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The NHS Outcomes Framework 2015/16

Technical Appendix

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The NHS Outcomes Framework 2015/16

Technical Appendix

Prepared by Department of Health

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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 indicators are included. Over this time the Department of Health has been improving the framework by refining existing indicators and developing new indicators.

This year's refresh of the NHS Outcomes Framework is more substantial than the previous years' as a result of a year-long coverage and refinement review. As part of this review we have engaged with stakeholders over summer 2014 on our proposed amendments for the 2015/16 framework and on the long-term development of the framework. The Department of Health's response to this stakeholder engagement has been published as one of the complementary documents to this Technical Appendix.

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 provides an overview of each domain. Each Domain chapter contains:

- An introduction to the domain (including indicator structure);
- Information on available international comparisons;
- Information on external drivers of outcomes;
- Details on alignment with other health and social care outcomes frameworks;
- Work in progress to further develop indicators;
- Specifications for indicators that are currently *in development* or where definitions are changing in the 2015/16 framework.

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 that represent outcomes that are already largely captured by the overarching indicators but which merit emphasis;
  - *Complementary indicators* – Indicators which complement the overarching indicators by extending 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. Technical specifications (and data, once available) for live indicators are published[1] on the Health and Social Care Information Centre (HSCIC) Indicator Portal (https://indicators.ic.nhs.uk/webview/);
- *In development* – Some elements of the indicator require further development and/or the indicator is yet to complete the HSCIC Indicator Assurance Process.

When an indicator classified as *in development* (at the time of the publication of this document) subsequently becomes *live*, the final technical specification will be made available on the HSCIC Indicator Portal. An *in development* indicator will become *live* once it has passed the HSCIC Indicator Assurance Process and is published on the HSCIC Indicator Portal.

Therefore, this Technical Appendix only provides technical specifications for *in development* indicators and for indicators that are *live* in the 2014/15 framework, but subject to new definitions for the 2015/16 framework.

The HSCIC Indicator Portal also contains a set of wider health and social care indicators, including social care and GP Practice data. Data for all *live* indicators are available on the HSCIC Indicator Portal (once available), with historical time series and disaggregations. The data are in raw format to allow analysis

This Technical Appendix is being published alongside an NHS Outcomes Framework refresh document which provides a summary of the progress made to the develop the framework over the past year and provides an 'at-a-glance' summary of the 2015/16 NHS Outcomes Framework.

Timely reporting of data

Before NHS Outcomes Framework (NHSOF) data can be published on the HSCIC Indicator Portal there is a lengthy collection, processing and publication process. Work is underway to improve the timeliness of NHS Outcomes Framework data publication, without compromising the robustness of data on the HSCIC Indicator Portal.

We have obtained provisional data from the Office of National Statistics (ONS) covering indicators 1a.i, 1a.ii, 1.1, 1.2, 1.3, and 1.4 on an exploratory basis. This monthly data is available with a lag of two months. The data obtained will be published on the Department of Health's website in November 2014 with commentary on the difference between its provisional status and the final data.

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[1] Or are expected to be published by April 2015.

The ‘Data sources breakdowns and timely reporting of data’ chapter of this Technical Appendix provides further information on:

- Each data source that underpins indicators in the NHS Outcomes Framework;
- Publication lags – by data source;
- Publication 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 sets an objective to ‘demonstrate progress against the five parts [domains] and all the outcome indicators in the [NHS Outcomes] framework’. The Department of Health is continually reviewing progress made against the mandate objectives.

The ‘External drivers’ sections in each domain chapter provide information on the external drivers of measured outcomes. Any assessment of progress against the NHS Outcomes Framework should be made in the context of an analysis of these external drivers and their expected impact on measured 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 chapters of this Technical Appendix provide information on what internationally comparable data is currently available. The Department of Health is also working with the Organisation for Economic Co-operation and Development (OECD) to understand the differences between countries’ data systems and to improve the 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 sets out which indicators are shared or complementary to indicators in the PHOF and/or 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 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.[2] We intend to identify key health inequalities measures, based on NHSOF indicators. These will be integral to assessing NHS England's progress using the NHSOF. We are progressing work on this set with a view to publishing the outcome before the NHSOF takes effect in April 2015.

The 'Equalities breakdowns' chapter of this Technical Appendix displays, for each indicator in the NHS Outcomes Framework, which breakdowns by the Equality protected characteristics are available.

A separate Equality Analysis will be published alongside the 2015/16 NHS Outcomes Framework which updates previous years' equality analyses.

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[2] 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 & Domain structure

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 classified as *in development* are provided in this Domain 1 chapter.

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
1c Neonatal mortality and stillbirths	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
1.4.v. One- and **vi.** Five-year survival from cancers diagnosed at stages 1&2	In development
Reducing premature death in people with mental illness	
1.5.i Excess under 75 mortality rate in adults with serious mental illness	Live
1.5.ii Excess under 75 mortality rate in adults with common mental illness	In development
1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services	In development

Reducing deaths in babies and young children	
1.6.i Infant mortality	Live
1.6.ii Five-year survival from all cancers in children	Live
Reducing premature death in people with a learning disability	
1.7 Excess under 60 mortality in adults with a learning disability	In development

The overarching indicators cover Potential Years of Life Lost (PYLL) from causes considered amenable to health care, life expectancy at 75, and neonatal mortality and stillbirths (which is not included in indicator 1a as ICD-10 does not classify mortality up to 28 days after a live birth). 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.

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

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

The improvement area indicators 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 1.4.i-vi and 1.6.ii 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.

Indicators 1.1, 1.2, 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 also. Specifically, not all of the 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 amenable. However, the NHS also contributes to reducing premature deaths from causes not considered 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.

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. To reflect the importance of early stage of diagnosis in improving cancer outcomes, we have introduced two in development indicators for one and five year survival from cancers diagnosed at stages 1 and 2.

International comparisons

Although there are many international comparisons for outcomes in Domain 1, the indicator definitions sometimes vary between countries.

Generally, international comparisons of mortality (including suicide) from defined causes by ICD-10 code are available from datasets published by the OECD,[3] the World Health Organisation (WHO)[4] and Eurostat.[5] Recent international comparisons of five-year cancer survival for breast and colorectal cancer are available in OECD's 'Health at a glance' report.[6]

International comparisons of Life Expectancy at 75 are published by Eurostat.[5]

International comparisons of infant and neonatal mortality rates are published by WHO[4] and OECD[3]. 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. The Europeristat Report[7] attempts to make comparisons between European countries using more consistent definitions.

There are currently no international comparisons available of excess mortality in people with serious mental illness using the NHS Outcomes Framework definition. However, the OECD has published indicators of excess mortality from schizophrenia and from bipolar disorder

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[3] http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT

[4] http://www.euro.who.int/en/data-and-evidence/databases

[5] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database

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

[7] http://www.europeristat.com/reports/european-perinatal-health-report-2010.html

in the 2013 edition of the 'Health at a Glance' report.[6] The UK has not contributed to this indicator because the relevant data source for England (the Mental Health Minimum Dataset)[8] does not include robust information on diagnosis. The Department of Health is working with the OECD to develop an internationally comparable indicator.

External drivers of outcome

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. Therefore, 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.

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, two factors need to be considered. Firstly, it is necessary to make allowance for drivers external to the health and social care system. Secondly, the impact that historic improvements in public health behaviour over recent decades, for good or for ill, will have on the impact on mortality over the next five and ten years, over which the NHS has limited influence, also needs to be considered. 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 to assess robustly the NHS's performance against Domain 1 of the NHS Outcomes Framework, analytical techniques are under investigation that makes 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) or Adult Social Care Outcomes Framework (ASCOF)

The indicators shared with the PHOF are:

- 1.1 – Under 75 mortality rate from cardiovascular disease (PHOH 4.4);
- 1.2 – Under 75 mortality rate 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.i – Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9);
- 1.6.i – Infant mortality (PHOF 4.1).

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[8] http://www.hscic.gov.uk/catalogue/PUB11538

Two indicators complementary to the PHOF:

- 1.4.v – One and 1.4.vi Five-year survival from cancers diagnosed at stages 1&2 (PHOF 2.19);
- 1.5.iii – Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services (PHOF 4.10)*.

* This new complementary indicator will be updated in the Public Health Outcomes Framework technical specifications in their first quarterly update of 2015.

Work in progress

Indicators 1.4.v – One- and vi Five-year survival from cancers diagnosed at stages 1 and 2

Indicator 1.5.ii – Excess under 75 mortality rate in adults with common mental illness

Indicator 1.5.iii – Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services

Work to develop these indicators is at an early stage:

1.4.v – In 2014, Public Health England (PHE) published PHOF indicator 2.19 – Cancer diagnosed at early stage.[9] This indicator is labelled as 'Experimental Statistics' because of the variation in data quality: the indicator values primarily represent variation in completeness of staging information. Therefore, we need to ensure that data on the stage of diagnosis and the link to survival is adequately robust at a national level before this indicator can go *live* (and five-year survival data will not be available for some time).

1.5.ii – Work to develop this indicator is at an early stage. We are investigating how to obtain data on adults with common mental illness from the GP Extraction Service (GPES). This data will then need to be linked to mortality data in order to develop the indicator.

1.5.iii – Work to develop this indicator is at an early stage. We are working to develop an appropriate definition of contact or attempted contact with NHS services, as well as a suitable timeframe around which recent contact from NHS services can refer.

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

A possible data source has been identified (via GPES) and work is ongoing between the Department of Health, NHS England, PHE and HSCIC to progress development and determine appropriate timescales. This work is closely linked with development of NHS England's mortality review function.

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[9] This measures the proportion of cancers diagnosed at stage 1 or 2 for the following cancers: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin.

Technical specifications for *in development* indicators

1.4.v. One and vi Five year survival from cancers diagnosed at stages 1 & 2	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: **Preventing people from dying prematurely.**
Outcome sought	Reducing premature mortality from the major causes of death.
Status	In development.
Rationale for inclusion	There is both lead time and length bias in the current cancer survival indicators. These new indicators will allow a more robust interpretation of cancer survival outcomes.
Detailed descriptor	**Plain English description:** A measure of survival at one and five years following early diagnosis of cancer. **Technical description:** A measure of the proportion of people still alive after i) one and ii) five years following a diagnosis of cancer at stage 1 or stage 2.
DATA SOURCES	
Data sources	National cancer registry.
Reporting frequency	To be determined.
Publication timing	
ICD-10 codes	To be determined. Likely to be invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus, non-Hodgkin lymphomas, and melanomas of skin.
CONSTRUCTION	
Proposed calculation methodology	To be determined. Will link to PHOF indicator 2.19 – Cancer diagnosed at early stage.
Changes since previous publication	N/A
Technical issues remaining to be resolved	N/A

1.5.ii Excess under 75 mortality rate in adults with common mental illness	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: **Preventing people from dying prematurely.**
Outcome sought	Reducing premature death in people with mental illness.
Status	In development.
Rationale for Inclusion	Until now, the only mental health indicator in Domain 1 of the NHS Outcomes Framework was excess mortality for people with serious mental illness (defined as in contact with secondary mental health services). However, we did not have any indicator for people with common mental illness. These people would never be in touch with secondary mental health services and only receive support from primary care services.
Detailed descriptor	**Plain English description:** A measure of the extent to which adults with a GP-diagnosed common mental health problem (such as depression and anxiety)[11] die younger than adults in the general population. **Technical description:** The ratio of the directly age-standardised mortality rate for people aged 18 to 74 with a GP-diagnosed common mental health problem (such as depression and anxiety) to the directly age-standardised mortality rate for the general population of the same age, expressed as a percentage.
DATA SOURCES	
Data sources	GP Extraction Service (GPES). ONS: mortality data. ONS: mid-year population estimates (to standardise the measure).
Reporting frequency	Annual.
Publication timing	N/A

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[11] Only deaths occurring a minimum of one year after diagnosis are counted in order to exclude cases where the diagnosis of a terminal physical condition (leading to the person's death) has given rise to the mental health problem.

ICD-10 codes	**ICD–10 codes**	**Condition**
	F32, F33, F41, F42, F43.1,	Depression, generalised anxiety disorder, mixed anxiety and depressive disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, or social anxiety disorder (NICE definition of common mental health problems).
CONSTRUCTION		
Proposed calculation methodology	Those people aged 18-74, whose GP Patient Record notes one of the following conditions: depression, generalised anxiety disorder, mixed anxiety and depressive disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder over a period of time (i.e. a year) are identified and matched by their NHS number to ONS mortality statistics covering the same period. The mortality rate in the population with common mental health problems is directly standardised to the national population. This is then compared to the national rate using a standardised mortality ratio.	
Changes since previous publication	N/A	
Technical issues remaining to be resolved	The number of years needed to have a sufficient sample size needs to be discussed with colleagues in the Information Centre.	

1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: **Preventing people from dying prematurely.**
Outcome sought	Reducing premature mortality in people with mental illness.
Status	In development.

