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2021/22 priorities and operational planning guidance: October 2021 – March 2022

Activity, performance and workforce technical definitions

Version 3, 18 October 2021

updates from previous versions are highlighted throughout the document

Contents

Summary

The purpose of this technical definitions document is to describe the indicators set out in the submission guidance. It sets out definitions, monitoring, accountability and planning requirements for each measure, covering activity, performance and workforce. Please see the accompanying documentation for further detail on the requirements for the finance collection.

Please direct any technical queries to: England.nhs-planning@nhs.net

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

Version Number	Date	Details of change
V1	30 September 2021	Initial Version
V2	06 October 2021	The treatment function table in appendix A has been extended to include treatment functions which were added to the NHS data dictionary in April 2021, additional rows are highlighted. The granularity of plans for some measures (marked with *) has been updated.
V3	18 October 2021	E.B.27- Faster Diagnosis Standard (page 34) has been removed.
V3	18 October 2021	The granularity of plans for E.B.32- Backlog (page 37) has been updated and highlighted.
V3	18 October 2021	The method of assigning the month of the activity for elective ordinary and non-elective admissions has been clarified.

Outpatients

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.8 Consultant-led first outpatient attendances (Specific Acute)

E.M.9 Consultant-led follow-up outpatient attendances (Specific Acute)

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’ – ie main specialty is not ‘560’, ‘950’ or ‘960’

Treatment function maps to Specific Acute (for E.M.8 and E.M.9)

Note: Treatment function 812 (Diagnostic Imaging) should be EXCLUDED.

Additionally, providers should not include the delivery of COVID vaccinations in the Outpatient Commissioning Data Set to SUS+ and should not include that activity in their operational plans.

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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

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

Note: The pre-populated figures included in the template are based on 2021/22 rules, plans should also be based on these rules: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-2021-22-operational-tool

E.M.32: Total outpatient attendances

Definitions

Detailed descriptor: All outpatient attendances (all TFC, consultant and non-consultant led).

Lines within indicator (units)

- E.M.32 Total outpatient attendances (all TFC; consultant and non-consultant led)
- E.M.32c Outpatient attendances (all TFC; consultant and non-consultant led) – First attendance face to face
- E.M.32d Outpatient attendances (all TFC; consultant and non-consultant led) – Follow-up attendance face to face
- E.M.32e Outpatient attendances (all TFC; consultant and non-consultant led) – First telephone or video consultation
- E.M.32f Outpatient attendances (all TFC; consultant and non-consultant led) – Follow-up telephone or video consultation

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.

Specifically, the number of outpatient attendances for which:

Der_Attendance_Type = ‘Attend’

StaffType = ‘All

Treatment function – All

Face to face and telephone/virtual will be determined by the coding of FIRST ATTENDANCE CODE.

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

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

Note: Treatment function 812 (Diagnostic Imaging) should be EXCLUDED.

Providers should not include the delivery of COVID vaccinations in the Outpatient Commissioning Data Set to SUS+ and should not include that activity in their operational plans.

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

Frequency of plans: Monthly.

Granularity of plans*: NHS acute providers and ICS.

E.M.33: Number of requests for specialist advice

Definitions

Detailed descriptor: Requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage approaches, that facilitate the seeking and/or provision of specialist advice prior to, or instead of, a referral to secondary care.

* v2 update, v1 read NHS acute providers and CCGs

Where that advice is expected to support a referrer to manage a patient without the need for an unnecessary outpatient appointment.

Lines within indicator (units):

E.M.33 Number of requests for specialist advice, including advice and guidance (A&G) or equivalent via other triage approaches

E.M.33a Number of requests for pre referral specialist advice (including Advice & Guidance models)

E.M.33b Number of requests for post referral specialist advice (including referral triage models)

Data definition: A count of all first requests raised for specialist advice within the period. Where there is a record of clinical dialogue that facilitated the seeking and/or provision of specialist advice prior to, or instead of, a referral to secondary care. Where that advice was expected to support a referrer to manage a patient without the need for an unnecessary outpatient appointment. As defined in the guidance for the System Elective Recovery Outpatient Collection (EROC).

Submissions should represent a co-ordinated, aggregate position across an integrated care system (ICS). Submissions should only include activity where the first request was raised by an organisation within the ICS; however, this may include requests directed to organisations beyond the ICS.

For E.M.33a and E.M.33b, please breakdown the E.M.33 figure by type of referral optimisation interaction as shown in the table below.

