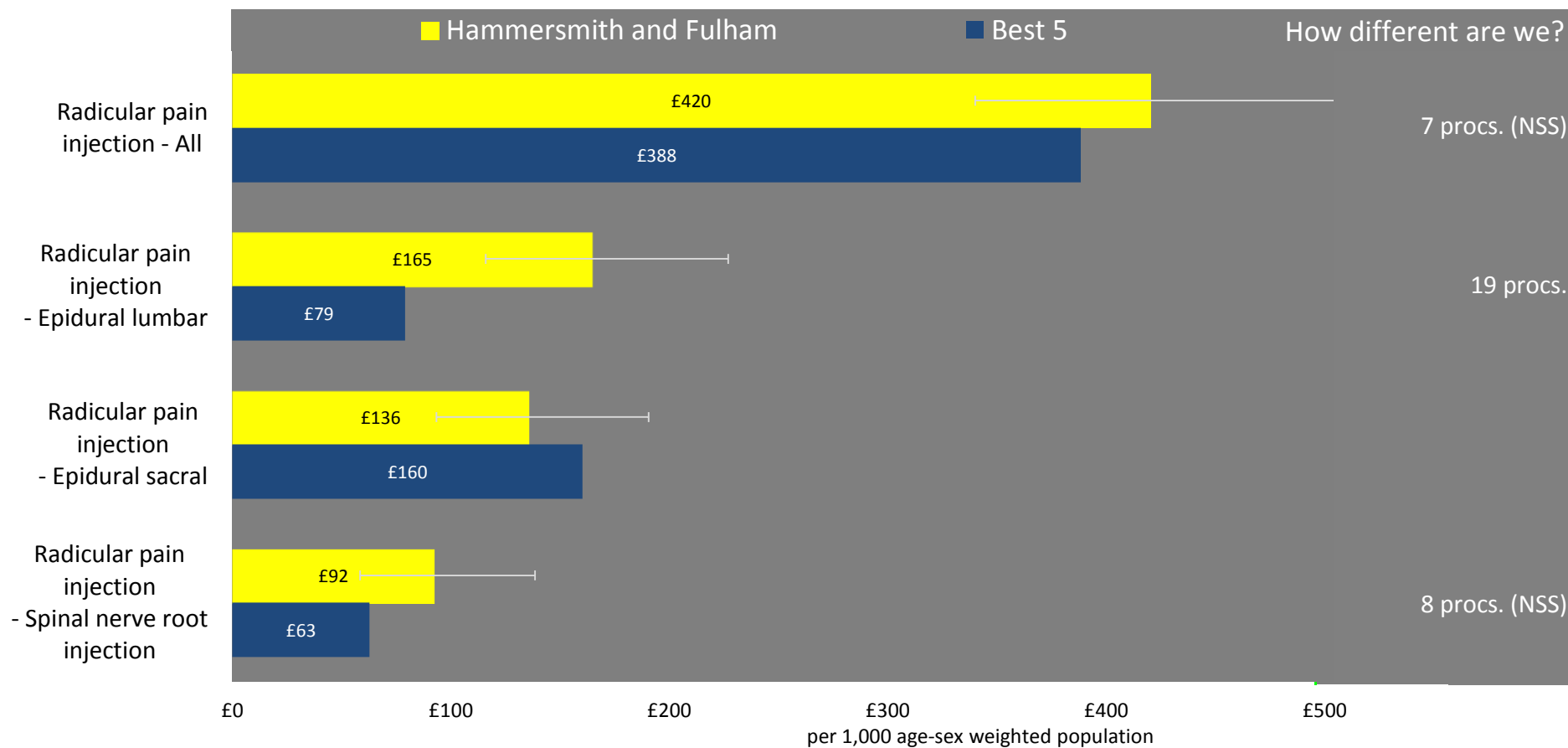
49



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 Procedures - Back and radicular pain continued

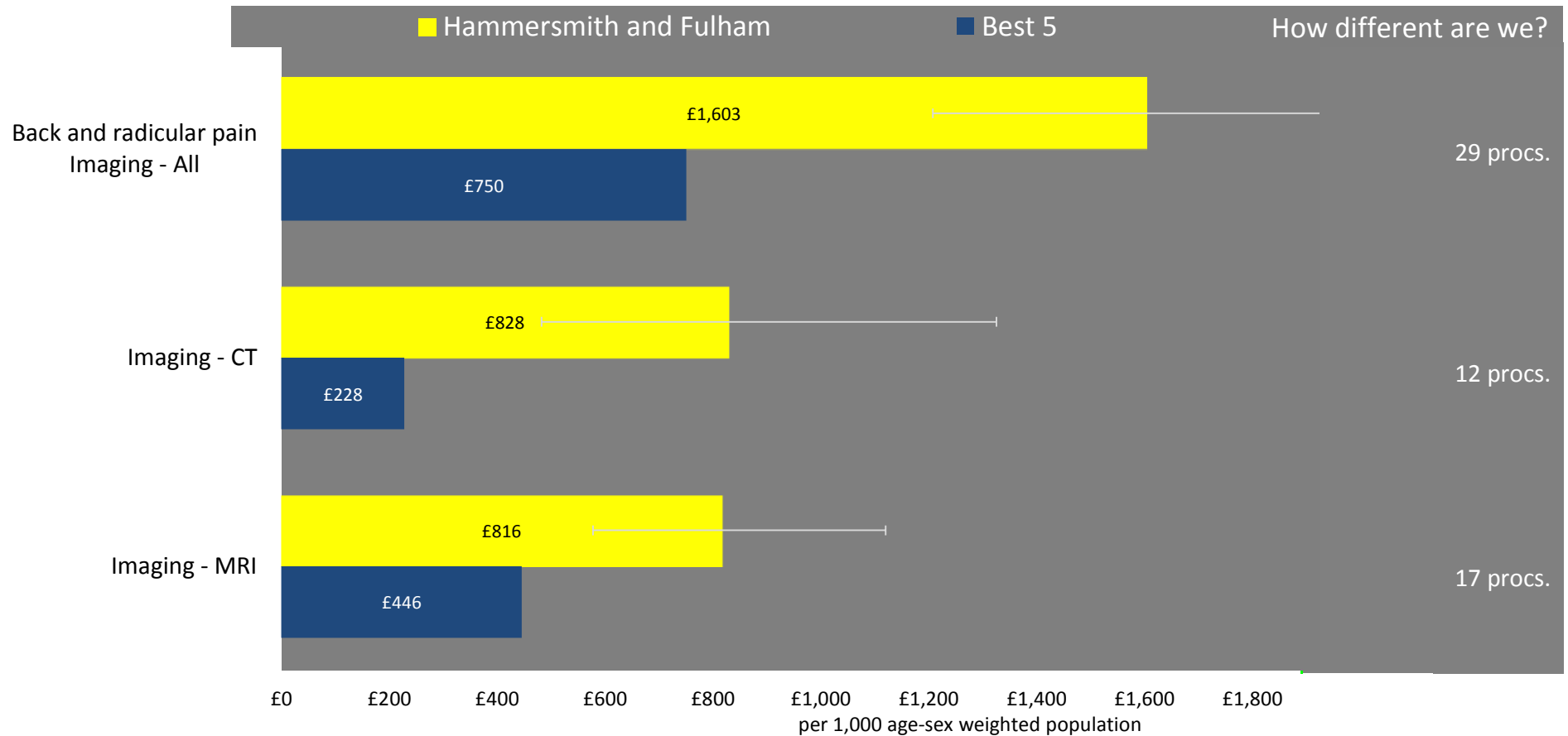
50



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 Procedures - Back and radicular pain continued

51



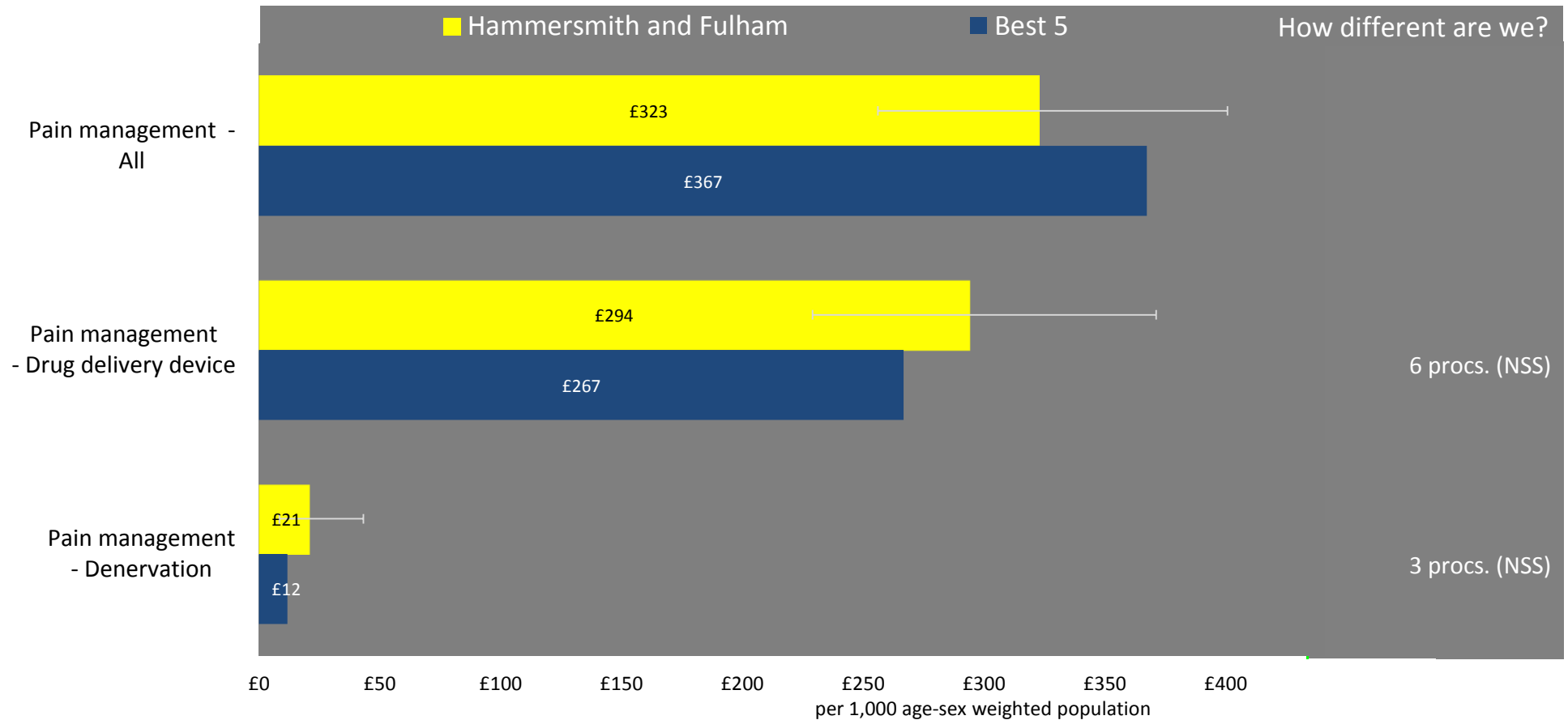
95% confidence intervals

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 Procedures - Back and radicular pain continued

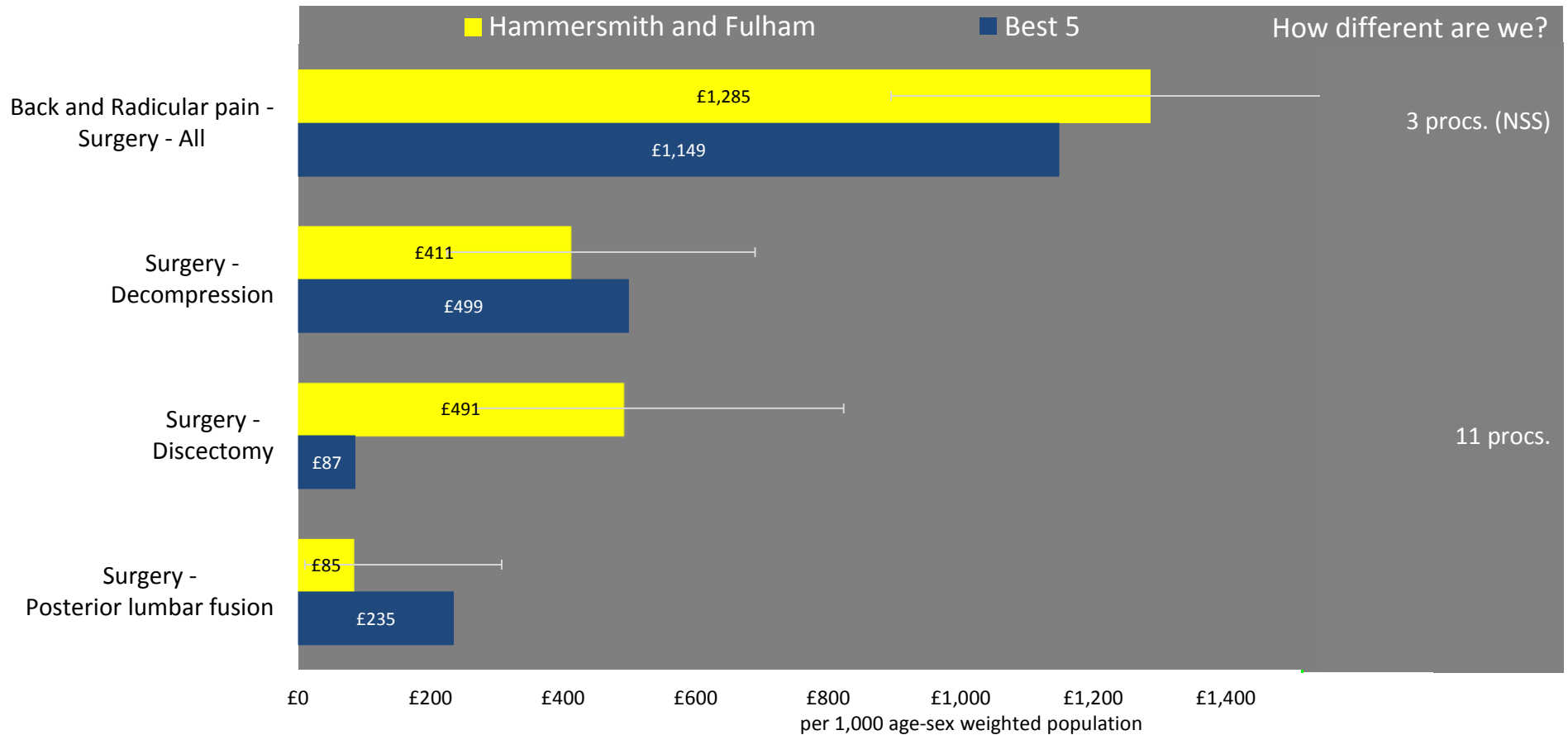
52



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 Procedures - Back and radicular pain continued

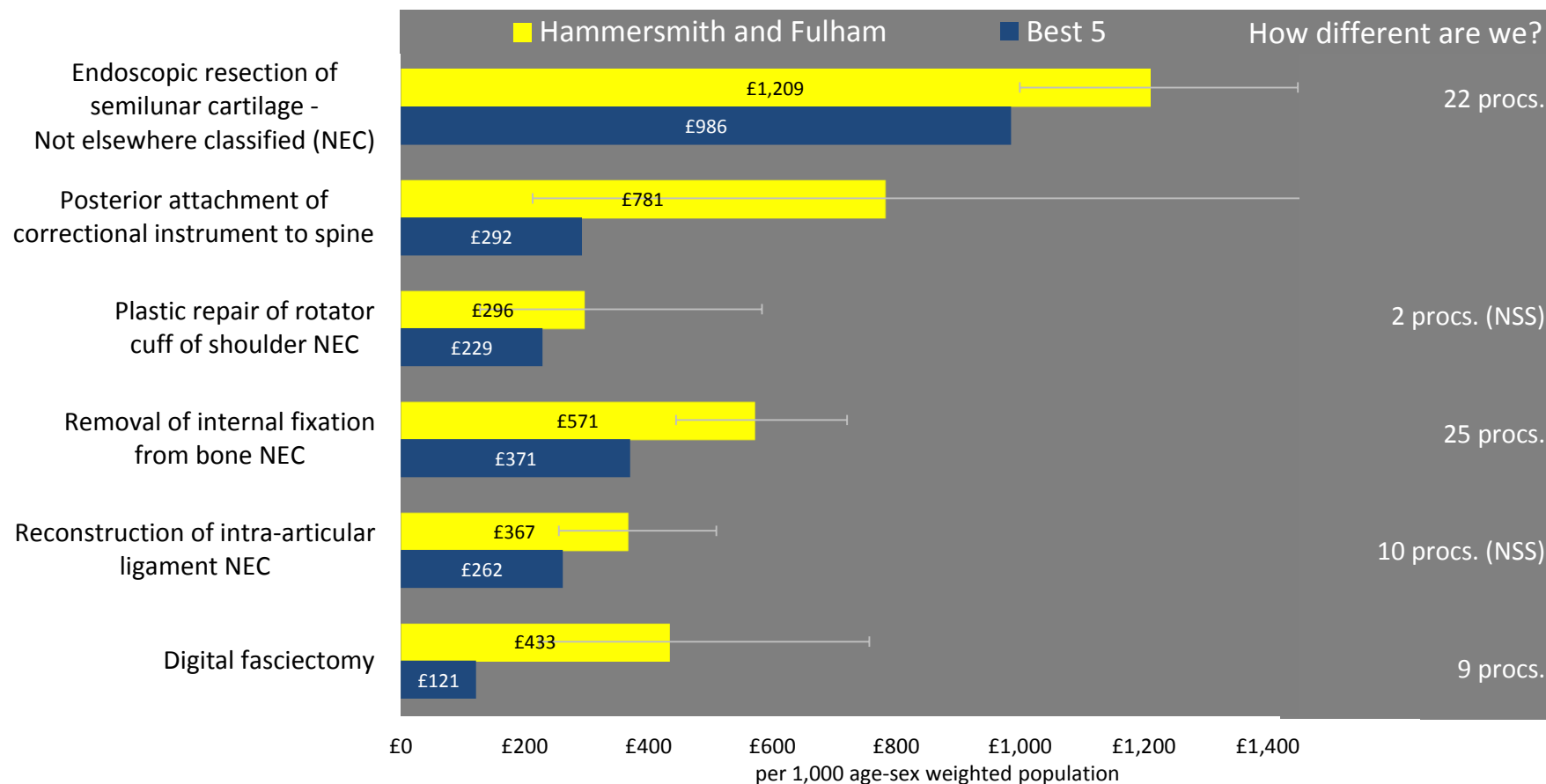
53



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 Procedures - Other high spend MSK

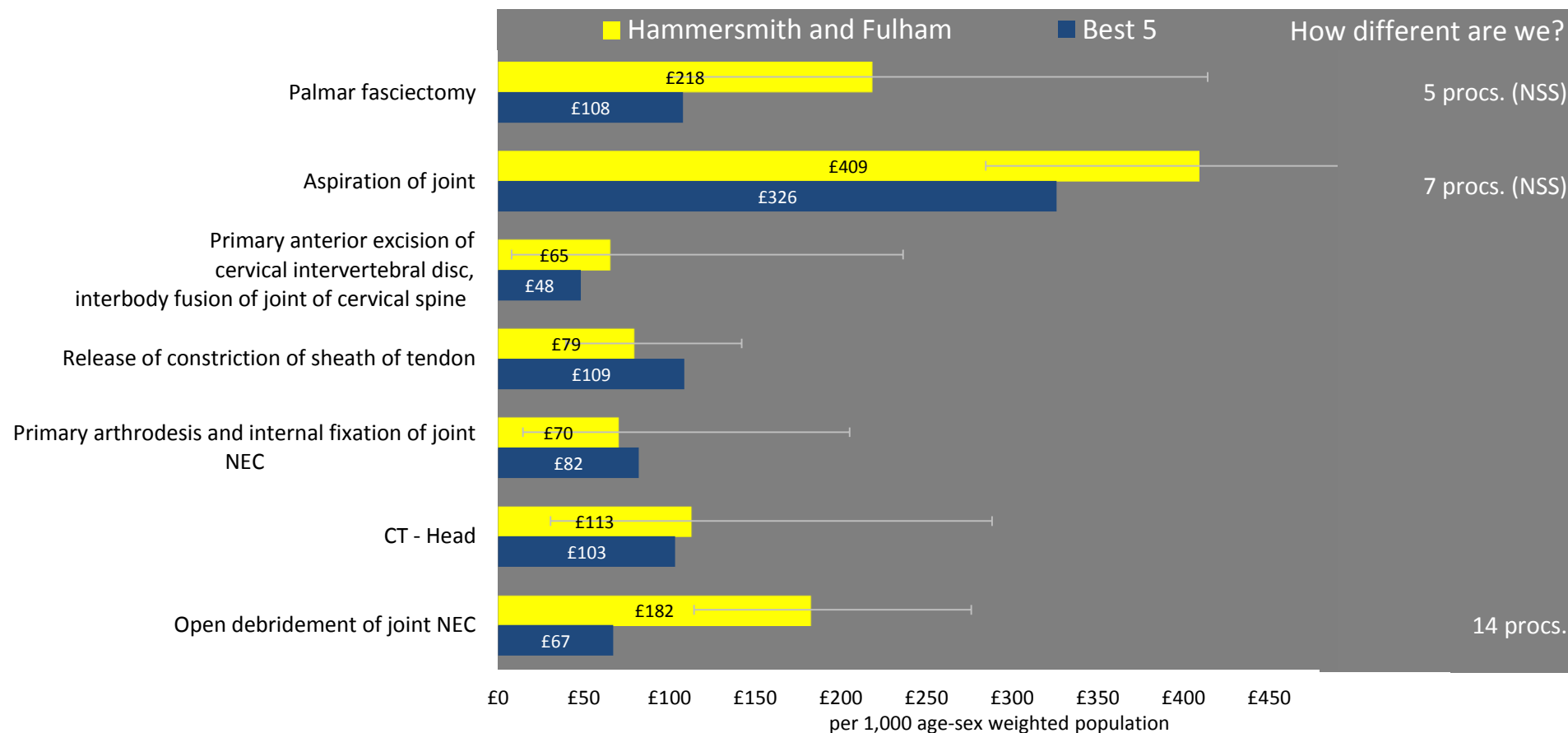
54



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 Procedures - Other high spend MSK continued

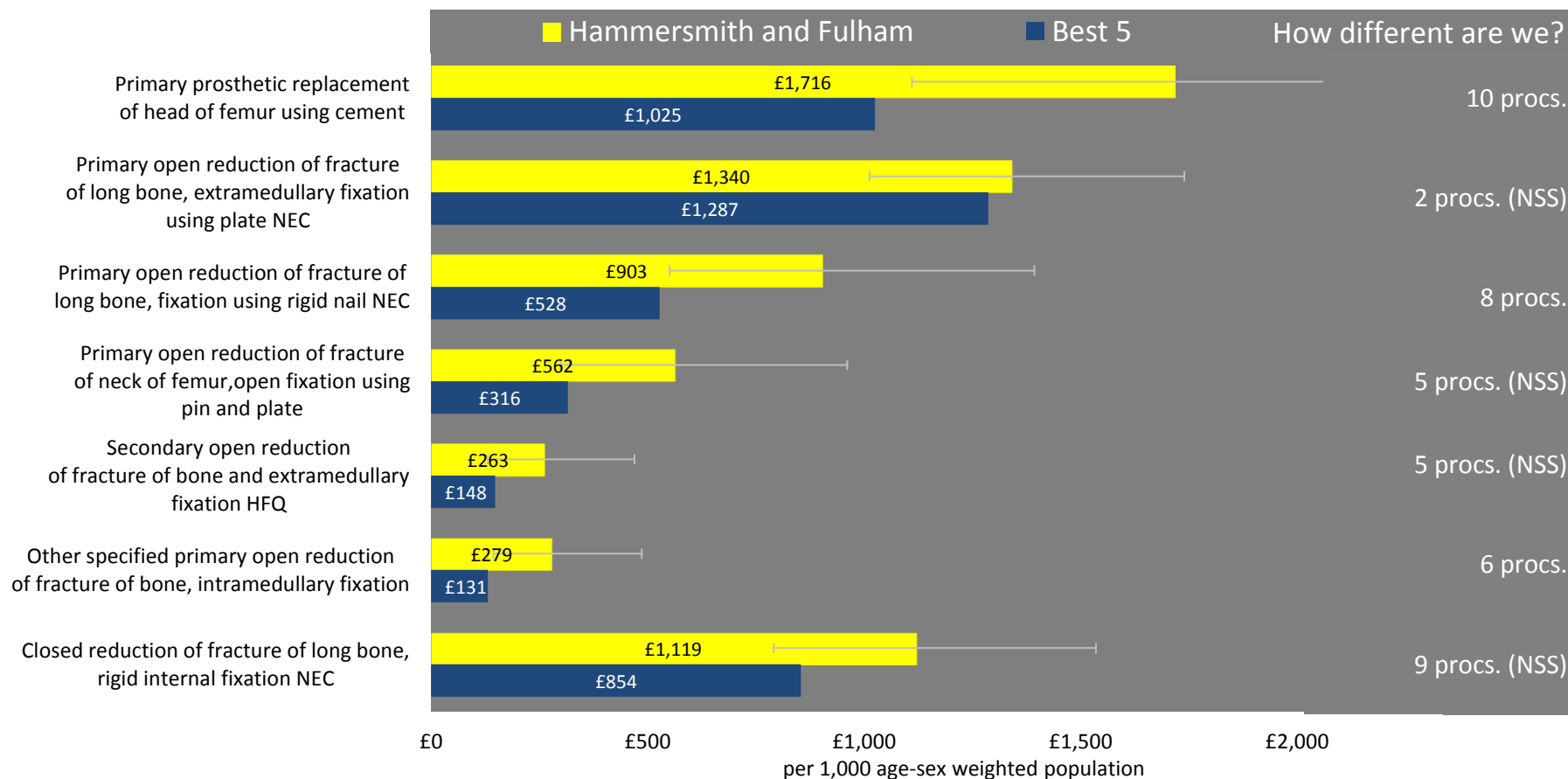
55



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 and injuries - Procedures

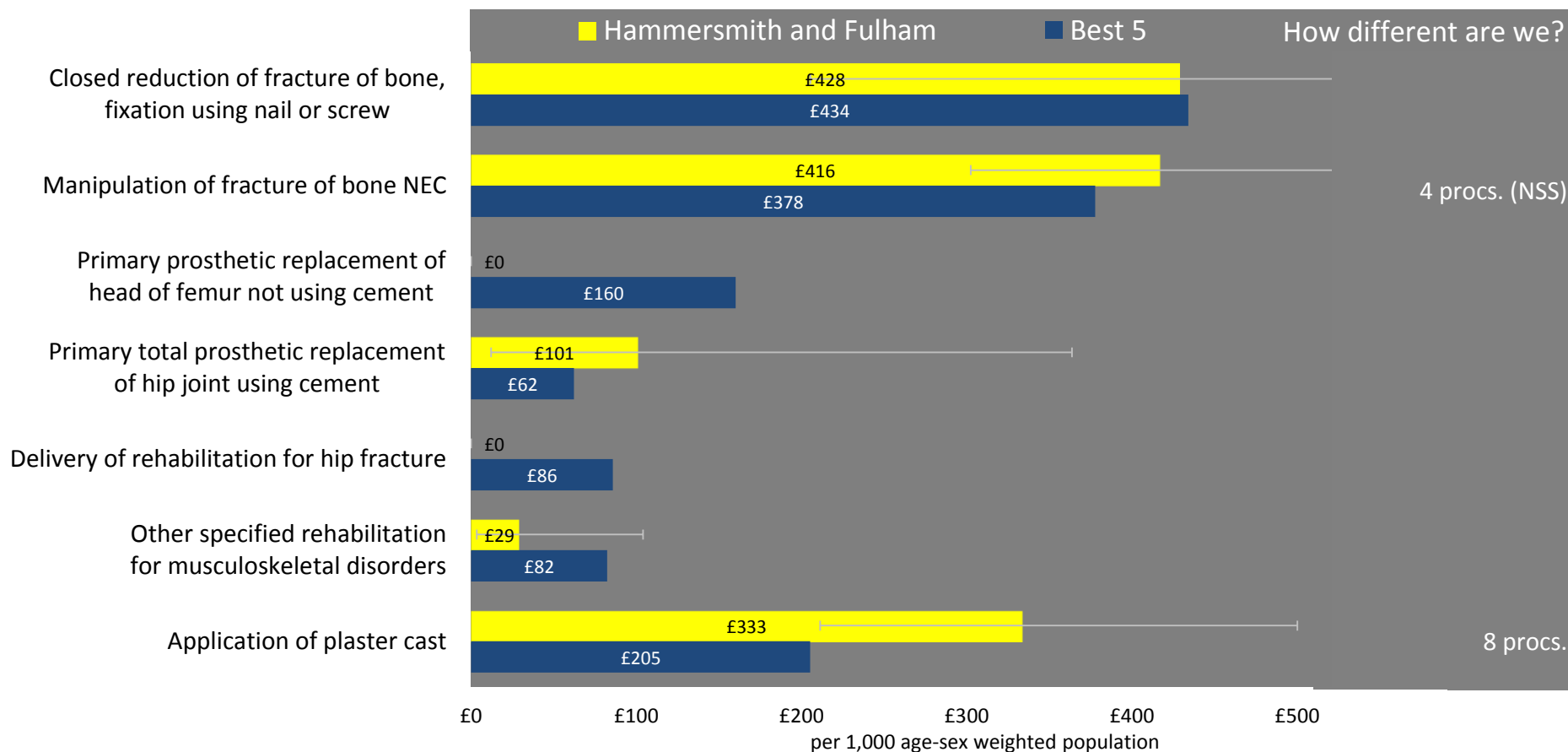
56



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 and injuries- Procedures continued

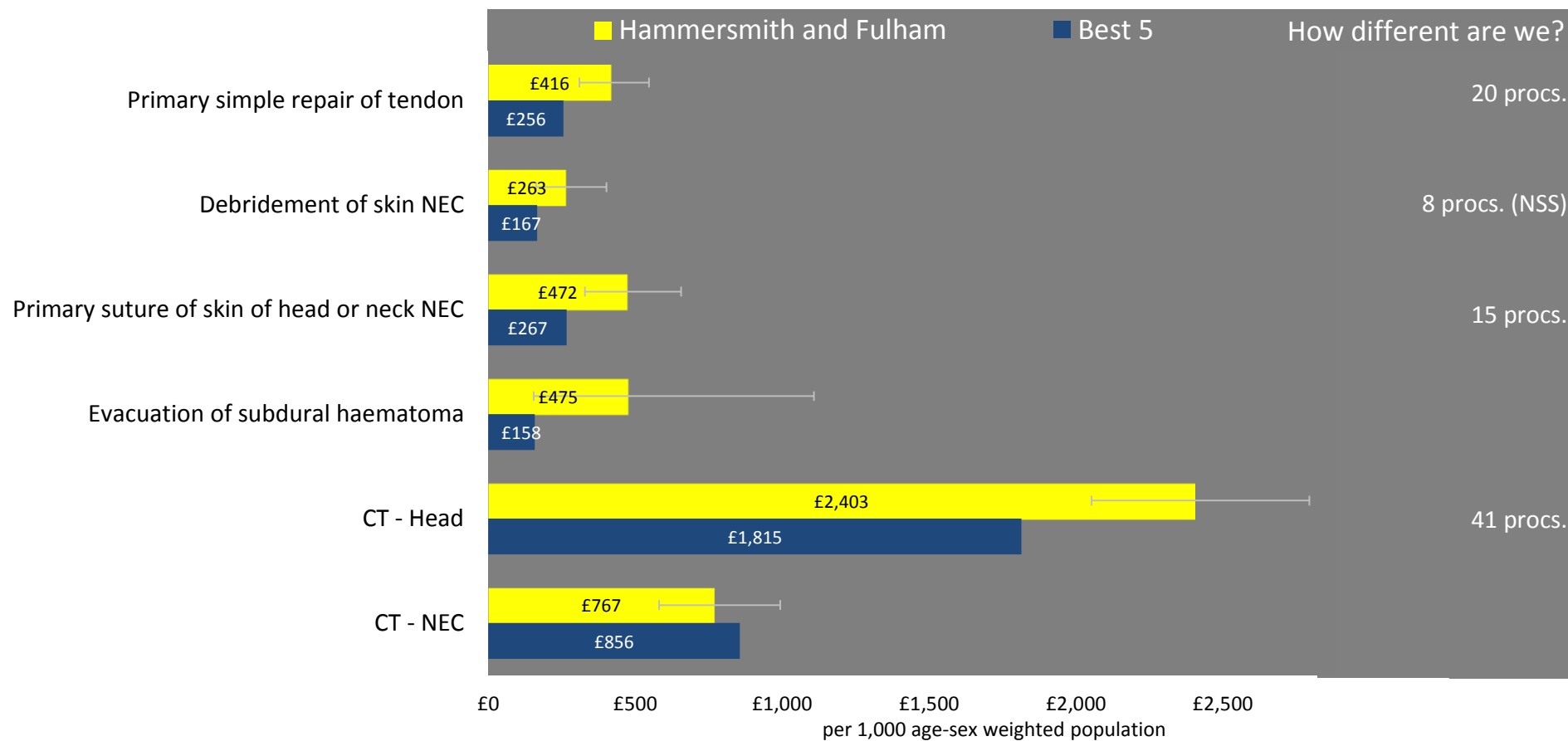
57



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 and injuries - Procedures continued

58



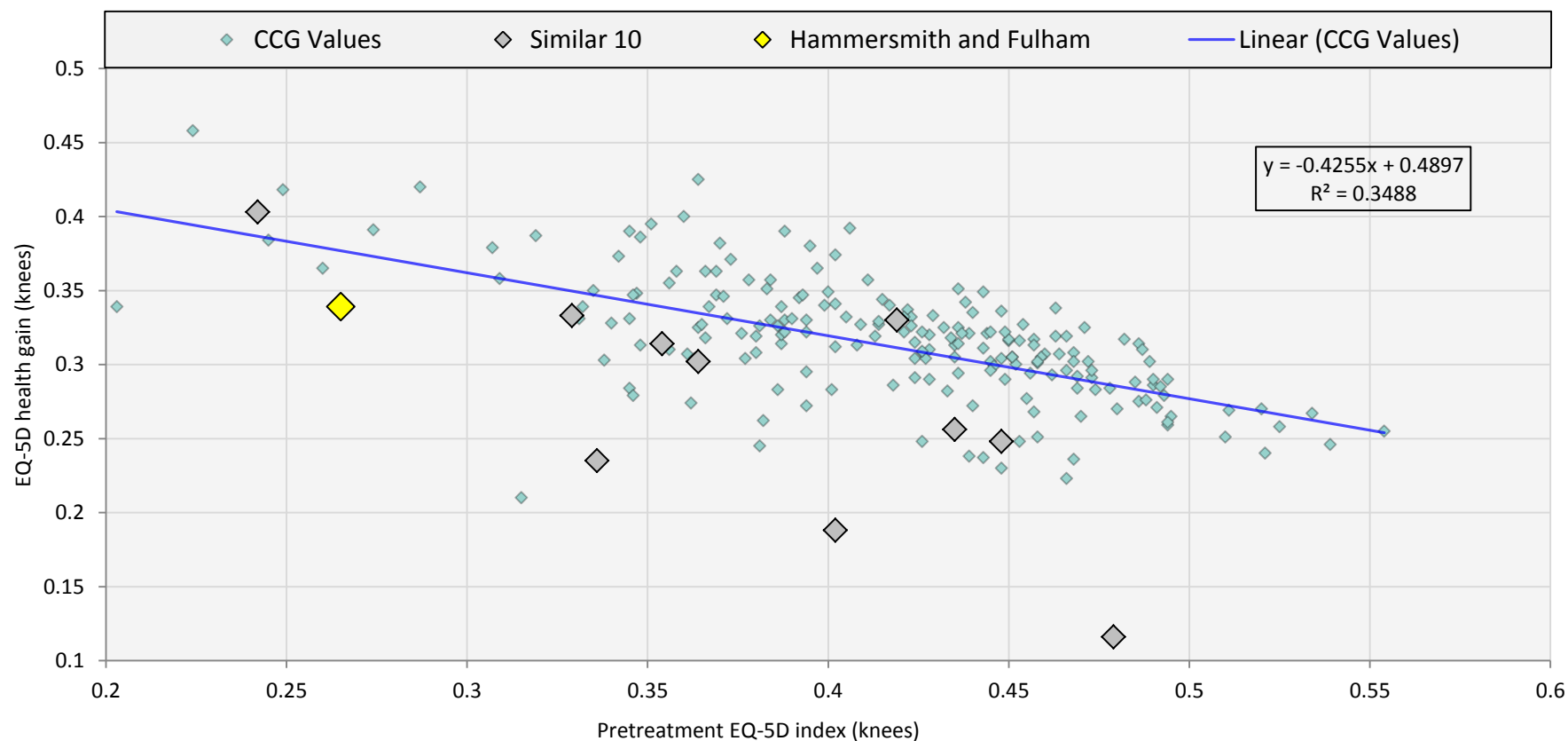
95% confidence intervals
NSS Not statistically significant*
 *Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

Scatter Plot Analysis

59

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/>



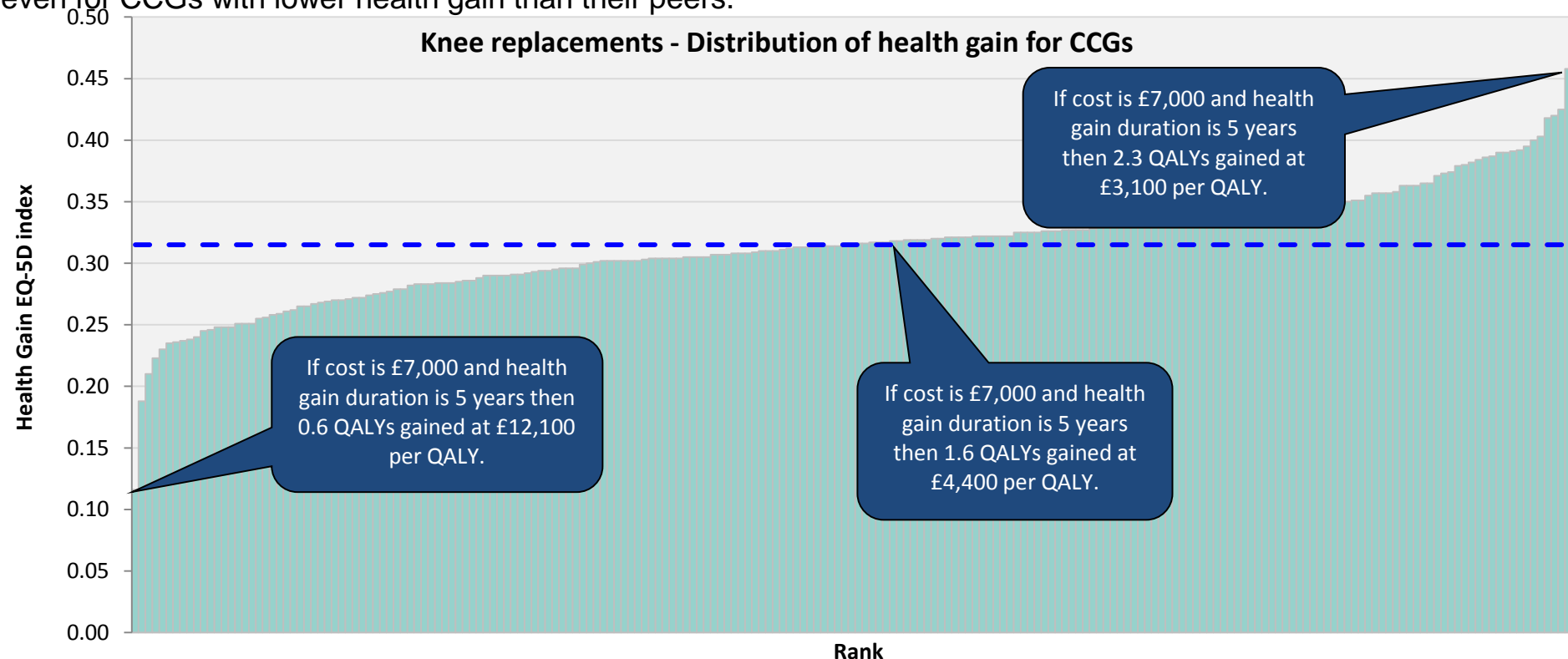
What is the range of health gain for knee replacements across CCGs?

60

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.

