



# NHS RightCare Commissioning for Value Focus Pack

Cardiovascular Disease  
April 2016

- Introduction: Welcome to your focus pack
- NHS RightCare
- Why act?
- Commissioning for Value
- Your most similar CCGs
- Being more ambitious
- 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 cardiovascular disease (CVD). 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 CVD. 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 and the CCG Improvement and Assessment Framework.

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**

“Cardiovascular disease is a frequent cause of premature mortality and comorbidity, with significant variations in rates of detection, management and healthcare expenditure around the country, some of which is unwarranted. These packs offer important regional insights and, along with RightCare, support clinicians and commissioners in identifying areas where greater value and better outcomes may be realised.”

**Professor Huon H Gray**  
**National Clinical Director for Heart Disease, 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.

# Your most similar CCGs

7

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:

- Kernow
- Gloucestershire
- Wiltshire
- West Hampshire
- Cumbria
- Ipswich and East Suffolk
- Coastal West Sussex
- South Worcestershire
- East Riding of Yorkshire
- Southern Derbyshire

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:

- Larger CCGs with older populations and more rural areas

High blood pressure (hypertension) is one of the leading risk factors for premature death and disability. Diseases caused by high blood pressure cost the NHS over £2billion every year. Aside from all the other opportunities identified in this pack, just by reducing the blood pressure of the nation, £850million of NHS and social care spend could be avoided over 10 years.

International comparison shows that improvement is possible. Only around four in ten adults in England with high blood pressure are both diagnosed and controlled to recommended levels. The rate achieved in Canada is seven in ten (achieved with similar resources).

If the average CCG matched the achievement of Canada nearly 3 million more people would have their hypertension detected and their blood pressure controlled. This would prevent an estimated 44,600 strokes, 29,900 heart attacks, 62,300 cases of heart failure and 23,900 deaths over a five year period\*.

The Hypertension Profiles document produced by the National Cardiovascular Intelligence Network, Public Health England (PHE) includes an estimate for your CCG of the opportunity to match Canadian performance and also includes key approaches to consider to reduce prevalence, increase detection and manage hypertension.

\* <http://www.yhpho.org.uk/hypertensionccg/default.aspx>  
<http://www.yhpho.org.uk/resource/view.aspx?RID=226091>



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 the National Cardiovascular Intelligence Network.

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.

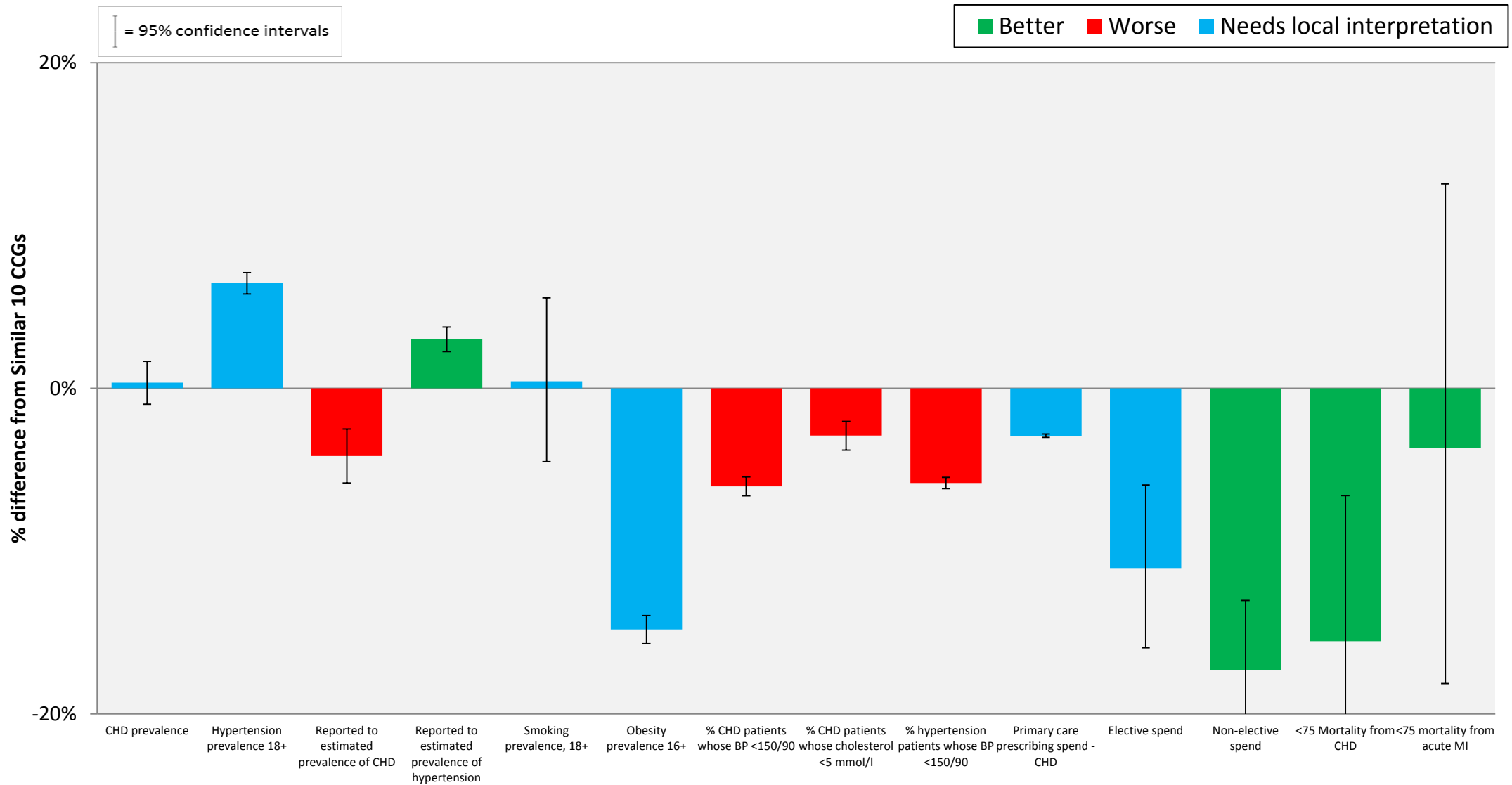
\*As the spend indicators have been updated since the publication of the 2016 refreshed 'Where to look' packs, figures for spend rates and potential opportunities may differ slightly from those packs

The indicators on the following pages are identical to the CVD related 'pathways on a page' from the previous Commissioning for Value packs; 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 72, 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.



## NICE Guidance:

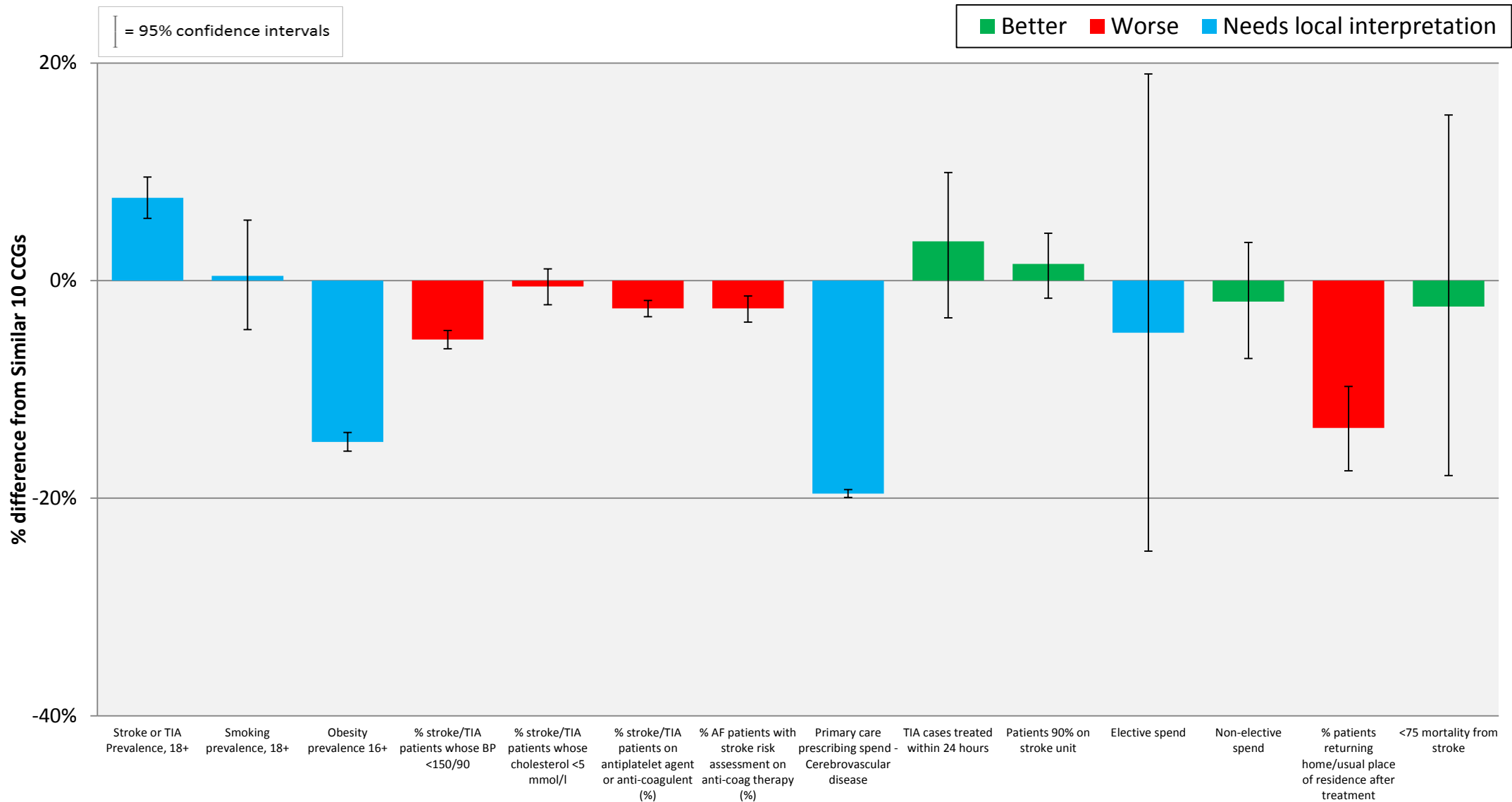
<http://pathways.nice.org.uk/>

NICE Pathways on: Hypertension, Cardiovascular Disease and Smoking

NHS RightCare CFV Cardiovascular disease focus pack

## PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-hf.aspx>



**NICE Guidance:**

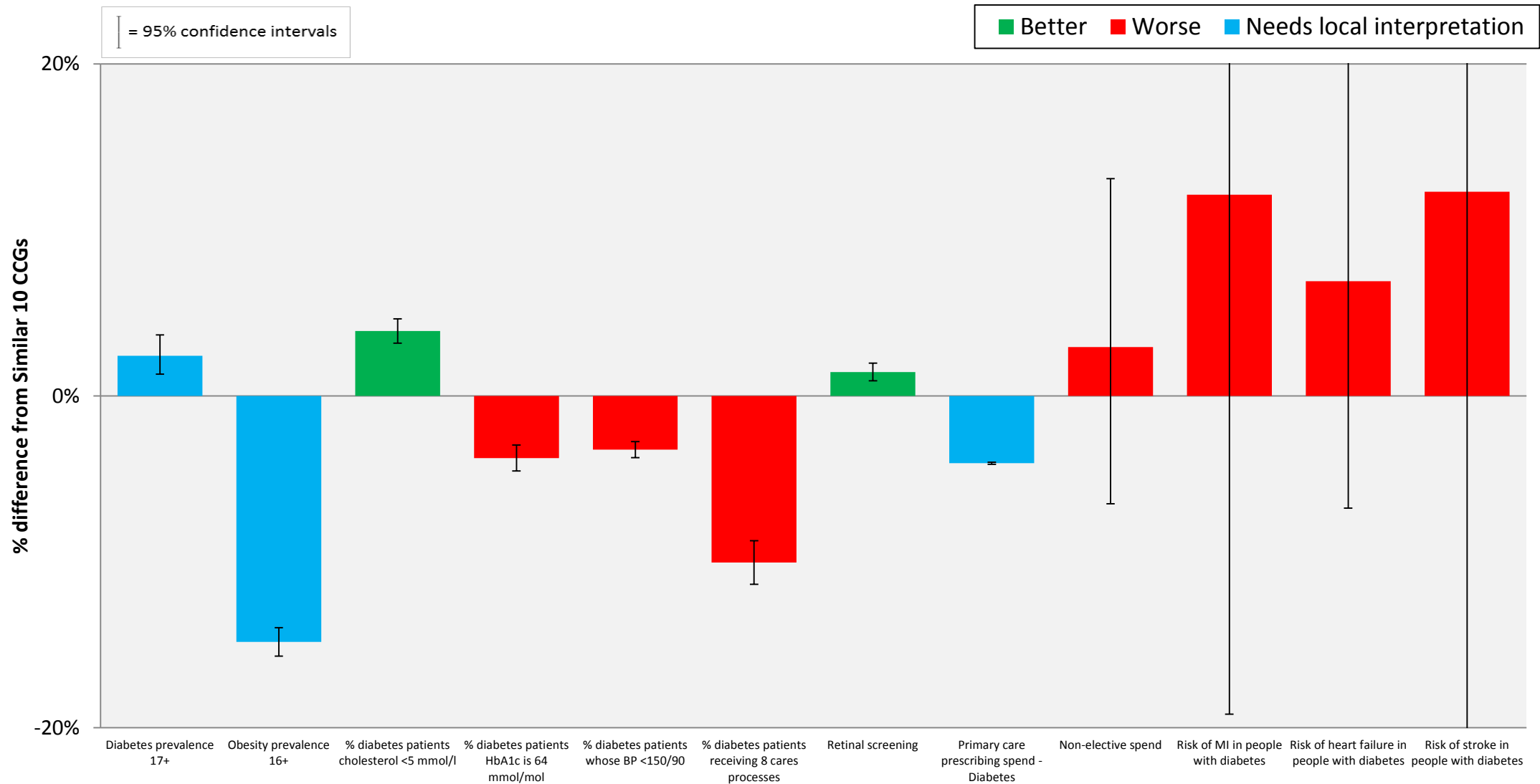
<http://pathways.nice.org.uk/pathways/stroke>

NHS RightCare CFV Cardiovascular disease focus pack

**PRIMIS Toolkit:**

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/grasp-suite/grasp-af/grasp-af.aspx>

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/warfarin-patient-safety.aspx>



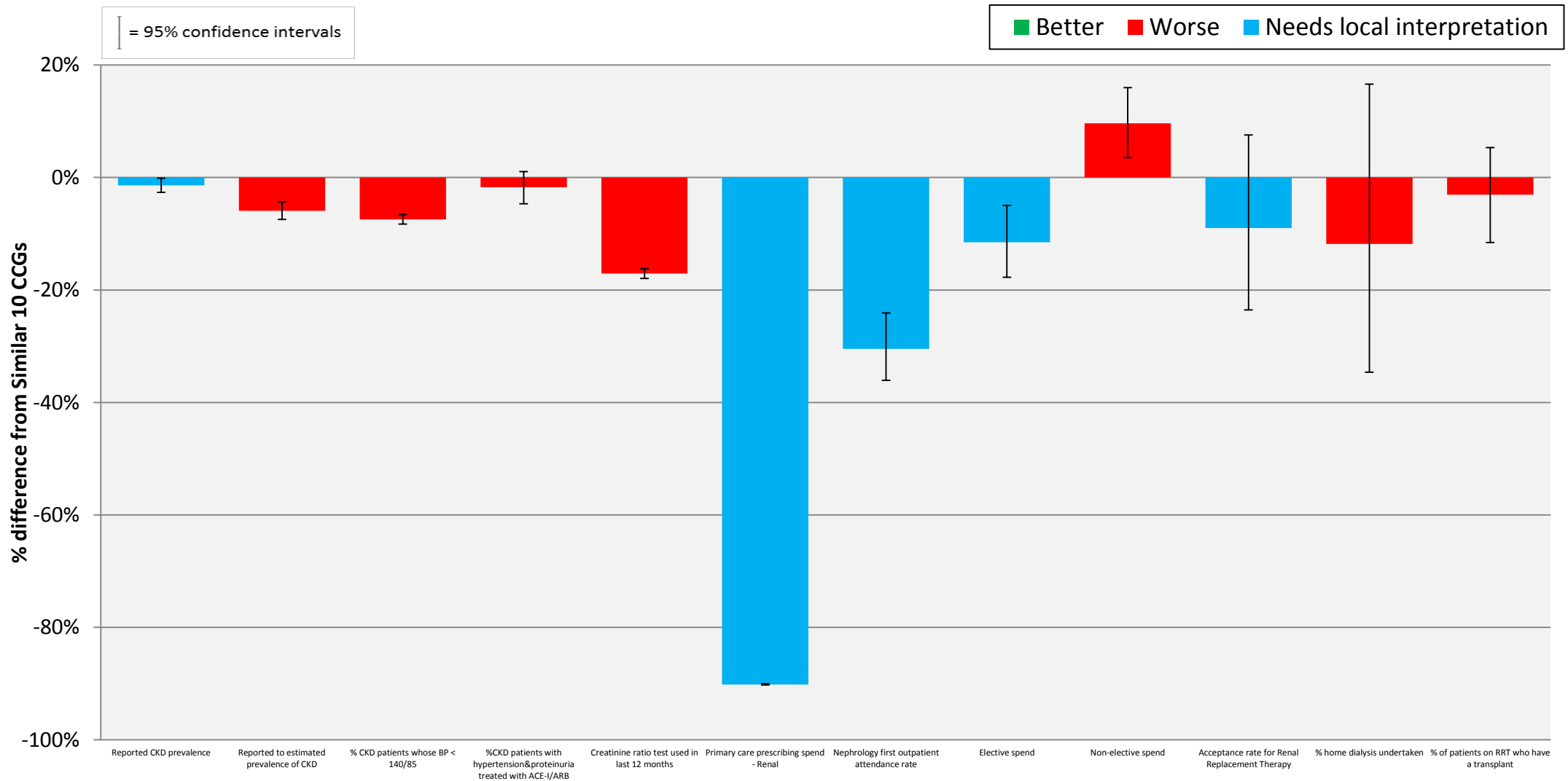
## NICE Guidance:

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

NHS RightCare CFV Cardiovascular focus pack

## PRIMIS Toolkit:

<http://www.nottingham.ac.uk/primis/tools-audits/tools-audits/diabetes-care.aspx>



## NICE Guidance:

<http://pathways.nice.org.uk/pathways/chronic-kidney-disease>

<http://pathways.nice.org.uk/pathways/acute-kidney-injury>

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) and 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. For example a CCG with a high rate of spend on emergency admissions for epilepsy patients may want to look at the QOF indicator on those who have been seizure free in the last 12 months.

The opportunity tables, starting on page 72, identify the best CCG in your similar 10, who you may want to contact – either directly or through your Delivery Partner.

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.

# Problems of Circulation - Spend

16



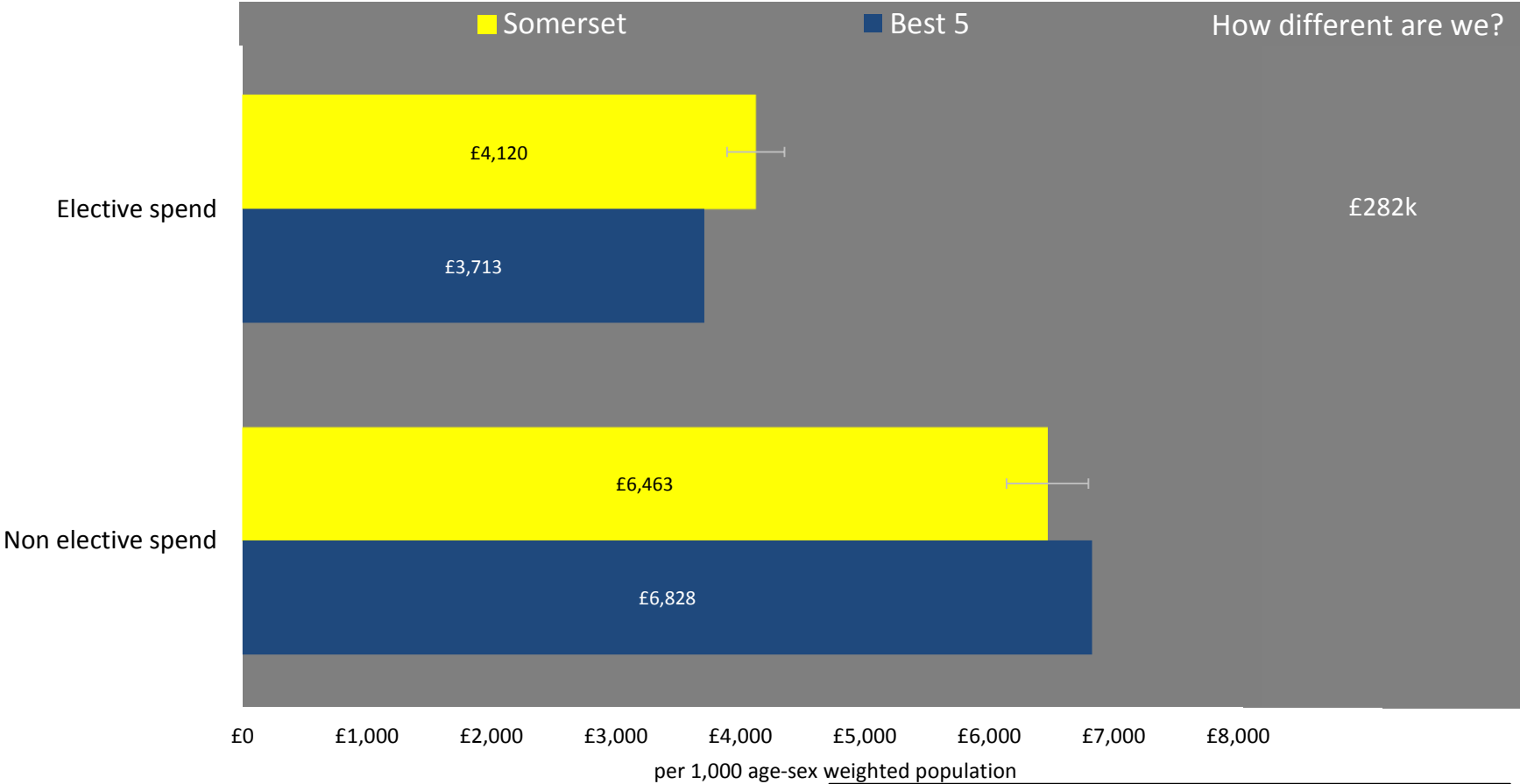
95% confidence intervals

**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



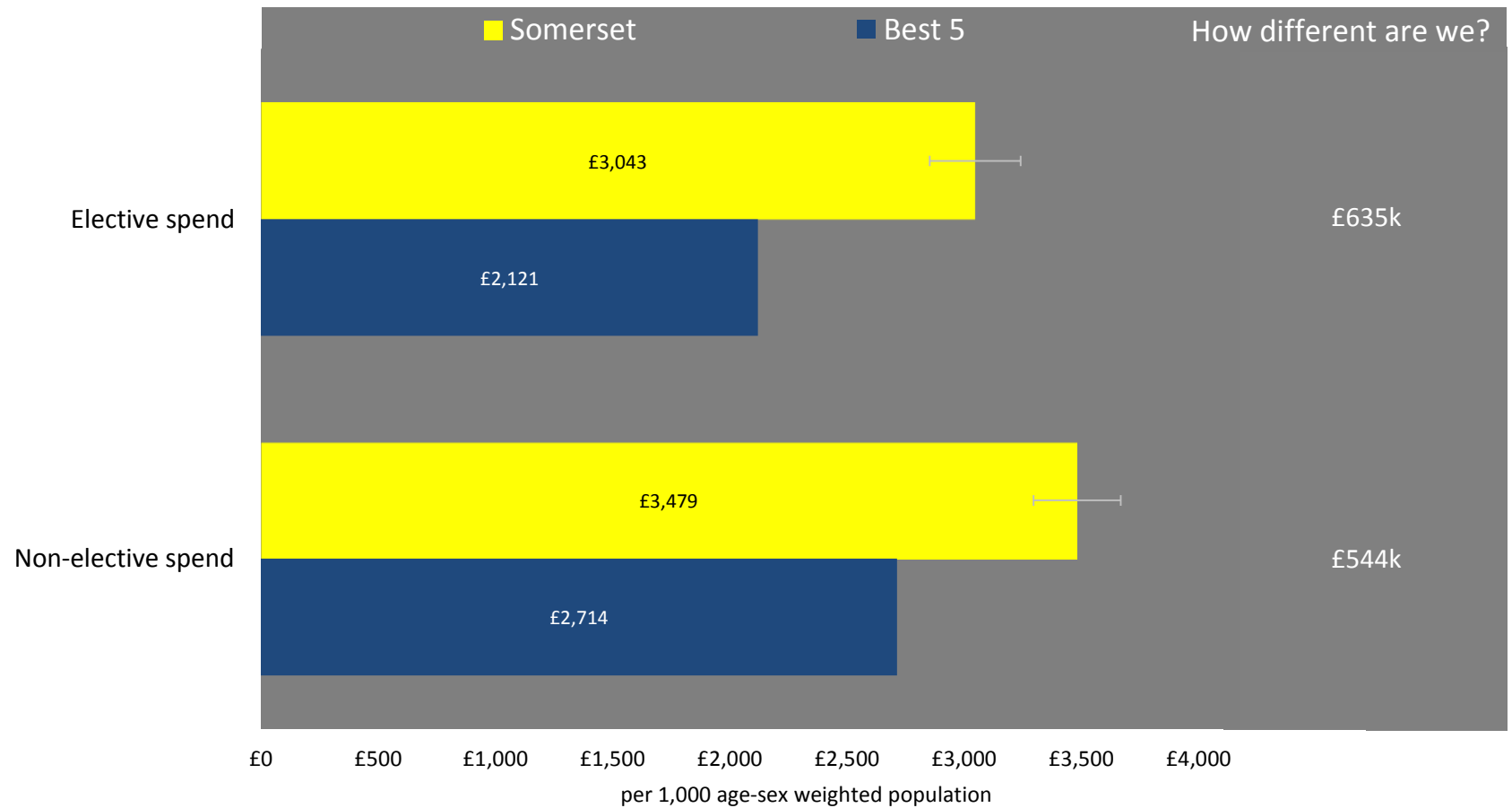
# Coronary Heart Disease - Spend



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

# Problems of Rhythm - Spend

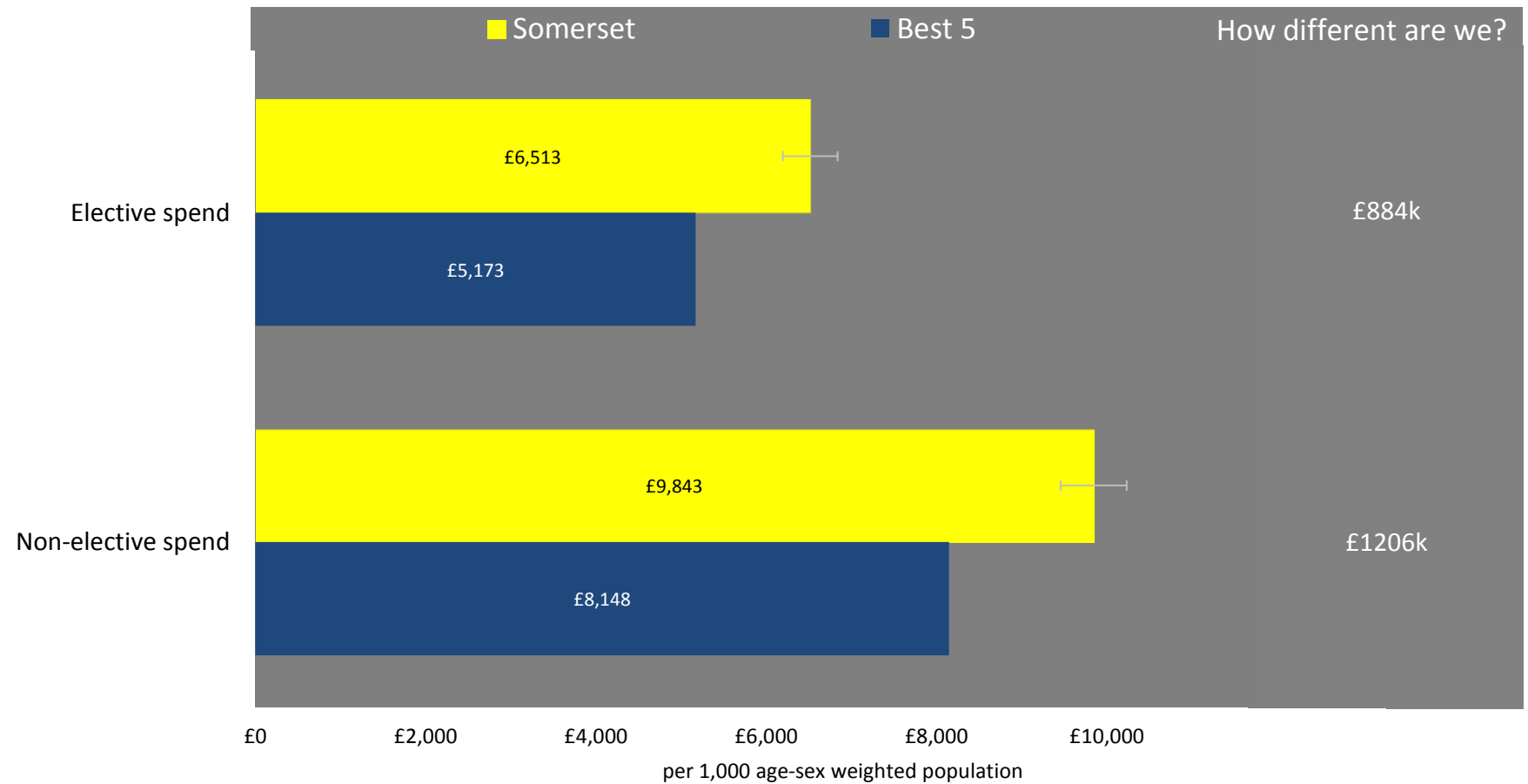
18



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

# Other Circulatory problems - Spend

19



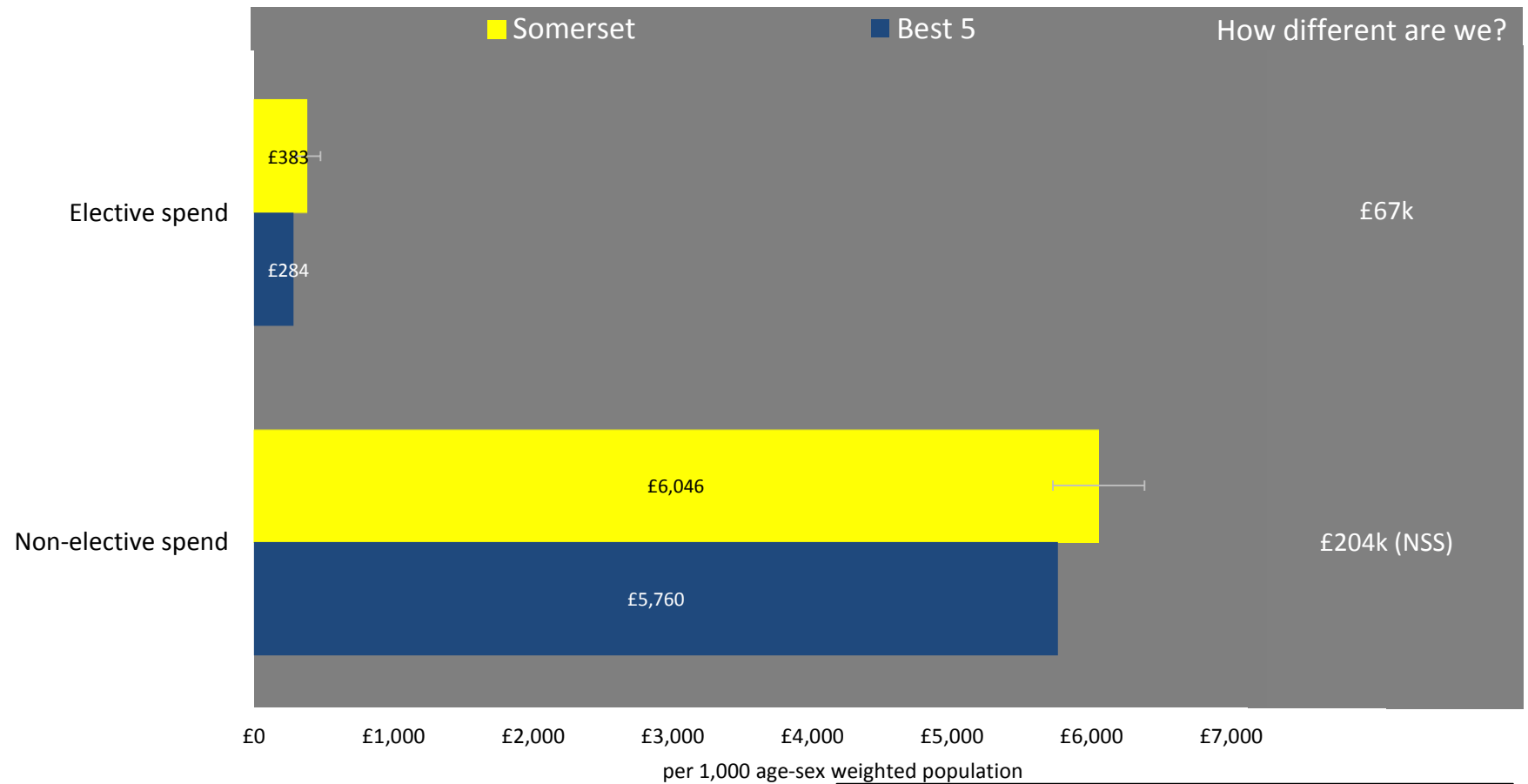
| 95% confidence intervals

**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

# Cerebrovascular disease - Spend

20



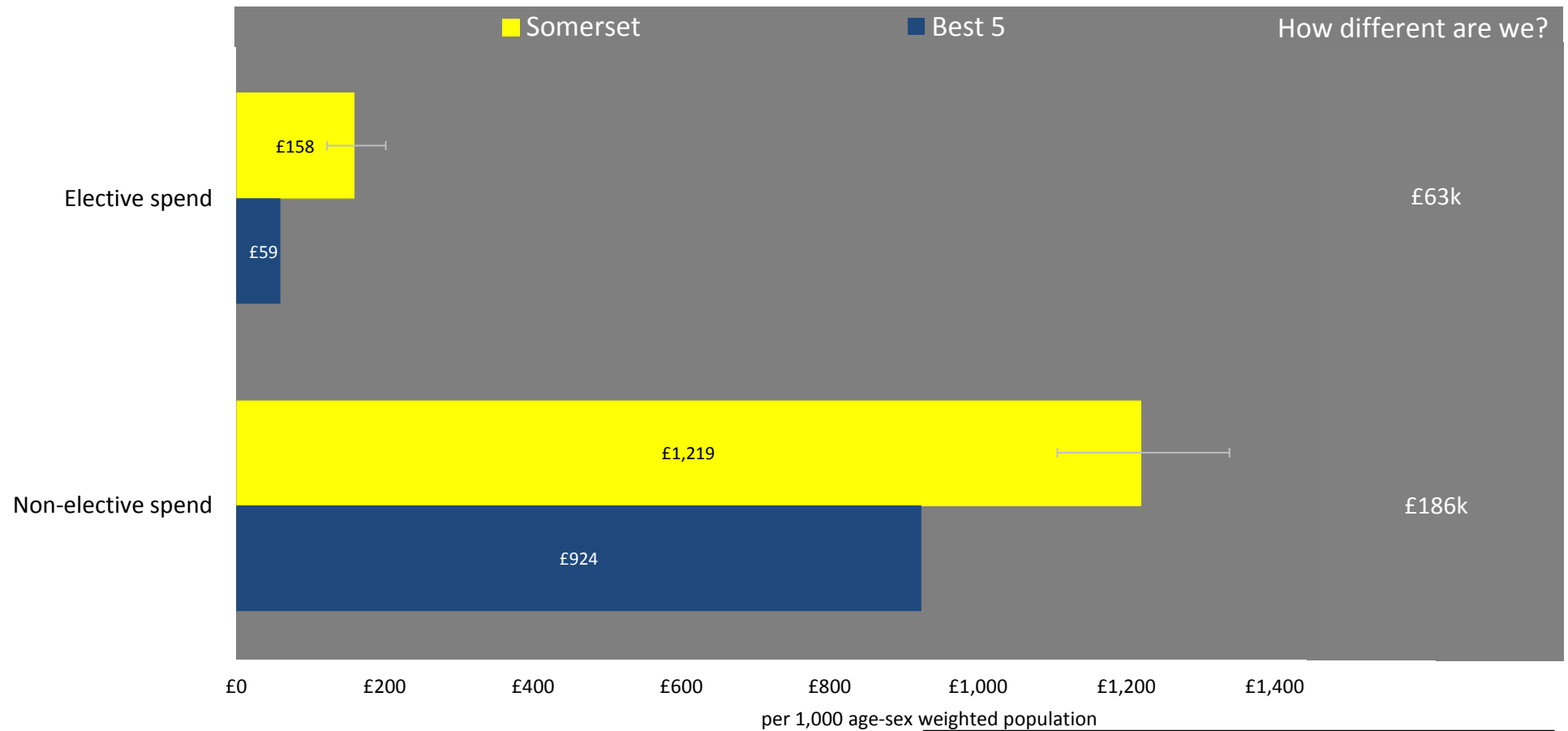
95% confidence intervals

**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

# Diabetes - Spend

21



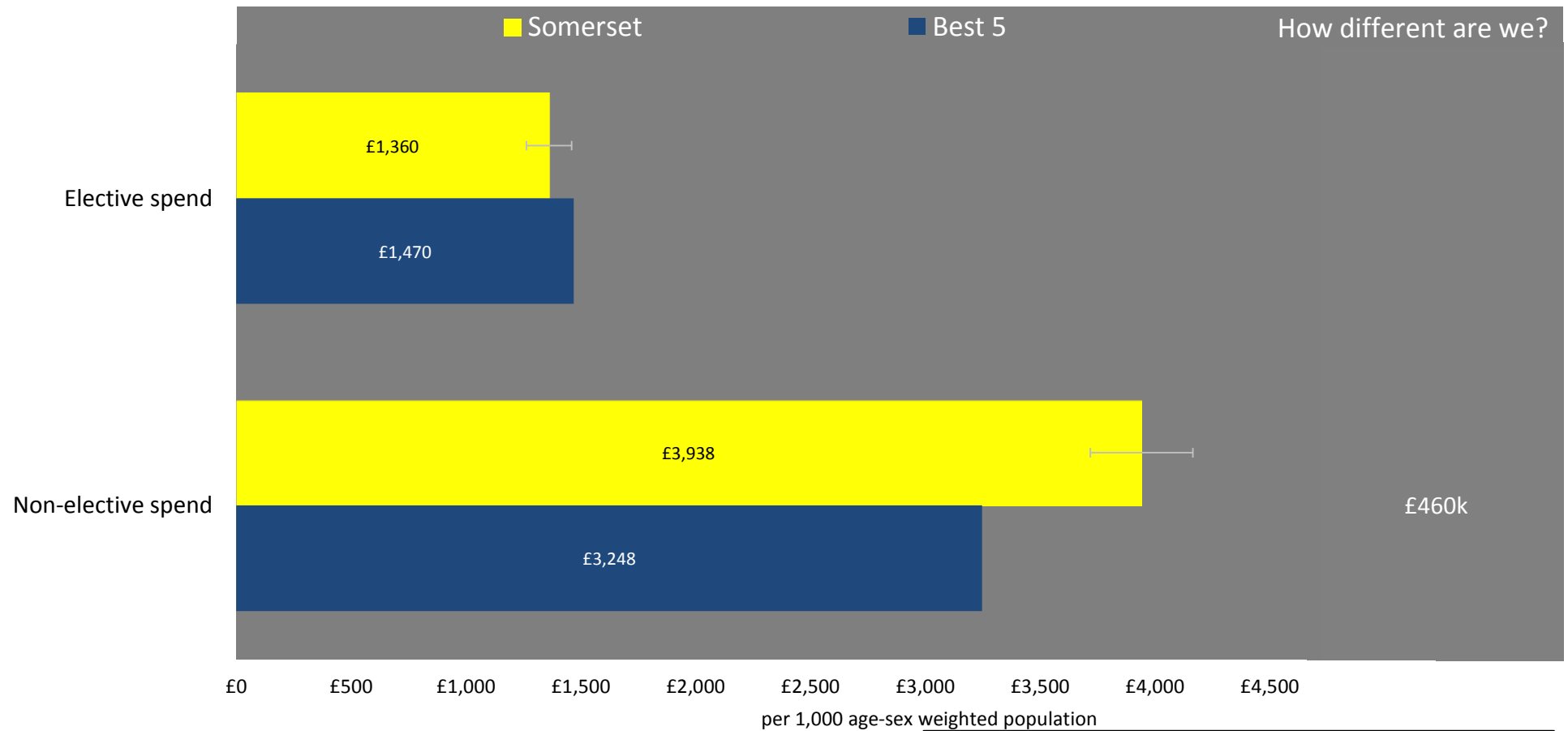
95% confidence intervals

**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

# Renal problems - Spend

22



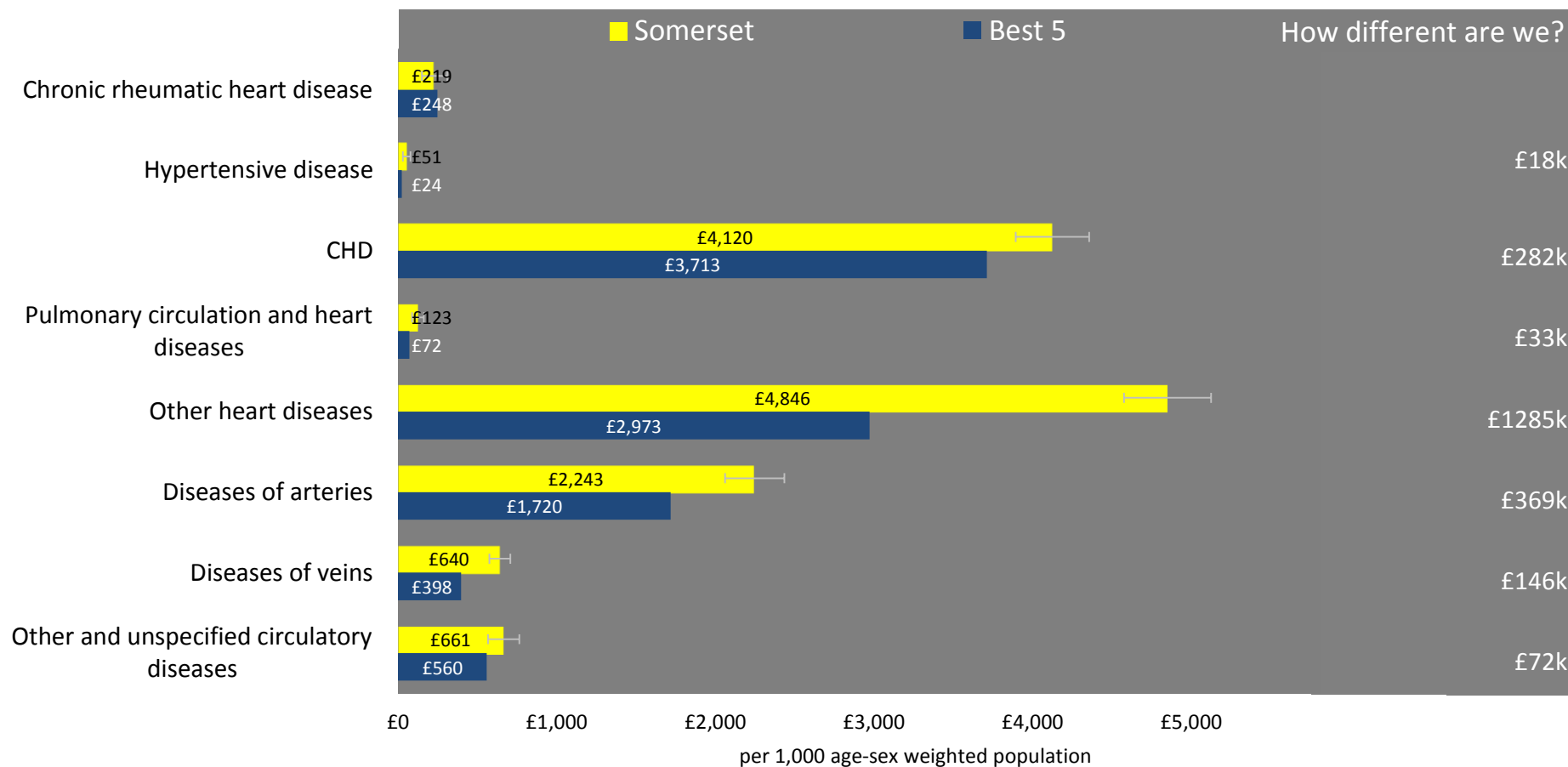
95% confidence intervals

**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

# CHD and other circulatory problems - elective spend

23



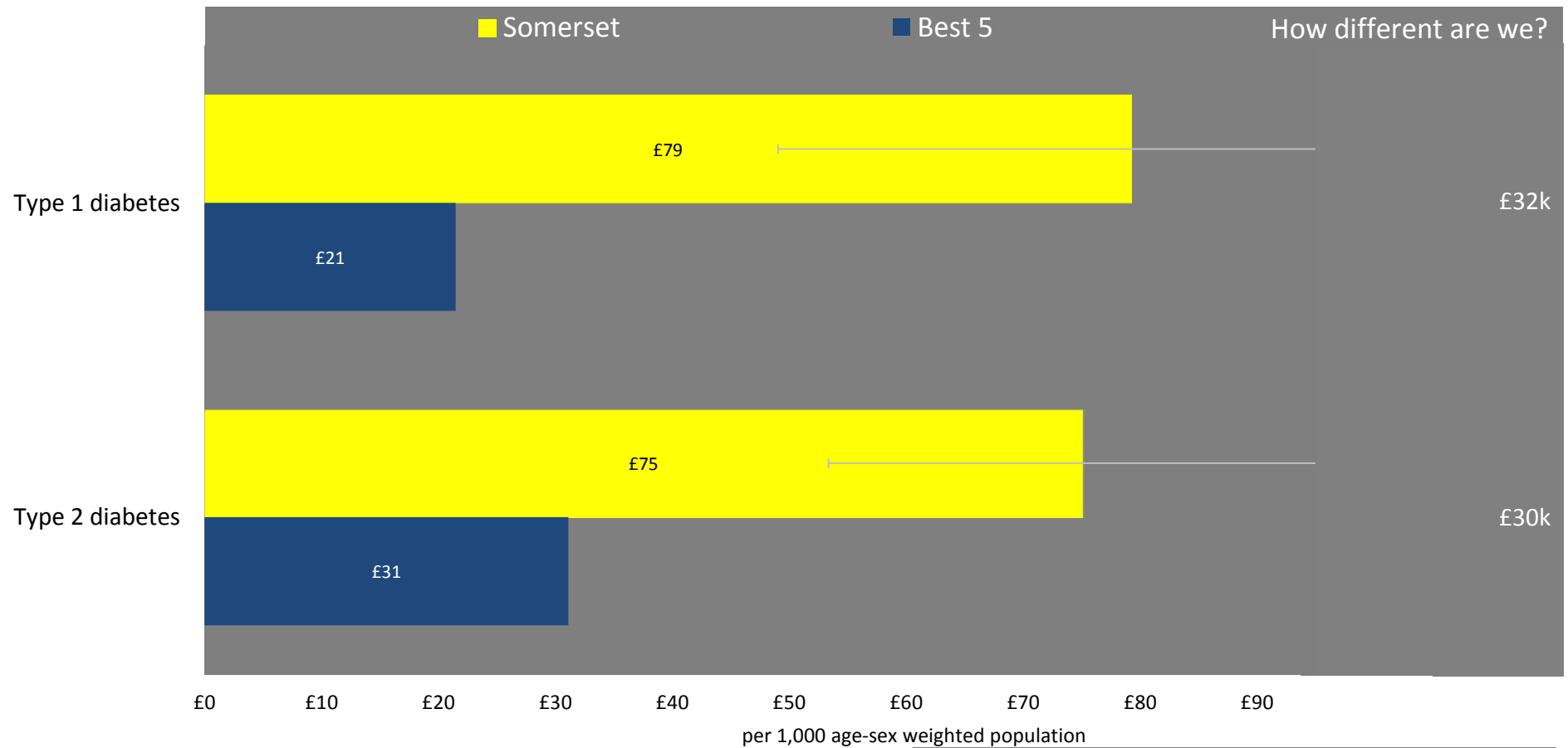
95% confidence intervals

**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

# Diabetes - elective spend

24



95% confidence intervals

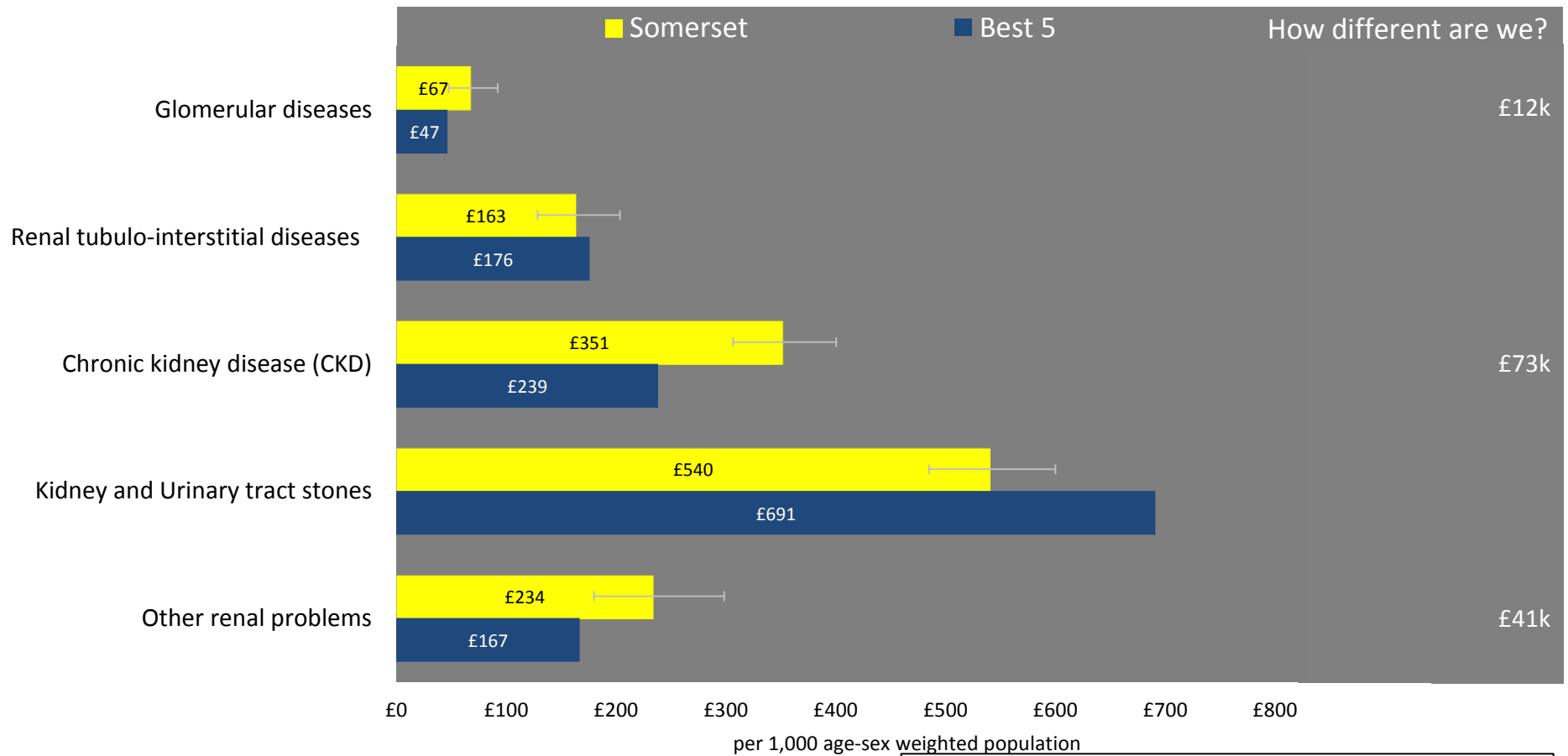
**NSS** Not statistically significant\*

\*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



# Renal - elective spend

25



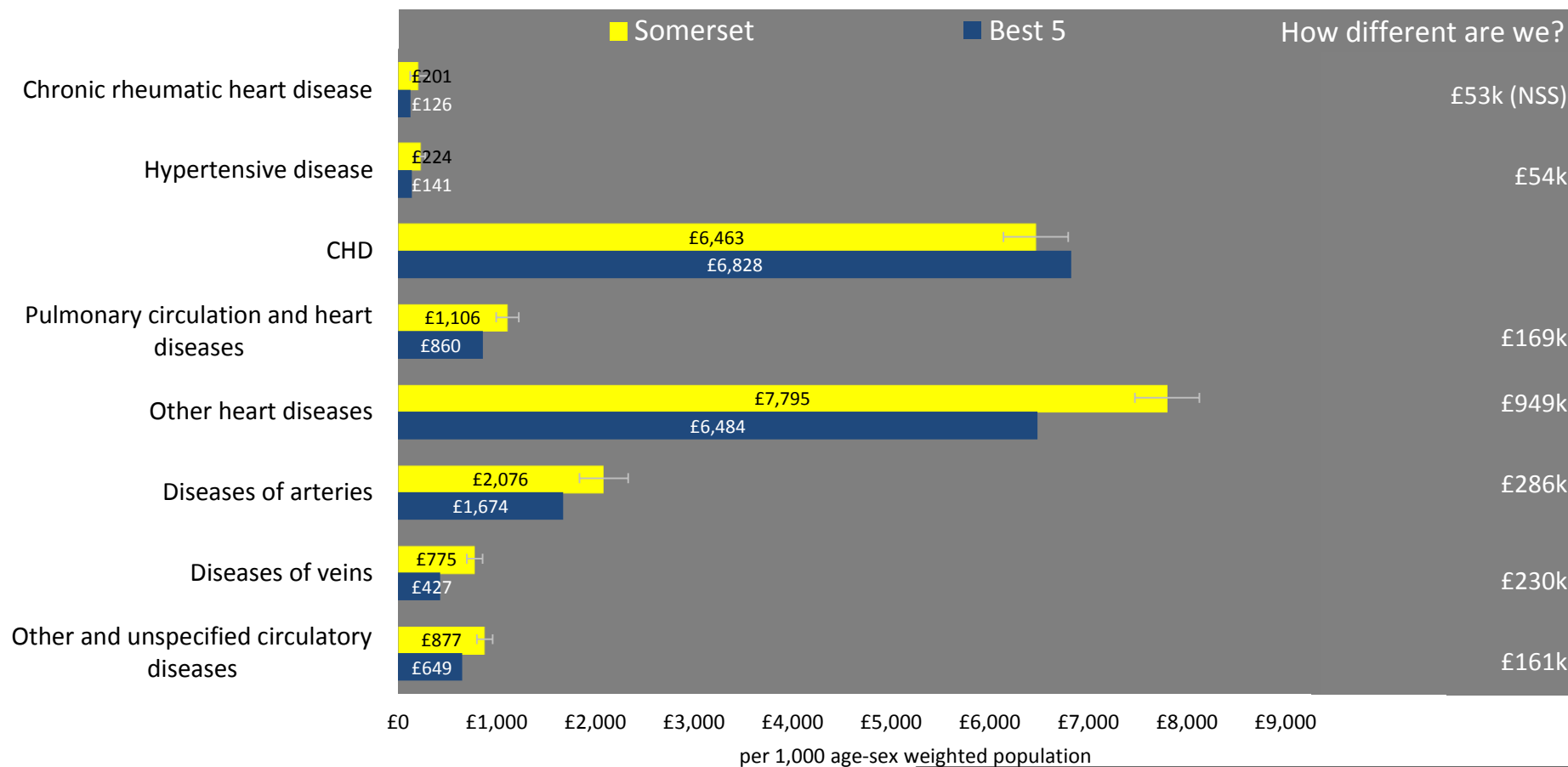
95% confidence intervals

**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

# CHD and other circulatory problems - non-elective spend

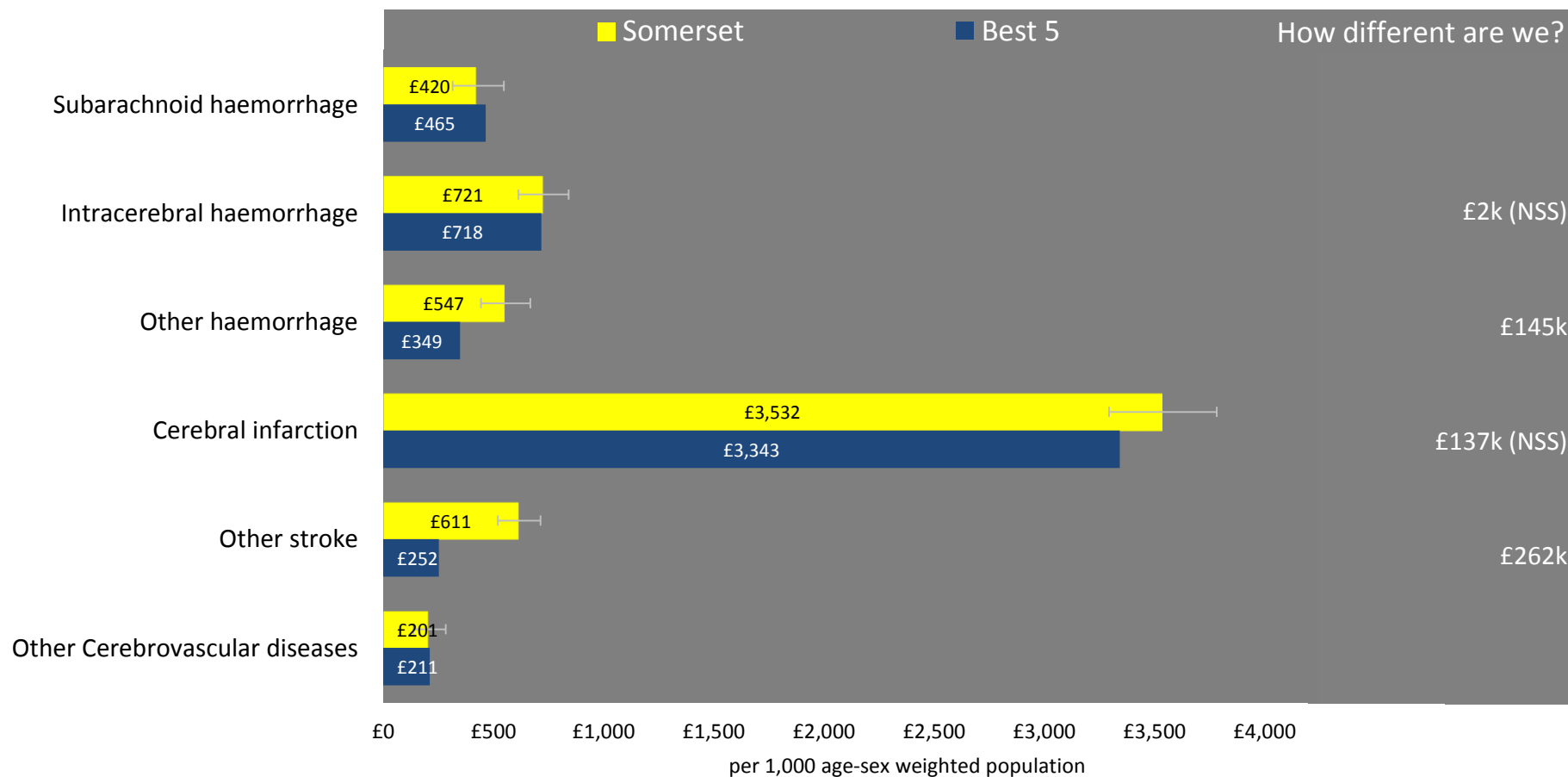
26



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

# Cerebrovascular disease - non-elective spend

27



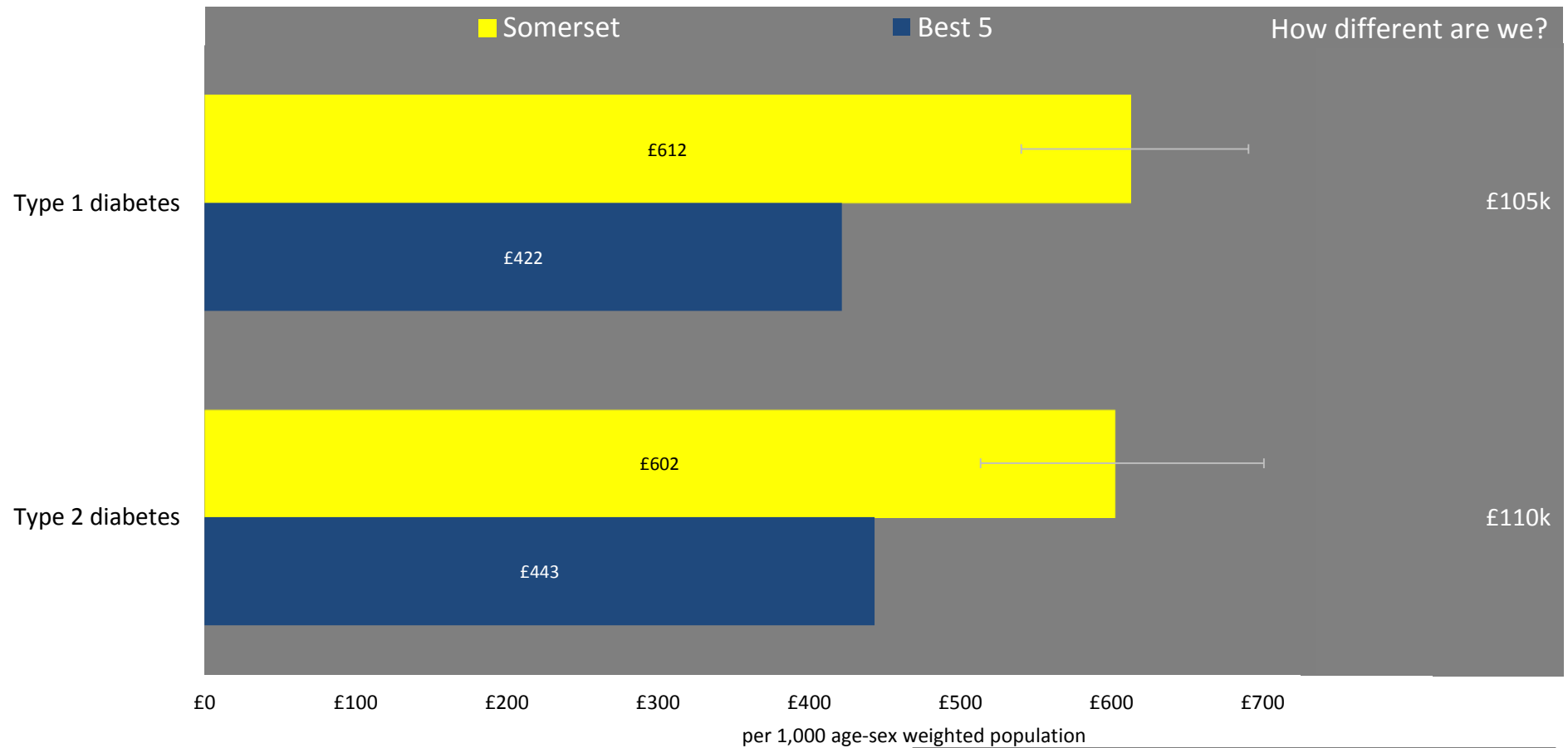
95% confidence intervals

**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

# Diabetes - non-elective spend

28



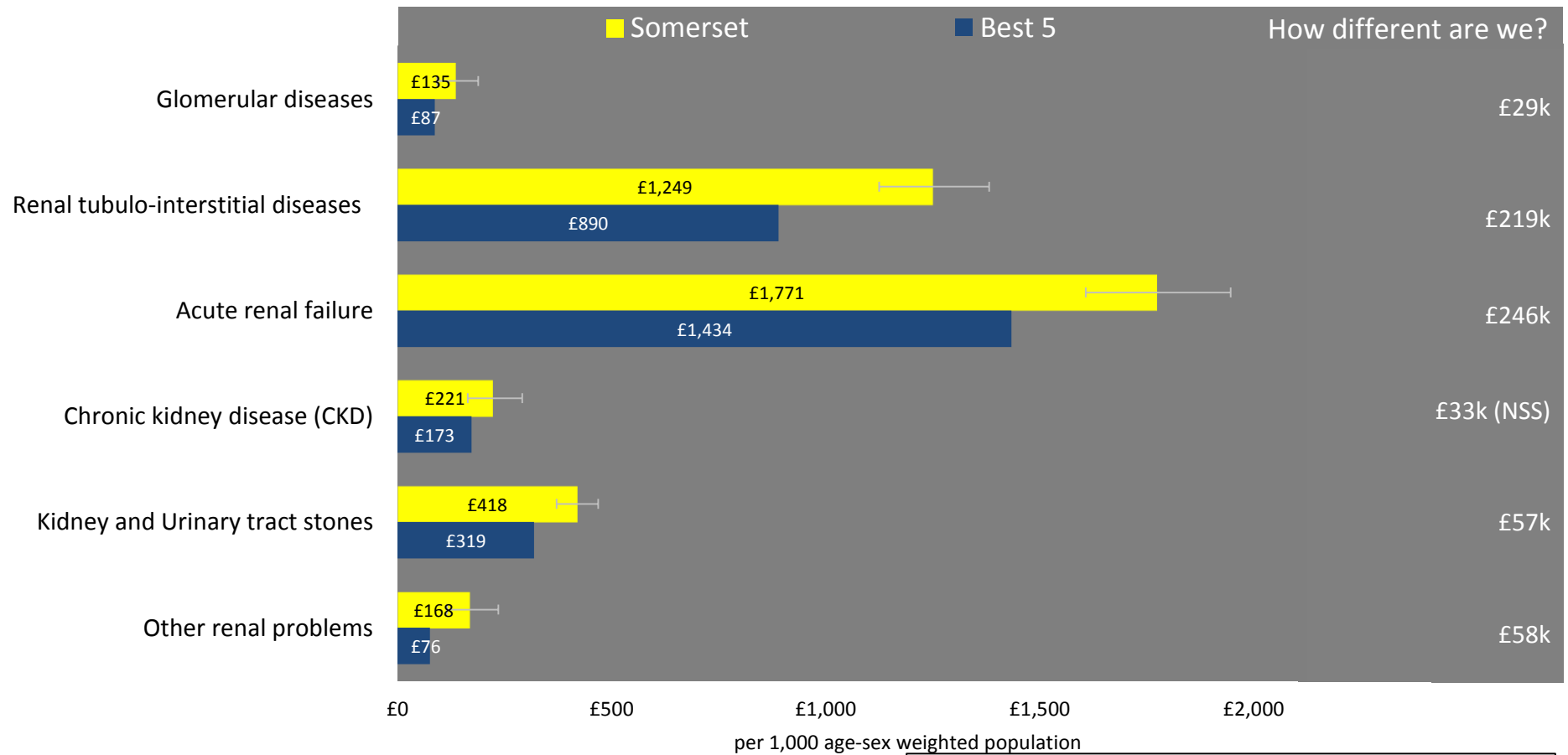
| 95% confidence intervals

**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

# Renal - non-elective spend

29



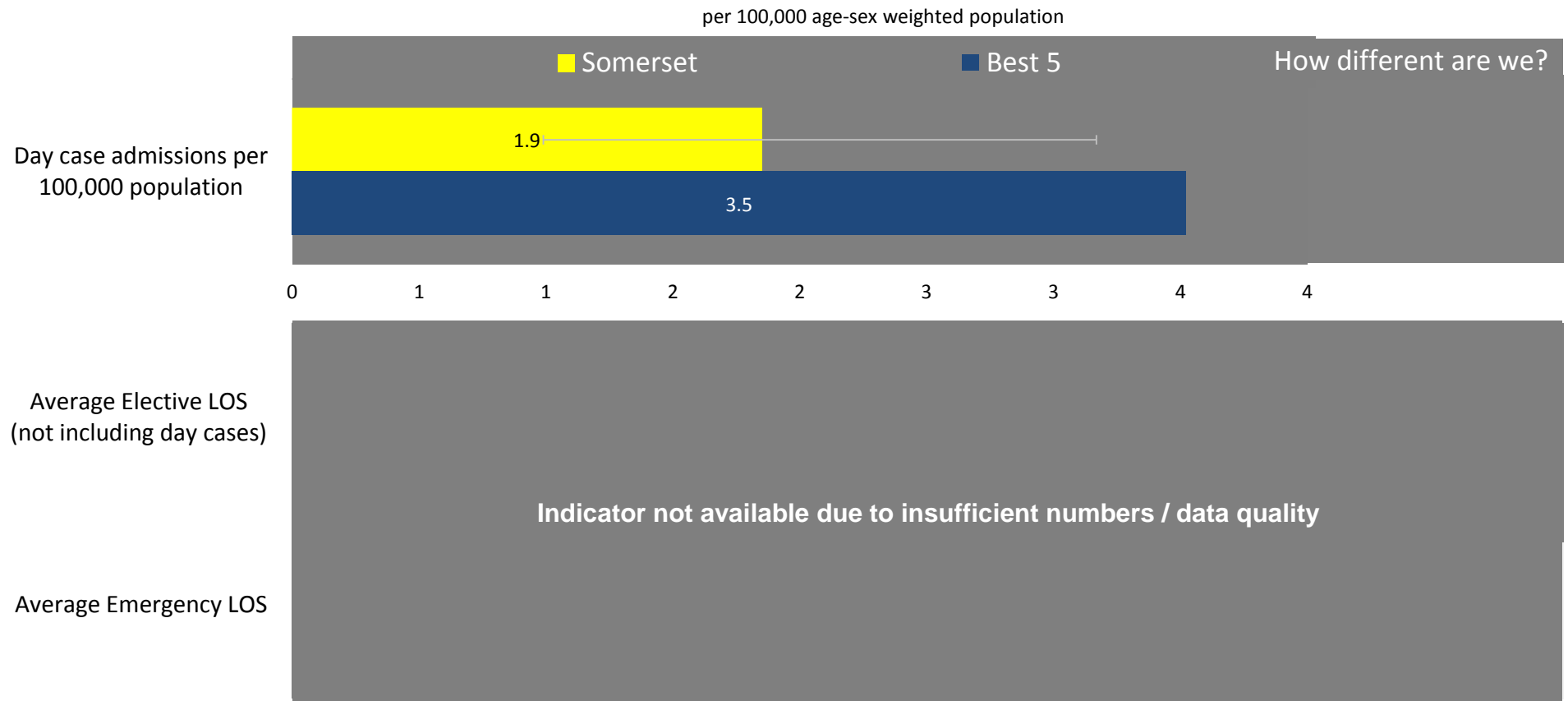
95% confidence intervals

**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

# Chronic rheumatic heart diseases - admissions

30



Mean length of stay (days)

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

# Hypertensive diseases - admissions

31

per 100,000 age-sex weighted population

■ Somerset

■ Best 5

How different are we?

