Technical Definitions for Commissioners

2016/17

Technical definitions for commissioners 2016/17

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First	30-12-2015	Original	

Contents

Executive Summary

The purpose of this Technical Definitions document is to describe the indicators in Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 and to set out for each measure definitions, monitoring, accountability and PLANNING REQUIREMENTS.

Where this information is available through other online sources the links in this document will direct the reader towards it.

E.A.3: IAPT roll-out

DEFINITIONS

Detailed Descriptor:

The commitment to continue to improve access to psychological therapy was set out in 'Achieving Better Access for Mental Health Services by 2020' and reinforced in the 2015 Comprehensive Spending Review. The primary purpose of this indicator is to measure improvement in access rates to psychological therapy services via the national Improving Access to Psychological Therapies (IAPT) programme for people with depression and/or anxiety disorders. The expectation is that services will build on the success achieved in 2015/16 and accelerate access over the next 5 years.

The effectiveness of local IAPT services is measured using this indicator and **E.A.S.2** which is focused on recovery of patients completing a course of treatment in IAPT services.

E.A.3 measures the proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes).

Lines Within Indicator (Units):

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

Numerator: The number of people who receive psychological therapies.

Denominator: The number of people who have depression and/or anxiety disorders (local estimate based on Adult Psychiatric Morbidity Survey 2000).

Data Definition:

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

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

For the denominator of this indicator, the expectation is NOT that CCGs carry out a survey of their own, but that they extrapolate local prevalence from the national Psychiatric Morbidity Survey 2000 as part of their needs assessment. NHS England has produced an estimate of prevalence at CCG level that may be helpful when sense checking CCGs prevalence submission for 2015-16.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: IAPT Minimum Data Set**,** HSCIC

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The expectation is that IAPT services will achieve a minimum of 15% access rate at the end of 2015/16 and develop a strategy to increase access further over the next 5 years towards addressing 25% of local prevalence.

NHS England will expect CCGs to commission services with this in mind and for the recovery rate to be a minimum of 50%.

A national access rate of 15% was achieved in 2014/15 and maintained in 2015/16. In 2016/17 all IAPT services are required to prepare to build capacity and set trajectories to deliver greater access over the next 5 years. In detail the expectation is that CCGs will achieve a minimum of 15% access rate by the end of 2016/17 and prepare to build further. Assessment will be based Access on a quarterly "run rate" requirement, in each quarter of 2016/17, of at least 3.75% of local prevalence entering services.

Timeframe/Baseline: Ongoing to 2016/17

Rationale:

This indicator focuses on improved access to psychological therapies, in order to address enduring unmet need. Around one in six adults in England have a common mental health disorder, such as depression or anxiety. Collecting this indicator will demonstrate the extent to which this need is being met.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, CCG plans, quarterly for 2016/17 via the Unify2 template

FURTHER INFORMATION

The IAPT Data Handbook explains the function of effective data collection and reporting in IAPT.

The IAPT data set contains detailed guidance on use of the technical specification and the central return process.

E.A.10: One-year survival from all cancers

DEFINITIONS

Please see: HSCIC indicators portal

- Clinical Commissioning Group Indicators
- Domain 1 – Preventing People from Dying Prematurely
- 1.10 One-year survival from all cancers

PLANNING REQUIREMENTS: No plans required

E.A.S.1: Estimated diagnosis rate for people with dementia

DEFINITIONS

Detailed Descriptor:

Diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.

Lines Within Indicator (Units):

Numerator: Number of people aged 65 or over diagnosed with dementia.

Denominator: Estimated prevalence of dementia.

Data Definition:

Numerator: Number of people, aged 65 and over, with a diagnosis of dementia recorded in primary care as counted within the Quality and Outcomes Framework (QOF) dementia registers. This figure is published annually by the Health and Social Care Information Centre as the QOF DEM1 indicator and monthly in the Quality Outcomes Framework (QOF) Recorded Dementia Diagnoses. The end of year assessment will be against the annual DEM1 value.

Denominator: Estimated prevalence of dementia in people aged 65 or over in the local population. The estimated prevalence for the CCG as calculated from the ONS population estimates multiplied by dementia prevalence rates from the second cohort Cognitive Function and Ageing Study (CFAS II):

Estimated dementia prevalence rates (CFAS II)

Age Group	Females	Males
65-69	1.8%	1.2%
70-74	2.5%	3.0%
75-79	6.2%	5.2%
80-84	9.5%	10.6%
85-89	18.1%	12.8%
90+	35.0%	17.1%

The prevalence estimate for a CCG will be the sum of prevalence estimates in the 12 age and gender specific groups given in the table. The same six age groups are used for each gender and are 5 year age bands from age 65 to 89 and one an age group, per gender, for people aged 90 and above. The prevalence estimate for an age and gender specific group is calculated by multiplying the prevalence rate given in the table by the matching age and gender specific population count for the CCG.

The population used in the final assessment will be the ONS mid-year population estimate for 2016. Before this is published, in-year monitoring will be against the ONS 2016 Subnational Population Projections for CCGs in England from the latest base available.

Indicator format: Percentage

MONITORING

Monitoring Frequency: Monthly

Annual - publication of final QOF 2016-17 is expected in October 2016

Monitoring Data Source:

- Quality and Outcomes Framework
- Health and Social Care Information Centre (HSCIC)
- Cognitive Function and Ageing Study (CFAS II) second cohort
- Population Statistics Office for National Statistics

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Improving the ability of people living with dementia to cope with symptoms, access to treatment and care and support. The planning guidance states that the national dementia diagnosis rate to two thirds (66.7%) should be achieved and sustained through 2016/17.

Timeframe/Baseline: Ongoing

Rationale:

A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, CCG plans, monthly for 2016/17 via the Unify2 template.

E.A.S.2: IAPT recovery rate

DEFINITIONS

The current measure of recovery based on “caseness” has been a useful measure of patient outcome and has helped to inform service development. This measure will continue in 2016/17.

However using this methodology means borderline cases that only show a very small change will be counted if they move across the threshold whereas more severe cases that show significant improvement but do not pass the cut-off will be excluded. More statistically robust indices of improvement ie reliable recovery and reliable improvement are reported in routine IAPT publications which provide a fairer assessment of the benefits of being seen in an IAPT service.

From 2016/17 NHS England will monitor progress against reliable change/improvement in shadow form with a view to setting a standard in 2017/18.

Further detail is available on the Improving Access to Psychological Therapies Data Set web page.

Detailed Descriptor:

The primary purpose of this indicator is to measure the maintenance of recovery rates in psychological services achieved at the end of 2015/16 via the national IAPT programme for people with depression and/or anxiety disorders. The effectiveness of local IAPT services is measured using this indicator and **E.A.3** which is focused on access to services as a proportion of local prevalence.

E.A.S.2 measures the proportion of people who complete treatment who are moving to recovery.

Lines Within Indicator (Units):

The number of people who are moving to recovery.

Numerator: The number of people who have finished treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness” and at final session did not).

Denominator: (The number of people who have finished treatment within the reporting quarter, having attended at least two treatment contacts and coded as discharged) minus (The number of people who have finished treatment not at clinical caseness at initial assessment).

Data Definition:

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

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

Definition of a 'case': A patient suffering from depression and/or anxiety disorders, as determined by scores on the Patient Health Questionnaire (PHQ 9) for depression and/or the Patient Health Questionnaire (GAD7) for anxiety disorders, or other anxiety disorder specific measure as appropriate for the patient's diagnosis.

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

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: IAPT Minimum Data Set, HSCIC

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Maintenance of at least 50% recovery rates is expected from those that achieved the standard at the end of 2015/16. Improvement is anticipated from areas where a rate of less than 50% was achieved with the expectation they will achieve at least 50% in 2016/17

Timeframe/Baseline: Ongoing to 2016/17

Rationale:

This indicator focuses on improved access to psychological therapies, in order to address enduring unmet need. Around one in six adults in England have a common mental health disorder, such as depression or anxiety. Collecting this indicator will demonstrate the extent to which this need is being met.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, CCG plans, quarterly for 2016/17 via the Unify2 template.

FURTHER INFORMATION

The IAPT Data Handbook explains the function of effective data collection and reporting in IAPT.

The IAPT data set includes detailed guidance on use of the technical specification and the central return process.

E.A.S.3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services

DEFINITIONS

For detailed technical definition please see the Better Care Fund (BCF) Technical Guidance.

PLANNING REQUIREMENTS

Plans required as per the BCF Technical Guidance

E.A.S.4: Healthcare acquired infections (HCAI) measure (MRSA)

DEFINITIONS

Please see: HSCIC indicators portal

- NHS Outcomes Framework
- Domain 5 – Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm
- Improvement Areas
- Reducing the incidence of avoidable harm
- 5.2 i. Incidence of healthcare-associated infection - MRSA

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Public Health England HCAI Data Capture System;

CCG Outcome Indicator Set

ACCOUNTABILITY

What success looks like, Direction, Milestones: Zero tolerance on MRSA.

Timeframe/Baseline: Ongoing

Rationale:
Tackling preventable healthcare associated infections, such as MRSA bloodstream infections, is one of the NHS's key priorities. With reported MRSA cases at an all-time low and many trusts reporting zero cases of MRSA bloodstream infection over the past year, we are clear that preventable MRSA bloodstream infections are not acceptable in NHS-funded services

PLANNING REQUIREMENTS: No plans required

E.A.S.5: Healthcare acquired infections (HCAI) measure (Clostridium difficile infections)

DEFINITIONS

Please see: HSCIC indicators portal

- **NHS Outcomes Framework**
- **Domain 5 – Treating and Caring for People in a Safe Environment and Protecting Them From Avoidable Harm**
- **Improvement Areas**
- **Reducing the incidence of avoidable harm**
- **5.2 ii. Incidence of healthcare-associated infection – C.difficille**

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Public Health England HCAI Data Capture System;

CCG Outcome Indicator Set

ACCOUNTABILITY

What success looks like, Direction, Milestones:
The 2016/17 annual CDI objectives for each CCG will be published by NHS England on the Clostridium difficile infection objectives web page in early 2016 and all CCGs should establish and report against monthly trajectories for CDI cases in order to ensure continued reduction.

Timeframe/Baseline: Ongoing

Rationale:
CDI is an unpleasant and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment. While the NHS has made significant progress is tackling CDI significant numbers of cases are still reported and CCGs should continue to focus on CDI prevention across the whole health economy.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template

E.B. 3: Referral to treatment pathways

DEFINITIONS

Detailed Descriptor:
The percentage of referral to treatment (RTT) pathways within 18 weeks for incomplete pathways.

