NHS Oversight Framework 2019/20: CCG Metrics Technical Annex

NHS England and NHS Improvement

NHS Oversight Framework 2019/20: CCG Metrics Technical Annex

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Introduction

The approach to the NHS Oversight Framework in 2019/20 comprises a set of 60 indicators. This Technical Annex provides the detail of the construction and purpose of each of the indicators. The detail is provided in a mostly standardised form, with slight differences for the small number of indicators which require more judgement and moderation in their construction.

The content of the Technical Annex is current at the time of publication. It is likely that there will need to be changes to the content, to reflect any changes to the indicator definitions which are refined following experience using the indicators, or corrections which are found necessary. Such updates, where needed, will be provided on NHS England's website.

New Service Models

Integrated primary care and community health services

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1. Patient experience of GP services (128b)	
Category, Sub-Category	New Service Models, Integrated primary care and community health services
Definition	This indicator is the weighted percentage of people who report through the GP Patient Survey that their overall experience of GP services was ‘very good’ or ‘fairly good’
Purpose (Rationale)	To assess the overall patient experience of GP services within CCGs
Evidence and policy base	This indicator is part of the new CCG assessment framework which is expected as part of the government’s mandate to the NHS. This indicator specifically relates to objective 6: To improve out-of-hospital care. This requires more services provided out of hospitals and nearer to home, a larger primary care workforce and greater integration with social care, so that care is more joined up to meet people’s physical health, mental health and social care needs. NHS England is expected to ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends where this is more convenient for them, and effective access to urgent care 24 hours a day, seven days a week. An overall patient experience measure will inform if patients are finding GP services satisfactory and over time, improving with the introduction of Primary Care Networks from July 2019. Good experience of GP services will indicate that practices within a CCG’s remit are delivering good services for their population and in context this would be while delivering additional services. The indicator will help to pinpoint areas who need to do more to achieve
Data	
Data source	GP Patient Survey (http://www.gp-patient.co.uk). Data for this indicator are from the GP Patient Survey. This survey is commissioned by NHS England and is conducted by the independent survey organisation Ipsos MORI. Current and previous years’ surveys are available on the GP Patient Survey website ‘Surveys and reports’ pages. Patients are eligible for inclusion in the survey if they had a valid NHS number, had been registered with a GP practice continuously for at least six months before being selected, and were 16 years of age or over. Details regarding eligibility, participation and sampling for the survey is available in the GP Patient Survey Technical Annex.

Data fields	All data fields used for this indicator are taken from the GP Patient Survey, and can be found in the file **'CCG data (weighted) (.csv)'** on the GP Patient Survey webpage: https://gp-patient.co.uk/surveysandreports The data field names below are those used in the most recent publication; descriptions of the fields (referred to as variables) can be found on the GP Patient Survey webpage: https://gp-patient.co.uk/surveysandreports The data fields used are as follows: 1. Question 31: "Overall, how would you describe your experience of your GP practice?" 1. Q28base 2. Q28_1 3. Q28_2 2. Overall, within the survey: 1. CCG_Code
Data filters	All respondents who answered question 31 "Overall, how would you describe your experience of your GP practice?" from the GP Patient Survey.
Data processing	Not applicable
Construction	
Numerator	The weighted number of respondents who had a 'Very good' or 'Fairly good' overall experience of their GP practice for each CCG. This is calculated by summing the following responses from question 31 for each CCG (GP Patient Survey): • Q28_1 'Overall experience of GP practice - Very good' • Q28_2 'Overall experience of GP practice - Fairly good'
Denominator	The total weighted number of respondents for question 31 for each CCG (GP Patient Survey): • Q28base 'Overall experience of GP Practice - Total responses'
Computation	This indicator is the weighted percentage of people who report through the GP patient survey that their overall experience of their GP practice was 'Very good' or 'Fairly good'. The percentage calculation is: Indicator value = p x 100

	where: $p = \frac{o}{n}$ and o is the numerator, the weighted number of respondents answering ‘Very good’ or ‘Fairly good’ to question 31 of the GP patient survey; n is the denominator, the weighted sum of respondents to question 31 of the GP patient survey.
Risk adjustment or standardisation type and methodology	Weighting Methodology The data used to construct the indicator is weighted. The GP Patient Survey includes a weight for non-response bias. This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who actually complete the questionnaire. The non-response weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GP Patient Survey. Further information on the weighting can be found in the latest technical annex at the following webpage. https://gp-patient.co.uk/surveysandreports
Output	
Frequency of publication	Annually

2. Patient experience of getting an appropriate GP appointment (128f) - Placeholder	
Category, Sub-Category	New Service Models, Integrated primary care and community health services
Definition	The work to develop the specific metric will be taken forward as part of the National Access Review
Purpose (Rationale)	
Evidence and policy base	
Data source	
Data fields	
Data filters	
Data processing	
Numerator	
Denominator	
Computation	
Risk adjustment or standardisation type and methodology	
Output	
Frequency of publication	Annually

3. Emergency admissions for urgent care sensitive conditions (127b)	
Category, Sub-Category	New Service Models, Integrated primary care and community health services
Definition	Rate of unplanned hospital admissions for urgent care sensitive conditions, per 100,000 registered patients.
Purpose (Rationale)	To reduce admissions to hospital for urgent care sensitive conditions which should be managed within a well performing UEC system without the need for an admission.
Evidence and policy base	A well performing UEC system should treat people with the right care, right place, first time. This should prevent unnecessary emergency admissions to hospital for conditions that should be dealt with effectively by the UEC system without the need for admission to hospital. These are called “urgent care sensitive conditions”. All parts of the UEC system have a part to play from NHS 111 to Ambulance to EDs. As systems undergo transformation improvement in this metric needs to be encouraged. This indicator extends the concept of ‘ambulatory care sensitive conditions’ by focussing on avoidable admissions for acute episodes of “urgent care sensitive conditions”. In this way UEC networks may monitor how effectively the services within their range of responsibility are managing demand for care for urgent conditions over time without admitting the patient to a hospital bed.
Data	
Data source	Secondary Uses Services (SUS) data Please note that from July 2017 onwards indicator values have been sourced from SUS (all historic values have been recalculated based on SUS data). GP-registered populations
Data fields	Admission method, Primary diagnosis, Age, CCG of residence, Year, Quarter Admission_Method Admission_Date Final_Derived_CCG age_on_admission der_primary_diagnosis_code
Data filters	Emergency = admission method starting with '2' See also list of conditions used in the Construction section below
Data processing	Not applicable
Construction	
Numerator	Number of emergency admissions for UEC sensitive conditions (defined in below) of residents within CCG or network area for urgent conditions by year. Finished Admission Episodes Emergency = admission method starting with '2' ‘Urgent conditions’ defined as the acute episodes which could be managed by a well-performing EUC system

<table>
<tr><td></td><td>without admission to an inpatient bed, where the primary diagnosis code:

<table>
<tr><td>COPD</td><td>J40; J41; J42; J43; J44</td></tr>
<tr><td>Acute mental health crisis</td><td>F</td></tr>
<tr><td>Non-specific chest pain</td><td>R072; R073; R074</td></tr>
<tr><td>Falls, 74 years</td><td>W0; W1</td></tr>
<tr><td>Non-specific abdominal pain</td><td>R10</td></tr>
<tr><td>Deep vein thrombosis</td><td>I80; I81; I82</td></tr>
<tr><td>Cellulitis</td><td>L03</td></tr>
<tr><td>Pyrexial child,6 years and under</td><td>R50</td></tr>
<tr><td>Blocked tubes, catheters and feeding tubes</td><td>T830</td></tr>
<tr><td>Hypoglycaemia</td><td>E10; E11; E12; E13; E14; E15; E161; E162</td></tr>
<tr><td>Urinary tract infection</td><td>N390</td></tr>
<tr><td>Angina</td><td>I20</td></tr>
<tr><td>Epileptic fit</td><td>G40; G41</td></tr>
<tr><td>Minor head injuries</td><td>S00</td></tr>
</table>

Pyrexial child (0-6) and cause code fall for those 75+.
Urgent care sensitive = based on main diagnosis and age (plus cause code for falls)</td></tr>
<tr><td>Denominator</td><td>GP-registered populations</td></tr>
<tr><td>Computation</td><td>The rate of emergency admissions for UEC sensitive conditions per 100,000 population</td></tr>
<tr><td>Risk adjustment or standardisation type and methodology</td><td>Direct Standardisation:
The indicator values are directly age standardised. The directly age standardised rate is the rate a standard population (European standard) would have if that population were to experience the age specific rates of the subject population.</td></tr>
<tr><td colspan="2">Output</td></tr>
<tr><td>Frequency of publication</td><td>Quarterly</td></tr>
</table>

4. Percentage of patients admitted, transferred or discharged from A&E within 4 hours (127c)	
Category, Sub-Category	New Service Models, Acute emergency care and transfers of care
Definition	The number of patients admitted, transferred or discharged from A&E within 4 hours as a percentage of the total number of attendances at A&E (for all types of A&E)
Purpose (Rationale)	A&E waiting times form part of the NHS Constitution. NHS England must take into account the expected rights and pledges for patients that are made in the constitution when assessing organisational delivery. This measure aims to encourage providers to improve health outcomes and patient experience of A&E.
Evidence and policy base	The national operating standard is that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department. This is the current indicator and measures the flow through the UEC system. Indicator development work is taking place as part of the UEC agenda and therefore new measures are likely to emerge to better reflect the transformed UEC system for inclusion in the framework.
Data	
Data source	NHS England: A&E attendances and emergency admissions monthly return (MSitAE) is used to measure A&E performance against the 4 hour measure using figures on number of attendances and number of attendances within 4 hours from arrival to admission, transfer or discharge. This data source is collected on a provider basis and not available by CCG. https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ NHS Digital: A&E Hospital Episode Statistics. A&E Hospital Episode Statistics on the number of A&E attendances at each provider and CCG is used to map provider data to CCGs and provide estimates of performance at CCG level.
Data fields	**A&E attendances and emergency admissions return:** • Number of A&E attendances (all types of A&E) • Number of A&E attendances within 4 hours from arrival to admission, transfer or discharge (all types of A&E) **A&E Hospital Episode Statistics (for mapping to CCG):** • Number of A&E attendances (all types of A&E)
Data filters	None
Data processing	Processing of MSitAE return: • For the monthly A&E return, NHS Trusts, NHS Foundation Trusts, Social Enterprises and GP Practices submit data to NHS England through a template via NHS Digital's SDCS system. Once data is submitted

	and signed-off locally, NHS England performs central validation checks to ensure good data quality. Mapping data from provider to CCG: • HES A&E attendance data provides a breakdown of A&E attendances by provider and CCG. • HES A&E data is used to estimate what proportion of activity (A&E attendances from all types of A&E) from a provider can be attributed to each CCG. • These proportions are applied to both numerator and denominator (provider based monthly collection figures on breaches and attendances) to assign numbers to each CCG. • These numbers are then used to calculate the estimated performance of the A&E 4 hour standard by CCG. • A limit of 1% is used - so any percentages of less than 1% for a mapping to a CCG were ignored in the calculations. Thus the numbers of attendances/breaches does not correspond to the actual figures and should only be used as a basis for estimating performance.
Construction	
Numerator	Total number of patients who have a total time in A&E within 4 hours from arrival to admission, transfer or discharge (all types of A&E)
Denominator	Total number of A&E attendances (all types of A&E)
Computation	Percentage of patients admitted, transferred or discharged from A&E within 4 hours = 1-(Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge / total number of attendances). The total number of A&E attendances, is defined as "An unplanned attendance when the A&E attendance category = 1 or 3", for both total attendances, and those where total time is within 4 hours, all types of A&E are included in the measure. Note the data on attendances and those within 4 hours should be apportioned to CCG as described above.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly (published quarterly)

5. Achievement of clinical standards in the delivery of 7 day services (130a)	
Category, Sub-Category	New Service Models, Acute emergency care and transfers of care
Definition	Compliance with the four priority clinical standards, 2, 5, 6 and 8 for delivery of 7 day services
Purpose (Rationale)	To encourage compliance with clinical standards with a view to reducing variation in outcomes and experience between patients admitted on weekdays and weekends
Evidence and policy base	The NHS Services, Seven Days a Week Forum developed 10 clinical standards describing the minimum level of service patients admitted through urgent and emergency routes should expect to receive every day of the week. Of these, four have been identified in discussion with the Academy of Medical Royal Colleges as having the most impact on improving outcomes and experience - standards 2, 5, 6 and 8. These standards cover: • Standard 2 – Time to Consultant Review • Standard 5 – Access to Diagnostics • Standard 6 – Access to Consultant-directed Interventions • Standard 8 – On-going Review The evidence base for these standards is derived from numerous existing sources including: • NCEPOD – National Confidential Enquiry into Patient Outcome and Death • Royal College of Physicians • Royal College of Surgeons • NICE • Academy of Medical Royal Colleges • Royal College of Radiologists The clinical case and associated documents describing the standards can be accessed at: https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/
Data	
Data source	NHS Improving Quality Seven Day Service Self-assessment Tool
Data fields	The indicator will be drawn from the responses to the key survey questions covering the 4 priority clinical standards. These are set out below. Clinical Standard 2: Percentage of patients reviewed by an appropriate consultant within 14 hours of admission Clinical Standard 5: Proportion of consultants who said that diagnostic tests were always or usually available when needed for critical and urgent patients

	Clinical Standard 6: Proportion of the nine possible consultant- directed interventions provided by the trust 7 days a week on-site or by formal arrangement Clinical Standard 8: Proportion of patients in the trust who need it, receive a daily or twice daily review by a consultant
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	The indicator will be calculated from the number of clinical standards met by acute hospital trusts serving each CCG population (see "Computation" for details). The numerator for calculating the score for each clinical standard is as follows: Clinical standard 2: Number of patients reviewed by an appropriate consultant within 14 hours of admissions Clinical standard 5: Number of diagnostic tests that were always or usually available when needed for critical and urgent patients, weighted by frequency of use. Clinical standard 6: Number of consultant-directed interventions provided on-site or by formal arrangement Clinical standard 8: Number of patients who needed and received once or twice daily consultant reviews (calculated separately for once and twice daily reviews)
Denominator	The denominators for each clinical standard are as follows: • Clinical standard 2: number of reviews required • Clinical standard 5: number of diagnostic tests available (6 in total) • Clinical standard 6: total number of available consultant directed interventions (9 in total) • Clinical standard 8: number of patients requiring once or twice daily reviews
Computation	For each clinical standard, the score will be the (numerator/denominator) * 100 expressed as either 1 or 0, depending on achievement of the standard at a 90% threshold. The four individual scores for the four standards will then be aggregated to give an overall score for each acute trust, up to a maximum of four for trusts who meet all four clinical standards above the 90% threshold. To calculate CCG level indicator values, data will be attributed to CCGs using a weighted average of the number of emergency admissions from each CCG to a particular trust.

	The final score for each CCG will therefore range between 0 and 4, depending on the achievement of the four standards of trusts providing services to the local population.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

6. Delayed transfers of care per 100,000 population (127e)	
Category, Sub-Category	New Service Models, Acute emergency care and transfers of care
Definition	Average Delayed transfers of care (delayed days) per day for all reasons per 100,000 population
Purpose (Rationale)	To encourage minimising delayed transfers of care, enable timely discharge or transfer to the most appropriate care setting and promote smooth flow through the system for medically optimised patients. This is one of the desired outcomes of social care.
Evidence and policy base	Measuring delayed transfers of care is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care, enabling timely discharge or transfer to the most appropriate care setting and promoting smooth flow through the system for medically optimised patients, is one of the desired outcomes of social care. Current data and indicators measure the flow through the UEC system. Indicator development work is taking place as part of the UEC agenda and therefore new measures are likely to emerge to better reflect the transformed UEC system for inclusion in the framework.
Data	
Data source	Monthly Delayed Transfers of Care Return (MSitDT) is used to measure Delayed Transfers of Care. This data source is collected on a local authority and provider basis and is not available by CCG. https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/ Exeter database of GP registrations is used to map LA data to CCG level. ONS population estimates for 2016 by district are used to calculate the no of delayed days per 100,000. These are obtained from the NHS Digital Population Statistics Database.
Data fields	Number of delayed days during the reporting period Population estimate for local authority (aged 18 +) Population estimates for 18+ are used because the Delayed Transfers of Care collection only relates to those aged 18 and over
Data filters	Not applicable
Data processing	1. Processing of Delayed Transfers of Care return and computation of average daily number:

	- For the monthly DTOC return, organisations submit data to NHS England through a template via NHS Digital's SDCS system. Once data is submitted and signed-off locally, NHS England performs central validation checks to ensure good data quality. Average number per day: Divide the number of delayed days across the reporting period by the number of days across the reporting period. 2. Mapping data from LA to CCG: - Exeter database provides population estimates based on GP registrations by LA and CCG. - Estimate what proportion of activity (delayed days) from an LA can be attributed to each CCG. Proportions based on population estimated proportions. - These proportions are applied to the average number of delayed days per day for each LA to assign numbers to each CCG. Giving an estimated average daily number of delayed days per CCG. 3. Adjust for population: - Calculate the rate per 100,000 population using ONS population estimates (aged 18+) for CCG level
Construction	
Numerator	Average number of delayed days per day (for all reasons)
Denominator	Population estimates for CCG (aged 18 +)
Computation	**Figures are calculated for each LA as outlined below:** **Map LA figures to CCG** Apply the proportions of each LA which should be assigned to each CCG to the LA figures to provide CCG level estimates, then calculate the estimated rate per 100,000. Delayed transfers of care (delayed days) per day per 100,000 population = (X/Y) x 100,000, where X = average delayed days (per day) for CCG (number of delayed days during the reporting period for CCG/number of days over the reporting period) and Y = Population estimates for local authority (aged 18 +) for CCG

Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly (published quarterly)

7. Population use of hospital beds following emergency admission (127f)	
Category, Sub-Category	New Service Models, Acute emergency care and transfers of care
Definition	Total length of all Finished Consultant Episodes where the patient's episode finished in the 12 months to the end of the quarter and their admission was from a source coded as an emergency, excluding day cases, per 1,000 population, adjusted for age, sex and need
Purpose (Rationale)	May indicate poor operation of primary and community services
Evidence and policy base	The indicator focuses on the extent of utilisation of healthcare resources from emergency sources and will be used to address critical business question regarding the extent of local health and care integration. Areas with a lower rate of emergency bed days are likely to have services in place which support people to remain independent and support timely discharge if they do have to be admitted to hospital
Data	
Data source	Secondary Uses Service (SUS) data to calculate bed days Please note that from July 2017 onwards indicator values have been sourced from SUS (all historic values have been recalculated based on SUS data). GP registration system linked to ONS postcode directory to derive LSOAs and attached index of multiple deprivation quintile. National Health Applications and Infrastructure Services (NHAIS) to provide population counts by age, sex and area. Population data is available by restricted access; an aggregated data file is assembled in NHS England to LSOA from postcode of residency using the ONS postcode directory and can be obtained: NHAIS: http://www.content.digital.nhs.uk/catalogue/PUB23139 Postcode directory (log in and search for 'NHS postcode'): https://data.gov.uk/ Need will be assessed through the Index of Multiple Deprivation (IMD) 2015: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015
Data fields	NHAIS: Year, Quarter, CCG, LSOA, Male 0-4, Male 5-9, Male 10-14, Male 15-19, Male 20-24, Male 25-29, Male 30-34, Male 35-39., Male 40-44, Male 45-49, Male 50-54, Male 55-59, Male 60-64, Male 65-69, Male 70-74,Male 75-79, Male 80-84, Male 85+

	Female 0-4, Female 5-9, Female 10-14, Female 15-19, Female 20-24, Female 25-29, Female 30-34, Female 35-39., Female 40-44, Female 45-49, Female 50-54, Female 55-59, Female 60-64, Female 65-69, Female 70-74,Female 75-79, Female 80-84, Female 85+ SUS: FCE, Method of admission (admimeth), Episode end date (epiend), CCG of Responsibility Episode (ccg_responsibility), duration (epidur), Age on admission (admiage), Sex of patient (sex), the 2011 Census lower layer super output area (LSOA11)
Data filters	FCE =1 to ensure only finished episodes are considered in the calculation. Episode end date between 'XXX' and 'YYY' to ensure the correct bed days are calculated for the period, where ‘YYY’ is the end of the assessment quarter and ‘XXX’ is one year prior to ‘YYY’ Admimeth in (‘21’,‘22’,’23’,’24’,’2A’,’2B’,’2C’,’2D’,‘28’) Treatment function code not in (‘501’,'560','700','710','711','712','713','715','720','721','722','723','724',’725’,’726’,’727’) These are the codes associated with midwifery and mental health. "Day cases" are always elective, so they are excluded through the choice of data fields (admimeth = emergency).
Data processing	Once extracted the data will be processed into the required geography.
Construction	
Numerator	For each age/sex banding the total duration of all Finished Consultant Episodes (FCEs) where the patient’s episode finished in the quarter and their admission was from a source coded as an emergency
Denominator	Registered population by age/sex/deprivation quintile bands associated with the area / 1000
Computation	Numerator / Denominator
Risk adjustment or standardisation type and methodology	Indirect Standardisation Standardised by age and gender to the national population rates.
Output	
Frequency of publication	Quarterly

8. Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting (131a)	
Category, Sub-Category	New Service Models, Acute emergency care and transfers of care
Definition	Number of NHS CHC full assessments in an acute hospital setting in the quarter as a percentage of total NHS CHC full assessments carried out in the quarter
Purpose (Rationale)	To be assured of NHS CHC assessment at the right time and in the right place as set out in the NHS National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.
Evidence and policy base	The NHS National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care sets out that it is preferable for eligibility for NHS CHC to be considered after discharge from hospital when the person's long-term needs are clearer, and for NHS-funded services to be provided in the interim.
Data	
Data source	NHS England Continuing Healthcare Report
Data fields	Numerator: Number of full comprehensive NHS CHC assessments carried out in the quarter whilst the individual was in an acute hospital Denominator: Total number of full NHS CHC assessments carried out in the quarter These allow for calculation of the percentage of full NHS CHC assessments that were carried out in an acute hospital each quarter. Note: Full assessments are measured by number of decision support tools (DSTs) carried out.
Data filters	The percentage of full NHS CHC assessments that were carried out in an acute hospital does not include: • Individuals eligible for Fast Track NHS CHC • NHS CHC claims for Previously Unassessed Periods of Care (PUPoCs)
Data processing	A number of data validation / quality checks are carried out
Construction	
Numerator	Number of NHS CHC full assessments in an acute hospital setting in the quarter
Denominator	Total NHS CHC full assessments carried out in the quarter
Computation	Numerator/Denominator expressed as a percentage
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly

9. **Personal health budgets (105b)**	
Category, Sub-Category	New Service Models, Personalisation and patient choice
Definition	Number of personal health budgets in place per 100,000 CCG population (based on the population the CCG is responsible for)
Purpose (Rationale)	To demonstrate the increasing number of patients with a personal health budget, as this is a key objective of the 5YFV and this directly measures this ambition. Further, the published planning guidance for 2016-17 to 2020-21 through 2016-17 Mandate specifically makes commitments around increasing the number of personal health budgets: https://www.england.nhs.uk/wp-content/uploads/2015/12/planning-guid-16-17-20-21.pdf
Evidence and policy base	The 2016-17 Mandate and the 2016-17 to 2020-21 Planning Guidance specifically commit to increasing the number of personal health budgets. This indicator directly tracks the commitment. During an informal data collection during 2016/17 (via the PHB delivery teams markers of progress), CCGs reported approx. 15,800 PHBs in place, This was an increase of approx. 106% on 2015/16 numbers however CCGs need to increase their implementation rate in order to meet the mandate commitment of between 50,000-100,000 PHBs in place by 2020. NHS England has a support programme in place to help CCGs implement PHBs and need to quantify the increase in numbers available via a robust count involving all CCGs.
Data	
Data source	NHS Digital http://www.content.digital.nhs.uk/PHB
Data fields	Data collection set up to reflect the indicator construction – see below for required fields.
Data filters	None
Data processing	NHS Digital collect the data and pass to NHS England who hold and process the data.
Construction	
Numerator	Total number of personal health budgets in place at some point in the quarter. This is the number of PHBs in place at beginning of quarter plus the number of new PHBs beginning in the quarter. Definition: A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local

	NHS team or by a partner organisation on behalf of the NHS (e.g. local authority). This can be administered in 3 ways: • A notional budget • A third party payment • A direct payment The numerator would include all personal budgets, regardless of whether they are accessed by a notional budget, third part payment or a direct payment. It would include those who access only part of their package of care via a personal health budget. If a person has combined PHB types (e.g. part of their NHS Continuing Healthcare package is covered by a notional budget and another element is covered by a direct payment) then these would be counted once.
Denominator	Responsible CCG population per 100,000
Computation	(Number of PHB in place at beginning of quarter + Number of new PHB beginning in the quarter)/PHB CCG population * 100,000 **Caveat:** The PHB data collection process changed from Q1 17/18. It is expected that there will be a settling in period for this collection with some data quality issues that will need to be addressed. The personal health budget team will work with CCGs throughout this financial year to tackle identified data reporting issues to ensure data is as robust as possible.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly

10. Utilisation of the NHS e-referral service to enable choice at first routine elective referral (144a)	
Category, Sub-Category	New Service Models, Personalisation and patient choice
Definition	The percentage of first outpatient appointments arising from referrals made using the NHS e-Referral Service (e-RS).
Purpose (Rationale)	The purpose of this indicator is twofold: 1) To provide assurance that CCGs taking responsibility for the e-RS component of the NHS Standard Contract which states that acute Trust providers can only accept referrals to 1st Outpatient Appointments via e-RS. 2) To measure the extent to which patients are being offered choice of provider at first referral and provide an evidence base for improvement. Currently there is no direct or systematic measure of the extent to which patients are being offered choice of provider, so this metric has been developed as a short-medium term proxy measure. By making referrals through e-RS, referrers should maximise their ability to offer meaningful choice to patients by having all relevant and up to date information available to inform the discussion. This metric therefore is incentivising the uptake of a key tool to support the operation of choice. A monthly metric based on e-RS data would sharpen and repeat the signal on the legal requirement to offer elective choice and on making all referrals through e-RS, and help to address low rates of people recalling being offered choice by their GPs as demonstrated in the annual choice survey. This indicator is currently the best data set available for a proxy measure of choice on a monthly basis, but will be retired when a direct, quantitative measure is developed and tested.
Evidence and policy base	Inclusion of a metric relevant to choice in the CCG Improvement and Assessment Framework will help to bring a local CCG focus on the **legal rights** to choice of provider and team for a first elective referral in physical and mental health services, which are at the heart of NHS choice policy. These choice rights are central to the 5 Year Forward View commitment to make good on the NHS' longstanding promise to **give patients choice over where and how they receive care**. Furthermore, the NHS Mandate tasks NHSE with ensuring that people are

	empowered to shape and manage their own health care and **make meaningful choices**. One aim of the NHS Planning Guidance 2016/17 – 2020/21 is to significantly improve patient choice by 2020. Although a proxy measure for choice, this indicator will be a further prompt for commissioners to establish baseline data, measure improvement and take appropriate actions where required. This indicator will also support the wider drive for increased utilisation of e-RS and improvement in timely access to high quality elective services, where e-RS as a key enabler of choice may help to improve waiting time performance by smoothing demand.
Data	
Data source	Numerator: Data submitted by Trusts to the national e-RS PMO, broken down by CCG, which details the number of paper referrals received each month. Denominator: Sum of "GP Referrals Made (All specialties)" from MAR, minus non-English Providers and Non-English Commissioners with an adjustment (based on percentages derived from HES) to remove referrals from dental practices. Referrals made by dental practices are excluded from the e-RS numerator, so NHS Digital abate the MAR denominator to adjust for referrals from dental practices, based on estimates of the percentage referrals that are from dental practices, in each CCG, calculated from hospital episode statistics (HES).
Data fields	Numerator from Trust data returns. Denominator from monthly hospital activity report (MAR) (commissioner based): Org code, GP Referrals Made (All specialties). Adjusted (based on percentages derived from HES) to remove referrals from dental practices
Data filters	
Data processing	The referring organisation is assigned to a CCG based on a look up of the 'Ref_Org_NACS' against the latest ODS GP practice information. Dental practices (V*) and military practices (A9*) are not assigned to a CCG on e-RS. CCG % utilisation scores therefore exclude referrals made by dental practices and military practices. e-RS referral data are adjusted as described above and

	counts of referrals for each CCG are calculated. Published MAR for the period for each CCG are adjusted (based on estimates derived from HES) to remove referrals from dental practices and used as the denominator. A percentage utilisation is therefore calculated for each CCG.
Construction	
Numerator	From Trust data returns providing a count of paper referrals received within a month period.
Denominator	From monthly activity report (MAR): GP Referrals Made (All specialties) by CCG, adjusted (based on percentages derived from HES) to remove referrals from dental practices.
Computation	e-RS referral data is filtered as described above and counts of referrals for each CCG are calculated. For the MAR-based denominator: Published MAR for the period for each CCG is adjusted to remove referrals from dental practices, and is used as the denominator. A percentage is calculated.
Risk adjustment or standardisation type and methodology	None No standardisation is required as the indicator is computed from population absolutes and is a percentage.
Output	
Frequency of publication	Monthly (published quarterly)

Preventing ill health and reducing inequalities

Smoking

11 Maternal smoking at delivery

Obesity

12 Percentage of children aged 10-11 classified as overweight or obese

Falls

13 Injuries from falls in people aged 65 and over

Antimicrobial resistance

14 Antimicrobial resistance: appropriate prescribing of antibiotics in primary care
15 Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care

Health inequalities

16 Proportion of people on GP severe mental illness register receiving physical health checks in primary care
17 Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions

11. Maternal smoking at delivery (125d)	
Category, Sub-Category	Quality of care and outcomes, Smoking
Definition	The percentage of women who were smokers at the time of delivery, out of the number of maternities
Purpose (Rationale)	To encourage the continued prioritisation of action to reduce smoking at delivery. Decreases in smoking during pregnancy will result in health benefits for the infant and mother, as well as cost savings to the NHS.
Evidence and policy base	Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions; attention and hyperactivity difficulties; learning difficulties; problems of the ear, nose and throat; obesity; and diabetes. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. There is also an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. Rates of smoking in pregnancy are currently measured by Smoking at Time of Delivery (SATOD). Whilst rates across England have declined there remains substantial variation across the country. Encouraging pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thus provide health benefits for the mother and reduce exposure to second hand smoke by the infant.
Data	
Data source	NHS Digital, Statistics on Women’s Smoking Status at Time of Delivery http://content.digital.nhs.uk/searchcatalogue?q=%22Statistics+on+Women%27s+Smoking+Status+at+Time+of+Delivery%2c+England%22&sort=Most+recent&size=10&page=1
Data fields	Org code; org name; number of maternities; number of women known to be smokers at time of delivery, year of the collection period; quarter in the year of the collection period
Data filters	From April 2017, to calculate the percentage of women who were known to be smokers at the time of delivery, NHS Digital have excluded women with unknown smoking status from the denominator.
Data processing	Not applicable
Construction	
Numerator	Number of women known to smoke at time of delivery.
Denominator	Number of maternities.

