The NHS Outcomes Framework 2013/14

Technical Appendix

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	For Information
Gateway Reference	18326
Title	The NHS Outcomes Framework 2013/14 - Technical Appendix
Author	The Department of Health
Publication Date	**13 November 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Allied Health Professionals, GPs, ALBs and Clinical Commissioning Groups
Circulation List	Directors of PH, PCT PEC Chairs, Directors of Finance, Communications Leads, Emergency Care Leads, Clinical Commissioning Groups
Description	This is an updated version of the NHS Outcomes Framework Technical Appendix 2012/13.
Cross Ref	The NHS Outcomes Framework 2012/13
Superseded Docs	
Action Required	N/A
Timing	**N/A**
Contact Details	NHS Outcomes Framework Policy Department of Health 79 Whitehall London SW1A 2NS
For Recipient's Use	

Contents

Introduction

This technical appendix sets out the detailed definitions and data sources for each indicator, grouped under the five domains of the NHS Outcomes Framework. Each section has an introduction that describes the domain, followed by detailed templates for each indicator, including a description of where and when the source data for the indicators are published.

Where available, the data for individual indicators have been published on the NHS Information Centre Indicator Portal (https://indicators.ic.nhs.uk/webview/). This website contains not only NHS Outcomes Framework indicators, but wider health and social care indicators, including social care and GP practice data. The majority of indicators in the NHS Outcomes Framework are now available on this site, with historical time series[1] and disaggregations. The data are in a raw format to allow subsequent analysis. The site is updated regularly with new data as they become available. As new placeholder indicators are developed, these will also be added to this site. This technical appendix signals for each indicator if data are published on the NHS IC Indicator Portal, at the time of writing.

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

- *Live* – Indicator development is complete, and as they becomes available, data are placed on the Indicator Portal.
- *In development* – Some elements of the indicator definition require further development,
- *Placeholder* – A need to measure this outcome has been identified, and one or more potential sources have been identified, but an indicator is yet to be developed, and publication on the portal is not imminent.

The Government's Mandate to the NHS Commissioning Board asks the Board to make continuous progress against all the five domains and the outcome indicators in the NHS Outcomes Framework. The NHS Commissioning Board must report on its progress each year, and the Government will publish an annual assessment of the Board's performance.

We will investigate, with the NHS Commissioning Board and the Outcomes Framework Technical Advisory Group, how we can assess progress at both indicator and domain level, for example by:

- ***Estimation of the underlying trend for each indicator as a basis for assessing gains attributable to improvements in the health and social care system.*** Outcomes are shaped both by the current quality of health and social care (H&SC) services and by historic and external determinants. In order to identify what change in outcomes might be attributable to changes in the quality of H&SC services, methods will be investigated for the estimation of the trajectory of outcomes that would have been expected based upon ***past*** developments of H&SC and any ***contemporary non-H&SC*** drivers of outcome, were the quality of ***current*** H&SC services held constant. This work will enable assessment of progress against individual indicators attributable to changes in the quality of ***current*** H&SC services. (For example, where there is an adverse underlying trend in an indicator, abating that trend would represent progress attributable to H&SC.) This analysis could draw upon aspects of the methodological work set out in the Technical Annex which accompanied the consultation on the draft

---

[1] Trend data are also presented in *NHS Outcomes Framework: a technical annex about setting levels of ambition* published at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition/

mandate to the NHS Commissioning Board, which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition.

- ***Assessment of aggregate improvement for Domain indicators using a Domain metric of improvement***. If it is possible to attribute improvement in each outcome area to current improvements in the quality of H&SC services, it may also be possible to construct a domain level measure of progress. This is important in order to allow assessment of progress for a domain as a whole to give appropriate weight to progress in individual indicators.

Additionally, for each domain, this document explores the availability of:

Inequalities metrics: For some domains it is possible to specify metrics of inequality; for others, work is in progress to do so. Where metrics are available, a further step would be to assess attributable progress in reducing inequality on a similar basis to that employed for assessment of aggregate progress, by estimation of the underlying trend and considering achievement relative to that trend.

International comparisons: For some domains and some indicators, international comparisons are already available and can serve to track progress in the contribution of the H&SC system independently of other factors that may drive outcomes in a similar way across comparator countries.

Separately, equality assessments for each domain and indicator, employing available disaggregation, can be used to support the health equality and inequalities duties set out in the Health and Social Care Act including consideration of variation by the equality characteristics.[2] A separate Equality analysis has been published alongside the NHS Outcomes Framework 2013/14 which updates the previous Equality analysis published with the NHS Outcomes Framework last year.[3]

This technical appendix also sets out which indicators are shared with or complement indicators in the Public Health Outcomes Framework and Adult Social Care Outcomes Framework. Shared indicators are those where there is a shared responsibility between the named frameworks and the indicator is exactly the same in each framework. Complementary indicators are those where there are different indicators in the named frameworks that look at the same issue from complementary perspectives. In both cases, joint contributions will be required to deliver improved outcomes across Health and Social Care.

There have been a number of changes to indicators since the last technical appendix. These are summarised in the introductory section to the NHS Outcomes Framework 2013/14 to which this document is appended.

---

[2] Gender, Age, Disability, Race, Sexual Orientation, Religion and Belief, Marriage and Civil Partnership, Gender Reassignment, Pregnancy and Maternity

[3] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_122944

Preventing people from dying prematurely

Indicator Structure

1.1 Domain 1, ***Preventing people from dying prematurely***, comprises two *overarching indicators* and seven *improvement areas*, summarised below.

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

1.2 The overarching indicators cover Potential Years of Life Lost from causes considered amenable to healthcare, and life expectancy at 75.

1.3 Deaths from causes considered ‘amenable’ to health care (as defined for indicators 1a.i and ii below) are premature deaths that should not occur in the presence of timely and effective health care. These indicators have been chosen to capture how successfully the NHS is meeting its objective to prevent people from dying prematurely where it can make a difference. With the exception of a very small number of deaths at age 75 and over, indicators 1a.i and ii cover the ages 0-74 because it is generally considered that most premature deaths occur in this age group, and because it is more difficult to determine the cause of death in older people because they often have multiple co-morbidities. However, 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 this domain. This indicator captures all deaths at ages 75 and over.

1.4 The improvement areas are of two sorts:

- Sub-indicators. Indicators which are wholly or substantially covered by the overarching indicators. Indicators 1.1, 1.2 and 1.4 relate to under 75 mortality from major diseases – CVD, respiratory diseases and cancer. These account for around 90% of the disease burden amenable to health care. Cancer survival is 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. Trends in these outcomes, therefore, provide a useful initial analysis of what accounts for progress in the overarching indicators. Amenable outcomes under indicators 1.5 and 1.7, excess mortality rate in adults respectively with serious mental illness and with a learning disability, are also largely captured in overarching indicator 1a. In this case, the reason for inclusion of separate indicators is concern that poor outcomes for these groups may reflect inequity.
- Complementary Indicators. Liver disease other than Hepatitis C is not counted as amenable under the ONS definition, and neonatal mortality up to the age of 28 days is not included in indicator 1a because cause of death is not classified by ICD-10 code for deaths up to 28 days after live birth. Yet many deaths up to 28 days and stillbirths, and some elements of liver mortality are amenable to healthcare. Therefore indicators 1.3 and 1.6.ii. complement the overarching indicators.

1.5 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 reckoned 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, all shared with the Public Health Outcomes Framework, reflects the contribution that the NHS can make to outcomes where there is shared responsibility with Public Health. The NHS contribution will include encouraging healthy behaviours and uptake of screening and vaccination options, in addition to providing appropriate diagnosis, care planning and treatment.

1.6 Together, the overarching indicators and the improvement indicators provide a picture of the NHS's contribution to preventing people from dying prematurely.

Work in Progress

1.7 The main issues pertaining to Domain 1 upon which work is continuing are:

- In the short term, replacement of existing cancer survival measures with aggregate survival measures respectively for all cancers in adults and children and for major cancers (colorectal, breast and lung) in adults, to allow for disaggregation by CCG, and to include rarer cancers. Over a longer period, work with the cancer registries to obtain data on the stage of disease at which patients are diagnosed, so as to control for sources of bias in estimates of survival**.** Initial work with data from a number of cancer registries is in progress to estimate the percentage of cancers diagnosed and their survival rates at each stage. (Indicator 1.4)

- Development of an indicator of the excess under 60 mortality rate in adults with a learning disability compared with the rate in the general population. (Indicator 1.7)
- Review of the best way to ensure that mortality outcomes for children are adequately captured and appropriately presented within Domain 1 as a whole.

Inequality

1.8 Outcomes for the overarching and complementary indicators should be assessed from an inequalities perspective.

1.9 One approach to measuring inequality with respect to an individual indicator of outcome is to assess the extent to which variation in outcome appears to be driven by social deprivation. This can be captured by what is known as a Slope Index of Inequality (SII) (see glossary).

1.10 The SII summarises the inequality in a specific outcome across England that is thought to be attributable to social inequality. It represents the gap in the outcome in question between the least and most deprived areas in England, to the extent that this reflects the relationship between the specific outcome and deprivation scores (the latter relationship being established by a statistical analysis of small area data for the whole population). It is assumed in general that the relationship is linear, so that linear regression is the appropriate estimation technique.

1.11 The use of the SII to measure inequality attributable to social circumstances relies upon an assumption that correlation with deprivation implicates deprivation as a causal factor behind inequality of outcome. It is precisely on this assumption that it is assumed that this inequality should be addressed, and that it should be amenable to improvement.

1.12 The Slope Index of Inequality, capturing correlation of outcomes with small-area deprivation, has been assessed as suitable for measuring inequalities in indicators 1a, 1b and 1.6ii, and it is proposed that data will be published on the NHS IC indicator portal.

1.13 Indicators 1.5 and 1.7 referred to above also capture an important aspect of inequality.

1.14 Further discussion of inequalities issues is included in the equalities assessment which accompanies the NHS Outcomes Framework 2013/14.

Drivers of the outcome

1.15 The most general external driver of the outcomes in Domain 1 is the incidence of the diseases themselves. Good estimates of incidence are not generally available so NHS performance needs to be judged in light of what can be discovered about changing trends in incidence.

1.16 Increased incidence can have the double effect of increasing the number of people at risk of death, and dilutes the resources available to treat these diseases.

1.17 For contributions from public health and social care, the impact upon outcomes, particularly disease incidence, is often lagged by a number of years, so that at the time of incidence such impacts are beyond the control of the NHS. For some, though, the effect may be contemporaneous – in either case, the NHS has a responsibility to work with public health and social care services jointly to improve outcomes.

1.18 Further details of the drivers of the outcomes in Domain 1, and initial work on methodology for disentangling contemporary health and social care impacts from historic and external drivers, are set out in the Technical Annex which accompanied the consultation on the draft mandate to the NHS Commissioning Board which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition.

International Comparisons

1.19 International comparisons for outcomes in this domain are plentiful. However, indicator definitions vary somewhat among different countries.

1.20 Generally, international comparisons of premature mortality from defined causes by ICD-10 code are available from datasets published by the Organisation for Economic Co-operation and Development (OECD) and the World Health Organisation (WHO). Recent international comparisons of 5-year cancer survival for breast and colorectal cancer are available in OECD's Health at a Glance bi-annual report, and from ad-hoc academic research.

1.21 International comparisons of infant and neonatal mortality rates are published by WHO and OECD, but some of the international variation in these rates may be due to variations among countries in how they register 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. There is currently no international comparison available of premature mortality in people with serious mental illness.

1.22 Details of historic trends and international comparisons of Domain 1 indicators are included in the Technical Annex which accompanied the consultation on the draft mandate to the NHS Commissioning Board, which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition.

Indicators shared with the Public Health Outcomes Framework

1.23 Improvements in Health and Social Care will not be delivered by the NHS alone. Responsibility for delivery of some of the Domain 1 indicators are shared with the Public Health Outcomes Framework (PHOF). These indicators are 1.1, 1.2, 1.3, 1.4, 1.5, 1.6.i.

1a.i and 1a.ii. Potential Years of Life Lost (PYLL) from causes considered amenable to health care: i. adults (age 20+) and ii. children and young people (under 20 years)

Outcome sought

Reduced PYLL from causes amenable to health care.

Status

1a.i Live 1a.ii In development

Updated definition

This indicator is split into two parts:
1a.i Adults (age 20+)
1a.ii Children and young people (under 20 years)

Indicator description: Rate of Potential Years of Life Lost (PYLL) from causes considered amenable to health care.

Indicator construction: Causes considered amenable to health care are those from which premature deaths should not occur in the presence of timely and effective health care. The concept of ‘amenable’ mortality generally relates to deaths under age 75, due to the difficulty in determining cause of death in older people who often have multiple morbidities. The Office for National Statistics (ONS) produces mortality data by cause, which excludes deaths under 28 days (for which cause of death is not classified by ICD-10 codes). These indicators therefore relate to deaths between 28 days and 74 years of age inclusive.

ONS consulted on a proposed list of causes considered amenable to healthcare in February 2011 and updated the list in April 2012 (see table below). ONS’s definition and related data for 2010 for England and Wales can be found at:
http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/2010/stb-avoidable-mortality.html

ICD–10 codes	**Condition group and cause**	**Age range included**
Infections		
A15–A19, B90	Tuberculosis	0–74
A38–A41, A46, A48.1, B50–B54, G00, G03, J02, L03	Selected invasive bacterial and protozoal infections	0–74
B17.1, B18.2	Hepatitis C	0 – 74
B20-B24	HIV/AIDS	All
Neoplasms		
C18-C21	Malignant neoplasm of colon and rectum	0-74
C43	Malignant melanoma of skin	0–74
C50	Malignant neoplasms of breast	0–74
C53	Malignant neoplasm of cervix uteri	0–74
C67	Malignant neoplasm of bladder	0–74
C73	Malignant neoplasm of thyroid	0–74

	gland	
C81	Hodgkin’s disease	0–74
C91, C92.0	Leukaemia	0–44
D10–D36	Benign neoplasms	0–74
Nutritional, endocrine and metabolic		
E10–E14	Diabetes mellitus	0–49
Neurological disorders		
G40-G41	Epilepsy and status epilepticus	0–74
Cardiovascular diseases		
I01-I09	Rheumatic and other valvular heart disease	0–74
I10–I15	Hypertensive diseases	0–74
I20–I25	Ischaemic heart disease	0–74
I60–I69	Cerebrovascular diseases	0–74
Respiratory diseases		
J09–J11	Influenza (including swine flu)	0–74
J12–J18	Pneumonia	0–74
J45– J46	Asthma	0–74
Digestive disorders		
K25-K28	Gastric and duodenal ulcer	0–74
K35–K38, K40–K46, K80–K83, K85, K86.1-K86.9, K91.5	Acute abdomen, appendicitis, intestinal obstruction, cholecystitis / lithiasis, pancreatitis, hernia	0–74
Genitourinary disorders		
N00-N07, N17-N19, N25-N27	Nephritis and nephrosis	0–74
N13, N20–N21, N35, N40, N99.1	Obstructive uropathy & prostatic hyperplasia	0–74
Maternal & infant		
P00–P96, A33	Complications of perinatal period	All
Q00–Q99	Congenital malformations, deformations and chromosomal anomalies	0–74
Unintentional injuries		
Y60-Y69, Y83-Y84	Misadventures to patients during surgical and medical care	All

One of the criteria for inclusion of a condition in the ONS definition was that the number of annual deaths caused by the condition should exceed 100. This has meant that conditions considered amenable specifically in children have been excluded, for example respiratory diseases other than pneumonia, influenza and asthma. The table below lists the conditions that were excluded on the grounds of small numbers, rather than amenability:

ICD–10 codes	**Condition group and cause**	**Ages included**	**Number of deaths, ages <20, 2010**
Infections			
A00–A09	Intestinal infectious diseases	0–14	3
A35– A36, A80	Other infections (diphtheria, other tetanus, acute poliomyelitis)	0–74	0
A37	Whooping cough	0–14	1
B05	Measles	1–14	0
Neoplasms			
C44	Other malignant neoplasms of skin	0–74	1
C62	Malignant neoplasm of testis	0–74	2
C54–C55	Malignant neoplasm of corpus uteri and uterus unspecified	0–44	0
Nutritional, endocrine and metabolic			
E00–E07	Disorders of thyroid gland	0–74	0
Respiratory diseases			
J00–J08, J20–J39, J47 – J99	Other respiratory	1–14	70
Maternal & infant			
O00 – O99	Pregnancy, childbirth and the puerperium	All	2

Indicator 1a.ii will include deaths under age 20 from the above conditions as well as those in the published ONS definition.

Indicator format: European Age-Standardised Potential Years of Life Lost rate per 100,000 population.

The methodology for calculating the PYLL rate uses the average age-specific period life expectancy (LE) for each five-year age band for the relevant year as the age to which a person in that age band who died from one of the amenable causes might be expected to live in the presence of timely and effective healthcare. The age-specific period LE is different for each year.

Period life expectancy is the average number of additional years a person can be expected to live for, if he or she experiences the age-specific mortality rates of the given time period for the rest of his or her life.

	Methodology published by ONS: http://www.ons.gov.uk/ons/rel/lifetables/interim-life-tables/2008-2010/rft-ilt-eng-2008-10.xls
Data source	Office for National Statistics: http://www.ons.gov.uk/ons/rel/subnational-health4/avoidable-mortality-in-england-and-wales/2010/stb-avoidable-mortality.html and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency**: Annual (calendar year). **Timing**: 2011 mortality data available from winter 2012/13. The ONS Statistical Bulletin on avoidable mortality for 2011 will be published in March 2013. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	Following the ONS consultation on avoidable mortality, there is now a defined list of causes of death considered amenable to healthcare, which is used to calculate indicator 1a.i. Indicator 1a.ii will use an extended definition for PYLL from amenable causes in children and young people under 20.
Historical comparisons	Source data available as a continuous time series from at least 1993, enabling the construction of this indicator from that year.
Data published on the IC indicator portal	Annual data from 2001 to 2010 for males and females at national level, broken down by cause group, (for indicator 1a prior to changes outlined above).

1b.i and 1b.ii Life Expectancy at 75: i. males and ii. females	
Outcome sought	Increased life expectancy at age 75, for males and females separately.
Status	Live
Updated definition	**Indicator description:** Period life expectancy at age 75 for (i) males and (ii) females **Indicator construction:** Period life expectancy is the average number of additional years a person can be expected to live for, if he or she experiences the age-specific mortality rates of the given time period for the rest of his or her life. The period life expectancy at age 75 for years to 2010 is based on historical mortality rates for years to 2010. Methodology published by ONS: http://www.ons.gov.uk/ons/rel/lifetables/interim-life-tables/2008-2010/rft-ilt-eng-2008-10.xls

	Indicator format: Number of years
Data source	ONS: Period expectations of life (years) based on historical mortality rates from 1981 to 2010 and assumed calendar year mortality rates from the 2010-based principal projections: http://www.ons.gov.uk/ons/rel/lifetables/period-and-cohort-life-expectancy-tables/2010-based/rft-engperiod10.xls
Reporting schedule for data source	**Frequency:** Every 2 calendar years. ONS use mortality and population data to produce single year Life Expectancy figures for individual ages on a 2-year basis, as part of ONS's 2-yearly population projections. **Timing:** 2012-based projections will be available in Autumn 2013.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Historical data available from ONS from 1981 to 2010, with projections to 2060: http://www.ons.gov.uk/ons/rel/lifetables/period-and-cohort-life-expectancy-tables/2010-based/rft-engperiod10.xls Latest published data are 2010-based.
Data published on the IC indicator portal	Annual data from 1990 to 2010 for males and females at national level; 3-year average annual data from 1991-93 to 2008-10 for males and females at regional and local level and 3-year average annual data from 2001-03 to 2008-10 for males and females by deprivation quintile.