Lines Within Indicator (Units):
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Data Definition:
A calculation of the percentage within 18 weeks for incomplete RTT pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.

The definitions that apply for RTT waiting times as well as guidance on recording and reporting RTT data can be found on the NHS England Consultant-led Referral to Treatment Waiting Times Rules and Guidance web page.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Consultant-led RTT Waiting Times data collection (National Statistics)

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Performance will be judged against the incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

Timeframe/Baseline: Ongoing

Rationale:
The operational standard that 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

This RTT waiting times standard leaves an operational tolerance to allow for patients who wait longer than 18 weeks to start their treatment for one or more of the following reasons:

- patient choice - patients choose not to accept earliest offered reasonable appointments along their pathway or choose to delay treatments for personal or social reasons
- co-operation - patients who do not attend appointments that they have agreed along their pathways

- clinical exceptions - where it is not clinically appropriate to start a patient's treatment within 18 weeks

In many trusts, we would expect delays as a result of patient choice to account for the bulk of this tolerance.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, CCG plans, monthly for 2016/17 via the Unify2 template

E.B.4: Diagnostic test waiting times

DEFINITIONS

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

Lines Within Indicator (Units):
The percentage of patients waiting 6 weeks or more for a diagnostic test (included in the Diagnostics Waiting Times and Activity Data Sets fifteen key diagnostic tests) at the end of the period.

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

Full definitions can be found in Monthly Diagnostic Waiting Times and Activity

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source: Monthly diagnostics data collection - DM01

ACCOUNTABILITY

What Success Looks Like, Direction, Milestones:
Diagnostic operational standard of less than 1% – the percentage of patients waiting six weeks or more for a diagnostic test should be less than 1%.

Timeframe/Baseline: Ongoing

Rationale:
Prompt access to diagnostic tests is a key supporting measure to the delivery of the NHS Constitution referral to treatment (RTT) maximum waiting time standards. Early diagnosis is also important for patients and central to improving outcomes, eg early diagnosis of cancer improves survival rates.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template

E.B.5: A&E waiting times – total time in the A&E department

DEFINITION

Detailed Descriptor: Percentage of patients who spent 4 hours or less in A&E.

Lines Within Indicator (Units):

1. Total number of A&E attendances.

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

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

Data Definition:

Full definitions can be found in the A&E attendances and emergency admissions monthly return definitions document.

A&E means a Type 1, Type 2, Type 3, Type 4 department or urgent care centre that averages more than 200 attendances per month. This average should be calculated over a quarter.

Types of A&E service are:

- Type 1 A&E department = A consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients
- Type 2 A&E department = A consultant led single specialty accident and emergency service (eg ophthalmology, dental) with designated accommodation for the reception of patients
- Type 3 A&E department/Type 4 A&E department/Urgent Care Centre = Other type of A&E/minor injury units (MIUs)/Walk-in Centres (WiCs)/Urgent Care Centre, primarily designed for the receiving of accident and emergency patients. A type 3 department may be doctor led or nurse led. It may be co-located with a major A&E or sited in the community. A defining characteristic of a service qualifying as a type 3 department is that it treats at least minor injuries and illnesses (sprains for example) and can be routinely accessed without appointment. An appointment based service (for example an outpatient clinic) or one mainly or entirely accessed via telephone or other referral (for example most out of hours services) or a dedicated primary care service (such as GP practice or GP-led health centre) is not a type 3 A&E service even though it may treat a number of patients with minor illness or injury.

Potential patients must be aware of A&E departments and perceive the service as an urgent and emergency care service. As a result, for a department to be classified under the above A&E nomenclature it must average over 200 attendances per month.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Monthly A&E Attendances and Emergency Admissions collection (MSitAE)

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Standard is 95% of patients seen within 4 hours

Timeframe/Baseline: Ongoing

Rationale:
Longer lengths of stay in the emergency department are associated with poorer health outcomes and patient experience as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen and financial effects. It is critical that patients receive the care they need in a timely fashion so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays and patients who are fit to go home are discharged safely and rapidly.

There is professional agreement that some patients need prolonged times in A&E. However, these exceptions are rare and unlikely to account for more than 5% of attendances. International literature suggests increases in adverse outcomes for patients who have been in A&E for more than 4-6 hours.

Excessive total time in A&E is linked to poor outcomes and patient delays should be minimised (but care should not be hurried or rushed). Changes in the practice of emergency medicine in some departments also means that more is being done for patients in A&E, which may take longer but is for the benefit of the patient.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template.

To be completed by lead CCG. Plans are to be submitted by lead commissioners of Type 1 Trusts. Plans submitted should be for all types of attendances to A&E.

E.B. 6-7: Cancer two week waits

DEFINITIONS

Detailed Descriptor:

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

Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer (**E.B.6**) and percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected (**E.B.7**).

Lines Within Indicator (Units):

E.B.6: All cancer two week wait

Numerator: Patients urgently referred with suspected cancer by their GP (GMP, GDP or Optometrist) who were first seen within 14 calendar days within the given month/quarter.

Denominator: All patients urgently referred with suspected cancer by their GP (GMP, GDP or Optometrist) who were first seen within the given month/quarter.

E.B.7: Two week wait for breast symptoms (where cancer was not initially suspected)

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

Denominator: All patients urgently referred for evaluation/investigation of “breast symptoms” by a primary or secondary care professional within a given month/quarter, (excluding those referred urgently for suspected breast cancer) who were first seen within the given month/quarter.

All referrals to a breast clinical team (excluding those for suspected cancer and those to family history clinics) should be included within the dataset supplied for **E.B.7**.

Data Definition:

Numerator and denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Amd 7/2015.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 7/2005, is available in the NHS Data Dictionary.

MONITORING

Monitoring Frequency: Monthly and Quarterly

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

ACCOUNTABILITY

What success looks like, Direction, Milestones:

E.B.6: All cancer two week wait
Performance is to be sustained at or above the operational standard of 93%.

E.B.7: Two week wait for breast symptoms (where cancer was not initially suspected).
Performance is to be sustained at or above the operational standard of 93%.

Timeframe/Baseline: Ongoing

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

This indicator also relates to a patient's right to be seen in two weeks as expressed in the NHS Constitution.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly and quarterly for 2016/17 via the Unify2 template

E.B.8-11: Cancer 31 day waits

DEFINITIONS

Detailed Descriptor:

Cancer 31 day waits.

Percentage of patients receiving first definitive treatment within one month (31-days) of a cancer diagnosis (measured from 'date of decision to treat') (**E.B.8**)

Percentage of patients receiving subsequent treatment for cancer within 31-days, where that treatment is a Surgery (**E.B.9**), an Anti-Cancer Drug Regimen (**E.B.10**) or a Radiotherapy Treatment Course (**E.B.11**)

Lines Within Indicator (Units):

E.B.8: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')

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

Denominator: Total number of patients receiving first definitive treatment for cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

E.B.9: 31-day standard for subsequent cancer treatments-surgery

Numerator: Number of patients receiving subsequent treatment of surgery within a maximum waiting time of 31-days during a given month/quarter, including patients with recurrent cancer.

Denominator: Total number of patients receiving subsequent treatment of surgery during a given month/quarter, including patients with recurrent cancer.

Scope: Those treatments classified as "Surgery" within the National Cancer Waiting Times Monitoring Dataset (NCWTMDS).

E.B.10: 31-day standard for subsequent cancer treatments - anti cancer drug regimens

Numerator: Number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a maximum waiting time of 31-days within a given month/quarter, including patients with recurrent cancer.

Denominator: Total number of patients receiving a subsequent/adjuvant anti-cancer drug regimen within a given month/quarter, including patients with recurrent cancer.

Scope: Using the definitions published in the NCWTMDS "Anti-Cancer Drug Regimens" includes: Cytotoxic Chemotherapy, Immunotherapy, Hormone Therapy - plus other specified and unspecified drug treatments.

E.B.11: 31-day standard for subsequent cancer treatments – radiotherapy

Numerator: Number of patients receiving subsequent/adjuvant radiotherapy treatment within a maximum waiting time of 31-days within a given month/quarter, including patients with recurrent cancer.

Denominator: Total number of patients receiving subsequent/adjuvant radiotherapy treatment within a given month/quarter, including patients with recurrent cancer.

Scope: Using the definitions published in the NCWTMDS "Radiotherapy Treatments" includes: Teletherapy (beam radiation), Brachytherapy, Chemoradiotherapy and Proton Therapy.

Data Definition:
Numerator and denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Amd 7/2015.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 7/15, is available in the NHS Data Dictionary.

MONITORING

Monitoring Frequency: Monthly and Quarterly

Monitoring Data Source:
Data are sourced from the CWT-Db on a monthly and quarterly basis

ACCOUNTABILITY

What success looks like, Direction, Milestones:

E.B.8: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')
Performance is to be sustained at or above the operational standard of 96%.

E.B.9: 31-day standard for subsequent cancer treatments-surgery
Performance is to be sustained at or above the operational standard of 94%.

E.B.10: 31-day standard for subsequent cancer treatments - anti cancer drug regimens
Performance is to be sustained at or above the operational standard of 98%.

E.B.11: 31-day standard for subsequent cancer treatments – radiotherapy
Performance is to be sustained at or above the operational standard of 94%.

Timeframe/Baseline: Ongoing

Rationale:

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, CCG plans, monthly and quarterly for 2016/17 via the Unify2 template

E.B.12-14: Cancer 62 day waits

DEFINITIONS

Detailed Descriptor:

E.B.12: Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer.

E.B.13: Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from a NHS Cancer Screening Service.

E.B.14: Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status.

Lines Within Indicator (Units):

E.B.12: All cancer two month urgent referral to first treatment wait

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

Denominator: Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP, GMP or Optometrist) referral for suspected cancer within a given month/quarter, for all cancers (ICD-10 C00 to C97 and D05).

E.B.13: 62-day wait for first treatment following referral from a NHS cancer screening service

Numerator: Number of patients receiving first definitive treatment for cancer within 62-days following referral from a NHS Cancer Screening Service within a given month/quarter (CD-10 C00 to C97 and D05).

Denominator: Total number of patients receiving first definitive treatment for cancer following referral from a NHS Cancer Screening Service within a given month/quarter (ICD-10 C00 to C97 and D05).

E.B.14: 62-day wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority

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

Denominator: Total number of patients receiving first definitive treatment for cancer following a consultant decision to upgrade their priority status within a given period.

Scope: Patients included in this indicator will not have been referred urgently for suspected cancer by their GP or referred with suspected cancer from a NHS Cancer Screening Service with suspected cancer (routine referrals from these services where cancer was not initially suspected may be upgraded).

