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Commissioning for Value: Pathways on a page

NHS Stockport CCG

November 2014

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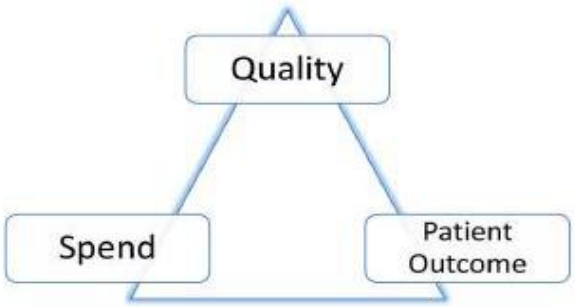
Introduction: What is Commissioning for Value?

The Commissioning for Value work programme originated during 2013/14 in response to requests from clinical commissioning groups (CCGs) that they would like support to help them identify the most impactful opportunities for change. It is a partnership between NHS England, Public Health England and NHS Right Care and the initial work was an integral part of the planning approach for CCGs.

Commissioning for Value is about identifying priority programmes which offer the best opportunities to improve healthcare for populations; improving the value that patients receive from their healthcare and improving the value that populations receive from investment in their local health system.

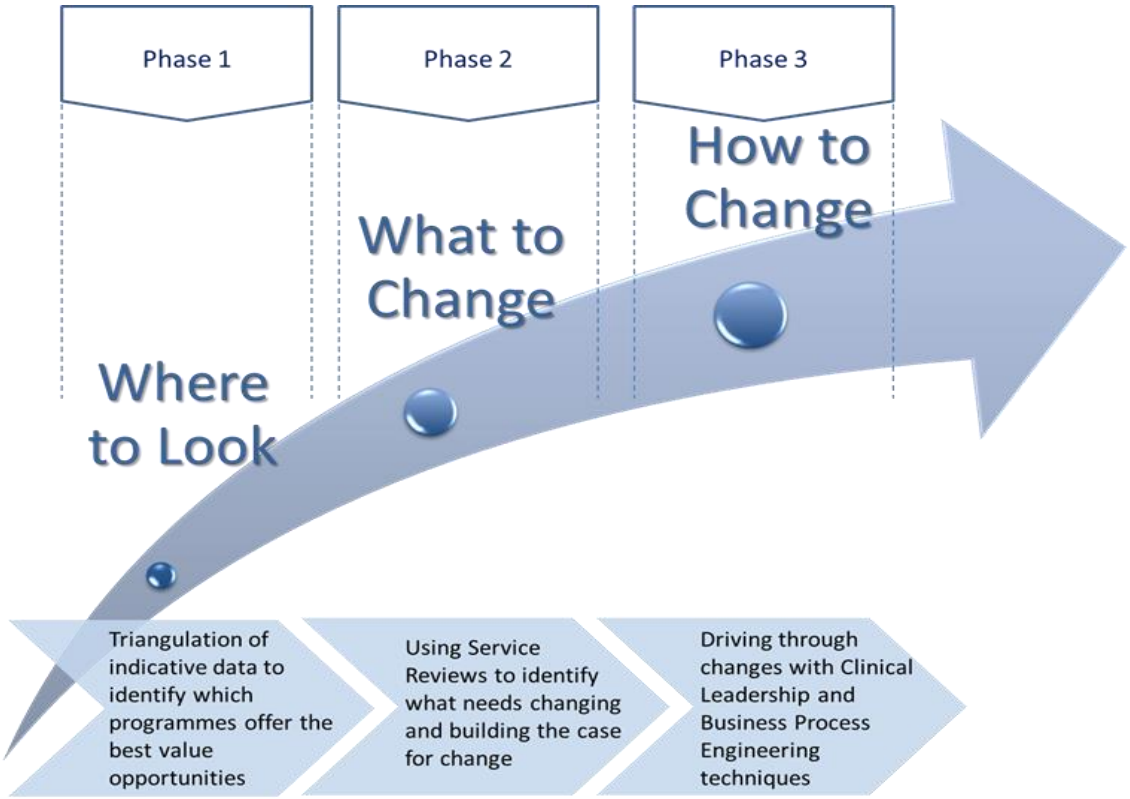
By providing the commissioning system with data, evidence, tools and practical support around spend, outcomes and quality, the Commissioning for Value programme can help clinicians and commissioners transform the way care is delivered for their patients and populations.

Commissioning for Value is not intended to be a prescriptive approach for commissioners, rather a source of insight which supports local discussions about prioritisation and utilisation of resources. It is a starting point for CCGs and area teams, providing suggestions on where to look to help them deliver improvement and the best value to their populations.



Elements of value

The Commissioning for Value approach



The Commissioning for Value approach is to identify value opportunities by looking at clinical programmes, as opposed to organisational or management structures and boundaries. Value opportunities exist where a health economy is an outlier and therefore will most likely yield the greatest improvement to clinical pathways and policies.

The approach begins with a review of indicative data to highlight the top priorities or opportunities for transformation and improvement.

Phases two and three then move on to explore *What to Change* and *How to Change*.

Supporting planning and transformation

The healthcare system is facing the challenges of increasing demand and limited resources. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

The forthcoming planning guidance for 2015/16 will emphasise the importance of Commissioning for Value to help support local discussion about prioritisation and utilisation of resources. By using the information contained in these latest packs and enhanced tools, CCGs will be able to ensure their plans focus on those opportunities which have the potential to provide the biggest improvements in health outcomes and resource utilisation.

The packs also support the vision set out in the recently published Five Year Forward View with its focus on the transformation of healthcare services to drive quality and efficiency.

Why act?

The benefits from using the Commissioning for Value approach and packs are beginning to be realised across the country. A number of CCGs have already seen improvements in financial and quality outcomes for their populations.

CCGs are using the Commissioning for Value approach to shift spend and improve processes	• Achieved turnaround (Warrington CCG) • Clinically led annual QIPP planning and delivery (Wigan Borough CCG) • Clinical leaders driving change (Vale of York CCG) • Galvanising commissioners in a growing number of health economies (30+ CCGs and growing)
CCGs are using the Commissioning for Value approach to achieve financial stability, eg in West Cheshire CCG	• Yr 1: 'Came from behind' - Implemented system mid year • Yr 2: 'Delivered as went along' - Began at year start, achieved by end • Yr 3: 'Planned ahead' - Began before year, over- achieved • Yr 4: 'Ahead of the curve' - 20% of QIPP delivered by start • Yr 5: 'Total focus on quality'
It's not just about the money. West Cheshire CCG saw quality improvements in just one year	• A&E attendances & admissions, elective & non-elective activity, outpatient firsts & follow-ups all decreased • Outcomes and quality improved • Integration occurred across health sectors and with social care

More information about some of the Commissioning for Value which has already taken place across the country can be seen in the 'Learning from others' section of this pack.

The Pathways on a Page pack

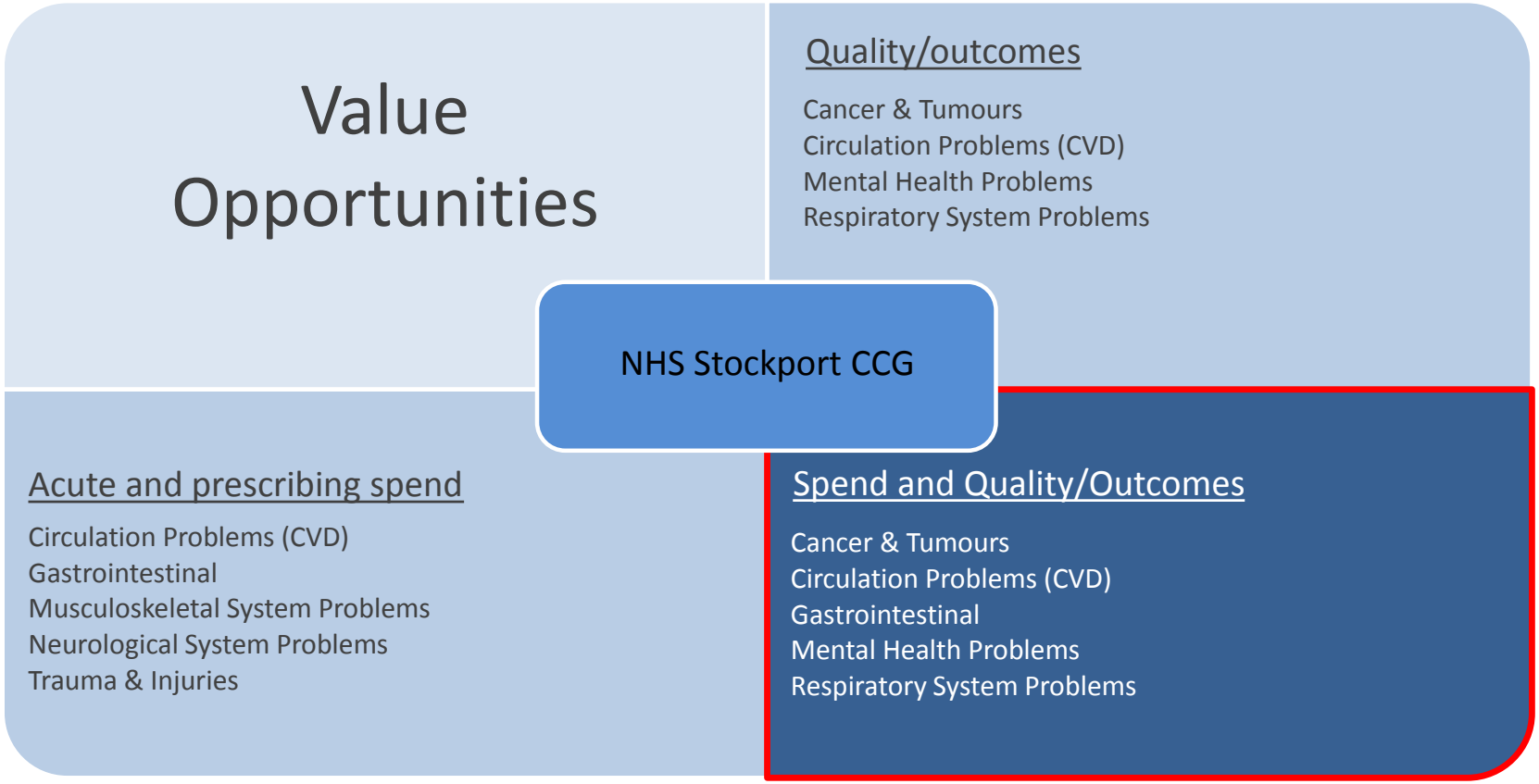
This ‘Pathways on a Page’ pack is the second in a series of Commissioning for Value support packs for CCGs. The National Clinical Directors and Intelligence Networks have helped to develop the pathways.

