**NHS Digital**

**Indicator Supporting Documentation**

IAP00333 Emergency alcohol-specific readmission to any hospital within 30 days of discharge following an alcohol-specific admission

**Application Form**

**Title: Alcohol-specific readmission to any hospital within 30 days after the last previous discharge following an alcohol-specific admission**

**Set or domain: CCG OIS 3.15**

**IAS Reference Code: IAP00333**

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| **Title** | Alcohol-specific readmission to any hospital within 30 days after the last previous discharge following an alcohol-specific admission |
| **Set or domain** | CCG OIS 3.15 |
| **Topic area** |  |
| **Definition** | Indirectly age and sex standardised ratio of emergency readmissions with a primary diagnosis or an external cause code of an alcohol-specific condition within 30 days of a previous discharge following an alcohol-specific admission, with 95% confidence intervals (CI).  This indicator is calculated as a ratio indirectly standardised by age and sex and is published with 95% confidence intervals, recognising the existence of natural variation between the CCG populations.  The age and sex specific rates of the standard population (the relevant national population) are applied to the age and sex structure of the subject population to give an expected number of events. The observed number of events is then compared to that expected and expressed as a ratio (observed/expected). For presentation purposes, the ratio is multiplied by 100. By definition, the standard population will have a ratio of 100. Ratios above 100 indicate that the number of events observed was greater than that expected from the standard rates, and ratios below 100 that it was lower.  The indicator is based on CIP spells, which are constructed by linking individual finished consultant episodes to other episodes where all are part of one continuous spell of care for a patient. Further information on the spell methodology can be found at: <http://content.digital.nhs.uk/media/11859/Provider-SpellsMethodology/pdf/Spells_Methodology.pdf>.  The indicator denominator includes emergency and elective admissions, whereas the numerator includes emergency admissions only. Elective readmissions are considered a positive action and therefore excluding them from the numerator allows the indicator to focus solely on the issue of emergency readmissions. |
| Indicator owner & contact details |  |
| Publication status |  |
| Purpose | The Clinical Commissioning Group Outcomes Indicator Set (CCG OIS) is an integral part of NHS England’s systematic approach to quality improvement. It is intended to provide clear, comparative information for CCGs, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.  This indicator forms part of Domain 3 - Helping people to recover from episodes of ill health or following injury. Some, but not all alcohol-specific admissions are potentially avoidable by high quality management in primary care and the community. Excessive consumption of alcohol may be amenable to influence and could result in a reduction in avoidable hospital admissions, which are costly and expose patients to avoidable clinical risks such as health care acquired infections. |
| Sponsor |  |
| Endorsement |  |
| Evidence and Policy base  Including related national incentives, critical business question, NICE quality standard and set or domain rationale, if appropriate | The introduction to Clinical Guideline 115 states that alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people  The introduction to Clinical Guideline 100 states that hazardous and harmful drinking are commonly encountered among hospital attendees; approximately 20% of patients admitted to hospital for illnesses unrelated to alcohol are drinking at potentially hazardous levels. Persistent drinking at hazardous and harmful levels can result in damage to almost every organ or system of the body. Continued hazardous and harmful drinking can result in alcohol dependence. |
| Data source | Hospital Episode Statistics (HES) |
| Justification of source and others considered | Data quality for HES APC is considered to be good. HES is a unique data source, whose strength lies in the richness of detail of patient level going back to 1989 for inpatient episodes. It is the data source for a wide range of healthcare analysis used by a variety of people including the NHS, Government, regulators, academic researchers, the media, and members of the public. Further information can be found at: <http://digital.nhs.uk/searchcatalogue?q=title%3a%22Hospital+Episode+Statistics%2c+Admitted+patient+care+-+England%22&sort=Most+recent&size=10&page=1#top> . |
| **Data availability** |  |
| **Data quality** | **i) What data quality checks are relevant to this indicator?**  **Coverage**  **Completeness**  **Validity**  **Default**  **Integrity**  **Timeliness**  **Other** |
|  | **If you included ‘Other’ as a data quality check, please describe the check, how it will be measured, and its reason for use below:** |
|  | **ii) What are the current values for the data quality checks selected?** The period of data the current values are calculated from should be stated. Current values should be recorded as a percentage and calculated as described below.  **Period of data:**  **Coverage: Calculation:**  **Completeness: Calculation:**  **Validity: Calculation:**  **Default:**  **Calculation:**  **Integrity:**  **Calculation:**  **Timeliness:**  **Calculation:**  **Other:  Calculation:** |
|  | **iii) What are the thresholds for the data quality checks selected?**  **Coverage:**  **Completeness:**  **Validity:**  **Default:**  **Integrity:**  **Timeliness:**  **Other:** |
|  | **iv) What is the rationale for the selection of the data quality checks and thresholds selected above?** |
|  | **v) Describe how you would plan to improve data quality should it not meet, or subsequently fall below, the thresholds required for this indicator.** |
|  | **vi) Who will own the data quality risks and issues for this indicator?**  **Name:**  **Job Title:**  **Role:**  **Email:**  **Telephone:** |
|  | **vii) Describe how the data quality risks and issues will be managed for this indicator, including the escalation process.** |
|  | **viii) Describe any assumptions you have made about data quality for this indicator.** |
|  | **ix) Describe any data quality constraints you are aware of for this indicator.** |

