Classification: official
Publications approval reference: 001559

Activity, performance and workforce technical definitions

v1.0

Contents

Executive Summary

The purpose of this technical definitions document is to describe the indicators set out in the 2020/21 Phase 3 Planning Submission Guidance (see section 5 of “Implementing phase 3 of the NHS response to the COVID-19 pandemic”). It sets out definitions, monitoring, accountability and planning requirements for each measure.

For any technical queries, please direct these to:

England.ops-planning@nhs.net

For any queries regarding SDCS, please contact data.collections@nhs.net

E.A.3: IAPT Roll-Out

DEFINITIONS

Detailed Descriptor: This indicator tracks our ambition to expand access to Psychological Therapies (IAPT) services.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.):

Numerator: Number of people receiving psychological therapies.

Denominator: Prevalence of common mental health disorders based on the 2000 APMS

The prevalence data is pre-populated in the planning template and will be used to calculate an IAPT access rate based on the inputted activity plans.

Data definition

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

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

MONITORING

Monitoring Data Source: IAPT data set

Monitoring Data Source URL: IAPT Data Set, NHS Digital

Monitoring Frequency: Quarterly

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

FURTHER INFORMATION

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

E.B.3a: RTT Waiting List

DEFINITIONS

Detailed descriptor: The number of RTT pathways on the waiting list who have yet to start treatment.

Lines within indicator (Units)

Count: The total number of incomplete RTT pathways at the end of the reporting period (often referred to as the size of the RTT waiting list).

Data definition

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

MONITORING

Monitoring frequency: Monthly

Monitoring data source: Consultant-led RTT Waiting Times data collection (National Statistics).

ACCOUNTABILITY

Timeframe/Baseline: Ongoing

Rationale: To support patients' right to start consultant-led non-emergency treatment within a maximum of 18 weeks from referral.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

Providers that are currently not able to report monthly RTT data should be excluded from STP plans.

E.B.30: Urgent cancer referrals

DEFINITIONS

Detailed Descriptor: Urgent referrals – Numbers of patients seen in a first outpatient appointment following urgent referrals from GP

Lines Within Indicator (Units)

Count: All patients urgently referred with suspected cancer by their GP (GMP, GDP or Optometrist) who received a first outpatient appointment in the given month.

All data should follow the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in the relevant information standard - Amd 89/2016.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 89/2016, is available in the NHS Data Dictionary.

MONITORING

Monitoring frequency: Monthly and Quarterly.

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS..

E.B.31: Cancer treatment volumes

DEFINITIONS

Detailed descriptor: Cancer 31 day waits.

Number of patients receiving first definitive treatment Following a diagnosis (decision to treat) within the period, for all cancers.

Lines within indicator (Units)

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

All data should follow the definitions and mandates for the National Cancer Waiting Times Monitoring Dataset (NCWTMDS) specified to the NHS in Amd 89/2016.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 89/2016, is available in the NHS Data Dictionary.

MONITORING

Monitoring frequency: Monthly and Quarterly.

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

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS..

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E.B.32: Number of patients waiting 63 or more days after referral from cancer PTL

DEFINITIONS

Detailed descriptor: The number of cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days of more after an urgent suspected cancer referral.

Lines Within Indicator (Units)

Cancer 62 day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days of more after an urgent suspected cancer referral at the end of the reporting period

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Data definition: Based on the weekly Cancer PTL – 62 day standard sum of
Section 1: 62 day PTL – Patients without a decision to treat: Total number of patients whose breach date has already passed
and
Section 2: 62 day PTL – Patients with a Decisions to Treat: Total number of patients whose breach date has already passed

The definitions that apply for the cancer 62 day PTL, as well as guidance on recording and reporting 62 day data, can be found on the SDCS portal.

MONITORING

Monitoring frequency: Weekly data.

Monitoring data source: Data are sourced from the cancer 62 day PTL

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, month end position for September to March 2020/21 via SDCS.

E.B.18: Number of 52+ Week RTT waits

DEFINITIONS

Detailed descriptor: The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more.

Lines Within Indicator (Units)

The number of incomplete RTT pathways (patients waiting to start treatment) of 52 weeks or more at the end of the reporting period.

Data definition: The number of 52+ week incomplete RTT pathways based on data provided by NHS and independent sector organisations and reviewed by NHS commissioners via SDCS.

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

MONITORING

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT Waiting Times data collection (National Statistics).

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

Providers that are currently not able to report monthly RTT data should be excluded from STP plans.

E.B.26: Diagnostic Test Activity

DEFINITIONS

Detailed descriptor: The number of diagnostic tests or procedures carried out for which the patient had waited on a waiting list.

Lines within indicator (Units)

The number of diagnostic tests or procedures (included in the Diagnostics Waiting Times and Activity Data Return) carried out during the month for which the patient had waited on a waiting list.

Plans are required for the following key tests:

E.B.26a – Magnetic resonance Imaging
E.B.26b – Computed Tomography
E.B.26c – Non-Obstetric Ultrasound
E.B.26d - Colonoscopy
E.B.26e – Flexi Sigmoidoscopy
E.B.26f - Gastroscopy

Data definition: The number of diagnostic tests for the specified test group carried out during the month, based on monthly diagnostics data provided by NHS and independent sector organisations and reviewed and validated by NHS commissioners, for which the patient had appeared on a waiting list.

Full definitions can be found on the Monthly Diagnostic Waiting Times and Activity Return webpage.

MONITORING

Monitoring frequency: Monthly

Monitoring data source: Monthly Diagnostics Waiting Times and Activity Return - DM01.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.
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E.H.9: Improve access to Children and Young People's Mental Health Services (CYPMH)

DEFINITIONS

Detailed Descriptor

This indicator is designed to demonstrate progress in increasing access to NHS funded community mental health services for children and young people (CYP) aged under 18.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

Numerator: Number of CYP aged under 18 receiving treatment by NHS funded community mental health services (rolling 12 months)

Denominator: Prevalence of CYP with a diagnosable mental health condition based on 2004 estimates.

Data definition

For the purposes of this planning process the definition of this indicator continues largely in line with previous years in the FYFVMH and the 2019/20 planning process, except for a change to 12-month rolling reporting described below.

12-month rolling data by quarter

Activity trajectories should be provided as a rolling 12-month period up to the end of the specified quarter. For example, 2020/21 Q1 activity will relate to access between the start of July 1st, 2019 up to June 30th, 2020.

In 2019/20 operational planning, the CYP access metric was defined as activity delivered in the specified quarters and was expected to reflect the seasonal variation. However, around a third of CCGs planned flat CYP access trajectories across the year, with their annual access figure divided evenly across the four quarters. The lack of alignment between plans and actual activity for planning and monitoring purposes may have contributed to a number of CCGs being behind the access trajectories.

The change to 12-month rolling data has been made as we expect that CCGs will be able to more accurately plan activity delivered in each quarter. The Q4 access figure will reflect planned activity across the whole of 2020/21. We would expect CCGs to be able to use the baseline data provided, combined with local intelligence, to plan trajectories as 12-month rolling activity by quarter.

Age cohort

The age is defined as that at the first contact i.e. the start of treatment. Only those who start treatment before their 18th birthday (i.e. up to the age of 17 and 364 days) count in the metric. The second contact can be after the 18th birthday.

Treatment and access definition

Treatment, as it is currently defined, constitutes two or more contacts. Those could be face to face, therapeutic non-face to face contacts[1] or indirect contacts such as a consultation between professionals or professional and carer that support the treatment of an individual child or young person. The individual is counted in the reporting period in which their second contact occurred.