The first packs - released in October 2013 - contained information on a range of improvement opportunities to help each CCG identify where its local health economy could focus its efforts – the ‘where to look’ phase. Those packs can be seen at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/. The next page shows the areas identified as those where your CCG could potentially make the greatest improvements in terms of spend and quality/outcomes.

This pack provides a more detailed look at these areas by providing a wider range of key indicators, using the latest published data, and presenting them along the lines of a pathway that patients may experience for different conditions. Alongside the areas highlighted last year, CCGs may wish to use the 13 pathways in this pack to complement that identification of improvement opportunities. CCGs may find that exploring the pathway in more detail in this way helps to identify new opportunities to prioritise as part of the planning process. Please note that pathways are not included for gastro-intestinal and neurological problems at this stage; additional indicators for these will be added to the Commissioning for Value tool in due course.

As with the original packs, the intention of these pathways is not to provide a definitive view on priorities but to help commissioners explore potential opportunities. These packs help commissioners to understand how performance in one part of the pathway may affect outcomes further along the pathway. This is a simplified version of a ‘focus pack’ or ‘deep dive’ and we encourage commissioners to use the full process for pathways that appear to offer the greatest areas for improvement. Page 26 provides further information on starting a deep dive.

Headlines for your health economy



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How to interpret your pathways on a page

On the following pages a selection of key indicators are presented following the patient pathway from left to right. Each indicator is shown as the percentage difference from the average of the 10 CCGs most similar to you. 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 'needs local interpretation' (blue) is used where it is not possible to make this judgement. For example, high prevalence may reflect that a CCG does truly have more patients with a certain condition, but it may reflect that the CCG has better processes in place to identify and record prevalence in primary care, or that registers have not been audited recently.

The original packs presented potential opportunities compared to the best performing five CCGs out of the similar ten. For presentational reasons these pathways on a page show performance compared to the average of the similar ten CCGs. This means that 'better' (green) means better than average and that improvement is still required to become 'good'. Commissioners are encouraged to consider how to achieve the level of the best performing CCGs and the interactive tool and deep dive process allows users to explore this in more detail.

In the original pack, higher spend on prescribing and elective admissions was included as a potential improvement opportunity. In this pack they are coloured blue because spending more in these areas might be a result of a specific strategy to identify and treat patients earlier, which may lead to lower spend on non-elective admissions and better outcomes for patients. Local investigation and interpretation is key to determining the opportunity to improve in these areas. In other words, CCGs should not discount any potential opportunities identified in the first pack for prescribing and elective admissions – these should still be explored, but it is important to consider the pathway as a whole and not individual elements separately.

Commissioners should work with local clinicians and public health colleagues to interpret these pathways.

How to interpret your pathways on a page (continued)

CCGs may also find it a powerful improvement tool to compare their pathways with those of their similar CCGs. By doing so, it may be possible to identify those CCGs which appear to have much better pathways for populations with similar demographics.

- NHS Southend CCG
- NHS Trafford CCG
- NHS Wirral CCG
- NHS North Tyneside CCG
- NHS Solihull CCG
- NHS Wakefield CCG
- NHS St Helens CCG
- NHS Dudley CCG
- NHS Rotherham CCG
- NHS Warrington CCG

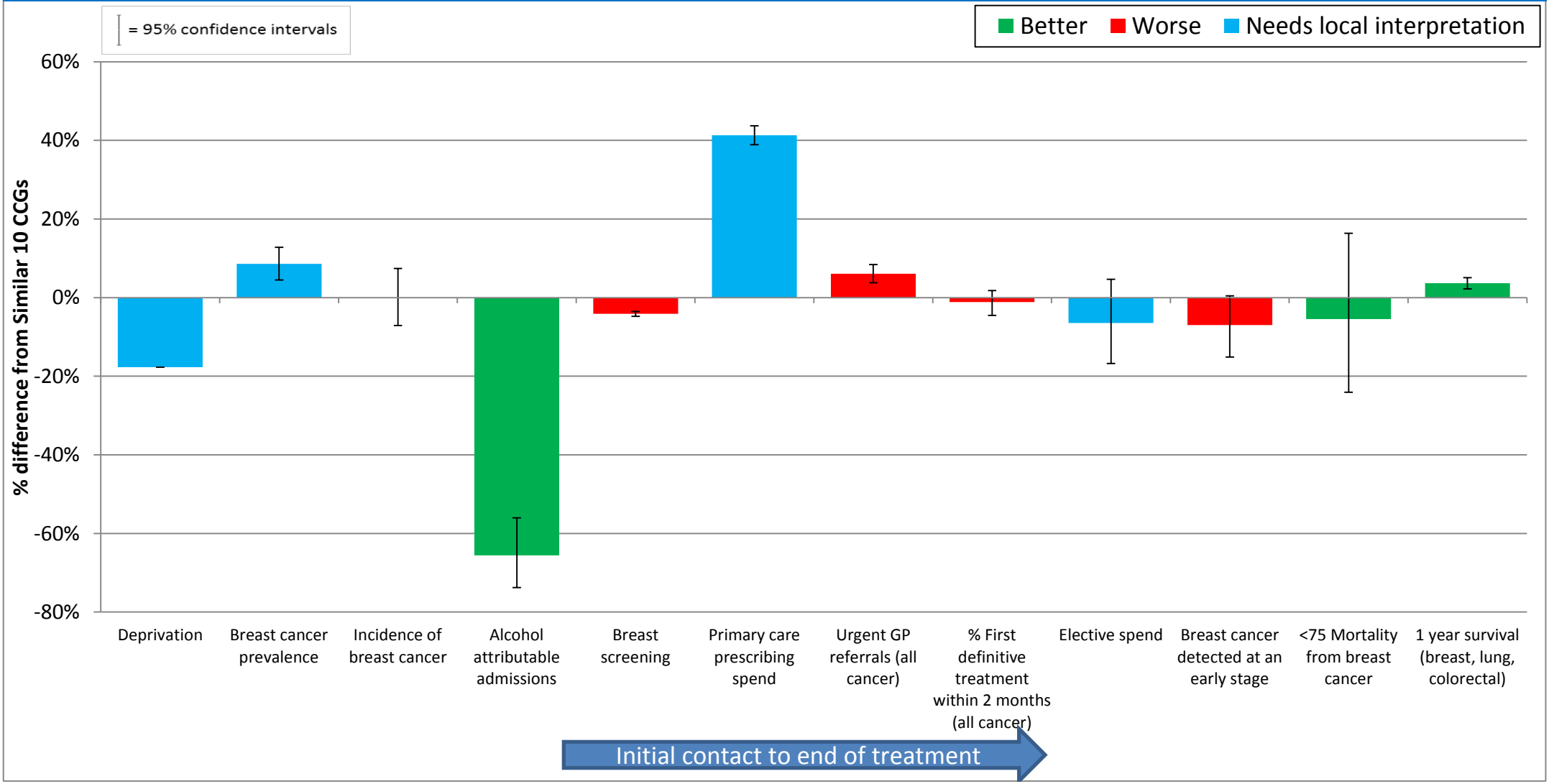
To enable a detailed understanding of the indicators, metadata will be published at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/ shortly, but longer descriptions of the indicators are available in the annex at the end of this pack.

Links to the NICE guidance are included for each pathway. All the pathways can be accessed at: http://pathways.nice.org.uk

Public Health England has also provided support packs to help CCGs understand variations across their cardiovascular (CVD) care pathway and get better value from their CVD services. These packs are available at http://www.yhpho.org.uk/default.aspx?RID=199884

Breast cancer pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/familial-breast-cancer
http://pathways.nice.org.uk/pathways/early-and-locally-advanced-breast-cancer
http://pathways.nice.org.uk/pathways/advanced-breast-cancer