Data Definition:
Numerator and denominator details are defined above.

All data are to be returned to the Cancer Waiting Times Database (CWT-Db) as per the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Amd 7/2015.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 7/2015 is available in the NHS Data Dictionary.

MONITORING

Monitoring Frequency: Monthly and Quarterly

Monitoring Data Source:
Data are sourced from the CWT-Db on a monthly and quarterly basis

ACCOUNTABILITY

What success looks like, Direction, Milestones:

E.B.12: All cancer two month urgent referral to first treatment wait
Performance is to be sustained at or above the published operational standard of 85%.

E.B.13: 62-day wait for first treatment following referral from a NHS cancer screening service
Performance is to be sustained at or above the published operational standard of 90%.

E.B.14: 62-Day wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority
There is no current operational standard, therefore will not be centrally assessed against a set threshold. These performance data will however be monitored and published as national statistics.

Timeframe/Baseline: Ongoing

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly and quarterly for 2016/17 via the Unify2 template

E.B.15.i: Ambulance clinical quality – Category A (Red 1) 8 minute response time

DEFINITIONS

Detailed Descriptor:

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

Lines Within Indicator (Units):

Numerator: The total number of Category A Red 1 incidents which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Denominator: The total number of Category A Red 1 incidents which resulted in an emergency response arriving at the scene.

Data Definition:

Numerator: The total number of Category A Red 1 incidents which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less.

Denominator: The total number of Category A Red 1 incidents which resulted in an emergency response arriving at the scene. If there have been multiple calls to a single incident only one incident should be recorded.

Category A Red 1 incidents: Presenting conditions that may be immediately life threatening and the most time critical and should receive an emergency response within 8 minutes, irrespective of location, in 75% of cases. For Category A Red 1 calls “the clock starts” when the call is presented to the control room telephone switch. The "clock stops" when the first ambulance service-dispatched emergency responder arrives at the scene of the incident. A legitimate clock stop position can include the responder arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the control room.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:

Ambulance Computer Aided Dispatch system. Monthly data collected via Unify2.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

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

Category A Red 1 incidents: Presenting conditions that may be immediately life threatening and the most time critical and should receive an emergency response within 8 minutes, irrespective of location, in 75% of cases.

Timeframe/Baseline: Ongoing

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

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template.

To be completed by lead CCG.

E.B.15.ii: Ambulance clinical quality – Category A (Red 2) 8 minute response time

DEFINITIONS

Detailed Descriptor:

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

Lines Within Indicator (Units):

Numerator: The total number of Category A Red 2 incidents which resulted in an emergency response arriving at the scene of the incident within 8 minutes.

Denominator: The total number of Category A Red 2 incidents which resulted in an emergency response arriving at the scene.

Data Definition:

Numerator: The total number of Category A Red 2 incidents which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less.

Denominator: The total number of Category A Red 2 incidents which resulted in an emergency response arriving at the scene. If there have been multiple calls to a single incident only one incident should be recorded.

Category A Red 2 incidents: Presenting conditions which may be life threatening but less time critical than Red 1 and should receive an emergency response within 8 minutes, irrespective of location, in 75% of cases.

Dispatch on Disposition (DoD) was introduced in January 2015 and allows Ambulance Trusts undertaking DoD additional time to triage Category A Red 2 calls.

Trust Name	Date started DoD	Maximum Clock Start Available
North East Ambulance Service NHS FT	October 2015	180 seconds
Yorkshire Ambulance Service NHS Trust	October 2015	180 seconds
West Midlands Ambulance Service NHS FT	October 2015	180 seconds
South Central Ambulance Service NHS FT	October 2015	180 seconds
South Western Ambulance Service NHS FT	October 2015	240 seconds*
London Ambulance Service NHS Trust	February 2015	180 seconds

* Changed from 180 which applied from Feb 2015

For trusts not undertaking DoD, for Category A Red 2 calls “the clock starts” from the earliest of the chief complaint information being obtained, a vehicle being assigned or 60 seconds after the time at which the call is presented to the control room telephone switch. The table above outlines the trusts undertaking DoD, the date they started and the maximum “clock start” available. “The clock starts” for trusts undertaking DoD is defined as the earliest of the chief complaint information being obtained, a vehicle being assigned or the maximum clock start available for the trust.

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

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Ambulance Computer Aided Dispatch system. Monthly data collected via Unify2.

ACCOUNTABILITY

What Success Looks Like, Direction, Milestones:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.

Category A Red 2 incidents: Presenting conditions that may be life threatening but less time critical than Red 1 and should receive an emergency response within 8 minutes, irrespective of location, in 75% of cases.

Timeframe/Baseline: Ongoing

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

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template.

To be completed by lead CCG.

E.B.16: Ambulance clinical quality – Category A 19 minute transportation time

DEFINITIONS

Detailed Descriptor:

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

Lines Within Indicator (Units):

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

Denominator: The total number of Category A incidents with an ambulance response arriving at the scene of the incident.

Data Definition:

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

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

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

Dispatch on Disposition (DoD) was introduced in January 2015 and allows Ambulance Trusts undertaking DoD additional time to triage Category A Red 2 calls. This additional triage time will impact on the overall performance for Category A calls.

Please refer to section E.B.15.ii Ambulance clinical quality – Category A (Red 2) 8 minute response time for more information on participating trusts and programme details.

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

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Ambulance Computer Aided Dispatch system. Monthly data collected via Unify2.

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Faster response times improve health outcomes and experience for patients with immediately life-threatening conditions.

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

Timeframe/Baseline: Ongoing

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

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

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, CCG plans, monthly for 2016/17 via the Unify2 template.

To be completed by lead CCG.

E.B.S.1: Mixed Sex Accommodation (MSA) breaches

DEFINITIONS

Detailed Descriptor:

Patient Experience: Breaches of same sex accommodation.

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

Since April 2011 all providers of NHS funded care have routinely reported breaches of sleeping accommodation as set out in the national guidance and hence attract contract sanctions in respect of each patient affected.

Lines Within Indicator (Units):

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

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

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

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

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

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

MSA Breach Rate Indicator Definition: The number of breaches of MSA sleeping accommodation per 1,000 FCEs.

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

Numerator: The number of MSA breaches for the reporting month in question.

Data Source: The Unify2 MSA data collection.

Denominator: The number of FCEs that finished in the month regardless of when they started.

Data source: HES Inpatient data (Hospital Episode Statistics).

Data Definition:
Guidance and definitions are available on the NHS England Mixed Sex Accommodation web page.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source: The Unify2 MSA data collection

ACCOUNTABILITY

What success looks like, Direction, Milestones:
All providers of NHS funded care are expected to eliminate MSA, except where it is in the overall best interest of the patient. Ability to deliver this requirement is the key indicator of success.

Timeframe/Baseline: Ongoing

Rationale:
Patients have told us that MSA is distressing to patients at a time when they feel at their most vulnerable.

The above focus means that organisations will be held to account for managing beds and facilities to eliminate MSA. It also better facilitates commissioners' application of sanctions to NHS organisations that breach the guidance. Publication of the associated breach data means that patients and the public will be better informed about an organisation's progress in eliminating MSA.

PLANNING REQUIREMENTS: No plans required

E.B.S.2: Cancelled Operations

DEFINITIONS

Detailed Descriptor:

All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days or the patient's treatment to be funded at the time and hospital of the patient's choice.

Lines Within Indicator (Units):

Numerator: The number of breaches of the cancelled operations standard in the quarter. A breach should be counted at the point it occurs ie if after 28 days of a last minute cancellation the patient has not been treated then the breach should be recorded. The last minute cancellation associated with this breach may have occurred in the same quarter or in a previous quarter. Please note that the 28 day period does not stop at the end of a quarter but is continuous.

Denominator: The number of last minute cancellations by the hospital for non-clinical reasons in the quarter. Last minute means on the day the patient was due to arrive, after the patient has arrived in hospital or on the day of the operation or surgery.

Data Definition:

Guidance and definitions are on the NHS England Cancelled Elective Operations web page.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

QMCO (Quarterly Monitoring Cancelled Operations)
Unify2 Performance monitoring arrangements.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Reduction in the number of cancelled operations.

Timeframe/Baseline: Ongoing

Rationale:

It is not in the patient's interest to have their operation cancelled.

PLANNING REQUIREMENTS: No plans required

E.B.S.3: Mental health measure – Care Programme Approach (CPA)

DEFINITIONS

Detailed Descriptor:

Care Programme Approach (CPA) 7 day follow up.

The proportion of those patients on CPA discharged from inpatient care who are followed up within 7 days.

Lines Within Indicator (Units):

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

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

Data Definition:

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

Exemptions:

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

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

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Unify2, Mental Health Minimum Data Set (MHMDS)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Achieving at least 95% rate of patients followed up after discharge each quarter.

Timeframe/Baseline: Ongoing

Rationale:
Reduction in the overall rate of death by suicide will be supported by arrangement for securing provision by commissioners of appropriate care for all those with mental ill health.

To reduce risk and social exclusion and improve care pathways to patients on CPA discharged from a spell of in-patient care.

PLANNING REQUIREMENTS: No plans required

E.B.S.4: Number of 52 week referral to treatment pathways

DEFINITIONS

Detailed Descriptor:
The number of referral to treatment (RTT) incomplete pathways greater than 52 weeks.

Lines Within Indicator (Units):
The number of incomplete pathways greater than 52 weeks for patients on incomplete pathways at the end of the period.

Data Definition:
The definitions that apply for RTT waiting times as well as guidance on recording and reporting RTT data can be found on the NHS England Consultant-led Referral to Treatment Waiting Times Rules and Guidance web page.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:
Consultant-led Referral to Treatment Waiting Times data collection (National Statistics)

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Zero RTT incomplete pathways greater than 52 weeks.

Timeframe/Baseline: Ongoing

Rationale:
NHS England introduced a zero tolerance of any referral to treatment waits of more than 52 weeks in 2013/14, with contractual penalties for each such wait.

PLANNING REQUIREMENTS: No plans required

E.B.S.5: A&E – 12 hour waits for admission via A&E

DEFINITIONS

Detailed Descriptor:

Patients who have waited over 12 hours in A&E from decision to admit to admission.

Lines Within Indicator (Units):

Total number of patients who have waited over 12 hours in A&E from decision to admit to admission.

