



Department
of Health

The NHS Outcomes Framework 2014/15 Technical Appendix

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Introduction

The NHS Outcomes Framework was developed in December 2010, following public consultation, and has been updated every year to ensure that the most appropriate measures are included. Over this time the Department of Health has been improving the framework by refining existing indicators and developing new indicators.

Indicators in the NHS Outcomes Framework are grouped into five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. For each Domain, there is a small number of overarching indicators followed by a number of improvement areas.

This Technical Appendix gives an overview of each domain. Each domain section contains:

- An introduction to the domain (including indicator structure);
- Information on available international comparisons;
- Information on external drivers of outcomes;
- Details on alignment with the other health and social care outcomes frameworks;
- Work in progress to further develop indicators;
- Specifications for indicators that are currently ‘in development’ or ‘placeholders’.

Indicators in the NHS Outcomes Framework are categorised as follows:

- *Overarching indicators* – Indicators of outcomes across the breadth of activity covered by each domain;
- *Improvement areas* – There are two types of improvement area indicator:
 - *Sub-indicators* – Indicators which are, at least partially, a sub-set of the overarching indicators but which merit independent emphasis;
 - *Complementary indicators* – Indicators which complement the overarching indicators and extend the coverage of the domain.

Together, the overarching indicators and the improvement areas provide a measurement framework to enable assessment of the NHS’s contribution to outcomes in each Domain, often jointly with public health and social care services, in the context of an understanding of external drivers of outcome.

The status of each indicator is shown by the following classification:

- *Live* – Indicator development is complete. Where available, the data for live indicators are published on the Health and Social Care Information Centre (HSCIC) Indicator Portal (<http://www.hscic.gov.uk/indicatorportal>);

- *In development* – Some elements of the indicator definition require further development;
- *Placeholder* – A need to measure this outcome has been identified, and one or more potential sources have been identified, but an indicator is yet to be developed, and publication on the HSCIC Indicator Portal is not imminent.

In previous years the specifications for each indicator in the NHS Outcomes Framework was published as part of this Technical Appendix. This led to some inconsistencies and inaccuracies emerging throughout the year between the information published in the Technical Appendix and the information published by the Health and Social Care Information Centre (HSCIC). In order to avoid any of these problems, and to ensure consistency, all of the specifications for the live indicators in the NHS Outcomes Framework for 2014/15 will be published in one document on the HSCIC website in the spring of 2014:

<http://www.hscic.gov.uk/indicatorportal>.

The HSCIC Indicator Portal is updated quarterly. When an indicator is listed as ‘in development’, as of the publication date of this document and subsequently becomes ‘live’, the final specifications will be made available on the HSCIC Indicator Portal.

Therefore this Technical Appendix only provides indicator specifications for ‘in development’ indicators, ‘placeholder’ indicators, and ‘live’ indicators where new definitions are being introduced in March 2014.

The HSCIC Indicator Portal also contains a set of wider health and social care indicators, including social care and GP practice data. The majority of indicators in the NHS Outcomes Framework are now available on this site, with historical time series and disaggregations. The data are in raw format to allow subsequent analysis. As new placeholder/in development indicators go live, these will also be added to the site. This Technical Appendix signals for each indicator whether data are published on the HSCIC Indicator Portal, at the time of publication.

Finally, this Technical Appendix is being published alongside a shorter Outcomes Framework refresh document which provides a summary of the progress made to develop the framework over the last year and provides an at-a-glance summary of the NHS Outcomes Framework for 2014/15.

Timely reporting of data

Before NHS Outcomes Framework data can be published on the HSCIC Indicator Portal, there is a lengthy collection, processing and publication process – typical of very large data-sets.

Work is underway to improve the timeliness of NHS Outcomes Framework data publication, without compromising the robustness of data on the HSCIC Indicator Portal.

The ‘Data Source breakdowns & Timely Reporting of Data’ section of this Technical Appendix provides additional information on:

- Each data source that underpins indicators in the NHS Outcomes Framework;
- Data lags – by data source;

- Data lags – by indicator.

Assessing progress against the NHS Outcomes Framework

The NHS Outcomes Framework forms an essential part of the way in which the Secretary of State for Health holds NHS England to account. The Mandate to NHS England (www.gov.uk/government/publications/nhs-mandate-2014-to-2015) sets an objective to demonstrate progress against all the five domains and all the indicators in the NHS Outcomes Framework.

The Department of Health is continually reviewing progress made against the Mandate objectives. To support openness and transparency the intention is to publish reports measuring NHS England's progress, including against the indicators in the NHS Outcomes Framework.

The 'External drivers' sections in each domain chapter provide information on the external drivers of outcomes. Any assessment of progress against the NHS Outcomes Framework should be made in the context of analysis of these external drivers and their expected impact on outcomes. The aim of such analysis is to understand the path that outcomes would have taken had the quality and quantity of health and social care services remained unchanged, so to provide a baseline against which progress can be measured.

International comparisons

The Mandate to NHS England includes an objective to demonstrate progress "where possible, by comparing our services and outcomes with the best in the world". The domain sections of this Technical Appendix provide details on what internationally comparable data is currently available. The Department of Health and NHS England are also working actively with the Organisation for Economic Co-operation and Development (OECD) to understand the differences between countries' data systems and to improve comparability of the OECD's Health Care Quality Indicators.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

This Technical Appendix also sets out which indicators are shared with or complement indicators in the PHOF and ASCOF:

- *Shared indicators* – those where there is a shared responsibility between the named services and the indicator is identical in each framework;
- *Complementary indicators* – those where there are different indicators in the frameworks that measure the same issue from complementary perspectives.

In both cases, joint contributions will be required to deliver improved outcomes.

Equalities and Inequalities

Equality assessments for each domain and indicator, employing available disaggregation, will be used to support the health equality and inequalities duties set out in the Health and Social Care Act 2012 including consideration of the Equality protected characteristics.¹ The 'Equalities breakdowns' section of this Technical Appendix displays, for each indicator in the NHS Outcomes Framework, which breakdowns by the Equalities protected characteristics are available.

A separate Equality Analysis has been published (www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015) alongside the NHS Outcomes Framework 2014/15, which updates previous years' equality analyses published alongside previous years' NHS Outcomes Frameworks: (www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014).

Finally, in assessing NHS England's performance, success will be measured not only by the average level of improvement but also by progress in reducing health inequalities and unjustified variation. For some domains it is possible to specify metrics of inequality; for others, work is in progress to do so. Where metrics are available, a further step would be to assess progress in reducing attributable inequality on a similar basis to that employed for the assessment of progress against each domain, by estimation of the underlying trend that would have occurred with unchanged quality and distribution of health and social care services, and considering progress relative to that trend.

¹ Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.

Domain 1

Preventing people from dying prematurely

Introduction

Indicator structure

1.1 An overview of indicators in Domain 1 is shown below. Specifications for the live indicators are published on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>). The specifications for the remaining indicators listed as 'in development' or 'placeholder', and indicators where new definitions will be introduced in March 2014, are provided at the end of this Domain 1 section.

Overarching indicators	Status
1a Potential Years of Life Lost (PYLL) from causes considered amenable to health care i Adults ii Children and Young people	Live
1b Life expectancy at 75 i males ii females	Live
Improvement areas	Status
Reducing premature mortality from the major causes of death	
1.1 Under 75 mortality rate from cardiovascular disease	Live
1.2 Under 75 mortality rate from respiratory disease	Live
1.3 Under 75 mortality rate from liver disease	Live
1.4 Under 75 mortality from cancer	Live
1.4.i. One and ii. Five-year survival from all cancers	Live
1.4.iii One and iv. Five-year survival from breast, lung and colorectal cancer	Live
Reducing premature death in people with serious mental illness	
1.5 Excess under 75 mortality rate in adults with serious mental illness	Live
Reducing deaths in babies and young children	
1.6.i Infant mortality ii Neonatal mortality and stillbirths	Live
1.6.iii Five-year survival from all cancers in children	In development
1.7 Excess under 60 mortality in adults with learning disabilities	Placeholder

1.2 The overarching indicators cover Potential Years of Life Lost (PYLL) from causes considered amenable to health care and life expectancy at 75. Deaths from causes considered ‘amenable’ to health care (as defined for indicators 1a.i and 1a.ii) are premature deaths that should not occur in most cases in the presence of timely and effective health care. These indicators have been chosen to capture how successful the NHS is at meeting its objective to prevent people from dying prematurely.

1.3 Indicators 1a.i and 1a.ii cover the ages one month to 74, as well as a very small number of deaths at age 75 and over. This is because cause of death in the first month of life is not coded by ICD10 code and in older people it is often difficult to determine cause of death due to the greater prevalence of co-morbidities.

1.4 To ensure that the NHS is held to account for doing all that it should to prevent avoidable deaths in older people, life expectancy at 75 is included as a second overarching indicator in Domain 1. This indicator reflects all deaths at ages 75 and over.

1.5 The improvement areas are of two sorts:

- *Sub-indicators:*
 - Indicators 1.1, 1.2, and 1.4 relate to under-75 mortality from major diseases (CVD, respiratory disease and cancer respectively). These account for around 90% of the disease burden amenable to healthcare. Trends in these outcomes, therefore, provide an initial analysis of what accounts for progress in the overarching indicators;
 - Indicators 1.4i-iv and 1.6.iii relate to cancer survival in adults and children and are included to capture the success of the NHS in preventing people of all ages from dying of cancer once they have been diagnosed with the condition;
 - Indicators 1.5 and 1.7 have been included in the framework because the outcomes for these groups are poor compared to the general population and continued focus is needed to address the inequality that currently exists;
 - Indicator 1.6.i includes amenable outcomes for infants of 28 days up to one year.
- *Complementary indicators:*
 - Indicator 1.3. Liver disease other than Hepatitis C is not counted as amenable under the Office for National Statistics (ONS) definition, yet many (as opposed to ‘most’ – as required by the ONS definition) of these deaths are amenable to healthcare;
 - Indicator 1.6.ii. Neonatal mortality up to the age of 28 days is not included in overarching indicator 1a because cause of death is not classified by ICD-10 code for deaths up to 28 days after live birth, yet many (as opposed to ‘most’ – as required by the ONS definition) of these deaths are amenable to healthcare.

1.6 Indicators 1.1, 1.2, and 1.4 also include some deaths that are not included in the ONS definition of amenable but some of which are nonetheless amenable. Hence, these indicators are to that extent complementary to the main indicator too. Specifically, not all of the causes of deaths under 75 from the major diseases are counted as amenable – only 77% of CVD, 27% of respiratory disease, 23% of cancer and 2% of liver disease deaths are considered deaths that have amendable causes. However, the NHS also contributes to reducing premature deaths from causes not defined as amenable. The inclusion

of the under-75 mortality indicators and infant mortality reflects the contribution that the NHS can make to outcomes in these areas. The NHS contribution will include encouraging healthy behaviours and uptake of screening and vaccination options, in addition to providing appropriate diagnosis, care planning and treatment.

1.7 As foreshadowed in last year's Technical Appendix, six cancer survival indicators (separate indicators for one-year and five-year survival from each of breast, lung and colorectal) have been merged into four composite indicators: 1.4.i-iv. The data for these new indicators will be available from March 2014, but in the meantime the data for former indicators 1.4.i – 1.4.vi will continue to be reported using the old definitions. It will still be possible to monitor survival for the three individual cancers as these will continue to be reported by the ONS, subject to the current ONS public consultation on outputs.

1.8 This change is a response to concerns that the 2013/14 NHS Outcomes Framework survival measures do not capture rarer forms of cancer, and could not be used at Clinical Commissioning Group (CCG) level.

1.9 The Department of Health's Cancer Outcomes Strategy sets an aim of saving an additional 5,000 lives per year from 2015 which is predicated on survival rates improving for all cancers. For technical reasons it is not possible to include survival measures for every type of cancer (although national data for the top 20 will be monitored) so an all-cancer survival index is the best way of meeting our objective to see improvements for everyone affected by cancer. Furthermore, the one-year all-cancer survival indicators (1.4.i and 1.4.iii) can robustly be disaggregated by CCG.

International comparisons

1.10 Although there are lots of international comparisons for outcomes in Domain 1, the indicator definitions vary between countries.

1.11 Generally, international comparisons of premature mortality from defined causes by ICD-10 code are available from datasets published by the OECD and the World Health Organisation (WHO). Recent international comparisons of five-year cancer survival for breast and colorectal cancer are available in OECD's 'Health at a Glance' bi-annual report² and from academic research.

1.12 International comparisons of Life Expectancy at 75 are published in the Human Mortality Database (<http://www.mortality.org/>), a collaboration between the University of California, Berkley and the Max Planck Institute for Demographic Research.

1.13 International comparisons of infant and neonatal mortality rates are published by WHO and OECD. Some of the international variation in these rates may be due to differences between countries in how they register non-surviving premature infants (whether they are reported as live births or not). In addition, some variations exist in the definitions of foetal deaths, and care should be taken when making comparisons between countries.

1.14 There are currently no international comparisons available of excess mortality in people with serious mental illness using the NHS Outcomes Framework definition. However

² http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312

the OECD is planning to publish indicators of excess mortality from schizophrenia and from bipolar disorder in the 2013 edition of the 'Health at a Glance' report. The UK has not contributed to this indicator because the relevant data source for England (the Mental Health Minimum Dataset (<http://www.hscic.gov.uk/catalogue/PUB11538>)) does not include robust information on diagnosis. The Department of Health and NHS England are working with the OECD to develop an internationally comparable indicator.

External drivers of outcomes

1.15 The predominant external driver of outcomes in Domain 1 is the incidence of the diseases themselves. High quality estimates of incidence are not generally available. So NHS performance will need to be assessed using estimates of incidence trends. Increased incidence increases the number of people at risk of death, and dilutes the resources available to treat these diseases relative to caseload.

1.16 Incidence and mortality outcomes are greatly affected by demographic and cohort effects. To understand the path that outcomes would have taken had the quality and quantity of health and social care services remained unchanged, as a baseline for the measurement of progress, it is therefore necessary to make allowance not only for drivers external to the health and social care system, but also for the impact that historic improvements in public health have had in diminishing the propensity of successive cohorts to fall ill. Patterns of health behaviour over the recent decades for good or for ill will have an impact upon mortality over the next five and ten years over which the NHS has limited influence, and this must be recognised in assessing the path that indicators take. Of course, the NHS has a responsibility to work with public health and social care services to improve outcomes for current cohorts by improving health behaviours, but it must be recognised that the full benefit of many such interventions will not be apparent in mortality data for many years or even decades. In order robustly to assess the NHS's performance against Domain 1 of the NHS Outcomes Framework, analytical techniques are under investigation that can make allowance for historic impacts upon cohort health. In particular, the Age-Period-Cohort approach (which estimates the separate effects of age, period i.e. contemporary, and cohort effects on mortality outcomes) can inform this analysis.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

1.17 The indicators shared with the PHOF are:

- 1.1 – Under 75 mortality rate from cardiovascular disease (PHOF 4.4);
- 1.2 – Under 75 mortality from respiratory disease (PHOF 4.7);
- 1.3 – Under 75 mortality rate from liver disease (PHOF 4.6);
- 1.4 – Under 75 mortality rate from cancer (PHOF 4.5);
- 1.5 – Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9);

- 1.6.i – Infant mortality (PHOF 4.1).

Work in progress

Indicators 1.4.i-iv – Cancer survival

1.18 Work is on-going with the cancer registries to obtain data on the stage of disease at which patients are diagnosed, so as to control for sources of bias in estimates of survival.

Indicator 1.6.iii – Five year survival from all cancers in children

1.19 Work is on-going to complete the development of Indicator 1.6.iii. The ONS will publish figures for the indicator in December 2013 based on data from the National Registry of Childhood Tumours, in a new statistical bulletin. These published figures will be available up to 2010 year of diagnosis only (followed up to 2011). The adult cancer survival indicators will be published at the same time and will include figures up to 2011 year of diagnosis (followed up to 2012). The indicators will subsequently be published on the HSCIC Indicator Portal in March 2014. From December 2014, data for Indicator 1.6.iii will be published on an equivalent basis to that for the adult cancer survival indicators as by then both child and adult cancer survival figures will be based on the ONS dataset.

1.20 The ONS, with the National Statistics Authority, will conduct an assessment of the childhood cancer survival index (the basis for Indicator 1.6.iii) in order to obtain National Statistics status in due course. Due to the small number of cases, these figures will be classified as Experimental Statistics, whilst awaiting assessment, when published by ONS.