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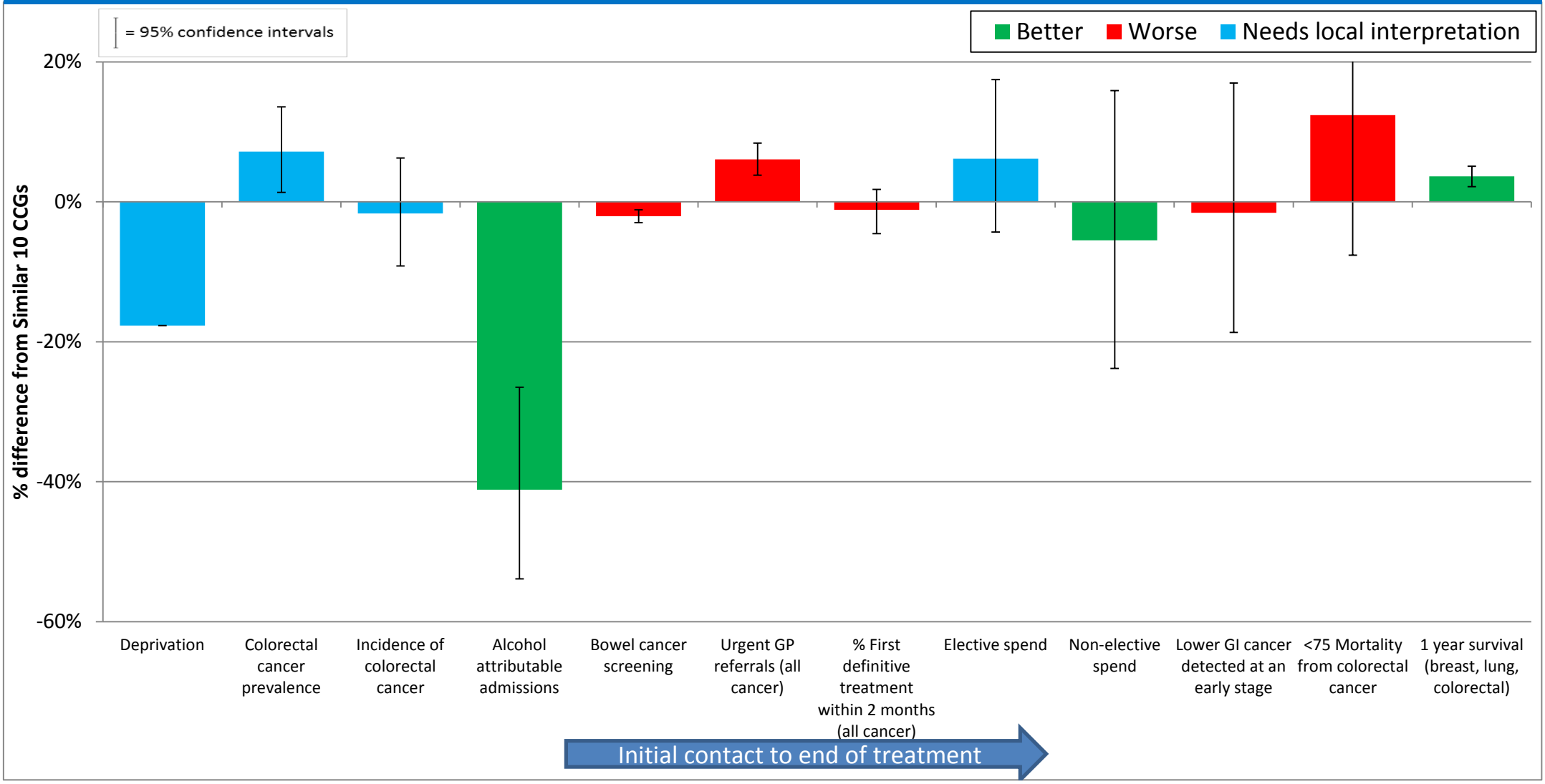
Lower gastrointestinal cancer pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/colorectal-cancer
http://pathways.nice.org.uk/pathways/colonoscopic-surveillance
http://pathways.nice.org.uk/pathways/gastrointestinal-conditions

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Lung cancer pathway

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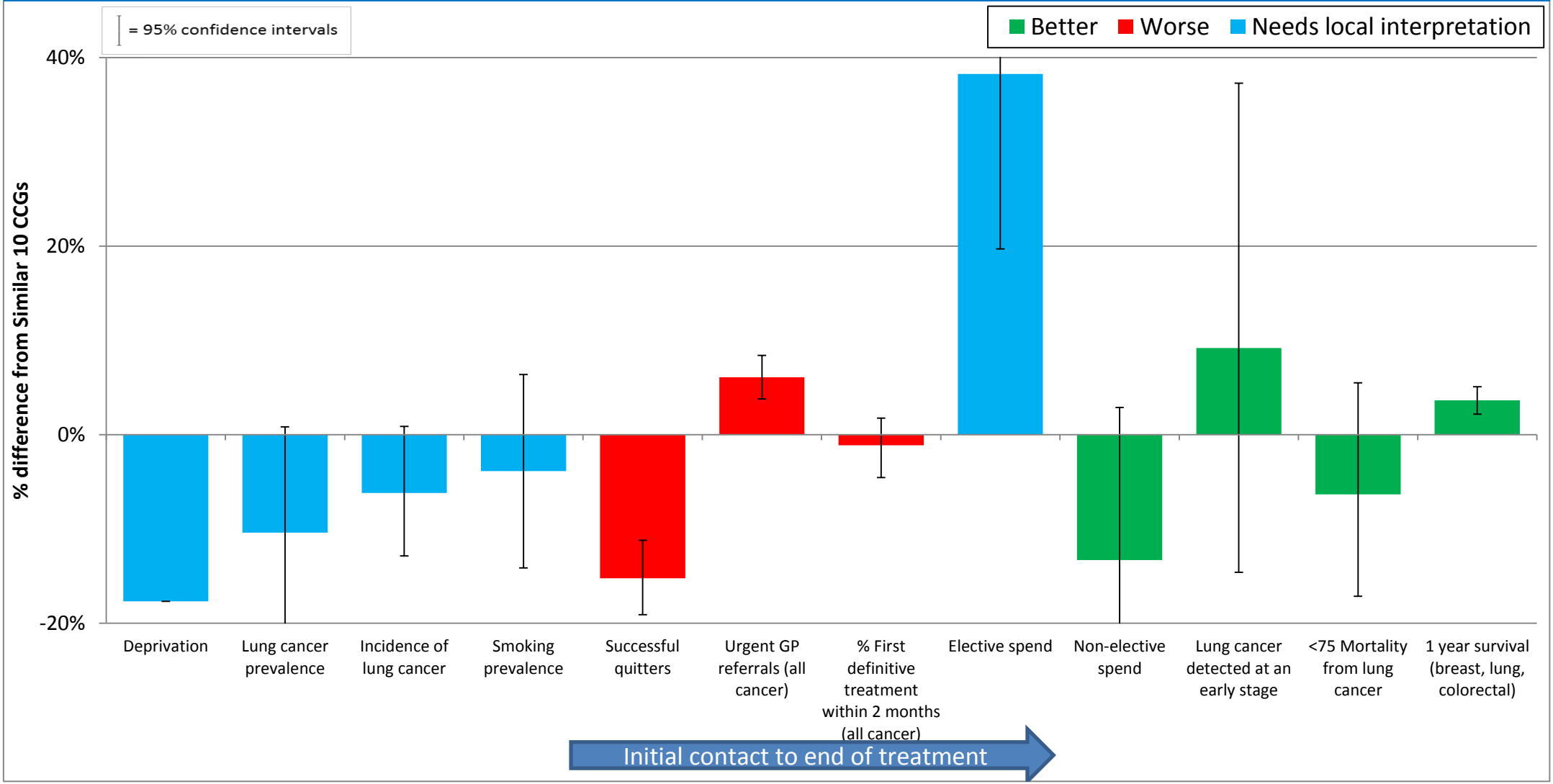

NICE guidance:

http://pathways.nice.org.uk/pathways/lung-cancer

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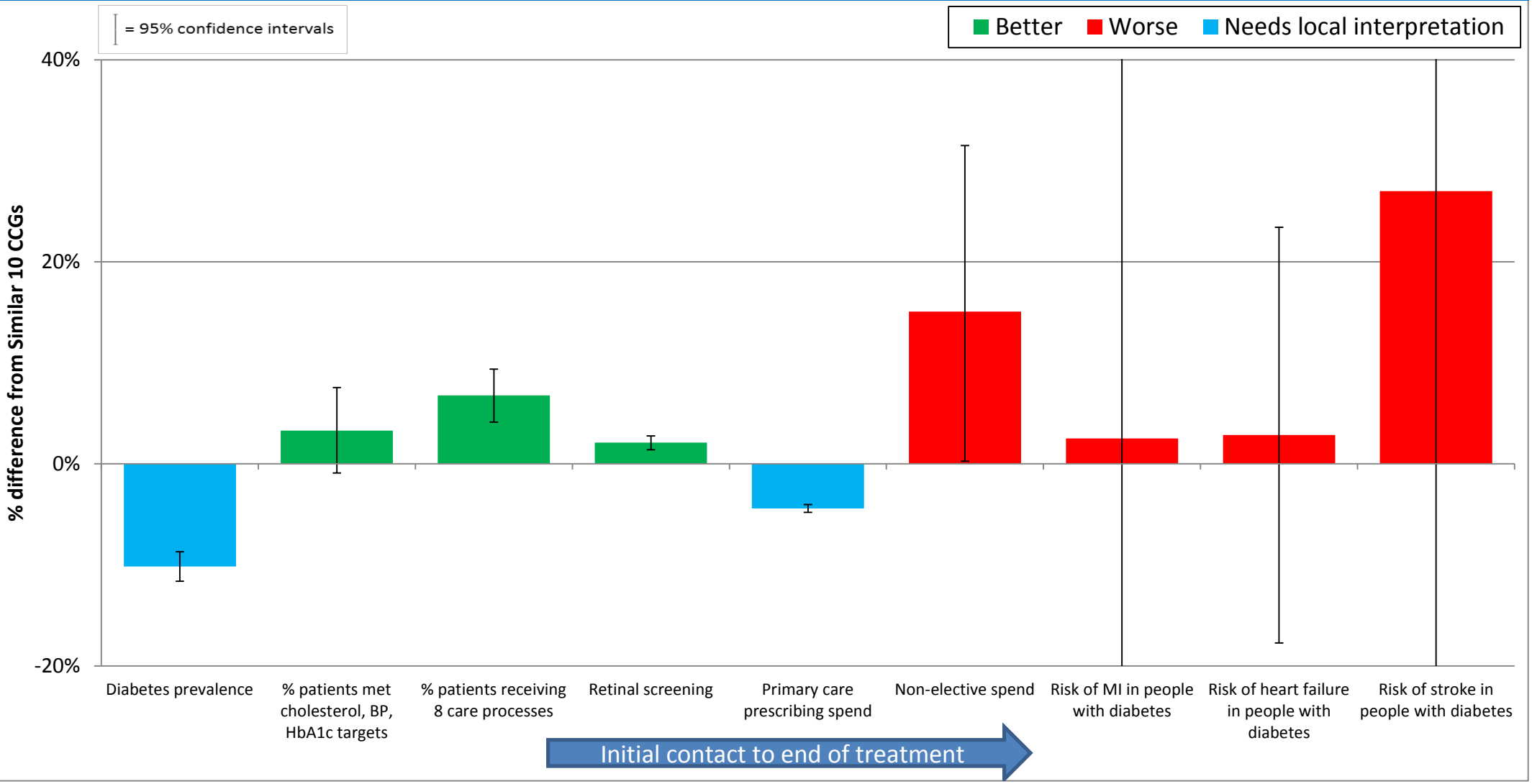
Diabetes pathway