Data Definition:

The waiting time for an emergency admission via A&E is measured from the time when the decision is made to admit, or when treatment in A&E is completed (whichever is later), to the time when the patient is admitted.

i) Time of decision to admit is defined as the time when a clinician decides and records a decision to admit the patient or the time when treatment that must be carried out in A&E before admission is complete – whichever is the later.

ii) An emergency admission via A&E is defined as an A&E attendance disposal under code 1 or code 7 (transfer to another healthcare provider). Time of admission is defined as:

For disposal code 1, the time when such a patient leaves the department to go to:

- an operating theatre
- a bed in a ward
- an X-ray or diagnostic test or other treatment directly en route to a bed in a ward (as defined below) or operating theatre. However, leaving A&E for a diagnostic test or other treatment does not count as time of admission if the patient then returns to A&E to continue waiting for a bed.

For disposal code 7, the time when such a patient is collected for transfer to another provider. Where a patient is transferred to another hospital it is expected that they will be taken immediately to a bed in an appropriate ward on arrival. The waiting period at the first Trust will end when the ambulance crew collect the patient for transfer. If further assessment and/or treatment is necessary in the A&E department of the second (receiving) Trust a fresh waiting period begins when assessment and/or treatment is completed in that A&E Department.

Include patients whose waiting time for an emergency admission is 12:00:01 hours or longer.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:

Monthly A&E Attendances and Emergency Admissions (MSitAE) collection

ACCOUNTABILITY

What success looks like, Direction, Milestones:
There should be no instances of 12 hour waits for admission.

Timeframe/Baseline: Ongoing

Rationale:
It is not acceptable for patients to be waiting in A&E for admission for this length of time.

PLANNING REQUIREMENTS: No plans required

E.B.S.6: Urgent operations cancelled for a second time

DEFINITIONS

Detailed Descriptor:

Number of urgent operations that are cancelled by the trust for non-clinical reasons which have already been previously cancelled once for non-clinical reasons.

Lines Within Indicator (Units):

Number of urgent operations that are cancelled by the trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.

Data Definition:

Include all urgent operations that are cancelled, including emergency patients (ie non-elective), who have their operations cancelled. In principle the majority of urgent cancellations will be urgent elective patients but it is possible that an emergency patient has their operation cancelled (eg patient presents at A&E with complex fracture which needs operating on. Patient's operation is arranged and subsequently cancelled).

Definition of 'urgent operation'

The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) should be followed. Broadly these are:

Immediate - Immediate (A) lifesaving or (B) limb or organ saving intervention. Operation target time within minutes of decision to operate.

Urgent - Acute onset or deterioration of conditions that threaten life, limb or organ survival. Operation target time within hours of decision to operate.

Expedited - Stable patient requiring early intervention for a condition that is not an immediate threat to life, limb or organ survival. Operation target time within days of decision to operate.

Elective - Surgical procedure planned or booked in advance of routine admission to hospital.

Broadly, (I), (II) and (III) should be regarded as 'urgent' for the purpose of meeting this requirement. The full text of the NCEPOD Classification of Interventions is available online.

An operation which is rescheduled to a time within 24 hours of the original scheduled operation should be recorded as a postponement and not as a cancellation. For postponements, the following apply:

- the 24 hour period is strictly 24 hours and not 24 working hours, ie it includes weekend/other non-working days
- the patient should not be discharged from hospital during the 24 hour period

- a patient cannot be postponed more than once (if they are then they count as a cancellation).

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source: Monthly sitrep (MSitRep)

ACCOUNTABILITY

What success looks like, Direction, Milestones:
No patient should have an urgent operation cancelled for a second time.

Timeframe/Baseline: Ongoing

Rationale: Improved patient experience and patient outcomes.

PLANNING REQUIREMENTS: No plans required

E.B.S.7: Ambulance handover times

DEFINITIONS

Detailed Descriptor: Ambulance handover delays

Lines Within Indicator (Units):

E.B.S.7a - Ambulance handover delays of over 30 minutes.

E.B.S.7b - Ambulance handover delays of over 1 hour.

Data Definition:

The guideline is that all handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes.

Data is collected for the number of handover delays longer than 30 minutes and of handover delays over one hour.

Clock start - arrival to Patient Handover performance (acute trusts):
When an ambulance wheels stop in the patient offloading bay (handbrake applied and 'Red at Hospital' button is pressed on the MDT).

Clock stop - Patient Handover/Trolley Clear performance (acute trusts):
The time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.

Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E.

Do Not count non-emergency patients.

Patients being transported between locations/trusts/hospitals (eg for outpatient clinics, tertiary care) should not be counted.

Ambulance trusts should not count the time required for crews to complete record forms, clean vehicles, re-stock vehicles or have a break.

MONITORING

Monitoring Frequency: For local determination

Monitoring Data Source:

Local data but currently winter daily sitreps collects data on 30 minute handovers at acute trusts

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Reductions expected in the number of handover delays.

Timeframe/Baseline: Ongoing

Rationale:
Delaying ambulances outside A&E as a result of a temporary mismatch between A&E/hospital capacity and numbers of elective/emergency patients arriving is not acceptable. Implementation of the full hospital escalation plan should ensure that A&Es have significant capacity to avoid most instances of ambulance queuing. Patients waiting in the back of ambulances is not acceptable, and there are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E.

PLANNING REQUIREMENTS: No plans required

E.B.S.8: Crew Clear

DEFINITIONS

Detailed Descriptor: Crew clear delays

Lines Within Indicator (Units):

E.B.S.8a - Crew clear delays of over 30 minutes

E.B.S.8b - Crew clear delays of over 1 hour

Data Definition:

The guideline is that following handover between ambulance and A&E the ambulance crew should be ready to accept new calls within 15 minutes.

Data is collected for the number of crew clear delays of longer than 30 minutes and of crew clear delays over one hour.

Clock start - Patient Handover/Trolley Clear performance (ambulance service):
The time at which clinical handover has been fully completed and the patient has been physically transferred onto hospital apparatus. Ambulance apparatus must have been returned enabling the ambulance crew to leave the department.

Clock stop - Crew Clear performance (ambulance service) and the ambulance turnaround process as a whole:
The time at which the ambulance crew has repatriated equipment, finalised paperwork, restocked where appropriate and cleaned the vehicle ready for the next call.

Count all accident, emergency and urgent patients if destined for A&E (either Type 1, 2 or 3). This includes GP urgent patients brought by ambulance to A&E.

Do Not count non-emergency patients.

Patients being transported between locations/trusts/hospitals (eg for outpatient clinics, tertiary care) should not be counted.

MONITORING

Monitoring Frequency: For local determination

Monitoring Data Source: Local data

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Reductions expected in the numbers of crew ready delays.

Timeframe/Baseline: Ongoing

Rationale:
Delaying ambulances outside A&E as a result of delays in crews being ready to respond to further calls is not acceptable. There are risks to patients in the community who are not able to receive a 999 response whilst ambulances are waiting at A&E and ambulance service capacity is severely constrained if crews do not promptly declare themselves clear to respond.

PLANNING REQUIREMENTS: No plans required

E.E.1: Percentage of all NHS England incomplete RTT pathways within 18 weeks of referral

DEFINITIONS

Detailed Descriptor:

Percentage of all NHS England (X24 Coded) incomplete RTT pathways within 18 weeks of referral.

Data Definition:

Numerator: Total number of NHS England (X24 Coded) incomplete pathways within 18 weeks at the end of the reporting period.

Denominator: Total number of NHS England (X24 Coded) incomplete pathways at the end of the reporting period.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:

NHS England Consultant-led Referral to Treatment Waiting Times

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard that 92% of incomplete pathways should be within 18 weeks.

Rationale: See Indicator E.B.3

PLANNING REQUIREMENTS: No plans required

E.E.2: Percentage of NHS England patients waiting 6 weeks or more for diagnostic tests

DEFINITIONS

Detailed Descriptor:

Percentage of NHS England (X24 coded) patients waiting 6 weeks or more for diagnostic tests.

Data Definition:

Numerator: Number of patients (whose treatment is commissioned by NHS England) waiting six weeks or more for a diagnostic test at the end of the period.

Denominator: The total number of patients waiting at the end of the period.

MONITORING

Monitoring Frequency: Monthly

Monitoring Data Source:

NHS England Monthly Diagnostic Waiting Times and Activity

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance should be in line with the operational standard, with less than 1% of all patients waiting six weeks or longer for diagnostic tests.

Rationale: See Indicator E.B.4

PLANNING REQUIREMENTS: No plans required

E.F.1 Population vaccination coverage – DTaP/IPV/Hib (1 year old)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - DTaP/IPV/Hib (1 year old).

Data Definition:

Numerator: Total number of children who received the completed course of DTaP/IPV/Hib vaccine at any time before or on their first birthday.

Denominator: Total number of resident children whose first birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

COVER is published in the last month of the quarter following the reported quarter (ie Q1 data would be published at the end of September). Annual data is published in late September.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 94.2% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.2: Population vaccination coverage – MenC (1 year old)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage – MenC (1 year old).

Data Definition:

Numerator: Total number of children who received the completed course of MenC vaccine at any time by their first birthday.

Denominator: Total number of resident children whose first birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 93.9% based on 2012-13 data taken from NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.3: Population vaccination coverage – PCV (1 year old)

DEFINITIONS

Detailed Descriptor:

Population vaccination coverage - PCV (1 year old).

Data Definition:

Numerator: Total number of children who received two doses of PCV vaccine at any time by their first birthday.

Denominator: Total number of resident children whose first birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 93.9% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.4: Population vaccination coverage – DTaP/IPV/Hib (2 years old)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - DTaP/IPV/Hib (2 years old).

Data Definition:

Numerator: Total number of children who received three doses of DTaP/IPV/Hib vaccine at any time by their second birthday.

Denominator: Total number of resident children whose second birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 95.7% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.5: Population vaccination coverage – PCV booster (2 years old)

DEFINITIONS

Detailed Descriptor:

Population vaccination coverage - PCV booster vaccination (2 years old).

Data Definition:

Numerator: Total number of children who received one dose of PCV booster vaccine on or after their first birthday and at any time up to their second birthday.

Denominator: Total number of resident children whose second birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 92.2% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.6: Population vaccination coverage – Hib/MenC booster (2 years old)

DEFINITIONS

Detailed Descriptor:
Population vaccination coverage - Hib/MenC booster (2 years old).

Data Definition:
Numerator: Total number of children who received one dose of Hib/MenC booster vaccine on or after their first birthday and at any time up to their second birthday.

Denominator: Number of resident children whose second birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:
Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Performance to be sustained at or above the operational standard of 92.2% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework.

PLANNING REQUIREMENTS: No plans required

E.F.7: Population vaccination coverage – MMR for one dose (2 years old)

DEFINITIONS

Detailed Descriptor:

Population vaccination coverage - MMR for one dose (2 years old).