Line	EROC type of referral optimisation interaction	Data definition
E.M.33a Number of requests for pre referral specialist advice	Specialist advice	Specialist advice to support a clinical dialogue, enabling a referring clinician to seek advice from a specialist prior to, or instead of, referral about a named patient. This can be: • synchronous, eg a telephone call, or • asynchronous, enabled electronically through: o the NHS e-Referral Service (e-RS) Advice & Guidance channel o other IT platforms or dedicated email addresses where all stakeholders agree that these will be used to leverage Advice & Guidance. Specialist advice may be provided by appropriately trained and commissioned specialists including both consultant and non-consultant led services in secondary care community or primary care providers, interface or intermediate services, and referral management systems. This will typically be accessed via a digital communication channel and facilitate a two-way dialogue and sharing of relevant clinical information in relation to the management of a named patient where at the outset of the interaction there is no clear intention to refer to secondary care. This is non face-to-face activity, with no referral or booking having yet been made, and as such there has been no RTT Clock Start.
E.M.33b Number of requests for post referral specialist advice	Referral triage providing specialist advice	Specialist-led assessment of a patient's clinical referral information to support a decision on primary care management or the most appropriate onward clinical pathway. Referrals may be returned to the original referrer with advice to continue to manage in the community, similar to specialist advice, but differing as a referral will have been created with the implicit expectation that onward care would be managed by the service receiving the referral. Referral triage can be undertaken by secondary care providers through referral assessment services (RAS) via e-RS, clinical assessment and triage services (CATS) and referral management centres (RMCs) providing intermediary levels of clinical triage, assessment and treatment between traditional primary and secondary care, or within primary care providers. This is non face-to-face activity, but as a referral has been made there has been a RTT Clock Start. However, no booking or ASI in lieu of a booking will have been made, and the episode/ patient is not automatically registered on the provider PTL.

Monitoring

Monitoring frequency: Monthly from Q3 2021/22.

Monitoring data source: Submissions to the System Elective Recovery Outpatient Collection including breakdown by [Type of Referral Optimisation Interaction].

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: ICS only.

E.M.34: Number of episodes moved or discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance

Definitions

Detailed descriptor: Sum of the following, in line with the definitions for the Provider Elective Recovery Outpatient Collection (EROC).

Number of episodes moved to patient initiated outpatient follow-up pathway as an outcome of their attendance	The patient is moved to a patient initiated outpatient follow-up (PIFU) pathway but is not discharged. This model would normally be used when there is the expectation that the patient may need to be seen again, or if a clinical or administrative activity would need to take place at their personalised follow-up pathway review date. This model may more commonly be used for patients who are on a longer-term pathway of care and may sometimes be called an 'open appointment' model. Note: If a patient has the option of initiating an appointment but is also given a timed appointment, this should still be captured here. *In version 6.3 of the CDS, additional codes will be added to the OUTCOME OF ATTENDANCE CODE (which will be renamed 'OUTPATIENT ATTENDANCE OUTCOME') to account for personalised follow-up outcomes, including PIFU and remote monitoring.*

Number of episodes discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance	The patient is discharged at the same time as they are moved to a patient initiated outpatient follow-up pathway. This model would normally be used when there is the expectation that the patient is unlikely to need to be seen again, and that no clinical or administrative activity would need to take place at their personalised follow-up pathway review date. This model may be more commonly used in surgical pathways and may sometimes be called an 'SOS' or 'see on symptom' model. *In version 6.3 of the CDS, additional codes will be added to the OUTCOME OF ATTENDANCE CODE (which will be renamed 'OUTPATIENT ATTENDANCE OUTCOME') to account for personalised follow-up outcomes, including PIFU and remote monitoring.*

The inclusion of both moved and discharged is to reflect that established providers of PIFU are taking both administrative approaches to manage their patients on a PIFU pathway. For example, a 'discharged to PIFU' model is often used for patients following surgery, while a 'moved to PIFU' model is often used for patients managing long-term conditions.

Lines within indicator (units)

E.M.34 Number of episodes moved or discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance

Data definition: A count of the number of outpatient attendances that resulted in a patient being moved or discharged to a formal patient initiated follow-up pathway.

Monitoring

Monitoring frequency: Monthly from Q3 2021/22.

Monitoring data source: Submissions to the Provider EROC of monthly figures for:

Number of episodes moved to patient initiated outpatient follow-up pathway as an outcome of their attendance.

Number of episodes discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance.

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and ICSs.