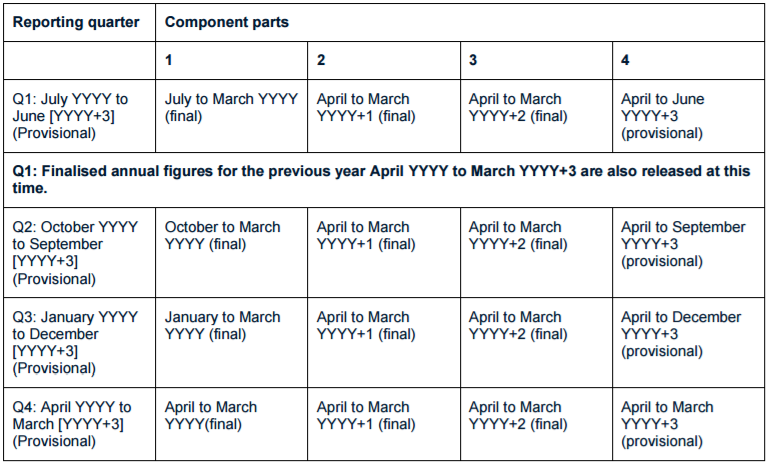
**x) Additional data quality information:**

Data will be reported on a rolling quarterly basis, using 3 years of data. In order to release data in a more timely way for users, provisional HES data will be used. However, care should be taken as it is subject to changes and revisions each month and should be treated as an estimate until the final annual data is released.

Provisional HES data is reported four months in arrears due to HES processing and quality controls. The final annual HES data will be reported eight months in arrears (November, following the financial year end) after the HES annual refresh. The annual refresh gives providers the opportunity to revise and update their submissions for the year. All previously reported provisional quarterly datasets will be replaced by a single annual dataset. Admitted Patient Care Data Quality notes are available via the following link for the relevant data period:

http://content.digital.nhs.uk/searchcatalogue?q=title%3a%22Provisional+Monthly+Hospital+Episode+Statistics%22&sort=Most+recent&size=10&page=1

Reporting periods are broken down as follows:



These indicators are official statistics and the publication date was pre-announced. There was no gap between the planned and actual publication date.

