Technical Guidance for the 2012/13 Operating Framework

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Technical Guidance for the 2012/13 Operating Framework

Prepared by Knowledge & Intelligence Branch

Contents

Executive summary

The purpose of this Technical Guidance is to describe the indicators in the Integrated Performance Measures in the NHS Operating Framework for 2012/13, and to set out for each measure:

- Definitions
- Monitoring Arrangements
- Accountability Expectations
- Planning Requirements, if applicable
- Further Information

PHQ01: Ambulance Clinical Quality- Category A 8 Minute Response Time

DEFINITIONS

Detailed Descriptor:

Improved health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls

Lines within Indicator (Units):

Numerator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Denominator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene.

Data Definition:

Numerator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less.

Denominator:
The total number of Category A incidents, which resulted in an emergency response arriving at the scene. If there have been multiple calls to a single incident, only one incident should be recorded.

Category A incidents: presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases. The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Ambulance Computer Aided Dispatch system

Monthly data collected via Unify

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.

Category A incidents: presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.

Timeframe/Baseline:

Ambulance services should aim for continuous improvement on these indicators and monitor as long a time series as possible (24 continuous months is preferable). In addition to comparing current performance with performance in the immediately preceding periods, services may also find it helpful to compare current performance against a baseline of activity in the same period in the previous year. This will allow services to place current performance in context, and stimulate discussion on how to continuously improve.

When comparing current performance with historical performance care should be taken to assess how much of the observed change in activity or performance is affected by changes in the coverage and quality of the data

Timeframe Until:

Ongoing

Rationale:

Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further guidance on all indicators included in the Ambulance Quality Indicators collection can be found on the Department of Health website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm
Changes from 2011/12 Planning Round:
This was an indicator (HQU03_01) in the 2011/12 planning round.

PHQ02: Ambulance Clinical Quality- Category A 19 Minute Transportation Time

DEFINITIONS

Detailed Descriptor:

Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene which is able to transport the patient in a clinically safe manner, if they require such a response.

Lines within Indicator (Units):

Numerator: The total number of calls resulting in an ambulance arriving at the scene of the incident within 19 minutes.

Denominator: The total number of Category A incidents with ambulance response arriving

Data Definition:

Numerator: The total number of Category A incidents, which resulted in a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner arriving at the scene within 19 minutes of the request being made

Denominator: The total number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident

Category A incidents: presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases.

The "clock stops" when the first emergency response vehicle able to transport the patient arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room.

Basis for Accountability:

This data will be reported for all Ambulance Trusts at a Trust-wide level

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Ambulance Computer Aided Dispatch system

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions. Category A incidents: presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases.
Timeframe/Baseline:
Ambulance services should aim for continuous improvement on these indicators and monitor as long a time series as possible (24 continuous months is preferable). In addition to comparing current performance with performance in the immediately preceding periods, services may also find it helpful to compare current performance against a baseline of activity in the same period in the previous year. This will allow services to place current performance in context, and stimulate discussion on how to continuously improve. When comparing current performance with historical performance care should be taken to assess how much of the observed change in activity or performance is affected by changes in the coverage and quality of the data"
Timeframe Until:
Ongoing
Rationale:
Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene which is able to transport the patient in a clinically safe manner, if they require such a response.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Further guidance on all indicators included in the Ambulance Quality Indicators collection can be found on the Department of Health website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm
Changes from 2011/12 Planning Round:
This was an indicator (HQU03_02) in the 2011/12 planning round.

PHQ03-05: Cancer 62 Day Waits (aggregate measure)

DEFINITIONS

Detailed Descriptor:

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

PHQ04: Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service.

PHQ05: Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.

Lines within Indicator (Units):

PHQ03: All Cancer Two Month Urgent Referral to Treatment Wait

Denominator:	Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period, for all cancers (ICD-10 C00 to C97 and D05)
Numerator:	Number of patients receiving first definitive treatment for cancer within 62-days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period, for all cancers (ICD-10 C00 to C97 and D05)

PHQ04: 62-Day Wait for First Treatment Following Referral from an NHS Cancer Screening Service

Denominator:	Total number of patients receiving first definitive treatment for cancer following referral from an NHS Cancer Screening Service within a given period (covers any cancer ICD-10 C00 to C97 and D05)
Numerator:	Number of patients receiving first definitive treatment for cancer within 62-days following referral from an NHS Cancer Screening Service during a given period (covers any cancer ICD-10 C00 to C97 and D05)

PHQ05: 62-Day Wait for First Treatment For Cancer Following a Consultants Decision to Upgrade The Patient's Priority

Denominator:	Total number of patients receiving first definitive treatment for cancer following a consultant decision to upgrade their priority status within a given period
Numerator:	Number of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.
Scope:	Patients included in this indicator will not have been referred

	urgently for suspected cancer by their GP or referred with suspected cancer from an NHS Cancer Screening Service with suspected cancer (routine referrals from these services where cancer was not initially suspected may be upgraded).

Data Definition:

Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008. A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf

The Department of Health is currently carrying out maintenance of the NCWTMDS, these developments may impact on the format of the required dataflow. Any changes will be communicated to the NHS if approved by the Information Standards Board for Health and Social Care.

Basis for Accountability:

Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING

Monitoring Frequency:

Monthly and Quarterly

Monitoring Data Source:

Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

PHQ03 - 04

Performance is to be sustained at or above the published operational standard

Details of current operational standards are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_103436

PHQ05

There is no current operational standard for this component, therefore this will not be

centrally reported against a set threshold. These performance data will however be monitored by the Department and published as national statistics.

Timeframe/Baseline:

Not Applicable

Timeframe Until:

Ongoing

Rationale:

Maintaining these standards will ensure that a cancer patient will receive timely access to treatment and move along their pathway of care at a clinically appropriate pace, thus providing better patient-centred care and improve cancer outcomes.

SHA Envelopes:

No

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

The All Cancer Two Month Standard was introduced by the NHS Cancer Plan (2000), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The 62-day wait for first treatment following referral from an NHS Screening Service was introduced by the Cancer Reform Strategy (2007), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

The 62-day standard was extended to include those patients whose priority is upgraded by the consultant responsible for their care in the same document.

As part of the development of Improving Outcomes: a Strategy for Cancer(2011) a

Review of Waiting Times Standards was undertaken which confirmed that these standards should be retained due to their benefits for patients. Both these documents are available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at: cancer-waits@dh.gsi.gov.uk

Changes from 2011/12 Planning Round:

The construction of indicator is unchanged from 2011/12 though it has been renumbered and the supporting text made more explicit.

PHQ 06-09: Cancer 31 Waits

DEFINITIONS

Detailed Descriptor:

Cancer 31 day waits-

Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (PHQ06)

Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (PHQ 07), an Anti-Cancer Drug Regimen (PHQ 08) or a Radiotherapy Treatment Course (PHQ 09).

Lines within Indicator (Units):

PHQ06: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')

Denominator:	Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)
Numerator:	Number of patients receiving first definitive treatment for cancer within 31 days of receiving a diagnosis (decision to treat) within a given period for all cancers (ICD-10 C00 to C97 and D05)

PHQ 07: 31-Day Standard for Subsequent Cancer Treatments-Surgery

Denominator:	Total number of patients receiving subsequent surgery within a given period, including patients with recurrent cancer.
Numerator:	Number of patients receiving subsequent surgery within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.
Scope:	Those treatments classified as "Surgery" within DSCN 20/2008

PHQ 08: 31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens

Denominator:	Total number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a given period, including patients with recurrent cancer.
Numerator:	Number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.
Scope:	Using the definitions published in DSCN 20/2008 "Anti Cancer Drug Regimens" might include: Cytotoxic Chemotherapy, Immunotherapy, Hormone Therapy and other and unspecified

drug treatments.

PHQ 09: 31-Day Standard for Subsequent Cancer Treatments-Radiotherapy

Denominator:	Total number of patients receiving subsequent/adjuvant radiotherapy treatment within a given period, including patients with recurrent cancer.
Numerator:	Number of patients receiving subsequent/adjuvant radiotherapy treatment within a maximum waiting time of 31-days during a given period, including patients with recurrent cancer.
Scope:	Using the definitions published in DSCN 20/2008 "Radiotherapy Treatments" might include: Teletherapy (beam radiation), Brachytherapy, Chemoradiotherapy and Proton Therapy.

Data Definition:

Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008. A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf

The Department of Health is currently carrying out maintenance of the NCWTMDS, these developments may impact on the format of the required dataflow. Any changes will be communicated to the NHS if approved by the Information Standards Board for Health and Social Care.

Basis for Accountability:

Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING

Monitoring Frequency:

Monthly and Quarterly

Monitoring Data Source:

Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

PHQ 06 - 09

Performance is to be sustained at or above the published operational standard

Details of current operational standards are available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_103436

Timeframe/Baseline:

Not applicable

Timeframe Until:

Not applicable

Rationale:

Maintaining these standards will ensure that cancer patients receive all treatments within their package of care within clinically appropriate timeframes, thus providing a better patient-centred care and improve cancer outcomes.

SHA Envelopes:

No

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

The All Cancer One-Month Standard was introduced by the NHS Cancer Plan (2000), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The 31-day subsequent treatment standards (Surgery, Anti-Cancer Drug Regimen and Radiotherapy) were introduced, with different operational timings, by the Cancer Reform Strategy (2007), a copy of which is available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

As part of the development of Improving Outcomes: a Strategy for Cancer(2011) a Review of Waiting Times Standards was undertaken, this confirmed that these standards should be retained due to their benefits for patients. Both these documents are available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at:
http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at: cancer-waits@dh.gsi.gov.uk

Changes from 2011/12 Planning Round:

The construction of indicator is unchanged from 2011/12 though it has been renumbered and the supporting text made more explicit.

PHQ10: Mental Health Measure- Early Intervention in Psychosis

DEFINITIONS

Detailed Descriptor:

The number of new cases of psychosis served by early intervention teams

Lines within Indicator (Units):

The number of new patients taken on by Early Intervention teams in the year

Data Definition:

Cases of First Episode Psychosis which have been taken on by Early Intervention teams for treatment and support since 1 April 2012 to 31 March 2013. Include all new cases taken on the caseload of an EI team from 1 April to the end of the latest Quarter.

Patients who are being monitored for a limited period because they are suspected cases should not be included in this count.

Basis for Accountability:

PCT performance against SHA envelopes
MH Trust performance against plans

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

UNIFY2

ACCOUNTABILITY

What success looks like, Direction, Milestones:

An early intervention service caseload builds up over a 3 year period. The expectation is that nationally there will be 7,500 new cases yearly and patients will stay engaged over three years. Success is that locally agreed plans are met yearly.

Timeframe/Baseline:

This is a national annual expectation

Timeframe Until:
Ongoing
Rationale:
Psychosis is a debilitating illness with far-reaching implications for the individual and his/her family. It can affect all aspects of life - education and employment, relationships and social functioning, physical and mental wellbeing. Without support and adequate care, psychosis can place a heavy burden on carers, family and society at large. Early treatment is crucial because the first few years of psychosis carry the highest risk of serious physical, social and legal harm.
SHA Envelopes:
SHA envelopes are contained in the Quarterly Reports in the Unify Report Library: http://nww.unify2.dh.nhs.uk/UNIFY/reporting/library.aspx

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, for non-FT MH Trusts
Planning Frequency:
Quarterly for 2012/13
Criteria for Plan Sign-off:
None

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was an indicator (SQU13) in the 2011/12 planning round*. No change for 12/13.*

PHQ11: Mental Health Measure- Crisis Resolution Home Treatment

DEFINITIONS

Detailed Descriptor:

Crisis Resolution Home Treatment episodes and Admissions gatekept -

The number of Home Treatment Episodes and the proportion of inpatients admissions gatekept by the crisis resolution home treatment teams

Lines within Indicator (Units):

Home treatment episodes (Commissioner measure): The number of Home Treatment episodes carried by Crisis Resolution/Home Treatment teams.

Gatekeeping (Provider measure): The proportion of admissions to the Trust's acute ward that were gatekept by the crisis resolution home treatment teams

Data Definition:

Home treatment episodes: Before an episode of home treatment commences, a patient will have been assessed by the team and a decision made that home treatment is appropriate. An episode of home treatment starts on the first day on which care is delivered to the patient at home or alternative community setting (home means the current place of residence which could include, for example, hostel accommodation) and ends with discharge from the CR/HT team's care. If an assessment is made at the patient's home and a decision made to provide home treatment, this may start during the same visit. However, it can only be judged to have started if *a firm decision to provide home treatment was made* at the time of assessment *and this is followed by treatment related action or discussion* during the same visit.

This measure is a count of the total number of treatment episodes and not the number of patients who received an episode of care during the year. This means that if a single patient received two or more separate episodes of care during the year each episode can be counted separately. However a separate episode is only counted if the patient has been discharged from the previous episode (noting that the discharge date is the formal end date for an episode). In addition, for two episodes involving the same patient to count as separate episodes, there must be a minimum interval of 14 days between the **last home visit** in the first episode and the **first home visit** in the second episode. Either an assessment visit or a treatment visit counts as a first home visit.

Gatekeeping: In order to prevent hospital admissions and give support to informal carers CR/HT are required to gatekeep all admissions to psychiatry inpatients wards and facilitate early discharge of service users. An admission has been gatekept if the team has assessed the service user before admission and if they were involved in the decision-making process that resulted in admission

Numerator: The number of admissions to the trust's acute wards (see list of

exclusions/exemptions below) that were gate kept by the crisis resolution home treatment teams

Denominator: The total number of admissions to the trust's acute wards (see exclusions)

Total Exemption to CR/HT Gatekeeping

- Patients recalled on Community Treatment Order.
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the trust for psychiatry treatment.
- Patients on leave under Section 17 of the Mental Health Act.
- Planned admissions for psychiatric care from specialist units such as eating disorder units are excluded.

Partial exemption:

- Admissions from out of the trust area where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local area. CR team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by CR teams.

Reference to the “Guidance statement on fidelity and best practice for CRTeams” report should be recommended for clarity on gatekeeping and good practice.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063015

Basis for Accountability:

Commissioner measure (number of home treatment episodes) - PCTs performance measured against SHA envelopes.
Provider measure (gatekeeping admissions to all inpatient wards) - Non-FT MH trusts will be assessed against the percentage of admissions that are gate kept by crisis resolution teams

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

Commissioner measure (number of home treatment episodes): NHS Information Centre Omnibus Survey
Provider measure (Proportion of admissions gatekept): DH Knowledge and Intelligence Team Unify2

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Commissioner measure: The returns for an individual PCT should show a progressive increase from Quarter to Quarter. 100,000 home treatment episodes yearly to people who would otherwise require hospital treatment Provider Measure: Achieving at least 95% of all admissions gatekept
Timeframe/Baseline:
HT episodes is a national yearly target
Timeframe Until:
Ongoing
Rationale:
A crisis resolution home treatment team provides intensive support for people in mental health crises in their own home: they stay involved until the problem is resolved. It is designed to provide prompt and effective home treatment, including medication, in order to prevent hospital admissions and give support to informal carers. Gatekeeping admissions prevent hospital admissions and give support to informal carers. All admissions to psychiatry inpatients wards are gatekept by CR/HT teams.
SHA Envelopes:
Commissioner measure (number of home treatment episodes): SHA envelopes are contained in the Quarterly Reports in the Unify Report Library: http://nww.unify2.dh.nhs.uk/UNIFY/reporting/library.aspx

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Please see NHS Information Centre Omnibus Survey website for further information Community Activity Mental Health Collection 2010-2011 Specific Guidance http://www.ic.nhs.uk/services/omnibus-survey
Changes from 2011/12 Planning Round:

This was an indicator (SQU14) in the 2011/12 planning round.

PHQ12: Mental Health Measure- Care Programme Approach (CPA)

DEFINITIONS

Detailed Descriptor:

Care Programme Approach (CPA) 7 day follow up-

The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days

Lines within Indicator (Units):

The indicator is the numerator divided by the denominator, expressed as a percentage

Numerator : The number of people under adult mental illness specialties on CPA who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care.