Data Definition:

Numerator: Total number of children who received one dose of MMR vaccine on or after their first birthday and at any time up to their second birthday.

Denominator: Total number of resident children whose second birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 92.3% based on NHS Immunisation Statistics, England - 2014-15 [NS].

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.8: Population vaccination coverage – MMR for one dose (5 years old)

DEFINITIONS

Detailed Descriptor:

Population vaccination coverage - MMR for one dose (5 years old).

Data Definition:

Numerator: Total number of children who received one dose of MMR on or after their first birthday and at any time up to their fifth birthday.

Denominator: Total number of resident children whose fifth birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 94.4% based on NHS Immunisation Statistics, England - 2014-15 [NS].

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.9: Population vaccination coverage – MMR for two doses (5 years old)

DEFINITIONS

Detailed Descriptor:

Population vaccination coverage - MMR for two doses (5 years old).

Data Definition:

Numerator: Total number of children who received two doses of MMR on or after their first birthday and at any time up to their fifth birthday.

Denominator: Total number of resident children whose fifth birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 88.6% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.10: Population vaccination coverage - Hib/MenC booster (5 years old)

DEFINITIONS

Detailed Descriptor:
Population vaccination coverage - Hib/Men C booster (5 years).

Data Definition:
Numerator: Number of children at age five years who have received one booster dose of Hib/MenC vaccine.

Denominator: Number of resident children whose fifth birthday falls within the time period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:
Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Performance to be sustained at or above the operational standard of 92.4% based on NHS Immunisation Statistics, England - 2014-15 [NS]

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.11: Population vaccination coverage - Hepatitis B (1 year old)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - Hepatitis B (1 year old).

Data Definition:

Numerator: Total number of infants with maternal Hep B positive status who have received three doses of Hepatitis B vaccine before their first birthday.

Denominator: Total number of children reaching their first birthday during the specified evaluation period with maternal Hep B positive status as defined in the Hepatitis B chapter of the immunisation against diseases "Green Book".

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at the achievable level of 100%.

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.12: Population Vaccination Coverage - Hepatitis B (2 years old)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - Hepatitis B (2 years old).

Data Definition:

Numerator: Total number of infants with maternal Hep B positive status who have received four doses of Hepatitis B vaccine before their second birthday.

Denominator: Total number of children reaching their second birthday during the specified evaluation period with maternal Hep B positive status as defined in the Hepatitis B chapter of the immunisation against infectious diseases green book.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - Cover of vaccination evaluated rapidly (COVER) programme.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.13: Population vaccination coverage - HPV

DEFINITIONS

Detailed Descriptor: Population vaccination coverage – HPV.

Data Definition:

Numerator: Number of females in Year 8 (aged 12 to 13 years) who have received all three doses of the HPV vaccine.

Denominator: Number of females in Year 8 (aged 12 to 13 years).

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source: Public Health England

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at the operational standard of 86.7% based on PHEs Human Papillomavirus (HPV) Vaccine Coverage in England, 2008/09 to 2013/14

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.14: Population vaccination coverage - PPV

DEFINITIONS

Detailed Descriptor: Population vaccination coverage – PPV.

Data Definition:

Numerator: Number of adults aged 65 years and over who have received one dose of PPV.

Denominator: Number of resident adults aged 65 years and over.

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source: Public Health England

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at the operational standard of 69.8% based on 2014-15 Pneumococcal polysaccharide vaccine (PPV): vaccine coverage estimates data.

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.15: Population vaccination coverage - Flu (aged 65+)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - Flu (aged 65+).

Data Definition:

Numerator: Number of adults aged 65 years and over vaccinated between 1st September and 31st January of the financial year.

Denominator: Number of resident adults aged 65 years and over.

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Public Health England - Vaccine uptake guidance

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 72.7% (based on 2014-15 Seasonal influenza vaccine uptake amongst GP patients in England data.

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.16: Population vaccination coverage - Flu (at risk individuals)

DEFINITIONS

Detailed Descriptor: Population vaccination coverage - Flu (at risk individuals).

Data Definition:

Numerator: Number of individuals aged between six months and 65 years who are in a clinical risk group (as defined in the immunisation against infectious diseases and detailed in the read-code specification produced by PRIMIS+) vaccinated between 1st September and 31st January of the financial year.

Denominator: Number of individuals aged between six months and 65 years who are in a clinical risk group (as defined in the immunisation against infectious diseases and detailed in the read-code specification produced by PRIMIS+).

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Public Health England - Vaccine uptake guidance and the latest coverage data

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 50.3% based on 2014-15 Seasonal influenza vaccine uptake amongst GP patients in England data.

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.17: Percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result

DEFINITIONS

Detailed Descriptor:

The percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result.

Data Definition:

Numerator: Total number of eligible women for whom a conclusive screening result was available for HIV at the day of report, including women who were known to be HIV positive at booking and were therefore not retested and women who transfer in for care during the reporting period with documented evidence of a screening test result during the pregnancy (and therefore not retested).

Denominator: Total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, excluding:

- women who miscarry
- opt for termination; or
- transfer out between booking and testing (ie prior to testing).

'Booking' is the point at which the woman first sees a midwife for an antenatal booking history, when details of the current pregnancy are documented in a maternity record (which may be an information system or a paper-based record). The maternity unit where a woman is 'booked to deliver' is responsible for capturing and reporting these data.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - UK National Screening Committee KPI

ACCOUNTABILITY

Timeframe/Baseline: Acceptable level ≥ 90.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.18: Percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for Syphilis, Hepatitis B and susceptibility to Rubella leading to a conclusive result

DEFINITIONS

Detailed Descriptor:

The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for Syphilis, Hepatitis B and susceptibility to Rubella leading to a conclusive result.

Data Definition:

Numerator: Number of women tested for each infection for whom a conclusive screening result was available for each of the screening tests on the day of the report, including women who were known to be hepatitis B positive at booking and therefore not retested and women who transfer in for care during the reporting period with documented evidence of a screening test result during the pregnancy (and therefore not retested).

Denominator: Number of women booked for antenatal care during the reporting period.

'Booking' is the point at which the woman first sees a midwife for an antenatal booking history, when details of the current pregnancy are documented in a maternity record (which may be an information system or a paper-based record). The maternity unit where a woman is 'booked to deliver' is responsible for capturing and reporting these data.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: UK National Screening Committee

ACCOUNTABILITY

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.19: Percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report

DEFINITIONS

Detailed Descriptor:

The percentage of pregnant women eligible for antenatal sickle cell and thalassaemia screening for whom a conclusive screening result is available at the day of report.

Data Definition:

Numerator: The total number of eligible women for whom a conclusive screening result was available for sickle cell and thalassaemia at the day of report, including women for whom a previous result is known (and were therefore not retested) and women who transfer in for care during the reporting period with documented evidence of a screening test result during the pregnancy (and were therefore not retested). In areas with low prevalence of sickle cell disease, this may include women at low risk of sickle cell disease for whom haemoglobinopathy analysis (E.F. HPLC) has not been indicated by FOQ.

Denominator: Total number of pregnant women booked for antenatal care during the reporting period, or presenting in labour without previously having booked for antenatal care, excluding:

- women who miscarry
- opt for termination
- transfer out between booking and testing; or
- known carriers who had direct access to pre-natal diagnosis.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - UK National Screening Committee KPI

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the achievable level of 99.0%.

Timeframe/Baseline: Acceptable level ≥ 95.0%

Rationale: Please see the NHS Screening KPI

PLANNING REQUIREMENTS: No plans required

E.F.20: Percentage of babies registered within the Local Authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe

DEFINITIONS

Detailed Descriptor:

The percentage of babies registered within the local authority area both at birth and at the time of report who are eligible for newborn blood spot screening and have a conclusive result recorded on the Child Health Information System within an effective timeframe.

Data Definition:

Numerator: Total number of eligible babies for whom a conclusive screening result for phenylketonuria (PKU) was available within an effective timeframe.

Denominator: Total number of babies born within the reporting period, excluding any baby who died before the age of 8 days. For the purposes of this KPI the cohort includes only babies for whom the previous PCT were responsible at birth and are still responsible for on the last day of the reporting period.

The effective timeframe is that a conclusive result for PKU is recorded within the appropriate Child Health Information System by 17 days of age.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - UK National Screening Committee KPI

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the achievable level of 99.9%.

Timeframe/Baseline: Acceptable level ≥ 95.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.21: Percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies)

DEFINITIONS

Detailed Descriptor:

The percentage of babies eligible for newborn hearing screening for whom the screening process is complete within 4 weeks corrected age (hospital programmes – well babies, all programmes – NICU babies) or 5 weeks corrected age (community programmes – well babies).

Data Definition:

Numerator: Total number of eligible babies for whom a decision about referral or discharge from the screening programme has been made within an effective timeframe. This includes:

- babies for whom a conclusive screening result was available by 4 weeks corrected age (for hospital screening programmes – well babies and all programmes – NICU babies)
- babies for whom a conclusive screening result was available by 5 weeks corrected age (for community screening programmes – well babies); or
- babies referred to an audiology department because a newborn hearing screening encounter was inconclusive by the above timescales.

The 'screening outcomes' relating to a complete screen within the national software solution for Hearing Screening are:

- clear response – no follow up required
- clear response – targeted follow up required
- no clear response – bilateral referral
- no clear response – unilateral referral
- incomplete – baby/equipment reason
- incomplete – equipment malfunction
- incomplete – equipment not available
- incomplete – screening contraindicated
- incomplete – baby unsettled.

Denominator: Total number of babies born within the reporting period whose mother was registered with a GP practice within the area, or (if not registered with any practice) resident within the area, excluding any baby who died before an offer of screening could be made.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: UK National Screening Committee KPI

ACCOUNTABILITY

What success looks like, Direction, Milestones:
Performance to be sustained at or above the achievable level of 99.5%

Timeframe/Baseline: Acceptable level ≥ 95.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.22: Percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth

DEFINITIONS

Detailed Descriptor:

The percentage of babies eligible for the newborn physical examination who were tested within 72 hours of birth.

Data Definition:

Numerator: Total number of eligible babies for whom a decision about referral (including a decision that no referral is necessary as a result of the newborn examination) for each of the conditions tested has been made within an effective timeframe.

Denominator: Total number of babies born within the reporting period whose mother was registered with a GP practice within the local authority area or (if not registered with any practice) resident within the local authority area, excluding any baby who died before an offer of screening could be made.
The 'effective timeframe' for the newborn physical examination is that a conclusive screening result should be available within 72 hours of birth.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - National Screening Committee KPI

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the achievable level of 99.5%.