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| **Quality assurance** |  |
| **Data linkage** |  |
| **Quality of data linkage** |  |
| **Data fields** | Data fields from HES: DIAG\_3\_01  DIAG\_4\_01  ADMIDATE  ADMIMETH  CAUSE\_3  CCG\_RESPONSIBILITY  CLASSPAT  EPIEND  EPIKEY  EPIORDER  EPISTAT  EPITYPE  SEX  STARTAGE\_CALC  CIP\_SPELL\_ADMIDATE  CIP\_SPELL\_ADMIMETH  CIP\_SPELL\_ADMISORC  CIP\_SPELL\_DISDATE  CIP\_SPELL\_DISMETH  CIP\_SPELL\_FIRST\_EPISODE |
| **Data filters** | Episode level filters that are applied to all records:   1. Field Name: DIAG\_3\_01, DIAG\_4\_01, CAUSE\_3 Conditions: DIAG\_3\_01 is equal to any of: F10, K70 OR DIAG\_4\_01 is equal to any of: E24.4, G31.2, G62.1, G72.1, I42.6, K29.2, K85.2, K86.0, Q86.0, R78.0, T51.0, T51.1, T51.9 OR CAUSE\_3 is equal to any of: X45, X65, Y15, Y90, Y91 Rationale: Selects alcoholic-specific conditions 2. Field Name: CCG\_RESPONSIBILITY Conditions: CCGs in England only Rationale: Excludes those registered with GPs outside of England Reference file provided at: <http://digital.nhs.uk/ccgois> 3. Field Name: CLASSPAT Conditions: Is equal to 1 or 2 Rationale: Selects ordinary cases and day case admissions only, excluding regular day/night attenders, maternity and births 4. Field Name: EPIORDER Conditions: Is equal to 1 Rationale: Selects the first episode in an admission episode 5. Field Name: EPISTAT Conditions: Is equal to 3 Rationale: Selects finished episodes only 6. Field Name: EPITYPE Conditions: Is equal to 1 Rationale: Selects general episodes only, excluding delivery and birth related episodes 7. Field Name: SEX Conditions: Is equal to 1 or 2 Rationale: Selects valid sex 8. Field Name: STARTAGE\_CALC Conditions: Is between 0 and 120 Rationale: Selects valid ages 9. Field Name: EPIEND Conditions: Is limited to records within the 36 month reporting period equal to the dates defined in 14 Rationale: Selects index admission episodes that ended in the 3 year reporting period  OR 10. Field Name: ADMIDATE Conditions: Is equal to the EPIEND filter detailed in 9, plus an additional 30 days. Rationale: Allows readmissions that relate to an index admission at the end of the reference period to be included in the data. These records may not appear in the denominator due to the filter on CIP\_SPELL\_DISDATE detailed in 14.   The Episode level filters are combined with the following Spell level filters:   1. Field Name: CIP\_SPELL\_FIRST\_EPISODE Conditions: Is equal to ‘Y’ Rationale: Selects the first episode in a spell 2. Field Name: CIP\_SPELL\_ADMISORC Conditions: Is not equal to any of the following: 51, 52, 53 Rationale: Excludes provider transfers 3. Field Name: CIP\_SPELL\_DISDATE Conditions: Is greater than or equal to CIP\_SPELL\_ADMIDATE Rationale: Data quality filter   Denominator (index admission) filters:   1. Field Name CIP\_SPELL\_DISDATE Conditions: Is limited to records within the 36 month reporting period equal to the dates defined in 9 Rationale: Selected relevant records for the denominator. 2. Field Name: CIP\_SPELL\_DISMETH Conditions: Is not equal to any of the following: 4, 5 Rationale: Excludes those discharged as dead and stillbirth   Numerator filters:   1. Field Name CIP\_SPELL\_DISDATE and CIP\_SPELL\_ADMIDATE Conditions: Difference between CIP\_SPELL\_DISDATE (index admission) and CIP\_SPELL\_ADMIDATE (readmission) is between 0 and 29 days Rationale: Date difference between admission and discharge from previous admission is 30 days or less 2. Field Name: CIP\_SPELL\_ADMIMETH Conditions: Is equal to 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D Rationale: Selects emergency readmissions only 3. Field Name: CLASSPAT Conditions: Is equal to 1 Rationale: Selects ordinary cases only for emergency readmissions 4. Field Name: PSEUDO\_HESID Conditions: Is equal to the PSEUDO\_HESID in the denominator record Rationale: Ensures that the denominator and numerators belong to the same person   Records that meet the criteria for inclusion through filters 1-13 are ordered by PSEUDO\_HESID, CIP\_SPELL\_ADMIDATE, CIP\_SPELL\_DISDATE and EPIKEY.  These records are tested to determine whether they meet the criteria for inclusion in the denominator (14-15). Where this is true, the next record in the ordered list is tested to determine whether it meets the criteria for inclusion in the numerator (16-19). |
| **Justifications of inclusions and exclusions**  and how these adhere to standard definitions | Rationales provided above |
| **Data processing** |  |
| **Numerator** | Of the denominator, the number of emergency readmissions to hospital where the first episode contains a primary diagnosis or an external cause code of an alcohol-specific condition, within 30 days of the previous discharge date. |