Indicator 1.7 – Excess under 60 mortality rate in adults with a learning disability

1.21 Investigation is continuing into a suitable data source for Indicator 1.7:

- Whether and to what extent and timescale NHS England's care data programme and/or the HSCIC's General Practice Extraction Service will be able to link primary care data with mortality data to deliver an appropriate and reliable data source;
- Whether there are possible alternative data sources. More information is set out in the table below.

Indicator specifications for in development and placeholder indicators

1.6.iii Five-year survival from all cancers in children					
OVERVIEW					
Indicator Family Name	NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely. Improvement area – Reducing deaths in babies and young children.				
Outcome sought	Improved five-year survival from all cancers in children.				
Status	In development, to go live in March 2014.				
Detailed descriptor	<p>Plain English description:</p> <p>A measure of the number of children diagnosed with cancer in a year who are still alive five years after diagnosis.</p> <p>Technical description:</p> <p>Five-year relative survival index for all cancers combined in children aged 0-14.</p>				
DATA SOURCES					
Data sources	<p>ONS: mortality data by cause.</p> <p>ONS: mid-year population estimates.</p> <p>ONS: cancer registrations data.</p> <p>National Registry of Childhood Tumours.</p>				
Reporting frequency	Annual (calendar year).				
Publication Timing	Autumn/winter after the end of the follow-up year.				
ICD-10 codes	<table> <tr> <th>ICD-10 codes</th><th>Condition</th></tr> <tr> <td>C00-C97</td><td>All childhood malignancies</td></tr> </table>	ICD-10 codes	Condition	C00-C97	All childhood malignancies
ICD-10 codes	Condition				
C00-C97	All childhood malignancies				
CONSTRUCTION					
Proposed calculation methodology	Cumulative all-cause survival (%) up to five years after diagnosis, all cancers combined, children (0-14 years) diagnosed over at least a 10-year period and with follow-up to the most recent year for which mortality data are available.				
Changes since previous publication	The indicator is expected to be published on the HSCIC indicator portal in March 2014.				
Technical issues remaining to be resolved	None.				

1.7 Excess under 60 mortality in people with a learning disability

OVERVIEW	
Indicator Family Name	<p>NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely.</p> <p>Improvement area – Reducing premature death in people with a learning disability.</p>
Outcome sought	Reduced premature mortality in adults with a learning disability.
Status	Placeholder.
Detailed descriptor	<p>Plain English description:</p> <p>A measure of the extent to which adults with a learning disability die younger than adults in the general population.</p> <p>Technical description:</p> <p>Excess under 60 mortality in adults with a learning disability.</p>
DATA SOURCES	
Data sources	To be decided, likely to be based on data extracted from GP practice systems.
Reporting frequency	To be decided.
Publication Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	Under 60 mortality in adults with a learning disability will be estimated. This will be compared to mortality in adults of the same age in the general population
Changes since previous publication	Investigation of a possible data source for this indicator is on-going – whether and to what extent and timescale NHS England's Care.data programme and/or the HSCIC's General Practice Extraction Service will be able to link primary care data with mortality data to deliver an appropriate and reliable data source, and what are the possible alternatives.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

New Indicator specifications – to go live in March 2014

1.4.i and 1.4.ii One- and five-year survival from all cancers	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely. Improvement area – Reducing premature mortality from the major causes of death.
Outcome sought	Reduced years of life lost from cancer.
Status	To go live in March 2014. Cancer survival indicators 1.4.i-iv will replace the existing one- and five-year cancer survival indicators (1.4.i-vi) for colorectal, breast and lung cancer in March 2014.
Detailed descriptor	<p>Plain English description:</p> <p>1.4.i: A measure of the number of adults diagnosed with any cancer (other than prostate) in a year who are still alive one year after diagnosis.</p> <p>1.4.ii: A measure of the number of adults diagnosed with any cancer (other than prostate) in a year who are still alive five years after diagnosis.</p> <p>Technical description:</p> <p>1.4.i: One-year net survival index for all cancers (other than prostate) in adults 15+.</p> <p>1.4.ii: Five-year net survival index for all cancers (other than prostate) in adults 15+.</p>
DATA SOURCES	
Data sources	ONS: mortality data by cause. ONS: mid-year population estimates. ONS: cancer registrations data.
Reporting frequency	Annual (calendar year).
Publication Timing	Autumn/winter following year end.
ICD-10 codes	<p>ICD-10 codes Condition</p> <p>C00-C97 All cancers, excluding prostate (C61)</p>

1.4.i and 1.4.ii One- and five-year survival from all cancers (continued)

CONSTRUCTION	
Proposed calculation methodology	<p>Net survival is an estimate of the probability of survival from the cancer alone. It can be interpreted as the survival of cancer patients after taking into account the background mortality that the patients would have experienced if they had not had cancer. Survival is a measure of the number of patients diagnosed with cancer in a year who are still alive a number of years after diagnosis.</p> <p>Prostate cancer was excluded from all analyses because it is more difficult to interpret survival trends for this cancer since the introduction of the PSA (prostate specific antigen) test. The test picks up asymptomatic cases which might otherwise never have been diagnosed, thus inflating incidence rates and apparently improving survival rates.</p> <p>To build a single index of cancer survival, separate estimates of survival are required for each combination of:</p> <ul style="list-style-type: none"> • Cancer or group of cancers • Age group • Sex • Year of diagnosis. <p>The index is constructed as a weighted sum of these survival estimates. The weights are chosen to keep the age- and sex-specific proportion of cases in a given cancer group constant over time. This means that the index is not affected by changes over time in the distribution of incident cancers. The survival index will only change over time if the levels of survival for a particular cancer or age group change over time.</p> <p>The methodology used to calculate the index is similar to that used for calculating the Index of Cancer Survival for Primary Care Trusts in England:</p> <p>http://www.ons.gov.uk/ons/dcp171778_292580.pdf</p>
Changes since previous publication	The indicators will be published on the HSCIC indicator portal in March 2014, following publication of the source data on the ONS website in December 2013.
Technical issues remaining to be resolved	None.

1.4.iii and 1.4.iv One- and five-year survival from breast, colorectal and lung cancers

OVERVIEW									
Indicator Family Name	NHS Outcomes Framework – Domain 1: Preventing people from dying prematurely. Improvement area – Reducing premature mortality from the major causes of death.								
Outcome sought	Reduced years of life lost from cancer.								
Status	To go live in March 2014. Cancer survival indicators 1.4.i-iv will replace the existing one- and five-year cancer survival indicators (1.4.i-vi) for colorectal, breast and lung cancer in March 2014.								
Detailed descriptor	<p>Plain English description:</p> <p>1.4.iii: A measure of the number of adults diagnosed with breast, colorectal or lung cancers in a year who are still alive one year after diagnosis.</p> <p>1.4.iv: A measure of the number of adults diagnosed with breast, colorectal or lung cancers in a year who are still alive five years after diagnosis.</p> <p>Technical description:</p> <p>1.4.iii: One-year net survival index for breast, colorectal and lung cancers combined in adults 15+.</p> <p>1.4.iv: Five-year net survival index for breast, colorectal and lung cancers combined in adults 15+.</p>								
DATA SOURCES									
Data sources	ONS: mortality data by cause. ONS: mid-year population estimates. ONS: cancer registrations data.								
Reporting frequency	Annual (calendar year).								
Publication Timing	Autumn/winter following year end.								
ICD-10 codes	<table> <tr> <th>ICD-10 codes</th><th>Condition</th></tr> <tr> <td>C50</td><td>Breast cancer</td></tr> <tr> <td>C18-C20</td><td>Colorectal cancer</td></tr> <tr> <td>C33-C34</td><td>Lung cancer</td></tr> </table>	ICD-10 codes	Condition	C50	Breast cancer	C18-C20	Colorectal cancer	C33-C34	Lung cancer
ICD-10 codes	Condition								
C50	Breast cancer								
C18-C20	Colorectal cancer								
C33-C34	Lung cancer								

1.4.iii and 1.4.iv One- and five-year survival from breast, colorectal and lung cancers (continued)

CONSTRUCTION	
Proposed calculation methodology	<p>Net survival is an estimate of the probability of survival from the cancer alone. It can be interpreted as the survival of cancer patients after taking into account the background mortality that the patients would have experienced if they had not had cancer. Survival is a measure of the number of patients diagnosed with cancer in a year who are still alive a number of years after diagnosis.</p> <p>To build a single index of cancer survival, separate estimates of survival are required for each combination of:</p> <ul style="list-style-type: none"> • Cancer or group of cancers • Age group • Sex • Year of diagnosis. <p>The index is constructed as a weighted sum of these survival estimates. The weights are chosen to keep the age- and sex-specific proportion of cases in a given cancer group constant over time. This means that the index is not affected by changes over time in the distribution of incident cancers. The survival index will only change over time if the levels of survival for a particular cancer or age group change over time.</p> <p>The methodology used to calculate the index is similar to that used for calculating the Index of Cancer Survival for Primary Care Trusts in England:</p> <p>http://www.ons.gov.uk/ons/dcp171778_292580.pdf</p>
Changes since previous publication	<p>The indicators will be published on the HSCIC indicator portal in March 2014, following publication of the source data on the ONS website in December 2013.</p>
Technical issues remaining to be resolved	<p>None.</p>

Domain 2

Enhancing quality of life for people with long-term conditions

Introduction

Indicator structure

2.1 An overview of indicators in Domain 2 is shown below. Specifications for the live indicators are published on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>). The specifications for the remaining indicator listed as 'placeholder' is provided at the end of this Domain 2 section.

Overarching indicator	Status
2 Health-related quality of life for people with long-term conditions	Live
Improvement areas	Status
Ensuring people feel supported to manage their condition	
2.1 Proportion of people feeling supported to manage their condition	Live
Improving functional ability in people with long-term conditions	
2.2 Employment of people with long-term conditions	Live
Reducing time spent hospital by people with long-term conditions	
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	Live
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	Live
Enhancing quality of life for carers	
2.4 Health-related quality of life for carers	Live
Enhancing quality of life for people with mental illness	
2.5 Employment of people with mental illness	Live
Enhancing quality of life for people with dementia	
2.6.i Estimated diagnosis rate for people with dementia	Live
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Placeholder

2.2 Domain 2 has one overarching indicator – the health-related quality of life for people with long-term conditions, which is based on responses to the GP Patient Survey (GPPS).

2.3 The improvement areas are of two sorts:

- *Sub-indicators:*
 - Indicators 2.1, 2.2 and 2.3.i relate to particular aspects of outcomes for those living with long-term conditions. Therefore, progress in these indicators provides a useful indication of progress in the overarching indicator;
 - Indicator 2.5 is derived from a sub-set of the data from which Indicator 2.2 is derived. It is nonetheless monitored separately to enable accountability for parity of esteem between physical and mental health.
- *Complementary indicators:*
 - Indicator 2.4 is complementary to the overarching indicator as the health of carers is not included in indicator 2, unless the carer also reports a long-term condition;
 - Indicator 2.3.ii is also complementary as it reflects outcomes for children, who are not included in indicator 2 (the same is true for the children included in Indicator 2.3.i);
 - Indicators 2.2 and 2.3 capture the benefits of improved quality of life for people with long-term conditions and its impact upon wider society, respectively through improved labour force participation and through reduced call upon acute care resources;
 - Indicators 2.6.i and 2.6.ii measure quality of life for people with dementia, who may be under-represented in responses to the GP Patient Survey used to construct Indicator 2, and for whom the EQ-5D™ health-related quality of life measures may not be appropriate.

Ambulatory care sensitive conditions

2.4 Outcomes for those with conditions that should normally be managed in a primary or community care setting (often referred to as ‘ambulatory care sensitive conditions’) are represented in the NHS Outcomes Framework by four indicators: indicators 2.3.i and 2.3.ii focussing on unplanned hospitalisation for chronic (i.e. long-term) ambulatory care sensitive conditions and, in Domain 3, indicators 3a and 3.2 focussing on emergency admissions for acute ambulatory care sensitive conditions. These indicators, across the two domains, should therefore be seen as jointly indicating the effectiveness of primary and community care.

International comparisons

2.5 International comparisons for outcomes in Domain 2 are not available on a strictly comparable basis from the World Health Organisation (WHO) or the Organisation for Economic Co-operation and Development (OECD). However, the OECD collects internationally comparable data on ‘avoidable admissions’ for asthma, COPD, hypertension, congestive heart failure and uncontrolled diabetes complications for its Health Care Quality Indicators project. Many of these indicators are published in the ‘Quality’ chapter of the OECD’s bi-annual report ‘Health at a Glance’.³

³ http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312

External drivers of outcomes

2.6 The predominant external drivers of the overarching indicator in Domain 2 – Health-related quality of life for people with long-term conditions – are likely to be the severity of long-term conditions, and the prevalence of co-morbidities. Prevalence of long-term conditions may also drive the indicator, to the extent that NHS resources are unable to respond in the short-run to increased demand for care. These external drivers also affect, to varying extents, the other indicators in Domain 2. However, many co-morbidities are amenable to secondary care prevention.

2.7 A further driver is the impact of deprivation upon health outcomes; this impact should be addressed by the health and social care system in the long term.

2.8 In addition, the employment consequences of having a long-term condition – as measured by indicators 2.2 and 2.5 – are likely to be externally driven to a significant extent by both the macro-economic cycle and the structure of in-work and out-of-work welfare payments. Analysis of the impact of these external drivers should be taken into account in assessing the performance of the health and social care system for Domain 2.

Sources of bias

2.9 Indicators based on survey data – Indicators 2, 2.1 and 2.4 (which use the GP Patient Survey), and Indicators 2.2 and 2.5 (which use the Labour Force Survey) – can be affected by several biases, including:

- Non-response bias (answers of respondents are not representative of the outcomes for non-respondents, perhaps even of those with the same characteristics);
- Response bias (bias resulting from problems in the measurement process);
- Gratitude bias (feelings of gratitude may inhibit negative evaluations and promote positive evaluations);
- Expectation bias (responses are given with reference to expectations, which may differ between respondents of different regions, ages, gender etc. and over time).

2.10 Survey-based indicators in Domain 2 also rely on people being able to identify themselves as having a long-term condition. It is likely that the propensity to self-report a condition is influenced by whether or not the person has a clinical diagnosis. Therefore, Indicators 2, 2.1, 2.2 and 2.5 may not provide an accurate representation of outcomes for people who have undiagnosed conditions. Furthermore, shifts in diagnosis rates might in themselves shift the average measured severity of the diagnosed population irrespective of the impact upon outcomes.

2.11 There is also a risk of bias in indicators based on administrative data collections (Indicators 2.3.i and 2.3.ii use Hospital Episodes Statistics data, and 2.6.i uses Quality and Outcomes Framework returns). Where data are systematically misreported or under-reported, these indicators will provide a biased understanding of the relevant outcomes. For example, there is anecdotal evidence that GPs fail to record all diagnosed dementia patients on their

QOF register. In this case, the numerator for 2.6.i may be an underestimate of the number of people who have been diagnosed with dementia.

2.12 Where appropriate and possible the risk of bias is addressed in the methodology, for example by using non-response weightings and age-gender standardisation (though this leaves the risk that even within a given response category non respondents may differ systematically from respondents). Contextual information is also published alongside several indicators to aid interpretation in light of the potential biases. The Department of Health is working to understand other sources of bias and take action where feasible.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

2.13 The indicators shared with the PHOF are:

- 2.2 – Employment of people with long-term conditions (PHOF 1.8);
- 2.6.i – Estimated diagnosis rate for people with dementia (PHOF 4.16).

2.14 The indicator complementary to the PHOF is:

- 2.5 – Employment of people with mental illness (PHOF 1.8).

2.15 The indicators complementary to the ASCOF are:

- 2 – Health-related quality of life for people with long-term conditions (ASCOF 1A);
- 2.2 – Employment of people with long-term conditions (ASCOF 1E);
- 2.4 – Health related quality of life for carers (ASCOF 1D);
- 2.5 – Employment of people with mental illness (ASCOF 1F);
- 2.6.ii – A measure of the effectiveness of post-diagnosis care for dementia in sustaining independence and improving quality of life (ASCOF 2F).

Work in progress

Indicator 2.6.i – Estimated diagnosis rate for people with dementia

2.16 The denominator for Indicator 2.6.i is based on prevalence rates estimated in the 2007 Dementia UK report.⁴ Whilst these estimates are viewed as the most authoritative to date, the underlying evidence base has expanded since the initial publication. Therefore, the Department of Health will analyse recent and on-going research into dementia prevalence (for example, findings from the CFAS II study),⁵ and where a more authoritative source is identified, the indicator will be updated in due course.

⁴ Knapp et al (2007) Dementia UK: The Full Report. Alzheimer's Society. Available online at: http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2

⁵ Matthews F et al. (2013) A two-decade comparison of prevalence of dementia in individuals aged 65 years and older from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. July, Lancet.