Computation	CCGs submit the following data items each quarter: • **Number of maternities** is defined as the number of pregnant women who give birth to one or more live or stillborn babies of at least 24 weeks gestation, where the baby is delivered by either a midwife or doctor at home or in an NHS hospital (including GP units). This count is the number of pregnant women, not the number of babies (deliveries). It does not include maternities that occur in psychiatric hospitals or private beds / hospitals. • **Number of women known to be smokers at the time of delivery** is defined as the number of pregnant women who reported that they were smokers at the time of giving birth. **Calculation** Percentage of women known to be smokers at the time of delivery: 100 x (Number of women known to be smokers at the time of delivery / Number of maternities) Note: women with unknown smoking status are now excluded from the denominator.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly

12. Percentage of children aged 10-11 classified as overweight or obese (102a)	
Category, Sub-Category	Quality of care and outcomes, Obesity
Definition	Number of children in Year 6 (aged 10-11 years) classified as overweight or obese in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England as a proportion of all children measured.
Purpose (Rationale)	To encourage action on overweight and obese children, as they are more likely to become overweight or obese adults, with consequent health problems
Evidence and policy base	The Health Survey for England (HSE) found that among boys and girls aged 2 to 15, the proportion of children who were classified as obese increased from 11.7 per cent in 1995 to 16.0 per cent in 2010, peaking at 18.9 per cent in 2004. There is concern about the rise of childhood obesity and the implications of such obesity persisting into adulthood. The risk of obesity in adulthood and risk of future obesity-related ill health are greater as children get older. Studies tracking child obesity into adulthood have found that the probability of overweight and obese children becoming overweight or obese adults increases with age. The health consequences of childhood obesity include: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying. The National Institute of Health and Clinical Excellence have produced guidelines to tackle obesity in adults and children - Obesity: the prevention, identification, assessment and management of overweight and obesity in adults and children. Available at http://guidance.nice.org.uk/CG43
Data	
Data source	PHE, National Child Measurement Programme, Prevalence of overweight and obesity by area of child residence (modelled) by Clinical Commissioning Group https://www.gov.uk/government/statistics/child-obesity-and-excess-weight-small-area-level-data
Data fields	Numerator, Denominator and % (indicator value) columns in tab called Year6_ExcessWeight
Data filters	Not applicable
Data processing	Not applicable
Construction	

Numerator	Number of children in Year 6 classified as overweight or obese in the academic year. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.
Denominator	Number of children in Year 6 (aged 10-11 years) measured in the National Child Measurement Programme (NCMP) attending participating state maintained schools in England.
Computation	% of children aged 10-11 years classified as overweight or obese. Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex. To produce as robust an indicator as possible at small area level, these prevalence estimates use three years of data combined.
Risk adjustment or standardisation type and methodology	Direct Standardisation Variables and methodology: Child growth reference was used to convert the height, weight and BMI measurements of individual children into standard deviation scores (z scores) or centiles (p scores). These z scores describe whether the child has a higher or lower value for that measure than would be expected of children of the same age and sex. The NCMP published prevalence data use the British 1990 growth reference (UK90) for BMI and the 2nd, 85th and 95th centiles to define children as underweight, overweight or obese according to age and sex. This definition is the most commonly used in England for population monitoring – for example in Health Survey for England (HSE) figures.
Output	
Frequency of publication	Annually

13. Injuries from falls in people aged 65 and over (104a)	
Category, Sub-Category	Quality of care and outcomes, Falls
Definition	Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population
Purpose (Rationale)	To indicate how well the NHS, public health and social care are working together to tackle issues locally
Evidence and policy base	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care[1]. The highest risk of falls exists for those aged 65 and above and it is estimated that about 30% of people (2.5 million) aged 65 and above living at home and about 50% of people aged 80 and above living at home or in residential care will experience a fall at least once a year. Falls that results in injury can be very serious - approximately 1 in 20 older people living in the community experience a fracture or need hospitalisation after a fall. Falls and fractures in those aged 65 and above account for over 4 million bed days per year in England alone, at an estimated cost of £2 billion[2]. The National Institute for Health and Clinical Excellence (NICE) has produced a quality standard that covers assessment after a fall and preventing further falls (secondary prevention) in older people living in the community and during a hospital stay. The standard is designed to drive measurable improvements in the 3 dimensions of quality – patient safety, patient experience and clinical effectiveness[3].
Data	
Data source	Secondary Uses Service (SUS) data Please note that from July 2017 onwards indicator values have been sourced from SUS (all historic values have been recalculated based on SUS data) GP-registered populations
Data fields	• der_primary_diagnosis_code – diagnosis code, 3 or 4 characters

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[1] Department of Health (2012), Improving outcomes and supporting transparency. Part 2: Summary technical specifications of public health indicators. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358

[2] Royal College of Physicians (2011), NHS services for falls and fractures in older people are inadequate, finds national clinical audit. Available at: https://www.rcplondon.ac.uk/news/nhs-services-falls-and-fractures-older-people-are-inadequate-finds-national-clinical-audit

[3] National Institute for Health and Clinical Excellence (2015), Falls in older people: Assessment after a fall and preventing further falls. Available at: http://www.nice.org.uk/guidance/qs86/

	• age_on_admission – age at start of episode • Admission_Method – method of admission • Sex – sex of patient • Admission_Date – date of admission • Der_Episode_Number – episode order • Source_of_Admission – source of admission • CDS_Type – episode type • Patient_Classification – patient classification • Final_Derived_CCG – CCG of responsibility
Data filters	Numerator: • der_primary_diagnosis_code = S00 – T98 (selects episodes relating to injury, poisoning and certain other consequences of external causes) • Der_Diagnosis_All = W00 – W19 (selects external cause codes for falls) • age_on_admission = 65 – 120 (restricts to over 65) • Admission_Method = 21, 22, 23, 24, 25, 28, 2A, 2B, 2C, 2D (restricts to emergency admissions) • Sex = 1 or 2 (allows direct age standardisation to enable comparable rates between CCGs and over time to be calculated) • Admission_Date = rolling quarter • Der_Episode_Number = 1 (restricts to first episode of care) • Source_of_Admission = is not equal to 51,52, 53 (excludes transfers) • CDS_Type = 1 (restricts data to general episodes) • Patient_Classification = 1 (restricts data to ordinary admissions – excludes day cases, regular/day-night attenders and mothers and babies using only delivery facilities) • Final_Derived_CCG = CCGs in England only (excludes patients who are registered with GPs outside England – reference file provided at: http://content.digital.nhs.uk/ccgois Denominator: • CCG level count of patients aged 65 and over registered with the constituent GP practices extracted from the NHAIS (Exeter) Systems. • Counts of registered patients are extracted each quarter and GP practices are mapped to CCGs using the mapping on this date. When calculating indicators, the count of registered patients and the GP to CCG mapping are taken from the relevant quarter.
Data processing	N/A
Construction	
Numerator	Emergency admissions for falls injuries classified by primary diagnosis codes (ICD10 code S00-T98) and

	external cause (ICD10 code W00-W19) and emergency admission codes (21, 22, 23, 24, 25, 2A, 2B, 2D, 28). Age at admission is 65 and over. Counted by first finished consultant episode in the financial year in which the episode ended, CCG of responsibility from the SUS data.
Denominator	CCG level count of patients registered with the constituent GP Practices using the quinary age bands 65-69, 70-74, 75-79, 80-84, 85-89 and 90+ (by sex).
Computation	Numerator/Denominator * 100,000 – directly age-sex standardised as per methodology outlined below.
Risk adjustment or standardisation type and methodology	Directly age-sex standardised rate, European Standard Population 2013 per 100,000. The directly age-sex standardised rate is the rate of events that would occur in a standard population if that population were to experience the age-sex specific rates of the subject population. The standard population used for the direct method is the European Standard Population. The age groups used are: 65-69, 70-74, 75-79, 80-84, 85-89, 90+. The methodology is based on that provided in APHO Technical Briefing 3: Commonly Used Public Health Statistics and their Confidence Intervals. http://fingertips.phe.org.uk/profile/guidance
Output	
Frequency of publication	Quarterly (rolling 12 months)

14. Antimicrobial resistance: appropriate prescribing of antibiotics in primary care (107a)	
Category, Sub-Category	Preventing ill health and reducing inequalities, Antimicrobial resistance
Definition	The number of antibiotics prescribed in primary care divided by the Item based Specific Therapeutic group Age-Sex related Prescribing Unit STAR-PU
Purpose (Rationale)	The purpose of this indicator is to encourage an improvement in appropriate antibiotic prescribing in primary care. Antimicrobial resistant infections impact on patient safety and the quality of patient care. Evidence suggests that antimicrobial resistance (AMR) is driven by over-using antibiotics and prescribing them inappropriately. Reducing the inappropriate use of antibiotics will delay the development of antimicrobial resistance that leads to patient harm from infections that are harder and more costly to treat. Reducing inappropriate antibiotic use will also protect patients from healthcare acquired infections such as Clostridium difficile infections and reduce the risk of Gram-negative blood stream infections.
Evidence and policy base	NICE QS61: Infection prevention and control. NICE advice KTT9: Antibiotic prescribing – especially broad spectrum antibiotics NICE NG15: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NICE Antimicrobial Prescribing Guidelines NHS England Patient Safety Alert: Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme 18 August 2015 NHS/PSA/Re/2015/007 Optimising use of antimicrobials is a key element within the UK 5-year action plan for antimicrobial resistance 2019 to 2024 supporting delivery of ambition 4: Provide safe and effective care to patients; and ambition 8: Demonstrate appropriate use of antimicrobials Code of Practice on the prevention and control of infections, under The Health and Social Care Act 2008 NHS Long Term Plan: 2.2 Antimicrobial Resistance ‘We will continue to optimise use, reduce the need for and unintentional exposure to antibiotics’
Data	

Data source	This information is sourced from the Antibiotic quality premium monitoring dashboard, which is published monthly on the NHS England website (https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/anti-dash/). The dashboard is updated monthly and presents 12 month rolling data. The dashboard supports both the 2017-19 Quality Premium Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups (https://www.england.nhs.uk/publication/technical-guidance-annex-b-information-on-quality-premium/) and the NHS Oversight Framework. Monthly data that feeds into the Antibiotic quality premium monitoring dashboard can be obtained from the Information Services Portal (ISP) or the electronic Prescribing Analysis and CosT tool (ePACT2) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. This metric is reported within the ePACT2 Antimicrobial Stewardship dashboard and is accessible to registered users of the system. Monthly data are combined to produce a 12 month figure that is used in the Antibiotic quality premium monitoring dashboard. STAR-PU weightings are derived from an anonymised random sample of approximately 800,000 patients registered with about 90 General Practices. They are calculated by extracting and analysing the cost or volume of prescribing by specific age groups and gender. NHS Digital analyse this data to calculate the weightings. They share these weightings with NHSBSA to join with prescribing data to create metrics that allows NHS organisations to compare specific prescribing activity in a uniform manner. These weightings have been used for many years and have proved to be an effective mechanism to identify and drive improvement opportunities. The current STAR-PU are STAR-PU (13), introduced in 2014 and available in the ePACT2 system.
Data fields	From the Antibiotic quality premium monitoring dashboard 'Antibiotics STAR PU 13' tab, most recent month for 'Indicator (ITEMS/STAR-PU)' Data for the Antibiotic quality premium monitoring dashboard are obtained from NHS BSA ePACT2 reports: Metric Title, Time period, NHS England, DCO name, CCG Name, CCG Code, Total number of prescription items for

	antibacterial drugs (BNF 5.1) within the CCG, Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group Age-Sex Related Prescribing Unit (STAR-PUs), Indicator (items/STAR-PU). Monthly data are combined to produce a 12 month figure that is used in the Antibiotic quality premium monitoring dashboard.
Data filters	Data for the Antibiotic quality premium monitoring dashboard are obtained from NHS BSA ePACT2: Data View set to CCG prescribing and time period. For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within NHS BSA ePACT2. Monthly data are combined to produce a 12 month figure that is used in the Antibiotic quality premium monitoring dashboard.
Data processing	Not applicable
Construction	
Numerator	Total number of prescription items for antibacterial drugs (BNF 5.1) within the CCG in the previous 12 months.
Denominator	Total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based Specific Therapeutic group Age-Sex Related Prescribing Units (STAR-PUs) for the previous 12 months.
Computation	Numerator divided by denominator. The computed figure is extracted from the Antibiotic quality premium monitoring dashboard For data at CCG level; prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG will be included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within NHS BSA ePACT2.
Risk adjustment or standardisation type and methodology	**Weighting Methodology:** There are differences in the age and sex of patients for whom drugs in specific therapeutic groups are usually prescribed. STAR-PUs (Specific Therapeutic Group Age-sex weightings Related Prescribing Units) allow more accurate and meaningful comparisons within a specific

	therapeutic group by taking into account the types of people who will be receiving that treatment. This weighting is designed to weight individual practice or organisation populations for age and sex to allow for better comparison of prescribing patterns. The total number of Oral antibacterials (BNF 5.1 sub-set) ITEM based STAR-PUs are used as the denominator of this indicator. STAR-PU weightings have been updated to reflect current prescribing practice, based on prescribing patterns in primary care in England in 2013. These were made available and introduced into national prescribing data sets in February 2014. The numerator represents actual population figures and do not need to be standardised. When used in conjunction with STAR-PUs data is comparable across CCGs.
Output	
Frequency of publication	Monthly (published quarterly)

15. Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care (107b)	
Category, Sub-Category	Preventing ill health and reducing inequalities, Antimicrobial resistance
Definition	The number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care.
Purpose (Rationale)	The purpose of this indicator is to encourage an improvement in appropriate antibiotic prescribing in primary care, in particular broad spectrum antibiotics. Antimicrobial resistant infections impact on patient safety and the quality of patient care. Evidence suggests that antimicrobial resistance (AMR) is driven by over-using antibiotics and prescribing them inappropriately. Reducing the inappropriate use of antibiotics will delay the development of antimicrobial resistance that leads to patient harm from infections that are harder and more costly to treat. Reducing inappropriate antibiotic use will also protect patients from healthcare acquired infections such as Clostridium difficile infections. Broad spectrum antibiotics, such as co-amoxiclav, cephalosporins and quinolones, should be prescribed in line with prescribing guidelines and local microbiology advice. Reducing inappropriate antibiotic use will protect patients from healthcare acquired infections such as Clostridium difficile infections and the development of bacterial resistance, and reduce the risk of Gram-negative blood stream infections.
Evidence and policy base	NICE QS61: Infection prevention and control NICE advice KTT9: Antibiotic prescribing – especially broad spectrum antibiotics NICE NG15: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use NICE Antimicrobial Prescribing Guidelines NHS England Patient Safety Alert: Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme 18 August 2015 NHS/PSA/Re/2015/007 Optimising use of antimicrobials is a key element within the UK 5-year action plan for antimicrobial resistance 2019 to 2024 supporting delivery of ambition 4: Provide safe and effective care to patients; and ambition 8: Demonstrate appropriate use of antimicrobials.

	Code of Practice on the prevention and control of infections, under The Health and Social Care Act 2008 NHS Long Term Plan: 2.2 Antimicrobial Resistance 'We will continue to optimise use, reduce the need for and unintentional exposure to antibiotics'
Data	
Data source	This information is sourced from the Antibiotic quality premium monitoring dashboard, which is published on the NHS England website (https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/anti-dash/). The dashboard is updated monthly and presents 12 month rolling data. The dashboard supports both the Quality Premium measures for 'Reducing Gram Negative Bloodstream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups (https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/), and the NHS Oversight Framework. Monthly data that feeds into the Antibiotic quality premium monitoring dashboard can be obtained from the electronic Prescribing Analysis and CosT tool (ePACT2) provided by NHS Business Services Authority which cover prescriptions prescribed by GPs, nurses, pharmacists and others in England and dispensed in the community in the UK. This metric is reported within the ePACT2 Antimicrobial Stewardship dashboard and is accessible to registered users of the system. Monthly data are combined to produce a 12 month figure that is used in the Antibiotic quality premium monitoring dashboard
Data fields	From the Antibiotic quality premium monitoring dashboard: 'Co-amoxiclav etc.' tab, most recent month for 'Indicator (ITEMS/ITEMS) %' Data for the Antibiotic quality premium monitoring dashboard are obtained from NHS BSA ePACT2 reports: Metric Title, Time period, NHS England DCO Team name, CCG Name, CCG Code, Number of prescription items for BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) within the CCG, Number of antibiotic prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 prescribed within the CCG, Indicator (%) Monthly data are combined to produce a 12 month figure that is used in the Antibiotic quality premium monitoring dashboard.

Data filters	Data for the antibiotic QP dashboard are obtained from NHS BSA ePACT2: • Data View set CCG prescribing and time period. • For data at CCG level, prescriptions written by a prescriber located in a particular CCG but dispensed outside that CCG are included in the CCG in which the prescriber is based. Prescriptions written in England but dispensed outside England are included. Prescriptions dispensed in hospitals, dental prescribing and private prescriptions are not included in the data. The data is to include prescribing by Out of Hours and Urgent Care services where relevant prescribing data is captured within NHS BSA ePACT2. • Monthly data are combined to produce a 12 month figure that is used in the antibiotic QP dashboard.
Data processing	Not applicable
Construction	
Numerator	Number of prescription items for BNF 5.1.1.3 (sub-section co-amoxiclav), BNF 5.1.2.1 (cephalosporins) and BNF 5.1.12 (quinolones) within the CCG in the previous 12 months.
Denominator	Number of antibiotic prescription items for BNF 5.1.1; 5.1.2.1; 5.1.3; 5.1.5; 5.1.8; 5.1.11; 5.1.12; 5.1.13 prescribed within the CCG in the previous 12 months.
Computation	Numerator divided by denominator. The computed figure is extracted from the Antibiotic quality premium monitoring dashboard.
Risk adjustment or standardisation type and methodology	None. Further standardisation is not required as presentation of this data as a percentage already takes into account the unequal volume of prescribing across CCGs, and as the indicator is computed from an absolute data sample adjustments are not required.
Output	
Frequency of publication	Monthly (published quarterly)

16. Proportion of people on GP severe mental illness register receiving physical health checks (123g)	
Category, Sub-Category	Preventing ill health and reducing inequalities, Health inequalities
Definition	The proportion of people on General Practice SMI registers who have received a full set of comprehensive physical health checks in a primary care setting in the last 12 months.
Purpose (Rationale)	This indicator tracks progress against the NHS's commitment to ensure that "by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year". Due to different methods of data collection for the primary and secondary care elements of this standard the two areas will be monitored separately. This indicator covers the primary care element only
Evidence and policy base	In 2016, the Five Year Forward View Mental Health (MH5YFVFV) set out NHS England's approach to reducing the stark levels of premature mortality for people living with serious mental illness (SMI) who die 15-20 years earlier than the rest of the population, largely due to preventable or treatable physical health problems. In the MHFYFV NHS England committed to leading work to ensure that "by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year". This equates to a target of 60% of people on the SMI register receiving a full and comprehensive physical health check. This commitment was reiterated in the Five Year Forward View Next Steps Due to different methods of data collection for the primary and secondary care elements of this standard the two areas will be monitored separately. This indicator covers the primary care element only.
Data	
Data source	NHS England Physical Health Checks for people with Severe Mental Illness https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/
Data fields	Numerator: The number of people on the General Practice Serious Mental Illness registers who have received a full set of comprehensive physical health checks in the last 12 months to the end of the reporting period delivered in a primary care setting.

	Denominator: The total number of people General Practice Serious Mental Illness registers at the end of the reporting period.
Data filters	None
Data processing	None
Construction	
Numerator	The number of people on the General Practice Serious Mental Illness registers who have received a full set of comprehensive physical health checks and the required follow up interventions as indicated in the last 12 months delivered in a primary care setting.
Denominator	The total number of people General Practice Serious Mental Illness registers.
Computation	Numerator / denominator
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly from Q3 2018/19

17. Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions (106a)	
Category, Sub-Category	Preventing ill health and reducing inequalities, Health inequalities
Definition	Absolute gradient of the relationship at Lower Super Output Area (LSOA) level between unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population and deprivation, measured by the Index of Multiple Deprivation (2015). The indicator measures the reduction over time of within-CCG variation in unplanned hospitalisation. Variation is measured by the gap between more and less deprived Lower Super Output Area (LSOA) rates of unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population. The measure uses the range of deprivation in England as a whole, which allows direct comparisons to be made between all CCGs. Measurement unit: Absolute Gradient of Inequality (AGI) = difference in age and sex standardised rate of unplanned hospitalisation for chronic ambulatory care sensitive conditions per 100,000 population, between the most and least deprived LSOAs in England. The scope of the indicator is unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions at LSOA level in England. The figures are produced using Secondary Uses Service (SUS) data. The admissions rate for each LSOA-CCG is constructed using the CCG of registration and LSOA of residence. The rate is indirectly age and sex standardised using the England rate in each year. The indicator is published on a quarterly basis for the 12 months to the end of the quarter, based on discharges within those 12 months. The population at the mid-point of the 12 months is used as the denominator.
Purpose (Rationale)	Inequalities persist and these should be reduced for the benefit of patients and for CCGs to meet legal duties. The indicator will encourage such action.
Evidence and policy base	There are large inequalities in the rate of unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions when comparing the most and least deprived areas nationally. Providing information on the level of inequalities within CCGs will shine a spotlight on variations in practice and

	will provide data to enable CCGs to explore levels of inequalities in order to address and reduce these. This indicator reflects variations in the quality of management of long-term conditions in primary, community and outpatient care as well as urgent care. It will help identify areas of ‘good practice’ and those where improvements should be made for the benefit of patients and the local health economy. It is seen as being sensitive to in-year change as a direct result of local action.
Data	
Data source	1. Secondary Uses Service (SUS) data; 2. GP registered population data derived from the Exeter system by LSOA, age and sex; 3. Indices of Deprivation (ID) 2015 (https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015)
Data fields	The following data fields within SUS are used to construct the indicator: 1. primary diagnosis 2. cause code 3. finished admission episode status 4. method of admission 5. episode end date 6. age at start of episode 7. sex 8. 2011 Lower Super Output Area
Data filters	For ambulatory care sensitive conditions: As per CCG OIS indicator 2.6 at https://indicators.hscic.gov.uk/webview/ For urgent care sensitive conditions: • Finished Admission Episodes • Emergency admissions = admission method starting with '2' • Filter on the conditions listed under Computation below which are used for the numerator
Data processing	Not applicable
Construction	
Numerator	Difference in the fitted rate of unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions between the LSOAs with the least and most deprived populations as measured by the Index of Multiple Deprivation (IMD) 2015.
Denominator	Not applicable
Computation	The definition of unplanned hospitalisation for chronic ambulatory care sensitive conditions is the same as that used for the corresponding, assured indicators in the NHS Outcomes Framework (NHS OF, indicator number 2.3.i)

and CCG Outcomes Indicator Set (CCG OIS, indicator number 2.6). This is detailed in the specification for indicator 2.6 at: https://indicators.hscic.gov.uk/webview/.