Denominator : The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric in-patient care. All patients discharged from a psychiatric in-patient wards are regarded as being on CPA.

Data Definition:

All patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care must be followed up within 7 days of discharge. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team.

Exemption:
Patients who die within 7 days of discharge may be excluded.
Where legal precedence has forced the removal of a patient from the country.
Patients transferred to NHS psychiatric inpatient ward.
CAMHS (child and adolescent mental health services) are not included.

The 7 day period should be measured in days not hours and should start on the day after the discharge.

Basis for Accountability:

PCT & MH Trust

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:
UNIFY2

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Achieving at least 95% rate of patients followed up after discharge each quarter
Timeframe/Baseline:
Ongoing
Timeframe Until:
Ongoing
Rationale:
Reduction in the overall rate of death by suicide will be supported by arrangement for securing provision by PCTs of appropriate care for all those with mental ill health. To reduce risk and social exclusion and improve care pathways to Patients on CPA discharged from a spell of in-patient care.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was an indicator (SQU15) in the 2011/12 planning round. It has not changed.

PHQ13: Mental Health Measure- Improved access to psychological services

DEFINITIONS

Detailed Descriptor:

The primary purpose of this indicator is to measure improved access to psychological therapies (IAPT) for people with depression and/or anxiety disorders. This is done using two indicators :
1. The proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes); and
2. The proportion of people who complete treatment who are moving to recovery

Lines within Indicator (Units):

Indicator 1: The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies

Numerator: the number of people who receive psychological therapies
Denominator: the number of people who have depression and/or anxiety disorders (local estimate based on Psychiatric Morbidity Survey)

Indicator 2: The number of people who are moving to recovery
Numerator: The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not)
Denominator: The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts.

Data Definition:

Relevant IAPT data items and the permissible values for each data item are defined in the IAPT Data Standard

Psychological therapy: NICE recommended treatment from a qualified psychological therapist (low or high intensity).

Definition of a 'case': a patient suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ9) for depression and/or the Patient Health Questionnaire (GAD7) for anxiety disorders, or other anxiety disorder specific measure as appropriate for the patient's diagnosis.

Completed treatment: This is a count of all those who have left treatment within the reporting quarter having attended at least two treatment contacts, for any reason including: planned completion; deceased; dropped out (unscheduled discontinuation); referred to another service or unknown

For the denominator of indicator 1, the expectation is NOT that PCTs carry out a

survey of their own, but that they extrapolate local prevalence from the national Psychiatric Morbidity Survey as part of their needs assessment

Basis for Accountability:

Although data units are sourced from providers, completion and submission of data returns are the responsibility of the Commissioner.
Services referred to are those complying with IAPT programme quality standards, that includes the delivery of NICE compliant (stepped care) therapies, and routine patient reported session by session outcome measures
The reporting lines cited in this guidance can be compiled using data compliant with the IAPT Data Standard.

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

Information Centre, Omnibus returns

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Ongoing improvement is anticipated.

Progress will be measured by looking at the increase in the proportion of people with anxiety disorders and depression by demographic group, who access evidence-based psychological therapies. Additionally, it is important to measure the recovery rate of those who receive treatment. Services able to collect and report against the lines indicated will have baseline data to assist them in complying with their statutory duties for equalities monitoring (which should be undertaken in conjunction with Equality Impact Assessment(s)), which will enable them to target improvements in service provision to improve access.

Timeframe/Baseline:

Quarter 2 2011/12

Timeframe Until:

March 2013.

Rationale:

This indicator focuses on i) improved access to psychological therapies, in order to address the enduring unmet need. Around one in six adults in England suffer from a

common mental health problem, such as depression or an anxiety disorder. Collecting this indicator will demonstrate the extent to which this need is being met. ii) of those who access treatment show movement towards recovery

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, commissioner plans

Planning Frequency:

Quarterly for 2012/13

Criteria for Plan Sign-off:

- The proportion of people who have depression and/or anxiety disorders who receive psychological therapies in line with NICE guidelines in each quarter of 2012/13 should be higher than the proportion in the previous quarter until full rollout has been achieved i.e. at least 15% of prevalence, and when achieved maintained.
- The recovery rate for each service in each quarter of 2012/13 should be higher than the previous quarter until 50% recovery rate is achieved and when achieved maintained..

FURTHER INFORMATION

Further Information:

The IAPT Data Handbook which explains the function of effective data collection and reporting in IAPT is available from http://www.iapt.nhs.uk/services/measuring-outcomes. Detailed guidance on use of the IAPT data set in compiling reports referred to here is contained in the appendices.

Changes from 2011/12 Planning Round:

Indicator 1 was in the 2011/12 planning round. Indicator 2 – The proportion of people who are referred for psychological therapies who enter treatment has been removed and replaced with the number of people who are moving to recovery.

PHQ14: People with long-term conditions feeling independent and in control of their condition

DEFINITIONS
Detailed Descriptor:
People with a long-term condition feeling independent and in control of their condition- This is a patient experience measure of the proportion of people with a long-term condition who are "supported by people providing health and social care services to manage their condition".
Lines within Indicator (Units):
Indicator construction: The indicator will be based on responses to questions in the GP Patient Survey as follows: **Numerator** For people who answer yes to the Question 30 "Do you have a long-standing health condition" (cited in template for indicator 2). The numerator is the total number of 'Yes, definitely' or 'Yes, to some extent' answers to GPPS **Question 32: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)?** *Please think about all services and organisations, not just health services* • Yes, definitely • Yes, to some extent • No • I have not needed such support • Don't know/can't say Responses will be weighted according to the following 0-100 scale: "No" = 0 "Yes, to some extent" = 50 "Yes, definitely" = 100 **Denominator** The denominator is the total number of 'Yes, definitely', 'Yes, to some extent' and 'No' answers to question 32 above. **Indicator format** Percentage (weighted numerator/denominator)
Data Definition:
The proportion of people with a long-term condition who are "supported by people providing health and social care services to manage their condition", with numerator and denominator as defined above
Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Data will available every six months

Monitoring Data Source:
GP patient survey (www.gp-patient.co.uk/)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
An increase in this indicator is desirable
Timeframe/Baseline:
Data will be available approximately three months after the end of each data collection period
Timeframe Until:
Ongoing
Rationale:
This indicator focuses attention on patient experience against exact national policy aims for people with long-term conditions. People with long-term conditions want greater control of their lives, to be treated sooner before their condition causes more serious problems and to enjoy a good quality of life. This means transforming the lives of people with long-term conditions to move away from the reactive care based in acute settings toward a more systematic patient-centred approach, where care is rooted in primary and community settings and underpinned by strong partnerships across the whole health and social care spectrum.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
None

FURTHER INFORMATION
Further Information:

Changes from 2011/12 Planning Round:
This was an indicator (SQU28) in the 2011/12 planning round. Following discussions with the DH's analytical team supporting this policy area, it has been agreed to weight responses as set out in the updated definition above.

PHQ15: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)

DEFINITIONS

Detailed Descriptor:

The proportion of persons aged over 18 with chronic conditions admitted to hospital as an emergency admission.

Lines within Indicator (Units):

This definition is based on the NHS IC Compendium of Population Health indicator: *Emergency hospital admissions: chronic conditions usually managed in primary care*.

Numerator: The number of finished and unfinished continuous inpatient spells (CIPS), excluding transfers, for patients with an emergency method of admission and with any of the primary diagnoses listed below (DIAG_01 in the 1st episode of the spell, ICD-10 codes).
B18.0 Chronic viral hepatitis B with delta-agent
B18.1 Chronic viral hepatitis B without delta-agent
J45 Asthma
J46X Status asthmaticus
I11.0 Hypertensive heart disease with (congestive) heart failure
I50 Heart failure
J81X Pulmonary oedema
I13.0 Hypertensive heart and renal disease with (congestive) heart failure
E10 Insulin-dependent diabetes mellitus
E11 Non-insulin-dependent diabetes mellitus
E12 Malnutrition-related diabetes mellitus
E13 Other specified diabetes mellitus
E14 Unspecified diabetes mellitus
J20 Acute bronchitis
J41 Simple and mucopurulent chronic bronchitis
J42X Unspecified chronic bronchitis
J43 Emphysema
J44 Other chronic obstructive pulmonary disease
J47X Bronchiectasis I20 Angina pectoris
I25 Chronic ischaemic heart disease
D50.1 Sideropenic dysphagia
D50.8 Other iron deficiency anaemias
D50.9 Iron deficiency anaemia, unspecified
D51 Vitamin B12 deficiency anaemia
D52 Folate deficiency anaemia
I10X Essential (primary) hypertension
I11.9 Hypertensive heart disease without (congestive) heart failure
G40 Epilepsy G41 Status epilepticus
F00 Dementia in alzheimers
F01 Vascular dementia

F02 Dementia in other diseases
F03 Unspecified dementia
I48X Atrial fibrillation and flutter

Denominator: Resident adult population estimate

Indicator format: rate per 100,000 population

Data Definition:

The proportion of persons aged over 18 with chronic conditions admitted to hospital as an emergency admission per 100,000 population

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Hospital Episode Statistics (HES) (NHS Information Centre, www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics–hes); and
Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-22371)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

There should be a reduction in unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) by population

Timeframe/Baseline:

Timeframe Until:

Rationale:

Healthcare contribution: Earlier and more accurate diagnosis, making optimal use of referral pathways and available interventions, support after primary treatment. Better support to people to self-manage their condition. Public health and social care contribution: Public health interventions that may mitigate disease progression including reducing tobacco use, alcohol consumption, illicit drug use, obesity, increasing physical activity. Other contributions include prevention, early identification and management of risk factors, including high cholesterol and blood pressure, diabetes and chronic kidney disease; the level and quality of support received from social care; TIA interventions; the quality of care received whilst living at home or in residential care e.g. recognition of the symptoms of stroke, medication compliance, mitigation of social isolation. The NHS has a responsibility to engage with social care and public health services to increase the effectiveness of its work for people who suffer from these chronic conditions. Drivers of the outcome beyond NHS control: Socio economic status, prevalence of co-morbidities.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This is a new indicator

PHQ16: Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

DEFINITIONS
Detailed Descriptor:
Rate of emergency admissions episodes in people under 19 (0 – 18 years) for asthma, diabetes or epilepsy per 100,000 population
Lines within Indicator (Units):
Numerator Total number of emergency admissions for people under 19 (0 – 18 years) where asthma, diabetes or epilepsy was the primary diagnosis. **Denominator** Mid-year population estimates for under 19s. Indicator format: rate per 100,000 population
Data Definition:
Rate of emergency admissions episodes in people under 19 (0 – 18 years) for asthma, diabetes or epilepsy per 100,000 population
Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Hospital Episode Statistics (HES) (NHS Information Centre, www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics–hes); and Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-22371)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
T here should be a reduction in unplanned hospitalisation in people under 19 (0 – 18

years) for asthma, diabetes or epilepsy per 100,000 population.
Timeframe/Baseline:
Timeframe Until:
Rationale:
Healthcare contribution: Earlier and more accurate diagnosis, making optimal use of referral pathways and available interventions, support after primary treatment. Better support to people to self-manage their condition. Public health and social care contribution: Public health interventions that may mitigate disease progression including reducing tobacco use, alcohol consumption, illicit drug use, obesity, increasing physical activity. Other contributions include prevention, early identification and management of risk factors, including high cholesterol and blood pressure, diabetes and chronic kidney disease. The level and quality of support received from social care. The quality of care received whilst living at home or in residential care e.g. recognition of the symptoms of stroke, medication compliance, mitigation of social isolation. The NHS has a responsibility to engage with social care and public health services to increase the effectiveness of its work for people who suffer from these chronic conditions Drivers of the outcome beyond NHS control: Socio economic status, prevalence of co-morbidities.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This is a new indicator

PHQ17: Emergency admissions for acute conditions that should not usually require hospital admission

DEFINITIONS

Detailed Descriptor:

Emergency admissions to hospital of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) usually managed in primary care.

Lines within Indicator (Units):

Numerator The number of spells, excluding transfers, for patients with an emergency method of admission and with any of the following primary diagnoses. ICD-10 codes:
J10 Influenza due to identified influenza virus
J11 Influenza, virus not identified
J13X Pneumonia due to Streptococcus pneumoniae
J14 Pneumonia due to Haemophilus influenzae
J15.3 Pneumonia due to streptococcus, group B
J15.4 Pneumonia due to other streptococci
J15.7 Pneumonia due to Mycoplasma pneumoniae
J15.9 Bacterial pneumonia, unspecified
J16.8 Pneumonia due to other specified infectious organisms
J18.1 Lobar pneumonia, unspecified
J18.8 Other pneumonia, organism unspecified
A36 Diphtheria
A37 Whooping cough
B05 Measles
B06 Rubella [German measles]
B16.1 Acute hep B with delta-agent (coinfectn) without hep coma
B16.9 Acute hep B without delta-agent and without hepat coma
B26 Mumps M01.4 Rubella arthritis
I24.0 Coronary thrombosis not resulting in myocardial infarction
I24.8 Other forms of acute ischaemic heart disease
I24.9 Acute ischaemic heart disease, unspecified
E86 Volume depletion
K52 Other noninfective gastroenteritis and colitis
A02.0 Salmonella enteritis
A04 Other bacterial intestinal infections
A05.9 Bacterial foodborne intoxication, unspecified
A07.2 Cryptosporidiosis A08 Viral and other specified intestinal infections
A09 Diarrhoea and gastroenteritis of presumed infectious origin
N10 Acute tubulo-interstitial nephritis
N11 Chronic tubulo-interstitial nephritis
N12 Tubulo-interstitial nephritis not spec as acute or chronic
N13.6 Pyonephrosis
N15.9 Renal tubulo-interstitial disease, unspecified;
N39.0 Urinary tract infection, site not specified;
N30.0 Acute cystitis

N30.8 Other cystitis
N30.9 Cystitis, unspecified
K25.0-K25.2, K25.4K25.6 Gastric ulcer
K26.0-K26.2, K26.4K26.6 Duodenal ulcer
K27.0-K27.2, K27.4K27.6 Peptic ulcer, site unspecified
K28.0-K28.2, K28.4K28.6 Gastrojejunal ulcer
K20 Oesophagitis
K21 Gastro-oesophageal reflux disease
L03 Cellulitis
L04 Acute lymphadenitis
L08.0 Pyoderma
L08.8 Other spec local infections of skin and subcutaneous tissue
L08.9 Local infection of skin and subcutaneous tissue, unspecified
L88 Pyoderma gangrenosum
L98.0 Pyogenic granuloma
I89.1 Lymphangitis
L01 Impetigo
L02 Cutaneous abscess, furuncle and carbuncle
H66 Suppurative and unspecified otitis media
H67 Otitis media in diseases classified elsewhere
J02 Acute pharyngitis
J03 Acute tonsillitis
J06 Acute upper respiratory infections multiple and unsp sites
J31.2 Chronic pharyngitis
J04.0 Acute laryngitis
A69.0 Necrotizing ulcerative stomatitis
K02 Dental caries
K03 Other diseases of hard tissues of teeth
K04 Diseases of pulp and periapical tissues
K05 Gingivitis and periodontal diseases
K06 Other disorders of gingiva and edentulous alveolar ridge
K08 Other disorders of teeth and supporting structures
K09.8 Other cysts of oral region, not elsewhere classified
K09.9 Cyst of oral region, unspecified
K12 Stomatitis and related lesions
K13 Other diseases of lip and oral mucosa
R56 Convulsions, not elsewhere classified
O15 Eclampsia
G25.3 Myoclonus

Denominator:
The resident population from ONS mid-year population estimates.

Indicator format: Age-standardised rate per 100,000 population

Data Definition:

Emergency admissions to hospital of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) usually managed in primary care.