1.1 Under 75 mortality rate from cardiovascular disease	
Outcome sought	Reduced premature mortality from cardiovascular disease
Status	Live
Updated definition	**Indicator description:** Mortality rate from cardiovascular disease, ages under 75, per 100,000 population. **Indicator construction:** ***Numerator*** Number of deaths under 75 from cardiovascular disease. Cardiovascular disease is defined in terms of the following ICD-10 codes: All ICD-10 codes in Chapter IX - Diseases of the circulatory system (I00-I99) ***Denominator***

	Resident population under 75 years. ONS mortality data by cause excludes deaths under 28 days for which cause of death is not classified by ICD-10 code. This indicator therefore relates to deaths between 28 days and 74 years of age inclusive. **Indicator format** Directly age-standardised rate per 100,000 population (using European Standard Population) – (*numerator/denominator)*100,000* This is a shared indicator with the Public Health Outcomes Framework.
Data source	ONS: mortality data by cause (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/dr-table5-2010.xls ONS: mid-year population estimates http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847 and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 mortality data will be available from winter 2012/13. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	- Historical time series available from NHS Information Centre Indicator Portal from 1993 to 2010 for England and geographical breakdown: https://indicators.ic.nhs.uk/download/NCHOD/Data/06A_076DRT0074_10_V1_D.xls - Source data available as a continuous time series from at least 1993.
Data published on the IC indicator portal	Annual data from 2001 to 2010 for persons, males and females at England, Care Trust, Local Authority, PCT, Region and SHA level; 2001 to 2010 England data for males and females by 5-year age-band; 2010 data for persons, males and females at County and ONS Classification level

1.2 Under 75 mortality rate from respiratory disease	
Outcome sought	Reduced premature mortality from respiratory disease.
Status	Live
Updated definition	**Indicator description:** Mortality rate from respiratory disease, ages under 75, per 100,000 population. **Indicator construction:** ***Numerator*** Number of deaths under 75 from respiratory disease Respiratory disease is defined in terms of the following ICD-10 codes: All ICD-10 codes in Chapter X - Diseases of the respiratory system (J00-J99) ***Denominator*** Resident population under 75 years ONS mortality data by cause excludes deaths under 28 days for which cause of death is not classified by ICD-10 codes. This indicator therefore relates to deaths between 28 days and 74 years of age inclusive. **Indicator format** Directly age-standardised rate per 100,000 population (using European Standard Population) – (*numerator/denominator)*100,000* This is a shared indicator with the Public Health Outcomes Framework.
Data source	ONS: mortality data by cause (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/dr-table5-2010.xls ONS: mid-year population estimates: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847 and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 mortality data will be available from winter 2012/13. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None

Historical comparisons	Source data available as a continuous time series from at least 1993, enabling the construction of this indicator from that year.
Data published on the IC indicator portal	Annual data from 2001 to 2010 for persons, males and females at England, Care Trust, Local Authority, PCT, Region and SHA level; 2001 to 2010 England data for males and females by 5-year age-band; 2010 data for persons, males and females at County and ONS Classification level

<table>
<tr><th colspan="2">1.3 Under 75 mortality rate from liver disease</th></tr>
<tr><td>Outcome sought</td><td>Reduced premature mortality from liver disease.</td></tr>
<tr><td>Status</td><td>Live</td></tr>
<tr><td>Updated definition</td><td>Indicator description: Mortality rate from liver disease, ages under 75, per 100,000 population.

Indicator construction:
<i>Numerator</i>
Number of deaths under 75 from liver disease

Definitions of liver disease in terms of the following ICD-10 codes:

<table>
<tr><td>K70</td><td>Alcoholic liver disease</td></tr>
<tr><td>K71</td><td>Toxic liver disease</td></tr>
<tr><td>K72</td><td>Hepatic failure, not elsewhere classified</td></tr>
<tr><td>K73</td><td>Chronic hepatitis, not elsewhere classified</td></tr>
<tr><td>K74</td><td>Fibrosis and cirrhosis of liver</td></tr>
<tr><td>K75</td><td>Other inflammatory liver diseases</td></tr>
<tr><td>K76</td><td>Other diseases of liver</td></tr>
<tr><td>K77</td><td>Liver disorders in diseases classified elsewhere</td></tr>
<tr><td>B15</td><td>Acute hepatitis A</td></tr>
<tr><td>B16</td><td>Acute hepatitis B</td></tr>
<tr><td>B17</td><td>Other acute viral hepatitis</td></tr>
<tr><td>B18</td><td>Chronic viral hepatitis</td></tr>
<tr><td>B19</td><td>Unspecified viral hepatitis</td></tr>
<tr><td>C22</td><td>Malignant neoplasm of liver and intrahepatic bile ducts</td></tr>
<tr><td>I81</td><td>Portal vein thrombosis</td></tr>
<tr><td>I85</td><td>Oesophageal varices</td></tr>
<tr><td>T86.4</td><td>Liver transplant failure and rejection</td></tr>
</table>

<i>Denominator</i>
Resident population under 75 years

ONS mortality data by cause excludes deaths under 28 days for which cause of death is not classified by ICD-10 codes. This indicator therefore relates to deaths between 28 days and 74 years of age inclusive.

Indicator format</td></tr>
</table>

	Directly age-standardised rate per 100,000 population (using European Standard Population) – (*numerator/denominator)*100,000* This is a shared indicator with the Public Health Outcomes Framework.
Data source	ONS: mortality data by cause (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/dr-table5-2010.xls ONS: mid-year population estimates: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847 and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 mortality data will be available from winter 2012/13. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Similar mortality indicators are published annually in the NHS IC Indicator Portal using the narrower definition of liver disease (Mortality from chronic liver disease including cirrhosis, ICD-10 K70, K73 and K74). Data for 2008-10 were published in March 2012: https://indicators.ic.nhs.uk/download/NCHOD/Data/25A_043DR0074_10_V1_D.xls Source data available as a continuous time series from at least 1993, enabling the construction of this indicator from that year.
Data published on the IC indicator	Annual data from 2001 to 2010 for persons, males and females at England, Care Trust, Local Authority, PCT, Region and SHA level; 2001 to 2010 England data for males and females by 5-year age-band; 2010 data for persons, males and females at County and ONS Classification level

1.4 Under 75 mortality rate from cancer	
Outcome sought	Reduced premature mortality from cancer.
Status	Live
Updated definition	**Indicator description:** Mortality rate from cancer, ages under 75, per 100,000 population **Indicator construction:** ***Numerator***

	Number of deaths under 75 from all cancers Cancer is defined in terms of the following ICD10 codes: All ICD-10 codes for Malignant Neoplasms in Chapter II - Neoplasms (C00-C97) ***Denominator*** Resident population under 75 years ONS mortality data by cause excludes deaths under 28 days for which cause of death is not classified by ICD-10 codes. This indicator therefore relates to deaths between 28 days and 74 years of age inclusive. **Indicator format** Directly age-standardised rate per 100,000 population (using European Standard Population) – (*numerator/denominator)*100,000* This is a shared indicator with the Public Health Outcomes Framework, subject to final publication of the Public Health Outcomes Framework.
Data source	ONS: mortality data by cause (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/dr-table5-2010.xls ONS: mid-year population estimates: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847 and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 mortality data will be available from winter 2012/13. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2010 definition	None
Historical comparisons	- Historical time series available from NHS Information Centre Compendium of Population Health Indicators from 1993 to 2009 for England and geographical breakdown: https://indicators.ic.nhs.uk/download/NCHOD/Data/11B_075DRT0074_09_V1_D.xls - Source data available as a continuous time series from at least 1993.

Data published on the IC indicator portal	Annual data from 2001 to 2010 for persons, males and females at England, Care Trust, Local Authority, PCT, Region and SHA level; 2001 to 2010 England data for males and females by 5-year age-band; 2010 data for persons, males and females at County and ONS Classification level

1.4.i-iv Cancer survival	
Outcome sought	Reduced years of life lost from cancer.
Status	In development
Updated definition	**Indicator description:** One-and five-year relative survival from the three major cancers: colorectal, breast and lung, are currently reported separately. These will be replaced with four aggregate indicators for those aged 15 and over (the purpose of the change being to include minor cancers and to enable robust disaggregation to CCG level): ▪ 1.4.i and ii One and five year survival for all cancers in adults 15+ ▪ 1.4.iii and iv One and five year survival for breast, lung and colorectal cancer together in adults 15+ Relative survival is an estimate of the probability of survival from the cancer alone. It is defined as the ratio of the observed survival and the survival that would have been expected if the cancer patients had experienced the same background mortality by age and sex as the general population. Survival is a measure of the number of patients diagnosed with cancer in a year who are still alive a number of years after diagnosis. The methodology used to calculate one-year survival is the 'classical' or 'cohort' approach. All patients diagnosed in the diagnosis period are followed up for one year. The methodology used to calculate the five-year survival estimates is the 'complete' approach. Only patients diagnosed in the first year of the diagnosis period are followed up for five years; those diagnosed in later years contribute as many years of follow-up as available. Five-year survival is the cumulative result of having survived during all previous intervals of time since the diagnosis, so one-year survival is implicitly included in the calculation of the five-year survival estimate. This is a robust method, and allows 5-year figures to be calculated timeously. Colorectal, breast and lung cancers are defined in terms of the following ICD-10 codes: Colorectal C18-C20, C21.8; Breast C50; Lung C33-C34 **Indicator format:** One- and five-year standardised relative survival percentage for adults (15–99 years).
Data source	ONS: mortality data by cause (England and Wales): http://www.ons.gov.uk/ons/rel/vsob1/mortality-statistics--deaths-registered-in-england-and-wales--series-dr-/2010/dr-table5-2010.xls ONS: mid-year population estimates:

	http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-231847 and http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html ONS: cancer registrations data: http://www.ons.gov.uk/ons/rel/vsob1/cancer-statistics-registrations--england--series-mb1-/no--41--2010/rft-cancer-registrations-2010.xls
Reporting schedule for data source	**Frequency:** Annual for mortality and survival data (calendar years). **Timing:** 2011 mortality data will be available from winter 2012/13. Five-year cancer survival estimates for cancers diagnosed in 2006-2010 and followed up to 2011 will be published shortly (for former indicators 1.4.i-vi, one and five year survival rates for colorectal, breast and lung cancer). New indicators 1.4.i-iv for cancers diagnosed in 2007-2011 and followed up to 2012 will be published in Autumn 2013. Mid-year population estimates for 2011 were released in September 2012.
Technical issues remaining to be resolved	None.
Sources of bias	Changes to the indicator may be biased as a representation of change to the outcomes sought due to lead time and length time bias. ***Lead time bias*** may occur when improved screening results in earlier diagnosis: earlier diagnosis will itself prolong measured survival, irrespective of whether death is deferred and premature mortality is reduced. ***Length time bias*** in measuring cancer survival arises because faster-growing tumours generally have a shorter asymptomatic phase than slower-growing tumours, and so are less likely to be detected. Faster-growing tumours are often associated with a poorer prognosis. Slower-growing tumours are hence likely to be over-represented in additional cases found through improved screening. Further work is required with the cancer registries to obtain data on the stage of disease at which patients are diagnosed, so as to control for sources of bias in estimates of survival**.**
Changes since December 2011 definition	Replaced 6 indicators covering 1 and 5 year survival for breast, lung and colorectal cancer respectively with 4 indicators: 1 and 5 year survival for all cancers and for breast, lung and colorectal cancer combined.
Historical comparisons	Historical time series available from ONS at: http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm%3A77-21521 http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-238375
Data published on the IC indicator portal	Annual data for colorectal cancers followed up to 2003 to 2010, and for breast and lung cancers followed up to 2001 to 2010, for males and females, with age breakdowns (for breast and lung cancers age breakdowns are only for cancers followed up to 2005 to 2010).

1.5 Excess under 75 mortality rate in adults with serious mental illness	
Outcome sought	Reduced premature mortality in adults with serious mental illness.
Status	Live
Updated definition	**Indicator description:** Excess under 75 mortality rate in adults with serious mental illness. The mortality rate in the population with serious mental illness is directly standardised to the national population. From this is subtracted the comparable mortality rate for the general population. **Indicator construction:** Premature mortality in adults with serious mental illness (SMI) less premature mortality in adults in the general population. 'Adults with serious mental illness' are defined as anyone aged 18 or over who has been in contact with the secondary mental care services in the current financial year or in ether of the two previous financial years who is alive at the beginning of the current financial year. Those aged 75 and over are excluded to align this indicator with the other premature mortality indicators in Domain 1, and those aged under 18 are excluded because children under 18 are not covered by the main data source (MHMDS). There is no evidence that children with SMI are at higher risk of death by disease. **Indicator format:** This is a shared indicator with the Public Health Outcomes Framework.
Data source	- ONS: Primary Care Mortality Database - IC: Mental Health Minimum Dataset (MHMDS): http://www.ic.nhs.uk/services/population-geography-information/demographics-and-statistics/primary-care-mortality-database http://www.mhmdsonline.ic.nhs.uk/
Reporting schedule for data source	**Frequency:** Annual for MHMDS and mortality data (financial year), and population data (mid-year estimates). **Timing:** 2011/12 MHMDS data will be available by January 2013. 2011 mortality and population data will be available from winter 2012/13.
Technical issues remaining to be resolved	None
Sources of bias	Changes to the criteria for inclusion in the MHMDS over time could change the risk of death for patients included in the indicator and bias the indicator as a representation of the outcome sought.

Changes since December 2011 definition	Data linkage between ONS mortality data and the MHMDS has been completed, using NHS number. See data linkage specification on the NHS IC indicator portal for details: https://indicators.ic.nhs.uk/webview/ The mental health rate is directly standardised by age and sex to the England population. The general population rate is the crude rate for England for people aged 18 to 74.
Historical comparisons	MHMDS data are not available for years before 2006/07, so the first year of the time series, published in June 2012, related to deaths in the year 2008/09
Data published on the IC indicator portal	Annual data from 2008/09 to 2010/11 for persons, males and females, at national level; persons data broken down by Upper Tier Local Authority and by age band.

1.6i Infant mortality	
Outcome sought	Reduced infant mortality.
Status	Live
Updated definition	**Indicator description:** Infant mortality rate, per 1,000 live births. **Indicator construction:** ***Numerator*** Number of deaths at ages under one year ***Denominator*** Live births **Indicator format** Crude rate per 1,000 live births – *(numerator/denominator)*1,000* This is a shared indicator with the Public Health Outcomes Framework.
Data source	ONS: Mortality Statistics childhood, infant and perinatal (formerly series DH3): http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2010/rft-cms-2010.xls
Reporting schedule for data source	Data for calendar years are updated annually. Source data for 2011 will be available from winter 2012/13.
Technical issues remaining to be resolved	None
Changes since December	None

2011 definition	
Historical comparisons	Source data available from 1927: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-213277
Data published on the IC indicator portal	Annual data from 1999 to 2010 for England for persons, males and females, for persons by SHA, PCO, LA, for persons and England by Age of Mother, IMD Quintile

1.6.ii Neonatal mortality and stillbirths	
Outcome sought	Reduced neonatal mortality and stillbirths
Status	Live
Updated definition	**Indicator description:** Stillbirth and neonatal mortality rate per 1,000 live births and stillbirths. **Indicator construction:** ***Numerator*** Number of neonatal deaths and stillbirths Neonatal deaths are defined as deaths 0-27 days after live birth. Stillbirths are defined as deaths in babies born after 24 or more weeks completed gestation and which did not, at any time, breathe or show signs of life. ***Denominator*** Live births and stillbirths **Indicator format** Crude rate per 1,000 live births and stillbirths – *(numerator/denominator)*1,000*
Data source	ONS: Mortality Statistics childhood, infant and perinatal (formerly series DH3): http://www.ons.gov.uk/ons/rel/vsob1/child-mortality-statistics--childhood--infant-and-perinatal/2010/rft-cms-2010.xls
Reporting schedule for data source	Data for calendar years are updated annually. Source data for 2011 will be available from winter 2012/13.
Technical issues remaining to be resolved	None
Changes since December 2011	None

definition	
Historical comparisons	Source data available from 1927: http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-213277
Data published on the IC indicator	Annual data from 1999 to 2010 for England for persons, males and females, for persons by SHA, PCO, LA, for persons and England by Age of Mother, IMD Quintile

1.6.iii Five-year survival from all cancers in children	
Outcome sought	Improved five-year survival rate from all cancers in children
Status	Placeholder
Updated definition	Five year survival for all cancers in children and young people under 15 years. Definition to be developed.
Data source	To be decided.
Reporting schedule for data source	To be decided.
Technical issues remaining to be resolved	Calculation of the indicator, standardisation method
Changes since December 2011 definition	New indicator.
Historical comparisons	"Historical comparisons of 5-year survival from Childhood Cancer, Great Britain, 1971-2005 are available at: http://www.ccrg.ox.ac.uk/datasets/survivalrates.htm"
Data published on the IC indicator	Not yet available.

1.7 Premature mortality for people with a learning disability	
Outcome sought	Reduced premature mortality in adults with a learning disability.
Status	Placeholder
Updated definition	**Indicator description:** Excess under 60 mortality rate in adults with a learning disability. **Indicator construction:** Under 60 mortality in adults with a learning disability will be estimated. From this will be deducted comparable mortality in adults of the same age in the general population. **Indicator format:** To be decided

Data source	To be decided, likely to be based on data extracted from GP Practice systems
Reporting schedule for data source	To be decided
Technical issues remaining to be resolved	Calculation of the indicator, standardisation method
Changes since December 2011 definition	New indicator
Historical comparisons	Unavailable
Data published on the IC indicator	Not yet available.

Domain 2

Enhancing quality of life for people with long-term conditions

Indicator Structure

2.1 Domain 2, ***Enhancing quality of life for people with long-term conditions,*** comprises one *overarching indicator* and six *improvement areas* as follows.

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

2.2 The improvement areas are of two sorts:

- Sub-indicators. The first three improvement area indicators, (2.1 – 2.3.i) relate to particular aspects of outcome for those living with long-term conditions. Progress in these indicators therefore provides a useful initial analysis of what accounts for progress in the overarching indicator. Indicator 2.5 is derived from a subset of the data from which indicator 2.2 is derived. It is nonetheless monitored separately as poor outcomes for this group may reflect inequity.
- Complementary Indicators. 2.4 is complementary to the overarching indicator as the health of carers is not included in indicator 2. Carer health is influenced by support both from the NHS and from social care. 2.3.ii is also complementary in that it reflects outcomes for children who are not included in the survey used for indicator 2. Quality of life for those with dementia (indicator 2.6.i and placeholder 2.6.ii) is unlikely to be properly represented in the overarching indicator given the

nature of the condition. 2.2 and 2.3 are also partly complementary, as they capture benefits of improved quality of life for people with long term conditions that fall upon wider society rather than the patients themselves (e.g. increased acute health care capacity from reduced admissions; greater economic contributions from LTC sufferers enabled to gain employment).

2.3 Together, the overarching indicator and the complementary improvement indicators provide a picture of the NHS's contribution to improving the quality of life for those affected by long-term conditions

2.4 Each of the indicators reflect changes in health related quality of life (HRQoL) of persons affected by long term conditions (although in the case of 2.3 some assumptions would be required to derive an estimate of implication for HRQoL for those suffering these conditions). The indicators picking up wider societal effects will also reflect impacts upon quality of life for those ultimately affected.

2.5 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 two indicators measuring emergency admissions that usually could have been avoided through better management in primary or community care: indicator 2.3.i focussing on chronic (i.e. long-term) conditions and indicator 3a focussing on acute conditions. These indicators should therefore be seen as complementing each other.

Work in Progress

2.6 The main issues in Domain 2 upon which work is continuing are:

- Development of a methodology to distinguish genuine improvements in outcome from spurious effects of changes in casemix.
- Development of indicators for particular groups that are not well represented in the survey responses, including in particular:
    - 2.6.ii, A placeholder for a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life.
    - Preliminary work to fill other recognised gaps:
        - quality of life for those with serious mental illness and for those with a learning disability (to the extent that these outcomes are not captured by indicator 2.5)
        - functional ability of children with long term conditions
        - quality of life for children and young people with mental illness.
        - quality of life for young carers

Inequality

2.7 Inequality in outcomes attributable to NHS care in Domain 2 may best be captured by reference to a Slope Inequality Indicator (see glossary) capturing correlation of outcomes (possibly using indicator 2) with small-area deprivation. This option is subject to developmental work.

2.8 Inequalities are also captured by indicator 2.5, as mentioned.

Drivers of the outcome

2.9 Further details of the drivers of the outcomes in Domain 2 are set out in the Technical Annex to the consultation which accompanied the draft mandate to the NHS Commissioning Board which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition.