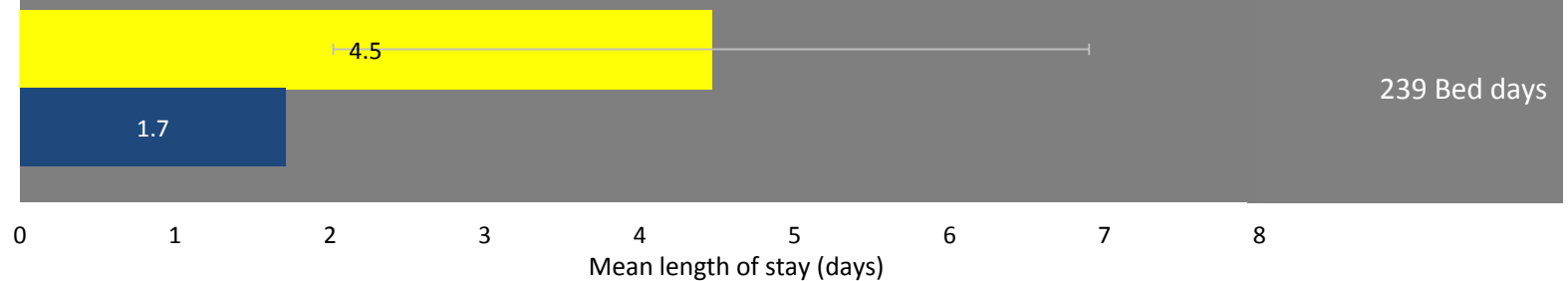
Day case admissions per  
100,000 population

Indicator not available due to insufficient numbers / data quality

Average Elective LOS  
(not including day cases)

Indicator not available due to insufficient numbers / data quality

Average Emergency LOS



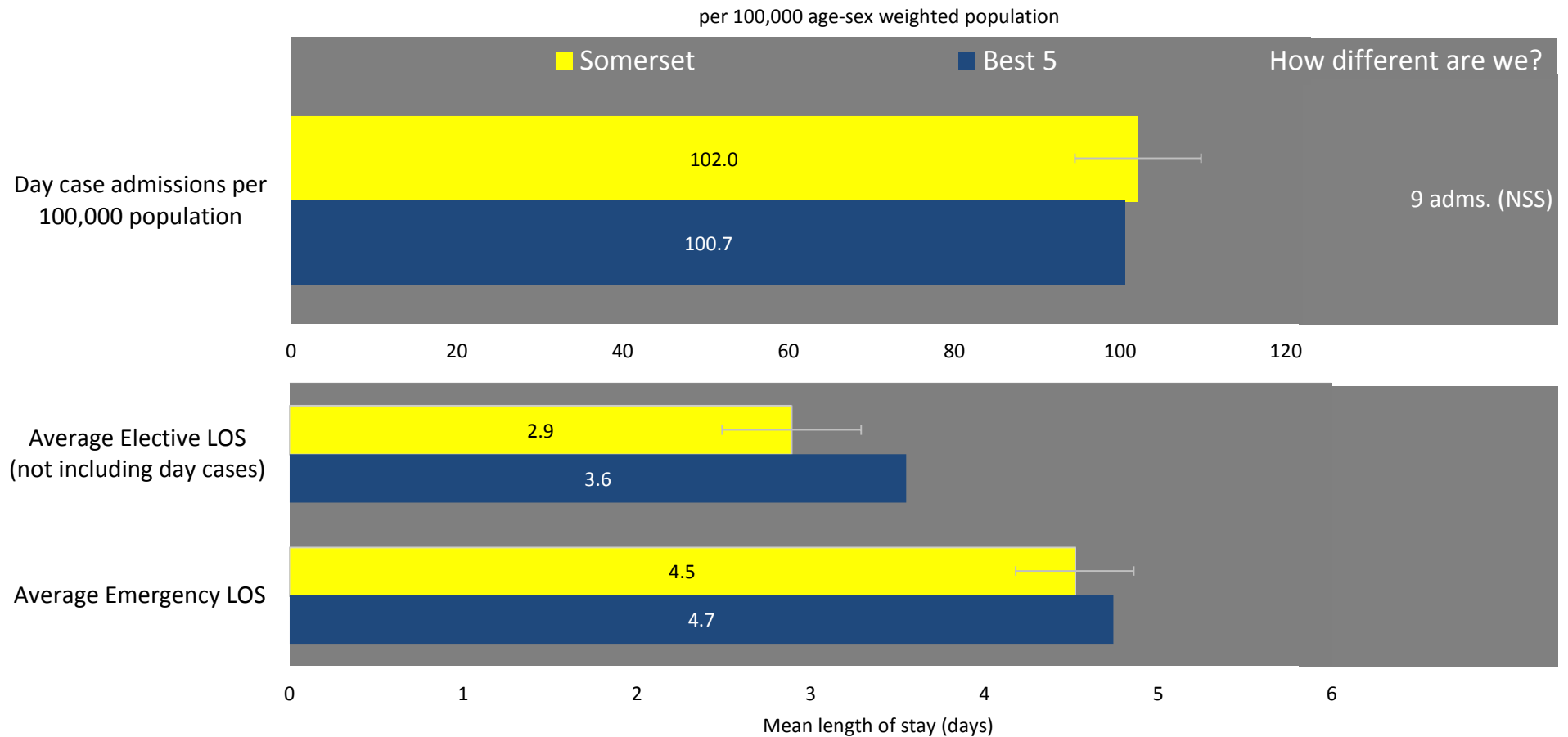
95% confidence intervals

**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

# Coronary heart diseases - admissions

32



95% confidence intervals

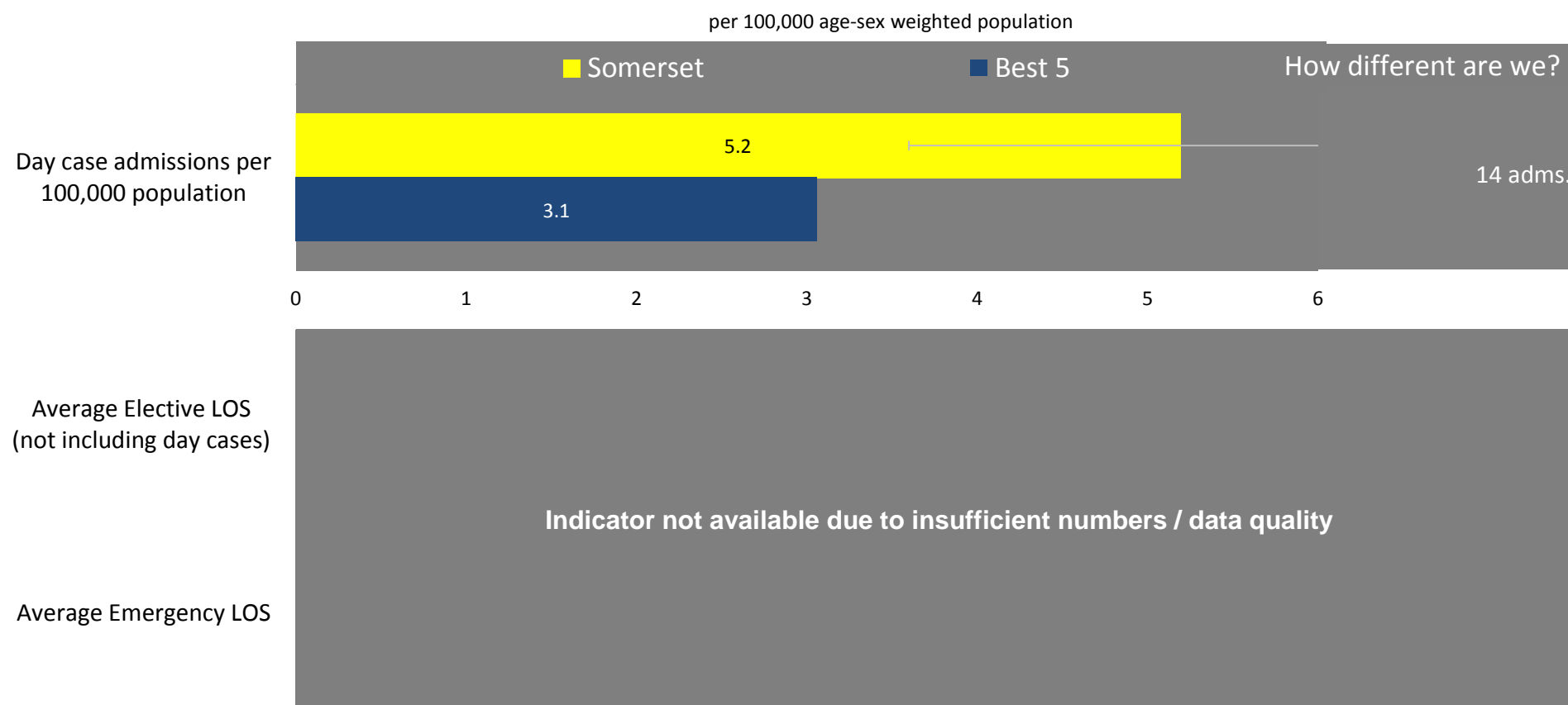
**NSS** Not statistically significant\*

\*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

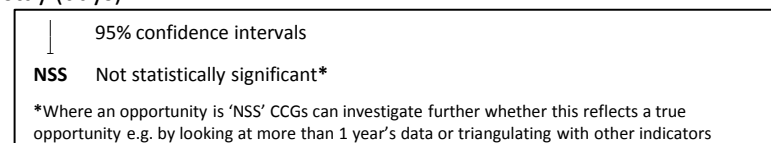


# Pulmonary heart disease and diseases of pulmonary circulation - admissions

33

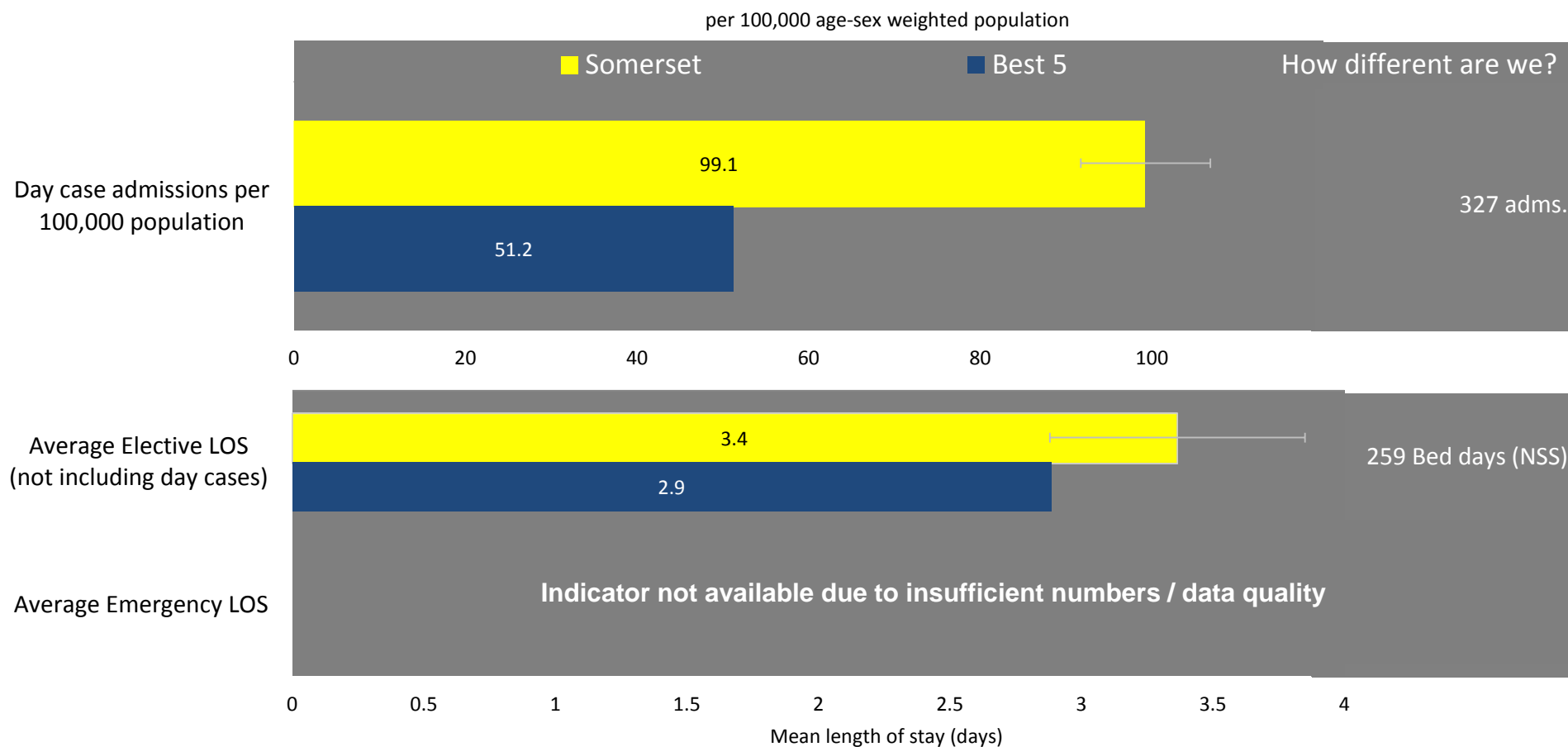


Mean length of stay (days)



# Other forms of heart diseases - admissions

34



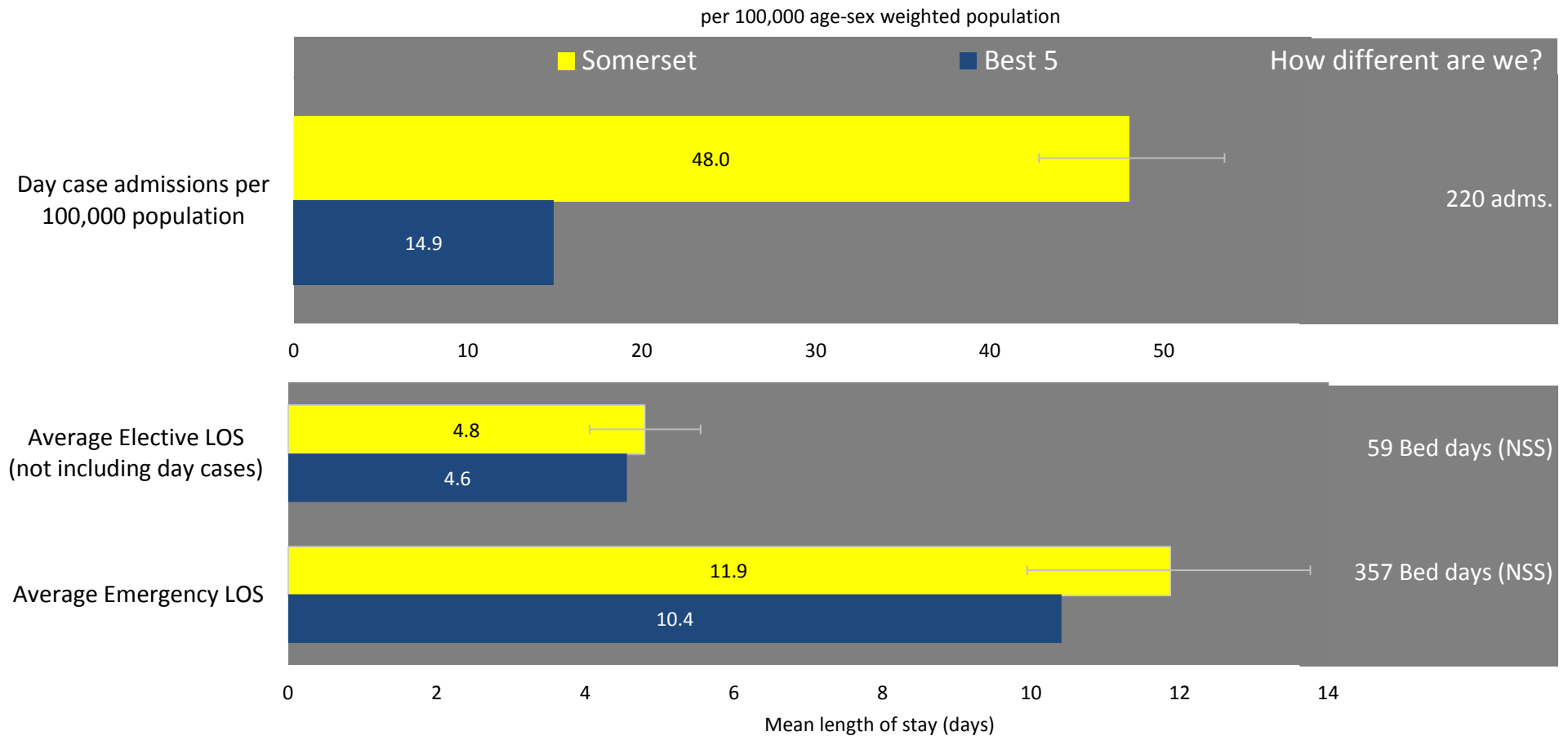
95% confidence intervals

**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

# Diseases of arteries and capillaries - admissions

35



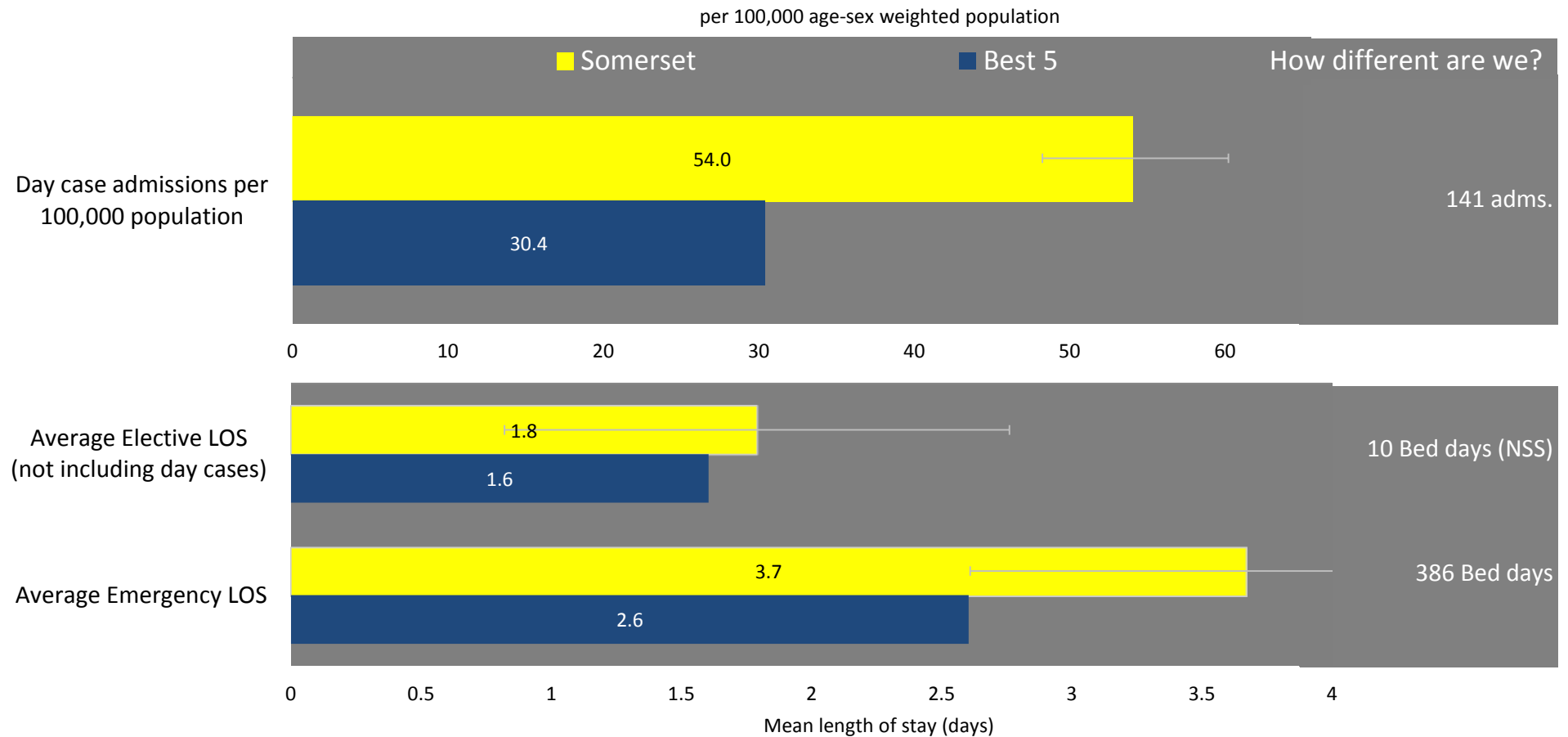
95% confidence intervals

**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

# Diseases of veins and lymph nodes - admissions

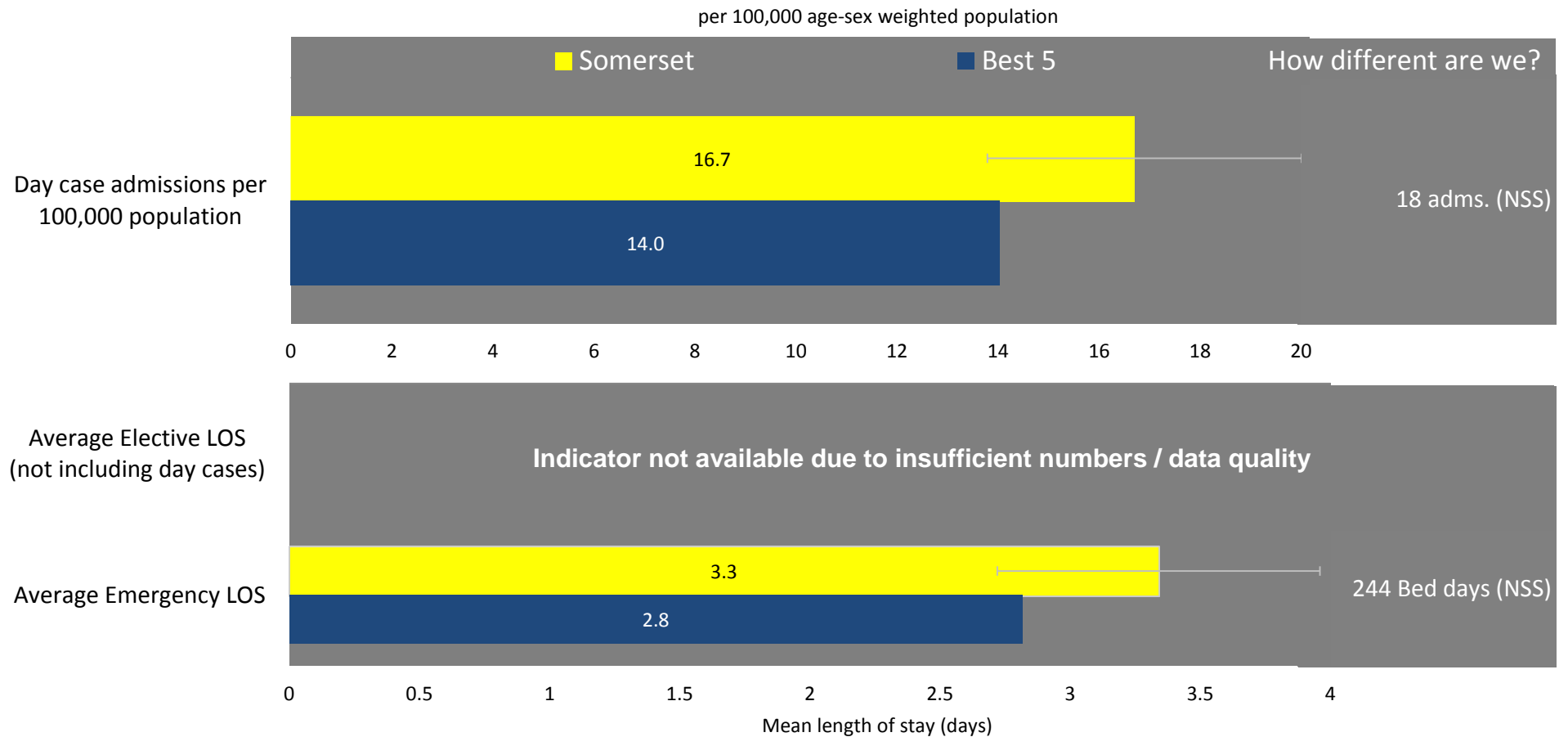
36



| 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

# Other disorders of circulatory system - admissions

37



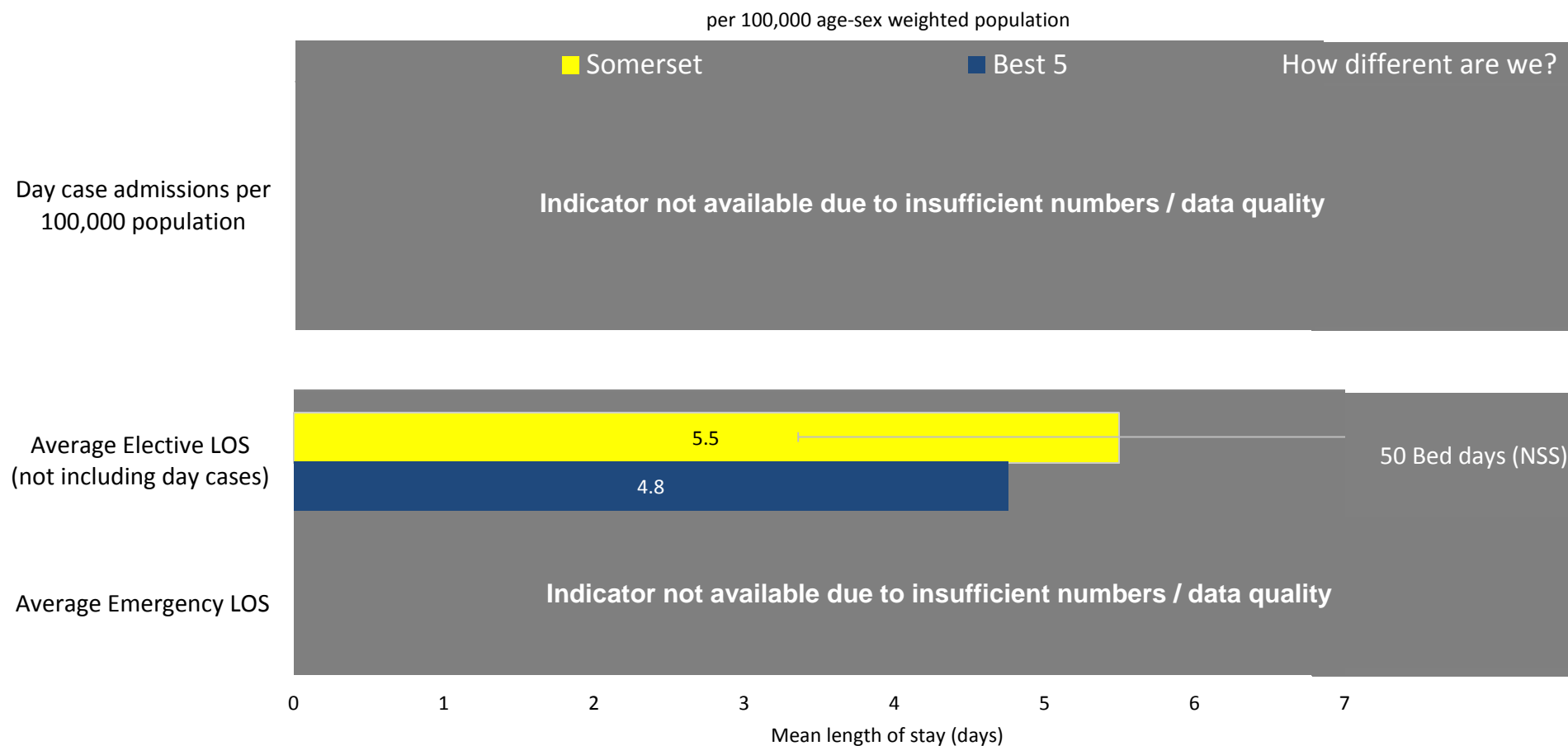
95% confidence intervals

**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

# All Cerebrovascular - admissions

38



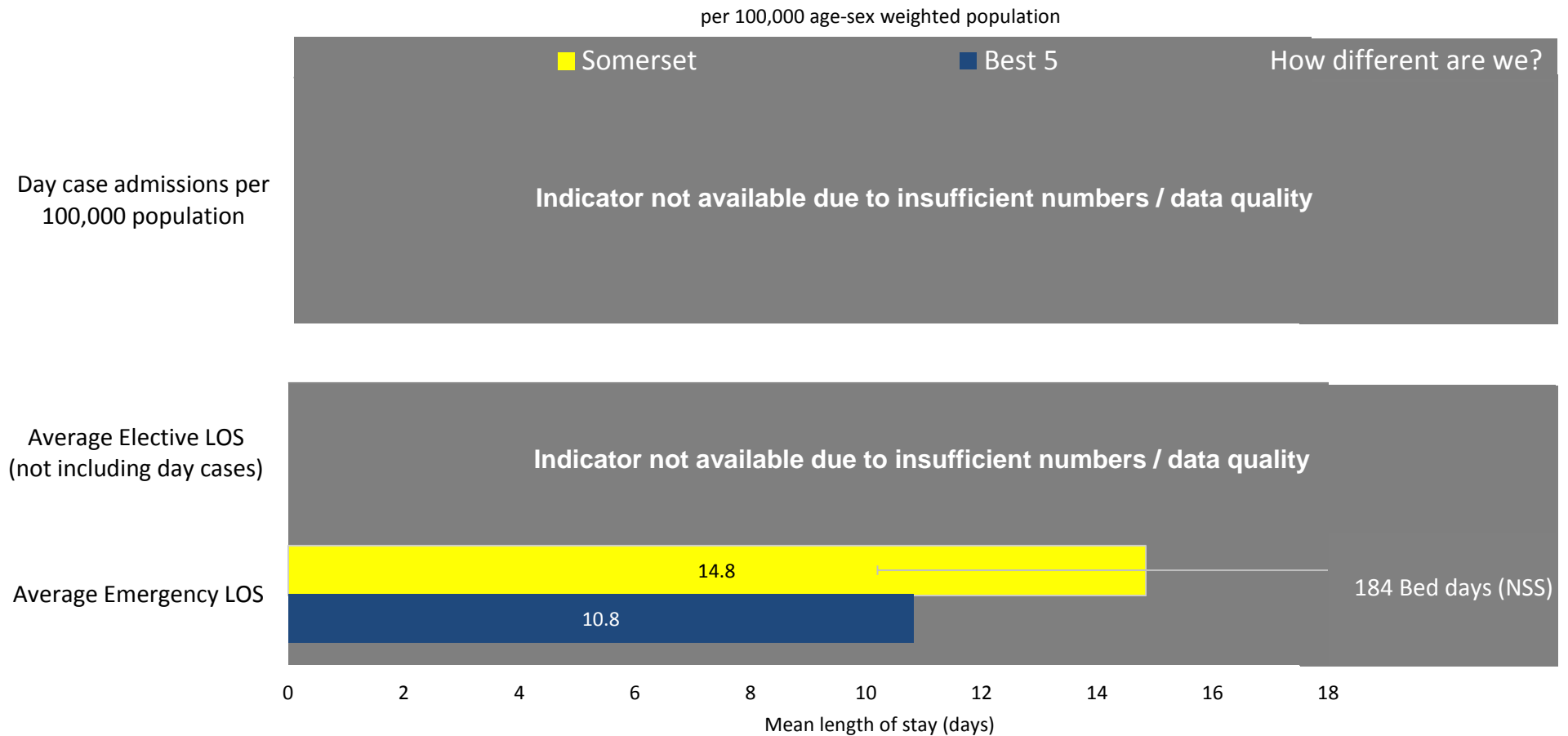
┆ 95% confidence intervals

**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

# Subarachnoid haemorrhage - admissions

39



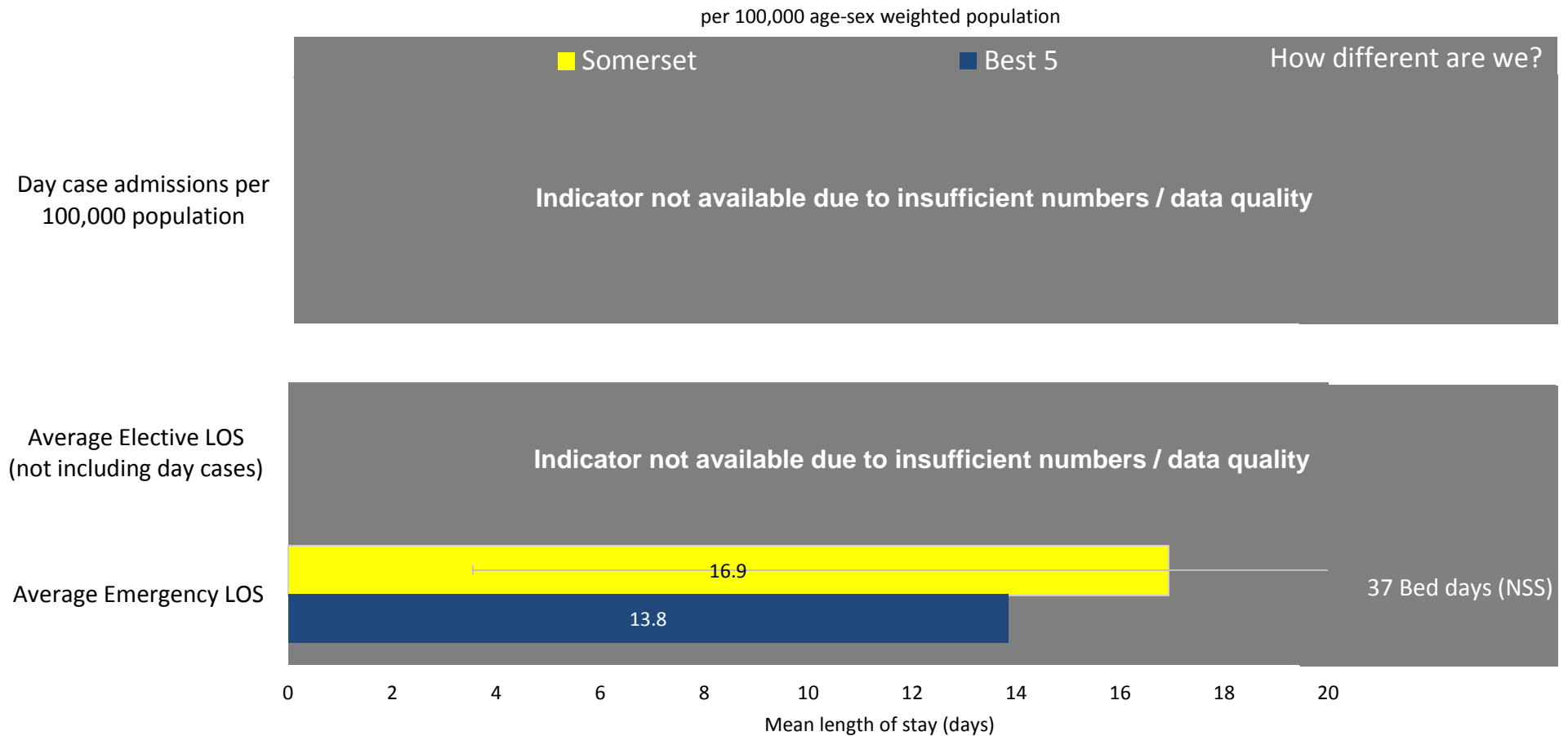
| 95% confidence intervals

**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

# Intracerebral haemorrhage - admissions

40



┆ 95% confidence intervals

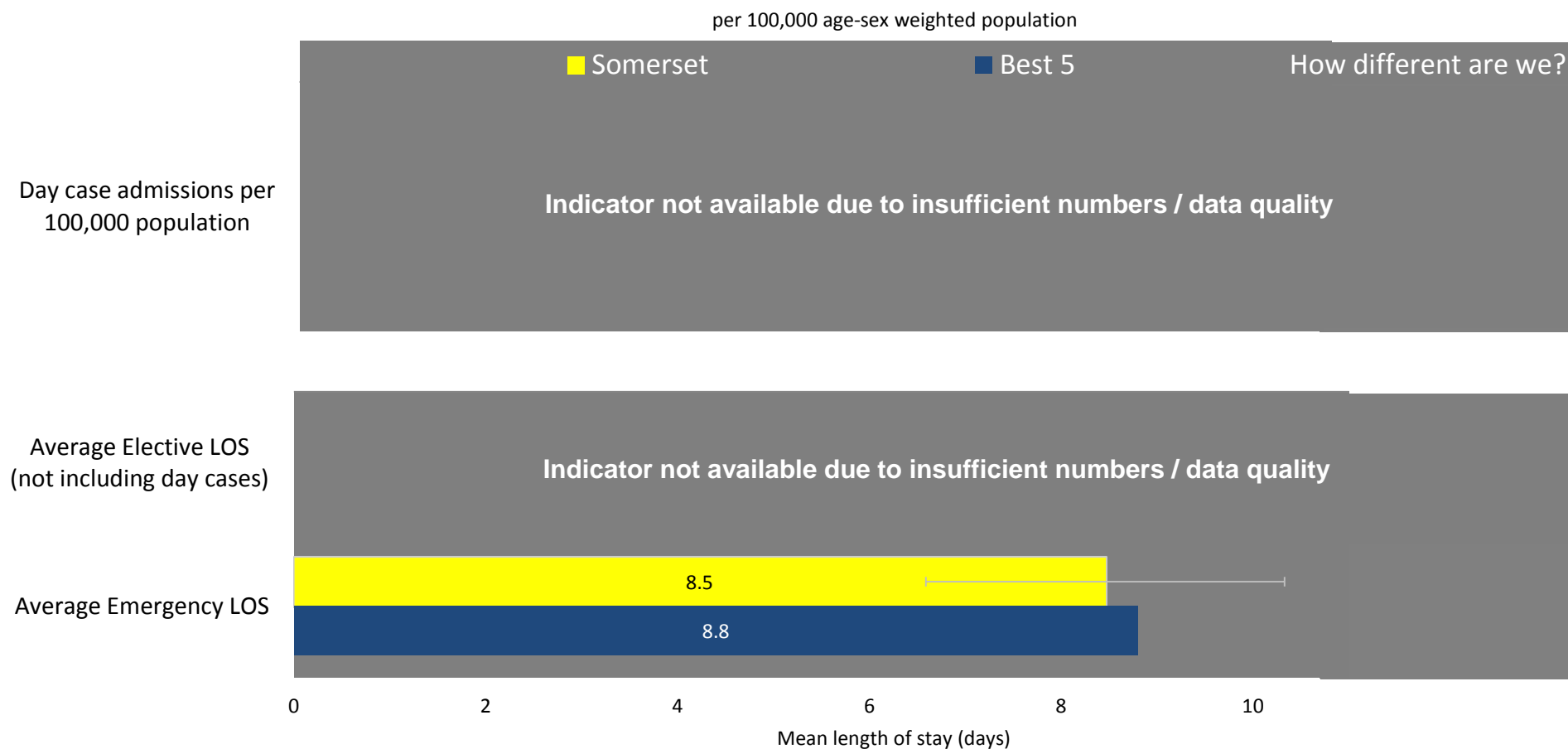
**NSS** Not statistically significant\*

\*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



# Other nontraumatic intracranial haemorrhage - admissions

41



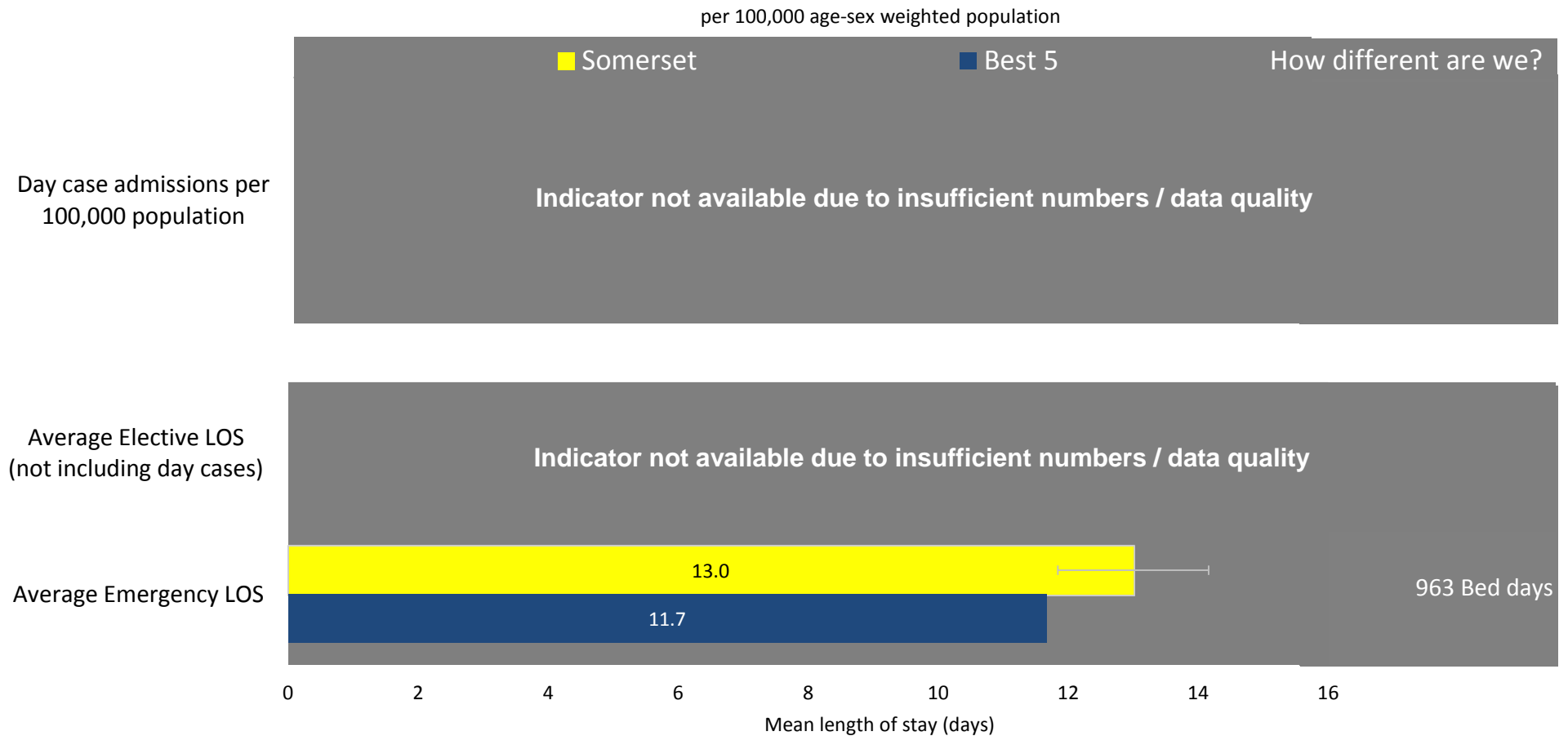
95% confidence intervals

**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

# Cerebral infarction - admissions

42



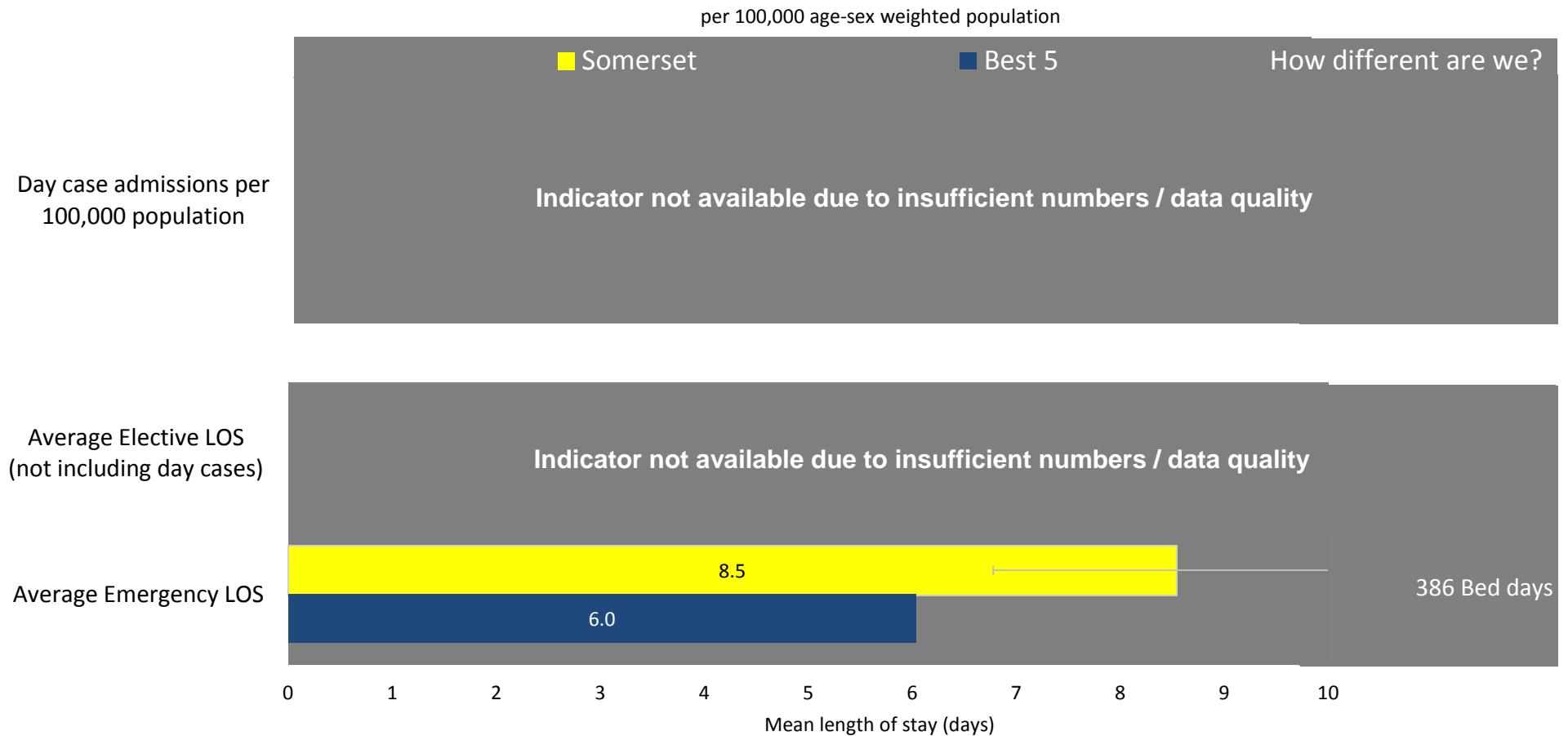
95% confidence intervals

**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

# Other Stroke - admissions

43



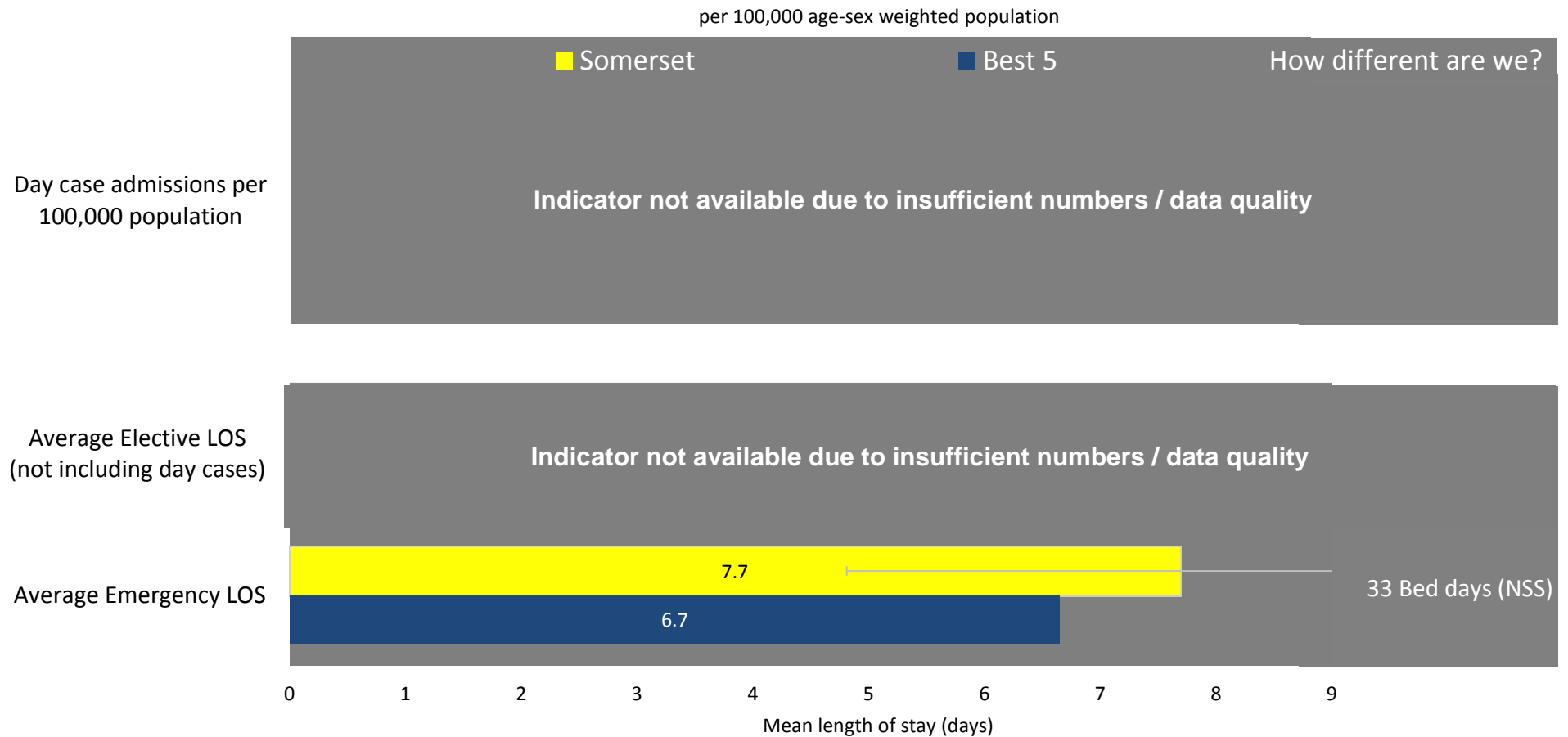
┆ 95% confidence intervals

**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

# Other Cerebrovascular diseases - admissions

44

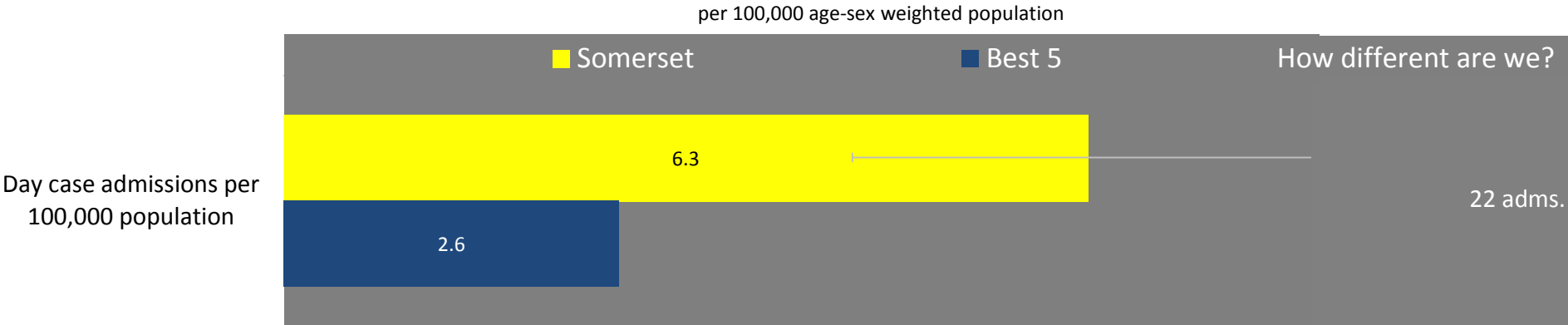


95% confidence intervals

**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

# All Diabetes - day case admissions



Average Elective LOS  
(not including day cases)

Indicator not available due to insufficient numbers / data quality

Average Emergency LOS

Mean length of stay (days)

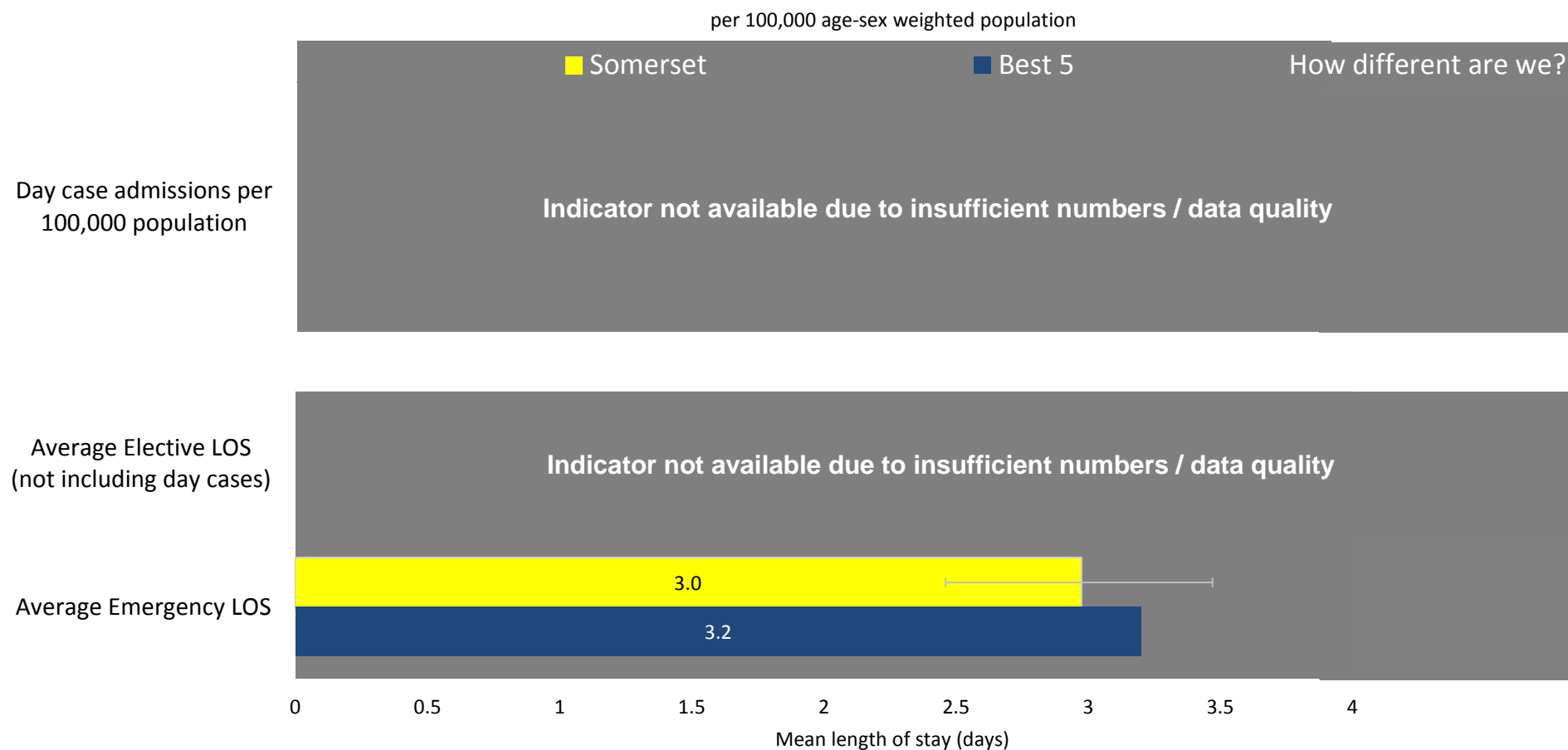
95% confidence intervals

**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

# Type 1 Diabetes - admissions

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

# Type 2 Diabetes - admissions

47



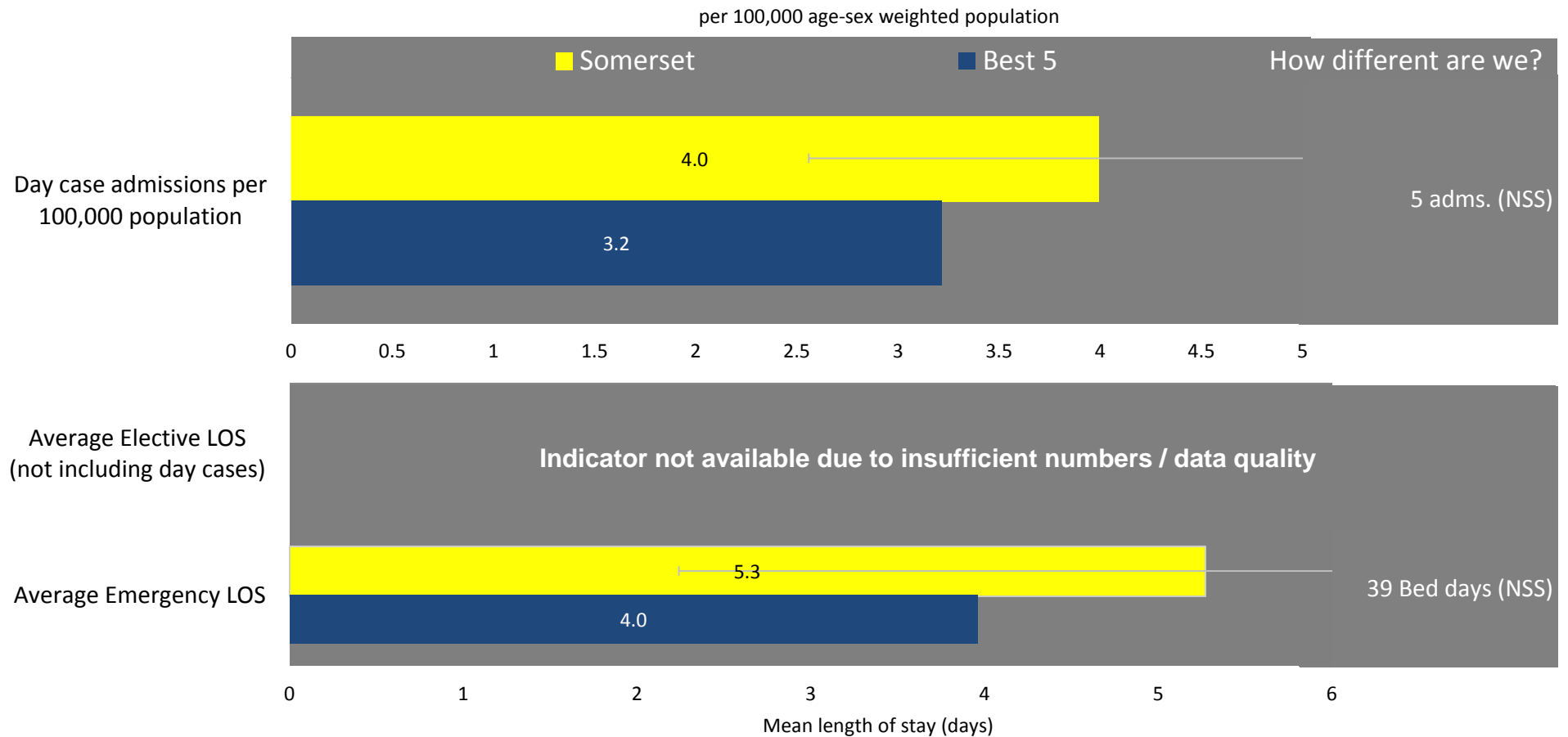
| 95% confidence intervals

**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

# Glomerular diseases - admissions

48



┆ 95% confidence intervals

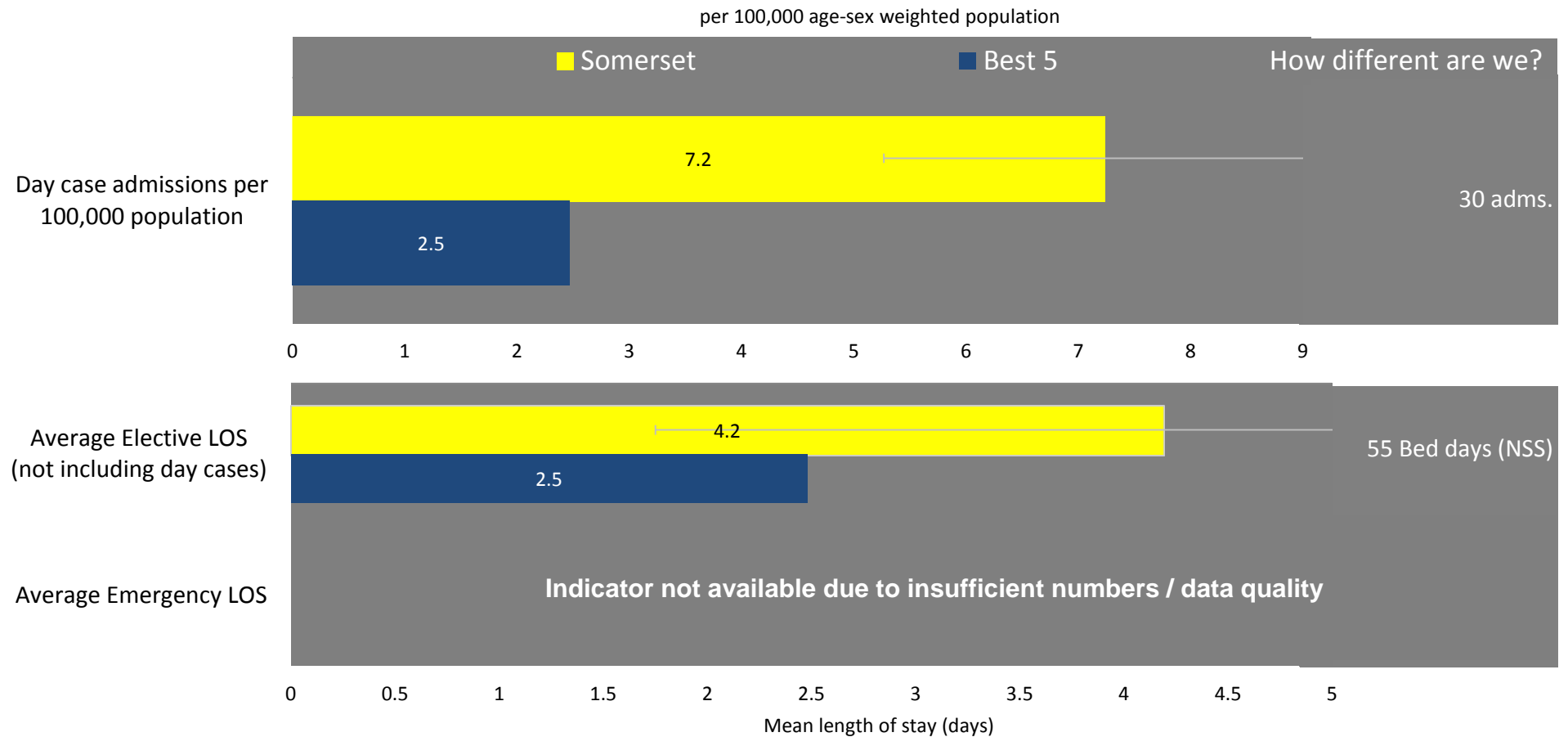
**NSS** Not statistically significant\*

\*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



# Renal tubulo-interstitial diseases - admissions

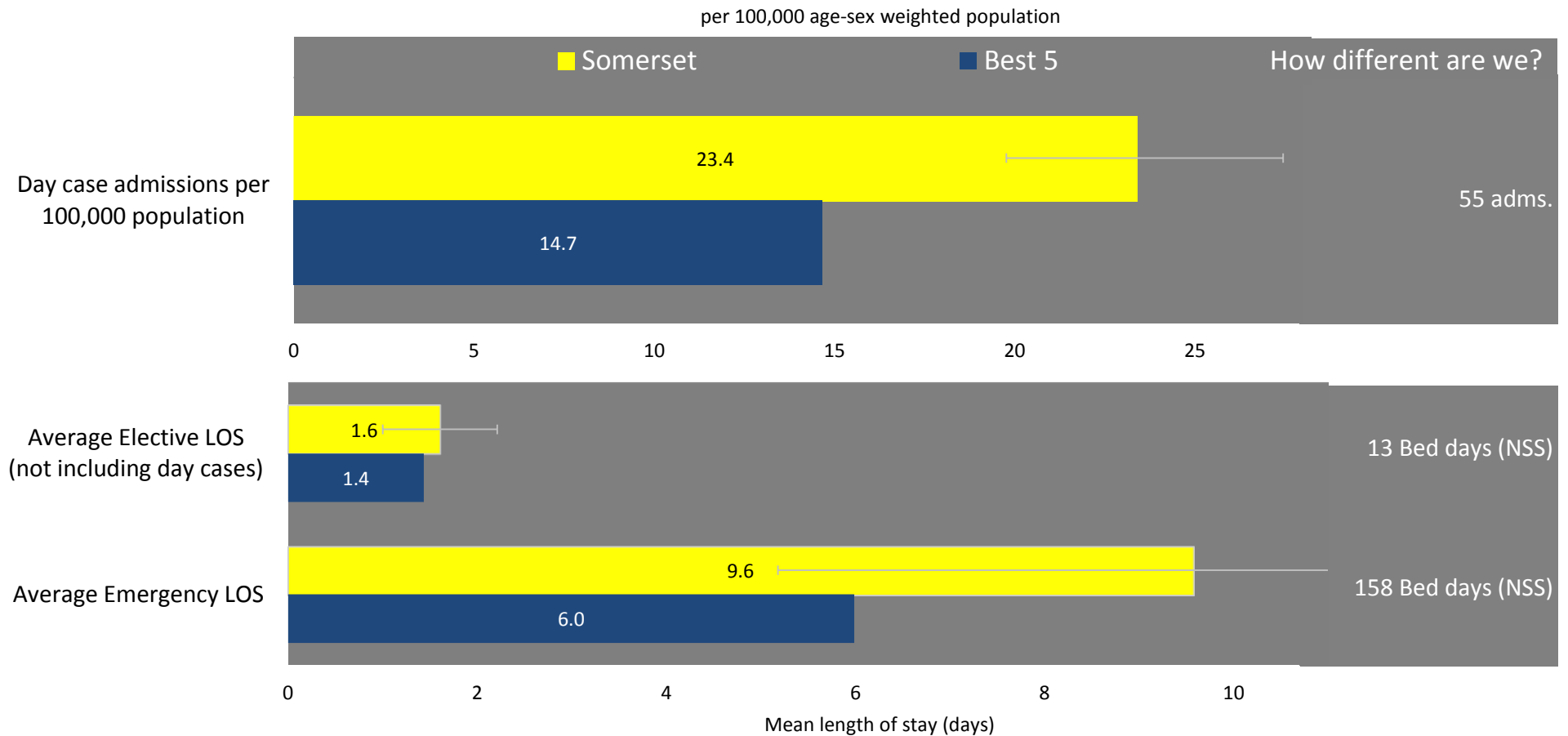
49



| 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

# Chronic kidney disease - admissions

50



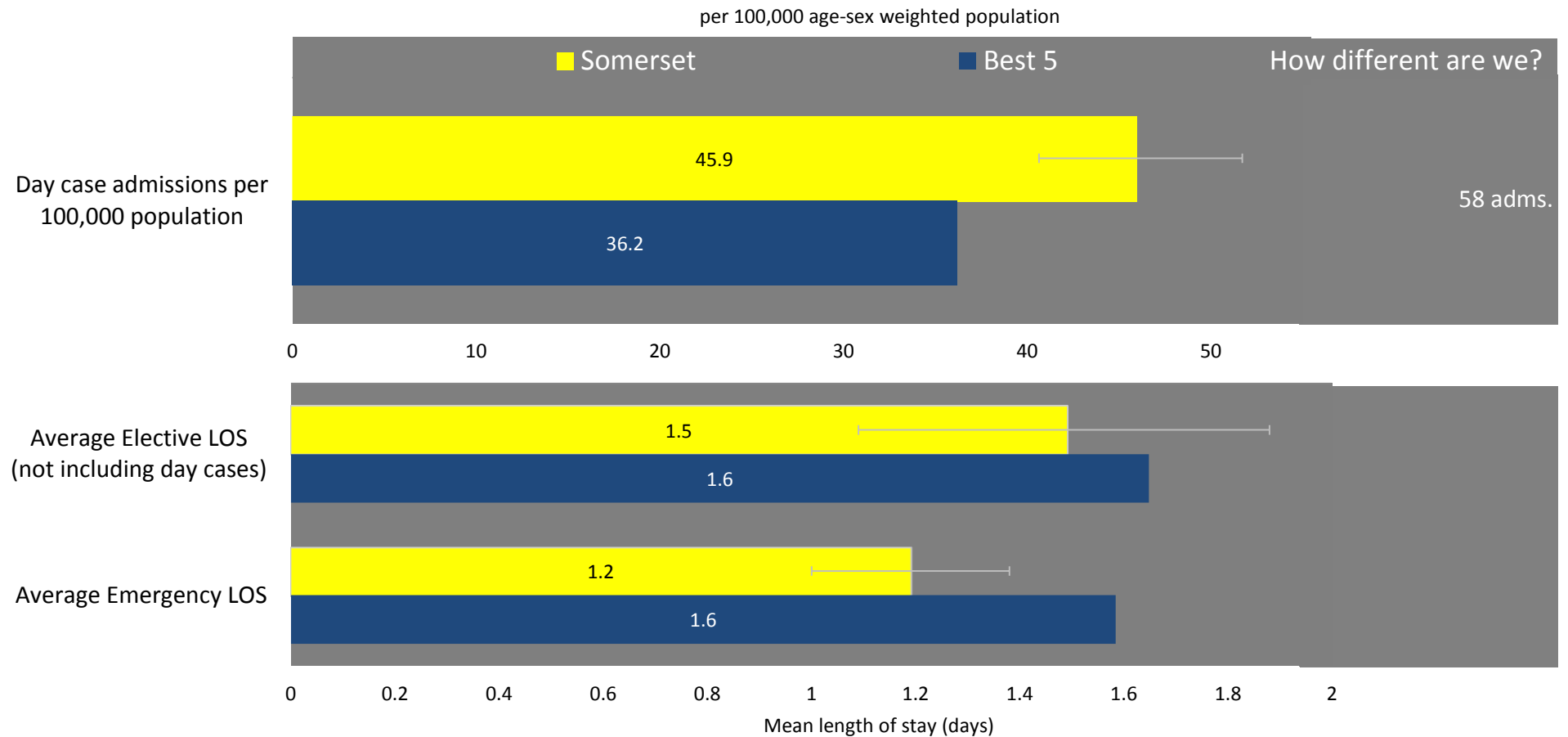
95% confidence intervals

**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

# Kidney and urinary tract stones - admissions

51



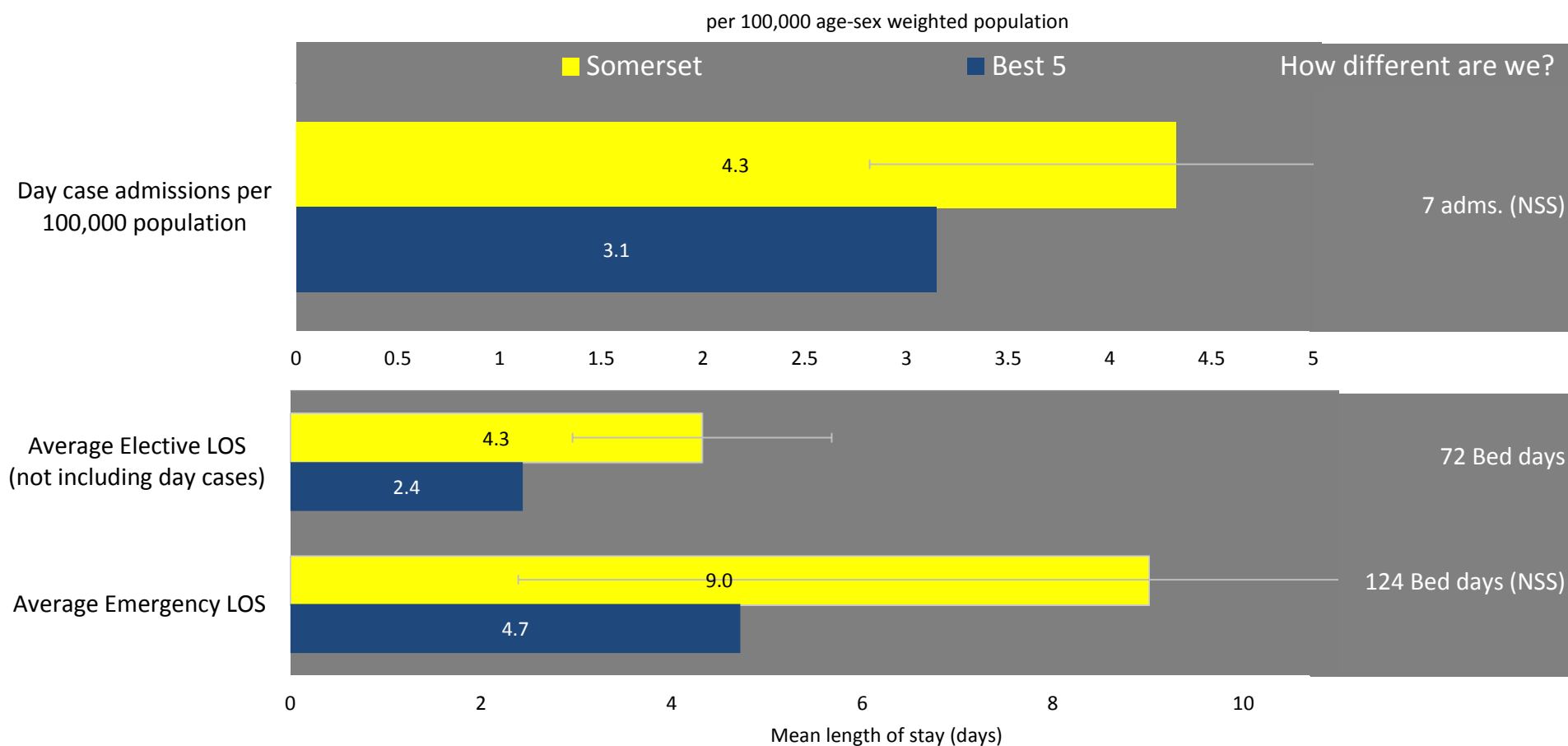
95% confidence intervals

**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

# Other renal problems - admissions

52



95% confidence intervals

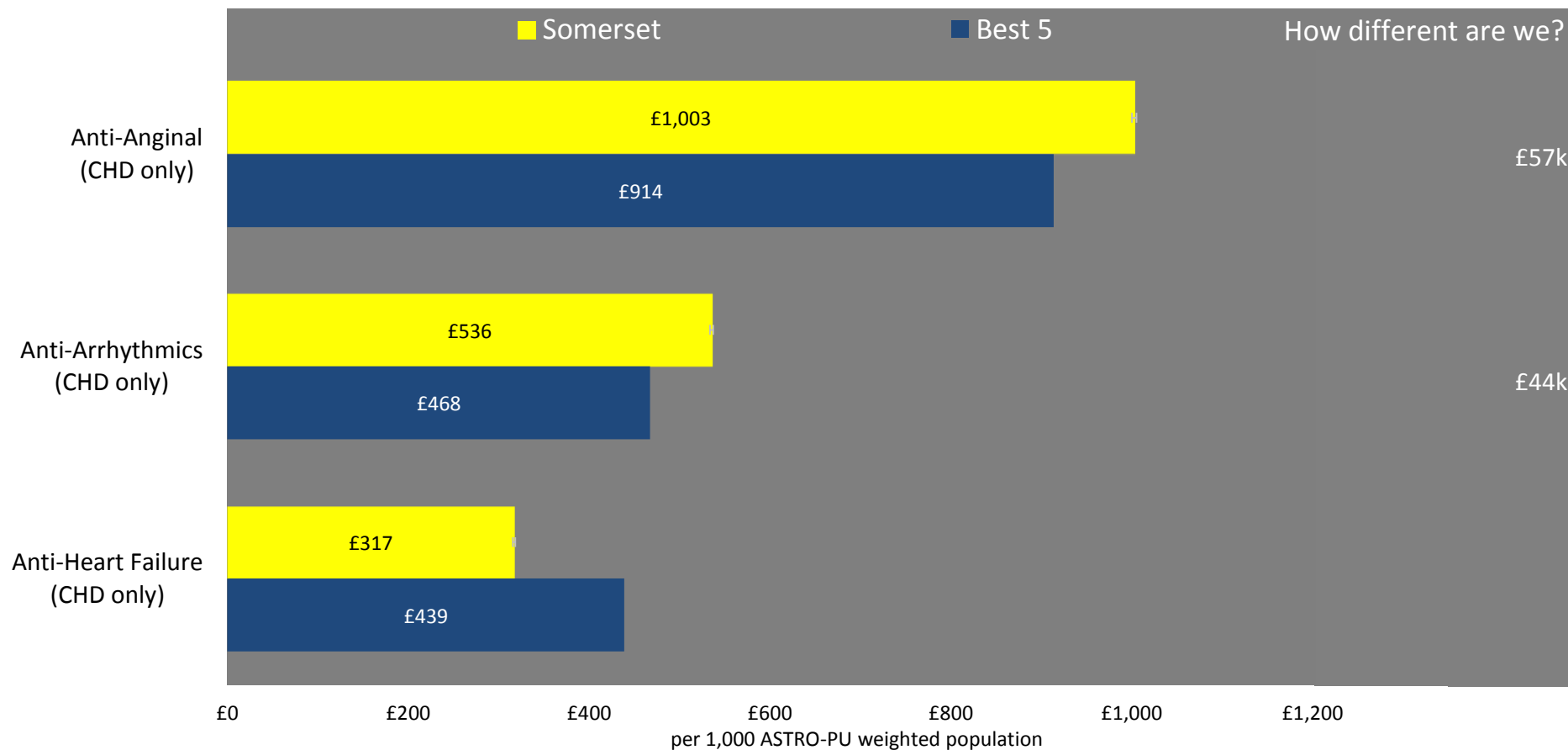
**NSS** Not statistically significant\*

\*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

# Circulatory (CHD) Primary Care Prescribing

Grouped Drugs

53



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

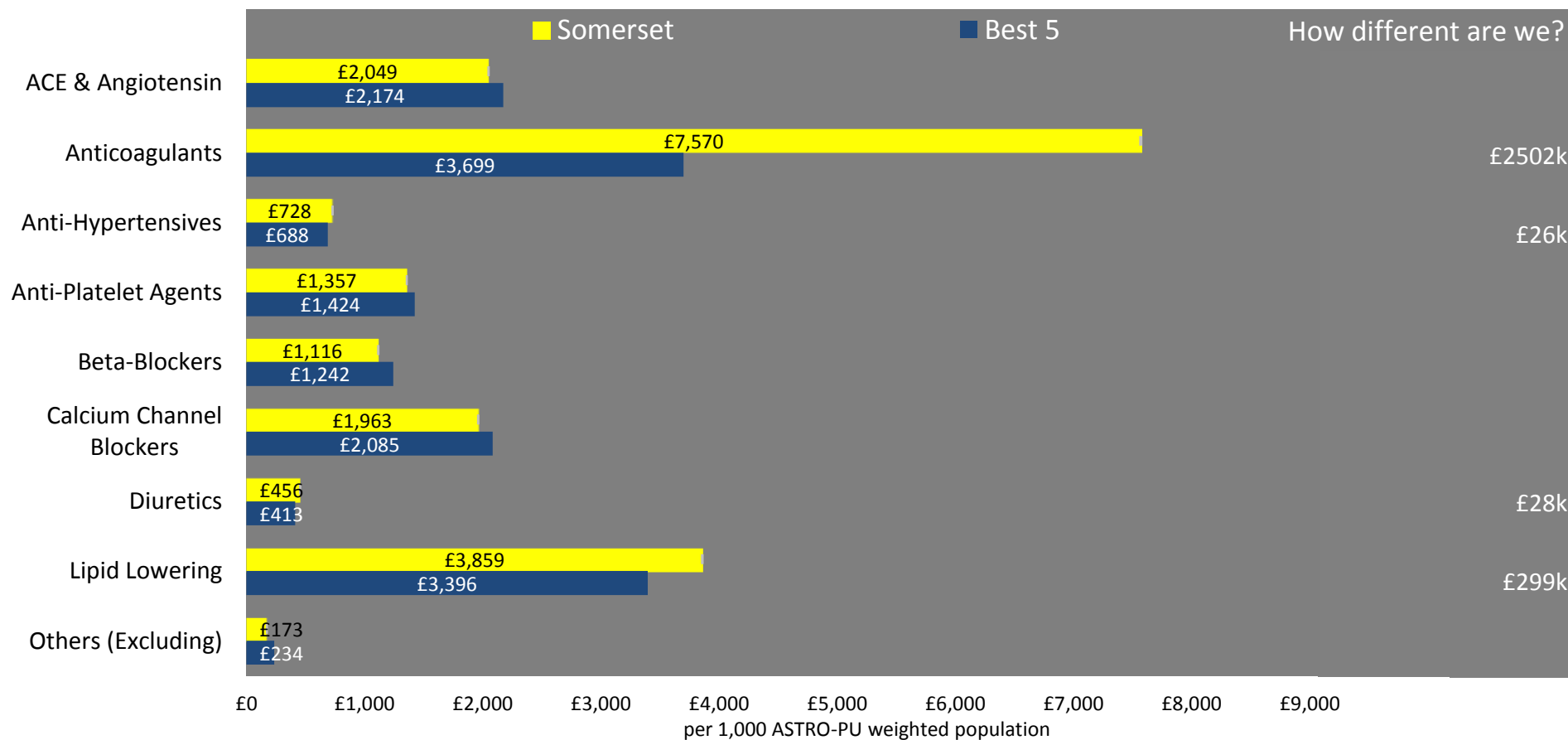
Innovation Scorecard: <https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/>