Counting access for individuals

The "individual" should be counted once in every year they receive two relevant care contacts (i.e. received treatment). For example, if a patient received one contact in Q1 2019/20 and one in Q4 2019/20 then they should only be included in the Q4 2019/20 count. This also means that an individual can be counted in more than one year. For example, if a person received two contacts in Q1 2018/19 and another two in Q4 2019/20 they should be included in both the Q1 2018/19 count and the Q4 2019/20 count. If treatment occurs around the end of a year, for example an individual has one contact in Q4 2018/19 and one in Q1 2019/20 for the same issue, they should only be counted once in Q1 2019/20.

Digital therapies

Digital therapeutic services commissioned as part of the local care pathway should be recorded in table MHS201 of the MHSDS as "other" in the consultation medium field.

MONITORING

Monitoring Data Source

Mental Health Services Dataset

Monitoring Frequency

Quarterly 12-month rolling data will be used for this planning exercise, but monthly data is available from NHS Digital and will be used to monitor progress.

[1] A therapeutic non-face to face contact, for example delivered by on line counselling service, is a therapeutic message that is informed and consistent with a mode of counselling/intervention, is directly related to the identified/coded problem and is intended to change behaviour. All three elements have to be present

Rationale

Early intervention, quick access to good quality care for children and young people remains a priority for the NHS. Demand continues to rise year on year, so areas need to maintain a focus on reducing waiting rimes, tackling inequalities in access and providing support to people who are waiting for care.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, 12-month rolling activity by quarter for 2020/21 submitted via SDCS.

FURTHER INFORMATION

The Mental Health Implementation Plan provides further detail around CYPMH commitments set out in the NHS Long Term Plan, including CYP access. It can be found here: https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24

E.H.12: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days

DEFINITIONS

Detailed Descriptor

The number of bed days for inappropriate Out of Area Placements (OAPs) in mental health services for adults in non-specialist acute inpatient care expected by quarter four of each financial year.

Out of Area Placements (OAPs) 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. 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 strong discharge management and 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 Area Placements (OAPs) with the aim of eliminating inappropriate OAPs for adults requiring non-specialist acute inpatient care by 2020/21 and that commitment is reflected in the NHS Long Term Plan.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

E.H.12a: Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider.

E.H.12b: Number of inappropriate OAP bed days for adults by quarter that are 'external' to the sending provider.

Data definition

Note: for many providers the E.H.12a and E.H.12b numbers will be identical.

Defining OAPs

An OAP occurs when a patient with assessed acute mental health needs who requires non-specialised inpatient care (CCG commissioned) is admitted to a unit that does not form part of the usual local network of services.

The national definition, published by DH in 2016, focuses on continuity of care. Due to the significant variations in Trust geographies and the need for some flexibility in relation to local decisions on service models, the approach to defining an out of area placement necessarily requires local and clinical interpretation, supported by a set of key principles. A placement is likely to be considered to be out of area if:

- Clinical continuity cannot be ensured by the sending provider, e.g. the person is placed at a different provider that does not form part of an integrated care pathway with the person's "home" CMHT, so the person's care coordinator cannot be actively engaged throughout the course of the inpatient admission to plan for and support discharge.
- The person is dislocated from their usual support network of family and friends and cannot easily be visited.
- There are associated costs being paid by the sending provider.

N.B. an OAP can also occasionally occur *within* a "home" provider spanning a very large geography where the same dislocation from the "home" CMHT takes place, where clinical continuity cannot be ensured and where dislocation from friends and family occurs. This does not mean the admitting unit necessarily needs to be geographically closest to the patient, but rather it means that the location of the admission should not negatively impact the individual's experience, quality or continuity of care.

We have worked with providers to develop **4 continuity principles** (see annex), which support providers/STPs in determining what does and does not constitute an out of area placement. Where providers are working across large geographies or where they have deemed it necessary to formally subcontract additional **local** bed capacity, it may be that these placements are not considered out of area if there is **full local assurance** that the continuity principles are consistently met.

There are some circumstances in which an out of area placement may be appropriate. An out of area placement may be appropriate when:

- The person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate).
- There are safeguarding reasons such as gang related issues, violence and domestic abuse.
- The person is a member of the local service's staff or has had contact with the service in the course of their employment.
- There are offending restrictions.
- The decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks.

This list is not exhaustive. There are other reasons why treatment in an out-of-area unit may be appropriate. In these cases, discharge and/or return to an appropriate local unit should be facilitated at the earliest point where this is in the individual's best interests.

An OAP is inappropriate if the reason is non-availability of a local bed.

MONITORING

Monitoring Data Source

NHS Digital – Mental health OAPs collection

https://digital.nhs.uk/data-and-information/publications/statistical/out-of-area-placements-in-mental-health-services

Monitoring Frequency

Quarterly for the purposes of this planning exercise (quarter four being the key milestone)

Monthly data is also available

Rationale

From recent data on OAPs, it is estimated that around **8,000 adults** who need acute inpatient care were sent out of area last year. This translates to **around 240,000 out of area bed days**, at a cost to the mental health system of over **£100 million**, funds which could be better spent on local service provision.

From this evidence, there are strong human, clinical and financial arguments for ensuring that people receive high quality acute care in the least restrictive setting and as close to home as possible.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

FURTHER INFORMATION

Annex A: Principles of Continuity

Principles of continuity	
1.	Clear shared pathway protocols between units/organisations – particularly around admissions and discharge.
2.	An expectation that a person's care coordinator: Visits as regularly as they would if the patient was in their most local unit and Retains their critical role in supporting discharge/transition.
3.	Robust information sharing, including the ability to: Identify cross-system capacity and Access full clinical records with appropriate IG in place where necessary.
4.	Support for people to retain regular contact with their families, carers and support networks e.g. this might be achieved with optional use of technology, transport provision etc.

E.H.13: People with severe mental illness receiving a full annual physical health check and follow up interventions

DEFINITIONS

Detailed Descriptor

This indicator measures the number of people and percentage of people on General Practice SMI registers who are receiving a comprehensive annual physical health check and follow-up care in either a primary or secondary care setting. This health check should include the follow elements:

1. a measurement of weight
2. a blood pressure and pulse check
3. a blood lipid including cholesterol test
4. a blood glucose test
5. an assessment of alcohol consumption
6. an assessment of smoking status
7. an assessment of nutritional status, diet and level of physical activity
8. an assessment of use of illicit substance/non-prescribed drugs
9. access to relevant national screenings
10. medicines reconciliation and review
11. general physical health enquiry including sexual health and oral health
12. indicated follow-up interventions

Physical health checks may be delivered in either a primary or secondary care setting. Monitoring this indicator is based on a subset of the elements of the health check listed above as set out the technical collection guidance for the physical health SMI Strategic Data Collection Service (SDCS) collection.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

Numerator: The number of people on the General Practice SMI registers who have received a physical health assessment in the 12 months to the end of the period

Denominator: Total number of people on the General Practice SMI registers by quarter

Data definition

Numerator: The number of people on the General Practice SMI registers who have received a comprehensive physical health assessment in the 12 months to the end of the reporting period.

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

Definition of receiving a physical health assessment: For the purpose of monitoring this indicator, a person is counted as having had a comprehensive physical health assessment if they have received the elements of the check outlined in the physical health SMI SDCS data collection technical guidance (i.e. all of the 6 component elements listed in Part 2 of the guidance) at any point in the 12 months to the end of the reporting period.