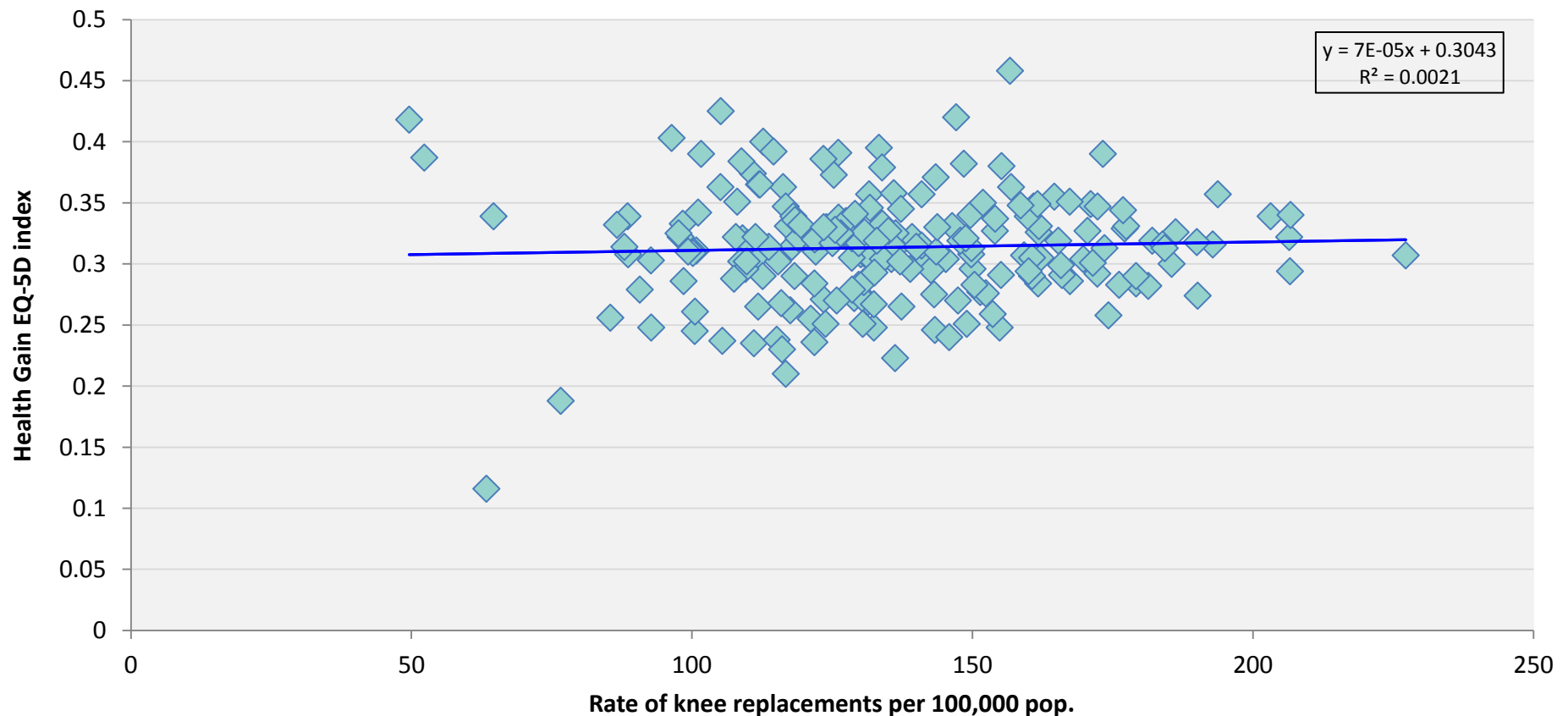


*Similarly for hip replacements except the health gain tends to be larger. The England average EQ-5D Index health gain is 0.437.

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

61

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.

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

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

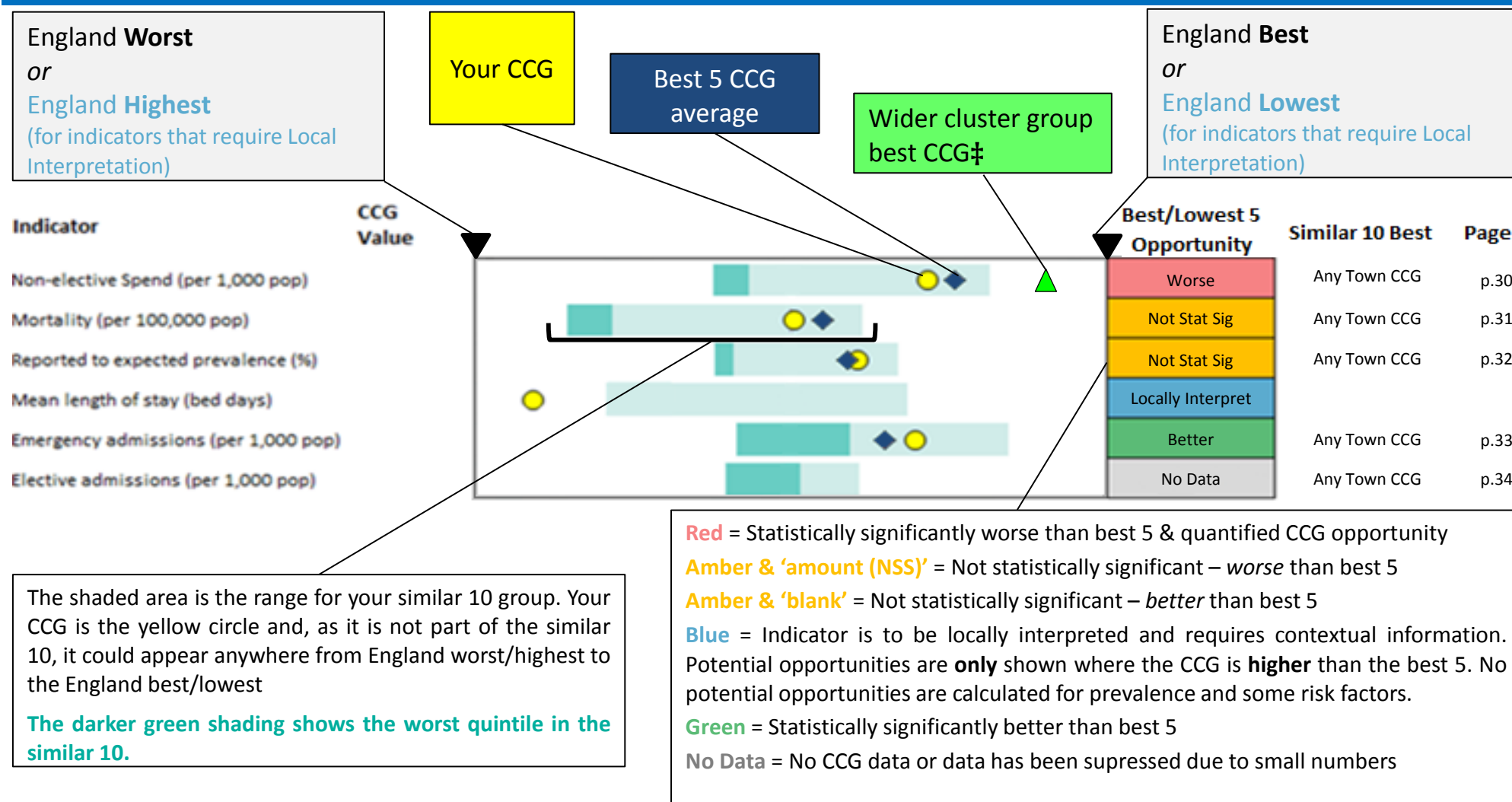
The width of the spine chart shows the England range. Your CCG is benchmarked against its similar 10 group. The shaded area of the spine chart within the table shows the range for the similar 10 group. Where the CCG is highest or lowest compared with its similar 10 group it is shown as outside that group 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

63



‡ 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.

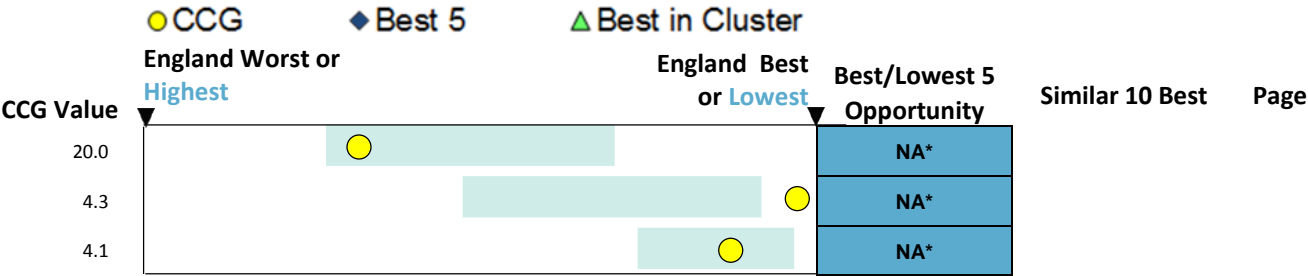
* per 1,000 age/sex weighted population
** per 100,000 age/sex weighted population
*** per 1,000 ASTRO-PU weighted population

Indicator

Smoking prevalence, 18+

Obesity prevalence, 16+

% GP registered population, 75+



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

NHS Hammersmith and Fulham CCG 65

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

Indicator



* 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

NHS Hammersmith and Fulham CCG 66

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

| Indicator | CCG Value | CCG | Best 5 | Best in Cluster | England Worst or Highest | England Best or Lowest | Best/Lowest 5 Opportunity | Similar 10 Best | Page |
|--|-----------|-----|--------|-----------------|--------------------------|------------------------|---------------------------|------------------------|------|
| Rate of DEXA scan activity (*) | 8.0 | | | | | | 559 Scans | | |
| % osteoporosis patients 50-74 treated with Bone Sparing Agent | 96.6 | | | | | | | Hammersmith and Fulham | p.78 |
| % patients 75+ years with fragility fracture treated with BSA | 74.3 | | | | | | 3 Pats (NSS) | City and Hackney | p.79 |
| All fracture admissions in people aged 65+ (per 1,000 pop. 65+) | 12 | | | | | | | Waltham Forest | p.80 |
| Hip fractures in people aged 65+ (**) | 395 | | | | | | | Brent | p.81 |
| Hip fractures in people aged 65-79 (**) | 166 | | | | | | | Waltham Forest | p.82 |
| Hip fractures in people aged 80+ (**) | 1092 | | | | | | | Brent | 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 (**) | 60 | | | | | | | | |
| Rate of knee replacements (**) | 65 | | | | | | | | |
| % of patients with RA who have had a review in the last 12 months | 80.0 | | | | | | 72 Pats | Wandsworth | p.84 |
| Rate of MRIs of spine (**) | 17 | | | | | | 5 Pats (NSS) | | |
| Emergency admissions for Back, neck and MSK pain (**) | 35 | | | | | | | Wandsworth | p.85 |
| Injuries due to falls in people aged 65+ (**) | 2378.0 | | | | | | 36 Adms (NSS) | Brent | p.86 |
| Unintentional and deliberate injury admissions, 0-24 years (**) | 114 | | | | | | 14 Adms | Camden | p.87 |
| Back, neck and MSK pain - day case admissions (**) | 111.1 | | | | | | 4 Adms (NSS) | | |
| Back, neck and MSK pain - Average LOS - elective (bed days) | 4.2 | | | | | | 7 Bed days (NSS) | | |
| Back, neck and MSK pain - Average LOS - emergency (bed days) | 8.5 | | | | | | | | |
| Rheumatoid & Inflammatory Arthritis - day case admissions (**) | 127.5 | | | | | | 92 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

NHS Hammersmith and Fulham CCG 67

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



* 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

NHS Hammersmith and Fulham CCG 68

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

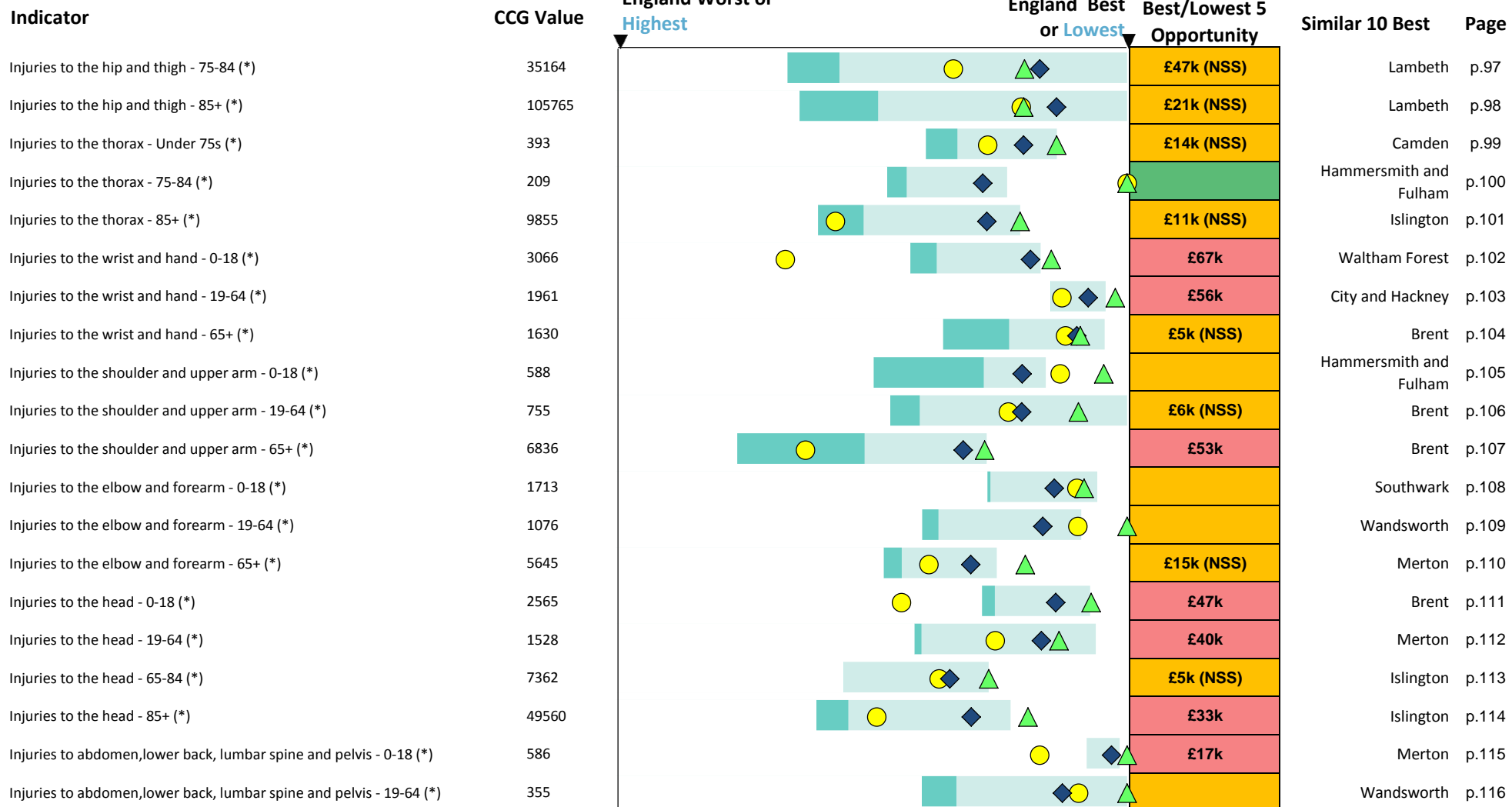
| Indicator | CCG Value | England Worst or Highest | CCG | Best 5 | Best in Cluster | England Best or Lowest | Best/Lowest 5 Opportunity | Similar 10 Best | Page |
|--|-----------|--------------------------|-----|--------|-----------------|------------------------|---------------------------|------------------------|------|
| MSK - Total (*) | 26116 | | | | | | | | |
| MSK - Elective (*) | 22100 | | | | | | | | |
| MSK - Non-elective (*) | 4066 | | | | | | £37k (NSS) | Wandsworth | p.88 |
| Trauma - Total (*) | 20381 | | | | | | £33k (NSS) | | |
| Trauma - Elective (*) | 3429 | | | | | | £178k | | |
| Trauma - Non-elective (*) | 16651 | | | | | | | Brent | p.89 |
| Back, neck and MSK pain - elective (*) | 3722 | | | | | | £20k (NSS) | | |
| Back, neck and MSK pain - non-elective (*) | 1205 | | | | | | | Hammersmith and Fulham | p.90 |
| Rheumatoid and Inflammatory Arthritis - elective (*) | 1194 | | | | | | £56k | | |
| Rheumatoid and Inflammatory Arthritis - non-elective (*) | 644 | | | | | | £8k (NSS) | Wandsworth | p.91 |
| Osteoporosis and fragility fractures - elective (*) | 684 | | | | | | £24k | | |
| Osteoporosis and fragility fractures - non-elective (*) | 880 | | | | | | £83k | Lambeth | p.92 |
| Osteoarthritis - elective (*) | 8785 | | | | | | | | |
| Osteoarthritis - non-elective (*) | 253 | | | | | | £2k (NSS) | Merton | p.93 |
| Other MSK conditions - elective (*) | 3014 | | | | | | £30k (NSS) | | |
| Other MSK conditions - non-elective (*) | 912 | | | | | | £29k | Wandsworth | p.94 |
| Other joint disorders - elective (*) | 3214 | | | | | | | | |
| Other joint disorders - non-elective (*) | 228 | | | | | | £1k (NSS) | Wandsworth | p.95 |
| Follow-up- to remove fracture plate - elective (*) | 499 | | | | | | £37k | | |
| Injuries to the hip and thigh - Under 75s (*) | 1490 | | | | | | £8k (NSS) | Brent | p.96 |

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

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 69

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



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

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 70

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

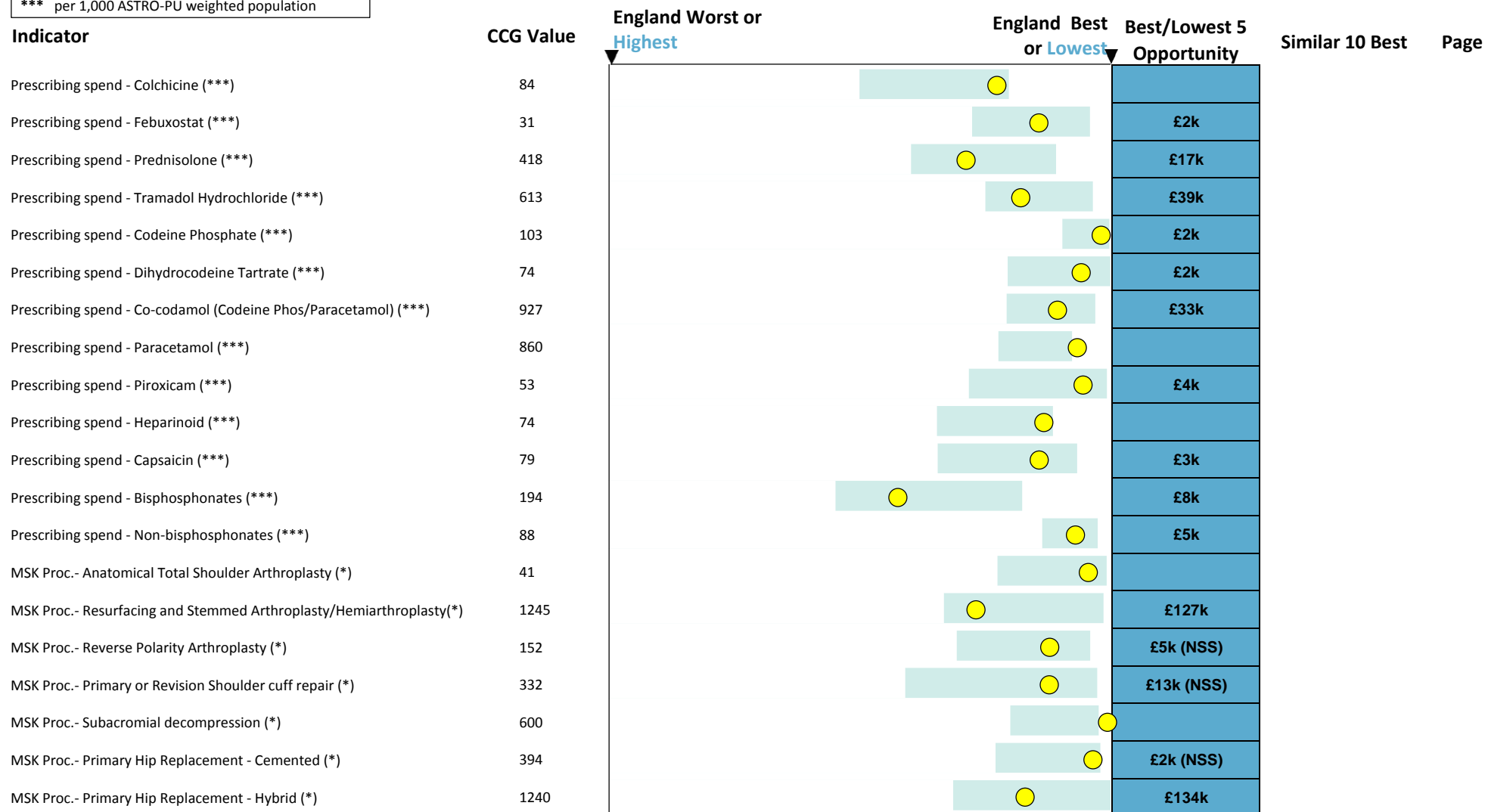
| Indicator | CCG Value | England Worst or Highest | CCG | Best 5 | Best in Cluster | England Best or Lowest | Best/Lowest 5 Opportunity | Similar 10 Best | Page |
|---|-----------|--------------------------|-----|--------|-----------------|------------------------|---------------------------|------------------------|-------|
| Injuries to abdomen,lower back, lumbar spine and pelvis - 65-84 (*) | 906 | | | | | | | Hammersmith and Fulham | p.117 |
| Injuries to abdomen,lower back, lumbar spine and pelvis - 85+ (*) | 7965 | | | | | | | Hammersmith and Fulham | p.118 |
| Injuries to the knee and lower leg - 0-18 (*) | 1072 | | | | | | £3k (NSS) | Brent | p.119 |
| Injuries to the knee and lower leg - 19-64 (*) | 2299 | | | | | | £63k (NSS) | Camden | p.120 |
| Injuries to the knee and lower leg - 65-84 (*) | 2445 | | | | | | | Hammersmith and Fulham | p.121 |
| Injuries to the knee and lower leg - 85+ (*) | 9459 | | | | | | | Hammersmith and Fulham | p.122 |
| Spend on admissions relating to fractures where a fall occurred (*) | 8437 | | | | | | | Hammersmith and Fulham | p.123 |
| Prescribing spend - MSK (*) | 4485 | | | | | | £13k | | |
| Prescribing spend -DMARDs for inflammatory arthritis (combined) (*) | 158 | | | | | | £1k | | |
| Prescribing spend - pain medication for MSK** (*) | 8277 | | | | | | £383k | | |
| Prescribing spend - Trauma and Injuries (*) | 1386 | | | | | | £28k | | |
| Prescribing spend - Naproxen (***) | 400 | | | | | | £19k | | |
| Prescribing spend - Ibuprofen (***) | 341 | | | | | | | | |
| Prescribing spend - Diclofenac Sodium (***) | 321 | | | | | | | | |
| Prescribing spend - Etoricoxib (***) | 108 | | | | | | £5k | | |
| Prescribing spend - Celecoxib (***) | 40 | | | | | | £4k | | |
| Prescribing spend - Methotrexate (***) | 59 | | | | | | £1k | | |
| Prescribing spend - Hydroxychloroquine Sulfate (***) | 86 | | | | | | £3k | | |
| Prescribing spend - Leflunomide (***) | 13 | | | | | | £1k | | |
| Prescribing spend - Allopurinol (***) | 106 | | | | | | £1k | | |

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

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 71

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

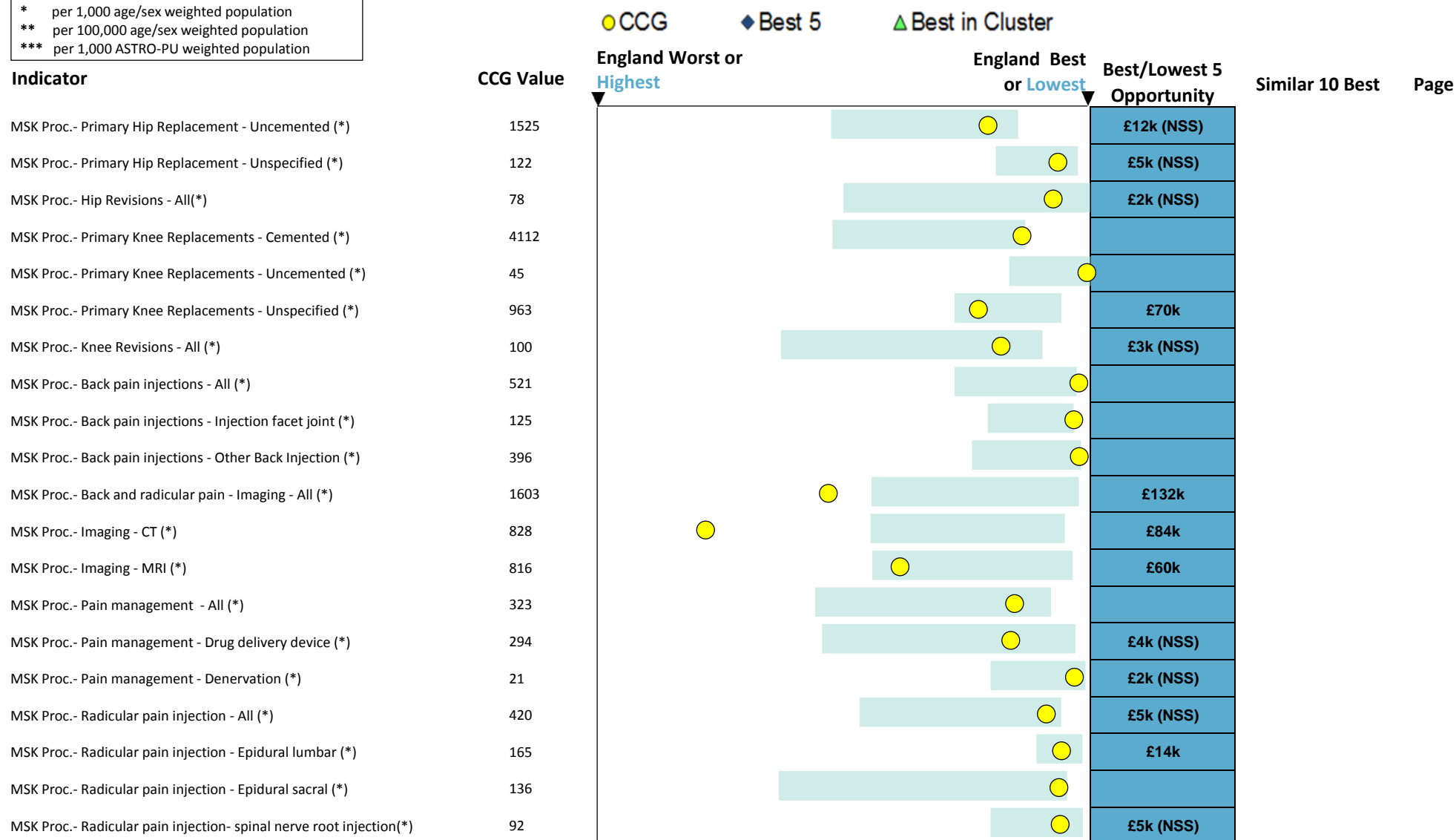


Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 72

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



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

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 73

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

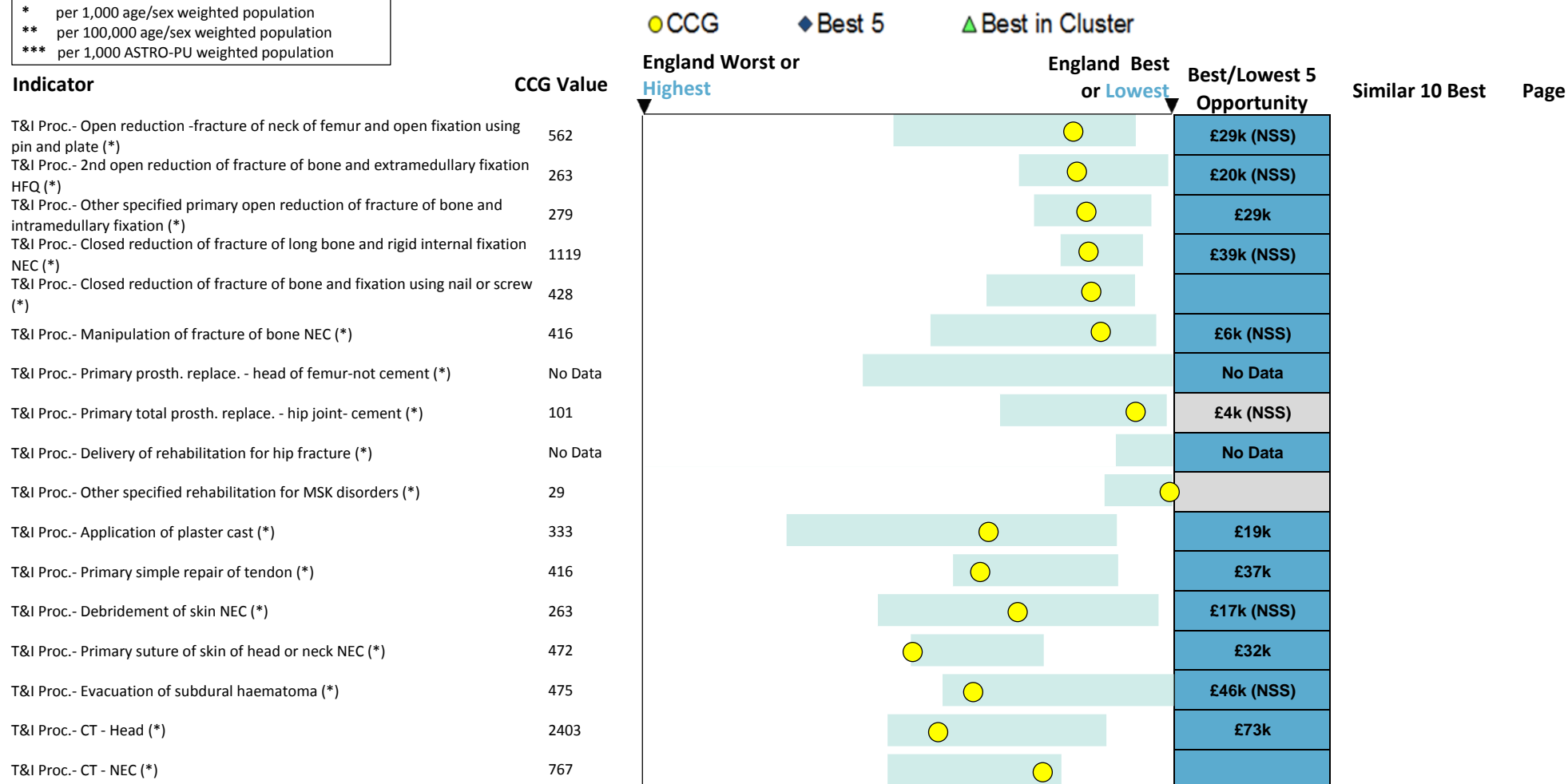


Please refer to slide 63 for full guidance on interpretation of this table of opportunities

MSK and Trauma & Injuries - Opportunity table - Spend

NHS Hammersmith and Fulham CCG 74

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



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

MSK and Trauma & Injuries - Opportunity table - Outcomes

NHS Hammersmith and Fulham CCG 75

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



*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

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

| Indicator | CCG Value | England Worst or Highest | CCG | Best 5 | Best in Cluster | England Best or Lowest | Best/Lowest 5 Opportunity | Similar 10 Best | Page |
|--|-----------|--------------------------|-----|--------|-----------------|------------------------|---------------------------|-----------------|-------|
| Mortality - all ages - transport accident (**) | 1.3 | | | | | | | Merton | p.140 |
| Life years lost Accidents (all) | 339.0 | | | | | | 87 Life years | Waltham Forest | p.141 |
| Life years lost falls (all) | 57.1 | | | | | | 4 Life years | Waltham Forest | p.142 |
| Life years lost transport (all) | 34.3 | | | | | | | Merton | p.143 |

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

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:

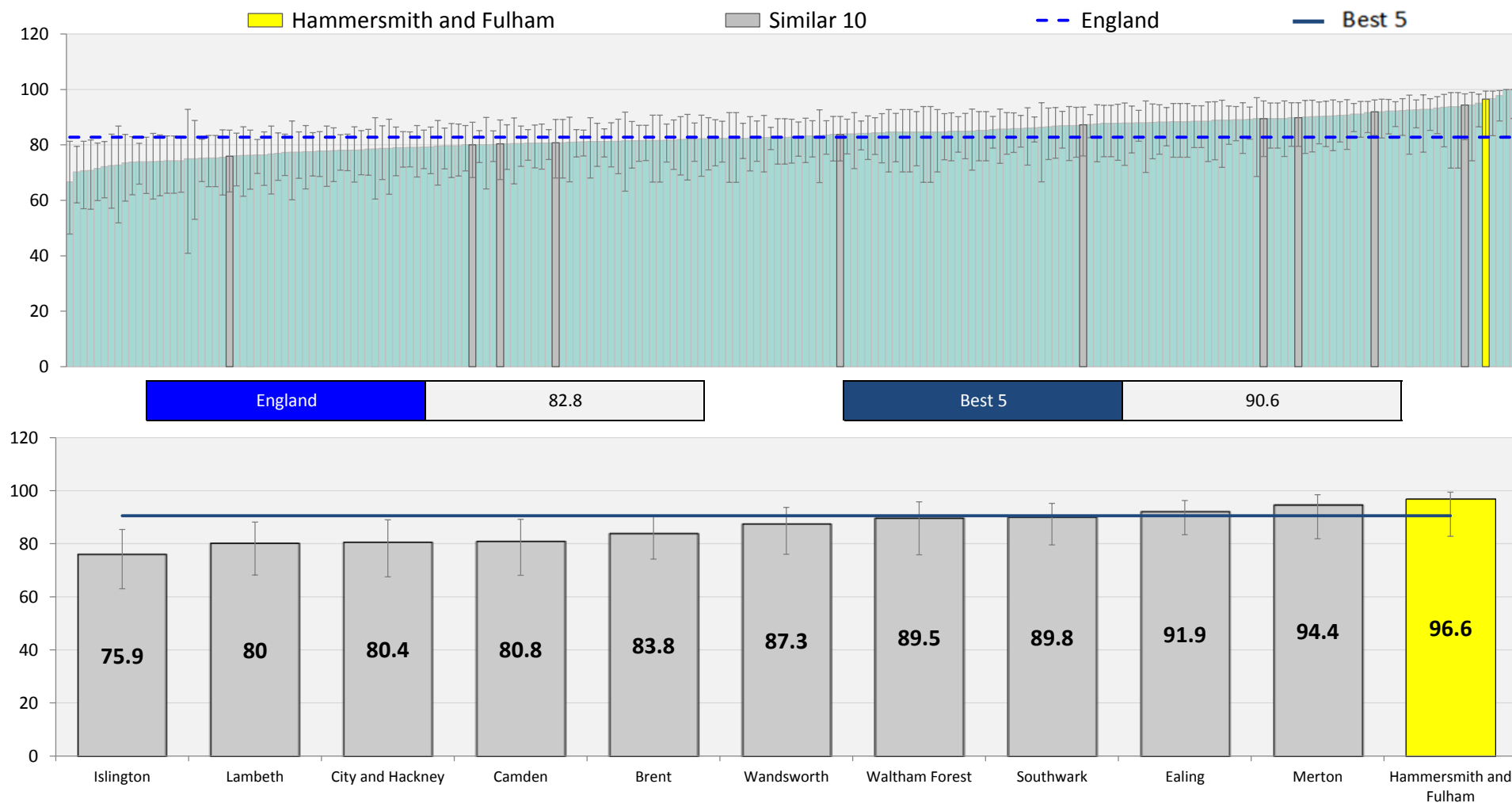
Shows your CCG and the Similar 10 group together with their indicator values. The Best 5 CCG average is shown by a dark blue line.

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

78



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)

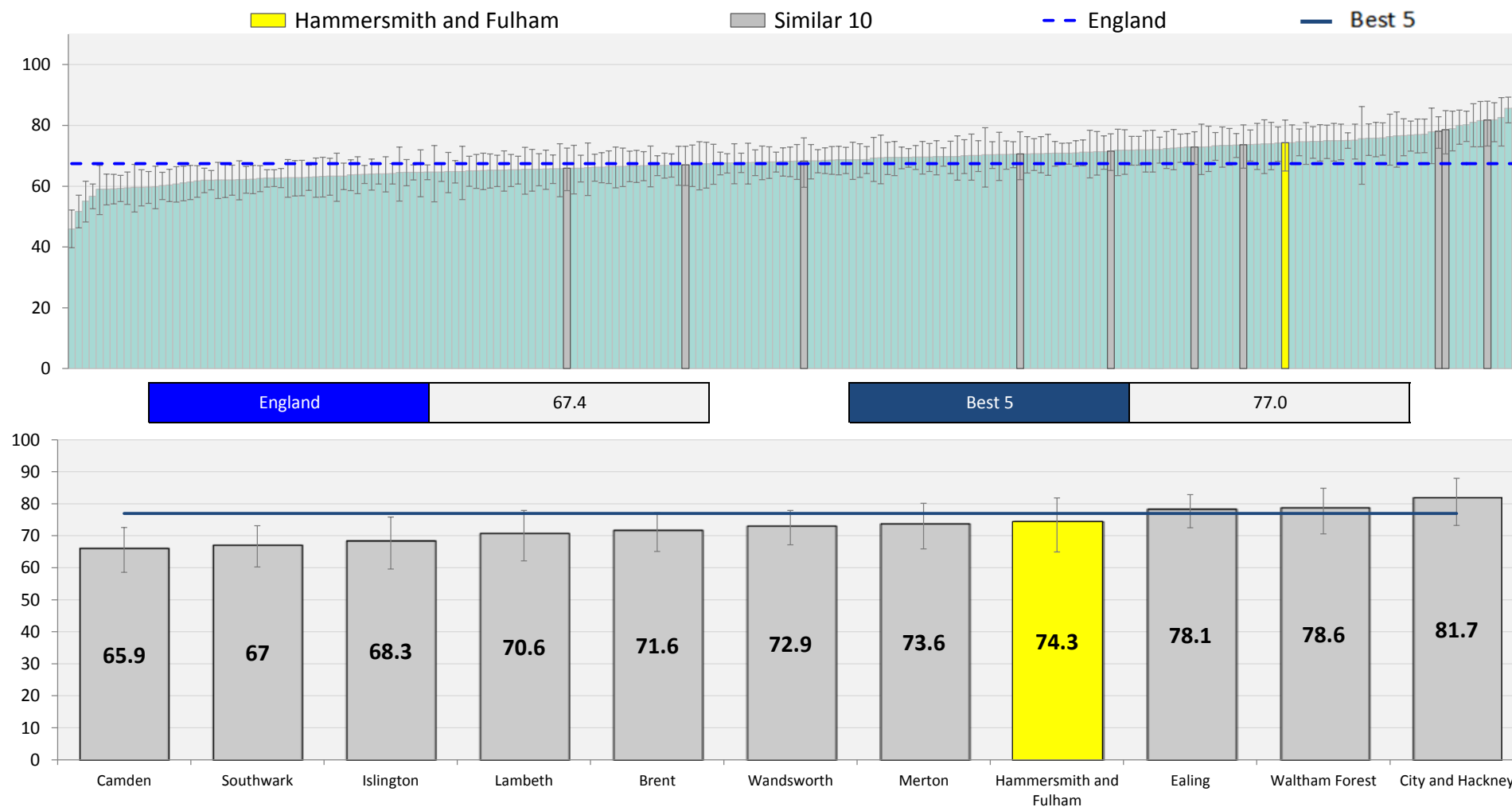
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

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

3 Pats (NSS)

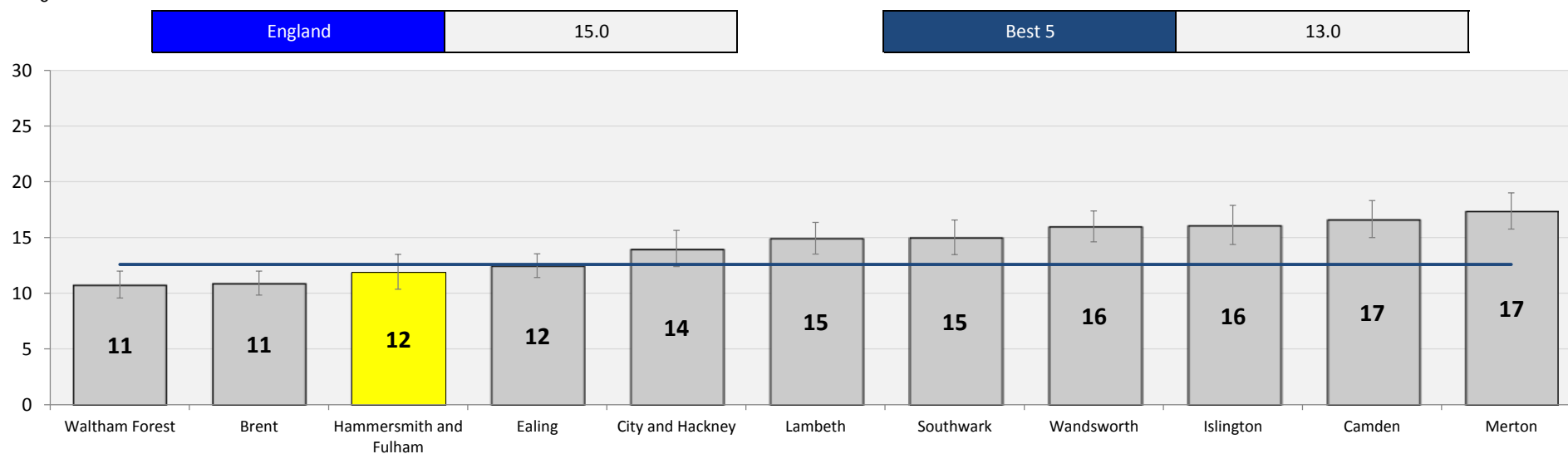
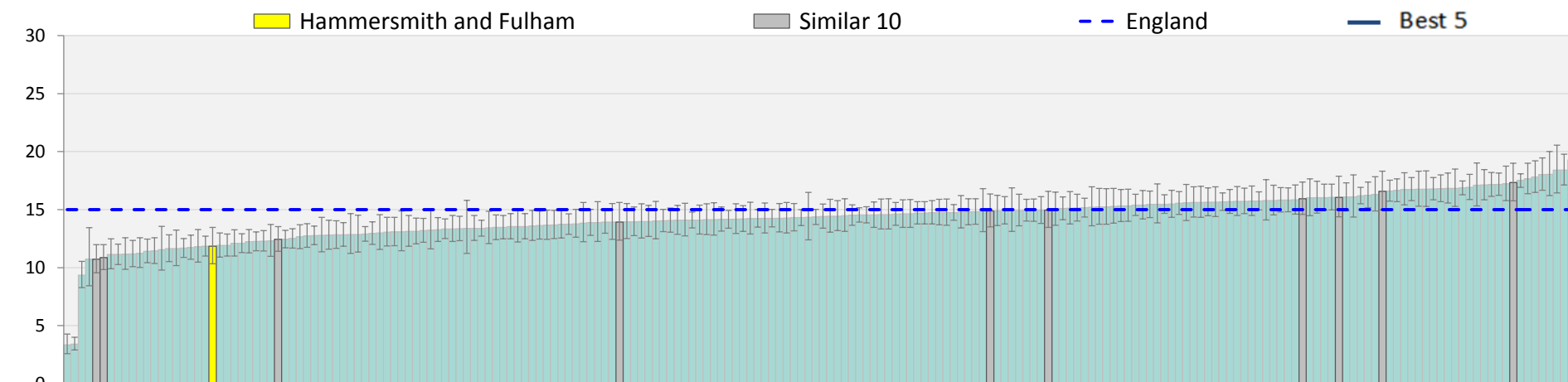
79