| **Denominator** | The number of Continuous In Patient (CIP) spell admissions where the first episode contains a primary diagnosis or an external cause code of an alcohol-specific condition (see Appendix 1 for details of ICD-10 codes). |
| **Computation** | This indicator is calculated as a ratio indirectly standardised by age and sex. |
| **Risk adjustment or standardisation type and methodology** | **Indirect Standardisation**  *Variables and methodology:*  The indirectly age and sex standardised ratio (ISR) is the ratio of events that would occur in a standard population if that population were to experience the age and sex specific rates of the subject population.  The ISR is given by:  Formula showing indirectly age and sex standardised ratio (ISR)  Where:  𝑂 is the total observed number of events in the local or subject population  𝐸 is the total number of expected events in the local or subject population, given the standard rates 𝜆𝑖 in the reference or standard population;  𝑂𝑖 is the observed numbers of events in the local or subject population in age and sex group 𝑖;  𝐸𝑖 is the expected number of events in the local or subject population in age and sex group 𝑖, given the standard rate 𝜆𝑖 in the reference or standard population;  𝑛𝑖 is the number of individuals in the local or subject population in age and sex group 𝑖;  𝜆𝑖 is the crude age-specific rate in the reference or standard population in age and sex group 𝑖;  The standard population used is the national count of the denominator. The following age bands are used: 0-18, 19-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74, 75-79, 80-84, 85-89, 90+. |
| **Justification of risk adjustment type and variables**  or why risk adjustment is not used |  |
| **Confidence interval / control limit use and methodology** | Confidence Intervals  *Methodology:*  Confidence intervals will be calculated as specified in ‘Commonly used public health statistics and their confidence intervals’ (APHO, March 2008). The 100(1– α)% confidence limits for the ISR are given by:  Formula to calculate confidence intervals  Where 𝑂𝑙𝑜𝑤𝑒𝑟 and *Oupper* are the lower and upper confidence limits for the observed number of events;  Using Byar’s[[1]](#footnote-1) method, the 100(1– *α*)% confidence limits for the observed number of events are given by:  Formula: confidence limits  Where *z* is the 100(1– *α*/2)th percentile value from the Standard Normal distribution. For example, for a 95% confidence interval, *α* = 0.05 and *z* = 97.5th percentile value from the Standard Normal distribution.  For small numerators of less than 389, Byar's method can be less accurate and an exact method based on the Poisson distribution can be used. For 95% confidence intervals, Byar's method is extremely accurate for numerators of 5 or more, but for 99.8% confidence intervals it is less accurate.  Using the link between the Poisson and distributions[[2]](#footnote-2) , the equations for 𝑂𝑢𝑝𝑝𝑒𝑟 and *Olower* above can be replaced by:  Formula: Where: 𝜒¬¬2lower is the 100(1– α/2)th percentile value from the 𝜒2 distribution with 2O degrees of freedom; 𝜒¬¬2upper is the 100(α/2)th percentile value from the 𝜒2 distribution with 2O+2 degrees of freedom  Where:  𝜒­­2lower is the 100(1– α/2)th percentile value from the 𝜒2 distribution with *2O* degrees of freedom;  𝜒­­2upper is the 100(α/2)th percentile value from the 𝜒2 distribution with *2O+2* degrees of freedom |
| **Justification of confidence intervals / control limits used** |  |
| **Presentation of indicator** | Indicator data is published in both .csv and .xlsx formats.  Data is available at CCG- and National-level for the reporting periods:   * 01/04/2014 to 31/03/2017 * 01/01/2014 to 31/12/2016 * 01/10/2013 to 30/09/2016 * 01/07/2013 to 30/06/2016 * 01/04/2013 to 31/03/2016 * 01/04/2012 to 31/03/2015 * 01/04/2011 to 31/03/2014   Column headings on the output file are:   * Reporting period * Period of coverage * Breakdown * ONS code * Level * Level description * Indicator value * CI lower * CI upper * Denominator * Numerator |
| **Contextual information provided alongside indicator**  with justification |  |
| **Calculation and data source of contextual information** |  |
| **Use of bandings, benchmarks or targets**  with justification |  |
| **Banding, benchmark or target methodology**  if appropriate |  |
| **Interpretation guidelines** |  |