Rationale for Inclusion	The Department believes that the NHS has a role in preventing suicide and increasing access to mental health services for those at risk. There is evidence that the NHS can influence outcomes in suicide when they have had contact with people beforehand. For example, effective care planning prior to discharge from hospital, early follow-up appointments and health professionals ensuring the adverse events that preceded the admission have been addressed could all reduce suicides. Currently the NHS Outcomes Framework does not capture suicides, apart from those in contact with secondary mental health services (indicator 1.5.i).
Detailed descriptor	**Plain English description:** To be developed. **Technical description:** To be developed.
DATA SOURCES	
Data sources	This indicator would be a subset of PHOF 4.10 which includes all suicide and mortality of undetermined intent. Linkage of this mortality data with NHS data sets will enable derivation of an indicator of mortality following contact with the NHS.
Reporting frequency	Annual.
Publication timing	
CONSTRUCTION	
Proposed calculation methodology	To be developed.
Changes since previous publication	N/A
Technical issues remaining to be resolved	The appropriate definition of contact or attempted contact with the NHS needs to be defined, as well as the time period prior to death to be included.

1.7 Excess under 60 mortality in people with a learning disability

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 1: **Preventing people from dying prematurely.**
Outcome sought	Reduced premature death in people with a learning disability.
Status	In development.
Detailed descriptor	**Plain English description:** A measure of the extent to which adults with a learning disability die younger than adults in the general population. **Technical description:** Excess under 60 mortality in adults with a learning disability.
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.

Domain 2

Enhancing quality of life for people with long-term conditions

Introduction & Domain structure

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 indicators classified as *in development* are provided in this Domain 1 chapter.

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 in hospital by people with long-term conditions	
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) **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.i Employment of people with mental illness	Live
2.5.ii Health-related quality of life for people with mental illness	In development
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	In development

Improving quality of life for people with multiple long-term conditions	
2.7 Health related quality of life for people with three or more long-term conditions	In development

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).

The improvement area indicators are of two sorts:

- *Sub-indicators*:
    - Indicators 2.1, 2.2, 2.3i and 2.7 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.i 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 having 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;
    - Indicator 2.5.ii measures quality of life for people with mental health problems, who may be under-represented in response to the GP Patient Survey used to construct indicator 2, and for whom the EQ-5D health-related quality of life measure may not be the most appropriate measure;
    - 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

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. These measure emergency admissions that could have been avoided through better management in primary or community care for adults and children: indicators 2.3.i and 2.3.ii focussing on chronic (i.e. long-term) conditions and, in Domain 3, indicators 3a and 3.2 focussing on acute conditions. These indicators, across two domains, should therefore be seen as jointly indicating the effectiveness of primary and community care.

International comparisons

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 report 'Health at a Glance'.[12]

External drivers of outcome

The predominant external drivers of overarching indicator 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 comorbidities. 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 comorbidities are amenable to secondary care prevention.

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.

In addition, the employment consequences of having long-term conditions (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

Indicators based on patient experience survey data can be affected by several biases: these are discussed more fully in the introduction to Domain 4.

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, 2.5 and 2.7 are unlikely to 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.

There is also a risk of bias in indicators based on administrative data collections (indicators 2.3.i-iii use Hospital Episodes Statistics data, and 2.6.i uses Quality and Outcomes Framework (QOF) 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

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

evidence that GPs fail to record all of their 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. This under-recording may diminish over time given the encouragement given to increase recorded diagnosis rates.

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) or Adult Social Care Outcomes Framework (ASCOF)

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).

The indicators complementary to the PHOF are:

- 2.5.i – Employment of people with mental illness (PHOF 1.8);
- 2.5.ii – Health-related quality of life for people with mental illness (PHOF 1.6).

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.i – Employment of people with mental illness (ASCOF 1F);
- 2.5.ii – Health-related quality of life for people with mental illness (ASCOF 1A);
- 2.6.ii – A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (ASCOF 2F);
- 2.7 – Health related quality of life for people with three or more long-term conditions (ASCOF 1A).

Work in progress

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

The denominator for Indicator 2.6.i is based on prevalence rates estimated in the 2007 Dementia UK report.[13] 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

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[13] 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

example, findings from the Delphi 2014 consensus exercise once finalised), and where a more authoritative source is identified, the indicator will be updated in due course.

Indicator 2.5.ii – Health-related quality of life for people with mental illness

The Department of Health has commissioned a research team at the University of Sheffield to develop a Patient-Reported Outcome Measure (PROM) to assess quality of life for people recovering from mental illness. It will be a generic measure that covers clusters 1-17 including common mental illness (e.g. depression, anxiety, OCD, phobias), severe and complex non-psychotic problems. This meets policy needs and at the same time means it will be able to take into account co-morbidities in mental and physical health. The PROM needs to be short and suitable for routine use. Indicator 2.5.ii will be developed in line with findings from this study, which will report at the end of 2015.

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

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 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.

Technical specifications for *in development* indicators

2.5.ii Health-related quality of life for people with mental illness	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 2: **Enhancing quality of life for people with long-term conditions.**
Outcome sought	Enhancing quality of life for people with mental health illness.
Status	In development.
Rationale for inclusion	The only existing indicator of quality of life for people with mental illness is employment of people with mental health illness. This is quite a limited proxy for quality of life for people with mental health illness.
Detailed descriptor	**Plain English description:** The overall aim of this new indicator is to measure the extent to which NHS care for people diagnosed with mental illness improves quality of life. It is expected that the indicator will be based on a summary of patients' rating on those dimensions of quality of life which are likely to be affected by mental illness. **Technical description:** To be decided.

DATA SOURCES	
Data sources	To be decided.
Reporting frequency	To be decided.
Publication timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	N/A
Technical issues remaining to be resolved	Design and validation of a PROM for this purpose.

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

OVERVIEW	
Outcome sought	Enhancing quality of life for people with dementia.
Status	In development.
Detailed descriptor	**Plain English description:** 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. **Technical description:** To be decided.
Alignment with other Outcomes Frameworks	Complementary with ASCOF 2F.

DATA SOURCES	
Data sources	To be decided.
Reporting frequency	To be decided.
Publication Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	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. This research is ongoing and has progressed since the publication of the 2014/15 NHS Outcomes Framework. 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: • 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? Indicator 2.6.ii will be developed in line with findings from this study, which will report in mid-2015.
Technical issues remaining to be resolved	Design and validation of a PROM for this purpose. Determination of a data collection methodology including sampling strategy and standardisation methodology.

Domain 3

Helping people to recover from ill-health or following injury

Introduction & Domain structure

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 classified as *in development* are provided in this Domain 3 chapter.

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** Physical health-related procedures	In development
3.1 Total health gain as assessed by patients for elective procedures **ii** Psychological therapies **iii** Recovery in quality of life for patients with mental illness	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

Improving recovery from fragility fractures	
3.5.i Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 30 days **ii** Proportion of patients with hip fractures 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
Improving dental health	
3.7.i Decaying teeth	In development
3.7.ii Tooth extractions in secondary care for children under 10	In development

Domain 3 comprises indicators both of adverse outcomes and indicators 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 (see ‘ambulatory care sensitive conditions’ – below);
- Indicators of the effectiveness of care are all complementary to the overarching indicators, as measured by indicators 3.1.i-iii;
- 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 hip fractures, and following discharge from hospital for all older people;
- Dental health – indicators 3.7.i-ii measure outcomes from NHS dentistry services.

Ambulatory care sensitive conditions

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. These measure emergency admissions that could have been avoided through better management in primary or community care for adults and children: indicators 2.3.i and 2.3.ii focussing on chronic (i.e. long-term) conditions and, in Domain 3, indicators 3a and 3.2 focussing on acute conditions.

These indicators, across two domains, should therefore be seen as jointly indicating the effectiveness of primary and community care.

International comparisons

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 outcome

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. Volume 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) or Adult Social Care Outcomes Framework (ASCOF)

One indicator shared with the PHOF:

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

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 services (ASCOF 2Bi);
- 3.6.ii – Proportion offered rehabilitation following discharge from acute or community hospital (ASCOF 2Bii).

One indicator complementary to the PHOF is:

- 3.7i – Decaying teeth (PHOF 4.02)*.

* This new complementary indicator will be updated in the Public Health Outcomes Framework technical specifications in their first quarterly update of 2015.

Work in progress

Indicator 3.1.i – Total health gain as assessed by patients for elective procedures: Physical health-related procedures

Indicator 3.1 currently reports total health gain assessed using EQ-5D, which measures health-related quality of life, for four elective surgical procedures separately: hip replacement, knee replacement, groin hernia surgeries and varicose vein removal surgeries. Total health gain is estimated by multiplying the average health gain for each procedure by the number of patients undertaking the respective procedure.

It was always the intention that the suite of elective interventions covered by indicator 3.1 would increase over time to include future PROMs, thereby encouraging NHS England to make progress in developing PROMs for other elective procedures. In order to reduce the number of potential sub-indicators, total health gain from PROMs for individual procedures will be aggregated. An analysis of whether it is more appropriate to use process-specific measures as the basis for measuring the outcome gain from interventions or the current EQ-5D measures will be conducted in 2015.

Indicator 3.1.ii – Total health gain as assessed by patients for elective procedures: Psychological therapies

The Department of Health is working closely with HSCIC and NHS England to finalise the specification of Indicator 3.1.ii – Total health gain as assessed by patients for psychological therapies. It is expected that this specification will be live for the framework in the 2015/16 financial year.

Indicator 3.1.iii – Total health gain as assessed by patients for elective procedures: Recovery in quality of life for patients with mental illness

Indicator 3.1.ii ('Total health gain as assessed by patients for elective procedures: psychological therapies') – currently in development, captures improvement in outcomes for people with non-severe mental illnesses and from a specific intervention. Therefore, there is a gap in coverage for both patients with severe mental illnesses and patients with common mental illnesses who have not received psychological therapies.

The Department of Health has commissioned a research team at the University of Sheffield to develop a new generic mental health recovery (patient reported) outcome measure. This work is scheduled for completion at the end of 2015, and results will be used to directly inform development of this new indicator. In the meantime, the NHS Outcomes Framework will develop an interim indicator based on the Health of the Nation Outcomes Scale (HoNOS), which measures quality of life for patients based on clinicians' reports and only covers secondary care.

Indicator 3.3 – Survival from major trauma

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 supplemented by one that reflects the extent of recovery.

Patient Reported Outcome Measures (PROMs) for major trauma are currently under development. Final recovery from severe injury can take 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. Major Trauma PROMs provide a better understanding of the physical and psychosocial impact of traumatic injury from the perspective of both adult and child patients.

A pilot study to trial the major trauma PROMs began in 2014. EQ5D-5L (an internationally accepted and validated quality of life tool), validated patient experience questions 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, are also included at

6 months follow-up. The pilot study began in October 2014 and it is anticipated that the first report of the major trauma PROMs will be available in July 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 severe injury (Injury Severity Score >15). Analysis and dissemination of the results will be carried out by TARN as an extension to this national trauma audit.

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

The data collection for indicator 3.4 on measuring recovery from stroke at six months started in January 2013. The latest data for the subsequent six-month follow up data cover the period January to March 2014 and completeness is low (around 15%).[14] The indicator specification is in progress and needs to account for the quality of the data. It is expected to be finalised in 2015/16.

Indicator 3.7.i Decaying teeth & Indicator 3.7.ii Tooth extractions in secondary care for children under 10

NHS England has been working with the NHS Business Services Authority (BSA) to establish the data collections for indicators 3.7.i and 3.7.ii. This will involve amending an existing data collection form (FP17). For indicator 3.7.i a new data item will be added to capture the level of tooth decay. For indicator 3.7.ii a data item will be amended to clarify the purpose of the referral and type of extraction undertaken to allow quality assurance of HES data. The revised form is expected to be in use, subject to legal advice, in 2015/16.

During 2015/16, the data collection will be quality assured. For indicator 3.7.ii, work will also be required to align the new data collection with existing HES data on extractions in secondary care.

Technical specifications for *in development* indicators

3.1 Total health gain as assessed by patients for elective procedures ***i. Physical health-related procedures*** ***ii. Psychological therapies***	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 3: ***Helping people to recover from episodes of ill-health or following injury.***
Outcome sought	Improving outcomes from planned treatments.