Basis for Accountability:
Commissioner

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Hospital Episode Statistics (HES): www.hesonline.nhs.uk. Data for 2011-12 will be published autumn/winter 2012. ONS mid-year population estimates – data are based on the latest revisions of estimates for the respective years, current as at 29 September 2011: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Reduction in emergency admissions to hospital of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure) usually managed in primary care.
Timeframe/Baseline:
Timeframe Until:
Rationale:
Healthcare contribution: Ensuring that the appropriate level of care is provided for these conditions in the community and unnecessary hospital admissions are avoided. Public health and social care contribution: Public health contributions to encouraging healthy behaviours, including reduced use of tobacco, alcohol and illicit drugs, quality of social care at home and in care homes, mitigation of social isolation. Drivers of the outcome beyond NHS control: Fuel poverty, prevalence of long-term conditions and co-morbidities.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This is a new indicator

PHQ18: Patient Experience Survey

DEFINITIONS

Detailed Descriptor:

Patient Experience of hospital care, as reported by patients in responses to the Care Quality Commission Inpatient Survey.

Lines within Indicator (Units):

Patient Experience is summarised with a single Overall Score between 0 and 100 reflecting the experiences that patients report in the survey, with 100 being the best possible experience and 0 being the worst.

This Overall Score is the mean average of scores for five different domains of patient experience. It can be disaggregated to give separate scores for these domains:

- Access & waiting
- Safe, high quality co-ordinated care
- Better information more choice
- Building closer relationships
- Clean comfortable friendly place to be

Data Definition:

Each of the above five domain scores are mean averages of the scores for individual questions within that domain. For example, the “Better information, more choice” domain score is the average of the scores for three questions:

- Were you involved as much as you wanted to be in decisions made about your care and treatment?
- Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?
- Did a member of staff tell you about medication side effects to watch for when you went home?

The score for each question depends upon how many patients select each of the possible options on the questionnaire. For example, for the above question “Were you involved as much as you wanted…”, a score of 100 is allocated to “Yes, definitely”, a score of 50 to “Yes, to some extent” and 0 to “No”. If 60%, 30% and 10% of respondents respectively tick these options, the score for the question is:

$$\frac{(60 \times 100 + 30 \times 50 + 10 \times 0)}{100} = 75$$

The questions appear in paper questionnaires posted to a random sample of inpatients, who then complete them and post them back. The survey covers both elective and emergency care patients, but not mental health or maternity care, nor patients under the age of 18.

A paper explaining the methods, reasoning and scope of this indicator, and including the full list of questions, and the scores allocated to responses, is on the DH website:

www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_126973

Basis for Accountability:

Surveys are conducted by acute trusts in line with standardised guidance and methodologies. Results can be aggregated to form regional and national scores. Support tools are available on the DH website to assist organisations understand their current performance, and to identify priority areas for improvement (see link below for further details):
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091660

MONITORING

Monitoring Frequency:

This nationally-coordinated survey is conducted on an annual basis, and time-series comparisons for the indicator are available for several previous years. This survey and indicator provide a robust snapshot of performance. Trusts may wish to also develop a more regular or continuous view of performance, which can be achieved by putting in place appropriate mechanisms for ensuring comparable in-year assessments – for example, by either locally replicating the national survey, or through the use of other patient feedback arrangements (such as through "real-time" approaches). A localised package is available from the NHS patient survey coordination centre for local organisations to support them in developing such approaches (further details are available via the link below)
www.nhssurveys.org/localsurveys

Monitoring Data Source:

Details provided above.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Success means increasing the above overall patient experience score.
Additionally, as part of the NHS Performance Framework, trusts are rated as "performing", "under review" or "underperforming", based upon their score for each of the above domains. Further details are available via the DH website:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126030

Timeframe/Baseline:

This survey is conducted annually. Survey fieldwork typically takes place between October and January each year with a sample of patients who had spent at least one night in hospital in the previous June, July or August . The complete set of local and national results are published by the Care Quality Commission each spring, although each NHS trust has access to their own local data well in advance of this date (usually in January, made available from their survey contractor or in-house survey team).

Timeframe Until:
N/A
Rationale:
Patient-centred care, and improving patient experience, are priorities for the coalition government – as is evident from the 2012/13 NHS Operating Framework. In addition, these priorities feature very strongly in the White Paper, and a number of the related consultations (including the NHS Outcomes Framework).
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
This indicator is one of the Overarching Indicators in Domain 4 of the NHS Outcomes Framework. In December 2011, DH will publish a refresh of the NHS Outcomes Framework, containing progress on other Improvement Area indicators in this domain. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944 Further details about the adult inpatient survey used for this indicator, and the national patient survey programme that it is part of, are available on the websites of the NHS national patient survey coordination centre and Care Quality Commission: www.nhssurveys.org www.cqc.org.uk/public/reports-surveys-and-reviews/surveys
Changes from 2011/12 Planning Round:
This was indicator HQU04 in the 2011/12 planning round.

PHQ19-21: Referral to Treatment Pathways

DEFINITIONS

Detailed Descriptor:

The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways.

Lines within Indicator (Units):

PHQ19 - the percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis

PHQ20 - the percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period

PHQ21 - the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Data Definition:

A calculation of the percentage within 18 weeks for completed admitted RTT pathways, completed non-admitted RTT pathways and incomplete RTT pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.

The definitions that apply for RTT waiting times are set out in the RTT Clock Rules Suite found here:
http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

Basis for Accountability:

Commissioner & Provider

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Consultant-led Referral to Treatment Waiting Times data collection (National Statistics)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Performance will be judged against the following waiting time standards: • Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90% • Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95% • Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92% Performance will also be assessed alongside other data including referrals, activity, finance and diagnostic test waiting times
Timeframe/Baseline:
N/A
Timeframe Until:
Ongoing.
Rationale:
As set out in the NHS Operating Framework for 2012/13, the operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks. The referral to treatment (RTT) operational standards should be achieved in each specialty by every organisation and this will be monitored monthly.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:

N/A

FURTHER INFORMATION

Further Information:

Data and full guidance can be found here:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm

Changes from 2011/12 Planning Round:

The approach to monitoring referral to treatment waits has changed from monitoring the 95th percentile waiting time for completed admitted and non-admitted, and incomplete referral to treatment pathways to monitoring the percentage of completed and incomplete RTT pathways within 18 weeks.

PHQ22: Diagnostic Test waiting times

DEFINITIONS

Detailed Descriptor:

The percentage of patients waiting 6 weeks or more for a diagnostic test.

Lines within Indicator (Units):

PHQ22 - the percentage of patients waiting 6 weeks or more for a diagnostic test (15 key diagnostic tests) at the end of the period

Data Definition:

The number of patients waiting 6 weeks or more for a diagnostic test (15 key tests) based on monthly diagnostics data provided by NHS and independent sector organisations and signed off by NHS commissioners as a percentage of the total number of patients waiting at the end of the period.

The definitions that apply for diagnostics are set out in the guidance here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

Basis for Accountability:

Provider & Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly diagnostics data collection - DM01

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance will be judged against the following standard:

- Diagnostic operational standard of 1% – the percentage of patients waiting 6 weeks or more for a diagnostic test should be less than 1%

Performance will also be assessed alongside other data including referrals, activity, finance and referral to consultant-led treatment waiting times.

Timeframe/Baseline:

N/A
Timeframe Until:
Ongoing.
Rationale:
As set out in the NHS Operating Framework for 2012/13, we expect less than 1 per cent of patients to wait longer than six weeks for a diagnostic test. This standard applies to all diagnostic tests. Monthly performance will be based on the 15 key diagnostic tests reported in the monthly diagnostics data collection (DM01).
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION
Further Information:
Data and full guidance can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm
Changes from 2011/12 Planning Round:
This is a new measure for 2012/13.

PHQ23: A&E waiting time- Total Time in the A&E Department

DEFINITIONS

Detailed Descriptor:

Percentage of patients who spent 4 hours or less in A&E

Lines within Indicator (Units):

1. Total number of A&E attendances.

2. Number of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge.

3. Percentage of A&E attendances where the patient spent 4 hours or less in A&E from arrival to transfer, admission or discharge

Data Definition:

Full definitions can be found in weekly sitrep guidance notes at the following address

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/WeeklySituationReports/index.htm

A&E, means a Type 1, Type 2 or Type 3 A&E department.

Types of A&E/Minor Injury Unit (MIU) service are:

Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

Type 2 A&E department = A consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients

Type 3 A&E department = Other type of A&E/minor injury units (MIUs)/Walk-in Centres, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services), or a dedicated primary care service (such as GP practice or GP-led health centre) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

Basis for Accountability:
Provider-basis, all A&E sites

MONITORING
Monitoring Frequency:
Weekly
Monitoring Data Source:
Weekly sitrep data (WSitAE).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Standard is 95% of patients seen within 4 hours
Timeframe/Baseline:
Timeframe Until:
Ongoing
Rationale:
Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen, and financial effects . It is critical that patients receive the care they need in a timely fashion, so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays, and patients who are fit to go home are discharged safely and rapidly. There is professional agreement that some patients need prolonged times in A&E. However, these exceptions are rare and unlikely to account for more than 5% of attendances. International literature suggests increases in adverse outcomes for patients who have been in the A&E for more than 4-6 hours. Excessive total time in the A&E is linked to poor outcomes and patient delays should be minimised (but care should not be hurried or rushed). Changes in the practice of emergency medicine in some departments also means that more is being done for patients in the A&E, which may take longer but is for the benefit of the patient.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was a previously headline indicator (HQU10) in the 2011/12 planning round, but measured median, 95th percentile and longest time in A&E sourced from Hospital Episode Statistics (HES). In 2012/13 the monitoring data source for national performance management this will change from HES to weekly situation report (SitRep) data.

PHQ24-25: Cancer 2 Week Waits (aggregate measure)

DEFINITIONS

Detailed Descriptor:

Two week wait (urgent referral) services (including cancer)-

Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer (PHQ24) and percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (PHQ25).

Lines within Indicator (Units):

PHQ24: All Cancer Two Week Wait

Denominator:	All patients urgently referred with suspected cancer by their GP (GMP or GDP) who were first seen within a period
Numerator:	Patients urgently referred with suspected cancer by their GP (GMP or GDP) who were first seen within 14 calendar days within a period

PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected)

Denominator:	All patients urgently referred for evaluation/investigation of “breast symptoms” by a primary or secondary care professional within a period, excluding those referred urgently for suspected breast cancer who were first seen within the period.
Numerator:	Patients urgently referred for evaluation/investigation of “breast symptoms” by a primary or secondary care professional during a period (excluding those referred urgently for suspected breast cancer) who were first seen within 14 calendar days during the period.

All referrals to a breast clinical team, excluding those for suspected cancer, and those to family history clinics should be included within the dataset supplied for PHQ25.

Data Definition:

Numerator and Denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Dataset Set Change Notice (DSCN) 20/2008. A copy of this DSCN can be accessed at: http://www.isb.nhs.uk/documents/dscn/dscn2008/dataset/202008.pdf

The Department of Health is currently carrying out maintenance of the NCWTMDS, these developments may impact on the format of the required dataflow. Any changes will be communicated to the NHS if approved by the Information Standards Board for Health and Social Care.

Basis for Accountability:

Provider (NHS Trusts, NHS Foundation Trusts and PCT Providers) and Commissioner

MONITORING

Monitoring Frequency:

Monthly and Quarterly

Monitoring Data Source:

Data are sourced from the CWT-Db on a monthly and quarterly basis.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

PHQ24: All Cancer Two Week Wait

Performance is to be sustained at or above the published operational standard

PHQ25: Two Week Wait for Breast Symptoms (where cancer was not initially suspected)

Performance is to be sustained at or above the published operational standard

Details of current operational standards are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_103436

Timeframe/Baseline:

Not Applicable

Timeframe Until:

Not applicable

Rationale:

These two week wait services are a vital component of the patient pathway, they ensure fast access to diagnostic tests, supporting the provision of an earlier diagnosis and therefore assist in improving survival rates for cancer. It remains important for patients with cancer or its symptoms, to be seen by the right person, with appropriate expertise, within two weeks to ensure that they receive the best possible survival probability and a lower level of anxiety than if they were waiting for

a routine appointment.

PHQ24 of this indicator also relates to a patient's right to be seen in two weeks as expressed in the NHS Constitution. Details of this are available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_113644.pdf

SHA Envelopes:

No

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

The All Cancer Two Week Wait was introduced by the NHS Cancer Plan (2000), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009609

The Two Week Wait for Breast Symptoms (where cancer was not initially suspected) was introduced by the Cancer Reform Strategy (2007), a copy of which is available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081006

As part of the development of Improving Outcomes: a Strategy for Cancer(2011) a Review of Waiting Times Standards was undertaken, this identified that these standards should be retained due to their benefits for patients. Both these documents are available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123371

Full guidance on the monitoring of these services and supporting information on the scope and patient pathways are available at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

Help and further support for monitoring these standards is available via e-mail at: cancer-waits@dh.gsi.gov.uk

Changes from 2011/12 Planning Round:

The construction of indicator is unchanged from 2011/12 though it has been renumbered and the supporting text made more explicit.

PHQ26: MSA Breaches

DEFINITIONS

Detailed Descriptor:

Patient Experience: Breaches of Same Sex Accommodation-

All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, in accordance with the definitions set out in the Professional Letter CNO/2010/3.

From April 2011, all providers of NHS funded care must routinely report breaches of sleeping accommodation, as set out in national guidance, and will attract contract sanctions in respect of each patient affected.

Each year, on or by 1 April, all such organisations must declare that they are compliant with the national definition or face financial penalties. PCTs should report to SHAs, on an exception basis, those organisations that have had financial sanctions applied, or those whose compliance status has changed.

Lines within Indicator (Units):

This data set supports the collection of consistently defined data on breaches of DH guidance on Mixed-Sex Accommodation. (NB: The policy commitment relates to gender, not sex, but to ensure a better public understanding it is referred to as Mixed-Sex Accommodation {MSA}).

The focus of the indicator and the associated central reporting, is on MSA breaches in respect of sleeping accommodation only - even though the NHS is required to monitor locally all justified mixing in sleeping accommodation, all mixed-sex sharing of bathroom/toilet facilities (including passing through accommodation or toilet/bathroom facilities used by the opposite gender). Locally, it will also monitor lack of provision of women-only day areas in mental health units.

A breach of the policy occurs each time an admitted patient is placed in MSA, outside the terms of the policy.

The collection of NHS organisations' MSA breaches in relation to sleeping accommodation commenced from 1 December 2010, with routine reporting from January 2011.

NHS organisations must submit aggregated data to the Unify2 data collection system, detailing the hospital site where the breach occurred and the patient's commissioning organisation.

For performance monitoring of MSA, it will be the MSA breach rate (MSA breaches per 1,000 FCEs), as well as the number of breaches, that will need to be monitored.

MSA Breach Rate Indicator Definition:
The number of breaches of mixed-sex accommodation (MSA) sleeping

accommodation, per 1,000 Finished Consultant Episodes.

Formula:
MSA Breach Rate = Numerator/Denominator x 1,000

Numerator:
The number of MSA breaches for the reporting month in question.
Data Source: MSA Unify2 data collection

Denominator:
The number of Finished Consultant Episodes (FCEs) that finished in the month, regardless of when they started.
Data source: Inpatient HES

For more information on the MSA breach rate indicator, please refer to the methodology paper on the MSA publication website. This can be located via:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/index.htm

Data Definition:

Providers are required to report all breaches of sleeping accommodation* - i.e. for each patient affected, via the Unify2 system. Detailed definition of what constitutes a breach of same sex guidance is provided in Professional Letter CNO/2010/3.

** "Sleeping accommodation" includes areas where patients are admitted and cared for on beds or trolleys, even where they do not stay overnight. It therefore includes all admissions and assessment units (including* clinical *decision units), plus day surgery and endoscopy units. It does not include areas where patients have not been admitted, such as accident and emergency cubicles.*

An Information Standards Notice (ISN) has been published for the MSA data collection (Ref: ISB 1573). This can be found at:
http://www.isb.nhs.uk/library/standard/226

New NHS Data Dictionary standards have been published for the MSA data collection. These can be found at:
http://www.isb.nhs.uk/documents/isb-1573/amd-168-2010/cr1207.pdf

Basis for Accountability:

Overall accountability rests with the provider organisation which will;
- report breaches in line with the arrangements specified above
- pursue the broader, improvement-based activities as would reasonably be associated with the level of breaches being published.