Indicator 2.6.ii – A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

2.17 Work is continuing to develop Indicator 2.6.ii. The Department of Health has commissioned a research team at the London School of Hygiene and Tropical Medicine to investigate the potential for a routine Patient-Reported Outcome Measure (PROM) for people with dementia. The study will investigate whether such measures are methodologically robust, acceptable and cost-effective. Indicator 2.6.ii will be developed in line with findings from this study, which will report in mid-2015.

Indicator specification for placeholder indicator

2.6.ii A measure of the effectiveness of post-diagnosis care for dementia in sustaining independence and improving quality of life	
OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 2: Enhancing quality of life for people with long-term conditions’ and on the next line within the same box ‘Improvement area – Enhancing quality of life for people with dementia.
Outcome sought	Sustained independence and improved quality of life for people diagnosed with dementia.
Status	Placeholder.
Detailed descriptor	<p>Plain English description:</p> <p>This indicator will measure the extent to which NHS care for people diagnosed with dementia sustains independence and improves quality of life. The detailed definition of the indicator will be developed in line with research findings expected in 2015.</p> <p>Technical description:</p> <p>To be decided.</p>
Alignment with other Outcomes Frameworks	Complementary with Adult Social Care Outcomes Framework Indicator 2F.
DATA SOURCES	
Data sources	To be decided.
Reporting frequency	To be decided.
Publication Timing	To be decided.

2.6.ii A measure of the effectiveness of post-diagnosis care for dementia in sustaining independence and improving quality of life (continued)

CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	<p>The Department of Health has commissioned a research team at the London School of Hygiene and Tropical Medicine to develop methodologically rigorous and feasible approaches to assess routinely the health-related quality of life (HRQL) of people with dementia. As part of the study, the researchers will investigate the routine use of a Patient Reported Outcome Measure (PROM) for dementia, in an attempt to answer several methodological questions:</p> <ul style="list-style-type: none"> • Does the PROM have adequate fundamental measurement properties? • Can proxy reports be substituted for self-reports? • Is the measure sensitive to minimally important differences? • Is the use of a PROM acceptable? • Is it cost-effective to use a PROM to measure dementia diagnosis? • Can dementia PROMs be mapped to generic PROMs? <p>Indicator 2.6.ii will be developed in line with findings from this study, which will report in mid-2015.</p>
Technical issues remaining to be resolved	Design and validation of a PROM for this purpose. Determination of sampling strategy and standardisation methodology.

Domain 3

Helping people to recover from ill-health or following injury

Introduction

Indicator structure

3.1 An overview of indicators in Domain 3 is shown below. Specifications for the live indicators are published on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>). The specifications for the remaining indicators listed as ‘in development’ are provided at the end of this Domain 3 section.

Overarching indicators	Status
3a Emergency admissions for acute conditions that should not usually require hospital admission	Live
3b Emergency readmissions within 30 days of discharge from hospital	Live
Improvement areas	Status
Improving outcomes from planned treatments	
3.1 Total health gain as assessed by patients for elective procedures i Hip replacement ii Knee replacement iii Groin Hernia iv Varicose veins	Live
3.1 Total health gain as assessed by patients for elective procedures v Psychological therapies	In development
Preventing lower respiratory tract infections (LRTI) in children from becoming serious	
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	Live
Improving recovery from injuries and trauma	
3.3 Survival from major trauma	In development
Improving recovery from stroke	
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	In development

Improvement areas	Status
Improving recovery from fragility fractures	
3.5.i Proportion of patients recovering to their previous levels of mobility / walking ability at 30 days ii Proportion of patients recovering to their previous levels of mobility / walking ability at 120 days	Live
Helping older people to recover their independence after illness or injury	
3.6.i Proportion of Older People (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services ii Proportion offered rehabilitation following discharge from acute or community hospital	Live

3.2 Domain 3 comprises indicators both of adverse outcomes and of the effectiveness of care:

- Indicators of adverse outcomes are the overarching indicators 3a and 3b, and the improvement area indicator 3.2. These indicators are designed to measure failures in the effectiveness of NHS care (in contrast to the indicators in Domain 5, which are designed to measure adverse outcomes and harm attributable to problems in the care itself). They will include some cases in which failure to deliver effective care leads to an avoidable premature fatality. Therefore, there is also an overlap with Domain 1.
- Within this group of indicators, 3a and 3.2 represent adverse outcomes for those with conditions that should normally be managed in a primary or community care setting (referred to as 'ambulatory care sensitive conditions'). As discussed in relation to Domain 2, outcomes for those with conditions that should normally be managed in a primary or community care setting are represented in the NHS Outcomes Framework by four indicators measuring emergency admissions that could have been avoided through better management in primary or community care for adults and children: indicators 3a and 3.2 focussing on acute conditions and, in Domain 2, indicators 2.3.i and 2.3.ii focussing on chronic (i.e. long-term) conditions. These indicators are best seen as joint indicators as they reflect the quality of primary care and community services working with social care. Admissions for these conditions are thought generally to reflect sub-optimal care that will result in poorer outcomes for patients including, but not limited to, the unwelcome admission itself.
- Indicators of the effectiveness of care are all complementary to the overarching indicators, in the following areas:
 - Elective care – Indicators 3.1.i-v measure outcomes for planned procedures as measured by Patient Reported Outcome Measures (PROMs) (3.1.i-iv) and for Psychological Therapies (3.1.v);
 - Emergency care – Indicators 3.3, 3.4, 3.5 and 3.6 measure outcomes for patients' recovery respectively from major trauma, from stroke, from fragility fractures, and following discharge from hospital for all older people.

International comparisons

3.3 International comparisons for outcomes in Domain 3 are not available from the World Health Organisation (WHO) or the Organisation for Economic Co-operation and Development (OECD). England is leading the field in the collection and publication of pre- and post-operative health status data to inform assessment of procedure effectiveness. However, in the future international comparisons may become available as there have been PROMs trials in Canada, Germany, Slovenia and Sweden.

External drivers of outcomes

3.4 The predominant driver of outcomes in Domain 3 is the volume and severity of incidents of ill health and injury. Outcomes for indicators 3a and 3.2 will be directly affected by changes in the volume of incidents for a given level of NHS effectiveness. Volumes will also affect outcomes for all Domain 3 indicators by its impact upon the availability of resources relative to caseload.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

3.5 The indicator shared with the PHOF is:

- 3b – Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11).

3.6 The indicators shared with the ASCOF are:

- 3.6.i – Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service (ASCOF 2Bi);
- 3.6.ii – Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2Bii).

Work in progress

Indicator 3.1.v – Total health gain as assessed by patients for psychological therapies

3.7 The Department of Health is working closely with HSCIC, NHS England and NHS Improving Quality to finalise the specification of Indicator 3.1.v – Total health gain as assessed by patients for psychological therapies. It is expected that this specification will be live for the financial year 2014/15.

Indicator 3.3 – Survival from major trauma

3.8 The Department of Health and NHS England have been working with the Trauma Audit Research Network (TARN) to produce an indicator measuring recovery from major trauma. Initially this is based upon annual estimates of the risk-adjusted odds of survival in patients with major trauma. This specification is now being finalised with the HSCIC. It is intended that this binary measure of outcome will eventually be replaced by one that reflects the extent of recovery. Patient Reported Outcome Measures (PROMs) are being developed. Final recovery from severe injury takes two years or longer in some cases but the level of recovery at six months post injury does give a reasonable indication of the final outcome.

3.9 A pilot study will begin in 2014 collecting PROMs. EQ5D status and return to employment / education will be the key general measures of outcome. Some other injury-specific tools, such as the Glasgow Outcomes Scale for head injury, may also be reported. It is anticipated that the first report of PROMs will be available in April 2015. If the data collection system proves robust, it is anticipated that all Major Trauma Centres will then start data collection on all patients with very severe injury (Injury Severity Score 15+) with the audit collated by TARN.

Indicator 3.4 – Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at six months

3.10 The data collection for indicator 3.4 on measuring recovery from stroke at six months started in January 2013. The subsequent six-month necessary follow up data were entered into the audit in July 2013. The indicator specification is being finalised and the first publication for this indicator is expected to use data entered in the audit from July 2013 to March 2014, and to be available in the autumn of 2014.

Indicator specifications for in development indicators

3.1.v Total health gain as assessed by patients for elective procedures: Psychological therapies

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 3: Helping people to recover from episodes of ill health or following injury Improvement area – Improving outcomes from planned treatments
Outcome sought	Increased health gain from psychological therapies
Status	In development
Detailed descriptor	<p>Plain English description:</p> <p>This indicator measures improvements in health as a result of using NHS psychological therapies. Initially, the indicator will focus on people with depression and anxiety disorders.</p> <p>Technical description:</p> <p>This indicator measures health gain from psychological therapies as assessed by people using therapies provided under the Improving Access to Psychological Therapies (IAPT) programme in England.</p>

3.1.v Total health gain as assessed by patients for elective procedures: Psychological therapies (continued)

DATA SOURCES	
Data sources	<p>Improving Access to Psychological Therapies (IAPT) dataset, published by the Health and Social Care Information centre (HSCIC)</p> <p>(http://www.hscic.gov.uk/article/2021/Website-Search?q=routine+iapt+monthly+data+quality&area=both)</p>
Reporting frequency	Publication planned quarterly and annually.
Publication Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	<p>The indicator will be based on client-reported outcomes collected during Improving Access to Psychological Therapies (IAPT) sessions using Patient-Reported Outcome Measures (PROMs) such as the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder 7 (GAD-7).</p> <p>Higher scores in these scales suggest increased severity of the mental health condition. Each of these outcome scales has a threshold above which the client is deemed to have a clinical diagnosis of a common mental disorder and each of these scales also includes a measurement error.</p> <p>Using these scales the indicator will measure health gain for each IAPT client in terms of the severity of their condition before and after treatment. Outcomes for all clients who have a clinical diagnosis of a common mental disorder prior to treatment and who have reported PROMs in two or more IAPT sessions will be aggregated in the indicator, which will thus reflect access as well as effectiveness.</p>
Changes since previous publication	<p>The Department is working closely with HSCIC, NHS England and NHS IQ to finalise the definition of the indicator. It is expected that this definition will be confirmed ahead of the 2014/15 financial year.</p> <p>Contextual indicators are also being developed to support interpretation of changes in Indicator 3.1.v and to facilitate comparison of total health gain from psychological therapies across the country.</p>

3.1.v Total health gain as assessed by patients for elective procedures: Psychological therapies (continued)

Technical issues remaining to be resolved	<p>This indicator is not risk-adjusted because whilst there is significant literature on the risk of developing common mental disorders, evidence on the amenability to treatment of different groups is lacking. Which groups are more or less likely to experience positive outcomes will be analysed and the indicator is expected to be risk adjusted accordingly in the future.</p> <p>Feasible breakdowns are now being considered. It should be possible to break the indicator down to CCG level and by gender, age, disability and ethnicity, where the sample size allows.</p>
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3.3 Survival from major trauma

OVERVIEW	
Indicator family name	<p>NHS Outcomes Framework – Domain 3: Helping people to recover from episodes of ill health or following injury</p> <p>Improvement area – Improving recovery from injuries and trauma</p>
Outcome sought	Improved recovery for patients with major trauma
Status	In development
Detailed descriptor	<p>Plain English description:</p> <p>This indicator measures the number of people that are alive 30 days after suffering a major injury following an accident or incident.</p> <p>Technical description:</p> <p>The indicator measures whether survival from major trauma in England is increasing or decreasing each year.</p>
DATA SOURCES	
Data sources	<p>Trauma Audit & Research Network (TARN)</p> <p>TARN is the national trauma audit and all trauma receiving hospitals must participate in this national clinical audit. For further information on TARN: https://www.tarn.ac.uk/</p>
Reporting frequency	Annually (financial year)
Publication Timing	Indicator data are expected to be published by the end of the summer for the previous financial year.

3.3 Survival from major trauma (continued)

CONSTRUCTION	
Proposed calculation methodology	<p>The odds ratio of survival will be calculated from a risk adjusted model with a patient case-mix of age, injury severity score (ISS), Glasgow Coma Scale (GCS), gender and an age by gender interaction and financial year.</p> <p>A six year dataset (2007/08 to 2012/13) will be initially used (in a logistic regression) to create the risk adjusted models. The model will produce coefficients for each financial year with 2012/13 as the baseline year and will be updated annually once a new year of data is included.</p> <p>The outputs of interest from the risk model are the coefficients for each year. These are estimated in relation to a baseline year (2012/13) and are the log of the odds ratio of survival between each year and the reference year. They are converted into odds ratio of survival which are then converted into the proportion of survivors to obtain the indicator figures.</p>
Changes since previous publication	<p>The indicator definition has been refined and the first data release is planned for 2013/14.</p>
Technical issues remaining to be resolved	<p>Assessment of the robustness of the following breakdowns for this indicator is underway:</p> <ul style="list-style-type: none"> • Trauma network • Age • Gender • Deprivation via postcode or area <p>Breakdowns for Disability, Religion or belief, Sexual orientation and Socio-economic group (National Statistics Socio-Economic Classification (NSSEC)) will not be available as data are not collected. Data recorded for ethnicity are incomplete so a breakdown by ethnic group is not feasible at this point.</p>

3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 3: Helping people to recover from episodes of ill health or following injury Improvement area – Improving recovery from stroke
Outcome sought	Effective recovery following a stroke
Status	In development
Detailed descriptor	<p>Plain English description:</p> <p>This indicator measures the extent to which people have recovered, 6 months, after suffering a stroke. Recovery is defined as, whether an individual is able to perform close to the level of daily activities that they achieved prior to suffering the stroke.</p> <p>Technical description:</p> <p>This indicator will measure recovery from stroke by using the Modified Rankin Scale (mRS) score at 6 months post admission to hospital, and adjusting the score to account for pre-morbid mRS score, age and National Institutes of Health Stroke Scale (NIHSS) score on arrival at hospital.</p> <p>The Modified Rankin Scale (mRS) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke. It is graded:</p> <ul style="list-style-type: none"> 0 No symptoms at all 1 No significant disability despite symptoms; able to carry out all usual duties and activities 2 Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance 3 Moderate disability; requiring some help, but able to walk without assistance 4 Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance 5 Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6 Death

3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months (continued)

DATA SOURCES	
Data sources	Sentinel Stroke National Audit Programme (SSNAP) – for further detail, see http://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme
Reporting frequency	Annually by financial year. Whether a more frequent release is feasible will be assessed after the first publication planned for autumn 2014.
Publication Timing	Data collection started in January 2013 and the first 6 month follow up data were entered into the audit from July 2013 onwards. The first publication for this indicator is expected to use data entered in the audit from July 2013 to March 2014, which will be available in autumn 2014. That is, the first release will cover only nine months of 2013/14. Afterwards, it will be assessed whether data are sufficient to produce a more frequent release.
CONSTRUCTION	
Proposed calculation methodology	Each patient will have an 'expected' change in their mRS score at 6 months compared with their pre-morbid mRS score and this expected change will be based on a predictive model which takes into account their pre-morbid mRS score, their NIHSS score on arrival and their age at admission. Their 'observed' change in their 6 month mRS score will then be compared with the expected change in mRS score and a figure given, which will be positive, negative or 0. For each breakdown of results (e.g. provider level), the median 'observed' minus 'expected' change in mRS score will be calculated.
Changes since previous publication	None

3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months (continued)

Technical issues remaining to be resolved

Adjustments will be made for age at admission, pre-morbid mRS score and admission NIHSS score. Once the data are available whether adjustments are required for gender and early mortality (e.g. 72 hour mortality) will be assessed.

Assessment of how to present the results – they could either be presented as medians or the median values could be grouped into categories and the results presented as a set number of categories.

Which breakdowns are robust will be assessed. Possible breakdowns for this indicator are:

- Age
- Gender
- Ethnicity

The number of patients may be too small to produce a robust estimate for the breakdowns below and this will be investigated when one year of data is available:

- Deprivation
- Subnational breakdowns:
 - i. CCG area
 - ii. NHS Area Team
 - iii. NHS Region
 - iv. Local Authority
 - v. Provider
 - vi. Strategic Clinical Networks

Breakdowns for Disability, Religion or belief, Sexual orientation and Socio-economic group (National Statistics Socio-Economic Classification (NSSEC)) will not be available as data are not collected.

Domain 4

Ensuring people have a positive experience of care

Introduction

Indicator structure

4.1 An overview of indicators in Domain 4 is shown below. Specifications for the live indicators are published on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>). The specifications for the remaining indicators listed as ‘in development’ are provided at the end of this Domain 4 section.