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

# Circulatory (CHD and Stroke) Primary Care Prescribing

Grouped drugs

54



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

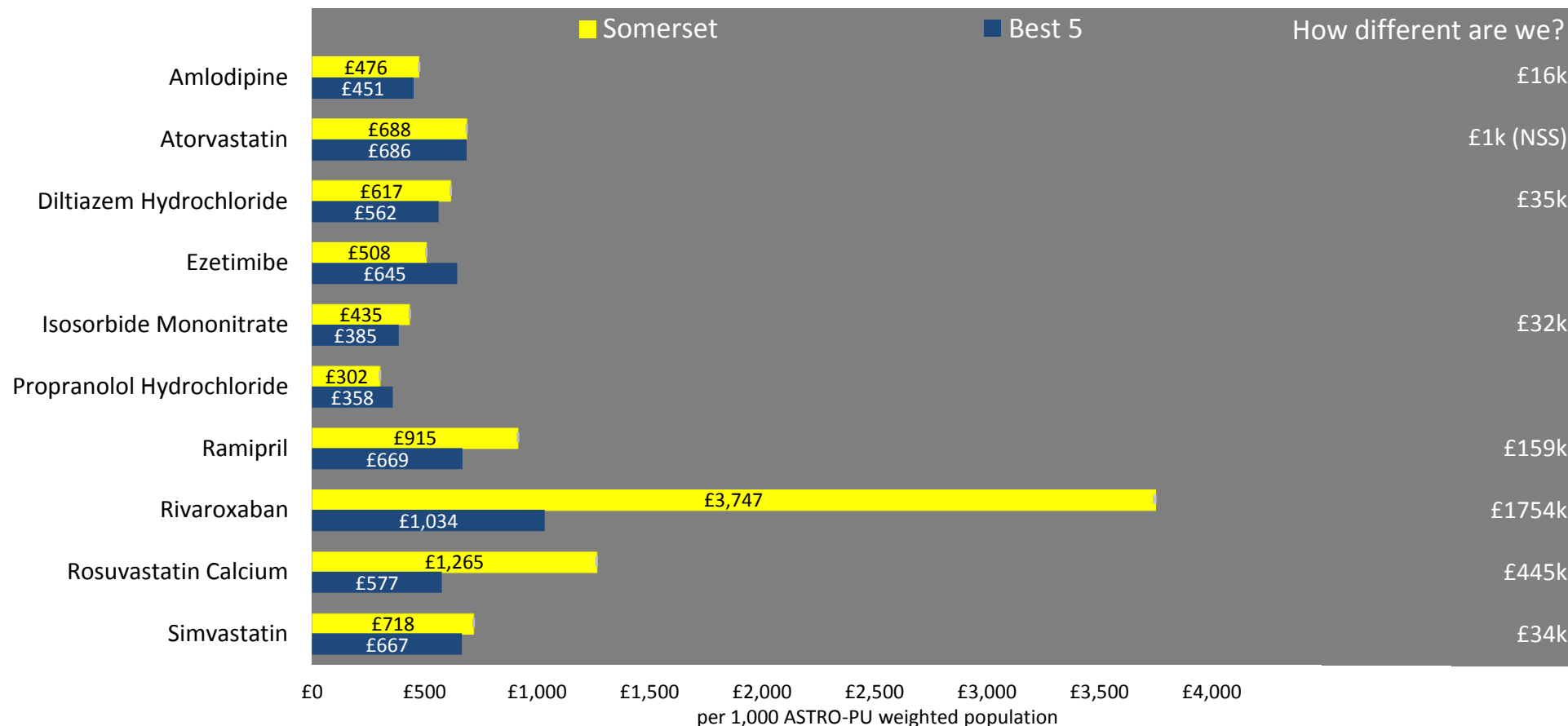
Innovation Scorecard: <https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/>

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

# Circulatory (CHD and Stroke) Primary Care Prescribing continued

## Individual drugs

55



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

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

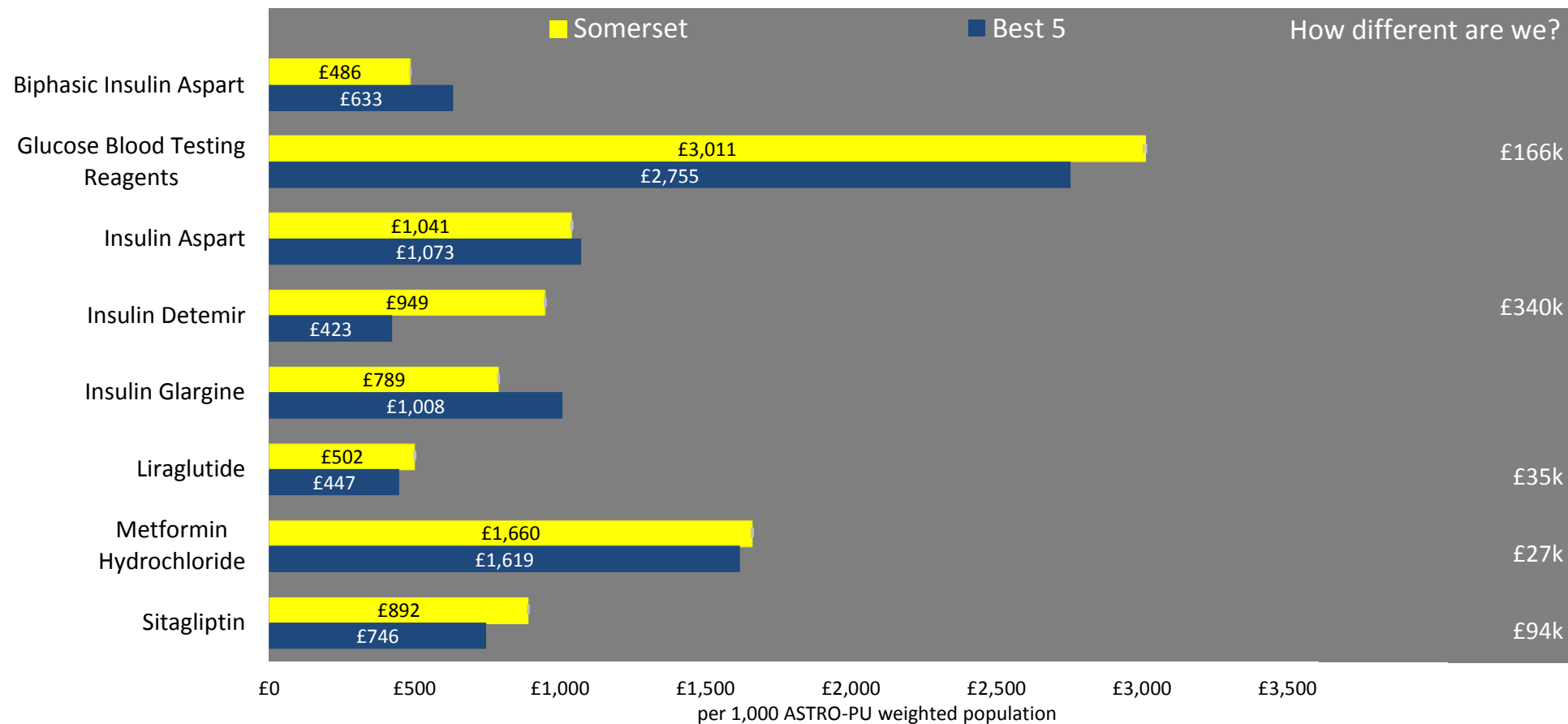
95% confidence intervals

**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

# Diabetes Primary Care Prescribing

56



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

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

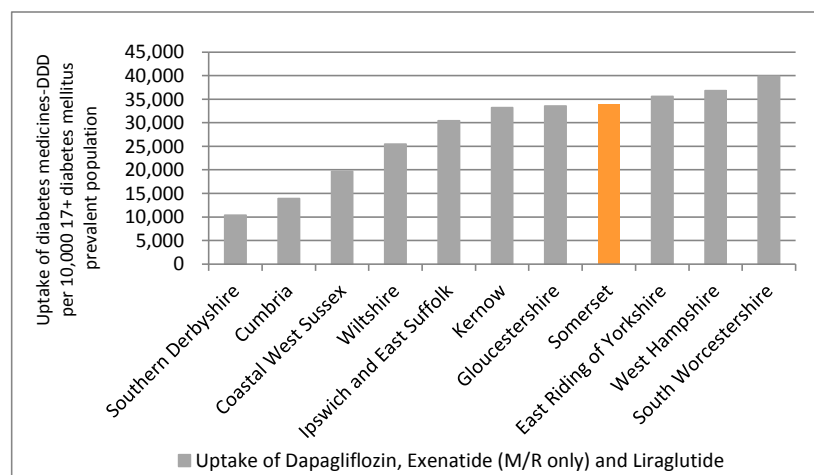
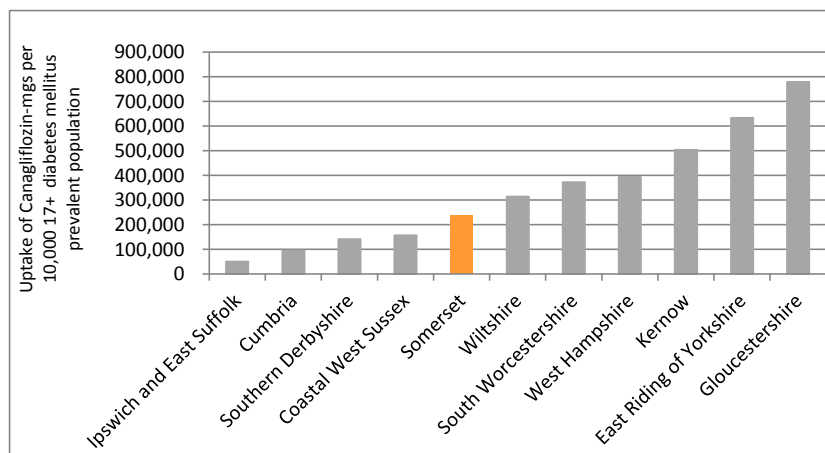
95% confidence intervals  
**NSS** Not statistically significant\*  
 \*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators



# Type 2 Diabetes Innovative Medicines

Does this CCG have appropriate uptake of innovative diabetes medicines?

57



Two charts are shown because uptake of medicines is measured in different units. Data are for Q1 2015-16.

The charts show ranked variation in uptake of innovative diabetes drugs ([TA288](#), [TA248](#), [NG28](#)) 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?

**Sources:** Innovation Scorecard January 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. Diabetes Mellitus Prevalence QOF 2014-15

**Note:** Uptake data from the innovation scorecard have not been adjusted for demography & disease prevalence.

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

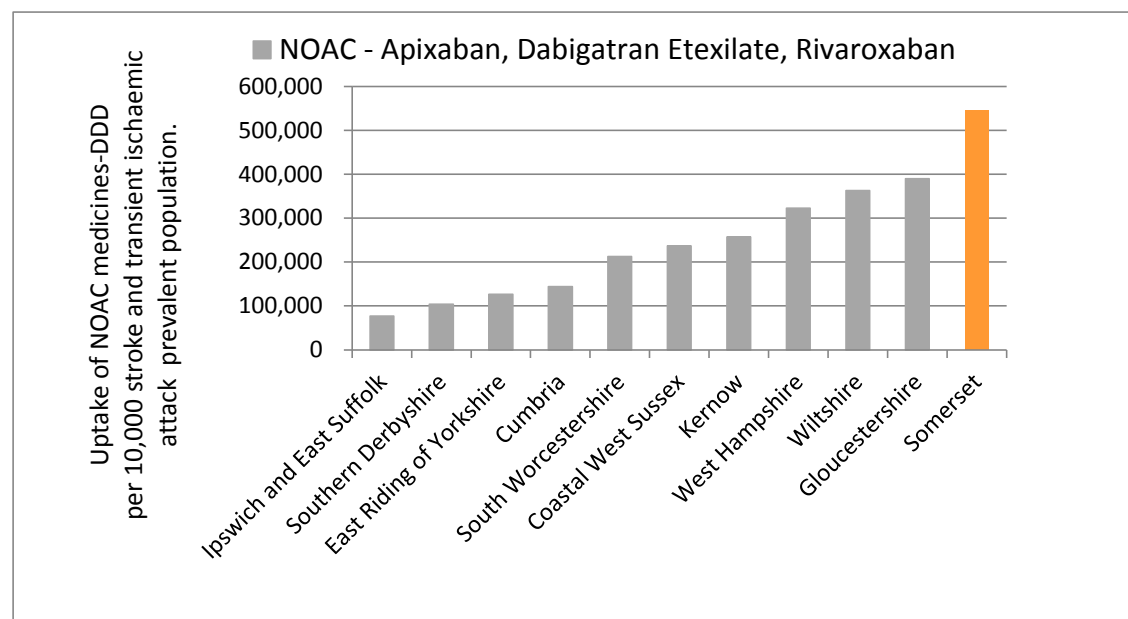
<https://www.england.nhs.uk/ourwork/innovation/innovation-scorecard/>

QOF: <http://www.hscic.gov.uk/catalogue/PUB18887>

# Stroke Innovative Medicines

Does this CCG have appropriate uptake of innovative Stroke(NOAC) medicines?

58



The charts show ranked variation in uptake of innovative NOAC (Novel Oral Anticoagulant) medicines ([TA249](#), [TA256](#), [TA275](#), [TA327](#)) for the prevention of stroke in Atrial Fibrillation 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?

**Sources:** Innovation Scorecard October 2015, 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. Stroke and transient ischaemic attack Prevalence QOF 2014-15

**Note:** NOAC group is also an option for secondary prevention of Deep Vein Thrombosis and/or Pulmonary Embolism. Uptake data from the innovation scorecard have not been adjusted for demography. Data from Q4 2014-15

<http://guidance.nice.org.uk/cg180/nicconsensusstatement/pdf/english>

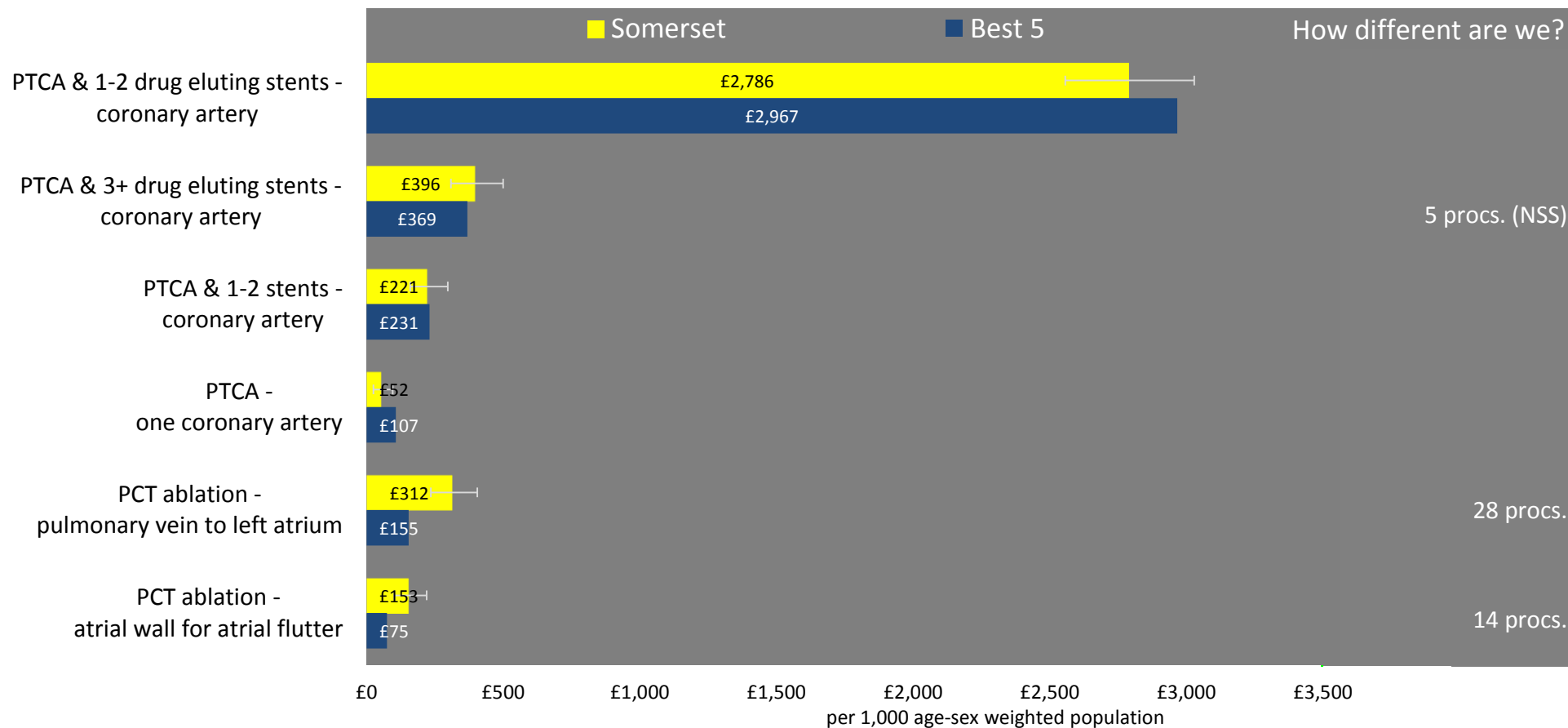
<http://www.hscic.gov.uk/catalogue/PUB19259>

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

QOF: <http://www.hscic.gov.uk/catalogue/PUB18887>

# Cardiology procedures

59



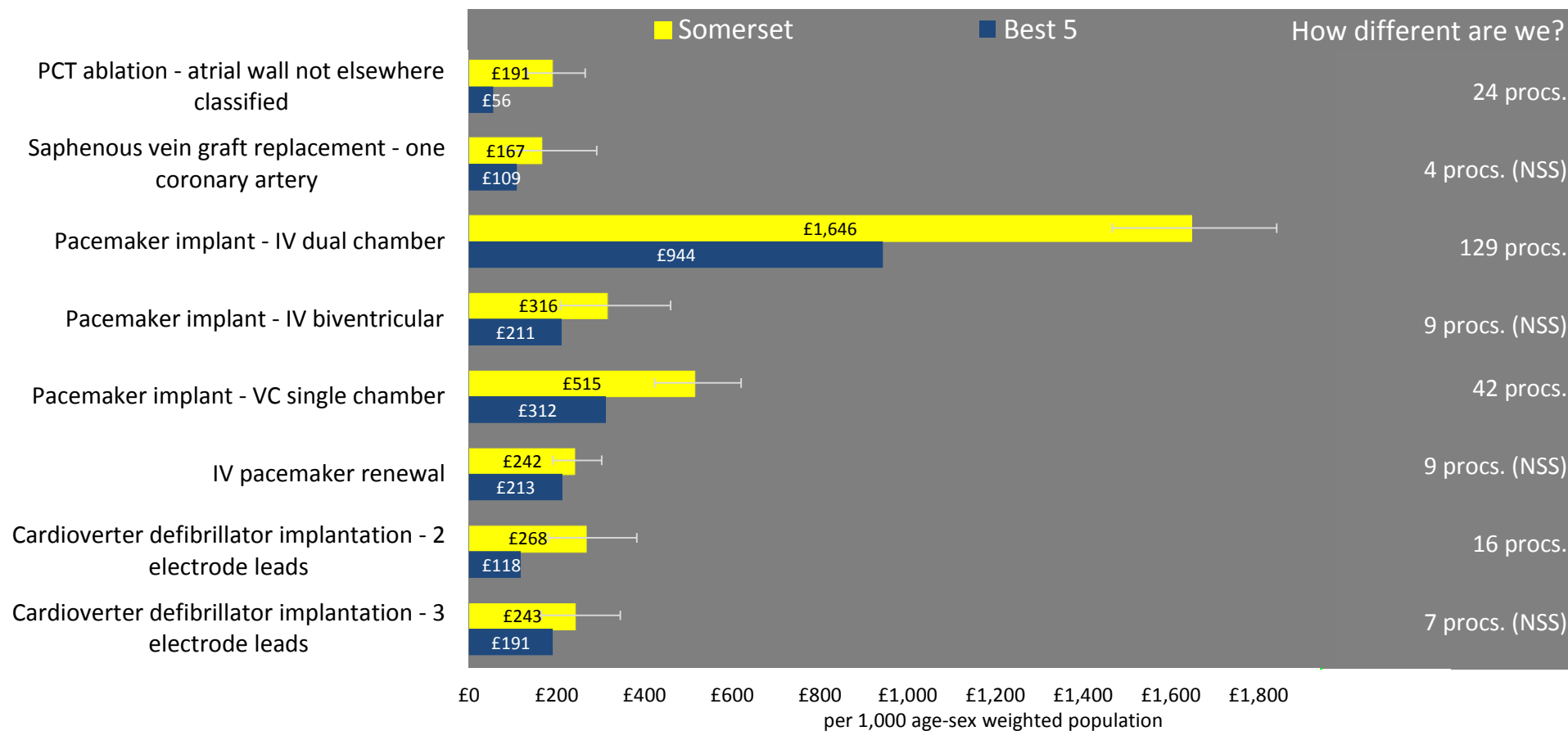
95% confidence intervals

**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

# Cardiology procedures continued

60



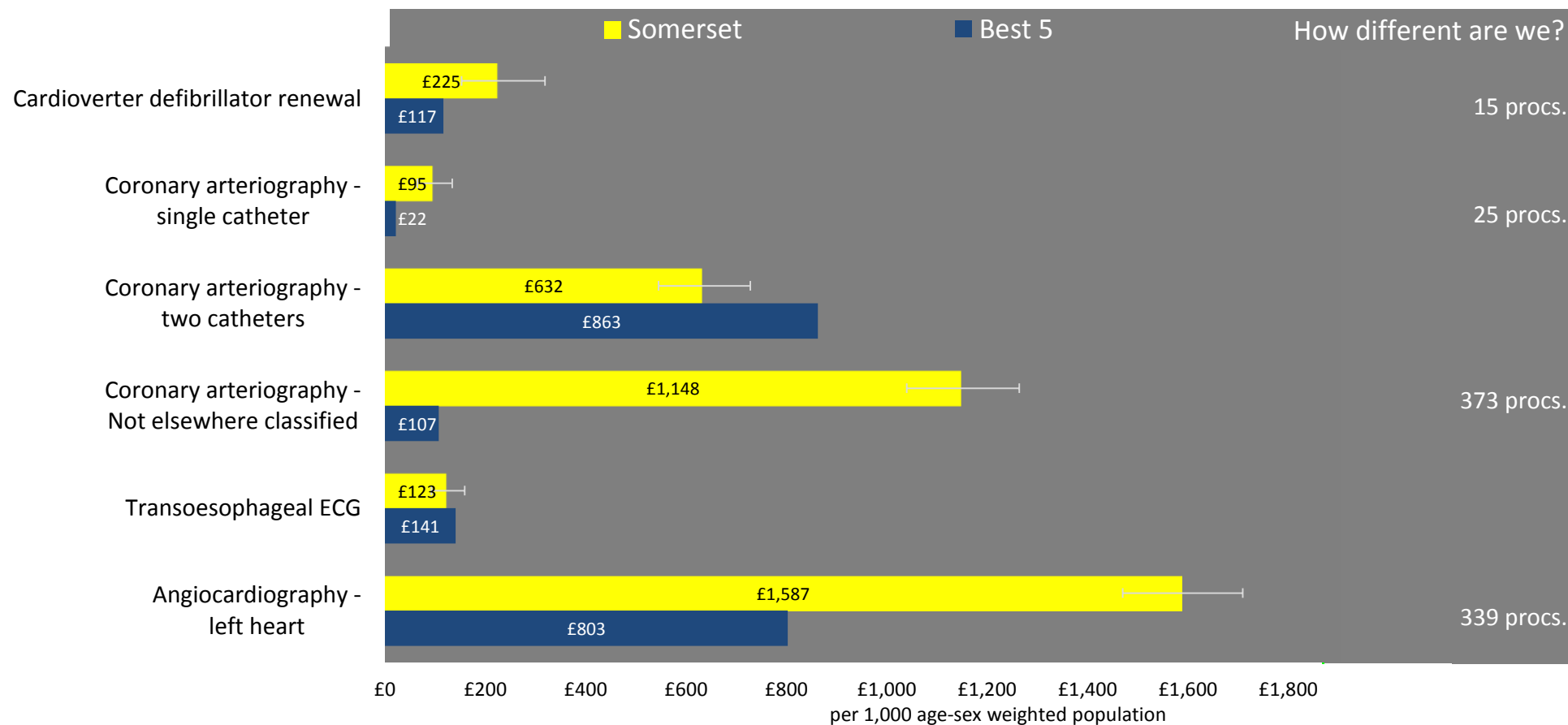
95% confidence intervals

**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

# Cardiology procedures continued

61



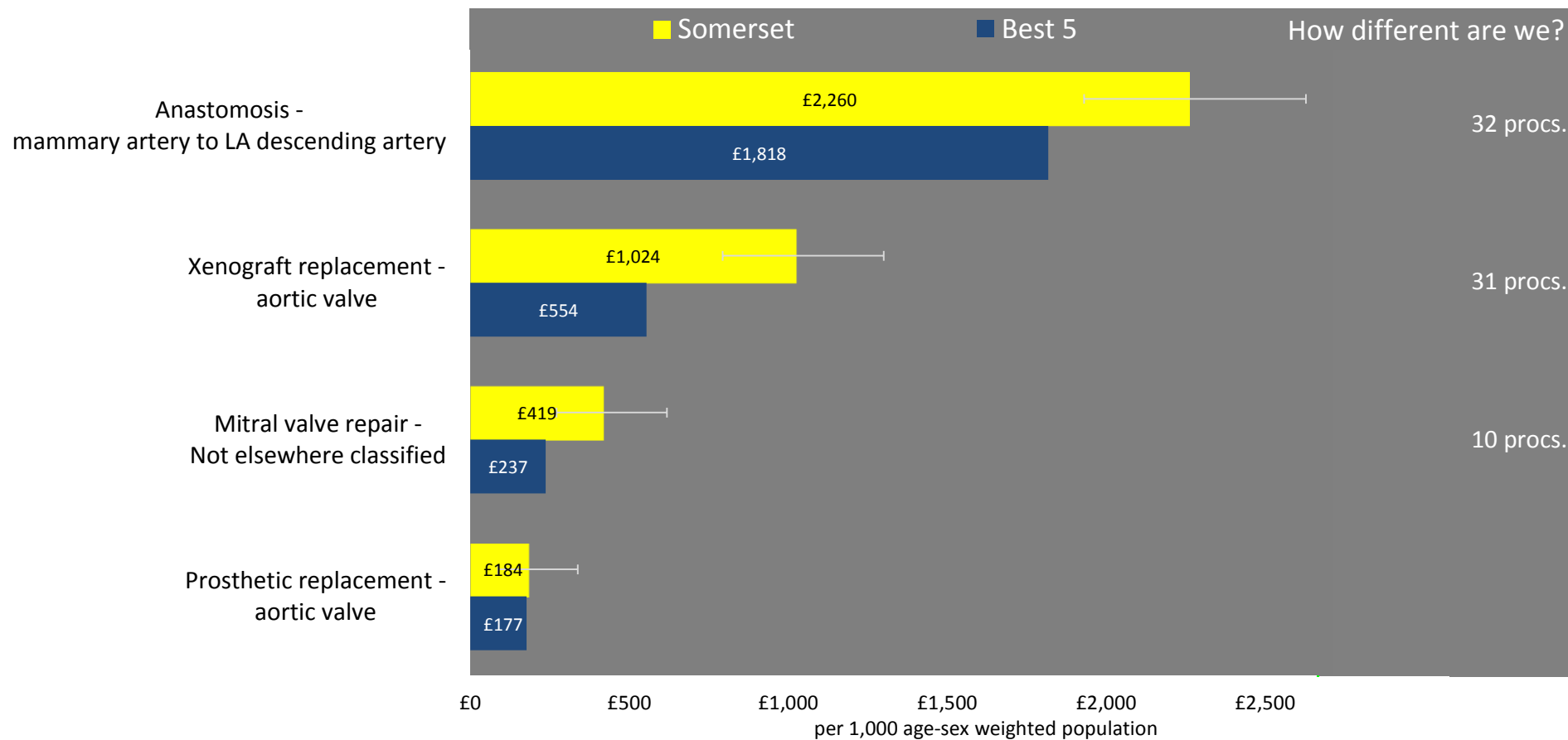
95% confidence intervals

**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

# Cardiac surgery procedures

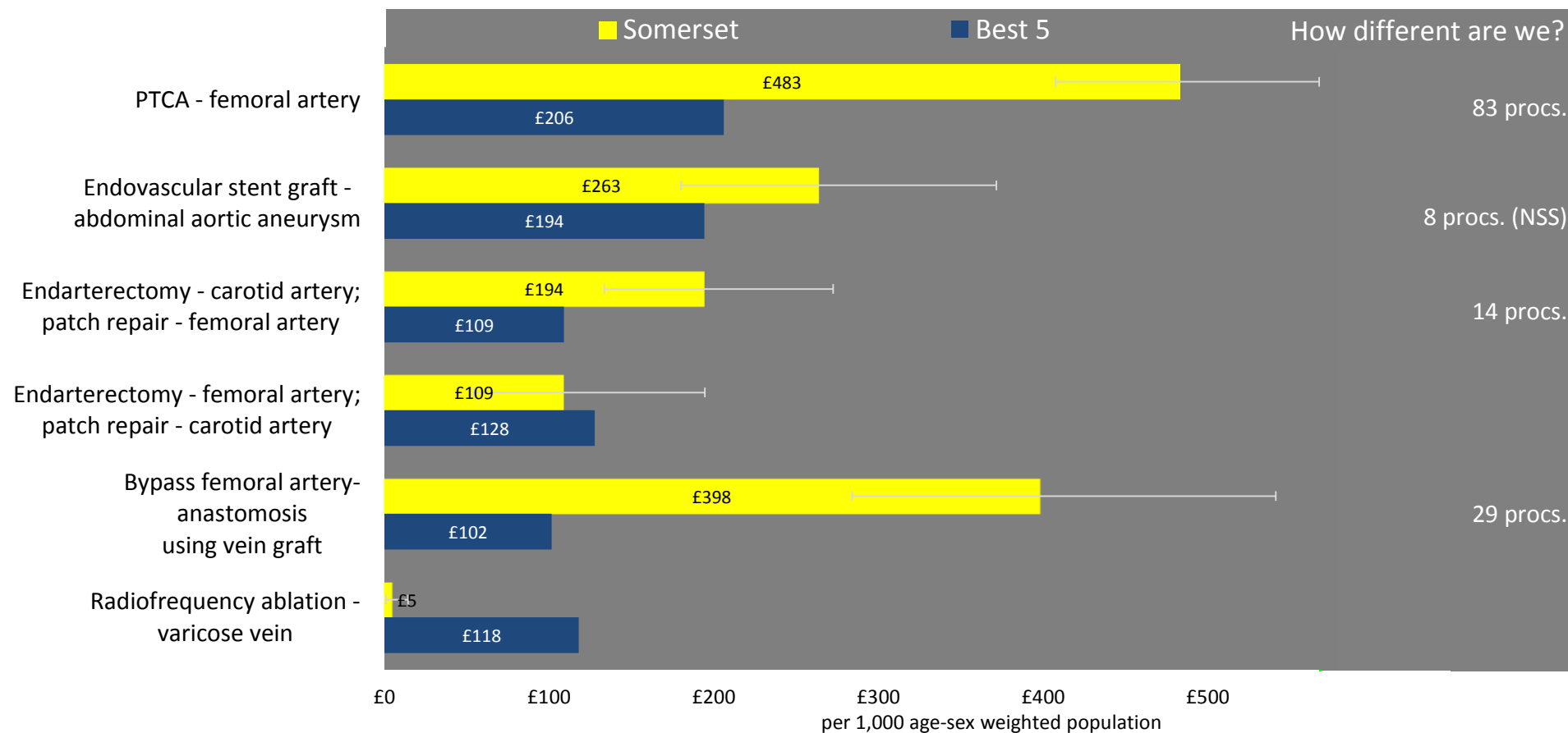
62



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



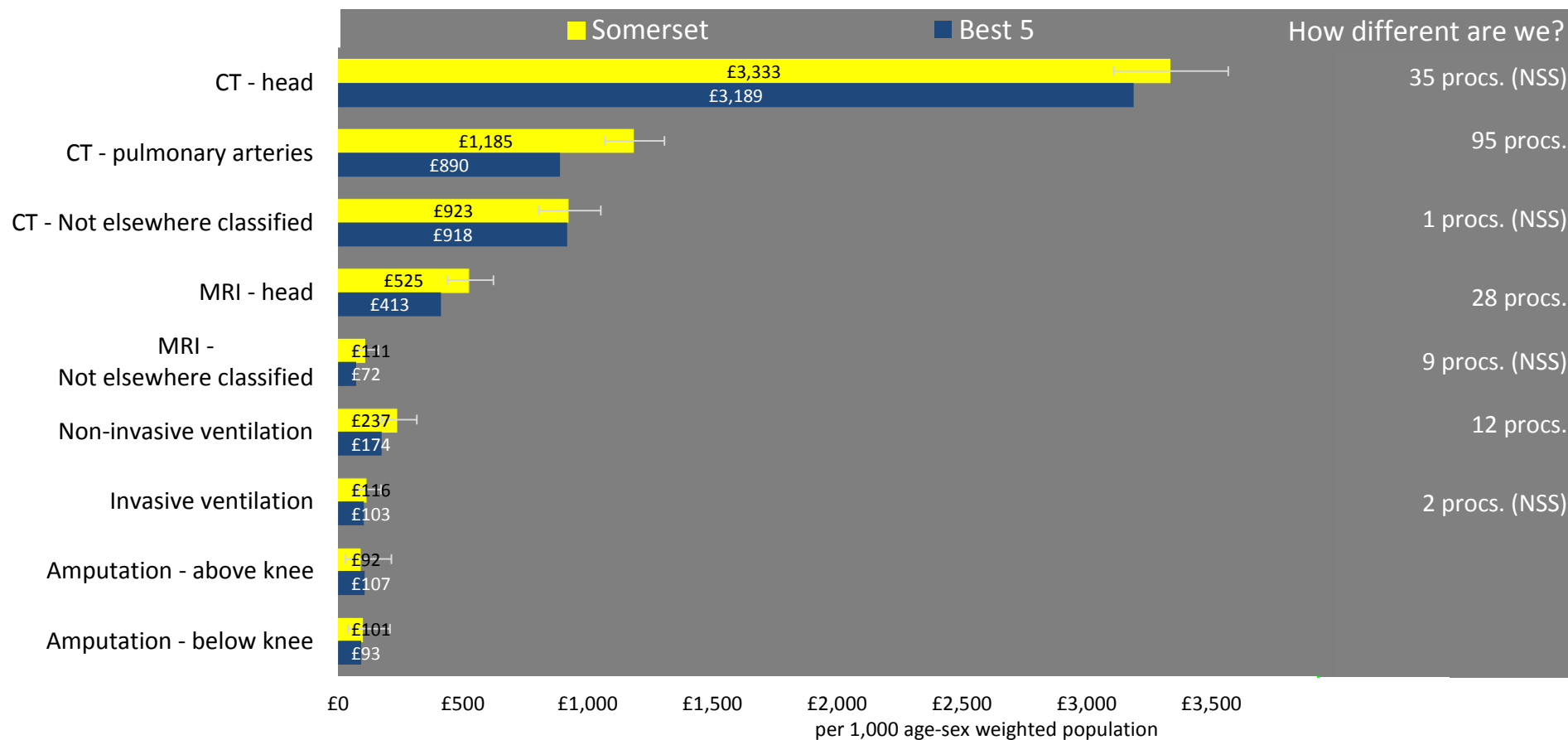
95% confidence intervals

**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

# Circulation - miscellaneous procedures

64



95% confidence intervals

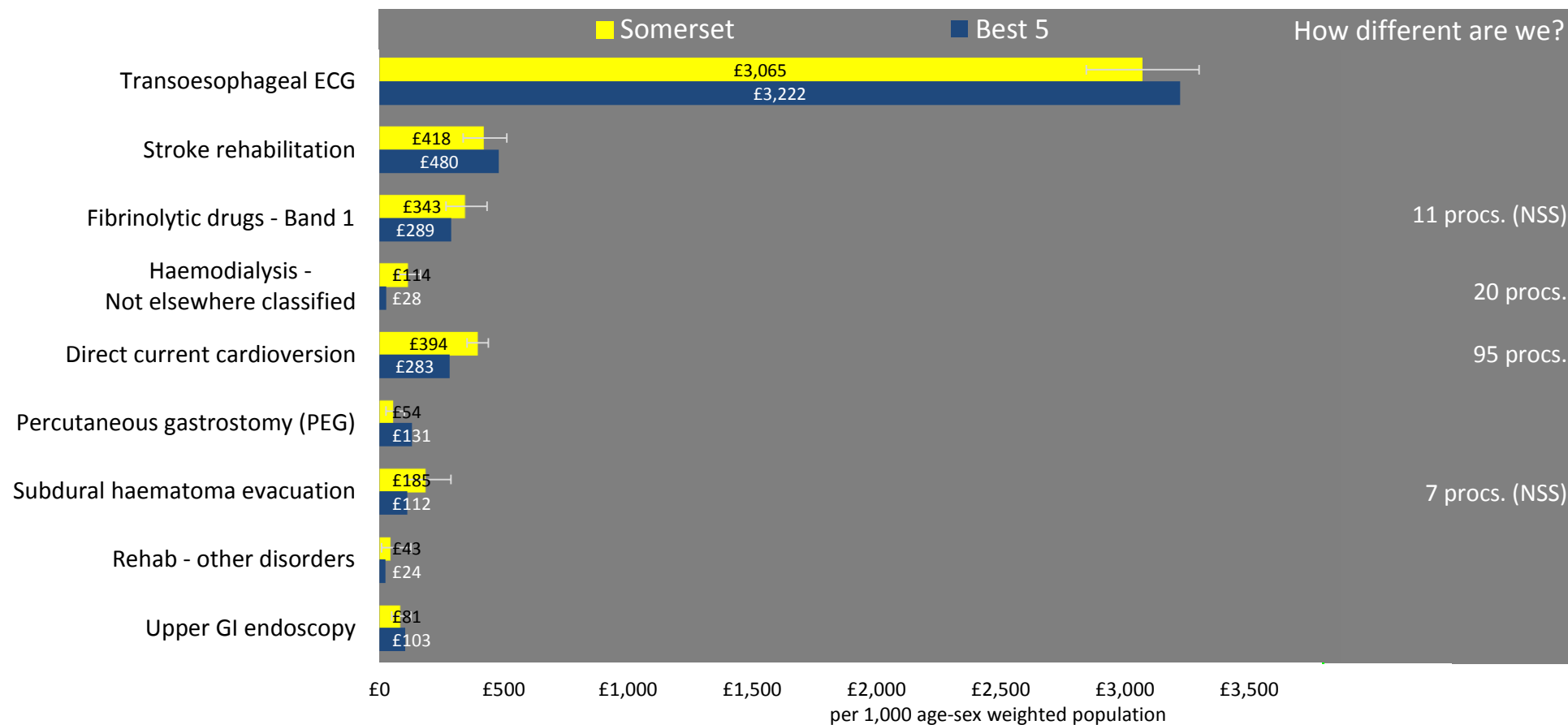
**NSS** Not statistically significant\*

\*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



# Circulation - miscellaneous procedures continued

65



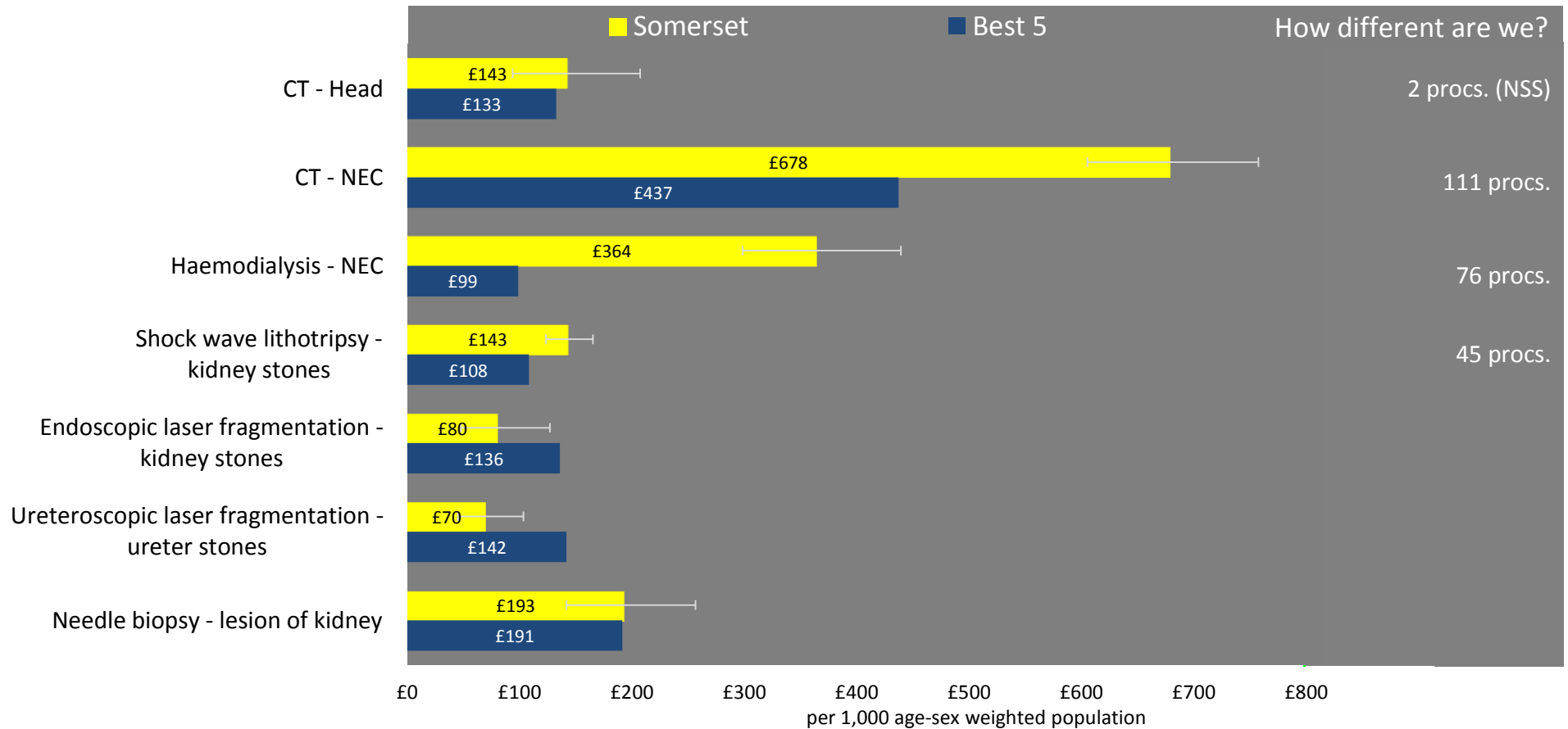
95% confidence intervals

**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

# Renal procedures

66



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

# Renal procedures continued

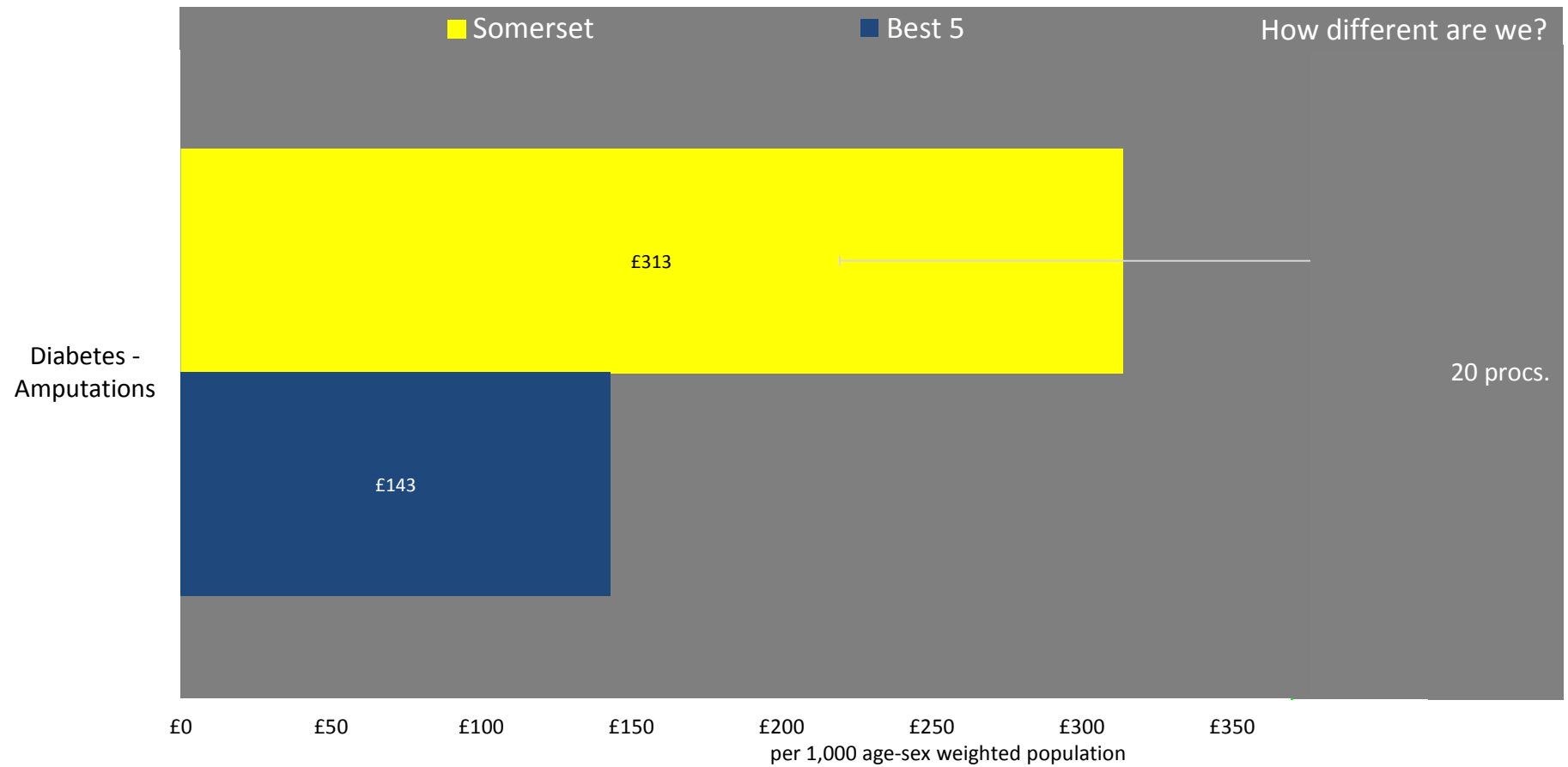
67



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\*

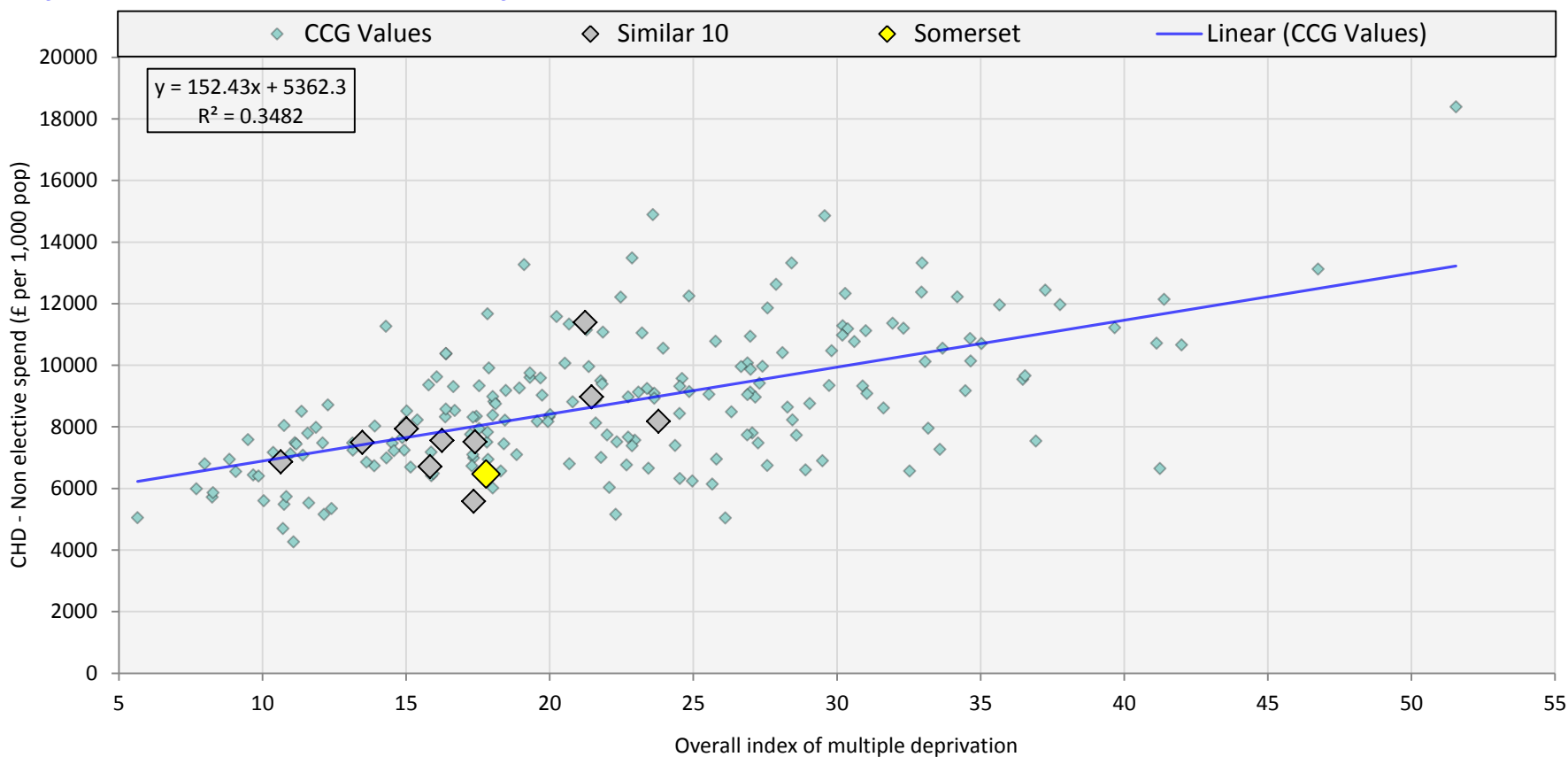
\*Where an opportunity is 'NSS' CCGs can investigate further whether this reflects a true opportunity e.g. by looking at more than 1 year's data or triangulating with other indicators

# Scatter Plot Analysis

69

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.

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



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

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

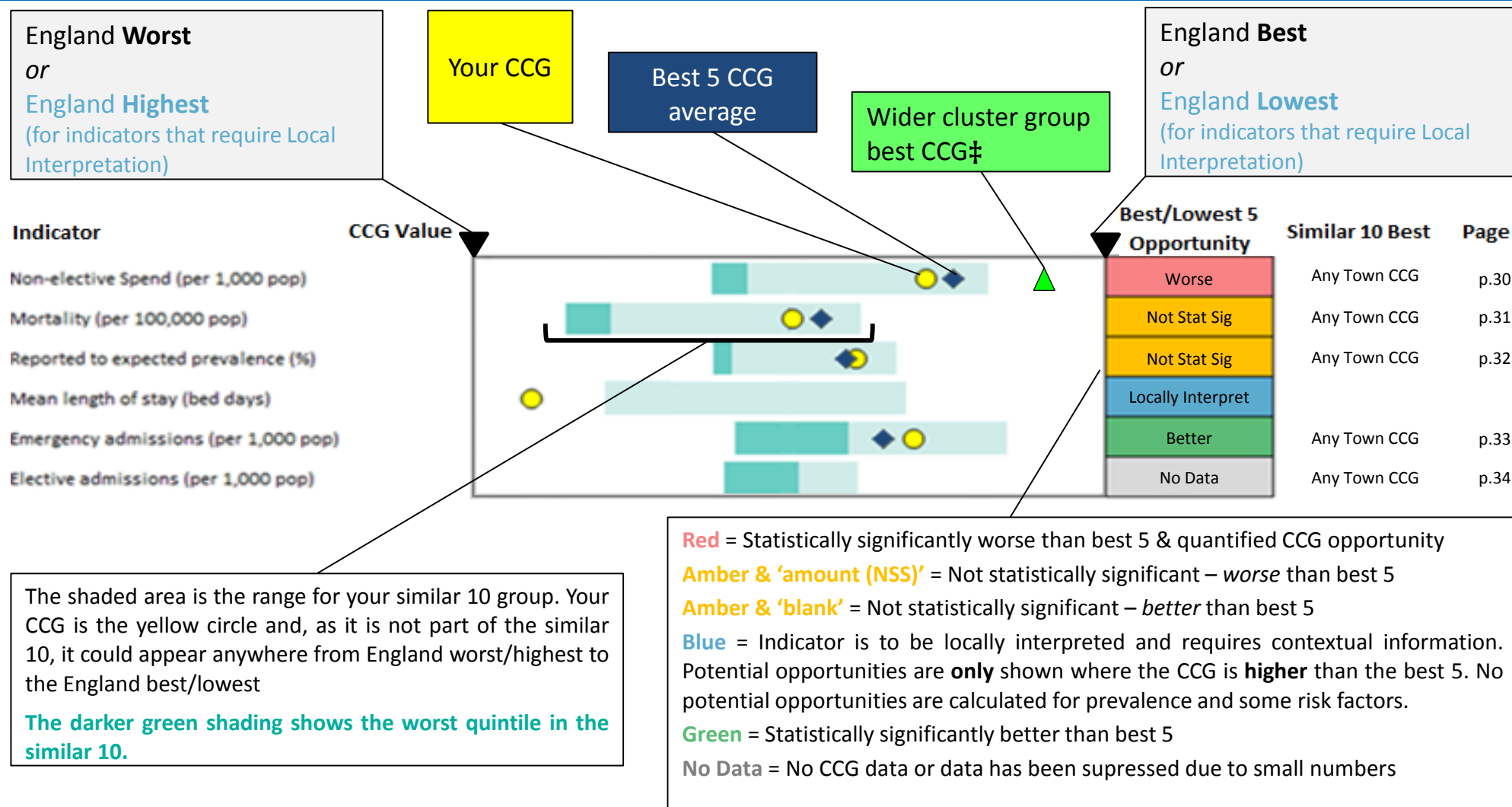
The width of the spine chart shows the England range. Your CCG is benchmarked against its similar 10 group. The shaded area of the spine chart within the table shows the range for the similar 10 group. Where the CCG is highest or lowest compared with its similar 10 group it is shown as outside that group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

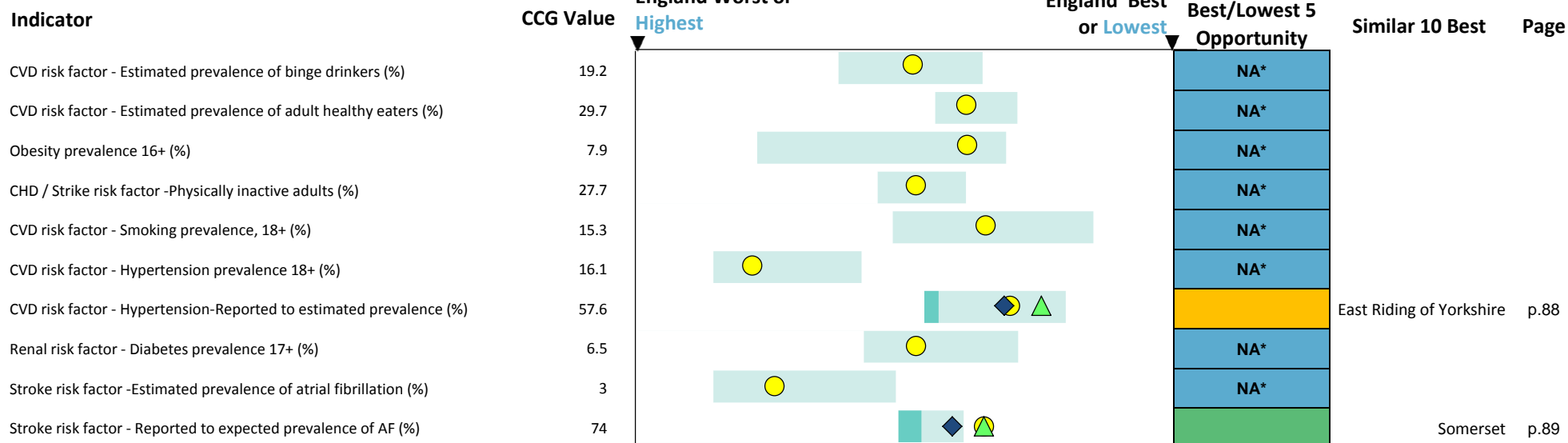
34



‡ 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 slide 7.