NHS Stockport CCG



NICE guidance:

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

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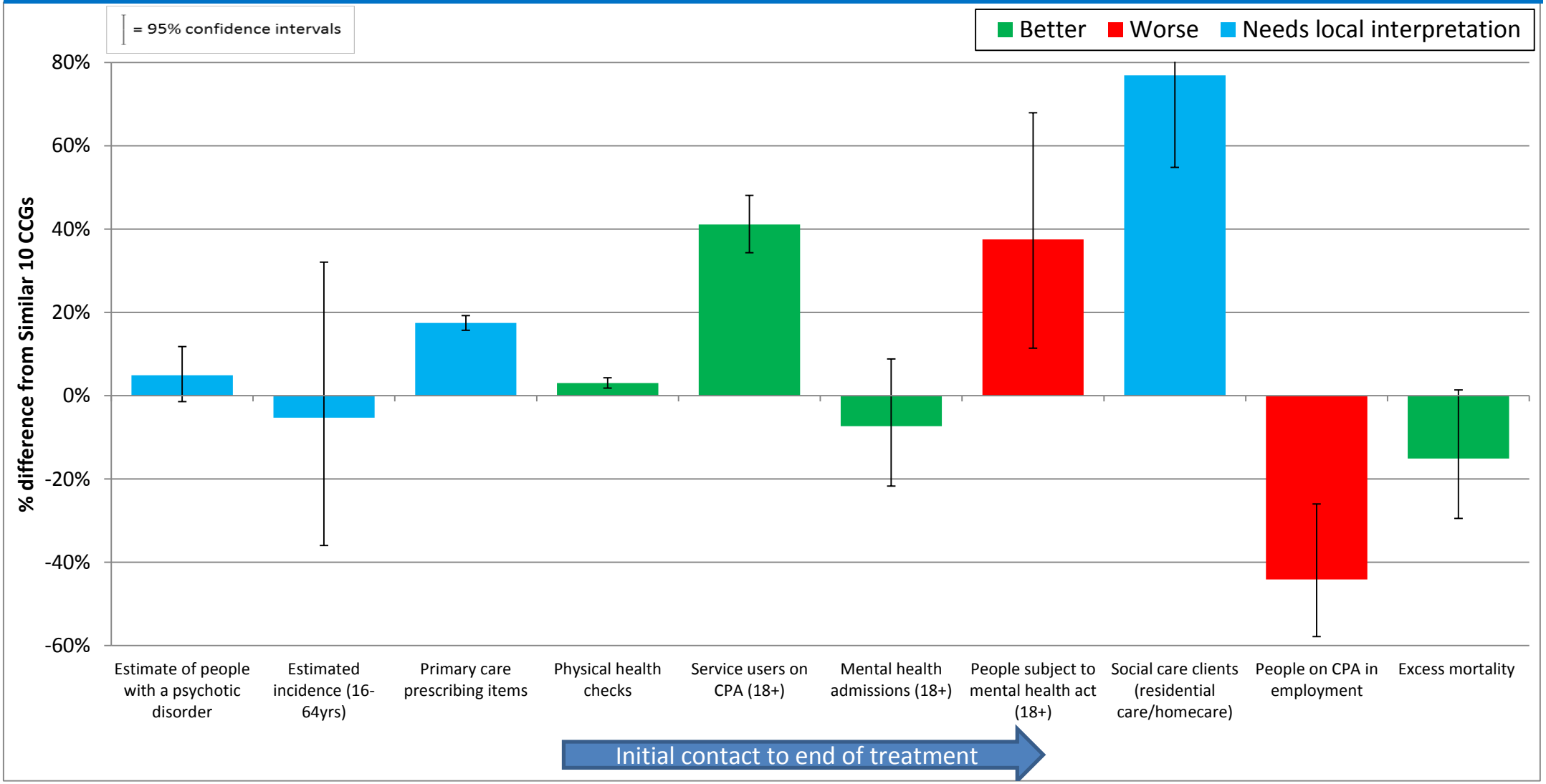
Psychosis pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/psychosis-and-schizophrenia

Other important psychosis indicators omitted for data quality issues:

http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/

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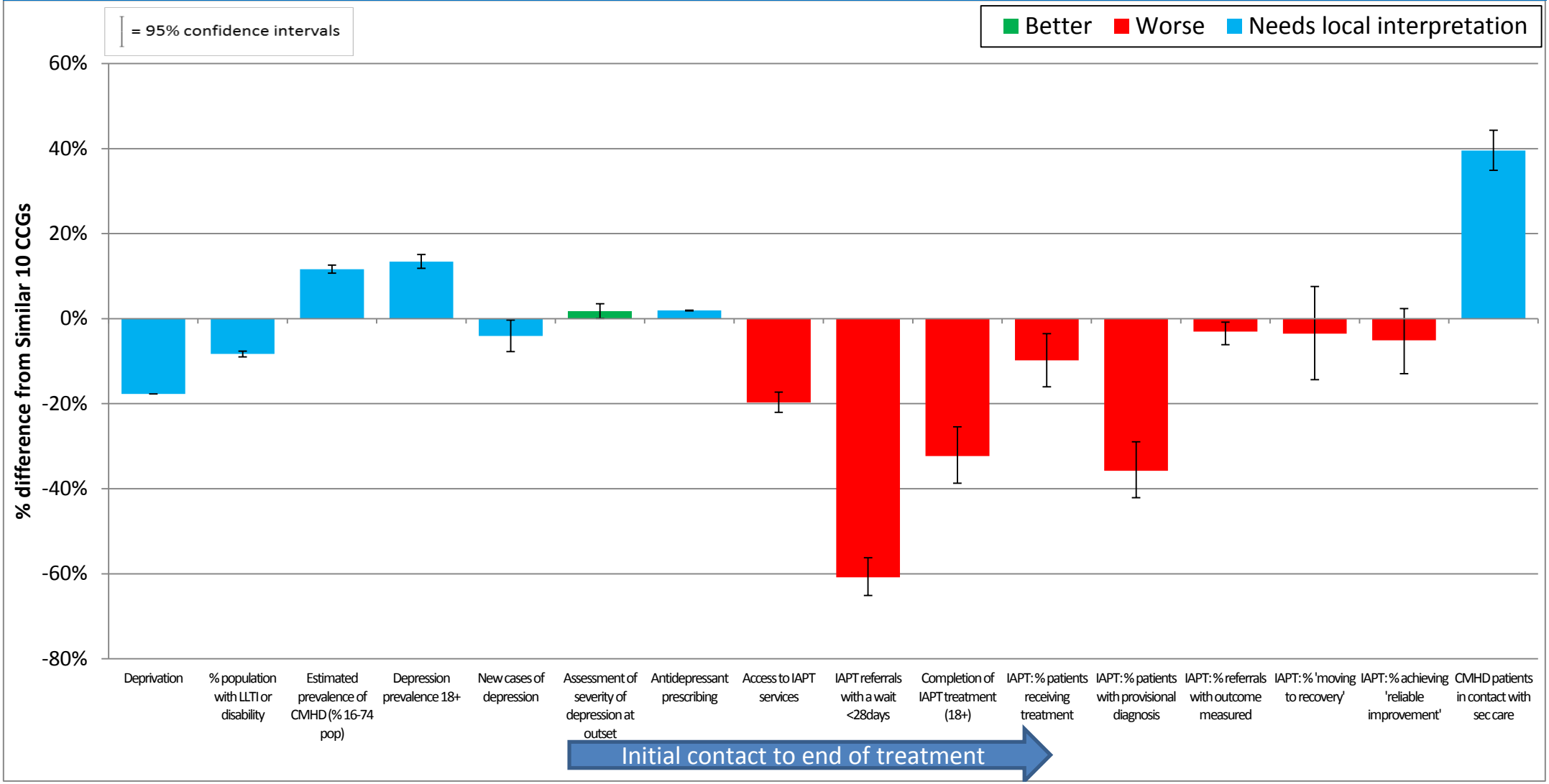
Common mental health disorder pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/common-mental-health-disorders-in-primary-care