Overarching indicators	Status
4a Patient experience of primary care i GP services ii GP out-of-hours services iii NHS Dental Services	Live
4b Patient experience of hospital care	Live
4c Friends and Family test	In development
Improvement areas	Status
Improving people’s experience of outpatient care	
4.1 Patient experience of outpatient services	Live
Improving hospitals’ responsiveness to personal needs	
4.2 Responsiveness to in-patients’ personal needs	Live
Improving people’s experience of accident and emergency services	
4.3 Patient experience of A&E services	Live
Improving access to primary care services	
4.4.i Access to GP services	Live
4.4.ii Access to NHS Dental services Dental services	Live
Improving women and their families’ experience of maternity services	
4.5 Women’s experience of maternity services	Live

Improving the experience of care for people at the end of their lives	
4.6 Bereaved carers' views on the quality of care in the last 3 months of life	Live
Improving the experience of healthcare for people with mental illness	
4.7 Patient experience of community mental health services	In development
Improving children and young people's experience of healthcare	
4.8 Children and young people's experience of outpatient services	In development
Improving people's experience of integrated care	
4.9 People's experience of integrated care	In development

4.2 All the improvement area indicators in Domain 4 are complementary to the overarching indicators, extending the scope of the Domain, with the exception of indicator 4.2, which is a sub-indicator of indicator 4b, highlighting certain aspects of inpatient care for improvement.

4.3 Together, the overarching indicators and the complementary improvement indicators provide a picture of the NHS's contribution to improving experience of care, including access to care. The indicators are based on information obtained directly from patients or their carers using patient surveys.

4.4 Knowledge of patient experience can highlight poor care and lead to service improvements (NHS Confederation, 2010⁶). The Mid Staffordshire NHS Foundation Trust Public Inquiry⁷ highlights that patient experience is an important indicator of the underlying performance of a service provider.

4.5 Personal experience and the experience of friends and family have been identified as key considerations when patients have a choice over service providers. As such, information about patient experience increases transparency in information, helping to support and increase patient choice and control.

4.6 Use of nationally coordinated surveys facilitates benchmarking over time and across the country where sample sizes allow. With this information, local clinicians and managers can understand the experience of local patients, and can assess where improvements could be made.

International comparisons

4.7 International surveys of patient experience on a whole population basis are carried out every three years by the Commonwealth Fund as part of their Health Policy Survey

⁶ The NHS Confederation, (2010). *Feeling better? Improving patient experience in hospital* http://www.nhsconfed.org/Publications/Documents/Feeling_better_improving_patient_experience_in_hospital_report.pdf

⁷ <http://www.midstaffspublicinquiry.com/report>

programme.⁸ Population surveys were carried out in 2004, 2007, and 2010, and the results of the 2013 survey will be reported in November 2013. In the intervening years physicians and sicker adults are surveyed.

4.8 The number of countries surveyed has increased from seven in 2010 and 2011 to eleven in 2013. The measures used are not exactly comparable to the patient experience measures in the NHS Outcomes Framework, but they can provide a useful context for analysing the relative position of the UK. The Organisation for Economic Co-operation and Development (OECD) is expected to publish four indicators of patient experience in the 2013 edition of 'Health at a Glance'⁹ relating to how responsive and how patient-centred care is, using data from the 2010 Commonwealth Fund survey.

Sources of bias

4.9 Indicators based on patient experience survey data can be affected by several biases, including:

- Non-response bias (answers of respondents are not representative of outcomes for non-respondents);
- Response bias (bias resulting from problems in the measurement process);
- Gratitude bias (feelings of gratitude may inhibit negative evaluations and promote positive evaluations);
- Expectation bias (responses are given with reference to expectations, which may differ between respondents of different regions, ages, gender etc. and over time).

4.10 Where appropriate and possible (as set out in individual indicator specifications) the risk of bias is addressed in the methodology, for example by standardising results for age (assuming that this reflects differences in expectations rather than experience) to take account of the tendency for older patients to report a more positive patient experience. However, there remains a risk that even within a demographic category respondents' experience is not representative of that of non-respondents. This risk is under investigation.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

4.11 The indicator complementary to the ASCOF is:

- 4.9 – Improving people's experience of integrated care.

⁸ <http://www.commonwealthfund.org/Content/Surveys/2007/2007-International-Health-Policy-Survey-in-Seven-Countries.aspx>; <http://www.commonwealthfund.org/Content/Surveys/2010/Nov/2010-International-Survey.aspx>

⁹ http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312

Work in progress

Indicator 4c – Friends and Family Test

4.12 The first set of data from the NHS Friends and Family Test was released in July 2013.¹⁰ A key advantage of the Friends and Family Test is that it allows hospital trusts to gain real time feedback on their services down to individual ward level and increases the transparency of NHS data to drive up choice and quality. As announced in the NHS Outcomes Framework 2013/14, an indicator related to the Friends and Family Test will be included in the framework. In the first instance this will cover A&E services and inpatient wards, although consideration will also be given to whether it is possible to include maternity services and other services currently rolling out the Friends and Family Test. The first set of Friends and Family Test data contained wide variations in the numbers of respondents and more data is required for us to set out the precise details of this indicator, but the intention is to have this indicator ready for the NHS Outcomes Framework in 2015/16. In the meantime, however, patients and the public can find easily searchable data for the Friends and Family Test on the NHS Choices website: <http://www.nhs.uk>.

Indicator 4.7 – Patient experience of community mental health services

4.13 Work is on-going to redesign the community mental health survey that underpins indicator 4.7. The redesign is intended to ensure that the survey reflects current service user experience and the needs of service providers and regulators. There is no intention to remove from the survey the topic area reflected in indicator 4.7 but the framing of the questions may change. Service users and providers, charities and experts have been consulted to inform this work. National Institute for Health and Care Excellence (NICE) guidelines have also been factored in. The new survey will run for the first time in 2014: we are working with the Picker Institute, who co-ordinate the survey on behalf of the Care Quality Commission (CQC), to understand how the changes will affect the time-series of indicator values.

Indicator 4.8 – Children and young people's experience of outpatient services

4.14 Work is on-going to develop indicator 4.8 which will be based on the paediatric outpatient survey developed by the Picker Institute. This outpatient survey is currently run voluntarily by a number of trusts to gain useful insights into their patients' views of services.

Indicator 4.9 – People's experience of integrated care

4.15 Indicator 4.9 is currently in development. In January 2013, the Department of Health commissioned an options appraisal on measurement of integrated care which recommended that a set of new questions be developed and inserted into existing patient and service user surveys. Following this, work to identify and develop appropriate questions was commissioned from the Picker Institute and the University of Oxford, with work conducted between July and September 2013. The Department of Health received recommendations from the research team in September 2013, proposing a shortlist of questions. Using this evidence in conjunction with expert advice and stakeholder feedback, seven questions have been identified for potential inclusion into existing patient and service user surveys.

4.16 Assessment of the feasibility of question inclusion (including cognitive testing within the context of surveys, necessary filters / demographics) to measure people's experience of

¹⁰ <http://www.england.nhs.uk/2013/07/30/nhsfft/>

integrated care is under way. In parallel, the Department of Health is investigating alternative question selection methodologies towards our aim of meaningful measurement of people's experience of integrated care.

Include measures of very poor patient experience in Domain 4

4.17 The Technical Appendix to the NHS Outcomes Framework 2013/14 suggested that consideration be given to measures of inequality in the experience of patients. The current indicators focus on good and average outcomes. We will be assessing how to measure patient experience, analysing the questions patients are asked on their experience and the metrics used to define levels of good and very poor experience.

Indicator specifications for in development indicators

4c Friends and Family Test	
OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care. Overarching indicator.
Outcome sought	Improvement in patients' experience of care in A&E and in inpatient wards.
Status	In development.
Detailed descriptor	<p>Plain English description:</p> <p>The indicator will be based on responses to the Friends and Family Test (FFT). The test asks patients whether they would recommend A&E and inpatient wards to their friends and family based on their own experience.</p> <p>Technical description:</p> <p>A measure of the extent that patients would recommend A&E and inpatient wards to their friends and family based on their own experience.</p>
DATA SOURCES	
Data sources	<p>The indicator will be based on responses to the Friends and family test. The test asks "How likely are you to recommend our [ward/ A&E Department] to friends and family if they needed similar care or treatment?" The question responses are on a six-point scale from extremely likely to extremely unlikely.</p> <p>The test is initially for all acute providers of adult NHS-funded care covering services for inpatients and patients discharged from A&E (type 1 and 2 A&E departments). Data is collected and reported on a monthly basis.</p>
Reporting frequency	To be decided.
Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	To be decided.

4c Friends and Family Test (continued)

Changes since previous publication	FFT was introduced as a placeholder in the 2013/14 Framework. The first FFT results were published in July 2013, for monthly data from April to June. These early results need to be treated carefully. Indicator development will continue once sufficient quality data is available for analysis.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

4.7 Patient experience of community mental health services

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 4: Ensuring people have a positive experience of care. Improvement area – Improving experience of healthcare for people with mental illness.
Outcome sought	Improvement in experience of healthcare for people with mental illness.
Status	In development.
Detailed descriptor	<p>Plain English description:</p> <p>This indicator measures patient experience of community mental health services based on the National community mental health survey.</p> <p>Technical description:</p> <p>Patient experience of community mental health services based on contact with a health and social care worker.</p>
DATA SOURCES	
Data sources	National patient survey programme.
Reporting frequency	Calendar year.
Timing	Data are available from the source provider in September and on the HSCIC between three and six months later.

4.7 Patient experience of community mental health services (continued)

CONSTRUCTION	
Proposed calculation methodology	<p>Figures will be based on the community mental health survey, which is completed by a sample of patients aged 16 and over who received care or treatment for a mental health condition, including services provided under the Care Programme Approach (CPA). Patients seen only once for an assessment, current inpatients and anyone primarily in receipt of learning disability, drug and alcohol, or forensic services were not eligible for to take part in the survey.</p> <p>A complete list of eligibility and participation criteria for the survey is available at the following link: http://www.cqc.org.uk/public/publications/surveys/community-mental-health-survey-2013</p> <p>Weighting</p> <p>Results are based on ‘standardised’ data. The Community Mental Health Survey is standardised by age and gender.</p> <p>Calculation</p> <p>The community mental health survey is being redesigned for 2014. The survey questions used to underpin the indicator will be selected from the final set of questions used in the survey once available. The indicator will continue to reflect the topic area used previously, relating to patient’s experience of contact with a health and social care worker. There is no intention to remove this topic area from the survey but the framing of the questions may change.</p> <p>Indicator format:</p> <p>To be decided.</p>
Changes since previous publication	<p>In development</p> <p>The community mental health survey that underpins indicator 4.7 is being redesigned for 2014. The indicator will be based on question(s) from the redesigned survey.</p>
Technical issues remaining to be resolved	<p>Calculation of the indicator.</p>

4.8 Improving children and young people's experience of healthcare

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care. Improvement area – Children and young people's experience.
Outcome sought	Improvement in children and young people's experience of healthcare.
Status	In development.
Detailed descriptor	<p>Plain English description:</p> <p>A measure of children and young people's experience of healthcare.</p> <p>Technical description:</p> <p>A measure of children and young people's experience of healthcare based on responses to a set of questions from a national paediatric outpatient experience survey.</p>
DATA SOURCES	
Data sources	The indicator will be based on questions from the paediatric outpatient survey produced by the Picker Institute. The survey is currently undertaken voluntarily by a small sample of trusts and work is in progress for the survey to be rolled out nationally.
Reporting frequency	To be decided.
Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	Over the last 12 months the Department of Health has been in negotiations with the Picker Institute to agree the terms of the contract for the survey to be rolled out nationally. Work is in progress between the Department of Health and NHS England to finalise the contract and implement the survey nationally.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

4.9 Improving people's experience of integrated care

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 4: Ensuring that people have a positive experience of care. Improvement area – Improving experience of integrated care.
Outcome sought	Improvement in experiences of care, support and treatment as integrated.
Status	In development.
Detailed descriptor	<p>Plain English description:</p> <p>A measure of the extent that people's experience of care, support and treatment is integrated within and across services.</p> <p>Technical description:</p> <p>A measure of the extent that health and social care services are integrated, based on people's responses to questions in patient and service user experience surveys.</p>
Alignment with other Outcomes Frameworks	Complementary with Adult Social Care Outcomes Framework Indicator 3E.

4.9 Improving people's experience of integrated care (continued)

DATA SOURCES	
Data sources	<p>The indicator will be based on the insertion of new survey questions into existing surveys.</p> <p>The proposed questions to measure experience of integrated care are listed below:</p> <ul style="list-style-type: none"> • “To what extent do you agree or disagree with the following statement... ‘Health and social care staff always tell me what will happen next’ (and an alternative question: “To what extent do you agree or disagree with the following statement... ‘Health and social care staff always ensure I know what will happen next’)? • “Do you have a named health or social care professional who co-ordinates your care and support?” • “Do you know who to contact if you need to ask questions about your condition or treatment?” • “Do you feel this person [named contact] understands you and your condition?” • “Do all the different people treating and caring for you work well together to give you the best possible care and support?” • “Were you involved as much as you wanted to be in decisions about your care and support?” • “Do health and social care services help you live the life you want as far as possible?” <p>These questions are subject to further testing over the coming months to determine their appropriateness for inclusion in existing surveys.</p>
Reporting frequency	To be decided.
Timing	To be decided.

4.9 Improving people's experience of integrated care (continued)

CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	The indicator was introduced as a placeholder in the 2013/14 Outcomes Framework. Over the last 12 months the Department of Health has commissioned research to determine the most effective way to capture information about people's experiences of integrated care. The key output of this research is a set of cognitively tested questions with the potential to be included in existing surveys. The seven questions outlined above are a subset of the questions proposed by the researchers. Work is now continuing to implement these questions and the Outcomes Framework indicator will be based on the questions identified.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

Domain 5

Treating and caring for people in a safe environment and protecting them from avoidable harm

Introduction

Indicator structure

5.1 An overview of indicators in Domain 5 is shown below. Specifications for the live indicators are published on the HSCIC Indicator Portal (<https://indicators.ic.nhs.uk/webview/>). The specifications for the remaining indicators listed as ‘in development’ are provided at the end of this Domain 5 section.

5.2 Overarching indicators 5a and 5b measure the number and severity of safety incidents and are seen as indicative of the culture of reporting harm and learning from it. As there is room to improve the levels of reporting safety incidents, for the time being any increases in these two indicators will be seen as positive – reflecting increased willingness to recognise and address safety problems.

Overarching indicators	Status
5a Patient safety incidents reported	Live
5b Safety incidents resulting in severe harm or death	Live
5c Hospital deaths attributable to problems in care	In development
Improvement areas	Status
Reducing the incidence of avoidable harm	
5.1 Deaths from venous thromboembolism (VTE) related events	In development
5.2.i Incidence of healthcare associated infection (HCAI) – MRSA	Live
5.2.ii Incidence of healthcare associated infection (HCAI) – C difficile	Live
5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers	In development
5.4 Incidence of medication errors causing serious harm	Live
Improving the safety of maternity services	
5.5 Admission of full-term babies to neonatal care	Live
Delivering safe care to children in acute settings	
5.6 Incidence of harm to children due to ‘failure to monitor’	Live

5.3 For indicator 5b, once the levels of reporting match the levels of occurrence, the desired direction of the indicator will be downwards: fewer safety incidents resulting in severe harm or death.

5.4 Indicators in the improvement areas are of two sorts:

- *Sub-indicators:*
 - Progress in sub-indicators provides a useful initial analysis of what accounts for progress in overarching indicators. Indicator 5.4 – Incidence of medication errors causing serious harm is a sub-indicator of indicator 5b.
 - Indicator 5.1 – Deaths from VTE related events, will be a sub-indicator of indicator 5c (once both are live).
- *Complementary indicators:*
 - In several areas of practice, data collection is sufficiently systematic (or plans to make it make it so are in hand) to generate reliable information regarding incidence. These practices are measured by the following indicators:
 - 5.2 Incidence of healthcare associated infection: i. MRSA bacteraemia; ii. C difficile;
 - 5.3 Proportion of patients with category 2, 3, and 4 pressure ulcers;
 - 5.5 Admission of full-term babies to neonatal care;
 - 5.6 Incidence of harm to children due to “failure to monitor”.

International comparisons

5.5 International comparisons of patient safety covering surgical complications and obstetric trauma are available from the Organisation for Economic Co-operation and Development (OECD)’s ‘Health at a Glance’ bi-annual report¹¹. These comparisons are based on the Agency for Healthcare Research and Quality (AHRQ) indicators developed in the USA and are not directly comparable to NHS Outcomes Framework indicators. However, there are some overlaps e.g. rates of post-operative pulmonary embolism or deep vein thrombosis.