International Comparisons

2.10 International comparisons of Domain 2 indicators on a strictly comparable basis are not available from WHO or OECD. 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. The most recent issue was published in November 2011 at http://www.oecd.org/health/healthpoliciesanddata/healthataglance2011.htm.

2.11 Detailed presentation of historic trends and international comparisons of Domain 2 indicators is included in the Technical Annex to the consultation on the draft mandate for the NHS Commissioning Board, which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition.

2 Health related quality of life for people with long-term conditions	
Outcome sought	Improved health-related quality of life for people with long-term conditions.
Status	In development
Updated definition	**Indicator description:** Average health status score for individuals aged 18 and over reporting that they have a long-term condition. **Indicator construction:** Average health status (EQ-5D*) score for individuals aged 18 and over reporting that they have a long-term condition. It assesses whether health-related quality of life is increasing over time for the population with long-term conditions, while controlling for measurable confounders (age, gender, disease mix, etc.). Health status is derived from responses to Q34 on the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument: • Mobility • Self-care • Usual activities • Pain/discomfort • Anxiety/depression *EQ-5D™ is a registered trademark of EuroQol. Further details are available from http://www.euroqol.org. A single measure of Health Related Quality of life for each survey respondent is derived using a standard tariff, itself elicited from a representative sample of the general population (For the derivation

	see Dolan, Gudex, Kind and Williams “A Social Tariff for EuroQol: Results from a UK General Population survey”, Discussion Paper 138, Centre for Health Economics, University of York. Available online at http://www.york.ac.uk/media/che/documents/papers/discussionpapers/CHE%20Discussion%20Paper%20138.pdf). The derived value takes a maximum score of 1 (full health) and is anchored at zero (a state of no intrinsic value, for example unconscious). Long-term condition status for individuals is obtained from ‘yes’ responses to Question 30 in the GP Patient Survey: **Do you have a long-standing health condition?** Response options: Yes, No, Don’t know/Can’t say Responses to Question 30 may be influenced by responses to Question 31 in the same survey asking about which medical conditions the respondent has. **Question 31: Which, if any, of the following medical conditions do you have? Please x all the boxes that apply to you:** • Alzheimer’s disease or dementia • Angina or long-term heart problem • Arthritis or long-term joint problem • Asthma or long-term chest problem • Blindness or severe visual impairment • Cancer in the last 5 years • Deafness or severe hearing impairment • Diabetes • Epilepsy • High blood pressure • Kidney or liver disease • Learning difficulty • Long-term back problem • Long-term mental health problem • Long-term neurological problem • Another long-term condition • None of these conditions • I would prefer not to say **Indicator format:** Number The indicator will be standardised to take demographic and health status factors into account, so that trends in the indicator can be distinguished from changes in the population. Standardisation will allow for a respondents’ mix of long term conditions, but not for those co-morbidities that are avoidable sequelae of other conditions.
Data source	- GP Patient Survey (GPPS) The most recent GP Patient Survey data covering 2011/12, is available at http://www.gp-patient.co.uk/results/ From 2011/12, health status (EQ-5D) and the questions required for case-mix adjustment have been included in the GPPS (www.gp-

	patient.co.uk/). - Health Survey for England (HSE) An alternative source that can be used to corroborate this indicator is the Health Survey for England (http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/index.htm) (Data from the annual Health Survey for England is available between 12 to 15 months after the end of each calendar year)
Reporting schedule for data source	**Frequency:** Bi-annually from the GPPS approximately three months after the end of each data collection period. **Timing:** Data for 2011/12 is available at - http://www.gp-patient.co.uk/results/
Technical issues remaining to be resolved	Work is underway with the Health and Social Care Information Centre’s Methodology Review Group to agree the standardisation methodology.
Sources of bias	Changes to the indicator may be biased as a representation of change to the outcomes sought due to unmeasured changes in: • The average period that the surveyed individuals have suffered a long-term condition, a major determinant of stage and severity of disease, and hence of health status. If the average period since incidence of the sampled population decreases, for example through earlier diagnosis, the measured health related quality of life of the sample will improve without genuine improvement of outcome. Conversely, if the period since incidence increases, for example as improvements in care defer mortality, the measured health related quality of life will decline without genuine deterioration of outcome. • Readiness to diagnose or report a "long standing health condition”, which might reflect change in tolerance of conditions by different age cohorts. For example, if a current cohort considers itself to suffer from a “long-term back problem” which an earlier cohort would have considered a normal part of ageing, the average casemix of the sample population will lighten.
Changes since December 2011 definition	The standardisation methodology for this indicator has changed and is still under development.
Historical comparisons	The EQ-5D question was included in the GP Patient Survey for the first time in 2011. The question was also asked in the HSE from 2003 but this is not directly comparable with the GP Patient Survey.
Data published on the IC indicator portal	Not yet published.

2.1 Proportion of people feeling supported to manage their condition	
Outcome sought	A greater proportion of people aged 18 and over suffering from a long-term condition feeling supported to manage their condition.
Status	In development
Updated definition	**Indicator description:** The proportion of people feeling supported to manage their long-term condition. **Indicator construction:** The indicator will be based on responses to questions in the GP Patient Survey as follows: ***Numerator*** For people who answer ‘yes’ to the Question 30 “Do you have a long-standing health condition” (cited in template for indicator 2). The numerator is the total number of ‘Yes, definitely’ or ‘Yes, to some extent’ answers to GPPS **Question 32: In the last 6 months, have you had enough support from local services or organisations to help you manage your long-term condition(s)?** *Please think about all services and organisations, not just health services* • Yes, definitely • Yes, to some extent • No • I have not needed such support • Don’t know/can’t say Responses will be weighted according to the following 0-100 scale: “No” = 0 “Yes, to some extent” = 50 “Yes, definitely” = 100 ***Denominator*** The denominator is the total number of ‘Yes, definitely’, ‘Yes, to some extent’ and ‘No’ answers to question 32 above. **Indicator format** Percentage (weighted numerator/denominator)
Data source	GP Patient Survey (www.gp-patient.co.uk/)
Reporting schedule for data source	**Frequency:** Bi-annual in future. **Timing:** Available approximately three months after the end of each data collection period in future so 2011/12 data released in summer 2012.
Technical issues remaining to be resolved	Work is underway with the Health and Social Care Information Centre’s Methodology Review Group to agree the standardisation methodology
Changes since	The standardisation methodology for this indicator has changed and is still under development.

December 2011 definition	
Historical comparisons	Series from GPPS available from Q3 2009/10. Summaries of quarterly data are available from: http://www.gp-patient.co.uk/results/results/annualsummary
Data published on the IC indicator	Not yet published.

2.2 Employment of people with long-term conditions	
Outcome sought	Improved functional ability, and ability to work, in people with long-term conditions.
Status	Live
Updated definition	**Indicator description:** Percentage of respondents in the Labour Force Survey (LFS) who have a long-term condition who are classed as employed using the International Labour Organisation (ILO) definition of employment, compared to the percentage of all respondents classed as employed. **Indicator construction:** For respondents in England, ***Numerator*** ***1. Employment rate of people with a long term-condition*** Number of people with a health problem or disabilities that they expect will last for more than a year are those where: The respondent responds 'yes' to the question *"Do you expect your health problems to last for more than a year".*(Please note that LFS responses are collected through interviews and the exact formulation of this question is left to the interviewer). AND who are in employment – *either an Employee, Self-employed, in Government employment & training programmes or an unpaid family worker (this is the ILO definition of Basic economic activity)* AND are of working age (ages 16-64) ***2. Employment rate of population*** Number of people who are in employment – *either an Employee, Self-employed, in Government employment & training programmes or an unpaid family worker (this is the ILO definition of Basic economic activity)* AND

	are of working age (ages 16-64) ***Denominator*** ***1. Number of people with a long- term condition of working age*** Number of people with a health problem or disabilities that they expect will last for more than a year AND are of working age (ages 16-64) ***2. Working age population*** Number of people who are of working age (ages 16-64) (For further details on the LFS variables, consult Volume 3: 2010 Details of LFS variables, http://www.ons.gov.uk/ons/guide-method/user-guidance/labour-market-statistics/index.html.) **Indicator format:** Percentage points gap between the employment rate for those with a long-term condition and the working-age population. LFS sample adjusted to estimate the difference in employment of people with long-term conditions and employment of people in the population as a whole.
Data source	Labour Force Survey (For information on the survey, consult http://www.esds.ac.uk/government/lfs/)
Reporting schedule for data source	**Frequency:** Quarterly. **Timing:** Datasets are made available by the Economic and Social Data (ESDS) service approximately two months after the end of the quarter. See http://www.esds.ac.uk/findingData/snDescription.asp?sn=6715 for further details
Technical issues remaining to be resolved	None
Sources of bias	Change in the indicator may be biased as a representation of the outcome sought by changes in the overall number and case-mix of those identifying themselves has having a long-term condition, see discussion on indicator 2.In addition, this indicator may be biased as a reflection of the ability to gain work of the population with long-term conditions by changes in financial incentives (including those implicit in the benefits system).

Changes since December 2011 definition	None
Historical comparisons	For comparable ten year series derived from LFS, see Department for Work and Pensions: Secretary of State Report on Disability Equality, December 2008 (see table ‘Employment rate of disabled people in comparison to the overall rate‘ on page 29 of the report, http://www.dwp.gov.uk/docs/sos-report-on-disability-equality.pdf).
Data published on the IC indicator	Quarterly data from 2006 Q3 to 2011 Q2 for persons, males and females, different age bands, religious and ethnic groups at national level, unitary authorities, and Government office regions.

2.3.i Unplanned hospitalisation for chronic ambulatory care sensitive conditions	
Outcome sought	Reduced serious deterioration in people with ambulatory care sensitive (ACS) conditions
Status	Live
Updated definition	The proportion of persons aged over 18 with chronic conditions admitted to hospital as an emergency admission. This definition is based on the Health and Social Care Information Centre’s Compendium of Population Health indicator: *Emergency hospital admissions: chronic conditions usually managed in primary care*. ***Numerator:*** The number of finished and unfinished continuous inpatient spells (CIPS), excluding transfers, for patients with an emergency method of admission and with any of the primary diagnoses listed below (DIAG_01 in the 1st episode of the spell, ICD-10 codes). **Vaccine preventable** B18.0 Chronic viral hepatitis B with delta-agent B18.1 Chronic viral hepatitis B without delta-agent **Asthma** J45 Asthma J46X Status asthmaticus **Congestive heart failure** I11.0 Hypertensive heart disease with (congestive) heart failure I50 Heart failure J81X Pulmonary oedema I13.0 Hypertensive heart and renal disease with (congestive) heart failure **Diabetes** E10 Insulin-dependent diabetes mellitus E11 Non-insulin-dependent diabetes mellitus E12 Malnutrition-related diabetes mellitus E13 Other specified diabetes mellitus

	E14 Unspecified diabetes mellitus **Chronic obstructive pulmonary disease** J20 Acute bronchitis J41 Simple and mucopurulent chronic bronchitis J42X Unspecified chronic bronchitis J43 Emphysema J44 Other chronic obstructive pulmonary disease J47X Bronchiectasis **Angina** I20 Angina pectoris I25 Chronic ischaemic heart disease **Iron deficiency anaemia** D50.1 Sideropenic dysphagia D50.8 Other iron deficiency anaemias D50.9 Iron deficiency anaemia, unspecified D51 Vitamin B12 deficiency anaemia D52 Folate deficiency anaemia **Hypertension** I10X Essential (primary) hypertension I11.9 Hypertensive heart disease without (congestive) heart failure **Convulsions and epilepsy** G40 Epilepsy G41 Status epilepticus **Dementia** F00 Dementia in alzheimers F01 Vascular dementia F02 Dementia in other diseases F03 Unspecified dementia **Atrial fibrillation and flutter** I48X Atrial fibrillation and flutter ***Denominator:*** Resident adult population estimate **Indicator format:** rate per 100,000 population
Data source	- Hospital Episode Statistics (HES) (Health and Social Care Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics–hes); and - Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** HES reports provisional data monthly, annual data by financial year is available in the autumn/winter after the end of the period. ONS population estimates available annually (calendar year). **Timing:** Latest HES monthly data is for July 2011, annual refresh for 2011/12 is due in November 2012. Mid-year population estimates for 2011 were released in September 2012.

Technical issues remaining to be resolved	The list of conditions and the appropriate age range are currently under review. We are investigating the scope for restricting the denominator to the incidence of the relevant conditions.
Changes since December 2011 definition	None
Historical comparisons	HES time series available back to 1991, adjusting for data quality and coding changes. However, direct comparisons may be difficult to make.
Data published on the IC indicator	Quarterly data from 2003/04Q1 to 2010/11Q4 for persons, males and females, different age bands, deprivation decile, condition, religious and ethnic groups at national level, Local Authorities and PCTs.

2.3.ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	
Outcome sought	Reduced unplanned time spent in hospital by children with specific long-term conditions that should be managed outside hospital.
Status	Live
Updated definition	**Indicator description:** Rate of emergency admissions episodes in people under 19 (0 – 18 years) for asthma, diabetes or epilepsy per 100,000 population **Indicator construction:** ***Numerator*** Total number of emergency admissions for people under 19 (0 – 18 years) where asthma, diabetes or epilepsy was the primary diagnosis. ***Denominator*** Mid-year population estimates for under 19s. **Indicator format**: rate per 100,000 population
Data source	- Hospital Episode Statistics (Health and Social Care Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics–hes); and - Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** HES reports provisional data monthly, annual data by financial year is available in the autumn/winter after the end of the period. ONS population estimates available annually (calendar year). **Timing:** Latest HES monthly data is for July 2011, annual refresh for 2011/12 is due in November 2012. Mid-year population estimates for 2011 were released in September 2012.

Technical issues remaining to be resolved	None
Changes since December 2011 definition	Under previous definition, rates for the three conditions were considered separately.
Historical comparisons	HES time series available back to 1991, adjusting for data quality and coding changes. However, direct comparisons may be difficult to make.
Data published on the IC indicator	Quarterly data from 2003/04Q1 to 2010/11Q4 for persons, males and females, different age bands, deprivation decile, condition, religious and ethnic groups at national level, Local Authorities and PCTs.

2.4 Health-related quality of life for carers	
Outcome sought	Improving health-related quality of life for carers.
Status	In development
Updated definition	**Indicator description:** Case-mix adjusted health status EQ-5D* score for individuals reporting that they are carers. **Indicator construction:** This indicator assesses whether health-related quality of life is increasing over time for this population, controlling for measurable confounders (age, gender, etc.). Health status is derived from responses to Q34 on the GP Patient Survey, which asks respondents to describe their health status using the five dimensions of the EuroQuol 5D (EQ-5D) survey instrument: • Mobility • Self-care • Usual activities • Pain/discomfort • Anxiety/depression *EQ-5D™ is a registered trademark of EuroQol. Further details are available from http://www.euroqol.org The last GP Patient Survey is available on http:// www.gp-patient.co.uk/download/Questionnaires/Y6Q1%20GP%20Patient%20Survey%20questionnaire.pdf A single measure of Health Related Quality of life for each survey respondent is derived using a standard tariff, itself elicited from a representative sample of the general population (For the derivation see Dolan, Gudex, Kind and Williams “A Social Tariff for EuroQol: Results from a UK General Population survey”, Discussion Paper 138, Centre for Health Economics, University of York. Available online at http://www.york.ac.uk/media/che/documents/papers/discussionpapers/CHE%20Discussion%20Paper%20138.pdf). The derived value takes

	a maximum score of 1 (full health) and is anchored at zero (a state of no intrinsic value, for example unconscious). The carer status is obtained from those answering “Yes…” to Question 56 in the GP patient survey: **Do you look after, or give any help or support to family members, friends, neighbours or others because of either** - **long-term physical or mental health/disability, or** - **problems related to old age?** *Do not count anything you do as part of your paid employment* No Yes, 1-9 hours a week Yes, 10-19 hours a week Yes, 20-34 hours a week Yes, 35-49 hours a week Yes, 50+ hours a week **Indicator format:** Number
Data source	GP Patient Survey The most recent GP patient survey covering 2012, is available on http://www.gp-patient.co.uk/questionnaires/ From 2011-12, health status (EQ-5D) and the questions required for case-mix adjustment have been included in the GP Patient Survey(http://www.gp-patient.co.uk/)
Reporting schedule for data source	**Frequency:** Bi-annually. **Timing:** Available approximately three months after the end of each data collection period, therefore 2011/12 data released in Summer 2012.
Technical issues remaining to be resolved	Work underway with the Health and Social Care Information Centre’s Methodology Review Group to agree standardisation methodology.
Sources of bias	Changes to the indicator may be biased as a representation of change to the outcomes sought due to unmeasured changes in: • the average case-mix of the people cared for, as this will not be apparent from the survey responses (so case-mix adjustment will not be possible as it is for indicator 2). • readiness to report a “long standing health condition” borne by those for whom care is provided, which might reflect change in tolerance of conditions by different age cohorts.
Changes since December 2011 definition	The standardisation methodology for this indicator has changed and is still under development.

Historical comparisons	Time series data not yet available as this is a new indicator.
Data published on the IC indicator portal	Not yet published.

2.5 Employment of people with mental illness	
Outcome sought	Improved functional ability, through employment, in people with mental illness.
Status	Live
Updated definition	**Indicator description:** Percentage of respondents in the Labour Force Survey (LFS) who have a mental illness who are classed as employed using the International Labour Organisation (ILO) definition of employment compared to the percentage of all respondents classed as employed. **Indicator construction:** For respondents in England, ***Numerator*** ***1. Proportion of people with a mental illness in employment*** Number of people with mental illness in employment are those where the respondent responds ‘yes’ to the question *“Do you expect your health problems to last for more than a year ?”*. (Note that LFS responses are collected through interviews and the exact formulation of this question is left to the interviewer). AND in response to the question *“What health problems do you have ?”* the respondent reports having one of the following from the overall list of conditions: *Depression, bad nerves or anxiety or Severe or specific learning difficulties (mental handicap), or Mental illness, or suffer from phobia, panics or other nervous disorder* (Note that LFS responses are collected through interviews and the exact formulation of this question is left to the interviewer) AND the respondent reports being in employment – either an *employee , self-employed, in, Government employment & training programmes, or and unpaid family worker (this is the ILO definition of Basic economic activity)* AND the respondent reports being of working age (ages 16-64)

	2. Proportion of the general population in employment Number of people who are in employment – either an *employee , self-employed, in, Government employment & training programmes, or and unpaid family worker (this is the ILO definition of Basic economic activity)* AND is of working age (ages 16-64) ***Denominator*** ***1. Number of people with a mental illness of working age*** Number of people with *a health problem or disabilities that they expect will last for more than a year)* AND *has Depression, bad nerves or anxiety (12) Severe or specific learning difficulties (mental handicap) (14) or Mental illness, or suffer from phobia, panics or other nervous disorders (15))* AND is of working age (ages 16-64) ***2. Working age population*** Number of people of working age (ages 16-64) (For further detail on the LFS variables, consult Volume 3: 2010 Details of LFS variables, http://www.ons.gov.uk/ons/guide-method/user-guidance/labour-market-statistics/index.html). **Indicator format** Percentage points – gap between the employment rate for those with a long-term condition and the working-age population.
Data source	Labour Force Survey (LFS)
Reporting schedule for data source	**Frequency:** Quarterly. **Timing:** Datasets are made available by the Economic and Social Data (ESDS) service approximately two months after the end of the quarter. See http://www.esds.ac.uk/findingData/snDescription.asp?sn=6715 for further details.
Sources of bias	Change in the indicator may be biased as a representation of the outcome sought by changes in the overall number and case-mix of those identifying themselves has having a mental illness or disability Average period that the surveyed individuals have suffered a long-term condition, readiness to diagnose and/or report a "long standing

	health condition", changes in the overall number and case-mix of those identifying themselves as having a long-term condition. In addition, this indicator may be biased as a reflection of the ability to gain work of the population with long-term conditions by changes in that population's willingness to work, which in turn is affected by changes to financial incentives (including those implicit in the benefit system).
Technical issues remaining to be resolved	It is recognised that this indicator reflects only a single aspect of the improvement area (quality of life for those with mental illness) – as it limited to employment as an outcome and to those in the labour market. It is hoped in that in due course that this indicator can be extended or complemented by a broader measure of recovery and by one that captures recovery and quality of life for all those with Severe as well as Mild and Moderate conditions.
Changes since December 2011 definition	None
Historical comparisons	Ten year series from 2001 can be derived from the LFS dataset.
Data published on the IC indicator portal	Quarterly data from 2006 Q3 to 2011 Q2 for persons, males and females, different age bands, religious and ethnic groups at national level, unitary authorities, and Government office regions.