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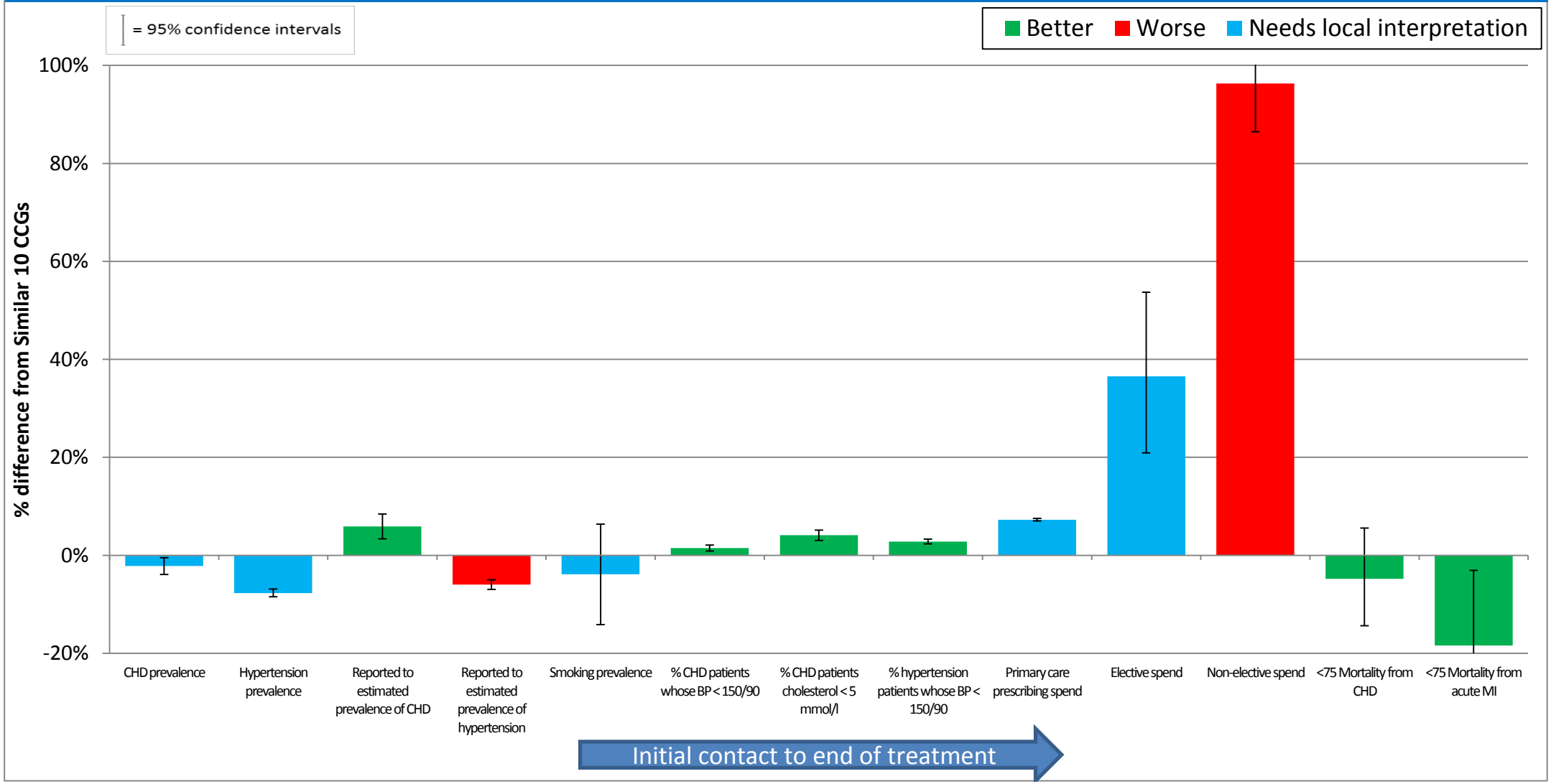
Heart disease pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/hypertension
http://pathways.nice.org.uk/pathways/cardiovascular-disease-prevention
http://pathways.nice.org.uk/pathways/smoking

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Stroke pathway

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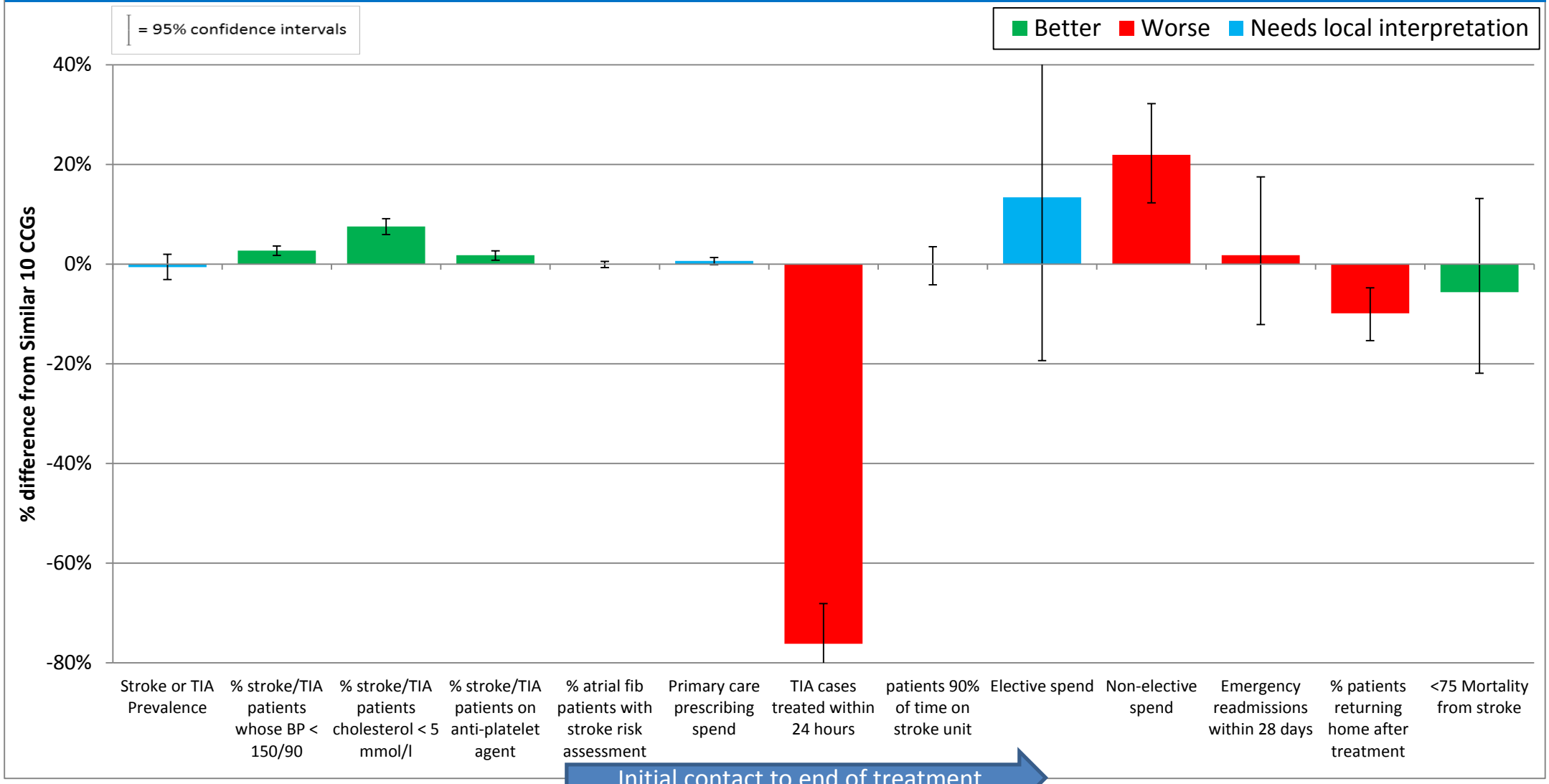

NICE guidance:

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

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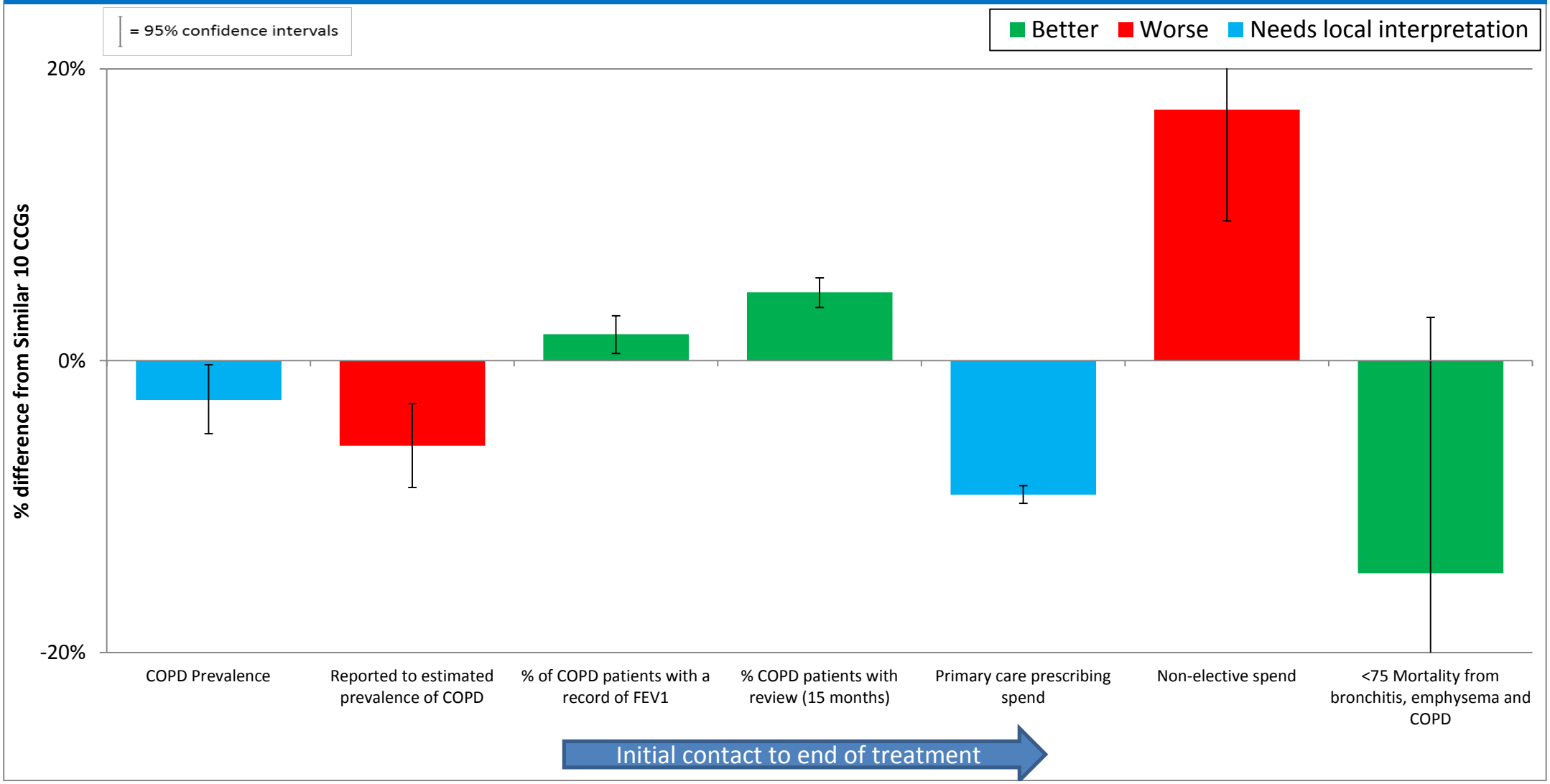
COPD pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/chronic-obstructive-pulmonary-disease