# Cardiovascular Disease Conditions - Opportunity table - Risk

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



Please note: For smoking, obesity, physical inactivity and healthy eating 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 71 for full guidance on interpretation of this table of opportunities



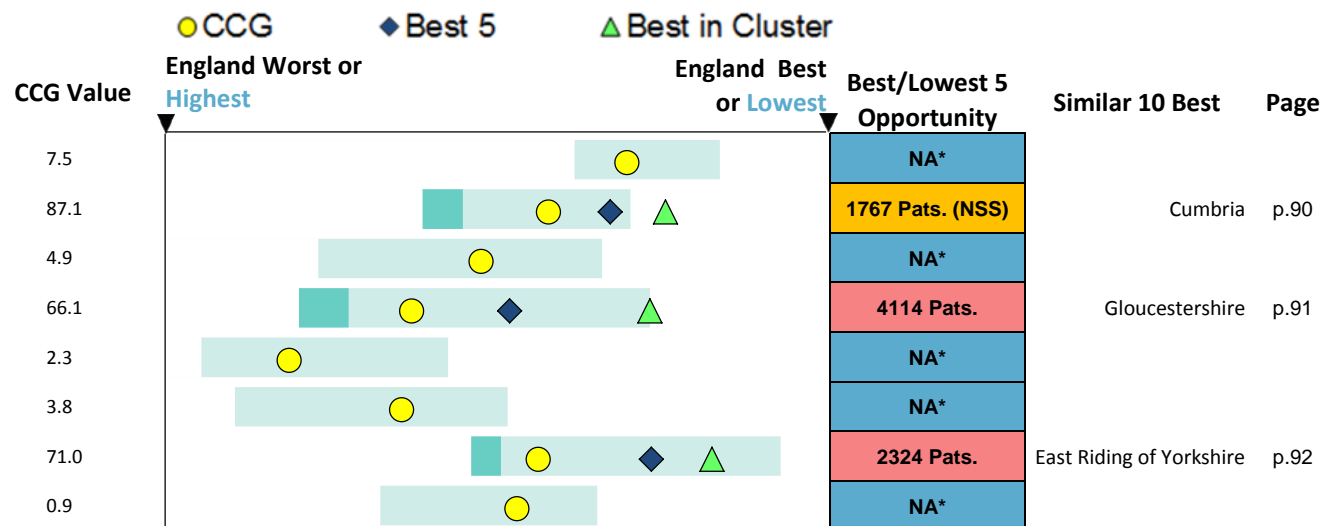
# Cardiovascular Disease Conditions - Opportunity table - Prevalence and detection

NHS Somerset CCG 73

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

## Indicator

Expected prevalence of diabetes (%)
Observed to expected prevalence of diabetes (%)
Reported CKD prevalence (%)
Reported to estimated prevalence of CKD (%)
Stroke or TIA Prevalence, 18+ (%)
CHD prevalence (%)
Reported to estimated prevalence of CHD (%)
Prevalence of heart failure (%)



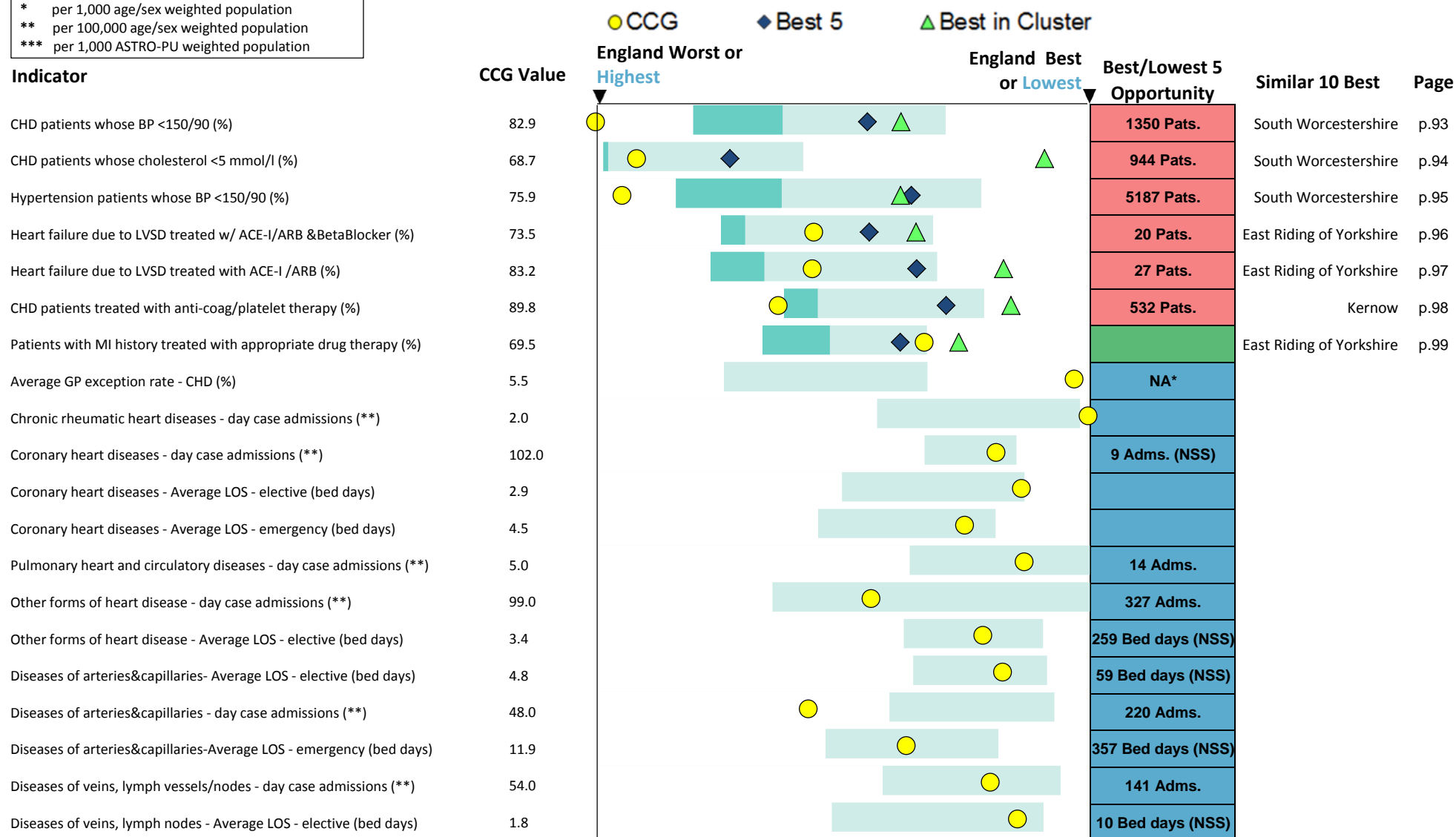
\* No opportunity is calculated for risk and reported prevalence indicators

Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Activity and quality

NHS Somerset CCG 74

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

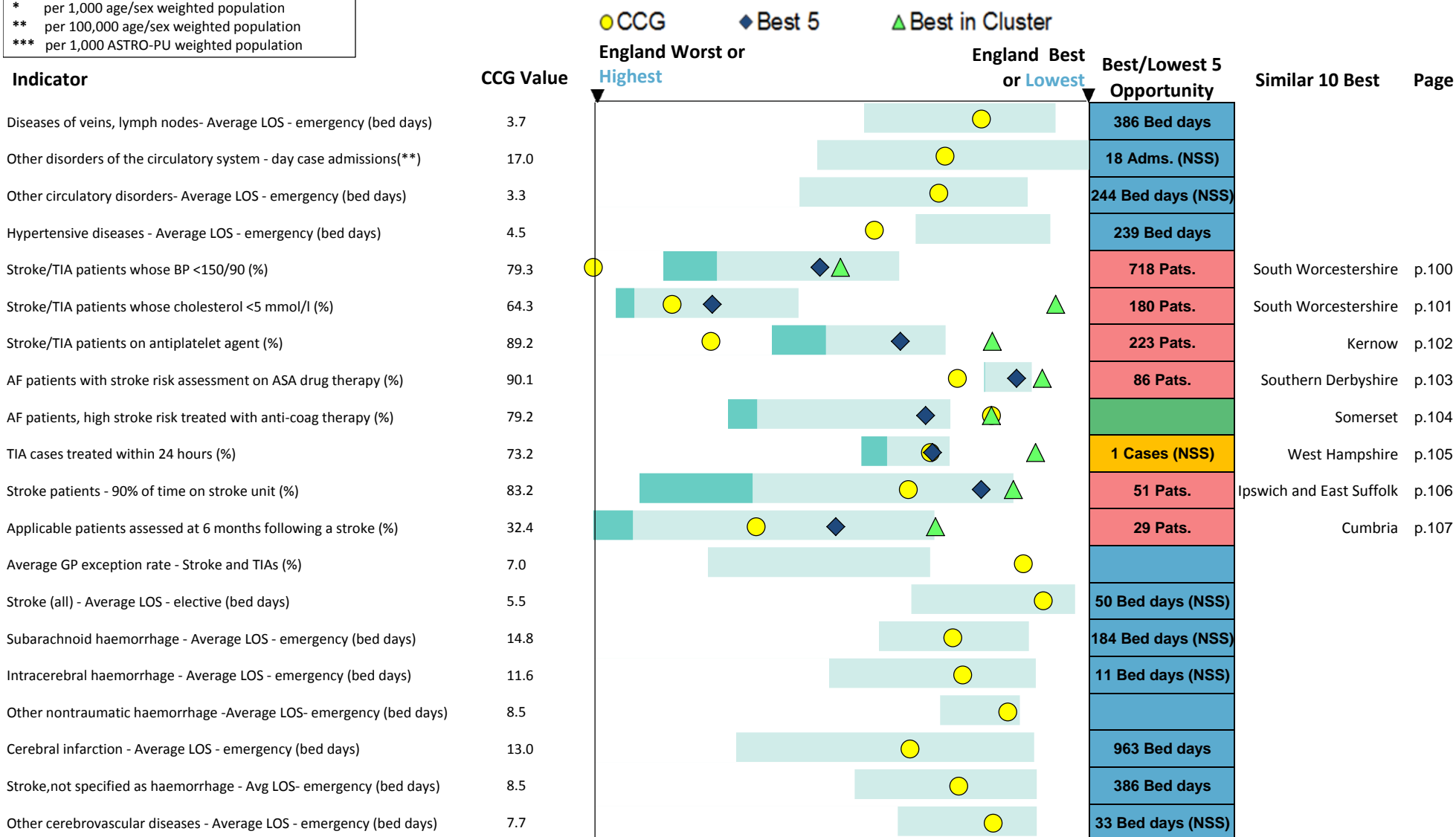


Please refer to slide 69 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Activity and quality

NHS Somerset CCG 75

\* 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 69 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Activity and quality

NHS Somerset CCG 76

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

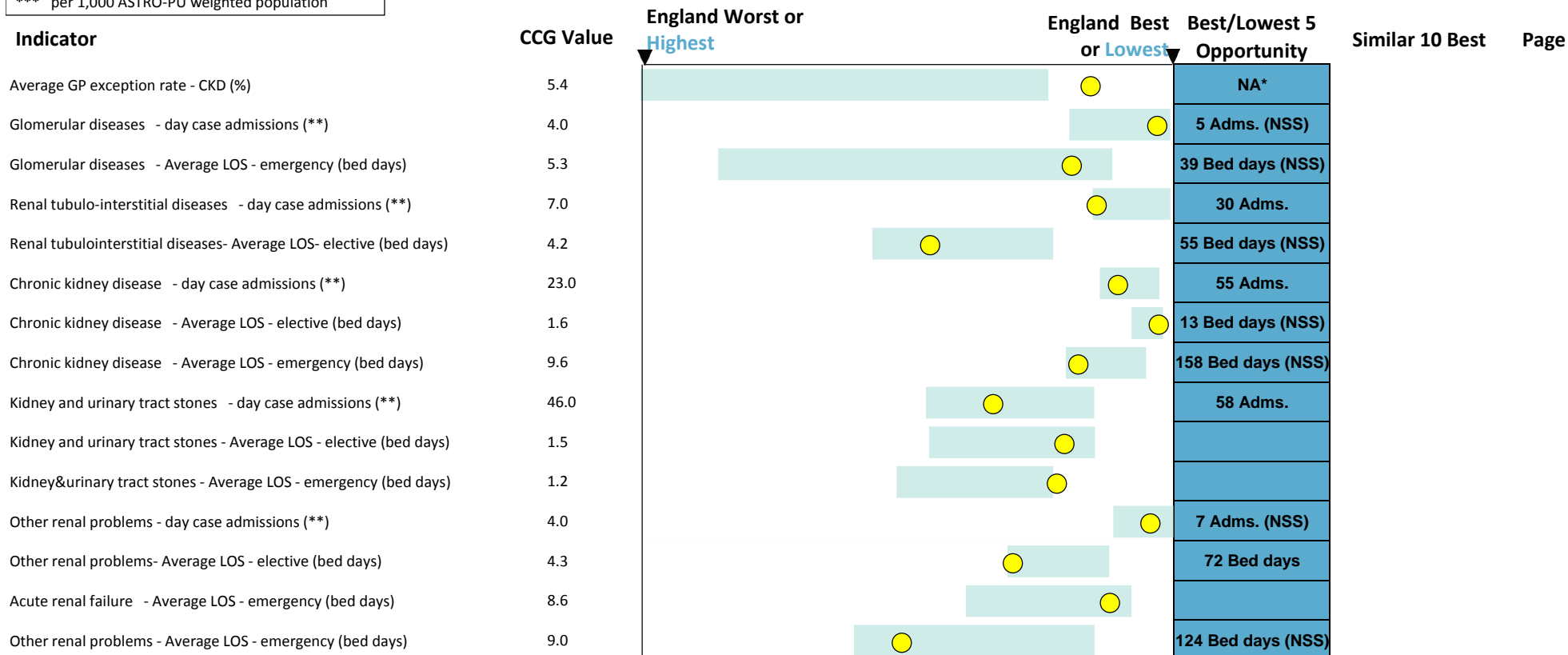
Indicator	CCG Value	England Worst or Highest	England Best or Lowest	Best/Lowest 5 Opportunity	Similar 10 Best	Page
Diabetes patients cholesterol <5 mmol/l (%)	72.1				South Worcestershire	p.108
Diabetes patients HbA1c is 64 mmol/mol (%)	66.7			1221 Pats.	South Worcestershire	p.109
Diabetes patients HbA1c <59mmol (%)	58.2			1405 Pats.	South Worcestershire	p.110
Diabetes patients whose BP <150/90 (%)	83.8			1112 Pats.	South Worcestershire	p.111
Diabetes patients whose BP <140/80 (%)	66.4			1719 Pats.	South Worcestershire	p.112
Patients receiving 8 cares processes (%)	56.7			1788 Pats.	South Worcestershire	p.113
Diabetes patients who have had retinal screening (12 months) (%)	83.1			362 Pats.	West Hampshire	p.114
Patients with diabetes who have had a flu vaccination (%)	76.2			963 Pats.	Cumbria	p.115
Patients with diabetes attending structured education (%)	63.7			64 Pats.	Wiltshire	p.116
Diabetes patients who have had a test for protein in urine (%)	72.2			2534 Pats.	East Riding of Yorkshire	p.117
Diabetes patients who have had a foot examination (%)	76.7			1873 Pats.	Ipswich and East Suffolk	p.118
Diabetes patients with kidney disease, treated with ACE-I (%)	79.7			50 Pats.	West Hampshire	p.119
Average GP exception rate - Diabetes (%)	7.7			NA*		
Diabetes - day case admissions (**)	6.0			22 Adms.		
Type 1 diabetes mellitus - Average LOS - emergency (bed days)	3.0					
Type 2 diabetes mellitus - Average LOS - emergency (bed days)	8.2			154 Bed days (NSS)		
CKD patients whose BP < 140/85 (%)	67.3			1520 Pats.	South Worcestershire	p.120
Patients w/ CKD,hypertension& proteinuria treated with ACE-I/ARB(%)	73.9			71 Pats.	West Hampshire	p.121
Creatinine ratio test used in last 12 months (%)	61.5			3312 Pats.	Southern Derbyshire	p.122
Nephrology first outpatient attendance rate (*)	0.9			70 Atts.		

Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Activity and quality

NHS Somerset CCG 77

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

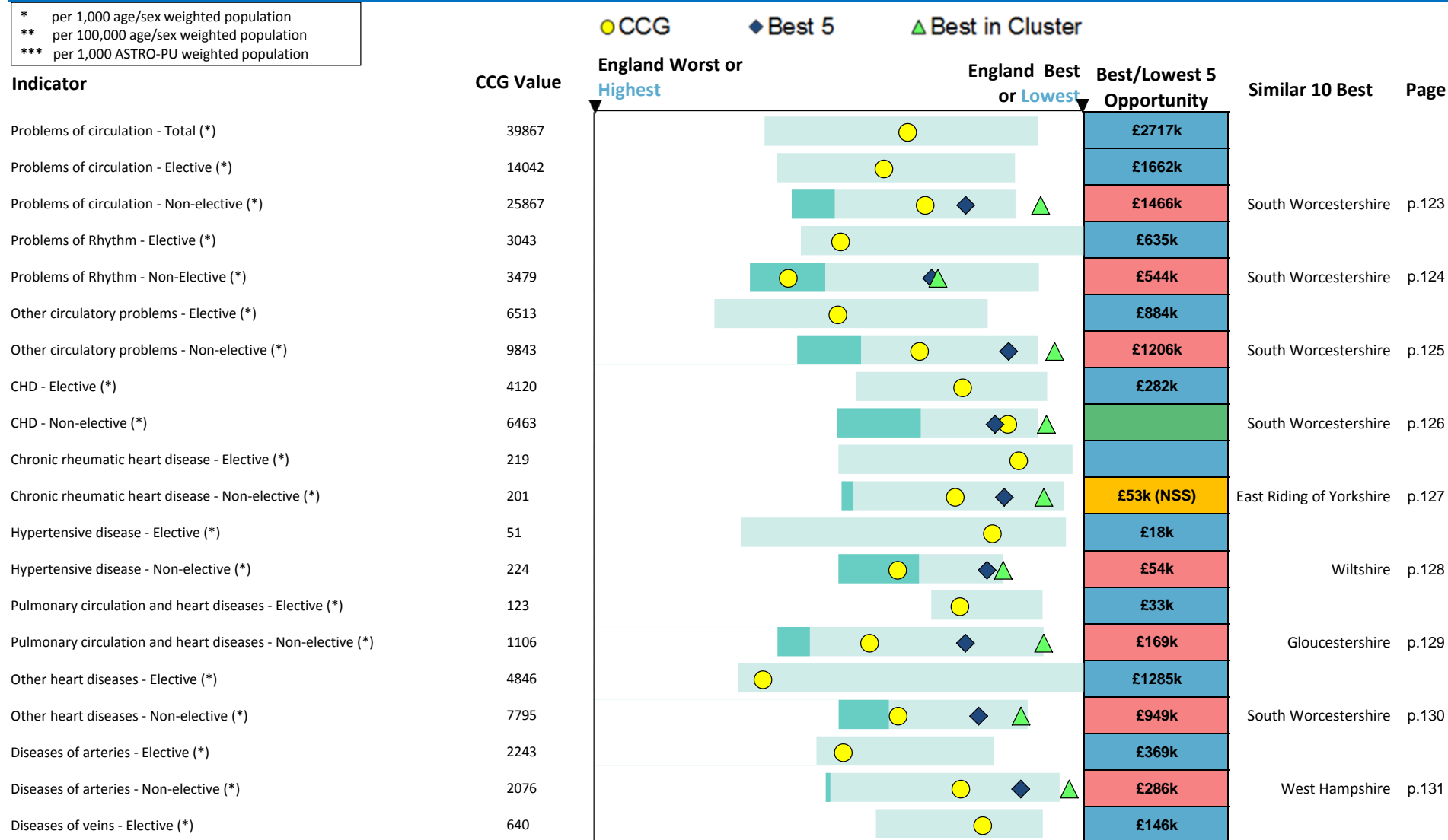


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 78

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

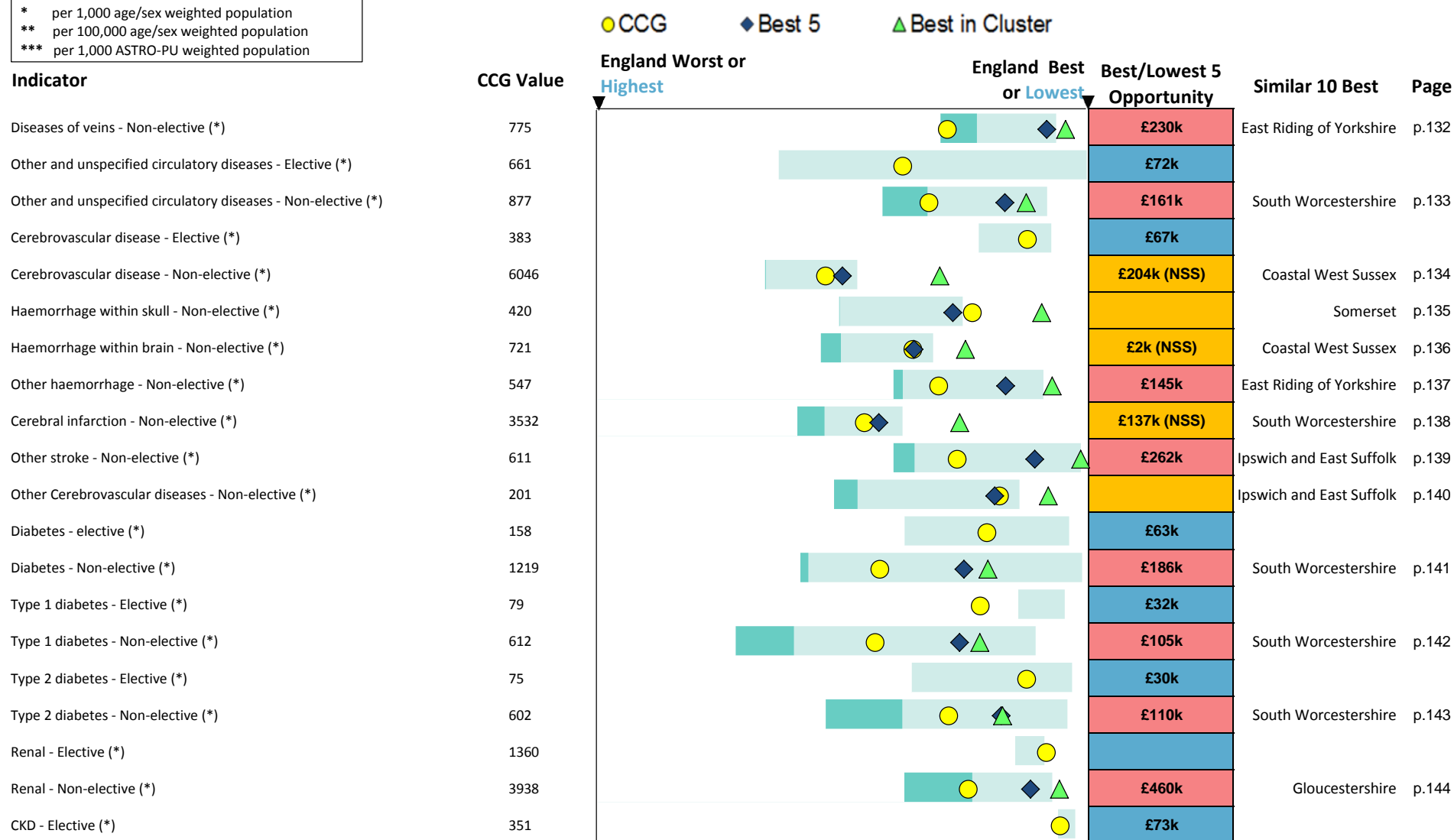


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 79

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

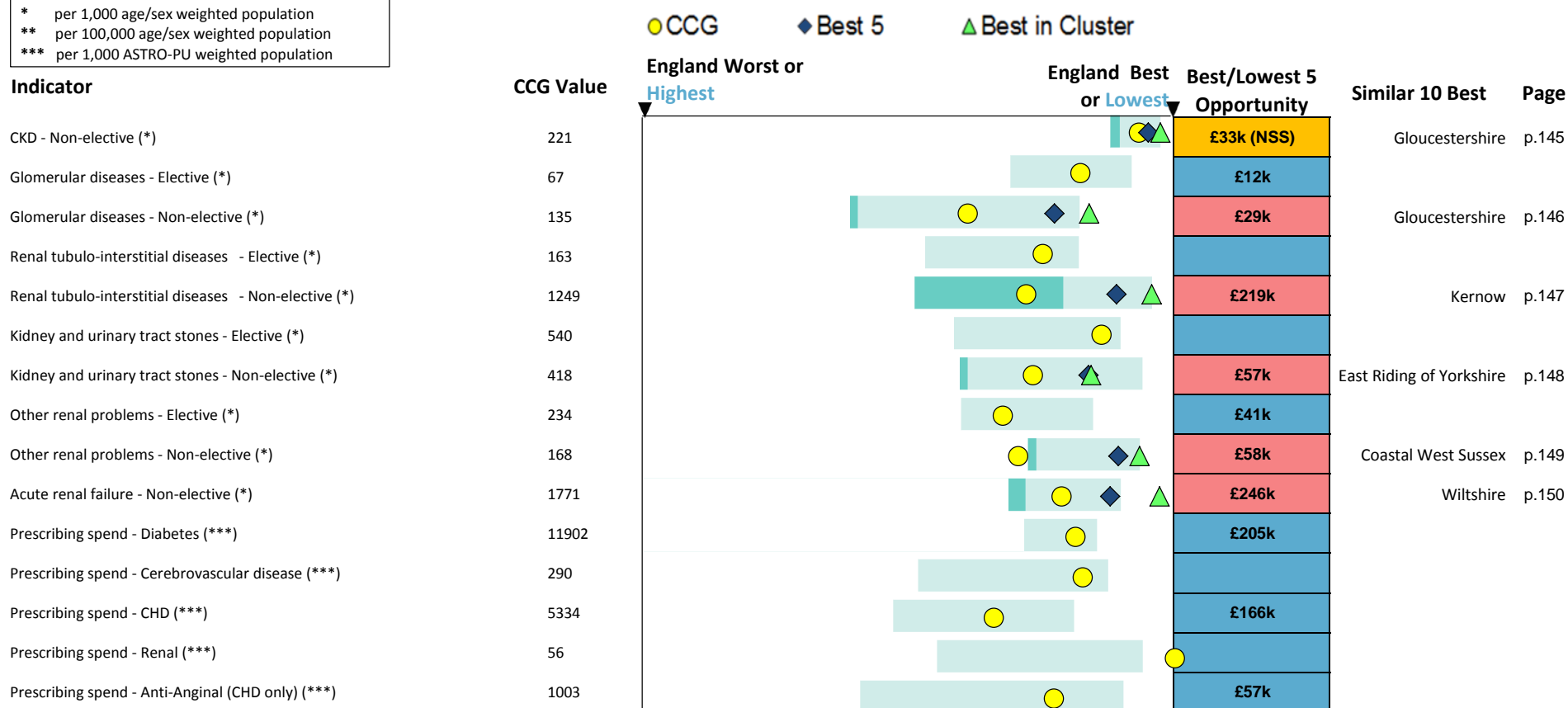


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 80

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



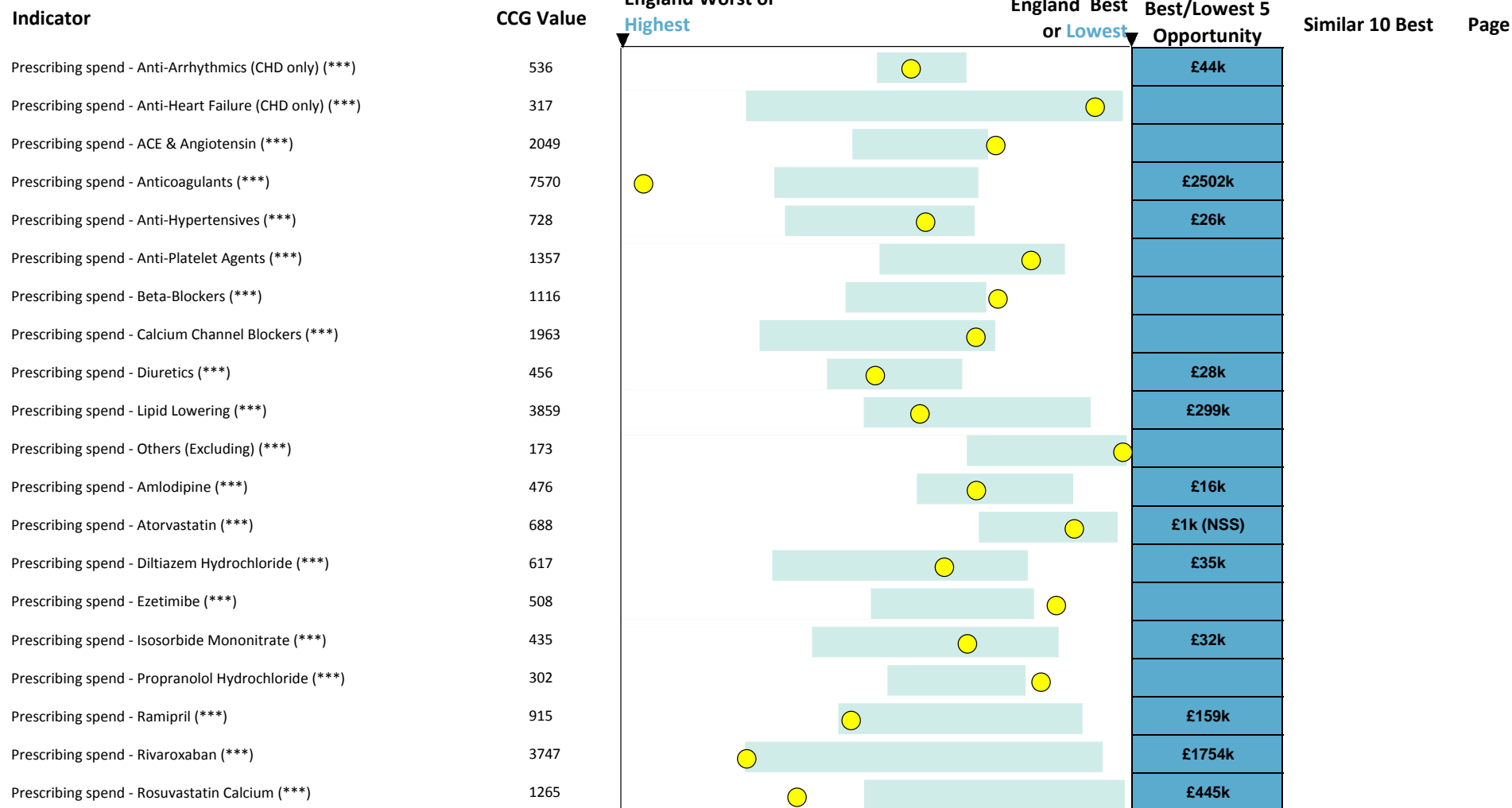
Please refer to slide 71 for full guidance on interpretation of this table of opportunities



# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 81

\* 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 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 82

\* 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 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 83

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

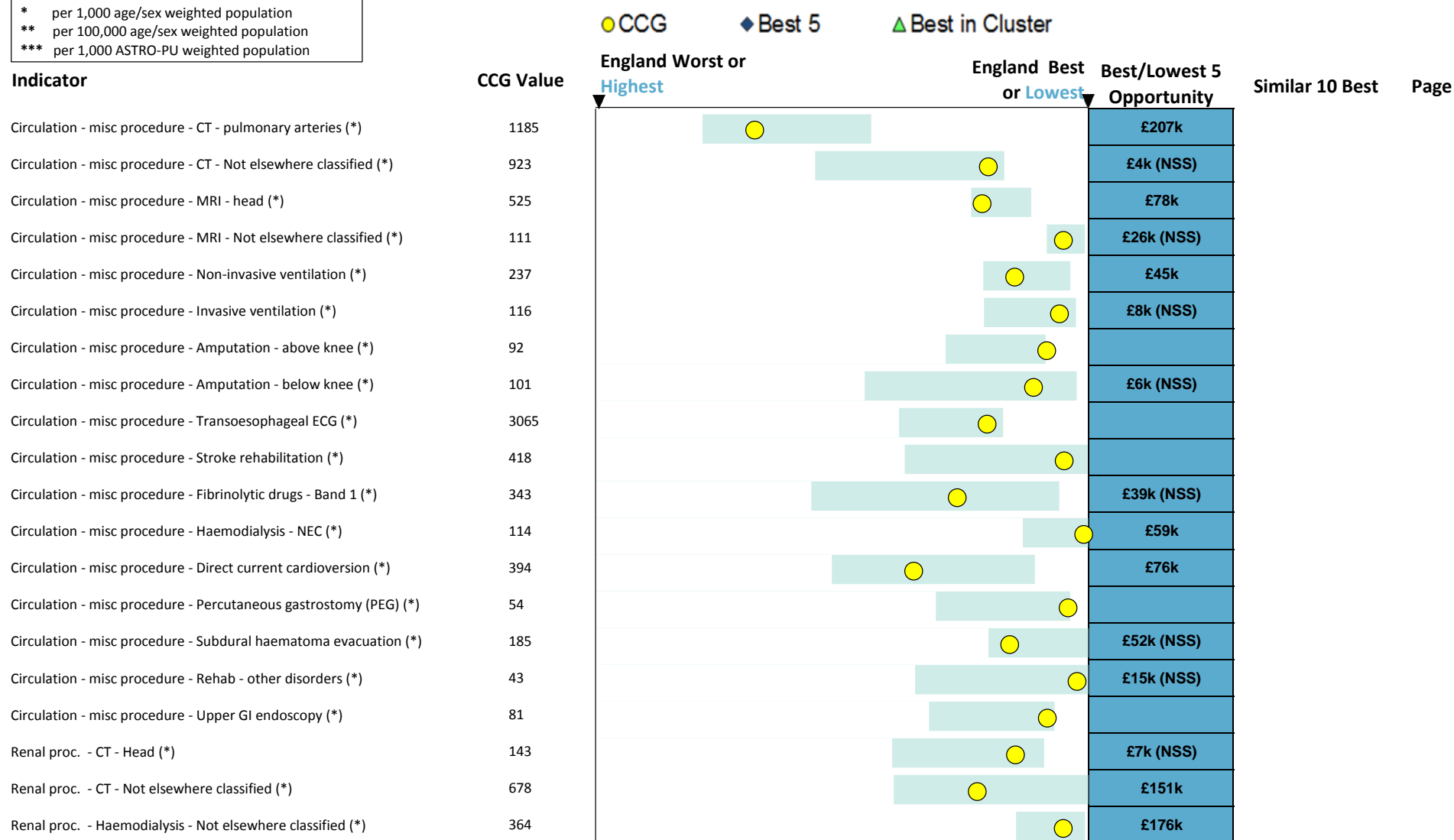


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 84

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

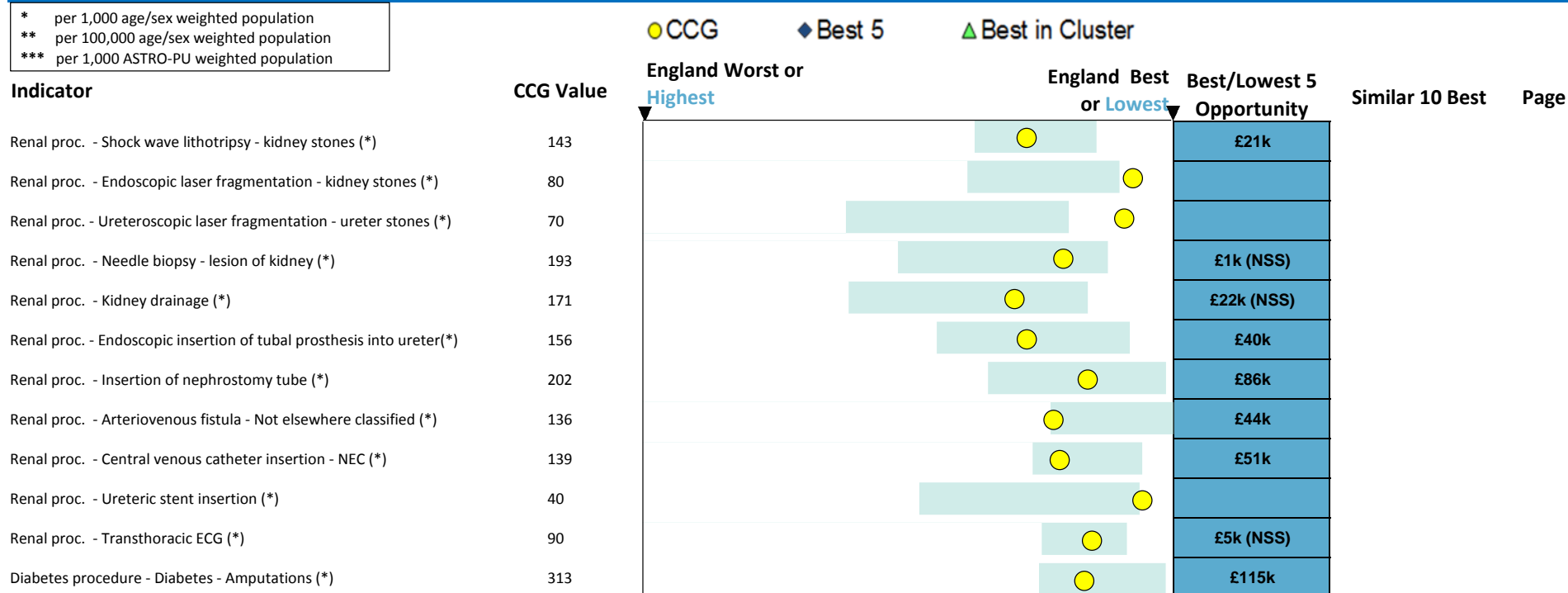


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Spend

NHS Somerset CCG 85

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

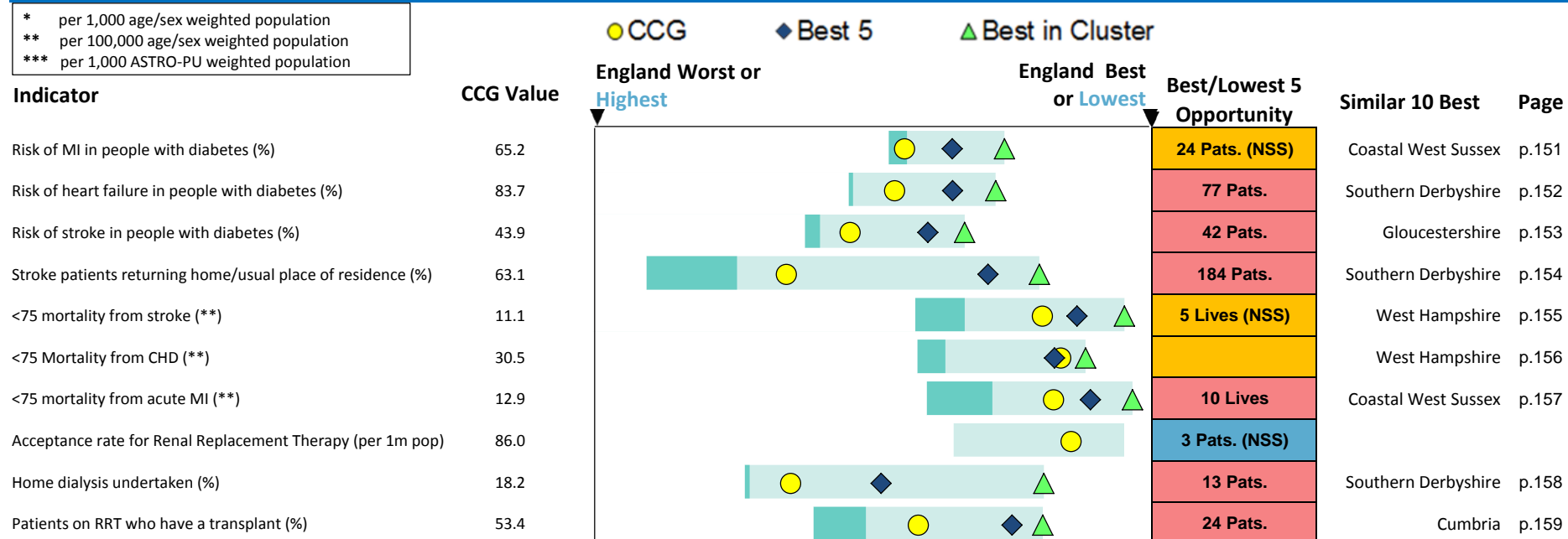


Please refer to slide 71 for full guidance on interpretation of this table of opportunities

# Cardiovascular Disease Conditions - Opportunity table - Outcomes

NHS Somerset CCG 86

\* 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 71 for full guidance on interpretation of this table of opportunities

The following pages, starting on page 86, 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 judgment on whether a lower or higher value is *better* e.g. lower value better for mortality, 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 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.

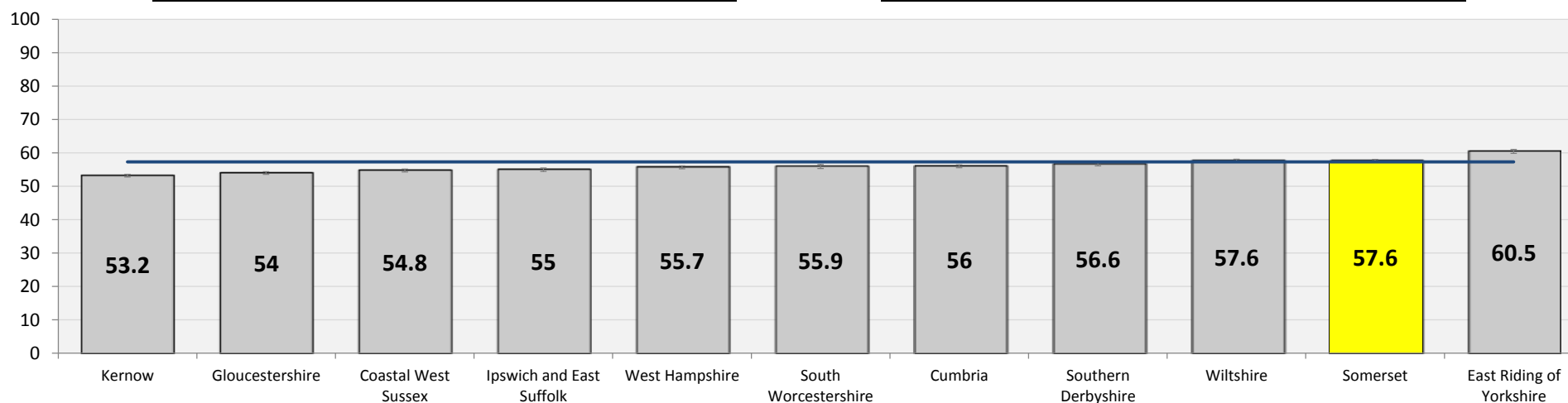
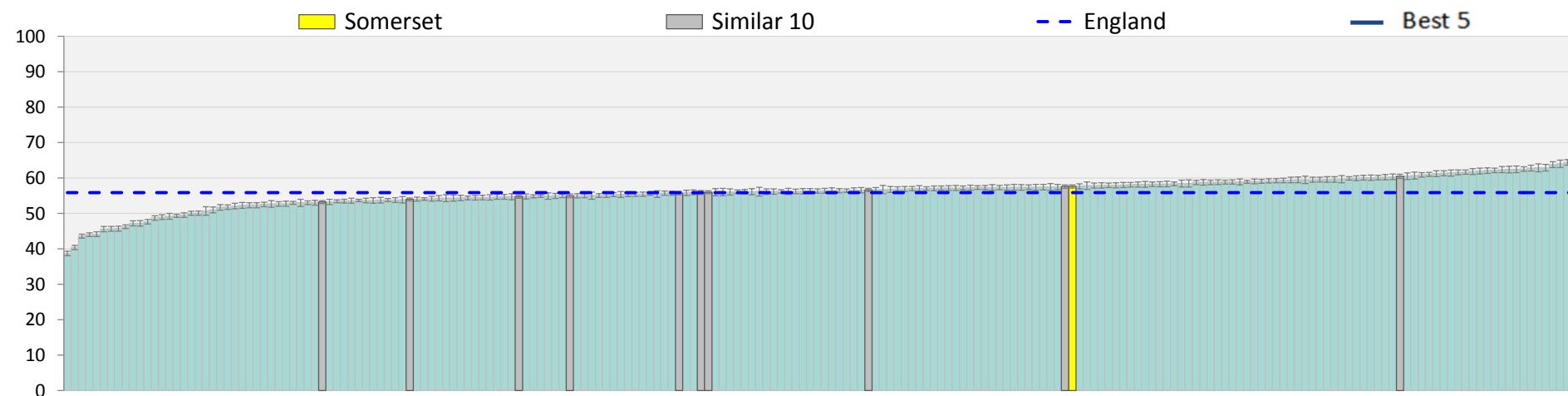
The full indicator name, source and time period are shown at the bottom left.

**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 website. The link is available on page 161.**

## CVD risk factor - Reported to estimated prevalence of hypertension (%)\*

\*See page 8 'Being more ambitious' for more detail on the detection and successful management of hypertension

88



Definition: Reported to estimated prevalence of hypertension (%)

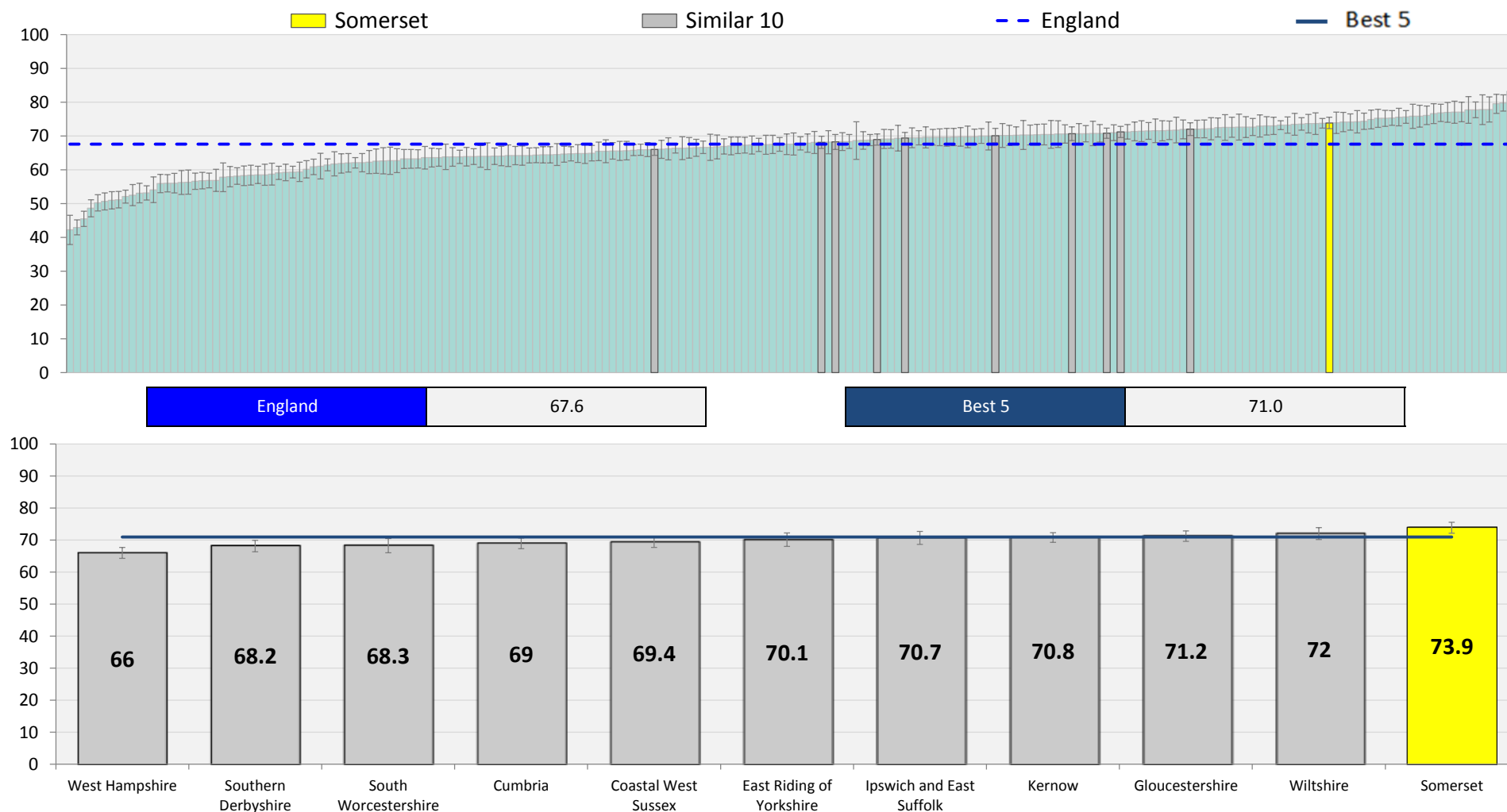
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre. Erpho Modelled estimate of prevalence

Year: 2014/15 (2011)



## Stroke risk factor - Reported to expected prevalence of AF (%)

89



Definition: Stroke - Atrial fibrillation observed prevalence compared to expected prevalence

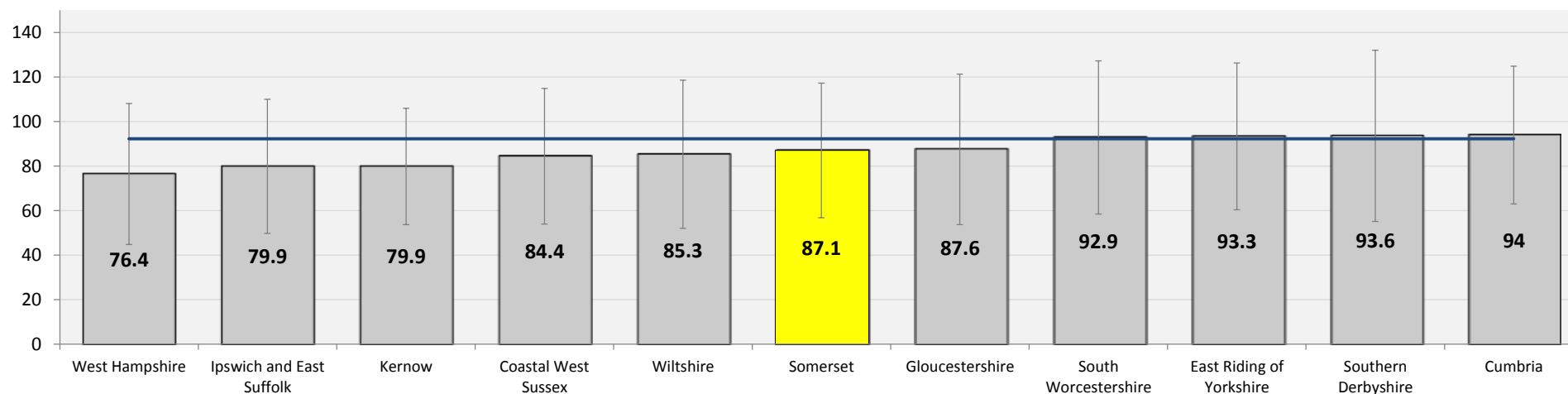
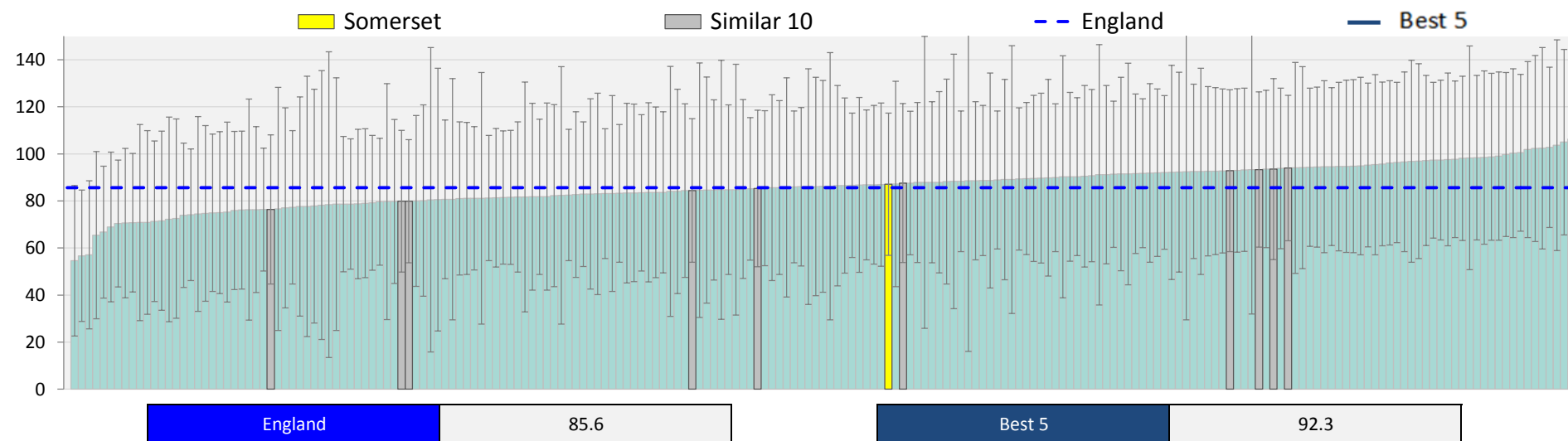
Source: QOF, HSCIC. Fingertips, PHE

Year: 2014/15, 2013/14

## Observed to expected prevalence of diabetes (%)

1767 Pats. (NSS)

90



Definition: Diabetes - Diabetes observed prevalence compared to expected prevalence in adults

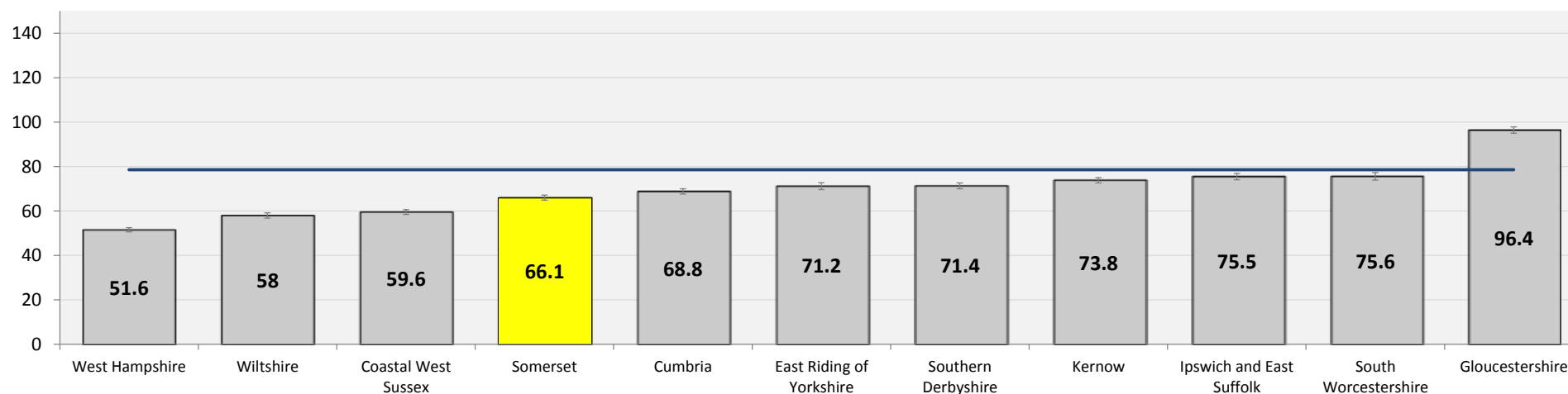
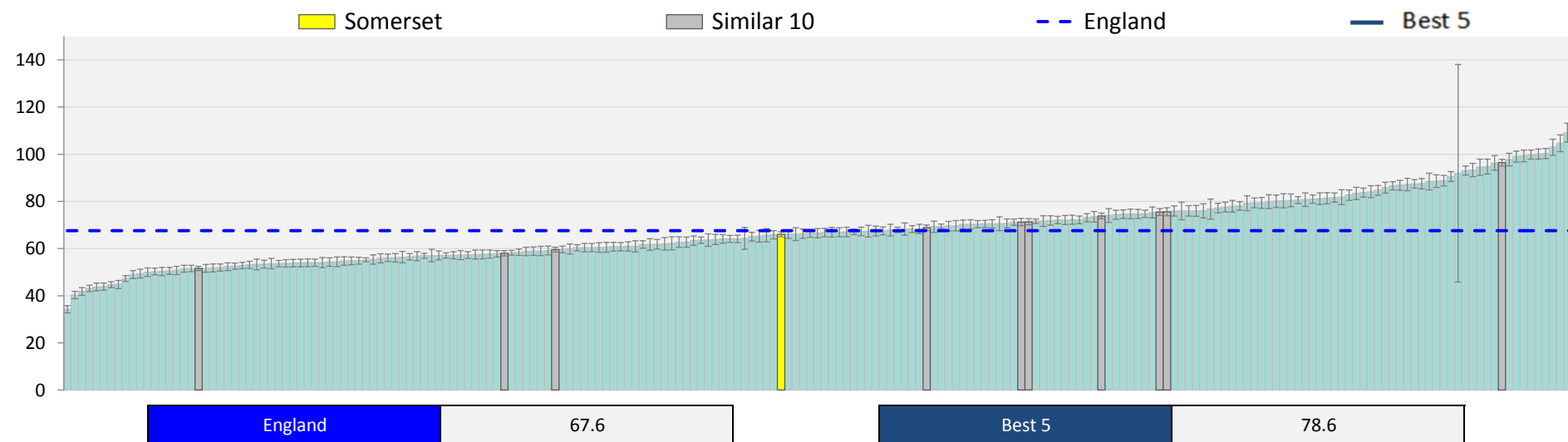
Source: Quality and Outcomes Framework, Health and Social Care Information Centre. Fingertips, Public Health England

Year: 2014/15, 2012

## Reported to estimated prevalence of CKD (%)

4114 Pats.

91



Definition: Chronic Kidney Disease (CKD) (%) Reported to estimated prevalence: Disease Register and Population

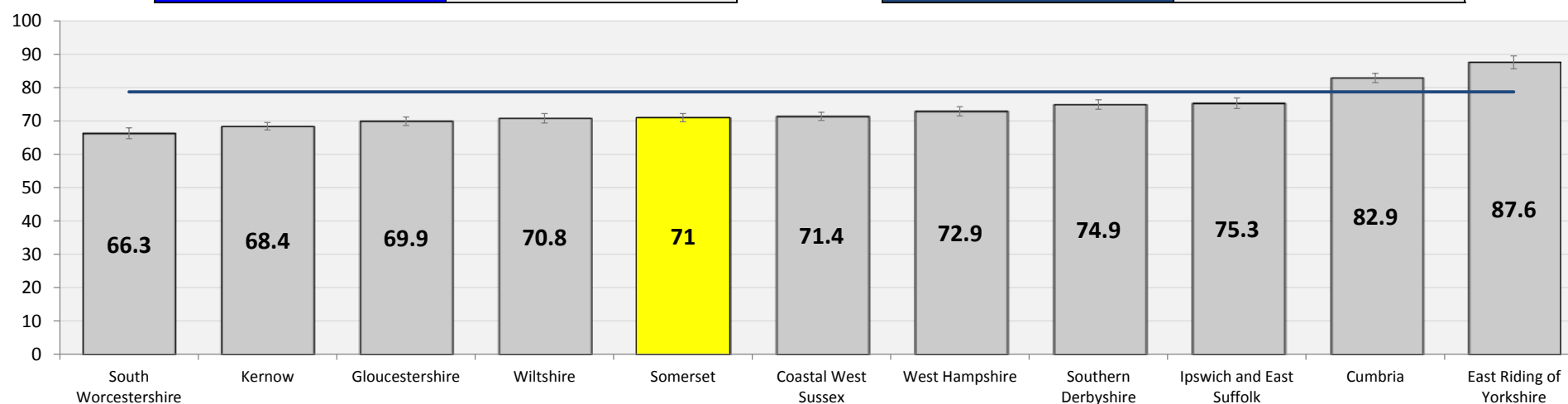
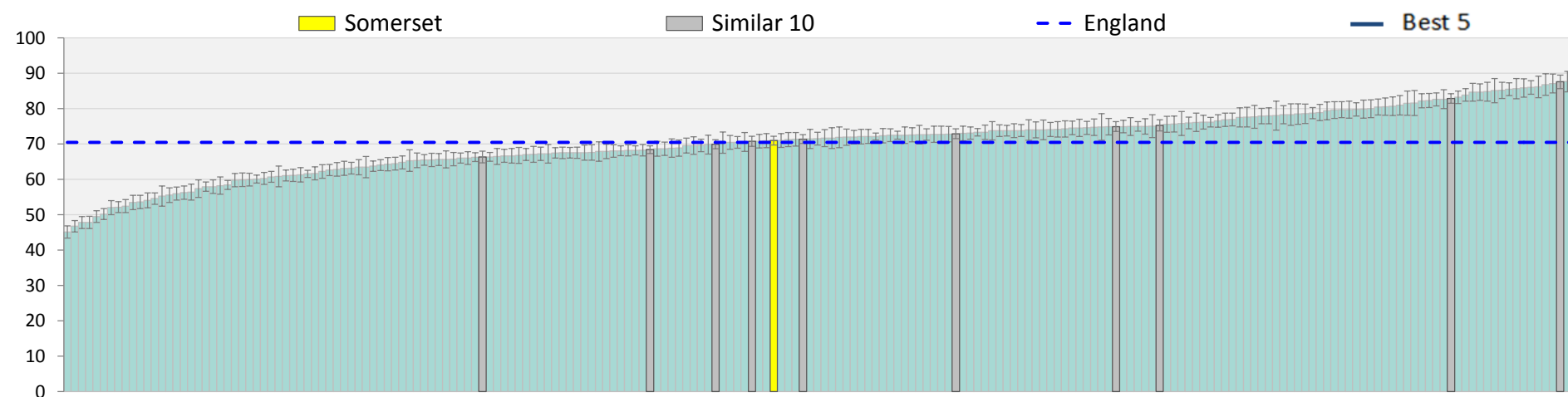
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre, CKD prevalence estimates, Grant Aitken, University of Southampton

Year: 2014/15

## Reported to estimated prevalence of CHD (%)

2324 Pats.

92



Definition: Reported to estimated prevalence of CHD (%)

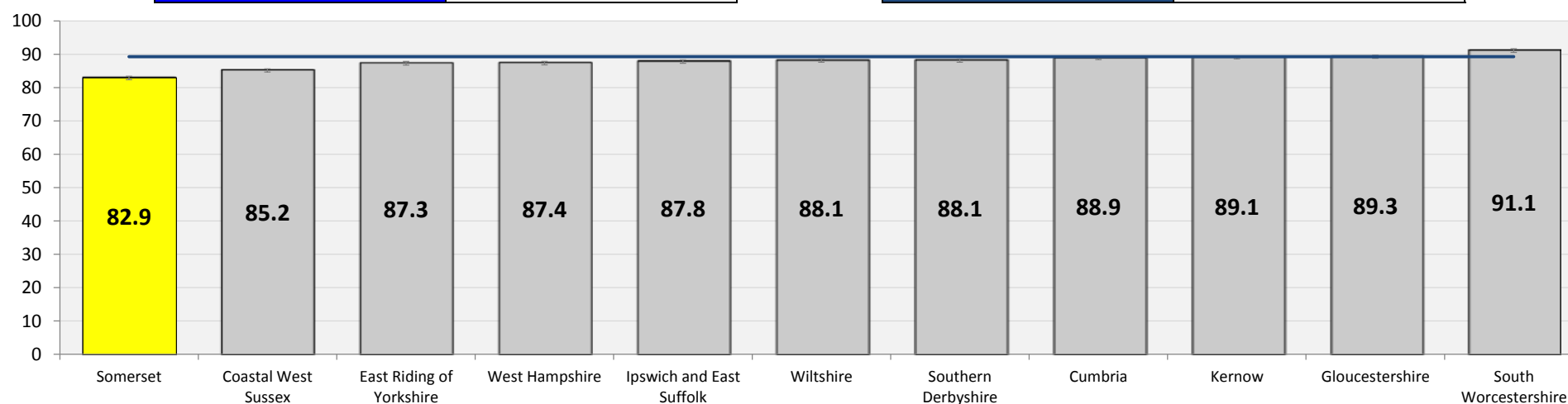
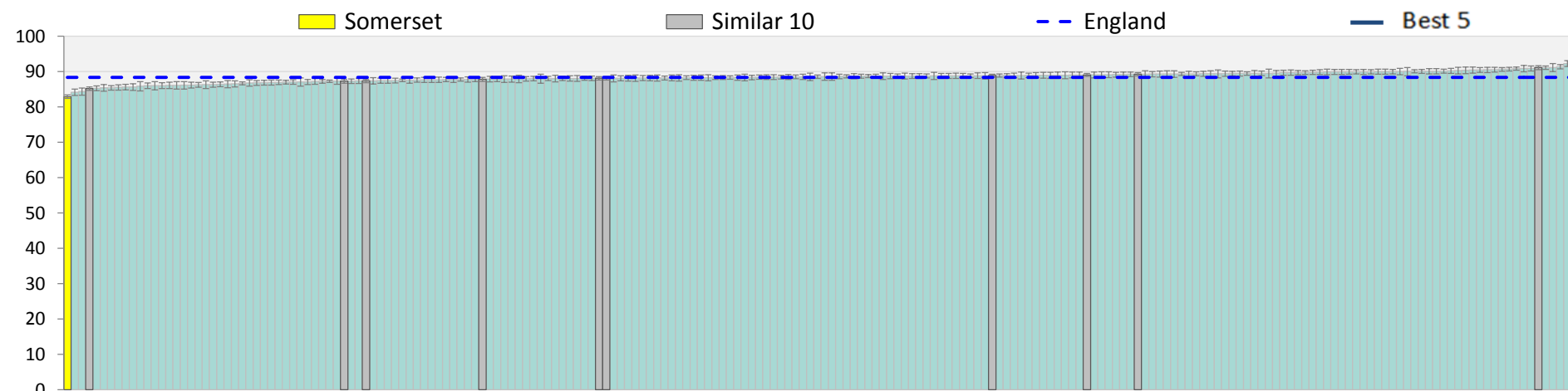
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre. Erpho Modelled estimate of prevalence

Year: 2014/15 (2011)

## CHD patients whose BP <150/90 (%)

1350 Pats.

93



Definition: The % of patients with CHD whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less

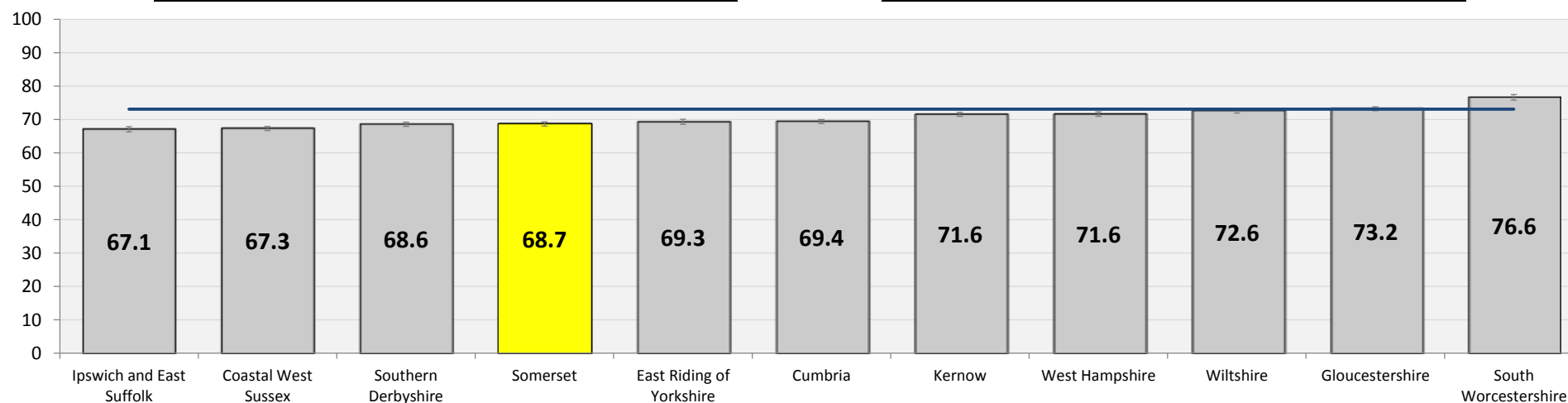
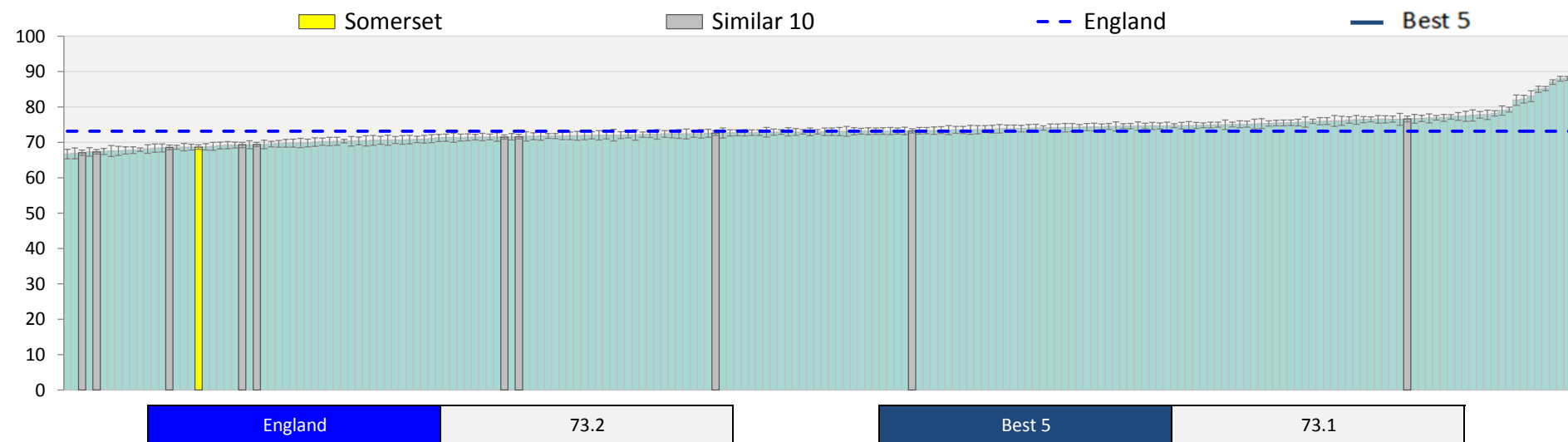
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

# CHD patients whose cholesterol <5 mmol/l (%)

944 Pats.

94



Definition: The % of patients with CHD whose last measured cholesterol (as measured within the last 12 months) is 5mmol/l or less (CHD08)

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

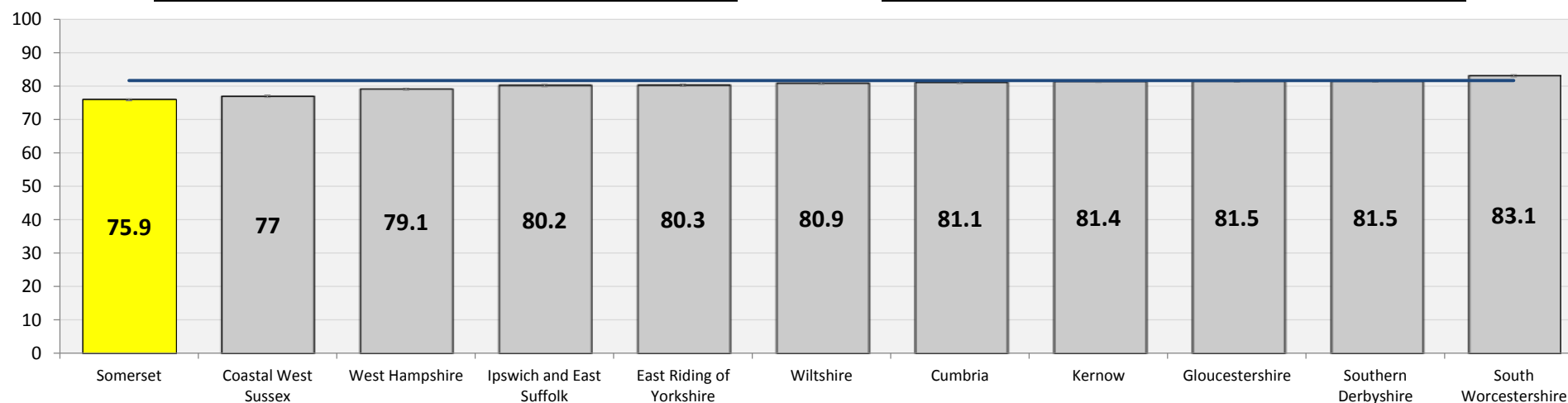
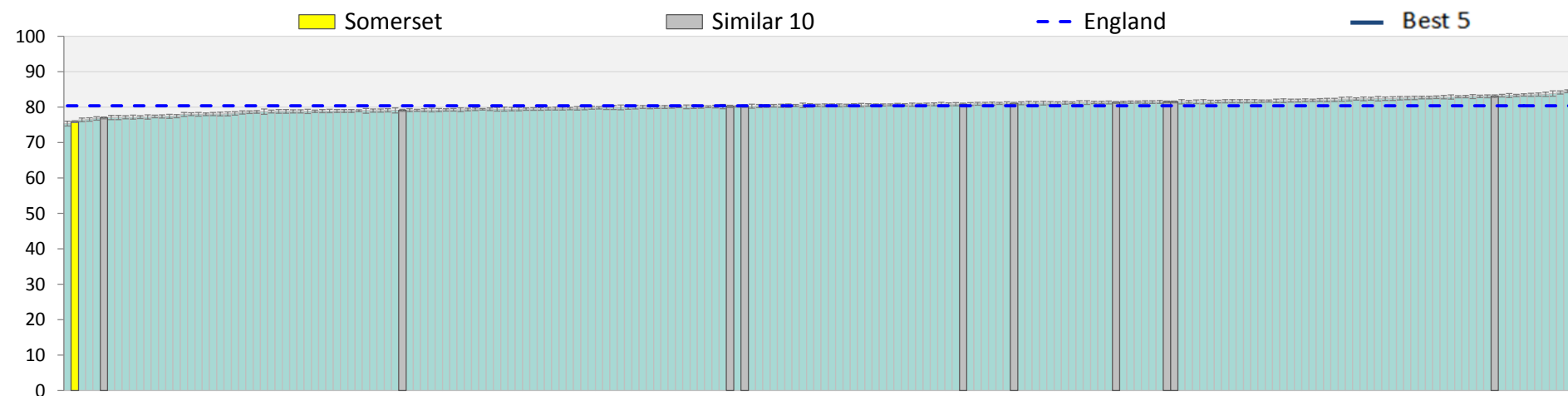
Year: 2013/14

## Hypertension patients whose BP <150/90 (%)\*

\*See page 8 'Being more ambitious' for more detail on the detection and successful management of hypertension

5187 Pats.

95



Definition: The % of patients with hypertension whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less

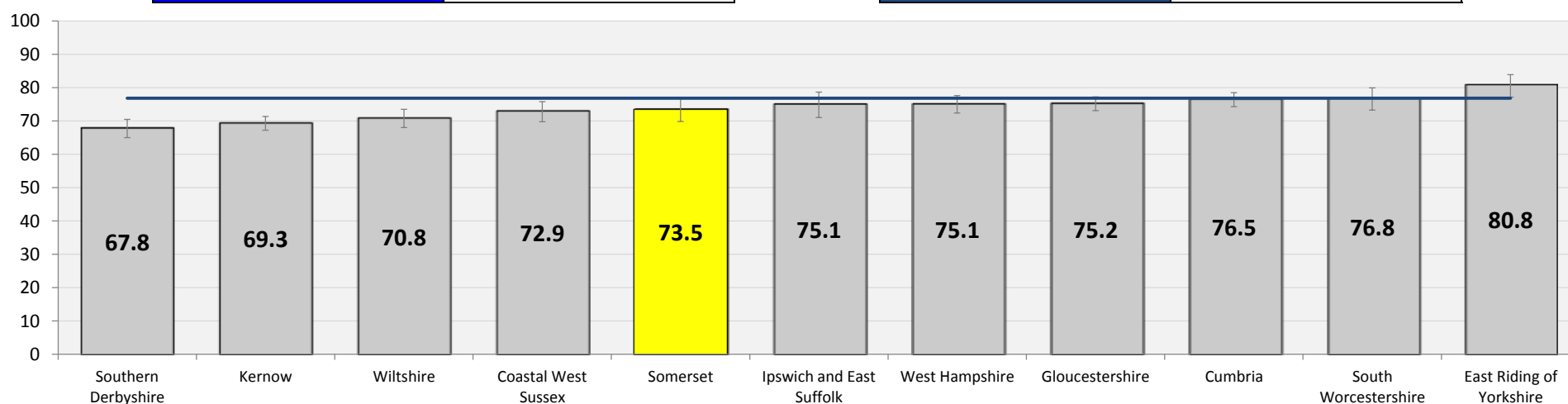
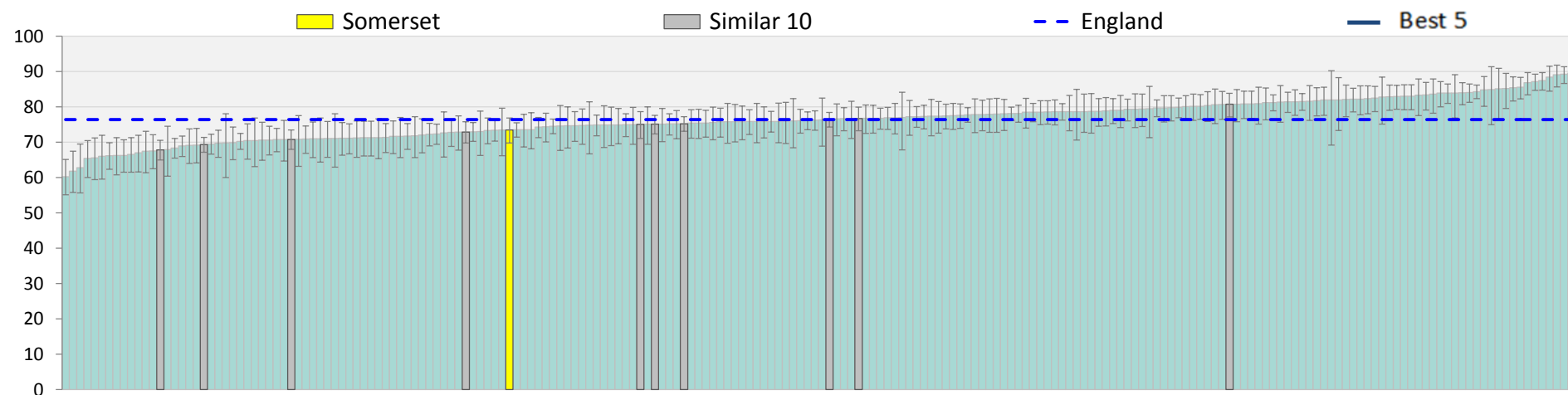
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