5.6 The data from different countries can be variable and caution is needed in interpreting the extent to which the data accurately reflects international differences in patient safety. Variations could be caused by differences in how countries code and record diagnoses and procedures. The OECD is working to improve comparability, for example by standardising for the number of secondary diagnoses used.

External drivers of outcomes

5.7 The predominant external driver of outcomes in Domain 5 is the volume and severity of need to which the NHS has to respond. Volume will affect outcomes for all Domain 5 indicators through its impact on the likelihood of engagement with the healthcare services and on the availability of resources relative to caseload. Increased severity of need will increase the likelihood that an individual will require care and complicate the delivery of safe care.

¹¹ http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312

Conversely, improved public health could reduce demand on the healthcare system, resulting in fewer safety incidents.

5.8 However, no attempt is made to adjust for changes in the amount of care activity taking place in different settings, as the NHS is expected to take into account safety when determining appropriate care settings for different patients.

Alignment with the Public Health Outcomes Framework (PHOF) and Adult Social Care Outcomes Framework (ASCOF)

5.9 There are no shared or complementary indicators with the PHOF or ASCOF in Domain 5.

Work in progress

Indicator 5c – Hospital deaths attributable to problems in care

5.10 At the moment, there is no robust overarching measure for the safety of healthcare services in general. The current set of patient safety indicators that make up domain 5 are constrained to measuring the number of patient safety incidents reported to the National Reporting and Learning System (indicators 5a, 5b, 5.4 and 5.6), and of specific forms of patient harm associated with healthcare.

5.11 In the refresh of the NHS Outcomes Framework for 2013/14, the Department of Health signalled an intention to begin addressing these constraints by developing a new indicator – hospital deaths attributable to problems in care.

5.12 Retrospective Case Record Review (RCRR) has been identified as the most sensitive approach for estimating the number of hospital deaths that are avoidable. This approach comprises clinical experts retrospectively reviewing patient healthcare records to assess the quality and safety of care provided, and appears particularly suited to the purposes of the NHS Outcome Framework.

5.13 Significant progress has been made on the development of this indicator. Academic and clinical experts from England and internationally have twice been convened to advise on the specification for the national Retrospective Case Record Review process. There is an agreed form for reviewers to use in judging the avoidability of hospital adult deaths from problems in care. The approach by which the national programme will be delivered is now being finalised.

5.14 Data to establish the baseline will derive from research studies led by the Department of Health Services Research & Policy at the London School of Hygiene and Tropical Medicine. The most recent data will be based on adult deaths in 2012 and will come from a newly-commissioned study to be published in autumn 2014 and will be directly comparable both to their previously published study¹² on adult deaths in 2009 and the national programme for indicator 5c.

¹² Hogan, H et al (2012) *Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study* BMJ Quality and Safety <http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159.full>

5.15 The national programme of RCRRs will begin from April 2014 reviewing deaths that will have occurred in 2013/14 and 2014/15. The results of these reviews are planned for publication in autumn 2015, though the feasibility of publishing in-year data, potentially on a monthly basis, is being assessed.

5.16 It is hoped that the methodology behind this indicator can be extended in due course to capture non-hospital deaths, and to cover severe harm short of death.

Indicator 5.1 – Deaths from VTE related events

5.17 Indicator 5.1 has changed from a measure of the ‘incidence of healthcare-related VTE’ to ‘deaths from VTE related events’. Such deaths are those where VTE is specified on the Medical Certificate of Cause of Death (MCCD) as being one of the conditions leading to, or directly causing death (Part 1, sub-sections a to c). Distinguishing between healthcare and community related VTE has proved unreliable in the originally intended data source – Hospital Episode Statistics. Measuring death as the outcome should also drive efforts to improve the prevention, detection and treatment of VTE before it causes death.

Indicator 5.3 – Proportion of patients with category 2, 3 and 4 pressure ulcers

5.18 The indicator title has notionally changed from ‘*Incidence of newly-acquired category 2, 3 and 4 pressure ulcers*’ as it was incorrectly published in 2013/14, but the indicator calculation methodology based on point-prevalence was correctly published.

5.19 The intended data source is the NHS Safety Thermometer though the feasibility of an alternative superior data source to measure the incidence and/or prevalence of pressure ulcers is currently being assessed. The recommendations on pressure ulcer reporting from the Tissue Viability Society¹³ are being taken into account, as well as those from the HSCIC Indicator Assurance Service on the suitability of the NHS Safety Thermometer as the intended data source for this indicator. If no such feasible alternatives are identified then the NHS Safety Thermometer will be used as the data source.

5.20 It is envisaged that an indicator will be developed in 2014/15, with exact timing dependent on the outcome of the assessment outlined above.

Indicator specifications for in development and place-holder indicators

5c Hospital deaths attributable to problems in care	
OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. Overarching indicator.
Outcome sought	Reduced number of avoidable deaths due to problems in care.
Status	In development.

¹³ Dealey, C et al (2012) *Achieving consensus in pressure ulcer reporting* Journal of Tissue Viability Volume 21, 72 – 83.

5c Hospital deaths attributable to problems in care (continued)

Detailed descriptor	<p>Plain English description:</p> <p>To be determined – see the later section on technical issues to be resolved.</p> <p>Technical description:</p> <p>To be determined – see the later section on technical issues to be resolved.</p>
DATA SOURCES	
Data sources	<p>A dedicated programme of Retrospective Case Record Reviews (RCRRs). The reviews will be conducted in two-stages by expert reviewers, who, at least in the introductory phase of the programme will be independent of the hospitals in which the death occurred. In the first stage the reviewer judges whether a problem in care contributed to the patient's death and in such cases the reviewer then judges on a six-point Likert scale and/or a continuous scale (values from 0 to 100) the extent to which the death could have been avoided in the absence of the problems.</p> <p>The intervals of the Likert scale are listed below:</p> <ol style="list-style-type: none"> 1. Definitely not avoidable 2. Slight evidence for avoidability 3. Possibly avoidable but not very likely, less than 50-50 but close call 4. Probably avoidable, more than 50-50 but close call 5. Strong evidence for avoidability 6. Definitely avoidable.
Reporting frequency	To be decided. Expected to be at least annual (financial year) but exploring ways to publish in-year results, potentially on a monthly basis.
Publication Timing	To be determined.
CONSTRUCTION	
Proposed calculation methodology	<p>The methodology needs further refinement (see 'technical issues to be resolved' section below).</p> <p>RCRRs will be conducted on a sample frame comprising all adult (≥ 18 years old) deaths in NHS acute hospitals excluding admissions for psychiatric care and obstetrics.</p>

5c Hospital deaths attributable to problems in care (continued)

Changes since previous publication	Development of indicator from a placeholder indicator.
Technical issues remaining to be resolved	<p>To confirm the sample frame and size per hospital.</p> <p>To decide on the definition of the indicator and in turn the calculation methodology. The aim is for the indicator value to reflect, as fully as possible, the reviewers' judgements of the degree to which deaths are avoidable. The Likert and continuous scales do this in conceptually different ways but both elicit a refined judgement from reviewers. We need to decide on which scale the indicator value will be based and how to exploit all of the information provided by that scale. If for example, the intervals 1 to 3 from the Likert scale were grouped to represent 'not avoidable' and 4 to 6 grouped to represent 'probably avoidable' then an indicator defined as the percentage of deaths that are probably avoidable would lose useful information about the degree of avoidability.</p> <p>To subject the indicator to the HSCIC Indicator Assurance Service.</p>

5.1 Deaths from venous thromboembolism (VTE) related events

OVERVIEW	
Indicator family name	<p>NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.</p> <p>Improvement area – Reducing the incidence of avoidable harm.</p>
Outcome sought	Reduced number of deaths from VTE related events.
Status	In development.

5.1 Deaths from venous thromboembolism (VTE) related events (continued)

Detailed descriptor	<p>Plain English description:</p> <p>The number of deaths from VTE related events that were diagnosed by a healthcare provider, per 100,000 resident population.</p> <p>Such deaths are those where VTE is specified on the Medical Certificate of Cause of Death (MCCD) as being one of the conditions leading to, or directly causing death (Part 1, sub-sections a to c).</p> <p>Technical description:</p> <p>Mortality rate from VTE related events diagnosed by a healthcare provider, per 100,000 resident population.</p>				
DATA SOURCES					
Data sources	<p>Numerator: Hospital Episode Statistics (HES) in combination with mortality data by cause, ONS.</p> <p>Denominator: the resident population as measured by ONS population data for the respective years.</p>				
Reporting frequency	To be determined.				
Publication Timing	<p>To be determined.</p> <p>HES reports provisional data monthly, annual data by financial year is available in the Autumn after the end of the period. The ONS population estimates and mortality data by cause are available annually (calendar year) in the autumn following year end.</p>				
CONSTRUCTION					
Proposed calculation methodology	<p>The detail of the calculation methodology is yet to be confirmed.</p> <p>It is proposed that a VTE related death is to be defined as one in which a death meets two criteria:</p> <ol style="list-style-type: none"> 1) one of the listed ICD-10 codes appears anywhere in Part 1 of the Medical Certificate Cause of Death; and 2) the death is associated with a hospital admission with a diagnosis of VTE using the listed ICD-10 codes. <p>List of ICD-10 codes for diagnosis of VTE related event:</p> <table> <tr> <td>ICD10 Code</td><td>Name</td></tr> <tr> <td>I260</td><td>Pulmonary embolism with mention of acute cor pulmonale</td></tr> </table>	ICD10 Code	Name	I260	Pulmonary embolism with mention of acute cor pulmonale
ICD10 Code	Name				
I260	Pulmonary embolism with mention of acute cor pulmonale				

5.1 Deaths from venous thromboembolism (VTE) related events (continued)

Proposed calculation methodology <i>(continued)</i>	ICD10 Code	Name
	I269	Pulmonary embolism without mention of acute cor pulmonale
	I800	Phlebitis/thrombophlebitis superficial vessels of lower extremities
	I801	Phlebitis and thrombophlebitis of femoral vein
	I802	Phlebitis/thrombophlebitis of other deep vessels of lower extremities
	I803	Phlebitis and thrombophlebitis of lower extremities, unspecified
	I808	Phlebitis and thrombophlebitis of other sites
	I809	Phlebitis and thrombophlebitis of unspecified site
	I821	Thrombophlebitis migrans
	I822	Embolism and thrombosis of vena cava
	I823	Embolism and thrombosis of renal vein
	I828	Embolism and thrombosis of other specified veins
	I829	Embolism and thrombosis of unspecified vein
	O223	Deep phlebothrombosis in pregnancy
	O229	Venous complication in pregnancy, unspecified
	O871	Deep phlebothrombosis in the puerperium
	O87.0	Superficial thrombophlebitis in the puerperium
	O87.9	Venous complication in the puerperium, unspecified
Changes since previous publication	Change from measurement of the incidence of healthcare-related VTE to death from VTE related events.	
Technical issues remaining to be resolved	<p>To develop the calculation methodology, including relevant standardisation such as age.</p> <p>To confirm the definition of deaths from VTE related events.</p> <p>To subject the indicator to the HSCIC Indicator Assurance Pipeline Process.</p> <p>To explore ways to capture VTE in ambulatory setting.</p>	

5.3 Proportion of patients with category 2, 3 or 4 pressure ulcers

OVERVIEW	
Indicator family name	<p>NHS Outcomes Framework – Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.</p> <p>Improvement area – Reducing the incidence of avoidable harm.</p>
Outcome sought	Reduced prevalence of serious pressure ulcers.
Status	In development.
Detailed descriptor	<p>Plain English description:</p> <p>The proportion of patients with category 2, 3 or 4 pressure ulcers documented following skin inspection on the day of survey, no matter when or where the pressure ulcer occurred, out of all patients in the care provider on day of survey.</p> <p>The categories of pressure ulcers are based on the European Pressure Ulcer scale:¹³</p> <ul style="list-style-type: none"> • Category II – partial thickness skin loss or blister. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured blister. • Category III – full thickness (fat visible). Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Some slough may be present. May include undermining and tunnelling. • Category IV – full thickness loss (bone visible). Full thickness tissue loss with exposed bone, tendon or muscle. Slough or Eschar may be present. Often includes undermining and tunnelling. <p>Patients' skin is inspected for pressure ulcers on a particular day each month.</p> <p>Technical description:</p> <p>Point prevalence of patients with category 2, 3 or 4 pressure ulcers.</p>

¹³ Defloor T et al. Statement of the European Pressure Ulcer Advisory Panel – pressure ulcer classification. J Wound Ostomy Continence Nurs 2005; 32:302-6.

5.3 Proportion of patients with category 2, 3 or 4 pressure ulcers (continued)

DATA SOURCES	
Data sources	The intended data source is the NHS Safety Thermometer though the feasibility of an alternative superior data source to measure the incidence and/or prevalence of pressure ulcers is currently being assessed. The recommendations on pressure ulcer reporting from the Tissue Viability Society ¹⁴ are being taken into account, as well as those from the HSCIC Indicator Assurance Pipeline Process on the suitability of the NHS Safety Thermometer as the intended data source for this indicator. If no such feasible alternatives are identified then the NHS Safety Thermometer will be used as the data source.
Reporting frequency	Monthly.
Publication Timing	NHS Safety Thermometer data are published monthly on the HSCIC website.
CONSTRUCTION	
Proposed calculation methodology	<p>Numerator: The number of patients with any pressure ulcer (count all pressure ulcers and those category 2 or greater).</p> <p>Denominator: The number of patients on the (care) unit or in the (care) facility during the time period.</p> <p>Format: percentage (numerator/denominator) *100</p>
Changes since previous publication	Change of indicator title from: 'Incidence of newly-acquired category 2, 3 and 4 pressure ulcers'. The title was incorrectly published but the indicator calculation methodology based on prevalence was correct.
Technical issues remaining to be resolved	<p>To confirm NHS Safety Thermometer as the intended data source.</p> <p>To confirm approach, if any, to risk adjust the measure for sub-national breakdowns.</p> <p>To consider amending pressure ulcer categories better to capture 'unstageable/unclassified' pressure ulcers.</p> <p>To subject the methodology to the HSCIC Indicator Assurance Pipeline Process.</p>

¹⁴ Dealey, C et al (2012) *Achieving consensus in pressure ulcer reporting* Journal of Tissue Viability Volume 21, 72 – 83.

Data Source breakdowns & Timely Reporting of Data

Table 1 provides details of the data sources which underpin the indicators in the NHS Outcomes Framework. Figures 1 and 2 display the data lags for the NHS Outcomes Framework, by data source and indicator respectively.

The Health and Social Care Information Centre (HSCIC) requires data to be finalised one month prior to publication on their indicator portal, so data published at the end of November will need to be ready at the end of October. This additional data lag is factored into the tables and charts here. However, the HSCIC is currently developing a new and improved portal, which will shorten this notice period, this should be in place by Autumn 2014.