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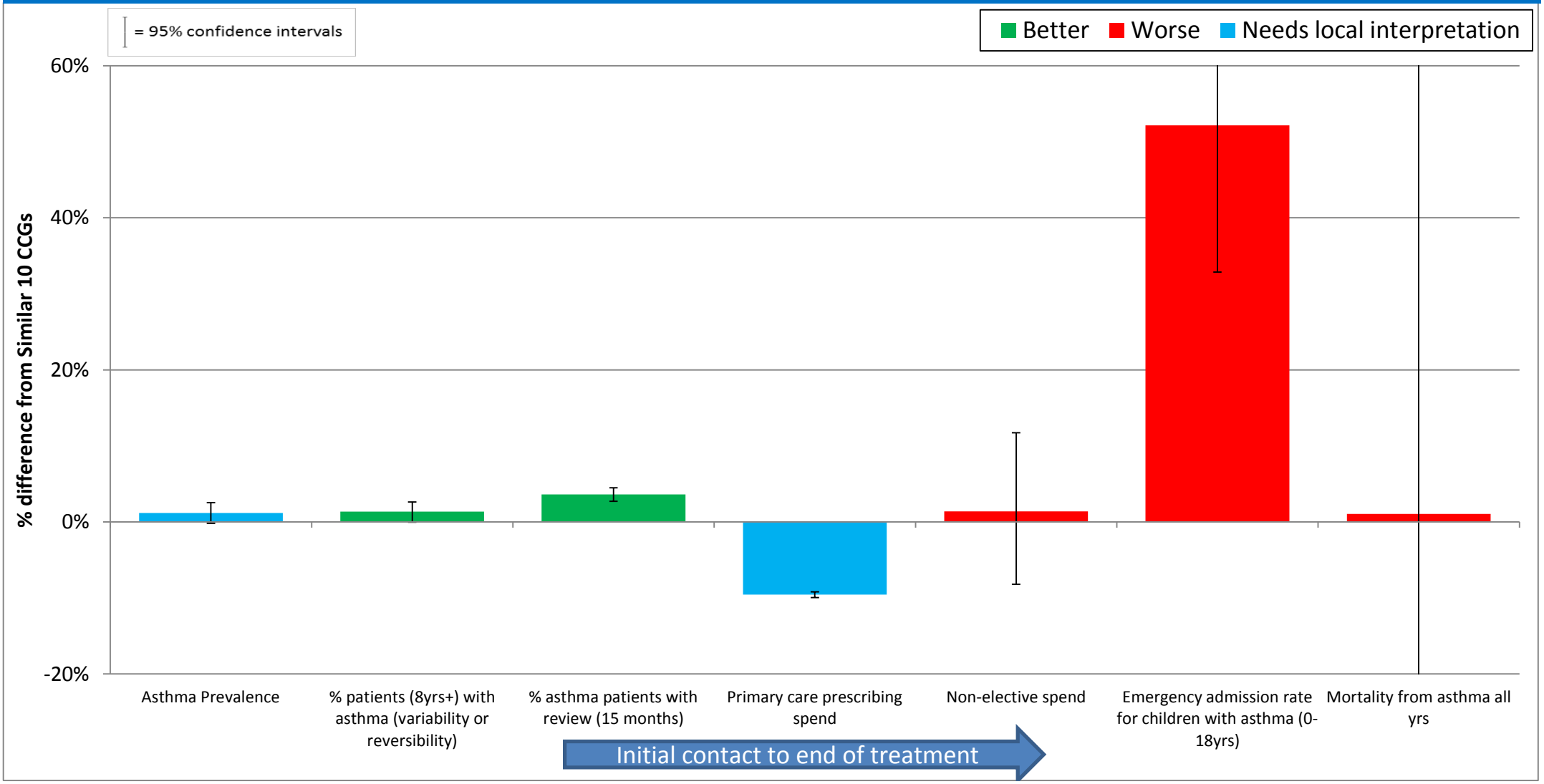
Asthma pathway

NHS Stockport CCG



NICE guidance:

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

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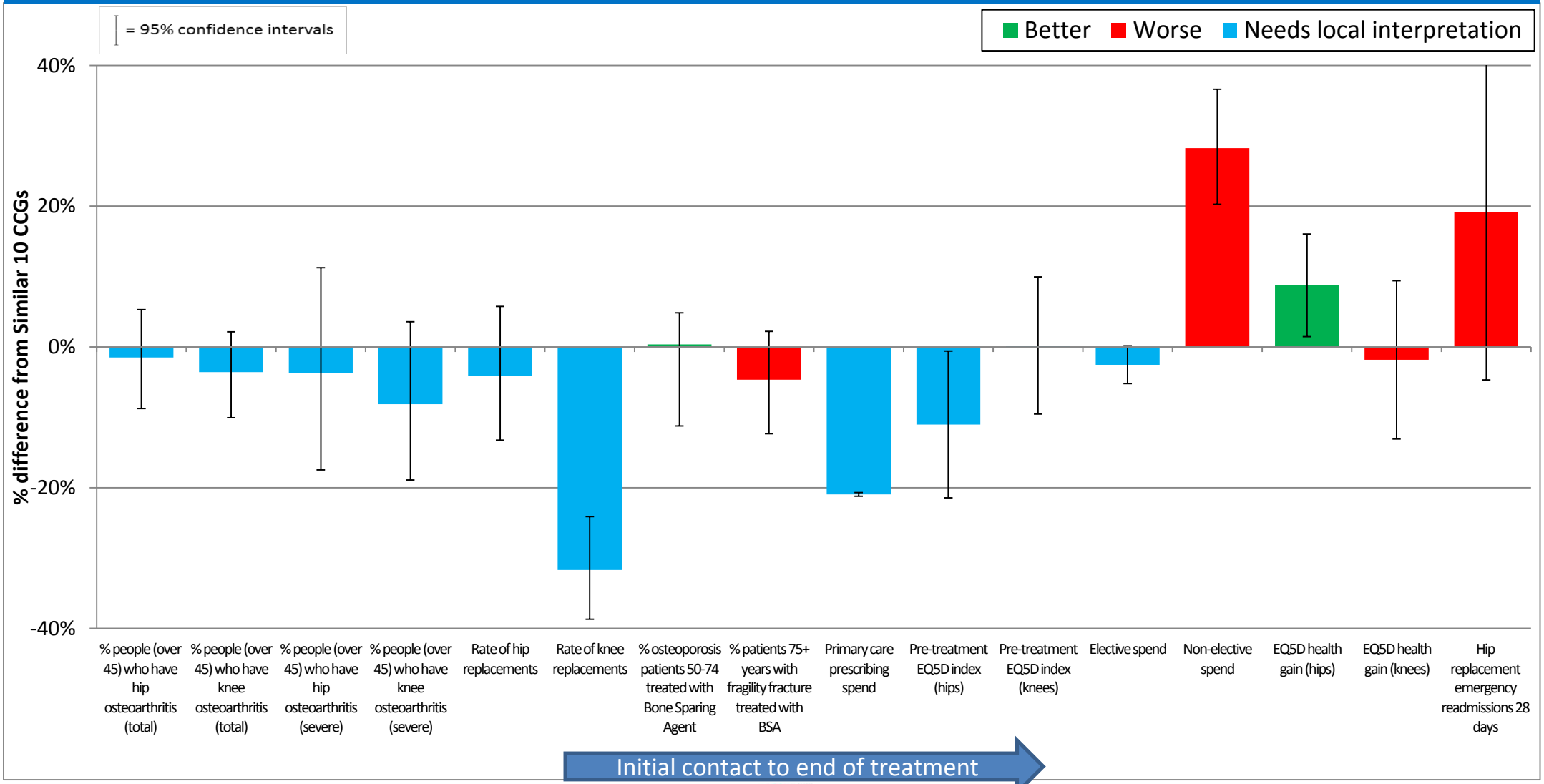
Musculoskeletal pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/musculoskeletal-conditions

Arthritis Research UK Musculoskeletal calculator:

http://www.arthritisresearchuk.org/mskcalculator

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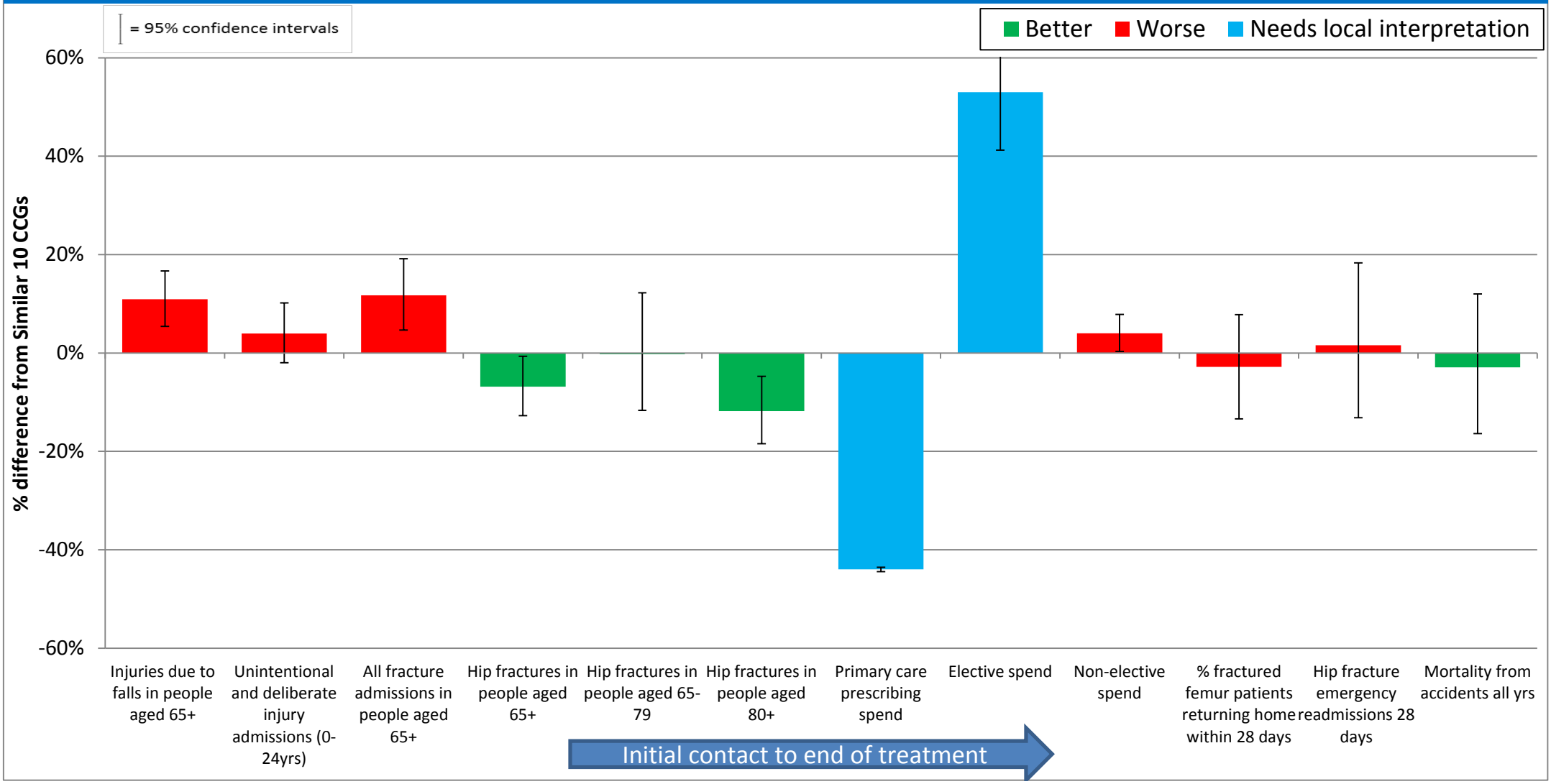
Trauma and injury pathway