Timeframe/Baseline: Acceptable level ≥ 95.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.23: Percentage of those offered screening for diabetic eye screening who attend a digital screening event

DEFINITIONS

Detailed Descriptor:

The percentage of those offered screening for diabetic eye screening who attend a digital screening event.

Data Definition:

Numerator: The number of subjects offered screening who attended a digital screening encounter during the reporting period.

Denominator: The number of eligible people with diabetes offered a screening encounter which was due to take place within the reporting period.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source:

Public Health England - UK National Screening Committee KPI DE1

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the achievable level of 80.0%.

Timeframe/Baseline: Acceptable level ≥ 70.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.24: Abdominal Aortic Aneurysm (AAA) KPI

DEFINITIONS

Detailed Descriptor: Abdominal Aortic Aneurysm (AAA) KPIs.

Data Definition:

Numerator: Number of eligible subjects offered a realisable opportunity to attend for initial screening during the reporting period, whether they actually attended or otherwise.

Denominator: Number of eligible men in their 65th year to whom the screening programme propose that a screening encounter during the reporting period should be offered. When calculated annually, this indicator must report all eligible men in their 65th year, excluding any who die or move out of the area of responsibility for the local programme before screening can be offered.

MONITORING

Monitoring Frequency: Annual

Monitoring Data Source:

Public Health England - UK National Screening Committee KPI AA1

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at the achievable level of 100.0%.

Timeframe/Baseline: Acceptable level ≥ 90.0%

Rationale: Please see the NHS Screening KPI guidance

PLANNING REQUIREMENTS: No plans required

E.F.25: Breast cancer screening coverage - percentage of eligible women screened adequately within the previous 3 years on 31st March

DEFINITIONS

Detailed Descriptor:

Breast cancer screening coverage: Percentage of eligible women screened adequately within the previous 3 years on 31st March.

Data Definition:

Numerator: Number of women aged 53–70 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous three years.

Denominator: Number of women aged 53–70 resident in the area (determined by postcode of residence) who are eligible for breast screening at a given point in time. Women ineligible for screening, and thus not included in the coverage figures, are those whose recall has been ceased for clinical reasons (for example, due to previous bilateral mastectomy).

MONITORING

Monitoring Frequency:

Published Annually - monthly updates are available through CSPNS but they are not published elsewhere.

Monitoring Data Source:

Public Health England - Public Health Outcomes Framework

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 75.4% (based on 2014-15 data

Timeframe/Baseline: Published in 2012

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.26: Cervical cancer screening coverage - percentage of eligible women screened adequately within the previous 3.5 or 5.5 Years (according to age) on 31st March

DEFINITIONS

Detailed Descriptor:

Cervical cancer screening coverage: Percentage of eligible women screened adequately within the previous 3.5 or 5.5 years (according to age) on 31st March.

Data Definition:

Numerator: The number of women aged 25–49 resident in the area (determined by postcode of residence) with an adequate screening test in the previous 3½ years plus the number of women aged 50-64 resident in the area with an adequate screening test in the previous 5½ years.

Denominator: Number of women aged 25–64 who are eligible for cervical screening at a given point in time.

MONITORING

Monitoring Frequency:

Published Annually - Monthly updates are available through CSPNS.

Monitoring Data Source:

Public Health England - Public Health Outcomes Framework

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard of 73.5% coverage of all women aged 25 to 64 based on 2014-15 data.

Timeframe/Baseline: Published in 2012

Rationale: Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.F.27: Bowel cancer screening - coverage over 2.5 Years

DEFINITIONS

Detailed Descriptor:

Bowel Cancer screening – 60-74 year olds coverage over 2.5 years.

Data Definition:

Numerator: Number of people aged 60–74 resident in the area (determined by postcode of residence) with a screening test result recorded in the previous 2½ years.

Denominator: Number of people aged 60–74 resident in the area (determined by postcode of residence) who are eligible for bowel screening at a given point in time.

MONITORING

Monitoring Frequency:

Annual updates are available through the Public Health Outcomes Framework.

Monitoring Data Source:

Public Health England - CSPNS (via HSCIC, Open Exeter)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

Performance to be sustained at or above the operational standard for 60-74 year olds coverage of 57.1% based on 2014-15 data.

PLANNING REQUIREMENTS: No plans required

E.G.1: Deliver chronic disease care to the same standard of process and outcomes as is required by the national service frameworks for: diabetes, CHD and long term conditions and mental health

DEFINITIONS

Detailed Descriptor:

NHS England Health commissioned services in prison (including commissioned social care services) deliver chronic disease care to the same standard of process and outcomes as is required by the National Service Frameworks for:

- Diabetes
- CHD and Long Term Conditions
- Mental Health (Green Indicator).

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Prison Health and Performance Quality Indicators (PHPQI); from 2014 onwards Health and Justice Indicators of Performance (HJIPs)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

100% of prisons self-reporting Green Indicator.

Rationale:

Patients achieve health care benefits that meet their individual needs through health care decisions and services based on what assessed research evidence has shown provides effective clinical outcomes. NICE technology assessments and the National Service Frameworks provide a good practice base from which to deliver equivalence of service for all NHS users, including prisoners.

The Quality Outcomes Framework (QOF) is a series of standard performance measurement indicators used by GPs and as such, reporting to support its use is available in SystmOne GP. The same reporting is also available in SystmOne Prison, the point to note being that the indicators and measurements remain exactly the same as for a GP practice - there has been no tailoring to reflect a potential change of circumstances applicable to a different care setting.

Guidance on preparing QOF reports is available from within SystmOne via F1, the standard access route for help on the system. A pdf file providing a brief user guide and answering common queries is available via this route.

This indicator seeks to assure commissioners of primary care services that services delivered within prisons are at an equivalent standard to those delivered in the wider

community. Please see the Public Health Outcomes Framework

PLANNING REQUIREMENTS: No plans required

E.G.2: Access and waiting time for outpatient first appointment following written referrals of prisoners

DEFINITIONS

Detailed Descriptor:

Access and waiting times for outpatient first appointment following written referrals of prisoners are equivalent to those experienced by the local population and fall within any specified targets for the NHS or locally agreed improved targets where relevant (Green Indicator).

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Prison Health and Performance Quality Indicators (PHPQI); from 2014 onwards Health and Justice Indicators of Performance (HJIPs).

ACCOUNTABILITY

What success looks like, Direction, Milestones:

100% of prisons self-reporting Green Indicator.

Rationale:

Standards for better health core standard 18 states that 'healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably'. Prisoners are members of the population and as such are entitled to the same level of service access to the general population. Difficulties do arise due to the significant movements of prisoners - such movement should not have a detrimental effect upon their access to services and subsequent waiting times.

PLANNING REQUIREMENTS: No plans required

E.G.3: Percentage of identified patients with a learning disability have an annual health check

DEFINITIONS

Detailed Descriptor:

Percentage of identified patients with a learning disability have an annual health check.

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Prison Health and Performance Quality Indicators (PHPQI); from 2014 onwards Health and Justice Indicators of Performance (HJIPs)

ACCOUNTABILITY

What success looks like, Direction, Milestones: 100%

Rationale:

Following 'Valuing People' in 2001 and the Disability Discrimination Act 2005, both the prison service and NHS have an obligation to ensure equitable and accessible services for people with a learning disability.

At any one time approximately 24,600 prisoners have a learning difficulty that could affect their ability to function within the prison environment. Of these around 5,700 have an IQ less than 70 and may be eligible for Learning Disability services.

People with learning disabilities have greater health needs and a shorter life expectancy than the general population and have difficulty accessing health care services, which is often exacerbated by attendant communication difficulties.

PLANNING REQUIREMENTS: No plans required

E.G.4: Percentage of all prisoners returning to prison from any other mental health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme

DEFINITIONS

Detailed Descriptor:

All prisoners returning to prison from any other mental health facility following treatment under the Mental Health Act (including section 3, 47, 48) are accompanied by a 117 aftercare programme (Green Indicator).

MONITORING

Monitoring Frequency: Annually

Monitoring Data Source:

Prison Health and Performance Quality Indicators (PHPQI) from 2014 onwards
Health and Justice Indicators of Performance (HJIPs)

ACCOUNTABILITY

What success looks like, Direction, Milestones:

100% of prisons self-reporting Green Indicator

Rationale:

Section 117 gives the statutory authorities a duty to make arrangements for a person's continuing support and care. It applies to people who have been detained under Section 3, Section 37, Section 47, and Section 48. Aftercare should be planned with the patient, their family and carers, as well as professionals, looking at both health and social care needs. Section 117 ensures continuity of care. The type of aftercare required will depend on the circumstances of the individual and health. Section 117 gives a considerable discretion to health and local authorities as to the nature of the services that can be provided. As people move through the prison estate their mental health record may be lost from area to area, it is therefore imperative that the health care unit source previous mental health history.

PLANNING REQUIREMENTS: No plans required

E.H.1-3: IAPT waiting times

DEFINITIONS

Detailed Descriptor:

The primary purpose of these indicators is to measure waiting times from referral to treatment in improved access to psychological therapies (IAPT) services for people with depression and/or anxiety disorders.

For planning purposes the indicator is focused on measuring waits for those finishing a course of treatment ie two or more treatment sessions and coded as discharged but also requires local monitoring of all referral to treatment starts.

Additionally in order to guard against perverse incentive we will monitor patterns of treatment across the pathway as follows:

- the proportion of people having a course of treatment and those having a single therapy session
- average number of treatment sessions
- the case mix of patients being seen within services ie by diagnosis and severity/complexity.

The work in 2014-15 on reducing waiting lists has highlighted the high number of patients with excess waits for continuation of treatment following their first treatment appointment. Such long waits are not good practice and are known to impact on recovery rates and patient experience. Resolving long waits is a local responsibility. In 2016-17 an additional supporting measure based on waits from first to second appointment is recommended in order to create greater visibility in the progress being made by commissioners in eliminating such waits.

Lines Within Indicator (Units):

PLANNING REQUIREMENTS

E.H.1_A1: The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Numerator: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 6 weeks of referral.

Denominator: The number of ended referrals that finish a course of treatment in the reporting period.

E.H.2_A2: The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Numerator: The number of ended referrals that finish a course of treatment in the reporting period who received their first treatment appointment within 18 weeks of referral.

Denominator: The number of ended referrals who finish a course of treatment in the reporting period.

Monitoring Requirements

E.H.1_B1: The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.

Numerator: The number of people who had their first treatment appointment within 6 weeks of referral in the reporting period.