# Heart failure patients from LVSD treated w/ ACE-I/ARB & BetaBlocker (%)

20 Pats.

96



Definition: HF004: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure

Source: Quality and Outcomes Framework, Health and Social Care Information Centre

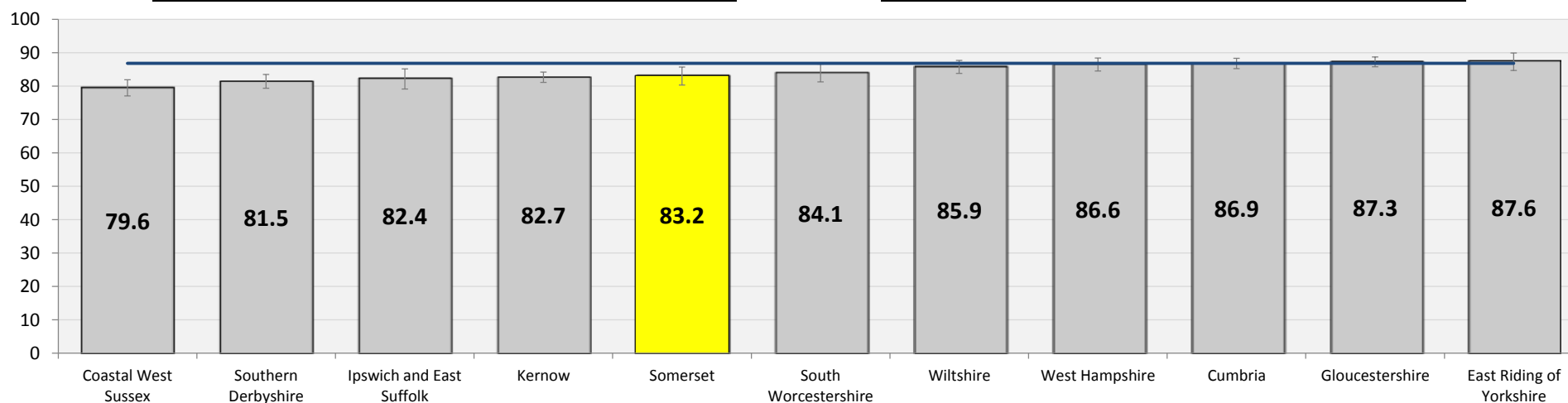
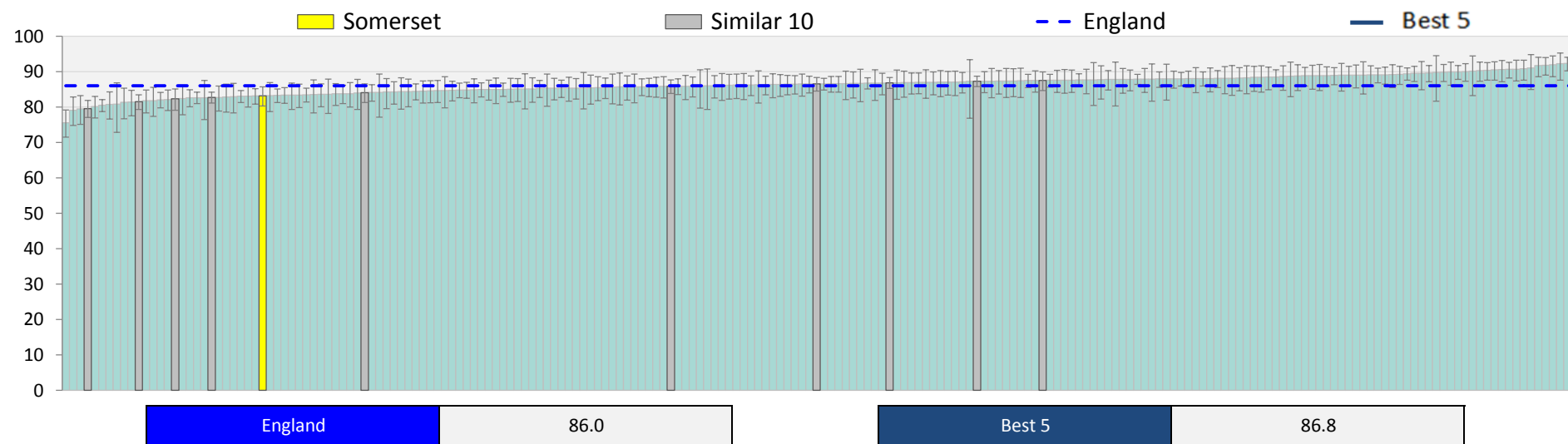
Year: 2014/15



# Heart failure patients from LVSD treated with ACE-I /ARB (%)

27 Pats.

97



Definition: HF003: In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB

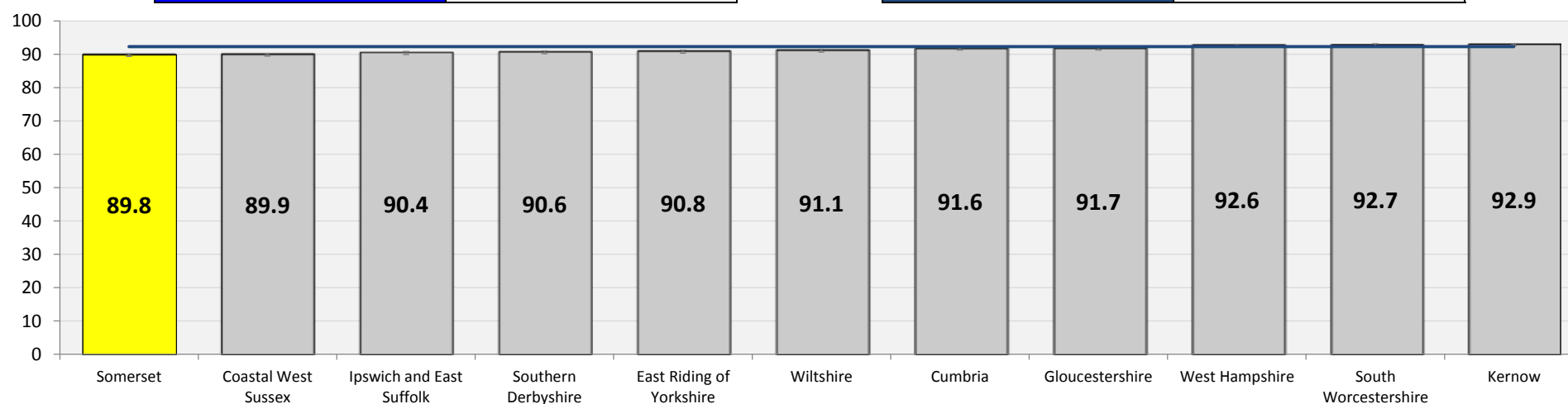
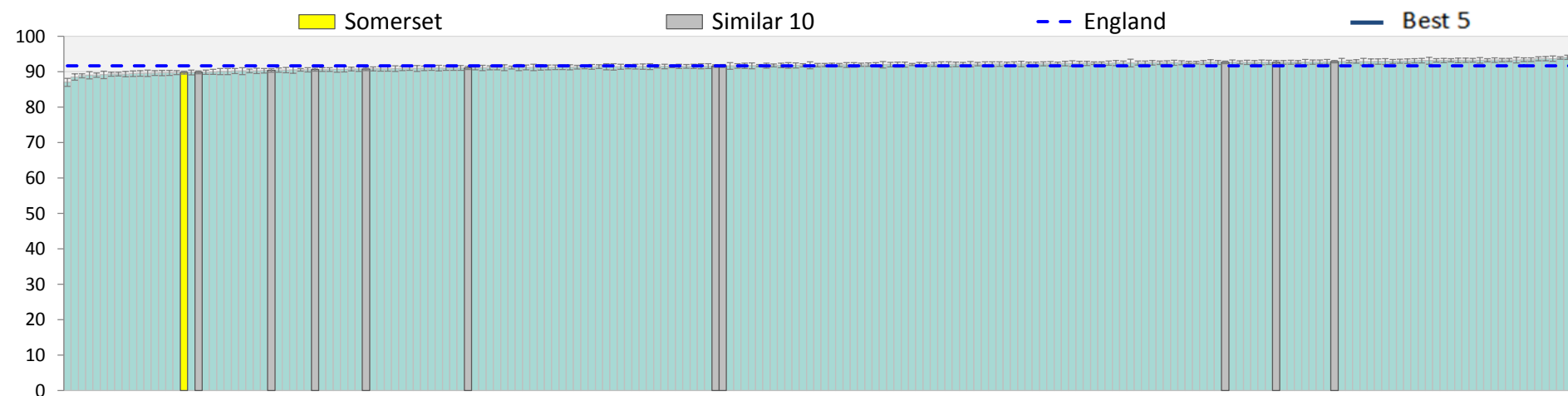
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## CHD patients treated with anti-coag/platelet therapy (%)

532 Pats.

98



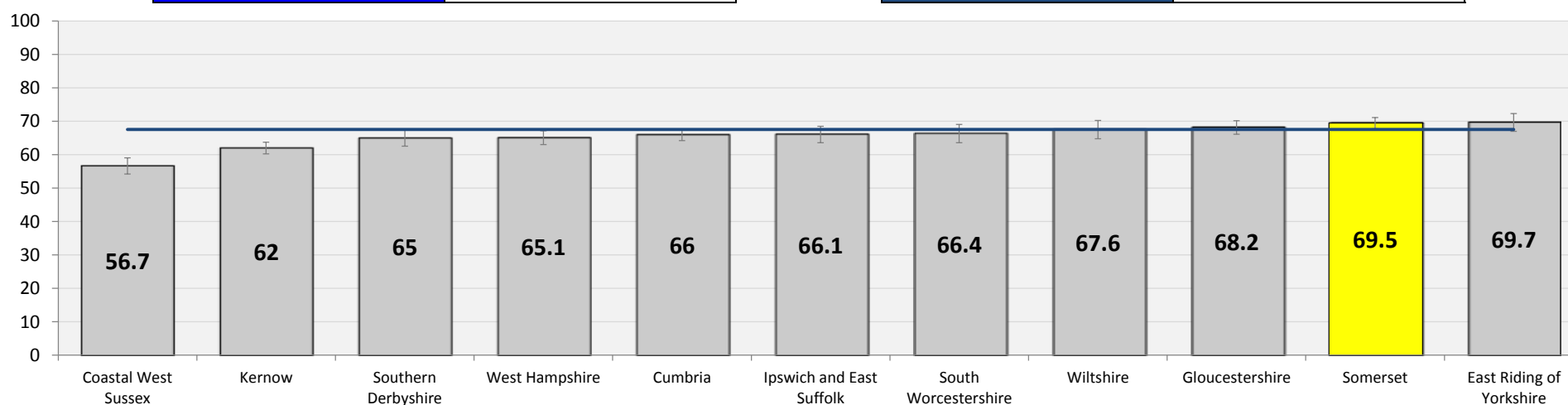
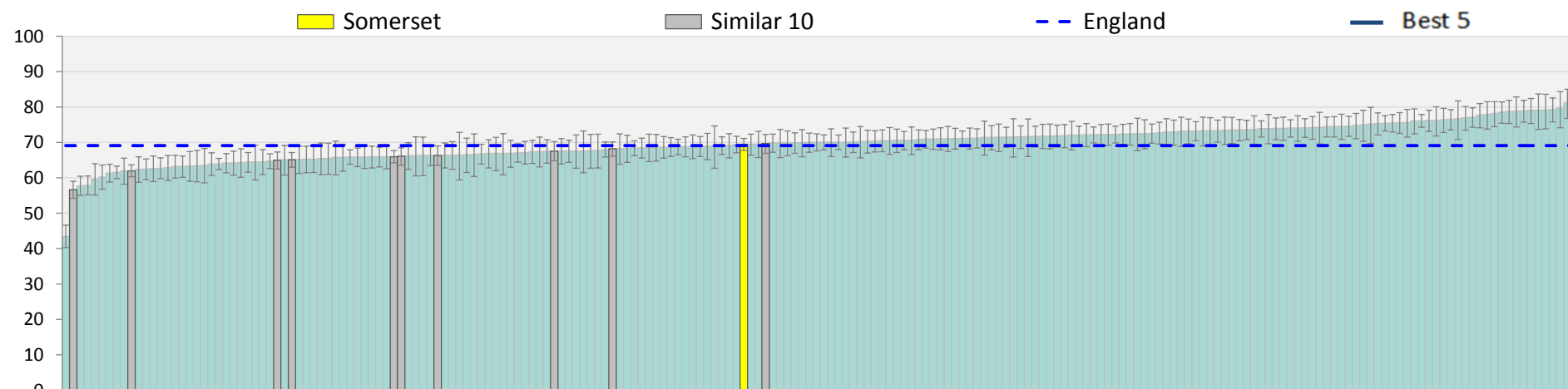
Definition: CHD005: The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken

Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

# Patients with MI history treated with appropriate drug therapy (%)

99



Definition: CHD006: The percentage of patients with a history of myocardial infarction (on or after 1 April 2011) currently treated with an ACE-I (or ARB if ACE-I intolerant), aspirin or an alternative anti-platelet therapy

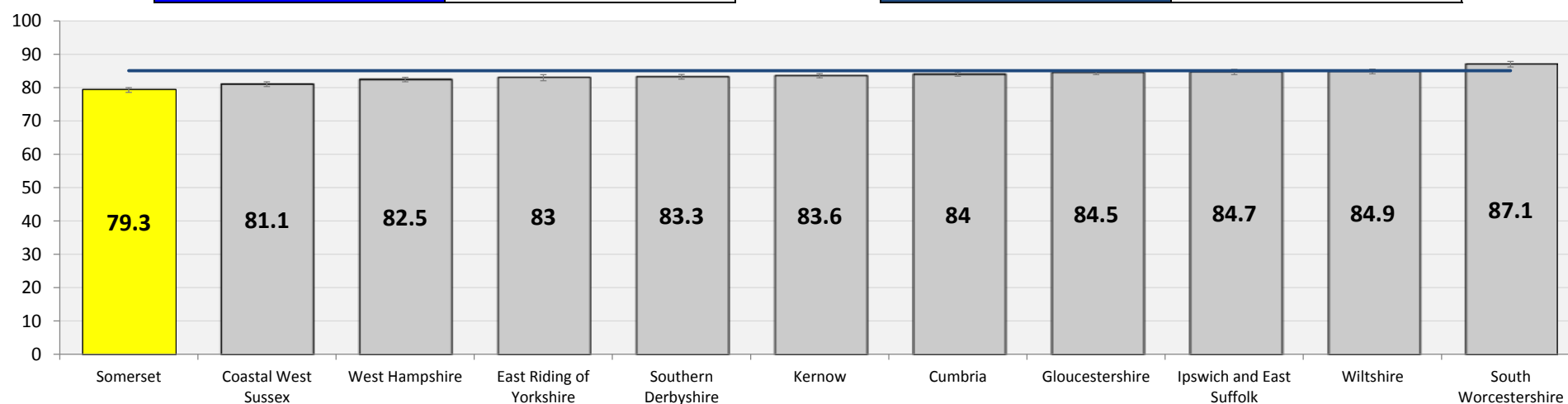
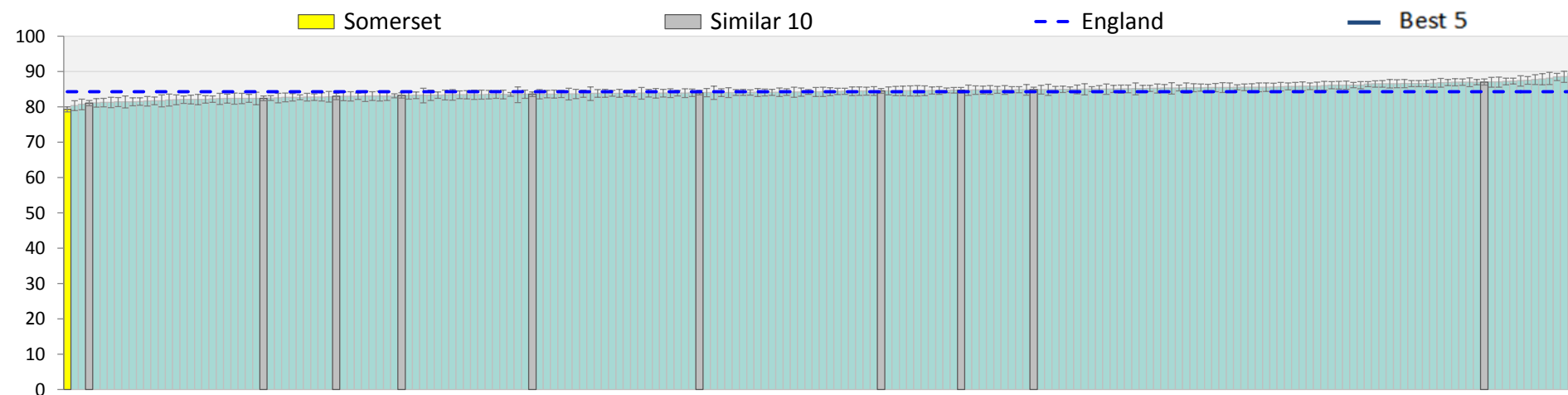
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## Stroke/TIA patients whose BP <150/90 (%)

718 Pats.

100



Definition: The % of patients with stroke or TIA whose last blood pressure reading (as measured within the last 12 months) is 150/90 or less

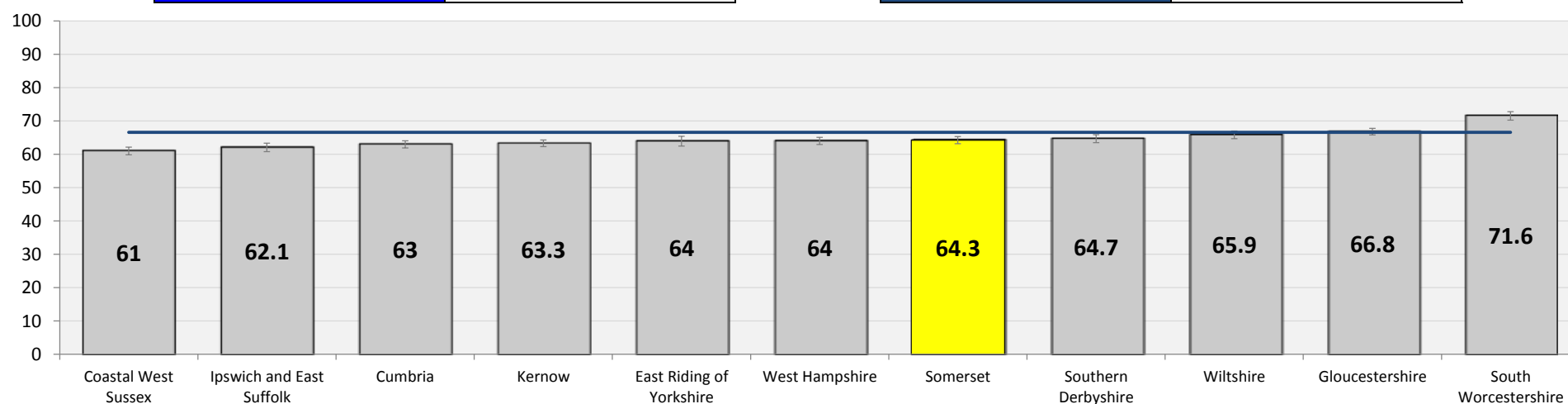
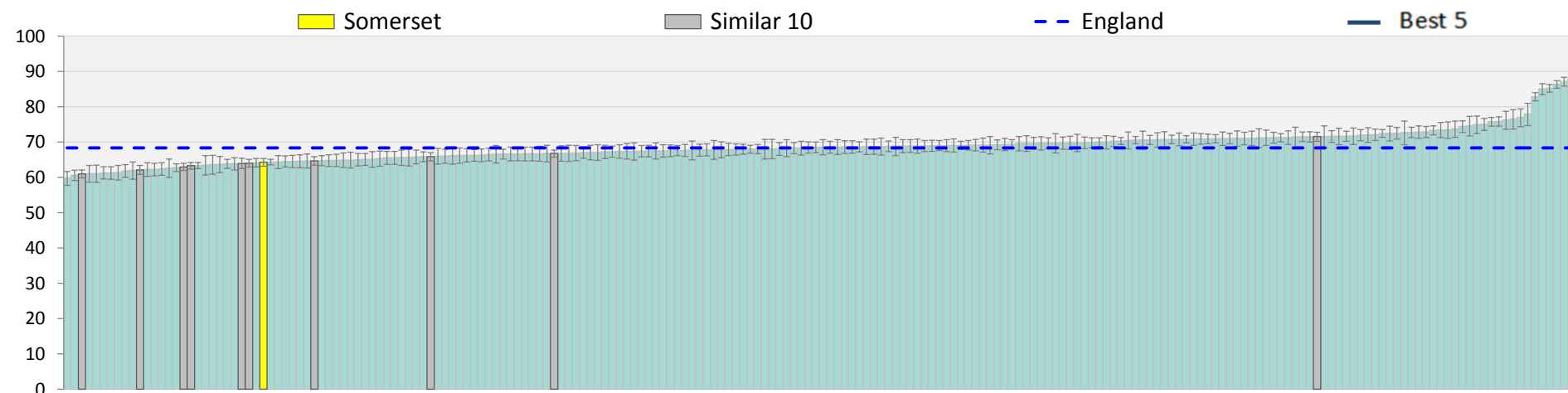
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

# Stroke/TIA patients whose cholesterol <5 mmol/l (%)

180 Pats.

101



Definition: The % of patients with stroke shown to be non-haemorrhagic, or a history of TIA, whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less

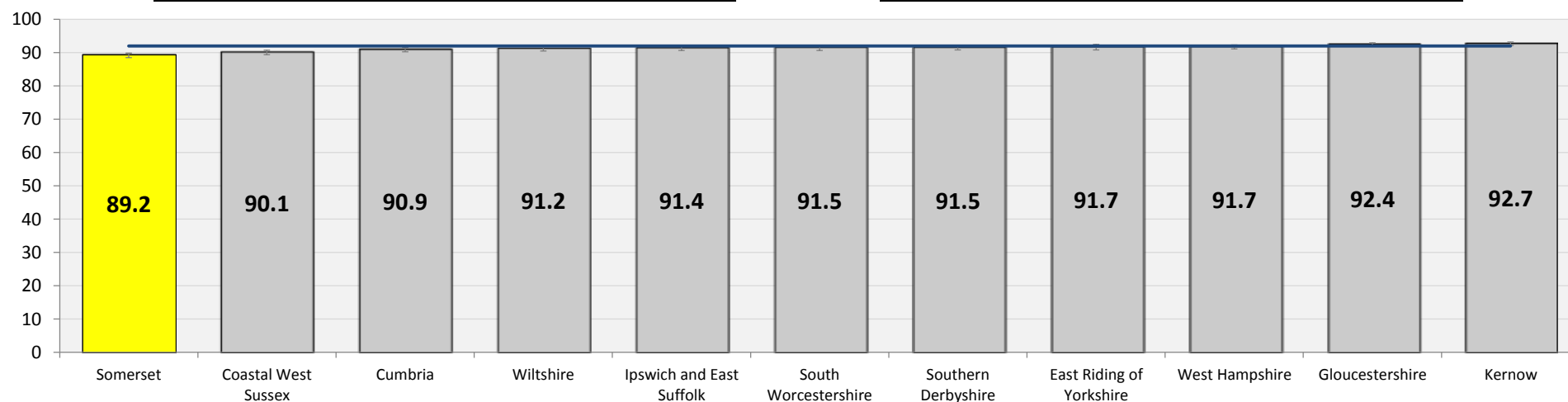
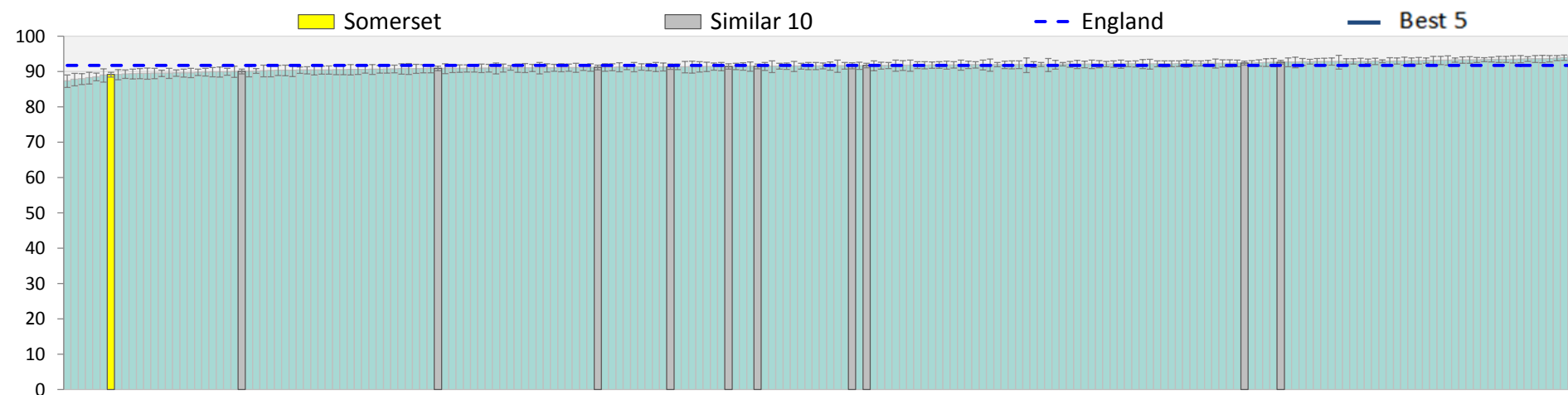
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2013/14

## Stroke/TIA patients on antiplatelet agent (%)

223 Pats.

102



Definition: The % of patients with a non-haemorrhagic stroke or TIA with a record that an anti-platelet agent or an anti-coagulant is being taken

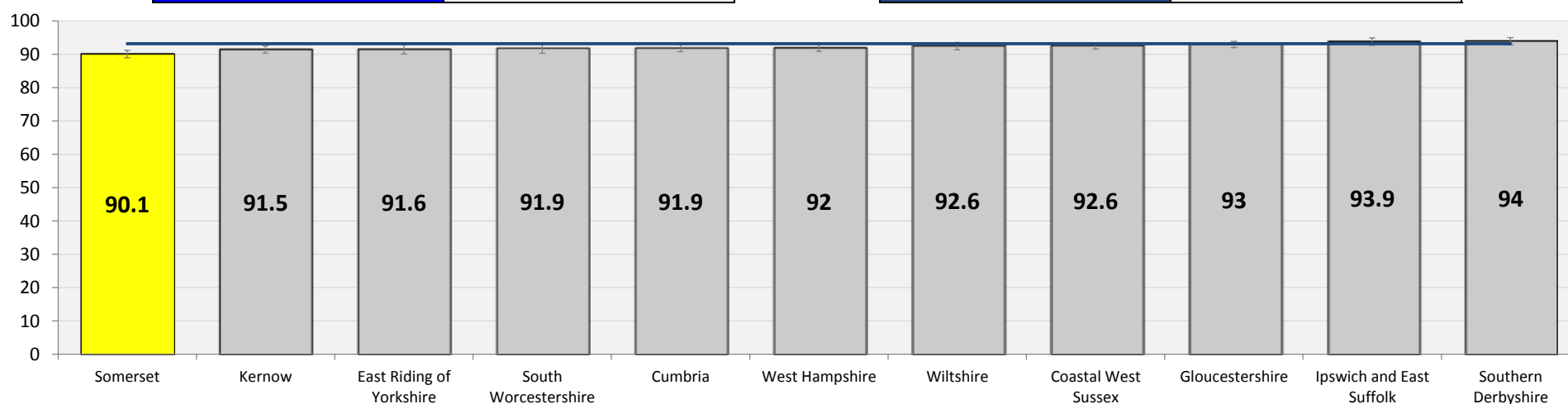
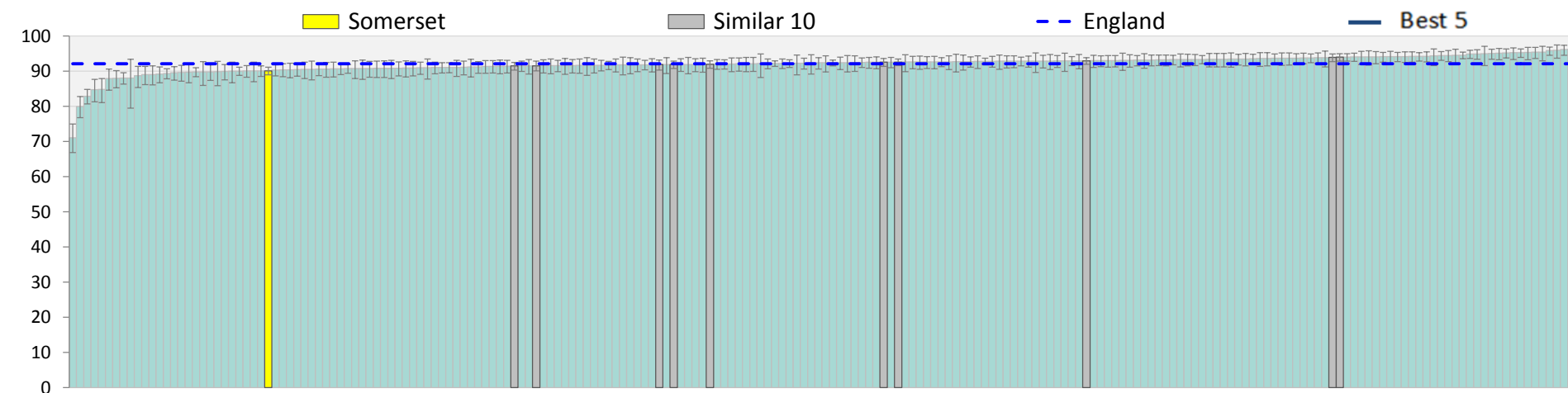
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

## AF patients with stroke risk assessment on ASA drug therapy (%)

86 Pats.

103



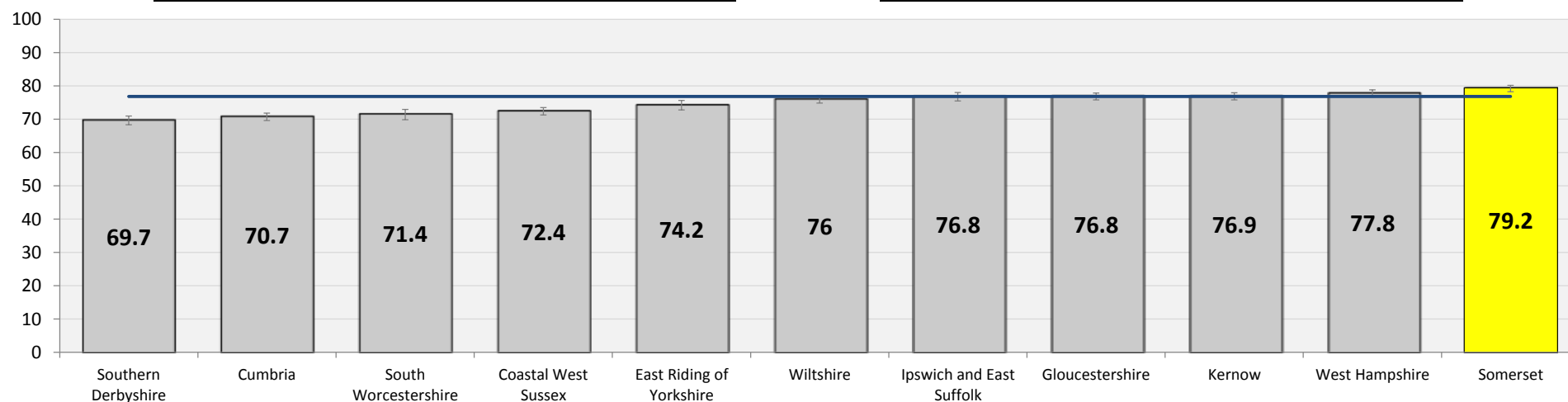
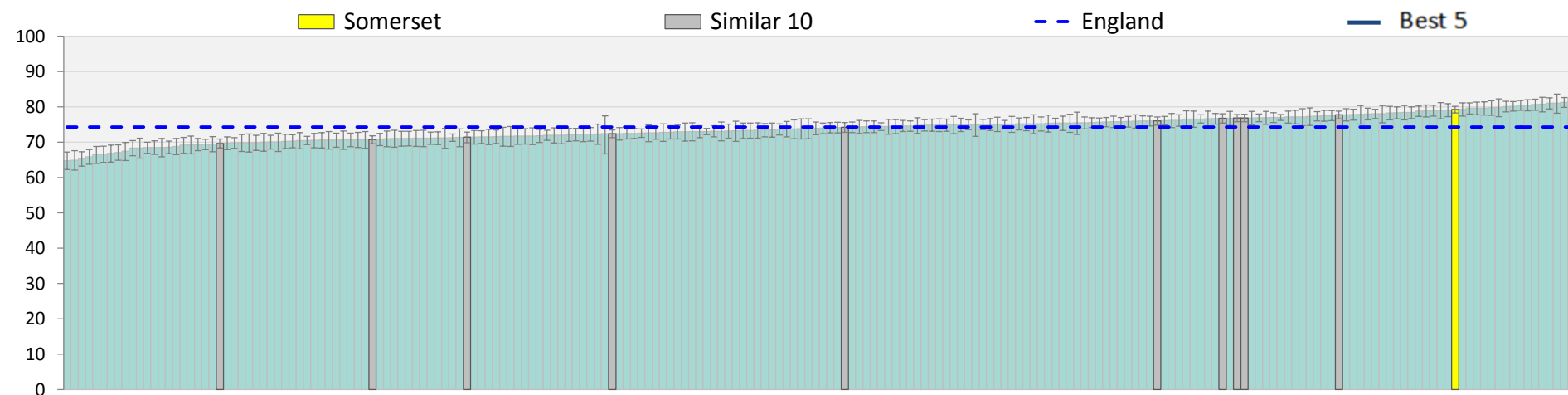
Definition: In those patients with atrial fibrillation in whom there is a record of a CHADS2 score of 1, the percentage of patients who are currently treated with anti-coagulation drug therapy or anti-platelet therapy

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

Year: 2014/15

# AF patients, high stroke risk treated with anti-coag therapy (%)

104



Definition: AF004: In those patients with atrial fibrillation whose latest record of a CHADS2 score is greater than 1, the percentage of patients who are currently treated with anti-coagulation therapy

Source: Quality and Outcomes Framework, Health and Social Care Information Centre

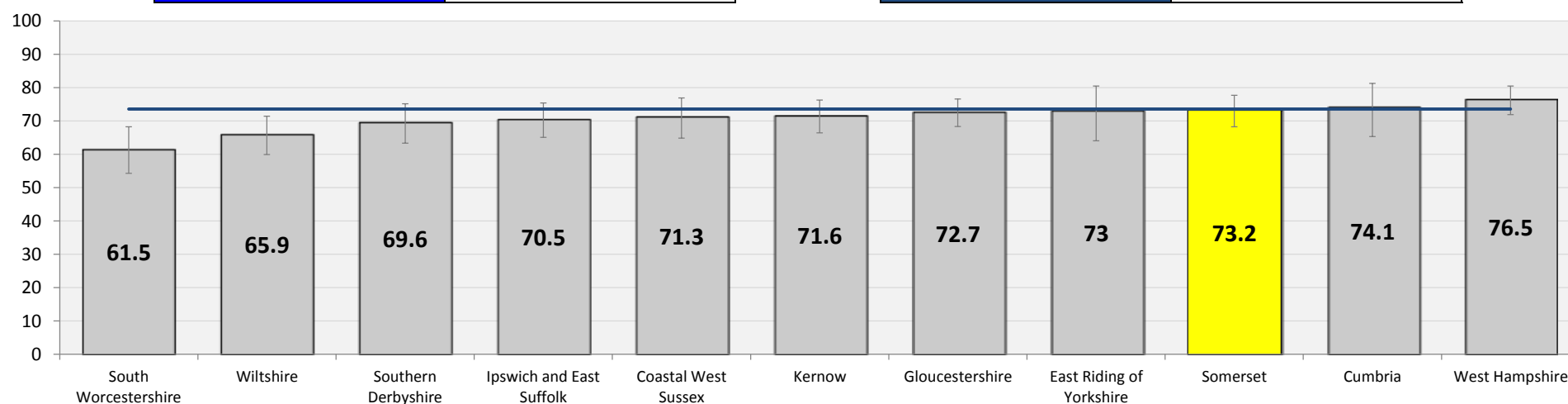
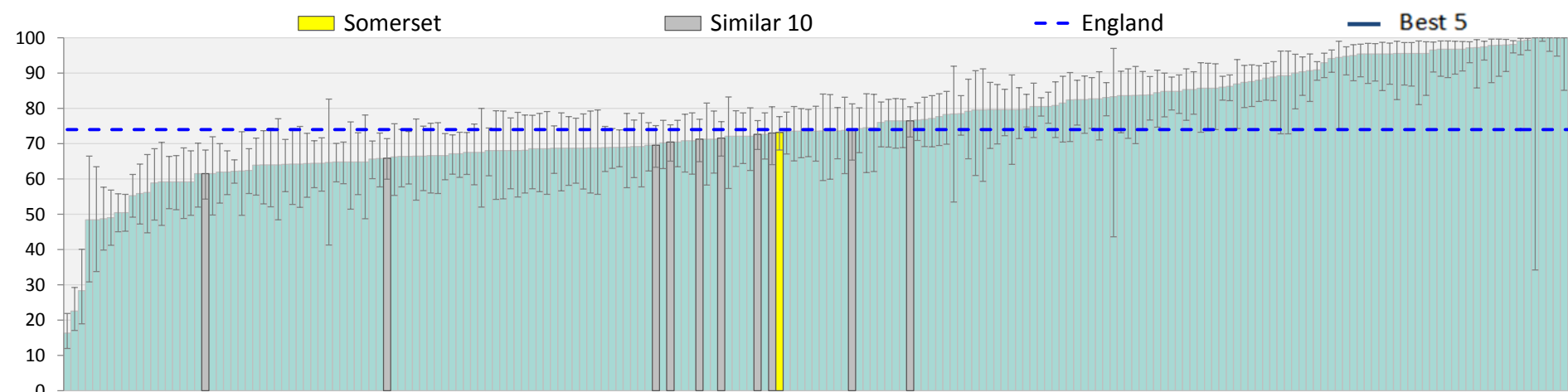
Year: 2014/15



## TIA cases treated within 24 hours (%)

1 Cases (NSS)

105



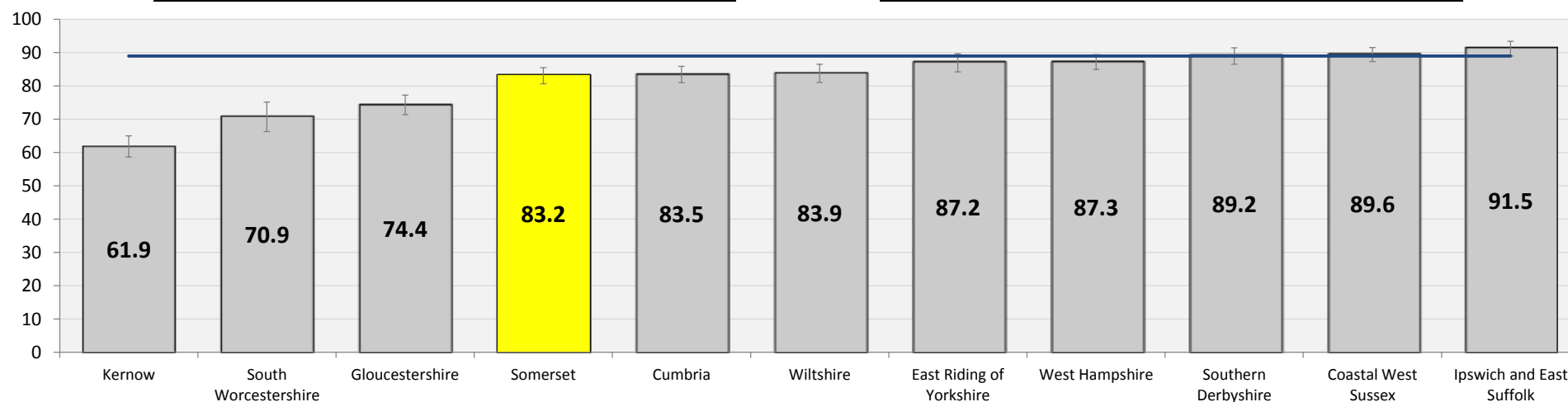
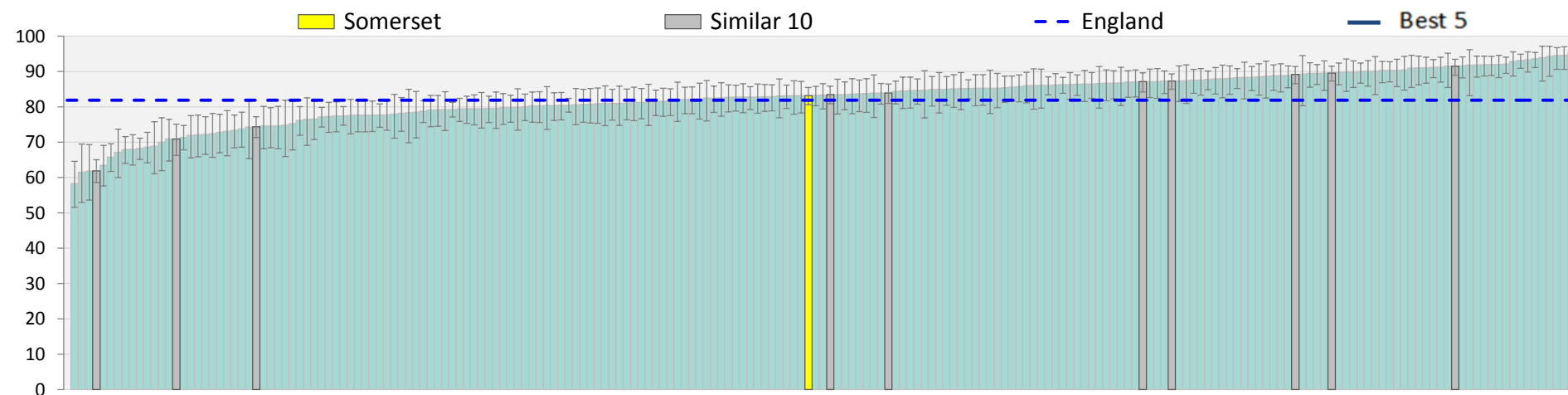
Definition: The % of TIA cases with a higher risk who are treated within 24 hours

Source: UNIFY2, NHS England - Integrated Performance Measures Monitoring Reports 2012/13, Attribution Data Set from the Exeter GP Registration System  
Year: 2012/13

# Stroke patients - 90% of time on stroke unit (%)

51 Pats.

106



Definition: The % of patients admitted to hospital following a stroke who spend 90% of their time on a stroke unit

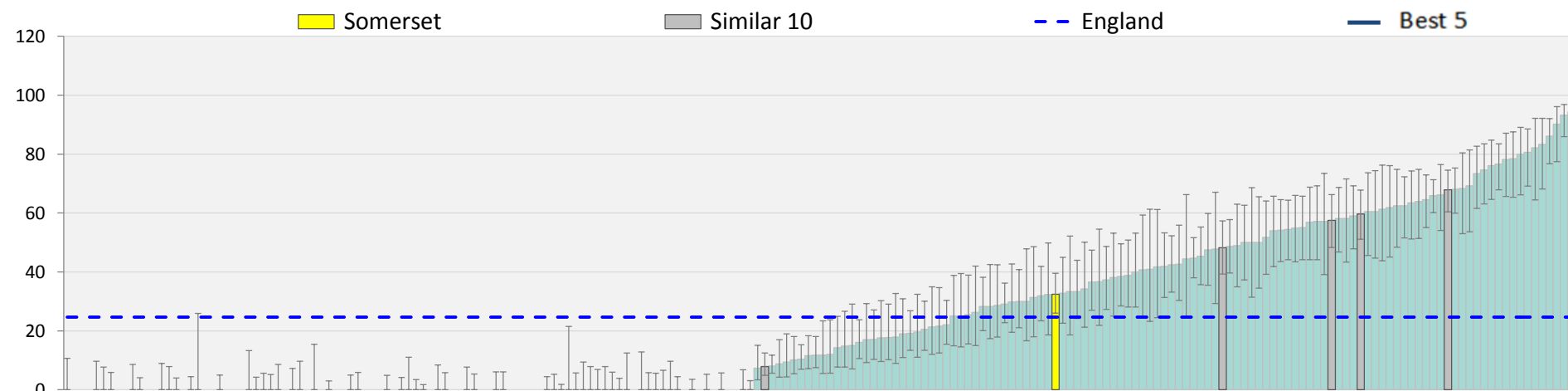
Source: Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP).

Year: 2014/15

# Applicable patients assessed at 6 months following a stroke (%)

29 Pats.

107

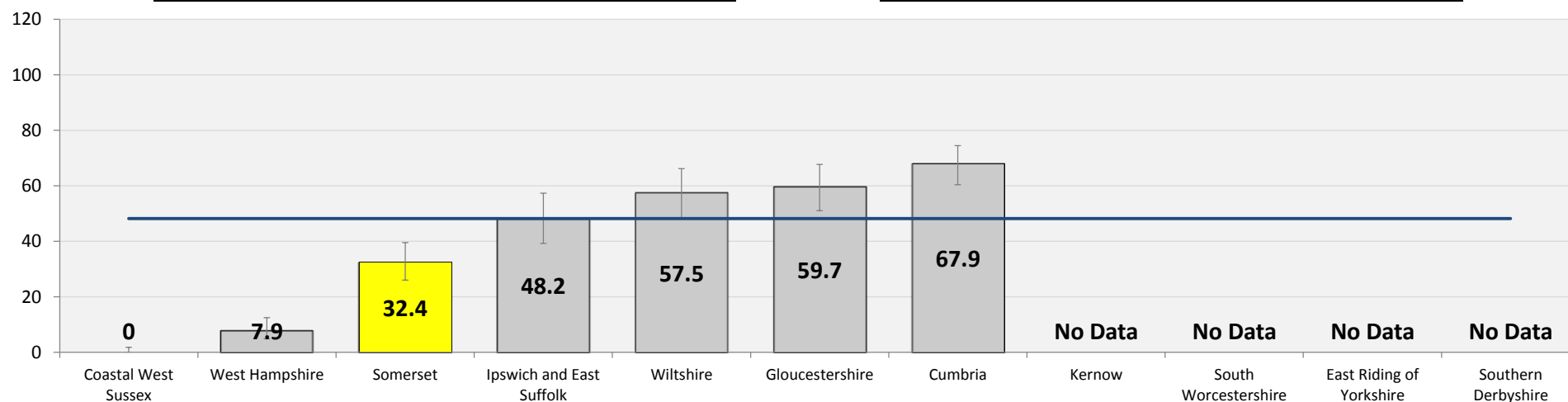


England

24.7

Best 5

48.2



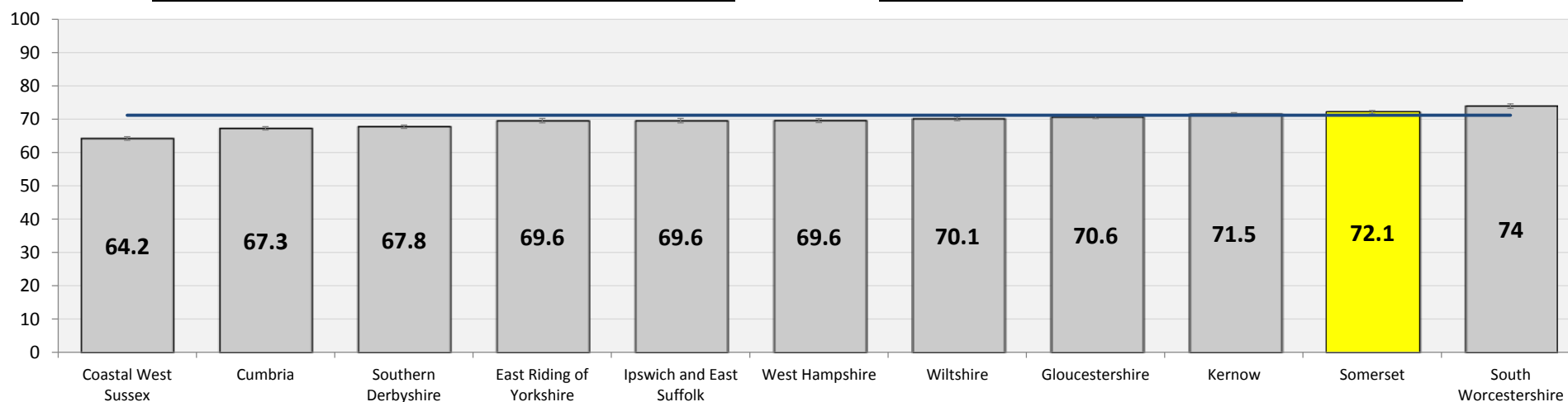
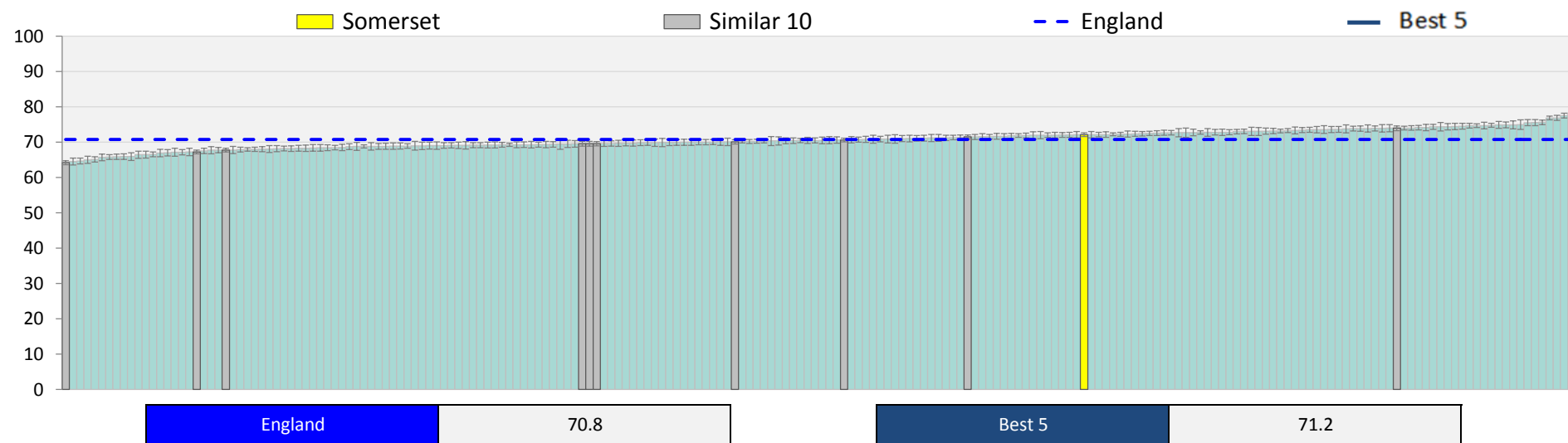
Definition: % Applicable patients who are assessed at 6 months following a stroke

Source: Sentinel Stroke National Audit Programme

Year: Jul-Sep 2015 - (Quarterly data therefore opportunity can multiplied by four for yearly opportunity)

## Diabetes patients cholesterol <5 mmol/l (%)

108



Definition: DM 004: The percentage of diabetic patients whose last cholesterol was 5mmol or less

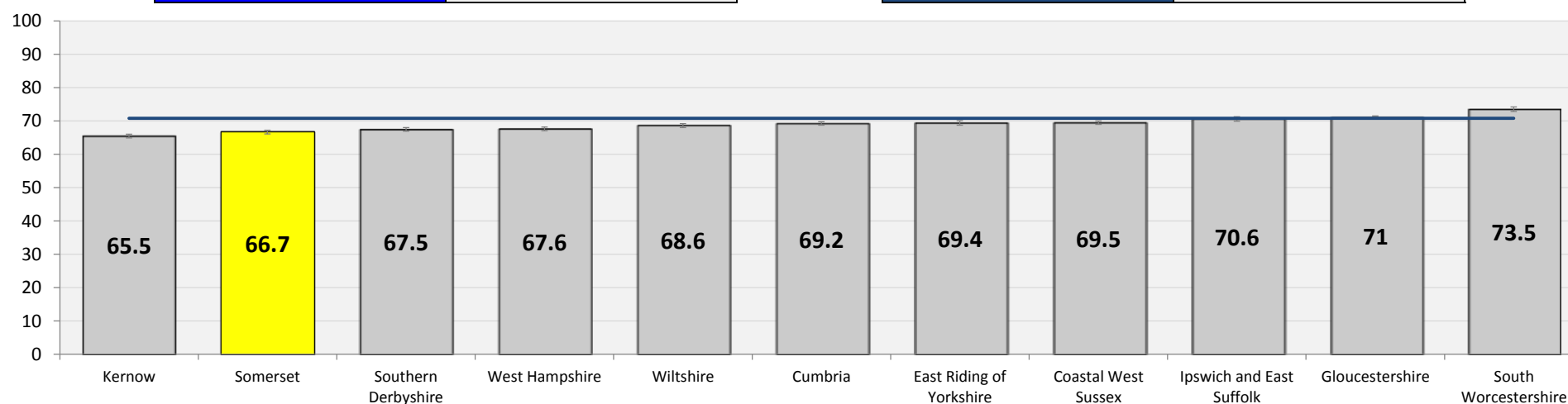
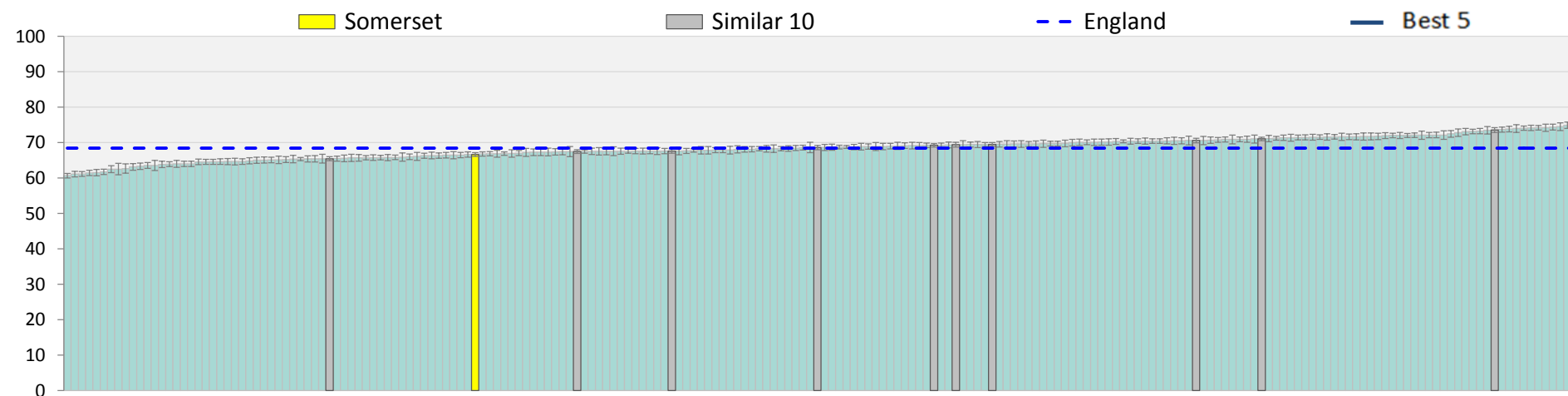
Source: Quality and Outcomes Framework (QOF) - Health & Social Care Information Centre (HSCIC)

Year: 2014/15

## Diabetes patients HbA1c is 64 mmol/mol (%)

1221 Pats.

109



Definition: DM009: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months

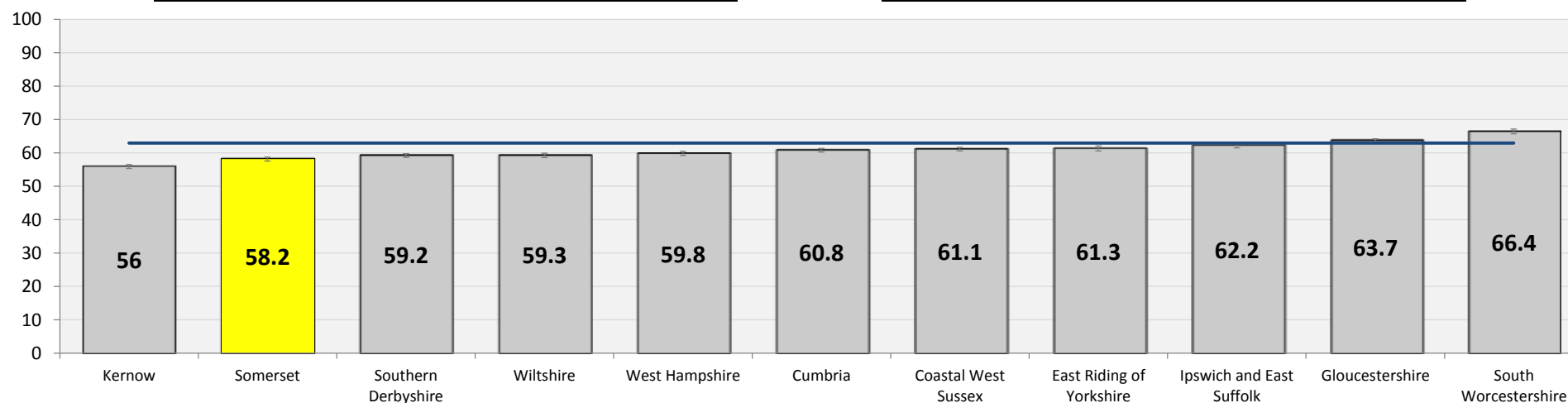
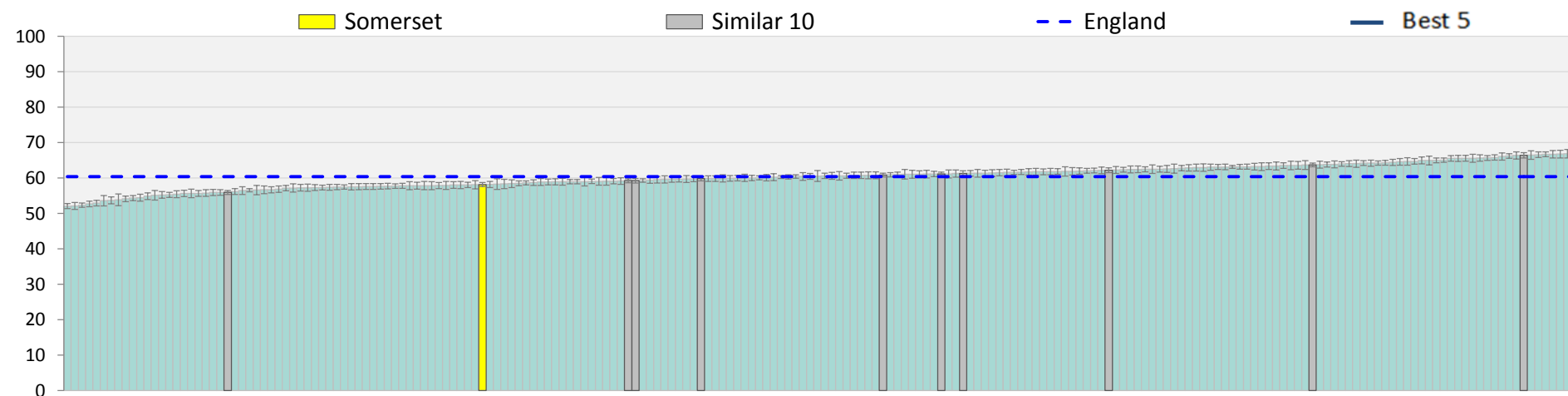
Source: Quality and Outcomes Framework (QOF) - Health & Social Care Information Centre (HSCIC)

Year: 2014/15

## Diabetes patients HbA1c <59mmol (%)

1405 Pats.

110



Definition: DM007: The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months

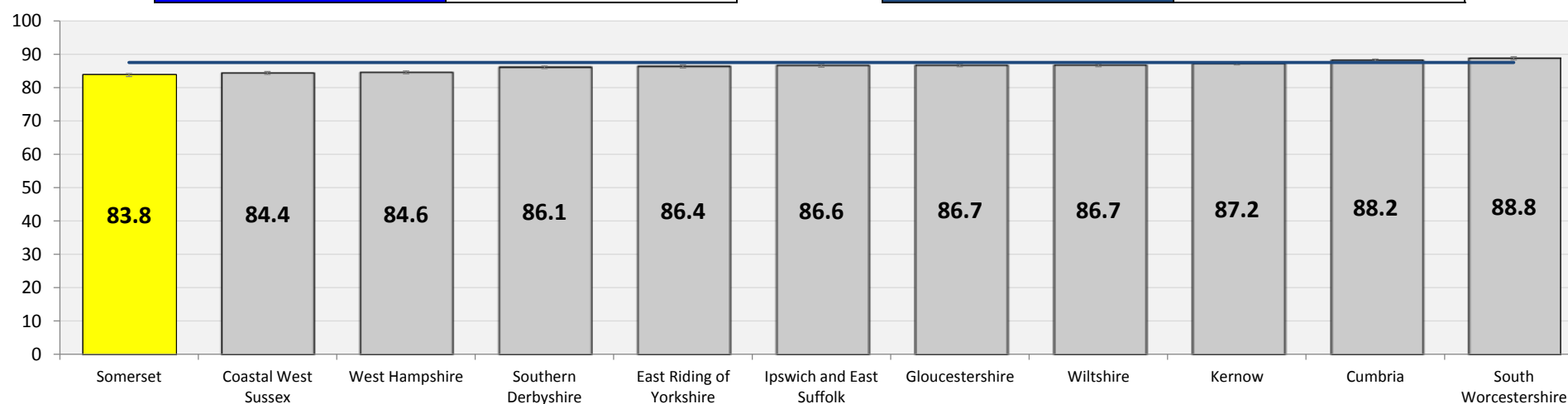
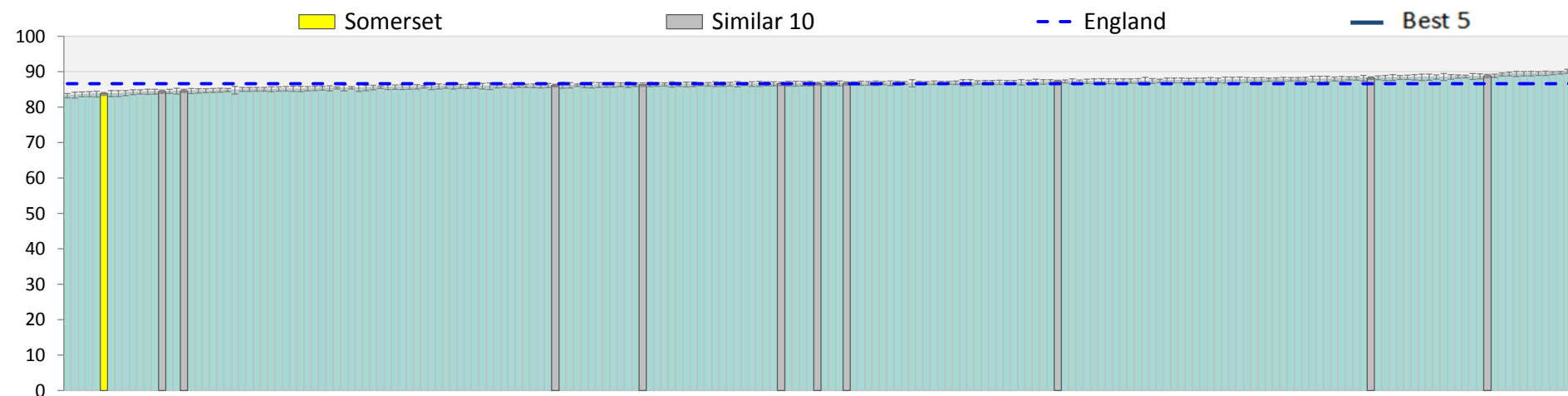
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## Diabetes patients whose BP <150/90 (%)

1112 Pats.

111



Definition: DM003: The percentage of diabetic patients whose last blood pressure was 150/90 or less

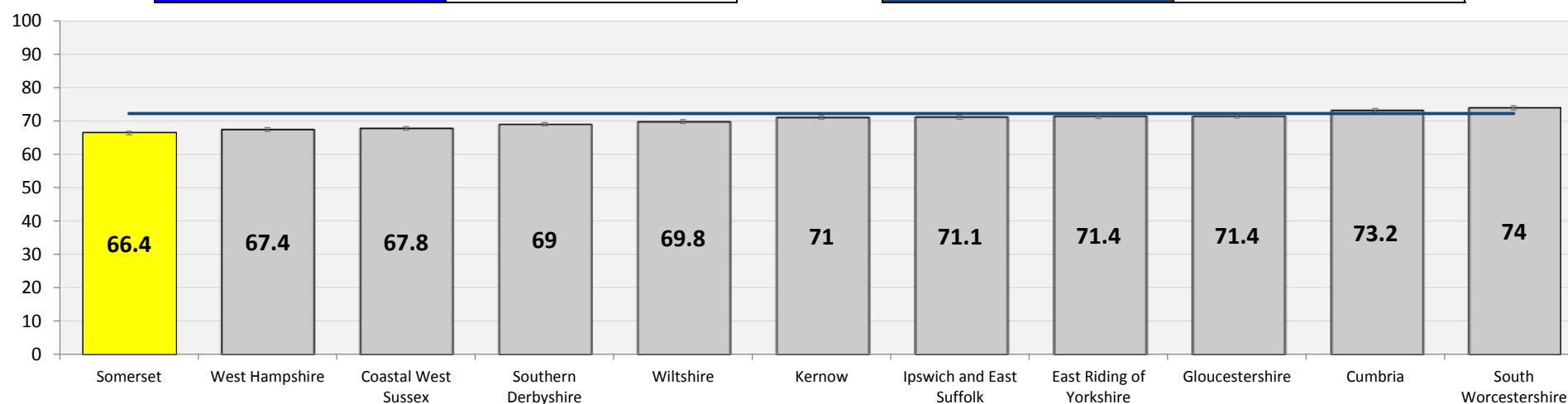
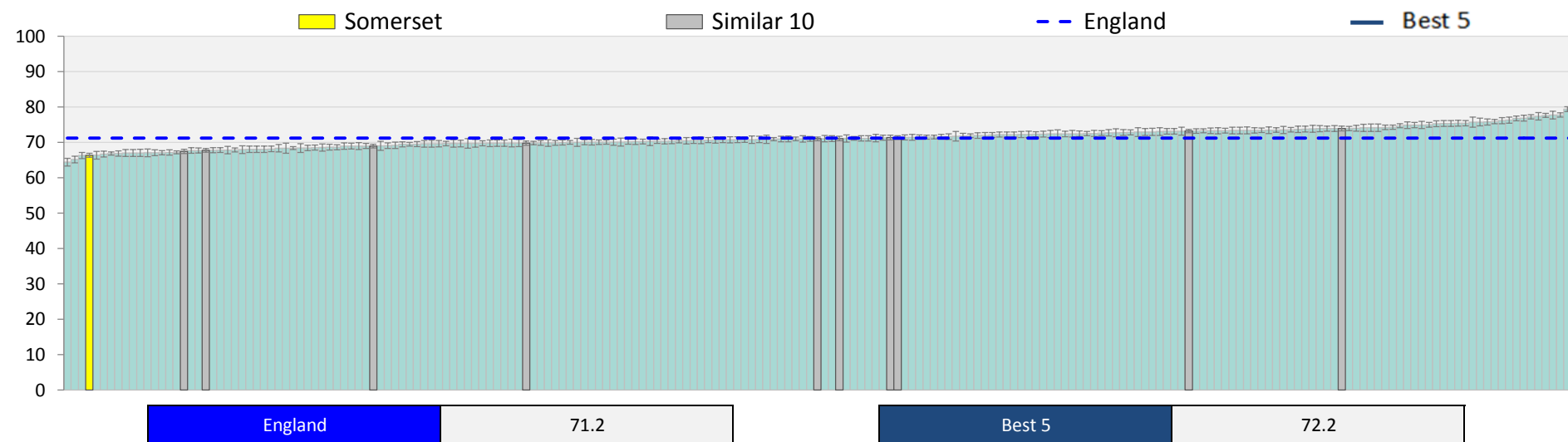
Source: Quality and Outcomes Framework (QOF) - Health & Social Care Information Centre (HSCIC)

Year: 2014/15

## Diabetes patients whose BP <140/80 (%)

1719 Pats.

112



Definition: DM003: The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less

Source: Quality and Outcomes Framework, Health and Social Care Information Centre