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+)

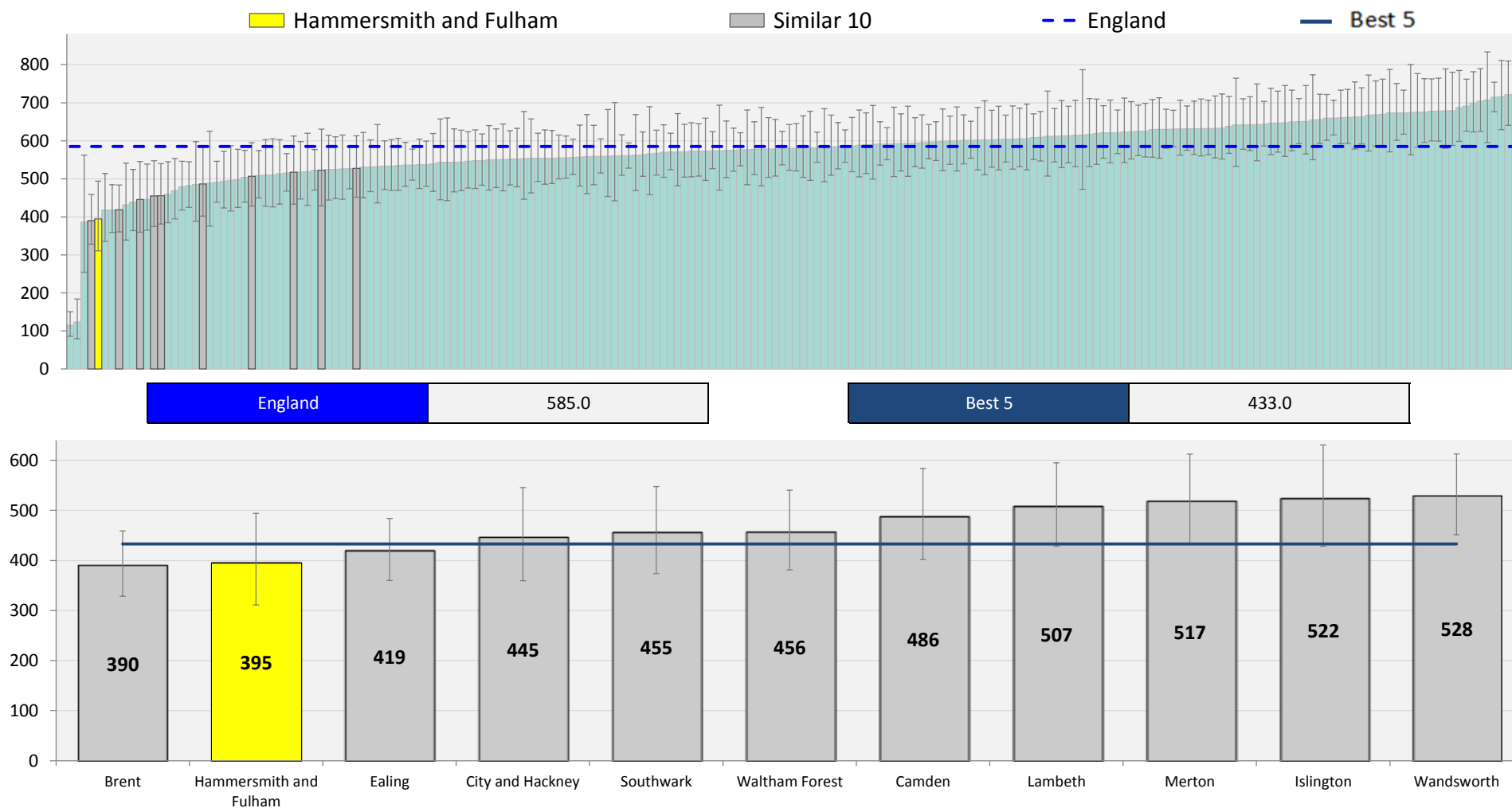
80



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)

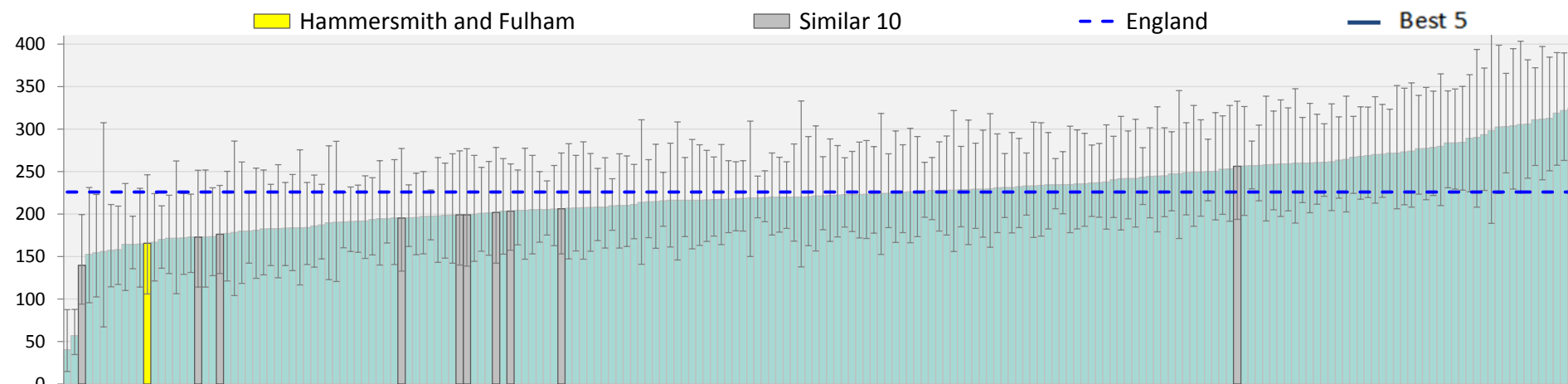
81



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)

82

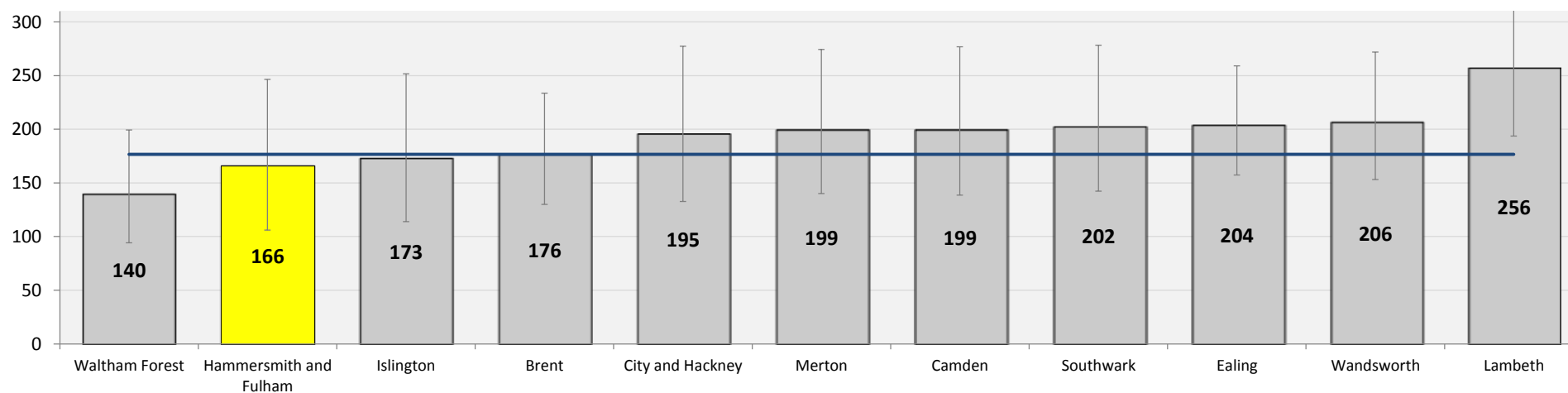


England

226.0

Best 5

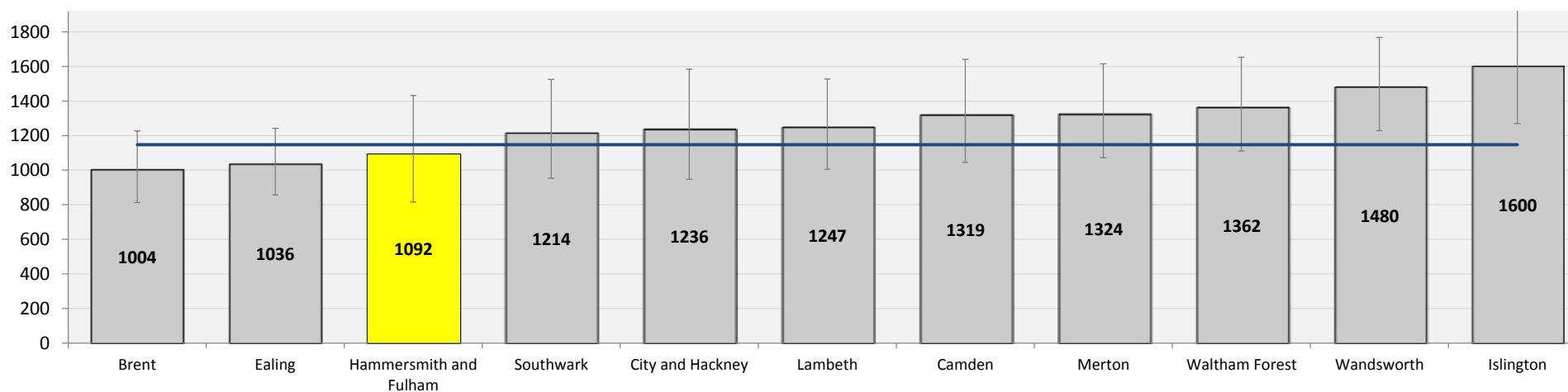
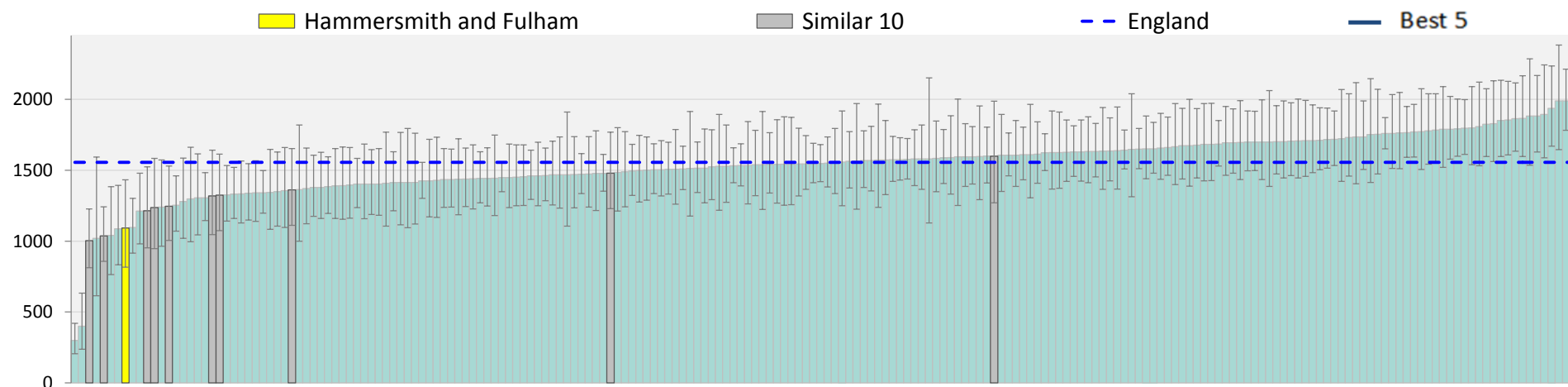
177.0



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)

83

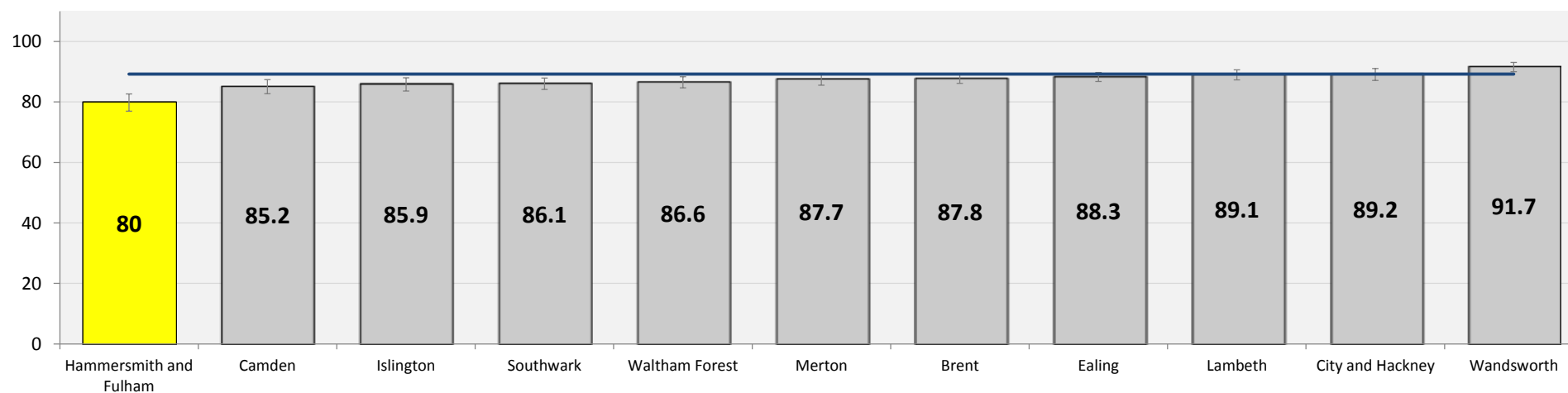
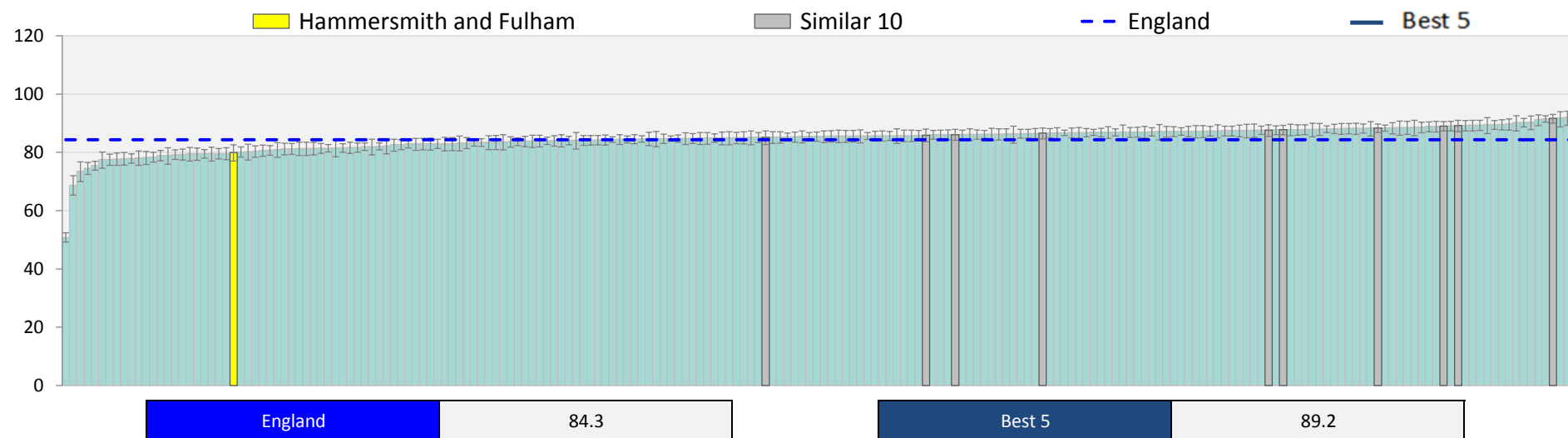


Definition: Hip fractures per 100,000 population aged 80+
 Source: Hospital Episode statistics (HES)
 Year: 2014/15

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

72 Pats

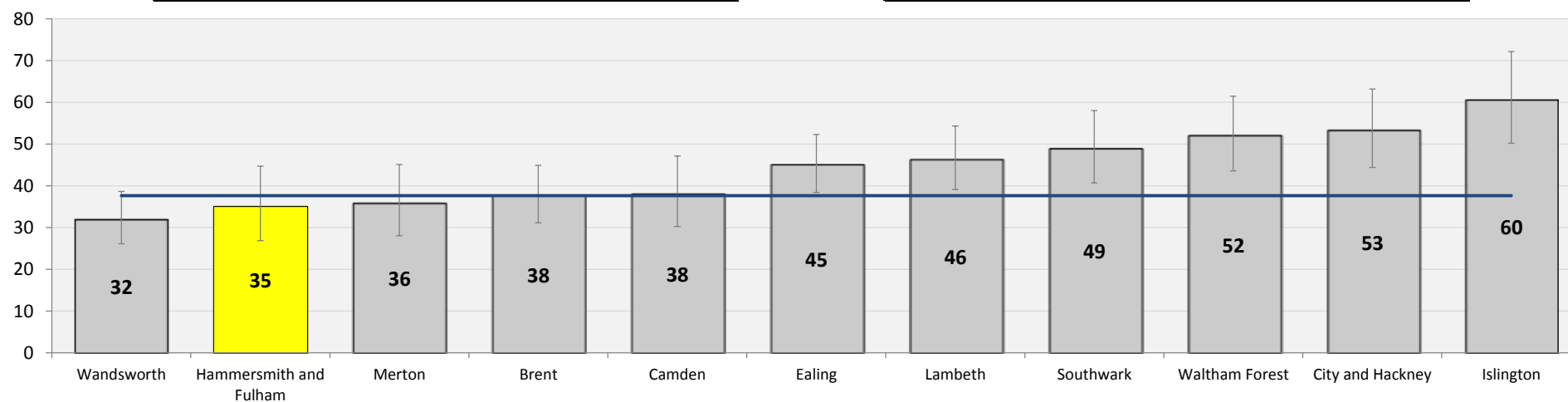
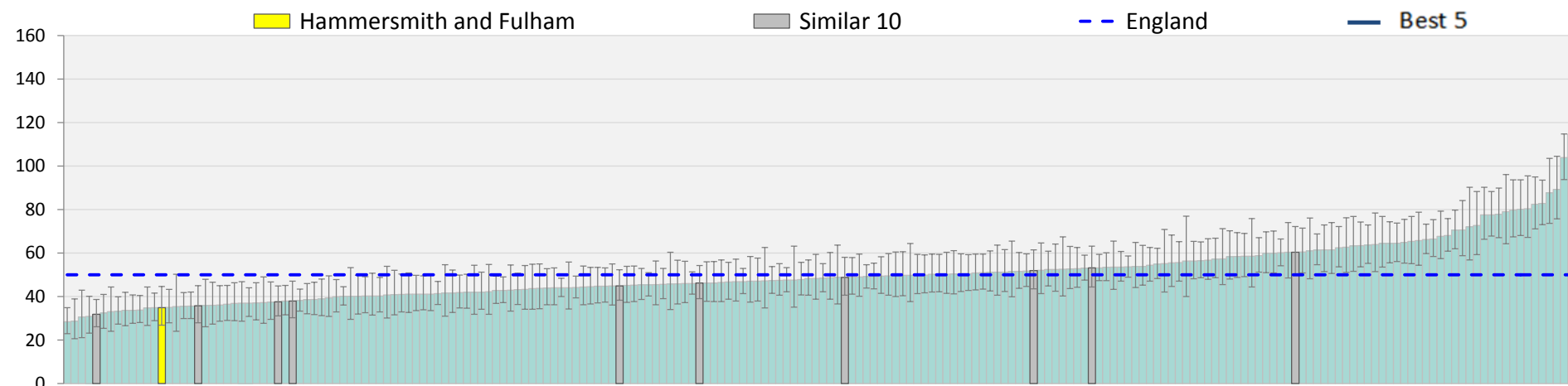
84



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)

85

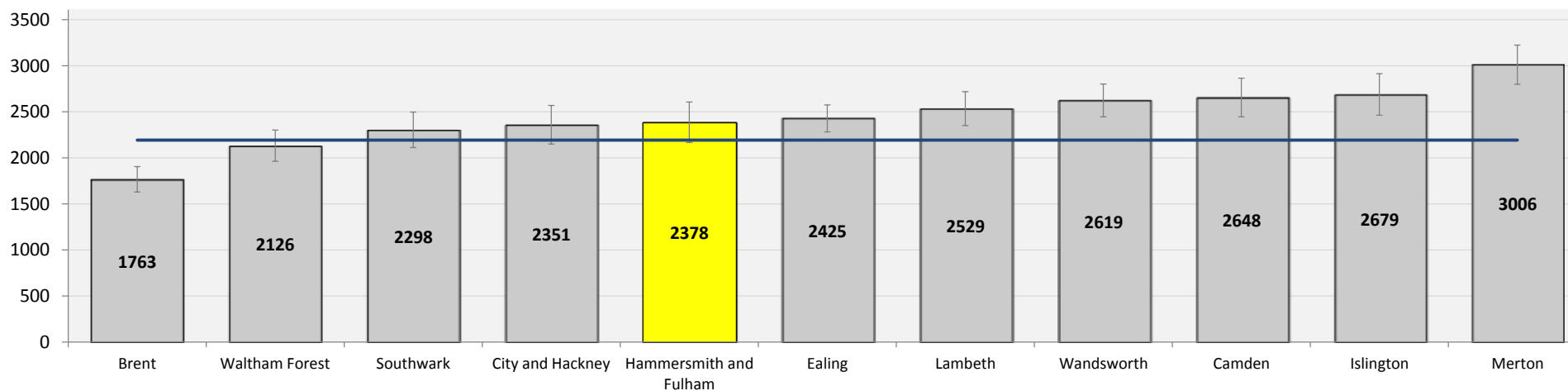
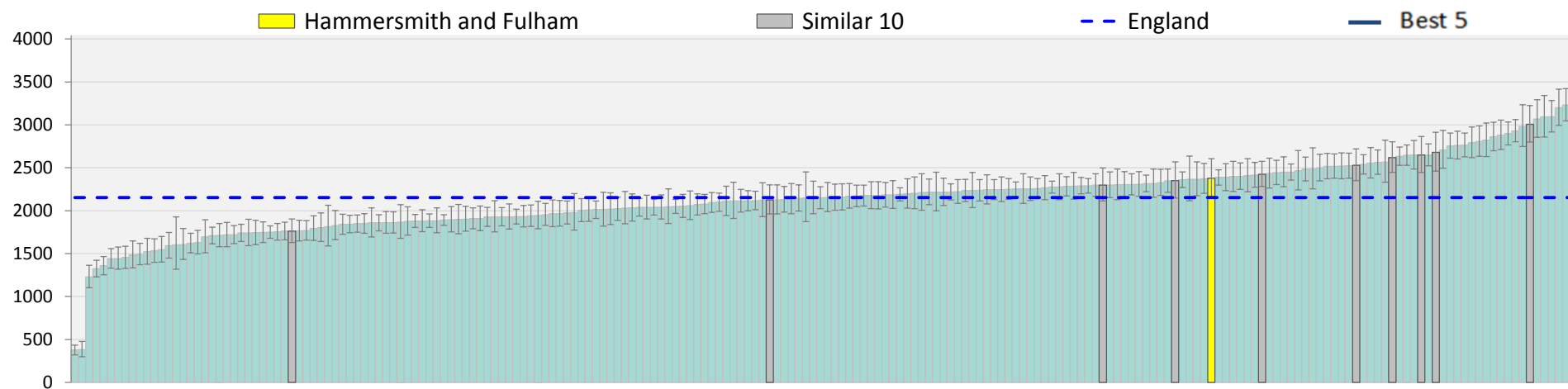


Definition: Number of Emergency admissions for back, neck and musculoskeletal pain per 100,000 Population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

36 Adms (NSS)

86

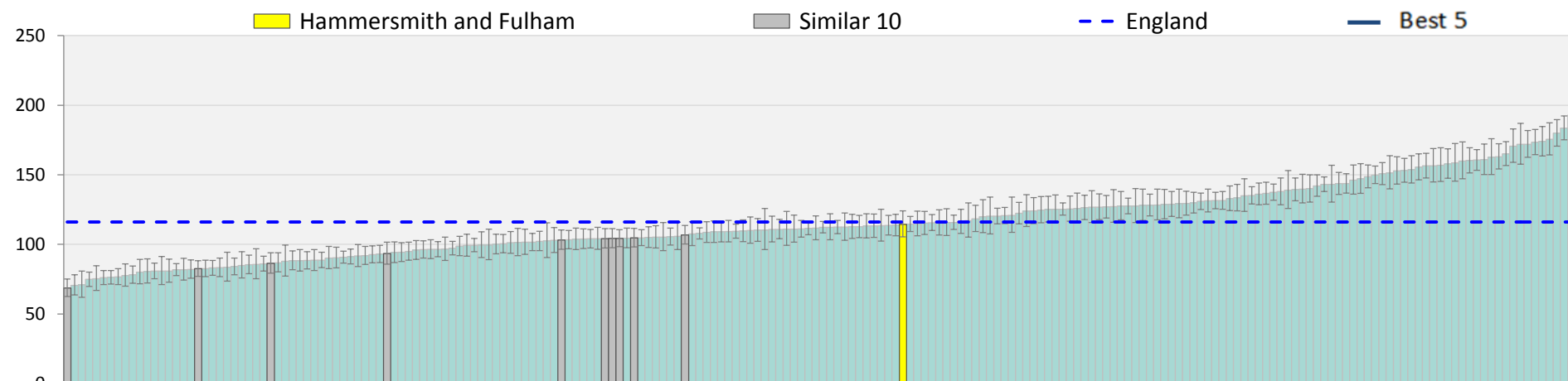


Definition: Injuries due to falls per 100,000 population aged 65+
 Source: Hospital Episode statistics (HES)
 Year: 2014/15

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

14 Adms

87

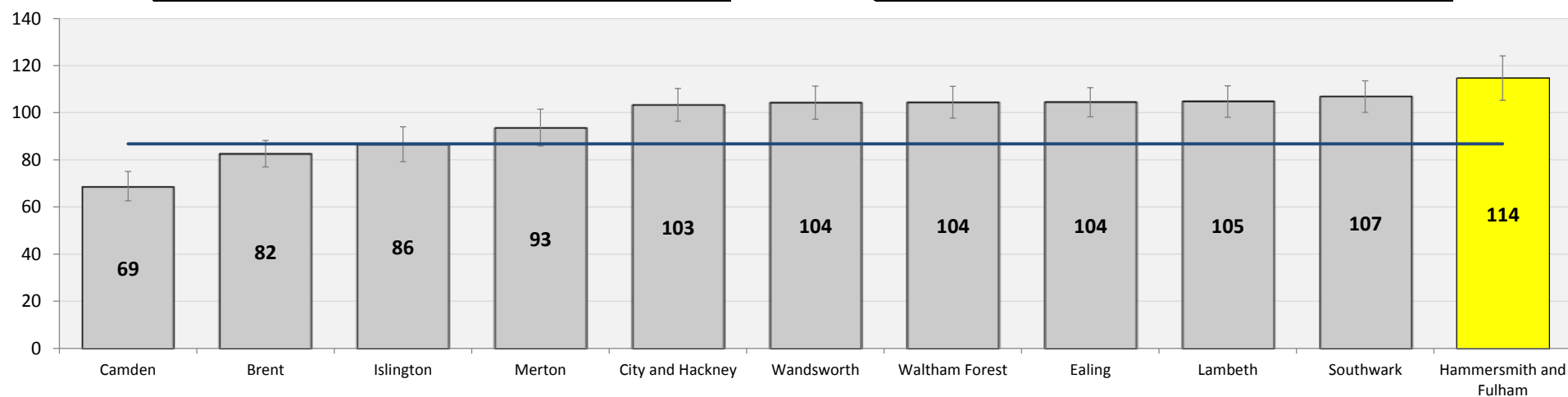


England

116.0

Best 5

87.0



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

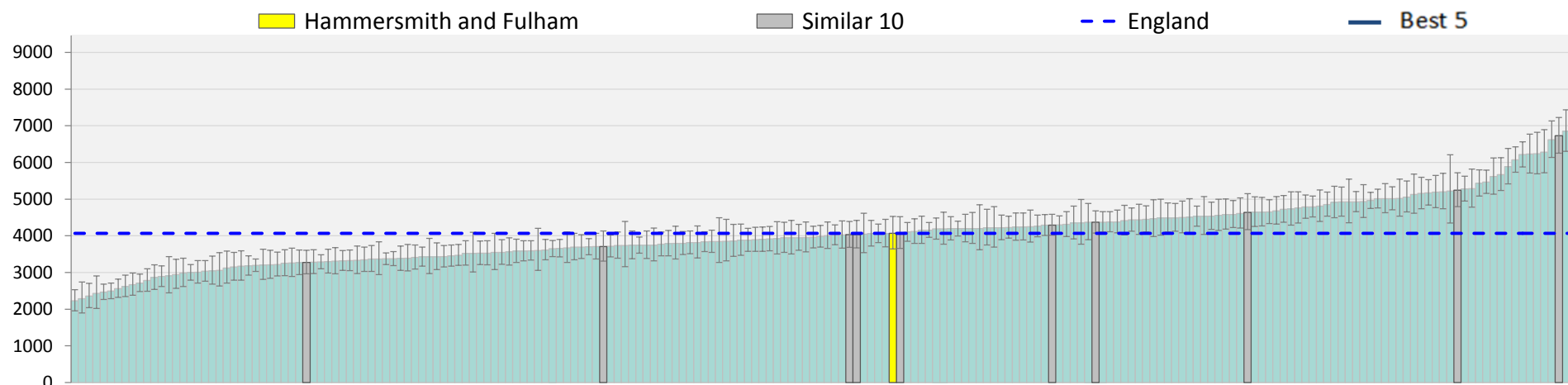
Source: Hospital Episode Statistics (HES), The Health and Social Care Information Centre. Office for National Statistics (ONS). Community Mental Health Profile (CMHP), Fingertips, Public Health England

Year: 2012/13

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

£37k (NSS)

88

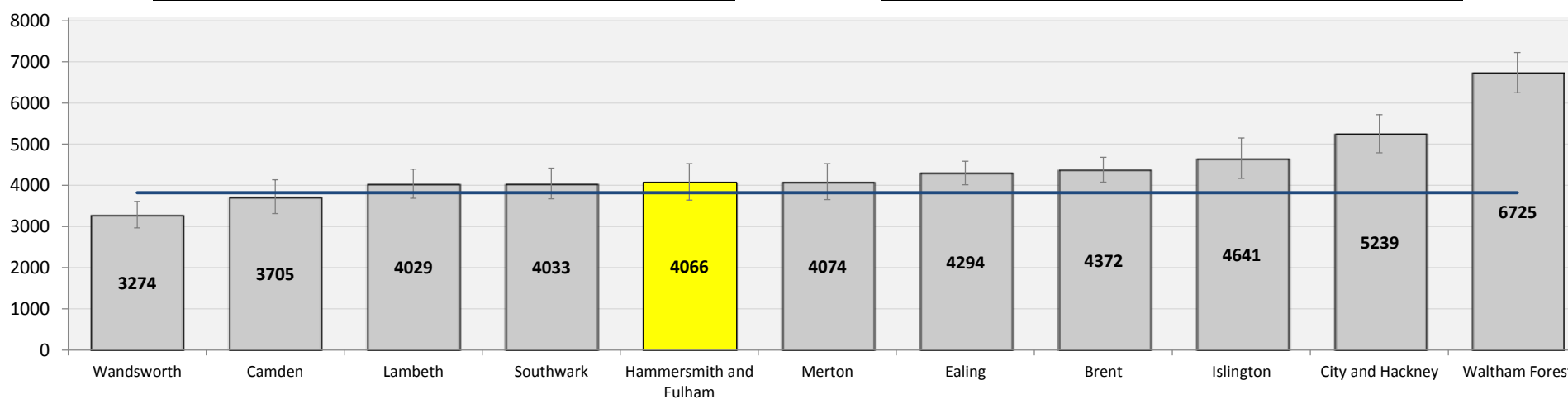


England

4069.0

Best 5

3823.0



Definition:

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

Source:

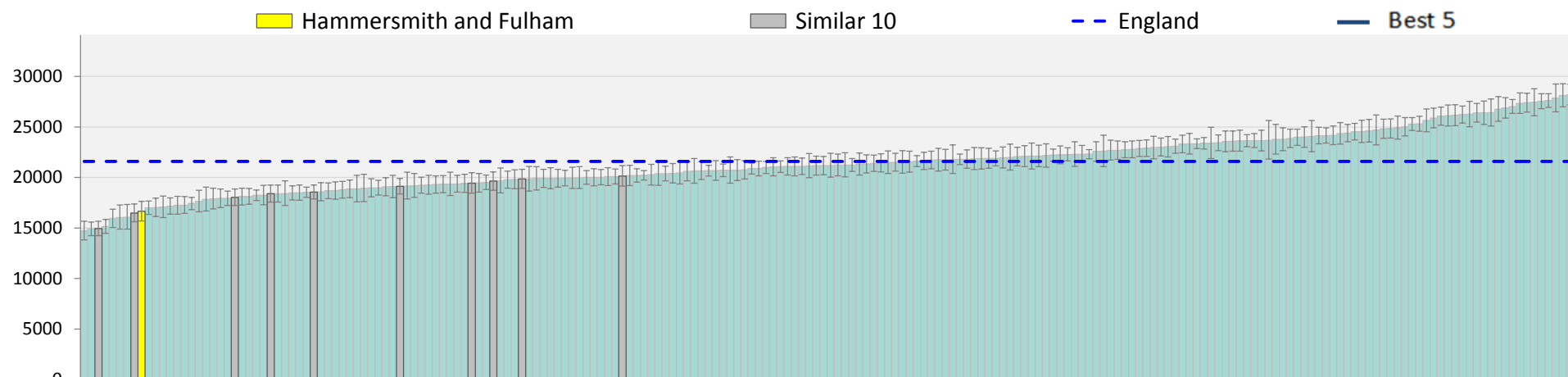
Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year:

2014/15

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

89

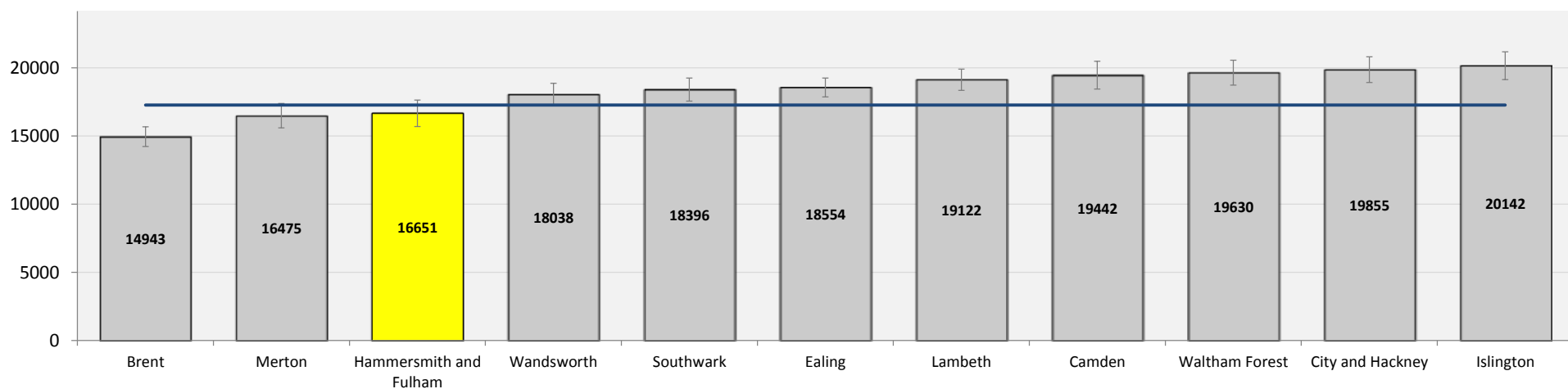


England

21584.0

Best 5

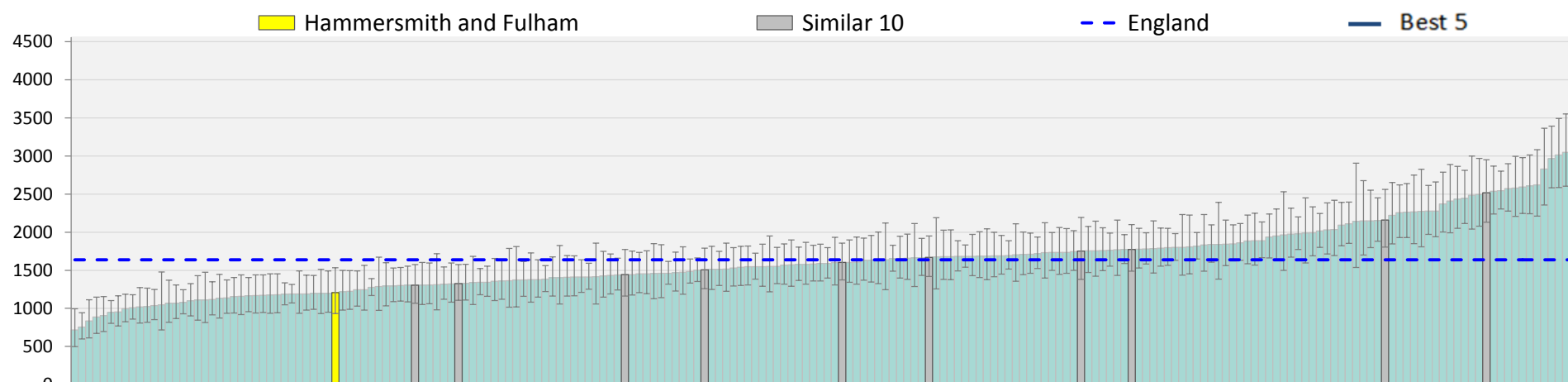
17281.0



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)

90

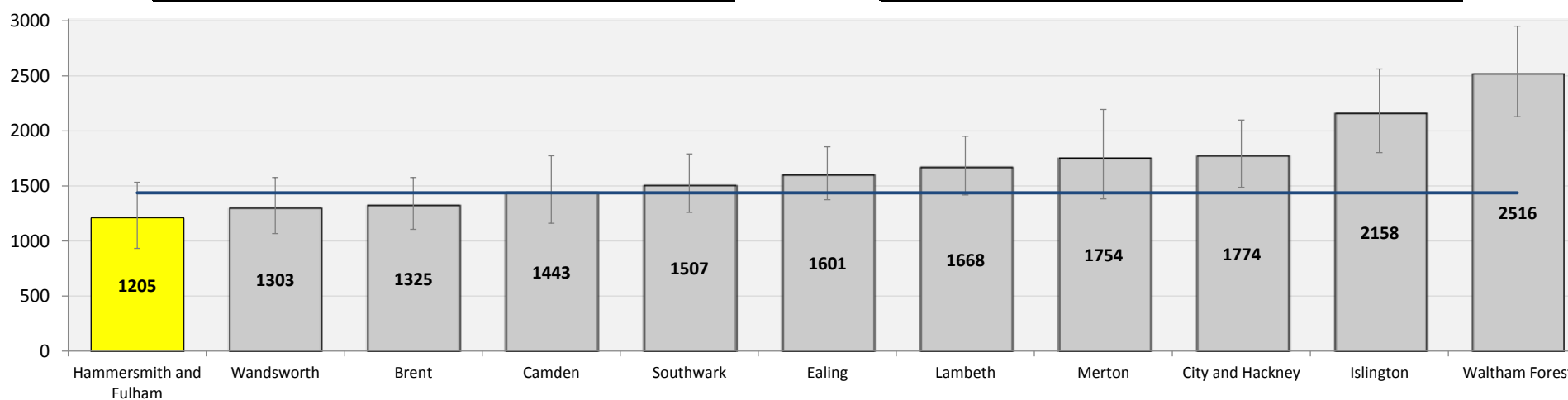


England

1639.0

Best 5

1436.0

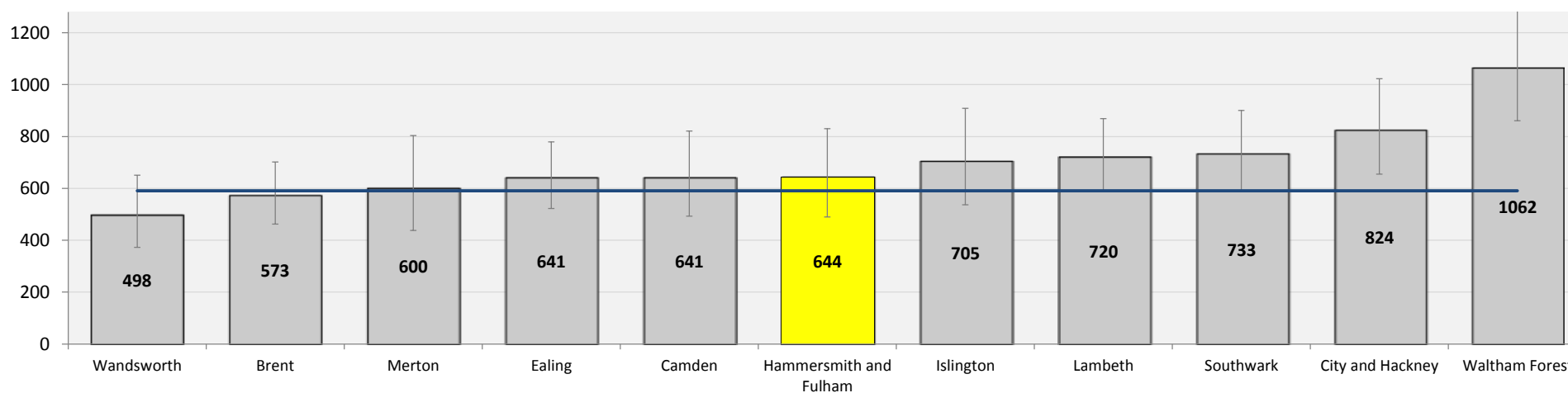
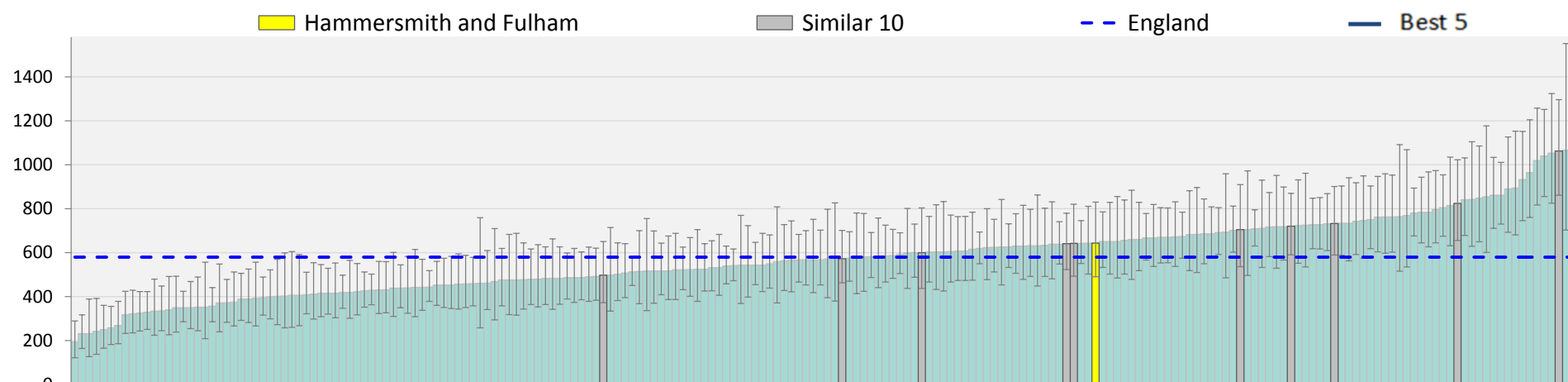