Table 1: NHS Outcomes Framework data sources, grouped alphabetically by Source Provider, then by Data Source title

A&E Survey	
Indicators in the NHS Outcomes Framework	4.3
Source Provider	Care Quality Commission (CQC)
Publication Schedule	This ad hoc survey is run around every three years was last published in December 2012, after fieldwork from May to August (calendar years)
Time Lag	Available from the source provider in the December of the reference year (calendar year) Available on the HSCIC Indicator Portal 2 months after the reference year (calendar year)

Community Mental Health Survey

Indicators in the NHS Outcomes Framework	4.7
Source Provider	CQC
Publication Schedule	Published annually in September after the reference year (calendar)
Time Lag	Available from the source provider 9 months after the reference year (calendar) Available on the HSCIC Indicator Portal 11 months after the reference year (calendar)

Inpatient Survey

Indicators in the NHS Outcomes Framework	4b, 4.2
Source Provider	CQC
Publication Schedule	Published annually in April
Time Lag	Available from the source provider 1 month after the reference year(financial) Available on the HSCIC Indicator Portal 5 months after the reference year (financial)

Maternity Services Survey

Indicators in the NHS Outcomes Framework	4.5
Source Provider	CQC
Publication Schedule	This ad hoc survey is run around every three years was last published in December 2010, after fieldwork from May to August (calendar years). There is another one due for publication in December 2013
Time Lag	Available from the source provider in the December of the reference year (calendar year) Available on the HSCIC Indicator Portal 2 months after the reference year (calendar year)

Outpatient Survey

Indicators in the NHS Outcomes Framework	4.1
Source Provider	CQC
Publication Schedule	This ad hoc survey is run around every three years was last published in February 2011, after fieldwork from June to October (calendar years)
Time Lag	Available from the source provider 2 months after the reference year (calendar year) Available on the HSCIC Indicator Portal 5 months after the reference year (calendar year)

National Hip Fracture Database (NHFD)

Indicators in the NHS Outcomes Framework	3.5
Source Provider	Health Quality Improvement Partnership (HQUIP)
Publication Schedule	Published annually, a national clinical NHFD National report published in September 2012 for period April 2011 to March 2012
Time Lag	Available from the source provider 6 months after the reference year (financial year) Available on the HSCIC Indicator Portal 8 months after the reference year (financial year)

Adult Social Care Combined Activity Returns (ASCAR)

Indicators in the NHS Outcomes Framework	3.6
Source Provider	HSCIC
Publication Schedule	Published annually in July
Time Lag	Available from the source provider 4 months at end of the reference year (financial year) Available on HSCIC Indicator Portal 8 months after the end of the reference year (financial year)

Hospital Episode Statistics (HES)

Indicators in the NHS Outcomes Framework	Numerator for: 2.3i, 2.3ii 3a, 3b, 3.2
Source Provider	HSCIC
Publication Schedule	Published in a provisional form monthly and quarterly Final annual confirmed HES data are released in the November following the financial year end
Time Lag	Final data available from the source provider 8 months after the reference year (financial year) Available on the HSCIC portal around 11 months after the reference year (financial year)

Mental Health Minimum Dataset (MHMDS) data linked over years and to the Primary Care Mortality Database (PCMD)

Indicators in the NHS Outcomes Framework	1.5
Source Provider	HSCIC
Publication Schedule	Published quarterly and refreshed annually
Time Lag	Available from the source provider 5 months after the end of the reference year (financial year), but the lag has been variable of late Available on the HSCIC Indicator Portal 8 months after the end of the reference period (financial year)

Patient Reported Outcome Measures (PROMs) (and HES)

Indicators in the NHS Outcomes Framework	3.1.i-iv
Source Provider	HSCIC
Publication Schedule	Published biannually around August (every two calendar years)
Time Lag	Available from the source provider 17 months after the reference year (financial year) Available on the HSCIC portal around 20 months after the reference year (financial year) around December

Quality and Outcomes Framework (QOF) Data

Indicators in the NHS Outcomes Framework	2.6.i
Source Provider	HSCIC
Publication Schedule	Published annually in November
Time Lag	Available from the source provider 8 months after the end of the reference year (financial year) Available on the HSCIC Indicator Portal around 11 months after the reference year (financial year)

GP Patient Survey (GPPS)

Indicators in the NHS Outcomes Framework	2, 2.1, 2.4 4a, 4.4
Source Provider	Ipsos MORI
Publication Schedule	Published annually in July after the end of the financial year
Time Lag	<p>Available from the source provider 4 months after the reference year (financial year)</p> <p>Each wave produces data 4 months after the end of each data collection period. GPPS is in 2 waves of 3 months each year. The first wave is conducted between July and September and the second between January and March</p> <p>Available on the HSCIC Indicator Portal 8 months after the end of the reference period (financial year)</p>

Dementia UK Report

Indicators in the NHS Outcomes Framework	2.6.i
Source Provider	Knapp et al (2007) report for the Alzheimer's Society
Publication Schedule	n/a
Time Lag	n/a

National Neonatal Research Database (NNRD)

Indicators in the NHS Outcomes Framework	Numerator for: 5.5
Source Provider	Neonatal Data Analysis Unit (NDAU)
Publication Schedule	Published annually (financial year)
Time Lag	<p>The NNRD is the source of the numerator for indicator 5.5 – this is available 1 month after the end of the reference period from the source provider. The ONS Birth Notifications is the source of the denominator for indicator 5.5 – this is available 22 months after the end of the reference period</p> <p>The indicator is available on the HSCIC Indicator portal 24 months after the end of the reference period (financial) taking into account of lag for numerator and denominator</p>

National Reporting and Learning System (NRLS)

Indicators in the NHS Outcomes Framework	5a, 5b, 5.4, 5.6
Source Provider	National Reporting and Learning System (NRLS)
Publication Schedule	Published bi-annually
Time Lag	Available from the source provider 5 months after the reference period (financial year) Available on the HSCIC Indicator Portal 8 months after the end of the reference period (financial year)

Cancer registration data

Indicators in the NHS Outcomes Framework	1.4i-iv
Source Provider	Office for National Statistics (ONS)
Publication Schedule	Published annually (calendar year) (survival data for cancers followed up to the end of 2011 was released October 2012)
Time Lag	Available from the source provider 10 months after the end of the reference period (calendar year) Available on the HSCIC Indicator Portal around 14 months after the end of the reference period (calendar year)

Labour Force Survey

Indicators in the NHS Outcomes Framework	2.2, 2.5
Source Provider	ONS
Publication Schedule	Published 6 monthly
Time Lag	Available from the source provider approximately 2 months after the end of that reference period in quarters usually November and May (calendar year) Available on the HSCIC portal website 3 months after the reference period (February and August)

National Bereavement Survey (VOICES)

Indicators in the NHS Outcomes Framework	4.6
Source Provider	ONS
Publication Schedule	Published annually in July after the end of the reference period (financial year)
Time Lag	Available from the source provider 4 months after the end of the reference period (financial year) Available on the HSCIC Indicator Portal 8 months after the end of the reference period (financial)

ONS Birth Notifications (NHS Numbers for Babies)

Indicators in the NHS Outcomes Framework	Denominator for: 5.5
Source Provider	ONS
Publication Schedule	Published annually (calendar year)
Time Lag	Available from the source provider 22 months after the end of the reference period (calendar year) Available on the HSCIC Indicator Portal 24 months after the end of the reference period (calendar year)

ONS mid-year population estimates

Indicators in the NHS Outcomes Framework	Denominator for: 1a, 1.1, 1.2, 1.3, 1.4, 1.5, 2.3i, 2.3ii, 2.6i, 3a, 3.2, 5a, 5b, 5.4
Source Provider	ONS
Publication Schedule	Published annually (calendar year)
Time Lag	Available from the source provider 8 months after the end of the reference period (calendar year) Available on the HSCIC Indicator Portal 11 months after the end of the reference period (calendar year)

ONS Mortality Statistics Childhood, infant and perinatal

Indicators in the NHS Outcomes Framework	1.6.i-ii
Source Provider	ONS
Publication Schedule	Published in October after the end of the reference period
Time Lag	Available from the source provider 10 months after the end of the reference period (calendar year) Available on the HSCIC Indicator Portal 14 months after the end of the reference period (calendar year)

ONS Mortality data by cause

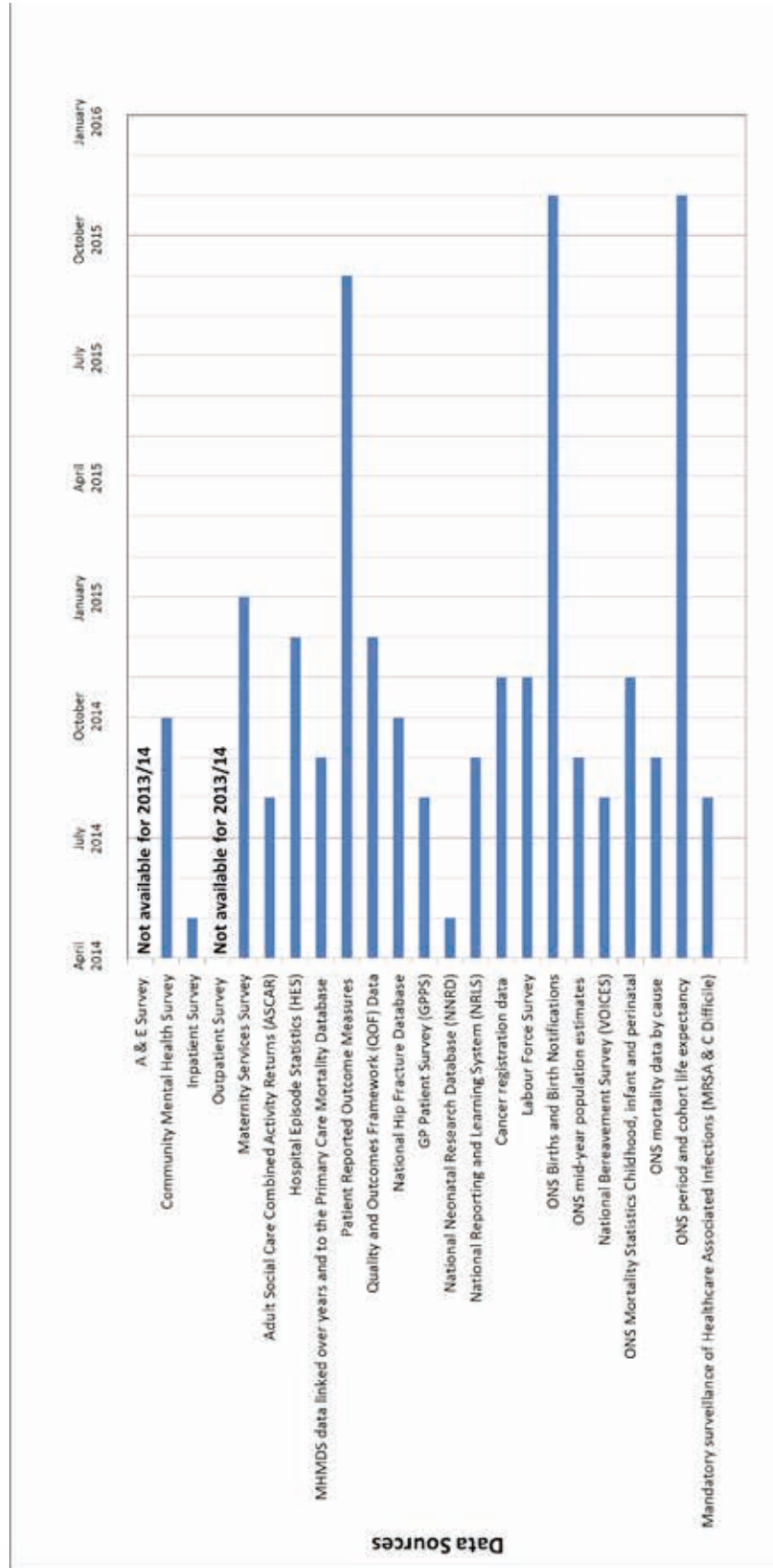
Indicators in the NHS Outcomes Framework	Numerator for: 1a, 1.1, 1.2, 1.3, 1.4
Source Provider	ONS
Publication Schedule	Published annually (calendar year)
Time Lag	Available from source provider 8 months after the end of the reference period (calendar year) Available on the Health and Social Care Information Centre's (HSCIC) Indicator Portal around 11 months after the reference period (calendar year)

ONS period and cohort life expectancy

Indicators in the NHS Outcomes Framework	1b
Source Provider	ONS
Publication Schedule	Published biannually (every two calendar years)
Time Lag	Available from the source provider 10 months after the end of the reference period (calendar year) Available on the HSCIC Indicator Portal 14 months after the end of the reference period (calendar year)

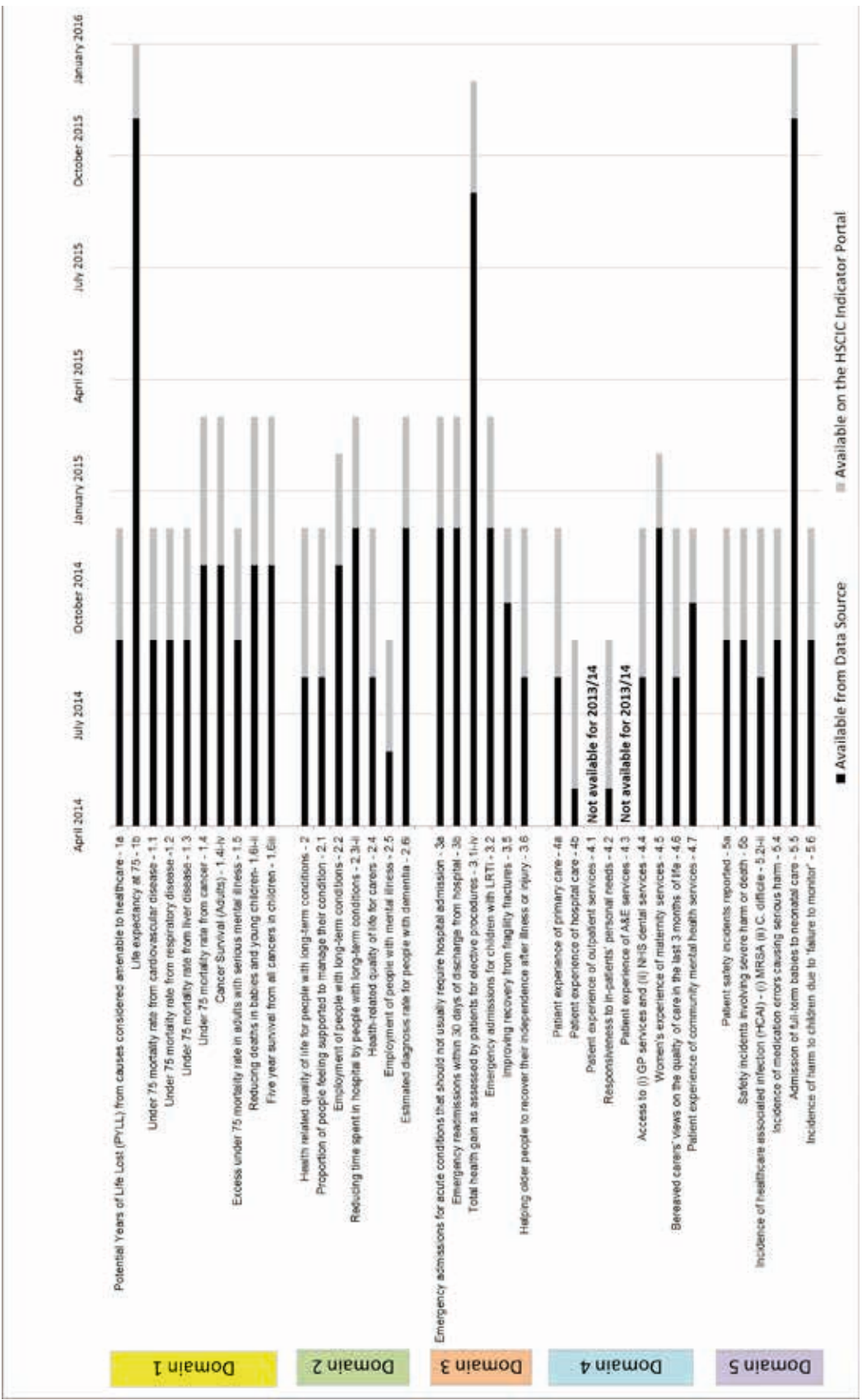
Mandatory surveillance of Healthcare Associated Infections (MRSA & C Difficile)	
Indicators in the NHS Outcomes Framework	5.2.i, 5.2.ii
Source Provider	Public Health England (PHE)
Publication Schedule	Published annually in July
Time Lag	<p>Available from the source provider 4 months after the end of the reference period (financial year)</p> <p>Available from the HSCIC Indicator portal 8 after the end of the reference period (financial year)</p>

Figure 1: Timeliness of data for assessment of 2013-14 NHS Outcomes Framework – by data source¹⁵



¹⁵ Some of the source data are based on calendar, not financial years. Where this is the case the availability of source data for 2013/14 is based on the 2013 calendar year. Outpatient, A&E and Maternity surveys are run on a less than annual frequency. For the Maternity survey, the chart reflects the lag for 2013/14 data. The Outpatient and A&E surveys do not currently cover the 2013/14 period.

Figure 2: Timeliness of data for assessment of 2013-14 NHS Outcomes Framework – by indicator¹⁶



¹⁶ Some of the indicator data are based on calendar, not financial years. Where this is the case the availability of indicator data for 2013/14 is based on the 2013 calendar year. Indicators 4.1, 4.3 and 4.5 are based on CQC surveys that are run on a less than annual frequency. For 4.5, the chart reflects the lag for 2013/14 data. For 4.1 and 4.3, there isn't currently a survey which covers the 2013/14 period.

Equalities breakdowns

Table 2 provides details, for each indicator in the NHS Outcomes Framework, where breakdowns are available against the Equalities protected characteristics.