Elective

E.M.10, E.M.35 and E.M.36: 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 (auto-calculated sum of E.M.10a and E.M.10b)

E.M.10a Total number of specific acute elective day case spells in the period

E.M.10c – of which children under 18 years of age

E.M.10b Total number of specific acute elective ordinary spells in the period

E.M.10d – of which children under 18 years of age

Also being collected for the first time in this planning collection are the following measures:

E.M.35 Total number of day case spells in the period by treatment function code:

E.M.35a Neurosurgery – Day Case (TFC 150)

E.M.35b Cardiology – Day Case (TFC 320)

E.M.35c Cardiac Surgery – Day Case (TFC 172)

E.M.35d Vascular Surgery – Day Case (TFC 107)

E.M.35e Neurology – Day Case (TFC 400)

E.M.35f Solid organ transplant – Day Case (TFC 102 or 174)

E.M.36 Total number of ordinary spells in the period by treatment function code:

E.M.36a Neurosurgery – Ordinary (TFC 150)

E.M.36b Cardiology – Ordinary (TFC 320)

E.M.36c Cardiac surgery – Ordinary (TFC 172)

E.M.36d Vascular surgery – Ordinary (TFC 107)

E.M.36e Neurology – Ordinary (TFC 400)

E.M.36f Solid organ transplant – Ordinary (TFC 102 or 174)

For these measures please follow the definition for day case/ordinary but filtered to the stated TFC only.

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 healthcare 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 (eg 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.

Note that the activity should be reported against the month in which the spell ends, i.e. discharge date.

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.

The two 'of which: children under the age of 18' elements should be determined by age at the time of admission.

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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs (E.M.35 and E.M.36 are required for providers only).

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

Note: The pre-populated figures included in the template are based on 2021/22 rules. Plans should also be based on these rules: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-2021-22-operational-tool

E.M.18: RTT completed admitted pathways

Definitions

Detailed descriptor: The number of completed admitted Referral to Treatment (RTT) pathways. Admitted pathways are RTT pathways that end in a clock stop for admission (day case or inpatient). The volume of completed admitted pathways is often referred to as RTT admitted activity.

Lines within indicator (units): The number of completed admitted RTT pathways in the reporting period.

Data definition: The number of completed admitted 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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

E.M.19: RTT completed non-admitted pathways

Definitions

Detailed descriptor: The number of completed non-admitted Referral to Treatment (RTT) pathways. Non-admitted pathways are RTT pathways that end in a clock stop for reasons other than an inpatient or day case admission for treatment; for example, treatment as an outpatient, or other reasons such as a patient declining treatment. The volume of completed non-admitted pathways is often referred to as RTT non-admitted activity.

Lines within indicator (units): The number of completed non-admitted RTT pathways in the reporting period.

Data definition: The number of completed non-admitted 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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

E.M.20: New RTT pathways (clock starts)

Definitions

Detailed descriptor: The number of new RTT periods: in other words, RTT pathways where the clock start date is within the reporting period. This will include those periods where the clock also stopped within the reporting period.

Lines within indicator (units): The number of new RTT pathways in the reporting period.

Data definition: The number of new 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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly**.**

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

E.B.3a: RTT waiting list

Definitions

Detailed descriptor: The number of incomplete Referral to Treatment (RTT) pathways.

Lines within indicator (units): The number of incomplete RTT pathways (patients waiting to start treatment) at the end of the reporting period.

Data definition: The number of 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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly**.**

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

E.B.19: Number of 104+ Week RTT waits

Definitions

Detailed descriptor: The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 104 weeks or more.

Lines within indicator (units): The number of incomplete RTT pathways (patients waiting to start treatment) of 104 weeks or more at the end of the reporting period.

Data definition: The number of 104+ 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 webpage.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Consultant-led RTT waiting times data collection (National Statistics).

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

Providers that are currently not able to report monthly RTT data should be excluded from ICS plans (both provider and CCG breakdowns).

Non-elective activity

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 (auto-calculated 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 days

E.M.11b: Number of specific acute non-elective spells in the period with a length of stay of one or more days (auto-calculated 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 one or more days (COVID)

E.M.11d: Number of specific acute non-elective spells in the period with a length of stay of one or more days (Non-COVID)

Data definition: A non-elective admission is one that has not been arranged in advance. A specific acute non-elective admissions may be an emergency admission or a transfer from a hospital bed in another healthcare provider other than in an emergency

Note that the activity should be reported against the month in which the spell ends, i.e. discharge date.

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 (ie 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 & 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

Frequency of plans

Monthly.