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[14] Further information on the publication of SSNAP audit data is available at https://www.rcplondon.ac.uk/projects/ssnap-clinical-audit. The January-March 2014 reports are available at https://www.strokeaudit.org/Documents/Results/National/JanMar2014/JanMar2014-PublicReport.aspx (see page 95)

Status	In development – expected to go live in 2015. The physical health component is currently reported separately for each procedure. The mental health component is now in development and expected to go live in 2015/16.
Rationale for inclusion	Rationalising these PROMs indicators supports the commitment to parity of esteem, and provide an incentive to expand PROMS to other procedures.
Detailed descriptor	**Plain English description:** This indicator measures improvements in health as both a result of planned physical health related procedures – such as medical procedures for groin hernia, hip replacement, knee replacement and varicose veins – and planned mental health related procedures – such as NHS psychological therapies for people with depression and anxiety disorders. **Technical description:** Total health gain from patients who report an improvement in health status following either elective physical health related procedures or mental health related procedures. Physical health related procedures currently cover groin hernia, hip replacement, knee replacement and varicose veins. Mental health related procedures will cover psychological therapies provided under the Improving Access to Psychological Therapies (IAPT) programme in England. Initially, these procedures will focus on people with depression and anxiety disorders.
DATA SOURCES	
Data sources	**For physical health related procedures:** PROMs dataset, published by the Health and Social Care Information centre (HSCIC) (available at: http://www.hscic.gov.uk/proms). **For mental health related procedures:** Improving Access to Psychological Therapies (IAPT) dataset, published by the Health and Social Care Information centre (HSCIC). (available at: http://www.hscic.gov.uk/article/2021/Website-Search?q=routine+iapt+monthly+data+quality&area=both).
Reporting frequency	**For physical health related procedures:** Annually. **For mental health related procedures:** Publication planned quarterly and annually.

Publication Timing	**For physical health related procedures:** Final annual confirmed PROMs data are released approximately 18 months after the end of the reporting year. Data for 2012/13 were released in August 2014. **For mental health related procedures:** Final quarter 4 2013/14 data were published on July 2014.
CONSTRUCTION	
Proposed calculation methodology	**For physical health related procedures:** The EQ-5D index case-mix adjusted **average** health gain is reported separately for groin hernia, hip replacement, knee replacement and varicose veins. Additionally, the number of eligible episodes is provided for each of the four procedures at England and Provider level. This information is used to calculate the **total** health gain, which is published at national level only. Then, the total health for these procedures will be added up to produce the total health gain following physical procedures. **For mental health related procedures:** This measure is now in development. 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), the Generalised Anxiety Disorder 7 (GAD-7) and Anxiety Disorder Specific Measures (ADSM). Higher scores in these scales suggest increased severity of the mental illness. 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. 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.
Changes since previous publication	Aggregating total health gain separately for physical related planned procedures and mental health planned procedures allows the indicator to expand by including new PROMs measures when available without the need to create a new sub-indicator for each new measure. A procedure breakdown will be published thereby informing on health gain for each procedure separately. The Department is working closely with HSCIC and NHS England to finalise the definition of the indicator 3.1.ii. It is expected that this definition will be confirmed during the 2015/16 financial year.

Technical issues remaining to be resolved	An analysis of whether it is more appropriate to use process-specific measures as the basis for measuring the outcome gain from interventions or the current EQ-5D measures will be conducted in 2015. These proposed changes will be submitted to the Health and Social Care Information Centre's Indicator Assurance Service, the publisher of the NHS Outcomes Framework indicators' data.

3.1.iii Recovery in Quality of Life for patients with mental illness	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 3: Helping people to recover from episodes of ill health or following injury.
Outcome sought	Improving outcomes from planned treatments.
Status	In development.
Rationale for inclusion	The current indicator 3.1 relates to IAPT services, a primary care intervention. This new proposed indicator will measure recovery for people receiving secondary mental health services.
Detailed descriptor	**Plain English description:** The methodology is being developed. It is expected that the indicator will be either the average change or (if feasible) the proportion of people who received treatments for mental health problems whose improvement in quality of life over the treatment has been greater than a clinically important minimum change. **Technical description:** The methodology is being developed. It is expected that the indicator will be either the average change in the (sum of) ratings to items 9, 10, 11 and 12 of the Health of the Nation Outcomes Scale (HoNOS) between each patient's initial assessment/first treatment and his/her last assessment/treatment appointment or (if feasible) the proportion of people whose change in the (sum of) ratings to items 9, 10, 11 and 12 of the HoNOS between initial assessment/first treatment and last assessment/treatment appointment has been greater than a clinically important minimum change.
DATA SOURCES	
Data sources	Mental Health Minimum Dataset.
Reporting frequency	Annual (financial year).
Publication timing	

CONSTRUCTION	
Proposed calculation methodology	The sum of the assigned values for each answer-option (0 – No problem, 1 – Minor problem requiring no action, 2 – Mild problem but definitely present, 3 – Moderately severe problem, 4 – Severe to very severe problem) for each of questions 9, 10, 11 and 12 of the HoNOS questionnaire is calculated for each patient's first and last appointment. The indicator will be either the average change in these scores or the proportion of patients whose improvement has been greater than a clinically important minimum value.
Changes since previous publication	N/A
Technical issues remaining to be resolved	This is an interim indicator based on HoNOS, which measures quality of life for patients based on clinicians' reports and only covers secondary care. The Department of Health has commissioned a research team at the University of Sheffield to develop a new generic mental health recovery (patient reported) outcome measure. This work is scheduled for completion at the end of 2015, and results will be used to directly inform development of a new patient-based indicator.

3.3. Survival from major trauma

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 3: ***Helping people to recover from episodes of ill-health or following injury.***
Outcome sought	Improving recovery from injuries and trauma.
Status	In development.
Detailed descriptor	**Plain English description:** This indicator measures how likely it is to survive 30 days after suffering a major injury following an accident or incident. **Technical description:** The indicator measures whether survival from major trauma in England is increasing or decreasing each year.

DATA SOURCES	
Data sources	Trauma Audit & Research Network (TARN) 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/
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.
CONSTRUCTION	
Proposed calculation methodology	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. 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 2007/08 as the baseline year and will be updated annually once a new year of data is included. The outputs of interest from the risk model are the coefficients for each year. These are estimated in relation to a baseline year (2007/08) and are the log of the odds ratio of survival between each year and the reference year.
Changes since previous publication	The indicator definition is being refined and the first data release is planned for 2015.
Technical issues remaining to be resolved	How to express or explain a complex measure such as odds ratio in a way that is understandable by users is now being considered. Assessment of the robustness of the following breakdowns for this indicator is underway: • Trauma network • Age • Gender • Deprivation via postcode or area 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.

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.***
Outcome sought	Improving recovery from stroke.
Status	In development.
Detailed descriptor	**Plain English description:** This indicator will measure recovery from stroke by comparing the Modified Rankin Scale (mRS) score at 6 months post admission to hospital with the pre-morbid mRS score, and then calculating the proportion of patients deemed to have a “good recovery” at 6 months. Recovery reflects whether an individual is able to perform close to the level of daily activities that they achieved prior to suffering the stroke. **Technical description:** This indicator will measure the proportion of patients who recover to their approximate pre-admission level of ability (defined as the same, better or one level worse) as measured by the Modified Rankin Scale (mRS), excluding those who were known to have died within 6 months of admission. 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: 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.

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.
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 (6 months after first patient records entered in January 2013). The indicator specification is in progress and needs to account for the quality of the data. It is expected to be finalised in 2015/16.
CONSTRUCTION	
Proposed calculation methodology	The proportion of patients who recover to their approximate pre-admission level of ability is obtained by calculating the number of patients who show a Modified Rankin Scale (mRS) score at six months that is the same, better or one level worse than their pre-stroke mRS score and then dividing it by the total number of patients who received an assessment at 6 months. Patients will be excluded from the analysis if they are known to have died within 6 months of admission.
Changes since previous publication	A simpler methodology than previously proposed is now being developed.
Technical issues remaining to be resolved	In order to compare between sub-groups such as gender, it is necessary to age-standardise. However, such comparisons will only be possible once sufficient case ascertainment is achieved in the national level indicator.

3.7.i Decaying teeth

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 3: ***Helping people to recover from episodes of ill-health or following injury.***
Outcome sought	Improved oral health as measured by reduced decay of teeth.
Status	In development.

Rationale for inclusion	This indicator fills a significant gap in coverage of the NHSOF – 29.8 million unique visits to NHS commissioned dentistry services last year.
Detailed descriptor	**Plain English description:** A measure of the average number of decayed teeth for those people who regularly visit an NHS dentist. **Technical description:** Average number of decayed teeth for patients who have attended a NHS dentist two or more times; as measured by their most recent course of treatment that took place during the reporting period and where the previous attendance was no more than two years before the most recent, excluding urgent treatment, free treatment, referrals and edentate patients.
DATA SOURCES	
Data sources	NHS BSA: FP 17 form.
Reporting frequency	Quarterly (financial year).
Publication timing	Autumn/winter after the end of the follow-up year. It is expected to go live from March 2016.
CONSTRUCTION	
Proposed calculation methodology	Arithmetic mean of recorded level of decay for patients who have attended a NHS dentist two or more times; as measured by their most recent course of treatment that took place during the reporting period and where the previous attendance was no more than two years before the most recent, excluding urgent treatment, free treatment, referrals and edentate patients. $$Average\ decay = \frac{1}{N}\sum_{i=1}^{N} decayed\ teeth_i$$ For i patients with at least two course of treatments in last 2 years; most recent score therefrom.
Changes since previous publication	N/A
Technical issues remaining to be resolved	The FP17 form needs to be adapted to collect the appropriate data items. NHS BSA have been contacted by NHS England to discuss feasibility.

3.7.ii Tooth extractions in secondary care for children under 10

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 3: ***Helping people to recover from episodes of ill-health or following injury.***
Outcome sought	Reduced levels of people aged 10 years and younger who are referred to secondary care for tooth extractions.
Status	In development.
Rationale for inclusion	This indicator fills a gap in the NHS Outcomes Framework for outcomes not covered by the above oral health indicator – the preventative and access aspects of NHS commissioned dentistry services.
Detailed descriptor	**Plain English description:** A measure of the level of tooth extractions for people aged 10 years and under in secondary care. **Technical description:** A count of Finished Consultant Episodes (FCEs) for extraction of one or more decayed primary or permanent teeth having a main procedure (OPCS4) code of F09 – surgical removal of tooth or F10 – simple extraction of tooth (derived from OPER_1D3), for 0 to 10 year olds (derived from START_AGE), in an identified financial year (derived from EPIEND).
DATA SOURCES	
Data sources	HSCIC: HES dataset.
Reporting frequency	Annually (calendar year).
Publication timing	Autumn/winter after the end of the follow-up year. It is expected to go live from March 2016.
CONSTRUCTION	
Proposed calculation methodology	A count of Finished Consultant Episodes (FCEs) for extraction of one or more decayed primary or permanent teeth having a main procedure (OPCS4) code of F09 – surgical removal of tooth or F10 – simple extraction of tooth (derived from OPER_1D3), for 0 to 10 year olds (derived from START_AGE), in an identified financial year (derived from EPIEND).
Changes since previous publication	N/A
Technical issues remaining to be resolved	Some extraction activity takes place in community settings. Work is ongoing to make sure it is captured by HES.

Domain 4

Ensuring people have a positive experience of care

Introduction & Domain structure

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 classified as *in development* are provided in this Domain 4 chapter.

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
4d Patient experience categorised as poor or worse **i** Primary care **ii** Hospital care	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 inpatients' 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 NHS 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 inpatient services	In development
Improving people's experience of integrated care	
4.9 People's experience of integrated care	In development

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 (Responsiveness to inpatients' personal needs), which is a sub-indicator of overarching indicator 4b (Patient experience of hospital care), highlighting aspects of inpatient care for improvement.

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

Knowledge of patient experience can highlight poor care and lead to service improvement (NHS Confederation, 2010).[15] The Mid-Staffordshire NHS Foundation Trust Public Inquiry[16] highlights that the quality of patient experience is an important indicator of the underlying performance of a service provider.

Personal experience and the experience of friends and family have been identified as important considerations when patients have a choice over service providers. As such, information about other patients' experience increases transparency, and can help to support and increase patient choice and control.

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.

For nationally coordinated surveys, acute trusts do not have to run more than two patient experience surveys per year. The inpatient survey is run annually, with other surveys run on a rotating basis; therefore annual data points are not available for all survey based indicators in Domain 4.

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[15] The NHS Confederation (2010), *Feeling better? Improving patient experience in hospital*. http://www.nhsconfed.org/publications/reports/pages/feeling-better-improving-patient-experience-in-hospital.aspx

[16] http://www.midstaffspublicinquiry.com/report

International comparisons

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 programme,[17] the most recent reported in November 2013. In the intervening years, physicians and sicker adults are surveyed.

The number of countries surveyed has increased from seven in 2007 to eleven in 2010 and 2013. The measures used differ from 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) published four indicators of patient experience in the 2013 edition of 'Health at a Glance'[18] relating to how responsive and how patient-centred care is, using data from the 2010 Commonwealth Fund survey.

