CCG Outcome Indicator Set:

Indicator 1.8
Emergency admissions for alcohol related liver disease

Domain 1
Preventing people from dying prematurely

Indicator quality statement

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Introduction

Context for the indicator quality statement

This indicator quality statement accompanies the Official Statistics release of the Clinical Commissioning Group (CCG) Indicator 1.8 – Emergency admissions for alcohol related liver disease.

Additional information can be found on the NHS Digital website: http://www.digital.nhs.uk

The following data source has been used to construct this indicator:

- Hospital Episode Statistics Admitted Patient Care (HES APC): https://digital.nhs.uk/hes
- Registered patient counts (National Health Application & Infrastructure Services (NHAIS), commonly known as 'Exeter’ System): https://digital.nhs.uk/services/nhais
- European Standard Population 2013

This indicator requires careful interpretation and should not be viewed in isolation, but instead be considered alongside information from other indicators and alternative sources such as patient feedback, staff surveys and similar material. When evaluated together, these will help to provide a holistic view of CCG outcomes and provide a more complete overview of the impact of the CCGs’ processes on outcomes.

This indicator has been assured through the Indicator Methodology Assurance Service which is managed by NHS Digital on behalf of the wider Health and Social Care system. Under the regulations within the Health and Social Care Act, a national database of quality assured indicators has been established. Indicators registered in the database must have been firstly appraised under the assurance process.

The full indicator methodology is set out in the accompanying Specification document.

Relevance

The degree to which the statistical product meets user needs in both coverage and content

The intended audience for the indicator is CCGs, the Department of Health and Social Care, provider managers, commissioning managers, clinicians, patients and the public.

This indicator forms part of Domain 1 - Preventing people from dying prematurely and is intended to act as a proxy for the overall management of alcohol related liver disease. Some, but not all admissions for liver disease, may be potentially avoidable by high quality management in primary care. 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 otherwise avoidable clinical risks such as health care acquired infections.
How actionable is the indicator?
It is expected that CCGs will use this to identify how improvements in care and the desired reduction in emergency hospital admissions will be delivered.

**Accuracy and Reliability**

How well the information is recorded and transmitted, and, where applicable, the proximity between and estimate and the unknown true value.

Data quality for both the numerator (HES APC) and denominator (NHAIS (Exeter)) is considered to be good. Further information can be found at:

- NHAIS (Exeter) Systems: https://digital.nhs.uk/services/nhais

The indicator is a rate per 100,000 registered patients directly standardised by age and sex using the European Standard Population 2013 for the population standard. The indicator is published with 95% confidence intervals recognising the existence of natural variation between the CCG patient lists.

**Timeliness and Punctuality**

**Timeliness** refers to the time gap between publication and the reference period. **Punctuality** refers to the gap between planned and actual publication dates.

Data will be reported quarterly, on a rolling annual basis. 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 three months in arrears due to HES processing and quality controls. The final annual HES data will be reported approximately nine months in arrears (December, 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. APC Data Quality notes are available via the following link: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics/the-processing-cycle-and-hes-data-quality

Reporting periods are broken down as follows:

- **Q1**: July to June. Comprised of July to March (final) and April to June (provisional). The finalised annual figures for the previous year – April to March (final) are also released at this time.
Q2: October to September. Comprised of October to March (final) and April to September (provisional)
Q3: January to December. Comprised of January to March (final) and April to December (provisional)
Q4: April to March. Comprised of April to March (provisional).

Finalised annual figures will be released post publication of annual HES figures by the secondary care team.

Registered patient counts are extracted from the NHAIS (Exeter) System on 1 April for the forthcoming financial year: https://digital.nhs.uk/services/nhais

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

Accessibility and Clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information.

Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

The indicators which support commissioning are available in the public domain from the NHS Digital website: http://www.digital.nhs.uk The publication includes the indicator data, the specification document and the indicator quality statement.

Coherence and Comparability

Coherence is the degree to which data that are derived from different sources or methods, but refer to the same topic, are similar.

Comparability is the degree to which data can be compared over time and domain.

As of the March 2020 release, the data included in the December 2019 publication for the 2018/19, July 2018 to June 2019 (Provisional) and October 2018 to September 2019 (Provisional) data periods has been revised. This is due to a revision of a large proportion of records for East Sussex Healthcare NHS Trust (RXC) which had missing information for the condition the patient was in hospital for and other conditions the patients suffer from. The revised data for these reporting periods also differs from that originally published in December 2019 in that the HES database is routinely updated (overwritten) on a monthly basis for the year in progress. Data for the two provisional periods remain provisional, but is now more complete than it was when the December 2019 publication was released. This effect cannot be readily separated from the effect of the East Sussex Healthcare NHS Trust (RXC) resubmission which
also took place after processing for the December 2019 publication.

