



METHODS



**Technical Guidance for  
Surgical Specialty Quality Dashboard:  
Plastics: Breast Reduction  
Surgery**

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V1.1



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## 1. Introduction

The Surgical Specialty Quality Dashboards have been created by Methods Insight Analytics working in partnership with the Royal College of Surgeons England and NHS England. The dashboards are to support commissioning guidance for specific surgical pathways and are provided for each Clinical Commissioning Group (CCG) in England. The data is for patients who have received treatment for interventions that have been agreed in consultation with the relevant clinical reference groups and is analysed on various indicators benchmarking against the national mean.

Each intervention is defined by a combination of ICD-10 diagnosis codes and OPCS 4.6 procedure codes. One or many of each of these can be used to determine patients who have been treated for each intervention.

### Spell Identification

Methods have employed a methodology of counting unique SPELL\_Identifier fields to pull back records from any episode where a patient has had an intervention. This ensures that we do not count multiple occurrences of an operation where it is coded in multiple episodes.



## 2. Dashboard Guidance

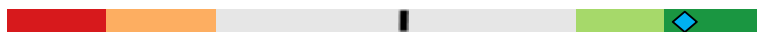
### 2.1. Spine Charts



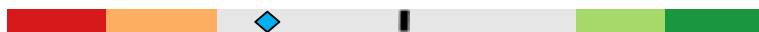
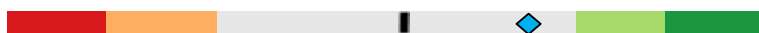
1. If an organisation is in this range their rate is much worse than expected by chance (99.8% or 3SD)
2. If an organisation is in this range their rate is worse than expected by chance (2SD or 95%)
3. If an organisation is in this range their rate is in the normal range of variation
4. The diamond represents the value for the organisation.
5. The vertical bar represents the average value for all acute Organisations in England
6. If an organisation is in this range their rate is better than expected by chance (2SD or 95%)
7. If an organisation is in this range their rate is much better than expected by chance (99.8% or 3SD)

Please note the scale of each chart is dynamic to show a range that enables each measure to be viewed clearly for the organisation in question.

The chart below shows an organisation whose performance on this indicator is better than the national picture by a degree that is unlikely to be explained by random chance



The two charts below show an organisation whose performance on this indicator does not differ from the national picture by more than can be explained by random chance.



The chart below shows an organisation whose performance on this indicator is worse than the national picture by a degree that is unlikely to be explained by random chance.



The chart below is for an indicator that does not have a desired direction for improvement. The Organisation shown in this example is within the expected range based on the national picture.





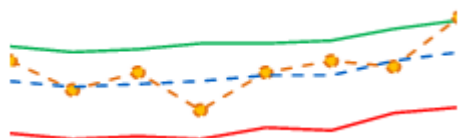
## 2.2. Notes on statistical process control

These charts are constructed using statistical process control (SPC) principles and use control limits to indicate variation from the national mean. The display shows both two standard deviation (95%) control limits and three standard deviation (99.8%) control limits. Values within these limits (the light grey section) are said to display 'normal cause variation' in that variation from the mean can be considered to be random. Values outside these limits (in the light green or orange sections) are said to display 'special cause variation' at a two standard deviation level, and a cause other than random chance should be considered. Values outside these sections (in the dark green or red sections) also display 'special cause variation' but against a more stringent test.

Variation at the two standard deviation level can be considered to raise an alert, and variation at the three standard deviation level to raise an alarm.

## 2.3. Time series charts

Methods use a 'sparkline' chart combined with SPC methodology to create an SPC sparkline. This shows how an organisation varies on a quality indicator over time and how it compares to national control limits over time.



The upper 3SD limit in this chart is shown as a green line which represents the highest expected quality of commissioned care for the indicator.

The lower 3SD limit in this chart is shown as a red line which represents the lowest expected quality of commissioned care for the indicator.

The actual values for the selected organisation is represented by the orange line and round data points.

The NHS England average (mean) value is represented by the dotted blue line.

The organisation in the example chart above was within national expected range for the last 7 quarters but improved the quality of the outcome measure so much that they had commissioned better than expected outcomes during the most recent quarter.



## 2.4. Directly Standardised Activity Rates

Activity may vary widely by age. Such variation complicates any comparisons made between two populations that have different age structures. For example, consider two areas A and B with equal-sized populations and identical activity rates. At first glance they appear to be the same.