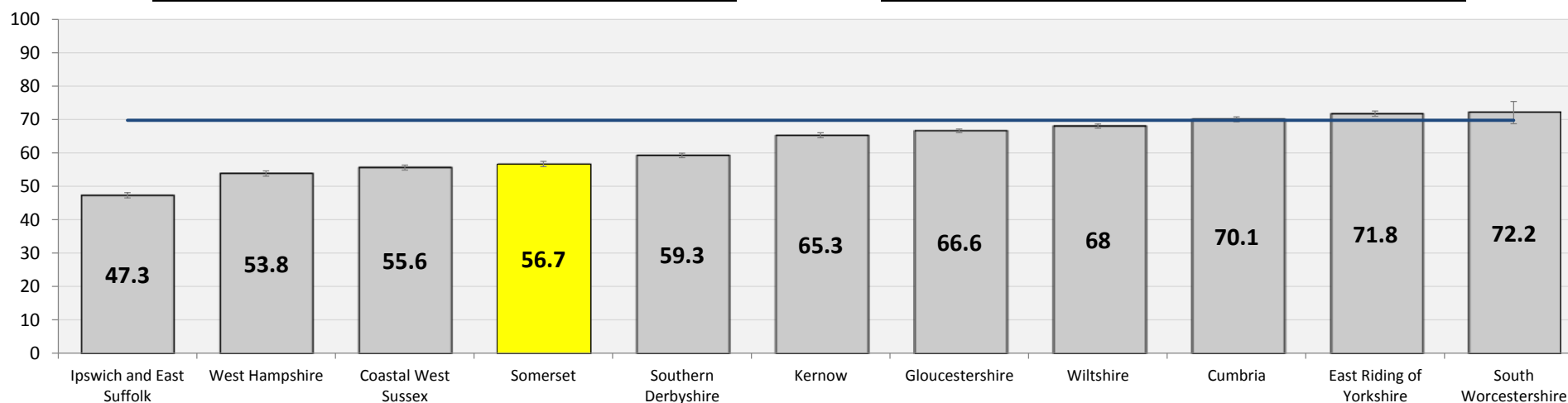
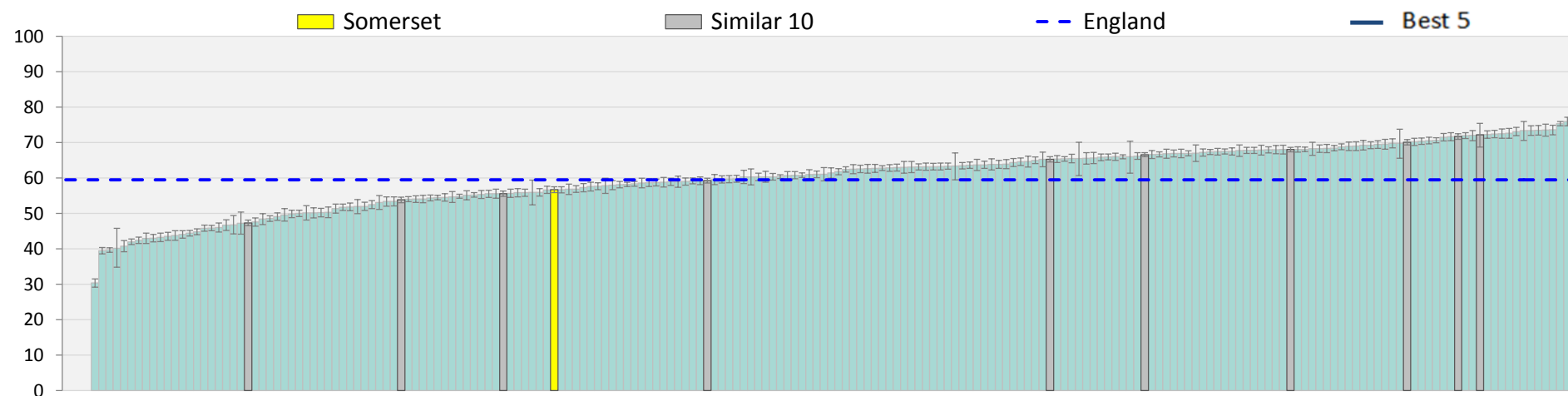
Year: 2014/15



## Patients receiving 8 cares processes (%)

1788 Pats.

113



Definition: % of all diabetes patients receiving eight care processes

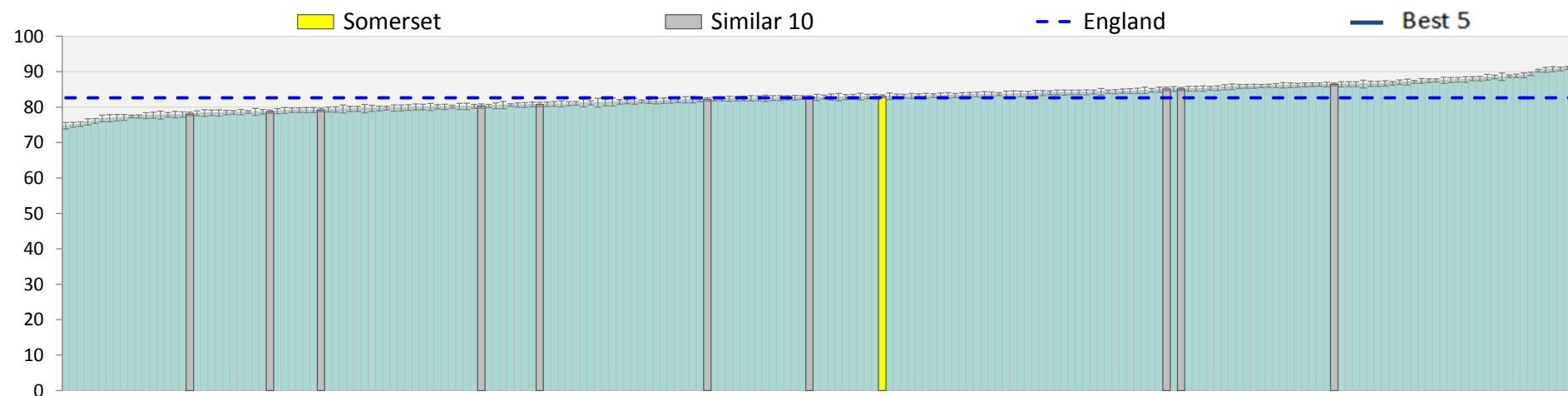
Source: The National Diabetes Audit 2012-13 Report 1, The Health and Social Care Information Centre

Year: 2012/13

# Diabetes patients who have had retinal screening (12 months) (%)

362 Pats.

114

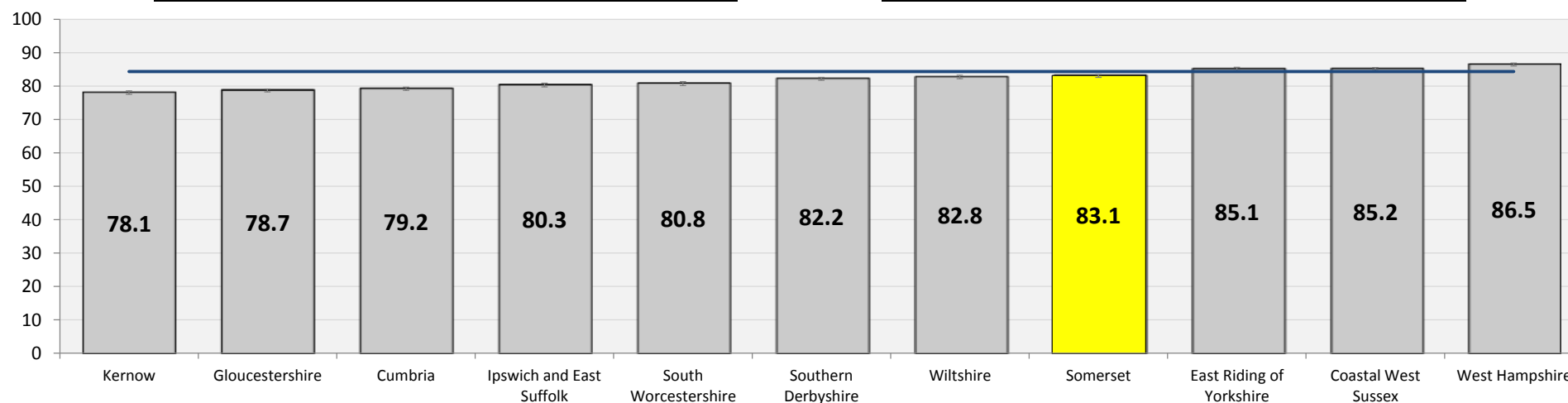


England

82.6

Best 5

84.3



Definition: % of all diabetes patients having retinal screening in the previous 12 months (DM011)

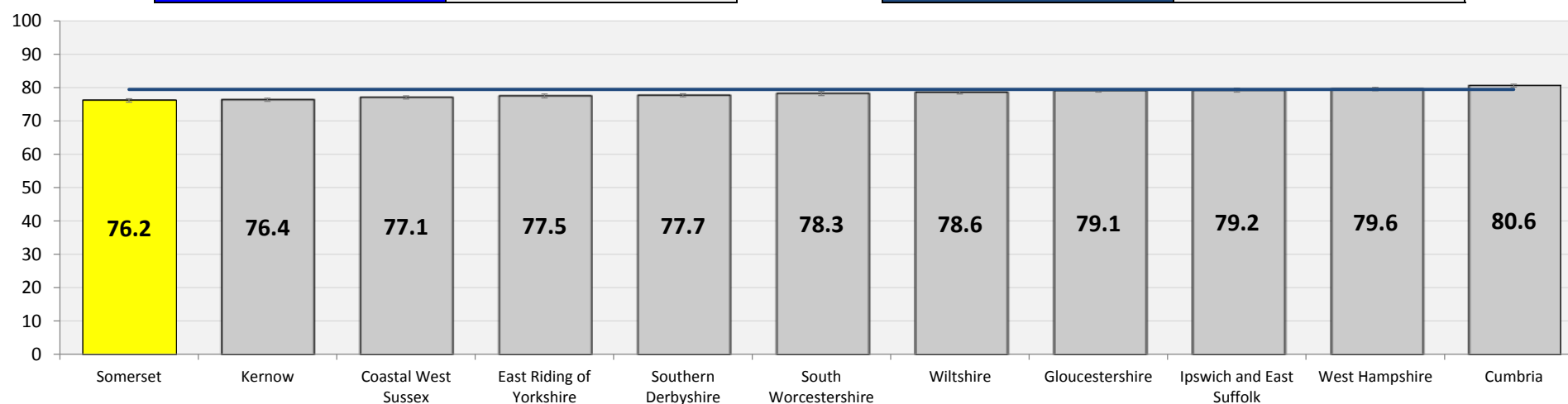
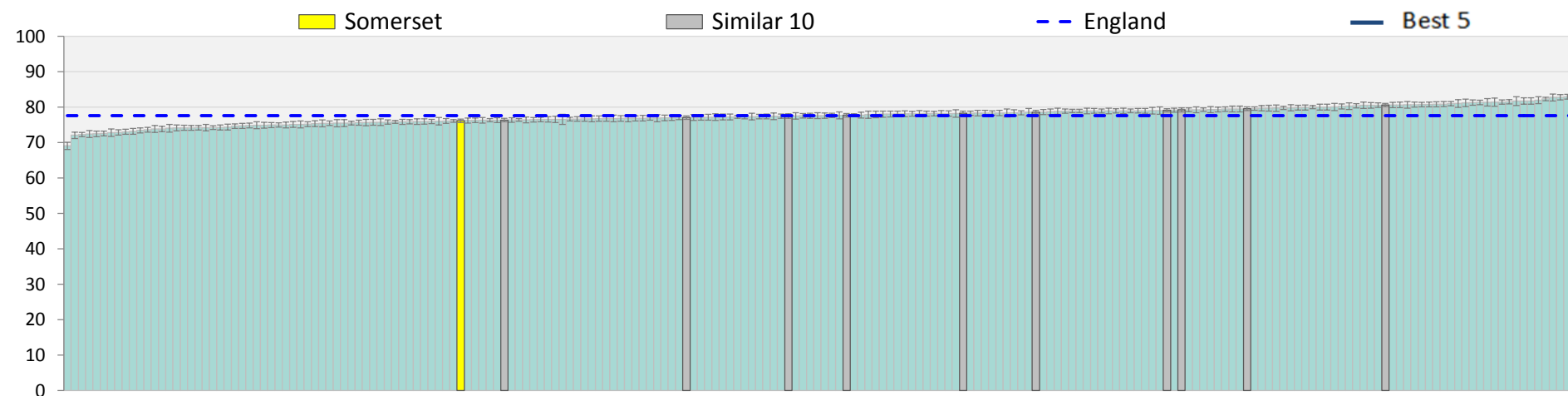
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2013/14

# Patients with diabetes who have had a flu vaccination (%)

963 Pats.

115



Definition: DM018: The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March

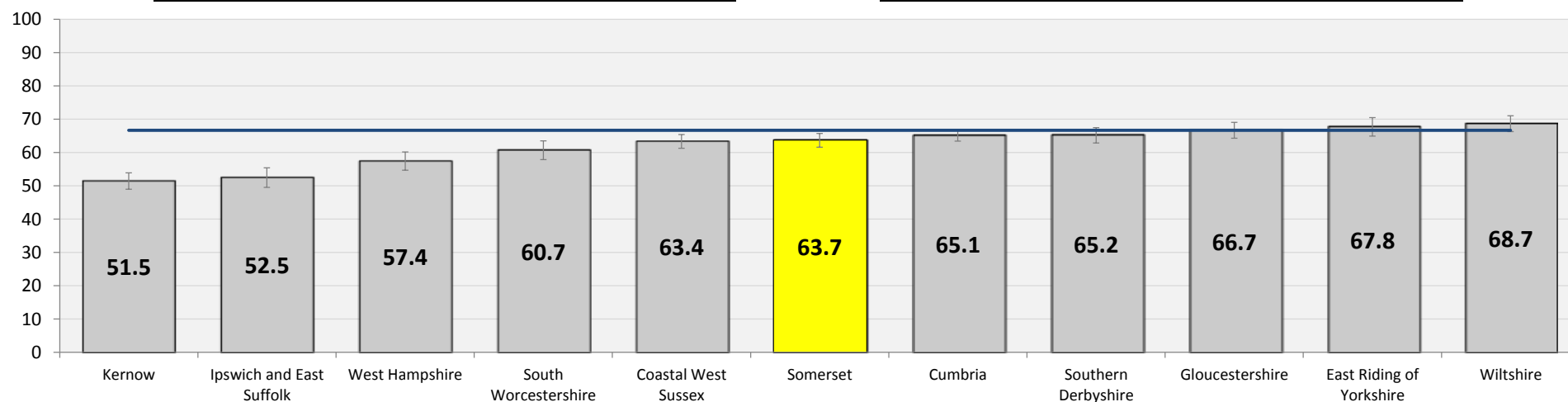
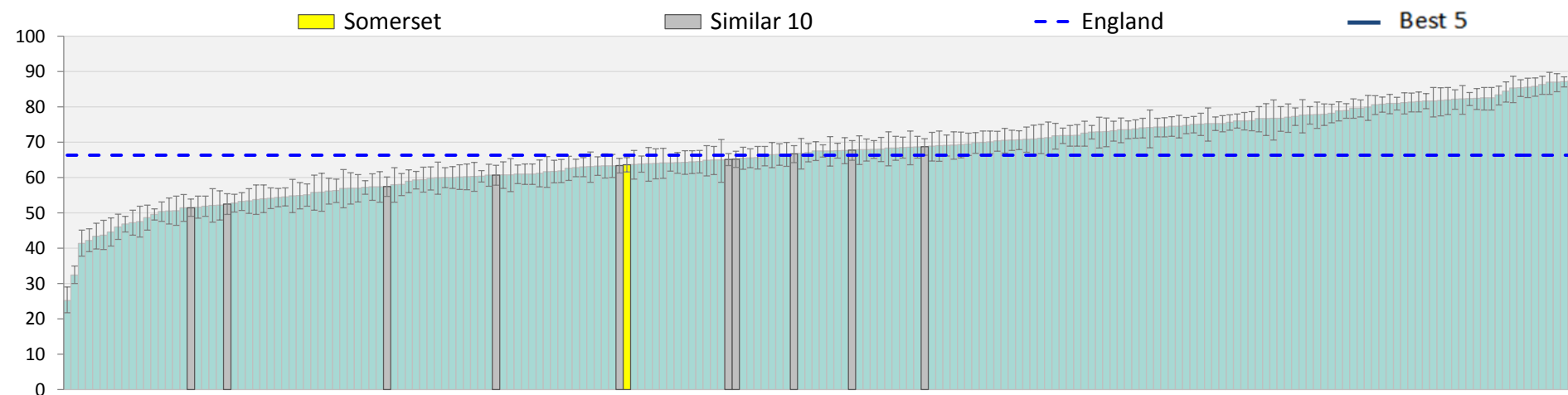
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## Patients with diabetes attending structured education (%)

64 Pats.

116



Definition: DM014: The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register

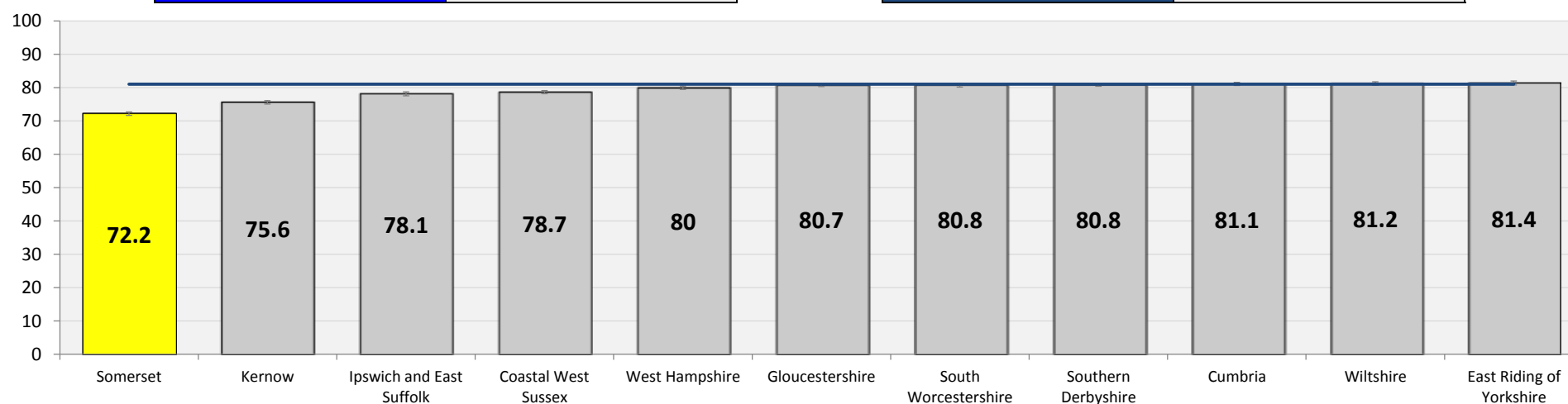
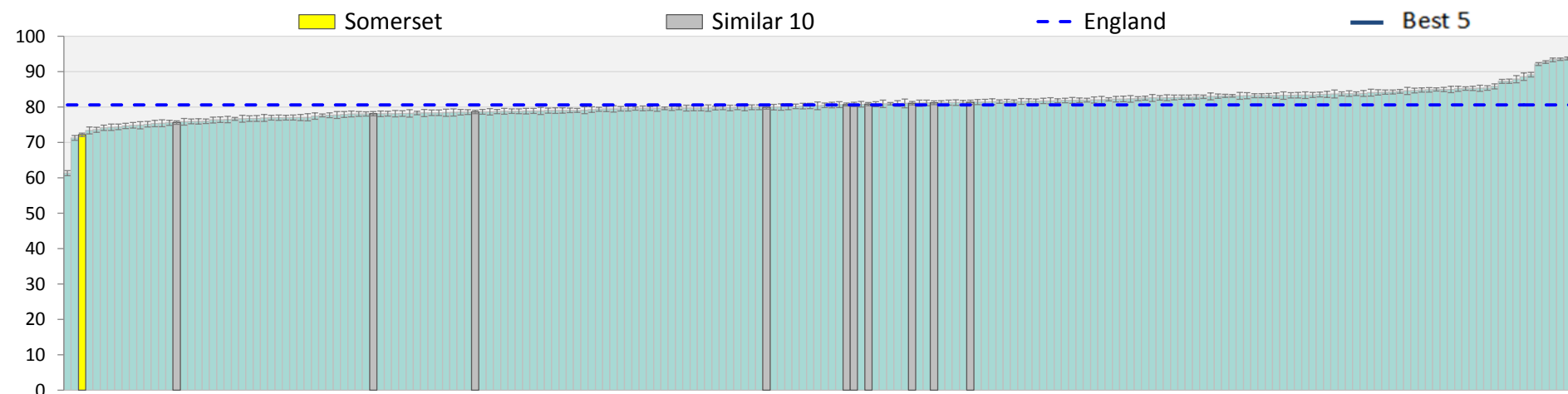
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## Diabetes patients who have had a test for protein in urine (%)

2534 Pats.

117



Definition: % Patients with diabetes who have a record of micro-albuminuria testing in the previous 12 months

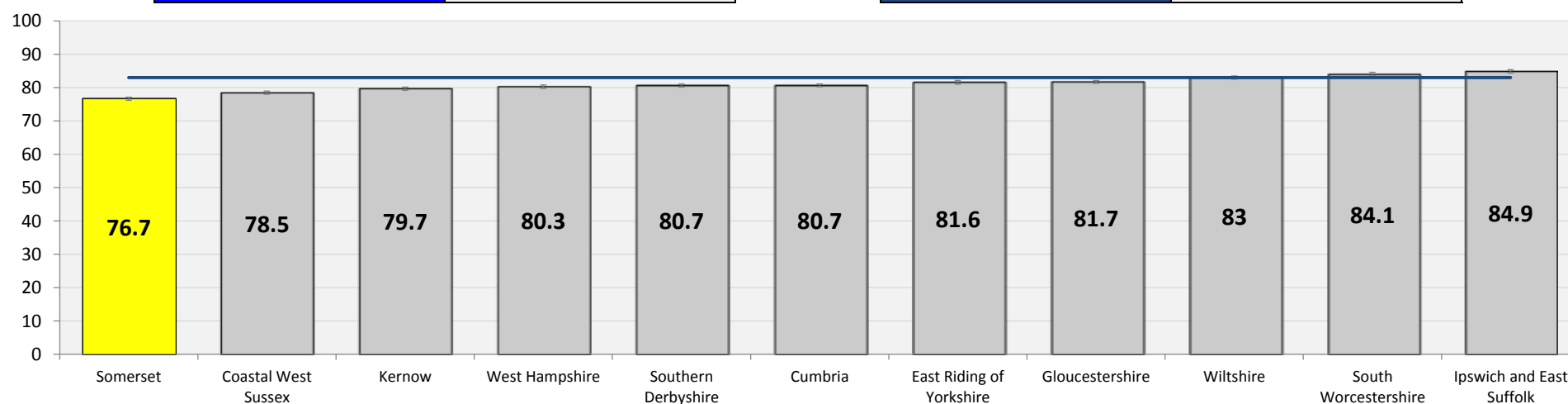
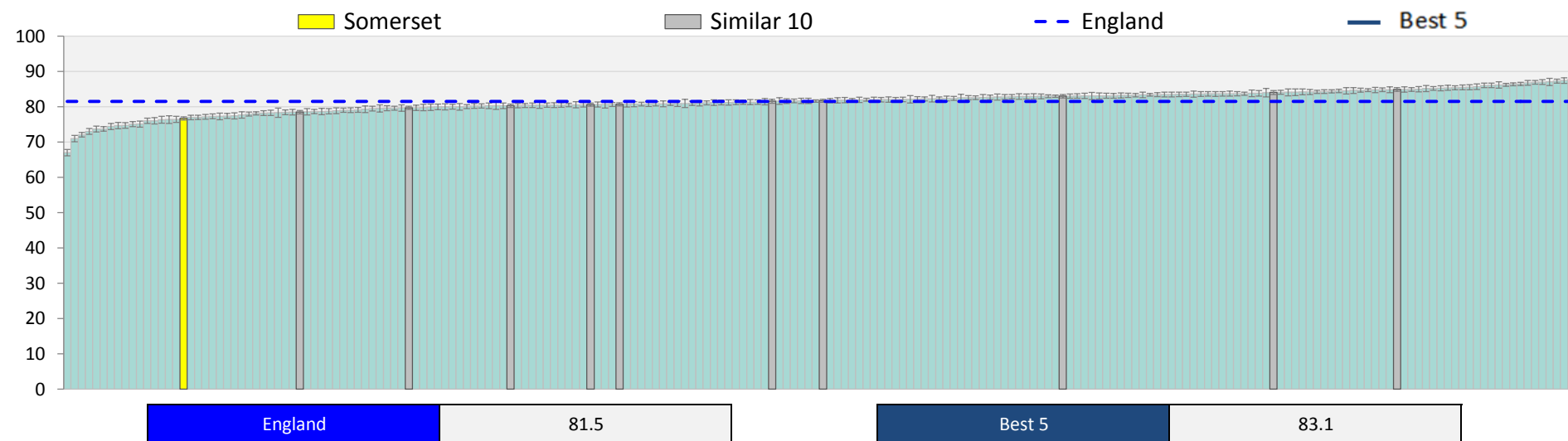
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2013/14

## Diabetes patients who have had a foot examination (%)

1873 Pats.

118



**Definition:** % Diabetes patients, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months, NICE 2010 menu ID: NM13

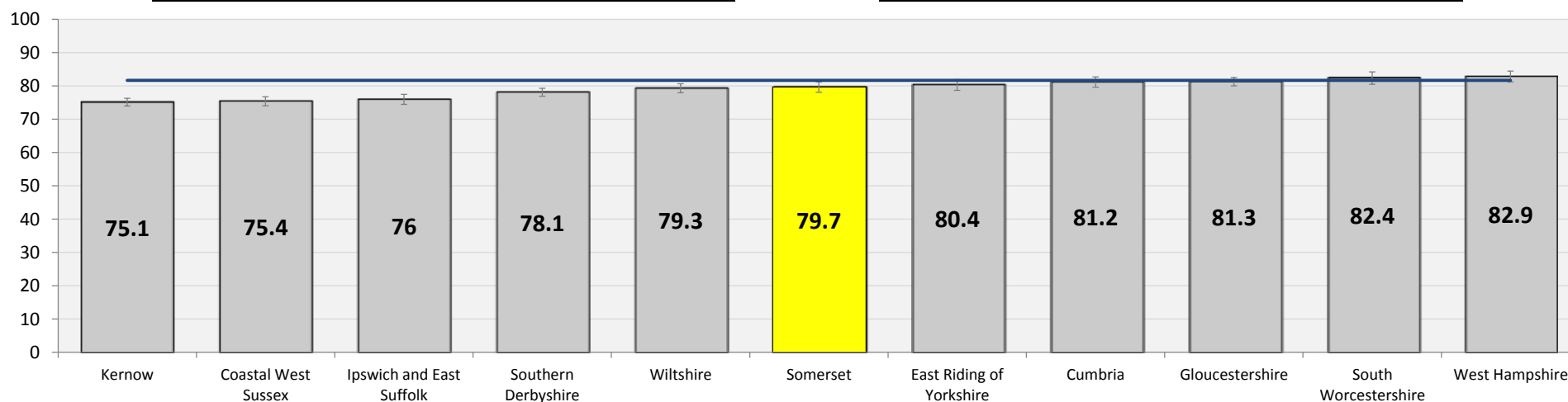
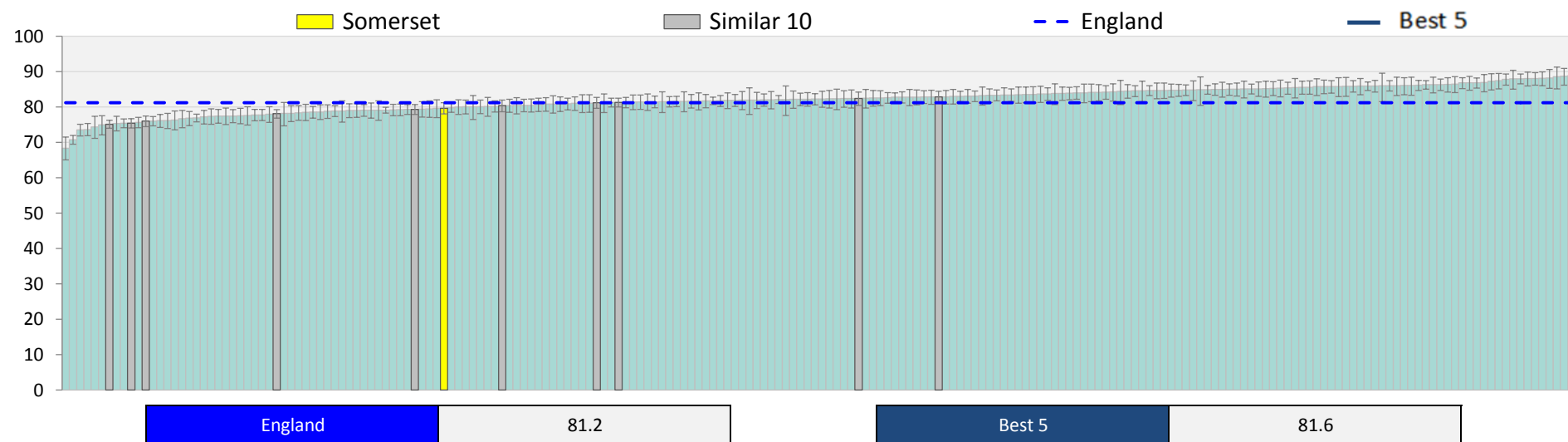
**Source:** Quality and Outcomes Framework, Health and Social Care Information Centre

**Year:** 2014/15

# Diabetes patients with kidney disease, treated with ACE-I (%)

50 Pats.

119



Definition: % Diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)

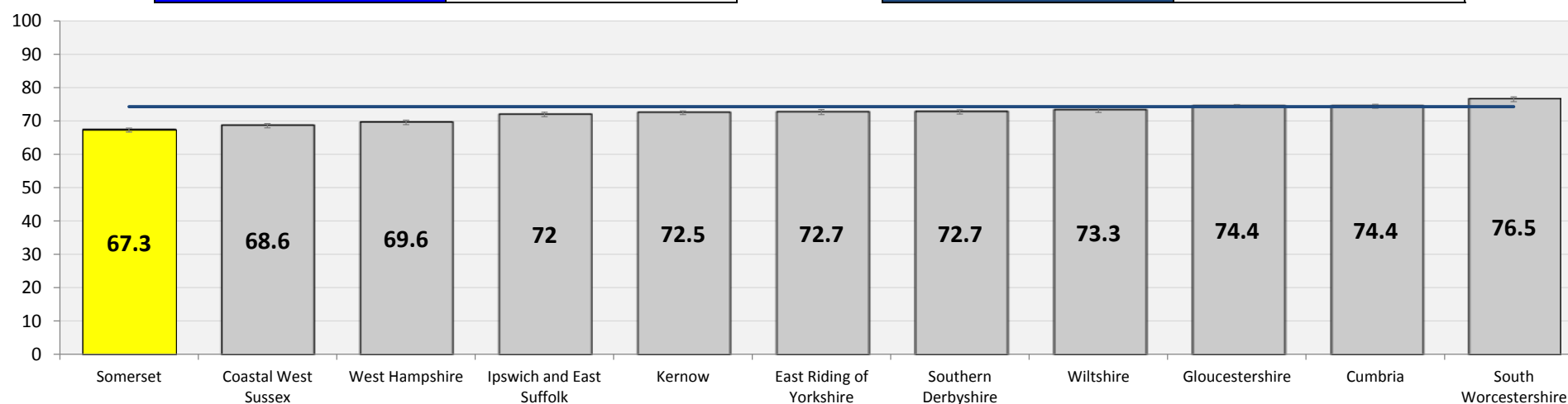
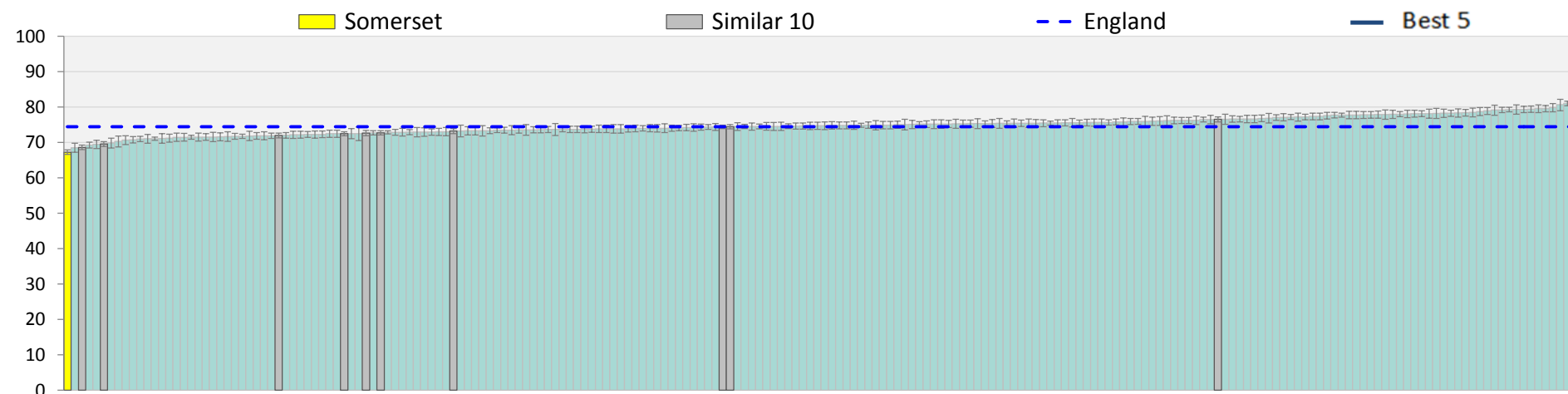
Source: Quality and Outcomes Framework, Health and Social Care Information Centre

Year: 2014/15

## CKD patients whose BP < 140/85 (%)

1520 Pats.

120



Definition: The % of patients on the CKD register in whom the last blood pressure reading (measured in the preceding 12 months) is 140/85 mmHg or less (CKD002)

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

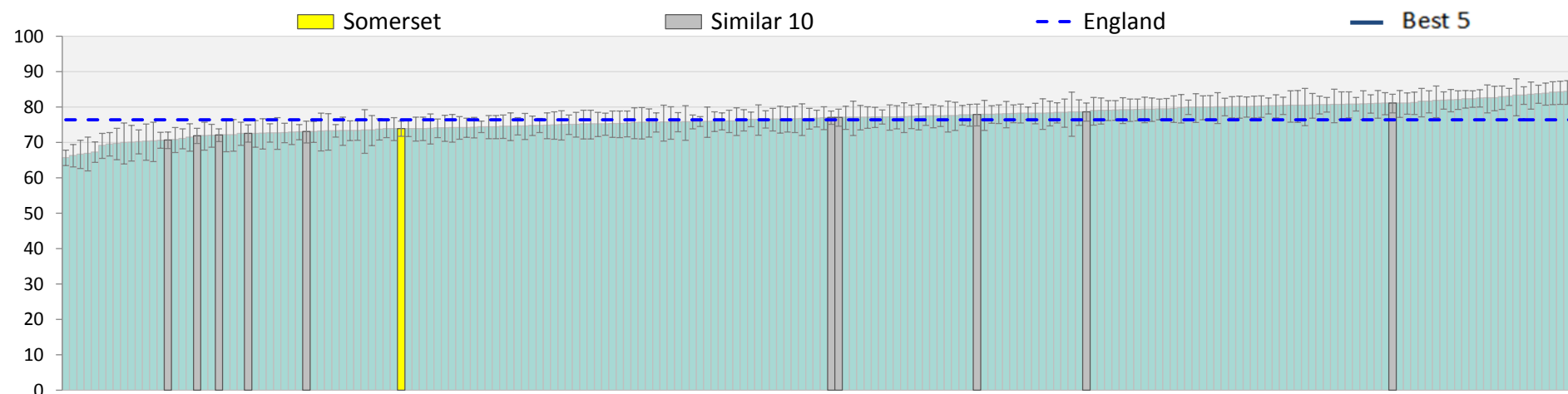
Year: 2014/15



# CKD patients with hypertension & proteinuria treated with ACE-I/ARB (%)

71 Pats.

121

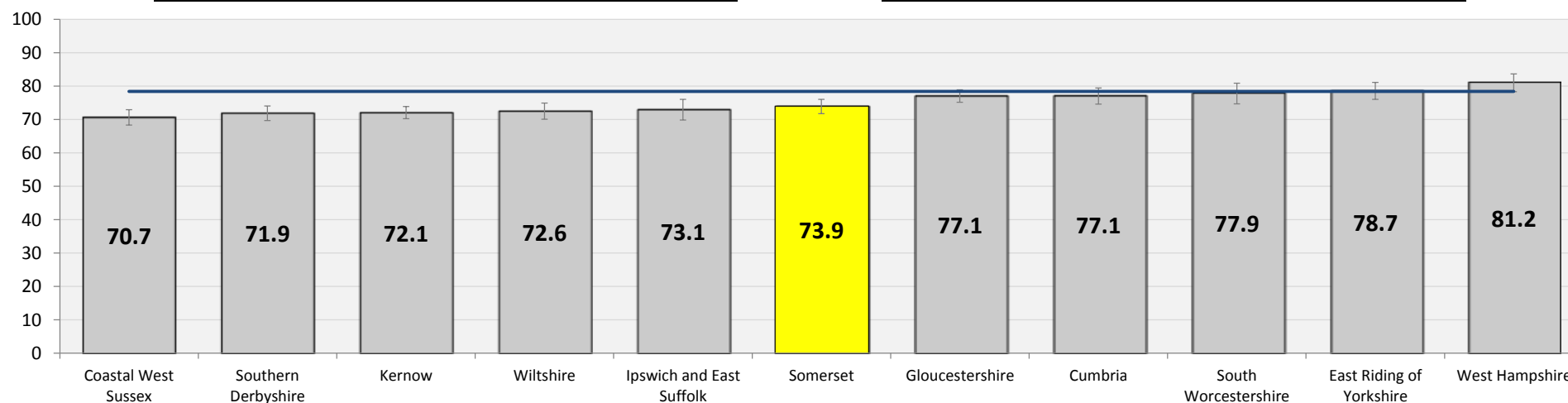


England

76.4

Best 5

78.4



Definition: The % of patients on the CKD register with hypertension and proteinuria who are treated with ACE-I or ARB

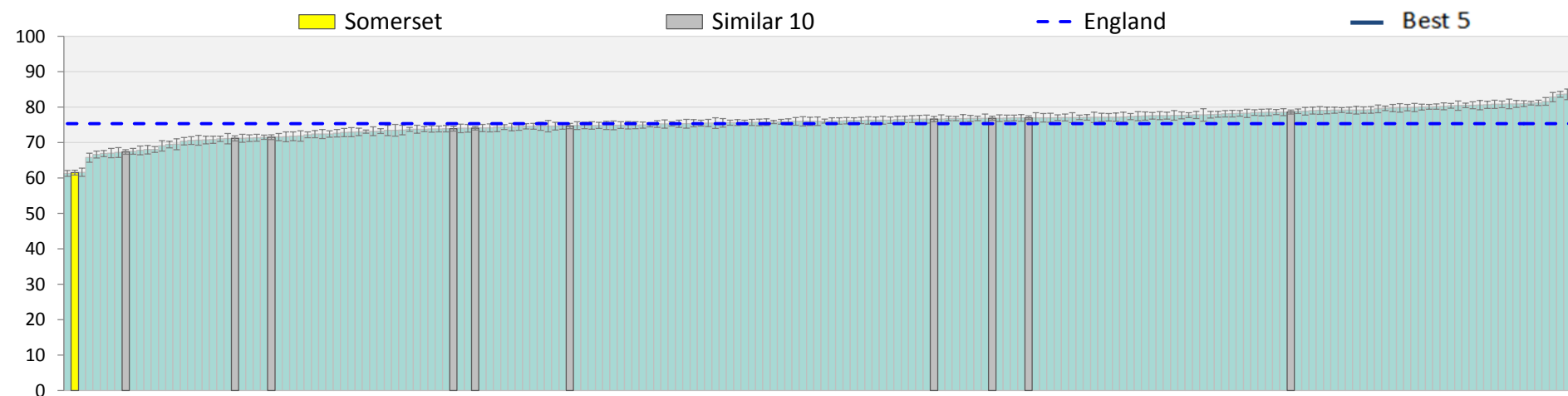
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

## Creatinine ratio test used in last 12 months (%)

3312 Pats.

122

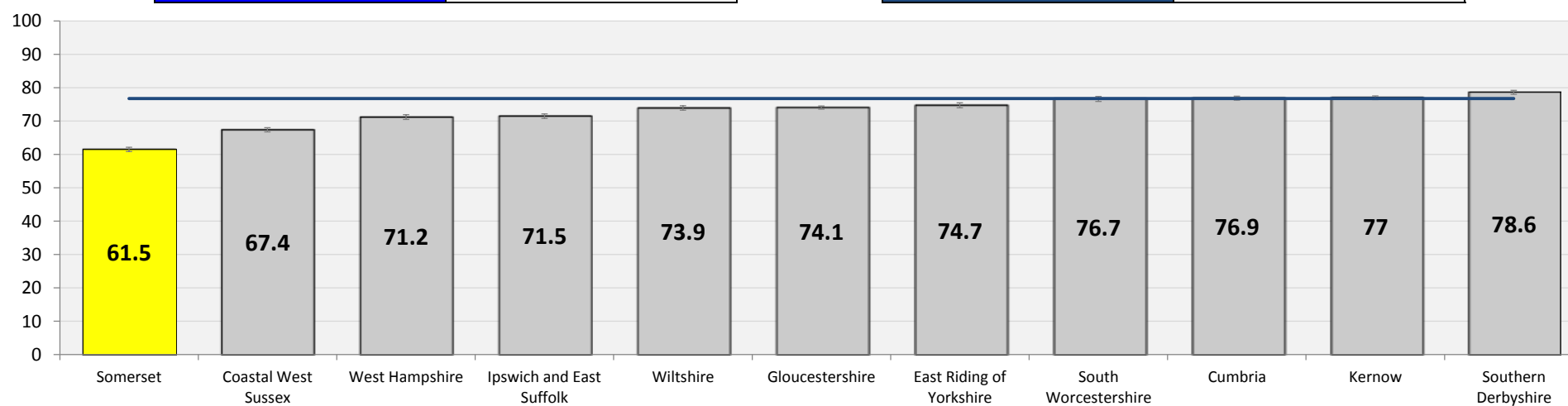


England

75.4

Best 5

76.8



Definition: The % of patients on the CKD register with hypertension and proteinuria who are treated with ACE-I or ARB

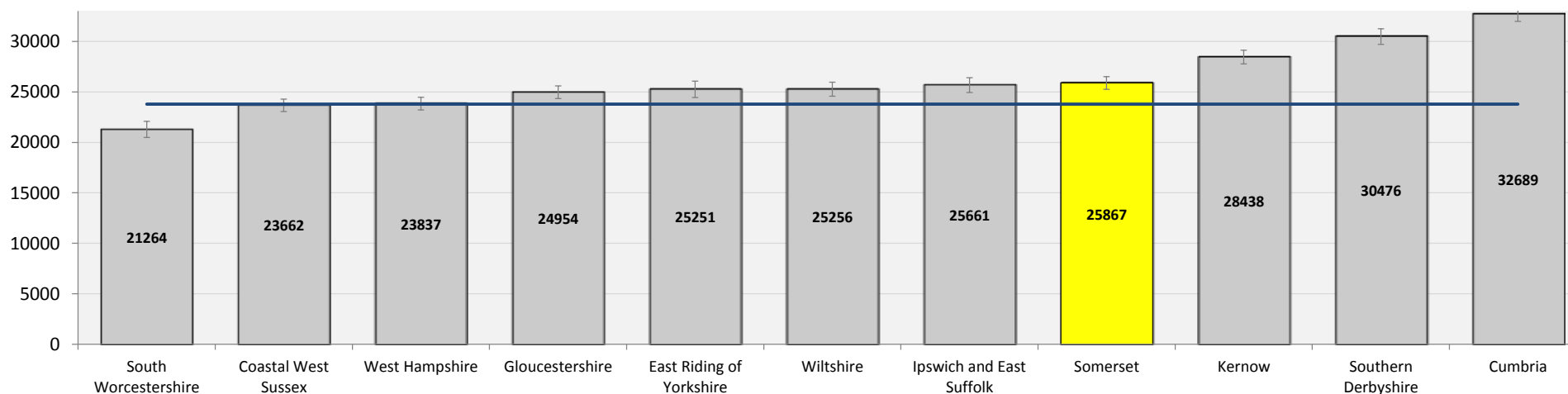
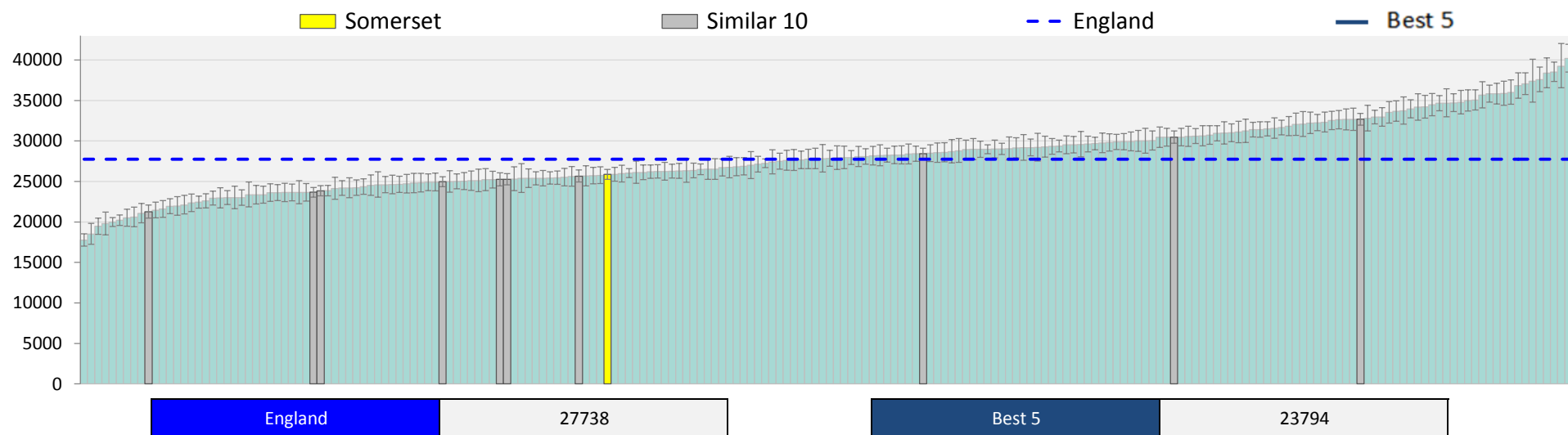
Source: Quality and Outcomes Framework (QoF), The Health and Social Care Information Centre

Year: 2014/15

## Problems of circulation - Non-elective spend (£ per 1,000 pop)

**£1466k**

123



Definition: Problems of circulation- Total spend on non-elective admissions per 1,000 population

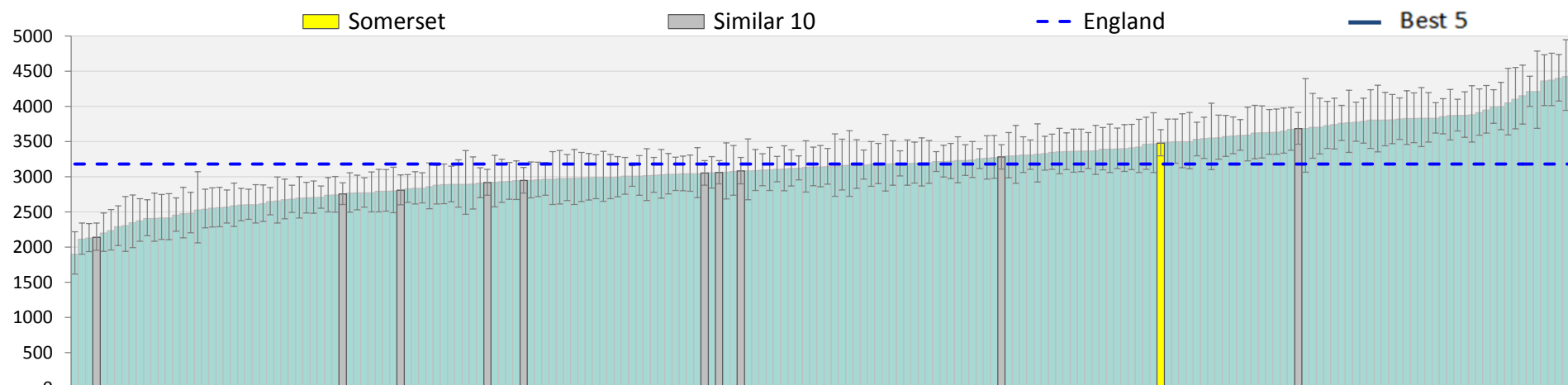
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Problems of Rhythm - Non-Elective spend (£ per 1,000 pop)

£544k

124

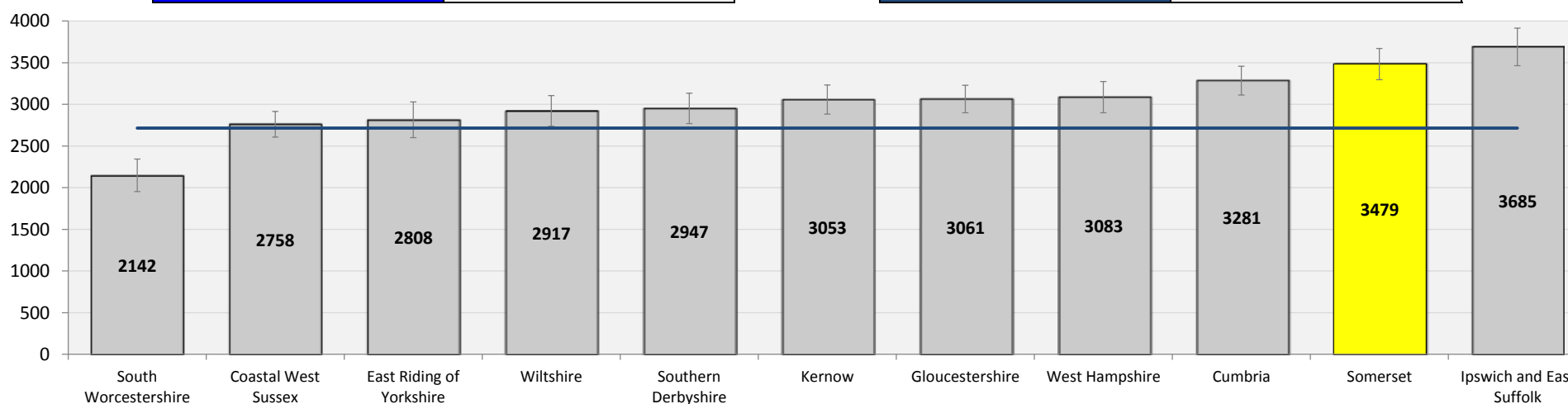


England

3180

Best 5

2714



Definition: Heart disease/Circulation - Problems of Rhythm - Total spend on non-elective admissions per 1,000 population

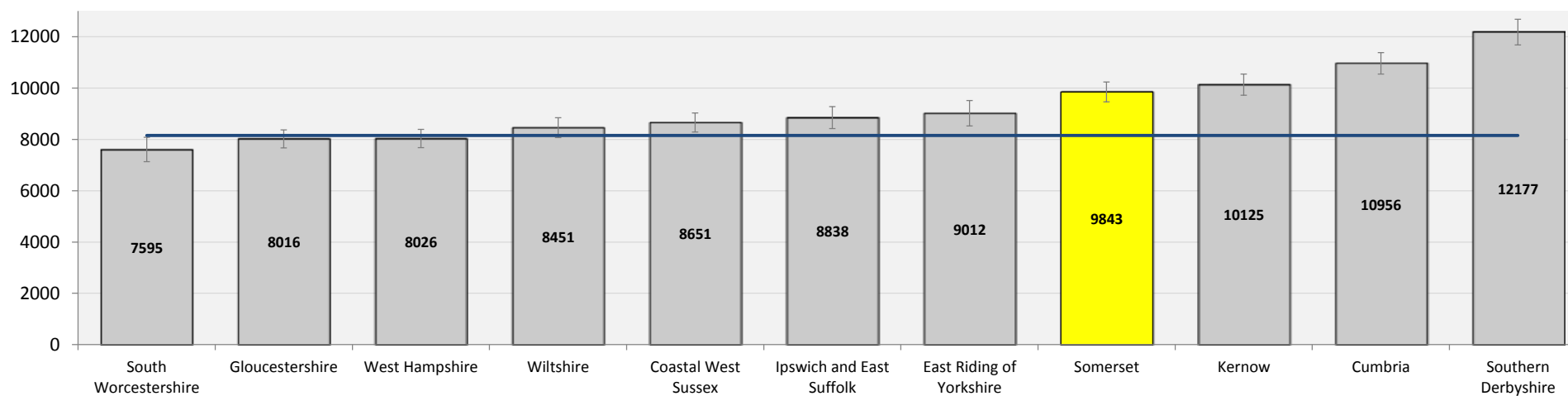
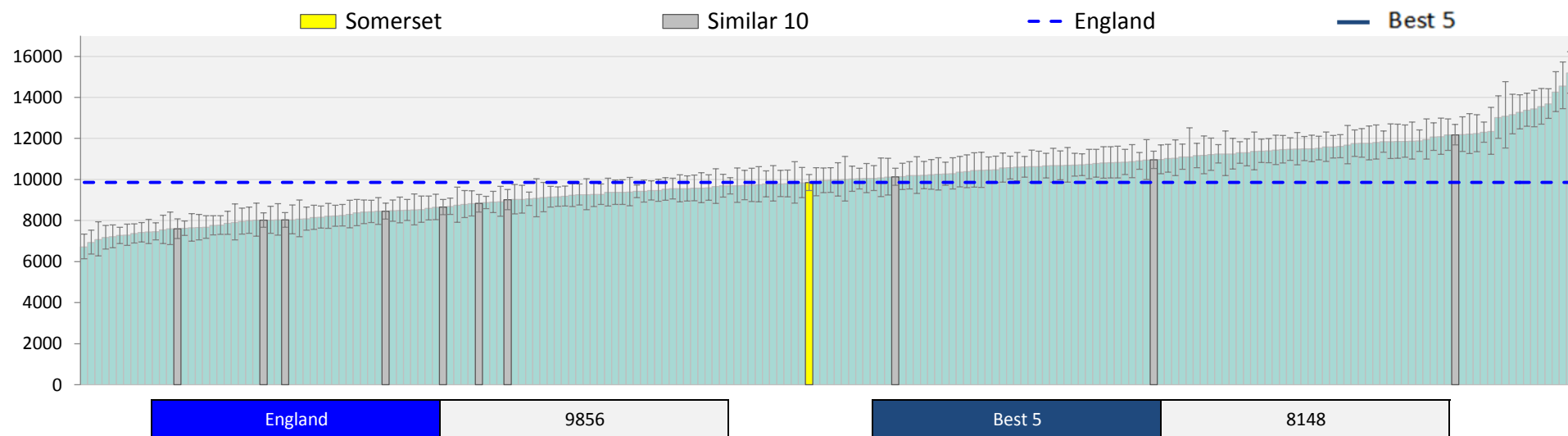
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Other circulatory problems - Non-elective spend (£ per 1,000 pop)

**£1206k**

125



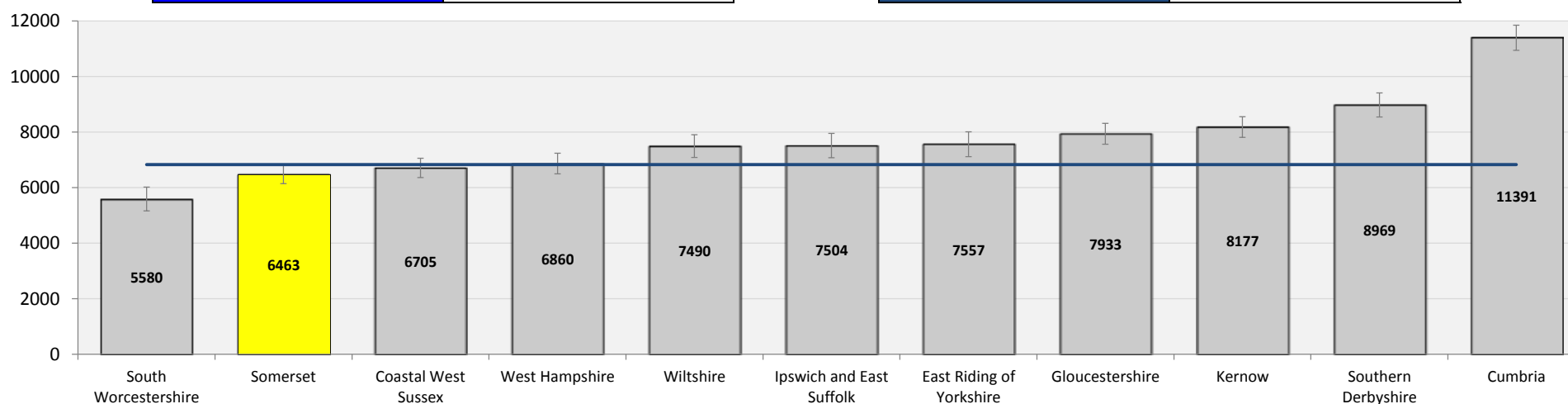
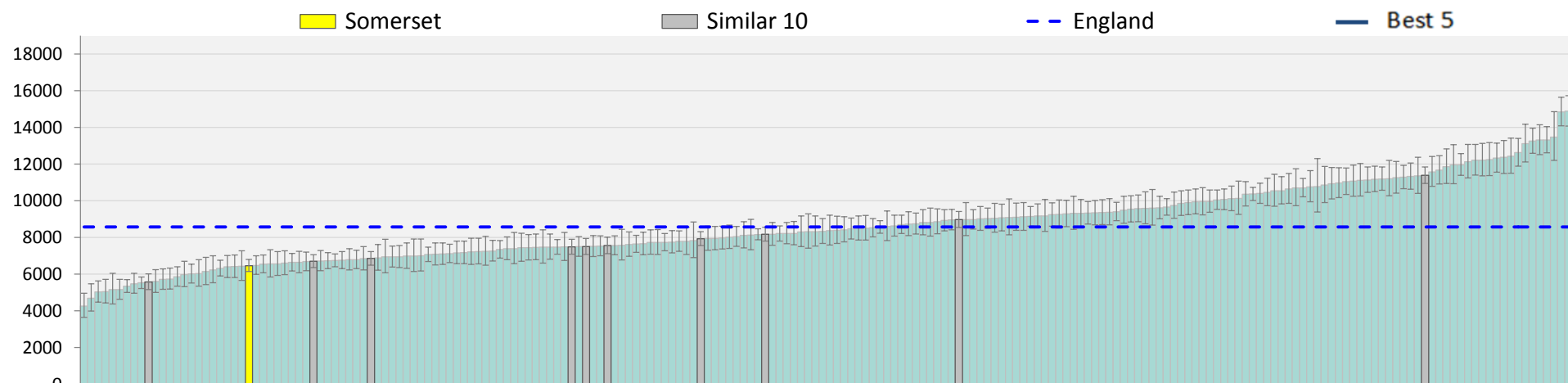
Definition: Heart disease/Circulation - Other circulatory problems - Total spend on non-elective admissions per 1,000 population

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

Year: 2014/15

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

126



Definition: Heart disease / circulation - Coronary heart diseases - Total spend on non-elective admissions per 1,000 population

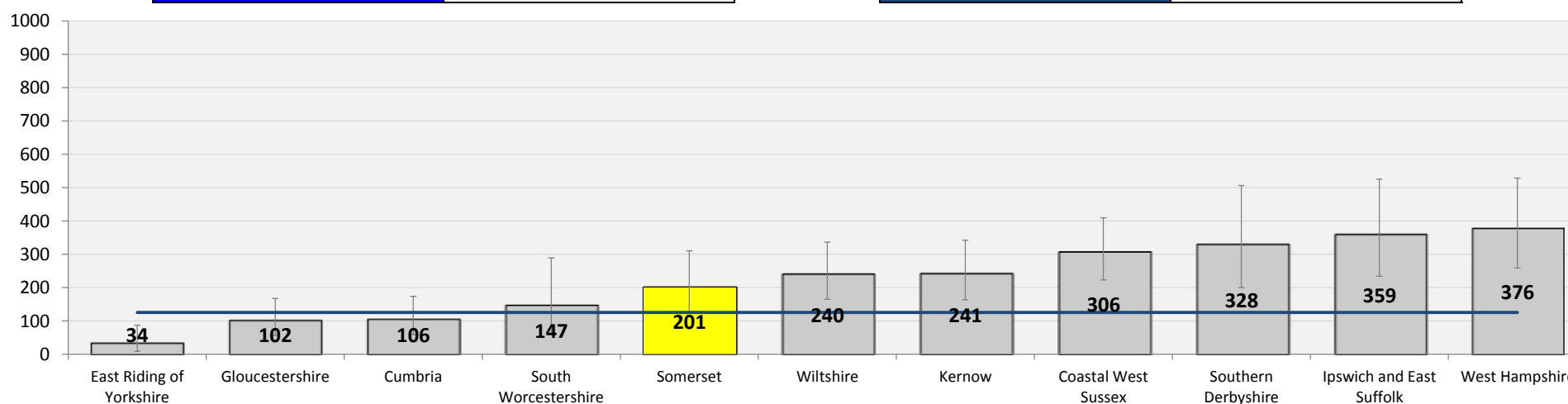
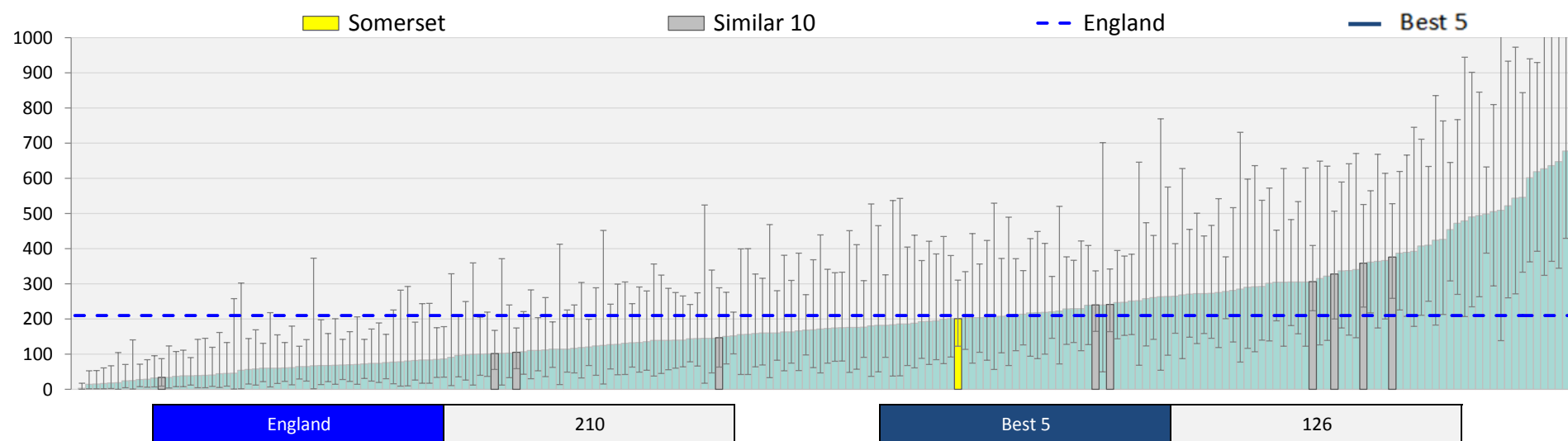
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

# Chronic rheumatic heart disease - Non-elective spend (£ per 1,000 pop)

£53k (NSS)

127



Definition: Heart disease / circulation - Chronic rheumatic heart diseases - Total spend on non-elective admissions per 1,000 population

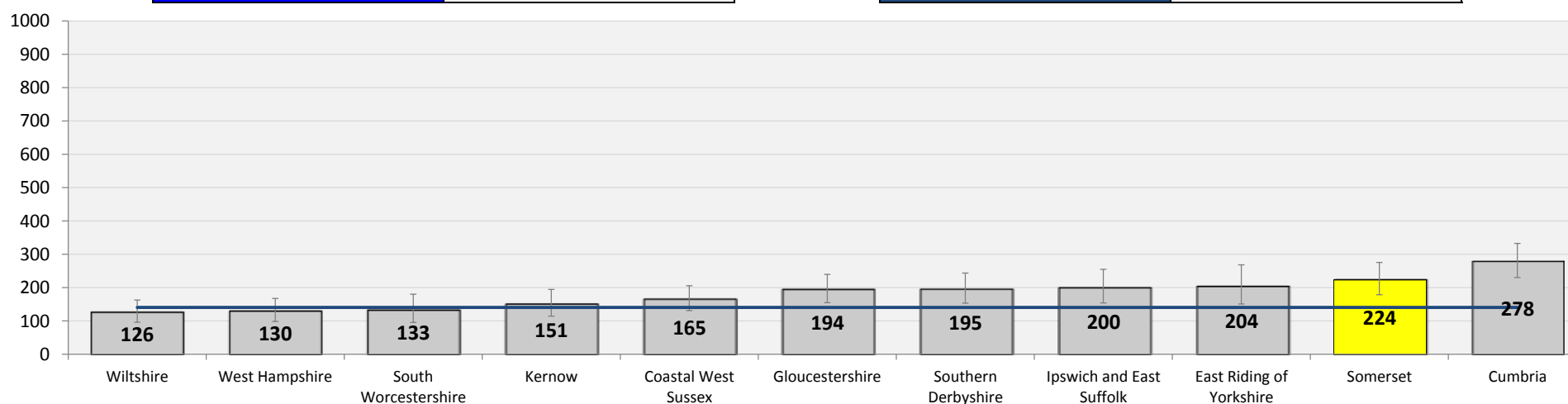
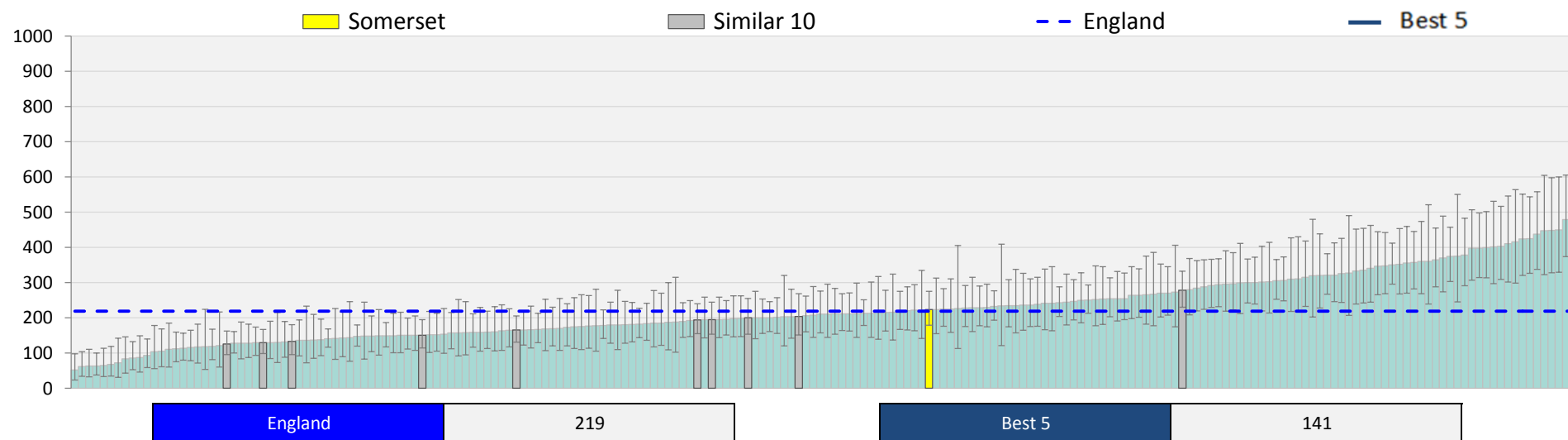
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Hypertensive disease - Non-elective spend (£ per 1,000 pop)

£54k

128



Definition: Heart disease / circulation - Hypertensive diseases - Total spend on non-elective admissions per 1,000 population

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

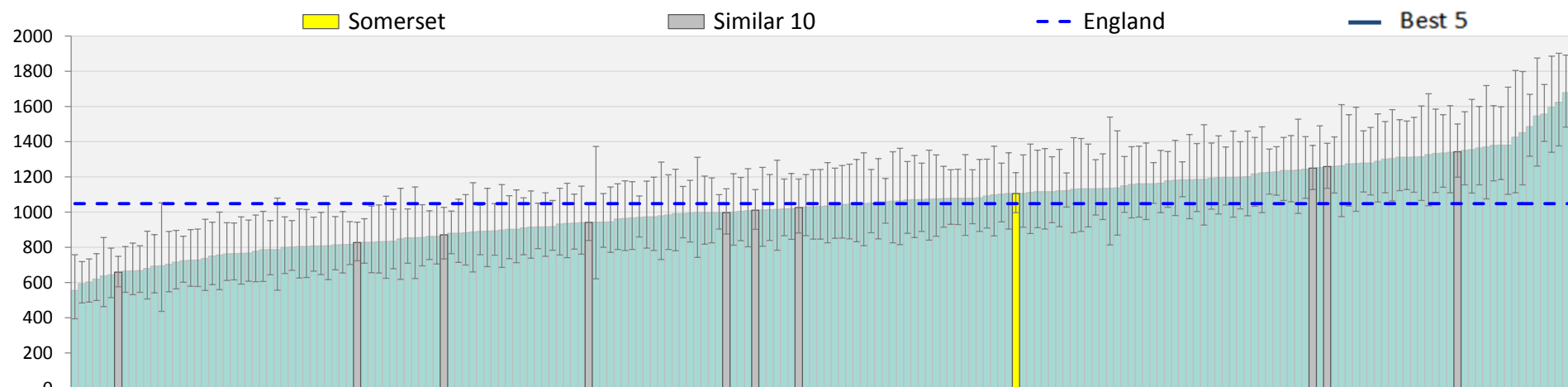
Year: 2014/15



## Pulmonary circulation and heart diseases - Non-elective spend (£ per 1,000 pop)

**£169k**

129

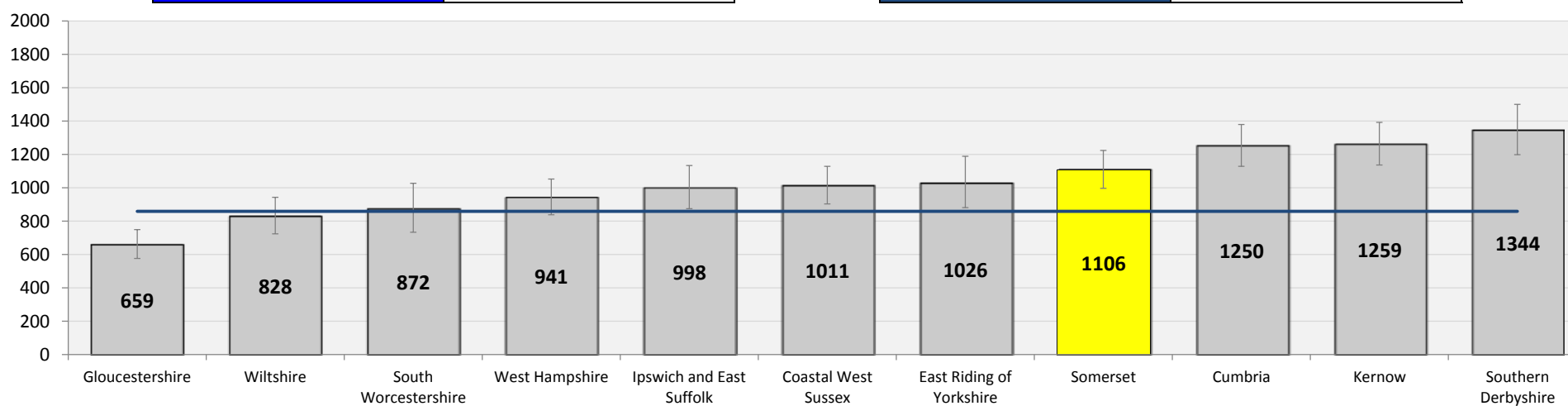


England

1048

Best 5

860



Definition: Heart disease / circulation - Pulmonary heart disease and diseases of pulmonary circulation - Total spend on non-elective admissions per 1,000 population