Denominator: The number of people who had their first treatment appointment in the reporting period.

E.H.2_B2: The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period.

Numerator: The number of people who had their first treatment appointment within 18 weeks of referral in the reporting period.

Denominator: The number of people who had their first treatment appointment in the reporting period.

E.H.3_C1: Number of ended referrals in the reporting period that received a course of treatment against the number of ended referrals in the reporting period that received a single treatment appointment.(See Table 7 in the reference tables in the Psychological Therapies: Annual Report on the use of IAPT services 2014/15) from which these figures come:
Number of ended referrals that finished a course of treatment: 468,881
Number of ended referrals that received one treatment appointment: 237,757

E.H.3_C2: Average number of treatment sessions
(See Table 8 in the reference table Psychological Therapies: Annual Report on the use of IAPT services 2014/15: Median number of treatment sessions for referrals that finished a course of treatment: 5)

E.H.3_C3: Re-focusing service provision on less severe cases (indicator in development)

Data Definition:

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

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

Referral date: The date a referral for assessment or treatment is received at the IAPT service or appointment processing agency such as single point of access or triage service.

Treatment session: This is coded as Appointment Type 02 – Treatment, 03 - Assessment and Treatment, and 05 - Review and Treatment in the IAPT data standard.

Finished course of treatment: This is a count of all those who have left treatment having attended at least two treatment contacts, for any reason including:

- planned completion
- deceased
- dropped out (unscheduled discontinuation)
- referred to another service
- unknown.

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: IAPT Minimum Data Set, HSCIC

ACCOUNTABILITY

What success looks like, Direction, Milestones:

NHS England has committed that "75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral (**E.H.1_ A1**), and 95% will be treated within 18 weeks of referral (**E.H.2._A2**)." Maintenance of at least the standard achieved at the end of 2015/16 is anticipated.

Timeframe/Baseline:

The milestones above **(E.H.1_A1** and **E.H.2_A2**) will be met by April 2016.

Rationale:

"Achieving Better Access to Mental Health Services by 2020" has identified three key areas where additional investment will be made to implement Mental Health access and/or waiting time standards. This includes a specific waiting time standard for adult IAPT services to ensure timely access to evidence based psychological therapies for people with depression and anxiety disorders.

In order to guard against perverse incentive NHS England will monitor patterns of treatment across the pathway using **E.H.3_C1**, **E.H.3_C2** and **E.H.3_C3.**

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2016/17 for both **E.H.1_A1** and **E.H.2_A2** only via the Unify2 template.

Local monitoring anticipated for **E.H.1_B1 and E.H.2_B2**.

FURTHER INFORMATION

NHS England will monitor the impact of patient initiated delays on the referral to treatment pathway throughout 2016/17.

The IAPT data set contains detailed guidance on use of the technical specification and the central return process.

NHS England has published guidance for how new access and waiting time standards for mental health services are to be introduced in 2015/16 across services for first episode psychosis, IAPT for common mental health conditions, and liaison mental health services in acute trust settings 'Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16'.

E.H.4: Percentage of people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral

DEFINITIONS

Detailed Descriptor:

The access and waiting time standard requires that more than 50% of people experiencing first episode psychosis will be treated with a NICE recommended package of care within two weeks of referral.

Both the maximum waiting time from referral to treatment **and** access to NICE recommended care must be met for the standard to have been fully achieved.

Maximum waiting time indicator
The proportion of people experiencing first episode psychosis or ARMS (at risk mental state) that wait 2 weeks or less to start a NICE recommended package of care.

Numerator: The number of people referred to the service assessed as having first episode psychosis or ARMS that start a NICE recommended care package within 2 weeks of referral.

Plus

The number of people assessed as not first episode psychosis or ARMS and referred back to referrer or onward referral within 2 weeks.

Denominator: The number of referrals to the service with suspected first episode psychosis in the reporting period.

NICE-recommended care delivery
Ongoing delivery of NICE recommended interventions and monitoring of outcomes for people will ultimately be measured through the Mental Health Services Dataset and submission of relevant SNOMED C-T codes.

Services will also be expected to participate in a national quality improvement network/accreditation scheme that will support demonstration of a team's ability to deliver the relevant NICE concordant interventions in line with NICE guidelines and quality standards.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The measure of success will be that more than 50% of people experiencing a first episode of psychosis are treated with a NICE recommended care package within two weeks of referral. It is expected that the standard should be delivered from April 2016 onwards. This should be reinforced through the NHS standard contract for 2016/17.

Commissioners were required to agree with mental health providers a Service Development and Improvement Plan, as part of their local 2015/16 contracts, setting out how the provider will prepare for and implement the standards during 2015/16, so that they can be achieved on an ongoing basis from 1 April 2016.

In addition, Foundation Trusts will also be expected to report on preparation of standard delivery to Monitor as part of the Risk Assessment Framework from Q4 2015/16.

Timeframe/Baseline:
Preparation for standard implementation during 2015/16 with delivery from April 2016.

Rationale:
The NHS Mandate set out the requirement for NHS England to work with the Department of Health and other stakeholders to develop a range of costed options in order to implement mental health access standards starting from April 2015. Achieving Better Access to Mental Health Services by 2020 stated that for early intervention services this would mean that more than 50% of people experiencing a first episode of psychosis would be treated with a NICE recommended care package within two weeks of referral by April 2016.

PLANNING REQUIREMENTS

Required to ensure delivery in line with the standard from 1 April 2016. No requirement to complete a Unify planning template.

FURTHER INFORMATION

NHS England has published guidance for how new access and waiting time standards for mental health services are to be introduced in 2015/16 across services for first episode psychosis, IAPT for common mental health conditions, and liaison mental health services in acute trust settings in the document 'Guidance to support the introduction of access and waiting time standards for mental health services in 2015/16'.

E.H.5: Percentage of acute hospitals with an effective on-site 24/7 urgent and emergency liaison mental health service covering all ages

DEFINITIONS

Detailed Descriptor:

Indicator in development. Best available evidence suggest that the minimum service specification that brings clinical and financial benefits is the 'Core 24' model as set out in South West Strategic Clinical Network's model specification.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

It is anticipated that the measure of success will be that services move towards 'core 24' service specification, to be measured in 2016/17 via a UNIFY collection, and/or the 3rd national survey of liaison mental health, as well as the commencement of CQC inspections of liaison mental health services in acute hospitals.

Rationale:

The NHS Mandate set out the requirement for NHS England to invest in effective models of liaison psychiatry in more acute hospitals. CQC's thematic review of crisis care highlighted that experience of people in mental health crisis presenting to emergency departments is 'unacceptable'. People with mental ill health are over 3 times as likely to present to emergency departments as the general population, and 5 times more likely to be admitted to acute hospitals[1]. This highlights the pressing need for acute hospitals to be equipped to identify, assess and care for people with mental ill health.

PLANNING REQUIREMENTS: No plans required

FURTHER INFORMATION

Key resources:

- Model service specifications for liaison mental health, produced by the South West Strategic Clinical Network (these include the specification for a 'Core 24' service)
- Commissioning guidance developed by the Joint Commissioning Panel for Mental Health
- RCPsych Quality Standards for liaison mental health

Access and quality standards for crisis care (including urgent and emergency liaison mental health) are under development by NHS England.

[1] Quality Watch - Mental ill health and hospital use

E.H.6: Percentage of local crisis resolution and home treatment teams able to provide a 24/7 gatekeeping function for acute mental health beds and a 24/7 intensive home-based alternative to admission in line with fidelity standards

DEFINITIONS

Detailed Descriptor:

Indicators in development over coming years as part of NHS England's Crisis and Acute care programme. Best available evidence is through the UCL Core Study fidelity scale, which is based on the original DH 2001guidance for Crisis Resolution and Home Treatment Teams (CRHTTs). UCL's Core fidelity scale can be used both as an assessment of current team functioning and to measure the outcome of service improvement activity.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

While we know that crisis resolution and home treatment teams exist in some form in every area, studies suggest that the majority are not resourced or operating in line with evidence based practice. Success will be achieved when CRHTTs are operating in line with the UCL core fidelity scale. A particular focus should be on teams operating 24/7, carrying out their function of 'gatekeeping' acute mental health admissions and providing intensive home treatment as an alternative to admission to acute mental health inpatient wards to those for whom it is appropriate.

This will be determined via metrics in the CCG assessment framework, to be reported on quarterly via Unify 2 data collection and robust regional assurance mechanisms.

Rationale:

Recent studies have shown that the majority of CRHTTs are not sufficiently resourced, with caseloads beyond levels that allow for safe and effective care or ability to fulfil their core functions of 'gatekeeping' and providing an intensive 24/7 community alternative to acute mental health admissions.[2]

PLANNING REQUIREMENTS

All CCGs should have in place with their mental health provider a service development and improvement plan (SDIP) for the development of local CRHTTs to bring them in line with the UCL Core fidelity scale. No requirement to complete a Unify planning template.

FURTHER INFORMATION

[2] The Core Study

Key resources:

As well as the fidelity scale, the UCL CORE resource pack contains practical tips, examples of positive practice, audio and video clips, case studies, links to relevant reading and useful websites, and views from service users and carers.

E.H.7: Percentage of CCGs with adequate provision of health based places of safety

DEFINITIONS

Detailed Descriptor:

Legislation is expected to come into effect from April 2017 (subject to Parliamentary passage), which would no longer permit police cells to be used as a place of safety for children and young people, and would reduce the length of time that adults may be detained in a police cell. CCGs are therefore required to work with partners in local Mental Health Crisis Care Concordat groups to reduce use of police cells. This includes working with police to improve local protocols for detaining people under s.136 of the Mental Health Act and ensuring that places of safety adhere to clinical, operational and physical standards set out by the Royal College of Psychiatrists, and chapter 16 of the revised Mental Health Act Code of Practice.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

While further indicators are under development through NHS England's mental health crisis and acute care programme, there are some existing data collections that are key indicators of how CCGs are working in partnership with crisis care concordat partners, such as police constabularies, mental health providers, emergency departments and local authorities:

S136 detention rates and use of police custody

- annual data on number of detentions under s.136 of the Mental Health Act (HSCIC data)
- annual data on number of detentions in police cells (National Police Chief Council data).

In view of anticipated legislative changes from April 2017, CCGs should work with partners to have eliminated use of police cells as places of safety for children and young people by this date, as well as ensuring they as used only in exceptional circumstances for adults. Emerging evidence from evaluation of 'street triage' pilots shows that certain functions of these models have been effective in reducing s.136 detentions, and in reducing police custody. The evaluation by UCL is expected to be published in early 2016.