Key

A	Available – Data is available on the Health and Social Care Information Centre (HSCIC) Indicator Portal (NHS OF or CCG Indicators sections) unless otherwise stated in the ‘Further Information’ column. Other publications may be from Department of Health, Office for National Statistics, international organisations, or research articles.
N	Not available or not applicable – Either the data are not collected or are not robust enough to be published e.g. due to small numbers or data quality, or breakdowns are not applicable.
D	In development – Not currently available but possible to construct, with publication planned by October 2014.
I	Under investigation – Work is underway to determine the feasibility of making these data available.
*	Starred items (i.e. A* or D*) indicate that the breakdown should be treated with particular caution. In the case of sub-national breakdowns this is because it will not be appropriate to make comparisons between areas without risk adjustment. In other columns this is because there is concern about completeness or accuracy.

Table 2 Equalities Breakdowns by Outcomes Framework Indicator

	Sub-national breakdown				Inequality and Equality Strands (National Only)								Other HSCIC Breakdowns	Further Information			
	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal	
Domain 1. Preventing people from dying prematurely																	
1a.i Potential Years of Life Lost (PYLL) from causes from causes considered amenable to health care – adults	N	D	A*	N	D	I	A	N	N	A	N	N	N	N	N	Condition All breakdowns shown for males and females separately	Data sourced from ONS Mortality data by cause. Indicator 1a.i is indicator 1.1 in the CCG Outcomes Indicator Set (CCG OIS). CCG breakdowns published in the CCG OIS https://indicators.ic.nhs.uk/webview/ and other sub-national breakdowns should be interpreted with caution – a small number of deaths in an area, particularly a local authority or a CCG, may produce a volatile time series.
1a.ii Potential Years of Life Lost (PYLL) from causes from causes considered amenable to health care – children and young people	N	I	I	N	I	I	I	N	N	A	N	N	N	N	N		Data sourced from ONS Mortality data by cause.

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity		
1b Life expectancy at 75, i males and ii females	A	A*	N	A*	N	A*	I	N	N	N	A	N	N	N	N	N	Unitary Authority	Data sourced from ONS Period life expectancy tables. International comparisons available from The Human Mortality Database http://www.mortality.org Regional, local authority and deprivation breakdowns should be interpreted with caution: they are expressed as three-year averages and therefore relate to a period which began more than three years before the publication date (for example figures available in 2012 relate to 2008-2010). Age breakdown does not apply as the indicator age is included in the definition of the indicator.
																	Published on HSCIC Indicator portal	

1.1 Under 75 mortality rate from cardiovascular disease	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity		
	A	A*	A*	A*	N	D	I	A	N	N	N	N	N	N	N	N	County, SHA, PCT, Unitary Authority All breakdowns also by gender	Data sourced from ONS Mortality data by cause. Data for international comparisons available from WHO European Detailed Mortality Database http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-detailed-mortality-database-dmdb2 Indicator 1.1 is indicator 1.2 in the CCG Outcomes Indicator Set (CCG OIS). CCG breakdowns published in the CCG OIS https://indicators.ic.nhs.uk/webview/ and other sub-national breakdowns should be interpreted with caution – a small number of deaths in an area, particularly a local authority or a CCG, may produce a volatile time series.

1.3 Under 75 mortality rate from liver disease	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information	
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity
		A*	A*	A*	N	D	I	A	N	N	A	N	N	N	N			N
Data sourced from ONS Mortality data by cause. Data for international comparisons available from WHO European Detailed Mortality Database http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-detailed-mortality-database-dmdb2 Indicator 1.3 is indicator 1.7 in the CCG Outcomes Indicator Set (CCG OIS). CCG breakdowns published in the CCG OIS https://indicators.ic.nhs.uk/webview/ and other sub-national breakdowns should be interpreted with caution – a small number of deaths in an area, particularly a local authority or a CCG, may produce a volatile time series.																		

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information		
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity	
1.4. Under 75 mortality from cancer	A	A*	A*	A*	N	D	I	A	N	N	A	N	N	N	N	N	Published on HSCIC Indicator portal	County, SHA, PCT, Unitary Authority All breakdowns also by gender	Data sourced from ONS Mortality data by cause. Data for international comparisons available from WHO European Detailed Mortality Database http://www.euro.who.int/en/what-we-do/data-and-evidence/databases/european-detailed-mortality-database-dmdb2 Indicator 1.4 is indicator 1.9 in the CCG Outcomes Indicator Set (CCG OIS). CCG breakdowns published in the CCG OIS https://indicators.ic.nhs.uk/webview/ and other sub-national breakdowns should be interpreted with caution – a small number of deaths in an area, particularly a local authority or a CCG, may produce a volatile time series.
	N	I	D	N	I	I	I	N	N	I	I	A	N	N	N	N		This is a new definition with data being published during 2014/15. Data sourced from ONS Cancer Survival Statistics.	
1.4.i One-year survival for all cancers (to be PUBLISHED during 2014/15)																			

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information	
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal	
1.4.ii Five-year survival for all cancers (to be <u>PUBLISHED</u> during 2014/15)	A*	–	N	N	N	–	–	D	–	N	D	N	N	N	N	N	–	This is a new definition with data being published during 2014/15. Data sourced from ONS Cancer Survival Statistics. International comparisons available for 2002. The lack of more recent data means caution is required interpreting these comparisons.
1.4.iii One-year survival for breast, lung and colorectal cancer (to be <u>PUBLISHED</u> during 2014/15)	N	–	D	N	N	–	–	D	–	N	D	N	N	N	N	N	–	This is a new definition with data being published during 2014/15. Data sourced from ONS Cancer Survival Statistics.
1.4.iv Five-year survival for breast, lung and colorectal cancer (to be <u>PUBLISHED</u> during 2014/15)	N	–	N	N	N	–	–	D	–	N	D	N	N	N	N	N	–	This is a new definition with data being published during 2014/15. Data sourced from ONS Cancer Survival Statistics.
1.5 Excess mortality rate in people with serious mental illness	N	D	–	A*	N	D	–	A	N	N	A	N	N	N	N	N	Condition	Data sourced from the Mental Health Minimum Dataset (MHMDS) linked to ONS Primary Care Mortality Database. Subnational breakdowns should be interpreted with caution due to the small number of deaths.

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment		
1.6.i Infant mortality (Cont.)	A*	A*	I	A*	N	A*	N	A*	N								Socio-economic classification of an infant death is based on father's occupation where available from the infant's birth certificate when it can be linked to the death certificate. This breakdown should be interpreted with caution as only 82% of all infant deaths can be linked in this way (for further detail consult the ONS Statistical bulletin: http://www.ons.gov.uk/ons/rel/child-health/infant-and-perinatal-mortality-in-england-and-wales-by-social-and-biological-factors/2011/stb-infant-and-perinatal-mortality--2011.html). Furthermore, the number of births by socio-economic classification used for the denominator is estimated from a sample of only 1 in 10 live births. Information on ethnicity is not routinely collected at birth or death registration but ONS links birth registration records with NHS Birth Notification records so that live births and linked deaths can be reported by ethnicity. Nationally, the ethnicity variable is 'Not Stated' for about 11 per cent of infant deaths. (further detail at: http://www.ons.gov.uk/ons/dcp171778_232681.pdf)

1.6.i Infant mortality (Cont.)

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal	
1.6.ii Neonatal mortality and stillbirths	N	A*	I	A*	N	A*	A*	N	A*	N	A	N	N	N	N	N	SHA, PCT, Age of mother	As for indicator 1.6.i
1.6.iii Five year survival for all cancers in children	A*	N	N	N	N	I	I	I	I	N	D	N	N	N	N	N	Data to be sourced from ONS Children's Cancer Survival Statistics. This indicator will use a new methodology currently in development, with data being published during 2014/15. Possible breakdowns will be known once the data source is ready and the indicator definition is finalised. A sex breakdown is expected. International comparisons are available from Eurocare 4 (further information at http://www.eurocare.it/Results/tabid/79/eurocare.it/Results.aspx) but should be interpreted with caution because the latest data available are for cancers diagnosed 1995-2002.	Data to be sourced from ONS Children's Cancer Survival Statistics. This indicator will use a new methodology currently in development, with data being published during 2014/15. Possible breakdowns will be known once the data source is ready and the indicator definition is finalised. A sex breakdown is expected. International comparisons are available from Eurocare 4 (further information at http://www.eurocare.it/Results/tabid/79/eurocare.it/Results.aspx) but should be interpreted with caution because the latest data available are for cancers diagnosed 1995-2002.
1.7 Reduced premature mortality in people with learning disabilities																	Possible breakdowns to be assessed once the indicator is developed	

	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information		
	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal			
Domain 2. Improving quality of life for people with long-term conditions																			
2 Health-related quality of life for people with long-term conditions	N	A	D	A	N	A	A	A	A	A	N	A	N	N	N	SHA, PCT	Data sourced from the GP Patient Survey (GPPS). Data for 2011/12 and 2012/13 precede the introduction of CCGs and are presented by SHA and PCT. Data from 2013/14 should be available by CCG in due course.		
	N	A	A	N	A	N	A	A	A	A	N	A	N	N	N	SHA, PCT	Data sourced from the GP Patient Survey (GPPS). Data for 2011/12 and 2012/13 precede the introduction of CCGs and are presented by SHA and PCT. Data from 2013/14 should be available by CCG in due course.		
2.1 Proportion of people feeling supported to manage their condition	N	A	D	A	N	A	A	A	A	A	N	A	N	N	N	SHA, PCT	Data sourced from the GP Patient Survey (GPPS). Data for 2011/12 and 2012/13 precede the introduction of CCGs and are presented by SHA and PCT. Data from 2013/14 should be available by CCG in due course.		
2.2 Employment of people with long-term conditions.	N	A	N	A	N	A	A	A	A	A	I	I	N	N	N		Data sourced from the Labour Force Survey (LFS).		

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information		
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity	
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)	A*	N	A	A*	N	A	A*	N	N	A	N	N	N	N	N	N	Published on HSCIC Indicator portal	SHA, PCT, Condition	Data sourced from Hospital Episode Statistics (HES) International comparisons on a strictly comparable basis are not available. However, the OECD collects internationally comparable data on 'avoidable admissions' for asthma, COPD, hypertension, congestive heart failure, uncontrolled diabetes and diabetes complications for its Health Care Quality Indicators project. Many of these indicators are published in the Quality chapter of the OECD's two-yearly report, Health at a Glance, most recent issue published November 2011: http://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance-2011_health_glance-2011-en CCG breakdowns are published for similar indicators in the CCG Outcomes Indicator Set (CCG OIS) but the rate is per 100,000 CCG population (i.e., the CCG population registered with the constituent GP practices) rather than per 100,000 England population estimates as in the NHS Outcomes Framework. Indicator 2.3.i is indicator 2.6 in the CCG OIS https://indicators.ic.nhs.uk/webview/ .

	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information
	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal
Domain 3. Helping people to recover from episodes of ill health or following injury																
3a Emergency admissions for acute conditions that should not usually require hospital admission	N	A	A*	N	A	N	A*	N	A	N	N	N	N	N	N	SHA, PCT, Condition Data sourced from Hospital Episode Statistics (HES). CCG breakdowns are published for similar indicators in the CCG Outcomes Indicator Set (CCG OIS) but the rate is per 100,000 CCG population (i.e., the CCG population registered with the constituent GP practices) rather than per 100,000 England population estimates as in the NHS Outcomes Framework. Indicator 3a is indicator 3.1 in the CCG OIS https://indicators.ic.nhs.uk/webview/ . Provider breakdown is not available for indicator 3a because provider catchment populations are not defined, so not allowing calculating a rate of admissions per 100,000 population. Ethnicity and local authority are not available for all patients, so these breakdowns should be treated with caution. The percentages of records for each quarter that are not classified for both breakdowns are also published.

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	HSCIC Indicator Published on portal	
3.1 Total health gain as assessed by patients for elective procedures: i Hip replacement; ii Knee replacement; iii Groin hernia; iv Varicose veins	N	N	A	D	A	A	N	A	A*	N	A	A	N	N	N	N	SHA, PCT	Data sourced from the Patient Reported Outcome Measures (PROMs) in Hospital Episode Statistics (HES). CCG breakdowns are published in the CCG Outcomes Indicator Set. Indicators 3.1 i-iv are indicators 3.3 a-d, respectively, in the CCG OIS https://indicators.ic.nhs.uk/webview/. The ethnicity breakdown is not available for all patients, so it should be treated with caution. The percentage of records for each quarter that are not classified is also published.
3.1v Total health gain as assessed by patients for elective procedures v Psychological therapies		Possible breakdowns to be assessed once the indicator is developed.																Data sourced from the Routine Monthly Improving Access to Psychological Therapies (IAPT) reports.

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information	
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	N	N	A	A*	N	A	N	A*	N	A	N	N	N	N	N	N	SHA, PCT, Condition	Data sourced from Hospital Episode Statistics (HES). CCG breakdowns are published for similar indicators in the CCG Outcomes Indicator Set (CCG OIS) but the rate is per 100,000 CCG population (i.e., the CCG population registered with the constituent GP practices) rather than per 100,000 England population estimates as in the NHS Outcomes Framework. Indicator 3.2 is indicator 3.4 in the CCG OIS https://indicators.ic.nhs.uk/webview/ . Ethnicity and local authority are not available for all patients, so these breakdowns should be treated with caution. The percentages of records for each quarter that are not classified for both breakdowns are also published.
3.3 Survival from major trauma																		Possible breakdowns to be assessed once the indicator is developed.
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months																		Possible breakdowns to be assessed once the indicator is developed.

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information	
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity
3.5.i The proportion of patients with fragility fractures recovering to their previous levels of mobility/ walking ability at 30 days	N	—	—	—	—	—	N	A	N	N	A	N	N	N	N	N	Mobility Category at admission	Data sourced from the National Hip Fracture Database (NHFD).
3.5.ii The proportion of patients with fragility fractures recovering to their previous levels of mobility/ walking ability at 120 days	N	—	—	—	—	—	N	A	N	N	A	N	N	N	N	N	Mobility Category at admission	Data sourced from the National Hip Fracture Database (NHFD).
3.6i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/ reablement services	N	A	N	A	N	N	N	A	N	N	A	N	N	N	N	N		Data sourced from the Adult Social Care Combined Activity (ASC-CAF) data Data for this indicator are published in the HSC IC Indicator Portal under the heading of Adult Social Care Outcomes Framework (ASCOF).

[illegible]

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity		
4.1 Patient experience of outpatient services	N	I	D*	N	A	N	N	I	I	N	I	I	N	N	N	N	Published on HSCIC Indicator portal	Data sourced from the Outpatient Survey
4.2 Responsiveness to in-patients' personal needs	N	I	D*	N	A	N	N	I	I	I	I	I	I	N	N	N		Data sourced from the Inpatient Survey
4.3 Patient experience of A&E services	N	I	D*	N	A	N	N	I	I	I	I	I	I	N	N	N		Data sourced from the Accident & Emergency Survey
4.4i Access to GP Services	N	D*	A	D*	A	D*	N	D*	D*	D*	D*	N	D*	N	N	N		Data sourced from the GP Patient Survey (GPPS) CCG and provider breakdowns available from http://www.gp-patient.co.uk/surveyresults
4.4ii Access to dental services	N	D*	A	D*	N	D*	N	D*	D*	D*	D*	N	D*	N	N	N		Data sourced from the GP Patient Survey (GPPS) CCG breakdown available from http://www.gp-patient.co.uk/surveyresults
4.5 Women's experience of maternity services	N	N	N	N	N	N	N	I	I	N	N	I	N	N	N	N		Data sourced from the Maternity Services Survey. Provider breakdowns are not possible since women may not have received antenatal care at the same trust where they received care during labour and birth, so responses to these questions cannot be attributed to a trust with certainty.
4.6 Survey of bereaved carers	N	I	I	I	I	I	N	D	I	I	D	N	N	N	N	N		Data sourced from the National Bereavement Survey (VOICES)

	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns	Further Information	
	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment			Pregnancy and Maternity
4.7 Patient experience of community mental health services	I	D*	N	A	N	N	I	I	I	I	N	I	N	N	N	Published on HSCIC Indicator portal	Data sourced from the Community Mental Health Survey
4.8 An indicator on children and young people's experience of healthcare	Possible breakdowns to be assessed once the indicator is developed																
4.9 An indicator on people's experience of integrated care	Possible breakdowns to be assessed once the indicator is developed																
Domain 5. Treating and caring for people in a safe environment and protecting them from avoidable harm																	
5a Patient safety incident reported																	Data sourced from the National Reporting and Learning System (NRLS)
	N	D*	D	N	A*	N	N	I	I	N	I	N	N	N	N	PCT	CCG level breakdown expected to be published on HSCIC Indicator portal from June 2014 Sub-national breakdowns to be treated with caution because of quality issues of NRLS data. See 'Data handling notes' at http://www.nrls.npsa.nhs.uk/resources/?entryid45=135