The definition of emergency admissions for urgent care sensitive conditions is that used for the emergency admissions for urgent care sensitive conditions indicator in the NHS Oversight Framework. This includes cases involving the following primary diagnoses, cause codes and age groups:

COPD	F40, J41; J43; J44
Acute mental health crisis	F
Non-specific chest pain	R072; R073; R074
Falls **Patients aged 74 years or over**	W0; W1-W19
Non-specific abdominal pain	R10
Deep vein thrombosis	I80; I81; I82
Cellulitis	L03
Pyrexial child **Patients aged 6 years or under**	R50
Blocked tubes, catheters and feeding tubes	T830
Hypoglycaemia	E10; E11; E12; E13; E14; E15; E161; E162
Urinary tract infection	N390
Angina	I20
Epileptic fit	G40; G41
Minor head injuries	S00

The admissions rate for each LSOA-CCG is constructed using the CCG of registration and LSOA of residence.

The indirectly age-standardised rate of unplanned hospitalisation per 100,000 registered population is calculated for every LSOA of residence.

The Absolute Gradient of Inequality (AGI) is calculated for each CCG by weighted least squares using the indirectly age-standardised rate of unplanned hospitalisation per 100,000 registered population as the dependent variable; the rank of IMD 2015 (on a scale of 0 to 1) as the independent variable, and the CCG's population in each LSOA as the weight. The coefficient on the rank of IMD is the slope and is called the AGI.

	As the IMD is on a scale of 0 to 1, the slope gives the expected difference in the rate of unplanned hospitalisation in the most deprived compared to the least deprived LSOA in England if they were in that CCG.
Risk adjustment or standardisation type and methodology	Indirect standardisation. The measure is standardised for age and sex because these are legitimate drivers in the variation in avoidable emergency admissions. Indirect standardisation must be used as there are many LSOAs that do not have populations in all age-sex groups.
Output	
Frequency of publication	Quarterly

Quality of care and outcomes

General

18 Provision of high quality care: hospitals
19 Provision of high quality care: primary medical services
20 Evidence that sepsis awareness raising among healthcare professionals has been prioritised by CCGs
21 Evidence based interventions

Maternity services

22 Neonatal mortality and stillbirths
23 Women’s experience of maternity services
24 Choices in maternity services

Cancer services

25 Cancers diagnosed at an early stage
26 People with urgent GP referral having first definitive treatment for cancer within 62 days of referral
27 One-year survival from all cancers
28 Cancer patient experience

Mental health

29 Improving Access to Psychological Therapies – recovery
30 Improving Access to Psychological Therapies – access
31 People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within two weeks of referral
32 Mental health out of area placements
33 Quality of mental health data submitted to NHS Digital (DQMI)

Learning disability and autism

34 Reliance on specialist inpatient care for people with a learning disability and/or autism
35 Proportion of people with a learning disability on the GP register receiving an annual health check
36 Completeness of the GP learning disability register
37 Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification

Diabetes

38 Diabetes patients that have achieved all the National Institute for Health and Care Excellence (NICE) recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children

39 People with diabetes diagnosed less than a year who attend a structured education course

People with long term conditions and complex needs

40 Estimated diagnosis rate for people with dementia
41 Dementia care planning and post-diagnostic support
42 The proportion of carers with a long term condition who feel supported to manage their condition
43 Percentage of deaths with three or more emergency admissions in last three months of life

Planned care

44 Patients waiting 18 weeks or less from referral to hospital treatment
45 Overall size of the waiting list
46 Patients waiting over 52 weeks for treatment
47 Patients waiting six weeks or more for a diagnostic test

18. Provision of high quality care: hospitals (121a) **19. Provision of high quality care: primary medical services (121b)**	
Category, Sub-Category	Quality of care and outcomes, General
Definition	A score from 0 – 100 for three sector-based indicators covering (a) Hospitals, (b) General Practices, both comprised of aggregated scores which have been allocated to CQC inspection ratings on five key questions for each service asking “Is it safe ?”, “Is it effective ?”, “Is it well-led ?”, “is it caring ?”, “is it responsive ?”. The ratings for each sector are designed to give the best estimate of services used by residents of that CCG. Services are rated as Inadequate, Requiring Improvement, Good or Outstanding. Scores will be applied to these ratings at the lowest rating level e.g. key question for a core service. The total score received will then be divided by the total available score for each area to form an overall proportional score which ranges between 0 and 100 i.e. if all services/locations/providers, for each sector, for that CCG area received a rating of outstanding across all five key questions
Purpose (Rationale)	This metric provides an overall score indicative of the quality of care in a CCG area as determined by CQC inspection ratings. The summary score by sector for each area allows CCGs to assess the quality of care in their area against an England average and provides a baseline to monitor improvements.
Evidence and policy base	Providing high quality care for all is a fundamental principle for health and social care services. CQC rate the quality of care by asking five key questions. In hospitals these questions are asked for each core service. The five key questions – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? These key questions are intended to provide a rounded assessment of quality. Using the lowest level of ratings provides the broadest possible assessment of progress. Over time this CQC indicator will enable people to look at improvements in the quality of care.
Data	
Data source	CQC ratings can be downloaded from this link under the download our directory section http://www.cqc.org.uk/content/how-get-and-re-use-cqc-information-and-data#directory
Data fields	The data is split out by sector with 3 sectors being covered separately – (a) Hospital (comprising Acute, Mental Health and Community), (b) Primary Medical Services (GPs cover nearly all the locations however the indicator also includes Out of hours and Urgent care services).

	For the Hospital sector the indicator is based on the ratings awarded to the core services rated for each of CQC's five key questions. For Acute and Mental Health hospitals the ratings are sourced at provider level to maximise coverage across the CCG areas and to be consistent across both hospital areas The GP indicator is calculated by the rating applied to each key question. For the GP indicator the rating is sourced at a location level for those registered within each sector. The five key questions are: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? The ratings are scored as follows: outstanding = 3, good = 2, requires improvement = 1, inadequate = 0.
Data filters	None
Data processing	Not applicable
Construction	
Numerator	The total score by sector (Hospital, Primary Medical Services) of core services/locations/providers inspected within the CCG. For each core service/location/provider rated the scores available on each key question are 3 = outstanding, 2 = good, 1 = requires improvement and 0 = inadequate for a maximum score of 15 per core service/location/provider. The numerator for each sector per CCG is the total score of the core services/locations/providers inspected within that CCG area. For hospitals, the key question ratings for each core service is converted to a number and added together across the locations that have been rated. The numerator for hospitals includes all rated services, which usually covers what CQC call ‘core services’ which are listed in CQC’s provider handbooks www.cqc.org.uk/content/provider-handbooks. The hospitals metric uses patient datasets to weight the numerator for Acute and Mental Health Services to reflect where residents from that CCG are visiting to receive their actual care. For example if Trust X provided 80% of attendances for a single CCG, 80% of this CCGs’ score would be comprised of the ratings from Trust X.

	For Primary Medical Services the numerator is solely formed from using the key question ratings for those locations situated in a CCG, i.e. each key question receives a score for GP. For the Hospital sector, their core services are rated by a key question.
Denominator	The denominator is the total maximum score available for that sector. For example, each GP provider is rated by CQC's 5 key questions and the highest rating of outstanding is given a score of 3 so each GP provider could have a maximum score of 15. Therefore the CCG's maximum score would be 15 * the number of registered GP providers, respectively. For hospitals it would be the weighted maximum score to reflect where the CCG residents have attended for acute and mental health services.
Computation	Divide the numerator by the denominator and multiply by 100. This is done individually for each sector indicator to form a proportional score for each CCG. The three sector indicators are not combined.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	121a and b: Biannually (six-monthly)

20. Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG (132a)	
Category, Sub-Category	Quality of care and outcomes, General
Summary	Evidence that sepsis awareness raising and the use of NEWS 2[4] (National Early Warning Score 2) amongst healthcare professionals in acute and ambulance trusts have been prioritised by the CCG and this can be demonstrated. It is expected that available commissioning mechanisms, such as the reference to a requirement for education around sepsis awareness raising and the use of NEWS2 in relevant service specifications or local quality and improvement schemes, will be used to do this. This indicator should be considered alongside indicators 107a and 107b "Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care"
Detailed description of indicator	The indicator is intended to encourage CCGs to develop and potentially fund a strategy to raise awareness of sepsis amongst healthcare practitioners in their area and the use of NEWS 2 in acute and ambulance settings specifically. CCGs are expected to provide evidence that they have prioritised the issue of sepsis awareness in their commissioning arrangements. This might be by the incorporation of references to such in service specifications or local incentive or quality improvement schemes. Some CCGs may want to show evidence of alternative equivalent arrangements and opportunities will be provided to report these. GP education is a complex area with regional hubs that straddle traditional geographical areas; the bulk of what is available being delivered by post graduate VTS training and regional updates. However, the demonstration that each GP practice has a sepsis lead/link and they update the rest of the practice would be a minimum requirement. The role of the GP practice sepsis lead/link: • Can be fulfilled by a non-clinical person • Should consider the breadth of infection prevention control (IPC), not just sepsis • Should ensure that all relevant colleagues in the practice have done the appropriate sepsis learning that the practice or CCG decides • Should ensure that sepsis/IPC messages are visible in the practice • Should be involved in encouraging the use of flu vaccinations of staff and vulnerable groups among patients

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[4] https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news-2

	CCGs should encourage all community bodies such as ambulance services, care/nursing/residential homes, and (private/NHS), Out of hours GPs, community nursing and all reception staff to implement training around sepsis awareness. CCGs should show support for local multidisciplinary educational events across the healthcare community. The awareness raised would be ultimately intended to improve local outcomes from sepsis such as reduced mortality rates. Although not part of this indicator other measures will be monitored and would be expected to improve, such as the sepsis CQUIN[5] in key local trusts.
Rationale for use and what it intends to achieve	Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with almost 37,000[6] deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented. The Secretary of State announced a number of measures to improve the recognition and treatment of Sepsis in January 2015. The NCEPOD 'Just Say Sepsis!' report also made a number of recommendations about the need for better identification and treatment of Sepsis. In July 2016, new NICE guidance was issued on the recognition, management and early diagnosis of sepsis. Problems in achieving consistent recognition and rapid treatment of Sepsis are currently thought to be responsible for significant avoidable mortality. It can be difficult to recognise when what can be a rather non-specific presentation of illness actually is sepsis rather than a self-limiting infection, and how rapidly deterioration with multi-organ failure can occur in sepsis leading to adverse outcomes with a high risk of death and long term disability. The proposed NHS Oversight Framework is an opportunity for us to encourage healthcare professionals to consider sepsis as a cause of deterioration in a patient and to follow NHS England Operational definition of sepsis advice: https://t.co/PuLeBHw9yU
Process of assessment	CCGs will need to demonstrate that they have prioritised the issue of the awareness of sepsis and the use of NEWS2 amongst relevant healthcare professionals within their CCG footprint. HEE have provided and will maintain a set of resources to do this (https://www.e-

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[5] https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-indicator-specification-information-april-18-2.pdf

[6] The incidence, and thus mortality figures, for sepsis were revised in late 2015 following the publication into the public domain of HES data by junior minister Ben Gummer. Mortality in England currently sits at approximately 30% according to the 2015 NCEPOD study 'Just say Sepsis' and to ICNARC. This estimated data therefore lead us to a figure of 36,847 lives claimed annually in England.

	lfh.org.uk/programmes/sepsis/) and it is expected that these will be referenced and promoted. CCGs are expected to demonstrate compliance with this indicator predominantly by means of an annual self-certification submission. The **annual self-certification**, as detailed at Annex 1, must be submitted to CCGs' relevant NHS England local team towards the end of each financial year. The result of the assessment will then be reported back to CCGs. Specific dates for the 2018/19 process will be communicated in due course. The self-certification must be signed by any one of the CCG's Accountable Officers to confirm the information given in the annual self-certification is accurate. Criteria for assessment will include: Evidence that a requirement for sepsis awareness raising and education on the use of NEWS2 is included in the commissioning priorities of the CCG and is included (or there is evidence of a planned commitment to include) in service specifications and in any local incentive schemes funded by the CCG (essential). Within GP practices, the demonstration that each practice has a sepsis lead/link and they update the rest of the practice (essential). HEE resources are referenced (essential). NHS England local teams will collate their CCGs' information from the self-certified returns onto a spreadsheet (provided by the Clinical Policy Unit) and send it to the team at their NHS England regional office. NHS England regional teams will then collate the spreadsheets for their region and allocate RAG ratings from R to G. These preliminary ratings will then be e-mailed to the Clinical Policy Unit who will then additionally allocate G* ratings using data they already collect from the sepsis CQUIN data. The team will then disseminate the RAG rating with suitable supporting actions back to NHS England local teams and CCGs (see below).
What is the published rating? Is contextual information required?	**G*** All in G below, but also that key local trusts are improving their performance against the national Sepsis and AMR CQUIN or both (requires a positive response to questions 1 and 2 and that the percentage of practices figure in question 3 is 75% or greater.

	Supporting action: Promote good performance against CQUIN. Share learning via case studies. **G** Evidence that the requirement for sepsis awareness raising and education on the use of National Early Warning Score (NEWS2) is included in the commissioning priorities of the CCG and is included (or there is evidence of a planned commitment to include) in service specifications and in any local incentive schemes funded by the CCG. That at least 75% of GP practices within the CCG have a nominated sepsis lead (this requires a positive response to questions 1 and 2 and that the percentage of practices figure in question 3 is 75% or greater). **Supporting action**: Promote good performance against CQUIN. **A** Evidence that the requirement for awareness raising and education on the use of National Early Warning Score (NEWS2) is included in the commissioning priorities of the CCG and is included (or there is evidence of a planned commitment to include) in service specifications and in relevant local incentive schemes funded by the CCG (this requires a positive response to questions 1 and 2). **Supporting action:** Highlight the target for GP sepsis leads. Promote good performance against CQUIN. **R** No evidence that the CCG has prioritised sepsis awareness raising in any of its commissioning or quality improvement arrangements (no positive response to any question). **Supporting action:** Signpost to HEE resources and case studies and encourage reference to them in relevant service specifications. Highlight the target for GP sepsis leads. Promote good performance against CQUIN.
Frequency of assessment	Annually
How is consistency of information / assessments ensured?	As well as the questionnaire responses, NHS England local teams may request that service specifications will be provided, or CCGs may want to present such evidence themselves in the additional comments/ examples sections. Details of local incentive and quality improvement schemes referencing the requirement for improvement in Sepsis awareness may be requested.

Annex 1: Annual assessment for indicator 43 (132a): Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG

Name of CCG: ___________________________ Date: ________________

Sepsis awareness raising and the use of NEWS2 (annual assessment)		
Requirements	Please complete	Additional comments/examples
1. The CCG confirms sepsis awareness raising and education on the use of National Early Warning Score (NEWS2) is included in the commissioning priorities of the CCG and is included (or there is evidence of a planned commitment to include) in service specifications and in any local incentive schemes funded by the CCG.	Choose an item. <Options are YES or NO>	
2. The CCG confirms that Health Education England resources around sepsis are referenced and used.	Choose an item. <Options are YES or NO>	
3. The CCG confirms the number and percentage of GP practices that have a sepsis lead / link.	No. of practices = % of practices =	

Signed by
Name of Accountable Officer: _______________________________________
Signature: _______________________________________
Date: _______________________________________

21. Evidence based interventions (134a)

Category, Sub-Category	Quality of care and outcomes, General
Definition	Application of the national clinical criteria set out in the Evidence-Based Interventions Policy by tracking activity for 17 interventions against published estimated activity goals.
Purpose (Rationale)	To encourage CCGs to implement the Evidence-Based Interventions Policy set out in statutory commissioning guidance to reduce inappropriate activity for 17 interventions to prevent avoidable harm to patients, to avoid unnecessary operations, and to free up clinical time by only offering interventions on the NHS that are evidence-based and appropriate.
Evidence and policy base	Evidence and policy base: The Evidence-Based Interventions Programme aims to ensure that interventions routinely available on the NHS are evidence-based and appropriate. The Programme focuses on 17 interventions split into two categories; 4 Category 1 interventions that should not be commissioned unless an IFR has been approved and 13 Category 2 interventions that should only be made available when specific clinical criteria are met. The evidence base for the inclusion of these interventions is derived from existing sources including: ☐ Academic studies ☐ Choosing Wisely recommendations ☐ NICE guidelines ☐ NICE accredited guidance ☐ Speciality Society guidance. ☐ EBI consultation with the commissioners, providers and clinicians, patients and members of the public. NHS England has published statutory commissioning guidance for each intervention and estimated activity goals for each intervention by CCG and STP [https://www.england.nhs.uk/evidence-based-interventions/]. A monthly dashboard can be accessed by CCGs to monitor their actual activity against estimated activity goals for each intervention [https://www.nhsbsa.nhs.uk/epact2].
Data	
Data source	Secondary Users Service Data Set, GP registered population

Data fields	age_at_start_of_Spell_SUS, sex, Spell_Dominant_Procedure, Spell_Primary_Diagnosis, der_diagnosis_all, Discharge_Date, Admission_Method
Data filters	Procedure, diagnostic and/or age codes; Admission_Method not like ('2%'); codes are published in the statutory commissioning guidance.
Data processing	NHSE will complete processing.
Construction	
Numerator	The reduction in the cost-weighted age-sex standardised rate that has been achieved between the baseline year and end of the current period (12 month rolling figures taken at the end of each quarter and based on the discharge date)
Denominator	the difference between the baseline and the goal cost-weighted age-sex standardised rate. The goal figure is the 25th percentile of the age-sex standardised rate of CCGs as defined in the statutory EBI guidance.
Computation	Based on RAG rating, the RAG thresholds are: o Green – More than 75% progress towards the goal figure from the baseline. CCGs that were already at or below the cost-weighted goal rate at the baseline are green unless their cost-weighted activity has increased. o Amber – 25% to 75% progress towards the goal figure from the baseline. o Red – Less than 25% progress towards the goal figure from the baseline.
Risk adjustment or standardisation type and methodology	Indirectly age-sex standardised rate (to confirm)
Output	
Frequency of publication	Quarterly

Intervention		**Cost-weight**
A	Surgery for snoring without obstructive sleep apnoea	973
B	D&C for heavy menstrual bleeding	985
C	Knee arthroscopy with osteoarthritis	2682
D	Injections for non-specific lower back pain without sciatica	589
E	Breast reduction	2701
F	Removal of benign skin lesions	626
G	Grommets	727
H	Tonsillectomy	1172
I	Haemorrhoid surgery	1018

J	Hysterectomy for heavy menstrual bleeding	2941
K	Chalazia removal	528
L	Shoulder decompression	3311
M	Carpal tunnel syndrome release	1204
N	Dupuytren’s contracture release	2613
O	Ganglion excision	1212
P	Trigger finger release	1231
Q	Varicose vein surgery	1051

22. Neonatal mortality and stillbirths (125a)	
Category, Sub-Category	Quality of care and outcomes, Maternity services
Definition	The number of stillbirths and neonatal deaths per 1,000 births. This indicator measures the rate of stillbirths and deaths within 28 days of birth per 1,000 live births and stillbirths, reported at CCG of residence level by calendar year. Rates are expressed in line with current conventions as per 1,000 live births and stillbirths; and rounded to one decimal place. The data included is the number of live births and stillbirths that occurred in the reference year. Neonatal mortality figures are based on the birth cohort from the reference period. A stillbirth is defined as a baby delivered at or after 24 weeks gestational age showing no signs of life, irrespective of when the death occurred. A neonatal death is defined as a live born baby born at 24 weeks gestational age or later, or with a birthweight of 400g or more who died before 28 completed days after birth. Data is presented for births where the mother was resident in an English Lower Super Output Area (LSOA) only.
Purpose (Rationale)	The indicator is the focus in the 2016/17 Mandate to NHS England to make measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50% by 2025; with a measurable reduction by 2020. This indicator forms part of 'Domain 1 - Preventing people from dying prematurely' in the NHS Outcomes Framework and is intended to act as a proxy for the overall management of pregnancy. The number of stillbirths and neonatal deaths is influenced by a range of factors. These factors include the quality care of care delivered to mother and baby and appropriate surveillance for all women. Even when the relevant service is not commissioned by a CCG, for example smoking cessation, the identification and referral of women with a need for such support falls within the role of maternity services commissioned by CCGs. The number is also influenced by effective support during the birth process and the postnatal period in services mainly commissioned by CCGs.
Evidence and policy base	The National maternity review 'Better Births' report outlined a vision for maternity services across England to become safer, more personalised, kinder, professional and more family friendly. This indicator is closely linked to the safety element of this vision and resonates with issues highlighted by the 2015 Morecambe Bay report. Problems during pregnancy such as miscarriage, foetal growth restriction and preterm birth remain common and stillbirth rates have

	not changed significantly in recent years. This indicator will monitor stillbirths and neonatal mortality rates and the success of CCG activities aimed at reducing them. While caution is required when making international comparisons of stillbirths and neonatal death rates due to differences in reporting methods and thresholds, evidence suggests that rates in England are higher than many other European countries and therefore show significant scope for improvement.
Data	
Data source	MBRRACE-UK - Perinatal Mortality Surveillance Report See https://www.npeu.ox.ac.uk/mbrrace-uk/reports The indicator data source is an extract from the MBRRACE-UK secure online reporting system, which collects detailed information on each stillbirth / neonatal death. The data is collected primarily for this indicator.
Data fields	MBRRACE-UK provides volumes of live births, stillbirths and neonatal deaths and a pre-calculated rate at CCG of residence level from the data. The following fields will be present: • CCG code • CCG name • Stillbirths • Neonatal deaths • Total live and stillbirths • Rate of stillbirths and neonatal deaths
Data filters	Data included is the number of live births and stillbirths that occurred in the reference year. Neonatal death figures are based on the birth cohort from the reference period. The following exclusions are applied to the data set: • Terminations of pregnancy are excluded from the indicator (including late terminations after 24 weeks gestational age) • Stillbirths / neonatal deaths that occur as a result of a congenital anomaly are excluded from the indicator • Births less than 24 weeks gestational age are excluded from the indicator (and any neonatal deaths associated with these births)
Data processing	Not applicable
Construction	
Numerator	The number of stillbirths and deaths within 28 days of birth, during a calendar year, by CCG of residence.
Denominator	The number of live births and stillbirths occurring during a calendar year by CCG of residence.
Computation	The indicator is calculated as a rate per 1,000 live births and stillbirths. Rates are rounded to one decimal place.

	Calculation is as follows: $\frac{\text{stillbirths and deaths within 28 days of birth}}{\text{total births}} \times 1{,}000$
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

23. Women’s experience of maternity services (125b)	
Category, Sub-Category	Quality of care and outcomes, Maternity services
Definition	Women’s experiences of maternity services based on the CQC National Maternity Services Survey. This indicator uses the CQC National Maternity survey results to specifically look at the user experience of maternity services, across the care pathway; and with regards to choice, information, confidence in staff and clinical care. The indicator is a composite value, calculated as the average of six survey questions from the survey. A composite indicator is preferred as it measures quality of experience, treatment and care throughout the care pathway (antenatal, intrapartum and postnatal) and to take into account the several policy priorities linked to choice, information provision, confidence in staff and clinical care. Women were eligible for the survey if they had a live birth within the sampling period, were aged 16 or older and gave birth in a hospital, birth centre or maternity unit, or had a home birth. A complete list of eligibility and participation criteria for the survey is available at the following link: http://www.cqc.org.uk/publications/surveys/maternity-services-survey-2017 The indicator is based on all valid survey responses for which the patient’s CCG of registration is available. Responses to the survey reflect women who gave birth during January or February of the reference year.
Purpose (Rationale)	Patient experience is one of the three domains of quality care, along with safety and clinical effectiveness. The purpose of this indicator is to encourage the improvement of patient experience in maternity services and support people to shape and manage their own health and care. To help service users make meaningful choices to achieve better health outcomes, progressing towards a person-centred NHS. This indicator strives to measure patient experience across the entirety of the maternity pathway, that is, antenatal, intrapartum and postnatal stages.
Evidence and policy base	The national maternity review ‘Better Births’ report outlined a vision for maternity services across England to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances. This indicator is intended to provide a

	summary measure of women's experience linked to the different aspects of this vision. This indicator aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This includes improving patient experience, supporting people to shape and manage their own health and care and make meaningful choices to achieve better health outcomes. Patient Experience, along with Safety and Clinical Effectiveness, is one of the three domains of Quality. A connection exists with the National Maternity Review's policy intentions of improving the experience of mothers and their families across the breadth of maternity services.
Data	
Data source	CQC National Maternity Services Survey. The CQC maternity survey data are primarily collected for the calculation of provider level scores and the sampling methodology is designed for this purpose. CCG level scores will be derived using the methodology outlined in the Construction section below. The data that inform the indicator are finalised.
Data fields	The following fields will be present to facilitate calculation of the indicator composite scores: • Code of the CCG billed for the care of respondent. • Anonymised respondent record number (for a count of number of records. This is a unique identifier for each record in the data set. It does not enable identification of the patient). • Age and parity grouping of respondent. • Status of response (responded/did not respond). Answer options, per question: 1. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy? Answer options: yes always; yes sometimes; no; don't know. 2. Thinking about your antenatal care, were you involved enough in decisions about your care? Answer options: yes always; yes sometimes; no; don't know/can't remember. 3. Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you? Answer options: yes during early labour; yes during the later stages of labour; yes during the birth; yes shortly after the birth; no not at all. 4. If you raised a concern during labour and birth, did you feel that it was taken seriously? Answer options: yes; no; I did not raise any concerns.

	5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? Answer options: yes always; yes sometimes; no; don’t know/can’t remember. 6. Did you feel that midwives and other carers gave you active support and encouragement about feeding your baby? Answer options: yes always; yes sometimes; no; I did not want/need this; don’t know/can’t remember.
Data filters	Data included are responses relating to the 6 questions above that are correctly completed, attributable to the CCG billed for the respondent’s care, and where respondent age and parity grouping can be determined.
Data processing	Not applicable
Construction	
Numerator	The sum of the standardised CCG scores for the six specified questions.
Denominator	The number of questions included within the composite indicator (6).
Computation	This is a composite indicator, calculated using the mean CCG score for 6 survey questions from the CQC National Maternity Survey. Individual questions are scored according to a pre-defined scoring regime (see further details below) that awards scores between 0 and 10. The mean CCG score for these questions will therefore take a value between 0 and 10, where 0 is the worst score and 10 is the best score. This value will be multiplied by 10 to generate a score out of 100. The possible scoring range of 0 to 100 matches that of a similar NHS Outcomes Framework indicator on women’s experience of maternity services. The questions cover experience across the whole maternity pathway: antenatal, intrapartum and postnatal: 1. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy? 2. Thinking about your antenatal care, were you involved enough in decisions about your care? 3. Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you? 4. If you raised a concern during labour and birth, did you feel that it was taken seriously? 5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding? 6. Did you feel that midwives and other carers gave you active support and encouragement about feeding your baby?

Results will be standardised by maternal age and parity (number of previous births) so that CCG scores reflect the score the CCG would have if it had the same respondent breakdown as in the national cut of the data.