| **Limitations and potential bias** | 1. This indicator requires careful interpretation and should not be used in isolation. It should be taken in conjunction with other indicators and information from other sources that together form a holistic view of CCG outcomes and a fuller overview of how CCG processes are impacting on outcomes. 2. Standardisation is by age and sex and does not encompass any other factors that could potentially influence the rate. 3. Differences in casemix (beyond that accounted for by standardisation), comorbidities and other potential risk factors also contribute to the variation. 4. There may be variation in the prevalence of particular conditions due to differing levels of deprivation, for other geo-demographic reasons or between patients of different ethnic heritages. 5. A number of factors outside the control of healthcare providers, such as the socio-economic mix of local populations, may determine whether a patient is admitted; thus this could influence rates. 6. The patterns of providing care may vary between organisations in terms of: extent of treatment in primary care settings; referral policies and practices; hospital outpatient facilities/walk-in clinics; and hospital inpatient admission policies and practices. 7. There may be local variation in data quality, particularly in terms of diagnostic and procedure coding.   Some factors causing or exacerbating relevant conditions are outside the control and influence of the NHS and CCGs. These can vary by region, and may include environmental factors such as air quality, occupational hazards and deprivation. |
| **Improvement actions** | It is expected that CCGs will use this indicator to identify how improvements in care and the desired reduction of alcohol-specific emergency readmissions will be delivered. A CCG may be able to invest in primary care or community-based services to offer more help to people with alcohol problems in order to reduce the number of alcohol-specific admissions and subsequent readmissions. |
| **Evidence of variability** |  |
| **Similar existing indicators** | There are two CCG OIS indicators relating to alcohol-specific conditions; one for alcohol-specific admissions (*CCG OIS 3.14 Alcohol-specific hospital admissions*) and one for alcohol-specific readmissions. The standardisation methodology differs between the two; with the alcohol-specific hospital admission indicator using direct standardisation and this alcohol-specific readmission indicator using indirect standardisation. It is accepted that directly standardised rates are preferable (to indirectly standardised ratios) as these provide a reliable means of comparing areas, such as CCGs. However, the readmissions indicator is calculated as a proportion and there is not the same level of consensus as to how to standardise proportions. As such, custom and practice has been to produce indirectly standardised proportions (based around comparing observed to expected figures). |
| **Coherence and comparability** | This indicator is linked directly to CCG OIS indicator 3.14 ‘Alcohol-specific hospital admissions’, which is published at national and CCG level quarterly covering a rolling 12 month period. As previously explained, the standardisation methodology differs between the two indicators, with the alcohol-specific emergency admissions indicator using direct standardisation, and the alcohol-specific readmissions indicator using indirect standardisation.  Also included in the CCG OIS is indicator 1.8 ‘Emergency admissions for alcohol related liver disease’, which is directly standardised and published at national and CCG level, quarterly covering a rolling 12 month period.  The Public Health Outcomes Framework includes indicator 2.18, Alcohol-related admissions to hospital, is published at national, regional, county and Unitary Authority level and is based on admissions that are linked to alcohol-attributable fractions [http://www.phoutcomes.info](http://www.phoutcomes.info/)/. |
| **Undesired behaviours and/or gaming** |  |
| **Approach to indicator review** | Comments can be made through various media, including NHS Digital general enquiries by email [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk) or by telephone 0300 303 5678.  As well as initially assuring the quality and methodology of this indicator, the NHS Digital’s Indicator Assurance Process will be used on an on-going basis to review any new indicators. User needs and feedback will be taken into consideration during this assurance process. |
| **Disclosure control** | When publishing the data, if the indicator is calculated from a numerator of 1 to 5, the value is suppressed to ensure an individual’s identity is not at risk of eing disclosed. If there is only one value suppressed in this way, the rate based upon the next lowest numerator is also suppressed; this reduces the risk of the first suppressed number being identifiable in isolation.  Ratios are rounded to one decimal place before publication. |
| **Copyright** | This indicator makes use of an existing data collection, so there are no additional data collection cost implications or burden. |