Definition: Back, neck and musculoskeletal pain - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£8k (NSS)

91

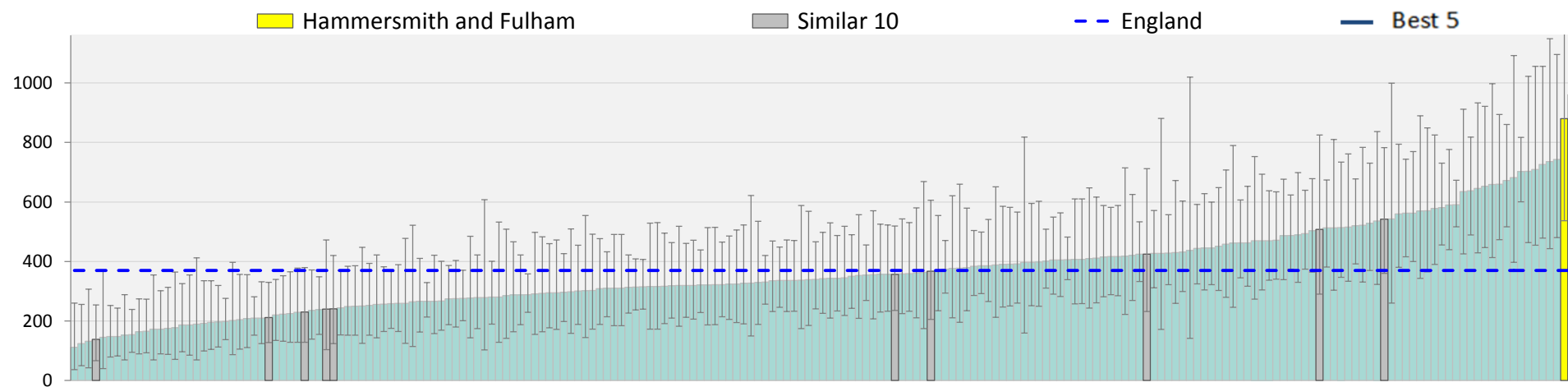


Definition: Rheumatoid and Inflammatory Arthritis - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£83k

92

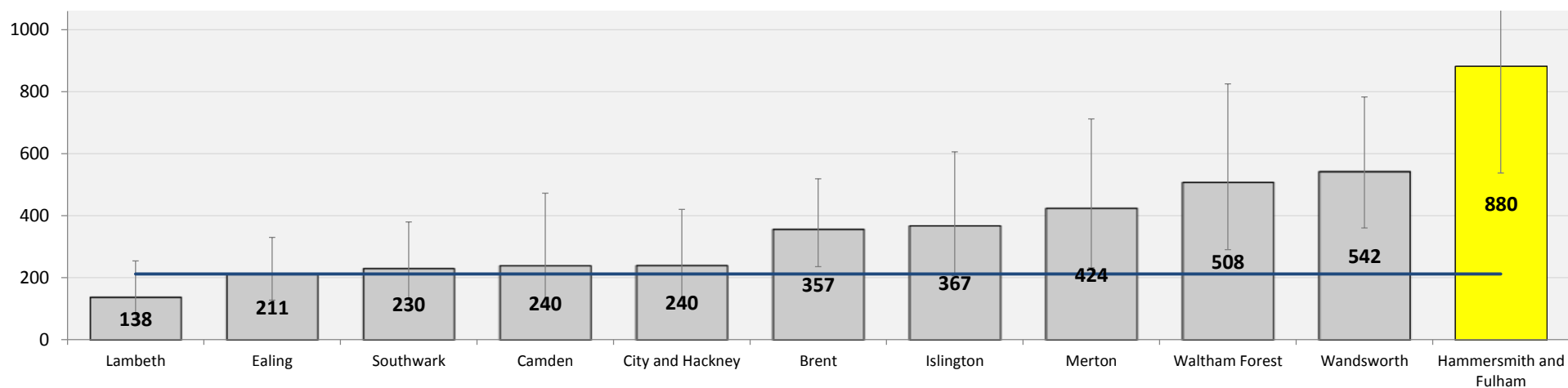


England

370.0

Best 5

212.0

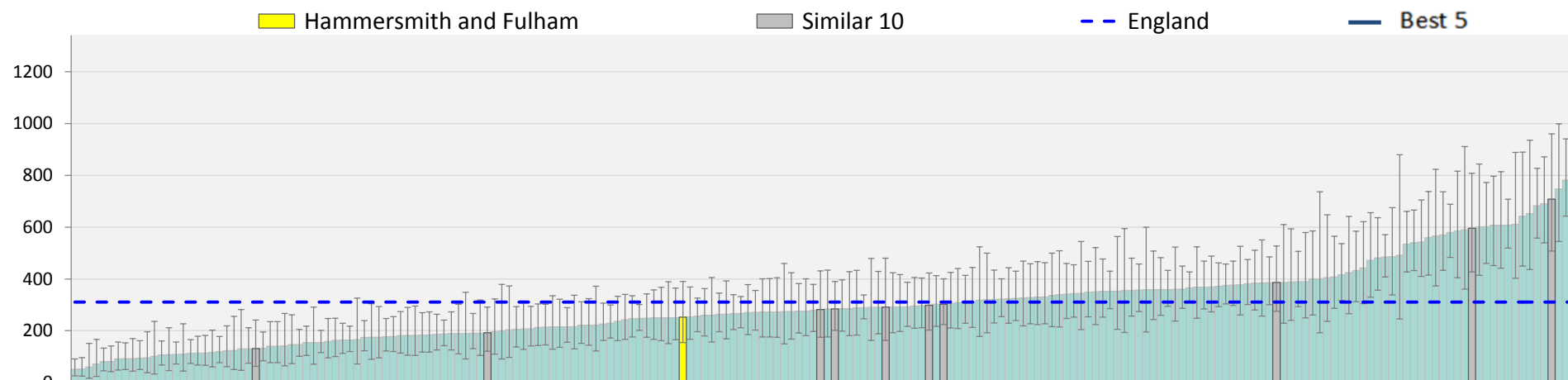


Definition: Osteoporosis and fragility fractures - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£2k (NSS)

93

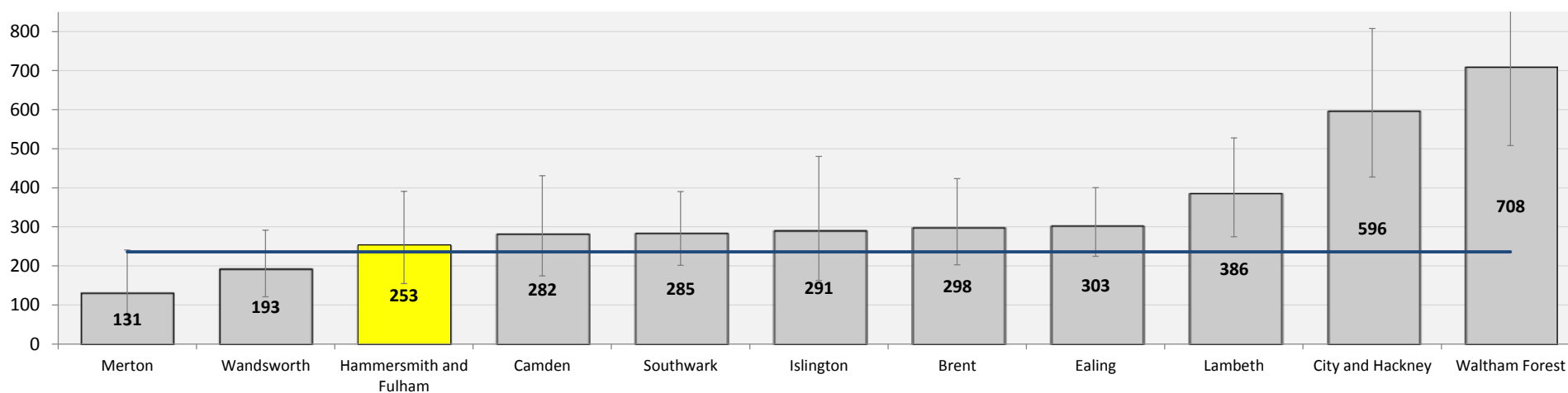


England

311.0

Best 5

236.0

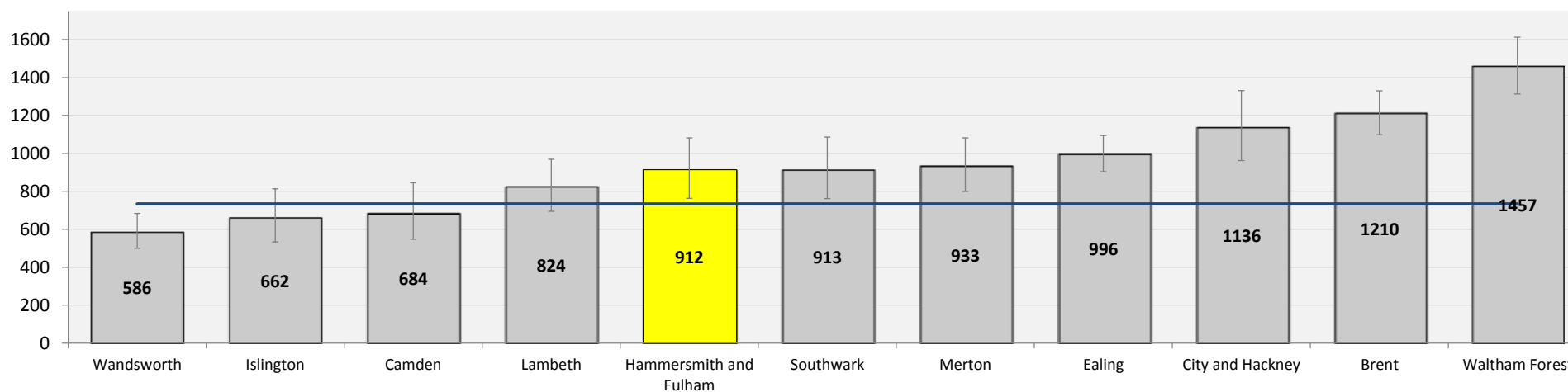
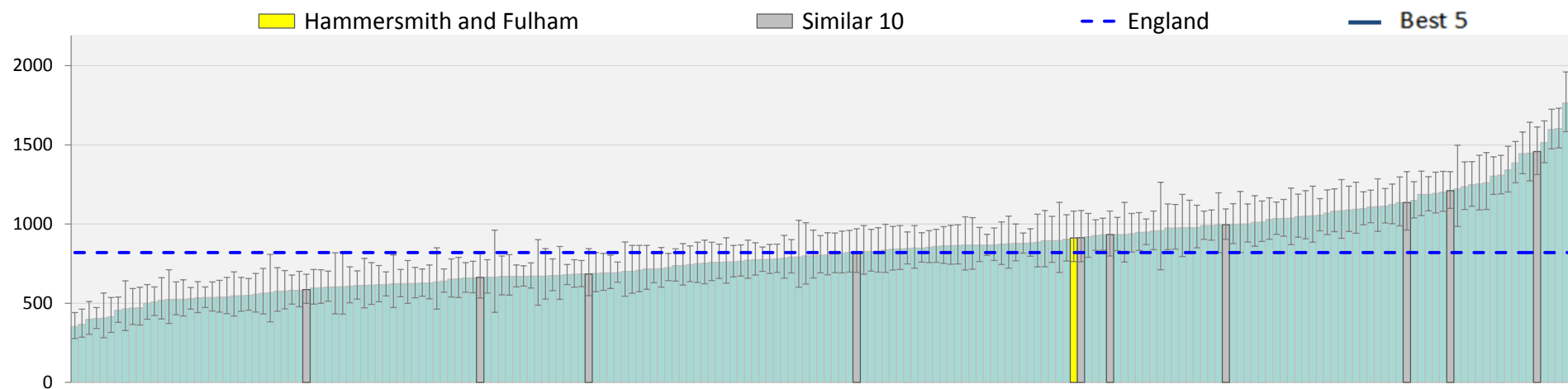


Definition: Osteoarthritis - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£29k

94

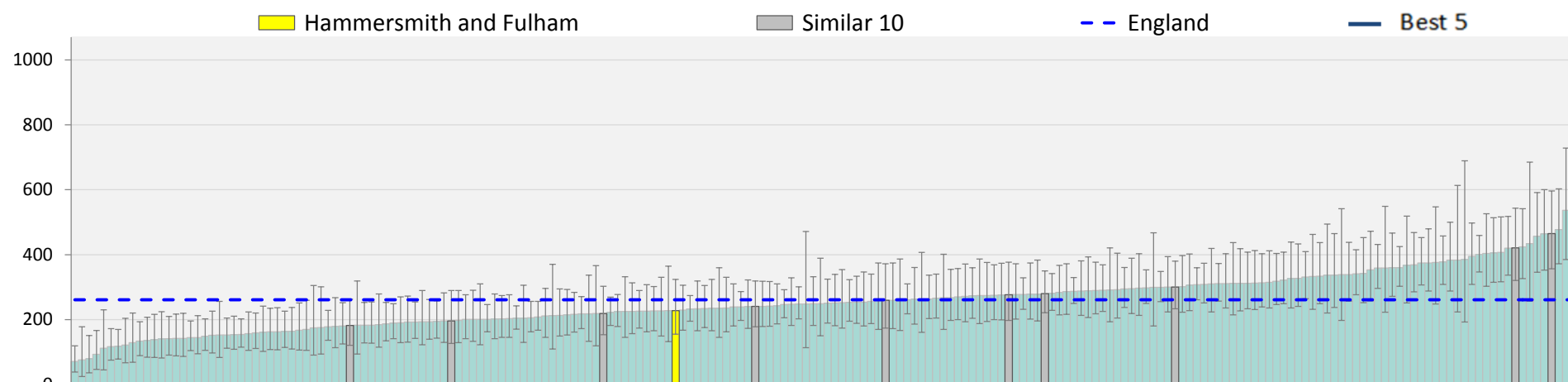


Definition: Other MSK - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£1k (NSS)

95

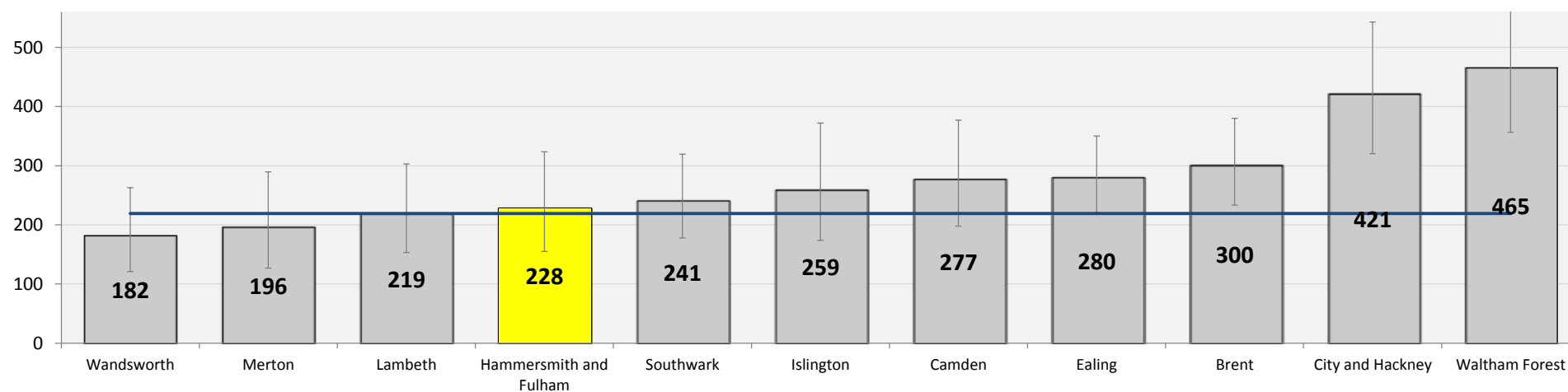


England

261.0

Best 5

219.0

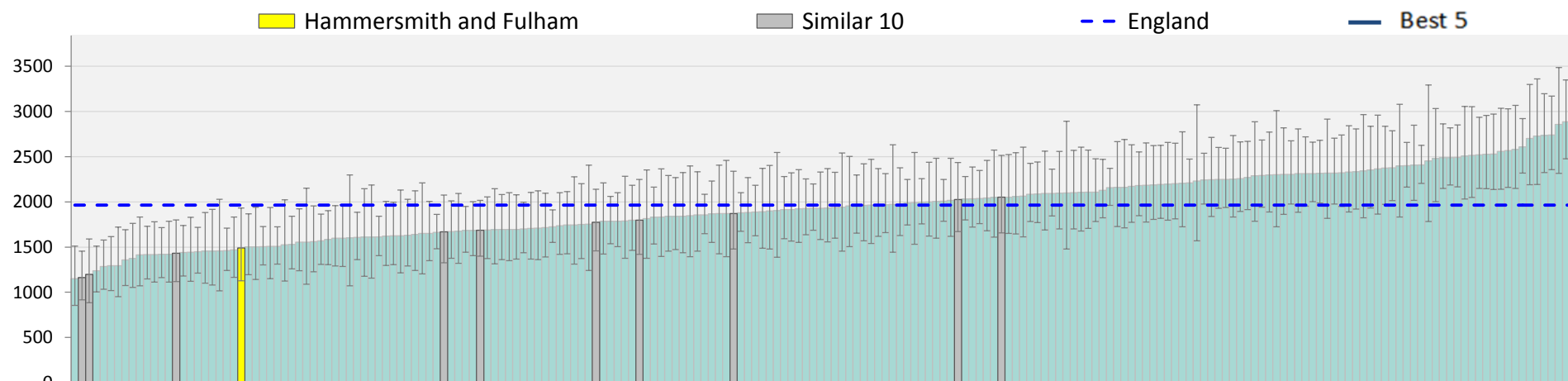


Definition: Other joint disorders (not including osteoarthritis or rheumatoid arthritis) - Total Non-elective spend on admissions per 1,000 population
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

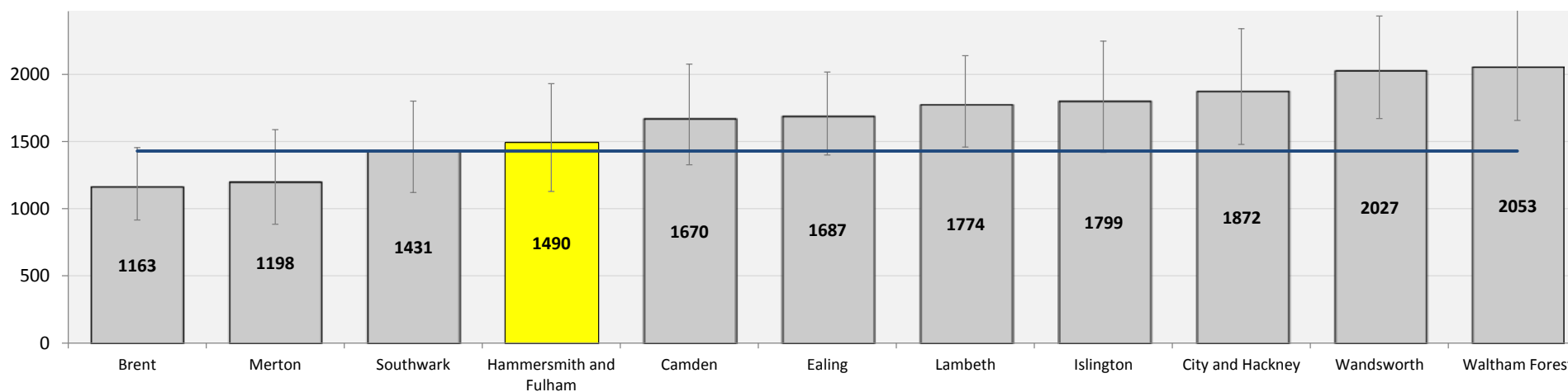
£8k (NSS)

96



England 1964.0

Best 5 1430.0

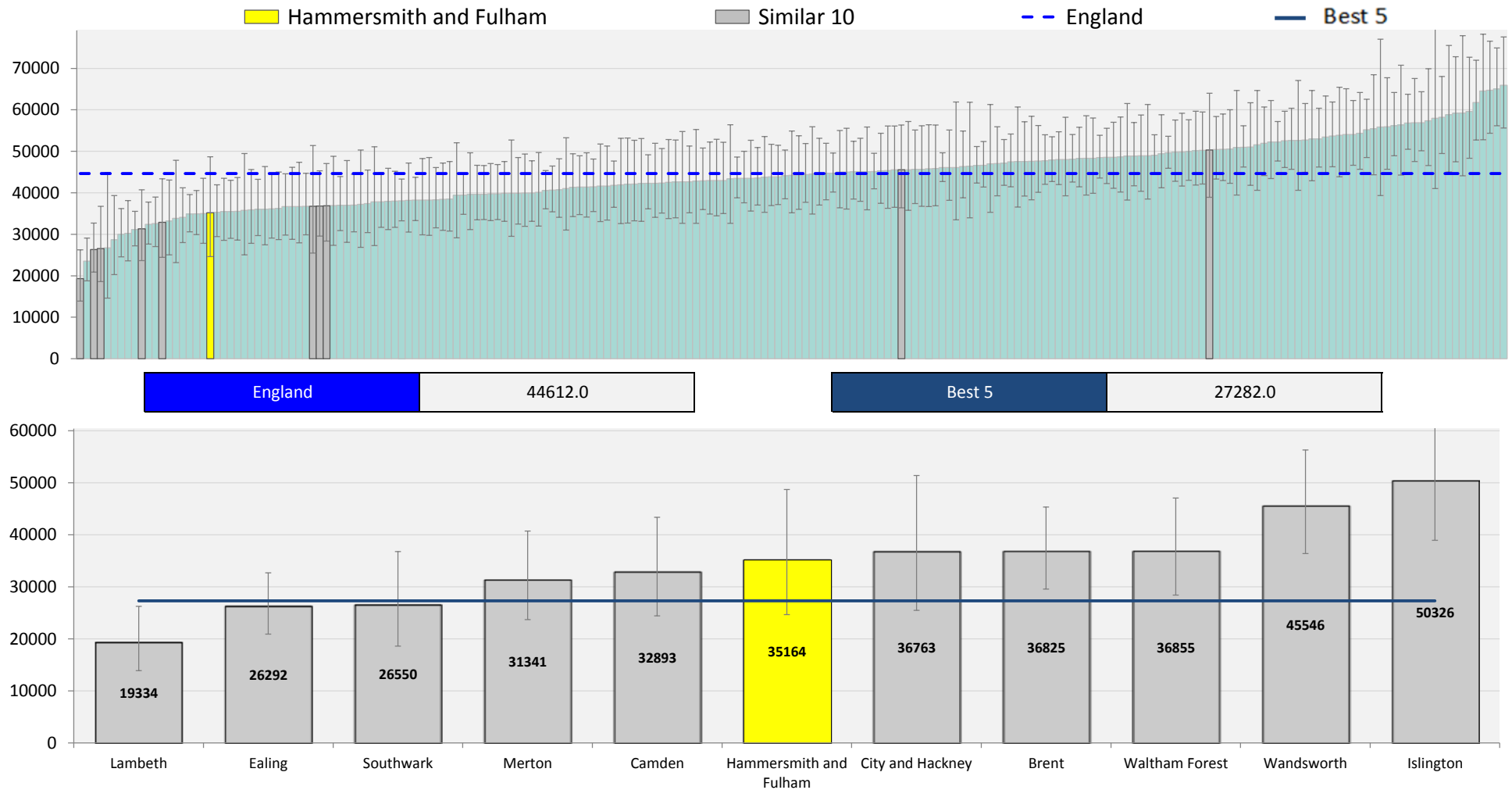


Definition: Spend - Injuries to hip and thigh - Under 75s
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£47k (NSS)

97

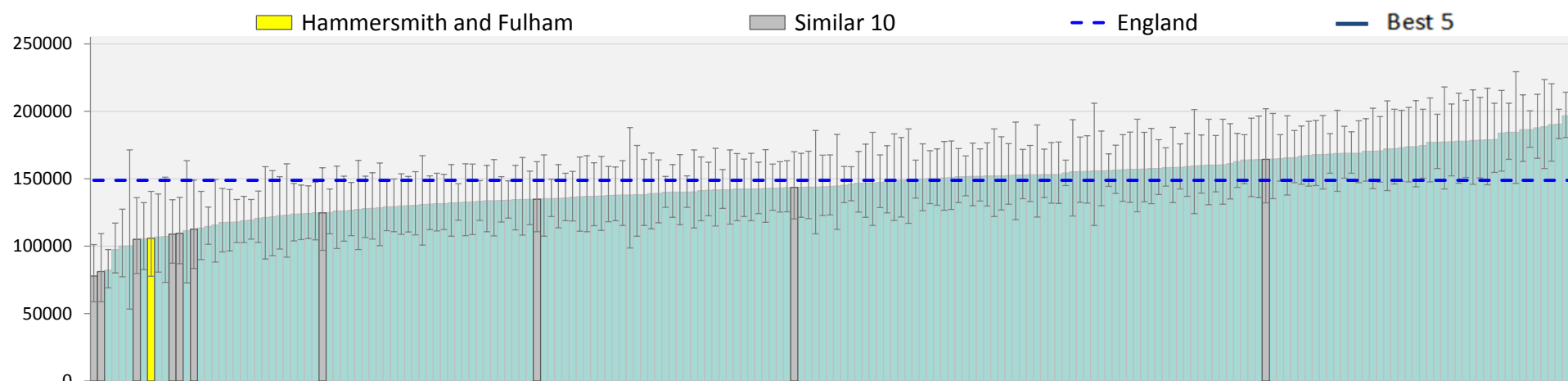


Definition: Spend - Injuries to hip and thigh - 75-84
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£21k (NSS)

98

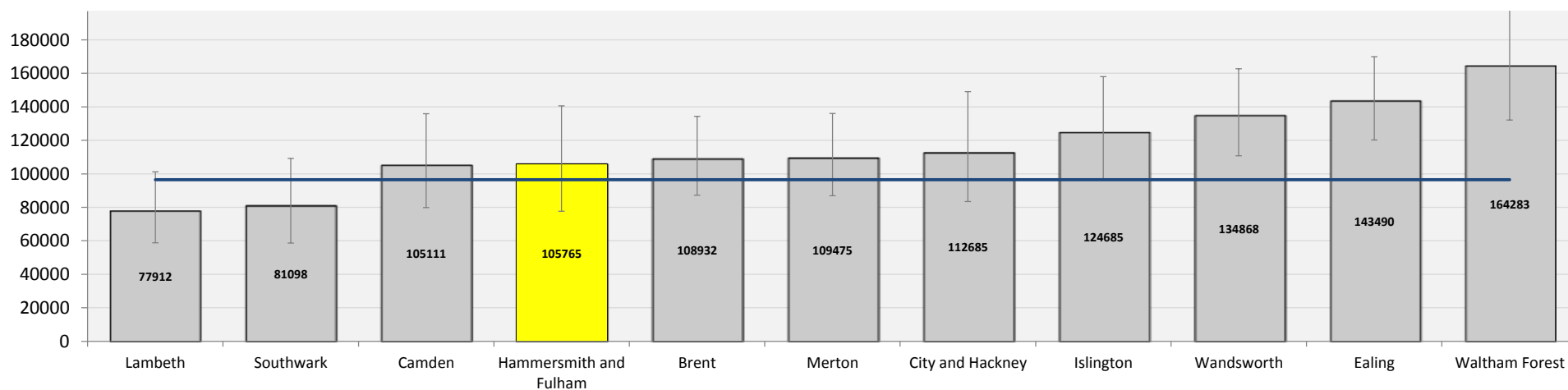


England

148722.0

Best 5

96506.0

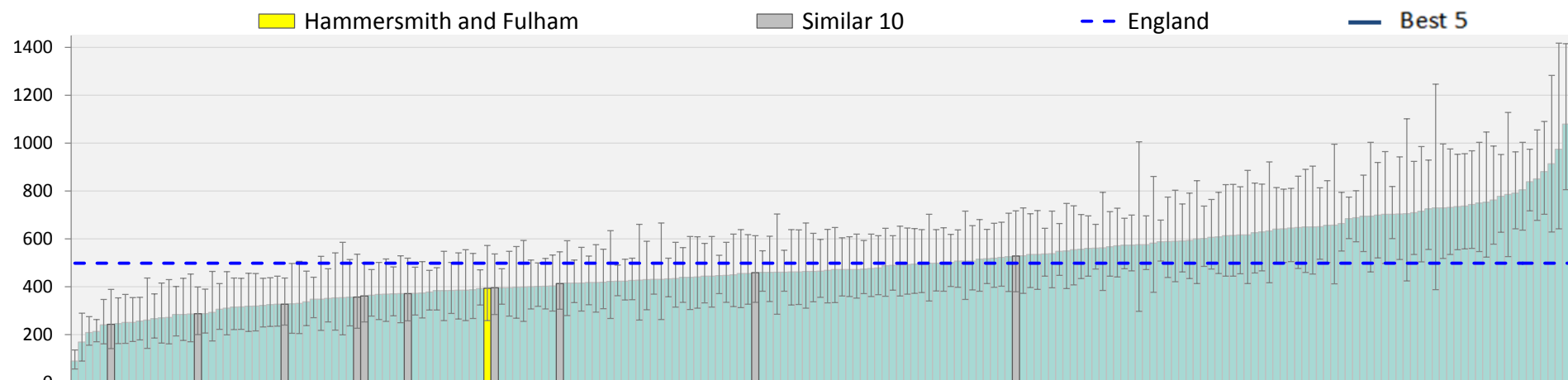


Definition: Spend - Injuries to hip and thigh - 85+
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£14k (NSS)

99

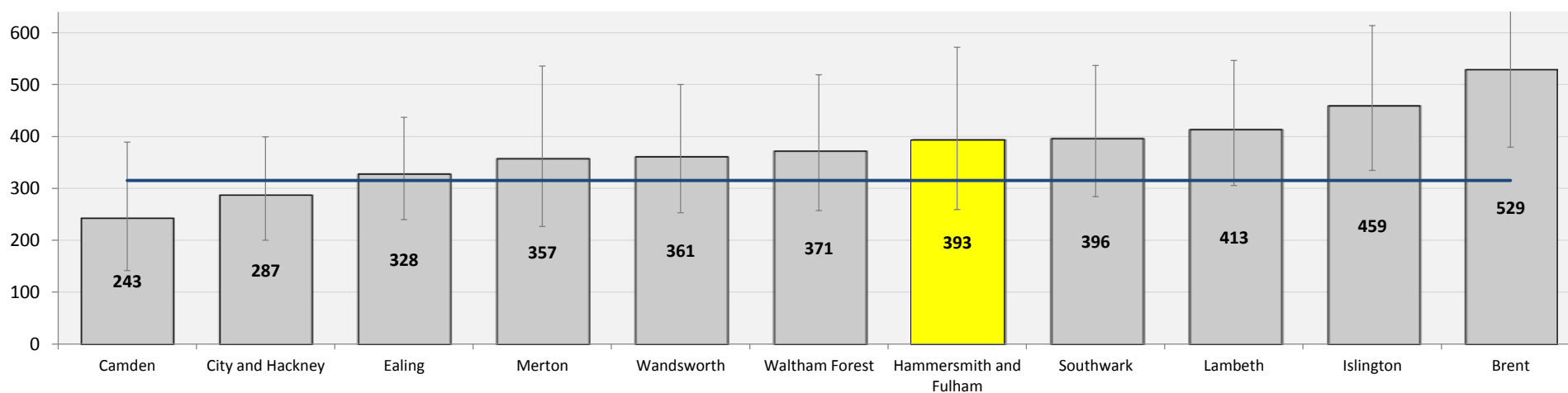


England

499.0

Best 5

315.0



Definition:

Spend - Injuries to thorax - Under 75s

Source:

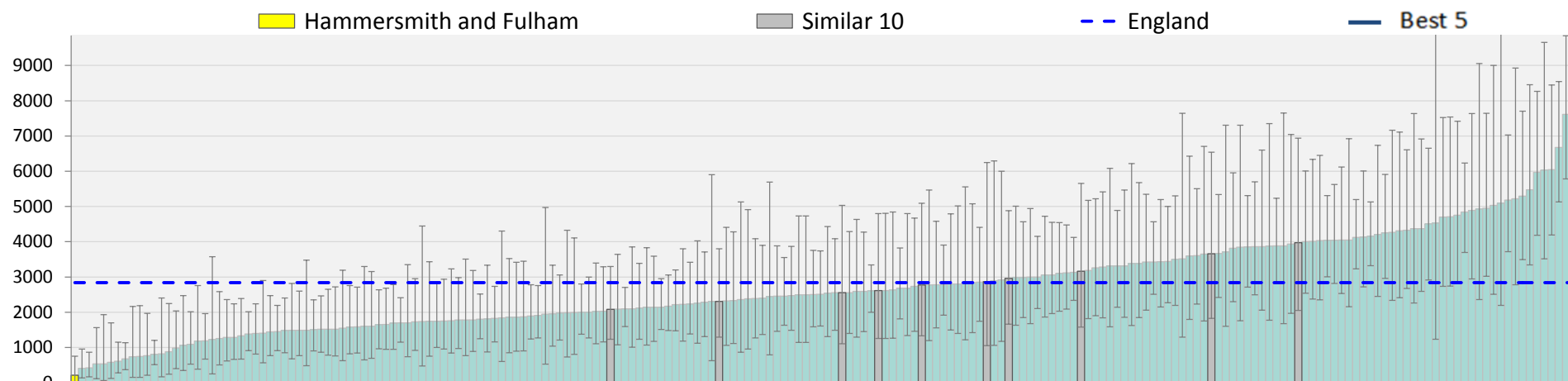
Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year:

2014/15

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

100

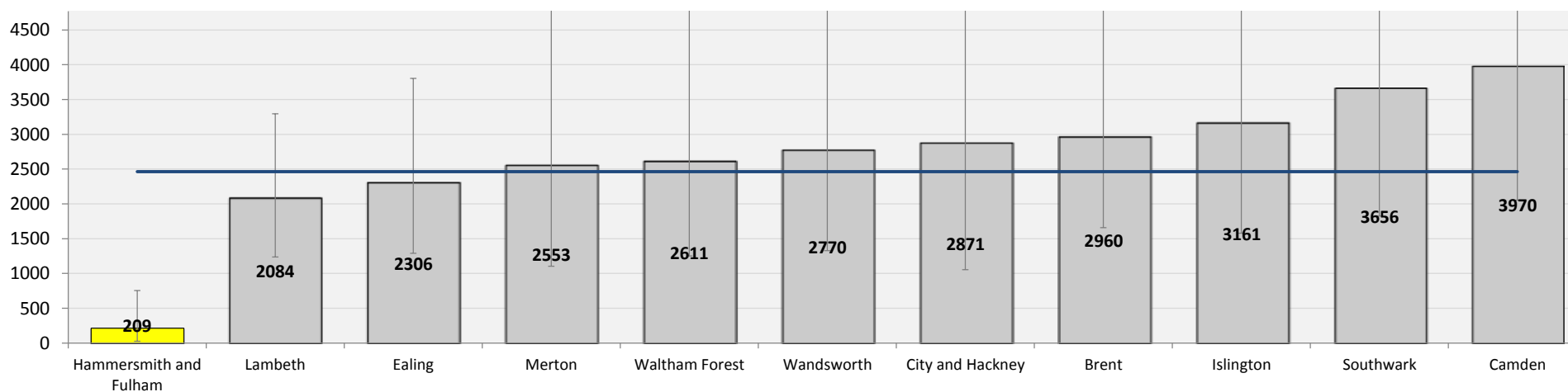


England

2838.0

Best 5

2465.0

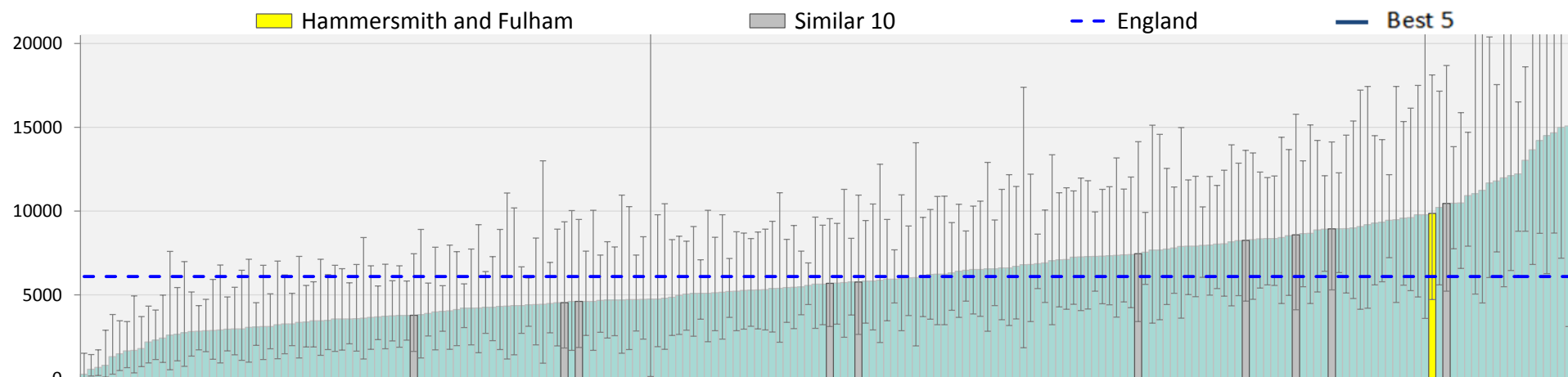


Definition: Spend - Injuries to thorax - 75-84
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£11k (NSS)