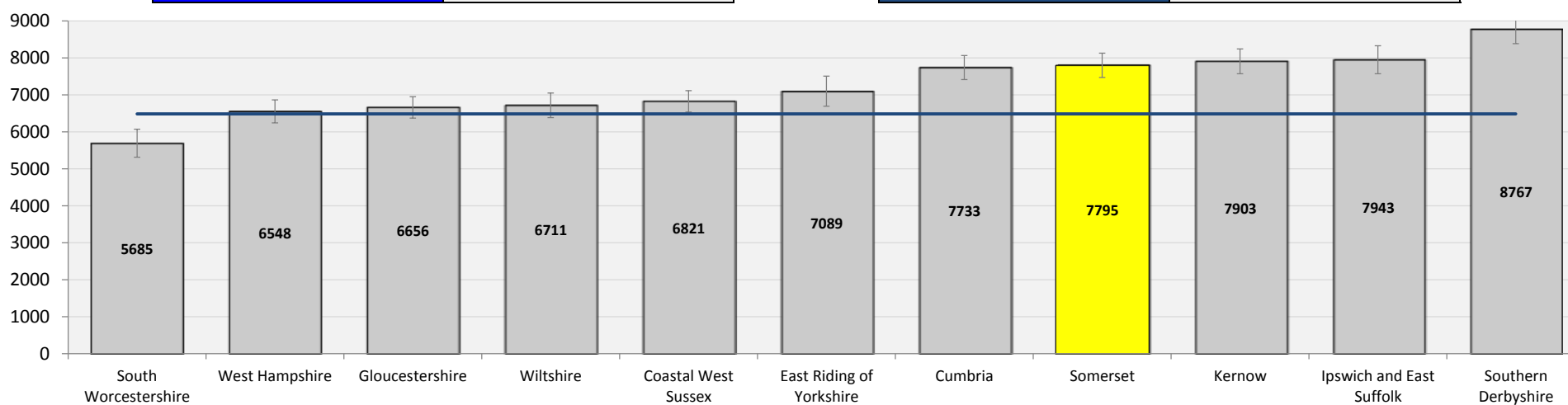
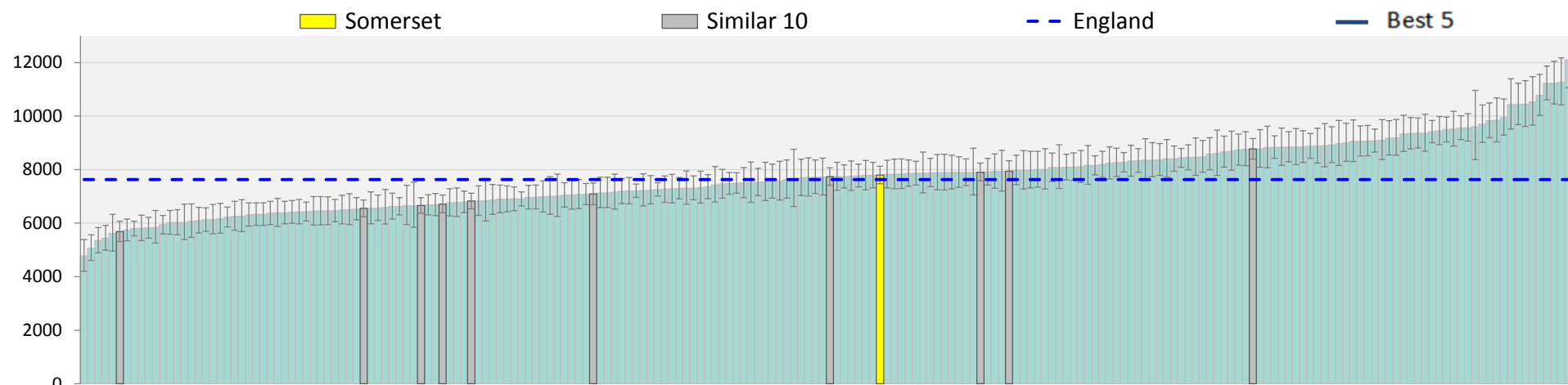
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Other heart diseases - Non-elective spend (£ per 1,000 pop)

£949k

130



Definition: Heart disease / circulation - Other forms of heart diseases - Total spend on non-elective admissions per 1,000 population

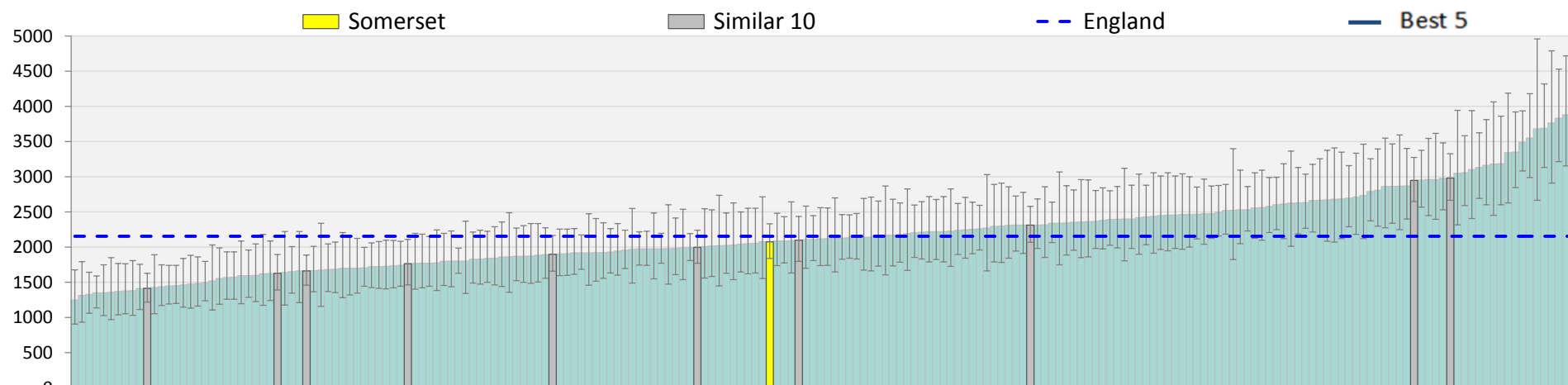
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Diseases of arteries - Non-elective spend (£ per 1,000 pop)

**£286k**

131

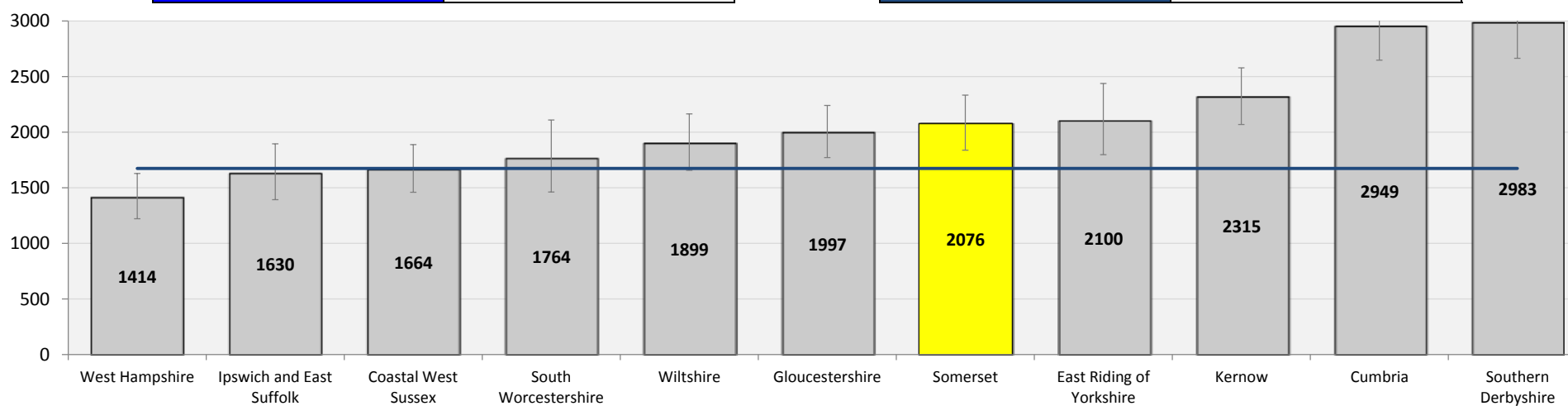


England

2156

Best 5

1674



Definition: Heart disease / circulation - Diseases of arteries, arterioles and capillaries - Total spend on non-elective admissions per 1,000 population

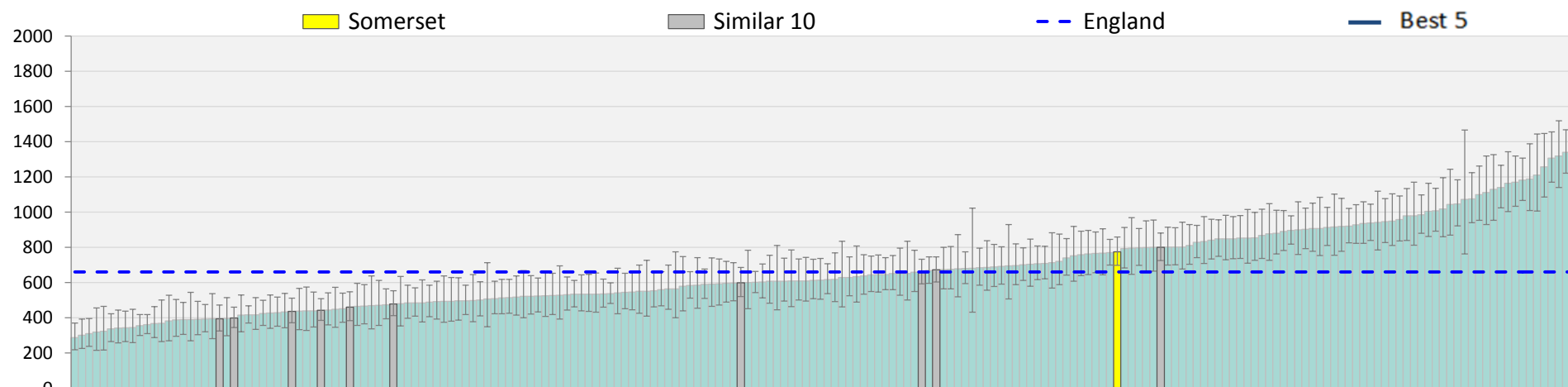
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Diseases of veins - Non-elective spend (£ per 1,000 pop)

£230k

132

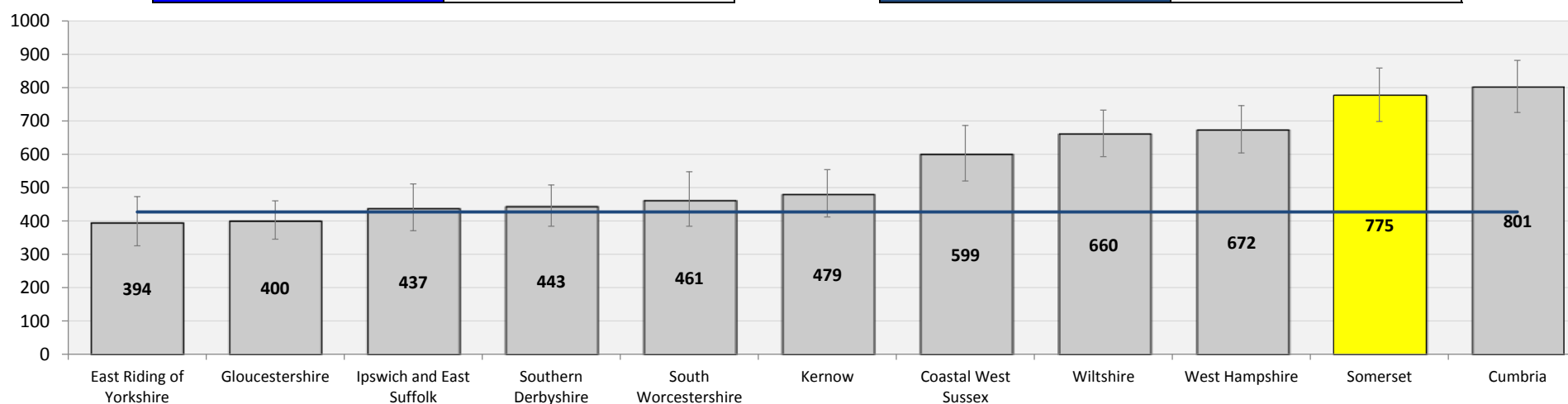


England

660

Best 5

427



Definition: Heart disease / circulation - Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified - Total spend on non-elective admissions per 1,000 population

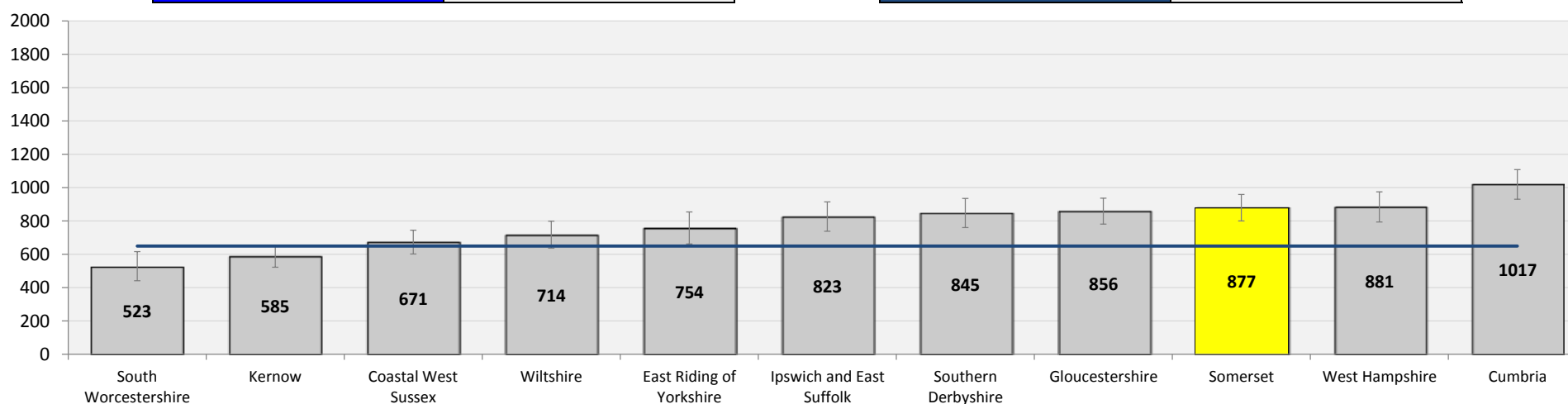
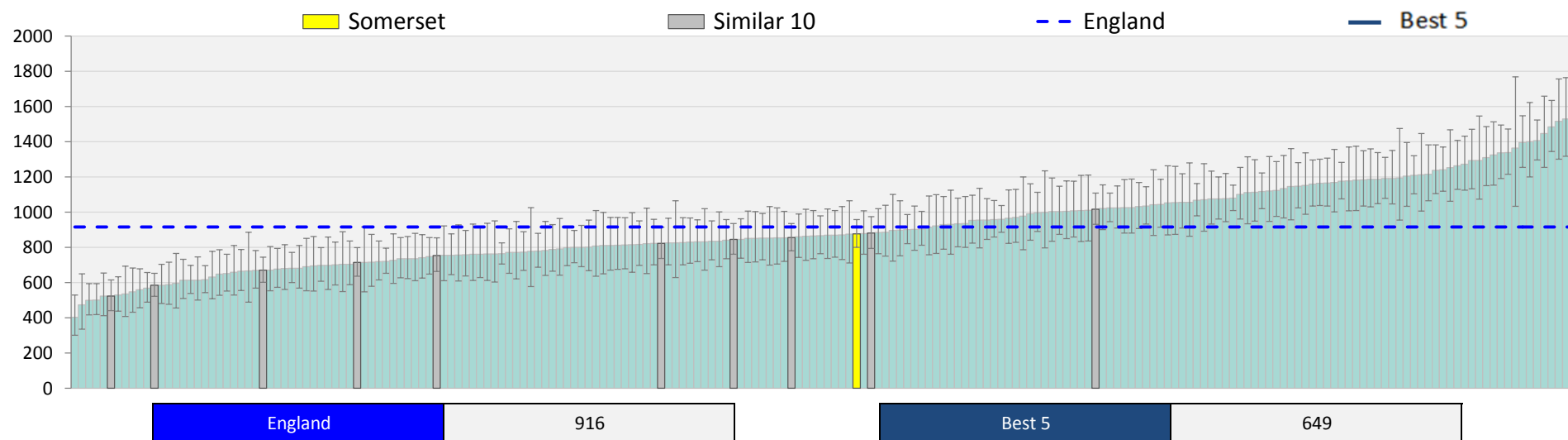
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Other and unspecified circulatory diseases - Non-elective spend (£ per 1,000 pop)

**£161k**

133



Definition: Heart disease / circulation - Other and unspecified disorders of the circulatory system (including Acute rheumatic fever) - Total spend on non-elective admissions per 1,000 population

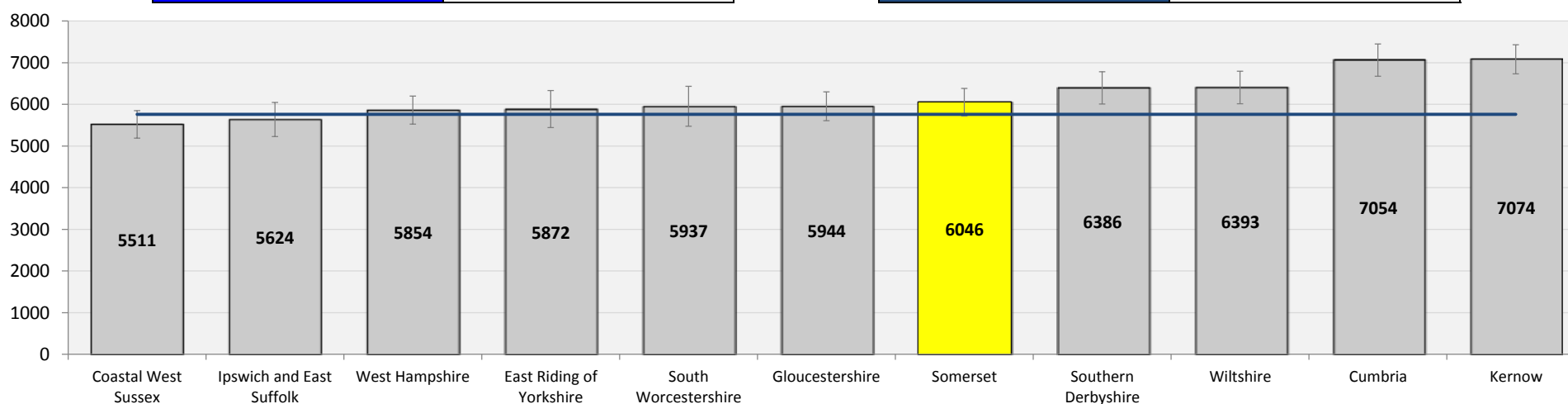
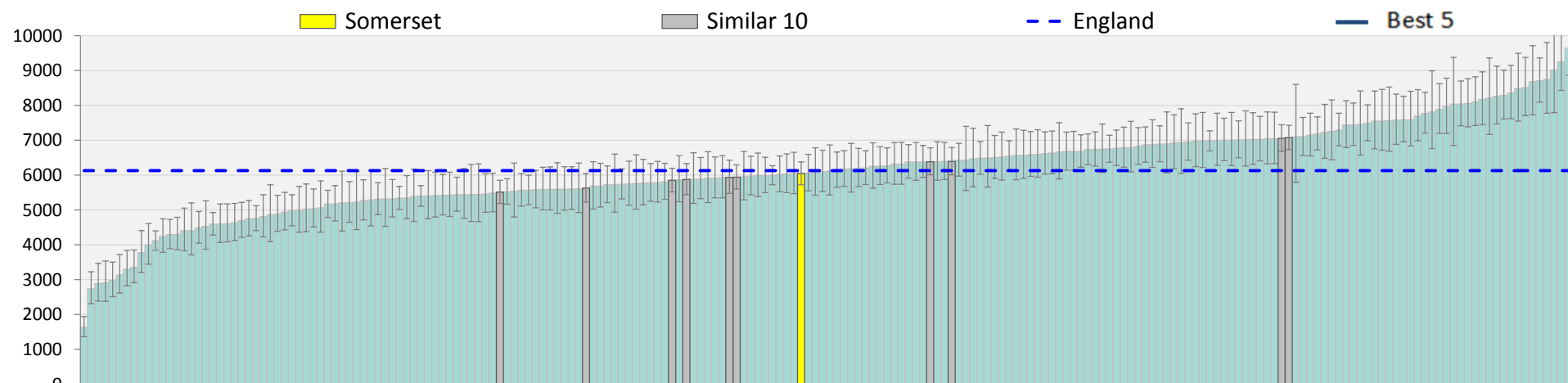
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

# Cerebrovascular disease - Non-elective spend (£ per 1,000 pop)

£204k (NSS)

134



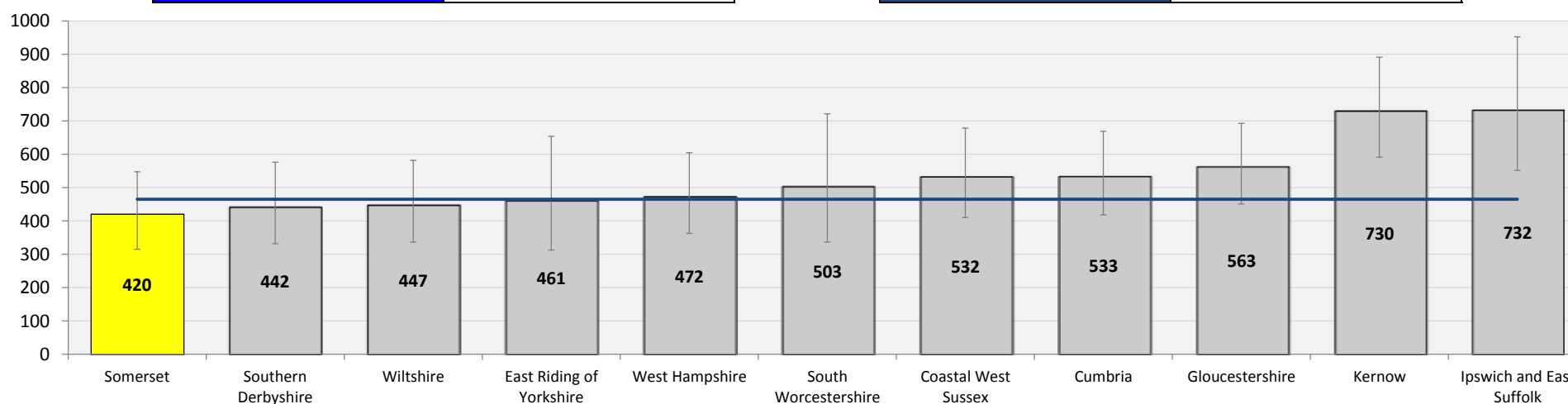
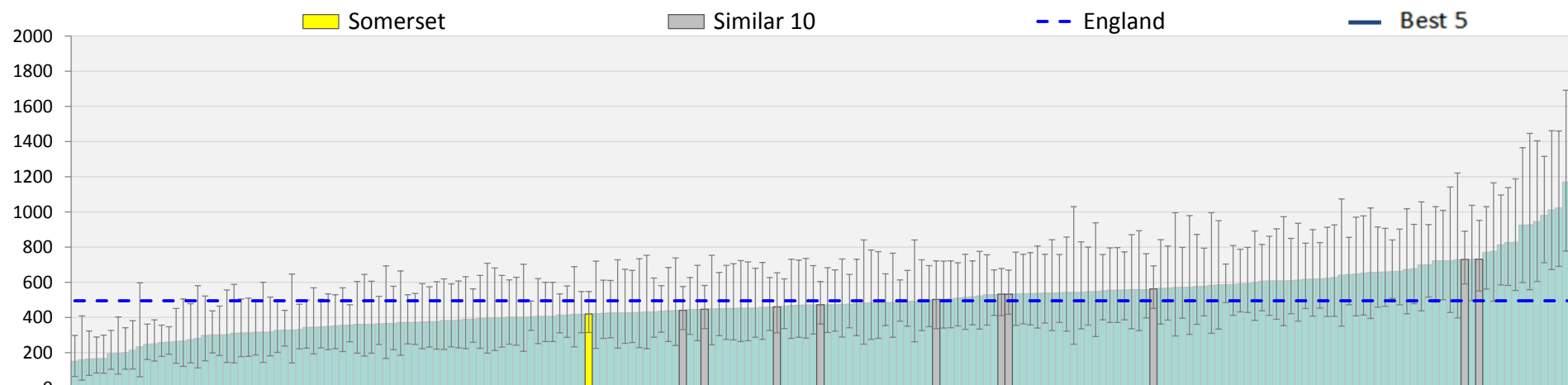
Definition: Stroke- Total spend on non-elective admissions per 1,000 population

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

Year: 2014/15

## Haemorrhage within skull - Non-elective spend (£ per 1,000 pop)

135



Definition: Stroke - Subarachnoid haemorrhage - Total spend on non-elective admissions per 1,000 population

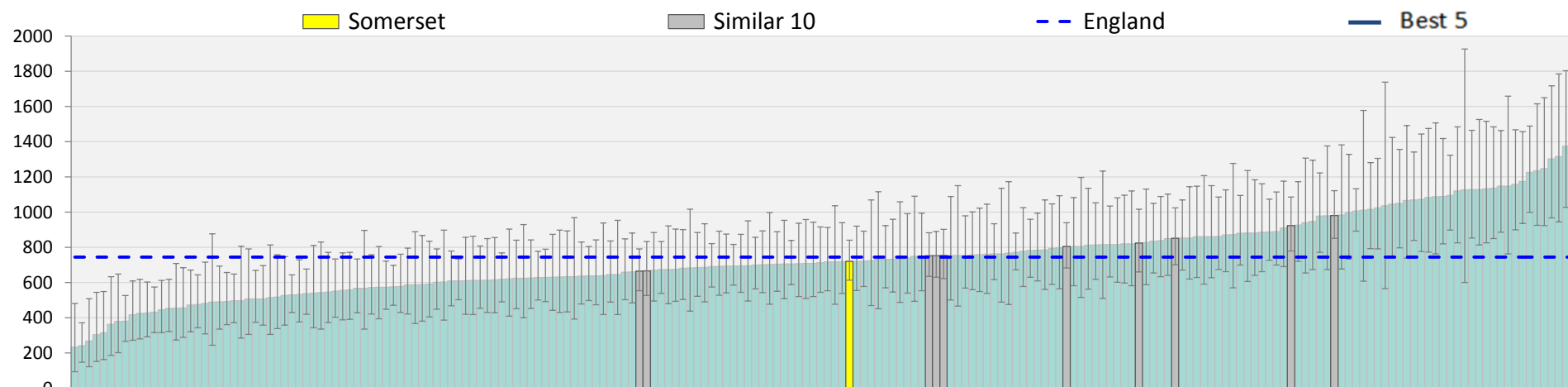
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

# Haemorrhage within brain - Non-elective spend (£ per 1,000 pop)

£2k (NSS)

136

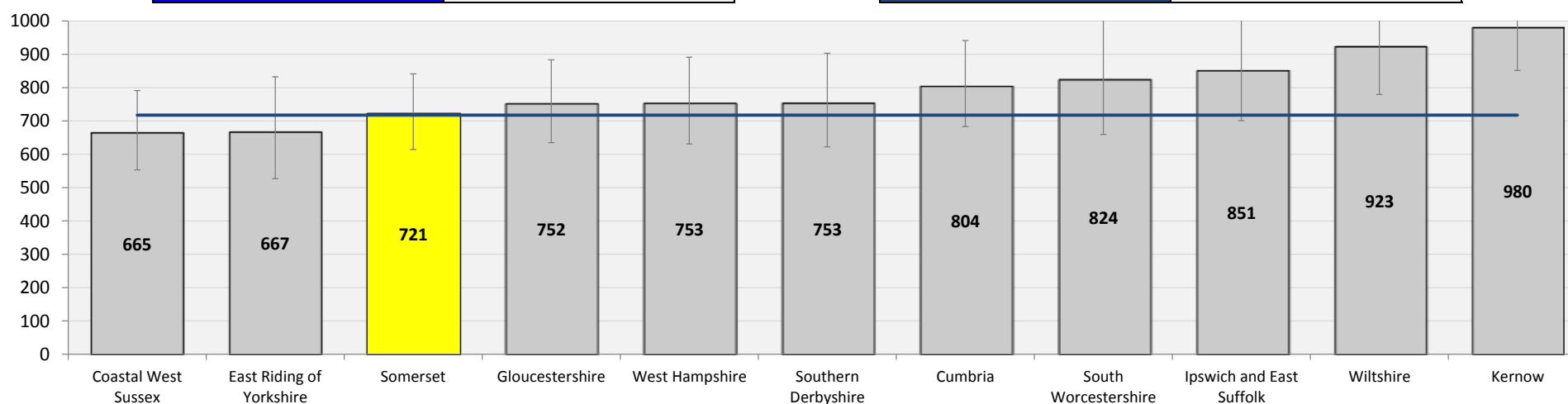


England

745

Best 5

718



Definition: Stroke - Intracerebral haemorrhage - Total spend on non-elective admissions per 1,000 population

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

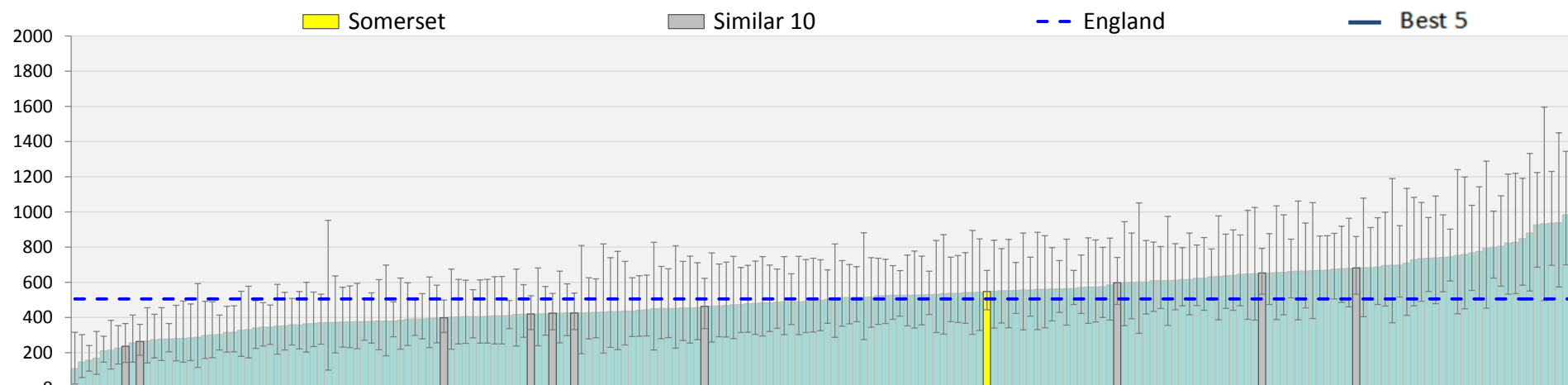
Year: 2014/15



## Other haemorrhage - Non-elective spend (£ per 1,000 pop)

**£145k**

137

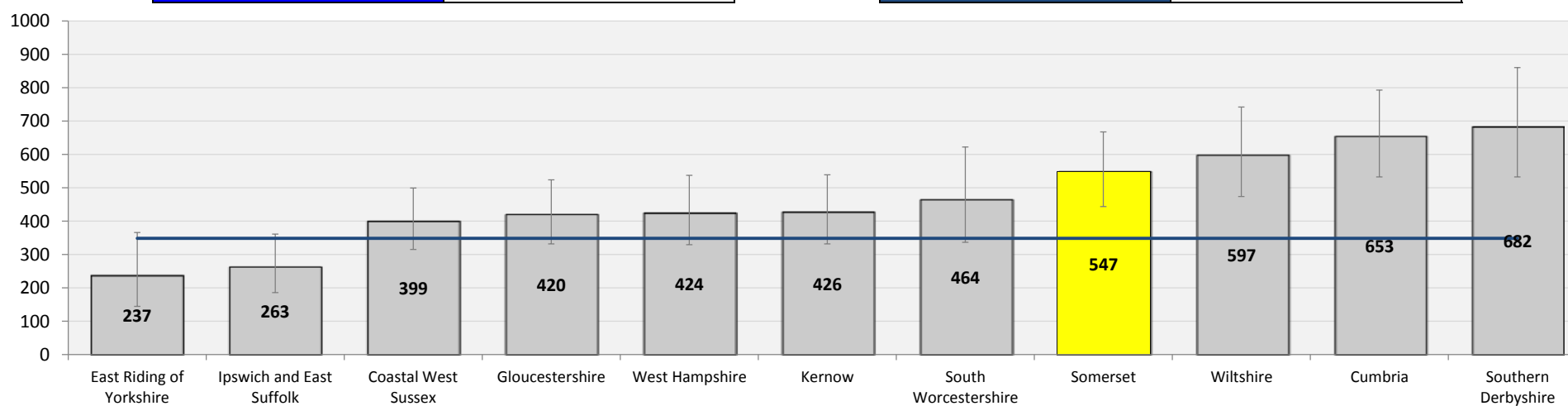


England

505

Best 5

349



Definition: Stroke - Other nontraumatic intracranial haemorrhage - Total spend on non-elective admissions per 1,000 population

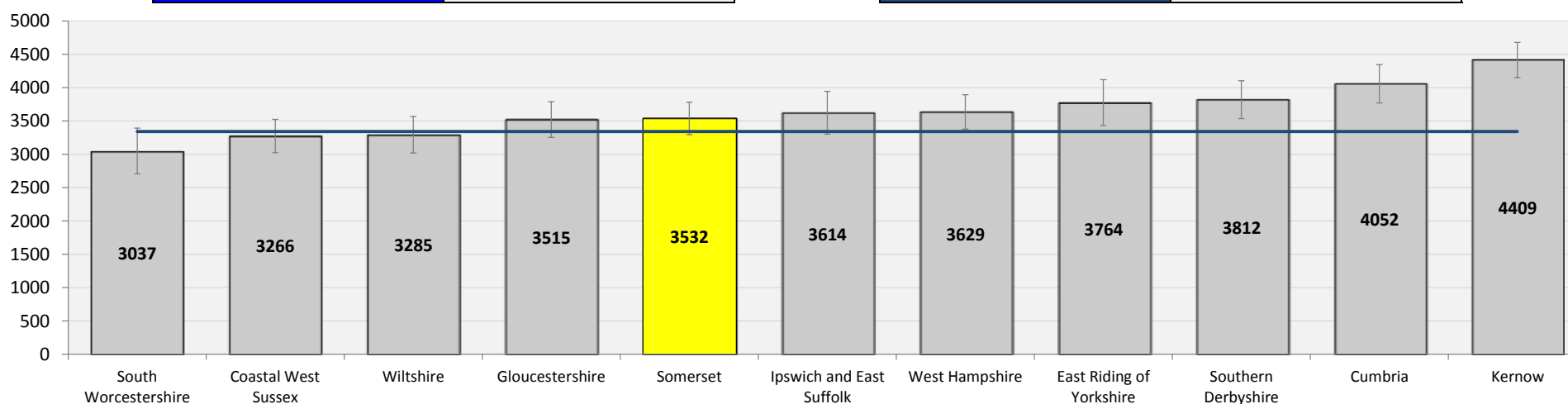
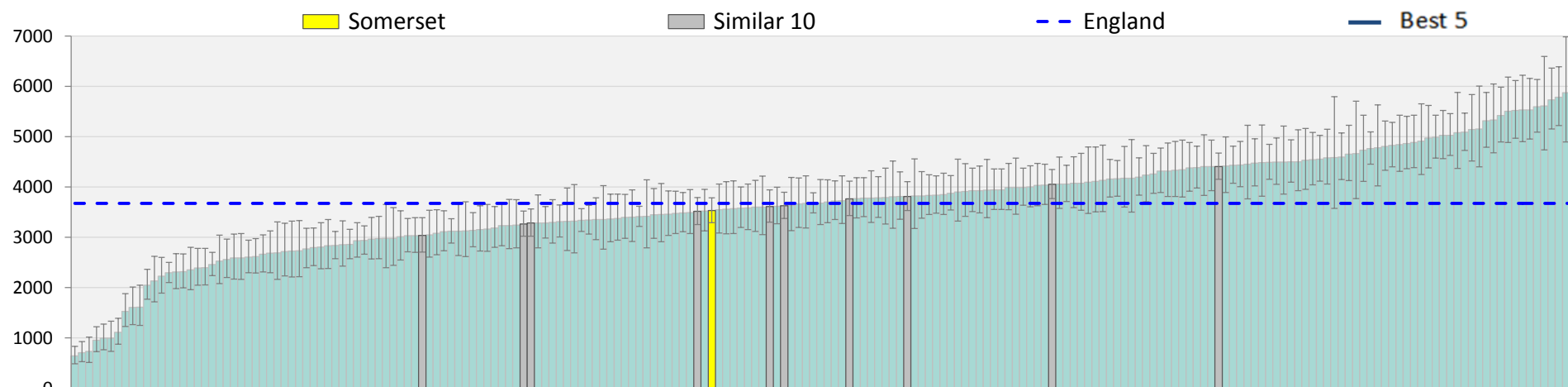
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

# Cerebral infarction - Non-elective spend (£ per 1,000 pop)

£137k (NSS)

138



Definition: Stroke - Cerebral infarction - Total spend on non-elective admissions per 1,000 population

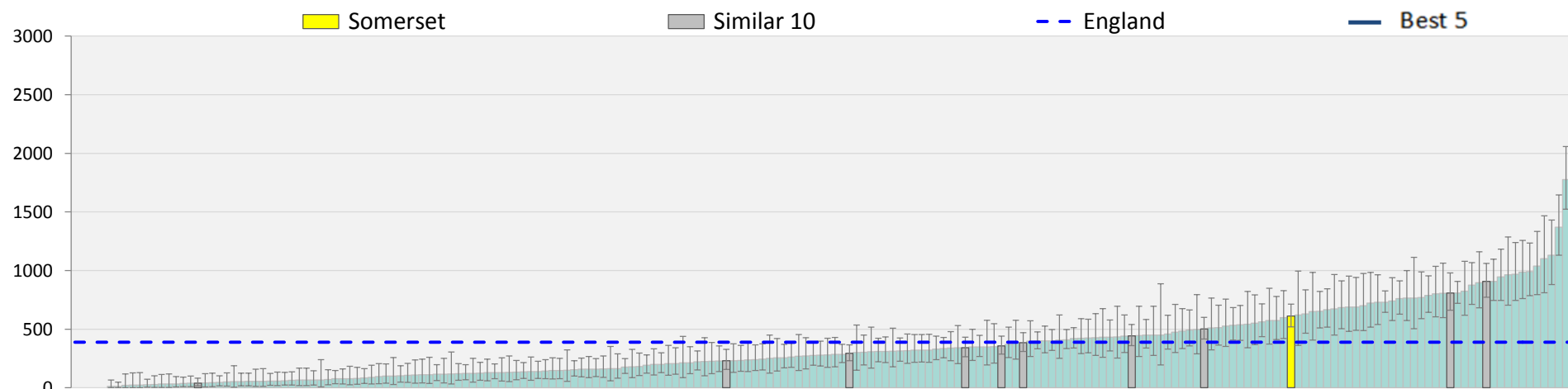
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Other stroke - Non-elective spend (£ per 1,000 pop)

£262k

139

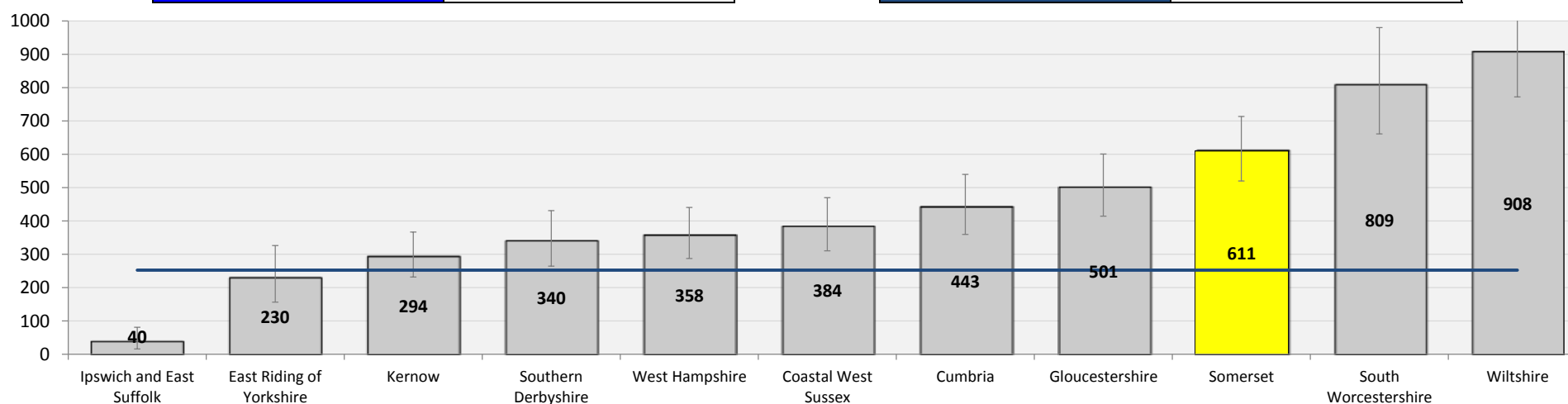


England

389

Best 5

252



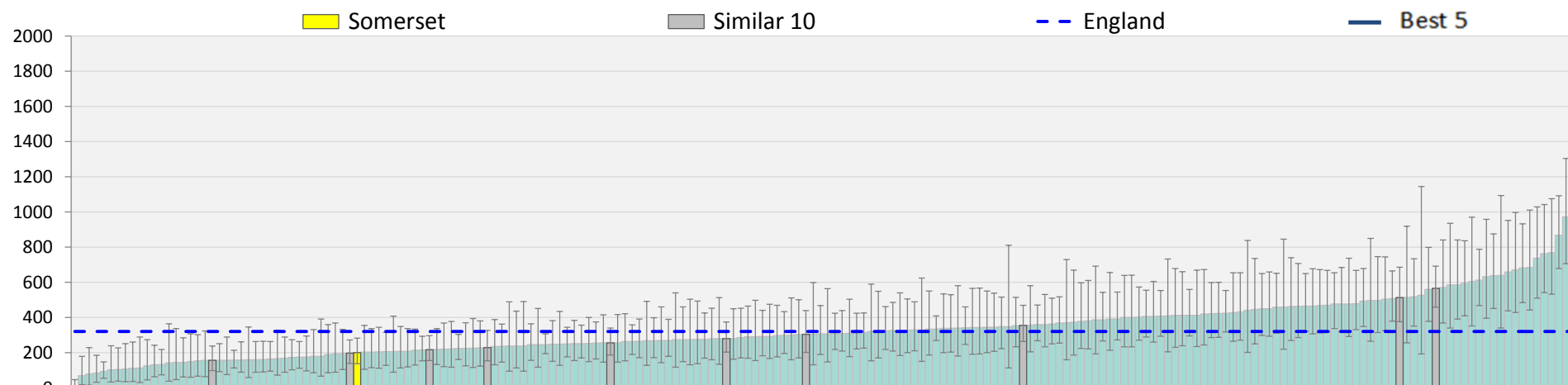
Definition: Stroke - Not specified as haemorrhage or infarction - Total spend on non-elective admissions per 1,000 population

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

Year: 2014/15

## Other Cerebrovascular diseases - Non-elective spend (£ per 1,000 pop)

140

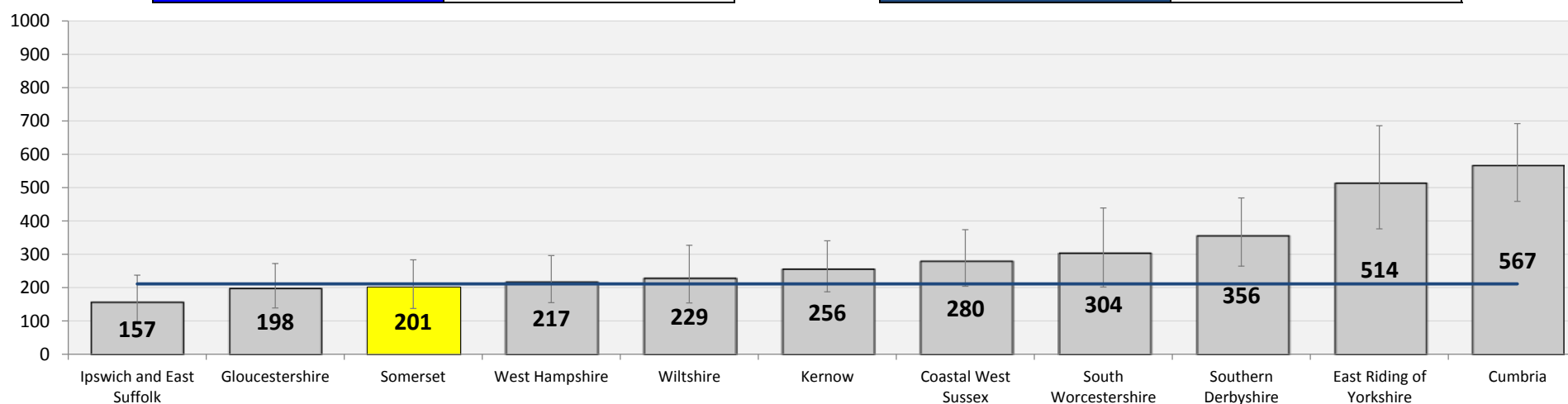


England

321

Best 5

211



Definition: Stroke - Other cerebrovascular diseases including occlusion and stenosis of cerebral and precerebral arteries not resulting in cerebral infarction - Total spend on non-elective admissions per 1,000 population

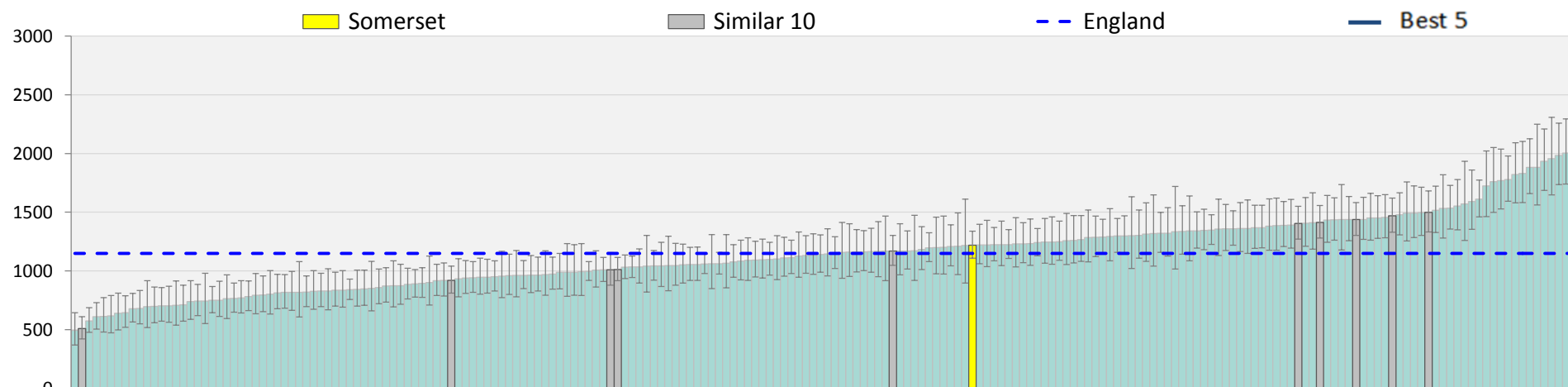
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

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

**£186k**

141

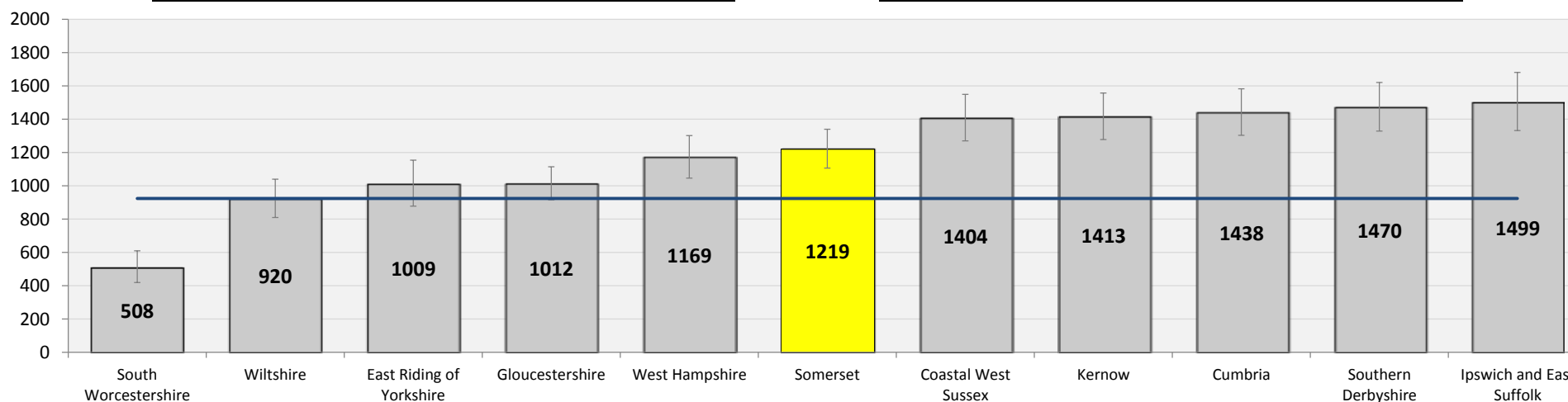


England

1148

Best 5

924



Definition: Diabetes- Total spend on non-elective admissions per 1,000 population

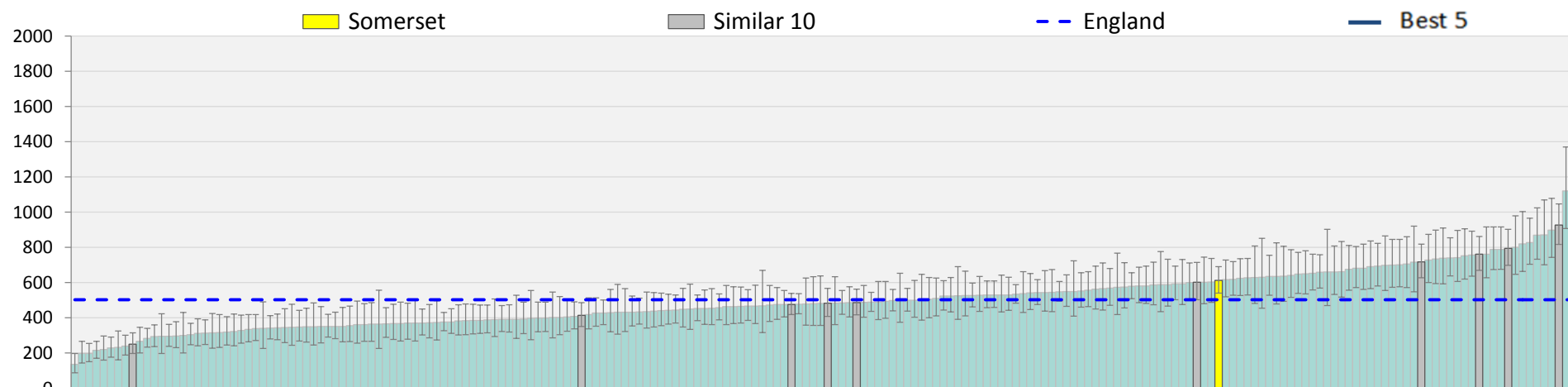
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Type 1 diabetes - Non-elective spend (£ per 1,000 pop)

**£105k**

142

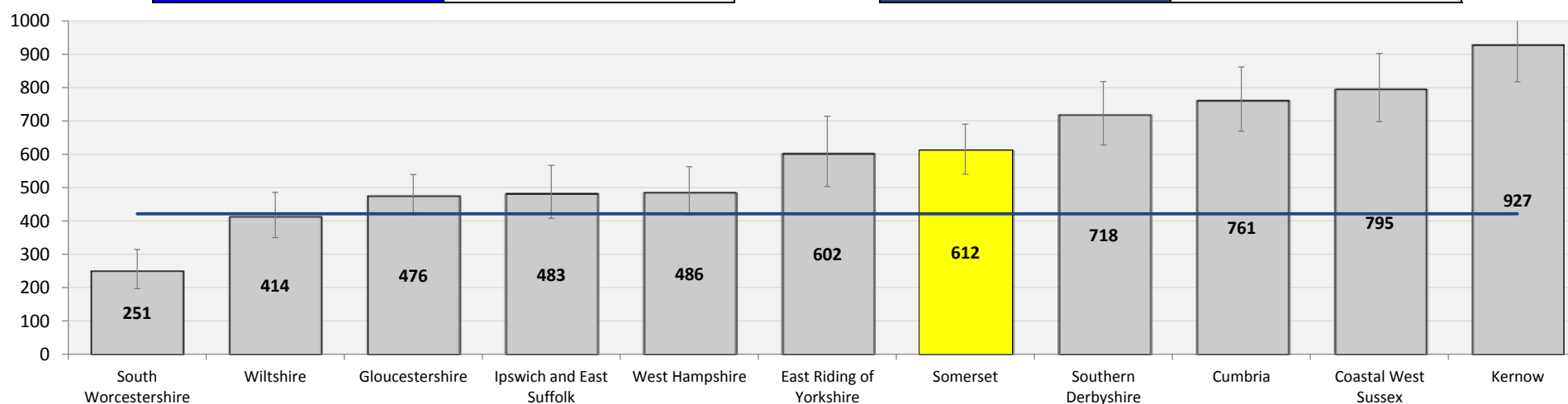


England

502

Best 5

422



Definition: Diabetes - Type 1 diabetes mellitus - Total spend on non-elective admissions per 1,000 population

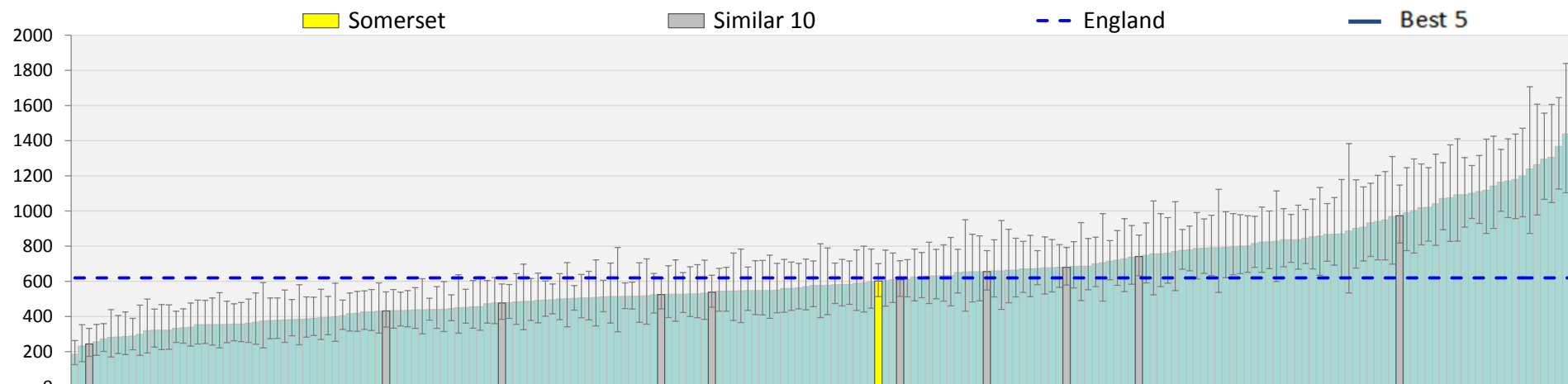
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Type 2 diabetes - Non-elective spend (£ per 1,000 pop)

**£110k**

143

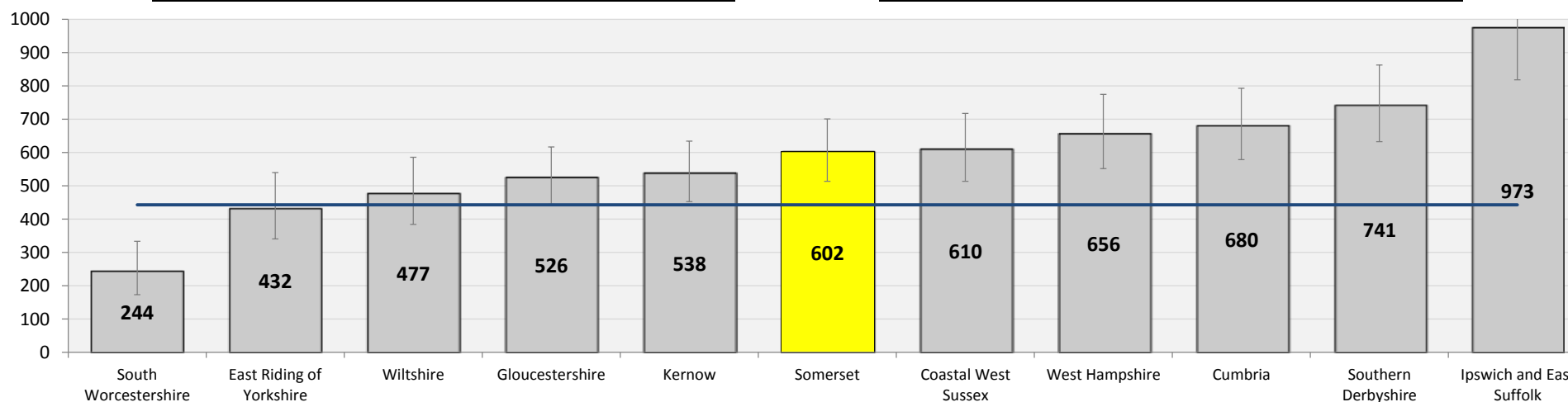


England

620

Best 5

443



Definition: Diabetes - Type 2 diabetes mellitus - Total spend on non-elective admissions per 1,000 population

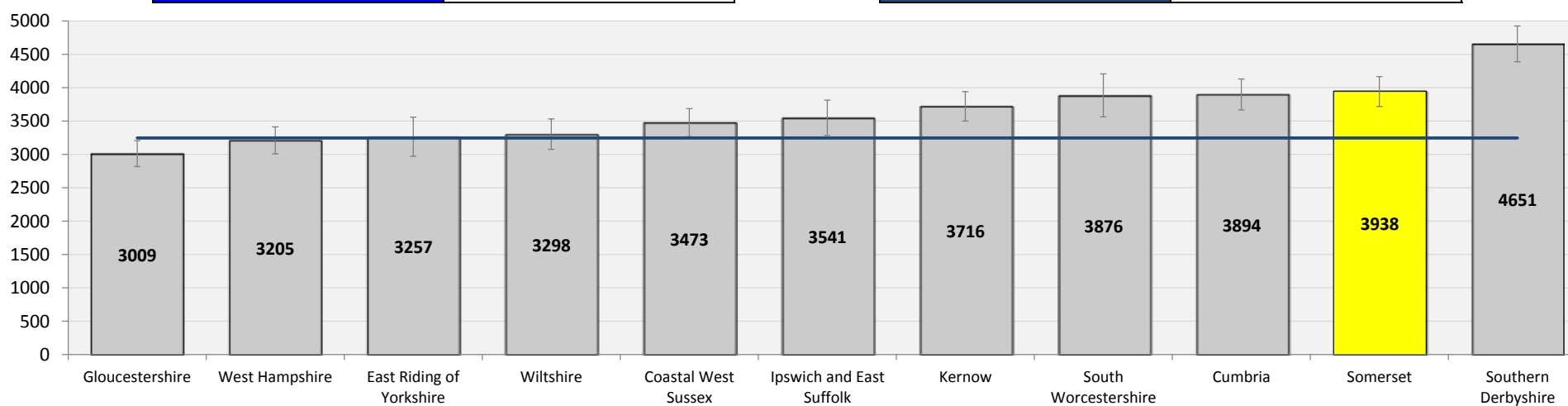
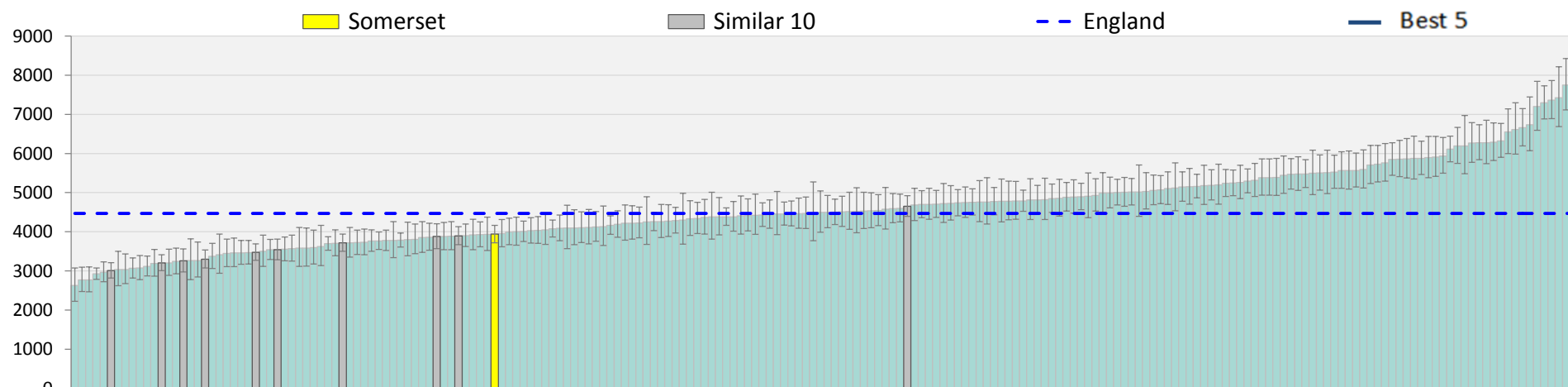
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

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

£460k

144



Definition: Renal - Total spend on non-elective admissions per 1,000 population

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

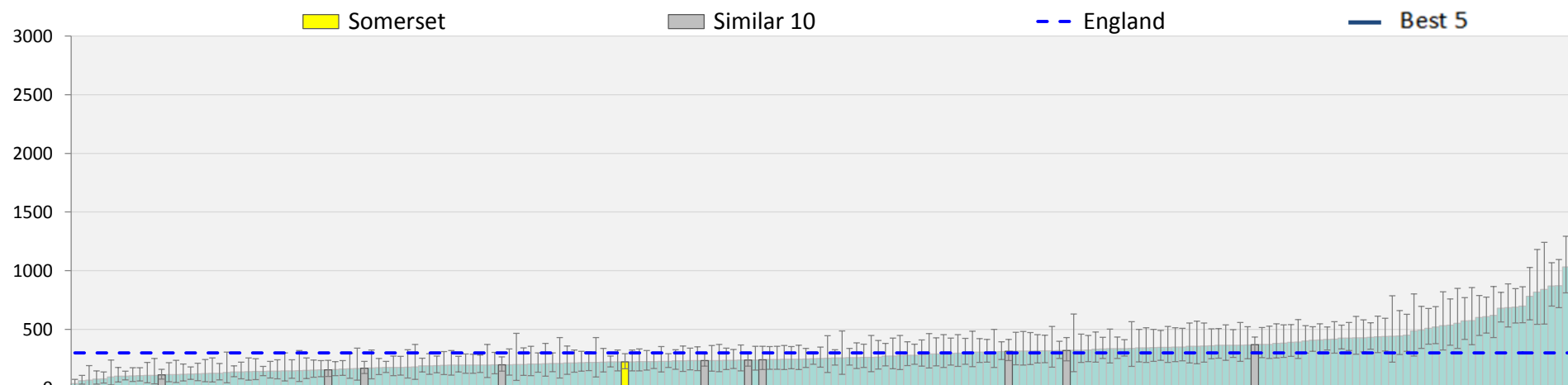
Year: 2014/15



## Chronic Kidney Disease - Non-elective spend (£ per 1,000 pop)

£33k (NSS)

145

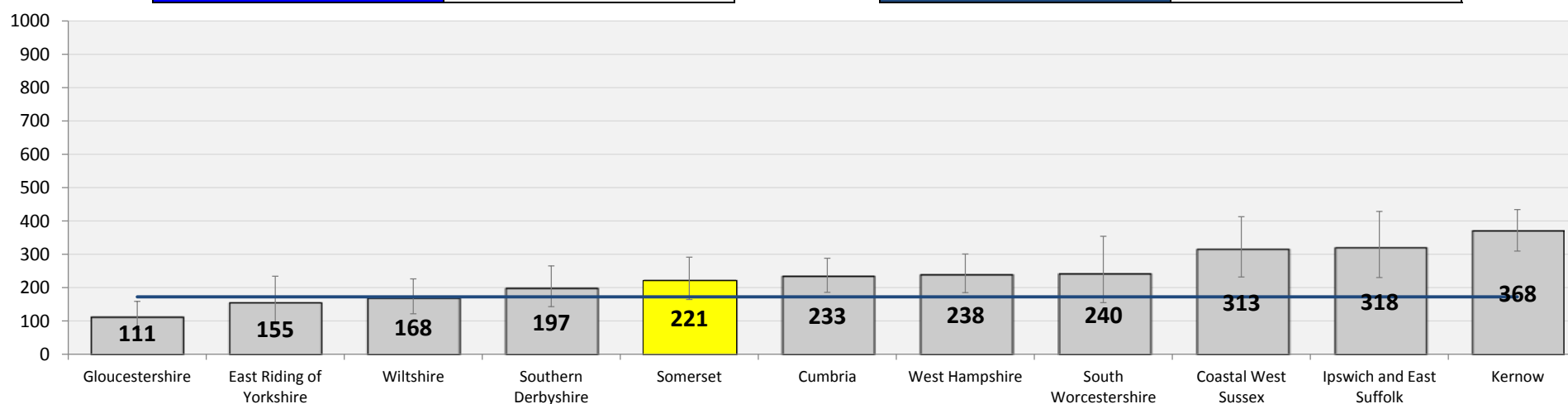


England

299

Best 5

173



Definition: Renal - Chronic kidney disease - Total spend on non-elective admissions per 1,000 population

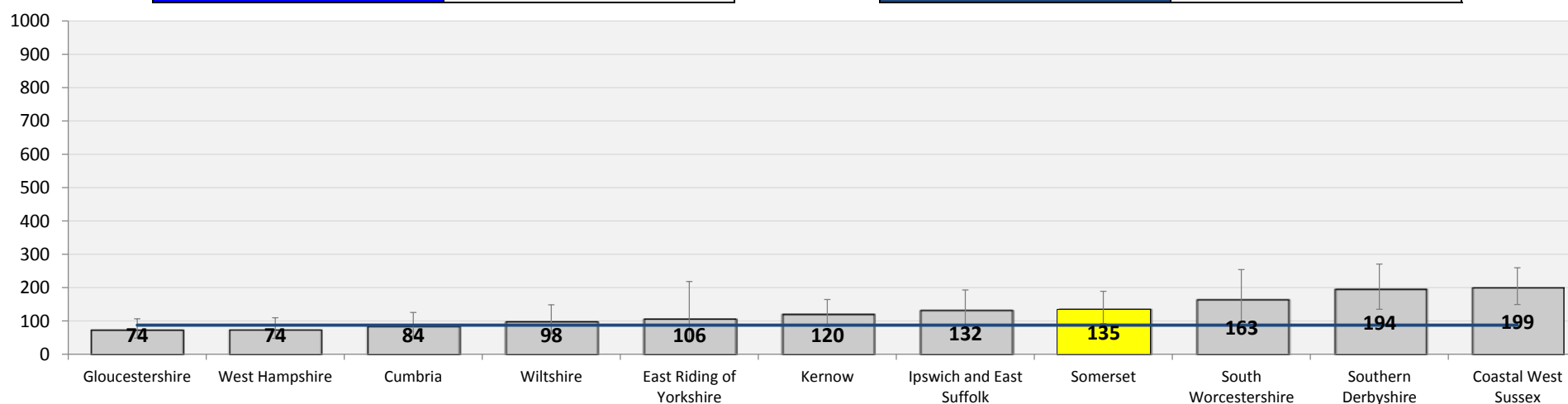
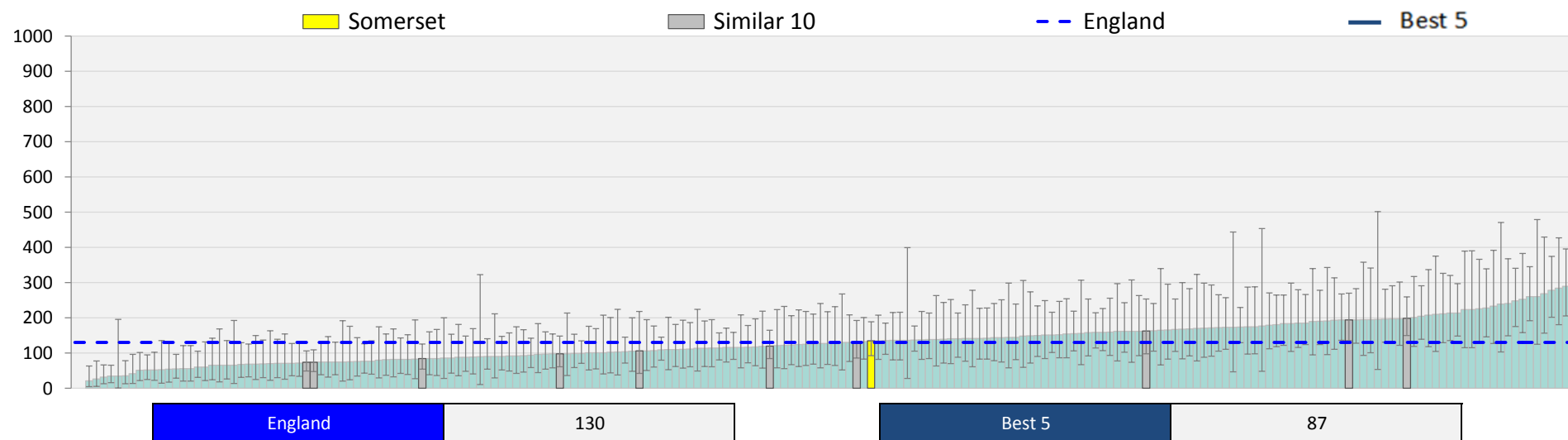
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Glomerular diseases - Non-elective spend (£ per 1,000 pop)

**£29k**

146



Definition: Renal - Glomerular diseases - Total spend on non-elective admissions per 1,000 population

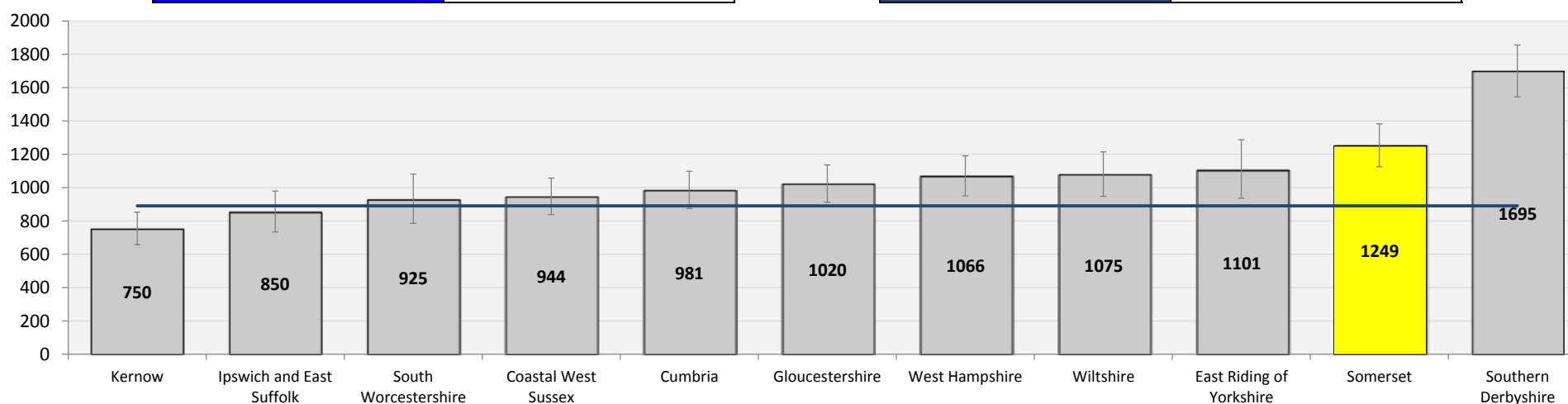
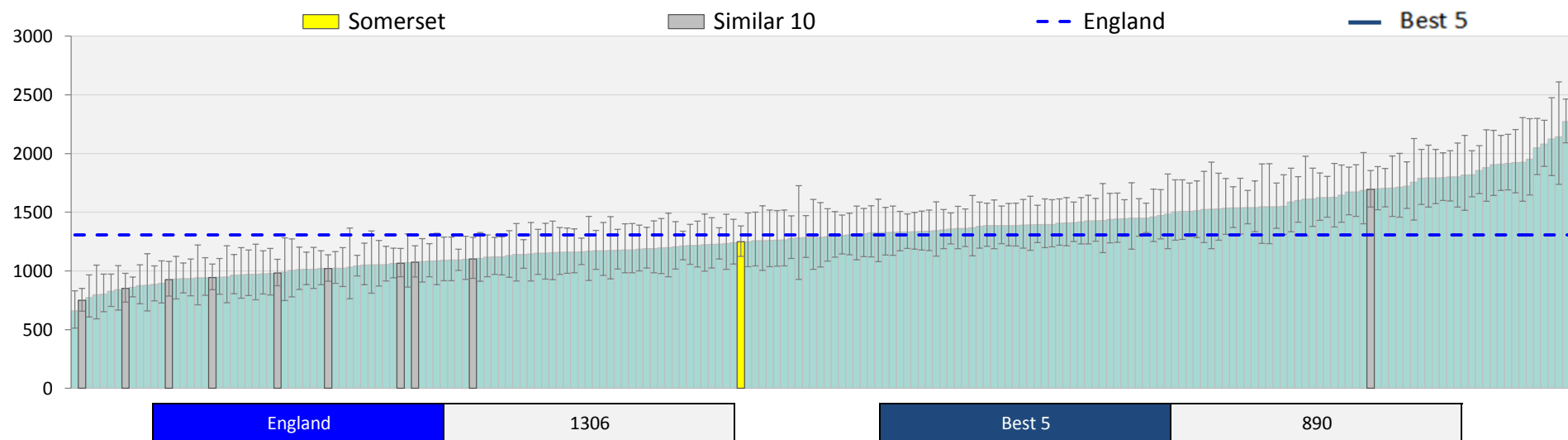
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Renal tubulo-interstitial diseases - Non-elective spend (£ per 1,000 pop)