Granularity of plans

NHS acute providers and CCGs.

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

Note: The pre-populated figures included in the template are based on 2021/22 rules. Plans should also be based on these rules: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-2021-22-operational-tool

Urgent and emergency care

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 (auto-calculated 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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

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

Note: The pre-populated figures included in the template are based on 2021/22 rules. Plans should also be based on these rules: https://digital.nhs.uk/services/national-casemix-office/downloads-groupers-and-tools/prescribed-specialised-services-2021-22-operational-tool

E.B.22: Ambulances – count of incidents by category

Definitions

Detailed descriptor: Incidents comprise not only calls that receive a face-to-face response from the ambulance service at the scene of the incident, but also calls that are successfully resolved with telephone advice with any appropriate action agreed with the patient.

Lines within indicator (units)

C1 incidents (A8) The count of incidents coded as C1 that received a response on scene.

C1T incidents (A9) The count of C1 incidents where any patients were transported by an ambulance service emergency vehicle.

Do not include incidents where an ambulance clinician on scene determines that no conveyance is necessary, or incidents with non-emergency conveyance. This is a subset of C1 incidents.

C2 incidents (A10) The count of incidents coded as C2 that received a response on scene.

C3 incidents (A11) The count of incidents coded as C3 that received a response on scene.

C4 incidents (A12) The count of incidents coded as C4 that received a response on scene.

All incidents (A7) The count of all incidents. This includes C1–C4 plus incidents referred from healthcare professionals and incidents that do not result in face-to-face contact.

Data definition: Reference codes A7–A12 correspond with NHS England and NHS Improvement's ambulance quality indicator guidance.

MONITORING

Monitoring frequency: Monthly.

Monitoring data source: NHS England and NHS Improvement ambulance quality indicators. Further information on data available to support this metric can be found on the ambulance quality indicators webpage.

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS ambulance providers.

E.M.28: NHS 111 referrals to SDEC (as an alternative to ED)

Definitions

Lines within indicator (units)

Numerator: Number of calls where the caller was referred into an SDEC service

Denominator: The number of calls where an SDEC service was an option for referral:

- of the number of calls with a disposition that requires attendance at a same day emergency care (E05) service, how many were SDEC selected
- all referrals where SDEC service type selected including DX022 has been reached and what service has been referred to
- all referrals not utilising DoS should also be included in the numerator and denominator for all SDEC service selections for referral.

This data collection covers both NHS 111 and CAS settings, along with the clinicians within these, and as such it should be assumed that all data items relate to both settings unless otherwise stated.

Calls from healthcare professionals (HCPs) into CAS from numbers other than NHS 111 (eg from a phone line dedicated exclusively for that purpose) should be included. No patient contacts other than those via NHS 111 should be included within this collection.

All data items provided should exclude NHS 111 online generated activity.

All data items provided should exclude activity generated by an ITK message, received by the IUC provider from outside the IUC service, which subsequently led to an HCP call back, with the exception of D19.

Some data items may not be relevant to all providers.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Management Information System.

Rationale: This will measure whether patients have a referral arranged by the IUC service at a SDEC service.

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: Clinical commissioning group.

Demand and capacity

E.M.26a: Overnight general and acute beds available and occupied.

Definitions

Detailed descriptor: The percentage of general and acute (G&A) overnight beds that are occupied, as an average over a monthly period. This uses the UEC daily sitrep definition of a general and acute bed open or occupied as at 8am each day, which should be consistent with relevant definitions from the KH03 beds return; these can be found here: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

They exclude maternity and mental health beds.

- Total G&A **overnight** beds open:
  - of the open beds, how many will be operationally separate for elective patients only and **cannot be used** for any other purpose, ie to bed urgent care patients at times of extreme pressure.
- Total G&A **overnight** beds occupied.

General and acute beds open

The number of general and acute bed beds available on the day of reporting.

This should include core bed stock including beds that are closed but occupied. Beds that are closed and empty should be subtracted from the core bed stock number.

For example: if 10 beds are closed for infection control of which six are occupied and four empty, exclude the four empty beds.

It should include areas opened for winter periods, which are intended to stay open for some time – ie not areas which are opened on the day to resolve extreme pressures (eg theatre space).

Lines within indicator (units)

Numerator: Average number of G&A overnight beds occupied.

Denominator: Average number of G&A overnight beds open.

Additional: Of the open beds, how many will be operationally separate for elective patients only and **cannot be used** for any other purpose, ie to bed urgent care patients at times of extreme pressure.