MONITORING

Monitoring Data Source

Severe Mental Illness Physical Health Checks collection

https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/

Monitoring Frequency

Quarterly using a rolling 12-month period

Rationale

People with SMI are at increased risk of poor physical health, and their life-expectancy is reduced by an average of 15–20 years mainly due to preventable physical illness. Two thirds of these deaths are from avoidable physical illnesses including heart disease and cancer, mainly caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital receive the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

FURTHER INFORMATION

Detailed guidance for the Severe Mental Illness Physical Health Checks collection is available on the NHS Digital website.

Detailed guidance on commissioning primary care services is available on the NHS England and Improvement website.

E.H.15: Number of women accessing specialist perinatal mental health services

DEFINITIONS

Detailed Descriptor

This metric is designed to demonstrate progress in increasing access to NHS funded specialist perinatal mental health community services.

Continued improvements in the coverage and quality of Mental Health Services Dataset (MHSDS) submissions are key to ensuring that delivery of this ambition can be accurately tracked.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

Numerator: Number of women accessing specialist community PMH service in the reporting period, reported from the Mental Health Services Dataset (12-month rolling)

Denominator: Total number of live births for the baseline year (2016)

The number of live births is pre-populated in the planning template and will be used to calculate an access rate by quarter, based on the inputted activity plans, to support local planning.

Data definition

Access to specialist perinatal mental health services is defined as women who have had at least one attended contact (face to face or business skype contact, excludes telephone, SMS or email) with a specialist community perinatal mental health service, which is recorded in the Mental Health Services Dataset against team code C02.

The Mental Health Services Data Set includes detailed guidance on use of the technical specification and the central return process.

Planning activity trajectories

Activity trajectories should be provided as a rolling 12-month period up to the end of the specified quarter. For example, 2020/21 Q1 activity will relate to access between the 1st July 2019 to the end of June 2020.

The Q4 access figure will reflect planned activity across the whole of 2020/21 (April 1st, 2020 up to the end of March 2021). We would expect STPs to be able to use the activity data provided combined with local intelligence, to plan trajectories as 12-month rolling activity by quarter.

MONITORING

Monitoring Data Source

Mental Health Services Data Set

Perinatal mental health data is extracted from the MHSDS by NHS England and NHS Improvement analysts to populate the mental health core data pack, which is available to all NHS employees via the FutureNHS Collaboration platform (registration required).

Monitoring Frequency

Perinatal mental health access data from the MHSDS is updated monthly with 12 month rolling totals.

Rationale

Up to 20% of women experience a mental illness during pregnancy or in the first year after delivering their baby. Women with a history of mental health illness are at significant risk of relapse during pregnancy, particularly if they stop taking their medication (often because they are unable to access expert mental health pharmacy or psychiatric advice). Suicide is a leading cause of maternal death. Mental health problems not only affect the health of women but can also have long-standing effects on children's emotional, social and cognitive development and comes with societal costs.

Specialist PMH services offer evidence-based psychiatric and psychological assessments and treatment for women with moderate/complex to severe mental health problems during the perinatal period. They can also provide pre-conception advice for women with a current or past severe mental illness who are planning a pregnancy. FYFV and NHS Long Term Plan access ambitions are in place to ensure that more women who require access to evidenced based specialist care are receiving it to achieve better outcomes for mothers, babies and families.

Measuring the number of women accessing specialist perinatal mental health services allows NHS England and NHS Improvement to establish if the number of women accessing specialist care is increasing in line with the published FYFV and NHS Long Term Plan trajectories.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

FURTHER INFORMATION

E.H.17: Number of people accessing Individual Placement and Support

DEFINITIONS

Detailed Descriptor

IPS (Individual Placement and Support) is a model of employment support integrated within community mental health teams which helps people with severe mental health conditions into employment.

To track our NHS Long Term Plan commitments, we are looking to track access to IPS services via the MHSDS. We will include referrals that have received one contact or more with an IPS team.

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

Numerator: Number of people accessing IPS services.

Data definition

A person is counted as having accessed an IPS service if they have had an attended, face to face contact.

MONITORING

Monitoring Data Source:

Quarterly monitoring template with eventual move to the MHSDS

Information on access to IPS services will be shared with NHS England and NHS Improvement and teams directly.

Monitoring Frequency:

Quarterly and in future monthly when moved to MHSDS

Rationale

People with severe mental health problems have low rates of employment (8% vs 75% in the general population). Individual Placement and Support (IPS) is an employment support intervention involving intensive, individual support, a rapid job search followed by placement in paid employment, and in-work support for both the employee and their

new employer. It is the best evidence-based way to help people in this group get and keep a paid job. Finding and keeping a job brings many benefits for people with severe and enduring mental illness, including: financial independence, improved self-esteem, greater well-being, greater social contact and independence, and reduced use of community mental health services. Despite good evidence for the effectiveness of the IPS model, it has not been widely implemented in UK mental health services.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

E.H.27: Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses

DEFINITIONS

Detailed Descriptor

This metric assesses activity within new and integrated models of primary and community mental health care that will support adults and older adults with severe mental illnesses..

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.)

Numerator only: Number of people receiving care from new models of integrated primary and community care for adults and older adults with severe mental illnesses

Data definition

This indicator shows the total number of people (aged 18+) seen within new models of primary and community mental health care, inclusive of dedicated community services - community adult eating disorders, community rehab and community personality disorder services.

New models will see people with a range of needs and diagnoses as set out from page 26 of the NHS Mental Health Implementation Plan 2019/20 – 2023/24, including but not limited to: psychosis, bipolar disorder, a 'personality disorder' diagnosis, eating disorders, severe depression and mental health rehabilitation needs – some of which may be co-existing with other conditions. This will include people who may have been under the care of a range of secondary care community mental health team types as traditionally configured, as well as people accessing expert mental health support via new models for the first time (e.g. people who did not meet/would not have met thresholds to access secondary care community mental health services as they were previously configured).

This indicator therefore only covers activity delivered through the new service models developed using transformation funding and does not include any activity delivered

through secondary care community mental health services as traditionally configured. It does not include IAPT services, inpatient services for people with SMI or dedicated CYP mental health services.

MONITORING

Monitoring Data Source

Bespoke programme activity reporting (template return agreed with each early adopter site) in 2019/20 and 2020/21, MHSDS reporting (fields covering technical specification) from 2021/22 -2023/24.

Monitoring Frequency

Relevant activity will be reported quarterly as part of the transformation funding routine assurance

Rationale

The Long Term Plan and Mental Health Act Review make clear that community-based care for adults and older adults with severe mental illnesses need to improve. Significant issues around access, quality and joined-up care need to be addressed through updating models of care using major new LTP investment. Improving primary and community mental health care is therefore the biggest mental health programme in the LTP, accounting for almost £1bn cash terms funding per year extra for the NHS by 2023/24.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, quarterly for 2020/21 submitted via SDCS.

E.M.7: Referrals made for a First Outpatient Appointment (General & Acute)

DEFINITIONS

Detailed descriptor: The sum of the total number of written referrals from General Practitioners and “other” referrals, for first consultant outpatient appointment, in general and acute specialties.

Lines Within Indicator (Units)
E.M.7a GP: The total number of written referrals made from GPs, for first consultant outpatient appointment, in general and acute specialties.

E.M.7b Other: The total number of other (non-GP) referrals requests made for first consultant outpatient appointment in general and acute specialties. See below for exclusions.

Total: The total number of GPs and other (non-GP) referrals requests made for first consultant outpatient appointment in general and acute specialties (GP + Other).

Data definition: The sum of the total number of written referrals made from GPs and the total number of other (non-GP) referrals made, for first consultant outpatient appointment, in general and acute specialties.