It is the local commissioner's responsibility to jointly sign-off the monthly data. Where breaches have occurred, commissioners and providers must meet to discuss sanctions.

Data have been made public from January 2011.

MONITORING
Monitoring Frequency:
Monitoring is based on a monthly data collection. Mandatory collection of data for non-FTs to begin in December 2010. Voluntary collection for FTs until April 2011, at which point this too becomes mandatory. Monthly publication is expected to take place on the third Thursday of every month.
Monitoring Data Source:
UNIFY {2} Performance monitoring arrangements. NB: Published data can be revised and amended within two months of publication. This will allow the outcome of meetings between providers and commissioners regarding breaches to be incorporated into the data.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient. Ability to deliver this requirement is the key indicator of success.
Timeframe/Baseline:
N/A.
Timeframe Until:
Ongoing
Rationale:
Patients have told us that mixed sex accommodation is distressing to patients at a time when they feel at their most vulnerable. The above focus means that organisations will be held to account for managing beds and facilities to eliminate MSA. It also better facilitates commissioners' application of sanctions to NHS organisations that breach the guidance. Publication of the associated breach data means that patients and the public will be better informed about an organisation's progress in eliminating mixed sex accommodation.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
National policy: Elizabeth.jones@dh.gsi.gov.uk and james.bird@dh.gsi.gov.uk **Performance management:** Gillian.donachie@dh.gsi.gov.uk
Changes from 2011/12 Planning Round:
This was an indicator (HQU08) in the 2011/12 planning round.

PHQ27: HCAI measure (MRSA)

DEFINITIONS

Detailed Descriptor:

Number of Meticillin resistant *Staphylococcus aureus* (MRSA) bacteraemia, as defined below.

Lines within Indicator (Units):

Infections (positive samples).

Data Definition:

An MRSA bacteraemia is defined as a positive blood sample test for MRSA on a patient. Reports of MRSA cases must include all MRSA positive blood cultures detected in the laboratories, whether clinically significant or not, whether treated or not, whether acquired in the Trust or elsewhere. Positive results on the same patient more than 14 days apart should be reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken.

In constructing the MRSA Objectives, use was made of rates based on both population sizes and numbers of occupied bed days. Sources and definitions used are:

For PCOs: The Office for National Statistics mid-year population estimates for 2010 for residents (all ages).

For acute trusts: The number of occupied bed days in the year derived from DH return KH03 – 2010-11 financial year.

Basis for Accountability:

PCOs (PCTs and Care Trusts) are accountable for all cases of MRSA bloodstream infections occurring in their responsible populations.

Cases will be attributed to responsible PCOs via the NHS Connecting for Health's Demographics Batch Service (DBS) using the NHS number and date of birth or, where this has not proved possible, they will be attributed to the *lead* PCO (sometimes called the *coordinating* PCO) for the trust reporting the case.

For acute trusts the basis of the assessment is the number of positive MRSA blood specimens (more than 14 days apart) taken from inpatients, excluding specimens taken on the day of admission or on the day following the day of admission. In addition, specimens from admitted patients where an admission date has not been recorded, or where it cannot be determined if the patient was admitted, are also attributed to the acute trust.

To illustrate:

admission day
admission day + 1
admission day + 2 - specimens taken on this day or later are trust apportioned

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

HPA HCAI Data Capture System

ACCOUNTABILITY

What success looks like, direction, milestones

The approach used to calculate the MRSA bloodstream infection Objectives requires organisations with higher baseline rates (acute trusts and primary care organisations) to make the greatest improvements in order to reduce variation in performance between organisations. It also seeks to maintain standards in the best performing organisations.

Appropriate Objective figures have been calculated centrally for each PCO and each acute trust based on a formula which, if the Objectives are met, will collectively deliver nationally a further national reduction in cases of 38% for acute trusts and 29% for PCOs whilst also reducing the variation in population and bed day rates between organisations. The Further Information section provides links to detailed documents with explanations of the formula used and the rationale behind it.

The Department is advising Commissioners that when considering how to respond to a breach of an organisation's MRSA Objective, they should take account of whether, despite exceeding their Objective, an organisation's MRSA bloodstream infection rate remains low in comparison to others of a similar size. This approach is being encouraged to facilitate proportionate application of sanctions relating to performance management aspects.

Timeframe/Baseline:

For each financial year the MRSA Objective for each trust or PCO is derived from the performance in the 12 months to the end of September of the previous year. Objectives for 2012-13 are derived from performance in the period October 2010 to September 2011. This is known as the baseline.

Timeframe Until:

The Indicator is set for the financial year 2012-13. The Indicator will be reviewed in Autumn 2012.

Rationale:

The Government has been clear the NHS should adopt a zero tolerance approach to all avoidable healthcare associated infections. The infections that the Department are seeking the NHS to minimise are those infections that have occurred through non-adherence to best practice in infection prevention and control practices. It is recognised there are some infections that cannot be prevented.

MRSA is still a significant patient safety issue with over 1,200 bacteraemias reported in the 12 months to September 2011 in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It can be very distressing for patients who acquire an infection, for their family and friends and for staff who treat them. Reducing MRSA bacteraemia will lead to significantly improved patient safety, outcomes as well as deliver cost savings and reputational gains for the NHS.

Organisations should take action to deliver further progress in reducing MRSA while at the same time improving or maintaining performance on reducing *Clostridium difficile* infections - an infection also of key concern to the public.

SHA Envelopes:

Envelopes have not been explicitly calculated for the SHAs, however their performance will be monitored based on the sum of their constituent PCOs. In addition, it will also be possible for PCOs to share their objectives as a PCT cluster for the purposes of performance management by the Department of Health, if this is how they wish to be held to account nationally and/or locally.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, provider and commissioner plans

Planning Frequency:

Monthly for 2012/13

Criteria for Plan Sign-off:

Organisation's plans for 2012-13 need to at least meet the objective calculated centrally.

Where the MRSA Objective requires no improvement relative to the baseline, the individual organisations plan should be set so that at a minimum it maintains the performance achieved in the 12 month period October 2010 to September 2011. Organisations are encouraged to look at setting local ambition that goes further than the minimum objective set by the Department of Health, where appropriate and achievable.

FURTHER INFORMATION
Further Information:
Further information on the Objective is available on Unify at: http://nww.unify2.dh.nhs.uk/InstantForum414/Topic10033833-10004211-1.aspx and from the HPA at https://nww.hcai.nhs.uk/MRSA/download.htm or https://secure1.hpanw.nhs.uk/mrsa/download.htm If you have any queries about the Objective, please contact hcaienquiries@dh.gsi.gov.uk
Changes from 2011/12 Planning Round:
This was an indicator (HQU01) in the 2011/12 planning round.

PHQ28: HCAI measure (*Clostridium difficile infections*)

DEFINITIONS

Detailed Descriptor:

Number of *Clostridium difficile* infections, as defined below, for patients aged 2 or more on the date the specimen was taken.

Lines within Indicator (Units):

Infections (cases diagnosed as *C. difficile* infections).

Data Definition:

A *C. difficile* infection is defined as a case where the patient shows clinical symptoms of *C. difficile* infection, and using the local Trust *C. difficile infections diagnostic algorithm (in line with DH guidance) is assessed as a positive case.* Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken.

In constructing the *C. difficile* Objectives use was made of rates based both on population sizes and numbers of occupied bed days. Sources and definitions used are:

For PCOs: The Office for National Statistics (ONS) population estimates for 2010 for residents aged 2 and over.

For acute trusts: The sum of episode durations for episodes finishing in 2010-11 where the patient was aged 2 or over at the end of the episode from Hospital Episode Statistics (HES).

Note: The Department has asked its expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) to provide further guidance to improve consistency in reporting. This guidance is expected to be available in early 2012.

Basis for Accountability:

PCOs (PCTs and Care Trusts) are accountable for all cases of *C. difficile* infection occurring in their responsible populations.

Cases will be attributed to responsible PCOs via the NHS Connecting for Health's Demographics Batch Service (DBS) using the NHS number and date of birth or, where this has not proved possible, they will be attributed to the *lead* PCO (sometimes called the *coordinating* PCO) for the trust reporting the case.

Acute provider trusts are accountable for all cases of *C. difficile* infection for which the Trust is deemed responsible. This is defined as a case where the sample was

taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

To illustrate:
admission day
admission day + 1
admission day + 2
admission day + 3 - specimens taken on this day or later are trust apportioned

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

HPA HCAI Data Capture System

ACCOUNTABILITY

What success looks like, direction, milestones

The approach used to calculate the *C. difficile* Objectives requires organisations with higher baseline rates (acute trusts and primary care organisations) to make the greatest improvements in order to reduce variation in performance between organisations. It also seeks to maintain standards in the best performing organisations.

Appropriate Objective figures have been calculated centrally for each PCO and each acute trust based on a formula which, if the objectives are met, will collectively deliver a further national reduction in cases of 26% for acute trusts and 18% for PCOs whilst also reducing the variation in population and bed day rates between organisations.

The Further Information section provides links to detailed documents with explanations of the formula used and the rationale behind it.

Timeframe/Baseline:

The baseline period is the 12 months October 2010 to September 2011. This means that Objectives have been set according to performance in this period.

Timeframe Until:

The Indicator is set for the financial year 2012-13. The Indicator will be reviewed in Autumn 2012.

Rationale:

The Government has been clear the NHS should adopt a zero tolerance approach to

all avoidable healthcare associated infections. The infections that the Department are seeking the NHS to minimise are those infections that have occurred through non-adherence to best practice in infection prevention and control practices. It is recognised there are some infections that cannot be prevented.

C. difficile infections are a significant patient safety issue with almost 20,000 reported cases in the baseline 12 month period (October 2010 to September 2011) in England. Along with other healthcare associated infections, it can cause illness and, sometimes, death. It is distressing for patients who acquire an infection, for their family and friends and for staff who treat them.

Although progress has been made over the last few years, particularly in terms of narrowing the gap between the best and worst performers, there is still considerable room for further improvement. Reducing *C. difficile* infections will lead to significantly improved patient safety outcomes as well as deliver increased cost savings and reputational benefits for the NHS.

Organisations should take action to ensure progress in reducing *C. difficile* infections, while at the same time improving or maintaining performance on reducing MRSA - an infection also of key concern to the public.

SHA Envelopes:

Envelopes have not been explicitly calculated for the SHAs, however their performance will be monitored based on the sum of their constituent PCOs.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, provider and commissioner plans

Planning Frequency:

Monthly for 2012/13

Criteria for Plan Sign-off:

Organisation's plans for 2012-13 need to at least meet the Objective calculated centrally. Organisations are encouraged to set local ambitions that goes further than the minimum objective set by the Department of Health, where appropriate and achievable.

FURTHER INFORMATION

Further Information:

Further information on the objective is available on Unify at:

http://nww.unify2.dh.nhs.uk/InstantForum414/Topic10033833-10004211-1.aspx

and from the HPA at https://nww.hcai.nhs.uk/MRSA/download.htm or https://secure1.hpanw.nhs.uk/mrsa/download.htm If you have any queries about the Objective, please contact hcaienquiries@dh.gsi.gov.uk
Changes from 2011/12 Planning Round:
This was an indicator (HQU02) in the 2011/12 planning round.

PHQ29: VTE Risk Assessment

DEFINITIONS

Detailed Descriptor:

VTE risk assessment for inpatient admissions-

% of all adult inpatients who have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool

Lines within Indicator (Units): % performance calculated from:

Numerator: Number of adult inpatient admissions reported as having had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool (including those risk assessed using a cohort approach in line with published guidance).

Denominator: Number of adults who were admitted as inpatients (includes day cases, maternity and transfers; both elective and non-elective admissions)

Basis for Accountability:

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Providers submit a mandatory monthly census data return through UNIFY2 – Department of Health

ACCOUNTABILITY

What success looks like, Direction, Milestones:

All providers of acute services should be delivering and sustaining improvements in performance towards the level specified by the national CQUIN goal in 2010/11 and 2011/12 (i.e. 90% of all adult inpatients risk assessed for VTE on admission to acute care providers).

Timeframe/Baseline:

1-31 March 2011

Timeframe Until:

Ongoing

Rationale:
VTE is a condition in which a blood clot (thrombus) forms in a vein. Blood flow through the affected vain can be limited by the clot, and may cause swelling and pain. Venous thrombosis occurs most commonly in the deep veins of the leg or pelvis; this is known as a deep vein thrombosis (DVT). An embolism occurs if all or part of the clot breaks off from the site where it forms and travels through the venous system. If the clot lodges in the lung a potentially serious and sometimes fatal condition, pulmonary embolism (PE) occurs. DVT and PE are the commonest manifestations of venous thrombosis. The term VTE embraces both the acute conditions of DVT and PE, and also the chronic conditions which may arise after acute VTE such as post thrombotic syndrome and pulmonary hypertension, both problems being associated with significant ill-health and disability. VTE is a significant cause of mortality, long-term disability and chronic ill health. It was estimated by a Health Committee Report in 2005 that there were around 25,000 deaths from VTE each year in hospitals in England and many these death were avoidable. VTE is now recognised as a clinical priority for the NHS by the National Quality Board and the NHS Leadership Team and the Three Professions (Academy of Medical Royal Colleges, Royal College of Nursing and Royal College of Pharmacists). Providers using the NHS Standard Acute Contract who achieve 90% against this indicator will be financially rewarded through the Commissioning for Quality and Innovation (CQUIN) payment framework in 2012/13, as in 2011/12. However the indicator is also included as a performance measure for national oversight in 2012/13 in order to ensure that all providers are improving their overall performance, even if they do not achieve the threshold required to receive a CQUIN payment.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Department of Health National VTE Risk Assessment Tool http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088215

NICE guidelines – The NICE clinical guideline 92, 'Venous thromboembolism – reducing the risk', (http://guidance.nice.org.uk/CG92)

NICE Quality Standard: -
http://www.nice.org.uk/aboutnice/qualitystandards/vteprevention

National NHS VTE Exemplar Centre Network:
http://www.kingsthrombosiscentre.org.uk/cgi-bin/kingsthrombosis/index.pl

Map of Medicine VTE Prevention Pathway:
http://healthguides.mapofmedicine.com/choices/map/index.html

A Guide for Delivering the CQUIN Goal on VTE Risk Assessment:
http://www.kingsthrombosiscentre.org.uk/kings/Delivering%20the%20CQUIN%20Goal_2ndEdition_LR.pdf

VTE Risk Assessment data collection: July-September 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_131539

Changes from 2011/12 Planning Round:

This was an indicator (SQU01) in the 2011/12 planning round.

PHQ30: Smoking Quitters

DEFINITIONS

Detailed Descriptor:

Number of clients of NHS Stop Smoking Services who report that they are not smoking four weeks after setting a quit date.

Lines within Indicator (Units):

Line 1: Number of 4-week smoking quitters that have attended NHS Stop Smoking Services

Data Definition:

The definitions are in line with the Russell Clinical guidelines (Thorax 1997). For details, see "NHS Stop Smoking Services: service and monitoring guidance 2011/12" at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

The data are collected from / submitted by PCTs to the NHS Information Centre using a web-based tool – all are currently part of the mandatory data return and are reported quarterly.

The results are published by the IC in their "Statistics on NHS Stop Smoking Services" series at: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The number of 4 week smoking quitters should continue to increase over time.

In order to fully measure success of the 4 week smoking quitters indicator, organisations may wish to observe the following two markers of good practice in the delivery of smoking cessation:

Percentage of those clients setting a quit date who report that they are not smoking four weeks after that date.
Percentage of those clients reporting that they are not smoking four weeks after setting a quit date whose smoking status at four weeks is confirmed by the results from a carbon monoxide (CO) test.