Sources of bias

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

- Non-response bias (when the achieved responses differ systematically from what would have been achieved if the whole sample had responded). These occur:
  - Where respondents differ systematically (for example by age or gender, from non-respondents) – this bias is redressed in these surveys by overweighting responses from the demographic categories that are under-represented; or
  - Where respondents in a given demographic category have a systematically different care experience from that of non-respondents – this bias is difficult to assess or to redress; care is needed particularly where response rates are low or variable.
- Response bias (a design effect) – cognitive biases that influence the responses of participants away from an accurate response, for example:
  - Gratitude bias (feelings of gratitude may inhibit negative evaluations and promote positive evaluations) – this bias is less likely to affect indicators that rely upon more objective questions rather than summary assessments;
  - Expectation bias (responses are given with reference to expectations, which may differ between respondents of different regions, ages, gender etc. and over time) – hard to detect, the possibility of such bias invites caution with respect to cross-sectional comparisons, particularly across different groups.

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[17] http://www.commonwealthfund.org/publications/surveys/2013/2013-commonwealth-fund- international-health-policy-survey

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

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

The indicator complementary to the ASCOF is:

- 4.9 – People's experience of integrated care (ASCOF 3E).

Work in progress

Indicator 4c – Friends and Family Test

The first set of data from the NHS Friends and Family Test (FFT) survey was released in July 2014.[19]

NHS England also published a review of the FFT in July 2014.[20] Relevant to the role of the FFT in the NHS Outcomes Framework is the following conclusion: "(p.42) FFT should be considered in the round and continue to be used alongside other ways of measuring patient experience such as the CQC patient survey programme and the GP Patient Survey. The centrally administered surveys should be considered as *summative* measurement tools, designed to take an accurate account and comparable reading of performance each year. The FFT, by contrast, should be understood as a *formative* measurement tool, which is designed to promote continual learning and improvement."

The Department of Health is considering the potential to develop an indicator for use in the NHS Outcomes Framework in light of the NHS England review.

Indicator 4d – Patient experience categorised as poor or worse i. Primary care, ii. Secondary care

It is problematic for anybody to have a poor or worse experience of care and as such it is an important outcome to be measured to complement measures of average experience of care. These indicators are constructed from a subset of the responses to most of the survey questions upon which the overarching indicators are based, on the basis of a transparent consultation regarding what responses are indicative of care that could appropriately be characterised as 'poor' or 'very poor'.

Indicator 4.7 – Patient experience of community mental health services

The survey on which this indicator is based has been re-developed in 2014, creating a need to re-specify the indicator using the revised questions. The new survey is available at http://www.nhssurveys.org/surveys/746, with a description of the changes to the survey available at: http://www.nhssurveys.org/surveys/750

The redesign was intended to ensure that the survey reflects current service user experience and the needs of service providers and regulators. 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. We are working with the Picker Institute, who co-ordinate the survey on behalf of the Care Quality Commission (CQC), to

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[19] http://www.england.nhs.uk/2013/07/30/nhsfft/

[20] http://www.england.nhs.uk/wp-content/uploads/2014/07/fft-rev.pdf

understand how the changes will affect the time-series of indicator values, and to design a new indicator.

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

Work is progressing to develop complementary indicator 4.8 which will be based on the paediatric inpatient surveys being implemented by CQC.

Indicator 4.9 – People's experience of integrated care

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 Picker 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 were identified for potential inclusion into existing patient and service user surveys.

Unfortunately, assessment of the feasibility of question inclusion (including cognitive testing within the context of surveys, necessary filters/demographics) has failed to find a survey vehicle and target population for which these questions would be meaningful. Work to uncover a feasible way to measure people's experience of integrated care continues.

Technical 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 recommending A&E and inpatient wards to their friends and family based on their own experience.
Status	In development.
Detailed descriptor	**Plain English description:** The indicator would be based on responses to the Friends and Family Test (FFT). The test asks patients whether they would recommend services to their friends and family based on their own experience. **Technical description:** A measure of the extent that patients would recommend A&E and inpatient wards to their friends and family based on their own experience.

DATA SOURCES	
Data sources	The indicator would 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. 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.
Reporting frequency	To be decided.
Timing	To be decided.
CONSTRUCTION	
Proposed calculation methodology	To be decided.
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. NHS England published a review of the appropriate uses of the FFT in summer 2014. The Department of Health is reviewing the appropriateness of the FFT to the NHS Outcomes Framework in light of the NHS England review.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

4d.i Patient experience chracterised as poor or worse – Primary care

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 4: **Ensuring that people have a positive experience of care.**
Outcome sought	Improved patients' experience of primary medical care.
Status	In development – expected to be live in May 2015.

Rationale for inclusion	It is problematic for anybody to have a poor or worse experience of care and, as such, it is an important outcome to be measured. The indicator will complement the existing overarching indicators 4a.i and 4a.ii so that NHS England is held to account for improving patient experience on average as well as for those in receipt of poor or worse experience of care.
Detailed descriptor	Across two questions from the GP Patient Survey, the average number of responses that characterise patient experience of care as being poor or worse per 100 patients.
DATA SOURCES	
Data sources	GP Patient Survey.
Reporting frequency	Annual (financial).
Publication timing	Three to four months after the end of the financial year.
CONSTRUCTION	
Proposed calculation methodology	**Numerator** The total weighted number of responses of 'fairly poor' or 'very poor' across the two questions in the survey. The two questions from the GP Patient Survey are: Q28: Overall, how would you describe your experience of your GP Surgery? Q45: Overall, how would you describe your experience of Out of Hours GP services? **Denominator** The total weighted number of respondents to at least one of the two questions. **Calculation** $\left(\frac{\mathit{Numerator}}{\mathit{Denominator}}\right) \times 100$ The numerator and denominator are weighted by GPPS weight for non-response bias (wt_new).
Changes since previous publication	N/A

Technical issues remaining to be resolved	To subject the methodology to the HSCIC Indicator Assurance Service.

4d.ii Patient experience characterised as poor or worse – Hospital care	
OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – Domain 4: **Ensuring that people have a positive experience of care.**
Outcome sought	Improved patients' experience of hospital care.
Status	In development – expected to be live in May 2015.
Rationale for inclusion	As for 4d.i
Detailed descriptor	Across 13 questions from the NHS Adult Inpatient survey, the average number of responses that characterise patient experience of care as being poor or worse per 100 patients.
DATA SOURCES	
Data sources	NHS Adult Inpatient Survey.
Reporting frequency	Annual (financial).
Publication Timing	Two months after the end of the financial year.
CONSTRUCTION	
Proposed calculation methodology	The measure is proposed to be constructed from 13 questions selected from those that form the existing overarching indicator 4b – Patient experience of hospital care. The questions and the responses that characterise patient experience as being poor or worse were selected by a group of patient experience policy experts. Starting with the full list of questions the experts filtered out those questions where either the question or the associated responses were judged to be too subjective or ambiguous for characterising patient experience as poor or worse or where the questions were not relevant for the majority of patients. With the 13 selected questions, the experts then judged in a consistent way which of the response options available for each question best characterised patient experience as being poor or worse.

Numerator

The total weighted number of responses that characterise experience of care as being poor or worse across the selected 13 questions from the existing over-arching indicator 4b – Patient experience of hospital care.

Denominator

The total number of respondents to at least one of the 13 questions.

The table below lists the questions on which the indicator is based. The right hand column lists the associated responses that have been selected as characterising 'poor' experience of care.

Question	Response options	Selected responses to characterise poor experience of care
Q16. Were you ever bothered by noise at night from hospital staff?	"No"; "Yes"	"Yes"
Q17. In your opinion, how clean was the hospital room or ward that you were in?	"Very clean"; "Fairly clean"; "Not very clean"; "Not at all clean"	"Not very clean" OR "Not at all clean"
Q21. How would you rate the hospital food?	"Very good"; "Good"; "Fair"; "Poor"	"Poor"
Q24. When you had important questions to ask a doctor, did you get answers that you could understand?	"Yes, always"; "Yes, sometimes"; "No"; "I had no need to ask"	"No"
Q26. Did doctors talk in front of you as if you weren't there?	"No"; "Yes, sometimes"; "Yes, often"	"Yes, often"

	Q27. When you had important questions to ask a nurse, did you get answers that you could understand?	"Yes, always"; "Yes, sometimes"; "No"; "I had no need to ask"	"No"
	Q29. Did nurses talk in front of you as if you weren't there?	"No"; "Yes, sometimes"; "Yes, often"	"Yes, often"
	Q31. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	"No"; "Yes, sometimes"; "Yes, often"	"Yes, often"
	Q32. Were you involved as much as you wanted to be in decisions about your care and treatment?	"Yes, definitely"; "Yes, to some extent"; "No"	"No"
	Q37. Were you given enough privacy when being examined or treated?	"Yes, always"; "Yes, sometimes"; "No"	"Yes, sometimes" OR "No"
	Q39. Do you think the hospital staff did everything they could to help control your pain?	"Yes, definitely"; "Yes, to some extent"; "No"	"No"

	Question	**Response options**	**Selected responses to characterise poor experience of care**
	Q51. On the day you left hospital, was your discharge delayed for any reason?	"No"; "Yes". **Exception**: Records excluded where: i) the answer to "What was the main reason for the delay?" is "Something else" AND ii) the answer to Q61, "How long was the delay?" is NOT "longer than 4 hours"	"Yes" (not including exceptions)
	Q67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	"Yes, always"; "Yes, sometimes"; "No"	"Yes, sometimes" OR "No"
	Calculation $$\left(\frac{Numerator}{Denominator}\right) \times 100$$ The numerator and denominator are weighted by NHS Inpatient Survey standardisation weight for age, gender and method of admission (PSAweight).		
Changes since previous publication	N/A		
Technical issues remaining to be resolved	To subject the methodology to the HSCIC Indicator Assurance Service.		

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.**
Outcome sought	Improvement in experience of healthcare for people with mental illness.
Status	In development.
Detailed descriptor	**Plain English description:** This indicator measures patient experience of community mental health services based on the national community mental health survey. **Technical description:** Patient experience of community mental health services based on contact with a health and social care worker.
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.
CONSTRUCTION	
Proposed calculation methodology	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 to take part in the survey. A complete list of eligibility and participation criteria for the survey is available at the following link: http://www.cqc.org.uk/content/community-mental-health-survey-2014

	Weighting Results are based on 'standardised' data. The community mental health survey is standardised by age and gender. **Calculation** The community mental health survey was redesigned for 2014. The survey questions used to underpin the indicator will be selected from the final set of questions used in the survey. **Indicator format:** To be decided.
Changes since previous publication	In development. The community mental health survey that underpins indicator 4.7 was redesigned for 2014. The indicator will be based on question(s) from the redesigned survey.
Technical issues remaining to be resolved	Calculation of the indicator.

4.8 Children and young people's experience of inpatient services

OVERVIEW	
Indicator family name	NHS Outcomes Framework – Domain 4: **Ensuring that people have a positive experience of care.** Improvement area – Improving children and young people's experience of healthcare.
Outcome sought	Improvement in children and young people's experience of healthcare.
Status	In development.
Detailed descriptor	**Plain English description:** A measure of children and young people's experience of healthcare. **Technical description:** A measure of children and young people's experience of healthcare based on responses to a set of questions from a suite of national paediatric inpatient experience surveys directed at children and (for younger children) their parents.

DATA SOURCES	
Data sources	The indicator will be based on questions from the paediatric outpatient survey produced by Picker Institute Europe. 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	It was previously intended to deliver an indicator from an outpatient survey constructed by Picker. However, agreement upon a contract for the survey to be rolled out nationally was not reached. In the meantime, a suite of surveys to elicit children's experience of inpatient care has become available, and should be a ready source of information.
Technical issues remaining to be resolved	Calculation of the indicator and standardisation methodology.

4.9 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	Improving people's experience of integrated care.
Status	In development.
Detailed descriptor	**Plain English description:** A measure of the extent that people's experience of care, support and treatment is integrated within and across services. **Technical description:** 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.

Alignment with other Outcomes Frameworks	Complementary with ASCOF 3E.
DATA SOURCES	
Data sources	The indicator may be based on the insertion of new survey questions into existing surveys, if this proves feasible. The proposed questions to measure experience of integrated care are listed below: • “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?” These questions have been subject to testing over the coming months to determine their appropriateness for inclusion in existing surveys. It has not so far been possible to find a location and presentation of these questions that proves meaningful upon cognitive testing with relevant patient groups.
Reporting frequency	To be decided.
Timing	To be decided.

CONSTRUCTION	
Proposed calculation methodology	To be decided.
Changes since previous publication	The indicator was introduced as a placeholder in the 2013/14 Outcomes Framework. The Department of Health commissioned research to determine the most effective way to capture information about people's experiences of integrated care. The resulting set of questions has now been considered and in some cases cognitively tested in the context of existing surveys. This process continues; it may prove necessary to revert to revisit the selected questions.
Technical issues remaining to be resolved	Question selection, 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 & Domain structure

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 classified as in development, and for those where the definition is amended in the 2015/16 NHSOF, are provided in this Domain 5 chapter.