Local capacity and operational standards of health based places of safety

CCGs should commission sufficient capacity of places of safety, with data provided through CQC's survey of health based places of safety. These should be commissioned to meet the legal requirements set out in the revised Mental Health Act Code of Practice, and the clinical, operational and physical standards produced by RCPsych. Clinically led audit against these standards should be encouraged.

CQC now routinely inspect health-based places of safety and they have produced two key publications with clear recommendations for commissioners and providers.

These are A safer place to be (survey of health-based places of safety, Oct 2014) and pp. 73-91 of Right here, right now (thematic review of crisis care, June 2015).

CCG performance will be monitored via metrics in the CCG assessment framework, to be reported on quarterly via Unify 2 data collection (tbc) and robust regional assurance mechanisms.

Rationale:
A Criminal Use of Police Cells, the joint review by Her Majesty's Inspectorate of Constabulary, Her Majesty's Inspectorate of Prisons and the Care Quality Commission, highlighted the issue of people in crisis being detained by police officers and taken to police stations, sometimes because mental health crisis services are unable to respond often because of a lack of capacity in the system. Police cells are not an appropriate place for people experiencing mental health crisis and should only ever be used in exceptional circumstances. Although excellent progress has been made in reducing use of police cells since 2011/12, there were still around 4000 detentions in 2014/15.

Legislation is expected to come into effect from April 2017 which makes police cell detentions for children and young people unlawful, and further limit flexibility to detain adults in police cells.

PLANNING REQUIREMENTS: No plans required

FURTHER INFORMATION

Key resources:

- CR159. Standards on the use of Section 136 of the Mental Health Act 1983 (England and Wales)
- Chapter 16 of the Mental Health Act Code of Practice
- CQC Survey of health-based places of safety
- pp 73-91 of CQC thematic review of crisis care
- Crisis Care Concordat

E.H.8: Percentage of CCGs building sustainable, system wide, transformation to deliver improvements in children and young people's mental health outcomes.

DEFINITIONS

Detailed Descriptor:

Indicator in development. Calculation and collection methodology to be agreed.

The indicator on transformation plans focuses on the extent to which CCGs have plans in place to deliver system wide transformation in CYP mental health outcomes. Further indicators relate to the 1 and 4 week access standards for Eating Disorder services.

ACCOUNTABILITY

What success looks like, Direction, Milestones:

The measure of success will be a sustainable, system-wide, transformation in the quality and reach of children and young people's mental health services, with a focus on improving outcomes for children and young people. Capturing this indicator will enable the delivery of transformation to be tracked.

Transformation plan refresh and general preparedness issues will be tracked through affirmative assurance in the delivery assurance template.

The indicator will comprise a count of the number of milestones achieved.

1) Has the CCG developed and published a local transformation plan which has been assured, includes baseline data and is this plan updated and republished annually?
2) Are the Children and Young People's Eating Disorder Team commissioned by the CCG providing a service in line with the model recommended in the access and waiting time standard and part of the relevant quality assurance network?
3) Does the CCG have collaborative commissioning plans in place with NHS England for tier 3 and tier 4 CAMHS?
4) Has the CCG published joint agency workforce plans detailing how they will build capacity and capability including implementation of Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT) transformation objectives?
5) Is the CCG forecast to have increased its spend on Mental Health Services for Children and Young People by at least their allocation of baseline funding for 2016/17 compared to 2015/16?

Rationale:

Three quarters of lifelong mental health disorders (excluding dementia) presents by the age of 18. This indicator focuses on the extent to which CCGs have plans in place to deliver system wide transformation in CYP mental health outcomes. The autumn statement (December 2014) and Budget (March 2015) announcements of extra funding to transform mental health services for children and young people allow us to move forward at scale and with pace. The announcements align with

recommendations set out in the Five Year Forward View and Future in Mind and are designed to build capacity and capability across the system so that by 2020 we will make measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people's mental health outcomes.

PLANNING REQUIREMENTS: No plans required

FURTHER INFORMATION

Key resources:

Full guidance on transformation plans can be found on the NHS England Mental Health - Local transformation plans web page.

E.J.1: Delayed Transfers of care per 100,000 population (attributable to NHS, social care or both)

DEFINITIONS

For detailed technical definition please see the Better Care Fund – Technical Guidance.

PLANNING REQUIREMENTS

Plans required as per BCF Technical Guidance

E.J.2: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

DEFINITIONS

For detailed technical definition please see the Better Care Fund – Technical Guidance.

PLANNING REQUIREMENTS

Plans required as per BCF Technical Guidance

E.J.3: Bed Days

DEFINITIONS
Indicator in development

PLANNING REQUIREMENTS: No plans required

E.K.1: Reliance on inpatient care for people with a learning disability and/or autism

DEFINITIONS

Detailed Descriptor:

To measure implementation of Building the Right Support CCGs are working as part of Transforming Care Partnerships (TCPs – collaborations of CCGs, local authorities and NHS England specialised commissioners) to reduce reliance on inpatient beds and build up community capacity. The number of inpatients is used as an indicator of the reliance on inpatient care. Each CCG should be working towards ensuring that no area should need more inpatient capacity to cater for:

- 10-15 inpatients in CCG-commissioned beds per million population
- 20-25 inpatients in NHS England-commissioned beds per million population.

Every area is expected to make this change by March 2019. Due to the small numbers involved, it is not possible to measure this reduction at a CCG level and so plans are required at TCP level. Inpatient data is based on where patients originally come from, not where their hospital bed is located.

The indicator will be monitored using the Assuring Transformation data collection. The in-scope definition for this data collection is:

Data should be recorded for each individual person who meets these requirements:

- a NHS commissioner is responsible for commissioning their care; and
- the person has an inpatient bed for mental and/or behavioural healthcare needs and has a learning disability or autistic spectrum disorder (including Asperger's syndrome).

Lines Within Indicator (Units):

The number of patients who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs.

Data Definition:

The in-scope definition includes all patients who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs. The definitions of learning disability and autism are those given in the published national service model and supplementary notes.

Inpatient setting: This refers to the service/setting within which the patient is receiving care (high secure beds, medium secure beds, low secure beds, acute admission beds within learning disability units, acute admission beds within generic mental health settings, forensic rehabilitation beds, complex continuing care and rehabilitation beds, psychiatric intensive care beds, CAMHS beds or other beds including those for specialist neuropsychiatric conditions).

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: Assuring Transformation

ACCOUNTABILITY

What success looks like, Direction, Milestones:
An overall reduction in the number of inpatients who have either a learning disability and/or an autistic spectrum disorder (including Asperger's syndrome) throughout 2016/17.

Timeframe/Baseline: Assuring Transformation 2015/16 data

Rationale:
As set out in 'Building the right support' areas should be moving towards building up community capacity and reducing unnecessary inpatient provision. There is a critical need to adopt a full-system approach in conjunction with all commissioners of care, to reduce the numbers of patients being admitted to, and detained in, hospital settings.

PLANNING REQUIREMENTS

Yes, quarterly for 2016/17 via the Unify2 template.

Count of inpatients at the end of the quarter, measured on a CCG of origin basis (that is, patients whose care is commissioned by NHS England specialised commissioners are included within the CCG of origin as reported in Assuring Transformation). Plans are collected at the level of Transforming Care Partnerships.

FURTHER INFORMATION

Data is published by HSCIC monthly and quarterly. Inpatient totals at month end are refreshed in each monthly publication to take account of late reporting of admissions and discharges. This indicator will be monitored against the refreshed totals.

E.K.6: Inpatients without a review in the last 26 weeks

DEFINITIONS

Detailed Descriptor:
The purpose of this indicator is to measure the number of inpatients with a learning disability and/or autism who have not had a care review within the last 26 weeks.

Lines Within Indicator (Units):
The number of current inpatients with a learning disability and/or autism who have not had a review in the last 26 weeks.

Data Definition:
The in-scope definition includes all patients who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs. The definitions of learning disability and autism are those given in the published Service Model.

Inpatient setting: This refers to the service/setting within which the patient is receiving care (high secure beds, medium secure beds, low secure beds, acute admission beds within learning disability units, acute admission beds within generic mental health settings, forensic rehabilitation beds, complex continuing care and rehabilitation beds, psychiatric intensive care beds, CAMHS beds or other beds including those for specialist neuropsychiatric conditions).

Review: A multi-agency review of the persons care and treatment, led by the care coordinator involving the person and their families/carers. This could include a Care Programme Approach (CPA) review or a Care & Treatment Review (CTR).

MONITORING

Monitoring Frequency: Quarterly

Monitoring Data Source: Assuring Transformation

ACCOUNTABILITY

What success looks like, Direction, Milestones:
100% of patients to have received a review in the last 26 weeks.

Timeframe/Baseline: Assuring Transformation 2015/16 data

Rationale:
This is an essential service standard and will also support delivery of the indicator E.K.1 on reducing the number of inpatients.

PLANNING REQUIREMENTS: No plans required

E.K.7: Proportion of people with a learning disability on the GP register receiving an annual health check

DEFINITIONS

Detailed Descriptor:
The proportion of people on the GP learning disability register that have received an annual health check during the year measured as a percentage of the CCG's registered learning disability population.

Lines Within Indicator (Units):
The proportion of people on the GP learning disability register that have received a learning disability annual health check during the year measured as a percentage of the CCG's registered learning disability population.

Data Definition:
The numerator is the number of patients to have received a learning disability annual health check within the last 12 months as set out in The Primary Medical Services (Directed Enhanced Services) Directions 2015.

The denominator is the number of patients on the learning disability register, registered with GP practices, aggregated to CCG level and published annually in the Quality and Outcomes Framework (QOF).

MONITORING

Monitoring Frequency: Annual

Monitoring Data Source:
Numerator is extracted from General Practice Extraction Service (GPES), denominator is a Quality and Outcomes Framework (QOF) indicator published on HSCIC Indicator Portal

ACCOUNTABILITY

What success looks like, Direction, Milestones:
An overall improvement in the number of people with a learning disability that receive an annual health check.

Timeframe/Baseline: 2014/15 baseline published in December 2015.

Rationale:
NHS England, ADASS and LGA's service model published on 30th October 2015 states that one of the key actions to ensure that people with a learning disability get good care and support from mainstream health services is for health commissioners to ensure that people with a learning disability over the age of 14 are offered annual health checks. The Confidential Inquiry into premature deaths of people with learning disabilities highlighted the importance of annual health checks.

PLANNING REQUIREMENTS: No plans required

Activity Measures

Full definitions of Activity measures will be made available on Unify2.