NHS Stockport CCG



NICE guidance:

http://pathways.nice.org.uk/pathways/falls-in-older-people

http://pathways.nice.org.uk/pathways/unintentional-injuries-among-under-15s

http://pathways.nice.org.uk/pathways/hip-fracture

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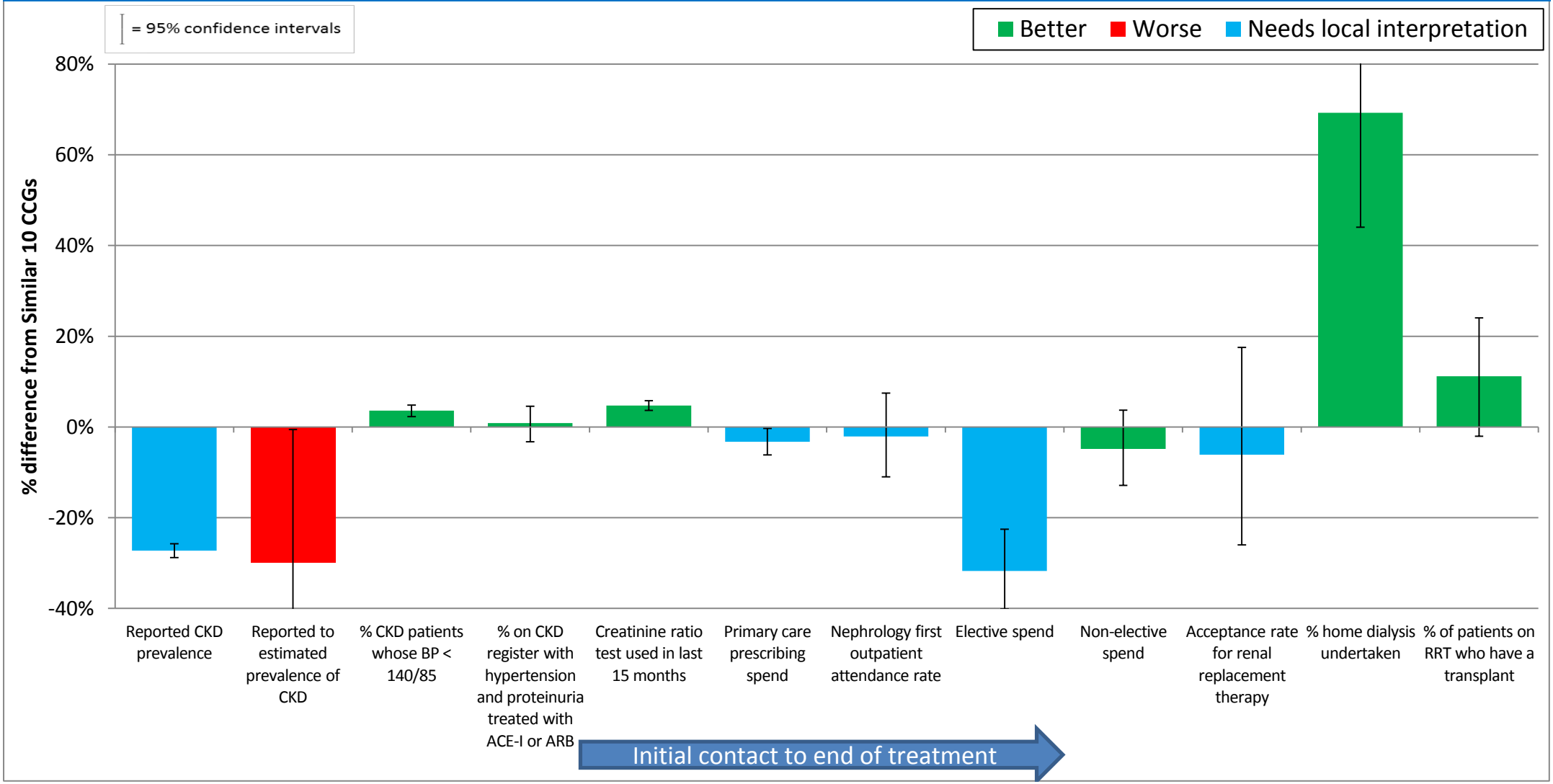
Renal pathway

NHS Stockport CCG



NICE guidance:

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

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

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Learning from others: 1

Commissioning for Value in Hardwick CCG: From pack to delivery in just seven months

Hardwick CCG received their initial Commissioning for Value pack, adopted the NHS Right Care approach, commissioned a deep dive in to COPD, engaged clinicians to identify improvement opportunities and are now implementing:

- Locally agreed and specified COPD pathway
- Enhanced nebulisers service in primary care
- Primary care COPD audit and support service to implement findings practice by practice
- Improved promotion of self-management
- Improved self-management support
- Enhanced organisation of Breathe Easy Groups (with British Lung Foundation)

In just seven months they have delivered:

- 30% reduction in emergency admissions
- £170,000 saving (just from initial impact – much more to come)

These are summarised examples of what others have done since the first Commissioning for Value pack.
See www.rightcare.nhs.uk/resourcecentre for full case studies.

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Learning from others: 2

Commissioning for Value in Slough CCG: Diabetes

"The Right Care methodology has been successfully applied to the management of diabetes in Slough"

Slough CCG

Following primary care pathway reform:

- Of patients with pre-diabetes whose results are available for evaluation, 100% saw a reduction in their HbA1c levels
- Of the patients with type 2 diabetes, 89% saw a reduction in their HbA1c levels
- 15 out of 16 practices showed an increase in the number of patients whose diabetes was controlled
- 15 out of 16 practices saw an increase from 72.25% to 80.06% of patients whose blood pressure was <140/80

Next step: Spread the use of the methodology across whole diabetes system and beyond

These are summarised examples of what others have done since the first Commissioning for Value pack. See www.rightcare.nhs.uk/resourcecentre for full case studies.

Next steps

CCGs may wish to consider the following next steps:

- Identify the priority programmes in your pack 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
- Link with the planning round and discuss at governing body and Health and Wellbeing Board level: Design optimal system – make case – decide – deliver
- Explore the Commissioning for Value online tool and compare your data with that of your peers. Re-visit regularly to explore the updates at http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
- Explore other resources, such as the 'how to' videos, deep dive guide, CVD Intelligence Network focus pack and NICE resources. See the NHS Right Care website at http://www.rightcare.nhs.uk/ for links.
- Commission a deep dive pack. If CVD is your priority area, use the CVD focus packs at http://www.yhpho.org.uk/default.aspx?RID=199884
- Identify local support to move on to phase 2 of the NHS Right Care approach: *What to Change.* Work with local transformation teams to support and deliver service redesign as captured in the principles of phase 3 of the NHS Right Care approach: *How to Change*

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Coming soon

We will be following up this set of packs with further products from the Commissioning for Value programme over the coming months. These will include:

- A set of Integrated Care packs (March 2015). These packs will include analysis to help commissioners understand how their most complex patients flow through the system and how the characteristics of these patients differ from similar CCGs, for example:
  - How many admissions to hospital the most complex patients have each year and how does this compare to similar CCGs?
  - How does the age structure of the most complex patients compare to similar CCGs?
  - What healthcare conditions do these patients have; what are the most common co-morbidities?
- A series of regional events for CCGs, area teams, CSUs, public health leads and other stakeholders (March 2015). These will take place across the country and help attendees work through their packs, better understand the data, meet CCGs with similar issues and suggest next steps
- New resources on the NHS Right Care resource centre, including new learning videos, casebooks and a handbook on the NHS Right Care approach. Find them at: http://www.rightcare.nhs.uk/
- A compendium Atlas of Variation aimed at reducing unwarranted variation across the main programmes of care (March 2015)
- A handbook on conducting 'deep dives' for prioritised pathways
- Updates to the Commissioning for Value online tools at http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value

Further support and information

The Commissioning for Value benchmarking tool (containing all the data used to create the CCG packs), full details of all the data used, and links to other useful tools are available online at: http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/

The NHS Right Care 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
- Tried and tested process templates
- Advice on how to produce 'deep dive' packs locally

These can be found at: http://www.rightcare.nhs.uk/index.php/commissioning-for-value/