Data definition:

> **Numerator:** The average number of occupied G&A overnight beds across the month using the UEC daily sitrep definition as at 8am each day.
>
> **Denominator:** The average number of available G&A overnight beds across the month using the UEC daily sitrep definition as at 8am each day.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Daily UEC sitrep, aggregated over a month. Further information on data available to support this metric can be found on the urgent and emergency care daily situation reports landing page.

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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers.

E.M.26c: Day general and acute beds open

Definitions

Detailed descriptor: The number of general and acute (G&A) day beds that are open, as an average over a monthly period. This uses the UEC daily sitrep definition of a general and acute bed open or occupied as at 8am each day which should be consistent with relevant definitions from the KH03 beds return; these can be found here: https://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/

They exclude maternity and mental health beds.

- Total G&A **day** beds open:
  - Of the open beds, how many will be operationally separate for elective patients only and **cannot be used** for any other purpose, ie to bed urgent care patients at times of extreme pressure.

For wards open day only, an occupied bed day is defined as a bed in which the treatment or care of at least one patient has taken place during the day. If more than one patient has occupied a bed during the same day, this should be reported as only one bed day.

General and acute beds open

The number of general and acute bed beds available on the day of reporting.

This should include core bed stock including beds that are closed but occupied. Beds that are closed and empty should be subtracted from the core bed stock number.

For example: if 10 beds are closed for infection control of which six are occupied and four empty, exclude the four empty beds.

It should include areas opened for winter periods, which are intended to stay open for some time – ie not areas which are opened on the day to resolve extreme pressures (eg theatre space).

Lines within indicator (units)

Average number of G&A day beds open.

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

Additional: Of the open beds, how many will be operationally separate for elective patients only and **cannot be used** for any other purpose, ie to bed urgent care patients at times of extreme pressure.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Daily UEC sitrep, aggregated over a month. Further information on data available to support this metric can be found on the urgent and emergency care daily situation reports landing page.

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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers.

E.M.26b: Adult critical care bed occupancy

Definitions

Detailed descriptor: The percentage of adult critical care (ACC) beds that are occupied, as an average over a monthly period. This uses the UEC daily sitrep definition of adult critical care beds open or occupied as at 8am each day.

Adult critical care beds: count all adult critical care (ITU, HDU or other) beds that are available for critical care patients (levels 2 and 3). Note that this should be the actual number of beds at that time and not the planned number of beds. Beds funded but not available due to staff vacancies should not be counted unless the vacancies have been filled by bank or agency staff. Beds that are not funded but are occupied should be counted.

The following counts should be consistent with those provided for the monthly sitrep return. Guidance can be found here: https://www.england.nhs.uk/statistics/statistical-work-areas/critical-care-capacity/

Lines within indicator (units)

Numerator: Average number of occupied ACC beds.

Denominator: Average number of open ACC beds.

Data definition:

> **Numerator:** The average number of occupied ACC beds across the month using the UEC daily sitrep definition as at 8am each day.

Denominator: The average number of open ACC beds across the month using the UEC daily sitrep definition as at 8am each day.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Daily UEC sitrep, aggregated over a month. Further information on data available to support this metric can be found on the urgent and emergency care daily situation reports webpage.

Rationale: Critical care bed occupancy is a key indicator in highlighting pressures within a care system. High levels of occupancy in critical care would mean less resource elsewhere in the system to deliver quality care for patients.

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers.

Diagnostics

E.B.26: Diagnostic test activity

Definitions

Detailed descriptor: The number of diagnostic tests or procedures carried out in the period.

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.

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
- E.B.26g – Cardiology – echocardiography

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.

This should include planned, unplanned and waiting list tests, but does not include screening.

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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

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Cancer

E.B.30: Urgent cancer referrals

Definitions

Detailed descriptor: Urgent referrals – numbers of patients seen in a first outpatient appointment following urgent referrals.

Lines within indicator (units)

Count: All patients urgently referred with suspected cancer by any source of referral excluding from a national screening programme 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 Data Set (NCWTMDS) specified to the NHS in the relevant information standard – Amd 16/2019

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 16/2019, 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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

E.B.31: Cancer treatment volumes

Definitions

Detailed descriptor: Cancer 31-day treatments.

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

Lines within indicator (units)

Count: 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 16/2019.

An interactive copy of the NCWTMDS definitions, including the changes specified in Amd 16/2019, 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

Frequency of plans: Monthly.

Granularity of plans: NHS acute providers and CCGs.