101

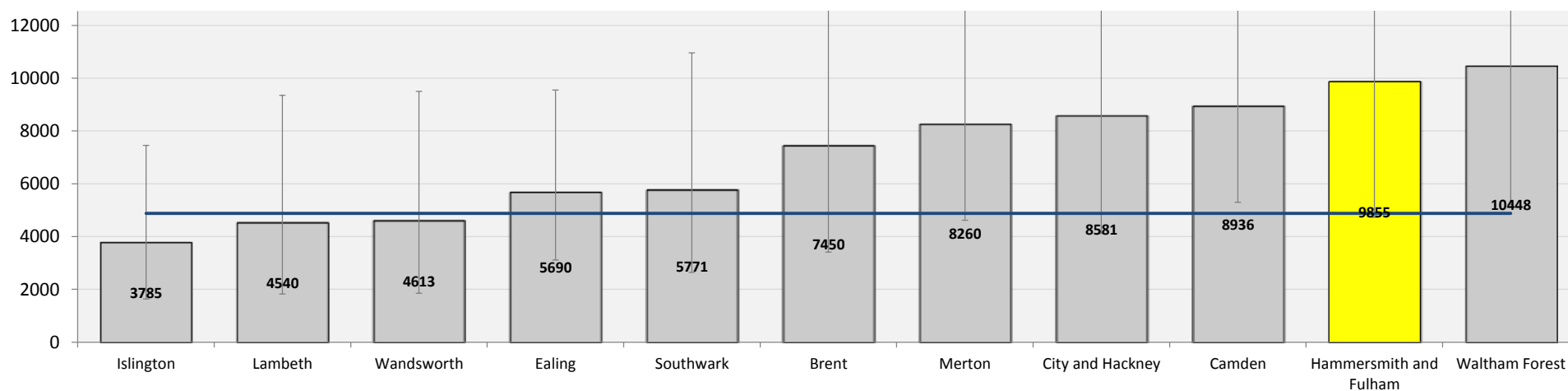


England

6100.0

Best 5

4880.0

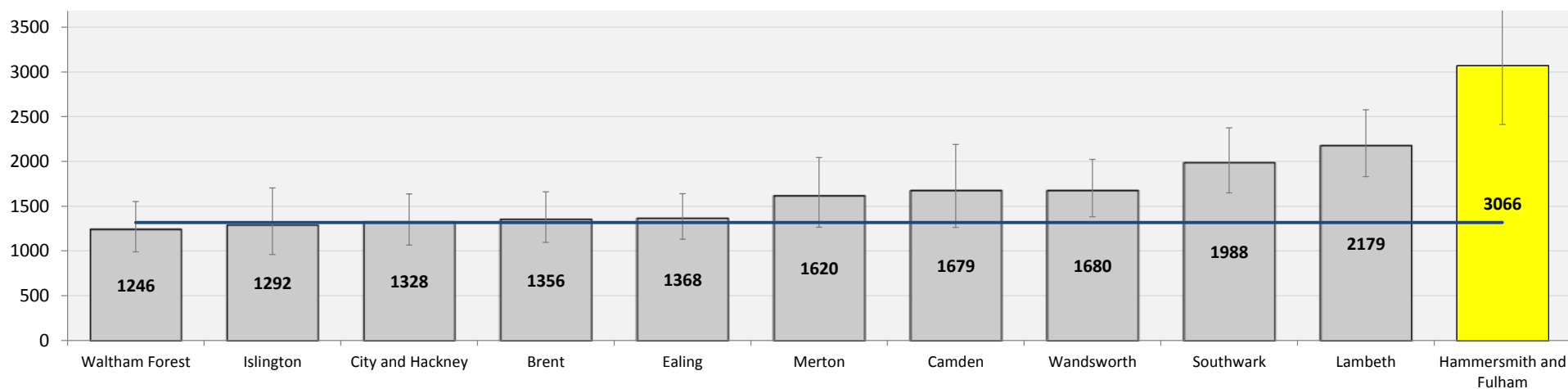
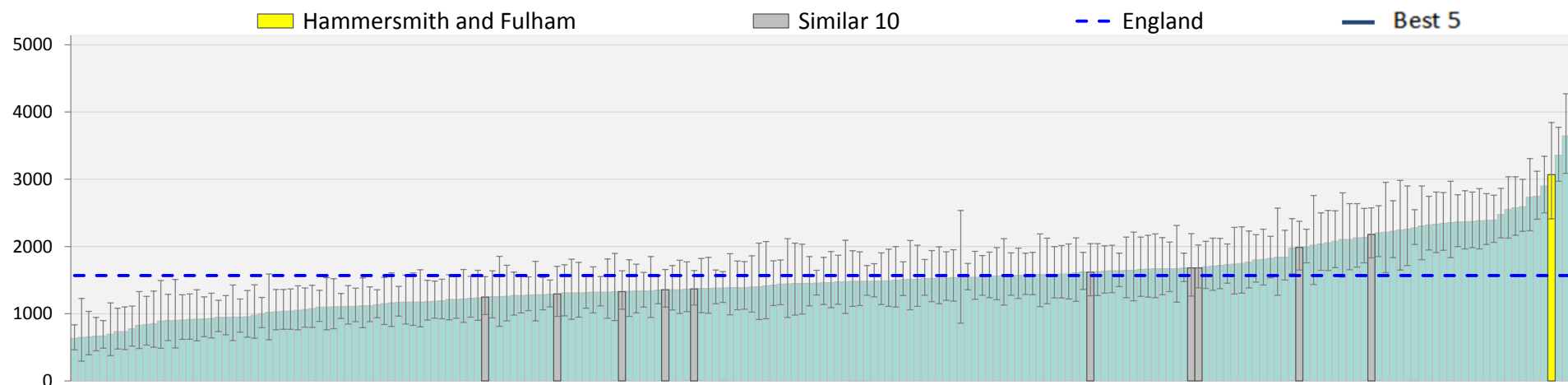


Definition: Spend - Injuries to thorax - 85+
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£67k

102

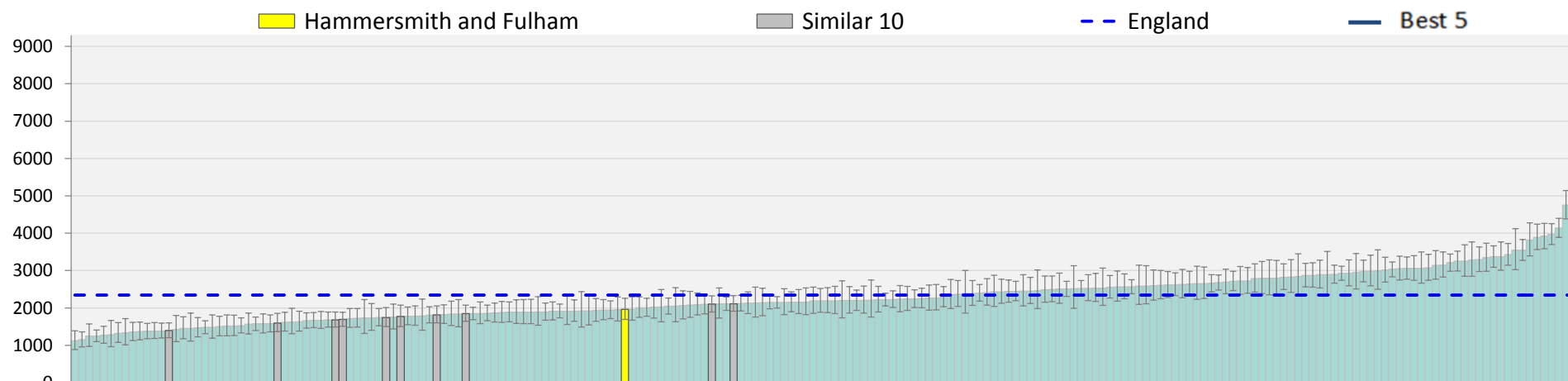


Definition: Spend - Injuries to wrist and hand - 0-18
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£56k

103

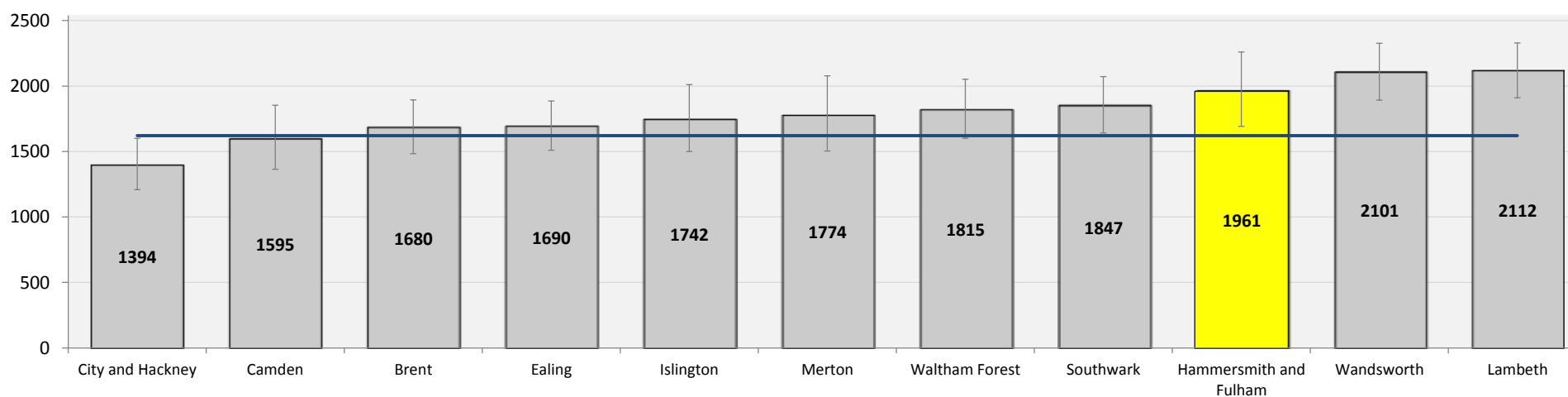


England

2347.0

Best 5

1620.0

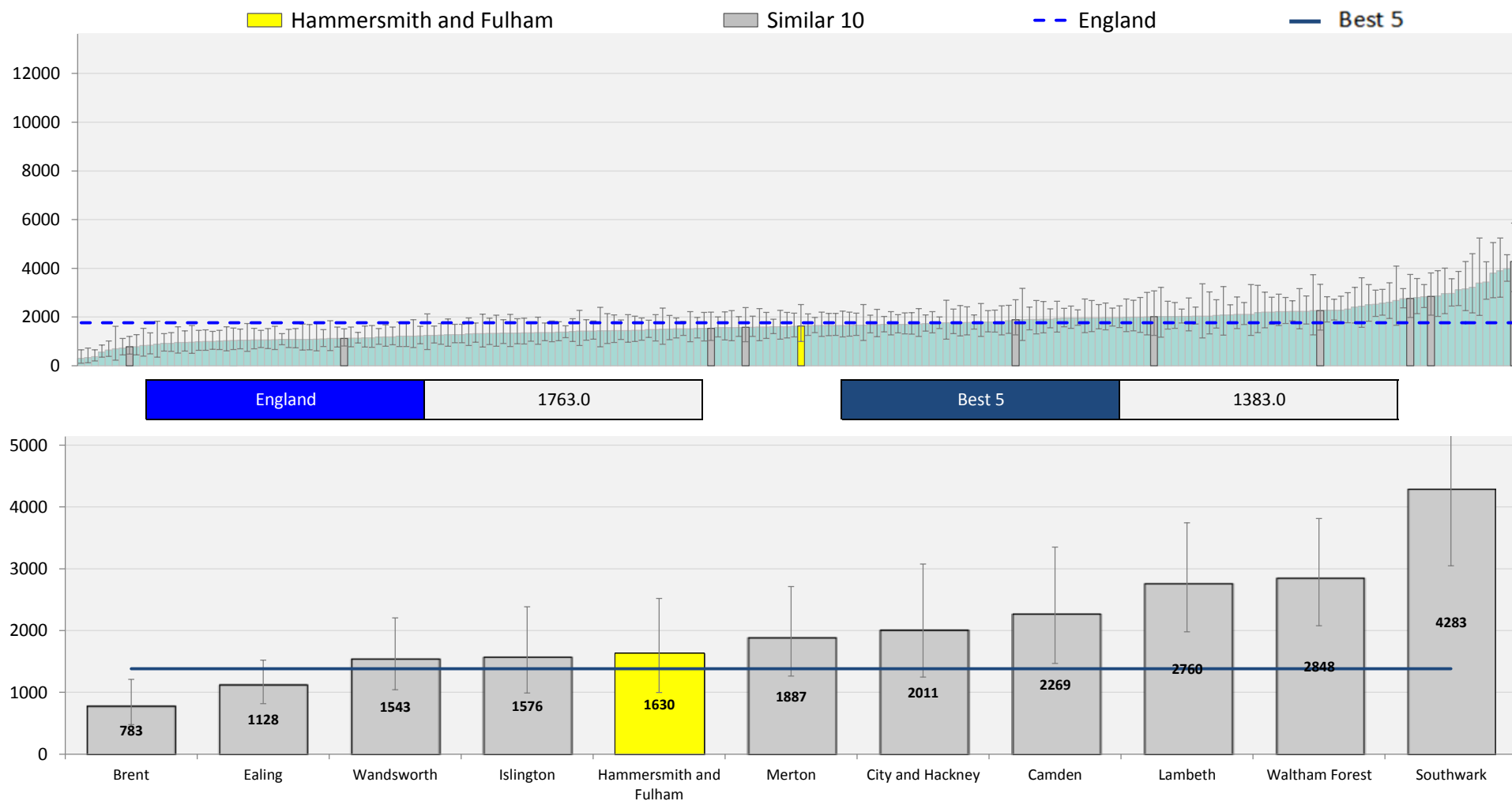


Definition: Spend - Injuries to wrist and hand - 19-64
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£5k (NSS)

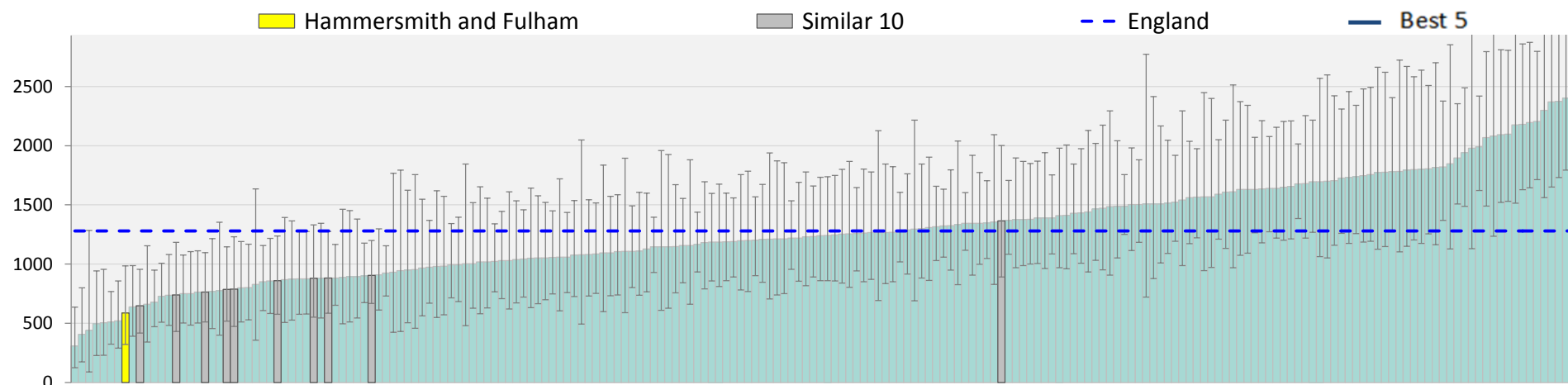
104



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)

105

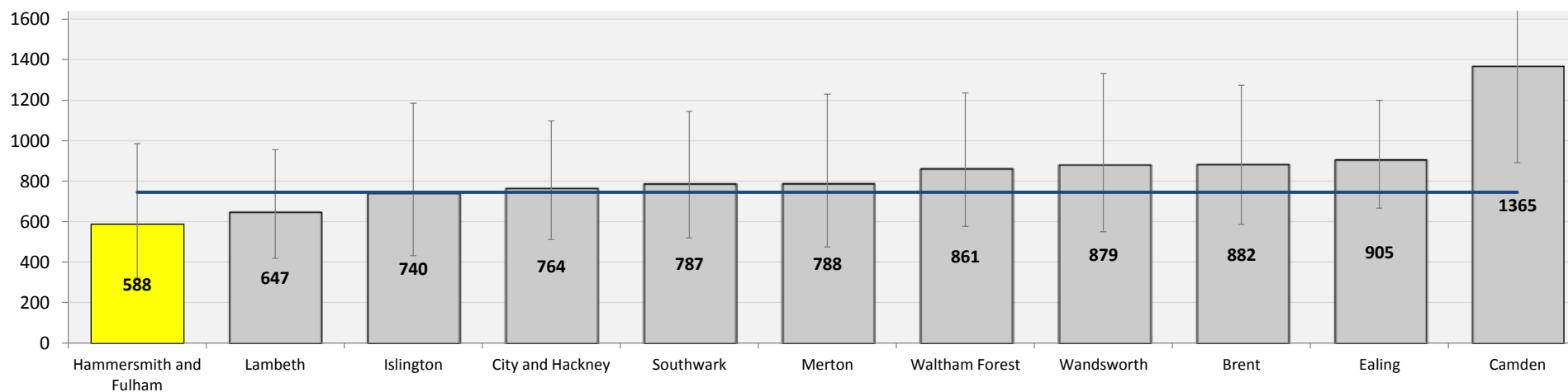


England

1280.0

Best 5

745.0



Definition: Spend - Injuries to shoulder and upper arm - 0-18

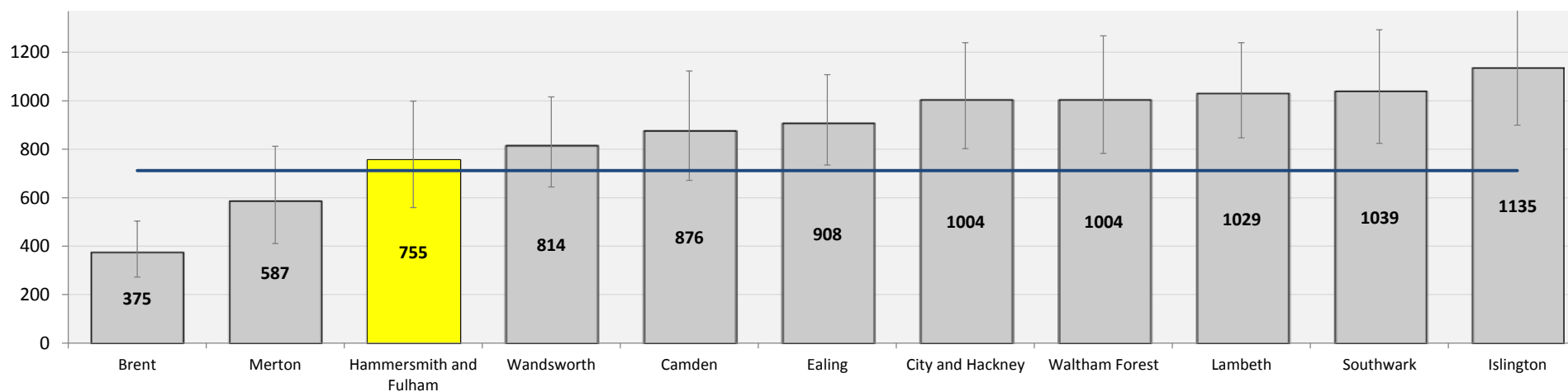
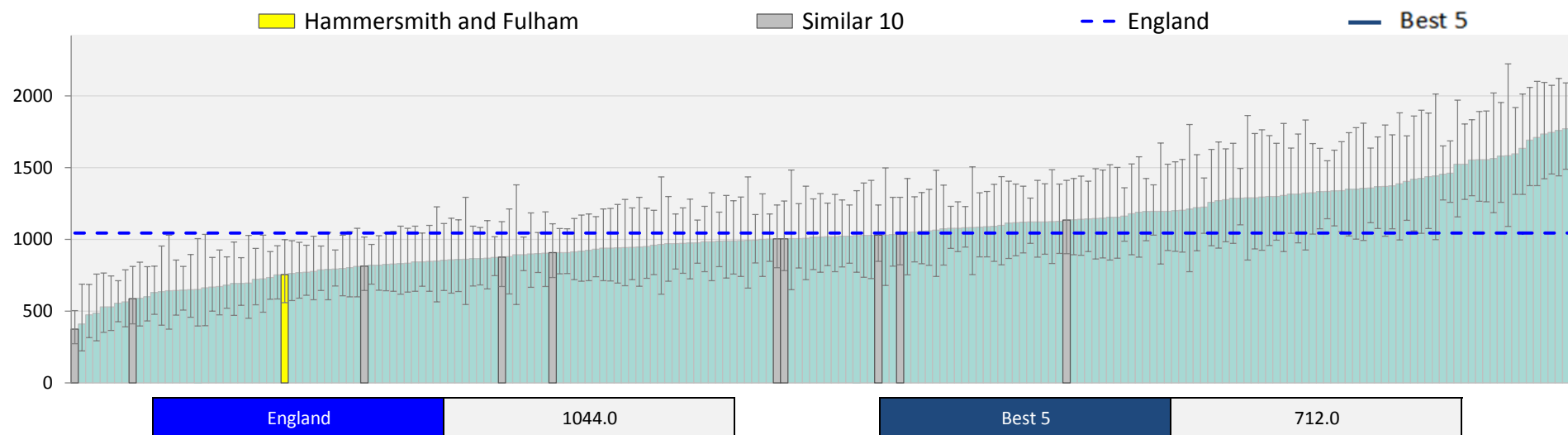
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

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

£6k (NSS)

106

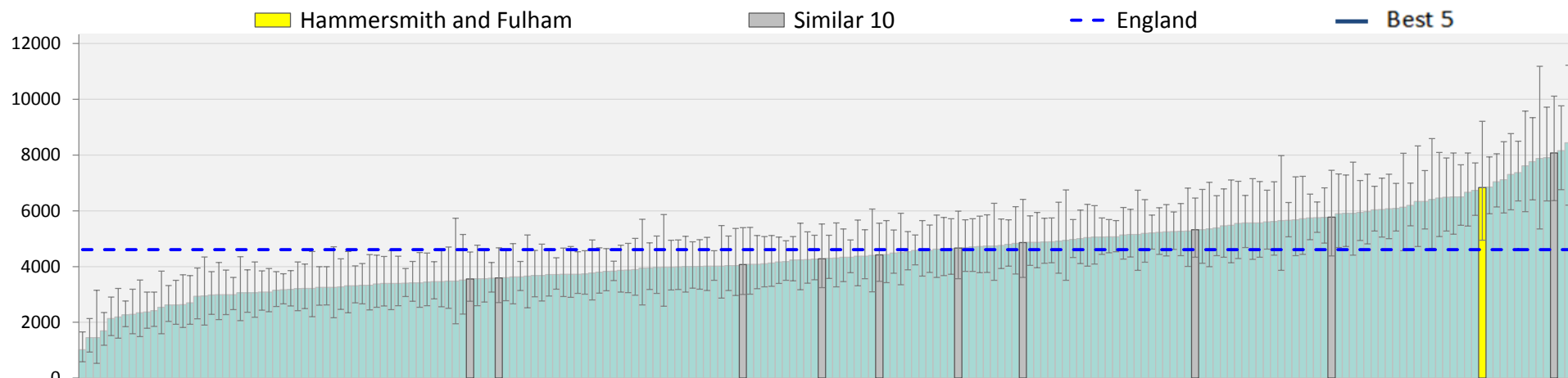


Definition: Spend - Injuries to shoulder and upper arm - 19-64
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£53k

107

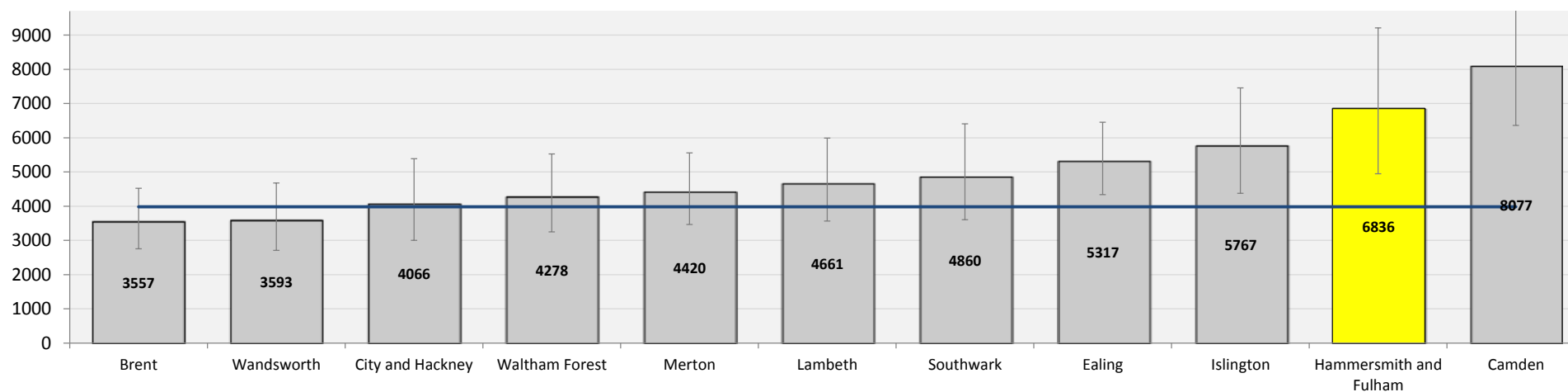


England

4611.0

Best 5

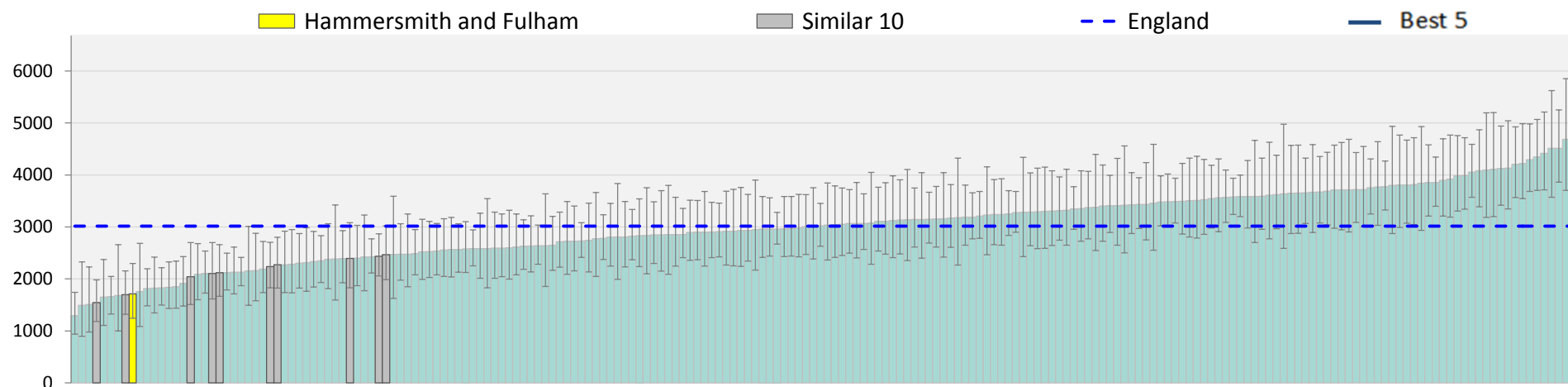
3983.0



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)

108

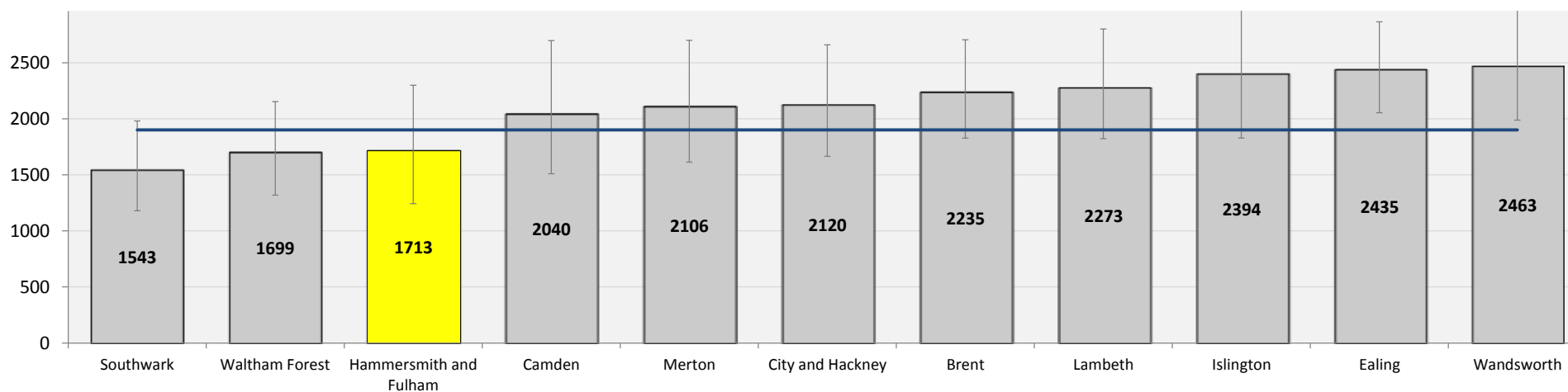


England

3017.0

Best 5

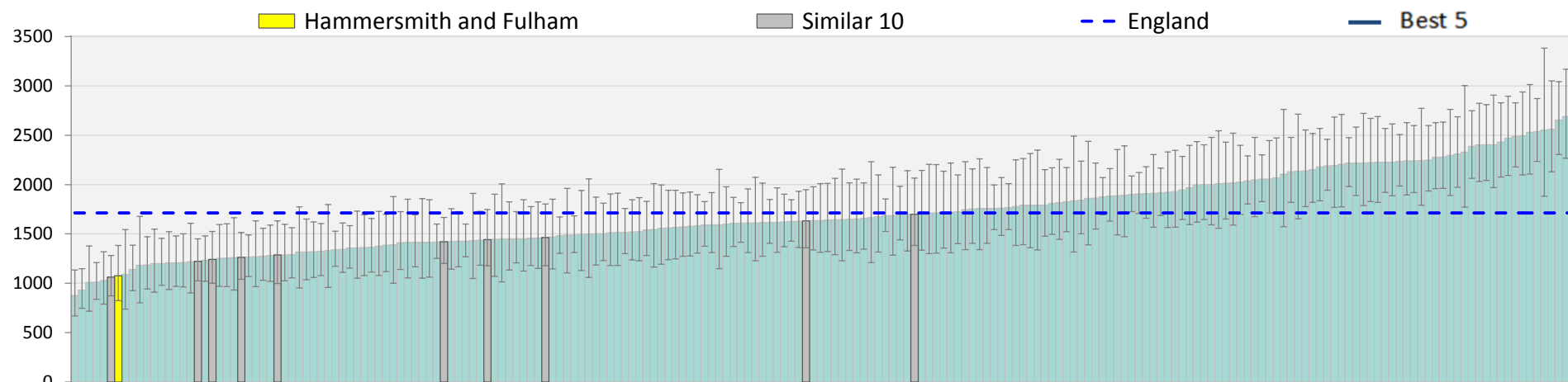
1901.0



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)

109

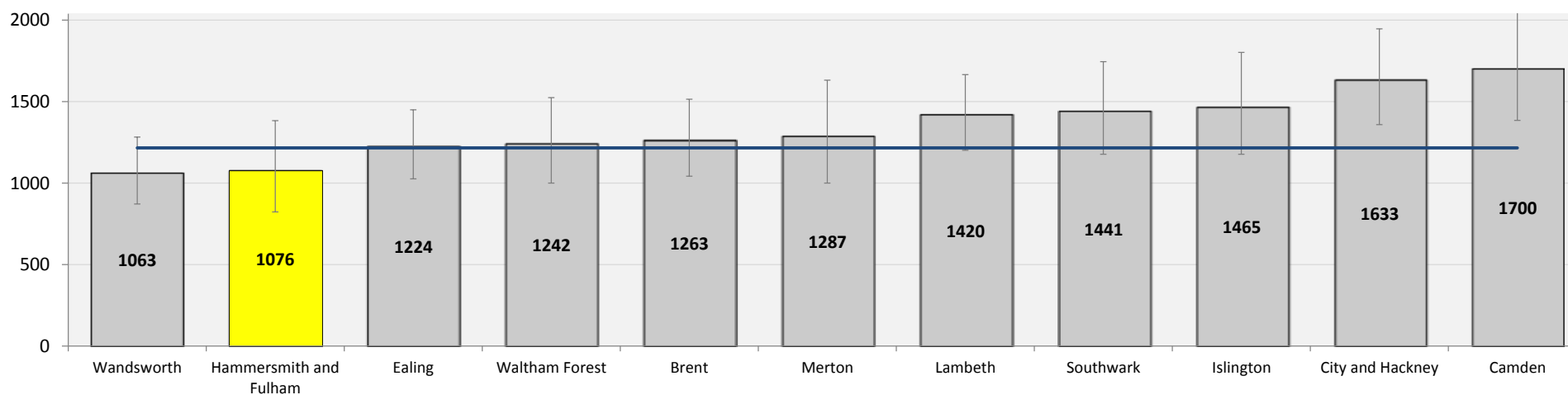


England

1713.0

Best 5

1216.0

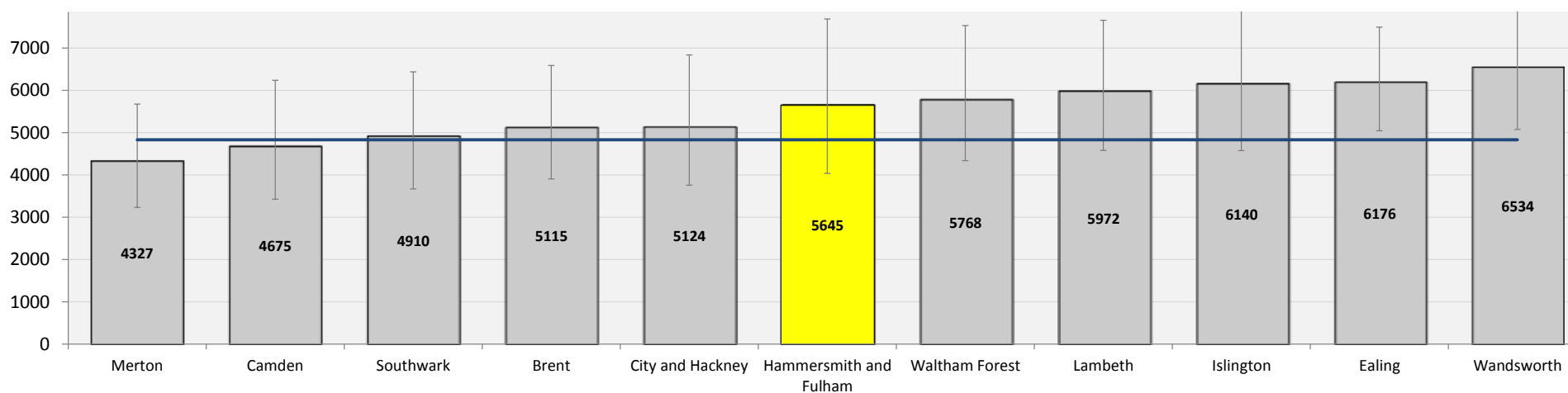
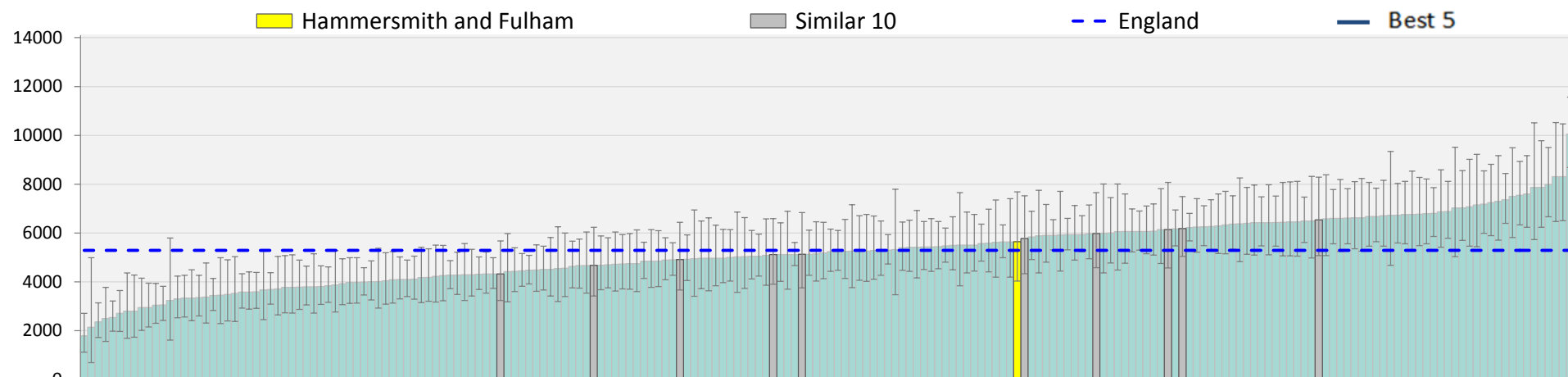


Definition: Spend - Injuries to elbow and forearm - 19-64
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£15k (NSS)

110

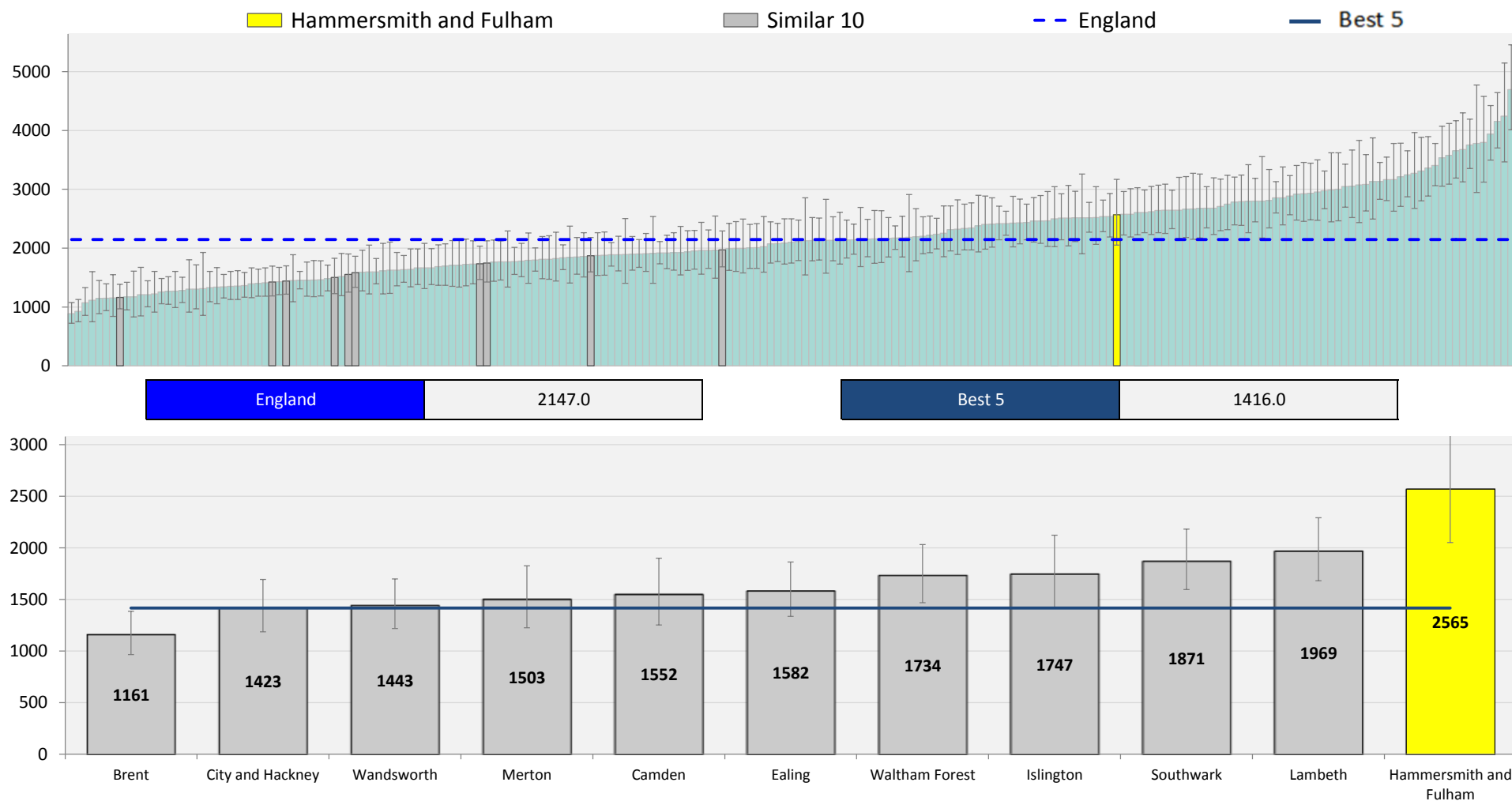


Definition: Spend - Injuries to elbow and forearm - 65+
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£47k

111

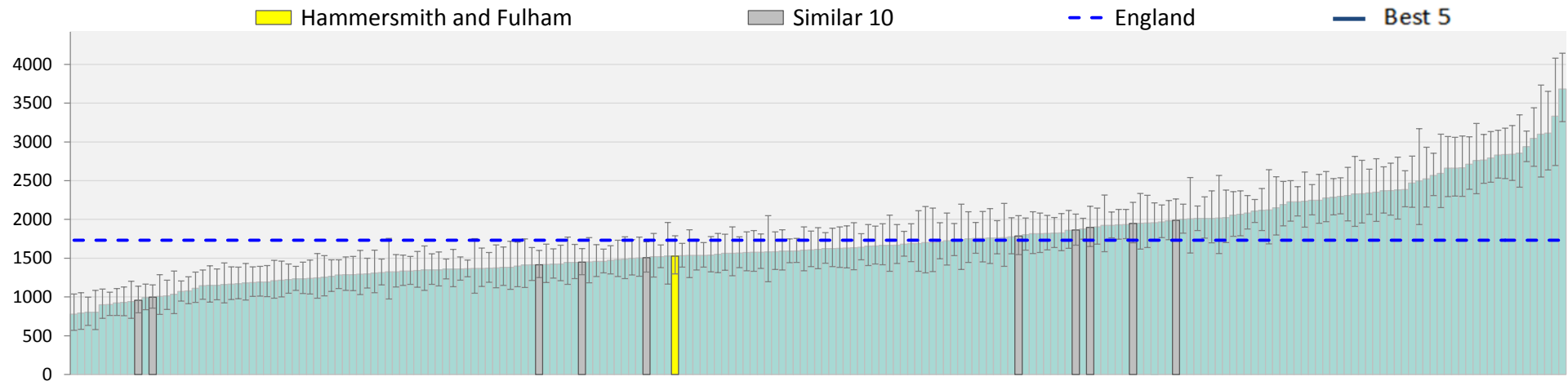


Definition: Spend - Injuries to the head - 0-18
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£40k