Overarching indicators	Status
5a Deaths attributable to problems in healthcare	In development
5b Severe harm attributable to problems in healthcare	In development
Improvement areas	Status
Reducing the incidence of avoidable harm	
5.1 Deaths from venous thromboembolism (VTE) related events	Live
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 Hip fractures from falls during hospital care	In development
Improving the safety of maternity services	
5.5 Admission of full-term babies to neonatal care	Live
Improving the culture of safety reporting	
5.6 Patient safety incidents reported	Live

Overarching *in development* indicator 5a is the same definition as indicator 5c in previous versions of the NHS Outcomes Framework, and will be based on retrospective case record review to measure deaths attributable to problems in healthcare. Overarching *in development* indicator 5b is a new indicator measuring severe harm attributable to problems in care; this too will be based upon retrospective case record review.

Indicators in the improvement areas are of two sorts:

- *Sub-indicators*:
  - Indicator 5.1: Deaths from VTE related events, will be a sub-indicator of indicator 5a (once both are *live*).
- *Complementary indicators*:
  - Indicator 5.2: Incidence of healthcare associated infection i. MRSA, ii. C difficile;
  - Indicator 5.3: Proportion of patients with category 2, 3 and 4 pressure ulcers;
  - New *in development* indicator 5.4: Hip fractures from falls during hospital care;
  - Indicator 5.5: Admission of full-term babies to neonatal care;
  - Indicator 5.6: Patient safety incidents reported – on the National Reporting and Learning System (NRLS), a measure of the culture of safety (given that there is evidence of substantial under-reporting). This was listed as indicator 5a in previous NHS Outcomes Frameworks.

International comparisons

International comparisons for patient safety covering surgical complications and obstetric trauma are available from the Organisation for Economic Co-operation and Development (OECD) 'Health at a Glance' report.[21] 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.

There is wide variation in the data from different countries 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, and by variation in the extent of under-reporting. The OECD is working with representatives from several countries to modify the indicator definitions and increase comparability.

External drivers of outcome

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.

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

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

Work in progress

Indicator 5a – Deaths attributable to problems in healthcare;

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

Indicator 5b – Severe harm attributable to problems in healthcare.

The Department of Health has previously signalled an intention to address the lack of reliable measures of harm done by developing a system of case note review. Retrospective Case Record Review (RCRR) involves taking a sample of deaths or serious detriments to health for review by clinical experts both for the presence of some problem in care and for the likelihood that the adverse outcome would have been avoided had the problem (the safety incident) not occurred. This allows a robust assessment of deaths and serious harm attributable to problems in care.

Significant progress has been made on the development of this programme. The initial focus has been on adult deaths and serious harm occurring in hospital, both due to the availability of notes and the concentration of acuity in the hospital environment. This is developing into indicator 5a (deaths) and 5b (serious harm). The intention is to expand the programme over time to include paediatric deaths and serious harms, and to extend the reach of the programme to include harms sustained and deaths occurring outside the hospital setting, including as a result of problems in primary or community care.

Data to establish the baseline for indicator 5a will derive from research studies led by NHS England, and 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 study due to be completed in early 2015, and will be broadly comparable to a previously published study[22] on adult deaths in 2009.

Additional commissioned research will review deaths that occurred in 2013/14, and deaths occurring in 2014/15 will be the subject of Trust review as the national methodology is piloted. The results of these reviews will be published in late 2015 and late 2016 respectively. The feasibility of publishing in-year data, potentially on a monthly basis, will also be assessed.

The methodology for assessing severe harms is now being developed by a research team.

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

The Tissue Viability Society are undertaking a full skin inspection audit based on a random sample of wards representative across NHS and blind to ward staff. They will compare results with NHS Safety Thermometer data as well as reported incidents to assess quality of these data sources and make recommendations for how to routinely measure pressure ulceration for national purposes such as the NHS Outcomes Framework.

Indicator 5.4 – Hip fractures from falls during hospital care

Formal approval to use the National Hip Fracture Database for this purpose is being sought.

Indicator 5.5 – Admission of full-term babies to neonatal care

We are amending the definition of this indicator to standardise the level of care provided by the neonatal units admission to which is counted in the indicator. The amended definition for this indicator is provided below.

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[22] 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

We shall also amend the quality statement for this indicator to reflect concern that there are a number of confounding factors that reduce the reliability of the indicator as an indicator of harm. These are mentioned in the technical specification below.

Technical specifications for in development indicators

5a Deaths attributable to problems in healthcare	
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.
Detailed descriptor	**Plain English description:** To be determined – see the later section on technical issues to be resolved. **Technical description:** To be determined – see the later section on technical issues to be resolved.
DATA SOURCES	
Data sources	A dedicated programme of Retrospective Case Record Reviews (RCRRs). The reviews are conducted in two-stages by expert reviewers. 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. The intervals of the Likert scale are listed below: 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	The methodology needs further refinement (see ‘technical issues to be resolved’ section below). RCRRs will in the first instance be conducted on a sample frame comprising all adult (>=18 years old) deaths in NHS acute hospitals excluding admissions for psychiatric care and obstetrics.
Changes since previous publication	Development of indicator from a placeholder indicator.
Technical issues remaining to be resolved	To confirm the sample frame and size per hospital. 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. Likert and continuous scales do this in conceptually different ways but both elicit a more 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. To subject the indicator to the HSCIC Indicator Assurance Service. To expand coverage to include children, and also to include deaths and problems occurring outside the acute setting.

5b Severe harm 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 quantum of severe harm due to problems in care.
Status	In development.
Detailed descriptor	**Plain English description:** To be determined – see the later section on technical issues to be resolved. **Technical description:** To be determined – see the later section on technical issues to be resolved.
DATA SOURCES	
Data sources	A dedicated programme of Retrospective Case Record Reviews (RCRRs).
Reporting frequency	To be decided. Expected to be at least annual (financial year).
Publication Timing	To be determined.
CONSTRUCTION	
Proposed calculation methodology	The methodology needs further refinement (see ‘technical issues to be resolved’ section below.)
Changes since previous publication	Development of indicator.
Technical issues remaining to be resolved	The sample frame has still to be developed – a definition and data source for severe harm is required. It is likely but to be confirmed that a similar process to that involved for Indicator 5a will be employed.

5.3 Proportion of patients with category 2, 3 or 4 pressure ulcers	
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	Improvement area – Reducing the incidence of avoidable harm.
Status	In development.
Detailed descriptor	**Plain English description:** 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 NHS patients on day of survey. The categories of pressure ulcers are based on the European Pressure Ulcer scale:[23] • 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. Patients' skin is inspected for pressure ulcers on a particular day each month. **Technical description:** Point prevalence of patients with category 2, 3 or 4 pressure ulcers.

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

DATA SOURCES	
Data sources	The Tissue Viability Society are undertaking a full skin inspection audit based on a random sample of wards representative across NHS and blind to ward staff. They will compare results with NHS Safety Thermometer data as well as HES to assess quality of these data sources and make recommendations for how to routinely measure pressure ulceration for national purposes such as the NHS Outcomes Framework.
Reporting frequency	Monthly.
Publication Timing	NHS Safety Thermometer data are published monthly on the HSCIC website.
CONSTRUCTION	
Proposed calculation methodology	*Numerator*: The number of patients with any pressure ulcer (count all pressure ulcers and those category 2 or greater). *Denominator*: The number of patients on the (care) unit or in the (care) facility during the time period. *Format*: percentage (numerator/denominator) * 100.
Changes since previous publication	Change of indicator title: ‘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	To confirm NHS Safety Thermometer as the intended data source, probably with annual validation from an ad hoc survey. To confirm approach, if any, to risk adjust the measure for sub-national breakdowns. To consider amending pressure ulcer categories to better capture ‘unstageable/unclassified’ pressure ulcers, which may affect casemix. To subject the methodology to the HSCIC Indicator Assurance Service.

5.4 Hip fractures from falls during hospital 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.**
Outcome sought	Improvement area – Reducing the incidence of avoidable harm.
Status	In development.
Rationale for inclusion	This is one of the major sources of patient safety harms, with approximately 2,500 cases a year. Patients who are already ill have very poor outcomes and greatly extended lengths of stay.
Detailed descriptor	**Plain English description:** The number of hip fractures from falls during hospital care as a proportion of all hospital admissions. **Technical description:** Incidence of hip fractures from falls during hospital care.
DATA SOURCES	
Data sources	National Hip Fracture Database (NHFD). Hospital Episode Statistics (HES).
Reporting frequency	To be determined.
Publication timing	To be determined.

CONSTRUCTION	
Proposed calculation methodology	**Numerator** The numerator will be sourced from the National Hip Fracture Database (NHFD), with a filter applied to the [admitted from] field that records where the hip fracture occurred: The [admitted from] field currently has the following options: • Own home/sheltered housing. • Residential care. • Nursing care. • This hospital site. • Other hospital site of this trust. • Other hospital trust. **Denominator** The denominator will be the total number of hospital admissions recorded in Hospital Episode Statistics (HES).
Changes since previous publication	N/A
Technical issues remaining to be resolved	• Formal approval to use NHFD for this purpose. • Assessment by NHFD whether amendment to the existing field, [admitted from], in the NHFD that records where the patient was admitted from, is necessary to clarify that it is about where the hip fracture occurred. • Calculation methodology, including any standardisation. • In time we hope to expand the indicator to cover hip fractures from falls in all healthcare settings. We will need to work with the NHFD to amend the options of the [admitted from] field so that patients in NHS-funded settings outside of hospital can be identified.

5.5 Admission of full-term babies to neonatal 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	Improving the safety of maternity services.
Status	Live.
Rationale for inclusion	Unexpected admission of a term baby to neonatal care may result from failure at many stages of the maternity pathway.
Detailed descriptor	**Plain English description:** The number of full-term babies (gestation greater than or equal to 37 weeks) admitted within 28 days of birth to a neonatal unit, expressed as a percentage of all full term births. **Technical description:** Number of full-term neonatal episodes, as a percentage of all full term births.
DATA SOURCES	
Data sources	**Denominator:** The total number of full-term babies (gestation greater than or equal to 37 weeks) provided from the annual Births and Birth notifications from the Office for National Statistics (ONS). **Numerator:** The total number of full-term babies (gestation greater than or equal to 37 weeks) admitted within 28 days of birth to a neonatal unit. Provided by the National Neonatal Research Database (Source provider: Neonatal Data Analysis Unit). Available annually (calendar years) one month after the end of the period.
Reporting frequency	Annual.
Publication timing	Available 22 months after the end of the period.

CONSTRUCTION	
Proposed calculation methodology	**Calculation** The number of full-term neonatal episodes, as a percentage of all full term births. (Numerator/denominator) * 100. **Denominator** The number of births where gestation period is greater than or equal to 37 weeks. **Numerator** Number of full-term babies (gestation greater than or equal to 37 weeks) admitted within 28 days of birth. • Live born infants, born greater than or equal to 37+0 weeks gestational age, admitted to neonatal units in England (first admission only). • Admitted within 28 days of birth. • Level of care on day of first admission is 1, 2 or 3 only.
Changes since previous publication	• Clarification that only admission to neonatal units with levels of care 1, 2, or 3 should be included in the indicator. • Additional material in the quality statement to accept that: – When plausibly evidenced by the confounding factors (increased incidence or diagnosis of conditions like severe growth restriction or congenital abnormality or risk of morbidity as a result of maternal factors that appropriately lead to admission, for example:- higher maternal age, maternal BMI, diabetes, or hypertension) increased admissions may not represent failure to deliver safe care; – There should be closer consideration of the combination of indicators of neonatal mortality and still birth with this indicator to assess whether increases may represent more active intervention (leading to more babies surviving to 37 weeks, at which point they might need neonatal care admission), and of the impact of supply of neonatal beds upon the admission threshold.
Technical issues remaining to be resolved	It may need to be considered that some avoidable term admissions may be admitted to paediatric areas and not neonatal, and thus, the numerator data source will be unable to identify these admissions. Many neonatal units have policies which do not readmit neonates from the community setting – we know a reasonable proportion of these term admissions are from the community.

5.6 Patient safety incidents reported

OVERVIEW	
Indicator Family Name	NHS Outcomes Framework – **Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.**
Outcome sought	Improving the culture of safety reporting.
Status	Live.
Rationale for inclusion	Not applicable as indicator already exists – see box on 'Changes since previous publication.'
Detailed descriptor	**Plain English description:** The number of patient safety incidents (PSI) reported to the National Reporting and Learning Service (NRLS) by provider organisations, per 100,000 population. A patient safety incident (PSI) is defined as 'any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare'. **Technical description:** The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS) by provider organisations, per 100,000 population.
DATA SOURCES	
Data sources	National Patient Safety Agency, (Source Provider: National Reporting and Learning System (NRLS), Quarterly Data Summary). National Patient Safety Agency, (Source Provider: National Reporting and Learning System (NRLS), Organisation Patient Safety Incident Reports. ONS Mid-Year Population Estimates
Reporting frequency	National Level – quarterly (calendar year). Trust Level – bi-annually (calendar year).
Publication timing	Six months after the end of the reporting period.