Calculating the composite score per CCG has several steps:

Selecting data for reporting
Data is selected in line with the following exclusions, which reflect those used in the CQC Maternity Survey methodology:

The CQC Maternity Survey excludes women:
- aged under 16 at the date of the delivery of their baby,
- whose baby had died during or since delivery,
- who had a stillbirth (including where it occurred during a multiple delivery),
- who were in hospital, or whose baby was in hospital, at the time the sample was drawn from the trusts' records,
- who had a concealed pregnancy (where it was possible to, identify from trusts' records),
- whose baby was taken into care (where known by the trust),
- who gave birth in a private maternity unit or wing,
- who did not have a UK postal address,
- any patient known to have requested their details are not used for any purpose other than their clinical care.

In addition to this, data are excluded where:
- respondent age group cannot be determined,
- respondent parity group cannot be determined,
- a respondent was not eligible to answer a given question,
- a respondent incorrectly answers a question (e.g. selecting all answer options when only one option is possible).

See the CQC Quality and Methodology Report and CQC Technical Documentation for more information.

CCG attribution
Care is attributed to the respondent's CCG of registration. This is derived from the CCG code provided in the dataset.

Question scoring
Scores are assigned to answer options to questions that are of an evaluative nature, of a range between 0 and 10. A score of 0 is assigned to answer options that reflect considerable scope for improvement, whereas an answer option is assigned score of 10 where it reflects the most

	positive possible patient experience. Where a number of answer options lay between negative and positive responses, they are placed at equal intervals along the scale. Where answer options were provided that did not have any bearing on performance (e.g. don't know/can't remember) a score is not assigned and the answer option is classed as not applicable. **Calculating composite scores** Respondent numerators are calculated by multiplying respondent's individual scores by their individual weighting. Score denominators are then calculated by assigning a value of 1 if a question was answered by the respondent, 0 if not. These are multiplied by the weighting allocated to respondents. The standardised mean score for each CCG per question is then calculated. This is achieved by dividing the sum of the weighted scores by the sum of the weighted number of eligible respondents for each question for each CCG. The composite indicator score per CCG is then calculated as the mean of the scores across the six questions multiplied by a factor of ten. **Standardisation (weighting)** Data is standardised for age and parity (see below). Please note that this methodology is applied to indicator 125b and 125c. This is as both indicators are a composite of 6 questions from the CQC National Maternity Survey. Applying the methodology used by CQC for each indicator therefore seems appropriate and aides comparability between results. See CQC Technical Documentation and CQC 2017 Scored Maternity Survey Questionnaire for more information.
Risk adjustment or standardisation type and methodology	Indirect standardisation. **Variables and methodology** Data are weighted for age and parity. The data set includes both sample age and response age. Where a respondent has included their age as part of their survey completion, response age has been used. Where an age has not been provided, the sample age has been used. The sample age is derived from trust level sample files, which are not available to NHS England. Dates of birth are not included in the dataset used by NHS England for the indicator calculation.

	- Parity is derived from answers to question G3 (“how many babies have you given birth to before this pregnancy?”). - Respondents are then grouped according to six age and parity categories (defined above). - Calculating the CCG proportions for age and parity, using the above approach. - Calculating respondent level proportions – divide national proportion of respondents in their age or parity group by corresponding CCG proportion. A maximum weighting cap is assigned to limit excessive weight being given to respondents in an extremely under-represented group. No minimum weighting cap is calculated as assigning very small weights to over-represented groups does not have the same potential to give excessive impact to the responses of small numbers of individual respondents.
Output	
Frequency of publication	Annually

24. Choices in maternity services (125c)	
Category, Sub-Category	Quality of care and outcomes, Maternity services
Definition	This indicator measures the choices offered to women in maternity services based on the CQC National Maternity Services Survey. The indicator uses survey results to specifically look at the choices offered to users of maternity services throughout the care pathway (antenatal, intrapartum and postnatal). The indicator is a composite value, calculated as the average score of six survey questions from the CQC Maternity Survey. The questions cover choice across the whole maternity pathway: antenatal, intrapartum and postnatal and capture activity for CCGs in England. A composite indicator is preferred as it measures the extent to which choice is offered at several points across the care pathway (antenatal, intrapartum and postnatal). Women were eligible for the survey if they had a live birth within the sampling period, were aged 16 or older and gave birth in a hospital, birth centre or maternity unit, or had a home birth. A complete list of eligibility and participation criteria for the survey is available at the following link: http://www.cqc.org.uk/publications/surveys/maternity-services-survey-2017 The indicator is based on all valid survey responses for which the patient's CCG of registration is available. Responses to the survey reflect women who gave birth during January or February of the reference year.
Purpose (Rationale)	The indicator seeks to measure and encourage improvement in aspects of women's experience during the maternity pathway relating specifically to choice and personalisation. The indicator is the best source currently available on personalisation and choice in maternity. The outcome of improving choice and personalisation in maternity services is sought.
Evidence and policy base	The national maternity review 'Better Births' report outlined a vision for maternity services across England to offer personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. This indicator seeks to measure aspects of women's experience relating to the choices offered to women; the quality of information provided; and the degree of involvement afforded to women along the maternity pathway. The Five Year Forward view promises to "make good on the NHS' longstanding promise to give patients choice over where and how they receive care".

	This indicator also aligns with NHS England’s Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This includes improving patient experience and create a person-centred NHS in which people are supported to shape and manage their own health and care; and make meaningful choices in order to achieve better health outcomes.
Data	
Data source	CQC National Maternity Services Survey. The CQC maternity survey data are primarily collected for the calculation of provider level scores and the sampling methodology is designed for this purpose. CCG level scores will be derived using the methodology outlined below. The data that inform the indicator are finalised.
Data fields	The following fields will be present to facilitate calculation of the indicator composite scores: • Code of the CCG billed for the care of respondent. • Anonymised respondent record number (for a count of number of records. This is a unique identifier for each record in the data set. It does not enable identification of the patient). • Age and parity grouping of respondent. • Status of response (responded/did not respond). Answer options, per question: 1. Were you offered any of the following choices about where to have your baby? Answer options: a choice of hospitals; a choice of giving birth in a midwife led unit or birth centre; a choice of giving birth in a consultant led unit; a choice of giving birth at home; not offered any choices; no choices due to medical reasons; don’t know/can't remember. 2. Did you get enough information from either a midwife or doctor to help you decide where to have your baby? Answer options: yes, definitely; yes, to some extent; no; no, but I did not need this information; don’t know/can’t remember. 3. Were you offered a choice of where your antenatal assessments would take place? Answer options: yes; no; don't know/can't remember. 4. Thinking about your care during labour and birth, were you involved enough in decisions about your care? Answer options: yes, always; yes, sometimes; no; I didn’t want/need to be involved; don’t know/can’t remember.

	5. Were decisions about how you wanted to feed your baby, respected by midwives? Answer options: yes, always; yes, sometimes; no; don't know/can't remember. 6. Were you given a choice about where your postnatal care would take place? Answer options: yes; no; don't know/can't remember.
Data filters	Data included are responses relating to the 6 questions above that are: correctly completed, attributable to the CCG billed for the respondent's care, and where respondent age and parity grouping can be determined.
Data processing	Not applicable
Construction	
Numerator	The sum of standardised CCG scores for the six specified questions.
Denominator	The number of questions included within the composite indicator (6).
Computation	This is a composite indicator, calculated using the mean CCG score for 6 survey questions from the CQC National Maternity Survey. Individual questions are scored according to a pre-defined scoring regime (see further details below) that awards scores between 0 and 10. The mean CCG score for these questions will therefore take a value between 0 and 10, where 0 is the worst score and 10 is the best score. This value will be multiplied by 10 to generate a score out of 100. The possible scoring range of 0 to 100 matches that of a similar NHS Outcomes Framework indicator on women's experience of maternity services. The questions cover elements of choice across the whole maternity pathway: antenatal, intrapartum and postnatal: 1. Were you offered any of the following choices about where to have your baby? (a choice of hospitals; a choice of giving birth in a midwife led unit or birth centre; a choice of giving birth in a consultant led unit; a choice of giving birth at home; not offered any choices) 2. Did you get enough information from either a midwife or doctor to help you decide where to have your baby? 3. Were you offered a choice of where your Antenatal assessments would take place? 4. Thinking about your care during labour and birth, were you involved enough in decisions about your care? 5. Were decisions about how you wanted to feed your baby, respected by midwives 6. Were you given a choice about where your postnatal care would take place? Results will be standardised by maternal age and parity (number of previous births) so that CCG scores reflect the

score the CCG would have if it had the same respondent breakdown as in the national cut of the data.

Calculating the composite score per CCG has several steps:

Selecting data for reporting
Data is selected in line with the following exclusions, which reflect those used in the CQC Maternity Survey methodology:

The CQC Maternity Survey excludes women:
- aged under 16 at the date of the delivery of their baby,
- whose baby had died during or since delivery,
- who had a stillbirth (including where it occurred during a multiple delivery),
- who were in hospital, or whose baby was in hospital, at the time the sample was drawn from the trusts' records,
- who had a concealed pregnancy (where it was possible to, identify from trusts' records),
- whose baby was taken into care (where known by the trust),
- who gave birth in a private maternity unit or wing,
- who did not have a UK postal address,
- any patient known to have requested their details are not used for any purpose other than their clinical care.

In addition to this, data are excluded where:
- respondent age group cannot be determined,
- respondent parity group cannot be determined,
- a respondent was not eligible to answer a given question,
- a respondent incorrectly answers a question (e.g. selecting all answer options when only one option is possible).

See the CQC Quality and Methodology Report and CQC Technical Documentation for more information.

CCG attribution
Care is attributed to the respondent's CCG of registration. This is derived from the CCG code provided in the dataset.

Question scoring
Scores are assigned to answer options to questions that are of an evaluative nature, of a range between 0 and 10. A score of 0 is assigned to answer options that reflect considerable scope for improvement, whereas an answer option is assigned score of 10 where it reflects the most positive possible patient experience. Where a number of answer options lay between negative and positive

	responses, they are placed at equal intervals along the scale. Where answer options were provided that did not have any bearing on performance (e.g. don't know/can't remember) a score is not assigned and the answer option is classed as not applicable. **Calculating composite scores** Respondent numerators are calculated by multiplying respondent's individual scores by their individual weighting. Score denominators are then calculated by assigning a value of 1 if a question was answered by the respondent, 0 if not. These are multiplied by the weighting allocated to respondents. The standardised mean score for each CCG per question is then calculated. This is achieved by dividing the sum of the weighted scores by the sum of the weighted number of eligible respondents for each question for each CCG. The composite indicator score per CCG is then calculated as the mean of the scores across the six questions multiplied by a factor of ten. **Standardisation (weighting)** Data is standardised for age and parity (see below). Please note that this methodology is applied to indicator 125b and 125c. This is as both indicators are a composite of 6 questions from the CQC National Maternity Survey. Applying the methodology used by CQC for each indicator therefore seems appropriate and aides comparability between results. See CQC Technical Documentation and CQC 2017 Scored Maternity Survey Questionnaire for more information.
Risk adjustment or standardisation type and methodology	Indirect standardisation. **Variables and methodology** Data are weighted for age and parity. The data set includes both sample age and response age. Where a respondent has included their age as part of their survey completion, response age has been used. Where an age has not been provided, the sample age has been used. The sample age is derived from trust level sample files, which are not available to NHS England. Dates of birth are not included in the dataset used by NHS England for the indicator calculation. • Parity is derived from answers to question G3 ("how many babies have you given birth to before this pregnancy?").

	• Respondents are then grouped according to six age and parity categories (defined above). • Calculating the CCG proportions for age and parity, using the above approach. • Calculating respondent level proportions – divide national proportion of respondents in their age or parity group by corresponding CCG proportion. A maximum weighting cap is assigned to limit excessive weight being given to respondents in an extremely under-represented group. No minimum weighting cap is calculated as assigning very small weights to over-represented groups does not have the same potential to give excessive impact to the responses of small numbers of individual respondents.
Output	
Frequency of publication	Annually

25. Cancers diagnosed at early stage (122a)	
Important Information	A new case-mix adjusted indicator is expected to be published in early 2020. This indicator (122a) will be replaced by the new case-mix adjusted measure. Provided that the new measure is published in time for inclusion, it will be used for the year-end assessment.
Category, Sub-Category	Quality of care and outcomes, Cancer services
Definition	New cases of cancer diagnosed at stage 1 and 2 as a proportion of all new cases of cancer diagnosed (specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas, and invasive melanomas of skin).
Purpose (Rationale)	The metric is designed to monitor the proportion of early staged cancers, which are associated with higher survival than late staged cancers. Diagnosis at an early stage of the cancer's development leads to dramatically improved survival chances. Specific interventions, such as screening programmes, information/education campaigns and greater GP access to diagnostic services all aim to improve rates of early diagnosis.
Evidence and policy base	Diagnosis at an early stage of the cancer's development leads to significantly improved survival outcomes[7] Supporting clinicians to spot cancers earlier and greater GP access to diagnostic and specialist advice is key as outlined in the Five Year Forward View. Improving cancer survival is one of the three key ambitions in the report, "Achieving world-class cancer outcomes: a strategy for England 2015-2020", published by the Independent Cancer Taskforce in July 2015.
Data	
Data source	Cancer Analysis System, National Cancer Registry, Public Health England http://www.ncin.org.uk/publications/survival_by_stage
Data fields	• Year of diagnosis • Site of the cancer (in ICD10 O2) • Stage of the cancer • Geographical area (derived from Postcode through National Statistics Postcode Lookup)
Data filters	Not applicable
Data processing	Data are extracted as numerator and denominator fields. • CCG Code/CCG Name

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[7] McPhail S, Johnson S, Greenberg D, Peake M, Rous B. Stage at diagnosis and early mortality from cancer in England. Br J Cancer. 2015 Mar 31;112 Suppl 1:S108-15.

	• Tumour group • Summary stage (stage of diagnosis) • Diagnosis year • Count
Construction	
Numerator	All cases of cancer diagnosed at stage 1 or 2, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas and invasive melanomas of skin
Denominator	All new cases of cancer diagnosed at any stage or unknown stage, for the specific cancer sites, morphologies and behaviour: invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary, uterus, non-Hodgkin lymphomas and invasive melanomas of skin
Computation	The number of new cancer cases (for the specified site, morphology and behaviour) diagnosed at stage 1 and 2 is divided by the total number of new cancer cases (for the specified site, morphology and behaviour) in the same area and multiplied by 100. Cancers where the stage is not recorded are included in the denominator, so a low proportion of cases with staging data will lead to the indicator showing a low proportion of cases diagnosed at stage 1 or 2. Result is displayed as a percentage to zero decimal places, rounded up. All ages are included. All sexes are included (Persons). Data are provided at CCG level.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

26. People with urgent GP referral having first definitive treatment for cancer within 62 days of referral (122b)	
Category, Sub-Category	Quality of care and outcomes, Cancer services
Definition	Measures the proportion of people with an urgent GP referral for suspected cancer that began their first definitive treatment within 62 days
Purpose (Rationale)	To ensure CCGs achieve and maintain the constitutional standard for waiting times from urgent GP referral for suspected cancer to first definitive treatment. The indicator is a core delivery indicator that spans the whole pathway from referral to first treatment covering the length of time from urgent GP referral, first outpatient appointment, decision to treat and finally first definitive treatment.
Evidence and policy base	Shorter waiting times can help to ease patient anxiety and, at best, can lead to earlier diagnosis, quicker treatment, a lower risk of complications, an enhanced patient experience and improved cancer outcomes. Improving cancer survival and patient experience are two of the three key ambitions in the report, "Achieving world-class cancer outcomes: a strategy for England 2015-2020", published by the Independent Cancer Taskforce in July 2015. The report also recommended a new 4 week standard from GP referral to definitive diagnosis by 2020. The 62-day pathway indicator will be reviewed once data are available for the new standard.
Data	
Data source	NHS England Statistics (https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/), derived from Cancer Waiting Times Database (CWT-Db)
Data fields	PERIOD; YEAR; MONTH; STANDARD; AREA TEAM; ORG CODE; CARE SETTING; CANCER TYPE; TOTAL TREATED; WITHIN STANDARD; BREACHES
Data filters	
Data processing	Data are extracted as numerator (within standard) and denominator (total treated) fields.
Construction	
Numerator	The number of people with an urgent GP referral for suspected cancer who received first treatment for cancer within 62 days in the reporting period
Denominator	The total number of people with an urgent GP referral for suspected cancer who were treated in the reporting period
Computation	The proportion (as a %) of people with an urgent GP referral for suspected cancer that began their first definitive treatment within 62 days
Risk adjustment or standardisation type and methodology	None

Output	
Frequency of publication	Quarterly

27. One-year survival from all cancers (122c)	
Category, Sub-Category	Quality of care and outcomes, Cancer services
Definition	A measure of the number of adults diagnosed with any type of cancer in a year who are still alive one year after diagnosis. All adults (15–99 years) who were diagnosed with a first, primary, invasive malignancy were eligible for inclusion. Patients diagnosed with malignancy of the skin other than melanoma were excluded. Non-melanoma skin cancer is a non-basal cell carcinoma which is regularly excluded from cancer indicators as its impact on health is much less than other cancers and there are comparatively large numbers of cases which could significantly impact any statistic that includes it. Cancer of the prostate was also excluded from the index, because the widespread introduction of prostate-specific antigen (PSA) testing since the early 1990s has led to difficulty in the interpretation of survival trends.
Purpose (Rationale)	To encourage work to improve cancer survival rates - a key component of the strategy to achieve world-class cancer outcomes.
Evidence and policy base	A study comparing relative survival during 1995-2007 in the UK, Sweden, Norway, Denmark, Australia and Canada[8] showed an improvement for breast, colorectal, lung and ovarian cancer patients in all jurisdictions. The UK was one of the lowest performing countries, but was at the time narrowing the gap in breast cancer. Data still not published shows a close in the survival gap for stomach and rectal cancers, while the gap for lung and colon cancers remain significant. The CONCORD-3 study of relative survival, conducted in 71 countries including the UK, revealed that, in 2010-2014, survival was high in the UK relative to other European countries in melanoma, oesophagus, paediatric brain cancer and leukaemias[9]. Although there was an increase from 2000-2004 in survival for cervix, lung, ovary, stomach, pancreas and adult brain cancer, the UK was still in 2010-2014 amongst the European countries with the lowest survival for those cancers. Improving cancer survival is one of the three key ambitions

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[8] Coleman MP, Forman D, Bryant H et al. Cancer survival in Australia, Canada, Denmark, Norway, Sweden and the UK, 1995-2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data. The Lancet 2011, 377: 127-138.

[9] Allemani C, Matsuda T, Di Carlo V, Harewood R, Matz M, Nikšić M, Bonaventure A, Valkov M, Johnson CJ, Estève J, Ogunbiyi OJ, Azevedo E Silva G, Chen WQ, Eser S, Engholm G, Stiller CA, Monnereau A, Woods RR, Visser O, Lim GH, Aitken J, Weir HK, Coleman MP; CONCORD Working Group. Global surveillance of trends in cancer survival 2000-14 (CONCORD-3): analysis of individual records for 37 513 025 patients diagnosed with one of 18 cancers from 322 population-based registries in 71 countries. Lancet. 2018 Mar 17;391(10125):1023-1075.

	in the report, Achieving world-class cancer outcomes: a strategy for England 2015-2020, published by the Independent Cancer Taskforce in July 2015. In additional to making overall improvements, the Taskforce would also like to see a reduction in CCG variation.
Data	
Data source	Statistical Bulletin: Index of Cancer Survival for Clinical Commissioning Groups in England. Published annually (calendar years) by the Office for National Statistics (ONS).
Data fields	Geography; Years since diagnosis; Survival (%); Precision for each calendar year of diagnosis
Data filters	The number of patients aged 15 to 99 years diagnosed with any type of cancer in a year who are still alive one year after diagnosis. Cancer is defined as a first, primary, invasive malignancy with two exclusions; Non-melanoma skin cancer (ICD-10 C44) and cancer of the prostate (C61).
Data processing	Not applicable
Construction	
Numerator	Net survival is the probability of survival derived solely from the risk of death from cancer, compensating for the risk of death from other causes (background mortality). Background mortality is accounted for through life tables of all-cause mortality rates for the general population in England. To obtain an unbiased estimation of net survival, age needs to be carefully modelled to account for the informative censoring associated with age[10]. ONS and PHE used flexible parametric models[11,12] with age and year of diagnosis as main effects and an interaction between age and year of diagnosis. A number of models were fitted to allow up to five degrees of freedom for both the baseline hazard function and time-dependent effects. The best-fitting statistical model was selected by assessing the relative goodness of fit using the Akaike Information Criterion (AIC)[13] and Bayesian Information Criterion (BIC), with scaling tests to check for oversensitivity and a likelihood ratio test to compare the best-fitting models according to AIC and BIC. A separate model was fitted for each CCG, type of cancer and sex. A publicly available program (stpm2) in Stata 15 was used to estimate net survival.
Denominator	See numerator

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[10] Danieli C, Remontet L, Bossard N, Roche L, Belot A. Estimating net survival: the importance of allowing for informative censoring. Stat Med 2012; 31: 775-86.

[11] Lambert PC, Royston P. Further development of flexible parametric models for survival analysis. Stata J 2009; 9: 265-90.

[12] Royston P, Parmar MK. Flexible parametric proportional-hazards and proportional-odds models for censored survival data, with application to prognostic modelling and estimation of treatment effects. Stat Med 2002; 21(15): 2175-97.

[13] Akaike H. A new look at the statistical model identification. IEEE Transactions on Automatic Control 1974; 19: 716-23.

Computation	One-year survival is a measure of the number of patients diagnosed with cancer in a year who are still alive one year after diagnosis. The methodology used to calculate one-year survival is the ‘classical’ or ‘cohort’ approach. All patients diagnosed in the diagnosis period are followed-up to one year later. Net survival is an estimate of the probability of survival from the cancer alone. It is defined as the ratio of the observed survival and the survival that would have been expected if the cancer patients had experienced the same background mortality by age and sex as the general population. It can be interpreted as the survival of cancer patients after taking into account the background mortality that the patients would have experienced if they had not had cancer. Net survival varies with age, sex and type of cancer and all of these factors can vary with time and between geographical areas, so the estimates are age, sex and cancer standardised to facilitate comparison. The survival index is constructed by using a weighted average of all the cancer survival estimates for each age, sex and cancer, using weights based on the International Classification of Survival Standard (ICSS)[14] for age-standardisation, with additional weighting applied to standardise for sex and cancer type.
Risk adjustment or standardisation type and methodology	The indicator is standardised for age, sex and cancer type. To make figures from the past comparable with those from today and in the future, it is necessary to adjust an all-cancers survival index for changes over time in the profile of cancer patients by age, sex and type of cancer within each CCG. This is because survival varies widely with all three factors. Overall cancer survival in a given CCG can change simply because the profile of its cancer patients changes, even if survival at each age, for each cancer and in each sex has not changed. For each CCG, this adjustment was made by using a weighted average of all the cancer survival estimates for each age, sex and cancer, using weights based on the International Classification of Survival Standard (ICSS) for age-standardisation, with additional weighting applied to standardise for sex and cancer type. All values of the cancer survival index in that CCG, past and future, are adjusted using the same standard weights. This means that the cancer survival index is not affected by changes over time in the proportion of cancers of different lethality in either sex – for example, a reduction in lung cancer or an increase in breast cancer. Similarly, the index will be unaffected by a change in the age profile of newly

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[14] Corazziari I, Quinn M, Capocaccia R (2004), ‘Standard cancer patient population for age standardising survival ratios’, European Journal of Cancer, Volume 40, pages 2,307 to 2,316.

	diagnosed cancer patients, or a shift in the proportion of a given type of cancer between men and women.
Output	
Frequency of publication	Annually

28. Cancer patient experience (122d)	
Category, Sub-Category	Quality of care and outcomes, Cancer services
Definition	Average score given to the question “Overall, how would you rate your care?” on a scale from 0 (very poor) to 10 (very good)
Purpose (Rationale)	To encourage progress towards the ambition set by the Independent Cancer Taskforce in July 2015 of continuous improvement in patient experience.
Evidence and policy base	Improving cancer patient experience (and quality of life) is one of the three key ambitions in the report “Achieving world-class cancer outcomes: a strategy for England 2015-2020”, published by the Independent Cancer Taskforce in July 2015. The Taskforce has set an ambition for continuous improvement in patient experience and to give it equal priority with clinical outcomes.
Data	
Data source	National Cancer Patient Experience Survey produced by Quality Health on behalf of NHS England http://www.ncpes.co.uk/
Data fields	SCN, provider code, provider name, cancer type, number of responses, score
Data filters	Not applicable
Data processing	Data is presented as the average score given to the overall patient experience question for each CCG, adjusted for case-mix.
Construction	
Numerator	Sum of all individual responses to the question "Overall, how would you rate your care?", on a scale from 0 (very poor) to 10 (very good)
Denominator	Count of all valid responses
Computation	Numerator / Denominator, as an average score.
Risk adjustment or standardisation type and methodology	Case-mix adjustment has been undertaken with this methodology: Abel, G. et al (2014). Cancer patient experience, hospital performance and case mix: evidence from England. Future Oncology, pp.1589-1598.
Output	
Frequency of publication	Annually

29. Improving Access to Psychological Therapies – recovery (123a)	
Category, Sub-Category	Quality of care and outcomes, Mental health
Definition	The percentage of people who finished treatment within the reporting period who were initially assessed as “at caseness”, have attended at least two treatment contacts and are coded as discharged, who are assessed as moving to recovery
Purpose (Rationale)	This indicator focuses on improved access to psychological therapies, in order to address enduring unmet need. This indicator assesses the effectiveness of local IAPT services.
Evidence and policy base	Around one in six adults in England suffer from a common mental health problem, such as depression or an anxiety disorder. The effectiveness of local IAPT services is measured using this indicator and the IAPT access rate which focuses on the access to services as a proportion of local prevalence. Research evidence indicates that 50% of people treated with CBT for depression or anxiety conditions recover during treatment. The use of CBT and evidence based psychological therapies for the treatment of depression and anxiety is outlined in the relevant NICE quality standards).
Data	
Data source	NHS Digital, Improving Access to Psychological Therapies Minimum Dataset (IAPT) http://content.digital.nhs.uk/iapt Quarterly data files are needed for calculating the indicator and can be accessed via this link: http://content.digital.nhs.uk/iaptreports
Data fields	Data fields from the quarterly NHS Digital csv data file: 1. Recovery 2. Notcaseness 3. FinishedCourseTreatment
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness” and at final session did not), in the latest three month period. This is the following data field from the quarterly csv files: **Recovery**
Denominator	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who

	have completed treatment not at clinical caseness at initial assessment), in the latest three month period. This is calculated using the following data fields from the quarterly csv files: **FinishedCourseTreatment - Notcaseness**
Computation	Numerator / Denominator = Recovery / (FinishedCourseTreatment - Notcaseness)
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly (monthly data files are also available but summing numbers from the monthly publications may give different results due to rounding of values and suppression of small numbers in published data)