The NHS England Learning Environment which includes a directory of support offers; a case study pinboard; and a peer-to-peer learning exchange can be found at: https://learnenv.england.nhs.uk/

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

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Annex: Full list of indicators

Breast Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Breast Cancer Prevalence (%)
Incidence of breast cancer per 100,000 population (all ages)
Rate of alcohol attributable admissions for breast cancer per 100,000 females aged 15+
% of women aged 50 - 70 screened for breast cancer in last three years
Spend on primary care prescribing for breast cancer per 1,000 weighted population
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for breast cancer per 1,000 population
% of breast cancers detected at an early stage (1 or 2)
Mortality from breast cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Lower Gastro Intestinal Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Colorectal Cancer Prevalence (%)
Incidence of colorectal cancer per 100,000 population (all ages)
Rate of alcohol attributable admissions for colorectal cancer per 100,000 population
% of people aged 60-69 who were screened for bowel cancer in the previous 30 months
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for lower GI cancer per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for lower GI cancer per 1,000 population
% of colorectal cancers detected at an early stage (1 or 2)
Mortality from colorectal cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Lung Cancer

Socioeconomic deprivation: overall Index of Multiple Deprivation score
Lung Cancer Prevalence (%)
Incidence of lung cancer per 100,000 population (all ages)
Smoking prevalence (%)
Smoking quit rates (successful quitters), per 100,000 population aged 16+
Rate of urgent GP referrals for suspected cancer per 100,000 population
% receiving first definitive treatment within two months of urgent referral from GP
Spend on elective and day-case admissions for lung cancer per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for lung cancer per 1,000 population
% of lung cancers detected at an early stage (1 or 2)
Mortality from lung cancer: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
One year net cancer survival (%) for breast, lung and colorectal cancers for ages 15-99

Annex: Full list of indicators (continued)

Diabetes

Diabetes Prevalence (%)
% of all diabetes patients meeting all three treatment targets (for cholesterol, blood pressure and HbA1c)
% of all diabetes patients receiving eight care processes
% of all diabetes patients having retinal screening in the previous 15 months (DM21)
Spend on primary care prescribing for diabetes per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for diabetes per 1000 population
Additional risk of complication for myocardial infarction among people with diabetes (%)
Additional risk of complication for heart failure among people with diabetes (%)
Additional risk of complication for stroke among people with diabetes (%)

Psychosis

Psychotic Disorder: estimated % of people aged 16+
New cases of psychosis: estimated incidence per 100,000 aged 16-64
GP prescribing of drugs for psychoses and related disorders: items per 1,000 population
Physical health checks for patients with Serious Mental Illness: summary score (average of the 6 physical health check indicators)
The number of people on Care Programme Approach per 100,000 population aged 18+
Mental health admissions to hospital: Rate per 100,000 population aged 18+
The number of people subject to the Mental Health Act per 100,000 population aged 18+
Social care mental health clients in residential care or receiving home care aged 18-64: Rate per 100,000 population
% of people aged 18-69 on Care Program Approach in employment
Excess under 75 mortality in adults with serious mental illness: standardised mortality ratio (%)

Common Mental Health Disorders

Socioeconomic deprivation: overall Index of Multiple Deprivation score
% of the total population with a limiting long term illness or disability
People estimated to have any common mental health disorder: estimated % of population aged 16-74
Depression Prevalence aged 18+ (%)
New cases of depression: adults with a new diagnosis of depression as % of all adults on the GP register
% of new cases of depression in the previous year who had an assessment of severity using an assessment tool validated for use in primary care (DEP06)
Antidepressant prescribing: Average daily quantities (ADQs) per STAR-PU
Access to Improving Access to Psychological Therapies (IAPT) services: People entering IAPT services as a % of those estimated to have anxiety/depression
Waiting < 28 days for IAPT: % of referrals (in month) waiting <28 days for first treatment
Completion of IAPT treatment: Rate completing treatment per 100,000 population aged 18+
% of IAPT patients receiving a course of treatment
% of IAPT patients given a provisional diagnosis
% of IAPT referrals with treatment outcome measured
% of people who are "moving to recovery" of those who have completed IAPT treatment
IAPT reliable recovery: % of people who have completed IAPT treatment who achieved "reliable improvement"
The number of people in contact with secondary care for a common mental health condition per 100,000 population aged 18+

Annex: Full list of indicators (continued)

Heart Disease

Coronary Heart Disease (CHD) Prevalence (%)
Hypertension Prevalence (%)
Reported to estimated prevalence of CHD (%)
Reported to estimated prevalence of hypertension (%)
Smoking prevalence (%)
% of patients with CHD whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (CHD 06)
% of patients with CHD whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (CHD 08)
% of patients with hypertension whose last blood pressure reading (as measured within the last 9 months) is 150/90 or less (BP 05)
Spend on primary care prescribing for CHD per 1,000 weighted population
Spend on elective and day-case admissions for CHD per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for CHD per 1000 population
Mortality from CHD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population
Mortality from acute MI: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

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Stroke

Stroke or Transient Ischaemic Attack (TIA) Prevalence (%)
% of patients with stroke or TIA whose last blood pressure reading (as measured within the last 15 months) is 150/90 or less (STROKE 06)
% of patients with stroke or TIA whose last measured cholesterol (as measured within the last 15 months) is 5 mmol/l or less (STROKE 08)
% of patients with a non-haemorrhagic stroke or TIA with a record that an anti-platelet agent (aspirin etc) or an anti-coagulant is being taken (STROKE 12)
% of patients with atrial fibrilliation in whom the risk of stroke has been assessed using CHADS2 in the previous 15 months (AF 05)
Spend on primary care prescribing for cerebrovascular disease per 1,000 weighted population
% of TIA cases with a higher risk who are treated within 24 hours
% of patients admitted to hospital following a stroke who spend 90% of their time on a stroke unit
Spend on elective and day-case admissions for cerebrovascular disease per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for cerebrovascular disease per 1,000 population
Emergency readmissions to hospital within 28 days for patients: stroke (%)
% of patients returning to usual place of residence following hospital treatment for stroke
Mortality from stroke: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

COPD

Chronic Obstructive Pulmonary Disease (COPD) Prevalence (%)
Reported to estimated prevalence of COPD (%)
% of COPD patients with a record of FEV1 in the preceding 15 months (COPD 10)
% of COPD patients having had a review in the previous 15 months (COPD 13)
Spend on primary care prescribing for Obstructive Airways Disease per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for Obstructive Airways Disease per 1,000 population
Mortality from bronchitis and emphysema and COPD: under 75 directly age-standardised rates (DSR) per 100,000 European Standard Population

Annex: Full list of indicators (continued)

Asthma

Asthma Prevalence (%)
% of patients aged 8 years and over diagnosed as having asthma from 1st April 2006 with measures of variability or reversibility (ASTHMA 08)
% of asthma patients who have had a review in the preceding 15 months (ASTHMA 09)
Spend on primary care prescribing for asthma per 1,000 weighted population
Spend on non-elective (emergency and other non-elective) admissions for asthma per 1,000 population
Emergency admission rate for children with asthma per 100,000 population aged 0–18 years
Mortality from asthma: all age directly age-standardised rates (DSR) per 100,000 European Standard Population

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Musculoskeletal

% of people (over 45) who have hip osteoarthritis (total)
% of people (over 45) who have knee osteoarthritis (total)
% of people (over 45) who have hip osteoarthritis (severe)
% of people (over 45) who have knee osteoarthritis (severe)
Primary hip replacements per 100,000 population
Primary knee replacements per 100,000 population
% of patients aged between 50-74 years with a fragility fracture in whom osteoporosis is confirmed in a DXA scan who are currently treated with an appropriate bone-sparing agent (OST 02)
% of patients aged 75+ years with a fragility fracture scan who are currently treated with an appropriate bone-sparing agent (OST 03)
Spend on primary care prescribing for Musculoskeletal problems per 1,000 weighted population
Pre-treatment EQ-5D Index: hip replacement
Pre-treatment EQ-5D Index: knee replacement
Spend on elective and day-case admissions for Musculoskeletal problems per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for Musculoskeletal problems per 1,000 population
Health Gain EQ-5D Index: hip replacement
Health Gain EQ-5D Index: knee replacement
Emergency readmissions to hospital within 28 days for patients: hip replacements (%)

Trauma & Injury

Injuries due to falls per 100,000 population aged 65+
Hospital admissions caused by unintentional and deliberate injury for those aged 0-24 per 10,000 population
Rate of all fracture admissions per 1,000 population aged 65+
Hip fractures per 100,000 population aged 65+
Hip fractures per 100,000 population aged 65 -79
Hip fractures per 100,000 population aged 80+
Spend on primary care prescribing for Trauma and Injuries per 1,000 weighted population
Spend on elective and day-case admissions for Trauma and Injuries per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for Trauma and Injuries per 1,000 population
% of patients returning to usual place of residence following hospital treatment for fractured femur
Emergency readmissions to hospital within 28 days for patients: hip fractures
Mortality from accidents: all age directly age-standardised rates (DSR) per 100,000 European Standard Population

Annex: Full list of indicators (continued)

Renal

Chronic Kidney Disease (CKD) Prevalence (%)
Reported to estimated prevalence of CKD (%)
% of patients on CKD register, whom the last blood pressure reading, measured in the preceding 15 months, is 140/85 or less (CKD03)
% of patients on the CKD register with hypertension and proteinuria who are treated with an angiotensin converting enzyme inhibitor (ACE-I) or angiotensin receptor blocker (ARB) (unless a contraindication or side effects are recorded) (CKD05)
% of patients on the CKD register with a record of a urine albumin creatinine ratio test in the preceding 15 months (CKD06)
Spend on primary care prescribing for renal problems per 1,000 weighted population
Nephrology first outpatient attendances per 1,000 population
Spend on elective and day-case admissions for renal problems per 1,000 population
Spend on non-elective (emergency and other non-elective) admissions for renal problems per 1,000 population
Number of people accepted onto Renal Replacement Therapy per 1,000,000 population
% of people receiving dialysis undertaking dialysis at home
% of patients on Renal Replacement Therapy who have a kidney transplant