112

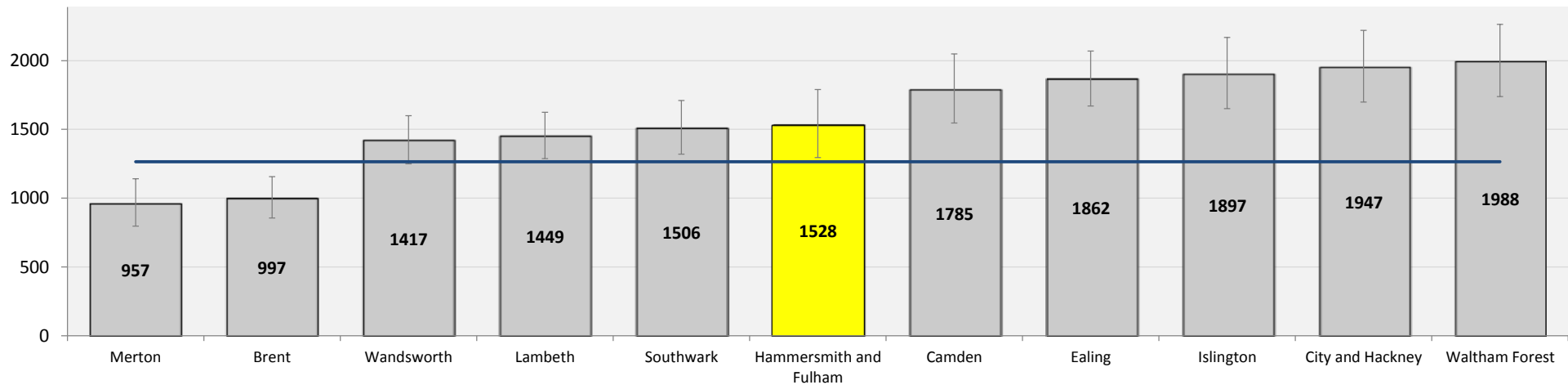


England

1732.0

Best 5

1265.0

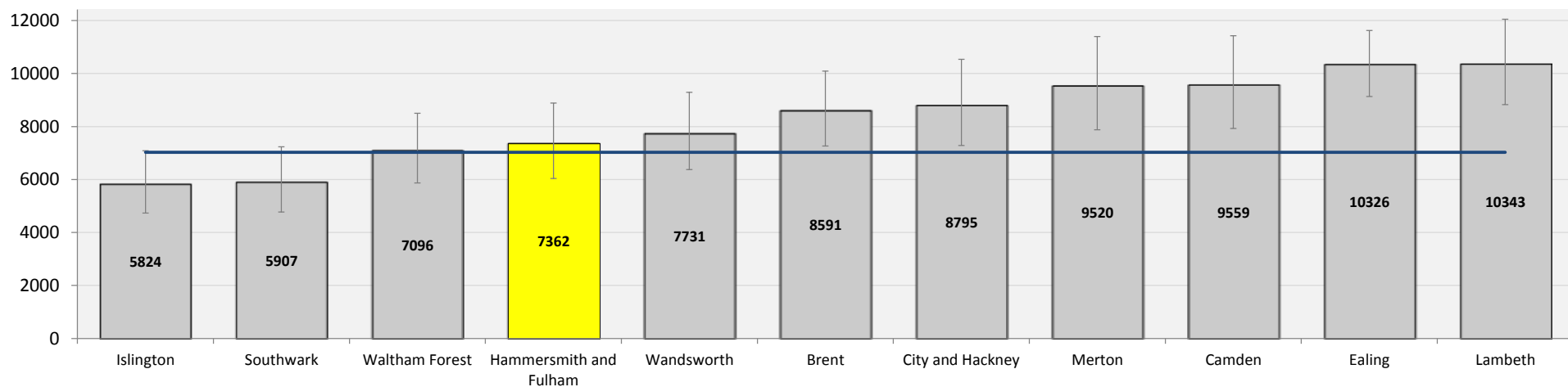
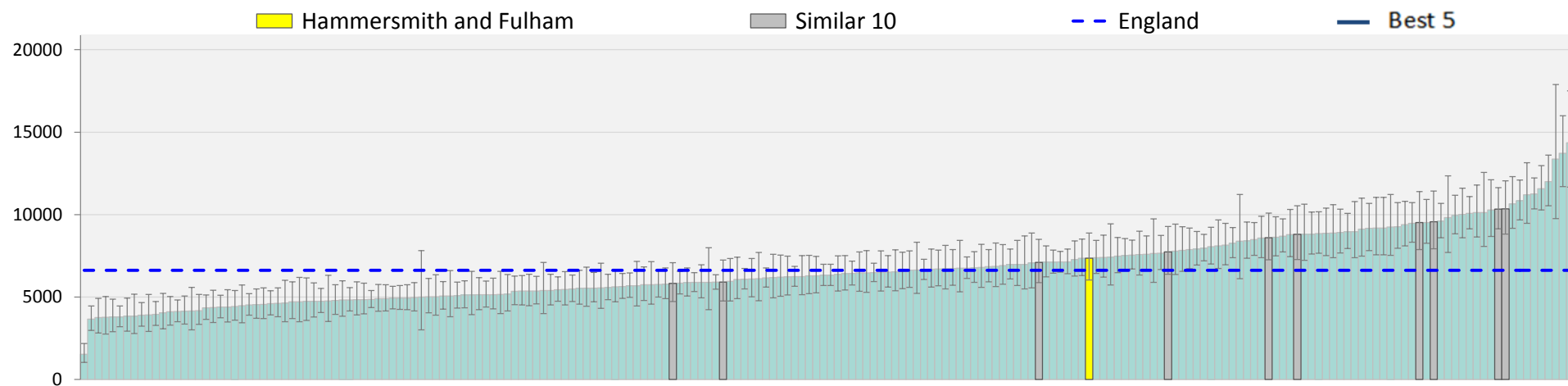


Definition: Spend - Injuries to the head - 19-64
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£5k (NSS)

113

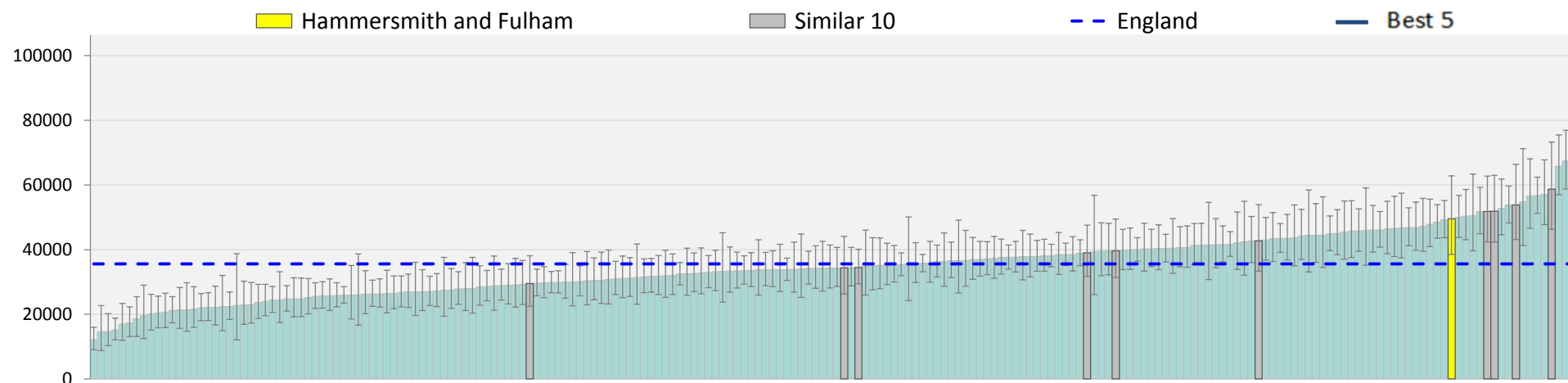


Definition: Spend - Injuries to the head - 65-84
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£33k

114

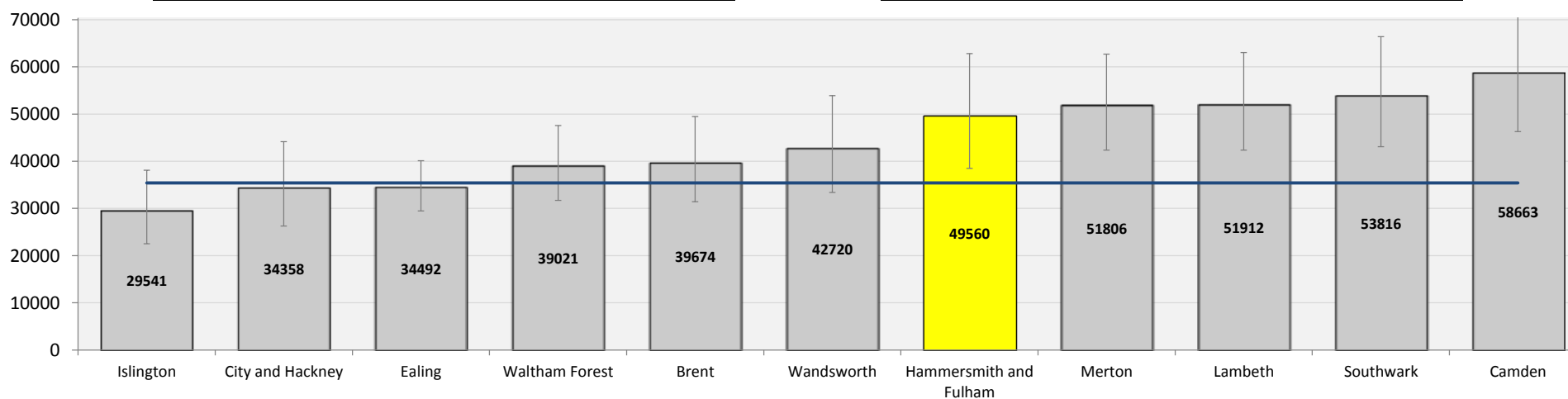


England

35562.0

Best 5

35417.0

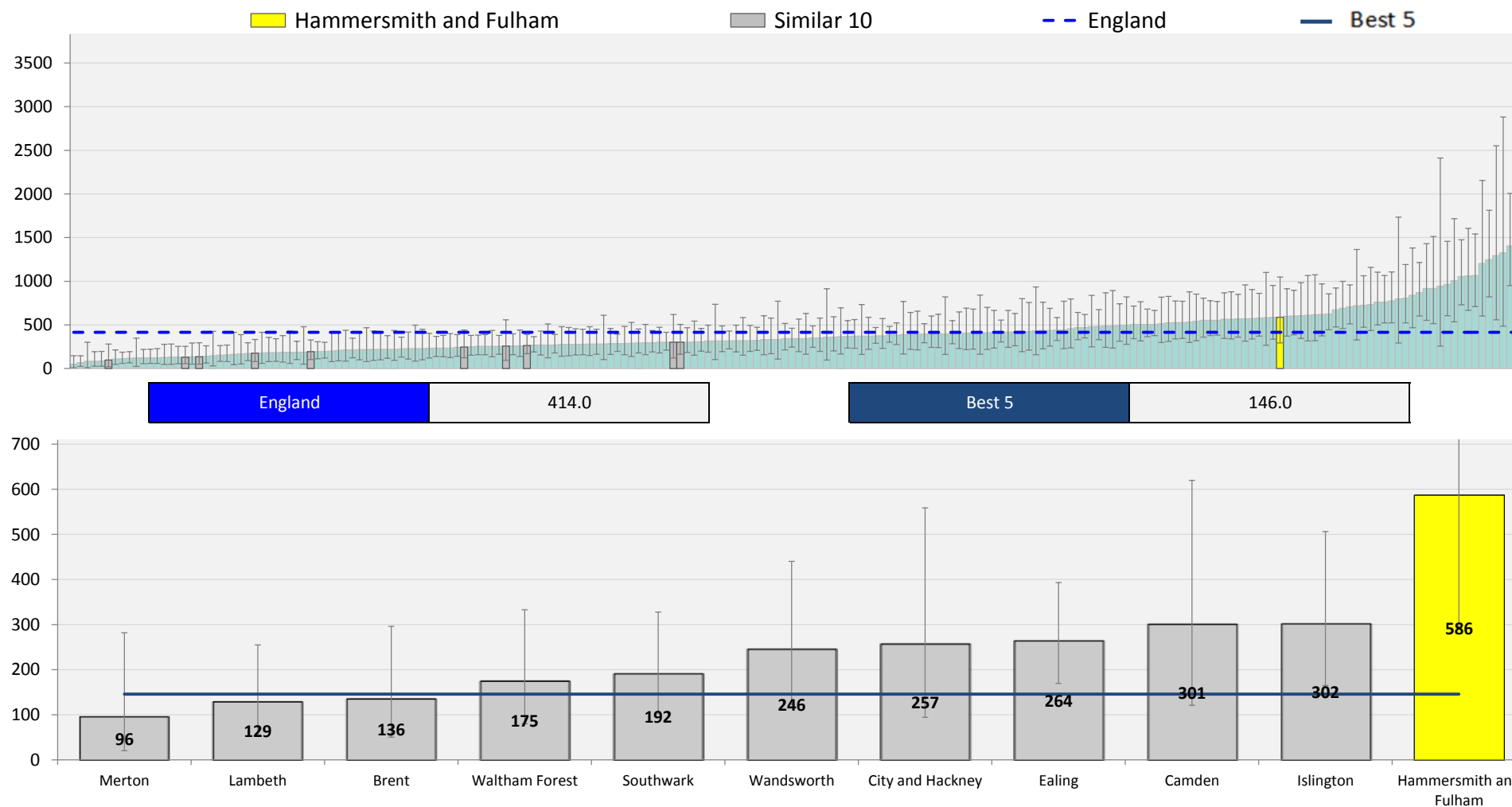


Definition: Spend - Injuries to the head - 85+
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£17k

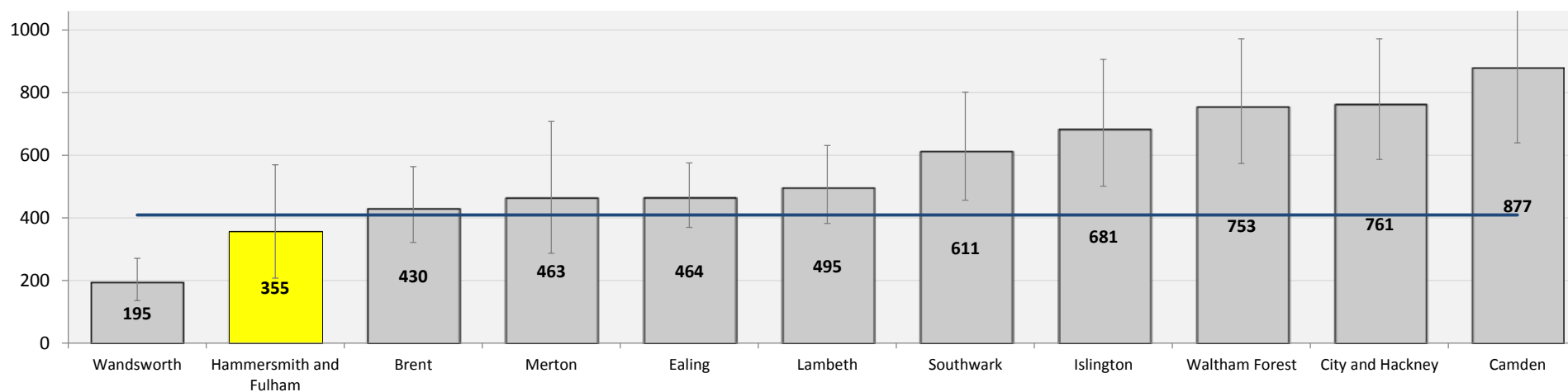
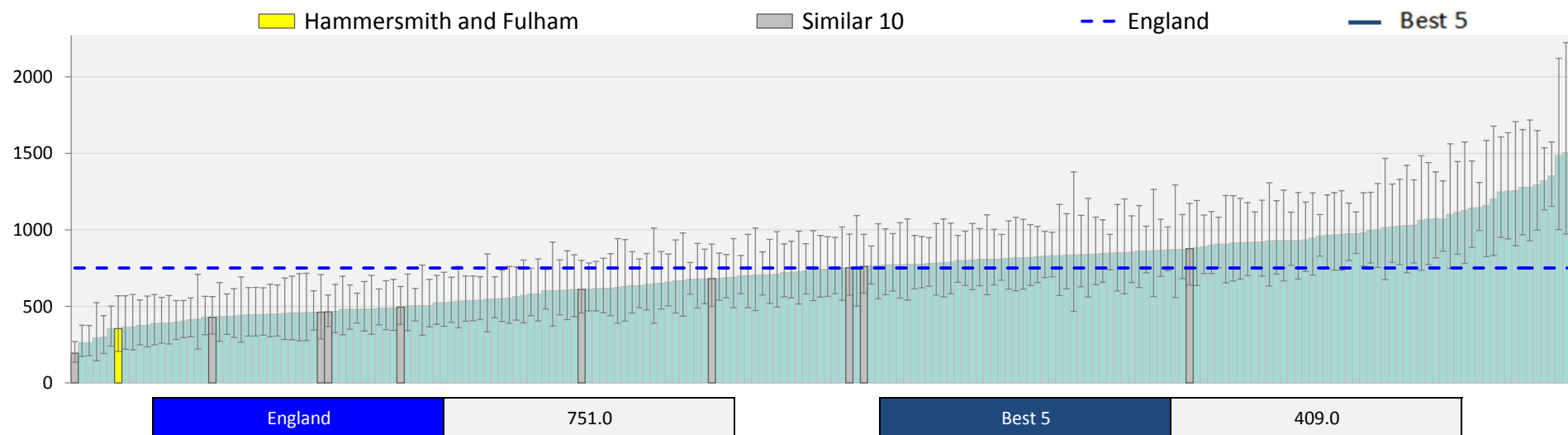
115



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)

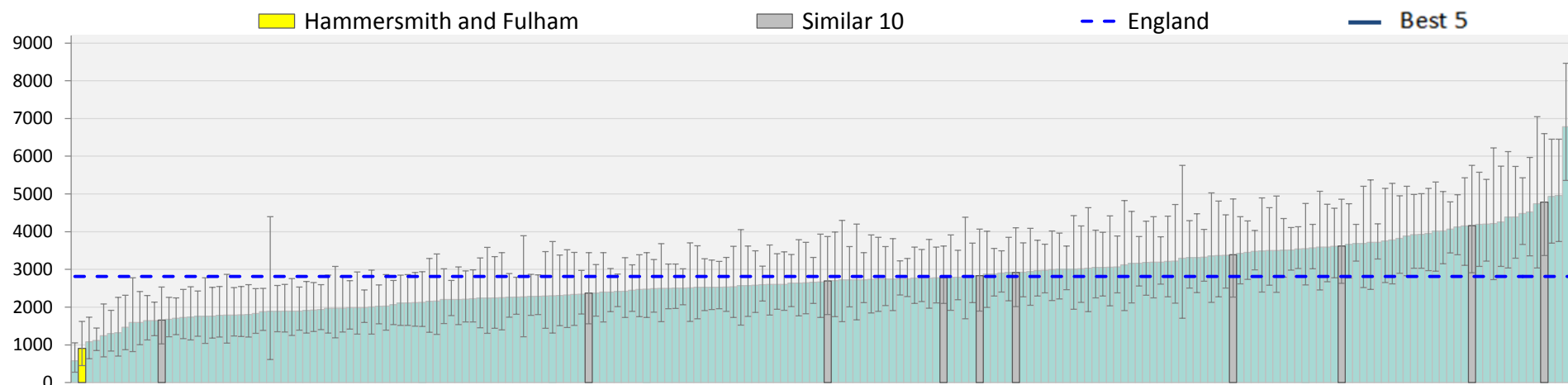
116



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)

117

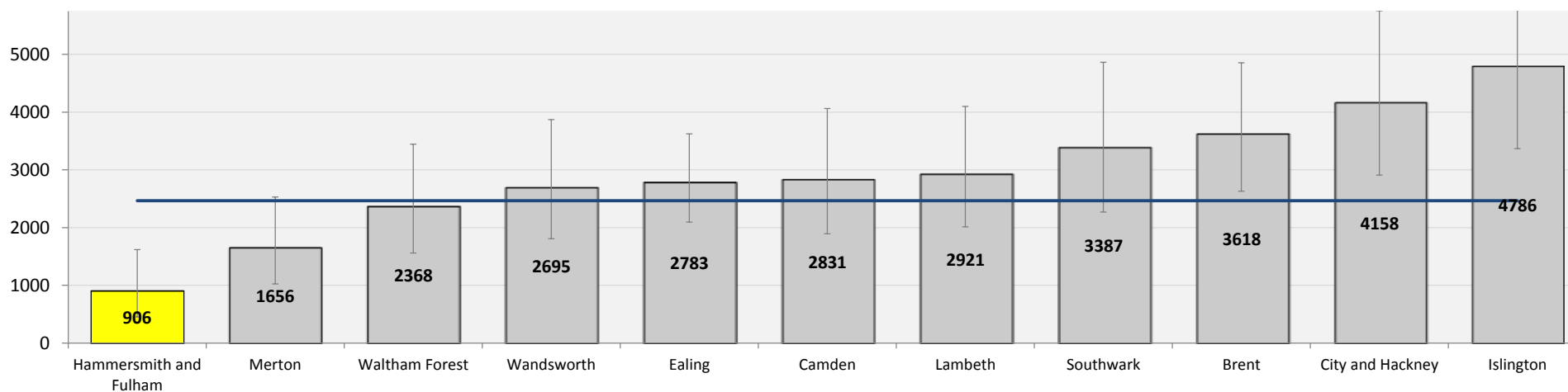


England

2813.0

Best 5

2467.0



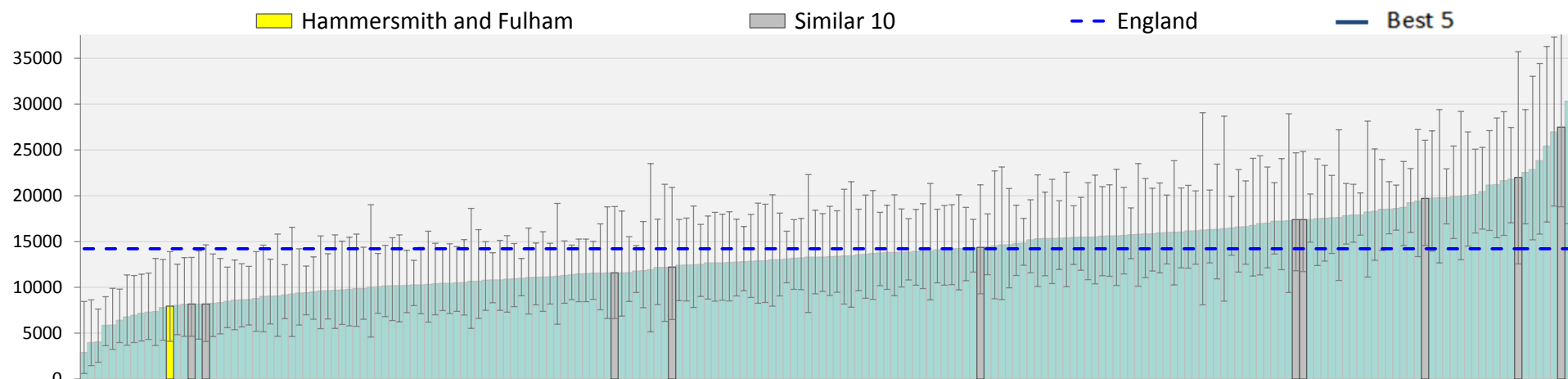
Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 65-84

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)

118

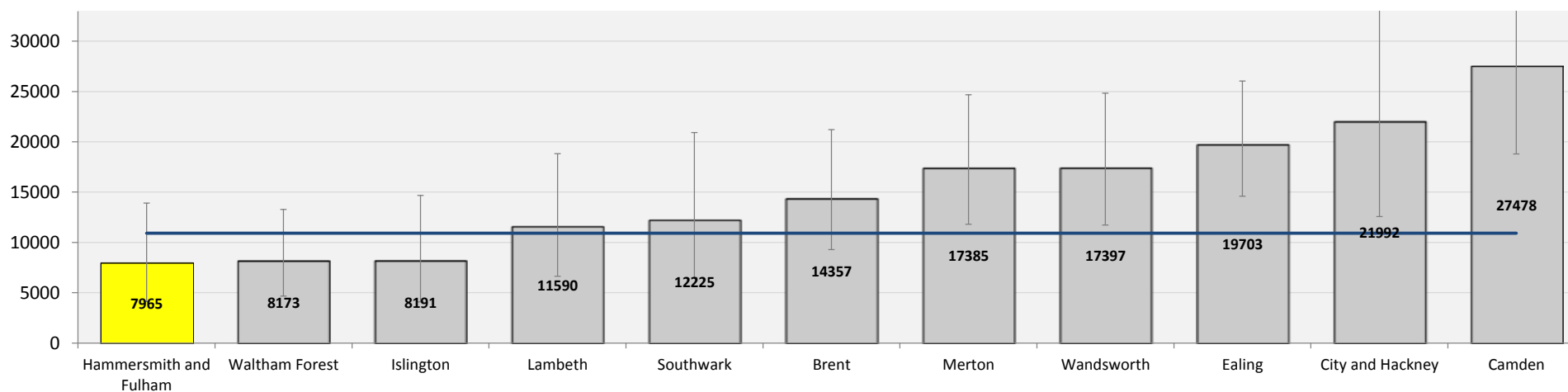


England

14209.0

Best 5

10907.0

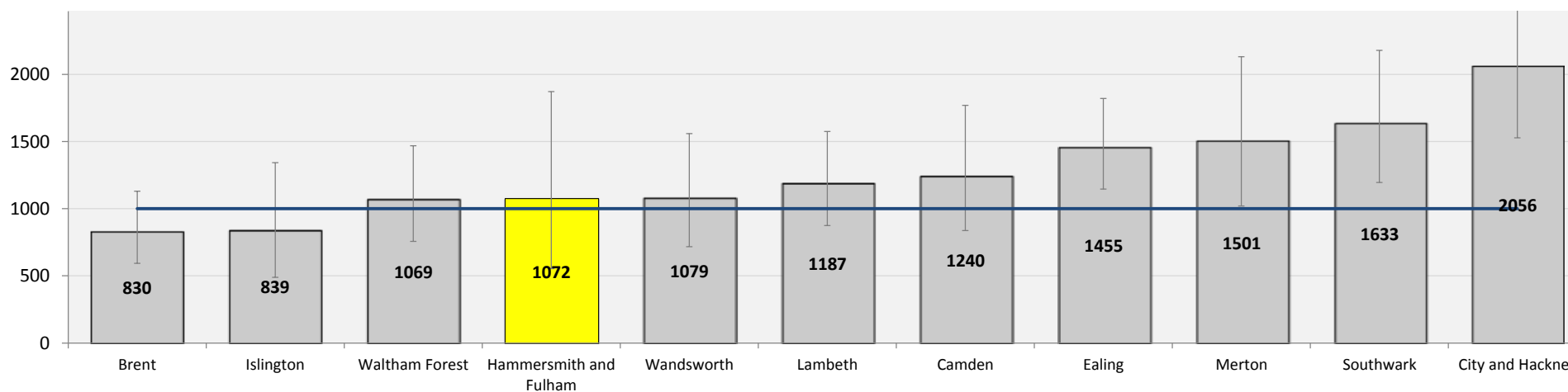
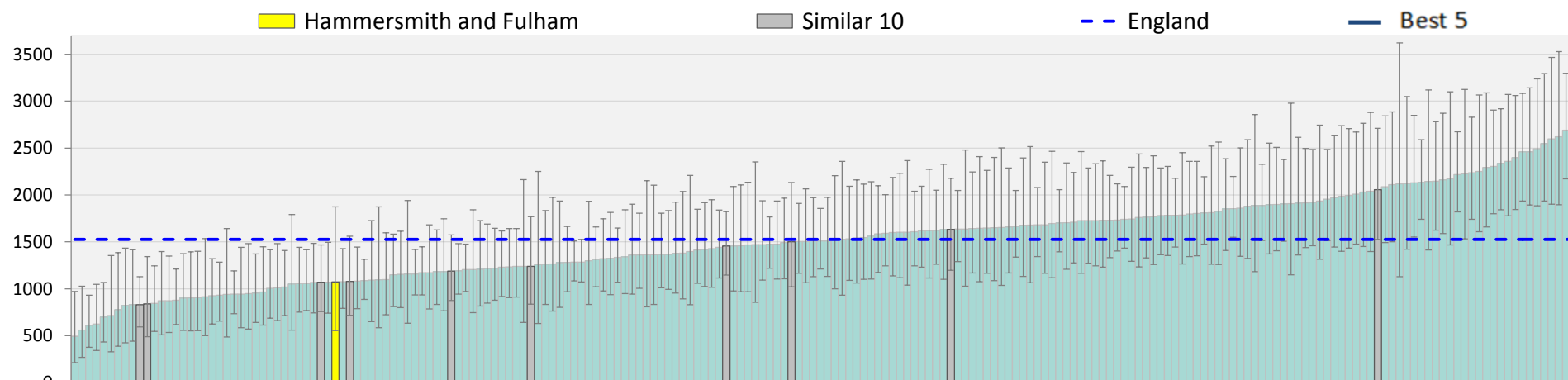


Definition: Spend - Injuries to the abdomen, lower back, lumbar spine and pelvis - 85+
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£3k (NSS)

119

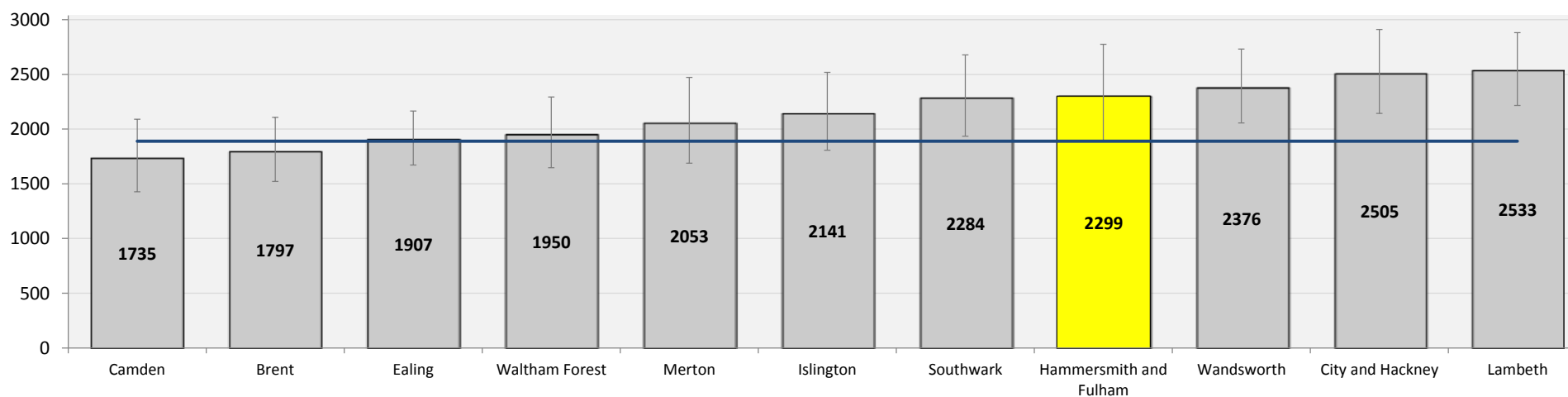
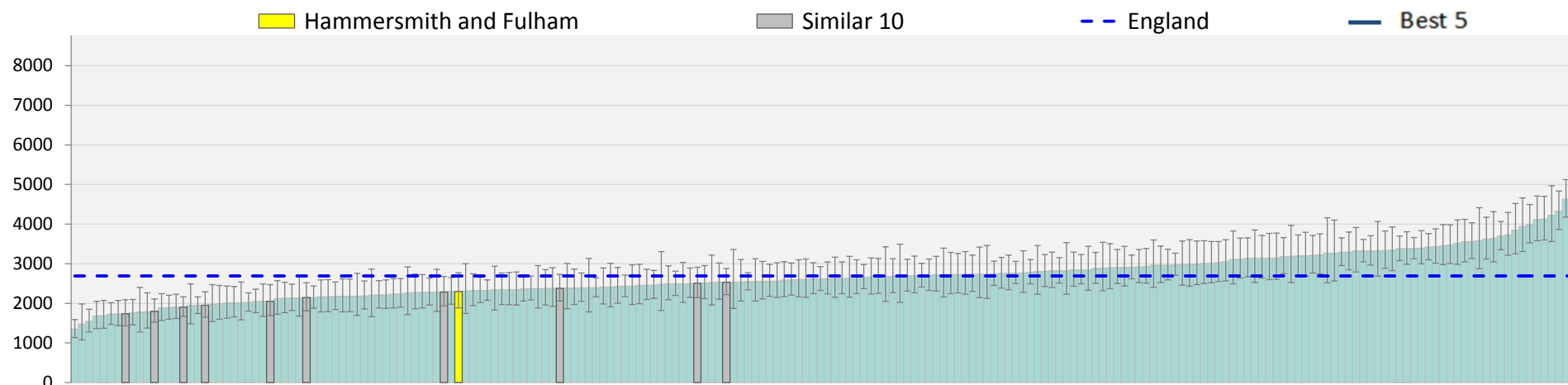


Definition: Spend - Injuries to the knee and lower leg - 0-18
 Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)
 Year: 2014/15

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

£63k (NSS)

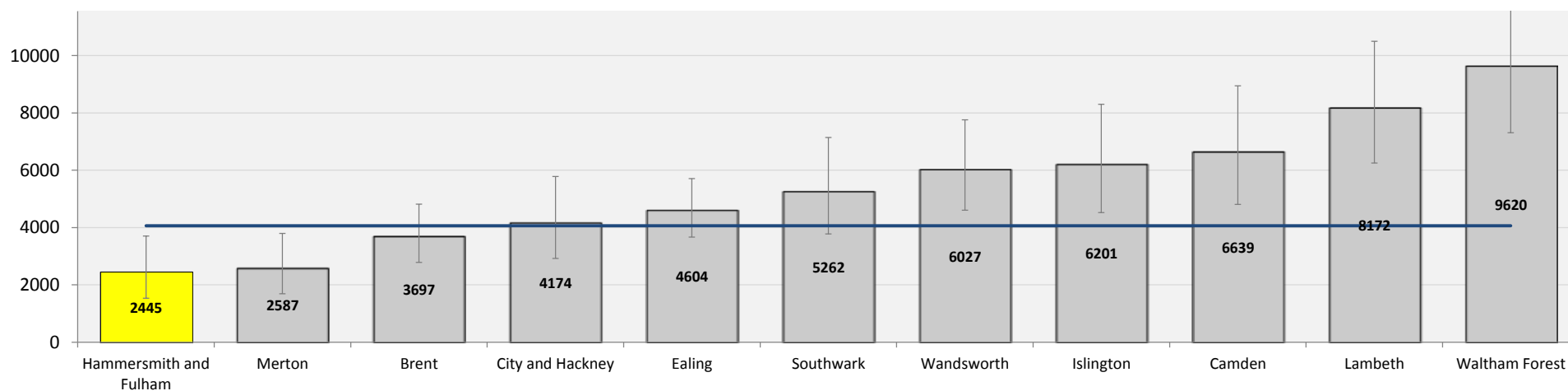
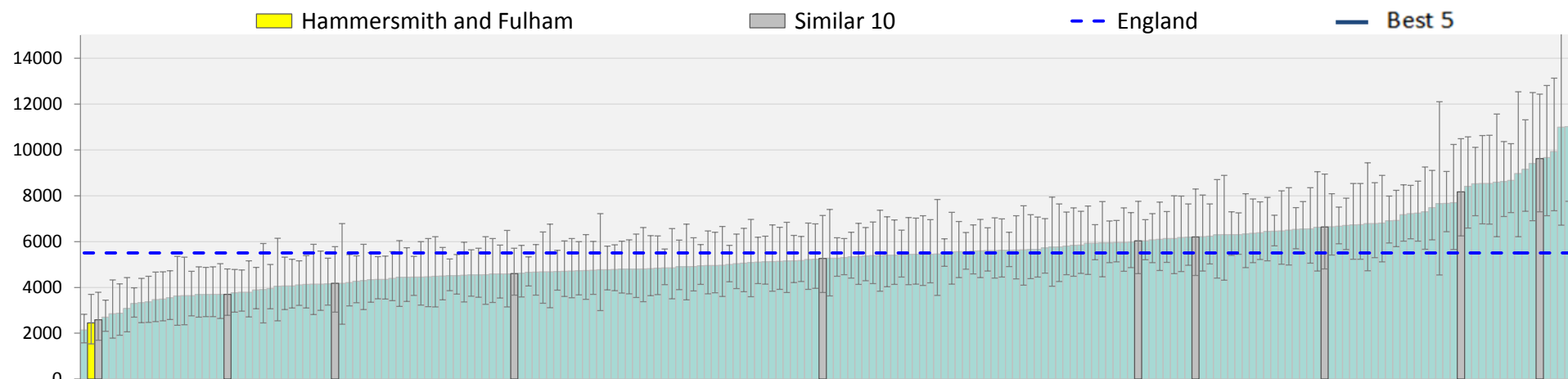
120



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)

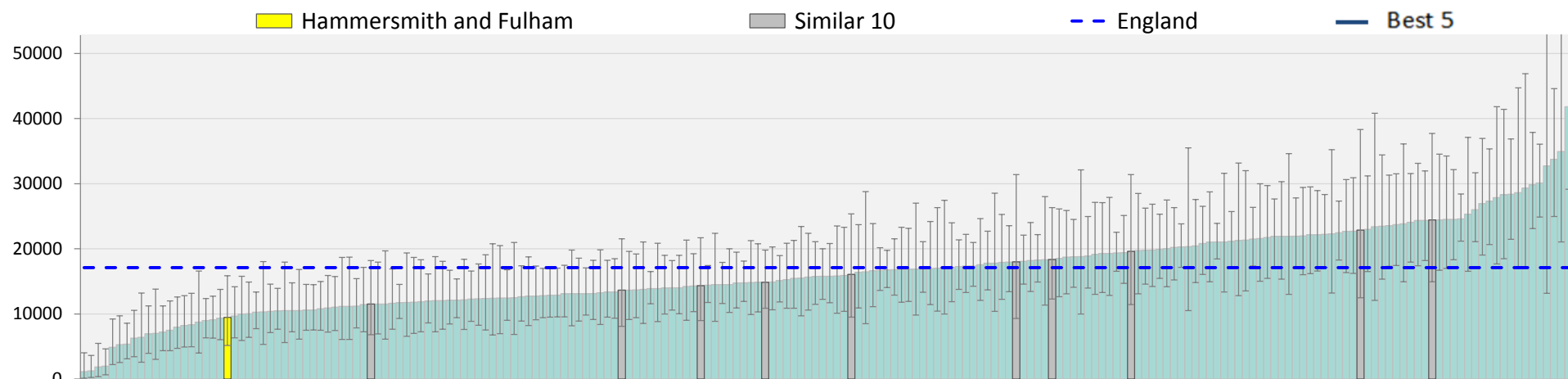
121



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)

122

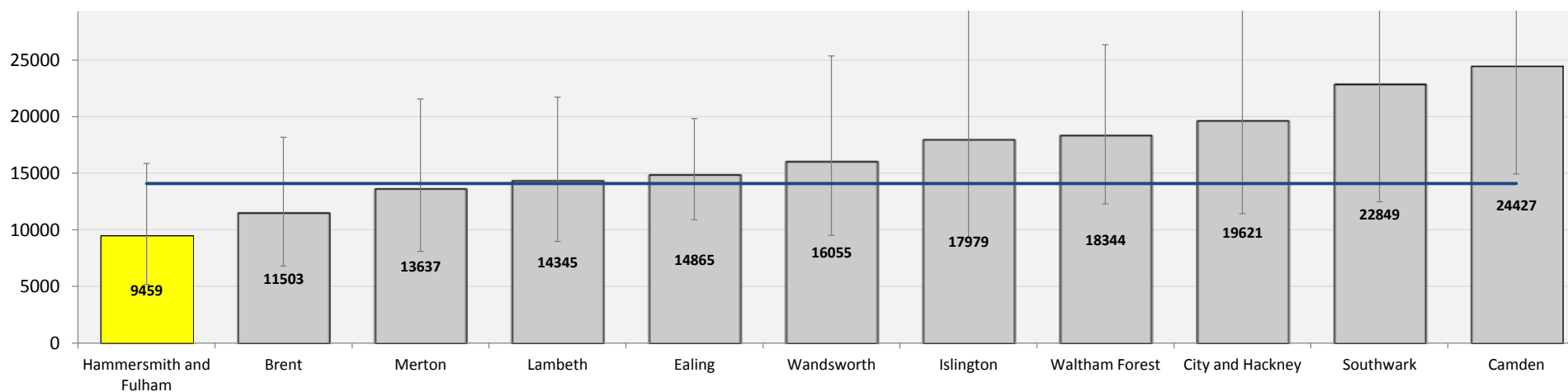


England

17101.0

Best 5

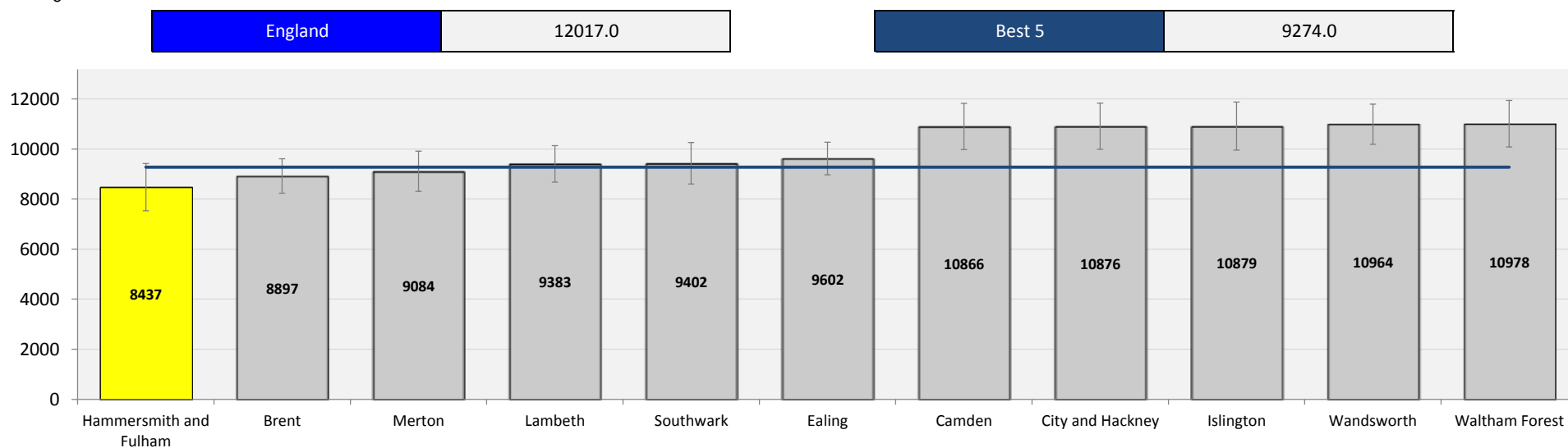
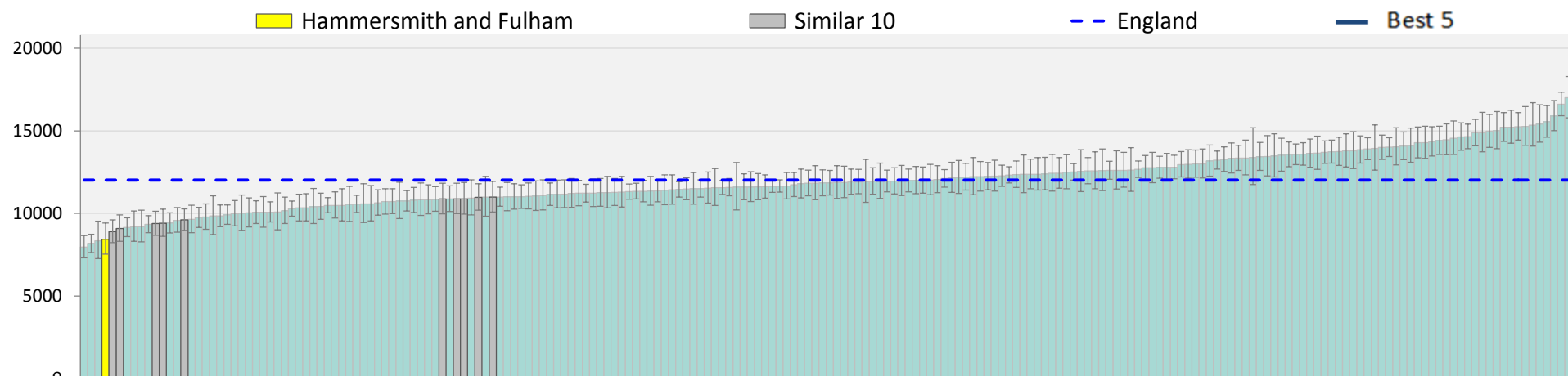
14081.0