2.6 i-iiQuality of life for people with dementia	
Outcome sought	Improving the ability of people with dementia to cope with symptoms
Status	2.6.i Live 2.6.ii Placeholder
Updated definition	This indicator is split into two parts: i. Estimated diagnosis rate for people with dementia ii. A placeholder for a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life. The second part of this indicator, 2.6.ii is intended to complement 2.6.i by ensuring that diagnosis rate leads to improved ability to cope and to deferred institutionalisation. (Deferred institutionalisation itself is subject to possible confounding by shifts in eligibility for funded care and in affordability for self-funders.) **Part 1 (2.6.i)** ***Numerator*** **Numbers of people diagnosed** – The number of people on the dementia register for England in the Quality and Outcomes Framework (QOF). This figure is published by the Health and Social Care Information Centre as the QOF DEM1 indicator.

	Denominator **Prevalence** – The Dementia UK report (2007) contains estimates of late onset dementia prevalence rates (ie how many people have dementia as a proportion of the population in that age band) by five year age bands from age 30 to 95+. These rates are available by gender and as a weighted average for all persons. **Indicator format** - Percentage
Data source	Data are taken from: Quality and Outcomes Framework (QOF), Health and Social Care Information Centre Dementia UK report (2007) GP Extraction Service (2.6.ii) New survey of patients and carers (as proxies) using DemQuol (2.6.iii) Office for National Statistics Population Statistics
Reporting schedule for data source	**Frequency:** Annual **Timing:** Last publication in October based on previous financial year end.
Technical issues remaining to be resolved	Part 2.6.i was published by the Health and Social Care Information Centre in September 2012 is a provisional indicator, since it represents aggregate England and Wales data. It also includes dementia cases from age 40 and above. An updated version of the indicator will be published in December 2012, covering England as well as cases from age 30 and above. Part 2.6.ii requires further development.
Changes since December 2011 definition	This indicator was a placeholder in the December 2011 publication. The definition above is therefore the first to define the indicator more precisely.
Historical comparisons	None
Data published on the IC indicator portal	Part 2.6.i - annual figure for 2010/11.

Domain 3

Helping people to recover from ill-health or following injury

Indicator Structure

3.1 Domain 3, ***Helping people to recover from ill-health or following injury,*** comprises two *overarching indicators* and six *improvement areas*, summarised below:

Overarching indicators
3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 30 days of discharge from hospital
Improvement areas
Improving outcomes from planned treatments
3.1 Total health gain as assessed by patients for elective procedures i Hip ii Knee replacement iii Groin Hernia iv Varicose veins v Psychological therapies
Preventing lower respiratory tract infections (LRTI) in children from becoming serious
3.2 Emergency admissions for children with lower respiratory tract infections (LRTI)
Improving recovery from injuries and trauma
3.3 Proportion of people who recover from major trauma
Improving recovery from stroke
3.4 Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months
Improving recovery from fragility fractures
3.5.i The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 days ii The proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 120 days
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

3.2 This domain comprises indicators both of adverse outcomes and indicators of the effectiveness of care.

3.3 The three measures of adverse outcomes are 3a, 3b and 3.2, which may reflect failures in the effectiveness of care in the total care system

3.4 These outcome indicators are designed to reflect failures in the effectiveness of care. (They contrast with Domain 5 outcomes, which are designed to reflect adverse outcomes, harms, attributable to problems in the care itself.) They will include some cases in which failure to deliver good care leads to an avoidable premature fatality, so there is some overlap with Domain 1. (This overlap with Domain 1 applies to a number of indicators in this Domain and in Domain 5.)

3.5 These indicators of adverse outcome are complemented by indicators of how well care improves health following ill-health or injury: 3.1, 3.3, 3.4, 3.5, 3.6.

3.6 One of these relates to elective care: 3.1.

3.7 The other four relate to urgent or emergency care: 3.3, 3.4, 3.5, 3.6

3.8 Together, the overarching indicators and the complementary improvement indicators combine progress in reducing the number of cases in which recovery has been interrupted by avoidable emergency admissions with those that measure positive progress in recovery. They provide a partial picture of the NHS's contribution to minimising the adverse impact of ill-health and injury upon the quality and length of life of those affected.

3.9 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 two indicators measuring emergency admissions that usually could have been avoided through better management in primary or community care: indicator 2.3.i focussing on chronic (i.e. long-term) conditions and indicator 3a focussing on acute conditions. These indicators should therefore be seen as complementing each other.

Work in Progress

3.10 The main issues pertaining to Domain 3 upon which work is continuing are:

- Indicator 3.1. Development of the Patient Reported Outcome Measures (PROMs) programme – as the number of PROMs expands (for example, a pilot for coronary revascularisation started at the end of 2011), we will consider how to include outcomes in this indicator, perhaps by using appropriate groupings, for example, by specialty.

- Indicator 3.3. Injuries and trauma – at the time of the first NHS Outcomes Framework, there were no indicators to measure this outcome. DH worked with a number of experts to develop an interim indicator using data within the Trauma Audit Research Network (TARN). This has produced an indicator of the proportion of people who recover from major trauma. Initially this is based upon risk-adjusted odds of survival in patients with major trauma. It is intended that this binary measure of outcome will eventually be replaced by one that reflects the extent of recovery. The next phase will be to test the collection of functional and quality of life measures for this patient population.

- Indicator 3.4. A new indicator to measure improving recovery from stroke continues to be developed. This indicator to fill this placeholder was chosen as part of the Innovation in Outcomes Competition held in 2011. It will be derived from the modified Rankin Scale (mRS) (measured at the time of the stroke and at 6-months follow-up) as part of a new stroke audit, the Sentinel Stroke National Audit Programme (SSNAP). Data for the first year of collection are expected in June 2014, but data for the first six months should be available by December 2013.

Inequality

3.11 Inequality in outcomes attributable to NHS care in Domain 3 will be explored using a variety of methodologies, according to the availability of disaggregated data.

Drivers of the outcome

3.12 The principal external driver of outcomes 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.

3.13 Further details of the drivers of the outcomes in Domain 3 are set out in the Technical Annex which accompanied the consultation on the draft mandate to the NHS Commissioning Board which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition. This also contains detailed presentation of historic trends and disaggregated data.

International Comparisons

3.14 International comparisons of Domain 3 indicators or similar are not available from WHO or OECD. England is leading the field in the collection and publication of pre- and post-operative procedure data in the NHS. There have been PROMs trials in Canada, Germany, Slovenia and Sweden.

1.6 The principal external driver of outcomes is the volume and severity of incidents of ill health and injury. Not only will changes in the volume of incidents directly affect outcomes for indicators 3a and 3.2 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 case load.

<table>
<tr><th colspan="2">3a Emergency admissions for acute conditions that should not usually require hospital admission</th></tr>
<tr><td>Outcome sought</td><td>Preventing conditions from becoming more serious.</td></tr>
<tr><td>Status</td><td>Live</td></tr>
<tr><td>Updated definition</td><td>
<p>Indicator description: Emergency admissions to hospital of persons with acute conditions (ear/nose/throat infections, kidney/urinary tract infections, heart failure, among others) that usually could have been avoided through better management in primary care.</p>
<p>Indicator construction: The indicator is defined as the number of admissions for these conditions as a proportion of the number of persons in England aged 19 years and above.</p>
<p>The list of conditions included in the definition was originally reviewed for the purposes of the NHS Outcomes Framework and was considered the most up-to-date and comprehensive list available at the time, taking account of the views of expert clinicians. However, as outlined below, the list is being reviewed again to further improve the definition. The indicator is standardised by age and sex.</p>
<p><i>Numerator</i>
The number of finished and unfinished continuous inpatient spells (CIPS), excluding transfers, for patients with an emergency method of admission and with any of the following primary diagnoses.</p>
<p>This is the list of codes currently used under this definition – but is being reviewed to improve the definition.
ICD-10 codes</p>
<table>
<tr><th colspan="2">Influenza, pneumonia</th></tr>
<tr><td>J10</td><td>Influenza due to identified influenza virus</td></tr>
<tr><td>J11</td><td>Influenza, virus not identified</td></tr>
<tr><td>J13X</td><td>Pneumonia due to Streptococcus pneumoniae</td></tr>
<tr><td>J14</td><td>Pneumonia due to Haemophilus influenzae</td></tr>
<tr><td>J15.3</td><td>Pneumonia due to streptococcus, group B</td></tr>
<tr><td>J15.4</td><td>Pneumonia due to other streptococci</td></tr>
<tr><td>J15.7</td><td>Pneumonia due to Mycoplasma pneumoniae</td></tr>
<tr><td>J15.9</td><td>Bacterial pneumonia, unspecified</td></tr>
<tr><td>J16.8</td><td>Pneumonia due to other specified infectious organisms</td></tr>
<tr><td>J18.1</td><td>Lobar pneumonia, unspecified</td></tr>
<tr><td>J18.8</td><td>Other pneumonia, organism unspecified</td></tr>
<tr><th colspan="2">Other vaccine preventable</th></tr>
<tr><td>A36</td><td>Diphtheria</td></tr>
<tr><td>A37</td><td>Whooping cough</td></tr>
<tr><td>B05</td><td>Measles</td></tr>
<tr><td>B06</td><td>Rubella [German measles]</td></tr>
<tr><td>B16.1</td><td>Acute hep B with delta-agent (coinfectn) without hep coma</td></tr>
</table>
</td></tr>
</table>

B16.9	Acute hep B without delta-agent and without hepat coma
B26	Mumps
M01.4	Rubella arthritis
Angina	
I24.0	Coronary thrombosis not resulting in myocardial infarction
I24.8	Other forms of acute ischaemic heart disease
I24.9	Acute ischaemic heart disease, unspecified
Dehydration and gastroenteritis	
E86	Volume depletion
K52	Other noninfective gastroenteritis and colitis
A02.0	Salmonella enteritis
A04	Other bacterial intestinal infections
A05.9	Bacterial foodborne intoxication, unspecified
A07.2	Cryptosporidiosis
A08	Viral and other specified intestinal infections
A09	Diarrhoea and gastroenteritis of presumed infectious origin
Pyelonephritis and kidney/urinary tract infections	
N10	Acute tubulo-interstitial nephritis
N11	Chronic tubulo-interstitial nephritis
N12	Tubulo-interstitial nephritis not spec as acute or chronic
N13.6	Pyonephrosis
N15.9	Renal tubulo-interstitial disease, unspecified;
N39.0	Urinary tract infection, site not specified;
N30.0	Acute cystitis
N30.8	Other cystitis
N30.9	Cystitis, unspecified
Perforated/bleeding ulcer	
K25.0-K25.2, K25.4-K25.6	Gastric ulcer
K26.0-K26.2, K26.4-K26.6	Duodenal ulcer
K27.0-K27.2, K27.4-K27.6	Peptic ulcer, site unspecified
K28.0-K28.2, K28.4-K28.6	Gastrojejunal ulcer
K20	Oesophagitis
K21	Gastro-oesophageal reflux disease
Cellulitis	
L03	Cellulitis
L04	Acute lymphadenitis
L08.0	Pyoderma

L08.8	Other spec local infections of skin and subcutaneous tissue
L08.9	Local infection of skin and subcutaneous tissue, unspecified
L88	Pyoderma gangrenosum
L98.0	Pyogenic granuloma
I89.1	Lymphangitis
L01	Impetigo
L02	Cutaneous abscess, furuncle and carbuncle
Ear, nose and throat infections	
H66	Suppurative and unspecified otitis media
H67	Otitis media in diseases classified elsewhere
J02	Acute pharyngitis
J03	Acute tonsillitis
J06	Acute upper respiratory infections multiple and unsp sites
J31.2	Chronic pharyngitis
J04.0	Acute laryngitis
Dental conditions	
A69.0	Necrotizing ulcerative stomatitis
K02	Dental caries
K03	Other diseases of hard tissues of teeth
K04	Diseases of pulp and periapical tissues
K05	Gingivitis and periodontal diseases
K06	Other disorders of gingiva and edentulous alveolar ridge
K08	Other disorders of teeth and supporting structures
K09.8	Other cysts of oral region, not elsewhere classified
K09.9	Cyst of oral region, unspecified
K12	Stomatitis and related lesions
K13	Other diseases of lip and oral mucosa
Convulsions and epilepsy	
R56	Convulsions, not elsewhere classified
O15	Eclampsia
G25.3	Myoclonus

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

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

Data source	- Hospital Episode Statistics (HES): www.hesonline.nhs.uk. Data for 2011/12 will be published in November 2012. - ONS mid-year population estimates – http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html

Sources of bias	**Frequency:** HES reports provisional data monthly, annual data by financial year are available in the autumn/winter after the end of the period. ONS data is available annually (calendar year) **Timing:** Annual refresh for 2011/12 are due in November 2012. Mid-year population estimates for 2011 were published in September 2012.
Reporting schedule for data source	Quality of coding is particularly pertinent to this indicator.
Technical issues remaining to be resolved	The list of conditions and the appropriate age range are currently under review. We are investigating the scope for restricting the denominator to the incidence of the relevant conditions.
Historical comparisons	None.
Changes since December 2011 definition	Quarterly values for the indicator have been calculated from Q1 2003/04 to Q4 2010/11 – see the IC Indicator Portal (https://indicators.ic.nhs.uk/webview/)
Data published on the IC indicator portal	Quarterly data from 2003/04 to 2010/11 for England for persons and for the following breakdowns: age, gender, medical conditions, deprivation, ethnicity. Quarterly data for the same period are also published by Local Authority, Primary Care Trust and Strategic Health Authority.

3b Emergency readmissions within 30 days of discharge from hospital	
Outcome sought	Effective recovery from illnesses and injuries requiring hospitalisation.
Status	Live
Updated definition	**Indicator description:** Emergency readmissions within 30 days of discharge from hospital. **Indicator construction:** Percentage of emergency admissions to any hospital in England occurring within 30 days of the last, previous discharge from hospital after admission. Readmissions for cancer and obstetrics are excluded. ***Numerator*** The number of finished and unfinished continuous inpatient (CIP) spells that are emergency admissions within 0-29 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main specialty upon readmission coded under obstetric; and those where the readmitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

	Denominator The number of finished CIP spells within selected medical and surgical specialties, with a discharge date up to March 31st within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded. **Indicator format:** standardised percentage rate.
Data source	Hospital Episode Statistics (HES)
Reporting schedule for data source	**Frequency:** HES reports provisional data monthly, annual data by financial year are available in the autumn/winter after the end of the period. **Timing:** Annual refresh for 2011/12 is due in November 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None.
Historical comparisons	Annual values for the indicator have been calculated from 2001/02 to 2010/11 – see the IC Indicator Portal (https://indicators.ic.nhs.uk/webview/)
Data published on the IC indicator portal	Annual data from 2001/02 to 2010/11 for persons, males and females and deprivation at national level and for government offices of the regions, Strategic Health Authorities and Primary Care Trusts.

3.1 i-v Total health gain as assessed by patients for elective procedures	
Outcome sought	Increased health gain from planned procedures
Status	3.1.i-iv Patient Reported Outcome Measures (PROMS) for elective procedures – Live 3.1.v – Psychological Therapies – in development.
Updated definition	**Indicator description**: Number of interventions together with measures of health status before and after intervention for selected elective procedures (procedures detailed below) reported separately in 3.1 i-iv for PROMs. 3.1.v is in development. The product of the average assessed effectiveness (based upon

before and after health status) and number provides an estimate of overall health gain from the elective procedures measured.

Patient's reported improvement in health status following elective procedures, currently covering groin hernia, hip replacement, knee replacement and varicose veins, are based upon the Patient Reported Outcome Measures (PROMs) programme. PROMs comprise a pair of questionnaires measuring health status completed by the patient, one before and one after surgery (at least three months after for groin hernia and varicose vein operations, or at least six months after for hip and knee replacements). A comparison of these measurements shows whether, and to what extent, the procedure has improved their health status.

A parallel approach is under development to estimate average effectiveness of psychological therapy in achieving recovery. This will build upon the definition of indicator PHQ13: Mental Health Measure-Improved access to psychological services in the NHS Operating Framework 2012/13
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_132045.pdf.

Indicator construction: For the purposes of the NHS Outcomes Framework:
- EQ-5D – a generic health status measure (see www.euroqol.org/)

There are four sets of procedures for which PROMs are collected and these are reported as the EQ-5D index case-mix adjusted average health gain only for the four separate indicators for the purposes of the NHS OF. These are:
i. Unilateral Hip Replacements (Primary and Revisions),
ii. Unilateral Knee Replacements (Primary and Revisions),
iii. Groin Hernia Surgery,
iv. Varicose Vein Surgery.

All patients receiving one of the relevant Procedures from an NHS-funded Provider are eligible to participate and should be invited to complete PROMs questionnaires. PROMs data are collected for patients aged 15 years and above.

A parallel mechanism is in place to collect information from patients undergoing psychological therapy under the Increasing Access to Psychological Therapy (IAPT) programme.

Indicator format: The average health gain adjusted for case-mix. The responses to the pre- and post-operative PROMs questionnaires are converted into pre- and post-operative health status measurements by the application of scoring algorithms, where appropriate. The difference between the pre- and post-operative health status scores is a measure of the outcome of the procedure.

The risk adjustment model takes into account variables such as

	patient characteristics, age, sex and the presence of comorbidities. For further information on the case-mix adjustment model please see http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_133445 The number of individuals receiving the procedures is multiplied by the assessed average risk-adjusted improvement in health status.
Data source	Health and Social Care Information Centre's PROMs data publication and dataset, part of the Hospital Episode Statistics dataset (see – http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1295)
Reporting schedule for data source	**Frequency:** Monthly. **Timing:** Data published in various ways – from April 2009 monthly on a cumulative basis for each financial year. The last publication of provisional monthly PROMs covers the period April 2011 to March 2012 (published on August 2012) – around a 5-month time lag for publication. In terms of annual data, the 2009/10 and 2010/11 final data are available now. Data for 2011/12 are currently provisional. Provisional quarterly data will become available for 2012/13 Q1 in November (Q2 in February etc). Annual data are published along with Q4. Data on the number of individuals receiving procedures is scheduled to be published from March 2013.
Technical issues remaining to be resolved	PROMs are currently only collected for the 4 elective procedures covered by this indicator. The DH is working presently with the National Cardiac Benchmarking Collaborative to pilot the collection of PROMs for elective Coronary Artery Bypass Grafts and Angioplasties. The pilot is due to report towards the end of 2013. As the PROMs programme develops and subject to positive results, we will need to consider if Outcome Framework indicators should in clude more elective procedures 3.1 v is now under development. The indicator will include information on the numbers receiving these elective procedures and on the effectiveness of the interventions.
Changes since December 2011 definition	The indicator now includes recovery following IAPT. The indicator now includes a measure of number of individuals receiving procedures as well as of their effectiveness.
Historical comparisons	The first annual publication for April 2009 to March 2010 came out in August 2011 and shows annual PROMs figures by month and organisation.

Data published on the IC indicator portal	Annual data for 2009/10 and 2010/11 for England for persons and for the following breakdowns: age, gender, disability, ethnicity and deprivation. Annual data for the same period are also available by Provider, Primary Care Trust and Strategic Health Authority.

3.2 Emergency admissions for children with lower respiratory tract infections (LRTIs)	
Outcome sought	Preventing lower respiratory tract infections in children from becoming more serious.
Status	Live
Updated definition	**Indicator description:** Emergency admissions to hospital of children with selected types of lower respiratory tract infections (bronchiolitis, bronchopneumonia and pneumonia). This definition is based on that used for an NHS IC Compendium of Population Health indicator on children and LRTIs. **Indicator construction:** The indicator is defined as the proportion of children aged up to 19 years of age admitted to hospital as an emergency admission for LRTIs. ***Numerator*** The number of finished and unfinished continuous inpatient (CIP) spells, excluding transfers, for patients aged 0-18 years with an emergency method of admission and with any of the following primary diagnoses for lower respiratory tract infections (ICD-10 codes) in the respective period: Bronchiolitis, bronchopneumonia and pneumonia**:** • J10.0 Influenza with pneumonia virus identified; • J11.0 Influenza with pneumonia, virus not identified; • J11.1 Influenza with other respiratory manifestations, virus not identified (bronchiolitis with influenza); • J12.- Viral pneumonia nec; • J13 Pneumonia due to Streptococcus pneumoniae; • J14 Pneumonia due to Haemophilus influenzae; • J15.- Bacterial pneumonia nec; • J16.- Pneumonia due to other infectious organisms nec; • J18.0 Bronchopneumonia, unspecified; • J18.1 Lobar pneumonia; • J18.9 Pneumonia unspecified; • J21.- Acute bronchiolitis. ***Denominator*** The denominator is the resident population estimate for under 19s. Data are based on the latest revisions of ONS mid-year population estimates for the respective years, current as at September 2012.