For GP referrals:
It is the total number of general and acute GP written referrals where:

- Referral Request Type = National Code 01 'GP referral request'.
- Written Referral Request Indicator = classification 'Yes'.

All written GP referral requests to a Consultant whether directed to a specific consultant or not, should be recorded, regardless of whether they result in an outpatient attendance.

An electronic message should be counted as written, as should a verbal request which is subsequently confirmed by a written request.

The referral request received date of the GP referral request should be used to identify referrals to be included in the return.

For other referrals:
It is the total number of general and acute other referrals requests excluding:

a. GP written referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 01 'GP referral request' and the WRITTEN REFERRAL REQUEST INDICATOR of the REFERRAL REQUEST is classification 'Yes'

b. Self-referrals; these are where the REFERRAL REQUEST TYPE of the REFERRAL REQUEST is National Code 04 'Patient self-referral request'

c. Initiated by the CONSULTANT responsible for the Consultant Out-Patient Episode referrals; these are where the SOURCE OF REFERRAL FOR OUT-PATIENTS of the REFERRAL REQUEST is National Code 01 'following an emergency admission' or 02 'following a domiciliary visit' or 10 'following an Accident and Emergency Attendance' or 11 'other'

d. Referrals initiated by attendance at drop-in clinic without prior appointment; these are where the OUT-PATIENT CLINIC REFERRING INDICATOR of the REFERRAL REQUEST is classification 'Attended referring Out-Patient Clinic without prior appointment'

For general and acute main specialties:

- **include: 100-192, 300-460, 502, 504, 800-834, 900 and 901**
- **exclude: 501, 700-715**

MONITORING

Monitoring Frequency: Monthly.

Monitoring Data Source: Monthly Activity Return (MAR) - Both providers and commissioners should ensure that their referrals information submitted through the Monthly Activity Return (MAR) is of good quality. Commissioners are required to check and sign-off their MAR data on SDCS each month.

ACCOUNTABILITY

Timeframe/Baseline: 2019/20 annual forecast outturn.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

E.M.8-9: Consultant Led Outpatient Attendances (Specific Acute)

DEFINITIONS

Detailed descriptor: All Specific Acute consultant-led outpatient attendances.

Lines within indicator (Units)
E.M.8c Consultant-led first outpatient attendances (face-to-face)
E.M.8d Consultant-led first outpatient attendances (telephone/video)

E.M.9c Consultant-led follow-up outpatient attendances (face-to-face)
E.M.9d Consultant-led follow-up outpatient attendances (telephone/video)

Data definition: A count of all outpatient attendances taking place within the period, whether taking place within a consultant clinic session or outside a session.

The patient must have been seen by a consultant, or a clinician acting for the consultant, for examination or treatment.

Specifically, the number of consultant outpatient attendances for which:

Der_Attendance_Type = 'Attend'
StaffType = 'Cons' i.e. main speciality is not '560', '950' or '960'
Treatment function maps to Specific Acute (for E.M.8 and E.M.9)
Treatment function maps to Specific Acute excluding TFC 812 (for E.M.8a and E.M.9a)

For first outpatient attendances, face-to-face:
Der_Appointment_Type = 'New'
First_Attendance = '1'

For first outpatient attendances, telephone/video:
Der_Appointment_Type = 'New'
First_Attendance = '3'

For follow up outpatient attendances, face-to-face:
Der_Appointment_Type = 'FUp'
First_Attendance = '2'

For follow up outpatient attendances, telephone/video:
Der_Appointment_Type = 'FUp'
First_Attendance = '4'

This includes outpatient attendance for all consultant outpatient episodes for all sources of referral.

Activity delivered in a primary care setting should also be included.

MONITORING

Monitoring frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

CCGs: CCG breakdowns should use identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2020-21

E.M.10: Total Elective Spells (Specific Acute)

DEFINITIONS

Detailed Descriptor: Number of Specific Acute elective spells.

Lines within indicator (Units)
E.M.10: Total number of Specific Acute elective spells in the period.

E.M.10a: Total number of Specific Acute elective day case spells in the period.

E.M.10b: Total number of Specific Acute elective ordinary spells in the period.

Data definition: An Elective Admission is one that has been arranged in advance. It is not an emergency admission, a maternity admission or a transfer from a hospital bed in another health care provider. The period the patient has to wait for admission depends on the demand on hospital resources and the facilities available to meet this demand.

E.M.10a: A day case admission must be an elective admission, for which a 'Decision To Admit' has been made by someone with the 'Right Of Admission'. Any patient admitted electively during the course of a day with the intention of receiving care, who does not require the use of a hospital bed overnight and who returns home as scheduled, should be counted as a day case. If this original intention is not fulfilled and the patient stays overnight, such a patient should be counted as an ordinary admission. Where clinical care is provided as a series of day case activities (for example chemotherapy or radiotherapy) this should be recorded as regular day / night activity (and therefore not be included in the day case count).

E.M.10b: Any patient admitted electively with the expectation that they will remain in hospital for at least one night, including a patient admitted with this intention who leaves hospital for any reason without staying overnight, should be counted as an ordinary admission. A patient admitted electively with the intent of not staying overnight, but who does not return home as scheduled, should also be counted as an ordinary admission.

It is the number of day case and ordinary (as defined above) elective spells relating to hospital provider spells for which:

Der_Management_Type is either 'DC' or 'EL'
Treatment function on the date of discharge maps to Specific Acute

Where 'DC' = Day Case and 'EL' = Ordinary Elective

MONITORING

Monitoring frequency: Monthly.

Monitoring data source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

CCGs: CCG breakdowns should use identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2020-21

E.M.11: Total Non-Elective Spells (Specific Acute)

DEFINITIONS

Detailed descriptor: Total number of Specific Acute non-elective spells.

Lines within indicator (Units)
E.M.11: Number of Specific Acute non-elective spells in the period (autocalculated sum of E.M.11a and E.M.11b).

E.M.11a: Number of Specific Acute non-elective spells in the period with a length of stay of zero
E.M.11b: Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (autocalculated sum of E.M.11c and E.M.11d
E.M.11c: Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (COVID)
E.M.11d: Number of Specific Acute non-elective spells in the period with a length of stay of 1 or more (Non-COVID)

Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.

It is the number of hospital provider spells for which:

- Der_Management_Type is 'EM' or 'NE'
- Treatment function maps to Specific Acute

Where 'EM' = Emergency and 'NE' = Non-Elective

E.M.11a: spells where the date of admission is the same as the discharge date (i.e. the episode does not span midnight).

E.M.11b,c and d: spells where the date of admission is **not** the same as the discharge date.

For COVID (E.M.11c), use ICD-10 codes U071 and U072. For Non-COVID (E.M.11d), exclude ICD-10 codes U071 and U072.

MONITORING

Monitoring frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

CCGs: CCG breakdowns should use identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2020-21

E.M.12: Type 1-4 A&E Attendances

DEFINITIONS

Detailed descriptor: Number of attendances at A&E departments, excluding planned follow-up attendances.

Lines within indicator (Units)
E.M.12a A&E Attendances – Type 1 & 2 attendances: Total number of attendances at all Type 1 and Type 2 A&E departments, excluding planned follow-up attendances.
E.M.12b A&E Attendances – Type 3 & 4 attendances: Total number of attendances at all Type 3 and Type 4 A&E departments, excluding planned follow-up attendances.
E.M.12 Type 1, 2, 3 & 4 attendances (autocalculated sum of E.M.12a and E.M.12b): Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1&2 + Types 3&4).