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)

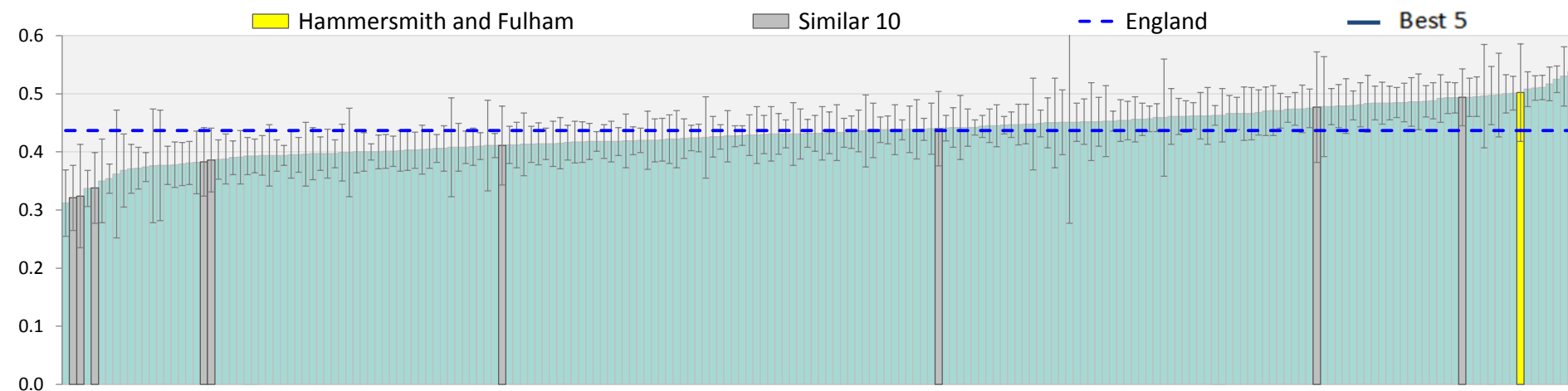
123



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)

124

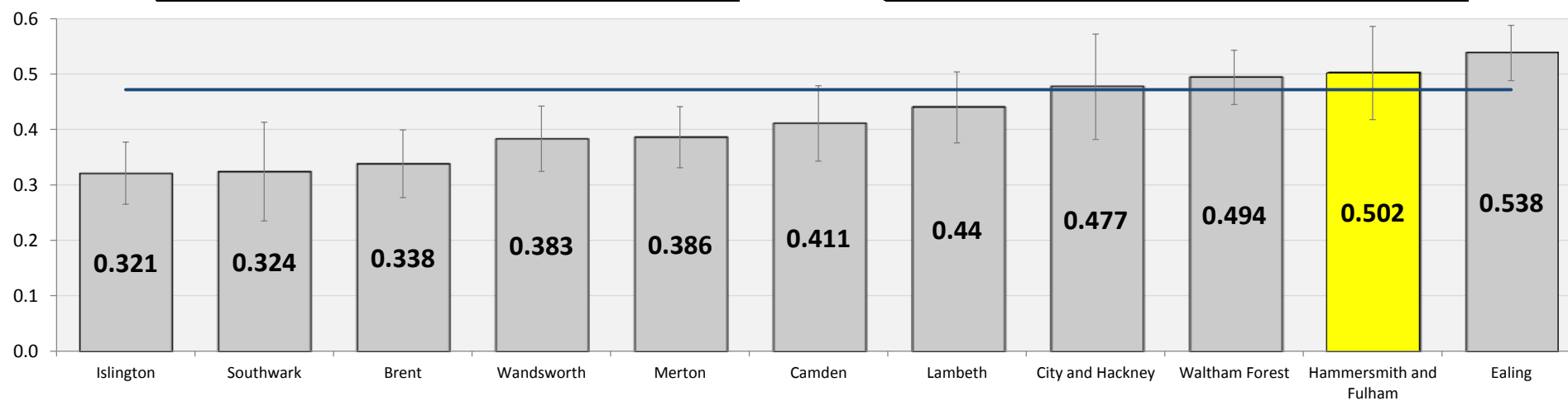


England

0.437

Best 5

0.472



Definition:

Hip replacement, EQ-5D, Health Gain

Source:

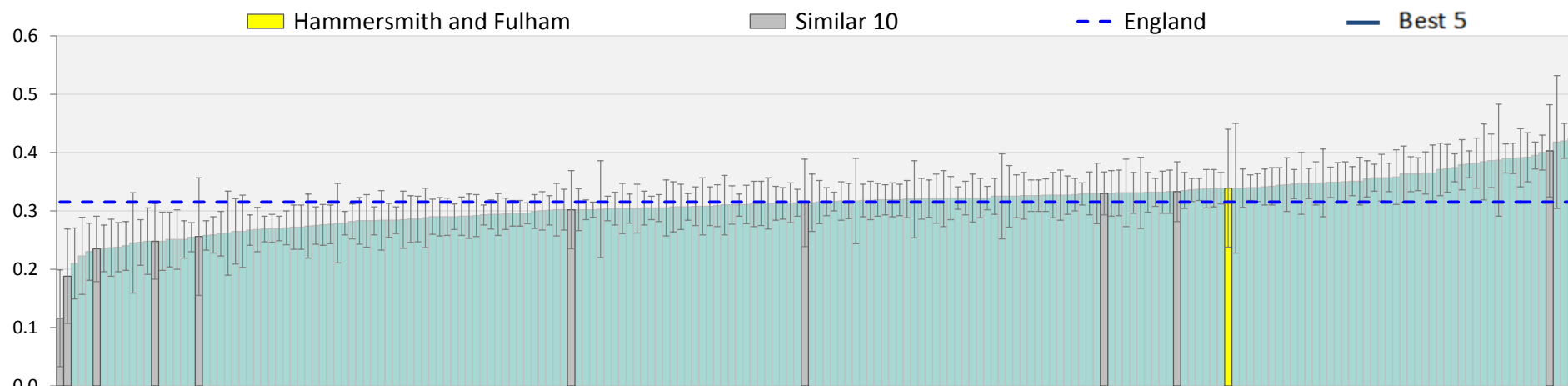
Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre

Year:

2014/15

EQ-5D health gain (knees)

125

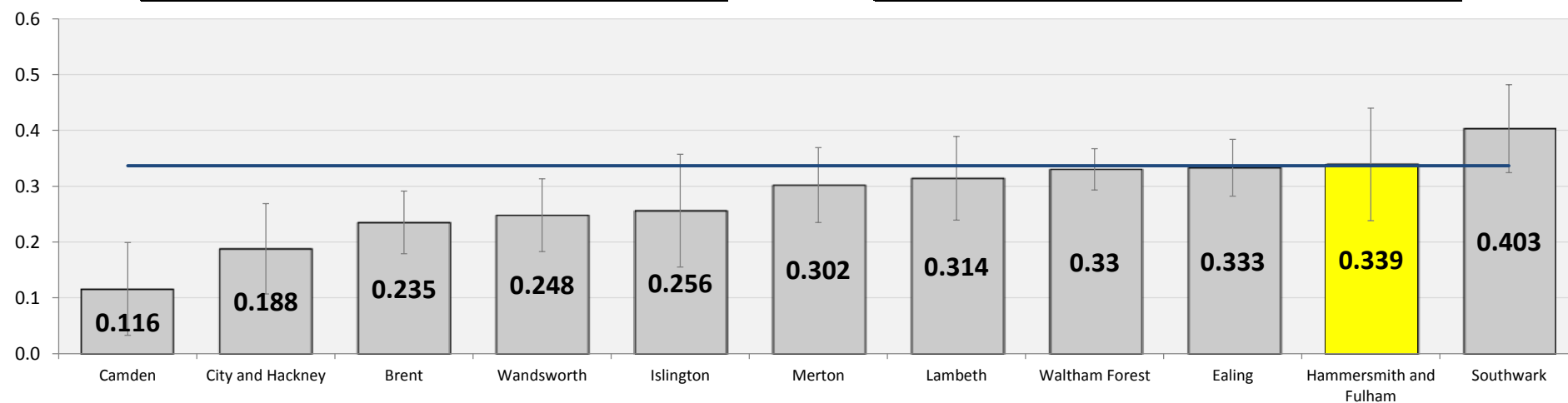


England

0.315

Best 5

0.336

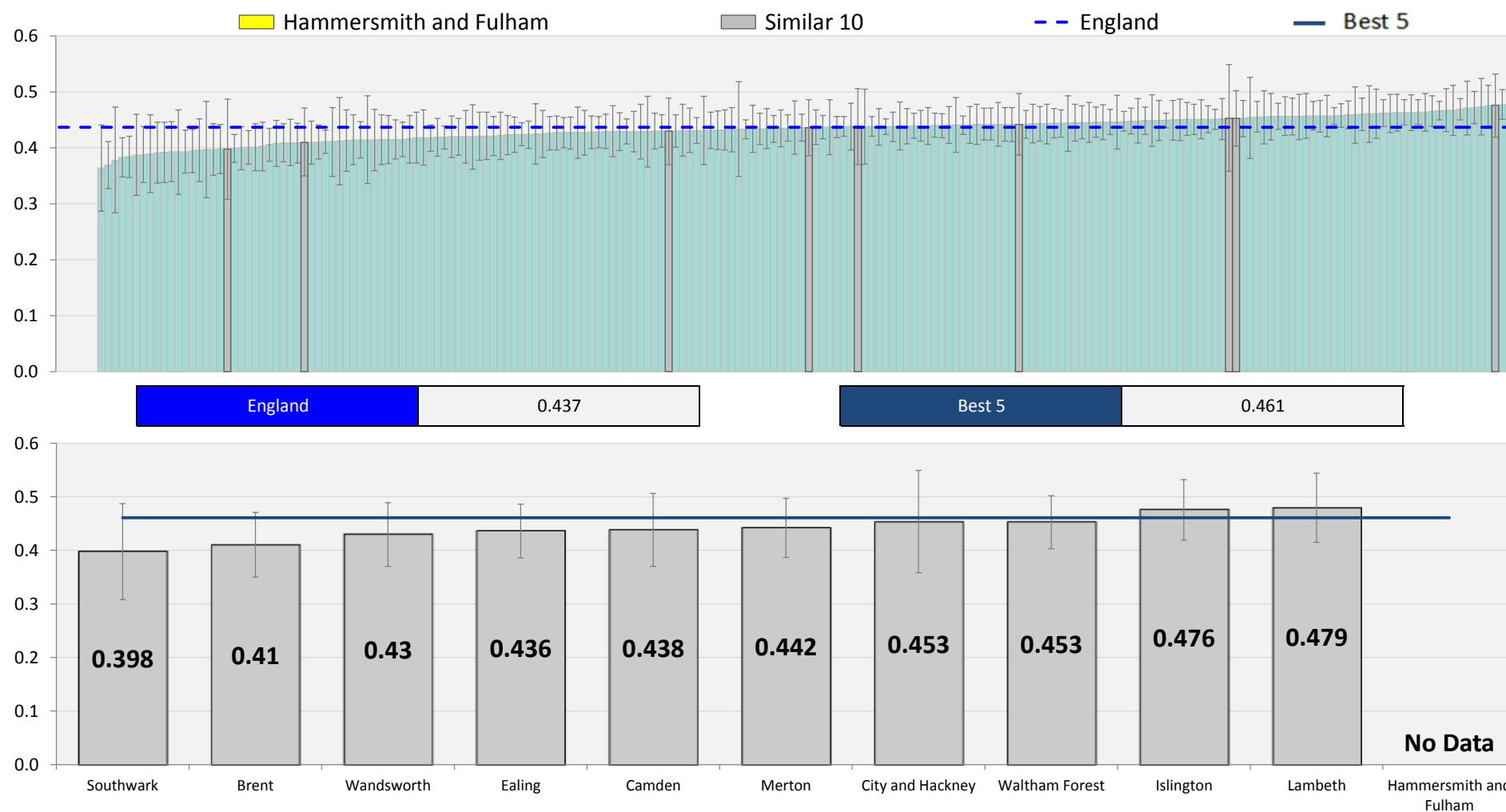


Definition: Knee replacement, EQ-5D, Health Gain
 Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
 Year: 2014/15

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

No Data

126



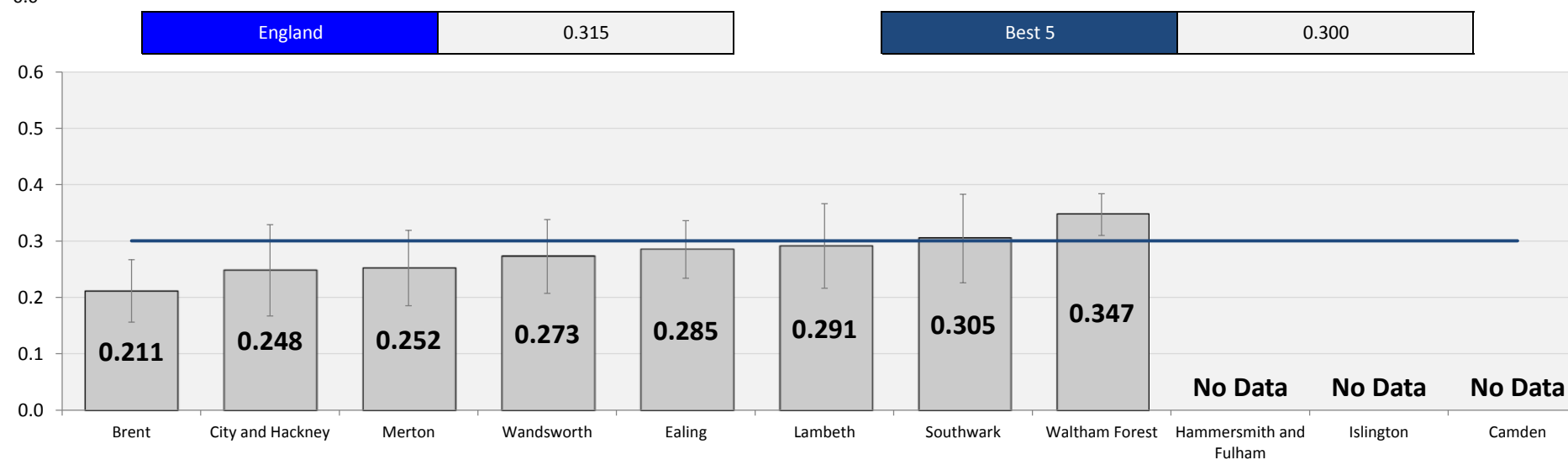
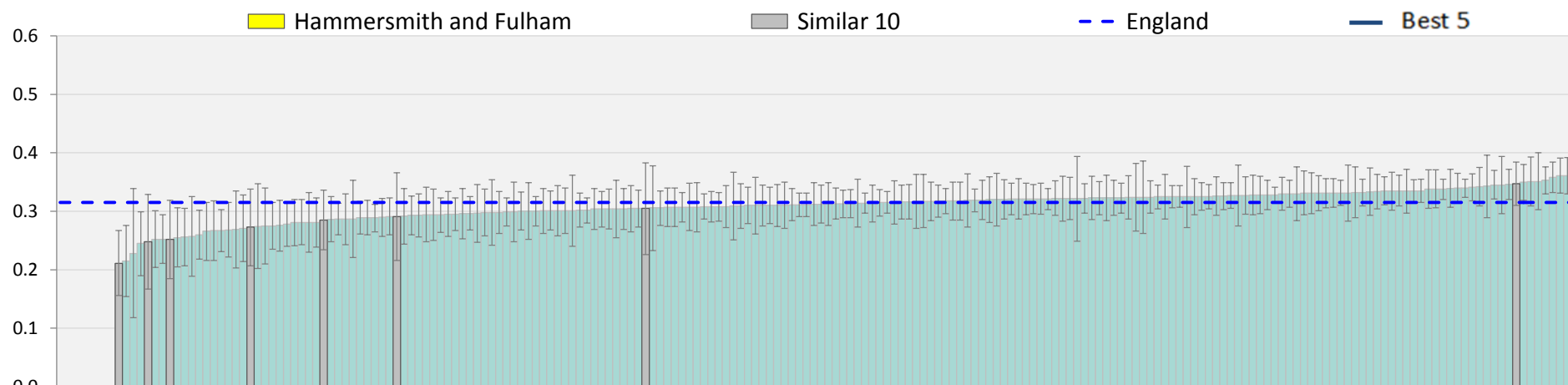
Definition: EQ-5D - Hip (primary) - Health gain (casemix adjusted)
 Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
 Year: 2014/15

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

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

No Data

127

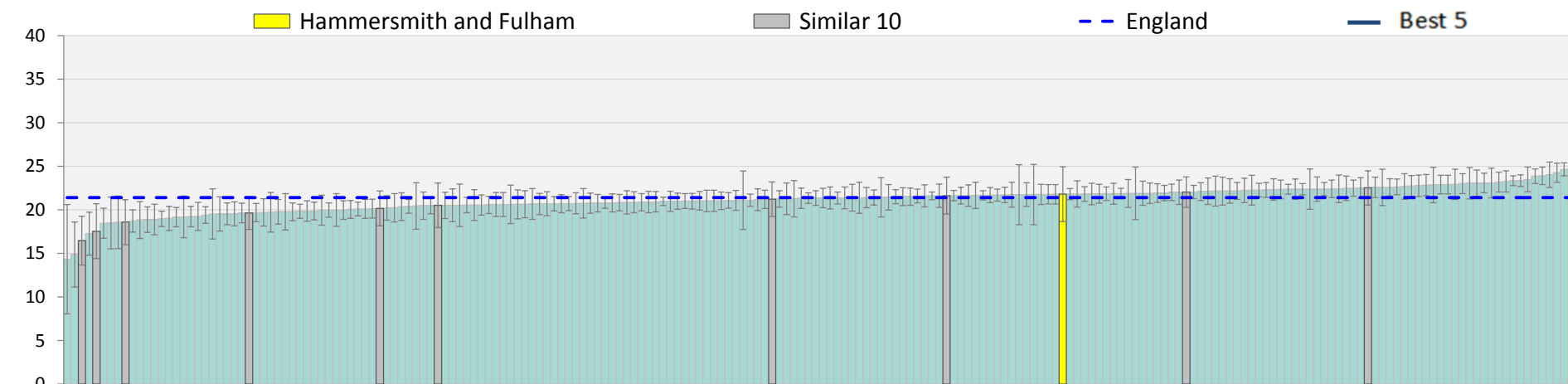


Definition: EQ-5D - Knee (primary) - Health gain (casemix adjusted)
 Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
 Year: 2014/15

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

Oxford score - Hip (primary) - Health gain

128

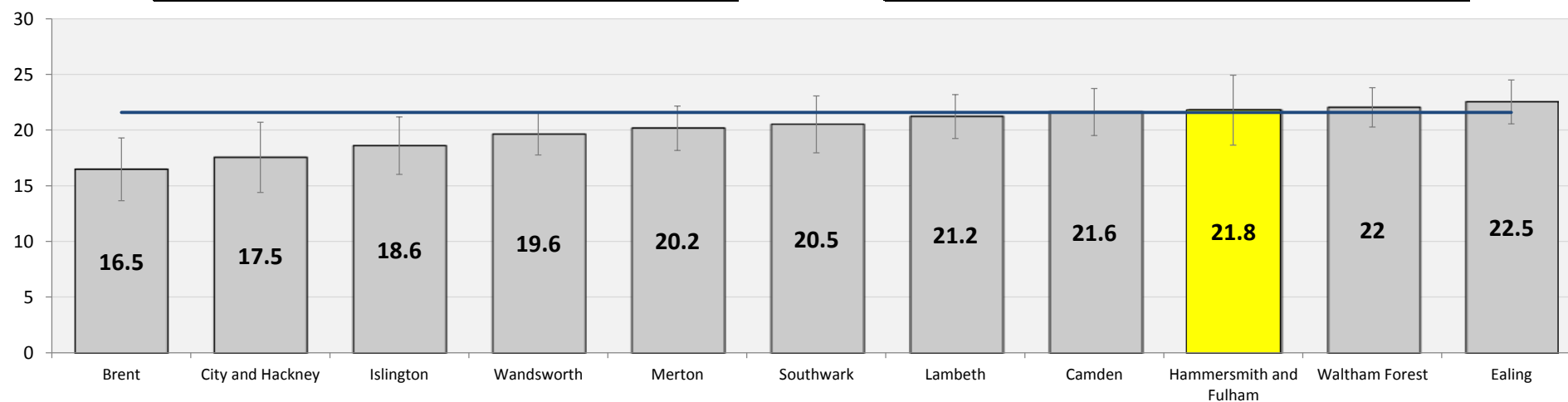


England

21.4

Best 5

21.6



Definition: Hip replacement, Oxford Hip Score, Health Gain

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

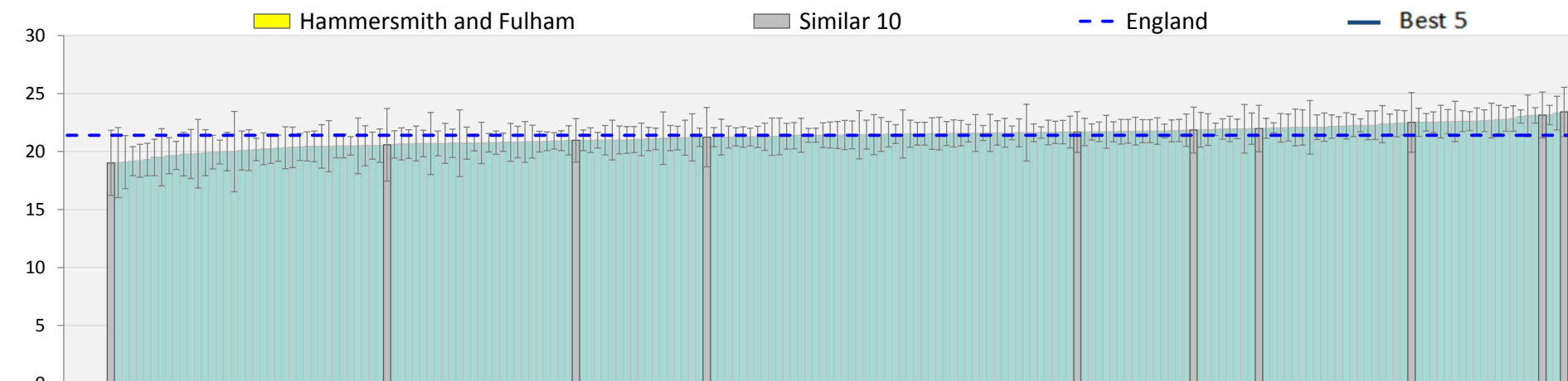
Year: 2014/15

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

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

No Data

129

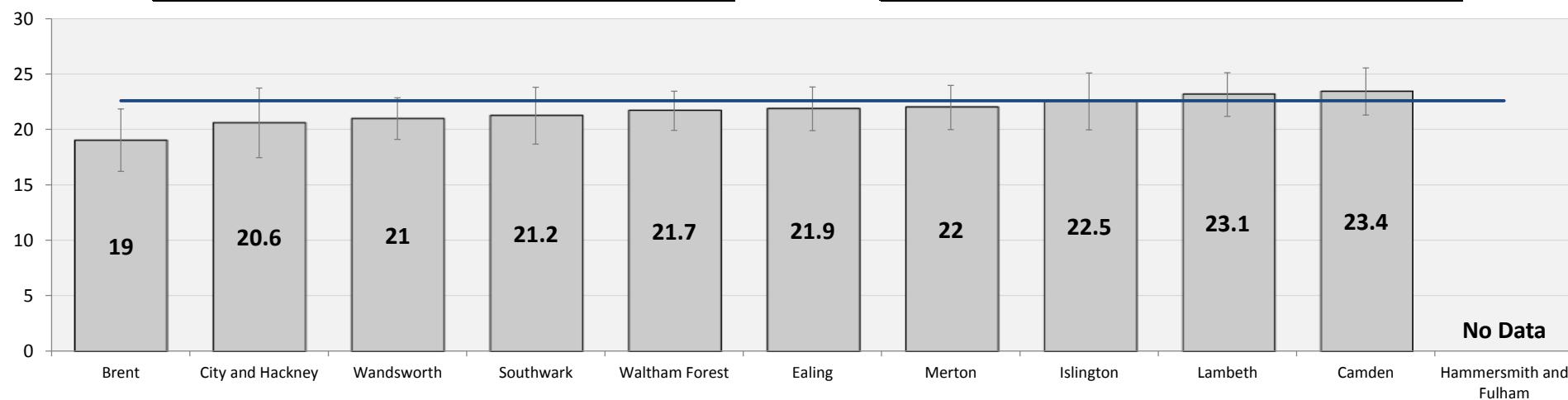


England

21.4

Best 5

22.6

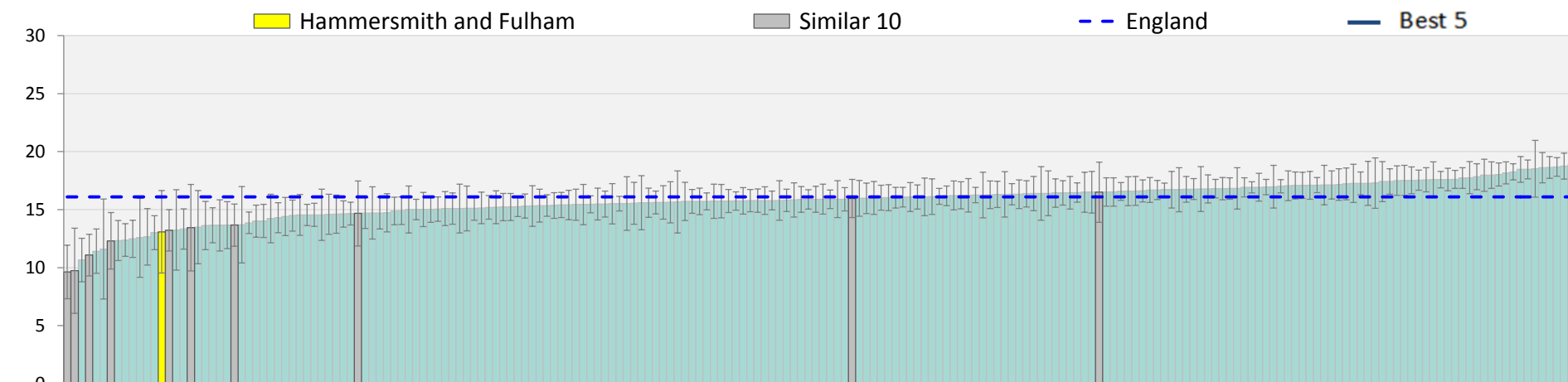


Definition: Hip replacement, Oxford Hip Score, Health Gain (casemix adjusted)
Source: Patient Reported Outcome Measures (PROMs), The Health and Social Care Information Centre
Year: 2014/15

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

Oxford score - Knee (primary) - Health gain

130

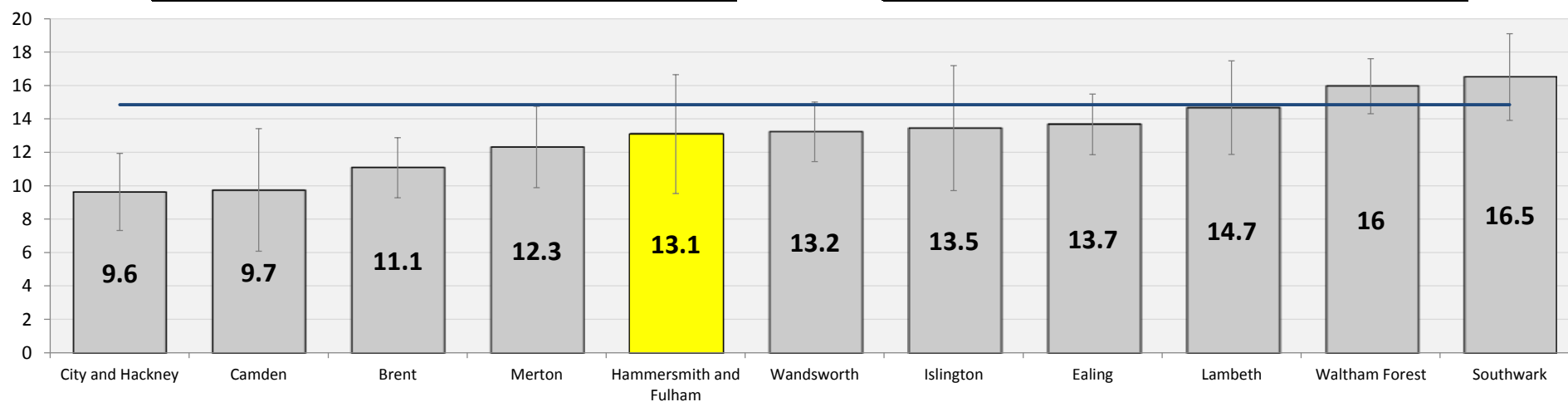


England

16.1

Best 5

14.9



Definition: Knee replacement, Oxford Knee Score, Health Gain

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

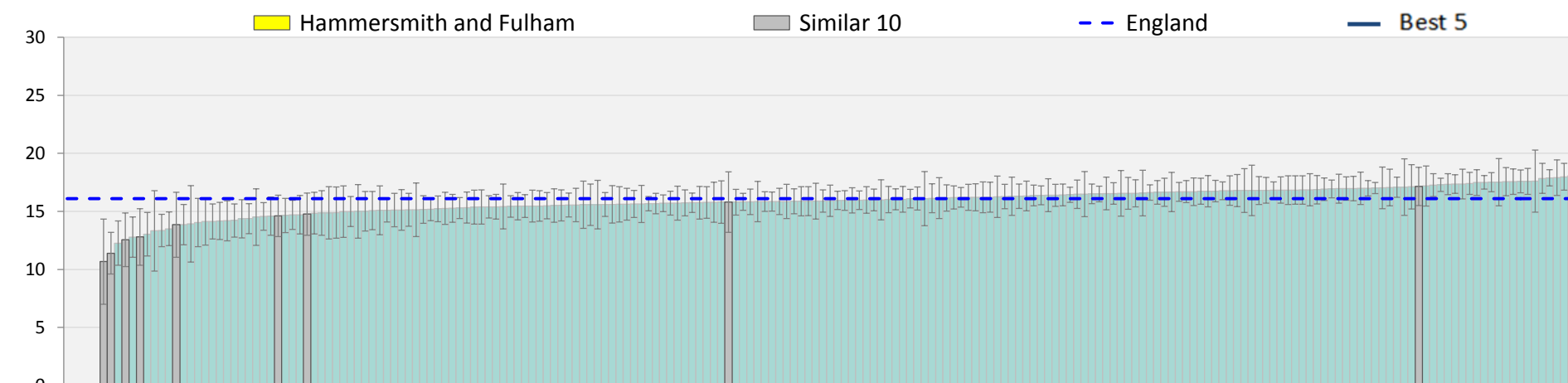
Year: 2014/15

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

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

No Data

131

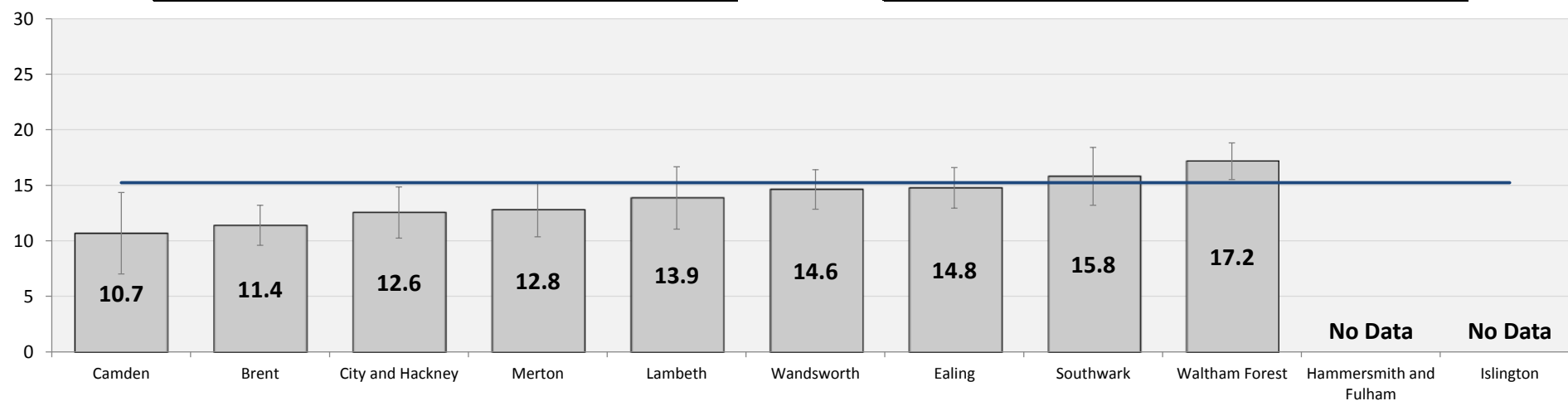


England

16.1

Best 5

15.2



Definition:

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

Source:

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

Year:

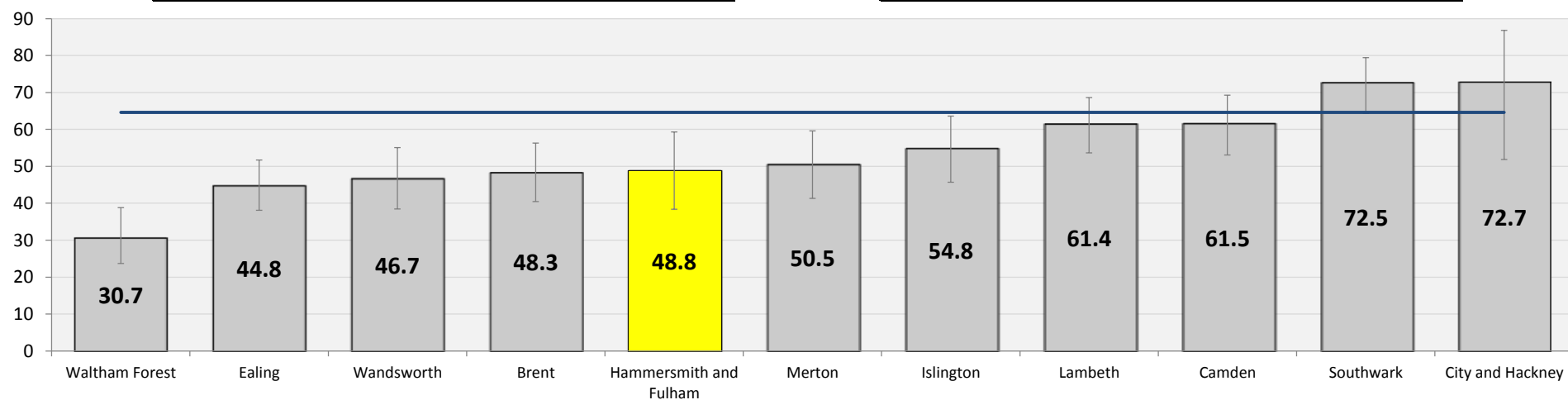
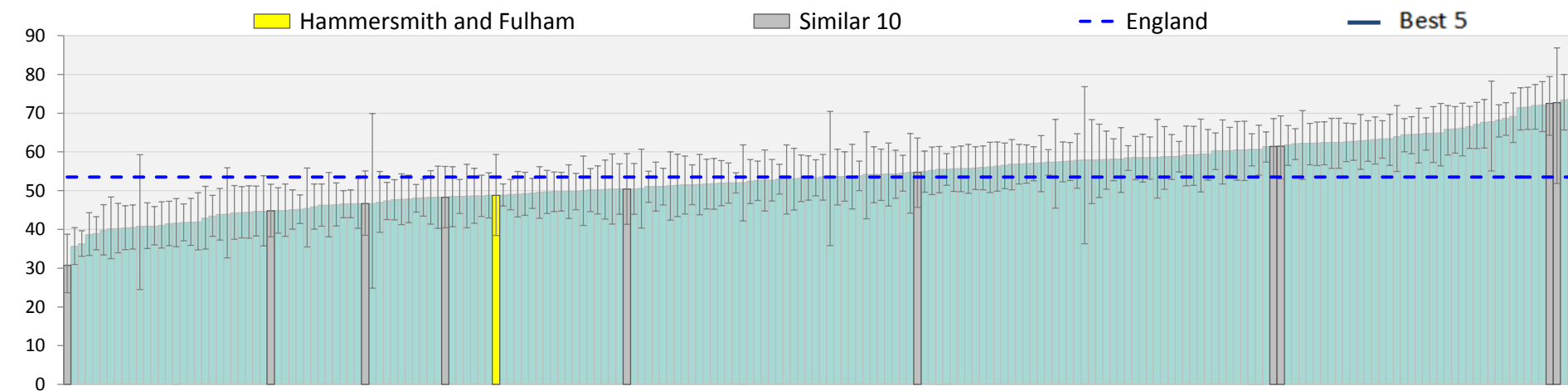
2014/15

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

% fractured femur patients returning home within 28 days

13 Pats

132

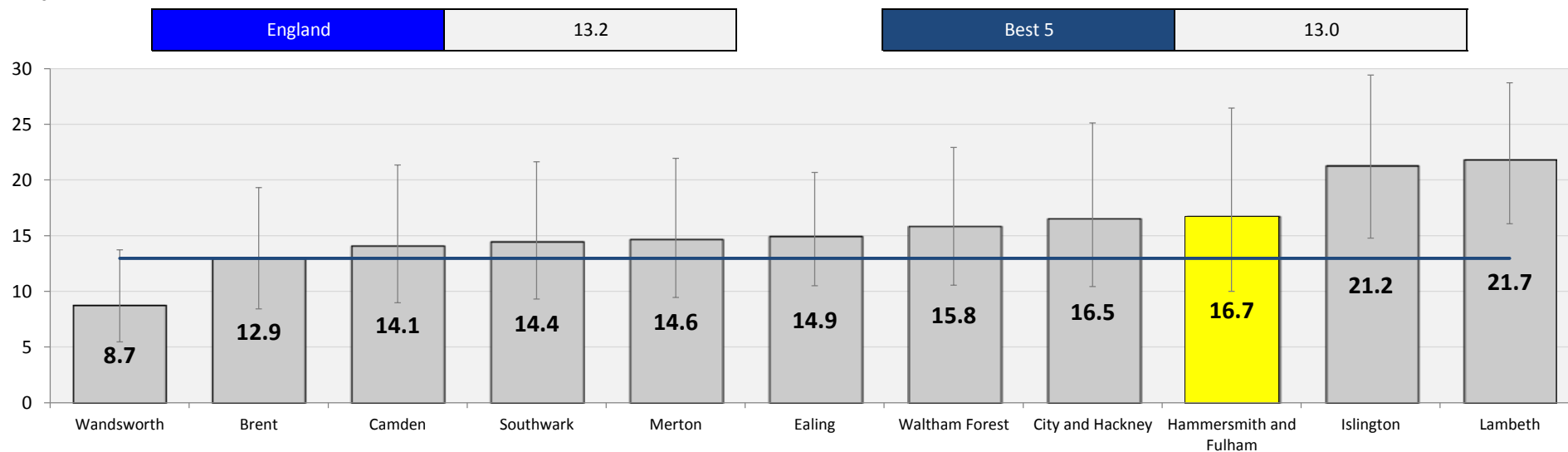
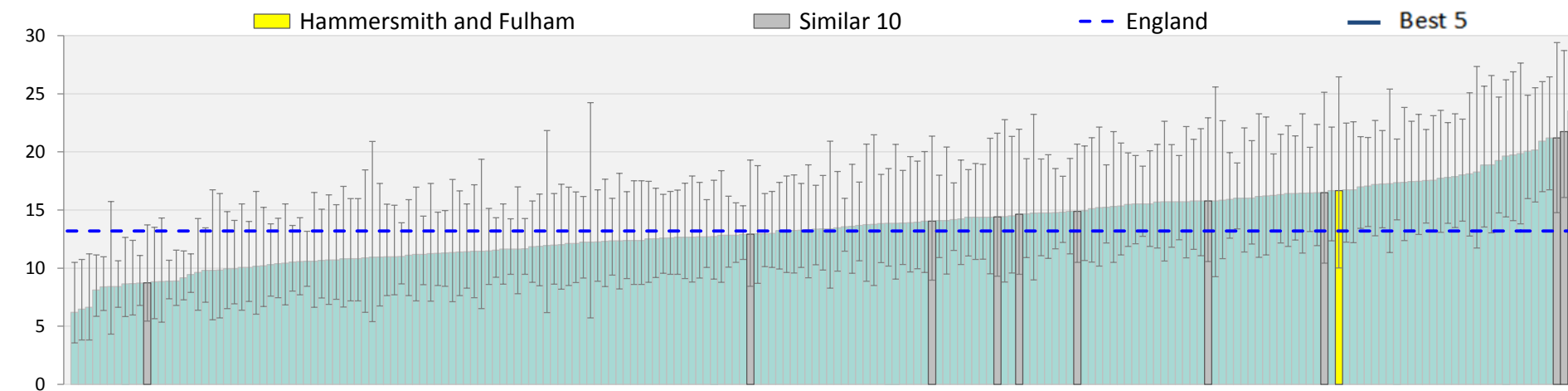