**£219k**

147



Definition: Renal - Renal tubulo-interstitial diseases - Total spend on non-elective admissions per 1,000 population

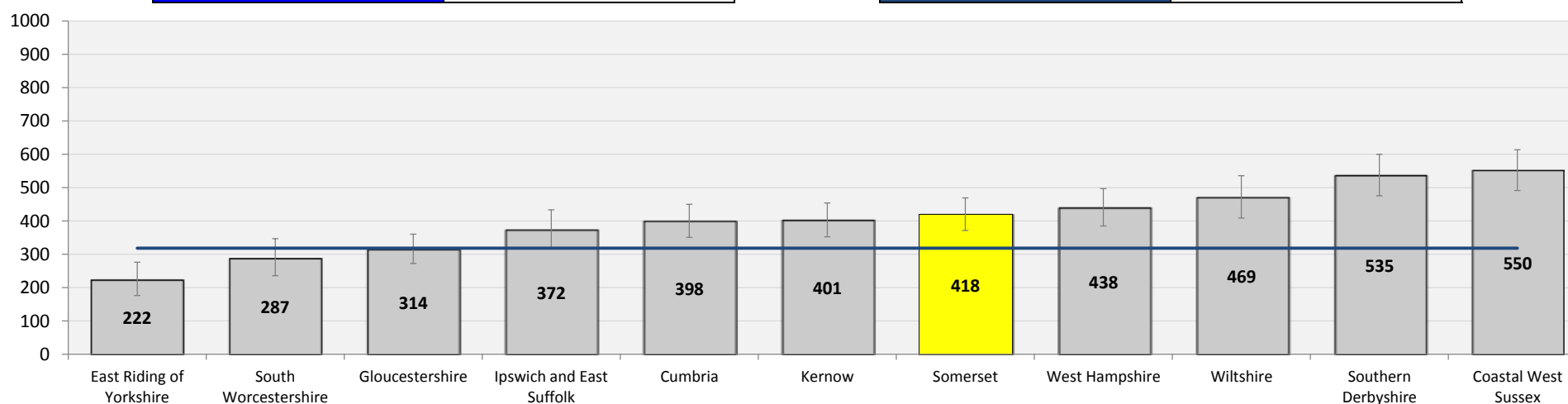
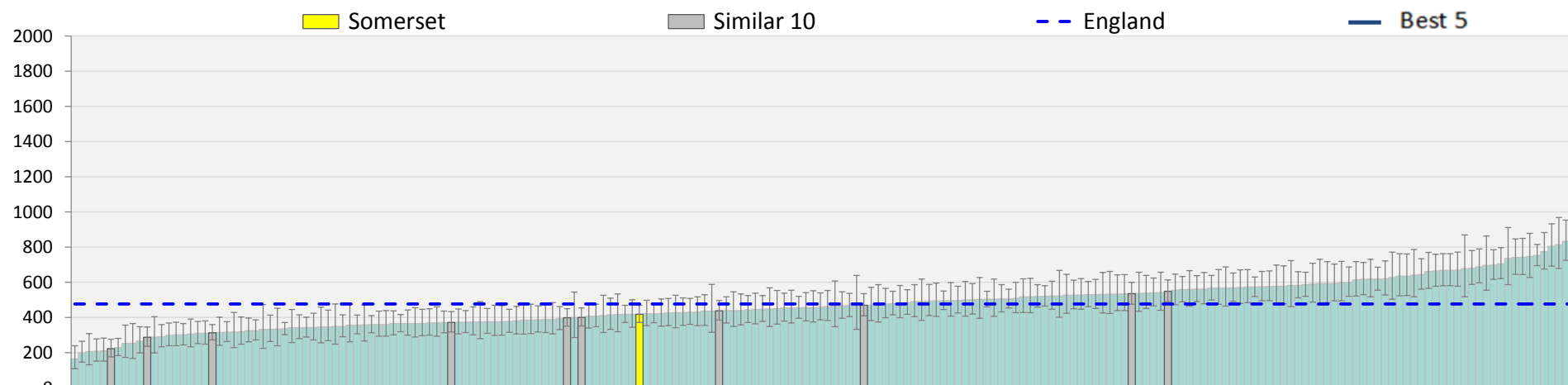
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Kidney and urinary tract stones - Non-elective spend (£ per 1,000 pop)

**£57k**

148



Definition: Renal - Urolithiasis - Total spend on non-elective admissions per 1,000 population

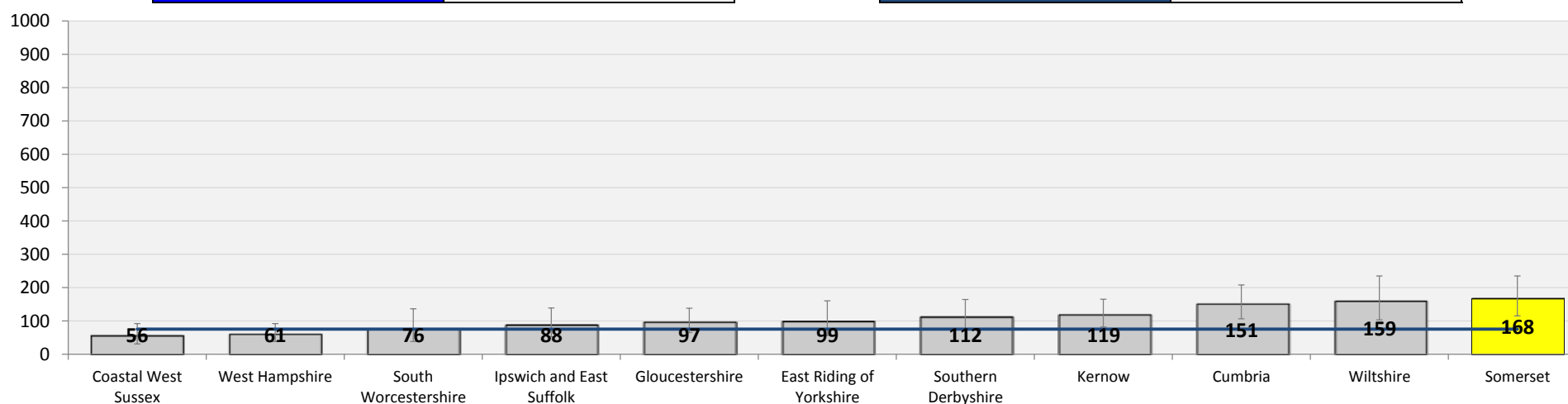
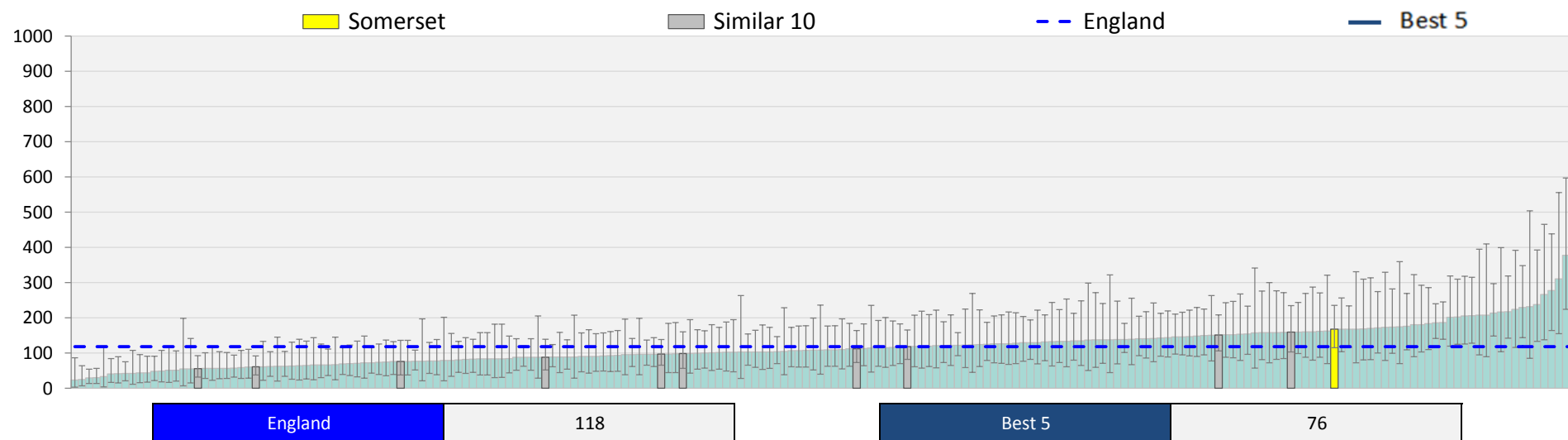
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Other renal problems - Non-elective spend (£ per 1,000 pop)

**£58k**

**149**



**Definition:** Renal - Other renal problems NEC (including unspecified kidney failure, congenital malformations of the urinary system, other disorders of kidney and ureter) - Total spend on non-elective admissions per 1,000 population

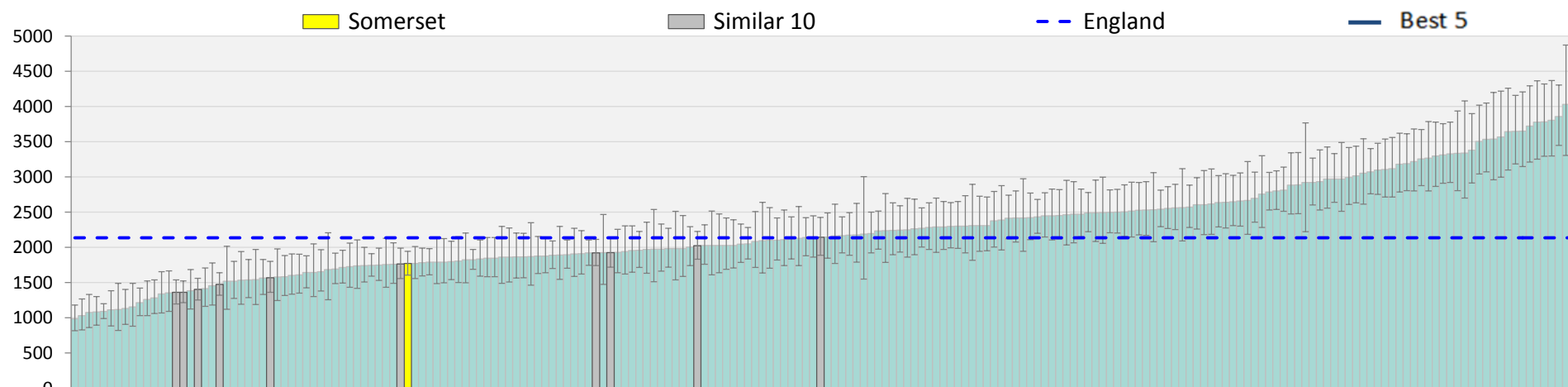
**Source:** Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

**Year:** 2014/15

## Acute renal failure - Non-elective spend (£ per 1,000 pop)

£246k

150

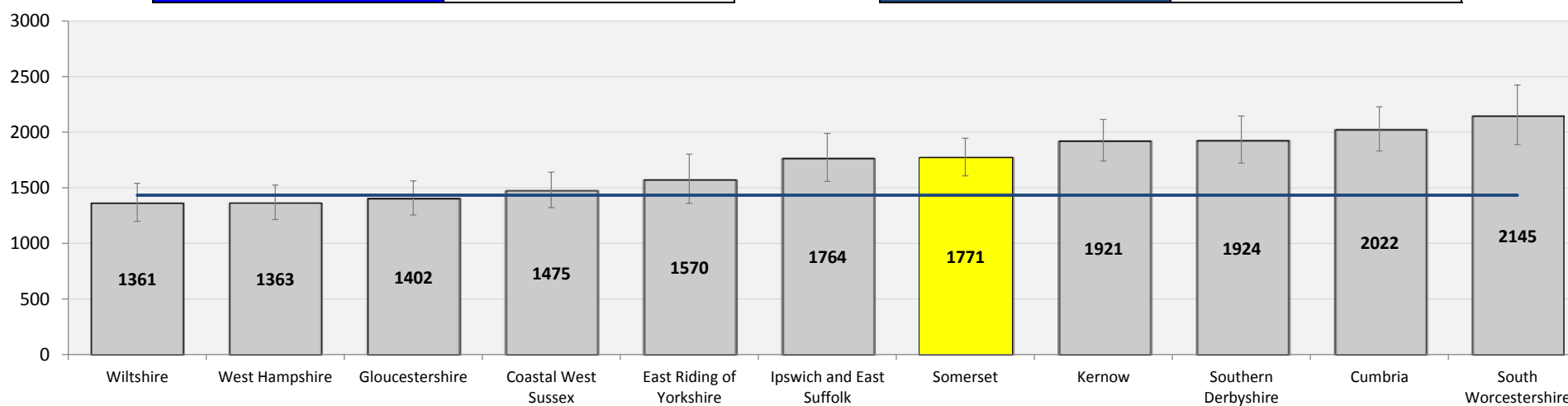


England

2138

Best 5

1434



Definition: Renal - Acute renal failure - Total spend on non-elective admissions per 1,000 population

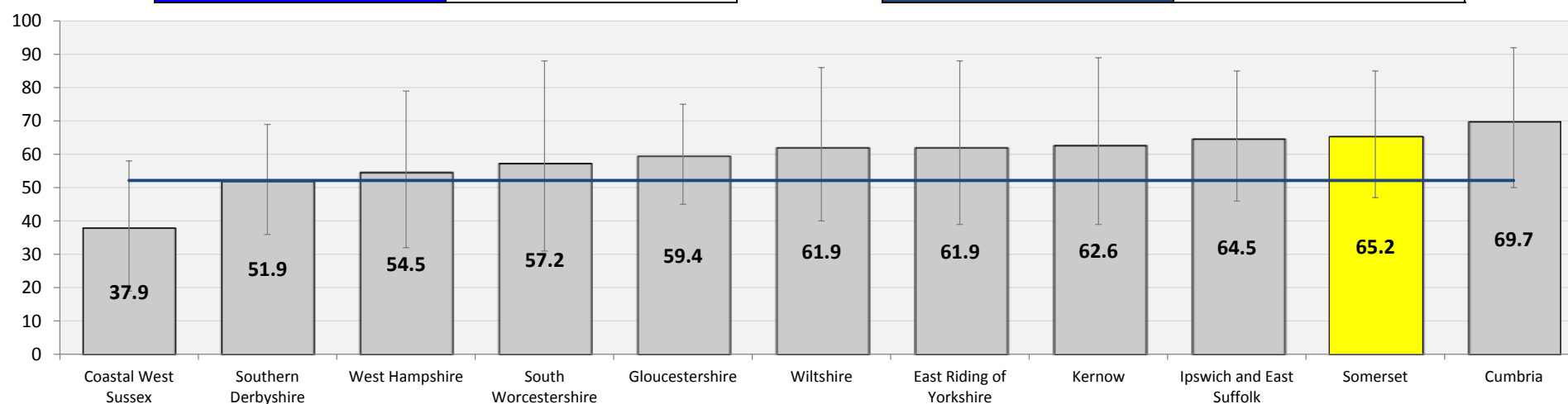
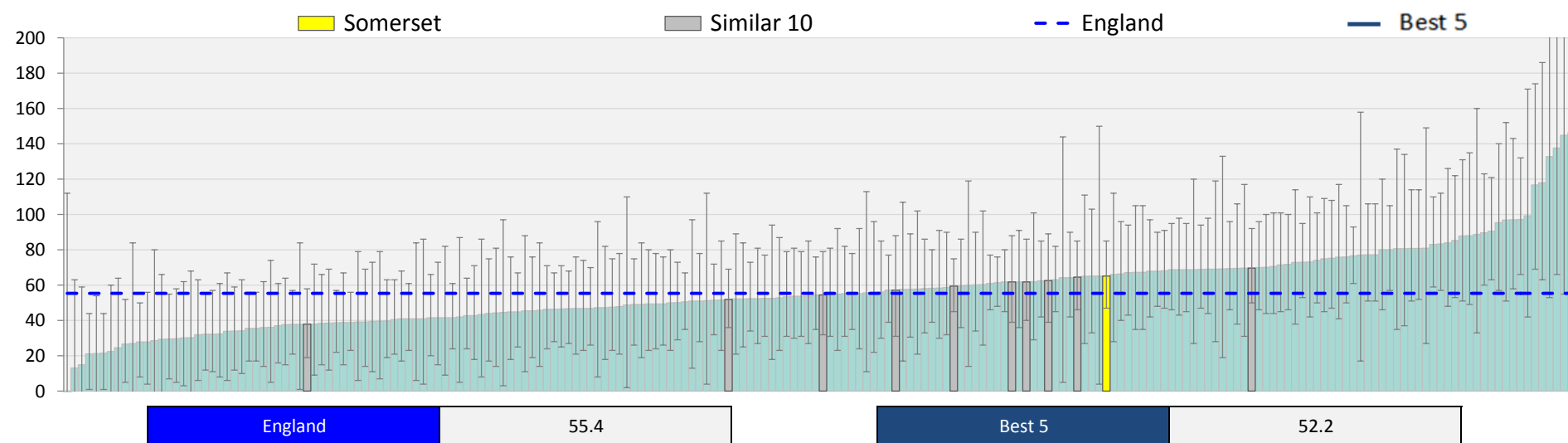
Source: Temporary National Repository – Hospital Admissions Databases, SUS SEM (Secondary User Services Extract Mart)

Year: 2014/15

## Risk of MI in people with diabetes (%)

24 Pats. (NSS)

151



Definition: Additional risk of complication for myocardial infarction among people with diabetes (%)

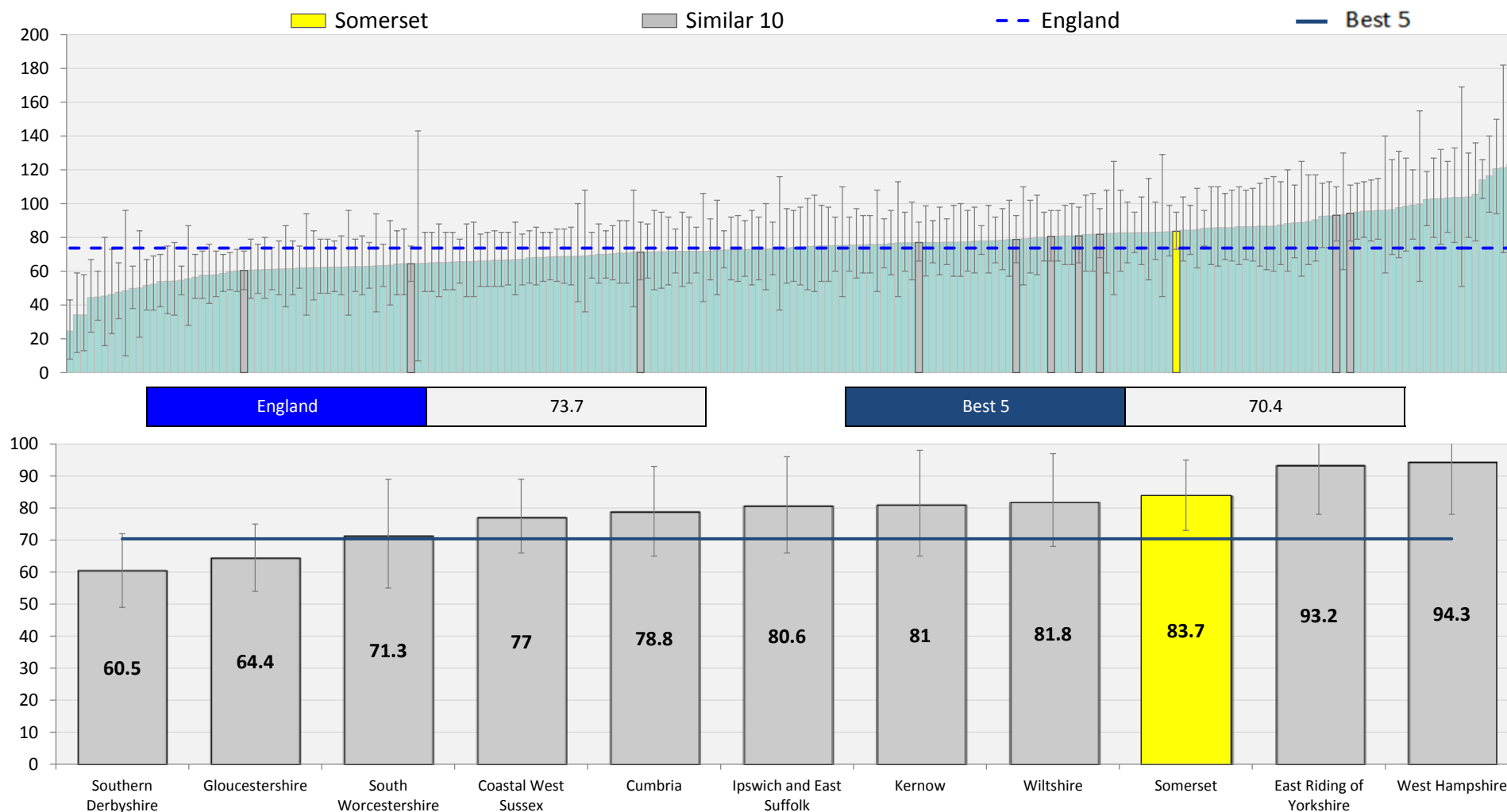
Source: The National Diabetes Audit 2011-12 Report 2, The Health and Social Care Information Centre

Year: 2011/12

## Risk of heart failure in people with diabetes (%)

77 Pats.

152



Definition: Additional risk of complication for heart failure among people with diabetes (%)

Source: The National Diabetes Audit 2011-12 Report 2, The Health and Social Care Information Centre

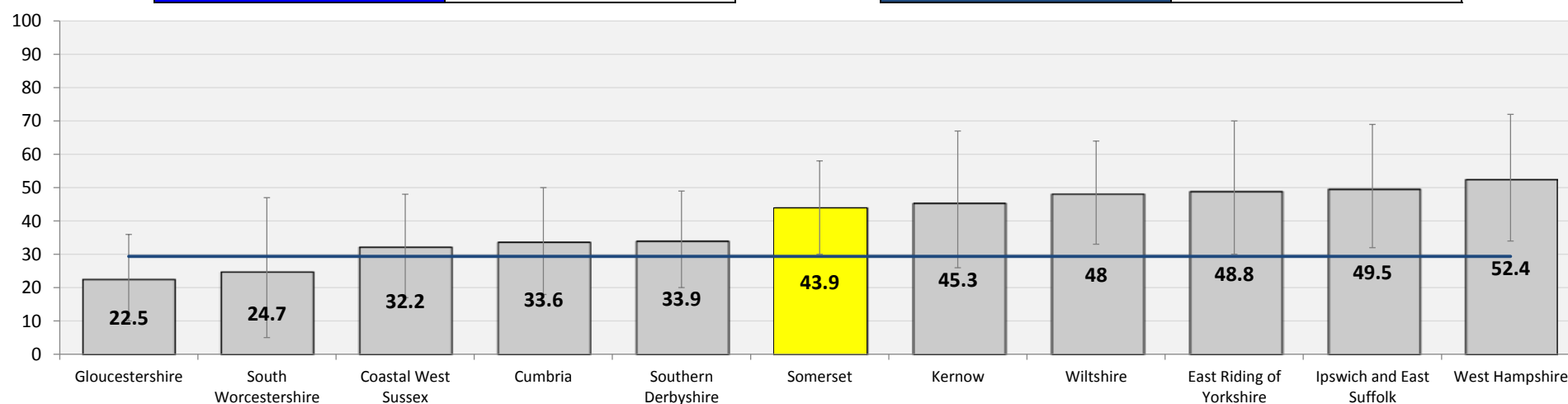
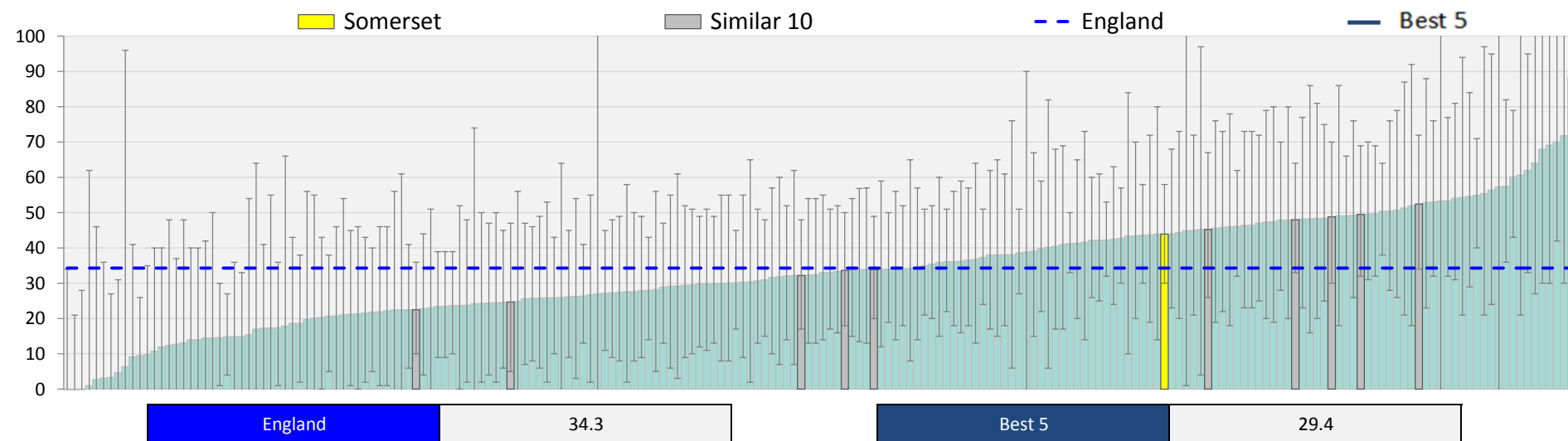
Year: 2011/12



## Risk of stroke in people with diabetes (%)

42 Pats.

153



Definition: Additional risk of complication for stroke among people with diabetes (%)

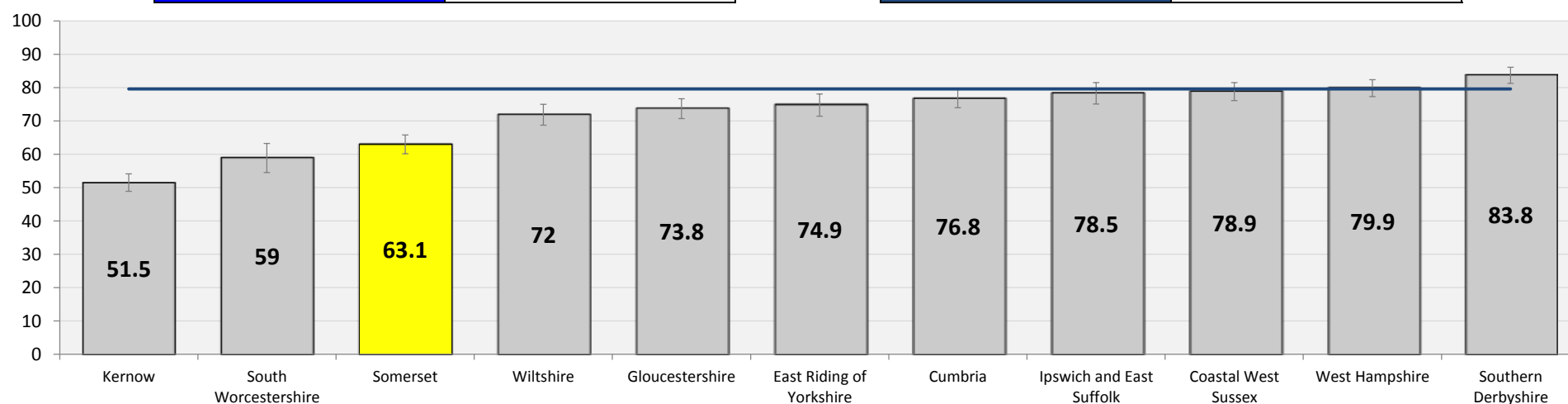
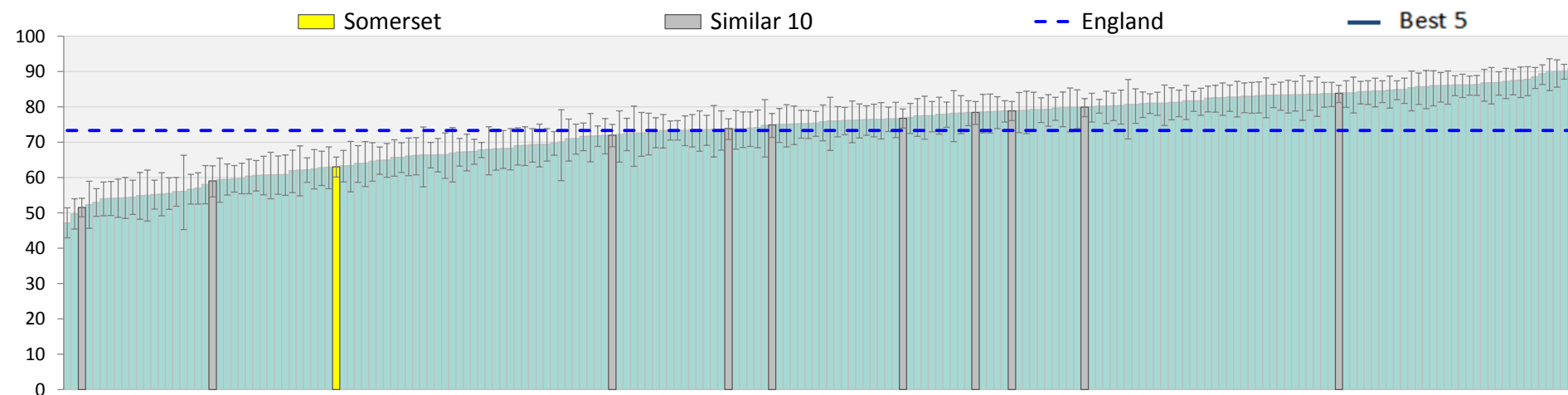
Source: The National Diabetes Audit 2011-12 Report 2, The Health and Social Care Information Centre

Year: 2011/12

# Stroke patients returning home/usual place of residence (%)

184 Pats.

154



Definition: The % of patients returning to usual place of residence following hospital treatment for stroke

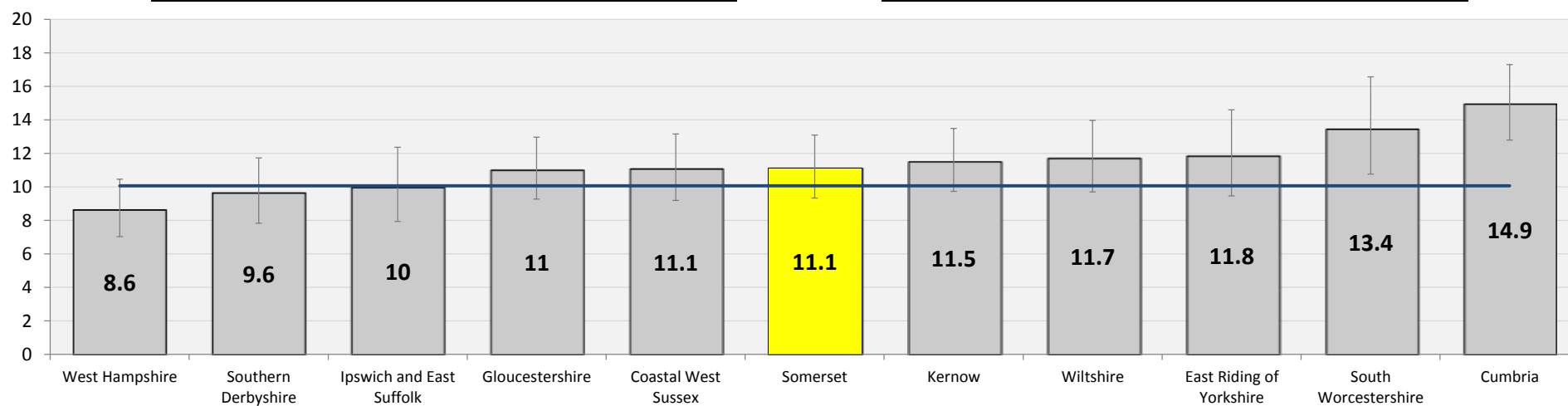
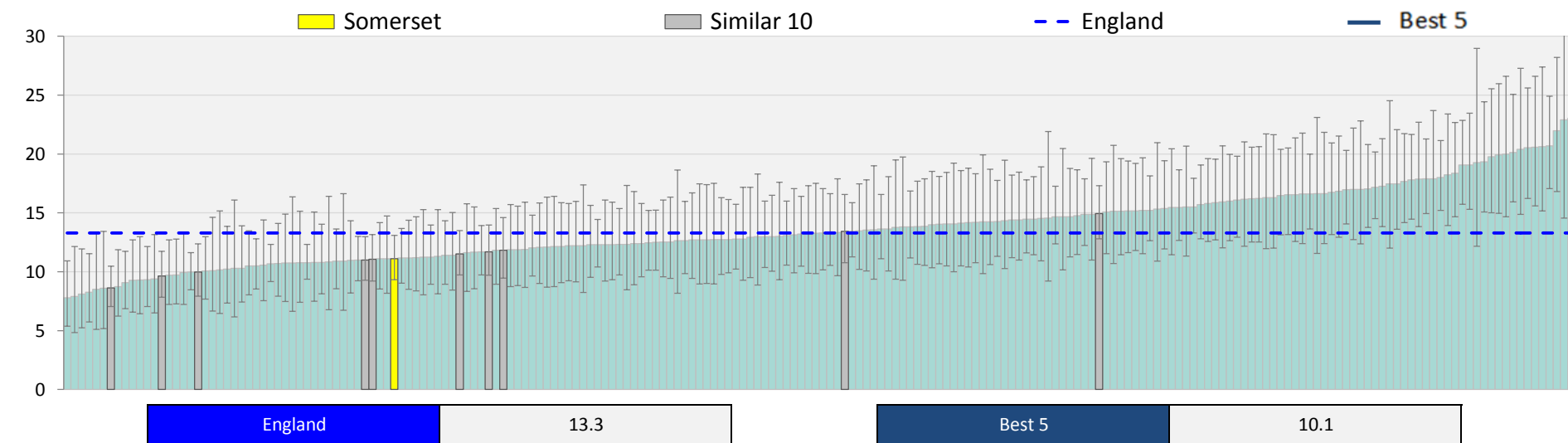
Source: Hospital Episode statistics (HES) via Business Objects (Methods)

Year: 2014/15

# <75 mortality from stroke (per 100,000 pop)

5 Lives (NSS)

155



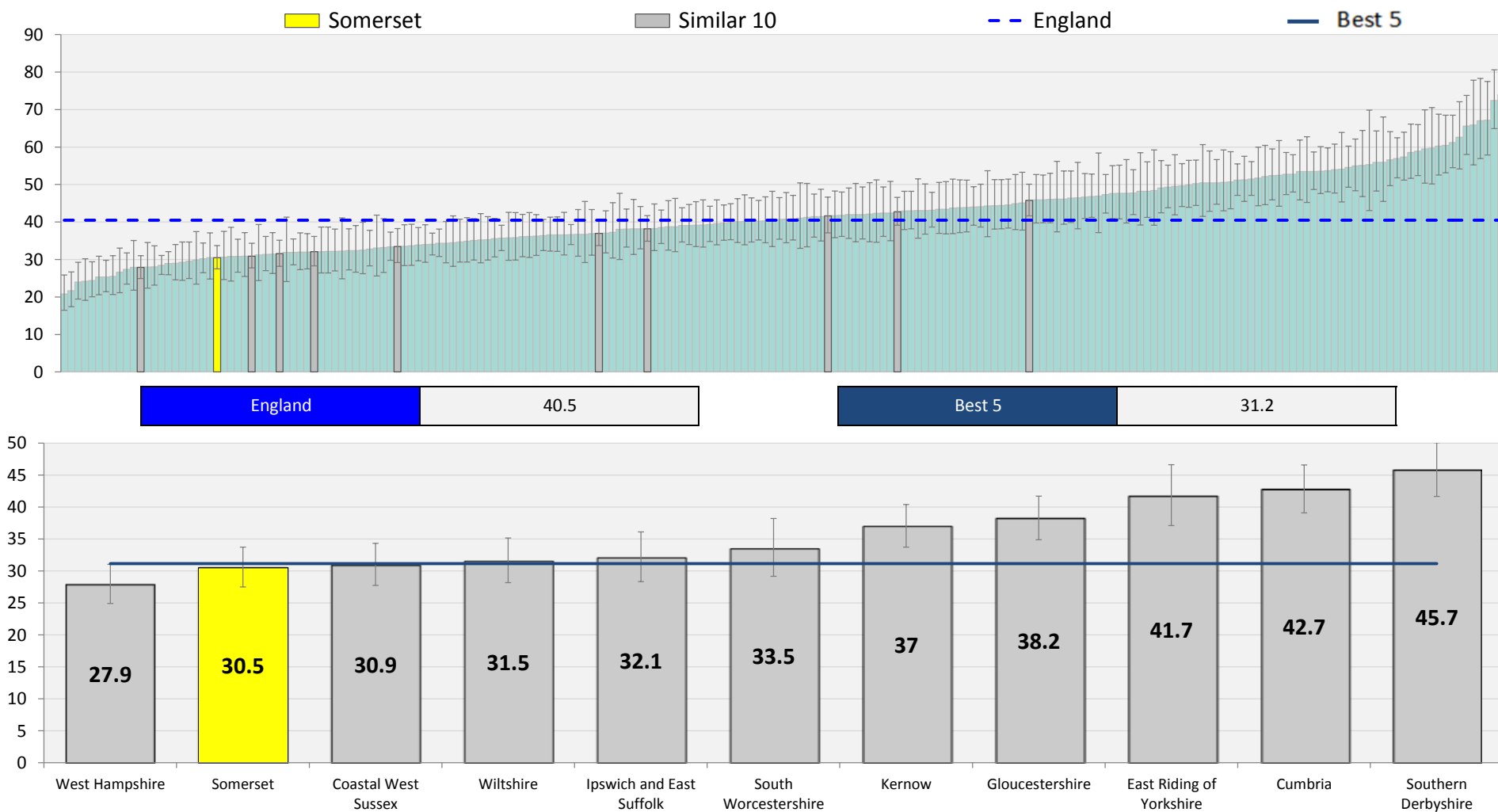
Definition: Mortality from stroke: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

Source: Primary Care Mortality Database, HSCIC

Year: 2011-13

## <75 Mortality from CHD (per 100,000 pop)

156



Definition: Mortality from CHD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

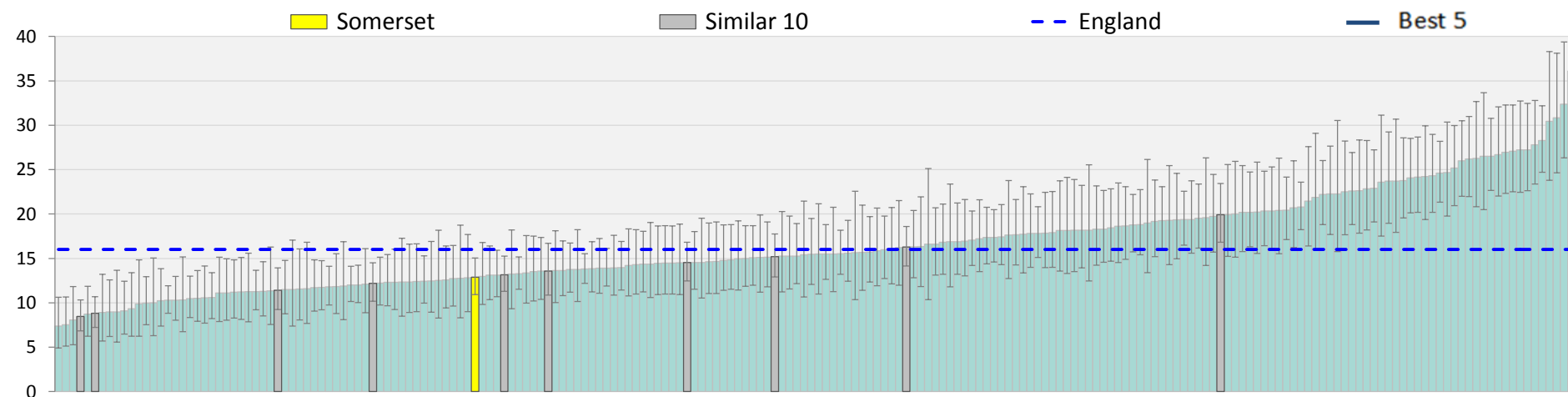
Source: Primary Care Mortality Database, HSCIC

Year: 2011-13

# <75 mortality from acute MI (per 100,000 pop)

10 Lives

157

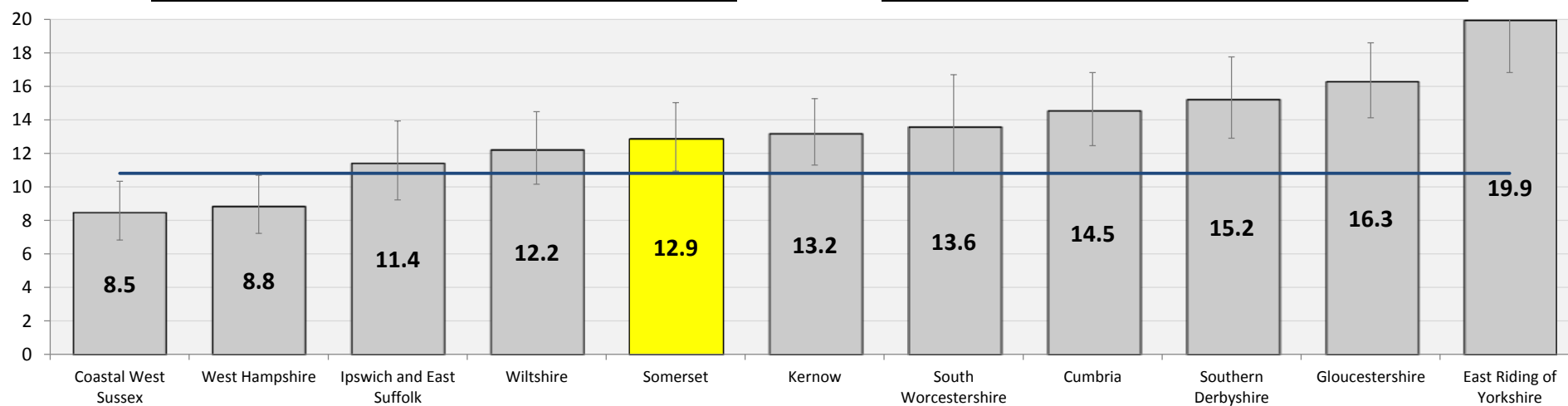


England

16.0

Best 5

10.8



Definition: Mortality from acute MI: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

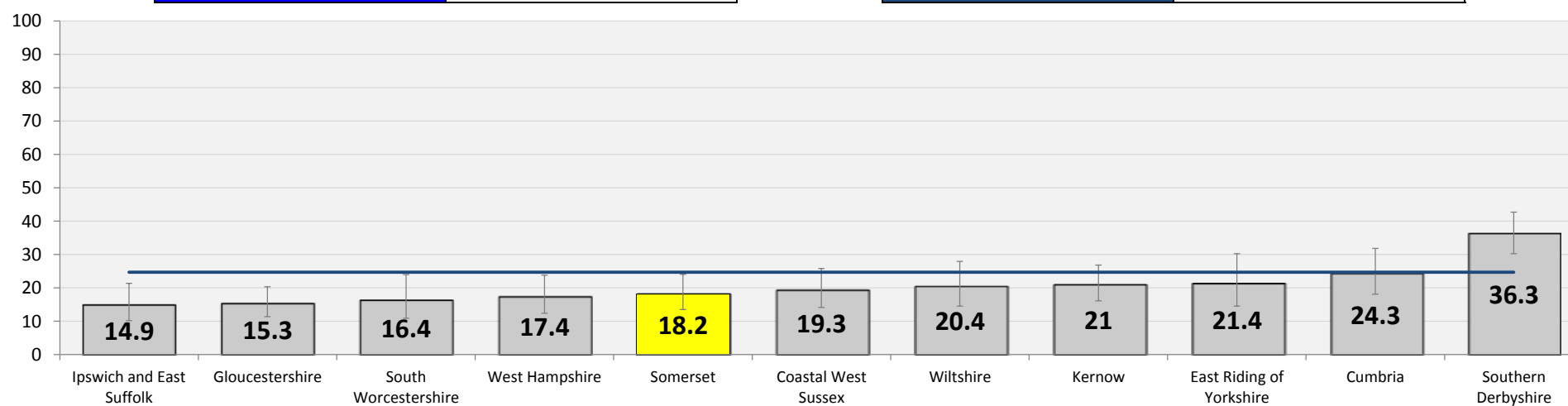
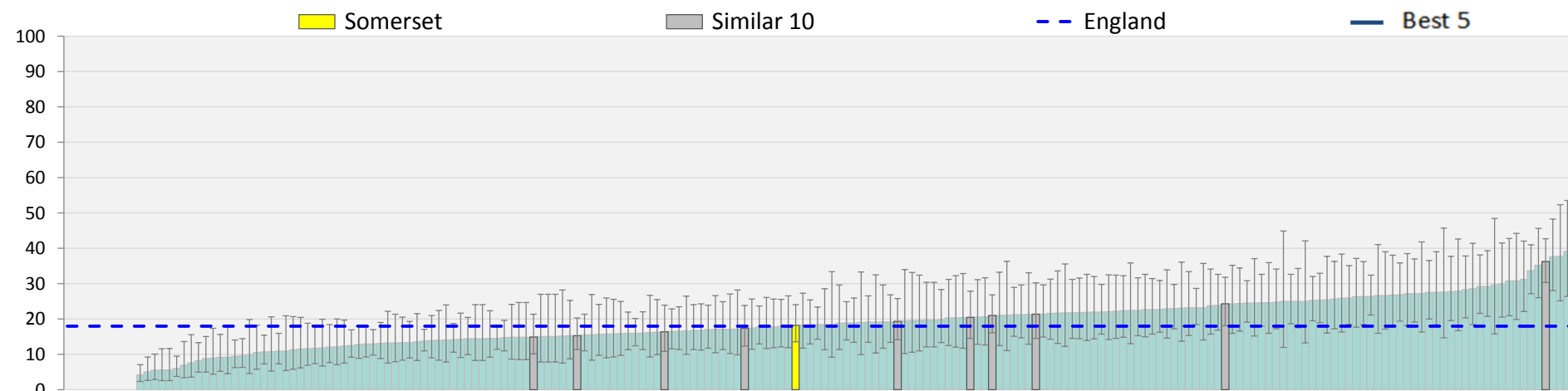
Source: Primary Care Mortality Database, HSCIC

Year: 2011-13

## Home dialysis undertaken (%)

13 Pats.

158



Definition: The % of people receiving dialysis undertaking dialysis at home

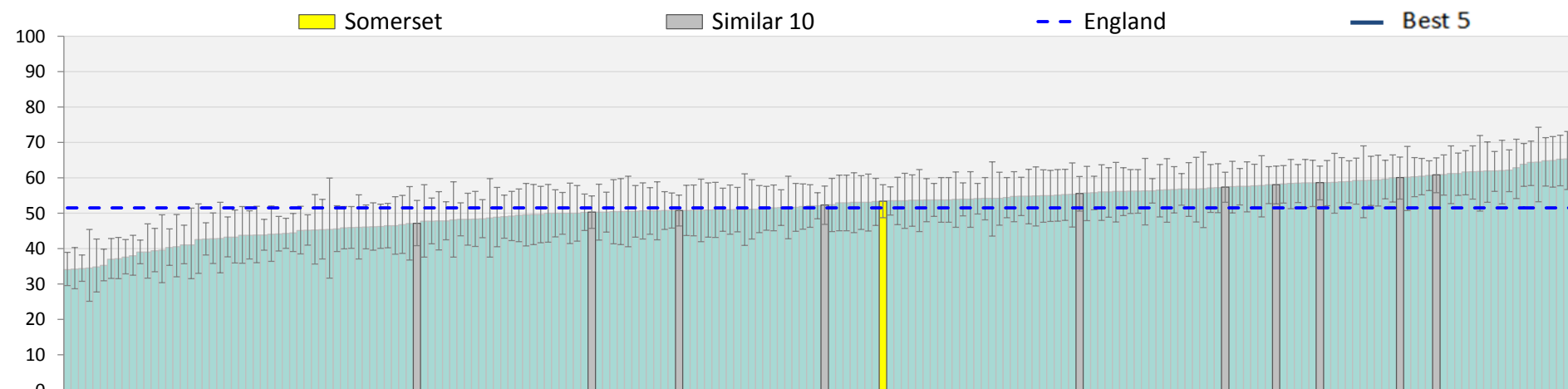
Source: UK Renal Registry

Year: 2011-13

## Patients on RRT who have a transplant (%)

24 Pats.

159

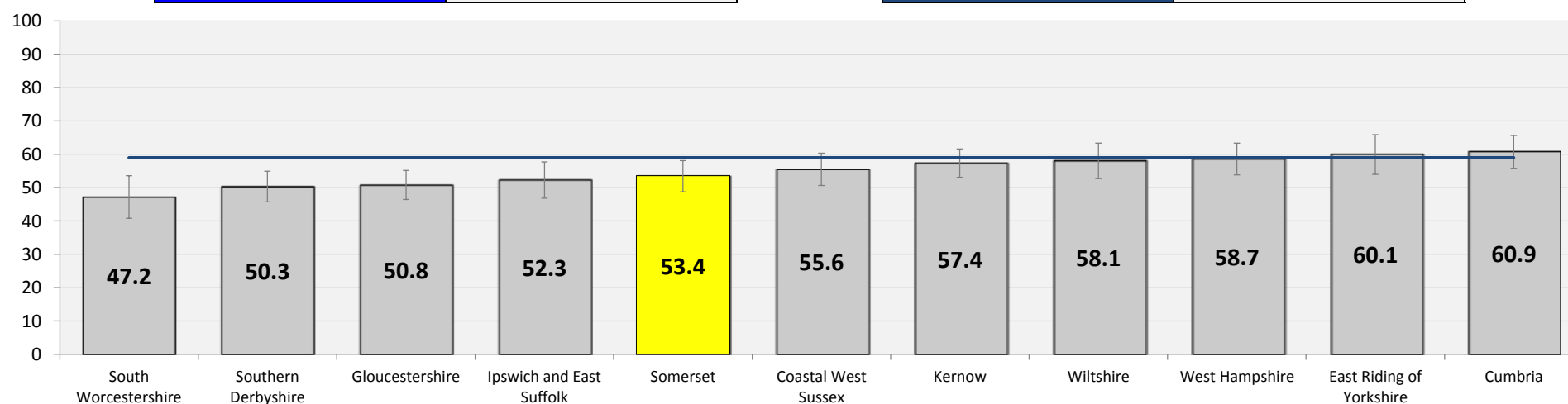


England

51.6

Best 5

59.0



Definition: The % of patients on Renal Replacement Therapy who have a kidney transplant

Source: UK Renal Registry

Year: 2013

Commissioners can take the following actions now:

- Identify the key opportunities for improvement within the pathways included in the CVD 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 resources including those provided by the National Cardiovascular Intelligence Network (NCVIN)
- Always consider risk factor reduction (e.g. smoking prevalence) as an opportunity to improve population health and reduce disease prevalence.
- Look at the CVD Primary Care Intelligence Packs published by the NCVIN in April 2016. They provide further intelligence (by CCG and practice) and evidence to support the case for improved detection and primary and secondary prevention in CVD
- 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](mailto:england.healthinvestmentnetwork@nhs.net)

# Further surgical resources available for review

162

There are further resources on key surgical pathways and data freely available at The Royal College of Surgeons The National Surgical Commissioning Centre.

All the resources listed below are freely available at the website, available on page 161.

- 1. 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 cardiovascular conditions and diabetes includes: **Weight assessment and management (Tier 3 services)** and **Varicose veins**
- 2. 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.

- Laparoscopic and open bariatric surgery
- Endothermal treatment with or without ulcer
- Surgery with or without ulcer
- Schlerotherapy with or without ulcer
- Other technique with or without ulcer



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=PL6lQwMACXkj1e17bcMvaHuy1gd9XrZT92>

Public Health England hypertension profiles document:

<http://www.yhpho.org.uk/resource/view.aspx?RID=223374>

National Cardiovascular Intelligence Network (NCVIN):

<http://www.ncvin.org.uk>

NCVIN CVD Primary Care Intelligence Packs:

<http://www.yhpho.org.uk/resource/view.aspx?RID=207915>

NHS RightCare website:

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

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

# Annex A: Condition and drug groupings

Programme Category Code	Programme Category Name
10A	Coronary Heart Disease
10B	Cerebrovascular disease
10C	Problems of Rhythm
10X	Problems of circulation (Other)

Condition Group	Programme Budget Category	Primary Diagnosis Code
Chronic rheumatic heart diseases	10X	Any Primary Diagnosis Code that begin with I05, I06, I07, I08 or I09 and mapped to 10X.
Hypertensive diseases	10X	Any Primary Diagnosis Code that begins with I10, I11, I12, I13 or I15 and mapped to 10X.
Coronary heart diseases	10A	Any Primary Diagnosis Code that begins with I20, I21, I22, I23, I24 or I25 and mapped to 10A.
Pulmonary heart disease and diseases of pulmonary circulation	10X	Any Primary Diagnosis Code that begins with I26, I27 or I28 and mapped to 10X.
Other forms of heart disease	10C, 10X	Any Primary Diagnosis Code that begins with I3, I4 or I5 and mapped to 10C or 10X.
Diseases of arteries, arterioles and capillaries	10X	Any Primary Diagnosis Code that begins with I70, I71, I72, I73, I74, I77, I78 or I79 and mapped to 10X.
Diseases of veins, lymphatic vessels and lymph nodes, not elsewhere classified	10X	Any Primary Diagnosis Code that begins with I80, I81, I82, I83, I86, I87, I88 or I89 and mapped to 10X.
Other and unspecified disorders of the circulatory system (including Acute rheumatic fever)	10A, 10C, 10X	A233 , A262, A395, A8353, A8382, B332, B376, B570, B572, I00, I01, I02, I95, I97, I98, I99, R000, R001, R002, R008, Z034, Z450, Z500, Z824, Z950, Z955

Condition Group	Programme Budget Category	Primary Diagnosis Code
Subarachnoid haemorrhage	10B	Any Primary Diagnosis Code that begins with I61 and mapped to 10B.
Intracerebral haemorrhage	10B	Any Primary Diagnosis Code that begins with I61 and mapped to 10B.
Other non-traumatic intracranial haemorrhage	10B	Any Primary Diagnosis Code that begins with I62 and mapped to 10B.
Cerebral infarction	10B	Any Primary Diagnosis Code that begins with I63 and mapped to 10B.
Stroke, not specified as haemorrhage or infarction	10B	Any Primary Diagnosis Code that begins with I64 or Z823 and mapped to 10B.
Other cerebrovascular diseases including occlusion and stenosis of cerebral and pre-cerebral arteries not resulting in cerebral infarction	10B	Any Primary Diagnosis Code that begins with I65, I66, I67, I68, I69 or G46 and mapped to 10B.

Condition Group	Programme Budget Category	Primary Diagnosis Code
Glomerular diseases	17B	Any Primary Diagnosis Code that begins with N00, N01, N02, N03, N04, N05, N06, N07 or N08 and mapped to 17B.
Renal tubulo-interstitial diseases	17B	Any Primary Diagnosis Code that begins with N10, N11, N12, N13, N14, N15 or N16 and mapped to 17B.
Acute renal failure	17B	Any Primary Diagnosis Code that begins with N17 and mapped to 17B.
Chronic kidney disease	17B	Any Primary Diagnosis Code that begins with N18 and mapped to 17B.
Urolithiasis	17B	Any Primary Diagnosis Code that begins with N20, N22 or N23 and mapped to 17B.
Other renal problems NEC (including unspecified kidney failure, congenital malformations of the urinary system, other disorders of kidney and ureter)	17B	I120, I129, N19, N25, N26, N27, N28, N29, Q60, Q61, Q62, Q63, Q64, R80X, R944, Z490, Z491, Z492, Z524, Z905, Z940, Z992



Condition Group	Programme Budget Category	Primary Diagnosis Code
Type 1 diabetes mellitus	04A	Any Primary Diagnosis Code that begins with E10 and mapped to 04A.
Type 2 diabetes mellitus	04A	Any Primary Diagnosis Code that begins with E11 and mapped to 04A.

Highest spend procedures mapped to Programme Budget Codes: 10A, 10B, 10C, 10X. The Programme Budget Code where the majority of spend falls is indicated.

OPCS Procedure Code	Full procedure description	Short name in focus packs
K751	Percutaneous transluminal balloon angioplasty and insertion of 1-2 drug-eluting stents into coronary artery (Majority PBC =10A)	PTCA & 1-2 drug eluting stents - coronary artery
K752	Percutaneous transluminal balloon angioplasty and insertion of 3 or more drug-eluting stents into coronary artery (Majority PBC =10A)	PCTA & 3+ drug eluting stents - coronary artery
K753	Percutaneous transluminal balloon angioplasty and insertion of 1-2 stents into coronary artery (Majority PBC =10A)	PTCA & 1-2 stents - coronary artery
K491	Percutaneous transluminal balloon angioplasty of one coronary artery (Majority PBC =10A)	PCTA - one coronary arty
K621	Percutaneous transluminal ablation of pulmonary vein to left atrium conducting system (Majority PBC =10C)	PCT ablation - pulmonary vein to left atrium
K622	Percutaneous transluminal ablation of atrial wall for atrial flutter (Majority PBC =10C)	PCT ablation - atrial wall for atrial flutter
K575	Percutaneous transluminal ablation of atrial wall NEC (Majority PBC =10C)	PCT ablation - atrial wall for atrial flutter
K401	Saphenous vein graft replacement of one coronary artery (Majority PBC =10A)	Saphenous vein graft replacement - one coronary artery
K606	Implantation of intravenous dual chamber cardiac pacemaker system (Majority PBC =10C)	Pacemaker implant - IV dual chamber
K607	Implantation of intravenous biventricular cardiac pacemaker system (Majority PBC =10C + 10X)	Pacemaker implant - IV biventricular

# Cardiology procedures continued

171

Highest spend procedures mapped to Programme Budget Codes: 10A, 10B, 10C, 10X. The Programme Budget Code where the majority of spend falls is indicated.

OPCS Procedure Code	Full procedure description	Short name in focus packs
K605	Implantation of intravenous single chamber cardiac pacemaker system (Majority PBC =10C)	Pacemaker implant - VC single chamber
K603	Renewal of intravenous cardiac pacemaker system (Majority PBC =10C)	IV pacemaker renewal
K592	Implantation of cardioverter defibrillator using two electrode leads (Majority PBC =10C + 10X)	Cardioverter defibrillator implantation - 2 electrode leads
K596	Implantation of cardioverter defibrillator using three electrode leads (Majority PBC =10C + 10X)	Cardioverter defibrillator implantation - 3 electrode leads
K594	Renewal of cardioverter defibrillator (Majority PBC =10C)	Cardioverter defibrillator renewal
K635	Coronary arteriography using single catheter (Majority PBC =10A)	Coronary arteriography - single catheter
K634	Coronary arteriography using two catheters (Majority PBC =10A)	Coronary arteriography - two catheters
K636	Coronary arteriography NEC (Majority PBC =10A)	Coronary arteriography - NEC
U202	Transoesophageal echocardiography (Majority PBC =10X)	Transoesophageal ECG
K633	Angiocardiology of left side of heart NEC (Majority PBC =10A)	Angiocardiology - left heart

# Cardiac surgery and vascular procedures

172

Highest spend procedures mapped to Programme Budget Codes: 10A, 10B, 10C, 10X. The Programme Budget Code where the majority of spend falls is indicated.

Procedure category	OPCS Procedure Code	Full procedure description	Short name in focus packs
Cardiac surgery procedures	K453	Anastomosis of mammary artery to left anterior descending coronary artery (Majority PBC =10A)	Anastomosis - mammary artery to LA descending artery
Cardiac surgery procedures	K262	Xenograft replacement of aortic valve (Majority PBC =10X)	Xenograft replacement - aortic valve
Cardiac surgery procedures	K255	Mitral valve repair NEC (Majority PBC =10X)	Mitral valve repair - NEC
Cardiac surgery procedures	K263	Prosthetic replacement of aortic valve (Majority PBC =10X)	Prosthetic replacement - aortic valve
Vascular procedures	L631	Percutaneous transluminal angioplasty of femoral artery (Majority PBC =10X)	PCTA - femoral artery
Vascular procedures	L271	Endovascular insertion of stent graft for infrarenal abdominal aortic aneurysm (Majority PBC =10X)	Endovascular stent graft - abdominal aortic aneurysm
Vascular procedures	L294	Endarterectomy of carotid artery and patch repair of carotid artery (Majority PBC =10B)	Endarterectomy - carotid artery; patch repair - femoral artery
Vascular procedures	L601	Endarterectomy of femoral artery and patch repair of femoral artery (Majority PBC =10X)	Endarterectomy - femoral artery; patch repair - carotid artery
Vascular procedures	L593	Bypass of femoral artery by anastomosis of femoral artery to popliteal artery using vein graft NEC (Majority PBC =10X)	Bypass femoral artery-anastomosis using vein graft

# Circulation: Miscellaneous procedures

173

Highest spend procedures mapped to Programme Budget Codes: 10A, 10B, 10C, 10X. The Programme Budget Code where the majority of spend falls is indicated.

OPCS Procedure Code	Full procedure description	Short name in focus packs
U051	Computed tomography of head (Majority PBC =10B)	CT - head
U354	Computed tomography of pulmonary arteries (Majority PBC =10X)	CT - pulmonary arteries
U212	Computed tomography NEC (Majority PBC =10X)	CT - NEC
U052	Magnetic resonance imaging of head (Majority PBC =10B)	MRI - head
U211	Magnetic resonance imaging NEC (Majority PBC =10B + 10X)	MRI - NEC
E852	Non-invasive ventilation NEC (Majority PBC =10X)	Non-invasive ventilation
E851	Invasive ventilation (Majority PBC =10A+10B+10X)	Invasive ventilation
X093	Amputation of leg above knee (Majority PBC =10X)	Amputation - above knee
X095	Amputation of leg below knee (Majority PBC =10X)	Amputation - below knee
U201	Transthoracic echocardiography (Majority PBC =10A + 10X)	Transoesophageal ECG
U543	Delivery of rehabilitation for stroke (Majority PBC =10B)	Stroke rehabilitation
X833	Fibrinolytic drugs Band 1 (Majority PBC =10B)	Fibrinolytic drugs - Band 1
X403	Haemodialysis NEC (Majority PBC =10X)	Haemodialysis - NEC
X501	Direct current cardioversion (Majority PBC =10C)	Direct current cardioversion
G445	Fibreoptic endoscopic percutaneous insertion of gastrostomy (Majority PBC =10B)	Percutaneous gastrostomy (PEG)
A411	Evacuation of subdural haematoma (Majority PBC =10B)	Subdural haematoma evacuation
U548	Other specified rehabilitation for other disorders (Majority PBC =10X)	Rehab - other disorders
G459	Unspecified diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract (Majority PBC =10A+10B+10X)	Upper GI endoscopy

OPCS Procedure Code	Full procedure description	Short name in focus packs
U051	Computed tomography of head	CT - Head
U212	Computed tomography NEC	CT - NEC
X403	Haemodialysis NEC	Haemodialysis - NEC
M141	Extracorporeal shock wave lithotripsy of calculus of kidney	Shock wave lithotripsy - kidney stones
M093	Endoscopic laser fragmentation of calculus of kidney	Endoscopic laser fragmentation - kidney stones
M271	Ureteroscopic laser fragmentation of calculus of ureter	Ureteroscopic laser fragmentation - ureter stones
M131	Percutaneous needle biopsy of lesion of kidney	Needle biopsy - lesion of kidney
M132	Percutaneous drainage of kidney	Kidney drainage
M292	Endoscopic insertion of tubal prosthesis into ureter NEC	Endoscopic insertion of tubal prosthesis into ureter
M136	Percutaneous insertion of nephrostomy tube	Insertion of nephrostomy tube
L742	Creation of arteriovenous fistula NEC	Arteriovenous fistula - NEC
L912	Insertion of central venous catheter NEC	Central venous catheter insertion - NEC
M274	Ureteroscopic insertion of ureteric stent	Ureteric stent insertion
U201	Transthoracic echocardiography	Transthoracic ECG

# Diabetes amputations

175

These procedures have been grouped into a single indicator to ensure there is sufficient data for analysis.

OPCS Procedure Code	Full procedure description
X095	Amputation of leg below knee
X111	Amputation of great toe
X119	Unspecified amputation of toe
X104	Amputation through metatarsal bones
X112	Amputation of phalanx of toe
X118	Other specified amputation of toe
X093	Amputation of leg above knee
U501	Delivery of rehabilitation for amputation of limb
X094	Amputation of leg through knee
X121	Reamputation at higher level
X108	Other specified amputation of foot
X101	Amputation of foot through ankle
X128	Other specified operations on amputation stump
X109	Unspecified amputation of foot
X123	Shortening of length of amputation stump
X122	Excision of lesion of amputation stump
X125	Drainage of amputation stump
X124	Revision of coverage of amputation stump
X083	Amputation of phalanx of finger
X084	Amputation of finger NEC
X273	Amputation of supernumerary toe

Condition drug groups	Chemical level drugs included
Lipid Lowering	Ezetimibe, Simvastatin, Rosuvastatin Calcium, Atorvastatin, Ciprofibrate, Pravastatin Sodium, Fenofibrate, Bezafibrate, Colestyramine, Simvastatin & Ezetimibe, Fluvastatin Sodium, Gemfibrozil, Nicotinic Acid Derivatives
ACE Inhibitors & Angiotensin Receptor Blockers	Ramipril, Candesartan Cilexetil, Lisinopril, Losartan Potassium, Olmesartan Medoxomil, Valsartan, Perindopril Erbumine, Irbesartan, Enalapril Maleate, Captopril, Eprosartan, Trandolapril, Telmisartan, Quinapril Hydrochloride, Perindopril Arginine
Anticoagulants	Rivaroxaban, Enoxaparin, Warfarin Sodium, Dabigatran Etxilate, Dalteparin Sodium, Tinzaparin Sodium, Apixaban, INR Blood Testing Reagents, Phenindione, Fondaparinux Sodium, Heparin Flushes, Acenocoumarol, Heparin Sodium
Beta-Blockers	Propranolol Hydrochloride, Bisoprolol Fumarate, Atenolol, Nebivolol, Labetalol Hydrochloride, Metoprolol Tartrate, Celiprolol Hydrochloride, Acebutolol Hydrochloride, Timolol, Nadolol, Oxprenolol Hydrochloride
Calcium Channel Blockers	Diltiazem Hydrochloride, Amlodipine, Felodipine, Nifedipine, Verapamil Hydrochloride, Lercanidipine Hydrochloride, Lacidipine, Isradipine, Nicardipine Hydrochloride
Anti-Platelet Agents	Aspirin, Doxazosin Mesilate, Ticagrelor, Clopidogrel, Dipyridamole, Prasugrel, Dipyridamole & Aspirin



Condition drug groups	Chemical level drugs included
Diuretics	Furosemide, Amiloride Hydrochloride, Co-Amilofruse (Amiloride HCl/Frusemide), Bumetanide, Metolazone
Anti-Hypertensives	Bendroflumethiazide, Indapamide, Moxonidine, Hydralazine Hydrochloride, Irbesartan with Diuretic, Methyldopa, Co-Tenidone (Atenolol/Chlortalidone), Aliskiren, Valsartan/Amlodipine, Co-Amilozide (Amiloride HCl/Hydchloroth), Atenolol With Calcium Channel Blocker, Terazosin Hydrochloride, Minoxidil, Olmesartan Medoxomil/Hydrochlorothiazide, Olmesartan Medoxomil/Amlodipine, Clonidine Hydrochloride, Ramipril with Calcium Channel Blocker, Chlortalidone, Hydrochlorothiazide, Xipamide
Anti-Arrhythmics (CHD only)	Digoxin, Dronedarone Hydrochloride, Sotalol Hydrochloride, Flecainide Acetate, Amiodarone Hydrochloride, Mexiletine Hydrochloride, Disopyramide, Disopyramide Phosphate, Propafenone Hydrochloride
Anti-Heart Failure (CHD only)	Eplerenone, Spironolactone, Carvedilol, Losartan Potassium With Diuretic, Perindopril Arginine with Diuretic, Telmisartan with Diuretic, Valsartan with Diuretic, Lisinopril with Diuretic, Enalapril Maleate with Diuretic, Amiloride HCl With Loop Diuretics, Chlorothiazide, Prazosin Hydrochloride
Anti-Anginal (CHD only)	Isosorbide Mononitrate, Ivabradine, Nicorandil, Glyceryl Trinitrate, Ranolazine, Isosorbide Dinitrate
Others (Excluding)	Omega-3-Acid Ethyl Esters, Tranexamic Acid, Midodrine Hydrochloride, Colesevelam Hydrochloride, Naftidrofuryl Oxalate, Cilostazol, Sildenafil(Vasodilator Antihypertensive), Bosentan

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

179

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) <a href="http://www.hscic.gov.uk/sus">http://www.hscic.gov.uk/sus</a>
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

180

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) <a href="http://www.hscic.gov.uk/sus">http://www.hscic.gov.uk/sus</a>
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

181

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) <a href="http://www.hscic.gov.uk/sus">http://www.hscic.gov.uk/sus</a>
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

182

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) <a href="http://www.hscic.gov.uk/sus">http://www.hscic.gov.uk/sus</a>
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

183

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) <a href="http://www.hscic.gov.uk/sus">http://www.hscic.gov.uk/sus</a>
Denominator	Age/Sex Standardised Population. Rate= (Numerator/Denominator) * 1000

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

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

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

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

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

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

Number of spells field counts all the patients admitted to hospital for a procedure and discharged in the financial year 2014/15 and groups into each age band.

[Patients admitted in 2014/15 but not discharged until 2015/16 will not count towards the spend. A small number of patients admitted in 2013/14 but not discharged until 2014/15 will count towards the spend for 2014/15.]

Net\_SLA\_Payment field is the cost before Market Forces Factor (MFF) is applied. This field gives spend on discharges for all patients in the age band in 2014/15.

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

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

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



# Prescribing spend indicators

184

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: Methodology

# How have the potential opportunities been calculated?

186

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

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

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

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

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