Data Definition:
Total A&E attendances are taken directly from SUS with the additional restriction of:

CDS 010
AEA_Attendance_Category <> 2
(Exclude planned follow up attendances)

For type 1 and type 2:
AEA_Department_Type in ('01', '02')

For type 3 and type 4:
AEA_Department_Type in ('03', '04')

CDS 011
EC_AttendanceCategory <> 4 (Exclude planned follow up attendances)

For type 1 and type 2:
EC_Department_Type in ('01', '02')

For type 3 and type 4:
EC_Department_Type in ('03', '04')

Total A&E attendances are taken directly from SUS, with no further restrictions other than the above.

MONITORING

Monitoring Frequency: Monthly.

Monitoring Data Source: Secondary Uses Service NCDR (SEM) - SUS NCDR is derived from SUS (SEM) and not the SUS PbR Mart.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

CCGs: CCG breakdowns should use identification rules (IR) to identify CCG-commissioned activity – https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-psp-planning-tool-2020-21

E.M.23: Ambulance Conveyance to an Emergency Department (ED)

DEFINITIONS

Detailed Descriptor:
Of Ambulance Emergency Incidents, the number of incidents where a patient was transported to an Emergency Department (ED)

Lines Within Indicator (Units – e.g. Numerator, Denominator etc.):
Numerator: Emergency Incidents where at least one patient was transported to an ED.

Technical Specification:
ED includes Stroke and Primary Percutaneous Coronary Intervention units.
ED does not include:

- Minor Injuries Unit, whether run by an Acute Trust or primary care organisation;
- Emergency, Medical, or Surgical Assessment Unit (EAU, MAU, SAU);
- Walk-in centres;
- Transport from hospital to hospice.
- Urgent Treatment Centres

Numerator includes incidents where the department transported to was not specified.
(Refer to current data specification taken from the website below.)

Calculation of Metric:
Number of Incidents with Transport to ED

MONITORING

Monitoring Data Source:
The NHS England and NHS Improvement Ambulance Quality Indicators (AQI).

Monitoring Data Source URL:
www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators

Monitoring Frequency:
Monthly, on the second Thursday after month end.

Timeframe/Baseline:
2019-20 baseline, monitored monthly during 2020-21

Rationale:

National policy developments and publications have emphasised the opportunity to reduce unnecessary pressures on the urgent and emergency care (UEC) system, by ensuring that ambulance services convey patients to an Emergency Department (ED) only if this is clinically appropriate for the patient's needs, or where no alternative exists for the patient's safe ongoing treatment and care.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS (required for Ambulance trusts only. Ambulance trusts have been mapped to a single STP for the purposes of submitting, but data provided should represent all activity for the trust).

FURTHER INFORMATION

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

DEFINITIONS

Detailed descriptor:
The indicator will be monitored using the Assuring Transformation data collection. Inpatient data is based on where patients originally come from, not where their hospital bed is located.

Data should be recorded for each inpatient who meets these requirements:

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

Lines within indicator (Units):

E.K.1a: Care commissioned by CCGs: The number of **adults** aged 18 or over from the CCG who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by a CCG. This will include all adults in inpatient wards that are not classified as low-, medium- or high-secure.

E.K.1b: Care commissioned by NHS England: The number of **adults** aged 18 or over from the CCG who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs, and whose bed is commissioned by NHS England. This will include all adults in inpatient wards that are classified as low- medium- or high-secure.

E.K.1c: Care for children
The number of **children** aged under 18 years from the TCP who have a learning disability and/or autistic spectrum disorder that are in inpatient care for mental and/or behavioural healthcare needs.

The population denominator will be provided.

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

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

MONITORING

Monitoring frequency: Quarterly.

Monitoring Data Source: Assuring Transformation.

Rationale
Areas should be continuing to reduce reliance on inpatient care and be building up community capacity. There is a critical need to adopt a full-system approach in conjunction with all commissioners of care, to reduce the numbers of patients being admitted to, and detained in, hospital settings.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, quarterly for 2020/21 submitted via SDCS.

E.K.3: Learning Disability Registers and Annual Health Checks delivered by GPs

DEFINITIONS

Detailed descriptor:
NHS England, the Association for the Directors of Adult Social Services (ADASS) and the Local Government Association's (LGA) published a service model on 30 October 2015. This states that one of the key actions to ensure people with a learning disability get good care and support from mainstream health services is for health commissioners to ensure people with a learning disability over the age of 14 are offered Annual Health Checks. The Annual Health Check scheme has been running since 2009.

In order to be eligible for a Learning Disability Annual Health Check, patients need to be on the GP Learning Disability Register. Progress in ensuring patients are offered an Annual Health Check is therefore dependent on them being identified and placed on the GP Learning Disability Register.

This indicator aims to monitor progress and will show which CCGs are not delivering learning disability services in line with this model.

Lines within indicator (Units):
Number of Annual Health Checks carried out for persons aged 14+ on
GP Learning Disability Register in the period.

NB: Plans should be set for the number of checks to be completed in each individual quarter - the quarterly plans should not be cumulative.

Data definition: The in-scope definition includes all registered patients aged 14 years or over, on GP practice Learning Disability Registers who have received an Annual Health Check.

MONITORING

Monitoring frequency: Quarterly.

Numerator: https://digital.nhs.uk/data-and-information/publications/statistical/learning-disabilities-health-check-scheme
LDHC001 (checks).

Denominator: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data

Rationale
To encourage CCGs to ensure people with a learning disability are on GP Learning Disability Registers, and those over the age of 14, are offered an Annual Health Check.

One of the key actions required to ensure people with a learning disability get good care and support from mainstream health services is for health commissioners to ensure people with a learning disability, over the age of 14, are offered an Annual Health Check. The Confidential Inquiry into premature deaths of people with learning disabilities highlighted the importance of Annual Health Checks.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, quarterly for 2020/21 via SDCS.

E.M.26: General and Acute bed occupancy

DEFINITIONS

Detailed descriptor:

The percentage of General and Acute (G&A) beds that are occupied, as an average over a monthly period. This uses the UEC daily sitrep definition of beds available or occupied as at 8am each day

Lines within indicator (Units)

Numerator: Average number of occupied G&A beds

Denominator: Average number of available G&A beds

Data definition

Numerator:

The average number of occupied G&A beds across the month using the UEC daily sitrep definition as at 8am each day.

Denominator:

The average number of available G&A beds across the month using the UEC daily sitrep definition as at 8am each day.
This will be the total G&A bed stock from the daily return, so should include any escalation beds

MONITORING

Monitoring frequency:

Monthly

Monitoring data source:

Daily UEC sitrep, aggregated over a month

Rationale

Reducing bed occupancy is a key element of improving hospital flow and enabling patients to be admitted from A&E in a more timely manner

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?

Yes, monthly for September to March 2020/21 via SDCS.

Workforce: Acute

DEFINITIONS

Detailed descriptor:

WTE forecast of staff broken down by Substantive, Bank and Agency. Substantive staff is then further broken down by professional group

Lines within indicator (Units)

Data definition

Substantive Staff:

Substantive staff WTE forecast based on WTEs who work in an organisation.

Substantive staff should include employees with the following ESR Status: Active Assignment, Internal Secondment, Acting Up. For organisation that do not use ESR, exclude staff who is out on external secondment and career break from the reporting numbers.

Substantive staff WTE should be based on WTEs who work in an organisation and exclude hosted staff and contractually employed staff who work in other organisations.

Substantive staff should exclude the following Type of contracts: Honorary, Bank, Widow/Widower.