CONSTRUCTION

Proposed calculation methodology

Numerator:

The numerator is the number of patient safety incidents, as submitted to the National Reporting and Learning System by an organisation based in England. Some organisations, such as community pharmacy which submit for England and Wales, and those submitted via eForms who choose not to disclose the organisation where the incident occurred, are excluded.

Denominator:

For national level figures, the rate is per hundred thousand population as per the ONS Mid-year population estimates.

Disaggregated data are calculated by type of trust. The choice of denominator and rate is dependent of the type of organisation, as detailed in the following table.

Type of Trust	Denominator	Rate
Acute	Admissions	100*(total incidents/admissions)
Mental health	Bed days	1000*(total incidents/bed days)
PCO Inpatient provision	Bed days	1000*(total incidents/bed days)
PCO No Inpatient provision	Count of incidents only	–
Ambulance	Count of incidents only	–

Disaggregations

The indicator will be reported by the following disaggregations, each of which will be available with a further split by adult and child age groups and incidents where no age is recorded, for example when an incident relates to a site, like a power-cut, rather than to a specific patient:

- Severe harm or death.
- No harm.
- Incidents of type medication error.

The degree of harm for a patient safety incident is defined in the NRLS as follows:

- ‘severe’ – the patient has been permanently harmed as a result of the PSI where ‘permanent harm’ is defined as permanent lessening of bodily functions; including: sensory, motor, physiological or intellectual; and
- ‘death’ – the PSI has resulted in the death of the patient.

Changes since previous publication	There are several changes to this indicator that was previously 5a: *Patient safety incidents reported*. These changes are: • A move from an over-arching to an improvement area indicator to better reflect the nature of the outcome. Improved readiness of the NHS to report and learn from harm is an important but intermediate outcome of safe care. • Disaggregation of patient safety incidents into types, levels and by patient age groups.
Technical issues remaining to be resolved	None.

Data Sources breakdowns and Timely Reporting of Data

Table 1 provides details of the data sources which underpin the indicators in the NHS Outcomes Framework. Figures 2 and 3 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 lag is factored into the tables and charts here. Table 1 includes all live indicators, in development indicators are not included, as sufficient data is unavailable. These in development indicators can be found below.

Figure 1: 2015/16 NHS Outcomes Framework indicators *in development*

Domain 1

1.4v One and **vi.** Five-year survival from cancers diagnosed at stages 1&2

1.5ii Excess under 75 mortality rate in adults with common mental illness

1.5iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services

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

Domain 2

2.5ii Health-related quality of life for people with mental illness

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

2.7 Health related quality of life for people with three or more long-term conditions

Domain 3

3.1 Total health gain as assessed by patients for elective procedures **i** Physical health related procedures

3.1 Total health gain as assessed by patients for elective procedures **ii** Psychological therapies **iii** Recovery in quality of life for patients with mental illness

3.3 Survival from major trauma

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

3.7.i Decaying teeth

3.7.ii Tooth extractions in secondary care for children under 10

Domain 4

4c Friends and Family test

4d Patient experience categorised as poor or worse **i** Primary care **ii** Hospital care

4.7 Patient experience of community mental health services

4.8 Children and young people's experience of inpatient services

4.9 People's experiences of integrated care

Domain 5

5a Deaths attributable to problems in healthcare

5b Severe harm attributable to problems in healthcare

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

5.4 Hip fractures from falls during hospital care

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	CQC
Publication Schedule	This ad hoc survey is run around every four years. Next publication to be in December 2014, after fieldwork from May to September 2014.
Time Lag	Available from the source provider in the December of the reference year (calendar year). Available on the HSCIC Indicator Portal 3 months after the reference year (calendar year).

Inpatient Survey	
Indicators in the NHS Outcomes Framework	4b, 4.2
Publisher	Care Quality Commission (CQC).
Publication Schedule	Published annually in April.
Time Lag	Available from the source provider 1 month after the data collection is complete (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. It was last published in December 2013, after fieldwork from May to August 2013.
Time Lag	Available from the source provider in 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/ Picker
Publication Schedule	This ad hoc survey is run around every three years. It was last published in February 2011, after fieldwork from June to October 2010.
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).

Mandatory surveillance of Healthcare Associated Infections (MRSA & C Difficile)	
Indicators in the NHS Outcomes Framework	5.2.i-ii
Source Provider	Health Protection Agency (HPA).
Publication Schedule	Published annually in July.

Time Lag	Available from the source provider 4 months after the end of the reference year (financial). Available from the HSCIC Indicator portal 8 after the end of the reference year (financial).

National Hip Fracture Database (NHFD)	
Indicators in the NHS Outcomes Framework	3.5i-ii
Source Provider	Health Quality Improvement Partnership (HQUIP).
Publication Schedule	Published annually, a national clinical NHFD National report published in September 2013 for period April 2012 to March 2013.
Time Lag	Available from the source provider 10 months after the reference year (calendar year). Available on the HSCIC Indicator Portal 11 months after the reference year(calendar year).

Adult Social Care Combined Activity Returns (ASCAR)	
Indicators in the NHS Outcomes Framework	3.6i-ii
Source Provider	HSCIC
Publication Schedule	Published annually in July.
Time Lag	Available from the source provider 4 months after end of the reference year (financial year). Available on HSCIC Indicator Portal 5 months after the end of the reference year (financial year).

Hospital Episode Statistics	
Indicators in the NHS Outcomes Framework	2.3.iii Numerator for: 2.3.i-2.3ii 3a, 3b, 3.2 5.1
Source Provider	HSCIC
Publication Schedule	Published in a provisional form monthly and quarterly. Final annual confirmed HES data are released in the December following the financial year end.
Time Lag	Final data available from the source provider 9 to 10months after the reference year (financial year). Available on the HSCIC portal around 11 months after the reference year (financial year).

Mental Health Minimum Database (MHMDS) data linked over years and to the Primary Care Mortality Database(PCMD), Office for National Statistics (ONS) mortality data by cause	
Indicators in the NHS Outcomes Framework	1.5i
Source Provider	HSCIC, ONS
Publication Schedule	Published quarterly (MHMDS-PCMD) and annually (ONS mortality) and refreshed annually.
Time Lag	Some variability, but MHMDS_PCMD data is generally available from the source provider 5 months after the end of the reference year (financial year). ONS mortality data is available 15 months after the end of the reference year (financial year). Available on the HSCIC Indicator Portal 18 months after the end of the reference period (financial year).

Quality and Outcomes Framework (QOF) dementia prevalence data	
Indicators in the NHS Outcomes Framework	2.6.i
Source Provider	HSCIC
Publication Schedule	Published annually in October after the end of the financial year.
Time Lag	QOF prevalence data available from the source provider 7 months after the reference year (financial year). Available on the HSCIC portal around 8 months after the reference year (financial year).

GP Patient Survey (GPPS)	
Indicators in the NHS Outcomes Framework	2, 2.1, 2.4 4a.i-iii, 4.4.i-ii
Source Provider	Ipsos Mori
Publication Schedule	Published annually in July after the end of the financial year.
Time Lag	Available from the source provider 4 months after the reference year (financial year). (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). Available on the HSCIC Indicator Portal 5 months after the end of the reference period (financial year).

National Neonatal Research Database (NNRD)	
Indicators in the NHS Outcomes Framework	Numerator 5.5
Source Provider	Neonatal Data Analysis Unit (NDAU).

Publication Schedule	Published annually (calendar year).
Time Lag	The NNRD is the source of the numerator for indicator 5.5 – this is available 1 month (calendar year) after the end of the reference period from the source provider. The indicator is available on the HSCIC Indicator portal 23 months after the end of the reference period (calendar year) taking into account the lags for numerator and denominator.

National Reporting and Learning System (NRLS)	
Indicators in the NHS Outcomes Framework	5.6
Source Provider	National Reporting and Learning Service (NRLS).
Publication Schedule	Published bi-annually.
Time Lag	Available from the source provider 6 months after the reference period (calendar year). Available on the HSCIC Indicator Portal 8 months after the end of the reference period (calendar year).

Cancer registration data	
Indicators in the NHS Outcomes Framework	1.4.i-iv, 1.6.ii
Source Provider	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 12 months after the end of the reference year (calendar year). Available on the HSCIC Indicator Portal around 14 months after the end of the reference year (calendar year).

Labour Force Survey (LFS)	
Indicators in the NHS Outcomes Framework	2.2, 2.5i
Source Provider	ONS
Publication Schedule	Published 3 monthly.
Time Lag	Available from the source provider approximately 3 months after the end of that reference period (quarters usually December, March, June and September (calendar year). Available on the HSCIC portal website 5 months after the reference period (February, May, August and November).

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.
Time Lag	Available from the source provider 4 months after the end of the reference period (survey period). Available on the HSCIC Indicator Portal 8 months after the end of the reference period (survey period).

ONS Birth Notifications (NHS Numbers for Babies)	
Indicators in the NHS Outcomes Framework	Denominator 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 23 months after the end of the reference period (calendar year).

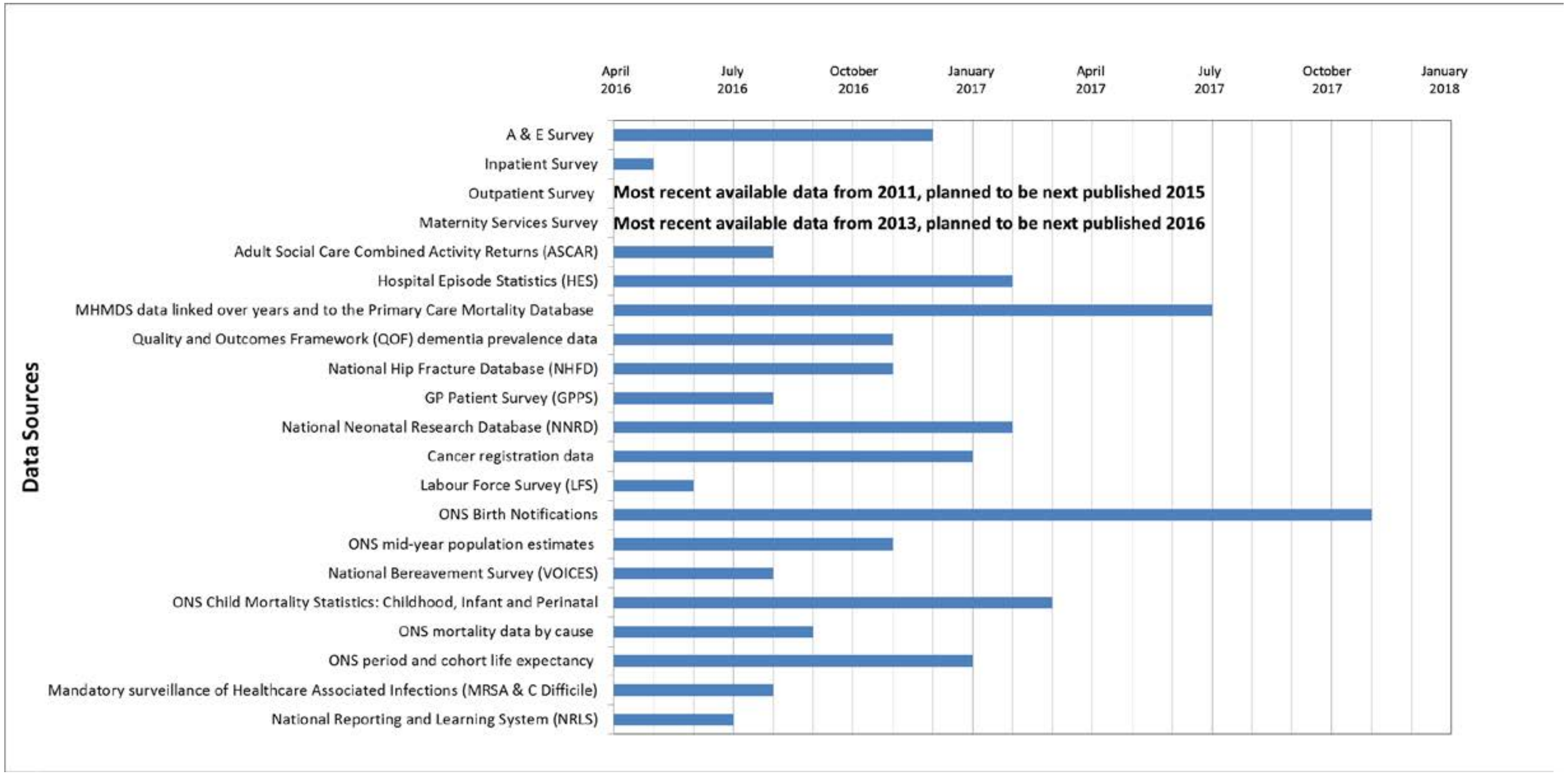
ONS mid-year population estimates	
Indicators in the NHS Outcomes Framework	Denominator for: 1a, 1.1, 1.2, 1.3, 1.4, 1.5i, 1.5iii 2.3.i-ii, 2.6.i (estimates for the very elderly) 3a, 3.2 5.1
Source Provider	ONS
Publication Schedule	Published annually (calendar year).
Time Lag	Available from source provider 6 months after the end of the reference year (calendar year). However, LSOA population estimates are published 10 months after the end of the reference year (calendar year). Available on the HSCIC Indicator Portal around 12 months after the reference year (calendar year).