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 or more after an urgent suspected cancer referral excluding non-site specific symptoms.

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 or more after an urgent suspected cancer referral excluding non site-specific symptoms at the end of the reporting period.

Data definition: Based on the weekly cancer PTL – 62-day standard sum of:

Section 1.1 Urgent suspected cancer (excluding non site-specific symptoms): 62-day PTL – Patients without a decision to treat: Day 63-104 + Day >104

and

Section 2.1 Urgent suspected cancer (excluding non site-specific symptoms): 62-day PTL – Patients with a decision to treat: Day 63-104 + Day >104

The definitions that apply for the cancer 62-day PTL, as well as guidance on recording and reporting 62-day data, can be found at: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancer-62-day-patient-target-list-canptl62

Monitoring

Monitoring frequency: Weekly data.

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

Planning requirements

Frequency of plans: Monthly (month end position).

Granularity of plans*: NHS acute providers.

* V3 update, v2 read NHS acute providers and CCGs.

Learning disabilities and autism

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

Definitions

Detailed descriptor: As part of strategic planning for the NHS Long Term Plan, CCGs were asked to set annual plans for **adult** inpatients (both CCG and specialised commissioned) from 2020/21 through to 2023/24. Quarterly plans for 2021/22 are now required.

TCPs were asked to set annual plans for **U18** inpatients through to 2023/24 as part of the strategic planning for the NHS Long Term Plan. Quarterly plans for under 18s 2021/22 are now required on an ICS footprint.

Adult inpatients

CCGs are required to set separate plans for 2021/22 for:

- The number of adults aged 18 and over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder and whose bed is **commissioned by a CCG**.
- The number of adults aged 18 or over from the CCG who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder and whose bed is **commissioned by NHS England or via a provider collaborative**.

A reduction in the number of inpatients in each quarter of 2021/22 is expected.

Under 18 inpatients

Planning for under 18s for 2021/22 will be on a ICS footprint rather than a TCP footprint as in previous years.

ICSs are required to set plans for 2021/22 for:

- The number of children under 18 from the ICS who are autistic, have a learning disability or both and who are in inpatient care for a mental disorder and whose bed is **commissioned by NHS England or via a provider collaborative**.

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 the treatment of a mental disorder and has a learning disability and/or is autistic (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 are autistic, have a learning disability or both and who are in inpatient care for treatment of a mental disorder, 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 are autistic, have a learning disability or both and who are in inpatient care for the treatment of a mental disorder, and whose bed is commissioned by NHS England or via a provider collaborative. 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 ICS who are autistic, have a learning disability or both and are in inpatient care for the treatment of a mental disorder and whose bed is commissioned by NHS England or via a provider collaborative.

The population denominators will be provided.

Data definition: The in-scope definition includes all adults and children who are autistic, have a learning disability or both and are in inpatient care for the treatment of a mental disorder. 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

Frequency of plans: Quarterly.

Granularity of plans: E.K.1a and b at CCG level, E.K.1c at ICS level.

E.K.3: Learning disability registers and annual health checks delivered by GPs

Detailed descriptor: The NHS Long Term Plan sets out actions to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people. As part of this there is a commitment to improve uptake of the existing annual health checks in primary care for people with a learning disability.

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

CCGs are expected to do two things:

- ensure people already on GP Learning Disability Registers are offered an AHC

- increase the numbers of people on their GP Learning Disability Registers and ensure these additional patients are offered an AHC.

CCGs are required to set separate plans for 2021/22 for:

- The number of people on GP Learning Disability Registers who will receive an AHC during the quarter.

Note: Plans should be set for the number of checks to be completed in each individual quarter – the quarterly plans should NOT be cumulative.

Note: Among CCGs, there is currently considerable variation in the percentage of the GP registered population who are on the GP Learning Disability Register.[*]This suggests that register coverage of people with a learning disability is better in some CCGs than others.

Nationally, 0.51% of the GP registered population is on the Learning Disability Register. It has been estimated around 2.5% of the population in England has a learning disability.

Lines within indicator (units)

Number of AHCs carried out for persons aged 14+ on GP Learning Disability Registers in the period.

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 AHC

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

[1] Data at CCG level on the GP registered populations and the numbers of patients on the Learning Disability Register are available from NHS Digital.

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 AHC.

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 AHC.

Planning requirements

Frequency of plans: Quarterly

Granularity of plans: CCG level only

Primary care

E.D.19: Appointments in general practice

Definitions

Detailed descriptor: Planned number of general practice appointments.