Record of Assurance provided by **Indicator Governance Board**

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| IAS Ref Code: | | IAP00333 |
| **Indicator Title** | | **Alcohol-specific readmission to any hospital within 30 days after the last previous discharge following an alcohol-specific admission** |
| Indicator Set | | CCG Outcomes Indicator Set |
| Description | | The indicator calculates the number of people who were re-admitted as an emergency with a primary diagnosis of an alcohol-specific condition within 30 days after a previous discharge following an alcohol-specific admission, as a percentage of total alcohol-specific admissions. |
| Initial IGB discussion | | 06/12/13 |
|  | **Strategic Considerations & Implications** | |
| Applicant / Sponsor Organisation | NHS England  \*Costing for assurance appraisal included in development cost | |
| Assurance process funded? | Yes | |
| Indicator rationale | The Clinical Commissioning Group Outcomes Indicator Set (CCG OIS) is an integral part of NHS England’s systematic approach to quality improvement. It is intended to provide clear, comparative information for CCGs, patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.  Alcohol dependence and harmful alcohol use are associated with increased risk of physical and mental health comorbidities including gastrointestinal disorders (in particular liver disease), neurological and cardiovascular disease, depression and anxiety disorders and ultimately, premature death.  An indicator measuring alcohol-specific hospital admissions has also been put forward for inclusion in the CCG Outcomes Indicator Set. | |
| Basis for rationale  [Details of quality statement, policy etc.] | This indicator is based on Quality Standard 11: Alcohol dependence and harmful alcohol use http://guidance.nice.org.uk/QS11.  The introduction to Clinical Guideline 115 states that alcohol dependence affects 4% of people aged between 16 and 65 in England (6% of men and 2% of women), and over 24% of the English population (33% of men and 16% of women) consume alcohol in a way that is potentially or actually harmful to their health or well-being. Alcohol misuse is also an increasing problem in children and young people  The introduction to Clinical Guideline 100 states that hazardous and harmful drinking are commonly encountered among hospital attendees; approximately 20% of patients admitted to hospital for illnesses unrelated to alcohol are drinking at potentially hazardous levels. Persistent drinking at hazardous and harmful levels can result in damage to almost every organ or system of the body. Continued hazardous and harmful drinking can result in alcohol dependence. | |
| Calculation Summary | The indicator is aggregated by Clinical Commissioning Group (CCG) and will be a numerator / denominator construct, reported as a percentage on a rolling 3 year basis.  Denominator: The number of admission spell records where the first episode contains a primary diagnosis of an alcohol-specific condition.  Numerator: The number of emergency admission spell records where the first episode contains a primary diagnosis of an alcohol-specific condition and the patient was discharged, within the last 30 days, after an admission which also has a primary diagnosis code in the first episode relating to an alcohol-specific condition.  This indicator is to be indirectly standardised by age and sex. Confidence intervals will be calculated as specified in ‘Commonly used public health statistics and their confidence intervals’ (APHO, March 2008).  ICD-10 diagnosis codes for alcohol-specific admissions are as follows:  E24.4 Alcohol-induced pseudo-Cushing’s syndrome  F10.- Mental and behavioural disorder due to use of alcohol  G31.2 Degeneration of nervous system due to alcohol  G62.1 Alcoholic polyneuropathy  G72.1 Alcoholic myopathy  I42.6 Alcoholic cardiomyopathy  K29.2 Alcoholic gastritis  K70.- Alcoholic liver disease  K86.0 Alcohol-induced chronic pancreatitis  T51.0 Toxic effect of alcohol, Ethanol  T51.1 Toxic effect of alcohol, Methanol  T51.9 Toxic effect of alcohol, unspecified  X45.- Accidental poisoning by and exposure to alcohol  A low rate of alcohol-specific readmissions is desirable | |