ONS Child Mortality Statistics: Childhood, Infant and Perinatal	
Indicators in the NHS Outcomes Framework	1c, 1.6.i
Source Provider	ONS
Publication Schedule	Next publication estimated January/February 2015.
Time Lag	Available from the source provider 13 to 14 months after the end of the reference year (calendar year). Available on the HSCIC Indicator Portal 17 months after the end of the reference year (calendar year).

ONS mortality data by cause	
Indicators in the NHS Outcomes Framework	Numerator for: 1a, 1.1, 1.2, 1.3, 1.4, 1.5iii
Source Provider	ONS
Publication Schedule	Published annually (calendar year).
Time Lag	Available from source provider 8 months after the end of the reference year (calendar year). Available on the Health and Social Care Information Centre's (HSCIC) Indicator Portal around 11 months after the reference year (calendar year).

ONS period and cohort life expectancy	
Indicators in the NHS Outcomes Framework	1b
Source Provider	ONS
Publication Schedule	Published biennial (every two calendar years) Next publication estimated October/November 2014.
Time Lag	Available 12 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).

Figure 2: Timeliness of data for assessment of 2015/16 NHS Outcomes Framework – by data source[23]



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[23] This information is based on lags of 2013/14 data, applied to 2015/16. These lags are based on estimates and are subject to change.

Figure 3: Timeliness of data for assessment of 2015-16 NHS Outcomes Framework – by indicator[24]

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[24] This information is based on lags of 2013/14 data, applied to 2015/16. These lags are based on estimates and are subject to change.

Indicators and their age ranges

Below is a table that details each indicator in the NHS Outcomes Framework and the age range that is covered by each indicator.

Indicator	Age Range
1a. Potential years of life lost (PYLL) from causes considered amenable to Healthcare **i.** adults **ii.** Children and young people	**1a.** 0–74 years (except for deaths relating to HIV and surgical misadventure which are all ages) **1a.i.** 20–74 years (except for deaths relating to HIV and surgical misadventure which are all ages) **1a.ii.** 0-19 years
1b. Life expectancy at 75 **i.** males **ii.** females	**i.** All ages **ii.** All ages
1c. Neonatal mortality and stillbirths	Age of Mother (all ages, from under 20 years to 40 years and above)
1.1 Under 75 mortality rate from cardiovascular disease	0-74 Years
1.2 Under 75 mortality rate from respiratory disease	0-74 Years
1.3 Under 75 mortality rate from liver disease	0-74 Years
1.4 Under 75 mortality rate from cancer **i** One- and **ii** Five-year survival from all cancers **iii** One- and **iv** Five-year survival from breast, lung and colorectal cancer **v** One- and **vi** Five-year survival from cancers diagnosed at stage 1&2	**1.4** 0-74 Years **i.** 15-99 years **ii.** 15-99 years **iii.** 15-99 years **iv.** 15-99 years **v.** In development **vi.** In development

1.5.i Excess under 75 mortality rate in adults with serious mental illness	18-74 Years
1.5.ii Excess under 75 mortality rate in adults with common mental illness	18-74 Years
1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services	In development
1.6.i Infant mortality	Age of Mother (all ages, from under 20 years to 40 years and above)
1.6.ii Five year survival from all cancers in children	0-14 Years
1.7 Excess under 60 mortality rate in adults with a learning disability	In development
2. Health-related quality of life for people with long-term conditions	18 years and above
2.1 Proportion of people feeling supported to manage their condition	18 years and above
2.2 Employment of people with long-term conditions	16-64 Years
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions	All ages
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	0-18 Years
2.4 Health-related quality of life for carers	18 years and above
2.5.i Employment of people with mental illness	16-64 Years
2.5.ii Health-related quality of life for people with mental illness	In development
2.6.i Estimated diagnosis rate for people with dementia	40 years and above
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	In development

2.7 Health-related quality of life for people with three or more long-term conditions	In development
3a. Emergency admissions for acute conditions that should not usually require hospital admission	All ages
3b. Emergency readmissions within 30 days of discharge from hospital	All ages
3.1 Total health gain as assessed by patients for elective procedures **i.** Physical health-related procedures **ii.** Psychological therapies **iii.** Recovery in quality of life for patients with mental illness	**i.** 10 years and above **ii.** In development **iii.** In development
3.2 Emergency admissions for children with LRTI	0-18 Years
3.3 Survival from major trauma	In development
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months	In development
3.5 Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days	(i) 60 years and above; (ii) 60 years and above
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	65 years and above
ii. Proportion offered rehabilitation following discharge from acute or community hospital	65 years and above
3.7.i Decaying teeth	In development
3.7.ii Tooth extractions in secondary care for children under 10	In development
4a. Patient experience of primary care **i.** GP services **ii.** GP Out-of-hours services **iii.** NHS dental services	**i.** 18 years and above **ii.** 18 years and above **iii.** 18 years and above

4b. Patient experience of hospital care	16 years and above
4c. Friends and family test	In development
4d. Patient experience characterised as poor or worse **i.** Primary care **ii.** Hospital care	In development
4.1 Patient experience of outpatient services	16 years and above
4.2 Responsiveness to in-patients' personal needs	16 years and above
4.3 Patient experience of A&E services	16 years and above
4.4 Access to i GP services and ii NHS dental services	18 years and above
4.5 Women's experience of maternity services	16 years and above
4.6 Bereaved carers' views on the quality of care in the last 3 months of life	18 years and above
4.7 Patient experience of community mental health services	16 years and over
4.8 Children and young people's experience of inpatient services	In development
4.9 People's experience of integrated care	In development
5a. Deaths attributable to problems in healthcare	In development
5b. Severe harm attributable to problems in healthcare	In development
5.1 Deaths from venous thromboembolism (VTE) related events	19 years and above
5.2 Incidence of healthcare associated infection (HCAI) **i.** MRSA **ii.** C. difficile	**i.** All Ages **ii.** 2 years and above
5.3 Proportion of patients with category 2, 3 and 4 pressure ulcers	In development
5.4 Hip fractures from falls during hospital care	In development

5.5 Admission of full-term babies to neonatal care	Under 28 days (and gestation period greater than 37 weeks)
5.6 Patient safety incidents reported	All Ages

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 benefits of publication do not justify the costs
D	**In development** – Not currently available but possible to construct
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, accuracy or interpretation

Table 2: Equalities Breakdowns by Outcomes Framework Indicator

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
Domain 1. Preventing people from dying prematurely																		
1a.i Potential Years of Life Lost (PYLL) from causes considered amenable to health care - adults	A*	A	A*	A*	N	A	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. 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 by selecting causes amenable to health care according to the Outcomes Framework and selecting the appropriate age groups. 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 considered amenable to health care - children and young people	A*	I	A	I	N	I	I	I	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 but PYLL comparisons would need to be constructed by selecting causes amenable to health care according to the Outcomes Framework, selecting the appropriate age groups and determining an appropriate life expectancy for each age group.
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 http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database# search for table: demo_mlexpec. 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.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
1c Neonatal mortality and stillbirths	N	A*	I	A*	N	A*	N	N	A*	N	A	N	N	N	N	N	Age of mother	Data sourced from ONS Child Mortality Statistics. International comparisons of infant mortality available from the WHO European Health For All database (HFA-DB). They should be treated with caution due to differences between countries in registration of premature births. Some countries have gestational age and/or weight limits which may result in lower infant mortality rates as the figures exclude very small and/or very premature babies, which are more vulnerable. Subnational breakdowns should be interpreted with caution due to the small number of deaths. 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)
1.1 Under 75 mortality rate from cardiovascular disease	A	A*	A*	A*	N	A	I	A	N	N	A	N	N	N	N	N	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.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
1.2 Under 75 mortality rate from respiratory disease	A	A*	A*	A*	N	A	I	A	N	N	A	N	N	N	N	N	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 1.2 is indicator 1.6 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	A	A*	A*	A*	N	A	I	A	N	N	A	N	N	N	N	N	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 1.3 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.
1.4. Under 75 mortality from cancer	A	A*	A*	A*	N	A	I	A	N	N	A	N	N	N	N	N	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.
1.4.i One-year survival for all cancers	N	I	A	N	N	I	I	A	I	N	D	N	N	N	N	N		Data sourced from ONS Cancer Survival Statistics.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
1.4.ii Five-year survival for all cancers	A*	I	N	N	N	I	I	A	I	N	D	N	N	N	N	N		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	N	I	A	N	N	I	I	A	I	N	D	N	N	N	N	N		Data sourced from ONS Cancer Survival Statistics.
1.4.iv Five-year survival for breast, lung and colorectal cancer	N	I	N	N	N	I	I	A	I	N	D	N	N	N	N	N		Data sourced from ONS Cancer Survival Statistics.
1.4.v One-year survival from cancers diagnosed at stages 1&2	Possible breakdowns to be assessed once the indicator is developed																	
1.4.vi Five-year survival from cancers diagnosed at stages 1&2	Possible breakdowns to be assessed once the indicator is developed																	
1.5.i Excess under 75 mortality rate in adults with serious mental illness	N	D	I	A*	N	D	I	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. OECD are developing an indicator to facilitate international comparisons. Subnational breakdowns should be interpreted with caution due to the small number of deaths.
1.5.ii Excess under 75 mortality rate in adults with common mental illness	Possible breakdowns to be assessed once the indicator is developed																	
1.5.iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services	I	A	I	A	N	I	I	I	I	I	A	I	I	I	I	I		Available breakdowns are still being assessed.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
1.6.i Infant mortality	A*	A*	I	A*	N	A*	N	N	A*	N	A	N	N	N	N	N	Age of Mother	Data sourced from ONS Child Mortality Statistics. International comparisons of infant mortality available from the WHO European Health For All database (HFA-DB). They should be treated with caution due to differences between countries in registration of premature births. The European Perinatal Health Report, http://www.europeristat.com/reports/european-perinatal-health-report-2010.html gives more robust comparisons using 2010 data. Subnational breakdowns should be interpreted with caution due to the small number of deaths. 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.ii Five year survival for all cancers in children	A*	N	N	N	N	I	I	A	I	N	D	N	N	N	N	N		Data sourced from ONS Children's Cancer Survival Statistics. International comparisons are available from Eurocare 5 (further information at http://www.eurocare.it/Eurocare5/tabid/64/Default.aspx).
1.7 Excess under 60 mortality in adults with learning disabilities	Possible breakdowns to be assessed once the indicator is developed																	
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	A	A	N	A	N	A	A	A	A	N	A	N	N	N	Number of LTCs	Data sourced from the GP Patient Survey (GPPS).

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
2.1 Proportion of people feeling supported to manage their condition	N	A	A	A	N	A	N	A	A	A	A	N	A	N	N	N	Number of LTCs	Data sourced from the GP Patient Survey (GPPS).
2.2 Employment of people with long-term conditions.	N	A	N	A	N	N	A	A	A	A	A	I	I	N	N	N	Unitary Authority/ Local Area	Data sourced from the Labour Force Survey (LFS).

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)	A*	A*	A	A*	N	N	N	A	N	N	A	N	N	N	N	N	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/. As geographic information is not available for all patients breakdowns by lower and upper tier local authority as well as region should be treated with caution. The percentage of records for each quarter where a local authority or a region could not be classified are also published. A breakdown by ethnicity was previously published when population estimates based on the 2001 Census where used as the denominator. However, this changed with moving to populations based on the 2011 Census. ONS advised us that they stopped producing any Population Estimates by Ethic Group (PEEGs) until they had completed an assessment of the 2001 PEEGs estimates against the 2011 estimates. This work is currently still ongoing. It is estimated that the ethnicity breakdown will be reinstated once ONS advises what PEEGs are appropriate to use. A breakdown by deprivation was also previously published using 2001 LSOA boundaries. With the move to 2011 LSOA boundaries this breakdown had to be taken out as an updated 2011 LSOA field (to derive deprivation deciles) is currently not included in the HES dataset. As soon as this is made available (potentially in 2015) we are able to start producing the deprivation breakdown again.