Definition: Percentage of patients returning to usual place of residence following hospital treatment for fractured femur
 Source: Hospital Episode statistics (HES)
 Year: 2014/15

Hip fracture emergency readmissions 28 days (%)

3 Pats (NSS)

133

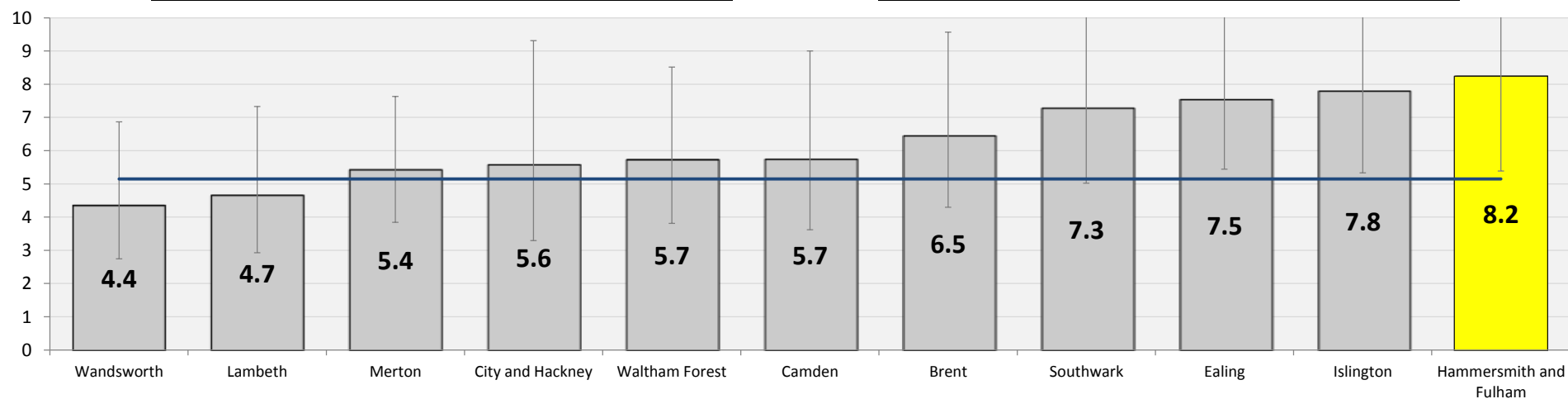
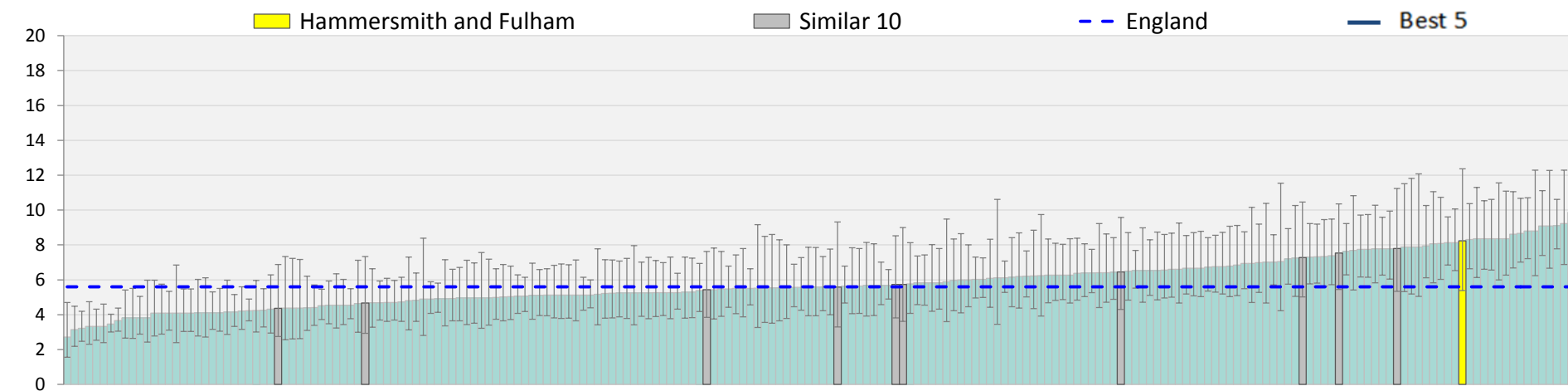


Definition: Emergency readmissions to hospital within 28 days for patients: hip fractures
 Source: Hospital Episode statistics (HES)
 Year: 2014/15

Hip replacement emergency readmissions 28 days (%)

7 Pats

134



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

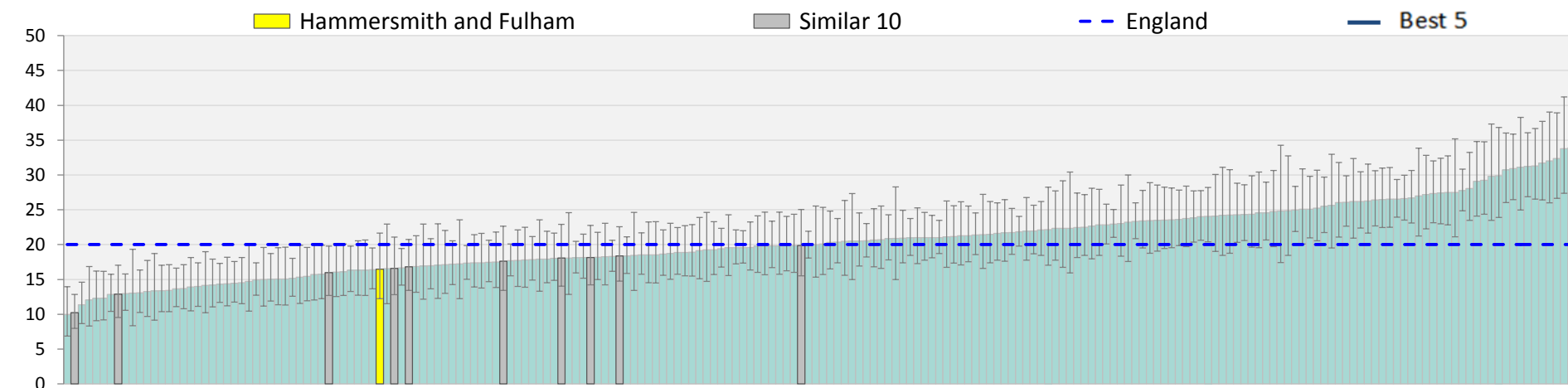
Source: Hospital Episode Statistics (HES), The Health and Social Care Information Centre. The Indicator Portal, The Health and Social Care Information Centre

Year: 2009/10-2011/12

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

4 Lives (NSS)

135

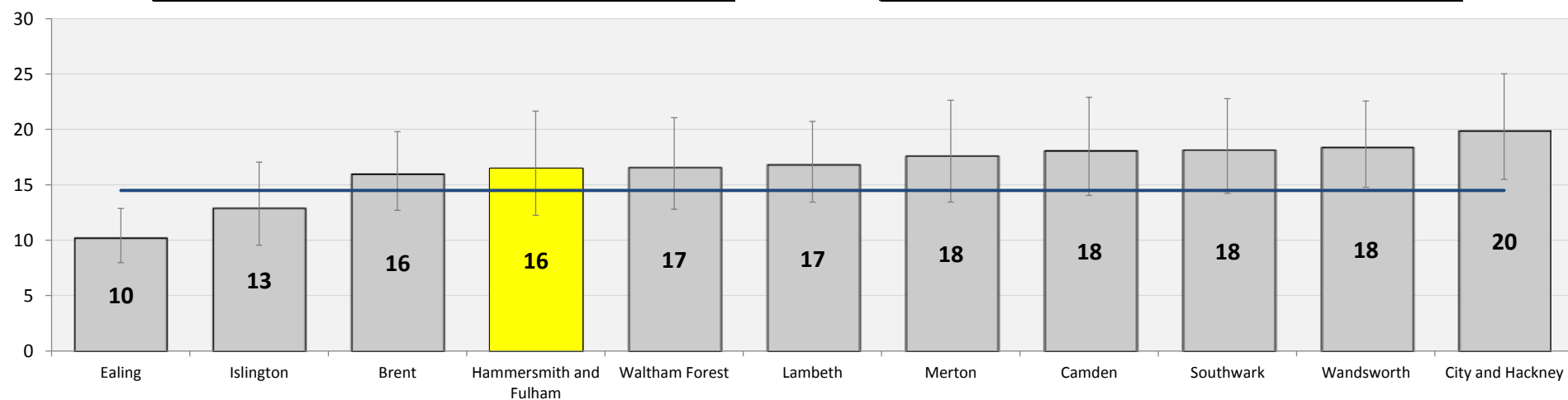


England

20.0

Best 5

14.0

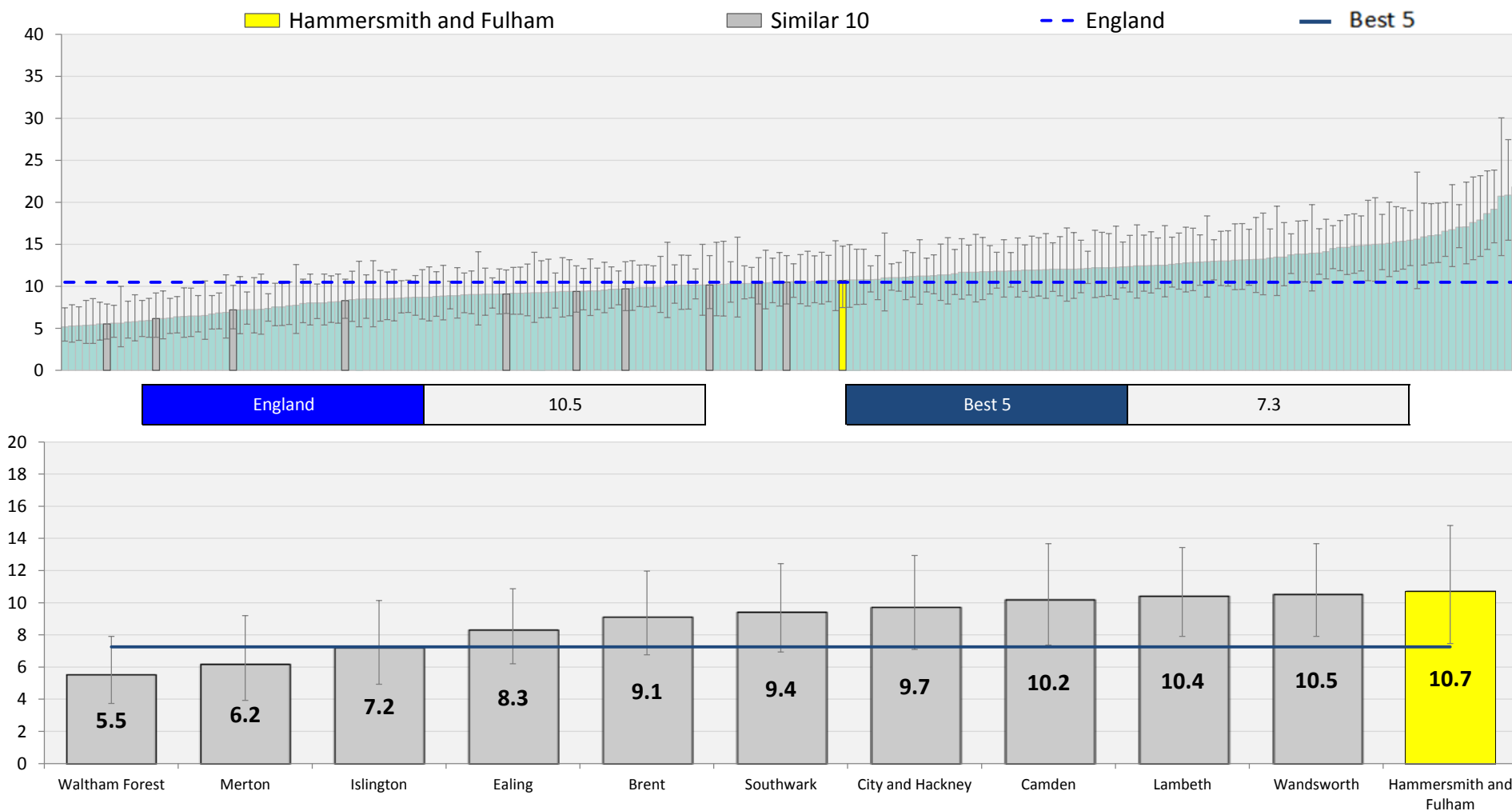


Definition: Mortality from accidents: all age directly age-standardised rates (DSR) per 100,000 European Standard Population
 Source: Primary Care Mortality Database, HSCIC
 Year: 2011-13

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

4 Lives

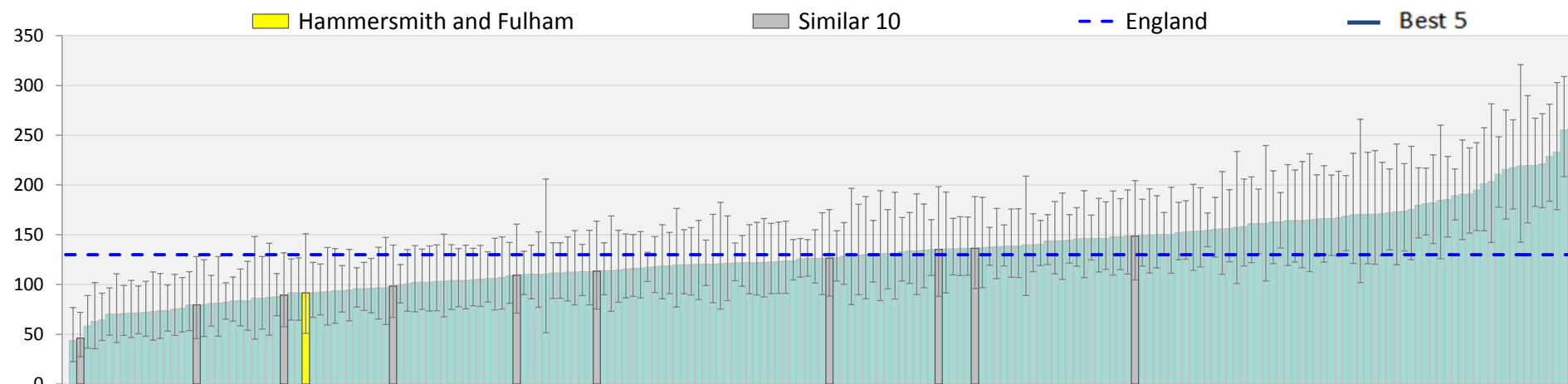
136



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)

137

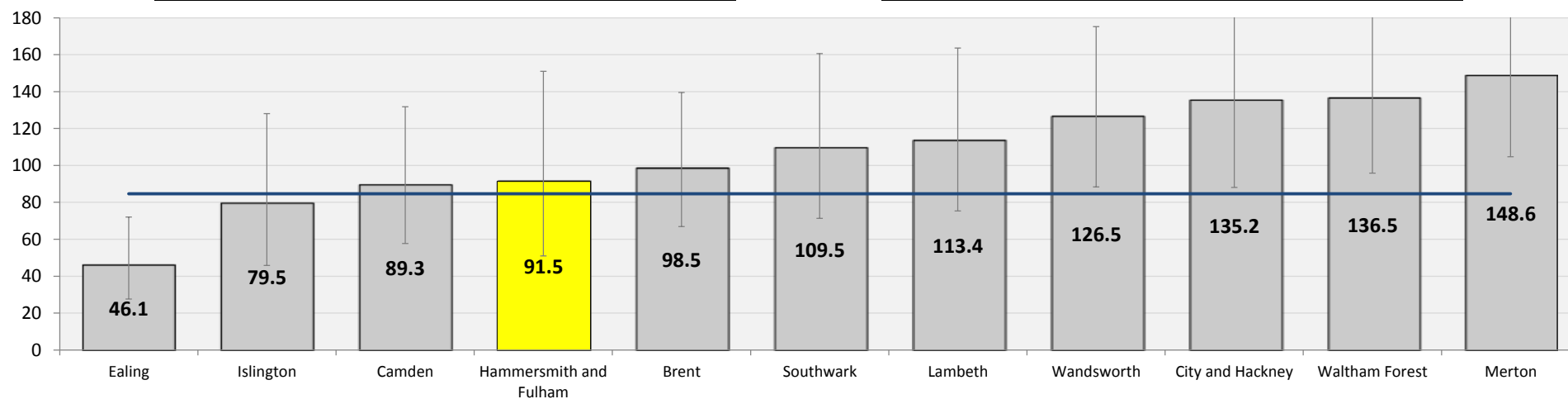


England

130.0

Best 5

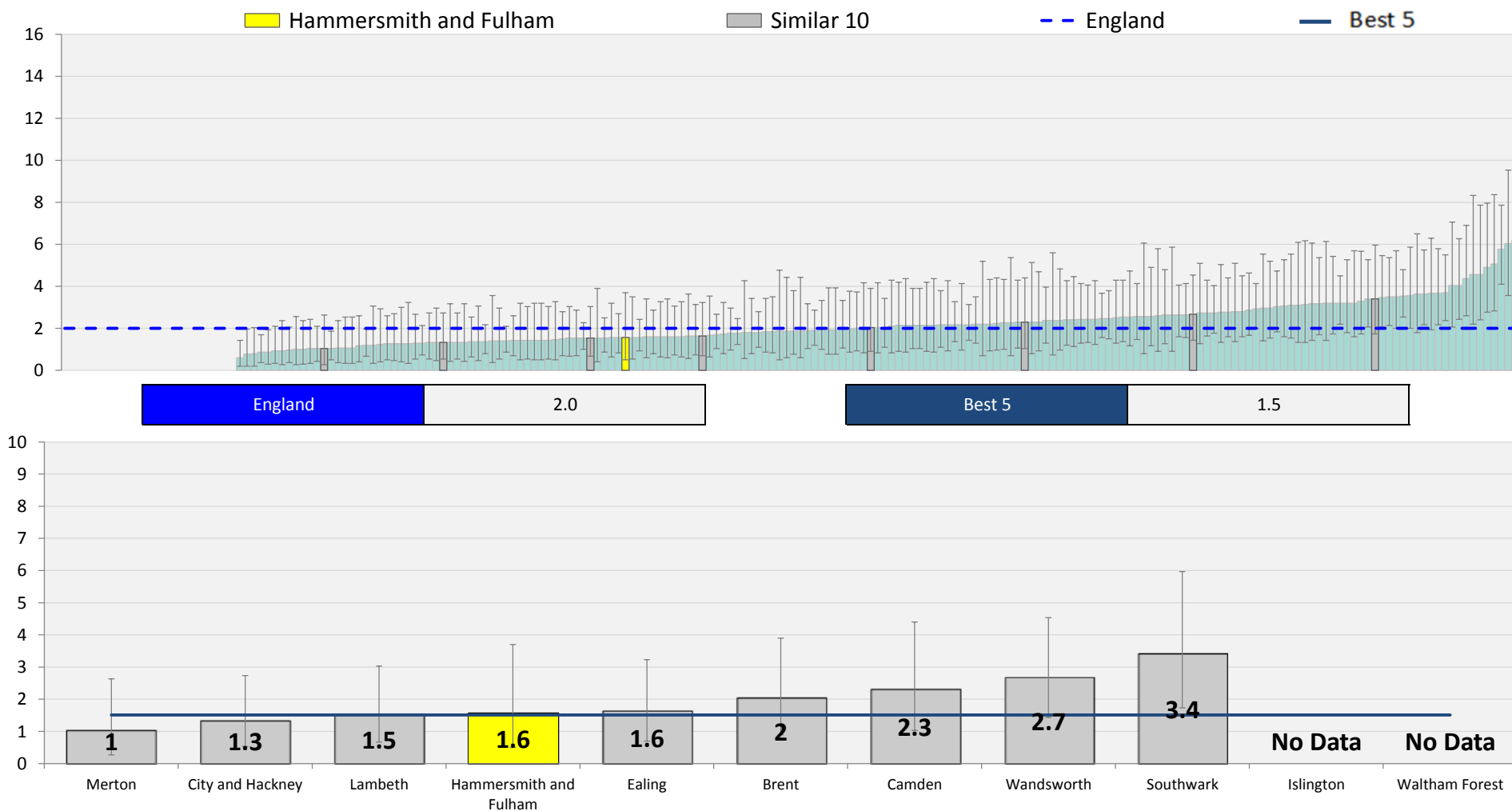
84.6



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)

138

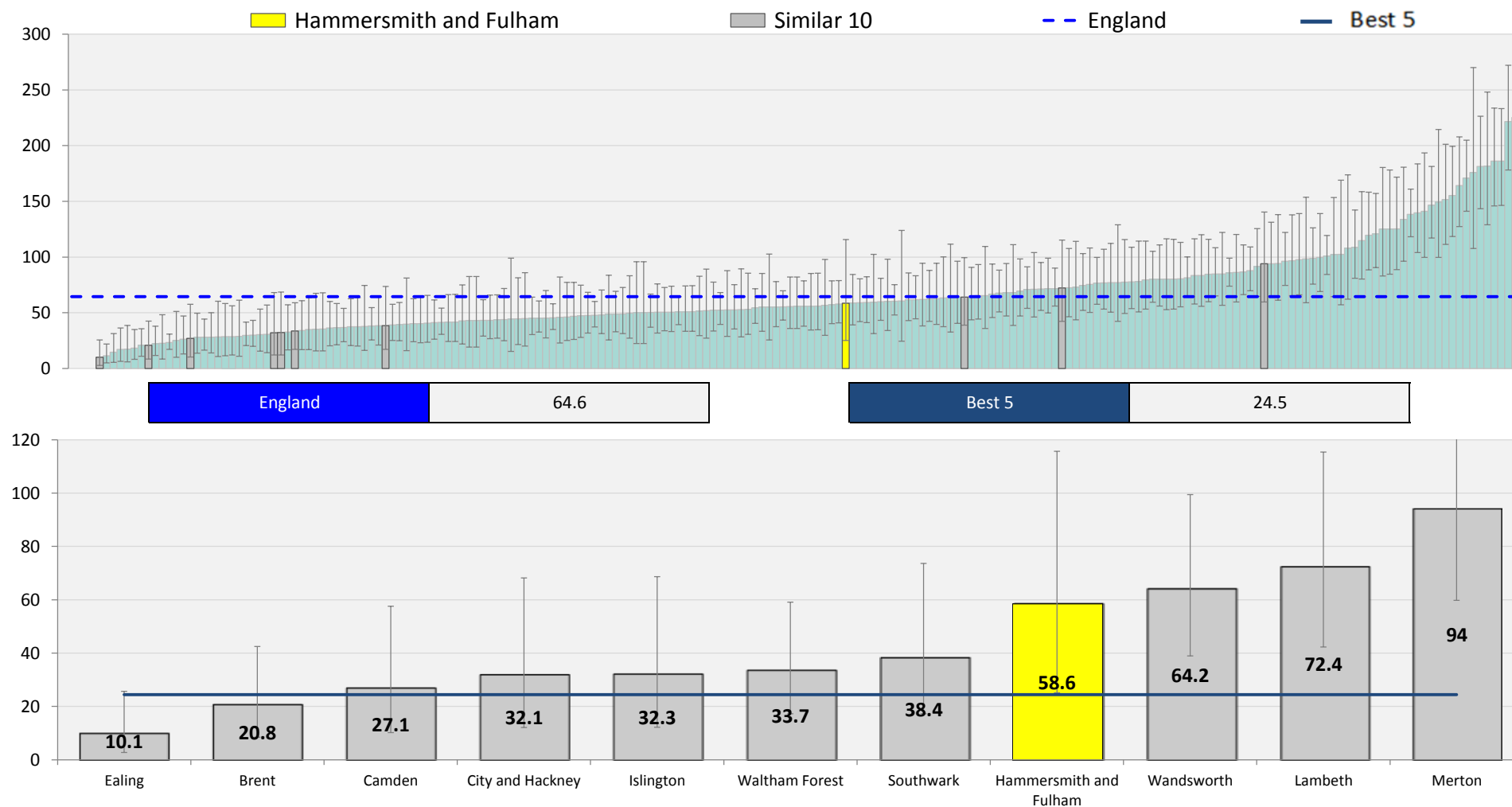


Definition: Mortality from accidental falls: Under 75 Directly age-standardised rates (DSR) per 100,000 European Standard population
 Source: Primary Care Mortality Database, HSCIC
 Year: 2011-13

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

1 Lives

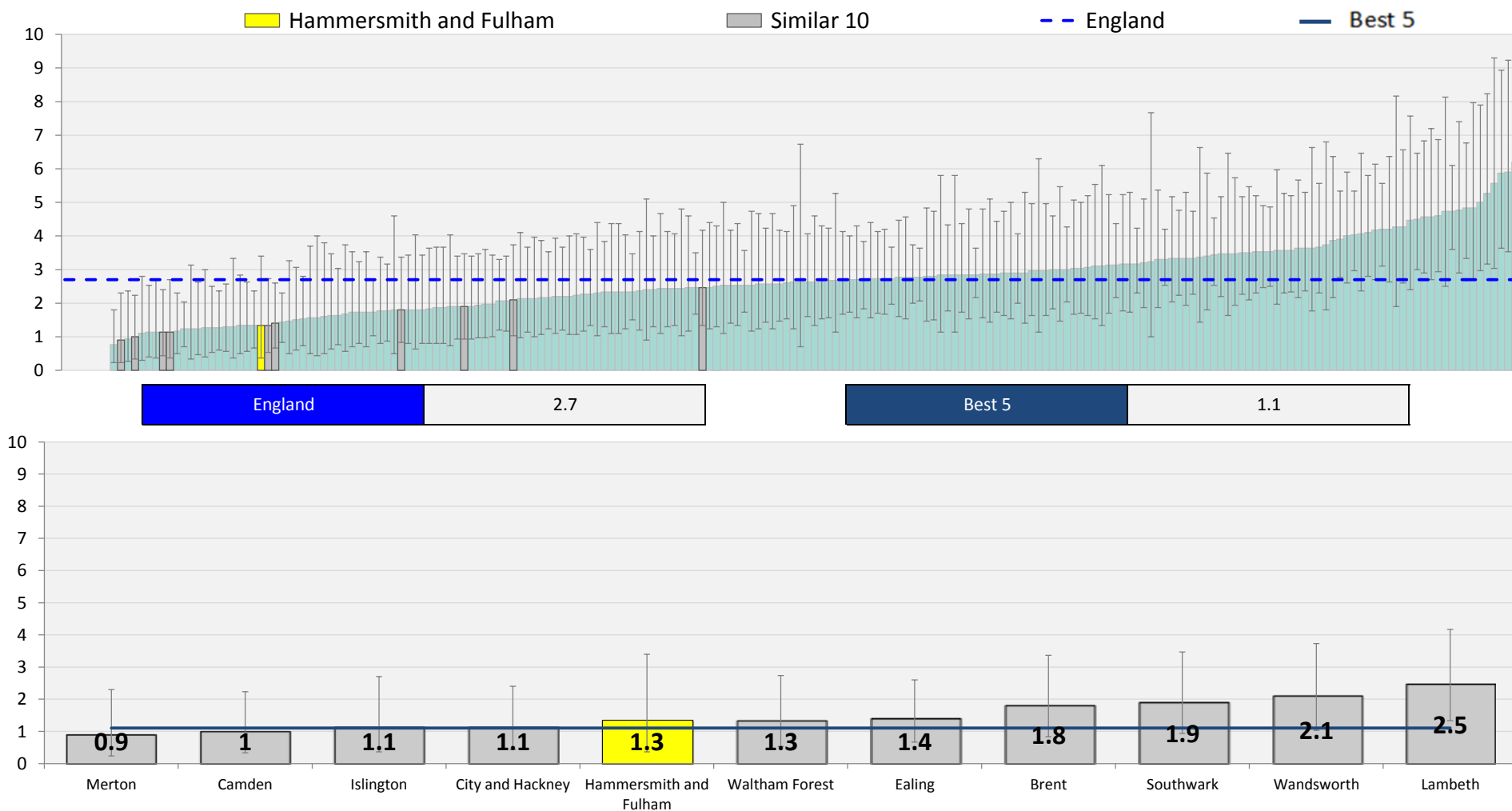
139



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)

140

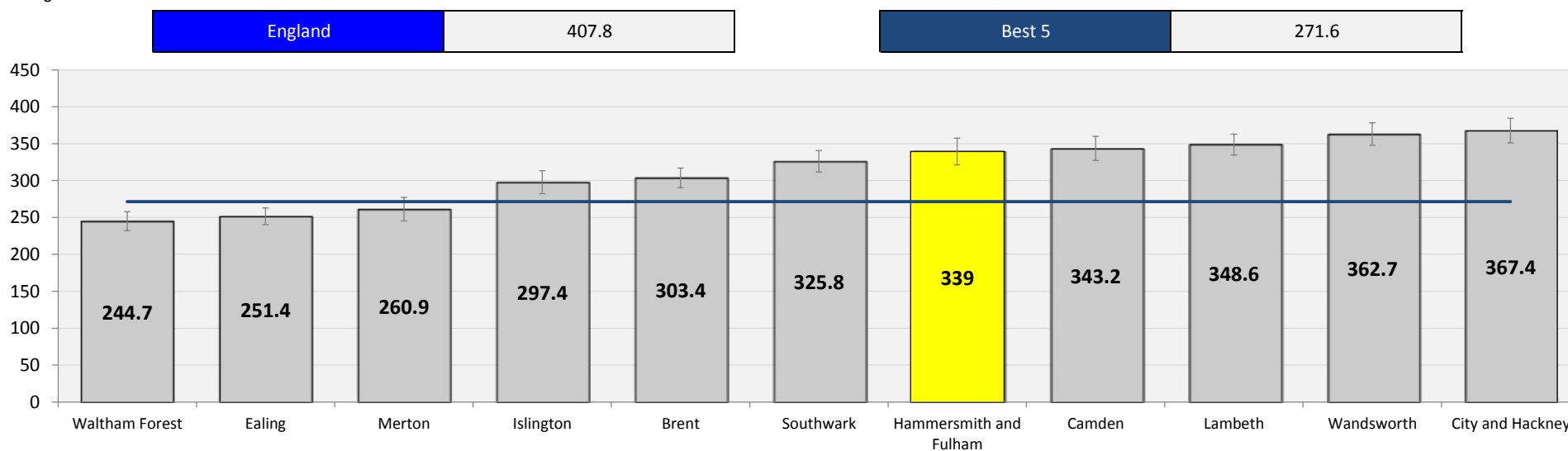
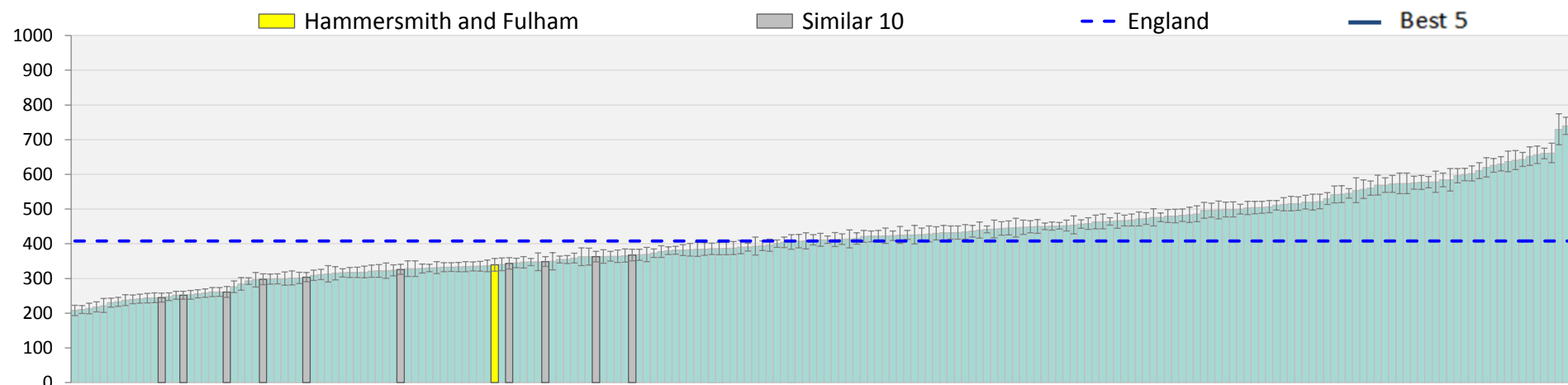


Definition: Mortality from transport accidents: Directly age-standardised rates (DSR) per 100,000 European Standard population
 Source: Primary Care Mortality Database, HSCIC
 Year: 2011-13

Life years lost Accidents (all)

87 Life years

141

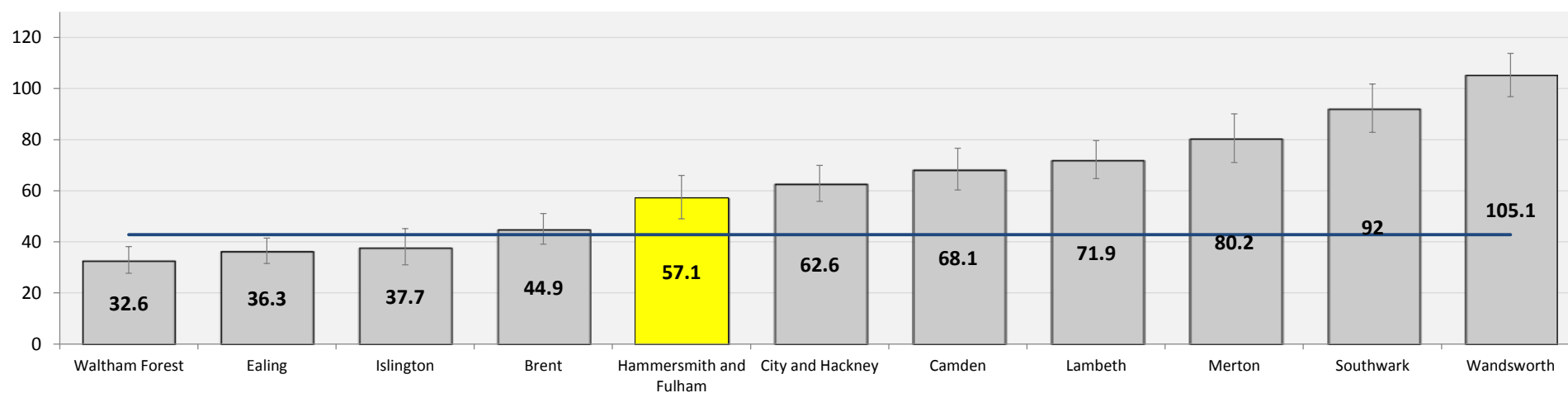
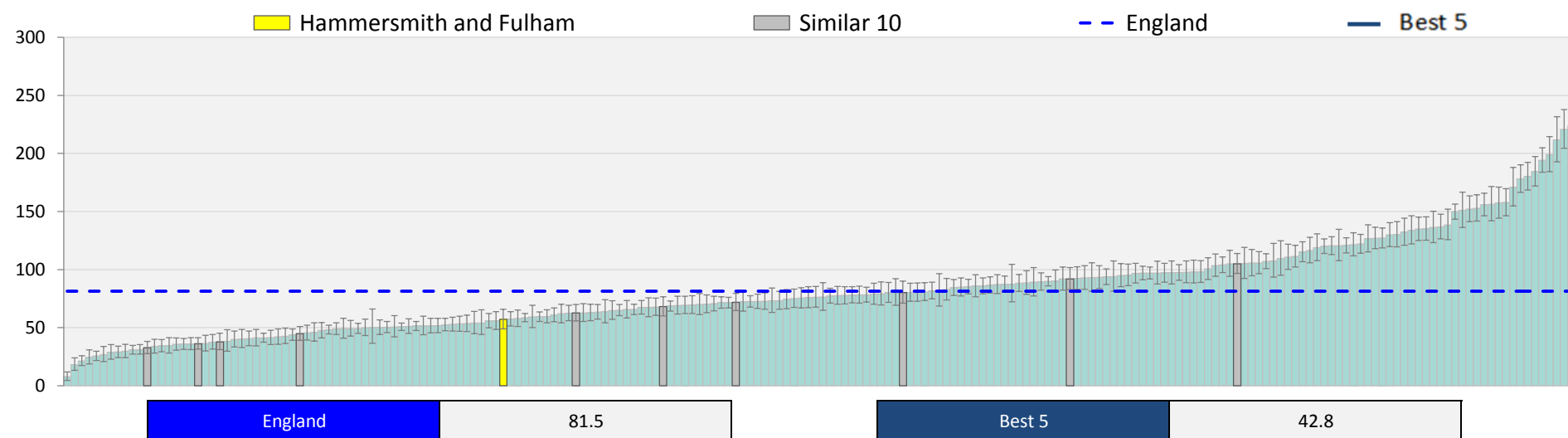


Definition: Years of life lost due to mortality from accidents: Directly age-standardised rates (DSR) per 100,000 European Standard population
 Source: Primary Care Mortality Database, HSCIC
 Year: 2011-13

Life years lost falls (all)

4 Life years

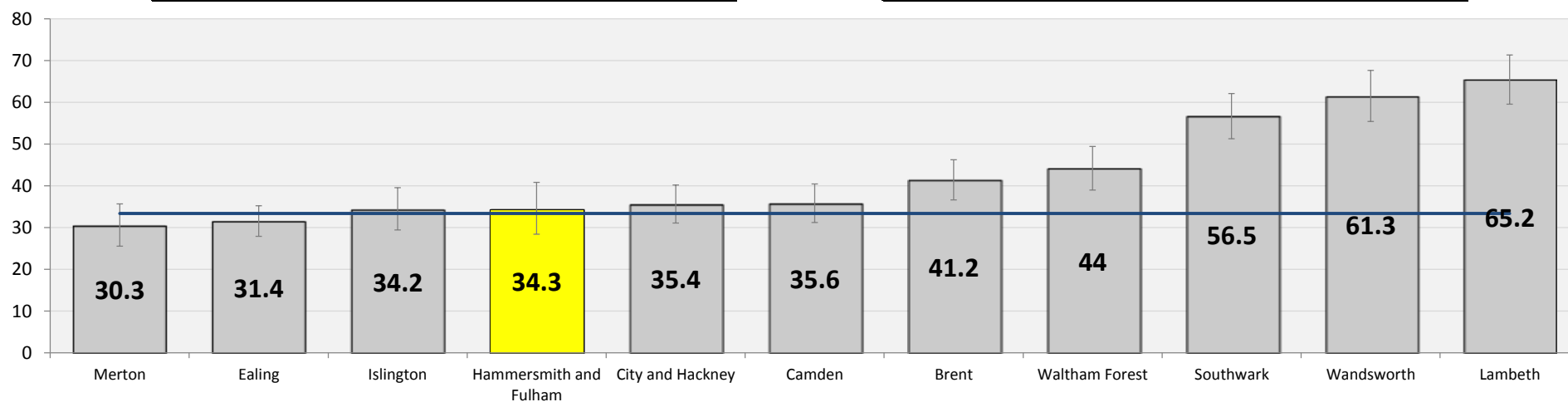
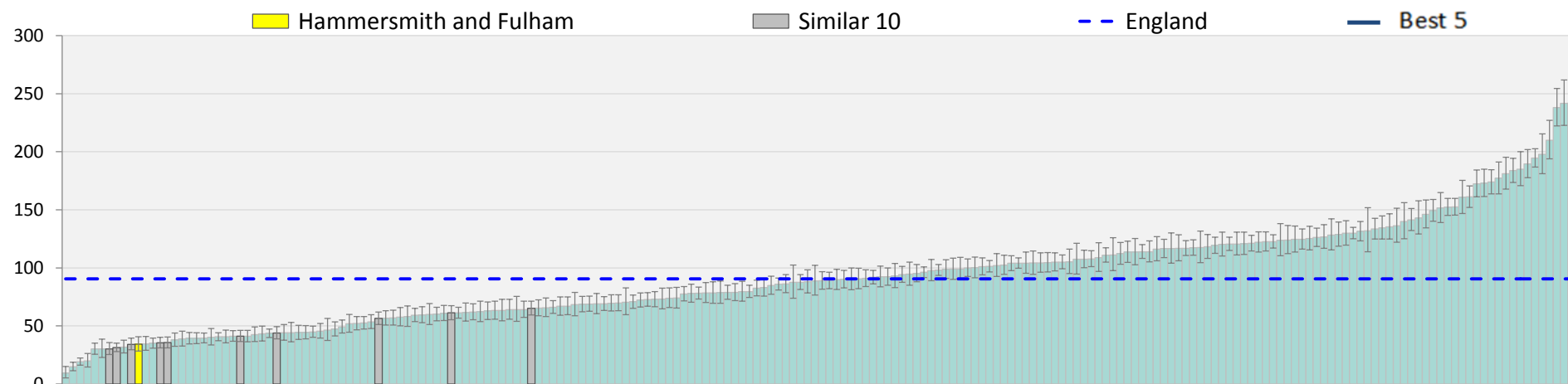
142



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)

143



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

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

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

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

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

Arthritis Research UK:

<http://www.arthritisresearchuk.org/>

National Osteoporosis Society:

<https://www.nos.org.uk/>

North East Quality Observatory Service:

<http://www.negos.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

150

| 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

151

| 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

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.

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

154

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

155

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 |

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 |

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

158

| 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 |

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

160

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

161

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 |

| 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 |

| 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

164

| 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

166

| | |
|------------------------|---|
| 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

167

| | |
|------------------------|---|
| 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

168

| | |
|------------------------|--|
| 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

169

| | |
|------------------------|---|
| 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

170

| | |
|------------------------|---|
| 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.

| | |
|------------------|--|
| 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

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’.

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?

176

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:

$$\text{Potential Opportunity} = (\text{CCG Value} - \text{Benchmark Value}) * \text{Denominator}$$

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.