	For further details on revisions to ONS mid-year population estimates, and their availability, see http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html. **Indicator format:** Quarterly age standardised rate per 100,000.
Data source	- Hospital Episode Statistics (www.hesonline.nhs.uk) -ONS mid-year population estimates http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Monthly (provisional), quarterly for HES data, annual for population estimates **Timing:** Annual refresh for 2011/12 is due in November 2012. Mid-year population estimates for 2011 were published in September 2012
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Quarterly values for the indicator have been calculated from Q1 2001/02 to Q4 2010/11 – see the IC Indicator Portal (https://indicators.ic.nhs.uk/webview/)
Data published on the IC indicator portal	Quarterly data from 2003/04 to 2010/11 for England for persons and for the following breakdowns: age, gender, medical conditions, deprivation, ethnicity. Quarterly data for the same period are also published by Local Authority, Primary Care Trust and Strategic Health Authority.

3.3. Proportion of people who recover from major trauma	
Outcome sought	Improved recovery for patients with major trauma
Status	In development
Updated definition	This indicator is under development. **Indicator description:** Adjusted odds of survival from major trauma in England, adjusted for age, injury severity and conscious level. **Indicator construction:** The odds of survival in a given year are calculated by dividing the number of people who survived by the number of people who died in that year.

	The indicator includes all patients male and female of all ages surviving to hospital with an injury severity score of >8 and fulfilling TARN eligibility criteria. which are: trauma admissions longer than 3 days, or admissions into an intensive care area, or after transfer for further care, or patients who die from their injuries. Simple isolated injuries are excluded. **Indicator format:** Number (adjusted odds)
Data source	Trauma Audit Research Network (TARN). See http://www.tarn.ac.uk for further details.
Reporting schedule for data source	TARN published data are available from http://www.tarn.ac.uk and three times a year in focussed reports. This proposed indicator would be published as a national figure annually.
Technical issues remaining to be resolved	How to include the extent of recovery in the indicator definition: a methodology is now under development. A DH-funded pilot on collecting cost-utility data for trauma patients (adults and children) will run in 2013/14.
Changes since December 2010 definition	The indicator definition has changed from the original proposal to base the indicator on Best Practice Tariff and quality of life measures, as described in the NHS Outcomes Framework 2012/13, following clinical advice and using readily available data.
Historical comparisons	Existing TARN data can be used as a baseline. The data have been collected for over 20 years, and data completion has been very high (>90% for Major Trauma Centres) since 2012.
Data published on the IC indicator portal	Not yet published.

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

Outcome sought	Effective recovery following a stroke.
Status	In development.
Updated definition	This indicator was selected as part of the Innovation in Outcomes Competition and the following definition continues to be developed. 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. The mRS score will be taken at diagnosis and at 6-months post stroke at a regular review. This could take place in primary care, elsewhere in the community, or in a hospital clinic. The method of this follow-up will vary but could be done in person at a 6-month review visit, via a

<table>
<tr><td></td><td>postal questionnaire or by phone.
It will cover adults with stroke aged 18 and over.
The mRS consists of the following scores –
Modified Rankin Scale
<table>
<tr><th>Score</th><th>Description</th></tr>
<tr><td>0</td><td>No symptoms at all</td></tr>
<tr><td>1</td><td>No significant disability despite symptoms; able to carry out all usual duties and activities</td></tr>
<tr><td>2</td><td>Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance</td></tr>
<tr><td>3</td><td>Moderate disability; requiring some help, but able to walk without assistance</td></tr>
<tr><td>4</td><td>Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance</td></tr>
<tr><td>5</td><td>Severe disability; bedridden, incontinent and requiring constant nursing care and attention</td></tr>
<tr><td>6</td><td>Dead</td></tr>
</table></td></tr>
<tr><td>Data source</td><td>Sentinel Stroke National Audit Programme (SSNAP) – for further detail, see https://audit.rcplondon.ac.uk/sentinelstroke/page/page.aspx?pc=welcome.</td></tr>
<tr><td>Reporting schedule for data source</td><td>Frequency: Annual (financial year).
Timing: Data collection will start on December 2012 and the first 6 month follow up data will be entered into the audit from June 2013 onwards (6 months after first patient records entered in December 2012). The indicator is expected to be published using one year's worth of data, which will be available on the Summer/Autumn 2014.</td></tr>
<tr><td>Technical issues remaining to be resolved</td><td>The SSNAP audit is due to replace the Stroke Improvement National Audit Programme (SINAP – http://www.rcplondon.ac.uk/resources/stroke-improvement-national-audit-programme-sinap) and the biannual National Sentinel Stroke Audit (https://audit.rcplondon.ac.uk/SentinelStroke/page/page.aspx?pc=welcome) from April 2012.</td></tr>
<tr><td>Changes since December 2011 definition</td><td>None</td></tr>
<tr><td>Historical comparisons</td><td>None</td></tr>
</table>

Data published on the IC indicator portal	Not yet published.

<table>
<tr><th colspan="2">3.5 Proportion of patients with a fragility fracture recovering to their previous levels of mobility at i. 30 days and ii. 120 days</th></tr>
<tr><td>Outcome sought</td><td>Effective recovery of mobility following a fragility fracture.</td></tr>
<tr><td>Status</td><td>In development.</td></tr>
<tr><td>Updated definition</td><td>This indicator will measure the proportion of patients recovering to a level of mobility at 30 and 120 days respectively no less than 1 mobility category in relation to their previous level of mobility. It will initially be based on measuring recovery from hip fractures only, using data from the National Hip Fracture Database (NHFD), which collects information about mobility before and after a hip fracture.

Indicator description: proportion of all surviving patients (male and female) in England aged 60 and over with a fragility fracture who have recovered their previous level of mobility or have descended 1 mobility category at:
i. 30 days
ii. 120 days

Indicator construction:

Numerator: Number of patients in the NHFD dataset who have survived to 30 / 120 days and have recovered their previous level of mobility or descended 1 mobility category.

Patients will be eligible for the 30 and 120 day analyses if they were alive on the given day and their mobility categories at admission and on the given day were available.

The order of ability used to determine whether patients were able to recover to their previous levels of mobility is below. Category 1 is the category with highest mobility :
1. Regularly mobile outdoors without aids (or assistance)
2. Mobile outdoors with only one aid
3. Mobile outdoors with 2 aids or a frame
4. Indoor mobility only, but never goes out unassisted
5. No functional mobility (wheelchair or assisted transfers or bedbound)

Mobility categories
The NHFD current dataset records walking ability indoors, walking ability outdoors and whether a patient is accompanied to walk outdoors at admission and at 30 and 120 days post-admission.

For walking ability indoors the available options are:</td></tr>
</table>

- Regularly walked without aids
- Regularly walked with one aid
- Regularly walked with two aids or frame
- Wheelchair or bedbound

For walking ability outdoors the available options are:

- Regularly walked without aids
- Regularly walked with one aid
- Regularly walked with two aids or frame
- Electric buggy
- Wheelchair or bedbound
- Never goes outdoors

For whether the patient is accompanied to walk outdoors the available options are:

- No
- Yes
- Wheelchair or bedbound
- Never goes outdoors

For this outcome indicator patients with the above characteristics will be grouped into five categories according to a simple algorithm for mobility. The rank order of ability is based on three variables detailed above:

- Unassisted walking Ability without aids
- Walking Ability with aids
- No functional mobility

Table 1: Summary of the mobility categories

Cat.	Description	Definition as per NHFD data fields
1	Regularly mobile outdoor without aids (or assistance)	Walking ability outdoors = “Regularly walked without aids” AND Accompanied to walk outdoors = “No”
2	Mobile outdoors with only one aid	Walking ability outdoors = “Regularly walked with one aid” AND Accompanied to walk outdoors = “No”
3	Mobile outdoors with 2 aids or a frame	Walking ability outdoors = “Regularly walked with two aids or frame” AND Accompanied to walk outdoors = “No”
4	Indoor mobility only, but never goes out	Walking ability indoors = “Regularly walked without aids”/ “Regularly walked with one aid” OR “Regularly

<table>
<tr><td></td><td>
<table>
<tr><td></td><td>unassisted</td><td>walked with two aids or frame”
AND
(Walking ability outdoors = “Electric buggy”/”Wheelchair or bedbound” OR “Never goes outdoors”
OR
Accompanied to walk outdoors = “Yes”)</td></tr>
<tr><td>5</td><td>No functional mobility (wheelchair or assisted transfers or bedbound)</td><td>Walking ability indoors = “Wheelchair or bedbound”
AND
Walking ability outdoors = “Electric buggy”/”Wheelchair or bedbound” OR “Never goes outdoors”</td></tr>
</table>

<i>Denominator</i> - Count of all NHFD case records started in the designated 12 month period plus 30 / 120 days for their follow-up where:
o The patient has survived to 30 / 120 days
o There is a completed data field for pre fracture mobility and a 30 day mobility record
There is a completed data field for pre fracture mobility and a 120 day mobility record
</td></tr>
<tr><td>Data source</td><td>The National Hip Fracture Database (NHFD) (see – http://www.nhfd.co.uk/)</td></tr>
<tr><td>Reporting schedule for data source</td><td>Frequency: Annual (national clinical audit report) financial year data.
Timing: The NHFD National report 2012 was published in September 2012 for the period April 2011 to March 2012.</td></tr>
<tr><td>Technical issues remaining to be resolved</td><td>The indicator definition is now being finalised.</td></tr>
<tr><td>Changes since December 2011 definition</td><td>The definition of the indicator has been refined after consultation with clinicians and the Fragility Fracture Programme Board, which includes representatives from Age UK, National Osteoporosis Society and National Hip Fracture Database, British Geriatric Society, British Orthopaedic Association, Age Anaesthesia and primary care.</td></tr>
<tr><td>Historical comparisons</td><td>Data are available from 2007 for hip fractures only.</td></tr>
<tr><td>Data published on the IC indicator portal</td><td>Not yet published.</td></tr>
</table>

3.6 Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services **i The proportion still at home 91 days after discharge into rehabilitation** **ii The proportion offered rehabilitation following discharge from acute or community hospital**	
Outcome sought	Helping older people to recover their independence after illness or injury.
Status	Live
Updated definition	**Indicator description:** i) The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services. ii) The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. **Indicator construction:** This will be a two-part measure which reflects both the effectiveness of rehabilitation services (i), and the coverage of the service (ii). The product of the two indicators provides an indirect estimate of health gain consequent upon intervention. i) The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. Those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months are not reported in the numerator. The collection of the denominator covers 1 October to 31 December for the relevant year, with a 91-day follow-up for each case included in the denominator to populate the numerator. ii) The proportion of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. This measure will take the denominator from part i) as its numerator (the number of older people offered rehabilitation services). The new denominator will be the total number of older people discharged from acute or community hospitals based on Hospital Episode Statistics (HES). **Indicator format:** Percentage of patients.

	This indicator shared with the Adult Social Care Outcomes Framework
Data source	*Adult Social Care Combined Activity Return (ASC-CAR)*, *Hospital Episode Statistics* Guidance for 2011/12 onwards can be found via the generic social care collection page at http://www.ic.nhs.uk/services/social-care/social-care-collections by clicking on the year. Guidance for HES data can be found at http://www.hesonline.nhs.uk
Reporting schedule for data source	**Frequency:** Annual (financial year). **Timing:** 2011/12 provisional data for i) was published by the NHS IC in September 2012 (See: http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/measures-from-the-adult-social-care-outcomes-framework-england--2011-12--provisional-release). This was previously NI125 in CLG's National Indicator List and historical data are available at http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/social-care-and-mental-health-indicators-from-the-national-indicator-set-2010-11-provisional-release. It will continue to be available annually. 2011/12 provisional data for ii) was published by the Health and Social Care Information Centre in September 2012 (See: http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/measures-from-the-adult-social-care-outcomes-framework-england--2011-12--provisional-release). These data covers the 3-month period to which the collection relates – Oct-Dec, with follow-up 91 days later, and annually thereafter.
Technical issues remaining to be resolved	Work is continuing to expand the measure to include individuals assessed only on health needs.
Changes since December 2011 definition	None
Historical comparisons	None
Data published on the IC indicator portal	2011/12 data have been published within the Adult Social Care Outcomes Framework by Local Authority, Government Regions and for Shire Counties, Unitary Authorities, Metropolitan Districts, Inner London and Outer London.

Domain 4

Ensuring people have a positive experience of care

Indicator Structure

4.1 Domain 4, ***Ensuring people have a positive experience of care***, comprises three *overarching indicators* and nine *improvement areas* based on patients’ responses to surveys covering their experience of care in different settings.

Overarching indicator
4a Patient experience of primary care i GP services ii GP out-of-hours services iii NHS Dental Services
4b Patient experience of hospital care
4c Friends and Family test
Improvement areas
Improving people’s experience of outpatient care
4.1 Patient experience of outpatient services
Improving hospitals’ responsiveness to personal needs
4.2 Responsiveness to in-patients’ personal needs
Improving people’s experience of accident and emergency services
4.3 Patient experience of A&E services
Improving access to primary care services
4.4.i Access to GP services
4.4.ii NHS Dental services
Improving women and their families’ experience of maternity services
4.5 Women’s experience of maternity services
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
Improving the experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services
Improving children and young people’s experience of healthcare
4.8 An indicator is under development
Improving people’s experience of integrated care
4.9 An indicator is under development

Work in Progress

4.2 Together, the overarching indicators and the complementary improvement indicators provide a picture of the NHS’s contribution to improving the experience of care, including access to care.

4.3 Work is in progress to develop a national Friends and Family Test, and an associated outcomes indicator, to be included as an additional overarching indicator. The test will measure whether people receiving NHS treatment would recommend the place where they received care to their friends and family. The national roll out of the test was one of a set of recommendations by the Nursing and Quality Care Forum in May 2012. The Friends and Family Test will be implemented in inpatient wards and A&E departments from April 2013.

4.4 In January 2012, the NHS Future Forum responded to the views reported by patient, service user and care organisations that too often patients experience gaps in service provision, failures in communication, and poor transitions between services. National Voices reported that integrated care was the top demand from patient, service user and carer organisations who wanted care to be co-ordinated and personalised around the patient. As highlighted by the Future Forum: "Integration is a vitally important aspect of the experience of health and social care for millions of people. It has perhaps the greatest relevance for the most vulnerable and those with the most complex and long term needs." However, at present, no direct measure of people's experience of integrated care exists.

4.5 In July 2012 we published the social care white paper *Caring for our Future* which restated our commitment for a clear, ambitious and measurable goal to drive further improvements in people's experience of integrated care. Such a measure is now included as a placeholder indicator 4.9. Research work aimed at advancing a methodology for capturing patient experience of integrated care is currently underway. Parallel measures should be included in the Adult Social Care Outcomes Framework and, where appropriate, within the Public Health Outcomes Framework.

Inequality

4.6 Patient experience surveys are specifically designed to capture the directly-reported experience of patients and service users, as opposed to capturing qualitative measures of satisfaction or perception. All the surveys used in this Domain are based on simple random sampling and are conducted using the highest of professional statistical and research standards. This includes careful processes for issuing reminders and checking response rates from different demographic groups in order to avoid any response bias in the results.

4.7 Inequality in outcomes attributable to NHS care can therefore be evaluated across the indicators proposed for Domain 4, although it is necessary to consider the size of any confidence interval or 'margin of error' on survey based measures.

4.8 Whilst inequality is generally assessed by considering variation by socio-economic grouping or other equality characteristics, it is also possible in this Domain to consider inequality in the quality of service across all patients receiving services. Whilst the quality of patient experience reflected in the various indicators may on average be good, it is appropriate to focus on the numbers of patients who receive very poor experience as an aspect of inequality.

4.9 The rationale for this focus is twofold:

- variation in care experience is intrinsically problematic: even were 99% of the population receiving excellent care experiences, it would still be problematic were 1% receiving poor care
- there is no intrinsic calibration of responses in the patient experience surveys – and it is intuitively plausible that the benefit of moving someone from a very poor to a fair experience is greater than a move from fair to very good – justifying a focus upon the worst outcomes.

4.10 Hence, it is appropriate to focus upon those receiving care that could legitimately be characterised as "**very poor**". To define this perspective precisely requires a measure of "very poor" experience appropriate for each patient experience area. This is most straightforward for areas, like **indicator 4a,** in which there is a single question inviting a global assessment of the experience of care.

4.11 Indicator 4b, patient experience of hospital care, is based on 20 survey questions grouped into five domains. The focus on the proportion of very poor responses can be applied to specific patient experience questions. Based on judgement and intuition, the table proposes an allocation of response to a "very poor" category.

Indicator 4b	**Questions for assessment of "Very Poor" response.**
1.1	**Q11 Was your admission date changed by the hospital?**
	No
	Yes, once
very poor	**Yes, 2 or 3 times**
very poor	**Yes, 4 times or more**
3.1	**Q41 Were you involved as much as you wanted to be in decisions about your care and treatment?**
	Yes, definitely
	Yes, to some extent
very poor	**No**
4.1	**Q31 When you had important questions to ask a doctor, did you get answers that you could understand?**
	Yes, always
	Yes, sometimes
very poor	**No**
4.2	**Q33 Did doctors talk in front of you as if you weren't there?**
very poor	**Yes, often**
	Yes, sometimes
	No
4.4	**Q37 Did nurses talk in front of you as if you weren't there?**
very poor	**Yes, often**
	Yes, sometimes
	No

5.2	Q22 In your opinion, how clean was the hospital room or ward that you were in?
	Very clean
	Fairly clean
Very poor	Not very clean
very poor	Not at all clean
5.4	Q45 Were you given enough privacy when discussing your condition or treatment?
	Yes, always
	Yes, sometimes
very poor	No
5.5	Q72 Overall, did you feel you were treated with respect and dignity while you were in the hospital?
	Yes, always
	Yes, sometimes
very poor	No
All to be weighted equally.	

4.12 For the other indicators “very poor assessment “ of care might be based on the following questions:

Indicator	**Questions for assessment of “very poor” response**
Indicator 4.1 Outpatient services	**29. Were you involved as much as you wanted to be in decisions about your care and treatment?**
	Yes, definitely
	Yes, to some extent
very poor	**No**
Indicator 4.3: A&E services	**Q39 Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?**
	Yes, definitely
	Yes, to some extent
very poor	**No**
Indicator 4.4.ii Acess to NHS Dental Services	**Were you successful in getting an NHS dental appointment?**
	Yes
very poor	**No**
Indicator 4.5 Maternity services	**D4 Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?**
	Yes, always
	Yes, sometimes
very poor	**No**

Indicator 4.7: Community mental health services **very poor**	**Did this person treat you with respect and dignity?** **Yes, definitely** **Yes, to some extent** **No**

4.13 Analyses of "very poor" care can be investigated both in overall terms, and separately from various inequality and equality perspectives.

4.14 It is proposed that this presentation of patient experience outcomes be published on the Health and Social Care Information Centre's indicator portal.

Possible sources of bias

4.15 There is potential for results to be influenced by changes in gratitude bias and patients' and service users' sense of engagement and involvement with the system. Where appropriate and possible (as set out in individual indicator definitions) this is reflected in the methodology, for example standardising results to take account of the slight tendency for older patients to give more positive responses.

Drivers of the outcome

4.16 Further details of the drivers of the outcomes in Domain 4 are set out in the Technical Annex which accompanied the consultation on the draft mandate to the NHS Commissioning Board which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition. This also details the presentation of historic trends and international comparisons.