30. Improving Access to Psychological Therapies – access (123b)	
Category, Sub-Category	Quality of care and outcomes, Mental health
Definition	The proportion of people that enter treatment against the level of need in the general population i.e. the proportion of people who have depression and/or anxiety disorders who receive psychological therapies.
Purpose (Rationale)	This indicator focuses on improved access to psychological therapies, in order to address enduring unmet need. This indicator assesses the effectiveness of local IAPT services.
Evidence and policy base	Around one in six adults in England suffer from a common mental health problem, such as depression or an anxiety disorder. The effectiveness of local IAPT services is measured using this indicator and the IAPT recovery rate, which focuses on the recovery of patients completing a course of treatment. The Five Year Forward View for Mental Health sets out an ambition to increase access to IAPT services. The expectation for 2018/19 is that in quarter four 4.75% (the equivalent of 19% annually) of people with a common mental health disorder will enter treatment.
Data	
Data source	1. NHS Digital, Improving Access to Psychological Therapies Minimum Dataset (IAPT) http://content.digital.nhs.uk/iapt Quarterly data files are needed for calculating the indicator and can be accessed via this link: http://content.digital.nhs.uk/iaptreports 2. CCG planning returns for 2018-19 (NHS England)
Data fields	Data fields from the monthly/quarterly NHS Digital csv data file: FirstTreatment Data fields from the CCG planning returns 2018-2019: Number of people who have depression and/or anxiety disorders
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	The number of people who have started treatment (psychological therapies) in the most recent three month period
Denominator	Number of people who have depression and/or anxiety disorders
Computation	Numerator / Denominator =

	FirstTreatment / Number of people who have depression and/or anxiety disorders
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly (monthly data files are also available but summing numbers from the monthly publications may give different results due to rounding of values and suppression of small numbers in published data)

31. People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral (123c)	
Category, Sub-Category	Quality of care and outcomes, Mental health
Definition	The percentage of people referred to service experiencing first episode psychosis or at “risk mental state” that start a NICE-recommended care package in the reporting period.
Purpose (Rationale)	To encourage compliance with the new access and waiting time standard. This standard came into effect on 1 April 2016 and requires that more than 50% of people experiencing first episode psychosis will be treated with a NICE-concordant package of care within 2 weeks of referral.
Evidence and policy base	This indicator focuses on improving access to evidence based care in Early Intervention in Psychosis (EIP) services. People who receive the right treatment at the right time from an EIP service can go on to lead full, hopeful and productive lives. Since 2004, EIP services have demonstrated that they can significantly reduce the rate of relapse, risk of suicide and number of hospital admissions. They are cost effective and improve employment, education and wellbeing outcomes (Craig et al., 2004; Garety et al., 2006; McCrone et al., 2010; Petersen et al., 2005). The EIP access and waiting time standard is part of NHS England’s Mandate commitment.
Data	
Data source	Initially EIP Waiting Times SDCS collection. In due course the intention is to monitor compliance with the EIP standard using data collected by NHS Digital via the Mental Health Services Dataset (MHSDS). This will be dependent on developing data quality and coverage of the MHSDS – the position on data collection via SDCS will be reviewed in the context of this.
Data fields	The number of patients who started treatment in the period - The number of patients who started treatment within two weeks.
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	The number of people referred to the service experiencing first episode psychosis or at ‘risk mental state’ that start treatment within 2 weeks of referral in the last twelve months.
Denominator	The number of people referred to the service experiencing first episode psychosis or at ‘risk mental state’ that start treatment in the last twelve months
Computation	Numerator / denominator

Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly (published quarterly)

32. Mental health out of area placements (123f)	
Category, Sub-Category	Quality of care and outcomes, Mental health
Definition	The rate of inappropriate Out of Area Placements (OAPs) in mental health services for adults in non-specialist acute inpatient care per 100,000 population. CCGs will be directly scored by comparing this rate (per 100,000 population) to a set of thresholds.
Purpose (Rationale)	In line with the recommendation set out in the *Five Year Forward View for Mental Health*, there is a national ambition to eliminate inappropriate Out of Area Placements (OAPs) for adults in acute mental health inpatient care by 2020-21. Rationale for including this data in the NHS Oversight Framework: Data on acute out of area placements has been collected nationally since November 2016, providing transparency and a means of monitoring progress towards the 2021 ambition. These data are obtained from a monthly provider-level collection. A CCG breakdown has been derived for the purposes of the NHS Oversight Framework in recognition of the key role CCGs have in reducing out of area placements alongside the providers they commission. However, this breakdown only gives an indication of CCG activity levels and should be viewed in conjunction with the provider level data. While the ambition is for all areas to eliminate inappropriate OAPs activity over the next two years, it is currently necessary to report OAPs activity as a rate per weighted local population to fulfil the benchmarking purpose of the NHS Oversight Framework Outside of the NHS Oversight Framework performance will also be assessed against progress to deliver planned local trajectories for reduction, to incentivise well-managed, safe and sustainable reduction.
Evidence and policy base	Out of area placements are associated with poor patient experience, poor clinical outcomes and high financial cost. The practice can lead to people being separated from their friends, families and support networks, disrupting the continuity of their care and potentially impeding recovery. Out of area placements (OAPs) are often a symptom of widespread problems in the functioning of the whole mental health system, and may indicate: • Insufficient community alternatives to admission placing avoidable demand on mental health providers' in-patient capacity • Insufficient in-patient capacity to meet unavoidable in-hospital demand.

	• Lack of swift access to appropriate level of support, resulting in avoidable deterioration of people's mental health • Lack of suitable housing and social care support preventing people being discharged from hospital when they are clinically well enough, leading to bottlenecks in acute care services The Five Year Forward view for Mental Health sets out the need to significantly reduce the use of out of Out of Area Placements (OAPs) with the aim of eliminating inappropriate OAPs s for adults requiring non-specialist acute inpatient care by 2020-21.
Data	
Data source	NHS Digital – Mental Health OAPs collection http://content.digital.nhs.uk/oaps Denominator: NHS Digital - Patients Registered at a GP Practice https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice
Data fields	Numerator: Total number of inappropriate OAP bed days over the period Denominator: NUMBER_OF_PATIENTS
Data filters	None
Data processing	Not applicable
Construction	
Numerator	The number of bed days due to inappropriate out of area bed days for adult non specialist acute mental health care.
Denominator	Patients registered at a GP practice aged 18+
Computation	Numerator / Denominator Rates will then be directly scored to give an assessment of how closely performance aligns with planned trajectories.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Rolling Quarter (collected monthly)

33. Quality of mental health data submitted to NHS Digital (DQMI) (123j)	
Category, Sub-Category	Quality of care and outcomes, Mental health
Definition	The average score against the Mental Health Services Dataset (MHSDS) component of the DQMI for providers commissioned by the CCG.
Purpose (Rationale)	Data are of high quality “if they are fit for their intended uses in operations, decision making and planning.” It is important because: • Acceptable data quality is crucial to operational and transactional processes and to the reliability of business analytics / business intelligence reporting, • High quality information leads to improved decision making which in turn results in better patient care, wellbeing and safety. There are potentially serious consequences if information is not correct, secure and up to date, • Management information produced from patient data is essential for the efficient running of the trust and to maximise utilisation of resources for the benefit of patients and staff, • Poor data quality puts organisations at significant risk of: damaging stakeholder trust; weakening frontline service delivery; incurring financial loss; and poor value for money The Data Quality Maturity Index (DQMI) is a quarterly publication intended to raise the profile and significance of data quality in the NHS.
Evidence and policy base	NHS England, NHS Improvement, Public Health England, Health Education England and NHS Digital, together with the Department of Health, are: • Developing a five year data plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. • Working to ensure that the Mental Health Services Data Set (MHSDS) is delivering relevant, timely and accurate data. This includes work to update the dataset and reporting requirements, to ensure the right information is reported nationally, and encouraging providers and commissioners to improve local systems and processes to make the data flow effectively.
Data	
Data source	NHS Digital quarterly DQMI publication: https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/data-quality

Data fields	MHSDS SCORE (%)
Data filters	Not applicable
Data processing	Calculation of weighted average of MHSDS DQMI score based on the activity levels of main providers of mental health services for the CCG.
Construction	
Numerator	Weighted mean of provider MHSDS DQMI scores
Denominator	N/A
Computation	Numerator / denominator
Risk adjustment or standardisation type and methodology	Not applicable
Output	
Frequency of publication	Quarterly

34. Reliance on specialist inpatient care for people with a learning disability and/or autism (124a)	
Domain, Area	Quality of care and outcomes, Learning disability and autism
Definition	The number of adult inpatients per million ONS resident adult population from the CCG (based on CCG of origin).
Purpose (Rationale)	To give a direct measure of the reliance on inpatient care for adults, and hence indicate whether a CCG is meeting its commitment to reduce the number of inpatients and transform services.
Evidence and policy base	CCGs are developing plans setting out trajectories to March 2020 so that no area should need more inpatient capacity than is necessary at any one time to cater to: • 18.5 adult inpatients in CCG-commissioned beds per million adult population. • 18.5 adult inpatients in NHS England-commissioned beds per adult million population. The reduction in inpatient numbers is a proxy measure for a reduction in the number of inpatient beds, and the transformational change to deliver more services in the community rather than through inpatient services. This change is a key objective of the Long Term Plan: https://www.england.nhs.uk/long-term-plan/
Data	
Data source	NHS Digital, Assuring Transformation collection, plus ONS 2017 mid-year population estimates http://content.digital.nhs.uk/assuringtransformation https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/clinicalcommissioninggroupmidyearpopulationestimates
Data fields	From Assuring Transformation: Count of Adult Inpatients by Originating CCG From ONS: Mid-2017 Population Estimates for Clinical Commissioning Groups in England for Adults aged 18+
Data filters	None – no exclusions apply
Data processing	None
Construction	
Numerator	Number of inpatients aged 18+ at the end of the reporting period, on a ‘CCG of Origin’ basis.
Denominator	Mid-2017 Population Estimate for adults aged 18+ in Clinical Commissioning Group
Computation	Numerator/Denominator expressed as a rate per million

Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly

35. Proportion of people with a learning disability on the GP register receiving an annual health check (124b)	
Category, Sub-Category	Quality of care and outcomes, Learning disability and autism
Definition	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 disabled population.
Purpose (Rationale)	To encourage CCGs to ensure that people with a learning disability over the age of 14 and over are offered annual health checks.
Evidence and policy base	NHS England's Long Term Plan states that action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability. To help do this, NHS England aims to improve uptake of the existing annual health check in primary care for people aged 14 and over with a learning disability, so that at least 75% of those eligible have a health check each year. This indicator aims to monitor progress and will show which CCGs are not delivering learning disability services in line with the target set out in the Long Term Plan. The annual health check scheme has been run since 2009. The Confidential Inquiry into premature deaths of people with learning disabilities highlighted the importance of annual health checks.
Data	
Data source	Published by NHS Digital Annual Health Checks: https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme GP Learning Disability Register (QOF): https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data
Data fields	From GP Contract Service GPES publication: Annual Summary field LD001 Health Checks From QOF publication: Prevalence, exceptions and achievements at CCG level. LD field Register
Data filters	None
Data processing	Health Check data from GP practices are aggregated up to CCG level. Practices are mapped to their respective CCGs using reference data current at 1 April 2019 (Source: Quality Outcomes Framework 2018/19, NHS Digital).
Construction	
Numerator	Number of Annual Health Checks carried out in the last 12 months

Denominator	CCG population on the GP Learning Disability Register
Computation	Numerator / Denominator*100
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

36. Completeness of the GP learning disability register (124c)	
Category, Sub-Category	Quality of care and outcomes, Learning disability and autism
Definition	The proportion of the population (all ages) that are included on a GP learning disability register
Purpose (Rationale)	Only around a quarter to a third of the estimated number of people with a learning disability are on a GP register. This means appropriate adjustments to their health care cannot be delivered – for example unless a person is on a GP register they are not eligible for a learning disability annual health check. The purpose of this indicator is to encourage practices to improve coverage on their LD registers, which will enable more people with learning disabilities to benefit from targeted interventions.
Evidence and policy base	Increasing the number of people on GP Learning Disability Registers is a key policy for the NHS England Learning Disability Programme. A fully populated Register allows key interventions such as annual health checks and screening programmes to be delivered, to help address and reduce the health inequalities experienced by people with learning disabilities. This indicator measuring the proportion of the population on a GP Learning Disability Register will give more prominence to this policy and will help to improve the registration rate.
Data	
Data source	Published by NHS Digital (QOF) https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data
Data fields	From Prevalence, achievements and exceptions at CCG level: Quality and Outcomes Framework publication. From QOF publication: Learning Disability
Data filters	None
Data processing	None
Construction	
Numerator	Number of people on a GP learning disability register
Denominator	Total GP list size (all ages)
Computation	Numerator / Denominator * 100
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

37. Learning disabilities mortality review: the percentage of reviews completed within 6 months of notification (124d)

Category, Sub-Category	Quality of care and outcomes, Learning disability and autism
Definition	The percentage of LeDeR reviews, of the death of a person with a learning disability aged 18 and above, completed within 6 months of notification to the programme.
Publication status	Data will be published.
Purpose (Rationale)	To try and ensure deaths of people with a learning disability are reviewed promptly, and within 6 months of the death, to inform service improvements.
Evidence and policy base	On average, adults with a learning disability die 16 years earlier than the general population. Public Health England estimate that there are 3,400 deaths per annum of people with a learning disability. In 2019, the Learning Disabilities Mortality Review Programme (LeDeR) found that the most common causes of death were pneumonia (25%) and Aspiration pneumonia (16%) NHS England's Long Term Plan states that **action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people.** The NHS has committed to reviewing every death of a person with a learning disability aged 4 and above in England. This indicator aims to monitor progress against the target of ensuring that all deaths are reviewed within 6 months.
Data	
Data source	University of Bristol, LeDeR programme. Link to be inserted
Data fields	Notification date, Total days since notification, Days since completion
Data filters	Excludes notifications that are on hold due to statutory or legally driven proceedings. Excludes children under 18

	years as these deaths are reviewed by the Child Death Overview Process.
Data processing	Calculation of days taken to complete review: Total days since notification minus days since completion. Calculation of date of completion: Date of notification + days taken to complete review. Calculation of reviews completed within 6 months from date if notification and date of completion.
Construction	
Numerator	Number of deaths notified to the programme within a 12 month period (30th Sept 2018 - 30th Sept 2019) where a review was completed within 6 months of notification.
Denominator	Number of reviews notified to the programme within a 12 month period (30th Sept 2018 - 30th Sept 2019).
Computation	Numerator/Denominator x 100 This value will be used to inform a RAG rating which will be used for the CCG assessment.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annual

38. Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children (103a)	
Category, Sub-Category	Quality of care and outcomes, Diabetes
Definition	The percentage of diabetes patients that have achieved all 3 of the NICE-recommended treatment targets, as follows: • Adults: HbA1c <=58mmol/mol (7.5%), prescription of statins for primary or secondary prevention of CVD and Blood pressure <=140/80 mmHg • Children:HbA1c <=58mmol/mol (7.5%)
Purpose (Rationale)	To incentivise CCGs to improve achievement rates for the NICE-recommended treatment targets
Evidence and policy base	The NHS Oversight Framework indicators encompass the triple aim of the NHS Forward View (better health and wellbeing for populations, better quality care for patients, and better value for taxpayers). They are not intended to provide comprehensive coverage of NHS England and CCG responsibilities. They are intended to be a small number of key metrics chosen to drive improvement in the highest priority areas. For adults, NICE recommends that the treatment and management of diabetes aims for specific treatment targets for glucose levels, blood pressure and cholesterol For children, NICE recommends that the treatment and management of diabetes aims for a specific treatment target for glucose levels. Achievement of the NICE recommended treatment targets plays an important role in the reduction of risk of the microvascular complications of diabetes (eye disease and blindness; kidney disease and kidney failure; foot disease, foot ulceration and amputation) and in the reduction of excess risk of cardiovascular disease (heart attack, angina, heart failure, stroke, and amputation). Whilst the National Diabetes Audit (NDA) reports against treatment targets in children, the National Paediatric Diabetes Audit (NPDA) does also. This indicator does not include the NPDA in its calculation due to an unknown degree of overlap (of children) between the two audits (work is ongoing to quantify this overlap). As reported in the NDA, concurrent achievement of all 3 NICE-recommended treatment targets in individuals with diabetes has not significantly improved in recent years. Additionally, the most recent NDA (2018-19) highlighted that only 20% of patients with type 1diabetes and 42% of

	patients with type 2 diabetes are concurrently achieving all 3 treatment targets. Note: Linkage of individual patient-level data to give information on the concurrent achievement of all 3 treatment targets in each individual is only achieved by the NDA, not by QOF. Achievement of NICE-recommended treatment targets will be influenced by a range of factors including, but not limited to: • In adults, delivery rates for the 8 NICE-recommended diabetes care processes (attributable to CCG) • In children, delivery rates for the 7 NICE-recommended diabetes care processes (attributable to CCG) • Self-management (attributable to CCG and patient) As such, it is expected that measuring treatment targets will incentivise CCGs to improve both delivery rates for the NICE-recommended care processes and the uptake of structured education, whilst allowing a degree of flexibility to potentially stimulate innovation in other treatment areas.
Data	
Data source	National Diabetes Audit (http://content.digital.nhs.uk/nda)
Data fields	http://content.digital.nhs.uk/media/23810/NDADPP-Pilot-Primary-Care-Extraction-Specification/pdf/NDA_DPP_Pilot_Primary_Care_Extraction_Specification.pdf NHS Number; Date of birth; Gender; Practice code; BP (Blood pressure); HbA1c; Statin prescription
Data filters	Diabetes diagnosis date (where before audit end date) Dissent from disclosure of personal confidential data by NHS Digital (where code exists without an appropriate withdrawn dissent code)
Data processing	Mapping of GP practices to CCGs, and aggregation of data.
Construction	
Numerator	Number of NDA-registered diabetes patients achieving all relevant treatment targets as recorded by the NDA (Adults: HbA1c ≤7.5%, prescription of statins for primary or secondary prevention of CVD and blood pressure <=140/80; Children (<12 years): HbA1c ≤7.5%)
Denominator	Number of NDA-registered diabetes patients with relevant values recorded
Computation	Numerator/Denominator expressed as a percentage
Risk adjustment or standardisation type and methodology	None
Output	

Frequency of publication	Annually

39. People with diabetes diagnosed less than a year who attend a structured education course (103b)	
Category, Sub-Category	Quality of care and outcomes, Diabetes
Definition	The percentage of people with diabetes diagnosed for less than one year who have a record of attendance at a structured education course. This is measured using the number of people who have attended a structured education course within 12 months of diagnosis, as recorded by the NDA.
Purpose (Rationale)	To incentivise CCGs to increase the number of diabetes patients attending structured education
Evidence and policy base	Poor management can be associated with higher risk of the microvascular complications of diabetes (eye disease and blindness; kidney disease and kidney failure; foot disease, foot ulceration and amputation) and higher risk of cardiovascular disease (heart attack, angina, heart failure, stroke, and amputation). As such, NICE recommends that newly diagnosed diabetes patients are attend a structured education course within 12-months of diagnosis in order to improve understanding, empowerment and self-management of diabetes. Whilst diabetes care process delivery and treatment target achievement are recommended in order to both monitor for the onset of diabetes complications and to minimise the risk of onset of diabetes complications, structured education is recommended to support self-management in order to achieve the same goals, as well as to achieve better understanding of the disease and better quality of life with diabetes. According to the latest NDA (2018-19), only 10.6% of patients newly diagnosed with type 1 diabetes in 2014 and 12.4% of patients newly diagnosed with type 2 diabetes in 2017 attended a structured education course, suggesting that there is scope for considerable improvement.
Data	
Data source	National Diabetes Audit (http://content.digital.nhs.uk/nda)
Data fields	http://content.digital.nhs.uk/media/23810/NDADPP-Pilot-Primary-Care-Extraction-Specification/pdf/NDA_DPP_Pilot_Primary_Care_Extraction_Specification.pdf Year; CCG code; CCG name; Number diagnosed; Structured education
Data filters	• Structured education attendance date (where before the audit end date)

	• Dissent from disclosure of personal confidential data by NHS Digital (where code exists without an appropriate withdrawn dissent code). • Structured education filter: o Field: NDA field for Education referral o Condition: Is equal to one of the codes detailed below o Attended diabetes structured education programme o Diabetes structured education programme completed o Attended diabetes education and self-management for ongoing and newly diagnosed structured programme (DESMOND) o Diabetes education and self-management for ongoing and newly diagnosed structured programme completed (DESMOND) o Attended expert patient education versus routine treatment diabetes structured education programme (XPERT) o Expert patient education versus routine treatment diabetes structured education programme completed (XPERT) o Attended dose adjustment for normal eating diabetes structured education programme (DAFNE) o Dose adjustment for normal eating diabetes structured education programme completed (DAFNE) • Remote diabetes structured education and support programme commenced (situation) • Remote diabetes structured education and support programme completed (situation)
Data processing	Mapping of GP practices to CCGs, and aggregation of data
Construction	
Numerator	Number of NDA-registered diabetes patients attending a structured education course within 12 months of diagnosis
Denominator	Number of NDA-registered diabetes patients who were newly diagnosed in the calendar year
Computation	Numerator/Denominator, expressed as a percentage Note that the method for calculating this indicator has been improved for the 2015-16 NDA compared to the 2014-15 NDA, which means figures across the two years are not comparable. The 2015-16 NDA relates to those newly diagnosed in calendar years 2013 and 2014 respectively and whether they were subsequently offered and attended structured education. Further details about the calculation method and how it compares to earlier years can be found

	at: http://content.digital.nhs.uk/catalogue/PUB23241/nati-diab-audi-rep1-meth-2015-16_V2.pdf
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

40. Estimated diagnosis rate for people with dementia (126a)	
Category, Sub-Category	Quality of care and outcomes, People with long term conditions and complex needs
Definition	Number of people aged 65 and over on the dementia register divided by the estimated prevalence rate from the CFAS II study applied to GP list size for submitting practices
Purpose (Rationale)	To encourage timely diagnosis by highlighting areas where diagnosis is lower than the national ambition.
Evidence and policy base	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.
Data	
Data source	Numerator: In year monitoring: NHS Digital monthly QOF dementia registers publications. Final assessment (if required) QOF March 2019 dementia registers. Denominator: 1. Prevalence rates from CFAS II study (used in current indicator, published in the Lancet) available at http://www.cfas.ac.uk/files/2015/08/Prevalence-paper-CFAS-2013.pdf 2. GP list sizes for submitting practices from NHS Digital monthly QOF collection The full definitions used to calculate this indicator are contained in the NHS Digital monthly publication Recorded Dementia Diagnosis: About This Release. This is available by selecting the most recent month in the list at https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses and then clicking the relevant file link in the file list for that month.
Data fields	Numerator and denominator at practice level as described below.
Data filters	Only currently active GP practices are included in the indicator. The raw GPES extract occasionally includes register counts from some closed GP practices and from other primary care types (e.g. walk in centres).
Data processing	Not applicable
Construction	

Numerator	For each practice in the CCG, the most recently available count of the number of people, aged 65 or over, who are on their GP Practice's dementia register. $\Sigma_i(Number\ of\ entries\ in\ dementia\ register_i)$ where i = 1, …, x where x is the count of currently active GP practices in the CCG If a practice's register has not been obtained through the GPES in a given month, then the practice's most recently available register is included in the numerator within the last six months. The GPES extract omits between 2% and 4% of practices in a given month, but with an unstable omission rate it is important to smooth the spikes in the indicator caused by variance in the practice set from which data are obtained. This methodology has been in place since April 2017.
Denominator	The denominator is the estimated number of people living with dementia in the CCG area. This is calculated from estimated prevalence rates for dementia, and GP list sizes for submitting practices. The prevalence rates for males and females from the age of 65 to 90+ are applied to male and female list sizes by 5-year age-band to derive an estimate of the total number of people with dementia in an area. $\Sigma_\mathrm{j}(\%\ \mathrm{Prevalence\ rate}_\mathrm{j} * \ \mathrm{List\ size}_\mathrm{j})$ where j = 65-69, 70-74, 75-79, 80-84, 85-89, 90+ is the age group for males and females
Computation	$\Sigma_i(Number\ of\ applicable\ entries\ in\ dementia\ register_i)$* $\Sigma_j(\%\ Prevalence\ rate_j * List\ size_j)$
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly (published quarterly)

41. Dementia care planning and post-diagnostic support (126b)	
Category, Sub-Category	Quality of care and outcomes, People with long term conditions and complex needs
Definition	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months
Purpose (Rationale)	Substantial effort has been made recently to increase the proportion of people living with dementia who have a formal diagnosis in primary care. Clinical evidence shows that formal care planning and other post-diagnostic support is positive for the patient and is expected to lengthen the time which they can live in the community. This indicator tests whether primary care is conducting a timely review of the patient's needs, including that: • patients are receiving an appropriate physical, mental health and social review; • a record is made of the patients' wishes for the future; • communication and co-ordination arrangements with secondary care (if applicable); • identification of the patient's carer(s)
Evidence and policy base	Patients diagnosed with dementia are expected to be offered annual face-to-face appointments specifically to review their diagnosis and/or their care plan or advanced care plan. This is in line with the NICE clinical guideline CG42."Dementia. Supporting people with dementia and their carers in health and social care", which is in support of two NICE Quality Standards: 1. NICE Quality Standard 1: Dementia; 2. NICE Quality Standard 30: Supporting people to live well with dementia.
Data	
Data source	Quality and Outcomes Framework (QOF) Indicator DEM004: The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months.
Data fields	Numerator and denominator per GP practice as described below.
Data filters	Only currently active GP practices are to be included in the indicator. The annual QOF extract is of high quality and does not include any extraneous practice records; however an assessment of the quality of a quarterly data feed has not yet been completed.
Data processing	Not applicable

Construction	
Numerator	For each practice in the CCG, the most recently available count of the number of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months $\Sigma_i\left(\begin{array}{c} Number\ of\ entries\ in\ dementia\ register \\ whose\ care\ plan\ has\ been\ reviewed\ in\ a \\ face-to-face\ interview\ in\ the \\ preceeding\ 12\ months \end{array}\right)_i$ where i = 1, …, x where x is the count of currently active GP practices in the CCG.
Denominator	For each practice in the CCG, the most recently available count of the number of people who are on their GP Practice’s dementia register. $\Sigma_j(Number\ of\ entries\ in\ dementia\ register_j)$ where j = 1, …, x where x is the count of currently active GP practices in the CCG.
Computation	$\frac{\Sigma_i\left(\begin{array}{c} Number\ of\ entries\ in\ dementia\ register \\ whose\ care\ plan\ has\ been\ reviewed\ in\ a \\ face-to-face\ interview\ in\ the \\ preceeding\ 12\ months \end{array}\right)_i}{\Sigma_j(Number\ of\ entries\ in\ dementia\ register_j)} * 100$
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

42. The proportion of carers with a long term condition who feel supported to manage their condition (108a)	
Category, Sub-Category	Quality of care and outcomes, People with long term conditions and complex needs
Definition	The proportion of carers with long term physical or mental health conditions, disabilities, or illnesses who feel supported to manage their condition(s). This is measured based on responses to questions from the GP Patient Survey. This indicator measures the degree to which carers with long term physical or mental health conditions, disabilities, or illnesses, which are expected to last for 12 months or more, feel they have had sufficient support from local services or organisations to manage their condition(s). Patients are encouraged to consider all services or organisations which support them in managing their condition, not just health services.
Purpose (Rationale)	As set out in the Five Year Forward view: ‘The five and a half million carers in England make a critical and underappreciated contribution not only to loved ones, neighbours and friends, but to the very sustainability of the NHS itself. We will find new ways to support carers, building on the new rights created by the Care Act, and especially helping the most vulnerable amongst them – the approximately 225,000 young carers and the 110,000 carers who are themselves aged over 85. This will include working with voluntary organisations and GP practices to identify them and provide better support. For NHS staff, we will look to introduce flexible working arrangements for those with major unpaid caring responsibilities’. This metric will help understand the amount of support given to carers who have one or more long term conditions.
Evidence and Policy Base	1.4 million carers in England care for more than 50 hours a week (*Facts about Carers – Policy Briefing*, May 2014, Carers UK). 21% of them are in poor health and yet 20% of them do not have access to any support; 6 in 10 of carers have reached breaking point, of those a quarter needing medical treatment as a result and 1 in 9 carers who had suffered breakdown said that it resulted in the person they care for being hospitalised or needing emergency social care while the carer recovered (*State of Caring 2016,* Carers UK). Generally carers report worse experience of primary care than non-carers and the difference in reported experience is more stark in young carers, who themselves have a higher incidence of long-term conditions (GP Patient Survey 2018). Improving the quality of support for carers, in particular early intervention and targeted support, is intended to reduce carer breakdown and thereby limit the associated use by the cared for person of in-patient services, social care and institutional care. It is now standard practice in healthcare systems worldwide to ask

	people to provide direct feedback on the quality of their experience, treatment and care. This indicator is used alongside additional information sources to provide local clinicians and managers with intelligence on the quality of local services from the patients' and service users' point of view and will ultimately play a role in driving improvements in the quality of service design and delivery.
Data	
Data source	GP Patient Survey (http://www.gp-patient.co.uk). Data for this indicator are from the GP Patient Survey. This survey is commissioned by NHS England and is conducted by the independent survey organisation Ipsos MORI. Current and previous years' surveys are available on the GP Patient Survey website Surveys and reports pages. Patients are eligible for inclusion in the survey if they had a valid NHS number, had been registered with a GP practice continuously for at least six months before being selected, and were 16 years of age or over. Details regarding eligibility, participation and sampling for the survey is available in the GP Patient Survey Technical Annex. All question numbers are based on the latest survey for which field work was carried out between January and March 2018.
Data fields	The data fields used are as follows: • Wt_new • Answers to Q38 • Answers to Q34 • Answers to Q35 • Answers to Q54 (Gender) • Answers to Q55 (Age) • Answers to Q59 (Carer) • CCG_Code
Data filters	Data are filtered based on response to question 59 of the GP Patient Survey, to isolate those who identify themselves as an unpaid carer. Question 59: Do you look after, or give any help or support to family members, friends, neighbours or others because of either: • long-term physical or mental ill health / disability, or • problems related to old age?