As of the December 2018 release the standard population used to calculate the indicator has changed to the European Standard Population 2013. As a result of this change data from previous releases are not directly comparable to releases from December 2018 onwards.

The number of CCGs reported on has changed within the time series because some CCGs have merged. Data reported on prior to the merge will include the old CCGs whereas data reported on after the merge will include the new merged CCG.

NHS Gateshead CCG (00F), NHS Newcastle North and East CCG (00G) and NHS Newcastle West CCG (00H) merged to form NHS Newcastle Gateshead CCG (13T) in the 2014/15 data onwards.

NHS Central Manchester CCG (00W), NHS North Manchester CCG (01M), NHS South Manchester CCG (01N) merged to form NHS Manchester CCG (14L) in 2017/18 data onwards.

NHS Bristol CCG (11H), NHS North Somerset CCG (11T) and NHS South Gloucestershire CCG (12A) merged to form NHS Bristol, North Somerset and South Gloucestershire CCG (15C) in the 2018/19 data onwards.

NHS Leeds North CCG (02V), NHS Leeds South & East CCG (03G) and NHS Leeds West CCG (03C) merged to form NHS Leeds CCG (15F) in the 2018/19 data onwards.

NHS Newbury & District CCG (10M), NHS North & West Reading CCG (10N), NHS South Reading CCG (10W) and NHS Wokingham CCG (11D) merged to form NHS Berkshire West CCG (15A) in the 2018/19 data onwards.

NHS Bracknell & Ascot CCG (10G), NHS Slough CCG (10T) and NHS Windsor, Ascot & Maidenhead CCG (11C) merged to form NHS East Berkshire CCG (15D) in the 2018/19 data onwards.

NHS Aylesbury Vale CCG (10Y) and NHS Chiltern CCG (10H) merged to form NHS Buckinghamshire CCG (14Y) in the 2018/19 data onwards.

NHS Birmingham Cross City CCG (13P), NHS Birmingham South and Central CCG (04X) and NHS Solihull CCG (05P) merged to form NHS Birmingham and Solihull CCG (15E) in the 2018/19 data onwards.

NHS Erewash CCG (03X), NHS Hardwick CCG (03Y), NHS North Derbyshire CCG (04J), NHS Southern Derbyshire (04R) merged to form NHS Derby and Derbyshire CCG (15M) in the 2019/20 data onwards.

NHS Northern, Eastern and Western Devon CCG (99P) and NHS South Devon and Torbay CCG (99Q) merged to form NHS Devon CCG (15N) in the 2019/20 data onwards.

There are no directly comparable indicators although indicator 13.13 in the Local Basket Of Inequality Indicators (LBOI) reports the rate of persons admitted to hospital with conditions directly related to the consumption of alcohol.

This indicator was constructed following consultation with clinical experts and the condition of alcoholic liver disease was approved by the research directorate and
Trade-offs between Output Quality Components

Trade-offs are the extent to which different aspects of quality are balanced against each other.

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 (patient feedback, staff surveys and other such material) 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. 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.

5. 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.

6. There may be local variation in data quality, particularly in terms of diagnostic and procedure coding.

7. 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.

Recommended improvements for future development
At present, there are no plans for any further disaggregations of the data.

Assessment of User Needs and Perceptions

The processes for finding out about users and uses, and their views on the statistical products.

Comments can be made through various media, including NHS Digital general enquiries by email enquiries@nhsdigital.nhs.uk or by telephone 0300 303 5678.

As well as initially assuring the quality and methodology of this indicator, NHS Digital’s Indicator Methodology 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.

**Performance, Cost and Respondent Burden**

The effectiveness, efficiency and economy of the statistical output. This indicator makes use of an existing data collection, so there are no additional data collection cost implications or burden.
Confidentiality, Transparency and Security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

This publication is subject to a standard NHS Digital risk assessment prior to issue. Disclosure control is implemented where judged necessary.

The indicator is calculated following the HES suppression rules. Where the indicator is calculated from a numerator or denominator between one and seven, the value is suppressed and replaced with an ‘*’. This is in order to protect against the potential for disclosing the identity of an individual.

At CCG level numerator values are rounded to the nearest five.

Detailed methodology specification documents and other supporting material are available on the NHS Digital website.

The UK Statistics Authority’s Code of Practice for Statistics is followed regarding security and release of information prior to publication:
https://wwwstatisticsauthority.gov.uk/code-of-practice/the-code/