4a Patient experience of primary care **i. GP services** **ii. GP Out of Hours services** **iii. NHS Dental services**	
Outcome sought	Improvement in patients' experiences of GP services, GP Out of Hours services and NHS Dental services.
Status	Live
Updated definition	**Indicator description:** These will be presented as separate indicators derived from the GP Patient Survey (GPPS) measuring experience of GP Services, GP Out of Hours services and NHS Dental Services. The indicators are based on the percentage of people responding Good or Very Good to each of the following questions: • Overall, how would you describe your experience of your GP Surgery? • Overall, how would you describe your experience of out-of-hours GP Services? • Overall, how would you describe your experience of NHS Dental Services? Subject to review, supplementary information will also be provided,

	indicating the percentage of survey respondents for each of the possible responses to each question. **Indicator construction:** ***Numerator*** Three separate numerators, one for each part of the indicator. Each is the number of people answering Good or Very Good to the questions above. ***Denominator*** Three separate denominators, one for each part of the indicator. Each is the total number of people answering the questions above. Data is weighted based on demographic data to ensure results are representative of the national population. The weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GPPS. The GPPS is sent to adults 18 years and above. **Indicator format:** This indicator will take values between 0-100, where 0 is the worst score and 100 is the best score.
Data source	The GP Patient Survey, from 2011/12 onwards (http://www.gp-patient.co.uk/results/).
Reporting schedule for data source	**Frequency:** The indicator is based on aggregated data from two collections each year. From June 2012 onwards, data is published on a rolling six-monthly basis, the indicator will only be produced annually based on data for the full financial year. Producing the indicator on a six-monthly basis will mean that data will overlap with the previously calculated score. **Timing:** The 2011/12 survey provides the first data, published in June 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Data do not currently exist in a directly comparable format, however, patient experience of primary care services has been measured through the GPPS before it was redesigned this year (see – http://www.gp-patient.co.uk/)

Data published on the IC indicator portal	National data for July 2011 to March 2012 for persons.

4b Patient experience of hospital care	
Outcome sought	Improvement in patients’ experiences of NHS inpatient care.
Status	Live
Updated definition	**Indicator description:** This Overall Patient Experience score is the average (mean) of five domain scores, and each domain score is the average (mean) of scores from a number of selected questions in the CQC Inpatient Services Survey. **Indicator construction:** ***Access & Waiting domain***: Q9: How do you feel about the length of time you were on the waiting list before your admission to hospital? (Scores: “I was admitted as soon as I thought was necessary” 100; “I should have been admitted a bit sooner” 50; “I should have been admitted a lot sooner” 0.) Q11: Was your admission date changed by the hospital? (Scores: “No” 100; “Yes, once” 67; “Yes, 2 or 3 times” 33; “Yes, 4 times or more” 0.) Q12: From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward? (Scores: “No” 100; “Yes, to some extent” 50; “Yes, definitely” 0.) ***Safe, high quality co-ordinated care domain*****:** Q40: Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you? (Scores: “No” 100; “Yes, sometimes” 50; “Yes, often” 0.) Q59: On the day you left hospital, was your discharge delayed for any reason? (Scores: “No” 100; “Yes 0”. Exception: Records are excluded where the answer to Q60 “What was the main reason for the delay?” is “Something else” and not “I had to wait for medicines”, “I had to wait to see the doctor” or “I had to wait for an ambulance”.) Q67: Did a member of staff tell you about any danger signals you should watch for after you went home? (Scores: “Yes, completely” 100; “Yes, to some extent” 50; “No” 0.) ***Better information, more choice domain*****:** Q41: Were you involved as much as you wanted to be in decisions about your care and treatment? (Scores: “Yes, definitely” 100; “Yes, to some extent” 50; “No” 0.) Q63: Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand? (Scores: “Yes, completely” 100; “Yes, to some extent” 50; “No” 0; “I did not need an explanation” and “I had no medicines” are excluded.) Q64: Did a member of staff tell you about medication side effects to watch for when you went home? (Scores: “Yes, completely” 100; “Yes, to some extent” 50; “No” 0; “I did not need an explanation” are

excluded.)

***Building closer relationships domain*:**
Q31: When you had important questions to ask a doctor, did you get answers that you could understand? (Scores: “Yes, always” 100; “Yes, sometimes” 50; “No” 0; “I had no need to ask” are excluded.)
Q33: Did doctors talk in front of you as if you weren’t there? (Scores: “No” 100; “Yes, sometimes” 50; “Yes, often” 0.)
Q35: When you had important questions to ask a nurse, did you get answers that you could understand? (Scores: “Yes, always” 100; “Yes, sometimes” 50; “No” 0; “I had no need to ask” are excluded.)
Q37: Did nurses talk in front of you as if you weren’t there? (Scores: “No” 100; “Yes, sometimes” 50; “Yes, often” 0.)

***Clean, friendly, comfortable place to be domain*:**
Q20 & Q21: Mean average of “Were you ever bothered by noise at night from other patients?” and “Were you ever bothered by noise at night from hospital staff?” (Scores for both: “No” 100; “Yes” 0.)
Q22: In your opinion, how clean was the hospital room or ward that you were in? (Scores: “Very clean” 100; “Fairly clean” 67; “Not very clean” 33; “Not at all clean” 0.)
Q28: How would you rate the hospital food? (Scores: “Very good” 100; “Good” 67; “Fair” 33; “Poor” 0.)
Q46: Were you given enough privacy when being examined or treated? (Scores: “Yes, always” 100; “Yes, sometimes” 50; “No” 0.)
Q48: Do you think the hospital staff did everything they could to help control your pain? (Scores: “Yes, definitely” 100; “Yes, to some extent” 50; “No” 0.)
Q72: Overall, did you feel you were treated with respect and dignity while you were in the hospital? (Scores: “Yes, always” 100; “Yes, sometimes” 50; “No” 0.)

Indicator format: Number.
Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score.

Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as “very poor” (see introductory section to this Domain). These data will be at national level. Assessment of question responses that indicate “very poor” care is based on considerations of experience that should not occur in a health care setting.

Only the overall score will be used as the high level outcome measure. However, performance can be disaggregated by each of the domains, and then again at the level of each individual survey question that makes up the indicator. Confirmation of the methodology used to construct the indicator is available on the DH website: www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516

	The 2011 questionnaire is on the Picker Institute site: www.nhssurveys.org/survey/1093
Data source	The Care Quality Commission's Adult Inpatient Survey – from the CQC nationally coordinated patient survey programme. The latest adult inpatient survey (2011) was published by CQC and the updated Overall Patient Experience measure, presenting results as used for this indicator, were published in April 2012 by DH at the following websites, respectively: http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm; http://transparency.dh.gov.uk/tools-for-understanding-patient-experience/ Guidance material for this survey (covering inclusion and exclusion criteria for compiling the sample frame) is available on the NHS national patient survey coordination centre website: www.nhssurveys.org.
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 data published April 2012. Data for 2012 will be available in April/May 2013. The national data for this measure are published annually on the DH website in accordance with national statistics guidelines (see the first link below). Detailed results for each provider, presented question by question, are also published on the CQC website (see second link below). http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHspatients/DH_087516; http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys.cfm
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Data are available for 2001/02, 2003/04, 2005/06, and yearly from 2007/08 to 2010/11. Source: DH, Overall patient experience measure updated to include results from the 2011 Inpatient Survey, www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients 2003/04, 2005/06 and yearly from 2007/08 to 2009/10: Patient experience scores published in May 2010.

	2007/08 to 2010/11: Patients experience scores published in May 2011.
Data published on the IC indicator portal	Annual data for 2003/04 to 2011/12 for persons at national level. Annual data for 2006/07 to 2011/12 for persons at provider level.

4.c Friends and Family Test	
Outcome sought	Improving the number of positive recommendations to friends and family by people receiving NHS Treatment for the place where they received this care.
Status	Placeholder
Updated definition	Under development. The Friends and Family Test will measure whether people receiving NHS treatment would recommend the place where they received care to their friends and family. The national roll out of the test was one of a set of recommendations by the Nursing and Quality Care Forum in May 2012. The Friends and Family Test will be implemented in inpatient wards and A&E departments from April 2013.
Data source	Under development
Reporting schedule for data source	To be decided
Technical issues remaining to be resolved	This indicator is a placeholder, it requires extensive development.
Changes since December 2011 definition	Not applicable – new indicator in development.
Historical comparisons	None
Data published on the IC indicator portal	Not yet published

4.1 Patient experience of outpatient services	
Outcome sought	Improvement in people's experiences of NHS outpatient care.
Status	Live
Updated definition	**Indicator description:** The indicator seeks to measure important elements of experience across the three stages of the care pathway: pre-visit; during the visit to the Outpatients department; and the transition/post-visit period.

	Indicator construction: The indicator is a composite, calculated as the average of five survey questions. ***Pre visit*** Q7: Before your appointment, did you know what would happen to you during the appointment? (Scores: “Yes, definitely” 100; “Yes, to some extent” 50; “No” 0.) ***During visit*** Q32: Did doctors and/or other staff talk in front of you as if you weren’t there? (Scores: “Yes, definitely” 0; “Yes, to some extent” 50; “No” 100.) Q35: Sometimes in a hospital or clinic, a member of staff will say one thing and another will say something quite different. Did this happen to you? (Scores: “Yes, definitely” 0; “Yes, to some extent” 50; “No” 100.) Q36: Were you involved as much as you wanted to be in decisions about your care and treatment? (Scores: “Yes, definitely” 100; “Yes, to some extent” 50; “No” 0.) ***Post visit/transition*** Q48: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (Scores: “Yes” 100; “No” 0; “Don’t know / Can’t remember” are excluded.) The Outpatient Questionnaire is for patients aged 16 and over. **Indicator format:** Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score. Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as “very poor”. These data will be at national level. Assessment of question responses that indicate “very poor” care is based on considerations of experience that should not occur in a health care setting. **Standardisation** Scores are standardised by age and gender. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score. Missing responses are presented in the survey but not included in the base number of respondents for percentages.
Data source	The Outpatient Survey is coordinated nationally by the Care Quality Commission as part of the NHS patient survey programme. Results from the last survey (2009) are published on the CQC website: www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/outpatient-survey-2009

Reporting schedule for data source	**Frequency:** The survey is conducted on an ad hoc, rolling basis. **Timing:** Data for the specific NHS Outcomes Framework indicator are not currently published in this form, although scored results for each individual question are routinely calculated. The underlying data source are published in similar form as an existing National Statistic composite indicator, but this indicator is designed to capture the whole of patient experience rather than those areas specifically requiring improvement. Source data are from the 2009 survey, data from the 2011 survey were published in February 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons.	Data for Question 7 (numbered Question 3 in 2009) and Question 48 (Question 44 in 2009) are available for 2004 and 2009; data for the other three questions (Question 32, Question 35 and Question 36 in 2009) are available for 2003, 2004 and 2009. See: Care Quality Commission Outpatient Services Survey 2009, www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/outpatient-survey-2009
Data published on the IC indicator portal	Annual data for 2009 and 2011 for persons at national and provider level.

4.2 Responsiveness to in-patients' personal needs	
Outcome sought	Improvement in hospitals' responsiveness to patients' personal needs.
Status	Live
Updated definition	**Indicator description:** Responsiveness to in-patients' personal needs. **Indicator construction:** The indicator is a composite, calculated as the average of five survey questions. Each question describes a different element of the overarching theme, "*responsiveness to patients' personal needs".* Q41: Were you involved as much as you wanted to be in decisions about your care and treatment? (Scores: "Yes, definitely" 100; "Yes, to some extent" 50; "No" 0.) Q44: Did you find someone on the hospital staff to talk to about your worries and fears? (Scores: "Yes, definitely" 100; "Yes, to some

	extent” 50; “No” 0; “I had no worries or fears” are excluded.) Q45: Were you given enough privacy when discussing your condition or treatment? (Scores: “Yes, definitely” 100; “Yes, to some extent” 50; “No” 0.) Q64: Did a member of staff tell you about medication side effects to watch for when you went home? (Scores: “Yes, completely” 100; “Yes, to some extent” 50; “No” 0; “I did not need an explanation” are excluded.) Q69: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital? (Scores: “Yes” 100; “No” 0; “Don’t know / Can’t remember” are excluded.) **Indicator format:** Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score. Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as “very poor”. These data will be at national level. Assessment of question responses that indicate “very poor” care is based on considerations of experience that should not occur in a health care setting. This indicator was developed as part of a national CQUIN goal for acute providers in 2009/10. Further information is available on the DH and the NHS Institute for Innovation and Improvement websites (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443).
Data source	The Care Quality Commission’s Adult Inpatient Survey – from the CQC nationally coordinated patient survey programme. The latest adult inpatient survey (2011) was published by the CQC at the following website: http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm Guidance material for this survey (covering inclusion and exclusion criteria for compiling the sample frame) is available on the NHS national patient survey coordination centre website: www.nhssurveys.org
Reporting schedule for data source	**Frequency:** Annual (calendar year). **Timing:** 2011 data published April 2012. Data for 2012 will be available around April/May 2013. The underlying data source is currently published (Adult Inpatient Survey), and scores for this indicator are available and are shared with SHAs, Trusts and PCTs, but no national level indicator is currently published.

	This indicator is currently being used as a national CQUIN goal for patient experience, covering acute providers. Further details are available on the NHS Institute for Innovation and Improvement website: www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical Comparisons	Data for each question are available for 2003/04, 2005/06, and yearly from 2007/08 to 2010/11. Source: Care Quality Commission Inpatient Services Survey http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm
Data published on the IC indicator portal	Annual data for 2003/04 to 2011/12 for persons at national and provider level.

4.3 Patient experience of accident and emergency services	
Outcome sought	Improvement in patients' experiences of Accident and Emergency (A&E) departments.
Status	Live
Updated definition	**Indicator description:** Patient experience of A&E services **Indicator construction:** The indicator is a composite measure, calculated as the average score of the five survey questions below. Each question describes a different element of the overarching theme: Improving people's experiences of Accident and Emergency services. The questionnaire is for patients aged 16 and over. Q12: While you were in the Emergency department, did a doctor or nurse explain your treatment in a way you could understand? (Scores: "Yes, completely" 100; "Yes, to some extent" 50; "No" 0; "I did not need an explanation" are excluded.) Q15: Did you have confidence and trust in the doctors and nurses examining and treating you? (Scores: "Yes, definitely" 100; "Yes, to

	some extent" 50; "No" 0.) Q21: Were you involved as much as you wanted to be in decisions about your care and treatment? (Scores: "Yes, definitely" 100; "Yes, to some extent" 50; "No" 0; "I was not well enough to be involved in decisions about my care" are excluded.) Q27: Do you think the hospital staff did everything they could to help control your pain? (Scores: "Yes, definitely" 100; "Yes, to some extent" 50; "No" 0; "Can't say / Don't know" are excluded.) Q39: Overall, did you feel you were treated with respect and dignity while you were in the Emergency department? (Scores: "Yes, all of the time" 100; "Yes, some of the time" 50; "No" 0) **Indicator format:** Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score. Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as "very poor". These data will be at national level. Assessment of question responses that indicate "very poor" care is based on considerations of experience that should not occur in a health care setting. **Standardisation** The scores are standardised by age and gender. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score. Missing responses are presented in the survey but not included in the base number of respondents for percentages.
Data source	The A&E survey is coordinated nationally by the Care Quality Commission as part of the NHS patient survey programme. The latest Emergency Department Survey (2008) is used to form this indicator. Results from the 2008 survey are published on the Picker Institute website: www.nhssurveys.org/surveys/392
Reporting schedule for data source	**Frequency**: The survey is run on an ad hoc rolling basis. **Timing**: The A&E Survey runs in 2012, with data available in 2013.
Technical issues remaining to be resolved	None
Changes since	None

December 2011 definition	
Historical comparisons	Results are available for 2003, 2004 and 2008. Source: NHS Surveys Emergency Department Surveys www.nhssurveys.org/surveys/392
Data published on the IC indicator portal	Annual data for 2008 for persons at national and provider level.

4.4 Access to i. GP services ii. NHS Dental services

Outcome sought	Improvement in patients' access to: - GP services; and - NHS dental services
Status	Live
Updated definition	This will be two separate indicators: **i) Indicator description:** Access to GP Services **Indicator construction:** This indicator will be based on responses to a single question within the GP Patient Survey (GPPS): Overall, how would you describe your experience of making an appointment? ***Numerator*** The number of people responding 'Very Good' or 'Fairly Good'. ***Denominator*** All respondents to the question. Responses are measured on a five point scale: Very good, Fairly good, Neither good nor poor, Fairly poor and Very poor. This is a new question in the redeveloped GPPS. **ii) Indicator description:** Access to Dental Services for those who have tried to get an NHS dental appointment in the last two years. **Indicator construction:** This indicator will be based on the single question: "Were you successful in getting an NHS dental appointment?" ***Numerator*** The numerator is all respondents stating 'Yes'. ***Denominator***

	All respondents who state “yes” or “no” to the question (responses “Can’t remember” are excluded). The GPPS is sent to adults 18 years and above. Data are weighted based on demographic data to ensure results are representative of the national population. The weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GPPS. **Indicator format:** The indicator is the percentage of patients who have tried to get an NHS appointment in the last two years and were able to, the last time they tried. Subject to review, supplementary information will also be provided, indicating the percentage of survey respondents for each of the possible responses to each question.
Data source	The GP Patient Survey, from 2011/12 onwards (http://www.gp-patient.co.uk/results/).
Reporting schedule for data source	Access to GP Services data was first published in June 2012. **Frequency:** The indicator is based on aggregated data from two collections each year. From June 2012 onwards, data will be published on a rolling six-monthly basis, the indicator will only be produced annually based on data for the full financial year. Producing the indicator on a six-monthly basis will mean that data will overlap with the previously calculated score. **Timing:** The 2011/12 survey provides the first data, published in June 2012. For NHS Dental Services, data are not aggregated across the year, therefore there is no overlap between December and June publications. The first data used to form this indicator was published in December 2011. Access to Dental Services data currently exists, however due to the change in weighting (mentioned above) it is not possible to compare the current data with previously published data.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None

Historical comparisons	For GP Access this indicator is based on new questions in the survey, therefore direct historical comparisons cannot be made. For NHS Dental Access the weighting methodology has changed for 2011/12, therefore, direct historic comparisons cannot be made. Despite no historical comparisons available on a directly comparable basis, patient experience of primary care services has been measured through the GPPS before it was redesigned this year (see – http://www.gp-patient.co.uk/).
Data published on the IC indicator portal	National data for July 2011 to March 2012 for persons.

4.5 Women's experience of maternity services	
Outcome sought	Improving women's experience of maternity services.
Status	Live
Updated definition	**Indicator description:** The indicator seeks to measure important elements of experience across the whole maternity pathway: antenatal, intrapartum and postnatal. **Indicator construction:** The indicator is a composite, calculated as the average (mean) of six questions from the 2010 CQC survey of women's experience of maternity services. ***Antenatal*** B6: Did you get enough information from a midwife or doctor to help you decide where to have your baby? (Options: "Yes, definitely" 100; "Yes, to some extent" 50; "No" 0; "No, but I did not need this information"; "Don't know / Can't remember".) B24: Thinking about your antenatal care, were you involved enough in decisions about your care? (Options: "Yes, always"; "Yes, sometimes"; "No"; "I did not want / need to be involved"; "Don't know / Can't remember".) ***Intrapartum (labour and delivery)*** C14: Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you? (Options: "Yes, during labour"; "Yes, shortly after the birth"; "Yes, during labour and shortly after the birth"; "No, not at all".) C16: Thinking about your care during labour and birth, were you involved enough in decisions about your care? (Options: "Yes, always"; "Yes, sometimes"; "No"; "I did not want / need to be involved"; "Don't know / Can't remember".) ***Postnatal*** D4: Thinking about the care you received in hospital after the birth of

	your baby, were you treated with kindness and understanding? (Options: “Yes, always”; “Yes, sometimes”; “No”; “Don’t know / Can’t remember”.) E5: Did you feel that midwives and other carers gave you active support and encouragement? (Options: “Yes, always”; “Yes, generally”; “No”; “Don’t know”; “I didn’t want or need this”.) Women who have had a live birth and are aged 16 years and older are included in this survey. **Indicator format:** Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score. Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as “very poor”. These data will be at national level. Assessment of question responses that indicate “very poor” care is based on considerations of experience that should not occur in a health care setting. **Standardisation** Responses are standardised by maternal age, parity (number of previous births) and response rate.
Data source	The Care Quality Commission’s Maternity Survey from the CQC nationally coordinated patient survey programme. Results from the last maternity survey (2010) are published on the CQC website (http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/maternity-services-survey-2010)
Reporting schedule for data source	**Frequency:** The survey is currently run on an ad hoc rolling basis. **Timing:** Results from the latest maternity survey (2010) are published on the CQC website: www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/maternityservices.cfm
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	The underlying data source is currently published (see above), but no composite indicator yet exists. The survey was conducted in 2007 and 2010. Source: Care Quality Commission Maternity Services Survey

	http://www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/maternityservices.cfm
Data published on the IC indicator portal	Annual data from 2010 for persons at national level.