These two markers plus the main 4 week smoking quitters indicators should continue to increase over time.
It is best practice for the percentage of clients reporting that they are not smoking 4 weeks after setting a quit date to be not less than 25% (this is the natural quit rate at 4 weeks) and should range from 35-70%. Reports outside of this range should trigger an exception reporting procedure at SHA level.
A best practice aspiration for commissioners for monitoring CO validation testing should be to achieve 85%.
These two sets of data are already collected as part of the NHS Information Centre return, so commissioners can observe them alongside the data collected on the number of 4 week smoking quitters.

Timeframe/Baseline:

2010/11

Timeframe Until:

Measured quarterly and annually until end of planning period.

Rationale:

These data provide important clinical indicators of the quality and efficacy of services provided to the population. The additional two markers of success are a best practice guide to help support a more clear observation of how the 4 week smoking quitters indicator is being delivered. Biochemical validation (CO or cotinine) is important as it provides a more accurate outcome measure than self report, and this allows for modelling of the impact of service provision on local and national prevalence. These data will support commissioners to link quality and efficacy of services to both the quality / cost effective (QIPP) and prevalence reduction agendas.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, commissioner plans

Planning Frequency:
Quarterly for 2012/13
Criteria for Plan Sign-off:
The number of four-week quitters in 2012/13 should be higher than the number of quitters in 2010/11.

FURTHER INFORMATION
Further Information:
NHS Stop Smoking Services: service and monitoring guidance 2011/12: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_125389 Statistics on NHS Stop Smoking Services: http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/nhs-stop-smoking-services
Changes from 2011/12 Planning Round:
None

PHQ31: Coverage of NHS Health Checks

DEFINITIONS

Detailed Descriptor:

Please calculate:

1. the percentage of people eligible for the NHS Health Check programme who have been offered an NHS Health Check *and*
2. the percentage of people eligible for the programme who have received an NHS Health Check.

The NHS Health Check programme is a systematic prevention programme that assesses an individual's risk of heart disease, stroke, diabetes and kidney disease. It is for people aged 40-74 who have not been previously diagnosed with one of these conditions (including hypertension) and consists of a face to face individual risk assessment followed by risk management advice (the risk assessment element of the check) and interventions (the risk management element of the check). For those at low risk, the risk management might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment.

The NHS Health Check: Vascular Risk Assessment and Management Best Practice Guide was published in April 2009 and this clearly explains the core tests and measures in the risk assessment element of the NHS Health Check, along with similar information about risk management interventions. It describes what every person should receive as the national offer of an NHS Health Check and appropriate processes will need to be in place to assure the quality of the service.

PCTs will be collecting this data as part of monitoring their LES or contracts with providers of this service.

Lines within Indicator (Units):

1. Number of eligible people who have been offered an NHS Health Check in 2012/13.
2. Number of eligible people who have received an NHS Health Check in 2012/13
3. Number of people aged 40-74 eligible for an NHS Health Check in 2012/13
4. Percentage of eligible people who have been offered an NHS Health Check in 2012/13
5. Percentage of eligible people that have received an NHS Health Check in 2012/13

Data Definition:

Determine the number of people aged 40-74 eligible for a NHS Health Check in 2012/13.

This data is to be drawn from that held at the Office for National Statistics collection.

We recommend that PCTs use ONS's 2008- resident based population projections for 2012 to calculate their population aged 40-74 eligible for an NHS Heath Check (published 27 May 2010 – see link). Best practice would be to determine the eligible population once at the start of the year to aid planning. This population would remain unchanged for the rest of the year, but acts as a baseline for individuals to be offered NHS Health Checks. Any fluctuations in the populations in year should be relatively small and not affect the rates to a great extent.
http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-163339

This should be adjusted to exclude people who have been diagnosed with:- ,

- Coronary heart disease,
- stroke,
- diabetes
- chronic kidney disease (stages 3 to 5)
- hypertension
- Atrial Fibrillation
- Transient Ischaemic Attack (TIA)
- Familial Hypercholesterolaemia
- Heart failure
- Peripheral Arterial Disease (PAD)

Those who have been prescribed statins are also not eligible for the NHS Health Check programme, and those previously found to be at high risk with a 10-year risk of cardiovascular disease ≥ 20% should also be excluded from the programme.

Read codes to assist in determining the exclusions have been identified and a list will be made available shortly.

- *Count the number of eligible people who have been offered a NHS Health Check during 2012/13.*

PCTs should offer NHS Health Checks to those eligible people aged 40-74 without an existing diagnosed vascular disease. The data we are seeking is the number of **people** who have been offered an NHS Health Check not the number of offers that have been made. Every person who receives an NHS Health Check will have been offered one and so this should be recorded. The offer can be anything from a formal invitation through to opportunistically asking whether the person would be interested in having a check e.g. in a pharmacy. It is important to record the number of people who have been offered an NHS Health Check so that take up rates can be calculated which can then be used to give an indication of the accessibility of the programme. **People should only be counted once even if they have had several offers of a check.**

- *Count the number of eligible people who have received a NHS Health Check during 2011/12.*

The NHS Health Check should be compliant with the Best Practice Guidance published in April 2009. A completed vascular risk assessment as part of an NHS Health Check is:-

- risk assessment undertaken,
- communication of risk given to the individual,
- individual lifestyle advice given to the person, and
- referral, as appropriate, to a lifestyle intervention or for further medical investigation.

The Best Practice Guide (see link) describes what every person should receive as the national offer of a NHS Health Check.
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098410.pdf

Basis for Accountability:

Commissioner.

MONITORING

Monitoring Frequency:

Quarterly, to see progress through the year on the number of NHS Health Checks offered, and the percentage take up within each PCT.

Monitoring Data Source:

IPMR commissioner return via Unify2

ACCOUNTABILITY

What success looks like, Direction, Milestones:

PCTs began phased roll out of the NHS Health Check programme from April 2009. 2011/12 was the last year of phased implementation of the programme. In 2012/13 full roll out should be reflected by a fairly stable number of NHS Health Checks being offered and conducted every year (nationally around 3m offered and we estimate about 2.2m conducted) as part of a five year rolling cycle – with every eligible being offered a check every five years. NHS Health Checks being carried out meet the Best Practice Guidance. High levels of take up by all those eligible is an important part of the programme and PCTs should aspire to improve their take up rates progressively from a minimum of 50% - economic modelling for the programme undertaken by the Department of Health assumed a 75% take up rate as achievable based on the take up rates achieved for the breast cancer screening programme.

Timeframe/Baseline:

1 April 2012
Timeframe Until:
31 March 2013
Rationale:
Collectively, vascular disease – heart disease, stroke, diabetes and kidney disease – affect the lives of more than four million people and kill 170,000 every year. They also account for more than half the mortality gap between rich and poor. Modelling work undertaken by the Department of Health has found that offering NHS Health Checks to all people between 40 and 74, and recalling them every five years would be clinically and cost effective. The NHS Health Check programme will assess people's risk of heart disease, stroke, chronic kidney disease and diabetes and be based on straightforward questions and measurements such as age, sex, family history, height, weight and blood pressure. A simple blood test will also be carried out to measure cholesterol. Everyone will receive a personal assessment, setting out the person's level of risk and exactly what they can do to reduce it. For those at low risk, this might be no more than general advice on how best to stay healthy. Others may be assisted to join a weight management programme or a stop smoking service. Those at the highest risk might also require preventive medication with statins or blood pressure treatment. Phased implementation of the programme began in 2009/10. The NHS Health Check: Vascular Risk Assessment and Management Best Practice Guide was published in April 2009 and this clearly explains the core tests and measures in the risk assessment element of the NHS Health Check, along with similar information about risk management interventions. It describes what every person should receive as the national offer of a NHS Health Check.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, for commissioners
Planning Frequency:
Quarterly for 2012/13
Criteria for Plan Sign-off:
PCTs began phased implementation of the NHS Health Check programme from April 2009 for which funding has been provided. Funding in PCTs baseline for 2012/13 is available to deliver full roll out of the programme. Plans for 2012/13

should therefore reflect this. Full roll out of the programme will be reached when PCTs are inviting at least a fifth of their eligible population every year as part of a 5 year rolling programme. Therefore, we would expect PCTs to plan for a programme which will enable 20% of their eligible cohort to have had an offer of a NHS Health Check in 2012/13. E.g. if a PCT has an eligible cohort of 100,000, for a five year programme, we would expect PCTs to divide that cohort by 5 and invite 20,000 people each year for NHS Health Check.

FURTHER INFORMATION

Further Information:

Changes from 2011/12 Planning Round:

The indicator for the NHS Health Check programme remains unchanged from 2011/12 Operating Framework.

PHS01: Financial forecast outturn & performance against plan

Financial forecast outturn performance against plan at organisational and SHA Cluster level. In addition, no PCT forecast deficits are expected and no provider should plan for a forecast deficit unless part of an agreed recovery plan, consistent with their TFA.

Plan required: Yes

PHS02: Financial performance score for NHS Trusts

Quarterly provider performance ratings to be given based on financial performance and position, including application of overriding rules.

Plan required: No

PHS03: Delivery of running cost targets

Actual running costs to be compared to target running costs at SHA Cluster regional level.

Plan required: Yes

PHS04: Progress on delivery of QIPP savings

QIPP delivery (savings and re-investment) in 2012/13 and QIPP for 2012/13 to 2014/15, including demonstrable link to workforce and activity.

Plan required: Yes

PHS05: Bed Capacity

DEFINITIONS

Detailed Descriptor:

General and Acute bed numbers

Lines within Indicator (Units):

HRS05_01 - the average number of available day only beds (general and acute)

HRS05_02 - the average number of available beds open overnight (general and acute)

HRS05_03 - the total number of available general and acute beds

Line 01 + Line 02 = Line 03.

Note: This indicator may be extended to cover more than just consultant-led general and acute beds. Further details will be provided at a later date and plans on these new lines will not be required.

Data Definition:

Includes consultant-led general and acute beds in units managed by the provider, but excludes mental illness, learning disabilities and maternity beds.

Also excludes beds commissioned from other providers, beds designated solely for the use of well babies, and residential care beds.

Note: This indicator may be extended to cover more than just consultant-led general and acute beds. Further details will be provided at a later date and plans on these new lines will not be required.

Basis for Accountability:

Provider.

MONITORING

Monitoring Frequency:

Quarterly.

Monitoring Data Source:

KHO3 return.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
That consultant-led bed numbers will continue to reduce, reflecting the move of activity into other primary care and community settings.
Timeframe/Baseline:
Q1 & Q2 2010/11
Timeframe Until:
March 2015
Rationale:
To be used as a proxy indicator of care moving into primary care and the community.
SHA Envelopes:
No

PLANNING REQUIREMENTS
Are Plans Required?:
No.
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION
Further Information:
The data submitted should be consistent with the revised KH03 guidance that has applied from Q1 2010/11. Guidance available here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/index.htm Data available here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_083781 http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/Beds/DH_077449
Changes from 2011/12 Planning Round:

This is a new indicator.

PHS06: Non-elective FFCEs

DEFINITIONS

Detailed Descriptor:

Total number of non-elective FFCEs in general & acute (G&A) specialties in a month

Lines within Indicator (Units):

Number of G&A non-elective FFCEs in the period

Data Definition:

Non-Elective FFCEs data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected from providers (both NHS and IS) who provide the data broken down by Commissioner.

Number of first finished consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:

- patient classification = ordinary admission;
- admission method = emergency admission, maternity admission, other admission (codes 21-83);
- episode number = 1.

Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care.

General & Acute specialties

- include: 100-192, 300-460, 502, 800-831, 900 and 901
- exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ad/admitted_patient_total_non-elective_admissions_de.asp

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Returns (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
There should be a reduction in the growth of the number of non-elective FFCEs
Timeframe/Baseline:
Quarter 2, 2011/12
Timeframe Until:
March 2015
Rationale:
To reduce inappropriate use of expensive emergency care, and improve use of other services where appropriate.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years; • and for consistency with the forecasts for beds, length of stay, elective activity and finance.

FURTHER INFORMATION
Further Information:
http://www.connectingforhealth.nhs.uk/systemsandservices/data/nhsdmds/faqs
Changes from 2011/12 Planning Round:
This was an indicator (HRS06) in the 2011/12 planning round.

PHS07: GP Written Referrals to Hospital

DEFINITIONS

Detailed Descriptor:

GP written referrals from GPs for a first outpatient appointment in G&A specialities-

Number of written referrals from GPs for a first outpatient appointment in general & acute specialties.

Lines within Indicator (Units):

Number of GP written referrals in the period

Data Definition:

The total number of GP written Referral Requests for a first Consultant Outpatient Episode in the period.

An electronic message should be counted as written, as should a verbal request which is subsequently confirmed by a written request.

It is the total number of GP written referrals where:
Referral Request Type = National Code 01 'GP referral request'
Written Referral Request Indicator = classification 'Yes'

General & Acute specialties

Include: 100-192, 300-460, 502, 800-831, 900, 901

Exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Return (MAR)

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Quarter 2, 2011/12
Timeframe Until:
March 2015
Rationale:
Commissioners need to show that their plans for referrals and activity are realistic, and will sustain compliance with the NHS constitution's right to access services within maximum waiting times.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are based on robust demand assumptions; • and for consistency with the forecasts for activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2011/12 Planning Round:
This was an indicator (SRS11) in the 2011/12 planning round.

PHS08: Other Referrals For a First Outpatient Appointment

DEFINITIONS

Detailed Descriptor:

Other referrals for a first outpatient appointment in general & acute specialities-

Referrals other than from a GP for a first outpatient appointment in general & acute specialties.

Lines within Indicator (Units):

Number of referrals in the period.

Data Definition:

The total number of other (non-GP) referral requests (written or verbal or electronic) for a first consultant outpatient episode in the period.

The total number of other Referral Requests (written or verbal) for a first Consultant Out-Patient Episode in the period. All referral requests to a Consultant whether directed to a specific consultant or not, should be recorded, regardless of whether they result in an outpatient attendance.

The referral request received date of the referral request should be used to identify referrals to be included in the return.

It is the total number of referrals requests excluding:
a. GP written referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 'GP referral request' and the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

b. Self-referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 04 'Patient self-referral request'

c. Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode referrals; these are where the SOURCE OF REFERRAL FOR OUT-PATIENTS of the REFERRAL REQUEST is National Code 01 'following an emergency admission' or 02 'following a domiciliary visit' or 10 'following an Accident And Emergency Attendance' or 11 'other'

d. Referrals initiated by attendance at drop-in clinic without prior appointment; these are where the OUT-PATIENT CLINIC REFERRING INDICATOR of the REFERRAL REQUEST is classification 'Attended referring Out-Patient Clinic without prior appointment'

General & acute specialties

Include: 100-192, 300-460, 502, 800-831, 900, 901

Exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Return (MAR)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Timeframe/Baseline:

Quarter 2, 2011/12

Timeframe Until:

March 2015

Rationale:

Commissioners need to show that their plans for referrals and activity are realistic, and will sustain compliance with the NHS constitution's right to access services within maximum waiting times.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast

Planning Frequency:

Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.

Criteria for Plan Sign-off:

None.

Forecasts will be assessed:

- to ensure that they are based on robust demand assumptions;
- and for consistency with the forecasts for activity and finance.

FURTHER INFORMATION

Further Information:

Connecting for Health website:
http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html

Changes from 2011/12 Planning Round:

This was an indicator (SRS12) in the 2011/12 planning round.

PHS09: First Outpatient Attendances following GP Referral

DEFINITIONS

Detailed Descriptor:

First outpatient attendances (consultant-led) following GP referral in general and acute specialties-

[This line is a sub-total of all first outpatient attendances (consultant-led) in general and acute specialties, PHS10]

Lines within Indicator (Units):

Number of attendances in the period.

Data Definition:

A count of all first outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances in general & acute specialties for which:

- Referral Request Type = National Code 01 'GP referral request';
- Written Referral Request Indicator = classification 'Yes';
- First Attendance of the Out-Patient Attendance Consultant Care Contact = National Code 1 'First attendance face to face' or 3 'First telephone or telemedicine consultation'.

General & Acute specialties: include: 100-192, 300-460, 502, 800-831, 900, 901 but exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner (data to be based on responsible commissioner).