	Don’t count anything you do as part of your paid employment. ☐ No ☐ Yes, 1 to 9 hours a week ☐ Yes, 10 to 19 hours a week ☐ Yes, 20 to 34 hours a week ☐ Yes, 35 to 49 hours a week ☐ Yes, 50 or more hours a week People who answer ‘Yes …’ are assumed a carer, regardless of how many hours of care they provide. Those who answer otherwise are not considered in the calculation. All invalid responses (where there is no value for gender or age or any other of the breakdown variables) are excluded from the calculation. Gender and age of a respondent are derived from questions 54 and 55 of the survey. Further, only people resident in an English region are included in the indicator. Data are then filtered based on questions 34 and 35 of the GP Patient Survey, to isolate those who report having one or more long-term physical or mental health condition, disability, or illness. Respondents are identified as having a long-term condition if they answer ‘Yes’ to question 34 of the GP Patient Survey. Question 34: Do you have any long-term physical or mental health conditions, disabilities or illnesses? By long-term, we mean anything lasting or expected to last for 12 months or more. Please include issues related to old age. ☐ Yes ☐ No ☐ Don’t know / can’t say ☐ I would prefer not to say If respondents fail to acknowledge their long-term condition in question 34 (those who answer ‘No’ or ‘Don’t know/can’t say’ but select a condition in question 35 they are recoded to a ‘Yes’ in question 34. Question 35: Which, if any, of the following long-term conditions do you have? ☐ Alzheimer’s disease or other cause of dementia ☐ Arthritis or ongoing problem with back or joints ☐ Autism or autism spectrum condition

	☐ Blindness or partial sight ☐ A breathing condition such as asthma or COPD ☐ Cancer (diagnosis or treatment in the last 5 years) ☐ Deafness or hearing loss ☐ A developmental disability, such as autism or ADHD ☐ Diabetes ☐ A heart condition, such as angina or atrial fibrillation ☐ High blood pressure ☐ Kidney or liver disease ☐ A learning disability ☐ A mental health condition ☐ A neurological condition, such as epilepsy ☐ A stroke (which affects your day-to-day life) ☐ Another long-term condition or disability ☐ I do not have any long-term conditions Question 38: In the last 12 months, have you had enough support from local services or organisations to help you to manage your condition (or conditions)? Please think about all services and organisations, not just health services. ☐ Yes, definitely ☐ Yes, to some extent ☐ No ☐ I haven't needed support ☐ Don't know / can't say
Data processing	Not applicable
Construction	
Numerator	The weighted number* of respondents who answer 'Yes, definitely' OR 'Yes, to some extent' to question 38 Respondents who answer 'Yes, to some extent' are deemed to feel half as supported as respondents who answer 'Yes, definitely'. Therefore, this group of responses is weighted by 0.5 when calculating the numerator. Given the data filter above, the numerator is therefore calculated as: $\Sigma i\ (wt\_newi \times 1)+\Sigma j\ (wt\_newj \times 0.5)$ where i = 1, …, m are respondents with a long-term condition who answer 'Yes, definitely'; and j = 1, …, n are respondents with a long-term condition who answer 'Yes, to some extent'. *A weight is applied to construct the indicator. The GP Patient Survey includes a weight for non-response bias (wt_new). This adjusts the data to account for potential differences between the demographic profile of all eligible

	patients in a practice and the patients who complete the questionnaire.
Denominator	The weighted number* of respondents who answer ‘Yes, definitely’ OR ‘Yes, to some extent’ OR ‘No’ to question 38 of the GP Patient Survey: $\Sigma k(wt\_newk \times 1)$ where k = 1, …, p are respondents with a long-term condition who answer ‘Yes, definitely’ OR ‘Yes, to some extent’ OR ‘No’. *A weight is applied to construct the indicator. The GP Patient Survey includes a weight for non-response bias (wt_new). This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who complete the questionnaire.
Computation	Indicator value = Numerator / Denominator
Risk adjustment or standardisation type and methodology	**Weighting Methodology** The data used to construct the indicator is weighted. The GP Patient Survey includes a weight for non-response bias. This adjusts the data to account for potential differences between the demographic profile of all eligible patients in a practice and the patients who actually complete the questionnaire. The non-response weighting scheme has been developed by Ipsos MORI, incorporating elements such as age and gender of the survey respondent as well as factors from the area where the respondent lives such as level of deprivation, ethnicity profile, ACORN classification and so on, which have been shown to impact on non-response bias within the GP Patient Survey. Further information on the weighting can be found in the latest technical annex at the following webpage. https://gp-patient.co.uk/surveysandreports **Standardisation** This indicator is indirectly standardised at the CCG level by age and gender.
Output	
Frequency of publication	Annually

43. Percentage of deaths with three or more emergency admissions in last three months of life (105c)	
Category, Sub-Category	Quality of care and outcomes, People with long term conditions and complex needs
Definition	Repeat emergency admissions during end of life care.
Purpose (Rationale)	The purpose of the indicator is to encourage improvement in the quality of end of life care in the following ways: • anticipatory planning and end of life care being addressed in a coordinated and timely way • key information about the person’s condition, needs and preferences being shared across the local health and care system, and • where unplanned needs arise (as they inevitably will for some people), in the speed and adequacy of urgent care response taking place where the person is, which should reduce the need for repeat emergency admissions during the last 90 days of life. The threshold of 3 or more is set to account for the fact that some unplanned needs may require emergency admission (e.g. an acute reversible event that may or may not be connected to the underlying condition, or an unexpected and sudden deterioration in symptom severity which requires urgent and close 24/7 medical and/or nursing management).
Evidence and policy base	A high number of emergency admissions during the last 3 months of life could indicate that care is not being co-ordinated, that care planning conversations are not taking place or the appropriate level of support to deliver a care plan and manage potential crises is not in place. There is evidence from the National Survey of Bereaved People (VOICES) that there is significant room for improvement in the co-ordination of care between hospital, GP and community services in the last three months of life, as well as room for improvement in care needed urgently in evenings and weekends in the last three months of life. The following policy documents support the inclusion of this indicator: NHS England’s ‘Urgent and Emergency Care Review’ requires localities to develop a clinical hub that supports 999, 111 and out-of-hours calls. Having timely access to advice can support people approaching the end of life and potentially avoid unnecessary emergency admissions. The ‘Ambitions for Palliative and End of Life Care: National Framework for Local Action’ comprises six ambitions, two

	of which are directly linked to this indicator: 'Maximising comfort and wellbeing', and 'Care is coordinated'. The government's response to the independent review into choice at the end of life include a six point 'End of Life Care commitment', setting out from the person's perspective what they should expect towards the end of life. These commitments include the person having an opportunity to have a care planning discussion informed by honest conversations, to have decisions about care plans recorded and shared with those involved in their care, to involve their families and carers in the discussion and delivery of care to the extent they wish, and for the person to know who to contact for help and advice at any time. If the Ambitions framework is delivered and the 'End of Life Care commitment in place, we would expect to see a reduction in repeat emergency admissions in the last 90 days of life.
Data	
Data source	Linked HES-ONS mortality data (in addition to full ONS death certificate data for total numbers of deaths). The ONS mortality data is linked to HES by matching person identifiable data in the ONS mortality dataset with patient identifiers in HES. Further information on linked HES-ONS data is available at the following link, including detailed information about the linking methodology: http://content.digital.nhs.uk/article/2677/Linked-HES-ONS-mortality-data
Data fields	• ENCRYPTED_HESID (Patient identifier) • DOR (Date of registration of death) • DOD (Date of death) • ADMIDATE (Admission date) • LSOA11 (Local super output area – in lieu of postcode) • EPISTAT (Episode status i.e. is it finished or not • CLASSPAT (Class of patient ordinary/day case/ regular attender…) • EPIORDER (order of episodes within a single admission) • ADMIMETH (Nature of the admission Emergency/Elective…) • SUBSEQUENT_ACTIVITY_FLAG (Indicates HES activity after date of death)

	- CAUSE_OF_DEATH_NEONATAL_1 (To identify neonatal deaths)
Data filters	There is no exclusion for type of death, other than to exclude neonatal deaths. This is because if there are repeated emergency admissions for any one patient, it should trigger a closer look at patient management and/or identification of the need for end of life care. The following sets out the filter fields from the dataset: • EPISTAT =3 (Finished episodes) • CLASPAT in (1,2,5) (Ordinary, Day case or maternity i.e. excludes regular attenders) • EPIORDER =1 (First episode per admission) • [ADMIMETH] in (21, 22, 23, 24, 28, 2A, 2B, 2C, 2D) (Emergencies) • SUBSEQUENT_ACTIVITY_FLAG<>1 (Only patients with no HES activity after death) • CAUSE_OF_DEATH_NEONATAL_1 is NULL (excludes neonatal deaths) • DOD - ADMIDATE<91 Admitted within 90 days of death
Data processing	Not applicable
Construction	
Numerator	Number of people who died who had 3 or more emergency admissions in the 90 days prior to death (where deaths are registered in a specified year)
Denominator	Number of deaths registered in the specified year
Computation	Numerator/denominator expressed as a percentage
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

44. Patients waiting 18 weeks or less from referral to hospital treatment (129a)	
Category, Sub-Category	Quality of care and outcomes, Planned care
Definition	The percentage of patients waiting to start non-emergency consultant-led treatment who were waiting 18 weeks or less at the end of the reporting period
Purpose (Rationale)	To measure and encourage compliance with this constitutional measure (operational standard)
Evidence and policy base	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. Patients can and do use waiting times information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment. The NHS Improvement Plan (June 2004) set out the aim that no-one would have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation. At the time there was little evidence in the UK on acceptable waiting times, but work showed that once waiting times were down to three months patients would not pay for marginal improvements in the private sector. Also some evidence from the EU showed that the maximum referral to treatment waiting time at which the public ceased to be concerned was about four months. Implementation of the aim was supported by a Clinical Advisory Group representing all specialties. Further professional endorsement came in June 2015, when Simon Stevens and the Secretary of State for Health accepted a recommendation from Sir Bruce Keogh that the incomplete pathway operational standard should became the sole measure of patients' constitutional right to start treatment within 18 weeks (the incomplete standard has been in place since 2012/13, and before that the completed pathway standards were in place from 2008/09). The mandate to NHS England sets the objective of maintaining and improving performance against core standards, which include the RTT incomplete pathway standard. The standard is also a quality requirement in the NHS Standard Contract. The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. The legislative basis for this right is the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, as amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2015. The NHS operational standard for

	Referral to Treatment (RTT) waiting times is that a minimum of 92% of patients yet to start their non-urgent consultant-led treatment should have been waiting less than 18 weeks from referral. NHS providers and commissioners need the RTT data to ensure they are meeting their patients' legal right, and to identify where action is needed to reduce inappropriately long waiting times.
Data	
Data source	NHS England monthly data collection: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Data fields	Total number of incomplete pathways (Total for RTT Part Name, Part_2) Total within 18 weeks (sum of 'Gt 00 To 01 Weeks SUM 1' to 'Gt 17 To 18 Weeks SUM 1' for RTT Part Name, Part_2)
Data filters	RTT pathways commissioned by non-English commissioners are excluded from the calculation.
Data processing	
Construction	
Numerator	Number of incomplete pathways at or within 18 weeks at the end of the reporting period
Denominator	Total number of incomplete pathways at the end of the reporting period.
Computation	Numerator as percentage of denominator
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly (published quarterly)

45. Overall size of the waiting list (129b)

Category, Sub-Category	Quality of care and outcomes, Planned care
Definition	The total number of incomplete Referral to Treatment (RTT) pathways at the end of the reporting period (often referred to as the size of the RTT waiting list).
Publication status	Published monthly
Purpose (Rationale)	To measure and encourage compliance with recovery milestones for the RTT constitutional measure (operational standard). The NHS Operational Planning and Contracting Guidance 2019/20 set out the following deliverable for RTT: • Building on the expectation that providers will deliver March 2019 waiting lists at the March 2018 level, all providers to reduce their waiting list during 2019/20
Evidence and policy base	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. Patients can and do use waiting times information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment. The NHS Improvement Plan (June 2004) set out the aim that no-one would have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation. At the time there was little evidence in the UK on acceptable waiting times, but work showed that once waiting times were down to three months patients would not pay for marginal improvements in the private sector. Also some evidence from the EU showed that the maximum referral to treatment waiting time at which the public ceased to be concerned was about four months. Implementation of the aim was supported by a Clinical Advisory Group representing all specialties. Further professional endorsement came in June 2015, when Simon Stevens and the Secretary of State for Health accepted a recommendation from Sir Bruce Keogh that the incomplete pathway operational standard should became the sole measure of patients' constitutional right to start treatment within 18 weeks (the incomplete standard has been in place since 2012/13, and before that the completed pathway standards were in place from 2008/09). The mandate to NHS England sets the objective of maintaining and improving performance against core standards, which include the RTT incomplete pathway

	standard. The standard is also a quality requirement in the NHS Standard Contract. The NHS Constitution sets out that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. The legislative basis for this right is the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, as amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2015. The NHS operational standard for Referral to Treatment (RTT) waiting times is that a minimum of 92% of patients yet to start their non-urgent consultant-led treatment should have been waiting less than 18 weeks from referral. NHS providers and commissioners need the RTT data to ensure they are meeting their patients' legal right, and to identify where action is needed to reduce inappropriately long waiting times.
Data	
Data source	NHS England monthly data collection: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Data fields	Total number of incomplete pathways (Total for RTT Part Type, Part_2)
Data filters	RTT pathways commissioned by non-English commissioners are excluded from the calculation.
Data processing	
Construction	
Numerator	Not applicable – the indicator is not a rate
Denominator	Not applicable – the indicator is not a rate
Computation	Sum of total number of incomplete pathways (Total for RTT Part Type, Part_2)
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly

46. Patients waiting over 52 weeks for treatment (129c)	
Category, Sub-Category	Quality of care and outcomes, Planned care
Definition	The number of incomplete Referral to Treatment (RTT) pathways of 52 weeks or more at the end of the reporting period.
Publication status	Published monthly
Purpose (Rationale)	To measure and encourage compliance with recovery milestones for the RTT constitutional measure (operational standard). The NHS Operational Planning and Contracting Guidance 2019/20 set out the following deliverable for RTT: • No patient will wait more than 52 weeks for treatment
Evidence and policy base	Waiting times matter to patients. Most patients want to be referred, diagnosed and treated as soon as possible. Patients can and do use waiting times information to inform their choice of where to be referred and also to understand how long they might expect to wait before starting their treatment. The NHS Improvement Plan (June 2004) set out the aim that no-one would have to wait longer than a maximum of 18 weeks from the time they are referred for a hospital operation by their GP until the time they have that operation. At the time there was little evidence in the UK on acceptable waiting times, but work showed that once waiting times were down to three months patients would not pay for marginal improvements in the private sector. Also some evidence from the EU showed that the maximum referral to treatment waiting time at which the public ceased to be concerned was about four months. Implementation of the aim was supported by a Clinical Advisory Group representing all specialties. Further professional endorsement came in June 2015, when Simon Stevens and the Secretary of State for Health accepted a recommendation from Sir Bruce Keogh that the incomplete pathway operational standard should became the sole measure of patients’ constitutional right to start treatment within 18 weeks (the incomplete standard has been in place since 2012/13, and before that the completed pathway standards were in place from 2008/09). The mandate to NHS England sets the objective of maintaining and improving performance against core standards, which include the RTT incomplete pathway standard. The standard is also a quality requirement in the NHS Standard Contract. The NHS Constitution sets out

	that patients can expect to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions if they want this and it is clinically appropriate. The legislative basis for this right is the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, as amended by the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) (No. 2) Regulations 2015. The NHS operational standard for Referral to Treatment (RTT) waiting times is that a minimum of 92% of patients yet to start their non-urgent consultant-led treatment should have been waiting less than 18 weeks from referral. NHS providers and commissioners need the RTT data to ensure they are meeting their patients' legal right, and to identify where action is needed to reduce inappropriately long waiting times.
Data	
Data source	NHS England monthly data collection: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/
Data fields	Number of incomplete pathways of 52 weeks or more ('Gt 52 Weeks SUM 1' for RTT Part Type, Part_2)
Data filters	RTT pathways commissioned by non-English commissioners are excluded from the calculation.
Data processing	
Construction	
Numerator	Not applicable – the indicator is not a rate
Denominator	Not applicable – the indicator is not a rate
Computation	Sum of number of incomplete pathways of 52 weeks or more ('Gt 52 Weeks SUM 1' for RTT Part Type, Part_2)
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Monthly

47. Patients waiting six weeks or more for a diagnostic test (133a)	
Category, Sub-Category	Quality of care and outcomes, Planned care
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.
Purpose (Rationale)	This indicator is used to monitor against the operation standard that less than 1% of patients should be waiting six weeks or more for a diagnostic test.
Evidence and policy base	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, e.g. early diagnosis of cancer improves survival rates.
Data	
Data source	Diagnostics Waiting Times and Activity Return (DM01), collected via SDCS. NHS England
Data fields	Number of patients waiting six weeks or more for a diagnostic test Total number of patients waiting for a diagnostic test
Data filters	Exclude NONC (non-English commissioned)
Data processing	Aggregate collection, collected via SDCS
Construction	
Numerator	Number of patients waiting six weeks or more for a diagnostic test
Denominator	Total number of patients waiting for a diagnostic test
Computation	Numerator/Denominator
Risk adjustment or standardisation type and methodology	Not applicable
Output	
Frequency of publication	Monthly (published quarterly)

Leadership and workforce

48 Quality of leadership
49 Probity and corporate governance
50 Effectiveness of working relationships in the local system
51 Compliance with statutory guidance on patient and public participation in commissioning health and care
52 Primary care workforce
53 Staff engagement index
54 Progress against the Workforce Race Equality Standard

48. Quality of CCG leadership (165a)	
Category, Sub-Category	Leadership and workforce
Summary	A number of key leadership areas will be assessed to determine how robustly the senior leaders of a CCG, both clinicians and managers, are performing their leadership role.
Detailed description of indicator	On the basis of evidence provided by the CCG, four key lines of enquiry (KLOE) will be reviewed. The KLOEs are reflective of the ‘well-led’ theme within the provider metric annexes. The frequency of review will be locally agreed based on the level of risk the CCG is carrying or issues that may emerge during the year. A review may only be required annually, unless there is leadership change. **Leadership capability and capacity** • The CCG leadership has a clear vision and credible strategy to deliver its functions, the NHS Long Term Plan which incorporates the Five Year Forward View, and its contribution to system plans. This may include sharing leadership roles with other CCGs and merger. • CCG leaders have the relevant capability and experience to effectively manage commissioning functions, quality, finance and the delivery of CCG plans. • The governing body functions effectively as a team, and demonstrates a strong clinical and multi-professional focus. There are effective links between the governing body and member practices. • The CCG focuses on talent management and develops clinical and managerial leaders to meet current and future operating challenges. Succession planning takes into account the risk of turnover in senior roles, and includes a focus on financial leadership. **Quality** • The governing body focuses on quality, delivery and finance. It regularly receives robust and appropriate information which it has the capability to challenge. Discussions focus on driving improvements in quality, safety, outcomes and delivery of constitutional and national standards, within the resources available. • The CCG has effective systems and processes for monitoring, analysing and acting on a range of information about quality, performance and finance, from a variety of sources, including patient feedback, so that the CCG is able to identify early warnings of a failing service.

	• The CCG actively and robustly manages contract performance and, where necessary, acts swiftly to implement actions which ensure patients continue to receive high quality care and that constitutional standards are met. • The CCG makes use of internal and external reviews, with learning acted on to make improvements, e.g. post-incident reviews, annual EPRR (Emergency Preparedness, Resilience and Response) report, Healthwatch reports. **Governance** • There are clear responsibilities, roles and systems of accountability to support good governance. Quality, performance, and finance risks are understood and managed. • Regular review of governance arrangements is built into the day to day operations of the governing body. • The CCG has effective arrangements in place to obtain appropriate advice for enabling it effectively to discharge its functions, in line with its statutory duty under section 14W of the NHS Act 2006 (as amended). • The CCG matches the characteristics of an organisation with strong financial leadership, described in Annex 2. **Leadership around transformation** • The CCG can demonstrate proactive involvement in the development and implementation of system-wide strategies to support the integration of services. Governing bodies are sighted on the impact and risk of system plans on the CCG. • CCG leaders understand the governance arrangements necessary to effectively support partnerships at each level of the system, including primary care networks. There is movement towards shared decision making. The CCG clearly understands where legal accountability sits, and has robust governance arrangements in place to underpin this. • Where appropriate, CCG human resource has been made available to support transformation across the system, including primary care network development, without losing current, operational CCG delivery focus. • As appropriate, the CCG takes a ‘whole-system’ approach, leading and supporting transformation to adopt new care models that best meet its population’s requirements. • The CCG can demonstrate that staff are supported to develop ‘system’ skills. Leaders encourage a culture of collaboration, openness and transparency ensuring effective working across boundaries. This enables, for

	example, the design and delivery of integrated care and a clear understanding of the system financial position. - CCGs actively promote the formation and evolution of primary care networks that are taking action as new collectives to improve the care model locally and deliver a tangible difference to health outcomes.
Rationale for use and what it intends to achieve	There is a well-established process in place for reviewing sources of insight and reaching a consistent, evidence-based judgement in this area. A medium-term aim would be for all CCGs to reach and maintain a green rating.
Process of assessment	Review of insight will be undertaken by local teams in the regions, including a senior level conversation or meeting with relevant director-level members of the regional, system and CCG teams. An evidence-based judgement will be made against the indicator criteria. A risk-based schedule of reviews will be put in place at the start of each year, although insight received may prompt a review outside of the schedule. For example, deteriorating performance on clinical indicators or finances may highlight concerns relevant to the key lines of enquiry in the quality of CCG leadership indicator. Evidence would be drawn from, but not limited to, oversight dashboard data and the CCG's own documents such as board papers, annual report and governance statement, reporting, monitoring and assurance systems, records of improvement actions undertaken, risk logs, clinical, internal and external audit reports, staff survey results, the organisational development (OD) plan, and staff turnover rates. Relevant STP/ICS documents will also be taken into account. This is in addition to annual feedback sought from Health and Wellbeing Boards. As the CCG’s risk level and local context will be taken into account, not all sources of evidence described above would necessarily be considered for all CCGs at each review. A green star/green/amber/red rating would be used: - A green rating would be given when the CCG has no issues or minor/low risk issues. - Within this banding, a CCG that is considered very good, with practice that could be replicated as an exemplar, would be awarded a green star rating. - An amber rating would be given when moderate weaknesses have been identified. - A red rating would be given when there is significant failure to meet requirements.
What is the published rating?	A RAG rating will be published with a small amount of text describing the criteria for each rating, as stated in the previous section.
Frequency of assessment	Quarterly

	The most current position will be reported on a quarterly basis.
How is consistency of information / assessments ensured?	Regional consistency checking, overseen by the regional director, and national moderation.

Annex 2: Characteristics of an organisation with good financial leadership for indicator 165a: Quality of CCG leadership

The following points describe what good looks like, but a CCG does not need to be meeting all the criteria to be performing well in terms of financial leadership. Any failures should be either minor or deemed low risk. The assessment of financial leadership should be a balanced judgement using all the criteria and any relevant local factors.

- A substantive[15] director of finance is in place and the chair of the audit committee is a qualified accountant;
- Good evidence of challenge of financial information by audit committee and governing body;
- The CCG operates a robust system of financial controls including segregation of duties;
- Budgets are actively used as part of the financial control environment;
- Standing Financial Instructions (SFIs) are kept up to date, are appropriate to the organisation, are understood by and followed by all staff;
- There is consistency of reporting between summary financial information reported internally and externally, across ledgers and related financial reporting such as agreement of balances;
- Good quality reports on the financial position and the financial control environment to the governing body;
- Good risk management processes operate in the CCG, including the identification, quantification and mitigation of risk, and robust processes for reporting risk to the governing body;
- Evidence of a good understanding of the CCG's underlying financial position;
- Clear links between financial and activity information;
- Reliable and well understood plans and forecasts;
- Realistic and robust QIPP plans which are supported by a sound delivery architecture.

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[15] In general an organisation with a series of interims and an issue recruiting will struggle with good financial leadership, although discretion may be applied to take into account the local circumstances.