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)										Other HSCIC Breakdowns		Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity	Published on HSCIC Indicator portal	
5b Safety incidents involving severe harm or death	N	D*	I	N	A*	N	N	I	I	N	I	I	N	N	N	N	PCT	Data sourced from the National Reporting and Learning System (NRLS) Sub-national breakdowns to be treated with caution because of quality issues of NRLS data. See 'Data handling notes' at http://www.nrls.npsa.nhs.uk/resources/?entryid45=135
5c An indicator on hospital deaths attributable to problems in care	Possible breakdowns to be assessed once the indicator is developed																	
5.1 Incidence of hospital related venous thromboembolism (VTE)	Possible breakdowns to be assessed once the indicator is developed																	
5.2.i Incidence of healthcare associated MRSA infection	N	A*	A*	I	A*	I	N	I	N	N	I	N	N	N	N	N	PCT	Data sourced from the Mandatory surveillance of Metillin Resistant Staphylococcus Aureus (MRSA) bacteraemia by Public Health England (PHE) Sub-national breakdowns to be treated with caution as they are not standardised. Please see associated 'Quality Statement' in the CCG Indicator section of the HSCIC Indicator Portal https://indicators.ic.nhs.uk/webview

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity		
5.2.ii Incidence of healthcare associated C. difficile infection	N	A*	A*	I	A*	I	N	I	N	N	I	N	N	N	N	N	PCT	Data sourced from the Mandatory surveillance of Clostridium difficile by Public Health England (PHE) Sub-national breakdowns to be treated with caution as they are not standardised. Please see associated 'Quality Statement' in the CCG Indicator section of the HSCIC Indicator Portal https://indicators.ic.nhs.uk/webview
5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers	Possible breakdowns to be assessed once the indicator is developed																	
5.4 Incidence of medication errors causing serious harm	N	D*	I	N	I	I	N	I	I	N	I	I	N	N	N	N		Data sourced from the National Reporting and Learning System (NRLS) Sub-national breakdowns to be treated with caution because of quality issues of NRLS data. See 'Data handling notes' at http://www.nrls.npsa.nhs.uk/resources/?entryid45=135
5.5 Admission of full-term babies to neonatal care	N	D*	I	I	I	I	I	I	I	N	I	I	N	N	N	N	PCT of Mother	Data sourced from the National Neonatal Research Database

	International comparisons	Sub-national breakdown				Inequality and Equality Strands (National Only)											Other HSCIC Breakdowns	Further Information
		Region	CCG	Local Authority	Provider	Deprivation	Socio-economic status	Age	Race	Religion or belief	Sex	Disability	Sexual orientation	Marriage and Civil Partnership	Gender Reassignment	Pregnancy and Maternity		
5.6 Incidence of harm to children due to 'failure to monitor'	N	—	—	—	—	—	N	—	—	N	—	—	N	N	N	N		Data sourced from the National Reporting and Learning System (NRLS) Sub-national breakdowns to be treated with caution because of quality issues of NRLS data. See 'Data handling notes' at http://www.nrls.npsa.nhs.uk/resources/?entryid45=135

Glossary

A&E department – Type 1

A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients.

A&E department – Type 2

A consultant led single specialty accident and emergency service (e.g. Ophthalmology, Dental) with designated accommodation for the reception of patients.

A&E Survey

The A&E survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. It asks about the experiences of people who have visited an emergency department. The A&E survey was conducted in 2003, 2004 and 2008. Almost 50,000 people aged 16 and over who had attended emergency departments in January, February or March 2008 responded to the 2008 survey, a response rate of 40%.

www.nhssurveys.org/results

Adult Social Care Combined Activity Return (ASC-CAR)

The Adult Social Care Combined Activity Return is a social care return managed by the Health and Social Care Information Centre (HSCIC). It provides information to support national indicators and data on the number of adults in residential and nursing placements funded by councils with adult social services responsibilities.

<http://www.hscic.gov.uk/socialcarecollections2013>

Adult Social Care Outcomes Framework (ASCOF)

The Adult Social Care Outcomes Framework sets out the desired outcomes for adult social care and how these will be measured. The framework is a set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care.

<https://www.gov.uk/government/publications/the-adult-social-care-outcomes-framework-2013-to-2014>

Ambulatory Care Sensitive (ACS) conditions

Ambulatory care sensitive (ACS) conditions are chronic conditions that can respond to care in an ambulatory care setting (e.g. at home or in the community rather than in an acute hospital). Actively managing patients with ACS conditions – through vaccination, better self-management, disease-management or case-management, or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.

CCG

Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. They replace Primary Care Trusts (PCTs).

Cohort

A cohort is a group of individuals who share a common characteristic or experience during a particular time-period. In the context of the NHS Outcomes Framework, a cohort is a group of individuals who were born in the same time period. A cohort effect in the context of the NHS Outcomes Framework, is variations over time between individuals who are born in different time periods, all other things being equal.

Community Mental Health Services Survey

The Community Mental Health Services Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. This survey has been run annually since 2003/04 and assesses the care experience of patients receiving community mental health services. The 2013 survey took the views of more than 13,000 people who received care or treatment for a mental health condition, including those who received care co-ordinated under the Care Programme Approach (CPA), but excluding patients under the age of 18, between July and September 2012, achieving a response rate of 29%.

<http://www.cqc.org.uk/public/publications/surveys/community-mental-health-survey-2013>

Deprivation

Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial. Deprivation is one of the 'Inequality and Equality strands' (see separate Glossary entry), and for the purpose of the NHS OF is measured by the Index of Multiple Deprivation (IMD) (see separate Glossary entry).

Emergency admission

When admission is unpredictable and at short notice because of clinical need.

http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp

Episode

The Healthcare Commission defines an episode as a single period of hospital care under one consultant, e.g. treatment of Patient A in hospital by Consultant A for a broken leg (see further example under Glossary entry 'Spell').

Equality Analysis

One of the underpinning principles of the NHS Outcomes Framework is to encourage the promotion of equality and reduce inequalities in outcomes from healthcare. The framework helps NHS England to play its full part in promoting equality in line with the Equality Act 2010, and to fulfil the health inequalities duties in the Health and Social Care Act (2012).

GP Patient Survey (GPPS)

The GPPS is run by Ipsos MORI. It assesses patients' experiences of the access and quality of care they receive from their local GPs, dentists and out-of-hours doctor services. Every 6

months, around 1.36 million questionnaires are sent out to adult patients, randomly selected from all patients registered with a GP in England. This means that each year around 2.7 million different patients in England are sent the questionnaire, and the overall response rate in 2012/2013 was 35%.

www.gp-patient.co.uk

Gratitude Bias in Patient Experience Surveys

Gratitude bias may occur when feelings of gratitude for the treatment received by the patient cause them to be less critical of the healthcare professionals who cared for them and of the quality of care received. The feelings of gratitude may inhibit negative evaluations and promote positive evaluations.

Healthcare Associated Infections (HCAI)

HCAI are infections resulting from medical care or treatment in hospital, nursing homes or the patient's own home.

www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI

Health Outcome

A health outcome is a change in the health status of an individual, group or population, which is attributable to an intervention or series of interventions.

Hospital Episodes Statistics (HES)

HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.

<http://www.hscic.gov.uk/hes>

ICD-10 codes

See Glossary entry for 'International Classification of Diseases'.

Index of Multiple Deprivation

The English Indices of Multiple Deprivation identify the most deprived areas across the country. They combine a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. The Indices are used widely to analyse patterns of deprivation, identify areas that would benefit from specific initiatives or programmes and as a tool to determine eligibility for specific funding streams.

<https://www.gov.uk/government/collections/english-indices-of-deprivation>

Inequality and Equality strands

In the Equalities breakdown table, in both the NHS Outcomes Framework Equality Analysis and this Technical Appendix, Inequality and Equality strands refer to the Equalities Protected characteristics (Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation), as defined in the Health and Social Care Act 2012, plus 'Deprivation' and 'Socio-economic status' (see separate Glossary entries for definitions).

Indicator Assurance Pipeline Process (IAPP)

The IAPP was developed by the Health & Social Care Information Centre on behalf of the National Quality Board (NQB). Its purpose is to ensure that outcome indicators used nationally are quality-assured and have open and transparent methodologies for all to access and use as they require.

<http://www.isb.nhs.uk/library/standard/239>

Infant Mortality

Infant mortality refers to deaths within the first year following live birth, usually expressed as a rate per 1,000 live births. Also see Glossary entries for 'Live Birth', 'Neonatal Mortality' and 'Stillbirth'.

Inpatient survey

The Inpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. Patients who were admitted to hospital with at least one overnight stay, excluding those who were treated for maternity or psychiatric reasons, are eligible to complete the survey. The last inpatient services survey was conducted between September 2012 and January 2013. Over 64,000 inpatients aged 16 and over responded to the survey, a response rate of 51%.

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2012>

International Classification of Diseases (ICD)

The ICD is published by the World Health Organization (WHO). It is the international standard diagnostic classification for all general epidemiological and many health management purposes and clinical use. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. The illnesses, diseases and injuries suffered by hospital patients are currently recorded using the International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organization (WHO). ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The classification is the latest in a series which has its origins in the 1850s. Typically, information about a patient's diagnosis is recorded in their notes by the clinician treating them and then translated into ICD-10 codes by a clinical coder.

www.who.int/classifications/icd/en

Labour Force Survey (LFS)

The LFS, which began in 1973 as an annual survey, is an unique source of articulated information using international definitions of employment and unemployment and economic inactivity, together with a wide range of related topics such as occupation, training, hours of work and personal characteristics of household members aged 16 years and over. From March 1992, quarterly data were made available and the survey became known as the Quarterly Labour Force Survey (QLFS).

<http://discover.ukdataservice.ac.uk/series/?sn=2000026>

Live Birth

A baby showing signs of life at birth after becoming completely expelled from its mother. Also see Glossary entries for 'Infant Mortality', 'Neonatal Mortality', and 'Stillbirth'.

Lower Respiratory Tract Infection (LRTI)

Lower respiratory tract infection, while often used as a synonym for pneumonia, can also be applied to other types of infection including lung abscess and acute bronchitis. Symptoms include shortness of breath, weakness, high fever, coughing and fatigue.

Maternity Services Survey

The Maternity Services Survey is co-ordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. The maternity survey was conducted in 2007 and 2010. Over 25,000 women who had given birth in January or February 2010 responded to the 2010 survey between April and August 2010, a response rate of 52%. All women aged 16 and over who received care from any of the 144 NHS Trusts in England and who had either given birth in a hospital, birth centre, maternity unit or at home were eligible to take part.

www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/maternity-services-survey-2010

Mental Health Minimum Dataset (MHMDS)

The Mental Health Minimum Data Set (MHMDS) contains record-level data about the care of adults and older people using secondary mental health services. The MHMDS covers not only services provided in hospitals, but also in outpatient clinics and in the community, where the majority of people in contact with these services are treated. It brings together key information from the mental health care pathway that has been captured on clinical systems as part of patient care. During processing, this information is compiled into a single patient record.

<http://www.hscic.gov.uk/mhmds>

Modified Rankin Scale (mRS)

The mRS measures the overall independence of stroke patients in daily life and, in this modified version, accommodates language disorders and cognitive defects. It also refers to previous activities, which could be important because patients may be independent but experience restrictions in comparison to their former lifestyle and feel dissatisfied with this.

From: van Swieten J, Koudstaal P, Visser M, Schouten H, et al. (1988). Inter-observer agreement for the assessment of handicap in stroke patients. *Stroke* 19 (5): 604–607. <http://stroke.ahajournals.org/content/19/5/604.full.pdf>

National Bereavement Survey (Views of Informal Carers – Evaluation of services (VOICES))

VOICES is a questionnaire on the experiences of care provided at the end of life developed by a research team based in the University of Southampton. There are several versions of VOICES including a version designed specifically for hospice and specialist palliative care services, developed in conjunction with St Christopher's Hospice (VOICES-SCH), a stroke version, a heart disease version and a VOICES short-form.

www.southampton.ac.uk/voices

National Hip Fracture Database (NHFD)

The NHFD is a joint venture of the British Geriatrics Society and the British Orthopaedic Association, and is designed to facilitate improvements in the quality and cost effectiveness of hip fracture care. As a national audit project, the NHFD is supported by NHSIC's National Clinical Audit Support Programme (NCASP). The NHFD is intended to focus attention on hip fracture both locally and nationally, benchmark its care across the country, and use continuous comparative data to create a drive for sustained improvements in clinical standards and cost effectiveness.

www.nhfd.co.uk

Neonatal Mortality

Neonatal mortality refers to deaths within the first 28 days following live birth, usually expressed as a rate per 1,000 live births. Also see Glossary entries for 'Infant Mortality', 'Live Birth', and 'Stillbirth'.

NHS Safety Thermometer

The NHS Safety Thermometer is a local improvement tool for measuring, monitoring, and analysing patient harms, and 'harm free' care. Safety Thermometer data is collected by teams across the health economy on a monthly or quarterly basis.

<http://www.hscic.gov.uk/thermometer>

Outpatient Survey

The Outpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. It assesses patients' experiences of their most recent visit to an outpatient department. The last Outpatient Survey was conducted between June and October 2011. Over 72,000 outpatients aged 16 and over responded to the survey, a response rate of 53%.

<http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/outpatient-survey-2011>

Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures (hip replacement; knee replacement; groin hernia; varicose veins), PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys. PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires before and after a procedure. Headline participation rate for the coverage period of April 2013 was 70.2%.

<http://www.hscic.gov.uk/proms>

Period Life Expectancy

Period life expectancy at a given age for an area is the average number of years a person would live if he or she experienced the particular area's age-specific mortality rates for that time period throughout his or her life. It makes no allowance for any later actual or projected changes in mortality. In practice, death rates of the area are likely to change in the future so period life expectancy does not therefore give the number of years someone could actually expect to live. In addition, people may live in other areas for at least some part of their lives.

www.gad.gov.uk/Demography%20Data/Life%20Tables/Period_and_cohort_eol.html

Primary Care

Primary care captures community based health services that are usually the first, and often the only, point of contact that patients have with the health service. It covers services provided by family doctors (GPs), community and practice nurses, community therapists (such as physiotherapists and occupational therapists), community pharmacists, optometrists, dentists and midwives.

Public Health Outcomes Framework (PHOF)

The Public Health Outcomes Framework sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are: increased healthy life expectancy, and reduced differences in life expectancy and healthy life expectancy between communities.

<http://www.dh.gov.uk/health/2012/01/public-health-outcomes/>

Reablement/Rehabilitation

Reablement/rehabilitation services are focused on improving people's health, well-being, confidence and independence after an acute episode of ill health, injury or a gradual decline in functioning in the community. They include all episodes of support provided that are intended to be time limited and aim at maximising the independence of the individual and reducing/eliminating their need for on-going support.

Region

In England, the region is the highest tier of sub-national division used by central government. The classification previously called 'Government Offices for the Regions' is used to maintain a regional level geography for statistical purposes. The regions are: North East; North West; Yorkshire and Humber; East Midlands; West Midlands; East of England; London; South East; South West.

<http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/administrative/england/government-office-regions/index.html>

Resident Population

The estimated resident population of an area includes all people who usually live there, whatever their nationality. Members of UK and non-UK armed forces stationed in the UK are included and UK forces stationed outside the UK are excluded. Students are taken to be resident at their term time address.

www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-uk--england-and-wales--scotland-and-northern-ireland/2009/index.html

Sentinel Stroke National Audit Programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) aims to improve the quality of stroke care by auditing stroke services against evidence based standards. SSNAP will build on the work of the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP).

<http://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme>

Socio-economic status

Socio-economic status is an economic and sociological combined measure of a person's economic and social position in relation to others. Socio-economic status is one of the 'Inequality and Equality strands' (see separate Glossary entry), and is measured by the ONS's National Statistics Socio-economic Classification (NS-SEC).

<http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html>

Spell

In general, a patient's entire stay in hospital is a spell. A spell can contain one episode (see Glossary entry 'Episode'), or several episodes. For example, if Patient A is admitted for a broken leg, but while still in hospital is diagnosed and treated for diabetes there would be two episodes within one spell. If the patient is transferred to another hospital, dies or is discharged, the episode and the spell end. The vast majority of spells contain only one episode.

www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1072

Stillbirth

A child born after 24 or more weeks completed gestation which did not, at any time after becoming completely expelled from its mother, breathe or show signs of life. Also see Glossary entries for 'Infant Mortality', 'Live Birth', and 'Neonatal Mortality'.

Trauma Audit & Research Network (TARN)

TARN's aim is to collect clinical and epidemiological data in order to provide a statistical base to support clinical audit, aid the development of trauma services and inform the research agenda.

www.tarn.ac.uk



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