| Risks & assumptions | The NICE CCGOIS Advisory Committee considered both ‘alcohol-related’ and ‘alcohol-specific’ admissions for this indicator. It was agreed that ‘alcohol-specific’ admissions are the most appropriate measure for this indicator set.  It was agreed that, where standardisation was necessary, indicators within the CCG OIS would be directly standardised. However, due to the small numbers in certain age bands and the need for a standard population, it is proposed for this indicator to be indirectly standardised by age and sex. This would align to other readmission indicators currently published on the HSCIC Indicator Portal, which all use indirect standardisation.  There are no planned changes to the HES collection that would impact on this indicator.  The list of indicators for inclusion in CCG OIS for 2014-15 may still be subject to change as NHS England review the indicator set. | |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | *Data Source:* Hospital Episode Statistics (HES) | |
| IG Considerations [e.g. release of under-lying data, intermediaries access to data, data ownership impact on production] | The underlying HES data are held by the HSCIC and are made available to customers via several mechanisms depending on their requirements. These include the publication of aggregated output; a chargeable extract service that covers both bespoke and routine extracts; and direct access via an interrogation tool to the underlying data for certain customers.  Commissioning Data Sets (CDS 6.2) are approved by ISB ref ISB0092.  HES has been approved by ROCR license number ROCR/OR/0014/FT6/009MAND. | |
| Potential impacts on other business areas [inc outstanding generic issues] | - | |
| Implementation Method  [inc production funding] | NHS England has commissioned HSCIC to produce and disseminate the CCG OIS indicators; this is funded via the Grant In Aid funding to HSCIC.  Collection of the data for the CCG OIS is via existing data collections, in this case HES. Testing and specification of the indicators is carried out by the Specification Development Service and construction of the indicators is provided by Clinical Indicators via the CI Platform.  Dissemination and presentation of the CCG OIS will be via a number of routes:  • The indicators and their underlying data will be made publically available via the HSCIC website and the Indicator Portal.  • The data will also be provided to NHS England for use in their internal Intelligence Tool.  • Subject to confirmation by NHS England, the calculated indicator, numerator and denominator for CCGs will be supplied by messaging to the Calculating Quality Reporting Service (CQRS) for use by CCGs as part of their management information | |

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|  | **Development Advice / Peer Review (undertaken as part of assurance process)** |
| Range of input during development | Advice has been taken from the NHS Classification Service (National Clinical Classifications Helpdesk) on which ICD-10 codes to use to filter for alcohol-specific conditions. |
| Assurance Service  Peer Reviewers: | Internal Review HSCIC  David Leese – Senior Information Analyst |
| Peer Review summary: | The peer reviewer made the following suggestions:   * Provide further clarification around the NICE recommendation to concentrate on alcohol specific conditions. This was addressed by the developer at MRG. * Reference that publishing as a percentage is in line with all other readmission indicators published by HSCIC. |