4.6 Bereaved carers’ views on the quality of care in the last 3 months of life	
Outcome sought	Improvement in the experience of care for people at the end of their lives.
Status	Live
Updated definition	**Indicator description:** Data for the indicator will be drawn from the national VOICES survey of bereaved carers, which ran for the first time in 2011/12. The survey is sent to informants identified on death certificates, and they, or someone they consider better placed to comment on the care given to the deceased, are asked to respond. The sample excluded deaths as a result of accidents, suicides or homicides, where death was recorded as occurring outside the home, or a communal establishment (such as outside, public venues etc) and where informant details were missing. **Indicator construction:** The indicator is based on an overarching question in the survey, which is underpinned by 4 supplementary questions covering different care settings. Overarching question: - Overall, and taking all services into account, how would you rate his/her care in the last three months of life? Outstanding Excellent Good Fair Poor Don’t know The supplementary questions cover: - Overall perception of the care s/he got [at home] from the GP in the last three months of his life - Overall perception of the care that s/he got from the staff in the hospice - Overall perception of the care that s/he got from the care home in the last three months of his life - Overall perception of the care that s/he got from the staff in the hospital on that [last] admission (responding for both doctors and nurses) **Indicator format:** The indicator is the percentage of respondents for each of the possible responses to the overarching question. “Don’t know” is not reported in the data.

Data source	VOICES survey of bereaved adults - http://www.dh.gov.uk/health/2012/07/voices/ and http://www.ons.gov.uk/ons/rel/subnational-health1/national-bereavement-survey--voices-/2011/stb-statistical-bulletin.html
Reporting schedule for data source	**Frequency:** Annual VOICES has been in use extensively in a range of locations but this is the first time it has been used nationally. Data from the pilot have been published on the DH website (http://www.dh.gov.uk/en/Publicationsandstatistics/publications/publicationsPolicyAndGuidance/DH_128787. **Timing:** First results for 2011 were published in July 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	The choice of question to be used for this measure has been finalised, as detailed above in the definition, and the first results for 2011 have now been published.
Historical comparisons	VOICES has been in use since 1993, both in England and abroad, and is internationally recognised as a valid tool for obtaining feedback on people's experience at the end of life, as well as that of the bereaved person. This is the first time VOICES has been used for a national survey and data published.
Data published on the IC indicator portal	National data for adults who died between November 2010 and June 2011.

4.7 Patient experience of community mental health services	
Outcome sought	Improvement in the experience of healthcare for adults (18 years and above) with mental illness.
Status	Live
Updated definition	**Indicator description:** Patient experience of community mental health services **Indicator construction:** The indicator is a composite measure, calculated as the average score of four survey questions from CQC's Community Mental Health Survey below. The questions relate patient's experience of contact with a health and social care worker. Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition… …Did this person listen carefully to you? …Did this person take your views into account? …Did you have trust and confidence in this person? …Did this person treat you respect and dignity?

	Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100, where 0 is the worst score and 100 is the best score. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score. Confirmation of the methodology used to construct the indicator is available on the DH website: http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/DH_087516 Only the overall score is used as the high level outcome measure. However, performance can be disaggregated at the level of each individual survey question that makes up the indicator. A breakdown of responses to individual questions within the survey, including historical trends, is published here: http://www.cqc.org.uk/sites/default/files/media/documents/mh11_historical_comparisons_tables_v1.5_final.doc Subject to review, additional information will be provided indicating the proportion of survey respondents giving a response that can be interpreted as "very poor". These data will be at national level. Assessment of question responses that indicate "very poor" care is based on considerations of experience that should not occur in a health care setting.
Data source	The Care Quality Commission's Community Mental Health Services Survey from the CQC nationally coordinated patient survey programme. The results from the latest Community Mental Health Survey (2010/11) were published in August 2011 by the CQC at the following website: www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/communitymentalhealthservices.cfm
Reporting schedule for data source	**Frequency:** Annual. **Timing:** Data for 2010/11 were published August 2011. The 2011/12 survey was published in September 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	The choice of questions to be used for this measure has been finalised as detailed above in the definition.

Historical comparisons	The Community Mental Health Services Survey has been run annually since 2003/04. The underlying data source is published on the CQC website (www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/community-mental-health-survey-2011), but no composite indicator yet exists.
Data published on the IC indicator portal	Annual data for 2010 to 2011 for persons at national and provider level.

4.8 Children and young people's experience of healthcare	
Outcome sought	Improving children and young people's experience of healthcare.
Status	Placeholder
Updated definition	This indicator to be constructed from questions to be determined, in line with the forthcoming Child and Young People's Health Outcomes Strategy.
Data source	Children's Patient Experience Questionnaire
Reporting schedule for data source	To be decided.
Technical issues remaining to be resolved	An indicator for Children's Patient Experience remains under development. When the first NHS Outcomes Framework was published there was no children's indicator to measure their experience of healthcare. The DH ran a competition to find a suitable indicator to fill this gap (see further detail in glossary). In July 2012, the Children and Young People's Health Outcomes Forum made recommendations for potential indicators to measure children and young people's experience and work is underway to test out possible definitions of indicators for inclusion. Further development of children's patient experience surveys are planned, this will be focussed separately on the major points of contact they have with the health system.
Changes since December 2011 definition	As explained above, there was no indicator for this improvement area in the first NHS Outcomes Framework. An indicator remains under development.
Historical comparisons	None
Data published on the IC indicator portal	Not yet published

4.9 People's experience of integrated care	
Outcome sought	Improved people's experience of integrated care
Status	Placeholder
Updated definition	Under development
Data source	Under development
Reporting schedule for data source	To be decided
Technical issues remaining to be resolved	This indicator is a placeholder, it has been identified by the Future Forum and others as a gap in the current NHS Outcomes Framework.
Changes since December 2011 definition	Not applicable – new indicator under development
Historical comparisons	None
Data published on the IC indicator portal	Not yet published.

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

Indicator Structure

5.1 Domain 5, ***Treating and caring for people in a safe environment and protecting them from avoidable harm***, comprises three overarching indicators (one of which is a placeholder) and six improvement areas.

Overarching indicators
5a Patient safety incident reporting
5b Safety incidents resulting in severe harm or death
5c Hospital deaths attributable to problems in care
Improvement areas
Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2.i Incidence of MRSA
5.2.ii Incidence of C *difficile*
5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing serious harm
Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care
Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to ‘failure to monitor’

5.2 The first two overarching indicators measure the culture of reporting harm and learning from it. Indicator 5a *Patient Safety incidents reported*, describes the readiness of the NHS to report harm. As there is room to improve the levels of reporting safety incidents, for the time being this indicator will be seen as a positive indicator of outcome – reflecting increased willingness to recognise and address safety problems.

5.3 Indicator *5b Safety incidents involving severe harm or death* was chosen as an indicator of reducing the severity of harm arising from safety problems. However, recent research published in the BMJ estimates the number of preventable deaths due to problems with care in English hospitals (see “work in progress” for reference). This research will inform the development of a new indicator *5c Hospital deaths attributable to problems in care*, which is currently a placeholder and will be developed over the coming months. Analysis of the number of incidents recorded under 5b suggests that this indicator (and its sub-indicator 5.4 *Safety incidents of type medication involving severe harm or death)* may also under-estimate the burden of harm from problems with care.

5.4 In time, the outcome sought for overarching indicator *5b Safety incidents involving severe harm or death,* is a reduction in the number of incidents recorded. Triangulation with indicator 5c should help to identify the reliability of indicator 5b as an assessment of harm done.

Work in Progress

5.5 Indicators in the improvement areas are of two sorts:

- Sub-indicator. Indicator *5.4 Incidence of medication errors causing serious harm and death,* is a sub-indicator of indicator *5b.* Progress in this indicator therefore provides a useful initial analysis of what accounts for progress in the overarching indicator.
- Complementary Indicators. In several areas of practice, data collection is sufficiently systematic (or plans to make it so are in hand) to generate reliable information regarding incidence.

5.6 These practices are measured by the following indicators :

- *5.1 Incidence of hospital-related venous thromboembolism*
- *5.2 Incidence of healthcare associated infection: i MRSA bacteraemia; ii* C.*difficile*
- *5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers*
- *5.5 Admission of full-term babies to neonatal care*
- *5.6 Incidence of harm to children due to "failure to monitor"*

5.7 Together, with robust data, overarching indicator 5b and 5c and the complementary improvement indicators would provide a picture of the risk and severity of harm arising from problems in care.

Inequality

5.8 Inequality in outcomes attributable to NHS care in Domain 5 will be explored using a variety of methodologies, according to the availability of disaggregated data for different indicators.

5.9 The domain as a whole addresses pertinent issues for a cross-section of client groups through indicators which are of particular relevance to those groups. For instance:

- Children – indicator 5.6
- Babies and women cared for by maternity services – indicator 5.5
- Elderly – indicators 5.1 and 5.3

Possible sources of bias

5.10 The indicators (other than 5c) may be biased to the extent that the propensity to record incidents varies over time: although the indicators selected are sourced from reliable data, there is a perverse risk that improving the culture of reporting in general may result in some spurious increases in incident numbers even for these indicators. However, bias is reduced where dedicated surveillance systems are in place, such as for healthcare associated infections.

Drivers of the outcome

5.11 The principal external driver of outcomes is the volume and severity of need to be addressed by the NHS. Volume will affect outcomes for all Domain 5 indicators by its impact upon the likelihood of engagement with the healthcare services and upon the availability of resources relative to case load. Increased severity of need (consequent for example upon success in reducing mortality from chronic conditions) will increase the likelihood that an individual will need care and complicate the delivery of safe care. Conversely, improved public health could reduce demands on the healthcare system, resulting in fewer safety incidents.

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

5.13 Further details of the drivers of the outcomes in Domain 5 are set out in the Technical Annex which accompanied the consultation on the draft mandate to the NHS Commissioning Board which was published in July 2012 at http://www.dh.gov.uk/health/2012/07/nhsof-levels-ambition. This also details the presentation of historic trends.

International Comparisons

5.14 OECD published international comparisons of indicators of patient safety in their Health at a Glance 2011 publication (published in November 2011). These indicators are based on the Agency for Healthcare Research and Quality (AHRQ) indicators developed in the USA and are not directly comparable to the NHS OF indicators. However, there are some areas of overlap, e.g. rates of postoperative pulmonary embolism or deep vein thrombosis.

5a Patient safety incidents reported	
Outcome sought	Improved readiness of the NHS to report harm and to learn from it.
Status	Live
Updated definition	**Indicator description:** Patient safety incidents reported to the National Reporting and Learning System (NRLS) by provider organisations in England, per 100,000 population **Indicator construction:** ***Numerator*** The number of patient safety incidents reported to the NRLS 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’. ***Denominator*** Mid-year population estimate for all persons, year in question or latest year available. **Indicator format:** rate per 100,000 population

Data source	Data are taken from: - National Reporting and Learning System - NRLS, http://www.nrls.npsa.nhs.uk/patient-safety-data/ (data workbooks); and - Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Quarterly for NRLS data, annual for population data. **Timing:** NRLS Quarterly Data Summaries are published approximately six months after the end of the period. Data to December 2011 was published in June 2012. Mid-year population estimates for 2011 were published in September 2012
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Data of sufficient quality for comparability over time are available from 2007 onwards.
Data published on the IC indicator portal	National data available up to October to December 2011. Data to March 2012 due to be published in December 2012

5b Safety incidents involving severe harm or death	
Outcome measured	Reduced extent of severe harm or death caused or contributed to by the NHS.
Status	Live
Updated definition	**Indicator description:** Patient safety incidents reported to the National Reporting and Learning System (NRLS), where degree of harm is recorded as “severe harm” or “death” by provider organisations in England, per 100,000 population. **Indicator construction** ***Numerator*** 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’ The ‘degree of harm’ for PSIs is defined as follows: ‘severe’ - the patient has been permanently harmed as a result of the

	PSI, and ‘death’ - the PSI has resulted in the death of the patient. ***Denominator*** Mid-year population estimate for all persons, year in question or latest year available. **Indicator format:** Rate per 100,000 population.
Data source	Data are taken from: - National Reporting and Learning System - NRLS, http://www.nrls.npsa.nhs.uk; and - Population statistics: Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Quarterly for NRLS data, annual for population data. **Timing:** NRLS Quarterly Data Summaries are published approximately six months after the end of the period. Data to December 2011 was published in June 2012. Mid-year population estimates for 2011 were published in September 2012
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Data of sufficient quality for comparability over time are available from 2007 onwards.
Data published on the IC indicator portal	National data available for July to September 2011. Data to March 2012 due to be published in December 2012

5c Hospital deaths attributable to problems in care	
Outcome measured	Reduced number of preventable deaths due to problems of care
Status	Placeholder
Updated definition	**Indicator description:** Under development. **Indicator construction:** Under development. **Indicator format:** Under development.
Data source	To be determined.
Reporting schedule for	To be determined.

data source	
Technical issues remaining to be resolved	This indicator is currently a placeholder within the NHS Outcomes Framework. The development of this indicator will be informed by a recent BMJ research study on preventable deaths by Hogan et al, ‘Preventable death due to problems in care in English acute hospitals: A retrospective case record review study’ published in the BMJ in July 2012 (http://qualitysafety.bmj.com/content/early/2012/07/06/bmjqs-2012-001159.full) A research programme on measuring harm in the Welsh NHS will also be explored for its application to England.
Changes since December 2011 definition	Not applicable – new indicator in development
Historical comparisons	None – new indicator
Data published on the IC indicator portal	Not yet published.

5.1 Incidence of healthcare-related venous thromboembolism	
Outcome sought	Reduced harm from failure to prevent venous thromboembolism (VTE) in a health care setting
Status	In development
Updated definition	**Indicator description:** Rate of hospital admissions for VTE **Indicator construction:** The recommendation of the National VTE Programme Board and regional clinical VTE leads is to use Hospital Episode Statistics as the basis for this indicator, as the best currently available option for measuring incidence. ***Numerator*** Number of hospital admissions with a primary or secondary diagnosis of VTE. *Proposed summary of ICD codes for VTE*

ICD10 Code	Name
I260	Pulmonary embolism with mention of acute cor pulmonale
I269	Pulmonary embolism without mention of acute cor pulmonale
I800	Phlebitis/thrombophlebitis superfic vessels low extremties
I801	Phlebitis and thrombophlebitis of femoral vein
I802	Phlebitis/thrombophlebitis oth deep vessels low extremties
I803	Phlebitis and thrombophlebitis of lower extremities, unspec
I808	Phlebitis and thrombophlebitis of other sites

I809	Phlebitis and thrombophlebitis of unspecified site
I821	Thrombophlebitis migrans
I822	Embolism and thrombosis of vena cava
I823	Embolism and thrombosis of renal vein
I828	Embolism and thrombosis of other specified veins
I829	Embolism and thrombosis of unspecified vein
O223	Deep phlebothrombosis in pregnancy
O229	Venous complication in pregnancy, unspecified
O871	Deep phlebothrombosis in the puerperium
O87.0	Superficial thrombophlebitis in the puerperium
O87.9	Venous complication in the puerperium, unspecified

	Denominator The denominator is the resident population. Data are based on the latest revisions of ONS mid-year population estimates for the respective years (current as at September 2012). For further details on revisions to ONS mid-year population estimates, and their availability, see http://www.statistics.gov.uk/hub/population/population-change/population-estimates/index.html. **Indicator format:** Age standardised rate per 100,000.
Data source	Hospital Episode Statistics (NHS Information Centre, www.ic.nhs.uk/statistics-and-data-collections/hospital-care/hospital-activity-hospital-episode-statistics–hes); and Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** HES reports provisional data monthly, annual data by financial year is available in the autumn/winter after the end of the period. The ONS population estimates are available annually (calendar year). **Timing:** Latest HES monthly data is for May 2012 (provisional), annual refresh for 2011/12 is due in November 2012. Mid-year population estimates for 2011 were published in September 2012.
Technical issues remaining to be resolved	Further alignment of the data source with national guidance on VTE prevention. Expert advice also suggests that VTE deaths within a set period following admission (eg 90 days) might provide an alternative way of measuring the burden of VTE on the population in healthcare settings. Further work is required to assess the feasibility of using this as an alternative indicator.
Changes since December 2011 definition	Advice from clinical experts suggests that HES provides the best current option for measuring incidence in hospital of VTE.

Historical comparisons	HES time series available back to 1991, adjusting for data quality and coding changes, however, direct comparisons may be difficult to make.
Data published on the IC indicator portal	Not yet published.

5.2.i Incidence of healthcare associated infection: MRSA bacteraemia	
Outcome sought	Reducing the incidence of healthcare associated infections (HCAI)
Status	Live
Updated definition	**Indicator description:** Overall number of cases of MRSA bacteraemia. **Indicator construction:** Based on mandatory surveillance of MRSA through the HPA Data Capture System. **Indicator format:** Number.
Data source	Mandatory surveillance of MRSA bacteraemia (Health Protection Agency – HPA)
Reporting schedule for data source	**Frequency:** Monthly, quarterly and annual summaries of surveillance data. **Timing:** Monthly data are published around two months following the period covered - data for October 2011 will be published on 7 December. The next annual summary for financial year 2011/12 is due around July 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	The HCAI Objectives, which seek to move the NHS towards a zero tolerance approach to avoidable infections, have always been expressed as a number – this approach has been validated by an External Reference Group involving: • British Infection Association • Department's expert advisory committee for Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) • Health Protection Agency (HPA) • Healthcare Infection Society • Infection Prevention Society • Royal College of Nursing • Royal College of Pathologists • Royal College of Physicians (RCP) • Royal College of Surgeons • Strategic Health Authorities • Together Everyone Achieves More (Patient Groups).

Historical comparisons	Source data are available back to 2001/02.
	Healthcare contribution: The consistent implementation of evidence based effective infection prevention and control practices. **Drivers of the outcome beyond NHS control:** Community onset infections and general colonisation rates.

5.2.ii Incidence of healthcare associated infection: *C. difficile*	
Outcome sought	Reducing the incidence of healthcare associated infection (HCAI)
Status	Live
Updated definition	**Indicator description:** Overall number of cases of *C. difficile* **Indicator construction:** Based on mandatory surveillance of *C. difficile* as reported to the HPA Data Capture System. **Indicator format:** Number.
Data source	Mandatory surveillance of *C. difficile* (HPA)
Reporting schedule for data source	**Frequency:** Monthly, quarterly and annual summaries of surveillance data **Timing:** Monthly data are published around two months following the period covered - data for October 2012 will be published in December 2012. The annual summary for financial year 2011/12 was published in July 2012.
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Source data are available back to 2007/08.
Data published on the IC indicator portal	Annual data from 2008/09 to 2010/11 at National, Regional, Primary Care Organisation and provider level.

5.3 Incidence of newly-acquired category 2, 3 and 4 pressure ulcers	
Outcome sought	Reducing harm associated by preventing serious pressure ulcers in healthcare
Status	In development
Updated definition	**Indicator description:** Incidence of newly-acquired category 2, 3 and 4 pressure ulcers. **Indicator construction** ***Numerator*** Number of patients with any pressure ulcer (count all ulcers and those Category 2 or greater) ***Denominator*** Number of patients on the (care) unit of in the (care) facility during the time period **Indicator format** – percentage (numerator/denominator) *100
Data source	NHS Safety Thermometer
Reporting schedule for data source	**Frequency:** Monthly **Timing:** NHS Safety Thermometer data are published monthly on the NHS HSCIC website. Data up to September were published on 10 October.
Technical issues remaining to be resolved	Ongoing review of the NHS Safety Thermometer given it is a novel data collection mechanism and there is a need to further understand the collection method and sampling frame.
Changes since December 2011 definition	Alternative data sources for this indicator were considered. Discussions with the NHS Information Centre and the QIPP Safe Care Workstream Steering Group identified the possible indicators available as HES data and the NHS Safety Thermometer, including the potential advantages and disadvantages of the two alternatives. The NHS Safety Thermometer records category 2 pressure ulcers, which are considered sufficiently serious to warrant inclusion in the definition.
Historical comparisons	NHS Safety Thermometer data available from April 2012 at http://www.ic.nhs.uk/services/nhs-safety-thermometer
Data published on the IC indicator portal	Not yet published.