		Sub-national breakdown				**Equality and Inequality Strands (National Only)**											**Other HSCIC Breakdowns**	**Further Information**
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	N	A*	A	A*	N	N	N	A	N	N	A	N	N	N	N	N	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 2.3.ii is indicator 2.7 in the CCG OIS https://indicators.ic.nhs.uk/webview/. As geographic information is not available for all patients breakdowns by lower and upper tier local authority as well as region should be treated with caution. The percentage of records for each quarter where a local authority or a region could not be classified are also published. A breakdown by ethnicity was previously published when population estimates based on the 2001 Census where used as the denominator. However, this changed with moving to populations based on the 2011 Census. ONS advised us that they stopped producing any Population Estimates by Ethic Group (PEEGs) until they had completed an assessment of the 2001 PEEGs estimates against the 2011 estimates. This work is currently still ongoing. It is estimated that the ethnicity breakdown will be reinstated once ONS advises what PEEGs are appropriate to use. A breakdown by deprivation was also previously published using 2001 LSOA boundaries. With the move to 2011 LSOA boundaries this breakdown had to be taken out as an updated 2011 LSOA field (to derive deprivation deciles) is currently not included in the HES dataset. As soon as this is made available (potentially in 2015) we are able to start producing the deprivation breakdown again.
2.4 Health-related quality of life for carers	N	A*	A*	A*	N	A	N	A	A	A	A	N	A	N	N	N		Data sourced from the GP Patient Survey (GPPS). Subnational breakdowns should be interpreted with caution due to the possible small number of cases.
2.5i Employment of people with mental illness	N	A	N	A	N	N	A	A	A	A	A	I	I	N	N	N	Unitary Authority/ Local Area, Condition	Data sourced from the Labour Force Survey (LFS).
2.5.ii Health-related quality of life for people with mental illness	Possible breakdowns to be assessed once the indicator is developed																	

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
2.6.i Estimated diagnosis rate for people with dementia	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N		No further breakdowns will be published because the rate is based on estimated prevalence and is not considered robust enough to disaggregate further
2.6.ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life	Possible breakdowns to be assessed once the indicator is developed																	
2.7 Health-related quality of life for people with three or more long-term conditions	Possible breakdowns to be assessed once the indicator is developed																	

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & 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	A*	N	N	N	A	N	N	A	N	N	N	N	N	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, therefore not allowing to calculate a rate of admissions per 100,000 population. As geographic information is not available for all patients breakdowns by lower and upper tier local authority as well as region should be treated with caution. The percentage of records for each quarter where a local authority or a region could not be classified are also published. A breakdown by ethnicity was previously published when population estimates based on the 2001 Census where used as the denominator. However, this changed with moving to populations based on the 2011 Census. ONS advised us that they stopped producing any Population Estimates by Ethic Group (PEEGs) until they had completed an assessment of the 2001 PEEGs estimates against the 2011 estimates. This work is currently still ongoing. It is estimated that the ethnicity breakdown will be reinstated once ONS advises what PEEGs are appropriate to use. A breakdown by deprivation was also previously published using 2001 LSOA boundaries. With the move to 2011 LSOA boundaries this breakdown had to be taken out as an updated 2011 LSOA field (to derive deprivation deciles) is currently not included in the HES dataset. As soon as this is made available (potentially in 2015) we are able to start producing the deprivation breakdown again.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
3b Emergency readmissions within 30 days of discharge from hospital	N	A	A	A*	N	A	N	D	D	N	A	N	N	N	N	N		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 3b is indicator 3.2 in the CCG OIS https://indicators.ic.nhs.uk/webview/. Provider breakdown is not available as readmissions are defined as emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge, and therefore can cut across providers. Local authority is not available for all patients, so should be treated with caution. The percentages of records for each quarter that are not classified are also published.
3.1i Total health gain as assessed by patients for elective procedures: physical health related procedures	Possible breakdowns to be assessed once the indicator is developed.																	
3.1ii Total health gain as assessed b patients for elective procedures: psychological therapies	Possible breakdowns to be assessed once the indicator is developed.																	
3.1iii Recovery in quality of life for patients with mental illness	Possible breakdowns to be assessed once the indicator is developed.																	

		Sub-national breakdown				**Equality and Inequality Strands (National Only)**											**Other HSCIC Breakdowns**	**Further Information**
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)	N	A*	A	A*	N	N	N	A	N	N	A	N	N	N	N	N	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/. As geographic information is not available for all patients breakdowns by lower and upper tier local authority as well as region should be treated with caution. The percentage of records for each quarter where a local authority or a region could not be classified are also published. A breakdown by ethnicity was previously published when population estimates based on the 2001 Census where used as the denominator. However, this changed with moving to populations based on the 2011 Census. ONS advised us that they stopped producing any Population Estimates by Ethic Group (PEEGs) until they had completed an assessment of the 2001 PEEGs estimates against the 2011 estimates. This work is currently still ongoing. It is estimated that the ethnicity breakdown will be reinstated once ONS advises what PEEGs are appropriate to use. A breakdown by deprivation was also previously published using 2001 LSOA boundaries. With the move to 2011 LSOA boundaries this breakdown had to be taken out as an updated 2011 LSOA field (to derive deprivation deciles) is currently not included in the HES dataset. As soon as this is made available (potentially in 2015) we are able to start producing the deprivation breakdown again.
3.3 Survival from major trauma	Possible breakdowns to be assessed once the indicator is developed.																	Data to be sourced from the Trauma Audit Research Network (TARN) database.
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.																	

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
3.5.i Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 30 days	N	A	A	A	A	A	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 Proportion of patients with hip fractures recovering to their previous levels of mobility/walking ability at 120 days	N	A	A	A	A	A	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	All breakdowns also by gender	Data sourced from the Adult Social Care Combined Activity (ASC-CAR) data. Data for this indicator are published in the HSC IC Indicator Portal under the heading of Adult Social Care Outcomes Framework (ASCOF).
3.6ii Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital	N	A	N	A	N	N	N	A	N	N	A	N	N	N	N	N	All breakdowns also by gender	Data sourced from the Adult Social Care Combined Activity (ASC-CAR) data. Data for this indicator are published in the HSC IC Indicator Portal under the heading of Adult Social Care Outcomes Framework (ASCOF).
3.7.i Decaying teeth	Possible breakdowns to be assessed once the indicator is developed																	
3.7.ii Tooth extractions in secondary care for children under 10	Possible breakdowns to be assessed once the indicator is developed																	
Domain 4. Ensuring that people have a positive experience of care																		
4a.i Patient experience of GP services	N	A*	A	A	A	A	N	A	A*	A	A*	N	A	N	N	N		Data sourced from the GP Patient Survey (GPPS). CCG and Provider breakdowns available from http://www.gp-patient.co.uk/surveyresults Interpretation of difference is complicated by likely systematic differences in gratitude bias between different groups of respondent.

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
4a.ii Patient experience of Out of hours GP services	N	A*	A	A	A	A	N	A	A*	A	A*	N	A	N	N	N		Data sourced from the GP Patient Survey (GPPS) CCG and Provider breakdowns available from http://www.gp-patient.co.uk/surveyresults Interpretation of difference is complicated by likely systematic differences in gratitude bias between different groups of respondent.
4a.iii Patient experience of NHS dental services	N	A*	A	A	N	A	N	A	A*	D*	A*	N	D*	N	N	N		Data sourced from the GP Patient Survey (GPPS) CCG breakdown available from http://www.gp-patient.co.uk/surveyresults Interpretation of difference is complicated by likely systematic differences in gratitude bias between different groups of respondent.
4b Patient experience of hospital care	N	I	A	N	A	N	N	I	A	I	I	I	I	N	N	N	Long Standing Condition	Data sourced from the Inpatient Survey.
4c Friends and Family test	Possible breakdowns to be assessed once the indicator is developed																	
4d.i Patient experience categorised as poor or worse: primary care	Possible breakdowns to be assessed once the indicator is developed																	
4d.ii Patient experience categorised as poor or worse: hospital care	Possible breakdowns to be assessed once the indicator is developed																	
4.1 Patient experience of outpatient services	N	I	N	N	A	N	N	I	I	N	I	I	N	N	N	N		Data sourced from the Outpatient Survey.
4.2 Responsiveness to in-patients' personal needs	N	I	A	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	N	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	A	A	A	A	A	N	A	A	A	A	N	A	N	N	N		Data sourced from the GP Patient Survey (GPPS). CCG and provider breakdowns available from http://www.gp-patient.co.uk/surveyresults

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
4.4ii Access to NHS dental services	N	A	A	A	N	A	N	A	A	D*	A	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 Bereaved carers' views on the quality of care in the last 3 months of life	N	I	N	I	I	I	N	D	I	I	D	N	N	N	N	N		Data sourced from the National Bereavement Survey (VOICES).
4.7 Patient experience of community mental health services	Possible breakdowns to be assessed once the indicator is developed																	
4.8 Children and young people's experience of inpatient services	Possible breakdowns to be assessed once the indicator is developed																	
4.9 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 Deaths attributable to problems in care	Possible breakdowns to be assessed once the indicator is developed																	
5b Severe harm attributable to problems in healthcare	Possible breakdowns to be assessed once the indicator is developed																	
5.1 Incidence of hospital-related venous thromboembolism (VTE)	N	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I		

		Sub-national breakdown				Equality and Inequality Strands (National Only)											Other HSCIC Breakdowns	Further Information
	International comparisons	Region	CCG	Local Authority	Provider	Deprivation	Socio-economic group	Age	Ethnicity	Religion or belief	Gender	Disability	Sexual orientation	Marriage/Civil Partnership	Gender Reassignment	Pregnancy & Maternity	Published on HSCIC Indicator portal	
5.2.i Incidence of healthcare associated MRSA infection	N	N	A*	I	A*	I	N	I	N	N	I	N	N	N	N	N		Data sourced from the Mandatory surveillance of Meticillin 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
5.2.ii Incidence of healthcare associated C. difficile infection	N	N	A*	I	A*	I	N	I	N	N	I	N	N	N	N	N		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 Hip fractures from falls during hospital care	Possible breakdowns to be assessed once the indicator is developed																	
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		Data sourced from the National Neonatal Research Database & ONS.
5.6 Patient safety incidents reported	N	D*	D	N	A*	N	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

Glossary

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 responses 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.
www.hscic.gov.uk/socialcarecollections2014

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 set of outcome measures, which have been agreed to be of value both nationally and locally for demonstrating the achievements of adult social care.
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 that 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 end for emergency hospital admission.

Care.data

Care.data is a new programme where information on GP records will be shared with the Health and Social Care Information Centre (HSCIC). This is to help the NHS plan and improve patient care for the whole country.
www.patient.co.uk/health/caredata-sharing-your-information

Care Quality Commission (CQC)

The Care Quality Commission (CQC) monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and publish these findings, including performance ratings to help people choose care.
www.cqc.org.uk

Clinical Commissioning Groups (CCGs)

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 2014 survey took the views of more than 13,500 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 September and November 2013, achieving a response rate of 29%.
http://www.cqc.org.uk/content/community-mental-health-survey-2014

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.
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. Also see Glossary entry ‘Spell’.

EQ-5D

EQ-5D is a standardised instrument for use as a measure of health outcome. Applicable to a wide range of health conditions and treatments, the EQ-5D health questionnaire provides a simple descriptive profile and a single index value for health status.
http://www.euroqol.org/home.html

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 Extraction Service (GPES)

The General Practice Extraction Service (GPES) is a centrally managed service that extracts information from general practice IT clinical systems for a wide range of purposes. It also forms part of the new process for providing payments to GPs and clinical commissioning groups (CCGs).
http://www.hscic.gov.uk/gpes

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 1.32 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 2.64 million different patients in England are sent the questionnaire, and the overall response rate in 2013/14 was 34%.
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.
www.hscic.gov.uk/hes

Health and Social Care Information Centre (HSCIC)

The Health and Social Care Information Centre (HSCIC) is an executive non-departmental public body of the Department of Health. Previously known as the NHS Information Centre, HSCIC is designed to be England's central, authoritative source of health and social care information.
www.hscic.gov.uk

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.

Healthcare Associated Infections (HCAI)

HCAI are infections resulting from medical care or treatment in hospital, nursing homes or the patient's own home.
http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI

Hospital Episode 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.

ICD-10 Codes

See Glossary entry for 'International Classification of Diseases'.

Index of Multiple Deprivation (IMD)

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.
www.gov.uk/government/collections/english-indices-of-deprivation

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.
www.isb.nhs.uk/library/standard/239

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).

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 2013 and January 2014. Over 62,000 inpatients aged 16 and over responded to the survey, a response rate of 49%.
http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2013

International Classification of Diseases (ICD)

The ICD is published by the World Health Organisation (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 illness, 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 Organisation (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 from 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 a 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).

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 Infections (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.

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

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, 2010 and 2013. Over 23,000 women who had given birth in January or February 2013 responded to the 2013 survey between April and August 2013, a response rate of 46%. 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.
http://www.cqc.org.uk/content/maternity-services-survey-2013

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

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'.

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/content/outpatient-survey-2011

Patient Reported Outcome Measure (PROMs)

Patient Reported Outcome Measure (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 2014 was 76.6%.
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.
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

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

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’.

Venous Thromboembolism (VTE)

Venous thromboembolism (VTE) is a condition where a blood clot forms in a vein. This is most common in a leg vein, where it’s known as deep vein thrombosis (DVT). A blood clot in the lungs is called pulmonary embolism (PE).
http://www.nhs.uk/Conditions/Thrombosis/Pages/Introduction.aspx

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