MONITORING

Monitoring Frequency:

Monthly.

Monitoring Data Source:
Monthly Activity Return (MAR).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Quarter 2, 2011/12
Timeframe Until:
Until March 2015
Rationale:
Commissioners need to show that their plans for referrals and activity are realistic, and will sustain compliance with the NHS constitution's right to access services within maximum waiting times.
SHA Envelopes:
No.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are consistent with sustaining 95th percentile and median waiting times; • and for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2011/12 Planning Round:
This was an indicator (SRS13) in the 2011/12 planning round.

PHS10: All First Outpatient Attendances

DEFINITIONS

Detailed Descriptor:

All first outpatient attendances (consultant-led) in general and acute specialties.

Lines within Indicator (Units):

Number of attendances in the period.

Data Definition:

A count of all outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances in general & acute specialties for which:

- first attendance = yes;
- attended or did not attend = attended (and was seen);
- First Attendance of the Out-Patient Attendance Consultant Care Contact = National Code 1 'First attendance face to face' or 3 'First telephone or telemedicine consultation'.

This includes first outpatient attendance for all consultant outpatient episodes for all sources of referral.

Activity delivered in a primary care setting lines should also be included.

General & Acute specialties: include: 100-192, 300-460, 502, 800-831, 900, 901 but exclude: 501,700-715

http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/out-patient_flows_data_set_fr.asp?shownav=1

Basis for Accountability:

Commissioner (data to be based on responsible commissioner).

MONITORING

Monitoring Frequency:

Monthly.

Monitoring Data Source:
Monthly Activity Return (MAR).

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Quarter 2, 2011/12
Timeframe Until:
March 2015
Rationale:
Commissioners need to show that their plans for referrals and activity are realistic, and will sustain compliance with the NHS constitution's right to access services within maximum waiting times.
SHA Envelopes:
No.

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed: • to ensure that they are consistent with sustaining 95th percentile and median waiting times; • and for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2011/12 Planning Round:
This was an indicator (SRS14) in the 2011/12 planning round.

PHS11: Elective FFCEs

DEFINITIONS

Detailed Descriptor:

Number of general & acute (G&A) elective admissions Finished First Consultant Episodes (FFCEs)

Lines within Indicator (Units):

Line 1: number of G&A elective ordinary admission FFCEs in the period

Line 2: number of G&A daycase FFCEs in the period

Line 3: total number of G&A elective FFCEs in the period

Note: Line 1 + Line 2 = Line 3

Data Definition:

Number of finished first consultant episodes (FFCEs) for the G&A specialties (see below) relating to hospital provider spells for which:

- patient classification = ordinary admission (1) Daycase admission (2);
- admission method = elective admission (admission method 11, 12, 13);

Exclude "well babies". These are defined as having admission method = other and neonatal level of care = normal care.

- episode number = 1

General & Acute specialties

include:100-192, 300-460, 502, 800-831, 900, 901

exclude: 501, 700-715

http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ad/admitted_patient_elective_admissions_(ordinary)_de.asp?shownav=1
http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/a/ad/admitted_patient_elective_admissions_(day_case)_de.asp?shownav=1

Basis for Accountability:

Commissioner

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Monthly Activity Return (MAR)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

That elective activity will reflect future demand and the move of activity into other primary care and community settings.

Timeframe/Baseline:

Quarter 2, 2011/12

Timeframe Until:

March 2015

Rationale:

Commissioners need to show that their plans for referrals and activity are realistic, and will sustain compliance with the NHS constitution's right to access services within maximum waiting times.

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required - provider forecast with SHA assurance of PCT sign off; and commissioner forecast

Planning Frequency:

Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.

Criteria for Plan Sign-off:

None.
Forecasts will be assessed:

- to ensure that they are consistent with sustaining 95th percentile and median

waiting times;
- and for consistency with the forecasts for beds, length of stay, outpatient activity and finance.

Please note that these forecasts of elective admissions will also be assessed using the criteria shown above for Daycase Rate (PSS07).

FURTHER INFORMATION
Further Information:
Connecting for Health website: http://www.connectingforhealth.nhs.uk/systemsandservices/data/datamodeldictionary/help/faqs-07/index_html
Changes from 2011/12 Planning Round:
This was an indicator (SRS15) in the 2011/12 planning round.

PHS12: A&E Attendances

DEFINITIONS

Detailed Descriptor:

Number of attendances at A&E departments in a quarter

Lines within Indicator (Units):

SRS16_01 Number of attendances at Type 1 A&E Departments

SRS16_02 Total Number of attendances at all A&E Departments

Note: Line 01 is subset of Line 02

Data Definition:

A&E Attendance figures are sourced from weekly SitRep data provided to the Department of Health by Trusts – this is a weekly total taken from a reporting period of 00.01 Monday to 24.00 Sunday.

'Total A&E attendances' is defined as the total of type 1, type 2 and type 3 attendances. This is automatically calculated on the SitRep submission form. Data from the forms are collated from Trusts into monthly totals by the DH and then aggregated into Strategic Health Authority and national totals by the NHS IC.

Basis for Accountability:

Provider level

MONITORING

Monitoring Frequency:

Quarterly - aggregated from weekly

Monitoring Data Source:

Weekly Sitrep data

ACCOUNTABILITY

What success looks like, Direction, Milestones:

There should be a reduction in the growth of the number of A&E attendances

Timeframe/Baseline:

Baseline of 2011-12

Timeframe Until:
March 2015
Rationale:
This workstream aims to ensure that patients requiring urgent and emergency care get the right care by the right person at the right place and time. There are large numbers of people presenting to accident and emergency departments because they either do not know how, or are unable, to access the care they feel they need when they want it. A reduction in the growth of the number of A&E attendances would indicate a reduction in inappropriate use of expensive emergency care, and improve use of other services where appropriate.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, provider forecast with SHA assurance of PCT sign off
Planning Frequency:
Firm quarterly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15
Criteria for Plan Sign-off:
None. Forecasts will be assessed to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years.

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was indicator SRS16 in the 2011/12 planning round.

PHS13: Ambulance Urgent & Emergency Journeys

DEFINITIONS

Detailed Descriptor:

Number of urgent and emergency journeys via ambulance, monthly

Lines within Indicator (Units):

Number of urgent and emergency journeys via ambulance, monthly

Data Definition:

The number of urgent and emergency journeys taking place each month.

Each patient conveyed is counted as an individual patient journey (e.g. two patients in one vehicle counts as two patient journeys).

Include only those patients conveyed as a result of a 999 call made by a member of the public or organisation, or as a result of being categorised as an emergency following a referral by a health care professional.

Journeys without patients should be excluded.

Basis for Accountability:

Ambulance Trust

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Ambulance Computer Aided Dispatch System

Monthly data collected via Unify

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Reduction in the growth in the number of ambulance journeys

Timeframe/Baseline:

Baseline of 2011-12

Timeframe Until:
March 2015
Rationale:
More joined up services should mean transfers of activity away from A&E and ambulance services into primary and community based care. Increasing the volume of "hear and treat" (clinical advice over the telephone) and "see and treat" (treatment at the scene of the incident) will also result in the proportion of patients conveyed by ambulance.
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
Yes, provider (ambulance trust) forecast with SHA assurance of PCT sign off
Planning Frequency:
Firm quarterly forecasts for 2012/13, and outline annual forecasts for 2013/14, 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed to ensure that they are based on robust demand assumptions that support delivery of QIPP over four years.

FURTHER INFORMATION
Further Information:
Further guidance on all indicators included in the Ambulance Quality Indicators collection can be found on the Department of Health website at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/AmbulanceQualityIndicators/index.htm
Changes from 2011/12 Planning Round:
This was an indicator (SRS17) in the 2011/12 planning round.

PHS14: Diagnostic Activity – Endoscopy based tests

DEFINITIONS

Detailed Descriptor:

The total number of diagnostic endoscopy test/procedures including:

- Colonoscopy
- Flexi sigmoidoscopy
- Cystoscopy
- Gastroscopy

Lines within Indicator (Units):

Total number of diagnostic endoscopy tests.

Data Definition:

Include all relevant tests and procedures funded by the NHS. This includes all referral routes (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and all settings in which they are carried out (i.e. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centre etc.).

Count one unit of activity for each distinct clinical test/procedure carried out. Examples are shown below.

If two different procedures are done on the same day, even if done during the same list, then this should count as two tests. Example would be OGD and colonoscopy which are often done on the same day or on the same list.

However, if a test is part diagnostic and part therapeutic then it should be designated one test. For example ERCP is often double counted as a first and second procedure on the same day/list but in most circumstances it should be counted as one procedure.

If the same procedure is done twice in one day but at separate times it should be two procedures: example would be OGD for upper gut bleeding. Sometimes the patient will need a second OGD later in the day if the bleeding is not controlled by the first procedure.

Include all categories of tests (as defined in DM01):

- Waiting list
- Planned
- Unscheduled

Basis for Accountability:

Commissioner and provider

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Monthly diagnostics data collection - DM01

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
2011/12
Timeframe Until:
March 2015
Rationale:
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
Yes – commissioner forecasts
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Data and full guidance can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm
Changes from 2010/11 Planning Round:
This is a new indicator.

PHS15: Diagnostic Activity – Non-endoscopy based tests

DEFINITIONS

Detailed Descriptor:

The total number of non-endoscopy based tests/procedures including:

- Imaging - Magnetic Resonance Imaging
- Imaging - Computed Tomography
- Imaging - Non-obstetric ultrasound
- Imaging - Barium Enema
- Imaging - DEXA Scan
- Physiological Measurement - Audiology - Audiology Assessments
- Physiological Measurement - Cardiology - echocardiography
- Physiological Measurement - Cardiology - electrophysiology
- Physiological Measurement - Neurophysiology - peripheral neurophysiology
- Physiological Measurement - Respiratory physiology - sleep studies
- Physiological Measurement - Urodynamics - pressures & flows

Lines within Indicator (Units):

Total number of diagnostic tests (non endoscopy)

Data Definition:

Include all relevant tests and procedures funded by the NHS. This includes all referral routes (i.e. whether the patient was referred by a GP or by a hospital-based clinician or other route) and all settings in which they are carried out (i.e. outpatient clinic, inpatient ward, x-ray department, primary care one-stop centre etc.).

Count one unit of activity for each distinct clinical test/procedure carried out. Examples are shown below.

Patient having angiography has one scan immediately prior to injecting contrast dye and then a further scan after injection of contrast dye – this would count as one distinct clinical test/procedure even though two scans have been carried out as part of the procedure. Alternatively if a patient has an angiography followed by an echocardiography on the same day, count this as two distinct clinical tests/procedures.

Similarly, a patient having more than one MR scan of a knee AT THE SAME VISIT would count as one unit of activity. However, patient having one CT scan of a knee and one CT scan of a shoulder would count as two units of activity.

Include all categories of tests (as defined in DM01)

- Waiting list
- Planned
- Unscheduled

Basis for Accountability:
Commissioner and provider

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
Monthly diagnostics data collection - DM01

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
2011/12
Timeframe Until:
March 2015
Rationale:
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
Yes - commissioner forecasts
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None.

Forecasts will be assessed for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION

Further Information:

Data and full guidance can be found here:

http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/HospitalWaitingTimesandListStatistics/Diagnostics/index.htm

Changes from 2011/12 Planning Round:

This is a new indicator.

PHS16: Numbers waiting on an Incomplete Referral to Treatment pathway

DEFINITIONS

Detailed Descriptor:

The total number of incomplete Referral to Treatment (RTT) pathways at the end of the period

Lines within Indicator (Units):

The total number of incomplete RTT pathways at the end of the period

Data Definition:

The number of incomplete RTT pathways at the end of the period based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.

The definitions that apply for RTT waiting times are set out in the RTT Clock Rules Suite found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/DH_089757

Basis for Accountability:

Commissioner and provider.

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Consultant-led Referral to Treatment Waiting Times data collection via Unify2 (National Statistics)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

This will be assessed against the standard of 92 per cent of patients on an incomplete pathway waiting no more than 18 weeks, and alongside other data, including referrals, activity, finance, and referral to treatment data - including for consistency with sustaining RTT waiting time standards.

Timeframe/Baseline:

2011/12
Timeframe Until:
March 2015
Rationale:
As set out in the NHS Operating Framework for 2012/13, the operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits as set out in the NHS Constitution remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks. The referral to treatment (RTT) operational standards should be achieved in each specialty by every organisation and this will be monitored monthly.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
Yes - commissioner forecasts
Planning Frequency:
Firm monthly forecasts for 2012/13, and outline annual forecasts for 2013/14 and 2014/15.
Criteria for Plan Sign-off:
None. Forecasts will be assessed for consistency with the forecasts for referrals, activity and finance.

FURTHER INFORMATION
Further Information:
Data and full guidance can be found here: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/ReferraltoTreatmentstatistics/index.htm
Changes from 2011/12 Planning Round:
No changes.

PHS17: Health Visitor Numbers

DEFINITIONS
Detailed Descriptor:
Number of health visitors (FTE)
Lines within Indicator (Units):
Health visitor numbers as a subset of the all Hospital and Community Health Services (HCHS) workforce by FTE using data from the Electronic Staff Record (ESR) and health visitor numbers not captured by ESR using data from the Health Visiting Minimum Data Set (HV MDS).
Data Definition:
High-level workforce statistics at a National and SHA level for health visitors
Basis for Accountability:
All trusts aggregated to national and SHA level

MONITORING
Monitoring Frequency:
Monthly (ESR and HV MDS) or Annually (Annual Census)
Monitoring Data Source:
ESR data. For Moorfields and Chesterfields FT, the actual census data as at 30 September 2011 HV MDS for health visitors not recorded on ESR.

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Delivery of extra 4200 health visitors by 2015.
Timeframe/Baseline:
May 2010
Timeframe Until:
2015

Rationale:

The Coalition Agreement contained a commitment to delivering an extra 4,200 health visitors to ensure families have a positive start, working in partnership with other health services, GPs, Sure Start Children's Centres and other early years services. The Departmental Business Plan stipulates that this commitment must be implemented by 2015.

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, at SHA level

Planning Frequency:

Quarterly

Criteria for Plan Sign-off:

- Plans to demonstrate increase in HV FTE numbers during 2012-13 and progress in all areas in growing the workforce, including training commissions, towards the additional 4,200 extra HVs by 2015, taking account of progress against signed off trajectories outlined in the HV MDS.

- Plans to demonstrate extended coverage of local delivery of the HCP during 2012-13.

- Confirmation that plans have been shared with LA children's services.

FURTHER INFORMATION

Further Information:

Changes from 2011/12 Planning Round:

This was an indicator (HRS08) in the 2011/12 planning round.

PHS18: Workforce Productivity

DEFINITIONS

Detailed Descriptor:

Workforce productivity measure

Lines within Indicator (Units):

1. Cost-weighted secondary care activity
2. Earnings weighted staff capacity
3. Workforce productivity =

(1+ % change in secondary activity) / (1+ % change in staff capacity) -1

Data Definition:

Cost-weighted secondary activity:

Weighted sum of

- non-elective G&A admissions (FFCEs),
- elective G&A admissions (FFCEs) (waiting list, booked or planned). National Commissioning Group activity (YDD82 in UNIFY) is excluded.
- First out-patient attendances (consultant led) in G&A specialties,
- A&E attendances (type 1 and 2 attendances only)

Weights are equal to the weighted average reference cost for each activity.

Earnings weighted staff capacity:

Weighted sum of number of staff in each staff group, with weights being average earnings of each staff group

Basis for Accountability:

Commissioner, aggregated to SHAs

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

Non-elective FFCEs: Monthly Activity returns
Elective FFCEs: Monthly Activity returns
First out-patient attendances: Monthly Activity returns
A&E attendances- type 1 and 2 : Weekly Sitreps
Staff numbers: ESR data
Staff earnings: iView data

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Workforce productivity should show an increase on previous year
Timeframe/Baseline:
2011-12
Timeframe Until:
End of planning period
Rationale:
Productivity is a measure of outputs over inputs. This indicator takes the output of the NHS as a measure of secondary care activity, and the input as staff capacity. As efficiencies are put in place, then it would be expected that for the same level of staff capacity, there would in an increase in activity.
SHA Envelopes:
N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was an indicator (HRS09) in the 2011/12 planning round.