Substantive staff is then further broken down by professional group, using staff codes as follows:

Registered nursing, midwifery and health visiting staff	N0A, N1A, N6A, N7A, NAA, NCA, N0H, N1H, N3H, N4H, N5H, N6H, N7H, NAH, NCH, NEH, NBK, N0K, N6K, N7K, NAK, NCK, N5H, N4H, N3H, NBK, N0K, N6K, N7K, NAK, NCK, N0J, N1J, N6J, NAJ, NCJ, N0C, N0L, N1C, N1L, N2C, N2L, N6C, N6L, N7C, N7L, NAC, NAL, NCC, NCL, N2J N2C, N2L, N2J, N0L, N1L, N6L, N7L, NAL, NCL, N0B, N1B, N6B, N7B, NAB, NCB, N0D, N0E, N4D, N5D, N6D, N6E, N7D, N7E, NAD, NAE, NCD, NCE, N0F, N0G, N4F, N5F, N6F, N6G, N7F, N7G, NAF, NAG, NCF, NCG, P2A, P2B, P2C, P2D, P2E, P3A, P3C, P3D, P3E
Allied health professionals	S0H, S1H, S6H, SAH, S0A, S1A, S4A, S7A, SAA, S0B, S1B, SAB, S0C, S1C, S4C, S6C, S7C, SAC, S0D, S1D, S2D, S4D, S7D, SAD, S0E, S1E, S6E, S7E, SAE, S0F, S1F, S7F, SAF, S0G, S1G, SAG, S0J, S1J, S6J, S7J, SAJ, SAI, S0I, S1I, S4I, S0T, S4T, SAT
Other scientific, therapeutic and technical staff	S0L, S2L, SAL, S1L, S0R, S1R, S4R, S7R, SAR, S0K, S1K, S6K, SAK, S0P, S2P, S3P, SAP, S4P, S0M, S1M, S2M, SAM, S0U, S1U, S6U, S7U, SAU, S0X, S1X, S2X, S3X, S4X, S6X, S7X, SAX
Health Care scientists	U0H, U0J, U1H, U1J, U2H, U2J, U3H, U3J, U4H, U4J, UAH, UAJ, U0A, U0B, U0C, U0D, U1A, U1B, U1C, U1D, U2A, U2B, U2C, U2D, U3A, U3B, U3C, U3D, U4A, U4B, U4C, U4D, UAA, UAB, UAC, UAD, U0E,

	U0F, U0G, U1E, U1F, U1G, U2E, U2F, U2G, U3E, U3F, U3G, U4E, U4F, U4G, UAE, UAF, UAG, UAK, U0K, U1K, U2K, U3K, U4K, UAL, U0L, U1L, U2L, U3L, U4L, UAM, U0M, U1M, U2M, U3M, U4M
Qualified ambulance service staff	A0A, A0B, A0C, A0D, A0E, A4A, A4B, A4C, A4D, A4E, AAA, A5A, A5B, A5C, A5D, A5E, A6A, A6B, A6C, A6D, A6E, ABA, ABB, ABC, ABD, ABE
Support to nursing staff	H1A, H1B, H1C, H1D, H1E, H1F, H1P, H2A, H2B, H2C, H2D, H2E, H2F, H2P, N8A, N8B, N8C, N8D, N8E, N8F, N8G, N8H, N8K, N8L, N9A, N9B, N9C, N9D, N9E, N9F, N9G, N9H, N9K, N9L, NFA, NFB, NFC, NFD, NFE, NFF, NFG, NFH, NFJ, NFK, NFL, P1A, P1D, P1E, NGA, NGB, NGC, NGD, NGE, NGF, NGG, NGH, NHA, NHB, NHC, NHD, NHE, NHF, NHG, NHH
Support to allied health professionals	S5A, S5B, S5C, S5D, S5E, S5F, S5G, S5H, S5J, S8A, S8B, S8C, S8D, S8E, S8F, S8G, S8H, S8I, S8J, S9A, S9B, S9C, S9D, S9E, S9F, S9G, S9H, S9J, S5I, S9I, H1G, H1H, H1J, H1L, H2G, H2H, H2J, H2L
Support to STT & HCS Staff	H1K, H1M, H1N, H2K, H2M, H2N, U5A, U5B, U5C, U5D, U5E, U5F, U5G, U5H, U5J, U5K, U5L, U5M, U6A, U6B, U6C, U6D, U6E, U6F, U6G, U6H, U6J, U6K, U6L, U6M, U7A, U7B, U7C, U7D, U7E, U7F, U7G, U7H, U7J, U7K, U7L, U7M, U8A, U8B, U8C, U8D, U8E, U8F, U8G, U8H, U8J, U8K, U8L, U8M, U9A, U9B, U9C, U9D, U9E, U9F, U9G, U9H, U9J, U9K, U9L, U9M, S5L, S5K, S5M, S5P, S5R, S5T, S5U, S5X, S8L, S8M, S8P, S8R, S8T, S8U, S8X, S9K, S9P, S9R, S9T, S9U, S9X
Support to Ambulance Staff	A2A, A8E, AEA, AEB, AEC, AED, AEE, AGA, A7A, A7B, A7C, A8A, A8B, A8C, A9C
Consultants (including Directors of Public Health)	101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 140, 141, 142, 145, 146, 147, 148, 151, 152, 153, 154, 155, 156, 161, 162, 163, 164, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 180, 182, 183, 184, 185, 186, 187, 188, 191, 193, 194, 196, 197, 199, 030, 034, 091, 045, 046, 047, 048, 061, 062, 063, 064, 066, 067, 068, 069, 070, 930, 971, 980, 026, 001, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 014, 015, 017, 018, 019, 020, 032, 033, 035, 037, 084, 085, 093, 094, 096, 099, 800, 921, 040, 041, 002, 097, 071, 072, 073, 074, 075, 077, 078, 086, 087, 088, 051, 052, 053, 054, 055, 056, 016, 080, 021, 022, 023, 024, 025, 027, 028, 029, 031, 036, 200, 201, 202, 203, 204, 205, 207, 210, 211, 220, 221, 230, 240, 241, 242, 244, 245, 246, 260, 261, 265, 266, 270, 271, 280, 042, 076, 082, 083
Career/Staff grades	101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 140, 141, 142, 145, 146, 147, 148, 151, 152, 153, 154, 155, 156, 161, 162, 163, 164, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 180, 182, 183, 184, 185, 186, 187, 188, 191, 193, 194, 196, 197, 199, 030, 034, 091, 045, 046, 047, 048, 061, 062, 063, 064, 066, 067, 068, 069, 070, 930, 971, 980, 026, 001, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 014, 015, 017, 018, 019, 020, 032, 033, 035, 037, 084, 085, 093, 094, 096, 099, 800, 921, 040, 041, 002, 097, 071, 072, 073, 074, 075, 077, 078, 086, 087, 088, 051, 052, 053, 054, 055, 056, 016, 080, 021, 022, 023, 024, 025, 027, 028, 029, 031, 036, 200, 201, 202, 203, 204, 205, 207, 210, 211, 220, 221, 230, 240, 241, 242, 244, 245, 246, 260, 261, 265, 266, 270, 271, 280, 042, 076, 082, 083
Trainee grades	101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 140, 141, 142, 145, 146, 147, 148, 151, 152, 153, 154, 155, 156, 161, 162, 163, 164, 166, 167, 168,