5.4 Incidence of medication errors causing serious harm	
Outcome sought	Reducing serious harm caused by medication errors.
Status	Live
Updated definition	**Indicator description:** Patient safety incidents reported to the National Reporting and Learning System (NRLS), where degree of harm is recorded as severe harm or death, and incident type is ‘medication’ by provider organisations in England, per 100,000 population. **Indicator construction:** ***Numerator*** The number of medication error incidents recorded as causing severe harm or death as described above. A patient safety incident (PSI) is defined as any unintended or unexpected incident(s) leading to actual harm for one or more person(s) receiving NHS funded healthcare. This indicator will filter for incidents identified as being of type ‘medication error’. The ‘degree of harm’ for PSIs reported relates to the following: ‘severe’ – when the patient has been permanently harmed as a result of the PSI, and ‘death’ when the PSI has resulted in the death of the patient. The term ‘serious’ is used here as an umbrella term to denote the total for PSIs resulting in ‘severe’ harm or ‘death’. ***Denominator*** – Mid-year population estimate for all persons, year in question or latest year available. **Indicator format:** Rate per 100,000 population.
Data source	Data are taken from: - National Reporting and Learning System - NRLS (National Patient Safety Agency), http://www.nrls.npsa.nhs.uk; and - Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html
Reporting schedule for data source	**Frequency:** Quarterly for NRLS data, annual for population data. **Timing:** NRLS Quarterly Data Summaries are published five months after the end of the period. Data to June 2012 is due in November 2012. Mid-year population estimates for 2011 were published in September 2012
Technical issues remaining to be resolved	None

Changes since December 2011 definition	None
Historical comparisons	The National Reporting and Learning System was established in 2003.
Data published on the IC indicator portal	National quarterly data from 2008/09 to 2010/11. Data for October 2011 to March 2012 due to be published in December 2012

5.5 Admission of full term babies to neonatal care

Outcome sought	Safe delivery of babies
Status	Live
Updated definition	**Indicator description:** Proportion of all term babies (>=37 weeks gestation) admitted to neonatal care. **Indicator construction** ***Numerator*** Number of admissions of a term baby to neonatal care. ***Denominator*** Number of term births. The denominator will be collected from birth notification records. **Indicator format:** Percentage (numerator/denominator)*100
Data source	National Neonatal Audit Programme (NNAP) for the numerator. Office for National Statistics analysis of births data for the denominator.
Reporting schedule for data source	**Frequency:** Annual **Timing:** Latest NNAP Annual Report, for 2011, was published in July 2012. ONS gestation specific births data for 2010 were published at: http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2010/gestation-specific-infant-mortality-in-england-and-wales--2010.html
Technical issues remaining to be resolved	None
Changes since December 2011 definition	None – however improved data sources for numerator and denominator have been identified, as set out above.
Historical comparisons	Data for 2010 and 2011 are available.

Data published on the IC indicator portal	Updated figures for calendar years 2010 and 2011 are due to be published in December 2012.

5.6 Incidence of harm to children due to 'failure to monitor'	
Outcome sought	Harm from failing to monitor children properly in an acute setting.
Status	Live
Updated definition	**Indicator description:** Total number of Patient Safety incidents reported in England to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS) where age of the patient at the time of the incident is less than 18 years, and incident categories are associated with 'failure to monitor'. **Indicator construction:** NRLS data are filtered to obtain reported incidents of 'failure to monitor' as follows: Care Setting is "Acute" AND Age at time of the incident is under 18 AND Degree of harm is reported as "Low" OR "Moderate" OR "Severe" OR "Death" AND EITHER Incident Category level 1 = "Implementation of care and ongoing monitoring / review" AND Incident Category level 2 = "Delay or failure to monitor" OR Incident Category level 1 = "Treatment, procedure" and Incident Category level 2 = "Treatment / procedure - delay / failure" OR Incident Category level 1 = "Treatment, procedure" and Incident Category level 2 = "Treatment / procedure - inappropriate / wrong" OR Incident Category level 1 = "Clinical assessment including diagnosis, scans, tests, assessments" and Incident Category level 2 = "Assessment - lack of clinical or risk assessment" **Indicator format:** Number
Data source	NRLS
Reporting schedule for data source	**Frequency:** Annual **Timing:** To be confirmed.

Technical issues remaining to be resolved	None
Changes since December 2011 definition	None
Historical comparisons	Data from 2008/09 onwards will be available
Data published on the IC indicator portal	National figures for 2008/09 to 2011/12.

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

ACORN classification
"ACORN is a geodemographic segmentation of the UK's population which segments small neighbourhoods, postcodes, or consumer households into 5 categories, 17 groups and 56 types."
From: www.caci.co.uk/acorn-classification.aspx

Adult Inpatient Survey
The Adult Inpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. The survey is conducted annually between October and January for a sample of patients who had an inpatient episode between July and August. It uses a postal self-completion survey approach, and is conducted among a sample of recent patients who spent at least one night in hospital. The survey covers both elective and emergency care patients, but does not include maternity, mental health patients or patients under the age of 16. The annual survey typically achieves responses from around 70,000 patients across England (a total response rate of around 50%). To reduce non-response bias, if patients do not respond initially or to a reminder after a few weeks, they receive another copy of the questionnaire after a further few weeks.
From:
www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm

Adult Social Care Combined Activity Return (ASC-CAR)
The Adult Social Care Combined Activity Return is a social care return managed by the National Information Centre. 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.
From: http://www.ic.nhs.uk/services/social-care/social-care-collections

Age cohort
An age cohort is a group of people in the same age group who are assumed to have experienced similar events and share a common history – e.g., the ‘baby boomers’. Cohort analysis can investigate the effect of age cohorts, particularly in health outcomes.

Ambulatory care sensitive (ACS) conditions
Ambulatory care sensitive (ACS) conditions are chronic conditions that include congestive heart failure, diabetes, asthma, angina, epilepsy and hypertension. Actively managing patients with ACS conditions – through vaccination; better self-management, disease-management or case-management; or lifestyle interventions – prevents acute exacerbations and reduces the need for emergency hospital admission.

Best practice tariff
Best practice tariffs represent one of the enablers for the NHS to improve quality, by reducing unexplained variation and universalising best practice. With best practice defined as care that is both clinical and cost-effective, these tariffs will also help the NHS deliver the productivity gains required to meet the tough financial challenges ahead. The aim is to have tariffs that are structured and priced appropriately both to incentivise and adequately reimburse for the costs of high quality care.
From: www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_105080

Case-mix adjustment
Patients are usually different in their clinical and demographic characteristics and these differences should be considered when assessing processes of health care. Case-mix adjustment is the statistical process of allowing for differences among patients' clinical and demographic characteristics when comparing outcomes of health care between areas, organisations or periods.

Children’s Outpatient Experience Questionnaire
The Children’s Outpatient Experience Questionnaire was developed by the Picker Institute Europe to measure the recent hospital outpatient experience of children aged 8 to 17 years. This questionnaire was a winning entry in the Innovation in Outcomes competition run by the DH.
From: www.dh.gov.uk/health/2011/10/winners-of-innovation-in-outcomes-competition-announced/

Commissioning for Quality and Innovation (CQUIN)
The CQUIN framework was introduced in April 2009 as a national framework for locally agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare providers’ income to the achievement of local quality improvement goals. The framework aims to embed quality goals in contracts between healthcare commissioners and providers.
From:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091443
www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

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 2011 survey took the views of more than 17,000 people who received specialist 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 16, between July and September 2010, achieving a response rate of 33%.

From: www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/community-mental-health-survey-2011

Compendium of Population Health Indicators, formerly NCHOD

“A wide-ranging collection of over 1,000 indicators designed to provide a comprehensive overview of population health at a national, regional and local level. These indicators were previously available on the Clinical and Health Outcomes Knowledge Base website (also known as NCHOD).”

From: https://indicators.ic.nhs.uk/webview/

Continuous Inpatient (CIP) Spell

A CIP spell is a continuous period of hospital care within the NHS from admission to discharge, regardless of any transfers which may take place. It can therefore be made up of one or more episodes and/or involve more than one hospital provider.

A CIP spell starts when a decision has been made to admit the patient, and a consultant has taken responsibility for their care. The spell ends when the patient dies or is discharged from hospital.

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

Employment and Support Allowance

Employment and Support Allowance is a benefit managed by the Department for Work and Pensions (DWP) which provides financial help to people who are unable to work because of illness or disability. It also provides personalised support to those who are able to work. For new clients, it has replaced Incapacity Benefit and Income Support paid because of an illness or disability from October 2008.

From:
www.direct.gov.uk/en/MoneyTaxAndBenefits/BenefitsTaxCreditsAndOtherSupport/Illorinjured/DG_171894

Episode

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

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

EQ-5D

EQ-5D™ is a standardised instrument for use as a measure of health status or health-related quality of life developed by the EuroQol Group. It is used internationally and is applicable to a wide range of health conditions and treatments, providing a simple descriptive profile for health status.

EQ-5D is primarily designed for self-completion by respondents and is suited for use in postal surveys, in clinics and face-to-face interviews. It is cognitively simple, taking only a few minutes to complete. Instructions to respondents are included in the questionnaire.

The EQ VAS is part of the EQ-5D (see above) self-report questionnaire. It is a standard vertical 20 cm visual analogue scale (similar to a thermometer) for recording an individual's rating for their current health-related quality of life state (often referred to as page 3 of the EQ-5D questionnaire).
From: www.euroqol.org/eq-5d/what-is-eq-5d.html

Equality Analysis
In developing, the first NHS Outcomes Framework one of underpinning principles of the framework was to ensure that it encouraged the promotion of equality and reduce inequalities in outcomes from healthcare. The framework will also help the NHS Commissioning Board 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 for the Secretary of State for Health, NHS Commissioning Board and Clinical Commissioning Groups.
From: https://www.wp.dh.gov.uk/health/files/2012/07/Equality-analysis.pdf

GP patient survey (GPPS)
The GPPS is a DH survey, run by Ipsos MORI, that assesses patients' experiences of local NHS services. The survey was first conducted in 2006. The questionnaire is sent to a random selection of around 2.8 million people aged 18 or older who are registered with a GP in England.
From: www.gp-patient.co.uk

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

Healthcare Associated Infections (HCAI)
HCAI are infections resulting from medical care or treatment in hospital, nursing homes or the patient's own home.
From: www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI

Health Care Quality Indicators (HCQI) project
The OECD HCQI project, initiated in 2002, aims to measure and compare the quality of health service provision in different countries. An expert group has developed a set of quality indicators at the health systems level, which allows the impact of particular factors on the quality of health services to be assessed. The OECD's Health at a Glance publications include a chapter on quality of care which presents indicators from the HCQI project considered suitable for international comparison.
From:
www.oecd.org/document/34/0,3746,en_2649_37407_37088930_1_1_1_37407,00.html

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.

Health Survey for England (HSE)
The HSE survey is designed to provide regular information on various aspects of the nation's health, and is now commissioned and published by the NHS IC. It comprises a series of annual surveys that began in 1991 and covers the adult population aged 16 and over living in private households in England. Children have been included every year since 1995.From:
www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/HealthSurveyForEngland/index.htm

Hospital Episodes Statistics (HES)
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and for NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals.
From: www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=537

ICD-10 codes
See 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 special initiatives or programmes and as a tool to determine eligibility for specific funding streams. The Index of Deprivation for 2010 was published in March 2011
From:
www.communities.gov.uk/corporate/researchandstatistics/statistics/subject/indicesdeprivation

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

Infant mortality
Infant mortality refers to deaths under one year of age, expressed as a rate per 1000 live births.
Neonatal mortality refers to deaths under 28 days, expressed as a rate per 1,000 live births.
Perinatal mortality refers to stillbirths and deaths at ages up to six completed days of life (early neonatal deaths), expressed as a rate per 1,000 stillbirths and live births.

Innovation in Outcomes Competition
The Innovation in Outcomes Competition was run by the DH in 2011 to invite people to suggest new, innovative indicators for the NHS Outcomes Framework, both where gaps existed in the framework at that time and in broader areas for future frameworks.
From:
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124920

Inpatients 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 2010 and January 2011. Over 66,000 inpatients aged 16 and over responded to the survey, a response rate of 50%.
From:
www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/inpatientservices.cfm

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 and health records. In addition to enabling the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes, these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. The illnesses, diseases and injuries suffered by hospital patients are currently recorded using the International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organization (WHO). ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The classification is the latest in a series which has its origins in the 1850s. In general, 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.
From: www.who.int/classifications/icd/en

Labour Force Survey (LFS)

The LFS is a quarterly sample survey of households living at private addresses in the UK. Its purpose is to provide information on the UK labour market that can then be used to develop, manage, evaluate and report on labour market policies. It is conducted by the Office for National Statistics.
From: www.esds.ac.uk/government/lfs

Lower layer super output areas (LSOAs)

A LSOA is a geographic area. It is part of an ONS geographic hierarchy designed to improve the reporting of small area statistics in England and Wales.
LSOAs are built from groups of contiguous Output Areas and have been automatically generated to be as consistent in population size as possible, and typically contain from four to six Output Areas. The minimum population is 1000 and the mean is 1500.There is a LSOA for each postcode in England and Wales.
From:
www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/l/lower_layer_super_output_area_de.asp?shownav=1 (see also http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/census/super-output-areas--soas-/index.html

Lower respiratory tract infection (LRTI)

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

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

Mental Health Minimum Dataset (MHMDS)
The MHMDS contains "record level data about NHS services delivered to over a million people with severe and enduring mental health problems each year between 2003 and 2010". It does not cover the services for people with common mental health problems that are provided in primary care, e.g. through GP surgeries, specialist mental health services delivered by independent hospitals or through specialist services for children and adolescents.
From: www.mhmdsonline.ic.nhs.uk

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). Interobserver agreement for the assessment of handicap in stroke patients. Stroke 19 (5): 604–607. http://stroke.ahajournals.org/content/19/5/604.full.pdf

National Centre for Health Outcomes Development (NCHOD) - Compendium of Clinical and Health Indicators. See glossary entry 'Compendium of Population Health Indicators, formerly NCHOD'

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".
From: www.nhfd.co.uk

National Sentinel Stroke Audit
The National Sentinel Stroke Audit is conducted by The Royal College of Physicians on behalf of the Intercollegiate Stroke Working Party and is centrally funded by the Healthcare Quality Improvement Partnership (HQIP). It monitors the rate of progress in stroke care services in England, Wales and Northern Ireland in a two year cycle. The audit consists of two components which focus on the organisation of care (Organisational Audit) and the process of care (Clinical Audit).
From: www.rcplondon.ac.uk/resources/national-sentinel-stroke-audit

NHS Safety Thermometer

The Safety Thermometer is a local improvement tool that is used to collect baseline information and measure outcomes and progress over time for each of the four harms being focussed on by DH’s QIPP Safe Care work stream (Safety Express). It is an Excel tool that was co-produced by frontline teams, the NHS Information Centre, the Chief Nursing Officer’s office (Energising for Excellence and High Impact Actions) and the Safety Express steering group. Safety Thermometer data is collected by teams across the health economy on a monthly or quarterly basis.

From: http://www.ic.nhs.uk/services/nhs-safety-thermometer

Outpatient survey

The Outpatient Survey is coordinated nationally by the Care Quality Commission (CQC) as part of the NHS patient survey programme. It assesses patients' experiences of their most recent visit to an outpatient department. The survey was conducted in 2003, 2004 and 2009. The last outpatient services survey was conducted between July and October 2009. Over 72,000 outpatients aged 16 and over responded to the survey, a response rate of 53%.

From: www.cqc.org.uk/aboutcqc/howwedoit/involvingpeoplewhouseservices/patientsurveys/outpatientservices.cfm

Patient-reported outcome measures (PROMs)

PROMs are measures of a patient’s health status or health-related quality of life. They are typically short, self-completed questionnaires, which measure the patients’ health status or health related quality of life at a single point in time.

The health status information collected from patients by way of PROMs questionnaires before and after an intervention provides an indication of the outcomes or quality of care delivered to NHS patients. Changes in health status as measured by PROMs, controlling for variation in patient characteristics and the influence of other factors, are attributed to the healthcare delivered to the patient by the provider and the wider healthcare system. This outcomes data can be used in a variety of ways to assess the quality of care delivered to NHS patients by providers.

From: DH (6 February 2009), Guidance on the routine collection of Patient Reported Outcome Measures (PROMs), www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_092625.pdf

Period life expectancies

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.

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

Public Health Outcomes Framework

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

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004.
From: http://www.qof.ic.nhs.uk/

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

Sentinel Stroke National Audit Programme (SSNAP)

The Sentinel Stroke National Audit Programme (SSNAP) is a new programme of work which aims to improve the quality of stroke care by auditing stroke services against evidence based standards. SSNAP will build on the work of the National Sentinel Stroke Audit (NSSA) and the Stroke Improvement National Audit Programme (SINAP).
From: http://www.rcplondon.ac.uk/projects/sentinel-stroke-national-audit-programme

Slope Inequality Indicator (SII)

The SII summarises the inequality in a specific outcome across England that is thought to be attributable to social inequality. It represents the gap in the outcome in question between the least and most deprived areas in England, to the extent that this reflects the relationship between the specific outcome and deprivation scores (the latter relationship being established by a statistical analysis of small area data for the whole population). It is also assumed in general that the relationship is linear (so that linear regression is the appropriate estimation technique).The use of the SII to measure social inequality (i.e. inequality attributable to social circumstances) relies upon an assumption that correlation with deprivation implicates deprivation as a causal factor behind inequality of outcome. In general, the extent to which improvement can be achieved by NHS interventions (through more equal access or through levelling up quality of care) or through public health interventions or through wider social interventions will vary from outcome to outcome.

Spell

In general, a patient's entire stay in hospital is a spell. A spell can contain one episode (see glossary entry “Episode”), or several episodes. For example, if Patient A is admitted for a broken leg, but while still in hospital is diagnosed and treated for diabetes by Consultant B, there would be two episodes (one for the broken leg under Consultant A, and one for diabetes under Consultant B). If the patient is transferred to another hospital, dies or is discharged, the episode and the spell end. The vast majority of spells contain only one episode.
From: www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1072

Standardised mortality rates (for age or gender)
Populations differ in their demographic composition and these differences should be considered when comparing mortality rates or other health indicators. Age- or gender-specific rates for an event (e.g. deaths) are the proportion of events in a specific age group or for each gender. To compare populations, age- or gender-specific rates are applied to a single population structure. There are two approaches to such standardisation: direct and indirect, both of which use a standard population structure, such as that of the WHO European standard population.
For further details, consult: APHO Technical Briefing 3: Commonly Used Public Health Statistics and their Confidence Intervals
www.apho.org.uk/resource/item.aspx?RID=48457

Stroke Improvement National Audit Programme (SINAP)
SINAP is a national clinical audit, run by the Stroke Programme at the Royal College of Physicians. SINAP collects information from hospitals about the care provided to stroke patients in their first three days in hospital. The aim for SINAP is that data will be submitted to the audit for all new stroke admissions across all relevant hospitals, and that the information and results from the audit are used to improve care for stroke patients.
From: www.rcplondon.ac.uk/resources/stroke-improvement-national-audit-programme-sinap

Trauma Audit & Research Network (TARN)
The TARN’s aim is to collect clinical and epidemiological data in order to provide a statistical base to support clinical audit, aid the development of trauma services and inform the research agenda.
From: www.tarn.ac.uk

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.
From: www.southampton.ac.uk/voices

WHO European standard population
The European Standard population is a notional population of 2 million, which is commonly used to standardise rates of morbidity and mortality.
From: http://www.wmpho.org.uk/localprofiles/metadata.aspx?id=META_EUROSTD