PHS19: Total Pay Costs

DEFINITIONS
Detailed Descriptor:
NHS Workforce total pay costs
Lines within Indicator (Units):
All Hospital and Community Health Services (HCHS) paybill using data from the Electronic Staff Record (ESR). The figures do not include data for primary care or some social enterprises and local authorities.
Data Definition:
High-level NHS HCHS paybill statistics at a National and SHA level for Hospital Doctors and Non Medical Staff by major staff groups and service priorities.
Basis for Accountability:
All trusts aggregated to national, SHA cluster and PCT cluster level

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
The monthly workforce statistics published by the NHS Information Centre. For Moorfields and Chesterfields FT, the actual census data as at 30 September 2011

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Baseline is 31 March 2012
Timeframe Until:
Ongoing
Rationale:

The NHS must make up to £20bn of efficiency savings by 2014 by reducing bureaucracy and doing things differently.

Efficiency gains will allow the NHS to reinvest in support for front line services and improving quality

SHA Envelopes:

PLANNING REQUIREMENTS

Are Plans Required?:

Yes, forecasts are required from SHA and PCT clusters

Planning Frequency:

Criteria for Plan Sign-off:

FURTHER INFORMATION

Further Information:

Changes from 2011/12 Planning Round:

NHS Information Centre now publish HCHS workforce data on a monthly basis drawn from the Electronic Staff Record

PHS20: Total Workforce (FTEs)

DEFINITIONS
Detailed Descriptor:
NHS Workforce
Lines within Indicator (Units):
All Hospital and Community Health Services (HCHS) workforce by FTE using data from the Electronic Staff Record (ESR) The figures do not include data for primary care or some social enterprises and local authorities.
Data Definition:
High-level NHS HCHS Workforce statistics at a National and SHA level for Hospital Doctors and Non Medical Staff by major staff groups and service priorities. Tables of headcount, FTE, role and turnover counts also available
Basis for Accountability:
All trusts aggregated to national, SHA cluster and PCT cluster level

MONITORING
Monitoring Frequency:
Monthly
Monitoring Data Source:
The monthly workforce statistics published by the NHS Information Centre. For Moorfields and Chesterfields FT, the actual census data as at 30 September 2011

ACCOUNTABILITY
What success looks like, Direction, Milestones:
Timeframe/Baseline:
Baseline is 31 March 2012
Timeframe Until:
Ongoing

Rationale:
The NHS must make up to £20bn of efficiency savings by 2014 by reducing bureaucracy and doing things differently. Efficiency gains will allow the NHS to reinvest in support for front line services and improving quality To understand the size, shape and structure of the NHS
SHA Envelopes:

PLANNING REQUIREMENTS
Are Plans Required?:
No.
Planning Frequency:
n/a
Criteria for Plan Sign-off:
n/a

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This was an indicator (SRS 02) in the 2012/13 planning round.

PHF01: Progress against tripartite formal agreements

DEFINITIONS

Detailed Descriptor:

Line 1:

Progression of trusts along the FT pipeline-

Percentage of Non – FTs within the SHA's region which are on track against their agreed milestones within the tripartite formal agreements between DH, the SHA and the Trust (to be agreed)

Line 2:

Assessment of risk to successful delivery of pipeline-

Percentage of non-FTs behind their expected position against the milestones within the tripartite formal agreements between SHA, Department and the Trust (to be agreed) by over 3 months.

Line 3:

Assessment of progress along the pipeline of trusts in category 4 (unsustainable provider classification)-

Percentage of non-FTs in Category 4 behind their expected position against the milestones within the tripartite formal agreements between the SHA, Department and the Trust (to be agreed) by over 3 months.

Lines within Indicator (Units):

Line 1: Number of non-FTs on track / total number of non-FTs in the region (in the pipeline)

Line 2: Number non-FTs that are more than 3 months behind their expected position / total number of non-FTs in the region

Line 3: Number of non-FTs in Category 4 that are more than 3 months behind their expected position / total number of non-FTs in the region (in the pipeline)

Data Definition:

Basis for Accountability:

SHA

MONITORING
Monitoring Frequency:
Quarterly (starting at end of 1st quarter 2012/13)
Monitoring Data Source:
SHA derived measure from SHA monitoring of trust performance

ACCOUNTABILITY
What success looks like, Direction, Milestones:
For line 1: Success is 100%. This may change depending on the position of Trusts following further analysis of Trust returns in January. For line 2 and 3: As low a % as possible
Timeframe/Baseline:
1 April 2012
Timeframe Until:
31 March 2014
Rationale:
Line 1: To assess progress against agreed milestones for the pipeline. Line 2: To provide an indicator of risk to pipeline delivery and facilitates the identification of issues. Line 3: To provide an indicator of progress within Trusts where the organisational solution is particularly challenging. A high % in this area poses a very high risk to delivery of the pipeline.
SHA Envelopes:
Not applicable

PLANNING REQUIREMENTS
Are Plans Required?:

No
Planning Frequency:
Criteria for Plan Sign-off:

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
These were indicators SRF01 – 03 in the 2011/12 Technical Guidance.

PHF02: Public Health

Completed transfers of public health functions to local authorities. This indicator is to be developed in 2012/13.

PHF03: Delegated Budgets

DEFINITIONS

Detailed Descriptor:

Single measure 'percentage of PCT commissioning spend delegated to GP practices' to monitor how emerging CCGs are progressing their development supported by PCT clusters.

Lines within Indicator (Units):

Numerator

Total value of proposals for delegation applied for by the pathfinder/CCG of total available commissioning funds

Denominator

Total value of funds delegated to the pathfinder/CCG of total available commissioning funds

Data Definition:

Total commissioning budget not retained elsewhere i.e. excluding primary care contracting, specialist commissioning, ambulance services, and public health commissioning.

Basis for Accountability:

Cluster leads will provide this data from 12/13 FIMS Operating Plans (PCT 09) and other finance data sources.

MONITORING

Monitoring Frequency:

Quarterly

Monitoring Data Source:

FIMS

ACCOUNTABILITY

What success looks like, Direction, Milestones:

100% of eligible budget delegated by PCT to emerging clinical commissioning groups by 1 April 2012

Timeframe/Baseline:

Mach 2012

Timeframe Until:

Ongoing

Rationale:

The indicator is designed to monitor progress in delegating commissioning responsibilities.

SHA Envelopes:

No

PLANNING REQUIREMENTS

Are Plans Required?:

No

Planning Frequency:

n/a

Criteria for Plan Sign-off:

n/a

FURTHER INFORMATION

Further Information:

The indicator is designed to monitor progress in delegating commissioning responsibilities. The denominator and numerator will be SHA-wide figures for the purposes of reporting. However, SHAs are likely to want to collect cluster and pathfinder/CCG level data. Where possible for pathfinder/CCG level reporting, known budgets will be calculated on a practice basis; where this is not possible the calculation for each pathfinder/CCG may use a population weighted capitation formula.

The proposed approach to calculate the 'total available commissioning funds' figure will be to start with planned spend for commissioning from readily available data in 11/12 FIMS Operating Plans (PCT 09) and then subtract budgets that will not be delegated, such as specialised commissioning, public health commissioning, and primary care contracting. Management costs should not be included in the total available commissioning funds figure and also not in budgets that are delegated and recorded against the indicator.

Attention should be paid to the following:

Specialised Commissioning

Specialised commissioning will not be undertaken by CCGs when authorised. Specialised commissioning is included in the secondary care sub-codes, mainly in 'General and Acute'. Clusters will be required to define what specialist commissioning each sub-code includes in order that this can be excluded from the overall figures.

Armed Forces

The commissioning of some secondary care services for armed forces personnel is changing and will be commissioned by the Ministry of Defence and the NHS Commissioning Board. It is not anticipated that these amounts will make a material difference on a SHA-wide basis. Until further guidance is received, this should be

included in the total budget that can be delegated.

Secondary Care Dental

This spend will not be delegated to CCGs and should be deducted from the total budget that can be delegated. The amounts are currently within acute expenditure where the provider is an acute trust, and may be difficult to separate out due to current contractual arrangements. Since the amounts will not be significant, if necessary they can be separated out a later date.

Ambulance Service

Ambulance service spend is expected to be included in CCG budgets. Currently, some pathfinders/CCGs are planning to take on delegated responsibility for commissioning ambulance services whereas in some areas, ambulance service spend is SHA-wide and will be retained by clusters during the transition. Whether ambulance service spend is included in the total budget available for delegation to pathfinders/CCGs will therefore be at the discretion of SHAs.

Public Health

Public health commissioning spend will not be included in the total budget available for delegation to pathfinders/CCGs. It is proposed that 11/12 figures, as stated in PCT's annual accounts, are used as an estimate. It is recognised that there will be some double counting within the public health expenditure, for example, specialist commissioning screening programmes and where public health spend is incurred in primary care. This means that the calculation will slightly understate the level of budget to be delegated. This is not expected to be a material difference at approximately 1-2%.

The PCT will remain accountable for the part of a joint commissioning arrangement that sits in its budget, or where budgets have not been formally pooled but a joint approach to commissioning has been agreed. It is understood that these budgets will be retained at a local level and not transfer to the NHS Commissioning Board, and therefore it is expected that they should be delegated to CCGs. The value of the PCT budget devolved to local authority control or aligned to joint commissioning should be included in the overall available commissioning budget where this is for commissioning that will not transfer to the NHS Commissioning Board.

It is proposed that pathfinders/emerging CCGs take on responsibility for overseeing the joint commissioning arrangements in a similar way to how PCTs (now as clusters) have that overseeing function now, and this should include practical management of the S75 arrangements and oversight of other joint arrangements. When responsibility for these services is transferred to the pathfinder/CCG, the relevant budget will be added to the delegated budget figure.

Delegated responsibilities part-year effect

In many cases it is expected that pathfinders/CCGs will take on delegated responsibilities on an incremental basis during the year, and therefore the overall

budget controlled from that point will increase. This indicator will not calculate delegated commissioning budgets on pro-rata basis; rather the indicator will capture the overall 'whole-year' available budget controlled at that point in time to demonstrate the split in responsibility.

Sub-Codes - FIMS, Purchase of Health Care by PCT ascribed to activity
Shaded sub-codes are included in the 'total available commissioning funds.'
Un-shaded sub-codes not included and retained by Clusters.

Analysis of Purchase of Health Care by PCT	Sub Code
Purchase of Primary Healthcare	
GMS,PMS, APMS and PCTMS	**100**
Prescribing Costs	**110**
Contractor Led GDS & PDS	**120**
Salaried Trust Led GDS & PDS	**130**
General Ophthalmic Services	**140**
Department of Health Initiative Funding	**150**
Pharmaceutical Services	**160**
Local Pharmaceutical Services Pilots	**170**
New Pharmacy Contract	**180**
Non-GMS Services from GPs	**190**
Other - *requires a decision on a case-by-case basis*	**200**
Total Primary Healthcare Purchased	**210**
Purchase of Secondary Healthcare	
Learning Difficulties	**220**
Mental Illness	**230**
Maternity	**240**
General and Acute	**250**
Accident and Emergency	**260**
Community Health Services	**270**
Other Contractual	**280**

Changes from 2011/12 Planning Round:

This indicator is the development of the indicator SRF08 from the 2011/12 planning round.

PHF04: Commissioning Development: Measure of £ per head devolved running costs

DEFINITIONS
Detailed Descriptor:
Measure of £ per head of devolved running costs to emerging Clinical Commissioning Groups.
Lines within Indicator (Units):
This indicator is under development.
Data Definition:
Under development
Basis for Accountability:

MONITORING
Monitoring Frequency:
TBC
Monitoring Data Source:
TBC

ACCOUNTABILITY
What success looks like, Direction, Milestones:
TBC
Timeframe/Baseline:
TBC
Timeframe Until:
TBC
Rationale:
TBC
SHA Envelopes:
TBC

PLANNING REQUIREMENTS
Are Plans Required?:
No

Planning Frequency:
n/a
Criteria for Plan Sign-off:
n/a

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This is a new indicator

PHF05: Commissioning Development: % authorisation of Clinical Commissioning Groups

DEFINITIONS
Detailed Descriptor:
Percentage of Clinical Commissioning Groups authorised.
Lines within Indicator (Units):
This indicator is under development and pending agreement of final authorisation process and content due for publication in February 2012.
Data Definition:
TBC
Basis for Accountability:
TBC

MONITORING
Monitoring Frequency:
TBC
Monitoring Data Source:
TBC

ACCOUNTABILITY
What success looks like, Direction, Milestones:
TBC
Timeframe/Baseline:
TBC
Timeframe Until:
TBC
Rationale:
TBC
SHA Envelopes:
TBC

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION
Further Information:
Changes from 2011/12 Planning Round:
This is a new indicator.

PHF06 : Tackling List Inflation- % of General Practice lists reviewed and cleaned

DEFINITIONS

Detailed Descriptor:

Improving the accuracy of existing GP patient lists and updating to more accurately reflect population changes such as births, deaths and people movements

Lines within Indicator (Units):

Measuring for each GP practice their efficiency in maintaining an accurate patient list of registered patients.

Indicators for measuring this will be based on reducing existing differences that exist between the number of current resident Office of National Statistics (ONS) and GP registered Exeter (NHAIS) populations

Data Definition:

List variation between GP practice registrations and ONS population estimates has existed for many years

Currently 2.5 million or 5% more people identified as “ghost patients” exist between ONS population estimates and GP registered lists. 5% is the England average; some PCTs have a smaller difference, some larger i.e. up to 30%.

When calculating PCT allocations, GP registrations are currently constrained to Office of National Statistics (ONS) resident populations. This means that PCT populations sum to the ONS estimated population for England, and this ensures that PCTs total allocations are not over-funded because of inaccurate GP patient lists.

For PCT allocations, reconciliation of lists to ONS populations is also undertaken below the national level. However, inaccurate lists will affect the relative distribution of funding across small areas and thereby reduce allocative efficiency.

Basis for Accountability:

Data will be PCT responsibility

MONITORING

Monitoring Frequency:

To issue regular ONS resident and Exeter registered population data that will provide details on patient numbers per practice, broken down by Carr-Hill age and sex bandings and comparing these monthly extracts against previous Exeter data to identify all changes since the last comparison was made to estimate likely list inflation at PCT level.

This should provide an indication of which PCTs are taking active measures to address potential Ghost Patients and provide indications over the scale of change achieved to-date.

Continued monthly Exeter extracts will similarly provide a month-by-month means of monitoring PCT activity. The data (and analysis) will be issued to SHAs for them to discuss locally with PCT clusters where greater action is required.

Monitoring Data Source:

Office of National Statistics (ONS) latest 2010 and 2011 annual population estimates for England and latest monthly Exeter registered patient extracts as taken from the Exeter NHAIS system..

ACCOUNTABILITY

What success looks like, Direction, Milestones:

PCTs to engage in more proactive list management responsibility with GP practices on a regular basis to ensure progress on reducing list variance.

Practices to record progress on list cleansing and report this with their SHA

PCTs and SHAs to further support working towards improving accuracy of existing GP lists in 2012-13 to below existing 5% level (with aim of achieving <3%). Those PCTs with practice list differences substantially in excess of >5% to be benchmarked against their achievement in reducing list differences to agreed levels as part of the process of handing over responsibility to the new NHS Commissioning Board from April 2013.

Timeframe/Baseline:

Now until 31 March 2013

Timeframe Until:

Working towards handing the new NHS Commissioning Board direct responsibility for improving list cleansing by April 2013 deadline.

Rationale:

GPs will need to demonstrate both robustness and accuracy of their lists that will be a factor contributing towards their authorisation as clinical commission groups. GPs will have to demonstrate their lists are sufficiently up to date and accurate to enable them to take on the budgetary responsibility in 2013.

SHA Envelopes:

Not applicable

PLANNING REQUIREMENTS

Are Plans Required?