	169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 180, 182, 183, 184, 185, 186, 187, 188, 191, 193, 194, 196, 197, 199, 030, 034, 091, 045, 046, 047, 048, 061, 062, 063, 064, 066, 067, 068, 069, 070, 930, 971, 980, 026, 001, 003, 004, 005, 006, 007, 008, 009, 010, 011, 012, 014, 015, 017, 018, 019, 020, 032, 033, 035, 037, 084, 085, 093, 094, 096, 099, 800, 921, 040, 041, 002, 097, 071, 072, 073, 074, 075, 077, 078, 086, 087, 088, 051, 052, 053, 054, 055, 056, 016, 080, 021, 022, 023, 024, 025, 027, 028, 029, 031, 036, 200, 201, 202, 203, 204, 205, 207, 210, 211, 220, 221, 230, 240, 241, 242, 244, 245, 246, 260, 261, 265, 266, 270, 271, 280, 042, 076, 082, 083
NHS Infrastructure support	G0A, G0B, G0C, G0D, G0E, G1A, G1B, G1C, G1D, G1E, G2A, G2B, G3B, H1R, H2R, G2D, G3D, G2C, G3C
Any Others	XXX, Z1A, Z1B, Z1C, Z1D, Z1E, Z2E, Z2F

Medical and Dental Staff Job Roles

Grade	Job Role
Consultants	Associate Postgraduate Dean, Clinical Director, Clinical Director – Dental, Clinical Director – Medical, Consultant, Dental Surgeon acting as Hospital Consultant, Director of Public Health, Medical Director, Professor, Radiographer - Diagnostic, Consultant, Senior Lecturer, General Dental Practitioner, General Dental Practitioner Locum, General Medical Practitioner, General Medical Practitioner Locum, GP Locum, GP Partner/Provider, GP Senior Partner, Salaried Dental Practitioner, Salaried General Practitioner, Vocational Dental practitioner
Career/Staff grades	Associate Specialist, Associate Specialist (Closed to new entrants), Associate Specialist (Closed), Clinical Assistant, Clinical Assistant (Closed to new entrants), Clinical Medical Officer, Clinical Medical Officer (Closed to new entrants), Hospital Practitioner, Hospital Practitioner (Closed to new entrants), Senior Clinical Medical Officer, Senior Clinical Medical Officer (Closed to new entrants), Specialist Dentist, Specialty Doctor, Staff Grade (Closed to new entrants), Staff Grade (Closed), Community Health Services Dental Locum, Community Health Services Medical Locum, Dental Officer, Dental Public Health Locum, 'Other' Community Health Service, Physician Associate, Public Health Medicine Locum, Regional Dental Officer, Senior Dental Officer, Senior Dental Officer (Closed), Special Salary Scale in Public Health Medicine, Trust Grade Doctor - Career Grade level, Trust Grade Doctor - Foundation Level, Trust Grade Doctor - House Officer Level, Trust Grade Doctor - House Officer Level (Closed), Trust Grade Doctor - SHO level, Trust Grade Doctor - SHO Level (Closed), Trust Grade Doctor - Specialist Registrar Level, Trust Grade Doctor - Specialist Registrar Level (Closed), Trust Grade Doctor - Specialty Registrar
Trainee grades	Dental Core Trainee, Foundation Dentist, Foundation Year 1, Foundation Year 2, House Officer - Post Registration, House Officer - Post Registration (Closed), House Officer - Pre Registration, House Officer - Pre Registration (Closed), Medical Student, Registrar, Registrar (Closed), Senior House Officer, Senior House Officer (Closed), Senior Registrar, Senior Registrar (Closed), Specialist Registrar, Specialist Registrar (Closed), Specialty Registrar

Bank and Agency Staff:

Bank and Agency staff should reflect gaps between the substantive staff and total planned workforce.

MONITORING

Monitoring frequency:

Monthly

Monitoring data source:

NHSE/I Monthly workforce returns.

PLANNING REQUIREMENTS

Are plans required and if so, at what frequency?
Yes, monthly for September to March 2020/21 via SDCS.

Appendix A: SUS Methodology

APC and OP activity is restricted to specific acute.
Specific acute replaces what was previously known as general and acute (G&A). The spell treatment function code (TFC) and main specialty (MS) are as at discharge.
Firstly, APC and OP activity is grouped by TFC into the categories:

- TFC Specific Acute (previously G&A)
- TFC Maternity – TFC 501 + 560
- TFC Mental Health & Learning Disabilities – TFC 700 to 727
- TFC Well Babies – TFC 424 only
- TFC Other – largely therapies
- TFC Unknown – data quality inadequate to categorise

The full breakdown of TFCs into the categories is given in the table below.
Additionally, a subset of TFCs classified as other have been excluded for the following reasons:

- They tend to be therapies undertaken in a hospital setting
- A large proportion of the activity is considered to be non-consultant
- They represent a small proportion of the overall total

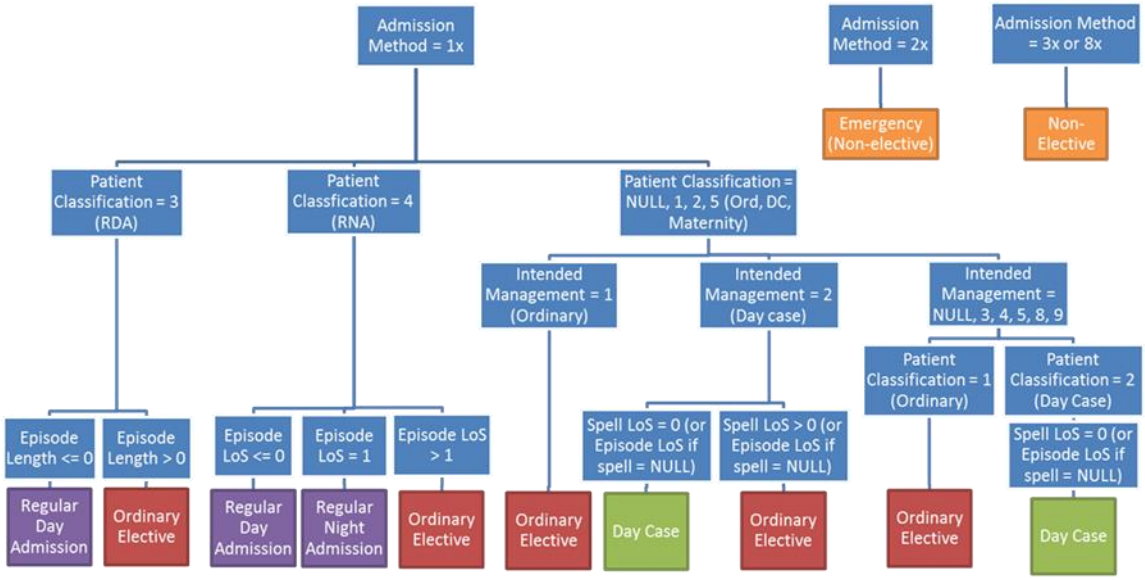
It was also agreed that outpatient activity should be further restricted to consultant led by applying a filter based on main specialty:

- Non-consultant – MS 560 Midwife episode
- Non-consultant – MS 950 Nursing episode
- Non-consultant – MS 960 Allied Health Professional episode
  Consultant – All other MS including not known

A number of additional derivations applied to SUS data are used throughout this annex. For the following derivations, information can be found on the corresponding links.