49. Probity and corporate governance (162a)	
Category, Sub-Category	Leadership and workforce
Summary	This indicator assesses CCGs' compliance with a number of requirements of the *revised statutory guidance on managing conflicts of interest for CCGs*. This indicator is to be considered along with each CCG's annual internal audit of conflicts of interest management, which will provide further assurance on the level of compliance with the statutory guidance.
Detailed description of indicator	This indicator consists of two parts: **Part one**: An annual self-certification that requests confirmation that: • The CCG has a clear policy for the management of conflicts of interest (in line with the *statutory guidance on managing conflicts of interest for CCGs*) and that the policy includes a robust process for the management of breaches. • The CCG has a minimum of three lay members. This includes confirmation of the number of CCG lay members and how many days they are employed per month. • The CCG's audit chair has taken on the role of the conflicts of interest guardian, supported by a senior CCG manager(s). • From 2018/19, 100% of relevant CCG staff have been offered the mandatory training on managing conflicts of interest and 90% of relevant CCG staff have completed it by 31st January 2019. The training is mandatory for: o CCG Governing Body Members o Executive members of formal CCG committees and sub-committees o Primary Care Commissioning Committee members o Clinicians involved in commissioning or procurement decisions o CCG governance leads o Anyone involved or likely to be involved in taking a procurement decision(s) **Part two:** A quarterly self-certification that requests confirmation that: • The CCG has processes in place to ensure individuals declare any conflict or potential conflict of interest as soon as they become aware of it, and within 28 days, ensuring accurate, up-to-date registers are complete for: o conflicts of interest; o procurement decisions; and o gifts and hospitality.

	- These registers are available on the CCG’s website and, upon request, at the CCG’s Head Quarters.
	- If there have been any breaches of the CCG’s policy on managing conflicts of interests. This includes confirmation that any breaches have been:
	  o published on the CCG’s website,
	  o communicated to NHS England.

Rationale for use and what it intends to achieve	CCGs need to appropriately and robustly manage conflicts of interest and demonstrate accountability to the public. The indicator aims to evidence the implementation of the revised *statutory guidance on managing conflicts of interest for CCGs* and that conflicts of interest are being robustly and proactively managed by CCGs.
Process of assessment	The self-certification (designed by the national co-commissioning team) would be signed off as accurate by the CCG's Accountable Officer and the CCG’s Audit Chair. The form should then be submitted to NHS England's local team. The local team will collate the information onto a spreadsheet and submit to the national co-commissioning team once responses have been obtained from all CCGs in their region. NHS England may follow up on any responses to enable a decision to be reached on the effectiveness of the CCG's systems and processes in managing conflicts of interest. NHS England’s local team and the national co-commissioning team will respond, as appropriate, to any identified need for support in the management of conflicts of interest.
What is the published rating? Is contextual information required?	The CCG will be rated as: - Compliant (if 100% of the criteria are met). - Partially compliant (if less than 100%, but more than 0%, of the criteria are met). - Not compliant (if 0% of the criteria are met). The contextual information in brackets would be required.
Frequency of assessment	Quarterly **Part One: Annual Assessment** The annual data collection will be in quarter 4 of 2018/19. The part one assessments are expected to be published in June 2019. **Part Two: Quarterly Assessment** Each quarterly data collection will be made the month following the end of each quarter. The data is published on MyNHS.

How is consistency of information / assessments ensured?	A template (designed by the national co-commissioning team) will be used to collect the data from each CCG. Local operational teams will discuss with the CCG where there is missing data or insufficient detail.

50. Effectiveness of working relationships in the local system (164a)	
Category, Sub-Category	Leadership and workforce
Definition	This indicator is a revision to the previous one which used the CCG 360° stakeholder survey as the data source, and it complements the quality of leadership indicator (ref: 51, 165a). The revised local relationships indicator is an assessment of a CCG’s working relationships with statutory bodies within its STP/ICS. It is an evidence-based judgement made by regional teams, informed by a survey of Health and Wellbeing Boards (HWBs) and other relevant local intelligence. NOTE: CCGs’ working relationships with patients and the public (including Healthwatch, patient groups and voluntary sector organisations) are assessed separately under the patient and community engagement indicator (ref: 50, 166a). CCGs’ working relationships with their GP member practices are separately assessed as part of the quality of leadership indicator (ref: 51, 165a).
Purpose (Rationale)	To identify the strength of CCGs’ partnerships with the statutory bodies within their local system, and where improvement and support may be necessary.
Evidence and policy base	Delivery of the NHS Long Term Plan is dependent on strong system working and streamlined commissioning.
Process of assessment	Regional teams will make a judgement in one of four categories (‘outstanding’/‘good’/’’requires improvement’/’inadequate’) in relation to the following statement**: ‘The CCG leadership actively promotes and develops strong and collaborative partnerships across the STP/ICS (system), at every level, for example in their contribution to Health and Wellbeing Boards and primary care networks, to seek to ensure that its population is getting the best health and care outcomes.’** Evidence to inform the assessment by regional teams should be taken from the ratings and comments from the survey by NHS England regional teams of HWBs. This survey will be designed to fulfil NHS England’s legal duty under section 14Z16 of the Health and Social Care Act 2012 to consult with each HWB *‘as to its views on the clinical commissioning group’s contribution to the delivery of any joint health and wellbeing strategy to which the group was required to have regard’*. In the survey, HWBs will be asked to rate each CCG’s contribution as either ‘outstanding’, ‘good’, ‘requires improvement’ or ‘inadequate’. They will also be asked to provide comments. Note: in the event of non-response by a HWB, their rating of the CCG will default to ‘inadequate.’ Regional teams will use the HWB rating and comments, plus any other relevant local intelligence, to substantiate

	their own assessment of each CCG's local relationships. In addition to HWBs, they will need to consider the views of each of the following key groups of stakeholders: • upper tier / unitary local authority/ies • NHS providers • other CCGs. So, whilst the regional team **must** take account of the HWB rating and comments in the HWB survey, there is the potential for their overall judgement to result in a significantly different rating, if they can show evidence as to why they have a different view to the HWB. The following sources in addition to the HWB survey may provide relevant evidence to inform the regional team's own assessment:- - the CCG's own documents such as board papers and annual report. - STP/ICS documentation detailing the contribution of individual CCGs. - information from the risk-based reviews of CCGs by regional teams (which inform the wider quality of leadership assessment). • An 'outstanding' rating would be given when the CCG demonstrates excellent and exemplary engagement practice with other statutory bodies within its STP/ICS. • A 'good' rating would be where a CCG has demonstrably strong working relationships with its partners. • A 'requires improvement' rating would apply where there are some weaknesses identified. • An 'inadequate' rating would be given where the CCG is judged to be failing to develop effective working relationships, e.g. repeated non-attendance at partnership meetings.
What will the published rating be?	The published rating for this indicator will be outstanding/good/requires improvement/inadequate, **as assessed by the regional team**.
Frequency of publication	Annually.
How is consistency of information / assessments ensured?	A common template for presenting the information in relation to this indicator will be supplied by the national assessment team to regional teams. There will be consistency checking of a sample of regional assessments by the national assessment team and regional directors will be asked to sign off the assessments for this indicator for all the CCGs within their region.

51. Compliance with statutory guidance on patient and public participation in commissioning health and care (166a)	
Category, Sub-Category	Leadership and workforce
Summary	This indicator aims to evidence CCGs' implementation of the revised statutory guidance on patient and public participation in commissioning health care and their compliance in fulfilling statutory duties.
Detailed description of indicator	This indicator is based on assessing 10 'key actions' outlined in the revised 'Patient and public participation in commissioning health care: Statutory guidance for clinical commissioning groups and NHS England' (published in April 2017), which enable CCGs to demonstrate they meet their statutory duties The 10 'Key actions' for CCGs and NHS England on how to embed involvement in their work are: 1. Involve the public in governance 2. Explain public involvement in commissioning plans 3. Demonstrate public involvement in Annual Reports 4. Promote and publicise public involvement 5. Assess, plan and take action to involve 6. Feedback and Evaluate 7. Implement assurance and improvement systems 8. Advance equality and reduce health inequality 9. Provide support for effective engagement 10. Hold providers to account Each CCG has been assessed based on their Annual Report and other public information where available online, including Constitution, Governing Body meeting records, involvement webpages, engagement plan, relevant reports. An assessment template, agreed by the Public Participation Working Group which was established in 2017, defines criteria closely linked with the 'key actions' and grouped under 5 domains: A. Governance; B. Annual Reporting; C. Practice; D. Feedback and Evaluation; E. Equalities and health inequalities. The scoring process for each domain assesses the CCG as meeting or not meeting individual criterion, and then as 'Inadequate', 'Requires Improvement', 'Good' or 'Outstanding' for each domain. Ratings from the 5 domains are taken to give an overall score out of 15 and a RAGG* rating for the CCG. The 2018/19 evidence submission approach will continue for 2019/20 and will be followed by a national assessment process. Adjustments will be made to the submission

	process to reflect CCGs that will merge as of 1st April 2020 to ensure the process best supports improvement across the system. Further guidance setting out full requirements for submission will be issued later this year.This assessment is intended to be useful for service improvement and is therefore also reported separately to each CCG along with improvement guidance – see process description below.
Rationale for use and what it intends to achieve	CCGs need to demonstrate public and patient participation in commissioning health care. Under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), CCGs have duties to involve the public in commissioning, section 14Z2. NHS England issues statutory guidance in respect of this duty, to which CCGs must have “due regard”. The NHS Constitution enshrines public ownership of the NHS as a fundamental value: ‘The NHS belongs to the people. It is there to improve our health and wellbeing, supporting us to keep mentally and physically well, to get better when we are ill, and when we cannot fully recover, to stay as well as we can to the end of our lives.’ The NHS is accountable to the public and must therefore be subject to a degree of public scrutiny and control. Successful health and care transformation depends on the engagement of patients and communities. Building on the Constitution, the Five Year Forward View sets out a vision for growing public involvement: ‘One of the great strengths of this country is that we have an NHS that – at its best – is ‘of the people, by the people and for the people…we need to engage with communities and citizens in new ways, involving them directly in decisions about the future of health and care services.’ The indicator aims to evidence CCGs implementation of the revised statutory guidance on Transforming Participation in Health and Care and the impact public involvement has had on the development of their business. It is complemented by a range of improvement support activities. The 2018/19 evidence submission approach will continue for 2019/20 and will be followed by a national assessment process. Adjustments will be made to the submission process to reflect CCGs that will merge as of 1st April 2020.

	Further guidance setting out full requirements for the 2019/20 submission process will be issued later this year. Any subsequent updates to statutory guidance) will be reflected in the indicator as appropriate
Process of assessment	This section describes the actual process for 2018/19 and the anticipated process for 2019/20 subject to review. For 2019/20 the assessment will continue to involve CCGs actively in an ‘evidence and submission’ process to promote and support improvement. It is anticipated that the process for 2019/20 will remain largely the same as for 2018/19 subject to minor improvements. **Step 1 – evidence and submission process** CCGs will be provided with an evidence submission template through which they will direct assessors to the best evidence for each criterion. This will form the basis of the assessment outlined in stage 2. This process will be reviewed to reflect and take into consideration CCGs that working towards a formal merger from April 2020. **Step 2 – desktop assessment:** Assessors from the NHS England Public Participation Team review information from CCG websites (provided by CCGs in the evidence submissions template) that demonstrates how they comply with their statutory responsibilities and the related ‘ten key actions’. Full guidance will be provided about the types of evidence that will be considered. The collected information is reviewed against the assessment framework, consisting of 49 criteria (see Annex 2), agreed by the Public Participation Working Group and linked to the statutory duties and ‘key actions’. Criteria are grouped under the following 5 domains: Domain A: Governance 1: Involve the public in governance 7: Implement assurance and improvement systems 10: Hold providers to account Domain B: Annual Reporting 3. Demonstrate public involvement in Annual Reports Domain C: Practice 2: Explain public involvement in commissioning plans 4: Promote and publicise public involvement 5: Assess, plan and take action to involve

9: Provide support for effective engagement

Domain D: Feedback and Evaluation
6: Feedback and Evaluate

Domain E: Equalities and Health Inequalities
8: Advance equality and reduce health inequality

In summary, the scoring process for each domain assesses the CCG as meeting or not meeting individual criteria, and then as ‘Inadequate’, ‘Requires Improvement’, ‘Good’ or ‘Outstanding’ for each domain. Ratings from the 5 ‘domains’ are taken to give an overall score out of 15 and a RAG rating for the CCG.

The detailed scoring process is as follows. The assessor reviews the available evidence against each criterion in the ‘good’ category. In order to achieve ‘good’ the CCG needs to meet a minimum number of criteria for the domain, as follows:

Domain A = 3 criteria met of 4
Domain B = 4 criteria met of 5
Domain C = 5 criteria met of 7
Domain D = 3 criteria met of 3
Domain E = 3 criteria met of 4

If a CCG does not meet ‘good’ for the domain it is rated either as ‘requires improvement’ subject to meeting the necessary criteria, or as ‘inadequate’.

In order to achieve ‘outstanding’ the CCG needs first to achieve the ‘good’ rating for that domain, then to meet a minimum number of criteria in the ‘outstanding’ category (in addition to having met good) as follows:

Domain A = 3 criteria met of 4
Domain B = 1 criteria met of 1
Domain C = 3 criteria met of 4
Domain D = 3 criteria met of 3
Domain E = 3 criteria met of 3

Ratings across each domain are scored as follows (0 = Inadequate, 1 = Requires Improvement, 2 = Good, 3 = Outstanding). These scores are totalled to reach a maximum score of 15. RAG ratings are determined using the following bandings 0-4 = RED, 5-9 = AMBER, 10-13= GREEN, 14-15 = GREEN STAR. If a CCG scores ‘inadequate’ in any category it is not possible to achieve above an AMBER rating. If a CCG achieves two or more ‘requires improvement’ it is not possible to achieve more than an AMBER rating.

	Any CCG that is newly formed as of 1st April 2019 will not be assessed for Domain B (Annual Report) and scoring formulae will be adjusted accordingly. **Step 3 – focus on improvement:** RAG rating and summary scores are provided for each CCG along with highlighted areas for improvement. The NHS England Participation Team will continue to provide tools and resources, and working with regional colleagues, to support CCG improvement against the key actions and this assessment framework. **Step 4 – publication:** Final assessment findings for 2019-20 will be shared with CCGs prior to national publication.
What is the published rating? Is contextual information required?	The final score (out of 15) and RAGG* rating will be published. CCGs will be provided with some narrative analysis of their assessment highlighting areas for improvement.
Frequency of assessment/publication	Annually
How is consistency of information / assessments ensured?	Consistency is ensured through use of a standard template (see Annex 2); guidance and training for assessors; moderation with input from internal and external partners.

Annex 3: Framework for indicator 51 (166a): CCG compliance with statutory guidance standards of patient and public participation in commissioning health and care

Domain A	**Domain B**	**Domain C**	**Domain D**	**Domain E**
1: Involve the public in governance 7: Implement assurance and improvement systems 10: Hold providers to account	3. Demonstrate public involvement in Annual Reports	2. Explain public involvement in commissioning plans 4. Promote and publicise public involvement 5. Assess, plan and take action to involve 9. Provide support for effective engagement	6. Feedback and Evaluate	8. Advance equality and reduce health inequality
Inadequate	**Inadequate**	**Inadequate**	**Inadequate**	**Inadequate**
No evidence to explain how the CCG involves the public in governance and how it is assured in relation to public involvement, or inadequate evidence that does not meet the standard for ‘requires improvement’.	Annual Report has no reference to patient and public involvement for the relevant year, or inadequate reference that does not meet the standard for ‘requires improvement’.	No information about public involvement and how this is promoted and supported in the CCG, or inadequate evidence that does not meet the standard for ‘requires improvement’.	No reference to how the CCG has fed back to the public about public involvement and the difference it has made, or inadequate reference that does not meet the standard for ‘requires improvement’.	No reference to equalities and/or health inequalities in relation to the CCG's participation activity, or inadequate reference that does not meet the standard for ‘requires improvement’.
Requires improvement	**Requires Improvement**	**Requires improvement**	**Requires improvement**	**Requires improvement**
The constitution and/or cross referenced strategy/policy provides only a brief and/or generic outline of the CCG’s arrangements for public involvement, which does not meet the standard for ‘good’.	The Annual Report has a limited description of public involvement activity, which does not meet the standard for ‘good’.	Only limited evidence about how the public are, and can be, involved and how the CCG promotes and supports this involvement, which does not meet the standard for ‘good’.	Only limited information about the difference that public involvement has made, which does not meet the standard for ‘good’.	Only limited information about how the CCG has considered equalities/health inequalities with regards to planning, targeting and undertaking public involvement, which does not meet the standard for ‘good’.
Good	**Good**	**Good**	**Good**	**Good**
The constitution, cross referenced strategy/policy and/or website describe: a) The key ways it involves the public in governance	Includes a detailed description of what public involvement activity has taken place (for example in planning, governance, reviewing, procurement, policy development).	Information about how to get involved is available in a range of formats (online, paper, telephone, social media etc) and easy to access.	The CCG website, and/or relevant published documents, have good information outlining public involvement activity and the difference it has made.	Evidence that the CCG understands its population and has identified those who may be least likely to be heard, or experience the worst health outcomes.
b) A statement of the principles it will follow in involving the public	Describes the difference public involvement has made.	There is information about different ways that people can get involved and influence the work of the CCG (for example through consultations, engagement meetings or roles on groups).	The CCG tells patients and the public, including those who have been involved, about the difference their involvement has made.	A range of inclusive approaches and methods of engagement are used to meet the needs of the community (including those protected by a characteristic under the Equalities Act 2010 and those affected by health and social

				inequalities) and are promoted through diverse community channels.
Public parts of Governing Body meetings and relevant papers are easily accessible to the public	Provides information about who has been engaged.	Public documents are written in plain English and produced in appropriate formats for the community	The CCG reviews its involvement activity, including how effective it has been, and takes action in response to what it has learnt.	The CCG demonstrates how it has worked with partners to enhance engagement, particularly with those who experience the worst health outcomes
Evidence of involvement of members of the public and/or their representatives in decision making committees and groups in the CCG	Demonstrates how networks, for example with the VCSE or patient groups, have influenced the CCG.	The CCG has published information outlining how it will involve the public across its business and decision making, outlining the range of appropriate methods they will use to engage with different groups, for example through a policy or strategy.		Public facing communications are accessible to local communities, for example in accessible formats and using a range of methods.
	Is accessible and appealing (see page 8-9 of the Annual Reporting Guidance)	The CCG uses a range of different appropriate participation methods to involve people across its business.		
		Evidence that a range of partners, for example patient groups and the VCSE, have been involved in developing and implementing CCG plans for commissioning.		
		Information about how the CCG supports members of the public who are involved (for example through training).		
Outstanding	**Outstanding**	**Outstanding**	**Outstanding**	**Outstanding**
The constitution, associated engagement policy/strategy and/or other relevant documents provide a clear vision for, and commitment to, patient and public involvement.	The Annual Report fully meets the requirements set out in the Guide to Reporting on the Legal Duty for Public Involvement	The CCG used a range of targeted outreach approaches, including working with the voluntary and community sector, to promote opportunities and broaden engagement to be more reflective of the population (for example seeking the views of children and young people, or other groups)	Feedback is communicated using creative and diverse methods.	There is clear evidence that the CCG considers equalities and health inequalities when planning and implementing its approach to public involvement.
Evidence that the Governing Body is assured about public involvement activity		The CCG has published information about providing information in	The CCG seeks the views of patients and the public, and their representatives,	Demographic monitoring is in place for public involvement and is

and the difference it has made.		accessible formats and assistance for those who require communications or other support to enable them to engage.	about their approach to public involvement.	used to inform improvement
Public involvement partners (for example members of the public or their representatives) are involved in assuring the CCG in relation to public involvement.		The CCG provides support for staff and members of the public and their representative on public involvement.	Clear evidence of the difference that public involvement has made to commissioning, decision making and/or services.	There is a link between the the CCGs approach or strategy for public involvement and EDS2.
The CCG reviews public involvement activity across its providers and takes action in response.		Plans for engagement are embedded and clearly evidenced throughout commissioning, operational or other published plans, demonstrating how the public have been or will be involved		

52. Primary care workforce (128d)	
Category, Sub-Category	Leadership and workforce
Definition	Number of GPs and practice nurses (full-time equivalent) per 1,000 weighted patients by CCG
Purpose (Rationale)	To provide a starting point for a conversation about whether GP services in the CCG have the appropriate workforce.
Evidence and policy base	This indicator specifically relates to objective 6 of the government's mandate to the NHS for 2016/17: To improve out-of-hospital care. This requires more services provided out of hospitals, a larger primary care workforce and greater integration with social care, so that care is more joined up to meet people's physical health, mental health and social care needs. NHS England is expected to ensure everyone has easier and more convenient access to GP services, including appointments at evenings and weekends where this is more convenient for them, and effective access to urgent care 24 hours a day, seven days a week. This workforce indicator will support measurement of the larger primary care workforce element of the mandate. A similar indicator is included in MyNHS (but using actual instead of weighted population figures)
Data	
Data source	The counts of GPs, nurses and other clinical staff are from the workforce Minimum Data Set, wMDS. Data from the wMDS are published quarterly by NHS Digital as "General and Personal Medical Services" data. Every other publication contains the detailed information required for this indicator. At time of writing, the most recent such publication, for September 2017, can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/general-and-personal-medical-services Monthly weighted patient data for GMS and PMS practices is sourced directly from NHAIS (NHS DIGITAL). Weighted patient data for APMS practices is sourced from the NHSD Payments to General Practice data series (https://digital.nhs.uk/data-and-information/publications/statistical/nhs-payments-to-general-practice).
Data fields	**Numerator:** Publication - General and Personal Medical Services, England - Experimental statistics Source - Excel file, Detailed Tables (2c, 12c, 18c)

	Data fields - All Practitioners; All Nurses; All Direct Patient Care **Denominator (Weighted patient data):** Publication - Technical Guide to determination of revenue allocations to CCGs and commissioning areas for 2016-17 to 2020-21 Source - Excel file, K1 – Primary Care (Medical) Data field - Normalised to GP practice registrations **Denominator (Weighted patient data – GMS & PMS practices):** Publication - NHAIS monthly data extract provided directly by NHS Digital Source - Excel file Data field – 'Number of Weighted Patients'. (Normalised to GP practice registrations). **Denominator (Weighted patient data – APMS practices):** Publication – NHS Payment to General Practice, England, 2016/17 Source - Excel file, Table 2 : NHS Payments to General Practices in England for 2016/17 by Individual General Practice Data field – 'Number of Weighted Patients (Last Known Figure)'. (Normalised to GP practice registrations).
Data filters	None
Data processing	Please note: The methodology for this indicator was updated in July 2018 (2018/19) NHS Oversight Framework publication.
Construction	
Numerator	Sum of 'All Practitioners'; 'All Nurses'; 'All Direct Patient Care' in the CCG. The NHS Digital publication includes data fields pre–aggregated to: 1. Full-time equivalent GPs ('All Practitioners') including GP Providers, Salaried/Other GPs, Registrars, Retainers, Locums and Not Stated 2. Full-time equivalent nurses ('All Nurses') including Practice Nurses, Practice Nurse Partners, Advanced Nurse Practitioners, Extended Role Practice Nurses, Nurse Specialists, District Nurses and Not Stated 3. Full-time equivalent direct patient care staff ('All Direct Patient Care') including Health Care Assistants, Dispensers, Phlebotomists, Pharmacists, Podiatrists, Physiotherapists, Therapists, Physician Associates, Direct Patient Care – Other, Not Stated
Denominator	Number of weighted patients (most recent at time of census).

	The number of weighted patients is as calculated by the NHS England allocation formula for primary medical care services; it is the sum of ‘Normalised to GP practice registrations’. The allocations data are based on registered patients’ data. Weighted patient counts for GMS and PMS practices are added to the separately sourced counts for APMS practices, filtered for open and currently active practices.
Computation	This indicator is the Number of GP, Nurse and Direct Patient Care Staff FTE per 1,000 weighted patients. The calculation is: $w = \frac{f}{p} \times 1000$ where: w is the number of FTE GPs, Nurses and Direct Patient Care Staff per 1,000 patients in a CCG; f is the total number of FTE GPs, Nurses and Direct Patient Care Staff in a CCG; p is the total number of weighted patients in the CCG.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Biannually (six-monthly)

53. Staff engagement index (163a)	
Category, Sub-Category	Leadership and workforce
Definition	This metric represents the overall level of staff engagement in the area covered by the CCG. It is calculated using engagement scores by provider from the NHS staff survey, which are mapped to CCG based on financial flows.
Purpose (Rationale)	To signal the expectation that CCGs demonstrate leadership across the organisations in their part of the NHS. One part of this leadership role will be in encouraging the growth of organisational cultures in which the workforce is highly engaged. The composite indicator of workforce engagement will show the extent of progress in good engagement across the patch which will inform discussions between the CCGs and their provider organisations on how further progress can be made.
Evidence and policy base	The link between good leadership and quality patient outcomes is increasingly understood. The NHS Leadership Academy, for instance, say “there’s so much evidence connecting better leadership to better patient care, Francis, Berwick, Keogh point to it and so does leading academic, Michael West . They all make the link between good leadership and making a positive difference to patient care, care outcomes and the experience of care”. A variety of research reports have demonstrated clear links between levels of engagement (a mixture of how motivated staff are, how much they are able to suggest and implement improvements, and how prepared they are to speak positively about their organisation) and a range of outcomes for trusts, including patient satisfaction, patient mortality, trust performance ratings, staff absenteeism and turnover. The more engaged a workforce is, the better the outcomes for patients; the difference between an average and good trust on engagement would be equivalent to around a 5% decrease in absenteeism or turnover, or about a 4% decrease in mortality. Engagement has been steadily increasing as shown by the results of the NHS staff survey. The role of CCGs in System Leadership is developing. NHS England’s website refers to “Support and development opportunities for CCGs (and HWBs) in 2014/15. “… NHS England has been working with the LGA, PHE and other national partners on the Health and Wellbeing System Improvement Programme and support for System Leadership development. A wide-range of development opportunities are available to CCGs and their local partners, and NHS England have worked to maximise the alignment to CCG development needs, in their role as statutory partners on health and wellbeing boards and local system leaders”. A recognition of this role is, for instance,

	demonstrated by The Advancing Quality Alliance (AQuA) whose CCG Systems leadership event in November 2015 had an agenda including “the role of CCGs as system leaders … how to create collective vision, shared purpose and engagement …” Detailed information of current levels of engagement is contained in the results of the NHS staff survey: http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/
Data	
Data source	• NHS Staff Survey – engagement index: https://www.england.nhs.uk/statistics/2015/02/24/the-2014-nhs-staff-survey-in-england/ • NHS financial flows (unpublished, but the spend used for each CCG can be shared with the relevant CCG). • NHS provider staff numbers – used in confidence grading: http://www.content.digital.nhs.uk/catalogue/PUB23277
Data fields	Engagement index by provider, financial flows matrix is simply a matrix detailing spend by CCG to each trust.
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	See computation
Denominator	See computation
Computation	For each provider the engagement index is calculated by the NHS staff survey. The CCG score is then calculated as the weighted average of the provider scores, weights are total CCG spend with the provider(s). The engagement index is calculated from three key findings each made up of a number of questions. These are detailed below. • Staff recommendation of the organisation as a place to work or receive treatment: ○ Care of patients/service users is my organisation’s top priority. ○ I would recommend my organisation as a place to work. ○ If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation. • Staff motivation at work: ○ I look forward to going to work. ○ I am enthusiastic when I am working.

	o Time passes quickly when I am working. • Staff ability to contribute towards improvement at work: o I am able to make suggestions to improve the work of my team/department. o There are frequent opportunities for me to show initiative in my role. o I am able to make improvement happen in my area of work. For exact details of the computation see the ‘Making sense of your staff survey data’ document, available here http://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2017/
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

54. Progress against the Workforce Race Equality Standard (163b)	
Category, Sub-Category	Leadership and workforce
Definition	For the NHS Oversight Framework indicator 163b we use the NHS staff survey indicator that shows the strongest, most consistent evidence of discriminatory treatment of BME staff when compared to white staff. This is KF 21: "Percentage believing that their trust provides equal opportunities for career progression or promotion." In turn, WRES Indicator 7 is aligned to staff survey indicator KF21. Therefore, NHS Oversight Framework indicator 163b (local providers' progress against the WRES) aims to represent where the 'patch' of each CCG is up to in terms of the WRES. Currently, NHS Oversight Framework 163b is made up of a weighted average of trust level scores for WRES indicator 7. Weights are given by the spend of the CCG on each of its providers and trust level scores are given by the sum of the staff survey indicators (KF 21).
Purpose (Rationale)	To signal the expectation that CCGs demonstrate leadership across the organisations in their part of the NHS. One part of this leadership role will be to demonstrate a commitment to equality, including race equality. CCGs will need to: – demonstrate their use of the Workforce Race Equality Standard within their own organisations; and – expect providers within their footprint to do the same. The latter should include providers' publication of their annual WRES data and associated action plan on their respective websites. The composite indicator of workforce race equality will show the extent of progress towards race equality across the patch. This will inform discussions between CCGs and their providers around how further progress can be made in race equality and more widely across other dimensions of equality.
Evidence and policy base	The link between good leadership and quality patient outcomes is increasingly understood. The NHS Leadership Academy, for instance, say "there's so much evidence connecting better leadership to better patient care, Francis, Berwick, Keogh point to it and so does leading academic, Michael West . They all make the link between good leadership and making a positive difference to patient care, care outcomes and the experience of care". This, in part, is the rationale behind the Workforce Race Equality Standard.