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|  | **Record of MRG Discussion** |
| Discussion dates: | 22/08/13  18/10/13 |
| By: | Heather Dawe HSCIC Programme Manager, Clinical Indicators  Paul Fryers PHE Deputy Director, East Midlands Knowledge and  Intelligence Team  Alyson Whitmarsh HSCIC Programme Manager, Clinical Audit  Chris Dew HSCIC Section Head, Clinical Indicators  Andy Sutherland HSCIC Statistics Head Of Profession  Irene Begaj UHB Statistical Intelligence Analyst  Paul Iggulden HSCIC Interim Head of Clinical Analysis, Research &  Development  Jonathon Hope HSCIC Principal Analyst, Clinical Audit |
| Summary of MRG discussions: | The indicator was presented and discussed alongside application *IAP00332: Alcohol-specific hospital admissions.*   * MRG was informed that NICE supported the view that ‘alcohol-specific’ admissions are the most appropriate measure for the CCG indicator set, as the use of alcohol-attributable fractions would create issues with admission and readmission selection in the indicator *Alcohol-specific readmission to any hospital within 30 days after the last previous discharge following an alcohol-specific admission (IAP00333)*. To maintain consistency between the two indicators, alcohol-specific admissions are used. * MRG members queried the removal of ICD 10 code T51.1 (Toxic effect of alcohol, Methanol) from the original application as a subjective issue, citing that this group could include those people producing their own alcohol where things go wrong and a high methanol content is produced as a result. * Additionally MRG felt that to maintain consistency with other definitions and what is contained in the Local Alcohol Profiles, it should be retained unless a very good reason could be found for its exclusion. * Subsequently the ICD-10 diagnosis codes for alcohol-specific admissions have been aligned with the conditions defined by the North West Public Health Observatory as alcohol-specific i.e. wholly-attributable to alcohol. * MRG members felt that clarification should be provided in the metadata for the differences in definitions for this indicator in comparison to other similar public health indicators. * There was discussion as to whether the indicator looked at only the primary diagnosis, and whether there was a possibility that codes such as F10 (Mental and behavioural disorder due to use of alcohol) would not be coded as a primary diagnosis and therefore likely to be missed. * MRG concluded that F10 can be used as a primary diagnosis code, and that the intent of the indicator was to count alcohol admissions, not secondary reasons. In this case, admissions are being used as a proxy for burden on acute services rather than the full burden of alcohol. * With regards as to whether to include just emergency readmissions or all readmissions, the developer proposed that they did not want to include those patients who were scheduled to return to hospital for further treatment. It was acknowledged by the group that although just including emergency readmissions would bring numbers down, there would be enough records for a valid indicator. * Using only emergency readmissions for this indicator will maintain consistency with existing readmission indicators in the HSCIC Indicator Portal, which each use emergency readmissions in the numerator. The following filter will be included in the numerator: CIP\_SPELL\_ADMIMETH in (21, 22, 23, 24, 28). * An explanation of the use of emergency readmissions only will be included in the Quality Statement. * MRG felt that the proposal to indirectly standardise due to small numbers in some age bands is appropriate, but it was noted that going forward, a statement should be produced as to why the readmissions use indirect standardisation and the admissions indicator uses direct standardisation to assist users. * Updated confidence interval methodology was provided to the group on request. Confidence intervals will be calculated as specified in ‘Commonly used public health statistics and their confidence intervals’ (APHO, March 2008). |
| *Outcome of MRG consideration:* | **No significant issues identified** |
| MRG statement of recommendation: | This indicator was recommended for discussion by IGB on completion of the above recommendations. |

Review:

|  |  |
| --- | --- |
| Review Timescale | 3 years / other |
| Rationale | [Issues to consider – Changes to process, policy data source, coding definitions HES definitions ]  The indicator is recommended for review in three years on the basis that no changes in the data source or rationale is expected |

IGB Sign-off:

|  |  |
| --- | --- |
| **Indicator Assurance Process Output** | *Final Appraisal Status* |
|  | 1. **Assured** |
|  | 1. **Assured with Comments** |
|  | 1. **Failed Assurance** |
| Basis of Sign-off  [Detail caveats and limitations ] |  |
| Sign-off Date |  |

1. [↑](#footnote-ref-1)
2. [↑](#footnote-ref-2)