Lines within indicator (units): Planned total number of appointments

Data definition: NHS Digital has been collecting data from general practice appointment systems and publishing it, collated by CCG area, since 2018. This published data provides a picture of general practice appointments. It includes details such as the number of appointments, the healthcare professional carrying them out and, where possible, the mode of delivery, eg face to face or telephone. Only appointments with a status of 'Booked, Attended or Did Not Attend' are included in the appointment total. Cancelled appointments are typically reallocated to other patients and so are not included in the total to avoid double counting. The total therefore should represent the number of appointments that took place, including DNAs, rather than those that were offered.

In August 2020, further guidance was issued setting out an agreed definition of an appointment, to ensure all appointments are being recorded in general practice appointment books and to fully capture the scale of work and workload in general practice. Plans should also include appointments to cover supporting the COVID-19 vaccination programme.

Monitoring

Monitoring frequency: Monthly.

Monitoring data source: Appointments in general practice collection published by NHS Digital. The data can be found here along with the data quality note.

Rationale: In response to a request from the Secretary of State to support general practice with more accurate information, NHS Digital has worked with professional representatives, system suppliers and NHS England and NHS Improvement to collect and collate data from the appointment systems held in general practice. The aim of

the publication is to inform users about activity and usage of GP appointments historically and how primary care is impacted by seasonal pressures, such as winter.

A programme of work is currently underway to increase the quality and completeness of this data. There is an enhanced data collection in place and functionality has been rolled out to system suppliers to introduce national category mapping. There is significant political interest in this area given the 50m manifesto commitment.

Planning requirements

Frequency of plans: Monthly.

Granularity of plans: CCG level only.

Workforce: acute, ambulance, community and mental health

Definitions

By organisation within the system, the whole time equivalent (WTE) forecast of staff, broken down by:

- substantive
- bank
- agency.

Throughout financial year 2021/22, by quarter. Additionally, the funded WTE establishment of substantive staff required for delivery of the service as at year end 2020/21 and year beginning 2021/22.

Establishment: The **total** budgeted for and funded WTE requirement as per the end of 2020/21 and beginning of 2021/22 identified within the organisation as required for delivery of the overall provision of service.

Substantive staff: Substantive staff WTE forecast based on WTEs who will **work within the organisation**. This should be defined as the usual organisation of work and the organisation held against the position, where the work itself physically takes place.

Substantive staff should include/exclude employees with the following ESR assignment status.

Include	Exclude
Active assignment Acting up Internal secondment Maternity	Out on external secondment – unpaid Inactive not worked Suspend no pay Career break Out on external secondment – paid Suspend with pay Assignment costing deletion

Substantive staff should include/exclude the following type of contracts:

Include	Exclude
Retainer scheme Fixed-term temp Non-exec director/chair Permanent Prof exec committee Locum	Bank Honorary Widow/widower

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

Professional group	Staff codes
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
Healthcare 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

Professional group	Staff codes
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, S8J, S9A, S9B, S9C, S9D, S9E, S9F, S9G, S9H, S9J, S5I, S9I, H1G, H1H, H1J, H1L, H2G, H2H, H2J, H2L
Support to STT and 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

Professional group	Staff codes
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

The forecast WTE utilisation required of Bank and Agency staff planned to address the shortfall between funded establishment and forecast substantive supply and/or other operational needs.

Monitoring

Monitoring frequency: Quarterly.

Monitoring data source: ESR.

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.

First, 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.

Note: For the current planning round there is an additional Total Outpatient measure which is not restricted to consultant-led/specific acute – please see E.M.28 for further details.