The NHS Staff Survey results and the Patient Survey results suggest that “the experience of Black and Minority Ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS. Put simply, if BME staff feel engaged, motivated, valued and part of a team with a sense of belonging, patients were more likely to be satisfied with the service they received. Conversely, the greater the proportion of staff from a BME background who reported experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction.”

Discrimination is reported at exceptionally high levels by several minority groups, particularly Black staff, Muslim staff, disabled staff and non-heterosexual staff, even when controlling for all other demographic and work-related factors. In addition the more a workforce is representative of the local community in terms of ethnicity, the more patients report being treated with civility, and the better the outcomes for the trust. This suggests that focussing on civil treatment may be an important driver of performance, particularly where staff ethnicity is not similar to that of patients. By measuring discrimination and incivility experienced by the BME staff employed by their providers, CCGs can assess the likely care their BME patients receive.

The role of CCGs in System Leadership is developing. NHS England’s website refers to “Support and development opportunities for CCGs (and HWBs) in 2014/15. “… NHS England has been working with the LGA, PHE and other national partners on the Health and Wellbeing System Improvement Programme and support for System Leadership development. A wide-range of development opportunities are available to CCGs and their local partners, and work has been done to maximise the alignment to CCG development needs, in their role as statutory partners on health and wellbeing boards and local system leaders”. A recognition of this role is, for instance, demonstrated by The Advancing Quality Alliance (AQuA) whose CCG Systems leadership event in November 20156 had an agenda including “the role of CCGs as system leaders … how to create collective vision, shared purpose and engagement …”

Detailed information of current levels of inequality is contained in the results of the NHS staff survey. (http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/2015-Results/)

	Patients First and Foremost - The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry, Presented to Parliament by the Secretary of State for Health by Command of Her Majesty, March 2013 A promise to learn – a commitment to act. Improving the Safety of Patients in England. National Advisory Group on the Safety of Patients in England, August 2013 The Keogh Mortality Review, Review Reports. NHS Choices, July 2013 http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/terms-of-reference.aspx Employee engagement and NHS performance, Michael A West, Lancaster University, Jeremy F Dawson, University of Sheffield. Work commissioned by Kings Fund, 2012 West, M et al 2012 NHS Staff Management and Health Quality Results from the NHS staff survey and related data.
Data	
Data source	1. NHS Staff Survey, KF 21: “Percentage believing that their trust provides equal opportunities for career progression or promotion”. 2. The above split into BME and White respondent groups – aligned to the Workforce Race Equality Standard, indicator 7 (“Percentage believing that their trust provides equal opportunities for career progression or promotion”) https://www.england.nhs.uk/statistics/2015/02/24/the-2014-nhs-staff-survey-in-england/ 3. NHS financial flows (unpublished, but the spend used for each CCG can be shared with the relevant CCG). 4. NHS provider staff numbers – used in confidence grading. http://www.content.digital.nhs.uk/catalogue/PUB23277
Data fields	Items as above, restricted by ethnicity of responders into BME and White, financial flows matrix is simply a matrix detailing spend by CCG to each trust.
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	See computation
Denominator	See computation

Computation	For each provider, the WRES score is calculated as the sum of the difference between the BME and White WRES key findings (NHS Staff Survey KF 21). The CCG score is then calculated as the weighted average of the provider scores: weights are total CCG spend with the provider(s). Where a provider has a missing score for BME responses due to small numbers, all the scores for that provider are treated as missing. The degree of missing data is reported in the confidence grade. Independent sector healthcare providers do not undertake the NHS Staff Survey and will present data based upon an equivalent to the KF 21 question as used within their own version of the NHS Staff Survey.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Annually

Finance and use of resources

55 In-year financial performance
56 Delivery of the mental health investment standard
57 CYP and Eating Disorders investment as a percentage of total mental health spend
58 Expenditure in areas with identified scope for improvement
59 Children and young people’s mental health services transformation
60 Reducing the rate of low priority prescribing

<table>
<tr><th colspan="2">55. In-year financial performance (141b)</th></tr>
<tr><td>Category, Sub-Category</td><td>Finance and use of resources</td></tr>
<tr><td>Summary</td><td>The indicator assesses whether the CCG’s actual and forecast financial performance is good.</td></tr>
<tr><td>Detailed description of indicator</td><td>The in-year financial performance indicator is based on the CCG’s financial performance in the year. In-year financial performance is assessed on a quarterly basis using the forecast outturn financial position alongside other criterion as shown below.

Please note, if a CCG is in receipt of CSF, the pre- CSF control total will be used for NHS Oversight Framework assessment.

The RAG rating will be assigned as follows:

<table>
<tr><th>GREEN</th><th>AMBER</th><th>RED</th></tr>
<tr><td>The CCG does not trigger any of the criteria that would result in a Red or Amber rating.</td><td>CCG does not meet any of the red criteria but meets <i>one or more</i> of the following:

• Is in receipt of CSF funding
• YTD variance between 0.1% and 2% away from control total
• Net risk above 1% and less than 2% of planned spend
• YTD QIPP less than 85% of plan
• Forecast QIPP less than 85% of plan
• MHIS classified as red.
• Running costs forecast is greater than running cost allocation for the year</td><td>The CCG is reporting <i>any</i> of the following:

• forecasting surplus below control total for the year or actual surplus below control total at the end of the year
• YTD financial performance more than 2% away from control total
• Net risk greater than 2% of planned spend
• Forecast QIPP less than 65% of plan or actual QIPP outturn less than 65% at the end of the year

There may be other indicators of significant financial distress such as material long-</td></tr>
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</td></tr>
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<table>
<tr><td></td><td><table><tr><td></td><td></td><td>standing disputes with providers or being in turnaround.</td></tr></table>
In exceptional circumstances where a CCG has failed to meet its financial duties due to factors that are truly beyond its control, this may be considered in assigning the assurance rating. CCGs may have their rating lowered where local information indicates that reported performance may not reflect the true position.
Following the closure of the CCGs accounts, ISA 260s will be analysed and audit comments will be considered and may impact on the overall final finance rating.</td></tr>
<tr><td>Rationale for use and what it intends to achieve</td><td>This is intended to give an indication of whether individual CCGs are meeting control totals and other financial targets.

Improvement against the In-year financial performance indicator will be possible quarterly if confidence in achievement of in-year control total increases.</td></tr>
<tr><td>Process of assessment</td><td>The indicator will be based on:
• Quarterly in-year financial performance; and
• An element of judgement by Regional teams with national moderation.

In-year financial performance is collected as part of monthly financial reporting processes.

The assessment is made formulaically using the CCG’s reported position with moderation by the Regional teams.

The Director of Financial Planning and Delivery will oversee the moderation process and ensure consistency across regions.</td></tr>
<tr><td>What is the published rating?</td><td>Red, amber or green rating.</td></tr>
<tr><td>Is contextual information required?</td><td>Contextual information is not required.</td></tr>
<tr><td>Frequency of assessment</td><td>The in-year financial performance indicator will be assessed quarterly after reporting of the CCG’s quarterly financial position and will therefore be available approximately two months after the end of each quarter.</td></tr>
<tr><td>How is consistency of information / assessments ensured?</td><td>The indicator is largely based on the reported financial information, but there are limited subjective judgements.

Where judgements are made by Regional teams:
• Regional teams will ensure consistency within their regions; and
• The Director of Financial Planning and Delivery will ensure consistency across regions.</td></tr>
</table>

56. Delivery of the mental health investment standard (123i)	
Category, Sub-Category	Finance and use of resources
Definition	The Mental Health Investment Standard (MHIS) is the requirement for CCGs to increase investment in mental health services [excluding Learning Disabilities and Dementia] in line with their overall increase in programme allocation each year. It is no longer acceptable for CCGs to plan to fail the MHIS.
Purpose (Rationale)	To ensure that investment in Mental Health services by CCGs is (at least) the same levels as all Programme areas.
Evidence and policy base	Delivery of the Five Year Forward View for Mental Health is underpinned by significant additional funding. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement to increase that baseline by at least the overall growth in allocations. Additional funding should not be seen in isolation and should not be used to supplant existing spend or balance reductions elsewhere. NHS England has committed to increasing the proportion of NHS spend on mental health, and has developed the MHIS to track whether this is being delivered. In simple terms the MHIS compares the growth of CCG spend on mental health with the growth of a CCG's allocation. The increase in mental health spend should be at least equal or greater in percentage terms to the overall percentage growth in allocation
Data	
Data source	Annual Plan returns completed by CCGs; Quarterly Non ISFE returns completed by CCGs.
Data fields	Not applicable
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	<u>Quarterly in-year monitoring:</u> Forecast total Mental Health spend (all categories excluding Learning Disabilities and Dementia).
Denominator	<u>Quarterly in-year monitoring:</u> Actual outturn total Mental Health spend (all categories excluding Learning Disabilities and Dementia) at the end of the previous financial year.
Computation	Calculate (Numerator/Denominator) and express as a percentage. This is the growth in MH spend.

	Compare the growth in MH spend percentage with the percentage growth in the CCG's overall Programme Allocation, as reported in the CCG's Annual Plan. The MHIS is achieved if the growth in MH spend percentage is equal to or exceeds the percentage growth in the CCG's overall Programme Allocation. CCGs will be allocated either a Red or Green rating depending on the outcome of the above computation.
Risk adjustment or standardisation type and methodology	Not applicable
Output	
Frequency of publication	Quarterly

57. CYP and CYP eating disorders investment as a percentage of total mental health spend (123k)

Domain, Area	CYP, Mental health
Definition	The indicator compares two calculations: “Children and Young People (CYP) and CYP Eating Disorder (ED) spend per the previous year’s outturn as a percentage of previous year’s total mental health spend” and the “Planned CYP and CYP ED spend as a percentage of planned total mental health spend”. The outturn percentage calculation is deducted from the Plan percentage calculation and the result should be zero or a positive figure, to demonstrate that investment in CYP and CYP ED is the same or increasing as a proportion of total mental health spend.
Publication status	
Purpose (Rationale)	To ensure that investment in CYP and CYP Eating Disorders (ED) is the same or increasing as a proportion of total mental health spend.
Evidence and policy base	Delivery of the Five Year Forward View for Mental Health and the Long Term Plan ambitions to improve outcomes for children and young people with mental health problems by improving access to high quality services continues to be underpinned by significant additional funding. This new money builds on both the foundation of existing local investment in mental health services and the ongoing requirement to increase that baseline by at least the overall growth in allocations. Additional funding for CYP and CYP ED should not be seen in isolation and should not be used to supplant existing spend or balance reductions elsewhere. NHS England has committed to increasing the investment in CYP and CYP ED as a proportion of total mental health spend.
Data	
Data source	Annual Plan returns completed by CCGS; Quarterly Non ISFE returns completed by CCGs.
Data fields	Not applicable
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	Quarterly In-year monitoring a) Previous year’s outturn spend for CYP and CYP ED b) Plan spend for CYP and CYP ED

Denominator	Quarterly In-year monitoring a) Previous year’s total mental health spend b) Plan total mental health spend
Computation	Calculation a) Numerator / Denominator as a percentage Calculation b) Numerator / Denominator as a percentage Deduct calculation a) from calculation b). Result should be zero or positive to demonstrate that investment in CYP and CYP ED is the same or increasing as a proportion of total mental health spend.
Risk adjustment or standardisation type and methodology	Not applicable
Output	
Frequency of publication	Quarterly

58. Expenditure in areas with identified scope for improvement (145a)	
Category, Sub-Category	Finance and use of resources
Definition	Reduction in growth in activity in programmes where there exist opportunities to improve outcomes and reduce activity
Purpose (Rationale)	To encourage CCGs to reduce activity in programmes where there exist opportunities to improve outcomes and reduce expenditure
Evidence and policy base	The RightCare programme key objective is to ensure improvements in value for money and allocative efficiency. The RightCare Intelligence packs are a key part of the programme and identify programmes and specific indicators where CCGs need to improve compared to their ten most similar CCGs in terms of population characteristics. These indicators encompass expenditure and outcomes and have been developed with stakeholders from across the health and care system.
Data	
Data source	SUS
Data fields	As required, dependent on programmes chosen.
Data filters	Not applicable
Data processing	Not applicable
Construction	
Numerator	Not applicable – the indicator is not a rate
Denominator	Not applicable – the indicator is not a rate
Computation	CCGs select healthcare programmes (such as Respiratory or Cancer) that they will prioritise and submit Delivery Plans setting out the interventions and improvements they will deliver. This indicator calculates growth in activity for selected programmes compared to growth in activity in the baseline period. The difference in growth in activity compared to baseline is then compared to the equivalent figure for CCGs which have not selected these programmes as a priority / submitted Delivery Plans for these programmes. The indicator calculation is therefore the percentage points difference compared to non-priority CCGs. Example; CCG A has selected MSK and Respiratory, and submitted Delivery Plans. Average annual activity growth from 2013/14 to 2015/16 across these two programmes = 3.0%

	Average annual activity growth from 2015/16 onwards across these two programmes = 1.0% Improvement in CCG A = 2.0% For all CCGs that have not selected these programmes and submitted Delivery Plans; Average annual activity growth from 2013/14 to 2015/16 across these two programmes = 3.0% Average annual activity growth from 2015/16 onwards across these two programmes = 1.5% Improvement in non-priority CCGs = 1.5% Indicator score for CCG A = 0.5% points improvement compared to non-priority CCGs The measure will then be directly scored with a rating of Red, Amber or Green for each CCG based on the improvement compared to non-priority CCGs The metric is based on the first phase of RightCare delivery plans, submitted by Wave One CCGs in January 2017 and by Wave Two CCGs in September 2017.
Risk adjustment or standardisation type and methodology	None. Indicators in the Commissioning for Value packs are indirectly age-sex standardised to allow comparison between CCGs. However, the purpose of this indicator is to monitor changes in expenditure over time so this is not essential.
Output	
Frequency of publication	Quarterly

59. Children and young people’s mental health services transformation (123d)	
Category, Sub-Category	Finance and use of resources
Definition	Percentage of children and young people aged under 18 with a diagnosable mental health condition who are receiving treatment from NHS funded community services
Purpose (Rationale)	This indicator is designed to demonstrate progress in increasing access to NHS funded community mental health services for children and young people.
Evidence and policy base	Improving access to mental health services is a priority for the Government and a mandate commitment for NHS England. The MH5YFV calls for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. The priority on children and young people’s mental health was reinforced by the Prime Minister in January 2016 with the announcement of a Green Paper which will include access as a key focus. An additional £1.25bn has been provided by the government specifically to ensure at least 70,000 more children and young people each year access high-quality, evidence based mental health care when they need it by 2020/21. CCGs are receiving an increasing proportion of this funding each year to 2020/21. This indicator is designed to monitor the CCG contribution to meeting the extra 70,000 commitment and accounting to government for the additional resource they have received. Data are limited, but this is the most significant national metric on CYP mental health. NHS England will make measurable progress towards closing the health and wellbeing gap and securing sustainable improvements in children and young people’s mental health outcomes.
Data	
Data source	Numerator – Due to the experimental nature of these indicators and the need to correct previously published data, the underlying data for 2017/18 has been published in a number of different places. Data for quarter 1 2017/18 is available at http://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/media/25960/ChildrenandyoungpeoplementalhealthindicatorsQ12017-18/xls/Children_and_young_people_mental_health_indicators_(Q1_2017-18).xlsx/ Data for quarter 2 2017/18 is available at:

	https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics/mental-health-services-monthly-statistics-final-september-provisional-october-2017 From Oct 2017 onwards the data are published as part of monthly statistics on https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-services-monthly-statistics Denominator – This estimated prevalence value is taken from indicator 2b as signed off as part of the 2017-2019 operational and contracting planning round. Please see section 3.4 and the joint technical definitions for more detail: https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/ These are local estimates published in the Public Health England Fingertips Tool. The prevalence given in the ONS survey Mental health of children and young people in Great Britain (table 4.14) were applied to the number of children aged 5-16 resident in the area stratified by age, sex and socio-economic classification (NS-SeC of household reference person). The socio-economic distributions were sourced from census table CT0203, giving National Statistics Socio-economic Classification (NS-SeC) of Household Reference Person (HRP) for all dependent children (note that the percentages for the sub-groups of group 1 given in the survey were pooled to obtain an estimate for all of social class 1). Detail on method is contained in the tool: https://fingertips.phe.org.uk/profile-group/mental-health/profile/cypmh All prevalence data are derived from the 2004 ONS study: http://content.digital.nhs.uk/catalogue/PUB06116/ment-heal-chil-youn-peop-gb-2004-rep2.pdf The study is being updated and expanded for publication in 2018.
Data fields	Numerator: Table 2: The number of children and young people, regardless of when their referral started, receiving at least two contacts (including indirect contacts) and where their first contact occurs before their 18th birthday. Denominator: CYPMH_2b (CCG planning returns 2018/19)
Data filters	None

Data processing	None
Construction	
Numerator	The number of children and young people aged under 18 with a diagnosable mental health condition receiving treatment in NHS funded community services in the reporting period.
Denominator	Total number of individual children and young people under 18 with a diagnosable mental health condition (i.e. the estimated prevalence of mental ill health in the population)
Computation	The 5YFV target as an annual increase in access, and so this measure needs to show how many CYP were seen in a given year. Quarterly figures are helpful to guide services in delivering increased access throughout the year, but it is the annual figure that CCGs will be assessed on. In order to avoid double-counting a single C/YP, two treatments within the same year are counted as one C/YP, and a C/YP having treatment that spans year end/beginning should not be double counted by adding them to each year's total.
Risk adjustment or standardisation type and methodology	None
Output	
Frequency of publication	Quarterly

60. Optimising prescribing: reducing the rate of low priority prescribing (109a)	
Domain, Area	Finance and use of resources
Definition	The Low Priority Prescribing (LPP) Indicator is a RAG rated score for each CCG. The overall RAG rating is based on two elements: 1. LPP Quality Score 2. LPP Financial Score More details on the calculation can be found in the Data and Construction sections.
Publication status	
Purpose (Rationale)	This indicator focuses on optimising prescribing in primary care by encouraging a reduction in the rate of prescribing of low priority medicines. The purpose of the indicator is to promote prescribing that is both clinically-effective and cost-effective, to support delivery of improved patient outcomes and the effective use of NHS resources.
Evidence and policy base	CCG guidance on ‘Items which should not be routinely prescribed in primary care’ outlines recommendations for 18 items which are the focus of this indicator. The objective of this guidance is to support CCGs in their decision-making, to encourage best practice prescribing, address unwarranted variation, and to provide clear national advice to make local prescribing practices more effective. The 18 items in the commissioning guidance are focused on the following categories: • Products of low clinical effectiveness, where there is a lack of robust evidence of clinical effectiveness or there are significant safety concerns; • Products which are clinically effective but where more cost-effective products are available, including products that have been subject to excessive price inflation; or • Products which are clinically effective but, due to the nature of the product, are deemed a low priority for NHS funding The guidance is based on recommendations from the National Institute of Health and Clinical Excellence (NICE), where relevant, in order to support CCGs in implementing NICE guidance; in particular identifying items which NICE consider to be ‘do not do’s’. Where NICE guidance was not available the evidence from a range of sources, for example; the Medicines and Healthcare products Regulatory Agency (MHRA), the British National Formulary, the Specialist Pharmacist Service and PrescQIPP Community Interest Company (CIC) evidence reviews, were considered.

Data	
Data source	The data used to construct this indicator is sourced from: • electronic Prescribing Analysis and Cost tool (ePACT2) which cover prescriptions prescribed in England and dispensed in the community in the UK (NHS BSA prescribing data) • GP registered patient numbers (NHSD)
Data fields	NHS BSA prescribing data: • Month/Year • Clinical commissioning group (CCG) • Drug Group • Items (number of items prescribed) • Spend (actual cost of prescriptions) • Age/Sex of patient NHSD GP registered patient numbers data split by: • CCG • Age/Sex of patient
Data filters	NHS BSA prescribing data: • Only includes items in Low Priority Prescribing wave one (the first 18 products included in the initial consultation). • Indicator is based on prescribing in each financial quarter.
Data processing	N/A
Construction	
Summary	For a full explanation of the methodology, including details of the prescribing goals, please see the LPP Indicator technical note published on the “Items which should not be routinely prescribed in primary care” webpage. The aim of the LPP Indicator is to better understand prescribing of low value medicines at a CCG level. The indicator will be published as part of the NHS Oversight Framework, however, CCG’s will also be able to access a breakdown of the quality and financial scores that underlie the indicator via the LPP Indicator step-by-step calculation document, published on the “Items which should not be routinely prescribed in primary care” webpage. **Overall LPP Indicator** The overall LPP Indicator is based on two components, the Quality score and the Financial score. Both elements of the indicator, the Quality and Financial scores, are converted in to RAG ratings and the overall LPP Indicator is a weighted average of the two individual RAG ratings. **LPP Quality score**

	The quality score is calculated at an individual product level and is based on the number of prescriptions dispensed over a specific period. Each of the 18 products in scope of the LPP Indicator is given an equal weighting in the quality score. Each CCG is awarded a maximum of two points for each product, a CCG gets one point for each of the criteria below: 1. The CCG prescribing rate has reduced or remained stable over the last financial year. 2. The CCG prescribing rate is at or below the national prescribing goal. The maximum possible quality score is 36. **LPP Financial score** The financial score is based on the total spend on all products in scope of the LPP Indicator. The financial score is the percentage difference between each CCG's actual spend and a spending benchmark. As this score is based on spend, products that are high value and/or high volume contribute more to the score than other products. *NB: Measuring the rate of prescribing* *Ideally, prescribing rates would be based on the volume of prescribing (how much is being prescribed) rather than the frequency of prescribing (the number of times an item is prescribed) to provide CCGs with a more accurate representation of prescribing within their catchment.* *Although the quality score is based on number of prescriptions for the 2019/20 NHS Oversight Framework, our aim for the future is to be able to consistently measure the volume of prescribing across a range of different products. We will work towards co-developing options, alongside CCGs, NHSD and prescribers, over the next 12 months.*
Numerator	Details provided in the computation section below.
Denominator	Details provided in the computation section below.
Computation	**Overall LPP Indicator** The LPP Indicator is an aggregate of the quality score and the financial score. The overall LPP Indicator is the weighted average of the individual quality and financial RAG ratings– the weighting is 60% of the quality score and 40% of the financial score. To combine the two elements of the indicator the individual quality and financial RAG ratings are converted into numerical values: • A Red RAG rating has a value of 1. • An Amber RAG rating has a value of 2. • A Green RAG rating has a value of 3. • A Green Star RAG rating has a value of 4. Once the overall LPP Indicator is calculated this is then converted back into a RAG rating using the thresholds below: • If the overall LPP Indicator is 4 then Green Star;

- If the overall LPP Indicator is equal to or greater than 3 and less than 4 then Green;
- If the overall LPP Indicator is equal to or greater than 2 and less than 3 then Amber; and
- If the overall LPP Indicator is less than 2 then Red.

The LPP Quality score

Score: The total score across all 18 products.

The score for each product is based on two criteria:

1. Has the CCG prescribing rate reduced or remained stable over the past financial year? If yes, then CCG gets one point
2. Is the CCG currently prescribing at or below the national prescribing goal? If yes, then CCG gets one point

There is a maximum of two points for each product.

The maximum possible quality score is 36. The higher the score the better the performance.

RAG rating: CCGs are grouped into RAG ratings based on their quality score. This is necessary to calculate the overall LPP Indicator.

- If score is below 10 then CCG gets a Red rating;
- If score is between 10 and 18 then CCG gets an Amber rating;
- If score is between 19 and 27 then CCG gets a Green rating; and
- If score is greater than or equal to 28 then CCG gets a Green Star rating

The LPP Financial score

Score: The percentage difference between a CCG's spend per 1,000 patients and the spending benchmark.

CCG spend per 1,000 patients: This is the total spend across all 18 products divided by the registered patient count, multiplied by 1,000.

Spending benchmark: This is the spend per 1,000 patients at the 15th percentile of the spending distribution in Q1. This means that each quarter we will be benchmarking CCGs against the spend at the lowest 15% of the distribution in Q1.

RAG rating: CCGs are grouped into RAG ratings based on their financial score. This is necessary to calculate the overall LPP Indicator.

- If score is greater than 75% then CCG gets a Red rating;
- If score is greater than 30% and less than or equal to 75% then CCG gets an Amber rating;
- If score is greater than 0% and less than or equal to 30% then CCG gets a Green rating; and
- If score is less than or equal to 0% then CCG gets a Green Star rating

Risk adjustment or standardisation type and methodology	**LPP Quality score:** The prescribing goal has been indirectly standardised to take account of the age and sex of a CCG patient population. This means that there is a unique prescribing goal for each CCG which reflects some of the characteristics of their patient population. **LPP Financial score:** The spending benchmark has not been standardised to take account of the age and sex of a CCG patient population. The benchmark is a rate of spend per 1,000 patients, so takes account of the total size of a CCG. This benchmark is the same for all CCGs.
Output	
Frequency of publication	Quarterly as part of the NHS Oversight Framework.