Suppose, however, that area A has a younger age structure than area B. Given that there is likely to be an increase in the number of interventions required with age, one would expect the older population in area B to show a higher rate of activity.

The most comprehensive way of comparing the activity rate of two populations is to present and compare their age-specific activity. However, when the number of populations being compared increases, the volume of data that needs to be considered quickly becomes unmanageable. What is needed is a single, easily interpreted, summary figure for each population that is adjusted to take into account its age structure. Such summary figures are calculated using age standardisation methods. It may also be desirable to standardise for other variables, such as sex or level of deprivation that may also potentially confound any comparisons.

For directly standardised rates the age-specific rates of the subject population are applied to the age structure of the standard population. This gives the overall rate that would have occurred in the subject population if it had the standard age-profile.



### 3. The Indicators

#### 3.1. Directly Standardised Activity Rate per 100000 population

|              |  |
|--------------|--|
| Numerator:   | Standard age/sex population x Rate of elective activity per 100000 population for same age/sex group         |
| Denominator: | Standard age/sex population  |
| Methodology: | Rate per 100000 population   |
| Data Source: | HES (Hospital Episode Statistics)<br>ONS: GP practice population age/sex 5 year age bands                    |
| Frequency:   | Quarterly  |
| Note:        | DISCH_DATE IS NOT NULL<br>ADMIMETH IN ('11','12','13')<br>Gender_Code IN ('1','2')<br>[Episode Number] = '1' |

#### 3.2. Average Length of Stay (Days)

|              |   |
|--------------|---|
| Numerator:   | Number of elective bed days (excluding daycase)   |
| Denominator: | Number of elective spells (excluding daycase)   |
| Methodology: | Average   |
| Data Source: | HES (Hospital Episode Statistics)   |
| Frequency:   | Quarterly   |
| Note:        | DISCH_DATE IS NOT NULL<br>ADMIMETH IN ('11','12','13')<br>CLASSPAT <> '2'<br>[Episode Number] = '1' |



### 3.3. 7/30 day Re-admission Rate (%)

Numerator: Total number of emergency re-admissions within 7/30 days of discharge

Denominator: Total number of discharges following an elective admission

Methodology: Percentage

Data Source: HES (Hospital Episode Statistics)

Frequency: Quarterly

Note: Discharge Episodes:  
DISCH\_DATE IS NOT NULL  
[Last Episode in Spell Indicator] = '1'  
CLASSPAT = '1'  
DISMETH <> '4'  
DISCH\_DATE IS NOT NULL  
ADMIMETH IN ('11','12','13')  
Admission Episodes:  
[Episode Number] = '1'  
CLASSPAT = '1'  
ADMIMETH IN ('21','22','23','24','28')

### 3.4. Re-operations within 30 days (%)

Numerator: Total number of re-operations within 30 days of discharge

Denominator: Total number of discharges following an elective admission

Methodology: Percentage

Data Source: HES (Hospital Episode Statistics)

Frequency: Quarterly

Note: Discharge Episodes:  
DISCH\_DATE IS NOT NULL  
[Last Episode in Spell Indicator] = '1'





CLASSPAT = '1'

DISMETH <> '4'

DISCH\_DATE IS NOT NULL

ADMIMETH IN ('11','12','13')

Admission Episodes:

[Episode Number] = '1'

CLASSPAT = '1'

### 3.5. Day case Rates (%)

Numerator: Number of elective procedures carried out as a daycase

Denominator: Total number of elective procedures carried out

Methodology: Percentage

Data Source: HES (Hospital Episode Statistics)

Frequency: Quarterly

Note: DISCH\_DATE IS NOT NULL

ADMIMETH IN ('11','12','13')

[Episode Number] = '1'



## 4. Interventions and Code Sets

### 4.1. Breast Reduction Surgery (not cancer)

#### Primary OPCS:

B31.1: Reduction mammoplasty

#### Secondary OPCS: (will be included after any Primary OPSC)

##### Bilateral:

Z94.1: Bilateral operation or

Z94.2: Right sided operation and Z94.3: Left sided operation

##### Unilateral:

Z94.2: Right sided operation or

Z94.3: Left sided operation or

Z94.4: Unilateral operation

#### Primary ICD-10:

N62: Hypertrophy of breast

Q83.0: Congenital absence of breast with absent nipple

Q83.8: Other congenital malformations of breast

Z41.1: Other plastic surgery for unacceptable cosmetic appearance