Not applicable

Planning Frequency:

Not applicable
Criteria for Plan Sign-off:
Not applicable

FURTHER INFORMATION
Further Information:
Changes from 2010/11 Planning Round:
This is a new indicator

PHF07: Bookings to Services Where Named Consultant Led Team was Available (Even if Not Selected)

DEFINITIONS

Detailed Descriptor:

Bookings to services where named consultant led team was available (even if not selected)

Lines within Indicator (Units):

For all PCTs:
Numerator: Bookings made through Choose and Book (CAB) to first outpatient services on the secondary care menu where there was at least one named clinician listed on the system, excluding those with a two week wait specialty.

Denominator: All bookings to first outpatient services on the secondary care menu made through CAB, excluding those with a two week wait specialty.

Data Definition:

CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service. Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included. Qualifying services are those with at least one named clinician listed (not just allocated).

Basis for Accountability:

Commissioner. (Data are based on PCT of responsibility).

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

CAB bookings from data extracted from the CAB system –daily booking extracts compiled into a bookings database and restricted to first outpatient bookings on the secondary care menu excluding 2ww specialty. The Named clinicians extract shows which services have named consultants listed.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

All patients should have the opportunity to choose a named clinician for first outpatient appointment from April 2012, even if they do not wish to take that

opportunity. The first step is for providers to attach named clinicians to services they list on CAB and the second is for patients to book into those services.

This indicator should be considered in conjunction with the System indicator, "Use of Choose and Book", to judge success. Success would look like a rapidly increasing % of CAB bookings being made to services where a named consultant-led team was available where there is also a high level of utilisation of Choose and Book overall. A high % on this indicator where utilisation of Choose and Book is low overall would only indicate that where services are listed they are listed against named consultant-led teams.

Timeframe/Baseline:

Not applicable.

Timeframe Until:

Not applicable.

Rationale:

The White Paper, Equity and excellence: Liberating the NHS, committed to introducing a choice of named consultant-led team where clinically appropriate. The intention is for everyone who needs to see a consultant to be able to make an appointment with a particular team headed by a named consultant. The Department of Health published its contractual guidance in October ahead of implementing this commitment from April 2012.

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

No.

Planning Frequency:

Not applicable.

Criteria for Plan Sign-off:

Not applicable.

FURTHER INFORMATION

Further Information:

The information is available to the NHS in the Named Clinician Time series report

available at nww.chooseandbook.nhs.uk/staff/reports/namedclin, based on the Named clinician Monthly Services report at the same link and the CAB booking extracts available from nww.chooseandbook.nhs.uk/staff/reports.
Changes from 2011/12 Planning Round:
This indicator has not changed.

PHF08: Proportion of GP Referrals to First OP Appointments Booked Using Choose and Book

DEFINITIONS

Detailed Descriptor:

Proportion of GP referrals to first OP appointments booked using Choose and Book.

Lines within Indicator (Units):

For all PCTs:
Numerator: GP referrals to first outpatient services booked using Choose and Book (CAB) in the period.
Denominator: Total referrals made by GPs to first outpatient services in the period.

Data Definition:

CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service. Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included.

Total GP referrals comprise written referrals from GPs for first consultant outpatient appointment (all specialties), regardless of whether or not they resulted in an outpatient attendance. Written referrals include electronic messages and those made verbally and confirmed in writing.

Basis for Accountability:

Commissioner. (Data are based on PCT of responsibility).

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

CAB bookings from data extracted from the CAB system –daily booking extracts compiled into a bookings database.

GP referrals from the DH Monthly Activity Return, adjusted to remove referrals from General Dental Practitioners based on a percentage advised by the PCT and updated on request.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Success would be a high percentage of GP referrals to first outpatient appointments being made using Choose and Book. Historically, the ambition was to achieve 90% of GP referrals to first outpatient appointments being made using CAB. Although there is no longer a target for CAB utilisation, this figure may serve as a useful guide for judging success. It should be noted that some referrals may remain outside the scope of CAB.

Timeframe/Baseline:

Not applicable.

Timeframe Until:

Not applicable.

Rationale:

Choose and Book is the electronic referral and booking system that supports patient choice by enabling GPs and patients to navigate through the increasing array of services available to them once a decision has been made to refer to a first consultant outpatient appointment. GPs can search for all secondary care services from across the country (provided by NHS and independent providers under a national contract), alongside all primary care services which are commissioned by their PCT. The patient can then book their appointment there and then in the GP practice or later at a more convenient time via the internet or by telephone.

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

No.

Planning Frequency:

Not applicable.

Criteria for Plan Sign-off:

Not applicable.

FURTHER INFORMATION

Further Information:

The information is given in the Month series sheet of the Weekly CAB bookings report available to the NHS via the following link: nww.chooseandbook.nhs.uk/staff/reports.

Changes from 2011/12 Planning Round:
This indicator has not changed.

PHF09: Trend in Value/Volume of Patients Being Treated at non-NHS Hospitals

DEFINITIONS

Detailed Descriptor:

Trend in volume of NHS-funded patients being treated at independent sector (non-NHS) facilities (Treatment centres and hospitals)

Lines within Indicator (Units):

For all PCTs:

Volume:
Numerator: GP referrals to first outpatient services at non-NHS providers booked using Choose and Book (CAB) in the period.
Denominator: All GP referrals to first OP services booked using CAB.

Data Definition:

CAB bookings comprise Unique Booking Reference Numbers (UBRNs) that are converted to a booking into an outpatient service. Re-bookings are excluded but onward referrals to an outpatient service, eg from an assessment service, are included. Qualifying services are those to any non-NHS provider.

Basis for Accountability:

Commissioner. (Data are based on PCT of responsibility).

MONITORING

Monitoring Frequency:

Monthly

Monitoring Data Source:

CAB bookings from data extracted from the CAB system –daily booking extracts compiled into a bookings database.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Patients should have the opportunity to choose a range of providers for their first outpatient appointment, including those in the Independent sector. This indicator shows a percentage of patients who have exercised choice, since it is likely that an alternative NHS provider was also offered to them. An increasing percentage of CAB bookings being made to the IS may be indicative of more choice being offered to patients.

This indicator should be considered in conjunction with the System indicator, "Use of Choose and Book". Relatively high percentages of CAB bookings being made to the IS may not be indicative of what is happening overall if CAB utilisation is low.

Timeframe/Baseline:

Not applicable.

Timeframe Until:

Not applicable.

Rationale:

Use of the independent sector is viewed as a good proxy measure of the take-up of choice as use of the independent sector implies that an NHS alternative was foregone. The measure is indicative and for benchmarking only as the availability of alternative independent sector providers differs across the country.

SHA Envelopes:

Not applicable.

PLANNING REQUIREMENTS

Are Plans Required?:

No.

Planning Frequency:

Not applicable.

Criteria for Plan Sign-off:

Not applicable.

FURTHER INFORMATION

Further Information:

The information is derived from the Weekly CAB bookings report available to the NHS via the following link: nww.chooseandbook.nhs.uk/staff/reports

Changes from 2011/12 Planning Round:

Same as in 2011/12

PHF10: % of patients with electronic access to their medical records

DEFINITIONS

Detailed Descriptor:

% of patients with electronic access to their medical records

This indicator cannot be reported using current data and so a proxy is to be used for 2012-13. The proxy is "The % of the total patient population who belong to general practices where patients are able to access their medical records electronically if they wish to do so **and** where patients have registered to be able to access their medical record electronically."

For more information on why this indicator is included for 2012-13 please see the Rationale section at the end of this document. Links to documents are provided in the Further Information section.

Lines within Indicator (Units):

1. The number of General Practices which have the capacity to make medical records access available electronically to their patients and (by reference to their list size) the total number of patients to which this applies.

2. The number of General Practices which have enabled patients to have electronic access to their medical records and (by reference to their list size) the total number of patients to which this applies.

3. The number of patients within 2. above who have registered to have electronic access

4. The number of patients who have accessed their general practice record electronically at least once in the preceding year

5. The total number of times medical records have been accessed by patients in the preceding year

Data Definition:

General practices and their list sizes: Practices are as reported on the NHAIS (Exeter) system that have an on-going responsibility for a registered population (i.e. branch surgeries are not counted separately) as are their list sizes.

Medical records: A medical record includes either 1-3 or 4 from the list below

1. medication
2. test results and letters
3. a summary or subset of the full medical record
4. the full medical record

Electronically available: Patients are able to register for electronic access to their

medical record as held in their general practice's clinical IT system

Patients: A patient must be registered with the practice.

Have the capacity to make medical records access available electronically: Software is in place on the general practice's IT system.

Have enabled patients to have electronic access to their medical records : Practice is fully ready to issue password or other access mechanism to patients i.e. technology is ready, training complete and patients have been informed of the service and invited to request access.

Patients which have accessed their general practice record electronically: Patient has logged into their electronic record within the period being reported

Capacity to make medical records access available electronically: The following functionality provides patients with access to elements of their medical records electronically:

1. Access to view/request medication
2. Access to view test results and letters
3. Access to view a summary or subset of the full medical record
4. Access to view a full medical record.

Qualifying functionality is that which enables patients to see all or part of their care record online. Access either to (a) **all three** of the elements of the record identified in points 1, 2 & 3 or (b) to the full medical record as identified in point 4 or (for the avoidance of any doubt) to (c) all four of the elements of the record identified in points 1, 2, 3 & 4 will qualify for this indicator.
While it will not qualify towards this indicator, we will, in addition to the above, also gather data on the number of General Practices whose patients can book and cancel appointments online.

The indicator reported will be aggregate of the list sizes of all "General Practices which have enabled patients to have electronic access to their medical records" as a percentage of aggregate list size of all general practices

Line 1- "The number of general practices which have the capacity to make medical records access available electronically to their patients" will be used to identify the current capability for patient access to records by Clinical Commissioning Group (CCG), PCT Cluster and SHA Cluster. It is acknowledged that at present some of these may have little if any capacity within their area.

Basis for Accountability:

PCT Cluster. Data supplied from general practice systems suppliers will be advised to SHA Clusters for validation.

MONITORING

Monitoring Frequency:

Quarterly. Report dates 31 March 2012, 30 June 2012, 30 September 2012, 31 December 2012 and 31 March 2013

Monitoring Data Source:

Line 1 - number of practices - from suppliers. PCT Clusters can infer this from reviewing details of deployed systems.
Line 1 – number of patients – from the NHAIS (Exeter) system

Line 2 – number of practices - from suppliers. PCT Clusters are not able to obtain this information directly.
Line 2 – number of patients – from the NHAIS (Exeter) system

Line 3 – number of patients - from suppliers. PCT Clusters are not able to obtain this information directly.

Line 4 – number of patients - from suppliers. PCT Clusters are not able to obtain this information directly.

Line 5 – number of patients - from suppliers. PCT Clusters are not able to obtain this information directly.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The baseline for this has been set during 2011-12. As of the end of September we reported that "it is now understood that 4,666 (55%) of general practices currently have functionality in place for patients to access their full medical records on-line and that 68 general practices (0.8%) have so far enabled this functionality for some of their patients, a small increase from the (revised) end June figure of 50. Some 3/4 of general practices have systems with functionality that can be enabled so that patients can book/cancel appointments on-line and view/request their repeat medication."

The overall objective is as stated in the Government's Autumn Statement issued on 24 November 2012 that "all patients in the NHS will have online [electronic] access - where they wish it - to their personal GP records by the end of this Parliament." (see links at the end of this document)

We therefore expect to see all GP systems offering this functionality by the end of this Parliament and to see GP practices increasingly implementing this functionality and offering this service.

The capability is presently patchy across the NHS so there will initially be differential opportunity to make progress .This indicator will show both the number of patients who could access their records (opportunity) and the number who are accessing their records (realisation of the opportunity).

In order to realise this opportunity where it exists, GP practices that can already provide online access are encouraged to do so as soon as possible. NHS Choices

will publish an interactive map at the earliest opportunity to depict progress, subject to successful passage of provisions in the Health and Social Care Bill relating to the powers of the Information Centre for Health and Social Care to require the supply of the necessary data.

Following a consultation earlier this year, as well as further advice from the NHS Future Forum, the Information Strategy for health and social care in England, will publish more information on the timetable and any further milestones for achievement of this objective.

Timeframe/Baseline:

We expect to see movement during 2012-13 from the baseline which will be reported at the start of the year towards 100% of practices enabling this functionality by the end of this Parliament, according to the timescales and any further milestones described in the forthcoming Information Strategy.

Timeframe Until:

This indicator will be reported during the duration of this Parliament, subject to amendment in line with the Information Strategy when published, experience in-year, the evolving needs of Clinical Commissioning Groups and plans introduced by the NHS Commissioning Board

Rationale:

Giving patients greater control of their care records is a headline objective within the White Paper *"Equity and Excellence:- Liberating the NHS" :*

"2.11 We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers."

At present, for most people, it is time-consuming and complex to view and understand up to date records of their own health and care. The length and complexity of records for those with the most significant health needs can be daunting. This is in increasingly marked contrast with peoples' experience of interaction with providers in other service sectors, state or private.

Experience in banking, where 22 million people routinely use online services, suggests that where convenience is improved, many people are keen to make transactions in this way. Most GP practices can offer on-line appointment booking (and cancelling), repeat prescription ordering and secure messaging, although only a minority presently do so. Other service sectors, including travel, retail and the DVLA, have improved user experience and efficiency through on-line interaction.

Research by The Health Foundation indicates that giving people greater access to and control over their health records:

- improves relationships with clinicians by promoting informed discussions and engendering a sense of involvement;
- means patients are better informed about their care and medication and enabled to highlight and request to correct errors and omissions, thereby

improving safety;

- improves the productivity of GP consultations by having a better shared understanding of the issues between the patient and doctor
- provides flexibility for people, who don't have to go to their general practice or hospital to access their records; and
- increases people's ability to manage their own health care and their confidence to do so, including those who have difficulties communicating in a face-to-face context.

Giving people access to their GP practice medical record is seen as one part of effecting a successful transformation in people's experience of NHS services.

In respect of the proposed indicator, suppliers of information systems have confirmed that they are able to provide information about general practices that have the capacity for patients to access their care records (Line 1) and about those general practices that have enabled this functionality (Line 2). Suppliers whose systems do not currently provide aspects of this functionality have now received a clear signal that the policy of providing patients with access to and control of their care records, initially GP records but increasingly all care records, is a key policy for the government.

PCT Clusters and SHA Clusters will have opportunity to provide more information about plans and progress towards giving patients greater access to their primary care records during the integrated planning and assurance process that the DH is running in conjunction with the NHS from the launch of the Operating Framework in November 2011.

The second line of the indicator will show movement towards the achievement of the ambition that "all patients in the NHS will have electronic access" while the third line will show movement towards the White Paper objective "We will enable patients to have control of their health records. This will start with access to the records held by their GP and over time this will extend to health records held by all providers"

We note that practices who are taking part will have a number of patients registered for basic electronic transaction access (usually medications and appointments), of which a subset will have access to the medical record as defined by 1-3 or 4 (electronic medical record access).

SHA Envelopes:

N/A

PLANNING REQUIREMENTS
Are Plans Required?:
No
Planning Frequency:
N/A
Criteria for Plan Sign-off:
N/A

FURTHER INFORMATION

Further Information:

The White Paper can be downloaded from the Department of Health website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

The consultation *"Liberating the NHS: An Information Revolution"* is also on the same website at www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/Informationrevolution/index.htm (see pages 16-21)

The government response in the form of an Information Strategy will be published by April 2012

The Autumn Statement is at http://www.cabinetoffice.gov.uk/sites/default/files/resources/Further_detail_on_Open_Data_measures_in_the_Autumn_Statement_2011.pdf

The Health Foundation research can be found at: http://www.health.org.uk/areas-of-work/influencing-policy/consultation-responses/the-personal-ownership-of-health-records/

Changes from 2011/12 Planning Round:

This replaces the indicator "the percentage of GP practices where there is the opportunity for patients to begin to have greater control through on-line access to their primary care records" which was a proxy for this indicator in 2011-12.