Der_Attendance_Type:
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/96193/
StaffType
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/111416/
Der_Appointment_Type
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Reporting/column/96072/

For the Der_Management_Type derived field, the following logic is used to identify the appropriate activity type based on the Admission Method, Patient Classification; Intended Management and Length of Stay (i.e. difference between Admission Date and Discharge Date) fields:


Admission Method = 1x
Admission Method = 2x
Admission Method = 3x or 8x
Emergency (Non-elective)
Non-Elective
Patient Classification = 3 (RDA)
Patient Classfication = 4 (RNA)
Patient Classification = NULL, 1, 2, 5 (Ord, DC, Maternity)
Intended Management = 1 (Ordinary)
Intended Management = 2 (Day case)
Intended Management = NULL, 3, 4, 5, 8, 9
Episode Length <= 0
Episode Length > 0
Episode LoS <= 0
Episode LoS = 1
Episode LoS > 1
Spell LoS = 0 (or Episode LoS if spell = NULL)
Spell LoS > 0 (or Episode LoS if spell = NULL)
Patient Classification = 1 (Ordinary)
Patient Classification = 2 (Day Case)
Spell LoS = 0 (or Episode LoS if spell = NULL)
Regular Day Admission
Ordinary Elective
Regular Day Admission
Regular Night Admission
Ordinary Elective
Ordinary Elective
Day Case
Ordinary Elective
Ordinary Elective
Day Case

Code	Description	Grouping
100	General Surgery	Acute
101	Urology	Acute
102	Transplantation Surgery	Acute
103	Breast Surgery	Acute
104	Colorectal Surgery	Acute
105	Hepatobiliary & Pancreatic Surgery	Acute
106	Upper Gastrointestinal Surgery	Acute
107	Vascular Surgery	Acute
108	Spinal Surgery Service	Acute
110	Trauma & Orthopaedics	Acute
120	ENT	Acute
130	Ophthalmology	Acute
140	Oral Surgery	Acute
141	Restorative Dentistry	Acute
142	Paediatric Dentistry	Acute
143	Orthodontics	Acute
144	Maxillo-Facial Surgery	Acute
150	Neurosurgery	Acute
160	Plastic Surgery	Acute
161	Burns Care	Acute
170	Cardiothoracic Surgery	Acute
171	Paediatric Surgery	Acute
172	Cardiac Surgery	Acute
173	Thoracic Surgery	Acute
174	Cardiothoracic Transplantation	Acute
180	Accident & Emergency	Acute
190	Anaesthetics	Acute
191	Pain Management	Acute
192	Critical Care Medicine	Acute
199	Non-UK provider; Treatment Function not known, treatment mainly surgical	Other
211	Paediatric Urology	Acute
212	Paediatric Transplantation Surgery	Acute
213	Paediatric Gastrointestinal Surgery	Acute
214	Paediatric Trauma and Orthopaedics	Acute
215	Paediatric Ear Nose and Throat	Acute
216	Paediatric Ophthalmology	Acute
217	Paediatric Maxillo-Facial Surgery	Acute
218	Paediatric Neurosurgery	Acute
219	Paediatric Plastic Surgery	Acute
220	Paediatric Burns Care	Acute
221	Paediatric Cardiac Surgery	Acute
222	Paediatric Thoracic Surgery	Acute
223	Paediatric Epilepsy	Other
241	Paediatric Pain Management	Acute
242	Paediatric Intensive Care	Acute
251	Paediatric Gastroenterology	Acute

252	Paediatric Endocrinology	Acute
253	Paediatric Clinical Haematology	Acute
254	Paediatric Audiological Medicine	Acute
255	Paediatric Clinical Immunology and Allergy	Acute
256	Paediatric Infectious Diseases	Acute
257	Paediatric Dermatology	Acute
258	Paediatric Respiratory Medicine	Acute
259	Paediatric Nephrology	Acute
260	Paediatric Medical Oncology	Acute
261	Paediatric Metabolic Disease	Acute
262	Paediatric Rheumatology	Acute
263	Paediatric Diabetic Medicine	Acute
264	Paediatric Cystic Fibrosis	Acute
280	Paediatric Interventional Radiology	Acute
290	Community Paediatrics	Other
291	Paediatric Neuro-Disability	Other
300	General Medicine	Acute
301	Gastroenterology	Acute
302	Endocrinology	Acute
303	Clinical Haematology	Acute
304	Clinical Physiology	Acute
305	Clinical Pharmacology	Acute
306	Hepatology	Acute
307	Diabetic Medicine	Acute
308	Blood and Marrow Transplantation	Acute
309	Haemophilia	Acute
310	Audiological Medicine	Acute
311	Clinical Genetics	Acute
313	Clinical Immunology and Allergy	Acute
314	Rehabilitation	Acute
315	Palliative Medicine	Acute
316	Clinical Immunology	Acute
317	Allergy	Acute
318	Intermediate Care	Acute
319	Respite Care	Acute
320	Cardiology	Acute
321	Paediatric Cardiology	Acute
322	Clinical Microbiology	Acute
323	Spinal Injuries	Acute
324	Anticoagulant Service	Acute
325	Sport and Exercise Medicine	Acute
327	Cardiac Rehabilitation	Acute
328	Stroke Medicine	Acute
329	Transient Ischaemic Attack	Acute
330	Dermatology	Acute
331	Congenital Heart Disease Service	Other
340	Thoracic Medicine	Acute
341	Respiratory Physiology	Acute

342	Programmed Pulmonary Rehabilitation	Acute
343	Adult Cystic Fibrosis	Acute
344	Complex Specialised Rehabilitation Service	Other
345	Specialist Rehabilitation Service	Other
346	Local Specialist Rehabilitation Service	Other
350	Infectious Diseases	Acute
352	Tropical Medicine	Acute
360	Genitourinary Medicine	Other
361	Nephrology	Acute
370	Medical Oncology	Acute
371	Nuclear Medicine	Acute
400	Neurology	Acute
401	Clinical Neurophysiology	Acute
410	Rheumatology	Acute
420	Paediatrics	Acute
421	Paediatric Neurology	Acute
422	Neonatology	Acute
424	Well Babies	Well Babies
430	Geriatric Medicine	Acute
450	Dental Medicine Specialties	Acute
460	Medical Ophthalmology	Acute
499	Non-UK provider; Treatment Function not known, treatment mainly medical	Other
501	Obstetrics	Maternity
502	Gynaecology	Acute
503	Gynaecological Oncology	Acute
560	Midwife Episode	Maternity
650	Physiotherapy	Other
651	Occupational Therapy	Other
652	Speech and Language Therapy	Other
653	Podiatry	Other
654	Dietetics	Other
655	Orthoptics	Other
656	Clinical Psychology	Other
657	Prosthetics	Other
658	Orthotics	Other
659	Drama Therapy	Other
660	Art Therapy	Other
661	Music Therapy	Other
662	Optometry	Other
663	Podiatric Surgery	Acute
700	Learning Disability	MH and LD
710	Adult Mental Illness	MH and LD
711	Child and Adolescent Psychiatry	MH and LD
712	Forensic Psychiatry	MH and LD
713	Psychotherapy	MH and LD
715	Old Age Psychiatry	MH and LD
720	Eating Disorders	MH and LD

721	Addiction Services	MH and LD
722	Liaison Psychiatry	MH and LD
723	Psychiatric Intensive Care	MH and LD
724	Perinatal Psychiatry	MH and LD
725	Mental Health Recovery and Rehabilitation Service	MH and LD
726	Mental Health Dual Diagnosis Service	MH and LD
727	Dementia Assessment Service	MH and LD
800	Clinical Oncology (Previously Radiotherapy)	Acute
811	Interventional Radiology	Acute
812	Diagnostic Imaging	Acute
822	Chemical Pathology	Acute
834	Medical Virology	Acute
840	Audiology	Other
920	Diabetic Education Service	Other