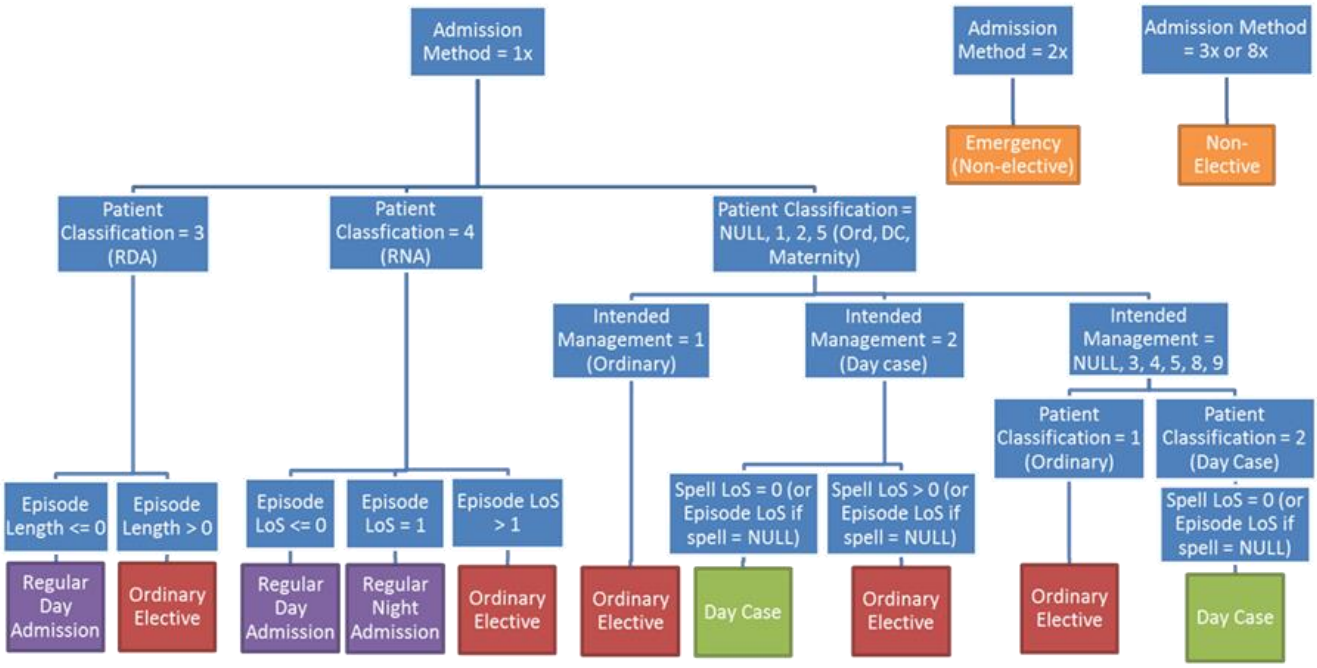
A number of additional derivations applied to SUS data are used throughout this appendix. For the following derivations, information can be found on the corresponding links.

Der_Attendance_Type:
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Live/column/338207/

Der_Staff_Type:
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Live/column/369604/

Der_Appointment_Type:
https://data.england.nhs.uk/ncdr/database/NHSE_SUSPlus_Live/column/337902/

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 (ie difference between admission date and discharge date) fields:



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
109	Bariatric Surgery Service	Acute
110	Trauma & Orthopaedics	Acute
111	Orthopaedic Service	Acute
113	Endocrine Surgery Service	Acute
115	Trauma Surgery Service	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
145	Oral and Maxillofacial Surgery Service	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
200	Aviation and Space Medicine Service	Acute
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

Code	Description	Grouping
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
230	Paediatric Clinical Pharmacology Service	Acute
240	Paediatric Palliative Medicine Service	Acute
241	Paediatric Pain Management	Acute
242	Paediatric Intensive Care	Acute
250	Paediatric Hepatology Service	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
270	Paediatric Emergency Medicine Service	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

Code	Description	Grouping
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
326	Acute Internal Medicine Service	Acute
327	Cardiac Rehabilitation	Acute
328	Stroke Medicine	Acute
329	Transient Ischaemic Attack	Acute
330	Dermatology	Acute
331	Congenital Heart Disease Service	Other
333	Rare Disease Service	Acute
335	Inherited Metabolic Medicine Service	Acute
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
347	Sleep Medicine Service	Acute
348	Post-COVID-19 Syndrome Service	Acute
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

Code	Description	Grouping
431	Orthogeriatric Medicine Service	Acute
450	Dental Medicine Specialties	Acute
451	Special Care Dentistry Service	Acute
460	Medical Ophthalmology	Acute
461	Ophthalmic and Vision Science Service	Acute
499	Non-UK provider; Treatment Function not known, treatment mainly medical	Other
501	Obstetrics	Maternity
502	Gynaecology	Acute
503	Gynaecological Oncology	Acute
504	Community Sexual and Reproductive Health Service	Other
505	Fetal Medicine Service	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
670	Urological Physiology Service	Acute
673	Vascular Physiology Service	Acute
675	Cardiac Physiology Service	Acute
677	Gastrointestinal Physiology Service	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

Code	Description	Grouping
726	Mental Health Dual Diagnosis Service	MH and LD
727	Dementia Assessment Service	MH and LD
730	Neuropsychiatry 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

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This publication can be made available in a number of other formats on request.

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